Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

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

Via Teleconference
(669) 900-6833
Meeting ID: 373 443 211
Password: 04082020

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 February 12, 2020 Quality Improvement Committee meeting **Possible Action:** Approve minutes of the February 12, 2020 Quality Improvement Committee meeting	Dr. Paul	6:10	5 min
4.	**CEO Update** Discuss status of current topics and initiatives	Ms. Tomcala	6:15	10 min
5.	**Follow-Up/Old Business**			
	a. CalAIM Overview	Dr. Nakahira	6:25	5 min
	b. Out of Network Requests for Ambulatory Surgical Centers (ASC)	Ms. Switzer	6:30	5 min
	c. Grievance and Appeals Report Q3	Mr. Breakbill	6:35	5 min
	d. Compliance Report Q1	Ms. Yamashita	6:40	5 min
6.	**Review of Quality Improvement (QI) Program Evaluation 2019** Annual review of the QI Program Evaluation 2019 **Possible Action:** Approve the QI Program Evaluation 2019	Ms. Chang	6:45	10 min
7.	**Review of QI Work Plan 2020** Annual review of the QI Work Plan 2020 **Possible Action:** Approve the QI Work Plan 2020	Ms. Chang	6:55	10 min

8.	**Assessment of Member Cultural and Linguistic Needs and Preferences** Review the Assessment of Member Cultural and Linguistic Needs and Preferences **Possible Action:** Approve the Assessment of Member Cultural and Linguistic Needs and Preferences	Ms. Switzer	7:05	10 min
9.	**Annual Review of QI Policies** **a.** QI.03 Distribution of QI Information **b.** QI.04 Peer Review Process **c.** QI.06 QI Study Design/Performance Improvement Program Reporting **d.** QI.08 Cultural and Linguistically Competent Services **e.** QI.09 Health Education Program and Delivery System Policy **f.** QI.11 Member Non-Monetary Incentives **g.** QI.12 Screening, Brief Intervention, and Referral to Treatment (BIRT) for Misuse of Alcohol **h.** QI.16 Managed Long Term Services and Support Care Coordination **i.** QI.28 Health Homes Program Policy **Possible Action:** Approve QI Policies as presented	Dr. Liu	7:15	10 min
10.	**Grievances and Appeals Report** Review of the Q4 Grievance and Appeals Report	Mr. Breakbill	7:25	10 min
11.	**Quality Dashboard** Review of the Quality Dashboard	Ms. Chang	7:35	10 min
12.	**Compliance Report** Review of the Compliance Report	Ms. Yamashita	7:45	10 min
13.	**Credentialing Committee Report** Review February 5, 2020 Credentialing Committee Meeting Report **Possible Action:** Approve the February 5, 2020 Credentialing Committee Meeting Report	Dr. Nakahira	7:55	5 min
14.	**Adjournment** The next QIC meeting will be held on June 4, 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.

Santa Clara Family Health Plan™

Quality Improvement Committee

Meeting Minutes

February 12, 2020

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

MINUTES - DRAFT

Members Present
Ali Alkoraishi, MD
Christine Tomcala, Chief Executive Officer
Jeffrey Arnold, MD *(via telephone)*
Jennifer Foreman, MD
Jimmy Lin, MD
Laurie Nakahira, D.O., Chief Medical Officer
Ria Paul, MD, Chair

Members Absent
Nayyara Dawood, MD

Staff Present
Jamie Enke, Manager, Process Improvement
Johanna Liu, PharmD, Director, Quality & Process Improvement
Ivy Douangphachanh, Quality Improvement Analyst
Nancy Aguirre, Administrative Assistant
Sandra Walle, Quality Improvement Coordinator
Tiffany Franke, Behavioral Health Case Manager
Zara Hernandez, Health Educator

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

1. Introduction

Ria Paul, MD, Chair, called the meeting to order at 6:00pm. Roll call was taken. A quorum was established at this time.

2. Meeting Minutes

Minutes of the December 4, 2019 Quality Improvement Committee (QIC) meeting were reviewed.

> **It was moved** by Jimmy Lin, MD**, seconded** by Ali Alkoraishi, MD**, and** the minutes of the December 4, 2019 QIC meeting were **approved**.

3. Public Comment

There were no public comments.

4. CEO Update

Christine Tomcala, Chief Executive Officer, Santa Clara Family Health Plan (SCFHP), reviewed the membership reports. As of February, 2020, there are 231,548 Medi-Cal members and 8,486 Cal MediConnect (CMC) members.

Ms. Tomcala announced SCFHP officially acquired the new Community Resource Center (CRC) located in San Jose, CA. Remodeling of the facility is currently underway and the CRC is on track to open near July, 2020.

Ms. Tomcala explained Medi-Cal Healthier California for All, formerly known as CalAIM, consists of reforms to the Delivery System, Program, and Payment of Medi-Cal. These new sets of proposals are designed to address many of the government's challenges such as, insufficient access to behavioral health care, children with complex medical needs, and clinical needs of justice involved populations as well as the aging population.

In regards to clinical implications, Laurie Nakahira, D.O., Chief Medical Officer, SCFHP, announced Whole Person Care will come to an end by the end of this year. However, Medi-Cal Healthier California for All has an Enhanced Case Management (ECM) program. ECM will encompass Whole Person Care and the Health Homes program and continue to serve a similar population.

5. Follow-Up / Old Business

a. Out of Network Requests for Ambulatory Surgical Centers (ASC)

Carmen Switzer, Manager of Provider Network Access, addressed a question raised at the previous QIC regarding the Out of Network (OON) Assessment. The assessment showed 47% of the Advanced Surgical Care (ASC) approvals were for Peninsula Eye Surgery Center and the Tri-County Vascular Care Center. The Contracting team is in the process of reaching out to both ASCs in effort to secure an agreement. Further updates will be provided at a future meeting.

b. Valley Medical Readmission Rates

Dr. Nakahira reviewed the Plan All Cause Readmission (PCR) rates for Medi-Cal and CMC, as a follow-up to Valley Medical's readmission rates reviewed at the previous QIC meeting. Dr. Nakahira reviewed the PCR rates in detail for all seven (7) networks by hospital and by diagnosis.

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

Jamie Enke, Manager, Process Improvement, SCFHP reviewed the following changes made to the QI Program Description 2020:

- Removal of Healthy Kids program
- Grammatical and structural improvements
- Removal of outdated information
- NCQA language incorporated
- Clarification to the QI Work Plan
- Clarification regarding a designated behavioral health physician
- Clarification to 2020 goals
- New staff roles in QI department: Process Improvement and Health Homes Program

Dr. Alkoraishi asked if this document is reviewed on an annual basis. Ms. Enke confirmed the QI Program Description is annually reviewed.

> **It was moved** by Dr. Lin**, seconded** by Jennifer Foreman, MD**, and** the QI Program Description 2020 was **approved**.

7. Review of Health Education (HE) Program Description 2020, HE Work Plan 2020, and HE Evaluation 2019

Zara Hernandez, Health Educator, SCFHP, reviewed the 2019 HE Program Evaluation. A Wellness Rewards Program was launched, focusing on eight (8) HEDIS measures. Gift cards are offered to members for completing health screenings/visits. Since the launch, SCFHP mailed over 30,000 letters to members from

July 2019 to December 2019, to offer motivation to complete a screening. So far, about 8,500 (27% compliance rate) of members have completed a screening.

Ms. Hernandez noted Healthy Kids has been removed from the 2020 HE Program Description. There are two (2) new Performance Improvement Projects (PIPs) that have been incorporated into the 2020 HE Work Plan: Adolescent Well Care (AWC) visits (ages 19-21) and Well-Child Visits in the first 15 months (W15).

> **It was moved** by Dr. Lin**, seconded** by Ms. Tomcala**, and** the HE Program Description 2020, HE Work Plan 2020, and HE Evaluation 2019 were **approved**.

8. Review of Cultural and Linguistics (C&L) Program Description 2020, C&L Work Plan 2020, and C&L Evaluation 2019

Ms. Hernandez reviewed the C&L Program Description 2020. The required DMHC Enrollee Assessment was completed in January 2020. Results were just received a few weeks ago and are in review. Further updates will be provided at a future meeting.

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the C&L Program Description 2020, C&L Work Plan 2020, and C&L Evaluation 2019 were **approved**.

9. Provider Satisfaction Report for MY2019

Ms. Switzer reviewed the results of the 2019 Provider Satisfaction Report. Most measures reflected an increase in provider satisfaction between 2018 and 2019.

Dr. Paul asked which efforts were made to result in the increase in satisfaction. Ms. Switzer explained an update to the system was made to ensure claims were processed in a timely manner, as well as education on the turnaround times for processing claims.

Dr. Alkoraishi asked if the appeals portion of the Provider Satisfaction Survey was relevant to Pharmacy. Ms. Switzer clarified the appeals are related to Utilization Management, regarding claim approvals or turnaround times.

Ms. Switzer noted a slight decrease in the Overall Provider Experience with SCFHP for Behavioral Health (BH) between 2018 and 2019. Dr. Alkoraishi asked if there are any known reasons for this decrease. Ms. Switzer explained meeting timely access after-hours has been a challenge for most BH providers. SCFHP will continue to investigate the reason(s) for this decrease.

Ms. Tomcala asked if the data relating to the Rate of Response was accurate, as the chart reflects all but one (1) provider group showed an increase in their response rate. Ms. Switzer will look into this and clarify this data at the following QIC meeting.

Response Rates for Valley Health Plan (VHP) for 2017/2018 were reviewed. Data relating to the VHP's Response Rates for 2018/2019 will not be available until March, 2020. Further updates will be provided at a future meeting.

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the Provider Satisfaction Report for MY2019 was **approved**.

10. Review of Population Health Assessment

Dr. Liu reviewed the Population Health Assessment for 2020. Dr. Liu highlighted an average of 29.8% CMC respondents of the Health Risk Assessment (2019) reported they run out of money to pay for food, rent, bills, or medicine. Respondents experiencing problems writing checks or keeping track of money had a higher than average percentile rate in Long Term Care (LTC), Serious Mental Illness (SMI), and Long Term Services and Support (LTSS) members.

In regards to the Health Status of chronic conditions information, Ms. Tomcala asked for clarification on the data displayed. Dr. Liu confirmed the data displayed represents all of Santa Clara County.

Improvements to the social determinants of health (SDOH) indicators such as education, employment, and income are needed. Ms. Tomcala asked to elaborate on how this can be done. Dr. Liu explained the Population Health Management Program can help connect members to available resources.

Dr. Lin asked how many CMC members are currently in LTSS. Dr. Liu estimated around 3,000.

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the Population Health Assessment was **approved**.

11. Review of Clinical, Behavioral, and Medical Preventative Practice Guidelines

Dr. Liu presented the Clinical, Behavioral, and Medical Preventative Practice Guidelines for 2020. After review, only the American Diabetes Association (ADA) guidelines needed to be updated.

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the Clinical, Behavioral, and Medical Preventative Practice Guidelines were **approved**.

12. American with Disabilities Act (ADA) Work Plan 2020

Dr. Liu reviewed the ADA Work Plan 2020 and noted an error in the title of the listed Responsible Party. The only change made to the ADA Work Plan for 2020 was in the reporting frequency for the Physical Accessibility Review measure. The frequency was updated to require review once every three (3) years.

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the ADA Work Plan 2020 was **approved as amended**.

13. Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis

Tiffany Franke, Behavioral Health Lead, SCFHP, reviewed the factors analyzed in the Continuity and Coordination between Medical Care and Behavioral Healthcare. Ms. Franke clarified this analysis is specific to CMC members, 18 years of age or older.

Ms. Tomcala inquired how improvement is expected if interventions are not implemented on certain factors. Ms. Franke explained two (2) interventions are selected for implementation per year, per NCQA requirements. Workgroups are held to determine the best area to implement an intervention. However, further discussion will be made to decipher how to address all areas in need of improvement.

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis was **approved**.

14. Annual Review of QI Policies

Dr. Liu reported there were no changes, aside from removing the Healthy Kids check box, made to the following policies during their annual review:

a. QI.05 Potential Quality of Care Issues (PQI)
b. QI.07 Physical Access Compliance
c. QI.10 Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the annual review of QI policies QI.05, QI.07, and QI.10 were **approved**.

15. Grievances and Appeals Report

The Grievances and Appeals Report was deferred to the next QIC meeting.

16. Quality Improvement Charter

The Quality Improvement Charter was deferred to the next QIC meeting.

17. Quality Dashboard

Dr. Liu reviewed the Quality Dashboard. Dr. Paul asked when the Health Homes Program is expected to come to an end. Dr. Liu explained a specific end date has not been disclosed, however, the Medi-Cal Healthier California for All has instructed health plans to integrate the Health Homes Program and Whole Person Care, which will be known as Enhanced Case Management (ECM). At this moment, the Health Homes Program is anticipated to come to an end by the end of the calendar year.

18. Compliance Report

The Compliance Report was deferred to the next QIC meeting due to the recent change in Compliance leadership.

19. Credentialing Committee Report

Dr. Nakahira reviewed the details of the Credentialing Committee Report. There were no comments made.

> **It was moved** by Dr. Lin**, seconded** by Dr. Alkoraishi**, and** the Credentialing Committee Report was **approved**.

20. Utilization Management Committee Minutes

Dr. Lin reviewed the minutes of the October 16, 2019 Utilization Management Committee (UMC) meeting minutes. There were no comments made.

> **It was moved** by Dr. Alkoraishi**, seconded** by Dr. Foreman**, and** the minutes of the October 16, 2019 UMC meeting were **approved**.

21. Adjournment

The next QIC meeting will be on April 8, 2020. The meeting was adjourned at 7:42 pm.

_____ _____

Ria Paul, MD, Chair of Quality Improvement Committee Date

Santa Clara Family Health Plan™

Quality Improvement

Program Evaluation 2019

Santa Clara Family Health Plan.

2019 QUALITY IMPROVEMENT PROGRAM EVALUATION

☑ Annual Evaluation

A. CLINICAL IMPROVEMENT ACTIVITIES

NCQA 2019 Quality Healthcare Effectiveness Data and Information Set (HEDIS) Measures for (Medi-Cal (MC), and Centers for Medicare and Medicaid Services for Cal Mediconnect (CMC): (2018 Measurement Year)

HEDIS Hybrid Measures Key:

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

HEDIS Administrative Measures Key:

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

	○ Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – IET (CMC)

A.1 Goal:

- Exceed Medi-Cal Managed Care (MMCD) Minimum Performance Levels (MPL), which is the 25th percentile, for all Medi-Cal HEDIS Measures.
- Develop and implement interventions for MMCD Auto-Assignment Measures and Quality Withhold related measures.
- Increase administrative (claims and encounter) data submissions across Networks.

A.2. Interventions:

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

A.3. Results:

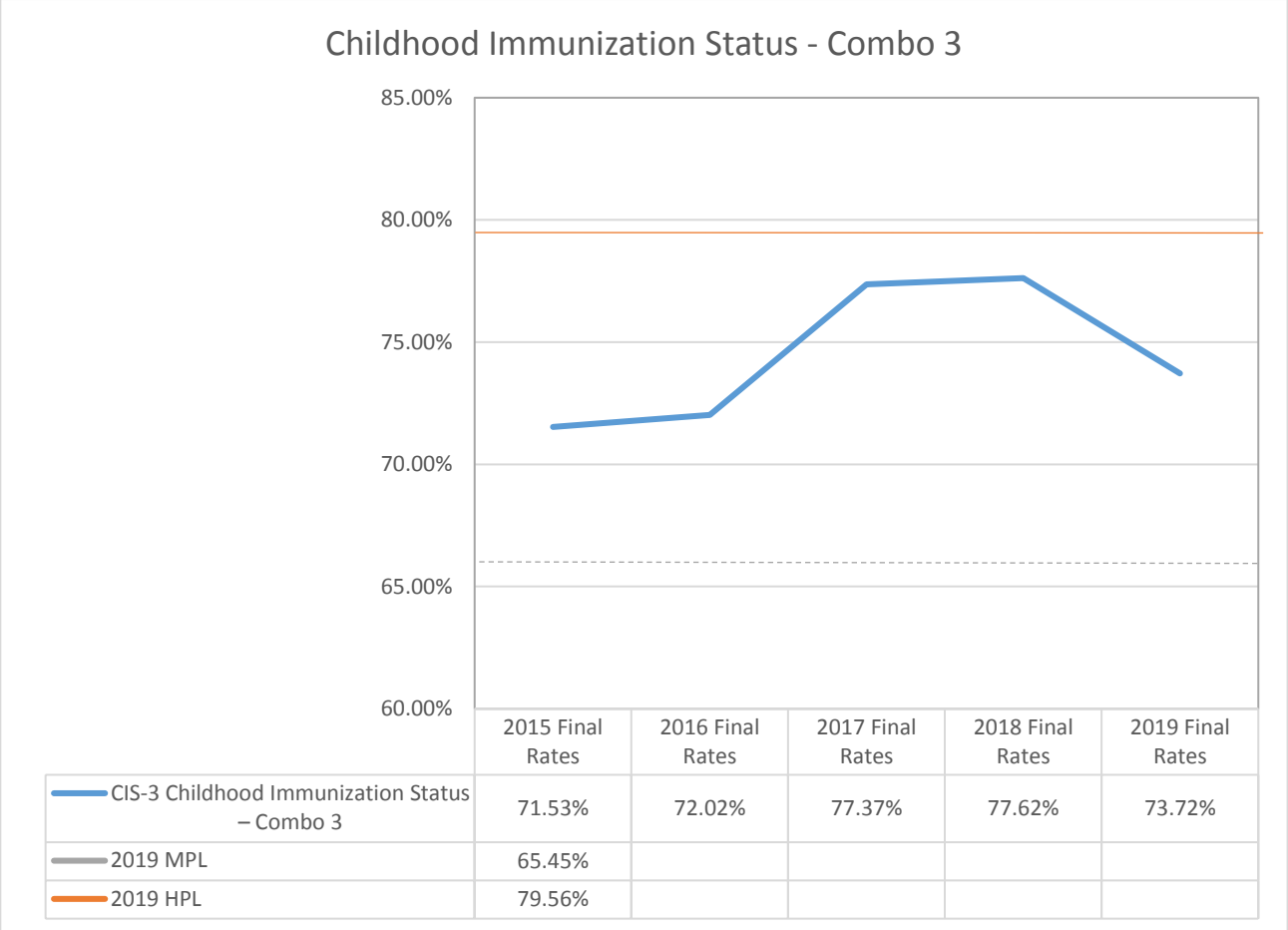
- Exceeded or at MMCD Minimum Performance Level (MPL) for all measures
- Medi-Cal measures CIS-3 and IMA-Combo 2 exceeded the HPL.
- Medi-Cal measure(s) that have improved significantly (>5%) from the prior year: Cervical Cancer Screening (CCS).
- Some Medi-Cal measures decreased significantly (>5%): Comprehensive Diabetes Care – HbA1c Poor Control and Control (CDC-H9 and CDC-H8) and Controlling Blood Pressure (CBP)
- All CMC measures reportable for Measurement Year 2018. There are no MPL's for the CMC line of business.

A.4. Analysis of Findings/Barriers/Progress

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

Immunization Measures Findings

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



	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates	2019 Final Rates
CIS-3 Childhood Immunization Status – Combo 3	71.53%	72.02%	77.37%	77.62%	73.72%
2019 MPL	65.45%				
2019 HPL	79.56%				

Analysis and Findings/Barriers/Progress

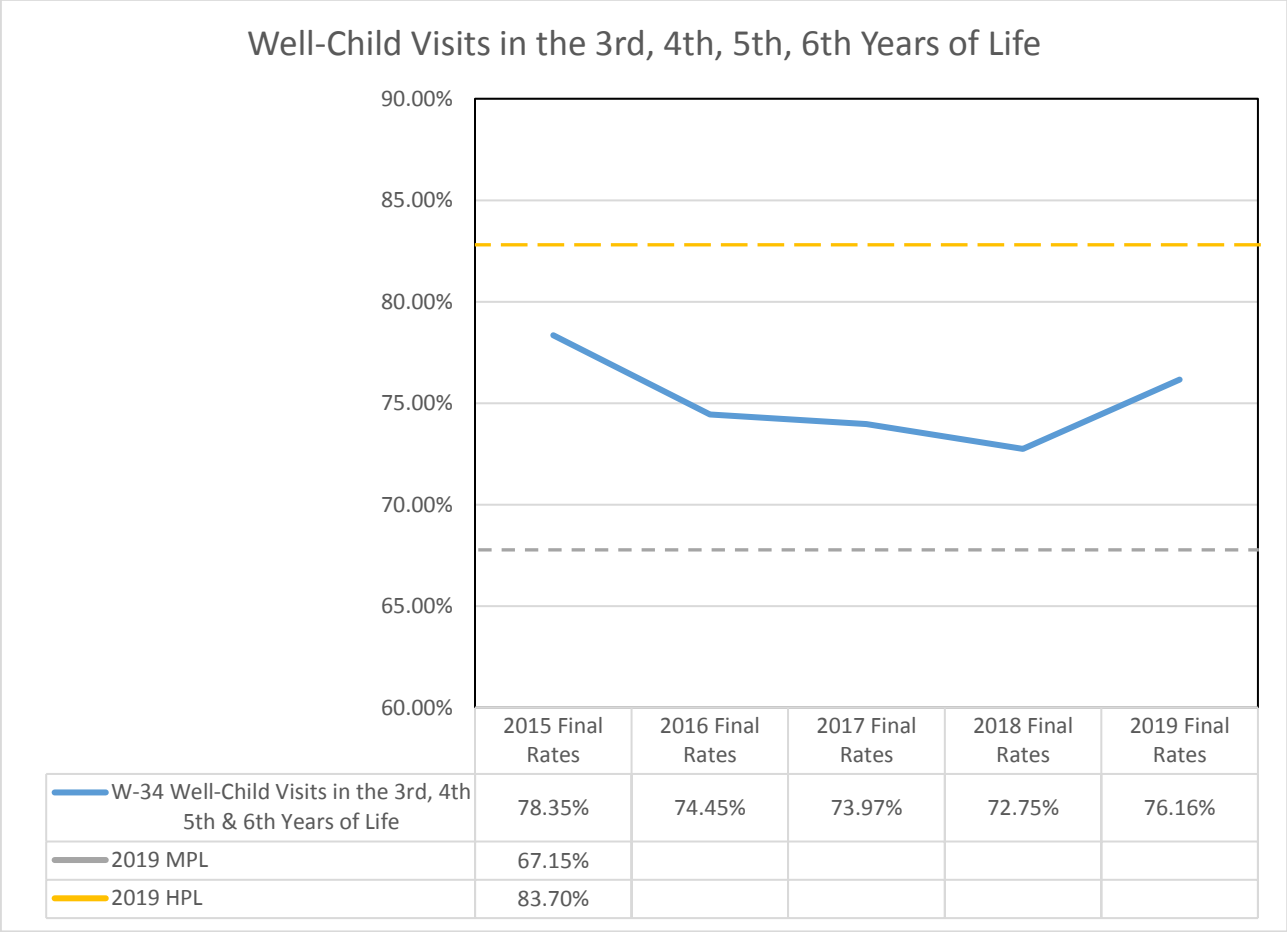
- Met goal of exceeding the MPL of 65.45% but remains below the HPL of 79.56%.
- SCFHP analysis on membership and claims data shows a continued pattern of immunizations given outside of the recommended timeframes for children 2 years of age.

Follow up/Actions:

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

Well Child Visits Key Findings

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



	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates	2019 Final Rates
W-34 Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	78.35%	74.45%	73.97%	72.75%	76.16%
2019 MPL	67.15%				
2019 HPL	83.70%				

Analysis and Findings/Barriers/Progress

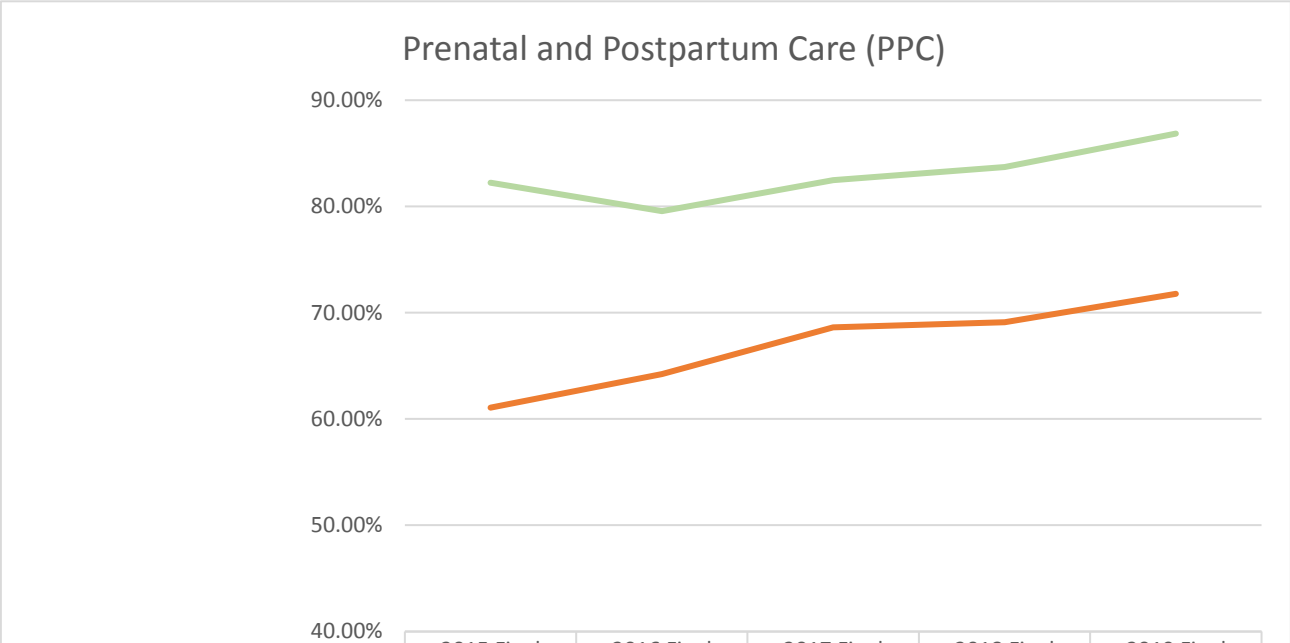
- Met goal of exceeding the MPL of 67.15%, and remains below the HPL of 83.70%.
- 2019 rate increased by 3.41% from HEDIS 2018.
- Possible increase in rate due to well-child reminder letters.

Follow up/Actions:

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

Adult Hybrid Measures: Prenatal / Postpartum Care Key Findings

PPC – Prenatal and Postpartum Care (MC)



	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates	2019 Final Rates
Prenatal & Postpartum Care - Timeliness of Prenatal Care	82.24%	79.56%	82.48%	83.70%	86.86%
Prenatal & Postpartum Care - Postpartum Care	61.07%	64.23%	68.61%	69.10%	71.78%

Analysis and Findings/Barriers/Progress

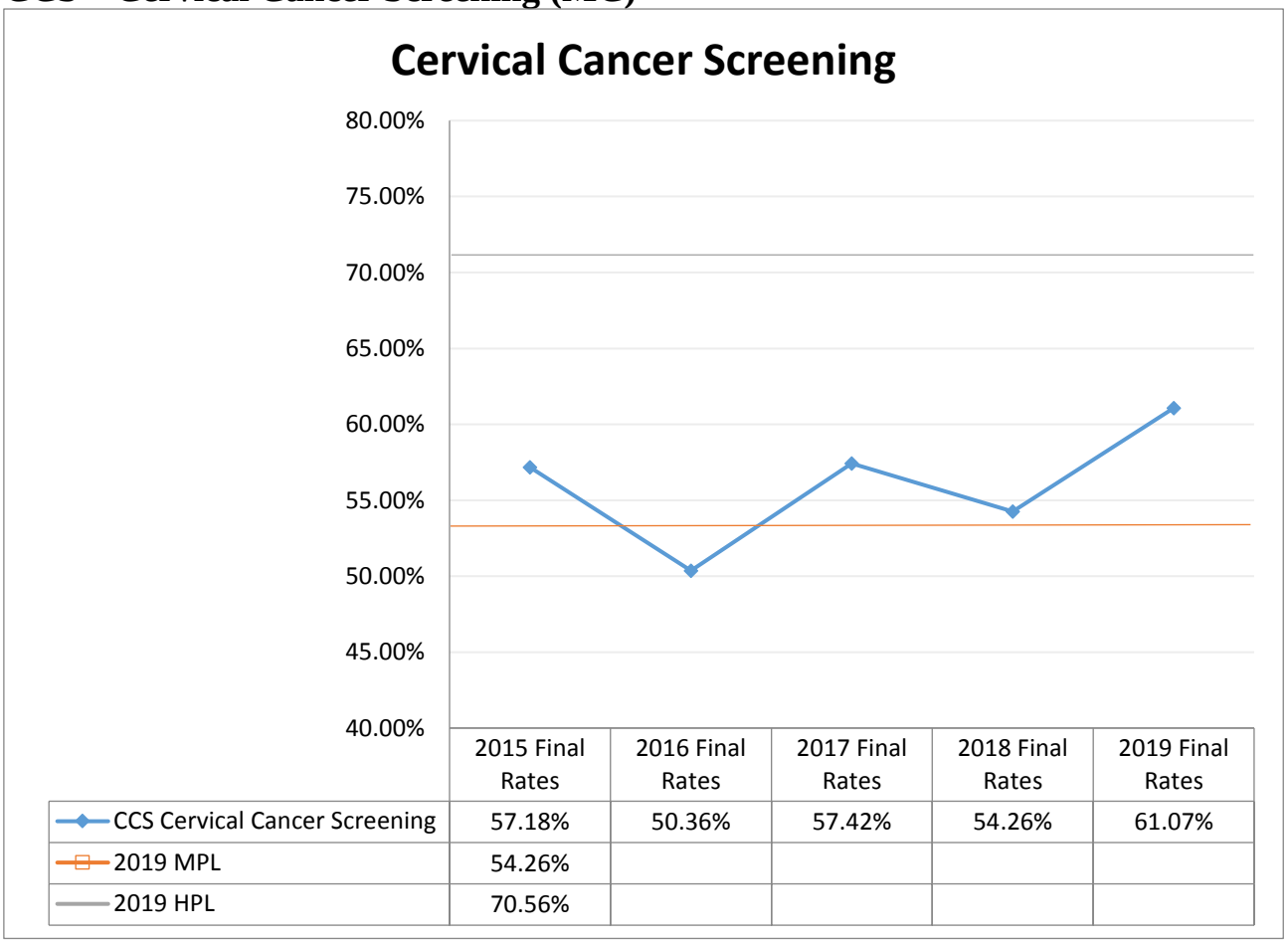
- Met goal of exceeding the MPL's (Prenatal visits 76.89%; Postpartum visits 59.61 %) and remains below the HPL (Prenatal visits 90.75%; Postpartum visits 73.97 %) of both indicators.
- For Prenatal visits, rate increased by 3.16%; Postpartum visits, rate increased by 2.68 %.
- Challenging to find expecting mother's before they enter the healthcare system.

Follow up/Actions:

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

Adult Measures: Cervical Cancer Screening Key Findings

CCS – Cervical Cancer Screening (MC)



	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates	2019 Final Rates
CCS Cervical Cancer Screening	57.18%	50.36%	57.42%	54.26%	61.07%
2019 MPL	54.26%				
2019 HPL	70.56%				

Analysis and Findings/Barriers/Progress

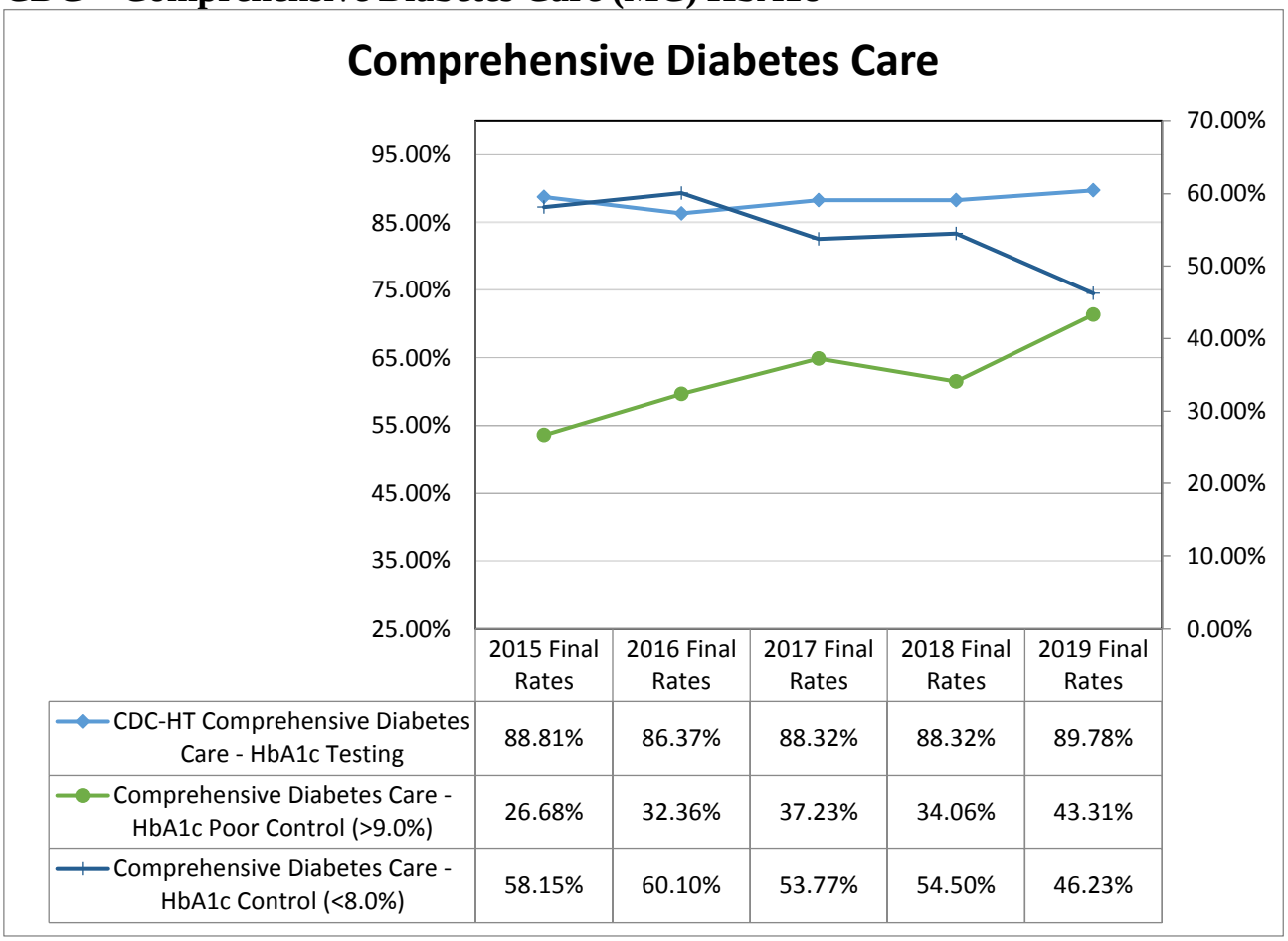
- Met goal to exceed the MPL of 54.26% but below HPL of 70.56%.
- Rate increased significantly by 6.81% from HEDIS 2018

Follow up/Actions:

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

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

CDC – Comprehensive Diabetes Care (MC) HbA1c



	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates	2019 Final Rates
CDC-HT Comprehensive Diabetes Care - HbA1c Testing	88.81%	86.37%	88.32%	88.32%	89.78%
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	26.68%	32.36%	37.23%	34.06%	43.31%
Comprehensive Diabetes Care - HbA1c Control (<8.0%)	58.15%	60.10%	53.77%	54.50%	46.23%

Analysis and Findings/Barriers/Progress

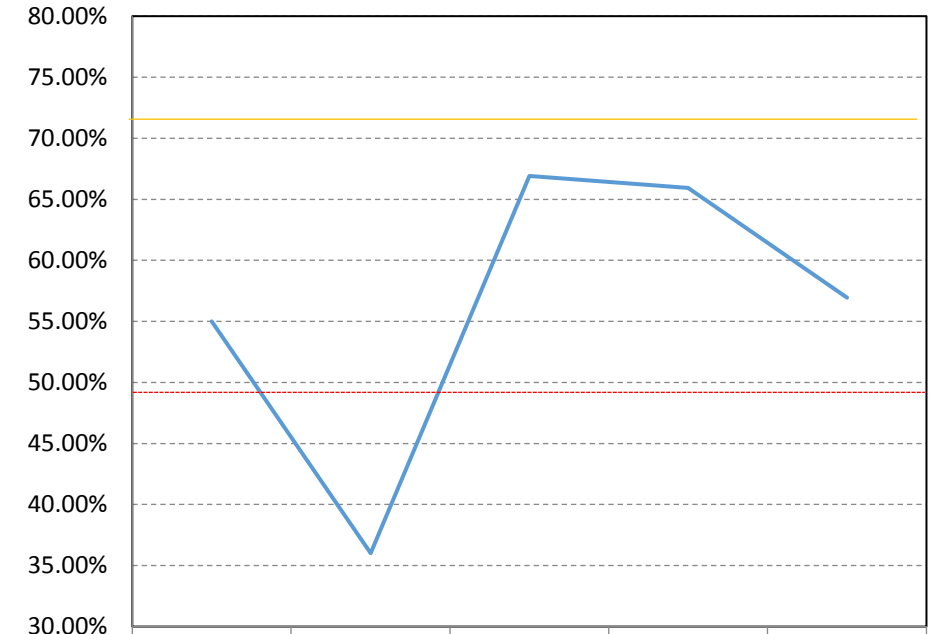
- Met goal of exceeding the MPL for all the CDC HbA1c indicators. MPL's are as follows:
  - CDC HT: 84.99%
  - CDC HbA1c Poor Control: 47.08%
  - CDC HbA1c Control: 44.44%
- Rate is flat for HbA1c Testing and increased 1.46% for CDC HbA1c Control from HEDIS 2018. For HbA1c Testing Poor Control a lower rate is better. HEDIS 2019 rate shows an increase of 9.25% from HEDIS 2018.

Follow up/Actions:

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

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

CBP - Controlling High Blood Pressure (MC)



	2015 Final Rates	2016 Final Rates	2017 Final Rates	2018 Final Rates	2019 Final Rates
Controlling High Blood Pressure	54.99%	36.01%	66.91%	65.94%	56.93%
2019 MPL	49.15%				
2019 HPL	71.04%				

Analysis and Findings/Barriers/Progress

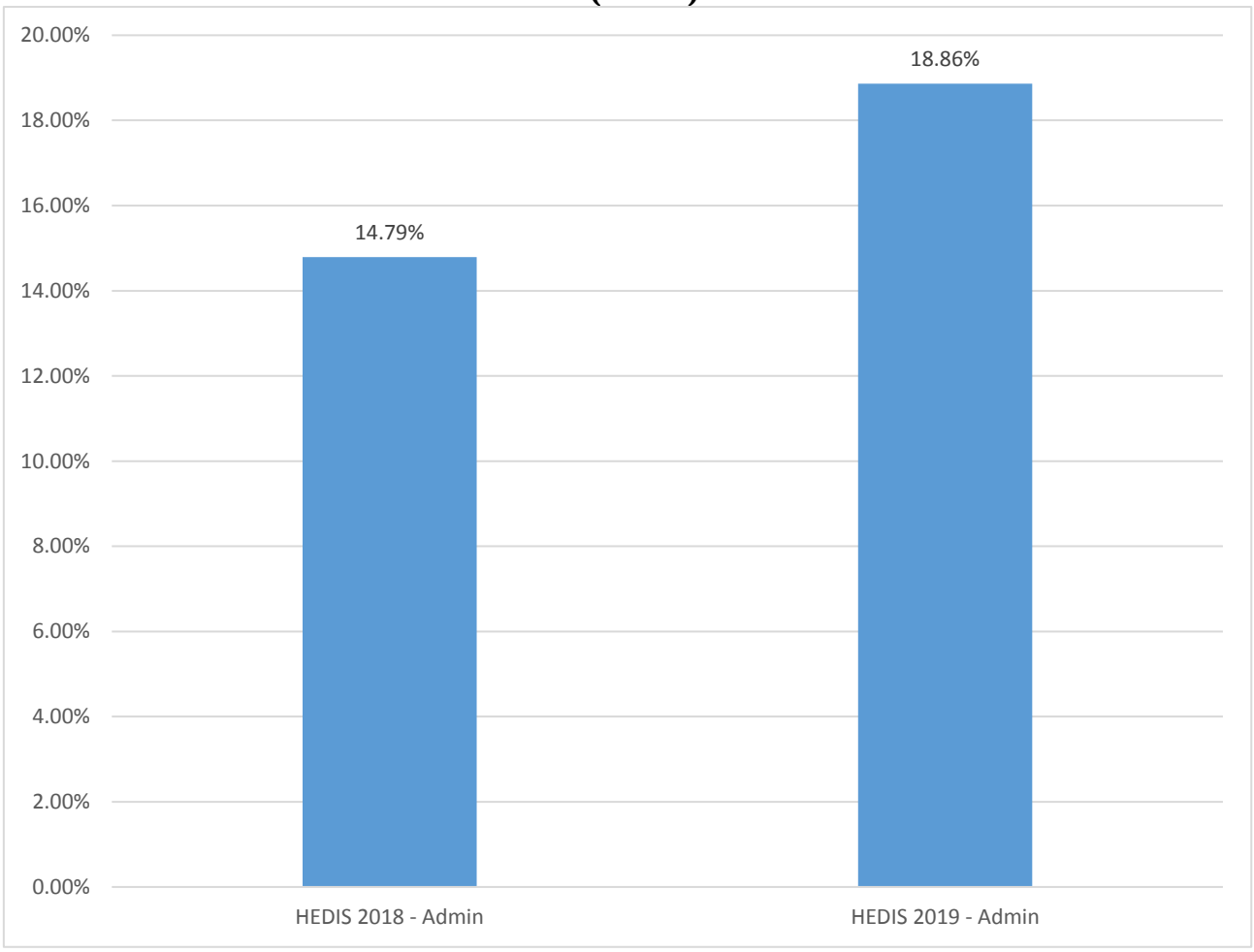
- Met goal of Blood Pressure Control exceeding the MPL of 49.15%, and below HPL of 71.04%.
- Rate decreased by 9.01%.
- Barriers for this measure include the challenge of this being a 100% chart pull measure, in addition to lack of supplemental data and EMR access.

Follow up/Actions:

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

Quality Withhold Measure: Plan All-Cause Readmission

PCR – Plan All-Cause Readmission – (CMC)



Analysis and Findings/Barriers/Progress

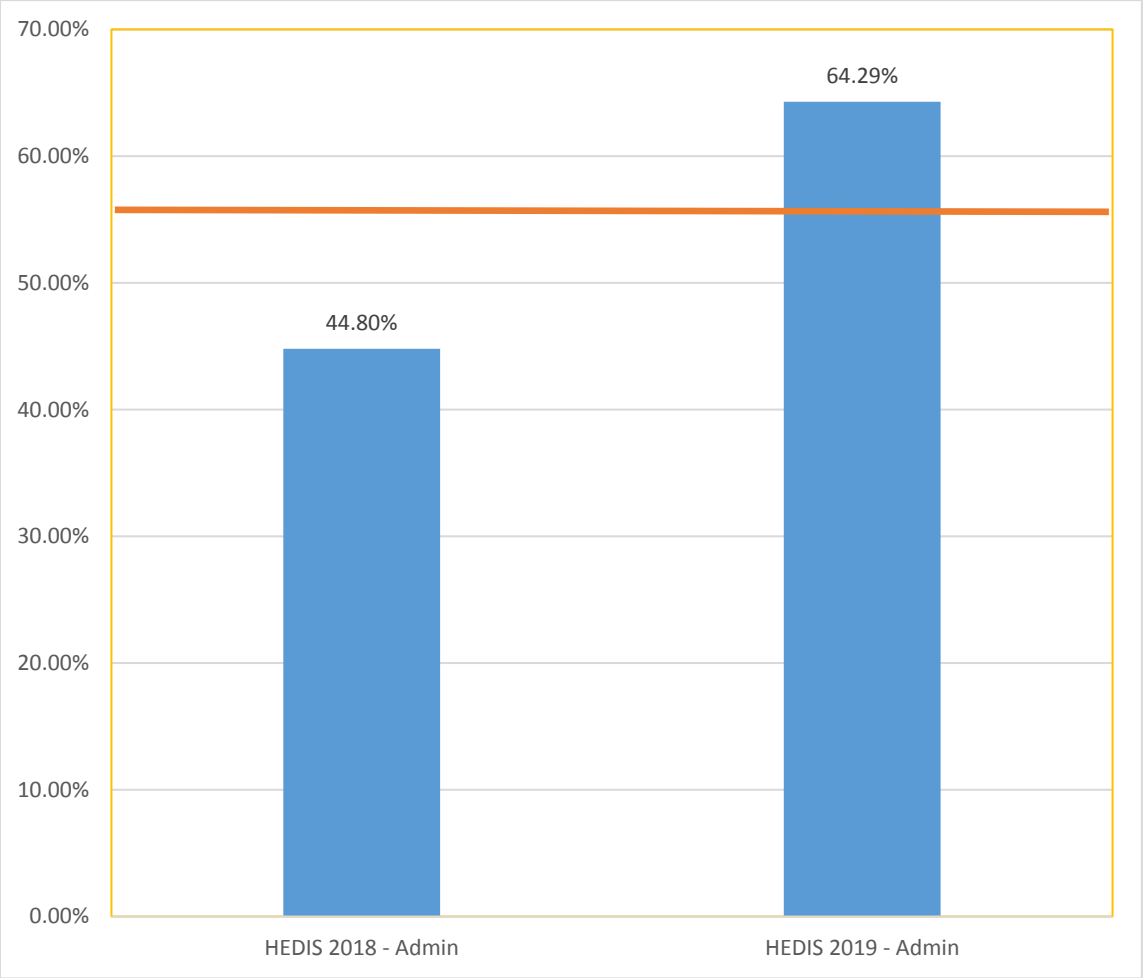
- Lower is better for PCR. HEDIS 2019 rate increased by 4.07%. CMS changed the Quality Withhold standard to use the Observed Readmission/Expected Readmissions (O/E) Ratio as the benchmark as of March 2018 with the ratio being less than 1. SCFHP's O/E Ratio for HEDIS 2018 is under 1 (0.8692), therefore meeting the Quality Withhold benchmark.
- Lack of timely notification of discharge is a barrier for this measure.

Follow up/Actions:

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

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

FUH – Follow-Up After Hospitalization for Mental Illness – 30 days (CMC)



Analysis and Findings/Barriers/Progress

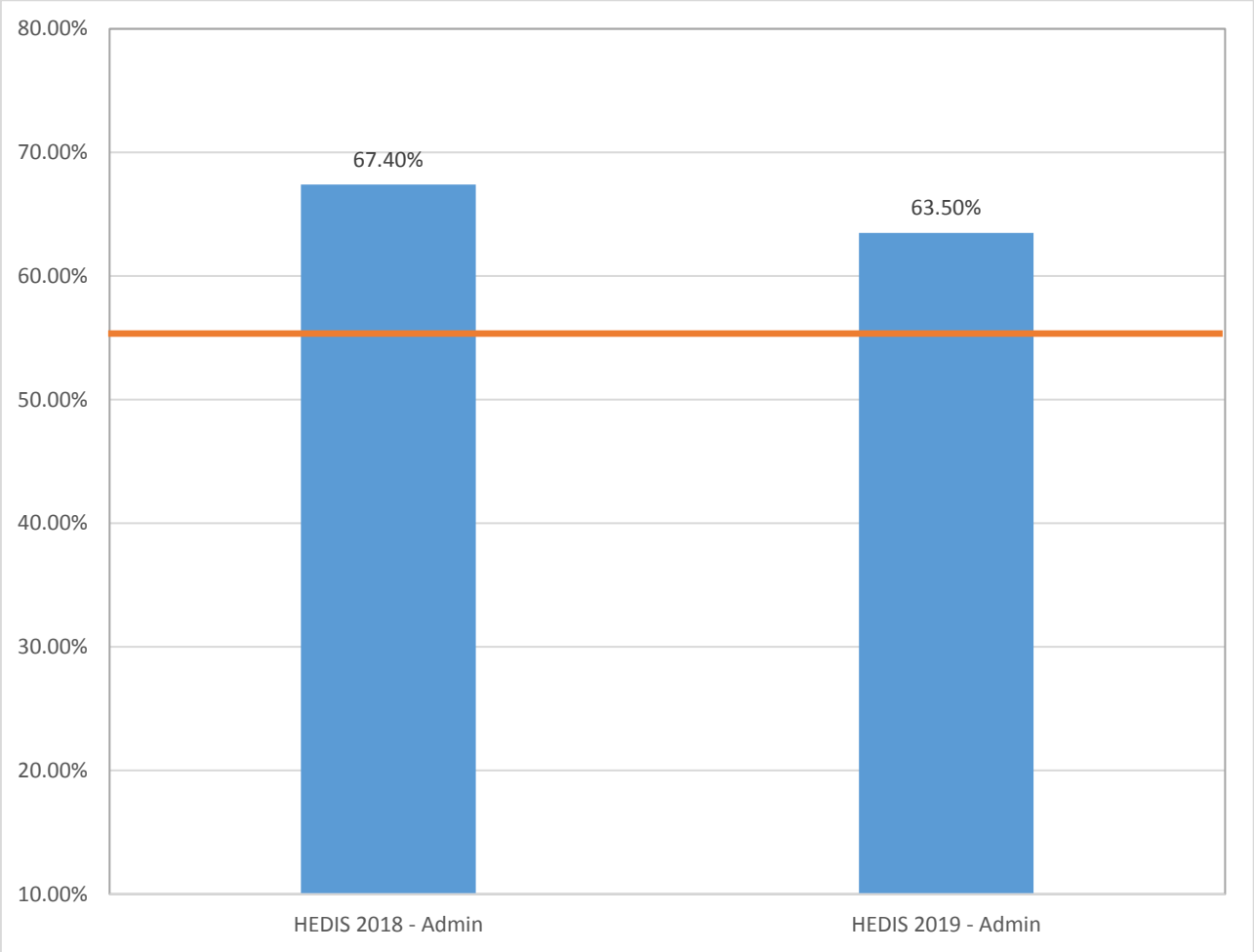
- Measure increased significantly by 19.49% from HEDIS 2018
- Significant rate increase due to collaboration with Santa Clara County to ensure that the Plan receives all encounters for members who were seen at the County Behavioral Health clinics and that members are entered into their system and appropriately identified as SCFHP members.

Follow up/Actions:

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

Quality Withhold Measure: Controlling High Blood Pressure

CBP – Controlling High Blood Pressure – (CMC)



Analysis and Findings/Barriers/Progress

- Measure decreased by 3.9% from HEDIS 2018
- Measure is above the Quality Withhold benchmark of 53.11% which meets goal.

Follow up/Actions:

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

B. Clinical Improvement Activities
External and Internal QIP's (2019 Measurement Year)

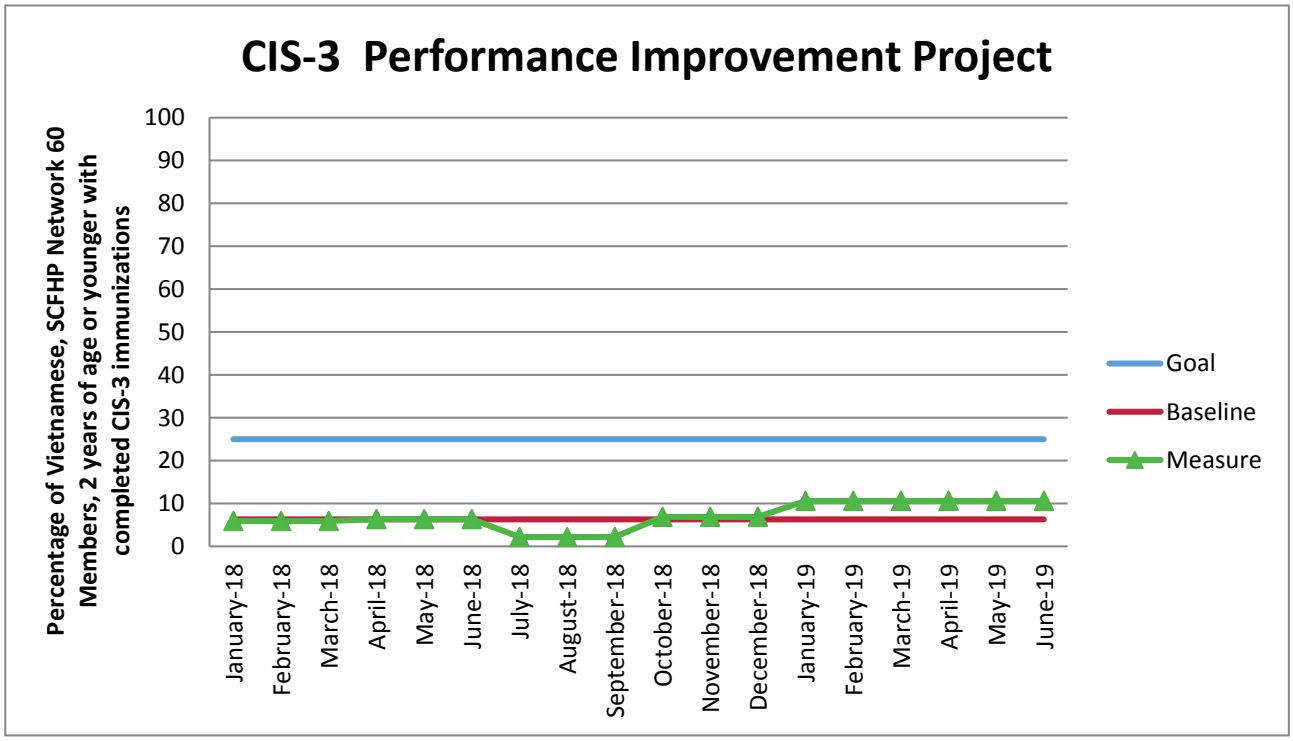
Disparities Childhood Immunization Status Combination 3(CIS-3)–DHCS Performance Improvement Project (PIP)

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

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

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

Smart Goal Results:



Analysis of Findings/Barriers/Progress

- The Plan has not achieved the SMART Aim goal in 2019 but there is an increase in the compliance rate. May be the result of successful intervention of incentivized gift card rewards.
- Only mailings were conducted to reach out to the targeted population. Since this is a hard-to-reach population, we may explore other methods of reaching the members.

- Members were also required to have multiple doctors' visits in order to complete the required immunizations to receive the $30 gift card. We see an opportunity to increase the gift card amount to motivate members to schedule and/or attend all scheduled appointments.
- Another barrier we have encountered is the amount of incorrect member contact information and obtaining transportation to appointments. Members usually missed about 5% of their required immunizations in order to be compliant.
- We will continue to work with providers and ask them to educate their patients about immunizations, schedule appointments, and complete all required immunizations within the appropriate immunization schedule timeframe.

Controlling Blood Pressure -DHCS Performance Improvement Project (PIP)

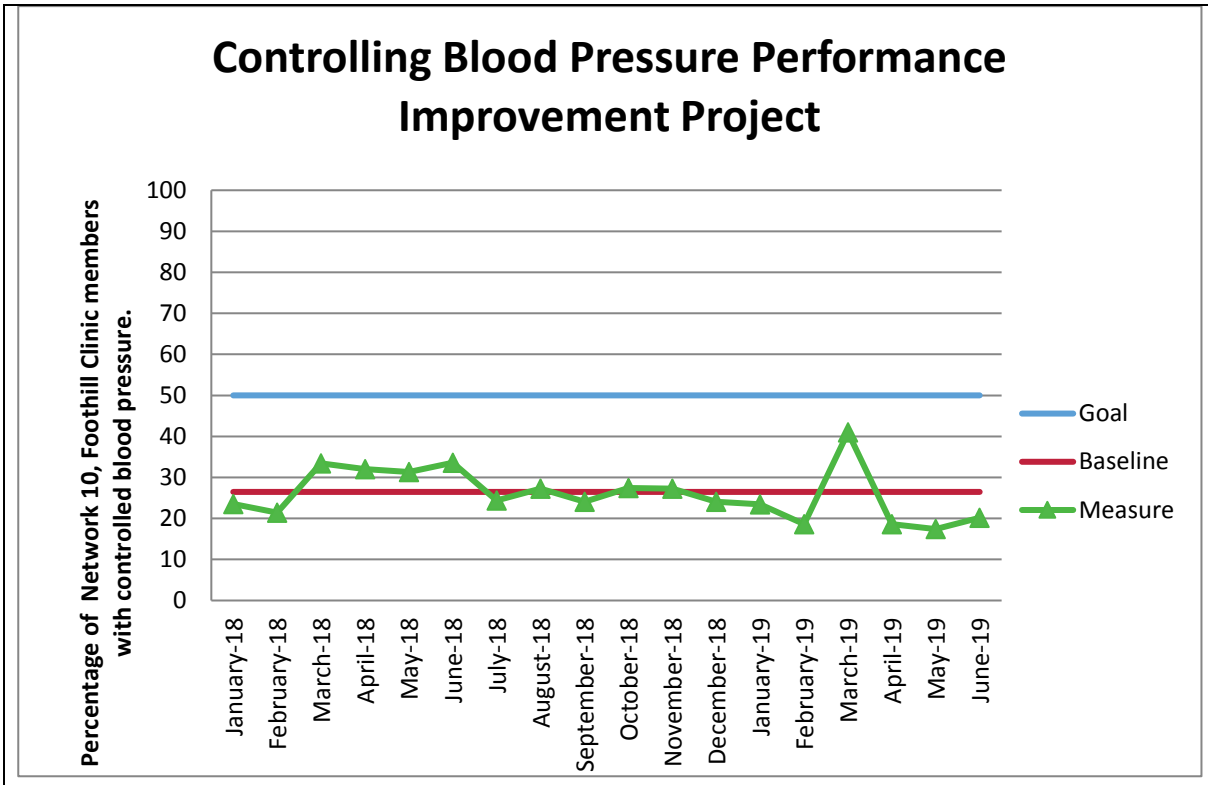
Goal: By 06/30/2019, increase the percentage rate of Network 10, Foothill Clinic members aged 18-85, with a diagnosis of hypertension, whose blood pressure is adequately controlled, during the previous rolling 12 months, from 26.47% to 50%.

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

Design

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

Smart Goal Results: 2019 results indicate an improvement over baseline for the CBP measure in 8 out of 12 months.



Analysis of Findings/Barriers/Progress

- From January 1, 2018 to June 30, 2019 the controlling blood pressure rate among Medi-Cal members aged 18 to 75 who reside in Santa Clara County and who have a Foothill Clinic/Network 10 PCP varied between 17.41%-40.98%
- The SMART Aim goal of 50 % was not met during the intervention testing and in fact the rate remained below 50% for the duration of the PIP cycle.
- There was no evidence supporting either meaningful or sustained improvement in the controlling blood pressure compliance rate for the measured population and the SMART Aim was never met.
- The Plan will not continue to offer members this particular incentive to complete their blood pressure check exam. The intervention as designed will be removed from operating procedures.
- The Plan is evaluating the need to implement a different intervention for this measure. The Plan tracks CBP rates to monitor results through its HEDIS processes.
- The HEDIS Project Manager is responsible to identify patterns in the rate that may signify the need for new improvement activities.
- The Quality team will continue to serve as quality improvement consultants for the HEDIS Project Manager to explore and address future quality improvement efforts. The Team plans to share the PIP results with the Plan's Quality Improvement Committee.

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

Goal:

- Increase total number of high risk members who had an ICP completed from in 59% 2018 to 68% in 2019
- Increase total number of low risk members who had an ICP completed from 58% in 2018 to 66.8% in 2019.

- Increase the total number of Cal MediConnect members with at least one documented discussion of care goals in the initial ICP from 56.9% in 2018 to 65% in 2019.

Intervention:

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

Design:

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

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

2019 Results:

Study Indicator 1: High Risk Members with an ICP Completed					
Period	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal
01/01/2017-12/31/2017	Baseline	1,206	2,080	58.00%	N/A
01/01/2018-12/31/2018	Re-measurement 1	1,437	2,458	59.00%	63.00%
01/01/2019-12/31/2019	Re-measurement 2	1,477	2,554	57.83%	68.00%

Study Indicator 2: Low Risk Members with an ICP Completed					
Period	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal
01/01/2017-12/31/2017	Baseline	2,578	4,641	55.50%	N/A
01/01/2018-12/31/2018	Re-measurement 1	2,853	4,941	58.00%	61.80%
01/01/2019-12/31/2019	Re-measurement 2	3,063	5,473	55.97%	66.80%

Study Indicator 3: Total number of CMC members with at least one documents discussion of care goals in the initial ICP					
Time Period	Indicator Measurement	Numerator	Denominator	Rate of Results	Goal
01/01/2017 - 12/31/2017	Baseline	145	791	18.30%	N/A
01/01/2018-12/31/2018	Re-measurement 1	432	759	56.90%	60.00%
01/01/2019-12/31/2019	Re-measurement 2	793	793	100.00%	65.00%

Analysis of Findings/Barriers/Progress

- In 2019, 1477 out of 2554 (57.83%) of Santa Clara Health Plan's Cal MediConnect high risk members had an ICP created for them. This is a small decrease from the baseline rate of 58% and is a decrease of 1.17 percentage points from the rate in 2018. For Study Indicator 2, 3063 out of 5473 low risk members (55.97%) had an ICP completed. This is 0.47 percentage points about the baseline in 2017 and a decrease of 2.03 percentage points over prior year.

- In 2019, 793, or 100% of Santa Clara Health Plan's Cal MediConnect members with an initial ICP completed had at least one documented discussion of care goals. This is an increase of 44.1% percentage points over the prior year rate of 56.9%. This significant increase from prior year are due to business process changes in the way ICPs are captured and reported out of the case management system as well as reporting enhancements.
- The barriers, in order of priority and reiterated through this process are
    1. Data
        a. Inconsistent and incomplete data collection for reporting purposes and ongoing routine evaluation of interventions and their effectiveness.
        b. Lack of integrated data across multiple software data programs.
    2. Member Outreach
        a. Lack of Care Goal discussions in members preferred language due to language indicator errors in eligibility file
    3. Resources
        a. Insufficient case management staffing
    4. Processes and Training
        a. Inadequate development and implementation of case management training materials.
- The plan developed the following actions to further improve existing interventions:
    1. CM staffing plan was revised to add 1 additional supervisor, 3 social work case managers, 2 RN case managers and 3 personal care coordinators
    2. Individual Care Plan (ICP) Outreach and Documentation processes were updated and included extensive staff training. The process improvements will allow the team to utilize the CM system for simultaneous ICP development to occur with the member during telephonic HRA engagement
    3. An enhanced Supervisor Review Procedure was developed to evaluate staff productivity and monitor for potential risks for regulatory non- compliance.
    4. Additional data improvements included the development of a real-time quality monitoring tool developed collaboratively between our CM and IT teams. This live report tracks each required regulatory requirement for ICP outreach beginning with the date that a member's most recent HRA was completed. This tool allows the internal CM leadership team to immediately adjust staff daily work assignments to ensure compliance with ICP outreach requirements.
    5. CM leadership team has also focused on including additional multi-lingual CM team members who help to facilitate improved telephonic communications with our members and also ensure that CM correspondence is processed in a member's preferred language.

C. Initial Health Assessment (IHA)

C.1 Goal:

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

C.2 Interventions:

- On an annual basis, SCFHP provides information regarding the IHA to Plan members and providers in the Member and Provider Newsletters, and on the SCFHP website.
- SCFHP promotes provider education for the IHA to its delegates and independent network providers.
- The Plan uses IHA specifications aligned with the methodology of other health plans in the geographic area.
- The Plan runs IHA compliance reports on a monthly and quarterly basis.
- Plan medical record review methodology allows closer tracking of IHA criteria. Additional improvements were made with respect to DHCS auditor input.

C.3 Results:

- No trending was possible for medical record review between 2018 and 2019 data, due to improvements in methodology. However, monthly claims tracking through 2018 shows improvement from Quarter 1 (44.6%) to Quarter 4 (51.9%), and an annual improvement from 2017 (37.9%) to 2018 (48.3%).

C.4 Analysis of Findings/Barriers/Progress

- QI Nurse continues to audit medical records to determine compliance with IHA criteria requirements and report results to the Quality Improvement Committee.
- QI Nurse monitors and submits IHA rates to the SCFHP Compliance Dashboard monthly and quarterly.
- QI Nurse provides internal staff trainings for member facing teams.
- QI Nurse continues to work with Provider Network Management team to train providers and delegates.
- QI Nurse prepares Corrective Action Plans for providers who have been trained and continue to score below the 80% passing rate.
- QI Team continues to work with the Community Health Partnership IHA Collaboration Workgroup on a quarterly basis.

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

D.1 Goal:

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

D.2 Intervention:

- Complete Full Facility Site Review of all PCP sites every third year unless required more frequently for corrective action reasons.
- Complete Full Facility Site Review for all newly contracted sites.
- Complete Full Facility Site Review for all PCPs who move location.
- Continue to collaborate with Anthem Blue Cross.
- Maintain most current materials for educating providers and staff during site reviews.
- Provide educational and supportive resources as needed for PCPs pre- and post-review.
- Involve Delegates and Provider Network Management more directly for noncompliant providers.

D.3 2019 Results:

- Completed **18** PCP FSRs.
- Completed **20** MRRs.
- Completed **3** Initial FSRs.
- Completed **18** FSR Part C reviews. (Providers with a FSR-C review in the last six years may attest no changes rather than having FSR-C completed.)
- **14** FSR Corrective Action Plans (CAPs) issued, monitored and validated. 10 CAPs closed, 4 have closure dates in 2020.
- **18** MRR CAPs issued, monitored and validated. 14 CAPs closed, 4 have closure dates in 2020.
- **3** providers had exempted pass for FSR, **2** had exempted pass for MRR.
- **2** providers had failing scores for FSR.
- Conducted **2** collaboration meetings with Anthem Blue Cross to share data.

D.4 Analysis of Findings/Barriers/Progress

- SCFHP successfully completed the DHCS FSR Oversight Audit of 16 providers. DHCS staff reviewed FSR A and B for 16 Plan PCPs and notified SCFHP of findings. SCFHP worked with delegates and administered and

closed 16 of 16 CAPs timely. However, due to the loss of our FSR Consultant, 6 re-reviews resulting from the audit were unable to be completed by the end of 2019.
- FSR Consultant unavailable last 4 months of 2019.
- Due to the additional workload from the DHCS audit of 16 PCPs and the loss of our FSR Consultant, we were unable to complete 4 initial reviews and 8 full reviews.
- 4 FSRs were completed by Anthem Blue Cross on behalf of SCFHP.
- Created new FSR/MRR/PAR database software for use by reviewers in office via web interface in collaboration with SCFHP IT Department to be field tested in 2020 which will expedite tracking and reporting of FSR results.
- Uploaded FSR results to DHCS FSR web portal timely in January and July 2019.
- FSR staff attended DHCS mandated Interrater Reliability training to maintain certification.
- Training for new FSR certified reviewer initiated.

E. Patient Safety: Provider Preventable Conditions (PPCs)

E.1 Goal:

To report 100% of identified PPCs to DHCS.

E.2 Intervention:

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

E.3 Results:

- 0 PPCs identified 1/2019 – 12/2019.

E.4 Analysis of Findings/Barriers/Progress

- There are current technical issues obtaining accurate data for PPCs report. IT is continuing to work to resolve.
- Will reissue PPC notice to network regarding reporting PPCs to DHCS and to SCFHP.

F. Potential Quality of Care Issues Summary

F.1 Goal:

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

F.2 Intervention:

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

F.3 Results:

- 569 PQI's were reported in 2019.
- All PQI from 2019 were closed. Of the 569 closed:
    - 20 were Level 0 – Does not meet PQI criteria, Not our member/Not our provider
    - 390 were Level 1 – Quality of Care is Acceptable
    - 37 were Level 1A – no Quality of Care found
    - 114 were Level 2 – Opportunity for Improvement, no adverse occurrence
    - 7 were Level 3 – Opportunity for Improvement, adverse occurrence
    - 1 were Level 4 – Immediate Jeopardy

- 10 Critical Incidents

F.4 Analysis of Findings/Barriers/Progress

- There was an increase in the number of PQIs in 2019. This was due to the following: increased grievances, process improvements and improved communication between the Customer service team, Quality team Grievance and Appeals team. The majority of PQIs reviewed were unsubstantiated, or closed as Level 1-Quality of Care is Acceptable issues.

- The Plan identified 10 PQI's with critical incidents in 2019. Of those, 5 involved cab companies, 4 occurred at a skilled nursing facility (SNF), 1 involved a provider. Critical Incidents are high priority cases. Those occurring at SNFs are reported to the California Department of Public Health Licensing and Certification office in San Jose for investigation. SCFHP uses those findings to create a CAP depending on the State's findings.
  - Level 1 – 5, no CAP
  - Level 1A – 2, no CAP
  - Level 2 – 0, no CAPs
  - Level 3 – 3, 1 CAP (SNF)

- 3 out of 10 PQIs were substantiated for quality of care. The increase in Critical Incidents in 2019 was due to an increased awareness on the part of plan staff regarding what constitutes a critical incident.

G. Timely Access and Availability

Provider Availability Assessment

G.1 Introduction:

Santa Clara Family Health Plan measures at least annually its primary care providers, high volume specialists, high impact specialists, and behavioral health providers to ensure members have an adequate number of providers located in their area to meet their health care needs.

G.2 Objectives:

Santa Clara Family Health Plan (SCFHP) measures the ratio of providers to members and geographic time and distance from member's home to provider offices, and compares results to Santa Clara Family Health Plan standards. Primary Care Providers (PCP) are defined as General Practice, Family Practice and Internal Medicine.

G.3 SCFHP Contracted Providers

Table II: Specialists (ALL) – Open/Close

Provider Group	# of Providers	Total Open	% Open	% Closed
Direct Network Providers	218	194	89%	11%
Palo Alto Medical Foundation	437	424	97%	3%
Physicians Medical Group of SJ	270	261	97%	3%
Premier Care	78	75	96%	4%
Valley Health Plan	378	343	91%	9%
Stanford	714	711	99%	1%
*LPCH				
Total	2095	2008	96%	4%

Tables C I, II and/or III:

LPCH: *Lucille Packard Children's Hospital contractual agreement with SCFHP includes mostly pediatric specialists. In addition, SCFHP does no have a PCP contract with LPCH.*

Stanford: *Contractual agreement wit SCFHP includes Specialists only.*

Premier Care: *There are no BH provic*

Table II-A: High Volume Specialists – Open/Close

Provider Type	# of Providers	Open	% Open	% Closed
Cardiologist	134	131	98%	2%
Ophthalmology	89	88	99%	1%
Physical Therapy	42	42	100%	0%
Gynecology	187	157	84%	16%
Total	452	418	92%	8%

Table II-B: High Impact Specialist – Open/Close

High Impact Provider	# of Providers	Open	% Open	% Closed
Hematologist /Oncologist	73	73	100%	0%

Table III: Behavioral Health – Cal MediConnect (CMC) Open/Close

Provider Group	Psychiatrist	Open	Psychologist	Open	Addiction Medicine	Open	Family/Marriage Counseling	Open	Clinical Social Worker	Open	Total Providers	Total Open	% Open	% Closed
Independent Physicians	34	34	2	2	1	1	28	28	22	22	87	87	100%	0%
LPCH														
Stanford														
Valley Health Plan	44	44	2	2	2	2	0	0	1	1	49	49	100%	0%
Palo Alto Medical Foundation	8	7	0	0	0	0	0	0	0	0	8	7	88%	12%
Physicians Medical Group of San Jo	1	1	0	0	0	0	0	0	0	0	1	1	100%	0%
Premier Care														
Total	87	86	4	4	3	3	28	28	23	23	145	144	97%	3%

Table IV: High Volume Behavioral Health

High Volume Provider	# of Providers	Open	% Open	% Closed
Psychiatrist	87	86	99%	1%
Clinical Social Worker	23	23	100%	0%

D. MEASURE – PROVIDER TO MEMBER RATIOS

Table I: Primary Care Provider

Provider Type (PCP)	Measure	Standard	Performance Goal
Family Practice	Family Practice Provider to Member	1:2000	90%
General Practice	General Practice Provider to Member	1:2000	90%
Internal Medicine	Internal Medicine Provider to Member	1:2000	90%

Table II: High Volume Specialist (HVS) and/or High Impact Specialist (HIS)

Provider Type	Measure:	Standard	Performance Goal
Cardiology	Cardiology Provider to Member	1:1200	90%
Gynecology	Gynecology Provider to Member	1:1200	90%
Ophthalmology	Ophthalmology Provider to Member	1:1200	
Hematology/Oncology	Hematology/Oncology Provider to Member	1:1200	90%

Table III: Behavioral Health Provider

Provider Type	Measure:	Standard	Performance Goal
Psychiatrist	Psychiatrist Provider to Member	1:1200	90%
Licensed Clinical Social Worker (LCSW)	LCSW Provider to Member	1:1200	90%
Psychologist	Psychologist Provider to Member	1:1200	90%
Family/Marriage Counseling	Family/Marriage Counselor to Member	1:1200	90%
Addiction Medicine	Addiction Medicine to Member	1:1200	90%

E. MEASURE – GEOGRAPHIC DISTANCE

Table I: Primary Care Provider

Provider Type (PCP)	Measure: Miles or Minutes	Performance Goal
Family Practice	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%
General Practice	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%
Internal Medicine	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%
Geriatrics	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%

Table II: High Volume Specialist (HVS) and/or High Impact Specialist (HIS)

Provider Type	Measure: Miles or Minutes	Performance Goal
Cardiology	15 miles or 30 minutes	90%
Gynecology	15 miles or 30 minutes	90%
Ophthalmology	15 miles or 30 minutes	90%
Hematology/Oncology	15 miles or 30 minutes	90%

Table III: Behavioral Health Provider

Provider Type	Measure: Miles or Minutes	Performance Goal
Psychiatrist	15 miles or 30 minutes	90%
Licensed Clinical Social Worker (LCSW)	15 miles or 30 minutes	90%
Psychologist	15 miles or 30 minutes	90%
Family/Marriage Counseling	15 miles or 30 minutes	90%
Addiction Medicine	15 miles or 30 minutes	90%

E. MEASURE – GEOGRAPHIC DISTANCE

Table I: Primary Care Provider

Provider Type (PCP)	Measure: Miles or Minutes	Performance Goal
Family Practice	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%
General Practice	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%
Internal Medicine	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%
Geriatrics	One within 10 miles (DHCS) / 15 miles (DMHC) or 30 minutes	90%

Table II: High Volume Specialist (HVS) and/or High Impact Specialist (HIS)

Provider Type	Measure: Miles or Minutes	Performance Goal
Cardiology	15 miles or 30 minutes	90%
Gynecology	15 miles or 30 minutes	90%
Ophthalmology	15 miles or 30 minutes	90%
Hematology/Oncology	15 miles or 30 minutes	90%

Table III: Behavioral Health Provider

Provider Type	Measure: Miles or Minutes	Performance Goal
Psychiatrist	15 miles or 30 minutes	90%
Licensed Clinical Social Worker (LCSW)	15 miles or 30 minutes	90%
Psychologist	15 miles or 30 minutes	90%
Family/Marriage Counseling	15 miles or 30 minutes	90%
Addiction Medicine	15 miles or 30 minutes	90%

F. RESULTS: The results demonstrate the Provider network availability as of June 30, 2018.

Table I: PROVIDER TO MEMBER RATIOS

Provider Type	Provider-- Member	Measure	Standard	Goal	Met/Not Met
Primary Care Provider					
Family Practice	**218—7,503**	**1:34**	1:2000	90%	**Met**
General Practice	**15--7,503**	**1:500**	1:2000	90%	**Met**
Internal Medicine	**260—7,503**	**1:28**	1:2000	90%	**Met**
Geriatrics	**5--7,503**	**1:1500**	1:2000	90%	**Met**
High Volume Specialist					
Cardiology	**131—7,503**	**1:57**	1:1200	90%	**Met**
Gynecology	**138—7,503**	**1:54**	1:1200	90%	**Met**
Ophthalmology	**95--7503**	**1:78**	1:1200	90%	**Met**
High Impact Specialist					
Hematology--Oncology	**73—7,503**	**1:102**	1:1200	90%	**Met**
High Volume Behavioral Health Providers					
Psychiatrist	**87--7,503**	**1:86**	1:1200	90%	**Met**
Clinical Social Worker	**23--7,503**	**1:326**	1:1200	90%	**Met**

Table II: GEOGRAPHIC DISTANCE

Provider Type	Members with Access	Members without Access	Standard	Goal	Met/Not Met
Primary Care Provider					
Family Practice	7,503	0	10 miles/15 miles or 30 min	90%	Met
General Practice	7,503	0	10 miles/15 miles or 30 min	90%	Met
Internal Medicine	7,503	0	10 miles/15 miles or 30 min	90%	Met
Geriatrics	6,753	750	10 miles/15 miles or 30 min	90%	Not Met
High Volume Specialist					
Cardiology	7,503	0	15 miles or 30 min	90%	Met
Ophthalmology	7,503	0	15 miles or 30 min	90%	Met
Gynecology	7,503	0	15 miles or 30 min	90%	Met
High Impact Specialist					
Hematology--Oncology	7,503	0	15 miles or 30 min	90%	Met
High Volume Behavioral Health Providers					
Psychiatrist	7,503	0	15 miles or 30 min	90%	Met
Clinical Social Worker	7,203	300	15 miles or 30 min	90%	Not Met

G.4 Provider Availability Analysis

Santa Clara Family Health Plan (SCFHP) contracts with a large number of independent providers and provider groups. The provider open/close analysis demonstrates that the majority of providers are open to new patients.

Overall the analysis demonstrates that SCFHP standards for specialist availability are realistic for the communities and delivery system within Santa Clara County. The majority of the members dwell in an urban environment and a small fraction of the members reside in the cities of Gilroy, Morgan Hill and San Martin located in the south east area of Santa Clara County. Rural communities often face challenges maintaining an adequate provider network, making it difficult for health plans to meet geographic time or distance and provider to member ratios. A study of mental health shortages in California by the Office of Statewide Health Planning and Development (OSHPD) indicated mental health shortages across many rural areas of the state.

Recruitment challenges and provider shortages could be the root cause for the deficiencies shown in this analysis. SCFHP contracting will assess and monitor recruitment activities and contractual opportunities in the south east area of Santa Clara County and other areas of the county as necessary to ensure members have adequate access to health care providers. When necessary, SCFHP will re-direct members to out-of-network specialists and behavioral health providers to ensure timely access standards of care are met.

G.4 Opportunities

Barrier	Opportunity	Intervention	Selected for 2018	Date Initiated
Lack of providers: Clinical Social Work, Addiction Medicine and Geriatric Medicine	• Recruit new providers when available in rural areas – Southeast area of SCFHP's service area.	• Monitor counties for new providers especially in rural areas.	Yes	Ongoing
Long wait times for PT appointments in San Jose	• Investigate if the Plan needs to explore adding other PT Provider's to the network.	• Explore contracting opportunities in San Jose	Yes	TBD

Provider Accessibility Assessment

G.5 Introduction:

The purpose of the Santa Clara Family Health Plan's (SCFHP) provider accessibility analysis is to demonstrate how the Plan has monitored timely access regulations during Measurement Year (MY) 2019. SCFHP has a Plan-to-Plan arrangement for delivery of care with Valley Health Plan (VHP) and Kaiser and they conduct their own surveys; thus, this report does not include VHP or Kaiser Survey results. The providers and groups included in this survey are Direct (individually contracted providers), Palo Alto Medical Foundation (PAMF), Physician Medical Group (PMG) and Premier Care (PC).

G.6 Objective:

On an annual basis SCFHP conducts access surveys to assess compliance with access standards that are established by SCFHP, CMS, DMHC and DHCS. SCFHP monitors and reports on timely access to appointments for primary care, specialists, behavioral health and ancillary services to meet regulatory requirements for CMS, DMHC, DHCS and accreditation requirements for NCQA. In addition, the Plan also conducts an annual after-hours survey.

Primary Care Providers are defined as physicians, nurse practitioners, certified nurse midwifes, and physician assistants licensed in the areas of Family Medicine, General Medicine and Internal Medicine.

Provider Appointment and Availability Survey (PAAS) and After-Hours

G.7 Goal

To ensure that SCFHP and its network providers meet appointment access standards established by the DMHC and other regulatory agencies.

G.8 Objectives

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

G.9 Measures – Appointments and After-Hours Care

Provider Type	Urgent Appointment	Non-Urgent/ Routine Appointment	Non-Life Threatening Appointment	Follow-up Care	After-Hours Care
Family Practice	48 hours	10-days	NA	NA	24-hours / 7-days a week
General Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Internal Medicine	48 hours	10-days	NA	NA	24-hours / 7-days a week
Oncology (HIS)	96 hours	15-days	NA	NA	NA
Gynecology (HVS)	96 hours	15-days	NA	NA	NA
Cardiology (HVS)	96 hours	15-days	NA	NA	NA
Ophthalmology (HVS)	96 hours	15-days	NA	NA	NA
BH - Prescribers	48 hours	10-days	6-hours	30-days	NA
BH – Non-Prescribers	48 hours	10-days	6-hours	30-days	NA

G.10 Provider Appointment Availability Survey (PAAS) Results

Primary Care Providers

A. Standard: Urgent Care Appointment within 48-hours (PCP providers combined)

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=361)	199	90%	No	68%	+1

B. Standard: Urgent Care Appointment within 48-hours (PCP provider break down)

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

C. Standard: Non-Urgent/Routine Appointment within 10-days (PCP providers combined)

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=361)	218	90%	No	84%	-7

D. Standard: Non-Urgent/Routine Appointment within 10-days (PCP provider break down)

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

Although PAMF showed a decrease in performance on both measures in 2019, we should take into account that the group complied with their 2018 corrective action plan to increase provider participation in access surveys. It may also be worth noting that with a 29% (urgent) and 27% (non-urgent) participation increase, results only showed a 5 percentage point (urgent) and 8 percentage point (non-urgent) decrease in performance from 2018.

Through access surveys, it appears the requirement to schedule urgent appointments within a 48-hour timeframe continues to be a challenge for providers. However, it may be worth noting that several provider groups may have other providers in the office who are available within the required timeframe to serve patients; therefore, the survey's focus on the availability of a specific provider may not reflect the way patients experience care and it may not provide a comprehensive picture of the access SCFHP offers.

Specialists – High Volume/High Impact

A. Standard: Urgent Care Appointment within 96-hours (High Volume/Impact Specialists)

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

*Oncology – High Impact Specialist (HIS)
Note that all other provider types in Table II A are High Volume Specialists (HVS)

B. Standard: Non-Urgent/Routine Appointment within 15-days (High Volume/Impact Specialists)

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

*Oncology – High Impact Specialist (HIS)
Note that all other provider types in Table II A are High Volume Specialists (HVS)

As shown in Table A, the urgent appointment standard was not met across all provider types and with the exception of Oncology, Cardiology, Gynecology and Ophthalmology showed a decrease in performance from 2018. As shown in Table B, while Cardiology and Oncology did not met goal, there was a marked improvement from 2018. The table also shows that Gynecology and Ophthalmology did not meet goal and showed a decrease in performance from 2018.

While the results show that goals were not met for high volume/impact specialists, we need to consider the actual number of respondents to judge the outcome of the survey. It is worth noting that the CAHPS survey showed an increase in satisfaction from 2018 to "received appointment to see a specialist as soon as needed (Q29)" by 3.32 percentage points.

Behavioral Health Providers – High Volume/High Impact

A. Psychiatry (N=83) – Prescribers (High Volume Provider)

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

B. Psychology (N=32) – Non-Prescribers

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	No	20%	NA
Urgent Care within 48-hours	4	90%	No	25%	NA
Non-Life Threatening Emergency within 6-hours	3	90%	N0	0%	NA
Follow-up Routine Care within 30-days	2	90%	No	50%	NA

C. Non-Physician Mental Health (N=63) – Non-Prescribers

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	No	80%	NA
Urgent Care within 48-hours	5	90%	No	60%	NA
Non-Life Threatening Emergency within 6-hours	4	90%	N0	0%	NA
Follow-up Routine Care within 30-days	3	90%	No	67%	NA

D. Marriage/Family Therapy (N=20) – Non-Prescriber (High Volume Provider)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	8	90%	No	75%	NA
Urgent Care within 48-hours	8	90%	No	63%	NA
Non-Life Threatening Emergency within 6-hours	5	90%	N0	20%	NA
Follow-up Routine Care within 30-days	3	90%	No	67%	NA

SCFHP has identified that some of the barriers to meeting the goals were a lack of extended office hours, hours of operation not suiting the patient and providers not aware of appointment access standards. In 2018 and 2019 results showed that prescribing and non-prescribing behavioral health providers have challenges with meeting the "non-life threatening emergency appointment within 6 hours" standard. This measure is fairly new to SCFHP's network providers and further education will be necessary to ensure the BH network is aware of this access requirement.

Although, the Availability of Provider Network analysis did not show deficiencies with prescribing or non-prescribing provider types in terms of time/distance or with provider to member ratios, access is always an important metric in monitoring our providers.

It is also important to note that SCFHP partners with the County Behavioral Health Services Department (CBHSD). The CBHSD conducts behavioral health screenings and refers SCFHP members to the County Mental Health clinic or a Community Based Organization (CBO) for services. SCFHP members are assisted with care coordination by the SCFHP Behavioral Health (BH) social workers. Mild to moderate behavioral health cases could be referred by the county to SCFHP behavioral health provider network.

SCFHP will continue its efforts to expand the behavioral health network in 2019/2020.

After Hours Survey

G12. Goal

To ensure that SCFHP providers meet after-hours access and timeliness standards established by the DMHC and other regulatory and accreditation agencies.

G13. Objective

SCFHP requires providers to direct patients with a life-threatening emergency to hang up and dial 911 and messaging to state that a call back from the after-hours on call provider will occur within 30-minutes.

G14. After Hours Results

A: PCP Access Compliance: 911 Information

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

B. PCP Timeliness Compliance: 30-minutes or less

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

Table A shows the rate of compliance at 82%; a decrease in performance by 10 percentage points from 2018. Table B shows the rate of compliance at 54%; an increase in performance by 2 percentage points from 2018. Although after-hours performance goals were not met, results showed an increase in compliance relevant to timeliness in 2019.

C. Behavioral Health (BH) Access Compliance: 911 Information

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

D. Behavioral Health (BH)Timeliness Compliance: 30-minutes or less

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

Although after-hours performance goals were not met, results showed an increase in compliance relevant to timeliness in 2019. Following survey results from 2018, provider outreach was conducted which may have contributed to performance improvements in 2019.

G.15 After-Hours Analysis

The after-hours results for access (911 information) showed the following rate of compliance for each group of providers: Direct (N=31) at 52%, Palo Alto Medical Foundation (N=282) at 79%, Physicians Medical Group (N=118) at 95%, and Premier (N=22) at 95%. It appears that Direct providers will require further education on after-hours messaging to ensure they instruct patients to call 911 or go to the emergency room in the event they are experiencing an emergency.

SCFHP conducted a further review on Palo Alto Medical Foundation after-hours access and found that one phone number which represents 46 PCP providers was deemed non-compliant – this phone number did not have the 911 message, but rather a menu where the patient would select which clinic to be transferred to. SCFHP was able to validate that once the patient is transferred to the clinic phone number, it had the appropriate 911 message. PAMF was contacted to advise them that they would need to include 911 messaging on the main number, and they agreed to update the message. It is worth noting that following the updated PAMF message, the overall rate of compliance for PCP providers is at 93%; 3 percentage points above goal.

The after-hours results for timeliness (call backs within 30-minutes) showed the following rate of compliance for each group of providers: Direct (N=31) at 48%, Palo Alto Medical Foundation (N=282) at 49%, Physicians Medical Group (N=118) at 65%, and Premier (N=22) at 68%. While the overall performance rating on timeliness fell short of goal, further data analysis revealed that members receive timely after-hours care through SCFHP 24/7 Nurse Line at no cost to members.

Regarding the 911 results, there were a total of 263 Direct providers and/or groups on the contact list of which 80% were compliant. PAMF had a total of 33 providers and/or groups on the contact list of which 85% were compliant. Non-compliant providers/groups in 2019 were issued a CAP and provider outreach will be conducted by the PNM department.

Regarding timeliness compliance (call back within 30-min), PAMF showed the highest non-compliant rate at 69%, followed by PMG at 20%. Following distribution of CAP notices to non-compliant BH providers, some providers contacted the Plan to learn more about this specific after-hours requirement.

Provider education should be a focus point to ensure provider after-hours messaging states that a return call will be made to the patient within 30-minutes.

Provider Satisfaction Survey

G.16 Introduction

Santa Clara Family Health Plan (SCFHP) contracted with Center for the Study of Services (CSS) to administer the Measurement Year (MY) 2019 Provider Satisfaction Survey (PSS). The following groups/delegates serve SCFHP members: Direct (independent providers), Palo Alto Medical Foundation (PAMF), Physicians Medical Group (PMG) and Premier Care. All direct providers and groups were targeted to participate in the provider satisfaction survey. In addition, SCFHP has a plan to plan agreement with Kaiser and Valley Health Plan to serve members; however, they administer their own annual provider satisfaction surveys and issue assessment reports directly to the regulators.

This report summarizes the 2019 Provider Satisfaction Survey (PSS) methodology and the results for SCFHP.

G.17 Goals

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

G.18 Objectives:

• Measure provider experience (satisfaction) at least annually.
• Evaluate provider's satisfaction with performance measures.
• Identify any areas for improving contracted provider's experience with the health plan.

• Develop interventions as appropriate to address gaps in service.

G.19 Performance 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)

G.20 Survey Updates - MY2018 vs MY2019

SCFHP followed DMHC's updated guidelines to include interpreter questions on the Provider Satisfaction Survey in MY2019. Due to this change, there is no comparison data from the previous year and some questions from the MY2018 were not included in the MY2019 survey within the following categories: Utilization Management, Customer Service and Provider Relations.
To ensure results are accurately presented, results as shown in the assessment and in the comparison chart did 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.

Note: SCFHP uses one survey instrument to conduct the survey and a full census approach, which includes providers from delegated groups. SCFHP acknowledges that to some extent the survey instrument may not be designed to capture quantifiable measures and/or reach conclusions. For example, delegated provider groups process their own claims for the Medi-Cal line of business. Therefore, it is possible that some providers from delegated groups will rate satisfaction on claims processing and appeals that do not involve SCFHP operations.

G.21 Rate of Response

Table I: Responses by IPA/Medical Group

Group	# Surveyed	Response #	Rate (%)
Direct	1890	97	5%
PAMF	476	20	4%
PMG	388	138	36%
PC	614	24	39%
Total	2820	284	10 %

Table II: Response by Provider Type

Group	# Surveyed	Response #	Rate (%)
PCP	401	108	27%
SPC	2169	145	7%
BH	250	31	12%
Total	2820	284	10%

G.22 Rate of Response – 2 year comparison

Chart I: Responses by IPA/Medical Group Affiliation

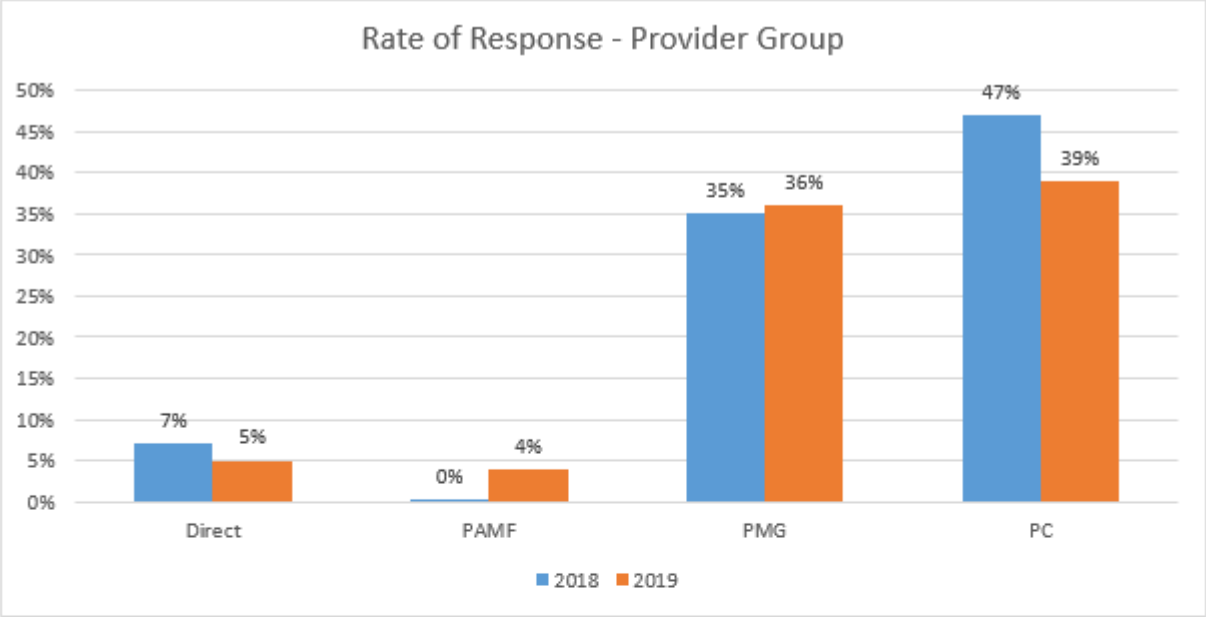
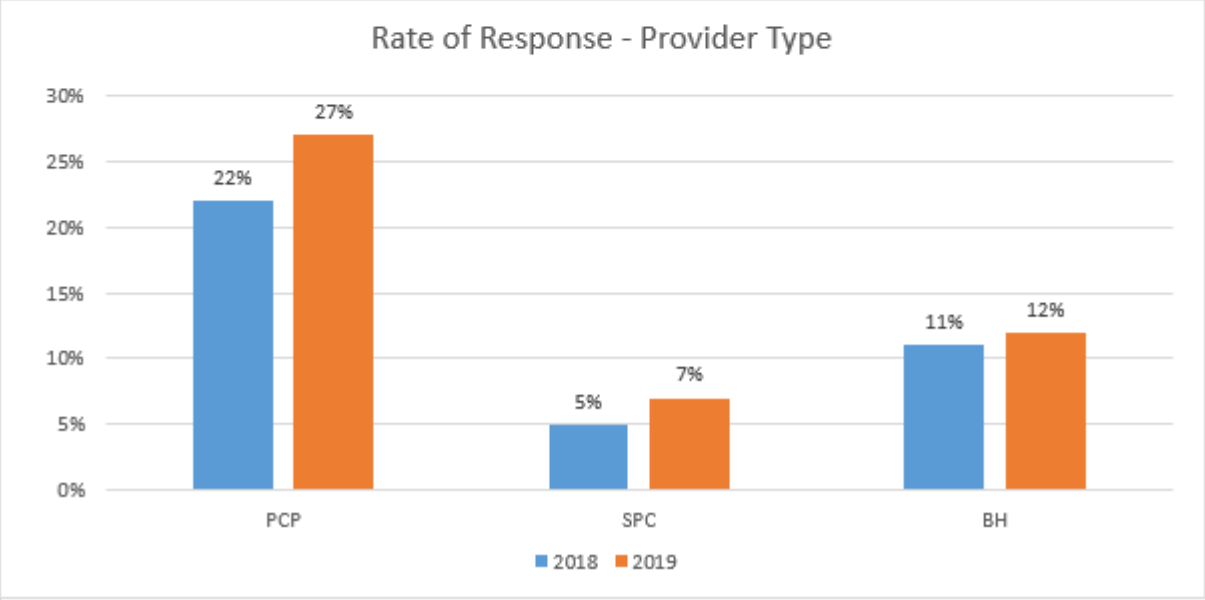


Chart II: Responses by Provider Type



Analysis: Charts I and II – With the exception of Direct provider groups, response rates in 2019 showed an increase across 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%.

G.23 Overall Provider Satisfaction

Chart I: Overall Satisfaction by Provider Type – MY2019

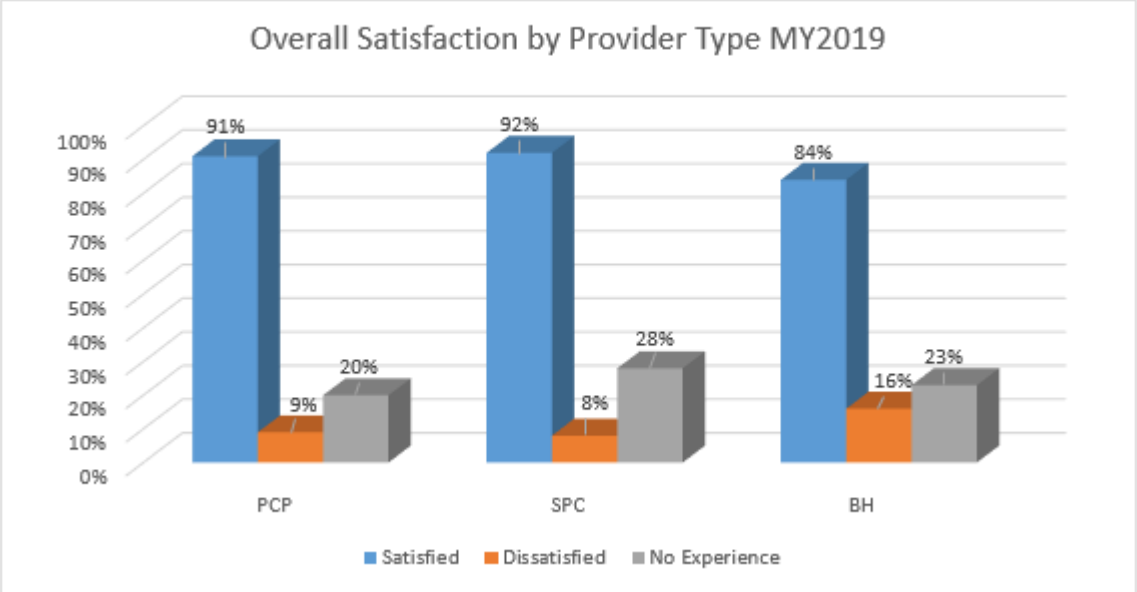
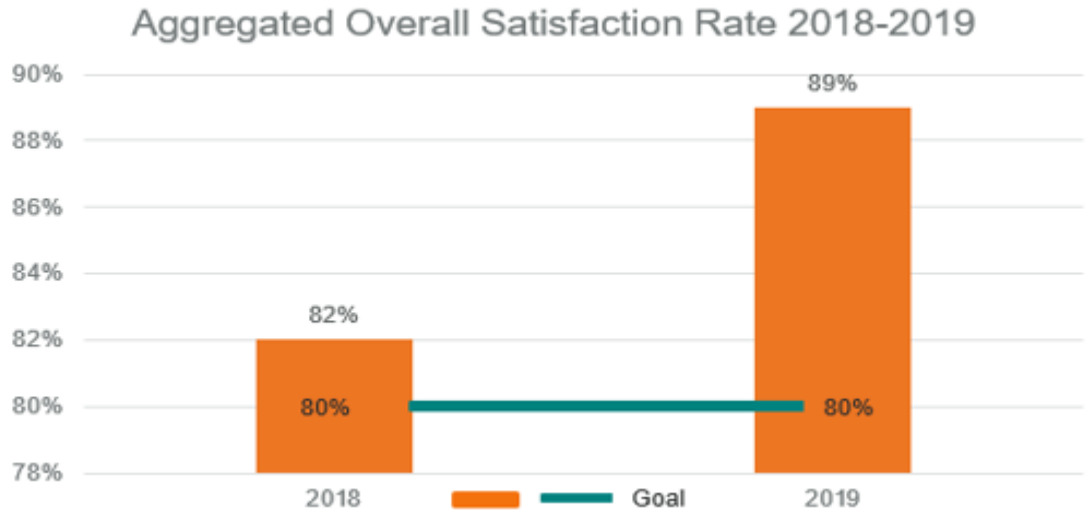


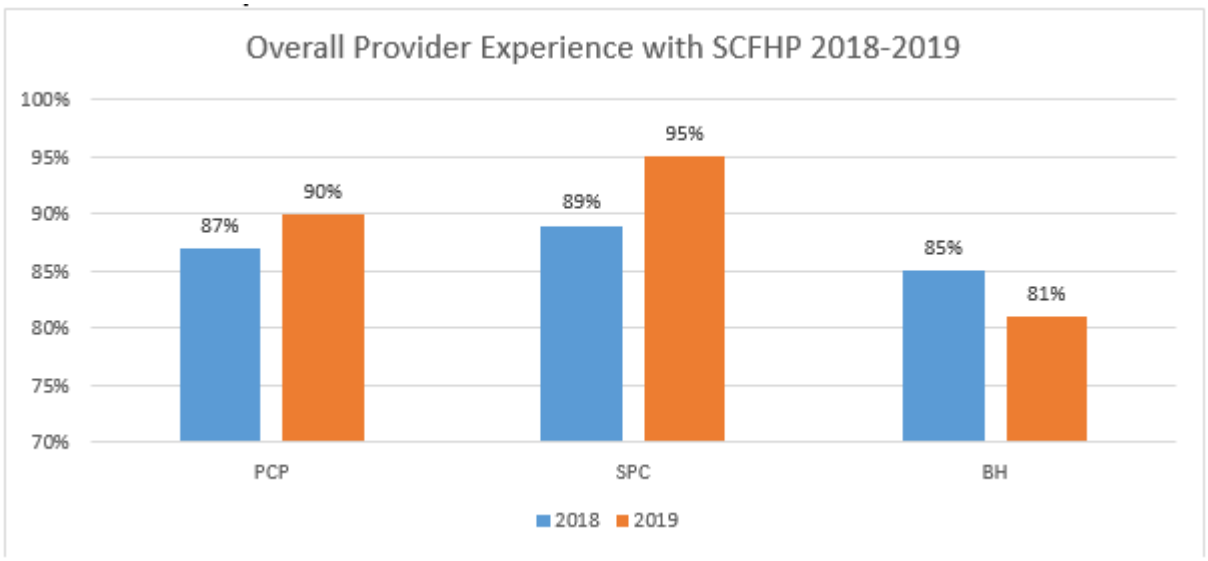
Chart II: Overall Satisfaction Rate 2018-2019



Analysis (Chart I): Specialists providers rated satisfaction the highest at 92%, followed by PCP's at 91% and Behavioral Health (BH) providers at 84%.

Analysis (Chart II): 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.

G.28 Provider Satisfaction Assessment



The total number of providers that answered Q9a = 217 (76%). Provider Satisfaction with overall experience with SCFHP increased across all provider types by 4percentage points in 2019. Overall provider experience with SCFHP rated at 89%, dissatisfaction at 11%, and 4% responded with "not applicable/no experience".

Table I: Overall Satisfaction by Primary Care Providers **Survey Q: 1-8**

Category	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Utilization Management	80%	Yes	93%	7%	+8	12%
Utilization Management Appeals	80%	Yes	84%	16%	+4	28%
Claims	80%	Yes	86%	14%	+3	39%
Claims Appeals	80%	Yes	84%	16%	+9	28%
Timely Access	80%	Yes	92%	8%	+5	16%
Customer Service	80%	Yes	96%	4%	+7	15%
Provider Relations	80%	Yes	97%	3%	+6	13%
Provider Network	80%	Yes	87%	13%	+11	11%
*SCFHP's Language Assistance Program	100%	No	99%	1%	NA	37%

The raw data report showed that PCP satisfaction on availability of behavioral health providers (Q7c) had the highest level of dissatisfaction at 73%. As referenced in the 2018 provider availability analysis, a study of mental health shortages in California by the Office of Statewide Health Planning and Development (OSHPD) indicated mental health shortages across many rural areas of the state. Additionally, according to data from the California Employment Development Department, demand for mental health and substance abuse social workers, and substance abuse and behavioral disorder counselors shortages has grown by 22.8 percent in the past 2 years. It was also noted that there are known provider shortages and recruitment challenges with behavioral health providers in the northeast and southeast areas of Santa Clara County, which are within rural communities. It is also worth noting that PCP satisfaction with access to BH providers increased by 17 percentage points in 2019; which in part contributes to SCFHP's efforts to expand its BH network by adding 9 ABA groups, 4 LMFT's, and 2 Psychologists in 2018/2019. As a continued effort to

ensure members have timely access to network providers, SCFHP will monitor provider recruitment activities and seek out providers who become available to join SCFHP's network.

Table II: Overall Satisfaction by Specialist Providers **Survey Q: 1-8**

Category	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Utilization Management	80%	Yes	92%	9%	+1	11%
Utilization Management Appeals	80%	Yes	82%	18%	+7	34%
Claims	80%	Yes	87%	13%	+8	20%
Claims Appeals	80%	Yes	87%	13%	+9	35%
Timely Access	80%	Yes	95%	5%	+8	49%
Customer Service	80%	Yes	93%	7%	+5	6%
Provider Relations	80%	Yes	94%	6%	+6	5%
Provider Network	80%	Yes	95%	5%	+9	22%
*SCFHP's Language Assistance Program	100%	No	90%	10%	NA	70%

The raw data reports showed that 22 specialist types responded to the 2019 survey. SCFHP is very pleased that all measures showed marked improvements from 2018. With the exception of SCFHP's Language Assistance Program, which fell short of goal by 10 percentage points, all measures exceeded the goal. The raw data showed that Direct Cardiology providers and PMG Dermatology rated all measures relevant to the language assistance program (Q8a-c) the lowest. As shown in Table II, specialist rated satisfaction the lowest on utilization management appeals-82%, claims-87% and claims appeals-87%. Although the goal was met in these areas, a further assessment was conducted to identify trends - the raw data showed that there were two specialist provider types (Oncology, Otolaryngology) that were the least satisfied with measures Q2a-c (claims processing, claims inquiries and dispute process), and the providers were from PMG, Premier and Direct (individually contracted). The raw data showed that there were two specialist provider types (OBGYN, Otolaryngology) that were the least satisfied with measure Q3a (timeliness/efficiency of UM appeals), and the providers were from PMG and Direct (individually contracted). The raw data also showed that there were two specialist provider types (OBGYN, Otolaryngology) that were the least satisfied with measure Q3b (timeliness/efficiency of claims appeals), and the providers were from PMG and Direct (individually contracted). These results indicate that a review of utilization appeals, claims processing and claims appeals on the provider types/groups listed above may help identify potential issues. SCFHP staff will collaborate internally, and if operational issues are identified, a correction plan will be established.

Table III: Overall Satisfaction by Behavioral Health Providers **Survey Q: 1-8**

Category	Goal	Goal Met	Very Satisfied/ Satisfied	Very Dissatisfied/ Dissatisfied	Change PY	Not Applicable/No Experience
Utilization Management	80%	Yes	89%	11%	+1	11%
Utilization Management Appeals	80%	No	47%	53%	-3	55%
Claims	80%	No	70%	30%	-4	24%
Claims Appeals	80%	No	44%	56%	-9	58%
Timely Access	80%	Yes	92%	8%	+3	35%
Customer Service	80%	Yes	89%	11%	+5	11%
Provider Relations	80%	Yes	88%	12%	+6	8%
Provider Network	80%	No	78%	22%	-3	11%
*SCFHP's Language Assistance Program	100%	Yes	100%	0	NA	34%

The raw data reports showed that 6 BH provider types responded to the 2019 survey. Compared to PCP's and specialists, the behavioral health providers had a much lower number of participation in the survey, likely due to circumstances where several BH providers manage their own schedules between patients, coupled with non-standard office hours. Of the 6 BH provider types that participated in the survey, it appears that psychiatry and LCSW providers consistently rated satisfaction below goal. SCFHP staff will collaborate internally, and if operational issues are identified, a correction plan will be established.

G.24 Conclusion:

While the 2019 provider satisfaction survey revealed improvements and strengths in most areas of operations, a review in the following areas may be warranted:

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

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

H.1 Goal:

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

H.2 Interventions:

- The Plan sent 2 reminder post cards and 6 phone calls to members regarding the importance of completing the CAHPS survey and providing the plan with feedback.
- The Plan published articles regarding CAHPS in both provider and member newsletters.
- The Plan included an oversample of 800 members (1600 total) to help improve the CAHPS response rate.
- The Plan implemented the official CAHPS surveys in Chinese and Vietnamese to increase response rate.
- The Plan worked with DSS Research to break down results by provider group.
- The Plan shared results with provider advisor committee and quality improvement committee and delegated groups.
- The Plan shared results with internal cross-functional workgroups, including Provider Network Management.
- The Plan worked with Customer Service to integrate CAHPS survey language in to existing call scripts to ensure members' needs are being met when they call SCFHP.

H.3 Results

- In 2019, the Plan response rate was 28.8 %, which is a 2.7% increase over prior year. Overall California response rate was 27.9%.
- Category results did not indicate a significant improvement in any category, however, moderate improvements were made in the following areas:
    - Getting Needed Care

- Getting Appointments and Care Quickly
- Customer Service
- Overall Rating of Health Plan

- The Plan had the highest increase year/year in the Overall Rating of Health Care Quality, improving from 8.4 in 2018 to 8.5 in 2019. This exceeded the CA MMP mean score and met the National MMP mean score.
- The Plan exceed the California MMP average in the following questions within the categories:
  - In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
  - In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?
  - In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
  - In the last 6 months, how often was it easy to use your prescription drug plan to fill prescriptions by mail?
  - Influenza Vaccination
  - Pneumonia Shot
  - Do you have serious difficulty walking or climbing stairs? (% saying no)*
  - Do you have difficulty dressing or bathing? (% saying no)*
  - Do you ever use the internet at home? (% saying yes)*

    *(THESE ARE STAND ALONE QUESTIONS)
- The Plan's scores decreased from 2018 in the following areas:
  - Getting Needed Prescription Drugs
  - Rating of Personal Doctor
  - Customer Service
  - Rating of Drug Plan

H.4 Analysis of Findings/Barriers/Progress

- The health plan response rate increased in 2019, leveling the 2017 rate at 29%.
- The plan successfully implemented 2 new languages (Chinese and Vietnamese) survey. The survey rate increased in 2019 and will continue to use this opportunity to improve response rate.
- Through the increase in responses, the Plan was able to obtain more actionable data.
- The interventions between year two and year three identified specific opportunities for improvement in Health Plan Composite Measures and Overall Health Plan rankings.
- Results were broken down by provider group for the first time in 2018 and added more provider groups in 2019. Held meetings with provider network management to develop strategies to share with provider group representatives.
- Continue to work with SPH Analytics, who has acquired DSS Research. Evaluate and leverage the new portal available for data analytics.

I. Appeals and Grievances

SCFHP

I.1 Goal:

Increase member satisfaction by addressing member grievances within mandated timelines.

I.2 Intervention:

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

I.3 Results:

- 2019 showed an improved compliance rate of 97.0% for standard grievances and appeals resolved in the mandated time frames, this was an improvement of over 1.05% from the prior year's rate of 95.95%.
- The lowest performing metric was related to expedited grievances and appeals where the compliance rate dipped over multiple quarters in 2019.

I.4 Analysis of Findings/Barriers/Progress

- Low number of Grievance and Appeals staff compared to the overall volume of cases received has presented a barrier
- Staff turnover also presented a barrier throughout the year
- Three staff members were hired in Q1 and Q2 2019 to address staffing deficiency
- A new grievance and appeals processing platform was introduced in 2019. The platform contains new monitoring reports that were developed and refined in late 2019 to flag potential untimely cases.

QI Program Effectiveness

The 2019 Quality Improvement (QI) Program was effective in demonstrating improvements in both the clinical and service areas for Medi-Cal, Healthy Kids and Cal MediConnect members. The Program resources, which include staffing, committee structure, external and internal practitioner participation, along with the plan's leadership, proved to be sufficient in meeting the QI Program's goals and objectives.

Santa Clara Family Health Plan™

Quality Improvement

Work Plan 2020

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Care	**QI Program Evaluation**	QI Program Annual Evaluation	CMC 2.16.3.3.4 NCQA 2018 QI1 Elements A and B	- To evaluate the results of QI initiatives and submit the results to DHCS and CMT - QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	- collect aggregate data on utilization - review of quality services rendered - review and analyze outcomes/findings from Improvement Projects, customer satisfaction surveys and collaborative initiatives - trending of measures to assess performance in the quality and safety of clinical care and quality of service - analysis and evaluation of the overall effectiveness of the QI Program and of its progress toward influencing network-wide safe clinical practices	- submission of QI Program evaluation to - QIC - Board	Annual Evaluation	QI Manager	Annually	May 2020		Approved by QIC: Adopted by Board:
Member Experience	**NCQA Health Plan Accreditation**	SCFHP provides members with the information they need to understand and use their pharmacy benefit.	NCQA 2020 ME 5 - Pharmacy Benefit Information	Ensure pharmacy benefit information provided to members on an ongoing basis is accurate	- The Pharmacy Department and Customer Service will collect data and review for accuracy and ensure quality of information being provided to members	- Annually the Pharmacy Department will report -data collection - assessment -actions	100%	Pharmacy Manager and Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Member Experience	**NCQA Health Plan Accreditation**	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2020 ME 6 - Personalized Information on Health Plan Services	Ensure members can use personalized information to navigate health plan services effectively	- The Customer Service Department will collect data on the quality and accuracy provided, compare information against goals, and determine deficiencies in delivery of information act to improve deficiencies identified	- Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions to improve data	100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Member Experience	**NCQA Health Plan Accreditation**	SCFHP provides members with the information they need to easily understand and use health plan benefits	NCQA 2020 - ME 6 Element D	Ensure quality and timely email communication to members is happening on an ongoing basis	- The Customer Service Department will collect data email responses to members is happening on an ongoing basis in a timely manner	Annually the Customer Service Department will report data collection, analysis, deficiencies, and actions of email responses to members	100%	Customer Service Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Member Experience	**NCQA Health Plan Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element A	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- SCFHP assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.	Analysis of cultural, ethnic, racial and linguistic needs of it's members relative to the provider network	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Service	**NCQA Health Plan Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element B	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioner providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care.	Analyze performance against primary care availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Service	**NCQA Health Plan Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element C	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists. 2. Establishes measurable standards for the number of each type of high-volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measurable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually.	Analyze performance against specialists (including high volume and high impact) availability standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Service	**NCQA Health Plan Accreditation**	SCFHP maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network	NCQA 2020 NET 1 Element D	SCFHP maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership.	- Evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against the standards annually	Analysis of behavioral health care practitioners access standards	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Service	**NCQA Health Plan Accreditation**	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services	NCQA 2020 NET 2 Elements A-C	SCFHP establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services.	Collect and perform analysis of data for primary care, specialty, and behavioral health 1. Regular and routine care appointments. 2. Urgent care appointments. 3. After-hours care	Analysis and report	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Service	**NCQA Health Plan Accreditation**	SCFHP monitors access to healthcare services and takes action to improve it	NCQA 2020 NET3 Elements A-C	SCFHP provides members adequate network access for needed healthcare services.	- SCFHP annually: 1. Analyzes data from member experience, complaints and appeals about network adequacy for non-behavioral healthcare, behavioral, and overall services 2. Analyzes data from member experience, complaints and appeals about network adequacy for behavioral healthcare services, behavioral, and overall services 3. Compiles and analyzes requests for and utilization of out-of-network services. 4. Prioritizes opportunities for improvement identified, 5. implements intervention 6. measure effectiveness of interventions	Annual report	100%	Provider Network Access Program Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Health Plan Accreditation**	SCFHP systematically collects, integrates and assesses member data to inform its population health management programs	NCQA 2020 PHM 2 Element B	SCFHP assesses the needs of its population and determines actionable categories for appropriate intervention.	- SCFHP annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members. 4. Assesses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental illness (SPMI)	Annual report	N/A	Health Educator	Annually	First quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Member Experience	**NCQA Health Plan Accreditation**	SCFHP has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement	NCQA 2020 PHM 6 Element A	- Quantitative results for relevant clinical, cost/utilization and experience measures -Comparison of results with a benchmark or goal. -Interpretation of results	-collect data on relevant cost, utilization and experience measures	Annual report	100%	Case Management Manager	Annually	First quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Member Experience	**NCQA Health Plan Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2020 ME 7 Elements C-D	To assess member experience with its services, the organization annually evaluates member complaints and appeals and member survey data (i.e. CAHPS), and identified opportunities for improvement	Collect valid measurement data for each of the following categories -quality of care -access -attitude and service -billing and financial issues -quality of practitioner office site Analyze and identify opportunities for improvement from the following sources -Member complaint and appeal data	Annual report	100%	Director, Grievance and Appeals Operations	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Member Experience	**NCQA Health Plan Accreditation**	SCFHP implements mechanisms to assess and improve member experience	NCQA 2020 ME 7 Elements E-F	Assess member experience with Behavioral Health services Evaluate and identify opportunities for improvement	-Evaluate member complaints and appeals --conduct member survey -Improve members experience with behavioral healthcare and service --Assess data from complaints and appeals or from member experience surveys --Identifying opportunities for improvement --implementing interventions --measuring effectiveness of interventions	Annual report	100%	Behavioral Health Manager	Annually	Fourth quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Care	**QI Program**	Development of a QI Work Plan and Evaluation each year and subsequent tracking of implementation	CMC 2.16.1 Medi-Cal Exhibit A, Attachment 4 .7	- To document and initiate appropriate modifications to the QI Program, and set QI goals each year. - To identify areas of focus for the QI program. - To organize and prioritize the workload with assignments given for accountability and responsibility	QI Program and QI Work Plan will be adopted on an annual basis	Submit the 2019 QI Evaluation and 2020 QI Work Plan for the Board Report	Annual Adoption	QI Manager	Annually	May 2020		Approved by QIC: Adopted by Board:
Quality and Safety of Clinical Care	**NCQA Health Plan Accreditation**	SCFHP monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network.	NCQA 2020 QI 3 Elements A-C	SCFHP annually identifies opportunities to improve coordination of medical care, act on opportunities identified, measuring effectiveness of improvement actions taken	A. Collect 1. Collect data on member movement between practitioners 2. Collect data on member movement across settings 3. Conduct quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting four opportunities for improvement B. Act Annually act to improve coordination of care activities identified in the Collect phase C. Measure Annually measure the effectiveness of improvement actions taken in the Act phase	Quantitative and qualitative analysis with identification of four opportunities for improvement documented in a report	100%	Health Services Director	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**UM Program**	Annual oversight of UM Program and Work Plan	CMC 2.11.5.1	- To document and initiate appropriate modifications to the UM Program, and set UM goals each year. - To identify areas of focus for the UM program. - To organize and prioritize the workload with assignments given for accountability and responsibility	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	- submission of UM Program evaluation to - UMC - QIC - Board	Annual Adoption	Medical Director UM	Annually	September 2020		Approved by QIC: Adopted by Board:
Quality of Service	**CAHPS**	Annual Oversight of CAHPS Survey and Work Plan		Complete annual survey, analyze results, identify opportunities for improvement and implement interventions	Develop improvement plans and other interventions based on results	Areas for improvement identified in the CAHPS 2020 survey	Annual recommendation	Process Improvement Manager or Designee	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Service	**HOS**	Annual Oversight of HOS Survey and Work Plan		Complete annual survey, analyze results, identify opportunities for improvement and implement interventions	Develop improvement plans and other interventions based on results	Areas for improvement identified in the HOS survey	Annual recommendation	Process Improvement Manager or Designee	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Quality of Service	**NCQA Plan Ratings**	Annual Oversight of NCQA Plan Ratings and Work plan		Analyze Results	Develop Improvement Plans based on results	Areas for improvement identified in results	Annua recommendation	Process Improvement Manager or Designee	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:
Timely Access	**Access/Availability**	Access to needed medical services in a timely manner is maintained	CMC 2.11.9.1		Measure and analyze data against goals for the following: 1. Regular & routine appointments within 30 days 2. Urgent Care appointments within 48 hours 3. After-hours care within 6 hours 4. Member services, by telephone ASA 30 seconds with abandonment rate <5% 5. PCP capacity		97%	Provider Services Director or Designee	Quarterly	February 2020 April 2020 Aug 2020 Dec 2020		Approved by QIC: Adopted by Board:

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews New applicants processed within 180 calendar days of receipt of application		100%	Provider Services Director or Designee	Quarterly	February 2020 April 2020 Aug 2020 Dec 2020		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews Recredentialing is processed within 36 months		100%	Provider Services Director or Designee	Quarterly	February 2020 April 2020 Aug 2020 Dec 2020		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practitioners	CMC 2.11.2.1		Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.		90%	Provider Services Director or Designee	Annually	August 2020		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practitioners	CMC 2.11.2.1		Measure and analyze practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary. Measured through quantifiable and measurable standards for the following: 1. Each type of PCP 2. Geographic distribution 3. Performance against standards for PCPs 4. Performance against geographic distribution		90%	Provider Services Director or Designee	Annually	August 2020		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**Case Management**	CM Program Annual Evaluation			CM Program and CM Work Plan will be evaluated for effectiveness on an annual basis		Annual Evaluation	CM Manager	Annually	June 2020		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**HEDIS Reporting**	Report HEDIS successfully by 6/15/2020	CMC 2.19.2.5 Medi-Cal Exhibit A Attachment 4.9	- To successfully report HEDIS for Medi-Cal and CMC by June 15, 2020 - To successfully complete MRRV without a second sample being reviewed - Successfully close the IS Grid by 6/1/2020 - ≤4 Medi-Cal HEDIS 2020 measures below the Medicaid Minimum Performance Level -CMC Composite HEDIS 2020 Average at 60%	- Create data warehouse - pull samples - request medical records - onsite audit - review of vendor numerator positive medical records prior to MRRV	Submission of the IDSS to NCQA by 6/15/2020	Annual Submission	HEDIS Project Manager	Annually	June 2020		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Statewide Disparity Performance Improvement Projects**	Increase rate of adolescent well care visits	CMC 2.16.4.3.1.2.2 Medi-Cal Exhibit A, Attachment 4.9.C.b	5.8% percent increase in adolescent well care rate over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement and use member incentive to improve rates		5.8% increase over baseline rate of 16.7% for Network 20	Process Improvement Project Manager	Quarterly			Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Statewide Child and Adolescent Performance Improvement Projects**	Increase rate of well child visits for children turning 15 months	Medi-Cal Exhibit A, Attachment 4.9.C.b	26.43% increase in W15 rate over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement and use member incentive to improve rates		26.43% increase over basline rate of 35.11% for Network 50	Process Improvement Project Manager	Quarterly			

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Clinical Care	**Internal Performance Improvement Projects Medi-Cal**	Comprehensive Diabetes Care - Poor Control	Medi-Cal Exhibit A Attachment 4.9.C.a	5% decrease in CDC-Poor Control rate over the life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement		By December 31, 2020, decrease by 5% from basline rate of 46.04%	Process Improvement Project Manager	Annually			
Quality of Service	**Internal Performance Improvement Projects CMC**	Increase number of members with an ICP and discussion of care goals	CMC 2.16.4.3.1.2.1	Increase the percentage of members with an ICP completed and percentage of members with documented discussion of care goals	- Plan will further develop and implement new processes and training materials to improve consistency of documentation within SCFHP's case management software program	Annual Submission	By December 31st 2020, increase by 5% from baseline in all three submeasures	Health Services Director	Annually	December 31st, 2020		
Quality of Clinical Care	**Chronic Clinical Performance Improvement Projects CMC**	Target Chronic Condition: Behavorial Health Condition - Mental Illness	CMC	Increase the number of follow up visits for members with a discharge from the Emergency Department with a diagnosis of mental illness	Plan will develop and implement a 3 year project to increase the precentage of discharges for members 6 years of age and older who were hopsitalzied for treametnet of selected mental illness or intentional self-harm diagnosis and who had a follow up visit with a metnal health practiioner within 30 days of discharge.	Annual Submission	By December 31, 2021, increase measure rate from 43.18 % to 53.18%.	Behavioral Health Manager and Process Improvement Project Manager	Annually	December 31, 2019 December 31, 2020 December 31, 2021		
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Cervical Cancer Screening (CCS)	DHCS 2020 Managed Care Accountibility Set	Increase the number of SCFHP women who have a screening exam for cervical cancer	- Develop and implement interventions based on a barrier analysis for CCS	successful implementation of intervention and evaluation of interventions effectiveness	-increase cervical cancer screening rates over the Medicaid 50th percentile (60.65%) - 61.07% HEDIS 2019	QI Manager or designee	Quarterly	October 2021		
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Childhood Immunization Status (CIS) – Combination 3	DHCS 2020 Managed Care Accountibility Set	Increase the number of SCFHP children who are compliant for their immunizations through Combo 10	- Develop and implement interventions based on a barrier analysis for CIS Combo 10	successful implementation of intervention and evaluation of interventions effectiveness	- Increase CIS Combo 10 rate over the Medicaid 50th Percentile (34.79%) - 49.39% HEDIS 2019	QI Manager or designee	Quarterly	October 2021		
Quality of Clinical Care	**Project: Diabetes**	HEDIS Measure: Comprehensive Diabetes Care (CDC) - HbA1c Testing	DHCS 2020 Managed Care Accountibility Set	Increase the number of SCFHP members with diabetes who have an HbA1c screening annually	- Develop and implement interventions based on a barrier analysis for CDC HbA1c Testing - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase CDC - HbA1c testing rate over Medicaid 50th percentile (88.55%) - 89.78% HEDIS 2019	QI Manager or designee	Quarterly	October 2021		
Quality of Clinical Care	**Project: Cardiovascular Conditions**	HEDIS Measure: Controlling High Blood Pressure (CBP)	DHCS 2020 Managed Care Accountibility Set	Increase the number of SCFHP members with hypertension who have their blood pressure below 140/90	- Develop and implement interventions based on a barrier analysis for CBP - work with network providers to develop an organized system of regular follow up and review of patients with hypertension - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase blood pressure control for members with hypertension over the Medicaid 50th percentile (61.04%) -56.93% HEDIS 2019	QI Manager or designee	Quarterly	October 2021		

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Clinical Care	**Project: Access & Availability of Care**	HEDIS Measure: Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	DHCS 2020 Managed Care Accountibility Set	Increase the number of SCFHP members who get timely prenatal care	- Develop and implement interventions based on a barrier analysis for PPC - Timely Prenatal Care - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase PPC Timeliness of Prenatal Care over the Medicaid 50th Percentile (83.76%) -86.86% HEDIS 2019	QI Manager or designee	Quarterly	October 2021		
Quality of Clinical Care	**Project: Utilization**	HEDIS Measure: Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	DHCS 2020 Managed Care Accountibility Set	Increase the number of SCFHP members who get their annual well child visit	- Develop and implement interventions based on a barrier analysis for W34 - Annual reminder letters for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase W34 rate over the Medicaid 90th Percentile (83.85%) - 76.16% HEDIS 2019	QI Manager or designee	Quarterly	October 2021		
Quality of Service	**Project: 120 Initial Health Assessment**	Initial Health Assessment and Staying Health Assessment	Exhibit A, Attachment 10.3	Ensure new enrollees to SCFHP receive an IHA within 120 calendar days of enrollment and HIF/MET within 90 days of the effective enrollment	- develop a reporting system that monitors the IHA and HIF/MET compliance across the plan - integrate medical record review for a sample of IHA visits each quarter as part of Facility Site Review - Provider training on IHA requirements - IHA Work Plan will be evaluated for effectiveness on an annual basis	- develop regular reporting mechanism to monitor ongoing performance - medical record audit of IHA visits and document compliance - training attestations	- Medicaid rate 80%	QI Manager or designee	Quarterly	December 2020		
Health Plan Accreditation	**NCQA Accreditation**	NCQA Accreditation of the CMC line of business	CMC	Maintain accreditation status for CMC line of business	- Ensure all business units are completing required activities, analyses and interventions per the annual NCQA work plan	- all required evidence collected for 2020 by December 31, 2020	Maintain accreditation	Process Improvement Manager	Annually	12/31/2020	Yes	The Plan achieved full accredidation on February 22, 2019. Will be going for reaccreditation in January 2022.
Safety of Clinical Care	**Facility Site Review**	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices		Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	- Review every 3 years as part of the Credentialing process - Review all new potential PCP offices prior to contracting - Provide follow/up and ongoing monitoring of timely correction of Critical Element (CE) deficiencies and Corrective Action Plan as mandated by DHCS guidelines. - Continue the collaborative process with the County's MCMC Commercial Plan	- successful submission of FSR scores on a semi annual basis		QI Nurse	Ongoing	Ongoing - Monthly	N/A	

2020 Quality Improvement Work Plan

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Safety of Clinical Care	**Quality of Care**	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	DPL 15-002	Complete all PQI's originating from Grievance and Appeals within 60 days	- update PQI policy - Roll out retraining of Medical Management and Member Services Staff - develop methodology for retrospective review of call notes to identify PQI's - ongoing reporting of PPC's to DHCS	- revised PQI policy - training materials used	90% of PQIs closed within 60 days	QI Nurse	Ongoing	Ongoing - Monthly	N/A	
Quality and Safety of Clinical Care	**NCQA Health Plan Accreditation**	SCFHP collaborates with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare.	NCQA 2020 QI 4 Elements A-C	SCFHP collaborates with behavioral healthcare practitioners and uses information at its disposal to coordinate medical care and behavioral healthcare.	SCFHP annually collects data about opportunities for collaboration between medical care and behavioral healthcare and conducts activtiies to improve coodiation, including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identify and selecting two opportunities for improvement, implement interventions and measure the effectiveness of the interventions.	Aggregate available data	100%	Behavioral Health Manager	Annually	Third quarter Quality Improvement Committee		Approved by QIC: Adopted by Board:

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

Date

Santa Clara Family Health Plan™

Assessment of Member Cultural and Linguistic Needs and Preferences Cal MediConnect

Prepared by: Carmen Switzer, Provider Network Access Manager

For review and approval by the Quality Improvement Committee

April 8, 2020

Introduction

Santa Clara Family Health Plan collects data on the cultural and linguistic needs and preferences of its membership and the availability of providers in the network with these same characteristics to determine the adequacy of the provider network to meet the needs of its members.

SCFHP is committed to provide language services at no cost and equal access to services for members with hearing or language related needs. Oral Interpreters, signers, bilingual providers are available at all key points of contact.

This report includes a data analysis for Cal-MediConnect and is exclusive to its members/enrollees.

Member and Provider Language Assessment

Member Language Assessment N=8428

Language	Member Count	% of Members Speak the Language	PY Change
English	2873	35%	5% ⇩
Spanish	1724	20%	1% ⇧
Vietnamese	1369	16%	3% ⇧
Chinese	1198	14%	2% ⇧
Other	1264	15%	0%

Top 3 - Most common non-English languages spoken by CMC Members:

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

- Table shows the total number of members who speak English and the top 3 most common non-English languages spoken by CMC members.

Member and Provider Language Assessment

Provider Language Assessment

Provider Type	# of Providers	Spanish	Vietnamese	Chinese
PCP	479	70	62	49
Specialist	1571	208	64	132
Behavioral Health	106	13	9	7

- Table shows the number of PCP's, Specialists and Behavioral Health providers who speak the top 3 languages spoken by CMC members.

Member and Provider Language Assessment

Provider to Member Ratios & Provider Percentages (Top 3 Languages) – *slides 5-8*

PCP, Specialists, Behavioral Health (ALL)

		Spanish (Member N=1724)			Vietnamese (Member N=1369)			Chinese (Member N=1198)		
Provider Type	**Provider Count**	**Providers-Spanish**	**% of Providers**	**Provider to Member Ratio**	**Providers-Vietnamese**	**% of Providers**	**Provider to Member Ratio**	**Providers-Chinese**	**% of Providers**	**Provider to Member Ratio**
PCP	479	70	15%	1:25	62	13%	1:22	49	10%	1:24
Specialists	1571	208	13%	1:8	64	4%	1:21	132	8%	1:9
Behavioral Health	106	13	12%	1:132	9	8%	1:152	7	7%	1:171

- Table shows the number and percentage of providers who speak the top 3 languages spoken by our CMC members.
- Provider to member ratios are also noted in the table.

Member and Provider Language Assessment

Primary Care Providers

		Spanish (Member N=1724)			Vietnamese (Member N=1369)			Chinese (Member N=1198)		
Provider Type	Provider Count	Providers-Spanish	% of Providers	Provider to Member Ratio	Providers-Vietnamese	% of Providers	Provider to Member Ratio	Providers-Chinese	% of Providers	Provider to Member Ratio
Family Practice	214	44	21%	1:39	25	12%	1:55	26	12%	1:46
General Practice	16	1	6%	1:1724	6	38%	1:228	1	6%	1:1198
Internal Medicine	249	25	10%	1:69	31	12%	1:44	22	9%	1:54

- Table shows the number and percentage of providers who speak the top 3 languages spoken by our CMC members.
- Provider to member ratios are also noted in the table.

Member and Provider Language Assessment

Santa Clara Family Health Plan

Specialists – High Volume/Impact

		Spanish (Member N=1724)			Vietnamese (Member N=1369)			Chinese (Member N=1198)		
Provider Type	**Provider Count**	**Providers-Spanish**	**% of Providers**	**Provider to Member Ratio**	**Providers-Vietnamese**	**% of Providers**	**Provider to Member Ratio**	**Providers-Chinese**	**% of Providers**	**Provider to Member Ratio**
Cardiology	95	11	10%	1:156	6	4%	1:228	5	3%	1:239
Ophthalmology	86	18	21%	1:95	11	13%	1:124	16	19%	1:75
Gynecology	176	45	26%	1:38	8	5%	1:171	14	8%	1:86
Hematology/Oncology	86	9	10%	1:191	6	7%	1:228	11	13%	1:108

- Table shows the number and percentage of High Volume/Impact Specialists who speak the top 3 languages spoken by our CMC members.
- Provider to member ratios are also noted in the table.

Member and Provider Language Assessment

Behavioral Health Providers

		Spanish (Member N=1724)			Vietnamese (Member N=1369)			Chinese (Member N=1198)		
Provider Type	Provider Count	Providers-Spanish	% of Providers	Provider to Member Ratio	Providers-Vietnamese	% of Providers	Provider to Member Ratio	Providers-Chinese	% of Providers	Provider to Member Ratio
Psychiatrist	88	4	5%	1:431	4	5%	1:342	5	6%	1:239
Clinical Social Worker	38	11	29%	1:156	5	13%	1:274	2	5%	1:599
Family & Marriage Therapy	35	7	20%	1:246	0	0%	0:0	3	9%	1:399

- Table shows the number and percentage of Behavioral Health providers who speak the top 3 languages spoken by our CMC members.
- Provider to member ratios are also noted in the table.

Member Translation Requests

Language Line Requests – Top 3 Languages

Language	Total Requests	Total Duration	% of Requests
Spanish (N=1724)	3562	571hrs, 40min	37%
Vietnamese (N=1369)	2766	488hrs, 46min	24%
Chinese (N=1198)	3140	551hrs, 37min	27%

- Table shows the number and percentage of members who requested language line assistance.

Member Translation Requests

Member Face to Face Requests

Translation Type	Total Request	Total Duration	% of Requests
Sign Language (N=13)	48	39hrs, 31min	56%
Spanish (N=1724)	4	4hrs, 25min	5%
Vietnamese (N=1369)	4	3hrs, 25min	5%
Chinese (N=1198)	20	21hrs, 11min	24%

- Table shows the number and percentage of members who requested face to face translation assistance.

Member Grievances

Service Type	Language	Description	Quarter
Language Line	Spanish	Member was dissatisfied with the quality of skills by the interpreter on the language line.	Q1
Language Line	Russian	Member was dissatisfied with the quality of skills by the interpreter on the language line.	Q2
SCFHP Customer Service	Spanish	Member reported that there were extended wait times to access a Spanish speaking Customer Service representative.	Q4
American Sign Language	Sign	Member was dissatisfied with the quality of skills by the interpreter who provided sign language assistance.	Q4

- Q1 & Q2 (2-complaints) - Language line complaints were reported to the Quality Cultural and Linguistics team who reported the incidents to the language line vendor. The language line vendor assured that the complaints would be addressed with their staff and will continue to work on improving the quality of interpretation services.
- Q4 (1-complaint)The CS director reported that the department is in the process of hiring additional Spanish-speaking team members.
- Q4 (1-complaint) Complaint was reported to the vendors Manager of Client Relations who assured that additional training and coaching will be provided to their ASL staff.

Data Collection: January-December 2019

Conclusion:

- Santa Clara Family Health Plan **(**SCFHP) serves a highly diverse membership.
- Assessment study showed that –
    - ❑ Fifty three percent (53%) of Santa Clara County citizens are speakers of a non-English language, which is higher than the national average of 22%.
    - ❑ Most common non-English language spoken in Santa Clara County is Spanish at 19%, and the next two most common languages are Chinese at 9% and Vietnamese at 7%.
- Eighty eight percent (88%) of interpreter services requests were Spanish, Vietnamese and Chinese.
- Bi-lingual providers and interpreter services (free of cost) are available to members when needed, which concludes that member needs are being met overall.

Santa Clara Family Health Plan will continue to evaluate the needs of its members to ensure they receive care and services in their preferred language.

Santa Clara Family Health Plan will also continue to seek contracts with providers who have diverse backgrounds and language skills to meet the needs of its members.

Study Data Source: Data USA

Santa Clara Family Health Plan™

Review of Quality Improvement Policies

QI.03 Distribution of QI Information,

QI.04 Peer Review Process**,**

QI.06 QI Study Design/Performance Improvement Program Reporting,

QI.08 Cultural & Linguistically Competent Services,

QI.09 Health Education Program and Delivery System,

QI.11 Member Non-Monetary Incentives,

QI.12 Screening, Brief Intervention, and Referral to Treatment (BIRT) for Misuse of Alcohol,

QI.16 Managed Long Term Services and Support Care Coodination, &

QI.28 Health Homes Program

POLICY

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

I. Purpose

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

II. Policy

A. At least annually, SCFHP Communicates Quality Improvement (QI) program information to practitioners, providers, and members. Information about QI program processes, goals, and outcomes are shared, as they relate to member care and services, in language that is easy to understand.

B. The Plan may distribute information through regular mail, e-mail, fax, the Web or mobile devices. If posted on the Web, practitioners, providers, and members will be notified of the posting and given the opportunity to request the information by mail.

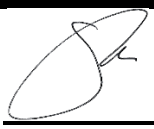
III. Responsibilities

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

IV. References

NCQA, 2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 04/10/2019	Title 04/10/2019
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 05/10/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Review	Quality Improvement		

POLICY

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

I. Purpose

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

II. Policy

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

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

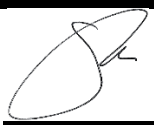
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 04/10/2019	Title 04/10/2019
Date	Date

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V1	Original	Quality Improvement	Approve 05/10/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Review	Quality Improvement		

POLICY

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

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

IV. References

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

The National Committee for Quality Assurance (NCQA), 2018 NCQA HEDIS Specifications, 2018

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 04/10/2019	Title 04/10/2019
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 05/10/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Review	Quality Improvement		

POLICY

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

I. Purpose

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

II. Policy

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

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

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

III. Responsibilities

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

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

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

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, DO
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Quality Improvement Committee	Approved 6/6/18		

POLICY

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

I. Purpose

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

II. Policy

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

A. The Health Education Program will provide classes and/or materials free of charge to beneficiaries including, but not limited to, the following topics:

a. Nutrition
b. Healthy weight maintenance and physical activity
c. Individual and group counseling and support services
d. Parenting
e. Smoking and tobacco use cessation
f. Alcohol and drug use
g. Injury prevention
h. Prevention of sexually transmitted diseases, HIV, and unintended pregnancy
i. Chronic disease management, including asthma, diabetes, and hypertension
j. Pregnancy care

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

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

I. Responsibilities

The Quality Department and Health Educator will do the following:

A. Ensure all programs and services are provided at no cost to members.
B. Ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for members and effective in achieving behavioral change for improved health.
C. Ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.
D. Maintain a program that provides educational interventions addressing the topics listed above.
E. Ensure that members receive point of service education as part of preventive and primary health care visits. Health Education shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for members.
F. Maintain policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and monitor the performance of providers that are contracted to deliver health education services to ensure effectiveness.
G. Periodically review the health education program to ensure appropriate allocation of health education resources and maintain documentation that demonstrates effective implementation of the health education requirements.
H. Ensure online self-management tools are useful and up-to-date and meet the language, vision, and hearing needs of members.

II. References

• Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with the California Department of Health Care Services and Santa Clara County Health Authority.
• NCQA 2020 Health Plan Accreditation Requirements PHM 4A-K (Wellness and Prevention), PHM 1B (Informing Members)

III. Approval/Revision History

First Level Approval	Second Level Approval
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, DO
Name Director of Quality and Process Improvement	Name Chief Medical Officer
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V2	Revised	Quality Improvement Committee	Approve 06/06/18	

POLICY

Policy Title:	**Member Non-Monetary Incentives**	**Policy No.:**	QI.11
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☐ CMC

I. Purpose

To establish guidelines for the administration of rewarding members who demonstrate effort and success in adopting health-promoting behaviors.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) may utilize non-monetary incentives to reward members who demonstrate effort and success in adopting health-promoting behaviors or changing health risk behaviors.
B. SCFHP obtains approval by DHCS prior to offering any type of member incentive for a member incentive (MI) program, focus group, or survey.
C. SCFHP will submit annual updates to justify the continuation of an ongoing member incentive (MI) program and an end of program evaluation to describe whether or not the MI program was successful.
D. For Focus Group Incentives (FGIs), SCFHP submits an evaluation that includes recruitment, participation methodology, and results summary. The FGI evaluation will also indicate if policy and program changes are warranted. For Survey Incentives, SCFHP will submit a copy of the survey, along with an evaluation that includes finding and recommendations.
E. No member incentives are offered to CMC members (Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72).

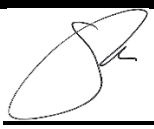
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 04/10/2019	Title 04/10/2019
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 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Review	Quality Improvement		

POLICY

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

I. Purpose

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

II. Policy

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

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

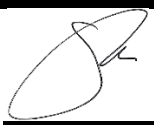
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 04/10/2019	Title 04/10/2019
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 11/09/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Review	Quality Improvement		

POLICY

Policy Title:	**Long Term Services and Supports (LTSS) Care Coordination**	**Policy No.:**	QI.16
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

This policy defines how SCFHP shall provide and manage Long Term Services and Supports (LTSS) so that its members receive coordinated care across a continuum of benefits and services that includes medical, behavioral health, LTSS and community resources.

The Plan promotes coordination of LTSS services with the goal of achieving optimal well-being and functionality at the least restrictive level of care most beneficial to individual members.

II. Policy

A. SCFHP shall maintain an LTSS program that coordinates and monitors access, availability, and continuity for Long Term Services and Supports (LTSS) for members. SCFHP, in partnership with members, providers, advocates and other community stakeholders shall support a person-driven long-term continuum of care where members with disabilities and chronic conditions have choice and access to an array of quality services. LTSS shall provide an alternative to institutional placement and be available to members who meet eligibility criteria.

B. SCFHP maintains LTSS Program procedures as well as Case Management and Utilization Management procedures that apply.

<u>LTSS Program Procedures include:</u>

1. LTSS Coordination of Services
2. In-Home Supportive Services Referrals and Coordination Community Based Adult Services (CBAS): Eligibility/Determination and Coordination, Referrals
3. Multipurpose Senior Services Program (MSSP) Referrals and Coordination
4. LTC Case Management and Care Transitions
5. Care Plan Options and Home and Community Services (HCBS) Coordination

III. Responsibilities

SCFHP Health Services integrates LTSS with internal departments to inform and identify members receiving or requesting LTSS, to coordinate services and to meet the following requirements:

A. Support coordinated care delivered by an appropriate network of providers

B. Support a comprehensive initial and annual health assessment of each member's physical, behavioral, psychosocial, functional and social support needs;

C. Support and participate in a members' interdisciplinary Care Team (ICT), as appropriate;

D. Facilitate the development of an individual care plan in consultation with the member that identifies goals, interventions, services and benefits to be provided

IV. References

NCQA 2019 Health Plan Accreditation Standards Population Health Management
APL 17-012 Care Coordination Requirements for Managed Long Term Services and Supports
APL 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities
DPL 15-001 Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
DPL 16-002 Continuity of Care
DPL 16-003 Discharge Planning for Cal MediConnect
DPL 17-001 Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect

V. Approval/Revision History

First Level Approval	Second Level Approval
 Signature Lori Andersen	 Signature Laurie Nakahira, D.O.
Name Director, Long Term Services and Support	Name Chief Medical Officer
Title 06/12/2019	Title 06/12/2019
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 08/05/2016	
V1	Reviewed	Quality Improvement	Approve 08/08/2017	
V2	Revised	Quality Improvement	Approve 02/13/2018	
V3	Revised	Quality Improvement	Approve 05/23/2019	
V3	Review	Quality Improvement		

POLICY

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

I. Purpose

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

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

II. Policy

A. SCFHP will be responsible for the overall administration of the HHP. SCFHP will have oversight of the CB-CMEs and their performance. CB-CMEs will provide all members with access to the same level of HHP service, in accordance with the tier/risk grouping that is appropriate for members' needs and HHP service requirements. SCFHP will perform regular auditing and monitoring activities to ensure that all HHP services are delivered according to the contract signed by the selected CB-CMEs and SCFHP. SCFHP will select and assess the readiness of community organizations to serve as CB-CMEs. Selected entities will need to provide all core services of the HHP, including:
   1. Comprehensive Care Management
   2. Care Coordination
   3. Health Promotion
   4. Comprehensive Transitional Care
   5. Individual and Family Support Services
   6. Referral to Community and Social Supports
   7. Housing Navigation

III. Responsibilities

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

B. SCFHP members are assigned to CB-CMEs based on the following factors:
   1. PCP Assignment
   2. Geographic Location of the Member

3. Behavioral Health Needs
4. CB-CME's Experience with Certain Populations (homelessness, Language, Demographic, etc.)

C. SCFHP will utilize Model 1
   1. CB-CMEs contracted for HHP embeds care coordinators on-site in the community provider offices
      i. CB-CMEs will employ staff that meet the care coordination ration of 1:60 over two years

D. Delegation will occur when applicable
   1. Delegated entity will use Model I or Model II
   2. Delegated entity will oversee Health Home responsibilities with their subcontracted CB-CMEs
      i. Delegated entity and their CB-CMEs will follow the same HHP policies and procedures set forth by SCFHP
      ii. To ensure consistency among all CB-CMEs under SCFHP and delegated entities, SCFHP will approve all CB-CME sites and contracts
   3. Delegated entity will be responsible for capturing data and reporting on the measures for each CB-CME they subcontract with.
   4. Delegated entity will be responsible for meeting all reporting deadlines set forth by SCFHP

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

F. Ensure that the CM-CME have the capacity to provide assigned HHP members with a multi-disciplinary care team.
   1. This is completed through site reviews prior to the initial launch date of HHP and during quarterly auditing reviews.

G. SCFHP will provide outreach to provider networks and hospital systems to strengthen multi-disciplinary participation from non-participating CB-CMEs
   1. Site visits, marketing materials, and ongoing informational webinars will be utilized to disseminate information (See Outreach Procedure)

H. Share information with CB-CMEs to assist with identifying patients and providing HHP services; data sharing agreements will be established with selected CB-CMEs and SCFHP:
   1. SCFHP will notify CB-CME of inpatient admissions and ED visits/discharges
   2. SCFHP will share each member's health history with assigned CB-CMEs
   3. Data will be exchanged between CB-CME and SCFHP to better track CMS-required quality measures and state-specific measures, including health status and outcomes data for the DHCS evaluation process.

I. Identify, review, and prioritize HHP eligible members by tier/risk grouping and assign members to CB-CMEs
   1. Identify members through the DHVS-provided Targeted Engagement List (TEL), internal TEL, and member/provider referrals
   2. Group members according to a tier structure, which should correlate with the member's risk grouping and intensity of services needed

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

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

L. Develop and administer payment structure for CB-CMEs
   1. Payment structure may consider the payments received from DHCS, member's tier/risk grouping and any other supplemental funding

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

CM-CME Responsibilities

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

B. Complete a readiness assessment as developed by SCFHP

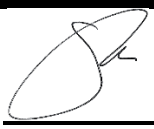
1. If services are insufficient, CB-CME will work with SCFHP to fulfill the readiness gaps to enrolling members

C. Ensure that providers with experience servicing frequent utilizers of health services and those experiencing homelessness, are available as needed per AB 361 requirements
D. Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
E. Ensure assigned HHP members receive access to HHP services including completing a patient-centered health action plan (HAP) within 90 days of enrollment
F. Maintain a strong and direct connection to the PCP and ensure PCP's participation in HAP development and ongoing coordination
G. Assess the HHP member's physical, behavioral, substance use, palliative, trauma-informed care, and social services need using screenings and assessments with standardized tools
H. Maintain a multi-disciplinary care team to provide the 7 core services
I. CB-CME will utilize assigned member lists provided by SCFHP to complete outreach and enrollment
J. Ensure needs are met based on the member's HAP and the tiered structure outlined by SCFHP
K. Utilize existing health information technology (HIT) to collect and share data to SCFHP
    1. If CB-CME does not have adequate technology, CB-CME will work with SCFHP to determine how information will be shared for HHP services and reporting purposes
L. CB-CME will attend required trainings for the HHP

IV. References

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

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 04/10/2019	Title 04/10/2019
Date	Date

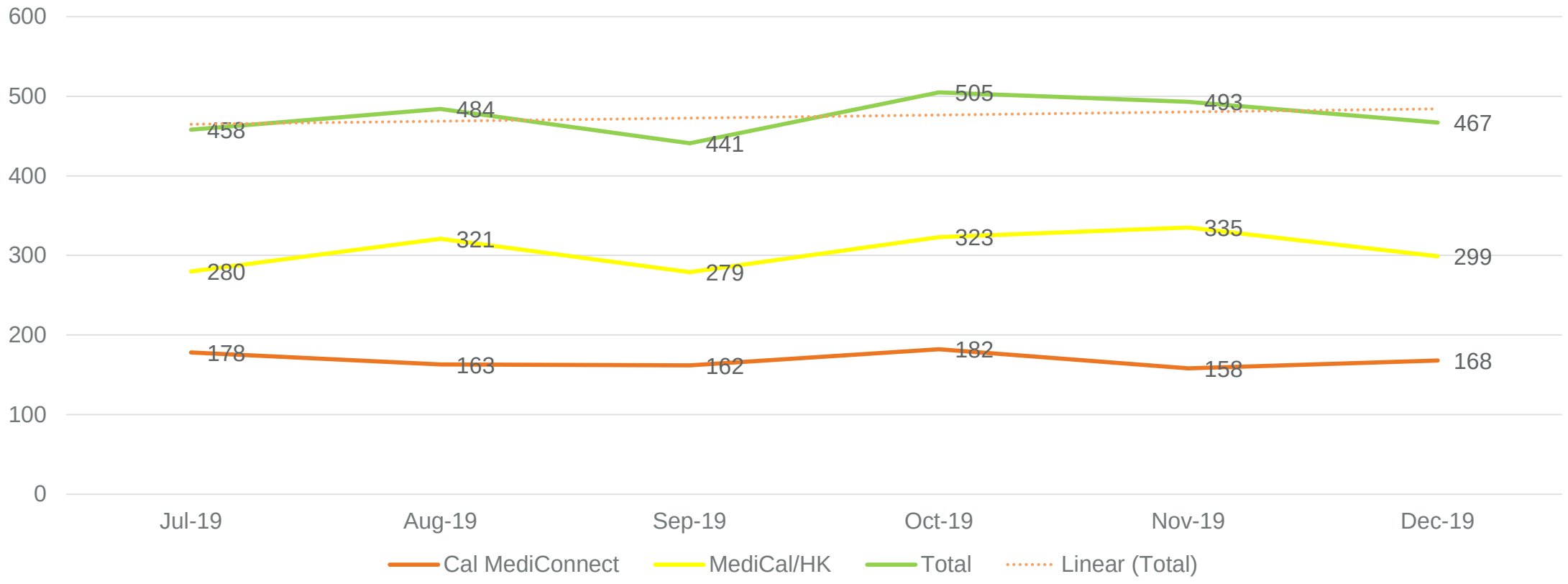
Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 02/13/2019	
V1	Reviewed	Quality Improvement	Approve 04/10/2019	
V1	Review	Quality Improvement		

Santa Clara Family Health Plan™

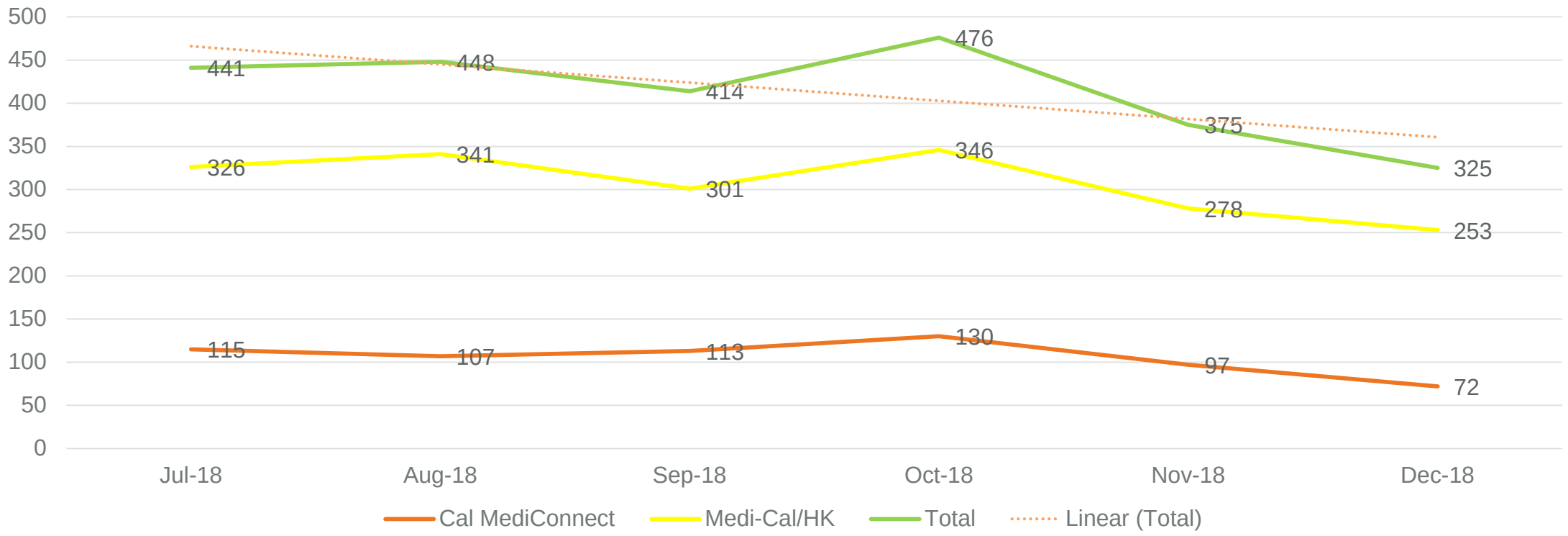
Grievance and Appeals Workgroup

Q3/Q4 2019 Review

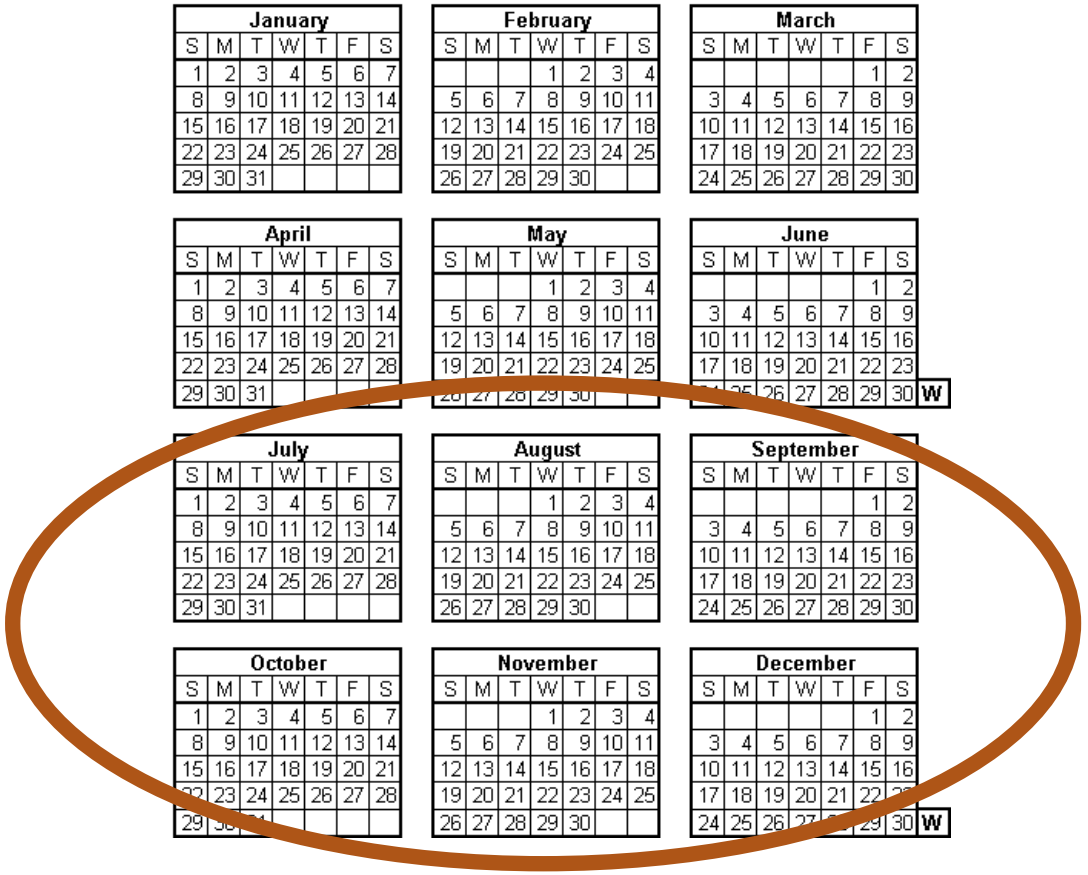
Q3/Q4 2019 Total Cases Received



Q3/Q4 2018 Total Cases Received



Medi-Cal & Healthy Kids



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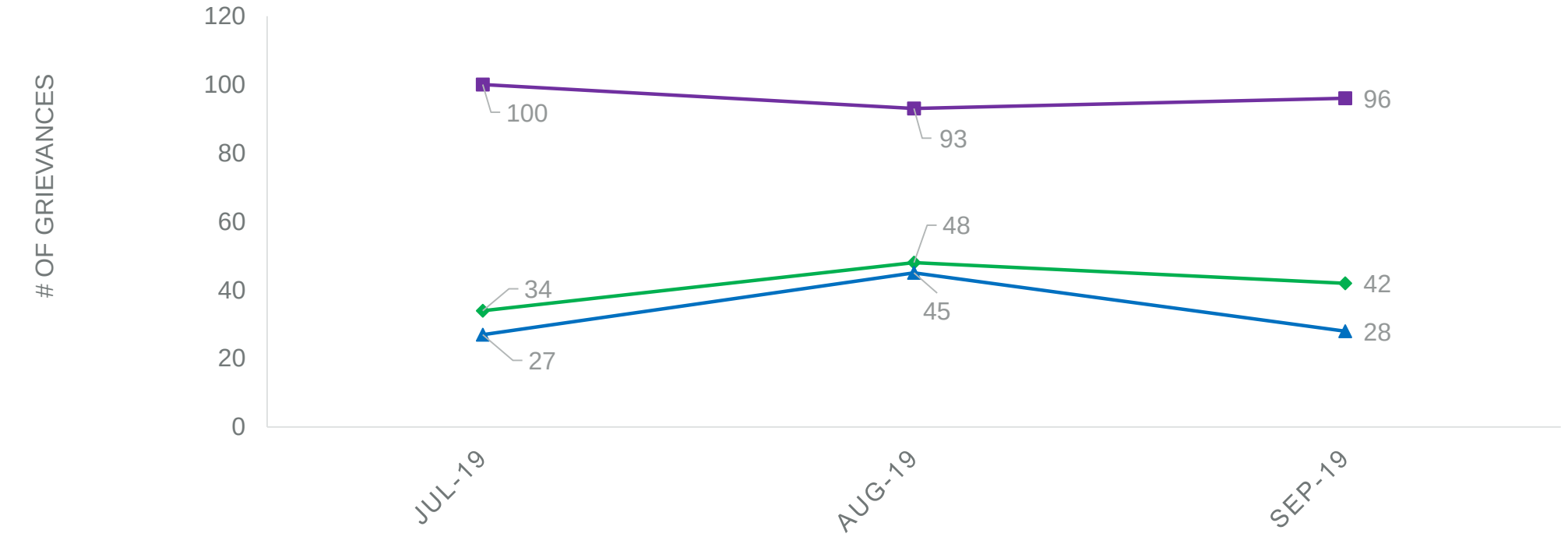
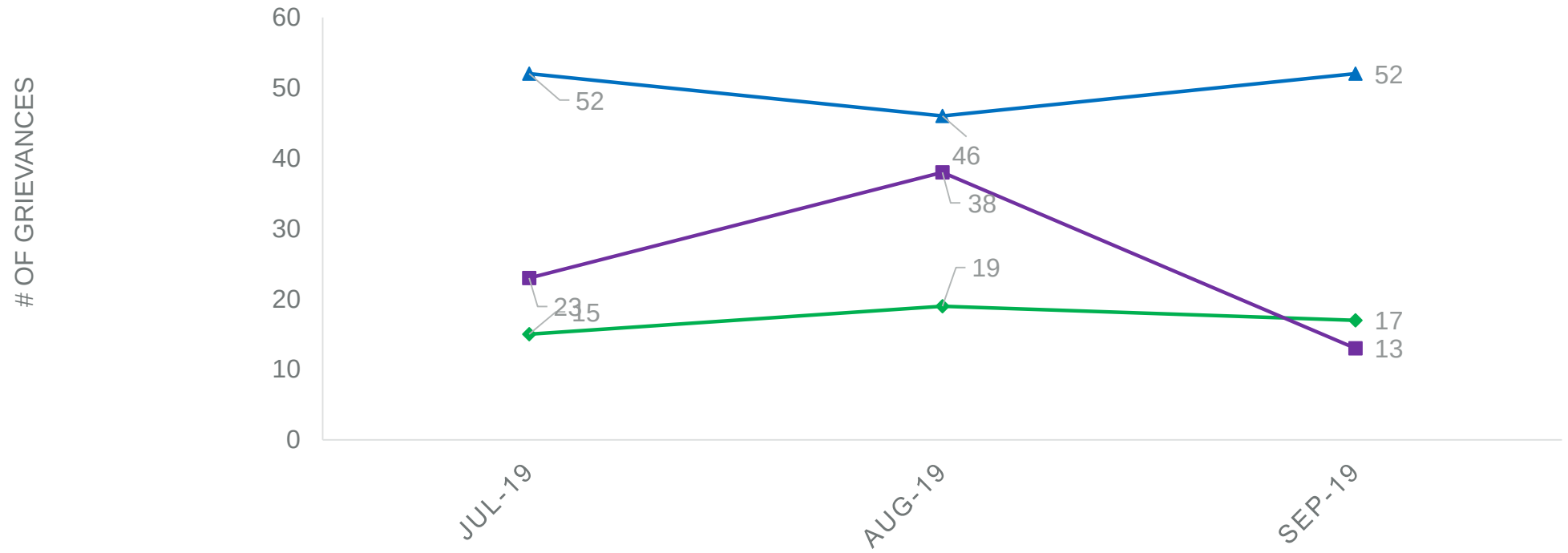
Q3/Q4 2019

Q3 2019:Top 3 Medi-Cal Grievance Categories



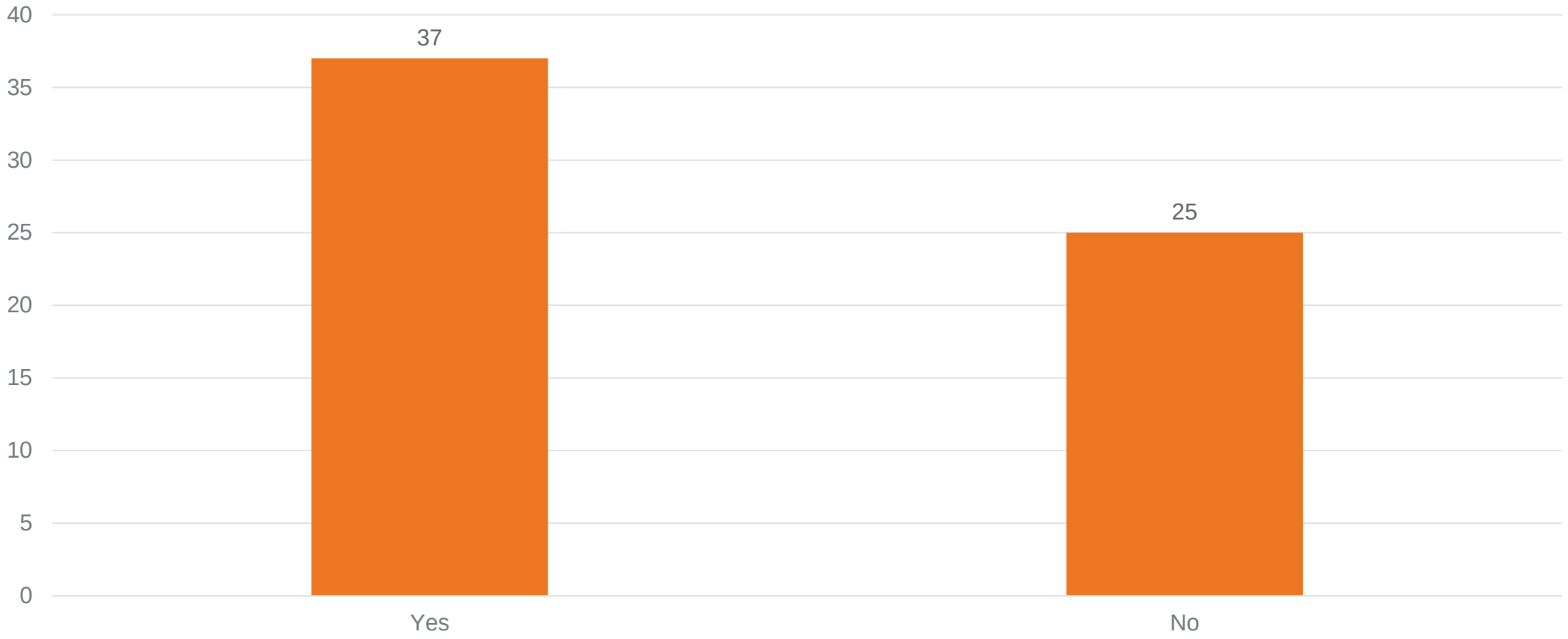
	Jul-19	Aug-19	Sep-19
Access	34	48	42
Quality of Service	100	93	96
Quality of Care	27	45	28

Q3 2019:Top 3 Medi-Cal Grievance Subcategories

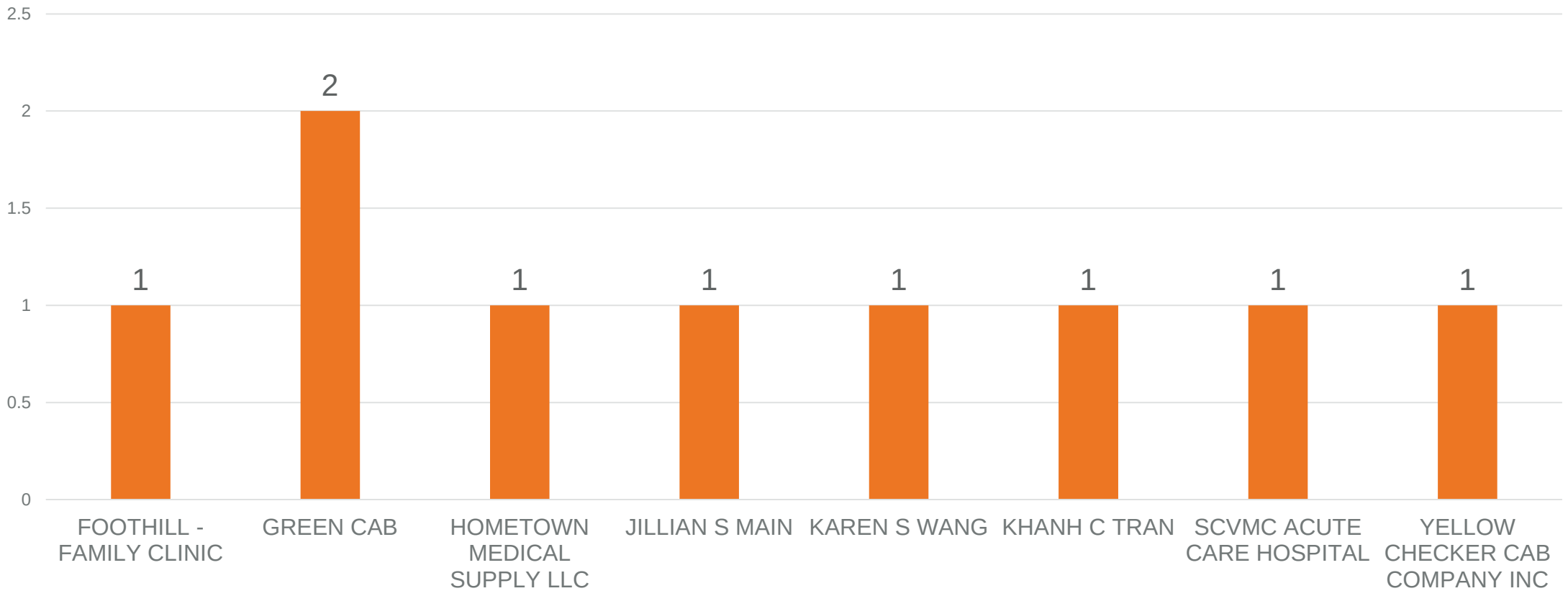


	Jul-19	Aug-19	Sep-19
QOS- Customer Service	15	19	17
QOC- Inappropriate Provider Care	23	38	13
QOS- Transportation	52	46	52

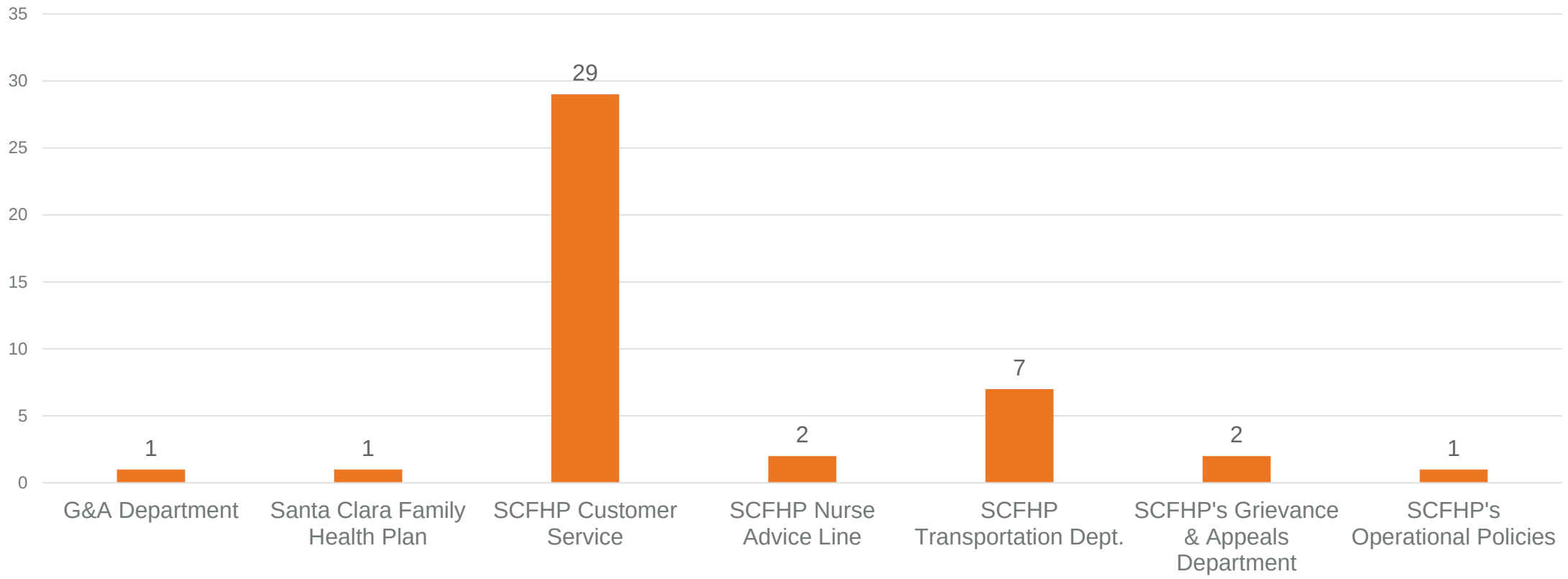
Q3 2019 Inappropriate Provider Care PQI Issues Flagged



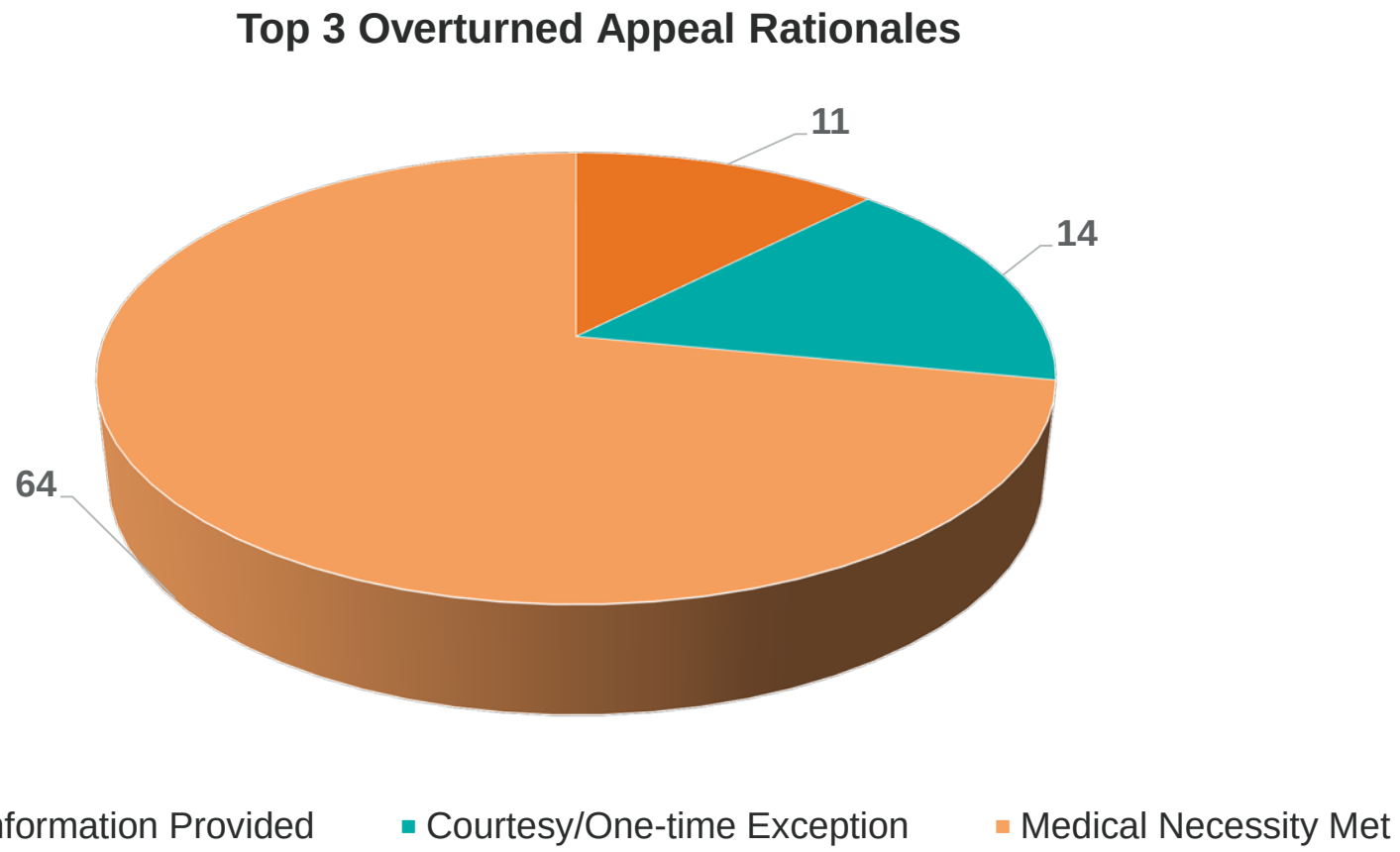
Customer Service Grievances by Provider



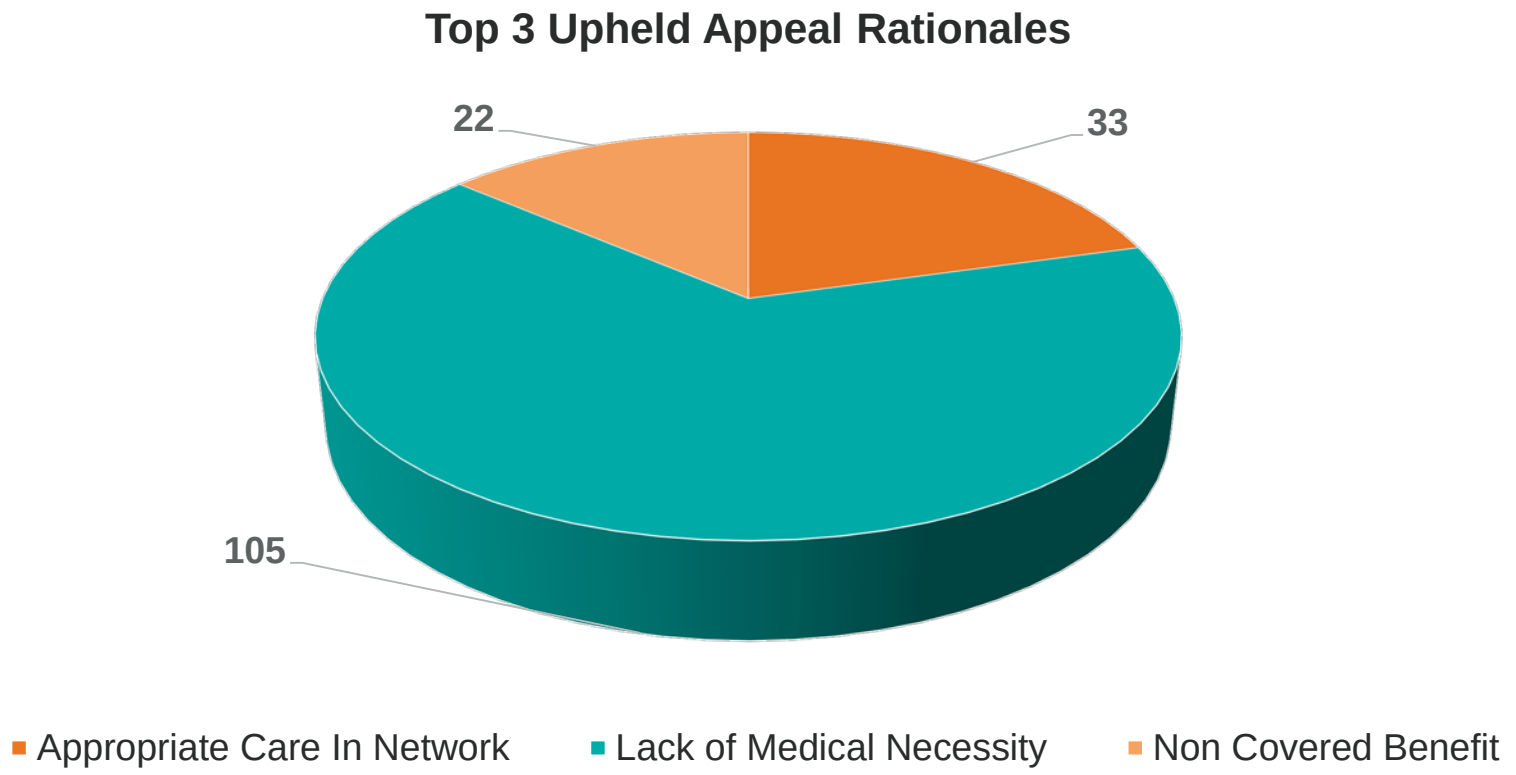
Customer Service Grievances by Internal Business Unit



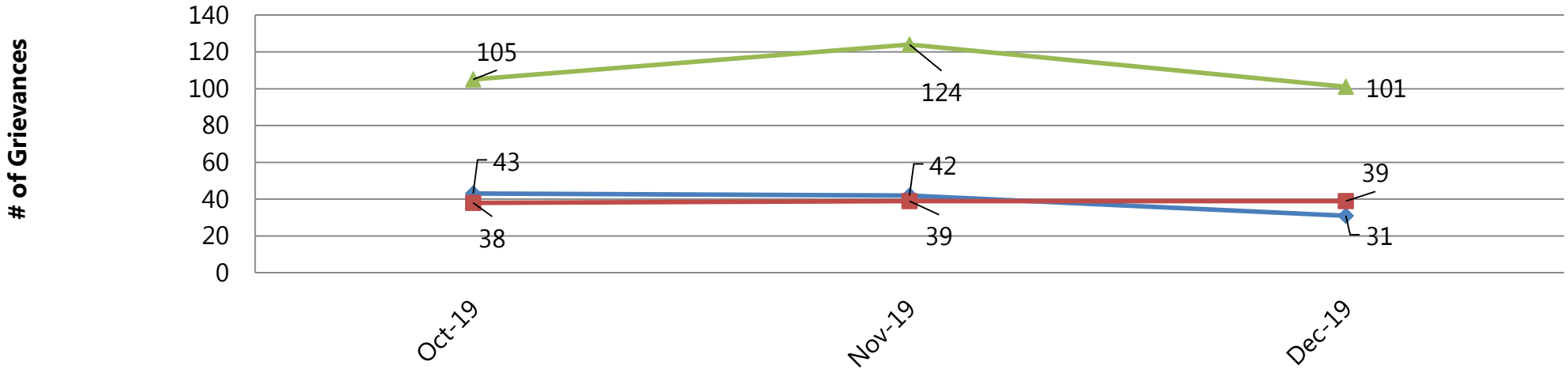
Q3 2019 Top 3 Overturned Appeal Rationales



Q3 2019 Top 3 Upheld Appeal Rationales

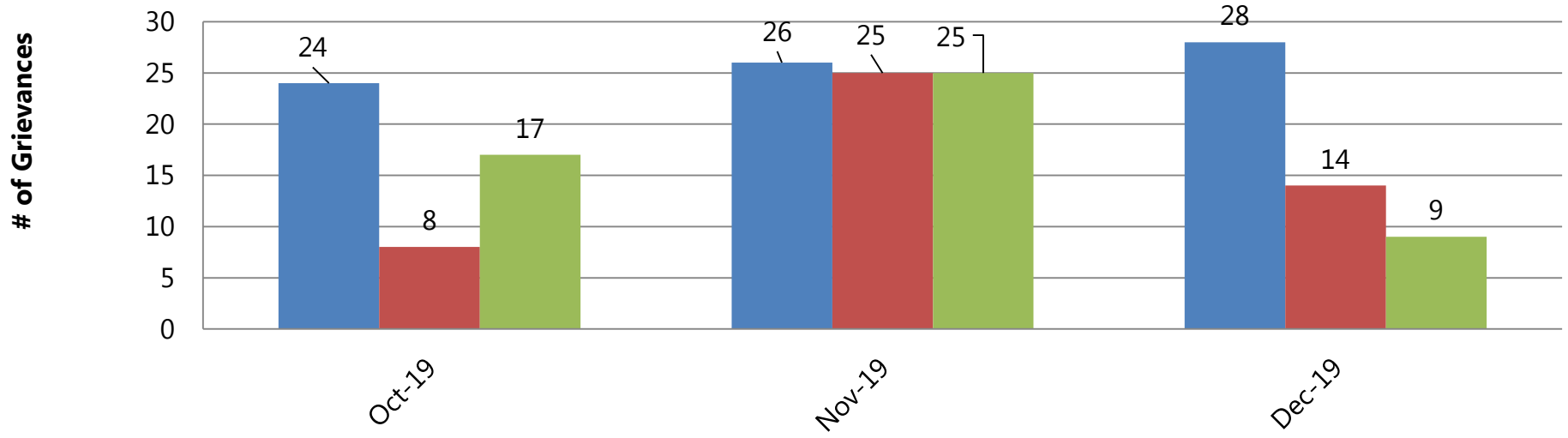


Q4 2019:Top 3 Medi-Cal Grievance Categories



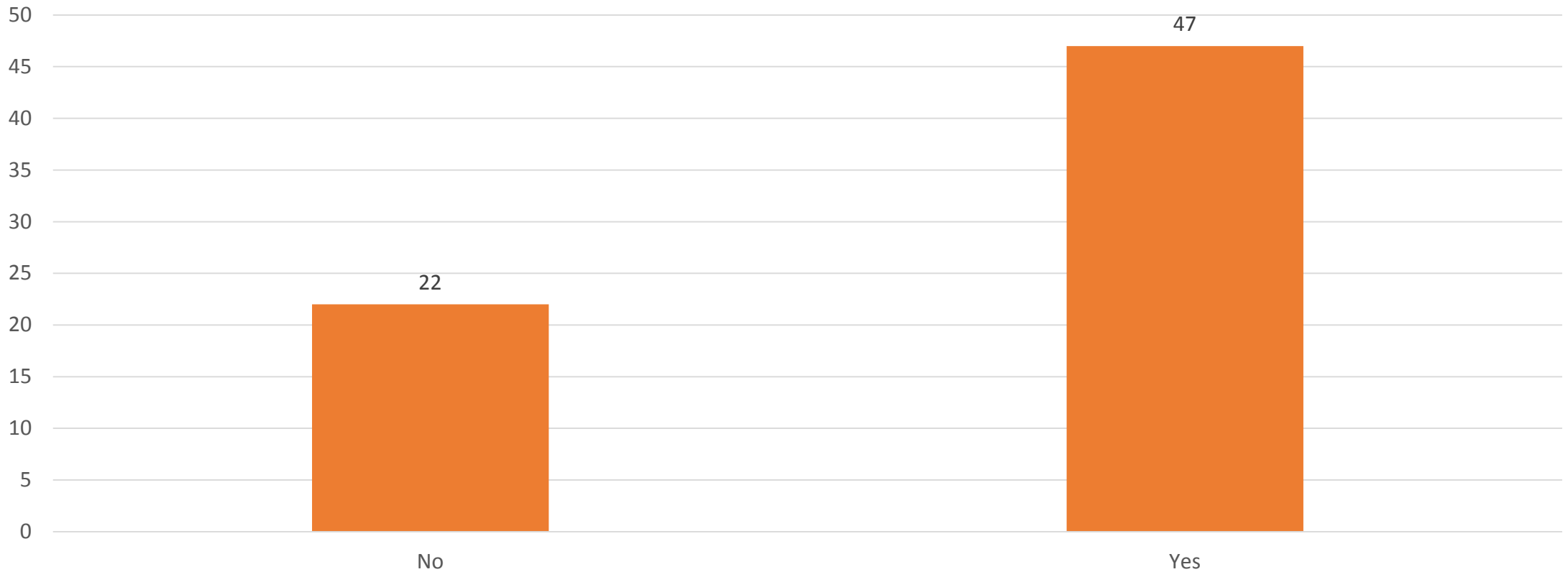
	Oct-19	Nov-19	Dec-19
Access	43	42	31
Quality of Care	38	39	39
Quality of Service	105	124	101

Q4 2019:Top 3 Medi-Cal Grievance Subcategories

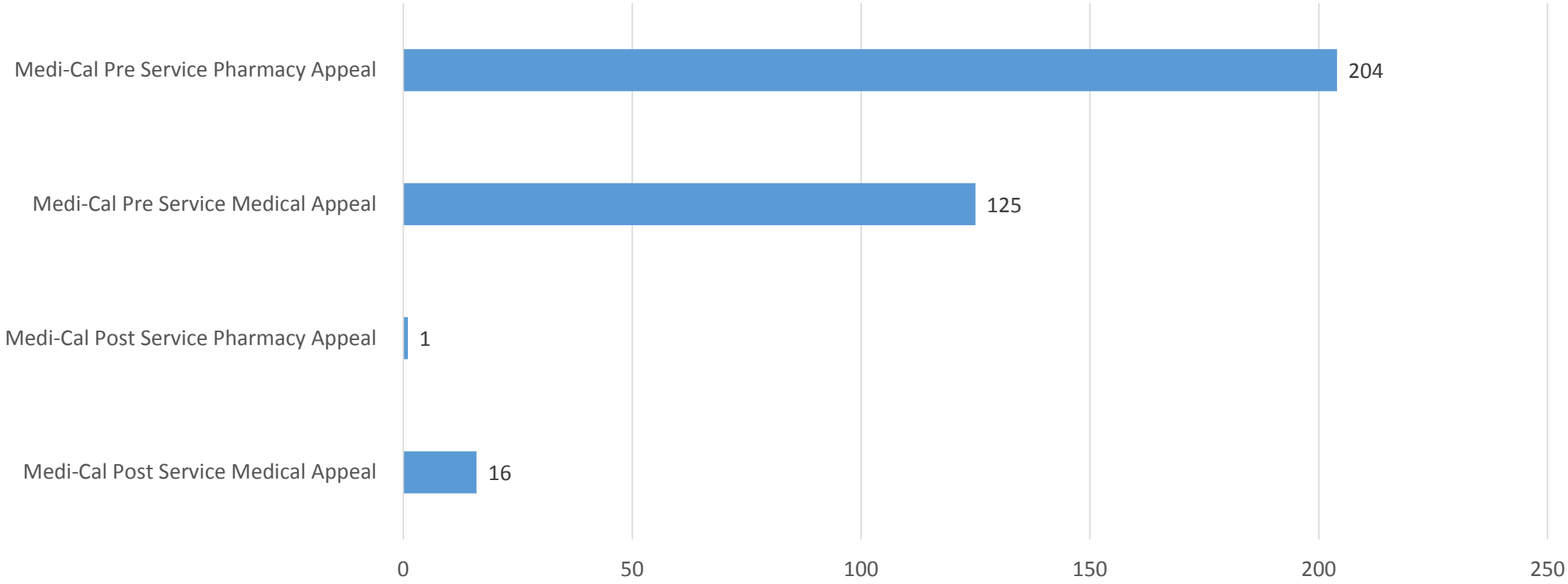


	Oct-19	Nov-19	Dec-19
QOC Inappropriate Provider Care	24	26	28
QOS Operational Policy	8	25	14
QOS Poor Provider/Staff Attitude	17	25	9

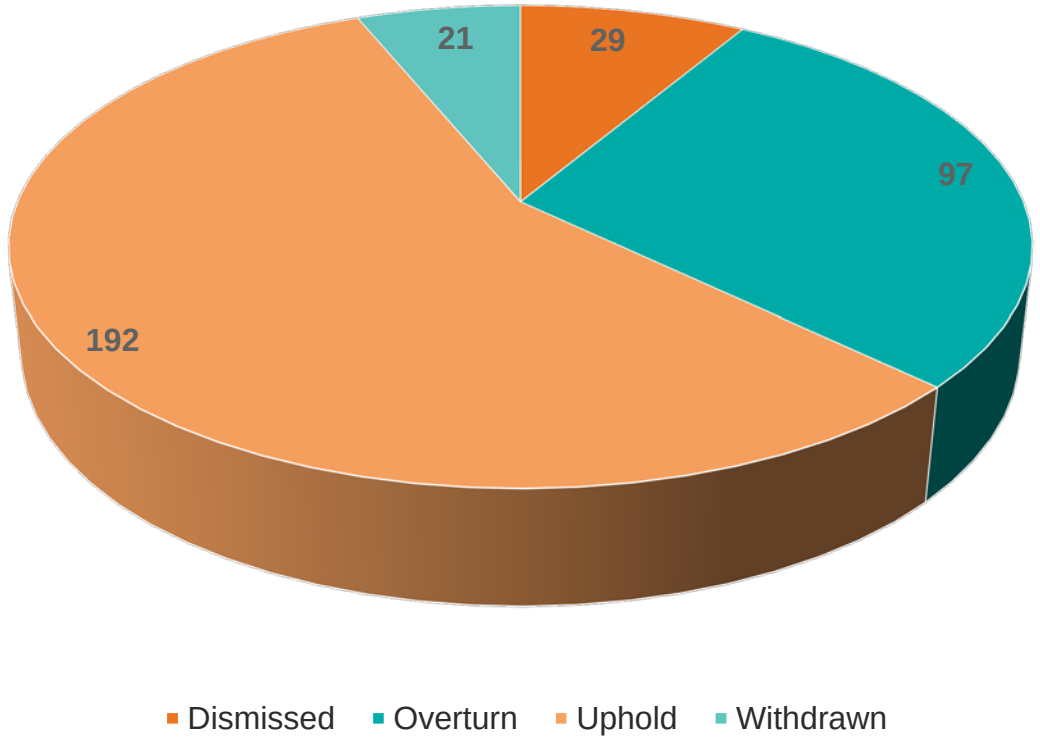
Q4 2019 Inappropriate Provider Care PQI Issues Flagged



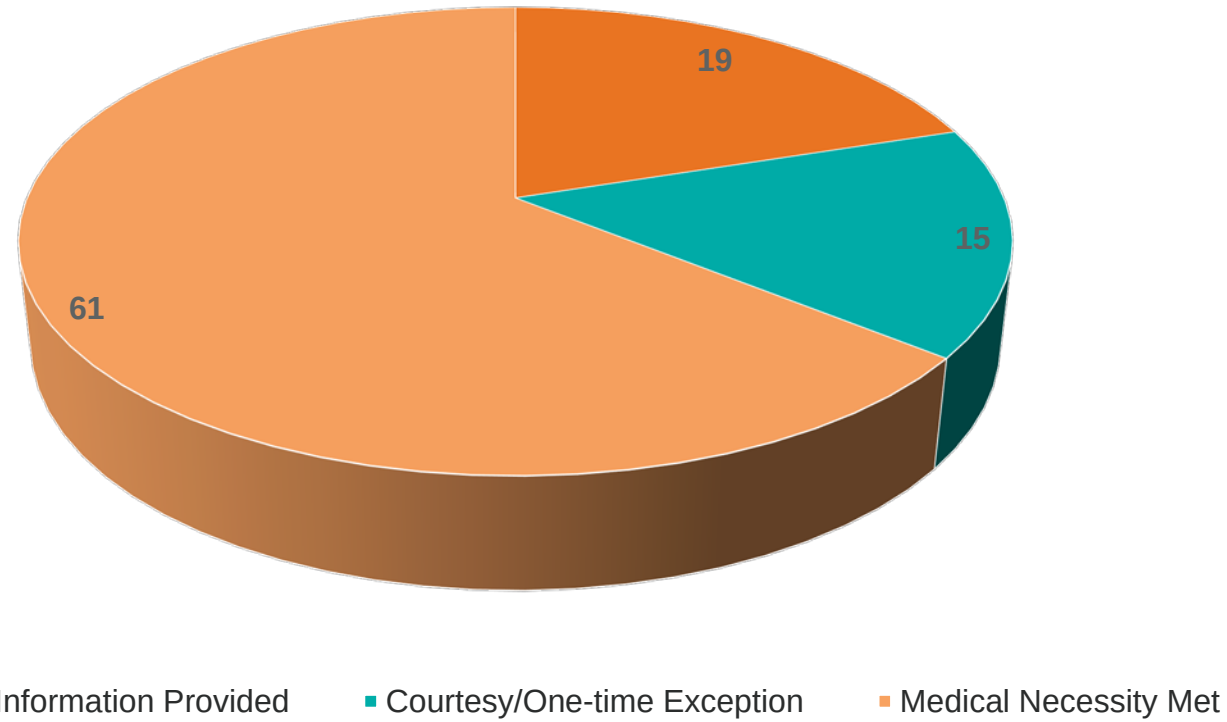
Q4 2019 Medi-Cal Appeals by Type



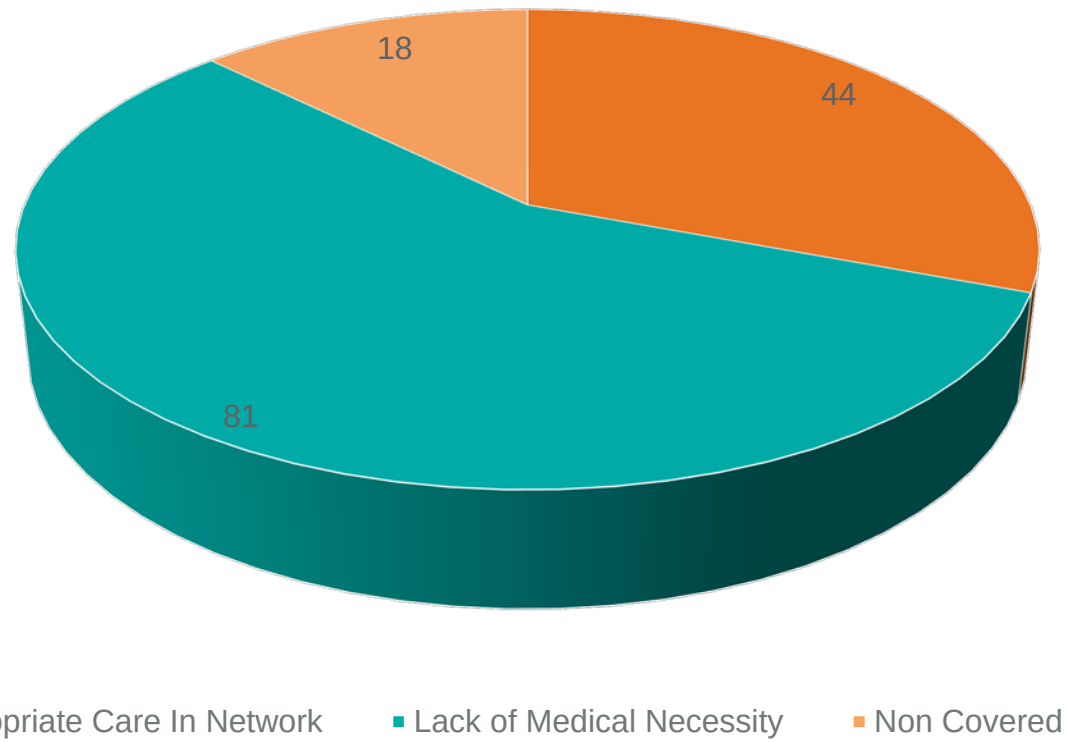
Q4 2019 Appeals by Determination



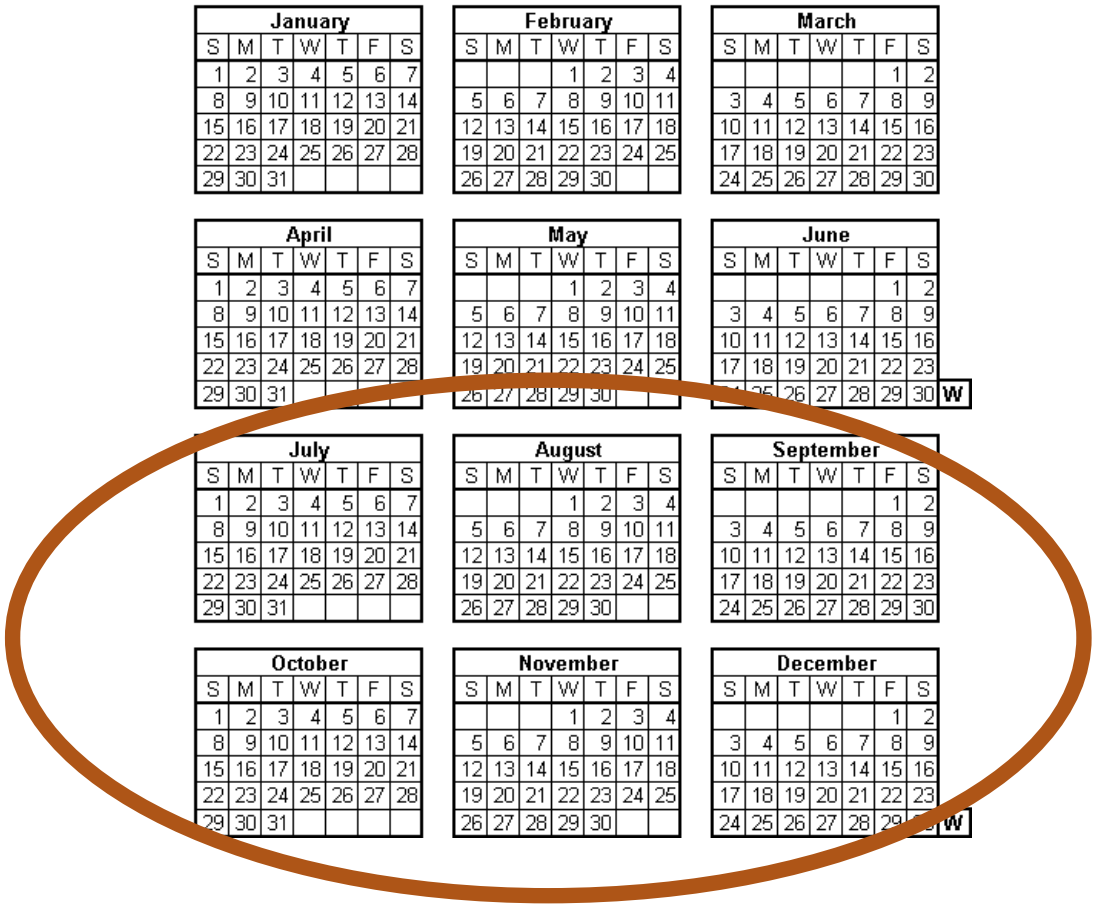
Q4 2019 Top 3 Overturned Appeal Rationales



Q4 2019 Top 3 Upheld Appeal Rationales



Cal Medi-Connect



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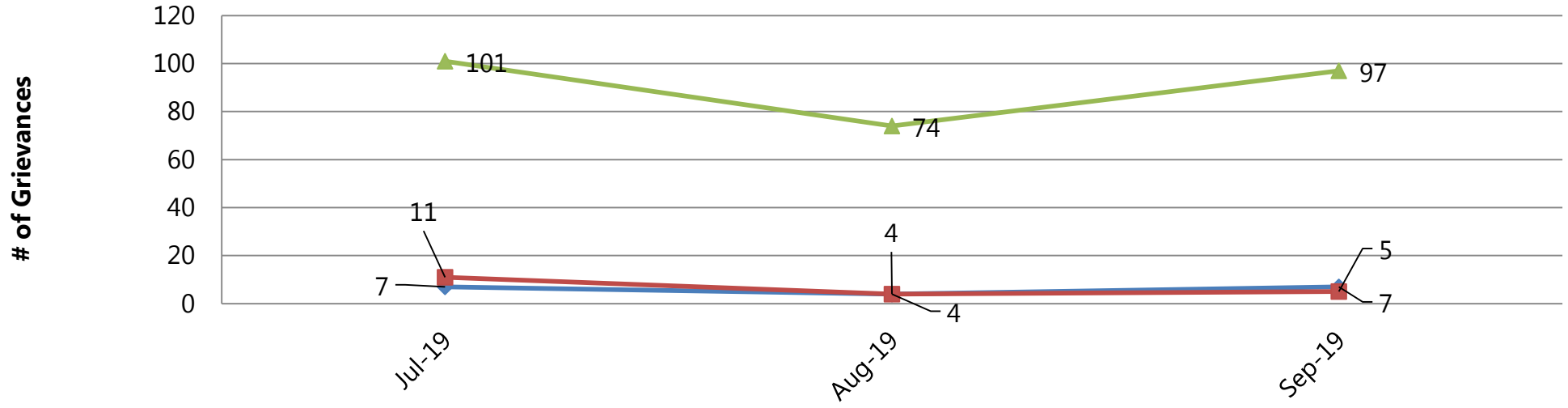
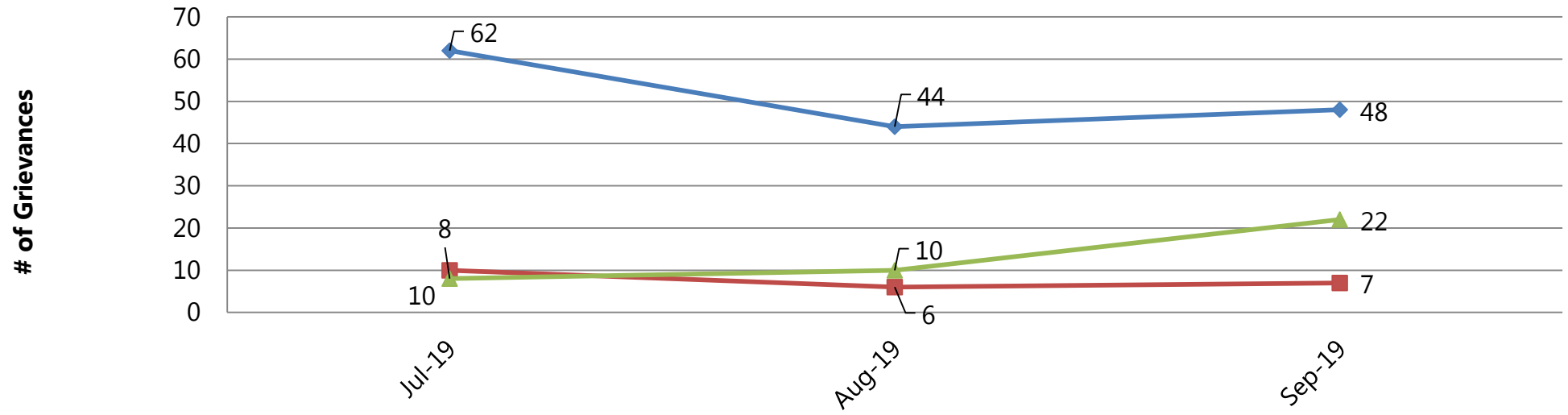
Q3/Q4 2019

Q3 2019:Top 3 Medi-Cal Grievance Categories



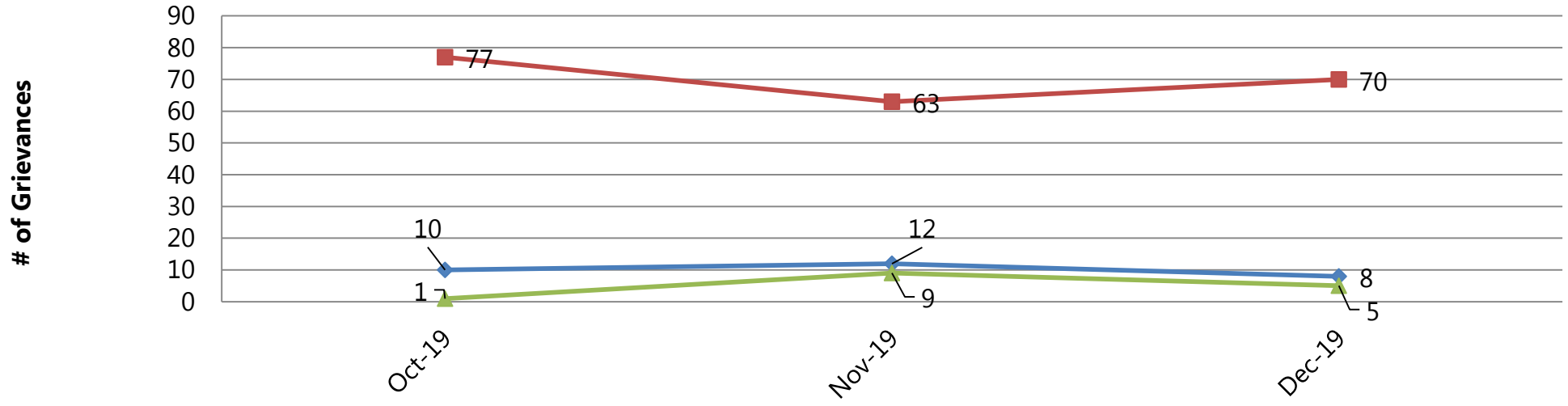
	Jul-19	Aug-19	Sep-19
Access	7	4	7
Quality of Care	11	4	5
Quality of Service	101	74	97

Q3 2019:Top 3 Medi-Cal Grievance Subcategories



	Jul-19	Aug-19	Sep-19
Billing/Balance Billing	62	44	48
Poor Provider/Staff Attitude	10	6	7
Transportation Services	8	10	22

Q4 2019:Top 3 Medi-Cal Grievance Categories



	Oct-19	Nov-19	Dec-19
Access	10	12	8
Quality of Service	77	63	70
Quality of Care	1	9	5

Q3/Q4 2019 Balance Billing Counts by Provider

Provider Full Name	Total
ACUTE CARE SURGERY MEDICAL GROUP INC	1
CAROL A SOMERSILLE	1
DANIEL OUYANG	1
DJO LLC	1
DUKE T KHUU	1
EL CAMINO HOSPITAL - REHABILITATION UNIT	1
EL CAMINO HOSPITAL-MOUNTAIN VIEW CAMPUS	7
EMERGENCY PHYSICIANS ASSOCIATES SAN JOSE PC	1
GOOD SAMARITAN HOSPITAL	7
JAMES E EGBERT	1
JFK MEDICAL CENTER LIMITED PARTNERSHIP- JFK MEDICAL CENTER	2
MEDICAL ANESTHESIA CONSULTANTS MEDICAL GROUP, INC	1
MINIMED DISTRIBUTION CORP	1
MOHAMMADREZA ROHANINEJAD	1
O'CONNOR HOSPITAL	15
PAMF GROUP	3
REGIONAL MEDICAL CENTER OF SJ	62
SAINT LOUISE REGIONAL HOSPITAL	12
SCVMC ACUTE CARE HOSPITAL	18
SETON MEDICAL CENTER HAYS	2
SILICON VALLEY DIAGNOSTIC IMAGING GROUP	7
SOUTH BAY PATHOLOGY MEDICAL ASSOCIATES	1
STANFORD MEDICAL CENTER HOSPITAL	42
SUNG H CHUN	1
VALLEY RADIOLOGY MEDICAL ASSOC	35
VHC - TULLY	1

Santa Clara Family Health Plan™

Grievance and Appeals Workgroup

April 1, 2020

Santa Clara Family Health Plan™

Quality Improvement Dashboard

December 2019- February 2020

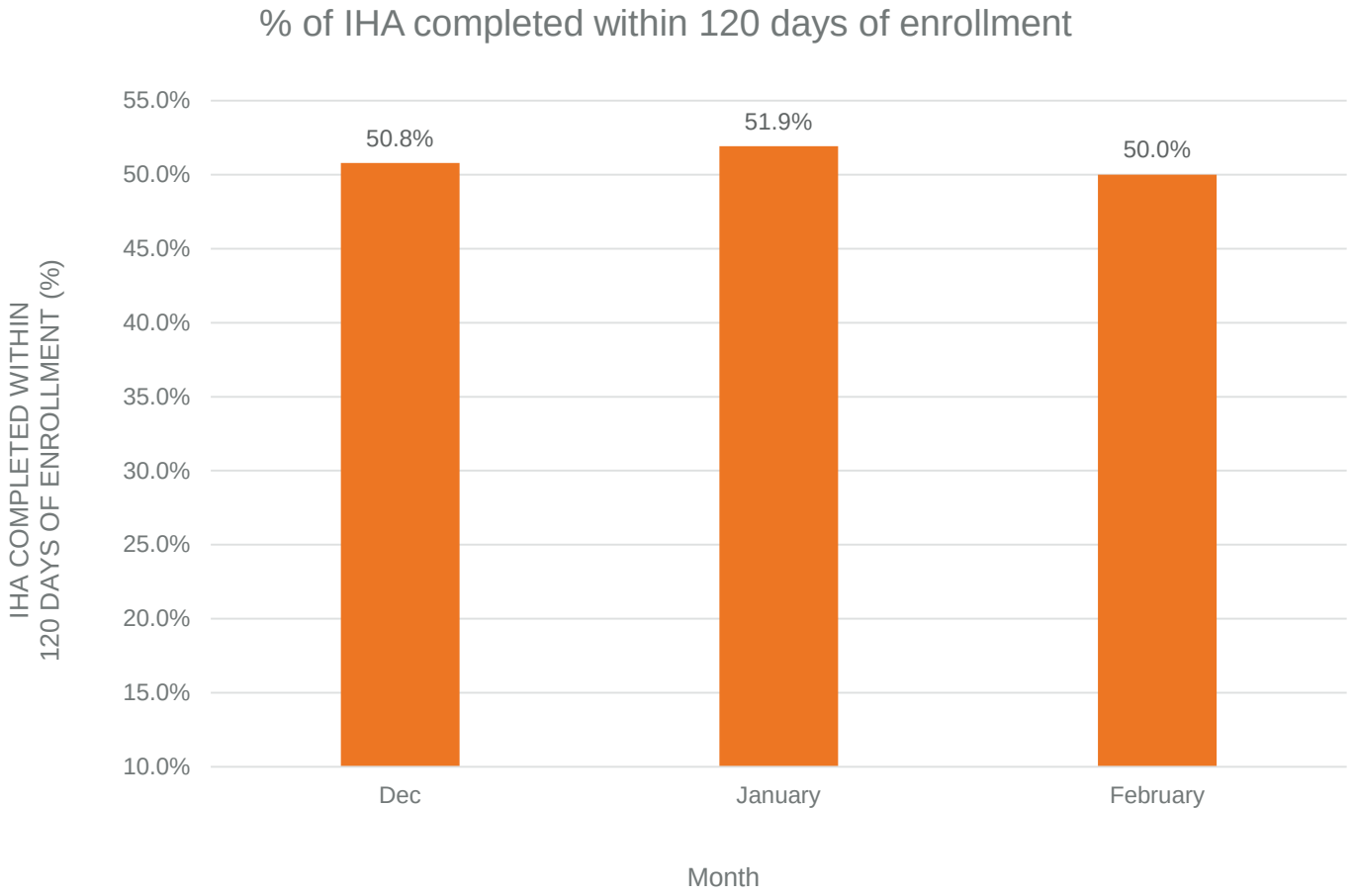
Initial Health Assessment (IHA)

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

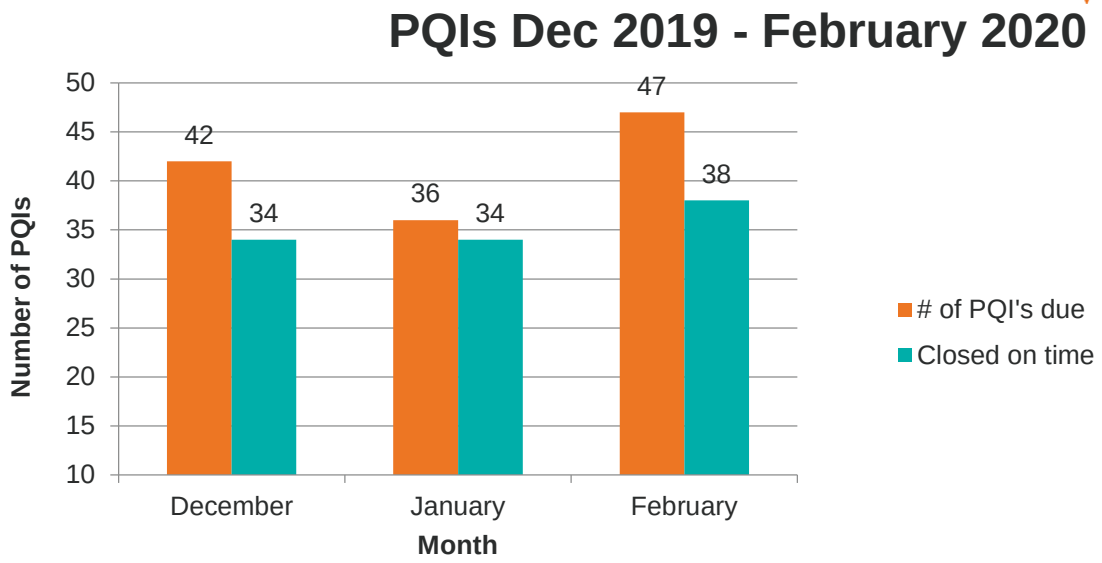
QI currently conducts quarterly IHA audits and provider education to continually improve IHA completion rates



Potential Quality of Care Issues

Santa Clara Family Health Plan

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

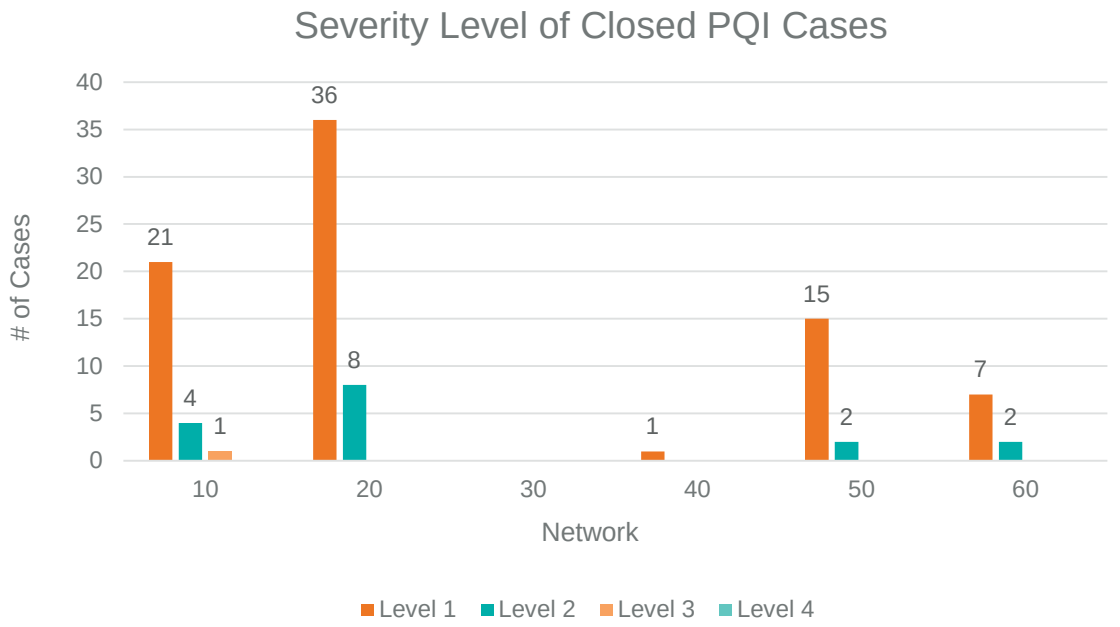


85%

Percentage of PQIs due from December 2019-February 2020 and closed on time within 60 days

81%

Percentage of PQI cases due in February 2020 closed on time



Health Homes Program (HHP)

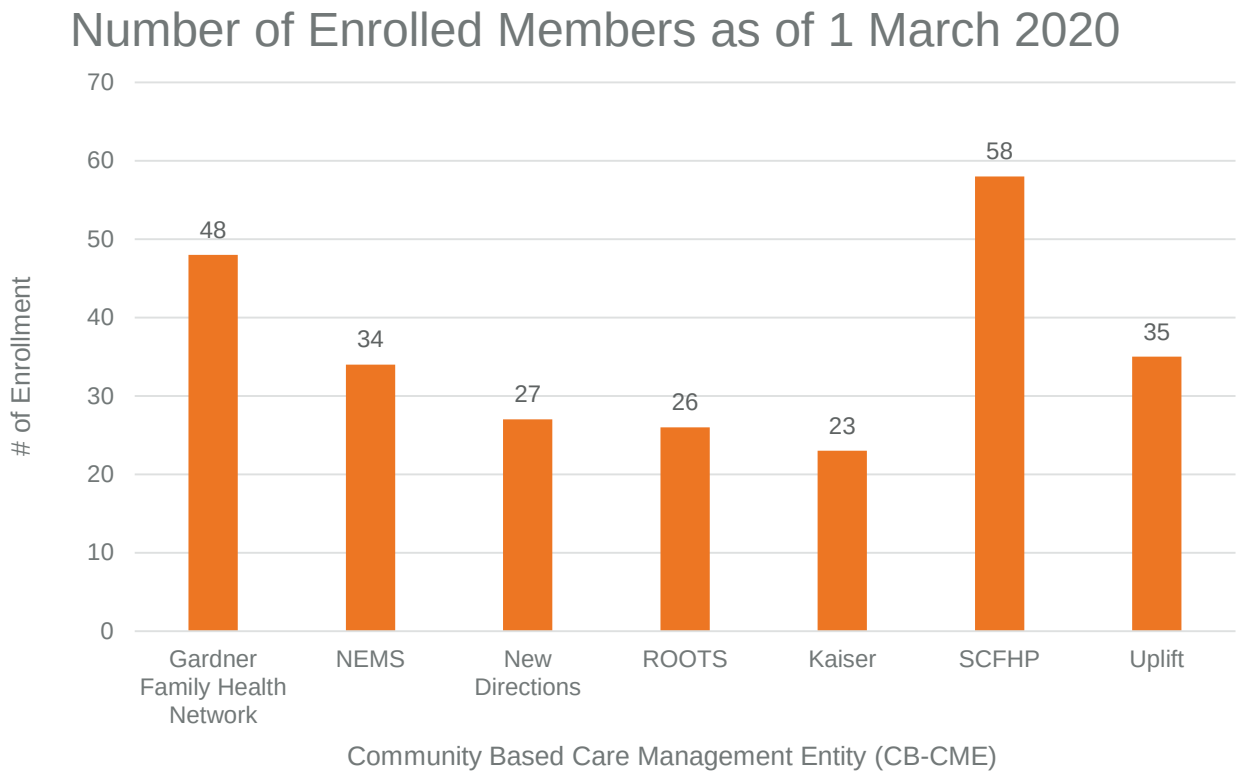
HHP launched July 1, 2019 with six Community Based Care Management Entities (CB-CMEs)

What is the Health Homes Program?

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

251

Members have verbally consented into Health Homes as of March 1, 2020

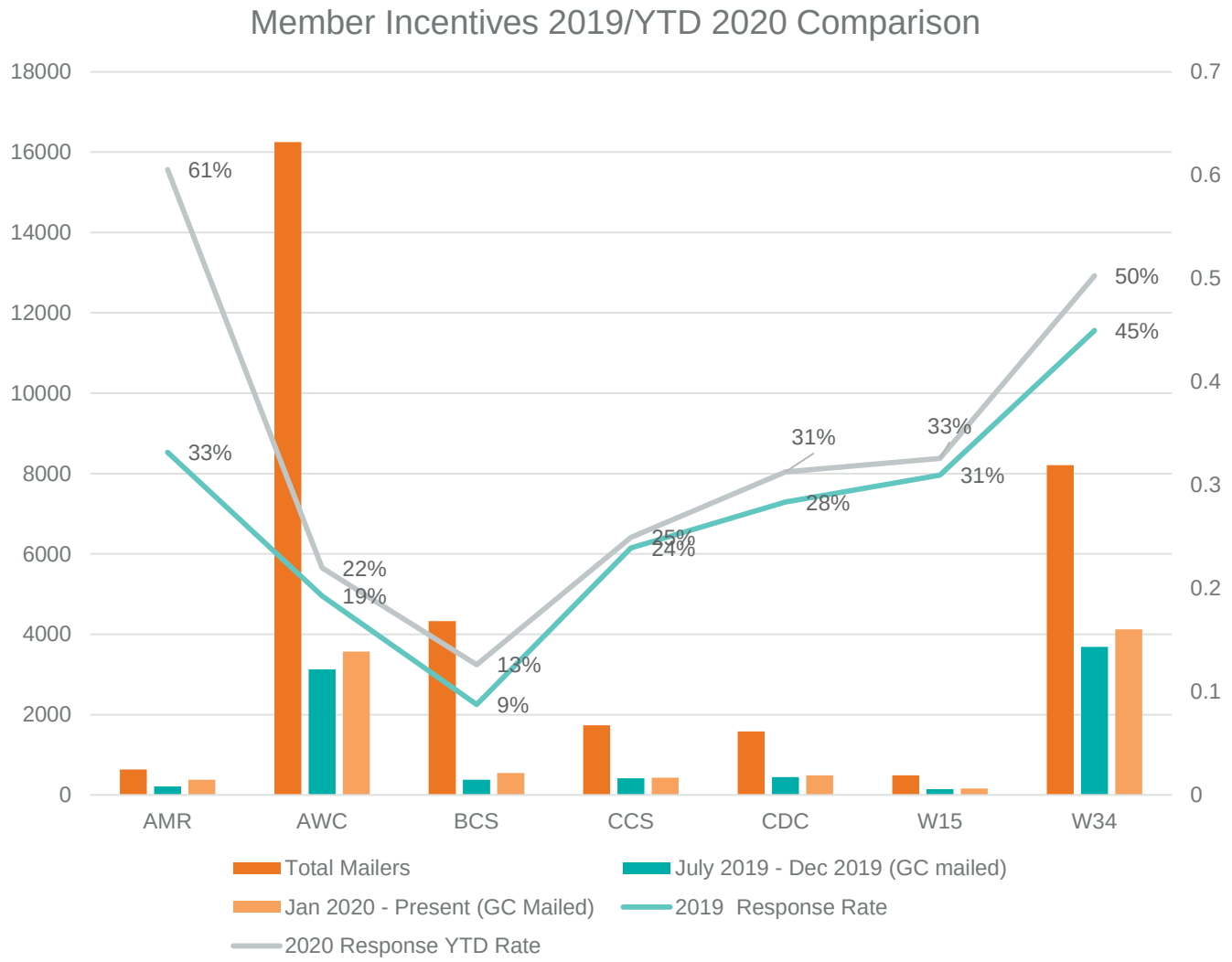


Member Incentives:
Wellness Rewards Mailing

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)	**18,138**
Average Compliant Rate	**30%**



Facility Site Review (FSR)

Santa Clara Family Health Plan

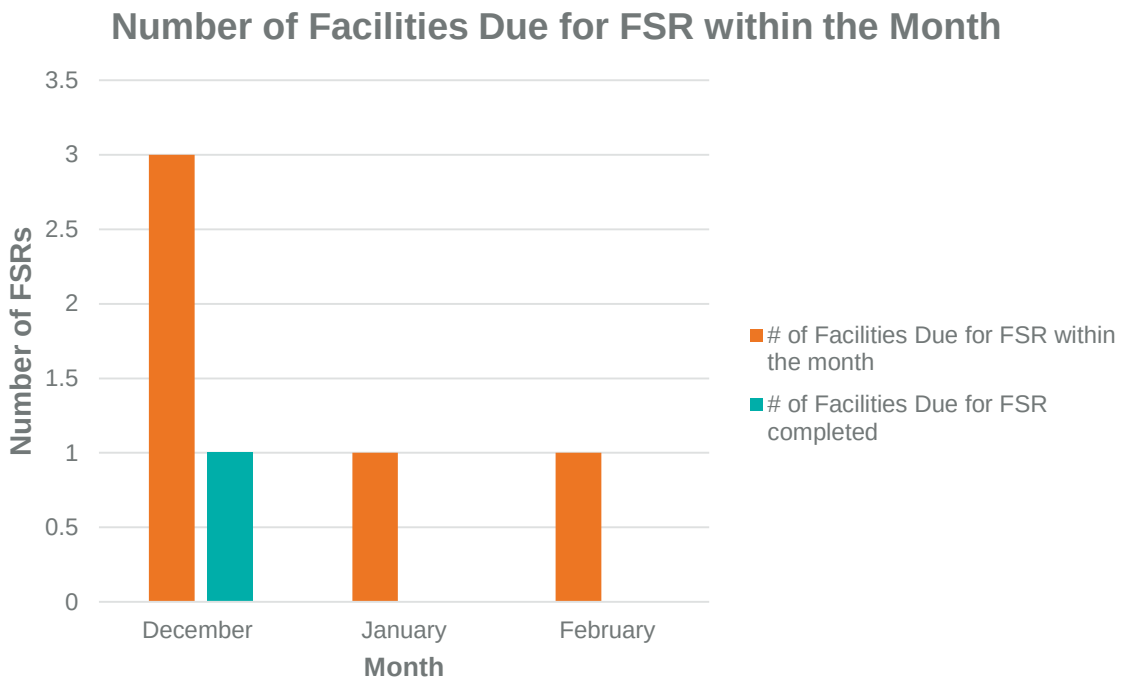
What is a FSR?
A FSR is a 3 part evaluation of all PCPs and high volume specialists to audit provider offices for patient safety

20%

Percentage of FSR due completed on time from December 2019 to February 2020

100%

Percentage of FSRs completed that passed with 80% or higher



Compliance Activity Report
February 27, 2020

2018 CMS Program Audit Update

The Plan requested, and CMS granted, an extension of time to complete the Revalidation Audit for the Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) Conditions. The primary purpose for the extension is to allow the Plan to recruit and train additional staff to achieve and sustain full compliance with respect to the relevant tasks.

Audit field work for the CCQIPE Conditions will now begin in August 2020. The auditors will evaluate data reflecting the Plan's performance between May 1, 2020 and July 31, 2020.

The Revalidation Audit for the Coverage Determinations, Appeals and Grievances (CDAG) and Compliance Program Effectiveness (CPE) Conditions is not affected by this extension. Field work for those Conditions will begin in March 2020 and May 2020, respectively.

The Final Revalidation Audit Report for the CDAG and CPE Conditions must be submitted to CMS on or before 6/19/2020, and the Final Report for the CCQIPE Conditions must be submitted on or before 9/25/2020.

Cal MediConnect

- The Plan is preparing for the 2020 Medicare Data Validation Audit (MDV), which will begin in the spring.
- The CMC Contract Management Team (CMT) previously directed several California Plans, including SCFHP, to submit a Performance Improvement Plan (PIP) demonstrating how the Plan will improve performance related to HRAs. SCFHP submitted a PIP addressing how we will bolster timely completion rates for ICPs. The PIP was accepted by the CMT, and SCFHP is submitting monthly status reports demonstrating progress on the measure.

Medi-Cal Healthier California for All

DHCS has continued to refine and revise the set of proposals it released in October 2019 to transform Medi-Cal through federal waiver updates and other mechanisms. The proposals were initially called CalAIM, but have since become known as Medi-Cal Healthier California for All. Medi-Cal managed care plans will be required to structure their services around a population health management plan, offer a new "enhanced care management" benefit and "in lieu of services" for the highest risk members, and become accredited by the National Committee on Quality Assurance. The five work groups DHCS assembled to provide input and feedback on its initial proposals—SCFHP staff were selected for two of the groups—will wrap up their work in February and the proposals will be finalized shortly thereafter. The primary initial focus will continue to be on meeting DHCS's July 1 deadline for submitting plans for transitioning Whole Person Care and Health Homes Program services into the new "enhanced care management" benefit and "in lieu of services."

2019 DMHC and DHCS Audit(s)

The 2019 DHCS Audit remains open. The CAP responses were initially submitted in August 2019 and the DHCS has been reviewing the Plan's responses and requesting additional information as needed.
The 2019 DMHC Preliminary Report was received in October 2019 with a total of 4 findings for the Medi-Cal and Healthy Kids Medical Survey. The Plan submitted corrective action responses for the four findings identified. The final DMHC Audit Report was received on February 6, 2020. The DMHC accepted two of the responses and requested a supplemental report for one of the remaining two findings.

2020 DHCS Audit

The Plan received the audit notice and pre-audit information request in December 2019. The Plan submitted the audit universes on January 13, 2020 and the pre-audit documents on January 17, 2020. However, the Plan has been receiving numerous additional request for documents on a daily basis. The on-site portion of the audit is scheduled for March 9 – 20th, 2020.

DMHC Complaints

The Plan received a total of 18 member complaints between December and February 2020. One case was forwarded to IMR.

Operational Compliance Report (Dashboard) – Corrective Actions

- Health Services (UM and CM): The business unit and IT are currently working on data verification. Hence, Compliance is postponing issuing CAPs until the team is able to produce accurate data.
- Quality Improvement: received 1 (one) CAP for not completing Facility Site Reviews (FSR) timely.
- Grievance and Appeals: In Q4 2019 4 (four) CAPs were issued to G&A. Two were closed in January 2020.
    - Medi-Cal's Standard Appeals Acknowledgement Letters sent within 5 calendar days, Expedited Appeals grouped on Resolution Letter Date and resolved within 72 hours, and Oct-Nov: Standard Grievances that received an Acknowledgement Letter within 5 Calendar days
    - CMC's Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days.
- Claims: For Medi-Cal, a Non-Compliance notification will be issued to Claims for missing Medi-Cal's Misdirected Claims Forwarded within 10 Business Days element for the month of December. IT fixed the problem immediately.
- Compliance: in Q4 2019, 1 CAP was issued to Compliance because 4 out of the 12 Board members did not complete their annual Compliance training within the required timeframe.

Joint Operations Committee (JOC) Meetings

As of January 1, 2020, the Provider Network Management department has accepted the responsibility of managing JOCs for Provider Groups and Adult Day Care Centers. The following JOCs have been held since the last Compliance Committee Meeting:

- November 2019: Golden Castle, VHP, PMGSJ
- December 2019: Focus Care, Kaiser
- January 2020: Carenet
- February 2020: Docustream, MedImpact, VHP

HIPAA Disclosures

There were 4 incidents between December 2019 and February 2020. Three incidents involved and were reported to DHCS by Kaiser. In the first three cases, members received another member's information. The other incident involved a SCFHP staff member. The staff member faxed an authorization to the incorrect provider.

FWA Activities

T&M (the Plan's FWA/SIU vendor) currently has 31 open cases for which it has identified anomalies through its datamining activities. T&M is currently reviewing the medical records for most of those cases, and has requested medical records for the others.

Santa Clara Family Health Plan™

Credentialing Committee Report

February 5, 2019

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee 02/05/2020

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	18	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	13	
Number practitioners recredentialed within 36-month timeline	13	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 01/31/2020	288	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1636	1576	904	819	406	138

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.