Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, June 9, 2021, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
(669) 900-6833
Meeting ID: 962 5812 9548
https://zoom.us/j/96258129548
Passcode: SCFHP123

AGENDA

1.	**Roll Call**	Dr. Paul	6:00	5 min
2.	**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	6:05	5 min
3.	**Meeting Minutes** Review minutes of the April 14, 2020 Quality Improvement Committee meeting. **Possible Action:** Approve minutes of the April 14, 2020 Quality Improvement Committee meeting	Dr. Paul	6:10	5 min
4.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:15	10 min
5.	**Assessment of Member Cultural and Linguistic Needs and Preferences** Review the Assessment of Member Cultural and Linguistic Needs and Preferences. **Possible Action:** Approve the Assessment of Member Cultural and Linguistic Needs and Preferences	Ms. Gambatese & Ms. Fadley	6:25	15 min
6.	**2020 Impact Analysis** Review performance of PHM goals and interventions for 2020. **Possible Action:** Approve the 2020 Impact Analysis	Ms. Chen	6:40	15 min
7.	**2021 Population Health Management (PHM) Strategy and Activities and Resource Grid** Review PHM Strategy and changes to Activities and Resources. **Possible Action:** Approve PHM Strategy and Activities and Resources Grid	Ms. Chen	6:55	15 min

8. Annual Review of QI Policies **a.** QI.17 Behavioral Health Care Coordination **b.** QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors **c.** QI.20 Information Sharing with San Andreas Regional Center (SARC) **d.** QI.21 Information Exchange Between SCFHP & Health Services Dept. **e.** QI.22 Early Start Program (Early Intervention Services) **f.** QI.23 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care **g.** QI.24 Outpatient Mental Health Services: Mental Health Parity **h.** QI.25 Intensive Outpatient Palliative Care **i.** QI.27 Informing Members of Behavioral Health Services **Possible Action:** Approve QI Policies as presented	Dr. Liu & Ms. McKelvey	7:10	10 min
9. Grievance and Appeals Report Q1 2021 Review the Grievance and Appeals Report Q1 2021. **Possible Action:** Approve the Grievance and Appeals Report Q1 2021	Mr. Hernandez	7:20	15 min
10. Quality Dashboard Review of the Quality Dashboard.	Dr. Liu	7:35	10 min
11. Compliance Report Review of the Compliance Report.	Mr. Haskell	7:45	5 min
12. Utilization Management Committee (UMC) Review draft minutes of the 04/21/2021 UMC meeting. **Possible Action:** Approve the 04/21/2021 UMC draft meeting minutes	Dr. Lin	7:50	5 min
13. Credentialing Committee Report Review 04/07/2021 Credentialing Committee Report. **Possible Action:** Approve the 04/07/2021 Credentialing Committee Report	Dr. Lin	7:55	5 min
14. Adjournment The next QIC meeting will be held on August 11, 2021.	Dr. Paul	8:00	

Notice to the Public—Meeting Procedures

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

Quality Improvement Committee

Meeting Minutes

April 14, 2021

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, April 14, 2021, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present	Specialty
Ali Alkoraishi, MD	Adult & Child Psychiatry
Nayyara Dawood, MD	Pediatrics
Jennifer Foreman, ND	Pediatrics
Jimmy Lin, MD	Internist
Christine Tomcala, Chief Executive Officer	
Members Absent	
Jeffery Arnold, MD	Geriatric Medicine
Laurie Nakahira, D.O., Chief Medical Officer	
Ria Paul, MD, Chair	Emergency Medicine

Staff Present
Chris Turner, Chief Operating Officer
Laura Watkins, Vice President , Marketing and Enrollment
Johanna Liu, PharmD, Director, Quality & Process Improvement
Angela Chen, Interim Director, Case Management
Lucile Baxter, Manager, Quality & Health Education
Mai Phuong Nguyen, Manager, Oversight
Victor Hernandez, Program Manager, Grievance and Appeals
Theresa Zhang, Manager, Communications
Byron Lu, Process Improvement Program Manager, Quality Improvement.
Nancy Aguirre, Administrative Assistant
Sandra Walle, Coordinator, Quality Improvement

1. **Roll Call**

   Johanna Liu, PharmD, Director, Quality and Process Improvement, acting Chair, called the meeting to order at 6:05 pm. Roll call was taken.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   Minutes of the February 9, 2021 Quality Improvement Committee (QIC) meeting were reviewed when a quorum was established.

   It was moved, seconded and the minutes of the February 9, 2021 QIC meeting were **unanimously approved.**

   Motion: Dr. Alkoraishi
   Second: Dr. Lin
   Ayes: Dr. Dawood, Dr. Foreman , Ms. Tomcala

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Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

4. CEO Update

Christine Tomcala, Chief Executive Officer, reported the current Plan membership is approximately 279,000 members. Of which, approximately 10,000 are Cal MediConnect (CMC) members and 269,000 are Medi-Cal (MC) members. This reflects a slight increase from the previous report in February, 2021. However, a lot of these members' aren't new members, but rather members whose redeterminations are on hold due to the public health emergency.

Ms. Tomcala announced the Governing Board has approved a new Strategic Plan as well as a new Mission, Vision and Values for our organization. Further details will be disclosed at a later date.

Ms. Tomcala shared that although SCFHP has not yet officially opened the Blanca Alvarado Community Resource Center, two vaccination clinics have been held there. Between both vaccination clinic days, 300 Johnson & Johnson vaccines were distributed. Now that the Johnson & Johnson vaccine production is paused, it is unknown as to when the next vaccination clinic will be. SCFHP looks forward to continuing to host vaccine clinics potentially going forward.

This concludes Ms. Tomcala's update. No questions were asked.

5. Assessment of Member Cultural and Linguistic Needs and Preferences

This item was deferred to the following QIC meeting.

6. Review of Quality Improvement (QI) Program Evaluation 2020

Lucille Baxter, Quality and Health Education Manager, presented the QI Program Evaluation 2020. The QI Program Evaluation 2020 includes four different categories: Clinical Improvement; Safety of Clinical Care; Quality of Service; and Members' Experience.

The Clinical Improvement category contains five sections: Quality Measures & Improvement Performance; Quality Improvement Projects (QIP); Performance Improvement Projects (PIP); Initial Health Assessment (IHA); and Health Outcomes Survey (HOS).

Dr. Lin asked if SCFHP sends providers a Gaps of Care list of their patients in need of appointments. Ms. Baxter explained the Gaps of Care list will be available on the Provider Portal in May, 2021, and will be updated monthly thereafter.

The Safety of Clinical Care category contains three sections: Facility Site Review (FSR) & Medical Record Review (MRR); Provider Preventable Conditions (PPCs); and Potential Quality of Care (PQI).

The Quality of Service category includes Access & Availability of Services. The Members' Experience category includes two sections: Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Grievance and Appeals.

Based on the results from the QI Program Evaluation, Ms. Baxter stated that the QI Program is adequately resources to meet, maintain, and improve areas around the quality and safety of clinical care and service, as well as member experience. The Quality Improvement Committee structure allows the departmental areas to gain clinical insights and understanding from the committee members; this is possible through the participation of practitioners and leadership involvement in the QI program. Updates to the QI program were discussed in the QI Program Description that was approved by the Quality Improvement Committee in February 2021.

It was moved, seconded and the QI Program Evaluation 2020 was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Ms. Tomcala
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

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7. Review of QI Work Plan 2021

Ms. Baxter presented the QI Work Plan 2021. The QI Work Plan is divided into four QI Activity categories: Quality of Clinical Care; Quality of Service; Members' Experience; and Safety of Clinical Care.

Ms. Baxter reviewed the deliverables, goals and objectives, previous barriers/issues, the timeframe, and staff responsible of each QI Activity.

It was moved, seconded and the QI Work Plan 2021was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Dr. Lin, Ms. Tomcala
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

8. Health Outcomes Survey (HOS)

Byron Lu, Process Improvement Program Manager, Quality Improvement, presented the HOS 2020. Mr. Lu explained the Medicare HOS is the first patient-reported outcomes measure used in Medicare managed care. HOS is mandatory for all Medicare Advantage contracts and is a multi-year survey, including the baseline survey and a follow up survey two years later. The data sources for HOS are the survey responses and the HEDIS rates. Mr. Lu noted there were a total of 226 HOS Cohort '20 respondents with a 59.1% response rate.

Mr. Lu presented the Physical Health and Mental Health results over two cohorts. Also reviewed were the performance measurements for Multiple Chronic Condition, BMI, and Prevalence of Chronic Medical Conditions.

There are two measures of functional health: Improving or Maintaining Physical Health; and Improving or Maintaining Mental Health. Also included are three HEDIS Effectiveness Care Measures: Improving Bladder Control – MUI; Monitoring Physical Activity – FAD; and Reducing the Risk of Falling – FRM.

Mr. Lu reviewed the HOS projected Star Rating for 2021 and 2022, as well as the Interventions.

9. Annual Review of QI Policies

Dr. Liu reviewed the QI policies: Qi.03, QI.04, QI06, QI.08, QI.09, QI.11, QI.12, and QI. 28. Angela Chen, Interim Director, Case Management (CM) reviewed the CM policies: QI.13, QI.15, QI.19, QI.30, QI.31, and QI.32.

a. **QI.03** – No changes made
b. **QI.04** – No changes made
c. **QI.06** – No changes made
d. **QI.08** – No changes made
e. **QI.09** – No changes made
f. **QI.11** – No changes made
g. **QI.12** – Further edits will be made, as this policy is transferring departments
h. **QI.13** – Updated
i. **QI.15** – Updated
j. **QI.19** – Updated
k. **QI.28** – No changes made
l. **QI.30** – Newly developed, to be incorporated in a training module
m. **QI.31** – Newly developed, to be incorporated in a training module
n. **QI.32** – Newly developed, to be incorporated in a training module

It was moved, seconded, and the QI Policies were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Ms. Tomcala
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

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10. Grievance and Appeals Report Q4 2020

Victor Hernandez, Quality Assurance Program Manager, Grievance and Appeals (G&A), presented the G&A Report Q4 2020. Mr. Hernandez noted the decrease in cases received in Q2 2020 and Q3 2020. However, in Q4 2020, SCFHP had more cases this year than last year by about 1,000.

Mr. Hernandez reviewed the cases received as well as the G&A rate per 1,000 members for MC and CMC. Also reviewed were the top three MC and CMC Grievance categories. Mr. Hernandez noted an unusual trend within the top 3 Grievance categories: Inappropriate Billing made it to the top three MC Grievances.

Ms. Tomcala asked if there were any commonalities regarding this unusual trend. Mr. Hernandez will take a closer look at this data and report back at the following QIC meeting.

Mr. Hernandez reviewed the G&A by network, vendor, reason, and rational for overturns.

It was moved, seconded, and the G&A Report Q4 2020 were **unanimously approved.**

Motion: Ms. Tomcala
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Foreman
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

11. Compliance Report

Mai Phuong Nguyen, Manager, Oversight, presented the Compliance Report, specifically, the Fraud, Waste, and Abuse (FWA) program. SCFHP is committed to implementing FWA awareness for all staff, governing board members, as well as providers and members, as all are important sources for identifying potential FWA.

Ms. Nguyen reviewed the number of ways SCFHP works to prevent FWA, including a Compliance Hotline, Compliance Electronic Mailbox, FWA Awareness, FWA training, and Internal and External Audits.

Ms. Nguyen noted in 2020, SCFHP added an internal Special Investigations Unit (SIU) team to its FWA program. During the period of January through March 2021, the SIU team has received 18 suspected FWA leads.

12. Utilization Management Committee (UMC)

Dr. Lin reviewed the draft UMC minutes for the 01/20/2021 meeting.

It was moved, seconded, and the draft minutes of the 01/20/2021 UMC meeting were **unanimously approved.**

Motion: Dr. Alkoraishi
Second: Dr. Dawood
Ayes: Dr. Foreman, Dr. Lin, Ms. Tomcala
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

13. Consumer Advisory Board (CAB)

In lieu of Dr. Nakahira, Dr. Liu reviewed the draft CAB minutes for the 03/04/2021 meeting.

It was moved, seconded, and the draft minutes of the 03/04/2021 CAB meeting were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Ms. Tomcala
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

14. Pharmacy and Therapeutics Committee (P&T)

Dr. Lin reviewed the draft P&T minutes for the 03/18/2021 meeting.

It was moved, seconded, and the draft minutes of the 03/18/2021 P&T meeting were **unanimously**

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approved.

Motion: Dr. Alkoraishi
Second: Dr. Dawood
Ayes: Dr. Foreman, Dr. Lin, Ms. Tomcala
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

15. Credentialing Committee Report

In lieu of Dr. Nakahira, Dr. Lin reviewed the 02/03/2021 Credentialing Committee Report.

It was moved, seconded, and the Credentialing Committee Report was **unanimously approved.**

Motion: Dr. Alkoraishi
Second: Dr. Lin
Ayes: Dr. Dawood, Dr. Foreman, Ms. Tomcala
Absent: Dr. Arnold, Dr. Nakahira, Dr. Paul

16. Adjournment

The next QIC meeting will be held on June 9, 2021. The meeting was adjourned at 7:55 pm.

_____ _____

Ria Paul, MD, Chair Date

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Santa Clara Family Health Plan
Assessment of Member Cultural and Linguistic Needs and Preferences
Reporting Year - 2020

Cal Medi-Connect - 2021

Prepared by: Karen Fadley, Provider Network Operations Data Analyst
For review and approval by the Quality Improvement Committee

INTRODUCTION

SCFHP believes that cultural competency is a best practice for valuing diversity, practicing inclusion and creating health equity. SCFHP continues to support developmental processes to ensure awareness of cultural, ethnic/racial differences.

SCFHP is committed to providing language services at no cost and equal access to services for members with hearing or language related needs. Oral Interpreters, signers, bilingual providers and provider staff are available at all key points of contact. These services are provided in all languages spoken by SCFHP members.

SCFHP annually assess the cultural, ethnic/racial and linguistic needs of its members relative to its provider network. Network provider characteristics (i.e., culture, ethnicity/race, spoken language) are assessed to ensure member preferences and needs are met.

DATA SOURCES AND COLLECTIONS

To assess member needs, data is collected from multiple sources to include:

- 2010 US Census
- Statistical Atlas
- Data USA
- CAHPS
- APL 17-011
- Provider Language Report via eVips
- Member Ethnicity/Race and Language Report via QNXT, 834
- Language Translation Usage: January 1, 2020 – Dec 31, 2020
- Member Complaints: January 1, 2020 – Dec 31, 2020

METHODOLOGY

SCFHP will use US Census, Statistical Atlas, Data USA and/or other sources to collect and examine data on the cultural ethnic/racial and linguistic composition of the population in its service area in Santa Clara County.

SCFHP extracts available enrollee demographic information from the 834 file to identify characteristics such as culture, ethnic/racial and primary language. SCFHP will extract available demographics on the same characteristics of its provider network by running reports from the eVips system. While the Plan does not have concrete data on provider ethnicity/race, conclusions are drawn from the languages spoken by network providers. For further evaluation, SCFHP also uses available publications on physician diversity in California to examine provider diversity statistics in its service area.

Santa Clara Family Health Plan and the California Department of Health Care Services (DHCS) uses the following methodology to identify enrollee threshold languages –

- A population group of mandatory eligible beneficiaries residing in the Plan's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language);

- A population group of mandatory eligible beneficiaries residing in the Plan's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes (Concentration Standard Language).

The DHCS issues an all plan letter (APL 17-011) to notify the health plans of which threshold languages were identified for each county in California. SCFHP's annual cultural and linguistic assessment incorporates the threshold languages the DHCS identifies in its service area in Santa Clara County. In addition, SCFHP follows state requirements regarding translation of written informing materials for members who have limited English proficiency and speak one of the languages which meet the threshold and concentration standards.

The DHCS updates threshold language data at least once every three fiscal years, to address potential changes to both numeric threshold and concentration standard languages within all Medi-Cal managed care counties.

SCFHP cultural and linguistic assessments include PCP's, high volume/impact specialists and high volume mental/behavioral health providers. PCP provider counts include family practice and internal medicine. Family practice provider counts include geriatric and general practice providers.

DEMOGRAPHICS

Data Source: US Census

County:		Cities:	Population
Santa Clara County		ALL	1,927,852

Data Source (Language *only*): Statistical Atlas

Santa Clara County Race and Hispanic Origin	Percentage	Language other than English spoken at Home (Top 3)	Percentage
White alone, percent (a)	52.4%	Spanish	18%
Black or African American alone (a)	2.8%	Chinese	9.4%
American Indian and Alaska Native alone (a)	1.2%	Vietnamese	6.5%
Asian alone, percent (a)	39.0%		
Native Hawaiian and Other Pacific Islander alone (a)	0.5%		
Two or More Races, percent	4.2%		
Hispanic or Latino, percent (b)	25.0%		
White alone, not Hispanic or Latino	30.6%		

(a) Includes persons reporting only one race
(b) Hispanics may be of any race--are included in applicable race categories

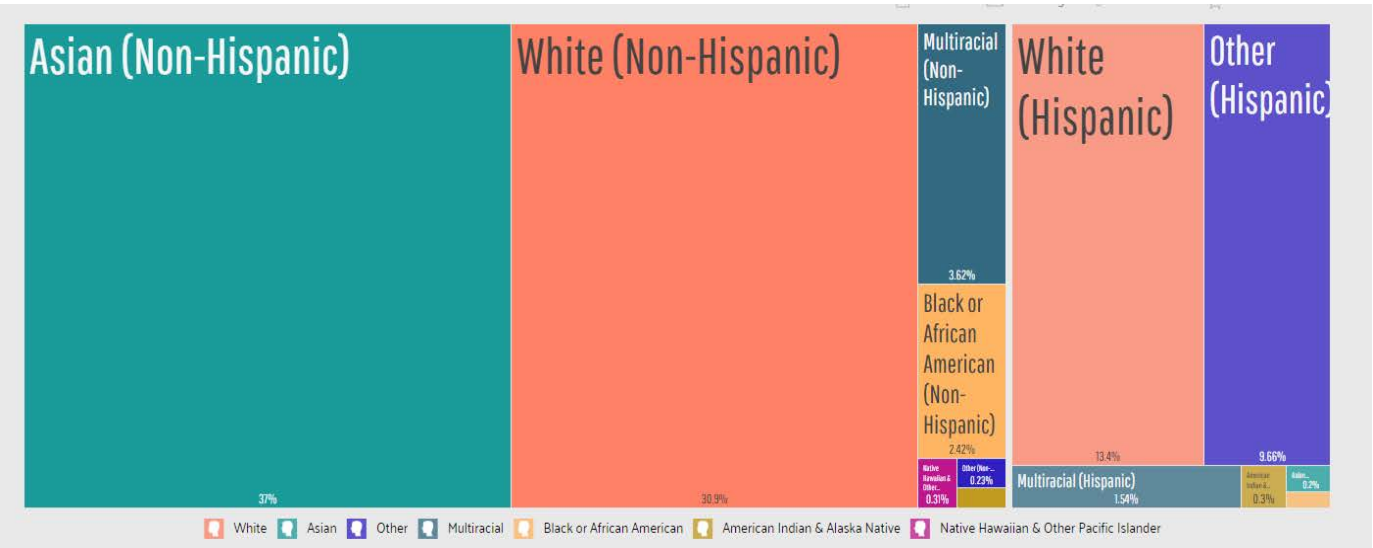
Data Source: Data USA, Censusreporter

Santa Clara County Age & Gender	Number/Percentage	Santa Clara County Health	Percentage
Persons under 5 years	5.8%	With disability, under 65	4.6%
Persons under 18 years	21.6%	Persons without Health Insurance	5.1%
Persons 65 years and over	13.9%		
Median Age	37.2%		
Female persons	49.3%		
Male persons	51.0%		

In 2018, Data USA reported that there were 1.2 times more Asian Alone residents (717k people) in Santa Clara County than any other ethnicity/race. There were 599k White Alone and 491k Hispanic or Latino residents, the second and third most common racial or ethnic groups.

To further assess and to gain a better understanding of SCFHP's service area, a study was conducted using Data USA, which reports that 53% of Santa Clara County citizens are speakers of a non-English language, which is higher than the national average of 22%. Data USA also reports that the most common non-English language spoken in Santa Clara County is Spanish at 19%, followed by Chinese at 9% and Vietnamese at 7%.

The following chart shows the races and ethnicities represented in Santa Clara County as a share of the total population.



CAL MEDI-CONNECT ENROLLMENT COUNT

LINE OF BUSINESS	Enrollment Count
Cal MediConnect (CMC)	9,820

DESCRIPTION OF CAL MEDI-CONNECT:

Cal Medi-Connect is a dual eligible plan for members who qualify for both Medicare and Medi-Cal. Cal Medi-Connect enrollees receives Medicare and Medi-Cal benefits from one plan, such as hospital, medical and prescription drug benefits (Medicare Parts A, B and D benefits), In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), care coordination, and nursing home care.

MEMBER LANGUAGE and CULTURAL ASSESSMENTS

Table I: Member Languages Spoken at Home (N=9,820)

Language	Member Count	% of Members Speak the Language
English	4,079	42%
Spanish	1,809	18%
Vietnamese	1,492	15%
*Chinese	1,358	14%
Tagalog	345	4%
Other	737	8%

*Chinese is the combined total of Chinese, Mandarin and Cantonese

Top 4 - Most common non-English languages spoken by CMC Members:

- **Spanish**
- **Vietnamese**
- **Chinese**
- **Tagalog**

As shown in Table I, SCFHP's Cal MediConnect member's most common non-English languages spoken are Spanish, Vietnamese, Chinese and Tagalog. Changes in member spoken languages from the previous year showed an increase in English at 7% a decrease in Spanish at 2%, Vietnamese decrease at 1%. Chinese remained the same, at 14% and Tagalog remained the same at 4% (no increase or decrease).

Table II: MEMBER ETHNICITY/RACE (Top 4)

Source: 834 Enrollment File

Culture	Member Count	%
Asian	2,785	28%
Hispanic/Latino	2,413	25%
Caucasian	1,313	13%
Pacific Islanders	580	6%

As shown in Table II, the top 4 member races are Asian, Hispanic/Latino, Caucasian and Pacific Islanders. The assessment showed that the Asian descent consist of two (2) races, Vietnamese at 15% and Chinese at 13%. Pacific Islanders were of the Filipino race and the data did not show the races under the Hispanic/Latino population

External publications and studies relevant to SCFHP's service area were used to assess cultural traits on the top three member ethnicity/race (excluding Caucasian). Following is a summary of the publications and studies reviewed:

***Source**: Santa Clara County Public Health*

Vietnamese

In 2011, the Santa Clara County Public Health Department (SCCPHD) completed the Vietnamese - American Health Assessment and reported that the Vietnamese culture, interactions and communication styles are important to adopt to meet the needs of this population. In Vietnamese culture, the traditional family is valued highly, and elders are greatly respected. For example, to show respect, elderly patients and family members should be addressed with a slight bow of the head. Certain hand gestures may be offensive to this population, such as placing your hand on your hip while speaking.

The assessment also revealed significant health disparities within the community as well as cultural and language barriers preventing access to vital services. In 2016, the city of San Jose (the largest city in SCFHP's service area), a city with one of the largest Vietnamese population in the nation, opened its first Vietnamese American Community Center; known as the Shirakawa Community Center. The center demonstrates a need in the community for a place that celebrates the Vietnamese culture and provides services for the growing demographics. Having a dedicated center for the Vietnamese community provides immigrants, refugees, youth, and seniors with a center that meets cultural needs to call their own.

The findings of the SCCPHD assessment also resulted in a recommendation by the Office of the County Executive to construct the Vietnamese - American Service Center; a health center that honors the Vietnamese culture and is expected to open its doors in summer 2021 in the city of San Jose. The service center will deliver integrated, accessible and culturally responsive social and health services to support the local community, specifically the Vietnamese - American community. Its fundamental goal is connecting the community to the County services they need, in a seamless and collaborative model. The service center model will bring key County agencies together, to work in collaboration and address the overall needs of the Vietnamese community.

Hispanic/Latino

Studies showed that Hispanics/Latinos are the third largest racial/ethnic group in Santa Clara County and are projected to be the largest group by 2050. As the Latino/Hispanic population grows, the public health system in the county will continue to expand and adjust to meet changing health needs.

In 2017, at the request of the Santa Clara County Board of Supervisors, the Santa Clara County Public Health Department conducted a study on Latino/Hispanic health, with the goal of providing information that can be used to generate solutions to health issues within this population. The study showed that reliance on traditional medicine and health practices is common among Latinos/Hispanics. Culture is central in their health habits and due to the influence of traditional medical beliefs and health practices, many Latinos/Hispanics may simultaneously seek the help of both Western medicine and traditional healers.

Latinos/Hispanics have a deep rooted tradition of looking to extended family members and close family friends for emotional support and resources, which may support healthy behaviors and improve health. Family involvement in health care is common and health care providers are strongly advised to encourage such involvement and to include the family as a resource and focus of care in health planning, whether for individuals or a community. Faith and church remain powerful sources of hope and strength in the Hispanic community, especially in times of sickness.

Pacific Islander

A study by the Stanford School of Medicine reported that Pacific Islanders are a very diverse group and that it is important to avoid stereotyping. The study showed that in order for the clinical interaction to be meaningful, Pacific Islanders need to develop a sense of trust with their health care providers. They may initiate this process by trying to establish a "connection" with their physician or health care provider. This connection may involve questions to the provider regarding the community lived in, the school attended or work places. Not uncommonly, Pacific Islanders patients will start off the encounter by asking questions, trying to "find that connection".

In 2017, the County of Santa Clara Public Health Department (CSCPHD) completed an assessment which presented both secondary data and primary health survey data on Asian/Pacific Islander communities residing in Santa Clara County. Findings from this assessment served as a building block in the county's efforts to address health disparities in the Asian/Pacific Islander community. In 2018, the CSCPHD partnered with the Asian Americans for Community Involvement (AACI) to raise awareness of the unique issues affecting health and wellbeing of this population and to establish strategies to address key areas of concern for health, mental health and social determinants of health for Asian/Pacific Islanders and identified gaps in achieving healthy communities.

SCFHP has a provider network where members have access to medical and mental health services with providers who are sensitive to cultural diversity. For example, Gardner Health Services and Asian Americans for Community Involvement (AACI) are contracted provider groups who are dedicated to improving the health status of the communities we serve, especially the disenfranchised, disadvantaged and most vulnerable members. Gardner Health Services and AACI aligns with SCFHP's mission to provide high quality, comprehensive medical and mental health care, including prevention and education, early intervention, treatment and advocacy services which are affordable, respectful, culturally, linguistically and age appropriate..

SCFHP and its provider network recognizes that every member encounter is unique; every patient is different i n age, gender, ethnicity or religion and will bring to the medical encounter their individualized perspectives and experiences. Resources to increase awareness of cultural diversity are available to SCFHP's provider network and staff and are intended to help build sensitivity to differences and styles as a goal to improve patient- provider and patient-office staff communications and to foster an environment that is non-threatening and comfortable for Plan members.

To ensure provider awareness of cultural, racial and ethnic differences, SCFHP providers are required to complete a cultural competency training program, offered on SCFHP's website, which includes a Cultural Competency Toolkit with a guide on understanding cultural differences and how to establish effective communications with patients of all ethnic/racial and cultural backgrounds. Training objectives are to teach an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care.

Santa Clara Family Health Plan™

PROVIDER NETWORK THRESHOLD LANGUAGE ASSESSMENT– *Tables I - III shows the percentage of SCFHP network providers who speak threshold languages (Spanish, Vietnamese, Chinese and Tagalog).*

Table I: Primary Care Providers

Source: eVIps/ICAT

		Spanish (Member N=1,809)		Vietnamese (Member N=1,492)		Chinese (Member N=1,358)		Tagalog (Member N=345)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of	Providers-Tagalog	% of Providers
Family Practice	266	59	22%	36	14%	21	8%	6	2%
Internal Medicine	260	30	12%	31	12%	26	10%	6	2%

Table II: Specialists - High Volume/Impact

Source: eVips/ICAT

		Spanish (Member N=1,809)		Vietnamese (Member N=1,492)		Chinese (Member N=1,358)		Tagalog (Member N=345)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of Providers	Providers-Tagalog	% of Providers
Cardiology	178	15	8%	8	4%	11	6%	0	0%
Ophthalmology	260	58	33%	32	18%	46	26%	2	1%
Gynecology	363	75	29%	16	6%	20	8%	0	0%
Hematology/Oncolog	221	17	13%	11	%	11	%	1	1%

Table III: Behavioral Health Providers – High Volume

Source: eVIps/ICAT

		Spanish (Member N=1,809)		Vietnamese (Member N=1,492)		Chinese (Member N=1,358)		Tagalog (Member N=345)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of Providers	Providers-Tagalog	% of Providers
Psychiatry	147	24	16%	8	5%	8	5%	0	0%
Clinical Social Worker	43	12	28%	8	19%	2	5%	0	0%
Family & Marriage Therapy	22	2	9%	0	0%	0	0%	1	.05%

As noted in the report above, SCFHP does not have concrete data on provider ethnicity/race, therefore conclusions are drawn from the languages spoken by network providers. Tables I-III shows the number of network providers who can speak the top 4 languages and meet member cultural, ethnic/racial needs. The tables do not include provider staff who may also speak the top 4 languages and who may share the same cultural, ethnic/racial characteristics of SCFHP members.

Comparison from previous year assessment shows that the number of providers that speak threshold languages remained steady.

LANGUAGE LINE OR TRANSLATION REQUESTS

Table I: Member Language Line Requests

Language	Total Requests	Total Duration	% of Requests
Spanish	6,093	1,103 hrs	30%
Vietnamese	5,735	1,077 hrs	30%
Chinese	5,294	966 hrs	26%
Tagalog	1,210	159 hrs	6%

Table II: Member Face to Face Requests

Translation Type	Total Request	Total Duration	% of Requests
Sign Language	56	90 hrs	79%
Spanish	1	2 hrs	1%
Vietnamese	4	3 hrs	6%
Chinese	3	7 hrs	4%
Tagalog	0	0	0

In Tables I & II, it shows the language line and member face to face translation data was analyzed two different ways, one was through the frequency of language selected and second was the duration of the calls and face to face translation services.

Available access to interpreter services for members is a foundational element of Medicare - Medicaid plans. This could take the shape of telephonic or face to face interaction with a qualified interpreter. SCFHP provides this service through a vendor free of charge to its members and providers. SCFHP members have access to interpreter services 24 hours a day, 7 days a week. The plan also hires bilingual customer service representatives to further promote timely and quality access to language interpretation.

To ensure provider awareness of language assistance services and requirements, SCFHP providers are required to complete a cultural competency training program, offered on SCFHP's website, which includes a Cultural Competency Toolkit with a guide on using interpreter services. Training objectives are to teach an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care.

To further understand membership language diversity and potential barriers to care due to language barriers, as shown above in Section F (Tables I and II), SCFHP annually reviews data from its Language Line and Face to Face interpreter services reports.

The raw data showed that thirty four (34) different languages were requested for interpreter services; some of which are not frequently seen, such as Portuguese-Creole, Swahili, and Tigrinya. While there were several other languages requested for interpreter services, it does not appear that there is a growing population outside of the threshold languages identified and spoken by SCFHP members in this report.

MEMBER GRIEVANCES and CAHPS RESULTS

Table I. Member Language, Ethnicity/Race Complaints

Service Type	Language	Description	Quarter
Interpreter	Spanish	Member was dissatisfied with interpreter services in that the interpreter did not show up for the appointment, resulting in member utilizing an ipad device to communicate through.	Q1
Interpreter	Spanish	Member was dissatisfied with the quality of skills by the interpreter.	Q2
Interpreter	Spanish	Member reported no interpreter services were offered, which enabled communication that member needed to speak with Dr. due to member does not speak English.	Q4
Language Line	Spanish	Member was dissatisfied with the quality of service provided to her Grandmother. Member requested itemized statement to submit to SCFHP for reimbursement. Member speaks Spanish only and no one in the office spoke Spanish.	Q4

An assessment of member complaints against language/interpreter services and cultural/racial preferences was completed as indicated in the chart above and the resolution of those complaints are as follows:

--Language/Interpreter complaints (Q1) was reported to the Quality Cultural and Linguistics team who reported the incident to the language/interpreter vendor. The vendor indicated that the member was informed ahead of time that the interpreter was running late due to prior patient time running over, and informed member they would be using Video Remote Interpretation (VRI), the service is on an ipad and is similar to Skype as the Interpreter is live. The language line vendor assured that the complaint would be addressed with their staff and will continue to work on improving the quality of interpretation services

-- (Q2) Complaint was reported to the Quality Cultural and Linguistics team who reported the incident to the language/interpreter vendor. The language/interpreter vendor assured that the complaint would be addressed with their staff and will continue to work on improving the quality of interpretation services.

-- (Q4 – 2) the complaints were reported to the Quality Cultural and Linguistics team who reported the incidents to the language/interpreter vendor. The language/interpreter vendor assured that the complaints would be addressed with their staff and will continue to work on improving the quality of interpretation services.

The assessment on member complaints did not identify trending and the data showed complaints within acceptable limits.

Table II: CAHPS Results – Doctors Who Communicate Well

Question	2018	2019	2020	PY Change	Goal	Met/ Not Met
Q13. Providing clear explanation	83.50%	84.40%	85.90%	+1.50	90%	Not Met
Q14. Listening carefully	86.60%	88.00%	87.60%	-.40	90%	Not Met
Q15. Showing respect	87.90%	87.70%	90.20%	+2.50	90%	Met

As shown in Table II, the CAHPS 2020 results showed improved provider communications where Q13-providing clear explanation showed an increase in satisfaction at 1.50 percentage points, Q15-Showing respect at 2.50 percentage points, and Q14--Listening carefully at -.40 percentage points showed a slight decrease from 2019 but an increase from 2018 at 1.00 percentage points. Overall it appears that provider communications has improved.

Conclusion:

SCFHP and Santa Clara County officials has a long-standing commitment to the health and well-being of all its community regardless of race, ethnicity, age or gender. SCFHP will continue to partner with community stakeholders to help improve the overall health of its diverse membership.

The assessment revealed that there are no significant disparities in meeting member cultural, ethnic/racial and linguistic preferences, which concludes that member needs are being met overall; thus, no adjustments to the provider network are necessary at this time.

While SCFHP did not identify disparities to meet language or cultural needs of its members, the Plan will continue to seek available providers with diverse backgrounds and language skills to ensure member needs continue to be met. SCFHP will also continue to evaluate the needs of its members to ensure they receive the care and services they need in a culturally sensitive manner and in their preferred language.

PARTICIPANTS:
Provider Network Operations Data Analyst
Timely Access and Availability Work Group
Quality Improvement
Behavioral Health
Grievances and Appeals
Provider Relations

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee (QIC)		None

2020 POPULATION HEALTH MANAGEMENT IMPACT ANALYSIS

Quality Improvement Committee
June 9, 2021

PHM 6 Population Health Management Impact Report

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PHM 6: Population Health Management Impact Analysis

BACKGROUND/INTRODUCTION

Santa Clara Family Health Plan (SCFHP) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to residents most in need in Santa Clara County. Established in January 1997, SCFHP was created by the Santa Clara County Board of Supervisors whom elects a board of directors for residents and reflects the cultural and linguistic diversity of the community. In addition, SCFHP providers, employees, and Board of Governors live in the areas that the health plan serves.

In 2020, SCFHP provided health care coverage to over 9,800 seniors and persons with disabilities through the Cal MediConnect (CMC) program. The CMC program manages the Medicare and Medi-Cal benefits for these members. Members choose from a network of 541 Primary Care doctors, 3,091 Specialists, 9 hospitals, 30 community health centers, 239 ancillary providers and 174 pharmacies throughout Santa Clara County. Through active partnerships with healthcare providers and community partnerships, SCFHP achieved a seal of National Committee for Quality Assurance (NCQA) accreditation in 2018 and demonstrates that the managed care model can achieve the highest standard of care and successfully meets the individual needs of health plan members through the Population Health Management (PHM) Program as outlined in the Population Health Management Strategy.

PURPOSE

Annually, SCFHP measures the effectiveness of the PHM Strategy to ensure that we are providing valuable and meaningful services to our members. This is done through the measurement of effectiveness of program services and activities to meet benchmark goals developed around specific areas of focus and targeted populations. The annual PHM Impact Analysis analyzes the impact of achieving quality outcomes for members through care management services and outlines new strategies to implement when opportunities for improvement are identified. This is performed through interpretation and quantitative comparison of results with established benchmarks set for relevant clinical, cost/utilization, and member experience measures:

- Clinical measures evaluate the comparison of incidence or prevalence rates for desirable or undesirable health outcomes or the clinical performance based on practice guidelines and clinical specifications for 4 focus areas designated by the PHM Strategy.
- Cost/utilization measures evaluate cost, resource use by occurrence or outcomes that demonstrate a desirable increase or decrease in utilization.
- Experience measures member feedback sourced from member satisfaction surveys and member complaints flagged by Grievance and Appeals specific to Complex Case Management (CCM).

This annual PHM Impact Analysis is reviewed at the Quality Improvement Committee (QIC) meeting, chaired by the Chief Medical Officer (CMO) and drives the PHM Strategy for the following year. The PHM Impact Analysis includes a quantitative and qualitative analysis of Case Management programs performed by the Population Health Management (PHM) Workgroup which includes the Manager and Director of Case Management, Director of Quality & Process

Improvement, Director of Long Term Services and Supports, Manager of Behavioral Health and NCQA Project Manager.

PHM Focus Areas & Target Populations

The focus areas and target populations of the PHM program focuses on a whole-person approach to identify members at risk and to provide strategies, programs, and services to mitigate or reduce that risk. We also aim to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions. SCFHP promotes a program that is both sustainable, person and family-centered, and enables CMC members to attain their personal health goals. We do so by providing timely access to appropriate, coordinated health care services and community resources, including home and community-based services and behavioral health services. SCFHP's plan of action for each of the Focus Areas include measurable goals for specific targeted member populations.

Focus Areas:

1) Keeping Members Healthy
2) Managing Members with Emerging Risk
3) Managing Multiple Chronic Illnesses
4) Patient Safety or Outcomes Across Settings
5) Member Experience with PHM Programs

Focus Area 1: Keeping Members Healthy

Focus Area Goal: Increase the number of newly enrolled CMC members with no claims or utilization data to have an annual wellness visit within 365 days of their enrollment by 5 percentage points compared to the prior year results.

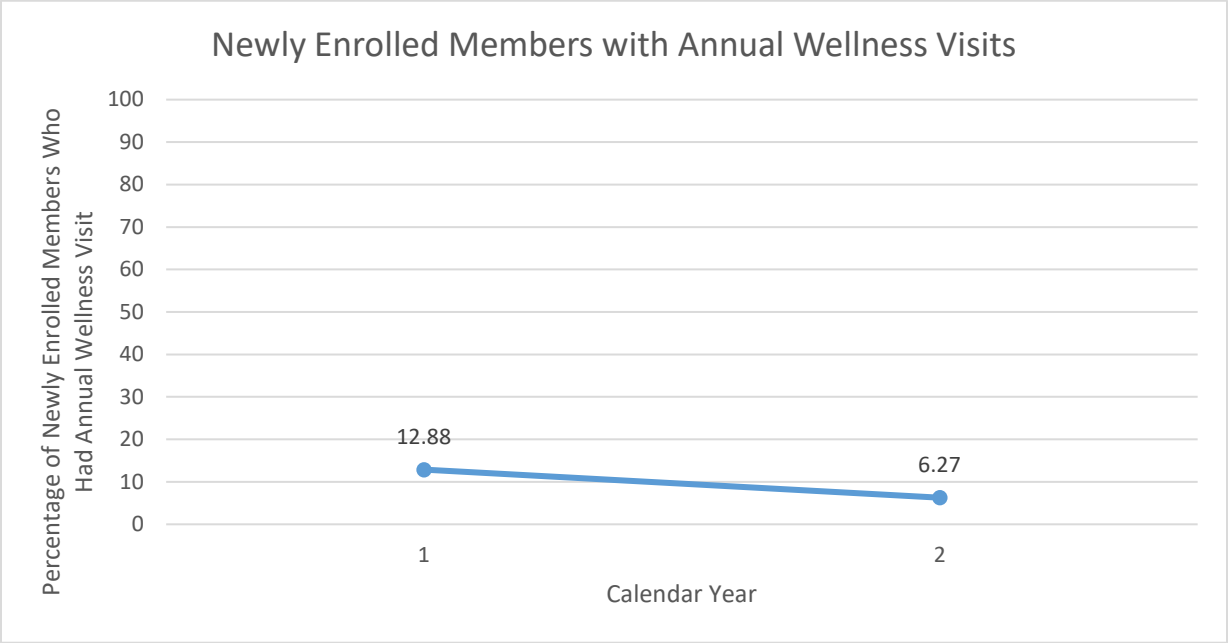
Goal Relevance Statement: Based on analysis of Information Technology (IT) Risk Stratification data, utilization information on many of our newly enrolled CMC members was minimal. Annual Wellness Visits (AWV) are critical to maintaining the health of all CMC members.

Population Targeted: All CMC members not residing in a skilled nursing facility (SNF).

Programs & Services: Basic Case Management, Transitions of Care (TOC), Provider Engagement.

Utilization Measure Methodology: This study compares the rate of in office Annual Wellness Visits of the 2,282 newly enrolled Cal MediConnect members in CY 2020 to the rates of in office Annual Wellness Visits for the 3,890 newly enrolled members in CY 2019. The analysis is based on the paid claims for office-based primary care visits billed services codes G0438 & G0439 of all CMC members from January 2020 – December 2020.

Quantitative Analysis:



The Annual Wellness Visit (AWV) Graph shows in 2019, 501 out of 3,890 of the newly enrolled members had one or more in-office Annual Visit encounters for a total of 12.88% of the newly enrolled population. In 2020, 143 of the 2,282 newly enrolled members who had one or more Annual Wellness Visit encounters for a total of 6.27%. A 10.43% negative percent change was noted in the current measurement year.

For members who are managed by specialists, an in-home Initial Health Assessment (IHA) is completed by an external vendor. In 2019, 41.49%, or 1,1614 of the 3,890, newly enrolled members received an IHA compared to 29.62%, or 676 of the 2,282, newly enrolled members in 2020.

This Focus Area goal was not met as we identified a significant decrease in members who received an Annual Wellness Visit. This may largely be due to many providers had office closures during CY 2020 due to restrictions related to the novel coronavirus, COVID-19. Even after provider offices and clinics reopened, many members may have avoided leaving their homes for fear of contracting the virus. In addition, many members may not have known that telephonic or video visits were available and/or they may not have the appropriate equipment to accomplish this. In-home IHA also had a decrease as many members may not have wanted individuals to enter their home outside of their immediate circle with whom they live for fear of introducing the virus into their home.

Care Coordination staff will continue to educate the members on the importance of seeing their PCP for an Annual Wellness Visit. In order to increase engagement and collaboration with the members, the PHM Workgroup will develop and implement new ways to ensure regular follow up with the member occurs throughout the year by the Care Coordination staff. We will continue to send IHAs to PCPs in our ongoing collaboration with PCPs.

PHM Work Group Qualitative Analysis & Opportunities for Improvement

Priority	Barrier	Opportunity	Action	Status
1	Inability to do in-person visits with limited Primary Care Provider (PCP) availability due to office closures	Increase member education and engagement and provide assistance to members who need assistance to access their PCP	Continue to remind members the importance of seeing PCP for AWV during initial and annual Health Risk Assessment (HRA) outreach and Individual Care Plan (ICP) development Develop and implement follow up outreach throughout the year for members who did not complete AWV and offer assistance	Ongoing Complete by Q3 2021
2	Members may not be aware that telehealth visits are available or be able to access telehealth visits	Educate members on the availability of telehealth visits and how it works	Case Coordination staff will make members aware of the availability of telehealth visits through during initial and annual Health Risk Assessment (HRA) outreach and Individual Care Plan (ICP) development Assist members to make telehealth visits with PCP if needed	Ongoing Ongoing
3	Members with Chronic Conditions managed by Specialist rarely adequately engage with PCP for annual visits.	Provide in-home Initial Health Assessment information to PCPs Through the ICP/ICT process	Care Coordination staff will continue to review Initial Health Assessments (IHA) and notify PCP.	Ongoing

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to increase the AWV percentage for the next measurement year.

Focus Area 2: Managing Members with Emerging Risk

Focus Area Goal: Increase glycated hemoglobin (HbA1c) control rate by 2 percentage points compared to baseline

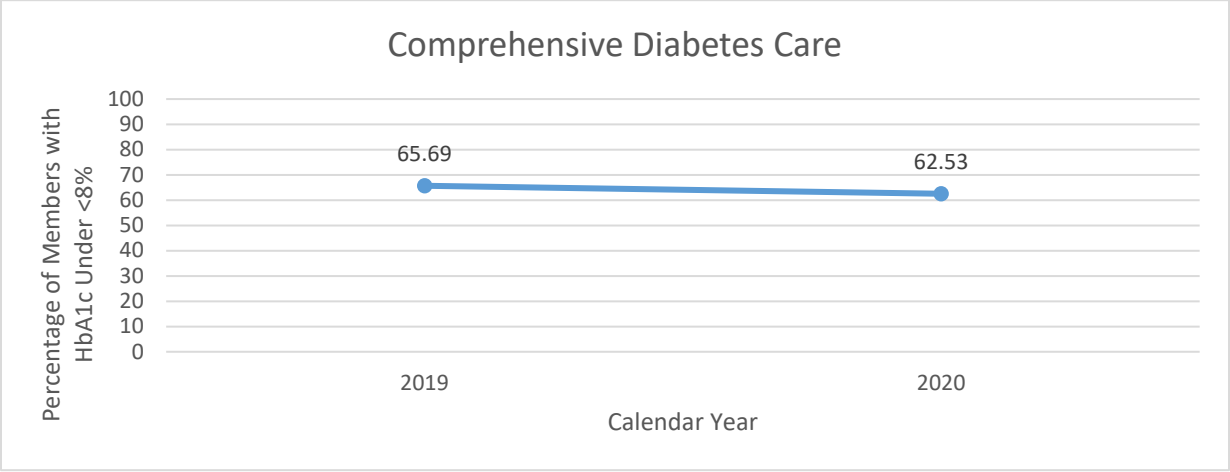
Goal Relevance Statement: Within SCFHP CMC line of business, there are 1,450 or 18% of members that meet the HEDIS definition of diabetes. The plan also has a larger population of Hispanic and Asian members who are at higher risk for diabetes. Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts decrease HbA1c and improve diabetic health outcomes for members.

Population Targeted: All members with a controlled chronic condition of diabetes with an HbA1c over 8%

Programs & Services: Basic Case Management, Complex Case Management, Health Education, Provider Engagement, Behavioral Health (SMI), Gaps in Care

Control Rate – Methodology: Data is gathered through claim/encounter data and pharmacy data. SCFHP uses both methods to identify the eligible population. Claims data includes members who are is identified through either method are included the sample. Members who have at least one acute inpatient encounter or at least 2 outpatient on different dates of services due to diabetes diagnosis. Pharmacy data includes members who were dispensed insulin or hypoglycemic / antihyperglycemics on an ambulatory basis during the measurement year. CPT codes are isolated to identify members most recent HbA1c level is <8.0% out of those that are not <8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Medical records are reviewed, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result.

Quantitative Analysis:



The Comprehensive Diabetes Care graph illustrates the percentage of members whose HbA1c was less than 8%. In 2019, the Comprehensive Diabetes Care Control Rate was 65.59%, or 270 of the 411 diabetic members whose HbA1c was lower than 8%. In 2020, this percentage decreased to 62.53%, or 411 of the 257 members. This outcome does not meet the goal of a 2 percentage point increase.

Due to restrictions and fears related to COVID-19, the negative percentage change may be due to members not wanting to leave their home for otherwise regularly scheduled follow up appointments and/or HgA1c testing. A change in diet may also have contributed as members and members' family may not have had access to fresh produce and resorted to an increase in processed foods due to the longer shelf life to reduce the need of going to the grocery store.

PHM Work Group Qualitative Analysis & Opportunities for Improvement:

Priority	Barrier	Opportunity	Action	Status
1	Members have difficulty maintaining blood glucose levels	Develop and implement Diabetes program to provide education and assist with coordinating care	Identify target population	Complete by Q3 2021
			Identify necessary actions to effectively manage diabetes	Complete by Q3 2021
			Implement targeted outreach to members to assist with obtaining necessary equipment and services	Complete by Q3 2021

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to increase the CDC percentage for the next measurement year.

Focus Area 3: Managing Multiple Chronic Illnesses

Focus Area Goal: Reduce the number of members with multiple unmanaged chronic conditions who also have had 3 or more avoidable Emergency Department (ED) visits in the past year, by 10 percentage points.

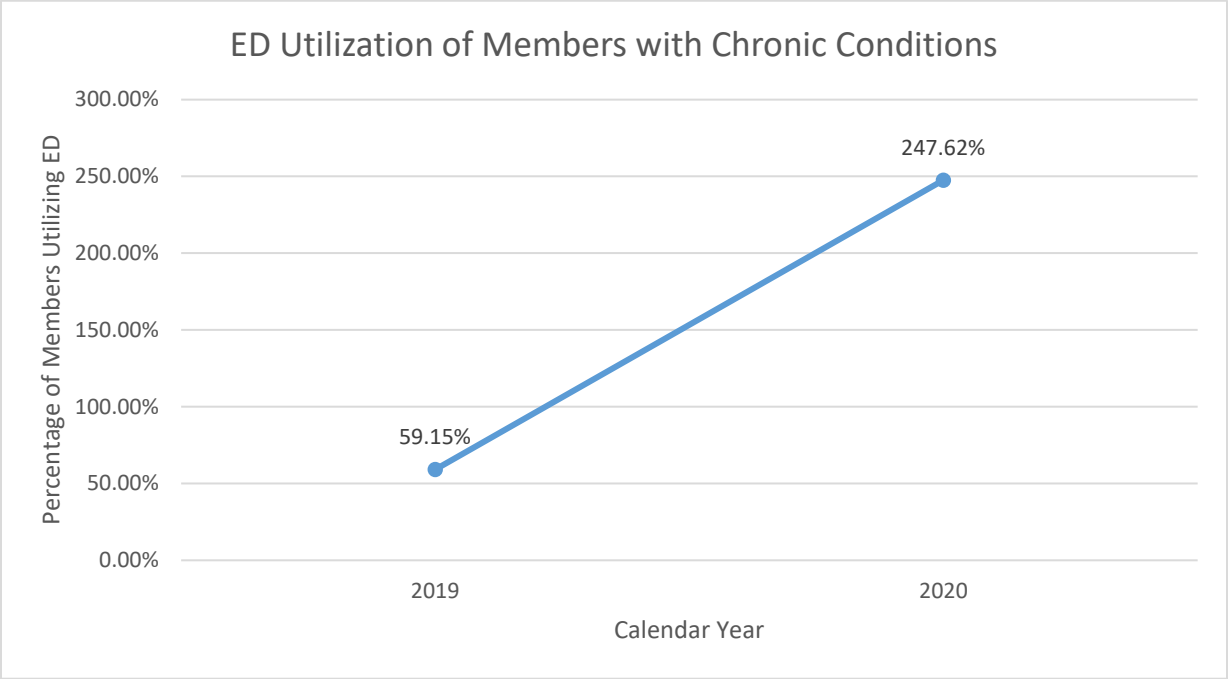
Goal Relevance Statement: Unmanaged multiple chronic conditions often results in avoidable ER utilization.

Population Targeted: Members who had one or more unmanaged chronic condition(s) that resulted in 3 or more ED visits in 2020 at a safety net hospital within Santa Clara County.

Programs and Services: Complex Case Management, Medication Therapy Management, 24 Hour Nurse Advice Line

Utilization Measure – Methodology: This study compares the amount of ED utilization in 12 months compared to the same targeted population in the measurement year.

Quantitative Analysis:



This graph illustrates a large increase in ED utilization by members with chronic conditions. In 2019, 71 of the members who had chronic conditions had 42 ED utilization. This drastically increased in 2020 where 42 members had 104 ED utilization.

The increase in ED utilization may be the result of decreased specialist availability, decreased willingness to attend follow up appointments, and decrease in medication adherence due to restrictions and closures related to COVID-19.

There is opportunity for increased follow up post ED utilization for further assessment of the member's needs. With targeted outreach, Care Coordination staff will be able to assist with obtaining necessary equipment and services to better manage the member's chronic condition that contributes to ED utilization.

PHM Work Group Qualitative Analysis & Opportunities for Improvement:

Priority	Barrier	Opportunity	Action	Status
1	Lack of ED follow up	Utilize available ED census data from safety net hospitals to target outreach and follow up	Develop and implement workflow for Care Coordination staff follow up post ED utilization	Complete by Q3 2021
			Provide education on available non-emergent services like the 24 Nurse Advise Line and	Ongoing

Priority	Barrier	Opportunity	Action	Status
			contracted urgent care clinics	

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to decrease ED utilization for the next measurement year.

Focus Area 4: Patient Safety or Outcomes across Settings

Goal: Decrease 30 Day Readmission rate for CMC members by 1 percentage point.

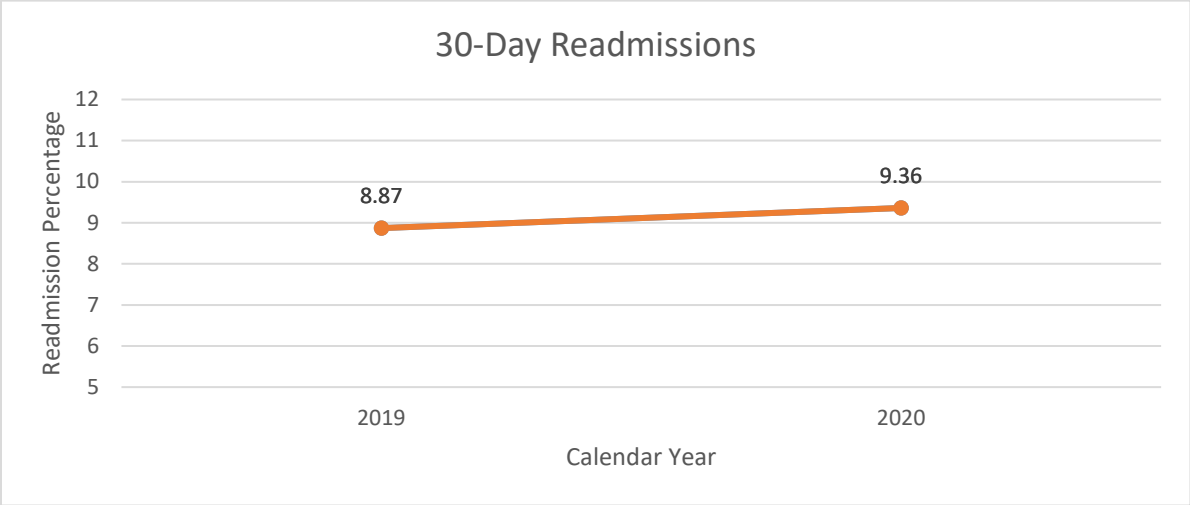
Goal Relevance Statement: Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members. Through targeted outreach as the member moves across the care continuum between different settings of acute care, long term care, behavioral health and home and community based settings, potential gaps will be identified and assistance will be provided to improve continuity of care.

Population Targeted: Members readmitted within 30 days of discharge

Programs & Services: Transitions of Care (TOC), Complex Case Management

Utilization Measure – Methodology: This study evaluates the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Quantitative Analysis



The 30-Day Readmission Graph illustrates in 2019 Plan All-Cause Readmissions (PCR) Observed Readmission Rate was 8.87% compared to 2020 which was 9.36% resulting in an increase of PCR. In 2019, there were 87 readmissions of the 981 hospitalizations compared to the 84 readmissions out of 897 in 2020.

The increase in readmissions may be due to decrease PCP and specialist availability for follow up in combination with unsafe discharges due to the overcrowding in hospitals related to COVID-19. The updated Transitions of Care program will be monitored closely for effectiveness. Priority will be put on Targeted Case Management programs along with automation opportunities and platform updates.

PHM Work Group Qualitative Analysis & Opportunities for Improvement

Priority	Barrier	Opportunity	Action	Status
1	Transitions of Care program was fragmented between business units	Reduce gaps as members move across the care continuum	Monitor newly implemented Transition of Care program for effectiveness	Ongoing
2	Increase collaboration with PCP	Collaborate with PCP and appropriate specialist for disease management	Notify PCPs of discharges Assist members to make follow up appointments with PCPs and specialists	Started In June 2021 Started in June 2021

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to decrease ED utilization for the next measurement year.

Focus Area 5: Member Experience with CCM

Santa Clara Family Health Plan (SCFHP) monitors Cal MediConnect (CMC) members' experience with Complex Case Management (CCM) Program with the goal of reaching a 90% or better satisfaction rating. The purpose of measuring member satisfaction for CM specific programs is to ensure adequate satisfaction with the program and that the program objectives are achieved. Annually, SCFHP completes an analysis which incorporates member survey questions and complaints related to CMC Complex case management services. This analysis allows the organization to identify opportunities for improving the CM and CCM program services through action plans in order to provide the highest quality of case management services. Annual survey results contribute to the overall Population Health Management (PHM) program effectiveness evaluation.

Process

Santa Clara Family Health Plan measures CCM program effectiveness and overall member satisfaction with the Complex Case Management services through quarterly reporting and annual monitoring of complaints from members related to Complex Case Management services by performing regular CCM member satisfaction surveys. All members that were enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of CM services. Members that meet inclusionary criteria are outreached by phone at least twice and are

offered assistance to complete the survey in their preferred language. Surveys are completed in the CM platform Essette. All survey responses are captured and reported by IT. Additionally the Grievance and Appeals department flags member complaints and reports them to CM leadership. Case Management leadership receives a report of survey outcomes and grievances and completes an annual analysis of all member experience data.

Satisfaction measures:

1. Information about the overall program.
2. The program staff.
3. Usefulness of the information disseminated.
4. Members' ability to adhere to recommendations.
5. Percentage of members indicating that the program helped them achieve health goals.

CCM Member Satisfaction Survey Inclusion Criteria:

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

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

Methodology

Essette case management was configured to house the survey assessment. Case Management staff conduct 2 telephonic outreach calls and document the outcomes with in the survey assessment. Then number of members who are reached to complete the survey is a subset of the number of members that the health plan attempted to reach. Survey responses are data entered the survey assessment in real time by Personal Care Coordinators (PCCs). Survey responses can be provided by member or formal/informal caregiver on record. Survey responses are scored based on the members answer to the questions. Answers are scored as follows Strongly Agree/Very Satisfied, Agree/Satisfied, Disagree/Somewhat Satisfied, and Strongly Disagree/Not at all Satisfied. Percentage for each response will be rounded up to report in whole numbers. Overall goal is to have members respond "agree or "strongly agree" for questions 1-15 and "satisfied" or "very satisfied" for question 16 for an overall satisfaction percentage rate of 95% or better. Members are also encouraged to leave feedback which is documented in the comments section. Survey responses are collected annually throughout the look back year starting January 1, 2020 through December 31, 2020. Survey responses were pulled into the CCM survey response report and analyzed.

Member Complaints

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

CCM Satisfaction Survey Results

2020 CCM Satisfaction Survey	Strongly Disagree		Disagree		Agree		Strongly Agree		Goal Met
Total Survey Sample: 21 Members enrolled in CCM in CY 2020	#	%	#	%	#	%	#	%	Y/N
The Program Staff		**0**		**0**					
My case manager treated me with respect	0	0	0	0	9	42.9	11	52.4	Y
My case manager listened to what I had to say.	0	0	0	0	15	71.4	6	28.6	Y
My case manager returned my phone calls in a timely manner.	0	0	0	0	18	85.7	3	14.3	Y
Usefulness of Information									
My case manager helped me find services that I needed.	0	0	0	0	20	95.2	1	4.8	Y
My case manager involved me in discussing and planning my care.	0	0	0	0	19	90.5	2	9.5	Y
I better understand my disease or condition after being in the case management program.	0	0	0	0	21	100.0	0	0.0	Y
My case manager helped me better communicate with my providers.	0	0	0	0	21	100.0	0	0.0	Y
Ability to Adhere to Recommendations									
I am able to better manage my health and health care after being in the case management program.	0	0	0	0	21	100.0	0	0.0	Y
I know what to do if I need help.	0	0	0	0	21	100.0	0	0.0	Y
I know what to avoid when it comes to my health conditions.	0	0	0	0	18	85.7	3	14.3	Y
Members Indicating that the Program Helped Them Reach Their Health Goals									
I feel like I have achieved my CCM goals.	0	0	0	0	20	95.2	1	4.8	Y
My situation is better because of my case manager's help.	0	0	0	0	19	90.5	3	14.3	Y

I feel ready to transition to a lower level of case management.	0	0	0	0	21	100.0	0	0.0	Y
Overall Program									
My Care Plan was clear and easy to understand.	0	0	0	0	20	95.2	1	4.8	Y
My input was considered when developing my plan of care.	0	0	0	0	21	100.0	0	0.0	Y
Overall, how satisfied are you with the Case Management Services you received?	**Very Unsatisfied**		**Dissatisfied**		**Satisfied**		**Very Satisfied**		**Goal Met**
Total	0	0	0	0.00%	16	76.2	5	23.8	Y

PHM Work Group Qualitative Analysis & Opportunities for Improvement

SCFHP met the 90% performance goal in focus areas

1. Information about the overall program (100%)
2. The Program staff (100%)
3. Usefulness of the information disseminated (100%)
4. Members ability to adhere to recommendations (100%)
5. Percentage of members indicating that the program helped them reach their health goals (100%)
6. Member Complaints (0)

The CCM program was effective in managing members with multiple unmanaged chronic conditions and impacting better health outcomes among those enrolled in the program for greater than 60 days. Enrollees and their caregivers have benefited from intensive care coordination support to address complex medical, psychosocial, and social determinants of health needs. Through the CCM program, the risk of adverse health outcomes for members decreased by linking members with doctors, pharmacy, specialty and DME providers in collaboration with the Interdisciplinary Care Team.

The Member Satisfaction surveys showed that 100% of members who engaged in the CCM program had better health outcomes due to actions directly related to linkage to covered benefits and community based services. Members agreed that overall the information provided by their CMs was useful, easy to understand and helped them reach their health goals.

Opportunities for improvement:
Priority will be put on Targeted Case Management programs, such as this, along with automation opportunities and platform updates to increase member engagement with Care Coordination staff.

Moderate CM Satisfaction Survey Results

NCQA 2020 Behavioral Health Member Survey		I Don't Know		No		Yes		Totals		Average Score	Performance Percentage	Goal Met
NCQA Area	Questions	#	%	#	%	#	%	#	%			Y/N
Overall Program Information	Overall, how satisfied are you with the Case Management Services you received?	-								8.1	81%	N
Program Staff	My case manager treated me with respect.	-								9.6	**96%**	**Y**
	My case manager listened to what I had to say.	-								9.3	**93%**	**Y**
	My case manager returned my phone calls in a timely manner.	-								8.3	83%	N
Usefulness of Information disseminated	Did you customize a care plan with behavioral health at SCFHP?	0	0%	1	4.3%	22	95.7%	23	100%	-	**95.7%**	**Y**
	My case manager involved me in discussing and planning my care.	-								9.0	**90%**	**Y**
	My case manager helped me find the benefits and community resources that I needed.	-								8.1	81%	N
	My case manager helped me better communicate with my providers.	-								8.2	82%	N
	I found the information my CM provided to be useful.	-								8.6	86%	N
Member's ability to adhere to recommendation	Did participating in BH help you to follow your treatment recommendations?	5	22.7%	2	9.1%	15	68.2%	22	100%	-	68.2%	N
	I know what to avoid when it comes to my health conditions.	-								8.7	87%	N
	I know what to do if I need help.	-								8.2	82%	N
Achieving member health goals	My situation is better because of my case manager's help.	2	9.1%	3	13.6%	17	77.3%	22	100%	-	77.3%	N
	I feel like I have achieved my health goals.	3	13.6%	6	27.3%	13	59.1%	22	100%	-	59.1%	N

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to increase member engagement and satisfaction with the assistance provided by Care Coordination staff.

NCQA 2020 BH Member Experience Survey Results Analysis

The Santa Clara Family Health Plan (SCFHP) – Behavioral Health Program set a goal to achieve 90% member satisfaction in four of five NCQA areas. A member experience survey was administered to SCFHP members who were both enrolled in the Cal Mediconnect (CMC) line of business and participated in behavioral health program case management services. One hundred CMC members were identified for contacting. A total of 23 responded to the survey. The five NCQA

areas include, information about the overall program, the program staff, usefulness of the information disseminated, member's ability to adhere to recommendations, and percentage of members indicating the program helped them reach their health goals. Respectively, the areas scored 81%, 90.7%, 86.9%, 79.1% and 68.2%.The overall satisfaction with behavioral health case management services received was 81%.

A focus group was conducted with SCFHP behavioral health (BH) case management staff to present the findings and identify barriers and areas of opportunity to improve member satisfaction in areas that scored below 80%. The following survey questions/statements scored below 80% and were the primary focus of the discussion;

- Did participating in BH help you to follow your treatment recommendations? (68.2%)
- My situation is better because of my case manager's help. (77.3%)
- I feel like I have achieved my health goals. (59.1%)

The group identified a variety of barriers to achieving member health goals and treatment adherence including member cognitive limitations, language barriers, health literacy, care giver support, coordination of transportation services, substance use, case management intensity, treatment confidentiality, and member's lived experience with other case management programs. Limited communication/collaboration with community partners and member engagement were identified as the primary barriers to achieving member health goals. BH case management staff suggested that implementing strategies to address these barriers should be the focus for the program moving forward. The group highlighted that members may be participating in multiple case management programs that they may be unaware of. Lack of communication and coordination between SCFHP and these alternate programs may create confusion and a misalignment of health goals if members have active care plans with multiple organizations. Participants also stated concerns with unengaged members and advised that a follow up process should be implemented to outreach to these members.

The group identified that these barriers present an opportunity to strengthen professional relationships and community partnership. The Behavioral Health Program seeks to accomplish increased collaboration with external behavioral health program partners by more clearly defining the population it serves, exploring opportunities to improve communication between Santa Clara County and SCFHP behavioral health case managers, and providing program education to community clinics. To improve member engagement and follow up, the behavioral health program seeks to implement a procedure to track unengaged members and conduct progressive outreach accordingly.

NCQA Area	Performance Percentage	Goal Met ≥ 90% performance
Information about the overall program	81%	No
The program staff	90.7%	Yes
Usefulness of the information disseminated	86.9%	No
Members ability to adhere to recommendations	79.1%	No
Percentage of members indicating that the program helped them reach their health goals	68.2%	No

Opportunities for improvement:
Priority will be put on Targeted Case Management programs, such as this, along with automation opportunities and platform updates to increase member engagement with Care Coordination staff.

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to increase member engagement and satisfaction with the assistance provided by Care Coordination staff.

Conclusion
Members and their caregivers have benefited from intensive support from Care Coordination, however, there is still need for improvement of expanding the criteria to enroll more members into Targeted Case Management programs.

The PHM Workgroup will continue establish action plans and evaluate the accuracy of actual CM impacts on this target group with in the greater HEDIS CDC metrics and consider different reporting strategies. Additionally staff will be provided additional training on case management best practices and in-services on the latest technologies in specialty diabetic supplies and resources to support new approaches to diabetic management.

CM programs continue to strive to keep members healthy through comprehensive annual wellness assessment and preventative screenings. Members who complete an Annual Wellness Visit (AWV) are more likely to receive important preventive care services like vaccines and cancer screenings than those who do not. In office AWVs focus on members self-identified health status, psychosocial, socio-economical, past medical history, level of independence and other potential risk factors. Due in part to the large CMC population and the number of members who rely on Specialty Care above Primary Care SCFHP contracted with Signify Health to complete in-home Initial Wellness Assessments (IHA). Initial Health Assessments are performed by nurse practitioners in the member's home and are comparable to in office AWVs. CM success in meeting this measure is largely due to evaluation and transmission of valuable assessment information to providers as well as member education on the importance of preventative screenings.

Targeted Case Management Programs identify members at risk and aim to promote safety across with additional evaluation and follow up. The value of connecting members with their PCP for discharge follow up has been shown to decrease the likelihood for readmissions. CM support post discharge promotes greater linkage to follow up services and ongoing management support through regular outreach and follow up to assist the member meets their health care goals.

Upcoming Improvements

In addition to increased collaboration within business units, many automation opportunities have also been identified to explore with IT. This, coupled with an anticipated platform version upgrade and updated and new procedures and workflows, will simply the work for Care Coordination staff so the focus will be on best assisting the member with care coordination needs.

Santa Clara Family Health Plan™

Population Health Management Strategy 2021

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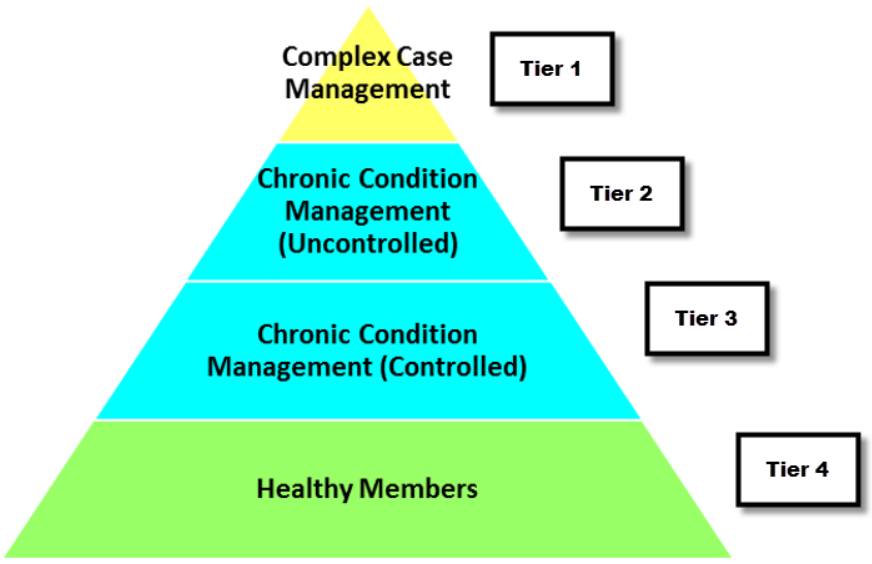
I. Comprehensive Population Health Management Strategy

In accordance with the NCQA 2021 Standards and Guidelines for the Accreditation of Health Plans, Santa Clara Family Health Plan (SCFHP) has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care, including the community setting, through participation, engagement and targeted interventions for a defined population. The framework is designed to address the four focus areas of population health, as outlined by NCQA, and in compliance with regulatory requirements set forth by the Center for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and Department of Managed Health Care (DMHC).

At a minimum, annual evaluations of the various elements of this Population Health Management (PHM) strategy will assess the Plan's performance against the Institute for Healthcare Improvement (IHI) Triple Aim dimensions to improve patient experience of care, improve the health of populations, and reduce the per capita cost of healthcare.

The member population is segmented into subset targeted populations based off assessment of population needs and there are specific programs and services to address the four focus areas. To accomplish this, SCFHP has developed a tier of programs and qualifying populations that would be eligible for each program. This tier stratification is applicable to both the Cal MediConnect (CMC) and Medi-Cal (MC) lines of business.

Populations Targeted for PHM:



A. Tier 1: Complex Case Management (CCM) Eligibility Criteria

Members who have 3 or more hospitalizations in the past year and one other Tier 1 criteria *or* members who meet three or more Tier 1 criteria:

- Age 75+ with 3 ADLs (as identified through the Health Risk Assessment)
- >3 Emergency Department (ED) visits in the past year
- Hospitalized in the past 180 days
- Member has a diagnosis of Dementia (as identified through claims data)
- 3 or more chronic conditions and at least one uncontrolled*

  **Uncontrolled is defined as 1 ED Visit or Inpatient stay within the past year, with a primary diagnosis of the member's chronic condition*

B. Tier 2: Chronic Condition Management Uncontrolled Eligibility Criteria

Newly enrolled members with no claims or utilization history *or* members that have at least one of the below criteria AND have at least one chronic condition that is uncontrolled:

- 75+ with 3 ADLs (as identified through the Health Risk Assessment)
- >3 ED Visits in the past year
- Hospitalized in the past 180 Days
- 3 or more hospitalizations in the past year
- 1 or more Social Determinant of Health (as identified through Health Risk Assessment)

OR

- Member is enrolled in the Multipurpose Senior Services Program (MSSP) or Community Based Adult Centers (CBAS) or In Home Supportive Services (IHSS)
- Member has uncontrolled symptoms of severe mental illness (SMI) (as identified through psychiatric admissions data)
- Member has been identified as homeless (through demographic data such as address or diagnosis code)

C. Tier 3: Chronic Condition Controlled Member Eligibility Criteria

Members that do not meet criteria for Tier 1 or 2 *and* have more than one controlled chronic conditions, and have greater than $3,000 claims costs per year after facility and pharmacy costs are removed, *or*

- Member is in Long Term Care (LTC) in a skilled nursing facility (SNF) with no discharge plan
- Member has been admitted to Hospice within the last 12 months
- Members with chronic conditions and SMI who are able to access primary and specialty services

D. Tier 4 Healthy Members Eligibility Criteria

All other members that do not meet criteria for Tiers 1-3 are eligible for Tier 4.

II. Population Health Program Focus Areas

SCFHP aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions. The following four areas of this strategy focus on a whole-person approach to identify members at risk and to provide strategies, programs and services to mitigate or reduce that risk:

1) Keeping members healthy
2) Managing members with emerging risk
3) Promoting member safety and positive outcomes across settings
4) Managing multiple chronic illnesses

III. Population Health Management Programs and Services by Focus Area

SCFHP promotes a program that is both sustainable and member-centered, and enables beneficiaries to attain or maintain personal health goals. This is done by providing timely access to appropriate, coordinated health care services, community resources, including home and community-based services, and behavioral health services.

Table 1: Programs and Services by Focus Area

Programs & Services	LOB		NCQA Focus Area				Tier
	CMC	MC	Keeping Members Healthy	Managing Members with Emerging Risk	Patient Safety or Outcomes Across Settings	Managing Multiple Chronic Illnesses	
Complex Case Management	X	X		X	X	X	1
Moderate Case Management	X	X	X	X	X	X	2
Basic Case Management	X	X	X	X	X		3, 4
Long Term Care Transitions	X	X	X	X	X	X	3
Transitions of Care	X	X	X	X	X	X	1 to 4
Behavioral Health Severe Mental Illness	X		X	X	X	X	2 to 4
Provider Engagement	X	X	X	X	X	X	1 to 4
Nurse Advice Line	X	X	X	X	X	X	1 to 4
Utilization Management & Concurrent Review	X	X	X	X	X	X	1 to 4
Health Education	X	X	X	X			1 to 4
Health Homes Program		X		X	X	X	2 to 4

Community Resources Integration	X		X	X	X	X	1 to 4
Medication Therapy Management (MTM)	X					X	1 to 4
Gaps in Care	X	X	X	X	X	X	1 to 4

IV. Population Health Management Goals

SCFHP's plan of action for each of the focus areas include measurable goals for specific targeted populations as follows:

Keeping members healthy

Goal: Increase the number of newly enrolled CMC members with no claims or utilization data have an Annual Wellness Visit within 365 days of their enrollment by 5 percentage points compared to the prior year results

Goal Justification: Annual Wellness Visits are critical to maintaining the health of all CMC members. Based on analysis of IT risk stratification data, SCFHP frequently does not have utilization information on many of our newly enrolled CMC members.

Population Targeted: All CMC members who are not receiving LTC in a SNF

Managing members with emerging risk

Goal: Increase diabetic control rate by 2 percentage points compared to prior year results

Goal Justification Statement: The plan also has a larger population of Hispanic and Asian members who are at higher risk for diabetes. Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts decrease HbA1c and improve diabetic health outcomes for members.

Population Targeted: All members with a controlled chronic condition of diabetes with an HbA1c over %

Promoting member safety or positive outcomes across settings

Goal: Decrease 30 Day Readmission rate for CMC members by 1 percentage point compared to prior year results

Goal Justification Statement: Members discharged from an acute or skilled nursing facility setting are at high risk for readmission if members do not understand their discharge instructions and next steps to managing their condition. By improving continuity of care across acute care, long term care, behavioral health and home and community-based settings, we can decrease the risk of readmission to the hospital. Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members.

Population Targeted: Members who were recently hospitalized

Managing multiple chronic illnesses

Goal: Reduce the number of members with multiple chronic conditions with 3 or more ED visits at safety net hospitals in Santa Clara County (SCC) in the past year by 10 percentage points.

Goal Justification Statement: The number of CMC members visiting a safety net hospital in the last year more than doubled. Unmanaged multiple chronic conditions often results in avoidable ED utilization.

Populations Targeted: All CMC members with 3 or more ED visits in the last year at a SCC safety net hospitals

V. Population Health Management Goal Outcomes by Focus Area & Target Population

Segmentation by Focus Area: Keeping Members Healthy						
Goal	**Programs & Services**	**Targeted CMC Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of Membership**
Newly enrolled CMC members with no claims or utilization data have an annual wellness visit within 365 days of their enrollment by 5 percentage points compared to the prior year results	1. Basic Case Management	All Tiers	Opt-out	Interactive	9908	100%
	2. Nurse Advice Line	All Tiers	Opt-Out	Interactive	9908	100%
	3. Health Education	All Tiers	Opt-In	Interactive & Passive	9908	100%
	4. Wellness & Prevention	Per benefit	Opt-Out	Interactive & Passive	9908	100%
	5. Community Resource Integration	All Tiers	Opt-Out	Interactive	9908	100%
	6. Provider Engagement	All Tiers	Opt-Out	Physician Passive & Interactive	9908	100%
	7. Gaps in Care	All Tiers	Non-Member driven	Data Sharing	9908	100%

Segmentation by Focus Area: Managing Members with Emerging Risk						
Goal	**Programs & Services**	**Targeted CMC Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of Membership**
Increase diabetic control rate by 2 percentage points compared to prior year results	1. Basic Case Management	All Tiers	Opt-Out	Interactive	9908	100%
	2. Health Education	All Tiers	Opt-In	Interactive	9908	100%
	3. Provider Engagement	All Tiers	Non-Member directed	Physician	9908	100%
	4. Behavioral Health, Severe Mental Illness (SMI)	Tier 2	Opt-Out	Interactive	256	3%
	5. Gaps in Care	All Tiers	Non-Member driven	Data Sharing	9908	100%

Segmentation by Focus Area: Patient Safety across settings						
Goal	**Programs & Services**	**Targeted CMC Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of Membership**
Decrease 30 day Readmission rate by 1 percentage point	1. Basic Case Management	All Tier	Opt-Out	Interactive	9908	100%
	2. Transition Of Care (TOC)	All Tiers	Opt-Out	Interactive	9908	100%
	3. Long Term Care Transitions	Tier 2	Opt-Out	Interactive & Passive	256	3%
	4. Provider Engagement	All Tiers	Opt-Out	Interactive & Passive	9908	100%

Segmentation by Focus Area: Managing Multiple Chronic Illness						
Goal	**Programs & Services**	**Targeted CMC Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of Membership**
Decrease the number of members with 3+ ED Visits by 10 percentage points	1. Complex Case Management	Tier 1	Opt-In	Interactive	194	2%
	2. Moderate Case Management	Tier 2	Opt-Out	Interactive	256	3%
	3. Medication Therapy Management	All Tier	Opt-In	Interactive	9908	100%
	4. Nurse Advice Line	All Tiers	Per benefit	Interactive	9908	100%
	5. Behavior Health Case Management	Tiers 2-4	Opt-Out	Interactive	9714	98%

IV. Description of Case Management Program and Service Activities

Members are identified for case management through multiple sources, including but not limited to, eligibility files, medical and pharmacy claims data, Health Risk Assessment data and utilization management data. Members may also self-refer, or be referred by providers, discharge planners, caregivers, delegates, vendors and community partners.

Members are assigned to CM programs based on risk stratification, member's responses to the health risk assessment, additional assessments, clinical evaluation and consultation with members to determine their willingness to participate. Members can move between programs as appropriate to provide the most appropriate level of support at the time.

A. Case Management Activities:

Health Information Form/ Member Evaluation Tool (HIF/MET)

SCFHP uses the HIF/MET data to help identify newly enrolled Medi-Cal members who may need expedited services. It is included in the new member packet mailed to all newly enrolled Medi-Cal beneficiaries including a postage paid business reply envelope for response.

Within the 90 days of a new member's effective date of enrollment, SCFHP Production Services and the Customer Service Department oversee the receipt and processing of completed HIF/MET forms returned via USPS mail and all HIF/MET data is entered into Case Management platform, Essette. Members that need Case Management (CM) intervention are identified and escalated to CM immediately through Essette. Referrals from HIF/METs include an outbound call to the member to discuss the results and follow up on care coordination as needed. If the member falls within the Seniors and Persons with Disabilities (SPD) population, the HIF/MET is used to initiate the completion of a Health Risk Assessment (HRA) and any subsequent care coordination as appropriate.

In addition, SCFHP Customer Service (CS) conducts at least two outreach calls to members if a completed HIF/MET is not returned within 30 days of the member's enrollment date.

Long Term Services and Supports (LTSS) Assessment

Care Coordination for members enrolled in Long Term Services and Supports (LTSS) benefit programs who are dually eligible for Medicare and Medi-Cal and not enrolled in the Cal MediConnect line of business is provided in collaboration with LTSS providers. SCFHP retains and compiles a copy of assessments and care plans for members enrolled in Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and Long Term Care (LTC) in a skilled nursing facility. This information is documented in Essette and a designated LTSS Care Coordinator or Case Manager conducts a review to determine if further care coordination is needed.

Health Risk Assessment (HRA)

CMC and Medi-Cal SPD members are assessed upon enrollment and, at a minimum, on an annual basis using the Health Risk Assessment (HRA). This tool consists of questions related to health, psychosocial needs, and Social Determinants of Health (SDOH) to assess the members' understanding of their health status and to identify wellness goals and appropriate assignment for Case Management programs and services. All assessments completed are analyzed to adjust clinical risk level of members.

Individual Care Plan (ICP)

Upon completion of an HRA or through any demonstrated need, an Individual Care Plan (ICP) will be developed with the members' participation. The ICP is to include the member's goals and preferences, measureable objectives, and community resources as appropriate, to meet member-prioritized health care goals. The ICP will be shared with the member and their Primary Care Provider (PCP) and members are encouraged to share the ICP with anyone that provides care coordination to them. ICP's are updated based on the member's condition and preferences and, at a minimum, on an annual basis. Members who cannot be reached or who refuse to engage in the

ICP process will receive a preventative ICP with their assigned care coordinators contact information.

Interdisciplinary Care Team (ICT)

SCFHP will assist members to identify their Interdisciplinary Care Team (ICT) when a need is demonstrated or as requested by the member or the member's authorized representative. ICTs are comprised of professionals appropriate for the needs, preferences, and abilities of the member and will integrate the member's medical care, LTSS needs, and behavioral health services as appropriate. The members' ICT will be led by professionally knowledgeable and credentialed personnel that will include, at a minimum, the member, individuals approved by the member, County In-Home Support and Services (IHSS) social worker, the member's Primary Care Provider, and SCFHP Care Coordination staff. Additional providers, such as social workers, specialists, LTSS providers, community-based case managers, and caregivers are included at the request of the member. The ICT collaborates with the member to stabilize medical conditions, increase compliance with the ICP, and meet ICP goals for optimal health and functional status. Meetings with a member's ICT will be offered and conducted periodically as needed for the member's care or if requested by the member. Members have the right to opt-out of participation on the ICT without disrupting their access to care coordination. Members who opt out will receive a preventative ICP with their assigned care coordinators contact information.

Use of SCFHP Software Systems to Coordinate Member and Provider Programs

The Case Management platform, Essette, includes data from all areas of the plan for care coordination communication. Data includes pharmacy claims, medical claims (including ED visits and hospitalizations), UM authorizations, and lab data. Member demographic data is pulled from the claims processing and Utilization Management platform, QNXT. SCFHP Care Coordination staff documents outreach to members in Essette for cross-departmental transparency and collaboration. Referrals to Case Management are also documented within Essette for appropriate follow up. Other pertinent information including, but not limited to, external assessments and Medication Therapy Management (MTM), are also pushed into the system and incorporated into the member's overall condition.

B. Case Management Programs

1. **Complex Case Management** is provided to all eligible members in Tier 1 and is described in detail in the corresponding procedure. These members are offered intensive support and are established based on member's preference and needs. Members are engaged in a thorough initial assessment.
2. **Moderate Case Management** is provided to members in Tier 2 and includes those members with multiple chronic conditions with at least one uncontrolled and complex social determinants of health. It includes members receiving MSSP services and care coordination around severe mental illness (SMI).

3. **Basic Case Management** is provided to members in Tiers 3 and 4 and includes, at a minimum, the completion of an HRA and further assessment as needed for benefit coordination in collaboration with the PCP.
4. **Transitions of Care (TOC)** is provided across all CM Tiers for members to support discharge planning from acute hospital or long term care facility. Outreach is made to members who recently discharged from the acute hospital, inpatient psychiatric hospital, or skilled nursing facility to ensure a safe transition to the appropriate level of care and minimize risk of readmission. This service is also provided to support continuity of care for members transitioning between providers. Members will be reassessed for the appropriate tier of CM after their transition period. Case management services include integration of the discharge plan into the current ICP including facilitating follow up visits to the member's providers, post-discharge medication reconciliation, and confirmation that the discharge plan has been implemented. If a member is not connected to a Behavioral Health (BH) care team in the community following discharge from an inpatient psychiatric hospital, both the discharging hospital and the BH CM will ensure coordination of a timely visit.
5. **Long Term Care (LTC) Transition** case management is provided to the subgroup of nursing facility members who are authorized for long term care but have been identified as able to discharge back to the community. Case management includes working with the member and their family or caregivers and the nursing facility team to assess readiness for discharge and coordination of a discharge plan. The LTC RN CM visits the member to conduct a face-to-face assessment, provides information about long term services and supports (LTSS) benefits and other community-based resources, and facilitates arrangement of and authorization for services and supports needed post-discharge. This includes addressing social determinants that may be a barrier to discharge including income benefits, lack of housing and family support and coordination with community resources. The CM coordinates closely, as appropriate with other community-based services targeted to nursing home residents including the Community Care Transitions (CCT) program and county initiatives such as the Whole Person Care program. The Case Manager conducts a TOC call following discharge notification and follows all TOC and case management processes as outlined below for TOC. After 30 days following transition, the member is referred to the appropriate CM team.
6. **Behavioral Health (BH) Case Management** is provided to members who are diagnosed with Severe Mental Illness (SMI) any tier, based on their level of stability. The BH CM team will participate with the other CM teams to coordinate the medical and LTSS case management services as needed. Behavioral Health Services as provided by the SCFHP BH CM team, include comprehensive services across all settings. Specific focus areas of BH Services include:
    - Reduction of ED visits for those who have any BH diagnosis;
    - Concurrent review and follow up for all members who are hospitalized in a psychiatric hospital;
    - Follow up after psychiatric hospitalization to ensure safety for members and that all members have a follow up visit with a BH provider at 7 and 30 days;
    - Care coordination with community BH providers for the SMI population who are served in Specialty Mental Health clinics.

7. **Health Homes Program (HHP)** is a benefit for Medi-Cal members enrolled in Managed Care Plans (MCPs). This program services members with multiple chronic conditions and social

determinants on July 1, 2019, and began serving members with Serious Mental Illness on January 1, 2020. The HHP serves eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries. SCFHP contracts with local clinics and agencies in the community to provide these services to our members on behalf of the plan. SCFHP also directly provides HHP services to a portion of eligible members that cannot be assigned to a local clinic and/or agency due to capacity or other reasons. This program will be transitioning to Enhanced Care Management in 2022.

C. Case Management Supportive Services

24/7 Nurse Advice Line:

The Nurse Advice Line is a nurse-driven telephonic support program that empowers members to better manage their health. Highly trained registered nurses help participants navigate through questions and concerns about symptoms, appropriate treatment choices, comorbid conditions and additional risk factors. Nurse Advice Line data is provided to SCFHP Care Coordination staff for review and follow-up as needed. All Nurse Advice Line calls resulting in a 911 disposition will be immediately referred to SCFHP Care Coordination staff for appropriate follow-up.

Whole Person Care Nursing Home Diversion Program

SCFHP has partnered with the Santa Clara County Health and Hospital System in the operation of their Whole Person Care (WPC) Pilot through the year 2021. One component of the WPC program is the Nursing Home Transition & Diversion Program that combines intensive case management, housing services and additional services to enable successful transitions for long term care members in a nursing facility. This program is administered by a provider contracted with the County – Institute on Aging (IOA) in partnership with community housing resources, safety net hospital, Behavioral Health Department and other community-based providers. SCFHP members may be identified for the program by the nursing facility staff, Institute on Aging or SCFHP UM or case management staff. The targeted population is members whose primary barrier to transition is the lack of housing and the need for ongoing intensive case management pre and post-discharge from Long Term Care. WPC case management is provided in collaboration with the SCFHP assigned case manager.

Provider Engagement

SCFHP engages providers in the member's care in various ways. Member PCPs are provided their specific CMC enrollment data monthly so that they can identify new members requiring an Initial Health Assessment (IHA). They also receive a copy of the member's ICP. Through IHA and the ICP, the provider can engage the member in discussions about preventative services, regular screenings, maintenance therapies, and health education programs, such as nutrition and physical activity education. PCPs are also members of the members' Interdisciplinary Care Team (ICT) and are invited to attend any scheduled ICT meetings. To further engage the provider network, educational materials are made available on the external SCFHP website. The Provider Network Operations (PNO) team also schedules visits and distributes a quarterly provider newsletter.

Utilization Management and Concurrent Review

The Utilization Management (UM) team includes clinical and non-clinical staff who determine medical necessity of inpatient and outpatient services. Concurrent review of hospitalization stays are completed by California-licensed RNs who collaborate with the facility and other providers to coordinate member's discharge needs and related follow up care. Care coordination related to discharge planning may include referrals to any available CM programs and coordinating benefits across health care settings, such as Durable Medical Equipment (DME), home health, Long Term Services and Supports (LTSS), behavioral health and outpatient services.

Within 72 business hours of a member's discharge to a residential home or his or her community setting such as an assisted living facility, the UM team notify the Case Management team of a member's discharge for Transition of Care (TOC) outreach and assessment. The TOC assessment within Essette evaluates for any member or caregiver support and/or resources which are needed to minimize gaps in care which may otherwise result in readmissions or preventable emergency room visits.

Health Education

The Health Education program has a variety of classes and workshops available for members to help maintain and improve their health and manage their illnesses. SCFHP works with a number of agencies within the community to provide programs covering topics from chronic disease, counseling services, weight management, smoking cessation, safety programs, and more. A complete list of these programs are available on the SCFHP website (www.scfhp.com). Members may self-refer to all programs, except for the Diabetes Prevention Program. Self-referral is completed through the mySCFHP Member Portal or by contacting Customer Service. Referrals are also received from PCPs and all SCFHP departments.

Community Resources Integration

Cal MediConnect and Medi-Cal SCFHP members face many barriers in the form of Social Determinants of Health (SDOH). From the population assessment, many members stated they ran out of money to pay for food, bills, rent, or medications. In order to help remove these barriers, SCFHP contracts and partners with Aunt Bertha (AB), a social care network that offers an online database of community resources specific to Santa Clara County. The LTSS team serves as the liaison with AB to coordinate updates and training for all case managers. This, combined with any additional community resources we are made aware of, assist the CMs with addressing social determinants of health experienced by Cal MediConnect and Medi-Cal SCFHP members. Designated SCFHP LTSS staff also manage local relationships with key community providers and attend relevant community meetings to stay abreast of available resources and changes in eligibility.

All CM staff receive initial and annual training on AB and community-based programs and services with detailed information on program scope, eligibility, referral processes and key contacts. This information is updated at least annually. Case managers and supporting staff also have access to trainings with providers, face-to- face visits and presentations by providers with new resources shared on an ongoing basis.

Community resources that address the most common social determinants of health needs identified by our members are food, housing, transportation, socialization, caregiver support and respite, legal services, public benefits and services such as protective services, and specialized case management (e.g. HIV). CM referrals are made as part of the individual care plan development and goal setting to facilitate coordination of benefits and community resources. Through AB Single Sign-on platform, SCFHP staff can directly send referrals to community based providers and AB will continue to update that referral status to make sure members have been connected to programs successfully. Cal MediConnect and Medi-Cal members may also access AB on their own through the SCFHP website and reports can be run to determine the highest needs identified by programs and resources searched by Cal MediConnect and Medi-Cal SCFHP members.

Medication Management Therapy (MTM)

The goal of MTM is to optimize drug therapy and improve therapeutic outcomes for members. Members that take medications for multiple different medical conditions may be eligible to receive MTM services at no cost. Members that qualify are automatically enrolled in to the program and mailed a welcome letter explaining the program and instructions for opting out. Specific eligibility criteria is posted both on www.scfhp.com and within the member handbook. MTM is only performed for the CMC line of business. MTM services may include:

- Calls from a pharmacist or other health professional to review all of the members' medications and discuss medication benefits, concerns, and questions
- Written, mailed summary of the medical review as well as a medication action plan and personal medication list
- Follow up from the pharmacist or other health professional every 3 months to ensure records are up to date as well as the safety and cost effectiveness of medications

Gaps in Care

When a member's profile is searched in QNXT, automated notifications pop up that alert the reader when a member has not received a specific wellness screening. Customer Service Representatives can provide members with this information when they call in to ask a question. Members who have questions or who need assistance to schedule appointments to their PCP or require transportation assistance can be helped immediately. Gaps in Care pop-ups also serve to alert the care coordination team to include annual wellness and prevention screening elements as a member's goal of care.

V. Informing Members

Cal MediConnect and Medi-Cal members are informed about all available PHM programs and services at any level of contact including the Plan's website, direct mail, e-mail, text or other mobile applications, telephone or in-person. Many programs offered are communicated to Cal MediConnect and Medi-Cal members within their Evidence of Coverage/Member Handbook document, which is mailed to members annually and upon enrollment, as well as through www.scfhp.com. Additionally, a catalog of all PHM programs was created and made available on the health plan website so that members may be informed of all programs that they may be eligible. The catalog will be updated annually and can be mailed to members upon their request. Members will receive a mailing on how to access this information on line or how to request it from customer services annually.

Cal MediConnect and Medi-Cal members deemed eligible for inclusion in any PHM program involving interactive contact may opt-out of participation at any time. Cal MediConnect and Medi-Cal members or their Authorized Representatives may request to opt-out by calling SCFHP's Customer Service department at 408-376-2000, sending a secure email to the SCFHP's case management department at www.CaseManagementhelpdesk@scfhp.com, or via USPS mail delivery.

VI. Population Health Delivery System Support

SCFHP provides support to practitioners and providers providing population health management to our members and to support the achievement of program goals. Below are a list of activities conducted by the Plan that support PHM programs or services not directed at individual members.

Table 2: Indirect Member Interventions for Cal MediConnect and Medi-Cal Lines of Business

Indirect Interventions	Focus Area(s)
SCFHP shares member data with providers to assist them in delivering services, programs and care to our members. We mail, fax, and/or verbally inform providers of their members individualized care plans and goals at least annually and after any updates. We also inform providers via fax when we have been unable to reach a member to complete a comprehensive Health Risk Assessment (HRA) and request their assistance. Additionally, we electronically send our providers member eligibility reports, language, and demographic data, and gaps in care reminders via the online provider portal.	1-4
SCFHP's Provider Network Operations (PNO) team completes provider education and required trainings, including the provision of continuing education units (CEUs/CMEs). These trainings include: cultural competency, Screening, Brief Intervention and Referral to Treatment (SBIRT), communicating across language barriers, Long Term Services and Supports (LTSS), and the Staying Healthy Assessment.	1-4
Quarterly provider newsletters, distributed by fax and e-mail and posted on the website	1-4
SCFHP presents quarterly to a Provider Advisory Council (PAC) on topics such as behavioral health treatment advances, opioid addiction, and other topics relevant to the characteristics of our SCFHP member population.	2, 3

Indirect Interventions	Focus Area(s)
SCFHP participates in monthly community Safety Net Network meetings. Discussions within these meetings with our community partners include topics such as food resources, housing, and resources that address social determinants impacting the member population.	1, 3
Coordination with Housing Services Information System: SCFHP participates in the County's Homeless Management Information System (HMIS) - an online database that enables organizations to collect data on the services they provide to people experiencing homelessness and people who are at risk for homelessness. Members who are in the HMIS database may have priority access to housing assistance.	2-4
Nursing Home Support and Training The LTSS team has designated clinical and provider network staff to manage relationships with all contracted nursing facilities serving a large member population. This includes conducting regular visits, to support utilization and case management for long term care members including collaboration for care transitions. A provider liaison monitors quality measures, troubleshoots issues related to authorizations claims, or contracting and conducts periodic trainings for SNF staff.	2-4
Behavioral Health Services coordinates and partners with the County Behavioral Health Services Department (CBHSD), community-based organizations, and providers to facilitate patient outcomes across all settings. This could include collaboration with acute and outpatient staff disposition, follow up and ongoing BH treatment for best outcome results. The coordination includes continuous education to Specialty Mental Health Clinics about the CMC population, consultation to providers and regular monthly CMC care coordination meetings.	1-4
Behavioral Health Services provides training materials to provider offices regarding SBIRT assessment and counseling.	1-4
Quality department provides intermittent training for contracted providers on appropriate wellness and preventative services (e.g. USPSTF, clinical practice guidelines) as appropriate. Clinical practice guidelines are also available to providers on the website.	1, 3
Pharmacy department performs quarterly drug use evaluations (DUEs) on various clinical areas (e.g. polypharmacy, asthma controller medication review) to look for gaps in care and contacts providers as appropriate for intervention.	1-4

Indirect Interventions	Focus Area(s)
SCFHP notifies the community and providers about Aunt Bertha and how to access it through scfhp.auntbertha.com in an e-newsletter. Providers can also access Aunt Bertha through the resource page found on the plan's website (scfhp.com).	1-4
SCFHP shares evidence-based guidelines with our provider network on the health plan website, scfhp.com. The information is located within the Provider Resources section on the website and includes guidelines for: i. Cervical Cancer Screening ii. Clinical and Preventive iii. BMI calculations iv. Recommended immunization schedules	1-4

VII. Coordination of Cal MediConnect and Medi-Cal Member Programs

Internal and external population health programs and services are coordinated across settings, providers and levels of care to minimize confusion to Cal MediConnect and Medi-Cal members from being contacted from multiple sources.

To provide care in a coordinated manner, SCFHP has several programs offered to Cal MediConnect and Medi-Cal members as specified in Section IV, depending on their clinical conditions and psychosocial needs. The health plan strives to provide the right care at the right time in the right place to members in order to improve patient experience of care, the health of populations and reduce the per capita cost of healthcare.

To better understand where the member is in the continuum of care, SCFHP Care Coordination staff collaborates with all internal departments, vendors, and community partners to identify potential member coordination opportunities, access and education needs. The CM team coordinates with community based service partners to align members with non-benefit resources to support their ICP through the ICT process.

Interdepartmental coordination is key to effective service coordination. SCFHP's case management software platform, Essette, acts as the central point of documentation for all care management programs and services related to the member. All members are assigned to an SCFHP Care Coordination staff member who acts as the primary point of contact for population health management support. In addition to the ICT discussed above, internal case conferencing across specialties is facilitated for coordination of care plan development and implementation across member needs including medical, LTSS and BH.

For care coordination across organizations, including delegates and community level case management programs, SCFHP Case Management programs coordinate with external partners as needed.

Members identified with Serious Mental Illness are assigned to the Behavioral Health Case Management program and are referred to community programs as appropriate; this referral process is coordinated through the appropriate Behavioral Health (BH) Care Coordination staff to ensure services are not duplicated by external programs, and that the needs (i.e. medical needs, social determinants of health) of

the member are met. In addition, BH collaborates with the county through county reporting of new assessments from their call center.

VIII. Impact Analysis of Population Health Management Strategy

At least annually, SCFHP conducts a comprehensive analysis of the impact of its PHM strategy that includes quantitative results for relevant clinical/cost and utilization and experience measures. Quantitative and qualitative analysis is conducted based on these results. Comparison of results with established benchmarks are evaluated for evidence of program effectiveness and room for improvement. This analysis will be conducted by the Health Services department in conjunction with IT, Member Services, Provider Services, and Grievance & Appeals to support the members and promote an effective Population Health Management Strategy.

Last Update:	**Author(s):**	**Approval Date:**
June 2021	Dr. Laurie Nakahira, Chief Medical Officer, Health Services Angela Chen, Interim Director, Case Management Shawna Cagle, Manager, Case Management Natalie McKelvey, Manager, Behavioral Health Lori Andersen, Director, Long Term Services and Supports (LTSS) Johanna Liu, Quality & Process Improvement Lucille Baxter, Quality & Health Education	

Santa Clara Family Health Plan

PHM 2C Activities and Resources based on the 2021 Population Health Assessment

Bold indicates new activity or resource

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
Financial insecurity Interventions aimed at finding options for members to access food, subsidize rent or utilities, and ensure members are aware of pharmacy benefits will be beneficial to all members.	• **Explore opportunities to improve social determinants of health (SDOH) and social needs for members by developing an SDOH strategy**	• Care coordination staff are trained annually in the Aunt Bertha platform that includes all community resources for this county. They are trained in how to use the system, make referrals and participate in a closed loop system so that referrals can be tracked to help them learn if the member actually received services referred. • Designated staff is assigned as a liaison to the Aunt Bertha staff to work on expanding agencies participating in the platform and to ensure that resources on Aunt Bertha are up to date. • **Community Resource Center (CRC) will allow for member access to SCFHP staff in Customer Service and Case Management and will facilitate member access to the Aunt Bertha platform on site.**	• Members who identify as needing help with financial security can be referred to resources on the Aunt Bertha platform that support the member's needs. Depending on the impact of the financial insecurity (e.g. housing stability, food insecurity), the resources needed may vary. Case Managers can also assist the member with accessing additional benefits such as CalFresh or Supplemental Security Income (SSI).

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
Language: Interventions should focus on ensuring members are aware of interpreter services, including language lines, know how access these services and are able to access them when needed.	• Annual refresher training and onboarding - for Providers to educate them on translation and interpreter services offered at no-cost 24/7 to SCFHP members • C&L Toolkit – created to educate Providers about LEP (limited English proficiency) speakers and services/tips available, quick reference guide with Language Line access numbers for Providers. • **SCFHP Member ID card – Medi-Cal cards have the member's preferred spoken language listed to help Providers identify members that need interpreter services. (April 2021)** • Quarterly Newsletters – all MC and CMC member newsletters have information on accessing language services free of charge. • Member letters – all member letters include tagline on language assistance services offered to them, and how to access the services free of charge.	• Annual internal refresher training C&L Training for Customer Service, Case Management, Behavioral Health, LTSS teams on interpreter/ translation services for LEP members. • SCFHP wide annual training through Litmos, (SCFHP's training portal) on Cultural Competency to describe the role of communication and language in providing culturally competent care. • **Hiring of 4 Outreach Coordinator full-time staff for Outreach Programs – staff proficient in Vietnamese, Cantonese, Tagalog, & Spanish. Outreach to members will be prioritized to the Coordinator who speaks that language. (May 2021)**	• **Planned expansion of Health Education programs for both Medi-Cal and Cal Medi-Connect lines of business.** - **Contracting with organizations to offer health education opportunities such as classes, workshops, webinars, etc. in additional threshold languages, including Vietnamese and Chinese both virtually and in-person at Community Resource Center.** • Supporting local community – SCFHP endorses and promotes health prevention and wellness by supporting call-to-action letters from supporting organizations on topics such as reducing tobacco use, asthma and allergy awareness.

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
Transportation: Interventions should aim to educate members about transportation benefits for medical appointments and connect members to community resources to aid their transportation needs.	• **Review Aunt Bertha data and determine if there are opportunities for improving education to staff and members on transportation benefits**	• Care coordination staff are trained annually in the Aunt Bertha platform that includes all community resources including those that address transportation needs. Additional trainings for staff are provided by providers including those providing paratransit.	• Care coordination staff and members have access to the Aunt Bertha platform that connects members to the appropriate contacts for transportation.

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
Admission for Sepsis: There is a need for further exploration to assess the behavior of SMI sub-population and those in LTSS, particularly enrollees in SNFs that may lead to infectious disease and eventually to sepsis so case managers can provide education to members on preventative strategies.	• **CDC handouts to members who are at risk of contracting sepsis or for members who have recovered from sepsis** • Educational materials and tools related to sepsis are provided on the SCFHP website targeted for providers.	• **In-service to CM staff on sepsis prevention and how to identify members at risk**	• Continue to share best practices, resources and trainings to BH and LTSS partners on sepsis

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
Behavioral Health Emergency Department (ED) admission: Interventions should focus on understanding this population and helping to address their needs to prevent ED visits.	• Identification of CMC and Medi-Cal members that have multiple ED visits for untreated or unstable symptomology by creating a report to review on a regular basis • Agreement of number of ED visits to qualify for outreach • Outreach to member/caregiver to assess current needs • **Education about how to access behavioral health treatment services on SCFHP website, Community Resource Center, and with contracted providers** • **SCFHP BH team plans on establishing and strengthening relationships with community based organizations who provide BH case management to members**	• Coordination with IT for creation of access to ED utilization • Hiring of one BH Supervisor to review utilization and assign to BH Case Manager • SCFHP Behavioral Health Social Work Case Managers to initiate outreach and complete assessment of need, connect to services • Ongoing education on motivational interviewing and stages of change model	• Connection to county behavioral health services: - For members who are not connected to county services: complete an assessment of need and current barriers to treatment by utilizing motivational interviewing techniques. Assist with calling BH Call Center to complete screening and placement of appropriate clinic. - For members who are currently connected to county services: Connect to member, caregivers, and BH provider/case manager to address barriers to treatment, supportive services to establish/maintain symptom management • Referrals to: - Peer Support Programs - Community Support groups - New Directions Care Coordination

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
COVID-19: Educate members on how to protect themselves and their families, identify signs and symptoms of potentially contracting COVID-19 and how to access vaccines as they become available.	• COVID flyer - Mailed flyer to refer members to our website for COVID information and resources, reiterate CDC COVID guidelines, call the nurse advice line for health questions, and call Customer Service for all other help • COVID Robocall - Robocalls to high risk members telling them they may be more vulnerable to COVID-19, reiterate CDC's guidelines to stay safe, call doctor for health questions or call nurse advice line, visit our website for more information on resources, and call Customer Service for questions. • COVID outbound calls – identified vulnerable populations & called these members to share resources and support • Case Management informed newly enrolled members of COVID resources • Inbound calls - All member facing teams (HHP, CM, Customer Service) had COVID talking points when speaking with members to share resources and support, if requested from member • Pharmacy - Formulary expanded to include disinfectant and gloves amidst pandemic; Refills available via mail-order for 90 day fills; pharmacy overrides to allow early refills • Transportation - Amended agreements with two vendors to make special accommodations and cleaning relating to transporting suspected or confirmed COVID members	• Shared COVID educational materials with all member facing staff • COVID workgroup – assembled COVID workgroup from different business units to meet on weekly basis • Email communication – COVID email communication to all-staff from CMO re: tips to stay safe, COVID info, etc. • Transitioned 97% of staff to work from home • **On-boarded temp staff for COVID vaccine outreach; some were bilingual to meet members' cultural & linguistic needs (March 2021)**	• Community Resource Sheet – used to share & promote local programs and organizations for different issues (e.g. food, housing, jobs) • **COVID vaccine community clinic – partnered with County Emergency Operations Center (EOC) to host vaccine clinic at SCFHP's Community Resource Center, available to all (April 2021, with more clinics planned in the future)** • **County partnership - Participated in County's COVID-19 Vaccine Community Stakeholders Working Group and subgroups to support the development and implementation of strategies to reach priority vulnerable groups, advise on communication strategies related to vaccine planning, and serve as a champion in support of vaccination and risk reduction. (ongoing)**

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
	• Telehealth - Added capability for Nurse Advice Line to offer members telephonic physician consultation • Website – created COVID webpage to share latest COVID news and information from the State and County • Members newsletter – shared educational COVID articles in newsletter • Social media – shared latest COVID news and information from the State and County • **Flyer – sent flyer to unvaccinated Medi-Cal members age 65+ to share information on how to schedule COVID vaccine appointment via phone or website (April 2021)** • **Live calls outreach – identified vulnerable populations & called these members to help schedule COVID vaccine appointment (March – May 2021)** • **Robocall – sent robocalls to unvaccinated members to share information on how to schedule COVID vaccine appointment via phone or website (Mary 2021)** • **Letter – send letter to unvaccinated members to share information on how to schedule COVID vaccine appointment via phone or website (pending – ETA early June)** • **Ad campaign - Launched COVID vaccine digital and radio ad campaign to promote COVID vaccination (April 2021)**		

Santa Clara Family Health Plan™

Review of Quality Improvement Policies

QI.17 Behavioral Health Care Coordination

QI.18 Sensitive Services, Confidentiality, Rights of Adults and Minors

QI.20 Information Sharing with San Andreas Regional Center (SARC)

QI.21 Information Exchange Between SCFHP & Health Services Dept.

QI.22 Early Start Program (Early Intervention Services)

QI.23 Alcohol Misuse: Screening and Behaioral Counseling Interventions in Primary Care

QI.24 Outpatient Mental Health Services: Mental Health Parity

QI.25 Intensive Outpatient Palliative Care

QI.27 Informing Members of Behavioral Health Services

POLICY

Policy Title:	**Behavioral Health Care Coordination**	**Policy No.:**	QI.17
Replaces Policy Title (if applicable):	**Cal MediConnect Behavioral Health Coordination Of Care Policy and Procedure**	**Replaces Policy No. (if applicable):**	**CM106_1**
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) promotes and coordinates seamless access and availability to appropriate behavioral health providers, community services and support for members identified with behavioral/mental health and substance use needs so that member may achieve optimal health and functionality.

II. Policy

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

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

C. SCFHP defines processes for the provision of Early, Periodic Screening, Diagnostic and Treatment (EPSDT) services for members 0 to 21 years of age which includes medically necessary Behavioral Health Treatment (BHT) services with or without an Autism diagnosis and other evidence based behavioral intervention services that develop or restore functioning. SCFHP provides BHT for members who are under 21, have a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary and that the member is medically stable without the need for 24 hour medical nursing monitoring. SCFHP requires Primary Care Physicians (PCP) to administer the Department of Health Services approved assessment tool as detailed in the procedure.

D. To define how SCFHP provides guidelines to PCPs regarding management and treatment for members with Behavioral Health conditions as outlined in the procedure Mental Health Services Provided by PCPs.

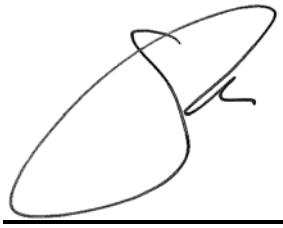
III. Responsibilities

Behavioral Health Services collaborates with other Health Services areas to coordinate care, and with QI to monitor coordination of care, for under/over utilization.

IV. References

3 Way Contract. (2014). *Contract between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services.*
NCQA Guidelines 2016
WIC Sections 14182.17(d)(4) and 14186(b)
28 CCR 1300.74.72(g)(3) through (5)
DHCS All Plan Letter 18-006, Responsibilities For Behavioral Health Treatment Coverage For Members Under The Age Of 21, 03/02/2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title 6/10/2020	Title 6/10/2020
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original; 06/10/2020	Quality Improvement Committee	Approve 06/10/2020	
V1	Review; 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Sensitive Services, Confidentiality, Rights of Adults and Minors**	**Policy No.:**	QI.18
Replaces Policy Title (if applicable):	Sensitive Services, Confidentiality, Rights of Adults and Minors	**Replaces Policy No. (if applicable):**	CM036_04
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

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

II. Policy

A. Santa Clara Family Health Plan (SCFHP) allows minor children and adult members to have access to sensitive, confidential medical services without the need for prior authorization.
   1. The following services are considered confidential and sensitive services for adult and minor children aged 12 and older without parental consent:
      a. Sexually transmitted diseases
      b. Family planning
      c. Sexual assault
      d. Pregnancy testing
      e. HIV testing and counseling
      f. Abortion
      g. Drug and alcohol abuse
      h. Outpatient mental health care

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

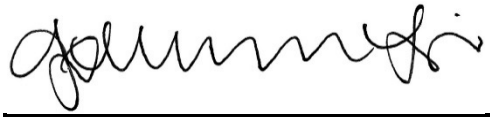
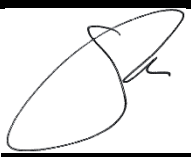
III. Responsibilities

A. Health Services works with IT, Provider and Customer Services, providers and community services to provide sensitive and confidential services to members without requiring prior authorization.

IV. References

Fed. Law 1987 OBRA, Sec. 4113 (c)(1)(B), 1905 (a)(4)(c); BBA
DHS Contract A-12, Exhibit A, Attachments 5, et. seq, 9, Items 1, 3, 8, 2. C
MMCD Pol. Letter #s: 94-13, 96-09, 97-08, 98-11
T22, CCR, 50063.5, 51009, 50063.5; Family Code §6925 et. seq., W & I Code §14132. et seq., 14451 et. seq. ; T28, CCR

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director of Quality and Process Improvement	Name Chief Medical Officer
Title 06/10/2020	Title 06/10/2020
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original 08/05/2016	Quality Improvement Committee	Approve 08/05/2016	
V1	Reviewed; 08/09/2017	Quality Improvement Committee	Approve 08/09/2017	
V1	Reviewed; 06/06/2018	Quality Improvement Committee	Approve 06/06/2018	
V1	Reviewed; 06/12/2019	Quality Improvement Committee	Approve 06/12/2019	
V1	Reviewed; 06/10/2020	Quality Improvement Committee	Approve 06/10/2020	
V1	Review; 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Information Sharing with San Andreas Regional Center (SARC): MOU**	**Policy No.:**	QI.20
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

This policy supports the agreement between San Andreas Regional Center (SARC) and the Santa Clara Family Health Plan (SCFHP) to perform care coordination and information exchange activities when Medi-Cal beneficiaries are accessing medically necessary Behavioral Health Treatment Services (BHT) without regard to diagnosis. The agreement addresses both new referrals for BHT and clients/beneficiaries receiving BHT when funding for this service is transitioning from SARC to SCFHP.

II. Policy

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

Santa Clara Family Health Plan

- SCFHP is responsible for coordination of services provided by SCFHP including primary care, and carve out services such as California Children's Services, Specialty Mental Health Services.
- SCFHP and/or its subcontracted providers and vendors shall arrange and pay for comprehensive diagnostic evaluations (CDE's) for members/clients who are suspected of needing BHT services.
- SCFHP and/or its subcontracted providers and vendors shall arrange and pay for BHT services for members who meet criteria as outlined in APL 18-006 or any revised version of these APL's.
- SCFHP shall provide client information to SARC to ensure appropriate care coordination, in compliance with all privacy laws.
- SCFHP and/or its subcontracted providers and vendors shall be available to assist, the SARC in the development of the Individual Program Plan (IPP) or Individualized Family Services Plan (IFSP) as necessary.

San Andreas Regional Center

- SARC shall provide client information, including comprehensive diagnostic evaluation(s), treatment plan(s), utilization data and assessment information to SCFHP upon receipt of appropriate release of information (ROI)
- SARC shall refer clients under age 21 who are diagnosed without regard to diagnosis for evaluation for medically necessary BHT services upon client/member request for BHT services.

- SARC shall provide case management & care coordination services related to SARC's Early Start Program clients to SCFHP for medically necessary BHT services.
- SARC shall provide case management and care coordination to eligible clients and assist those clients in maintaining an ongoing relationship with the SCFHP's assigned primary care provider when medical needs arise.
- SARC will identify a staff person to be the primary liaison to SCFHP. The liaison will meet not less than quarterly to ensure continuous communication and resolve any operational, administrative and policy complications.
- SARC will share information on community resources to SCFHP and/or its sub-contracted providers and vendors.
- SARC shall provide Targeted Case Management (TCM) services to eligible clients and their families to assure timely access to health, developmental, social, educational, and vocational services.

TCM includes, but is not limited to:

a. Coordination of health related services with SCFHP to avoid duplication of services; and
b. Provision of referrals to specialty centers and follow-up with schools, social workers and others involved in the IPP and IFSP

- SARC agrees to provide periodic training to SCFHP's staff as requested by the SCFHP concerning SARC services and requirements
- SARC shall work collaboratively with SCFHP to resolve timely access and coordination of care issues.

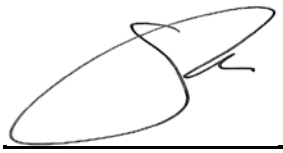
III. Responsibilities

See Memorandum of Understanding between SARC and SCFHP. Policies and Procedures to be attached. Health Services works collaboratively with plan benefits, compliance, QA , IT, plan and community providers to coordinate members' Behavioral Health Treatment services and members' Behavioral Health managed care.

IV. References

Center for Medicare & Medicaid Services approved California State Plan Amendment (SPA) 14-026
Section 1915 C waiver, CA.336 HCBS Waiver for Californians with Developmental Disabilities
DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Regional Centers, 03/02/2018
DHCS All Plan Letter 18-006 Responsibilities For Behavioral Health Treatment Coverage For Members Under The Age Of 21, 03/02/2018

Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title 06/10/2020	Title 06/10/2020
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original 08/05/2016	Quality Improvement Committee	Approve 08/05/2016	
V1	Reviewed 08/09/2017,	Quality Improvement Committee	Approved 08/09/2017	
V1	Reviewed; 08/09/2018	Quality Improvement Committee	Approved 08/09/2018	
V1	Reviewed; 06/12/2019	Quality Improvement Committee	Approved 06/12/2019	
V1	Reviewed; 06/10/2020	Quality Improvement Committee	Approved 06/10/2020	
V1	Review; 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara Behavioral Health Services Department**	**Policy No.:**	QI.21
Replaces Policy Title (if applicable):	Information Exchange Between Santa Clara Family Health Plan & County of Santa Clara County	**Replaces Policy No. (if applicable):**	HS 409
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

This policy is to provide detailed instructions for how Santa Clara County Behavioral Health Services Department and Santa Clara Family Health Plan (SCFHP) will perform activities to support the provision of Medi-Cal Specialty Mental Health and/or drug Medi-Cal services as a managed care benefit under the Medi-Connect program. SCFHP and the County of Santa Clara Behavioral Health Services Department (formerly known as Santa Clara County Mental Health Department and Santa Clara County Department of Alcohol and Drugs) entered into a MOU effective January 1, 2014 to specify how roles and responsibilities between the two entities were to be performed.

II. Policy

It is the policy of the SCFHP to provide coordination of care for the purpose of providing services to CMC members which are coordinated with Santa Clara County BHSD, their mental health clinics and contractors. The SCFHP and the CBHSD will follow the medical necessity criteria for Medi-Cal specialty mental health 1915 (b) waiver services described in Title 9, California Code of Regulations. DHCS has developed a matrix of Roles and Responsibilities "Behavioral Health Benefits in the Duals Demonstration" which is attached to the MOU. Medical necessity for Drug Medi-Cal Substance Abuse Services will be as found in Title 22, California Code of Regulations (CCR).

III. Responsibilities

1. Assessment Process

The SCFHP and CBHSD shall develop and agree to written policies and procedures regarding screening and assessment processes that comply with all federal and state requirements. SCFHP completes a Health Risk Assessment (HRA) pursuant to the CMC three way contract guidelines. SCFHP Behavioral Health Department reviews and/or completes the HRA with special attention to the depression Indicators as well as Severe Mental Illness indicators. The HRA, in conjunction with claims and pharmacy Information, is utilized to create a preliminary interdisciplinary care plan (ICP). The ICP is reviewed with the member and sent to the member's primary care physician and the member's Specialty Mental Health provider for their review and changes.

2. Referrals

The SCFHP and the CBHSD shall develop and agree to written policies and procedures regarding referral processes including:

a. CBHSD will accept referrals from SCFHP staff, providers, and members' self-referral for determination of medical necessity
b. SCFHP will accept referrals from CBHSD for services needed are provided by the SCFHP and not the CBHSD and the member does not meet the Medi-Cal Specialty mental health and/or Drug Medi-Cal medical necessity criteria. This will include mild to moderate levels of care needs which are the responsibility of SCFHP.

3. Information Exchange

a. CBHSD will develop and agree to information sharing policies and procedures. CBHSD Director has provided a memo to County Clinics and Sub-contractors stating that basic information may be shared in order to determine if a member is being seen and who is the provider in the agency.
b. SCFHP will create a list of members who are receiving Medi-Cal specialty mental health services, and/or Drug Medi-Cal services.
c. A signed mental health release of information is obtained from the member in order to 1. Share information with behavioral health services agencies; 2. Provide care coordination and 3. Complete and updated ICP and an interdisciplinary care team (ICT) meeting as needed.
d. The information sharing policies and procedures developed by the CBHSD and SCFHP will include milestones agreed upon for shared roles and responsibilities for sharing personal health information. Meetings with County BHSD providers and their contractors will be held to provide training to discuss the policies and procedures which have been agreed upon for sharing of personal health information.

4. Care Coordination

a. The SCFHP and CBHSD will develop and agree to policies and procedures for coordinating Medical and behavioral health care for members enrolled in SCFHP and receiving Medi-Cal specialty mental health or Drug Medi-Cal services.
b. The policies and procedures will include:
    - An identified point of contact from both CBHD and SCFHP who will initiate and maintain ongoing care coordination
    - CBHSD and their contractors will participate in ICT's for members receiving County services and identified as needing an ICT.
    - At the County's request, the SCFHP will assist the CBHSD in developing behavioral health care plans
    - SCFHP will have a process for reviewing and updating the care plans as clinically indicated and following a hospitalization or significant change such as level of care.
    - SCFHP will have regular quarterly meetings to review the care coordination process
    - SCFHP will coordinate with the County to perform an annual review, analysis & evaluation of the effectiveness of the care management program to identify actions to implement and improve the quality of care and delivery of services.

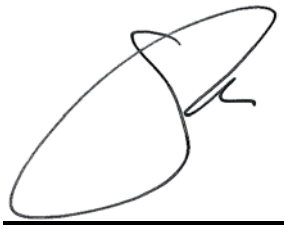
IV. References

California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000
Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
DHCS Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Enrollees, D. Mental Health Services
MMCD Policy Letter 00-01

POLICY

Title 9, CCR, Chapter 11, Division 1, Section (s) 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205 (b) (1); 1830.210; 1850.210 (I); 1850.505
Title 22, CCR, Chapter 3, Article 4, Section (s) 51305; 51311; 51313; 51183
Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (1) and the State of California Alcohol and/or Other Drug Program Certification Standards Welfare and Institutions Code Section 5600.3; and 14016.5

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Jeff Robertson, MD	Signature Laurie Nakahira, MD
Name Medical Director	Name Chief Medical Officer
Title 06/10/2020	Title 06/10/2020
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original 06/06/2018	Quality Improvement Committee	Approved 06/06/2018	
V1	Reviewed; 06/03/2019	Quality Improvement Committee	Approved 06/12/2019	
V1	Reviewed; 06/10/2020	Quality Improvement Committee	Approved 06/10/2020	
V1	Review; 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Early Start Program (Early Intervention Services)**	**Policy No.:**	QI.22
Replaces Policy Title (if applicable):	Early Start Program (Early Intervention Services): Developmental Delay Identification, Referral and Care Coordination	**Replaces Policy No. (if applicable):**	CM.005_03
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) ensures that eligible members receive early screening, counseling and treatment for developmental delay or disabilities.

II. Policy

Santa Clara Family Health Plan (SCFHP) identifies members (aged 0 to 2.9 years) who have, or are at risk of acquiring developmental delays or disabilities and need early intervention services. SCFHP will coordinate the referral of members to the Early Start Program, which is a collaborative effort between the San Andreas Regional center (SARC) and the Santa Clara County Office of Education.

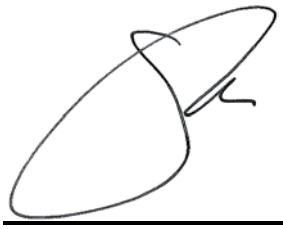
III. Responsibilities

The Health Services Department of the SCFHP is responsible for referring members to Early Start as they are identified by the primary care physicians, case managers and others. The Department is also responsible to notify SCFHOP delegates of their responsibilities to refer to Early Start.

IV. References

DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Health Care Plans and Regional Centers, 03/02/2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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V1	Original 02/08/2017	Quality Improvement Committee	Approved 02/08/2017;	
V2	Revised 06/06/2018	Quality Improvement Committee	Approved 06/06/2018;	
V3	Revised 06/02/2019	Quality Improvement Committee	Approved 06/02/2019	
V4	Revised 06/10/20	Quality Improvement Committee	Approved 06/10/2020	
V4	Review 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care**	**Policy No.:**	QI.23
Replaces Policy Title (if applicable):	Screening, Brief Intervention and Referral for Treatment for Misuse of Alcohol	**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) primary care providers will provide Alcohol Misuse: Screening and Behavioral Counseling (AMSC) Interventions in Primary Care settings for members 18 years of age and older who misuse alcohol.

II. Policy

A. SCFHP's policy is to support the contracted network in providing an expanded alcohol screening for members 18 years of age and older who answer "yes" to the alcohol question in the Individual Health Education Behavioral Assessment (IHEBA).
B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) expanded contractual requirements for identification of potential alcohol misuse problems.
C. Providers in SCFHP primary care settings must offer and document AMSC services are offered.
D. The SCFHP will not limit behavioral counseling interventions. Beneficiaries who meet criteria for an alcohol use disorder or whose diagnosis is uncertain, are to be referred for further evaluation to the County Gateway program at 1-800-488-9419.

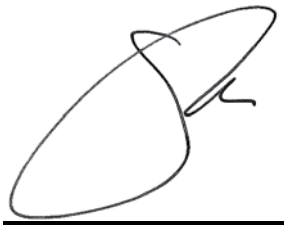
III. Responsibilities

The Quality Improvement Department is responsible for monitoring compliance with the policy and to collaborate with the assistance of the Health Education, Provider Services and Behavioral Health Departments to train/educate providers in the provision of the AMSC.

IV. References

DHCS All Plan Letter 17-016 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
Title 42 CFR Requirements with the Mental Health Parity Rule

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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Title 06/10/2020	Title 06/10/2020
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V1	Original 02/21/2018	Quality Improvement Committee	Approve 02/21/2018	
V1	Reviewed 06/03/2019	Quality Improvement Committee	Approve 06/03/2019	
V1	Reviewed 06/10/2020	Quality Improvement Committee	Approve 06/10/2020	
V1	Review 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Outpatient Mental Health Services: Mental Health Parity**	**Policy No.:**	QI.24
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

To define the contractual responsibilities of Santa Clara Family Health Plan (SCFHP) for the provision of services to adults and children with mental health disorders resulting in mild to moderate distress in the areas of mental, emotional or behavioral functioning. The responsibilities also include referring to and coordinating with the Santa Clara County Behavioral Health Services Department (CBHSD).

II. Policy

It is the policy of SCFHP to provide access to outpatient mental health services for beneficiaries who do not meet the criteria for Specialty Mental Health Services (SMHS). These mild to moderate services will be provided by licensed mental health professionals, in addition to primary care physicians within their scope of practice. The treatment limitations will not be more restrictive than the treatment limitations applied to medical or surgical benefits to ensure parity in access to mental health services. SCFHP will not restrict access to an initial mental health assessment by requiring a prior authorization. SCFHP will be responsible for the arrangement and payment of an initial mental health assessment performed by a network mental health provider unless there is no in-network provider available who can provide the necessary service.

III. Responsibilities

SCFHP will ensure that authorization determinations are based on medical necessity in a manner which is consistent with current evidence-based clinical practice guidelines.

These policies and procedures will be consistently applied to medical/surgical, mental health and substance use disorders.

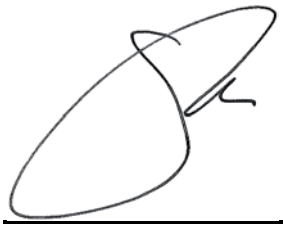
SCFHP will be responsible for outpatient mental health services as follows:

1. Individual and group mental health evaluation and treatment
2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies and supplements (excluding carded out medications)
5. Psychiatric consultation

IV. References

DHCS All Plan Letter 17-018 Medi-Cal Managed Care Health Plan Responsibilities For Outpatient Mental Health Services, 10/27/2017
Mental Health Parity Final Rule (CMS-2333-F)
Title42, CFR 438.915 (a) (b)
CA Health and Safety Code 1367.01

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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V1	Original 02/21/2018	Quality Improvement Committee	Approved 02/21/2018	
V1	Reviewed 06/03/2019	Quality Improvement Committee	Approved 06/03/2019	
V1	Reviewed 06/10/20	Quality Improvement Committee	Approved 06/10/2020	
V1	Review 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Intensive Outpatient Palliative Care**	**Policy No.:**	QI.25
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

To promote access to appropriate and effective symptom management and palliative care in accordance with Final Draft All Plan Letter (APL) 17-015 and Senate Bill (SB) 1004, with the intent that members facing serious illness may achieve optimal quality of life.

II. Policy

A. The Intensive Outpatient Palliative Care (IOPC) program is established to provide processes and procedures that enable SCFHP to improve the health and health care of its members with palliative care needs

B. To define the fundamental components of SCFHP palliative care services, which include: Advance Care Planning; Palliative Care Assessment and Consultation; Plan of Care; Palliative Care Team; Care Coordination; Pain and Symptom Management; and Mental Health and Medical Social Services. The structure of the IOPC program is organized to promote quality palliative care, client satisfaction and cost efficiency through the use of collaborative patient-centered palliative care services, evidence-based guidelines and protocols, and targeted goals and outcomes.

C. SCFHP defines the process of how the plan coordinates palliative care services for members with serious illness and helps them access needed resources and care.

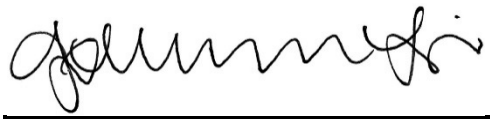
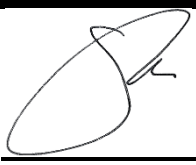
III. Responsibilities

A. Health Services collaborates with other SCFHP departments (IT, Claims, Benefits, Provider Services, and Member Services) as well as contracted IOPC providers and member providers and delegates to identify, coordinate services, coordinate benefits, and provide eligible members with IOPC palliative care services.

IV. References

California Welfare and Institutions Code (WIC) Section 14132.75
Final Draft APL 17-015, October 2017

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 06/10/2020	Title 06/10/2020
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original 06/12/2019	Quality Improvement Committee	Approved 06/12/2019	
V1	Reviewed 06/10/2020	Quality Improvement Committee	Approved 06/10/2020	
V1	Review 06/09/2021	Quality Improvement Committee		

POLICY

Policy Title:	**Informing Members of Behavioral Health Services**	**Policy No.:**	QI.27
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

The purpose of this policy is to address how members are informed of their eligibility for services through the Santa Clara Family Health Plan (SCFHP), the Santa Clara County Behavioral Health Services Department and under the Behavioral Health (BH) Department. The information to the members includes:

A. Member eligibility to participate in the BH programs
B. How to use BH program services
C. How to opt in or out of BH program services

II. Policy

It is the policy of the SCFHP, specifically, the BH Department to offer services to those Cal Medi Connect (CMC) members who are diagnosed with a Severe Mental Illness (SMI) and/or Substance Use Disorder (SUD). Services include care coordination to ensure that the members receive the specialty mental health, substance use treatment, physical health and other psycho-social services they need to be able to live in the least restrictive environment possible and to be as healthy as possible. In addition, the BH Department will provide consultation and support to the other departments and the community to assist all those members with a behavioral health diagnosis and/ or substance use disorder to access needed services.

A. Eligible members will be identified through claims, referrals from community providers, and referrals from other departments, from the Health Risk Assessment (HRA) or through self-referral. In addition, through data-sharing agreements and MOUs, the County Behavioral Health Services Department will provide information to the SCFHP BH Department to identify the members who are eligible for Specialty Mental Health Services.
    1. Behavioral Health program services will be initiated through outreach to the member, completion of the HRA and care plan and care coordination to assist the member to meet their own goals.
    2. The BH Social Worker or Personal Care Coordinator (PCC) will explain to the member that the County Behavioral Health Services Department will provide a screening through their Call Center to determine if the member is qualified for Specialty Mental Health.
    3. The member receives information from the BH Social Worker or PCC that if the member is not eligible for Specialty Mental Health services, then the SCFHP will assist with providing services such as counseling and care coordination.
    4. The information regarding BH services is also provided on the SCFHP website www.SCFHP.com

5. Information on how to reach the County Call Center is provided on the member identification card.
6. Members may participate in the BH program as they would any of the SCFHP programs. The member may opt out of any part of the case management program including the HRA and care plan or ICP.

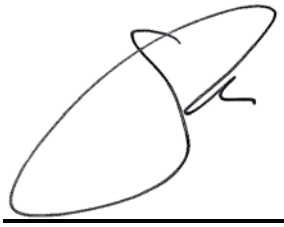
III. Responsibilities

Behavioral Health Services Department has the primary responsibility for carrying out the policy requirements. Case management and the Customer Services Department may be responsible for referring members into BH services.

IV. References

DPL # 14-003 CROSSOVER CLAIMING RESPONSIBILITY FOR MENTAL HEALTH SERVICES PROVIDED TO CAL MEDICONNECT BENEFICIARIES

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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v1	Original 11/08/2018	Quality Improvement Committee	Approved 11/08/2018	
v1	Reviewed 06/03/2019	Quality Improvement Committee	Approved 06/03/2019	
v1	Reviewed 06/10/2020	Quality Improvement Committee	Approved 06/10/2020	
v1	Review 06/09/2021	Quality Improvement Committee		

Santa Clara Family Health Plan™

Quality Improvement Committee

Q1 2021 Grievance & Appeals Data

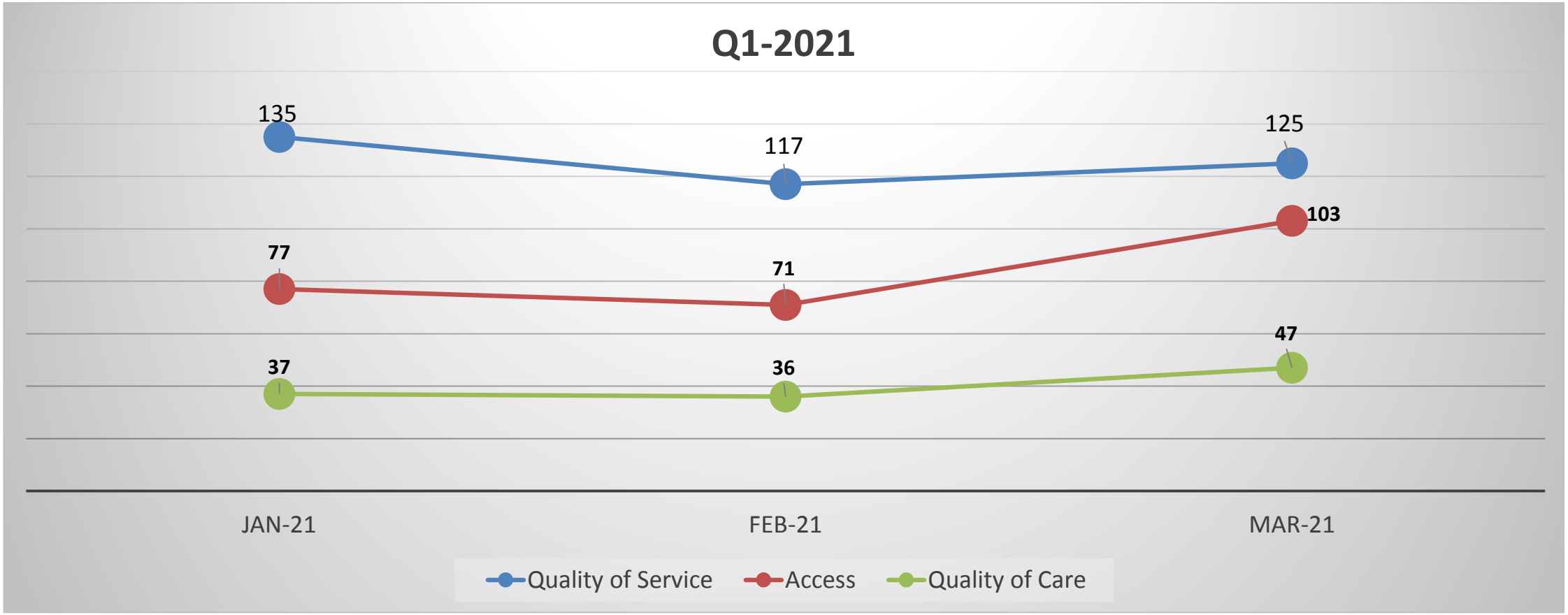
Total Grievances & Appeals

(*Rate per 1000 Members*)

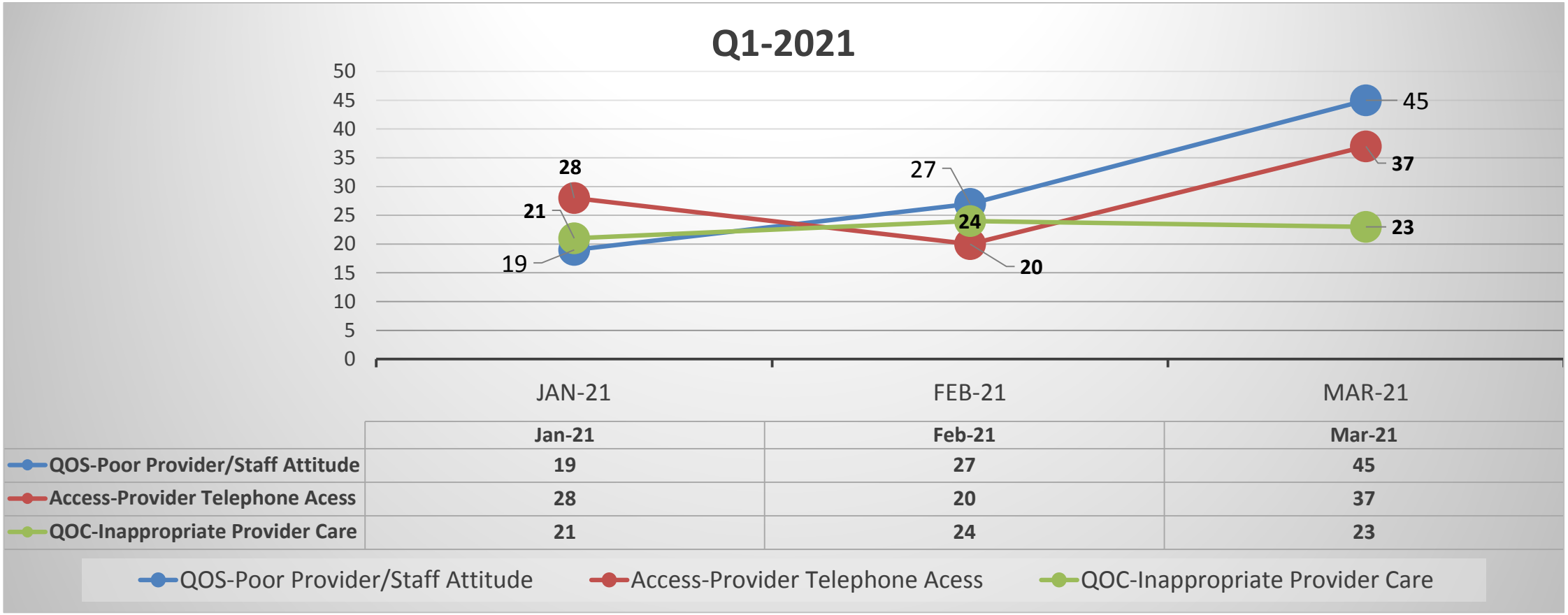
	Jan-20	Feb-20	Mar-20	Jan-21	Feb-21	Mar-21
Total Appeals	**70**	**88**	**77**	**96**	**89**	**99**
CMC Total Membership	**8,401**	**8,486**	**8,601**	**9,807**	**9,893**	**9,880**
Rate per 1,000	8.33234	10.37	8.95245	9.78893	8.99626	10.0202
Total Grievances	**150**	**152**	**147**	**115**	**139**	**165**
CMC Total Membership	**8,401**	**8,486**	**8,601**	**9,807**	**9,893**	**9,880**
Rate per 1,000	17.855	17.9119	17.091	11.7263	14.0503	16.7004

	Jan-20	Feb-20	Mar-20	Jan-21	Feb-21	Mar-21
Total Appeals	121	97	94	92	102	127
MC Total Membership	**231,435**	**231,548**	**233,229**	**263,093**	**265,095**	**266,962**
Rate per 1,000	0.52282	0.41892	0.40304	0.34969	0.38477	0.47572
Total Grievances	234	263	244	276	253	299
MC Total Membership	**231,435**	**231,548**	**233,229**	**263,093**	**265,095**	**266,962**
Rate per 1,000	1.01108	1.13583	1.04618	1.04906	0.95437	1.12001

Q1 2021:Top 3 Medi-Cal Grievance Categories

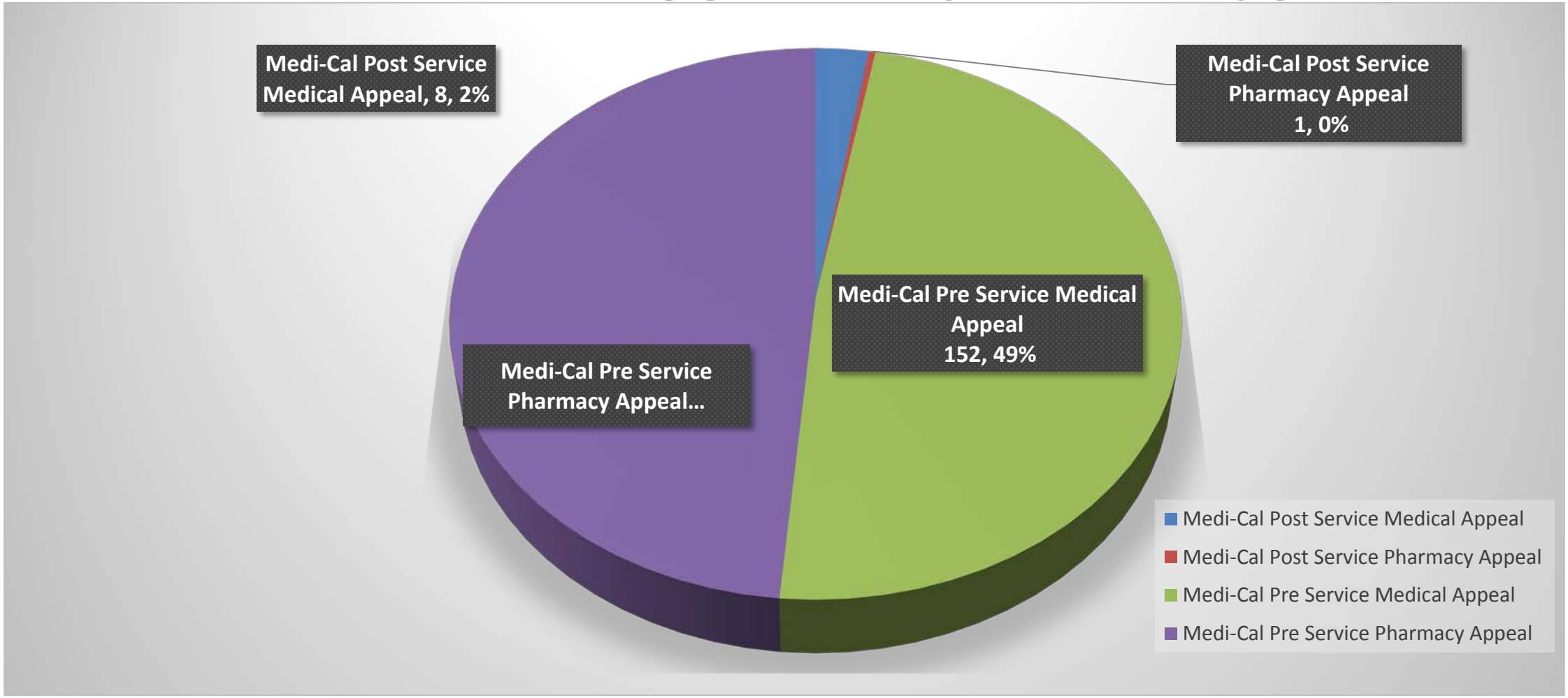


Q1 2021:Top 3 Medi-Cal Grievance Subcategories

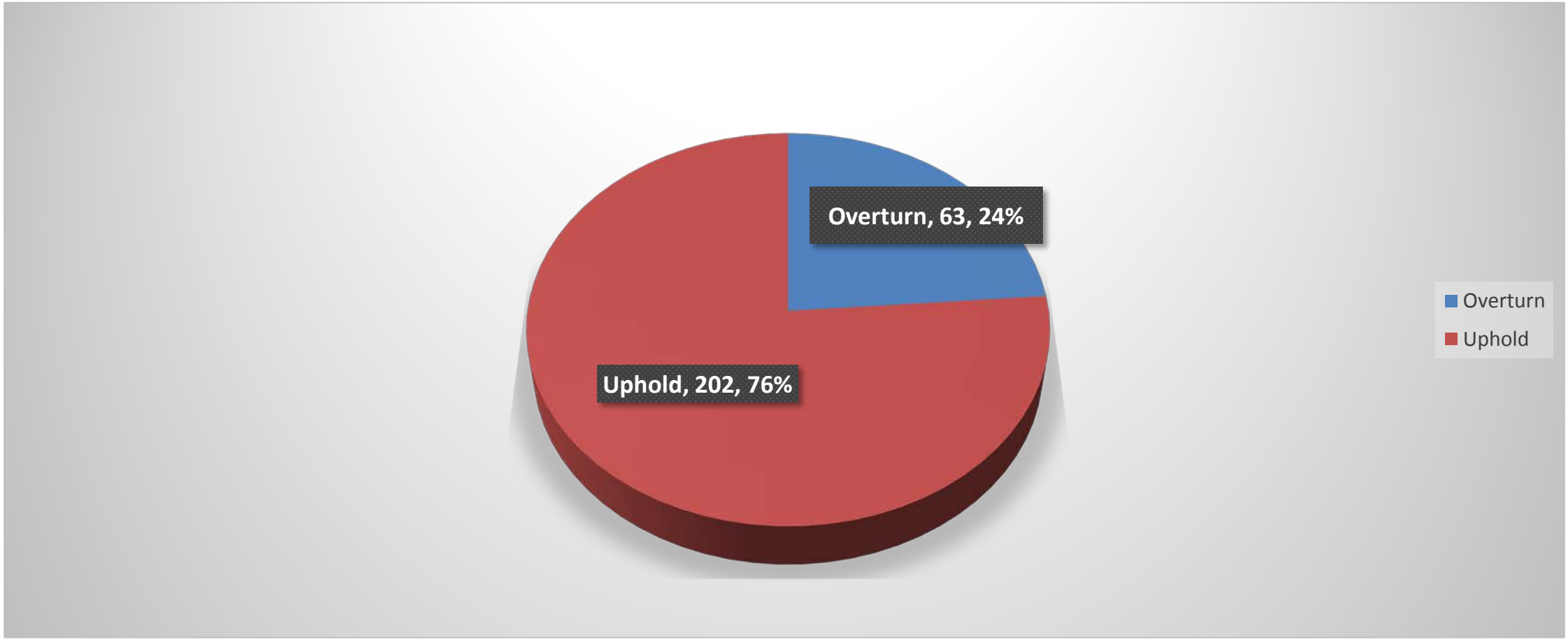


	Jan-21	Feb-21	Mar-21
QOS-Poor Provider/Staff Attitude	19	27	45
Access-Provider Telephone Acess	28	20	37
QOC-Inappropriate Provider Care	21	24	23

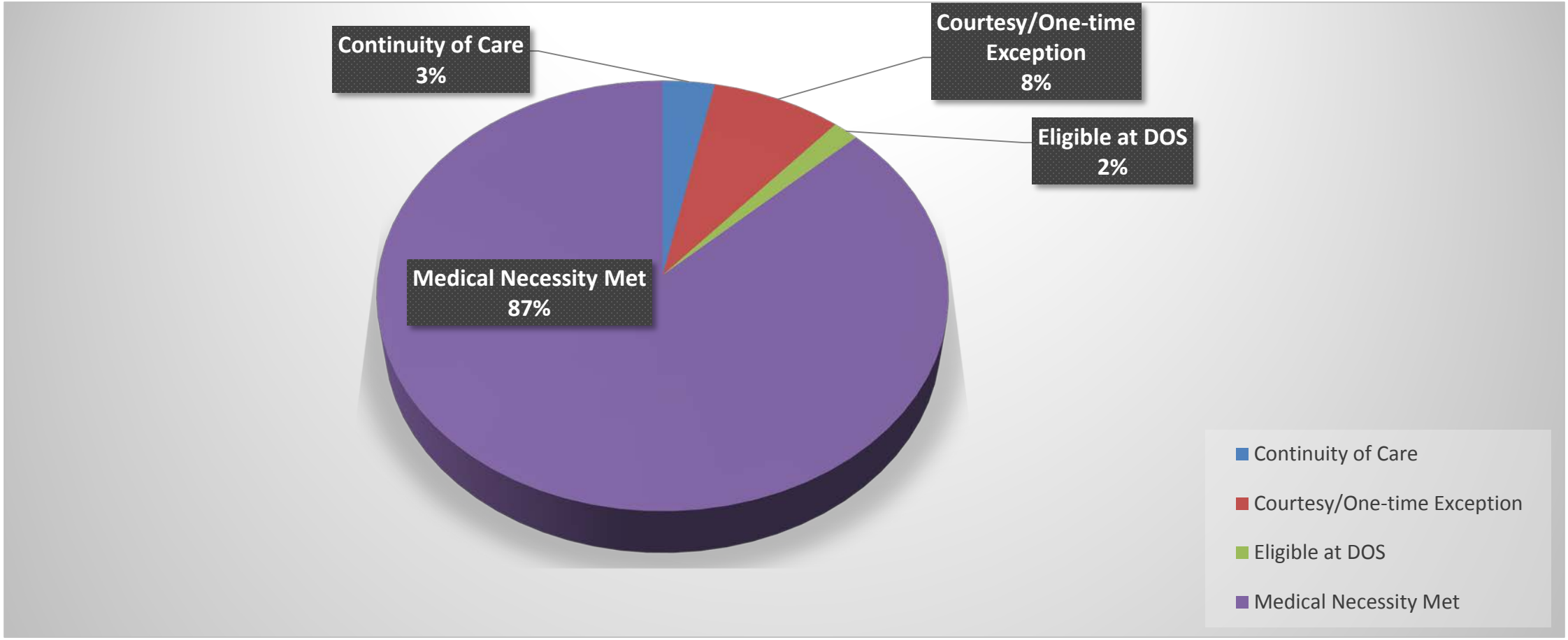
Q1 2021 Medi-Cal Appeals by Case Type



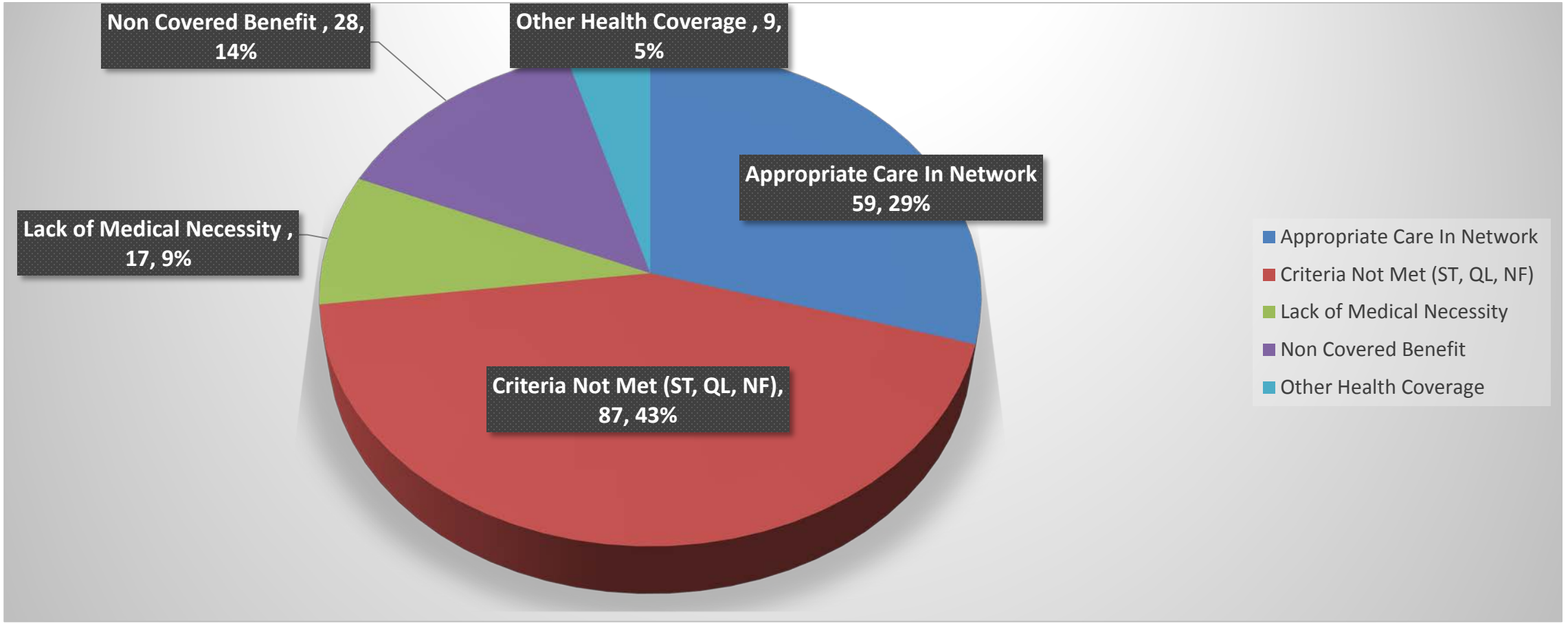
Q1 2021 MC Appeals by Disposition



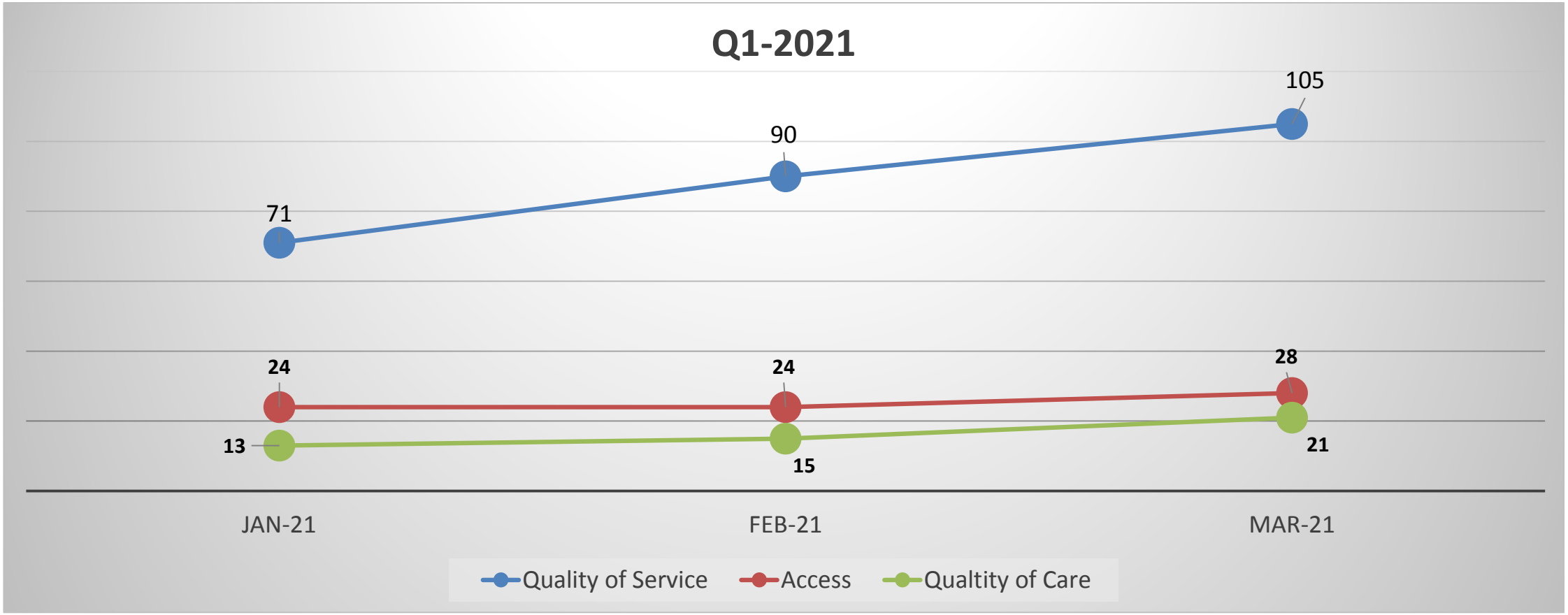
Q1 2021 MC Appeals: Overturn Rationale



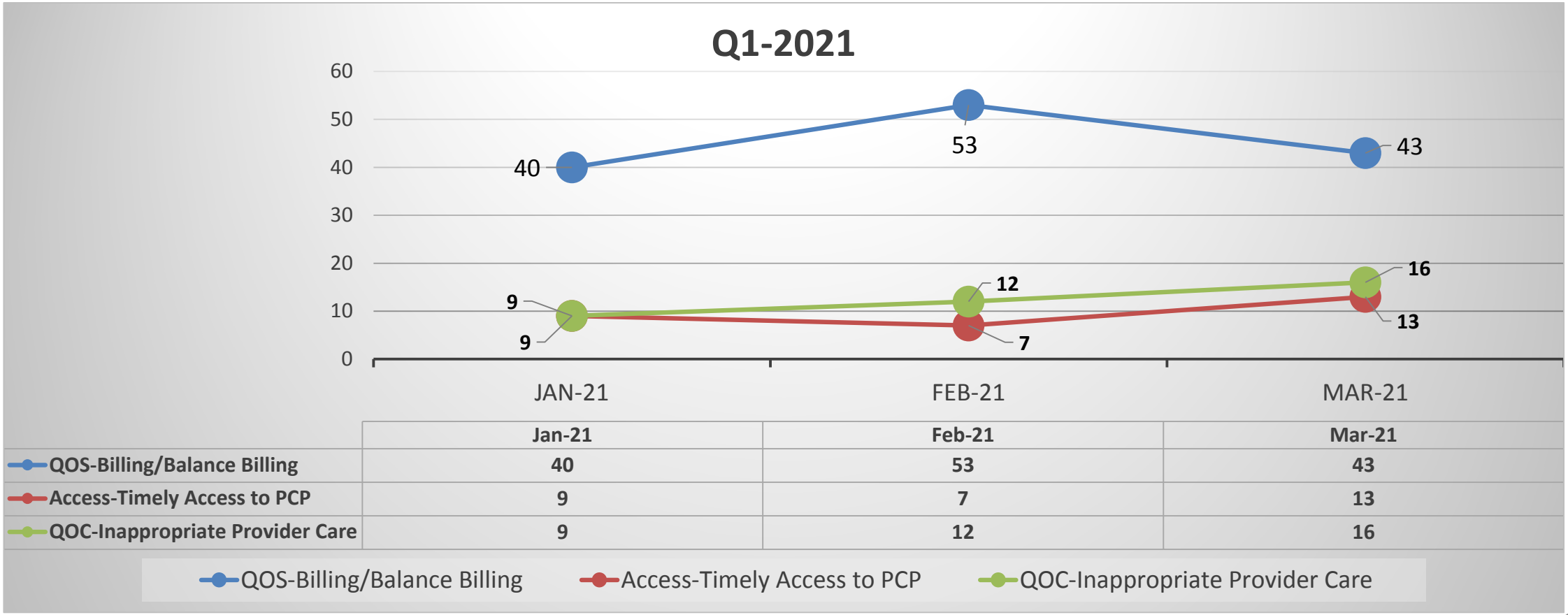
Q1 2021 MC Appeals: Uphold Rationale



Q1 2021:Top 3 Cal MediConnect Grievance Categories

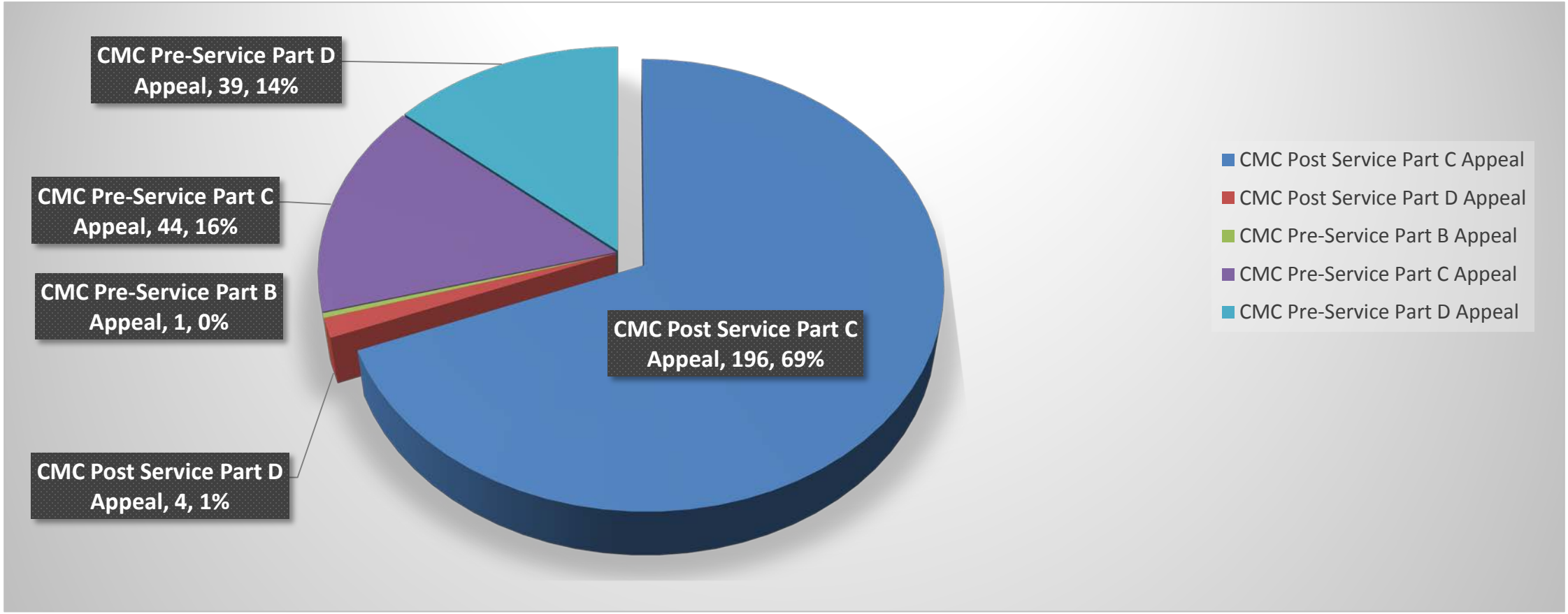


Q1 2021:Top 3 Cal MediConnect Grievance Subcategories

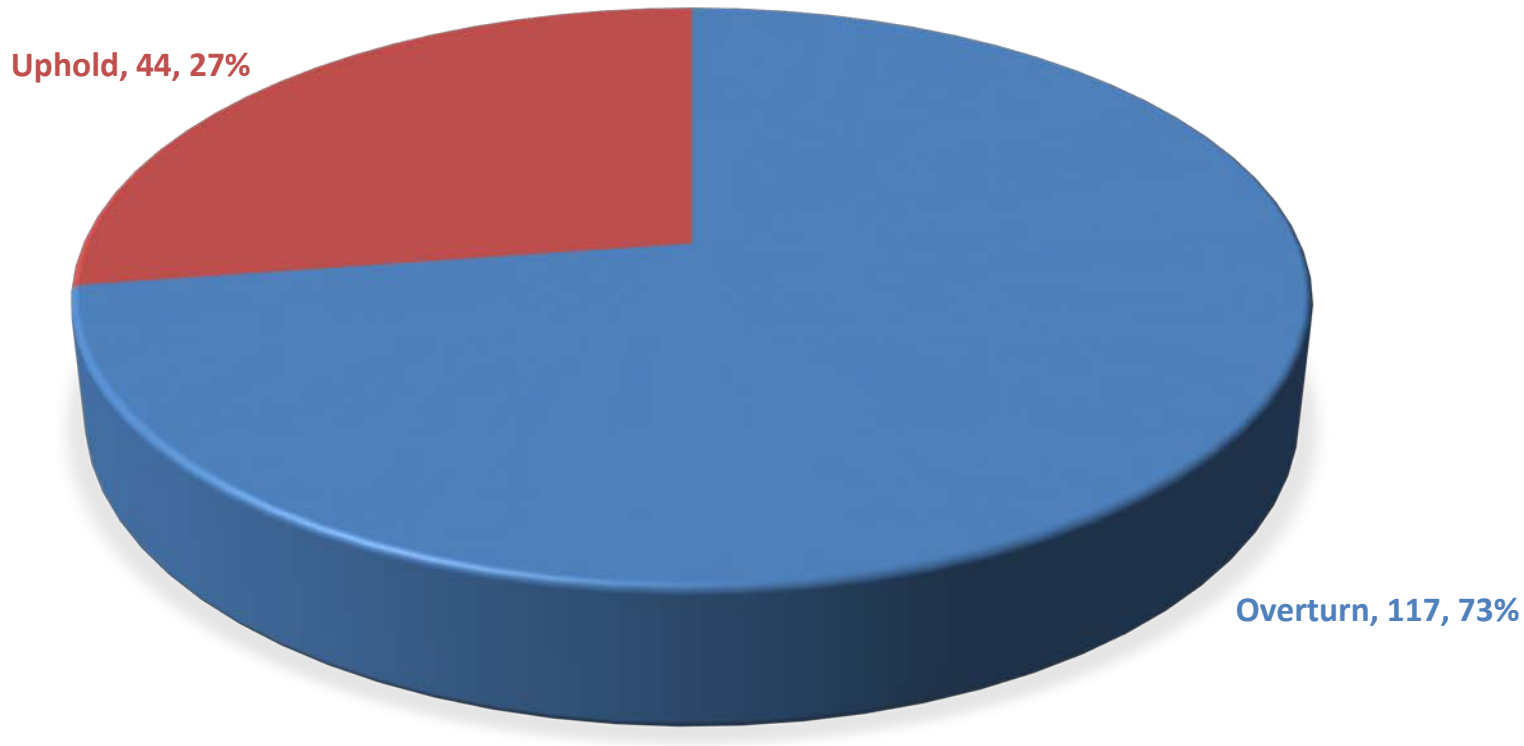


	Jan-21	Feb-21	Mar-21
QOS-Billing/Balance Billing	40	53	43
Access-Timely Access to PCP	9	7	13
QOC-Inappropriate Provider Care	9	12	16

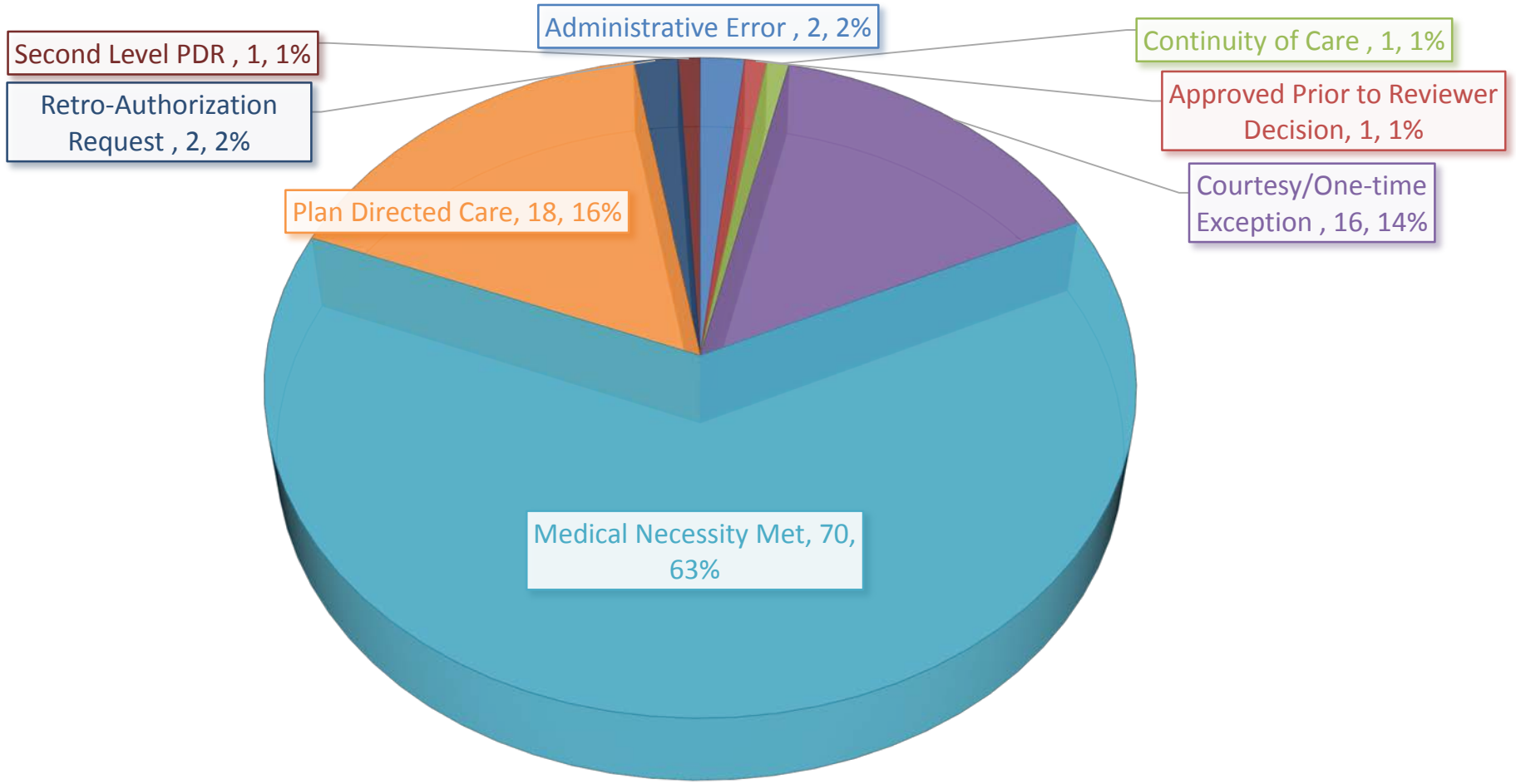
Q1 2021 CMC Appeals by Case Type



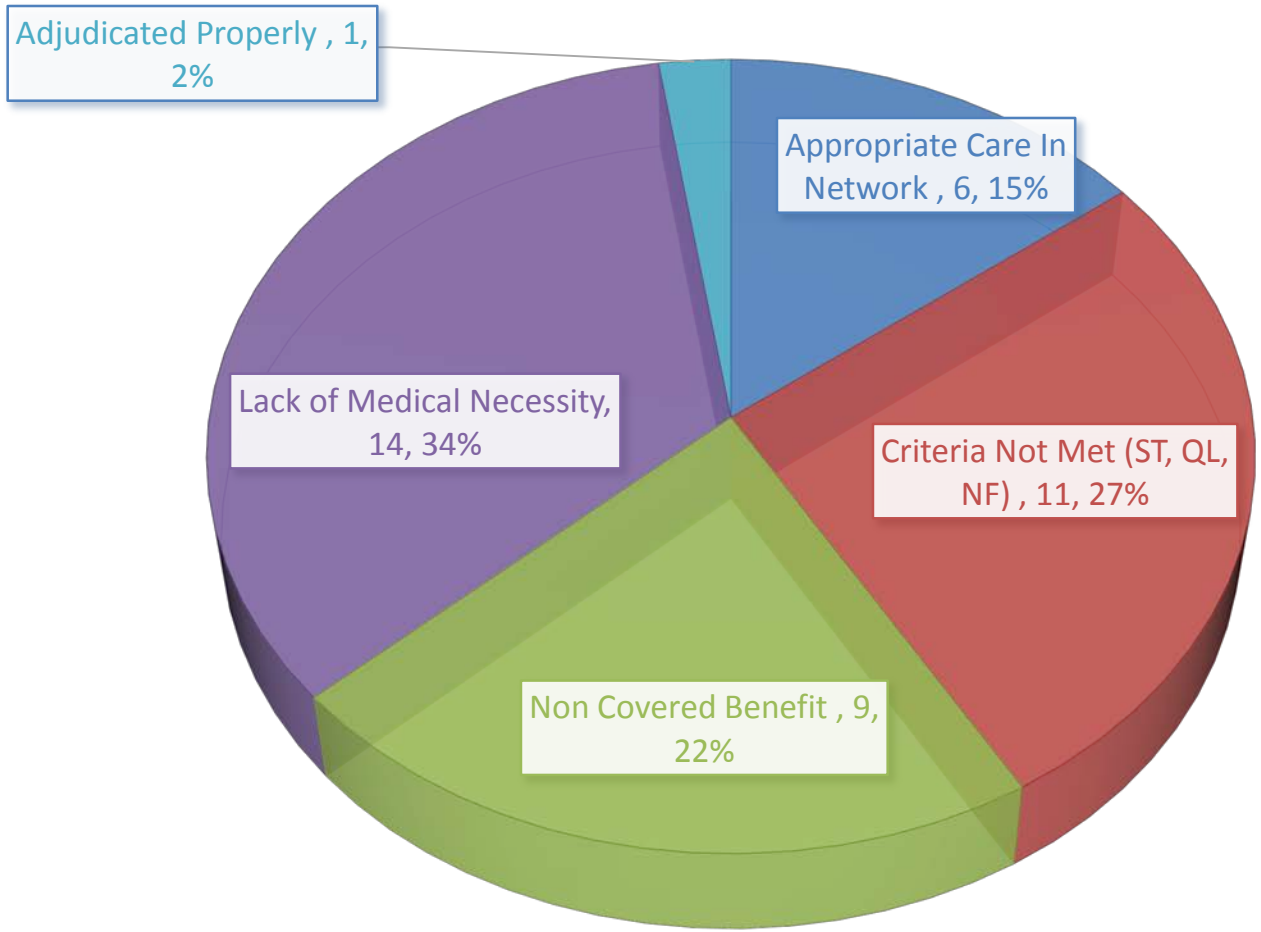
Q1_2021 CMC Appeals by Disposition



Q1_2021 CMC Appeals: Overturn Rationale



Q1_2021 CMC Appeals: Uphold Rationale



Santa Clara Family Health Plan™

Quality Improvement Committee

Q1 2021 Grievance & Appeals Data

Santa Clara Family Health Plan™

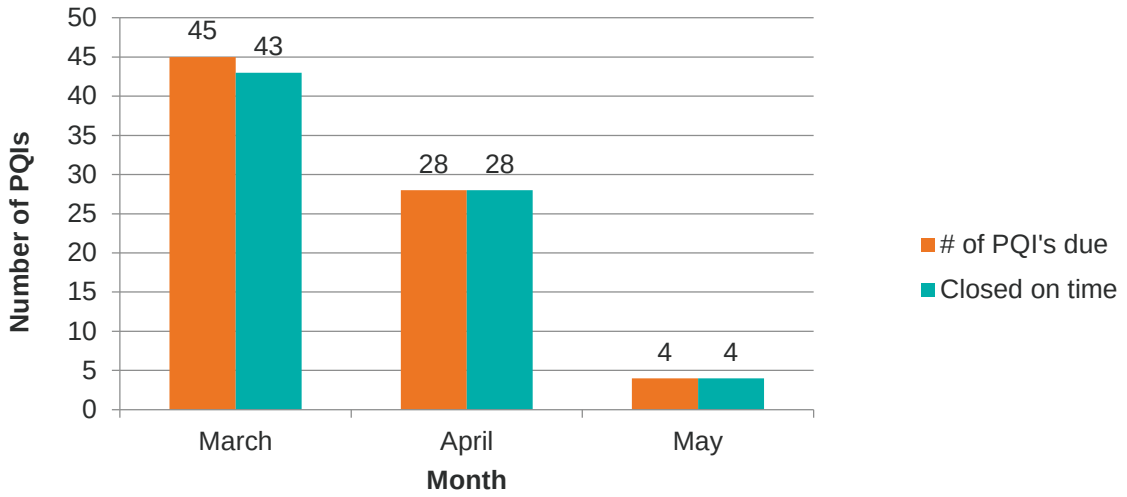
Quality Improvement Dashboard

March 2021 – May 2021

Potential Quality of Care Issues

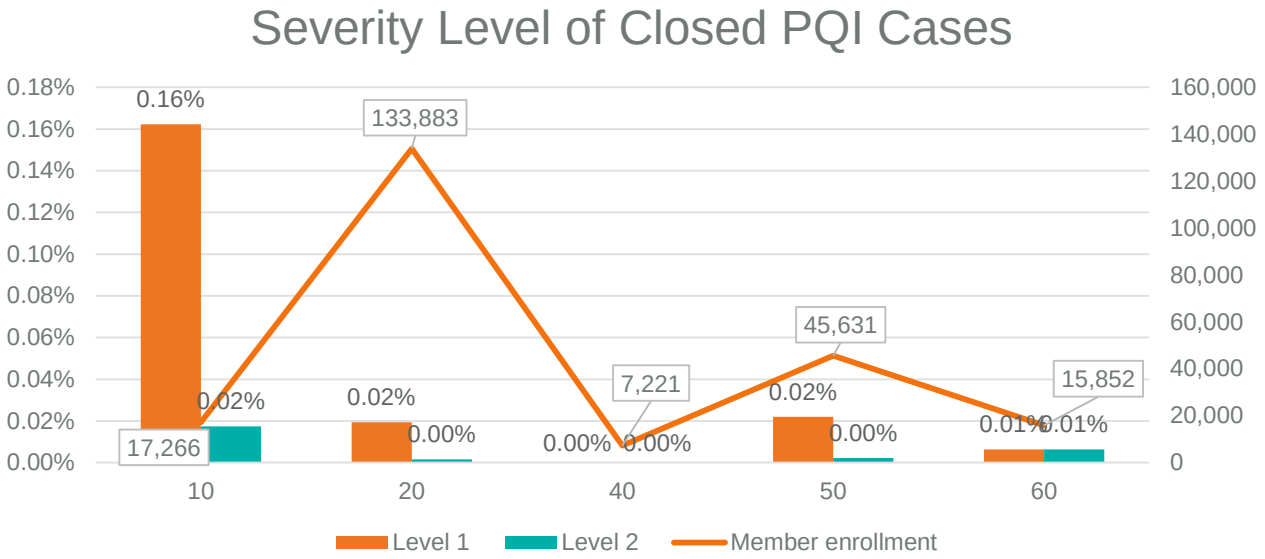
Santa Clara Family Health Plan

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



97.4%

Percentage of PQIs due from March 2021 - May 2021 closed on time within 90* days



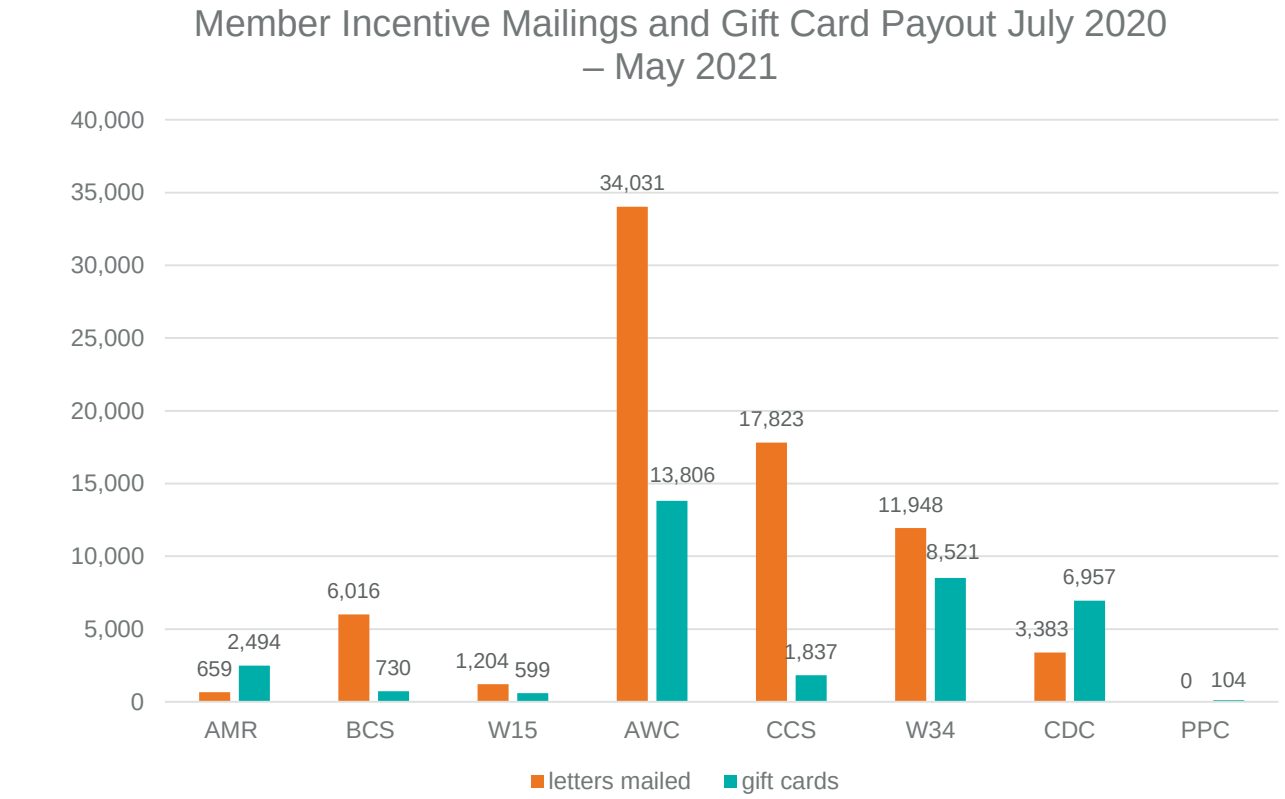
*PQIs received starting March 1st, 2021 were closed within 90 days instead of 60 days

Member Incentives:
Wellness Rewards Mailing

Letters to non-compliant members started in July for: W15, W34, AWC, BCS, CCS, CDC, AMR

*PPC is referral based, no mailers

Total # of mailers sent since July 2020	75,064
Total # of gift cards mailed since July 2020	35,048

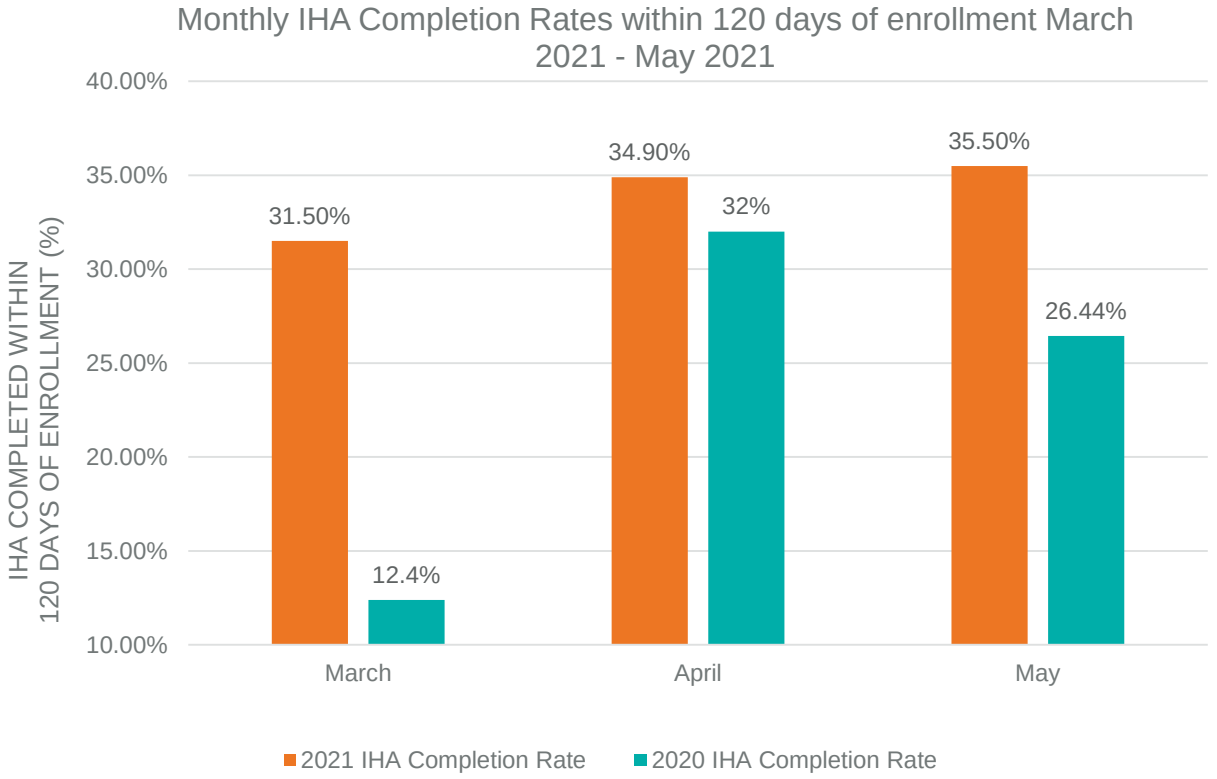


Initial Health Assessment (IHA)

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 currently conducts quarterly IHA audits and provider education to continually improve IHA completion rates

*DHCS has temporarily suspended the requirement to complete IHAs for members within 120 days of enrollment until the COVID-19 emergency declaration has ended. The IHAs will have to be completed once this emergency is over.

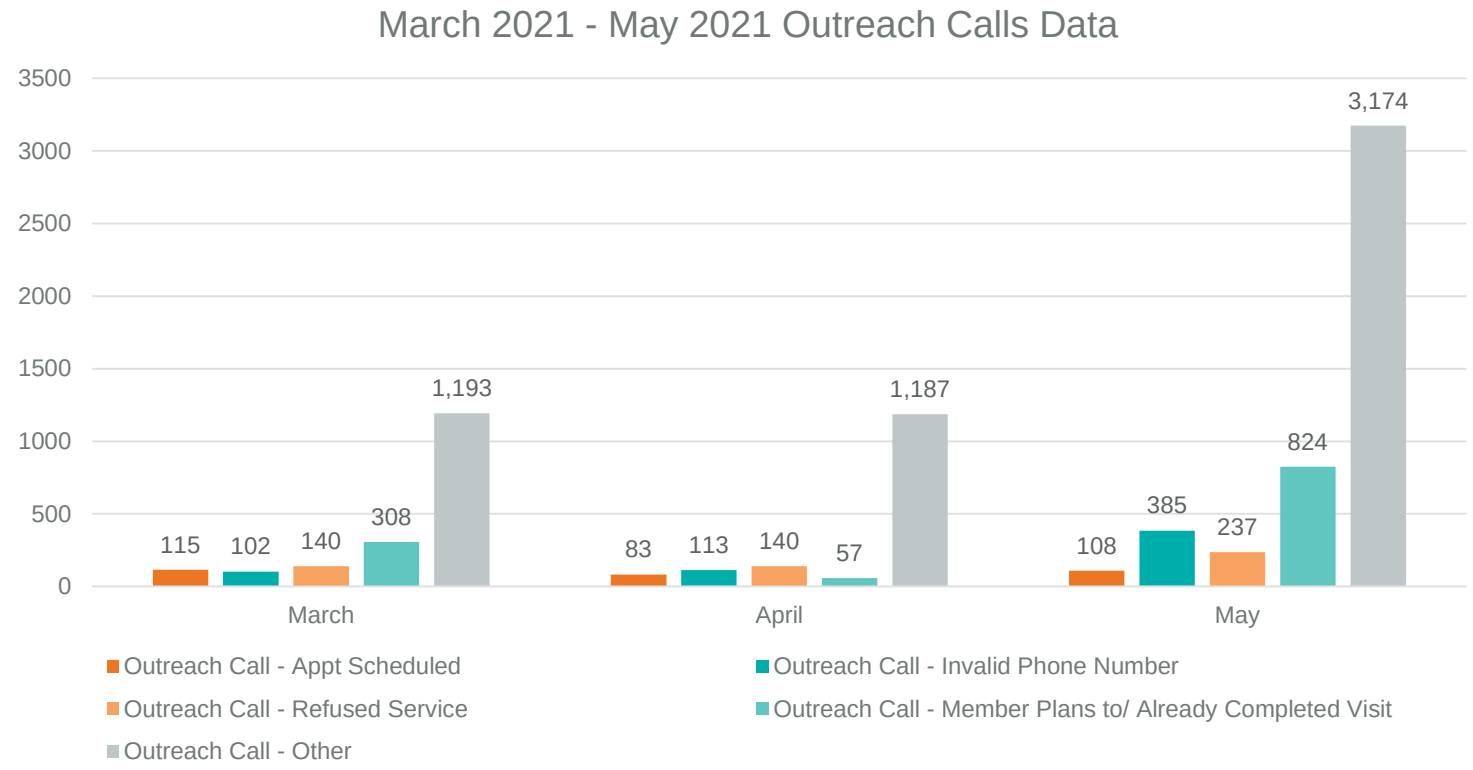
*These IHA rates may change in the future months owing to the 90-day claims lag

Outreach Call Campaign

Dedicated outreach call staff conduct calls to members for health education promotion, to help schedule screenings and visits while offering Wellness Rewards

Campaigns completed (March 2021 – May 2021)

Cervical Cancer Screening (CCS)	Blood Lead Screening
Comprehensive Diabetes Care (CDC)	Premier Care – Initial Health Assessment
Colorectal Cancer Screening (COL)	PIP – CCS – Caucasians, Asian Indian, and Asian Pacific
Engaged in Healthcare	Chlamydia Screening (Ages 21 – 24 Only)
Well-Child Visit (W30)	Well-Visit – Adolescent (WCV)



8,166

Total number of attempted outreach in March 2021- May 2021

*Outreach call - Other include member demographic change requests, dis-enrollment requests, specific questions from members, calls that go to voicemails and other miscellaneous requests

Health Homes Program (HHP)

Santa Clara Family Health Plan

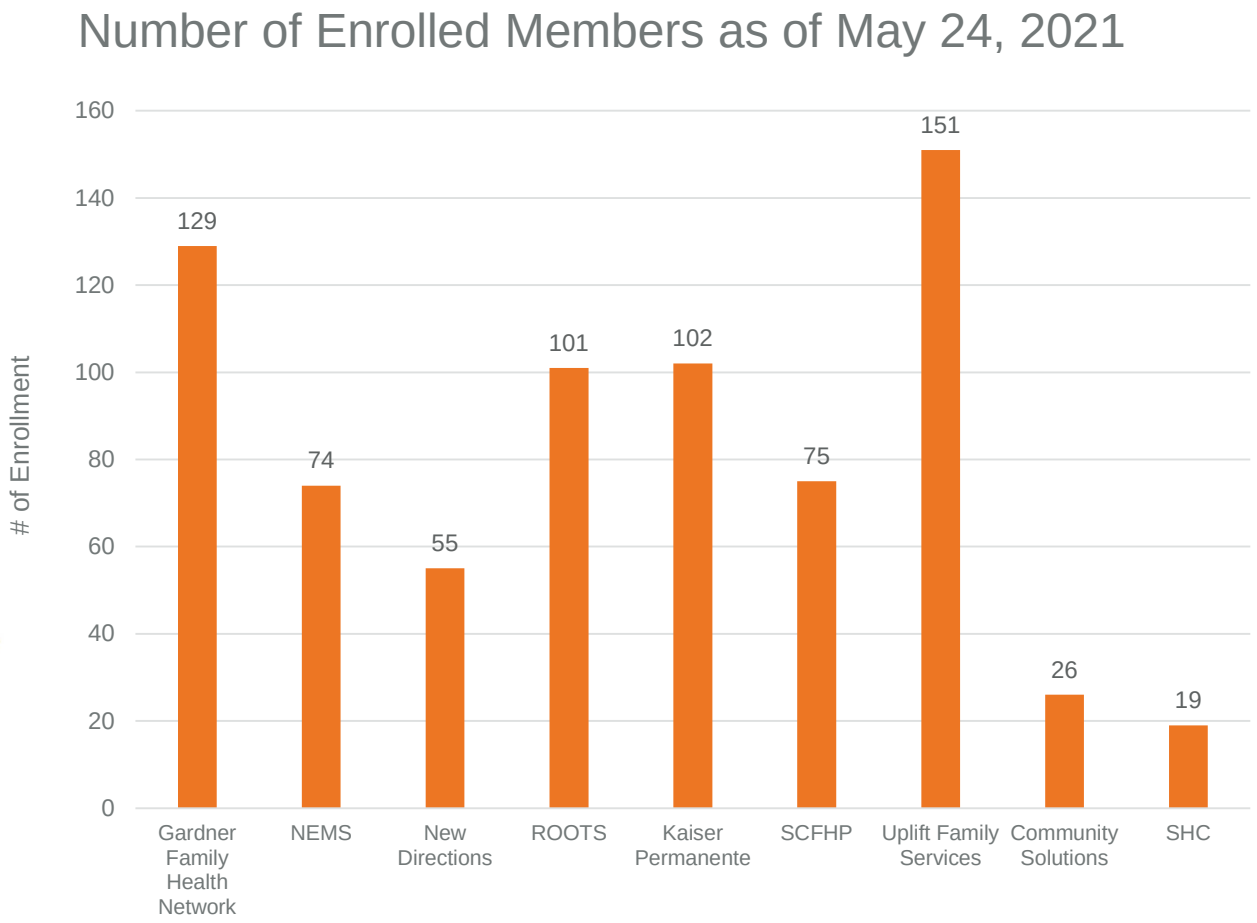
HHP launched with Community Based Care Management Entities (CB-CMEs) on July 1, 2019 for Chronic Conditions and on January 1, 2020 for Serious Mental Illness

What is the Health Homes Program?

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

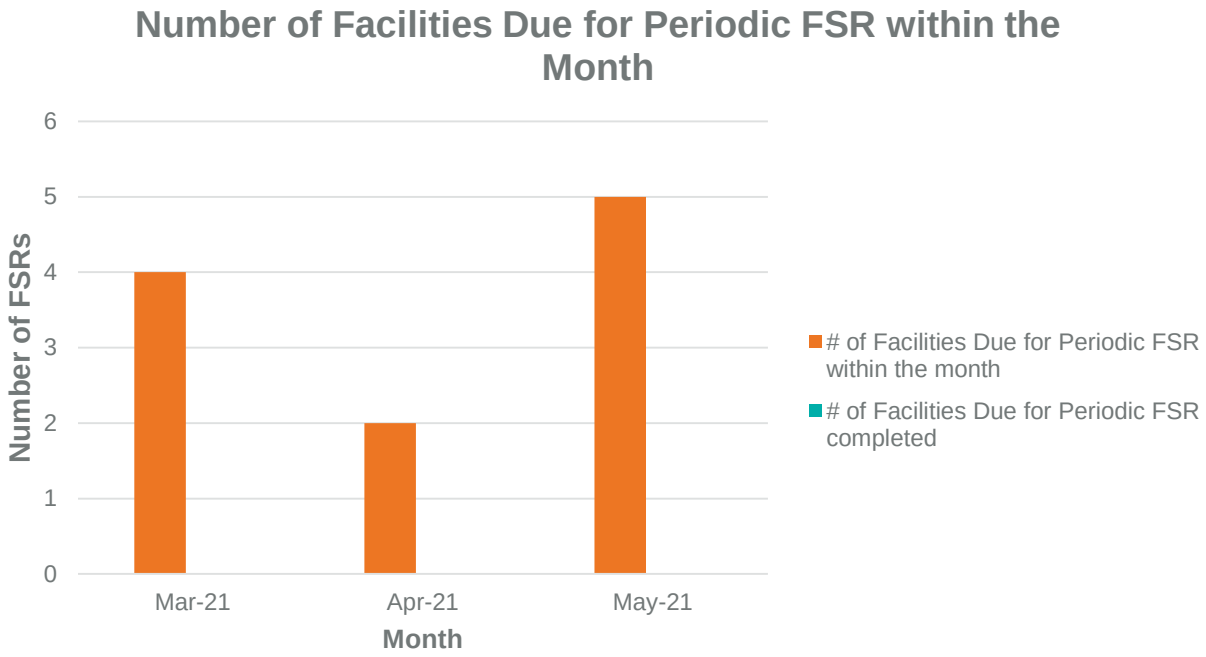
732

Members have verbally consented into Health Homes as of May 24, 2021



Facility Site Review (FSR)

What is a FSR?
A FSR is a 3 part evaluation of all PCPs and high volume specialists to audit provider offices for patient safety



FSRs were not conducted due to the **COVID-19 situation-** Extensions have been approved by DHCS

*DHCS has temporarily suspended the requirement to conduct FSRs until the COVID-19 emergency declaration is rescinded. The FSRs will have to be completed once this emergency is over

*FSR Master Trainer (MT) started working on virtual initial FSRs for new provider sites. MT completed 2 virtual initial FSR in 2021. One initial FSR was completed in February 2021 and the other was completed May 2021. FSR MT has begun contacting provider sites that are due for the periodic site and medical record reviews

Regulatory Audit Report

June 9, 2021

- **Medicare Data Validation (MDV)**
  The Plan is currently undergoing the annual Medicare data validation audit. SCFHP engaged Advent Advisory Group to complete a validation of various reporting to CMS for calendar year 2020 operational activities. The audit validates data submitted for the Part D program, specifically for Appeals, Grievances, Coverage Determinations, Medication Therapy Management, and Improving Drug Utilization Review Controls. Advent's team conducted a virtual interview at the end of April to review our overall reporting process and is currently reviewing our source documentation. Advent will be submitting final results to CMS by the end of June.

- **Department of Health Care Services (DHCS) Medi-Cal Managed Care Audit**
  Our 2021 annual DHCS audit, covering only Medi-Cal, occurred between March 8 and March 19, covering a review period of March 2020 through February 2021. At the conclusion of the audit, DHCS discussed with the Plan its preliminary findings. Based on that conversation, we expect the preliminary audit report may include findings relating to delegation oversight of utilization management and transportation vendor enrollment, as well as timely completion of initial health assessments. The preliminary report is anticipated in June.

- **Department of Managed Health Care (DMHC) Medi-Cal Managed Care Audit**
  Also in March, the Plan underwent a follow-up audit of our 2019 DMHC audit. The scope of the audit was limited to the outstanding deficiencies in our 2019 audit final report, which related to delegate oversight of utilization management and providing proof of a response for post-stabilization care requests within the required timeframe. DMHC did not share any preliminary findings of the follow-up audit with the Plan. A preliminary report is expected sometime this summer.

- **Corrective Action Plans**
  The Plan has been working since last Fall to implement corrective actions relating to the six findings in the final 2020 DHCS audit. All but one of the tasks included in our corrective action plans (CAPs) have been implemented. The remaining task relates to the finding that the Plan did not complete initial health assessments within the required timeframe. The task requires a reconfiguration of the primary care provider assignment process that is on track to be completed in June.

Santa Clara Family Health Plan™

Utilization Management Committee

Meeting Minutes

April 21, 2021

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, April 21, 2021 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - DRAFT

Members Present
Jimmy Lin, M.D., Internal Medicine, Chair
Ali Alkoraishi, M.D., Psychiatry
Ngon Hoang Dinh, OB/GYN
Laurie Nakahira, D.O., Chief Medical Officer
Habib Tobbagi, PCP, Nephrology

Members Absent
Dung Van Cai, D.O., Head & Neck
Indira Vemuri, Pediatric Specialist

Staff Present
Christine Tomcala, Chief Executive Officer
Dang Huynh, PharmD, Director, Utilization Management & Pharmacy
Lily Boris, M.D., Medical Director
Natalie McKelvey, Manager, Behavioral Health
Luis Perez, Supervisor, Utilization Management
Hoang Mai Vu, Utilization Management & Discharge Planning Nurse
Amy O'Brien, Administrative Assistant

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:05 p.m. Roll call was taken and a quorum was established. Dr. Huynh introduced the new SCFHP Utilization Management and Discharge Planning Nurse, Hoang Mai Vu.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the January 20, 2021 Utilization Management Committee (UMC) meeting were reviewed.

It was moved, seconded, and the minutes of the January 20, 2021 UMC meeting were **unanimously approved.**

Motion: Dr. Nakahira
Seconded: Dr. Tobbagi
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

4. Chief Executive Officer Update

Christine Tomcala, Chief Executive Officer, highlighted the Plan's collaboration with the County Emergency Operations center to hold pop-up vaccination clinics at the Community Resource Center (CRC). At least 300 vaccines were administered during each clinic. The most recent clinic was held on January 19, and SCFHP

was given 470 vaccines. Of those 470 vaccines, there were some left over, which may be attributable to the vaccine hesitancy issue. Ms. Tomcala confirmed SCFHP will connect with Dr. Lin on the best way to inform his patients of upcoming clinics.

Dr. Tobbagi expressed concern with vaccine waste. Ms. Tomcala advised that, up until yesterday's clinic, vaccine waste was not an issue. SCFHP provides the location; the Public Health department coordinates all the staffing and clinical details. The Public Health department is concerned about vaccine waste and this issue is being addressed. Dr. Lin asked for the date of the next clinic. Ms. Tomcala replied that Public Health does not give the Plan advance notice. SCFHP has requested that Public Health devise a more routine schedule which would encourage more public participation and less vaccine waste. Dr. Nakahira directed Dr. Lin to our website which has a link to the Public Health Department. Vaccine availability has increased and Levi Stadium is under consideration as a potential pop-up vaccination site. Ms. Tomcala welcomes the committee's ideas and recommendations to overcome vaccine hesitancy amongst our members.

5. Chief Medical Officer Update

a. General Update

Dr. Laurie Nakahira, Chief Medical Officer, began with a reminder to committee members to sign the annual SCFHP confidentiality agreement. Dr. Nakahira provided the Committee with a COVID-19 update. The Plan provides assistance to members who are 65 years of age and older to help them make vaccine appointments online in conjunction with the Public Health department. Public Health has agreed to reserve a certain number of vaccine appointments for our high-risk members. The Plan continues to call our members to confirm if they have been vaccinated, provide assistance on how to make appointments to be vaccinated, and, if applicable, the reasons why vaccination is declined. The most common reason given is concern over long-term side effects.

Dr. Nakahira continued with the Plan's successful completion of the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) audits in March 2021. A final audit report is pending. The Plan is focusing on Enhanced Case Management (ECM) and In-Lieu-of-Services (ILS). The Plan is preparing for the sun-setting of the County's Whole Person Care and Home Health programs.

b. Annual Confidentiality Agreements

This item was addressed in the CMO update.

6. Old Business/Follow-Up Items

a. Plan-All-Cause Readmission (PCR) Rates

Dr. Dang Huynh, PharmD, Director Utilization Management and Pharmacy, presented an overview of PCR Rates, and ways to reduce the number of readmissions. PCRs are readmissions that occur in acute settings within 30 days. The Plan's Fiscal Year goal is to reduce Medi-Cal PCRs to 7.48%. Dr. Huynh described the strategies the UM department will implement in order to achieve this goal. The UM department is expanding their TLC in the Case Management department, so calls, follow-up reviews, and HRA's are all in alignment. UM is identifying individuals who are candidates for further outreach, and working with the Plan's provider groups for more oversight on their concurrent review and discharge planning processes, which reduces their PCR, as well as the Plan's PCR. The UM department has built strong relationships with the Plan's contracted hospitals to strategize a more proactive approach to prior authorizations and timely discharge planning procedures. Finally, the UM department will improve their analytics on ADT data to support provider groups. Dr. Lin stated that Medicare readmissions rates are significantly higher than the Plan's 9.58%, and he approves of the Plan's emphasis on communication with contracted hospitals and providers.

7. UM Program Evaluation - 2020

Dr. Lily Boris, Medical Director, presented the Committee with the annual review of the UM Program Evaluation for 2020. The UM Program Evaluation is a requirement of the state, as well as the NCQA. It is divided into Quality of Clinical Care and Quality of Service. The UM department successfully completed quality of clinical care and corresponding HEDIS metrics such as: current reporting; quality of inpatient care; readmissions; the UM Program Description; medical necessity criteria policy; and prior authorizations on outpatient and inpatient stays. The only 2 items that were not completed were Item #9 Track and Monitor Behavioral Health Inpatient Stays for Cal MediConnect, and Item #16 Conduct Member and Provider Satisfaction Surveys. Item #9 was not measured, as the Plan did not have access to the data set. A new parameter has been built so the Plan can provide this information next year. Item #16 was not completed as Medi-Cal and Medicare satisfaction surveys are conducted outside of the Plan's purview. Otherwise, all quality of clinical care and HEDIS items were reviewed and completed in a timely fashion.

It was moved, seconded and the UM Program Evaluation - 2020 was **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

8. UM Work Plan – 2021

Dr. Boris next presented the UM Work Plan for 2021 to the Committee. The UM Work Plan reflects the goals for 2021. The requirements are divided by quarter. Dr. Boris highlighted item #9 Track and Monitor Behavioral Health Inpatient Stays for Cal MediConnect, as the strongest focus area of the 2021 Work Plan. Dr. Boris also directed the committee's attention to item #15 Annual Inter-Rater Reliability which should be conducted on an annual basis, not a bi-annual basis as listed in the Work Plan, with achievement of an 80% pass rate for all UM staff.

It was moved, seconded and the UM Work Plan – 2021 was **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

9. Care Coordinator Guidelines

Mr. Luis Perez, Supervisor, UM, provided an overview of the UM Care Coordinator Guidelines to the Committee. Dr. Lin remarked that it appears there is improvement on SNF transitions to long-term care, and Mr. Perez agreed. Dr. Lin asked if patients in hospice care remain under SCFHP, or do they qualify for carve out? Mr. Perez clarified hospice care patients remain under the jurisdiction of SCFHP.

Ms. Natalie McKelvey, Manager, Behavioral Health, presented an overview of the Behavioral Health Care Coordinator Guidelines to the Committee. Ms. McKelvey explained that the most important factor for Care Coordinator Guidelines is to follow APL 19-014. The Care Coordinator can approve anything less than 25 hours per week in direct services. Anything above 25 hours per week requires a Manager or a doctor's review and approval.

It was moved, seconded and the Care Coordinator Guidelines were **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Cai, Dr. Dinh, Dr. Vemuri

10. UM 1B Annual Assessment of Senior Level Practitioners for NCQA – 2020

Dr. Boris gave an overview of the 2020 UM 1B Annual Assessment of Senior Level Practitioners, as required by NCQA. The purpose is to determine how a senior level practitioner participates in the Plan's UM Committee. Dr. Boris co-chairs this committee with Dr. Lin. Dr. Alkoraishi also participates in this committee to address the Behavioral Health perspective. Dr. Boris explained how the answers to 6 targeted questions demonstrate the fact that senior level practitioners meet the necessary NCQA standards and elements.

11. Home Health Services Authorization Procedure

Dr. Huynh presented the Committee with an overview of the purpose of procedure HS.01.23 Home Health Services Authorization. Dr. Huynh explained that the UM department uses MTV as the criteria in order to evaluate the number of approved visits. The MTV recommendation for the 50th percentile is limited to commercial and Medi-Care lines of business. As the Plan has Medi-Cal beneficiaries, a procedure was developed which clearly outlines how the UM team will approve the numbers of visits for Medicare and Cal MediConnect beneficiaries. The UM reviewer will be able to approve up to 200% of the Medicare 50th percentile recommended visits. Any additional visits will require appropriate notes that establish medical necessity.

Dr. Boris directed the Committee's attention to the MCG criteria. Dr. Boris explained that the Plan relies on MCG criteria in situations where neither Medicare nor Medi-Cal have clear criteria for what constitutes an approval or denial. It was necessary for the UM team to show specific reasons for denials of service, as the Plan's auditors require a concrete procedure. Dr. Lin expressed his concern with the establishment of the 200% of the 50th percentile guideline. Ms. Tomcala responded that our members deserve the right care at the right time. Dr. Boris reminded Dr. Lin that the Plan's Medi-Cal and MediCare patients have a higher acuity, and the typical Medicare patient does not have the co-morbidity rate or social issues of the typical Medi-Cal patient. Dr. Boris emphasized that all patients must still meet the criteria of medical necessity.

Dr. Huynh explained that this procedure will help to establish the maximum number of home health visits that will be approved per patient on a case by case basis. During audits, the Plan can explain their rationale for approvals or denials through use of this procedure. Dr. Boris stated that the UM department will do an evaluation of this procedure after 6 months and discuss the results at the October 2021 meeting.

Dr. Dinh joined the meeting at 6:42 p.m.

12. Reports

a. Membership

Dr. Boris gave a brief summary of the Membership Report from April 2020 through April 2021. Cal MediConnect membership has increased to 9,924 members, and Medi-Cal membership has increased to 269,043 members. The Plan's total population has increased from 243,774 members to 278,967 members, largely attributable to the pause on Medi-Cal redeterminations due to COVID. The majority of our members remain delegated to Valley Health Plan, with the remaining majority delegated to Physicians Medical Group, Kaiser Permanente, and Premier Care.

b. Over/Under Utilization by Procedure Type/Standard UM Metrics

Dr. Boris presented the Committee with the UM objectives and goals. Dr. Boris summarized the results of the Medi-Cal SPD and non-SPD lines of business for the calendar year 2020, with a comparison to the results from 2019. Dr. Boris also summarized the results for the Cal MediConnect line of business, with a comparison to the data from 2019. Dr. Boris next summarized the number of admissions and re-admissions for both the Medi-Cal and Cal MediConnect lines of business. Ms. Tomcala asked if admissions and readmissions were affected by COVID and the fact that many elective procedures were put on hold. Dr. Boris replied that the UM department will analyze COVID admissions and readmissions for 2020 and bring these

results to the July 2021 meeting. Dr. Huynh advised that some of the data may have been affected by the HEDIS change.

Dr. Boris concluded with a summary of the Cal MediConnect readmission rates, which have increased since 2019. The UM team will perform analysis to determine how COVID may have affected this increase in PCR rates.

c. Dashboard Metrics

- Turn-Around Time – Q1 2021

Mr. Perez summarized the Cal MediConnect Turn-Around Time metrics for Q1 2021. The turn-around times in all categories are compliant at 99% or better, with the exceptions of expedited pre-service prior authorization requests with a 95.9% rate, expedited Part C initial determinations at 96.9%, standard prior authorization requests for Part B drugs at 94.6%, and expedited prior authorization requests for Part B drugs at 97.4%.

Mr. Perez next summarized the Turn-Around times for Medi-Cal authorizations for Q1 2021. The turn-around times for all Medi-Cal authorizations combined is compliant at 98% or better.

Dr. Huynh explained that some of the turn-around times were impacted by issues with the mail room and the fax line. The UM Department is focusing on better reporting, streamlining processes, and additional training, with a commitment to 100% compliance with contractual and regulatory requirements. Dr. Huynh explained to Dr. Lin that even 1 non-compliant case found by the CMS auditors triggers an impact analysis to determine if there are additional cases of non-compliance.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q1 2021

Dr. Huynh summarized the data from the Q1 2021 Cal MediConnect and Medi-Cal Quarterly Referral Tracking reports for the Committee. Dr. Huynh explained that the UM team tracks the cycle of prior authorizations from the time the prior authorization is issued through to claims payment. The average claims cycle is 90 days. This report is affected by a claims data lag. Dr. Huynh explained that the annual review, which incorporates this data lag, presents a more accurate picture of timeframes within the claims cycle. Dr. Lin asked how the 2020 results compare with 2019. Dr. Huynh replied that he will review these numbers and present the results at the July 2021 meeting. Dr. Huynh agrees that COVID has affected the number of outpatient services and prior authorization requests.

e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q1 2021

Dr. Boris summarized the results of the Q1 2021 Quality Monitoring of Plan Authorizations and Denial Letters for the Committee. Dr. Boris reported that the UM department received a 100% score in virtually all categories, with the exception of a small handful of written notifications that either contained unexplained medical terminology, grammatical and punctuation errors, or omitted the rationale for the denial. Dr. Huynh will ensure these errors will be reviewed with all UM staff members. UM leadership will continue to take an active role in QA oversight.

f. Behavioral Health UM

Ms. Natalie McKelvey, Manager, Behavioral Health, presented an overview of utilization of the Behavioral Health Treatment program. Ms. McKelvey highlighted the number of developmental screenings, and Dr. Lin remarked on the high number of Q1 screenings for VHP and PMG. Ms. McKelvey believes this could be due to a claims lag, or the fact that the providers do not promptly bill for services. Ms. McKelvey will provide an update at the July 2021 meeting. Ms. McKelvey discussed how important it is for BH providers to complete ACES Aware training and conduct trauma screenings. Ms. McKelvey discussed the fact that the Plan provides assistance to providers in how to conduct trauma screenings which includes peer-to-peer training via Zoom.

Dr. Tobbagi asked for an explanation of payment structure, and Ms. McKelvey advised the County is responsible for providing specialty mental health, and health plans are responsible for serving the mild to

moderate symptoms population. The payment structure is complicated, as it is based primarily on the patient's function level. A discussion ensued amongst Ms. McKelvey, Dr. Tobbagi, and Dr. Lin as to the Plan's top 10 billing providers, and the cost of BH services. Ms. McKelvey advised BH is not a capitated service with respect to autism. The Plan follows the APL and EPSDT requirements for treatment for kids. Treatment plans are approved every 6 months to confirm medical necessity. Dr. Tobbagi asked about the amount of compensation for initial BH consultations for adults. Ms. McKelvey replied she does not have the specific numbers, but the Plan pays over the Medicare and Medi-Cal rates.

Dr. Boris pointed out that, with respect to the bar graph which shows the top 10 billing providers, the graph includes all BH treatment provided from 2018-2020 and includes children who receive a combination of ABA therapy in the home. Ms. McKelvey clarified the bar graph does not include speech or occupational therapies. The BH team regularly meets with ABA providers to ensure the standard of medical necessity is met, and discussions continue to understand what the community standard is for BH treatment.

Dr. Tobbagi asked why so many patients are having trouble getting referrals to Stanford when they change their primary care physician. Dr. Nakahira and Dr. Boris agreed this may be an issue with Stanford's process. They will research this issue to confirm there is not a problem with the Plan's referral process.

13. Adjournment

The meeting adjourned at 7:26 p.m. The next meeting of the Utilization Management Commitment is on July 21, 2021 at 6:00 p.m.

_____ _____

Jimmy Lin, M.D, Chair
Utilization Management Committee

Date

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee 04/07/2021

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	34	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	6	
Number practitioners recredentialed within 36-month timeline	6	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 03/31/2021	291	

(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	1384	1220	777	828	420	135

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.