Santa Clara
Family Health Plan
The Spirit of Care

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Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, May 10, 2017
6:00 PM - 7:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Introduction**	Ms. Tomcala/Dr. Paul	6:00	5 min.
	a. Introduction of new committee members: Darrell Evora and Jeffrey Arnold, MD			
2.	**Meeting Minutes**	Dr. Paul	6:05	5 min.
	Review minutes of the February 08, 2017 Quality Improvement Committee meeting. **Possible Action:** Approve 02/08/2017 minutes			
3.	**Public Comment**	Dr. Paul	6:10	5 min.
	Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes.			
4.	**CEO Update**	Ms. Tomcala	6:15	10 min.
	Discuss status of current topics and initiatives.			
5.	**Action Items**	Mr. Aguirre	6:25	25 min.

a. Review Quality Improvement Committee Charter

b. Review of Quality Improvement Policies

i. QI.01 Conflict of Interest
ii. QI.02 Clinical Practice Guidelines
iii. QI.03 Distribution of Quality Improvement Information
iv. QI.04 Peer Review Process
v. QI.05 Potential Quality of Care Issues
vi. QI.06 Quality Improvement Study Design/Performance Improvement Program Reporting
vii. QI.07 Physical Access Compliance
viii. QI.08 Linguistics Culture
ix. QI.09 Health Education Program and Delivery System Policy
x. QI.10 IHA and HEBA Assessments Policy

xi. QI.11 Member Non-Monetary Incentives
xii. QI.12 SBIRT
Possible Action: Approve Quality Improvement policies.

c. Adult Preventive Health Guidelines — Dr. Boris
Possible Action: Approve Adult Preventive Health Guidelines

d. Review of QI Work Plan, QI Program Evaluation, and QI Program Description — Mr. Aguirre
Possible Action: Approve QI Work Plan, QI Program Evaluation and QI Program Description

e. Review of Complex Case Management Outcomes for 2016 and CM Program Evaluation — Ms. Carlson
Possible Action: Approve Case Management Program Evaluation

f. Review of Health Education Program Evaluation and Health Education Work Plan — Ms. Sheu-Ma
Possible Action: Approve Health Education Program Evaluation and Health Education Work Plan

g. Review of Americans with Disabilities Act Workplan — Mr. Aguirre
Possible Action: Approve Americans with Disabilities Act Workplan

h. Review and Adoption of Optum Complex Case Management Policies — Ms. Carlson
i. Care Plans and Goals CM-010
ii. Data Collection Tools and Assessments CM-007
iii. Identification-Case Opening and Closure Criteria CM-009
iv. Program Content Development Review and Approval Process QI-004
v. Program Satisfaction-Feedback QI-020
Possible Action: Approve and Adopt Optum Complex Case Management Policies

i. Review and Approval of Optum 2016 Quality Improvement Program Description and Work Plan — Ms. Carlson
Possible Action: Approve Optum 2016 Quality Improvement Program Description and Work Plan

6. Discussion Items — 6:50 — 15 min.

a. Access and Availability — Mr. Aguirre

b. Appeals and Grievances — Mr. Aguirre

c. Disease Management Outcomes for 2016 — Ms. Carlson

d. CY 2017 Annual Review of SCFHP CMC Population Demographics & Specific Health Conditions — Dr. Boris

7. Committee Reports

a. Credentialing Committee — Dr. Lin — 7:05 — 5 min.
Review February 01, 2017 and April 05, 2017 reports of the Credentialing Committee.
Possible Action: Accept February 01 and April 05, 2017 Credentialing Committee Reports as presented

b. Pharmacy and Therapeutics Committee — Dr. Lin — 7:10 — 5 min.
Review minutes of the December 15, 2016 Committee Meeting.
Possible Action: Accept December 15, 2016 Pharmacy and Therapeutics Committee minutes as presented

c. Utilization Management Committee — Dr. Lin — 7:15 — 5 min.
Review minutes of the January 18, 2017 and March 22, 2017 Committee Meetings.
Possible Action: Accept January 18 and March 22, 2017 Utilization Management Committee minutes as presented

d. Dashboard — Mr. Aguirre — 7:20 — 10 min.
Possible Action: No action required.

e.	**Consumer Advisory Board** **Possible Action:** No action required.	Ms. Andersen	7:30	10 min.
8.	**Adjournment**	Dr. Paul	7:40	

Notice to the Public—Meeting Procedures

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

The Quality Improvement Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.

In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Caroline Alexander 48 hours prior to the meeting at 408-874-1835.

To obtain a copy of any supporting document that is available, contact Caroline Alexander at 408-874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 210 E. Hacienda Avenue, Campbell.

This agenda and meeting documents are available at www.scfhp.com.

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, February 08, 2017

Voting Committee Members	Specialty	Present Y or N
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	N
Jimmy Lin, MD	Internist	Y
Ria Paul, MD	Geriatric Medicine	N
Jeff Robertson, MD, CMO	Managed Care Medicine	Y
Christine Tomcala, CEO	N/A	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y
Andres Aguirre, MPH	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	N
Jennifer Clements	Director of Provider Operations	Y
Darryl Breakbill	Grievance and Appeals Operations Manager	Y
Sandra Carlson, RN	Director of Health Services	Y
Carel Peterson, RN	Manager of Case Management	Y
Caroline Alexander	Administrative Assistant	N

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman was absent so Jeff Robertson, MD, CMO called the meeting to order at 6:05 p.m. Quorum was established.			
Review and Approval of November 09, 2016 minutes	The minutes of the November 09, 2016 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the November 09, 2016 meeting were approved as presented.		
Public Comment	No public comment.			
CEO Update	Christine Tomcala reported membership is currently at 278,843 members, down 2500 members in Medi-Cal. Plan has been notified by DHCS/DMHC audit to take place first two weeks of April. Installing QNXT as core claims system for Medi-Cal,			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	already in place for Cal MediConnect. One single core operating system, approximate implementation June 2017. Discussion of ACA replace/repeal. Less dollars and more state control. Association is advocating for us. Governor's budget, because CCI but keep Cal MediConnect and move IHSS back to counties. Moving forward with D-SNP application in case Cal MediConnect goes away, due February 15th, 2 year Cal MediConnect.			
Action Items A. Review of Quality Improvement Policies	Two policies were presented to the committee: CM.10 Early Start Program (Early Intervention Services) QI.02 Clinical Practice Guidelines	All policies were approved as presented.		
B. Review of QI Program Description	Dr. Liu presented the QI Program Description for review and approval.	QI Program Description approved as presented.		
C. Review of Case Management Program Description	Ms. Petersen and Ms. Carlson presented the Case Management Program Description for review and approval. There are 4 levels of Case Management: • Level 3 Complex Case Management • Level 2 Complex Case Management • Level 1 Moderate Case Management • Population Monitoring-Basic Case Management New software program for Case Management.	Case Management Program Description approved as presented.		
D. Health Education Program Description	Mr. Aguirre presented the Health Education Program Description for review and approval. Increasing Health Education monitoring, utilization. More involvement with Consumer Advisory Committee (CAC). Add community classes as needed.	Health Education Program Description approved as presented.		
E. Cultural and Linguistics Program Description	Mr. Aguirre presented the Cultural and Linguistics Program Description for review and approval. Interpreter services and translation are available through the Language Line. The Cultural and Linguistics Program includes assessment, monitoring and enhancement of all services provided directly by the Health Plan, as well as all services provided by contracted providers, including pharmacies and ancillary services.	Cultural and Linguistics Program Description approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Discussion Items A. Access and Availability	Ms. Clements presented the Access and Availability report. Will routinely monitor Access and Availability: • Surveys of appointment availability, partnered with ICE • Access and Availability Workgroup from different departments in house to identify additional issues not in the survey	Report data and findings at next QIC	Jennifer Clements	May 10, 2017
B. Appeals and Grievances	Mr. Breakbill presented the Grievance and Appeals report for the 3rd and 4th Quarter of 2016. Total number of grievances for Medi-Cal decreased from 562 in 3rd Quarter to 469 in 4th Quarter. Total number of appeals for Cal Medi-Connect decreased from August 2016 to January 2017. Total number of grievances increased from August 2016 to January 2017. Cal MediConnect Part D Trends from July 2016 through January 2017: Ambien, Vistaril, and Lidocaine patches were the top 3 number of appeals for Part D. Part C Trends were as follows: MRI/PET/SPECT Scans: 10 appeals DME: 6 appeals Out of Network Provider Requests: 4 appeals			
Committee Reports A. Credentialing Committee	Dr. Lin presented the December 07, 2016 Credentialing Committee Report. No issues to report. It was moved, seconded to approve Credentialing Committee report as presented.	Credentialing Committee report was approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the 3rd Quarter 2016 Pharmacy and Therapeutics Committee minutes. Epipen generic is now available. Zepatier is formulary and Harvoni for Hep C.	3rd Quarter 2016 Pharmaceutical and Therapeutics Committee minutes were approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
C. Utilization Management Committee	Dr. Lin presented the 4th Quarter 2016 Utilization Management Committee minutes. Summarized updates to the Medi-Cal Prior Authorization Grid. Inpatient admission will require prior authorization. Hemodialysis no longer requires prior authorization unless out of area. Non contracted providers require prior authorization. Oncology no longer requires prior authorization.	4th Quarter 2016 Utilization Management Committee minutes were approved as presented.		
D. Dashboard	Dr. Liu presented the 4th Quarter Dashboard report, including data through the end of 4th Quarter 2016. HEDIS measures related to auto assignment. HEDIS measures related to quality withhold. Nine facility site reviews performed. 29 Potential Quality Issues reported. 23 Level 1: No quality issue determined. 6 Level 2: Opportunity for improvement. Initial Health Assessment Rate for 4th Quarter was 39%.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Adjournment	Meeting adjourned by Dr. Jeff Robertson at 7:20 p.m.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Next Meeting	Wednesday, May 10, 2017- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____
Ria Paul, MD
Quality Improvement Committee Chairperson

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Conflict of Interest**	**Policy No.:**	QI.01
Replaces Policy Title (if applicable):	Conflict of Interest	**Replaces Policy No. (if applicable):**	QI-03
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

The purpose of this policy is to avoid a conflict of interest from occurring as related to Quality Improvement Committee (QIC) activities.

II. Policy

Practitioners and SCFHP staff serving as voting members on any QI Program related Committee or the Quality Improvement Committee (QIC), are not allowed to participate in discussions and determinations regarding any case where the committee member was involved in the care received by a member under review by the committee. Additionally, committee members may not review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issue.

All employees and committee participants sign a Conflict of Interest Statement on an annual basis. Fiscal and clinical interests are separated, as SCFHP and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care, and there are no financial incentives for UM decision-makers that could encourage decisions that would result in under-utilization.

III. Responsibilities

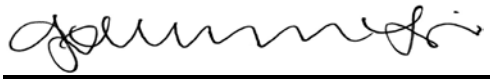
The Quality Improvement Department provides and maintains a Conflict of Interest statement to all Plan Committees that report up to the QIC annually. The Utilization Management Committee, Pharmacy and Therapeutics Committee, Credentialing and Peer Review Committee and Appeals Sub-Committee all sign the agreement and are obligated to report any potential conflict of interest related to committee activities their committee chairperson.

IV. References

Dept. of Plan Surveys; CalMediConnect; Quality Management System (TAG). (2015, October 27). Retrieved April 12, 2016, from Department of Managed Healthcare; CA: https://www.dmhc.ca.gov/LicensingReporting/HealthPlanComplianceMedicalSurvey.aspx#.Vw1T1e_n-Uk

Quality Improvement 1115 Waiver(TAG). (2015, February 11). Retrieved April 12, 2016, from California Department of Managed Healthcare: https://www.dmhc.ca.gov/Portals/0/LicensingAndReporting/MedicalTechnicalAssistanceGuides/1115_qi_02_11_15.pdf

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/18/2016	Title 05/18/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Clinical Practice Guidelines**	**Policy No.:**	QI.02
Replaces Policy Title (if applicable):	Development of Clinical Practice Guidelines	**Replaces Policy No. (if applicable):**	QM008_001
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To ensure a consistent process for development and revisions of Clinical Practice Guidelines.

II. Policy

Santa Clara Family Health Plan (SCFHP) adopts and disseminates Clinical Practice and Preventive Care Guidelines relevant to its members for the provision of preventive, acute and chronic medical services and behavioral health care services. These guidelines are adopted to help practitioners make appropriate decisions for specific clinical circumstances, preventive health and behavioral healthcare services.

A. These guidelines are based on up to date evidence 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.

B. SCFHP adopts at least two medical based and two behavioral health based clinical practice guidelines.

C. The guidelines are reviewed and updated at least every two years by the Quality Improvement Committee (QIC).

D. The guidelines are available for viewing on the provider web page of the health plan website, in the Provider Manual and upon request.

E. In addition to the clinical practice guidelines, SCFHP adopts preventive health guidelines for the following:
   1. Care for children up to 24 months old
   2. Care for children 2-19 years old
   3. Care for adults 20-64 years old
   4. Care for adults over 65 years old

F. SCFHP annually measures performance against at least two important aspects of the disease management programs

G. SCFHP annually evaluates provider adherence to CPGs and Preventive Health Guidelines through analysis demonstrating a valid methodology to collect data.
    a. The QI Department analyzes pertinent HEDIS scores and claims data. The analysis includes quantitative and qualitative analysis or performance.
    b. Member satisfaction and grievances are tracked and reported to the QIC at least annually and acted upon as recommended by the QIC.

III. Responsibilities

Health Services Department, Quality Improvement Department and plan providers develop and adhere to Clinical and Preventive Practice Guidelines which are reviewed / revised at least annually. Evaluation of the guidelines occurs every 2 years.

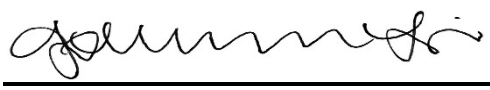
IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 2/2/2017	Title 2/2/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
v**2**	**Revised**	**Quality Improvement**	**Approve 2/8/2017**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

a. At least annually, the Plan communicates Quality Improvement (QI) program information to practitioners, providers and members. Information about QI program processes, goals, and outcomes are shared, as they relate to member care and services, in language that is easy to understand.
b. The Plan may distribute information through regular mail, e-mail, fax, the Web or mobile devices. If posted on the Web, practitioners, providers and members will be notified of the posting and given the opportunity to request the information by mail.

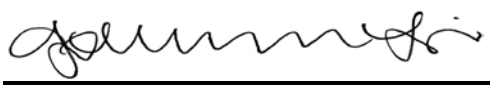
III. Responsibilities

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

IV. References

NCQA, 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
05/18/2016	05/18/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

III. Responsibilities

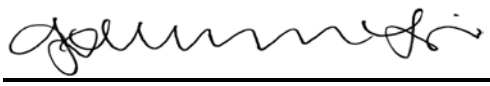
QI continuously monitors, evaluates and develops plans to improve upon PQIs. QI, Health Services, Customer Service, IT, Grievances & Appeals and credentialing monitor for PQIs. The QI Department tracks and trends valuable data which can identify PQIs. All PQIs have the potential for peer review.

IV. References

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

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/18/2016	Title 05/18/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

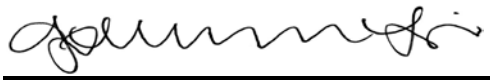
IV. References

California Code and Regulations:

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

California Health and Safety Code section 1367.1

V. Approval/Revision History

First Level Approval	Second Level Approval
	
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Title 05/18/2016	Title 05/18/2016
Date	Date

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v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

SCFHP utilizes sound statistical techniques, measurable and quantitative data and reporting techniques that produce reliable and timely data. Procedure details are documented in the associated Procedure Document Q106_01 Quality Improvement Study Design/Performance Improvement Program Reporting.

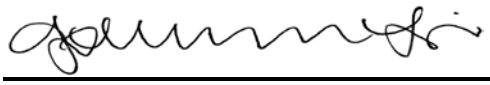
III. Responsibilities

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

IV. References

The Centers for Medicare and Medicaid Services (CMS). Medicare Managed Care Manual Chapter 5, Quality Assessment
The National Committee for Quality Assurance (NCQA), 2016.
NCQA HEDIS Specifications, 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/18/2016	Title 05/18/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original**	**Quality Improvement**	**Approve 5/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Physical Access Compliance**	**Policy No.:**	QI07
Replaces Policy Title (if applicable):	Physical Access Compliance Policy	**Replaces Policy No. (if applicable):**	QM107
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

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

II. Policy

Santa Clara Family Health Plan (SCFHP) conducts a physical accessibility review at every contracted Primary Care Physician (PCP) office, defined high volume specialist, Community-Based Adult Services (CBAS) and ancillary practice site listed in the Plan's provider directory.

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

III. Responsibilities

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

IV. References

Access to Medical Care for Individuals with Mobility Disabilities, July 2010, U.S. Department of Justice, Civil Rights Division, Disability Rights Section

DPL14-005 – Facility Site Reviews/Physical Accessibility Reviews
APL15-023 – Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers

PL 12-006 - Revised Facility Site Review Tool

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California, Department of General Services, Division of the State Architect. Updated April 27, 2010
DHCS/SCFHP Contract:
Exhibit A, Attachment 4 - QUALITY IMPROVEMENT SYSTEM

4. Quality Improvement Committee

8. Quality Improvement Annual Report

10. Site Review

Exhibit A, Attachment 7 - PROVIDER RELATIONS

5. Provider Training

Exhibit A, Attachment 9 - ACCESS AND AVAILABILITY

11. Access for Disabled Members

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title November 9, 2016	Title November 9, 2016
Date	Date

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v1	**Original**	**Quality Improvement**	**Approve:11/9/2016**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

See associated procedures QI.08.01, QI.08.02, QI.08.03, QI.08.04, and QI.08.05 for detailed process for meeting these objectives.

III. Responsibilities

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

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

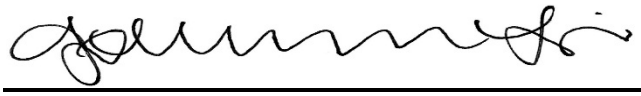
iii. Quality Improvement, Marketing Communications and Outreach, and Compliance maintain a list of member threshold languages which is reviewed and updated as needed based on member assessment needs but no later than every three years based on the results of the Group Needs Assessment survey.

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

IV. References

CMS.gov; Managed Care Manual, Chapter 13
NCQA 2016
California Code of Regulations (28 CCR 1300.67.04) (d) (9) (A) (B) (C)
DHCS Contract; Title 22 CCR Section 53876, Title 22 CCR 53853 (c)
CA Health and Safety Code Sections 1367.04 (b)(1)(a), (b)(4) and (b)(5) and section 1367.04(h)(1)
Civil Rights Act of 1964, (42 U.S.C. Section 2000d, and 45 C.F.4. Part 80)
PL -99 03
APL 99005
CFR 42 § 440.262

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
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Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
January 31, 2017	January 31, 2017
Date	Date

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v1	**Original**			

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

The purpose of this policy is to:

A. Describe the Health Education Department and its functions.
B. Define the standards and quality of health education classes and materials.

II. Policy

The Health Education Department of Santa Clara Family Health Plan (SCFHP) seeks to educate and empower health plan members to:

A. Appropriately use the managed care system, preventive and primary health care services
B. Improve their well-being and reduce their risk of disease and injury through adoption of healthy behaviors
C. Understand and adhere to self-care and treatment regimens in the management of chronic and acute conditions.

It is the policy of SCFHP that the Health Education Department will coordinate member educational material and care guidance with the Health Services Department to make certain that recommendations and guidelines to members are aligned with Clinical Practice Guidelines and Utilization Management medical necessity criteria

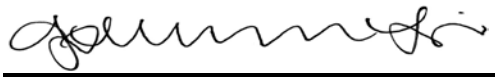
III. Responsibilities

The Health Education Department within the Quality Improvement department of Santa Clara Family Health Plan is responsible for ensuring the policy is enforced with the assistance of the Marketing and Provider services department, and whichever department support is needed to ensure this policy is followed.

IV. References

DHCS Contract Exhibit A, Attachment 10 Section 8.A,
NCQA 2016 Health Plan Accreditation Requirements MEM 8. and MEM 2

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, Pharm D	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/10/2016	Title 08/15/2016
Date	Date

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v1	**Original**	**Quality Improvement Committee**	**Approved; 08/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	Initial Health Assessments (IHA's) and Individual Health Education Behavior Assessment (IHEBA)	**Policy No.:**	QI.10
Replaces Policy Title (if applicable):	Initial Health Assessments (IHA's) and Behavioral Assessment (HEBA)	**Replaces Policy No. (if applicable):**	HE004_05
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

1. The purpose of this policy is to describe the required completion of the Initial Health Assessments (IHA's) and the Individual Health Education Behavior Assessment (IHEBA) by contracted providers.
2. To define the process that Santa Clara Family Health Plan (SCFHP) will oversee the completion of the SHAs, IHAs and IHEBAs

II. Policy

1. It is the policy of Santa Clara Family Health Plan (SCFHP) to support the contracted network in the use and administration of the SHA to all Medi-Cal members as part of the Initial Health Assessment (IHA) and to periodically re-administer the SHA according to contract requirements in a timely manner
2. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) contractual requirements for an IHA and an IHEBA is to be performed within 120 days of a member's enrollment in SCFHP and that the subsequent IHEBA is re-administered at appropriate age intervals.

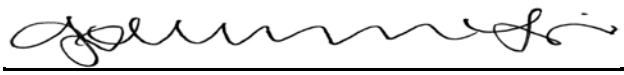
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/10/2016	Title 08/15/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Member Non-Monetary Incentives**	**Policy No.:**	QI.11
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☐ CMC

I. Purpose

The purpose of this policy is to establish guidelines for the administration of rewarding members who demonstrate effort and success in adopting health-promoting behaviors.

II. Policy

SCFHP may utilize non-monetary incentives to reward members who demonstrate effort and success in adopting health-promoting behaviors or changing health risk behaviors.

A. SCFHP obtains approval by DHCS prior to offering any type of member incentive for a member incentive (MI) program, focus group, or survey.
B. SCFHP will submit annual updates to justify the continuation of an ongoing MI program and an end of program evaluation to describe whether or not the MI program was successful.
C. For Focus Group Incentives (FGIs), SCFHP submits an evaluation that incudes recruitment, participation methodology, and results summary. The FGI evaluation will also indicate if policy and program changes are warranted. For Survey Incentives (Sis), SCFHP will submit a copy of the survey, along with an evaluation that includes findings and recommendations.
D. No member incentives are offered to CMC members (Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72).

III. Responsibilities

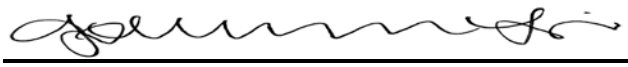
It is the responsibility of the Quality Improvement (QI) department and all departments within the QI department and departments administering incentives, focus groups, and surveys to ensure SCFHP is in compliance with relevant regulations.

IV. References

MMCD APL 16-005, February 25, 2016; AB 915 (Chapter 500., Statutes of 2007): Welfare and Institutions (W&I) Code 14407.1

Title 28. CCR. Section 1300.46, Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72.

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 08/10/2016	Title 08/15/2016
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	

POLICY

Santa Clara
Family Health Plan

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

I. Purpose

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

II. Policy

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

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

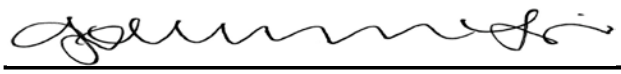
III. Responsibilities

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

IV. References

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

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 05/15/2017	Title 05/15/2017
Date	Date

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V1	**Reviewed**	**Quality Improvement**	**Approve: 5/10/2017**	

Santa Clara Family Health Plan

Quality Improvement Program

2017

Table of Contents

I. Introduction

The Santa Clara County Health Authority, operating business as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). It is a public agency established to enter into a contract with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. In 2001, SCFHP commenced providing health care to children enrolling in the Healthy Kids Program. The Centers for Medicare and Medicaid Services (CMS) contracted with SCFHP from 2007 – 2009 to serve as a Special Needs Plan (SNP) in Santa Clara County. In 2014, CMS and the State of California contracted with SCFHP for the Managed Long Term Services and Supports (MLTSS) programs. In 2015, CMS contracted with SCFHP for the Dual Demonstration Project.

SCFHP is dedicated to improving the health and well-being of the residents of our region. SCFHP continues to realize its vision of serving new enrollees, consistent with our mission and core values.

II. Mission Statement

The Mission of Santa Clara Family Health Plan (SCFHP) is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with select practitioners and 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 publicly funded, local health plan, we have a unique responsibility to work toward improving the health status of the community in which we are based. SCFHP continually promotes community health 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 Santa Clara Family Health Plan (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 Board of Directors assumes ultimate responsibility for the Quality Improvement Program and has established the Quality Improvement Committee to oversee this function. The Board passed a resolution defining the QI Program Description as an organization-wide commitment. This resolution 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.

IV. Purpose

SCFHP is committed to the provision of a well-designed and well-implemented Quality Improvement Program (QI Program). The Plan's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This 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 will foster 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 quality of care issues are identified and corrected.

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 will provide 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 will implement 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, and services received promoting patient safety at all levels of care.

In order to fulfill its responsibility to members, the community and other key stakeholders, regulatory agencies and accreditation organizations, the Plan's Board of Directors (BOD) has adopted the following Quality Improvement Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and Board of Directors.

V. Goals

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

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 its demographics, high-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 to a network of providers with experience in providing care to the population
E. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service
F. Member and provider satisfaction, including the timely resolution of complaints and grievances
G. Risk prevention and risk management processes
H. Compliance with regulatory agencies and accreditation standards
I. The effectiveness and efficiency of the Medi-Cal and CMC internal operations
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 it's mission, vision, and values
L. Compliance with Clinical Practice Guidelines and evidence-based medicine
M. Compliance with regulatory agencies and for CMC the accreditation standards (NCQA)
N. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
O. Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers
P. Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals for patient safety and coordination of care

VI. Functions

The QI Program Description supports and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that our members receive.

The QI Program Description supports the QI Department functions, which include:

A. Implement a multidimensional and multi-disciplinary QI work plan that effectively and systematically monitors and evaluates the quality and safety of clinical care and quality of service rendered to members.
B. Monitor, evaluate and act on clinical outcomes for members
C. Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members
D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
    1. Drive improvement of quality of care received
    2. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Support the maintenance of quality standards across the continuum of care and all lines of business
F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)
G. Coordinate and drive improvements with HEDIS compliance and access to preventive care and management of chronic conditions to HEDIS standards
H. Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the Quality Improvement Program
I. Support collaboration and quality processes and effectiveness of continuous quality improvement activities across the organization
J. Conduct effective oversight of delegated providers

All SCFHP members have timely access to health care that is delivered by qualified practitioners and delivery systems, which meets or exceeds standards determined by the Plan, the Centers for Medicare and Medicaid Services (CMS), the California Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA).

VII. Objectives

The objectives of the QI Program Description include to:

A. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
B. Support practitioners with participation in quality improvement initiatives of SCFHP and all governing regulatory agencies
C. Establish 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
D. Measure the compliance of contracted practitioners' medical records against SCFHP's medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance
E. Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improve performance and/or validate a problem or measure conformance to standards. Oversee delegated activities by:
    1. Establishing performance standards
    2. Monitoring performance through regular reporting
    3. Evaluating performance annually
F. Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include, but are not limited to, an annual evaluation of:
    1. Medical record review
    2. Rates of referral to specialists
    3. Hospital discharge summaries in office charts
    4. Communication between referring and referred-to physicians
    5. Analysis of member complaints regarding difficulty obtaining referrals
    6. Identification and follow-up of non-utilizing members
    7. Practice Pattern Profiles of physicians
    8. Rates of referrals per 1000 members
    9. Performance measurement of practice guidelines
G. Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of potential quality of care concerns through complaints and grievances collected through the Member Services Department.
H. Evaluate the QI Program Description and Work Plan at least annually and modify as necessary. The evaluation addresses:
    1. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    2. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
I. Analysis of 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)
J. Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals, and assessments of goals

K. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members
L. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VIII. Scope

The QIP provides for the review and evaluation of all aspects of health care, encompassing both clinical care and service provided to external and internal customers. External and internal customers are defined as Members, practitioners, providers, employers, governmental agencies, and SCFHP employees.

All departments participate and collaborate in the quality improvement process. The Chief Medical Officer and the Director of Quality integrate the review and evaluation of components to demonstrate the process is effective in improving health care. The measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

A. The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service
B. All activities will reflect the member population in terms of age groups, 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:
    1. Access to Preventive Care (HEDIS)
    2. Behavioral Health Services
    3. Continuity and Coordination of Care
    4. Emergency Services
    5. Grievances
    6. Inpatient Services
    7. Maintenance of Chronic Care Conditions (HEDIS)
    8. Member Experience and Satisfaction
    9. Minor Consent/Sensitive Services
    10. Perinatal Care
    11. Potential Quality of Care Issues
    12. Preventive Services for children and adults
    13. Primary Care
    14. Provider Satisfaction
    15. Quality of Care Reviews
    16. Specialty Care

D. Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:
    1. UM Metrics
    2. Prior authorization
    3. Concurrent review
    4. Retrospective review
    5. Referral process
    6. Medical Necessity Appeals
    7. Case Management
    8. Complex Case Management
    9. Disease Management
    10. California Children's Services (CCS)

IX. QI Work Plan

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

A. Quality of clinical care
B. Quality of Service
C. Safety of clinical care
D. QI Program scope
E. Yearly objectives
F. Yearly planned activities
G. Time frame for each activity's completion
H. Staff responsible for each activity
I. Monitoring of previously identified issues
J. Annual evaluation of the QI Program
K. Priorities for QI activities based on the specific needs of SCFHP's organizational needs and specific needs of SCFHP's populations for key areas or issues identified as opportunities for improvement
L. Priorities for QI activities based on the specific needs of SCFHP's populations, and on areas identified as key opportunities for improvement
M. Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified (PQI)
N. The Work Plan supports the 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 Work Plan that supports the UM Program Description and the monitoring and evaluation activities conducted for UM related functions.

X. QI Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be 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 Medicare such as Quality Improvement Activities (QIAs)
E. Chronic Care Improvement Project (CCIP)

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services

A. Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
B. Case Management
C. Coordination and continuity of care for Seniors and Persons with Disabilities (in house)
D. Provisions of chronic and 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, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
B. Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
C. 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
D. Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
E. 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 will have at least one (and frequently more) quality indicator(s). 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 will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS measures are acceptable.

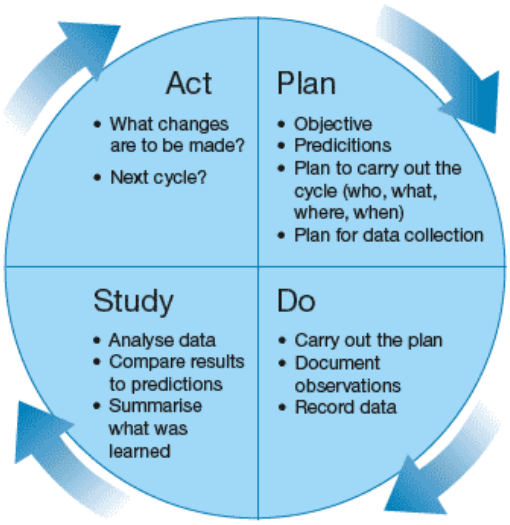
Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Data Warehouse will be utilized.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% 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 dependent 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

XI. QI Quality Issue Identification

SCFHP utilizes a full range of methods and tools of that program, including Sentinel Event monitoring. A sentinel 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.

Sentinel events can include:

A. Potential Quality Issues (PQI)
B. Potential Quality of Care Concern
C. Unexpected death during hospitalization
D. Complications of care (outcomes), inpatient and outpatient
E. Reportable events for long-term care (LTC) facilities include but are 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
F. Reportable events for community-based adult services (CBAS) centers include but are not limited to falls, injuries, medication errors, wandering incidents, emergency room transfers, and 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 will increase 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 Credentialing and Peer Review Committee to determine the appropriate course of action and/or evaluate the actions recommended by 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
D. Case Management
E. Pharmacy Data
F. Group Needs Assessments
G. Results of Risk Stratification
H. HEDIS Performance
I. Member and Provider Satisfaction
J. Quality Improvement Projects (QIPs)
K. Health Risk Assessment data

An example of identification of risk and quality potential or actual issues include:

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

<u>Protocol for Using Quality Monitors Screens</u>

Case Management and Referrals 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 Utilization Management. 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 to have potential quality of care issues, the Quality Improvement RN Clinical Review staff will abstract the records and prepare the documents for review by the CMO or Medical Director. The case is routed back to the Quality staff who initiated the review for closure of the case.

When the Chief Medical Officer agrees that a quality of care problem exists, the CMO reviews the case, assigns a priority level, initiates corrective action, or recommends corrective action as appropriate. For case of neglect or abuse, follow-up or corrective action may include referrals to Child or Adult Protective Services.

In-Home Supportive Services (IHSS) Quality Monitoring

SCFHP will participate in the stakeholder workgroup established by the Department of Health Services, the State Department of Social Services, and the California Department of Aging to develop the universal assessment process, including a universal assessment tool, for home-and community-based services, as defined in subdivision (a) of Section 14186.1. The stakeholder workgroup shall include, but not be limited to, consumers of IHSS and other home- and community-based services and their authorized representatives, the county, IHSS, Multipurpose Senior Services Program (MSSP), and CBAS providers, and legislative staff. The universal assessment process will be used for all home-and community-based services, including IHSS. In developing the process, the workgroup shall build upon the IHSS uniform assessment process and hourly task guidelines, the MSSP assessment process, and other appropriate home- and community-based assessment tools.

In developing the universal assessment process, a universal assessment tool will be developed that will facilitate the development of plans of care based on the individual needs of the recipient. The workgroup shall consider issues including, but not limited to, how the results of new assessments would be used for the oversight and quality monitoring of home- and community-based services providers.

SCFHP will work closely with the local IHSS Agency to develop an appropriate monitoring and oversight plan to adhere to quality assurance provisions and individual data and other standards and requirements as specified by the State Department of Social Services including state and federal quality assurance requirements. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

Quality Improvement Activities – Long Term Care Facilities

Monitoring of the quality of care provided to SCFHP members, including those residing in LTC facilities, includes, but is not limited to, the following:

- Member complaint and/or grievance trends.
- Provider complaint and/or grievance trends.
- Case review of potential quality of care issue referrals triggered by quality monitors (sentinel events), or utilization management activities.
- Member satisfaction surveys.
- Focused review of topics, including those specifically related to special needs populations such as members residing in LTC facilities.

Topics for review are identified through the monitoring process. Proposed study indicators shall be reviewed by the QI Committee and approved prior to commencing the study. Initiation of quality improvement projects will be directed to the identified needs of members residing in LTC facilities. Focused quality improvement audits, as necessary, for members residing in LTC facilities are performed by the Concurrent Review Case Managers, or Quality Analysts, during on-site facility visits.

Results of quality improvement activities are presented to the Quality Department for review, analysis and summarizing. LTC facilities are notified if there is a need to execute corrective action plans (CAPs). Follow-up reviews will be conducted at LTC facilities when CAPs are executed. SCFHP assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for SCFHP members in LTC facilities, including the local Regional Center, Licensing and Certification, Medi-Cal Operations Division and the Ombudsman's Office. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

XII. QI Program Activities

The QI Program's scope includes implementation of QI activities or initiatives. The QI Committee and related committee and work groups select the activities that are designed to improve performance on selected 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 will be given 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 provides care resulting in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Board of Directors 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 and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken 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 (chronic 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 of the Clinical Quality Improvement, Utilization Management and Pharmacy and Therapeutics Committees. Guidelines will be reviewed and revised, as applicable, at least every two years.

Preventive Health/HEDIS®-Measures

The Quality Improvement Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually based on product type, i.e. Medi-Cal or Medicare. Initiatives, such as for Pap smear education and compliance, are put in place to encourage member compliance with preventive care.

Disease Management Programs

The health care services staff, Quality Improvement Committee (QIC) and network practitioners identify members with, or at risk for, chronic medical conditions. The Quality Improvement Committee is responsible for the development and implementation of disease management programs for identified conditions. Disease management programs are designed to support the practitioner- patient relationship and plan of care. The programs will emphasize the prevention of exacerbation and complications using evidence-based practice guidelines. The active disease management programs and their components will be identified in the annual UM work plan.

Complex case management and chronic care improvement are major components of the disease management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs. Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The case managers'/care coordinators help members navigate the care system and obtain necessary services in the most optimal setting.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

1. Primary care services
2. Behavioral health care services
3. Inpatient hospitalization services
4. Home health services
5. 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 are accomplished:

A. Information Exchange – 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 of 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 – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
E. Implementations of Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

XIII. QI Organizational Structure

The Quality Improvement Department

The Department support and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that are members receive.

A. Monitor, evaluate and act on clinical outcomes for members
B. Conduct review and investigations for potential or actual Quality of Care matters
C. Conduct review and investigations for clinical grievances, including Potential Quality Issues (PQIs).
D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
    1. Drive improvement of quality of care received
    2. Minimize rework and costs
    3. Minimize the time involved in delivering patient care and service
    4. Empower staff to be more effective
    5. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Support the maintenance of quality standards across the continuum of care and all lines of business
F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)

Chief Medical Officer (CMO)

The Chief Medical Officer has an active and unrestricted license in the state of California. The CMO serves as the Chairperson for the Quality Improvement Committee and is responsible to report to the Board of Directors at least quarterly on the Quality Improvement program including reports, outcomes, opportunities for improvement and 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 General Staff meetings, senior management team meetings, and other internal meetings.

Medical Director

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

The Medical Director(s) is required to supervise all medical necessity decisions and conducts medical necessity denial decisions. A Medical Director is the only Plan person authorized to make a clinical denial based on medical necessity. The Plan pharmacist(s) may make a denial based on medical

necessity regarding pharmaceuticals.

Director of Quality

The Director of Quality is a registered nurse or other qualified person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Director of Quality reports to the Chief Medical Director and is responsible for directing the activities of the Plan's quality management staff in monitoring and auditing 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 senior executive staff, both clinical and non-clinical, 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 coordinates the Plan's QI Committee proceedings in conjunction with the CMO; report to the Board relevant QI activities and outcomes, support corporate initiatives through participation on committees and projects as requested; review statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

Quality Manager

The Quality Manager is a person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Quality Manager reports to the Director of Quality and is responsible for managing the activities of the Plan's quality management staff in monitoring and auditing 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 Quality Manager assists the Director of Quality 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 Quality Manager facilitates the Plan's QIC proceedings in conjunction with the CMO; supports corporate initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

QI Nurse, RN

The QI Nurse reports to the Quality Manager and oversees the investigations of member grievances, supports HEDIS reviews, investigates and prepares cases for potential quality of care (QOC) reviews and potential quality issues (PQI) for the 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 (PIP) and Chronic Care Improvement Projects (CCIP). The QI Nurse is also a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Evaluations (IHEs), and assists with other QI activities at the direction of the Quality Manager.

QI Project Manager

The QI Project Manager provides leadership, coordination, and management of quality improvement projects. Director of Quality his position is responsible for developing and maintaining processes that enhance the operationalization of QI processes, management of software applications(s), and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

HEDIS Project Manager

The HEDIS Project Manager provides leadership, coordination, and 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(s), and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

QI Health Educator

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

Coordinator, QI

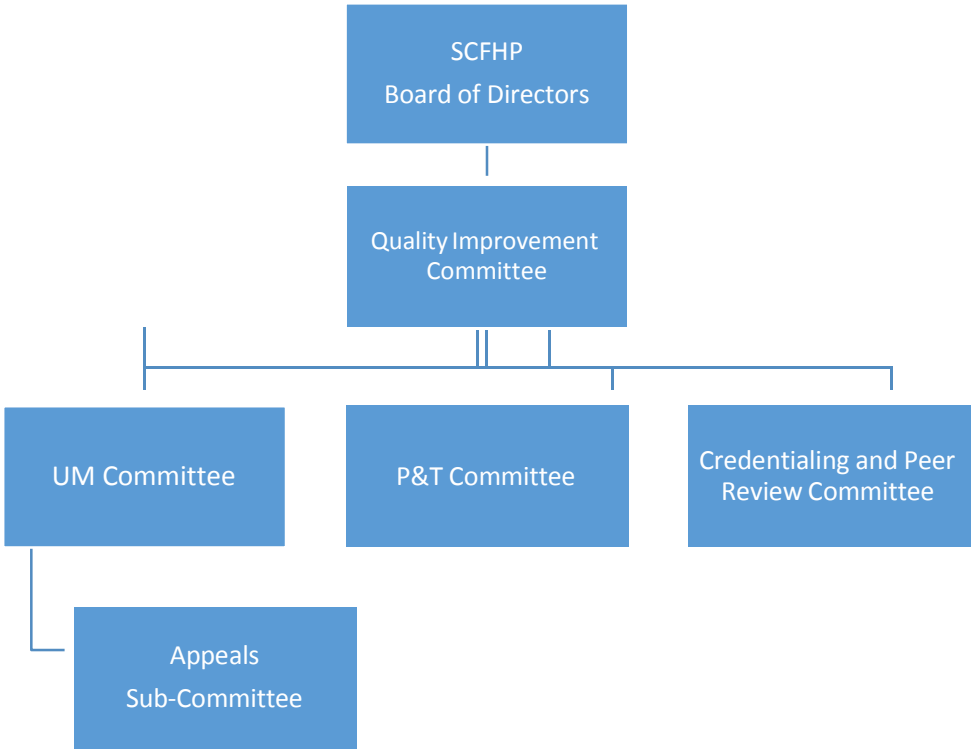
Quality Improvement Coordinators are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management preferred. QI Coordinators report to the Quality Manager and their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and 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 action or improvement initiatives as identified through Plan's quality improvement activities and quality of care reviews. Committee Structure
Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the Board of Directors.

SCFHP involves a contracted network licensed behavioral specialist who is a psychiatrist or Ph.D. level psychologist to serve on the QI Committee and the UM Committee and as an advisor to the QI Program structure and processes. The designated behavioral health practitioner advises the Clinical Quality Improvement Committee 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.

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

A. Voting members
B. Plan support staff
C. Quorum

D. Meeting frequency
E. Meeting terms
F. Goals
G. Objectives



In addition the Grievance/Appeals Committee conducts analysis and intervention and reports to the QI Committee.

Board of Directors

The Board of Directors is responsible to review, act upon and approve the overall QI Program, Work Plan, and annual evaluation. The Board of Directors receives at least quarterly progress and status reports from the QI Committee describing interventions and actions taken, progress in meeting objectives, and improvements achieved. The Board shall also make recommendations additional interventions and actions to be taken when objectives are not met.

The Director of Quality is responsible for the coordination and distribution of all quality improvement related data and information. The Quality Improvement Committee reviews, analyzes, makes recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The Chief Executive or the Chief Medical Officer communicates the QI C 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.

XIV. Committee Structure

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 QIC actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. Plan's QIC is comprised of network physicians representing the range of practitioners within the network and across the regions in which it operates, including a BH practitioner. Plan executive leadership and QI staff may also attend the QIC as appropriate

The purpose of the QI Committee is to monitor and assess 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 QI Committee oversees the performance of delegated functions and contracted provider and practitioner partners. The composition of the QI Committee includes a participating Behavioral Health Practitioner 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 QI Committee provides overall direction for the continuous improvement process and evaluates for activities that are consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and interdepartmental approach and adequate resources for the program. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided the highest quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QI Committee.

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

The QI Committee shall develop, oversee, and coordinate member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QI Committee also recommends strategies for dissemination of all study results to SCFHP-contracted providers and practitioners, and contracted groups.

The QI Committee provides overall direction for the continuous improvement process and monitors that activities are consistent with SCFHP's strategic goals and priorities. It promotes efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

Utilization Management Committee

The Utilization Management Committee promotes the optimum utilization of health care services, while

protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic

monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UM Committee actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. Plan's UM Committee is comprised of network physicians representing the range of practitioners within the network and across the regions in which it operates, including a BH practitioner. Plan executive leadership and UM/QI staff may also attend the UMC as appropriate.

The UM Committee (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 UM Work Plan.

The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as adoption of Evidence Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and 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 to medical care, continuity and coordination of medical and behavioral health care, as well as 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 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, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to SCFHP's members. The P&T Committee includes practicing physicians and the contracted provider networks. A majority of the members of the P&T Committee are physicians (including both Plan employee physicians and participating provider physicians), and the membership 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 P&T Committee involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacological drugs.

The P&T Committee also involves mental health prescribing practitioners 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

Peer Review is coordinated through the QI Department and communicated with the Credentialing process. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases will be presented to the Credentialing and Peer Review Committee to assess if documentation is complete, and no further action is required. The QI Department also 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 is based on referrals to the QI Department originated from multiple areas, which include, but are not limited to, the following: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

XV. Role of Participating Practitioners

Participating practitioners 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, disease management 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 levels of care and service
F. Are involved with policy setting
G. Participate with the following committees
    1. Quality Improvement Committee
    2. Pharmacy and Therapeutics Committee
    3. Utilization Management Committee
    4. Credentialing and Peer Review Committee
    5. Additional committees as requested by the Plan

XVI. Pharmacy Services

Pharmacy Services are overseen by the Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is two-fold, utilizing the Pharmacy Benefit Manager (PBM) national P&T Committee for the Medicare line of business and a Plan Based P&T Committee for the Medi-Cal line of business as well as to oversee QI monitoring of medication management outcomes, and approve applicable programs and policies and procedures. The P&T Committee oversees the development, maintenance, and improvement of SCFHP's formularies. The P&T Committee recommends policy on all matters related to the use of drugs to promote the clinically appropriate use of pharmaceuticals based on sound clinical evidence. The P&T Committee reports organizationally to SCFHP's Quality Improvement Committee. SCFHP has adopted its PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements.

SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state. SCFHP maintains a closed drug formulary for the Medi-Cal (Medicaid) line of business.

The Plan has adopted the PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements. SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state.

Current versions of SCFHP's formularies are posted on the Plan's web site and are accessible to both members and practitioners. SCFHP pharmaceutical management procedures are included within the formulary as well as in the *Member Guide* (Combined Evidence of Coverage and Disclosure Form) and Provider Manual. Members, prescribers, and pharmacies may receive a printed copy of the formulary upon request.

SCFHP develops its own medical exception review criteria and/or adopts its PBM's criteria. The P&T Committee reviews and approves each set of criteria (both Plan developed and PBM-developed criteria) prior to use and performs an annual review of all criteria. When applying the criteria in a review of a request, SCFHP's criteria are applied when they exist. When Plan-developed criteria do not exist, the appropriate clinical references will be applied.

Member safety is integrated into all components of the Plan's QI Program, and is especially applicable to Pharmacy Services who conducts monitoring and evaluation and takes interventions when application while reviewing processes

SCFHP's pharmaceutical quality improvement process includes measures and reporting systems to address the identification and reduction of medication errors and adverse drug interactions. The PBM's utilization review (DUR) edits provide on-line messaging to dispensing pharmacists. The PBM identifies drug-drug interactions based on three severity levels supported by nationally recognized references (e.g., First Data Bank, NDDF Plus, and National Drug Data File). Eight (8) on-line DUR edits are used and send a message to the dispensing pharmacist when "triggered":

A. Drug Interaction
B. Drug dosage
C. Ingredient duplication
D. Age precaution
E. Pregnancy precaution
F. Gender conflict
G. Therapeutic duplication
H. Late refill

The PBM identifies and notifies SFHP of members and prescribers affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons. SCFHP uses these reports to notify affected physicians and members within 30 calendar days of the FDA notification. An expedited process is followed for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. When the FDA recalls a drug, the product is immediately removed from SCFHP's formularies and active prior authorizations are terminated.

SCFHP conducts retrospective drug utilization of pharmacy claims and other records, through computerized drug claims processing and information retrieval systems to identify patterns of inappropriate or medically unnecessary care among members or associated with specific drugs or groups of drugs.

SCFHP monitors and implements processes to prevent over-utilization and under-utilization of prescribed medications, including but not limited to the following elements:

A. Compliance programs designated to improve adherence/persistency with appropriate medication regimens
B. Monitoring procedures to discourage over-utilization through multiple prescribers or multiple pharmacies
C. Quantity versus time edits
D. Early refill edits

XVII. Behavioral Health Services

SCFHP will monitor and improve the quality of behavioral health care and services provided through and based on applicable contract requirements. The QI program includes services for behavioral health and review of the quality and outcome of those services delivered to the members within our 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 Clinical Director for Behavioral Health services shall be involved in the behavioral aspects of the QI Program. The Clinical Director shall be available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data, and follow-up on identified issues.

XVIII. Utilization Management

Utilization Management activities and related UM activities including Case Management, Disease Management, and Model of Care programs and processes as addressed in the Utilization Management Program Description.

The outcomes of UM activities are measured and reported to the UM Committee and are defined in the UM Work Plan.

Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:

11. UM Metrics
12. Prior authorization
13. Concurrent review
14. Retrospective review
15. Referral process
16. Medical Necessity Appeals
17. Case Management

18. Complex Case Management
19. Disease Management
20. California Children's Services (CCS)
21. Early and Periodic Screening, Diagnosis and Treatment (ESPDT)

Monitoring Utilization Patterns

To monitor and analyze that appropriate care and service to members, SCFHP's Utilization Management Committee performs an annual assessment of utilization data to identify potential under- and over-utilization issues or practices. Data analysis is conducted using various data sources such as medical service encounter data, pharmacy, dental and vision encounter reporting to identify patterns of potential or actual inappropriate utilization of services. The QI Department works closely with the UM Department, Chief Medical Officer Director of Health Care Services and Plan Medical Directors to identify problem areas and provide improvement recommendations to the QIC for approval. Once approved, the QI and UM Departments will implement approved actions to improve appropriate utilization of services.

The California DHCS also requires submission of selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures. These measures may be audited as part of the EAS/HEDIS Compliance Audit and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, SCFHP adheres to DHCS notification to the Plan of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

XIX. 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 promotion of 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. Standardized mechanisms for member identification through use of data
B. Documented process to assess the needs of member population
C. Multiple avenues for referral to case management and disease management programs
D. Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
E. Ability of member to opt out
F. Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education
G. Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

H. Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
I. Coordinating services for members for appropriate levels of care and resources
J. Documenting all findings
K. Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
L. Ongoing assessment of outcomes

The Interdisciplinary Care Teams (ICT) includes three (3) levels of ICTs that reflect the health risk status of members. Each are offered an ICT. All members are stratified using a plan-developed stratification tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. The members are stratified into high, moderate and low risk levels.

The low risk members are managed by the basic ICT at the PCP level. Moderate members may be managed by the primary ICT at the Medical Group level, if delegated. High risk members are managed by the Complex ICT at the Plan level or through a delegation agreement by an NCQA Certified organization.

For high risk members, the ICT includes the member if feasible, Medical Director, PCP/specialist as necessary, Case Management Team, Behavioral Health Specialist, and Social Worker. A treating Specialist may be invited to an ICT meeting if the need is identified. The teams are designed to see that members' needs are identified and managed by an appropriately composed team. Additional disciplines, such as the Clinical Pharmacist, Dietician, and/or Long Term Care Manager, may be included in the ICT based on the member's specific needs.

Interdisciplinary Care Teams process includes:

A. Basic ICT for Low Risk Members:

1. Basic CM by PCP in collaboration with the case manager
    a. Initial Health Assessment (IHA)
    b. Initial Health Behavioral Assessment (IHEBA)
    c. Identification of appropriate providers and facilities(such as medical, rehabilitation and support services)
    d. Direct communication between provider, member and family
    e. Member and family education
    f. Coordination of carved out/linked services
    g. Referral to appropriate community resources/agencies

B. Primary ICT for Moderate Risk Members:

1. Basic CM as above
2. Record of Medication History
3. Assessment of Health History
4. Development of ICP
    a. Specific to member needs
    b. Member and PCP input
    c. Updated at least annually
5. Identification of appropriate providers and facilities (such and medical, rehabilitation and support services) to meet member care needs
6. Direct communication between provider, member/family or caregiver and case manager/care coordinator
7. Member, family and/or caregiver education including healthy lifestyle changes as appropriate
8. Coordination of carved out and linked services, and referral to appropriate continuity resources and other agencies

C. Complex ICT for High Risk Members:

1. Basic CM as above
2. Record of Medication History
3. Assessment and Health History
4. Basic CM Services
5. Development of Care Plan (ICP)
    a. Specific to member needs
    b. Member and PCP input
    c. Updated at least annually
6. Management of acute/chronic illness(s)
7. Management of emotional/social support issues
    a. By multidisciplinary team
8. Intense coordination of resources
    a. Goal for member to regain optimal health or improved functioning
    b. Focused community based coordination of medical, BH and LTSS benefits and resources including IHSS, MSSP and CBAS.

D. Team Composition (As appropriate for identified needs): Member, Caregiver, or Authorized Representative, Medical Group Medical Director, Plan Clinical/Medical Group Case Manager, PCP and/or Specialist, Social Worker, and Behavioral Health Specialist
    1. Roles and responsibilities of this team
    2. Consultative for the PCP and Medical Group teams
    3. Encourages member engagement and participation in the IDT process
    4. Coordinating the management of members with complex transition needs and development of ICP
    5. Providing support for implementation of the ICP by the Medical Group
    6. Tracks and trends the activities of the IDTs
    7. Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
    8. Oversight of the activities of all transition activities at all levels of the delivery system
        a. Meets as often as needed until member's condition is stabilized.

XX. Cultural and Linguistics

SCFHP will monitor that services, both clinical and non-clinical, 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 needs and planned interventions involve member input and are vetted through the Customer Advisory Committee prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

A. Analysis of significant health care disparities in clinical areas
B. Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
C. Consider outcomes of member grievances and complaints
D. Conduct patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language specific risks
E. Identify and reduce a specific health care disparity with culture and race
F. Provide information, training and tools to staff and practitioners to support culturally competent communication

All individuals providing linguistic services to SCFHP members shall be 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 compliance ability to serve as an interpreter will be maintained by the Plan.

Interpreter services are provided to the member at no charge to the member.

SCFHP offers 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 patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity. And language specific risks to improve cultural competency in materials
C. Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs to improve cultural competency communications
D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy to meet the needs of underserved groups.

SCFHP has designated the Director of Quality 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 Spanish staff
D. Cultural competency trainings such as:
    1. Cultural Competency Workshops
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 withal regulatory and oversight requirements. SCFHP contracts with an NCQA Certified Vendor Organization (CVO). The Plan credentials all new applicants prior to executing a contract to see members and 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. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS, and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, allied health and midlevel practitioners, which include, but are not limited to practitioners who work independently including behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and Direct contracts.

Healthcare Delivery Organizations

SCFHP performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every 36 months thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies and as applicable, accreditation status.

Use of Quality Improvement Activities in the Re-credentialing Process

Findings from quality improvement activities are included in the Re-credentialing process. Should an egregious 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, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

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

SCFHP does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted groups. The Plan does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 02-02. SCFHP assumes responsibility and conducts and coordinates FSR/MRR for the non-delegated groups.

SCFHP collaborates with the delegated entities to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs. 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 02-02 and SCFHP policies.

Medical records of new providers shall be 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 Groups make certain that each member medical record is maintained 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 promote timely access by members to information that pertains to them.

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 is a significant part our quality and risk management functions. Our member safety efforts are clearly articulated both internally and externally, and include strategic efforts specific to member safety. The QI Program Description is based on a needs assessment, and includes the areas:

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, and targets based on the risk assessment
C. Plans to conduct appropriate patient safety training and education are available to members, families, and health care personnel/physicians
D. Health Education and Promotion
E. Group Needs Assessment
F. Over- and under- Utilization monitoring
G. Medication Management
H. Case Management and Disease 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), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
B. Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
C. Utilizing facility site review, Physical Accessibility Review Survey (PARS), and medical record review results from practitioner and healthcare delivery organization 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
D. 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 identifying and remediate potential and actual safety issues, and to monitor ongoing staff education.

A. Ambulatory setting
    1. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    2. Annual blood-borne pathogen and hazardous material training
    3. Preventative maintenance contracts to promote that equipment is kept in good working order
    4. Fire, disaster, and evacuation plan, testing, and annual training
B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings
    1. Falls and other prevention programs
    2. Identification and corrective action implemented to address post-operative complications
    3. Sentinel events identification and appropriate investigation and remedial action
    4. Administration of Flu/Pneumonia vaccine
C. Administrative offices
    1. Fire, disaster, and evacuation plan, testing, and annual training

XXIV. Member Experience and Satisfaction

SCFHP supports continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction by monitoring member and provider complaints, member and provider satisfaction, and member and provider 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, depending upon the intervention.

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 and Systems (CAHPS) member satisfaction survey, monitoring member complaints and direct feedback from the Member Policy Committee. The Membership Services Department is responsible for coordinating the CAHPS surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the Quality Improvement Committee with specific recommendations for performance improvement interventions or actions.

Provider satisfaction is assessed annually using 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. Plan also uses another approach to obtain more real-time data related to new provider satisfaction. Provider Services

Member Grievances and Provider Complaints

The QI Department investigates and resolves all member 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 QI Committee. The QI Committee will recommend specific physician/provider improvement activities.

All administrative member grievances are tracked and resolution is facilitated by the Appeals and Grievance Coordinator. 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 QI Committee at least quarterly, along with recommendations for QI activities based on results.

All provider complaints are tracked and resolution is facilitated by the Provider Network Department. Data is reported to and analyzed by the QI Committee 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 reviewed through the Plan's Compliance Committee. The Delegation Committee reports to compliance. The portion of Delegation Oversight specific to the QI Program are the reporting submitted by the delegated entities and the functional operational area overseeing corrective action plans.

Through Delegation Oversight, the Plan monitors include, but are not limited to, the following:

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

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

A. Evaluation, oversight, and monitoring of the delegation agreement to determine what services can 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 its 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, encounters, claims, and pharmacy. 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 disease management population identification, risk stratification, process measures, and outcomes measures. SCFHP staff creates and maintains the data base with quarterly data updates.

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

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

<u>Identification and Stratification of Members</u>

Using clinical business rules, the database can identify members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect 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 will be available through UM Metrics such as 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 preventative 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 diabetic.

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 will be the primary conduit for targeting and prioritizing heath education, disease management, and HEDIS-related interventions.

By analyzing data that SCFHP currently receives (i.e. claims data, pharmacy data, and encounter data), the data warehouse will identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide SCFHP in not only targeting the members, but also the 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 will be utilized. Training for each data element (quality indicator) will be accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be coordinated by the Director of Quality or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, will be 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. Demonstrated Improvement
   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. Sustained Compliance with Improvement
   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 necessarily 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:

Clinical Care and Service:

A. Access and Availability
B. Continuity and Coordination of Care
C. Preventive care, including:
    1. Initial Health Risk Assessment
    2. Initial Health Education
    3. Behavioral Assessment
D. Patient Diagnosis, Care, and Treatment of acute and chronic conditions
E. Complex Case Management: 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.
F. Drug Utilization
G. Health Education and Promotion
H. Over- and Under- Utilization monitoring
I. Disease Management Outcomes

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 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.

All records and proceedings of the Quality Improvement Committee 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.

All information is maintained in confidential files. The medical groups hold all information in strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement." This Agreement requires the member to maintain confidentiality of any

and all information discussed during the meeting.

XXIX. Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QI Committee quarterly in order to facilitate communication along the continuum of care. The QI Committee reports activities to the Board of Directors, through the CMO or designee, on a quarterly basis. QI Committee 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. Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on the Plan's website, in addition to the annual article in both practitioner and member newsletter.
D. The information to be shared with practitioners and members includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service.
E. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
F. Included in annual practitioner education through Provider Relations and the Provider Manual

XXX. Annual Evaluation

The QI Committee 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 Board of Directors.

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

1. A description of completed and ongoing QI activities that address quality of care and safety of clinical care and quality of service
2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services
3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward

influencing network wide safe clinical practices
4. 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:

1. The adequacy of QI Program resources
2. The QI Committee structure
3. Amount of Practitioner participation in the QI Program, policy setting, and review process
4. Leadership involvement in the QI Program and review process
5. Identification of needs to restructure or revise the QI Program for the subsequent year

Practitioners and members are advised of the availability of a summary of the QIP posted on the Plan's web site and that the summary is also available upon request. This summary includes information about the QIP's goals, processes, and outcomes as they relate to member care and service.

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Care	**QI Program**	Development of a QI Work Plan and Evaluation each year and subsequent tracking of implementation	CMC 2.16.1 Medi-Cal Exhibit A, Attachment 4 .7	- To document and initiate appropriate modifications to the QI Program, and set QI goals each year. - To identify areas of focus for the QI program. - To organize and prioritize the workload with assignments given for accountability and responsibility	QI Program and QI Work Plan will be adopted on an annual basis	Submit the 2016 QI Evaluation and 2017 QI Work Plan for the Board Report	Annual Adoption	QI Manager	Annual	May-17		Approved by QIC: Adopted by Board:
Quality of Care	**QI Program Evaluation**	QI Program Annual Evaluation	CMC 2.16.3.3.4	- To evaluate the results of QI initiatives and submit the results to DHCS and CMT - QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	- collect aggregate data on utilization - review of quality services rendered - review and analyze outcomes/findings from Improvement Projects, customer satisfaction surveys and collaborative initiatives	- submission of QI Program evaluation to - QIC - Board	Annual Evaluation	QI Manager	Annual	May-17		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**UM Program**	Annual oversight of UM Program and Work Plan	CMC 2.11.5.1	- To document and initiate appropriate modifications to the UM Program, and set UM goals each year. - To identify areas of focus for the UM program. - To organize and prioritize the workload with assignments given for accountability and responsibility	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis	- submission of UM Program evaluation to - UMC - QIC - Board	Annual Adoption	Medical Director UM	Annual	September-17		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Access to needed medical services in a timely manner is maintained	CMC 2.11.9.1		Measure and analyze data against goals for the following: 1. Regular & routine appointments within 30 days 2. Urgent Care appointments within 48 hours 3. After-hours care within 6 hrs 4. Member services, by telephone ASA 30 seconds with abandonment rate <5% 5. PCP capacity		97%	Provider Services Director	Quarterly	April 2017 Sept 2017 Dec 2017		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews New applicants processed within 180 calendar days of receipt of application		100%	Credentialing Manager	Quarterly	Feb 2017 April 2017 Sept 2017 Dec 2017		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Access/Availability**	Credentialing program activities monitored	CMC 2.10.5		Credentialing file reviews Recredentialing is processed within 36 months		100%	Credentialing Manager	Quarterly	Feb 2017 April 2017 Sept 2017 Dec 2017		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practioners	CMC 2.11.2.1		Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.		90%	Provider Services Director	Annual	August-17		Approved by QIC: Adopted by Board:
Quality of Service	**Access/Availability**	Availability of Practioners	CMC 2.11.2.1		Measure and analyze practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary. Measured through quantifiable and measurable standards for the following: 1. Each type of PCP 2. Geographic distribution 3. Performance against standards for PCPs 4. Performance against geographic distribution		90%	Provider Services Director	Annual	August-17		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Medi-Cal and CMC	**Utilization Management**	CM Program Annual Evaluation			CM Program and CM Work Plan will be evaluated for effectiveness on an annual basis		Annual Evaluation	CM Manager	Annual	May-17		Approved by QIC: Adopted by Board:
Medi-Cal and CMC	**HEDIS Reporting**	Report HEDIS successfully by 6/15/2017	CMC 2.19.2.5 Medi-Cal Exhibit A Attachment 4.9	- To successfully report HEDIS for Medi-Cal and CMC by June 15, 2017 - To successfully complete MRRV without a second sample being reviewed - Successfully close the IS Grid by 6/5/2017 - Have no Medi-Cal HEDIS measures below the NCQA Medicaid 25th percentile (MPL)	- Create data warehouse - pull samples - request medical records - onsite audit - review of vendor numerator positive medical records prior to MRRV - complete at least one Verisk warehouse build with CMC data including drawing samples	- Submission of the IDSS to NCQA by 6/15/2017 - CMC Test warehouse	Annual Submission	HEDIS Project Manager	Annual	June-17	-	Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Statewide Collaborative Performance Improvement Projects**	Increase retinal eye exam screening for members with diabetic retinopathy	CMC 2.16.4.3.1.2.2 Medi-Cal Exhibit A, Attachment 4.9.C.b	Five percent increase in diabetic retinal eye exam rates over the 18 month life of the project	Collaborate with clinic or medical group to improve rates on a small scale using Rapid Cycle Improvement	Final submission August 15, 2017	37% for Network 50 by the end of the PIP Five percent increase over baseline rate of 32%	QI Project Manager	Quarterly	August-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Internal Performance Improvement Projects Medi-Cal**	Controlling blood pressure for members with hypertension	Medi-Cal Exhibit A Attachment 4.9.C.a	4.2 percent increase in CBC rate over the 18 month life of the project	Use Member Incentive to improve rates on a small scale using Rapid Cycle Improvement	Final submission August 15, 2017	50% for Network 10 by the end of the PIP. 4.2 percent increase over baseline rate of 45.8%	QI Project Manager	Annual	August-17		Approved by QIC: Adopted by Board:
Quality of Service	**Internal Performance Improvement Projects CMC**	The general topic for the PIP must be on improving care coordination with a focus on the integration of the long-term services and supports (LTSS) programs. The MMP may focus on one or more of the four (community based adult services, in-home supportive services, multipurpose senior services program, and nursing facilities) LTSS programs.	CMC 2.16.4.3.1.2.1	Decrease rate of potentially avoidable hospital readmission rates within 30 days of hospital discharge	- SNF's will submit hospital interfacility transfer/discharge forms when submitting prior authorizations and long term care authorizations - Members flagged for risk of re-admission by UR nurse will be monitored by weekly calls to the SNF to review plan of care	Annual Submission	By June 30th, 2017, decrease rate of potentially avoidable hospital readmissions within 30 days of hospital discharge of CMC members from all SNFs to hospitals from 22.8% to 17.8%.	QI Manager or designee	Annual	January-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Internal Performance Improvement Projects CMC**	HEDIS Measure: Reducing readmissions within 30 days of discharge (PCR)	CMC 2.16.4.3.1.2.1	Successfully submit PIP for the CMC line of business	- HEDIS test run of CMC data for barrier analysis - Collaborate within the Medical Management department to start an initial PDSA cycle	submit a first PIP resubmission to CMS for approval	- Three percent reduction in readmission rates from baseline - 9/17/14 - 10/16/15 PCRB 16.41%	QI Project Manager	Annual	October-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Cervical Cancer Screening (CCS)	DHCS 2016 External Accountability Set	Increase the number of SCFHP women who have a screening exam for cervical cancer	- Develop and implement interventions based on a barrier analysis for CCS - Reminder letters on birthday month - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	-increase cervical cancer screening rates over the Medicaid 25th percentile (55.92%) - 50.36% HEDIS 2016	QI Manager or designee	Quarterly	October-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Prevention and Screening**	HEDIS Measure: Childhood Immunization Status (CIS) – Combination 3	DHCS 2016 External Accountability Set	Increase the number of SCFHP children who are compliant for their immunizations through Combo 3	- Develop and implement interventions based on a barrier analysis for CIS Combo 3 - Televox reminder calls for non compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase CIS Combo 3 rate over the Medicaid 50th Percentile (71.06%) - 72.02% HEDIS 2016	QI Manager or designee	Quarterly	Ongoing - Monthly		Approved by QIC: Adopted by Board:

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Quality of Clinical Care	**Project: Diabetes**	HEDIS Measure: Comprehensive Diabetes Care (CDC) - HbA1c Testing	DHCS 2016 External Accountability Set	Increase the number of SCFHP members with diabetes who have an HbA1c screening annually	- Develop and implement interventions based on a barrier analysis for CDC HbA1c Testing - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase CDC - HbA1c testing rate over Medicaid 90th percentile (91.73%) - 88.81% HEDIS 2015	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Cardiovascular Conditions**	HEDIS Measure: Controlling High Blood Pressure (CBP)	DHCS 2016 External Accountability Set	Increase the number of SCFHP members with hypertension who have their blood pressure below 140/90	- Develop and implement interventions based on a barrier analysis for CBP - work with network providers to develop an organized system of regular follow up and review of patients with hypertension - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- increase blood pressure control for members with hypertension over the Medicaid 50th percentile (54.80%) -36.01% HEDIS 2016	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Access & Availability of Care**	HEDIS Measure: Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care	DHCS 2016 External Accountability Set	Increase the number of SCFHP members who get timely prenatal care	- Develop and implement interventions based on a barrier analysis for PPC - Timely Prenatal Care - do a meta analysis of the interventions done by other Medi-Cal health plans in the region to find the most effective type of prenatal program - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase PPC Timeliness of Prenatal Care over the Medicaid 50th Percentile (82.25%) - 79.56% HEDIS 2016	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Clinical Care	**Project: Utilization**	HEDIS Measure: Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	DHCS 2016 External Accountability Set	Increase the number of SCFHP members who get their annual well child visit	- Develop and implement interventions based on a barrier analysis for W34 - Annual reminder postcards for non-compliant members - develop a system to evaluate effectiveness of interventions	successful implementation of intervention and evaluation of interventions effectiveness	- Increase W34 rate over the Medicaid 90th Percentile (82.97%) - 74.45% HEDIS 2016	QI Manager or designee	Quarterly	November-17		Approved by QIC: Adopted by Board:
Quality of Service	**Project: 120 Initial Health Assessment**	Initial Health Assessment and Staying Health Assessment	Exhibit A, Attachment 10.3	Ensure new enrollees to SCFHP receive an IHA within 120 calendar days of enrollment and HIF/MET within 90 days of the effective enrollment	- develop a reporting system that monitors the IHA and HIF/MET compliance across the plan - integrate medical record review for a sample of IHA visits each quarter as part of Facility Site Review - Provider training on IHA requirements - IHA Work Plan will be evaluated for effectiveness on an annual basis	- develop regular reporting mechanism to monitor ongoing performance - medical record audit of IHA visits and document compliance - training attestations - fully implement IHA work plan by 12/31/17	- Medicaid rate 100%	QI Manager or designee	Quarterly	December-17		Approved by QIC: Adopted by Board:
Health Plan Accreditation	**NCQA Accreditation**	NCQA Accreditation of the CMC line of business	CMC	Obtain accreditation status by CY 2018	- obtain provisional accreditation by Q3 2017	-provisional accreditation for CMC line of business	Achieve provisional accreditation	Medical Services Project Manager	Annual	October-17		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**ADA Workplan**	Development of a Work Plan and Evaluation each year and subsequent tracking of implementation	CMC	Successfully implement the ADA	ADA Work Plan will be evaluated for effectiveness on an annual basis	Fully Implement ADA work plan by 12/31/2017	Successful Implementation	QI Review Nurse	Quarterly	December-17		

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed	Assessments, Findings, Monitoring of Previous Issues
Safety of Clinical Care	**Facility Site Review**	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices		Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	- Review every 3 years as part of the Credentialing process - Review all new potential PCP offices prior to contracting - Provide follow/up and ongoing monitoring of timely correction of Critical Element (CE) deficiencies and Corrective Action Plan as mandated by DHCS guidelines. - Continue the collaborative process with the County's MCMC Commercial Plan	- successful submission of FSR scores on a semi annual basis		QI Nurse	Ongoing	Ongoing - Monthly		Approved by QIC: Adopted by Board:
Safety of Clinical Care	**Quality of Care**	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	DPL 15-002	Complete all PQI's originating from Grievance and Appeals within 30 days Complete all PQI's from other sources in 60 days	- update PQI policy - Roll out retraining of Medical Management and Member Services Staff - develop methodology for retrospective review of call notes to identify PQI's - ongoing reporting of PPC's to DHCS	- revised PQI policy - training materials used	100%	QI Nurse	Ongoing	Ongoing - Monthly		Approved by QIC: Adopted by Board:
CMC	**Model of Care**	- Fully implement and measure the effectiveness of the Model of Care		-establish an ongoing monitoring process of the MOC -implment interventions to improve MOC outcomes	-implement MOC work group - develop MOC work plan	-MOC work plan	100%	QI Project Manager	Ongoing	Ongoing - Quarterly		Approved by QIC: Adopted by Board:

2017 Quality Improvement Work Plan

Jeff Robertson, MD
Chief Medical Officer
Santa Clara Family Health Plan

Date

Santa Clara Family Health Plan

The Spirit of Care

2016 QUALITY IMPROVEMENT PROGRAM EVALUATION

☑ Annual Evaluation

Executive Summary:

A. CLINICAL IMPROVEMENT ACTIVITIES
NCQA 2016 Quality HEDIS Measures: (2015 Measurement Year)

HEDIS Hybrid Measure Key:

- Childhood Immunization Status – CIS (MC & HK)
- Well Child Visits in First 15 Months – W15 (HK)
- Well Child Visits 3,4,5,6 – W34 (MC & HK)
- Cervical Cancer Screening – CCS (MC)
- Timely Prenatal and Postpartum Care – PPC (MC)
- Comprehensive Diabetes Care – CDC (MC & CMC)
- Weight Assessment and Counseling –WCC (MC)
- Immunization for Adolescents – IMA (MC & HK)
- Controlling High Blood Pressure – CBP (MC & CMC)
- Adolescent Well Care Visits – AWC (HK)
- Adult BMI Assessment – ABA (CMC)
- Colorectal Cancer Screening – COL (CMC)
- Medication Reconciliation Post-Discharge – MRP (CMC)
- Care of Older Adults – COA (CMC)

HEDIS Administrative Measure Key:

- Chlamydia Screening – CHL (HK)
- All Cause Readmission – ACR (MC) / PCR (CMC)
- Ambulatory Care – AMB (MC)
- Cervical Cancer Screening – CCS (MC)
- Use of Imaging Studies for Low Back Pain –LBP (MC)
- Appropriate Treatment for Children w/ Upper Respiratory Infection – URI (HK)
- Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis – AAB (MC)
- Appropriate Testing for Children w/ Pharyngitis – CWP (HK)
- Use of Appropriate Medication for People w/ Asthma – ASM (HK)
- Children's & Adolescent's Access to PCPs – CAP (MC & HK)
- Annual Monitoring for Patients on Persistent Medication – MPM (MC)
- Annual Dental Visit – ADV (HK)
- Medication Management for People with Asthma – MMA (MC)
- Follow-Up After Hospitalization for Mental Illness – FUH (CMC)

A.1 Goal:

- Exceed Medi-Cal Managed Care (MMCD) Minimum Performance Levels (MPL) ALL Medi-Cal HEDIS Measures.
- Develop and implement interventions for MMCD Auto-Assignment Measures and for CMS Quality Withhold Measures.
- Increase administrative (claims and encounter) data submissions across Networks.

A.2. Interventions:

- Collect and report Hybrid Healthcare Effectiveness Data and Information Set (HEDIS) rates for ALL Product Lines within specified timeframe
- Tested distribution of non-compliant lists for CCS and CDC – HbA1c Testing in Q4 to targeted PCP offices
- Developed member incentives to support CDC – Retinal Eye Exam, Controlling High Blood Pressure, and Cervical Cancer Improvement Projects
- Facility Site Review Nurse performed on site visits to provider offices regarding accurate coding, preventive well visit schedules, and BMI documentation.
- Facility Site Review Nurse educated providers to follow AAP / SCFHP recommended annual Well-Care Visits and immunization schedule and AGOG recommended Cervical Cancer Screenings
- HEDIS results and analysis presented to:
  - SCFHP Board of Directors & SCFHP Quality Improvement Committee,
- Quality Improvement Activities:

- Continued immunization reminder postcards to parents with children at 17 months of age to receive recommended immunizations.
- Education in Quarterly Member Newsletters, for immunizations, well child visits, diabetic care, prenatal and postpartum care and dental care.

A.3. Results:

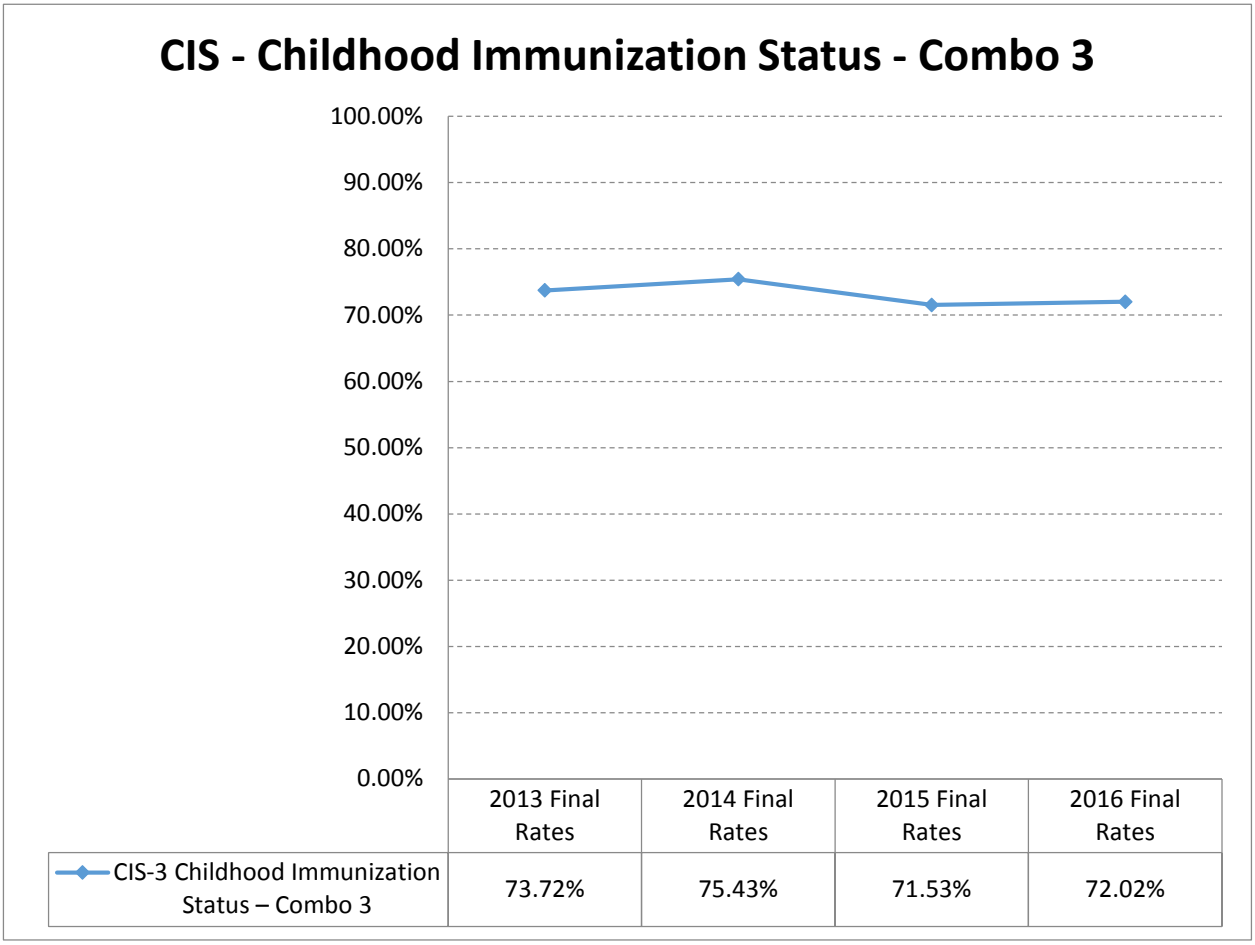
- Exceeded MMCD Minimum Performance Level (MPL) for all measures except Controlling High Blood Pressure, Comprehensive Diabetes Care – Blood Pressure Control and Cervical Cancer Screening.
- Three Medi-Cal measures exceeded the HPL, Comprehensive Diabetes Care—HbA1c Control (<8%), Medication Management for People with Asthma Medication Compliance 50% Total, Medication Management for People with Asthma Medication Compliance 42% Total.
- Medi-Cal measures that have improved significantly (>5%) from the prior year; Comprehensive Diabetes Care – HbA1c Poor Control, Medication Management for People with Asthma Medication Compliance 50% Total, Medication Management for People with Asthma Medication Compliance 42% Total.
- Medi-Cal measures that decreased significantly (>5%); Cervical Cancer Screening, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity, Use of Imaging Studies for Low Back Pain, Controlling High Blood Pressure, Comprehensive Diabetes Care – Blood Pressure Control, Annual Monitoring of Patients on Persistent Medications – Digoxin.
- 2016 was the first year reporting CMC HEDIS measures. The late start to HEDIS medical record retrieval that impacted the Medi-Cal blood pressure rates also negatively impacted the CMC blood pressure rates, resulting in the CBP measure being non-reportable. There are no MPL's for the CMC line of business.

A.4. Analysis of Findings/Barriers/Progress

- Due to Administrative Data Volume being flat, continued chart abstraction and Pinpoint chart chase logic is necessary to improve key measures.
- A Provider/Network dashboard for each measure is necessary to define further provider interventions.
- HEDIS Member outreach and incentives is important to increase key measures.
- Providers / Networks continue to require assistance for data issue improvements:
  - Provider Address discrepancies
  - Coding issues
  - Timely data submission

Immunization Measures Findings

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



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CIS-3 Childhood Immunization Status – Combo 3	73.72%	75.43%	71.53%	72.02%

Analysis and Findings/Barriers/Progress

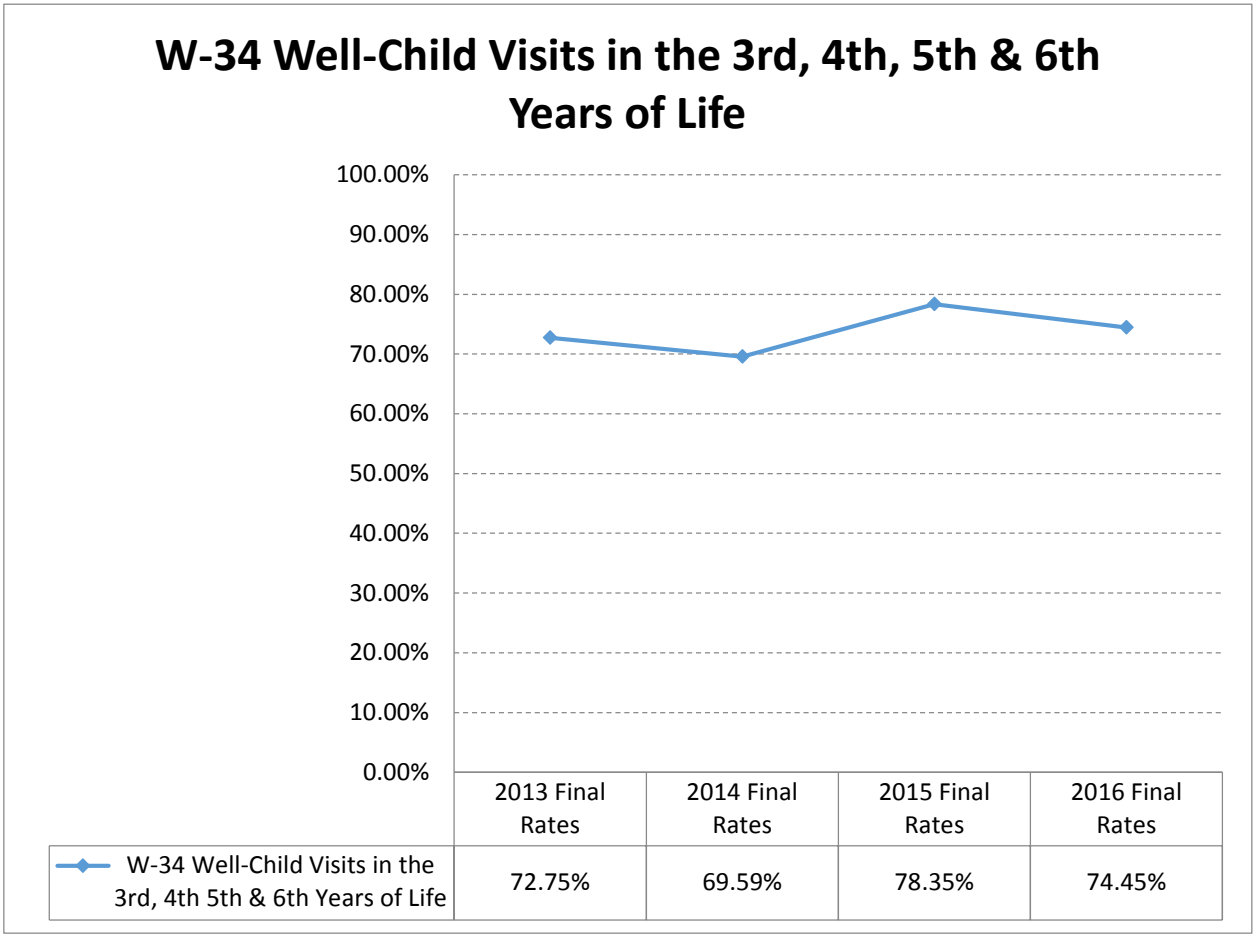
- Above the MPL of 66.19% and remains below the HPL of 81.25%.
- SCFHP analysis on membership and claims data shows a continued pattern of immunizations given outside of the recommended timeframes for children 2.

Follow up/Actions:

- Focus ideas on new interventions in 2016 (HEDIS 2017) for providers on immunization schedule.
- Focus ideas on new interventions in 2016 for member outreach and incentives.
- Continue to utilize CAIR for missing immunization status in claims and/or PCP medical record.
- Mine CAIR for additional numerator events that were not matched from the HEDIS extract.

Well Child Visits Key Findings

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



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
W-34 Well-Child Visits in the 3rd, 4th 5th & 6th Years of Life	72.75%	69.59%	78.35%	74.45%

Analysis and Findings/Barriers/Progress

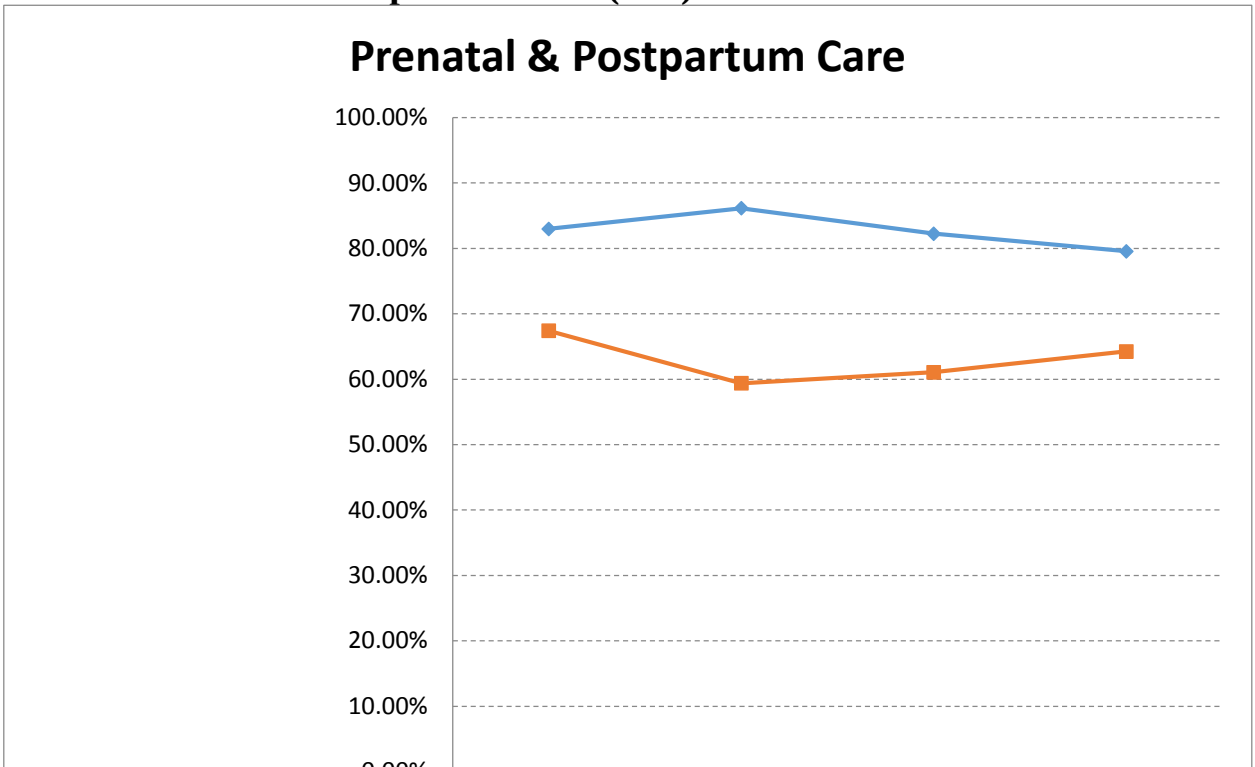
- Above the MPL of 65.54% and remains below the HPL of 83.75%.
- 2016 rate dropped by 4% from HEDIS 2015.

Follow up/Actions:

- Focus ideas on new interventions in 2016 for member outreach with incentives.
- Focus ideas on new interventions in 2016 for Providers on well child visit schedule.
- Pinpoint chart chases for this measure for 2016 data.

Adult Hybrid Measures: Prenatal / Postpartum Care Key Findings

PPC – Prenatal and Postpartum Care (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
PPC-Pre Timeliness of Prenatal Care	82.97%	86.13%	82.24%	79.56%
PPC-Pst Postpartum Care	67.40%	59.37%	61.07%	64.23%

Analysis and Findings/Barriers/Progress

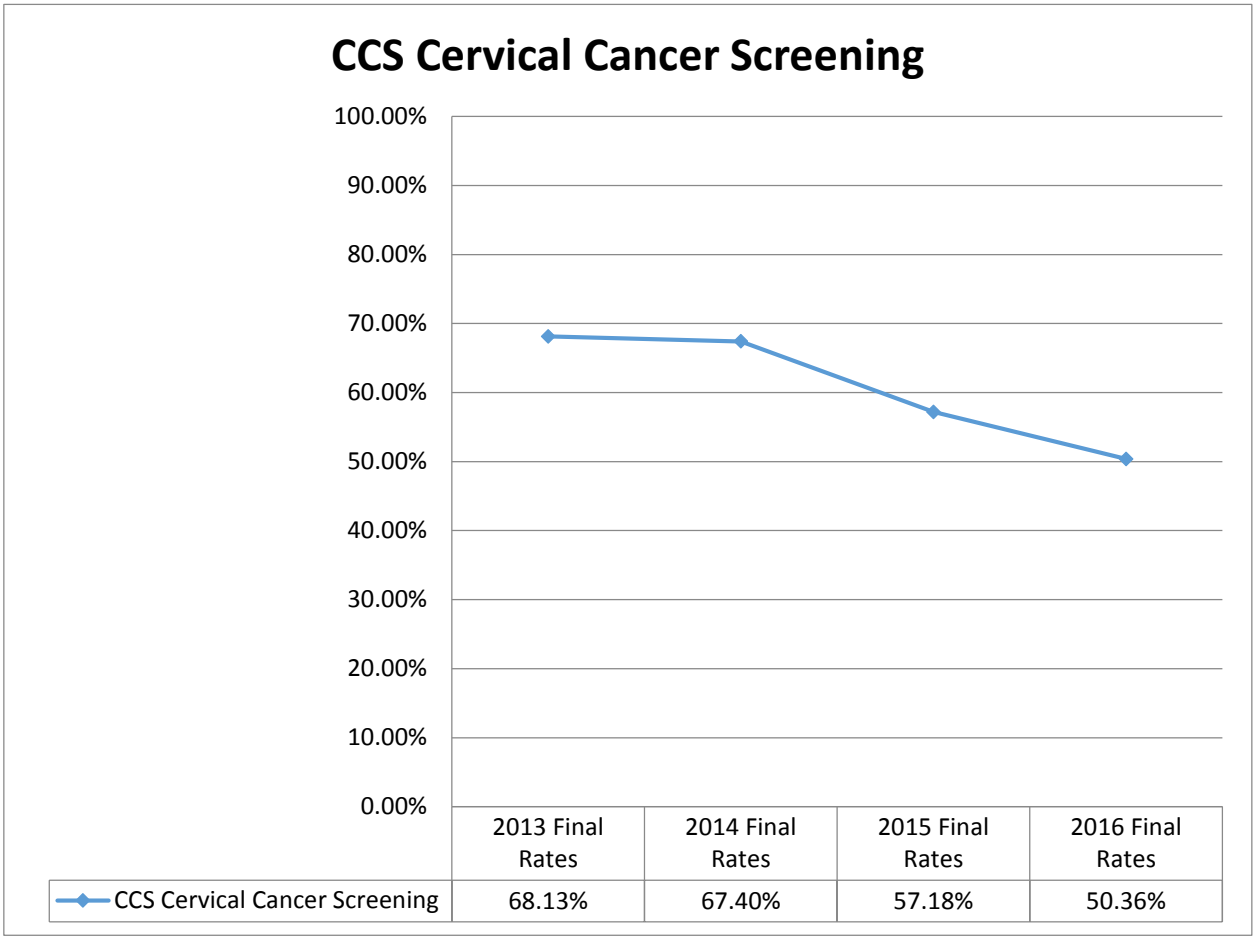
- Above the MPL's and remains below the HPL's of both indicators.
- For Postpartum visits, rate increased by 3%.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2016 data.

Adult Measures: Cervical Cancer Screening Key Findings

CCS – Cervical Cancer Screening (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CCS Cervical Cancer Screening	68.13%	67.40%	57.18%	50.36%

Analysis and Findings/Barriers/Progress

- Measure is below MPL of 54.33% but below HPL of 73.08%.
- Decrease in rate is attributed to members not going to see their primary care physicians for screenings.
- As a result of the final compliance rate being below the MPL, the plan had to institute a Improvement Plan.

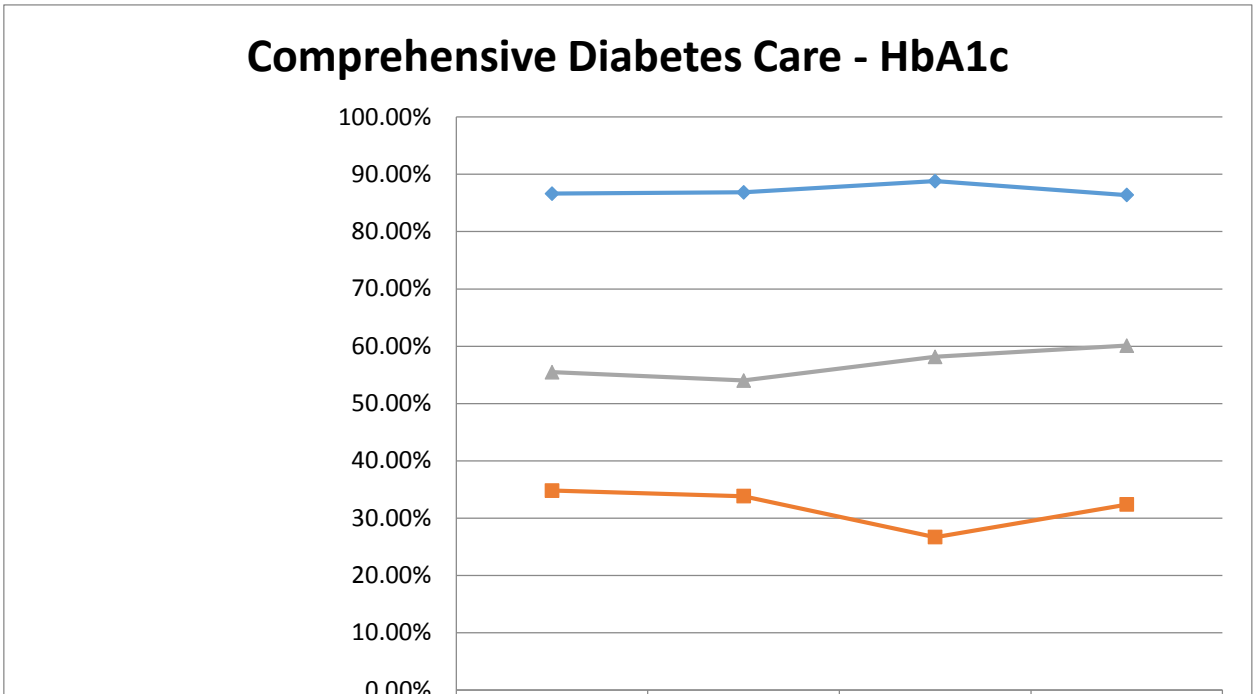
Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders.
- Pinpoint chart chases for this measure for 2016 data.
- The plan implemented a member incentive of a $15 Target gift card.

The plan partnered with a clinic to do a rapid cycle improvement where there was data exchanged every two weeks during the intervention period.

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

CDC – Comprehensive Diabetes Care (MC) HbA1c



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CDC-HT HbA1c Testing	86.62%	86.86%	88.81%	86.37%
CDC-H9 HbA1c Poor Control (>9.0%)	34.79%	33.82%	26.68%	32.36%
CDC-H8 HbA1c Control (<8.0%)	55.47%	54.01%	58.15%	60.10%

Analysis and Findings/Barriers/Progress

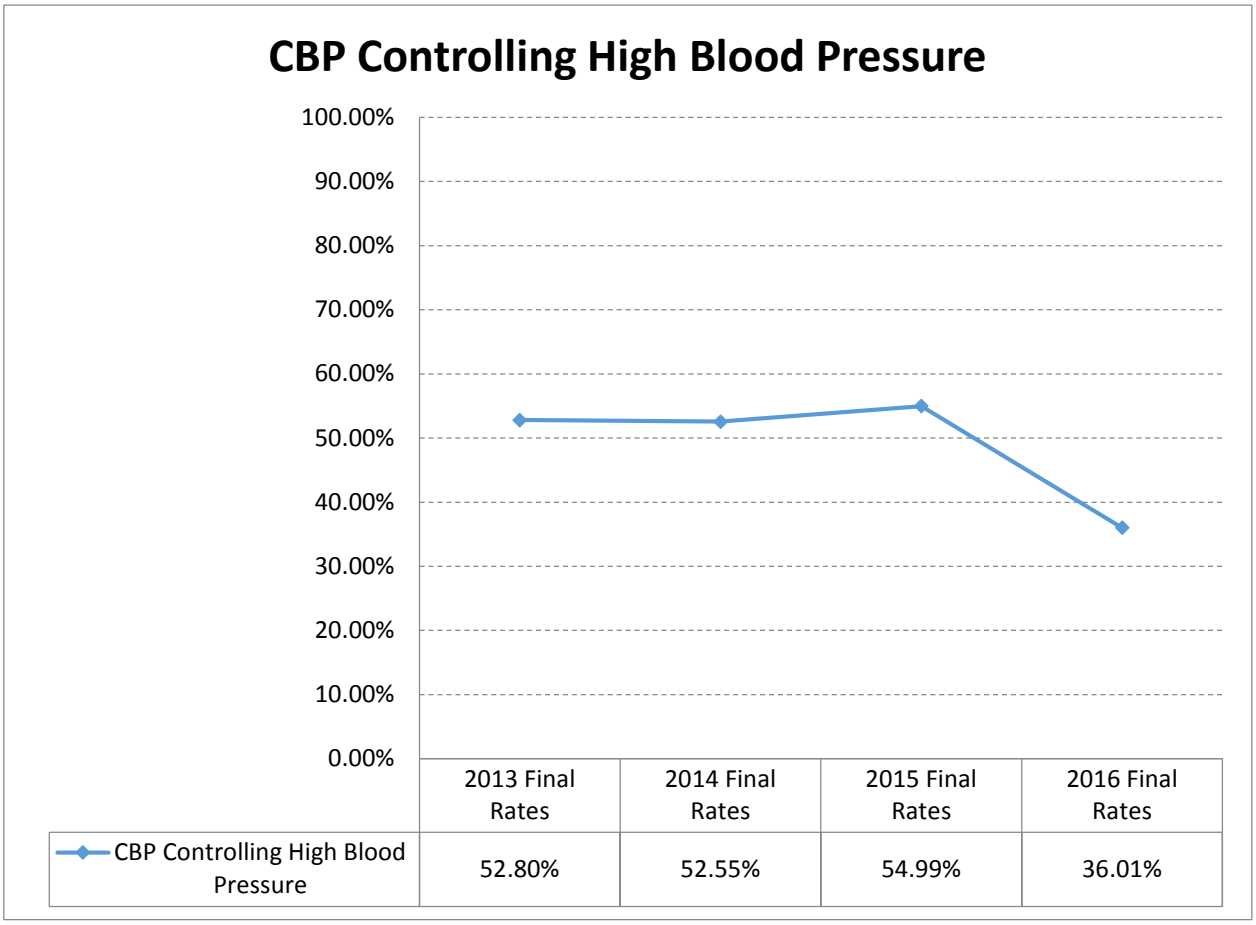
- Above the MPL for all the CDC HbA1c indicators.
- Rate increased a little over 5% for HbA1c Poor Control, lower rate is better.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.
- Pinpoint chart chases for this measure for 2016 data.

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

CBP - Controlling High Blood Pressure (MC)



	2013 Final Rates	2014 Final Rates	2015 Final Rates	2016 Final Rates
CBP Controlling High Blood Pressure	52.80%	52.55%	54.99%	36.01%

Analysis and Findings/Barriers/Progress

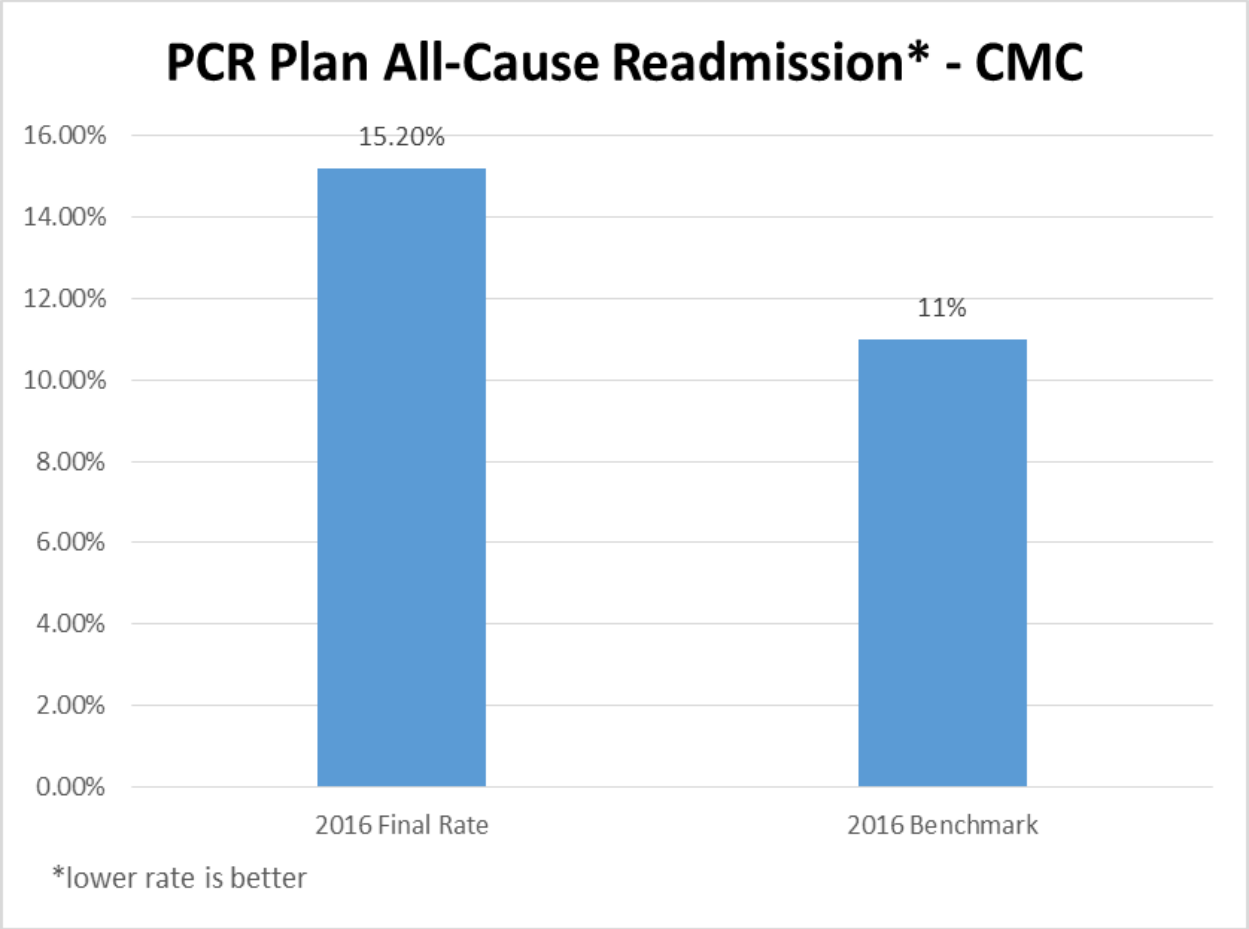
- Blood Pressure Control is below the MPL of 43.55%.
- Rates decreased due to delay in medical record review process.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.
- MMCD/DHCS mandated Improvement Plan:
  - Combined Improvement Plan with Performance Improvement Project. The project offered a $15 gift card for members who discussed hypertension with their PCP. The incentive form had to be signed by the PCP.

Quality Withhold Measure: Plan All-Cause Readmission

PCR – Plan All-Cause Readmission – (CMC)



Analysis and Findings/Barriers/Progress

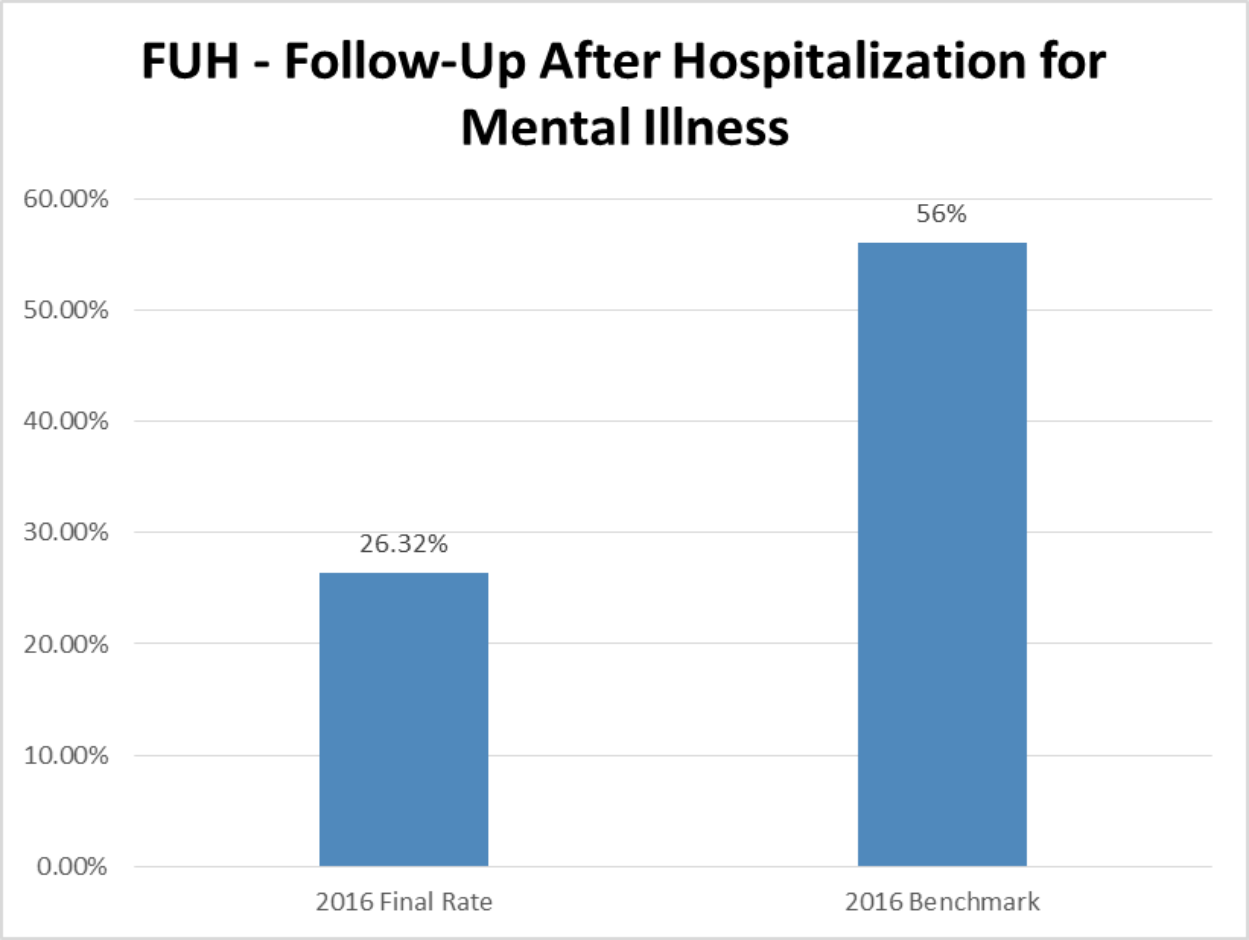
- Measure is higher than the 2016 benchmark, a lower rate is better.

Follow up/Actions:

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

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

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



Analysis and Findings/Barriers/Progress

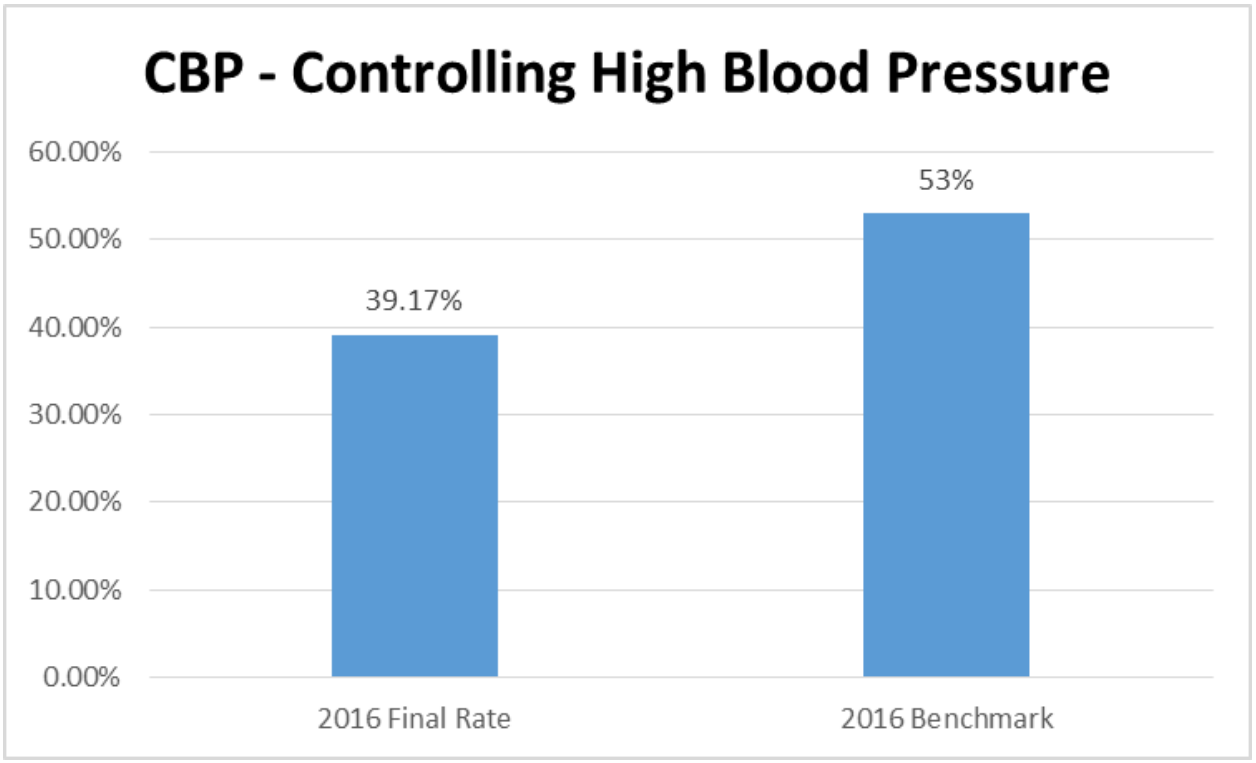
- Measure is below the 2016 benchmark.

Follow up/Actions:

- Monitor and collaborate with Behavioral Health delegates to ensure members obtain follow-up appointment after hospitalization for mental illness.

Quality Withhold Measure: Controlling High Blood Pressure

CBP – Controlling High Blood Pressure – (CMC)



Analysis and Findings/Barriers/Progress

- Measure is below 2016 benchmark.

Follow up/Actions:

- Focus ideas on new intervention in 2016 for member reminders and outreach.

B. Clinical Improvement Activities
External and Internal QIP's (2016 Measurement Year)

All Cause Readmissions CMS Quality Improvement Project –

B.1 Goal: To decrease readmission rates for any reason to below 11% by the end of 2018.

B.2 Intervention: Contact 90% of members within 72 hours of discharge from Regional Medical Center, to conduct a transition of care discharge call.

B.3 Design

This three year QIP began in January of 2016 and will continue until December of 2018. Case Managers use a daily census report from Regional Medical Center to identify all discharged members. The Case Manager makes three attempts to contact the member within 72 hours of discharge to conduct a successful transition of care discharge call that helps prevent a readmission to the hospital within 30 days of discharge.

Diabetes Retinopathy Eye Exam–DHCS Performance Improvement Project(PIP)

B.1 Goal: By 06/30/2017, increase the rate of diabetic eye exams among Medi-Cal Type 1 and Type 2 diabetic members aged 18 to 75 who reside in Santa Clara County, who have a Physicians Medical Group(PMG)/Network 50 Primary Care Provider and had a retinopathy diagnosis in the previous rolling 12 month period from 44.89% to 49.89%.

B.2 Intervention: Promote a reminder flyer and incentive for eligible PMG members for completing annual eye exam

B.3 Design

This 18 month PIP began in January of 2016 and will continue through June of 2017. On a monthly basis, a list of eligible members is generated to identify those that have not completed a diabetic retinopathy eye exam. The members are mailed a Health Education flyer with a reminder to complete a diabetic eye exam. Members are informed that if they submit proof \of a completed eye exam to Health Education they will receive a $15 Target gift card.

Controlling Blood Pressure -DHCS Performance Improvement Project(PIP)

B.1 Goal: By 06/30/2017, increase the percentage rate of Network 10 members aged 18-85, with a diagnosis of hypertension, whose blood pressure is adequately controlled, during the previous rolling 12 months from 45.8% to 50%.

B.2 Interventions: Promote a reminder and incentive for eligible Network 10 members for completing a blood pressure check.

B.3 Design

This 18 month PIP began in January of 2016 and will continue through June of 2017. On a monthly basis, a list of eligible members is generated to identify those that have not completed an annual blood pressure exam. The members are mailed a Health Education flyer with a reminder to complete a blood pressure exam. Members are informed that if they submit proof \of a completed blood pressure exam to Health Education they will receive a $15 Target gift card.

Decreasing Potentially Avoidable Readmissions –LTSS Performance Improvement Project(PIP)

B.1 Goal: By June 30th, 2017, decrease rate of potentially avoidable hospital readmissions within 30 days of hospital discharge of CMC members from all SNFs to hospitals from 22.8% to 17.8%.

B.2 Interventions: SNF community partners will submit 100% of member, hospital interfacility transfer forms (IFTFs) to SCFHP for review.

B.3 Design

This 18 month PIP began in January of 2016 and will continue through June of 2017. IFTF forms will be reviewed by SCFHP and appropriate level of care coordination will be provided by SCFHP to insure follow up care goals are met. This in turn will decrease potentially avoidable readmissions.

C. Initial Health Assessment (IHA)

C.1 Goal:
To ensure all SCFHP members completes a Stay Healthy Assessment (SHA) in accordance with the timeframes appropriate by age and that documentation is evidenced in their medical record

C.2 Interventions:
- SCFHP provides information on IHA to the members and providers annually in the Member Newsletter
- SCFHP continues to promote provider education on the IHA with its delegate and independent network providers
- Plan updated it's IHA specifications to align with the methodology of other health plans in the geographic area
- Plan runs IHA compliance reports on a quarterly basis

C.3 Results:
- Plan's IHA compliance rate increased slightly over the previous methodology.

C.4 Analysis of Findings/Barriers/Progress

- QI Nurse will audit medical records based on the new methodology to determine validity of the methodology

D. Patient Safety: Facility Site / Medical Record Review

D.1 Goal:

All contracted SCFHP PCP's receive a Facility Site Review Part A, B and C every three years. All newly contracted SCFHP PCP's complete and pass Facility Site Review Part A and C

D.2 Intervention:

- Complete FSR/MRR Review on all PCP sites that were due for a three year review.
- Complete FSR review for all newly contracted sites.
- Transition Part C reviews from Provider Services to Quality Nurse.
- Continue to Collaborate with Anthem Blue Cross.
- Review and update Medical Record Standards

D.3 Results:

- 52 PCP sites completed FSR reviews
- 51 MRRs completed
- Five Initial FSRs completed
- Two Collaboration meetings held with Anthem Blue Cross to share data.
- 51 FSR Part C reviews completed.

D.4 Analysis of Findings/Barriers/Progress

- 34 FSR Corrective Action Plans (CAPs) issued, monitored and validated. 30 CAPs closed (remainder issued have closure dates in 2017).
- 43 MRR CAPs issued, monitored and validated. 40 CAPs closed (remainder issued have closure dates in 2017).

E. Potential Quality of Care Issues Summary

E.1 Goal:

To increase awareness of the PQI process within the health plan.

E.2 Intervention:

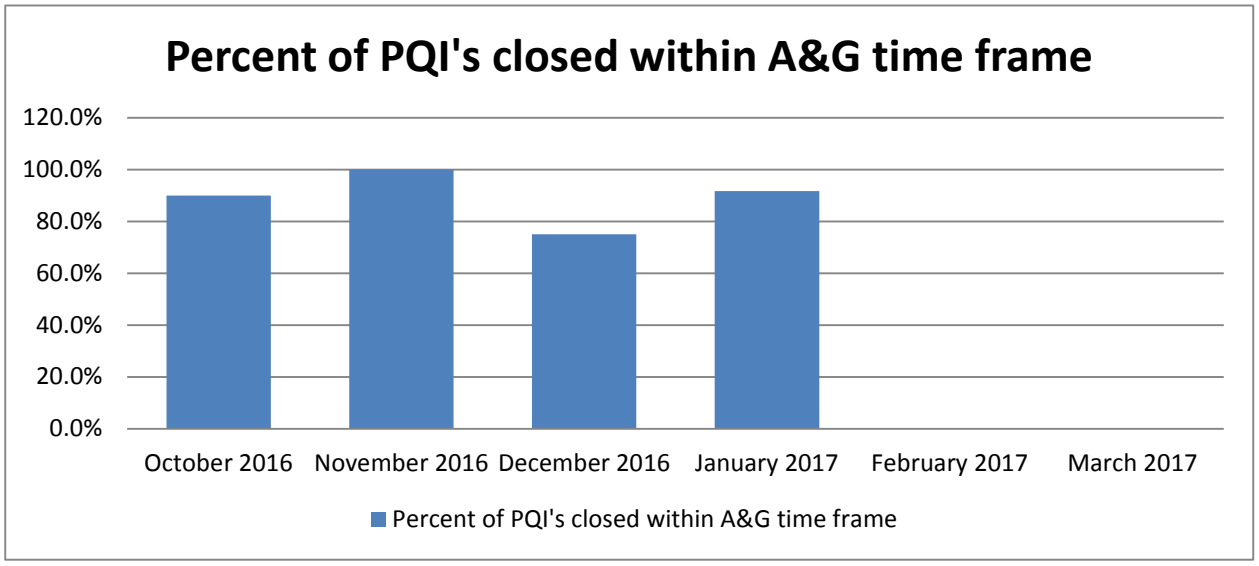
- Continue to monitor/track and trend member grievances for analysis of issues and correlation with other reports for identification of areas requiring improvement activities
- Continue to submit quarterly member grievances to the QIC for review and appropriate action related to access of care, quality of care, and denial of services
- Continue to monitor/track and trend PQI for identification of quality of care and systems issues.
- Continue to submit quarterly PQI report to QIC for review and appropriate action.

E.3 Results:

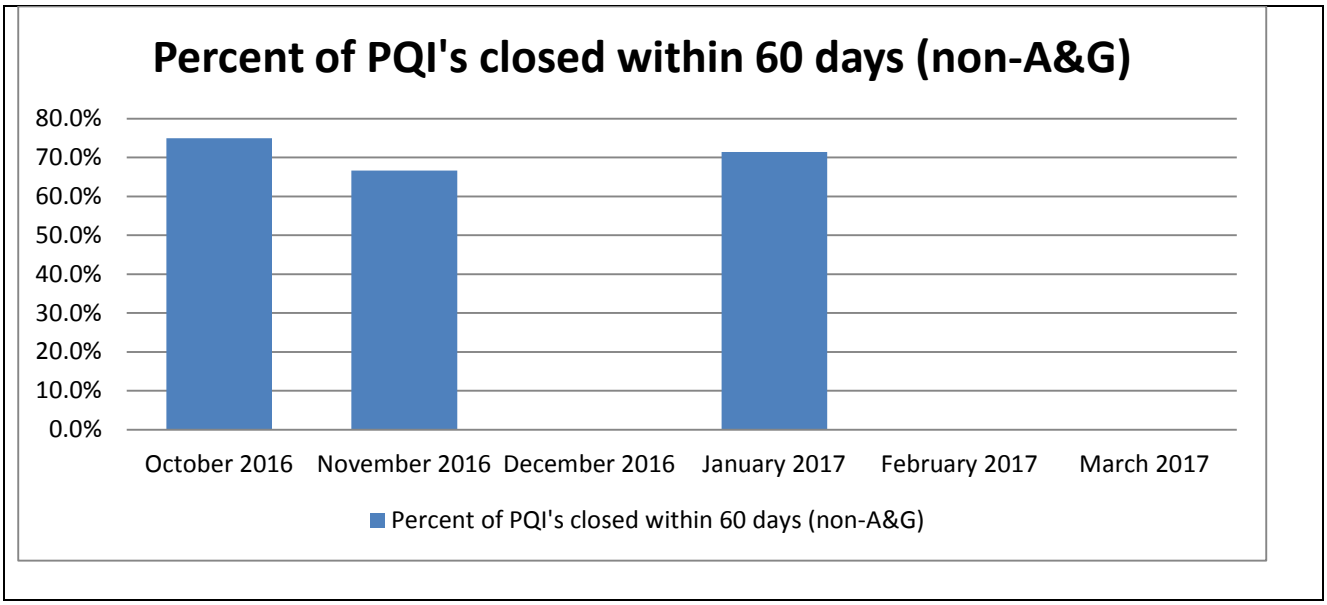
- 104 PQI's reported in 2016
- 72 were Level 1 – No Quality of Care Issue
- 29 were Level 2 - Improvement Needed
- Three were Level 3 – Unacceptable Quality of Care

E.4 Analysis of Findings/Barriers/Progress

- Reports need to go to QIC every quarter.



2016 QUALITY IMPROVEMENT PROGRAM EVALUATION
☑ Annual Evaluation



Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Pregnant Women	pg. 73 Exhibit A, Attachment 10 Scope of Services	-Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	-Chart audits and provider training	- Provider Training and FSR results	All providers trained	QI & Health Educator, Provider Services		Continuous	
Services for All Members	Health Education	-Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004	-Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships	- P&P's for health education system -List of health ed classes that cover all required health ed topic areas. -Provider/Vendor Contracts/MOU's	Baseline	Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	
Services for All Members	Health Education	Ensure effective health ed program		-Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	-Use findings from GNA to select educational strategies and methods -Measure pre and post educational intervention behavior	-P&P's for delivery of health ed program using educational strategies appropriate for Members. -Health Education Program	Organized delivery of health ed program	Health Educator		Continuous	
Services for All Members	Health Education			-Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	-Test reading materials using SMOG, etc., -Field test material at CAC meetings	- P&P's that define appropriate reading levels -Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)	100%			Continuous	
	Health Ed		pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004 NCQA 2016 Health Plan Accreditation Requirements MEM 8 and MEM 2	-Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions -alcohol and drug use, including avoiding at risk drinking -Identifying depressive symptoms	- contract with health education vendors to provide classes to meet requirement	- Health Ed courses/activities	Baseline	Health Educator		Continuous	

Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Member Services	Health Ed	Member Services	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Written Member informing materials will be translated into identified threshold and concentration languages.	-P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication -P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing, Health Educator, and Cultural and Linguistics		Continuous	
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	Inform members in writing of their rights annually	Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.	All members informed	Marketing, Health Educator	Annually		
Provider Training	Health Ed	Practitioner Education and Training	DHS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	-Practitioner education and training by provider services -Health ed updates during JOC's	- sign in sheet of provider training -JOC minutes	All providers trained	Health Educator, Provider Services, QI		Continuous	
Incentives	Health Ed	MMCD on-going monitoring activities	MMCD PL 12-002	Evaluation summary	-Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	-Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation/update summary	Health Educator	30 days after end of program incentive	Continuous	
Incentives	Health Ed	-Justify continuation of on-going incentive program	MMCD PL 12-002	Justify continuation of MI program	-Provide brief explanation(update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submission to MMCD	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	

Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Website	Health Ed and C&L	Health Ed and member informing resources on SCFP website are easy to read and translated into the threshold languages	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Ensure member informing resources are at sixth grade level or lower and translated into threshold languages.	- Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower.	Health Educator and Marketing		Continuous	Member newsletters Translated Health Ed referral forms on website Feb. '17
Health Education		Written Health Education Materials	APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	- Approve written member health ed materials using Readability and suitability checklist by qualified health educator.	-Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	-For previously approved material, review every three years	Continuous	
Health Education		Evaluation of Plan's self-management tools for usefulness to members	NCQA 2016 Health Plan Accreditation Requirements MEM 8 and MEM 2	To ensure self-management tools are useful to members and meets the language, vision, and hearing needs of members	-Develop an evaluation tool/survey	-Evaluation results summary	Baseline	Health Educator	Every 36 months		
Health Education		Review plan's online web-based self-management tools.	NCQA 2016 Health Plan Accreditation Requirements MEM 8 and MEM 2	To ensure online web-based self-management tools are up to date	-Review and update online web-based self-management tools including the plan website and portal	-Updated web-based self-management tools	Baseline	Health Educator		Continuous	
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure member medical records include health education behavioral assessment and referrals to health education services		-P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. -Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI and Health Educator			
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	-Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	-Written information in Evidence of Coverage	All members of childbearing age informed of right to access to qualified family planning provider	Marketing and Health Educator			

Health Education Workplan 2017											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Quality of Services	Access and Availability	Create Health Ed Work plan	pg. 61 Exhibit A, Attachment 9 Access and Availability, DHS APL Policy Letter 17-002		-Incorporate GNA findings and annual and ongoing review of data into work plan -Approval of Health Ed Workplan by QI Committee -Submit Health Ed Workplan to MMCDHealthEducationmailbox@dhcs.ca.gov	-Approved Health Ed Workplan	Baseline	QI Manager and Health Educator	Annually	July '17	
Community Advisory Committee	Access and Availability	Community Advisory Committee	pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01, APL 17-002	-Have a Community Advisory Committee in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	-Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues from GNA findings.	-CAC Meeting minutes -Report GNA findings to CAC	Baseline	QI, Health Educator, and Marketing		Continuous	

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Services for Adults	Exhibit A, Attachment 10 Scope of Services Exhibit A Attachment 11 Case Management and Coordination of Care Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure IHA for adult members is performed within 120 calendar days of enrollment -Ensure performance of initial complete history and physical exam for adults to include health education behavioral risk assessment and member and family education.	For 2017, Stand alone project: See IHA work plan provider training -FSR (every 3 yrs)	-P&P for administration of a disease management program ~~-P&P for case management coordination of care of LEA (local education agencies)services~~	Baseline	QI and Health Educator		Continuous	Sept.'16 Policy QI.09 & QI.10
Scope of Services	Scope of Services	Pregnant Women	pg. 73 Exhibit A, Attachment 10 Scope of Services	-Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	-Chart audits and provider training	-Provider Training and FSR results	Baseline	QI, Health Educator and Provider Services		Continuous	Risk Assessment tool implemented in 2016
Services for All Members	Health Education	-Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004	-Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships	-List of health ed classes that cover all required health ed topic areas.		Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	Policy QI.09 & Procedure QI.09.01 Health Ed referral form Health Ed page and referral form on SCFHP website
Services for All Members	Health Education	Ensure effective health ed program		-Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	-Use findings from GNA to select educational strategies and methods -Measure pre and post educational intervention behavior	-Health Education Program	Organized delivery of health ed program	Health Educator		Continuous	Policy QI.09 & Procedure QI.09.01 Ongoing search for classes/materials in threshold languages Class audits
Services for All Members	Health Education			-Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	-Test reading materials using SMOG, etc, -Field test material at CAC meetings	-Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)				Continuous	Readability & Suitability checklists: no field testing needed for '16

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
	Health Ed			-Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions		-Health Ed courses/activities	Baseline	Health Educator		Continuous	CCS MI incentive DEE MI incentive Health Ed Classes April '16
Member Services	Health Ed	Member Services	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Written Member informing materials will be translated into identified threshold and concentration languages.	-P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication -P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing and Health Educator		Continuous	EOB
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	-Inform members in writing of their rights annually	-Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.		Marketing, Health Educator	Annually		June '16
Provider Training	Health Ed	Practitioner Education and Training	DHS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	-Practitioner education and training	-Certification log of provider training -JOC meeting minutes of health ed updates	All providers trained	Health Educator, Provider Services, QI		Continuous	Ongoing Certification of Training logs by provider services JOC health ed updates

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Incentives	Health Ed	MMCD on-going monitoring activities	MMCD PL 12-002	Evaluation summary	-Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	-Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation summary	Health Educator	30 days after end of program incentive	Continuous	CCS MI eval summary submitted Childhood obesity/nutrition MI eval summary submitted DEE MI eval summary submitted Postpartum MI eval summary submitted
Incentives	Health Ed	-Justify continuation of on-going incentive program	MMCD PL 12-002	-Justify continuation of MI program	-Provide brief explanation(updat e) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submitted to MMCD	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	N/A Update not due yet until '17.
Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	pg. 101 Exhibit A, Attachment 13 Member Services	-Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions -Address appropriate reading level and translation of materials.	-Ensure member informing resources are at sixth grade level or lower and translated into threshold languages.	-Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower.	Health Educator and Marketing		Continuous	Ongoing member newsletters

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Health Education		Written Health Education Materials	APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	-Approve written member health ed materials using Readability and suitability checklist by qualified health educator.	-Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	-For previously approved material, review every three years	Continuous	N/A No previous materials or current materials approved by health educator using Readability and suitability checklist
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	-Ensure member medical records include health education behavioral assessment and referrals to health education services		-P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. -Provide list and schedule of health ed classes and/or programs to providers ~~-Submit P&P for application and use of Health Information Form (HIF) data submitted thru the Member Evaluation Tool (MET)~~		QI & Health Educator		Jun-16	Policy QI.10 IHA and HEBA Assessments Policy and Procedure Health Ed Referral form on provider tab on SCFHP website August '16
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	-Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	-Written information in Evidence of Coverage		Marketing, Health Educator			Evidence of Coverage June '16
Quality of Services	Access and Availability	Conduct group needs assessment to identify health education and cultural and linguistic needs	pg. 61 Exhibit A, Attachment 9 Access and Availability, DHCS APL Policy Letter 10-012		-Conduct GNA	-GNA Summary Report submitted to DHCS within 6 mos of completion of each GNA -Annual GNA update electronically submitted every yr on October 15th, except in yrs when full GNA report is completed and executive summary submitted to MMCD. -Electronically submit an Executive Summary of GNA Report every yrs	Every 5 yrs perform GNA Update Annual update GNA summary report	QI Manager and Health Educator	Every 5 yrs & Annual update	October 15th, 2016	Policy QI.09 & Procedure QI.09.01 GNA report completed and submitted to MMCD October '16

Health Education Workplan 2016-Evaluation											
Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Community Advisory Committee	Access and Availability	Community Advisory Committee	pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01	-Form a Community Advisory Committee pursuant to Title 22 CCR Section 53876 (c)(CAC) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	-Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues affecting groups who speak a primary language other than English.	-Meeting minutes -Record of plan members on CAC		QI and Health Educator, Marketing		Continuous	

Santa Clara
Family Health Plan
The Spirit of Care

SCFHP Americans with Disabilities Act Workplan.

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

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Workplan	ADA Workplan is reviewed and evaluated on an annual basis	Annual			
Responsible Party	Identify responsible individual for ADA Compliance	Annual			
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: CBAS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: LTSS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: Nursing Home	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: IHSS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Potential* Quality of Care Issues identified by: CBAS	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: IHSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Patient Safety	Number of *Potential* Quality of Care Issues identified at: LTSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: Nursing Home	Quarterly	Q1 2017-4 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: CBAS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: LTSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Patient Safety	Number of *Validated* Quality of Care Issues identified by: Nursing Home	Quarterly	Q1 2017-4 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: IHSS	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	PAR Site Identification: Plan refreshes claims history to identify new high volume specialists and ancillary providers for review	Annual	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of LTSS sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Access	Physical Accessibility Review: Number of CBAS sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Number of referrals to: CBAS	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		
Access	Number of referrals to: LTSS	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		
Access	Number of referrals to: Nursing Home	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Access	Number of referrals to: IHSS	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of IHSS sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of Nursing Home sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of High Volume Specialists	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		
Access	Physical Accessibility Review: Number of Ancillary sites reviewed	Quarterly	Q1 2017-0 Q2 2017- Q3 2017- Q4 2017-		

Domain	Measure	Reporting Frequency	Rate	Goal	Findings
Preventive Care	HEDIS: Care of Older Adults - Functional Status Assessment	Annual	Q4 2017		
Preventive Care	Medication Reconciliation Post-Discharge	Annual	Q4 2017		
Group Needs Assessment - Full	Group Needs Assessment Report shared at: Consumer Advisory Committee Quality Improvement Committee	Every Five Years	CY 2021		
Group Needs Assessment - Annual Update	Group Needs Assessment Annual Update shared at: Consumer Advisory Committee Quality Improvement Committee	Annual	CY 2017		
Health Education	Plan monitors health education referrals for CMC members: Number of referrals from members who are also in CBAS, LTSS, IHSS or Nursing Homes	Quarterly	Q1 2017- 0 Q2 2017- Q3 2017- Q4 2017-		
Patient Safety	Plan monitors grievances for reasonable accommodations and access to services under ADA	Quarterly	Q1 2017- Q2 2017- Q3 2017- Q4 2017-		methodology still in development
Group Needs Assessment - Full	Group Needs Assessment Report will analyze results to understand underlying causes of barriers to health care access.	Every Five Years	CY 2021		
Workplan	Plan will identify issues within its system that require improvement to promote access and ADA compliance	Annual			

OPTUM™	**Optum™** **Policy and Procedure** **CM: Care Plans and Goals**

Policy Owner (Division/Department): CM Operations/Quality Department	**Document Number:** CM-010
	Original Issue Date: 11/15/2007
	Committee Approval Date: 6/14/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 6/14/2016

This Policy Applies To:					
☐ **All Staff**	☒ Clinical Operations ☐ Enrollment Services ☐ Health Solutions	☐ Marketing/Sales/Client Services ☐ Medical Affairs ☐ Technology	☐ Other		
☐ **All Programs**					
☐ **All Disease Management**	☐ Asthma ☐ HF	☐CAD ☐ Maternity	☐ COPD ☐ MSP	☐ Depression ☐ Other	☐Diabetes
☒ **All Case Management**	☐ Complex	☐ Maternity	☐ NICU	☐ Oncology	☐ Other
☐ **All Utilization Management**	☐ NICU	☐ Oncology	☐ Other		
☐ **Nurse 24**					
☐ **BioPharma**					
☐ **Wellness**	☐ Wellness Portal	☐ Health Coaching			
☐ **Maternity Home Care**					
☒ **Accreditation/Regulatory**	☒ NCQA	☒ URAC	☐ Joint Commission	☐ Regulatory	

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
1/7/2014	CM-010 CM: Care Plans and Goals
6/18/2014	CM-010 CM: Care Plans and Goals
6/3/2015	CM-010 CM: Care Plans and Goals
12/11/2015	CM-010 CM: Care Plans and Goals
6/14/2016	CM-010 CM: Care Plans and Goals

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	Senior Medical Director	6/10/2016
Susan Garcia	VP Case Management and Triage	6/9/2016
Diane Orlando	VP Clinical Affairs	6/14/2016

POLICY STATEMENT:

The purpose of this policy is to outline the process for case managers to develop and prioritize case management care plans and goals.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Case Management	A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality cost-effective outcomes.
Case Manager	A healthcare professional designated as the case manager with such appropriate background and specialty, such as registered nurse, social worker, physician, rehabilitation counselor, etc.
Long-Term Goals	Section of the individualized case management plan that aims to achieve sustaining health improvement or optimal health status specific to the program participant and may include anticipated case results and/or criteria for case closure.
Program Participant	An individual who is enrolled in any activities or services provided by an Alere Health program.
Short-Term Goals	Section of the individualized case management plan that addresses the acute or immediate health status of the program participant.

PROCEDURE:

A. Alere Health requires case managers to develop program participant specific, individualized case management care plans with prioritized long and short term goals upon the completion of the initial comprehensive nursing assessment and after each reassessment or change in the program participant's condition. The care management plan considers the program participant's and caregiver's goals, preferences and desired level of involvement. The case manager will evaluate the program participant's support systems, transportation/shelter/food needs, safety requirements, spoken and written language preferences, any visual or hearing needs, religious and cultural beliefs to develop an individualized, program participant centered care plan. Care plans are developed in collaboration with the program participant, family/caregiver, practitioner and other healthcare professionals (as needed) who have expertise in the program participant's diagnosis.

B. Care plans must include development and communication of program participant self-management plans. Self-management plans are components of the care plan and are activities that program participants can perform for themselves to manage their condition. Self-management activities may include but are not limited to:
   1. Maintaining a prescribed/recommended diet;
   2. Exercising as appropriate to condition;
   3. Avoiding certain medications, foods and alcohol while pregnant or for a specific condition;
   4. Charting daily readings (weight, blood pressure, blood sugar);
   5. Changing a wound dressing as directed;
   6. Hydrating appropriately, especially for a pregnant woman;

7. Parent/caregiver involvement during infant's NICU stay (breast feeding/holding/etc.);

8. Preparing for discharge of NICU infant.

C. The case manager will identify issues/problems based on the assessment of the program participant's needs and will assign short- and long-term goals that:
   1. Are measurable and have clearly identifiable timeframes;

   2. Describe specific interventions and resources needed to accomplish the goals;

   3. Include collaborative approaches to be used to facilitate the care plan as well as when coordinating and transitioning care; and

   4. Have time frames for re-evaluation, follow-up, and response to services.

D. The case manager will prioritize all goals by assigning: Priority, Progran Participant/Caregiver Preference or by choosing both. Program specific work instructions are available which outline how goals are prioritized for each program. Then the case manager assigns each goal as high, medium or low in the order of importance to be addressed and worked on.

E. The case management process includes reassessing and adjusting the care plan and its goals, as needed. The case manager will evaluate and update the care plans when there is a change in the program participant's needs and on a minimum basis according to the following schedule:
   1. Complex: Weekly;

   2. Chronic: Every other week;

   3. Oncology/Multi Acuity Program: Weekly for those program participants with high acuity; twice a month for those with moderate acuity and monthly for those with low acuity or when there is a change in the program participant's needs;

   4. NICU: weekly;

   5. Maternity: Every thirty (30) calendar days.

F. The case management plan includes an assessment of the program participant's progress toward overcoming barriers to care and meeting treatment goals. The case manager will identify barriers to meeting goals or complying with the care plan. The case manager will address all obstacles to a program participant achieving their goals.
   1. An assessment of barriers will examine the program participant's:
      a. Understanding of the condition and treatment.
      b. Desire to participate in the case management plan.
      c. Belief that participation will improve their health.
      d. Financial or transportation limitations that may hinder the program participant from participating in care.
      e. Mental and physical capacity to participate in care.

   2. A barrier analysis is performed for each goal and may include barriers such as:
      a. Care of spouse/family member/children;
      b. Change in eligibility;
      c. Degree of Illness;
      d. Denial of condition;

e. Functional limitations;
f. Inability to comprehend;
g. Lack of financial resources;
h. Lack of support systems;
i. Lack of transportation;
j. Language barrier;
k. Loss of family member / loved one;
l. Other medical conditions;
m. Program participant request;
n. Care plan inconsistent with guidelines;
o. Readiness to change.

3. The case manager will document the barriers and actions to be utilized for plan compliance in the program participant's care plan.

4. The care plan goals, barriers (even if no barriers are identified), and outcomes are documented in the program participant's record.

G. The case manager facilitates referrals to resources, as appropriate to the program participant's needs and client contracts. All referrals will be followed up by the case manager on the next program participant's scheduled communication or sooner at the case manager's discretion to determine whether the program participant acted on the referral. (see policy QI-033 Care Coordination - Referral Process for further details)

H. During contact with the program participant, the case manager will assess the program participant's progress toward overcoming barriers to care and meeting treatment goals. The case manager will reassess and adjust the care plan and goals as needed.

OPTUM™	**Optum™** **Policy and Procedure** **CM: Data Collection Tools and Assessments**

Policy Owner (Division/Department): CM Operations/Quality Department	**Document Number:** CM-007
	Original Issue Date: 11/15/2007
	Committee Approval Date: 6/14/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 6/14/2016

This Policy Applies To:	
☐ **All Staff**	☒ Clinical Operations ☐ Marketing/Sales/Client Services ☐ Other ☐ Enrollment Services ☐ Medical Affairs ☐ Health Solutions ☐ Technology
☐ **All Programs**	
☐ **All Disease Management**	☐ Asthma ☐CAD ☐ COPD ☐ Depression ☐Diabetes ☐ HF ☐ Maternity ☐ MSP ☐ Other
☒ **All Case Management**	☐ Complex ☐ Maternity ☐ NICU ☐ Oncology ☐ Other
☐ **All Utilization Management**	☐ NICU ☐ Oncology ☐ Other
☐ **Nurse 24**	
☐ **BioPharma**	
☐ **Wellness**	☐ Wellness Portal ☐ Health Coaching
☐ **Maternity Home Care**	
☒ **Accreditation/Regulatory**	☒ NCQA ☒ URAC ☐ Joint Commission ☐ Regulatory

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
6/18/2014	CM-007 CM: Data Collection Tools and Assessments
6/3/2015	CM-007 CM: Data Collection Tools and Assessments
12/11/2015	CM-007 CM: Data Collection Tools and Assessments
6/14/2016	CM-007 CM: Data Collection Tools and Assessments

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	Senior Medical Director	6/10/2016
Susan Garcia	VP Case Management and Triage	6/9/2016
Diane Orlando	VP Clinical Affairs	6/14/2016

POLICY STATEMENT:

The purpose of this policy is to describe how Alere Health makes appropriate tools and information, designed for the purpose of program performance improvement, available for the case management team to utilize.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Case Manager	A healthcare professional designated as the case manager with such appropriate background and specialty, such as a registered nurse, social worker, physician, rehabilitation counselor, etc.
Program Participant Record	An electronic or paper file containing demographic, clinical, and non-clinical information about a program participant.
Treatment History	Therapies or procedures used to care for a program participant's identified health conditions and comorbidities. Treatment history covers at least the onset of the condition that qualifies the program participant for case management.

PROCEDURE:

A. The case management team is provided with a computer and telephone which enables documentation of information in the program participant's record with availability of the information to those with a need to know.

B. Alere Health's case management system is based on evidence based guidelines or algorithmic logic scripts and other prompts to guide case managers through an assessment and ongoing management of program participants. The system includes but is not limited to the following functions:
   1. Automated features that provide accurate documentation for each entry, recording actions or interactions with program participants, practitioners, or providers and automatic date, time and user stamps.
   2. Automated prompts and reminders for next steps or follow-up contact as required by the case management plan.

C. Other tools and information provided include but are not limited to the following:
   1. A structured initial orientation program with ongoing training and annual competencies;
   2. Organizational policies and procedures;
   3. Clinical guidelines and regulatory standards;
   4. Client-specific information;
   5. Workflow processes and algorithms;
   6. Websites approved by the Website Approval Committee;
   7. Approved reference materials;
   8. Access to medical directors and other disciplines (pharmacy, etc.) for consultation;

9. Community resource information;

10. Case reviews;

11. Frequent and consistent feedback from their immediate manager based on audit and case review results; and

12. Complaint and incident reporting systems.

D. The case manager conducts a thorough assessment including a needs assessment and interviews the program participant, family and/or caregiver as soon as possible after obtaining consent for case management, but no later than 30 days from the date of the of the determination that the member is eligible for case management services. All findings are documented in the program participant's record. The case manager will explicitly document any assessment items that are found to be not appropriate (not applicable) and the reason why.

E. Data supplied by the program participant, family or caregiver in the initial assessment should include at a minimum:
   1. Current health status and clinical history, including condition-specific issues;

   2. The case manager evaluates and documents the program participant's:
      a. Health status specific to identified health conditions and likely medical and behavioral health comorbidities,
      b. Clinical history, including disease onset; key events such as acute exacerbations, inpatient stays; and treatment history, such as physical/occupational/speech therapy, surgery, medication and radiation therapy.

   3. Treatment plan;

   4. Medication Safety (see policy CM-013 CM Medication Safety)
      a. Current and past medications including schedules and dosages
      b. Medication knowledge and adherence
      c. Use and adherence of medications including experienced side-effects
      d. Access to and use of current medication list
      e. Sharing of current medication list with treating provider(s)
      f. Need for medication reconciliation
      g. Need for medication therapy management services, as appropriate

   5. Resources required to meet immediate needs for health care and evaluation of available benefits from the health plan, and community resources. (see policy QI-033 Care Coordination-Referral Process);
      a. Assessment of program participant's health benefits and other pertinent financial information regarding benefits may include but are not limited to:
         1) Benefits covered by the client and by providers
         2) Services carved-out by the client
         3) Supplemental services such as community mental health, Medicare, Medicaid, long term care and support, disease management and palliative care programs
      b. Assessment of the program participant's eligibility for community resources.

   6. During the initial assessment the case manager assesses the caregiver's resources and involvement.
      a. Family/caregiver involvement in the program participant's care and decision making about the care plan
      b. Level of assistance the program participant needs and if a caregiver is available to provide needed assistance

7. Psychosocial status including evaluation of caregiver resources, the adequacy of the resources and the caregiver's involvement;
   a. Possible psychosocial issues that may affect the program participant's ability to adhere to the care plan may include but are not limited to:
      1) Beliefs or concerns about the condition or treatment
      2) Perceived barriers to meeting treatment requirements.
      3) Program participant's input, including perception of needs such as health care needs and social services and supports.

8. Safety concerns;

9. Initial assessment of mental health status, including cognitive functions;
   a. The case manager evaluates and documents the program participant's ability to communicate, understand instructions and process information about their illness.

10. Initial assessment of the activities of daily living;
    a. The case manager evaluates and documents the program participant's functional status which may include but is not limited to mobility and the ability to eat, bathe, toilet, and dress oneself.

11. Initial assessment of life-planning activities;
    a. The case manager evaluates and documents the program participant's planning surrounding wills, living wills or advanced directives and health care powers of attorney.
       1) If expressed life-planning instructions are not on record, the case manager determines if a discussion is appropriate based on the program participant's circumstances.
       2) If life planning activities are not appropriate to the program participant's situation, this will be documented in the program participant's clinical record.

12. Initial assessment of health behaviors;
    a. The case manager evaluates and documents the program participant's possible health behaviors such as nutrition, physical activity, and tobacco use that may impede the program participant's ability to adhere to the care plan.

13. Evaluation of cultural and linguistic needs, preferences or limitations to effectively communicate with the program participant;
    a. The case manager evaluates and documents the program participant's:
       1) Preferred spoken and written language
       2) Family traditions related to illness, death dying, parenting and childbirth, as applicable
       3) Health care treatments or procedures that are religiously or spiritually discouraged or not allowed
       4) The need for culturally and linguistically appropriate services reflecting individual needs, if applicable.

14. Evaluation of visual and hearing needs, preferences, or limitations;
    a. The case manager evaluates and documents if the program participant has normal hearing and vision or impairments. If impairments are present, the case manager documents what devices are needed to assist with functioning with the impairments.

15. Care coordination needs, including transitions of care. (see policy CM-012 CM: Care Transitions);

16. Verification of program participant's primary care practitioner

F. Subsequent assessments are conducted throughout the case management process and will include some or all of the above assessment categories as individualized to the program participant's health status and needs.

G. Documentation of initial assessments and subsequent assessments
   1. Data provided during the initial assessments is documented in the program participant's record.

   2. If any of the above items were not identified as issues/concerns, documentation must reflect that there was no issue ex: No safety concerns noted.

   3. If any of the above items are identified as not applicable, they are documented as not applicable ex: a baby in the NICU's health behaviors.

OPTUM™	**Optum™** **Policy and Procedure** **CM: Identification, Case Opening and Closure Criteria**

Policy Owner (Division/Department): CM Operations/Quality Department	**Document Number:** CM-009
	Original Issue Date: 4/1/1999
	Committee Approval Date: 8/31/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 8/31/2016

This Policy Applies To:	
☐ **All Staff**	☒ Clinical Operations ☐ Marketing/Sales/Client Services ☐ Other ☐ Enrollment Services ☐ Medical Affairs ☐ Health Solutions ☐ Technology
☐ **All Programs**	
☐ **All Disease Management**	☐ Asthma ☐CAD ☐ COPD ☐ Depression ☐Diabetes ☐ HF ☐ Maternity ☐ MSP ☐ Other
☒ **All Case Management**	☐ Complex ☐ Maternity ☐ NICU ☐ Oncology ☐ Other
☐ **All Utilization Management**	☐ NICU ☐ Oncology ☐ Other
☐ **Nurse 24**	
☐ **BioPharma**	
☐ **Wellness**	☐ Wellness Portal ☐ Health Coaching
☐ **Maternity Home Care**	
☒ **Accreditation/Regulatory**	☒ NCQA ☒ URAC ☐ Joint Commission ☐ Regulatory

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
6/18/2014	CM-009 CM: Identification, Case Opening and Closure Criteria
12/16/2014	CM-009 CM: Identification, Case Opening and Closure Criteria
6/3/2015	CM-009 CM: Identification, Case Opening and Closure Criteria
6/14/2016	CM-009 CM: Identification, Case Opening and Closure Criteria
8/31/2016	CM-009 CM: Identification, Case Opening and Closure Criteria

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	Senior Medical Director	8/31/2016
Susan Garcia	VP Case Management and Triage	8/31/2016
Diane Orlando	VP Clinical Affairs	8/23/2016

POLICY STATEMENT:

This policy describes the processes for identification, case opening and closure for all of Optum's case management programs including Chronic, Complex, Maternity, NICU and Oncology.

REFERENCE DOCUMENTS:

QI-033 Referral Policy

DEFINITIONS:

Case Management	A collaborative process which accesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs using communication and available resources to promote quality and cost-effective outcomes.
Case Opening	A case is opened when an eligible individual is determined to be qualified for program enrollment by a case manager and accepts participation in the program.
Case Closing	A case is closed when activity on a case ceases.
Case Manager	A healthcare professional with appropriate background and specialty, such as registered nurse, social worker, physician, rehabilitation counselor, etc.
Discharge	To release from care.
Healthcare Professional	Employees or contracted consultants of the organization who are professionally licensed, certified and/or registered and qualified to provide clinical services, including telehealth services.
Practitioners	A professional who provides health care services. Practitioners are usually required to be licensed as defined by law.
Program Participant	An individual who is enrolled in any activities or services provided by an Optum program.
Providers	An institution or organization that provides services for program participants. Examples of providers include hospitals and home health agencies.

PROCEDURE:

A. Optum assesses the characteristics and needs of its program participant population and relevant subpopulations by:
   1. Quarterly:
      a. Tracking and trending program participant surveys;
      b. Tracking and trending program participant complaints;
      c. Hiring bi-lingual case managers where indicated or using Language Line;
      d. Conduct quality improvement subcommittee (QISC) work plan reports and reviews;
      e. Reviewing culturally and linguistically appropriate websites suggested by staff at the website committee meeting.

   2. Optum reviews and updates its case management processes and resources, if necessary, to address program participant needs annually by:
      a. Assessment of the needs of children and adolescents (refer to policy QI-034 Provision of Services to Minors);
      b. Assessment of the needs of individuals with disabilities;
      c. Assessment of the needs of individuals with serious and persistent mental illness (SPM), as applicable;

d. Collecting demographic and language data and identifying culturally specific needs;
e. Ongoing communication with client management regarding expected population changes;
f. An analysis of annual data is completed and posted in the annual program evaluation document with program processes and resource changes, as applicable, including goals and action plans.

B. Optum systematically identifies program participants who quality for case management, at a minimum, on a monthly basis.

C. Optum uses the following data sources to identify individuals as eligible for each case management program, depending on applicability: :
1. Claim or encounter data
2. Hospital discharge data
3. Pharmacy and lab data
4. Health appraisals or risk appraisals/scoring tool
5. Data collected through the UM management process including pre-certification data, concurrent review data, prior authorization data and hospital admission data.
6. Data supplied by purchasers, i.e., health plans, employer groups
7. Data supplied by individuals or caregivers
8. Data supplied by practitioners

D. Optum has multiple avenues for individuals to be considered for case management services, depending on applicability and including referrals from any of the entities listed below:
1. Health information line
2. Disease management program
3. Discharge planner
4. Utilization management program
5. Member or caregiver
6. Practitioner
7. Case management program
8. Client or third-party administrator
9. 24/7 BabyLine
10. Vendors of home service
11. Clinic or Provider

E. Eligibility
   1. All members referred to an Optum case management program are assessed against specific eligibility criteria. Client-specific workflows may be used where applicable.

   2. Eligibility data is automatically uploaded and run through an automated data certification process.

   3. The Triage Engine, a proprietary rule based algorithm, runs Optum's proprietary program identification on a daily basis for data files received daily and on a monthly basis for files received monthly.

   4. Eligibility is checked real time every time the triage process is processed. Eligibility is based upon the most recent eligibility file received from the client.

F. Enrollment Process and Stratification
   1. If eligibility criteria are met, case management staff will contact members for enrollment and stratification into the program according to client, program or referral type processes.

G. Cases may be closed when they meet any of the criteria listed below:
   1. Condition has improved or stabilized;

   2. All goals are closed;

   3. Program participant can independently self-advocate for health services;

   4. Program participant has determined no further needs or has requested closure or is no longer compliant with program (including unable to reach);

   5. Program participant is no longer eligible based on clinical criteria or coverage;

   6. Client requests closure;

   7. Program participant expired; or

   8. Program specific criteria

	**Optum™** **Policy and Procedure** **Program Content - Development, Review & Approval Process**

Policy Owner (Division/Department): VP Clinical Compliance and Integrity	**Document Number:** QI-004
	Original Issue Date: 8/1996
	Committee Approval Date: 3/23/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 3/23/2016

This Policy Applies To:					
☐ **All Alere Staff**	☒ Clinical Operations ☐ Enrollment Services ☐ Health Solutions	☐ Marketing/Sales/Client Services ☐ Medical Affairs ☐ Technology	☐ Other		
☐ **All Alere Programs**					
☒ **All Disease Management**	☐ Asthma ☐ HF	☐CAD ☐ Maternity	☐ COPD ☐ MSP	☐ Depression ☐ Other	☐Diabetes
☒ **All Case Management**	☐ Complex	☐ Maternity	☐ NICU	☐ Oncology	☐ Other
☒ **All Utilization Management**	☐ NICU	☐ Oncology	☐ Other		
☒ **Nurse 24**					
☐ **BioPharma**					
☒ **Wellness**	☐ Wellness Portal	☐ Health Coaching			
☐ **Maternity Home Care**					
☒ **Accreditation/Regulatory**	☒ NCQA	☒ URAC	☐ Joint Commission	☐ Regulatory	

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
3/26/2014	QI-004 Program Content - Development, Review and Approval Process
3/25/2015	QI-004 Program Content - Development, Review and Approval Process
3/23/2016	QI-004 Program Content - Development, Review and Approval Process

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	VP Senior Medical Director	3/23/2016
Gail Gibbons	VP Clinical Compliance and Integrity	3/23/2016
Diane Orlando	VP Clinical Affairs	3/23/2016

POLICY STATEMENT:

This policy describes the process by which Alere develops, reviews, evaluates, adopts, and integrates evidence-based guidelines and information received from Recognized Sources/Authorities and company Proprietary Program Content into programs.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Evidence-based Guidelines	Systematically developed descriptive tools or standardized specifications of care to assist Practitioner and Program Participant decisions about appropriate health care for specific clinical circumstances. Practice guidelines are typically developed through a formal process and are based on authoritative sources, including clinical literature and expert consensus. Practice guidelines may be called practice parameters, treatment protocols, clinical criteria and clinical guidelines. (NCQA)
Program Content	Includes all the educational information and interventions Alere directs towards Program Participants and Practitioners to improve management of a condition, reduction of risk and/or health maintenance (i.e. materials, practitioner reminders, scripts for phone calls). Program Content is consistent with evidence-based guidelines and may include additional information gathered from Recognized Sources/Authorities.
Proprietary Program Content	Program Content developed and owned by Alere.
Recognized Sources/Authorities	Organizations that develop or promulgate evidence-based guidelines. Recognized sources or authorities include, but are not limited to nationally recognized organizations, such as the American Heart Association (AHA) or American Academy of Pediatrics (AAP), government research sources, such as the National Institute of Health (NIH) or Center for Disease Control (CDC), and clinical literature from respected medical sources.

PROCEDURE:

A. Alere uses nationally recognized, evidence-based guidelines, information from recognized sources/authorities and proprietary program content as the basis for program and intervention design.

B. Alere offers program content materials in multiple modalities. This includes verbal (telephonic), print, digital, or in person in accordance with program policies and/or client agreements.

C. Annual Review and Approval of Program Content Materials
   1. Program source materials such as: evidence-based guidelines, and key program content from recognized sources/authorities are monitored, reviewed and approved at least annually by the Scientific Advisory Board (SAB) or other designated quality committee.
      a. This review includes review of government research sources and clinical or technical literature, and proprietary program materials.
      b. Board–certified practitioners, practicing physicians, subject matter expert physicians are involved in the review process as applicable.

2. Program participant and practitioner materials, including wellness program, digital program information and tools are reviewed at least annually to ensure consistency with evidence-based guidelines and other key program source materials.

3. Internal staff educational/telephonic scripts that support program participant education are reviewed with guideline changes and updated as needed to ensure they are consistent with program policies, procedures, and source materials.

D. Evidence-based Guideline Updates
   1. Designated staff monitors nationally recognized organizations that develop or promulgate evidence-based guidelines in order to identify when changes to guidelines occur.

   2. Updated guidelines are reviewed and approved by medical advisory and distributed to program and content subject matter experts to implement changes to applicable program materials.

E. Development of Proprietary Program Content
   1. Proprietary program content is developed with involvement from actively practicing physicians and/or other qualified practitioners with current knowledge relevant to the subject matter and/or clinical decision support tools to assure the following:
      a. Materials are based on scientifically valid and documented clinical principles and processes.
      b. Materials are based upon principles appropriate to the functions of the company programs.
      c. The company uses the results of quality review studies in developing and updating clinical support tools.
      d. The special needs of program participants.
      e. All proprietary content is reviewed and approved by medical advisory and may include additional subject matter expert clinicians as necessary.

   2. Key program materials are evaluated at the time of development and at least every three years to ensure that the language used in the material is easy to understand by the program participant. The following methods may be utilized:
      a. We utilize acceptable industry tools (MS Word Flesch-Kincaid) to test readability. Goals for testing include updating content in response to federal guidelines changes. Readability levels of all program materials range between 4^{th}-8^{th} grade level or below to the extent practical and/or to use plain language to provide clear explaination of medical terminology or health information.
      b. Usability testing: Includes assessing the targeted audience, efficiency, memorability, and satisfaction
      c. Conducting focus groups that represent the demographic population including but not limited to consumers, program participants and/or internal staff.

   3. Ongoing evaluation of key program materials is conducted in the following manner:
      a. Reviewing program participant satisfaction survey results related to program materials
      b. Reviewing program participant feedback related to program materials
      c. Reviewing special communication needs assessment

F. Review of New Information
   1. Alere utilizes up-to-date medical findings in preparing program content by reviewing the source of new information, e.g., government research sources, professional societies, foundations or clinical or technical literature.
      a. Members of the SAB or designated quality committee, in addition to Alere clinicians and program specialists are responsible for ongoing review of new information that might relate to Alere programs.

   2. The medical advisory review of new information includes:
      a. An assessment of costs and benefits to program participants in terms of the ability to improve outcomes for the program participants.
      b. Documentation of the decision to implement a change or not.

G. Designated staff tracks and manages documentation that consists of information related to program source materials, including adopted evidence-based guidelines, guideline updates and some key information gathered from recognized sources/authorities.

H. Practitioners with patients in high-acuity programs are notified via the practitioner's welcome letter that they have access to a designated practitioner's website where a list of current program sources, i.e., nationally recognized evidence based guidelines can be found.

I. Providing Program Information to Staff
   1. Training is provided as needed to staff who may communicate with program participants and/or practitioners as indicated below:
      a. Training consists of identifying program support information and reviewing content with staff
      b. Training is provided on an ongoing basis; at the time of new employee orientation, and any time program materials or evidence-based guidelines are updated.
      c. Licensed care management staff is provided access to all program content source materials.

J. Integration of Approved Program Source Materials into Program Content
   1. At least annually or upon adoption of new or updated evidence-based guidelines and/or information from recognized sources/authorities, designated staff reviews both program participant and practitioner program materials and update materials as needed.

OPTUM™	**Optum™** **Policy and Procedure** **Program Satisfaction/Feedback**

Policy Owner (Division/Department): Quality Department	**Document Number:** QI-020
	Original Issue Date: 4/1999
	Committee Approval Date: 3/23/2016
Access to All Staff on MyAlere: ☒Yes ☐No	**Effective Date:** 3/23/2016

This Policy Applies To:	
☐ **All Alere Health Staff**	☒ Clinical Operations ☐ Marketing/Sales/Client Services ☐ Other ☒ Enrollment Services ☐ Medical Affairs ☐ Health Solutions ☐ Technology
☐ **All Alere Health Programs**	
☒ **All Disease Management**	☐ Asthma ☐CAD ☐ COPD ☐ Depression ☐Diabetes ☐ HF ☐ Maternity ☐ MSP ☐ Other
☒ **All Case Management**	☐ Complex ☐ Maternity ☐ NICU ☐ Oncology ☐ Other
☒ **All Utilization Management**	☐ NICU ☐ Oncology ☐ Other
☒ **Nurse 24**	
☒ **BioPharma**	
☒ **Wellness**	☐ Wellness Portal ☐ Health Coaching
☐ **Maternity Home Care**	
☒ **Accreditation/Regulatory**	☒ NCQA ☒ URAC ☐ Joint Commission ☐ Regulatory

Policy and Procedure History	
Committee Approval Date	Supersedes (Document No. / Title)
3/26/2014	QI-020 Program Satisfaction/Feedback
3/25/2015	QI-020 Program Satisfaction/Feedback
3/23/2016	QI-020 Program Satisfaction/Feedback

Approved By:		
Name	Title	Electronic Approval Date:
Dan Sullivan	VP Senior Medical Director	3/23/2016
Diane Orlando	VP Clinical Affairs	3/23/2016

POLICY STATEMENT:

The purpose of this policy is to describe the process by which Alere Health obtains and analyzes feedback about satisfaction with the programs and services provided to program participants, practitioners, and clients.

REFERENCE DOCUMENTS:

None

DEFINITIONS:

Client	Employer group, health plan, payor or sponsoring organization contracted with Alere Health.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as defined by law. (NCQA)
Program Participant	An individual who is enrolled in any activities or services provided by an Alere Health program.

PROCEDURE:

A. As specified by Alere Health's Annual Quality Program, client contracts, regulatory requirements, and/or accreditation standards, Alere Health solicits information from program participants, practitioners and/or clients in a variety of methods including mail, telephonic, in person, and/or online.

B. Program Participant Feedback & Satisfaction
   1. All Alere Health Disease Management, Nurse 24, Case Management, WCH Home Care, Depression Management, Coaching (telephonic or online) and Wellness portal programs evaluate program participant satisfaction at least annually, or per specific client contract.

   2. Program participant satisfaction surveys collect information based on the program participant's experiences and satisfaction with the Alere Health program. Categories for data collection may include the following components:
      a. Overall program
      b. Program staff
      c. Educational information
      d. Program participant - reported health outcomes
      e. Access to the program
      f. Number of program participant contacts with the program
      g. Program recommendation to others

   3. Program participant complaints and program participant satisfaction results are collected for review of program participant feedback in our quality committee meetings.

C. Practitioner Feedback & Satisfaction
   1. All Alere Health's Disease Management programs evaluate program practitioner satisfaction at least annually.

   2. Other Alere Health programs evaluate program practitioner satisfaction in accordance with client agreements.

3. Practitioner satisfaction surveys collect information based on the practitioner's experiences and satisfaction with the Alere Health program. Categories for data collection may include the following components:
   a. Perception of the usefulness of program content
   b. Satisfaction with personal interactions with the program
   c. Perception of the program's impact on patients' use of services
   d. Perception of the program's impact on patients' health status relative to the target condition.

4. Practitioner complaints and practitioner satisfaction results are collected for our review process of practitioner feedback in our quality committee meetings.

D. Client Feedback & Satisfaction
   1. Alere Health evaluates client satisfaction for all CM, UM and Nurse24 programs in accordance with client agreements and in aggregate on the book of business at least annually.

   2. Other Alere Health programs evaluate program client satisfaction in accordance with client agreements.

   3. Client complaints and program participant satisfaction results are collected for our review process of client feedback in our quality committee meetings.

E. Report to Quality Committees
   1. Analysis of the information includes comparison of the results against past performances/thresholds and an analysis of the cause of any deficiencies noted.

   2. Results are utilized to improve the services provided including barrier analysis; corrective action plans and remeasures results after actions are taken.

   3. Results are reported to the quality committees, opportunities for improvement are identified, action plans to improve results are developed and remeasured at least annually.

2016 Quality improvement program description and work plan

Approvals:

Dan Sullivan, vice president, senior medical director	3/31/2016
Betsy Piazza, senior vice president, care management	3/30/2016
Diane Orlando, vice president, clinical affairs	3/30/2016

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Our mission
Our mission is to empower consumers to take ownership of their health.

Our vision
Our vision is to bring hope, help, health and happiness to those in need. Our health advocates and licensed health care professionals help individuals lead healthier lives by managing chronic conditions, offering specialty care and improving overall health and well-being.

Our core values
Integrity, Compassion, Relationships, Innovation, Performance

Introduction
In 2014, Optum announced the acquisition of Alere Health and its subsidiaries. Optum is a leading provider of health care consulting, technology, information management and population health management services designed to modernize the health care system and improve overall individual and population health. Alere Health is a leader in population health management with over 25 years of experience serving regional and local health plans, employers, and states. The acquisition by Optum, official as of January 9th, 2015, reflects the importance and growing appreciation of the value Alere Health brings to its customers, and especially our shared customers and partners.

At Optum, we're passionate about making the health system work better for everyone. Optum is a health services and innovation company on a mission. We have 94,000 people dedicated to improving the health system for everyone in it. We power modern health care by combining data and analytics with technology and expertise. We focus on three key areas of change: modernizing the system's infrastructure, advancing care and supporting people as they take control of their own health.

The backbone of our strategy is to address the barriers to behavioral change, starting with the individual and where they are in their life, considering socio-economic, environmental and behavioral factors, in addition to their health needs. Across Optum, we embrace a shared purpose of lowering the impact of chronic illness on those in our programs by employing evidence-based behavioral change methodologies, high-touch, personalized services and the innovative use of technology. By also enabling the sharing of clinical information within the health care ecosystem we can improve each individual's quality of life and deliver value to our customers. For the remainder of this document, the Optum services provided by legacy Alere Health will be referred to as Alere Health.

Quality improvement goals 2016
- Continue to improve overall clinical performance with clinical and quality outcomes
- Continue to improve customer satisfaction
- Continue to evaluate and enhance the effectiveness of Alere Health programs by launching identified quality improvement projects
- Aggressively pursue operational process improvement to drive service delivery efficiency and effectiveness while maintaining a high level of quality and customer service
- Continue to improve program participant engagement
- Continue to reduce unplanned utilizations
- Continue to support health plan client's HEDIS and STAR metrics ratings
- Maintain URAC case management, utilization management and health call center accreditations

- Maintain NCQA Wellness and Health Promotion with Performance Measures accreditation
- Achieve re-accreditation of NCQA Disease Management and Case Management programs

At Alere Health we provide the following suite of integrated programs and resources:

- Wellness solutions offer a comprehensive integrated suite of programs and services that leverages industry-proven methodologies to develop, implement, track and measure customized health improvement strategies. Our wellness programs integrate with the client's existing programs to enable a single view of an individual's health status across the care continuum. Services include the health portal, health and productivity assessment, Alere Health personal health record, screening services, and virtual coaching. Alere Health also recently incorporated social media and gaming strategies to keep program participants engaged. Alere Health's wellness and health promotions program has achieved NCQA Accreditation with Performance Measures.
- Disease management programs help individuals at-risk and those diagnosed with chronic health conditions to better manage their health through education, empowerment and support. The programs available include heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, asthma, maternity, musculoskeletal pain and depression. Alere Health program staff proactively contact individuals to assess the severity of their condition, the presence of comorbid conditions and any barriers to care. Our disease management programs provide guidance and education using digital, mail and/or telephonic interventions, as well as monitors biometric and symptom data and program progress. In addition, program staff members help increase compliance with evidence-based treatment guidelines and practitioner treatment plans, and change behavior through contemporary behavioral change strategies. Alere Health's disease management programs are accredited by NCQA.
- Nurse24 is a nurse-driven telephonic support program that empowers program participants to better manage their health. Nurse24 offers assistance to program participants coping with chronic and acute illness, episodic or injury-related events and other health care issues. Highly trained registered nurses are available 24/7 to monitor and process health care inquiries that help program participants make informed health care decisions. Alere Health's Nurse24 program is accredited for Health Call Center by URAC and is certified as a Health Information Line by NCQA.
- Complex case management provides services for program participants with chronic and complex diagnoses involving multiple chronic conditions, catastrophic injuries and illnesses, which may be compounded by major social, psychological and financial issues. The major goals are to improve quality of life and reduce health care costs. The Complex Case Management program is both URAC and NCQA accredited.
- Oncology case management program is a comprehensive cancer treatment and support program that uses structured approaches to improve compliance and enhance quality of life or improve end-of-life care. Health care professionals strive to manage the disease and treatment side effects and provide effective and efficient coordination of care. The Oncology Program utilizes a program participant-centric primary case manager model and a team approach to educate, monitor and support program participants. The Oncology case management program is both URAC and NCQA accredited.
- Maternity risk assessment and case management program offers a personalized approach which addresses the rising number of high-risk pregnancies with poor birth outcomes and the increasing cost of neonatal intensive care unit (NICU) care. The program includes the early identification of pregnancy risk, which combined with our periodic assessments and education, improve overall outcomes. Alere Health's OB risk assessment and education program is NCQA accredited for disease management. The maternity case management program is both NCQA and URAC accredited for case management.
- Neonatal Intensive Care Unit (NICU) care management program improves outcomes of infants admitted to the NICU or other specialty care units. Alere Health improves clinical outcomes by providing case and utilization management to all infants admitted to the NICU, increases family satisfaction and lowers client health care costs. Distinctive program features

include: unparalleled nursing; practitioner, informatics and programmatic expertise; a database of more than 200,000 NICU program participants from which we produce proprietary clinical guidelines; robust management tools with real-time reporting; 24/7 access to NICU nurse case managers and detailed family educational materials. The NICU case management and utilization management programs are both URAC and NCQA accredited for case management and URAC accredited for utilization management.

- Biopharma Program is a pharmaceutical support unit that offers innovative solutions to pharmaceutical companies seeking to improve compliance and persistency through programs that support program participants by educating them about their condition and prescribed treatment regimen. These programs are designed to apply scripted education and information to help program participants understand their diagnosis and treatment and to make educated choices about their care.

Quality program structure

The Quality Improvement Program and Work Plan describe the structure, program content, and roles and responsibilities of quality resources. An effective quality management program must be systematically data-driven, and focused on measuring and improving program quality and safety. Creating involvement by all organizational departments unites the organization in working toward common goals and objectives through interaction and communication. For an organization to be credible in today's health care market, it must establish a quality program (from both the internal and external customers' perspective). Improving quality means improving processes, and that requires monitoring and continuous assessment to maintain standards and identify opportunities for improvement. A good quality program ensures that the risk of customer dissatisfaction and negative outcomes are significantly reduced, resulting in a better work environment, optimized program participant care and safety, improved customer loyalty and repeat business.

Alere Health recognizes that it must focus on quality to ensure exceptional service and exceed customer expectations. To this end, Alere Health utilizes best practice industry standards from URAC, NCQA, and the Joint Commission, as well as recognized evidenced-based guidelines from reputable organizations. Additionally, Alere Health continuously monitors gaps between actual and desired practices, processes and results for improvement opportunities.

Quality improvement process

Alere Health's Quality Improvement Program includes process planning, measurement and improvement activities for all programs. Specific measures are collected across multiple service lines to allow tracking and trending of common processes. The quality plan contains measures specifically tailored to evaluate their high volume, high-risk, and problematic areas. The goal of the quality improvement process is to continuously improve care and service provided.

The Quality Program utilizes innovative prospective, concurrent, and retrospective methods integrated throughout the organization to achieve its goals, which includes improving the quality of products and services, increasing program participant and practitioner satisfaction, optimizing resource utilization, and continuously improving processes to facilitate achievement of Alere Health's mission and vision. Statistical methods and tools are used to measure, assess and enhance processes by identifying opportunities for improvement, and then developing, implementing, and monitoring improvement strategies.

The program includes clinical and operational functions that directly or indirectly impact the quality of services provided to program participants, practitioners and client organizations. It is designed to involve all disciplines and employees. Organization-wide, quality teams participate in data collection for various measures and process improvement activities. Project teams are chartered by the Quality Improvement Committee (QIC) or one of its subcommittees to conduct cross-functional interdisciplinary projects.

Data is systematically collected, analyzed, summarized, and presented with recommendations to the Quality Improvement Committee and its subcommittees. The identification of opportunities for improvement, generated by continuously monitoring activities, leads to interventions designed to improve the overall program performance and the quality and safety of service provided to program participants.

Alere Health's Work Plan is the main report reviewed at quality committee meetings. It contains indicators of the quality of care and service program participants receive. Program-specific performance indicators represent the scope of the program to monitor planned activities and quality initiatives. Yearly objectives or goals are set based on the review of the previous performance and internal operations expectations. Quality improvement projects are monitored via the work plan and project-specific documents that identify the scope and time frame of each project. The work plan is reviewed and analyzed at the appropriate quality committee each quarter.

A formal program evaluation is conducted yearly to assess the overall effectiveness of the quality program and to determine program efficacy. The evaluation addresses all aspects of the quality improvement process as outlined in this program description and is presented to the QIC and the Executive Management Team (EM) for approval.

Quality program and work plan

- Aim: To promote processes that improve organizational performance; provide a customer-driven quality program; identify and implement changes that increase customer satisfaction; identify, reduce and eliminate redundancy and inefficiency; and assist in maximizing financial performance through increased cost efficiency.
- Rationale: The quality program is designed to measure the level of excellence of care and services; identify opportunities for improvement; provide a methodology for planning and implementing change and assist in achievement of organizational goals. Issues addressed include customer service, quality of care, regulatory and financial.
- Measures: Data is collected on specific key indicators. Numeric calculations are based on and compared to predetermined thresholds. Results are analyzed for improvement opportunities based on these thresholds and identified needs.
- Quality Improvement Projects: When potential opportunities for improvement are identified, quality teams initiate a QI project specific to that concern. This application is a scientific methodology to impact change to these identified opportunities. This facilitates development, implementation and evaluation of process change.

Quality programs charter elements

- Quality program design and implementation
- Client and operational performance monitoring
- Operational and clinical data analysis
- Quality improvement activities and projects
- Best practices identification and communication
- Quality assurance and process control
- Program participant and practitioner rights and responsibilities
- Customer satisfaction and complaint analysis

Behavioral health care

Alere Health incorporates recognized motivational principles training for health care professionals that interact and engage program participants. It is our goal to collaborate with program participants in order to facilitate their ability to make informed decisions with their practitioner(s) that take into account the best scientific evidence available as well as the program participant's values and preferences. Our objective is to ensure all program participants receive information to

encourage and reinforce self-management skills. Our health care professionals are trained to assess program participant's medical and behavioral health via frequent telephone communications, and to provide medication management and referrals to behavioral health services, when indicated. Motivational principles facilitated by a collaborative and program participant-centered approach are used to elicit, strengthen and encourage the program participant's motivation for change and self-management.

Designated practitioners

Behavioral health care practitioner

Alere Health ensures oversight of the behavioral health aspects of its programs by contracting with a psychiatric consultant who sits on the scientific advisory board and the quality improvement committee. The practitioner is involved in the review of evidence-based guidelines and program content materials, development of new products, and oversight of the behavioral health aspects of Alere Health's programs.

Medical directors

The senior medical director is a member of the quality improvement committee and is responsible for the following key functions:

- Participates in the design, review and implementation of clinical programs
- Provides clinical oversight of the medical directors, and clinical quality metrics
- Ensures Alere Health obtains and maintains appropriate industry accreditations

Alere Health has multiple practitioners who participate in the development of program content and provide oversight for the development, implementation, ongoing improvement and maintenance of quality programs. This team also provides input to the executive management team for strategic decision-making and planning.

Actively practicing practitioners

Alere Health involves actively practicing practitioners in many components of the quality improvement program. Practitioners sit on several committees, including the Scientific Advisory Board. Other practitioners participate on a consultation basis as needed.

Organizational structure

Accountability to the governing body

The Executive Management Team is Alere Health's governing body and is comprised of executive leadership from operations, medical affairs, heath management strategy, human resources, finance, legal, technology, product, marketing and sales, and client management. The executive management is responsible for organizational governance and has delegated the responsibility of the quality management/improvement program to the quality improvement committee and its subcommittees. The quality improvement committee and its subcommittees are the functional building blocks of the Company's quality oversight process. Executive management meets regularly, participates on the quality improvement committee and is responsible for reviewing and approving Alere Health's Quality Program, QI Work Plan and Annual Evaluation each year.

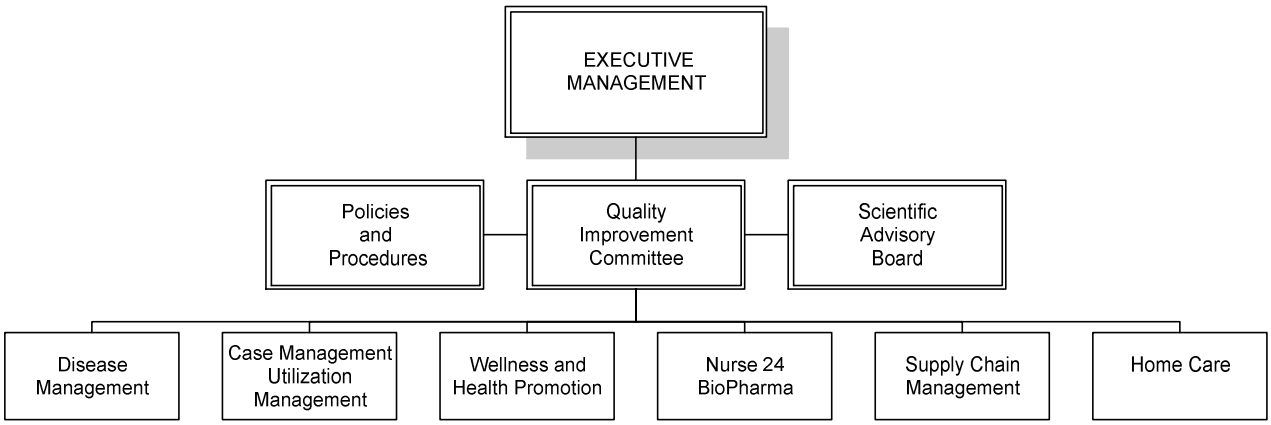
Functional areas and responsibilities

Alere Health is committed to ensuring our business units are connected by clear, consistent communications, policies and procedures, unified strategic goals and adherence to our mission and vision. We strive to continuously improve our programs and services through performance and operational measurement, opportunity and barrier analysis, and appropriate quality improvement activities. Operational areas of Alere Health work together to develop, implement and continuously improve the array of programs offered, and fulfill program objectives. A brief summary of the roles and responsibilities of our key operational areas is provided below:

- Clinical leadership provides leadership for and manages the health intelligence function of the company, which includes the following core areas and their responsibilities:
  - Clinical integrity is responsible for ensuring that the quality of all program clinical content is consistent with approved evidence-based guidelines and represents "best practices" in the industry.
  - Reporting and analytics is responsible for providing data-driven performance management.
  - Medical affairs is responsible for providing strong clinical expertise and support to clinical operations and clinical quality.
- The operations leadership team manages the operational functions which includes the following core areas of responsibility:
  - Enrollment services are responsible for program participant outreach, educating on the benefits and elements of the program, gaining acceptance to the program and when applicable, completing a health risk assessment.
  - Fulfillment is responsible for the print and fulfillment of the educational materials and communications sent to the program participants and the program participant's practitioners.
  - Device management is responsible for medical device procurement, recertification (testing), preparation, shipping, initial set-up and on-going troubleshooting of the devices within the program participant's home.
  - Clinical operations is responsible for arming program participants with knowledge, skills and motivation that will help them make informed decisions about their care and improving outcomes.
- Other key business functions include:
  - Human resources is responsible for providing strategic leadership to the Alere Health management team by focusing on talent management, employee engagement and implementing strategic projects that support a workplace culture that promotes the company values. In addition, the department provides leadership guidance and coaching, and day-to-day issue resolution of employee issues and concerns.
  - Finance is responsible for directing the organization's financial goals, objectives, and budgets; overseeing the investment of funds and managing associated risks, supervising cash management activities, executing capital-raising strategies to support a firm's expansion, including dealing with mergers and acquisitions; and preparing financial reports that summarize and forecast the organization's financial position, such as income statements, balance sheets, and analyses of future earnings or expenses.
  - Legal and regulatory affairs are responsible for ensuring that Alere Health complies with all regulations and laws pertaining to our business.
  - Product is responsible for all aspects of product management from ideation of new products to enhancement of existing products. Product leads our Research and Development (R&D) effort and works closely with the clinical/operational and technical teams on product delivery and monitoring. Product marketing falls within this group, allowing it to manage projects from start to finish.
  - Marketing is responsible for promoting and marketing Alere Health's programs.
  - Sales is responsible for contacting potential customers and providing market feedback to Alere Health.
  - Client services is responsible for ensuring Alere Health's health management services and tools meet the needs of our clients and potential clients.
  - Technology solutions is responsible for all aspects of internal and external customer-facing applications and services. The technology solutions team manages the telecom infrastructure, help desk(s), application development of new features and functions, development of clinical and non-clinical applications, and data processing.

Quality improvement structure

The organizational chart below describes the quality oversight reporting structure of Alere Health's Quality Improvement committees.



Quality improvement committee (QIC)

The quality improvement committee is a multidisciplinary committee that retains operational accountability for the design and implementation of the quality program. Chaired by the vice president, clinical affairs, membership includes representatives from clinical quality, medical affairs, human resources, finance, product, marketing, legal and regulatory affairs, clinical operations, supply chain management, technology, health intelligence, and sales/client services. This committee is scheduled to meet at a minimum four times per year.

This committee has the authority, as vested by the governing body, of overseeing the quality and safety of services provided to program participants. Key responsibilities and functions include but are not limited to:

- Recommending policy decisions.
- Analyzing and evaluating the results of QI activities.
- Ensuring practitioner participation in the QI program through planning, design, implementation or review.
- Instituting necessary actions.
- Ensuring follow up as appropriate.
- Ensuring all quality committees maintain signed and dated meeting minutes.
- Providing oversight of quality committees to ensure opportunities for improvement are identified and appropriate actions are taken.
- Ensuring program participant safety is monitored and appropriate action taken, when needed.
- Ensuring adequate resources are available for integration of quality improvement activities throughout the company.
- Conducting an annual review and approval of Alere Health's quality program and QI work plan and annual program evaluation documents.
- Reporting to the executive council.

Policy and procedure committee (PPC)

The QIC has given the policy and procedure committee authority to retain operational accountability for review and approval of enterprise policies and procedures. The PPC is a multidisciplinary committee chaired by the policy and procedure manager. Membership includes representatives from medical affairs, clinical operations, supply chain management, clinical quality, human resources, legal and regulatory affairs, product, marketing, technology and client services. The committee is scheduled to meet quarterly, but is required to meet at least

three times per year. Responsibilities and functions include, but are not limited to, ensuring annual review of policies and procedures and maintaining a centralized library that houses company policies and procedures.

Quality sub-committee
Alere Health's sub-committees oversee the day-to-day activities of programs related to wellness, disease management, clinical enrollment, nurse information line, case management, utilization management, homecare, supply chain management, policies and procedures, and the scientific advisory board. These committees are chaired by quality vice presidents and directors. Members include representatives from the following core functions: clinical operations, medical affairs, clinical integrity, analytics, performance management, product, learning and performance and client services. They are scheduled to meet quarterly. Responsibilities and functions include tracking and trending day-to-day operations, identifying, developing and implementing opportunities for improvement and overseeing quality initiative projects.

Scientific advisory board (SAB)
The scientific advisory board provides expert, scientific evaluation and approval of peer-reviewed literature and evidence-based guidelines for the clinical management of Alere Health programs. Voting members are board-certified medical experts from appropriate specialties who serve Alere Health in a consulting/advisory capacity. This committee meets via teleconference or e-communication at least annually or more often as needed. Responsibilities and functions include, but are not limited to, reviewing evidence-based guidelines at least once every two years, review of new information related to Alere Health's programs, and costs and benefits to program participants to improve outcomes for the population managed.

Staffing, data sources and analytical resources

Alere Health accepts nothing short of exceptional customer service, market-leading products and "best-of-class" services. To ensure excellent services and products, quality is integrated throughout Alere Health. All core departments have designated staff responsible for conducting quality assurance processes. In addition, the Quality department ensures appropriate accreditations and/or certifications are achieved and maintained for each product brought forward.

Quality initiatives may be initiated or managed in departments or by a quality committee. Task forces may be formed consisting of representatives from the impacted core business units. Alere Health also employs individuals with Six Sigma certification to lead selected quality initiative projects. This provides expertise in program design, statistics and analysis, and ensures the ability to design sound studies.

Having access to and the ability to manage data is necessary to support measurement aspects of quality initiative activities. The clinical applications deliver a unique, seamless experience to program participants, a robust intuitive user interface, a streamlined workflow supporting our full suite of services, and an application tightly integrated with our touch points.

Culturally and linguistically diverse membership

Alere Health understands that health care organizations delivering services that respect and respond to health beliefs and practices, and cultural and linguistic needs of diverse program participants can help bring about more positive health outcomes. Alere Health's objective is to provide appropriate services to all program participants. Opportunities for improvement are identified based on these results.

Alere Health provides program participants with access to a national language line service when translations are requested or needed. Alere Health contracts with a national telephonic language

service that offers translation services for more than 150 languages. Employees who communicate with potential or current program participants have access to this service and utilize it when needed. In addition, written program materials are available in Spanish and are distributed in accordance with client agreements.

Additional resource materials can also be mailed to program participants that include lists of interpreter resource services and aids available for program participants with special communication needs. Cultural Diversity and Sensitivity training is mandatory for all employees who communicate with program participants. It is provided during orientation and as part of continuing education thereafter.

Alere Health's objective is to provide information, training and tools to employees that support culturally competent communication. Alere Health has developed and implemented assessment tools that are utilized by staff who communicate directly with eligible individuals and program participants. These tools help identify program participant special needs, such as hearing and/or vision impairment, special language needs including health literacy issues, and/or special cultural race/ethnicity needs. Special communication needs are evaluated at least annually as part of Alere Health's Population Assessment. Opportunities for improvement are identified based on these results.

Alere Health staff screens each program participant to identify special needs that may impact program participation, such as hearing, vision, physical or cognitive limitations. Alere Health uses Telecommunications Device for the Deaf (TDD) and/or Telephone Typewriter (TTY) devices to communicate with program participants with hearing limitations. In addition, Alere Health monitoring devices are available with high volume controls and all program participants receive printed program materials.

Individuals with visual limitations can participate in our programs by communicating telephonically with our health care professionals. In addition, some program materials are available in 12-point font or on audiotape and some monitoring devices are available in Braille.

Health Literacy is the degree to which individuals are able to obtain, process and understand basic health information and services needed to make appropriate health decisions. This includes the ability to read and comprehend prescription bottles, appointment slips and other essential health-related materials. The ability to read, understand and act on health information is a shared responsibility between program participants and practitioners. Alere Health understands that program participants with low health literacy are less likely to comply with prescribed treatment or seek preventive care. They are at higher risk for hospitalization and tend to remain in the hospital longer and require additional care, thus driving up annual health care costs.

Program participants are often reluctant to admit they have difficulty understanding health information and instructions, and often have well-practiced coping mechanisms that mask their problems. Alere Health's health care professionals also assess program participants for barriers that might be related to cognitive abilities. If a program participant is limited in his/her ability to communicate, understand instructions and process information the health care professional will seek permission to discuss the program participant's participation and care with the designated caregivers.

Program participants with complex health needs

Many of our program participants have serious life-limiting or advanced comorbid chronic diseases, such as metastatic cancer, progressive neurological and neuromuscular diseases, infectious diseases, major organ failure and traumatic injury. Case managers continuously assess the health needs of our program participants. In addition, our disease management programs address program participants' chronic and comorbid conditions and have the ability to

refer a program participant with complex health needs to case management services or other internal or external specialists or programs, when available.

Safety management

Safety is the cornerstone of high-quality health care. Alere Health's programs are administered by health care professionals with the goal of arming program participants with the information and support they need to improve self-care. An integral part of many of Alere Health's programs is to ensure program participant safety by frequently assessing health status, medication adherence, and mental well-being, as well as care coordination and care transition planning. Health care professionals are provided with comprehensive policies, procedures, guidelines, training and tools to evaluate and identify potential risks to program participants.

Key elements

Program participant assessment

Alere Health's health care professionals conduct a comprehensive assessment of each program participant upon enrollment in the program and on an ongoing basis. This assessment includes medication management, cognitive function, depression screening and other safety factors, such as home safety, fall risk and whether the individual has the ability to participate in a device-monitoring program. Once safety issues are identified, the health care professional provides appropriate education and customized interventions for the program participant.

Medication management

Case management (CM) and disease management (DM) Programs conduct a full medication review during the initial assessment on all program participants and during transitions of care. Health care professionals provide education on medication side effects and assess the program participant's adherence with their medication regimen. If there is any concern or need for medication reconciliation identified, the health care professional will work with the program participant, other health care providers or the program participant's practitioner for resolution. Any FDA alerts about actual or potential problems with prescription, over-the-counter (OTC) medications and medical devices that might pertain to our program participants, are part of ongoing training provided to health care professionals.

Transition/coordination of care

Whenever a CM or DM program participant's health status changes (for example, moving from home to a hospital as the result of a chronic condition; moving from the hospital to a rehabilitation facility after surgery), case managers provide care coordination and referrals as needed. The need for medication reconciliation is assessed and education regarding any medication or treatment plan changes is provided.

Medical director consultation

Alere Health Medical Directors provide clinical oversight to all Alere Health programs. They are available 24 hours a day, 7 days a week for disease management, case management and Nurse24 programs for consultation on complex cases, standard treatment plans, quality of care issues, and medication questions. Medical Directors are available during business hours for all other programs and as needed. Medical directors are required to have a current, unrestricted clinical license, qualifications to perform program specific clinical oversight, board certification and post-graduate experience in direct patient care.

External quality of care (EQOC)

Quality of care complaints are defined as an oral or written expression of dissatisfaction relating to the program participant's practitioner, treatment plan, health care facility or health plan benefits. All EQOC issues are entered into the Alere Health complaint/safety reporting portal. Client reports are generated per client agreements. If the issue pertains to a treatment plan, the health care professional may consult with their supervisor and the Alere Health medical director.

Care gaps/CareAlerts
Alere Health identifies gaps in care that could indicate lack of appropriate screenings/tests or adherence to a program participant's treatment plan. Care gaps display to internal staff so they can address issues with the program participant and his/her practitioner as needed. CareAlerts are written notifications to practitioners and/or program participants that address some of these same issues.

Urgent and emergency medical conditions
An urgent medical condition is defined as a medical condition that requires care within 24 hours to prevent serious deterioration of health following the onset of an unforeseen condition or injury, such as a sore throat, fever, minor lacerations, and some broken bones. The health care professional will advise the program participant or caregiver to call the practitioner or go to the ER.

An emergency medical condition is defined as a medical condition manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. This includes harm to self or others, headache with loss of neurological function, chest pain or shortness of breath not relieved by current treatment plan. In these situations, health care professionals will advise the program participant or their caregiver to go to the ER or call 911. In situations when the program participant or their caregiver is unable or unwilling to go to the ER or call 911, the health care professional will activate emergency medical services.

Alere Health staff makes follow-up calls to program participants within 24 business hours of the report of the incident to determine the outcome of the incident, offer support and resources and also contact the program participant's practitioner.

Program oversight/reporting relationships
The QIC is responsible for the oversight of safety management and reviews reports at least annually.

Monitoring and evaluation of outcomes
The below safety events are entered into the Alere Health complaint/safety reporting portal by health care professionals:

- Alere Health staff initiates a 911 call or a police welfare check to a program participant's home.
- Program participant is contemplating suicide and the situation is determined to be imminent.
- Program participant is threating to harm another person and the situation is determined to be imminent.
- Program participant reports an incident of child or elder abuse.
- Program participant reports a fall or injury as the result of using an Alere Health device.

The above situations are monitored and evaluated by the quality department. Designated individuals are responsible for investigating reported safety events. A log is maintained to identify trends and patterns. Reports are presented to the QIC for evaluation and identification of opportunities for improvement.

Satisfaction performance

Alere Health utilizes program participant, practitioner and client satisfaction results, as well as complaints to assess service delivery and quality of care. Process improvement opportunities are identified by analyzing trends in satisfaction results. Tracking complaints yield a picture of

perceived or actual breaks in quality of care or service. Alere Health's quality improvement committee reviews satisfaction results, complaints, and opportunities for improvement at each meeting. The quality improvement committee maintains overall responsibility for satisfaction performance.

Program participant satisfaction
Measuring program participant satisfaction is one of the best mechanisms for soliciting feedback from program participants related to their perspectives and issues. Overall impressions as well as specific comments can be used to improve processes, identify specific problems, and develop quality improvement projects to continuously improve program participant's experiences.

All Alere Health disease management, Nurse24, case management, coaching (telephonic or online) and wellness portal programs evaluate program participant satisfaction at least annually, or per specific client contract. Categories for data collection may include the following components:

- Overall program satisfaction
- Program staff
- Educational information
- Program participant - reported health outcomes
- Access to the program
- Number of program participant contacts with the program

Practitioner satisfaction
Measuring practitioner satisfaction is one of the best mechanisms for soliciting feedback directly from the program participant's treating practitioners. Overall impressions as well as specific comments can be used to improve processes and identify specific problems to assure practitioners understand and see value with Alere Health's programs.

All Alere Health's disease management programs evaluate program practitioner satisfaction at least annually. Other Alere Health programs evaluate program practitioner satisfaction in accordance with client agreements. Practitioner satisfaction surveys collect information based on the practitioner's experiences and satisfaction with the Alere Health program as provided to their patients. Categories for data collection may include the following components:

- Perception of the usefulness of program content
- Satisfaction with personal interactions with the program
- Perception of the program's impact on program participants' use of services
- Perception of the program's impact on program participants' health status relative to treatment plan goals

Client feedback and satisfaction
Alere Health evaluates client satisfaction for all programs annually. Assessing client satisfaction provides Alere Health with actionable data that includes unbiased client feedback and client perceptions of quality, products, and services. Once client satisfaction results are reviewed and analyzed, opportunities for improvement are identified and work plans are put into place.

Complaints
Alere Health monitors and reports complaints in compliance with established regulations, accreditation standards and/or other contractual requirements. Alere Health further recognizes that complaints indicate perceived or actual breaks in the quality of the care and service provided by Alere Health. Appropriately documenting each of these episodes, as well as tracking and trending, is essential to providing optimal customer service and quality care. Alere Health addresses individual customer issues as well as identifies process improvement opportunities.

Program participants in the disease management, Nurse24, wellness, and case management programs have the right to communicate complaints to Alere Health and receive instructions on

how to use the complaint process, including knowing Alere Health's standards of timeliness for responding to and resolving issues of quality and complaints.

Program participants are informed of their rights via written program materials, staff interactions or Alere Health's website. Language Line interpretation services are available for program participants, his/her representative, caregiver or practitioner to register oral complaints.

Any staff member may receive a complaint from a program participant, his/her representative, caregiver, client, practitioner, vendor, or other 3rd party. Alere Health staff are required to enter a complaint into Alere Health's secure, online complaint/safety reporting portal within 1 business day, if possible. The staff member receiving the complaint will utilize good customer service techniques to resolve the complaint during the initial contact. All complaints are entered into the complaint/safety reporting portal, even those that are resolved during the initial contact/first call. Once the complaint is entered, investigation of the root cause begins.

The investigation may include discussions with staff that received the complaint, review of the program participant's electronic record and/or program materials and communications. Once completed, the findings and action plan are documented in the complaint/safety reporting portal. Alere Health's goal is to resolve/close all complaints with the complainant within 28 calendar days of receipt.

Wellness and health promotion (WHP) programs

The wellness and health promotion program empowers individuals to improve their health and make sustainable lifestyle changes by providing a comprehensive set of tools and services. These tools and services are designed to educate and motivate healthy and at-risk individuals as well as those with chronic conditions to make lifestyle changes and to take other steps to target, engage, and reduce health risks.

Individuals are motivated to participate in our wellness program and to make healthy lifestyle changes through targeted, personalized and integrated programs. These programs are reinforced by population health challenges and communications. Our science-based programs provide a high level of flexibility and choice. Core elements that deliver this experience include: Annual program strategy and design, Health and Productivity Assessment, incentive management, self-management tools, screening services, coaching services, and a personal health record.

Client engagement

Alere Health assesses the client's current wellness and health promotion program, as well as:

- Leadership engagement
- Communication strategies
- Corporate culture
- Work facilities and policies
- Existing wellness program
- Benefit design
- Workforce demographics which include employees' race/ethnicity and language needs and
- Other resources offered by the client.

Alere Health provides the client with information that describes the advantages, disadvantages and the effectiveness of offering incentives to eligible individuals. The following activities are frequently tied to incentives:

- Completing health assessments.
- Participating in activities.
- Achieving improved health outcomes during the assessment stage and annually thereafter.

- Alere Health does not manage incentive fulfillment, but we have the capability to provide data to third parties that do, such as program participants who completed health assessments and activities.

A customized written implementation plan is developed for each client that includes the following elements: objectives, quantifiable goals, a communication plan, activities to engage the population, and steps to address areas identified by the client assessment. The plan also details the type and frequency of reports that will be required and provided to the client.

During the assessment stage and annually thereafter, Alere Health reviews the client's demographic and special needs reports. Alere Health has the capability to provide the health assessment, education materials, and self-management tools in Spanish. The coaching staff has access to a national interpreter service and can meet many language needs. Program participants with hearing impairments can participate in the wellness program, since most materials are available both in digital format and by mail upon request.

Alere Health uses nationally recognized, evidence-based guidelines, information from recognized sources/authorities and proprietary program content as the basis for program and intervention design. Program source materials, such as evidence-based guidelines and key program content from recognized sources/authorities are monitored, reviewed and approved at least every two years by the Scientific Advisory Board/Group. In addition, the health and productivity assessment and the wellness program self-management tools are reviewed and approved every two years by subject matter experts.

Engaging the population
To increase health awareness and skills for improving and managing health for the population, Alere Health offers evidence-based services to all eligible individuals on at least the following topics:

- Healthy weight (body mass index (BMI)) management
- Smoking and tobacco use cessation
- Encouraging physical activity
- Healthful eating
- Managing stress
- Avoiding risky drinking
- Identifying depressive symptoms
- Clinical preventive services

Individuals are motivated to participate in the wellness program and to make healthy lifestyle changes through targeted, personalized and integrated programs. These programs are reinforced by population health challenges and communications. Alere Health's science-based programs provide a high level of flexibility and choice. Core elements that deliver this experience include:

- Program participant health portal
  - Customized, personalized user experience
  - Engaging content and calls to action, leading to positive outcomes
  - Customized client key initiatives and programming
  - Mobile responsive
- Health and productivity assessment (HPA)
  - Science-based, behavioral health strategy questionnaire
  - Personalized report provides behavioral and medical risks
  - Recommends appropriate interventions and programs for personalized experience
- Screening services
  - Reach entire population with at-home and on-site screening
  - Quantifiable results to identify health risks
  - Results auto-populate program participant health data record

- Self-management tools/virtual coaching
  - Online science-based behavior change programs
  - Personalized, actionable information tailored to the individual
- Healthwise® Knowledgebase
  - Provides comprehensive, current, evidence-based information that supports a variety of health care decisions
  - URAC-accredited online resource
  - Available in English and limited Spanish
  - Includes goal-specific topics including activity, diet, weight, tobacco and stress. Condition-specific libraries cover a wide range of disease states as well as personal and family health topics, such as CHF, asthma, diabetes, CAD, pregnancy, first aid and mental health.
  - Decision tools to help people understand the facts, compare their options, and make informed decisions about a broad range of health topics.
- Coaching
  - Behavior change coaching using social cognitive theory and various other applicable theories
  - Flexible, unlimited, multi-modal communication with a coach
  - Promotes and increases individual engagement
- Personal health record (PHR)
  - Tailored PHR with program participant health history and metrics
  - Integrated with Alere Health clinical application

Health portal

The health portal's content, tools and resources are organized and prioritized based on the client's needs and assessments and usually include the following features:

- Client-specific promotions and activities
- Program participant message center
- Secure single sign-on capability
- Customized content delivery
- Incentive tracking and management system
- Integration of third-party programs
- Health and productivity assessment
- Health resources, content and tools
- Personal health records
- Access to digital behavior change programs
- 24/7 access

Health and productivity assessment

Alere Health's health and productivity assessment (HPA) is a fully integrated tool that provides the opportunity to identify at-risk and high-risk individuals, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. It is available in digital format and in print.

Upon completion of the HPA, individuals receive a targeted action plan with recommended programs prioritized based on their risk factors and readiness to make changes. In this way, the system provides targeted programming at the "teachable moment" when individuals are most aware of their health.

The HPA can be administered annually and helps individuals identify risk factors they can address to better manage their health. It includes questions on demographics, health history including medical conditions, current treatment and medication status, preventive screenings/immunization status, self-perceived physical and mental health status, readiness to

change lifestyle risk factors, safety behaviors and special needs, such as hearing impairment, vision impairment and language preference.

The individual's HPA report provides an overall summary of his/her risks and reference information to help him/her understand the results and comparison to previous results when applicable. In addition, it provides a clinical summary describing the risk factors, as well as information on recommended virtual coaching (VC) to assist the individual in making behavioral changes to reduce these risks.

Alere Health uses the following data sources to identify the WHP needs of eligible individuals and develop targeted follow up: HPA results or equivalent clinical data, demographic, biometric, claims and referral data gathered from client activities. Specific criteria are applied to the available data so the individual can be directed to targeted activities that include information about increasing health awareness and skills, opportunities for engagement and activity, self-management tools, coaching and preventive health services for at least the following: Healthy weight (BMI) maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, and clinical preventive services.

Health advisor
Upon completion of the HPA and according to client contract, program participants are provided the option of calling into the Health Advisor team as an added program feature. After welcoming the program participant to Alere Health and providing a brief overview of the call objectives and time expectations, the Health Advisor will review the individual's HPA results and summarize the primary components (Alere Health and client-based services) of the wellness program. Program participants will receive guidance on risk-appropriate intervention activities, the process to receive incentive points/credits and referrals to applicable disease management, coaching services or other client resources.

Screening services
Alere Health has the capability to capture biometric data and currently contracts with vendors to provide screening data in accordance with client agreements. Standard screenings include, but are not limited to, tests such as total cholesterol, high-density lipoprotein, low-density lipoprotein, triglycerides, A1C, cotinine and blood pressure. The services include a feedback report for each individual as well as an aggregate client management report after each event. Results of health screenings are used in combination with health assessment data to trigger education either on-site or telephonically, depending on the service contracted.

Self-management tools/virtual coaching
Alere Health's virtual coaching programs are comprehensive tools that address the following wellness and health promotion areas: healthy weight (BMI) maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, and managing stress.

The virtual coaching program allows a member to choose a focus area such as reach a healthy weight, improve your diet, feel less stress, be more active and live tobacco free. After selecting a focus area, the program participants are asked to set a goal, complete a short Initial health assessment and are then presented with a personalized action plan. The action plan utilizes the principals of behavior change to provide the program participant with personalized, actionable to-do's to help them meet their health goals. The virtual coaching program is self-paced, allowing the program participant to move through the curriculum at their own pace. Program participants can also find educational materials on their action plan in the form of articles, videos, and seminars.

The virtual coaching program contains resources and tools that help individuals determine risk factors, provide guidance on health issues, and recommend ways to improve health, support reducing risk or maintaining low risk. Examples of some of the self-management tools included in

each focus area are interactive quizzes, worksheets that can be personalized, digital logs of physical activity, caloric intake and portion size charts.

Virtual coaching content is reviewed at least every two years to ensure that the language is easy to understand and that program participants' special needs, including hearing and vision impairments are addressed.

Coaching solutions

The coaching program encourages program participants to make positive lifestyle changes to promote the life-long practice of good health, prevent chronic conditions and reduce health care costs. It incorporates telephonic, digital and print modalities to maximize the impact of the intervention. Education and guidance are offered in the following areas: healthy weight (BMI) maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services and customized programs designed to address other health issues.

Individuals are identified for the program if their HPA indicates a specific health risk criteria and a willingness to make changes to improve health. Enrollment outreach begins as soon as an individual completes the HPA in digital format and is identified as eligible for the program.

Coaching communications, like all Alere Health interventions, are personalized according to each program participant's values, preferences, and readiness to make lifestyle changes. Coaching outreach is driven by a program participant's specific needs. Alere Health systems allow the coach to view, input or edit the following program participant information: demographics, contact preference, HPA results, contact history log, goal tracking, behavioral change tracking, barrier analysis, planned follow-up schedule, external referral and follow-up times, preferred language, job characteristics, health organizations available for referral and national or community resources.

The program utilizes a primary coach model that allows a program participant and a health coach to develop a personal relationship in which a coach can help identify motivators and identify and assist the program participant in overcoming barriers. Coaches help program participants develop action plans that include specific incremental goals and ways to overcome barriers and boost confidence to sustain long-term behavior change. Coaches can also provide referrals to disease management and case management organizations, EAPs, managed behavioral health care organizations, and national or community resources, in accordance with client agreements.

Communications range from weekly to monthly, depending on the program and the program participant's preference. Each program participant receives a coaching workbook that includes information about what to expect once enrolled in the program, goal-setting resources, and worksheets and tools that promote healthy behavior change.

Communication assistance is available to program participants with special needs. In addition, program participants have unlimited access to a coach for six months. Access to Health Coaches is available by telephone from 9 a.m.-7 p.m. Monday to Thursday, and from 9 a.m.-6 p.m. Friday to Sunday in the program participant's time zone as well as by secure email.

Alere Health coaches have a variety of clinical backgrounds and include registered dietitians, exercise physiologists, respiratory therapists, and Master's-level counselors and social workers. Coaches undergo an extensive training curriculum that includes: evidence based guidelines around health promotion topics, coaching strategy, behavior change theory, cultural competence, goal setting, the referral process, confidentiality, emergency situations and concise online communication techniques. They use established science-based behavior-change principles, motivational interviewing and positive reinforcement to help individuals identify and work on health risks they're ready to address. Coaches are continuously evaluated by supervisors and given feedback on their performance.

Quit for Life
The Quit For Life® program is the tobacco track for coaching within the Alere Health coaching solution. It is the nation's leading tobacco cessation program. The Quit For Life® Program employs an evidence-based combination of physical, psychological and behavioral strategies to enable program participants to take responsibility for and overcome their addiction to tobacco use. Using an integrated mix of medication support, phone-based cognitive behavioral coaching and web-based learning and support tools, the Quit For Life® Program produces an average quit rate of 43% for employers.

The Quit For Life® program is the only commercial tobacco cessation program in the U.S. with proof of effectiveness published in multiple peer-reviewed scientific journals over the course of 25 years. We treat each tobacco user as a unique individual and tailor the intensity of treatment based on each individual's specific needs and attributes so his or her participation in the program is most likely to result in a successful quit.

Weight Talk
The American Diabetes Association® supported Weight Talk® Program, which is the weight focused track for coaching within the Alere Health coaching solution, is an evidence-based personal coaching program designed to achieve measurable, sustainable weight loss. Unlike "self-help" weight loss products, the Weight Talk® program is delivered through regular phone-based coaching sessions with a dedicated coach, supported by specialized calls with registered dietitians. The experience is highly personalized, deeply supportive, and proven effective. Program participants set realistic weight loss goals and then learn how, through small, tailored changes across multiple behaviors, to achieve and maintain a healthy weight for the rest of their lives.

Designed by international obesity expert Dr. Jennifer Lovejoy, the Weight Talk® program delivers impressive results. Program participants can expect a reduction in weight by at least 5 percent, with significant improvements in nutrition, activity, stress, blood pressure, cholesterol, and overall health, and also meaningful increases in their confidence and knowledge to maintain their new weight and healthy behaviors.

Program oversight/reporting relationships
Wellness program data is reported at least quarterly, via the Quality Improvement Work Plan, to the designated quality committee for review and analysis of data, discussion of barriers, identification of opportunities for improvement, and development of QI initiatives.

Monitoring and evaluation of outcomes
Alere Health has achieved Full NCQA Accreditation with Performance Measures. This means measuring and monitoring the metrics listed in the NCQA Technical Specifications, in addition to measures related to access, coaching operations, and program participant satisfaction. NCQA WHP Technical Specifications are a prescribed set of metrics established by NCQA that require annual audits by a Certified HEDIS Compliance Auditor (a comparable process to the Health Plan's annual HEDIS audit). The following lists the categories of measures that are included:

- Health assessment completion.
- Health promotion for the population.
- Staying healthy.
- Prevalence and number of core risks identified on health assessment.
- Risk Reduction: BMI reduction and maintenance, smoking or tobacco use quit rate, and physical activity level.

Wellness and health promotion 2016 goals

- Building out the Quit for Life tobacco cessation program within our Apollo clinical/portal applications from the legacy 4D platform. This will allow for Alere Health to provide a more enhanced experience for our Quit for Life program participants and more integrated approach to transitioning between products and services.

- Define various program structures for our Lifestyle and Weight Talk coaching products to support external payer client needs and support the growth of Alere Health products and services.
- Launch, test and learn opportunities such as the Mental Health/Quit for Life pilot to address the mental health needs of those we are able to communicate with via tobacco cessation efforts.
- Identify digital opportunities to enhance our current product offering and to allow program participants to engage further via digital components and less with a live operations agent.
- Develop metrics and benchmarks to track the health and quality of the Wellness Solutions/Portal-Incentives product; institute process for monitoring and taking proactive actions to enhance quality, correct issues and continue to collect value points to enhance our go-to-market story.
- Conduct ongoing user testing for the portal to assist in identifying areas for improvement and satisfaction.
- Develop and launch several enhancements to next gen portal including:
    - Multi-lingual portal (Q1)
    - Action Plan (Q2)
    - Health Assessment Report (Q2)
    - Goal Setting Process (Q3)
    - Navigation (Q3)
    - Expanded Focus Areas (Q4)
    - Incentive Dashboard (Q4)
    - Library (Q4)
    - Others as determined by ongoing review of user testing and customer needs

Disease management (DM) programs

Alere Health has NCQA accredited disease management programs for the following chronic diseases and conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, heart failure, musculoskeletal pain management, depression, high-risk pregnancy and first year of life.

Goals and objectives

The goal of Alere Health's disease management programs is to help program participants manage their conditions and achieve compliance with nationally recognized guideline recommendations. This is done through a unique combination of multimodal interventions and through the development of a therapeutic alliance between program participants and the clinician, program participant-empowering education, and nurse-program participant relationships. Health care professionals work with program participants and treating practitioners to:

- Slow disease progression and development of complications through proven program interventions.
- Change behaviors and improve lifestyle choices by using demonstrated behavior change methodologies.
- Improve compliance with guidelines, medication adherence and practitioner care plans
- Manage medications and enhance symptom control.
- Educate program participants about recommended preventive screenings and tests in accordance with national evidence-based guidelines.
- Reduce unnecessary hospitalizations.
- Prevent medication errors.
- Empower program participants to become more actively engaged in the management of their health.

Program content/evidence-based guidelines

Alere Health uses nationally recognized, evidence-based guidelines, information from recognized sources/authorities, and proprietary program content as the basis for program development,

intervention, and design. Program source materials are monitored, reviewed and approved at least annually by the scientific advisory board.

Access to health care professionals
Health care professionals are available by telephone, via IM CHAT, or secure email 24 hours a day, 7 days a week.

Identification and stratification
Identification and stratification is the first step in the program enrollment process. Alere Health has the ability to integrate data from the following data sources when applicable and available:

- Medical claims
- Pharmacy data
- Behavioral health data
- Health assessment results
- Laboratory results
- Utilization and case management data
- Health management results
- Wellness and coaching program data
- Electronic health records and
- Data from individuals and practitioners

At the core of Alere Health's programs is a rigorous ongoing identification process that includes predictive modeling and data analysis. Alere Health utilizes Impact Pro™, a leading predictive modeling application, combined with proprietary risk stratification criteria to group individuals into different risk categories for disease management. The key advantage of the predictive modeling and stratification approach is that we can incorporate multiple data sources into the process. Individuals are stratified based on utilization markers in their medical claims data. The risk scores are further determined based on an individuals' input and gaps in care information. This method allows individuals to be engaged in a meaningful experience using multi-technology modalities with data-driven support that is individually centered and promotes shared care management between an individual's personal practitioner and Alere Health's health care professionals.

Program participants are further stratified according to their actual clinical history and findings as documented at the time of their initial assessment. Program participants are not only re-evaluated on a monthly basis from claims, but also each time a health care professional communicates with them. Program participants using remote biometric monitoring devices are further stratified as often as daily when data is received by Alere Health. This drives real time intervention(s) based on biometric risk scoring.

Alere Health enrolls individuals in one program at a time. If an individual meets the specific criteria for multiple program enrollments and those programs are available through Alere Health, he/she is targeted for the program at the highest level in the hierarchy. Alere Health's standard hierarchy for programs and conditions is as follows:

1. NICU Case Management (CM)
2. Burn Trauma/Catastrophic CM
3. Complex CM
4. Oncology CM
5. Chronic CM
6. FYOL
7. DM - Maternity
8. DM – HF
9. DM - COPD
10. DM - CAD
11. DM - Diabetes
12. DM - Asthma

13. DM - MSP
14. DM – Depression

Consistent application of criteria process
Alere Health technology and operations have comprehensive processes in place to ensure the consistent application of criteria to identify eligible individuals for each DM program and then stratify appropriately. When client data files are received, the procedures listed below are followed:

- All received data from the client or client's data vendors is catalogued and tracked through the system processes.
- Client data is standardized, certified, and transferred to a cumulative database containing client-specific tables.
- All processes are automated where practical to ensure consistent, controlled processing.
- Proprietary, program-specific identification and stratification algorithms and criteria are run against the client data and potential program participants are identified each time associated data files are received.
- As part of the identification and stratification process, program participants are stratified into high or low acuity, with specific levels of intervention as appropriate, based upon the associated data.
- Identified program participants are automatically verified for eligibility and loaded to the clinical application where the enrollment team also confirms eligibility and disposition.
- Member eligibility is automatically checked every time new eligibility data is received from the client.
- A detailed hierarchy for programs and conditions is applied to ensure the program participant is placed in the program that is ranked highest based on their condition.
- Alere Health evaluates the accuracy of the rule-based identification process using a variety of methods, including: reviewing and updating program criteria ICD-9, IDC-10 and CPT codes at least annually; updating NDC/GPI codes monthly, and utilizing IT quality improvement projects to determine removal of false positives. In addition, enrollment staff confirms the condition with the identified individual prior to enrollment.

Disease management system
Alere Health's clinical platform allows the health care professional to view, input or edit the following program participant information: demographics, contact preferences (including language, vision and hearing needs), contact history log, self-management goal-tracking, information on condition monitoring, treatment plan and adherence to plan, comorbidities and other health conditions, health behaviors, medications, psychosocial issues, results from depression screening, lab results if applicable, and schedule for follow-up contacts.

Interventions based on program participant needs or risk level
Targeted interventions include verbal and written education specific to a program participant's chronic condition, complications, and assigned risk level. This ensures program participants receive the most appropriate interventions and yield the best health improvement opportunities.

There are also instances in which program participants require special considerations and/or exceptions. This may prioritize one intervention over another and may exclude a program participant from a particular intervention such as:

- Urgent safety issues such as the threat of harm to self or others will need to be resolved prior to beginning any other interventions. Alere Health will refer these cases to local authorities, the employer's EAP, behavioral health practitioner or facility in accordance with law and regulation, the client contract, or other interventions as appropriate.
- If the program participant has just been discharged from the hospital and does not feel well enough to participate in Alere Health's designated disease management program then he/she can be put on a temporary absence until he/she is able to fully participate and resume regularly scheduled phone calls.

- Positive depression screening results: The program participant will be referred to the employer's EAP, a behavioral health practitioner or facility, or case management in accordance with the client contract.
- Health behaviors such as tobacco use, especially if enrolled in our chronic disease or maternity programs: Alere Health will refer the program participant to his/her practitioner or an available smoking cessation program.
- Psychosocial needs/issues such as problems with a caregiver, food, transportation, communication or with paying for medications. Alere Health will refer him/her to local community resources, if available or the client's designated case management program in accordance with the client agreement.
- Physical disabilities such as inability of a program participant to use a program biometric device. He/she will be enrolled in a telephonic-only program.
- Mental/cognitive disability: If the program participant has trouble communicating or understanding, the health care professional may ask to talk with a caregiver, family member or authorized representative.
- Hearing disability: The health care professional will inform the program participant or caregiver of the availability of the TDD or TTY service.
- Vision disability: If the program participant mentions he/she has limited vision, the health care professional will communicate with the caregiver to obtain information that requires reading, for example medication names and dosages.
- Language barrier: If the program participant or staff member feels an interpreter would be helpful, the program participant will be connected to the contracted language line.

Comorbidities assessment

Comorbidities are initially identified at the time of the initial assessment and stratification. During this process, an individual is targeted for enrollment in the DM program that Alere Health believes will be the most effective and have the greatest impact on his/her quality of life. As a program participant answers questions during initial and ongoing assessments, other health issues or related conditions (like migraine headaches, obesity, hypertension, and depression) may be introduced. The health care professional discusses these health issues and the primary condition with the program participant and incorporates them into the plan of care, addressing all relevant gaps in care, and support better management of that condition as well as the assigned program condition. This allows us to provide a holistic approach when addressing the program participant's needs at any given time.

Depression screening

Health care professionals screen all high and moderate acuity program participants for depression risk during the initial assessment and periodically thereafter using the two question Whooley survey. A "yes" response to either question indicates a positive screening. Identification of postpartum depression in a previously pregnant program participant may result in a referral to case management, dependent on client contract. Alere Health offers a postpartum depression program for maternity program participants that utilize the Edinburgh Postpartum Screen Assessment. Health care professionals provide encouragement to the program participant along with resources and referrals to client-specific behavioral health services. In addition, Alere Health provides comorbid management of depression in the DM Chronic programs. This management is focused on compliance with the treatment plan prescribed by their behavioral health provider, and evaluation of the severity of their depression which would result in a referral to a behavioral health vendor or their practitioner.

Healthy behaviors

Alere Health health care professionals know that an individual program participant's health behaviors may impede his/her ability to manage a condition, which is why health care professionals provide continuous emotional support and encouragement to change behavior. Alere Health DM programs offer a self-management strategy that reinforces a program participant's capacity for self-reliance and self-determination through education, affirmation,

information, advocacy, collaborative planning and problem-solving. Through educational materials and telephonic interactions, Alere Health helps program participants identify behavioral health issues and encourages them to improve lifestyle-related behaviors to meet their goals. Health care professionals may also refer program participants to local and national entities like Weight Watchers® or fitness programs, in accordance with client agreements.

Because Alere Health knows that program participants need to learn behavioral skills to successfully manage their disease, our health care professionals have participated in comprehensive Cognitive Social Theory training. This behavior change method helps the nurse identify the barriers to changing a behavior and focuses efforts on helping the individual address those barriers by incorporating the program participant's individualized motivation.

For example, if a program participant with diabetes is not getting an annual LDL test, the nurse will probe the underlying reasons and work with the program participant to resolve the issue. Setting short-term obtainable goals is one of the techniques involved in this training so that program participants gain a quick win and are motivated to continue. The goal is to increase the probability of a positive change and set the program participant up for success.

Behavioral health

Alere Health understands that providing general information to a program participant about his/her chronic condition is not always sufficient. It is important to understand the issues that may be preventing a program participant from accessing or adhering to his/her practitioner's treatment plan. Psychosocial concerns related to a health condition such as: lack of family support; transportation; financial barriers; cultural, religious, ethnic beliefs; and health literacy contribute to overall health and well-being.

Health care professionals assess and identify barriers that might be related to psychosocial circumstances and cognitive abilities. If barriers are identified, the program participant is referred to a health care professional who will work toward understanding and addressing identified issues in a language and at a literacy level the program participant can understand. Often, referrals are made to special resources to assist program participants and work toward eliminating barriers relating to access to care including transportation and finances. If it is determined the program participant has limitations related to his/her ability to communicate, understand instructions or process information about his/her illness, the health care professional will get permission to discuss participation and care with the designated caregiver.

Obtaining consumer input

Alere Health is committed to process and program improvement. Feedback from program participants and consumers provides valuable information to maximize program effectiveness. In addition to tracking and trending complaints and satisfaction survey results from program participants, practitioners, and clients, Alere Health communicates with client organizations in an effort to obtain feedback about program content, relevancy, delivery and customer service. Changes may be made to printed program materials, oral communications or delivery modes, as needed.

Caregiver/family support available to program participants

Health care professionals assess caregiver support during the initial assessment. After the program participant's initial assessment is completed, the health care professional will communicate with the designated caregiver with the program participant's consent. He/she will confirm/secure caregiver authorization from the program participant and evaluate the type of assistance caregivers can provide. Once assessments are completed, the health care professional evaluates whether caregiver support is adequate to meet the program participant's needs.

Coordination with treating practitioners

To optimize continuity of care, activity-based interventions are coordinated with treating practitioners. Program participants are encouraged to communicate with their practitioners about their health conditions and treatment. Alere Health confirms treating practitioner information during the enrollment process.

Program materials are sent to the practitioner within 45 days of enrollment of their patient and include a welcome letter with a brief program description and details about how to use the program. The welcome letter also includes instructions for accessing the decision support materials and clinical practice guidelines which are provided on a practitioner website and is updated whenever changes are made. Practitioners are also directed to this site upon request.

Decision support information includes evidence-based guidelines and notification of care opportunities. Actively practicing practitioners are involved in the development and review of these materials through communication with the Clinical Integrity team and the Scientific Advisory Board. Evidence-based guidelines are available at all times on Alere Health's practitioner website and upon request. Care Gap/Alert notifications are also provided to practitioners in an effort to fill gaps in care before they escalate into high-risk or high-cost events. These reports are data-driven, easy-to-understand and offer actionable information. Alere Health provides the following care gap reports:

- Alert report: This report is faxed to a practitioner when pre-determined clinical criteria are not met or when a nurse believes clinical information requires practitioner review and program participant intervention within 24 hours.
- Status report: This report is faxed to a practitioner when a nurse determines clinical and/or psychosocial information should be transmitted to the practitioner, but does not require review within 24 hours.
- Medication report: This report is faxed to a practitioner when a nurse or a Pharmacy Benefit Manager (PBM) upload identifies a medication issue or absence of a condition-specific guideline medication requiring practitioner review. It lists all the medications the program participant is taking and includes a request to review the program participant's records for other class medications that may be appropriate for managing his/her condition.
- Health data fax: This report is faxed to a practitioner when a health care professional requests specific health data results from the practitioner's records, such as lab results or other biometric data. This is then used to develop a personalized plan of care for the program participant.
- CareAlert: This report is faxed or mailed to a practitioner when an analysis of a program participant's medical, pharmacy, and/or lab claims data indicates a gap in standard care, preventive testing or medication compliance. Alere Health's CareAlert functionality applies predictive modeling algorithms to identify drug interactions, dangerous side effects and clinical gaps in care across an entire population. This identifies opportunities to improve safety and quality of care for program participants. Customized engagement strategies allow treating practitioners and health care professionals to monitor a program participant's progress, medication adherence and potential risk management issues. CareAlerts are sent per client contract.

Referrals to additional resources

When appropriate, the Alere Health health care professional may refer a program participant to additional programs such as case management, behavioral health programs, wellness, coaching or community resources. Information available to program participants, practitioners and health plan clients in order to facilitate referrals may include treatment plan, testing, treatment and adherence data, comorbidities, depression screening results, assessment of health behaviors and psychosocial behaviors as appropriate to the referral type. Alere Health health care professionals follow up with the program participant at the next scheduled contact to determine the referral outcome.

Program oversight/reporting relationships
Oversight to the Alere Health's disease management programs is provided by Alere Health executive management, the quality improvement committee and contracted consultants who are professionally licensed, certified and/or registered and qualified to provide clinical services.

Monitoring and evaluation of outcomes
Disease management data, including participation rates are reported at least quarterly via the QI Work Plan to the designated quality committee for review and analysis, discussion of barriers, identification of opportunities for improvement, and development of QI initiatives. Further analysis occurs at the QIC each quarter. Quality activities and formal Quality Improvement Projects are approved at these committee meetings.

Asthma DM program

The asthma program strives to improve quality of life, increase productivity and reduce clinical service utilization, such as admissions, and absenteeism. It helps individuals identify and manage asthma triggers, allergies, exercise, weather and emotions related to the condition by:

- Learning about their disease and the health risks associated with it.
- Adhering to their practitioner's care plan and medication regimen.
- Recognizing and controlling symptoms that may worsen the condition.
- Identifying individual asthma triggers such as dust, mold, cold air, cigarette smoke, allergies and exercise, and how to manage them.
- Learning medication therapy options and appropriate rescue inhaler usage.
- Understanding when to seek medical attention.

Evidence-based guidelines

- Guidelines for the Diagnosis and Management of Asthma (EPR3), 2007
- Diagnosis and Management of Asthma, ICSI, July 2012

Targeted interventions

- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times a year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times a year
  - Text messages for program participants who have opted in

Monitoring performance

- Controller Meds
- Short-acting beta agonist usage
- Flu and pneumococcal vaccinations
- Contact rate
- Hospital readmissions

Program graduation
Program participants graduate from the program at the end of twelve months if the following criteria have been met:

- Moderate level:
  - No hospital/ER visits in the past six months

- High level:
  - No oral steroid use
  - No hospital/ER visits in the past twelve months
  - Experienced shortness of breath less than once per day in the past 4 weeks
  - Awakened by symptoms less than 2 times per week in the past 4 weeks
  - Used rescue inhaler or nebulizer medication less than once per day in the past 4 weeks

Coronary artery disease DM program

The coronary artery disease (CAD) program strives to generate reductions in trends in myocardial infarctions, mortality rates, CAD-related admissions, and costly treatment procedures, such as repeat angioplasty and bypass surgery. By working with program participants to alter their regular routines, we can frequently reduce disabling symptoms that may also result in absenteeism and a reduced quality of life. Alere Health helps program participants understand and manage their condition to prevent disease progression, disability and the development of other chronic conditions by helping them:

- Adhere to their practitioner's care plan and medication regimen.
- Recognize early symptoms of a heart attack and when to seek medical treatment.
- Make healthy lifestyle choices like eating healthfully, exercising and quitting smoking, which may keep blood pressure, cholesterol and other risks in check.
- Learn about treatment options.
- Monitor their blood pressure at home as appropriate.

Evidence-based guidelines

- AHA/ACC Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update
- AHA Guideline: Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women: Update, 2011
- AHA 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk
- 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JNC 8)
- 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults (ATP4)
- 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk
- 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults

Targeted interventions

- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in

Biometric monitoring

The CAD blood pressure monitoring program includes current interventions for the CAD program in addition to weekly blood pressure and symptom monitoring. The systolic and diastolic blood pressure values are graphed and display indicators for values outside of set clinical guideline

parameters. Symptom answers are graphically displayed with indicators for missing and significant data.

Call outreach
The health care professional will attempt an outreach call to the program participant after device data review and finding that their blood pressure is out of normal range or having 3 or more days of reported symptoms. (American Heart Association 140/90 or if comorbid Diabetes 130/80)

Monitoring performance
- LDL Test w/in 12 months, Beta Blocker Post MI
- Aspirin usage
- Antilipidemic usage
- Flu and pneumococcal vaccinations
- Contact rates
- Hospital readmissions

Chronic obstructive pulmonary disease DM program

The chronic obstructive pulmonary disease (COPD) program strives to reduce medical service utilization (hospitalizations), reduce absenteeism, increase productivity and improve quality of life. It helps program participants maximize remaining lung function and recognize early symptoms of a lung infection or worsening of their condition by teaching them to adhere to their care plans and medications, how to recognize and control symptoms that worsen their condition, and how to access smoking cessation resources.

Evidence-based guidelines
- Initiative for Chronic Obstructive Lung Disease (GOLD) 2014
- ATS Standards for the Diagnosis and Care of Patient with Pulmonary Obstructive Disease, 2014
- Diagnosis and Management of Stable Chronic Obstructive Disease: A Clinical Practice Guideline
- ICSI Chronic Obstructive Pulmonary Disease Guidelines, 2013, March

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in
  - Biometric monitoring as appropriate

Biometric monitoring
Program participants may use the biometric monitoring device to answer symptom questions once a day. The data is transmitted to Alere Health wirelessly or via a telephone line. A health care professional reviews device symptom data daily.

Call outreach
The health care professional will attempt an outreach call to the program participant after device data review and:
- Finding that symptoms are out of normal range for two or more days in a row or
- Per the health care professional's clinical judgement

Monitoring performance
- Bronchodilator use and smoking/tobacco use
- Flu and pneumococcal vaccinations
- Contact rates
- Hospital readmissions

Diabetes DM program

Alere Health's diabetes program helps program participants manage diabetes through medication, diet and exercise by teaching them:
- About diabetes and health risks associated with complications.
- To change unhealthy behaviors, such as smoking, poor nutrition, and/or lack of exercise.
- To recognize and control diabetes symptoms.
- To adhere to practitioners' treatment plans and medication regimens.
- Ways to improve self-care skills, including daily foot exams and glucose monitoring.
- To complete preventive exams and screenings that can lead to early detection of diabetes complications.

Evidence-based guidelines
- ADA Clinical Practice Recommendations, 2014, January
- Standards of Medical Care in Diabetes-2014
- ADA, National Standards for Diabetes Self-Management Education and Support, 2014, January

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in
  - Biometric monitoring as appropriate

Biometric monitoring
The Alere Health DayLink® Monitor (DLM) is placed in a program participant's home to capture blood glucose monitoring and symptom data. Blood glucose levels and diabetes symptom data are collected daily and reviewed by a health care professional every 14 days.

Call outreach
An outreach call is made to the program participant to verify information following the 14 day data review if:
- Blood glucose values are out of normal range (ADA guidelines are 70-130 mg/dl or <180 mg/dl two hours after a meal)

- Blood glucose values greater than 250 mg/dl twice in one week or more
- Program participant reports any symptoms via DLM

Monitoring performance
- Annual A1C test/control, LDL test/control, microalbumin test/control and foot and retinal exams
- Flu and pneumococcal vaccinations
- Contact rates
- Hospital readmissions

Heart failure DM program

The heart failure (HF) DM program is targeted for high-risk individuals with heart failure. This program helps program participants slow disease progression, disability, and development of other chronic conditions. It does this by teaching program participants:
- About their disease and health risks associated with it
- How to recognize/control heart failure symptoms that may worsen their condition
- To adhere to their care plans and medication regimens
- To weigh themselves daily and assess weight change
- To change unhealthy behaviors, such as smoking, inactivity and poor nutrition
- To recognize when to seek medical treatment

Evidence-based guidelines
- ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, 2013 October.
- ICSI Guideline - Heart Failure in Adults, 2013, July.
- HFSA, Comprehensive Heart Failure Practice Guideline, 2010, June.

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - 24/7 Nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in
  - Biometric monitoring as appropriate (if purchased)

Biometric monitoring

When indicated, the Alere Health DayLink® Monitor (DLM) is placed in a program participant's home to record his/her weight and heart failure symptoms. The DLM consists of a scale and monitoring unit. Program participants are asked to weigh themselves each morning and evening. Their weights are transmitted to Alere Health wirelessly or through telephone lines. Once received, the data is automatically reviewed and assigned an acuity score based on assessment of weight, symptom responses and other available data. System reports are generated and reviewed daily by licensed staff. Program participants and/or their practitioner may be contacted based on daily monitoring results.

Monitoring performance
- ACE inhibitor or ARB use, beta blocker use, aspirin use, daily weights
- Flu and pneumococcal vaccinations
- Hospital readmissions

Musculoskeletal pain management DM program

The musculoskeletal pain management (MSP) program helps program participants understand and better manage chronic musculoskeletal pain and maximize their ability to perform daily activities. The program addresses the following conditions: back pain (neck, upper and lower back), fibromyalgia, osteoarthritis, rheumatoid arthritis, regional musculoskeletal disorders (RMD) and tension and migraine headaches.

Alere Health staff help program participants use appropriate health care services focused on improving their ability to function. Alere Health provides telephonic and online pain management strategies and also provides educational materials to maximize the impact of interventions.

Program components include:
- Medication compliance and lifestyle integration, leading to improved quality of life.
- Ways to reduce exacerbation or recurrence of musculoskeletal pain.
- Information that assists the program participant in preventing further injury or deterioration.
- Evaluating day-to-day activity and helping remove aggravating factors to reduce missed work days.

Evidence-based guidelines
- Pain: Carpal tunnel
  - Carpal Tunnel Syndrome (Acute and Chronic). Work Loss Data Institute, 2013, May
  - Carpal tunnel syndrome. ACOEM, 2011
- Pain: Elbow
  - Elbow (Acute and Chronic). Work Loss Data Institute, 2013, May
  - ACOEM, Elbow Disorders, 2012, December
- Pain: Forearm, wrist, and hand, not including carpal tunnel syndrome
  - Forearm, wrist, and hand (acute and chronic), not including carpal tunnel syndrome. Work Loss Data Institute, 2013, May
  - Hand, wrist, and forearm disorders, not including carpal tunnel syndrome. ACOEM, 2011
- Pain: Shoulder
  - Work Loss Data Institute - Shoulder (Acute and Chronic), 2013, June
  - ACOEM, Shoulder disorders, 2011, July
- Pain: Low back pain
  - Work Loss Data Institute - Low Back - Lumbar and Thoracic (Acute and Chronic), 2013, December
  - ICSI Guideline: Adult Acute and Sub-acute Low Back Pain, 2012, November
- Pain: Neck and upper back
  - Work Loss Data Institute - Neck and Upper Back (Acute and Chronic), 2013, May

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials
  - Nurse24 access 24/7
  - Health portal access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in

- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in

Monitoring performance
- Migraine Therapy
- RA:DMARD Usage
- Hospital admissions
- Adherence to treatment plan

Program graduation
Program participants graduate from the program at the end of twelve months if the following criteria have been met:
- No hospital/ER visits in the past six months
- No open care gaps for medications
- Effective treatment plan in place to relieve pain

Depression DM program
Alere Health has a behavioral health management program for program participants with major depression disorders and/or anxiety disorders. The goal of the program is to teach and help facilitate medication compliance and follow-up care, prevent non-adherence or lapses of medication administration, encourage program participants to partner with their practitioner and also how to recognize symptoms. The program strives to enhance program participants' management of depression and/or anxiety by:
- Increasing compliance through understanding and individual support
- Enhancing overall well-being by practicing healthy behaviors
- Knowing what to expect from behavioral health therapies and medications
- Making healthier lifestyle choices and avoiding health risks
- Adhering to practitioner office visits and follow up
- Partnering with the practitioner to create a treatment plan

Evidence-based guidelines
- APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder - 3rd Edition, 2010
- ICSI - Adult Depression in Primary Care Guideline, 2013, September
- Generalized Anxiety, Panic Disorders, Phobias, Obsessive-Compulsive Disorder, Stress inclusive of PTSD.
- American Psychiatric Association, Practice Guideline for the Treatment of Patients with Panic Disorder, 2009
- Canadian Psychiatric Association, Clinical Practice Guideline for the Management of Anxiety Disorders, 2014
- Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition ©American Psychiatric Association
- National Institute for Health and Clinical Excellence, Management of Anxiety in Adults in Primary Secondary and Community Care, 2007
- Acute Stress Disorder and Posttraumatic Stress Disorder (2004) Guideline Watch (2009) American Psychiatric Association
- VA/DoD Guideline, The Management of Posttraumatic Stress, 2010

Targeted interventions
- All levels (low, moderate, high):
  - Unlimited inbound calls to health care professionals
  - Mailed program materials

  - 24/7 nurse24 access
  - CareAlerts, if purchased, sent to program participants and practitioners (if purchased)
- Moderate level:
  - Health care professionals contact program participants 3-4 times/year
  - Text messages for program participants who have opted in
- High level:
  - Health care professionals contact program participants 6-12 times/year
  - Text messages for program participants who have opted in

Monitoring performance
- Compliance with medications
- Compliance with practitioner visits for managed behavioral health conditions

Program graduation
Program participants graduate from the program at the end of twelve months if the following criteria have been met:
- No hospital/ER visits in the past six months
- No open care gaps for medications
- No difficulty making and keeping therapy appointments
- No thoughts of self-harm

Maternity (high-risk pregnancy) DM program
The maternity disease management program provides risk assessment, targeted education, stratification and referrals for case management services, and a delivery outcome assessment including postpartum depression screening according to client contract.

The initial maternity risk assessment is conducted at program enrollment, ideally between 12 and 15 weeks gestation, to determine risks for pregnancy complications. During the assessment, individualized education is provided to the program participant based upon responses. At the conclusion of the assessment, program participants are stratified into the low-risk pregnancy disease management program or if one or more risks are identified, the case management program. A second risk assessment is conducted at about 28 weeks gestation at which time a previously low risk program participant may become identified as high-risk and referred to case management. After each risk assessment, a report summarizing clinical findings and verbal education is sent to both the program participant and the practitioner.

Evidence-based guidelines
- American Congress of Obstetricians and Gynecologists (ACOG)
- Centers for Disease Control and Prevention (CDC)
- ICSI: Routine Prenatal Care and Management of Labor
- National Institutes of Health (NIH)
- Case Management Society of America (CMSA)
- American Academy of Pediatrics (AAP)

Targeted interventions
All program participants in the maternity high-risk pregnancy disease management program receive education, printed materials and clinical support in addition to the following:
- Scripted education based upon responses to the risk assessments followed by written educational reminders in the report summary.
- Printed welcome packet which includes personalized risk assessment report summaries and a pregnancy guide book.
- Access to BabyLine™, the 24 hour toll-free telephone line, and access to evidence-based education on a health portal.

Monitoring performance

- First prenatal visit
- Smoking
- Flu vaccination
- Postpartum depression

Disease management 2016 goals

- Expand action plan key focus areas to incorporate a more dynamic action plan, starting with diabetes and adding additional conditions during 2016.
- Enhance the member experience for disease management by providing digital interactive tools within the newly developed action plan on the Alere Health portal.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update DM processes and program participant resources if necessary.
- Achieve NCQA reaccreditation for all DM programs.
- Continue to reduce hospital readmission rates and evaluate need for any improvements to post-hospitalization follow up.

First year of life program (FYOL)

Alere Health's first year of life care management program provides care management for infants up to 15 months of age. This is accomplished through collaboration with a multi-disciplinary team that includes practitioners, payers and other resources necessary to facilitate appropriate health care services. Through on-going program touches, type and frequency determined by stratification level, caregivers are guided and supported to better understand and meet the needs of the infant during this critical time of growth and development.

The Alere Health first year of life program provides both assessment and management for infants post NICU or newborn nursery discharge through the first year of life, as well as caregiver education and anticipatory guidance by experienced care managers. A tiered care management approach is utilized based on infant risk stratification at program enrollment with subsequent re-evaluation of risk based on needs.

The program focuses on areas that are important for all infants such as nutrition, immunizations, growth and development, home safety, follow-up visits with practitioners, and caregiver education, as well as issues specific to individual infants such as ongoing medical needs, home health care or DME needs, medications and/or social issues. In addition to reinforcing the benefits of adherence to the recommended practitioner visits, immunizations, screenings and care management of the most medically and/or socially fragile, education is provided on multiple topics including parenting, safety, developmental milestones and family planning.

Access to health care professionals

The FYOL program ensures that program participants and practitioners have timely access to program staff. Business hours are Monday through Friday, from 8 am to 8 pm EST and from 9 am to 6 pm EST on Saturdays.

Eligibility

To be enrolled in the first year of life program, infants must be younger than one year old and in the home environment.

Enrollment

Enrollment outreach is made to the caregivers of eligible infants. This includes a program announcement postcard and telephonic outreach by non-clinical staff. The announcement postcard notifies caregivers about the program, encourages them to contact the program for more information and to enroll, and alerts them to expect a program call. When the caregiver is reached for the program enrollment call, the program and benefits of enrollment are explained.

Enrollment is voluntary and includes completion of program consent and an infant risk assessment. The infant risk assessment covers multiple categories to determine if risk(s) are present. The presence of one or more risks stratifies the infant to moderate for further clinical assessment. If no risks are identified, stratification is low.

Clinical assessment
Infants with moderate risk receive a clinical assessment by a registered nurse. The clinical assessment allows for the collection of in-depth information about the infant's health and developmental status. The clinical assessment results in moderate or high stratification.

Ongoing management
Infants in the moderate or high stratification levels receive ongoing care management provided by experienced registered nurses. Scheduled outreach for infants in the moderate risk level follows the Early and Periodic Screening Diagnostic and Treatment (EPSDT) schedule based on age, at a minimum at months 1, 2, 4, 6, 9 and 12. Infants stratified as high-risk, receive monthly outreach calls. Individualized support, care planning with interventions designed to close gaps in care, and coordination of care are provided based on the infant's individual needs. In the event that the infant re-stratifies to the low risk level, the infant will receive the low risk level workflow.

Infants in the low risk level receive telephonic Interactive Voice Response (IVR) touches on the EPSDT schedule at months 1, 2, 4, 6, 9 and 12. The IVR calls contain a brief assessment designed to identify the potential development of risks and messaging regarding the importance of practitioner visits, encouragement for compliance with the next visit and information regarding important milestones or benefits specific to the infant's age. Automatic warm transfer from the IVR to the program is offered should the assessment identify a potential risk alert. If warm transfer is accepted, the caregiver is transferred to the program staff for assessment of risk. If the transfer is declined, the caregiver is encouraged to contact the program for further assessment.

Evidence-based education during contacts includes
- Regular schedule of practitioner visits, immunizations and screenings
- Feeding and elimination
- Developmental milestones
- Parenting
- Safety

Satisfaction survey
Program enrollees are called via IVR at age 15 months for a program satisfaction survey.

Disenrollment
Program disenrollment can occur at any time. Disenrollment reasons include: requested by the caregiver, loss of eligibility and program completion.

Program fulfillment
- Announcement postcard
- Program participant welcome letter with guide
- Practitioner welcome letter
- Program participant unable to reach for ongoing management letter

Guide: a reference book entitled "Your Baby's First Year of Life" is sent to the caregiver of all program participants. "Your Baby's First Year of Life" stresses the importance of following the practitioner visit schedule, immunizations, feeding, safety and resources. It also provides a place for caregivers to record when the next visit is scheduled to take place, questions for the practitioner, immunizations and milestone memories. It is based on the EPSDT schedule of care and the guidelines and resources detailed below.

Transition plan
The health plan case manager, health care practitioner and guardian can request the latest FYOL care plan summary. The care plan summary may be used for the purpose of care transitions.

Guidelines and resources
The FYOL program utilizes evidence-based guidelines/resources that include:
- Bright Futures: Guidelines for Health Supervision of Children and Adolescents, AAP
- AAP Guidelines for Pediatric Home Health Care
- Pediatric Home Care for Nurses, 3rd edition, Votroubek and Tobacco, 2010
- EPSDT schedule of care

First year of life quality improvement 2016 goals
- Improve well-baby visits and immunization compliance
- Support caregivers to advocate for their infants and provide a safe and healthy environment
- Identify and provide timely interventions and/or care coordination for at risk infants

Nurse24 health information program

Alere Health's nurse24 program is a nurse-driven telephonic/online support program available to a client's entire population 24 hours a day, 365 days a year. Staff members responding to program participant clinical inquiries are registered nurses with active and verified licenses and are qualified to provide clinical services. Telephonic, chat and secure electronic messaging services are available to program participants and are recorded unless a program participant refuses to be recorded.

Telephonic communications
- The first message a caller hears when reaching nurse24 is *"If this is an emergency, hang up and dial 911 or your local emergency services."*
- Depending on client contracts, incoming telephone calls are first routed to non-clinical staff to determine appropriate call routing.
- All callers with a medical/clinical need or question are transferred to a registered nurse, no messages are taken.
- If the caller has a non-medical/clinical need or question, the call is assessed and handled by the non-clinicians (ex: requests transfer to the health plan, returning a call to another Alere Health department, etc.).
- Staff have access to a contracted national interpreter line when needed.
- Health Assistants (HA) have clinical monitoring, oversight and immediate availability of a licensed clinical staff person for clinical issues beyond service requests. They do not perform clinical activities. Health Assistants:
  - Are qualified and trained to perform screening of service requests.
  - Are supported by policies and procedures on the collection of non-clinical data.
  - Are trained in the principles and procedures of screening, collection and transfer of service requests.
  - Through an established process, promptly transfer a telephone call or other communication requiring clinical intervention to a licensed registered nurse.

Secure electronic communications
- Online chat and secure messaging are available through the program participant health portal. Electronic messages are answered within 24 hours of receipt.
- All communications, including call dispositions are documented in the program participant's electronic record.
- Registered nurses respond to questions from callers regarding clinical triage and health Information.

Health care professionals are required to identify themselves by first name, title and company name to every caller prior to responding to the caller's questions about Alere Health's nurse24 Program, including questions about where Alere Health obtained their information and how the program works. Health care professionals also screen callers to determine whether triage or health education services are required.

Health education services may include:

- Answering questions about medications or health related issues on calls or chats.
- Advising callers and chat program participants on self-care options prior to a health care visit.
- Helping callers and chat program participants communicate effectively with their practitioner.

Triaging services may include:

- Helping callers determine whether to seek care based on symptom assessment.
- Helping callers determine what level of care is most appropriate for their condition.

Alere Health's nurse24 program is accredited by URAC for Health Call Center (HCC) and certified by NCQA for Health Information Line (HIL).

Program content/clinical decision support tools

Alere Health utilizes an accredited knowledgebase called Healthwise® Coach to guide triage activities. The nurse24 registered nurses have additional tools, including evidence-based guidelines to help triage calls effectively and appropriately. Alere Health's nurse24 staff have access to consult with or seek advice from a Medical Director with a current, unrestricted license(s), qualified to provide advice for services provided and post-graduate experience in direct patient care. At a minimum of annually, the Medical Director(s), N24 leadership, Clinical Integrity VP and Scientific Advisory Board practitioners, still in active practice, review the results of quality review studies used in developing and updating clinical decision support tools.

Linkage to contact history

The nurse24 staff can link callers to their previous utilization of nurse24 services by viewing their documented electronic record. If a caller is enrolled in another Alere Health program, nurse24 staff can view his/her clinical record as well as his/her primary nurse's availability and can perform warm transfers when needed.

Clinical triage

Clinical Triage is defined by URAC as classifying consumers in order of clinical urgency and directing them to appropriate health care resources according to clinical decision support tools. Trained in telephone triage, the registered nurses help callers navigate questions and concerns about symptoms, appropriate treatment choices, comorbid conditions and additional risk factors. Alere Health has policies and procedures in place to ensure clinical triage communications are handled in a timely manner by a clinical staff person and that individuals calling with potentially emergent situations are provided a safe mechanism to access emergency treatment.

Follow up

Callers who were advised to seek care for their urgent or emergent health conditions are called back by the registered nurse to assess that needed care was obtained, the outcome and the caller's current health status. In addition, callers who left secure messages are responded to within 24 hours of receipt.

Feedback to caller's practitioner

Alere Health has a policy and procedure for communicating pertinent health issues obtained during the triage process to practitioners at the caller's request or if contracted.

Monitoring/evaluation of outcomes and reporting structure
Alere Health monitors access to the health information line at least monthly by reviewing data related to average answer speed and abandonment rates. In addition, the nurse24 registered nurses' performance is evaluated at least monthly to ensure appropriate triage and follow up occur. Outcome reports, including satisfaction and complaints are presented internally to the appropriate QI committees for review, evaluation, barrier analysis, identification of opportunities for improvement and development of interventions at least quarterly.

Quality improvement projects
The following are N24's quality improvement projects:
- Safety: Disclaimer Notification and Documentation QIP #1a and b to continue in 2016
- Program Participant Satisfaction Improvement Project QIP #2 – I to continue in 2016

Nurse24 2016 goals
- Meet goals for incoming calls average speed of answer and call abandonment rates.
- Maintain the chat goal of ≤45 seconds' average speed of answer while exploring opportunities for improvements.
- Continue tracking and trending all clinically triaged calls.
- QIP #1a – Increase use of disclaimers when speaking with program participants.
- Continue consistent Staff Performance results.
- Improve Complaints Entered ≤1 business day result by 5 percentage points consistently.
- Continue Healthwise® Coach Product resource with regular reviews, updates and internal approvals.

Case management (CM) program

Alere Health has both URAC and NCQA accredited case management programs for complex, maternity, oncology, and NICU. These programs are designed to provide intensive resources to assist program participants to understand their diagnoses, prognoses and make educated choices about their care. The NICU program is also URAC accredited for Health Utilization Management (HUM). All of Alere Health's case managers and utilization managers are registered nurses with a minimum of a current, unrestricted license to practice in their resident state of the United States. In addition, many also hold additional state licenses as applicable to their position.

Objectives and goals
The goal of Alere Health's case management programs is to help the program participant and their family meet their comprehensive medical, behavioral health and psychosocial needs. Case managers build relationships by educating, supporting and empowering the program participant, their family and their care giver. The case managers work with the program participant, care giver and their treating practitioners (licensed or certified professional who provides medical care services) to:
- Ensure proper treatment plan in the appropriate setting
- Assure program participant/care giver compliance with the treatment plan
- Manage the side effects of all treatments
- Coordinate all care - whole member management
- Advanced Directive/End-of-Life Planning as appropriate
- Maximize state of health and improve the quality of life for the program participant
- Reduce costs associated with managing program participants in active treatment

Program content/evidence-based guidelines
Alere Health's programs were developed and based on evidence-based guidelines, information from recognized sources and proprietary program content. Program materials are reviewed every two years by at least two appropriate practitioners and approved by the Scientific Advisory Board. Appropriate practitioners are physicians with board certifications in an

appropriate specialty. The systematic review of the program guidelines and information include:

- Reviewing program content against the evidence used to develop the programs.
- Assessing whether program participant materials are consistent with current evidence, and if they are not, putting actions in place to make them consistent.
- Assessing whether staff training materials are consistent with current evidence and assuring actions are taken to make them consistent as applicable.
- Reviewing program content for cultural and linguistic appropriateness.

Alere Health's case management electronic information systems' ongoing evaluations include regular multidisciplinary team meetings that include representatives from operations, client services, technology solutions, applications development, product management, project specialists, training/performance and quality. The purpose of the meetings is to update the attendees on system performance issues, IT updates, release scheduling plans and to point out any special projects. The frequency of the meetings varies according to projects, actions required and planned releases. These meetings occur quarterly but may occur more frequently when needed. Meeting agendas, minutes, and/or release results are shared with the team members following the meetings and are reported to appropriate oversight committee.

Case management consent and disclosures

As early as possible in the case management communication with the program participant, Alere Health requires, at a minimum, that a verbal consent is obtained and clearly documented in the electronic medical record. Generally, consent is obtained while in the process of screening or informing the program participant about the case management program. After enrolling the program participant, Alere Health's staff answer questions that the program participant may have and a welcome packet is sent. The welcome packet includes a welcome letter with information from the case manager as well as contact information, a copy of Alere Health's program participant's rights and responsibilities and a disclosure document that reiterates the case manager's role, including that they are accountable for coordinating care, and the nature of the case management relations, particularly when a third party payer is involved.

Program participants are also informed of any process or requirement used to determine when information obtained in the case management relationship will be disclosed to the third parties. The program participant is informed of any process for them to be provided with written or electronic notification of case management actions and recommendations. Program participants are made aware of the availability of a complaint process and the method to access it. Also at this time the program participant, their family, and/or care giver is informed about self-management, shared decision making, and knowledgeable use of medications training that will be made available as needed.

Program participant education and engagement

Educating program participants is a fundamental role of a case manager and is key to program participant's achieving their care plan and self-management goals. All Alere Health case managers are trained in behavioral change models and motivation and engagement principles upon hire. In order to assist program participants to meet their care plan and self-management goals, case manager program interventions include, but are not limited to:

- Providing health education/information that supports the program participant, and the family/caregiver's ability to achieve the program participant-centric case management goals.
- The use of culturally and linguistically appropriate services to reflect individual learning needs as applicable.
- The use of individual and personalized health education tools to reinforce self-management skills.
- Informing program participants and the families/caregivers of their role relative to transitions of care and interactions with health care practitioners.

Case management process

The applications supporting these programs include algorithmic logic scripts and other prompts to guide case managers through assessment and ongoing management of program participants. The clinical aspects of these prompts or scripts also include automated features that provide accurate documentation for each entry; recording actions or interaction with program participants, practitioners, or providers; and automatic date, time and user stamps. To facilitate program participant-centered care planning, the application includes features to set prompts and reminders for next steps or follow-up contact.

The purpose of the case management programs is to ensure that program participants receive appropriate care at the appropriate time so that health outcomes can be improved and utilization of emergency rooms and hospitalizations can be reduced. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a program participant's health needs using communication and available resources to promote quality cost-effective outcomes. The case management process includes the following components:

- Initial assessment and documentation of the program participant's current health status, treatment plan, clinical history, medications, and daily activities including medical and behavioral health condition-specific issues.
- Evaluation of cultural and linguistic and visual and hearing needs, preferences or limitations.
- Evaluation of caregiver resources and involvement.
- Evaluation of any safety concerns including medication safety and need for reconciliation of medications and the need for medication therapy management services.
- Evaluation of available benefits within the organization.
- Management of care transitions including the identification of problems causing care transitions and prevention of unplanned transitions, when possible.
- Initial assessment of life-planning activities if applicable.
- Evaluation of community resources.

Case managers facilitate and document in collaboration with the program participant/care giver:

- An individualized program participant-centered case management plan including prioritized short and long term goals, that consider the program participant's and caregivers' goals, preferences and desired level of involvement in the case management plan.
- Identification of interventions with timelines to meet the goals.
- Identification of barriers to meeting goals or complying with the plan.
- Facilitation of program participant referrals to resources and follow-up process to determine whether program participants act on referrals.
- Development of a schedule for follow up and communication with program participants.
- Development and communication of program participant self-management plans.
- A process to assess progress against case management plans for program participants.
- As part of the case management process, case managers will assess the need for coordination of follow-up services for evaluation and management including referrals for:
  - Health care services
  - Behavioral health care services
  - Social services and support
  - Providers
- Locating available community resources, including vendors to assist with program participant-identified and health care-related issues.
- Collaborative approaches are used for the purpose of facilitating the case management plan as well as the coordination and transitioning of care.
- All referrals will be followed up by the case manager on the next program participant's scheduled communication.

Measurement and quality improvement
Alere Health's case management programs measure and work to improve program performance, program participant experience, program effectiveness and program participant participation via our case management program work plans. Measures are identified based on evidence-based and/or clinical practice guidelines, client requirements, state or federal laws and/or accreditation requirements.

Alere Health case management programs have a process to use case review findings to determine if case management program performance measures are being met. Each case management program maintains no less than two quality improvement projects that address opportunities for error reduction or performance improvement related to the services covered by the accreditation. They also have additional measures for evaluating the effectiveness of the case management program.

Medical director rounds/team reviews
The purpose of the medical director rounds/team reviews is to support the case management process through the review of individual cases, which may result in:

- Improved quality health care
- Decreased fragmentation of care
- Enhancement of the program participant's quality of life
- Efficient utilization of program participant care resources, and
- Cost containment

Cases enrolled in case management services are reviewed by the program medical director or other supervisor in collaboration with the case manager at regular intervals specific to each program. Medical Director rounds/team reviews include meetings with the medical director, clinical supervisor and those case managers who have identified cases that would benefit from consultation with the medical director.

The medical director's role is to coach case managers on program participant advocacy, identify areas for program participant self-advocacy, and provide education on clinical conditions specific to cases. The case manager's role is to assess the urgency of the situation, follow the process for urgent or non-urgent consultation, prepare to present cases, have key questions ready and provide appropriate follow up.

Complex case management (CCM) program

Complex case management programs focus on program participants with significant chronic or life-limiting diagnoses including, but not limited to, the following: cancer, cardiovascular disease, cerebrovascular disease, diabetes, infectious diseases, respiratory disease and trauma.

Access to health care professionals
The complex case management program ensures that program participants and practitioners have timely access to program staff and that program staff communicate consistent messages to these individuals. The case management department responds to regular communications within one business day. Specific access hours are:

- 8:30 a.m.-5 p.m. Monday through Friday (in the program participant's time zone).
- Program participants may reach a registered nurse 24 hours a day, seven days a week-including holidays.

Identification/stratification/enrollment
Alere Health has developed a three-tier electronic and case manager screening process that identifies individuals who might benefit from the program that consists of:

- Technology process

- Alere Health collects data from multiple sources that may include claims, pharmacy, utilization information (including hospital discharge data), client targeted referrals and referrals from Alere Health programs, individuals or practitioners. Once automated electronic screening of these data sources is conducted, the data is sent to staff to initiate the enrollment process. Individuals must have at least one chronic or life-limiting diagnosis as follows:
  - Cancer and possible cancer indicators: Lung, brain, head and neck, pancreatic, liver cancer; metastatic cancer; malnutrition, dehydration, nausea/vomiting, chronic pain.
  - Cerebrovascular disease: Stroke requiring intensive rehabilitation or prolonged facility admission.
  - Complex diabetes: Diabetes with heart disease, peripheral vascular disease, cerebrovascular disease, kidney failure.
  - Cardiovascular disease: Heart failure, cardiomyopathy, cor pulmonale.
  - Infectious disease: Diseases indicating immunosuppression, opportunistic infection, presence of other disease, or causing encephalopathies (histoplasmosis, Jakob-Creutzfeldt, leukoencephalopathy).
  - Respiratory diseases: Severe asthma, chronic obstructive pulmonary disease, respiratory failure.
  - Progressive neuromuscular disease: Amyotrophic lateral sclerosis, bulbar palsy.
  - Major organ failure: Heart failure, liver failure, kidney failure.
  - Trauma: Severe trauma with head injury and/or requiring prolonged facility care or complex home care.

- Prequalification process
  - Staff members contact eligible individuals by telephone and inform them of the program purpose and benefits. Program eligibility is verified by utilizing a symptom assessment tool. IGAO (Issues, Goals, Actions, and Outcomes) is a structured method of identifying, recording and addressing case management needs. This method provides a rigorous structure for care delivery that is highly reproducible and measurable. The issues and goals are organized into seven care domains: Knowledge and Choice, Treatment Plan, Family and Living Environment, Pain and Symptom Management, Practitioner and Provider Coordination, Terminal Care Planning, and Benefit Plan. The individual must have issues present in at least two care domains to qualify for a case management program. When this is confirmed, the individual is assigned to a case manager and warm transferred when possible.
- Qualification and enrollment process
  - The case manager conducts a more comprehensive assessment by telephone or on-site to confirm the individual's condition, obtains verbal acceptance and formally opens a case in the appropriate case management program. Written consent is obtained for the record when an on-site visit is conducted to complete an initial assessment. Written consent is attempted for those cases with a telephonic initial assessment. At this point the individual is enrolled in one of the case management programs and a case is opened. Cases identified as not meeting the criteria for the CCM programs will be directed to internal disease management services or back to the health plan for external disease management services.
- Interventions
  - All program participants receive a welcome packet which includes general program information, a medical release of information form, Alere Health's Rights and Responsibilities Statement, and contact information.
  - Program participant communications with a health care professional:
    - Complex case management:
      - On-site or telephonic initial assessment
      - Weekly and as needed communications with a health care professional
    - Chronic case management:
      - Telephonic initial assessment

- Bi-weekly and as needed communications with a health care professional (multi-acuity):
  - Telephonic initial assessment
  - May have an onsite visit as needed
  - Monthly and as needed communications with a health care professional

Quality improvement projects for 2016

- Improve Medication Management for Program Participants (QIP 1, Safety)
- Program Participant Voluntary Disenrollment Rates (QIP 2)

Complex and chronic case management 2016 goals

- Reducing unplanned transitions by continuing to analyze, identify areas for improvement and implement identified interventions.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

Maternity case management

Alere Health's maternity case management program provides obstetrical case management in collaboration with a multi-disciplinary team that includes providers, payers and other members necessary to facilitate appropriate health care services. Program participants are elevated to this more intensive level of care based upon responses to the initial or follow-up health risk assessment, other interactions such as BabyLine™ calls or by direct referrals to the case management program by practitioners or health plan case managers.

Access to health care professionals

The maternity case management program ensures that program participants and practitioners have timely access to program staff and that program staff communicate consistent messages to these individuals. The case management department responds to regular communications within one business day, and attempts to reach program participants who trigger to case management within 72 hours. Case managers are available Monday through Thursday from 9 am to 11pm EST and Friday from 9 am to 8 pm EST. Outreach is conducted up to 8 pm EST.

Identification of eligible individuals/case manager assessment

An initial maternity disease management risk assessment is typically conducted between 12 and 15 weeks gestation to determine potential risk for pregnancy-related complications for all eligible enrollees. A second risk assessment is conducted at 28 weeks gestation. At the conclusion of each assessment, program participants are systematically stratified into the low-risk pregnancy disease management program or the high-risk maternity case management program. At-risk or high-risk triggers include:

- History of pregnancy complication in a previous pregnancy (for example, history of preterm labor, history of gestational diabetes, history of pregnancy-induced hypertension, history of preterm delivery, history of postpartum depression).
- Current high-risk pregnancy condition (for example, multiple gestation, hyperemesis gravidarum, preterm labor, vaginal bleeding, placental problems, abnormal amniotic fluid levels, infections).
- Comorbid medical conditions (for example, diabetes, chronic hypertension, cardiac conditions, blood clotting conditions, renal conditions).

- Behavioral health or psychosocial issues (for example, smoking during pregnancy, alcohol use during pregnancy, recreational drug use during pregnancy, barriers to obtaining adequate prenatal care, potential or identified domestic abuse).

Evidence-based guidelines
- American Congress of Obstetricians and Gynecologists (ACOG)
- ICSI: Routine Prenatal Care and Management of Labor
- Centers for Disease Control and Prevention (CDC)
- Case Management Society of America (CMSA)

Case management assessment
The telephonic initial assessment process allows for the collection of in-depth information about the program participant's situation and functional status. It identifies the absence or presence of signs and symptoms of disease or pregnancy complications. The assessment allows the case manager to determine the program participant's ability to manage her pregnancy, and any barriers that may prevent the program participant from realizing a positive pregnancy outcome. The assessment is designed as a comprehensive approach to problem solving. The case management plan is developed to address barriers identified as interfering with the program participant's ability to improve her health status and sense of well-being. To complete the assessment, information is collected from all relevant sources while maintaining confidentiality and meeting compliance and regulatory requirements.

Case management interventions
Experienced high-risk perinatal case managers:
- Perform a comprehensive telephonic clinical assessment to identify risks.
- Create a care plan with mutually agreed upon long- and short-term goals.
- Initiate appropriate clinical interventions based on agreed upon triggers and the program participant's condition.
- Coordinate care management, benefits and resources with the client and or health plan.
- Evaluate the program participant's progress and identify changes in condition, coordinate care and communicate with practitioner regarding implementation of the treatment plan.
- Provide referrals to appropriate health care and community resources.
- Access to the 24/7 BabyLine™, which provides advice and guidance by experienced registered nurses from enrollment to six-weeks postpartum.
- The organization identifies and evaluates practice patterns and treatment plans based on outcome analysis to achieve appropriate care and cost effective outcomes.

Quality improvement projects for 2016
- Preventing Smoking and Exposure to Secondhand Smoke(QIP 1 – Safety)
- Spacing Conception(s) Post Delivery (QIP 2)
- Hospitalizations (Inpatient and Emergency) Counts – Monthly

Maternity case management 2016 goals
- Continue to identify at-risk mothers for unplanned transitions of care by analyzing, identifying and implementing areas for improvement.
- Reducing unplanned transitions by analyzing and identifying areas for improvement.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

Oncology case management program

Alere Health's oncology case management program focuses on pediatric and adult individuals with a cancer diagnosis and who are in active treatment. The case managers are required to hold a URAC approved certification within four years of accepting an oncology case management position.

Program content/evidence-based guidelines

Alere Health's oncology program is based on proprietary treatment guidelines developed and reviewed on an ongoing basis by the oncology utilization management committee. This committee is made up of practicing oncologists representing multiple specialty services and approved by the scientific advisory board. Guidelines are based on the latest research, literature and practice evidence from a combination of various reputable medical journals and nationally recognized cancer organizations including the National Comprehensive Cancer Network, American Society of Clinical Oncology, American Cancer Society, Association of Community Cancer Centers, and the National Cancer Institute.

Access to case management

The oncology case management program ensures that program participants and practitioners have timely access to program staff. Specific access hours are:

- 8:30 a.m.-5 p.m. Monday through Friday (in the program participant's time zone)
- Program participants may reach a registered nurse 24 hours per day, seven days a week, including holidays

The oncology case management goal is to close gaps in care within the cancer population. Service is designed to enhance and facilitate existing cancer delivery systems for eligible individuals. Activities focus on improving outcomes through program participant education and counseling, proactive assessment and interventions review and coordination of care. By incorporating best practices and coordination with practitioners and program participants, Alere Health provides an integrated solution to proactively manage this expensive and debilitating disease. This is demonstrated through consistent clinical, quality and financial outcomes, including a cancer-specific return on investment.

Identification and stratification

Individuals are identified for this program if they have a cancer diagnosis. Acuity levels are assigned after initial automated stratification and completion of the initial assessment, but may change at any time based on other assessments. Nurses may change acuity based upon the clinical needs of the program participant.

- Low acuity
  - Program participants may have just completed a treatment, or are waiting to begin treatment, or have completed one treatment and need to heal before starting another treatment. This also applies to the program participant who has completed all treatments and is receiving preparatory education to discharge them from the program.
- Moderate acuity
  - Program participants with sporadic symptoms or less severe side effects who can benefit from individualized education and interventions before they seek emergency care. (Karnofsky 80-90 or Eastern Cooperative Oncology Group [ECOG score of 1-2]).
- High acuity
  - Program participants with high potential to be exacerbated by cancer treatment. These program participants have, or are at risk for significant symptoms and side effects that could lead to emergency care or hospitalization. (ECOG $\geq$2 or Karnofsky $\leq$70).

Interventions

- Low acuity
  - Telephonic initial assessment
  - Printed welcome packet

  - Telephonic communications at least monthly
- Moderate acuity
  - Telephonic or on-site initial assessment
  - Printed welcome packet
  - Telephone calls at least bi-weekly
- High acuity
  - On-site initial assessment
  - Printed welcome packet
  - Telephone calls at least weekly

Discussing end-of-life issues with program participants and their caregivers/families is a standard component of Alere Health's case management programs and is initiated early in the program participant's course of care.

Participation in the oncology case management program ends when the active cancer treatment episode concludes. During a program participant's routine team review, or any time during the management process, a member of the clinical team may determine that participation should end. This may be appropriate if case management goals have been achieved, the program participant is deceased, an individual is no longer eligible under current insurance policy, the program participant/family no longer wishes to participate, the program participant is not compliant with the case management program or the account/client requests closure.

When active cancer treatment concludes, the program participant enters a period of preparation to assure readiness for discharge. During this time, the case manager defines the transitional needs and a plan for the program participant, whether they involve preparation for long-term follow-up care or transition to hospice or other facility. In the event of recurrence of the diagnosis, the program participant will be re-evaluated for readmission to the program.

Quality improvement projects for 2016

- Improve Medication Management for Program Participants (QIP 1, Safety)
- Program Participant Voluntary Disenrollment Rates (QIP 2)

Oncology case management 2016 goals

- Reducing unplanned transitions by analyzing and identifying areas for improvement.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of the program participant and relevant subpopulations to update the case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Report all program metrics via the work plan at the quarterly quality meetings.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

NICU case management/utilization management program

The NICU care management program is a unique combination of case management and utilization management and holds URAC accreditation in case management and health utilization management and is also NCQA accredited in case management.

The NICU utilization management program consists of oversight of the appropriateness of care and treatment of premature and fragile neonates, supported by Alere Health's Clinical Management Guidelines. Inpatient care is reviewed concurrently to support, educate and

advocate for families, identify and address potential inefficiencies and fragmentation, advance the definition and progress of the plan of care, and ensure development of an optimal discharge plan.

Program content and evidence-based guidelines
Alere Health utilizes internally developed clinical management guidelines and level of care criteria based on scientific evidence and expert opinion reflecting current medical practice. These guidelines are used by Alere Health to make utilization review recommendations based on medical appropriateness. The guidelines also outline discharge planning activities that serve as the basis for care planning, along with the American Academy of Pediatrics anticipatory guidance education materials. Once the infant is discharged to home, the American Academy of Pediatrics Guidelines are utilized for ongoing care planning.

Alere Health employs a development process that meets all regulatory and accreditation requirements and produces sound and explicit guidelines. The guidelines are evaluated annually and updated as necessary. They are developed with practitioners and other providers with current, expert knowledge in the subject matter under review.

Access to health care professionals
The NICU care management program ensures that program participants and practitioners have timely access to program staff and that program staff communicate consistent messages. The NICU program operates during normal business hours from 8 a.m.-5 p.m. in all time zones. During these hours, a NICU employee is available to direct all incoming calls from both health care providers and family members. If the NICU employee is unavailable, the incoming call is directed to the voice mail/e-mail system. In addition, there is a 24/7 on-call case manager who can be reached through our voice mail/pager system. During non-business hours, weekends, and holidays, utilization review employees are available via phone/e-mail.

Instructions for accessing employees are provided through the Alere Health phone system, ensuring that a health care provider or family has access to utilization and care management personnel at all times.

The scope of duties within the utilization management function includes case management from birth through the first year of life and quality review of members from admission through the initial episode of care. This includes inpatient, sub-acute and home care coordination as well ongoing telephonic case management, as needed.

Identification of eligible individuals
Case management services are provided to infants who meet any of the following conditions:
- Birth weight ≤ 2000 grams
- Surgical candidates
- Diagnosis of Neonatal Abstinence Syndrome
- ECMO Therapy
- Organ transplant candidates
- Complex needs or comorbid conditions
- Complex psychosocial needs

Inpatient services
Medical appropriateness review for all levels of NICU infants is completed according to Alere Health's developed and approved criteria and coordination with the client. Proactive case management, including onsite or telephonic medical record/case review, is conducted for concurrent review, discharge planning and coordination of services.

Sub-acute or home care services
Activities related to sub-acute or homecare settings are conducted according to client-specific protocols and contractual agreement. Proactive care management and medical appropriateness

reviews of alternative care (rehabilitative or skilled) and home care settings are completed concurrently and include:

- Alternative care review
- Coordination of durable medical equipment (DME) and home health care services
- Coordination of home infusion therapy services

Interventions

- Care Plans
  - An individualized assessment of each infant is the basis of a plan that addresses the specific needs of the infant and the family. The plan is necessary to achieve the best clinical outcome, provide appropriate discharge planning and ensure that necessary post-discharge care and support is provided.
- Baby Steps
  - Introduces the Alere Health NICU case manager and outlines services provided by the program. It provides answers to many questions families may have such as, why their infant maybe in the NCIU, ways to care for themselves and their newborn, milestones for their infant and planning for their infant to go home.
- Educational materials produced by the American Academy of Pediatrics are also provided to program participants. These materials provide anticipatory guidance on topics, such as breastfeeding, safety, car seats, choosing a pediatrician and immunization.

NICU utilization management staff qualifications

First line utilization management reviews are completed by case managers who are licensed registered nurses. Applicants are carefully screened prior to their employment and are oriented in the principles and procedures of utilization review for URAC and client-specific standards.

Alere Health medical directors hold board certification in Neonatal-Perinatal Medicine by the American Board of Medical Specialties (ABMS) or the Advisory Board of Osteopathic Specialists. Alere Health medical directors provide clinical oversight of the program. Expert practitioners in the field of neonatology are available for review and consultation as needed.

Case managers are required to possess a URAC-recognized certification in case management within four (4) years of hire. All case management supervisors hold a URAC-recognized certification in case management and provide nursing leadership and oversight of the program. Alere Health case managers have an average of 14 years of NICU experience.

Medical appropriateness determinations

Notifications of admissions are received by one or more of the following mechanisms:

- A participating hospital and/or the client notify Alere Health via a toll-free telephone number, by fax or through the web portal.
- A participating hospital notifies the Alere Health case manager of a new admission.
- Immediately upon notification of the admission, Alere Health verifies the infant's member and benefit eligibility via client specific computer access or a client representative

Review methodology

The case manager reviews the hospital medical record for the appropriate information; consults with the attending neonatologist, RNs, social worker, and family; and documents the review in the Alere Health case management system. When a review is conducted over the phone, clinical updates are received from the hospital case manager, the attending neonatologist, and/or NICU nursing staff. Telephone calls or faxed reports may be used to acquire the necessary information.

Each infant is reviewed on a frequency determined by the severity of illness review. Influencing factors are:

- The Alere Health Grouper assignment (The grouper assignment is a classification system that categorizes infants by weight and diagnostic group)

- The admitting diagnosis(es)
- The clinical management guideline(s) applied
- The level of care criteria and discharge criteria

Inpatient
The case manager attends multidisciplinary meetings and "rounds" weekly to collaborate on the infant's treatment plan. Review of medical records for inpatient case management includes:

- Identification of the member and the admitting practitioner
- Member face sheet for demographics and coordination of benefits
- History and physical/admitting note, physical status of member, and plan of care
- Birth weight, gestational age, Apgar scores
- Diagnoses (primary, secondary and tertiary, if applicable)
- Assigned Alere Health grouper
- Level of care: recommended and actual
- Estimated length of stay
- Proposed procedure(s), treatment(s) or service(s)
- Dates of procedure(s), treatment(s) or service(s)
- Practitioner orders for appropriate laboratory requests, X-rays, medications, etc. as they relate to the infant's condition
- Diagnostic results for diagnostic procedures
- Medication and intravenous fluid documentation
- Nurse entries for member condition and consistencies in charting (consistency with other clinical documentation)

Audits
Staff performance is assessed through case audit and inter-rater evaluations.

Discharge
Typically the NICU program discharges the program participant/care giver after the infant has been discharged to home

Quality improvement projects for 2016

- Preventing Smoking and Exposure to Secondhand Smoke (QIP 1, Safety)All Attempts Made Toward Initial Family Contact <48 Hours of IA (QIP 2)
- Report/Review Hospitalization (Inpatient and Emergency) Counts - Monthly

NICU case management and utilization management 2016 goals

- Reduce unplanned neonatal readmissions by analyzing and identifying areas for improvement post-discharge.
- Improve program participant engagement by using motivational principles and collaboration to educate program participants in self-management and decision making skills.
- Annually assess the characteristics and needs of program participant and relevant subpopulations to update case management processes and program participant resources if necessary.
- Comply with all applicable case management accreditation standards and state and federal requirements, as applicable.
- Maintain the goal of case managers achieving case management certification within four years of employment with Alere Health.

BioPharma program

Alere Health's pharmaceutical support unit offers innovative solutions to pharmaceutical companies seeking to improve compliance and persistency through programs that support program participants by educating them about their condition and prescribed treatment regimen. Individuals targeted for participation in the pharmaceutical support programs may have limited knowledge of their diagnosis/condition, and side effect/symptom management needs. These programs are designed to apply scripted education and information to help them understand their diagnoses and treatment and to make educated choices about their care. Each program offered within the Alere Health pharmaceutical support unit is a unique client-specific program focused on a specific drug product and FDA-approved indications and labeling. Alere Health health care professionals deliver telephonic support to program participants in a pharmaceutical support program.

Non-compliance with prescribed medications and treatment is a significant problem and a key driver of health care costs. Several factors contribute to this problem, including lack of program participant knowledge about the expected efficacy of a drug, how to take medications and how to prevent or manage side effects. Because practitioners see a high number of patients in a short amount of time, they may not have time to educate patients adequately about their illnesses. That includes fully explaining the treatment regimens and the consequences of non-compliance as well as informing program participants about potential side effects and how to properly manage them.

Goals and objectives

The programs strive to improve compliance and persistency with the client product through:

- Personalized educational and psychosocial support
  - Alere Health pharmaceutical support programs encourage program participant autonomy and self-determination by providing education that supports program participants and families in clinical decision-making. We help program participants develop the skills necessary to take control of their lives. We support program participants, their families and caregivers as an advocate for health care information as it relates to the specific prescribed drug treatment regimen.
- Improved quality of life
  - Alere Health pharmaceutical support program participants have consistently indicated that our programs have positively impacted their quality of life by providing education and proactive management information related to their condition, clinical symptoms and needs.

Pharmaceutical support program process

Alere Health health care professionals help program participants focus on altering behaviors and provide ongoing educational support designed to improve adherence to prescription medications. Clinical and technology capabilities and procedures address the following elements:

- An individual's right to decline participation or dis-enroll from support programs and services offered by Alere Health.
- Initial assessment of program participant's health status, including diagnosis and current treatments is completed by a registered nurse.
- Documentation of current clinical status.
- Ongoing status of continued compliance and persistency with the product.
- Evaluation of cultural and linguistic needs, preferences or limitations.
- Evaluation of program participant and/or caregiver resources related to the prescribed regimen.
- Evaluation of available benefits relative to the prescribed drug regimen and information on potential options to narrow or close financial or access gaps.
- Identification of barriers to meeting goals or complying with the plan.
- A defined communication schedule for contact with the program participant based on analysis of side effect data, compliance data and known "drop off" points in therapy.

- Coordination of services with other client-specific resources and vendors to improve and enhance the program participant experience, and improve the opportunity for treatment completion.
- Program participant/caregiver education and support provided through client approved scripting and education materials.
- Proactive management of anticipated clinical symptoms or needs are assessed by registered nurses only.
- Program participant safety issues.
- Program participant advocacy.

Client-specific objectives and goals are further addressed through customizations in the following areas: enrollment activities, call frequency and cadence, disease-specific assessments, medication adherence objectives, adverse event reporting, multiple referral sources, hours of operation, program reporting, and program participant satisfaction surveys.

FDA labeling and fair balance requirements

All pharmaceutical support programs are delivered utilizing approved scripting and information-based on FDA-approved labeling for the drug and it's indications for use. Alere Health program personnel work closely with the client's clinical, product marketing and professional development and review committees to assure that scripting and educational materials are compliant with the client's understanding of FDA required labeling and Fair Balance requirements. Alere Health does not provide any materials that are not approved by or provided by the client for use.

Alere Health's pharmaceutical support program scripts are embedded in the clinical application of all programs, placing appropriate approved program scripting and educational information at the fingertips of clinical personnel. The delivery of the approved scripting to program participants is monitored and reviewed on an ongoing basis by the program management and quality improvement program staff. Satisfaction levels of the program participants in these programs is measured and reported on an ongoing basis to the client.

Identification of eligible individuals

The pharmaceutical company's sales and marketing units develop and support these programs. The field sales staff provides additional support through its direct-to-practitioner education. The most common referral sources include:

- Practitioner offices (forwarded to the pharmaceutical company database vendor)
- Practitioner office providing the program number to the program participant for self-referrals
- Product Support lines administered by the pharmaceutical company
    - Information provided by the specialty pharmacy about the program, self-referrals resulting from product website information, magazine ads and/or condition-specific informational websites.

Enrollment

Program participants have generally signed opt-in consent prior to contact with the program, but the processes are defined by the pharmaceutical company requesting services. Participation is not limited to the product user. It is also open to the product user's caregivers, friends, family or other interested parties.

Alere Health confirms consent to participate in any outbound call activities prior to enrollment in any of the outbound contact programs. Alere Health exchanges program participant information with the pharmaceutical company database vendor only after confirming that proper HIPAA compliant agreements are in place. Alere Health does not routinely share individual program participant level data with pharmaceutical company program personnel. Alere Health does provide periodic recorded program participant calls for quality monitoring to the pharmaceutical company. The calls are de-identified to protect the privacy of the caller.

Questionnaires
An initial questionnaire is completed with all incoming calls. All inbound and outbound calls are recorded for quality monitoring purposes and each caller is made aware of this at the start of the call. Agreement to participate on a recorded line is required. Questionnaires include basic information about a program participant's diagnosed condition and his/her current experience with the product. The information collected is used to confirm eligibility (receiving the drug for an approved indication) and to define the call sequencing or scheduling based on product experience.

Follow up calls
Calls are provided via outbound call schedules as defined in the individual client product design. The number of calls and information given to enrolled program participants varies based on market research completed by the pharmaceutical company requesting services aimed at touching program participants at times when product users are likely to experience symptoms or issues that may cause use drop-off. Each of the follow-up calls generally includes a brief questionnaire to confirm the program participant is still using the product. Each call generally has a defined educational purpose and the call scripting is developed to meet those needs. All calls also allow for the program participant to ask questions based on his/her experience with the product. The programs include a list of frequently asked questions (FAQ) that allow the health assistant or health care professional to respond to individual program participant needs, as applicable. When a program participant asks a question not included on the list of frequently asked questions, the staff must refer the program participant to his/her practitioner. Program staffers are not permitted to respond in an ad hoc manner; they must respond only within the scripts provided by the client.

Training and specialized product training
Health care professionals who provide services in the pharmaceutical support programs are hired and employed by Alere Health to support specific clients. Clients have the right to review resumes and interview potential program staff prior to final hiring decisions. Health care professionals must complete the Alere Health New Hire Orientation in addition to client-specific education. The Alere Health Learning and Performance team provides training for specific product support program administration.

Practitioner services
Services provided to practitioners are defined by the pharmaceutical client and may include use of the frequently asked questions or mailed information, or may require call transfer activities to product resources within the client's product support framework.

Monitoring and evaluation of outcomes
Alere Health tracks multiple operational, clinical and quality metrics and reports measurable results to demonstrate program impact to our clients. Examples of measurements include enrollment/disenrollment rates, program participants by program levels, program participant program completion, communication with providers, fulfillment reports, and program satisfaction.

BioPharma 2016 goals
- Continue increasing the number of program participants
- Implementation of the outbound call program
- Implementation of the live chat program
- Implementation of the automatic file feed from Covance to Alere Health to increase enrollments in the program.
- Expand the 2016 work plan to include measures for the implemented products that can be tracked and trended.

Appendix A – 2016 quality improvement work plan summary

The measures listed below are some of the key program indicators that will be reported to the division/program-specific quality subcommittee for review, analysis, identification of opportunities, and recommendations for interventions to improve performance results. The quality improvement committee will then review the performance measures and subcommittee analysis, and make decisions about future actions and interventions to be developed and implemented.

The 2016 quality improvement work plan report is a working document that will be clarified and modified as needed. The report will include data from calendar year (CY) 2015, if available, and 2016. Goals will be set based on analysis of industry benchmarks and research documents, past Alere Health performance, and client requirements.

Alere Health is also monitoring Stars measures that are key to our programs and program participants. In an effort to support client Star ratings, 2016 initiatives will focus on reducing readmissions, and improving clinical indicators in our program participants with diabetes and CAD. (Star measures are marked with an asterisk "*")

Measure	Program	Committee Review
Annual Reporting • 2016 quality program and work plan • 2015 quality program evaluation • 2016 population assessment • Program guidelines review/approval • Program content, printed materials, staff scripting • Cultural and diversity training • HIPAA training	DM, CCM, maternity CM, wellness, oncology CM and NICU CM and UM, Nurse24, BioPharma	annual
Safety Events	all	annual
Access Telephone: Calls answered <30 seconds, ASA, abandonment rate	DM, wellness, maternity NICU CM/UM, Nurse24	quarterly
Performance Monitoring: Call auditing/documentation auditing	all	quarterly
Complaints Participants, practitioners, clients volume and closure in less than 28 days from receipt	all	quarterly
Satisfaction Survey Participant	all	quarterly
Satisfaction Survey Client	DM, wellness, CCM, maternity, oncology, NICU CM/UM, Nurse24, BP	annual
Satisfaction Survey Practitioner	DM (each), UM	annual
Wellness Programs		
Health assessment content review	wellness	annual
Self-management tools/virtual coach review	wellness	annual
Coaching: Initial enrollment timeliness	wellness/coaching	quarterly
NCQA Technical Specifications	wellness	annual
Disease Management Programs		
Post processing referral	DM (aggregate)	annual
Enrollment - qualified accept rate	DM (aggregate)	quarterly
Clinical engagement - initial assessment	DM (aggregate)	quarterly
Active participation rate	DM (each)	quarterly
Access: Telephone ASA and CAR	DM (aggregate)	quarterly

Measure	Program	Committee Review
Utilization: Admissions, *readmits, ER visits	COPD, CAD, diabetes, HF, asthma	quarterly
Eligible outcome rate	maternity	quarterly
Clinical performance indicators - *flu, pneumococcal vaccinations	asthma, COPD. CAD, diabetes, HF	quarterly
• Asthma: Controller meds, short-acting beta agonist usage	asthma	quarterly
• COPD: Bronchodilator usage, controller meds,	COPD	quarterly
• CAD: BB post heart attack, *LDL screen and control, daily antithrombotic medication, *hypertension (ACE or ARB), *medication adherence for cholesterol	CAD	quarterly
• Diabetes: *Annual A1C test, *LDL test, *LDL control, *retinal exam, *microalbumin, *A1C control, *medication adherence	diabetes	quarterly
• Heart failure: ACE or ARB, beta blocker usage	heart failure	quarterly
• MSP: Rheumatoid arthritis DMARDs, migraine therapy	MSP	quarterly
• Depression: Antidepressant compliance, continuation phase - psychiatric visits	depression	quarterly
• Maternity: First prenatal visit, postpartum depression rate	maternity	quarterly
• All programs - smoking/tobacco use, seasonal flu		
• Maternity: NICU admissions and NICU days/1000	maternity	annual
• FYOL - well-being visits and immunization rates		
• Quality improvement projects	DM (each)	quarterly
Nurse24 - Health Information Line/Health Call Center		
Access - telephonic ASA and CAR, utilization patterns, chat line, secure messages and response timeliness	N24	quarterly
Health information activities	N24	quarterly
Triaged activities, dispositions	N24	quarterly
Two quality improvement projects	N24	quarterly
Case Management Programs		
Clinical enrollment		
Active participation rates	all	quarterly
TEN's prequalification accept rate	CCM	quarterly
Average calls per month	CCM, NICU	quarterly
Individuals refused CM services: URAC measure 5	all	quarterly
Clinical engagement		
Care transitions – identification of participants who are at risk	all	monthly
Care transitions – rates of admissions to facilities and ED	all	annually
Percent of participants say yes to AD discussion at IA and subsequent assessments	CCM, ONC	quarterly
Percent of participants with any AD at case closure	CCM, ONC	quarterly
Number of successful contacts with participant/CG per month	CCM, ONC	quarterly
Number of successful contacts with internal and external providers per month	CCM	quarterly

Measure	Program	Committee Review
Hospice participation	CCM, ONC	quarterly
Relevant subpopulation assessment	all	annually
3 performance improvement indicators/quality improvement projects	all	quarterly
Utilization Management Programs		
Initial review completion timeliness	NICU	quarterly
Concurrent review completion timeliness	NICU	quarterly
Annual review of guidelines	NICU	annually
Maintain UM state licenses	NICU	annually
Inter rater results	NICU	quarterly
2 quality improvement projects	NICU	quarterly
BioPharma		
Offers to mail program information to caller	Biopharma	quarterly
Reminder to participant that MD is the primary source for condition and treatment info	Biopharma	quarterly
Appropriate documentation of adverse events	Biopharma	quarterly
Accurately provides program information and/or education per program specific protocol	Biopharma	quarterly
Provides approved program scripts in addressing callers without use of generalizations or personal interpretation	Biopharma	quarterly
Appropriate fulfillment provided (appropriate to the call needs identified and was not duplicative)	Biopharma	quarterly
Appropriate referrals made to client specific resources	Biopharma	quarterly

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: February 1, 2017

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	7	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	7	
Number practitioners recredentialed within 36-month timeline	7	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 1/31/17	177	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds	42	47	9	6	8	0
Total # of Recreds	0	0	11	0	0	0
(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	805	671	641	669	343	104

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

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

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

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

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee April 5, 2017

Areas of Review or Committee Activity
Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	15	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	13	
Number practitioners recredentialed within 36-month timeline	13	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 3/31/17	200	

	Stanford	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Initial Creds	1	23		53	11	4
Total # of Recreds	267	158		280	15	9
(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	803	616	699	679	371	118

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

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

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

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

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD	Internist	Y
Hao Bui, BS, PharmD	Walgreens	Y
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	Y
Peter Nguyen, MD	Family Practice	N
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, Pharm D	SCVMC Pharmacy Director	Y
Ali Alkoraishi, MD	Psychiatry	Y
Johanna Liu, PharmD	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	N

Non-Voting Staff Members	Title	Present Y or N
Lily Boris, MD	Medical Director	N
Caroline Alexander	Administrative Assistant	Y
Christine Tomcala	Chief Executive Officer	N
Tami Ogino, PharmD	Clinical Pharmacist	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Dang Huynh, PharmD	Pharmacy Manager	Y

Item	Discussion	Follow-Up Action
	The meeting convened at 6:15 PM.	
I.	**REVIEW, REVISE, AND APPROVE MEETING MINUTES of September 15, 2016.** The minutes were reviewed by Committee as submitted.	Upon motion duly made and seconded, the P&T Committee minutes of **September 15, 2016** were approved as submitted and will be forwarded to the QI Committee and Board of Directors.

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
II.	**REPORTS** **a. Health Plan Updates** Dr. Liu presented the update on behalf of Dr. Robertson. Membership growth has stabilized. For contracting, update recently with specialty pharmacy. Were providing specialty pharmacy services through Valley Medical Center and Diplomat. Diplomat relationship was through Medi-Impact. Diplomat and Med-Impact split so no more preferred pricing relationship. RFP was performed. Decided to use Alpha Script Pharmacy based in Peninsula. Working on implementation plan to bring on Alpha Script and taper off Diplomat with as little disruption as possible to members and providers. **b. Appeals and Grievances** Dr. Liu presented the 3rd Quarter 2016 Pharmacy Appeals. Increase in Part D appeals during month of August. 11 were upheld, 12 overturned for CMC line of business. Top two medications appealed during third quarter were Ambien and Vistaril. These are both high risk medications. Lidocaine patches also a top drug for appeals in the third quarter. **c. Membership** Dr. Liu presented the membership update. Medi-Cal is currently at 272, 581 and Cal MediConnect is 7,546. Total membership is 280, 127. **d. Pharmacy Dashboard** Dr. Otomo presented the Pharmacy Dashboard for Medi-Cal and Cal MediCconnect. 100% for Medi-Cal one day turnaround time for prior authorizations. Cal MediConnect turnaround time is at 91% for 24 hour turnaround time (only one fallout). For MTM CMR Completion Rate, reached goal of 22% for the year.	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
III.	**OLD BUSINESS/ DISCUSSION ITEMS** **a. Medical PA Grid for Medi-Cal and Cal MediConnect** Dr. Otomo presented the update on the Medicare and Medi-Cal Prior Authorization List. Cover all the same drugs except for one. For Medi-Cal, Synagis requires prior authorization. On Cal MediConnect it is not included. **b. Total Claims data for Medi-Cal** Dr. Huynh presented the 3rd Quarter claims data for Medi-Cal and Cal MediConnect. Medi-Cal: total of 502,304 claims: 89% Generic; 11% Brand. Healthy Kids: total of 1,043 claims: 88% Generic, 12% Brand. Cal MediConnect: total of 80,756 claims: 83.1% Generic, 16.9% Brand. Increase in Medi-Cal claims from 2nd Quarter to 3rd Quarter. Decrease in Healthy Kids claims from 2nd Quarter to 3rd Quarter. Increase in Cal MediConnect claims from 2nd Quarter to 3rd Quarter.	Upon motion duly made and seconded, the Prior Authorization Grids were approved as presented. Present update at next P&T Committee meeting March 16, 2017.

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
IV.	**NEW BUSINESS**	
	a. Formulary Modifications Dr. Otomo presented Formulary Modifications made since interim from last Pharmacy and Therapeutics Committee meeting: • Added quantity limits as Santa Clara Family Health Plan was an outlier in this area • Removed OTC cough and cold products (not covered under Medi-Cal) Decision was made and implemented as a safety decision back in 2011. $5 copay for OTC cough and cold products, and patients were given option of products such as Guaifenesin with Codeine at no cost. Patients were choosing the no cost product, thus risk of prescribing narcotics. Presented as a formulary change. Change was due to Federal law. Noted: Opinion of the committee that this formulary change is not in the best interest of the patients. • Added Enbrel with prior authorization to formulary • Removed age limits on Celebrex • Removed all chemicals from formulary: powders	Update Levothyroxine to 1.5 tablets per day per recommendation of Dr. Parashar-Rokicki. Motion to accept formulary changes as presented, with Levothyroxine change to 1.5 tablets per day. With exception committee does not approve removal of OTC cough and cold products. Motion made, seconded and approved Dr. Liu to seek DHCS guidance. Run impact report. Share findings with CEO and CMO. If approved, add select OTC cough and cold medications back to formulary and retro-date.
	b. PA Guideline Review Project Dr. Huynh presented Brand Name Criteria for prior authorization request. Changed to approve for 4 months or as clinically appropriate. (Formerly approve for 12 months). Also presented Compounded Medications Criteria for prior authorization request. Presented Off Label Non-FDA Approved Medications Criteria. Dr. Otomo presented General Criteria for Utilization Management. Covers medications with no specific criteria for coverage.	Upon motion duly made and seconded, prior authorization criteria were accepted as presented.

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Item	Discussion	Follow-Up Action
IV.	**c. MedImpact P & T Minutes** Dr. Huynh reviewed the MedImpact P&T Minutes and approved as written.	Upon motion duly made and seconded, MedImpact minutes were approved as written.
	d. New Drugs Dr. McCarty presented new drugs. i. Basaglar-Propose add to formulary with quantity limit, and remove Lantus from formulary. Grandfather existing members. ii. Sarilumab & Baricitinib-Informational only. iii. Stelara (ustekinumab)-Presented as informational only	Upon motion duly made and seconded, recommendation was approved as presented.
	e. Class Reviews Dr. McCarty presented class updates and recommendations. i. Growth Hormones Multiple Somatropin Agents. Discussed top seven products. Norditropin least costly of all products. Propose keep on formulary with prior authorization required for FDA approved labeling. Remove Competitor products from formulary. Review by exception request with prior authorization. Prior authorization criteria to include required use of Norditropin first. ii. HIV Update No discussion at this time. iii. Fertility Agents No discussion at this time.	Upon motion duly made and seconded, recommendations were approved as presented.
	f. 4Q2016 Drug Trend and Utilization Review **g. Medi-Cal Formulary Drug Updates** **h. Generic Pipeline-Presented as informational only**	Informational only. No action required.
V.	**ADJOURNMENT** The meeting was adjourned at 7:45 PM.	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
December 15, 2016

Submitted by:

Caroline Alexander Date: 3/16/17
Caroline Alexander
Administrative Assistant, SCFHP

Internal Approved By:

Date: 3/16/17
Johanna Liu, PharmD
Director of Quality & Pharmacy, SCFHP

External Approved by:

Date: 3/16/2017
Jimmy Lin, MD
Pharmacy & Therapeutics Chair

Santa Clara Family Health Plan

The Spirit of Care

MINUTES

UTILIZATION MANAGEMENT COMMITTEE

January 18, 2017

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Ngon Hoang Dinh, DO	Head and Neck Surgery	N
Indira Vemuri, MD	Pediatrics	N
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	N
Lily Boris, MD	Medical Director	Y
Jana Alegre	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	N
Sherry Holm	Behavioral Health Manager	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Meeting called to order by chair at 6:05 p.m. The minutes of the October 19, 2016 meeting were approved as presented.	
II. CEO Update	Dr. Robertson presented the CEO update on behalf of Christine Tomcala, CEO. State is dissolving Coordinated Care Initiative (CCI) and reinstating as Cal MediConnect without IHSS. Extended to end of 2019. Expect decrease in growth of MediCal expansion.	
III. Old Business	Dr. Boris presented an update on readmission analysis as a follow up from the October 19th UM committee meeting. Looked at 30 day readmission rate by network. Medi-Cal Non SPD rate was 18.62%, with Network 10 having the highest readmission rate. SPD readmission rate average was 24.99%, with Network 10 and Network 60 having the highest readmission rate. Medi-Cal Overall	

ITEM	DISCUSSION	ACTION REQUIRED
	readmission rate was 20.79%. MCDS 30 day readmission rate (duals patients without Medicare part A) averaged 24.61% readmission rate. Cal MediConnect readmission rate was 13.80% which we are trending.	
IV. Action Items	a. Review of Policies Ms. Alegre presented a summary of changes to the UM Policies. Twelve policies were presented for review and approval. Edited HS.01 to HS.05 with NCQA verbiage. Added HS.09 Interrater Reliability. After motion duly made, seconded, all policies were approved as presented. b. Adopt Hierarchy of UM Criteria-HS.02 Ms. Alegre presented HS.02 Hierarchy of UM Criteria to the committee. Procedure adopted from this policy. Using Noridian for CMC line of business. For Medi-Cal line of business using MCG criteria and Medi-Cal guidelines as well as MD review. More specific in procedure and in policy more generalized. c. UM Program Description 2017 Dr. Boris presented a summary of the changes to the UM Program Description. Manages our UM processes. Only updates added were new NCQA requirements in 2017. Recommendation by Dr. Alkoraishi to look at Section M on Confidentiality in regards to 42 CFR Part 2 (release of information regarding substance abuse). After motion duly made, seconded, UM Program Description 2017 approved as presented.	Lily Boris and Jeff Robertson to look into this. If edited, will bring UM Program Description back to April UM Committee meeting.

ITEM	DISCUSSION	ACTION REQUIRED
V. Standing Reports	a. Membership Dr. Robertson presented an update on membership. Steady growth throughout the year of 2016. Ended the year at 280,000 overall membership. Common to have a dip in membership in January because members lose eligibility and reapply to get coverage retroactively applied. Most of loss occurred in Net 20. b. UM Reports 2016 i. Turn Around Time (Cal MediConnect/Medi-Cal) Dr. Boris presented Cal MediConnect and Medi-Cal dashboard for turnaround time on authorization requests. For Cal MediConnect, the goal is 95% in all areas. For Pre-Service Organization Determinations, the percentage of timely decisions made within 14 days is 94.8% as of December 2016. The percentage of timely decisions made within 72 hours is 93.7%. For Concurrent Organization Determinations, the percentage of timely decisions made within 24 hours is 72.4%. The percentage of timely decisions made within 30 days is 96.7%. For Medi-Cal, the goal is 95% in all areas. For Routine Authorizations, the percentage of timely decisions made within 5 business days of request is 96.8% as of December 2016. The percentage of timely decisions made within 72 hours of request is 96.4%. Data on the percentage of timely decisions made within 24 hours of request is unavailable at this time. Percentage of retrospective reviews completed within 30 calendar days of request is 96.8%. ii. Standard Utilization Metrics Dr. Boris presented the Standard Utilization Metrics. Medi-Cal non SPD average length of stay has remained at about 4, discharges per thousand 3.44. Medi-Cal SPD average length of stay increased from 4 to 5.26 days, discharges per thousand 12.93. CMC average length of stay is 6 days, discharges per thousand 271.3. For NCQA Medicaid Benchmark Comparisons, non SPD 90% are higher than us, average length of stay 4.03 days. For SPD we are in top 10%, average length of stay is 5.26. CMC population at 271.32 discharges per thousand, Medi-Cal SPD 155.13 discharges per thousand. Above NCQA mean by about 30 days for well managed. Every procedure down or flat for frequency of selected procedures with exception of Male age 45-64 Bariatric Surgery which increased (4 cases). Medi-Cal Behavioral Health Metrics ADHD Medicaid Percentile Rank is 25 to 50th percent.	Jana Alegre to check on language of CMC and NCQA on timeliness of Concurrent Review (Business Days for 24 hour turnaround time)

ITEM	DISCUSSION	ACTION REQUIRED
	iii. Specialty Referral Tracking Dr. Boris presented an update on Specialty Referral Tracking. SCFHP received a CAP in the last DHCS audit, of April 2016 due to not having a referral tracking system in place. The UMC adopted HS.01.02 Referral Tracking Procedure. On an annual basis UMC would look at 3 months of prior authorizations,in accordance with the procedure. The patient selection will review any member that has not had a claim in the system by the time of the calls. .. Outbound calls are made to patients to see if they received service. 42 of 62 (74% of authorizations had paid claim). 16 of 62 (25% had no matching claim). After calls, members stated they had procedure but received no claim (51 of 62 had procedure). We looked at 11 that had no matching claims: one was PMG delegate, so no access to claim. One member unsure if they got procedure done. Four members unable to reach, Four auths cancelled or denied, one procedure cancelled by physician (for cardiac concerns). The study shows that 90% either received services or had an auth cancelled/denied. This first study was to determine if there was a problem (barriers to getting procedure such as transportation, language barrier). Barrier analysis done to determine reason why 10% did not get procedure. UMC Recommends that the study be repeated study annually. Please see attachment for the details of the findings. c. Mental Health Update (Behavioral Health Utilization Data/ABA Utilization Data) Ms. Holm presented the Behavioral Health Utilization Data update. All Behavioral Health Treatment except for Kaiser and Valley Health Plan transition from San Andreas Regional Center for all diagnosed children with autism (over 3 years old). Members served ranged from 69 in January 2016 to 162 in December 2016. For Behavioral Health Utilization, 209 members with outreach activities (served in County & Community based clinics), 90 hospitalized members, 109 Health Risk Assessments, and 60 per month intensive case management. Medi-Cal members served in FQHC and Central Wellness ranged from 98 in January 2016 to 127 in December 2016. Cal MediConnect members served in FQHC and Central Wellness ranged from 210 in January 2016 to 160 in September 2016. Data was not yet available for the 4th Quarter of 2016 on Cal MediConnect members served d. Committee Membership/Charter Dr. Robertson reviewed the UM Committee charter. All current committee members have agreed to remain on committee.	UMC recommended that the Specialty Tracking policy be completed annually.
VI. Adjournment	Meeting adjourned at 6:55 p.m.	
NEXT MEETING	The next meeting is scheduled for Wednesday, April 19, 2017, 6:00 PM	

ITEM	DISCUSSION	ACTION REQUIRED

Prepared by:

_____ Date _____
Caroline Alexander
Administrative Assistant

Reviewed and approved by:

_____ Date _____
Jimmy Lin, M.D.
Committee Chairperson

Santa Clara Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
March 22, 2017

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Yes
Ngon Hoang Dinh, DO	Head and Neck Surgery	No
Indira Vemuri, MD	Pediatrics	Yes
Dung Van Cai, MD	OB/GYN	Yes
Habib Tobaggi, MD	Nephrology	Yes
Jeff Robertson, MD, CMO	Managed Care	Yes
Ali Alkoraishi, MD	Adult and Child Psychiatry	Yes

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	No
Lily Boris, MD	Medical Director	Yes
Jana Castillo	Utilization Management Manager	No
Sandra Carlson	Health Services Director	No
Sherry Holm	Behavioral Health Manager	No
Caroline Alexander	Administrative Assistant	No

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	The meeting was started with a quorum at 5:30 PM.	None
II. CEO Update	N/A	None
III. Old Business	None	None

ITEM	DISCUSSION	ACTION REQUIRED
IV. Review Items a. Exhibit: 1. Procedure HS.04.01 is reviewed with committee members b. Exhibit: 2. 4th Quarter 2016 plan Quality Monitoring and findings are submitted to UMC in accordance to the stated procedure.	• Dr. Boris reviewed the recent DMHC audit findings on behalf of DHCS for CMC. The findings included: that Finding #1: For decisions to deny service authorization requests, notices to enrollees are not produced in a manner, format, and language that can be easily understood. As a response, the plan updated the Procedure HS.04.01 to include CMC. The UM activities will be conducted in accordance to the procedure quarterly. Therefore, a CMC Quarterly Quality report was completed for 4th quarter 2016 and the results presented to UMC. The findings of review of 30 authorizations for multiple elements are summarized: o 30 unique authorizations were pulled with a random sampling. ▪ Of the sample 27% or 8/30 were expedited • 100% of the expedited authorizations were processed within 72 calendar hours • 95% or 21/22 of the standard authorizations met timeliness factors ▪ 70% or 21/30 of the denials were medical necessity denials ▪ 100% of denials received physician review ▪ 100% of the files had the correct letter template	The committee reviewed the attached information on Quarterly Quality monitoring of SCFHP QA process for denial notifications and is in agreement with quarterly updates to UMC. This is the first report and the UMC will follow the reports and agrees that a template for common denials and staff training is appropriate.

ITEM	DISCUSSION	ACTION REQUIRED
	o Review of the letter content shows that 60% or 18/30 of the letters had clear denial language. o However, 40% or 12/30 did not have evidence of clear denial language. ▪ Most common errors were: • MCG guideline not clearly identified. • If non contracted practitioner was denied, an appropriate alternative contracted practitioner was not provided to the member. • Denial verbiage is not stated in a member friendly language. • **Follow-Up** The Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows: o Created a template for denial letter verbiage that is member centric. ▪ Start with the common denial reason. • For non-contracted provider denials and redirection to in network, work with customer service to include in network	

ITEM	DISCUSSION	ACTION REQUIRED
	alternatives. o Train staff on denial process and notifications regulatory requirements (verbiage and TAT)	
Item 2. a. Exhibit: 3 Plan has updated Procedure HS.01.02 to include CMC (see attached) b. Exhibit: 4 Plan is presenting the follow up of : Update on Specialty Referral Tracking for CMC (see attached report for discussion)	Dr. Boris reviewed the recent DMHC audit findings on behalf of DHCS for CMC. The Plan does not have an established system to track and monitor specialty referrals requiring prior authorization for CMC. As such, the procedure HS.01.02 was updated to include CMC line of business. To complete the Santa Clara Family Health Plan's (SCFHP) process for tracking referrals and meet the guidance of HS.01.02 (Referral Tracking) to their completion and drive improvements through the monitoring of provider referral and specialist care patterns of practice. These were randomly selected with Cal MediConnect members. Please see attachment for complete information. • The findings of review authorizations for are summarized: o 19/35 or 54% had the procedure requested	The committee agrees with adding CMC LOB. They reviewed the report and acknowledged that the CMC members are difficult to contact. The UMC will continue to monitor.

ITEM	DISCUSSION	ACTION REQUIRED
	• Of the 16 left in the sample without matching claims: o 1 deceased o 1 member's daughter was unsure (DME) o 1 member went to SNF instead (Empress Care) o 1 member still waiting (DME – Commode Chair and Cane) o 12 unable to reach • **Recommendation based on this review is for annual follow up.** o Match pharmacy data with our auth data for the next annual follow up. o UM: Referred one member to DME vendor to resolve outstanding DME item	
VI. Adjournment		
NEXT MEETING	The next meeting is scheduled for Wednesday, April 19, 2017, 6:00 PM	

Prepared by:

_____ Date _____

Lily Boris, MD
Med Director

Reviewed and approved by:

_____ Date _____

Jimmy Lin, M.D.
Committee Chairperson

Santa Clara
Family Health Plan
The Spirit of Care

Quality Improvement Committee
Consumer Advisory Board – Cal MediConnect Member Feedback
2016 & Q1 - 2017

The following are issues of Cal MediConnect (CMC) program management and enrollee care identified by CMC members during the monthly Consumer Advisory Board meetings. SCFHP is required to share this member input with the QI Committee quarterly.

Summary of Issues:

Phone

1. The Valley Medical Center (VMC) Call Reminder Line has a "click-click" then hangs up. Issue is several years old. Members have complained about it but nothing has happened.

   Action Taken: Unable to recreate concern. Determined this issue is outside of the scope of the Cal MediConnect program. Complaints have been previously submitted by member to Valley Medical Center (Hospital).

2. Members are bothered by the number of calls from SCFHP (and/or Delegate) weekly; at times are overwhelmed with the volume.

3. Members struggle to understand some staff with strong accents

4. Delays with Customer Service line after hours. Member was on hold for 20 minutes before prompted to leave a message. SCFHP

   Action Taken: Customer Services Rep followed-up with member to get more specifics.

SCFHP After-Hours Nurse Line – Support and Customer Service issue. Nurse line placed caller on hold for 20 minutes only to then be prompted for leaving a voice mail message. Caller was frustrated for time spent on hold.

Action Taken: Unable to establish systemic issue. Continue to track other future complaints and monitor for recurrence.

Customer Service/Case Management Support for Member– With an Authorization for DME supplies ending, along with problems related to a wrong physician and diagnosis for auth, a CMC Member contacted Case Management (CM) for help and Customer Service, but didn't get a call back. Crescent Provider told member they had to see doctor before auth could be approved, but they couldn't schedule and were almost hospitalized.

Action Taken: Nurse Case Manager notified and successfully resolved the case/issue.

Pharmacy Co-Pay - Member was surprised by new Pharmacy co-pays and expressed difficulty with paying them at times.

Additional Input on CMC Program Management and Enrollee Care

- Case Management/Care Coordination
  - Satisfied working with their case managers and getting the help that they need.
  - Linking with the case manager helped member access IHSS services.
  - Value the combination of medical and social services provided to meet member needs.
  - Appreciation for case manager "check-in" call, particularly in her own language (Spanish).
- Providers
  - Excellent service received from the nursing staff and doctors at a Specialty Clinic at Stanford and Fair Oaks (Valley Health Plan) clinics.
- Pharmacy
  - Received excellent service from SCFHP and Pharmacy for prescriptions not typically covered.
- Other
  - Suggestion: provide members with a written summary of how transportation benefit can be arranged including what's different, if after hours
  - Health plan resolution of member billing issue
  - Acupuncture coverage has been beneficial to a member.