



Santa Clara Family
Health Plan™

Santa Clara Family Health Plan

Quality Improvement Program 2020



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I. Introduction

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

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

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

II. Mission Statement

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

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

III. Authority and Accountability

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

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



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

IV. Purpose

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

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

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

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

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

V. Goals

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



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

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

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

VI. Objectives

The objectives of the QI Program Description include:



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



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

VII. Scope

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

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

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



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

VIII. QI Work Plan

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

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

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

IX. QI Methodology

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

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



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

QI Project Selections and Focus Areas

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

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

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

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

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

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



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

QI Project Quality Indicators

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

QI Project Measurement Methodology

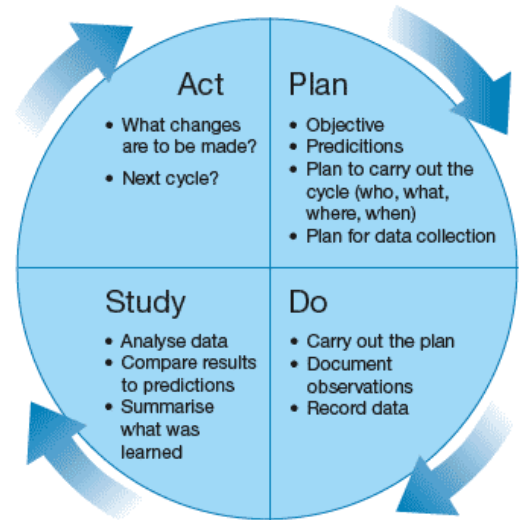
Methods for identification of target populations are clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, centralized data from the health plan's internal data warehouse is used.

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

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



- Plan**
- 1) Identify opportunities for improvement
 - 2) Define baseline
 - 3) Describe root cause(s)
 - 4) Develop an action plan
- Do**
- 1) Communicate change/plan
 - 2) Implement change plan
- Study**
- 1) Review and evaluate result of change
 - 2) Communicate progress
- Act**
- 1) Reflect and act on learning
 - 2) Standardize process and celebrate success



X. QI Quality Issue Identification

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

Adverse events can include:

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

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



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

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

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

Protocol for Using Quality Monitor Screens

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

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

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



XI. QI Program Activities

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

Prioritization

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

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

Use of Committee Findings

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

Clinical Practice Guidelines

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

Preventive Health/HEDIS Measures

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



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

Continuity and Coordination of Care

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

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

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

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

XII. QI Organizational Structure

Quality Improvement Department

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

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



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

Chief Medical Officer

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

Medical Director

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

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

Director of Quality and Process Improvement

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



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

Quality Improvement Manager

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

Process Improvement Manager

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

QI Supervisor

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

QI Nurse, RN

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



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

HEDIS Project Manager

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

Process Improvement Project Manager

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

Health Homes Program Manager

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

QI Analyst

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

Health Educator

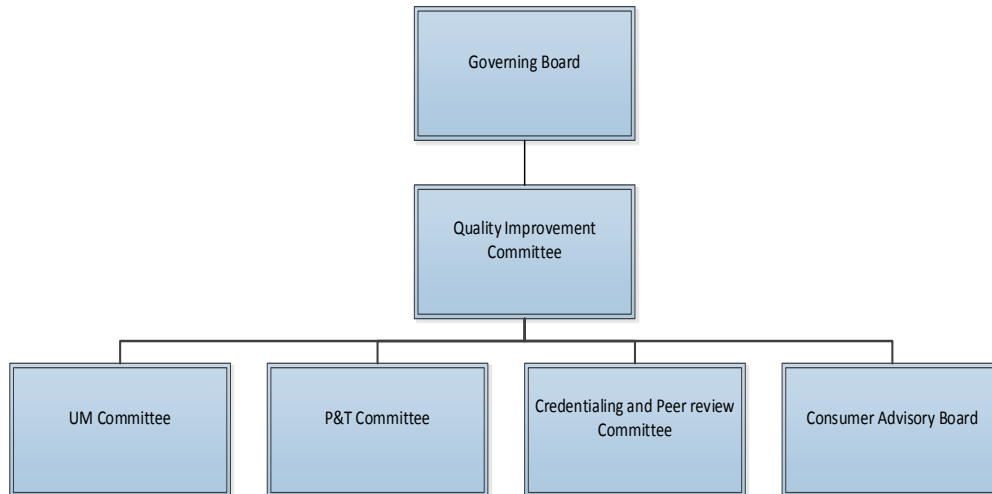
The Health Educator is a Certified Health Education Specialist (CHES) responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance with state and federal regulatory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

Quality Improvement Coordinator

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

XIII. Committee Structure Overview

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



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

- A. Goals
- B. Objectives

- C. Voting members



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

XIV. Committee Structure

Governing Board

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

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

Quality Improvement Committee (QIC)

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

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

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

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



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

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

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

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

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

Utilization Management Committee

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

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

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

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



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

Pharmacy and Therapeutics Committee

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

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

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

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

Credentialing and Peer Review Committee

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



XV. Role of Participating Practitioners

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

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

XVI. Behavioral Health Services

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

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



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

XVII. Utilization Management

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

XVIII. Population Health Management

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

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

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

XIX. Care of Members with Complex Needs

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

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



XX. Cultural and Linguistics

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

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

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

Interpreter services are provided to the member at no charge.

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

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

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

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

XXI. Credentialing Processes

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



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

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

Healthcare Delivery Organizations

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

Use of Quality Improvement Activities in the Re-credentialing Process

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

Monitoring for Sanctions and Complaints

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



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

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

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

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

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

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

Medical Record Documentation Standards

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

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

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

XXIII. Member Safety

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

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

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

Member Safety prevention, monitoring and evaluation include:

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

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

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



- c. Sentinel events identification and appropriate investigation and remedial action
- d. Administration of Flu/Pneumonia vaccine
- C. Administrative offices
 - a. Fire, disaster, and evacuation plan, testing, and annual training

XXIV. Member Experience and Satisfaction

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

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

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

Member Grievances and Provider Complaints

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

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

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

XXV. Delegation Oversight

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



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

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

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

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

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

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

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



XXVI. Data Integrity/Analytics

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

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

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

Identification and Stratification of Members

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

Identify Potential of Over- and Under- Utilization of Services

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

Identify Missing Preventive Care Services

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

Identify Members for Targeted Interventions



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

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

Medical Record Review

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

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

Interventions

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

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

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

Improvement Standards

- A. Demonstrating Improvement



- a. Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.
- B. Sustaining Improvement
 - a. Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

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

Documentation of QI Projects

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

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

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

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

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



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

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

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

Administrative Oversight:

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

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

XXVII. Conflict of Interest

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



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

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

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

XXVIII. Confidentiality

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

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

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

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XXIX. Communication of QI Activities

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

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

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



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

XXX. Annual Evaluation

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

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

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

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

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