Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

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

MINUTES

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

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

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

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

1. **Introduction**

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

2. **Meeting Minutes**

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

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

3. **Public Comment**

   There were no public comments.

4. **CEO Update**

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

5. Follow-Up / Old Business

There were no follow-up items.

6. Action Items

a. Network Adequacy Assessment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Quality & Accuracy Assessment of Pharmacy Benefit Information

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

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

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

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

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

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

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

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

d. Continuity and Coordination of Medical Care

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

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

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

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

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

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

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

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

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

e. Member Experience Analysis

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

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

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

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

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

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

7. Discussion Items

a. Access and Availability – VHP Access Report-MY2018

b.

Ms. Switzer explained the Provider Access and Availability Survey (PAAS) was conducted to ensure VHP meets the provider appointment access standards established by DMHC and meet the needs of VHP's members. The After-Hours survey was conducted to ensure that VHP meets the after-hours timely access standards established to meet the needs of members and address any deficiencies. Ms. Switzer reviewed the methodology and measures used. The results show the PCP's performance fell below the goal for both standards. There showed an improvement in urgent care appointments and a decrease in non-urgent care appointments for Specialists. For Psychiatry, there was a decrease in performance in urgent care appointments and an increase in performance for non-urgent care appointments. For Non-Provider Mental Health (NPMH), there was a decrease for urgent care appointments and an increase for non-urgent care appointments.

Ms. Switzer reports VHP was able to demonstrate the ability to provide urgent and non-urgent care appointments to its enrollees at a high level and in a timely manner. VHP is able to develop interventions to continue to improve performance for timely access in the future. Ms. Switzer reviewed some of VHP's interventions identified through the analysis.

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

It was asked if the patients relating to this survey were new patients or established patients. Ms. Switzer clarified the survey relates to any patient. Johanna Liu, PharmD, Director of Quality and Process Improvement, asked if VHP required to conduct this survey The results show an improved rate of compliance for both Access & Timeliness standard.

c. CAHPS

d. Health Outcomes Survey

Johanna Liu, PharmD, Director of Quality and Process Improvement, reviewed the requirements for the Initial Health Assessment (IHA) to be completed. The IHA requires completion within the first 120 days of plan enrollment. There are five elements required for completion credit:

- Comprehensive history
- Administration of preventive services (screenings, immunizations, etc.)
- Comprehensive physical and mental status exam

- Diagnosis and plan of care
- Staying Healthy Assessment (SHA) Questionnaire

New criteria has been added for 2019 review which include, outreach attempts by providers for members who haven't scheduled the IHA or have cancelled the appointment. Documentation is required within the medical record as well as two attempts via telephone and mail.

Dr. Liu reported a 90% IHA records retrieval rate in Q1 and a rate of 62% for Q2. The IHA audit compliance results reflect a total of 26% being fully compliant in Q1 and 12% in Q2. SHA is the element with greatest opportunity for improvement. Other areas of improvement include, improving provider education regarding required documentation, outreach, and ongoing support based on provider feedback. Helping keep members informed of when the IHA is due, adding IHA reminders to the Member Portal, and timely member education regarding need for IHA and portal use, are additional areas for improvement.

8. Committee Reports

a. Credentialing Committee

Dr. Liu asked if the committee would accept the written report rather than a verbal report as Dr. Nakahira was unable to attend. The committee reviewed the Credentialing Committee report for September 26, 2019.

It was moved, seconded, and the September 26, 2019 Credentialing Committee Report was **unanimously approved**.

b. Pharmacy and Therapeutics Committee

Minutes of the June 20, 2019 Pharmacy and Therapeutics Committee (P&T) meeting were reviewed by Jimmy Lin, MD.

It was moved, seconded, and the June 20, 2019 Pharmacy and Therapeutics Committee meeting minutes were **unanimously approved**.

c. Quality Dashboard

Dr. Liu reviewed what a Facility Site Review (FSR) is. A FSR is a 3 part evaluation of all PCPs and high volume specialists to audit provider offices for patient safety. Dr. Liu reported 100% of FSR's passed with 80% or higher in Q2 2019.

An IHA is a comprehensive assessment completed during a new Medi-Cal member's initial visit with their PCP within 120 days of joining the plan. Dr. Liu reported a completion rate of 43.3% in June, 46.8% in July, and 47.4% in August 2019. The Quality Improvement department is currently developing a work plan to improve the IHA completion rate.

Dr. Liu reported a 100% of June's Potential Quality of Care Issues (PQI) cases were closed on time. 88% of PQIs due in Q3 were closed on time.

Dr. Liu announced Health Homes Program (HHP) launched July 1, 2019 with six Community Based Care Management Entities (CB-CME). HHP is designed to coordinate care for Medi-Cal beneficiaries with chronic conditions and/or substance use disorders. 130 members have verbally consented into Health Homes as of September 27, 2019.

Dr. Liu reported a total number of 159 PQIs received in Q2 investigated by the Quality Team. Network 20 (VHP) has the highest number of cases (38) of level 1 issues.

Dr. Liu shared SCFHP is partnered with two different health centers, Indian Health Center and Gardner Health Center, to facilitate Cervical Cancer Screening (CCS) Clinic Days. Members are scheduled for a pap smear and those who complete the test are given a $30 gift card at the end of their appointment. Dr. Liu reported an average of 58% completion rate for Clinic Days as of September 26, 2019.

9. Adjournment

The next QIC meeting will be on February 19, 2019. The meeting was adjourned at pm.

Ria Paul

Ria Paul, MD, Chair of Quality Improvement Committee

4/27/2020

Date