Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, February 12, 2020, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
Residence
3411 S. Conway Ct.
Kennewick, WA CA 99337

Via Teleconference
Business
751 South Bascom Avenue
San Jose, CA 95128

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 December 4, 2019 Quality Improvement Committee meeting **Possible Action:** Approve minutes of the December 4, 2019 Quality Improvement Committee meeting	Dr. Paul	6:10	5 min
4.	**CEO Update** Discuss status of current topics and initiatives	Ms. Tomcala	6:15	5 min
5.	**Follow-Up/Old Business**			
	a. Out of Network Requests for Ambulatory Surgical Centers (ASC)	Ms. Switzer	6:20	5 min
	b. Valley Medical Readmission Rates	Ms. Andersen	6:25	5 min
6.	**Review of Quality Improvement (QI) Program Description 2020** Review the QI Program Description 2020 **Possible Action:** Approve the QI Program Description 2020	Ms. Chang	6:30	5 min
7.	**Review of Health Education (HE) Program Description 2020, HE Work Plan 2020, and HE Evaluation 2019** Review the HE Program Description 2020, HE Work Plan 2020, and HE Evaluation 2019 **Possible Action:** Approve the HE Program Description 2020, HE Work Plan 2020, and HE Evaluation 2019	Ms. Hernandez	6:35	5 min

8.	**Review of Cultural and Linguistics (C&L) Program Description 2020, C&L Work Plan 2020, and C&L Evaluation 2019** Review the C&L Program Description 2020, C&L Work Plan 2020, and C&L Evaluation 2019 **Possible Action:** Approve the C&L Program Description 2020, C&L Work Plan 2020, and C&L Evaluation 2019	Ms. Hernandez	6:40	10 min
9.	**Provider Satisfaction Report for MY2019** Review the Provider Satisfaction Report for MY2019 **Possible Action:** Approve the Provider Satisfaction Report for MY2019	Ms. Switzer	6:50	5 min
10.	**Review of Population Health Assessment** Review of Population Health Assessment **Possible Action:** Approve the Population Health Assessment	Dr. Liu	6:55	5 min
11.	**Review of Clinical, Behavioral, and Medical Preventative Practice Guidelines** Review the Clinical, Behavioral, and Medical Preventative Practice Guidelines **Possible Action:** Approve the Clinical, Behavioral, and Medical Preventative Practice Guidelines	Ms. Chang	7:00	5 min
12.	**American with Disabilities Act (ADA) Work Plan 2020** Review the ADA Work Plan 2020 **Possible Action:** Approve the ADA Work Plan 2020	Ms. Chang	7:05	5 min
13.	**Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis** Review the Continuity and Coordination between Medical Care and Behavioral and Healthcare Analysis **Possible Action:** Approve the Continuity and Coordination between Medical Care and Behavioral and Healthcare Analysis	Ms. Franke	7:10	5 min
14.	**Annual Review of QI Policies** **a.** QI.05 Potential Quality of Care Issues **b.** QI.07 Physical Access Compliance **c.** QI.10 IHA and IHEBA Assessments **Possible Action:** Approve QI Policies as presented	Dr. Liu	7:15	5 min
15.	**Grievances and Appeals Report** Review of the Grievance and Appeals Report	Mr. Breakbill	7:20	10 min
16.	**Quality Improvement Charter** Review of the Quality Improvement Charter	Dr. Liu	7:30	10 min
17.	**Quality Dashboard** Review of the Quality Dashboard	Ms. Chang	7:40	5 min
18.	**Compliance Report** Review of the Compliance Report	Ms. Yamashita	7:45	5 min
19.	**Credentialing Committee Report** Review December 20, 2019 Credentialing Committee Meeting Report **Possible Action:** Approve the December 20, 2019 Credentialing Committee Meeting Report	Dr. Nakahira	7:50	5 min

20. Utilization Management Committee Minutes Review minutes of the October 16, 2019 Utilization Management Committee Meeting **Possible Action:** Accept October 16, 2019 Utilization Management Committee Meeting minutes as presented	Dr. Lin	7:55	5 min
21. Adjournment Next Quality Improvement Committee meeting: April 8, 2020	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.

Regular Meeting of the

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Wednesday, December 4, 2019, 6:00 PM - 8:00 PM
Santa Clara Family Health Plan, Redwood
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Ria Paul, MD, Chair
Jimmy Lin, MD
Ali Alkoraishi, MD
Christine Tomcala, Chief Executive Officer
Laurie Nakahira, D.O., Chief Medical Officer

Members Absent
Jeffrey Arnold, MD
Jennifer Foreman, MD
Nayyara Dawood, MD

Staff Present
Chris Turner, Chief Operating Officer
Johanna Liu, PharmD, Director, Quality & Process Improvement
Tanya Nguyen, Director, Customer Service
Darryl Breakbill, Director, Grievance and Appeals
Lori Andersen, Director, Long Term Services and Support
Janet Gambatese, Director, Provider Network Management
Jamie Enke, Manager, Process Improvement
Mai Chang, Manager, Quality Improvement

Others Present
Carmen Switzer, Manager, Provider Network Access *(via telephone)*

1. **Introduction**

   Ria Paul, Chair, called the meeting to order at 6:04pm. Roll call was taken.

2. **Meeting Minutes**

   Minutes of the November 19, 2019 Quality Improvement Committee (QIC) meeting were reviewed.

   > **It was moved, seconded, and** the minutes of the November 19, 2019 Quality Improvement Committee meeting were **approved**.

3. **Public Comment**

   There were no public comments.

4. **CEO Update**

   Christine Tomcala, Chief Executive Officer, noted there are no additional updates since the last Quality Improvement Committee (QIC) meeting on Tuesday, November 19, 2019.

5. Follow-Up / Old Business

There were no follow-up items.

6. Action Items

a. Network Adequacy Assessment

Carmen Switzer, Manager of Provider Network Access, explained Santa Clara Family Health Plan (SCFHP) monitors the adequacy of its network on access, availability, and member experience. This is done annually to identify opportunities of improvement. The Network Adequacy Assessment report includes a summary of findings from NET 1 (provider availability) and NET 2 (provider accessibility) reports and includes new information relevant to NET 3 (i.e., out of network requests/approvals). Combined reporting elements helps the Plan determine if there are gaps that need to be addressed.

Ms. Switzer reported the NET 1 report (availability of network providers) showed that the standards for geographic time or distance were not met for General Practice, however, the NET 1 report also showed that the combined Primary Care Provider (PCP) network relevant to Cal MediConnect (CMC), meets provider-to-member ratios at 1:16.

The NET 2 report (accessibility assessment) showed that the PCP's combined performance is at 68%; 22 percentage points below goal for urgent care appointment standards. For non-urgent care appointment standards, the PCP's combined performance is at 84%; 6 percentage points below goal.

After-hours access compliance on 911 messaging was also assessed within the NET 2 report. SCFHP worked with Palo Alto Medical Foundation (PAMF) to address a main phone line that affected 48 PCP's compliance rate on access compliance. Following the updated PAMF message, the overall rate of compliance for PCP providers is at 93%; 3 percentage points above goal. Behavioral Health (BH) providers showed a marked improvement in 2019. For the after-hours timeliness compliance on 30-minutes or less, the NET 2 report concluded that PCP's and BH providers are unfamiliar with the after-hours timeliness standard. Ms. Switzer noted provider education on after-hours timeliness compliance will be a focus point in 2019/2020.

Ms. Switzer reported results for the high volume and high impact specialist on appointment availability. As noted in the NET 2 report, although SCFHP made efforts to increase the number of respondents in 2019 by improving provider demographic data and enhancing provider communications, the response rate did not increase from 2018. The response rates were not sufficient enough to draw meaningful conclusions. The same applies to the BH providers including, Psychiatry, Psychology, Mental Health, and Marriage/Family Therapy.

Ms. Switzer reviewed the results for the Member Satisfaction with Behavioral Health Survey and noted members undergoing active behavioral health treatment (BHT) are difficult to contact due to frequent changes in contact information and where they access BH services. This may explain why the response rate was only at 13%.The assessment showed that members were satisfied overall with access to BH providers.

Ms. Switzer reported there were a total of 38 grievances, within a 7,822 CMC member population, for non-BH providers. Compared to 2018, access grievances per 1,000 members increased from 2.4 to 4.85 regarding non-BH providers and increased from none to .3 for BH providers. There are no billing/financial grievances to report for 2019 and there were none reported in 2018. With the exception of Psychiatry, there were no other member grievances relevant to non-BH or BH providers that did not meet specific access standards or that were classified as high-volume or high-impact. As reported in NET2 (accessibility of provider network), the Psychiatry (1) complaint was due to member/provider scheduling conflicts. It was noted that customer service worked with the member's social worker to find a provider that meets the member's scheduling needs.

Ms. Switzer reported results relating to appeals. Compared to 2018, access appeals per 1,000 members increased from.67 to 1.2 regarding non-BH providers and there was no change relevant to BH providers. There are no billing/financial appeals to report for 2019 and none were reported in 2018. All 9 appeals were pre-service appeals. The following are 2 examples:

- Ophthalmology (N-1) – Member requested an out-of-network (OON) provider to perform cataract surgery and the Plan redirected the member to an in-network provider
- Pulmonary (N=1) – Member requested an OON providers, and the Plan determined that there were in-network providers available to serve the member

Ms. Switzer explained SCFHP reviews OON utilization activity on an annual basis to assess CMC members use of OON providers and other services. Data reflects a total of 412 prior authorizations (PA); 334 of which were approved and 78 of which were denied. The threshold per 1,000 members is 25 for the number of PAs received and 25 for PAs approved; SCFHP did not meet these goals. The threshold per 1,000 members for PAs denied is 5; SCFHP did not meet the goal. However, the BH provider PAs requests were approved at 100% and the non-BH provider PAs requests were approved at 81%. Eighty nine (89%) of the OON denials (78) were denied due to medical necessity and 11% were denied due to services being available within network.

Jimmy Lin, MD, asked for additional examples of OON utilization, as he understands most needs should be able to be covered within network. Ms. Switzer acknowledged his questions and noted further explanation would be addressed in the next segment of her presentation.

Ms. Switzer explained within the Health Home (HH) program, Sequoia HH was responsible for 60% of the OON requests, and South Springs HH was responsible for 36% and 4% (3 facilities) were responsible for out of service (OOS) area encounters. Ms. Switzer added the OON requests were retro actively submitted to the Plan, and those requests were approved to ensure Continuity of Care (COC). For acute hospital, the OON inpatient approvals were admissions from out of state (19%), OOS area (80%) and 1% were in service area emergency room admissions that are subject to EMTALA provisions.

Dr. Lin asked if it financially costs SCFHP more to go OON, rather than remain in network. Ms. Tomcala addressed the question with an example. If someone arrives at UCSF on an emergency basis, then they would have to accept Medi-Cal, but if someone needs a specialty services available at UCSF, then this would be a lot more expensive. Dr. Lin asked if people generally get referred back to UCSF if there are other in-network facilities/specialty providers available, as the total amount of OON provider use is 412. Laurie Nakahira, D.O., Chief Medical Officer, added some insight on the PA process within the Utilization Management (UM) department. If a member has specialty needs and want to go to UCSF, the will Plan deny and refer the member to Stanford. However, if Stanford cannot provide the service(s), they can refer the member to UCSF, and SCFHP will approve this.

Ms. Switzer continued with the OON requests for Ambulatory Surgical Centers (ASC). The OON approvals (N=30), involved 4 ASC's – Peninsula Eye Surgery Center and Tri-County Vascular Care are responsible for 47% of ASC OON approvals. The Plan is currently working with these facilities regarding a previous discussion to contract with SCFHP. Ms. Switzer will provide an update on this matter at the following Quality Improvement Committee (QIC) meeting.

For BH OON requests, Ms. Switzer reported 6 OON approvals were for Discovery Counseling, who has since entered a contract with SCFHP; Two OON approvals were for Gardner Family Care, who also entered a contract with SCFHP; and 1 was due to COC. For Psychiatry, the 1 OON approval was for AACI BH, who has since entered a contract with SCFHP. The other 2 requests were relevant to COC. For Psychology, 8 OON approvals were for Memory Check Psychological, who has since entered a contract with SCFHP. The other 4 requests were due to COC (2) and retroactive requests (2).

Ms. Switzer concluded that overall the NET 1-3 analyses demonstrated that:

- SCFHP standards for provider availability are realistic for the communities and delivery system within Santa Clara County.
- With the exception of General Practice, SCFHP was able to demonstrate its ability to meet performance goals relevant to provider to member ratios and geographic distances across all in network primary care providers, high volume and high impact specialists (including BH).
- Although there were low response rates relevant to the appointment and availability survey, SCFHP concludes that there are several network providers (medical and BH) who are unaware of appointment access standards.
- A high percentage of providers are unaware of the after-hours messaging requirement – *return call within 30-minutes or less.*
- Overall findings on member complains indicated 2 primary categories – timeliness and communication and the reports showed that member complaints were managed effectively and timely by SCFHP.
- The majority of OON requests and approvals were relevant to COC, retro-active requests, and out of area hospital admissions.

Ms. Switzer listed opportunities for improvement as well as interventions by identifying barriers. For those providers that show non-compliance, the intervention will begin with a corrective action plan (CAP), followed by a resurvey within 30 days. The providers that show continued non-compliance through the research will be required to complete the Plan's access training and submit an attestation to the Plan.

Ms. Switzer reported there was 1 provider for primary care that was resurveyed. This provider came back with 100% compliance. There were 2 Specialists that were resurveyed; one of which came back as non-compliant, followed by an attestation submitted to the Plan. For PAMF, 56% of their PCPs for urgent care came back compliance compliant through the survey and 89% of the providers that were resurveyed came back compliant for the non-urgent appointments for primary care. For Specialists, 18% of providers that were resurveyed came back as compliant for urgent appointments, and for non-urgent appointments, 29% were compliant. For Psychiatry, 2 were resurveyed and were non-compliant. For the non-physician MH providers, 50% were compliant through the survey process. Training has been completed and attestations have been submitted along with their Corrective Action Letter (CAL) to the Plan. Within their CAL, they noted that although the survey shows non-compliance, they feel the results do not reflect their patient's experience or access to the Plan. In addition, they book appointments within different facilities, so they do believe their patients receive care within those standards.

Ms. Switzer reported Physician's Medical Group (PMG) did well on training their providers on the access program. Of their primary care providers, 89% of them came back compliant through the surveys, 55% compliant on the urgent for specialist, and 92% for non-urgent for specialist. For Psychiatrists, there was 1 who had received the training program and submitted attestation.

Ms. Switzer explained the Plan is currently working on the direct provider network. Thus far, 30% of attestations have been collected from providers, including some of those that are through Stanford. Last year, through these reports, one of the interventions was to update our training materials, which has been done. Since then, the Plan has received a lot of positive feedback from the provider network. In addition, SCFHP has produced an updated matrix, which shows all of the standards that providers need to follow. The Plan has been very consistent in providing this information to our provider network via fax blast, and will continue to do so.

Darryl Breakbill, Director of Appeals and Grievances, suggested an offline conversation with Ms. Switzer regarding the methodology used for the grievance and appeals portion of the report as the access numbers and rate of grievances and appeals is slightly different, by a few, compared to his report.

It was moved, seconded, and the Network Adequacy Assessment was **unanimously approved**.

b. Quality & Accuracy Assessment of Personalized Information of Health Plan Services

Tanya Nguyen, Director of Customer Service, explained SCFHP has the responsibility to provide access to accurate, quality personalized health information via the SCFHP Website and the telephone. This includes the ability to request or reorder a SCFHP member ID card, to change PCPs, and to determine how and when to obtain referrals and/or authorizations for specific services.

SCFHP members have no financial responsibility beyond a copay for pharmacy benefits. There is no copay for medical services. SCFHP ensures the availability of this information by:

- Telephone – SCFHP Customer Service Representatives (CSRs) are trained to handle PCP changes, member ID card requests, and the determination of services requiring a referral or authorization and to address inquiries. CSRs are able to educate members on how to obtain specific services and/or an authorization.
- SCFHP Website – Members may submit requests for SCFHP member ID cards and to change PCPs via the SCFHP Website. The website includes a list of services requiring an authorization and instructions for obtaining an authorization.

Ms. Nguyen explained the methodology SCFHP uses to ensure the quality of the information provided to members is through annual evaluations through a selection of certain call categories to identify opportunities to improve the quality and accuracy of the information provided by CSRs to members. The goal is to achieve 100% in both accuracy and quality.

Ms. Nguyen reviewed the data results in more detail, beginning with SCFHP's Website on accuracy of information provided for referrals and authorizations. The evaluation includes a total sample size of 5. The criteria includes:

- The information on how and when to obtain a referral and authorization for medical services is populated correctly
- Information accurately reflect what services SCFHP would pay for and if there is any limits on the services
- Information accurately reflect what services are excluded or not covered by SCFHP

Following accuracy, SCFHP's Website was evaluated on quality of information for referrals and authorizations. The criteria includes:

- The link for the member handbook moves to the correct page
- Detailed instructions are provided on what chapter/section of the member handbook on how and when to obtain referrals and authorizations for specific services

Ms. Nguyen reviewed the data results for SCFHP's Website on the accuracy and quality of information provided to PCP change and ID card requests. The evaluation includes a total sample size of 10. The criteria includes:

- The member's request and response were documented with accuracy
- The request was executed in the database system (PCP updated, ID card ordered)
- The appropriate contact code was selected
- The acknowledgement/confirmation sent to members within 1 business day.

Ali Alkoraishi, MD, asked what the contact codes are. Ms. Nguyen explained that within the call center, there are codes for different reasons members call in, and a code is assigned from that list for every phone call. This gives the Plan the opportunity to precisely review data on specific categories of phone calls received.

Dr. Paul asked if the sample size is enough to properly evaluate the criteria, as the sample size (5) for quality of information for referrals and authorizations on SCFHP's Website is fairly small. Ms. Nguyen explained there are no specific sample size listed on NCQA standards, and being that SCFHP did not

have a real contact, simulations were put in place to reflect the real requests of about 50% of the population.

The final evaluation was on telephone interactions on the accuracy and quality of information provided to members. The evaluation was assessed by the following criteria:

- Was the inquiry initiated by the member or member's representative?
- Did the CSR explain whether or not a service requires a referral and/or a prior authorization (PA)?
- If a services requires a PA, whether CSR accurately explains how to obtain a PA and/or offers members to initiate an organization determination
- If a service does not require a PA, did the CSR explain how to locate a network provider to a member?
- Did the agent document the call in the database system and select the appropriate contact code(s)?
- Did the CSR summarize accurately the service request or interaction in the database system?

Ms. Nguyen reviewed the accuracy and quality analysis and reported the accuracy measures met the target goal of 100% for all criteria. For quality measures, SCFHP met the goal at 100% for the telephone interactions and 90% for the Website as there was a delay in responding to one of the PCP change requests. A plan for correction is to develop a daily monitor process to ensure all of the requests are processed timely.

Ms. Nguyen shared a sample of an audit sheet used within the Call Center to ensure accuracy and quality of personalized information on Health Plan Services over the telephone. This sheet checks CSR's knowledge and accuracy of information given to members.

It was moved, seconded, and the Quality & Accuracy Assessment of Personalized Information of Health Plan Services was **unanimously approved**.

c. Quality & Accuracy Assessment of Pharmacy Benefit Information

Ms. Nguyen explained SCFHP has a responsibility to ensure that members can contact the organization over the telephone and receive accurate, quality information on drugs, coverage, and cost. SCFHP conducts monthly quality monitoring to assure the quality of the information provided to members related to pharmacy benefits. In addition, SCFHP also conducts an annual evaluation through the selection of certain call categories to identify opportunities to improve the quality and accuracy of the pharmacy benefit information provided by CSRs to members.

The methodology used for this assessment is to annually audit the information provided to members over the telephone by its CSRs. The auditor randomly selects 10 calls during which a member has requested information on pharmacy benefits. The calls are checked for CSRs ability to provide accurate information of:

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

Ms. Nguyen explained audits are to be performed on an annual basis by collecting data on the quality and accuracy of the pharmacy benefits information provided over the telephone. The audit period is from 07/01/18 through 06/30/19. The goal for accuracy and quality is 100%.

Ms. Nguyen reported SCFHP did not test the quality and accuracy of the ability for members to order a refill on an existing mail-order prescription (factor 3) because SCFHP does not offer a mail order service. This factor is not applicable for SCFHP.

For measuring accuracy on financial responsibility of a drug, there were no calls associated with the need for CSRs to locate an in-network pharmacy or conduct a proximity search. Therefore, there is no data to report on these factors. Measure 2 – exception process, met the accuracy goal of 100% in all audit questions. During the accuracy audit, none of the calls had an interaction in which the member asked about drug interactions, common side effects, or the availability of generic substitutes. Therefore, there is no data to report.

For measuring the quality on financial responsibility for a drug, SCFHP met the quality goal at 100%. None of the calls had an interaction in which the CSR needed to educate the member that using a generic medication would lower member's financial responsibility. The measure on quality for the exception process meets the quality goal of 100%. There were no calls associated with locating in-network pharmacies and proximity search, therefore, there is no data to report on these factors.

It was moved, seconded, and the Quality and Accuracy Assessment of Pharmacy Benefit Information was **unanimously approved**.

d. Continuity and Coordination of Medical Care

Lori Andersen, Director of Long Term Services and Support (LTSS), explained SCFHP monitors activities directed at improving continuity and coordination of medical care and takes action, as necessary, to improve the outcomes of the monitored activities. Annually, SCFHP reviews data associated with member movement between practitioners and member movement between settings. Through analysis, SCFHP identified four opportunities for improvement. During 2019, the following opportunities were monitored for aspects of continuity and coordination of medical care:

- Measure 1: Medication Reconciliation Post Discharge (MRP) – HEDIS
- Measure 2: Comprehensive Diabetes Care (CDC) Eye Exam Rate – HEDIS
- Measure 3: PCP Follow up After 30 days of Discharge
- Measure 4: Plan All-Cause Readmission (PCR) – HEDIS

SCFHP sets performance goals for each measure, and through the analysis process, identifies opportunities to improve. The quantitative analysis process includes a review of results and trends over time and compares those results against an established performance goal. The qualitative analysis process utilizes the trend data to identify potential root cause and barriers applicable against achieving the performance goal.

Ms. Andersen reviewed the first measure – Medication Reconciliation Post Discharge. For members 18 years of age or older, this measure identifies the percentage of discharges within the measurement/calendar year from whom medications were reconciled from the date of discharge through 30 days post-discharge. The data reflects a small decrease from 2017 at 37% to 2018 at 29%. The best available source to measure Medication Reconciliation (MRP) is our HEDIS data. The current MRP rate of 55.5% is both an administrative and hybrid HEDIS rate. The admin rate for the 2018 HEDIS was 3.02%. However, once the hybrid chart review was completed, we see a marked increase up to 55.74%. This reflect physicians are actually documenting medication reconciliation in their notes, but apparently not always billing for the care provided. As such we lack admin/claims data.

Ms. Andersen reviewed the next measure – Comprehensive Diabetes Care (CDC) Eye Exam Rate. The data shows SCHFP has consistently hit the target goal for three consecutive years, therefore, further qualitative analysis or opportunity for improvement is not required at this time.

The next measure is PCP Follow-up after 30 days of Discharge Rate. The goal for comparison is 85% of members with an acute inpatient hospital discharge within the reporting period have an ambulatory care follow-up visit within 30 days of discharge. The performance goal (85%) was not met and the highest rates of 30 day follow-up visits was 82% in Q1 and Q2 of 2018. The 2018 cumulative rate of 81% shows improvement from 2017 and that SCFHP is 4 percentage points away from meeting the goal. The gap indicates opportunities for improvement in the existing process of encouraging members to schedule and keep appointments with their physicians after discharge from an acute inpatient hospital stay. A barrier analysis was completed to identify opportunities and interventions to improve the rate of members receiving 3-day follow-up. One of the interventions, as part of the transition of care (TOC) call follow-up, the case manager will send a notification letter to PCP with discharge information.

Ms. Andersen reviewed the final measure – All-Cause Readmissions (PCR) HEDIS Rates. SCFHP missed the goal of 11% by 2.5 percentage points in 2016, and 3.8 percentage points in 2017. In 2018, SCFHP met and improved on the goal of 14.66% indicating a decreasing trend overall. While an improvement from 2017, opportunities remain to improve internal and external processes to prevent unplanned acute readmissions within 30 days of discharge and continue to maintain below the CMS benchmark of 14.66%. One of the interventions is to expand the capacity of the TOC calls.

Dr. Paul asked what the readmission rate for Valley Medical is. It is unknown, but the information will be gathered and shared at the next meeting.

It was moved, seconded, and the Continuity and Coordination of Medical Care was **unanimously approved**.

e. Member Experience Analysis

Mr. Breakbill explains member complaints and appeals may impact overall member satisfaction, so SCFHP tracks and trends compliant and appeal activity to identify barriers to care and identify potential interventions.

The BH Member Satisfaction Survey is another means to monitor the member experience. The member experience assessment is used to identify areas of improvement and help meet the specific needs of SCFHP members. SCFHP reviews data associated with complaints and appeals and the BH Member Satisfaction Survey on an annual basis. The quantitative analysis process includes a review of results and compares those results against any established performance goals. This process uses the trend data to identify potential root cause and barriers applicable to improving performance and quality. The data collected is aggregated into the following categories:

- Quality of Care
- Access
- Attitude/Service
- Billing/Financial
- Quality of Practitioner Office Site

SCFHP's goals are to maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each quarter and to maintain a rate not to exceed 5.0 Non-BH & BH grievances/appeals per 1000 members for each category.

Mr. Breakbill reports for both Quality of Care and Access, SCFHP met the threshold. However, in Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site, SCFHP did not meet the threshold. In analyzing the 280 Attitude/Service grievances, data shows 81 of them were a result of a durable medical equipment (DME) vendor, and an additional 74 were a result of transportation services. In analyzing the 287 Billing/Financial complains/grievances, data shows 113 of them are a result of a specific hospital not understanding the Cal MediConnect (CMC) product and how it pays for the member's bill, and appeals were result of non-contracted providers failing to recognize the PA rules for services rendered to SCFHP members. There were no members receiving BH services that filed appeals or grievances within CY 2018.

It was moved, seconded, and the Member Experience Analysis was **unanimously approved**.

7. Discussion Items

a. Access and Availability – VHP Access Report-MY2018

Ms. Switzer presented a summary of the assessments that VHP conducted for the Provider Access and Availability Survey (PAAS) and the After-Hours Survey. Ms. Switzer reviewed the methodology and measures used by VHP.

Provider Appointment Availability Survey (PAAS):

The results on the VHP report showed that all provider types fell below goal (90%) on appointment standards (urgent and/or non-urgent) as follows:

PCP:

- Urgent Care Appointments within 48 hours was at 70 percent (70 %). This is a thirteen percent (13%) decrease compared to MY2017.
- Non-urgent Care Appointments within ten days was at 89 percent (89%). This is a decrease of 6 percent (6%) compared to MY2017, and only 1 percent (1%) below the goal of 90%.

Specialists:

- Urgent Care Appointments with PA within 96 hours was at 57 percent (57%). This is a four percent (4%) increase compared to MY2017.
- Non-Urgent Care Appointment within 15 days was at 66 percent (66%). This is a decrease of 3 percent (3%) compared to MY2017

Psychiatry:

- Urgent Care Appointments within 48 hours was at 70 percent (70 %). This is a thirteen percent (13%) decrease compared to MY2017.
- Non-urgent Care Appointments within ten days was at 89 percent (89%). The MY2018 result is a decrease of 6 percent (6%) compared to MY2017, and only 1 percent (1%) below the goal of 90%.

NPMH:

- Urgent appointment with prior authorization within 96 hours was at 64%, a decrease rate of compliance compared to MY2017.
- Non-Urgent appointment within 10 days was at 85%; an improved rate of compliance compared to MY2017.

Ancillary:

- Non Urgent appointment within 15 days was at 87 percent (87%) compliance, which indicates an improved rate of compliance of 12 percent (12%) compared to MY2017.

Ms. Switzer stated that VHPs PAAS report included the following conclusions:

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

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

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

After Hours Survey:

Ms. Switzer explained the After-Hours Survey methodology reported by VHP – the survey was administered using the telephone methodology, conducted on November 3, 2018 during non-business hours. VHP's response rate was 97%. Both PCPs and BH providers did not meet the goal for Access Compliance, however, the results showed an increase rate of compliance in comparison to the previous year. The same applies for both PCPs and BH providers relating to Timeliness Compliance: 30-minutes or less. Although neither met the goal, the results showed an increase in compliance compared to the previous year.

It was asked if the patients relating to this survey were new patients or established patients. Ms. Switzer clarified the survey relates to any patient. Johanna Liu, PharmD, Director of Quality and Process Improvement, asked if VHP required to conduct this survey. Ms. Switzer stated that VHP is required to conduct the surveys.

Ms. Switzer stated that the VHP PAAS and After Hours reports showed access interventions which explained that the efforts would be applied to improve performance for timely access in the future.

b. CAHPS

Jamie Enke, Manager of Process Improvement, reported the results of the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, administered by Centers for Medicare and Medicaid Services (CMS). This survey enhances CMS' ability to monitor the quality of care and performance of health plan contracts. This survey is conducted telephonically with an expanded sample size (800) of 1,600 CMC members. The response rate was 28.8%, reflecting an improved response rate of 2.7 percentage points.

Ms. Enke reviewed the 2019 updates. Some of which include implemented Chinese and Vietnamese language surveys and CAHPS reminders and notifications via provider newsletters. The opportunities for improvement include overall rating of Health Plan, Drug Plan, and Personal Doctor, Customer Service, Getting Needed Care, Getting Appointments and Care Quickly, and Care Coordination.

Ms. Enke explained there will be cross functional workgroups to conduct qualitative analyses and identify opportunities for improvement and intervention as well as meeting with the provider groups in monthly quality meetings to deliver results and gather feedback.

c. Health Outcomes Survey

Ms. Enke reported the results of the cohort 2019 Health Outcomes Survey (HOS), a patient-reported outcome measure that's used in Medicare managed care. In 2016, SCFHP had a baseline survey of cohort 2019. This baseline report became available in 2017. Presented today is the data collection done in 2018.

There are two components to the HOS survey: physical health and mental health. The physical health results show SCFHP performed the same as the national average. The mental health results show SCFHP performed better than all MAOs in California.

Ms. Enke reviewed next steps and recommendations. One of which is to request beneficiary-level data from CMS. Another is to conduct qualitative analysis with interdisciplinary team members to review results and identify opportunities of intervention, as well as inform Case Management of HOS Cohort 19 Follow-up findings.

Dr. Paul asked if SCFHP sends any educational materials to members, to notify a survey is on the way. Dr. Liu explained SCFHP does not for the HOS survey as the sample size is so small in comparison to the CAHPS survey.

8. Committee Reports

a. Credentialing Committee

Laurie Nakahira, D.O., Chief Medical Officer reviewed the Credentialing Committee report for October 30, 2019. All (29) initial practitioners were credentialed within 180 days of attestation signature. There were two re-credentialed practitioners, both of which were re-credentialed within the 36-month timeline. The total number of practitioners in network (excluding delegated providers) as of 08/31/2019 is 288, of which zero were terminated.

It was moved, seconded, and the October 30, 2019 Credentialing Committee Report was **unanimously approved**.

b. Pharmacy and Therapeutics Committee

Minutes of the September 19, 2019 Pharmacy and Therapeutics Committee (P&T) meeting were reviewed by Jimmy Lin, MD.

It was moved, seconded, and the September 19, 2019 Pharmacy and Therapeutics Committee meeting minutes were **unanimously approved**.

c. Quality Dashboard

Dr. Liu reported a steady 50-51% completion rate for the Initial Health Assessment (IHA) during Medi-Cal member's first visit with their PCP. The Quality Improvement department is currently developing a work plan to improve the IHA within 120 days of enrollment with the Plan.

Dr. Liu reported 76% of the Potential Quality of Care Issues (PQIs) opened from July through September were closed on time. As of November 22nd, 2019, the Health Homes program has a total of 222 patients enrolled. For Cervical Cancer Screening (CCS), the number of gift cards that were mailed out to compliant members was 149.

Dr. Alkoraishi asked how often it is recommended to have CCS completed. Dr. Liu replied the CCS should be completed every 3 years, up to 5 years.

9. Adjournment

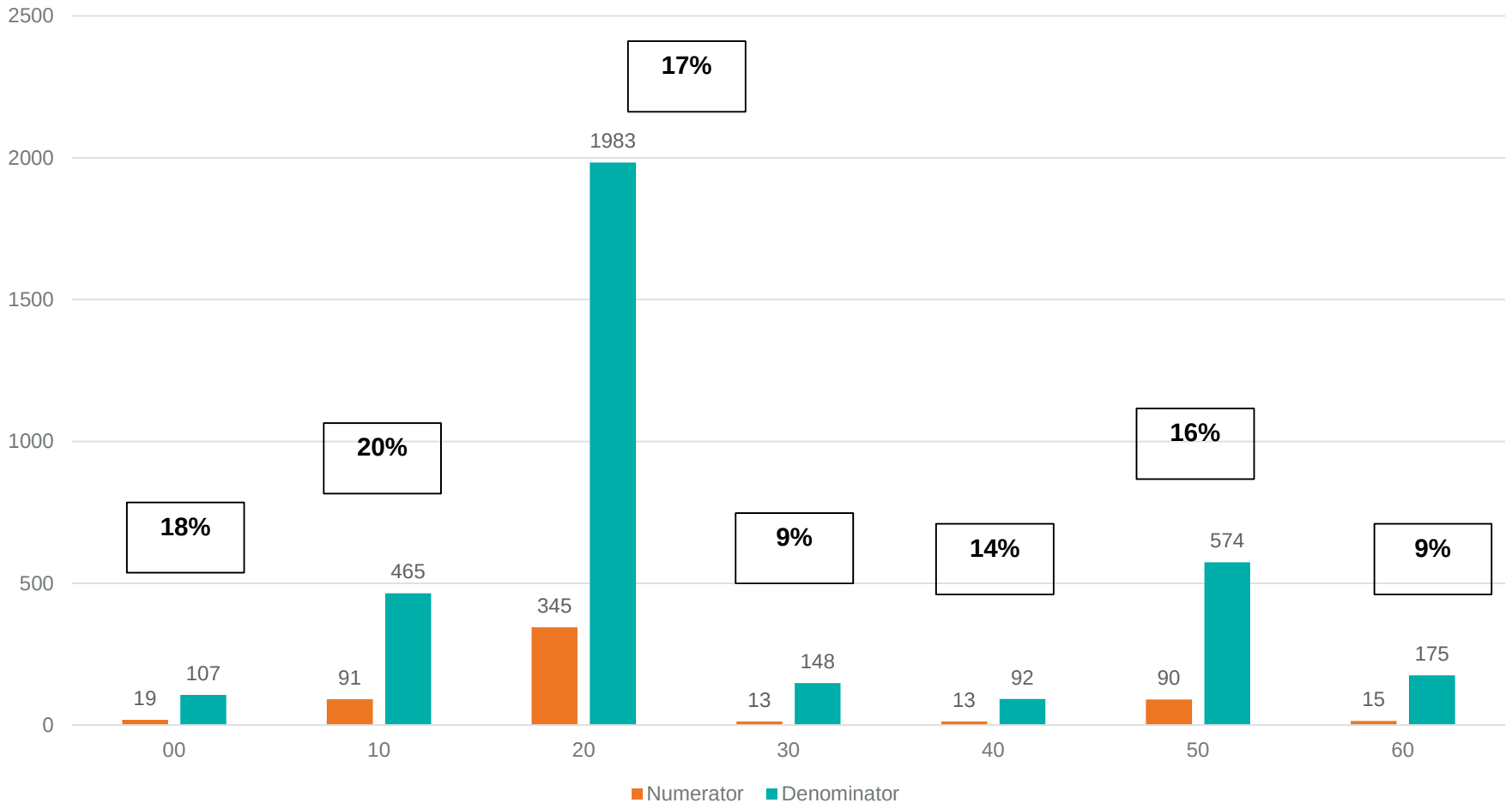
Dr. Liu reviewed 2020 calendar dates for the QIC meeting. The next QIC meeting will be confirmed via a calendar invite, but is anticipated for February 12, 2019. The meeting was adjourned at 7:59pm.

_____ _____

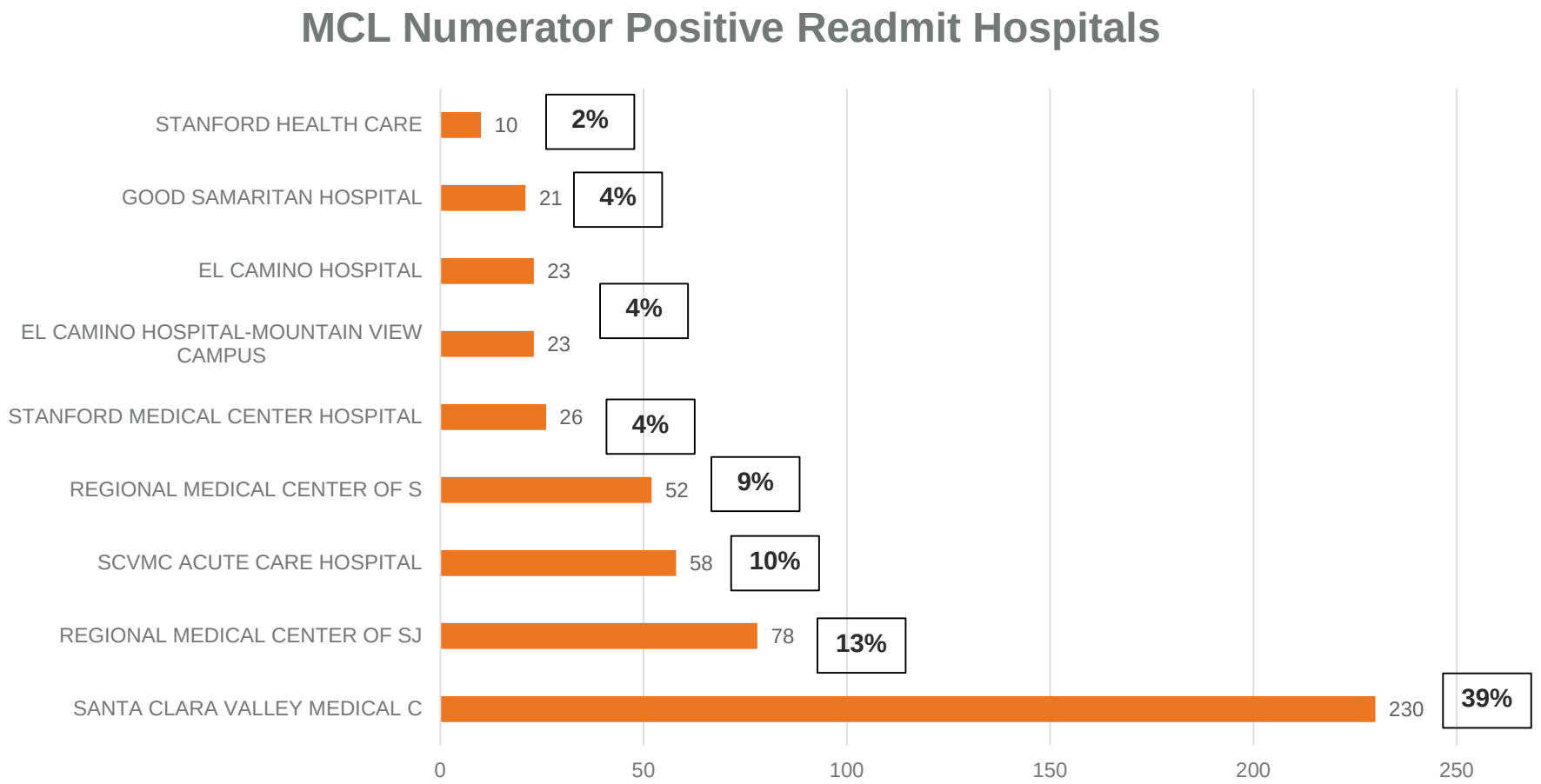
Ria Paul, MD, Chair of Quality Improvement Committee Date

Plan All Cause Readmission (PCR) Medi-Cal (MCL)

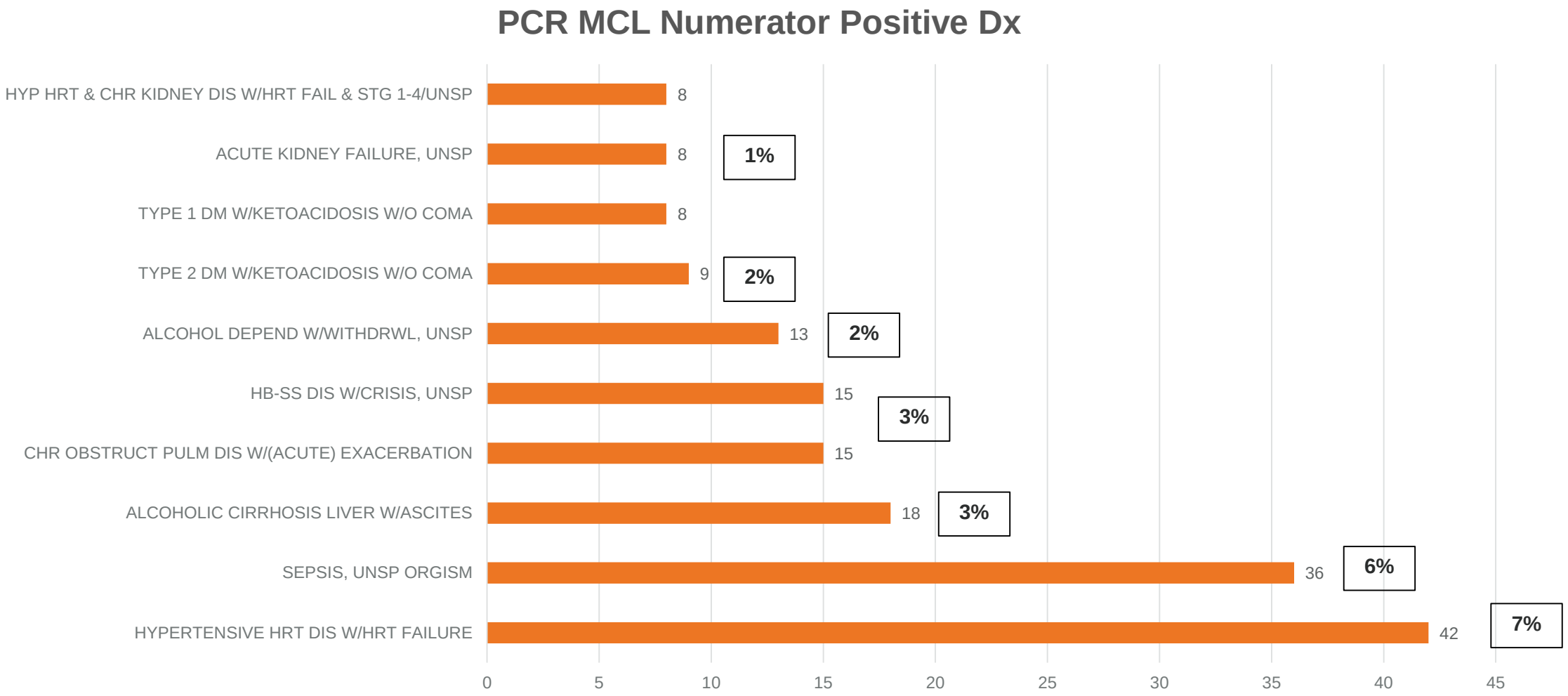
7/1/2018 - 6/30/2019 PCR MCL Numerator Positive



PCR Medi-Cal by Hospital

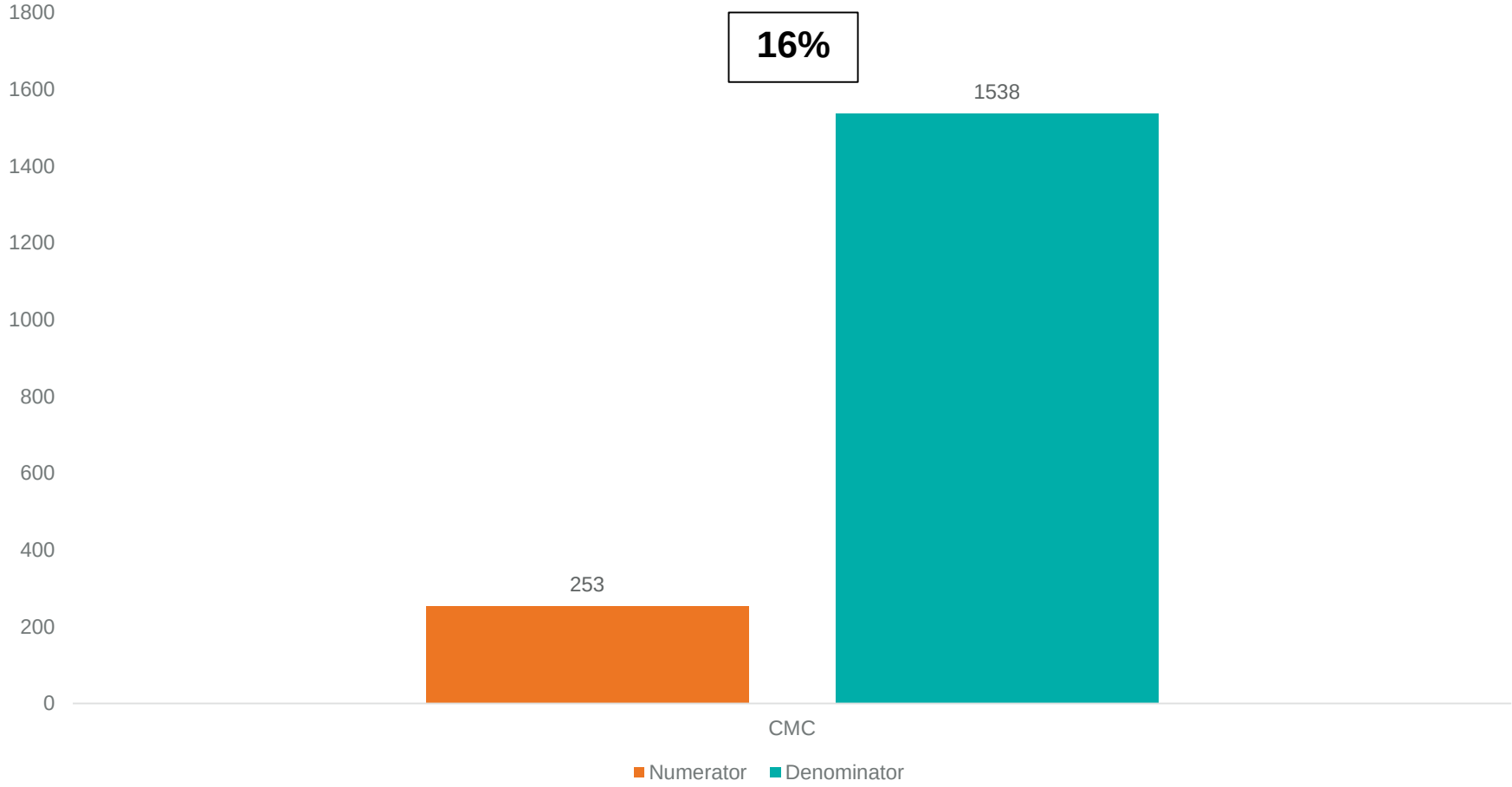


PCR Medi-Cal by Diagnosis

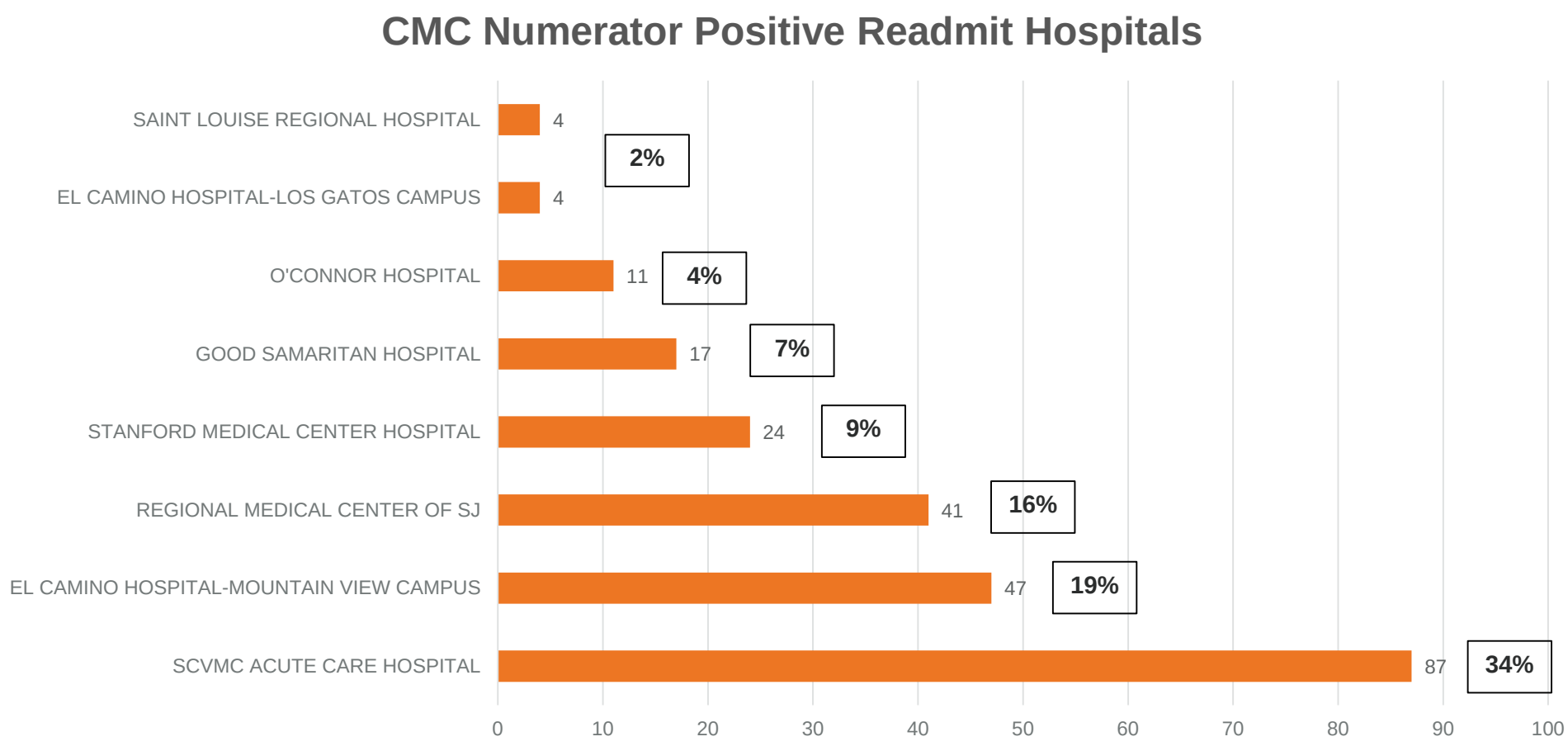


Plan All Cause Readmission (PCR) Cal MediConnect (CMC) Overall

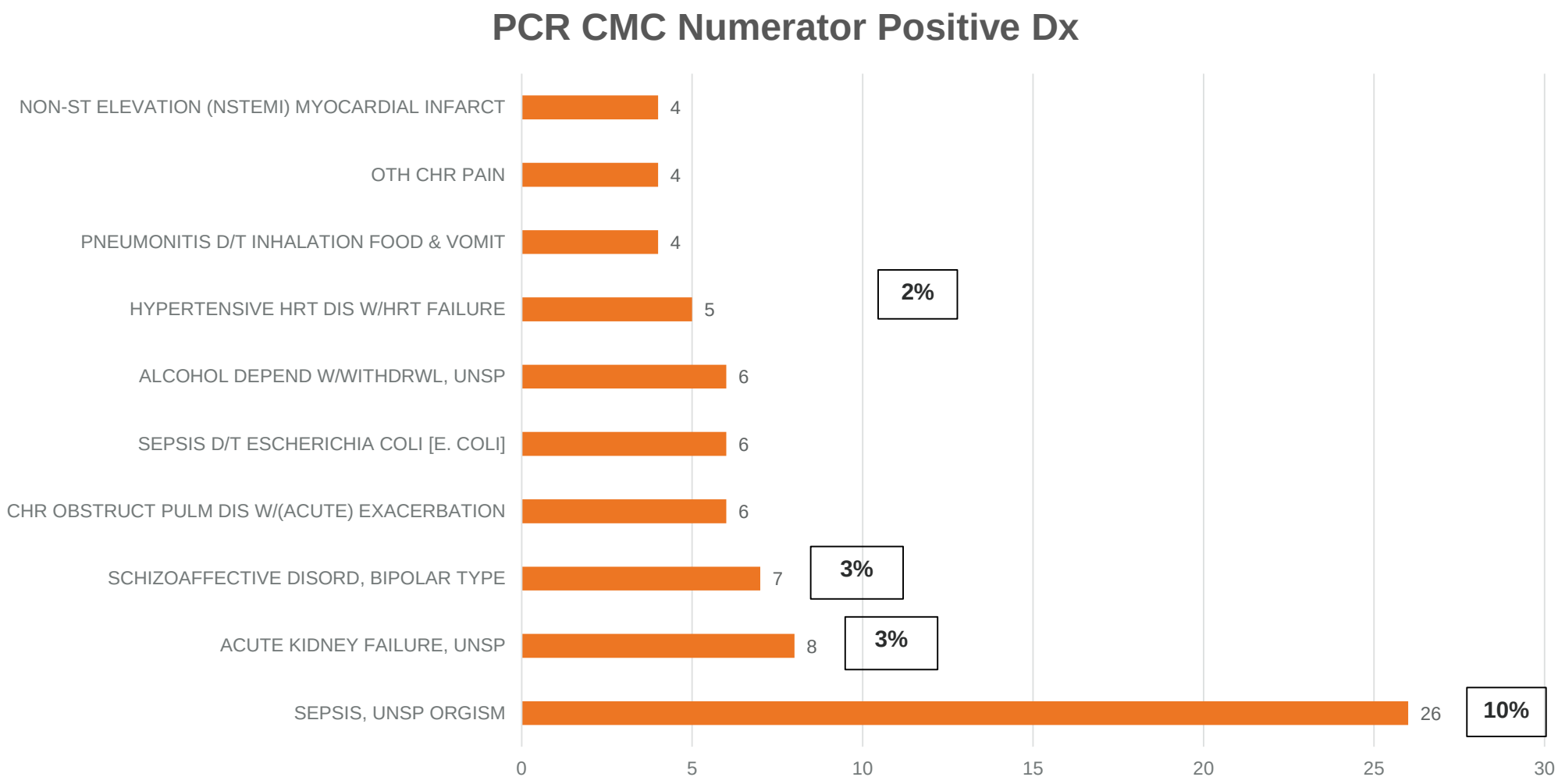
7/1/2018 - 6/30/2019 PCR CMC



PCR CMC by Hospital



PCR CMC by Diagnosis



Santa Clara Family Health Plan

Quality Improvement Program 2020

Santa Clara Family Health Plan™

Table of Contents

I. Introduction

The Santa Clara County Health Authority, operating as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975 and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). SCFHP is a public agency contracted with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. Since 2015, SCFHP has held a three-way contract with DHCS and the Centers for Medicare and Medicaid Services to offer a Cal MediConnect Plan (Medicare-Medicaid Plan).

- SCFHP serves 231,435 Medi-Cal enrollees in Santa Clara County as of January 2020.
- 8,401 members are enrolled in SCFHP's Cal MediConnect (CMC) plan as of January 2020.

SCFHP is dedicated to improving the health and well-being of the residents of Santa Clara County and monitors, evaluates, and takes effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. SCFHP is accountable for the quality of all covered services.

II. Mission Statement

The mission of SCFHP is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase good health care at an affordable price. Working in partnership with providers, SCFHP acts as a bridge between the health care system and those who need coverage.

One of SCFHP's core values is our belief that as a local, public, not-for-profit health plan, we have a unique responsibility to continually improve the health status of the community by incorporating a comprehensive approach to health care and wellness. SCFHP maintains a comprehensive Quality Improvement (QI) Program that systematically monitors and continually drives improvements to the quality of care to our members, provides for culturally and linguistically appropriate services, identifies over- and under- utilization and substandard care, monitors member satisfaction and member safety and takes corrective actions and interventions when necessary.

III. Authority and Accountability

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

SCFHP's Governing Board assumes ultimate responsibility for the QI Program and has established the Quality Improvement Committee (QIC) to oversee this function as a Board committee. This supports the Board playing a central role in monitoring the quality of health care services provided to members and striving for quality improvement in health care delivery. The Board authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QI Program

Description. The CEO has delegated oversight of the day-to-day operations of the QI Program to the Chief Medical Officer (CMO).

IV. Purpose

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

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

A. It is organized to identify and analyze significant opportunities for improvement in care and service.
B. It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
C. It is focused on QI activities carried out on an ongoing basis to promote efforts which support improving patient experience of care, improving health of populations and reducing per capita cost of health care.

SCFHP recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, the Plan provides for the delivery of quality care with the primary goal of improving the health status of Plan members. Where the member's condition is not amenable to improvement, the Plan implements measures to possibly prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. The QI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Plan's QI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members.

In order to fulfill its responsibility to members, the community and other key stakeholders, regulatory agencies and accreditation organizations, the Plan's Governing Board has adopted the following QI Program Description. The program description is reviewed and approved at least annually by the QIC and Governing Board.

V. Goals

The goal of Quality Improvement is to deliver care that enables members to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

A. Quality of physical health care, including primary and specialty care.
B. Quality of behavioral health services focused on recovery, resiliency and rehabilitation.
C. Quality of long-term services and supports (LTSS).
D. Adequate access and availability to primary, behavioral health services, specialty health care, and LTSS providers and services.
E. Continuity and coordination of care across all care and settings, and for transitions in care.
F. Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS, across the care continuum.

Additional goals and objectives are to monitor, evaluate and improve quality of care, including:

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

VI. Objectives

The objectives of the QI Program Description include:

A. Keeping members healthy
B. Managing members with emerging risk
C. Ensuring patient safety or outcomes across settings
D. Overseeing programs dedicated to helping members manage multiple chronic conditions through case management and the coordination of services and supports
E. Leading the processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement.
F. Supporting practitioners with participation in quality improvement initiatives of SCFHP and its governing regulatory agencies.
G. Establishing clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation
H. Measuring the compliance of contracted practitioners' medical records against SCFHP's medical record standards at least once every three years; taking steps to improve performance and re-measure to determine organization-wide and practitioner specific performance.
I. Developing studies or quality activities for member populations using demographic data to identify barriers to improving performance, validate a problem, and/or measure conformance to standards.
J. Overseeing delegated activities by:
    a. Establishing performance standards
    b. Monitoring performance through regular reporting
    c. Evaluating performance annually
K. Evaluating under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon member need. These methods include, but are not limited to, an annual evaluation of:
    a. Medical record review
    b. Rates of referral to specialists
    c. Hospital discharge summaries in office charts
    d. Communication between referring and referred-to physicians
    e. Member complaints
    f. Non-utilizing members, including identification and follow-up
    g. Practice pattern profiles of physicians
    h. Performance measurement of adherence to practice guidelines
L. Coordinating QI activities with other activities, including, but not limited to, the identification and reporting of risk situations, adverse occurrences from UM activities, and potential quality of care concerns through grievances.
M. Evaluating the QI Program Description and Work Plan at least annually and modifying as necessary. The Work Plan is updated quarterly. The evaluation includes:
    a. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    b. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data

N. Analyzing the results of QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality of services)
O. Developing recommendations to inform the QI Work Plan for the upcoming year to include a schedule of activities for the year, measurable objectives, plan for monitoring previously identified issues, explanation of barriers to completion of unmet goals, and assessments of the completed year's goals
P. Implementing and maintaining health promotion activities and population health management programs linked to QI actions to improve health outcomes. These activities include, at a minimum, identification of and outreach to of high-risk and/or chronically ill members, education of practitioners, and outreach and education programs for members
Q. Maintaining accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VII. Scope

The QI Program provides for the review and evaluation of all aspects of health care, encompassing both clinical care and service provided to members.

All departments participate and collaborate in the quality improvement process. The CMO and the Director of Quality and Process Improvement oversee the integration of quality improvement processes across the organization. The measurement of clinical and service outcomes and of member satisfaction are used to monitor the effectiveness of the process.

A. The scope of quality review is reflective of the health care delivery systems, including quality of clinical care and quality of service.
B. Activities reflect the member population in terms of age groups, cultural and linguistic needs, disease categories and special risk status.
C. The scope of the QI Program includes the monitoring and evaluation and driving improvements for key areas, including but not limited to the following:
    a. Healthcare Effectiveness Data and Information Set (HEDIS)
        i. Access to Preventive Care
        ii. Maintenance of Chronic Care Conditions
    b. Behavioral health services
    c. Continuity and coordination of care
    d. Emergency services
    e. Grievances
    f. Inpatient services
    g. Member experience and satisfaction
    h. Minor consent/sensitive services
    i. Perinatal care
    j. Potential quality of care issues
    k. Preventive services for children and adults
    l. Primary care
    m. Provider satisfaction

n. Quality of care reviews
o. Specialty care

D. Refer to the Utilization Management Program, Population Health Management Strategy and the Case Management Program for QI activities related to the following:
   a. UM metrics
   b. Prior authorization
   c. Concurrent review
   d. Retrospective review
   e. Referral process
   f. Medical necessity appeals
   g. Case management
   h. Complex case management
   i. Population health management (PHM)
   j. California Children's Services (CCS)

VIII. QI Work Plan

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

A. Safety of clinical care
B. QI Program scope
C. Yearly planned activities and objectives that address quality and safety of clinical care, quality of service and members' experience
D. Time frame for each activity's completion
E. Staff responsible for each activity
F. Monitoring of previously identified issues
G. Annual evaluation of the QI Program
H. Priorities for QI activities based on the specific needs of the organization for key areas or issues identified as opportunities for improvement
I. Priorities for QI activities based on the specific needs of SCFHP's populations, and on areas identified as key opportunities for improvement
J. Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI initiatives based on trends identified (PQI)
K. Comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures

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

IX. QI Methodology

SCFHP applies the principles of Continuous Quality Improvement (CQI) to all aspects of the service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

A. Quantitative and qualitative data collection and data-driven decision-making.

B. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field.
C. Feedback provided by members and providers in the design, planning, and implementation of its CQI activities.
D. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS.
E. Issues identified by SCFHP, DHCS and/or CMS.
F. QI requirements of this contract as applied to the delivery of primary and specialty health care services, behavioral health services and LTSS.

QI Project Selections and Focus Areas

Performance and outcome improvement projects are selected from the following areas:

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

The QI Project methodology described in items A-E below is used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, behavioral health, LTSS, specialty care, emergency services, inpatient services, and ancillary care services.

A. Access to and availability of services, including appointment availability, as described in policy and procedure.
B. Case Management.
C. Coordination and continuity of care for Seniors and Persons with Disabilities.
D. Provision of complex care management services.
E. Access to and provision of preventive services.

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

A. Staff and physicians provide vital information necessary to support continuous improvement in work processes
B. Individuals and department stakeholders initiate improvement projects within their area of authority, which support the strategic goals of the organization.
C. Specific performance improvement projects may be initiated by the state or federal government.

D. Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.
E. Project coordination occurs through the various leadership structures: Governing Board, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort.
F. These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality Indicators

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

QI Project Measurement Methodology

Methods for identification of target populations are clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, centralized data from the health plan's internal data warehouse is used.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes are a minimum of 411 (with 3 to 15% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on SFCHPs' previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

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

Plan 1) Identify opportunities for improvement

2) Define baseline

3) Describe root cause(s)

4) Develop an action plan

Do 1) Communicate change/plan

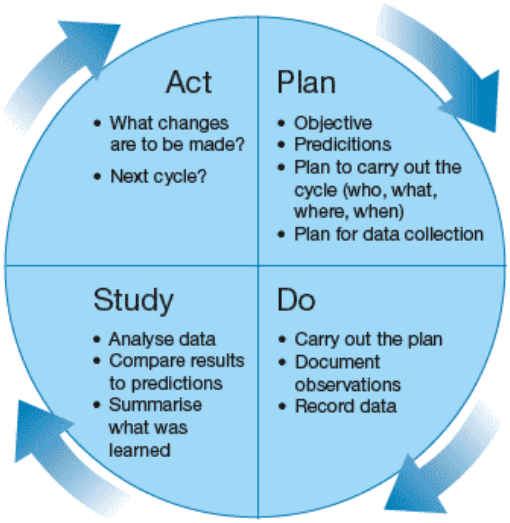
2) Implement change plan

Study 1) Review and evaluate result of change

2) Communicate progress

Act 1) Reflect and act on learning

2) Standardize process and celebrate success



X. QI Quality Issue Identification

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

Adverse events can include:

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

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

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

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

A. Claims information/activity
B. Encounter data
C. Utilization data
D. Case management data, such as notes, care plans, tasks and assessments
E. Pharmacy data
F. Population needs assessments
G. Results of risk stratification
H. HEDIS performance
I. Member and provider satisfaction surveys
J. Quality Improvement Projects (QIPs)
K. Performance Improvement Projects (PIPs)
L. Chronic Care Improvement Projects (CCIPs)
M. Health Risk Assessment data
N. Consumer Assessment of Healthcare Providers & Systems (CAHPS)
O. Health Outcomes Survey (HOS)
P. Regulatory reporting

Protocol for Using Quality Monitor Screens

Case Management and Utilization Management staff apply the quality monitor screens to each case reviewed during pre- certification and concurrent review. Contracted LTC facilities and CBAS centers must report all identified reportable events to the Director of Long Term Services and Supports. All potential quality issues are routed to the Quality Department. When it is decided that medical records are required, the Quality staff contacts the appropriate inpatient facility and ambulatory care site to obtain copies of the medical record. It may be necessary for a Quality staff member to visit the facility/site to review the record.

When a case is identified as having potential quality of care issues, the Quality Improvement Clinical Review staff abstracts the records and prepares the documents for review by the CMO or Medical Director.

The CMO or Medical Director reviews the case, assigns a priority level, initiates corrective action, and/or recommends corrective action as appropriate. For cases of neglect or abuse, follow-up or corrective actions may include referrals to Child or Adult Protective Services.

XI. QI Program Activities

The QIC and related committee and work groups select the activities that are designed to improve performance on targeted high volume and/or high-risk aspects of clinical care and member service.

Prioritization

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

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

Use of Committee Findings

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient practice. The vast majority of practicing physicians provide care resulting in favorable outcomes. The QI Program takes direct action to identify, recognize, and replicate/encourage methodologies that result in favorable outcomes. Information about such results is communicated to the Governing Board and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process. All quality improvement activities are documented and the result of actions taken are recorded to demonstrate the program's overall impact on improving health care and the delivery system.

Clinical Practice Guidelines

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

Preventive Health/HEDIS Measures

The Quality Improvement Committee determines aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators are monitored

annually based on product type, i.e. Medi-Cal or CMC. Initiatives are put in place to encourage member compliance with preventive care, such as for Pap smear education and compliance.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across practice and provider sites. Survey data regarding members' experience with continuity and coordination of care at their provider office is collected and analyzed annually. This information is disseminated to and evaluated by internal and external stakeholders. As meaningful clinical issues relevant to the membership are identified, they are addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

A. Primary care services
B. Behavioral health care services
C. Inpatient hospitalization services
D. Home health services
E. Skilled nursing facility services

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

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

XII. QI Organizational Structure

Quality Improvement Department

The QI Department supports the organization's mission and strategic goals by implementing processes to monitor, evaluate and take action to improve the quality of care and services that our members receive. The QI Department is responsible for:

A. Monitoring, evaluating and acting on clinical outcomes for members.
B. Conducting reviews and investigations for potential or actual Quality of Care matters.
C. Conducting reviews and investigations for clinical grievances, including Potential Quality Issues (PQIs).

D. Designing, managing and improving work processes to:
    a. Drive improvement of quality of care received
    b. Minimize rework and costs
    c. Optimize the time involved in delivering patient care and service
    d. Empower staff to be more effective
    e. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Supporting the maintenance of quality standards across the continuum of care and all lines of business.
F. Leading cross-functional Process Improvement projects to improve efficiency across the organization
G. Maintaining company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA).

Chief Medical Officer

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

Medical Director

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

The Medical Director(s) is required to conduct medical necessity denial decisions, supervise all medical necessity decisions made by clinical staff and resolve grievances related to medical quality of care. A Medical Director is the only Plan personnel authorized to deny care based on medical necessity. The Plan pharmacist(s) may make a denial based on medical necessity regarding pharmaceuticals.

Director of Quality and Process Improvement

The Director of Quality and Process Improvement is a qualified person with experience in data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to Plan members. The Director of Quality and Process Improvement reports to the Chief Medical Officer and is responsible for directing the activities of the Plan's quality improvement staff in monitoring the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Director of Quality assists the Plan's executive staff, in overseeing the activities of the Plan operations to meet

the Plan's goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Director of Quality and Process Improvement coordinates the Plan's QIC proceedings in conjunction with the CMO; reports to the Board relevant QI activities and outcomes, supports organization initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data and recommends performance improvement initiatives while incorporating best practices as applicable.

Quality Improvement Manager

The Quality Improvement Manager provides leadership, and coordination to the QI Team and is a person with experience in data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to Plan members. The Quality Improvement Manager reports to the Director of Quality and Process Improvement and is responsible for managing the activities of the Plan's quality improvement staff in monitoring the Plan's health care delivery system relating to quality improvement, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Improvement Manager assists the Director of Quality and Process Improvement in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members.

Process Improvement Manager

The Process Improvement Manager provides leadership, coordination and management to the Process Improvement Team as it relates to improving internal processes impacting the quality of care and quality of service provided to Plan Members. The Process Improvement Manager reports to the Director of Quality and Process Improvement and is responsible for managing the Process Improvement team in reviewing the Plan's internal health care delivery systems, managing activities of the Plan's CAHPS and Health Outcomes Survey (HOS) surveys, Health Homes Program and overseeing NCQA accreditation activities.

QI Supervisor

The QI Supervisor provides leadership, coordination and oversight of the PQI investigation process, FSR, IHA audits, and HEDIS medical record reviews. The QI Supervisor reports to the QI Manager and is responsible for developing and maintaining processes that enhances the operationalization of QI activities to meet the organizational goals, including improving the health status and outcomes of its members.

QI Nurse, RN

The QI Nurse reports to the QI Manager and oversees investigations of member grievances related to PQI, supports HEDIS medical record reviews, and investigates and prepares cases for PQIs for Medical Director or CMO review. The QI Nurse also assists with ongoing QI studies and reviews which include but are not limited to Performance Improvement Projects (PIPs) and Chronic Condition Improvement Projects (CCIPs), and supports the Health Education Program team with a clinical perspective. The QI

Nurse can also be a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, and medical record reviews, monitors compliance with Initial Health Assessments (IHAs), and assists with other QI activities at the direction of the Quality Improvement Manager.

HEDIS Project Manager

The HEDIS Project Manager provides coordination and project management of HEDIS and HEDIS- related quality improvement projects. This position is responsible for developing and maintaining processes that enhance the operationalization of HEDIS processes, management of software applications, and supporting reporting requirements to DHCS, CMS, NCQA, and achieving SCFHP goals of improved quality of care and service.

Process Improvement Project Manager

The Process Improvement (PI) Project Manager provides coordination and project management of Plan process improvement projects, PIPs, CCIPs, NCQA, CAHPS and HOS Surveys. The PI Project Manager is responsible for working collaboratively and cross-functionally with internal and external stakeholders, including staff, consultants, auditors and surveyors to create efficiencies and quality improvements, as well as applying six sigma principals to processes at SCFHP. Additionally, this position is responsible for developing and maintaining processes that enhance the operationalization of Quality Improvement processes and support reporting requirements to DHCS, CMS and achievement of SCFHP goals of improved quality of care and service.

Health Homes Program Manager

The Health Homes Program Manager provides coordination and program management of the Health Homes Program (HHP). This position is responsible for developing and maintaining processes related to the operationalization of Health Homes processes, supporting reporting requirements to DHCS, and contracting with Community-Based Care Management Entities (CB-CMEs) to achieve a collaborative and effective program for Plan members. This position implements the quality monitoring of the program and oversees contracted partner activities to ensure the quality of care and quality of service to HHP enrollees. The Health Homes Program Manager represents SCFHP, promotes the HHP in the community and conducts program training and education with local providers, associations and community-based organizations.

QI Analyst

The QI Analyst has experience in ongoing measurement, data optimization, reporting and analysis in a health care setting. The QI Analyst is responsible for reviewing and performing quality assurance validation of data inputs, root case analysis, documentation of test cases, processes improvements and audit data accuracy and reporting. The QI Analyst works under the direction of the Director of Quality and Process Improvement and works in collaboration with other departments.

Health Educator

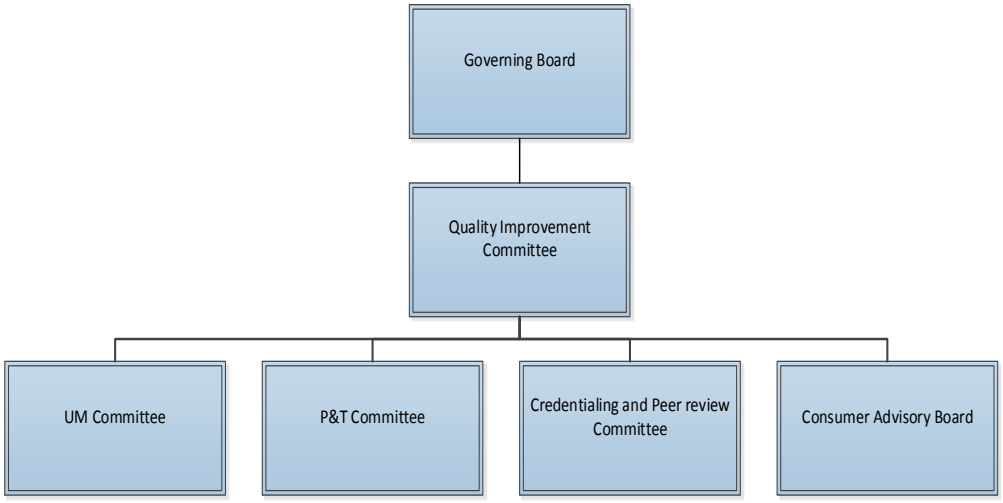
The Health Educator is a Certified Health Education Specialist (CHES) responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance with state and federal regulatory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

Quality Improvement Coordinator

The QI Coordinator has experience in a health care setting, data analysis and/or project coordination. The QI Coordinator reports to the Quality Improvement Manager or Process Improvement Manager and their scope of work includes medical record audits, data collection for quality improvement studies and activities, data analysis, implementation of improvement activities, and complaint response with follow up review of risk management and sentinel/adverse event issues. A QI Coordinator may specialize in one area of the quality process or may be cross trained across several areas. The QI Coordinator collaborates with other departments as needed to implement corrective actions or improvement initiatives as identified through the Plan's quality improvement activities and quality of care reviews.

XIII. Committee Structure Overview

Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the Governing Board.



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

A. Goals
B. Objectives

C. Voting members

D. Plan support staff
E. Quorum
F. Meeting frequency
G. Meeting terms

XIV. Committee Structure

Governing Board

The Governing Board is responsible to review, act upon and approve the overall QI Program, Work Plan, and Annual Evaluation. The Governing Board routinely receives reports from the QIC describing actions taken, progress in meeting quality objectives and improvements made. The Board makes recommendations regarding additional interventions and actions to be taken when objectives are not met.

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

Quality Improvement Committee (QIC)

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

The purpose of the QIC is to monitor and ensure that all QI activities are performed, integrated, and communicated internally and to the contracted network and partners to achieve the end result of improved care and services for members. Although Delegation Oversight is overseen by the Plan's Compliance Committee, the QIC oversees the performance of delegated functions and contracted provider and practitioner partners including but not limited to quality of care, quality of service, and access and availability.

The composition of the QIC includes contracted providers from a range of specialties as well as other representatives from the community, including but not limited to representatives from contracted hospitals, Medical Directors from contracted IPAs, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, a designated behavioral health practitioner, who is a psychiatrist or Ph.D. level psychologist, to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care. The designated behavioral health practitioner advises the QIC to support efforts that goals, objectives and scope of the QI Program are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

The QIC provides overall direction for the continuous improvement process and evaluation of activities, consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and

interdepartmental approach. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, it strives to ensure that members are provided the highest quality of care, that the plan adopts evidence based clinical practice guidelines (CPG), completes an annual review and updates the CPGs to make certain they are in accordance with recognized clinical organizations. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

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

The QIC develops, oversees, and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects through which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of study results, including but not limited to member experience, health plan ratings and HEDIS, to contracted providers and practitioners, and contracted groups.

In addition, the Grievance and Appeals Committee conducts an analysis of the plan's grievance and appeals cases and reports results to the QIC, including any intervention projects to improve services for plan members.

Utilization Management Committee

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

The UMC actively involves participating network practitioners in utilization review activities to the extent that there is not a conflict of interest. The Plan's UMC is comprised of network physicians representing the range of practitioners within the network and across the service area in which it operates, including a Behavioral Health practitioner. Plan executive leadership and Utilization Management/Quality Improvement staff may also attend the UMC, as appropriate.

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

The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, to ensure decisions are evidence-based, and to comply with regulatory and other agency standards. The UMC is also responsible for annual adoption of preventive care guidelines and medical necessity criteria. The Committee meets quarterly and reports to the QIC.

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

Pharmacy and Therapeutics Committee

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

In addition, the P&T Committee reviews and evaluates current pharmacy-related issues that are interdisciplinary and involve interfacing between medicine, pharmacy and other practitioners involved in the delivery of health care to SCFHP's members. The P&T Committee includes participating physicians, pharmacists, and Plan employee physician(s), and represents a cross section of clinical specialties including a behavioral health practitioner, in order to adequately represent the needs and interests of all plan members.

The behavioral health prescribing practitioners are involved in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step-therapy.

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

Credentialing and Peer Review Committee

SCFHP's Credentialing and Peer Review Committee uses a peer review process to make decisions regarding health plan credentialing and recredentialing of its contracted practitioners and those applying to contract with the Plan, and to serve as the Peer Review Committee when quality review is requested by the Quality Improvement Committee (QIC). Medical staff triages potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to the Credentialing and Peer Review Committee to assess if documentation is complete, and whether further action is required. The QI Department tracks, monitors, and trends service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the Credentialing and Peer Review Committee at time of re-credentialing. Quality of care case referral to the QI Department originating from multiple activities, which include, but are not limited to: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

XV. Role of Participating Practitioners

Participating practitioners, including a behavioral health practitioner who is either a medical doctor or PHD/PsyD, serve on the QI Program Committees as necessary to support each committee's function. Through these committees' activities, network practitioners:

A. Review, evaluate and make recommendations for credentialing and re-credentialing decisions.
B. Review individual cases reflecting actual or potential adverse occurrences.
C. Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, population health programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures.
D. Review proposed QI study designs.
E. Participate in the development of action plans and interventions to improve care and service to members.
F. Participate with one or more of the following committees:
    a. Quality Improvement Committee
    b. Pharmacy and Therapeutics Committee
    c. Utilization Management Committee
    d. Credentialing and Peer Review Committee
    e. Additional committees as requested by the Plan

XVI. Behavioral Health Services

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

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

Reporting to the CMO, the Manager of Behavioral Health is involved in the behavioral aspects of the QI Program. The Manager of Behavioral Health is available to assist with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, providing behavioral health QI statistical data, and follow-up on identified issues.

XVII. Utilization Management

Please refer to the Utilization Management Program Description for Utilization Management activities and related UM activities including Case Management, and Population Health programs and processes.

XVIII. Population Health Management

The Population Health Management (PHM) program is developed, implemented and evaluated by the Health Services team with input and oversight by the QI Team and QIC. The QI Team annually conducts a population assessment to identify the needs and characteristics of SCFHP's member population. The Health Services team reviews the results of the assessment and identifies programs that would be beneficial to SCFHP's sub populations. The Population Health Program has four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

The QI Team works with Health Services to identify and set goals as part of the PHM Strategy. The PHM Strategy is brought to the QIC for review and approval annually.

XIX. Care of Members with Complex Needs

Please refer to the Case Management program description and the Population Health Management Strategy document for complete details on care of members with complex needs. SCFHP is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is to promote the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

A. Providing case management teams focusing on members who have had an organ transplant, or are diagnosed with HIV/AIDS, progressive degenerative disorders and/or metastatic cancers.
B. Improving access to primary and specialty care to facilitate the receipt of appropriate services for members with complex health conditions.
C. Coordinating care for members who receive multiple services.
D. Identifying and reducing barriers to services for members with complex conditions.

XX. Cultural and Linguistics

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

SCFHP is committed to member centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Identified population needs and planned interventions involve member input and are vetted through the Consumer Advisory Committee and Consumer Advisory Board prior to full implementation, as determined by the plan's Health Educator.

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

Interpreter services are provided to the member at no charge.

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

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

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

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

XXI. Credentialing Processes

SCFHP conducts a credentialing process that is in compliance with the National Committee for Quality Assurance (NCQA), the Department of Health Care Services (DHCS), the Department of Managed Health

Care (DMHC), and the Centers for Medicaid and Medicare Services (CMS). SCFHP contracts with a Credentials Verification Organization (CVO) who performs primary source verification. The Plan credentials new applicants prior to the effective date of the practitioner's agreement and in advance of the practitioner delivering care to members, and re-credentials network practitioners at least every 36 months.

The comprehensive credentialing process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status, and judgment, thus ensuring the competency of practitioners working within the SCFHP contracted delivery system. The scope of the credentialing program includes all licensed Physicians (MD), Oral Surgeons, Dentists (DDS), Podiatrists (DPM), Doctors of Osteopathy (DO), Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Mid-Wife (CNM), Clinical Nurse Specialists (CNS), Chiropractors (DC), Optometrists (OD), Clinical Psychologists (Ph.D.), Behavioral Health Practitioners such as Marriage Family Therapists (LMFT), Licensed Clinical Social Workers (LCSW), and other ancillary, allied health professionals or mid-level practitioners, as applicable, both in the delegated and direct contracts.

Healthcare Delivery Organizations

SCFHP performs credentialing and re-credentialing of ancillary providers and health care delivery organizations (these include, but are not limited to, hospitals, home health and hospice agencies, skilled nursing facilities, free standing surgical centers, behavioral healthcare providers that provide mental health or substance abuse services in inpatient residential or ambulatory settings, and other medical providers such as FQHCs, laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, end stage renal disease (ESRD) providers, and similar providers as applicable) upon initial contracting, and every 36 months thereafter. The intent of this process is to assess whether these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies and are maintaining their accreditation status as applicable.

Use of Quality Improvement Activities in the Re-credentialing Process

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

Monitoring for Sanctions and Complaints

SCFHP has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, sanctions or limitations on licensure, Medicare and Medicaid sanctions, CMS preclusion list, potential quality issues (PQI), and member complaints between re-credentialing periods.

XXII. Facility Site Review, Medical Record and Physical Accessibility Review

SCFHP does not delegate Primary Care Provider (PCP) site and medical records review to its contracted groups. SCFHP assumes responsibility and conducts and coordinates Facility Site Review (FSR) and Medical Record Review (MRR) in accordance with standards set forth by MMCD Policy Letter 14-004.

SCFHP collaborates with other health plan partners to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for PCPs contracted with health plan partners. Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 14-004 and SCFHP policies.

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

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

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

Medical Record Documentation Standards

SCFHP requires that its contracted practitioners maintain medical records in an accurate and timely manner that is current, detailed, organized, and easily accessible to treating practitioners. All member data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc.). The medical record should also indicate timely access by members to information that is pertinent to them, such as health education materials.

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

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

XXIII. Member Safety

The monitoring, assessment, analysis and promotion of member safety matters are integrated into all components of member enrollment and health care delivery organization continuum oversight and are a significant part the Plan's quality and risk management functions. Member safety efforts are clearly

articulated both internally and externally, via newsletter, email, fax, web and verbal communications. Member safety efforts include:

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

Member Safety prevention, monitoring and evaluation include:

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

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

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

c. Sentinel events identification and appropriate investigation and remedial action
d. Administration of Flu/Pneumonia vaccine

C. Administrative offices
a. Fire, disaster, and evacuation plan, testing, and annual training

XXIV. Member Experience and Satisfaction

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

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

Provider satisfaction is assessed annually using a valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services.

Member Grievances and Provider Complaints

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

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

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

XXV. Delegation Oversight

The Delegation Oversight process and Delegation Oversight Committee are overseen by the Plan's Compliance Committee. The Delegation Oversight Committee reports to the Compliance department. Delegation Oversight activities that are specific to the QI Program include reports submitted by

delegated entities and the functional operational area that has responsibility for overseeing corrective action plans.

Through Delegation Oversight, Plan monitoring includes, but is not limited to, the following:

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

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

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

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

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

XXVI. Data Integrity/Analytics

The clinical data warehouse aggregates data from SCFHP's core business systems and processes, such as member eligibility, provider data, encounters, claims, and pharmacy data. The data warehouse is maintained by the Information Systems (IS) Department. The data warehouse allows IS to provide analytic support to the QI Program. The data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as the identification of members eligible for specific population health management programs, risk stratification, process measures, and outcomes measures. SCFHP staff create and maintain the data base with quarterly data updates.

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

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

Identification and Stratification of Members

Using clinical business rules, the database can identify members with a specific chronic disease condition, such as asthma, diabetes, mental health issues or congestive heart failure. It then can identify the acuity of the member based on their emergency department (ED) and inpatient utilization data. . Once the member has been identified with a specific disease condition and acuity, the Case Management team works with the member to further identify treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Potential of Over- and Under- Utilization of Services

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

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventive care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50, or a retinal eye exam for a member with diabetes. This information is called a gap in care. This information is then disseminated to the Population Health Management and Case Management teams to address with the member.

Identify Members for Targeted Interventions

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

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

Medical Record Review

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

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

Interventions

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

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

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

Improvement Standards

A. Demonstrating Improvement

a. Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. Sustaining Improvement
   a. Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

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

Documentation of QI Projects

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

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

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

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

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

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

A. Clinical care and service
B. Access and availability
C. Continuity and coordination of care
D. Preventive care, including:
    a. Initial risk assessment (IHA)
    b. Behavioral assessment
E. Patient diagnosis, care, and treatment of acute and chronic conditions
F. Complex case management:
    a. SCFHP coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the utilization and case management department, which details this process in its utilization management and case management programs and other related policies and procedures
G. Drug Utilization
H. Health Education
I. Over- and Under- Utilization monitoring
J. Population health program outcomes and performance against program goals

Administrative Oversight:

A. Delegation oversight
B. Member rights and responsibilities
C. Organizational ethics
D. Effective utilization of resources
E. Management of information
F. Financial management
G. Management of human resources
H. Regulatory and contract compliance
I. Customer satisfaction
J. Fraud and abuse* as it relates to quality of care

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

XXVII. Conflict of Interest

Network practitioners serving on any QI program-related committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and

determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues.

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

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

XXVIII. Confidentiality

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

In addition, all committee and subcommittee members are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance. Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting.

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

This

XXIX. Communication of QI Activities

Results of performance improvement activities are communicated to the appropriate department, and/or multidisciplinary committee as determined by the nature of the activity. The QI subcommittees report their summarized information to the QIC quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of SCFHP staff.

Communication of QI trends to SCFHP's contracted entities, members, practitioners and providers is through the following:

A. Practitioner participation in the QIC and its subcommittees
B. Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
C. Practitioner and member newsletters regarding relevant QI program topics

D. The QI Program description, available to providers and members on the SCFHP website. This includes QI program goals, processes and outcomes as they relate to member care and service. Members and/or providers may obtain a paper copy by contacting Customer Service.
E. Included in annual practitioner education through provider relations and the Provider Manual

XXX. Annual Evaluation

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

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

A. A description of completed and ongoing QI activities that address quality of care, safety of clinical care, quality of service and members' experience
B. Trending and monitoring of measures and previously identified issues to assess performance in the quality and safety of clinical care and quality of services
C. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices
D. Barrier analysis

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

A. The adequacy of QI program resources
B. The QIC structure
C. Amount of practitioner participation in the QI program, policy setting, and review process
D. Leadership involvement in the QI program and review process
E. Identification of needs to restructure or revise the QI program for the subsequent year

Health Education

Santa Clara Family Health Plan

2019 Program Evaluation

Library & Resource Page

- Internal library of approved Health Ed resources created for staff to mail to members.
- Intranet page created for staff for access to job aids, FAQs

Contracts

- 1 renewed (Healthier Kids Foundation)
- 1 new (Customer Motivators)

Class Audits

- YMCA Camp
- Healthier Kids Foundation
- ACT for Mental Health

Member Incentives

Concluded 3 programs and evals submitted to DHCS

- Comprehensive Diabetes Care –Nephropathy
- Controlling Blood Pressure (CBP)
- Childhood Immunizations (CIS-3)

Launched Wellness Rewards Program (Q2)

Health improvement program for Medi-Cal members offering gift cards for completing health screenings/visits

Focusing on 8 HEDIS measures:

1. Prenatal Care – 3 tier ($30, car seat, sleep pod)
2. Breast Cancer Screening - $20
3. Cervical Cancer Screening- $30
4. Asthma Medication Ratio - $15/quarter
5. Adolescent Well-Care Visit - $30
6. Comprehensive Diabetes Screening – $25
7. Well-Child Visits in the first 15 months – $30
8. Well-Child Visits 3-6 year old - $30

2020 Program Description

What's changed?

Updated description to add DHCS Population Needs Assessment (PNA) – annual version of Group Needs Assessment. GNA is no longer required every 3 years.

- Goal of PNA is to improve health outcomes and ensure Plan is meeting needs of all Medi-Cal members.

2020 Work Plan

Health Education Programs

- Renewing contracts
- Launch Texting Campaign to MC members
- Focus on marketing strategies for current programs
- Ongoing trainings with member-facing staff

Member Incentives

- Discussing plans for 2020 incentives
- Continue to partner for clinic days
- Launch 2 new Process Improvement Projects (PIPS)
  - AWC – narrowed focus on VHP network, ages 19-21
  - W15 – narrowed focus PMG network

Cultural & Linguistics

2019 Program Evaluation

QNXT Language Attribute
- Developed process for capturing alternate language/format requests
- Completed training to staff December 2019

Staff Language Proficiency
- Developed process with HR for ongoing monitoring of staff language proficiency

DMHC Enrollee Assessment
- DMHC requirement every 3 years to better understand the communication and language preferences of members.
- Kicked off Oct 2019, Completed January 2020

2020 Program Description

What's Changed?

Updated description to add DHCS Population Needs Assessment (PNA) – annual version of Group Needs Assessment. GNA is no longer required every 3 years.
- Goal of PNA is to improve health outcomes and ensure Plan is meeting needs of all Medi-Cal members.

2020 Work Plan

Population Needs Assessment (PNA)
- Due annually
- Analyze CAHPs results
- First submission due to DHCS June 30th 2020

Staff Language Proficiency
- Testing to be implemented July 2020 annually

Santa Clara Family Health Plan™

Provider Satisfaction Survey Assessment-MY2019

Prepared by: Carmen Switzer, Provider Network Access Manager

For review by the Quality Improvement Committee

February 12, 2020

INTRODUCTION

- Santa Clara Family Health Plan (SCFHP) contracted with Center for the Study of Services (CSS) to administer the MY2019 Provider Satisfaction Survey (PSS).

- The following provider types, groups/delegates were targeted to participate in the survey:

  - ❑ Direct (Individually Contracted Providers)
  - ❑ Palo Alto Medical Foundation (PAMF)
  - ❑ Physicians Medical Group (PMG)
  - ❑ Premier Care (PC)

  - ❑ Primary Care Providers (PCP)
  - ❑ Specialists (SPC)
  - ❑ Behavioral Health Providers (BH)

- Valley Health Plan (VHP) and Kaiser administer their own annual provider satisfaction surveys. VHP serves approximately 50% of SCFHPs members, therefore a summary of their PSS report is included in this presentation.

METHODOLOGY

- There were 3,545 providers in the SCFHP network to be surveyed using a fax-only methodology.
- To reduce the burden on offices where multiple providers share a single fax number, a sample was generated of all unique fax numbers (716) associated with providers in the SCFHP provider network.
- Each fax number was assigned a unique 8-digit identification number to track responses.
- The fax methodology consisted of four (4) fax waves:
  - ❑ Wave 1: July 11, 2019
  - ❑ Wave 2: July 17, 2019
  - ❑ Wave 3: July 23, 2019
  - ❑ Wave 4: July 29, 2019

GOALS AND OBJECTIVES

Goals:

- To ensure that SCFHP providers have a positive experience with health plan services.

Objectives:

- Measure provider experience (satisfaction) at least annually.
- Evaluate provider's satisfaction with performance measures.
- Identify any areas to improve contracted provider's experience with the health plan.
- Develop interventions as appropriate to address gaps in service.

Standards for Provider Satisfaction:

- Eighty percent (80%) of provider's will be satisfied (Q1-7 & 9)
- One hundred percent (100%) of provider's will be satisfied (Q8)

Provider Satisfaction Survey

SURVEY UPDATES - MY2018 vs MY2019

- **Interpreter Questions** -- SCFHP followed DMHC's updated guidelines to include interpreter questions on the Provider Satisfaction Survey in MY2019.

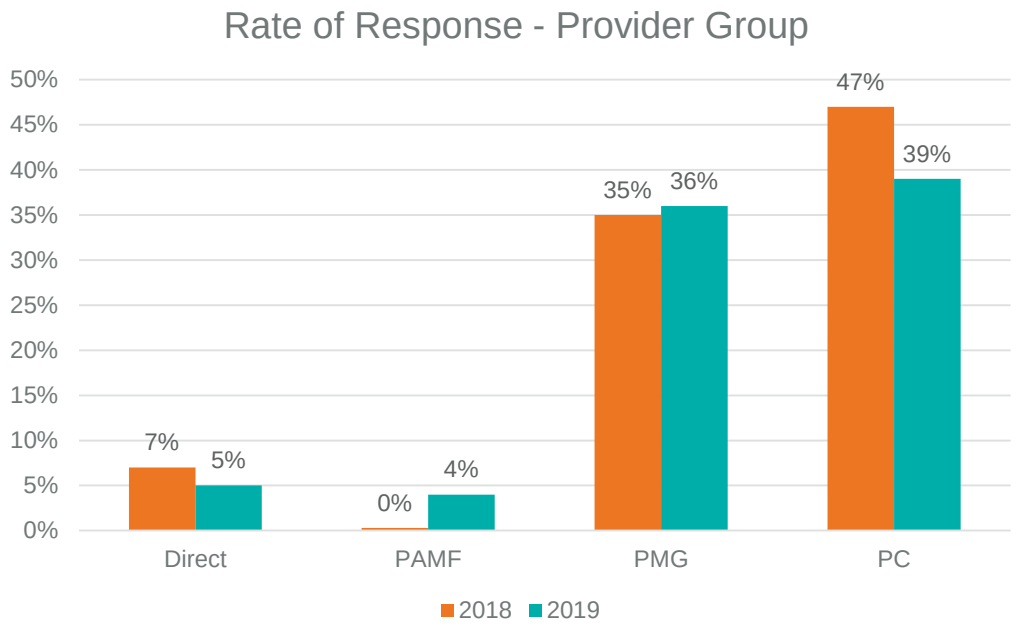
- **Not Applicable/No Experience** -- To ensure results are accurately presented, results as shown in the assessment do not include providers who responded with "not applicable/no experience". However, not applicable/no experience ratings were assessed and are noted throughout the report. This change was applied in 2019; therefore 2018 satisfaction ratings were adjusted accordingly to accurately report changes from previous year.

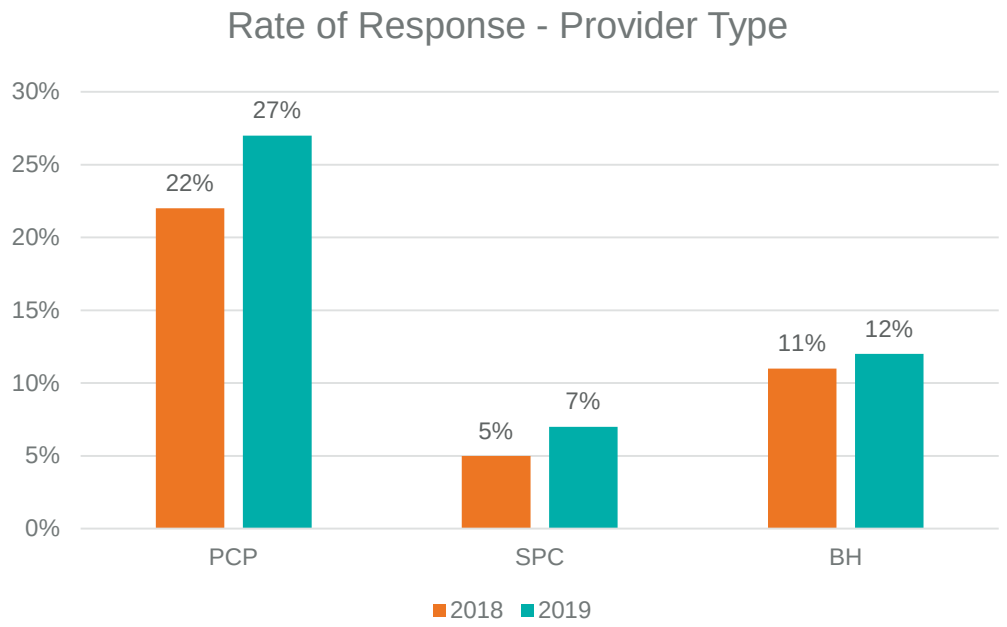
- Attachments include the survey instruments for 2018 and 2019:

Note: SCFHP uses one survey instrument to conduct the survey and a full census approach, which includes providers types and groups listed on slide 2. SCFHP acknowledges that to some extent the survey instrument may not be designed to reach meaningful conclusions. For example, some provider groups process most of their medical claims for the Medi-Cal line of business. Therefore, it is possible that some of those providers groups will rate satisfaction on claims processing and appeals that do not involve SCFHP operations.

Provider Satisfaction Survey

Rate of Response – 2 year comparison

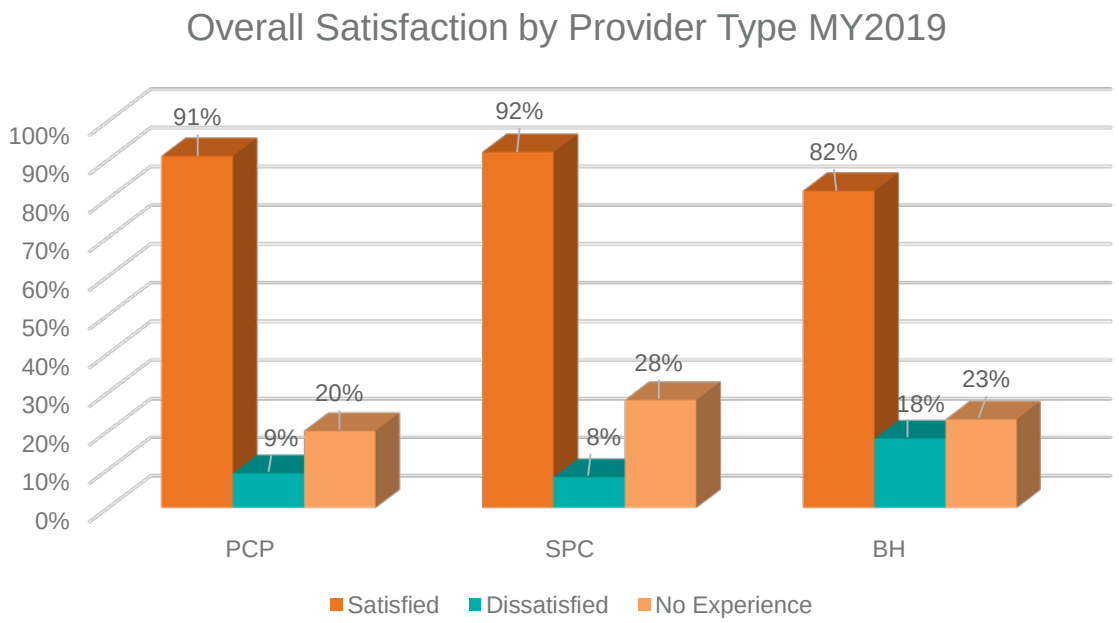


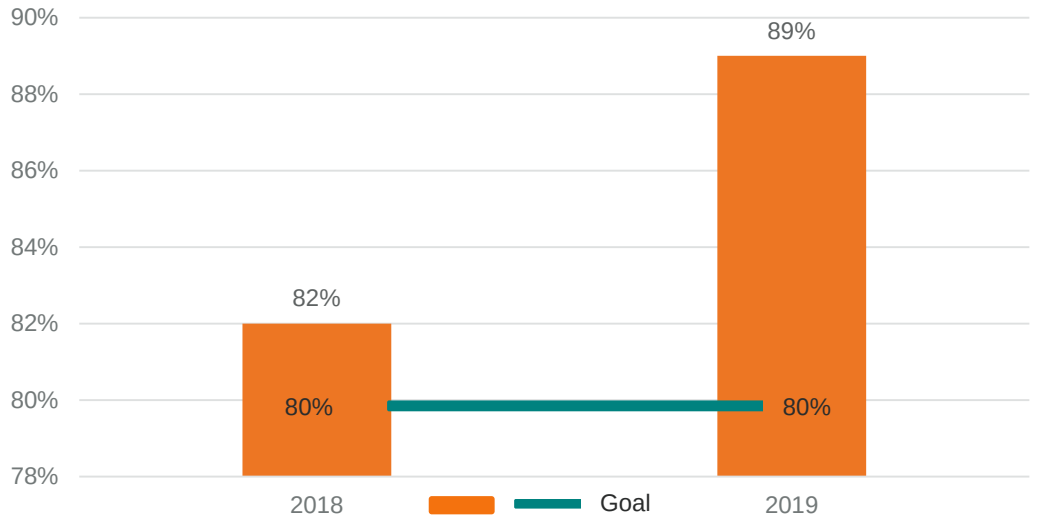


- With the exception of Direct providers, response rates in 2019 showed an increase across all groups and provider types.
- Premier Care (PC) participation increased from 39% to 47%.
- PAMF showed participation in 2019 at 4%.
- PCP participation increased from 22% to 27%.

Provider Satisfaction Survey

Overall Provider Satisfaction





- Specialist providers rated satisfaction the highest at 92%.
- PCP providers rated satisfaction at 91%.
- BH providers rated satisfaction at 82%.

- Overall satisfaction in MY2018 and MY2019 met and exceeded goal.
- The aggregated satisfaction rate across all provider types was met at 89%, which yields 9 percentage points above goal.

Provider Satisfaction Survey

Santa Clara Family Health Plan

RESULTS – All Respondents (PCP, SPC, BH)

Table I: Utilization Management

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q1a: timeliness of prior authorization process (N=248)	80%	Y	85%	15%	+2	8%
Q1b: timeliness of referral process (N=225)	80%	Y	94%	6%	+5	16%
Q1c: friendliness/helpfulness of UM staff (N=244)	80%	Y	95%	5%	+7	11%

- Provider satisfaction increased across all UM measures in 2019.
- SPC satisfaction rated the highest on measure Q1a-91%
- PCP satisfaction rated the highest on measures Q1b-97% and Q1c-99%.
- BH rated satisfaction the lowest on measure Q1a-81%.

Provider Satisfaction Survey

Santa Clara Family Health Plan

Table II: Claims

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q2a: timeliness of clean claims processing (N=209)	80%	N	77%	23%	+3	25%
Q2b: promptness to answer claims inquiries (N=206)	80%	Y	83%	17%	+4	25%
Q2c: timeliness/efficiency of dispute process (N=192)	80%	N	78%	22%	NA	34%

- While provider satisfaction did not meet goal on measures Q2a and Q2c, satisfaction increased by 3 percentage points and 4 percentage points in 2019.
- PCP's rated satisfaction the highest on all 3 measures Q2a-88%, Q2b-85% and Q2c-86%.
- BH rated satisfaction the lowest on measures Q2a & Q2c, and Specialists rated the lowest on measure Q2b.
- Measure Q2c is new in 2019; thus, there is no previous year (PY) data available.

Provider Satisfaction Survey

Table III: Appeals

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q3a: timeliness/efficiency of UM appeals process (N=176)	80%	N	72%	27%	-3	39%
Q3b: timeliness/efficiency of claims appeals process (N=172)	80%	N	72%	28%	-9	40%

- Results showed a decrease in provider satisfaction in 2019.
- Specialist providers rated satisfaction the highest on measures Q3a-86% and Q3b-87%.
- BH provider rated satisfaction the lowest on both measures.

Provider Satisfaction Survey

Santa Clara Family Health Plan

Table IV: Patient Timely Access

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q4a: urgent care (N=163)	80%	Y	97%	3%	+11	36%
Q4b: non-urgent primary care (N=168)	80%	Y	98%	2%	+7	35%
Q4c: non-urgent specialist care (N=206)	80%	Y	95%	6%	+5	25%
Q4d: non-urgent ancillary (N=173)	80%	Y	89%	11%	+10	33%
Q4e: non-urgent behavioral health (N=162)	80%	Y	87%	12%	+5	39%

- Provider satisfaction with patient access to care increased across all measures in 2019.
- All provider types rated satisfaction above goal on all measures.
- BH providers rated satisfaction the highest on measures Q4a-b at 100%, and the lowest on measures Q4c-92%, Q4d-84% and Q4e-83%.

Provider Satisfaction Survey

Santa Clara Family Health Plan

Table V: Customer Service

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q5a: ability to answer calls promptly (N=245)	80%	Y	91%	9%	+9	11%
Q5b. ability to resolve concerns/issues (N=243)	80%	Y	90%	10%	+7	11%
Q5c. friendliness/helpfulness of staff (N=243)	80%	Y	98%	2%	+10	11%

- Goal was met on all measures, and provider satisfaction with the CS team increased across all measures in 2019.
- BH rated the highest on measure Q5c-100%, and the lowest on measures Q5a-b at 84%.

Provider Satisfaction Survey

Table VI: Provider Relations

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q6a: ability to answer calls promptly (N=250)	80%	Y	93%	7%	+6	8%
Q6b. ability to resolve concerns/issues (N=248)	80%	Y	91%	9%	+7	9%
Q6c. friendliness/helpfulness of staff (N=246)	80%	Y	96%	4%	+8	9%

- Goal was met on all measures, and provider satisfaction with the PR team increased across all measures in 2019.
- PCP rated the highest on measure Q6c-99%, and BH rated the lowest on measures Q5a-b at 85%.

Provider Satisfaction Survey

Santa Clara Family Health Plan

Table VII: SCFHP Provider Network

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q7a: quality of SCFHP's provider network (N=242)	80%	Y	88%	12%	+8	8%
Q7b: availability of medical providers (N=223)	80%	Y	92%	8%	+8	19%
Q7c: availability of behavioral health providers (N=211)	80%	Y	81%	24%	+9	17%

- Goal was met on all measures and provider satisfaction with SCFHP's provider network increased across all measures in 2019.
- PCP rated satisfaction the lowest on measure Q7c at 73%, followed by BH at 74%.

Provider Satisfaction Survey

Santa Clara Family Health Plan

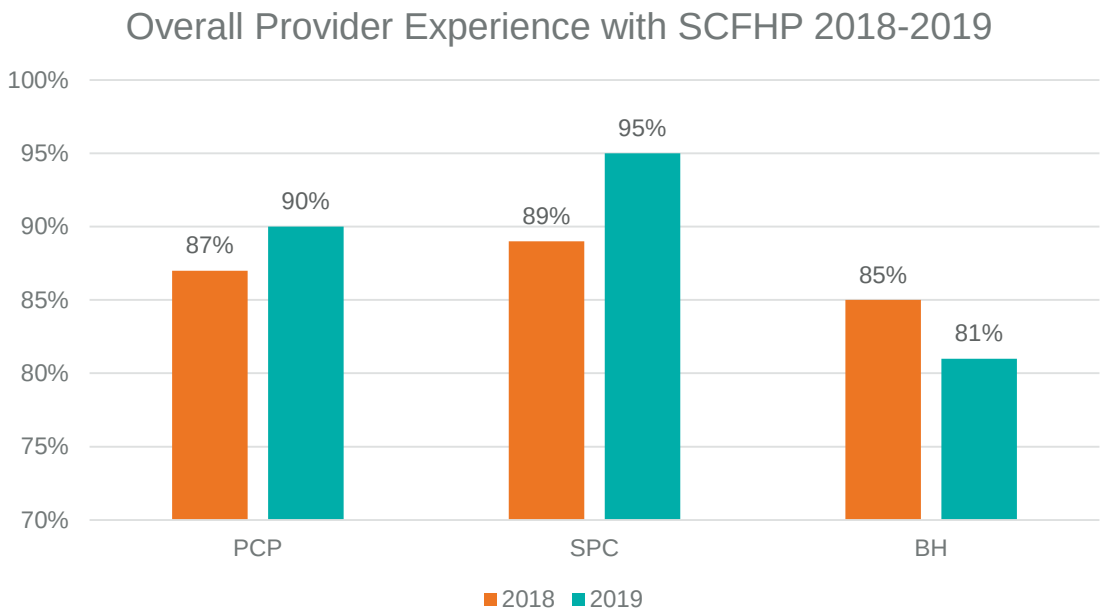
Table VIII: SCFHP's Language Assistance Program

Survey Question / # of Respondents	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Q8a: coordination of appointments (N=128)	100%	N	97%	3%	NA	47%
Q8b: availability of interpreters (N=125)	100%	N	97%	3%	NA	47%
Q8c: competency of interpreters (N=124)	100%	N	96%	4%	NA	48%

- This survey section is a new measure 2019; thus, there is no previous year (PY) data available.
- SPC rated satisfaction the lowest on measure Q8c-89%, and BH providers rated satisfaction in all measures at 100%.

Provider Satisfaction Survey

Table IX: Overall Experience with SCFHP - Comparison Chart (2018-2019)



Q9a: Overall experience with Santa Clara Family Health Plan.

- The total number of providers that answered question Q9a = 217 – 76%.
- Provider satisfaction with SCFHP services increased across all providers types in 2019 by 4 percentage points.
- Overall provider experience with SCFHP rated at 89%, dissatisfaction at 11%, and 4% responded with “not applicable/no experience”.

Conclusion

While the Plan is pleased that most measures met SCFHP's performance goals, and overall results indicate strengths in most operational areas, the survey results revealed a need for improvement in the following areas:

- Timeliness of clean claims processing
- Timeliness/efficiency of claims disputes
- Timeliness/efficiency of claims appeals
- Timeliness/efficiency of UM appeals
- Availability of Behavioral Health Providers

SCFHP department leadership and staff will collaborate internally on the areas above, and if operational issues are identified, a correction plan will be established.

SCFHP values its network providers and will continue to improve operations to satisfy and meet provider needs and expectations.

VHP Provider Satisfaction Survey

Valley Health Plan (VHP) contracted with Center for the Study of Services (CSS) to administer the MY2018 Provider Satisfaction Survey (PSS) and uses a similar methodology as SCFHP.

- Overall Performance Goal: 80%
- PCP Satisfaction with Auth/Ref: 70%

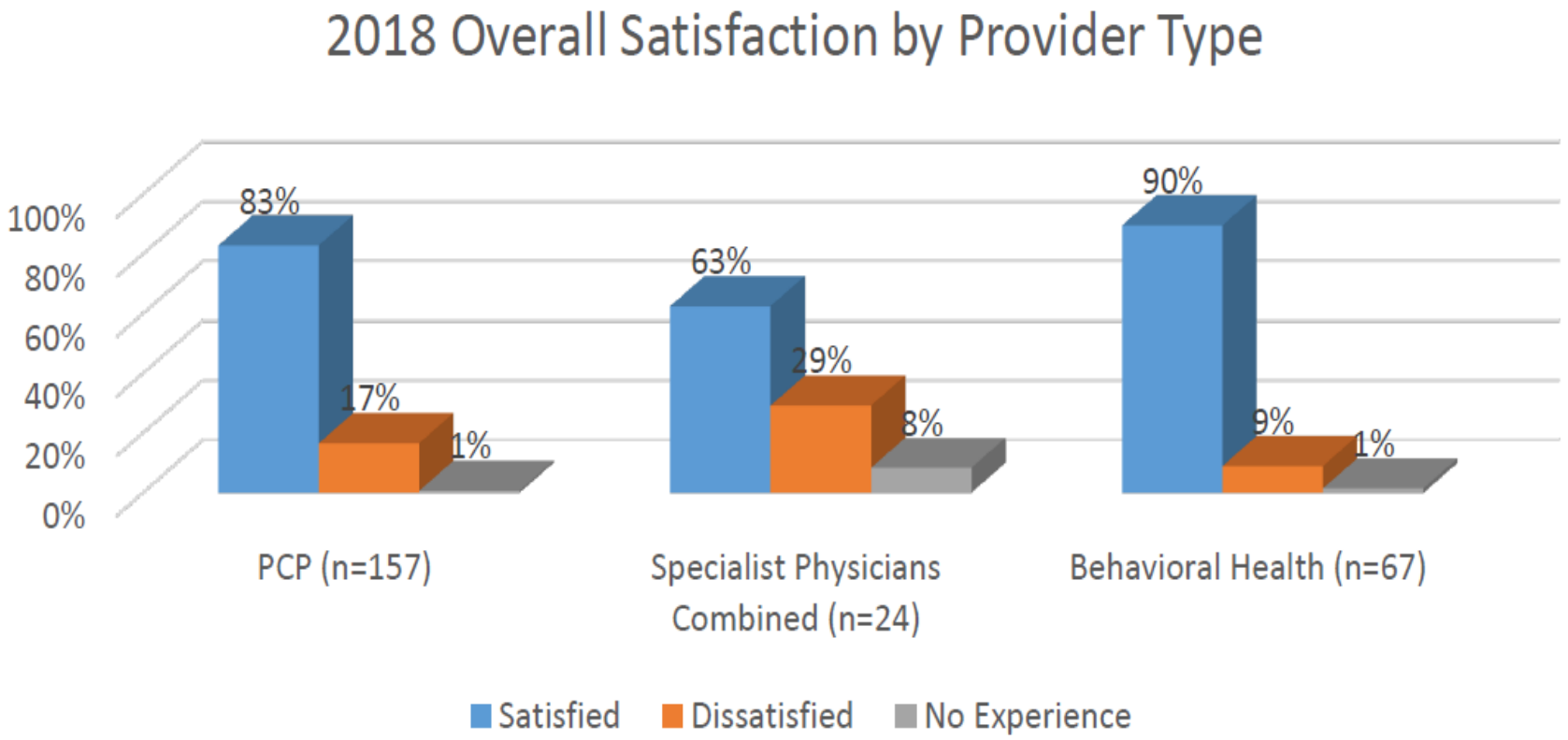
Response Rate:

- VHP reported that there are a total of 1,457 providers in their "database", all of which were targeted to participate in the survey.
- Total Surveys Completed = 253 (response rate at 26%)
  - PCP (N=162)
  - SPC (N=24)
  - BH (N=67)

Response Rate 2017/2018 Comparison:

Provider Type	2018	2017	Change
PCP	35%	18%	+17
SPC	9%	6%	+3
BH	26%	36%	-10

VHP Provider Satisfaction Survey



VHP Provider Satisfaction Survey

Rate Scores by departments w/ (2 years comparison)	Current 2018 253 Total Respondents (all provider type)			MY 2017			Satisfaction Rate Change from 2017
	Satisfied	Dissatisfied	No Experience	Satisfied	Dissatisfied	No Experience	↑↓
Utilization Management							
1a) Utilization Management Clarity (n=253)	63%	19%	18%	79%	3%	18%	↓
1b) Utilization Management Efficiency (n=248)	45%	17%	38%	100%	0%	0%	↓
Authorization Process/Treatment plan							
2a) Inpatient Authorization (n=250)	39%	7%	54%	31%	3%	66%	↑
2b) Outpatient Authorization (n=250)	70%	17%	13%	84%	3%	13%	↓
2c) Outpatient Treatment Plans (n=248)	61%	18%	21%	68%	3%	29%	↓
Complaints/Claims							
3a) Claims Processing (n=245)	60%	10%	29%	37%	43%	21%	↑
3b) Complaint Resolution (n=242)	51%	9%	40%	28%	25%	47%	↑
Health Education Materials							
4) Health Promotion and Patient Education (n=244)	43%	5%	52%	37%	7%	56%	↑

VHP Provider Satisfaction Survey

Rate Scores by departments w/ (2 years comparison)	Current 2018 253 Total Respondents (all provider type)			MY 2017			Satisfaction Rate Change from 2017
	Satisfied	Dissatisfied	No Experience	Satisfied	Dissatisfied	No Experience	↑↓
Customer Service Staff's							
5b) Customer Service- knowledge (n=251)	63%	12%	24%	68%	13%	19%	↓
5a) Customer Service- promptness (n=252)	64%	10%	26%	57%	24%	19%	↑
5c) Customer Service- get answers (n=251)	62%	12%	25%	56%	25%	19%	↑
Utilization Management Staff's							
6a) Utilization Management- promptness (n=251)	55%	22%	12%	81%	3%	16%	↓
6b) Utilization Management- knowledge (n=251)	60%	16%	25%	81%	3%	16%	↓
6c) Utilization Management- get answers (n=251)	57%	66%	25%	81%	3%	16%	↓
Provider Relations Staff's							
7a) Provider Relations- promptness (n=252)	60%	12%	29%	57%	29%	13%	↑
7b) Provider Relations- knowledge (n=252)	61%	10%	29%	60%	26%	13%	↑
7c) Provider Relations- get answers (n=252)	60%	10%	29%	57%	29%	13%	↑

VHP Provider Satisfaction Survey

VHP reported —

Provider satisfaction improved in the following areas:

- Inpatient Authorization
- Claims Processing, Complaint Resolution
- Health Provider and Patient Education
- Customer service-promptness and get answers
- Provider Relations- promptness, knowledge, and get answers

Opportunities for improvement remain in the following areas:

- Utilization Management
- Utilization Management Staffs
- Authorization Process/Treatment plan

VHP Provider Satisfaction Survey

VHP also reported the following:

Opportunities for Improvement:

- Upcoming measurement year will be focusing on working collaboratively with all operational departments to review and re-assess the survey questionnaires to ensure a well-designed tool is able to capture the data based on provider feedback and also serve as a tool for improving communication between providers and organization.

VHP Conclusion:

- VHP will focus on the functional area of dissatisfaction and will work collaboratively within department to improve the satisfaction experience from our providers.

- VHP values our providers and is adhered to creating the most positive provider satisfaction experience as much as possible. The intervention above will be the main focus for VHP to work on for MY 2019.

2020 Cal MediConnect (CMC) Population Health Assessment

Committee Review: February 12, 2020

Table of Contents

Background

Santa Clara Family Health Plan (SCFHP) is a not-for-profit organization established in 1997 that offers comprehensive and affordable health coverage for low-income residents in Santa Clara County, California. SCFHP currently services over 8,400 beneficiaries under its Cal MediConnect (CMC) line of business. In order to qualify for the optional program, beneficiaries must meeting the following criteria: live in Santa Clara County; be 21 years of age or older; have both Medicare Part A and B; and be eligible for full-scope Medi-Cal.

Introduction

This report reviews general member demographic information as well as more specific information within the framework of the social determinants of health (SDOH) to better understand the SCFHP CMC population in regards to who they are and some of their needs. While the report looks at the SCFHP CMC population as a whole, it also looks at three sub-populations of members enrolled in the CMC program, as well as a few combinations of the sub-populations: individuals currently in Long Term Care (LTC); those who have severe mental illness (SMI) and those utilizing Long-Term Support & Services (LTSS).

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

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

1. Population Demographics

SCFHP serves a diverse CMC population, with women making up a little over 58% of the population. Beneficiaries aged 65 and older represent 81% of the population. Hispanic beneficiaries made up a quarter of the CMC population during calendar year 2019, with Caucasians representing 16%, and Vietnamese representing 13%. Over 40% of the population lists English as their primary language. Other languages that represent over 5% of the SCFHP population include: Spanish at 18%; Vietnamese at 14%; and Mandarin Chinese at 8%. Approximately 91% of SCFHP CMC enrollees have disabilities. Majority of these members (49%) were not in LTC, SMI and did not utilize LTSS during the measurement year. CMC enrollees utilizing LTSS have higher rate with disabilities compared to other subpopulation such as LTC and SMI.

Gender

Gender	Member Count	Percentage
Female	5,635	58.3%
Male	4,028	41.7%
Total	**9,663**	**100.0%**

Table 1.1. Member Demographics: Gender.

Age

Age Group	Member Count	Percentage
<65 years	1,845	19.1%
65-74 years	3,953	40.9%
75+ years	3,865	40.0%
Total	**9,663**	**100.0%**

Table 1.2. Member Demographics: Age.

Ethnicity (ethnicities that make up >= 5% of the SCFHP CMC population)

Ethnicity	Member Count	Percentage
Hispanic	2,431	25.2%
Caucasian	1,602	16.6%
Vietnamese	1,264	13.1%
Chinese	1,132	11.7%
Other	740	7.7%
Filipino	710	7.4%
Asian/Pacific	528	5.5%
All remaining ethnicities with less than 5%	1,256	13.0%
Total	**9,663**	**100.0%**

Table 1.3. Member Demographics: Ethnicity.

Language (languages that make up >=5% of the SCFHP CMC population)

Primary Language	Member Count	Percentage
English	4,099	42.4%
Spanish	1,728	17.9%
Vietnamese	1,368	14.2%
Chinese *	1,198	12.4%
All remaining languages with less than 5%	1,270	13.1%
Total	**9,663**	**100.0%**

Table 1.4. Member Demographics: Primary Language

*Chinese includes Mandarin and Cantonese speakers.

Disabled Population

CMC Population	Member Count	Percentage
Disabled population	8595	88.9%
Others	1068	11.1%
Total	**9663**	**100.0%**

Table 1.5. Member Demographics: Disabilities

CMC population	Total Subpopulation	Disabled subpopulation	Percentage
LTC	303	119	1.2%
SMI	1393	1215	12.6%
LTSS	2819	2661	27.5%
Non LTC, non SMI & non LTSS	48855148	4600	47.6%
Total	**9663**	**8595**	**88.9%**

Table 1.6. CMC Beneficiaries with disabilities by sub-population (LTC, SMI, LTSS)

2. Social Determinants of Health

According to the World Health Organization (WHO), social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, age, and play that impact a wide range of health, functioning, and quality-of-life outcomes and risks. These social and/or demographic characteristics of individuals, groups, communities, and societies have been shown to have powerful influences on health and well-being at the individual and population levels.[7] Social determinants are also the root cause of health disparities, a measure of differences in health outcomes between populations. It is vital to address social determinants of health to decrease health disparities and move towards achieving health equity. Health equity implies that everyone should have a fair opportunity to attain their full potential wellness and that no one should be disadvantaged from achieving this potential.

In reviewing our CMC population, we opted to review the SDOH by utilizing the framework outlined by *Healthy People 2020* [4]and supported by the CDC:

(1) Economic Stability: financial resources; poverty; employment; food security; housing stability
(2) Education: graduating from high school; enrollment in higher education; language and literacy; early childhood education and development
(3) Social and Community Context: cohesion within a community; civic participation; discrimination; conditions in the workplace; incarceration
(4) Health and Health Care: access to healthcare; access to primary care; health insurance coverage; health literacy; understanding of an individual's own health
(5) Neighborhood and Built Environment: quality of housing; access to transportation; availability of healthy foods; quality of water or air; neighborhood crime and violence

To do so, we utilized data from multiple sources: Health Risk Assessment (HRA); Consumer Assessment of Healthcare Providers and Systems (CAHPS); Health Outcomes Survey (HOS); and Risk Adjustment In Home Assessment results. [*Appendix C – Data Sources*]

Economic Stability

One of the vital indicators of economic instability is food insecurity and housing instability and therefore are social determinants of health. A healthy diet is key to having positive health outcomes. Not being able to access nutritious meals can create various health problems.[1] According to the article "Housing and Health: An Overview of the Literature", people who are not chronically homeless, but face housing instability in the form of moving frequently, falling behind on rent, or couch surfing are more likely to experience poor health in comparison to their stably housed peers.[2]

Three different data sources indicates that almost 30% of CMC members ran out of money for their food, rent, bills or medicines. Also 2.71% CMC members responded that they have to make decision between food, medication and other basic necessities because of financial instability. These figures, in conjunction with rates of members who report having problems writing checks, keeping track of money, or who need assistance managing money, potentially indicate a lack of financial knowledge.

The SMI and LTSS population more specifically have higher rates than plan average indicating that they run out of money to pay for their basic necessities.

It was also identified that 9.15% of CMC population delayed or did not fill the prescription because they felt they couldn't afford it which again indicate lack of knowledge about covered benefits and services along with community resources.

Financial Resources

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Members who have to make choices between food, medication, heat, or other necessities because of financial concerns	2.7% (N=1,400)				2019 Signify SDOH Report – 1/13/2020
Members who delayed or did not fill a prescription because they felt they could not afford it	9.1%				2019 Santa Clara CAHPS Report Survey
Respondents who run out of money to pay for food, rent, bills, or medicine	29.8% (N=5,021)	9.0% (N=133)	32.3% (N=735)	32.4% (N=1,490)	HRA Results (2019)
Respondents with problems writing checks or keeping track of money	22.8% (N=4,976)	69.7% (N=139)	37.9% (N=740)	44.4% (N=1,559)	HRA Results (2019)
Respondents in need of assistance managing money	15.9% (N=1,400)				2019 Signify SDOH Report – 1/13/2020

Table 2.1. Economic Stability and Financial Resources.

Education

The level of education is highly important and increasingly recognized as social determinant of health. Higher levels of education plays vital role in opening doors for employment opportunities, improve ability to make better decision regarding health and increase awareness of available social and personal resources that are for physical and mental health. Post-secondary education is fast becoming a minimum requirement to be eligible for employment.[3] CMC enrollees in Santa Clara County are more likely to have college degrees than CMC enrollees elsewhere in the state, but SCFHP still has higher rates of CMC enrollees without a high school diploma than those who opt-out of CMC with SCFHP.

Measure	SCFHP Rate	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Highest level of education:				SCAN ('15-'17)
Not a high school graduate	40%	44%	29%	
High school graduate	21%	22%	22%	
Some college/trade school	17%	19%	19%	
College graduate	19%	12%	26%	

Table 2.2. Level of education achieved.

Language and Health Literacy

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

Spanish (18%) and Vietnamese (14%) are most commonly spoken languages by SCFHP CMC members (Table 1.4). However 16% of CMC enrollees faced language barrier to care which is higher than average in the state of California (12%).

Measure	SCFHP Rate/Score	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Respondents who said their health care provider did not speak their language and/or had no interpreter available	16%	12%	17%	SCAN ('15-'17)

Table 2.3. Language

In 2019, SCFHP's primary language vendor, was utilized for over 8,500 calls for CMC beneficiaries. Request were made for 47 languages. Top three request languages included: Spanish (2,752), Chinese (2,284) and Vietnamese (2,044). Table 2.5. Shows the breakdown of language services utilization by CMC beneficiaries in 2019. Although there are more beneficiaries that speak Vietnamese than Chinese, there were more requests for Chinese interpretation (28%) than Vietnamese (24%). This suggests lack of awareness about the benefit.

Language	Number of Calls	Percentage
Spanish	2,752	32%
Chinese	2,361	28%
Vietnamese	2,044	24%
Tagalog	497	6%
Farsi	212	2%
Russian	198	2%
Punjabi	122	1%
Korean	71	1%
Khmer	58	1%
Hindi	48	1%
Other	209	2%
Total	**8,572**	**100%**

Table 2.4. Telephone Utilization of Interpretation Services by CMC Beneficiaries in 2019

Social and Community Context

Support System

Social support system or social relationship is key part for physical and mental health. Relationships are often interpreted as social cohesion, social capital and social network. Having a social network also provides emotional support (e.g. motivation to be compliant on treatment regimen or encourage to get back to regular routine after traumatic event) and instrumental support (e.g. ride to medical appointment).[4]

CMC members with SMI report higher rates of no family members or people (no social support) to help when needed also no one to assist them if their primary caregiver is unavailable than the plan average and the LTC and LTSS populations.

All three sub-populations of interest LTC, SMI, and LTSS report higher than plan-average rates of needing a ride or assistance to see the doctor, friends, or family. Access to transportation may be inhibiting access to care for SCFHP CMC enrollees, and/or the sub-populations specifically. Transportation to medically necessary services is a covered benefit of the health plan.

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Respondents without family members or others willing and able to help when needed	16.1% (N=5,256)	15.7% (N=146)	18.1% (N=759)	16.4% (N=1,552)	HRA Results (2019)
Respondents in need of a ride to see the doctor or friends	49.0% (N=5,073)	80.6% (N=145)	60.4% (N=751)	80.6% (N=1,552)	HRA Results (2019)
Respondents in need of assistance to see family or friends	40.1% (N=4,870)	65.6% (N=134)	49.5% (N=712)	72.5% (N=1,481)	HRA Results (2019)
Respondents who have no one to assist them if their primary caregiver is unavailable	39.8% (N=4,768)	28.8% (N=142)	39.4% (N=725)	38.3% (N=1,525)	HRA Results (2019)

Table 2.5. Support System

Social Interactions

The high rates reported for living alone and experiencing loneliness or social isolation, in conjunction with the data below, indicated that all three sub-populations experience rates of loneliness higher than the overall SCFHP CMC population.

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Living alone	26.6% 20.3% (N=5,325)	 18.1% (N=138)	 24.9% (N=769)	 27.9% (N=1,597)	2019 Santa Clara MCAHPS Report Survey HRA Results (2019)
"Yes" response to the question: are you afraid of anyone or is anyone hurting you?	3.2% (N=5,256)	2.0% (N=144)	4.7% (N=759)	4.2% (N=1,550)	HRA Results (2019)
Members experiencing loneliness or social isolation	13.9% (N=1,400)				2019 Signify SDOH Report – 1/13/2020

Table 2.6. Social Interaction

Loneliness or Social Isolation

The high rates reported for CMC enrollees that they never feel lonely, although members utilizing LTSS services reported that they felt loneliness more than 15 days a month (8.24%) to most of the days (8.37%).

Question (from HRA 2019) Over the past month (30 days), how many times have you felt lonely?	All CMC N=4,908	LTC N=121	SMI N=698	LTSS N=1,469
<5 days	17.2%	31.4%	27.0%	21.44%
>15 days	5.8%	6.6%	8.0%	8.24%
Most Days(Always feel Lonely)	5.4%	7.4%	7.7%	8.37%
None(never feel Lonely)	71.4%	54.5%	57.1%	61.95%

Table 2.7. Loneliness or Social Isolation

Health and Health Care

Access to Care

CAHPS and SCAN reports/surveys indicate that there is still opportunity to improve access to care – less than 80% of respondents said that they were getting their needed care, or getting appointments and care quickly. SCFHP has lower rates of satisfaction than the statewide average for CMC enrollees with the wait time to see a doctor when they need an appointment, while a higher rate of respondents report that the physician they were seeing is not available through the SCFHP provider network.

Measure	SCFHP Rate/Score	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Getting needed care	77.4%			2019 Santa Clara CAHPS Report Survey
Getting appointments & care quickly	70.8%			2019 Santa Clara CAHPS Report Survey
Good communication from clinicians	91.4%			2019 Santa Clara CAHPS Report Survey
Respondents satisfied with the wait to see a doctor when they need an appointment	73%	78%	75%	SCAN (’15-’17)
Respondents who said the doctor they were seeing is not available through SCFHP	20%	18%	17%	SCAN (’15-’17)

Table 2.8. Access to Care

Health Literacy

SCFHP CMC enrollees have a higher rate of misunderstanding their services and coverage than CMC enrollees throughout California in general.

Measure/Question	SCFHP Rate	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Respondents who had a misunderstanding about health care services or coverage	22%	19%	23%	SCAN (’15-’17)

Table 2.9. Health Literacy

Health Status

SCFHP CMC Enrollees have, based on claims data, higher prevalence of hyperlipidemia, diabetes, chronic kidney disease, and osteoporosis than the national average for the same conditions, as well as higher than Santa Clara County.

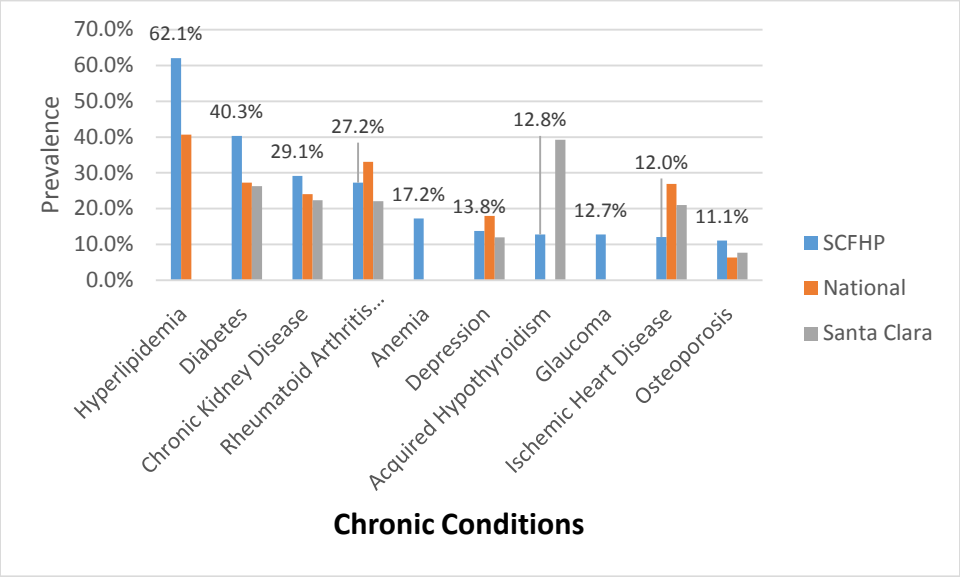


Table 2.10. Prevalence of chronic conditions at SCFHP (top 10)

Knowledge of Condition

The variability in the rates of self-reported knowledge of condition compared to condition prevalence based on claims data can potentially indicate a gap in health literacy.

- Are providers explaining conditions to the patients in a way that patients understand?
- Are providers asking patients to repeat the conditions back to them, ensuring an understanding of their health status?
- Are patients told the medical term for their condition, but lack an understanding of what the condition impacts?

Chronic Condition		SCFHP Prevalence	Knowledge of Condition[1]			
			CMC (N=4,694)	LTC (N=134)	SMI (N=698)	LTSS (N=1,465)
Hyperlipidemia	High Cholesterol	62.1%	51.1%	43.2%	48.7%	53.5%
Diabetes	Diabetes	40.2%	33.7%	24.6%	35.2%	35.8%
Chronic Kidney Disease	Kidney Problem	29.1%	5.0%	7.4%	7.7%	6.8%
Rheumatoid Arthritis Osteoarthritis	Arthritis/Arthritis-Rheumatoid	27.2%	25.1%	20.9%	26.5%	33.8%
Anemia		17.2%				
Depression	Depression	13.7%	15.4%	23.1%	30.2%	20.1%
Acquired Hypothyroidism	Thyroid problems	12.7%	11.1%	21.6%	14.6%	1.1%
Glaucoma	Limited Vision	12.7%	9.0%	17.1%	10.7%	12.1%
Ischemic Heart Disease	Heart Problems/Congestive Heart Failure (CHF)	12.0%	15.4%	20.1%	30.6%	22.6%
Osteoporosis	Osteoporosis	11.0%	13.0%	17.1%	9.0%	16.7%

Table 2.11.Knowledge of condition

Quality of Care

Fewer SCFHP CMC Enrollees expressed satisfaction with their physicians working together than CMC enrollees across the state and then individuals who opted-out of the SCFHP CMC program.

Measure/Question	SCFHP Rate/Score	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Respondents satisfied with the way their providers work together	77%	83%	80%	SCAN (’15-’17)

Table 2.12. Quality of care

The HEDIS scores below are measures for which SCFHP is at less than or equal to the 10th percentile for CMC.

Measure/Question	Sub measure	SCFHP Rate/Score	2020 MPL	Data Source
BCS: Breast Cancer Screening		63.2%	73.3%	HEDIS 2019 YTD
COL: Colorectal Cancer Screening		51.3%	72.4%	HEDIS 2019 YTD
CDC: Comprehensive Diabetes Care	Eye Exam	60.0%	74.1%	HEDIS 2019 YTD
	HbA1c Testing	82.9%	94.4%	HEDIS 2019 YTD
	Medical Attention for Nephropathy	88.4%	96.2%	HEDIS 2019 YTD
OMW: Osteoporosis Management in Women Who Had a Fracture		29.4%	46.3%	HEDIS 2019 YTD
MRP: Medication Reconciliation Post-Discharge		3.4%	54.0%	HEDIS 2019 YTD
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack		81.8%	90.4%	HEDIS 2019 YTD
Pharmacotherapy Management of COPD Exacerbation		57.1%	71.4%	HEDIS 2019 YTD
Statin Therapy for Patients with Cardiovascular Disease	Statin Adherence 80% - Total	55.9%	76.5%	HEDIS 2019 YTD
Statin Therapy for Patients with Diabetes	Statin Adherence 80% - Total	41.0%	74.6%	HEDIS 2019 YTD

Table 2.12. HEDIS

Neighborhood and Built Environment

Access to Transportation

Despite transportation utilization and costs increasing rapidly for the plan, 16% of respondents to the SCAN survey reported issues with transportation that kept them from getting needed healthcare, while 29% of CMC respondents on a Risk Adjustment in Home Assessment report indicated that they need assistance with driving and/or arranging transportation.

Measure/Question	Rate	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Respondents with transportation problems that kept them from getting needed healthcare	16%	13%	18%	SCAN ('15-'17)
Members who need assistance with driving and/or arranging transportation	29.00% (N=1,400)			2019 Signify SDOH Report – 1/13/2020

Table 2.13. Access to Transportation

Housing

99% of SCFHP CMC enrollees have housing, however less than quarter population need help with instrumental activities of daily living.

Measure/Question	Rate/Score	Data Source
Members who need help with laundry and/or housekeeping	24.8% (N=1,400)	2019 Signify SDOH Report – 1/13/2020

Table 2.14. Housing

Quality of Air & Water

Air quality: According to Bay Area Air Quality Management District, there is no significant difference in air quality from 2018.[5]

Water quality: According to Santa Clara Valley Water District review there are no contaminants above maximum levels in 2019. [6]

3. Sub-population

This document looks at three sub-populations – members in Long Term Care (LTC), members with Severe Mental Illness (SMI), and members utilizing Long Term Support Services (LTSS).[*Appendix A* – Sub-Population Definitions 39% SCFHP CMC beneficiaries eligible for subpopulation. As these three groups are not mutually exclusive, a few combinations are also included. These combinations are made based on the one or more services utilized by subpopulation in measurement year (2019). Combinations such as members in LTC with SMI and who also utilized LTSS in measurement year; members in LTC with SMI who did not utilize LTSS; members in LTC who utilized LTSS but do not have SMI; members who have SMI and utilized LTSS.

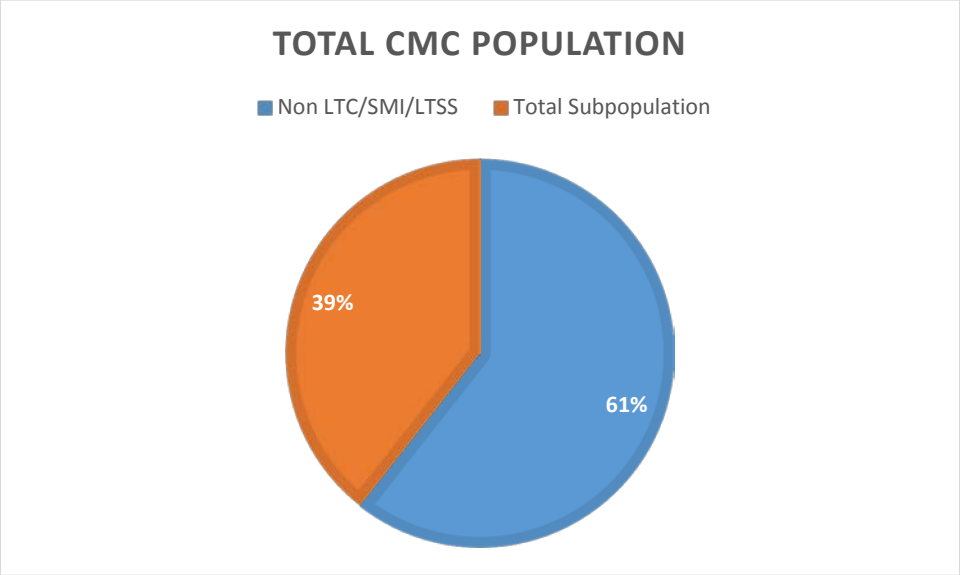


Chart 3.1. Total CMC population

Long Term Care

LTC is an institute who provides variety of services medical and non-medical needs of people with disabilities and/or chronic illness who cannot care for themselves for longer period. The goal of these services are to indorse independence, maximize quality of life and meet the need of patients. SCFHP CMC beneficiaries has a very small sub-population (3.14%) of members in LTC.

Serious Mental Illness

Approximately 1,400 (14.42%) CMC enrollees have a mental health diagnosis. SCFHP collaborates with the County Behavioral Health Services Department (CBHSD), which serves consumers ages 18 and above. The CBHSD Call Center screens individuals for functional impairments, such as homelessness, lack of support, and recent job loss, etc. and direct individuals based on diagnosis. Once the screening has been completed, CBHSD refers individuals who are identified as SMI to either a county mental health clinic or a community based organization (CBO) for services. These are considered specialty mental health providers and may include: psychiatry, therapy, and case management. Please refer to the CBHSD screening tools in Appendix B.

Those identified as mild to moderate are accommodated within a county clinic or are referred to SCFHP for placement within the health plans' network for services. SCFHP Behavioral Health Department's Social Workers assists with care coordination for all beneficiaries that are referred, including: shared

care plans, integrating care plan goals, assistance with transportation to medical appointments, coordinating medical care with primary and specialty care and behavioral health care to identify unmet needs, ensuring follow up care is received, etc. The health plan receives SMI referrals from CBHSD and SCFHP staff. Services are initiated within 15 days once a referral is received.

Long Term Support Services

A subset of the CMC population are beneficiaries living with multiple chronic conditions and limited functional capacity that makes it difficult for them to live independently without LTSS. These individuals require assistance with at least three activities of daily living, are in poor or fair health and may have cognitive impairments or behavioral health issues. They can either be living in the community or a long-term care nursing facility, and a population at high risk for falls and isolation due to their impairments. Nearly 2,819 (29.17%) enrollees utilized LTSS in the measurement year. The following LTSS programs are included for CMC beneficiaries:

- In Home Supportive Services (IHSS)
- Community-based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)

Of the sub-populations and amalgamations reviewed, the largest population was those who utilize LTSS services (regardless of whether or not they have SMI or utilized LTC). On the other side, Only 23 SCFHP CMC enrollees have SMI and also utilized LTC and LTSS in the measurement year. In this report sub-populations with less than 150 member count are excluded from further utilization assessment as there is not enough data to study the need in emergency room and inpatient utilization.

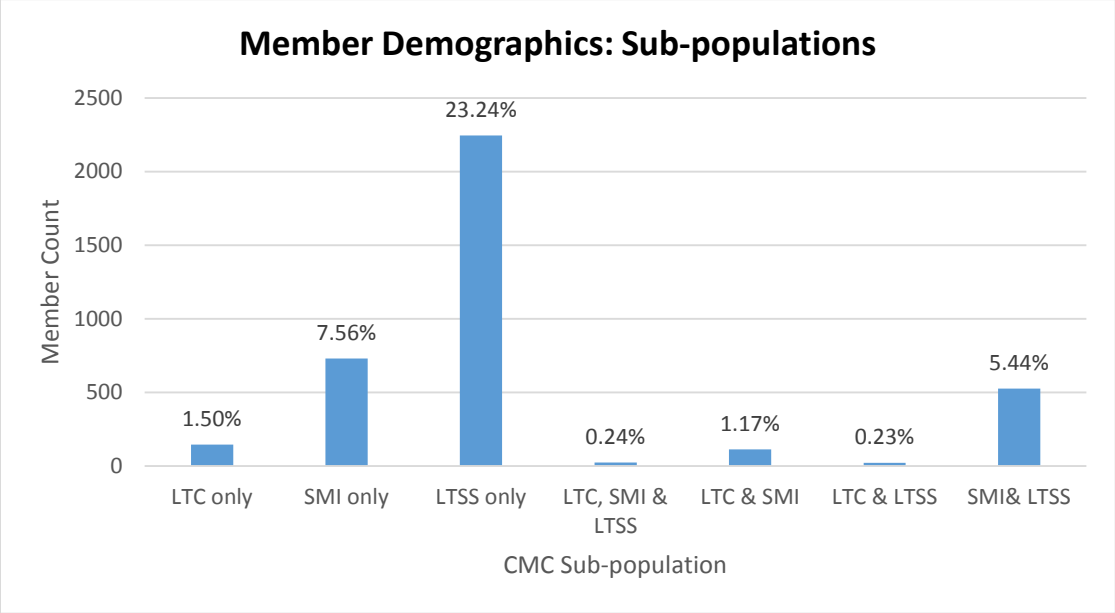


Chart 3.1. Member Demographics: Sub-Population

Utilization

The report below provides an overview of most common discharge diagnosis from emergency room(ER) visits and inpatient admissions for SCFHP CMC beneficiaries.

Inpatient Utilization

Reviewing the in-depth utilization below indicates that the most common diagnosis for inpatient hospitalization is sepsis among the LTC, LTSS and SMI sub-populations. Hypertensive heart disorder and acute kidney failure are the second most common discharge diagnosis among CMC enrollees with SMI and/or member utilizing LTSS. Inpatient discharge diagnosis 'schizoaffective disorder, bipolar type' is mainly noticed among the SMI population.

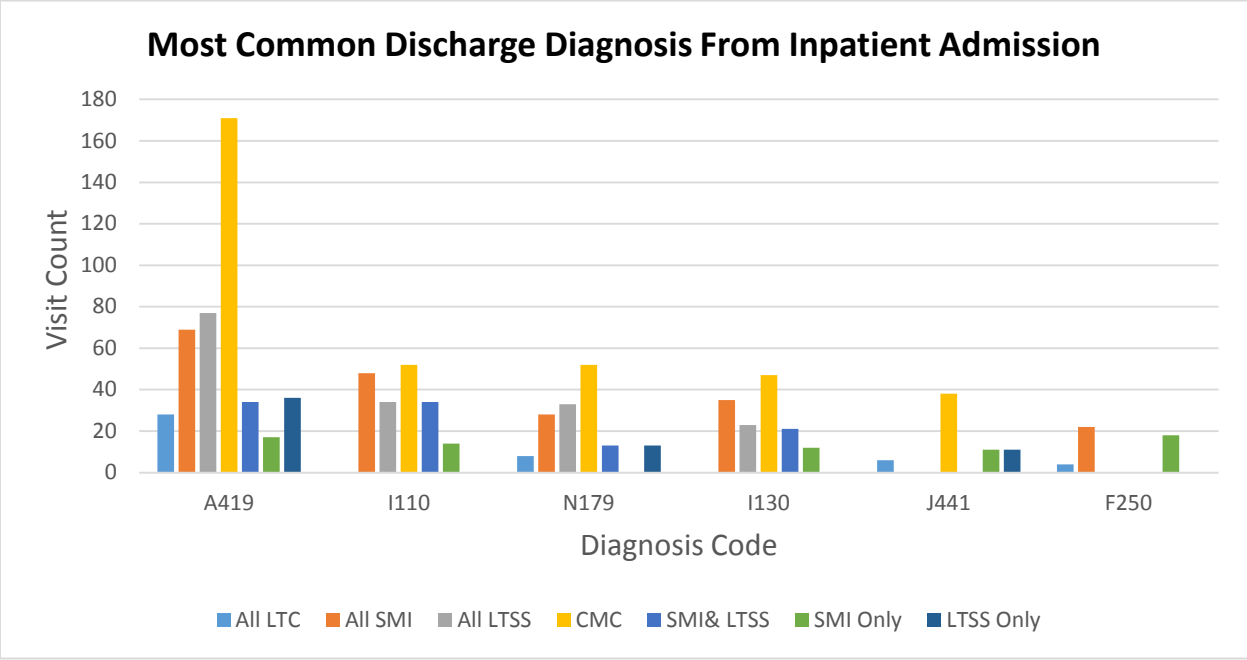


Table 3.1.1. Most common discharge diagnosis from inpatient admission

Diagnosis Code	Description
A419	SEPSIS, UNSP ORGISM
I110	HYPERTENSIVE HRT DIS W/HRT FAILURE
N179	ACUTE KIDNEY FAILURE, UNSP
I130	HYP HRT & CHR KIDNEY DIS W/HRT FAIL & STG 1-4/UNSP
J441	CHR OBSTRUCT PULM DIS W/(ACUTE) EXACERBATION
F250	SCHIZOAFFECTIVE DISORD, BIPOLAR TYPE

Table 3.1.2. Description of diagnosis code

Emergency Room Utilization

The most common discharge diagnosis from ER visits among LTC, SMI and LTSS sub-populations are chest pain, urinary tract infection and dizziness. Members utilizing LTSS have been to the ER more often than the LTC and SMI sub-populations. Merely 17 ER visits were identified among the LTC sub-population with the most common discharge diagnosis being 'abdominal pain' and 'schizoaffective disorder, bipolar type'.

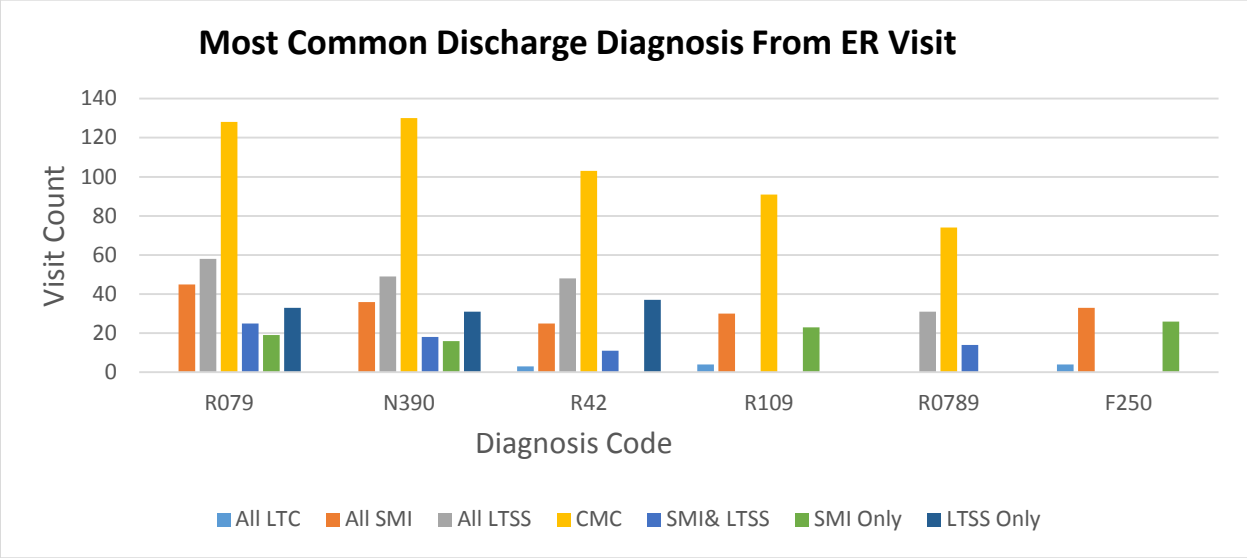


Table 3.1.2. Most common discharge diagnosis from ER visit

Diagnosis Code	Description
R079	CHEST PAIN, UNSP
N390	URINARY TRACT INFECT, SITE NOT SPEC
R42	DIZZINESS & GIDDINESS
R109	UNSP ABD PAIN
R0789	OTH CHEST PAIN
F250	SCHIZOAFFECTIVE DISORD, BIPOLAR TYPE

Table 3.1.3. Description of diagnosis code

4. CONCLUSION

The goal of this report is to identify the needs of SCFHP's CMC population and identify gaps. Key indicators were identified and analyzed focusing on sub-populations LTC, SMI and LTSS. Based on the assessment of the data, the following conclusions can be made:

- According to Health Risk Assessment (HRA), the LTSS and SMI sub-populations have higher rates of reporting that they run out of money to pay for their basic needs (food, rent, etc.). There is a need for interventions focusing on financial resources available to LTSS and SMI sub- populations.
- The lack of knowledge about health care services and coverage is most likely due to language barriers and access to care. The SCAN ('15-'17) data indicates that 22% of SCFHP CMC enrollees have higher rates around misunderstanding health care services and coverage than CMC enrollees throughout California (19%). 16% CMC enrollees faced language as barrier while receiving care despite the availability of free interpreter services for CMC enrollees. This suggests that future interventions should focus around language and health literacy. There is also a need for interventions with provider offices to improve their quality of service about offering interpreter service to CMC members.
- A large proportion of the CMC population speak Spanish (25.1%), Vietnamese (16.5%) and Chinese (13.0%). Request for Chinese interpretation were greater (28.0%) than request for Vietnamese interpretation (24.0%). This suggests lack of awareness about the benefit. Further analysis will need to be conducted in to the disparities in utilization of language service by ethnicity.
- Education, employment and income correlate strongly with an individual's health status. Interventions to improve these indicators intend to improve the overall health of our members.
- The Health Risk Assessment data (HRA) show that all sub-populations (LTSS, LTC and SMI) report issues arranging transportation to see their provider, family and/or friends. All sub-populations would benefit from additional knowledge about community resources for social support.
- The LTSS sub-population visit the ER most frequently and/or had an inpatient admission in with in past calendar year, compared to LTC sub-population however SCFHP had a small population of CMC enrollees who have utilized LTC. There is a need for interventions to identify the contributing factors for ER and inpatients visits for the LTSS sub-population.
- Members in LTC are most likely to be hospitalized for sepsis, but the primary reason for an emergency room visit for these members is actually a diagnosis of "Schizoaffective disorder, bipolar type". Therefore, ED visits among SMI and LTC members are more often due to Schizoaffective disorder. There is a need for further exploration to assess the behavior of SMI sub-population that may lead to infectious disease and eventually to sepsis.
- The SMI sub-population has more ER visit counts (33) than inpatient hospitalizations (22) for 'Schizoaffective disorder, bipolar type' in the measurement year. The SMI population is more likely to go to the ER for chest pain or urinary tract infection (UTI). The SMI population also has a high frequency of having a hypertensive heart disorder and/or sepsis at the time of discharge from the hospital. The data shows that there is an opportunity for intervention

to improve the follow-up care for SMI members who go to the ER for chest pain and/or UTI so they do not get readmitted later due to worsening of their condition.

- Based on HRA responses, CMC enrollees, in general, have a high rate of reporting that they never feel lonely. However, members utilizing LTSS reported that they felt lonely more than 15 days a month (8.2%) to most days (8.3%). In addition, 27.9% of LTSS members report that they live alone. There is a link between members who report feeling lonely and living alone. The data suggests that resources should be provided to this population to promote social connectedness/reduce loneliness.

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

Using this evidence, SCFHP will explore new ways to strengthen existing interventions and identify new strategies, activities and resources to address beneficiaries' needs.

Appendix

Appendix A – Sub-Population Definitions

Long Term Care (LTC)

Individuals with a MLTSS Risk Category similar to “Institute” were classified as LTC

Severe Mental Illness (SMI)

For this population, we utilized the SMI definition employed by the Health Homes Program (HHP).

Long Term Support & Services (LTSS)

Individuals with a MLTSS Risk Category of “CBAS and MSSP” or “IHSS” were classified as LTSS

Appendix B –Santa Clara County BHSD Screening Tool

Santa Clara County BHSD Screening Tool

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

Insurance Type_____ Medi-Cal Plan Name_____Provider Network_____

Preferred Language_____ Identified Culture_____

Address_____ City_____Zipcode_____ Phone(___)_____-_____

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

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

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

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

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

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

Referral Disposition_____

Symptom description/details_____

_____

_____

Brief summary of relevant history_____

_____

_____

Screener Signature_____

Screener Name_____ Screener title_____ Date_____/_____/_____

* Examples of stressors include, but are not limited to, homelessness, recent death in family, job loss, divorce, etc.

** This does not include drugs for medical use, or to treat a medical condition

Revised Jan 6, 2017

Appendix C – Data Sources

Health Risk Assessment (HRA)

This assessment is a self-reported questionnaire that is provided to low-risk CMC members within the first 90 calendar days, or 45 calendar days for high-risk members, of enrollment into SCFHP. It includes questions about the beneficiary's demographics, current health status, change in health status, and hospitalizations. It can also be used to identify SDOH, such as safety at home, family and community involvement (or lack thereof), and nutritional risk, among others. Some questions related to general information (name, birthdate, demographics etc.) and contact information have been removed from this survey for the purpose of this appendix, but a full-length version is available upon request from the SCFHP team.

Questions:

1. Marital Status (Single; Married; Divorced; Widowed; Separated)
2. Race/Ethnicity (African American; Asian; Caucasian; Hispanic; Native American or Alaska Native; Native Hawaiian or Pacific Islander; Other; Unknown)
3. Your preferred language – Speak (English; Spanish; Tagalog; Chinese; Russian; Vietnamese; Other)
4. Your preferred language – Read (English; Spanish; Tagalog; Chinese; Russian; Vietnamese; Other)
5. Do you want to choose someone to be your authorized representative with Santa Clara Family Health Plan?
6. How would you describe your general health? (Excellent; Very Good; Good; Fair; Poor)
7. Do you have or have you been treated for any of these conditions in the past 12 months (please check all that apply)? (Arthritis; Depression; Liver Disease; Asthma; Diabetes; Memory Problems; Cancer; Developmental Disability; Organ Transplant; Chronic Pain; Hearing Problem; Schizophrenia/Bi-polar; COPD; Infectious Disease; Seizures; Congestive Heart Failure; Kidney Disease; Stroke; Coronary Artery Disease; Limited Vision; Other)
8. How many different medications are you taking? (0; 1-5; 6-10; 11+)
9. In the last 6 months, did anyone from a doctor's office, pharmacy or your prescription drug plan contact you to make sure you filled or refilled a prescription? (Yes; No)
10. During the past four weeks, how much did pain interfere with your normal activities? (Not at all; A little bit; Moderately; Quite a bit; Extremely)
11. Are you currently receiving treatment for pain? (Yes; No)
12. Do you smoke or use tobacco? (Yes; No)
13. Would you like help quitting (Yes; No)
14. Do you feel you drink too much alcohol? (Yes; No)
15. Are you using any drugs or taking prescription medications in a way that's not prescribed? (Yes; No)
16. Do you need help taking your medicines? (Yes; No)
17. Do you need help filling out health forms? (Yes; No)
18. Do you need help answering questions during a doctor's visit? (Yes; No)
19. Are you using any of these supplies or equipment right now (please check all that apply)? (Walker; Wheelchair; Prosthetics; Portable toilet; Hospital bed/Hoyer lift;

Tube feeding supplies; diabetes supplies; incontinence supplies; ostomy supplies; nebulizer; suction supplies; wound care supplies; c-pap or bi-pap; ventilator; oxygen; blood pressure monitor; eyeglasses/contacts; hearing aids; other; none)

20. Do you need help with getting any supplies or equipment at this time?
21. Do you need help with any of these actions (check for each item)? (taking a bath or shower; eating; getting dressed; using the toilet; brushing teeth, brushing hair, shaving; walking; getting out of bed or a chair; going up stairs; making meals or cooking; doing house or yard work; washing dishes or clothes; shopping and getting food; getting a ride to the doctor or to see your friends; writing checks or keeping track of money; using the phone; keeping track of appointments; going out to visit family or friends; other)
22. Are you getting all the help you need with these actions? (Yes; No)
23. Can you live safely and move easily around in your home? (Yes; No)
24. If no, does the place where you live have (good lighting; good heating; good cooling; rails for any stairs or ramps; hot water; indoor toilet; a door to the outside that locks; stairs to get into your home or stairs inside your home; elevator; space to use a wheelchair; clear ways to exit your home)
25. Have you fallen in the last month? (Yes; No)
26. Are you afraid of falling? (Yes; No)
27. What type of residence do you live in? (Own your own residence; rented room; homeless; rent your residence; board and care; nursing facility; family member's residence; assisted living facility; other)
28. Who do you live with? (alone; spouse or significant other; family member; friend; other)
29. Are you getting any of these resources in your community? (transportation services; case manager; CBAS/adult day health center; county alcohol or drug outpatient program; county mental health case management services; food assistance programs; wellness organizations; help paying utility bills/rent; hospice/palliative care program; in-home supportive services; San Andreas Regional Center; Social Security; Veterans Affairs; other community resources)
30. Are you interested in getting information about resources in your community? (Yes; No)
31. Do you have family members or others willing and able to help you when you need it? (Yes; No)
32. Do you ever think your caregiver has a hard time giving you all the help you need? (Yes; No)
33. Do you sometimes run out of money to pay for food, rent, bills, or medicine? (Yes; No)
34. Over the past month (30 days), how many times have you felt lonely? (None – I never feel lonely; less than 5 days; more than half the days; most days – I always feel lonely)
35. Over the past month (30 days) how often have you felt tense, anxious or depressed? (Almost every day; sometimes; rarely; never)
36. Have you had any changes in thinking, remembering or making decisions? (Yes; No)
37. Are you afraid of anyone or is anyone hurting you? (Yes; No)
38. Is anyone using your money without your ok? (Yes; No)

39. Given all that was covered here, what would you say are your main concerns right now?
40. Would you like to create a care plan with goals that may help you address these concerns? (Yes; No)
41. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- A program started by the Agency for Healthcare Research and Quality (AHRQ) whose purpose is to understand the patient experience with health care
- CAHPS surveys are designed to assess patient experience in a specific health care setting

Health Outcomes Survey (HOS)

- The Medicare Health Outcomes Survey (HOS) is the first patient-reported outcomes measure used in Medicare managed care.
- The goal is to gather data that can be used in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health
- All managed care organizations with Medicare contracts must participate

Signify Health – In Home Assessment (IHA)

- Signify Health is a vendor hired to visit members at home and administer an initial health assessment
- Questions are shown below. Some questions are not listed below for length but the full questionnaire can be requested from SCFHP.
    1. Does the individual take any prescription medications? (Yes; No)
    2. In the past 6 months, has medication cost inhibited medication use? (Yes; No)
    3. Does individual understand the reason(s) for each medication they are taking? (Yes; No)
    4. In the past 6 months, has access to a pharmacy inhibited medication use? (Yes; No)
    5. Oxygen available or in use? (Yes; No)
    6. Are any of the following used regularly? (Multivitamin; calcium supplements; fish oil; antacid/PPI; ibuprofen; naproxen; aspirin, chronic use; aspirin, intermittent use; acetaminophen; antihistamine)
    7. Reason(s) for OTC or supplement use? (Pain; preventive; osteoarthritis; GERD; Other)
    8. Over the past 6 months, indicate the number of the following types of hospital visits: current ER or urgent care (from plan); ER or urgent care (update from individual); last hospitalization primary diagnosis; current hospitalizations (from plan); hospitalizations (update from individual)
    9. Compared to other people your age, how would you describe your health? (excellent; very good; good; fair; poor; refused; don't know/not sure)
    10. Compared to 1 year ago, how would you rate your physical health in general now? (Much better; slightly better; about the same; slightly worse; much worse)

11. Compared to 1 year ago, how would you rate your emotional health (such as feeling anxious, depressed, or irritable) in general now? (Much better; slightly better; about the same; slightly worse; much worse)
12. In the past 4 weeks, have you had too little energy to do the things you want to do? (Yes; No)
13. During the past 30 days, how many days did poor physical or mental health keep you from your usual activities, self-care, or recreation? (0-5; 6-10; 11-15; 16-20; 21-25; 26-30)
14. What is your current living situation? (Home, apt, condo; assisted living facility; senior/low income housing; long-term care facility; other)
15. Currently living alone? (Yes; No)
16. Are you a caregiver for someone else? (Yes; No)
17. Who else lives with you? (Spouse/domestic partner; child/children; long-term care setting; other family/friend; other)
18. Help needed to go out of the house? (Yes; No)
19. Because of financial concerns, does individual have to make choices between food, medication, heat, or other necessities? (Yes; No)
    a. Specify choices due to financial concerns (food; medications; electric/gas service; telephone; transportation; other)
20. Does individual have any special needs? (Yes; No)
21. Home safety could be improved to better support ADLs? (Yes; No)
22. Do you feel unsafe in your home? (Yes; No)
23. Does individual use Durable Medical Equipment (DME) on a regular basis? (Yes; No)
24. Is your caregiver providing adequate support for your needs? (Yes; No; N/A)
25. Difficulties with activities of daily living? (Yes; No)
26. Difficulties with instrumental activities of daily living? (Yes; No)
27. In the past 12 months, did you talk with a doctor or other health care provider about your level of exercise or physical activity? (Yes; No)
28. In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? (Yes; No)
29. Do you regularly experience any of the following (stress; loneliness/social isolation; anger; anxiety, of such intensity, that it interferes with daily activities; current or recent hallucinations)

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2020 Clinical and Preventive Guidelines Update

Agency	Guideline	Update	Change
American College of Chest Physicians	Antithrombotic Guidelines	N	
National Institute of Health	Asthma Clinical Guidelines	N	
American Diabetes Association	Diabetes Clinical Guidelines	Y	updated to 2019 guidelines - add CME training
American College of Cardiology/American Heart Association	Hyperlipidemia Guidelines	N	
Joint National Committee Treatment of Hypertension [JNC 8]	Hypertension Clinical Guidelines	N	
Institute for Clinical Systems Improvement	Adult Depression Clinical Guidelines	N	
American Academy of Pediatrics	Childred and Adolescents with ADHD Guidelines	N	
American Academy Of Child and Adolescent Psychiatry Guidelines	Children and Adoelscents with Depressive Disorder Clinical Guidelines	N	
American Association of Family Physicians	Adult (22-64) Preventive Guidelines	N	
CDC's Advisory Committeee of Immunization Practices	Adult (22-64) Preventive Guidelines	N	
US Preventive Screening Health Services Task Force	Adult (22-64) Preventive Guidelines "A" and "B" Recommendations	N	
American Association of Pediatrics	Child and Adolescents (0 months to 21 years) Preventive Guidelines	N	
Child Health and Disability Prevention (CHDP)	Health Assessment Guidelines	N	
American Association of Family Physicians	Child and Adolescents (0 months to 21 years) Preventive Guidelines	N	
CDC's Advisory Committeee of Immunization Practices	Child and Adolescents (0 months to 21 years) Preventive Guidelines	N	
US Preventive Screening Health Services Task Force	Child and Adolescents (0 months to 21 years) Preventive Guidelines	N	
American College of Obstetricians and Gynecology	Prenatal Preventive Guidelines	N	
Child Health and Disability Prevention (CHDP) - CPSP	Prenatal Preventive Guidelines	N	
CDC's Advisory Committeee of Immunization Practices	Seniors (65+ Years) Preventive Guidelines	N	
US Preventive Screening Health Services Task Force	Seniors (65+ Years) Preventive Guidelines	N	
US Preventive Screening Health Services Task Force	Treating Tobacco Use and Dependence Guidelines - A and B Recommendations	N	

SCFHP Americans with Disabilities Act Workplan

SCFHP maintains a robust Americans with Disabilities Act (ADA) Workplan. The plan is comprised of different metrics measuring patient safety, access, health education, grievance monitoring, and delivery of preventive care

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Workplan	ADA Workplan is reviewed and evaluated on an annual basis	Annual	February 2020		
Responsible Party	Identify responsible individual for ADA Compliance	Annual	February 2020	February 2020	Director of Quality and Pharmacy has oversight for ADA Compliance.
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: CBAS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: LTSS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: Nursing Home	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: IHSS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of *Potential* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Patient Safety	Number of *Potential* Quality of Care Issues identified at: IHSS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: LTSS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: Nursing Home	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: LTSS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: Nursing Home	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: IHSS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Access	PAR Site Identification: Plan refreshes claims history to identify new high volume specialists and ancillary providers for review	Annual	1/31/2020	1/31/2020	
Access	Physical Accessibility Review: Number of LTSS sites reviewed	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Access	Physical Accessibility Review: Number of CBAS sites reviewed	Quarterly (only required once every three years)			
Access	Number of referrals to: CBAS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Access	Number of referrals to: MSSP	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Access	Number of referrals to: Nursing Home	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Access	Number of referrals to: IHSS	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Access	Physical Accessibility Review: Number of High Volume Specialists	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Access	Physical Accessibility Review: Number of Ancillary sites reviewed	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Preventive Care	HEDIS: Care of Older Adults - Functional Status Assessment	Annual	6/30/2020		
Preventive Care	Medication Reconciliation Post-Discharge	Annual	6/30/2020		
Population Needs Assessment	Population Needs Assessment Report shared at: Consumer Advisory Committee Quality Improvement Committee	Annual	8/31/2020		

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Health Education	Plan monitors health education referrals for CMC members: Number of referrals from members who are also in CBAS, LTSS, IHSS or Nursing Homes	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Patient Safety	Plan monitors grievances for reasonable accommodations and access to services under ADA	Quarterly	3/31/2020 6/30/2020 9/30/2020 12/31/2020		
Workplan	Plan will identify issues within its system that require improvement to promote access and ADA compliance	Annual	12/31/2020		

Santa Clara Family Health Plan™

NCQA – Continuity and Coordination Between Medical Care and Behavioral Healthcare Analysis

Calendar Year 2018 Review

Overview

Overview of SCFHP's analysis of the continuity and coordination between medical and behavioral healthcare - National Committee for Quality Assurance (NCQA)

- Review of Factors:
  1. Exchange of information between behavioral and medical care
  2. Diagnosis, treatment and referral of behavioral disorders commonly seen in primary care
  3. Appropriate use of psychotropic medications
  4. Management of co-existing medical and behavioral disorders (Intervention completed)
  5. Prevention programs for behavioral health
  6. Special needs of members with severe and persistent mental illness (Intervention completed)

The analysis reviewed data for CY 2018 – this will serve as our baseline year for comparison.

Factor 1 – Exchange of Information

SCFHP collects data on the exchange of information between Behavioral Health Specialists and relevant medical delivery systems by conducting a medical record review.

- Reviewed medical records as requested through Santa Clara County Behavioral Health for CMC Members connected to county behavioral health services
- Review for timeliness: Did Behavioral Health Providers provide prescribed medication lists to Primary Care Physicians (PCPs) at minimum once per year, with updates provided within one month of a medication change?
- Goal: 80% of the total number of samples meet the timeliness standard.

Factor 1 – Exchange of Information

SCFHP collects data on the exchange of information between Behavioral Health Specialists and relevant medical delivery systems by conducting a medical record review.

- EMR for Members connected to VHC clinics for both PCP and BH services auto-passed as both providers have access to medication lists
- Barrier to complete data collection: SCCBH Department recently changed processes for data requests/information; the process was in progress through 2019.
- SCFHP did not receive the requested data in time & could not determine timeliness for 39 of our 60 Members (65%)
- We did not meet our goal at this time as Pass Rate = 35%. SCFHP to explore additional information requests through PCPs for next year review.
- We did not choose this Factor for implementation of an intervention at this time.

Factor 2 – Appropriate diagnosis, treatment, & referral of behavioral disorders commonly seen in primary care

The SCFHP looks at the results of the HEDIS measure Antidepressant Medication Management (AMM) to monitor that members with a behavioral health diagnosis of depression are being appropriately treated.

- Reviewed HEDIS AMM measure for CY 2018
- Goal: To maintain a rate in the HEDIS 75th percentile for both the Effective Acute Phase Treatment and Effective Continuation Phase Treatment measures.

CY 2018 RESULTS (Quantitative):
In CY 2018 our data shows:

- SCFHP scored in the 50th HEDIS percentile for the AMM Effective Acute Phase Rate. (132/187 = 70.6%)
- SCFHP scored in the 50th HEDIS percentile for the AMM Effective Continuation Phase. (110/187 = 58.8%)

Factor 2 – Appropriate diagnosis, treatment, & referral of behavioral disorders commonly seen in primary care

Rate Description	Mean	P10	P25	P50	P75	P90	Rate
AMM-Rate- Effect Acute Phase Treatment	70.02	60	64.63	70.2	75.26	79.94	70.59%
AMM-Rate- Effect Continuation Phase Treatment	55.22	43.89	49.1	54.63	60.94	67.87	58.82%
Eligible Population per 1000 MY	26.66	15.49	19.41	25.01	31.79	41.06	24.49

The suggested goal was to achieve 75th percentile for both rates. At this time, we did not meet either goal for the continuation phase nor for the acute phase.

For the Acute Phase, we were 5.08 percentage points behind the 75th percentile.
For the Continuation Phase, we were 6.31 percentage points behind the 75th percentile.

We did not meet our goal at this time. We did not choose this Factor for the implementation of an intervention at this time.

Factor 3 – Appropriate Use of Psychotropic Medications

The SCFHP collects data on Behavioral Health and Primary Care Practitioner adherence to prescribing guidelines concerning antidepressant medication prescriptions.

Two main avenues for obtaining antidepressant medications:

- Behavioral Health Provider/Psychiatrist prescription (typically as connected through the county mental health system)
- Access through Primary Care/Internal Medicine Doctor prescription.

There are a limited number of psychiatrists available to members throughout the county, many only available through SCCBH Department assignment.
Primary Care Practitioner (PCP) comfort in using their medical credentials to prescribe antidepressants is a consideration to be addressed.

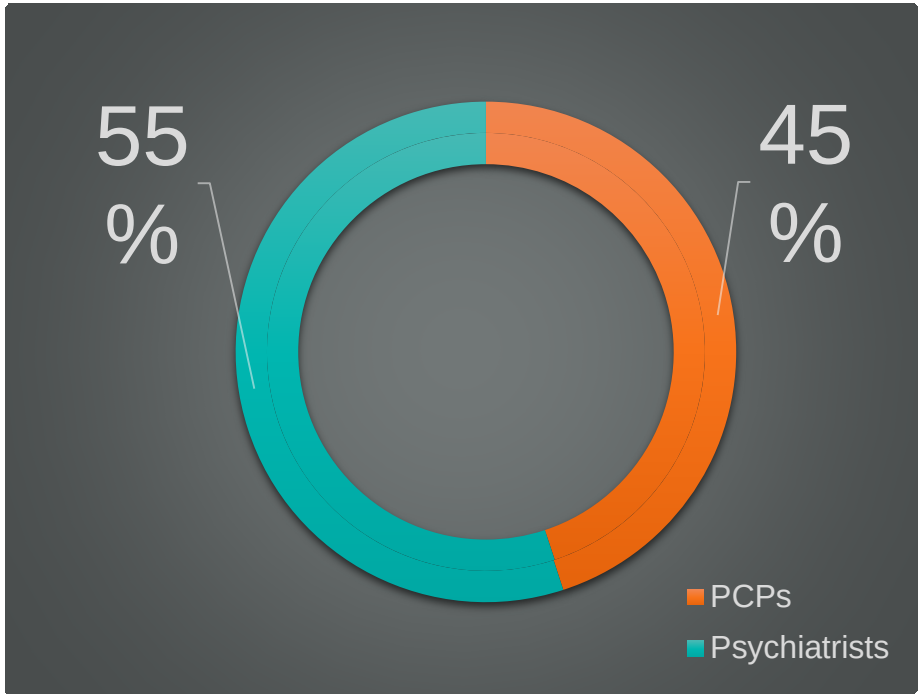
Goal:

To have 75% of antidepressant medication prescriptions through Primary Care Practitioners (PCP) and 25% of antidepressant medication prescriptions through Behavioral Health Providers/Psychiatrists in CY 2018.

Factor 3 – Appropriate Use of Psychotropic Medications

RESULTS:
Of the total number of antidepressant medications prescribed (N = 2596):

- 45% were prescribed by Primary Care Physicians
- 55% were prescribed by Psychiatrists



CY 2018 Data

Of the Total Number of individual prescriptions (N = 2596)

- 1430 were prescribed by psychiatrists
- 1166 were prescribed by PCPs (Internal Medicine, Family Practice, General Practice, Geriatric Medicine)
- Of the total, 262 were prescribed by other types of medical professional (e.g. Neurologists, Cardiologists, Urologists, etc).

For the purposes of analyses we will not include practitioners which do not fit into the PCP or Psychiatrist categories.

N = 1430 + 1166 = 2596.

PCPs prescribing antidepressants for M2M (Mild to Moderate) Members = 45%

(Total Number of PCP antidepressant prescriptions / total number of prescriptions for antidepressant medications = 1166 / 2596 = 45%)

Psychiatrists prescribing antidepressants for M2M (Mild to Moderate) Members = 55%

(Total Number of Psychiatrist antidepressant prescriptions / total number of prescriptions for antidepressant medications = 1430 / 2596 = 55%)

Factor 3 – Appropriate Use of Psychotropic Medications

We did not meet our goal (75% prescriptions for antidepressants through PCP and 25% through Psychiatrists). We chose not to implement an intervention for this factor at this time, but will modify our goal moving forward to:

Our suggested goal to pursue is:
To increase the ratio of Primary Care Practitioner (PCP) antidepressant medication prescriptions by 5 percentage points in CY 2019 compared to antidepressant medication prescribed by Behavioral Health Specialists/Psychiatrists.

Of the scripts written, there were *348 unique PCPs* identified and *98 unique BH Practitioners* identified.

It should be noted that access to medications through Psychiatrists is largely limited by county assignment and community organization availability; many psychiatrists through the County are connected to specific organizations, many of which serving Members with Severe Mental Illness as opposed to Mild to Moderate illnesses. Members going to see PCPs for medications may likely to be seen and receive a script more promptly.

Factor 4 – Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders

The SCFHP collects data on Members identified as having dual diagnoses of Schizophrenia as well as Diabetes Mellitus II (DM2).

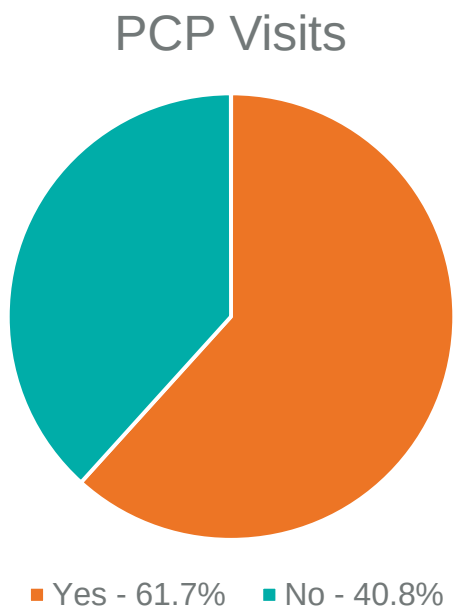
Goal:
Of our unique CMC members with diagnoses of Schizophrenia and Diabetes Mellitus II, 75% will have had at minimum one visit with their Primary Care Provider within the Calendar Year 2018.

Total number of Members with diagnoses of Schizophrenia and Diabetes Mellitus Type II were identified through claims data in Calendar Year 2018
(N = 94).

Of these Members, 58 were identified as having had a Primary Care Practitioner (PCP) annual visit (61.7%) and 36 were identified as not having has a Primary Care Practitioner (PCP) visit (38.3%)

The goal of 75% was not met by 13.3 percentage points.

The next slide reviews our intervention to address this factor.



Factor 4 – Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated
Members of this subpopulation may not prioritize health care/annual PCP visits. (Deficit of Knowledge)	Provide outreach and education to remind all Members of the importance of Health Care provider follow up appointments	3 outgoing calls to connect with Member and remind to: Schedule PCP Annual Wellness exam + Have A1c blood testing completed	N	n/a
Communication between PCP and Psychiatrists often limited due to consent forms and misunderstanding of HIPPA	Member education regarding benefits of permitting certain data to be shared across multiple providers	Article within SCFHP Newsletter stating importance and benefits of signing a release of information to allow sharing of medical record information between member providers	N	n/a
Many Members diagnosed with SMI meet with BH Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care	Information to Member and Providers to educate on need for DM2 follow up and potential medication influence on blood sugar (medical discussion)	Letter to BH and PCP Providers to Promote overall Health of Members – encourage Member to have follow up completed	Y	12/2019

- Workgroup to review Barriers and Discuss Interventions was conducted 10/2019

- An intervention to increase Provider awareness to support Members who are remiss in completing health care treatment recommendations was implemented December 2019; secure fax (using Right Fax) to each Member's Behavioral Health Provider as well as established PCP to promote outreach to Member for completing A1C testing for the monitoring of Diabetes Mellitus Type II.

The SCFHP benefit of case management and care coordination was mentioned as part of the A1C testing reminder memo, along with a phone number to CMC Customer Service to promote connection of Members with additional support.

Factor 5 – Secondary preventative behavioral healthcare program implementation (background/quick review)

The SCFHP collects data on Members identified as having a diagnosis of depression and/or depressive symptoms for the purpose of follow up regarding necessary interventions.

Data pulled from the Health Plans annual Health Risk Assessment (HRA) identified Members who have self-reported a diagnosis of depression and/or depressive symptoms as present within the previous CY 2018.

Rationale for Program:
In the US, Major Depression affects 6.7% of the Adult population, or more than 16 million people per year [1]. Within Santa Clara County, the average of those diagnosed with depression is 14% [2].

The program is based on data collected on PHQ-9 assessments completed CY 2018. The Health Plan identified the need for PHQ-9 (Patient Health Questionnaire) assessment completion and score based care considerations / follow up care monitoring.

[1] Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

[2] Source: Santa Clara County Public Health Department, 2013-14 Behavioral Risk Factor Survey (Use through 2016 - survey conducted every 3-4 years)

Factor 5 – Secondary preventative behavioral healthcare program implementation

Goal:
For 80-100% of CMC Members with a depression indicator found within the HRA to be provided with a PHQ-9 assessment to help identify/direct options for symptom management;

Need being addressed:
- Identify who is experiencing depressive symptoms via Health Risk Assessment responses,
- Use of a reliable, valid and empirically tested tool (PHQ-9) to identify severity of symptoms,
- PHQ-9 Score communication to PCP and BH Provider (if Member is connected)
- Triage resources and referrals to connect Member to supportive treatment, &
- Reassessment opportunity offered to Members (6 month follow up) to verify intervention effectiveness and potential modifications/opportunities for improvement.

Clinician completes PHQ-9 and reviews scoring.
Score of:
- 10-14 Mild/Moderate Depression (Recommend: PCP for antidepressant + therapy)
- 15-19 Moderate/Severe Depression (Recommend: PCP for antidepressant + therapy)
- 20-27 Severe Depression (Recommend: PCP for antidepressant + therapy + complete mini Suicide questionnaire)

Watch for any signs/symptoms which may indicate Severe Mental Illness as well as depression; likely referral needed for County to assess for SMH treatment (psychiatry and case management provided through county/community based organizations)

Factor 5 – Secondary preventative behavioral healthcare program implementation

Within Calendar Year 2018:
- 4376 Unique Members had identified symptoms and/or a diagnosis of Depression on their Health Risk Assessment.

Of the 4376 Members, 328 Members had been offered to complete a PHQ-9:
- 142 Members declined to complete the assessment (43%)
- 186 Members agreed to complete the assessment (57%)

PHQ-9 offer rate for the overall population = 7.5% (328/4376)
PHQ-9 completion rate for offered = 57% (186/328)

Our goal was to have 80-100% of the unique Member population to have completed a PHQ-9; the total number of outreach for surveys is low (7.5%) and for PHQ-9 completion does not quite meet our goal (57%).

Two areas of improvement identified include:
- Increased outreach and offering of PHQ-9 to Members (staff interventions/trainings – increase outreach)
- Increased education of completing PHQ-9 Questionnaire and treatment options (member interventions – increase)

We did not meet our goal at this time. We did not choose to complete an official intervention for this Factor this year (trainings ongoing).

Factor 6 – Special needs of members with severe and persistent mental illness

The Santa Clara Family Health Plan (SCFHP) collects data based originally on the parameters of the HEDIS measure Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC); to increase number of Members addressed, increased the Severe Mental Illness diagnoses in our data pull.

Initial data showed a low total population for this data pull (N = 4) which is very low, thus for this factor we have expanded the HEDIS measure to include other Severe Mental Illness (SMI) diagnoses, including:

- Schizophrenia
- Schizoaffective Disorders
- Bipolar Disorders
- Unspecified Psychosis

Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia: Assesses adults 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

After modifying the parameter, our population for this measure increased from 4 to 31 Members.

Factor 6 – Special needs of members with severe and persistent mental illness

Our suggested goal: to have 75% of Members completing follow-up treatment care with their providers.

RESULTS:

- Total Number of Members with SMI (as defined) and ICD-10 code indicating Cardiovascular Disease, N = 31.

- Of the 31 Members, 25.8% followed up for Cardiovascular care with their Provider in 2017.

The suggested goal was to achieve 75% follow-up treatment care as evidence by completion of LDL-C lab. The Santa Clara Family Health Plan did not meet this goal by 49.2 percentage points.

An intervention was completed to promote engagement in care considerations for this population.

Factor 6 – Special needs of members with severe and persistent mental illness

Barrier	Opportunity	Intervention	Selected for 2019?	Date Initiated
Many Members diagnosed with SMI meet with BH Providers more often than PCP or Specialists – lack of BH Provider awareness to necessary medical care	Letter to BH and PCP Providers to Promote overall Health of Members – encourage Member to have medical follow up completed	Fax letter to providers (BH & PCP) for medical follow up need (LDL-C lab order)	N	n/a
Lack of support – Member may have forgotten to follow up and complete necessary follow up for medical conditions	Notify Members of identified need (3 outbound calls to Members)	Notify Members of identified need (3 outbound calls to Members)	Y	10/2019

It was suggested within the BH Workgroup that many members with severe mental Illnesses may lack support for follow up treatment recommendations regarding their own medical care.

An intervention to increase Member support to complete LDL-C testing for Cardiovascular Health was implemented October 2019.

Three outbound calls were completed for the identified CMC Members to encourage them to connect with their PCP to complete LDL-C testing for Cardiovascular health monitoring and treatment recommendations. Assistance in completing this task was offered to Members who were reachable via telephone calls.

Santa Clara Family Health Plan™

Questions?

Contact Tiffany Franke, Behavioral Health Lead at tfranke@scfhp.com or Mansur Zahir, Process Improvement Project Manager at MZahir@scfhp.com

POLICY

Policy Title:	**Potential Quality of Care Issue (PQI)**	**Policy No.:**	QI.05
Replaces Policy Title (if applicable):	Potential Quality of Care Issues	**Replaces Policy No. (if applicable):**	QM002_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

IV. References

California Code and Regulations:

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

California Health and Safety Code section 1367.1

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 02/13/2019	Title 02/13/2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 5/10/2016	
V1	Reviewed	Quality Improvement	Approve 5/10/2017	
V1	Reviewed	Quality Improvement	Approve 6/6/2018	
V1	Reviewed	Quality Improvement	Approve 2/13/2019	
V2	Revised	Quality Improvement		

POLICY

Policy Title:	**Physical Access Compliance**	**Policy No.:**	QI.07
Replaces Policy Title (if applicable):	Physical Access Compliance Policy	**Replaces Policy No. (if applicable):**	QM107
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

To define the process Santa Clara Family Health Plan (SCFHP) follows to monitor ADA requirements are assessed and compliance is maintained at practice sites for Primary Care Practices, high volume specialists, Community-Based Adult Services (CBAS), and ancillary practices.

II. Policy

SCFHP conducts a physical accessibility review at every contracted Primary Care Physician (PCP) office, defined high volume specialist, CBAS, and ancillary practice site listed in the Plan's provider directory.

SCFHP drives corrective actions when needed, and monitor the results of the physical assessment review which are made available to SCFHP members following the Department of Healthcare Services (DHCS) requirements.

III. Responsibilities

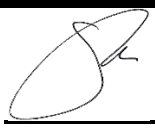
SCFHP Quality Improvement Department (QI) performs site reviews and reports to the Quality Improvement Committee (QIC). Complaints regarding related office accessibility issues are reported by QI to PR/Credentialing as appropriate. Customer Service/IT reports track/trend provider access complaints.

IV. References

1. Access to Medical Care for Individuals with Mobility Disabilities, July 2010, U.S. Department of Justice, Civil Rights Division, Disability Rights Section
2. DPL14-005 – Facility Site Reviews/Physical Accessibility Reviews
3. APL15-023 – Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
4. PL 12-006 - Revised Facility Site Review Tool
5. Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
6. 2009 California Building Standards Code with California Errata and Amendments
7. State of California, Department of General Services, Division of the State Architect. Updated April 27, 2010
8. DHCS/SCFHP Contract:
   Exhibit A, Attachment 4 - QUALITY IMPROVEMENT SYSTEM
9. Quality Improvement Committee
10. Quality Improvement Annual Report
11. Site Review
12. Exhibit A, Attachment 7 – PROVIDER RELATIONS
13. Provider Training
14. Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY

15. Access for Disabled Members

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 02/13/2019	Title 02/13/2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 11/9/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 02/13/2019	
V1	Review	Quality Improvement		

POLICY

Policy Title:	**Initial Health Assessments (IHA) and Staying Healthy Assessment (SHA)**	**Policy No.:**	QI.10
Replaces Policy Title (if applicable):	Quality Improvement	**Replaces Policy No. (if applicable):**	HE004 05
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

The purpose of this policy is to describe the required completion of the Initial Health Assessments (IHA) and the Staying Healthy Assessment (SHA) by contracted providers.

To define the process that Santa Clara Family Health Plan (SCFHP) will oversee the completion of IHAs and SHAs.

II. Policy

A. It is the policy of SCFHP to support the contracted network in the use and administration of the SHA to all Medi-Cal members as part of the IHA and to periodically re-administer the SHA according to contract requirements in a timely manner.

B. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) contractual requirements for an IHA and a SHA to be performed within 120 days of a member's enrollment in SCFHP and that the subsequent SHA is re-administered at appropriate age intervals.

III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 02/13/2019	Title 02/13/2019
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 08/10/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 02/13/2019	
V1	Review	Quality Improvement		

Santa Clara
Family Health Plan

Santa Clara County Health Authority

QUALITY IMPROVEMENT COMMITTEE CHARTER

Purpose

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

Members

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

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

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

Meetings

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

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

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

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

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

Responsibilities

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

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

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

- The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Compliance with regulatory agencies and accreditation standards
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Design, measure, assess, and improve the quality of the organization's governance, management, and support processes
- Monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers
- Provide oversight of quality monitors from the contracted facilities to continuous assess that the care and service provided satisfactorily meet quality goals

Santa Clara Family Health Plan™

YTD Quality Improvement Dashboard
February 2020

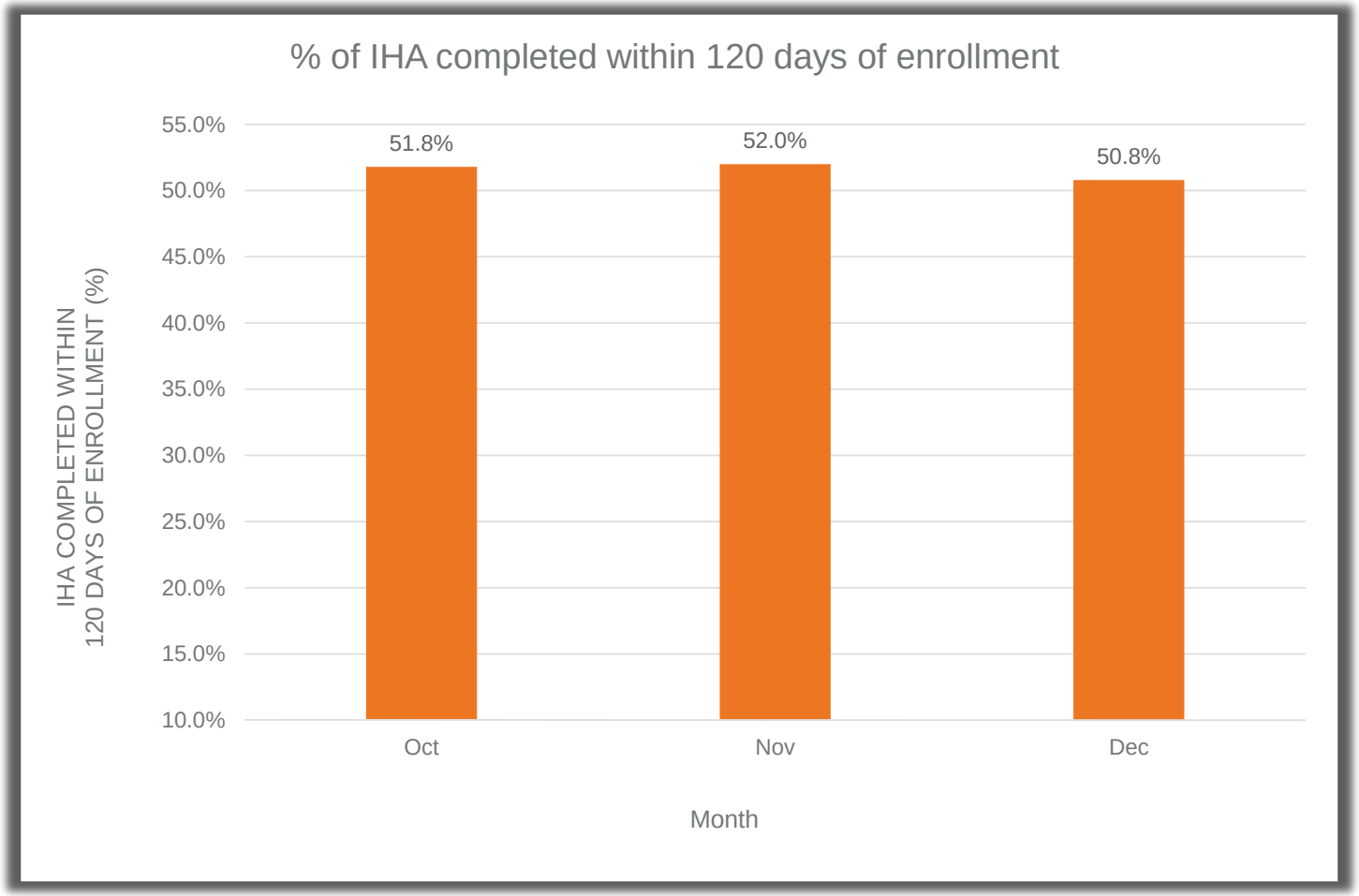
Initial Health Assessment (IHA)

Santa Clara Family Health Plan

What is an IHA?

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

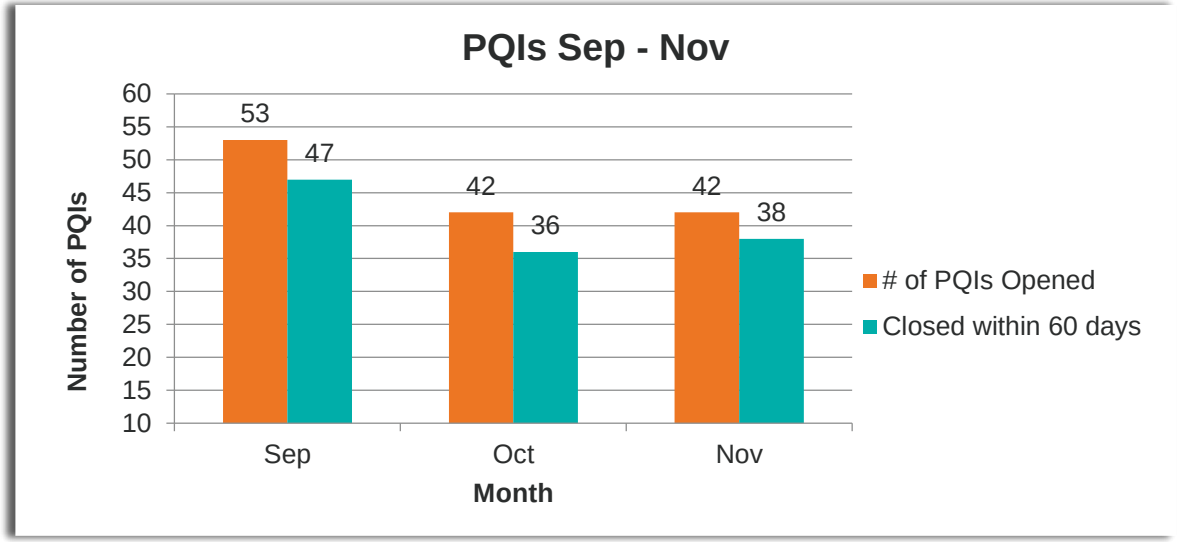
QI is currently developing a work plan to improve IHA completion rate



Potential Quality of Care Issues

Santa Clara Family Health Plan

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

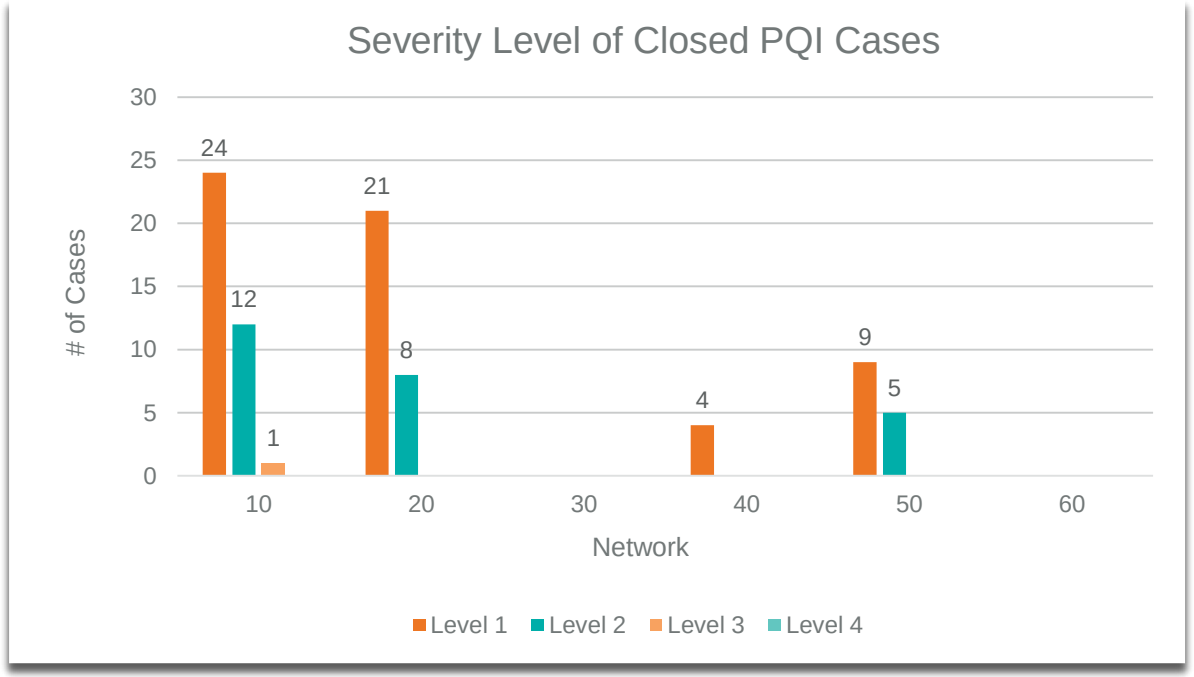


88%

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

90%

Percentage of Nov PQI cases closed on time



Health Homes Program (HHP)

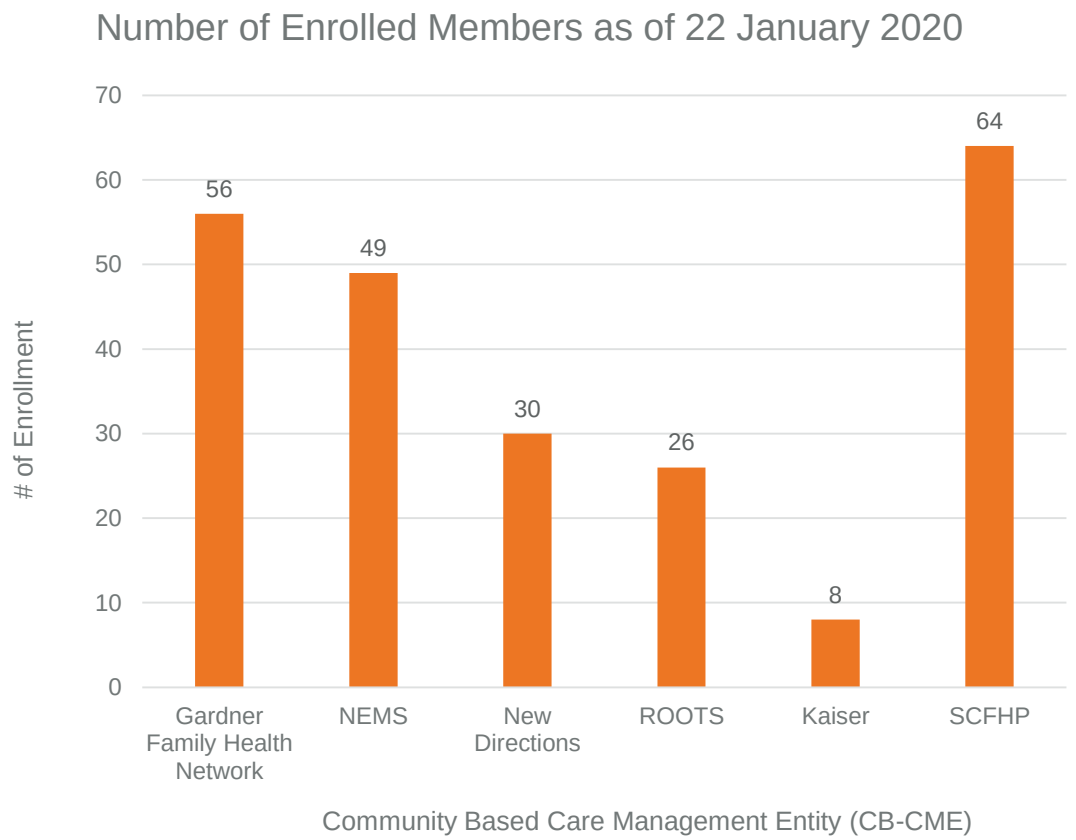
HHP launched July 1, 2019 with six Community Based Care Management Entities (CB-CMEs)

What is the Health Homes Program?

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

233

Members have verbally consented into Health Homes as of January 22, 2020

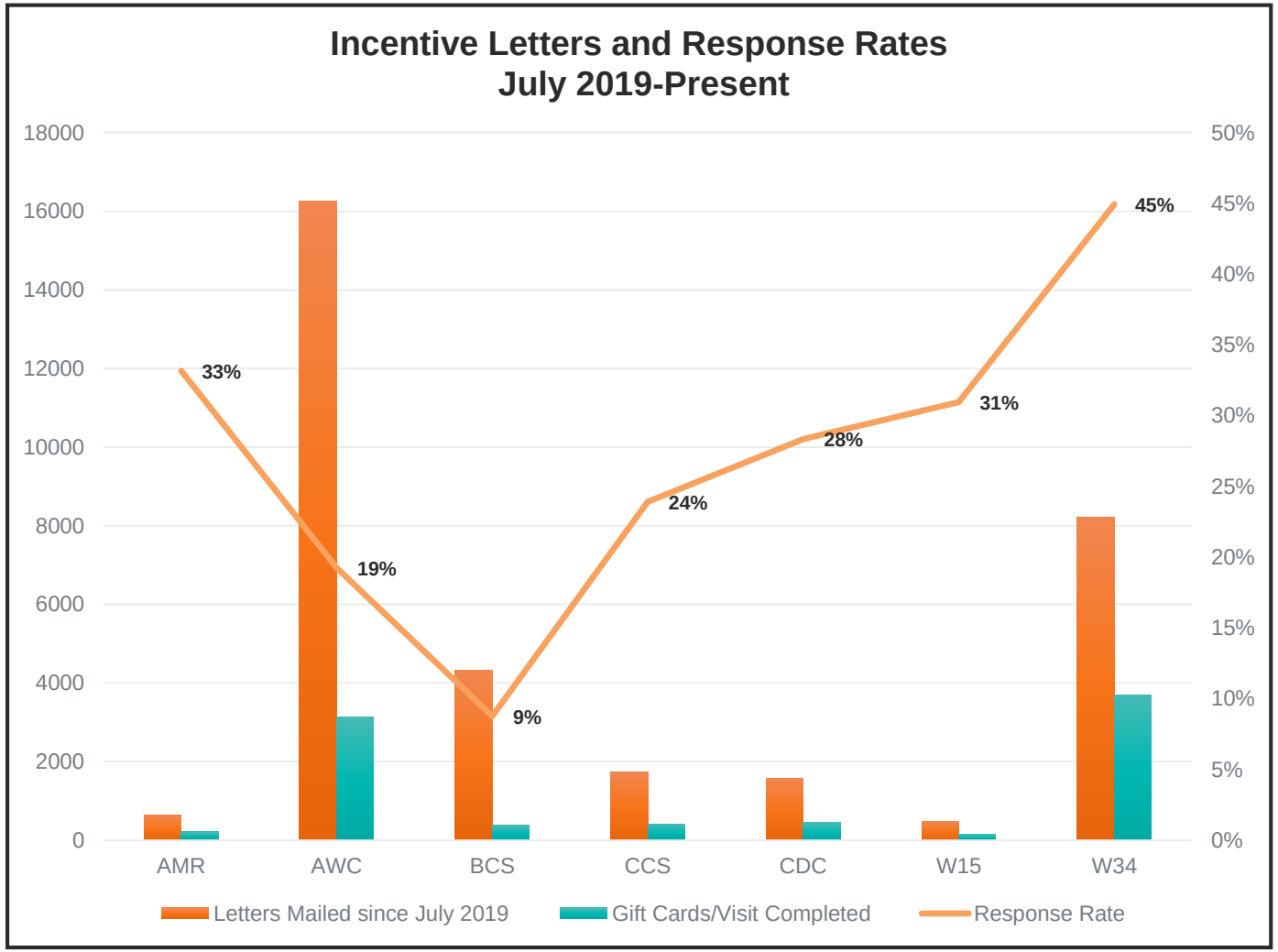


Member Incentives:
Wellness Rewards Mailing

What is the Wellness Rewards Mailing?

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

Total # of mailers sent since July '19	33,232
Total # of gift cards mailed (member completed visit)	8,424
Average Compliant Rate	27%



QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee 12/20/2019

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	54	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	NA	
Number practitioners recredentialed within 36-month timeline	NA	
% recredentialed timely	NA	NA
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 08/31/2019	281	

(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	1627	1559	793	810	408	139

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

Actions Taken

1. All current network practitioners were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. - # currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

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

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

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, October 16, 2019, 6:30 PM - 8:00 PM
Santa Clara Family Health Plan, Redwood Conference Room
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES

Members Present
Ali Alkoraishi, MD, Psychiatry Specialist
Dung Van Cai, MD, OB/GYN Specialist
Ngon Hoang Dinh, DO, Head & Neck Surgery
Jimmy Lin, MD, Internal Medicine, Chairperson
Habib Tobbagi, MD, PCP, Nephrology Specialist
Indira Vemuri, Pediatric Specialist

Staff Present
Lily Boris, MD, Medical Director
Angela Chen, Manager, Utilization Management
Dang Huynh, Director, Pharmacy
Natalie McKelvey, Manager, Behavioral Health
Amy O'Brien, Administrative Assistant
Luis Perez, Supervisor, Utilization Management
Divya Shah, Health Educator

Members Absent
Laurie Nakahira, DO, Chief Medical Officer

Staff Absent
Christine Tomcala, CEO

1. Introduction

Dr. Jimmy Lin, Chair, called the meeting to order at 6:33 pm. Roll call was taken and a quorum was established. Absent this evening were Laurie Nakahira, DO, Chief Medical Officer and Christine Tomcala, CEO.

Dr. Boris introduced Angela Chen, Manager of Utilization Management as a new member of the Committee. Dr. Boris also introduced Divya Shah, Health Educator, and Dang Huynh, Director of Pharmacy as guest speakers for this evening.

2. Review and Approval Meeting Minutes

The Minutes of the July 17, 2019 Utilization Management Committee meeting were reviewed.

It was **moved, seconded, and** the Minutes of the July 17, 2019 Utilization Management Committee meeting were **unanimously approved.**

3. Public Comment

There were no public comments.

4. CEO Update

There was no CEO update, as Ms. Tomcala was absent this evening.

5. CMO Update

Dr. Boris gave the following CMO update on behalf of Dr. Nakahira:

a. General Update

Dr. Boris advised SCFHP has been in active participation with California Home Medical Equipment (CHME), and their contract with SCFHP will be terminated, effective December 31, 2019. SCFHP has been transitioning their services. A list of vendors will be uploaded to the website. Dr. Boris advised if there are specific Members that are of concern while the Plan transitions through this process, SCFHP will ensure our UM team reaches out to them. SCFHP has identified all the Members in need of vent and oxygen supplies, and enteral supplies, and most of those Members have already been transitioned to other vendors. Dr. Boris stated the biggest item will probably be in regards to DME repairs.

Dr. Vemuri expressed concerns specific to conflicting information between Shield and CHME. Dr. Boris confirmed SCFHP is using Shield at the present time, and, in an effort to make it seamless for Providers and patients, SCFHP has been transitioning members to Shield. Dr. Boris requested Dr. Vemuri forward her any cases where conflicts in services have occurred, and she is happy to follow-up on those cases.

As of October 1, 2019, Healthy Kids transitioned to Medi-Cal. At present, there are only 2 remaining Members in the Healthy Kids program. For those 2 Members, SCFHP is continuing coverage through the end of December 2019.

b. Update – Completion of CMS IVA Audit

SCFHP finished their audits with their regulators. One report is pending. The CMS IVA audit report came back with some corrective action plans (CAPs).

Dr. Boris opened the floor to questions. Dr. Alkaroishi asked for clarification on which agency is absorbing the Healthy Kids program. Dr. Boris reiterated that the Healthy Kids program is transitioning to Medi-Cal. Dr. Lin requested clarification on the demographics of the Healthy Kids population. Dr. Boris stated she does not have the appropriate data available on the demographics particular to this program.

Dr. Ngon Hoang Dinh and Dr. Ali Alkoraishi arrived at 6:50 p.m.

6. Old Business/Follow-Up Items

Presented by Dr. Boris.

b. Post Bariatric Surgery Update

Per the Committee's request, SCFHP looked at all the Members who had bariatric surgery during the period of 1/1/2017 – 8/1/2019. Medi-Cal had the highest number of Members who received bariatric surgery for a total of 126 Members. By network, Net 20, which is Valley Health Plan, had the most Members who received bariatric surgery, and Net 40, Palo Alto Medical Foundation, had the fewest. There were no bariatric surgeries for Net 6, which is Premier Care. In the Cal Medi-Connect program, only 6 Members received bariatric surgery, for a total number of 132 Members who received a bariatric surgery procedure.

The average age of the recipients is age 42. Of these 87% of the recipients were female, and 13% of the recipients were male. Dr. Boris also conducted a small sampling of pre-op and post-op BMIs. In the pre-op category, the highest BMI was 55, and the lowest BMI was 42. In the post-op category, the lowest BMI was 34, and the highest BMI was 55. It appears the most rapid weight loss occurred early on in the weight loss process.

c. Bariatric CME Request

A Bariatric CME request has been forwarded to the Provider Network Management Team.

d. MCG S-516: Gastric Restrictive Procedures, Sleeve Gastrectomy, by Laparoscopy

The MCG is provided to the committee. Dr. Boris included the most common procedure which is a restrictive laparoscopic sleeve gastrectomy, along with the MCG criteria.

e. How to Access Health Education Handout

Dr. Boris introduced Divya Shah to talk about health education. Ms. Shah summarized how members can enroll in our health education programs, and she provided an overview of the different health-related topics available to Members. Members can self-refer to all programs. They can enroll either via the Customer Service line; via an email to the Health Education department; through the online Member portal; and/or their physician(s) can refer them to health education programs.

f. Health Education Materials and Classes for Members

Ms. Shah summarized some of the classes and workshops available; such as, classes for chronic disease management; counseling for stress and anger management services; fitness membership programs; nutrition and weight management, which includes Weight Watchers; parenting education; prenatal education; our car seat safety program; and smoking cessation classes. For the Weight Watchers program, SCFHP asks Members to complete a trial period, and we provide them with 3 vouchers to try out 3 different sessions of the program. Members are asked for their weight loss tracking sheets to confirm their attendance. Additional vouchers are then sent to cover the next 10 weeks' worth of meetings. Dr. Vemuri inquired as to whether or not Providers can refer their patients to this program. Ms. Shah confirmed Providers just need to complete the 'Health Education Referral' form, available on our website under the Provider section. Once SCFHP receives the form, we follow-up with the Member.

g. Language Assistance Contact Information

Ms. Shah summarized SCFHP's draft of our 'Interpreting Services Reference Guide' which was compiled specifically for our Providers. Once this guide has been finalized, the information will be posted on the SCFHP website as part of our cultural competency toolkit. This information will also be fax blasted to all Providers. Ms. Shah then summarized how to use and access the California Relay services (CA/TTY). Ms. Shah also gave an overview on how to schedule an in-person interpreter. Dr. Lin inquired as to how many Providers use these services. Dr. Boris advised there are a significant number of Providers who request and use the in-person interpreting services. The usage of this particular service is across the board for all facilities; it is not specific to only one facility. Members can also request these services. Dr. Boris advised that if any of our Providers experience an issue with the telephone interpreting services, please send an email to 'quality@scfhp.com', and we will contact our vendor to request they provide their interpreters with additional training. This concluded Ms. Shah's health education presentation.

Divya Shah exited the meeting at 7:00 p.m.

7. Action items

Presented by Dr. Boris.

a. Policy Update: HS.01 Prior Authorization

Dr. Boris advised SCFHP was requested to update policy HS.01 Prior Authorization. Dr. Boris explained that SCFHP added some additional managed-care language which states that SCFHP will arrange for all medically necessary Medi-Cal and Medicare covered services, and to ensure these services are provided in an amount no less than what is offered to Members under fee-for-service. We also added verbiage that the Plan will establish procedures for authorization requirements respective to medically necessary enteral nutrition products or formulas.

b. Medical Covered Services Prior Authorization (PA) Grid and Medical Benefit PA Grid

Dr. Boris presented the 2020 'Medical Covered Services Prior Authorization Grid.' The Plan added some clarifying verbiage respective to hearing aids repairs, as well as requests over the benefit limit. In addition, reference to IMRT was removed, as it has now become the standard of care for most cancer treatments.

Dr. Boris then introduced Dang Huynh to discuss the 2020 'Medical Benefit Drug Prior Authorization Grid'. Dr. Huynh explained one of the main changes to this grid includes the change from 'MCG: MCG Health Care Guidelines', to 'PA: Prior Authorization'. The Plan still utilizes MCG; however, it is clearer to state 'Prior Authorization', as, when MCG is not available, there is a hierarchy of coverage determination criteria. Otherwise, items in yellow denote new verbiage or terms, and items in red denote deletions. Drugs that are not currently included on this grid, but recommended to add were Zolgensma for spinal muscular atrophy, and Xembify, an IVIG. This concludes Dr. Huynh's presentation.

Dr. Lin initiated a discussion regarding the cost of immunotherapy and asked how the State accounted for the costs of some of these drugs. Dr. Boris advised that if a child has a CCS-eligible condition, that cost is carved out to CCS, and the Plan does not see the cost. Dr. Boris reminded them that the medications on our 2020 grid are specific to medications submitted for prior authorization to the UM department, and not through pharmacy outpatient benefit.

A motion was called to approve the revised Policy HS.01 Prior Authorization, and the 'Medical Covered Services Prior Authorization Grid' along with the 'Medical Benefit Prior Authorization Grid'. **It was moved, seconded, and** the revised Policy HS.01 Prior Authorization, the Medical Covered Services Prior Authorization Grid, and the Medical Benefit Prior Authorization Grid were all **unanimously approved.**

8. Reports

Presented by Dr. Boris on behalf of Dr. Nakahira.

a. Membership Reports

Dr. Boris advised the Membership report covers April 2019 through September 2019. At that time, the Plan had 3,512 Healthy Kids Members; 234,478 Medi-Cal Members; and 8,194 Cal Medi-Connect Members. Our total membership as of September 2019 was 246,184 Members. As of October 1, 2019 there will only be 2 Healthy Kids Members, as the remainder will transition to Medi-Cal.

b. Standard Utilization Metrics

Dr. Boris next briefly summarized the Standard Utilization Metrics. Dr. Boris explained the Plan was unable to produce an inpatient readmission report, as the Medi-Cal formula utilized a tool called All Cause Readmissions, which is a different formula used to determine readmissions. Medi-Cal now uses Plan All-Cause Readmissions, and we are going through our data to align with Medi-Cal. We hope to have the report for the next UMC meeting in January. The plan will have the final HEDIS for the end of the year presented at the next UMC meeting in January.

c. Hospital Specific Metrics: Readmission

Dr. Boris next summarized the Hospital Specific Metrics. The Plan looked at Plan All-Cause Readmissions for Medi-Cal by network, by hospital from 1/1/2018-4/29/2019. Total numerator and denominator and percentage of readmissions were used to calculate the data. Zero represents people with MediCare primary and Medi-Cal secondary. 10 is what SCFHP maintains, which is about 19%; 20 represents Valley Health Plan at 18%; Kaiser is relatively low by comparison. Network 50 is PMG and Network 60 is Premier Care. The largest volume of admissions and readmissions was at Valley Health Plan; however, they also have the largest population.

For Medi-Cal and Medi-Care the hospital with the highest rate of readmissions is Santa Clara Valley Medical Center; Regional Medical Center has the second highest rate of readmissions. The numbers do differ from Medi-Cal versus Cal Medi-Connect. On the lower end of the readmissions spectrum is O'Connor Hospital.

By diagnoses, the number 1 diagnosis that leads to the highest number of Plan All-Cause Readmissions is Sepsis. The diseases with next highest number of Plan All-Cause Readmissions are Hypertensive Heart Disease with heart failure; Chronic Kidney Disease; Sepsis specific to E-coli; and a smaller number of Acute Respiratory Failure with Hypoxia cases.

The Plan also looked at Cal Medi-Connect, which is managed by the Plan. Their total Plan All-Cause Readmission rate is about 14% for that time period. There are a large number of Cal Medi-Connect patients who receive their services at Santa Clara Valley Medical Center. Santa Clara Valley Medical Center is the top re-admitter, with El Camino Hospital and Regional Medical Center second, and the Los Gatos campus of El Camino Hospital with the lowest rate of Cal Medi-Connect readmissions. By diagnoses, the number 1 diagnosis is Sepsis, with Hypertensive Heart Disease with heart failure second, and Alcoholic Cirrhosis third. Otherwise, the next most common diagnoses are the more age-related diseases such as COPD, Chronic Kidney Disease, and Diabetes Types I and II.

Part of the reason this analysis was done is to ensure our programs are focused on the patients on whom the Plan should direct their focus and provide support. Dr. Lin inquired about the Plan's case management program. Dr. Boris advised we provide case management via the telephone and in person. This includes behavioral health case managers; social workers; medical case managers; and non-clinical case coordinators. The majority of case management is conducted via telephone. Dr. Lin asked for the number of nurse case managers we have on staff. Ms. Chen advised we currently have 4 nurse Case Managers, and a couple of nurses with a home health background. Ms. McKelvey stated we currently have 4 Licensed Clinical Social Workers and 2 Personal Care Coordinators. Dr. Boris confirmed for Dr. Lin we manage groups 10 and group 40, and all of Cal Medi-Connect. Dr. Alkoraishi inquired as to how the admissions or profiles may have changed since our acquisitions of O'Connor Hospital and St. Louise Regional Hospital. Dr. Boris advised that since our purchases of these hospitals back in March of 2019 there has not been sufficient claims rollout to specifically target the timeframes. The Plan did include the claims data in their initial analysis; however, since the life of the claims has not completely run out, the numbers were too small upon which to draw conclusions. The Plan will continue to monitor.

d. Referral Tracking Quarterly Report – Q3 2019

Dr. Boris next discussed the 'Referral Tracking Report. The Plan does an annual rollup, with quarterly numbers. The report is specific to the number of authorizations and whether or not the Claim was paid. The Plan continues to stand at 50.4% because the claims run out. At the end of the year, the UM department will reach out to approximately 50 members to learn why they did not receive services.

e. Turn Around Time Report – Q3 2019

Next, Dr. Boris discussed the 'Turn-Around Time Report', which goes through August 2019. Dr. Boris advised the Plan did very well on the current CMS audit in terms of timeliness of authorizations. The timeliness of decisions was reviewed with the committee for the urgent, concurrent, retro, and standard authorizations.

f. UM Call Center Metrics – Q2 & Q3 2019

Dr. Boris next reported the UM Call Center metrics. The UM department, on average, takes approximately 2,000 inbound Medi-Cal calls per month. Their abandonment rate is consistently less than 5%. Their average hold time is very low at 30 seconds. For the most part, the UM department has met the standards, with the exception of Q2 and Q3. The UM department also takes approximately 1,000 Cal MediConnect calls, for a total of approximately 3,000 calls per month. Dr. Lin asked how many people in the UM department actually take calls. Dr. Boris and Mr. Perez advised there are 4 people in the UM department who take calls. Dr. Boris advised the UM department met the Provider service levels for Q1-Q4. 80% to 90% of the calls were answered, and the average abandonment rate is 1.7% to 3.9%. The UM department is definitely meeting their call stats.

g. HS.04.01 Quality Monitoring – Q3 2019

Dr. Boris next presented the standard quarterly report on Quality Monitoring, wherein the Plan reviews 30 total denial letters per quarter, and examines all the elements that the Plan is audited on. Half of the letters the Plan reviews are Medi-Cal, and the other half are Cal Medi-Connect, and 100% were denials. The Plan also looks at expedited, as well as standard, requests. They all met turnaround times. The only exception was the standard wherein 3 out of the 4 expedited Cal Medi-Connect authorizations required a phone call from the UM department to the Member, and only 1 Member received a phone call. Otherwise, all the standards were met. On September 8, 2019, the Plan did an update to the QNXT system, and the final quality check should be completed by October 31, 2019.

h. Inter-Rater Reliability (IRR) Report – 2019 2/2

Dr. Boris summarized the Inter-Rater Reliability findings for the UM department Dr. Boris advised all of the staff were tested. Care Coordinator and Nursing remediation was done concurrently; staff reviewed all of the case studies and remediation actions together, which was helpful for all staff involved. This concluded Dr. Boris's presentations for the evening.

9. Behavioral Health UM Reports

a. Early and Periodic Screening, Diagnostic & Treatment (EPSDT)

Ms. McKelvey presented the new APL on the EPSDT benefit for those under 21. For the most part there are no changes; however, there is no longer any capitation to services. Rather, services that are a part of EPSDT will be based on the individual child and what that child needs. The focus is really on prevention and 'Bright Futures'. Screening is a major priority, and the agency has a metric

for screening. Otherwise, any other changes were primarily to the grammar and style of the APL. There are not enough significant changes to warrant any policy changes as far as the Plan is concerned. A discussion ensued between Dr. Vemuri and Ms. McKelvey in regards to the Plan's procedures when a Provider makes a referral for therapy. Dr. Vemuri stated she has one child who was denied twice. It was determined that Dr. Vemuri actually received a "Void" notice which indicates that there was incomplete information. Dr. Boris advised Dr. Vemuri to forward them the information, which they will review in order to provide her with a response.

b. Metrics Reports

Ms. McKelvey went on to discuss the Behavioral Health Q3 metrics for Medi-Cal. Her YTD data shows that there are 175 Members receiving Behavioral Health treatment, with 197 Members receiving Behavioral Health treatment for Q3 2019. Unfortunately, the County has not released any data to the Plan on who receives mental health benefits. The last time the County released this data to the Plan was March 2019. Our mild-to-moderate referrals have slowed down. The number for those receiving Case Management does seem incorrect at 20 Members for Q3 2019. Dr. Lin asked if those in the mild-to-moderate category are taken care of by their primary care physicians. Ms. McKelvey and Dr. Boris agreed, although the low number might be attributed to the Plan being in the process of coordinating therapy referrals for Psychiatry, individual therapy, family therapy, etc. so the number might yet be correct. Dr. Lin also asked how Kaiser fits in to the picture. Kaiser is fully delegated for their behavioral health. Ms. McKelvey advised the Plan has a new MOU with substance abuse which will be presented at an upcoming meeting once she has more information. For Cal Medi-Connect, again, the County has not provided the Plan with any current data on how many Members are receiving behavioral health benefits. There are approximately 40 Cal Medi-Connect Members receiving intensive Case Management. In addition, there were 7 opt-outs in Q3 2019, and they have not received any recent mild-to-moderate referrals from the Call Center. This concluded Ms. McKelvey's presentation.

10. Adjournment

The meeting adjourned at 7:30 p.m.

The next UMC meeting is scheduled for Wednesday, January 15, 2020 at 6:30 p.m.

Minutes prepared by:
Amy O'Brien, Administrative Assistant

Jimmy Lin, MD, Utilization Management Committee Chairperson

1/15/2019
Date