Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, December 4, 2019, 6:00 PM - 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 November 19, 2019 Quality Improvement Committee **Possible Action:** Approve November 19, 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 the 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.	**Follow-Up / Old Business** None	All	6:20	5 min
6.	**Action Items**		6:25	45 min
	a. Network Adequacy Assessment Review the Network Adequacy Assessment **Possible Action:** Approve the Network Adequacy Assessment	Ms. Switzer		
	b. Quality & Accuracy Assessment of Personalized Information of Health Plan Services Review the Quality & Accuracy Assessment of Personalized Information of Health Plan Services **Possible Action:** Approve the Quality & Accuracy Assessment of Personalized Information of Health Plan Services	Ms. Nguyen		

c.	**Quality and Accuracy Assessment of Pharmacy Benefit Information** Review the Quality and Accuracy Assessment of Member Telephone Access Pharmacy Benefit Information **Possible Action:** Approve the Quality and Accuracy Assessment of Pharmacy Benefit Information	Ms. Nguyen		
d.	**Continuity and Coordination of Medical Care** Review the Continuity and Coordination of Medical Care **Possible Action:** Approve the Continuity and Coordination of Medical Care	Ms. Andersen		
e.	**Member Experience Analysis** Review the Member Experience Analysis **Possible Action:** Approve the Member Experience Analysis	Mr. Breakbill		
7.	**Discussion Items**		7:10	35 min
a.	**Access and Availability – VHP Access Report-MY2018**	Ms. Switzer		
b.	**CAHPS**	Ms. Enke		
c.	**Health Outcomes Survey**	Ms. Enke		
8.	**Committee Reports**		7:45	15 min
a.	**Credentialing Committee** Review of October 30, 2019 report of the Credentialing Committee Meeting **Possible Action:** Accept October 30, 2019 Credentialing Committee Report as presented	Dr. Nakahira		
b.	**Pharmacy and Therapeutics Committee** Review minutes of the September 26, 2019 Pharmacy and Therapeutics Committee Meeting **Possible Action:** Accept September 26, 2019 Pharmacy and Therapeutics Committee minutes as presented	Dr. Lin		
c.	**Quality Dashboard**	Dr. Liu		
9.	**Adjournment** Next Quality Improvement Committee meeting: February 19, 2019	Dr. Paul	8:00	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Governing Board 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.
- To obtain a copy of any supporting document that is available, contact Nancy Aguirre at 408-874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Santa Clara Family Health Plan™

Assessment of Network Adequacy 2019

Cal Medi-Connect

Prepared by: Carmen Switzer, Provider Network Access Manager

For review and approval by the Quality Improvement Committee

December 4, 2019

Introduction

Santa Clara Family Health Plan (“SCFHP” or “Plan”) monitors the adequacy of its network on access, availability and member experience and annually reviews and analyzes data to identify opportunities for improvement.

Opportunities to improve network adequacy are identified and prioritized based on an evaluation of member experience, availability and accessibility of providers and services, and out of network requests for services.

This report includes a summary of findings from the NET 1 (provider availability) and NET 2 (provider accessibility) reports and includes new information relevant to NET 3 (i.e., out of network requests/approvals). Combined reporting elements helps the Plan determine if there are network gaps that need to be addressed.

Availability Assessment (NET 1)

Table I: Time and Distance Standards **Member Count = 7822**

Provider Type	Members with Access	Members without Access	% with no Access	Standard	Goal	Met/Not Met
Primary Care Providers						
General Practice	**5,416**	**2,406**	**31%**	5 miles and 10 min	90%	Not Met

- The NET 1 report (availability of network providers) showed that the standards for geographic time or distance were not met for General Practice in multiple cities in the southeast area of Santa Clara County.
- The NET 1 report also showed that SCFHP's PCP's combined network meets provider to member ratios at 1:16.
- SCFHP has a combined network of PCP providers (Family Practice, General Practice and Internal Medicine) available in the southeast area of Santa Clara County where members who reside in this area are assigned to a PCP without incident.

Accessibility Assessment (NET 2)

The accessibility of network providers were assessed in the NET 2 report. The network accessibility tables in the next few slides show the provider types that did not meet the Plan's performance goal of 90% on appointment and after-hours access.

Primary Care Provider – Appointment Availability

Table I: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Family Medicine (N=156)	95	90%	No	58%	-11
General Practice (N=12)	6	90%	No	83%	+1
Internal Medicine (N=193)	98	90%	No	63%	No Change

- As noted in the NET 2 report, PCP's combined performance is at 68%; 22 percentage points below goal.

Accessibility Assessment (NET 2)

<u>Primary Care Provider</u> – Appointment Availability

Table II: Standard - Non-Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Family Medicine (N=156)	104	90%	No	88%	-4
General Practice (N=12)	6	90%	No	83%	+1
Internal Medicine (N=193)	108	90%	No	81%	-11

- As noted in the NET 2 report, PCP's combined performance is at 84%; 6 percentage points below goal.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

After-Hours

Table III: Standard - Access Compliance: 911 Messaging

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=504)	453	90%	No	82%	-10
BH (N=328)	299	90%	No	80%	+9

- As noted in the NET 2 report, SCFHP worked with PAMF to address a main phone line that affected 46 PCP's compliance rate on access compliance.
- Following the updated PAMF message, the overall rate of compliance for PCP providers is at 93%; 3 percentage points above goal.
- BH providers showed a marked improvement in 2019.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

After-Hours

Table IV: Standard - Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=504)	453	90%	No	54%	+2
BH (N=328)	299	90%	No	40%	-7

- As noted in the NET 2 report, the assessment concluded that PCP's and BH providers are unfamiliar with the after-hours timeliness standard.
- Provider education on after-hours timeliness will be a focus point in 2019/2020.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

High Volume and High Impact Specialists – Appointment Availability

Table V: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=134)	33	90%	No	68%	-3
Gynecology (N=187)	44	90%	No	47%	-34
Ophthalmology (N=89)	22	90%	No	62%	-38
*Oncology (N=74)	20	90%	No	58%	+2

Table VI: Standard - Non-Urgent Care

Provider Group	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=134)	33	90%	No	81%	+11
Gynecology (N=187)	27	90%	No	57%	-33
Ophthalmology (N=89)	14	90%	No	87%	-9
*Oncology (N=74)	12	90%	No	84%	+34

*Oncology is a high impact specialist (HIS) – all other provider types are high volume specialists (HVS)

- As noted in the NET 2 report, although SCFHP made efforts to increase the number of respondents in 2019 by improving provider demographic data and enhancing provider communications, the rate of response did not increase from 2018.
- Response rates were not sufficient enough to draw meaningful conclusions.

Accessibility Assessment (NET 2)

High Volume Behavioral Health – Appointment Availability

Table VII: Psychiatry-High Volume / Prescribers (N=83)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	12	90%	No	58%	NA
Urgent Care within 48-hours	12	90%	No	25%	NA
Non-Life Threatening Emergency within 6-hours	12	90%	NA	0%	NA
Follow-up Routine Care within 30-days	12	90%	No	58%	NA

Table VIII: Psychology / Non-Prescribers (N=32)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	No	20%	NA
Urgent Care within 48-hours	4	90%	No	25%	NA
Non-Life Threatening Emergency within 6-hours	3	90%	No	0%	NA
Follow-up Routine Care within 30-days	2	90%	No	50%	NA

Accessibility Assessment (NET 2)

Table IX: Non-Physician Mental Health / Non-Prescribers (N=63)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	No	80%	NA
Urgent Care within 48-hours	5	90%	No	60%	NA
Non-Life Threatening Emergency within 6-hours	4	90%	No	0%	NA
Follow-up Routine Care within 30-days	3	90%	No	67%	NA

Table X: Marriage/Family Therapy – Non-Prescriber (High Volume Provider) – (N=20)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	8	90%	No	75%	NA
Urgent Care within 48-hours	8	90%	No	63%	NA
Non-Life Threatening Emergency within 6-hours	5	90%	No	20%	NA
Follow-up Routine Care within 30-days	3	90%	No	67%	NA

- As noted in the NET 2 report, although SCFHP made efforts to increase the number of respondents in 2019 by improving provider demographic data and enhancing provider communications, response rates did not increase from 2018.
- Response rates were not sufficient enough to draw meaningful conclusions.

Member Satisfaction with Behavioral Health

Santa Clara Family Health Plan

Member Satisfaction Survey

Table I: Survey Sample Size

Category	Count
# to Survey	279
# of Respondents	37
# of Non-respondents	242
% Completed	13%

Table II: Behavioral Health Survey Results – "Access"

Measures	# Responded	# Always/Usually	Rate of Compliance	Goal	Goal Met	PY Change
How often did you get an appointment as soon as you wanted? (Q7)	37	32	86%	90%	No	+2
How often did you see someone as soon as you wanted when you needed help right away? (Q8)	37	26	70%	90%	No	-4

- Members undergoing active BH treatment are difficult to contact due to frequent changes in contact information and where they access BH services. This may explain why the response rate was only at 13%.
- The assessment showed that members were satisfied overall with access to behavioral health providers.

Grievance and Appeals

Grievances

Member Count = 7822

Grievance Category	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Grievances	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	38	4.85	5.0	Yes	2	.3	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0	Yes	0	0	5.0	Yes
Total	38	4.85	5.0	Yes	2	.3	5.0	Yes

- Compared to 2018**,** access grievances per 1,000 members increased from 2.4 to 4.85 regarding non-behavioral health providers and increased from none to .3 for behavioral health providers.
- There are no billing/financial grievances to report for 2019 and there were none reported in 2018.
- With the exception of Psychiatry, there were no other member grievances relevant to non-behavioral health or behavioral health providers that did not meet specific access standards or that were classified as HVS or HIS.
- As reported in NET 2 (accessibility of provider network), the Psychiatry (1) complaint was due to member/provider scheduling conflicts. It was noted that customer service worked with the members LCSW to find a provider that meets the members scheduling needs. The member was readily established with a new Psychiatrist.

Grievance and Appeals

Santa Clara Family Health Plan

Appeals

Member Count = 7822

Appeals Category	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met	Total Appeals	Per 1,000 members	Goal per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Access	9	1.2	5.0	Yes	0	0	5.0	Yes
Billing and Financial (related to network adequacy)	0	0	5.0	Yes	0	0	5.0	Yes
Total	9	1.2	5.0	Yes	0	0	5.0	Yes

- Compared to 2018**,** access appeals per 1,000 members increased from .67 to 1.2 regarding non-behavioral health providers and there is no change relevant to behavioral health providers.

- There are no billing/financial appeals to report for 2019 and none were reported in 2018.

- All 9 appeals were pre-service appeals and the following are 2 examples:

  - ❑ Ophthalmology (N=1) – Member requested an OON provider to perform cataract surgery and the Plan redirected the member to an in-network provider.

  - ❑ Pulmonary (N=1) -- Member requested an OON provider, and the Plan determined that there were in-network providers available to serve the member

Out of Network Requests

SCFHP reviews out of network utilization activity on an annual basis to assess Cal-MediConnect members use of out of network providers and other services.

Out of Network Encounters **Member Count = 7822**

Category	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met	Total	Per 1,000 members	Threshold per 1,000 members	Goal Met
	Non-Behavioral Health				Behavioral Health			
Prior Authorizations (PA)	412	53	25	No	9	1	2	Yes
PA's Approved	334	43	25	No	9	1	2	Yes
PA's Denied	78	10	5	No	0	0	2	NA

- Non-behavioral health provider requests were approved at 81%.
- The behavioral health provider requests were approved at 100%.
- Eighty nine (89%) of the OON denials (78) were denied due to medical necessity and 11% were denied due to services were availability in network.

Out of Network Requests

Santa Clara Family Health Plan

Non-Behavioral Health Providers

Provider Type	Assessment Reason(s)	# of OON Approvals	Approval: COC	Approval: Retro-Authorization	Timely Access Issue	Provider is now PAR/or in Process	Other
General Practice	TD/Access	0	NA	NA	NA	NA	NA
Cardiology	HVS/Access	3	3	NA	NA	NA	NA
Ophthalmology	HVS/Access	1	1	NA	NA	NA	NA
Gynecology	HVS/Access	0	NA	NA	NA	NA	NA
Oncology	HIS/Access	2	2	NA	NA	NA	NA
Physical Therapy	GA	9	6	1	NA	NA	2
ASC	10+	30	12	10	NA	NA	8
Home Health	10+	136	NA	136	NA	NA	NA
Acute Hospital	10+	54	NA	NA	NA	NA	54
Total	**NA**	**235**	**24**	**147**	**NA**	**NA**	**64**

- **Home Health (HH):**
  - Sequoia HH was responsible for 60% of the OON requests, South Springs HH was responsible for 36% and 4% (3 facilities) were responsible for out of service area encounters.
  - The OON requests were retro actively submitted to the Plan, which were approved to ensure continuity of care.
- **Acute Hospital:**
  - The OON inpatient approvals were admissions from out of state (19%), out of service area (80%) and 1% were in service area emergency room admissions that are subject to EMTALA provisions.
- **Ambulatory Surgical Center (ASC):**
  - The OON approvals (N=30), involved 4 ASC's -- Peninsula Eye Surgery Center and Tri-County Vascular Care are responsible for 47% of ASC OON approvals.

Out of Network Requests

Santa Clara Family Health Plan

Behavioral Health Providers

Provider Type	Assessment Reason	# of Approvals	Approval: COC	Approval: Retro-Authorization	Timely Access Issue	Provider is now PAR/or in Process	Other
Marriage/Family Therapists	HVS/Access	9	1	NA	NA	8	NA
Psychiatry (HVS)	HVS/Access	3	2	NA	NA	1	NA
Psychology	Access	12	2	2	NA	8	NA
Total	**NA**	**24**	**5**	**2**	**NA**	**17**	**NA**

- **Marriage/Family Therapy:**
  - Six (6) OON approvals were for Discovery Counseling who has since entered a contract with SCFHP.
  - Two (2) OON approvals were for Gardner Family Care who has since entered a contract with SCFHP.
  - One (1) was due to COC.

- **Psychiatry:**
  - One (1) OON approval was for AACI Behavioral Health who has since entered a contract with SCFHP.
  - The other two (2) requests were relevant to continuity of care (COC).

- **Psychology:**
  - Eight (8) OON approvals were for Memory Check Psychological who has since entered a contract with SCFHP.
  - The other four were due to COC (2) and retro active requests (2).

Conclusion

Overall the NET 1-3 analyses demonstrated that –

- SCFHP standards for provider availability are realistic for the communities and delivery system within Santa Clara County.
- With the exception of General Practice, Santa Clara Family Health Plan was able to demonstrate its ability to meet performance goals relevant to provider to member ratios and geographic distances across all in network primary care providers, high volume and high impact specialists (including behavioral health).
- Although there were low response rates relevant to the appointment and availability survey, SCFHP concludes that there are several network providers (medical and behavioral health) who are unaware of appointment access standards.
- A high percentage of providers are unaware of the after-hours messaging requirement – *return call within 30-minutes or less.*
- Overall findings on member complaints indicated two primary categories – timeliness and communication and the reports showed that member complaints were managed effectively and timely by SCFHP.
- The majority of out of network requests and approvals were relevant to continuity of care, retro-active requests and out of area hospital admissions.

OPPORTUNITIES:

Barrier	Opportunity	Intervention	Selected for 2019	Date Initiated
Timely access— Urgent appointments within 48-hours, 96-hours Providers are unaware of appointment access standards	• Improve access to urgent care appointments • Educate providers on access standards	• Following CAP, resurvey non-complaint providers • Require providers who show continued non-compliance through resurveys to complete SCFHP"s access training and submit an attestation. • Submit SCFHP's access matrix via fax blast to network providers.	Yes Yes Yes	In Process In Process 12/2019
Appointment Access—Behavioral Health non-life threatening emergency within 6-hours BH providers are unaware of appointment access standards - Non-life threatening emergency within 60 Shortage of BH providers	• Increase the number of BH providers within SCFHP's network • Educate BH providers on timely access standards • BH network development	• Following CAP, resurvey non-complaint providers. • Require providers who show continued non-compliance through resurveys to complete SCFHP's access training and submit an attestation. • Submit SCFHP's access matrix via fax blast to network providers. • Continue to seek contracting opportunities with behavioral health providers.	Yes Yes Yes Yes	Ongoing In Process 12/2019 Ongoing
PCP's and Behavioral Health Providers After-Hours Access (return call within 30min or less) – Providers are unaware of --- 1. After-hours messaging requirements 2. Calls are required to be returned within 30-minutes.	• Improve after- hours access • Educate providers on after-hours access	• Following CAP, conduct provider outreach (Training) • Submit SCFHP's access matrix via fax blast to network providers.	Yes Yes	In Process 12/2019
In-office wait times exceed 15 minutes	• Educate providers on in-office wait times	• Submit SCFHP's access matrix via fax blast to network providers.	Yes	12/2019

Santa Clara Family Health Plan
Personalized Information on Health Plan Services:
Website and Telephone Functionality - 2019 Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee
December 4, 2019

I. Overview

In order to best serve our members, it is important for members to have the ability to easily obtain personalized health plan information.

Santa Clara Family Health Plan (SCFHP) has the responsibility to provide access to accurate, quality personalized health information via the SCFHP website and the telephone. This includes the ability to request or reorder an SCFHP member ID card, to change primary care practitioners (PCPs), and to determine how and when to obtain referrals and/or authorizations for specific services.

SCFHP members have no financial responsibility beyond a copay for pharmacy benefits. There is no copay for medical services.

SCFHP ensures the availability of this information by:

1) Telephone – SCFHP Customer Service Representatives (CSRs) are trained to handle PCP changes, member ID card requests, and the determination of services requiring a referral or authorization and to address inquiries. CSRs are able to educate members on how to obtain specific services and/or an authorization; if there is a copay and the amount of the copay for pharmacy benefits and to offer assistance including the ability to initiate an Organization Determination on behalf of a member.
2) SCFHP Website – Members may submit requests for SCFHP member ID cards and to change PCPs via the SCFHP Website. The website includes a list of services requiring an authorization and instructions for obtaining an authorization.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the information provided by CSRs to members.

II. Methodology

A. Via Telephone

Annually, SCFHP audits Customer Service telephone calls to and from members. The auditor (Customer Service Quality Manager) randomly selects 20 member contacts based on select call categories of member requested information on determining how and when to obtain referrals and authorizations for specific services or for information on costs for pharmacy services. The auditor assesses the call to determine whether the member was able to obtain answers to their inquiries. To determine the quality and accuracy of member inquiries, the auditor reviews the CSR's call documentation for completeness. The audit is performed on an annual basis by collecting and assessing data on the completion of an evaluation form (see Appendix A for Audit Sheet). Data included in this analysis was captured from July 1, 2018 through June 30, 2019.

SCFHP members do not have any financial responsibility for covered services as long as members follow the plan's rules such as receiving services within the SCFHP network or contracted providers.

B. Via Web

Customer Service receives confirmation through Microsoft Outlook when a member completes a request to reorder an ID card or change a PCP. A dedicated staff person in the Customer Service department checks the e-mail inbox intermittently throughout each business day to assure a timely response to the member. The staff responds to the members request and documents the request in the QNXT call tracking system using appropriate contact codes.

SCFHP audits requests received via the Health Plan website for turnaround times to identify opportunities for improvement. The audit will be performed on an annual basis by collecting data on the quality and accuracy of PCP change and ID card requests received. The auditor uses the test account to check the accuracy and quality of how and when to obtain referrals and authorization for specific services.

Goals:

Accuracy: 100%

Quality: 100%

Table 1: Website- Accuracy of information provided for referral and authorization

Evaluation Criteria	Total Sample	Accuracy Goal Met	% Goal Accuracy Goal Met
information is accurately showing if a referral and/or authorization is required for specific service			
1.The information on how and when to obtain a referral and authorization for medical services is populated correctly	5	5	100%
2. Information accurately reflect what services SCFHP would pay for and if there is any limits on the services	5	5	100%
3. Information accurately reflect what services are excluded or not covered by SCFHP	5	5	100%

Table 2: Website- Quality of information for referral and authorization

Evaluation Criteria	Total Sample	Quality Goal Met	% goal Quality Goal Met
Information is legible, complete and allows the member to understand			
1. The link for the member handbook moves to the correct page	5	5	100%
2. Detailed instructions are provided on what chapter/section of the member handbook to refer to on how and when to obtain referrals and authorizations for specific services	5	5	100%

Table 3: Website- Accuracy & Quality of information provided to PCP change and ID card Requests

Evaluation Criteria	Total Sample	Accuracy Goal Met	% goal Accuracy Goal Met	Quality Goal Met	% goal Quality Goal Met
1. The member's request and response were documented with accuracy	10	10	100%	10	100%
2. The request was executed in the database system (PCP updated, ID card ordered)	10	10	100%	10	100%
3. The appropriate contact code was selected	10	10	100%	10	100%
4. The acknowledgement/confirmation sent to member within one-business day	10	10	100%	9	90%

III. Data

Table 1: Telephone interactions: Accuracy of information provided is assessed for the following.

Evaluation Criteria	Total Sample	Accuracy Goal Met			% Accuracy Goal Met
Job Knowledge		Yes	No	N/A	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	20	0	0	100%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		Yes	No	N/A	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the CSR summarize accurately the service request or interaction in the data base system?	20	20	0	0	100%

Table 2: Telephone interactions: Quality of information is assessed for the following during accuracy review.

Evaluation Criteria	Total Sample	Quality Goal Met			% Quality Goal Met
Job Knowledge		**Yes**	**No**	**N/A**	
1. Was the inquiry initiated by the member or member's representative?	20	20	0	0	100%
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization?	20	20	0	0	100%
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination.	20	20	0	0	100%
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member?	20	20	0	0	100%
Call Documentation		**Yes**	**No**	**N/A**	
1. Did the agent document call in the data base system and select appropriate contact code(s)?	20	20	0	0	100%
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system?	20	20	0	0	100%

III. Accuracy and Quality Analysis

A. Accuracy: Accuracy measures met the target goal of 100% for Job Knowledge evaluation criteria 1, 2 and 4 as well as Call Documentation criteria 1 and 2.

Website: All of the website measures met the accuracy goal at 100%.

B. Quality: Quality measures met the goal at 100% of the target goal of 100% for the Telephone and met at 90% for the Website since there was delay in responding to one of the PCP change requests.

Deficiency	Accuracy or Quality	Plan for Correction	Target Date of Completion	Re-audit Completed? Y/N	Re-audit Completion Date
Delay in responding to PCP change request	Quality	Develop a daily monitor process to ensure all of the requests are processed timely	December 2019		

APPENDIX A

Audit Sheet

Reviewed by: **Date Reviewed:** **QNXT call number:**

Call recording number:

Accuracy and Quality of Personalized Information on Health Plan Services over the telephone

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	**Call # Date**		**Accuracy Goal Met**	**Quality Goal Met**
Job Knowledge	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Was the inquiry initiated by the member or member's representative? Accuracy: The CSR confirmed who the caller was in relationship to the member. Quality: The CSR verified personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR explain whether or not a service requires a referral and/or a prior authorization? Accuracy: The CSR confirms whether or not the requested service requires an authorization. Quality: The CSR clearly explains whether or not the member needs prior authorization and/or verifies the status of the authorization if there is one on the member's file before obtaining the requested service.				
3. If a service requires a prior authorization, whether CSR accurately explain on how to obtain an authorization and/or offers member to initiate an organization determination. Accuracy: The CSR accurately explains how the member can obtain an authorization or referral. Quality: The CSR explains thoroughly how the member can obtain and offer to initiate an organization determination.				
4. If a service does not require a prior authorization, did the CSR explain how to locate a network provider to the member? Accuracy: The CSR accurately provides list of network provider to the member Quality: The CSRs provides list of network provider and offer to schedule an appointment with network providers				

Measure: Determine how and when to obtain referrals and authorizations for specific services, as applicable.	Call # Date		Accuracy Goal Met	Quality Goal Met
Call Documentation	**Y/N**	**N/A**	**Y/N**	**Y/N**
1. Did the agent document call in the data base system and select appropriate contact code(s)? Accuracy: The agent used the correct contact code for the interaction. Quality: The agent did not use incorrect contact codes that do not pertain to the interaction.				
2. Did the agent summarize accurately and clearly the service request or interaction in the data base system? Accuracy: The agent clearly documents all aspects of the interaction with the member. Quality: The agent's documentation is easy to understand by the auditor without the need for the auditor to listen to the call.				

Accuracy and Quality of Personalized Information on Health Plan Services via the Health Plan Website

Evaluation Criteria	Total Sample	Accuracy Goal Met	% goal Accuracy Goal Met	Quality Goal Met	% goal Quality Goal Met
1: The member's request and response were documented with accuracy					
2. The request was executed in the database system (PCP updated, ID card ordered)					
3. The appropriate contact code was selected					
4. The acknowledgement/confirmation sent to member within one-business day					

SANTA CLARA FAMILY HEALTH PLAN

Pharmacy Benefit Information 2019: Telephone Accuracy and Quality Analysis

Prepared by: Tanya Nguyen, Director of Customer Service
For review and approval by the Quality Improvement Committee December 4, 2019

I. Overview

Pharmaceutical benefits and drugs change periodically throughout the year. In an effort to best serve members, Santa Clara Family Health Plan (SCFHP) has a responsibility to ensure that members can contact the organization over the telephone and receive accurate, quality information on drugs, coverage, and cost.

SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members related to pharmacy benefits. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the pharmacy benefit information provided by CSRs to members.

II. Methodology: Telephone

Annually, Santa Clara Family Health Plan audits the information provided to members over the telephone by its Customer Service Representatives (CSRs). The auditor randomly selects 10 calls during which a member has requested information on pharmacy benefits. The calls are checked for the ability for CSRs to provide accurate reflection of:

a. Financial responsibility per LIS level (copays)
b. Initiate the exceptions process
c. Order a refill for an existing mail-order prescription
d. Assistance to locate an in-network pharmacy
e. Assistance to conduct a pharmacy proximity search based on zip codes in Santa Clara County
f. Determine potential drug to drug interactions
g. Determine drug side effects and significant risks, and
h. Determine the availability of a generic substitution.

The audit will be performed on an annual basis by collecting data on the quality and accuracy of the pharmacy benefit information provided over the telephone (see Appendix A for audit sheets). The audit period is from 07/01/18 through 06/30/19.

Goal:

Accuracy: 100%

Quality: 100%

III. Data

Table 1: Accuracy and Quality of Pharmacy Benefit Information for financial responsibility, exceptions process, location of in-network pharmacy, conducting a proximity search, determining drug-drug interactions, common side effects, and the availability of generic substitutions.

Measure	Total Sample	Accuracy Goal Met			% Accuracy Goal Met	Quality Goal Met			% Quality Goal Met
Job Knowledge		**Yes**	**No**	**N/A**		**Yes**	**No**	**N/A**	
Measure: Factor 1 Financial responsibility									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did CSR respond correctly to member's financial responsibility (e.g. copay)?	10	10	0	0	100%	10	0	0	100%
3. Did CSR educate member about the financial benefit of filling 90 day supply when applicable?	0/0	0/0	0/0	0/0	0/0				
4. Did CSR educate member that using a generic medication would lower member's financial responsibility?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
5. Call Documentation: Did the CSR select the appropriate contact code(s)?	10	10	0	0	100%	10	0/0	0/0	100%
Measure: Factor 2 Exceptions process									
1. Was the request initiated by member or member's rep?						10	0	0	100%
2. Did the CSR follow exception process?	10	10	0	0	100%	10	0	0	100%
3. Did the member agree to initiate exception process?						10	0	0	100%
4. If member agreed, did CSR initiate exception process while member/member's rep on the phone?	10	10	0	0	100%	10	0	0	100%
5. Did CSR inform member of the next step after submitting the exception request?	10	10	0	0	100%	10	0	0	100%
6. Was the exception request submitted for the correct medication in Med Access system?	10	10	0	0	100%				
7. Was the exception request submitted correctly (standard vs expedited) per member's request?	10	10	0	0	100%				

8. Call Documentation: Did the CSR select the appropriate contact code(s)?						10	0	0	100%
Measure	**Total Sample**	**Accuracy Goal Met**			**% Accuracy Goal Met**	**Quality Goal Met**			**% Quality Goal Met**
Job Knowledge		**Yes**	**No**	**N/A**		**Yes**	**No**	**N/A**	
Measure: Factor 3 Order a Refill for an existing prescription; SCHFP does not offer mail order services therefore this Factor NA.									
Measure: Factor 4 and 5 Location of in-network pharmacy, conducting a proximity search									
1. Was the request initiated by member or member's rep?						0/0	0/0	0/0	0/0
2. Did the CSR locate and provide name, address, phone number, hours of operation of an in-network pharmacies correctly to the member? Including extended-day supply, compounding services, home delivery, etc.	0/0	0/0	0/0	0/0	0/0				
3. Did the CSR assist member in conducting a proximity search for a network pharmacy based on zip code?						0/0	0/0	0/0	0/0
4. If yes (question # 3), did CSR conduct a proximity search correctly per member's request?	0/0	0/0	0/0	0/0	0/0				
5. Call Documentation: Did the CSR select the appropriate contact code(s)?						0/0	0/0	0/0	0/0
Measure: Factor 6, 7, 8 Determining drug-drug interactions, common side effects, availability of generic substitutions									
1. Was the request initiated by member or member's rep?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
2. Did the CSR transfer request to Pharmacy Helpdesk?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0
Call Documentation: Did the CSR select the appropriate contact code(s)?	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0

*Some questions related to both quality and accuracy and some related to one area or the other. If a cell is grey it does not relate to that area of review.

IV. Accuracy and Quality Analysis

SCFHP did not test the quality and accuracy of the ability for members to order a refill on an existing, mail-order prescription (Factor 3) because SCFHP does not offer a mail order service. This factor is not applicable for SCFHP. If members wish to order from their in-network retail pharmacy by mail this is done with the retail pharmacy, if available.

For factor 1, 2, 4, 5, 6, 7 and 8, both accuracy and quality measures were audited. The greyscale in the tables indicate some questions were not required for accuracy and quality for some factors and were colored grey which are intentionally left unanswered.

Accuracy:

The measures for Factor 1, financial responsibility for a drug; Factor 4 and 5, there were no calls associated with the need for CSRs to locate an in-network pharmacy or conduct a proximity search. Therefore, there is no data to report on these factors.

In the area of Job Knowledge, Factor 2 measure, exception process met the accuracy goal of 100% in all audit questions. Question 5 “CSR inform member of the next step after submitting the exception request” and question 8 “CSR selected the appropriate contact code” were significantly improved compared to 90% and 70% in the previous year, respectively.

During the accuracy audit, none of the calls had an interaction in which the member asked about drug-drug interactions, common side effects, or the availability of generic substitutes Therefore, there is no data to report on Factor 6, 7 and 8.

Quality:

The measures for Factor 1 financial responsibility for a drug, met the quality goal at 100% for Job Knowledge questions 1, 2, and 5 as well as Call Documentation requirements. None of the calls had an interaction in which CSR needed to educate the member that using a generic medication would lower member's financial responsibility since member have limited financial responsibility.

The measures for Factor 2, exceptions process, met the quality goal of 100% for Job Knowledge questions 1-5. Call Documentation requirements for this factor also met 100% of the target goal.

The measures for Factors 4 and 5, there were no calls associated to locate in-network pharmacies and proximity search. Therefore, there is no data to report on these factors.

During the quality audit, none of the calls had an interaction in which the member asked about drug-drug interactions, common side effects, or the availability of generic substitutes. Therefore, there is no data to report on these factors.

Deficiencies:

There are no deficiencies found for this audit period.

APPENDIX A

Audit Sheet #1

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 1. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factor 1 Financial Responsibility.

Factor 1 Financial Responsibility	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did CSR respond correctly to member's financial responsibility (e.g. copay)?				
3. Did CSR educate member about the financial benefit of filling 90 day supply when applicable?				
4. Did CSR educate member that using a generic medication would lower member's financial responsibility?				
Call Documentation	Y/N	N/A	Y/N	Y/N
5. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #2

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 2. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factor 2 Exceptions Process.

Factor 2 Exceptions Process	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR follow exception process? Accuracy: The CSR accurately follows and completes all applicable steps of the exception submission process. Quality: The CSR ensures that the member understands all steps of the exception submission process.				
3. Did the member agree to initiate exception process? Quality: The CSR obtains verbal acknowledgement from the member to initiate the exception process.				
4. If member agreed, did CSR initiate exception process while member/member's rep on the phone? Accuracy: The CSR completes the exception process during the live call. Quality: The CSR confirms with the member that the exception request has been submitted during the live call.				
5. Did CSR inform member of next steps after exception request submission? Accuracy: The CSR informs the member of the next steps after submitting the exception request. Quality: The CSR verifies that the member understands the next steps after submitting the exception request.				
6. Was the exception request submitted for the correct medication in Med Access? Accuracy: The CSR correctly submits the exception request for the desired medication, dosage, etc.				
7. Was the exception request submitted correctly (standard vs expedited) per member's request? Accuracy: The CSR submits the request based on the member's request.				
Call Documentation	Y/N	N/A	Y/N	Y/N
8. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #3

Audit Sheet #3

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 3. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factors 4 and 5 Finding the location of an in-network pharmacy and conducting a proximity search.

Factors 4 and 5 Finding the location of an in-network pharmacy and conducting a proximity search	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR locate and provide name, address, phone number, hours of operation of an in-network pharmacies correctly to the member? Including extended-day supply, compounding services, home delivery, etc. Accuracy: The agent provides the name, address, phone number, and hours of operation for an in-network pharmacy when requested by the member.				
3. Did the CSR assist member in conducting a proximity search for a network pharmacy based on zip code? Quality: The CSR provides the name and details of a network pharmacy based on the member's desired zip code.				
4. If yes (question #3), did CSR conduct a proximity search correctly per member's request? Accuracy: The CSR provides a proximity search based on the member's desired location details, such as city or zip code.				
Call Documentation	Y/N	N/A	Y/N	Y/N
5. Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selected the appropriate contact code to summarize the interaction.				

Audit Sheet #4

Reviewed by: **Date Reviewed:**

QNXT call number: **Call recording number:**

Table 4. Accuracy and Quality of Pharmacy Benefit Information over the Telephone for Factors 6, 7, and 8 Determining drug-drug interactions, a drug's common side effects, and the availability of generic substitutes.

Factors 6, 7, and 8 Determining drug-drug interactions, a drug's common side effects, and the availability of generic substitutes.	Call # Date		Accuracy Goal Met	Quality Goal Met
Job Knowledge	Y/N	N/A	Y/N	Y/N
1. Was the request initiated by member or member's rep? Quality: The agent verifies personal representative status or obtained verbal consent for non-member callers, as necessary.				
2. Did the CSR transfer request to Pharmacy Helpdesk? Accuracy: The CSR transfers a request regarding drug-drug interactions, common side effects, or the availability of generic substitutes to the Pharmacy Help Desk as appropriate.				
Call Documentation	Y/N	N/A	Y/N	Y/N
Did the CSR select the appropriate contact code(s)? Quality: For the call documentation, the CSR selects the appropriate contact code to summarize the interaction.				

Santa Clara Family Health Plan
Member Experience, Including Behavioral Health: 2018 Analysis

Prepared by:

Victor Hernandez, Grievance & Appeals Quality Assurance Program Manager
Darryl Breakbill, Director, Grievance and Appeals Operations

For review by the Quality Improvement Committee, December 4, 2019

I. Overview

Santa Clara Family Health Plan (SCFHP) uses feedback from members and employs mechanisms to assess and improve the member experience, including behavioral health. Since member complaints and appeals may impact overall member satisfaction, SCFHP tracks and trends compliant and appeal activity to identify barriers to care and identify potential interventions.

The behavioral health member satisfaction survey is another means to monitor the member experience. The member experience assessment is used to identify areas of improvement and help meet the specific needs of SCFHP members. SCFHP reviews data associated with complaints and appeals and the Behavioral Health Member Satisfaction Survey on an annual basis. The quantitative analysis process includes a review of results and compares those results against any established performance goals. In future measurement years, the quantitative analysis will also track trends year over year. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable to improving performance and quality. The process incorporates opportunities and/or interventions to address the root cause. In CY2018, the following measures were monitored for aspects shaping the Member Experience by conducting at a minimum, a quantitative analysis of all of the results and a qualitative analysis of non-behavioral health results:

1. Member complaint and appeals categories:
    a. Non-Behavioral Health
    b. Behavioral Health
2. Member Satisfaction Survey
    a. Behavioral Health

1. Member Complaints and Appeals

SCFHP collects data on five major categories of member grievances and appeals.

Methodology: SCFHP's Grievance and Appeals (G&A) Department uses the QNXT information system and the Grievance and Appeals database to document, collect, store and calculate grievance and appeals data which includes behavioral health-related issues. The data included in this analysis was captured in calendar year 2018 (January 1-December 31). The G&A Department utilizes an internal code set to categorize grievances and appeals. These codes are cross-walked to five categories required by NCQA. The data is then collected for the entire SCFHP Cal MediConnect population and is aggregated into the following categories:

- Quality of Care
- Access
- Attitude/Service

- Billing/Financial
- Quality of Practitioner office site

Standards and Thresholds:

SCFHP's goals are to:

- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each quarter, and
- Maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each category

  If a grievance and/or appeal exceeds this threshold, a root cause analysis will be conducted to identify the root cause and develop initiatives to address underlying issues. Internal and external stakeholders will be included as needed to assist in the root-cause analysis as well as remediation of the issues.

Member Complaints/Grievances and Appeal Categories

Table 1. CMS Member Complaints/Grievances Categories

Complaint / Grievance Category	1Q-2018	2Q-2018	3Q-2018	4Q-2018	(Jan. 1-Dec. 31, 2018)	Grievances / per 1,000 members 18.31 = 2018 average 9.649 = 2017 average
Quality of Care	**4** *0.53*	**19** *2.53*	**25** *3.33*	**29** *3.86*	**77**	**10.246**
Access	**5** *0.67*	**5** *0.67*	**15** *2.00*	**19** *2.53*	**44**	**5.855**
Attitude/Service	**48** *6.39*	**81** *10.78*	**79** *10.51*	**72** *9.58*	**280**	**37.259**
Billing/Financial	**75** *9.98*	**83** *11.04*	**58** *7.72*	**71** *9.45*	**287**	**38.190**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0.000**
Total	**132**	**188**	**177**	**191**	**688**	**91.550**

Quantitative Analysis: Member Complaints/Grievances

SCFHP tracks and trends all member complaints/grievances for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all complaints from the Cal MediConnect membership. The data as shown in Table 1 represents all member complaints/grievances and is not a sample.

In 2018, the complaints/grievances analysis showed that two categories consistently did not meet the threshold throughout the year: Attitude/Service and Billing/Financial. Attitude and Service increased by 69% with a result of 48 in the first quarter and a result of 81 in the second quarter. The third and fourth quarter remained closer to the second quarter's numbers, with a result of 79 and 72 respectively. Billing/Financial was consistently high throughout the year. However, Billing/Financial decreased by 43% from a result of 83 in the second quarter and a result of 58 in the third quarter. This is also the highest result and the lowest result in 2018 for Billing/Financial respectively.

In addition, Attitude/Service had a result of 37 grievances per 1,000 members and Billing/Financial had a result of 38 grievances per 1000 members for all of 2018. Out of the remaining three categories, Quality of Care and Access were also above the threshold when looking at all of 2018. Quality of Care had a result of 10 grievances per 1,000 members and Access had a result of 6 grievances per 1000 members. On a quarterly basis, they were below their threshold. Quality of Care also had the largest overall increase, nearly quintupling over the course of the year with a result of 4 in the first quarter to a result of 29 in the fourth quarter. The last category, Quality of Practitioner Office Site, met the goal and remained flat throughout the year.

Table 2. CMS Member Appeal Categories

Appeals Category	1Q-2018	2Q-2018	3Q-2018	4Q-2018	(Jan. 1-Dec. 31, 2018) Total Appeals	Appeals / per 1,000 members
Quality of Care	**0**	**0**	**0**	**0**	**0**	**0.000**
Access	**0**	**0**	**0**	**0**	**0**	**0.000**
Attitude/Service	**0**	**0**	**0**	**0**	**0**	**0.000**
Billing/Financial	**121** *16.10*	**112** *14.90*	**72** *9.58*	**60** *7.98*	**365**	**48.570**
Quality of Practitioner Office Site	**0**	**0**	**0**	**0**	**0**	**0.000**
Total	**121**	**112**	**72**	**60**	**365**	**48.570**

Quantitative Analysis: Member Appeals

SCFHP tracks and trends all member appeals for each of the five categories listed above. In addition to the quarterly analysis, an annual analysis is completed. The collection methodology includes all appeals inclusive of pre-service authorization and post-service claims appeals filed by a member or member representative. The data as shown in Table 2 is representative of all member appeals and is not a sample.

In 2018, the appeals analysis showed a significant decrease in the second half of the year in the following category: Billing/Financial. The Billing and Financial category halved their appeals over the course of the year with a result of 121 in the first quarter and a result of 60 in the fourth quarter. However, the results indicate 49 appeals per 1000 members which does not meet the goal. The remaining four categories, Quality of Care, Access, Attitude/Service and Quality of Practitioner Site had results of zero appeals and, therefore, met the goal.

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals (Tables 1 & 2)

In analyzing the Attitude/Service grievances, the following root causes were determined for the high amount of grievances:

- Out of the 280 Attitude/Service grievances, 81 of them were a result of a durable medical equipment (DME) vendor. This would be 40% of all Attitude/Service grievances in 2018. The DME vendor was a preferred vendor for DME services in 2018. Around the end of 2018, SCFHP as a whole noticed that this DME vendor contributed a large amount of grievances and had other compliance concerns related to timeliness of authorizations and delivery of supplies. Starting in Q2 2019, SCFHP began to transition to another DME vendor as a preferred vendor. The contract for the original DME vendor is set to expire January 1, 2020.
- Out of the 280 Attitude/Service grievances, 74 of them were a result of transportation services. This would be 36% of all Attitude/Service grievances in 2018. One vendor had more grievances than other transportation vendors, with a total of 46 out of 74 transportation grievances involving them. This vendor also received more members as other transportation vendors merged under them. This merge happened in the third quarter of 2018. This led to an increase in grievances for this vendor. The vendor's program manager met with the G&A Director and agreed to increase the amount of management positions that can address grievances. This should lead to quicker solutions and responses.

In analyzing the Billing/Financial complaints/grievances the following root cause was determined to be responsible for the Q3 2018 increase:

- Out of the 287 Billing/Financial grievances, 113 of them are a result of a specific hospital. The billing staff at this hospital has claimed to not understand the Cal MediConnect (CMC) product and how it pays for the member's bills. The billing staff believed they could bill the members directly for the amount that Medi-Cal did not pay. The G&A Department has since worked with this hospital's billing staff to understand CMC and how it handles payment. More importantly, the hospital in question is now aware that they are not permitted to bill or balance bill members according to state and federal laws.

In analyzing the Billing/Financial appeals the following root causes were determined to be responsible for the increase:

- Post-service (claims payment) appeals were a significant portion of the Billing/Financial appeals category. This is a result of non-contracted providers failing to recognize the prior authorization rules for services rendered to SCFHP members. Specifically, all services requested intended to be rendered by a non-contracted provider require review and authorization by SCFHP's Utilization Management (UM) Department. Rather than the services being requested on a pre-service basis, providers rendered the services and then requested payment through the claims process. The claims were denied which led to appeals being filed.

There has one specific provider that submitted a major amount of appeals. Fortunately, that provider is now contracted. SCFHP will work with the provider to identify any remaining claims denied prior to their contracted status and work to close any older matters out.

Time Frame: January 1, 2018 - December 31, 2018						
Behavioral Health Complaint / Grievance/Appeal Category	**1Q-2018**	**2Q-2018**	**3Q-2018**	**4Q-2018**	**Total Grievances**	**BH Grievances/per 1,000 members** *(2017 AVG = 7,482)*
Quality of Care	0	0	0	0	0	0
Access	0	0	0	0	0	0
Attitude/Service	*0*	0	0	0	0	0
Billing/Financial	0	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0	
Total	**0**	**0**	**0**	**0**	**0**	

Qualitative Analysis: Root Causes- Member Complaints/Grievances and Appeals

No data is available. There were no members receiving behavioral services that filed appeals or grievances within CY 2018.

Santa Clara Family Health Plan™

Valley Health Plan – MY2018
Provider Access and Availability Assessment

Prepared by: Carmen Switzer, Provider Network Access Manager

December 4, 2019

Introduction

PAAS: To ensure that VHP meets the provider appointment access standards established by DMHC and to meet the needs of VHP's members.

Program Objectives

- Measure appointment access to different types of practitioners at least annually.
- Evaluate VHP's timely access performance in comparison to benchmarks and goals.
- Identify areas for improvement related to appointment timely access.
- Develop interventions, as appropriate, to address deficiencies and/or gaps in care.

After-Hours: To ensure that VHP meets the after-hours timely access standards established to meet the needs of members and address any deficiencies.

Program Objectives

- Measure after-hours access by providers at least annually
- Telephone triage or screen wait time doesn't exceed 30 or less minutes
- Evaluate VHP's after-hours access performance measures.
- Identify any areas for improving after-hours access.
- Develop interventions as appropriate to address gaps in service.

Provider Appointment and Availability Survey

Santa Clara Family Health Plan

Methodology

VHP has elected to administer the survey using the Three Step Protocol and followed the sequence as suggested in the DMHC's methodology. VHP transmitted the providers' data to the survey vendor, Center for the Study of Services (CSS) via DMHC's Contact List (CL) Templates. CSS reviewed the CL and removed duplicate providers by following the de-duplication rules set forth in the methodology.

Table I: Response Rates

	Total # of Providers	Eligible/ Completed	Ineligible	Refused
Ancillary	32	15	3	14
PCP	693	287	161	245
SPEC	434	68	106	260
NPMH	269	41	77	131
Total	**1,428**	**411**	**347**	**650**

Measures

Table I: Appointments and After-Hours

Provider Type	Urgent Appointment	Non-Urgent/ Routine Appointment	Non-Life Threatening Appointment	Follow-up Care	After-Hours Care
PCP	48 hours	10-days	NA	NA	24-hours / 7-days a week
SPC	96 hours	15-days	NA	NA	24-hours / 7-days a week
NPMH	96 hours	10-days	NA	NA	24-hours / 7-days a week
Ancillary	NA	15-days	NA	NA	NA

- The table includes appointment and after-hours measures for Primary Care Providers (PCP), Specialists (SPC), Non-Physician Mental Health (NPMH) and Ancillary.

Results

Santa Clara Family Health Plan

Table I: Primary Care Provider (PCP)

Performance For PCPs STANDARD (N=287)	# of PCP Respondents	# of PCP Respondents w/ Compliance	MY2018 % Compliance	MY2017 % Compliance	2 Year Comparison	Goal	Goal Met (Y/N)
Urgent Care Appointments w/no Prior Authorization (PA) w/in 48 Hours	259	182	70%	83%	↓	90%	N
Non-Urgent Appointments w/in 10 Days	287	256	89%	95%	↓	90%	N

- The MY2018 result for PCP's performance fell below the goal for both standards.
- The performance for Urgent Care Appointments within 48 hours was 70 percent (70 %). This is a thirteen percent (13%) decrease when compared to the result from MY2017.
- The performance for Non-urgent Care Appointments within ten days is 89 percent (89%). The MY2018 result is a decrease of 6 percent (6%) compared to the result from MY2017 and only 1 percent (1%) below the goal of 90%.

Results

Santa Clara Family Health Plan

Table II: Specialists (SPC)

Performance for Specialist Physicians (SCP) Combined (N=56)	# of SCP Respondents	# of SCP Respondent w/ Compliance	MY2018 % Compliance	MY2017 % Compliance	2 Years Comparison	Goal	Goal Met Y/N
Urgent Appointments w/PA w/in 96 Hours	53	30	57%	53%	↑	90%	N
Non-Urgent Appointments w/in 15 days	56	37	66%	69%	↓	90%	N

- The MY2018 result for the SCPs' performance fell below the goal for both standards.
- The performance for Urgent Care Appointments with PA within 96 hours is 57 percent (57%).
- The performance for Non-Urgent Care Appointment within 15 days is at 66 percent (66%).

Results

Santa Clara Family Health Plan

Table III: Psychiatry

Performance for Psychiatry Specialty (PS) (N=12)	# of PS Respondents	# of PS Respondents w/ Compliance	MY2018 % of Compliance	MY2017 % of Compliance	2 Years Comparison	Goal	Goal Met (Y/N)
Urgent Appointments w/PA w/in 96 Hours	9	1	11%	43%	↓	90%	N
Non-Urgent Appointments w/in 15 days	12	10	83%	75%	↑	90%	N

- The MY2018 result for PS performance fell below the goal for both standards.
- The performance for Urgent Appointments with PA within 96 hours is 11 percent (11%). This is a decreased rate of compliance when compared to the performance for MY2017.
- The performance for Non-urgent Appointment within 15 days is at 83 percent (83%), which is an improved rate of compliance when compared to the performance in MY2017.

Results

Santa Clara Family Health Plan

Table IV: NPMH

Performance for NPMH (N=41)	# of NPMH Respondents	# of NPMH Respondents w/ Compliance	MY2018 % of Compliance	MY2017 % of Compliance	2 Years Comparison	Goal	Goal Met (Y/N)
Urgent Appointments w/PA w/ 96 Hours	33	21	64%	89%	↓	90%	N
Non-Urgent Appointments w/in 10 days	40	34	85%	81%	↑	90%	N

- The MY2018 result for NPMH performance fell below the goal for both standards.
- The performance for urgent appointment with prior authorization within 96 hours is at 64%, a decrease rate of compliance compare to MY2017.
- The Non-Urgent appointment within 10 days is at 85% indicate an improved rate of response in comparison to the result for MY2017.

Results

Table V: Ancillary

Performance for Ancillary Provider (N=15 facilities)	# of Respondents	# of Respondents w/ Compliance	MY2018 Rate of Compliance	MY2017 Rate of Compliance	Change	Goal	Goal Met Y/N
Non-Urgent Appointments w/in 15 days	15	13	87%	75%	↑	90%	N

- VHP's MY2018 performance for Ancillary Facility Provider did not meet the goal.
- The result came in at 87 percent (87%) compliance, which indicates an improved rate of compliance of 12 percent (12%) when compared to the MY2017 result.

Conclusion

- Through the Provider Appointment and Availability Survey (PAAS) report, VHP was able to demonstrate the ability to provide urgent and non-urgent care appointment to its enrollees at a high level and in a timely manner.

- While the overall results fell below the desirable 90% goal, VHP's providers showed improvement for four measures as shown in the Tables above.

- Additionally, the PAAS survey results allowed VHP to gain an enhanced level of understanding on providers' performance and affords VHP with important knowledge about how to intervene to improve performance and how to target specific providers to more closely monitor and evaluate timely access.

- Most significantly, VHP is able to develop interventions, as appropriate, to continue to improve performance for timely access in the future.

Opportunities for Improvement

Intervention	Description of Activities	Barrier Addressed	Time Frame
Identify ways to increase the number of respondents to the PAAS for the all provider types especially for Specialist and Ancillary providers.	1) Communicating to the providers in advance of the survey that is coming and the importance of their responses to the survey. 2) Provide clear communication to providers on the limited time frames that is allowed for responses to be counted. 3) Inform the providers who refused to participate in MY2018 on the importance of participating on the survey and remind providers about contractual obligations on Timely Access. 4) Offer information on how the provider or provider group may provide appointment information through Extraction instead of traditional survey method.	Statistically limited responded	In advance of 2019 survey
Identify ways to increase the rate of compliance of those providers who responded and completed the survey	1) Educate providers on standard requirements ties to both urgent and non-urgent appointment. 2)) provide better clarity around the questions asked on the survey.	Improving the compliance rate of 90% goal	In advance of 2019 survey
Identify ways to increase more eligible provider by decreasing the number of ineligible providers due to bad contact information	1) Verify and updates provider who has bad phone, fax, email address in MY2018	Improve provider contact and rate of response	In advance of 2019 survey

- VHP has prioritized the opportunities that will be implemented to improve performance for timely access with all practitioners.
- These interventions were identified based on the analysis. The table outlines the key interventions.

After Hours Survey

Methodology

- The After-Hours survey was administrated by CSS survey vendor using the telephone methodology. The telephone survey was conducted between November 3, 2018 and November 20, 2018 and during non-business hours (7:00 PM-7:00 AM Pacific Standard Time).

Response Rate:

- VHP provided a database consisting of 1162 Providers, which included 291 behavioral health Providers and 871 primary care Providers.

(1050) Completed Surveys = 97% (Response Rate)

Results

Table I: After-Hours – Access Compliance: 911 Information

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=798)	718	100%	No	90%	+12
BH (N=252)	189	100%	No	75%	+11

- Both PCPs & BH providers did not meet the goal for Access Compliance Rate for MY 2018.
- Although the goal was not met, the survey result for both provider types showed an increase rate of compliance in comparison to previous MY year.
- PCP improved by 12%, while BH improved by 11%.

Results

Table II: After-Hours –Timeliness Compliance: 30-minutes or less

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=798)	573	100%	No	47%	+19
BH (N=252)	119	100%	No	72%	+60

- Both PCP & BH providers did not meet the goal for Timeliness Compliance Rate for MY 2018.
- Although the goal was not met, the survey result for both provider types showing an increase in rate of compliance compared to the previous MY year.
- The PCP improved by 19% and the BH practitioner improved significantly by 60% of compliance rate compared to MY2017.

Results

Santa Clara Family Health Plan

Table III: After-Hours

Name of Network	Denom. (# of respond)	Access Compliance (911)				Timeliness Compliance (30 Mins.)			
		MY 2018 Numerator	MY2018 %	MY2017 Rate	Change from 2017	MY 2018 Numerator	MY 2018 %	MY2017 Rate	Change from 2017
California IPA (Cal IPA)	18	17	94%	68%	↑	14	78%	37%	↑
Individually Contracted Provider (ICP)	129	76	59%	66%	↓	36	28%	7%	↑
Northern Cal Advantage Medical Group (NCAMG)	25	23	92%	78%	↑	12	48%	35%	↑
Palo Alto Medical Foundation (PAMF)	438	414	95%	82%	↑	360	82%	31%	↑
SCCIPA	134	119	89%	87%	↑	76	57%	47%	↑
Santa Clara Valley Medical Center (SCVMC)	64	53	83%	82%	↑	27	42%	6%	↑
Stanford Hospitals & Clinics	208	172	83%	70%	↑	141	68%	12%	↑
Verity Medical Foundation	34	33	97%	77%	↑	26	76%	38%	↑

Results

- Overall provider networks' results showed an improved rate of compliance for both Access & Timeliness standard.

- For Access compliance standard:
  - ➢ Of the 8 provider networks:
    - 7 out of 8 provider networks achieved an increase rate of compliance compare to MY2017.
    - Verity Medical Foundation achieved the highest rate of compliance at 97% and Cal IPA, NCAMG, PAMF are in the 90% rate of compliance.
    - 3 networks (SCCIPA, SCVMC, and Stanford) results are in 80%.
    - ICP network decreased by 7%.

- For Timeliness compliance standard:
  - ➢ Of the 8 provider networks:
    - Timeliness compliance standard are improved across all 8 networks.
    - Stanford & PAMF Network show significant improvement (51% increase for Stanford and 51% for PAMF network)

Results

- VHP believes members' are receiving the necessary after-hours care and service through additional services provided by VHP.
- VHP provides additional after-hours access resources through MD Live, at telehealth services 24/7 and a 24-hours Nurse Advice line.
- VHP's members can utilize the 24-hours nurse advice line at any time of the day and can sign up for the MD Live to schedule medical and behavioral health appointments for urgent and non-emergency conditions.
- Both of the services are available to VHP's members at no charges.
- For MY2018, with members having access to additional after-hours resources with MD Live and the Nurse Advice Line and no grievances or potential quality issue (PQI) related to after-hours access indicated evidence that members are receiving the necessary care during the after-business hours.

Conclusion

- VHP strives to ensure that plan's members have sufficient access to care during business and non-business hours. Therefore, VHP adheres to after-hours requirements by DMHC and the plan's accreditation organizations.

- The after hour survey result did not meet the standard access and timeliness goals for MY2018. However, the result did indicate an improvement in comparison to MY 2017.

- While the result fell below the high standard rate of 100% compliance rate, VHP took pride in taking steps at improving the compliance rate with our provider each year.

- In reviewing the intervention that was developed from previous year, VHP has put in a significant amount of efforts in 2018 to work with the providers to help them understand and adhere to the after hour standard and regulations.

Opportunities for Improvement

Description of Intervention for MY 2019	Barrier Addressed	Time Frame	Progress
1. Provider Relations department will share the non-compliance results and expected corrective action plans with all applicable providers	Providers are not aware of the after-hours standard of care and requirements or the survey	April 2019	In progress
2. Provider Relations department will re-educate all providers on the After-Hours standards through the methods: • Send written communication to Providers outlining the expectation of their compliance • Publish the after-hours standard and requirements on the VHP's website • Publish information in the provider bulletin.		April 2019	
3. Provider Relations Department will re-audit applicable providers to ensure providers comply with the standards.		On-going	In progress

- The table outlines the key interventions that VHP has either started implementing and/or will continue to implement in 2019.

Santa Clara Family Health Plan™

Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2019 Results

Jamie Enke, Manager, Process Improvement

CAHPS 2019

Overview

- CAHPS is a consumer satisfaction survey that the health plan is required to administer annually by the Centers for Medicare and Medicaid Services (CMS)
- SCFHP contracts with DSS to conduct the survey
- Results available annually in the Fall and published by CMS
- Results impact NCQA accreditation and CMS Star Ratings

CAHPS 2019

CAHPS Objectives

- Provide Medicare beneficiaries and the general public with information to help them make more informed choices among health plans
- Help plans identify problems and improve the quality of care and services by providing them with information about their performance relative to that of other health plan contracts in their state/region/nation
- Enhance CMS' ability to monitor the quality of care and performance of health plan contracts
- Other uses: give feedback to providers, identify strengths and opportunities, track trends over prior years

CAHPS 2019

Methodology

- Conducted telephonically and by mail March ’19 – May ‘19
  - 2 mailings
  - 6 telephone calls
- SCFHP mails two reminder postcards to members
- Sample size = 1,600 CMC members
- Official survey sent in English, Spanish, Chinese and Vietnamese

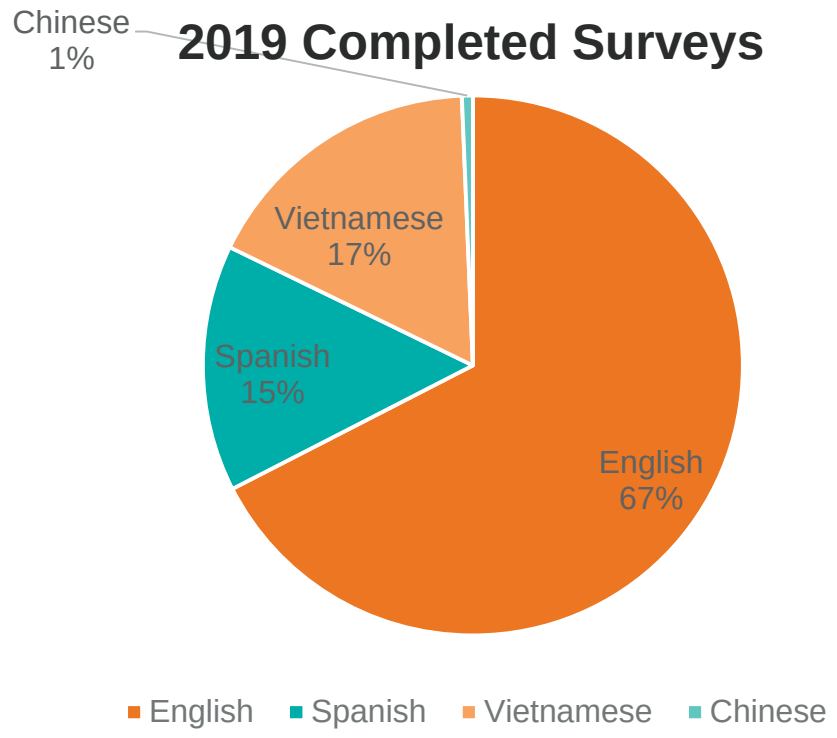
CAHPS 2019

Survey Response Breakdown:

Beneficiaries eligible for the survey were those 18 years and older who were enrolled in the plan and had been continuously enrolled for six months or longer (at the time of the sample draw).

Response Rate: 28.8%

Sample size:	1600
Ineligibles:	65
Total Completed Surveys:	461
-Mail:	348
-Phone:	113



CAHPS 2019

2019 Updates

- Implemented Chinese and Vietnamese language surveys
- 2019 Response Rate = 28.8%
  - +2.7 percentage points from 2018 response rate
  - CA MMP average response rate in 2019 was 27.9%
- CAHPS reminder in February 2019 Provider newsletter
- CAHPS notification in Spring 2019 CMC Member newsletter
- Provided feedback to contracted provider groups regarding CAHPS 2018 performance
- Maintained +800 member oversample to the standard 800 members of the official survey

CAHPS 2019s

SCFHP's Overall Performance

- SCFHP's overall performance similar to 2018
- Added languages did not lead to significantly different results
- Per DSS analysis, there were no statistically significant changes compared to prior year (2018)
- The **Customer Service** composite continues to trend upward, significantly increasing over a two year span (2017 – 2019)

CAHPS 2019

Overall Performance: Providers

	SCFHP Mean Score			Yr/Yr Change		National MMP Mean Score	CA MMP Mean Score	ABC + Caremore Mean Score
Composite	2017	2018	2019	17/'19	18/'19	2019	2019	2019
Getting Needed Care	3.17	3.25	3.32	↑ 0.15	↑ 0.07	3.45	3.38	N/A
Getting Appointments and Care Quickly	3.02	3.15	3.18	↑ 0.16	↑ 0.03	3.33	3.24	3.19
Doctors Who Communicate Well	N/A	N/A	N/A	N/A	N/A	3.73	3.70	N/A
Care Coordination	3.52	3.47	3.50	↓ (0.02)	↑ 0.03	3.57	3.51	N/A

***ABC + Caremore** = *Anthem Blue Cross in Santa Clara and Los Angeles Counties*

CAHPS 2019

Overall Performance: SCFHP

	SCFHP Mean Score			Yr/Yr Change		National MMP Mean Score	CA MMP Mean Score	ABC + Caremore Mean Score
Composite	2017	2018	2019	17/'19	18/'19	2019	2019	2019
Customer Service	N/A	3.52	3.59	N/A	↑ 0.07	3.71	3.67	N/A
Getting Needed Prescription Drugs	N/A	3.63	3.61	N/A	↓ (0.02)	3.68	3.61	N/A

CAHPS 2019

Highest Year/Year Decrease (2018-2019)

		SCFHP Mean Score			Yr/Yr Change		National MMP Mean Score	CA MMP Mean Score	ABC + Caremore Mean Score
Category	Description	2017	2018	2019	17/'19	18/'19	2019	2019	2019
Question 8	In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	2.60	2.88	2.71	↑ 0.11	↓ (0.17)	2.85	2.75	2.69

CAHPS 2019

Highest Year/Year Increase (2018-2019)

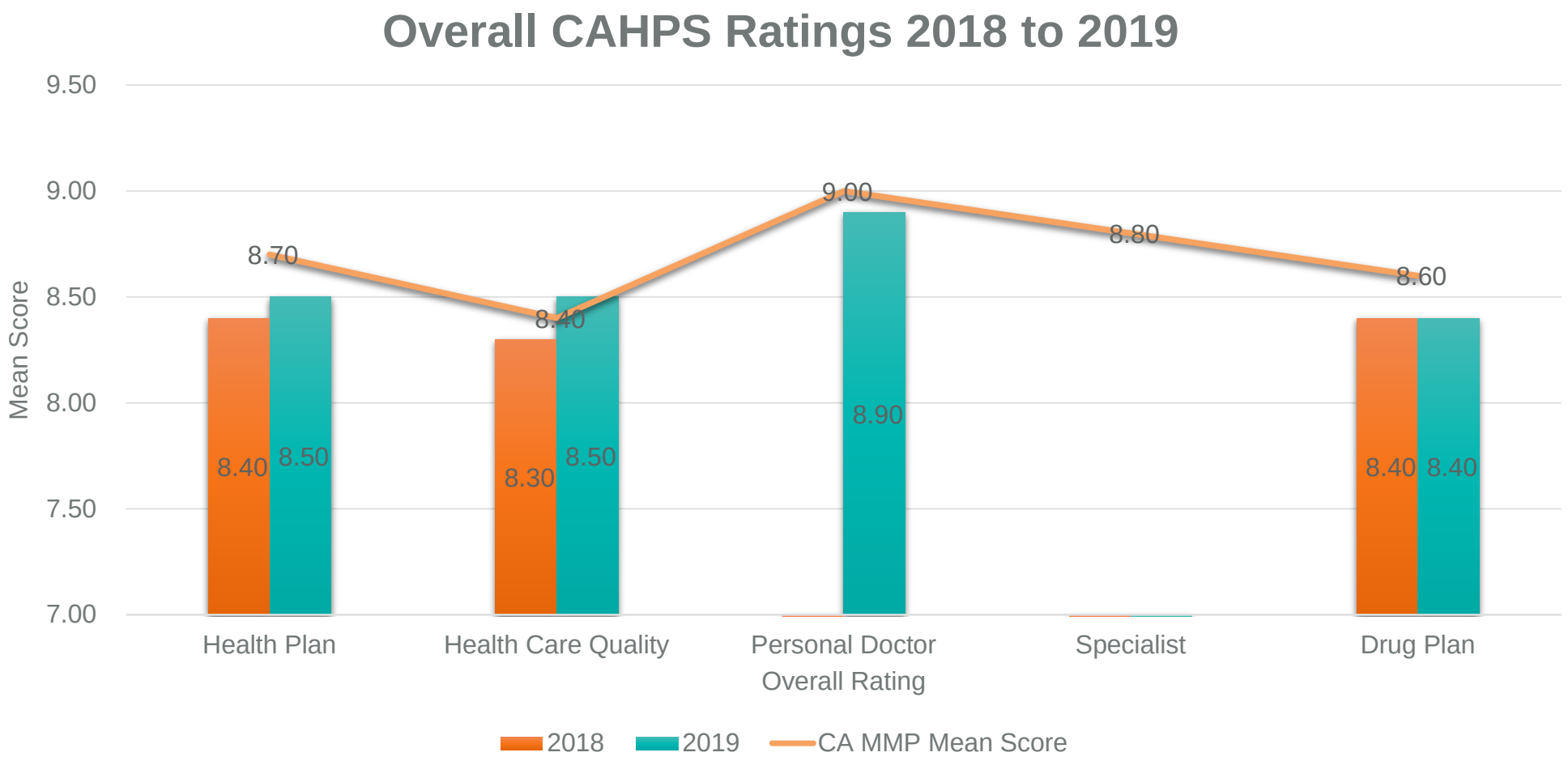
		SCFHP Mean Score			Yr/Yr Change		National MMP Mean Score	CA MMP Mean Score	ABC + Caremore Mean Score
Category	Description	2017	2018	2019	17/'19	18/'19	2019	2019	2019
Overall Rating of Health Care Quality	0-10 scale. 10 (best), 0 (worst)	8.18	8.30	8.50	↑ 0.32	↑ 0.20	8.50	8.40	N/A

CAHPS 2019

Other Notable Increases

		SCFHP Mean Score			Yr/Yr Change		National MMP Mean Score	CA MMP Mean Score
Category	**Description**	**2017**	**2018**	**2019**	**17/'19**	**18/'19**	**2019**	**2019**
Question 10	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	3.31	3.31	3.41	↑ 0.10	↑ 0.10	3.47	3.39
Question 34	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	N/A	3.25	3.36	N/A	↑ 0.11	3.49	3.45
Question 32	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	N/A	3.21	3.32	N/A	↑ 0.11	3.40	3.31
Overall Rating of Health Plan	0-10 scale. 10 (best), 0 (worst)	8.15	8.40	8.50	↑ 0.35	↑ 0.10	8.70	8.70

CAHPS 2019


Overall CAHPS Ratings 2018 to 2019
9.50
9.00
8.50
8.00
7.50
7.00
Mean Score
8.70
8.40
9.00
8.80
8.60
8.40
8.30
8.50
8.90
8.40
8.40
Health Plan
Health Care Quality
Personal Doctor
Specialist
Drug Plan
Overall Rating
2018
2019
CA MMP Mean Score

CAHPS 2019

Opportunities for Improvement*

- **Overall Rating of Health Plan**
- **Overall Rating of Drug Plan**
- **Overall Rating of Personal Doctor**
- **Customer Service**
  - "In the last 6 months, how often did your health plan's customer service give you the information or help you needed?" (0.09 points below the CA MMP Mean Score)
- **Getting Needed Care**
  - "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?" (0.13 points below CA MMP Mean Score)
- **Getting Appointments and Care Quickly**
  - "In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?" (Decreased by 0.17 points from 2018)
- **Care Coordination**
  - Multiple questions that addressed whether or not the member's doctor talked to them about their prescription drugs scored lower than the CA MMP Mean Score

**Opportunities for Improvement identified based on Composites and Overall Ratings that scored lower than the CA MMP Mean*

CAHPS 2019

Next Steps

- Meet with provider groups in monthly quality meetings to deliver results and gather feedback on improving scores for 2020
- Implement cross-functional workgroups to conduct qualitative analyses on CAHPS results and identify interventions to address opportunities for improvement
- Collaborate with Marketing to continue 2020 CAHPS campaign promotion and evaluate other opportunities for outreach

Santa Clara Family Health Plan™

2016 - 2018 Health Outcomes Survey (HOS): Follow-Up Results for Cohort 19

Jamie Enke, Manager, Process Improvement

Health Outcomes Survey (HOS)

"The Medicare HOS is the first patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid and reliable clinically meaningful data that have many uses, such as targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of functional health outcomes measurement."

— *www.HOSonline.org*

HOS Timeline

Cohort 19 Overview

- **2016 Baseline Report**
  - Sample size = 1,200
  - 976 (81.3%) beneficiaries did not respond to the baseline survey or were determined to be ineligible
  - Available in English and Spanish

- **2018 Follow Up Survey**
  - Analytical sample size = 224
  - Response rate = 62%* (compared to 69.2% nationally)
  - Responses fielded from May through July of 2018
  - Available in English and Spanish

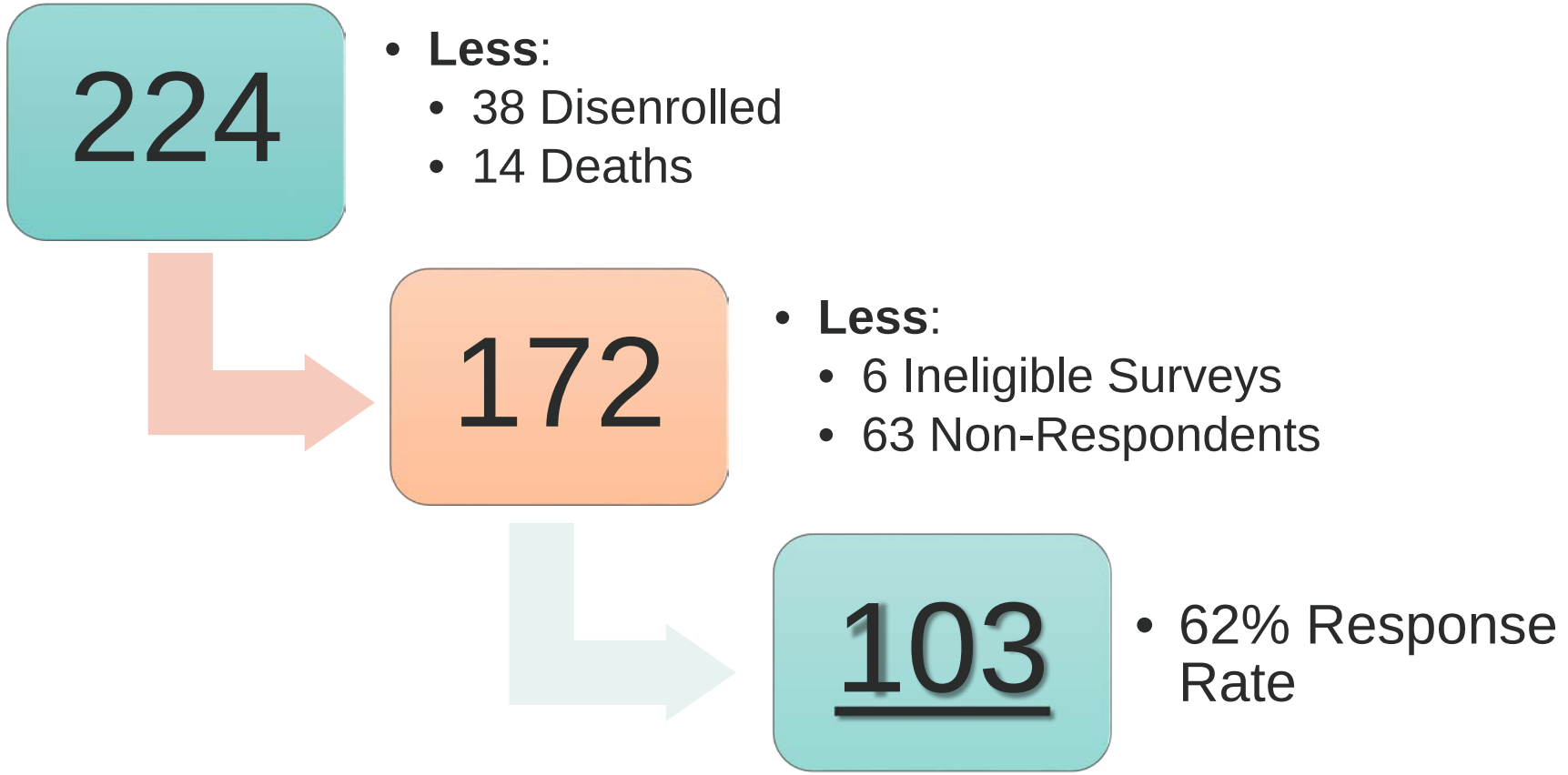
**Response Rate = [Respondent Sample/(Eligible Sample-Ineligible Surveys)] x 100%.*

HOS Timeline

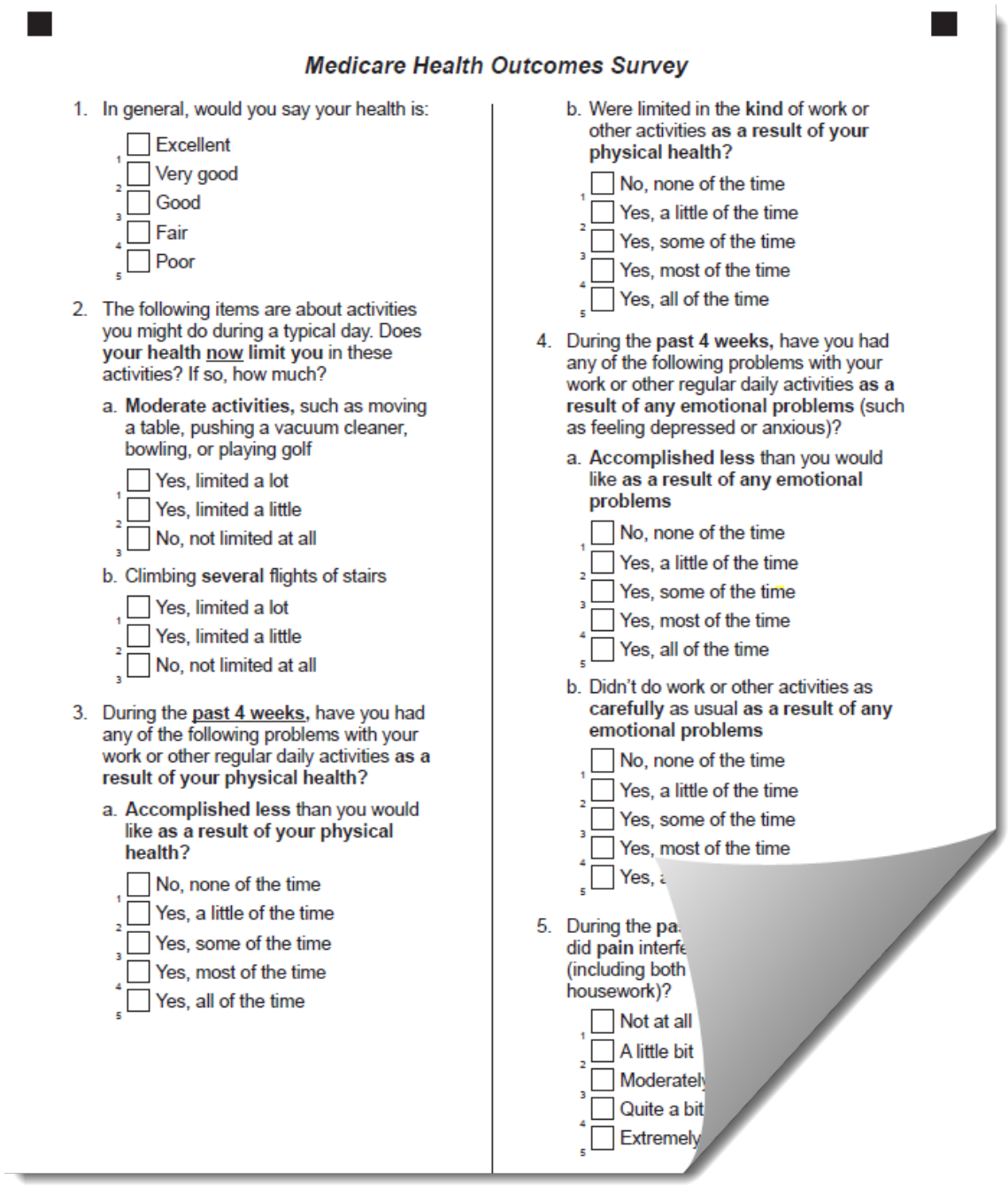
Medicare HOS Survey Administration Timeline				
Year	Data Collection		Reports	
	Baseline	*Follow Up*	*Baseline*	*Follow Up*
2020	Cohort 23	Cohort 21	Cohort 22	Cohort 20
2019	Cohort 22	Cohort 20	Cohort 21	Cohort 19
2018	Cohort 21	Cohort 19	Cohort 20	
2017	Cohort 20		Cohort 19	
2016	Cohort 19			

HOS Cohort 19 Respondents

Analytical Sample:



EXAMPLE:
Page 2 of HOS Survey



Medicare Health Outcomes Survey

1. In general, would you say your health is:
   - 1 ☐ Excellent
   - 2 ☐ Very good
   - 3 ☐ Good
   - 4 ☐ Fair
   - 5 ☐ Poor

2. The following items are about activities you might do during a typical day. Does **your health <u>now</u> limit you** in these activities? If so, how much?
   a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
   - 1 ☐ Yes, limited a lot
   - 2 ☐ Yes, limited a little
   - 3 ☐ No, not limited at all

   b. Climbing **several** flights of stairs
   - 1 ☐ Yes, limited a lot
   - 2 ☐ Yes, limited a little
   - 3 ☐ No, not limited at all

3. During the **<u>past 4 weeks</u>,** have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**
   a. **Accomplished less** than you would like **as a result of your physical health?**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes, all of the time

   b. Were limited in the **kind** of work or other activities **as a result of your physical health?**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes, all of the time

4. During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?
   a. **Accomplished less** than you would like **as a result of any emotional problems**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes, all of the time

   b. Didn't do work or other activities as **carefully** as usual **as a result of any emotional problems**
   - 1 ☐ No, none of the time
   - 2 ☐ Yes, a little of the time
   - 3 ☐ Yes, some of the time
   - 4 ☐ Yes, most of the time
   - 5 ☐ Yes,

5. During the **pa**
   did **pain** interfe
   (including both
   housework)?
   - 1 ☐ Not at all
   - 2 ☐ A little bit
   - 3 ☐ Moderately
   - 4 ☐ Quite a bit
   - 5 ☐ Extremely

HOS Results

Performance Measurement Results – Physical Health

- Results describe changes in health status over time.
- Rates combine risk-adjusted, two year mortality rates and changes in Physical Health Component Scores (PCS) to determine primary health outcome
- SCFHP performed as expected (the same as the national average)

Table 1: Trends in Physical Health Results over Three Cohorts for MAO H7890

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2016-2018 Cohort 19	15.20%	61.97%	22.83%	77.17%	⇔
2015-2017 Cohort 18	NA	NA	NA	NA	
2014-2016 Cohort 17	NA	NA	NA	NA	

HOS Results

Performance Measurement Results – Mental Health

- Results describe changes in mental health status over time
- Rates combine risk-adjusted, two year changes in Mental Health Component Scores (MCS) to determine primary mental health outcome
- SCFHP performed significantly better than expected
- SCFHP performed better than all MAOs in California

Table 2: Trends in Mental Health Results over Three Cohorts for MAO H7890

	Percent Better*	Percent Same*	Percent Worse*	Percent Better+Same*	Performance Results**
2016-2018 Cohort 19	15.21%	73.93%	10.86%	89.14%	⬆
2015-2017 Cohort 18	NA	NA	NA	NA	
2014-2016 Cohort 17	NA	NA	NA	NA	

HOS Results

Self-Rated General and Comparative Health Status

Table 3: *2016-2018 Cohort 19 Performance Measurement* Distributions of Beneficiaries with Worse Self-Rated General and Comparative Health Status for MAO H7890, California, and HOS Total

	General Health Fair or Poor		Comparative Physical Slightly Worse or Much Worse		Comparative Mental Slightly Worse or Much Worse	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
H7890	41.2%	40.8%	38.2%	42.4%	19.0%	23.7%
California	28.1%	30.5%	27.0%	29.7%	12.9%	15.6%
HOS Total	22.9%	25.7%	23.0%	26.8%	10.2%	11.9%

HOS Results

Multiple Chronic Conditions

- Table 4 shows the distribution of respondents with multiple (i.e., two or more) chronic medical conditions at baseline and follow up

Table 4: *2016-2018 Cohort 19 Performance Measurement* Distribution of Beneficiaries with Multiple Chronic Medical Conditions§ for MAO H7890, California, and HOS Total

	Multiple Chronic Medical Conditions§	
	Baseline	Follow Up
H7890	75.7%	77.8%
California	74.6%	76.7%
HOS Total	75.4%	77.4%

§ Multiple chronic medical conditions are defined as having two or more conditions.

HOS Results

Healthy Days Measure

- Healthy Days Measures serve as indicators of populations with greater risk for disease or injury

Table 5: *2016-2018 Cohort 19 Performance Measurement* Distribution of Beneficiaries with Worse Health for the Healthy Days Measures for MAO H7890, California, and HOS Total

	14 or More Days of Poor Physical Health		14 or More Days of Poor Mental Health		14 or More Days of Activity Limitations	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
H7890	28.7%	28.9%	17.2%	11.7%	24.0%	25.3%
California	19.1%	20.6%	11.3%	12.4%	13.3%	14.9%
HOS Total	17.1%	18.9%	9.3%	10.2%	11.3%	13.0%

HOS Results

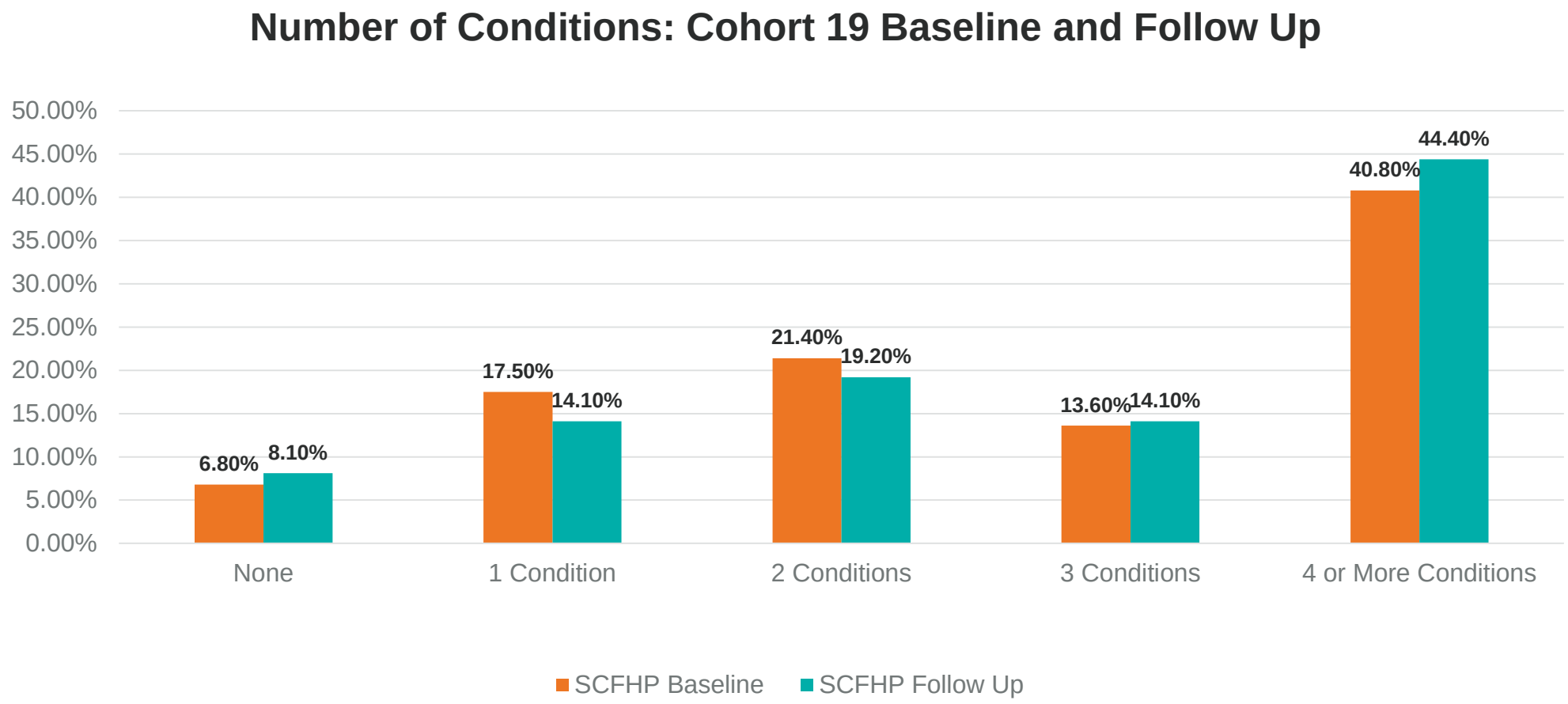
Body Mass Index (BMI)

Table 6: *2016-2018 Cohort 19 Performance Measurement* Distribution of Beneficiaries in Extreme Categories of the BMI Measures for MAO H7890, California, and HOS Total

	Underweight (BMI < 18.5)		Overweight (BMI 25 to 29.99)		Obese (BMI ≥ 30)	
	Baseline	Follow Up	Baseline	Follow Up	Baseline	Follow Up
H7890	3.2%	6.6%	36.2%	29.7%	19.1%	26.4%
California	2.7%	3.3%	36.4%	35.8%	24.4%	23.5%
HOS Total	1.7%	2.1%	38.0%	37.3%	31.5%	30.7%

Note: BMI categories were modified beginning with the *2017 Cohort 20 Baseline* Report. Underweight was changed from "<20" to "<18.5."

HOS Results


Number of Conditions: Cohort 19 Baseline and Follow Up
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
6.80%
8.10%
17.50%
14.10%
21.40%
19.20%
13.60%
14.10%
40.80%
44.40%
None
1 Condition
2 Conditions
3 Conditions
4 or More Conditions
SCFHP Baseline
SCFHP Follow Up

HOS Results

Prevalence of Chronic Conditions

- **72.4%** of respondents reported that they had **Hypertension**, the most prevalent of all chronic conditions in the SCHFP survey population (roughly the same percentage as in the baseline survey)
- Respondents reporting that they had **Osteoporosis** and **Pulmonary Disease** increased by **5.5** and **5.7 percentage points**, respectively (highest percentage point increase of all listed chronic conditions)
- There was a decrease in Cohort 19 respondents reporting that they had **Arthritis in the Hand or Wrist (-5.1 percentage points)**, and **Myocardial Infarction (-1.3 percentage points)**

HOS Results

Prevalence of Chronic Conditions

Table 15: *2016-2018 Cohort 19 Performance Measurement* Prevalence of Chronic Medical Conditions for MAO H7890 and HOS Total at Baseline and Follow Up

Medical Conditions	MAO H7890		HOS Total	
	Baseline N (%)	Follow Up N (%)	Baseline N (%)	Follow Up N (%)
Hypertension	75 (72.8%)	71 (72.4%)	56,821 (65.9%)	57,667 (67.1%)
Arthritis - Hip or Knee	47 (46.5%)	48 (49.0%)	37,039 (43.1%)	38,141 (44.5%)
Arthritis - Hand or Wrist	34 (33.7%)	28 (28.6%)	30,729 (35.8%)	31,710 (37.1%)
Diabetes	33 (32.0%)	33 (33.7%)	22,402 (26.0%)	23,029 (26.8%)
Sciatica	28 (27.5%)	26 (27.1%)	21,136 (24.7%)	21,620 (25.3%)
Other Heart Conditions	17 (16.7%)	19 (20.0%)	17,345 (20.2%)	18,872 (22.1%)
Osteoporosis	34 (34.3%)	39 (39.8%)	17,139 (20.0%)	18,321 (21.5%)
Pulmonary Disease	19 (18.8%)	24 (24.5%)	14,067 (16.3%)	15,222 (17.7%)
Depression	22 (22.0%)	21 (21.6%)	14,369 (16.7%)	14,679 (17.2%)
Any Cancer (except skin cancer)	13 (12.7%)	14 (14.7%)	12,204 (14.6%)	13,222 (15.9%)
Coronary Artery Disease	17 (16.8%)	17 (17.9%)	10,252 (12.0%)	10,817 (12.7%)
Congestive Heart Failure	10 (9.9%)	11 (11.6%)	5,997 (7.0%)	7,305 (8.6%)
Myocardial Infarction	8 (7.8%)	6 (6.5%)	6,728 (7.8%)	7,118 (8.3%)
Stroke	8 (7.8%)	9 (9.3%)	5,650 (6.6%)	6,370 (7.4%)
Gastrointestinal Disease	3 (3.1%)	7 (7.3%)	4,134 (4.8%)	4,163 (4.9%)

HOS Results

Next Steps/Recommendations:

- Request beneficiary-level data from CMS
- Conduct qualitative analysis with interdisciplinary team members to review results and identify opportunities for intervention
- Inform Case Management of HOS Cohort 19 Follow Up findings

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee 10/30/20/19

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	29	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	2	
Number practitioners recredentialed within 36-month timeline	2	
% 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 08/31/2019	288	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**
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	1577	1496	748	802	412	139

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 were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. - # 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.

MINUTES –Open Session Draft

Regular Meeting of the

Santa Clara County Health Authority
Pharmacy and Therapeutics (P&T) Committee

Thursday, September 19, 2019, 6:00-8:00 PM
Santa Clara Family Health Plan, Redwood Conference Room
6201 San Ignacio Ave, San Jose, CA 95119

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

Non-Voting Committee Members	Specialty	Present (Y or N)
Darryl Breakbill	SCFHP Appeals & Grievance Director	Y
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Michelle Huynh	SCFHP Pharmacy Coordinator	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Janet Gambatese	SCFHP Provider Network Management Director	Y

Public	Title/Association	Present (Y or N)
Gio Ottobre	Immunology Account Representative, Merck	Y

1. **Roll Call / Establish Quorum**
   Dr. Lin called the meeting to order at 6:11 PM. Roll call was taken. Quorum was established.

2. **Public Comment**
   There were no comments from the public.

3. **Open Meeting Minutes**
   The committee reviewed the Pharmacy & Therapeutics Committee meeting minutes from June 20, 2019. Dr. Lin motioned to accept the meeting minutes as presented. It was motioned by Dr. Nguyen and seconded by Dr. Alkoraishi. The motion carried.

4. **Standing Agenda Items**
   a. **CMO Health Plan Updates**
      Dr. Nakahira stated that SCFHP recently completed the Centers for Medicare & Medicaid Services (CMS) validation audit and is awaiting results. SCFHP's Healthy Kids line of business will be ending on October 1, 2019. All current Healthy Kids members, except two members, will be transitioned into the Medi-Cal line of business. The two members not getting transitioned are siblings and are not eligible to be Medi-Cal members. SCFHP is currently working with the two members to determine if they would be eligible to be enrolled into the Valley Kids system.

   b. **Plan/Global Medi-Cal Drug Use Review: Concomitant Anticholinergic and Antipsychotic Use**
      Dr. Otomo shared a summary of a recent educational article posted by the Department of Health Care Services (DHCS) Drug Use Review (DUR) Board regarding the risks of concomitant anticholinergic and antipsychotic use. Dr. Otomo stated that SCFHP completed a retrospective study earlier this year which revealed that there were only two Medi-Cal members on both a second generation antipsychotic and either trihexyphenidyl or benztropine for six months or longer. The doctors of these two members were aware of the risks of concomitant therapy with these drugs.

   c. **Appeals & Grievance 2Q2019 Report**
      Mr. Breakbill presented the 2019 2nd Quarter Appeals and Grievance reports:
      i. For Medi-Cal, there were a steady number of appeals and number of appeals upheld. The majority of appeals were upheld due to lack of medical necessity.
      ii. For Cal MediConnect, the volume of appeals and the uphold rate were lower than Medi-Cal. The higher volume of Medi-Cal appeals may be partially attributed to second prior authorization request submissions that are forwarded to Appeals & Grievances if received within 60 days of a denied prior authorization for the same medication from the same provider. Some of the commonly appealed medications in Cal MediConnect include: sildenafil, diclofenac 1% gel, Lyrica, and hydrocodone-acetaminophen.

   d. P&T Committee Charter
      Dr. Huynh presented the revised P&T Committee Charter, which is reviewed annually. The main revision was the addition of the statement that SCFHP's Chief Medical officer and Director of Pharmacy shall be automatically designated as voting P&T Committee members. Additional revisions were limited to formatting.

      Dr. Nguyen motioned to accept the charter as presented, and it was seconded by Dr. Bui. The motion carried.

Adjourn to Closed Session
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5. **Closed Meeting Minutes**
   Review SCFHP 2Q2019 P&T Closed Minutes
   Possible Action: Approve SCFHP P&T Closed Minutes

6. **Metrics & Financial Updates**
   a. Membership Report
   b. Pharmacy Dashboard
   c. Drug Use Evaluation
   d. Drug Utilization & Spend

7. **Discussion and Recommendations for Changes to SCFHP's Cal MediConnect Formulary & Coverage Determination Criteria**
   a. MedImpact 2Q2019 P&T Minutes
   b. MedImpact 3Q2019 P&T Ad Hoc Minutes
   c. MedImpact 3Q2019 P&T Part D Actions
   Possible Action: Approve MedImpact Minutes & Actions

8. **Discussion and Recommendations for Changes to SCFHP's Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**
   a. Old Business/Follow-Up
      i. Ciprodex Indication
      ii. Mycobutin TB Treatment Duration
   b. Formulary Modifications
      Possible Action: Approve recommendations
   c. Fee-for-Service Contract Drug List Comparability
      Possible Action: Approve recommendations
   d. Prior Authorization Criteria
      i. New or Revised Criteria:
         1. Brand Name
         2. Enbrel (etanercept)
         3. Humira (adalimumab)
         4. Insulin Pens
         5. Januvia (sitagliptin)
         6. Off-label
         7. Oncology
         8. Opioid Safety Edits
         9. Quantity Limit
         10. Taltz (ixekizumab)
         11. Trintellix (vortioxetine)
         12. Xelpros (latanoprost)
         13. Zyvox (linezolid)
      ii. Annual Review:
         1. Compound Medications
         2. Duragesic (fentanyl patch)
         3. Emend (aprepitant)

4. Myrbetriq (mirabegron)
5. Nicotrol (nicotine)
6. Opioids – Reauthorization
7. Penlac (ciclopirox solution)
8. Retacrit (epoetin alfa-epbx)

Possible Action: Approve criteria

9. New Drugs and Class Reviews

a. Sleep Pharmacology
   i. Sunosi (solriamfetol)
   ii. Wakix (pitolisant)

b. Rheumatoid Arthritis
   i. Rinvoq (upadacitinib)

c. Oncology Update
   i. Xpovio (selinexor)
   ii. Piqray (alpelisib)
   iii. Polivy (polatuzumab vedotin-piiq)
   iv. Turalio (pexidartinib)

d. Community-Acquired Bacterial Pneumonia: Xenleta (lefamulin)
e. Irritable Bowel Syndrome with Constipation **informational only*
   i. Tenapanor
   ii. Tegaserod
f. Vyleesi (bremelanotide)
g. Lumateperone
h. Semaglutide (oral)
i. New Derivatives/Formulations/Combinations
j. Biosimilar Update
k. New and Expanded Indications

Possible Action: Approve recommendations

Reconvene to Open Session

Committee reconvened to open session at 7:50 PM.

10. Discussion Items

a. **New and Generic Pipeline**

Dr. McCarty presented the new and generic pipeline. Oral semaglutide is awaiting approval, and it is expected to be a “blockbuster drug” coming out in October 2019. AR101, a drug for peanut allergy, may also be a “blockbuster drug” potentially in the first quarter of next year. Generic Lyrica was released in July and is much more cost-effective than the brand product.

11. Adjournment

Next meeting is Thursday, December 12, 2019.

The meeting was adjourned at 7:54 PM.

Santa Clara Family Health Plan™

YTD Quality Improvement Dashboard

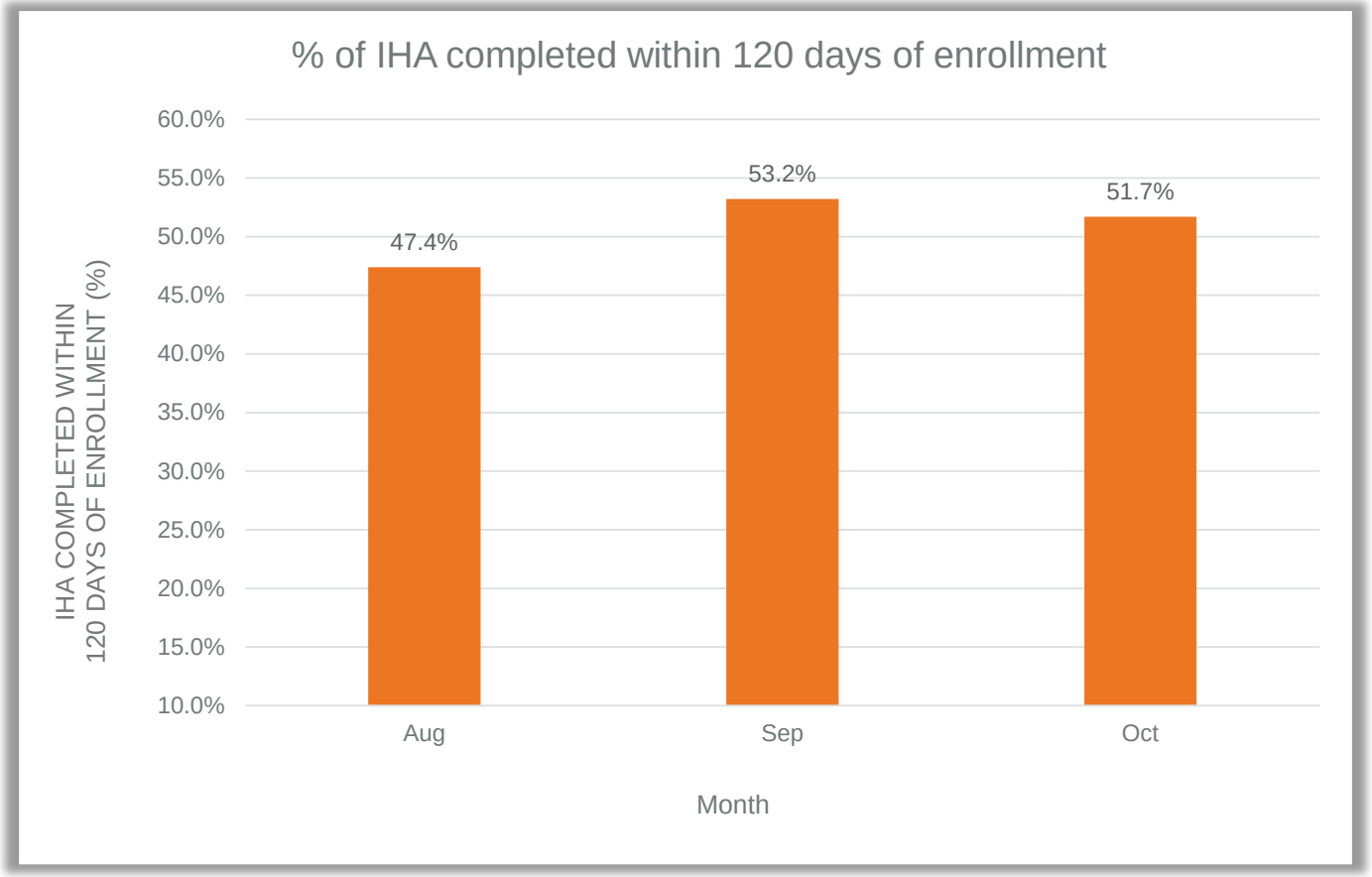
Initial Health Assessment (IHA)

Santa Clara Family Health Plan

What is an IHA?

An IHA is a comprehensive assessment completed during a new MC member's initial visit with their PCP within 120 days of joining the plan

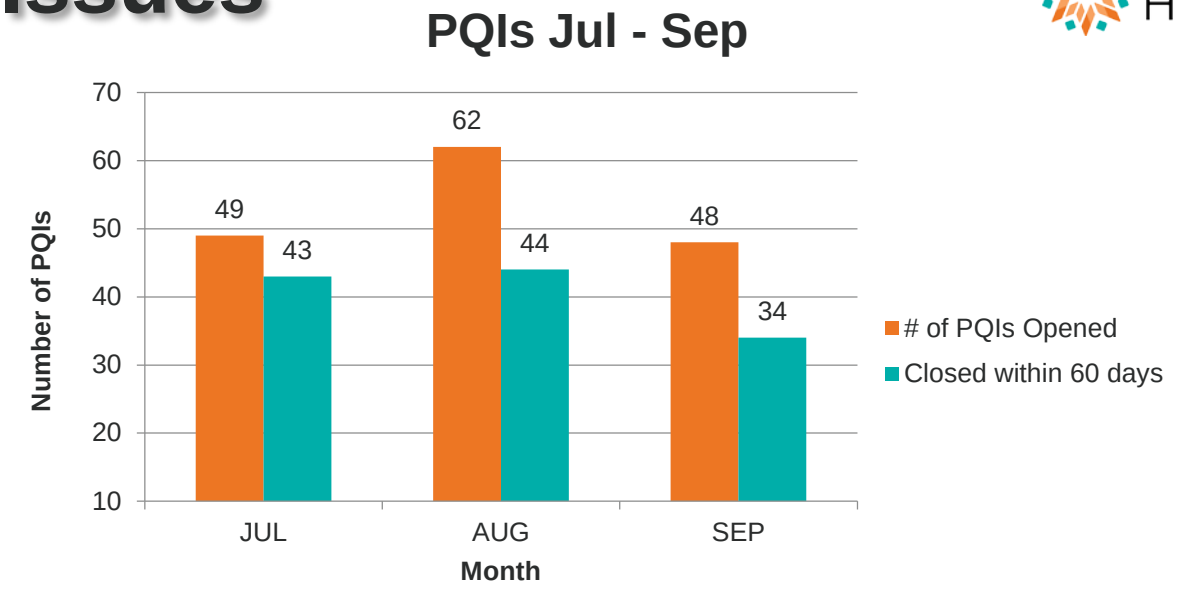
QI is currently developing a work plan to improve IHA completion rate



Potential Quality of Care Issues

Santa Clara Family Health Plan

Quality helps ensure member safety by investigating all potential quality of care (PQI) issues

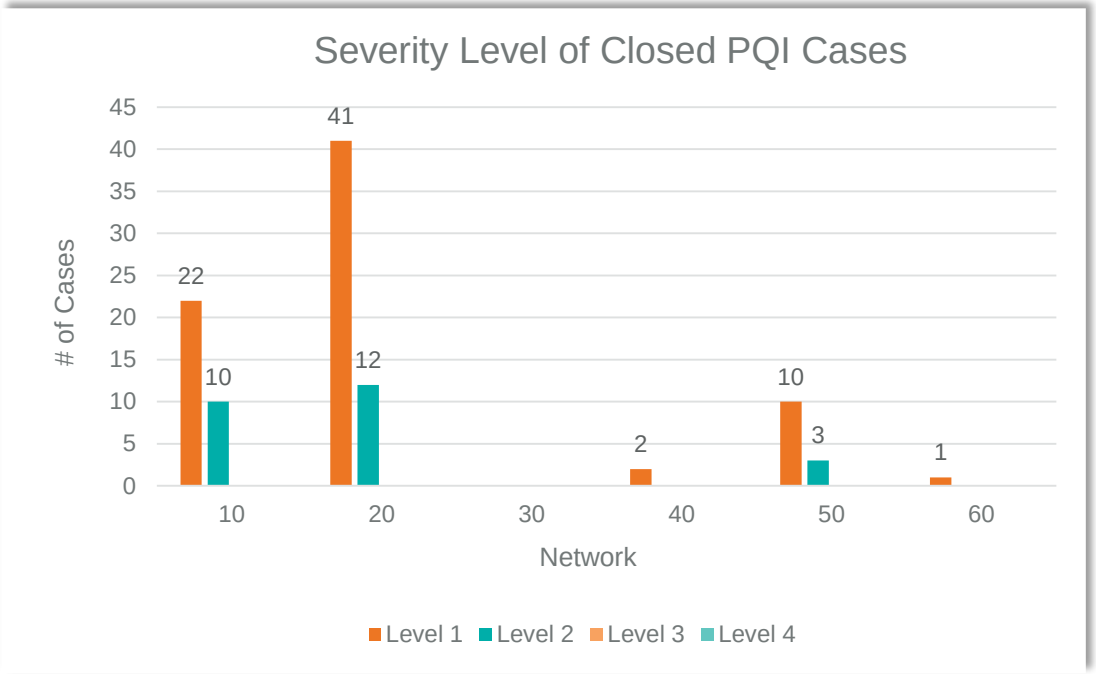


76%

Percentage of PQIs opened from Jul-Sep and closed on time

88%

Percentage of July PQI cases closed on time



Health Homes Program (HHP)

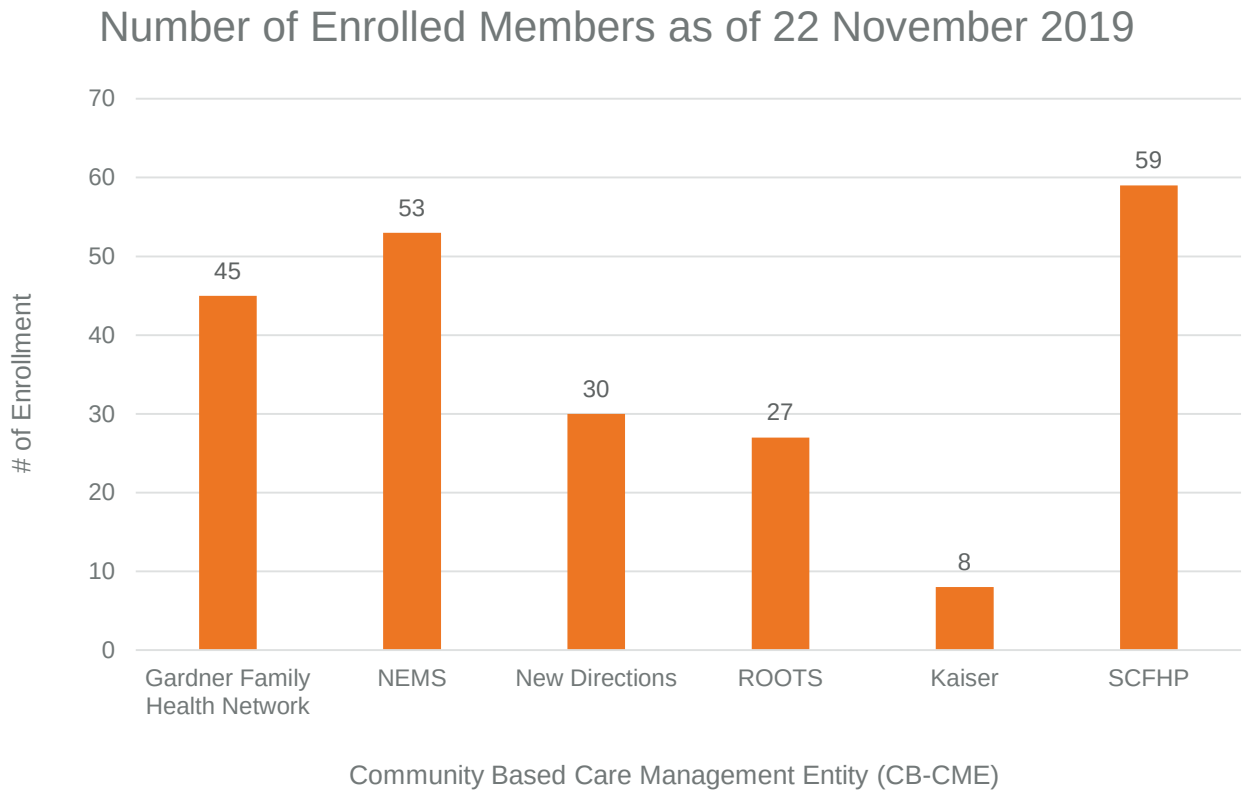
HHP launched July 1, 2019 with six Community Based Care Management Entities (CB-CMEs)

What is the Health Homes Program?

HHP is designed to coordinate care for Medi-Cal beneficiaries with chronic conditions and/or substance use disorders

222

Members have verbally consented into Health Homes as of November 22, 2019



Member Incentives:
Wellness Rewards Mailing and Cervical Cancer Screening (CCS) Clinic Days

Santa Clara Family Health Plan

What is the Wellness Rewards Mailing?

In July 2019 we began mailing out letters to members who were not compliant for the measures: W15, W34, AWC, BCS, CCS and CDC

149

The number of gift cards that were mailed out to compliant members since initiating the mailings

What are CCS Clinic Days?
Members are scheduled to get a pap smear done. Those who show up and complete the test are given a $30 gift card at the end of their appointment