Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, April 10, 2019, 6:00-8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

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

AGENDA

1.	**Introduction**	Dr. Paul	6:00	5 min
2.	**Meeting Minutes** Review meeting minutes of the February 13, 2019 Quality Improvement Committee. **Possible Action:** Approve February 13, 2019 Quality Improvement Committee Minutes	Dr. Paul	6:05	5 min
3.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Quality Improvement Committee reserves the right to limit the duration of public comment period to 30 minutes.	Dr. Paul	6:10	5 min
4.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:15	5 min
5.	**Action Items**		6:20	45 min
a.	**Review of Quality Improvement Program Evaluation 2018** Annual review of the Quality Improvement Program Evaluation 2018 **Possible Action:** Approve the Quality Improvement Program Evaluation 2018	Ms. Liu		
b.	**Review of Quality Improvement Work Plan 2019** Annual review of the Quality Improvement Work Plan 2019 **Possible Action:** Approve the Quality Improvement Work Plan 2019	Ms. Chang		
c.	**Review of Population Health Assessment 2019** Annual review of the Population Health Assessment 2019 **Possible Action:** Approve Population Health Assessment 2019	Ms. Shah		
d.	**Review of Experience with Complex Case Management Report 2019** Annual review of Experience with Complex Case Management Report 2019 **Possible Action:** Approve Experience with Complex Case Management Report 2019	Ms. Carlson		
e.	**Review of Quality Improvement Policies** **i.** QI.01 Conflict of Interest **ii.** QI.02 Clinical Practice Guidelines	Dr. Liu		

iii. QI.03 Distribution of Quality Improvement Information
iv. QI.04 Peer Review Process
v. QI.06 Quality Improvement Study Design/Performance Improvement Program Reporting
vi. QI.08 Cultural and Lingustically Competent Services
vii. QI.09 Health Education Program and Delivery System Policy
viii. QI.11 Member Non-Monetary Incentives
ix. QI.12 SBIRT
x. QI.28 Health Homes Program Policy
Possible Action: Approve Quality Improvement Policies QI.01, QI.02, QI.03, QI.04, QI.06., QI.08, QI.09, QI.11, QI.12, QI.28

6.	**Discussion Items**		7:05	30 min
	a. Appeals and Grievances	Mr. Breakbill		
	b. Access and Availability	Ms. Switzer		
	c. Initial Health Assessment (IHA): 3Q & 4Q Reports	Ms. Chang		
7.	**Committee Reports**			
	a. Credentialing Committee Review February 27, 2019 report of the **Credentialing Committee** Meeting. **Possible Action:** Accept February 27, 2019 Credentialing Committee report as presented	Dr. Nakahira	7:35	5 min
	b. Pharmacy and Therapeutics Committee Review minutes of the December 13, 2018 **Pharmacy and Therapeutics Committee** Meeting. **Possible Action:** Accept December 13, 2018 Pharmacy and Therapeutics Committee minutes as presented	Dr. Lin	7:40	5 min
	c. Utilization Management Committee Review minutes of the January 16, 2019 **UM Committee** Meeting. **Possible Action:** Accept January 16, 2019 Utilization Management Committee minutes as presented	Dr. Lin	7:45	5 min
	d. Compliance Report	Ms. Larmer	7:50	5 min
	e. Quality Dashboard	Dr. Liu	7:55	5 min
8.	**Adjournment**	Dr. Paul	8:00	

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.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Nancy Aguirre 48 hours prior to the meeting at 408-874-1835 or naguirre@scfhp.com.
- To obtain a copy of any supporting document that is available, contact Nancy Aguirre at 408-874-1835 or naguirre@scfhp.com. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.

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

Santa Clara Family Health Plan

Meeting Minutes
SCCHA Quality Improvement Committee
Wednesday, February 13, 2019 6pm

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

Non-Voting Staff Members	Title	Present? Y or N
Johanna Liu, PharmD	Director, Quality and Pharmacy	Y
Robin Larmer	Chief Compliance and Regulatory Affairs Officer	Y
Jeff Robertson, MD	Medical Director	N
Darryl Breakbill	Director, Grievance and Appeals Operations	N
Matthew Garduno	Data Analyst, Grievance & Appeals	Y
Mary Perryman	Supervisor, Grievance & Appeals	Y
Zara Hernandez	Coordinator, Quality Improvement	Y
Eric Tatum	Director, Provider Network Management	Y
Carmen Switzer	Provider Network Access Manager	Y
Mai Chang	Manager of Quality Improvement	Y
Chris Turner	Chief Operating Officer	N
Mansur Zahir	Project Manager, Process Improvement	Y
Jessica Bautista	Program Manager, Health Homes	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman was absent so Laurie Nakahira, DO Chief Medical Officer (CMO) called the meeting to order at 6:09pm. Quorum was established at this time.			
Review and approval of December 5, 2018 meeting minutes	The minutes of the December 5th, 2018 Quality Improvement Committee meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the December 5th, 2018 meeting were approved as presented.		
Public Comment	No public comment.	No public comment.		
CEO Update	Christine Tomcala reported membership as of January 2019 is 251,000. There is a decline in Medi-Cal members, which is not specific to the Health Plan. The entire county is seeing this trend due to high-cost of living so people are moving out of county, undocumented members; and members are no longer eligible as they are above the income level. Ms. Tomcala indicated that the Health Plan will be undergoing audits with the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS). DMHC and DHCS will be onsite in March. The National Committee for Quality Assurance (NCQA) survey is underway for the Cal MediConnect (CMC) line of business. NCQA auditors were onsite for file reviews and the Health Plan hopes to have results soon. Membership as of January 2019 is 251,000 members. There has been a decline in Medi-Cal members, which is not specific to the Health Plan. The entire county is seeing this trend due to high living costs in the Bay Area. The Plan will be undergoing audits for CMC audit. Initial stages			

	for DHCS will be onsite in March. NCQA survey is underway for CMC LOB. Also came onsite and the HP hopes to have results soon. Ms. Tomcala also reported that O'Conner and St. Louise acquisition by the County has started but not definitive.			
Action Items A. Review of Quality Improvement Program Description 2019	Ms. Chang presented the Quality Improvement Program (QI) Description for 2019 (all attendees were given the program description as handouts): Ms. Chang described the following changes to the QI Program: • In Section I - Introduction, language was updated to include membership numbers for each line of business. • In Section XII - Organizational Structure, language was updated to include new positions and job descriptions of the QI Staff. • In Section XIII - Committee Structure Overview, Grievance and Appeals Review committee was removed from the organizational chart since they do not report to QIC. Consumer Advisory Board (CAB) was added as a reporting committee to QIC. • In Section XXI – Facility Site Review (FSR), Medical Records, and Physical Accessibility Review, language was updated to clarify the FSR process. The previous language was outdated. • In Section XVIII – Care of Members with Complex Needs, language was added to reference the Population Health Management Strategy document.	Upon motion dully made and seconded. Approved as presented.		

B. Review Health Education Program Description 2019, Work Plan 2019, and Evaluation 2018.	Ms. Shah presented an overview of Health Education's Work Plan for 2019, and Evaluation for 2018. Health Education Evaluation 2018**:** • Completed 4 contracts, working on renewing contracts with community partners. Added 2 new programs: YMCA for a Diabetes Camp for kids from grades K-10; Chronic Pain Management. class offered through the Health Trust. • Class audits were completed for 4 vendors. 2 vendors were not audited as they did not have any upcoming classes in 2018 in English. • Member incentive Programs: Health Education completed their Controlling Blood Pressure (CBP) incentive program for year 2017 and submitted an evaluation to the DHCS. Targeted incentive programs for hypertension, immunizations for Vietnamese children, pregnancy and diabetes were launched in 2018: Dr. Foreman inquired why the immunization incentive was only limited to Physicians Medical Group and Premier Care of Northern California. Ms. Shah stated this incentive is part of DHCS' Performance Improvement Projects (PIPs) surrounding disparities. Based on analysis of data, disparity existed for Vietnamese children in these two networks. Ms. Shah presented Health Education Program Description for 2019 and the Work Plan for 2019. Minor changes were made to the Program Description and added language about the CAB changes, but included text about Consumer Advisory Board (CAB). The Health Education Work Plan 2019:	Upon motion dully made and seconded. Approved as presented.		

	• Health Education will continue updating their contracts with vendors and expand class offerings. A comprehensive online health education resource library with materials that can be sent to members as well as providers is in progress. • New programs will be added: asthma medication, high blood pressure, well-woman visits (such as breast screenings), well-child visits, and diabetes. In addition, Health education plans to implement at least 2 additional programs to focus on health disparities. Ms. Larmer asked about childhood immunizations and if Ms. Shah knew what impact it's having on our members in this early stage. Ms. Shah explained that the impact has been minimal, as the target population is very small and only 20 forms have been received to date.			
C. Review Cultural & Linguistics (C&L) Description 2019, Work Plan 2019, and Evaluation 2018.	Ms. Shah presented an overview of Cultural & Linguistics (C&L) Description 2019, Work Plan for 2019, and Evaluation for 2018. C&L Program Evaluation 2018: • C&L added a new interpretation vendor, Hanna Interpretation Services, in response to a notice of noncompliance that was received from the DHCS for a French interpreter. • C&L focused efforts on updating the internal staff training to include info/resources on gender identity, sexual orientation, and health plan specific information. • C&L is working with IT to add a language attribute to QNXT, which is the company wide claims	Upon motion dully made and seconded. Approved as presented.		

	processing program as well as how calls with members are logged from Customer Service. 2019 Program Description: • Minor changes were made to the 2019 C&L Program. 2019 Work Plan: • C&L all-staff training. HR and the all-staff training were on two different platforms. The goal is to work to make it on a single platform. The Cultural Competency training will be sent to all staff in the next few weeks. • C&L will continue to monitor the Language Attribute project with IT for 3 months, and make any changes as necessary.			
D. Review Quality Improvement Policies	Dr. Liu presented QI policies: QI.05 – Potential Quality of Care Issues – no changes QI.07 Physical Access Compliance – no changes QI.10 IHA and IHEBA Assessments – no changes QI.28 Health Homes Program – this is a new program requirement through the State of CA which will go live in Santa Clara County on July 1, 2019. This is a new policy that will govern all of the procedures. There is also a 2nd launch date starting January 2020 for members with Serious Mental Illness (SMI). Health Homes Program is an intensive case management, care coordination and housing navigation program for Medi-Cal members who meet criteria from the state. SCFHP is working to credential a network of community	Upon motion dully made and seconded. Approved as presented.		

	based care management entities (CB-CMEs) to serve this population. Dr. Arnold asked if there is a scoring grid or way to identify which members qualify for this program. Dr. Liu clarified that the state provides specific criteria and the Health Plan is in the process of creating criteria. Dr. Liu stated that they are seeking clarification from the State on the final eligibility list, to ensure it's accurate. The list received from the State contained outdated data. There was a motion to approve from Dr. Nakahira, moved to second and approved as presented.			
E. American Disabilities Work Plan 2019	Ms. Chang presented the ADA Work Plan: The work plan monitors different metrics around patient safety, access, health education, grievance, and delivery of preventative care. It tracks any PQI (potential quality of care) or actual quality of care issues. The work plan lists all of these measures that will be tracked for the year, and Ms. Chang plans to bring back to the group any findings in 2020. There was a motion to approve from Dr. Nakahira, moved to second and was approved as presented.	Upon motion dully made and seconded. Approved as presented.		
F. Cal MediConnect Advisory Board (CAB) Charter	Dr. Liu presented the CAB Charter which would make it a subcommittee of the QIC. The Health Plan has always had a Cal MediConnect Consumer Advisory board (CAB) and is informally reported to the QIC. There is also a Medi-cal Consumer Advisory Committee (CAC) and that is a direct committee of the board. Dr. Liu stated that they wanted the same path for CAB to the committee as well for CMC members.	Upon motion dully made and seconded. Approved as presented.		

	The purpose of CAB is to give CMC members, their caregivers, and anyone that serves them in our community, a voice to the Health Plan ensuring the Health Plan understands their needs and are doing the best to meet them. There was a motion to approve from Dr. Nakahira, moved to second and was approved as presented.			
G. Timely Access and Availability Results	Ms. Switzer reported the Access and Availability survey results for measurement year 2018. The plan conducts 3 different access surveys per year as required by DMHS and DHCS. The Plan looks for opportunities to improve accessibility and results are prioritized into different action plans. PAAS- PCP results for scheduling - urgent care within 48 hours: 2018: 68% 2017: 72% means Change: -4%; goal not met. PCP for non-urgent/routing care scheduling within 10 business days: 2018: 90% 2017: 91% means Change: -1%; goal not met. Specialists for scheduling urgent visits within 96 hours: 2018 Cardiology: 71% 2017 Cardiology: 73 Result: -2%; Goal 100%, goal not met. 2018 Endocrinology: 53%	Upon motion dully made and seconded. Approved as presented.		

	2017 Endocrinology: 24% Result: Goal 100%, goal not met. 2018 Gastroenterology: 42% 2017 Gastroenterology: 13% Result: Goal 100%; goal not met. 2018 Psychology: 60% 2017 Psychology: 1% Result: Goal 100%; goal not met. Provider Group results for scheduling non-urgent visits within 15 business days: Cardiology: 70% compliance rate in 2018. -2% change from 2017. Goal is 100%; goal not met. Endocrinology: 50% compliance rate in 2018. 32% increase from 2017. Goal is 100%; goal not met. Gastroenterology: 30% compliance rate in 2018. 29% increase from 2017. Goal is 100%, goal not met. Psychology: 70% compliance rate in 2018. 69% increase from 2017. Goal is 100%, goal not met. *Non Physician Mental health - urgent care appts within 96 hours:* None of applied behavioral health met the standard of 100%, social workers met 67%. The goal for social workers is 100%. No results presented for psychology. *Non Physician Mental health - non urgent care within 15 business days:* Compliance for clinical social workers and marriage/family counseling were met at 100%, meeting			

	goal. No results were available for psychology and applied behavioral health had a compliance rate of 0% and did not meet the goal. *Ancillary providers:* These providers have met the standard the last 2 years, including 2018. The standard is to schedule within 15 business days. The second survey was presented for PCPs for after-hours. Providers must have an after-hours message on voicemail letting patients know what to do in case of an emergency. 480 providers were sampled. 100% of PCPs met this goal in 2018, a 12% increase from 2017. For providers who let patients know via voicemail that they will call them back within 30 minutes or less, only 44% of providers sampled (N=480) met this goal, a 30% decrease from 2017. SCFHP will be providing education on call-backs within 30 minutes as a focus point for measurement year 2019. The final survey was presented – Third Next Available Appointment (TNAA). *Table 1 shows the 3rd next avail appointment for new patients coming into the practice. 2 of these providers met the goal For 2018:* PCP – 0% compliance OBGYN – 50% compliance Dermatologists - 100% compliance Gastroenterologists – 100% compliance Otolaryngologists – 50% compliance Peds Neurologists – 0% compliance *For TNAA for established patients:* PCP – 80% compliance			

	OBGYN – 80% compliance Dermatologists - 100% compliance Gastroenterologists – 100% compliance Otolaryngologists – 50% Peds Neurologists – 0% compliance *Wait time for Return Call During Business Hours (non med related): Standard is 1 business day.* PCP – 100% compliance – met goal of 100% OBGYN – 60% compliance – did not meet goal of 100% Dermatologists - 100% compliance – met goal of 100% Gastroenterologists – 100% compliance – met goal of 100% Otolaryngologists – 100% - met goal of 100% Peds Neurologists – 100% compliance – met goal of 100% *Does Office have an After-Hours Message directing patients on how to access care?* All providers were in 100% of compliance, met 100% goal. *PAAS (Provider Appointment and Availability Survey).* This is re-surveying results for urgent and non-urgent appts. Resurvey results showed that approximately 65% of providers met the standards. Providers who showed continued non-compliance are required to complete SCFHP's access training program. Ms. Switzer discussed barriers/ opportunities/interventions related to the access and availability surveys: *1) Timely access for non-compliant providers*- Opportunity to improve access to urgent and non-urgent appts. The planned intervention is to improve training materials (completed) and conduct provider outreach (in process)			

	2) Lack of knowledge for access standards- Opportunity to educate providers on timely access standards. Intervention methods include improving training materials (completed) and conduct provider outreach (in process). *3) After-hours Access (return call within 30 minutes or less)* - Opportunity to improve after-hours access. Intervention methods include improving training materials (completed) and educating providers with SCFHP's Access Standards Grid. SCFHP's is researching using online webinars as a different training platform. Dr. Dawood inquired what methods are used to communicate with providers. Ms. Switzer stated that communication is done primarily through fax blast. Dr. Dawood stated that not all providers prefer faxing and suggested that SCFHP review annually with providers what the best mode of communication is (fax, email, phone, etc.).			
6a. Appeals and Grievances	Mr. Garduno presented the Appeals and Grievances report. There was a higher volume of grievances cases in July – Oct 2018 due to a number of no-shows and late arrivals for transportation for members. Total appeals from January 2018 – December 2018 were consistent, with the exception of a drop in appeals in September 2018. Total grievances from January 2018 – December 2018 also stayed consistent. Grievance has implemented a new program called Beacon, which will help streamline	Upon motion dully made and seconded. Approved as presented.		

	processes. Pharmacy appeals and medical appeals: Pharmacy usually has a higher overturn rate than medical appeals. Pharmacy's initial review timeframe is one business day, which leaves little time to request and submit information. CMC Rates per 1000: For January 2018 – December 2018, CMC appeals drastically dropped from 35 cases to 18 cases. The Appeals & Grievances Manager will conduct a root cause analysis to determine why this drop occurred. CMC Appeals by Determination: There is currently a higher volume of appeals that are still in process. Cases have 60 calendar days for processing. These cases need documentation and if the documentation comes in, the 60 calendar days reset and a case can be open for up to 120 days. Overall timeliness for Appeals & Grievances: Total California Home Medical Equipment (CHME) grievances for Healthy Kids/Medi-Cal membership: range from a low of 6 in February and June of 2018, to a high of 27 from August – October 2018. Total CHME grievances for CMC: Range from 4 in January 2018 – to a high of 25 in Sept. Total of 341 complaints filed since January 1, 2018. Appeals & Grievances was understaffed for part of 2018, and lost a member of their team in October. Since October, Appeals and Grievances have doubled in staff and are implementing a new program (called Beacon) for			

	tracking and monitoring timeliness of grievances.			
6B. VHP PQI Access Review	Ms. Chang presented access review for PQI (potential quality issues) related to Valley Health Plan: In Q3 and Q4 of 2018, there were 29 access-related PQI issues. 21 of these cases were related to members not being able to obtain appointments with their PCP or specialist. The highest number of specialty cases was for members who could not obtain appointments with dermatologist at 28.6%. SCFHP Quality met had two meetings with VHP quality team to discuss this issue. They shared this information, along with the timely access standards. The resolutions are as follows: • 9 cases were referred to an out of network provider or were able to obtain an earlier appointment after filing a grievance. • 2 members switched PCPs. • 2 members were referred to urgent care. • Other cases were reviewed by CMO and was determined that the wait time for the appointments were appropriate based on the condition of the member. The Medical Director recommended that SCFHP discuss these PQI cases with Valley Health Plan to understand how access-related issues are resolved and how members are triaged. No Corrective Action Plan was given to Valley Health Plan at this time. The Quality Improvement team will continue to monitor any PQIs related to access. Dr. Foreman inquired as to why there is a higher number	Upon motion dully made and seconded. Approved as presented.		

	of cases regarding Dermatologists. Ms. Chang stated that the plan always seen a higher number of complaints with this specialty. Most of the community clinics are now on E-Consult and the dermatology specialty has recently been added to the program.			
6C. QIC Charter Review	Dr. Liu presented the QIC Charter: The QIC Charter is being presented for review due to the Cal MediConnect CAB being added as a subcommittee to the QIC. Additionally, Dr. Liu recommended amending language in the QIC Charter under 'Meetings' – which states that committee members must attend at least 2 meetings per year. The change should state that "committee members must attend at least 50% of meetings in a calendar year." After the QIC approves the changes, the revised QIC Charter will be sent to the Governing Board for final approval.	Recommended changes will be presented to the Governing Board as appropriate.		
7a. Credentialing Committee	Dr. Nakahira presented a summary of the December 12, 2018 Credentialing Committee report. Two initial providers were credentialed. 29 providers were re-credentialed. There were no terminations, suspensions, rejections or denials. The Health Plan has a total 265 providers (excludes delegates) as of November 30, 2018.	Approved as presented		
7b. Pharmacy & Therapeutics Committee	Dr. Lin presented summary of the September 20, 2018 Pharmacy & Therapeutics (P&T) Committee. Pharmacy appeals & grievances for Q3 2018 was presented. There were no changes to charter. Updates were made to the Hepatitis C policy. The age requirement is 12 years or older and no longer looking at fibrosis score. For state	Approved as presented		

	covered drugs, the Plan will apply transition of care logic to non-Part-D drugs. Opioid Strategy was presented.			
7c. Utilization Management Committee	Dr. Lin presented summary of October 17, 2018 Utilization Management (UM) Committee report. 2019 Prior Authorization grid was reviewed. The new grid combines all lines of businesses with a separate grid for medications. Cal MediConnect 2017 Program Evaluation was presented and approved. Dashboard metrics and standard Utilization metrics were presented. Quality Monitoring Report for Q3 2018 was also presented.	Approved as presented		
7d. Compliance Report	Ms. Larmer presented the Audit Overall Work Stream Status tracker. This lists all of the business units that may have had a compliance risk and any corrective actions. Many corrective actions center around Grievance & Appeals and authorizations. Grievance & Appeals is a critical risk area, and an area sited in Audit Findings. Next steps: all corrective actions that were submitted have been accepted by CMS. The Health Plan will need to evaluate corrective actions by July 31st and Ms. Tomcala will need to attest that these conditions and actions were completed.			
7e. Quality Dashboard	Dr. Liu presented the Quality Improvement dashboard. PQI issues dashboard – a number of cases (about 70) are overdue. Usually these are processed within 60 days. QI is working through the backlog of these cases. Reasons for the overdue cases is due to staff turnover and internal interpretation via clinical reviewers. Clarification was provided to clinical reviewers to streamline review process and QI has also hired temporary staff to help ensure these cases are being processed timely. Facility Site Review (FSR) – total of 5 were completed in			

	Q4 2018 with 100% of the sites reviewed in a timely manner. Quality Projects – Controlling High Blood Pressure – 986 eligible, 36 received actual incentive = 4% Childhood Immunizations – 350 eligible, 18 received incentive = 5% Comprehensive Diabetes Screening – 212 eligible, 13 received incentive = 6% Prenatal – 59 received gift card, 31 received car seat, 40 received sleep pod. Initial Health Assessment (IHA) –1112 members eligible for IHA in Q4 2018. 47.5% completed IHAs within 120 days of member's enrollment into the Health Plan. The Committee discussed whether members who have a lapse in Medi-Cal coverage are assigned to the same provider after re-enrolling with the Health Plan. Dr. Foreman indicated that when she spoke with the Plan she was advised that if the lapse was over a certain amount of months, the member is not assigned to the same person. Dr. Foreman stated she does not know what the HP defines as a "new" member. Ms. Tomcala stated that it's up to the state to define what "new" means and that per the Health Plan's algorithm, if a member comes back after having a lapse, the Plan should be looking at who they saw before and assigning them to the same provider. Dr. Dawood indicated her practice has experienced situations where a member had a lapse in coverage, comes back, and is not reassigned to the same provider. This causes front office staff to scramble and work with the Health Plan to fix the issue so that the member can be seen. The Health Plan tries to maintain the same provider			

	and Ms. Tomcala asked Dr. Dawood to provide examples of patients with this situation for further research by the Health Plan Final housekeeping item: Previous meetings were held at 6:30pm. Dr. Liu asked the Committee members if they were in agreement to continue meetings at 6pm -8pm. There was agreement and future agendas and invites will be updated as appropriate.			
Adjournment	Meeting adjourned by Dr. Nakahira at 7:56pm			
Next Meeting	Wednesday, April 10th at 6pm	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____
Ria Paul, MD
Quality Improvement Committee Chairperson

Santa Clara Family Health Plan.

2018 QUALITY IMPROVEMENT PROGRAM EVALUATION

☑ Annual Evaluation

A. CLINICAL IMPROVEMENT ACTIVITIES

NCQA 2018 Quality HEDIS Measures for (Medi-Cal (MC), and Centers for Medicare and Medicaid Services (CMC): (2018 Measurement Year)

HEDIS Hybrid Measures Key:

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

HEDIS Administrative Measures Key:

- All Cause Readmission – ACR (MC) / PCR (CMC)
- Ambulatory Care – AMB (MC & CMC)
- Use of Imaging Studies for Low Back Pain –LBP (MC)
- Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis – AAB (MC)
- Children's & Adolescent's Access to PCPs – CAP (MC)
- Annual Monitoring for Patients on Persistent Medication – MPM (MC)
- Follow-Up After Hospitalization for Mental Illness – FUH (CMC)
- Asthma Medication Ration – AMR (MC)
- Breast Cancer Screening – BCS (MC & CMC)
- Osteoporosis Management in Women Who Had a Fracture – OMW (CMC)
- Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis – ART (CMC)
- Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) – SRP (CMC)
- Pharmacotherapy Management of COPD Exacerbation – PCE (CMC)
- Statin Therapy for Patients with Cardiovascular Disease – SPC (CMC)
- Statin Therapy for Patients with Diabetes – SPD (CMC)
- Antidepressant Medication Management – AMM (CMC)
- Follow-Up After Emergency for Department Visit for Mental Illness – FUM (CMC)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – FUA (CMC)
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions – FMC (CMC)
- Non-Recommended PSA-Based Screening in Older Men – PSA (CMC)
- Potentially Harmful Drug-Disease Interactions in the Elderly – DDE (CMC)
- Use of High-Risk Medications in the Elderly – DAE (CMC)
- Use of Opioids at High Dosage – UOD (CMC)
- Use of Opioids from Multiple Providers – UOP (CMC)
- Adults' Access to Preventative/Ambulatory Health Services – AAP (CMC)

	o Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – IET (CMCC)

A.1 Goal:

- Exceed Medi-Cal Managed Care (MMCD) Minimum Performance Levels (MPL), which is the 25th percentile, for 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:

- Collect and report Hybrid Healthcare Effectiveness Data and Information Set (HEDIS) rates for ALL Product Lines within specified timeframe.
- Develop member incentives to support CDC – Nephropathy, Prenatal Care, Childhood Immunizations and Hypertension.
- Present HEDIS results and analysis to:
  - SCFHP Board of Directors & SCFHP Quality Improvement Committee.
- Quality Improvement Activities:
  - Continue immunization reminder letters to parents with children at 17 months to 2 years of age to receive recommended immunizations.
  - Mail Well-child visit reminder letters to children 3-6 years old.
  - Provide education in Quarterly Member Newsletters, Provider eNewsletters, for immunizations, well child visits, diabetic care, and prenatal and postpartum care.
  - Outbound call campaign for gaps in care reminders.
  - Gaps in Care reminders in QNXT

A.3. Results:

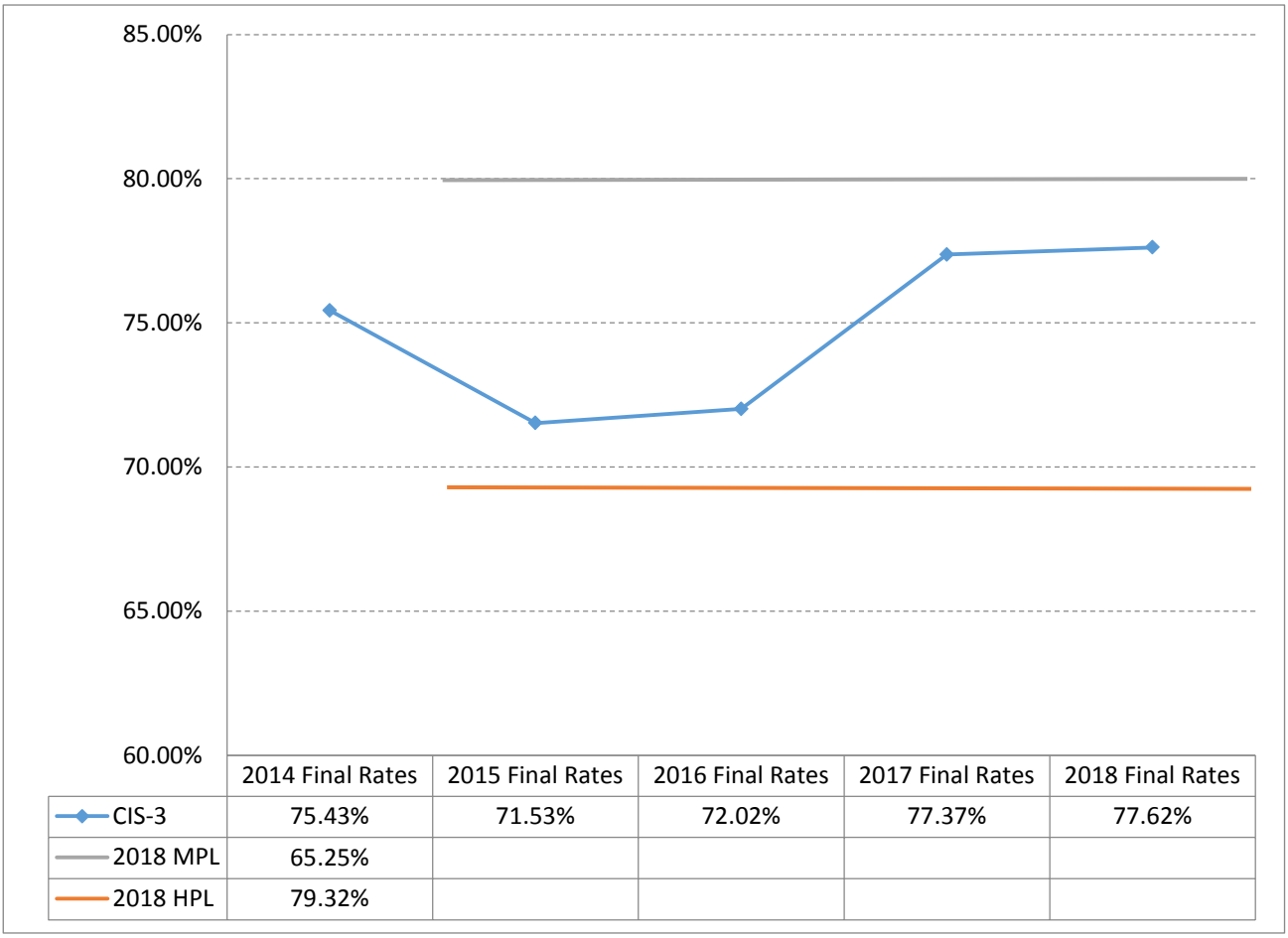
- Exceeded or at MMCD Minimum Performance Level (MPL) for all measures except CDC - Nephropathy.
- Medi-Cal measure IMA-Combo 2 exceeded the HPL.
- Medi-Cal measures that have improved significantly (>5%) from the prior year: Asthma Medication Ration (AMR), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB), and Immunizations for Adolescents – Combo 2 (IMA).
- No Medi-Cal measures decreased significantly (>5%).
- All CMC measures reportable for 2018. There are no MPL's for the CMC line of business.

A.4. Analysis of Findings/Barriers/Progress

- Due to Administrative Data Volume being flat, continued chart abstraction and Pinpoint chart chase logic is necessary to improve key measures.
- HEDIS Member outreach and incentives is important to increase key measures.
- Providers / Networks continue to require assistance for data issue improvements:
  - Provider Address discrepancies
  - Coding issues
  - Timely data submission
- Lack supplemental/EMR data

Immunization Measures Findings

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



	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates
CIS-3	75.43%	71.53%	72.02%	77.37%	77.62%
2018 MPL	65.25%				
2018 HPL	79.32%				

Analysis and Findings/Barriers/Progress

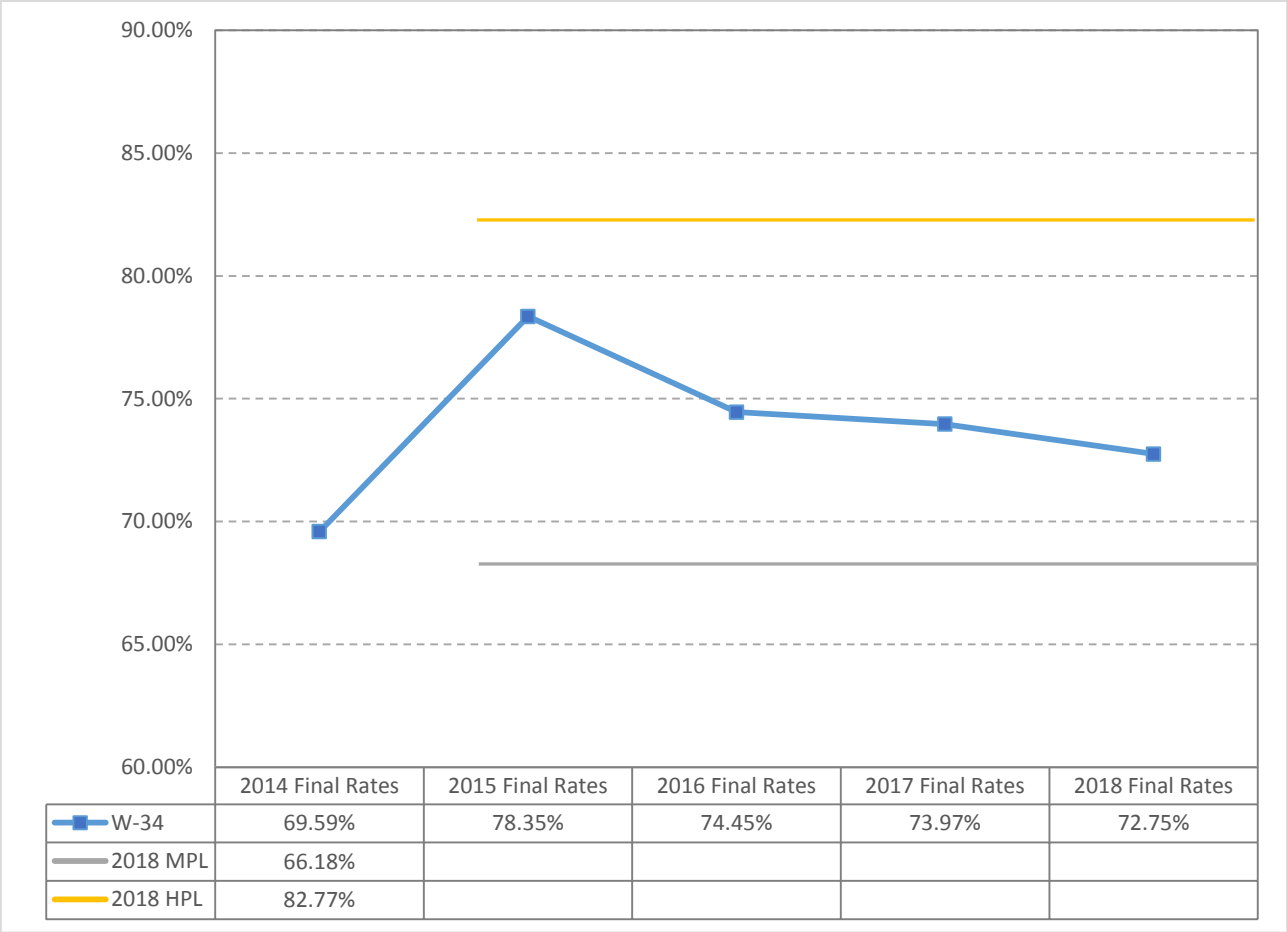
- Met goal of exceeding the MPL of 65.25% but remains below the HPL of 79.32%.
- SCFHP analysis on membership and claims data shows a continued pattern of immunizations given outside of the recommended timeframes for children 2.

Follow up/Actions:

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

Well Child Visits Key Findings

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



	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates
W-34	69.59%	78.35%	74.45%	73.97%	72.75%
2018 MPL	66.18%				
2018 HPL	82.77%				

Analysis and Findings/Barriers/Progress

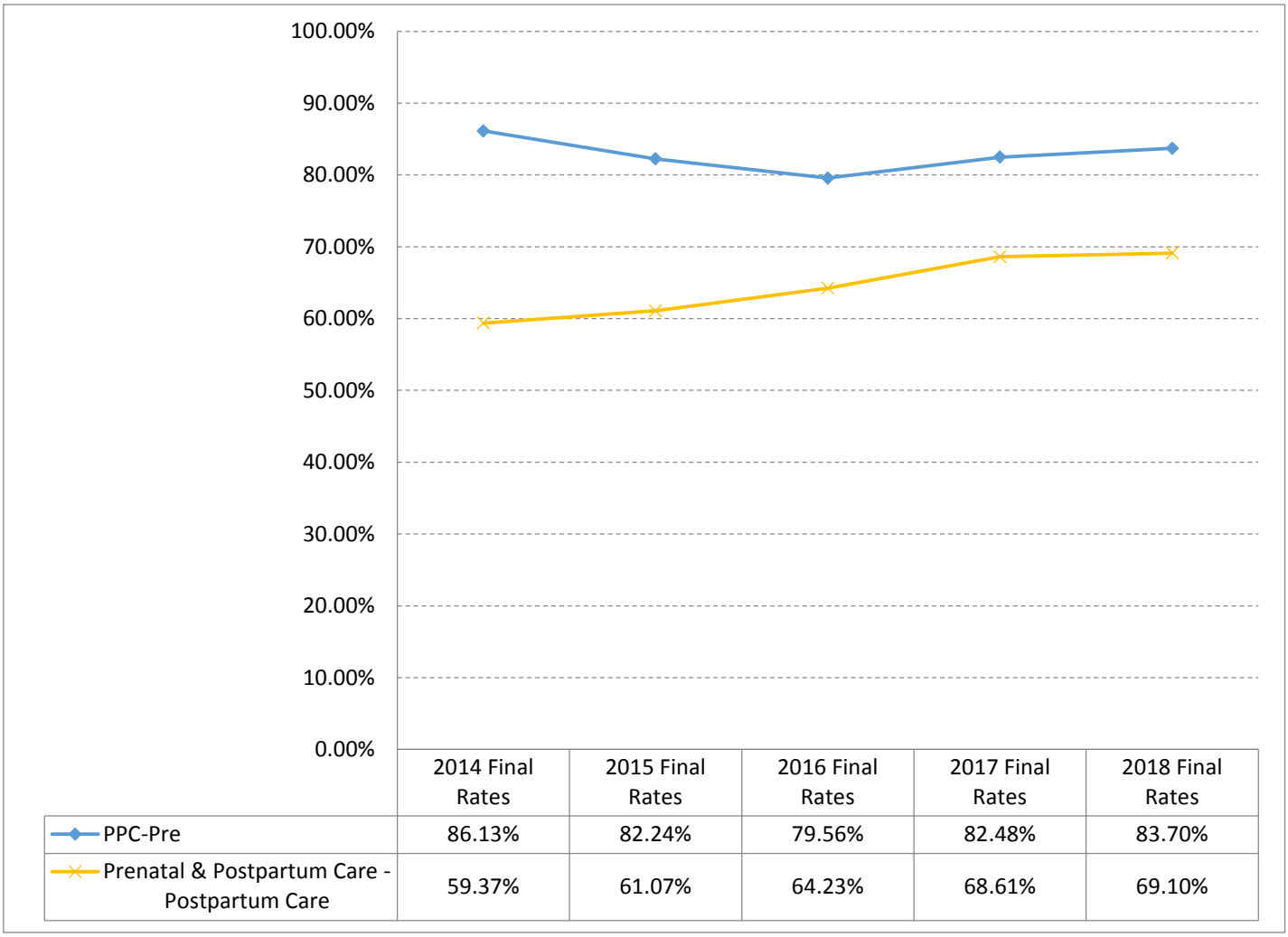
- Met goal of exceeding the MPL of 66.18%, and remains below the HPL of 82.77%.
- 2018 rate dropped by 1.22% from HEDIS 2017.
- Possible gap in data from delegates may have led to decrease of rate.

Follow up/Actions:

- Focus ideas on continue interventions in 2019 for member outreach with incentives to encourage members to see their PCP.
- Focus ideas on continue interventions in 2019 for Providers on well child visit schedule.
- Continue reconciliation of encounter data to close any data gaps.

Adult Hybrid Measures: Prenatal / Postpartum Care Key Findings

PPC – Prenatal and Postpartum Care (MC)



	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates
PPC-Pre	86.13%	82.24%	79.56%	82.48%	83.70%
Prenatal & Postpartum Care - Postpartum Care	59.37%	61.07%	64.23%	68.61%	69.10%

Analysis and Findings/Barriers/Progress

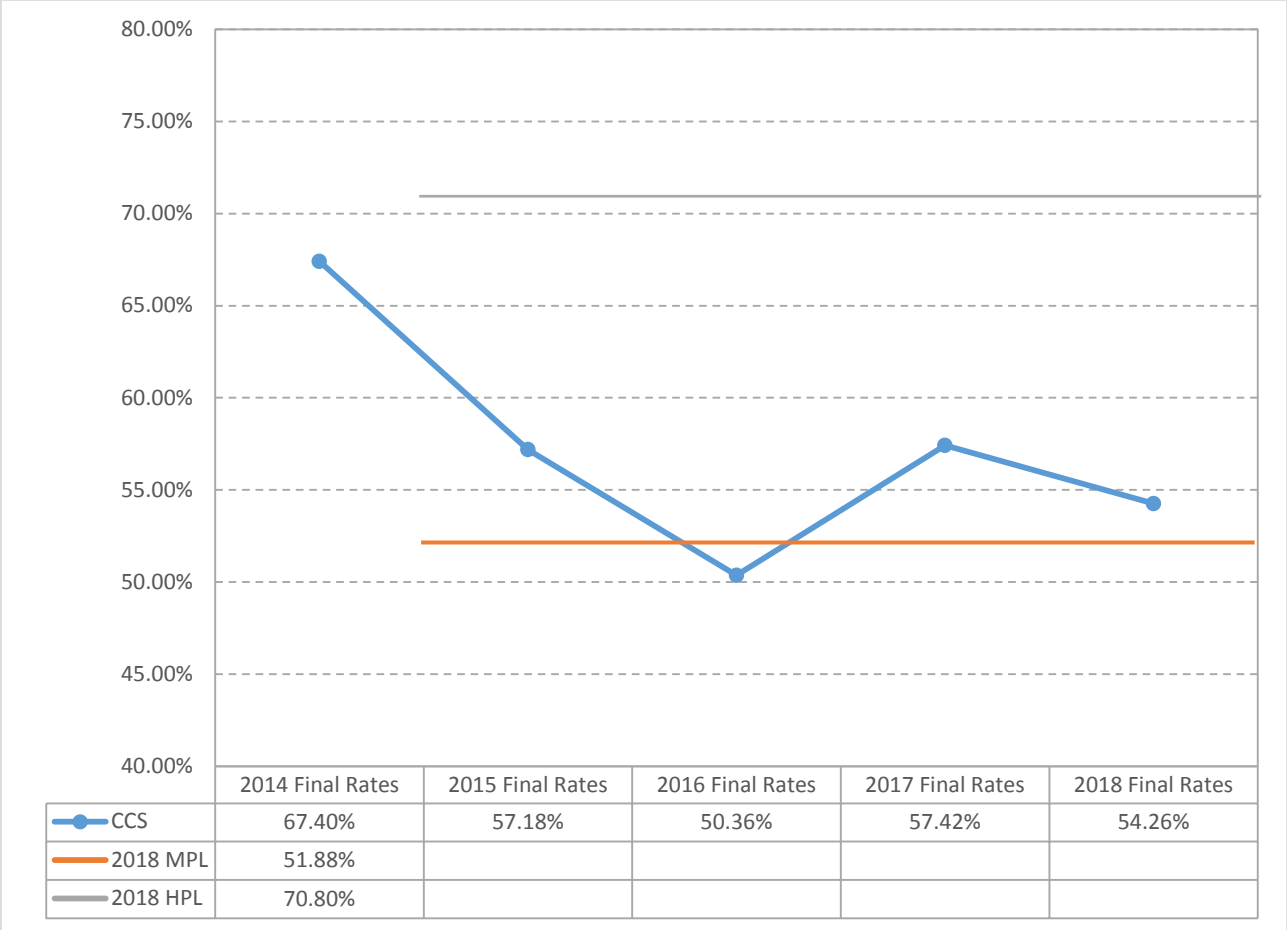
- Met goal of exceeding the MPL's (Prenatal visits 77.66%; Postpartum visits 59.59%) and remains below the HPL (Prenatal visits 91.67%; Postpartum visits 73.67%) of both indicators.
- For Prenatal visits, rate increased by 1.22%; Postpartum visits, rate increased by .49%.
- Challenging to find expecting mother's before they enter the healthcare system.

Follow up/Actions:

- Continue intervention in 2019 for member reminders and outreach.
- Open prenatal incentive to all members.
- Pinpoint chart chases for this measure for 2019 data.
- Continue to partner with community organizations where expectant mothers may receive non-healthcare related services.

Adult Measures: Cervical Cancer Screening Key Findings

CCS – Cervical Cancer Screening (MC)



	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates
CCS	67.40%	57.18%	50.36%	57.42%	54.26%
2018 MPL	51.88%				
2018 HPL	70.80%				

Analysis and Findings/Barriers/Progress

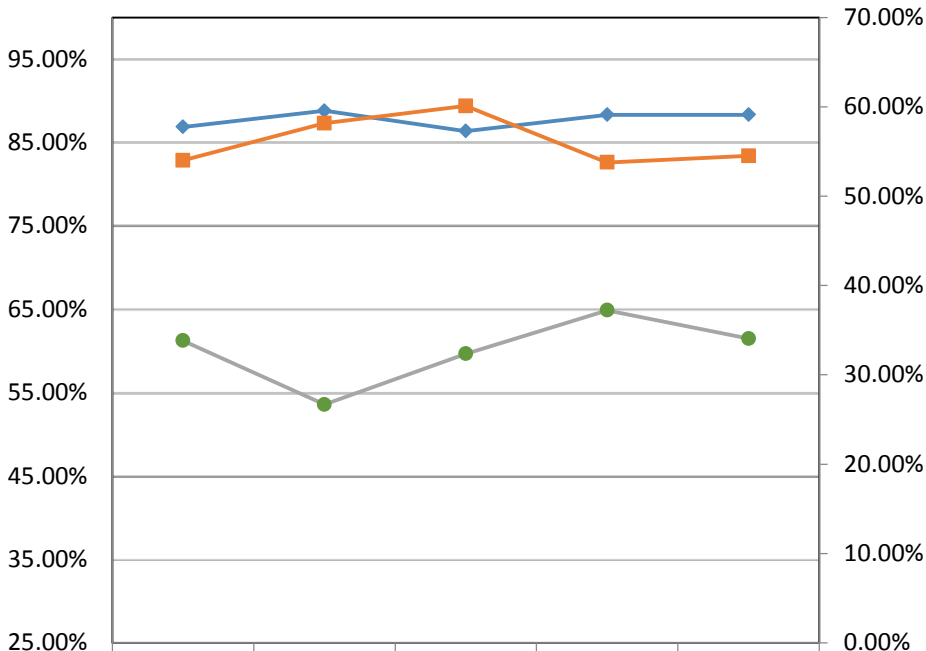
- Met goal to exceed the MPL of 51.88% but below HPL of 70.80%.
- Rate decreased 3.16% from HEDIS 2017.
- A barrier encountered for improvement of this measure relates to reluctance by some members of some ethnic groups to get this screening done which can be attributed to cultural disparities.

Follow up/Actions:

- Focus interventions in 2019 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2019 data.

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

CDC – Comprehensive Diabetes Care (MC) HbA1c



	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates
CDC-HT	86.86%	88.81%	86.37%	88.32%	88.32%
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	33.82%	26.68%	32.36%	37.23%	34.06%
Comprehensive Diabetes Care - HbA1c Control (<8.0%)	54.01%	58.15%	60.10%	53.77%	54.50%

Analysis and Findings/Barriers/Progress

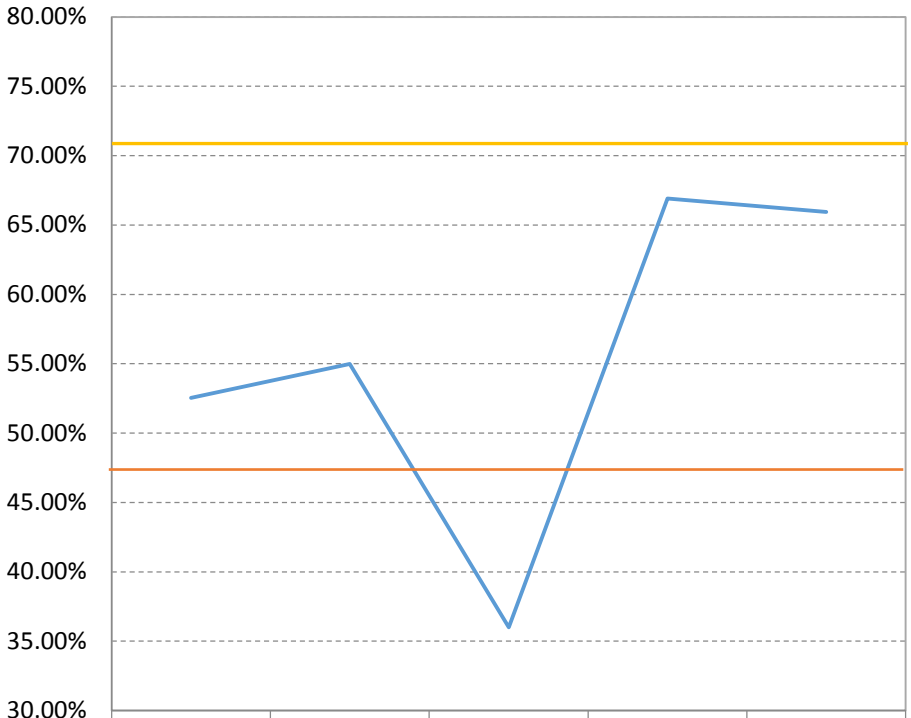
- Met goal of exceeding the MPL for all the CDC HbA1c indicators. MPL's are as follows:
  - CDC HT: 84.32%
  - CDC HbA1c Poor Control: 48.57%
  - CDC HbA1c Control: 41.94%
- Rate is flat for HbA1c Testing and increased .73% for CDC HbA1c Control from HEDIS 2017. For HbA1c Testing Poor Control a lower rate is better. HEDIS 2018 rate shows a decrease of 3.17% from HEDIS 2017.

Follow up/Actions:

- Focus ideas on new intervention in 2019 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2018 data.

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

CBP - Controlling High Blood Pressure (MC)



	2014 Final Rates	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates
Controlling High Blood Pressure	52.55%	54.99%	36.01%	66.91%	65.94%
2018 MPL	47.69%				
2018 HPL	71.69%				

Analysis and Findings/Barriers/Progress

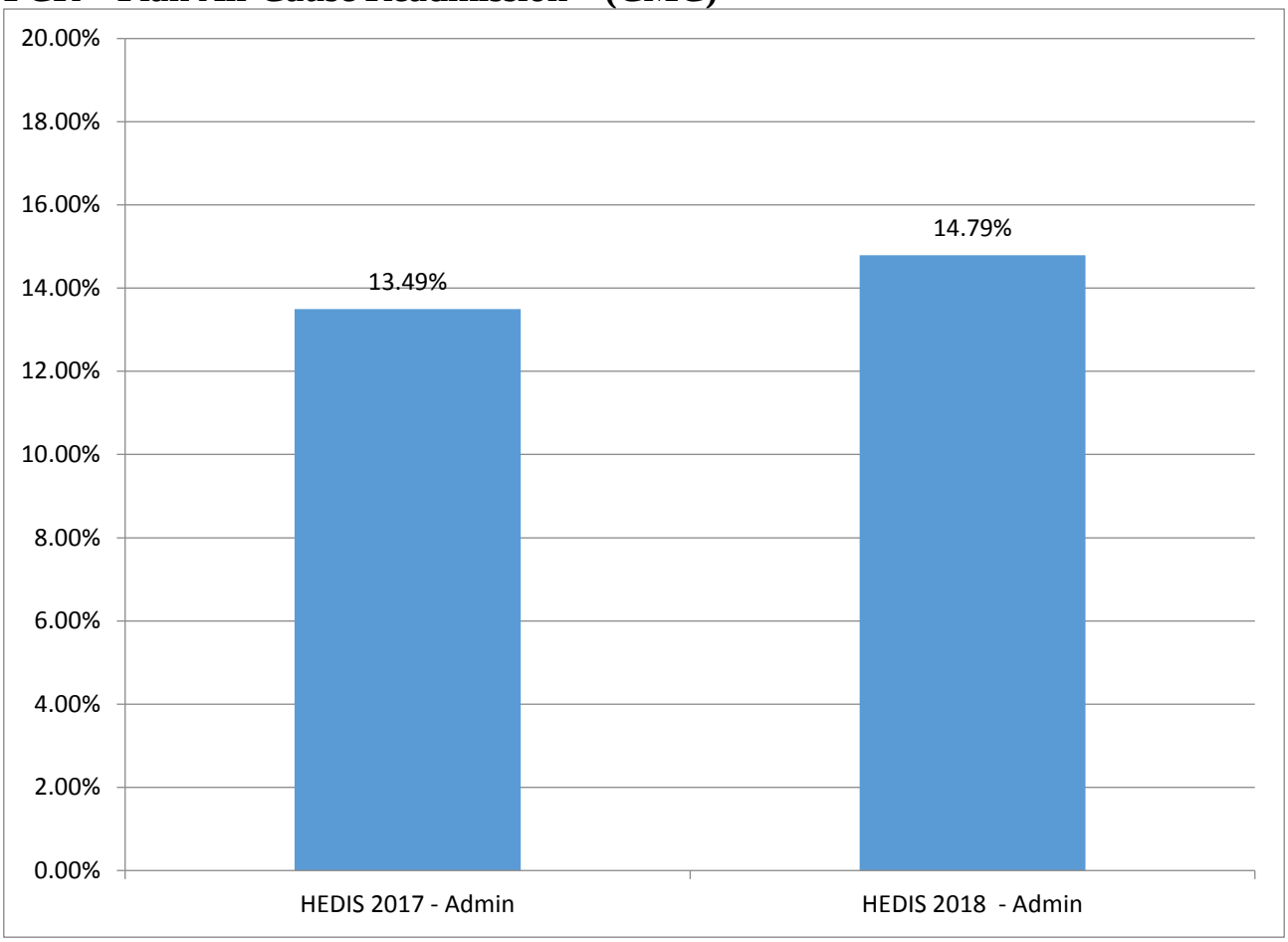
- Met goal of Blood Pressure Control exceeding the MPL of 52.55%, and below HPL of 71.69%.
- Rate decreased by .97%.
- Barriers for this measure include the challenge of this being a 100% chart pull measure, in addition to lack of supplemental data and EMR access.

Follow up/Actions:

- Continue interventions in 2019 for member reminders and outreach. Incentive form to be signed by the PCP.
- Discuss data share opportunities with delegate groups.

Quality Withhold Measure: Plan All-Cause Readmission

PCR – Plan All-Cause Readmission – (CMC)



Analysis and Findings/Barriers/Progress

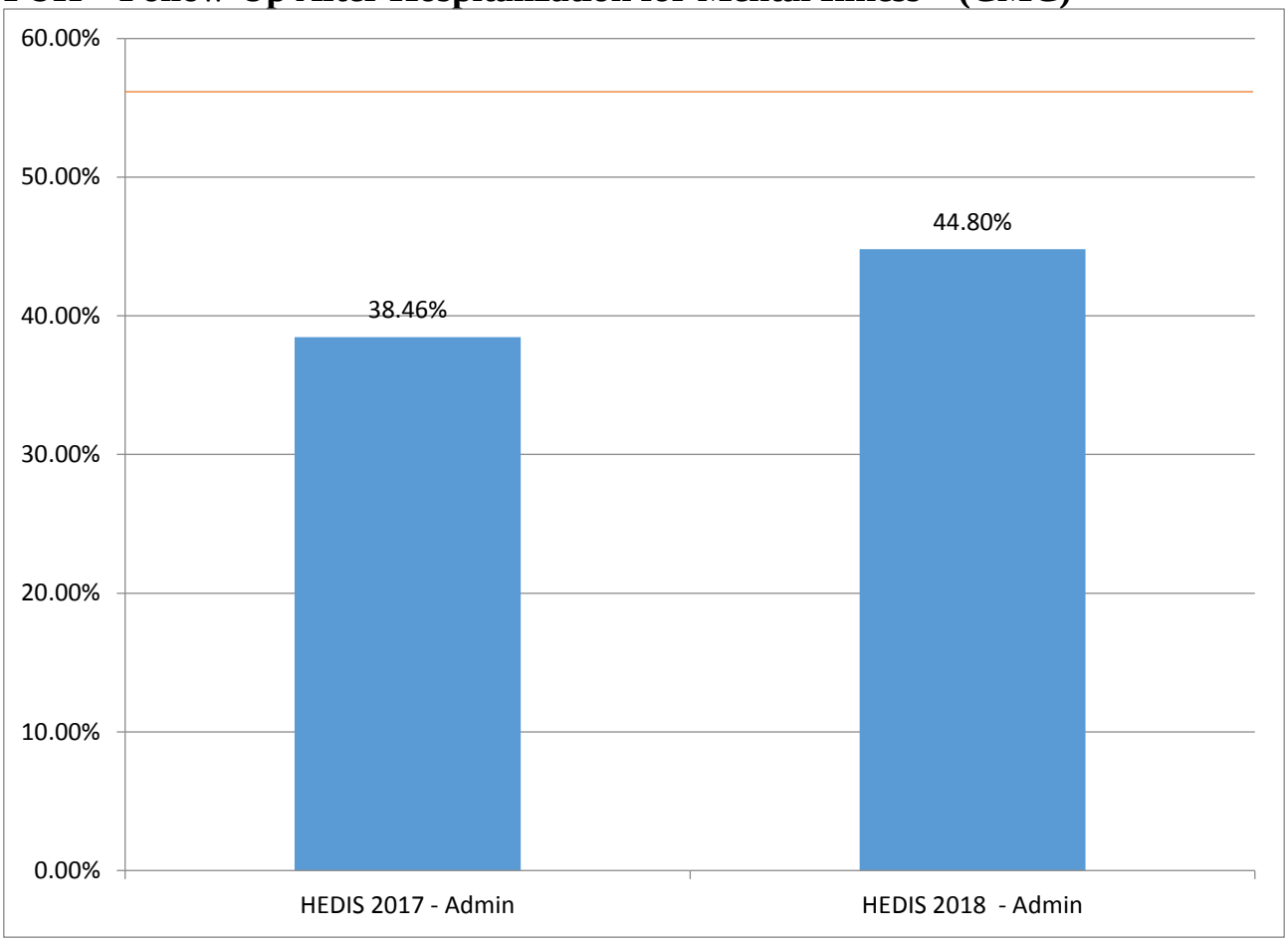
- Lower is better for PCR. HEDIS 2018 rate increased by 1.30%. CMS changed the Quality Withhold standard to use the Observed Readmission/Expected Readmissions (O/E) Ratio as the benchmark as of March 2018 with the ratio being less than 1. SCFHP's O/E Ratio for HEDIS 2018 is under 1, therefore meeting the Quality Withhold benchmark.
- Lack of timely notification of discharge is a barrier for this measure.

Follow up/Actions:

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

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

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



Analysis and Findings/Barriers/Progress

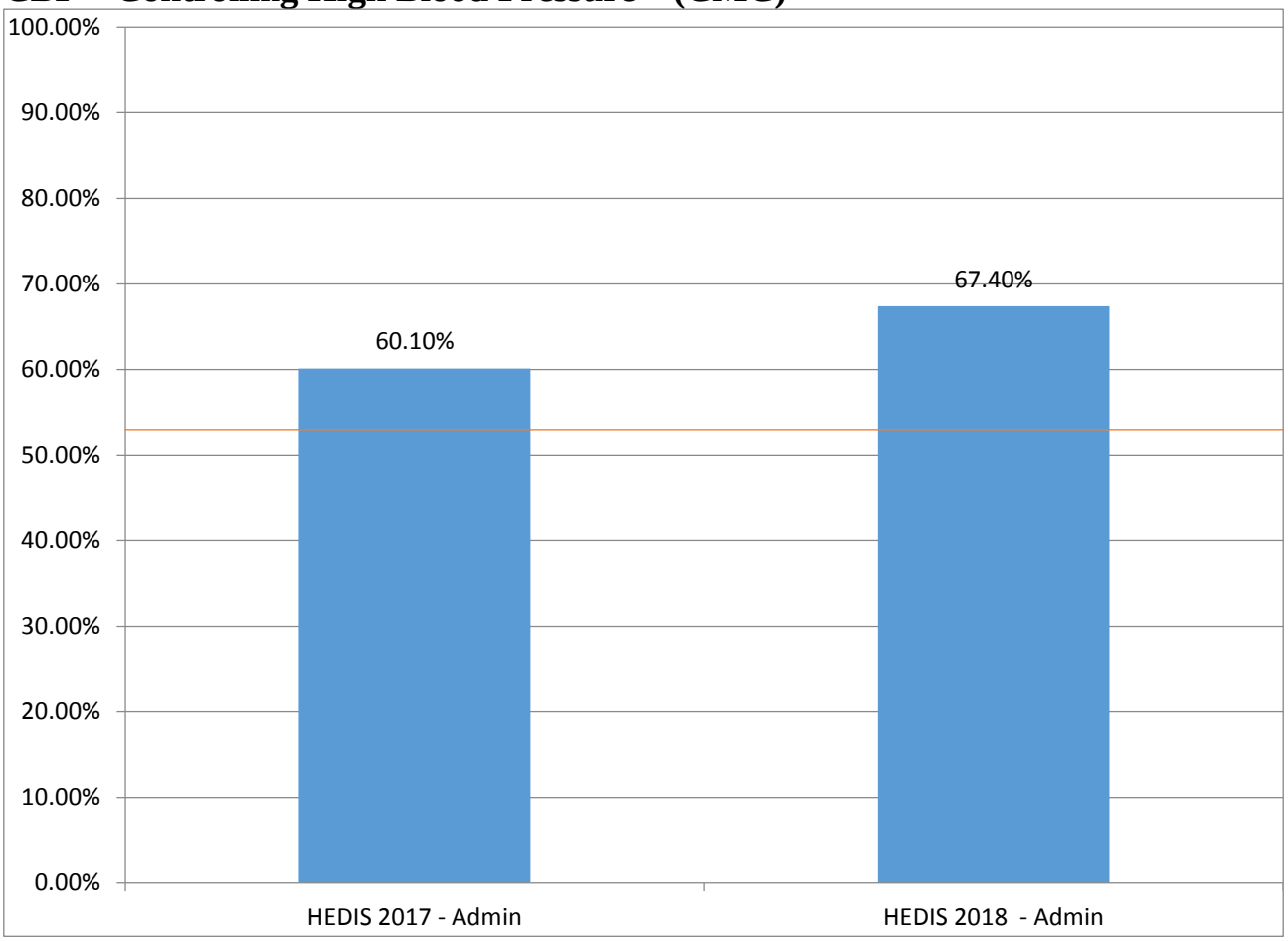
- Measure is below the Quality Withhold benchmark of 56%, but met the 10% improvement score of 40.21% for HEDIS 2018.
- Barriers for this measure include not being notified of hospitalization and patient not getting follow up care from the right provider types.

Follow up/Actions:

- Continue to monitor and collaborate with Behavioral Health delegates to ensure members obtain follow-up appointment after hospitalization for mental illness.
- Meet with County Behavioral Health Services (CBHS) on a monthly basis to collaborate and get data.

Quality Withhold Measure: Controlling High Blood Pressure

CBP – Controlling High Blood Pressure – (CMC)



Analysis and Findings/Barriers/Progress

- Measure is above the Quality Withhold benchmark of 53.11% which meets goal.

Follow up/Actions:

- Continue interventions in 2019 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2018 data.
- Discuss data share opportunities with delegated groups.

B. Clinical Improvement Activities
External and Internal QIP's (2018 Measurement Year)

All Cause Readmissions CMS Quality Improvement Project (QIP)

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

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

Design
This three year QIP began in January of 2016 and ended on December 31, 2018. Medical Management staff used a daily census report from Regional Medical Center to identify all discharged Cal Med connect members. Staff made three attempts to contact the member within 72 hours of discharge to conduct a successful transition of care discharge call to help prevent a readmission to the hospital within 30 days of discharge.

Results:
For the intervention post discharge calls, results indicate that for 2018, 69 enrollees (28.8%) out of 239 eligible enrollees received a post discharge call within 72 hours of discharge. The low number of successful completions is largely the result of an inadequately designed intervention strategy. 72 hours was not a feasible goal and it should have been 72 business hours. Additionally, the goal would have been more attainable if the intervention had been limited to members being discharged to home rather than to any setting such as a Skilled Nursing Facility.

The percentage of enrollees who experienced a readmission within 30 days of discharge through 12/1/ 2018 was 13.22%. This is an increase from the 2017 rate of 12.69% but a decrease from the 2016 rate of 16.86%. The 2015 baseline rate was 15.1%. By year three, SCFHP's goal was to further decrease and get closer to 11% by the end of the QIP. SCFHP improved from the baseline rate 2 out of the 3 measurement years but the 3 year goal was not met.

Analysis of Findings/Barriers/Progress
The three year goal was not met due to deficiencies in the initial design of the intervention but the process as designed was eventually was stabilized as of July 2018 with no further implementable, feasible, improvements identified.

Individual Care Plan (ICP) CMS , Performance Improvement Project (PIP)

Goal:
- Increase total number of high risk members who had an ICP completed from in 58% 2017 to 63% in 2018
- Increase total number of low risk members who had an ICP completed from 56.8 % in 2017 to 61.8% in 2018.
- Increase the total number of Cal MediConnect members with at least one documented discussion of care goals in the initial ICP from 18.33% in 2017 to 60% in 2018

Intervention:
The Medical Management Department has implemented interventions including data reviews, increased member outreach, staff training, process improvements and resource/staffing models to meet goals.

Design:
This three year project began in January 2018 and will conclude on December 31, 2020. The study question is:

- Do targeted interventions increase the percentage of eligible members with an ICP completed and the percentage of eligible members with documented discussions of care goals?

2018 Results:

Study Indicator 1 Title: High risk members with an ICP completed						
Time Period Measurement Covers	**Indicator Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Goal**	**Statistical Test, Statistical Significance, and *p* Value**
01/01/2017-12/31/2017	**Baseline**	1206	2080	58.0%	n/a	n/a
01/01/2018-12/31/2018	**Re-measurement 1**	1437	2458	59.0%	63.0%	Fisher's exact test - The two-tailed P value equals 0.8829. The association between rows (groups) and columns (outcomes) is considered to be not statistically significant.
01/01/2019-12/31/2019	**Re-measurement 2**	n/a	n/a	n/a	68.0%	n/a

Study Indicator 2 Title: Low risk members with an ICP completed						
Time Period Measurement Covers	**Indicator Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Goal**	**Statistical Test, Statistical Significance, and *p* Value**
01/01/2017-12/31/2017	**Baseline**	2578	4641	55.5%	n/a	n/a
01/01/2018-12/31/2018	**Re-measurement 1**	2853	4941	58%	61.8%	Chi-square with Yates correction. Chi squared equals 1.258 with 1 degrees of freedom. The two-tailed P value equals 0.2620. This considered to be not statistically significant.
01/01/2019-12/31/2019	**Re-measurement 2**	n/a	n/a	n/a	66.8%	n/a

Study Indicator 3 Title: Total number of CalMediConnect members with at least one documented discussion of care goals in the initial ICP						
Time Period Measurement Covers	**Indicator Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Goal**	**Statistical Test, Statistical Significance, and *p* Value**
01/01/2017-12/31/2017	**Baseline**	145	791	18.3%	n/a	n/a
01/01/2018-12/31/2018	**Re-measurement 1**	432	759	56.9%	60.0%	Fisher's exact test, Less than 0.0001(extremely statistical significant)
01/01/2019-12/31/2019	**Re-measurement 2**	n/a	n/a	n/a	65.0%	n/a

Analysis of Findings/Barriers/Progress

- In 2018, 1437 out of 2458 (59.0%) of Santa Clara Health Plan's Cal MediConnect high risk members had an ICP created for them. This is an improvement from the baseline rate 58.0% but based on Fisher's exact test, the two-tailed P value equals 0.8829 and is considered to be not statistically significant from the baseline rate of 58.0%. The Plan closed the gap but missed the Re-measurement Year 1 goal of 63.0% by 4 percentage points.
- The original 2017 baseline rate was re calculated for 2017 based on the revised California 1.5 reporting requirements released in February of 2018. The original rate reported was 56.8 %. The re calculated rate remained about the same at 56.0%. In 2018, 2853 of 4941(58.0%) of Santa Clara Health Plan's Cal MediConnect low risk members had an ICP created for them. This is an increase of 2 percentage points from the re calculated baseline rate. Using Chi-square with Yates correction, the Chi squared equals 1.258 with 1 degrees of freedom. The two-tailed P value equals 0.2620. This is considered to be not a statistically significant improvement. The Plan closed the gap but missed the Re-measurement Year 1 goal of 61.8% by only 3.8 percentage points.
- In 2018, 432 of 759 or 56.9% of Santa Clara Health Plan's Cal MediConnect members with an initial ICP completed had at least one documented discussion of care goals. This is an increase of 38.6 percentage points over the baseline rate of 18.3%. Statistically, based on Fisher's exact test**, t**his represents an extremely significant increase over the baseline rate. The Plan closed the gap by a significant amount even though the Plan fell short of the Re-measurement Year 1 goal 60% by 3 percentage points.
- The barriers, in order of priority and reiterated through this process are
    1. Data-Inconsistent and incomplete data collection for reporting purposes and ongoing routine evaluation of interventions and their effectiveness.
    2. Data- Lack of integrated data across multiple software data programs.
    3. Member Outreach- Lack of Care Goal discussions in members preferred language due to language indicator errors in eligibility file
    4. Resources-Insufficient case management staffing
    5. Processes and Training-Inadequate development and implementation of case management training materials.
- The plan has developed the following actions to further improve existing interventions:
    1. CM staffing plan was revised to add 1 additional supervisor, 3 social work case managers, 2 RN case managers and 3 personal care coordinators
    2. Individual Care Plan (ICP) Outreach and Documentation processes were updated and included extensive staff training. The process improvements will allow the team to utilize the CM system for simultaneous ICP development to occur with the member during telephonic HRA engagement
    3. An enhanced Supervisor Review Procedure was developed to evaluate staff productivity and monitor for potential risks for regulatory non- compliance.
    4. Monthly Risk Stratification Report, RP3532, was enhanced to capture monthly changes in members risk stratification levels, including the reason for the risk stratification change (poly pharmacy,

inpatient admissions, ER visits, etc.), in accordance with regulatory DPL's and three-way contract specifications to allow for increased member outreach and possible changes to member's ICP

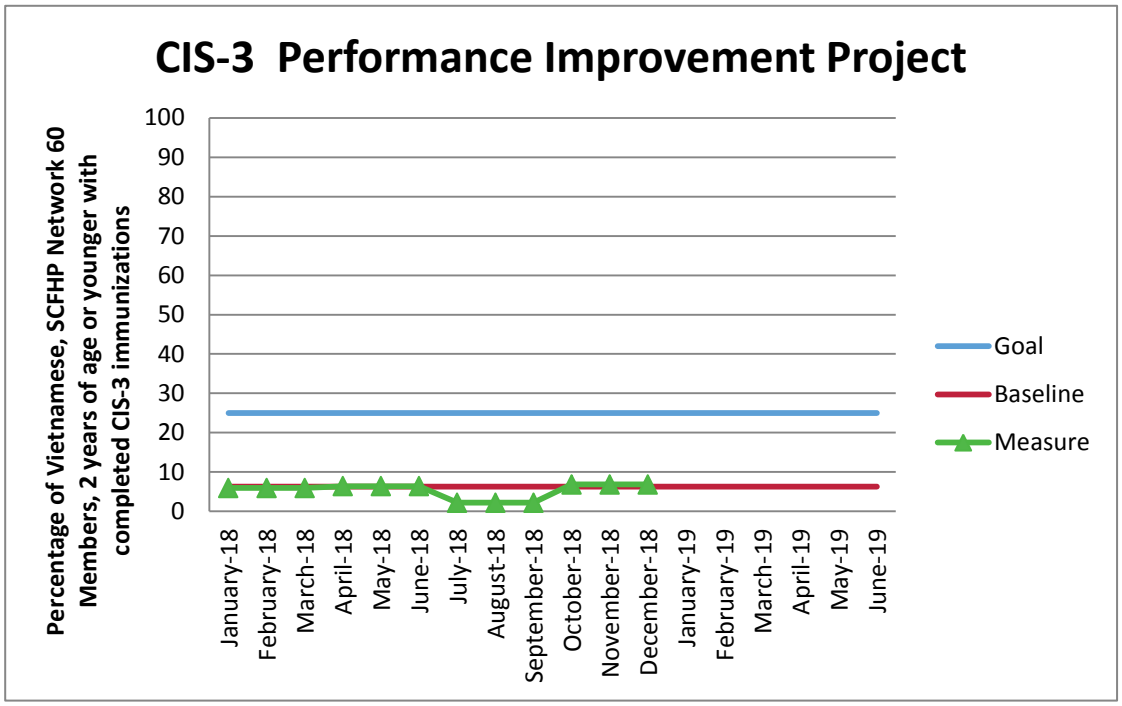
Disparities Childhood Immunization Status Combination 3(CIS-3)–DHCS Performance Improvement Project(PIP)

Goal: By June 30, 2019 increase the rate of childhood immunizations among Medi-Cal Vietnamese children 2 years and younger who reside in Santa Clara County and have a SCFHP Network 60 PCP by 18.7% or from 6.3% to 25%.

Intervention: Promote a reminder flyer and incentive for eligible Premier Care members for completing a series of immunization by the age of 2.

Design:
This 18 month PIP began in January of 2018 and will continue through June of 2019. Starting in October 2018, a list of eligible members was generated to identify those that have not completed all CIS-3 immunizations. The members are mailed a Health Education flyer with a reminder to complete their immunizations. Members are informed that if they submit proof of the completed immunizations to Health Education, they will receive a $30 Target gift card.

Smart Goal Results:



Analysis of Findings/Barriers/Progress
The Plan has not achieved the goal in 2018 but the member incentive intervention was not initiated until October. The Plan will continue to test the intervention through June of 2019 with final results to be submitted in September, 2019.

Controlling Blood Pressure -DHCS Performance Improvement Project(PIP)

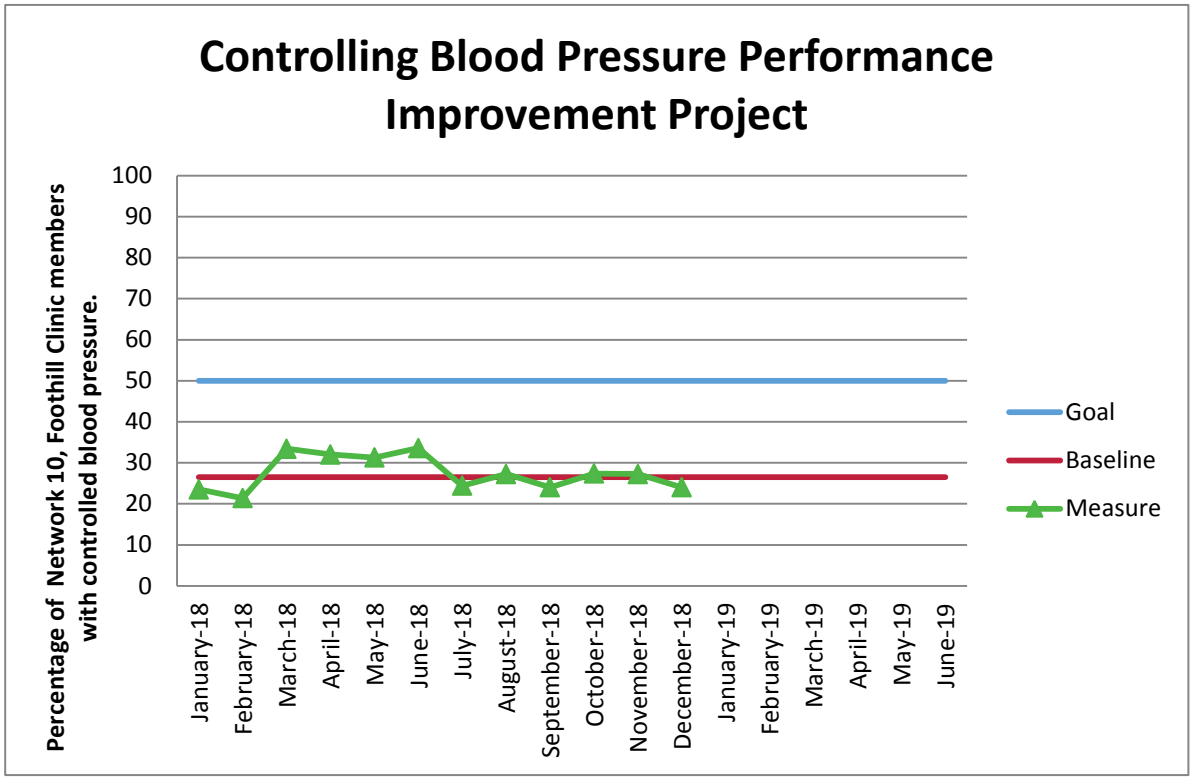
Goal: By 06/30/2019, increase the percentage rate of Network 10, Foothill Clinic members aged 18-85, with a diagnosis of hypertension, whose blood pressure is adequately controlled, during the previous rolling 12 months, from 26.47% to 50%.

Interventions: Promote a reminder and incentive for eligible Network 10, Foothill Clinic members for completing a blood pressure check.

Design

This 18 month PIP began in January of 2018, and will continue through June of 2019. On a monthly basis, a list of eligible members is generated to identify Foothill members that have not completed an annual blood pressure exam. The members are mailed a Health Education flyer with a reminder to complete a blood pressure exam. Members are informed that if they submit proof of a completed blood pressure exam to Health Education they will receive a $25 Target gift card.

Smart Goal Results: 2018 results indicate an improvement over baseline for the CBP measure in 7 out of 12 months.



Analysis of Findings/Barriers/Progress

The Plan has achieved improved results from baseline in the majority of months since the PIP was initiated and has received recommendation from HSAG to continue testing the intervention through June with final results to be submitted in August, 2019.

C. Initial Health Assessment (IHA)

C.1 Goal:

To ensure all SCFHP members complete an Initial Health Assessment (IHA) within 120 days of enrollment into the Plan, and a Staying Healthy Assessment (SHA) form in accordance with the timeframes appropriate by age. In addition, documentation of the completed assessments is evidenced in their medical record.

C.2 Interventions:

- On an annual basis, SCFHP provides information regarding the IHA to Plan members and providers in the Member and Provider Newsletters, and on the SCFHP website.
- SCFHP promotes provider education for the IHA to its delegates and independent network providers.
- The Plan updated its IHA specifications to align with the methodology of other health plans in the geographic area.
- The Plan runs IHA compliance reports on a monthly and quarterly basis.
- Plan medical record review methodology was changed to allow closer tracking of IHA criteria.

C.3 Results:

- No trending was possible for medical record review between 2017 and 2018 data, due to a change in methodology. However, monthly claims tracking through 2018 shows improvement from Quarter 1 (44.6%) to Quarter 4 (51.9%), and an annual improvement from 2017 (37.9%) to 2018 (48.3%).

C.4 Analysis of Findings/Barriers/Progress

- QI Nurse continues to audit medical records to determine compliance with IHA criteria requirements and report results to the Quality Improvement Committee.
- QI Nurse monitors and submits IHA rates to the SCFHP Compliance Dashboard monthly.
- QI Nurse provides internal staff trainings for member facing teams.
- QI Nurse continues to work with Provider Network Management team to train providers and delegates.
- QI Team continues to work with the Community Health Partnership IHA Collaboration Workgroup on a quarterly basis.

D. Patient Safety: Facility Site Review (FSR) / Medical Record Review(MRR)

D.1 Goal:

All contracted SCFHP Primary Care Providers (PCP's) receive a FSR Part A (site), Part B (medical records) and Part C (physical accessibility) evaluation every three years. PCPs that score below 80% are monitored more frequently. All newly contracted SCFHP PCP's must complete and pass FSR Part A and C as part of their contract. FSR Part B is completed within 90 days of effective date. SCFHP PCPs who move office locations are reviewed within 30 days of the date QI is notified of the move.

D.2 Intervention:

- Complete FSR A/B/C review of all PCP sites at least every third year unless required more frequently for corrective action reasons.
- Complete FSR A/B/C review for all newly contracted sites.
- Complete FSR A/B/C review for all PCPs who move location.
- Continue to collaborate with Anthem Blue Cross.
- Maintain current materials for educating providers and staff during site reviews.

D.3 2018 Results:

- Completed 32 PCP FSR site reviews.
- Completed 37 MRRs (includes MRRs repeated for low scoring providers).
- Completed 1 Initial FSR.
- Conducted 2 collaboration meetings with Anthem Blue Cross to share data.
- Completed 30 FSR Part C reviews. (Providers with a FSR-C review in the last six years may attest no changes rather than having FSR-C completed.)

D.4 Analysis of Findings/Barriers/Progress

- 26 FSR Corrective Action Plans (CAPs) issued, monitored and validated. 19 CAPs closed (remainder issued have closure dates in 2019).
- 35 MRR CAPs issued, monitored and validated. 28 CAPs closed (remainder issued have closure dates in 2019).

E. Patient Safety: Provider Preventable Conditions (PPCs)

E.1 Goal:

To report 100% of identified PPCs to DHCS.

E.2 Intervention:

- Review encounter data submitted by network providers for evidence of PPCs that must be reported.

E.3 Results:

- 0 PPCs identified 1/2018 – 12/2018.

E.4 Analysis of Findings/Barriers/Progress

- There are current technical issues obtaining accurate data for PPCs report. IT has been notified and working to resolve.
- Will reissue PPC notice to network regarding reporting PPCs to DHCS and to SCFHP.

F. Potential Quality of Care Issues Summary

F.1 Goal:

To identify, address, investigate, report and resolve any potential quality of care issues (PQI) to ensure that services provided to members meet established professional quality of care standards and improve member outcomes. This includes Critical Incidents (CI) and Provider Preventable Conditions (PPC's).

F.2 Intervention:

- QI Nurse reviews and track and trends member grievances for PQIs and CIs.
- QI Nurse analyzes issues and correlates with other reports to identify areas requiring improvement activities.
- QI Nurse submits monthly PQI data to the SCFHP Compliance Dashboard.
- QI submits quarterly PQI report to QIC for review and appropriate action.

F.3 Results:

- 472 PQI's were reported in 2018.
- 386 PQI's were closed in 2018. Of the 386 closed;
    - 5 were Level 0 – Does not meet PQI criteria, Not our member/Not our provider
    - 275 were Level 1 –Quality of Care is Acceptable
    - 87 were Level 2 - Opportunity for Improvement, no adverse occurrence
    - 10 were Level 3 – Opportunity for Improvement, adverse occurrence
    - 0 were Level 4-Immedicate Jeopardy.
    - 9 Critical Incidents

F.4 Analysis of Findings/Barriers/Progress

- There was an increase in the number of PQIs in 2018. This was due to the following: increased grievances, process improvements and improved communication between the Grievance and Appeals team and the Quality team. A new tracking system was implemented as well. The majority of PQIs reviewed were unsubstantiated, or closed as Level 1- Quality of Care is Acceptable issues.

- The Plan identified 9 PQI's with critical incidents in 2018. Of those, 6 involved cab companies, 1 occurred at a skilled nursing facility (SNF), 1 involved a provider and 1 involved home care. Critical Incidents are high priority cases. Those occurring at SNFs are reported to the California Department of Public Health Licensing and Certification office in San Jose for investigation. SCFHP uses those findings to create a CAP depending on the State's findings.
    - Level 1 – 1, no CAP (Cab)
    - Level 2 – 4, no CAPs (2 Cab, 1 SNF, 1 PCP)

- Level 3 – 1, no CAP (Cab)
- Open, investigation in progress – 3 (2 Cab, 1 Home Care)

- The increase in Critical Incidents in 2018 was due to an increased awareness on the part of plan staff regarding what constitutes a critical incident after additional training.

G. Timely Access and Availability

G.1 Goal:

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

G.2 Objectives:

- Complete the following surveys annually:
  - Provider Appointment and Availability Survey (PAAS)
  - Third Next Available Appointment (TNAA)
  - After-Hours Survey (AHS)
  - Provider Satisfaction Survey (PSS)
  - Member Satisfaction Survey (MSS) - Customer Service
- Measure timely appointment access, at least annually.
- Measure primary care after-hours access, at least annually.
- Evaluate SCFHP's timely access performance in comparison to goals.
- Identify areas to improve timely appointment access.
- Develop interventions as appropriate to address deficiencies and/or gaps in care.

G.3 Results:

Table I: Primary Care Provider (PCP)

A. Standard: Urgent Care Appointment within 48-hours

# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
480	261	177	100%	No	68%	72%	-4%

B. Standard: Non-Urgent/Routine Appointment within 10-days

# Surveyed	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
480	276	248	100%	No	90%	91%	-1%

Table II: Specialists

A. Standard: Urgent Care Appointment within 96-hours

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=103)	34	24	100%	No	71%	73%	-2%
Endocrinology (N=33)	8	5	100%	No	63%	24%	+39%
Gastroenterology (N=74)	12	5	100%	No	42%	13%	+29%
Psychiatry (N=90)	5	3	100%	No	60%	1%	+59%

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

Provider Group	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Cardiology (N=131)	40	28	100%	No	70%	72%	-2%
Endocrinology (N=33)	14	7	100%	No	50%	18%	+32%
Gastroenterology (N=74)	20	6	100%	No	30%	1%	+29%
Psychiatry (N=90)	10	7	100%	No	70%	1%	+69%

Table III: Non-Physician Mental Health

A. Standard: Urgent Care Appointment within 96-hours

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Applied Behavioral (N=6)	2	0	100%	No	0%	NA	NA
Clinical Social Worker (N=10)	3	2	100%	No	67%	NA	NA
Marriage/Family Counseling (N=21)	3	1	100%	No	33%	NA	NA
Psychology (N=20)	0	NA	100%	NA	NA	NA	NA

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

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Applied Behavioral (N=6)	1	0	100%	No	0%	NA	NA
Clinical Social Worker (N=10)	3	3	100%	Yes	100%	NA	NA
Marriage/Family Counseling (N=21)	1	1	100%	Yes	100%	NA	NA
Psychology (N=20)	0	NA	100%	NA	NA	NA	NA

Table IV: Ancillary

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

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
Physical Therapy (N=10)	9	9	100%	Yes	100%	100%	0
Mammogram (N=3)	2	2	100%	Yes	100%	100%	0
MRI (9)	5	5	100%	Yes	100%	100%	0

AFTER-HOURS SURVEY

GOALS

(Ctrl)

To ensure that SCFHP primary care providers meet after-hours access standards established by the Plan, DMHC and other regulatory agencies and to ensure members access to health care needs are met.

OBJECTIVES

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

RESULTS

Table I:

A. PCP Access Compliance: 911 Information

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=480)	401	401	100%	Yes	100%	88%	+12%

B. PCP Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=480)	401	176	100%	No	44%	74%	-30%

C. Mental Health Access Compliance: 911 Information

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=153)	98	98	100%	Yes	100%	NA	NA

D. Mental Health Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=153)	84	10	100%	No	12%	NA	NA

Third Next Available Appointment Survey

GOALS
Assess the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

DEFINITION:
The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. For example, an appointment may be open at the time of a request because of a cancellation or other unexpected event. Using the "third next available" appointment eliminates these chance occurrences from the measure of availability.

OBJECTIVES:

- Measure the average length of time between the survey date and the third available appointment.
- Measure the time it takes the providers office to answer the call (standard: 60 seconds or less) and
- Measure the timeframe in which a member would receive a return call from the provider's office (medical triage/screening and non-medical related inquires-standard: 30 minutes or less).
- Survey also includes an After-Hours inquiry.

The providers to be surveyed are Primary Care Providers (PCP), Specialists and Obstetrics and Gynecology (for the initial prenatal care visit only).

RESULTS

Table I:

A. Office Call Pick Up (within 60-seconds)

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=10)	10	10	100%	Yes	100%	NA	NA
Dermatologist (N=1)	1	1	100%	Yes	100%	NA	NA
Gastroenterologists (N=4)	4	4	100%	Yes	100%	NA	NA
Otolaryngoloists (N=3)	3	3	100%	Yes	100%	NA	NA
Pediatric Neurologists (N=2)	2	2	100%	Yes	100%	NA	NA

B. Appointment Availability – 3rd Date (New Patient)

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=10)	10	0	100%	No	0%	NA	NA
OBGYN (N=10)	10	5	100%	No	50%	NA	NA
Dermatologist (N=1)	1	1	100%	Yes	100%	NA	NA
Gastroenterologists (N=4)	4	4	100%	Yes	100%	NA	NA
Otolaryngoloists (N=3)	2	1	100%	No	50%	NA	NA
Pediatric Neurologists (N=2)	2	0	100%	No	0%	NA	NA

C. Appointment Availability – 3rd Date (Established Patient) PCP/SPC ONLY

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=10)	10	8	100%	No	80%	NA	NA
Dermatologist (N=1)	1	1	100%	Yes	100%	NA	NA
Gastroenterologists (N=4)	4	4	100%	Yes	100%	NA	NA
Otolaryngoloists (N=3)	2	1	100%	No	50%	NA	NA
Pediatric Neurologists (N=2)	2	0	100%	No	0%	NA	NA

D. Average In-Office Wait Time PCP/SPC ONLY

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=10)	10	10	100%	Yes	100%	NA	NA
Dermatologist (N=1)	1	1	100%	Yes	100%	NA	NA
Gastroenterologists (N=4)	4	4	100%	Yes	100%	NA	NA
Otolaryngoloists (N=3)	3	3	100%	Yes	100%	NA	NA
Pediatric Neurologists (N=2)	2	2	100%	Yes	100%	NA	NA

E. Wait Time for a Return Call During Business Hours- Medical Triage/Screening

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=10)	10	4	100%	No	40%	NA	NA
OBGYN (N=10)	10	8	100%	No	80%	NA	NA
Dermatologist (N=1)	1	1	100%	Yes	100%	NA	NA
Gastroenterologists (N=4)	4	4	100%	Yes	100%	NA	NA
Otolaryngoloists (N=3)	3	3	100%	Yes	100%	NA	NA
Pediatric Neurologists (N=2)	2	1	100%	No	50%	NA	NA

F. Wait Time for a Return Call During Business Hours- Non-Medical Related

Provider Type	# Responded	# Compliant	Goal	Goal Met	MY2018 Rate of Compliance	MY2017 Rate of Compliance	% Change MY2018
PCP (N=10)	10	10	100%	Yes	100%	NA	NA
OBGYN (N=10)	10	6	100%	No	60%	NA	NA
Dermatologist (N=1)	1	1	100%	Yes	100%	NA	NA
Gastroenterologists (N=4)	4	4	100%	Yes	100%	NA	NA
Otolaryngoloists (N=3)	3	3	100%	Yes	100%	NA	NA
Pediatric Neurologists (N=2)	2	2	100%	Yes	100%	NA	NA

G.4 Analysis of Findings/Barriers/Interventions

INTERVENTIONS:

Following data collection and generation of reports on survey results, SCFHP issues corrective action letters to providers who do not meet access standards. PAAS resurveys were completed within 60 days from the date on the CAP letters. The resurveys were conducted in October 2018 and resurveyed providers who showed continued non-compliance were issued a requirement to complete SCFHP's timely access training program and to submit a training attestation. SCFHP's PNM staff continue to conduct provider outreach and train non-compliant providers on timely appointment standards.

OPPORTUNITIES

Barrier	Opportunity	Intervention	Selected for 2019	Date Initiated
Timely access	• Improve access to urgent and non-urgent care appointments • Expand behavioral health provider network	• Improve training materials • Conduct provider outreach(Training/BH Contracting) • Provider Access Communications-Fax Blast	Yes	On-going
After-Hours Access (return call within 30min or less)	• Improve after-hours access	• Improve training materials • Provider Access Communications-Fax Blast	Yes	On-going
Wait time return call – Triage/Screening & Non-Medical Related	• Improve provider call backs for triage/screening	• Improve training materials • Provider Access Communications-Fax Blast	Yes	On-going

H. Consumer Assessment of Healthcare Providers and Systems(CAHPS)

H.1 Goal:

Use Consumer Assessment of Healthcare Providers & Systems (CAHPS) results to improve member satisfaction and for results to exceed California Medicare Medicaid Plan's (MMP) average scores in all categories.

H.2 Interventions:

- The Plan sent 2 reminder post cards to members regarding the importance of completing the CAHPS survey and providing the plan with feedback.
- The Plan included an oversample of 800 members (1600 total) to help with CAHPS response rate.
- The Plan tested sending out CAHPS surveys in Chinese and Vietnamese to measure the effect of these two languages to the results.
- The Plan worked with DSS Research to break down results by provider group.
- The Plan conducted training to member and provider facing departments on the results from year one and two to brain storm ideas on how to improve rates.
- The Plan shared results with provider advisor committee and quality improvement committee and delegated groups.

H.3 Results

- In 2018, the Plan response rate was 26.1 %. Overall California response rate was 27.8%.
- Category results indicate:
  - The Plan showed significant improvement in:
    - Rating of Health Plan
  - The Plan showed moderate improvement in:
    - Rating of Drug Plan
    - Customer Service
  - The Plan stayed about the same in:
    - Getting Needed Prescription drugs
    - Getting needed care
    - Getting needed appointments and care
    - Rating of personal doctor
    - Rating of specialists
    - Doctors who communicate well
- The Plan did not exceed the California MMP average in any of the Categories.
- The Plan exceed the California MMP average in the following questions within the categories:
  - In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
  - In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
  - In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?
  - In the last 6 months, how often was it easy to use your prescription drug plan to fill a prescription at a local pharmacy?
  - In the last 6 months, how often was it easy to use your prescription drug plan to fill prescriptions by mail?
  - Influenza Vaccination
  - Pneumonia Shot

H.4 Analysis of Findings/Barriers/Progress

- The health plan decreased in its 2018 CAHPS response rate from 29% in 2017, but accomplished the process goal of getting more actionable data and was only slightly lower than the overall California rate.
- The interventions between year two and year three identified specific opportunities for improvement in Health Plan Composite Measures and Overall Health Plan rankings.
- With changes in the CMS process that allowed for additional languages, the Plan tested using Chinese and Vietnamese survey's and found that inclusion of those languages in the official survey would have increased scores and response rates. Chinese and Vietnamese will be part of the official survey in 2019.
- Results were broken down by provider group for the first time and shared with provider group representatives.
- Plan has reached out to its providers directly and shared provider group level results and broad areas for improvement.

I. Appeals and Grievances

SCFHP

I.1 Goal:

Increase member satisfaction by addressing member grievances within mandated timelines.

I.2 Intervention:

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

I.3 Results:

- 2018 showed an improved compliance rate of 95.95% for standard grievances resolved in the mandated time frames, this was an improvement of over 7% from the prior year's rate of 88.3%.
- The lowest performing time frame was Q4 2018 where the compliance rate dipped to 88.9% in the month of November.

I.4 Analysis of Findings/Barriers/Progress

- Low number of grievance staff compared the volume of grievances received has presented a barrier
- Lack of monitoring process prevented G&A Management from overseeing timeliness
- Staff turnover also presented a barrier throughout the year
- G&A Staffing needs were addressed by approving additional staff to the department. Three additional Coordinator positions were approved. Additionally, a G&A Data Analyst has been hired to assist with making performance metrics transparent.

QI Program Effectiveness

The 2018 Quality Improvement(QI) Program was effective in demonstrating improvements in both the clinical and service areas for Medi-Cal, Healthy Kids and Cal MediConnect members. The Program resources, which include staffing, committee structure, external and internal practitioner participation, along with the plan's leadership, proved to be sufficient in meeting the QI Program's goals and objectives.

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Care	**QI Program Evaluation**	QI Program Annual Evaluation	CMC 2.16.3.3.4 NCQA 2018 QI1 Elements A and B	- To evaluate the results of QI initiatives and submit the results to DHCS and CMT - QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	- collect aggregate data on utilization - review of quality services rendered - review and analyze outcomes/findings from Improvement Projects, customer satisfaction surveys and collaborative initiatives - trending of measures to assess performance in the quality and safety of clinical care and quality of service - analysis and evaluation of the overall effectiveness of the QI Program and of its progress toward influencing network-wide safe clinical practices	- submission of QI Program evaluation to - QIC - Board	Annual Evaluation	QI Manager	Annually	May-19		Approved by QIC: Adopted by Board:
Quality of Care	**Member Safety**	SCFHP provides members with the information they need to understand and use their pharmacy benefit.	NCQA 2018 MEM2C	Ensure pharmacy benefit information provided to members on an ongoing basis is accurate	- The Pharmacy Department and Customer Service will collect data and review for accuracy and ensure quality of information being provided to members	- Annually the Pharmacy Department will report -data collection - assessment -actions	100%	Pharmacy Manager and Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2018 MEM3C	Ensure members can use personalized information to navigate health plan services effectively	- The Customer Service Department will collect data on the quality and accuracy provided, compare information against goals, and determine deficiencies in delivery of information act to improve deficiencies identified	- Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions to improve data	100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2018 MEM3D	Ensure quality and timely email communication to members is happening on an ongoing basis	- The Customer Service Department will collect data email responses to members is happening on an ongoing basis in a timely manner	Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions of email responses to members	100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1A	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- SCFHP assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.	Analysis of cultural, ethnic, racial and linguistic needs of it's members relative to the provider network	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1B	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioner providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.	Analyze performance against primary care availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1C	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists. 2. Establishes measurable standards for the number of each type of high-volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measurable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually.	Analyze performance against specialists (including high volume and high impact) availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2018 NET1D	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against the standards annually	Analysis of behavioral health care practitioners access standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services	NCQA 2018 NET2A -C	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services.	Collect and preform analysis of data for primary care, specialty, and behavioral health 1. Regular and routine care appointments. 2. Urgent care appointments. 3. After-hours care	Analysis and report	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP monitors access to healthcare services and takes action to improve it	NCQA 2018 NET3A-C	SCFHP provides members adequate network access for needed healthcare services.	- SCFHP annually: 1. Analyzes data from member experience, complaints and appeals about network adequacy for non-behavioral healthcare, behavioral, and overall services 2. Analyzes data from member experience, complaints and appeals about network adequacy for behavioral healthcare services, behavioral, and overall services 3. Compiles and analyzes requests for and utilization of out-of-network services. 4. Prioritizes opportunities for improvement identified, 5. implements intervention 6. measure effectiveness of interventions	Annual report	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Health Plan Accreditation	**NCQA Accreditation**	SCFHP systematically collects, integrates and assesses member data to inform its population health management programs	NCQA 2018 PHM2B	SCFHP assesses the needs of its population and determines actionable categories for appropriate intervention.	- SCFHP annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members. 4. Assesses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental	Annual report	100%	Health Educator	Annually	First quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP coordinates services for its highest risk members with complex conditions and helps them access needed resources.	NCQA 2018 PHM5	SCFHP helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.	-SCFHP implements on an annual basis a member survey on members experience with case management -collects member complaint data on an ongoing basis from grievance process	Annual report	100%	Case Management Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement	NCQA 2018 PHM6A	- Quantitative results for relevant clinical, cost/utilization and experience measures -Comparison of results with a benchmark or goal. -Interpretation of results	-collect data on relevant cost, utilization and experience measure	Annual report	100%	Case Management Manager	Annually	First quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP monitors member experience with its services and identifies areas of potential improvement	NCQA 2018 QI4A	-Using valid methodology, the organization collects and performs an annual analysis to measure its performance against its standards for access to Member Services by telephone	- Annual analysis to measure telephone access against standards	Annual report	100%	Customer Service Director	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2018 QI4C	To assess member experience with its services, the organization annually evaluates member complaints and appeals	Collect valid measurement data for each of the following categories -quality of care -access -attitude and service -billing and financial issues -quality of practitioner office site	Annual report	100%	Grievance Manager	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2018 QI4D	SCFHP annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis	Analyze and identify opportunities for improvement from the following sources -Member complaint and appeal data -CAHPS survey	Annual report	100%	Performance Improvement Manager	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Health Plan Accreditation	**NCQA Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2018 QI4E & F	Assess member experience with Behavioral Health services Evaluate and identify opportunities for improvement	-Evaluate member complaints and appeals --conduct member survey -Improve members experience with behavioral healthcare and service --Assess data from complaints and appeals or from member experience surveys --Identifying opportunities for improvement --implementing interventions --measuring effectiveness of interventions	Annual report	100%	Behavioral Health Director	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	Assessing Experience With the UM Process	NCQA 2018 QI4G	SCFHP annually assessment of experience with the UM process	Collect and analyzing data on member experience to identify improvement opportunities. Collects and analyzing data on practitioner experience to identify improvement opportunities. Take action designed to improve member experience based on assessment of member data. Take action designed to improve practitioner experience based on assessment of practitioner data	Annual report	100%	Utilization Manager	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Care	**QI Program**	Development of a QI Work Plan and Evaluation each year and subsequent tracking of implementation	CMC 2.16.1 Medi-Cal Exhibit A, Attachment 4 .7	- To document and initiate appropriate modifications to the QI Program, and set QI goals each year. - To identify areas of focus for the QI program. - To organize and prioritize the workload with assignments given for accountability and responsibility	QI Program and QI Work Plan will be adopted on an annual basis	Submit the 2018 QI Evaluation and 2019 QI Work Plan for the Board Report	Annual Adoption	QI Manager	Annually	May-19		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.	NCQA 2018 QI5A - C	SCFHP annually identifies opportunities to improve coordination of medical care, act on opportunities identified, measuring effectiveness of improvement actions taken	A. Collect 1. Collect data on member movement between practitioners 2. Collect data on member movement across settings 3. Conduct quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting four opportunities for improvement B. Act Annually act to improve coordination of care activities identified in the Collect phase C. Measure Annually measure the effectiveness of improvement actions taken in the Act phase	Quantitative and qualitative analysis with identification of four opportunities for improvement documented in a report	100%	Health Services Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Medi-Cal and CMC	**UM Program**	Annual oversight of UM Program and Work Plan	CMC 2.11.5.1	- To document and initiate appropriate modifications to the UM Program, and set UM goals each year. - To identify areas of focus for the UM program. - To organize and prioritize the workload with assignments given for accountability and responsibility	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	- submission of UM Program evaluation to - UMC - QIC - Board	Annual Adoption	Medical Director UM	Annually	September-19		Approved by QIC: Adopted by Board:
Quality of Service	**CAHPS**	Annual Oversight of CAHPS Survey and Work Plan		Complete Annual Survey, Analyze Results,	Develop Improvement Plans based on results	Areas for improvement identified in the CAHPS 2019 survey	Annual recommendation	QI Project Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Service	**HOS**	Annual Oversight of HOS Survey and Work Plan		Complete Annual Survey, Analyze Results, Develop Improvement Plans based on results	Develop Improvement Plans based on results	Areas for improvement identified in the HOS survey	Annual recommendation	QI Project Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Service	**NCQA Plan Ratings**	Annual Oversight of NCQA Plan Ratings and Work plan		Analyze Results	Develop Improvement Plans based on results							Approved by QIC: Adopted by Board:
Timely Access	**Access/Availability**	Access to needed medical services in a timely manner is maintained	CMC 2.11.9.1		Measure and analyze data against goals for the following: 1. Regular & routine appointments within 30 days 2. Urgent Care appointments within 48 hours 3. After-hours care within 6 hours 4. Member services, by telephone ASA 30 seconds with abandonment rate <5% 5. PCP capacity		97%	Provider Services Director	Quarterly	February 2019 April 2019 Aug 2019 Dec 2019		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews New applicants processed within 180 calendar days of receipt of application		100%	Credentialing Manager	Quarterly	February 2019 April 2019 Aug 2019 Dec 2019		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews Recredentialing is processed within 36 months		100%	Credentialing Manager	Quarterly	February 2019 April 2019 Aug 2019 Dec 2019		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practitioners	CMC 2.11.2.1		Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.		90%	Provider Services Director	Annually	August 2019		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practitioners	CMC 2.11.2.1		Measure and analyze practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary. Measured through quantifiable and measurable standards for the following: 1. Each type of PCP 2. Geographic distribution 3. Performance against standards for PCPs 4. Performance against geographic distribution		90%	Provider Services Director	Annually	August 2019		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**Utilization Management**	CM Program Annual Evaluation			CM Program and CM Work Plan will be evaluated for effectiveness on an annual basis		Annual Evaluation	CM Manager	Annually	June 2019		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**HEDIS Reporting**	Report HEDIS successfully by 6/15/2018	CMC 2.19.2.5 Medi-Cal Exhibit A Attachment 4.9	- To successfully report HEDIS for Medi-Cal and CMC by June 17, 2019 - To successfully complete MRRV without a second sample being reviewed - Successfully close the IS Grid by 6/1/2019 - Medi-Cal Composite HEDIS 2019 Average to be at 70%. -CMC Composite HEDIS 2019 Average at 60%	- Create data warehouse - pull samples - request medical records - onsite audit - review of vendor numerator positive medical records prior to MRRV	Submission of the IDSS to NCQA by 6/17/2019	Annual Submission	HEDIS Project Manager	Annually	June 2019		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Statewide Disparity Performance Improvement Projects**	Increase rate of childhood immunization status combo 3 for vietnamese children	CMC 2.16.4.3.1.2.2 Medi-Cal Exhibit A, Attachment 4.9.C.b	6.3% percent increase in immunization rates over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement		25% for Network 60 by the end of the PIP 6.3% increase over baseline rate of 18.7%	QI Project Manager	Quarterly			Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Internal Performance Improvement Projects Medi-Cal**	Controlling blood pressure for members with hypertension	Medi-Cal Exhibit A Attachment 4.9.C.a	23.53% percent increase in CBP rate over the 18 month life of the project	Use Member Incentive to improve rates on a small scale using Rapid Cycle Improvement		50% for Network 10 by the end of the PIP. 23.53 percent increase over baseline rate of 26.47%	QI Project Manager	Annually			

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Service	**Internal Performance Improvement Projects CMC**	Increase number of members with an ICP and discussion of care goals	CMC 2.16.4.3.1.2.1	Increase the percentage of members with an ICP completed and percentage of members with documented discussion of care goals	- Plan will further develop and implement new processes and training materials to improve consistency of documentation within SCFHP's case management software program	Annual Submission	By December 31st 2018, increase by 5% from baseline in all three submeasures	Health Services Director	Annually	January 2019	Ongoing	
Quality of Clinical Care	**Chronic Clinical Performance Improvement Projects CMC**	Target Chronic Condition: Behavorial Health Condition - Mental Illness	CMC	Increase the number of follow up visits for members with a discharge from the Emergency Department with a diagnosis of mental illness	Plan will develop and implement a 3 year project to increase the precentage of discharges for members 6 years of age and older who were hopsitalzied for treametnet of selected mental illness or intentional self-harm diagnosis and who had a follow up visit with a metnal health practiioner within 30 days of discharge.	Annual Submission	By December 31, 2021, increase measure rate from 43.18 % to 53.18%.	Behavioral Health Manager and QI Project Manager	Annually	December 31, 2019 December 31, 2020 December 31, 2021		
Quality of Clinical Care	**Internal Performance Improvement Projects Medi-Cal and CMC**	HEDIS Measure: Controlling High Blood Pressure (CBP)	DHCS 2019 External Accountability Set	Increase member awareness of availibility of blood pressure monitor	Develop and implement intervention to educate members and providers on the availibility of a blood pressure monitor.	Annual Submission	By December 31, 2019, increase the number of blood pressure monitor scripts by 10%.	Pharmacy Manager and QI Project Manager	Annually	December 2019		
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Cervical Cancer Screening (CCS)	DHCS 2019 External Accountability Set	Increase the number of SCFHP women who have a screening exam for cervical cancer	- Develop and implement interventions based on a barrier analysis for CCS - Reminder letters on birthday month - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	-increase cervical cancer screening rates over the Medicaid 25th percentile (51.88) - 54.26% HEDIS 2018	QI Manager or designee	Quarterly	October-19		
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Childhood Immunization Status (CIS) – Combination 3	DHCS 2018 External Accountability Set	Increase the number of SCFHP children who are compliant for their immunizations through Combo 3	- Develop and implement interventions based on a barrier analysis for CIS Combo 3 - Televox reminder calls for non compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase CIS Combo 3 rate over the Medicaid 50th Percentile (71.58%) - 77.37% HEDIS 2017 - 77.62% HEDIS 2018	QI Manager or designee	Quarterly	Ongoing - Monthly		
Quality of Clinical Care	**Project: Diabetes**	HEDIS Measure: Comprehensive Diabetes Care (CDC) - HbA1c Testing	DHCS 2019 External Accountability Set	Increase the number of SCFHP members with diabetes who have an HbA1c screening annually	- Develop and implement interventions based on a barrier analysis for CDC HbA1c Testing - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase CDC - HbA1c testing rate over Medicaid 75th percentile (90.05%) - 88.32% HEDIS 2018	QI Manager or designee	Quarterly	October-19		
Quality of Clinical Care	**Project: Cardiovascular Conditions**	HEDIS Measure: Controlling High Blood Pressure (CBP)	DHCS 2019 External Accountability Set	Increase the number of SCFHP members with hypertension who have their blood pressure below 140/90	- Develop and implement interventions based on a barrier analysis for CBP - work with network providers to develop an organized system of regular follow up and review of patients with hypertension - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase blood pressure control for members with hypertension over the Medicaid 50th percentile (56.93%) -65.94% HEDIS 2018	QI Manager or designee	Quarterly	October-19		

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Clinical Care	**Project: Access & Availability of Care**	HEDIS Measure: Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	DHCS 2019 External Accountability Set	Increase the number of SCFHP members who get timely prenatal care	- Develop and implement interventions based on a barrier analysis for PPC - Timely Prenatal Care - do a meta analysis of the interventions done by other Medi-Cal health plans in the region to find the most effective type of prenatal program - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase PPC Timeliness of Prenatal Care over the Medicaid 50th Percentile (83.56%) -83.70% HEDIS 2018	QI Manager or designee	Quarterly	October-19		
Quality of Clinical Care	**Project: Utilization**	HEDIS Measure: Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	DHCS 2019 External Accountability Set	Increase the number of SCFHP members who get their annual well child visit	- Develop and implement interventions based on a barrier analysis for W34 - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase W34 rate over the Medicaid 90th Percentile (82.77%) - 72.75% HEDIS 2018	QI Manager or designee	Quarterly	October-19		
Quality of Service	**Project: 120 Initial Health Assessment**	Initial Health Assessment and Staying Health Assessment	Exhibit A, Attachment 10.3	Ensure new enrollees to SCFHP receive an IHA within 120 calendar days of enrollment and HIF/MET within 90 days of the effective enrollment	- develop a reporting system that monitors the IHA and HIF/MET compliance across the plan - integrate medical record review for a sample of IHA visits each quarter as part of Facility Site Review - Provider training on IHA requirements - IHA Work Plan will be evaluated for effectiveness on an annual basis	- develop regular reporting mechanism to monitor ongoing performance - medical record audit of IHA visits and document compliance - training attestations	- Medicaid rate 100%	QI Manager or designee	Quarterly	December-19		
Health Plan Accreditation	**NCQA Accreditation**	NCQA Accreditation of the CMC line of business	CMC	Obtain full accreditation status by CY 2019	- obtain full accreditation by Q1 2019	-full accreditation for CMC line of business	Achieve full accreditation	Performance Improvement Manager	Annually	October-18	Yes	The Plan achieved full accredidation on February 22, 2019.
Safety of Clinical Care	**Facility Site Review**	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices		Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	- Review every 3 years as part of the Credentialing process - Review all new potential PCP offices prior to contracting - Provide follow/up and ongoing monitoring of timely correction of Critical Element (CE) deficiencies and Corrective Action Plan as mandated by DHCS guidelines. - Continue the collaborative process with the County's MCMC Commercial Plan	- successful submission of FSR scores on a semi annual basis		QI Nurse	Ongoing	Ongoing - Monthly	N/A	

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Safety of Clinical Care	**Quality of Care**	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	DPL 15-002	Complete all PQI's originating from Grievance and Appeals within 60 days	- update PQI policy - Roll out retraining of Medical Management and Member Services Staff - develop methodology for retrospective review of call notes to identify PQI's - ongoing reporting of PPC's to DHCS	- revised PQI policy - training materials used	100%	QI Nurse	Ongoing	Ongoing - Monthly	N/A	
Health Plan Accreditation	**NCQA Accreditation**	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2018 QI6 A	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information 2. Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care 3. Appropriate use of psychotropic medications 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders 5. Primary or secondary preventive behavioral healthcare program implementation 6. Special needs of members with severe and persistent mental illness	Aggregate available data	100%	Behavioral Health Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2018 QI6 B	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identify and selecting two opportunities for improvement from QI6A 4. Taking collaborative actions to address two identified opportunity for improvement from QI6A	Analyze data identified in QI6A	100%	Behavioral Health Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2018 QI6 C	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually measures the effectiveness of improvement actions taken for activities identified in QI6B	measure effectiveness of collaborative actions take as part of QI6B	100%	Behavioral Health Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

2019 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues

Laurie Nakahira, DO
Chief Medical Officer
Santa Clara Family Health Plan

Date

Santa Clara Family Health Plan (SCFHP)
Cal MediConnect (CMC)
Population Assessment
2019

TABLE OF CONTENTS

BACKGROUND

Santa Clara Family Health Plan (SCFHP) is a not-for-profit organization established in 1997 that offers comprehensive and affordable health coverage for low-income residents in Santa Clara County, California. SCFHP current services over 7,500 beneficiaries covered under its Cal MediConnect (CMC) line of business. In order to qualify for the program, beneficiaries must meet the following criteria: live in Santa Clara County, be 21 years of age or older, have both Medicare Part A and B, and be eligible for full scope Medi-Cal. Reporting requirements for this program closely follow the reporting requirements for Centers for Medicare & Medicaid Services (CMS) Medicare Advantage programs. SCFHP serves 75% of the CMC population in Santa Clara County, while Anthem Blue Cross serves the remaining 25%.

INTRODUCTION

This report provides an overview of SCFHP's CMC beneficiary demographics and explores the population by breakdown of geographic location, disabilities, ethnicity, and language. It examines various social determinants of health and health disparities affecting residents of Santa Clara County and SCFHP's CMC beneficiaries, providing insight on factors that directly impact health outcomes. This report also assesses the needs of SCFHP's beneficiary subpopulations, including those with multiple chronic conditions, severe mental illnesses (SMI), beneficiaries receiving long-term services and support, and the homeless.

Additionally, this report dives into SCFHP's Healthcare Effectiveness Data and Information Set (HEDIS) data, the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and the beneficiary self-reported Health Risk Assessment (HRA). Various data sources were utilized to assess the needs of beneficiaries, including: reports from CMS, the Santa Clara County Public Health Department, SCFHP's claims, encounter, pharmacy, socioeconomic, and demographic data.

Using this data, SCFHP can address the needs of beneficiaries and help connect them with appropriate programs and services. Furthermore, SCFHP will be able to strengthen existing practices and develop new resources and interventions to better serve SCFHP beneficiaries, moving towards reducing health disparities and a more equitable future.

SCFHP CMC BENEFICIARY DEMOGRAPHICS CALENDAR YEAR (CY) 2018

SCFHP serves a diverse population. Women make up 58% of the CMC population, whereas men make up 42%. Beneficiaries ages 65 and older make up 80% of the population, while beneficiaries ages 64 and under make up 20%. Table 1 summarizes the SCFHP CMC beneficiary demographics for 2018. This includes beneficiaries who were eligible at any time during calendar year 2018. Asians make up a majority of the CMC population at 39%, followed by Hispanics at 26%.

Table 1. SCFHP CMC Beneficiary Demographics CY2018.

ETHNICITY	NUMBER OF MEMBERS	PERCENTAGE
AFRICAN AMERICAN	326	4%
ALASKAN/AMER INDIAN	38	0%
ASIAN/PACIFIC	3506	39%
CAUCASIAN	1642	18%
HISPANIC	2357	26%
OTHER/UNKNOWN	1083	12%
TOTAL	**8952**	**100%**

Disabled Population

Table 2 summarizes the number of beneficiaries with disabilities by ethnicity within the SCFHP CMC population. Asians had the highest number of disabled beneficiaries at 36% followed by Hispanics at 25%.

Table 2. SCFHP CMC beneficiaries with Disabilities by Age and Ethnicity.

ETHNICITY	AGES 65+	AGES UNDER 65	TOTAL	PERCENTAGE
AFRICAN AMERICAN	126	105	231	3%
ALASKAN/AMER INDIAN	16	13	29	0%
ASIAN/PACIFIC	2535	181	2716	40%
CAUCASIAN	738	460	1198	18%
HISPANIC	1358	350	1708	25%
OTHER/UNKNOWN	706	161	867	13%
TOTAL	**5479**	**1270**	**6749**	**100%**

Disease State

Table 3 summarizes the top ten emergency room (ED) diagnoses for CMC beneficiaries and Table 4 summarizes the top ten diagnoses for hospitalizations among CMC beneficiaries in 2018. Urinary Tract infections were the number one reason for ED visits and the seventh most common diagnoses for hospitalizations among CMC beneficiaries in 2018. Interestingly, cardiovascular conditions, including chest pain, hypertension, and heart disease, were the most common diagnoses for CMC beneficiaries for ED and hospitalizations in 2018. This data suggests that future interventions should focus on cardiovascular health for this population. Further analysis of the data is needed to determine if there is a disparity among certain ethnicity groups or subpopulations.

Table 3. Top Ten ED Diagnoses for CMC Beneficiaries.

RANKING	DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION	NUMBER OF VISITS
1	N39.0	Urinary tract infection, site not specified	129
2	R07.9	Chest pain, unspecified	124
3	R42	Dizziness and giddiness	98
4	R07.89	Other chest pain	91
5	R10.9	Unspecified abdominal pain	77
6	I10	Essential (primary) hypertension	72
7	M54.5	Low back pain	59
8	R51	Headache	59
9	R05	Cough	55
10	F43.25	Adjustment disorder with mixed disturbance of emotions and conduct	54

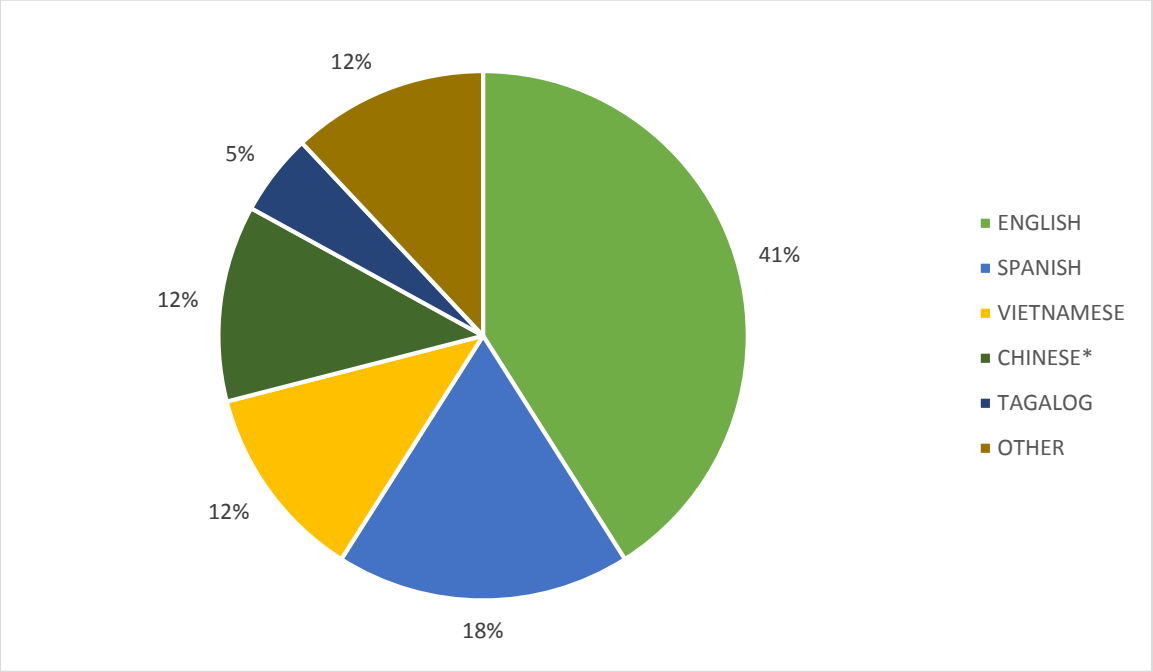
Table 4. Top Ten Hospitalization Diagnoses for CMC Beneficiaries.

RANKING	DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION	NUMBER OF VISITS
1	A41.9	Sepsis, unspecified organism	401
2	I11.0	Hypertensive heart disease with heart failure	94
3	I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	92
4	A41.51	Sepsis due to Escherichia coli [E. coli]	68
5	J69.0	Pneumonitis due to inhalation of food and vomit	64
6	N17.9	Acute kidney failure, unspecified	63
7	N39.0	Urinary tract infection, site not specified	52
8	J44.1	Chronic obstructive pulmonary disease with (acute)	50
9	J18.9	Pneumonia, unspecified organism	46
10	I63.9	Cerebral infarction, unspecified	44

Language Utilization

SCFHP has five threshold languages as defined by the California Department of Healthcare Services (DHCS), including English, Spanish, Vietnamese, Tagalog, and Chinese (Mandarin and Cantonese). These languages are the most frequently spoken languages among SCFHP beneficiaries. SCFHP partners with language vendors to provide telephonic and face-to-face interpreter services and utilizes California Relay Services for TDD/TTY services. All language services are provided at no cost to beneficiaries. Figure 1 summaries the languages spoken by CMC beneficiaries in 2018.

Figure 1. Language Spoken by SCFHP CMC Beneficiaries 2018.



*Chinese includes Mandarin and Cantonese speakers.

In 2018, Language Line Interpreter Services, SCFHP's primary language vendor, was utilized for over 8,600 calls for CMC beneficiaries. Requests were made for 44 different languages. The top three request languages included: Spanish (3,107), Chinese (2,284), and Vietnamese (1,572). Table 5 shows the breakdown of language services utilization by CMC beneficiaries in 2018.

Table 5. Telephone Utilization of Interpreter Services by CMC Beneficiaries in 2018.

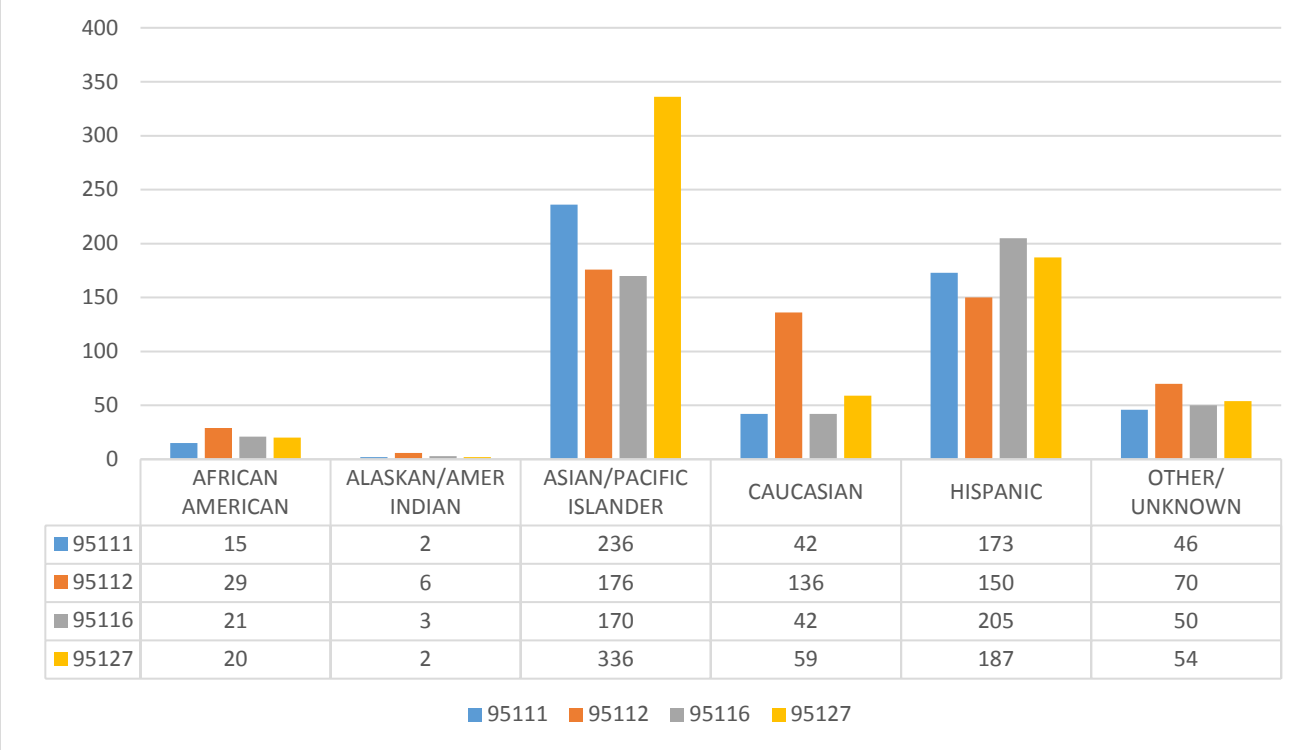
LANGUAGE	NUMBER OF CALLS	PERCENTAGE
SPANISH	3,107	36%
CHINESE	2,284	27%
VIETNAMESE	1,572	18%
TAGALOG	558	6%
RUSSIAN	238	3%
FARSI	235	3%
PUNJABI	114	1%
CAMBODIAN	79	1%
KOREAN	74	1%
HINDI	59	1%
OTHER	284	3%
TOTAL	**8,604**	**100%**

SOCIAL DETERMINANTS

According to the World Health Organization (WHO), social determinants of health are the conditions in which people are born, grow, live, work, age, and play that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These social and/or demographic characteristics of individuals, groups, communities, and societies have been shown to have powerful influences on health and well-being at the individual and population levels.[1] Social determinants are also the root cause of health disparities, a measure of differences in health outcomes between populations. It is vital to address social determinants of health to decrease health disparities and in turn move towards achieving health equity. Health equity implies that ideally everyone should have a fair opportunity to attain their full potential and that no one should be disadvantaged from achieving this potential.

A geographic analysis of SCFHP's CMC beneficiary population was conducted to determine where in the county beneficiaries resides. This data was examined further to explore the ethnic distribution among these four zip codes (see Figure 2). Asians followed by Hispanics are the most predominant ethnic groups.

Figure 2. SCFHP CMC Beneficiary Ethnic Distribution by Zip Codes 95111, 95112, 95116, and 95127.



	AFRICAN AMERICAN	ALASKAN/AMER INDIAN	ASIAN/PACIFIC ISLANDER	CAUCASIAN	HISPANIC	OTHER/ UNKNOWN
95111	15	2	236	42	173	46
95112	29	6	176	136	150	70
95116	21	3	170	42	205	50
95127	20	2	336	59	187	54

Using data from the 2016 Santa Clara County (SCC) Zip Code Profiles[6], social determinants were examined among the four zip codes and SCC overall. The social determinants include: ethnicity, language, income, education, access to nutritious foods, housing, and exposure to crime and violence.

Demographic Snapshot

Ethnicity and language were examined among the four zip codes. Zip code 95127 has the highest population, with Hispanics being the predominant group. Interestingly, 95116 has the highest percentage of individuals who speak a language other than English at home. Table 6 providers a demographic snap shot of Santa Clara County and Zip Codes 95111[2], 95112[3], 95116[4], and 95127[5].

Table 6. Demographic snapshot of SCC and Zip Codes 95111, 95112, 95116, and 95127.

METRIC	95111	95112	95116	95127	SANTA CLARA COUNTY*
Population	58,466	55,927	51,496	61,325	1,781,642
Number of SCFHP CMC Beneficiaries	514	567	491	443	-
Percent of SCFHP CMC Beneficiaries	0.87%	1%	0.95%	0.72%	-
African American	4%	4%	2%	2%	2%
API	34%	24%	24%	21%	32%
Latino	51%	44%	65%	59%	27%
White	10%	25%	7%	16%	35%
Speaks a language other than English at home	74%	53%	80%	67%	52%

*Santa Clara County data column is provided for comparison for the overall county.

Economic and Educational Opportunities

Median income among the four zip codes is significantly low in comparison to Santa Clara County. Overall, the 95116 zip code has the highest number of individuals that have less than a high school education at 37% and the lowest median income level at $47,413. Interestingly, the 95127 zip code has the highest median income at $70,692, but only 20% of individual are college graduates. In comparison, the 95112 zip code has a higher number of individuals who are college graduates at 32%.

Table 7 summarizes the economic and educational opportunities of residents in the four zip codes. The 95116 zip code has the highest number of families and children living under the 185% Federal Poverty Line (FPL).

Table 7. Economic and Educational Opportunities among Residents in SCC and Zip Codes 95111, 95112, 95116, and 95127.

METRIC	95111	95112	95116	95127	SANTA CLARA COUNTY
Median income	$57,047	$55,927	$47,413	$70,692	$93,854
Families percent below 185% FPL	38%	37%	43%	26%	16%
Children percent below 185% FPL	49%	50%	56%	40%	25%
Education - Less than high school	34%	23%	37%	28%	13%
Education - High school graduate	24%	21%	26%	27%	15%
Education - Some college or associates degree	26%	24%	22%	24%	24%
Education - College graduate or higher	16%	32%	16%	20%	47%

Access to Affordable and Nutritious Foods

According to the centers for Disease Control and Prevention (CDC), food deserts are areas that lack access to affordable produce, whole grains, low-fat milk, and other foods that make up a full and healthy diet. Often, food deserts have a higher number of convenience stores, where healthy foods are less available.[7] In addition, food swamps have been described as areas with a high-density of establishments selling high-calorie fast food and junk food, relative to other healthier food options.[8] Access to affordable and nutritious food is vital in maintaining overall health. However, studies show that low-income and racial-ethnic minorities are more likely than Whites to live near unhealthy food retailers, which has been associated with poor diet.[9]

Table 8 summarizes access to affordable and nutritious foods among the four zip codes. Interestingly, zip code 95116 has less fast food outlets per square mile in comparison to zip codes 95112 and 95127. It also has the least distance to full service grocery stores for residents in the area in comparison to all other zip codes. Furthermore, even though there are more residents living under the FPL, only 16% of residents are receiving CalFresh benefits in comparison to 95127, which has a lower number of residents living under the FPL, but the highest utilization of CalFresh benefits. This data suggests that individuals may not be aware of the availability of CalFresh benefits. Overall, the data suggests that the four zip codes have adequate access to full service grocery stores in comparison to the overall county.

Table 8. Access to Affordable and Nutritious Foods in SCC and Zip Codes 95111, 95112, 95116, and 95127

METRIC	95111	95112	95116	95127	SANTA CLARA COUNTY
Distance (in miles) to full service grocery store	0.47	0.55	0.4	0.42	0.56
Distance (in miles) to nearest farmers market	1.67	0.67	1.12	1.27	1.6
Percent of households receiving CalFresh	17%	10%	16%	19%	5%
Fast food outlets per square mile	1.9	6.2	3.9	6.3	2.8

Access to Affordable and High Quality Housing

According to the article "Housing and Health: An Overview of the Literature", people who are not chronically homeless, but face housing instability in the form of moving frequently, falling behind on rent, or couch surfing are more likely to experience poor health in comparison to their stably housed peers.[10] The article continues to discuss how the stress of unstable housing can result in disruption to employment, social networks, education, and the receipt of social service benefits. It can also decrease the effectiveness of health care by making proper storage of medication difficult or impossible. According to the 2016 report, "Perspectives on Helping Low-Income Californians Afford Housing", California has a housing shortage and the high housing costs make it difficult for many Californians to find housing that is affordable and that meets their needs. This forces them to make trade-offs, such as living in overcrowded housing.[11] Residential crowding can contribute to psychological distress[12].

Table 9 summarizes access to affordable housing among residents in the four zip codes. Among the four zip codes we reviewed, the 95112 zip code reported the highest percentage of renters at 71%. Interestingly, this zip code had the lowest percentage of cost burdened households at 51% and the lowest percentage of overcrowded households at 13% in comparison to the other zip codes. Overall, the percentage of costs burdened households and overcrowded households is considerably higher across all four zip codes in comparison to the overall county.

Table 9. Access to Affordable Housing in SCC and Zip Codes 95111, 95112, 95116, and 95127

METRIC	95111	95112	95116	95127	SANTA CLARA COUNTY
Renters	44%	71%	61%	52%	43%
Cost burdened - 30% or more of household income allocated to rent	64%	51%	59%	64%	46%
Overcrowded Households	19%	13%	26%	16%	8%

Safe Communities Free of Crime and Violence

According to Healthy People 2020, crime and violence can have a direct impact on health outcomes for victims and witnesses, including lifelong negative physical, emotional, and social consequences[13].

For the four zip codes examined in SCC, the 95112 zip code reported the highest average of violent crimes within 1 mile of households at 72.73, however, this zip code had the lowest percentage of adults who reported crime/violence/drug activity as a major problem at 66% of all zip codes. Interestingly, the 95116 zip code reported an average of 46.6 violent crimes within 1 mile of households, but 83% of adults reported crime/violence/drug activity as a major problem (see Table 10).

Table 10. Safe Communities Free of Crime and Violence in SCC and Zip Codes 95111, 95112, 95116, and 95127.

METRIC	95111	95112	95116	95127	SANTA CLARA COUNTY
Average violent crimes within 1 mile of household	23.09	72.73	46.6	39.25	16.04
Reporting crime/violence/drug activity as a major problem	75%	66%	83%	81%	42.00%

Opportunities for Improvement

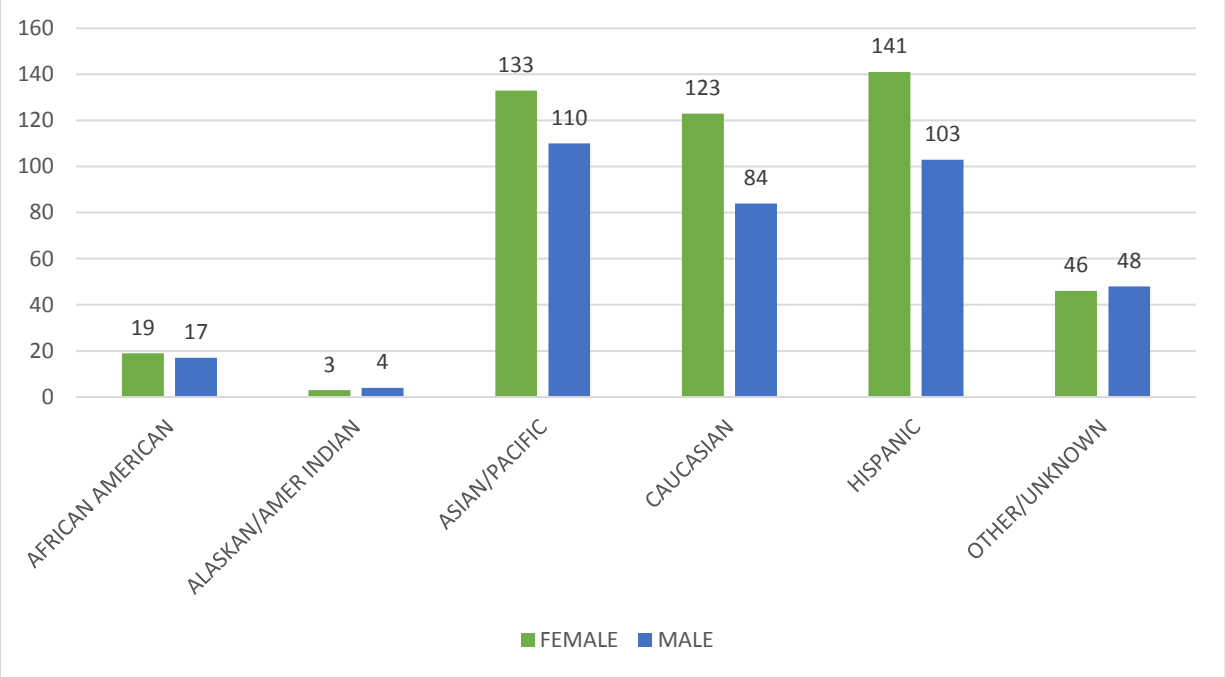
The data suggests there is adequate access to nutritious foods across all four zip codes and is comparable to the county average. Families and children living under the FPL is considerably high in these areas in comparison to the county, however, the data for Calfresh utilization is low. This suggests that individuals and families may not be aware of this benefit and there is a need to raise more awareness. Overcrowded and cost burdened households among the four zip codes is considerably higher than the county average, suggesting there is a need for interventions to help individuals find affordable housing.

SUBPOPULATIONS

Multiple Chronic Conditions

As of December 2018, SCFHP identified 7,751 eligible beneficiaries current enrolled with SCFHP. The population was stratified to identify those who have three or more chronic conditions. Approximately 11% (831 beneficiaries) were identified as having three or more chronic conditions with one uncontrolled condition. Figure 3 provides a breakdown of the population by ethnicity and gender. Overall, Hispanics represent a majority of the population with multiple chronic conditions (244 beneficiaries) followed by Asians (243 beneficiaries) and Caucasians (207 beneficiaries). Generally, there are more females with multiple chronic conditions.

Figure 3. SCFHP CMC Beneficiaries with 3 or more Chronic Conditions by Ethnicity and Gender.



Long-Term Support Services (LTSS)
A subset of the CMC population are beneficiaries living with multiple chronic conditions and limited functional capacity that makes it difficult for them to live independently without long-term services and supports (LTSS). These individuals require assistance with at least three activities of daily living, are in poor or fair health and may have cognitive impairments or behavioral health issues. They can either be living in the community or in a long-term care nursing facility and are a population at high risk for falls and isolation due to their impairments.

A 2017 evaluation of the CMC program in California (University of California San Francisco-UCSF Cal MediConnect Rapid Cycle Polling Project) surveyed dual-eligible (or qualifying for both Medicare and Medi-Cal) beneficiaries and found that 50% reported needs help with personal care (eating, bathing, dressing or getting around the house). Of those who reported needing LTSS assistance, 4 out of 10 had unmet personal care or routine needs. Of all the dually-eligible surveyed, 84% reported that they were receiving In Home Supportive Services (IHSS), a consumer-directed personal assistance program.
The data from the 2017 CMC evaluation highlighted how care coordination, a center component of CMC, can deliver better outcomes in LTSS. Social determinants of health that impact LTSS needs including: lack of adequate access to food, low literacy, low educational attainment, homelessness, extreme poverty and caregiver need or burden. Approximately 40% of SCFHP's beneficiaries have not graduated from high school and about 60% report that they receive SSI payment.

Severe Mental Illness (SMI) in the CMC Population
Of all CMC beneficiaries, approximately 1,000 (14%) have a mental health diagnosis. SCFHP collaborates with the County Behavioral Health Services Department (CBHSD), which serves consumers ages 18 and above. The CBHSD Call Center screens individuals for functional impairments, such as homelessness, lack of support, and recent job loss, etc. and can direct individuals based on whether they have a diagnosis. Once the screening has been completed, CBHSD refers individuals who are identified as SMI to either a County Mental Health clinic or a community based organization (CBO) for services. These are considered Specialty Mental Health providers and may include: psychiatry, therapy, and case management. For an example of the CBHSD screening tools, see Appendix A.

Those identified as mild to moderate are accommodated within a County clinic or are referred to SCFHP for placement within the health plans' network for services. SCFHP Behavioral Health Department's Social Workers assists with care coordination for all beneficiaries that are referred, including: shared care plans, integrating care plan goals, assistance with transportation to medical appointments, coordinating medical care with primary and specialty care and behavioral health care to identify unmet needs, ensuring follow up care is received, etc. Services are initiated within 15 days once a referral is received.

In addition to receiving referrals from CBHSD, referrals are also received from internal SCFHP staff. Beneficiaries may also be identified through historical and current claims data, pharmacy information and responses from the self-reported SCFHP Health Risk Assessment (HRA).

Table 11 and 12 summarizes the top ten behavioral health ED and hospitalization diagnoses for CMC beneficiaries. Commonalities between the two groups include diagnoses for alcohol use and schizophrenia/schizoaffective.

Table 11. Top Ten Behavioral Health ED Diagnoses for CMC Beneficiaries

RANKING	DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION	NUMBER OF VISITS
1	F43.25	Adjustment disorder with mixed disturbance of emotion	54
2	F25.0	Schizoaffective disorder, bipolar type	45
3	F41.9	Anxiety disorder, unspecified	35
4	F25.9	Schizoaffective disorder, unspecified	17
5	F20.0	Paranoid schizophrenia	13
6	F20.9	Schizophrenia, unspecified	10
7	F29	Unspecified psychosis not due to substance or known physiological condition	10
8	F32.9	Major depressive disorder, single episode, unspecified	10
9	F10.129	Alcohol abuse with intoxication, unspecified	8
10	F10.920	Alcohol use, unspecified with intoxication, uncomplicated	8

Table 12. Top Ten Behavioral Health Hospitalization Diagnoses for CMC Beneficiaries

RANKING	DIAGNOSIS CODE	DIAGNOSIS DESCRIPTION	NUMBER OF VISITS
1	F25.0	Schizoaffective disorder, bipolar type	20
2	F10.239	Alcohol dependence with withdrawal, unspecified	8
3	F20.0	Paranoid schizophrenia	5
4	F20.9	Schizophrenia, unspecified	5
5	F25.9	Schizoaffective disorder, unspecified	5
6	F03.90	Unspecified dementia without behavioral disturbance	4
7	F10.231	Alcohol dependence with withdrawal delirium	3
8	F15.93	Other stimulant use, unspecified with withdrawal	3
9	F29	Unspecified psychosis not due to a substance or known physiological condition	3
10	F31.30	Bipolar disorder, current episode depressed, mild	3

For beneficiaries with SMI diagnoses, symptoms are a barrier in accessing primary care and specialty care due to their inability to navigate the systems involved. These beneficiaries exhibit a high level of anxiety and have difficulty staying organized enough to manage these aspects of their lives.

Barriers to care include the lack of housing, including housing with support services, in the county. Beneficiaries who utilize most their Supplement Security Income (SSI) checks to pay for board and care homes are left with little funding for additional food, transportation, or incidentals. Furthermore, unlicensed board and care homes are utilized for placement and do not assist beneficiaries with medication management, transportation or other needed services, which are vital to managing their condition. Lack of connection to the beneficiaries Primary Care Provider (PCP) is another barrier to accessing care for the SMI population.

Opportunities for Improvement

For the SMI population there are several opportunities for improvement identified. There is a need for increased presence of internal psychiatry services within the SCFHP network and increased connection with the beneficiary's PCP. Decentralizing transportation services to community mental health providers so that providers can assist with transportation arrangement as appointments are schedule would help promote timely access to care. Increasing the availability of "health homes" providing wraparound services to the SMI population would also be beneficial. Health homes would serve as a one stop model of services which would include medical management, case management, and activities to decrease the social determinants impacting the SMI population.

Homeless Population

SCFHP lacks consistent data on the impact of homelessness in its membership and has opted to use county specific data as a proxy. This report relies on homelessness data from the Santa Clara County Point-in-Time Census to draw conclusions on the state of homelessness in Santa Clara County. The biennial Point-in-Time Census is the only source of nationwide data on sheltered and unsheltered homelessness, and is required by the U.S. Department of Housing and Urban Development (HUD) of all jurisdictions receiving federal funding to provide housing and services for individuals and families experiencing homelessness[14].

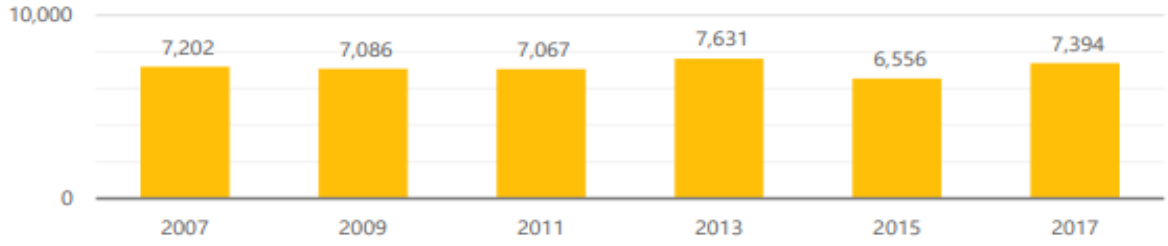
HUD defines a chronically homeless individual as someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years, and also has a long term disabling condition[15]. Many survey respondents reported experiencing multiple physical or mental health conditions.

Survey Demographics

In 2017, Santa Clara County conducted its homeless population census and found there were a total of 7,394 individuals experiencing homelessness, a 13% increase since 2015. Out of those that were homeless, 74% reported being unsheltered. Figure 4 shows the results of the biennial Point-In-Time count from 2007-2017.

Figure 4.

TOTAL NUMBER OF HOMELESS INDIVIDUALS ENUMERATED DURING THE POINT-IN-TIME HOMELESS CENSUS WITH TREND, SANTA CLARA COUNTY



Source: Applied Survey Research. (2007-2017). Santa Clara County Homeless Census and Survey.

TOTAL NUMBER OF HOMELESS INDIVIDUALS ENUMERATED DURING THE POINT-IN-TIME HOMELESS CENSUS, SHELTERED VS. UNSHELTERED

Source: Applied Survey Research. (2017). Santa Clara County Homeless Census and Survey.

Eight percent (8%) of respondents were under the age of 25, 23% were between the ages of 25 and 50, 61% were between the ages of 41 and 60, and 9% were 61 years and older. Over one-third of respondents (34%) identified as female, 64% identified as male, and 1% as transgender. The remaining 1% identified as neither female, male, nor transgender. About 42% of respondents reported identify as Hispanic or Latino. When compared to the Santa Clara County general population, more individuals identified as Black or African American (16% homeless compared to 3% SCC general population), whereas a very small percentage of the homeless surveyed identified as Asian when compared to the general population (4% compared to 34%). Over two-thirds (64%) of individuals reported they had been homeless for over a year or more.

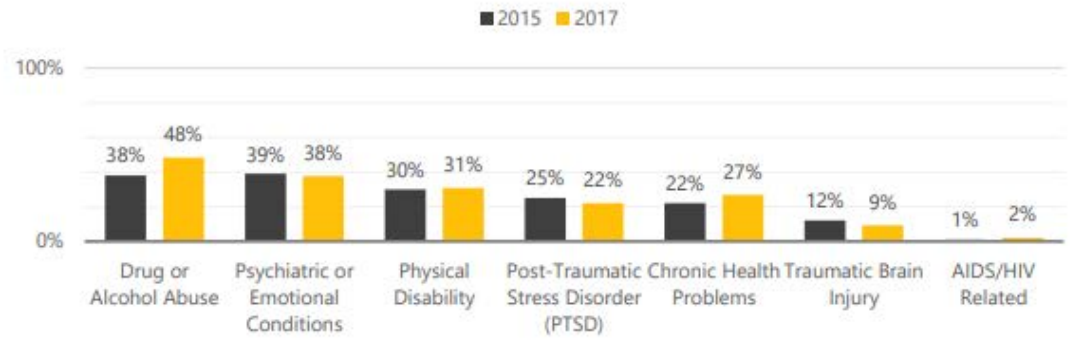
Cause of Homelessness

According to the report, it is difficult to identify the primary cause of an individual's inability to obtain or retain housing as it is often the result of multiple and compounding causes. People who experience homelessness face significant barriers in obtaining permanent housing, such as housing affordability and availability to accessing the economic and social supports (e.g. increased income, rental assistance, case management) needed to access and maintain permanent housing. An inability to secure adequate housing can lead to an inability to address other basic needs, such as healthcare and adequate nutrition. About 62% of survey respondents reported that they could not afford rent.

Health Conditions

The average life expectancy for individuals experiencing homelessness is 25 years less than those in stable housing. Without regular access to healthcare and without safe and stable housing, individuals experience preventable illness and often endure longer hospitalizations. Homeless members are hospitalized four times higher than the average for the population over all[16]. It is estimated that those experiencing homelessness stay four days (or 36%) longer per hospital admission than non-homeless patients. Drug or alcohol abuse among Santa Clara County homeless census survey respondents was higher in 2017 than in 2015 (48% compared to 38%). Similarly, chronic health problems were cited more frequently in 2017 than in 2015 in the same survey (27% and 22%, respectively). Figure 5 summarizes different health conditions the homelessness population faces.

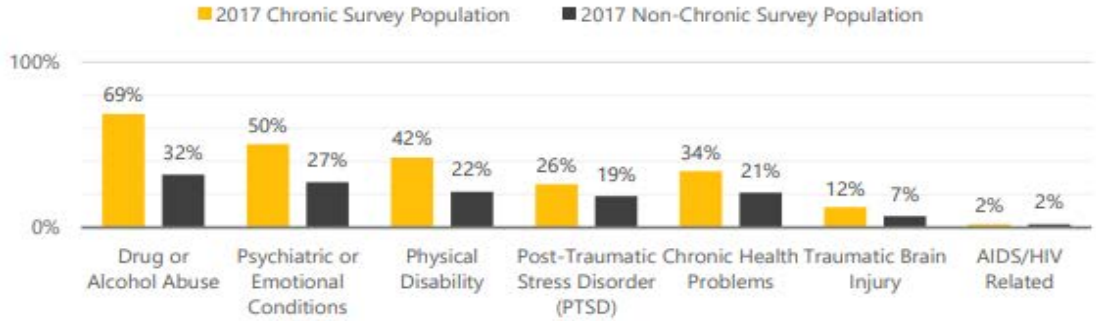
Figure 5. Health Conditions



2015 n: 880-902; 2017 n: 548-570
Source: Applied Survey Research. (2015-2017). Santa Clara County Homeless Census and Survey.
Note: Multiple response question. Percentages may not add up to 100.

Figure 6 shows a comparison of health conditions among chronically and non-chronically homeless survey respondents. In general, higher rates of health conditions were reported among those who were chronically homeless compared to their non-chronically homeless counterparts.

Figure 6. Health Conditions, Chronic and Non-Chronic Comparison



Chronic Survey Population: 239-255; Non-Chronic Survey Population: 309-318
Source: Applied Survey Research. (2017). Santa Clara County Homeless Census and Survey.
Note: Multiple response question. Percentages may not add up to 100.

SCFHP CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY 2018

The CAHPS survey is conducted annually to assess the experiences of beneficiaries in Medicare Advantage and Prescription Drug Plans, including Medicare-Medicaid Plans (MMPs). The 2018 survey was conducted in the first half of 2018 and measure beneficiaries experiences with SCFHP over the previous six months. The survey sample was drawn from all individuals who had been members of the plan for at least six month. The survey asked about overall health plan ratings, prescription drug composite, overall rating of drug plan, Medicare-specific and HEDIS measures collected through CAHPS, two items about contact from a doctor's office, pharmacy, or drug plan, and six single item measures. Some categories were scored as N/A because there weren't enough responses to permit reporting or the score had very low reliability. Overall, SCFHP had a response rate of 26.1% for the CAHPS survey in comparison with 27.8% average for all MMP contracts in California, and 29.5% for all MMP contracts nationally.

Health Plan Composite Measures

Responses to individual survey questions were combined to summarize measures of beneficiaries' experiences with their health plans. SCFHP scored less than the national and state averages. The doctors who communicate well did not apply to SCFHP (see Table 13).

Table 13.

Health Plan Composite Measure	National MMP	State MMP – California	SCFHP
Getting Needed Care	3.43	3.36	3.25
Getting Appointment and Care Quickly	3.30	3.23	3.15
Doctors Who Communicate Well	3.71	3.68	N/A
Customer Service	3.68	3.64	3.52
Care Coordination	3.56	3.50	3.47

Overall Health Plan Ratings

Survey respondents rated their health plan, care received from their plan overall, their personal doctor, and the specialist (if any) they had seen most frequently in the past 6 months. SCFHP scored lower in the categories of rating of health plan and rating of health care quality in comparison to the national and state averages. Personal doctor and specialist categories were not applicable to SCFHP (see table 14).

Table 14.

Overall Health Plan Ratings	National MMP	State MMP - California	SCFHP
Rating of Health Plan	8.6	8.6	8.4
Rating of Health Care Quality	8.5	8.4	8.3
Personal Doctor	9.0	9.0	N/A
Specialist	8.9	8.8	N/A

Prescription Drug and Overall Rating of Drug Plan

Beneficiaries were asked about prescription drugs and the overall rating of the drug plan. SCFHP scored lower compared to the National MMP average for getting needed prescriptions and was equal to the State MMP average. For overall rating of drug plan, SCFHP scored slightly lower than the national and state averages for this category (see table 15).

Table 15.

Prescription Drugs and Overall Rating of Drug Plan	National MMP	State MMP – California	SCFHP
Getting Needs Prescriptions	3.68	3.63	3.63
Overall Rating of Drug Plan	8.6	8.5	8.4

Medicare-Specific HEDIS Measures

Beneficiaries were asked whether they received a flu vaccination recently and whether they had ever received a pneumonia vaccination. For the flu vaccine, SCFHP scored 82%, significantly higher than the national and state averages. SCFHP scored higher than the national and state averages for pneumonia vaccination (see table 16).

Table 16.

Medicare-Specific and HEDIS Measures	National MMP	State MMP – California	SCFHP
Annual Flu Vaccine	66%	69%	82%
Pneumonia Vaccination	56%	58%	65%

Contact from Doctor's Office, Pharmacy, or Drug Plan

Beneficiaries were asked whether their doctor's office, pharmacy, or health plan contacted them about making sure they filled their prescriptions and were taking their medications as directed. SCFHP's score for reminders to fill prescriptions was equal to the national and state averages. For reminders to take medications, SCFHP scored slightly lower in comparison to the state and national averages (see table 17).

Table 17.

Contact from Doctor's office, Pharmacy, or Drug Plan	National MMP	State MMP – California	SCFHP
Reminders to fill prescriptions	58%	58%	58%
Reminders to take medications	48%	50%	47%

Single Item Measures

Beneficiaries were asked whether they had delayed or not filled a prescription. Additional, they were also asked about daily activities (difficulty walking or climbing stairs, difficulty dressing or bathing, difficulty performing errands alone), whether or not they spent one or more nights in the hospital, and internet usage at home. SCFHP scored below the state average for delaying or not filling a prescription. In general, SCFHP beneficiaries also reported more difficulty with daily activities and also more beneficiaries report that they spent one or more nights in the hospital in comparison to the national and state averages (see table 18).

Table 18.

Single Item Measures	National MMP	State MMP – California	SCFHP
Delaying or Not Filling a Prescription	94%	92%	90%
Difficulty walking or climbing stairs	48%	52%	58%
Difficulty dressing or bathing	75%	76%	75%
Difficulty performing errands alone	63%	65%	66%
Spent one or more nights in hospital	84%	87%	89%
Internet use at home	37%	37%	44%

Opportunities for Improvement

SCFHP performed above the state average for the annual flu and pneumonia vaccines measure. SCFHP scored below the state average on the following measures, including: getting needed care, getting appointments and care quickly, rating of health care quality, rating of health plan, customer service, care coordination, and getting needed prescription drugs.

SCFHP CMC HEALTH RISK ASSESSMENT (HRA) SURVEY DATA 2018

The health risk assessment (HRA) is a self-reported questionnaire that is provided to low-risk CMC members within the first 90 calendar days or 45 calendar days for high-risk members of enrollment into SCFHP. The HRA questionnaire includes questions about the beneficiary's demographics, current health status, change in health status, hospitalizations. It is also used to identify social determinants of health such as safety at home, family involvement (or lack thereof), and nutritional risk.

The data below summarizes HRA responses from 2018 from 994 beneficiaries that completed a HRA. If the beneficiary completed more than one HRA during the year, only data from the most recent HRA was included in the data set below. Areas examined include:

- Hospitalizations and overnight stay settings
- Housing, including safety and family support
- Nutritional risks
- Current health status and change in the last 12 months.

HRA questions relevant to the indicators discussed below can be found in Appendix B.

Hospitalizations

When asked if they had an overnight stay over the past 12 months, CMC beneficiaries have the option to choose from hospital, psychiatric, rehabilitation, skilled nursing facilities or other. Approximately 38% of the beneficiaries reported they had an overnight stay at a hospital (Figure 7). Generally, women reported more overnight stays at a hospital than men and Hispanics reported the highest number of hospitalizations in 2018. Figure 8 summarizes the breakdown of hospitalizations by ethnicity and gender. Of all reported hospitalizations, 65% of the beneficiaries were ages 65 and older.

Figure 7. Beneficiary reported overnight stay settings in the last 12 month.

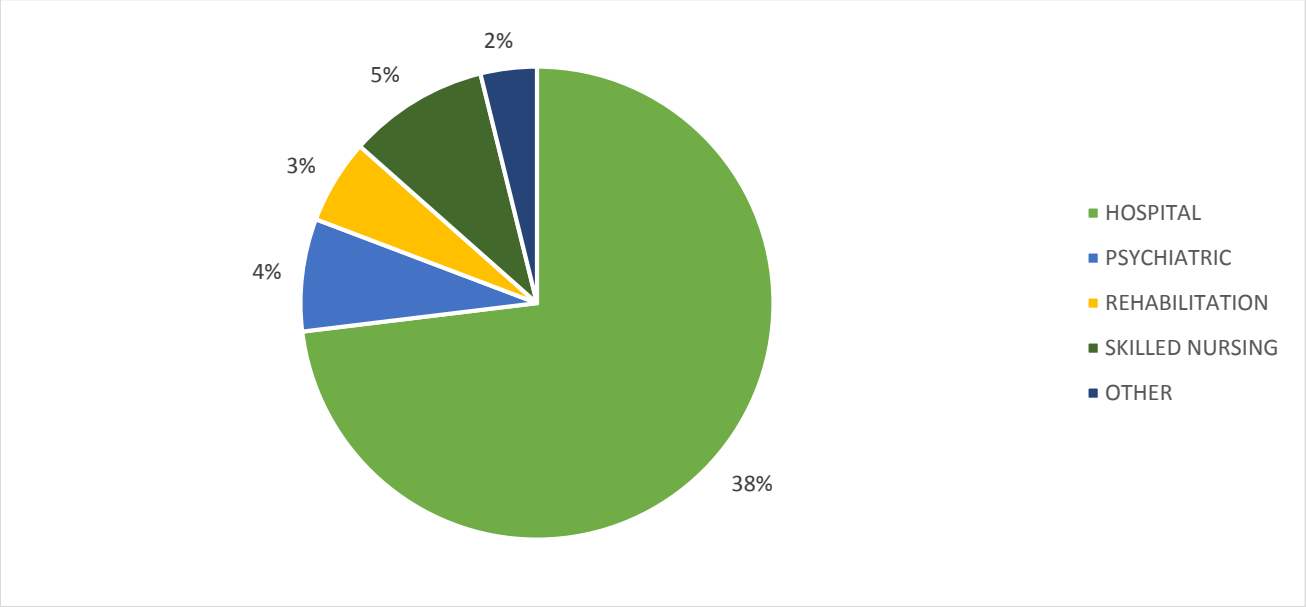
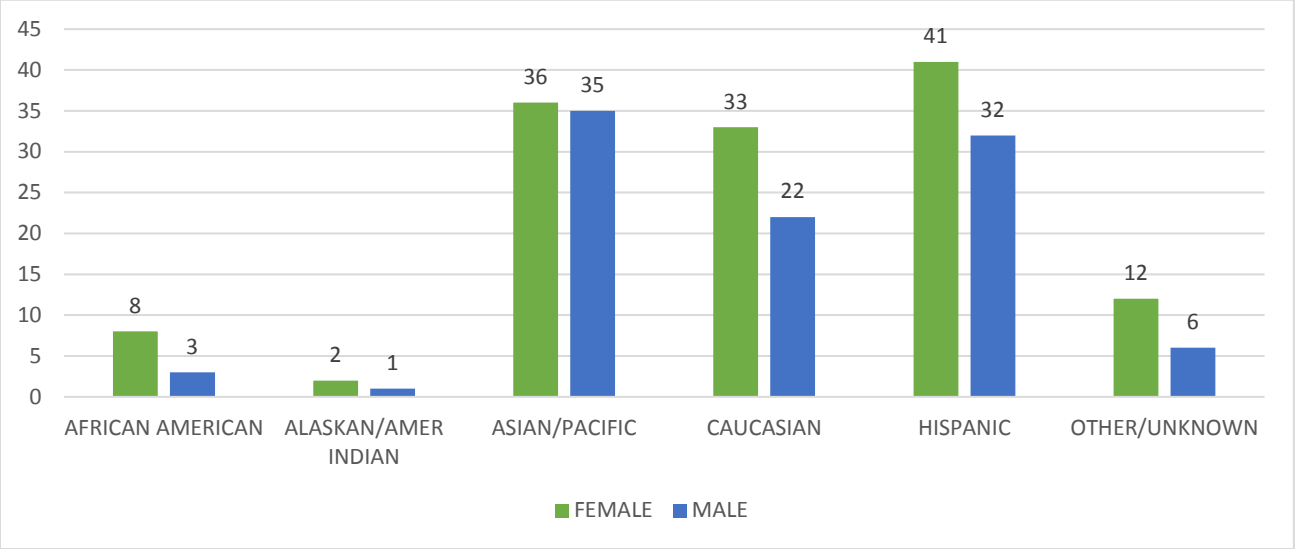


Figure 8. Beneficiary reported hospitalizations by ethnicity and gender.



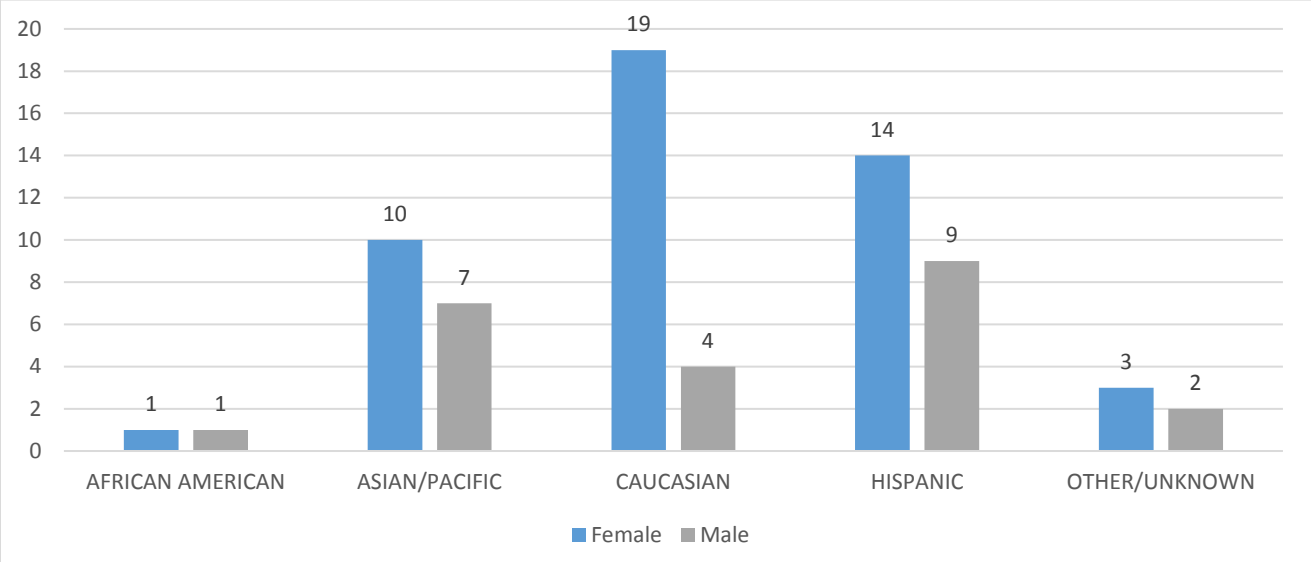
Nutritional Needs

The HRA asks beneficiaries about their nutritional needs. The following nutrition indicators were analyzed as a social determinant:

- Lost or gained 10 pounds in the last 6 months, involuntarily
- Not always able to shop/cook/feed self
- Not enough money to buy food needed

Hispanics and Caucasians beneficiaries had the highest number of responses for all nutrition indicators. By gender, females had the highest number of responses for all indicators. By age, beneficiaries 65 and older had the highest number of responses for all indicators. Figure 9 summarizes the nutritional needs indicators listed above by gender and ethnicity.

Figure 9. Beneficiary reported nutritional needs by ethnicity and gender.

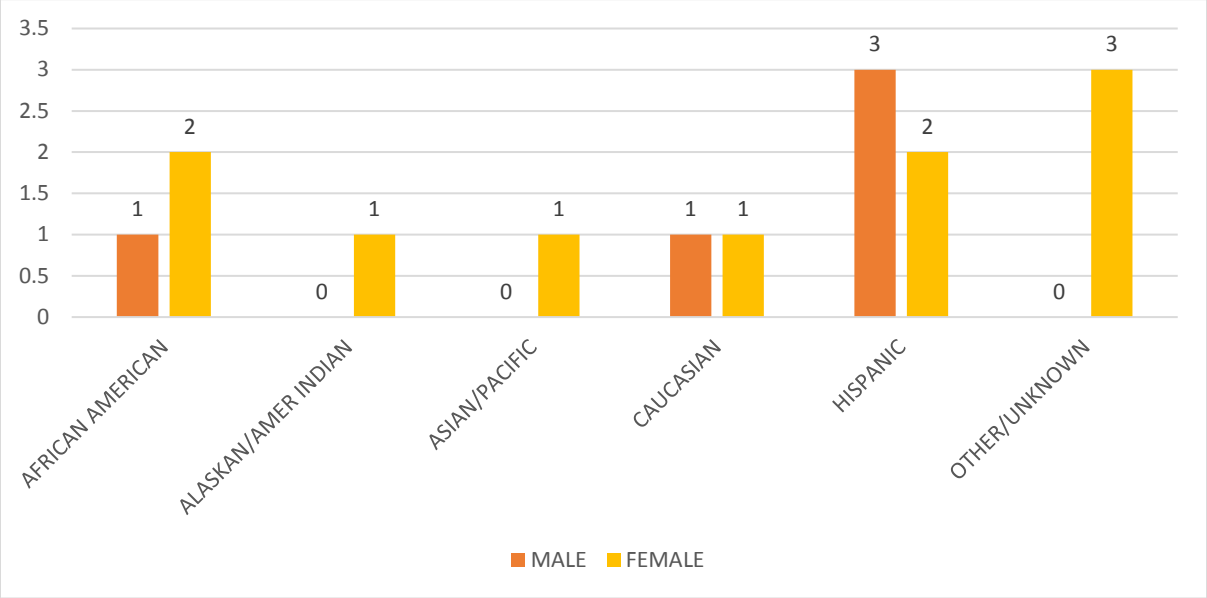


Safety and Social Supports
Beneficiaries are asked about safety in their home. Specifically, beneficiaries are asked if anyone in their household or family has been:

- Verbally abused or controlled their actions
- Hurt, beaten, or neglected them
- Made them feel fear or threatened

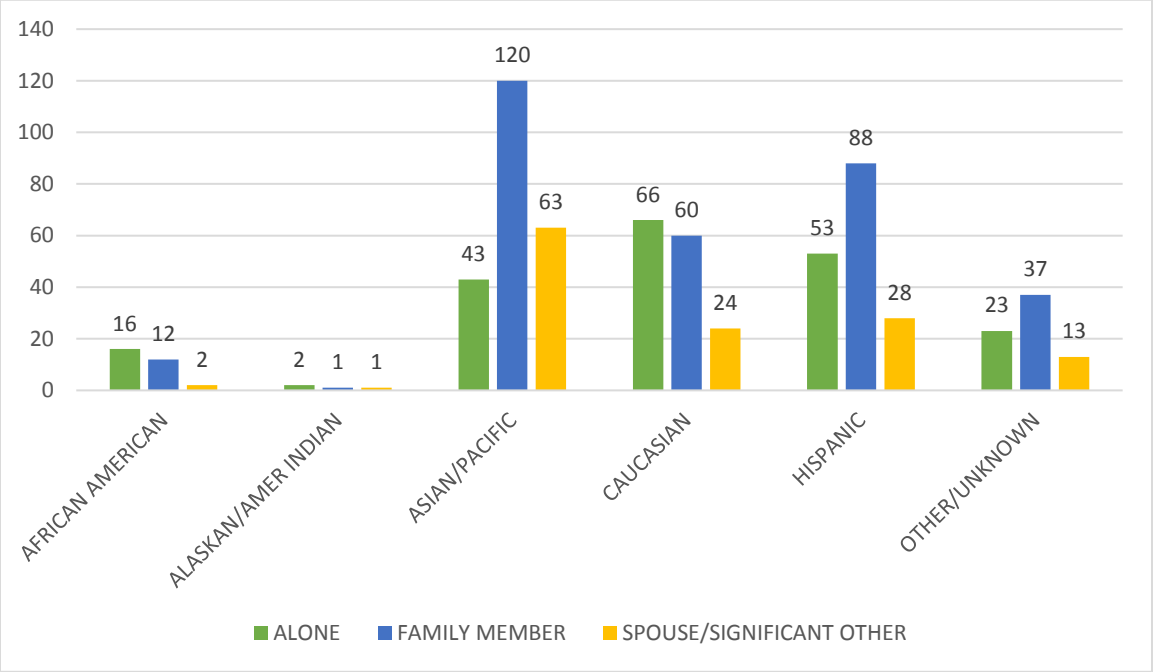
Of all ethnicities, Hispanics had the highest responses for all indicators. By gender, females had the most Reponses. By age group, beneficiaries 64 and under had the highest number of responses. Figure 10 summarizes responses to safety indicators by ethnicity and gender.

Figure 10. Beneficiary reported safety indicators by ethnicity and gender.



Living Conditions
Living arrangements were analyzed using the following assumption: living along was categorized as negative and living with a family member or significant other as positive. These indicators serve as proxies for the strength of the beneficiary's social support network. When the responses were examined by ethnicity, 26% of Hispanics and 19% of Caucasians were the most likely to live with a family member or spouse. Of all ethnicities, Caucasians were most likely to live alone at 33% followed by Hispanics at 26%. Females were more likely to live alone at 57% compared to males at 43%. Females were also more likely than males to live with a family member or spouse. Beneficiaries ages 65 and older were more likely to live with a significant other or family member at 69% in comparison to those ages 64 and under at 31%. Of those 65 and older, 64% were more likely to live alone in comparison to 36% of beneficiaries 64 and under. Figure 11 summarizes HRA responses related to living conditions.

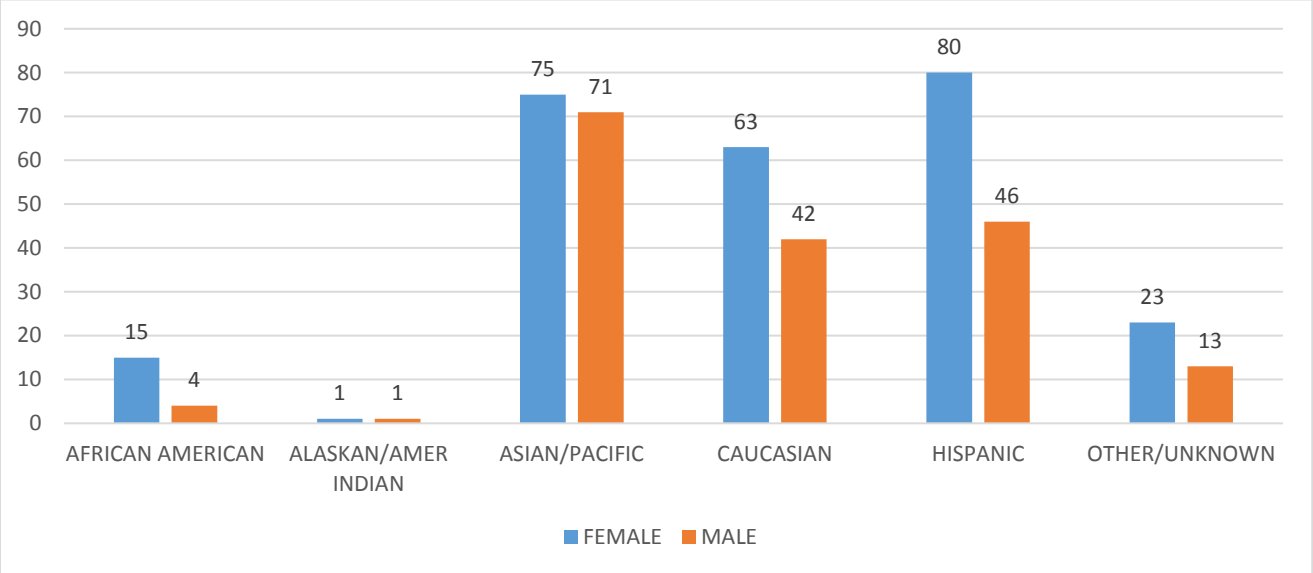
Figure 11. Beneficiary reported living condition indicators by ethnicity.



Health Status Change

Health status change was analyzed based on responses received about daily activities of living. Specifically, responses for two indicators "more difficult" and "slightly more difficult" were combined for analysis. Hispanics and Asians reported that their ability to perform daily routines was more difficult in comparison to last year. By gender, 15% of females reported that performing daily routines was more difficult in comparison to 11% of males. Among age groups, 17% of beneficiaries ages 65 and older reported that at their ability to perform daily routines was more difficult than in comparison to last year compared to 9% of those 64 and under. Figure 12 summarizes health status change by ethnicity and gender as reported by beneficiaries.

Figure 12. Beneficiary reported health status change by ethnicity and gender.



Opportunities for Improvement

The data reported by CMC beneficiaries suggests there is that there is a need for further analysis for hospitalizations among Asian and Hispanic beneficiaries and to determine whether their hospitalization was due to having multiple chronic conditions. Also, there is a need to connect beneficiaries to resources for nutritious foods and resources for strengthening social supports.

SCFHP HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS) DATA 2018

SCFHP's 2018 HEDIS data (Calendar Year 2017 services) was analyzed review timely care for chronic conditions, transitions of care across acute to primary care for mental health issues, the ability to reduce numbers of readmissions, as well as the ability of primary care providers to monitor persistence medication use.

Comprehensive Diabetes Care

Diabetes is a chronic condition that impacts many residents in Santa Clara County. The incidence rate of diabetes has steadily increased from 2000, up to 8% by 2009. The Comprehensive Diabetes Care (CDC) HEDIS measure assesses adults 18-75 years of age with diabetes (type 1 and 2) who had hemoglobin A1c (HbA1c) testing, a retinal eye exam, and nephropathy screening. Within SCFHP's CMC population, 1,402 beneficiaries were identified as diabetics using the HEDIS definition. In 2018, SCFHP reported a 91.73% overall compliance rate, which was below the national 25th percentile in comparison to Medicare Advantage plans. The 2018 rate increased slightly from the 2017 rate of 91.24%. Tables 19-21 provide an overview of each CDC screening compliance by ethnicity among SCFHP CMC diabetic beneficiaries.

Overall, compliance for the nephropathy screening was the highest at 92%, followed by HbA1c screening at 90%, and retinal eye exam at 68%. Hispanics make up the largest ethnicity group in the CDC measure at 463 beneficiaries and had a 90% compliance rate for HbA1c and 94% compliance rate for nephropathy screening. Interestingly, their compliance rate for the retinal eye exam was only 66%. Caucasians had the lowest compliance for retinal eye exam at 59% followed by African Americans at 61%. There was no statistical significance for HbA1c screening (p=0.01) and Nephropathy screening (p=0.01) by for those that were compliant and non-compliant by ethnicity. However, there was a statistical significant for eye exams for those that were compliant and non-compliant by ethnicity at p=0.11.

Table 19. CDC HbA1c Screening Compliance by Ethnicity among SCFHP CMC Diabetic Beneficiaries.

HbA1c				
ETHNICITY	NON-COMPLIANT	COMPLIANT	TOTAL	PERCENTAGE COMPLIANT
AFRICAN AMERICAN	5	59	64	92%
ALASKAN/AMER INDIAN	0	9	9	100%
ASIAN/PACIFIC	38	403	408	91%
CAUCASIAN	31	206	237	87%
HISPANIC	48	415	463	90%
OTHER/UNKNOWN	22	166	188	88%
TOTAL	**144**	**1258**	**1402**	**90%**

Table 20. CDC Nephropathy Screening Compliance by Ethnicity among SCFHP CMC Diabetic Beneficiaries.

Nephropathy				
ETHNICITY	**NON-COMPLIANT**	**COMPLIANT**	**TOTAL**	**PERCENTAGE COMPLIANT**
AFRICAN AMERICAN	7	57	64	89%
ALASKAN/AMER INDIAN	1	8	9	89%
ASIAN/PACIFIC	27	414	441	94%
CAUCASIAN	24	213	237	90%
HISPANIC	28	435	463	94%
OTHER/UNKNOWN	20	168	188	89%
TOTAL	**107**	**1295**	**1402**	**92%**

Table 21. CDC Retinal Eye Exam Compliance by Ethnicity among SCFHP CMC Diabetic Beneficiaries.

Eye Exam				
ETHNICITY	**NON-COMPLIANT**	**COMPLIANT**	**TOTAL**	**PERCENTAGE COMPLIANT**
AFRICAN AMERICAN	25	39	64	61%
ALASKAN/AMER INDIAN	2	7	9	78%
ASIAN/PACIFIC	97	344	441	78%
CAUCASIAN	97	140	237	59%
HISPANIC	156	307	463	66%
OTHER/UNKNOWN	67	121	188	64%
TOTAL	**444**	**958**	**1402**	**68%**

Plan All-Cause Readmission

The Plan-All Cause Readmission (PCR) measure assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. Readmission occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time. A high rate of readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination, therefore a lower percentage means better performance. Unplanned readmissions are associated with increased mortality and higher health care costs. They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.[17] In 2018, SCFHP reported a compliance rate of 14.79% compared to 13.49% in 2017. African Americans had a highest percentage of readmissions at 21% followed by Caucasians, Chinese, and Asian Indians at 18% (see table 22). There is a statistical significance between the no readmission and readmission within 30 day groups by ethnicity with p = 0.02.

Table 22. SCFHP CMC Beneficiaries Plan All-Cause Readmissions by Ethnicity.

ETHNICITY	NO READMISSION	READMISSION WITHIN 30 DAYS	TOTAL	PERCENTAGE OF READMISSIONS
AFRICAN AMERICAN	42	11	53	21%
ALASKAN/AMER INDIAN	7	1	8	13%
ASIAN/PACIFIC	302	48	350	14%
CAUCASIAN	287	62	349	18%
HISPANIC	347	49	396	12%
OTHER/UNKNOWN	78	12	90	13%
TOTAL	**1063**	**183**	**1246**	**15%**

Follow-Up after Hospitalization for Mental Illness

The Follow Up after Hospitalization (FUH) measures focuses on post discharge follow-up within 30 days for beneficiaries who had a hospitalization for mental illness. The follow-up visit can occur in multiple outpatient settings or partial inpatient stays. Like the PCR measure, this measure focuses on the transitions of care from acute to outpatient settings for a specific type of discharge. In 2018, SCFHP reported a compliance rate of 44.80% for thirty-day visits, which was a great increase from the 2017 rate of 38.46%. When examining by ethnicity, Hispanics were the least compliant at 36% followed by Caucasians at 38% (see table 23). There is no statistical significance between the no 30-day follow-up and 30-day follow-up groups with at p =0.84, however, drawing valid conclusions based on ethnicity is difficult due to the small population size.

Table 23. Follow Up after Hospitalization for Mental Illness among SCFHP CMC Beneficiaries

ETHNICITY	No 30-DAY FOLLOW-UP	30-DAY FOLLOW-UP	TOTAL	PERCENTAGE COMPLIANT
AFRICAN AMERICAN	0	1	1	100%
ASIAN/PACIFIC	2	4	6	67%
CAUCASIAN	13	8	21	38%
HISPANIC	7	4	11	36%
NO ETHNICITY	0	2	2	100%
TOTAL	**22**	**19**	**41**	**46%**

Opportunities for Improvement

For diabetic beneficiaries, the data shows they are compliant with screenings for HbA1c and nephropathy screenings. Rates for retinal eye exam are considerably low in comparison to HbA1c and nephropathy screenings, especially among Caucasians, African Americans, and Hispanics. For the PCR measure, there is a need to focus on the African American population to reduce the number of readmissions.

CONCLUSION

The overall goal of this report was to identify the needs of SCFHP's CMC population and identify opportunities for improvement. Key indicators were identified and analyzed using factors such as age, ethnicity, and gender. Areas identified for improvement include the following:

- There is a need for interventions focusing on cardiovascular conditions. Claims data for the top ten ED and hospitalization diagnoses showed cardiovascular conditions, including hypertension, heart disease, and chest pain, as the top diagnoses for CMC beneficiaries. Further analysis will need to be conducted to determine disparities by ethnicity.
- Diabetes screening for retinal eye exam is an area where beneficiaries have a lower compliance in comparison to other diabetes screenings. Interventions should focus on Caucasians, African Americans, and Hispanics.
- Plan all cause readmissions data shows that African Americans have the highest number of readmissions among all ethnicities and interventions should focus on this population.
- For the SMI population the following opportunities have been identified:
    - Increased presence of internal psychiatry services within the SCFHP network
    - Increased connection with the beneficiary's PCP
    - Decentralizing transportation services to community mental health providers
    - Increasing availability of health homes providing wraparound services
- A 2017 study determined that 4 out of 10 beneficiaries had unmet personal care and routine needs, suggesting there should be more resources focusing on this area.
- The Santa Clara County 2017 Homeless Census and Survey Comprehensive report provided insight into the homeless population in the county. Interventions should focus on Hispanics and African Americans due to the prevalence of homelessness among these ethnicity groups.
- The Santa Clara County Zip Code Profiles provided insight into access to affordable and nutritious foods. Overall, the four zip codes analyzed had a large percentage of families and children living under the FPL in comparison to the county, however, the data for Calfresh utilization is low. This suggests that there may be a lack of awareness about this benefit and there is a need to raise more awareness.
- Overall, SCFHP CMC beneficiaries identifying as Hispanics and Asians were more likely to have three or more chronic conditions. The same ethnic groups also reported a decrease in health status over the last year and being hospitalized at least once in the last 12 months. Further analysis is needed to determine the cause of hospitalizations among beneficiaries with multiple chronic conditions and ethnicity.
- SCFHP serves a diverse beneficiary population. All interventions should take into consideration the beneficiary populations needs and ensure all services are provided in a culturally relevant manner.

The data analyzed in this report provides key information about the CMC population's healthcare experience and barriers that may exist to obtaining care and maintaining optimal health. It also provides insight into social determinants of health and the role they plan in shaping an individual's healthcare experience.

Using the information in this report, SCFHP will explore new ways to strengthen existing interventions and identify new strategies to address beneficiaries' needs.

APPENDIX

Appendix A – Santa Clara County BHSD Screening Tool

Santa Clara County BHSD Screening Tool

Beneficiary Name_____ Gender Identity ☐ Male ☐ Female ☐ Other_____ Date of Birth____/____/____

Insurance Type_____ Medi-Cal Plan Name_____ Provider Network_____

Preferred Language_____ Identified Culture_____

Address_____ City_____ Zipcode_____ Phone(___)_____-_____

Conservator/Caregiver/other consented contact_____ Phone(___)_____-_____

Primary Care Physician_____ _____Location_____ VMC PCP (Y/N)_____

Probation/Parole (Y/N)____AB109 (Y/N)_____ Preferred Clinic_____

Crisis Screening conducted (Y/N)_____ Mandated report required (Y/N)_____ if Y, date filed_____/_____/_____

Referral Criteria		
List A	List B	List C
1 ☐ MH sx, impairments and stressors	1 ☐ 2 Psychiatric Hospitalizations in 12 months	☐ 3+ psychiatric hospitalizations in 12 months
2 ☐ Comorbid Physical and MH condition	2 ☐ 2 EPS visits in 12 months	
3 ☐ Situationally driven life stressors *	3 ☐ Functionally significant Psychosis (specify below)	
4 ☐ Hx of Trauma/PTSD impacting functioning	4 ☐ Recent and/or ongoing SI/HI, or self harm bx	☐ 3+ EPS contacts in 12 months
5 ☐ Isolation or lack of social/family support	5 ☐ Eating disorder with related medical issues	
6 ☐ Hx of SI/HI or attempts	6 ☐ Requires Assistance with ADLs due to MH symptoms	
7 ☐ Behavior problems, i.e. aggressive bx	7 ☐ Receiving services from San Andreas Regional Center	
8 ☐ Behavior incongruent with age (18-21)	8 ☐ Used illicit and/or prescrip. drugs/ETOH (last 30 days**)	
9 ☐ 3+ ED visits due to MH concerns	9 ☐ Personality Disorder w/significant fx impairment	
10 ☐ 1 acute psych hospitalization in 12 mo		
	Note: If #8 in list B selected, conduct SUTS screening (ASAM)	

Referral Algorithm		
Criteria	Disposition	Call
4 or less in List A, and None in List B	(Age 18-59) Refer to Mild to Moderate or FFS provider (Age 60+) Refer to Specialty MH OA program	BHS Call Center 1-800-704-0900
5 or more in List A, (4 or more for 18-21) or 1 or more in List B	Refer to Specialty MH services	BHS Call Center 1-800-704-0900
1 from List C	Refer to FSP	BHS Call Center 1-800-704-0900

Referral Disposition_____

Symptom description/details_____

_____

_____

Brief summary of relevant history_____

_____

_____

Screener Signature_____

Screener Name_____ Screener title_____ Date_____/_____/_____

* Examples of stressors include, but are not limited to, homelessness, recent death in family, job loss, divorce, etc.
** This does not include drugs for medical use, or to treat a medical condition

Revised Jan 6, 2017

Appendix B – Relevant HRA Questions

1. In the last 12 months have you stayed overnight as a patient?
2. Has someone in your family or household:
    a. Been verbally abusive or tried to control your actions
    b. Hurt, beaten, or neglected you
    c. Made you feel fear or threatened.
3. Have you ever experience any of the following:
    a. Lost or gained 10 pounds in the last 6 months, involuntarily
    b. Not always able to shop/cook/or feed self
    c. Not enough money to buy food needed
4. Who do you live with?
    a. Alone
    b. Family member
    c. Significant other/spouse
    d. Friend
    e. Other
5. Compared to last year, would you say your ability to perform your daily routines is:
    a. Slightly easier
    b. Much easier
    c. Same
    d. Slightly difficult
    e. Much difficult

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Member Satisfaction with Complex Case Management Program

Survey results for January – April 2019	Survey results for June – December 2018
SCFHP ***did*** meet the 90% performance goal in four areas 1. Help in finding services needed (91%) 2. Increased understanding of the member's condition (100%) 3. Improved ability to manage own health (100%) 4. Improved overall health situation (91%) 5. Member Grievances (0) *11/13 qualifying respondents	SCFHP ***did not*** meet the 90% performance goal in four areas: 1. Help in finding services needed (71%) 2. Increased understanding of the member's condition (71%) 3. Improved ability to manage own health (72%) 4. Improved overall health situation (72%) 5. Member Grievances (0) *9/12 qualifying respondents

Contributing factors to suboptimal performance rates in 2018 include:

- Limited survey format
- Insufficient types of written health education and community resource materials
- Narrowly detailed survey questions

Issues noted were the survey format, in which not all members can be reached telephonically and the survey content which was not detailed enough to evaluate specific program elements that need improvement. Written resource material regarding health education on community resources was limited and or not provided regularly. (Page 8)

2019 Action Plan:

In January 2019 the Survey was updated and configured in the CM platform Essette to include 7 additional questions specific to; care planning elements, help finding resources and understanding health condition. Initiated the development of a CCM Experience Survey document that can be mailed to the member directly from the CM platform Essette. CM leadership identified additional health education and community resources and implemented them available in Essette to supplement member education and provide reference materials for ongoing support. (Page11)

2019 Survey Summary

Due to the corrective actions initiated after the first survey for June-December 2018, SCFHP was able to increase the 2019 cohort by 29% from 9 to 11 participating respondents out of 13 qualifying members. CM continues to have (0) grievances filed for CCM services. Overall satisfaction remained the same at 90% throughout both reporting periods. There was a 20% increase in satisfaction when it came to receiving help finding services needed and understanding members own condition. There was a 28% increase in satisfaction with in the area of members feeling more confident managing their health. By Q3 2019 SCFHP will have fully implemented the mailed survey process and projects an increase in the rate of survey participation in the next reporting cycle. (Page 9)

Santa Clara Family Health Plan™

Experience with Complex Case Management

(NCQA Requirement PHM 5 Element F)

Presented to: Quality Improvement Committee on April 10, 2019

Presented by: Sandra Carlson, Director, Medical Management

Experience with Case Management

- The Case Management Department evaluates member's experience with Complex Case Management (CCM) Services by obtaining feedback from members and analyzing member complaints for the purpose of identifying opportunities for improvement.
- 100% of members enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of CM services.

Specific feedback measured:

A. Information about the overall program
B. The program staff
C. Usefulness of the information
D. Member's ability to adhere to the recommendations
E. Percentage of members indicating that the program helped them achieve health goal.
F. Member complaints

CCM Satisfaction Methodology

- Members who were enrolled in CCM for 60 days or more are provided telephonic outreach by coordination staff not directly involved in their care.
- Survey period is January – April 2019 there were a total of 11 respondents
- Survey responses are collected on an ongoing basis and reported monthly. And are analyzed and interpreted as part of Evaluating PHM Strategy Effectiveness on an annual basis.
- Feedback data is documented in and reported from the CM software platform Essette.
- There are a total of 16 survey questions
- Responses to questions are scored on a 1-4
- **4** = Strongly agree
- **1** = Strongly disagree
- Highest score possible is 64

GOAL

Survey responses are scored based on the members answer to the questions. Answers are scored as follows 4=Strongly Agree/Very Satisfied, 3=Agree/Satisfied, 2=Disagree/Somewhat Satisfied, 1=Strongly Disagree/Not at all Satisfied with the highest score possible being 64. Overall **goal** is to have members respond “agree or “strongly agree” for questions 1 – 15 and “satisfied” or “very satisfied” for question 16 for an overall satisfaction percentage rate of 90% or higher.

CCM Member Satisfaction Report	Strongly Agree		Agree		Disagree		Strongly Disagree		Sample Size	90% Goal Met
	N	%	N	%	N	%	N	%	11	Yes / No
My case manager treated me with respect.	9	82	2	18	0	0	0	0	11	Yes
My case manager listened to what I had to say.	10	91	1	9	0	0	0	0	11	Yes
My case manager returned my phone calls in a timely manner.	10	91	1	9	0	0	0	0	11	Yes
My case manager helped me find services that I needed.	10	91	1	9	0	0	0	0	11	Yes
My case manager involved me in discussing and planning my care.	9	82	2	18	0	0	0	0	11	Yes
I better understand my disease or condition after being in the case management program.	7	64	4	36	0	0	0	0	11	Yes
My case manager helped me better communicate with my providers.	4	36	7	64	0	0	0	0	11	Yes
I am able to better manage my health and health care after being in the case management program.	7	64	4	36	0	0	0	0	11	Yes
I know what to do if I need help.	4	36	7	64	0	0	0	0	11	Yes
I feel like I have achieved my CCM goals.	4	36	7	64	0	0	0	0	11	Yes
My situation is better because of my case manager's help.	7	64	4	36	0	0	0	0	11	Yes
I feel ready to transition to a lower level of case management.	3	27	7	64	0	0	1	9	11	Yes
I know what to avoid when it comes to my health conditions.	2	18	9	82	0	0	0	0	11	Yes
My Care Plan was clear and easy to understand.	3	27	8	73	0	0	0	0	11	Yes
My input was considered when developing my plan	4	36	7	64	0	0	0	0	11	Yes
	Very Satisfied		Satisfied		Somewhat Satisfied		Not at all Satisfied			
Overall, how satisfied are you with the Case Management Services you received?	10	91	0	0	1	9	0	0	11	Yes

Survey results for January– April 2019

SCFHP ***did*** meet the 90% performance goal in four areas

1. Help in finding services needed (91%)
2. Increased understanding of the member's condition (100%)
3. Improved ability to manage own health (100%)
4. Improved overall health situation (91%)
5. Member Grievances (0)

CCM Satisfaction Survey

Quantitative Analysis/Summary

- 91% of respondents stated they were overall satisfied or somewhat satisfied resulting in meeting the 90% goal for measure A.
- 100% percent of respondents believe that their assigned case manager treated them with respect, listened to what they had to say and returned phone calls in a timely manner meeting the 90% goal for measure B.
- 100% of respondents felt they better understood their condition by being involved in the care planning process and being provided assistance with communication with providers about available resources meeting the 90% goal for measure C.
- 100% of respondents felt they had a better understanding of what to avoid, what to do if they need help and are better able to manage their health care after participating in the CCM Program meeting the 90 % goal for measure D.
- 100% percent of respondents felt their situation is better because they were able to achieve their CCM goals and were ready to transition to a lower level of case management meeting the 90% goal for measure E.

CCM Satisfaction Summary

Qualitative Analysis/Summary

Due to the corrective actions taken from December – April SCFHP was able to increase the 2019 cohort by 29% from 9 to 11 participating respondents out of 13 qualifying members. CM continues to have (0) grievances filed for CCM services. Overall satisfaction remained the same at 90% throughout both reporting periods. There was a 20% increase in satisfaction when it came to receiving help finding services needed and understanding members own condition. There was a 28% increase in satisfaction with in the area of members feeling more confident managing their health. By Q3 2019 SCFHP will have fully implemented the mailed survey process and projects an increase in the rate of survey participation in the next reporting cycle.

CCM Member Complaints

- Grievance and Appeals (G&A) notifies the CM Supervisory team via direct email of members' complaints regarding the CCM program
- There are currently (0) CCM grievance cases open for members enrolled in CCM since June 1, 2018
- CCM care managers provide information to enrolled members about how to and/or will assist members to file a grievance or appeal if necessary
- Since there are no complaints regarding CCM, a qualitative analysis cannot be conducted. SCFHP will continue to monitor for complaints in CY 2019.

2018 Survey results June – December

SCFHP ***did not*** meet the 90% performance goal in four areas:

1. Help in finding services needed (71%)
2. Increased understanding of the member's condition (71%)
3. Improved ability to manage own health (72%)
4. Improved overall health situation (72%)
5.

Contributing factors to suboptimal performance rates include:

- Limited survey format
- Insufficient types of written health education and community resource materials
- Narrowly detailed survey questions

Issues noted were the survey format, in which not all members can be reached telephonically and the survey content which was not detailed enough to evaluate specific program elements that need improvement. Written resource material regarding health education on community resources was limited and or not provided regularly.

2019 Action Plan:

July 2018 – October 2018 CCM survey responses resulted in a 72% satisfaction rate overall. We identified several areas of improvement that we have been addressed including increasing member access to low/no cost resources and community programs, expanding opportunities to complete the satisfaction survey by mail option and expanding the survey questions. All 3 interventions were initiated and have resulted in optimal results for this performance period.

In January 2019 the Survey was updated and configured in the CM platform Essette to include 7 additional questions specific to; care planning elements, help finding resources and understanding health condition. Initiated the development of a CCM Experience Survey document that can be mailed to the member directly from the CM platform Essette. CM leadership identified additional health education and community resources and implemented them available in Essette to supplement member education and provide reference materials for ongoing support.

Santa Clara Family Health Plan

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

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

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Santa Clara Family
Health Plan™

Santa Clara Family Health Plan Member Satisfaction with Complex Case Management: 2018 Analysis

Quality Improvement Committee: April 10, 2019

Author: Shawna Cagle, Manager, Case Management

I. Introduction

Santa Clara Family Health Plan (SCFHP) monitors Cal MediConnect (CMC) members' experience with the Complex Case Management (CCM) Program to ensure adequate satisfaction with the program objectives is achieved. Annually, SCFHP completes an analysis which incorporates member survey questions and complaints related to CMC Complex case management services. This analysis allows the organization to identify opportunities for improving CCM program services through action plans in order to provide the highest quality of case management services. Annual survey results contribute to the overall Population Health Management (PHM) program effectiveness evaluation.

Member Satisfaction with CCM Processes

Santa Clara Family Health Plan measures CCM program effectiveness and overall member satisfaction with the Complex Case Management services through annual monitoring of complaints from members related to Complex Case Management services by performing regular CCM member satisfaction surveys. All members that were enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of CM services. Members that meet inclusionary criteria are outreached by phone at least twice and are offered assistance to complete the survey in their preferred language. Surveys are completed in the CM platform Essette. All survey responses are captured and reported by IT. Additionally the Grievance and Appeals department flags member complaints and reports them to CM leadership. Case Management leadership receives a report of survey outcomes and grievances and completes an annual analysis of all member experience data.

CCM Member Satisfaction Survey Inclusion criteria:
All members who participated in CCM for 60 days or more who have transitioned to a lower level of case management. Members have the right to refuse to participate in all or parts of the survey.

Members who were able to be reached by phone and who were willing to complete the 16 question survey were pulled into the survey population.
Results were generated from the survey population that met the inclusion criteria who participated in answering all 16 survey questions.

CCM Program Evaluation Process:

1. Members who complete the CM transition process are notified that they will receive a call in the following 30 days to complete the CCM Satisfaction Survey.
2. Members receive 2 or more calls to complete the survey.
3. Members are provided assistance to complete the survey in their preferred language.
4. Surveys are completed in the Case Management platform Essette.
5. IT pulls survey responses into the CCM survey response template.
6. CCM survey data is compiled and a report is provided to CM management.
7. Survey results and member grievance data is analyzed.
8. Potential gaps and inefficiencies are identified for areas of improvement.

9. Overall member satisfaction with the CCM experience drives potential action plans and is reported annually to the Quality Improvement Committee.

Methodology

Essette case management was configured to house the survey assessment. Case Management staff conduct 2 telephonic outreach calls and document the outcomes with in the survey assessment. Then number of members who are reached to complete the survey is a subset of the number of members that the health plan attempted to reach. Survey responses are data entered the survey assessment in real time by Personal Care Coordinators (PCCs). Survey responses can be provided by member or formal/informal caregiver on record. Survey responses are scored based on the members answer to the questions. Answers are scored as follows 4=Strongly Agree/Very Satisfied, 3=Agree/Satisfied, 2=Disagree/Somewhat Satisfied, 1=Strongly Disagree/Not at all Satisfied with the highest score possible being 80. Overall goal is to have members respond "agree or "strongly agree" for questions 1 – 15 and "satisfied" or "very satisfied" for question 16 for an overall satisfaction percentage rate of 90%. Members are also encouraged to leave feedback which is documented in the comments section. Survey responses are collected on an ongoing basis throughout the look back year starting June 1, 2018. Survey responses are pulled into CCM survey response report. Report data is analyzed by CM Manager.

During this sample look back period 13 members met the inclusion criteria but only 11 were reached and chose to complete the survey.

This report includes survey results from a portion of the 2018 -19 look back period form December 2018 – April 2017. In October 2018 we identified that the CCM survey lacked enough detail to evaluate specific program areas. In December 2018 the CCM survey was updated to include additional questions to meet NCQA PHM 5F requirements. Total question count went from 9 to 16. Additionally the response choices were reduced to 4 from 6 to 4. ("not sure"& "refused to answer" were eliminated) please see crosswalk below. The additional questions added in December are in **BOLD.**

Factor 1 Analyzing member feedback	
	Question Mapping
Information about the overall program	• Overall, how satisfied are you with the Case Management Services you received? • **My Care plan was clear and easy to understand.** • **My input was considered when developing my plan of care.**
The program staff	• My case manager treated me with respect. • My case manager listened to what I had to say. • My case manager returned my phone calls in a timely manner.

Usefulness of the information disseminated	• I better understand my disease or condition after being in the complex case management program. • My case manager involved me in discussing and planning my care. • My case manager helped me find the services that I needed. • **My case manager helped me better communicate with my providers.**
Member' ability to adhere to recommendations	• I am able to better manage my health and health care after being in the case management program. • **I know what to do if I need help.** • **I know what to avoid when it comes to my health conditions.**
Percentage for members indicating that the program helped them achieve health goals.	• My situation is better because of my case manager's help. • **I feel ready to transition to a lower level of case management.** • **I feel like I have achieved my CCM goals.**

Member Complaints

The process for measuring member CCM complaints is through the Grievance and Appeals department. Member filed grievances for CCM are flagged and reported directly to Case Management Leadership. CCM Leadership works directly with G &A to resolve the grievance. CCM grievances are measured and reported annually. To date there have been (0) grievances for CCM services.

Satisfaction Survey Results

CCM Member Satisfaction Report	Strongly Agree		Agree		Disagree		Strongly Disagree		Sample Size	90% Goal Met
	N	%	N	%	N	%	N	%	11	Yes / No
My case manager treated me with respect.	9	82	2	18	0	0	0	0	11	Yes
My case manager listened to what I had to say.	10	91	1	9	0	0	0	0	11	Yes
My case manager returned my phone calls in a timely manner.	10	91	1	9	0	0	0	0	11	Yes
My case manager helped me find services that I needed.	10	91	1	9	0	0	0	0	11	Yes
My case manager involved me in discussing and planning my care.	9	82	2	18	0	0	0	0	11	Yes
I better understand my disease or condition after being in the case management program.	7	64	4	36	0	0	0	0	11	Yes
My case manager helped me better communicate with my providers.	4	36	7	64	0	0	0	0	11	Yes
I am able to better manage my health and health care after being in the case management program.	7	64	4	36	0	0	0	0	11	Yes
I know what to do if I need help.	4	36	7	64	0	0	0	0	11	Yes
I feel like I have achieved my CCM goals.	4	36	7	64	0	0	0	0	11	Yes
My situation is better because of my case manager's help.	7	64	4	36	0	0	0	0	11	Yes
I feel ready to transition to a lower level of case management.	3	27	7	64	0	0	1	9	11	Yes
I know what to avoid when it comes to my health conditions.	2	18	9	82	0	0	0	0	11	Yes
My Care Plan was clear and easy to understand.	3	27	8	73	0	0	0	0	11	Yes
My input was considered when developing my plan	4	36	7	64	0	0	0	0	11	Yes
	Very Satisfied		Satisfied		Somewhat Satisfied		Not at all Satisfied			
Overall, how satisfied are you with the Case Management Services you received?	10	91	0	0	1	9	0	0	11	Yes

Analysis:

SCFHP sets goals for each performance measure and through the analysis process, identifies opportunities to improve member satisfaction with the CCM process. Performance measures analyzed in this report are specific to NCQA PHM 5F survey content requirements regarding members overall satisfaction with CCM services including experience with the following 5 measures:

A. Information about the overall program
B. The program staff
C. Usefulness of the information disseminated
D. Members ability to adhere to recommendations
E. Percentage of members indicating that the program helped them achieve health goals.
F. Member Grievances

Quantitative analysis

- **91%** of respondents stated they were overall satisfied or somewhat satisfied resulting in meeting the 90% goal for measure **A**.
- **100%** percent of respondents believe that their assigned case manager treated them with respect, listened to what they had to say and returned phone calls in a timely manner meeting the 90% goal for measure **B**.
- **100%** of respondents felt they better understood their condition by being involved in the care planning process and being provided assistance with communication with providers about available resources meeting the 90% goal for measure **C**.
- **100%** of respondents felt they had a better understanding of what to avoid, what to do if they need help and are better able to manage their health care after participating in the CCM Program meeting the 90 % goal for measure **D.**
- **91 %** percent of respondents felt their situation is better because they were able to achieve their CCM goals and were ready to transition to a lower level of case management meeting the 90% goal for measure **E.**
- **(0)** Member Grievances

Quantitative analysis showed that for this portion of the performance period Santa Clara Family Health Plan met all goals and there are no new opportunities for improvement identified at this time related to satisfaction with the CCM process.

Qualitative analysis

SCFHP met the 90% or above performance goal for all 5 measures.
July 2018 – October 2018 CCM survey responses resulted in a 72% satisfaction rate overall. We identified several areas of improvement that we have been addressed including increasing member access to low/no cost resources and community programs, expanding opportunities to complete the satisfaction survey by mail option and expanding the survey questions. All 3 interventions were initiated and have resulted in optimal results for this performance period.

2019 Survey Summary

Due to the corrective actions taken from December – April SCFHP was able to increase the 2019 cohort by 29% from 9 to 11 participating respondents out of 13 qualifying members. CM continues to have (0) grievances filed for CCM services. Overall satisfaction remained the same at 90% throughout both reporting periods. There was a 20% increase in satisfaction when it came to receiving help finding services needed and understanding members own condition. There was a 28% increase in satisfaction with in the area of members feeling more confident managing their health. By Q3 2019 SCFHP will have fully implemented the mailed survey process and projects an increase in the rate of survey participation in the next reporting cycle.

<2018 Barrier and Opportunity Analysis Table

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated	Progress
Members do not understand their condition well enough and are not satisfied with the service provided because of inadequate provision of tools and materials assisting the member in self-management.	Case Managers will have access to Health Education material and resources that can be made available to Member and Caregiver.	Provide ongoing training to CCM Case Management Staff on health education materials, resources and free/low cost community programs available to members.	Yes	January 2019	**Complete**
Not all members eligible to complete the Survey were reached by phone.	To format the survey into a paper questionnaire that can be mailed to the member.	Create a CCM Experience Survey document that can be mailed to the member directly through the Case Management Platform (Essette) Correspondence module.	Yes	January 2019	**In Progress**
Current survey questions lack enough detail to evaluate specific program areas that need improvement	Revise survey questions to better identify areas of case management support members feel they need.	Configure additional questions with the current CCM Survey Assessment in Essette.	Yes	January 2019	**Complete**

Member Satisfaction with the CCM Process Reporting

Approving Committee	Date of Approval	Recommendations

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

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

III. Responsibilities

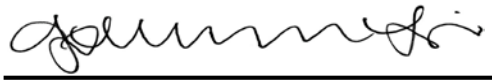
The Quality Improvement Department provides and maintains a Conflict of Interest statement to all Plan Committees that report up to the QIC annually. The Utilization Management Committee, Pharmacy and Therapeutics Committee, and Credentialing and Peer Review Committee all sign the agreement and are obligated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

IV. References

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

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
06/06/2018	06/06/2018
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1.0	**Reviewed**	**Quality Improvement**	**Approve 5/10/2017**	
V1.0	**Reviewed**	**Quality Improvement**	**Approve 06/06/2018**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

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

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

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

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

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

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

III. Responsibilities

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

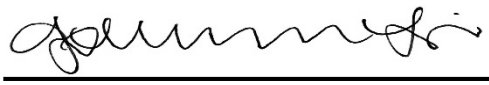
IV. References

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

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

NCQA Guidelines. 2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 6/6/2018	Title 6/6/2018
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
v**2**	**Revised**	**Quality Improvement**	**Approve 5/10/2017**	
V2	**Reviewed**	**Quality Improvement**	**Approve 06/06/2018**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

III. Responsibilities

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

IV. References

NCQA, 2018

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
06/06/2018	06/06/2018
Date	Date

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

V1	**Reviewed**	**Quality Improvement**	**Approve 5/10/2017**	
V1	**Reviewed**	**Quality Improvement**	**Approve 06/06/2018**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

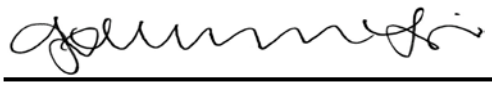
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
06/06/2018	06/06/2018
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve 5/10/2017**	
V1	**Reviewed**	**Quality Improvement**	**Approve 06/06/2018**	

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

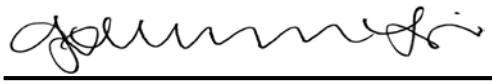
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
06/06/2018	06/06/2018
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1.0	**Reviewed**	**Quality Improvement**	**Approve 05/10/2017**	
V1.0	**Reviewed**	**Quality Improvement**	**Approve 06/06/2018**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

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

III. Responsibilities

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

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

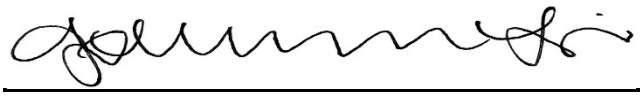
iii. Quality Improvement, Marketing Communications and Outreach, and Compliance maintain a list of member threshold languages, which is reviewed and updated as needed based on member assessment needs, but no later than every five years based on the results of the GNA survey.

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

IV. References

CMS.gov; Managed Care Manual, Chapter 13
NCQA 2018
California Code of Regulations (28 CCR 1300.67.04) (d) (9) (A) (B) (C)
DHCS Contract
Title 22 CCR Section 53876
Title 22 CCR 53853 (c)
CA Health and Safety Code Sections 1367.04 (b)(1)(a), (b)(4) and (b)(5)
Section 1367.04(h)(1)
Civil Rights Act of 1964, (42 U.S.C. Section 2000d, and 45 C.F.4. Part 80)
PL – 99-003
APL 99-005
APL 17-011
CFR 42 § 440.262

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
6/06/18	6/06/18
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approved 06/06/2018**	

Santa Clara
Family Health Plan

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

I. Purpose

The purpose of this policy is to describe Santa Clara Family Health Plan's (SCFHP) Health Education Program and its functions. Health Education at SCFHP is operationalized within the Quality Improvement Department.

II. Policy

The Health Education Program provides organized programs, services, functions, and resources necessary to deliver health education, health promotion, and patient education. It includes assessment, monitoring, and evaluation of all services provided by SCFHP and contracted Vendors.

A. The Health Education Program will provide classes and/or materials free of charge to beneficiaries including, but not limited to, the following topics:
   a. Nutrition
   b. Healthy weight maintenance and physical activity
   c. Individual and group counseling and support services
   d. Parenting
   e. Smoking and tobacco use cessation
   f. Alcohol and drug use
   g. Injury prevention
   h. Prevention of sexually transmitted diseases, HIV, and unintended pregnancy
   i. Chronic disease management, including asthma, diabetes, and hypertension
   j. Pregnancy care

B. SCFHP also offers self-management tools through the Member Portal.

C. All SCFHP members are eligible to receive Health Education classes through SCFHP.

III. Responsibilities

The Quality Department and Health Educator will do the following:

A. Ensure all programs and services are provided at no cost to members.

B. Ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for members and effective in achieving behavioral change for improved health.

C. Ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

D. Maintain a program that provides educational interventions addressing the topics listed above.
E. Ensure that members receive point of service education as part of preventive and primary health care visits. Health Education shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for members.
F. Maintain policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and monitor the performance of providers that are contracted to deliver health education services to ensure effectiveness.
G. Periodically review the health education program to ensure appropriate allocation of health education resources and maintain documentation that demonstrates effective implementation of the health education requirements.

IV. References

- Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with the California Department of Health Care Services and Santa Clara County Health Authority.
- NCQA 2018 Health Plan Accreditation Requirements PHM 4A-K (Wellness and Prevention), PHM 1B (Informing Members)

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	**Signature** Jeff Robertson, MD
Name Director of Quality and Pharmacy	**Name** Chief Medical Officer
Title 06/06/2018	**Title** 06/06/2018
Date	**Date**

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V2	Revised	**Quality Improvement Committee**	**Approve 06/06/2018**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

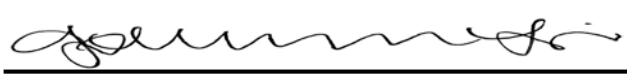
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
06/06/2018	06/06/2018
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	
V1	**Reviewed**	**Quality Improvement Committee**	**Approve: 05/10/2017**	
V1	**Reviewed**	**Quality Improvement Committee**	**Approve: 06/06/2018**	

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

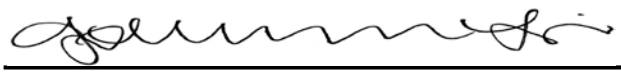
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 06/06/2018	Title 06/06/2018
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve: 11/9/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve: 5/10/2017**	
V1	**Revised**	**Quality Improvement**	**Approve 06/06/2018**	

POLICY

Santa Clara Family Health Plan

Policy Title:	Health Homes Program	Policy No.:	QI.28
Replaces Policy Title (if applicable):		Replaces Policy No. (if applicable):	
Issuing Department:	Quality Improvement	Policy Review Frequency:	Annually
Lines of Business (check all that apply):	× Medi-Cal	□ Healthy Kids	□ CMC

I. Purpose

The Health Homes Program (HHP) offers coordinated care to individuals with multiple chronic health conditions, including mental health, substance use disorders and those experiencing homelessness. The HHP is a team-based clinical approach that includes the member, their providers, and family members (when appropriate). The HHP builds linkages to community supports and resources, as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

The Medi-Cal HHP offers comprehensive, high quality health care for eligible Santa Clara Family Health (SCFHP) Plan Medi-Cal members. The purpose of this policy is to identify all of the HHP requirements for SCFHP and selected Community-Based Care Management Entities (CB-CMEs). SCFHP will work with selected CB-CMEs to facilitate care planning, care coordination, care transitions, and housing navigation services. SCFHP will utilize communication and reporting capabilities to perform health promotion, encounter reporting, and quality of care reporting. Selected CB-CMEs will serve as the community-based entity with responsibilities that will ensure members receive access to HHP services.

II. Policy

SCFHP will be responsible for the overall administration of the HHP. SCFHP will have oversight of the CB-CMEs and their performance. CB-CMEs will provide all members with access to the same level of HHP service, in accordance with the tier/risk grouping that is appropriate for members' needs and HHP service requirements. SCFHP will perform regular auditing and monitoring activities to ensure that all HHP services are delivered according to the contract signed by the selected CB-CMEs and SCFHP. SCFHP will select and assess the readiness of community organizations to serve as CB-CMEs. Selected entities will need to provide all core services of the HHP, including:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports
- Housing Navigation

I. SCFHP Responsibilities:

a. Maintain the HHP infrastructure with contracted CB-CMEs and ensure that the roles and division of responsibility between the CB-CME and SCFHP are clearly identified

b. SCFHP members are assigned to CB-CMEs based on the following factors:

i. PCP Assignment

ii. Geographic Location of the Member

iii. Behavioral Health Needs

~~a.~~iv. CB-CME's Experience with Certain Populations (Homelessness, Language, Demographic, etc.)

~~i.~~c. SCFHP will utilize Model I

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i. ~~All qualified members will be served by Model I~~ CB-CMEs contracted for HHP embeds care coordinators on-site in the community provider offices

~~i.~~1. CB-CMEs will emply staff that meet the care coordination ratio of 1:60 over two years

~~0.~~ ~~Model II will only be used if delegation occurs~~

~~iii.~~d. ~~SCFHP will partially use delegation~~ Delegation will occur when applicable

i. ~~Delegation will occur if the delegated health plan can implement Health Homes Model I and/or Model II~~ Delegated entity will use Model I or Model II

ii. Delegated entity will oversee Health Home responsibilities with their subcontracted CB-CMEs

i. Delegated entity and their CB-CMEs will follow the same HHP policies and procedures set forth by SCFHP

ii. To ensure consistency among all CB-CMEs under SCFHP and delegated entites, SCFHP will approve all CB-CME sites and contracts

iii. Delegated entity will be responsible for capturing data and reporting on the measures for each CB-CME they subcontract with

~~1.~~iv. Delegated entity will be responsible for meeting all reporting deadlines set forth by SCHFP

~~0. Model II should only be used if the delegated plan provides adequate reason to why care management services cannot be held at the CB-CME~~

~~. Selected CB-CMEs will either be a care management entity or a clinic based facility with care management services~~

~~. The same care management system will be used among all CB-CMEs and delegated health plans to ensure reporting and information sharing can be completed on a timely basis Ensure that the CB-CME has the capacity to provide assigned HHP members with a multi-disciplinary care team~~

e. SCFHP is responsible for selecting, and overseeing the implementation of a shared HIT platform that will assist in data collection and reporting

f. Ensure that the CB-CME have the capacity to provide assigned HHP members with a multi-disciplinary care team

i. This is completed through site reviews prior to the initial launch date of HHP and during quarterly auditing reviews

~~e.~~g. SCFHP will provide outreach to provider networks and hospital systems to strengthen multi-disciplinary participation from non-participating CB-CMEs

i. Site visits, marketing materials, and ongoing informational webinars ~~–~~will be utilize to disseminate information (See Outreach Procedure)

~~f.~~h. Share information with CB-CMEs to assist with identifying patients and providing HHP services; data sharing agreements will be established with selected CB-CMEs and SCFHP:

i. SCFHP will notify CB-CME of inpatient admissions and ED visits/discharges
ii. SCFHP will share each member's health history with assigned CB-CMEs
iii. Data will be exchanged between CB-CME and SCFHP to better track CMS-required quality measures and state-specific measures, including health status and outcomes data for the DHCS evaluation process

~~g.~~i. Identify, review and prioritize HHP eligible members by tier/risk grouping and assign members to CB-CMEs

i. Identify members through the DHCS-provided Targeted Engagement List (TEL), internal TEL, and member/provider referrals
ii. Group members according to a tier structure, which should correlate with the member's risk grouping and intensity of services needed

~~h.~~j. Reduce the duplication of services to the member by verifying eligible members' involvement in other case management programs (e.g.~~,~~ Whole Person Care)

~~i.~~k. Develop CB-CME training tools as needed, as well as coordinate trainings to strengthen skills for CB-CMEs in conjunction with HHP

~~j.~~l. Develop and administer payment structure for CB-CMEs

i. Payment structure may consider the payments received from DHCS, member's tier/risk grouping and any other supplemental funding

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~~k.~~m. Prepare SCFHP's Customer Service, Nurse Advice Line, and other staff as necessary to ensure HHP members' needs can be addressed

II. **CB-CME Responsibilities**

a. CB-CMEs retain overall responsibility for all duties that the CB-CME has agreed to perform for SCFHP, as defined in the contract between the CB-CME and SCFHP
   i. CB-CME will perform all seven core services to the HHP-eligible member, as defined in the DHCS HHP Program Guide

b. Complete a readiness assessment as developed by SCFHP
   i. If services are insufficient, CB-CME will work with SCFHP to fulfill the readiness gaps prior to enrolling members

c. Ensure that providers with experience servicing frequent utilizers of health services and those experiencing homelessness, are available as needed per AB 361 requirements

d. Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate

e. Ensure assigned HHP members receive access to HHP services including completing a patient-centered health action plan (HAP) within 90 days of enrollment

~~i.~~f. Maintain a strong and direct connection to the PCP and ensure PCP's participation in HAP development and ongoing coordination

~~ii.~~g. Assess the HHP member's physical, behavioral, substance use, palliative, trauma-informed care, and social services need using screenings and assessments with standardized tools

~~f.~~h. Maintain a multi-disciplinary care team to provide the 7 core services~~outreach and enrollment~~

i. CB-CME will utilize assigned member lists provided by SCFHP to complete outreach and enrollment

~~ii.~~j. Ensure needs are met based on the member's HAP and the tiered structure outlined by SCFHP

~~g.~~k. Utilize existing health information technology (HIT) to collect and share data to SCFHP
   i. If CB-CME does not have adequate technology, CB-CME will work with SCFHP to determine how information will be shared for HHP services and reporting purposes

~~h.~~l. CB-CME will attend required trainings for the HHP

~~. CB-CME may utilize community health workers to conduct outreach and other services as appropriate~~

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~~III.~~I. **References**

- Department of Health Care Services. (2018). *Medi-Cal Health Homes Program-Program Guide.* Sacramento, CA
- Department of Health Care Services. (2018). *All Plan Letter 18-012.* Sacramento, CA: Managed Care Quality and Monitoring Division.
- Legislative Counsel's Digest. (2013). *AB-361 Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Population with Chronic and Complex Conditions.* Sacramento, CA: Marjorie Swartz.

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~~IV.~~II. **Approval/Revision History**

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

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

POLICY

Insert Version # of policy	Indicate if this is an original, reviewed or revised policy	Name of the Committee reviewing prior to going to Board	Indicate whether the committee approved or is recommending approval & Date	Indicate Approve or Ratify & Date

Santa Clara Family Health Plan™

Quality Improvement Committee- CHME Grievances

Q1 2019 Reporting

CHME Grievances

	18-Jan	18-Feb	18-Mar	18-Apr	18-May	18-Jun	18-Jul	18-Aug	18-Sep	18-Oct	18-Nov	18-Dec	19-Jan	19-Feb	19-Mar
Total CHME Grievances	10	6	15	16	12	8	21	22	27	27	26	26	6	17	11
Healthy Kids Membership	3,209	3,250	3,415	3,454	3,220	3,196	3,278	3,187	3,163	3,217	3,460	3,345	3,252	3,375	3,348
Medi-Cal Membership	253,257	254,141	253,025	251,680	249,188	248,766	247,755	245,954	245,884	244,493	243,399	242,695	239,998	240,010	239,836
Total Membership	256,466	257,391	256,440	255,134	252,408	251,972	251,033	249,141	249,047	247,710	246,859	246,040	243,250	243,385	243,184
Rate per 1,000	0.039	0.023	0.058	0.063	0.048	0.032	0.084	0.088	0.108	0.109	0.105	0.106	0.025	0.07	0.045

	18-Jan	18-Feb	18-Mar	18-Apr	18-May	18-Jun	18-Jul	18-Aug	18-Sep	18-Oct	18-Nov	18-Dec	19-Jan	19-Feb	19-Mar
Total CHME Grievances	4	6	8	6	8	4	9	12	25	19	17	7	4	19	5
CMC Membership	7389	7417	7409	7435	7440	7503	7523	7540	7600	7601	7625	7695	7750	7814	7884
Rate per 1,000	0.541	0.809	1.08	0.807	1.075	0.533	1.196	1.592	3.289	2.500	2.230	0.910	0.052	2.430	0.634

Totals 403 complaints filed since 1/1/18

Santa Clara Family Health Plan™

Darryl Breakbill

Director, Grievance & Appeals Operations

Santa Clara Family Health Plan™

Provider Satisfaction Survey Results-MY2018

Prepared by: Carmen Switzer, Provider Network Access Manager

For review by the Quality Improvement Committee

April 10, 2019

Introduction

Santa Clara Family Health Plan ("SCFHP" or "Plan") conducts an annual Provider Satisfaction Survey. Survey results are used to assess network provider satisfaction with the Plan.

For MY2018, SCFHP increased the number of survey items to learn more about the provider experience. These measures helped fulfill both SCFHP's NCQA accreditation process and more specific metrics for internal quality improvement. Due to these changes, only the timely access and referral/authorization measures included on the MY2017 instrument have historical data.

STANDARDS AND THRESHOLDS FOR PROVIDER SATISFACTION:

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

Opportunities to improve provider satisfaction are identified and prioritized based on survey outcomes.

Note: *This report does not include Valley Health Plan or Kaiser providers, as they conduct their own annual surveys.*

Provider Satisfaction Survey

Table 1: Provider Participation

A. Response Rating by IPA/Medical Group Affiliation

Provider Type	Providers Surveyed	Response Count	Response Rate (%)
Individually Contracted Providers	272	95	34.9%
Palo Alto Medical Foundation	372	1	0.3%
Physicians Medical Group of San Jose, Inc.	284	100	35.2%
Premier Care of Northern California, Inc.	38	18	47.4%
TOTAL	966	214	22.2%

B. Response Ratings by Provider Type

Provider Type	Providers Surveyed	Response Count	Response Rate (%)
Primary Care Providers	372	81	21.8%
Specialty Care Providers	496	105	21.2%
Other Providers	98	28	28.6%
TOTAL	966	214	22.2%

Provider Satisfaction Survey

Survey Results

A. Overall Satisfaction with SCFHP

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

B. Overall Satisfaction with Prior Authorization/Referral Process

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

- Overall provider satisfaction with SCFHP is at 86%.
- Provider satisfaction with the prior authorization/referral process showed a decrease of nine (9) percentage points from MY2017.

Provider Satisfaction Survey

C. Primary Care Providers (N=81)

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

- Goal was not met for claims/appeals and timely access, both of which rated at 75% and provider satisfaction with SCFHP's provider network rated at 66%.
- Provider satisfaction ratings for UM, Customer Service and Provider Relations exceeded the goal.

Provider Satisfaction Survey

D. Specialist Providers (N=105)

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

- Goal was not met for any measures by Specialists providers; however, Customer Service and Provider Relations were 1 to 2 percentage points away from meeting the goal.
- We need to take into account that several providers responded that some of the measures were non-applicable or had no experience.

Provider Satisfaction Survey

E. Behavioral Health Providers (N=28)

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

- Satisfaction ratings with Provider Relations and the SCFHP provider network exceeded the goal.
- All other measures fell short from meeting the goal; however, we need to take into account that several providers responded that the measures were non-applicable or had no experience.

Interpreter Services Satisfaction Survey

Table I: Primary Care Provider (PCP)

A. **Q1:** Are you satisfied with the coordination of appointments with an interpreter?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
469	273	109	87	219	2	52	80%

B. **Q2:** Are you satisfied with the availability of an appropriate range of interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
469	273	109	87	222	1	50	81%

C. **Q3:** Are you satisfied with the training and competency of available interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
469	273	109	87	220	2	51	80%

Interpreter Services Satisfaction Survey

Table II: Specialist

A. **Q1:** Are you satisfied with the coordination of appointments with an interpreter?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
300	94	146	60	56	0	36	93%

B. **Q2:** Are you satisfied with the availability of an appropriate range of interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
300	94	146	60	57	0	35	95%

C. **Q3:** Are you satisfied with the training and competency of available interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
300	94	146	60	54	0	38	90%

Interpreter Services Satisfaction Survey

Table III: NPMH

A. **Q1:** Are you satisfied with the coordination of appointments with an interpreter?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
62	8	38	16	7	0	1	88%

B. **Q2:** Are you satisfied with the availability of an appropriate range of interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
62	8	38	16	7	0	1	88%

C. **Q3:** Are you satisfied with the training and competency of available interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
62	8	38	16	7	0	1	88%

Interpreter Services Satisfaction Survey

Table IV: Ancillary

A. Q1: Are you satisfied with the coordination of appointments with an interpreter?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
23	16	6	1	13	0	3	81%

B. Q2: Are you satisfied with the availability of an appropriate range of interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
23	16	6	1	12	0	4	75%

C. Q3: Are you satisfied with the training and competency of available interpreters?

# Surveyed	# Responded	# Refused	# Ineligible	# Satisfied	# Not Satisfied	# Responded N/A	% Satisfied
23	16	6	1	12	0	4	75%

- Most providers rated their satisfaction with SCFHP's interpreter services at or above 80%.
- Ancillary providers rated Q2 and Q3 five (5) percentage points below the goal at 75%

Conclusion

SCFHP met both threshold measures in MY2018, as follows:

- **Overall Satisfaction with SCFHP Services** – Goal 80% / Met at 86%
- **Overall Satisfaction with Prior Authorization/Referral Process** – Goal 70% / Met at 77%

While the Plan is pleased that both threshold measures were met, the prior authorization and referral process results showed a decrease in satisfaction by 9 percentage points from MY2017; thus, there may be room for improvement in this area, which could include provider education on the authorization/referral process.

As noted in the presentation, there were several new measures added to the survey in MY2018; therefore, the Plan will further assess the results and determine steps to address and improve provider satisfaction as necessary.

In addition, SCFHP will continue to look at ways to increase awareness of timely appointment access standards.

Santa Clara Family Health Plan™

Initial Health Assessment (IHA)

Quality Improvement Department

Mai Chang, QI Manager

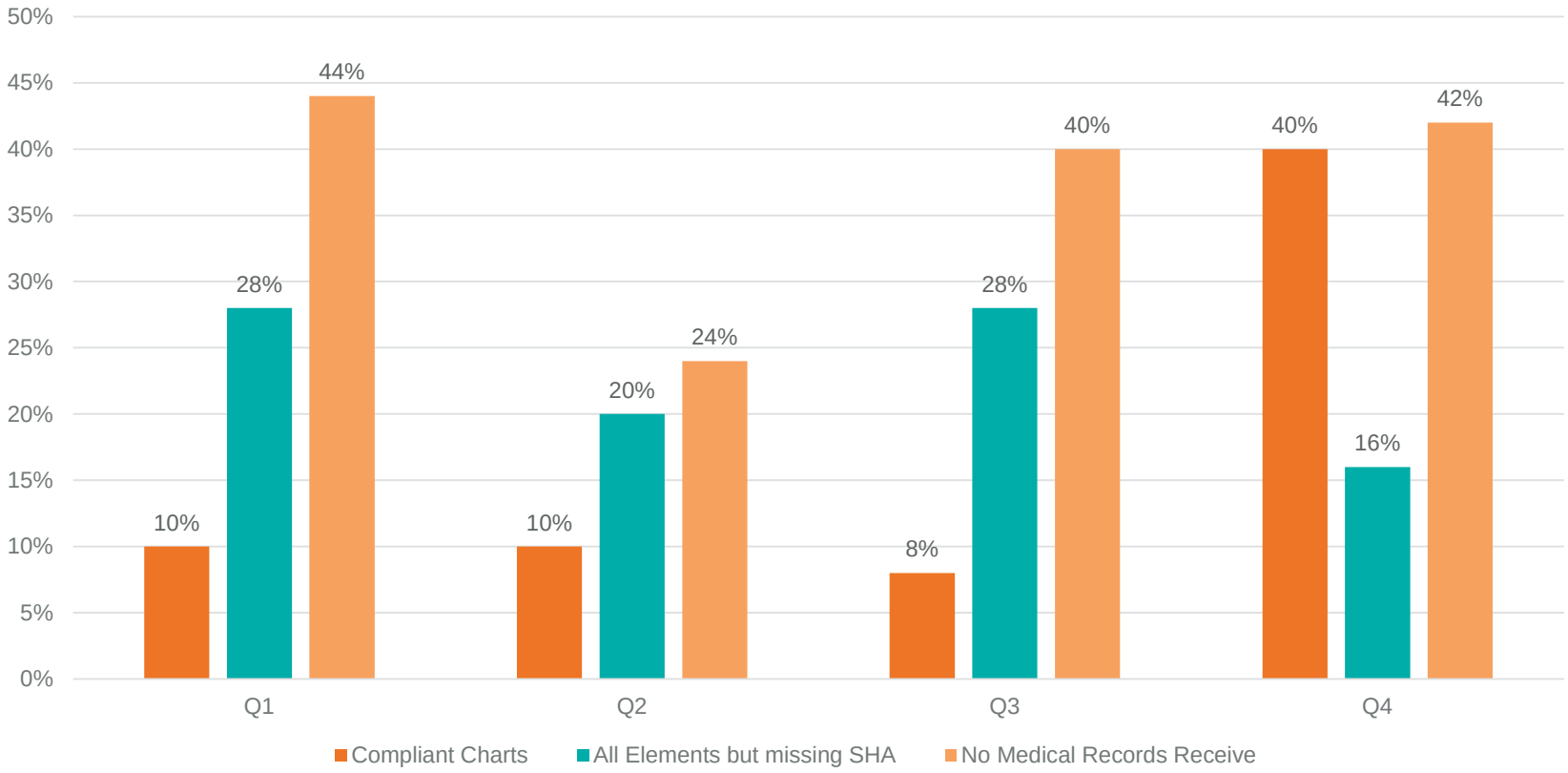
Initial Health Assessment (IHA)

Complete medical, social, and needs assessment in the first 120 days of plan enrollment

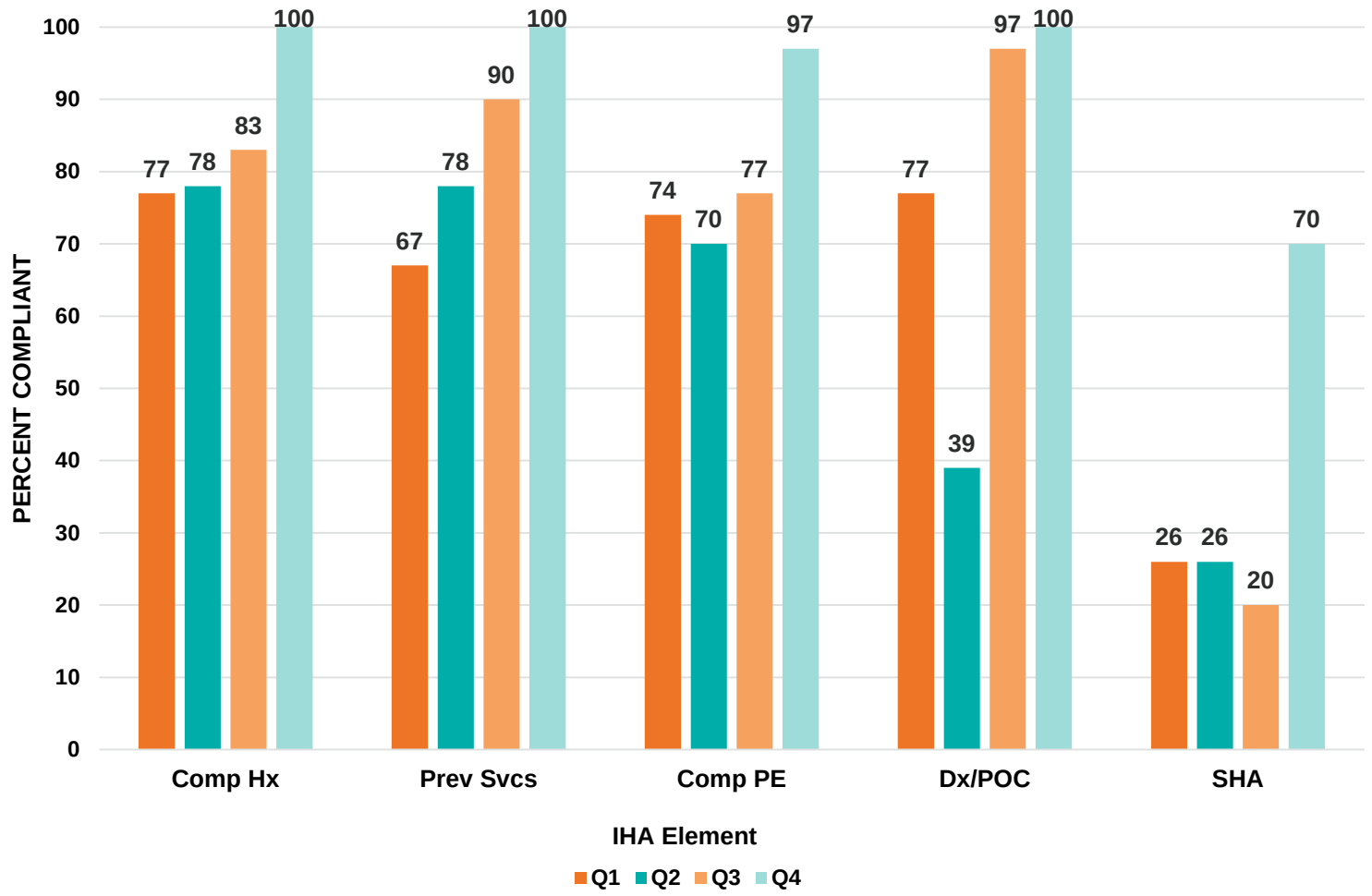
- **Five elements required for completion credit:**

1 - Comprehensive history
2 - Administration of preventive services (screenings, immunizations, etc.)
3 - Comprehensive physical and mental status exam
4 - Diagnosis and plan of care
5 - Staying Healthy Assessment (SHA) Questionnaire

IHA Audit Components



IHA – Percent Compliant Charts by Element



Initial Health Assessment

Findings

- Reviewed charts from a random sample across all networks
- High percentage of partially compliant charts in Q1 – Q3 2018
- Q4 2018 has the highest IHA compliance rate
- High number of providers do not submit medical records for review
- SHA remains the element with the greatest opportunity in improvement

Initial Health Assessment

Barriers - Providers

Providers do not:

- Check the SCFHP portal on a regular basis for newly assigned members
- Document attempted contacts to schedule appointments for new members
- Use the required SHA questionnaires or other state approved forms during IHAs

Initial Health Assessment

Overcoming Barriers - Providers

Continue provider education:

- Provider Portal use
- Required documentation, including outreach
- More efficient, effective use of the SHA
- Ongoing support and education based on provider feedback

Initial Health Assessment

Barriers - System

- Discrepancies in IHA codes used for office visits within the 120 day timeframe
- Difficulty reaching Medi-Cal members to schedule appointments
- Members change providers in the first 120 days
- Completing the SHA is time consuming and does not easily integrate with EMR systems
- Lack of training about all IHA requirements
- Most of the remaining providers do not submit all 5 charts requested.

Initial Health Assessment

Overcoming Barriers - System

- IHA codes on Provider Resource page
- Include all new members in IHA audit even if there is no IHA claim present
- Monitor provider outreach attempts to members
- Updated IHA training in the provider training packet going out in 2019
- Re-auditing providers who failed IHA audit in a previous quarter
- Corrective Action Plan to providers who failed multiple IHA audits or did not submit medical records for review

Questions?

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee February 27, 2019

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	7	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	6	
Number practitioners recredentialed within 36-month timeline	6	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 01/31/2019	266	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1484	1291	711	761	395	118

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Actions Taken

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

Outcomes & Re-measurement

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

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Meeting Minutes

Santa Clara Family Health Plan™

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
CLOSED SESSION - **Pharmacy & Therapeutics Committee**
Thursday, December 13, 2018
6:00 PM - 8:00 PM
6201 San Ignacio Avenue San Jose, CA 95119

MINUTES

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

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

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:06 PM.	
2	**Public Comment**	
	No public comment.	

3	**Past Meeting Minutes**	
	The SCFHP 3Q2018 P&T Minutes from September 20, 2018 were reviewed by the Committee as submitted.	Upon motion duly made and seconded, the SCFHP 3Q2018 P&T Minutes from September 20, 2018 were approved and will be forwarded to the QI Committee and Board of Directors.
4	**Plan Updates**	
	CMO Health Plan Updates Dr. Nakahira introduced herself as the new Chief Medical Officer at the plan and shared her professional background.	
	Appeals & Grievances Dr. Huynh presented the Appeals & Grievances report Q3 2017 through Q3 2018. Slight decrease in Medi-Cal appeals, downward trend. Slight decrease in Part C & D Appeals, downward trend. Committee asked about the most common grievance. Dr. Liu responded that she believes that the most common grievance is regarding transportation.	
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	their views on different benefit areas. This survey happens in Q2 of every year. Survey will be facilitated in English and Spanish with a pilot in Vietnamese and Chinese.	
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5	**Metrics & Financial Updates**	
	Membership Report Dr. Nakahira presented the membership report. Slight decline in Medi-Cal line of business membership. Slight increases in CMC membership.	
	Pharmacy Dashboard Dr. Otomo presented the Pharmacy Dashboard. For Medi-Cal, prior authorization (PA) volume increased from September to October, then decreased in November. PA turnaround time has remained compliant at >95% for both urgent and standard PAs. The second biannual inter-rater reliability to check the concurrence of PA decisions within the Pharmacy department and medical doctors is scheduled for December 21, 2018. There will be 10-15 cases selected to review. For Cal MediConnect, PA volume decreased in November. PA turnaround time has remained compliant at 100% for expedited and standard PAs. CMR completion rate goal increased from 22% to 40% for CY2018, and as of the October MTM reports, the plan had a 35% CMR completion rate. Daily denied claims review has remained compliant around 99%.	

	Drug Use Evaluation Results Dr. McCarty presented the Drug Use Evaluation (DUE) Results for 4Q18. For the Polypharmacy DUE program that identified members taking multiple chronic medications from multiple prescribers, 1,016 members were identified in 4Q17, 914 of those members were still active during the 7/2018-9/2018 follow up period, and 516 members of those members were not identified on the 4Q18 Polypharmacy report. This demonstrated a 56.5% success rate for the Polypharmacy 4Q17 intervention.	
	Drug Utilization & Spend Review Dr. McCarty presented the Drug Utilization & Spend Review. For both Medi-Cal and CMC, diabetes remains the top spend in 3Q18. For Medi-Cal, inflammatory disease and neoplastic disease remain as high cost drug categories. Biggest cost decrease occurred in the infectious disease-viral drug category. For CMC, there was a decrease in cost in behavioral health drugs and an increase in cost in drugs for hematological disorders.	
6	**Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria**	
	Dr. Huynh presented an overview of the MedImpact 3Q2018 P&T minutes as well as the MedImpact 4Q2018 P&T Part D Actions.	Upon motion duly made and seconded, the MedImpact 3Q2018 P&T Minutes, and MedImpact 4Q2018 P&T Part D Actions were approved as submitted.
7	**Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**	
	Formulary Modifications Dr. Otomo presented the formulary changes since the last P&T meeting. Notable changes included removal of alendronate 40mg from formulary, addition of Epogen back to formulary with PA due to the unavailability of Retacrit, removal of EZ Flu syringe kit from formulary, removal of ciprofloxacin ER tablets from formulary, addition of sodium polystyrene sulfonate powder to formulary, removal of Armour Thyroid from formulary, removal of step therapy from liothyronine, and addition of Brilinta to formulary.	Upon motion duly made and seconded, formulary modifications were approved as presented.

	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented the list of changes to the Medi-Cal fee-for-service (FFS) contract drug list (CDL) with recommendations to maintain formulary comparability. The state added: - Somatuline Depot with code 1 restriction – recommended to add to formulary with medical benefit restriction (Tier 3). - Tibsovo with code 1 restriction – recommended to add to formulary with PA - Mektovi with code 1 restriction – recommended to add to formulary with PA - Braftovi with code 1 restriction – recommended to add to formulary with PA - Lumoxiti with code 1 restriction – recommended to add to formulary with medical benefit restriction (Tier 3) No recommended actions for the other CDL changes.	Upon motion duly made and seconded, formulary recommendations were approved as presented.
	Prior Authorization Criteria Dr. Nguyen presented the following PA criteria for approval by the committee: 1. Amitiza – new PA criteria 2. Humira – addition of 2 new GPIDs; addition of new pediatric doses for uveitis 3. Zarxio – annual review, no changes	Upon motion duly made and seconded, prior authorization criteria were approved as presented.
8	**Discussion and Recommendations for Changes to SCFHP Medical Benefit Drug Prior Authorization Grid for SCFHP CMC, Medi-Cal, & Healthy Kids**	
	Prior Authorization & Step Therapy Review Dr. Huynh presented the 2019 Medical Benefit PA Grid and explained that there will now be one PA grid for all lines of business. The other change for 2019 is that since Medicare now allows step therapy (ST) for Medicare Part B drugs, the plan will be implementing ST for any drugs that have an available biosimilar. All ST restrictions are listed on the grid. The PA criteria for Part B drugs will continue to follow MCG criteria.	Upon motion duly made and seconded, the 2019 Medical Benefit PA Grid was approved as presented.
9	**New Drugs and Class Reviews**	
	New Drugs and Class Reviews Dr. McCarty presented the following new drugs and class reviews: 1. Xofluza – New single-dose drug for influenza. Recommended to add to formulary with quantity limit (QL) 1 per fill and 1 fill per year 2. Oncology	Upon motion duly made and seconded, all recommendations were approved as presented.

	- Tibsovo is a new drug for relapsed or refractory acute myeloid leukemia with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. Discussed during CDL updates and comparability. Recommended to add to formulary with PA. - There are new agents to treat metastatic non-small cell lung cancer (NSCLC) with EGFR mutations. Recommended to add Tagrisso to formulary with PA. 3. New entities: - Differin (adapalene) OTC 0.1% gel – Recommended to add this OTC to formulary with QL 45g/30 days and remove the RX formulation from formulary. Recommended to add Altreno (tretinoin) 0.05% lotion to formulary with ST to match the other formulary tretinoin products and QL 45g/30 days. 4. Xarelto: - New 2.5mg tablet available to be used with aspirin to reduce the risk of major cardiovascular events in patients with chronic coronary artery disease or peripheral artery disease. Recommended to add Xarelto 2.5mg tablet to formulary with PA and QL 2/day. - Recommended to remove PA from Xarelto 10mg, 15mg, and 20mg tablets and add QL (10mg & 20mg = 1/day; 15mg = 2/day and 21/fill)	
	Reconvene in Open Session Committee reconvened to open session at 7:56 PM.	
8	**Discussion Items**	
	New Drugs and Generic Pipeline Dr. McCarty presented the new drugs and generic pipeline. High impact-interest drugs include: Onpattro, Takhzyro, dasotraline, Ajovy, Emgality, Talzenna, Xofluza, lorlatinib, solriamfetol, caplacizumab, bremelanotide, netarsudil/latnoprost, siponimod, sotaglifozin, risankizumab, selinexor, cladribine, and esketamine. High impact generic pipeline drugs include: Onfi, Byetta, Nuvaring, Remodulin, Epclusa, Harvoni, Tracleer, Restasis, and Sensipar.	
9	**Adjournment at 7:59 PM**	

Santa Clara Family Health Plan™

Date 3/21/19

Jimmy Lin, MD, Chair
Pharmacy and Therapeutics Committee Chairperson

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
OPEN SESSION - **Pharmacy & Therapeutics Committee**
Thursday, December 13, 2018
6:00 PM - 8:00 PM
6201 San Ignacio Avenue San Jose, CA 95119

MINUTES

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

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

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:06 PM.	
2	**Public Comment**	
	No public comment.	

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9	**Adjournment at 7:59 PM**	

Date 3/21/19

Jimmy Lin, MD, Chair
Pharmacy and Therapeutics Committee Chairperson

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
January 16, 2019

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

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	N
Natalie McKelvey	Manager of Behavioral Health	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the October 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	
IV. CEO Update **V. CMO Update**	Dr. Robertson presented the CEO & CMO Updates noting the current and upcoming audits for the first half of the year. We completed our Medicare Audit in September a lot of remediation almost done they will come back for a 2nd CMS Independent Validation Audit sometime	No action required

ITEM	DISCUSSION	ACTION REQUIRED
	between May – July 2019. In addition, DHCS/DMHS will be onsite March 18-22, 2019, NCQA (1st Survey submitted 12/11/2018, Onsite February 4-5, 2019. Dr. Robertson further reported the Plan implemented a change to the Division of Financial Responsibility (DOFR) for Valley Health Plan, our largest delegate with half of our members. Previously they did not have responsibility for out of area health care and skilled nursing care beyond two months. The care of patients whether in or out of the area was effective 1/1/2019. Ms. Tomcala reported on the governor's new proposals that would affect the Health Plan; 1) carving out pharmacy as a statewide fee for service and also proposed extending coverage to undocumented youth up through age 26. In addition. There have been discussions in the community regarding the County purchasing O'Connor and St. Louise Hospitals. The attorney general is now raising some concerns about that.	
VI. Old Business/Follow up items	**a.** Ms. Boris presented the MCG Criteria for Colonoscopy, EGD, and Up-to-date criteria for Frenulectomy. Prior authorization requirements were renmovedewed for a colonoscopy procedures because there is no way of determining whether it is a screening colonoscopy of a follow-up colonoscopy. SCFHP Ddoes not have Prior authorization criteria for colonoscopy any longer. Dr. Robertson noted the prior authorization preventive services - was eliminated because the State does not allow the Plan to authorize preventive services such as screening colonoscopy. **b.** Ms. Castillo presented data for Skilled Level of Care to Long Term Care Level of Care for the period of 6/1/2018 – 12/31/2018. Data is as follows: • 345 total skilled authorizations • 578 total LTC authorizations • Combined skilled and LTC authorization and identified duplicate members with skilled and LTC authorizations • Verified that the LTC authorizations were after the skilled authorization	No action required.

ITEM	DISCUSSION	ACTION REQUIRED
	48 members transitioned from skilled level of care to LTC level of care • 46 out of 48 LTC authorizations are still current and active • Two had an end date in August and November. Ms. Castillo noted that the definition of LTC are members who are institutionalized in a long term care facility that has daily needs for their ADL's daily living and they need to meet Medi-Cal criteria for long term care. The previously used term was Custodial Care, institutional not requiring any skilled therapy but unable to live outside the institution.	
VII. Action Items	**a.** UM Program Description 2019 Ms. Carlson provided an update on changes made to the 2018 Utilization Management Program Description noting there were spelling corrections, verbiage and context changes. The changes are as follows: **1.** Cover page: Changed date from ***2018 to 2019*** **2.** Page 5: spelling correction **3.** Page 9: context change, "The Utilization Management ***Department"*** changed to Utilization ***"staff"*** **4.** Page 11: context change, "The Health Services ***Utilization Manager*** is responsible for the day to day…" changed to the Health Services ***Director and Utilization Manager*** are responsible…" **5.** Page 11: context change, ***"UM Lead Coordinator"*** changed to ***UM Supervisor.*** Responsibilities section updated to include daily operation management of UM activities to include, "productivity ***and quality monitoring"*** **6.** Page 12: context change, "Utilization Review and Discharge Planning Nurses"' changed to "Utilization Review and Discharge Planning ***Registered*** Nurses" ***7.*** Page 12: context change (Section g), ***Utilization Management review Nurse (LVN) added along with description, "Under the guidance and direction of the UM department RN Mangere or Health Services Director, Licensed Vocational nurses are responsible for performing prospective and retrospective pre-service clinical review for inpatient and outpatient authorization requests in compliance with all applicable state and federal regulatory requirements, SCFHP policies and procedures, and applicable business requirements. Following regulatory or evidence-based guidelines, assesses for medical necessity of services and/or benefit coverage which result in approved determination for services or the need to collaborate with Medical Directors for potential denial considerations.***	Approved as presented

ITEM	DISCUSSION	ACTION REQUIRED
	8. Page 13: context change, "Case management services at the SCFHP are licensed registered ***nurses"*** changed to ***"(RN) or licensed clinical social workers (LCSW)"*** **9.** Page 20: spelling correction **b. Annual Review of UM Policies** Ms. Boris presented changes to Utilization Management Policies HS.01 thru HS.15 noting tall policies meet DHCS, DMHC, CMS and NCQA requirements. To meet regulatory requirements and ensure effectiveness of the program structure changes have been made. **i. HS.01 Prior Authorization** Title Change from Prior-Authorization /Or determinations Updated section H&I **H.** The Plan maintains a ***procedure for*** Continuity of Care for both medical and behavioral health services. ~~**I.**~~ Out of Area ***and Out of Network*** requests are processed in accordance to the ***Member's Evidence of coverage, the*** Plan's Continuity of Care ***procedure*** for medical and behavioral health ***and reviewed based on medical necessity.*** **ii. HS.02 Medical Necessity Criteria** Update section B: The Plan maintains a Utilization Management (UM) Program description and Prior Authorization Procedure which further describe the Plan's utilization of Medical Necessity Criteria. The following factor apply: **B.** Criteria is specific to ***services and*** procedures ***requested.*** **iii. HS.03 Appropriate Use of Professional** Update section B and D: **B.** The Plan specifies the type of personnel responsible for each level of UM decision making which includes: • Non-licensed staff may apply established and adopted UM ***Care Coordinator*** guidelines that do not require clinical judgement. ***D.*** Non-licensed and licensed staff receive training and daily supervision ***by UM Supervisor, UM Manager, Medical Management Director and Medical Directors.*** **iv. HS.04 Denial Notification** Update section C: **C.** Letters to members for denial, delay, or modification of all or part of the requested service include the following.	The content and numbering as stated on the Agenda were Approved, with the caveat to correct the numbering issue, and updating HS.09 section 4, with the definition to Medical Management Leadership

ITEM	DISCUSSION	ACTION REQUIRED
	8. Provided in the language noted on the member's plan file ***within the DHCS threshold language requirement*** **9.** Advises that notifications are available in ***other*** languages upon request **v. HS.05 Evaluation of New Technology** No changes from 2018. **vi. HS.06 Emergency Services** No changes from 2018. **vii. HS.07 Clinical Practice Guidelines** Re numbered from HS.14 to HS.07 Update sections D,E,F, and I: *D.* ***Non contracted providers and Out of area providers will follow Out of Network/Out of Area Procedure for Utilization review.*** *E.* ***SCFHP notifies LTC providers of required supporting documentation for Utilization review.*** When PAR submissions do not include required documentation, SCFHP will follow up with the nursing facility with 3 outreach attempts to request the documents and if they are not received, the PAR will be **reviewed and possibly** denied **by a medical professional for insufficient information.** *F.* Changed ~~***RN***~~ to ***Licensed Nurse*** ***I. Bed Hold*** ***a.*** SCFHP shall include as a separate benefit any leave of absence or Bed Hold that a nursing facility provides in accordance with Medi-Cal requirements ***b.*** Bed Holds (BH) and should be submitted by the SNF at the time of transfer ***c.*** **T**he member's attending physician must write a physician order for a discharge or transfer at the time a member requires a discharge or transfer from an LTC facility to a General Acute Care Hospital and include an order for Bed Hold. ***d.*** Bed Hold (BH) ***is limited to seven (7) calendar days per discharge*** **viii. HS.08 Second Opinion** No changes from 2018 **ix. HS.09 Interrater Reliability** Update section B, III and IV: ***B.*** **Review** **4.** All cases will be reviewed ***by Medical Management Leadership*** for a consensus decision-making within 1 week following due date. **III. Records**	Specify in Policy what Medical Management Leadership is, managers and above.

ITEM	DISCUSSION	ACTION REQUIRED
	All results and internal Corrective Action Plans CAPS) remain confidential and are maintained within Health Services and are reported to the ***UMC.*** ***IV. Responsibilities*** ***Health Services coordinates with both internal and external stakeholders in development, execution, maintenance and revisions to Denial Notifications. This includes but is not limited to collaboration with Quality, Benefits, IT, UM Committee, QIC, providers and community resources*** **i. HS.10 Financial Incentive** No changes from 2018 **ii. HS.11 Informed Consent** No changes from 2018 **iii. HS.12 Preventive Health Guidelines** No changes from 2018 **iv. HS.13 Nurse Advise Line** No changes from 2018 **v. HS.14 Transportation Services** Emergency medical transportation does not require prior authorization. Non-emergency medical (NEMT) and non-medical transportation services (NMT) as specified in an AP17-01 non-emergency medical and non-medical transportation services requires a physician's certification statement for physicians to have a signature for all non-medical transportation services. **vi. HS.15 Long Term Care Utilization Review** No Changes from 2018 Ms. Carlson noted that moving forward HS.13 Nurse Advice Line Policy and procedures will be moved to claims and presented at the next QIC meeting.	

ITEM	DISCUSSION	ACTION REQUIRED
VIII. Reports	**a. Membership** Dr. Robertson gave an update on membership noting that Medi-Cal experienced a gradual but linear decline, and we contribute this to three factors; 1) the economy is improving, and members are getting jobs and no longer qualifying for Medi-Cal 2) Santa Clara County is expensive and people are moving to less costly counties, and 3) the uncertainty around immigration status. Between those three things, we have seen a loss of approximately 4,000 members. The upside is the Cal Medi-Connect Medicare line of business 2018 UM Report whereas we had a loss of 150-200 a month through much effort we have turned that around and we are now growing that, not tremendous growth. 150 Medicare lives is about 1,000 Medi-Cal lives as far as the cost and amount of work involved. Do not know when it will stabilize. It looks like 250,000 a year and a half ago 285,000. **b. UM Reports 2018** **i. Dashboard Metrics** Dr. Boris reported that the 2018 UM Reports have compliance requirements around doing prior authorizations in a timely matter. We do have the Utilization Dashboard for Cal Medi-Connect as well as for Medi-Cal. Ms. Castillo reported on our daily, weekly, and quarterly tracking, so that you have an idea of the changes that have been made and how it has positively affected what you are seeing on the metrics. Cal MediConnect lines of business. • Cal MediConnect (CMC) standard Part C, October 99.2%, November 98.8%, and December 99.0%. • Expedited Part C, October 98.6%, November 98.6%, December 100%, and Year to date 96.4% • Retrospective Review - 100% last quarter and Year to Date 96.7%. Medi-Cal line of business – DHCS goal is 95% compliance. • Routine Authorization - October 97.6%, November 96.8%, December 97.7% and Year to date 92.6% • Expedited Authorizations – October 99.1 %, November 100%, December 98.7%, and Year to date 97.1%	

ITEM	DISCUSSION	ACTION REQUIRED
	• Retrospective Review - October 99.1%, November 99.4%, December 100%, and Year to Date 97.5% Ms. Castillo pointed out that we are required to monitor not just our decision making time but also our notification time. This was brought to our attention during our CMS Audit, so we are monitoring closely and this is added to the dashboard. We are monitoring our notification time from the time that a decision is made to the that we notify our providers and members. **ii. Standard Utilization Metrics** Dr. ~~Ms~~. Boris presented the Standard Utilization Metrics data for 10/1/2017 thru 9/30/2018. Discharge per thousand per member months. Our goals for this year, we are going to be developing some department specific goals so we are going to use some of these, get some clarity on them, and use them for our department goals. More details in upcoming meeting. • **Inpatient Utilization: Medi-Cal –Non-SPD:** 3.75 and average length of stay is less than 4 (moms, kids & families) • **Inpatient Utilization: Medi-Cal – SPD:** around 12 and average length of stay climbed to almost 1 day above the average for children. (seniors and persons with disabilities) • **Inpatient Utilization: Cal MediConnect (CMC):** 258 Cal MediConnect and average length of stay doubles to six. (Medicare and Medi-Cal dual eligible patients) • **Medi-Cal Inpatient Utilization NCQA Medicaid Benchmark Comparisons:** 3.75 for non-SPD and the average length of stay 12. Rank less than 10% on non-SPD but greater than 90%, means a higher utilization on SPD population. Average length of stay 4-4.75. • **Medi-Cal SPD & CMC Inpatient Utilization MCG & NCQA Medicare Benchmark Comparisons:** For the CMC line of business, we look more like a loosely managed plan compared to National Medicare patients, which is not an apples to apples comparison but it is the best we have. NCQA Medicare mean at 214 still above NCQA mean. Bed days is average length of stay is ½ day higher	Highlight going forward

ITEM	DISCUSSION	ACTION REQUIRED
	• **Inpatient Readmission: Medi-Cal – Non-SP:** part of these are HEDIS rates all cause readmission. Those 4 quarters average around 16%. • **Inpatient Readmissions: Medi-Cal – SPDs:** 21% is a high number SPD act and behave more like our Cal MediConnect product, but they do not have Medicare supporting their resource utilization. • **Inpatient Readmissions: Cal MediConnect (CMC):** Q3 2018 abnormally low at 10%, this will self-adjust as more claims come through. We remain right around 15% • **Cal MediConnect (CMC) Readiness Rates Compared to NCQA Medicare Benchmarks**: A comparison for18-64, 65 and above, and our 18-64 always have a readmission rate that is higher primarily because that population in CMC has disabilities that are resulting in their Medicare benefit. • **Frequency of Selected Procedures: Medi-Cal**: There were no dramatic shifts in frequency of procedures; most members are on the downward trend. We did look bariatric weight loss procedures and still see the highest bariatric ages 20-24, BMI is 39-64. • **ADHD Medi-Cal Behavioral Health Metrics:** looks at children prescribed ADHD medication both initiation phase and maintenance phase, antidepressants and cardiovascular monitoring. **c. MLTSS Dashboard** Ms. Castillo reported that MLTSS covers long-term care authorizations and CBAS authorizations for our community based adult services, also known as adult day cares. Cal MediConnect is 100% compliant and Medi-Cal MLTSS remains 95%, averaging 98% - 100%. **d. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q4 18)** Ms. Castillo presented the Q4 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 4th quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 4th Quarter review of 2018, the findings are as follows: III. For the dates of service and denials for October, of CY 2018 were pulled in the 4th quarter sampling year. a. 30 unique authorizations were pulled with a random sampling.	

ITEM	DISCUSSION	ACTION REQUIRED
	i. 60% or 12/30 were Medi-Cal LOB and 40% or 18/30 CMC LOB ii. 100% or 30/30 were denials 1. 10 of the 30 were expedited, processed in 72 hours - 20 were standard depending on whether they were Medi-Cal or CMC – 5 business days or 14 days 2. 80% or 8/10 were compliant with regulatory turnaround, 20% were not of our random sample iv. 90% of the standard authorization were compliant and 2 were non-compliant v. 67% or 20/30 were medical denials, and 10/30 were administrative denials vi. 100% or 30/30 cases were denied by MD vii. 100% or 30/30 provided member and provider notification viii. 70% or 7/10 expedited authorization provided oral notification to member ix. 97% member letters are of member's preferred language x. 97% or 29/30 letters were readable and rationale for denial was provided xi. 97% or 29/30 letters included the criteria or EOC that the decision was based upon xii. 100% or 30/30 letters included interpreter rights and instructions on how to contact CMO or Medical Director Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from those finding presented to UMC are as follows: • Provide staff training regarding oral notification to member following an expedited service authorization determination. • Provide staff training in managing regulatory turnaround time based on LOB. • Provide staff training in quality monitoring including denial language and checking members preferred language prior to sending members UM letters. • Continue QA monitoring and reporting. **e. Referral Tracking**	

ITEM	DISCUSSION	ACTION REQUIRED
	Ms. Castillo presented the data for the Referral Tracking report for 2018 noting the report was completed for the rolling 12-month look back of: January 1, 2018 to December 31, 2018. Findings: **1.** There were 14,554 unique authorizations for all lines of business (roughly 1200 auths/month). • Cal MediConnect: 5126 o 2297 without Claims • Healthy Kids: 40 o 19 without claims • Medi-Cal 9388 o 3979 without claim **2.** It was identified that there is an average 3 months claim lag time. • 53.5% Authorized services were rendered within 90 days of authorization • 2.3% were rendered after 90 days of authorization • 44.2% were not yet rendered to date. Follow Up **1.** 55 unique case authorization were pulled for sample calls. • 21 Cal MediConnect • 34 Medi-Cal **2.** Types of Services • 1 EGD • 1 Home Health • 7 MRI • 25 Outpatient therapy • 3 Sleep studies • 1 SBRT • 7 Transportation • 10 Other **3.** 14 of 55 cases confirmed that they received services already. **4.** Reasons why member did not get service: • Members refuse service – 1	

ITEM	DISCUSSION	ACTION REQUIRED
	• Member is too sick to receive service – 2 • Scheduling issue – 5 • Taking care of family member, waiting for holidays to pass, member or provider scheduling issues • Wants to talk to PCP prior to receiving service – 1 • Service location issue – 2 **5.** 30 unreachable member to confirm reason for incomplete services **6.** Zero termed members **f. Nurse Advice Line Stats** Ms. Carlson presented the Nurse Advice Line Stats by Line of Business for the dates of October 1, 2018 – December 31, 2018. Call Volume summary by disposition; • Medi-Cal 2,114, Healthy Kids 56 calls, and Cal MediConnect 94 calls Highest volume for Triage Guidelines used for call types; • Medi-Cal: CareNet Health Information only, Influenza/Flu like symptoms, abdominal pain, fever, and Cough/URI • Healthy Kids: Croup, Fever, and Abdominal pain, vomiting with diarrhea • Cal MediConnect: Influenza/Flu like symptoms, CareNet Information only, Cough/URI, and abdominal or pelvic pain **g. Annual report on physician peer to peer process** Dr. ~~Ms~~. Boris noted that in accordance with Procedures HS.02.02, the provider dispute process includes a Peer to Peer (P2P) review with the SCFHP physicians who make determinations (in case denials of service.) It is the goal of SCFHP medical team to ensure quality of service and return calls when there is a requested P2P. YTD there were 19 requests for Peer-to-Peer Reviews. All 19 cases were reviewed for compliance. This ensures that the P2P process is working and that the community physician requests for call back are completed and do in fact occur. The findings are as follows: 1. 84% (16/19) calls were completed with the SCFHP physician and the requesting physician	

ITEM	DISCUSSION	ACTION REQUIRED
	2. 81% (13/16) had documentation of the call in our QNXT system SCFHP recommendation to UMC: 1. Corrective Action: a. Since 6/2017, QNXT system holds authorization for all Lines of Business (Medi-Cal, Cal MediConnect, and Healthy Kids.) As such, both physicians know the system and have agreed to enter their call documentation into QNXT. b. The current findings are that the majority of the physician calls are completed. Only three calls were not returned. Two of the cases have no notes, and one case was redirected successfully to Stanford Medical Center. c. SCFHP will reinforce the use of QNXT fir the completion of P2P call notes within the original authorization **d. Conflict of Interest Forms** Dr.~~Ms~~. Boris reported on the annual confidentiality agreement and asked all members to sign and return at the close of the meeting. Dr. Robertson introduced Natalie McKelvey the new manager in Behavioral Services you may recall Sherri Holm retired. We do not intend to replace the director position and so Ms. McKelvey is picking up our internal operations. Dr. Robertson responded to Dr. Kai's question regarding autism noting that this is a Brown Act Meeting so we cannot discuss items that are not on the agenda. What I can tell you is 900 children receiving autism services, behavioral treatment out of about 96,000 children which about 1%. Pretty close to the prevalence of autism in the community. We have a high saturation. If you would like a more detailed discussion we can add as this as an agenda item at next meeting.	Add Autism as Agenda item for next meeting

ITEM	DISCUSSION	ACTION REQUIRED
IX. Behavioral Health UM Reports	**i. Turn around time/dashboard metrics** Ms. McKelvey reported on the UM Dashboard for Behavioral Health noting that Cal MediConnect 100%; Medi-Cal 99%; Timely Decisions 89%; Retrospective for timely notification 100%; Retrospective for 99.3%. **ii. Technical assistance guide (TAG) update fir Behavioral Health** Ms. McKlevey presented a report on the Behavioral Health Technical Assistance Guide factors (TAG). California law requires the DMHC to conduct a routine medical survey of each licensed full service and specialty health plan at least once every three years specifically surrounding the following areas: • Quality Assurance • Grievances and Appeals (enrollee complaints) • Access and Availability • Utilization Management (referrals and authorizations) • Overall plan performance in meeting enrollees' health care needs A Technical Assistance Guide (TAG) is used by surveyors to measure a health plan's performance and determine compliance. Each requirement listed will cite the statutory/regulatory citations, those to be interviewed in the survey, documents to be reviewed, and lists the key elements to meet the standards. TAG tools are updated as necessary based on legislative and regulation changes. DMHC has provided TAGS specific to Behavioral Health to help guide our program to ensure compliance. **iii. DMHC findings update and recommendations** Procedure QI.17.01 (Medically Necessary Behavioral Health Treatment Services/EPSDT) was updated to reflect current APL 18-006. **iv. ASD evaluation of timely screening and diagnosis for CY 2018** Ms. McKelvey presented the ASD evaluation for timely screening and diagnosis for CY 2018. The American Academy of Pediatrics (AAP) recommends all children receive autism-specific screening at 18 and 24 months of age, in addition to the broad developmental screening (Ages and Stages Questionnaire) at 9, 18, and 24 months.	

ITEM	DISCUSSION	ACTION REQUIRED
	In July 2017, SCFHP pays the developmental screening code: 96110 as an additional fee-for-service payment if billed with a (Child Health and Disability Prevention) CHDP visit. In CY 2018, SCFHP met with Healthier Kid Foundation and First Five of Santa Clara County to help promote the use of age appropriate screening. Dr. Robertson noted that it is a separately reimbursable code at $58 and most physicians are not aware of this. Health Education sent a memo to providers also included an article in the PCP news. The results are as follows: 2016 - 134 2017 - 284 2018 - 2817	
X. Adjournment	Meeting adjourned at 8:00 PM	

ITEM	DISCUSSION	ACTION REQUIRED
NEXT MEETING	The next meeting is scheduled for Wednesday, April 17, 2019, 6:30 PM	

Prepared by:

_____ Date _____

Reviewed and approved by:

_____ Date _____

Jimmy Lin, M.D.
Committee Chairperson

Compliance Activity Report
February 28, 2019

2018 CMS Program Audit Update

The Plan received CMS' Final Report on December 13, 2018. The Report cited a total of 25 Corrective Action Required (CAR) Conditions, in addition to the 7 Immediate Corrective Action Required (ICAR) Conditions previously identified. The Plan submitted Corrective Action Plans (CAPs) for each of the CARs, and on February 1, 2019, all CAPs were deemed reasonable and accepted by CMS (ICARS were previously submitted to and accepted by CMS).

Pursuant to Audit protocol, the Plan must engage an independent audit firm to validate the Plan's correction of the Conditions cited in the Report. The independent auditor's report, and the CEO's attestation that all Conditions have been corrected, must be submitted to CMS within 180 days of CMS' acceptance of the CAPs, or by July 31, 2019. The Plan is in the process of engaging a validation audit firm, and work on all CAPs is ongoing (please refer to accompanying CAP tracker).

On February 27, 2019, the Plan was advised that a Civil Monetary Penalty will be imposed, as anticipated.

Cal MediConnect

- The 2018 Medicare Data Validation (MDV) corrective actions have been completed. The Plan is in preparation for the 2019 MDV audit (to be scheduled).
- The Plan completed its 2018 HSAG/PMV Audit. Out of the three measures reviewed, the audit team was able to validate the data for Core Measure 2.1 (members with an assessment within 90 days of enrollment). The audit team was unable to validate measures CA 1.2 (high risk members with ICP within 30 working days after HRA) and CA 1.4 (low risk members with an ICP within 30 working days of HRA) because Q1 – Q3 activity was conducted by a former vendor, and the Plan is unable to access the vendor's system to validate the corresponding data. HSAG raised no concerns regarding SCFHP's data for Q4 (when services were conducted in-house), but ultimately did not have sufficient data to justify a "reportable" designation.
- Annual CMC Reporting of Core and CA Specific measures is due at the end of February 2019. Compliance has been working with various Business Units on preparing the data for submission.
- Compliance has revised its process for dissemination of guidance received through HPMS memos to encourage greater engagement by business units and enhance Compliance's monitoring of implementation of the guidance.
- Internal audit tools are being updated to ensure the tools match CMS/DHCS 2019 CMC guidance and specifications.

CMS Notice of Noncompliance

The Plan received a CMS Notice of Noncompliance for failure to submit two attestations by the deadline in June 2018.

Medi-Cal

- SCFHP issued a 2019 EOC Errata to members to advise them of the new 2019 Medi-Cal benefits (Pediatric Palliative Care, Diabetes Prevention Program and the Health Home Program). A full EOC will be made available once DHCS issues the 2019 EOC template to Plans (anticipated in early spring 2019).
- DHCS is planning to move County Children's Health Initiative Program (CCHIP) into Medi-Cal in 2019. This shift will affect SCFHP, Santa Francisco Health Plan and Health Plan of San Mateo. The details of the transition are still being worked out.

2018 DHCS Audit

The Plan submitted additional information for the 8 CAPs that were requested for the 2018 DHCS Follow-Up Audit. The additional information was reviewed, and DHCS has accepted the CAPs and closed the audit.

2019 DMHC and DHCS Audit(s)

As previously reported, DMHC will conduct a Routine survey of the Plan starting on March 18, 2019. DHCS will also conduct its 2019 audit concurrently in March 2019, with some (but not all) activities conducted jointly with DMHC.

Both agencies have requested and been provided pre-audit documentation and data universes, and we continue to receive follow up requests. In general, the volume of pre-audit material and depth of the auditors' inquiries, particularly with respect to delegation oversight, appears more detailed than in previous years.

DMHC Complaints

The Plan received a total of 19 member complaints between November 2018 and January 2019. Two cases were forwarded to IMR.

Operational Compliance Report (Dashboard) – Corrective Actions

- Enrollment missed two measures in January 2019 due to late file submission by the vendor.
  - Two CMC CAPs were issued to the Business Unit on February 20, with a response expected by February 27, 2019.
- Customer Service's measures have shown a positive trend upward, but they remain below goal.
  - Two CMC CAPs and four Medi-Cal CAPs were issued to the Business Unit on February 20, 2019, with an expected response by February 27, 2019.
- Case Management continues an upward trend for CMC HRA and ICP completion. For Medi-Cal, the data provided for two SPD HRAs measures does not meet the goal, and data for two measures is missing.
  - Two CMC CAPs and four Medi-Cal CAPs were issued to the Business Unit on February 20, 2019, with an expected response by February 27, 2019.
- Grievance and Appeals metrics have fluctuated for both CMC and Medi-Cal, with a negative trend downward for many elements.
  - The Business Unit will be asked to update its work plan for achieving compliance in 2019.

Joint Operations Committee (JOC) Meetings

The following JOCs have been held since the last Compliance Committee Meeting:

- December: Kaiser, County Behavioral Health Services Department, VSP
- January: Liberty Dental, Signify Health (Advance Health), Focus Care
- February: DocuStream, VHP, CHME, CBHSD, Language Line, PMG, Cotiviti (Verscend), Carenet, MedImpact

HIPAA Disclosures

There were 6 unauthorized disclosures of PHI between November 2018 and January 2019. All were reported to DHCS, though none were determined to constitute a breach. The Compliance team is currently evaluating the need for refreshed and/or enhanced HIPAA training for staff and FDRs.

FWA Activities

No new cases of potential FWA have been identified since November 2018. However, T&M has requested and is awaiting medical records from 6 providers in connection with anomalies identified through its datamining activities.

Santa Clara Family Health Plan™

QUALITY IMPROVEMENT

DASHBOARD

April 2019

QUALITY IMPROVEMENT

DASHBOARD

Quarter 1 2019

Facility Site Review Timeliness	
Completed Timely	**100%**

Potential Quality of Care Issues	
Cases Opened	117
Cases Closed	21
% Closed	**18%**

Initial Health Assessement	
# Enrolled	
# Completed	
% Completed	**#DIV/0!**

Gaps In Care	
Month	# Alerts Turned Off
January	8
February	9
March	8

QUALITY IMPROVEMENT

DASHBOARD - CAHPS / HOS - CMC Only

Santa Clara Family Health Plan™

CAHPS Results					
Measure	**2016 Results**	**2017 Results**	**2018 Results**	**2018 CA MMP**	**Trend**
C03 - Annual Flu Vaccine	83%	77%	82%	69%	
C23 - Getting Needed Care	N/A	3.17	3.25	3.36	
C24 - Getting Appointments and Care Quickly	3.09	3.02	3.15	3.23	
C25 - Customer Service	N/A	N/A	3.52	3.64	
C26 - Rating of Health Care Quality	N/A	8.2	8.3	8.4	
C27 - Rating of Health Plan	8.3	8.2	8.4	8.6	
C28 - Care Coordination	N/A	3.5	3.47	3.5	
D07 - Rating of Drug Plan	8.4	8	8.4	8.5	
D08 - Getting Needed Prescription Drugs	N/A	N/A	3.63	3.63	

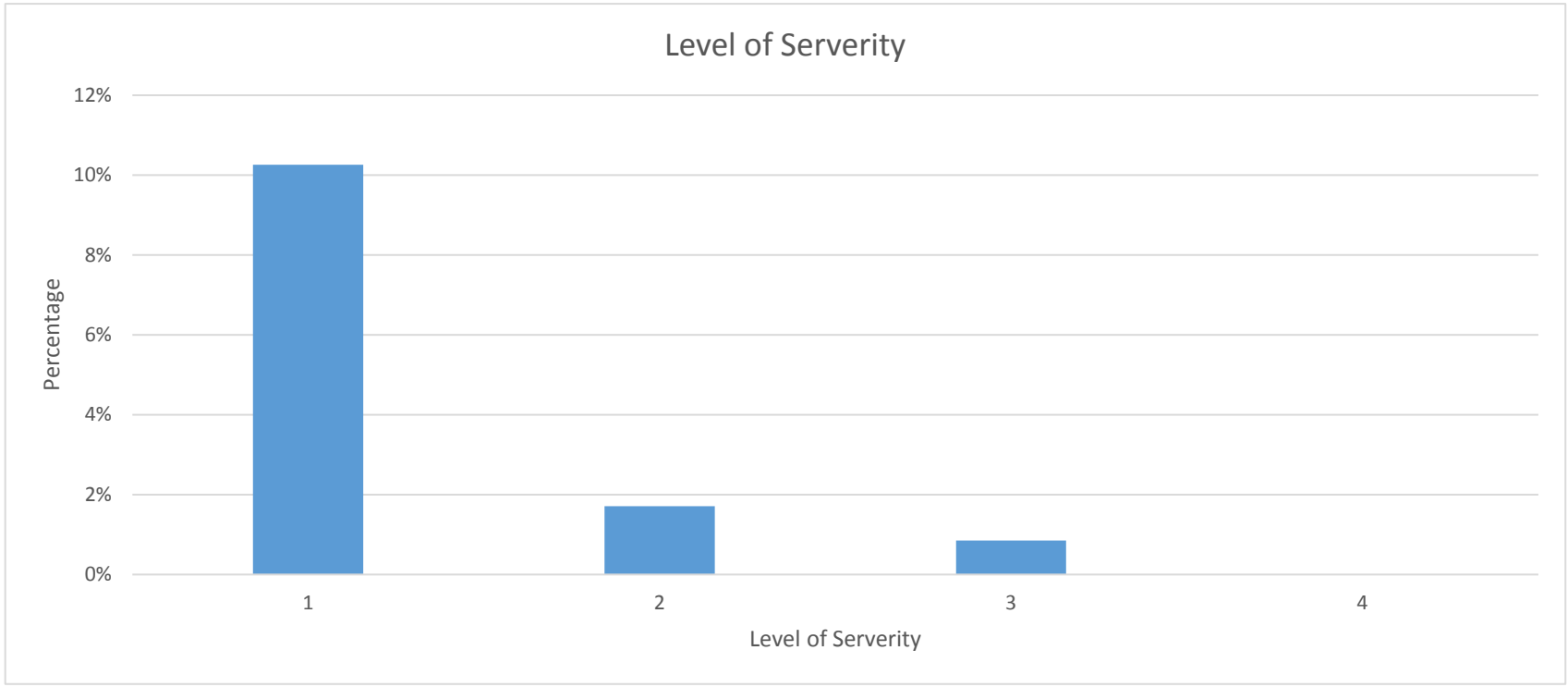
HOS Results			
Component	**2016 Results**	**2017 Results**	**2017 Baseline**
Physical Component Score	36.4	35.2	39.1
Mental Component Score	49.7	48.7	52.8
General Health			
Excellent to Good	54.8%	46.9%	71.1%
Fair to Poor	45.2%	53.1%	28.9%
Self- Rated Physical Health Compared to One Year Ago			
Much Better to About the Same	64.1%	60.9%	73.3%
Slightly Worse or Much Worse	35.9%	39.1%	26.7%
Self-Rated Mental Health Compared to One Year Ago			
Much Better to About the Same	81.30%	75.5%	87.0%
Slightly Worse or Much Worse	18.70%	24.5%	13.0%

QUALITY IMPROVEMENT

DASHBOARD - Potential Quality of Care (PQI) Issues

Quarter 1 2019

Potential Quality of Care Issues	
Cases Opened	117
Cases Closed	21
Percent Closed	**18%**



QUALITY IMPROVEMENT

DASHBOARD - Potential Quality of Care (PQI) Issues

Data as of April 4, 2019

# of PQI's Opened

Month	# of Open PQIs
January 2019	23
February 2019	31
March 2019	63
Total	117

Closed PQIs

January 2019	Level of Severity			
Network	1	2	3	4
10	0	0	0	0
20	4	1	1	0
30	0	0	0	0
40	1	0	0	0
50	1	1	0	0
60	0	0	0	0
Total	6	2	1	0

February 2019	Level of Severity			
Network	1	2	3	4
10	2	0	0	0
20	2	0	0	0
30	0	0	0	0
40	0	0	0	0
50	0	0	0	0
60	0	0	0	0
Total	4	0	0	0

Total PQIs Received	117

Total Closed To Date					
	Level of Severity				
Network	**1**	**2**	**3**	**4**	**Total**
10	3	0	0	0	3
20	7	1	1	0	9
30	0	0	0	0	0
40	1	0	0	0	1
50	1	1	0	0	2
60	0	0	0	0	0
Total	12	2	1	0	15
Percentage	10%	2%	1%	0%	

March 2019	Level of Severity			
Network	1	2	3	4
10	1	0	0	0
20	1	0	0	0
30	0	0	0	0
40	0	0	0	0
50	0	0	0	0
60	0	0	0	0
Total	2	0	0	0

QUALITY IMPROVEMENT

DASHBOARD - Facility Site Reviews (FSR)

Quarter 1 2019

Facility Site Reviews	January 2019	February 2019	March 2019	Total
month	1	4	2	7
# of FSRs completed	1	4	2	7
# of FSRs that passed	1	4	2	7
# of FSRs with corrective action	1	4	2	7
% of FSRs completed timely	100.0%	100.0%	100.0%	100%

QUALITY IMPROVEMENT

DASHBOARD - Initial Health Assessment (IHA)

SCFHP Completion - Q1 2019

Initial Health Assessment	January 2019	February 2019	March 2019	Total
# of members eligible for an IHA	2,460	3,156	3,379	8,995
# of IHA completed within 120 days of enrollment	1,080	1,343	1,319	3,742
% of IHA completed within 120 days of enrollment	43.9%	42.6%	39.0%	41.6%

Specific Network IHA Completion - Q1 2019

Initial Health Assessment	Network					
	10	20	30	40	50	60
# of members eligible for an IHA	1084	5478	721	204	1561	433
# of IHA completed within 120 days of enrollment	555	2100	363	121	553	201
% of IHA completed within 120 days of enrollment	51.20%	38.34%	50.35%	59.31%	35.43%	46.42%

QUALITY IMPROVEMENT

DASHBOARD - Quality Projects

Quarter 1 2019

Santa Clara Family Health Plan™

Incentives - Medi-Cal

Incentive	Eligible Members	Incentive Received	Q1 Percentage
Controlling High Blood Pressure	322	10	3%
Childhood Immunization Status - Combo 3	169	7	4%
Comprehensive Diabetes Care - Nephropathy	120	0	0%

Prenatal Program

Incentive	Incentive Received
Gift Card	9
Carseat	8
Sleep Pod	12

Performance Improvement Project - Cal MediConnect

Individual Care Plan Completion

Study Indicator	Completion Goal	Quarter 4 2018	Quarter 1 2019
High risk members	63%	57.00%	N/A
Low risk members	61.80%	56.00%	N/A