Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Tuesday, June 14, 2022, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
(669) 900-6833
Meeting ID: 962 5812 9548
https://zoom.us/j/96258129548
Passcode: SCFHP123

AGENDA

1.	**Roll Call**	Dr. Paul	6:00	3 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Quality Improvement Committee (QIC) reserves the right to limit the duration of the public comment period to 30 minutes.	Dr. Paul	6:03	2 min
3.	**Meeting Minutes** Review draft minutes of the 04/12/2022 QIC meeting. **Possible Action:** Approve draft minutes of the 04/8/2022 QIC meeting	Dr. Paul	6:05	5 min
4.	**Chief Executive Officer (CEO) Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:10	10 min
5.	**Cal MediConnect (CMC) Cultural & Linguistics (C&L) Provider Assessment** Review the CMC C&L Provider Assessment. **Possible Action:** Approve the CMC C&L Provider Assessment	Ms. Fadley	6:20	10 min
6.	**CMC Population Health Assessment (PHA) 2022** Review the CMC PHA. **Possible Action:** Approve the CMC PHA 2022	Ms. Baxter	6:30	10 min
7.	**CMC Population Health Management (PHM) Impact Analysis Report 2021** Review the CMC PHM Impact Analysis Report 2021. **Possible Action**: Approve CMC PHM Impact Analysis Report 2021	Ms. Chen	6:40	10 min
8.	**CMC and Medi-Cal (MC) PHM Strategy 2022** Review the CMC and MC PHM Strategy 2022. **Possible Action:** Approve the CMC and MC PHM Strategy 2022	Ms. Chen	6:50	10 min
9.	**Compliance Report** Review the Compliance Report.	Mr. Haskell	7:00	10 min

10. Activities and Resources Grid Review of the Activities and Resources Grid. **Possible Action**: Approve the Activities and Resources Grid	Ms. Chen	7:10	10 min
11. Annual Review of QI Policies **a.** QI.08 Cultural and Linguistically Competent Services **b.** QI.20 Information Sharing with San Andreas Regional Center (SARC) **c.** QI.22 Early Start Program (Early Intervention Services) **d.** QI.33 Enhanced Care Management (ECM) Denial and Disenrollment Policy **Possible Action:** Approve the QI policies as presented.	Ms. Chen, Ms. Baxter, & Ms. Bautista	7:20	5 min
12. Grievance & Appeals (G&A) Report Q1 2022 Review the G&A Report Q1 2022. **Possible Action:** Approve the G&A Report Q1 2022	Mr. Oliveira	7:25	10 min
13. Quality Dashboard Review the Quality Dashboard.	Ms. Baxter	7:35	10 min
14. Utilization Management Committee (UMC) Review draft minutes of the 04/20/2022 UMC meeting. **Possible Action:** Accept the 04/20/2022 UMC draft meeting minutes	Dr. Lin	7:45	5 min
15. Consumer Advisory Board (CAB) Review draft minutes of the 06/02/2022 CAB Committee meeting. **Possible Action:** Accept the 06/02/2022 CAB draft meeting minutes	Dr. Nakahira	7:50	5 min
16. Credentialing Committee Report Review 04/06/2022 Credentialing Committee Report. **Possible Action:** Approve the 04/06/2022 Credentialing Committee Report	Dr. Nakahira	7:55	5 min
17. Adjournment The next QIC meeting will be held on August 9, 2022.	Dr. Paul	8:00	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Quality Improvement Committee on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Committee may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Nancy Aguirre 48 hours prior to the meeting at (408) 874-1835.
- To obtain a copy of any supporting document that is available, contact Nancy Aguirre at (408) 874-1835. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com.

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Tuesday, April 12, 2022, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes

Members Present	Specialty
Ali Alkoraishi, MD	Adult & Child Psychiatry
Nayyara Dawood, MD	Pediatrics
Jennifer Foreman, MD	Pediatrics
Jimmy Lin, MD	Internist
Laurie Nakahira, D.O., Chief Medical Officer	
Christine Tomcala, Chief Executive Officer	
Members Absent	
Ria Paul, MD, Chair	Geriatrics

Staff Present
Chris Turner, Chief Operating Officer
Tyler Haskell, Interim Compliance Officer
Lori Andersen, Director, Long Term Services and Support
Angela Chen, Director, Case Management & Behavioral Health
Duyen Nguyen, PharmD, Clinical Pharmacist
Stephanie Sit, Quality Improvement Nurse
Lucille Baxter, Manager, Quality & Health Education
Charla Bryant, Manager, Clinical Quality & Safety
Karen Fadley, Manager, Provider Data, Credentialing and Reporting
Ashley Kerner, Manager, Administrative Services
Mauro Oliveira, Manager, Grievance and Appeals
Robert Scrase, Manager, Process Improvement
Amber Tran, Project Manager, Process Improvement
Emily Hennessy, Consultant, Long Term Services & Supports
Nancy Aguirre, Administrative Assistant
Robyn Esparza, Administrative Assistant

1. Roll Call

Laurie Nakahira, D.O., Chief Medical Officer (CMO), Acting Chair, called the meeting to order at 6:05pm. Roll call was taken and quorum was established.

Dr. Nakahira announced the reassignment of Johanna Liu, PharmD, Director, Quality and Process Improvement. Dr. Liu's last day with The Plan is 05/13/2022. Dr. Nakahira thanked Dr. Liu for her 8 years of service to the Health Plan, and for her significant contributions to the growth and quality of the organization.

2. Public Comment

There were no public comments.

3. Meeting Minutes

Meeting minutes of the 02/08/2022 Quality Improvement Committee (QIC) meeting were reviewed.

It was moved, seconded and the minutes of the 02/08/2022 QIC meeting were **unanimously approved.**

Motion: Dr. Alkoraishi
Second: Dr. Foreman
Ayes: Dr. Dawood, Dr. Lin, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

4. Chief Executive Officer (CEO) Update

Christine Tomcala, Chief Executive Officer (CEO), was pleased to announce SCFHP passed the National Committee for Quality Assurance (NCQA) Medicare Accreditation Renewal Survey for the Cal MediConnect (CMC) line of business.

Ms. Tomcala noted The Plan is looking to become NCQA accredited for the Medi-Cal (MC) line of business.

5. Medi-Cal (MC) & Cal MediConnect (CMC) Quality Improvement (QI) Work Plan 2022

Lucille Baxter, Manager, Health and Education, presented the MC & CMC QI Work Plan 2022. Every year, the Quality, Grievance and Appeals (G&A), and Health Services departments, come together to create the QI Work Plan. The QI Work Plan includes quality metrics and goals to be accomplished for the coming year.

Divided into two (2) lines of businesses, MC and CMC, the activities, including the Quality of Clinical Care, Member Services, and Quality of Service, are outlined in the Work Plan 2022. Ms. Baxter noted G&As have been incorporated into this Work Plan.

It was moved, seconded and the MC & CMC QI Work Plan 2022 was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

6. MC & CMC QI Program Evaluation 2021

Ms. Baxter presented an overview of the QI Program Evaluation 2021. Included in the QI Program Evaluation 2021, is the 2021 QI Work Plan for MC and CMC lines of business. This Work Plan focuses on the Quality of Clinical Care, Member Services, and Quality of Service.

Ms. Baxter reviewed the Table of Contents, highlighting the contents of Clinical Improvement, Safety of Clinical Care, Quality of Service, and Member Experience.

It was moved, seconded and the MC & CMC QI Program Evaluation 2021 was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

7. Pharmacy Benefit Information Analysis

Duyen Nguyen, PharmD, Clinical Pharmacist, presented the Pharmacy Benefit Information Analysis. SCFHP has a responsibility to provide accurate, quality information on pharmacy benefits to CMC members through the website. Annually, The Plan audits the information on the website by randomly selecting one (1) drug in each of the four (4) formulary tiers, one (1) excluded drug, and one (1) newly added drug. The goal for both accuracy and quality is 100%.

Dr. Duyen reported both accuracy and quality measures met goal at 100%. There were no deficiencies identified. Additionally, there were no significant changes to the CMC pharmacy member portal since the

previous report in August 2020.

It was moved, seconded and the Pharmacy Benefit Information Analysis was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Foreman
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

8. Quality Dashboard

Ms. Baxter presented the Quality Dashboard and an overview of the Wellness Rewards Program – a calendar year program offered to members who complete preventative screenings and close gaps in care. Year to date, (YTD), a total of 7,990 gift cards have been mailed to members.

Ms. Baxter reviewed the results for the Outreach Call Campaign, an internal program where staff conduct calls to members to promote health education. A total of 7,422 calls were made from January 2022 – March 2022. Also reviewed were the completion rates for the Initial Health Assessment (IHA). Reports indicate a decrease in completion rates from January 2022 – March 2022.

Ms. Baxter reviewed the Potential Quality of Care Issues (PQIs), noting 98.4% of PQIs, due from January – March 2022, closed on time (within 90 days). Also, Facility Site Reviews (FSR) have resumed. Between January 2022 and March 2022, there were 22 FSRs completed.

In an effort to improve the HEDIS MC and CMC rates, alerts have been loaded into QNXT, so that internal staff can remind members about screenings and/or visits they are due for. Ms. Baxter noted a total of 3,341 QNXT Gaps in Care (GIC) alerts were terminated between January – March 2022.

9. Compliance Report

Tyler Haskell, Interim Compliance Officer, presented the Compliance Report. Mr. Haskell noted SCFHP recently received two (2) notices of non-compliance from CMS in February 2022 for late submissions of attestations and policies & procedures related to the use of a formulary for the Medicare Part D program. There are no penalties or corrective actions required by CMS, and steps have been taken to ensure future timely submissions.

The 2022 Department of Health Care Services (DHCS) Annual Audit took place between March 7 and March 18 2022, covering a review period of March 2021 through February 2022. Unlike previous DHCS audits, which covered only the MC line of business, this audit covered both MC and CMC. During the exit conference, DHCS verbally indicated potential findings in several areas, with other areas still under review.

Mr. Haskell noted in January 2022, SCFHP received notice of the Department of Managed Health Care (DMHC) Financial Audit that will be conducted by June 2022. This audit occurs every three (3) years and examines the financial health and sustainability of The Plan. The Finance department is responding to document requests from DMHC.

10. Annual Review of QI Policies

Dr. Nakahira reviewed policies QI.03, QI.04, QI.06, QI.08, QI.09, QI.11, QI.15, QI.16, QI.19, QI.23, QI.28, and QI.30, and noted the changes made, if applicable.

a. QI.03 Distribution of QI Information – *No changes except for the reference NCQA 2022*
b. QI.04 Peer Review Process – *No Changes*
c. QI.06 QI Study Design/Performance Improvement Program Reporting – *No changes except for the reference NCQA 2022*
d. QI.08 Cultural and Linguistically Competent Services – *Included the Consumer Advisory Board (CAB) meeting and updated reference NCQA 2022*
e. QI.09 Health Education Program and Delivery System - *No changes except for the reference NCQA 2022*
f. QI.11 Member Non-Monetary Incentives – *No changes*
g. QI.15 Transitions of Care – *No changes*

h. QI.16 Managed Long Term Services and Support Care Coordination – *No changes*
i. QI.19 Care Coordination Staff Education and Training – *No changes*
j. QI.23 Alcohol and Drug Screening Assessment, Brief Intervention, and Referral to Treatment (SABIRT) – *Replaces SBIRT APL 18-014; New APL SBIRT has USPSTF; Updated the definition of risky drinking of ETOH & substance use with screenings & BH counseling intervention to reduce ETOH & substance use in adolescents & adults; MCP is requiring ETOH or SUD Rx MCP must arrange for referral to the county department for outpatient Rx SUD; Requirements are consistent with USPSTF grade A/B, AAP/Bright futures, MCAL provider manual; List of screening tools; Brief assessment; Brief intervention & referral for Rx*
k. QI.28 Health Homes Program – *Retiring HHP ending 2022*
l. QI.30 Health Risk Assessment – *No changes*

Emily Hennessy, Consultant, Long Term Services & Supports, reviewed the two (2) new policies QI.31 and QI.32, and noted these policies will need to be renumbered, as there is currently a QI.31 and QI.32 in use.

m. QI.31 Community Supports (CM) – *New policy 2022*
n. QI.32 Enhanced Care Management (EMC) – *New policy 2022*

It was moved, seconded and policies QI.03, QI.04, QI.06, QI.08, QI.09, QI.11, QI.15, QI.16, QI.19, QI.23, QI.28, QI.30, QI.31 and QI.32 were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Foreman
Ayes: Dr. Alkoraishi, Dr. Dawood, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

11. Consumer Advisory Board (CAB)

Dr. Nakahira reviewed the draft minutes of the 03/03/2022 CAB meeting.

It was moved, seconded and the 03/03/2022 draft CAB meeting minutes were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

12. Pharmacy & Therapeutics Committee (P&T)

The draft minutes of the 03/17/2022 P&T Committee meeting were reviewed by Dr. Lin, Chair, Pharmacy and Therapeutics Committee.

It was moved, seconded and the 03/17/2022 draft meeting minutes were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Dawood, Dr. Foreman, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

13. Credentialing Committee Report

Dr. Nakahira reviewed the 02/23/2022 Credentialing Committee Report.

It was moved, seconded and the 02/23/2022 Credentialing Committee Report was **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Dawood
Ayes: Dr. Alkoraishi, Dr. Foreman, Dr. Nakahira, Ms. Tomcala
Absent: Dr. Paul

14. Adjournment

The next regular QIC meeting will be held on June 14, 2022. The meeting was adjourned at 7:07PM.

_____ _____

Ria Paul, MD, Chair Date

Santa Clara Family Health Plan
Assessment of Member Cultural and Linguistic Needs and Preferences
Measurement Year - 2021

Cal Medi-Connect - 2022

Prepared by: Claudia Graciano, Provider Network Access Program Manager
For review and approval by the Quality Improvement Committee

INTRODUCTION

SCFHP believes that cultural competency is a best practice for valuing diversity, practicing inclusion and creating health equity. SCFHP continues to support developmental processes to ensure awareness of cultural, ethnic/racial differences.

SCFHP is committed to providing language services at no cost and equal access to services for members with hearing or language related needs. Oral Interpreters, signers, bilingual providers and provider staff are available at all key points of contact. These services are provided in all languages spoken by SCFHP members.

SCFHP annually assess the cultural, ethnic/racial and linguistic needs of its members relative to its provider network. Network provider characteristics (i.e., culture, ethnicity/race, spoken language) are assessed to ensure member preferences and needs are met.

DATA SOURCES AND COLLECTIONS

To assess member needs, data is collected from multiple sources to include:

- 2021 US Census
- Statistical Atlas
- Data USA
- CAHPS
- APL 21-004
- Provider Language Report via eVips
- Member Ethnicity/Race and Language Report via QNXT, 834
- Language Translation Usage: January 1, 2021 – Dec 31, 2021
- Member Complaints: January 1, 2021 – Dec 31, 2021

METHODOLOGY

SCFHP will use US Census, Statistical Atlas, Data USA and/or other sources to collect and examine data on the cultural ethnic/racial and linguistic composition of the population in its service area in Santa Clara County.

SCFHP extracts available enrollee demographic information from the 834 file to identify characteristics such as culture, ethnic/racial and primary language. SCFHP will extract available demographics on the same characteristics of its provider network by running reports from the eVips system. While the Plan does not have concrete data on provider ethnicity/race, conclusions are drawn from the languages spoken by network providers. For further evaluation, SCFHP also uses available publications on physician diversity in California to examine provider diversity statistics in its service area.

Santa Clara Family Health Plan and the California Department of Health Care Services (DHCS) uses the following methodology to identify enrollee threshold languages –

- A population group of mandatory eligible beneficiaries residing in the Plan's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language);

- A population group of mandatory eligible beneficiaries residing in the Plan's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes (Concentration Standard Language).

The DHCS issues an all plan letter (APL 21-004) to notify the health plans of which threshold languages were identified for each county in California. SCFHP's annual cultural and linguistic assessment incorporates the threshold languages the DHCS identifies in its service area in Santa Clara County. In addition, SCFHP follows state requirements regarding translation of written informing materials for members who have limited English proficiency and speak one of the languages which meet the threshold and concentration standards.

The DHCS updates threshold language data at least once every three fiscal years, to address potential changes to both numeric threshold and concentration standard languages within all Medi-Cal managed care counties.

SCFHP cultural and linguistic assessments include PCP's, high volume/impact specialists and high volume mental/behavioral health providers. PCP provider counts include family practice and internal medicine. Family practice provider counts include geriatric and general practice providers.

DEMOGRAPHICS

Data Source: US Census

County:		**Cities:**	**Population**
Santa Clara County		ALL	**1,885,508** (-2.6% from 2020)

Data Source (Language *only*): Statistical Atlas

Santa Clara County Race and Hispanic Origin	**Percentage**	**Language other than English spoken at Home (Top 3)**	**Percentage**
White alone, percent (a)	52.4%	Spanish	18%
Black or African American alone (a)	2.8%	Chinese	9.4%
American Indian and Alaska Native alone (a)	1.2%	Vietnamese	6.5%
Asian alone, percent (a)	39.0%		
Native Hawaiian and Other Pacific Islander alone (a)	0.5%		
Two or More Races, percent	4.2%		
Hispanic or Latino, percent (b)	25.0%		
White alone, not Hispanic or Latino	30.6%		

(a) Includes persons reporting only one race
(b) Hispanics may be of any race--are included in applicable race categories

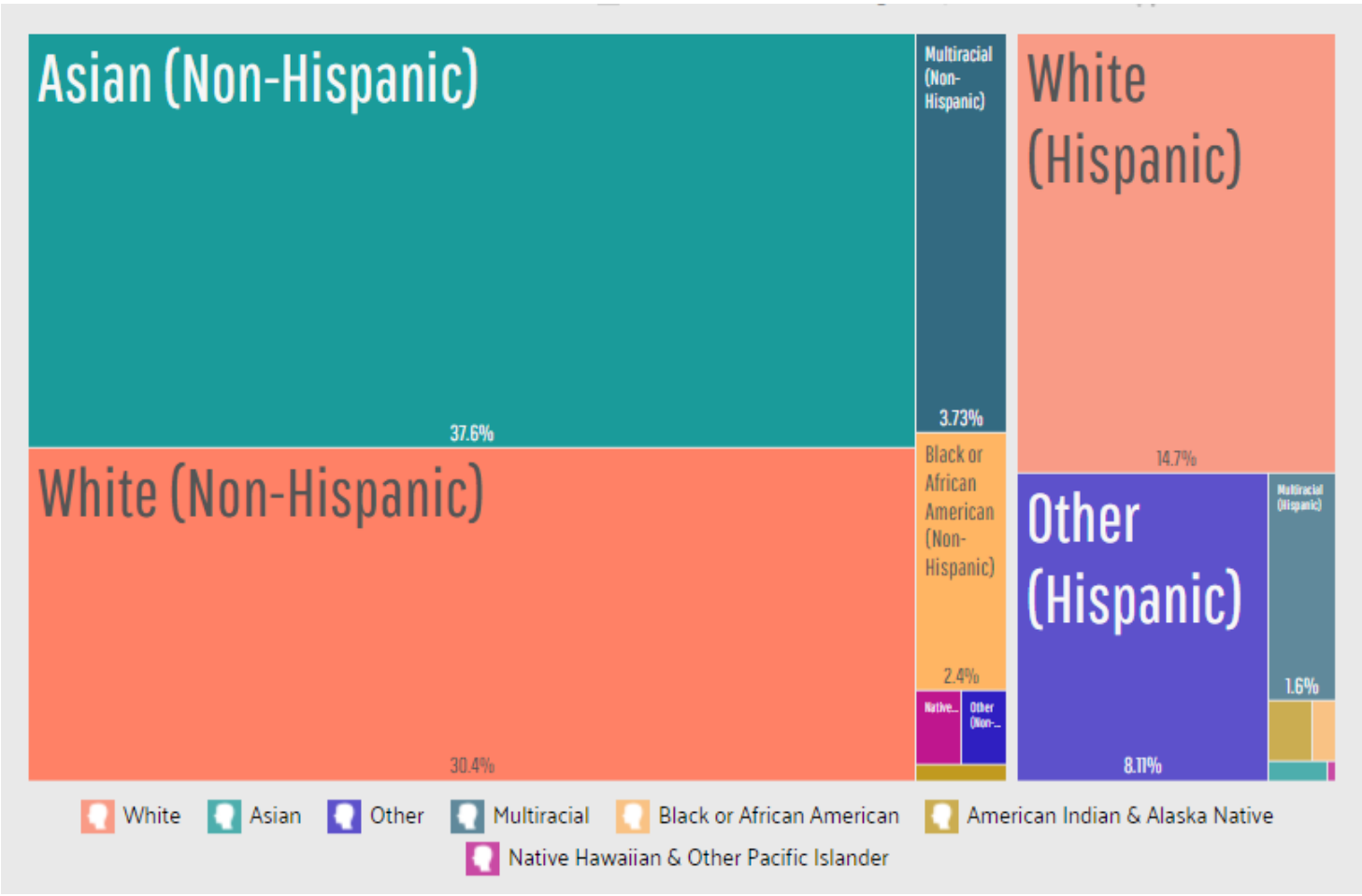
Data Source: 2019 US Census

Santa Clara County Age & Gender	**Number/Percentage**	**Santa Clara County Health**	**Percentage**
Persons under 5 years	5.8%	With disability, under 65	4.5%
Persons under 18 years	21.6%	Persons without Health Insurance	5.5%
Persons 65 years and over	13.9%		
Median Age	37.2%		
Female persons	49.3%		
Male persons	51.0%		

In 2021, US Census reported that there were 1.3 times more Asian Alone residents (724k people) in Santa Clara County than any other ethnicity/race. There were 586k White Alone and 482k Hispanic or Latino residents, the second and third most common racial or ethnic groups.

To further assess and to gain a better understanding of SCFHP's service area, a study was conducted using Data USA, which reports that 54.3% of Santa Clara County citizens are speakers of a non-English language, which is higher than the national average of 22%. Data USA also reports that the most common non-English language spoken in Santa Clara County is Spanish at 17.6%, followed by Chinese at 9.7% and Vietnamese at 6.73%.

The following chart shows the races and ethnicities represented in Santa Clara County as a share of the total population.



AL MEDI-CONNECT ENROLLMENT COUNT

Source: 834 Enrollment File

LINE OF BUSINESS	Enrollment Count
Cal MediConnect (CMC)	10,264 (4.5% increase from 2020)

DESCRIPTION OF CAL MEDI-CONNECT:

Cal Medi-Connect is a dual eligible plan for members who qualify for both Medicare and Medi-Cal. Cal Medi-Connect enrollees receives Medicare and Medi-Cal benefits from one plan, such as hospital, medical and prescription drug benefits (Medicare Parts A, B and D benefits), In-Home Supportive Services (IHSS), Community Based Adult Services (CBAS), care coordination, and nursing home care.

MEMBER LANGUAGE and CULTURAL ASSESSMENTS

Table I: Member Languages Spoken at Home (N=10,264)

Language	Member Count	% of Members Speak the Language
English	4,159	41%
Spanish	1,908	19%
Vietnamese	1,632	16%
*Chinese	1,444	14%
Tagalog	337	3%
Other	292	3%

*Chinese is the combined total of Chinese, Mandarin and Cantonese

Top 4 - Most common non-English languages spoken by CMC Members:

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

As shown in Table I, SCFHP's Cal MediConnect member's most common non-English languages spoken are Spanish, Vietnamese, Chinese and Tagalog. Changes in member spoken languages from the previous year showed a decrease in English at 1% a increase in Spanish at 1%, Vietnamese increased by 1%. Chinese remained the same, at 14% and Tagalog decreased by 1%, overall no significant increase or decrease in the threshold languages.

Table II: MEMBER ETHNICITY/RACE (Top 4)

Source: 834 Enrollment File

Culture	Member Count	%
Hispanic	2,436	24%
Vietnamese	1,552	15%
Chinese	1,370	13%
Caucasian	1,283	13%

As shown in Table II, the top 4 member races are Hispanic, Vietnamese, Chinese and Caucasian.

External publications and studies relevant to SCFHP's service area were used to assess cultural traits on the top three member ethnicity/race (excluding Caucasian). Following is a summary of the publications and studies reviewed:

***Source**: Santa Clara County Public Health*

Hispanic

Studies showed that Hispanics/Latinos are the third largest racial/ethnic group in Santa Clara County and are projected to be the largest group by 2050. As the Hispanic population grows, the public health system in the county will continue to expand and adjust to meet changing health needs.

In 2017, at the request of the Santa Clara County Board of Supervisors, the Santa Clara County Public Health Department conducted a study on Latino/Hispanic health, with the goal of providing information that can be used to generate solutions to health issues within this population. The study showed that reliance on traditional medicine and health practices is common among Latinos/Hispanics. Culture is central in their health habits and due to the influence of traditional medical beliefs and health practices, many Latinos/Hispanics may simultaneously seek the help of both Western medicine and traditional healers.

Latinos/Hispanics have a deep rooted tradition of looking to extended family members and close family friends for emotional support and resources, which may support healthy behaviors and improve health. Family involvement in health care is common and health care providers are strongly advised to encourage such involvement and to include the family as a resource and focus of care in health planning, whether for individuals or a community. Faith and church remain powerful sources of hope and strength in the Hispanic community, especially in times of sickness.

Vietnamese

In 2011, the Santa Clara County Public Health Department (SCCPHD) completed the Vietnamese - American Health Assessment and reported that the Vietnamese culture, interactions and communication styles are important to adopt to meet the needs of this population. In Vietnamese culture, the traditional family is valued highly, and elders are greatly respected. For example, to show respect, elderly patients and family members should be addressed with a slight bow of the head. Certain hand gestures may be offensive

to this population, such as placing your hand on your hip while speaking.

The assessment also revealed significant health disparities within the community as well as cultural and language barriers preventing access to vital services. In 2016, the city of San Jose (the largest city in SCFHP's service area), a city with one of the largest Vietnamese population in the nation, opened its first Vietnamese American Community Center; known as the Shirakawa Community Center. The center demonstrates a need in the community for a place that celebrates the Vietnamese culture and provides services for the growing demographics. Having a dedicated center for the Vietnamese community provides immigrants, refugees, youth, and seniors with a center that meets cultural needs to call their own.

The findings of the SCCPHD assessment also resulted in a recommendation by the Office of the County Executive to construct the Vietnamese - American Service Center; a health center that honors the Vietnamese culture and is expected to open its doors in summer 2021 in the city of San Jose. The service center will deliver integrated, accessible and culturally responsive social and health services to support the local community, specifically the Vietnamese - American community. Its fundamental goal is connecting the community to the County services they need, in a seamless and collaborative model. The service center model will bring key County agencies together, to work in collaboration and address the overall needs of the Vietnamese community.

Chinese (data is within the Asian/Pacific Islander report)

A study by the Stanford School of Medicine reported that Pacific Islanders are a very diverse group and that it is important to avoid stereotyping. The study showed that in order for the clinical interaction to be meaningful, Pacific Islanders need to develop a sense of trust with their health care providers. They may initiate this process by trying to establish a "connection" with their physician or health care provider. This connection may involve questions to the provider regarding the community lived in, the school attended or work places. Not uncommonly, Pacific Islanders patients will start off the encounter by asking questions, trying to "find that connection".

In 2017, the County of Santa Clara Public Health Department (CSCPHD) completed an assessment which presented both secondary data and primary health survey data on Asian/Pacific Islander communities residing in Santa Clara County. Findings from this assessment served as a building block in the county's efforts to address health disparities in the Asian/Pacific Islander community. In 2018, the CSCPHD partnered with the Asian Americans for Community Involvement (AACI) to raise awareness of the unique issues affecting health and wellbeing of this population and to establish strategies to address key areas of concern for health, mental health and social determinants of health for Asian/Pacific Islanders and identified gaps in achieving healthy communities.

SCFHP has a provider network where members have access to medical and mental health services with providers who are sensitive to cultural diversity. For example, Gardner Health Services and Asian Americans for Community Involvement (AACI) are contracted provider groups who are dedicated to improving the health status of the communities we serve, especially the disenfranchised, disadvantaged and most vulnerable members. Gardner Health Services and AACI aligns with SCFHP's mission to provide high quality, comprehensive medical and mental health care, including prevention and education, early intervention, treatment and advocacy services which are affordable, respectful, culturally, linguistically and age appropriate..

SCFHP and its provider network recognizes that every member encounter is unique; every patient is different i n age, gender, ethnicity or religion and will bring to the medical encounter their individualized perspectives and experiences. Resources to increase awareness of cultural diversity are available to SCFHP's provider network and staff and are intended to help build sensitivity to differences and styles as a goal to improve patient- provider and patient-office staff communications and to foster an environment that is non-threatening and comfortable for Plan members.

To ensure provider awareness of cultural, racial and ethnic differences, SCFHP providers are required to complete a cultural competency training program, offered on SCFHP's website, which includes a Cultural Competency Toolkit with a guide on understanding cultural differences and how to establish effective communications with patients of all ethnic/racial and cultural backgrounds. Training objectives are to teach an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care.

Santa Clara Family Health Plan™

PROVIDER NETWORK THRESHOLD LANGUAGE ASSESSMENT– *Tables I - III shows the percentage of SCFHP network providers who speak threshold languages (Spanish, Vietnamese, Chinese and Tagalog). *The numbers below are rounded up to the nearest tenth.*

Table I: Primary Care Providers

Source: eVIps/ICAT

		Spanish (Member N=1,908)		Vietnamese (Member N=1,632)		Chinese (Member N=1,433)		Tagalog (Member N=337)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of	Providers-Tagalog	% of Providers
Family Practice	238	56	24%	26	11%	25	11%	5	2%
Internal Medicine	258	29	11%	31	12%	29	11%	6	2%

Table II: Specialists - High Volume/Impact

Source: eVips/ICAT

		Spanish (Member N=1,908)		Vietnamese (Member N=1,632)		Chinese (Member N=1,433)		Tagalog (Member N=337)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of Providers	Providers-Tagalog	% of Providers
Cardiology	133	15	11%	10	13%	4	3%	0	0%
Ophthalmology	199	69	17%	27	14%	29	15%	6	3%
Gynecology	266	79	30%	15	5%	7	3%	0	0%
Hematology/Oncolog	118	13	11%	7	6%	2	2%	1	1%

Table III: Behavioral Health Providers – High Volume

Source: eVIps/ICAT

		Spanish (Member N=1,908)		Vietnamese (Member N=1,632)		Chinese (Member N=1,433)		Tagalog (Member N=337)	
Provider Type	Provider Count	Providers-Spanish	% of Providers	Providers-Vietnamese	% of Providers	Providers-Chinese	% of Providers	Providers-Tagalog	% of Providers
Psychiatry	174	23	13%	9	5%	4	2%	2	1%
Clinical Social Worker	50	14	28%	9	18%	2	4%	0	0%
Family & Marriage Therapy	16	2	13%	0	0%	0	0%	0	0%

As noted in the report above, SCFHP does not have concrete data on provider ethnicity/race, therefore conclusions are drawn from the languages spoken by network providers.Tables I-III shows the number of network providers who can speak the top 4 languages and meet member cultural, ethnic/racial needs. The tables do not include provider staff who may also speak the top 4 languages and who may share the same cultural, ethnic/racial characteristics of SCFHP members.

Comparison from previous year assessment shows that the number of providers that speak threshold languages remained steady.

LANGUAGE LINE OR TRANSLATION REQUESTS

Table I: Member Language Line Requests

Language	Total Requests	Total Duration	% of Requests
Spanish	4,847	883 hrs	39%
Vietnamese	3,139	478 hrs	25%
Chinese	4,005	540 hrs	32%
Tagalog	359	61 hrs	3%

Table II: Member Face to Face Requests

Translation Type	Total Request	Total Duration	% of Requests
Sign Language	111	117 hrs	60%
Spanish	29	30 hrs	16%
Vietnamese	22	25 hrs	12%
Chinese	22	24 hrs	12%
Tagalog	0	0	0%

In Tables I & II, it shows the language line and member face to face translation data was analyzed two different ways, one was through the frequency of language selected and second was the duration of the calls and face to face translation services.

Available access to interpreter services for members is a foundational element of Medicare - Medicaid plans. This could take the shape of telephonic or face to face interaction with a qualified interpreter. SCFHP provides this service through a vendor free of charge to its members and providers. SCFHP members have access to interpreter services 24 hours a day, 7 days a week. The plan also hires bilingual customer service representatives to further promote timely and quality access to language interpretation.

To ensure provider awareness of language assistance services and requirements, SCFHP providers are required to complete a cultural competency training program, offered on SCFHP's website, which includes a Cultural Competency Toolkit with a guide on using interpreter services. Training objectives are to teach an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care.

To further understand membership language diversity and potential barriers to care due to language barriers, as shown above in Section F (Tables I and II), SCFHP annually reviews data from its Language Line and Face to Face interpreter services reports.

The raw data showed that twenty eight (28) different languages were requested for interpreter services; some of which are not frequently seen, such as Portuguese, Swahili, and Tigrinya. While there were several other languages requested for interpreter services, it does not appear that there is a growing population outside of the threshold languages identified and spoken by SCFHP members in this report.

MEMBER GRIEVANCES

Table I. Member Language, Ethnicity/Race Complaints

Service Type	Language	Description	Quarter
Provider	Spanish	Member was dissatisfied with their Primary Care Physician, they did not offer and interpreter and refused to schedule an appointment	Q1
Interpreter	Farsi	Member was dissatisfied with the interpreter, arrived 34 minutes late.	Q2
Interpreter	Mandarin	Member reported face to face interpreter did not show up and member was unable to be seen.	Q3
Interpreter	American Sign Language (ASL)	Member was dissatisfied with the face to face interpreter, the interpreter arrived 20 minutes late and offered medical advice once the provider left the room. Member stated they have had negative experiences with this interpreter the past 2-3 months.	Q4

An assessment of member complaints against language/interpreter services and cultural/racial preferences was completed. The chart above are some examples from each quarter, the resolution of those complaints are as follows:

(Q1) Compliant was reported to the Quality Cultural and Linguistics team for tracking purposes. The provider was educated regarding interpreter services. The provider shared they did not refuse to see the member, they were advising to bring a family member along to understand treatment plan and follow ups.

(Q2) Compliant was reported to the Quality Cultural and Linguistics team who reported the incident to the language/interpreter vendor. The language/interpreter vendor investigated and found that the interpreter did arrive on time (checked in at 2:45 pm, appointment time was 3:00 pm) and was asked to wait outside because there were too many people in the waiting area. The interpreter waited outside until they were called in for the appointment (3:25 pm).

(Q3) the complaint was reported to the Quality Cultural and Linguistics team who reported the incidents to the language/interpreter vendor. The language/interpreter vendor assured that the complaints would be addressed with their staff and will continue to work on improving the quality of interpretation services.

(Q4) the complaint was reported to the Quality Cultural and Linguistics team who reported the incidents to the language/interpreter vendor. The language/interpreter vendor states that due to the short notice to book this encounter, the interpreter did call the providers office to explain he was running late in an effort to accommodate the members request. The interpreter also denied providing any medical advice, once the

doctor left the room he only helped member to schedule their next appointment. The vendor agreed to no longer schedule services with this interpreter for the member for future request and share this interpreter is a valued employee and they disagree with the members view on his professionalism.

The assessment on member complaints did not identify trending and the data showed complaints within acceptable limits.

Conclusion:

SCFHP and Santa Clara County officials has a long-standing commitment to the health and well-being of all its community regardless of race, ethnicity, age or gender. SCFHP will continue to partner with community stakeholders to help improve the overall health of its diverse membership.

The assessment revealed that there are no significant disparities in meeting member cultural, ethnic/racial and linguistic preferences, which concludes that member needs are being met overall; thus, no adjustments to the provider network are necessary at this time.

While SCFHP did not identify disparities to meet language or cultural needs of its members, the Plan will continue to seek available providers with diverse backgrounds and language skills to ensure member needs continue to be met. SCFHP will also continue to evaluate the needs of its members to ensure they receive the care and services they need in a culturally sensitive manner and in their preferred language.

PARTICIPANTS:
Provider Network Operations Data Analyst
Timely Access and Availability Work Group
Quality Improvement
Behavioral Health
Grievances and Appeals
Provider Relations

Approving Committee	Date of Approval	Recommendations
Quality Improvement Committee (QIC)		None

Santa Clara Family Health Plan™

2022 Cal MediConnect (CMC) Population Health Assessment

June 14, 2022

Lucille Baxter, Manager of Quality and Health Education

2022 Cal-MediConnect (CMC) Population Health Assessment

Agenda

1. Introduction
2. Top Needs and/or Populations Identified:
    a. Financial Insecurity
    b. Language
    c. Transportation
    d. Admission for Sepsis
    e. Members with Multiple Uncontrolled Chronic Conditions
3. Next Steps

2022 CMC Population Health Assessment

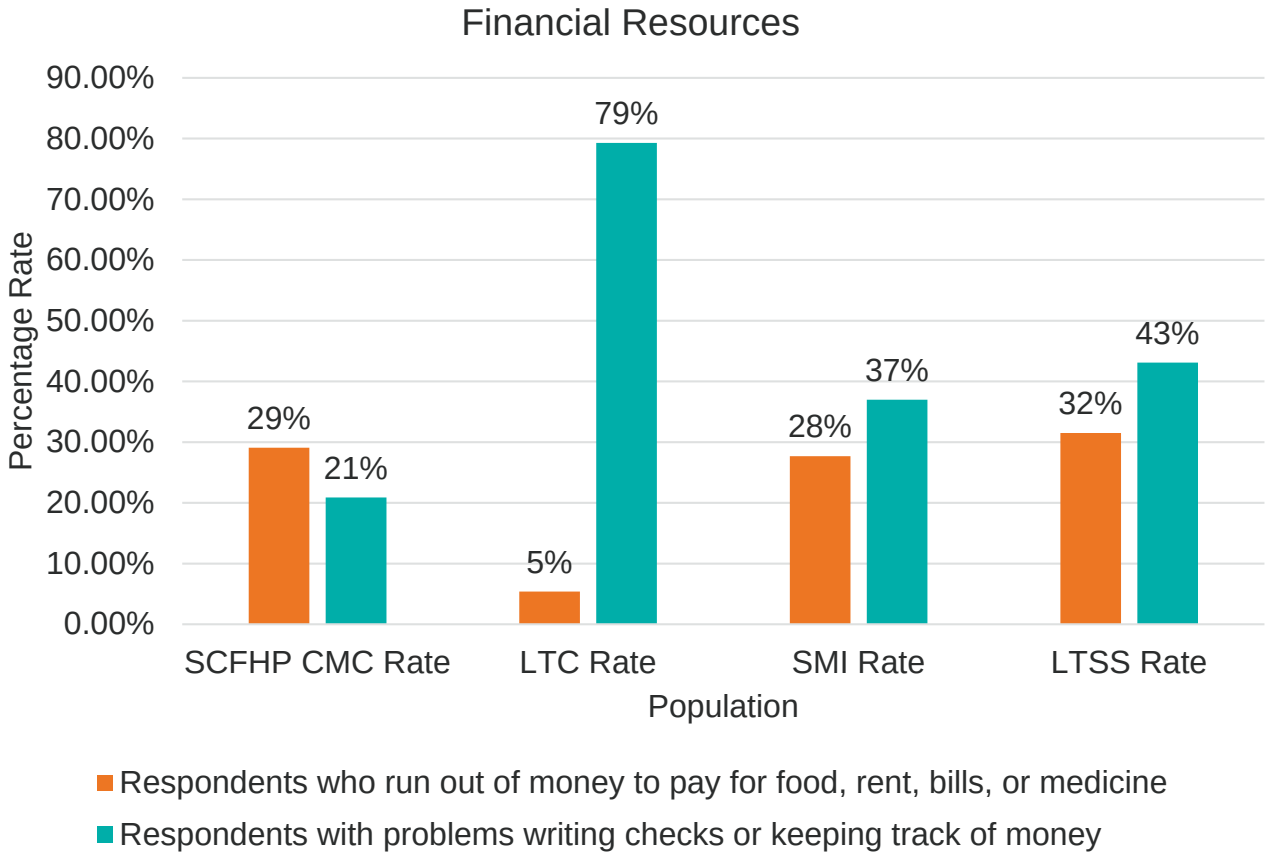
Introduction

- SCFHP annually assesses the characteristics and needs of its CMC membership by analyzing multiple data sources (e.g. claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics)
- Purpose of the population health assessment (PHA):
  - Address member needs and connect them with appropriate programs and services
  - Strengthen existing practices and develop new resources and interventions to better serve CMC members, reduce disparities, and improve outcomes

2022 CMC Population Health Assessment

Financial Insecurity

- 29% of SCFHP CMC members reported they run out of money to pay for food, rent, bills, or medicine.
- 21% of SCFHP CMC members had problems writing checks or keeping track of their money.

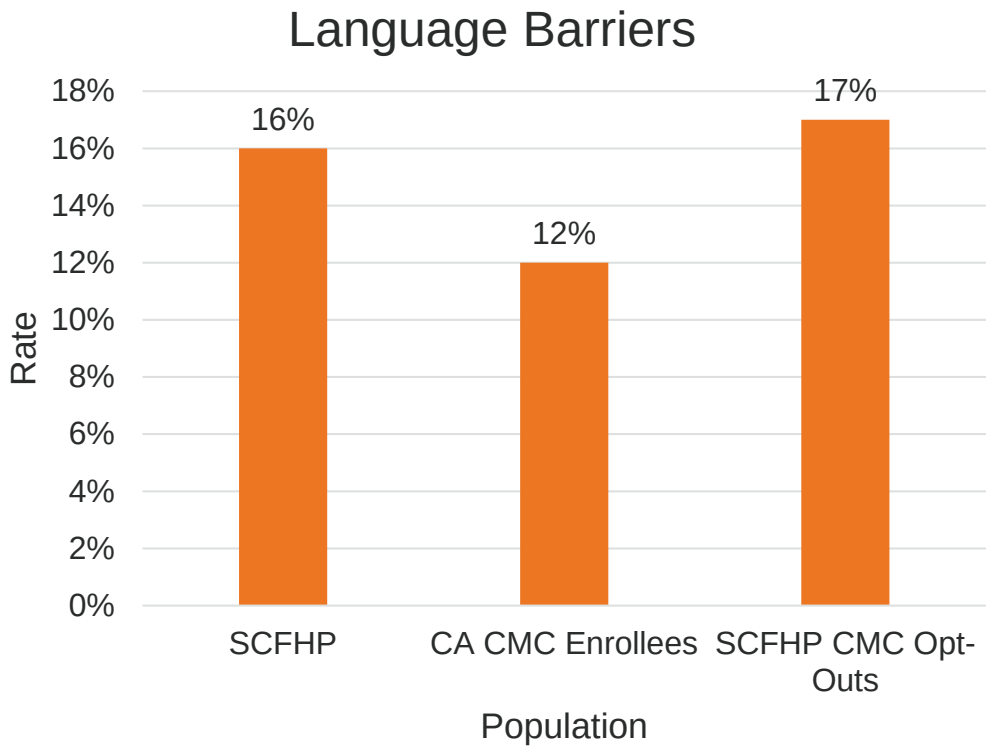


Data Source: Health Risk Assessment Result 2021

2022 CMC Population Health Assessment

Language

- 16% of SCFHP CMC members reported that their health care provider did not speak their language and/or had no interpreter available.

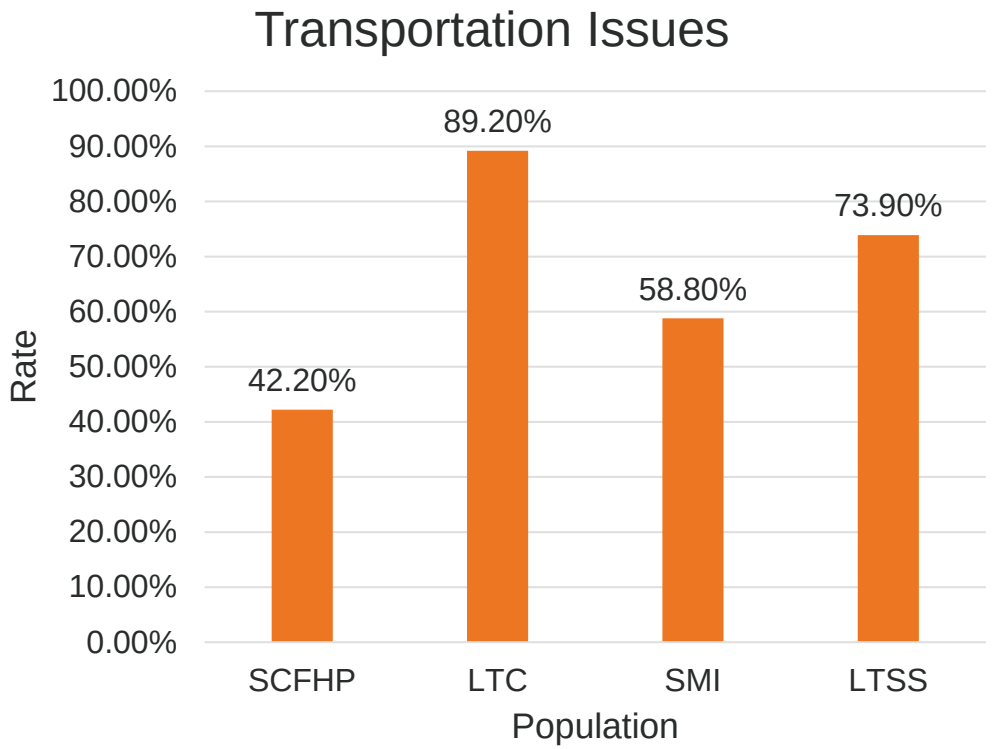


Data Source: SCAN ('15-'17)

2022 CMC Population Health Assessment

Transportation

- 42.20% of SCFHP CMC members needed a ride to see the doctor or friends.
- CMC members with Long Term Care (LTC) and Long Term Services and Supports (LTSS) report higher rates of needing a ride to see their doctor or friends than the average member

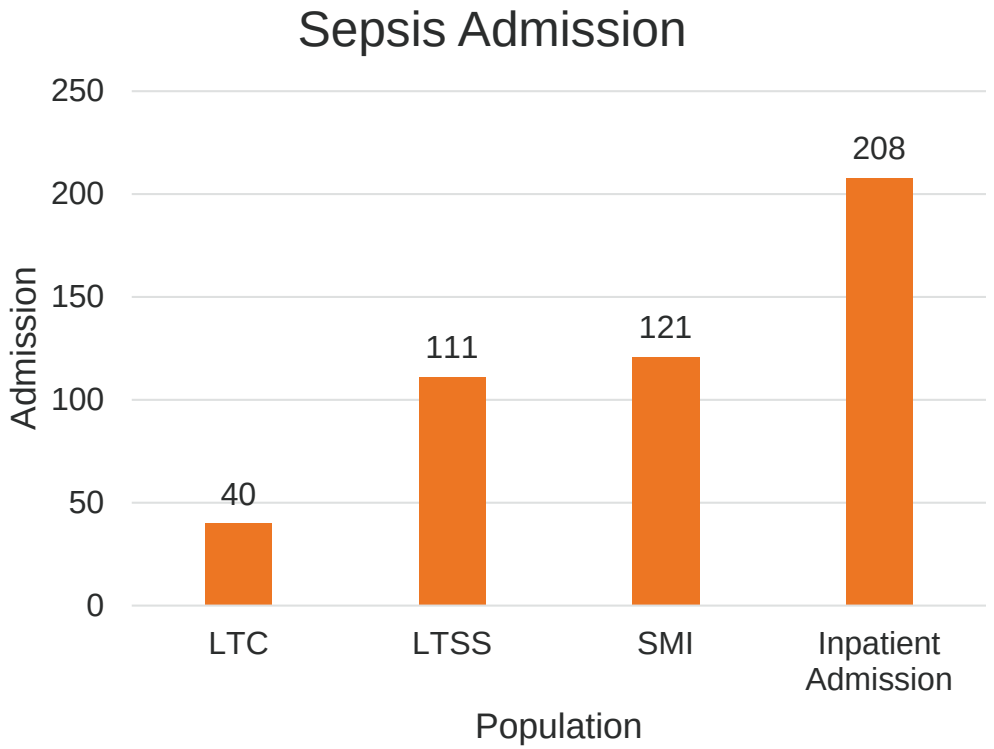


Data Source: Health Risk Assessment Result 2021

2022 CMC Population Health Assessment

Admission for Sepsis

- The most common diagnosis for inpatient hospitalization is Sepsis among the LTC, LTSS, and SMI sub-populations.



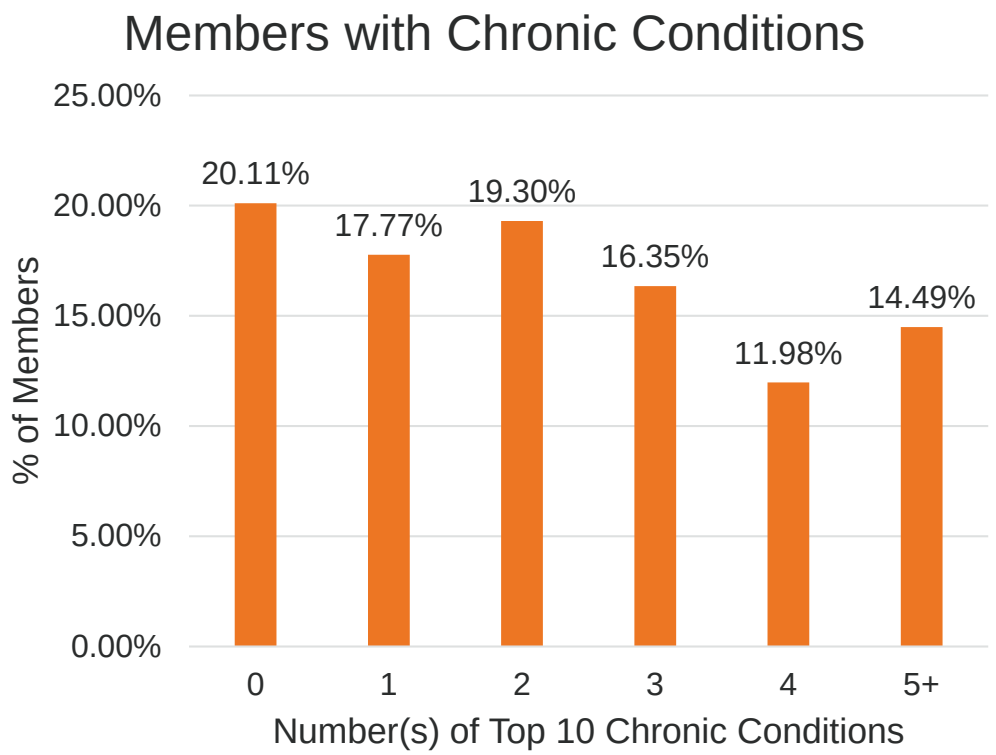
Total admission for Sepsis= 480

2022 CMC Population Health Assessment

Members with Multiple Uncontrolled Chronic Conditions

- 80% of the CMC enrollees have 1+ chronic condition
- 42% of the CMC members have 3+ chronic conditions
- Top 10 chronic conditions:

1. Hyperlipidemia
2. Diabetes
3. Chronic kidney disease
4. Rheumatoid arthritis
5. Anemia
6. Depression
7. Acquired hypothyroidism
8. Ischemic heart disease
9. Osteoporosis
10. Glaucoma



2022 CMC Population Health Assessment

Next Steps

- Review and update population health management (PHM) activities and resources accordingly to address identified member needs.
- Review community resources for integration into program offerings to address identified member needs.

Santa Clara Family Health Plan™

Questions?

2022 Cal MediConnect (CMC) Population Health Assessment

Quality Improvement Committee Review: June 14, 2022

Table of Contents

Background

Santa Clara Family Health Plan (SCFHP) is a not-for-profit organization established in 1997 that offers comprehensive and affordable health coverage for low-income residents in Santa Clara County, California. SCFHP currently services over 11,000 beneficiaries under its Cal MediConnect (CMC) line of business. In order to qualify for the optional program, beneficiaries must meet the following criteria: live in Santa Clara County; be 21 years of age or older; have both Medicare Part and B and be eligible for full-scope Medi-Cal.

Introduction

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

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

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

1. Population Demographics

SCFHP serves a diverse CMC population, with women making up 59% of the population. A large portion of the CMC population are ages 60 and older. Beneficiaries ages 60 to 89 represent 83% of the CMC population. Hispanic beneficiaries made up 24% of the CMC population during calendar year 2021, with Vietnamese representing 15%, Caucasian representing 13% and Chinese representing 12%. Over 40% of the population lists English as their primary language. Other languages that represent the SCFHP population include: Spanish at 20%; Vietnamese at 17%; and Chinese at 14%. Approximately 95% of SCFHP CMC enrollees have disabilities. Majority of the CMC population who are disabled are 65 years and older. CMC enrollees utilizing LTSS have higher rates with disabilities compared to other subpopulations such as LTC and SMI.

Gender

Gender	Member Count	Percentage
Female	6,814	59.05%
Male	4,725	40.95%
Total	**11,539**	**100.00%**

Table 1.1. Member Demographics: Gender

Age

Age Group	Member Count	Percentage
< 29 years	55	0.48%
30-39 years	186	1.61%
40-49 years	297	2.57%
50-59 years	678	5.88%
60-69 years	2939	25.47%
70-79 years	4279	37.08%
80-89 years	2389	20.70%
90-99 years	675	5.85%
100+ years	41	0.36%
Total	**11,539**	**100.00%**

Table 1.2. Member Demographics: Age

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

Ethnicity	Member Count	Percentage
HISPANIC	**2,786**	**24.14%**
<65 years	530	4.59%
65-74 years	1221	10.58%
75+ years	1035	8.97%
VIETNAMESE	**1,753**	**15.19%**
<65 years	122	1.06%
65-74 years	1012	8.77%
75+ years	619	5.36%
CAUCASIAN	**1,524**	**13.21%**

<65 years	495	4.29%
65-74 years	594	5.15%
75+ years	435	3.77%
CHINESE	**1,480**	**12.83%**
<65 years	37	0.32%
65-74 years	491	4.26%
75+ years	951	8.25%
OTHER	**1,027**	**9.03%**
<65 years	261	2.29%
65-74 years	508	4.47%
75+ years	258	2.27%
FILIPINO	**667**	**5.78%**
<65 years	61	0.53%
65-74 years	328	2.84%
75+ years	278	2.41%
All remaining ethnicities with less than 5%	**2,302**	**19.94%**
Total	**11,539**	**100.00%**

Table 1.3. Member Demographics: Ethnicity

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

Primary Language	Member Count	Percentage
ENGLISH	**4,616**	**43.30%**
<65 years	1426	13.38%
65-74 years	2033	19.07%
75+ years	1157	10.85%
SPANISH	**2,202**	**20.65%**
<65 years	228	2.14%
65-74 years	1030	9.66%
75+ years	944	8.85
VIETNAMESE	**1,867**	**17.51%**
<65 years	97	0.91%
65-74 years	1094	10.26%
75+ years	676	6.34%
CHINESE*	**1,564**	**14.68%**
<65 years	17	0.16%
65-74 years	484	4.54%
75+ years	1063	9.98%
AMERICAN SIGN LANGUAGE	**17**	**0.16%**
<65 years	14	0.13%
65-74 years	3	0.03%

75+ years	0	0%
All remaining languages with less than 5%	**1,306**	**11%**
Total	**11,539**	**100.00%**

Table 1.4. Member Demographics: Primary Language

*Chinese includes Mandarin and Cantonese speakers.

Disabled Population

CMC Population	Member Count	Percentage
NON-DISABLED	**511**	**4.42%**
<65 years	185	1.60%
65-74 years	186	1.61%
75+ years	140	1.21%
DISABLED	**11,028**	**95.58%**
<65 years	1683	14.59%
65-74 years	4934	42.76%
75+ years	4411	38.23%
Total	**11,539**	**100.00%**

Table 1.5. Member Demographics: Disabilities

CMC Population	Non-Disabled				Disabled			
Age	# of Total Members	Sum of LTC	Sum of LTSS	Sum of SMI	# of Total Members	Sum of LTC	Sum of LTSS	Sum of SMI
<65 years	185	17	40	28	1683	21	498	485
65-74 years	186	31	3	32	4934	49	876	403
75+ years	140	69	2	36	4411	103	2015	524

Table 1.6. CMC Beneficiaries by subpopulation (LTC, SMI, LTSS)

2. Social Determinants of Health

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

In reviewing CMC population, SCFHP opted to review the SDOH by utilizing the framework outlined by *Healthy People 2030* [4] and supported by the CDC:

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

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

Economic Stability

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

Three different data sources indicates that almost 29% of CMC members ran out of money for their food, rent, bills or medicines. Also 1.74% CMC members responded that they have to make decision between food, medication and other basic necessities because of financial instability. These figures, in conjunction with rates of members who report having problems writing checks, keeping track of money, or who need assistance managing money, potentially indicate a lack of financial knowledge.

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

It was also identified that 2.60% of CMC population delayed or did not fill the prescription because they felt they couldn't afford it which again indicate lack of knowledge about covered benefits and services along with community resources.

Financial Resources

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Members who have to make choices between food, medication, heat, or other necessities because of financial concerns	1.74% (N=863)				2021 Signify SDOH Report – 11/3/2021
Members who delayed or did not fill a prescription because they felt they could not afford it	2.60% (N=533)				2021 Santa Clara CAHPS Report Survey
Respondents who run out of money to pay for food, rent, bills, or medicine	29.1% (N=6,670)	5.4% (N=204)	27.7% (N=880)	31.5% (N=2,030)	HRA Results (2021)
Respondents with problems writing checks or keeping track of money	20.9% (N=6,617)	79.3% (N=203)	37.0% (N=872)	43.1% (N=1,983)	HRA Results (2021)
Respondents in need of assistance managing money	2.78% (N=863)				2021 Signify SDOH Report – 11/3/2021

Table 2.1. Economic Stability and Financial Resources

Education

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

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

Table 2.2. Level of education achieved

Language Ultilization

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

Spanish (20%), Vietnamese (17%), and Chinese (14%) are most commonly spoken languages by SCFHP CMC members (Table 1.4). However, 16% of CMC enrollees faced language barriers to care which is higher than average in the state of California (12%).

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

Table 2.3. Language

Face-to-Face Interpretation Requests by Language	Number of Requests
Spanish	29
Vietnamese	22
Chinese	22
Tagalog	0
American Sign Language	111
Other	1
Total	**185**

Table 2.4. Face-to-Face Interpretation Requests in 2021

Alternative Format	Number of Requests
Audio CD	1
Braille	0
Large Print	15
Total	**16**

Table 2.5. Alternative Format Requests in 2021

In 2021, SCFHP's primary language vendor was utilized for 185 CMC beneficiaries for face-to-face interpretation services for their health care needs. 16 CMC beneficiaries have submitted alternative format request to receive their health information as large print, audio CD or in braille.

In 2021 Q1-Q3, SCFHP's primary language vendor, was utilized for over 12,000 calls for CMC beneficiaries. Telephone interpretation requests were made for 47 languages. Top three requested languages included: Spanish (3,897), Chinese (3,126), and Vietnamese (2,994). Table 2.5. shows the breakdown of language services utilization by CMC beneficiaries in 2021 Q1-Q3. Although there are more beneficiaries that speak Vietnamese than Chinese, there were more requests for Chinese interpretation (26%) than Vietnamese (25%). This suggests that's members are seeking assistance from family members to assist with health needs and not utilizing SCFHP interpretation services.

Language	Number of Calls	Percentage
Spanish	3,897	32.3%
Chinese	3,126	25.9%
Vietnamese	2,994	24.9%
Tagalog	710	5.9%
Farsi	237	2.0%
Punjabi	183	1.5%
Russian	182	1.5%
Other	397	6.0%
Total	**12,049**	**100%**

Table 2.6. Telephone Utilization of Interpretation Services by CMC Beneficiaries in 2021 Q1-Q3

Social and Community Context

Support System

Social support system or social relationship is key part for physical and mental health. Relationships are often interpreted as social cohesion, social capital and social network. Having a social network also provides emotional support (e.g. motivation to be compliant on treatment regimen or encourage to get back to regular routine after traumatic event) and instrumental support (e.g. ride to medical appointment).[3]

CMC members with LTC and LTSS report higher rates of needing a ride or see the doctor or friends than the plan average and the LTC populations.

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

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Respondents without family members or others willing and able to help when needed	13.5% (N=6,675)	13.2% (N=204)	15.6% (N=880)	11.8% (N=2,022)	HRA Results (2021)
Respondents in need of a ride to see the doctor or friends	42.2% (N=6,691)	89.2% (N=204)	58.8% (N=880)	73.9% (N=2,025)	HRA Results (2021)
Respondents in need of assistance to see family or friends	33.7% (N=6,594)	69.5% (N=203)	46.4% (N=862)	64.1% (N=1,977)	HRA Results (2021)

Table 2.7. Support System

Social Interactions

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

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Living alone	28.3%				2021 Santa Clara CAHPS Report Survey
"Yes" response to the question: are you afraid of anyone or is anyone hurting you?	4.4% (N=6,741)	1.9% (N=204)	4.9% (N=886)	5.5% (N=2,036)	HRA Results (2021)
Members experiencing loneliness or social isolation	4.87% (N=863)				2021 Signify SDOH Report – 11/3/2021

Table 2.8. Social Interaction

Loneliness or Social Isolation

The high rates reported for CMC enrollees that they never feel lonely, although members utilizing LTSS services reported that they felt loneliness more than 15 days a month (10%) to most of the days (9%).

Over the past month (30 days), how many times have you felt lonely?	All CMC N=6,699	LTC N=197	SMI N=877	LTSS N=2,019
<5 days	22.1%	71.5%	29.2%	26.9%
>15 days	7.3%	8.6%	10.1%	10.3%
Most Days (Always feel Lonely)	6.6%	4.6%	11.1%	9.4%
None (Never feel Lonely)	64.0%	15.2%	49.5%	53.4%

Table 2.9. Loneliness or Social Isolation

Health and Health Care

Access to Care

According to HEDIS® measure Adults Access to Preventive/Ambulatory Health Services (AAP) rate is 91%. This measure assesses whether members 20 years and older had a preventive or ambulatory visit to their physician in 2021. Health care visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions. CAHPS and SCAN reports/surveys indicate that there is still opportunity to improve access to care – less than 76% of respondents said that they were getting their needed care, or getting appointments and care quickly. SCFHP has lower rates of satisfaction than the statewide average for CMC enrollees with the wait time to see a doctor when they need an appointment, while a higher rate of respondents' report that the physician they were seeing is not available through the SCFHP provider network.

Measure	SCFHP Rate/Score	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Getting needed care	75.9%			2021 Santa Clara CAHPS Report Survey
Getting appointments & care quickly	73.5%			2021 Santa Clara CAHPS Report Survey
Good communication from clinicians	91.7%			2021 Santa Clara CAHPS Report Survey
Respondents satisfied with the wait to see a doctor when they need an appointment	73%	78%	75%	SCAN ('15-'17)
Respondents who said the doctor they were seeing is not available through SCFHP	20%	18%	17%	SCAN ('15-'17)

Table 2.10. Access to Care

Health Literacy

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

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

Table 2.11. Health Literacy

Health Status

SCFHP CMC beneficiaries have, based on claims data, higher prevalence in the listed below conditions than the national average for the same conditions, as well as higher than Santa Clara County. 80% of the CMC enrollees have at least one chronic condition and 42% of the CMC members have three or more chronic conditions.

Top 10 chronic onditions are as follows:

1. Hyperlipidemia
2. Diabetes
3. Chronic Kidney Disease
4. Rheumatoid Arthritis
5. Anemia
6. Depression
7. Acquired hypothyroidism
8. Ischemic Heart Disease
9. Osteoporosis
10. Glaucoma

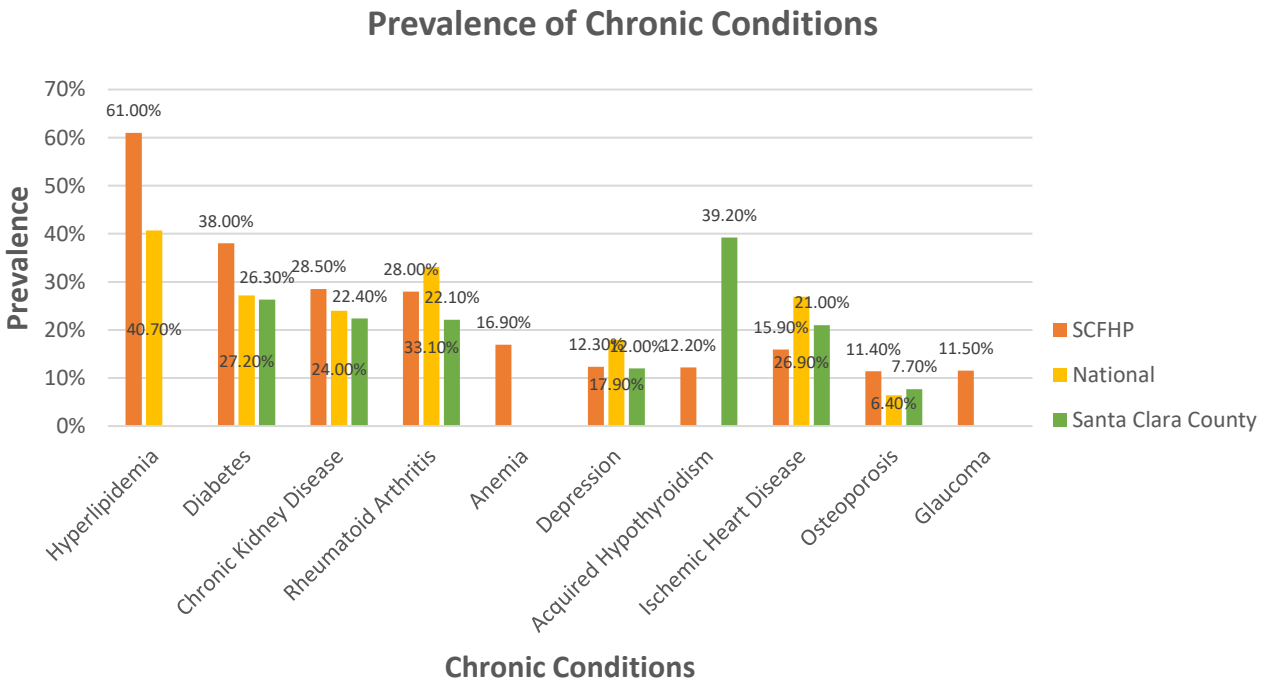


Table 2.12. Top 10 prevalence of chronic conditions for CMC members at SCFHP

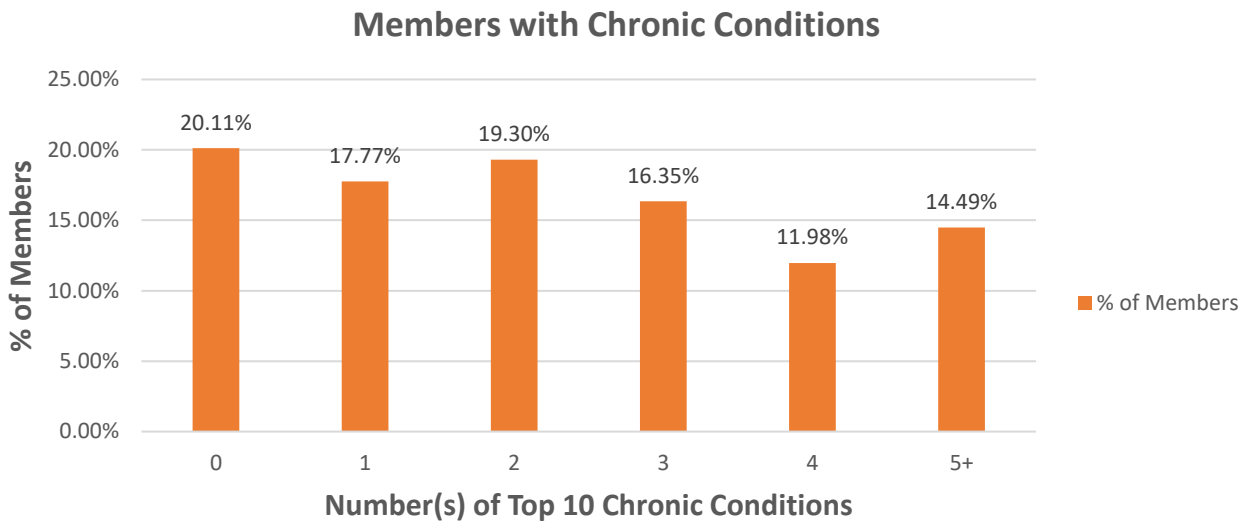


Table 2.13. SCFHP CMC members with multiple top 10 chronic conditions

Knowledge of Condition

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

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

Chronic Condition		SCFHP Rate	National Rate	Santa Clara County Rate	Knowledge of Condition[1]			
					CMC (N=6,097)	LTC (N=205)	SMI (N=869)	LTSS (N=1986)
Hyperlipidemia	High Cholesterol	61.0%	40.70%		52.3%	84.1%	73.8%	64.8%
Diabetes	Diabetes	38.0%	27.20%	26.30%	37.0%	39.5%	39.7%	37.4%
Chronic Kidney Disease	Kidney Problem	28.5%	24.00%	22.40%	4.9%	15.6%	11.0%	7.0%
Rheumatoid Arthritis Osteoarthritis	Arthritis/ Arthritis-Rheumatoid	28.0%	33.10%	22.10%	32.7%	32.7%	32.2%	40.5%
Anemia		16.9%			9.6%	45.3%	34.6%	18.0%
Depression	Depression	12.3%	17.90%	12.00%	16.9%	38.5%	28.0%	21.1%
Acquired Hypothyroidism	Thyroid problems	12.2%		39.20%	9.4%	25.6%	18.5%	12.8%
Ischemic Heart Disease	Heart Problems/ Congestive	15.9%	26.90%	21.00%	5.0%	15.6%	18.6%	7.5%

	Heart Failure (CHF)							
Osteoporosis	Osteoporosis	11.4%	6.40%	7.70%	9.4%	17.9%	11.7%	15.7%
Glaucoma	Limited Vision	11.5%			27.8%	36.6%	27.5%	33.6%

Table 2.14. Knowledge of condition

Quality of Care

Fewer SCFHP CMC beneficiaries expressed satisfaction with their physicians working together than CMC enrollees across the state and then individuals who opted-out of the SCFHP CMC program. SCFHP CMC program is made up of doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. They all work together to provide the members with the care they need such as health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. LTSS help you stay at home instead of going to a nursing home or hospital.

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

Table 2.15. Quality of care

The HEDIS scores below are measures for which SCFHP is at less than or equal to the 10th percentile for CMC in 2021.

Measure	Sub Measure	SCFHP Rate/Score	2021 Quality Compass 50th Percentile	Data Source
BCS: Breast Cancer Screening		64.91%	70.34%	HEDIS 2021 Preliminary Rates
COL: Colorectal Cancer Screening		60.18%	72.02%	HEDIS 2021 Preliminary Rates
CDC: Comprehensive Diabetes Care	Eye Exam	69.83%	69.34%	HEDIS 2021 Preliminary Rates
	HbA1c Testing	91.00%	92.46%	HEDIS 2021 Preliminary Rates
	Medical Attention for Nephropathy	91.00%	94.74%	HEDIS 2021 Preliminary Rates
OMW: Osteoporosis Management in Women Who Had a Fracture		20.45%	37.28%	HEDIS 2021 Preliminary Rates

MRP: Medication Reconciliation Post-Discharge		37.47%	63.75%	HEDIS 2021 Preliminary Rates
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack		83.33%	87.80%	HEDIS 2021 Preliminary Rates
Pharmacotherapy Management of COPD Exacerbation	Bronchodilator	93.18%	83.52%	HEDIS 2021 Preliminary Rates
Statin Therapy for Patients with Cardiovascular Disease	Statin Adherence 80% - Total	87.05%	85.13%	HEDIS 2021 Preliminary Rates
Statin Therapy for Patients with Diabetes	Statin Adherence 80% - Total	85.39%	83.76%	HEDIS 2021 Preliminary Rates

Table 2.16. HEDIS

Neighborhood and Built Environment

Access to Transportation

Despite transportation utilization and costs increasing rapidly for the plan, 16% of respondents to the SCAN survey reported issues with transportation that kept them from getting needed healthcare, while 13% of CMC respondents on a Risk Adjustment in Home Assessment report indicated that they need assistance with driving and/or arranging transportation.

Measure	Rate	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Respondents with transportation problems that kept them from getting needed healthcare	16%	13%	18%	SCAN ('15-'17)
Members who need assistance with driving and/or arranging transportation	13% (N=863)			2021 Signify SDOH Report – 11/3/2021

Table 2.17. Access to Transportation

Housing

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

Measure	Rate	Data Source
Members who need help with laundry and/or housekeeping	6.26% (N=863)	2021 Signify SDOH Report – 11/3/2021

Table 2.18. Housing

Quality of Air & Water

Air quality: According to Bay Area Air Quality Management District, there were 2 days where particulate matter of 2.5 exceeded the national standard compared to 25 days on 2021.[5]

Water quality: According to Santa Clara Valley Water District review there are no contaminants above maximum levels in 2021.[6]

3. Subpopulation

This document looks at three subpopulations – members in Long Term Care (LTC), members with Severe Mental Illness (SMI), and members utilizing Long Term Support Services (LTSS). [*Appendix A* – Subpopulation Definitions 38% SCFHP CMC beneficiaries eligible for subpopulation. As these three groups are not mutually exclusive, a few combinations are also included. These combinations are made based on the one or more services utilized by subpopulation in measurement year (2021). Combinations such as members in LTC with SMI and who also utilized LTSS in measurement year; members in LTC with SMI who did not utilize LTSS; members in LTC who utilized LTSS but do not have SMI; members who have SMI and utilized LTSS.

Long Term Care (LTC)

LTC is an institute who provides variety of services medical and non-medical needs of people with disabilities and/or chronic illness who cannot care for themselves for longer period. The goal of these services are to indorse independence, maximize quality of life and meet the need of patients. SCFHP CMC beneficiaries has a very small subpopulation (1.5%) of members in LTC. However, these members experience many barriers in the form of social determinants of health. For example, 89% LTC members require a ride to see the doctor. 79% have difficulty writing checks or keeping track of money. Social determinants of health such as transportation and financial management needs have to be addressed in the case management of LTC members.

Serious Mental Illness (SMI)

Approximately 1,500 (12.24%) CMC enrollees have a mental health diagnosis. SCFHP collaborates with the County Behavioral Health Services Department (CBHSD), which serves consumers ages 18 and above. The CBHSD Call Center screens individuals for functional impairments, such as homelessness, lack of support, and recent job loss, etc. and direct individuals based on diagnosis. Once the screening has been completed, CBHSD refers individuals who are identified as SMI to either a county mental health clinic or a community based organization (CBO) for services. These are considered specialty mental health providers and may include: psychiatry, therapy, and case management. Please refer to the CBHSD screening tools in Appendix B.

Those identified as mild to moderate are accommodated within a county clinic or are referred to SCFHP for placement within the health plans' network for services. SCFHP Behavioral Health Department's Social Workers assists with care coordination to meet the needs of all beneficiaries that are referred, including: shared care plans, integrating care plan goals, assistance with transportation to medical appointments, coordinating medical care with primary and specialty care and behavioral health care to identify unmet needs, ensuring follow up care is received, etc. The health plan receives SMI referrals from CBHSD and SCFHP staff. Services are initiated within 15 days once a referral is received.

Long Term Support and Services (LTSS)

A subset of the CMC population are beneficiaries living with multiple chronic conditions and limited functional capacity that makes it difficult for them to live independently without LTSS, SCFHP defines these members as the disabled population. These individuals require assistance with at least three activities of daily living, are in poor or fair health and may have cognitive impairments or behavioral health issues. These members frequently have needs related to transportations and financial insecurity. 74% of LTSS members reported needed transportation help in order to see their doctor or family members. 32% reported running out of money and 43% reported having trouble tracking money. They can either be living

in the community or a long-term care nursing facility, and a population at high risk for falls and isolation due to their impairments. Nearly 3,400 (29.37%) enrollees utilized LTSS in the measurement year. To meet the needs of SCFHP's members with disabilities the following LTSS programs are included for CMC beneficiaries:

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

Of the subpopulations and amalgamations reviewed, the largest population was those who utilize LTSS services (regardless of whether or not they have SMI or utilized LTC). On the other side, 14% SCFHP CMC enrollees have SMI and also utilized LTC and LTSS in the measurement year. In this report subpopulations with less than 150-member count are excluded from further utilization assessment as there is not enough data to study the need in emergency room and inpatient utilization.

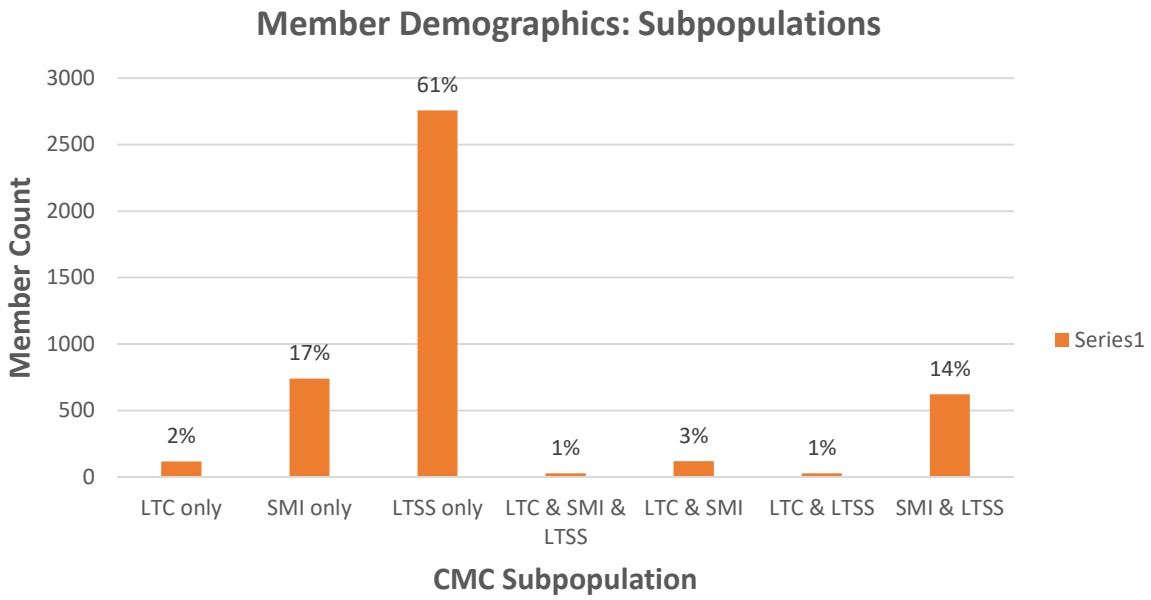


Chart 3.1. Member Demographics: Subpopulation

Utilization

The report below provides an overview of most common discharge diagnosis from emergency room (ER) visits and inpatient admissions for SCFHP CMC beneficiaries. The overall utilization for CMC enrollees in 2021 were 18% had an ER visit and 12% had an inpatient admission.

Inpatient Utilization

Reviewing the in-depth utilization below indicates that the most common diagnosis for inpatient hospitalization is sepsis among the LTC, LTSS and SMI subpopulations. Hypertensive heart and chronic kidney disorder and acute respiratory disease are the second and third most common discharge diagnosis among CMC enrollees with SMI and/or member utilizing LTSS.

LTC Top 5 Primary Diagnosis (Dx1)

Diagnosis Code	Description	Total
A419	Sepsis, unspecified organism	40
A4189	Other specified sepsis	12
U07.1	COVID-19	9
I110	Hypertensive heart disease with heart failure	7
N179	Acute kidney failure, unspecified	6

LTSS Top 5 Primary Diagnosis (Dx1)

Diagnosis Code	Description	Total
A419	Sepsis, unspecified organism	111
I130	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	43
U07.1	COVID-19	38
I110	Hypertensive heart disease with heart failure	30
N179	Acute kidney failure, unspecified	22

SMI Top 5 Primary Diagnosis (Dx1)

Diagnosis Code	Description	Total
A419	Sepsis, unspecified organism	121
I130	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	67
I110	Hypertensive heart disease with heart failure	59
U07.1	COVID-19	34
N179	Acute kidney failure, unspecified	31

Table 3.1.1. Most Common Discharge Diagnosis From Inpatient Admission

Diagnosis Code	Description	Total
A419	Sepsis, unspecified organism	208
U07.1	COVID-19	78
I130	Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	67
I110	Hypertensive heart disease with heart failure	60
A4189	Other specified sepsis	45

Emergency Room Utilization

The most common discharge diagnosis from ER visits among LTC, SMI and LTSS subpopulations are chest pain, dizziness, and urinary tract infection. Members utilizing LTSS have been to the ER more often than

the LTC and SMI subpopulations. The most ER visits among ethnicities were American Indian/Alaskan Native, Black or African Ancestry and White. The most ER visits among languages were American Sign Language with 1,143 visits.

LTC Top 5 Primary Diagnosis (Dx1)

Diagnosis Code	Description	Total
R42	Dizziness & giddiness	9
R0789	Other chest pain	9
R51.9	Headache, unspecified	8
K9423	Gastrostomy malfunction	7
R079	Chest pain, unspecified	6

LTSS Top 5 Primary Diagnosis (Dx1)

Diagnosis Code	Description	Total
N390	Urinary tract infection, site not specified	46
R42	Dizziness & giddiness	39
R079	Chest pain, unspecified	37
F4325	Adjustment disorder with mixed disturbance of emotions and conduct	27
R55	Syncope and collapse	26

SMI Top 5 Primary Diagnosis (Dx1)

Diagnosis Code	Description	Total
R079	Chest pain, unspecified	45
F4325	Adjustment disorder with mixed disturbance of emotions and conduct	41
R0789	Other chest Pain	34
N390	Urinary tract infection, site not specified	30
F29	Unspecified psychosis not due to a substance or known physiological condition	28

Table 3.1.2. Most Common Discharge Diagnosis From ER Visit

Diagnosis Code	Description	Total
R079	Chest Pain, unspecified	100
R42	Dizziness & giddiness	96
N390	Urinary tract infection, site not specified	95
R0789	Other Chest Pain	89
R51.9	Headache, unspecified	84

Utilization by Ethnicity

Ethnicity	Emergency Room	Inpatient Hospital	Mental Health	Professional
American Indian/Alaskan native	794	1,405	305	30,504
Asian Indian	225	790	289	16,018
Black or African Ancestry	750	1,656	816	20,792

Chinese	145	729	176	14,742
Filipino	281	1,303	136	20,632
Hispanic or Latino	530	1,596	351	20,117
Other	530	1,113	761	17,736
Other Asian/Pacific Islander	322	1,140	482	14,815
Unknown	376	1,352	405	16,457
Vietnamese	165	575	162	13,705
White	630	2,312	1,438	23,137
Total	**397**	**1,294**	**489**	**18,006**

Utilization by Language Groupings

Language	Emergency Room	Inpatient Hospital	Mental Health	Professional
Arabic	339	4,154	658	23,541
Cambodian	165	457	419	10,295
Chinese	126	688	115	14,395
English	604	1,735	960	20,590
Farsi	439	1,474	182	23,556
Ilocano	237	600	257	11,489
Korean	233	860	621	12,923
Other Non-English	273	863	425	15,236
Russian	226	1,776	396	22,948
Sign American	1,143	1,571	111	23,820
Spanish	409	1,330	151	18,368
Tagalog	339	1,479	21	20,734
Unknown	212	1,092	958	12,396
Vietnamese	156	683	111	14,317
Total	**397**	**1,293**	**489**	**18,037**

4. Conclusion

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

- The lack of knowledge about health care services and coverage is most likely due to language barriers and access to care. The SCAN ('15-'17) data indicates that 22% of SCFHP CMC enrollees have higher rates around misunderstanding health care services and coverage than CMC enrollees throughout California (19%). 16% CMC enrollees faced language as barrier while receiving care despite the availability of free interpreter services for CMC enrollees.[8] This suggests that future interventions should focus around language and health literacy. There is also a need for interventions with provider offices to improve their quality of service about offering interpreter service to CMC members.
- A large proportion of the CMC population speak Spanish (19.08%), Vietnamese (16.18%) and Chinese (13%). To improve awareness of interpretation service is very important.
- Education, employment and income correlate strongly with an individual's health status. Interventions to improve these indicators intend to improve the overall health of our members.
- The Health Risk Assessment data (HRA) show that all subpopulations (LTSS, LTC and SMI) report issues arranging transportation to see their provider, family and/or friends. All sub-populations would benefit from additional knowledge about community resources for social support.
- Based on HRA responses, CMC enrollees, in general, have a high rate of reporting that they never feel lonely. However, members utilizing LTSS reported that they felt lonely more than 15 days a month (10.3%) to most days (9.3%). In addition, 28.3% of LTSS members report that they live alone. There is a link between members who report feeling lonely and living alone. The data suggests that resources should be provided to this population to promote social connectedness/reduce loneliness.
- The LTSS subpopulation visit the ER most frequently and/or had an inpatient admission in with in past calendar year, compared to LTC subpopulation, however SCFHP had a small population of CMC enrollees who have utilized LTC. There is a need for interventions to identify the contributing factors for ER and inpatients visits for the LTSS subpopulation.
- Members in LTC are most likely to be hospitalized for sepsis, but the primary reason for an emergency room visit for these members is actually a diagnosis of "Schizoaffective disorder, bipolar type". Therefore, ED visits among SMI and LTC members are more often due to Schizoaffective disorder. There is a need for further exploration to assess the behavior of SMI subpopulation that may lead to infectious disease and eventually to sepsis.
- The SMI population is more likely to go to the ER for sepsis. The SMI population also has a high frequency of having a hypertensive heart and chronic kidney disease with heart failure at the time of discharge from the hospital. The data shows that there is an opportunity for intervention to improve the follow-up care for SMI members who go to the ER for chest pain so they do not get readmitted later due to worsening of their condition.

The data analyzed in this report provides key information about the CMC population's health care experience and barriers that may exist to obtaining care and maintaining optimal health. It also provides

insight into social determinants of health and the role they plan in shaping an individual's health care experience and outcomes.

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

Appendix

Appendix A – Subpopulation Definitions

Long Term Care (LTC)

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

Severe Mental Illness (SMI)

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

Long Term Support & Services (LTSS)

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

Appendix B –Santa Clara County BHSD Screening Tool

Santa Clara County BHSD Screening Tool

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

Insurance Type_____ Medi-Cal Plan Name_____Provider Network_____

Preferred Language_____ Identified Culture_____

Address_____ City_____Zipcode_____ Phone(___)_____-_____

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

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

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

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

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

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

Referral Disposition_____

Symptom description/details_____

_____

_____

Brief summary of relevant history_____

_____

_____

Screener Signature_____

Screener Name_____ Screener title_____ Date_____/_____/_____

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

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

Revised Jan 6, 2017

Appendix C – Data Sources

Health Risk Assessment (HRA)

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

Questions:

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

Health Outcomes Survey (HOS)

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

Signify Health – In Home Assessment (IHA)

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

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

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Santa Clara Family Health Plan™

2021 Population Health Management Impact Analysis - CMC

June 14, 2022

Shawna Cagle, Manager of Case Management

2021 Population Health Management Impact Analysis

Agenda

1. Introduction
2. Focus Areas and Target Populations
   a. Keeping Members Healthy
   b. Managing Members with Emerging Risks
   c. Managing Multiple Chronic Illnesses
   d. Patient Safety or Outcomes Across Settings
   e. Member Experience with Case Management Services
3. Next Steps

2021 Population Health Management Impact Analysis

Introduction

Purpose of Impact Analysis Report:

- Measure effectiveness of PHM program, services, and activities to meet benchmark goals developed around specific areas of focus and targeted populations
- Analyze impact of achieving quality outcomes for members through care management services and outline new strategies to implement when improvement opportunities are identified

2021 Population Health Management Impact Analysis

Focus Areas and Target Populations

- Focus on whole-person approach to identify members at risk and to provide strategies, programs, and services to mitigate or reduce risk
- Maintain or improve members' physical and psychosocial wellbeing and address health disparities through cost-effective and tailored solutions
- Focus Areas:
  - Keeping Members Healthy – **met**
  - Managing Members with Emerging Risk– **met**
  - Managing Multiple Chronic Illnesses– **met**
  - Patient Safety or Outcomes Across Settings – **not met**
  - Member Experience with PHM Programs
    - Complex Case Management – **met**
    - Behavioral Health – **not met**

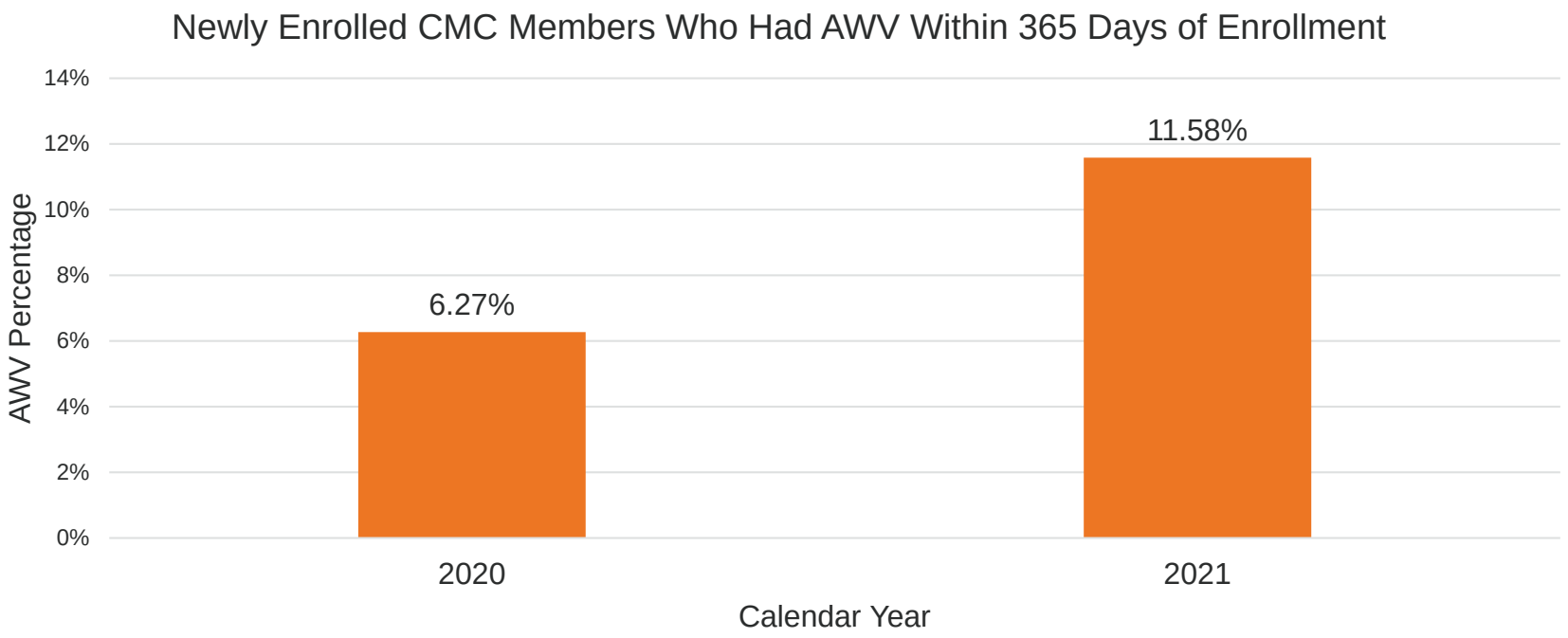
2021 Population Health Management Impact Analysis

Focus Area 1: Keeping Members Healthy

- **Focus Area Goal**: Increase the number of newly enrolled CMC members with no claims or utilization data to have an annual wellness visit within 365 days of their enrollment by 5 percentage points compared to the prior year results.
- **Goal Relevance Statement:** Based on analysis of Information Technology (IT) Risk Stratification data, utilization information on many of our newly enrolled CMC members was minimal. Annual Wellness Visits (AWV) are critical to maintaining the health of all CMC members.
- Increase by 5.31% from previous year - Goal **met!**

2021 Population Health Management Impact Analysis

Focus Area 1: Keeping Members Healthy



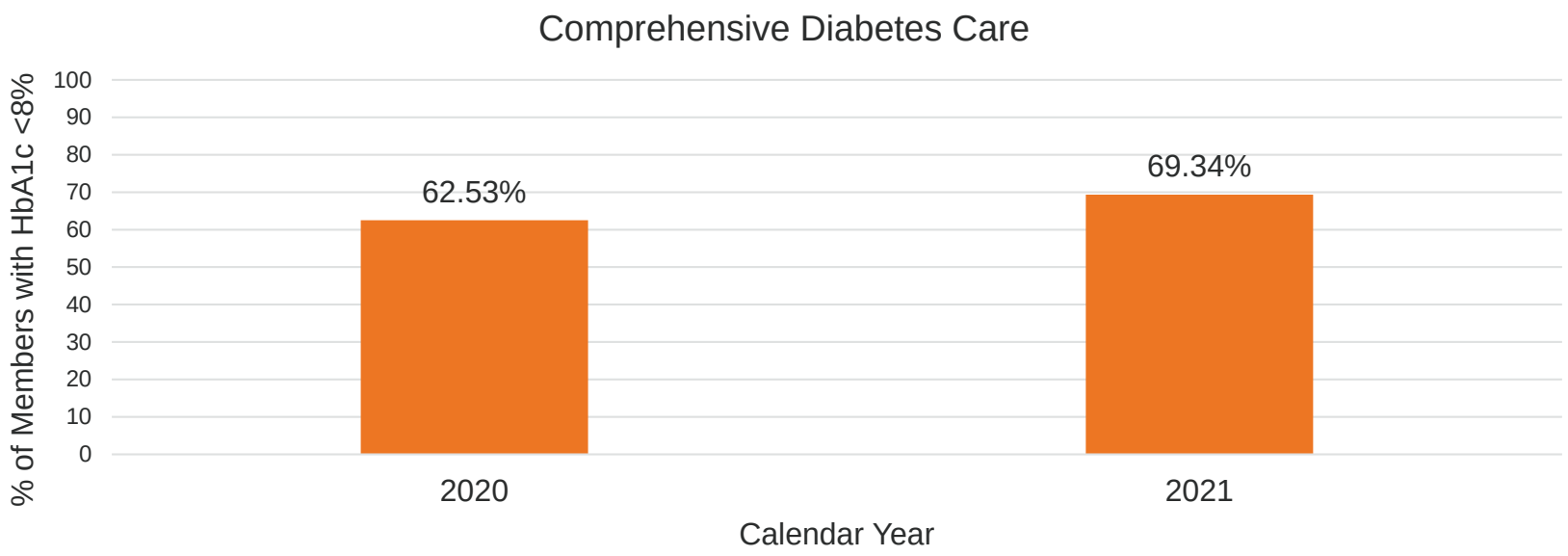
2021 Population Health Management Impact Analysis

Focus Area 2: Managing Members with Emerging Risk

- **Focus Area Goal:** Increase glycated hemoglobin (HbA1c) control rate by 2 percentage points compared to baseline
- **Goal Relevance Statement:** Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts decrease HbA1c and improve diabetic health outcomes for members.
- Increase of 6.81% from previous year - Goal **met!**

2021 Population Health Management Impact Analysis

Focus Area 2: Managing Members with Emerging Risk



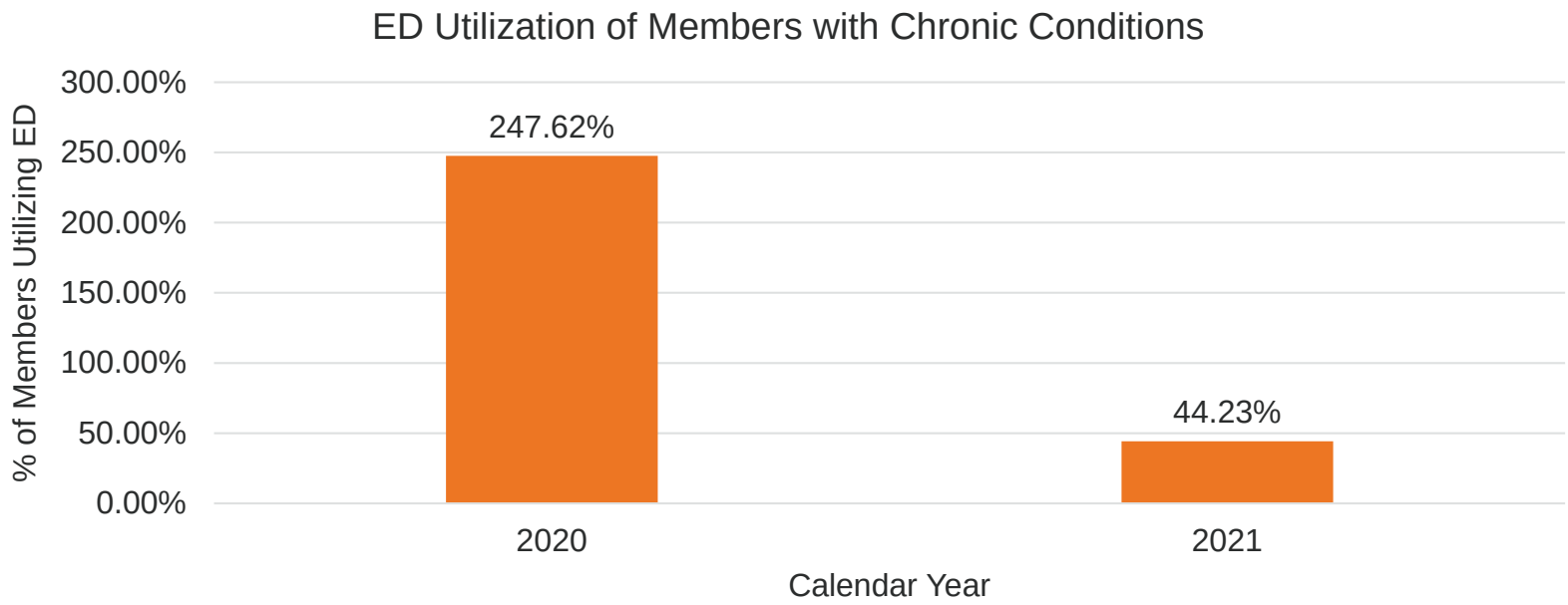
2021 Population Health Management Impact Analysis

Focus Area 3: Managing Multiple Chronic Illnesses

- **Focus Area Goal**: Reduce the number of members with multiple unmanaged chronic conditions who also have had 3 or more avoidable Emergency Department (ED) visits in the past year, by 10 percentage points.
- **Goal Relevance Statement:** Unmanaged multiple chronic conditions often results in avoidable ER utilization.
- Decrease of 203.39% from previous year. Goal **met!**

2021 Population Health Management Impact Analysis

Focus Area 3: Managing Multiple Chronic Illnesses



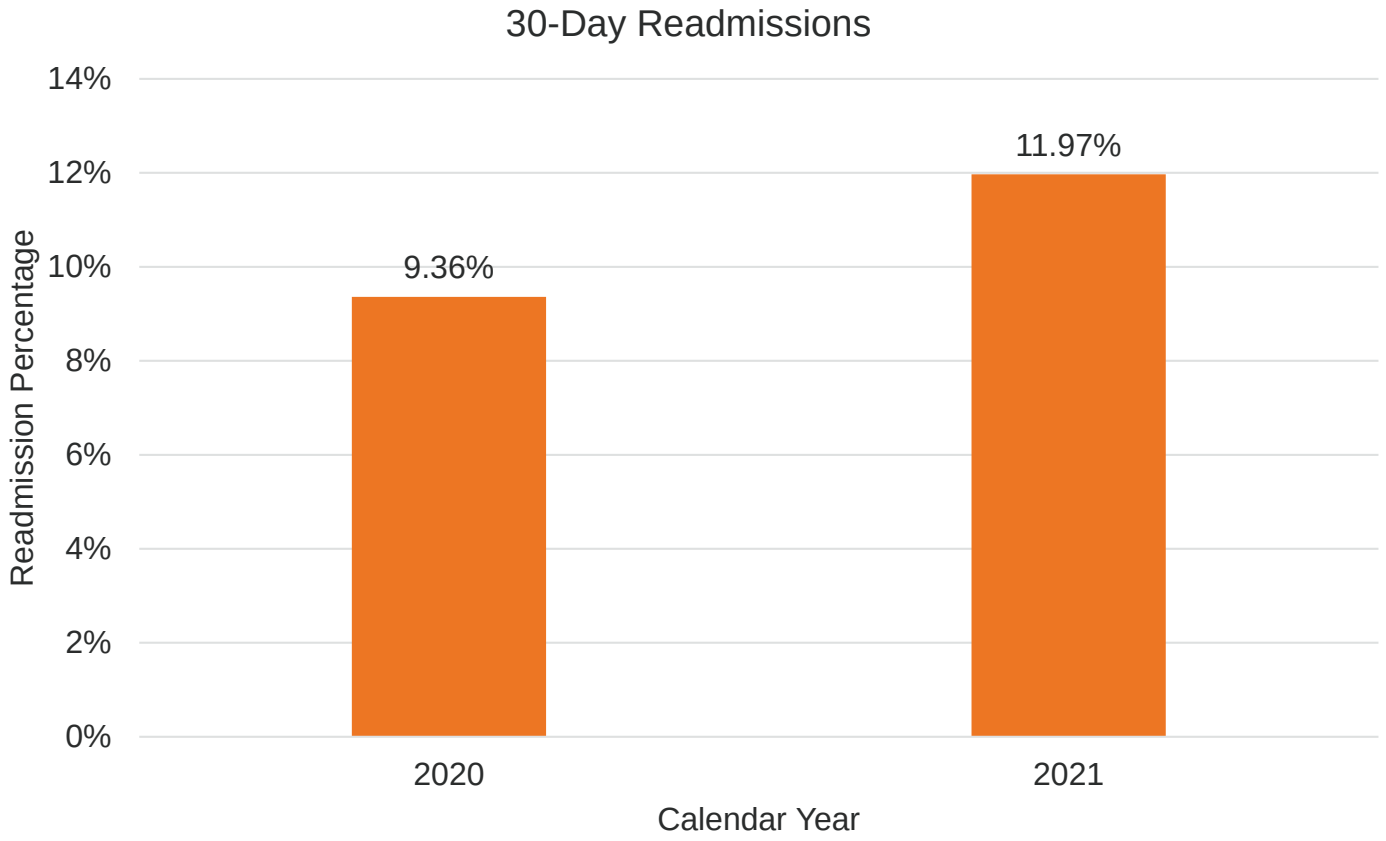
2021 Population Health Management Impact Analysis

Focus Area 4: Patient Safety or Outcomes Across Settings

- **Goal:** Decrease 30 Day Readmission rate for CMC members by 1 percentage point.
- **Goal Relevance Statement:** Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members. Through targeted outreach as the member moves across the care continuum between different settings of acute care, long term care, behavioral health and home and community based settings, potential gaps will be identified and assistance will be provided to improve continuity of care.
- Increase by 2.61% from previous year - Goal **not met**

2021 Population Health Management Impact Analysis

Focus Area 4: Patient Safety or Outcomes Across Settings



2021 Population Health Management Impact Analysis

Focus Area 4: Patient Safety or Outcomes Across Settings

Barrier Analysis & Opportunities for Improvement

Priority	Barrier	Opportunity	Action	Status
1	Transitions of Care program was fragmented between business units	Reduce gaps as members move across the care continuum	Continue to monitor and optimize existing Transition of Care program for efficiency	Ongoing
2	Increase collaboration with PCP	Collaborate with PCP and appropriate specialist for disease management	Notify PCPs and specialists of discharges for appropriate and timely follow up	Ongoing

2021 Population Health Management Impact Analysis

Focus Area 5: Member Experience with PHM Programs

- Member Experience with Complex Case Management (CCM)
  - Monitor CMC members' experience with CCM Program with the goal of reaching a 90% or better satisfaction rating
- SCFHP met the 90% performance goal in all focus areas
  1. Information about the overall program (100%, **met**)
  2. The program staff (100%, **met**)
  3. Usefulness of the information disseminated (100%, **met**)
  4. Members ability to adhere to recommendations (100%, **met**)
  5. Percentage of members indicating that the program helped them reach their health goals (100%, **met**)

2021 Population Health Management Impact Analysis

Focus Area 5: Member Experience with PHM Programs

- Member Experience with Behavioral Health (BH) Case Management
  - BH Program set a goal to achieve 90% member satisfaction in four of five NCQA areas
    1. Information about the overall program (scored: 91.36%, **met**)
    2. The program staff (scored: 97.88%, **met**)
    3. Usefulness of the information disseminated (scored: 89.72%, **not met**)
    4. Members ability to adhere to recommendations (scored: 89.32%, **not met**)
    5. Percentage of members indicating that program helped them reach health goals (scored: 75%, **not met**)

2021 Population Health Management Impact Analysis

Focus Area 5: Member Experience with PHM Programs

- Member Experience with Behavioral Health (BH) Case Management
  - Barrier Analysis:
    - Limited communication/collaboration with community partners and member engagement were identified as primary barriers
    - Lack of communication and coordination between SCFHP and alternate programs may create confusion and misalignment of health goals
    - Additional barriers identified: Cognitive limitations, Language barriers, Health literacy, Care giver support, Substance abuse

2021 Population Health Management Impact Analysis

Next Steps

- Strengthen community partnership and collaboration
- Improve member engagement and follow up by implementing a procedure to track unengaged members and conduct progressive outreach
- Identify automation opportunities to explore with IT including updates to the existing care coordination platform
- Continuous monitoring and optimizing of procedures and workflows to maximize efficiency and simplify work for Care Coordination staff so the focus will be on how to best assist the member reach their health care goals

Santa Clara Family Health Plan™

Questions?

2021 POPULATION HEALTH MANAGEMENT (PHM) IMPACT ANALYSIS CAL MEDI-CONNECT (CMC)

Quality Improvement Committee
June 14, 2022

PHM 6 Population Health Management Impact Analysis Report

PHM 6: Population Health Management Impact Analysis

BACKGROUND/INTRODUCTION

Santa Clara Family Health Plan (SCFHP) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to residents most in need in Santa Clara County. Established in January 1997, SCFHP was created by the Santa Clara County Board of Supervisors whom elects a board of directors for residents and reflects the cultural and linguistic diversity of the community. In addition, SCFHP providers, employees, and Board of Governors live in the areas that the health plan serves.

In 2021, SCFHP provided health care coverage to over 10,431 seniors and persons with disabilities through the Cal MediConnect (CMC) program. The CMC program manages the Medicare and Medi-Cal benefits for these members. Members choose from a network of 541 Primary Care doctors, 3,091 Specialists, 9 hospitals, 30 community health centers, 239 ancillary providers and 174 pharmacies throughout Santa Clara County. Through active partnerships with healthcare providers and community partnerships, SCFHP achieved a seal of National Committee for Quality Assurance (NCQA) accreditation in 2018 and demonstrates that the managed care model can achieve the highest standard of care and successfully meets the individual needs of health plan members through the Population Health Management (PHM) Program as outlined in the Population Health Management Strategy.

PURPOSE

Annually, SCFHP measures the effectiveness of the PHM Strategy to ensure that we are providing valuable and meaningful services to our members. This is done through the measurement of effectiveness of program services and activities to meet benchmark goals developed around specific areas of focus and targeted populations. The annual PHM Impact Analysis analyzes the impact of achieving quality outcomes for members through care management services and outlines new strategies to implement when opportunities for improvement are identified. This is performed through interpretation and quantitative comparison of results with established benchmarks set for relevant clinical, cost/utilization, and member experience measures:

- Clinical measures evaluate the comparison of incidence or prevalence rates for desirable or undesirable health outcomes or the clinical performance based on practice guidelines and clinical specifications for 4 focus areas designated by the PHM Strategy.
- Cost/utilization measures evaluate cost, resource use by occurrence or outcomes that demonstrate a desirable increase or decrease in utilization.
- Experience measures member feedback sourced from member satisfaction surveys and member complaints flagged by Grievance and Appeals specific to Complex Case Management (CCM).

This annual PHM Impact Analysis is reviewed at the Quality Improvement Committee (QIC) meeting, chaired by the Chief Medical Officer (CMO) and drives the PHM Strategy for the following year. The PHM Impact Analysis includes a quantitative and qualitative analysis of Case Management programs performed by the Population Health Management (PHM) Workgroup which includes the Manager of Case Management, Director of Case Management & Behavioral Health,

Director of Quality & Process Improvement, Director of Long Term Services and Supports, and NCQA Project Manager.

PHM Focus Areas & Target Populations

The focus areas and target populations of the PHM program focuses on a whole-person approach to identify members at risk and to provide strategies, programs, and services to mitigate or reduce that risk. We also aim to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions. SCFHP promotes a program that is both sustainable, person and family-centered, and enables CMC members to attain their personal health goals. We do so by providing timely access to appropriate, coordinated health care services and community resources, including home and community-based services and behavioral health services. SCFHP's plan of action for each of the Focus Areas include measurable goals for specific targeted member populations.

Focus Areas:

1) Keeping Members Healthy
2) Managing Members with Emerging Risk
3) Managing Multiple Chronic Illnesses
4) Patient Safety or Outcomes Across Settings
5) Member Experience with PHM Programs

Focus Area 1: Keeping Members Healthy

Focus Area Goal: Increase the number of newly enrolled CMC members with no claims or utilization data to have an annual wellness visit within 365 days of their enrollment by 5 percentage points compared to the prior year results.

Goal Relevance Statement: Based on analysis of Information Technology (IT) Risk Stratification data, utilization information on many of our newly enrolled CMC members was minimal. Annual Wellness Visits (AWV) are critical to maintaining the health of all CMC members.

Population Targeted: All CMC members not residing in a skilled nursing facility (SNF).

Programs & Services: Basic Case Management, Transitions of Care (TOC), Provider Engagement.

Utilization Measure Methodology: This study compares the rate of in office Annual Wellness Visits of newly enrolled Cal MediConnect members in CY 2021 to the rates of in office Annual Wellness Visits for newly enrolled members in CY 2020. The analysis is based on the paid claims for office-based primary care visits billed services codes G0438 & G0439 of all CMC members from January 2021 – December 2021.

Quantitative Analysis:

The Annual Wellness Visit (AWV) Graph shows in 2020, 143 out of 2,282 of the newly enrolled members had one or more Annual Wellness Visit encounters for a total of 6.27% of the newly enrolled population. In 2021, 174 of the 1,502 newly enrolled members who had one or more

Annual Wellness Visit encounters for a total of 11.58%. This is an increase of AWV by 5.31% from the previous year.

For members who are not connected to a primary care provider, an in-home Initial Health Assessment (IHA) is completed by an external vendor if agreed upon by the member. In 2020, 29.62%, or 676 of the 2,282, newly enrolled members received an IHA compared to 86.75%, or 1,303 of the 1,502, newly enrolled members in 2021.This is an increase of IHA by 57.13%.

This Focus Area goal was met as we identified a significant increase in members who received an AWV and IHA. This may be largely due to members regaining access to their providers as the pandemic restrictions eased. Also, the drastic increase in in-home assessments may be related to members feeling more comfortable to inviting healthcare providers into their home again.

Care Coordination staff will continue to educate the members on the importance of seeing their PCP for an Annual Wellness Visit. In order to increase engagement and collaboration with the members, the PHM Workgroup will develop and implement new ways to ensure regular follow up with the member occurs throughout the year by the Care Coordination staff and continue our ongoing collaboration with PCPs.

PHM Work Group Qualitative Analysis & Opportunities for Improvement

Priority	Barrier	Opportunity	Action	Status
1	Inability to do in-person visits with limited Primary Care Provider (PCP) availability due to COVID-19 related fears	Increase member education and engagement and provide assistance to members who need assistance to access their PCP	Continue to remind members the importance of seeing PCP for AWV during initial and annual Health Risk Assessment (HRA) outreach and Individual Care Plan (ICP) development	Ongoing
2	Members may not be aware that telehealth visits are available or be able to access telehealth visits	Educate members on the availability of telehealth visits and how to access	Continue to educate members of the availability of telehealth visits through during initial and annual Health Risk Assessment (HRA) outreach and Individual Care Plan (ICP) development Assist members to make telehealth visits with PCP if needed	Ongoing Ongoing

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to increase the AWV percentage for the next measurement year.

Focus Area 2: Managing Members with Emerging Risk

Focus Area Goal: Increase glycated hemoglobin (HbA1c) control rate by 2 percentage points compared to baseline

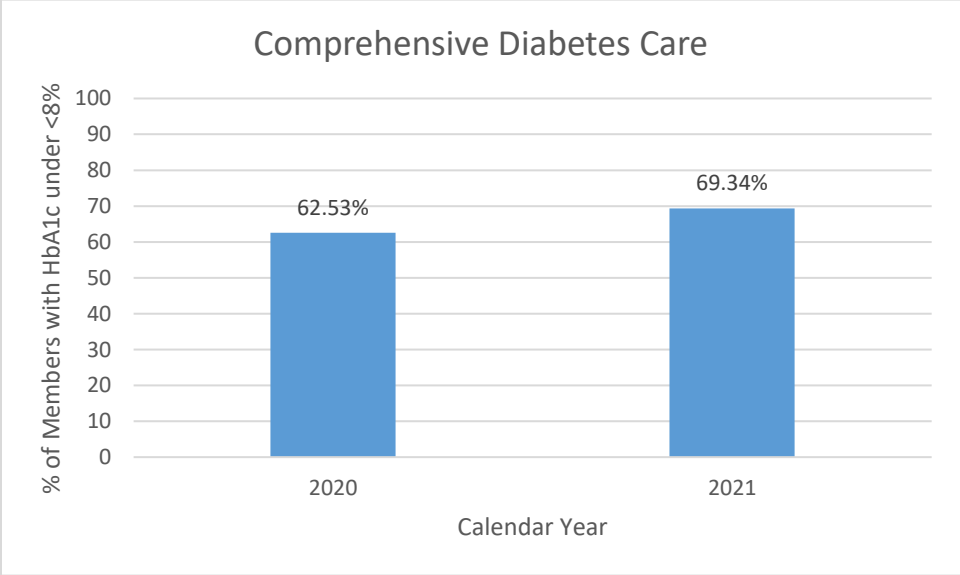
Goal Relevance Statement: Within SCFHP CMC line of business, there are 2,152 of members that meet the HEDIS definition of diabetes. Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts decrease HbA1c and improve diabetic health outcomes for members.

Population Targeted: All members with a controlled chronic condition of diabetes with an HbA1c over 8%

Programs & Services: Basic Case Management, Complex Case Management, Health Education, Provider Engagement, Behavioral Health (SMI), Gaps in Care

Control Rate – Methodology: Data is gathered through claim/encounter data and pharmacy data. SCFHP uses both methods to identify the eligible population. Claims data includes members who are is identified through either method are included the sample. Members who have at least one acute inpatient encounter or at least 2 outpatient on different dates of services due to diabetes diagnosis. Pharmacy data includes members who were dispensed insulin or hypoglycemic / antihyperglycemics on an ambulatory basis during the measurement year. CPT codes are isolated to identify members most recent HbA1c level is <8.0% out of those that are not <8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Medical records are reviewed, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result.

Quantitative Analysis:



The Comprehensive Diabetes Care graph illustrates the percentage of members whose HbA1c was less than 8%. In 2020, the Comprehensive Diabetes Care Control Rate was 62.53%, or 257 of the

411 diabetic members whose HbA1c was lower than 8%. In 2021, this percentage increased to 69.34%, or 285 of the 411 members. This outcome meets the goal of a 2 percentage point increase.

PHM Work Group Qualitative Analysis & Opportunities for Improvement:

Priority	Barrier	Opportunity	Action	Status
1	Members have difficulty maintaining blood glucose levels	Enroll members in the appropriate Diabetes Management program	Continue to collaborate within Health Services to optimize the Diabetes Management programs spread over Quality, Case Management, and Pharmacy teams.	Ongoing

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to increase the CDC percentage for the next measurement year.

Focus Area 3: Managing Multiple Chronic Illnesses

Focus Area Goal: Reduce the number of members with multiple unmanaged chronic conditions who also have had 3 or more avoidable Emergency Department (ED) visits in the past year, by 10 percentage points.

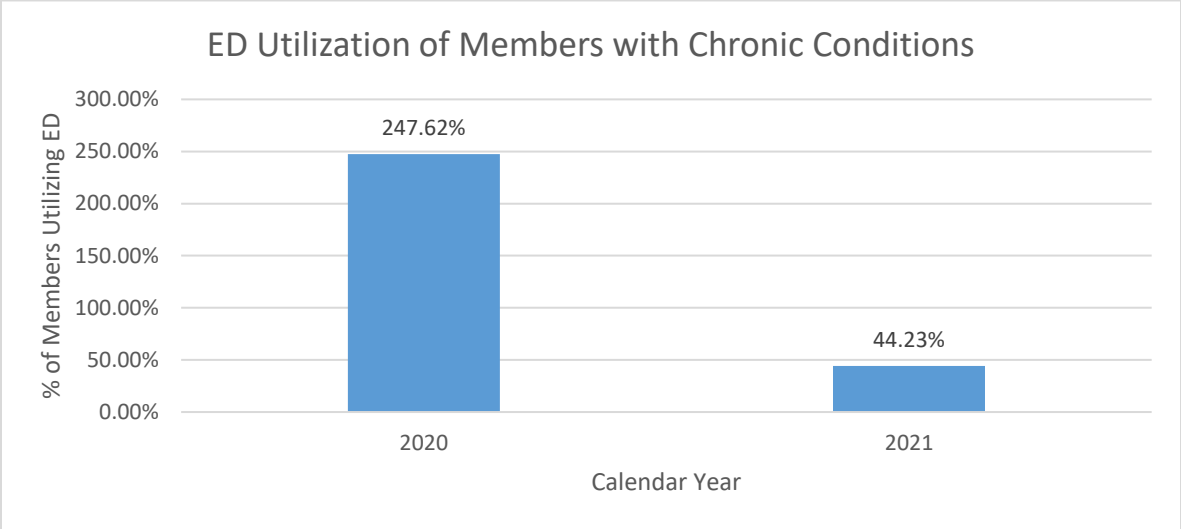
Goal Relevance Statement: Unmanaged multiple chronic conditions often results in avoidable ER utilization.

Population Targeted: Members who had one or more unmanaged chronic condition(s) that resulted in 3 or more ED visits in 2021 at a safety net hospital within Santa Clara County.

Programs and Services: Complex Case Management, Medication Therapy Management, 24 Hour Nurse Advice Line

Utilization Measure – Methodology: This study compares the amount of ED utilization in 12 months compared to the same targeted population in the measurement year.

Quantitative Analysis:



This graph illustrates a large decrease in ED utilization by members with chronic conditions. In 2020, 42 of the members who had chronic conditions had 104 ED utilization, equating to 247.62%. This drastically decreased in 2021 where 46 members had 104 ED utilization, equating to 44.23%. This outcome meets the goal of a 10 percentage point decrease.

PHM Work Group Qualitative Analysis & Opportunities for Improvement:

Priority	Barrier	Opportunity	Action	Status
1	Lack of ED follow up	Utilize available ED census data from safety net hospitals to target outreach and follow up	Develop and implement workflow for Care Coordination staff follow up post ED utilization	Complete by Q3 2021
			Provide education on available non-emergent services like the 24 Nurse Advise Line and contracted urgent care clinics	Ongoing

Recommendation: Over the last 3 years, we have noticed large fluctuations with the data findings related to this goal, leading us to re-evaluate the purpose and the logic of this data. After reviewing this data year over year, we will be shifting our focus to a different goal for the current year's strategy as want to focus on members with multiple chronic conditions and their perceived health condition. This effort will further promote the member-centric individual care plans that we develop with the member and their Interdisciplinary Care Team to empower the members to drive their own health and well-being. For this focus area, our new goal will to evaluate self-management of members with a chronic condition

Focus Area 4: Patient Safety or Outcomes across Settings

Goal: Decrease 30 Day Readmission rate for CMC members by 1 percentage point.

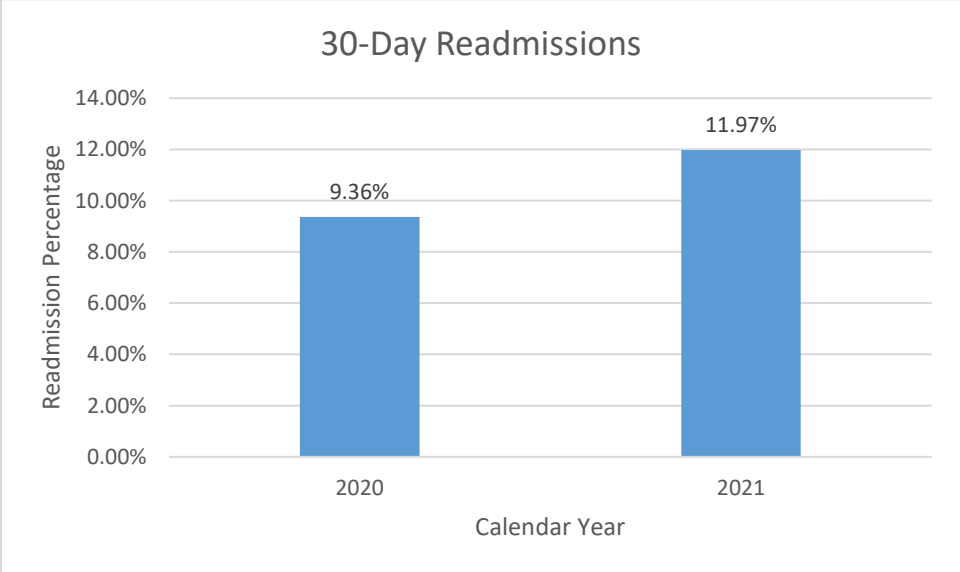
Goal Relevance Statement: Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members. Through targeted outreach as the member moves across the care continuum between different settings of acute care, long term care, behavioral health and home and community based settings, potential gaps will be identified and assistance will be provided to improve continuity of care.

Population Targeted: Members readmitted within 30 days of discharge

Programs & Services: Transitions of Care (TOC), Complex Case Management

Utilization Measure – Methodology: This study evaluates the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Quantitative Analysis



The 30-Day Readmission Graph illustrates in 2020 Plan All-Cause Readmissions (PCR) Observed Readmission Rate was 9.36% compared to 2021 which was 11.97% resulting in an increase of PCR. In 2020, there were 84 readmissions of the 897 hospitalizations compared to the 125 readmissions out of 1,044 in 2021. This outcome does not meet the goal of a 1 percentage decrease.

The increase in readmissions may be due to decrease PCP and specialist availability for follow up in combination with unsafe discharges due to the overcrowding in hospitals related to COVID-19.

The updated Transitions of Care program will be monitored closely for effectiveness. Priority will be put on Targeted Case Management programs along with automation opportunities and platform updates.

PHM Work Group Qualitative Analysis & Opportunities for Improvement

Priority	Barrier	Opportunity	Action	Status
1	Transitions of Care program was fragmented between business units	Reduce gaps as members move across the care continuum	Continue to monitor and optimize existing Transition of Care program for efficiency	Ongoing
2	Increase collaboration with PCP	Collaborate with PCP and appropriate specialist for disease management	Notify PCPs and specialists of discharges for appropriate and timely follow up	Ongoing

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to decrease readmissions for the next measurement year.

Focus Area 5: Member Experience with CCM

Santa Clara Family Health Plan (SCFHP) monitors Cal MediConnect (CMC) members' experience with Complex Case Management (CCM) Program with the goal of reaching a 90% or better satisfaction rating. The purpose of measuring member satisfaction for CM specific programs is to ensure adequate satisfaction with the program and that the program objectives are achieved. Annually, SCFHP completes an analysis which incorporates member survey questions and complaints related to CMC Complex case management services. This analysis allows the organization to identify opportunities for improving the CM and CCM program services through action plans in order to provide the highest quality of case management services. Annual survey results contribute to the overall Population Health Management (PHM) program effectiveness evaluation.

Process

Santa Clara Family Health Plan measures CCM program effectiveness and overall member satisfaction with the Complex Case Management services through quarterly reporting and annual monitoring of complaints from members related to Complex Case Management services by performing regular CCM member satisfaction surveys. All members that were enrolled in CCM are provided the opportunity to complete the survey within 30 days of their transition to a lower level of CM services. Members that meet inclusionary criteria are outreached by phone at least twice and are offered assistance to complete the survey in their preferred language. Surveys are completed in the CM platform Essette. All survey responses are captured and reported by IT. Additionally the Grievance and Appeals department flags member complaints and reports them to CM leadership. Case Management leadership receives a report of survey outcomes and grievances and completes an annual analysis of all member experience data.

Satisfaction measures:

1. Information about the overall program.
2. The program staff.
3. Usefulness of the information disseminated.
4. Members' ability to adhere to recommendations.
5. Percentage of members indicating that the program helped them achieve health goals.

CCM Member Satisfaction Survey Inclusion Criteria:

All members who participated in CCM for 60 days or more who have transitioned to a lower level of case management. Members have the right to refuse to participate in all or parts of the survey.

Members who were able to be reached by phone and who were willing to complete the 16 question survey were pulled into the survey population. Results were generated from the survey population that met the inclusion criteria who participated in answering all 16 survey questions.

Methodology

Essette case management was configured to house the survey assessment. Case Management staff conduct 2 telephonic outreach calls and document the outcomes with in the survey assessment. The number of members who are reached to complete the survey is a subset of the number of members that the health plan attempted to reach. Survey responses are data entered the survey assessment in real time by Personal Care Coordinators (PCCs). Survey responses can be provided by member or formal/informal caregiver on record. Survey responses are scored based on the members answer to the questions. Answers are scored as follows Strongly Agree/Very Satisfied, Agree/Satisfied, Disagree/Somewhat Satisfied, and Strongly Disagree/Not at all Satisfied. Percentage for each response will be rounded up to report in whole numbers. Overall goal is to have members respond "agree or "strongly agree" for questions 1-15 and "satisfied" or "very satisfied" for question 16 for an overall satisfaction percentage rate of 95% or better. Members are also encouraged to leave feedback which is documented in the comments section. Survey responses are collected annually throughout the look back year starting January 1, 2021 through December 31, 2021. Survey responses were pulled into the CCM survey response report and analyzed.

Member Complaints

The process for measuring member CCM complaints is through the Grievance and Appeals department. Member filed grievances for CCM are flagged and reported directly to Case Management Leadership. CCM Leadership works directly with G &A to resolve the grievance. CCM grievances are measured and reported annually. To date there have been (0) grievances for CCM services. In CY 2021, there were 19 grievances for case management.

2021 CCM Satisfaction Survey	Disagree		Strongly Disagree		Agree		Strongly Agree		Goal Met
Total Survey Sample: 7 Members enrolled in CCM in CY 2021	#	%	#	%	#	%	#	%	**Measure Met Y/N**
The Program Staff									
My case manager treated me with respect.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
My case manager listened to what I had to say.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
My case manager returned my phone calls in a timely manner.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
Usefulness of Information									
My case manager helped me find services that I needed.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
My case manager involved me in discussing and planning my care.	0	0.00%	0	0.00%	3	42.9%	4	57.1%	**Y**
I better understand my disease or condition after being in the case management program.	0	0.00%	0	0.00%	2	33.3%	4	66.7%	**Y**
My case manager helped me better communicate with my providers.	0	0.00%	0	0.00%	1	14.3%	6	85.7%	**Y**
Ability to Adhere to Recommendations									
I am able to better manage my health and health care after being in the case management program.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
I know what to do if I need help.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
I know what to avoid when it comes to my health conditions.	0	0.00%	0	0.00%	3	42.9%	4	57.1%	**Y**
Members Indicating that the Program Helped Them Reach Their Health Goals									
I feel like I have achieved my CCM goals.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
My situation is better because of my case manager's help.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
I feel ready to transition to a lower level of case management.	0	0.00%	0	0.00%	2	33.3%	4	66.7%	**Y**

Overall Program									
My Care Plan was clear and easy to understand.	0	0.00%	0	0.00%	2	28.6%	5	71.4%	**Y**
My input was considered when developing my plan of care.	0	0.00%	0	0.00%	1	14.3%	6	85.7%	**Y**
Overall, how satisfied are you with the Case Management Services you received?	**Very Unsatisfied**		**Unsatisfied**		**Satisfied**		**Very Satisfied**		**Goal Met**
Total	0	0.00%	0	0.00%	6	85.9	1	14.30 %	Y

PHM Work Group Qualitative Analysis & Opportunities for Improvement

SCFHP met the 90% performance goal in focus areas

1. Information about the overall program (100%)
2. The Program staff (100%)
3. Usefulness of the information disseminated (100%)
4. Members ability to adhere to recommendations (100%)
5. Percentage of members indicating that the program helped them reach their health goals (100%)

The CCM program was effective in managing members with multiple unmanaged chronic conditions and impacting better health outcomes among those enrolled in the program for greater than 60 days. Enrollees and their caregivers have benefited from intensive care coordination support to address complex medical, psychosocial, and social determinants of health needs. Through the CCM program, the risk of adverse health outcomes for members decreased by linking members with doctors, pharmacy, specialty and DME providers in collaboration with the Interdisciplinary Care Team.

The Member Satisfaction surveys showed that 100% of members who engaged in the CCM program had better health outcomes due to actions directly related to linkage to covered benefits and community based services. Members agreed that overall the information provided by their CMs was useful, easy to understand and helped them reach their health goals.

Opportunities for improvement: Priority will be put on Targeted Case Management programs, such as this, along with automation opportunities and platform updates to increase member engagement with Care Coordination staff.

Recommendation: We will continue to review this measure and develop and implement strategies and tactics to increase member engagement and satisfaction with the assistance provided by Care Coordination staff.

Behavioral Health Member Satisfaction Survey Inclusion Criteria:

All members who participated in Behavioral Health (BH) Case Management and discharged from the program. Members have the right to refuse to participate in all or parts of the survey.

Members who were able to be reached by phone and who were willing to complete the survey were pulled into the survey population. Results were generated from the survey population that met the inclusion criteria who participated in answering the survey questions.

Methodology

Essette case management was configured to house the survey assessment. BH Case Management staff conduct 3 telephonic outreach calls and document the outcomes with in the survey assessment tool. The number of members who are reached to complete the survey is a subset of the number of members that the health plan attempted to reach. Survey responses are entered into the survey assessment in real time by BH Staff. Survey responses can be provided by the member or formal/informal caregiver on record. Survey responses are scored based on the members answer to the questions. Answers are scored on a scale of 1 to 10 or as Yes/No/Don't Know. 1 to 10 scale and Yes/No response questions were used as this is a familiar way to BH members and easy for them to understand. Counts and percentage for each response will be rounded up to report to the first decile point. Scores for questions with 1 to 10 rating are averaged. Members are also encouraged to leave feedback which is documented in the comments section. Survey responses are collected annually throughout the look back year starting January 1, 2021 through December 31, 2021. Survey responses were pulled into the BH satisfaction survey response report and analyzed.

NCQA 2021 Behavioral Health Member Survey		I Don't Know		No		Yes		Totals		Average Score	Performance Percentage	Goal Met
NCQA Area	Questions	#	%	#	%	#	%	#	%	-		Y/N
Overall Program Information	Overall, how satisfied are you with the Case Management Services you received?	-								9.13	91.36%	-
	Performance Percentage for Area	**-**								**9.13**	**91.36%**	**Y**
Program Staff	My case manager treated me with respect.	-								9.86	98.64%	-
	My case manager listened to what I had to say.	-								9.81	98.18%	**-**
	My case manager returned my phone calls in a timely manner.	-								9.68	96.82%	-
	Performance Percentage for Area	**-**								**9.78**	**97.88%**	**Y**
Usefulness of Information disseminated	Did you customize a care plan with behavioral health at SCFHP?	0	0%	6	27.27%	16	72.73%	22	100%	-	**-**	**-**
	My case manager involved me in discussing and planning my care.	-								9.75	97.50%	**-**
	My case manager helped me find the benefits and community resources that I needed.	-								8.68	86.82%	-
	My case manager helped me better communicate with my providers.	-								8.31	83.18%	-
	I found the information my CM provided to be useful.	-								9.13	91.36%	-
	Performance Percentage for Area									**8.97**	**89.72%**	**N**
Member's ability to adhere to recommendations	Did participating in BH help you to follow your treatment recommendations?	2	9%	3	14%	17	77%	22	100%	-	-	-
	I know what to avoid when it comes to my health conditions.	-								9.01	90.91%	-
	I know what to do if I need help.	-								8.77	87.73%	-
	Performance Percentage for Area	**-**								**8.93**	**89.32%**	**N**
Achieving member health goals	My situation is better because of my case manager's help.	3	13.64%	0	0%	19	86.36%	22	100%	-	86.36%	-
	I feel like I have achieved my health goals.	4	18.18%	4	18.18%	14	63.64%	22	100%	-	63.64%	-
	Performance Percentage for Area										**75%**	**N**

NCQA 2021 BH Member Experience Survey Results Analysis

The Santa Clara Family Health Plan (SCFHP) – Behavioral Health Program set a goal to achieve 90% member satisfaction in four of five NCQA areas. A member experience survey was administered to CMC members who participated in behavioral health program case management services. A random sample of 100 CMC members were identified for outreach. A total of 22 members responded to the survey. The five NCQA areas include information about the overall program, the program staff, usefulness of the information disseminated, member's ability to adhere to recommendations, and percentage of members indicating the program helped them reach their health goals. Respectively, the areas scored 91.36%, 97.88%, 89.72%, 89.32% and 75%.The overall satisfaction with behavioral health case management services received was 88.65%.

A focus group was conducted with SCFHP behavioral health (BH) case management staff to present the findings and identify barriers and areas of opportunity to improve member satisfaction in areas that scored below 80%. The group identified a variety of barriers to achieving member health goals and treatment adherence including member cognitive limitations, language barriers, health literacy, care giver support, coordination of transportation services, substance use, case management intensity, treatment confidentiality, and member's lived experience with other case management programs. Limited communication/collaboration with community partners and member engagement were identified as the primary barriers to achieving member health goals. The group highlighted that members may be participating in multiple case management programs that they may be unaware of. Lack of communication and coordination between SCFHP and these alternate programs may create confusion and a misalignment of health goals if members have active care plans with multiple organizations. Staff also stated concerns with unengaged members and advised that a follow up process should be implemented to outreach to these members.

These identified barriers present an opportunity to strengthen community partnership and collaboration. To improve member engagement and follow up, the behavioral health program seeks to implement a procedure to track unengaged members and conduct progressive outreach accordingly.

Opportunities for improvement:
Priority will be put on Targeted Case Management programs, such as this, along with automation opportunities and platform updates to increase member engagement amongst all Care Coordination staff.

Recommendation:
We will continue to review this measure and develop and implement strategies and tactics to increase member engagement and satisfaction with the assistance provided by Care Coordination staff.

Conclusion
Members and their caregivers have benefited from intensive support and assistance with care coordination, however, there is still need for improvement of expanding the criteria to enroll more members into Targeted Case Management programs.

The PHM Workgroup will continue to establish action plans and evaluate the accuracy of actual case management impacts on targeted groups within the greater HEDIS metrics and consider different reporting strategies. Additionally, staff will be provided additional training on case management best practices to provide standardize support to members.

CM programs continue to strive to keep members healthy through comprehensive annual wellness assessment and preventative screenings. Members who complete an Annual Wellness Visit (AWV) are more likely to receive important preventive care services like vaccines and cancer screenings than those who do not. In-office AWVs focus on members self-identified health status, psychosocial, socio-economical, past medical history, level of independence and other potential risk factors. SCFHP will continue to contract with a vendor to complete in-home Initial Health Assessments (IHA) performed by nurse practitioners in the member's home and are comparable to in office AWVs. Our success in meeting this measure is largely due to evaluation and transmission of valuable assessment information to providers as well as member education on the importance of preventative screenings.

Targeted Case Management Programs identify members at risk and aim to promote safety across with additional evaluation and follow up. The value of connecting members with their PCP for discharge follow up has been shown to decrease the likelihood for readmissions. CM support post discharge promotes greater linkage to follow up services and ongoing management support through regular outreach and follow up to assist the member meets their health care goals.

Upcoming Improvements
In addition to increased collaboration within business units, many automation opportunities have also been identified to explore with IT including updates to the existing care coordination platform. This, coupled with constant monitoring and optimizing of procedures and workflows to maximize efficiency, will simplify the work for Care Coordination staff so the focus will be on how to best assist the member reach their health care goals.

Santa Clara Family Health Plan™

Population Health Management (PHM) Strategy 2022 - CMC & MC

June 14, 2022

Shawna Cagle, Manager of Case Management

PHM Strategy 2022 - CMC & MC

Agenda:

1. Introduction
2. Populations Targeted for PHM
3. Programs and Services
4. Annual PHM Goals
    a. Keeping Members Healthy
    b. Managing Members with Emerging Risk
    c. Patient Safety Outcomes Across Settings
    d. Managing Multiple Chronic Illnesses

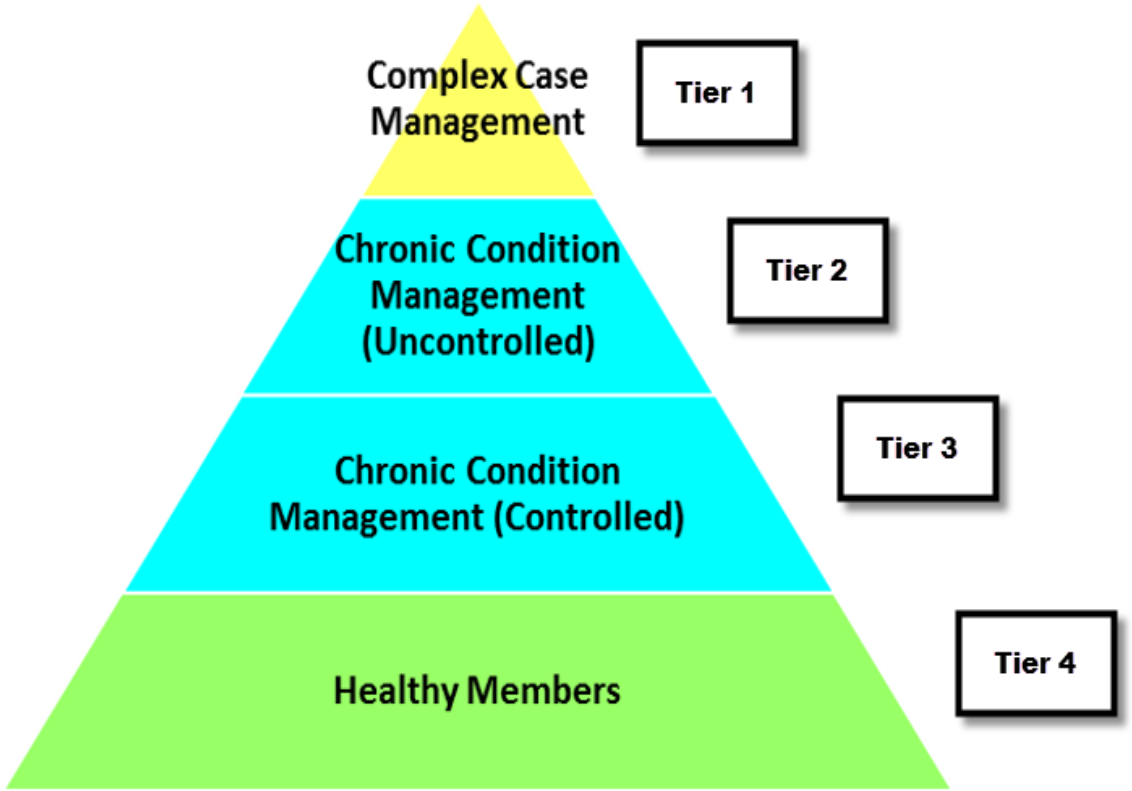
PHM Strategy 2022 - CMC & MC

Introduction

- In accordance with the NCQA 2022 Standards and Guidelines, SCFHP has developed a framework to address member needs across the continuum of care through targeted interventions for defined populations
- Framework addresses the four focus areas of population health, as outlined by NCQA:
    - Keeping members healthy
    - Managing members with emerging risk
    - Patient safety outcomes across settings
    - Managing multiple chronic illnesses

PHM Strategy 2022 - CMC & MC

Populations Targeted for PHM



PHM Strategy 2022 - CMC & MC

Programs and Services

Programs & Services	LOB		NCQA Focus Area				Tier(s)
	CMC	MC	Keeping Members Healthy	Managing Members with Emerging Risk	Patient Safety or Outcomes Across Settings	Managing Multiple Chronic Illnesses	
Complex Case Management	X	X		X	X	X	1
Moderate Case Management	X	X	X	X	X	X	2
Basic Case Management	X	X	X	X	X		3, 4
Long Term Care	X	X	X	X	X	X	2 to 3
Transitions of Care	X	X	X	X	X	X	1 to 4
Behavioral Health Severe Mental Illness	X		X	X	X	X	1 to 4
Provider Engagement	X	X	X	X	X	X	1 to 4
Nurse Advice Line	X	X	X	X	X	X	1 to 4
Utilization Management & Concurrent Review	X	X	X	X	X	X	1 to 4
Health Education	X	X	X	X			1 to 4
Enhanced Care Management		X	X	X	X	X	1 to 4
Community Supports		X	X	X	X	X	1 to 2
Community Resources Integration	X	X	X	X	X	X	1 to 4
Medication Therapy Management (MTM)	X					X	1 to 4
Gaps in Care	X	X	X	X	X	X	1 to 4

PHM Strategy 2022 - CMC & MC

PHM Goal - Keeping Members Healthy

Line of Business	Goal	Goal Justification	Population Targeted
CMC	Increase the number of newly enrolled CMC members with no claims or utilization data to have an Annual Wellness Visit (AWV), including the In-Home Assessment (IHA), within 365 days of their enrollment by 5 percentage points compared to the prior year results.	Based on analysis of IT risk stratification data, SCFHP discovered that we did not have utilization information on many of our newly enrolled CMC members. Annual Wellness visits are critical to maintaining the health of all CMC members.	All CMC members (not in LTC facility)
MC	100% of newly enrolled MC SPD members to have an Initial Health Assessment (IHA) annual wellness visit as a goal in their care plan.	Completing an IHA allows SCFHP to understand the needs of the member and develop a care plan with the PCP accordingly.	All new MC SPD members

PHM Strategy 2022 - CMC & MC

PHM Goal - Managing Members with Emerging Risk

Line of Business	Goal	Goal Justification	Population Targeted
CMC	Increase diabetic control rate by 2 percentage points compared to prior year results	In CY 2021, 20.63% of CMC members had diabetes. Uncontrolled diabetes can lead to cardiac disease and progressive decline in health.	All CMC members with a uncontrolled (<8%) chronic condition of diabetes with an HbA1c over 9%
MC	Increase diabetic control (< 8%) rate by 2 percentage points compared to prior year results	Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts to decrease HbA1c and improve diabetic health outcomes for members.	All MC members with a uncontrolled (<8%) chronic condition of diabetes with an HbA1c over 9%

PHM Strategy 2022 - CMC & MC

PHM Goal - Patient Safety Outcomes Across Settings

Line of Business	Goal	Goal Justification	Population Targeted
CMC	Decrease 30 Day Readmission rate for CMC members by 1 percentage point compared to prior year results	The intent is to promote transitions of care for CMC members discharged from an acute or skilled nursing facility setting and improve continuity of care across acute care, long term care, behavioral health and home and community-based settings. Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members.	CMC members readmitted within 30 days of discharge
MC	Decrease 30 Day Readmission rate for MC members by 1 percentage point compared to prior year results	The intent is to promote transitions of care for MC members discharged from an acute or skilled nursing facility setting and improve continuity of care across acute care, long term care, behavioral health and home and community-based settings. Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members.	MC members readmitted within 30 days of discharge

PHM Strategy 2022 - CMC & MC

PHM Goal - Managing Multiple Chronic Illnesses

Line of Business	Goal	Goal Justification	Population Targeted
CMC	95% of CMC members with a chronic illness report improved self-management of their illness on patient-reported outcome surveys within 24 months of enrollment.	The intent is to empower and encourage CMC members with chronic illnesses to take a proactive approach in monitoring and controlling their health.	CMC members not enrolled in CCM
MC	95% of MC members with a chronic illness report improved self-management of their illness on patient-reported outcome surveys within 24 months of enrollment.	The intent is to empower and encourage MC members with chronic illnesses to take a proactive approach in monitoring and controlling their health.	MC members not enrolled in CCM

PHM Strategy 2022 - CMC & MC

Next Steps

- Continuously monitor and measure effectiveness of programs, services, and activities to meet goals developed around specific areas of focus and targeted populations
- Conduct annual PHM Impact Analysis to analyze the impact of PHM Strategy and identify new strategies to implement when opportunities for improvement are identified

Santa Clara Family Health Plan™

Questions?

Population Health Management (PHM) Strategy 2022
Cal-MediConnect (CMC) and Medi-Cal (MC)

Table of Contents

I. Comprehensive Population Health Management Strategy Introduction

In accordance with the National Committee for Quality Assurance (NCQA) 2022 Standards and Guidelines for the Accreditation of Health Plans, Santa Clara Family Health Plan (SCFHP) has developed a basic framework to support a cohesive plan of action for addressing member needs across the continuum of care including the community setting, through participation, engagement, and targeted interventions for a defined population. The framework is designed to address the four focus areas of population health, as outlined by NCQA, while using Cal MediConnect (CMC) and/or Medi-Cal (MC) Department of Health Care Services (DHCS)/Department of Managed Health Care (DMHC) required methods via health risk assessment (HRA) and individualized care planning (ICP) through an Interdisciplinary Care Team (ICT) approach. At a minimum, annual evaluations of various elements of this PHM strategy will assess the Plan's performance against the Institute for Healthcare Improvement (IHI) Triple Aim dimensions to improve patient experience of care, improve the health of populations and reduce the per capita cost of healthcare.

The goal of the comprehensive PHM strategy is to improve health equity for SCFHP members and how their care is managed. This goal supports SCFHP's mission to improve the well-being of our members by addressing their health and social needs in a culturally competent manner, and partnering with providers and organizations in our shared commitment to the health of our community, with the ultimate vision of health for all. This work falls under SCFHP's 3-year strategic plan to deliver exceptional quality outcomes and health equity for all members, with the goal of becoming a leader in community health.

This work is carried out by several groups. SCFHP has a Population Health Management Work Group, which includes diverse representation from Case Management, Quality Improvement, Long Term Support Services (LTSS), Utilization Management (UM), Pharmacy, and Clinical Quality and Safety. The purpose of this workgroup is to develop action plans and monitor and control programs, services, and activities related to the PHM strategy for meeting the care needs of our diverse population.

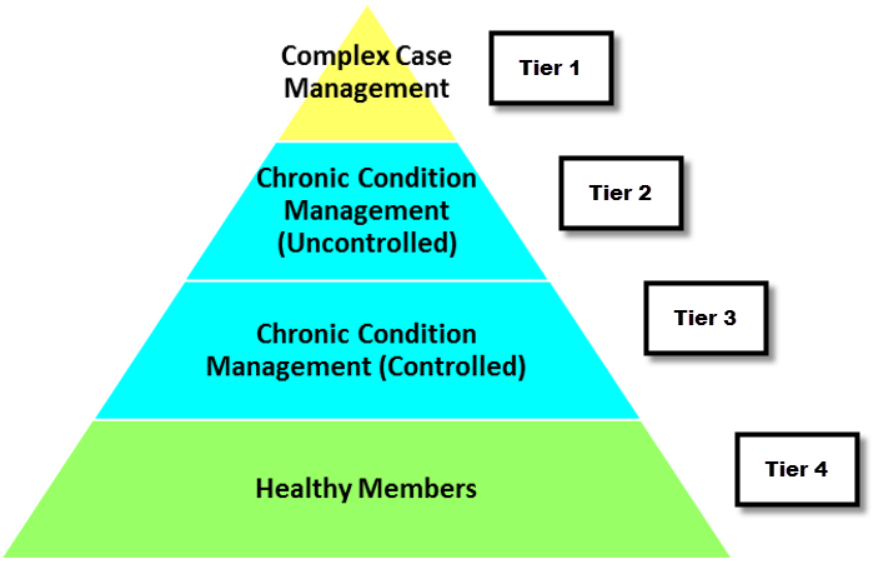
SCFHP also has a Member Health Equity Steering Committee. This committee consists of department representatives from Quality Improvement, Community Engagement, Customer Service, Grievance & Appeals, Case Management (CM), and Long Term Services and Supports (LTSS). At least one member of the PHM Work Group acts as a liaison to the Member Health Equity Council to keep both groups informed. The Member Health Equity Steering Committee collaborates closely with the Consumer Advisory Committee (for Medi-Cal LOB), Consumer Advisory Board (for CMC LOB), and the SCFHP Blanca Alvarado Community Resource Center Resident Advisory Group to develop, strengthen, and/or expand initiatives that promote health equity and reduce health disparities among members. The committee also serves as an advisory body to the executive team in support of the Strategic Plan and Plan Objectives.

SCFHP's Social Determinants of Health (SDOH) cross-functional team, led by LTSS, consists of department representatives from Case Management, Behavioral Health (BH), Quality Improvement (QI), Provider Network Operations (PNO), and Marketing and Communications. This group meets monthly to discuss SDOH related items and takes a deliberate approach to selecting data, intelligence, partnerships, and initiatives that enable SCFHP to provide impactful and sustainable SDOH programs and services. The main functions of this team are to establish social needs priorities for SCFHP informed by an SDOH data strategy, partner with internal and external stakeholders to identify & address social needs, track and

strategically engage in SDOH related community initiatives and partnerships and oversee Community Supports Network development and operations.

These groups work to improve members' health outcomes by analyzing data to understand risks (through stratification, segmentation, and tiering) to develop strategies and provide appropriate support services to our members. The member population is segmented into subset targeted populations based off assessment of population needs and there are specific programs and services to address the four focus areas. To accomplish this, SCFHP has developed a tier of programs and qualifying populations that would be eligible for each program. This tier stratification is applicable to both CMC and Medi-Cal.

Populations Targeted for PHM:



A. Tier 1: Complex Case Management (CCM) Eligibility Criteria

Members have 3+ hospitalizations in the past year and one other Tier 1 criteria *or* members meet three or more Tier 1 criteria:

- Age 75+ with 3 ADLs (as identified through Health Risk Assessment responses)
- >3 ED visits in the past year
- Hospitalized in the past 180 days (includes psychiatric admissions)
- Member has a diagnosis of Dementia (identified through claims data, and member self-disclosure)
- Member having acute or uncontrolled symptoms of severe mental illness (SMI) (identified through psychiatric admissions data)
- 3+ Chronic Conditions and at least one uncontrolled*

  **Uncontrolled is defined as 1 ED Visit or Inpatient stay within the past year, with a primary diagnosis of the member's chronic condition*
- Members who meet this criteria may be enrolled in either Enhanced Care Management (ECM) or CCM but not both

B. Tier 2: Chronic Condition Management Uncontrolled Eligibility Criteria

Newly enrolled members with no claims or utilization history ***or*** members that have at least one of the below criteria AND have at least one chronic condition that is uncontrolled:

- 75+ with 3 ADLs (as identified through HRA responses)
- >3 ED Visits in the Past Year
- Hospitalized in the Past 180 Days
- 3+ Hospitalizations in the Past Year
- 1+ Social Determinant of Health (as identified through HRA responses)

OR

- Member is enrolled in the Multipurpose Senior Services Program (MSSP) or Community Based Adult Centers (CBAS) or In Home Supportive Services (IHSS)
- Member has uncontrolled symptoms of severe mental illness (SMI) (identified through psychiatric admissions data)
- Member has been identified as homeless (through demographic data such as address, HMIS (once HMIS data is available) and/or diagnosis code)

C. Tier 3: Chronic Condition Controlled Eligibility criteria

Members that do not meet criteria for Tier 1 or 2 ***and*** have more than one controlled chronic conditions, and have greater than $3,000 claims costs per year after facility and pharmacy costs are removed, ***or***

- Member is in Long Term Care (LTC) with no discharge plan
- Member has been admitted to Hospice within the last 12 months
- Members with chronic conditions and SMI who are able to access primary and specialty services

D. Tier 4: Healthy Members Eligibility Criteria

All other members that do not meet criteria for Tiers 1-3 are eligible for Tier 4.

II. Population Health Program Focus Areas

SCFHP aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored solutions. The following four areas of this strategy focus on a whole-person approach to identify members at risk and to provide strategies, programs, and services to mitigate or reduce that risk:

1. Keeping members healthy
2. Managing members with emerging risk
3. Patient safety or outcomes across settings
4. Managing multiple chronic illnesses

III. PHM Programs and Services by Focus Area

SCFHP seeks to promote a program that is both sustainable, person-and family-centered, and enables beneficiaries to attain or maintain personal health goals. We do so by providing timely access to appropriate, coordinated health care services and community resources, including home- and community-based services and behavioral health services.

Table 1: Programs and Services by Focus Area

Programs & Services	LOB		NCQA Focus Area				Tier(s)
	CMC	MC	Keeping Members Healthy	Managing Members with Emerging Risk	Patient Safety or Outcomes Across Settings	Managing Multiple Chronic Illnesses	
Complex Case Management	X	X		X	X	X	1
Moderate Case Management	X	X	X	X	X	X	2
Basic Case Management	X	X	X	X	X		3, 4
Long Term Care	X	X	X	X	X	X	2 to 3
Transitions of Care	X	X	X	X	X	X	1 to 4
Behavioral Health Severe Mental Illness	X		X	X	X	X	1 to 4
Provider Engagement	X	X	X	X	X	X	1 to 4
Nurse Advice Line	X	X	X	X	X	X	1 to 4
Utilization Management & Concurrent Review	X	X	X	X	X	X	1 to 4
Health Education	X	X	X	X			1 to 4
Enhanced Care Management		X	X	X	X	X	1 to 4

Community Supports		X	X	X	X	X	1 to 2
Community Resources Integration	X	X	X	X	X	X	1 to 4
Medication Therapy Management (MTM)	X					X	1 to 4
Gaps in Care	X	X	X	X	X	X	1 to 4

IV. PHM Goals

SCFHP's plan of action for each of the focus areas include measurable goals for specific targeted Cal MediConnect (CMC) and Medi-Cal (MC) populations are as follows:

Keeping Members Healthy

Line of Business	Goal	Goal Justification	Population Targeted
CMC	Increase the number of newly enrolled CMC members with no claims or utilization data to have an Annual Wellness Visit (AWV), including the In-Home Assessment (IHA), within 365 days of their enrollment by 5 percentage points compared to the prior year results.	Based on analysis of IT risk stratification data, SCFHP discovered that we did not have utilization information on many of our newly enrolled CMC members. Annual Wellness visits are critical to maintaining the health of all CMC members.	All CMC members (not in LTC facility)
MC	100% of newly enrolled MC SPD members to have an Initial Health Assessment (IHA) annual wellness visit as a goal in their care plan.	Completing an IHA allows SCFHP to understand the needs of the member and develop a care plan with the PCP accordingly.	All new MC SPD members

Managing Members with Emerging Risk

Line of Business	Goal	Goal Justification	Population Targeted
CMC	Increase diabetic control rate by 2 percentage points compared to prior year results	In CY 2021, 20.63% of CMC members had diabetes. Uncontrolled diabetes can lead to cardiac disease and progressive decline in health.	All CMC members with a uncontrolled (<8%) chronic condition of diabetes with an HbA1c over 9%
MC	Increase diabetic control (< 8%) rate by 2 percentage points compared to prior year results	Uncontrolled diabetes can lead to cardiac disease and progressive decline in health. Programs and services are aligned with HEDIS efforts to decrease HbA1c and improve	All MC members with a uncontrolled (<8%) chronic condition of diabetes with an HbA1c over 9%

		diabetic health outcomes for members.	

Patient Safety or Outcomes Across Settings

Line of Business	Goal	Goal Justification	Population Targeted
CMC	Decrease 30 Day Readmission rate for CMC members by 1 percentage point compared to prior year results	The intent is to promote transitions of care for CMC members discharged from an acute or skilled nursing facility setting and improve continuity of care across acute care, long term care, behavioral health and home and community-based settings. Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members.	CMC members readmitted within 30 days of discharge
MC	Decrease 30 Day Readmission rate for MC members by 1 percentage point compared to prior year results	The intent is to promote transitions of care for MC members discharged from an acute or skilled nursing facility setting and improve continuity of care across acute care, long term care, behavioral health and home and community-based settings. Programs and services are aligned with HEDIS efforts to reduce all cause readmissions and improve health outcomes for members.	MC members readmitted within 30 days of discharge

Managing Multiple Chronic Illnesses

Line of Business	Goal	Goal Justification	Population Targeted
CMC	95% of CMC members with a chronic illness report improved self-management of their illness on patient-reported outcome surveys within 24 months of enrollment.	The intent is to empower and encourage CMC members with chronic illnesses to take a proactive approach in monitoring and controlling their health.	CMC members not enrolled in CCM
MC	95% of MC members with a chronic illness report	The intent is to empower and encourage MC members with	MC members not enrolled in CCM

	improved self-management of their illness on patient-reported outcome surveys within 24 months of enrollment.	chronic illnesses to take a proactive approach in monitoring and controlling their health.	

V. PHM Goal Outcomes by Focus Area & Target Population

Segmentation by Focus Area: Keeping Members Healthy (CMC) Goal: Increase the number of newly enrolled CMC members with no claims or utilization data to have an Annual Wellness Visit (AWV), including the In-Home Assessment (IHA), within 365 days of their enrollment by 5 percentage points compared to the prior year results.					
Programs & Services	**Targeted CMC Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of CMC Membership**
1. Basic Case Management	All Tiers	Opt-out	Interactive	9,207	100%
2. Nurse Advice Line	All Tiers	Opt-Out	Interactive	9,207	100%
3. Health Education	All Tiers	Opt-In	Interactive & Passive	9,207	100%
4. Wellness & Prevention	Per benefit	Opt-Out	Interactive & Passive	9,207	100%
5. Community Resource Integration	All Tiers	Opt-Out	Interactive	9,207	100%
6. Provider Engagement	All Tiers	Opt-Out	Physician Passive & Interactive	9,207	100%
7. Gaps in Care	All Tiers	Non-Member driven	Data Sharing	9,207	100%

Segmentation by Focus Area: Keeping Members Healthy (MC) Goal: 100% of newly enrolled MC SPD members to have an Initial Health Assessment (IHA) annual wellness visit as a goal in their care plan.					
Programs & Services	**Targeted MC Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible MC Members**	**% of MC Membership**
1. Basic Case Management	All Tiers	Opt-out	Interactive	274,031	100%
2. Nurse Advice Line	All Tiers	Opt-Out	Interactive	274,031	100%
3. Health Education	All Tiers	Opt-In	Interactive & Passive	274,031	100%

4. Wellness & Prevention	Per benefit	Opt-Out	Interactive & Passive	274,031	100%
5. Community Resource Integration	All Tiers	Opt-Out	Interactive	274,031	100%
6. Provider Engagement	All Tiers	Opt-Out	Physician Passive & Interactive	274,031	100%
7. Gaps in Care	All Tiers	Non-Member driven	Data Sharing	274,031	100%

Segmentation by Focus Area: Managing Members with Emerging Risk (CMC and MC) *Goal:* Increase diabetic control rate by 2 percentage points compared to prior year results							
Programs & Services	**Targeted Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of CMC Membership**	**# of Eligible MC Members**	**% of MC Membership**
1. Basic Case Management	All Tiers	Opt-Out	Interactive	9,207	100%	274,031	100%
2. Health Education	All Tiers	Opt-In	Interactive	9,207	100%	274,031	100%
3. Provider Engagement	All Tiers	Non-Member directed	Physician	9,207	100%	274,031	100%
4. Behavioral Health, Severe Mental Illness (SMI)	Tier 2	Opt-Out	Interactive	324	3%	8,147	2%
5. Gaps in Care	All Tiers	Non-Member driven	Data Sharing	9,207	100%	274,031	100%

Segmentation by Focus Area: Patient Safety across settings (CMC and MC) Goal: Decrease 30 day Readmission rate by 1 percentage point							
Programs & Services	**Targeted Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of CMC Membership**	**# of Eligible MC Members**	**% of MC Membership**
1. Basic Case Management	All Tier	Opt-Out	Interactive	9,207	100%	274,031	100%
2. Transition Of Care (TOC)	All Tiers	Opt-Out	Interactive	9,207	100%	274,031	100%

Segmentation by Focus Area: Patient Safety across settings (CMC and MC) Goal: Decrease 30 day Readmission rate by 1 percentage point							
Programs & Services	**Targeted Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of CMC Membership**	**# of Eligible MC Members**	**% of MC Membership**
3. Long Term Care Transitions	Tier 2	Opt-Out	Interactive & Passive	324	3%	8,147	2%
4. Provider Engagement	All Tiers	Opt-Out	Interactive & Passive	9,207	100%	274,031	100%

Segmentation by Focus Area: Managing Multiple Chronic Illness (CM and MC) Goal: 95% of members with a chronic illness report improved self-management of their illness on patient-reported outcome surveys within 24 months of enrollment.							
Programs & Services	**Targeted Population**	**Opt-in / Out**	**Member Communication**	**# of Eligible CMC Members**	**% of CMC Membership**	**# of Eligible MC Members**	**% of MC Membership**
1. Complex Case Management	Tier 1	Opt-In	Interactive	213	2%	136	.0005%
2. Moderate Case Management	Tier 2	Opt-Out	Interactive	324	3%	8,147	3%
3. Medication Therapy Management	Tier 1-4	Opt-In	Interactive	9,207	100%	274,031	100%
4. Nurse Advice Line	Tier 1-4	Per benefit	Interactive	9,207	100%	274,031	100%
5. Behavior Health Case Management	Tiers 2-4	Opt-Out	Interactive	8,670	94%	273,895	99%

Racial Bias Assessment in Segmentation

SCFHP gathers and analyzes data from multiple sources to understand members' risks (through stratification, segmentation, and tiering) to develop strategies and provide appropriate support services to members and their needs. Based on a member's potential risk or risk status, they are assigned to Tiers 1-4 where they may be eligible for programs and services. SCFHP is committed to analyzing our processes and methodologies to address possible racial bias and ensure equity for all our members. For example, in assessing CMC members' tier stratification, SCFHP found that although Vietnamese members accounted for 14% of total CMC membership, only 4% were stratified as Tier 1. However, when comparing this to the Caucasian group, Caucasian members account for 13% of total membership but make up 25% of Tier 1 members (the second highest group). This trend of the Caucasian group having a disproportionately higher weight in Tier 1 relative to its size in population runs true within our Medi-Cal members as well, in which 24% of Tier 1 members are Caucasian but account for only 10% of the total population. The reverse is also

found with Vietnamese Medi-Cal members, in which Vietnamese members account for 16% of the total population but make up 7% of Tier 1. Member tier stratification is based on meeting critiera. Members in Tier 1 are the most complex due the complications of their health. This comparison between our Vietnamese versus Causian members may have different factors that explain this disproproration weight. Different ethnic groups have different approaches to healthcare, support system, cultural beliefs, etc., that may contribute to the member's overall conditions and needs.

VI. Description of Case Management Program and Service Activities

Members are identified for case management through multiple sources, including, but not limited to eligibility files, medical and pharmacy claims data, Health Risk Assessment (HRA) data, and utilization management data. Members may also self-refer, or be referred by providers, discharge planners, caregivers, delegates, vendors, and community partners.

Members are assigned to CM programs based on risk stratification, member's responses to the health risk assessment, additional assessments, clinical evaluation and consultation with members to determine their willingness to participate. Members can move between programs as appropriate to provide the most appropriate level of support at the time.

A. Case Management Activities:

Health Information Form/ Member Evaluation Tool (HIF/MET)

SCFHP uses the HIF/MET data to help identify newly enrolled Medi-Cal members who may need expedited services. It is included in the new member packet mailed to all newly enrolled Medi-Cal beneficiaries including a postage paid business reply envelope for response.

Within the 90 days of a new member's effective date of enrollment, SCFHP Production Services and the Customer Service Department oversee the receipt and processing of completed HIF/MET forms returned via USPS mail and all HIF/MET data is entered into Case Management Platform, Essette. Members that need Case Management (CM) intervention are identified and escalated to CM immediately through Essette. Referrals from HIF/METs include an outbound call to the member to discuss the results and follow up on care coordination as needed.

If the member falls within the Seniors and Persons with Disabilities (SPD) population, the HIF/MET is used to initiate the completion of a Health Risk Assessment (HRA) and any subsequent care coordination as appropriate.

In addition, SCFHP Medical Management Personal Care Coordinator conducts at least two outreach calls to members if a completed HIF/MET is not returned within 30 days of the member's enrollment date.

Long Term Services and Supports (LTSS) Assessment

Care Coordination for members enrolled in LTSS benefit programs who are dually eligible for Medicare and Medi-Cal and not enrolled in the Cal MediConnect line of business is provided in collaboration with LTSS providers. SCFHP retains and compiles a copy of assessments and care plans for members enrolled in Community-Based Adult Services (CBAS), Multipurpose Senior

Services Program (MSSP), and Long Term Care (LTC) in a skilled nursing facility. This information is documented in Essette and a designated LTSS Care Coordinator or Case Manager conducts a review to determine if further care coordination is needed.

Health Risk Assessment (HRA)

CMC and Medi-Cal SPD members are assessed upon enrollment and, at a minimum, on an annual basis using the Health Risk Assessment (HRA). This tool consists of questions related to health, psychosocial needs, and Social Determinants of Health (SDOH) to assess the members' understanding of their health status and to identify wellness goals and appropriate assignment for Case Management programs and services. All assessments completed are analyzed to adjust clinical risk level of members.

Individual Care Plan (ICP)

Upon completion of an HRA or through any demonstrated need, an Individual Care Plan (ICP) will be developed with the members' participation. The ICP is to include the member's goals and preferences, measureable objectives, and community resources as appropriate, to meet member-prioritized health care goals. The ICP will be shared with the member and their Primary Care Provider (PCP) and members are encouraged to share the ICP with anyone that provides care coordination to them. ICP's are updated based on the member's condition and preferences and, at a minimum, on an annual basis. Members who cannot be reached or who refuse to engage in the ICP process will receive a preventative ICP with their assigned care coordinators contact information.

Interdisciplinary Care Team (ICT)

SCFHP will assist members to identify their Interdisciplinary Care Team (ICT) when a need is demonstrated or as requested by the member or the member's authorized representative. ICTs are comprised of professionals appropriate for the needs, preferences, and abilities of the member and will integrate the member's medical care, LTSS needs, and behavioral health services as appropriate. The members' ICT will be led by professionally knowledgeable and credentialed personnel that will include, at a minimum, the member, individuals approved by the member, County In-Home Support and Services (IHSS) social worker, the member's Primary Care Provider, and SCFHP Care Coordination staff. Additional providers, such as social workers, specialists, LTSS providers, community-based case managers, and caregivers are included at the request of the member. The ICT collaborates with the member to stabilize medical conditions, increase compliance with the ICP, and meet ICP goals for optimal health and functional status. Meetings with a member's ICT will be offered and conducted periodically as needed for the member's care or if requested by the member. Members have the right to opt-out of participation on the ICT without disrupting their access to care coordination. Members who opt out will receive a preventative ICP with their assigned care coordinators contact information.

Use of SCFHP Software Systems to Coordinate Member and Provider Programs

Essette is the care management platform that includes data from all areas of the plan for care coordination communication. Data includes pharmacy claims, medical claims (including ED visits

and hospitalizations), UM authorizations, and lab data to inform member care planning by the case manager and the ICT. Member demographic data flows from QNXT, our claims processing platform, which is the source of truth for that information. Care coordination outreach by all departments is documented in Essette for cross departmental transparency. Case management referrals are also documented within Essette. There is ongoing initiatives to include information from additional vendors, such as assessments, medication therapy management, etc.

B. Case Management Programs

1. **Complex Case Management** is provided to all eligible members in Tier 1 and is described in detail in the corresponding PHM strategy and QI.13 policy summary. These members are offered intensive support and are established based on member's preference and needs. Members are engaged in a thorough initial assessment.
2. **Moderate Case Management** is provided to members in Tier 2 and includes those members with multiple chronic conditions with at least one uncontrolled and complex social determinants of health. It includes members receiving MSSP services and care coordination around severe mental illness (SMI).
3. **Basic Case Management** is provided to members in Tiers 3 and 4 and includes at a minimum, the completion of a HRA and further assessment as needed for benefit coordination in collaboration with the PCP.
4. **Transitions of Care (TOC)** is provided across all CM Tiers for members to support discharge planning from acute hospital or long term care facility. Outreach is made to members who recently discharged from the acute hospital, inpatient psychiatric hospital, or skilled nursing facility to ensure a safe transition to the appropriate level of care and minimize risk of readmission. This service is also provided to support continuity of care for members transitioning between providers. Members will be reassessed for the appropriate tier of CM after their transition period. Case management services include integration of the discharge plan into the current ICP including facilitating follow up visits to the member's providers, post-discharge medication reconciliation, and confirmation that the discharge plan has been implemented. If a member is not connected to a Behavioral Health (BH) care team in the community following discharge from an inpatient psychiatric hospital, both the discharging hospital and the BH CM will help to coordinate a visit.
5. **Long Term Care (LTC) Transition** case management is provided to the subgroup of nursing facility members who are authorized for long term care but have been identified as able to discharge back to the community. Case management includes working with the member and their family or caregivers and the nursing facility team to assess readiness for discharge and coordination of a discharge plan. The LTC RN CM visits the member to conduct a face-to-face assessment, provides information about long term services and supports (LTSS) benefits and other community-based resources, and facilitates arrangement of and authorization for services and supports needed post-discharge. This includes addressing social determinants that may be a barrier to discharge including income benefits, lack of housing and family support and coordination with community resources. The CM coordinates closely, as

appropriate with other community-based services targeted to nursing home residents including the Community Care Transitions (CCT) program and other programs serving this population including Community Supports (CS). The Case Manager conducts a TOC call following discharge notification and follows all TOC and case management processes as outlined below for TOC. After 30 days following transition, the member is referred to the appropriate CM team.

6. **Behavioral Health (BH) Case Management** is provided to members who have behavioral diagnosis in any tier, based on their level of stability. The BH CM team collaborates with the other CM teams to coordinate the medical and LTSS case management services as needed across all settings. Specific focus areas of BH Services include:
    - Reduction of ED visits for those who have any BH diagnosis;
    - Follow up after psychiatric hospitalization to ensure safety for members and that all members have a follow up visit with a BH provider at 7 and 30 days; and
    - Coordination of care with community BH providers as needed and appropriate
7. **Enhanced Care Management (ECM)** is a whole person care approach that addresses the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services. ECM provides intensive and comprehensive care management services to targeted individuals that is community based, high touch, and person centered. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease unnecessary utilization and duplication of services.
8. **Community Supports** are medically-appropriate and cost-effective alternatives to Medi-Cal covered benefits and seek to address combined medical and social determinants of health (SDOH) needs to avoid higher levels of care (e.g., emergency department (ED) visits, in-patient (IP) stays, skilled nursing facility (SNF) stays). Community Supports are optional for plans to provide and optional for members to receive. There are 14 DHCS-approved Community Supports that can be found in the Community Supports Policy Guide.

C. Case Management Supportive Services

24/7 Nurse Advice Line:

The Nurse Advice Line is a nurse-driven telephonic support program that empowers members to better manage their health. Highly trained registered nurses help participants navigate through questions and concerns about symptoms, appropriate treatment choices, comorbid conditions and additional risk factors. Nurse Advice Line data is provided to SCFHP Care Coordination staff for review and follow-up as needed. All Nurse Advice Line calls resulting in a 911 disposition will trigger a referral to SCFHP Care Coordination staff.

Provider Engagement

SCFHP engages providers in the member's care in various ways. Member PCPs are provided their specific CMC enrollment data monthly so that they can identify new members requiring an Initial Health Assessment (IHA). They also receive a copy of the member's ICP. Through IHA and the ICP, the provider can engage the member in discussions about preventative services, regular screenings, maintenance therapies, and health education programs, such as nutrition and physical activity education. PCPs are also members of the members' Interdisciplinary Care Team (ICT) and

are invited to attend any scheduled ICT meetings. To further engage the provider network, educational materials are made available on the external SCFHP website. The Provider Network Operations (PNO) team also schedules visits and distributes a quarterly provider newsletter.

Utilization Management and Concurrent Review

The Utilization Management (UM) team includes clinical and non-clinical staff who review prior authorization request of inpatient and outpatient services. Medical necessity are determined by licensed clinical staff. Concurrent review of inpatient stays including hospitalization are completed by California-licensed Registered Nurses (RNs) who collaborate with the facility and other providers to coordinate member's discharge needs and related follow up care. Care coordination related to discharge planning may include referrals to any available CM programs and coordinating benefits across health care settings, such as skilled nursing facility placement, home health, Long Term Services and Supports (LTSS), behavioral health and outpatient services.

Within 3 calendar days of a Cal MediConnect member's discharge to a residential home or his or her community setting such as an assisted living facility, the UM team notify the Case Management team of a member's discharge for Transition of Care (TOC) outreach and assessment. The TOC assessment within Essette evaluates for any member or caregiver support and/or resources which are needed to minimize gaps in care which may otherwise result in readmissions or preventable emergency room visits.

Health Education

The Health Education program has a variety of classes and workshops available for members to help maintain and improve their health and manage their illnesses. SCFHP works with a number of agencies within the community to provide programs covering topics from chronic disease, counseling services, weight management, smoking cessation, safety programs, and more. A complete list of these programs are available on the SCFHP website (www.scfhp.com). Members may self-refer to all programs, except for the Diabetes Prevention Program. Self-referral is completed through the mySCFHP Member Portal or by contacting Customer Service. Referrals are also received from PCPs and all SCFHP departments.

Community Resources Integration

Cal MediConnect and Medi-Cal SCFHP members face many barriers in the form of social determinants of health. In order to help remove these barriers, SCFHP contracts and partners with FindHelp (FH), a social care network that offers an online database of community resources specific to Santa Clara County. The LTSS team serves as the liaison with FH to coordinate updates and training for all case managers. This, combined with any additional community resources we are made aware of, assist the CMs with addressing social determinants of health experienced by Cal MediConnect and Medi-Cal SCFHP members. Designated SCFHP LTSS staff also manage local relationships with key community providers and attend relevant community meetings to stay abreast of available resources and changes in eligibility.

All CM staff receive initial and annual training on FH and community-based programs and services with detailed information on program scope, eligibility, referral processes, and key contacts. This information is updated at least annually. Case managers and supporting staff also have access to

trainings with providers, face-to- face visits and presentations by providers with new resources shared on an ongoing basis.

Community resources that address the most common social determinants of health needs identified by our members are food, housing, transportation, socialization, caregiver support and respite, legal services, public benefits and services such as protective services, and specialized case management (e.g. HIV). CM referrals are made as part of the individual care plan development and goal setting to facilitate coordination of benefits and community resources. Through FH Single Sign-on (SSO) platform, SCFHP staff can directly send referrals to community based providers and FH will continue to update that referral status to make sure members have been connected to programs successfully. The LTSS team will work with trusted and reliable organizations and contracted vendors to ensure their organization is claimed on FH and continuously updated. This will also allow for CMs to utilize the closed-loop referral function to ensure the best care for members. Cal MediConnect and Medi-Cal members may also access FH on their own through the SCFHP website and reports can be run to determine the highest needs identified by programs and resources searched by Cal MediConnect and Medi-Cal SCFHP members.

Medication Management Therapy (MTM)

The goal of MTM is to optimize drug therapy and improve therapeutic outcomes for members. Members that take medications for multiple different medical conditions may be eligible to receive MTM services at no cost. Members that qualify are automatically enrolled in to the program and mailed a welcome letter explaining the program and instructions for opting out. Specific eligibility criteria is posted both on www.scfhp.com and within the member handbook. MTM is only performed for the CMC line of business. MTM services may include:

- Calls from a pharmacist or other health professional to review all of the members' medications and discuss medication benefits, concerns, and questions
- Written, mailed summary of the medical review as well as a medication action plan and personal medication list
- Follow up from the pharmacist or other health professional every 3 months to ensure records are up to date as well as the safety and cost effectiveness of medications

Gaps in Care (GIC)

When a member's profile is searched in QNXT, automated notifications will pop-up that will alert the reader when a member has not received a specific wellness screening or follow-up with PCP. Customer Service Representatives and member facing team staff can provide members with this information when they call in to ask a question. Members who have questions or who need assistance to schedule appointments to their PCP or require transportation assistance can be helped immediately. Gaps in Care pop-ups also serve to alert the care coordination team to include annual wellness and prevention screening elements as a member's care goal.

VII. Informing Members

Cal MediConnect and Medi-Cal members are informed about all available PHM programs and services at any level of contact including the Plan's website, direct mail, e-mail, text or other mobile applications, telephone or in-person. Many programs offered are communicated to Cal MediConnect and Medi-Cal

members within their Evidence of Coverage/Member Handbook document, which is mailed to members annually and upon enrollment, as well as through www.scfhp.com. Additionally, a catalog of all PHM programs was created and made available on the health plan website so that members may be informed of all programs that they may be eligible for. The catalog will be updated annually and can be mailed to members upon their request. Annually, Cal MediConnect and Medi-Cal members will receive a mailing on how to access this information on line or how to request it from customer services.

Cal MediConnect and Medi-Cal members deemed eligible for inclusion in any PHM program, involving interactive contact, may opt-out of participation at any time. Cal MediConnect and Medi-Cal members or their Authorized Representatives may request to opt-out by calling SCFHP's Customer Service department at 408-376-2000, sending a secure email to the SCFHP's Case Management Department at www.CaseManagementhelpdesk@scfhp.com, or via USPS mail delivery.

VIII. Population Health Delivery System Support

SCFHP provides support to practitioners and providers providing population health management to our members and to support the achievement of program goals. Below are a list of activities conducted by the Plan that support PHM programs or services not directed at individual members.

Table 2: Indirect Member Interventions for Cal MediConnect and Medi-Cal Lines of Business

Indirect Interventions	Focus Area(s)
SCFHP shares member data with providers to assist them in delivering services, programs and care to our members. We mail, fax, and/or verbally inform providers of their members individualized care plans and goals at least annually and after any updates. We also inform providers via fax when we have been unable to reach a member to complete a comprehensive Health Risk Assessment (HRA) and request their assistance. Additionally, we electronically send our providers member eligibility reports, language, and demographic data, and gaps in care reminders via the online provider portal.	1-4
SCFHP's Provider Network Operations (PNO) team completes provider education and required trainings, including the provision of continuing education units (CEUs/CMEs). These trainings include: cultural competency, Screening, Brief Intervention and Referral to Treatment (SBIRT), communicating across language barriers, Long Term Services and Supports (LTSS), the Staying Healthy Assessment, and Interdisciplinary Care Team (ICT).	1-4
Quarterly provider newsletters, distributed by fax and e-mail and posted on the website	1-4

Indirect Interventions	Focus Area(s)
SCFHP presents quarterly to a Provider Advisory Council (PAC) on topics such as behavioral health treatment advances, opioid addiction, and other topics relevant to the characteristics of our SCFHP member population.	2, 3
SCFHP participates in monthly community Safety Net Network meetings. Discussions within these meetings with our community partners include topics such as food resources, housing, and resources that address social determinants impacting the member population.	1, 3
Coordination with Housing Services Information System: SCFHP participates in the County's Homeless Management Information System (HMIS) - an online database that enables organizations to collect data on the services they provide to people experiencing homelessness and people who are at risk for homelessness. Members who are in the HMIS database may have priority access to housing assistance.	2-4
Nursing Home Support and Training The LTSS team has designated clinical and provider network staff to manage relationships with all contracted nursing facilities serving a large member population. This includes conducting regular visits, to support utilization and case management for long term care members including collaboration for care transitions. A provider liaison monitors quality measures, troubleshoots issues related to authorizations claims, or contracting and conducts periodic trainings for SNF staff.	2-4
Behavioral Health Services coordinates and partners with the County Behavioral Health Services Department (CBHSD) that also includes Substance Use Treatment Services (SUTS), community-based organizations, and providers to facilitate patient outcomes across all settings. This could include collaboration with acute and outpatient staff disposition, follow up and ongoing BH/SUTS treatment for best outcome results. The coordination includes continuous collaboration with providers and provider training and education as appropriate.	1-4
Quality department provides intermittent training for contracted providers on appropriate wellness and preventative services (e.g. USPSTF, clinical practice guidelines) as appropriate. Clinical practice guidelines are also available to providers on the website.	1, 3

Indirect Interventions	Focus Area(s)
Pharmacy department performs quarterly drug use evaluations (DUEs) on various clinical areas (e.g. polypharmacy, asthma controller medication review) to look for gaps in care and contacts providers as appropriate for intervention.	1-4
SCFHP notifies the community and providers about Aunt BerthaFindHelp and how to access it through scfhp.findhelp.com scfhp.auntbertha.com in an e-newsletter. Providers can also access Aunt BerthaFindHelp through the resource page found on the plan's website (scfhp.com).	1-4
SCFHP shares evidence-based guidelines with our provider network on the health plan website, www. scfhp.com. The information is located within the Provider Resources section on the website and includes guidelines for: i. Cervical Cancer ScreeningPreventive Screenings • US Preventive Services Task Force – A and B Recommendations • Treating Tobacco Use and Dependence • The American College of Obstetricians and Gynecologists (ACOG) Clinical Information • Child Health and Disability Prevention (CHDP) Health Assessment Guidelines • Centers for Disease Control and Prevention (CDC) 2021 Sexually Transmitted Diseases Treatment Guidelines • Adopted clinical and preventive guidelines Clinical and Preventive ii. BMI calculations • BMI chart: Boys 2-20 years • BMI chart: Girls 2-20 years iii. Recommended immunization schedules • Recommended adult immunization schedule • Recommended immunization schedule for persons aged 0 through 18 years	1-4

IX. Coordination of Cal MediConnect and Medi-Cal Member Programs

Internal and external population health programs and services are coordinated across settings, providers and levels of care to minimize confusion to Cal MediConnect and Medi-Cal members from being contacted from multiple sources.

To provide care in a coordinated manner, SCFHP has several programs offered to Cal MediConnect and Medi-Cal members as specified in Section IV, depending on their clinical conditions and psychosocial needs. The health plan strives to provide the right care at the right time in the right place to members in

order to improve patient experience of care, the health of populations and reduce the per capita cost of healthcare.

To better understand where the member is in the continuum of care, SCFHP Care Coordination staff collaborates with all internal departments, vendors, and community partners to identify potential member coordination opportunities, access and education needs. The CM team coordinates with community based service partners to align members with non-benefit resources to support their ICP through the ICT process.

Interdepartmental coordination is key to effective service coordination. SCFHP's case management software platform, Essette, acts as the central point of documentation for all care management programs and services related to the member. All members are assigned to an SCFHP Care Coordination staff member who acts as the primary point of contact for population health management support. In addition to the ICT discussed above, internal case conferencing across specialties is facilitated for coordination of care plan development and implementation across member needs including medical, LTSS and BH.

For care coordination across organizations, including delegates and community level case management programs, SCFHP Case Management programs coordinate with external partners as needed.

Members identified with Serious Mental Illness are assigned to the Behavioral Health Case Management program and are referred to community programs as appropriate; this referral process is coordinated through the appropriate Behavioral Health (BH) Care Coordination staff to ensure services are not duplicated by external programs, and that the needs (i.e. medical needs, social determinants of health) of the member are met. In addition, BH collaborates with the county through county reporting of new assessments from their call center. The behavioral health case manager communicates regularly with the medical and behavioral health care teams to assist with access issues. BH also coordinates treatment and care for members who have been discharged from acute settings by following-up and collaborating with providers from the acute setting.

X. Health Equity

Every SCFHP member, regardless of the line of business or primary care assignment, should have access to the same level of care and resources when addressing social needs. However, through case studies, we have identified that not all members receive the same type of care navigation and assistance to address social needs. This is due to providers not having the needed training, resources, or time to address such complex issues. In order to address this issue, a project was created out of the cross-functional SDOH team of member facing stakeholders, who will map out the member journey based on the line of business and primary care assignment to determine gaps in care navigation. The group will develop solutions to address these gaps and implement at least one change by FY 2023.

Project Description	Departments Involved	Tasks	Target Date
Care Coordination for non-delegated members	• Case Management • ECM • Community Supports • LTSS • Community Resource Center • Customer Service	• Map Current and Future state • Create and train staff on workflow for staff	12/31/2022

XI. Impact Analysis of Population Health Management Strategy

At least annually, SCFHP conducts a comprehensive analysis of the impact of its PHM strategy that includes quantitative results for relevant clinical/cost and utilization and experience measures. Quantitative and qualitative analysis is conducted based on these results. Comparison of results with established benchmarks are evaluated for evidence of program effectiveness and room for improvement. This analysis will be conducted by the Health Services department in conjunction with IT, Member Services, Provider Services, and Grievance & Appeals to support the Cal MediConnect and Medi-Cal members and promote an effective Population Health Management Strategy.

Appendix A: Activities and Resources Based on Population Health Assessment

Need or Population Identified	**Activities**	**Internal Resources/Staffing**	**Community Resources**
Financial insecurity Interventions aimed at finding options for members to access food, subsidize rent or utilities	Designated SCFHP Long Term Services and Support (LTSS) staff assigned to providing training to Cal MediConnect (CMC) Case Managers on available community resources for rental assistance, utility assistance, and food. Provide training and education to Santa Clara Family Health Plan (SCFHP) staff and contracted providers on CalAIM Community Supports, such as housing services, transition services and medically supportive foods, offerings for Medi-Cal member. Partner with housing sector to address housing related issues for members through screening, identification, navigation and tenancy.	All Case Management (CM) staff receive initial and annual training on the FindHelp (FH), formerly known as Aunt Bertha, platform and community-based programs and services with detailed information on program scope, eligibility, referral processes, and key contacts. Designated LTSS staff is assigned as a liaison to the FH staff to work on expanding agencies participating in the platform and to ensure that resources on FH are up to date. Designated SCFHP LTSS staff also manage local relationships with key community providers and attend relevant community meetings to stay abreast of available resources and changes in eligibility Community Resource Center (CRC) will allow for member access to SCFHP staff and will facilitate member access to the FH platform on site.	Members who identify as needing help with financial security can be referred to resources on the FH platform that support the member's needs. Depending on the impact of the financial insecurity (e.g. housing stability, food insecurity), the resources needed may vary. Case Managers can also assist the member with accessing additional benefits such as CalFresh or Supplemental Security Income (SSI).

Language: Interventions should focus on ensuring members are aware of interpreter services, know how to access these services, and providers are able to offer them when needed.	Annual refresher training and onboarding for Providers to educate them on translation and interpreter services offered at no-cost 24/7 to SCFHP members Cultural & Linguistics (C&L) Toolkit – created to educate Providers about LEP (limited English proficiency) speakers and services/tips available, quick reference guide with Language Line access numbers for Providers. SCFHP Member ID cards have the member's preferred spoken language listed to help Providers identify members that need interpreter services. Quarterly Newsletters – all CMC member newsletters have information on accessing language services at no cost to members. Member letters – all member letters include tagline on language assistance services offered to them, and how to access the services at no cost.	Annual internal refresher training C&L Training for member facing teams including, but not limited to Customer Service, Case Management, Behavioral Health, LTSS, Medicare Outreach, & Quality Improvement (QI) Outreach teams on interpreter/ translation services for LEP members by C&L team. SCFHP wide annual training through Litmos, (SCFHP's training portal) on Cultural Competency to describe the role of communication and language in providing culturally competent care. 4 Outreach Coordinators full-time staff for Quality Outreach Program– staff proficient in Vietnamese, Cantonese, Tagalog, & Spanish. Outreach to members will be prioritized to the Coordinator who speaks that language.	Planned expansion of Health Education programs Contracting with organizations to offer health education opportunities such as classes, workshops, webinars, etc. in additional threshold languages, including Vietnamese and Chinese, both virtually and in-person at Community Resource Center. Supporting local community – SCFHP endorses and promotes health prevention and wellness by supporting call-to-action letters from supporting organizations on topics such as reducing tobacco use, asthma, and allergy awareness.
Admission for Sepsis: There is a need for further exploration to assess the behavior of SMI sub-population and those in LTSS, particularly enrollees in SNFs that may lead to infectious disease and eventually to sepsis so case managers can	CDC handouts to members who are at risk of contracting sepsis or for members who have recovered from sepsis Educational materials and tools related to sepsis are provided on the SCFHP website targeted for providers.	In-service to CM staff on sepsis prevention and how to identify members at risk	Continue to share best practices, resources and trainings to BH and LTSS partners on sepsis

provide education to members on preventative strategies.			
Members with Multiple Uncontrolled Chronic Conditions	Tier 1 & 2 - Complex and Moderate case management (CCM): Comprehensive assessment within 60 days of identification for CCM Intensive engagement up to weekly with the CM team for CCM HRA and care planning identifies chronic conditions and member goals Coordination of medical care	All care teams will be cross-trained to provide CCM Multidisciplinary teams with RNs, Social Work Case Managers and Personal Care Coordinators (PCCs), specialty CM for behavioral health and LTSS and external stakeholders and providers	External case managers, County Behavioral Health including Substance Use Treatment Services, Long Term Services and Supports providers and other community organizations Community-based providers for physical activity, nutrition programs including Medically Tailored Meals. Santa Clara County Health & Hospital System (SCCHHS) and other county departments including Aging & Adult Services, In-Home Supportive Services (IHSS), public nutrition programs
Comprehensive diabetes care for members with uncontrolled A1C >9%, targeting Caucasian, Vietnamese, and Hispanic members	Diabetes Focus Groups for English and Spanish-speaking members Diabetes Health Disparity Education Program by Clinical Pharmacist Coordinators enroll eligible members and schedule appointments for pharmacists Pharmacists telephonically outreach enrolled members once/month Pharmacists fax recommendations to provider office after each encounter with member. Coordinators follow up with providers, help with administrative tasks	Have English, Spanish, and Vietnamese speaking staff (Pharmacists and Coordinators) to outreach members Conduct social screenings and connect members to other plan resources and services. Work with Case Management (CM) and Social Determinants of Health (SDOH) teams to refer members appropriately and learn resources to share with members.	Meetings with partner community-based organizations provide updates on program enrollment, project updates, share best practices, etc. Attend Joint Operating Committee (JOC) meetings with partners

Last Update:	Author(s):	Approval Date:
June 2021	Dr. Laurie Nakahira, Chief Medical Officer, Health Services Angela Chen, Interim Director, Case Management Lori Andersen, Director, Long Term Services and Supports (LTSS) Shawna Cagle, Manager, Case Management Natalie McKelvey, Manager, Behavioral Health Andrea Smith, Supervisor, Case Management Johanna Liu, Quality & Process Improvement Lucille Baxter, Quality & Health Education	June 9, 2021
June 2022	Angela Chen, Director, Case Management Lori Andersen, Director, Long Term Services and Supports (LTSS) Dang Huynh, Director, Utilization Management and Pharmacy Shawna Cagle, Manager, Case Management Lucille Baxter, Manager, Quality & Health Education Gaya Amirthavasar, Manager, Social Determinants of Health Jessica Bautista, Manager, Community Based Case Management	June 14, 2022

Compliance Activity Report

June 14, 2022

- **Medicare Data Validation Audit**
  The Plan is currently undergoing the annual Medicare data validation audit. SCFHP engaged Advent Advisory Group to complete a validation of various reports to CMS for calendar year 2021 operational activities. The audit validates data submitted for the Part D program, specifically for Appeals, Grievances, Coverage Determinations, Medication Therapy Management, and Improving Drug Utilization Review Controls. Advent's team conducted a virtual interview in April to review our reporting process and is currently reviewing our source documentation. Advent will be submitting final results to CMS by the end of July.

- **Department of Managed Health Care (DMHC) Routine Audit**
  The Plan recently received notice of a routine DMHC survey to be held in October, covering the overall performance of the Plan. DMHC has requested certain documents be submitted in June. Compliance is leading the preparation and document response in advance of the audit.

- **Department of Managed Health Care (DMHC) Triennial Financial Audit**
  The Plan will begin a financial audit conducted by DMHC on June 13. This audit occurs every three years and examines the financial health and sustainability of the health plan, including cash, investments, liabilities, billing processes, claims data, and provider disputes. Finance has taken the lead in responding to document requests from DMHC.

Santa Clara Family Health Plan™

Activities and Resources Grid Based on Population Health Assessment

Need or Population Identified	Activities	Internal Resources/Staffing	Community Resources
Financial insecurity Interventions aimed at finding options for members to access food, subsidize rent or utilities	Designated SCFHP Long Term Services and Support (LTSS) staff assigned to providing training to Cal MediConnect (CMC) Case Managers on available community resources for rental assistance, utility assistance, and food. Provide training and education to Santa Clara Family Health Plan (SCFHP) staff and contracted providers on CalAIM Community Supports, such as housing services, transition services and medically supportive foods, offerings for Medi-Cal member. Partner with housing sector to address housing related issues for members through screening, identification, navigation and tenancy.	All Case Management (CM) staff receive initial and annual training on the FindHelp (FH), formerly known as Aunt Bertha, platform and community-based programs and services with detailed information on program scope, eligibility, referral processes, and key contacts. Designated LTSS staff is assigned as a liaison to the FH staff to work on expanding agencies participating in the platform and to ensure that resources on FH are up to date. Designated SCFHP LTSS staff also manage local relationships with key community providers and attend relevant community meetings to stay abreast of available resources and changes in eligibility Community Resource Center (CRC) will allow for member access to SCFHP staff and will facilitate member access to the FH platform on site.	Members who identify as needing help with financial security can be referred to resources on the FH platform that support the member's needs. Depending on the impact of the financial insecurity (e.g. housing stability, food insecurity), the resources needed may vary. Case Managers can also assist the member with accessing additional benefits such as CalFresh or Supplemental Security Income (SSI).
Language: Interventions should focus on ensuring members are aware of interpreter services, know how to access these services, and providers are able	Annual refresher training and onboarding for Providers to educate them on translation and interpreter services offered at no-cost 24/7 to SCFHP members Cultural & Linguistics (C&L) Toolkit – created to educate Providers about LEP (limited English proficiency) speakers	Annual internal refresher training C&L Training for member facing teams including, but not limited to Customer Service, Case Management, Behavioral Health, LTSS, Medicare Outreach, & Quality Improvement (QI) Outreach teams on interpreter/	Planned expansion of Health Education programs Contracting with organizations to offer health education opportunities such as classes, workshops, webinars, etc. in additional

to offer them when needed.	and services/tips available, quick reference guide with Language Line access numbers for Providers. SCFHP Member ID cards have the member's preferred spoken language listed to help Providers identify members that need interpreter services. Quarterly Newsletters – all CMC member newsletters have information on accessing language services at no cost to members. Member letters – all member letters include tagline on language assistance services offered to them, and how to access the services at no cost.	translation services for LEP members by C&L team. SCFHP wide annual training through Litmos, (SCFHP's training portal) on Cultural Competency to describe the role of communication and language in providing culturally competent care. 4 Outreach Coordinators full-time staff for Quality Outreach Program– staff proficient in Vietnamese, Cantonese, Tagalog, & Spanish. Outreach to members will be prioritized to the Coordinator who speaks that language.	threshold languages, including Vietnamese and Chinese, both virtually and in-person at Community Resource Center. Supporting local community – SCFHP endorses and promotes health prevention and wellness by supporting call-to-action letters from supporting organizations on topics such as reducing tobacco use, asthma, and allergy awareness.
Admission for Sepsis: There is a need for further exploration to assess the behavior of SMI sub-population and those in LTSS, particularly enrollees in SNFs that may lead to infectious disease and eventually to sepsis so case managers can provide education to members on preventative strategies.	CDC handouts to members who are at risk of contracting sepsis or for members who have recovered from sepsis Educational materials and tools related to sepsis are provided on the SCFHP website targeted for providers.	In-service to CM staff on sepsis prevention and how to identify members at risk	Continue to share best practices, resources and trainings to BH and LTSS partners on sepsis
Members with Multiple Uncontrolled Chronic Conditions	Tier 1 & 2 - Complex and Moderate case management (CCM): Comprehensive assessment within 60 days of identification for CCM	All care teams will be cross-trained to provide CCM Multidisciplinary teams with RNs, Social Work Case Managers and Personal Care Coordinators (PCCs), specialty CM for	External case managers, County Behavioral Health including Substance Use Treatment Services, Long Term Services and Supports providers and other

	Intensive engagement up to weekly with the CM team for CCM HRA and care planning identifies chronic conditions and member goals Coordination of medical care	behavioral health and LTSS and external stakeholders and providers	community organizations Community-based providers for physical activity, nutrition programs including Medically Tailored Meals. Santa Clara County Health & Hospital System (SCCHHS) and other county departments including Aging & Adult Services, In-Home Supportive Services (IHSS), public nutrition programs
Comprehensive diabetes care for members with uncontrolled A1C >9%, targeting Caucasian, Vietnamese, and Hispanic members	Diabetes Focus Groups for English and Spanish-speaking members Diabetes Health Disparity Education Program by Clinical Pharmacist Coordinators enroll eligible members and schedule appointments for pharmacists Pharmacists telephonically outreach enrolled members once/month Pharmacists fax recommendations to provider office after each encounter with member. Coordinators follow up with providers, help with administrative tasks	Have English, Spanish, and Vietnamese speaking staff (Pharmacists and Coordinators) to outreach members Conduct social screenings and connect members to other plan resources and services. Work with Case Management (CM) and Social Determinants of Health (SDOH) teams to refer members appropriately and learn resources to share with members.	Meetings with partner community-based organizations provide updates on program enrollment, project updates, share best practices, etc. Attend Joint Operating Committee (JOC) meetings with partners

Annual Review of Quality Improvement Policies
June 14, 2022

Policy No.	Policy Title	Changes
QI.08 v	Cultural and Linguistically Competent Services	Include requirements outlined in APL 22-002. Added 21-004 to part IV (references).
QI.20 v	Information Sharing with San Andreas Regional Center (SARC)	No Change
QI.22 v	Early Start Program (Early Intervention Services)	No Change
QI.33 v1	Enhanced Care Management (ECM) Denial and Disenrollment	No Change

POLICY

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

I. Purpose

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

II. Policy

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

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

See associated procedures Cultural and Linguistically Competent Services, Language Assistance Program, Member Document Translations, Standing Requests for member Materials in Alternate Languages and Formats, and Ad Hoc Requests for Member Materials in Alternate Languages and Format, Face-to-Face interpreter services, Population Needs Assessment for detailed process for meeting these objectives.

III. Responsibilities

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

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

POLICY

C. Quality Improvement, Marketing Communications and Outreach, and Compliance maintain a list of member threshold languages, which is reviewed and updated as needed based on member assessment needs, but no later than every three years based on the DHCS' threshold language data.

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

E. SCFHP ensures effective communication with members with visual impairments or other disabilities by the complying with Title II of the American Disabilities Act (ADA) and ensuring provision of written materials in alternative formats and by tracking and fulfilling member and AR alternative format selections or requests (AFS) including large print, Braille, and encrypted and unencrypted Audio/Data CD. SCFHP follows DCHS requirements on encryption process for members who select encrypted Audio or Data CD as their format.

F. Quality Improvement and Information Technology (IT) participates in regular data sharing with Department of Health Care Services (DCHS) and collects and stores alternative format selections and requests from and for members and/or authorized representative (AR). Data will also be shared with delegate and contracted providers, as appropriate.

IV. References

CMS.gov; Managed Care Manual, Chapter 13
NCQA 2022
California Code of Regulations (28 CCR 1300.67.04) (d) (9) (A) (B) (C)
DHCS Contract
Title 22 CCR Section 53876
Title 22 CCR 53853 (c)
CA Health and Safety Code Sections 1367.04 (b)(1)(a), (b)(4) and (b)(5)
Section 1367.04(h)(1)
Civil Rights Act of 1964, (42 U.S.C. Section 2000d, and 45 C.F.4. Part 80)
PL – 99-003
APL 99-005
APL 17-011
APL 21-004
APL 22-002
CFR 42 § 440.262
APL 19-011

V. Approval/Revision History

First Level Approval	Second Level Approval

POLICY

Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical Officer
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	Approved 06/06/2018	
v2	Revised	Quality Improvement Committee		

Policy Title:	**Information Sharing with San Andreas Regional Center (SARC): MOU**	**Policy No.:**	QI.20
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services – Behavioral Health	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

This policy supports the agreement bsetween San Andreas Regional Center (SARC) and the Santa Clara Family Health Plan (SCFHP) to perform care coordination and information exchange activities when Medi-Cal beneficiaries are accessing medically necessary Behavioral Health Treatment Services (BHT) without regard to diagnosis. The agreement addresses both new referrals for BHT and clients/beneficiaries receiving BHT when funding for this service is transitioning from SARC to SCFHP.

II. Policy

SCFHP is responsible for the provision of BHT as a managed care health benefit, including the coordination of the client's care with SARC and the BHT provider(s). SARC will support SCFHP's care coordination by providing necessary client information to SCFHP and vendors in accordance with any and all privacy laws and regulations.

A. Santa Clara Family Health Plan
   1. SCFHP is responsible for coordination of services provided by SCFHP including primary care, and carve out services such as California Children's Services and Specialty Mental Health Services.
   2. SCFHP and/or its subcontracted providers and vendors shall arrange and pay for comprehensive diagnostic evaluations (CDE's) for members/clients who are suspected of needing BHT services.
   3. SCFHP and/or its subcontracted providers and vendors shall arrange and pay for BHT services for members who meet criteria as outlined in APL 19-014 or any revised version of these APL's.
   4. SCFHP shall provide client information to SARC to ensure appropriate care coordination, in compliance with all privacy laws.
   5. SCFHP and/or its subcontracted providers and vendors shall be available to assist, the SARC in the development of the Individual Program Plan (IPP) or Individualized Family Services Plan (IFSP) as necessary.

B. San Andreas Regional Center

1. SARC shall provide client information, including comprehensive diagnostic evaluation(s), treatment plan(s), utilization data and assessment information to SCFHP upon receipt of appropriate release of information (ROI)
2. SARC shall refer clients under age 21 who are diagnosed without regard to diagnosis for evaluation for medically necessary BHT services upon client/member request for BHT services.
3. SARC shall provide case management & care coordination services related to SARC's Early Start Program clients to SCFHP for medically necessary BHT services.
4. SARC shall provide case management and care coordination to eligible clients and assist those clients in maintaining an ongoing relationship with the SCFHP's assigned primary care provider when medical needs arise.
5. SARC will identify a staff person to be the primary liaison to SCFHP. The liaison will meet not less than quarterly to ensure continuous communication and resolve any operational, administrative and policy complications.
6. SARC will share information on community resources to SCFHP and/or its sub-contracted providers and vendors.
7. SARC shall provide Targeted Case Management (TCM) services to eligible clients and their families to assure timely access to health, developmental, social, educational, and vocational services. a. TCM includes, but is not limited to:
    i. Coordination of health-related services with SCFHP to avoid duplication of services; and
    ii. Provision of referrals to specialty centers and follow-up with schools, social workers and others involved in the IPP and IFSP
    iii. SARC agrees to provide periodic training to SCFHP's staff as requested by the SCFHP concerning SARC services and requirements
    iv. SARC shall work collaboratively with SCFHP to resolve timely access and coordination of care issues.

III. Responsibilities

A. See Memorandum of Understanding between SARC and SCFHP. Policies and Procedures to be attached. Health Services works collaboratively with plan benefits, compliance, QA, IT, plan and community providers to coordinate members' Behavioral Health Treatment services and members' Behavioral Health managed care.

IV. References

Center for Medicare & Medicaid Services approved California State Plan Amendment (SPA) 14-026
Section 1915 C waiver, CA.336 HCBS Waiver for Californians with Developmental Disabilities
DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Regional Centers, 03/02/2018

DHCS All Plan Letter 19-014 Responsibilities for Behavioral Health Treatment Coverage For Members Under The Age Of 21, 11/12/2019

V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen Director, Case Management & Behavioral Health	Laurie Nakahira, D.O. Chief Medical Officer
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		Approve	08/05/2016
V1	Reviewed		Approve	06/03/2019
V2	Revised	Quality Improvement	Approve	06/09/2021
V2	Reviewed	Quality Improvement		06/14/2022

Policy Title:	**Early Start Program (Early Intervention Services)**	**Policy No.:**	QI.22
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services – Behavioral Health	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

Santa Clara Family Health Plan (SCFHP) ensures that eligible members receive early screening, counseling and treatment for developmental delay or disabilities.

II. Policy

Santa Clara Family Health Plan (SCFHP) identifies members (aged 0 to 2.9 years) who have, or are at risk of acquiring developmental delays or disabilities and need early intervention services. SCFHP will coordinate the referral of members to the Early Start Program, which is a collaborative effort between the San Andreas Regional center (SARC) and the Santa Clara County Office of Education

III. Responsibilities

The Health Services Department of the SCFHP is responsible for referring members to Early Start as they are identified by the primary care physicians, case managers and others. The Department is also responsible to notify SCFHP delegates of their responsibilities to refer to Early Start.

IV. References

DHCS All Plan Letter 18-009 Memorandum of Understanding Requirements for Medi-Cal Managed Health Care Plans and Regional Centers, 03/02/2018

V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen Director, Case Management & Behavioral Health	Laurie Nakahira, D.O. Chief Medical Officer
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**	
V2	Revised			02/08/2017
V3	Revised			06/06/2018
V4	Revised			06/03/2019
V5	Revised	Quality Improvement		06/09/2021
V5	Reviewed	Quality Improvement		06/14/2022

POLICY

Santa Clara Family Health Plan™

Policy Title:	**ECM Denial and Disenrollment Policy**	**Policy No.:**	QI.33
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	LTSS	**Procedure Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

The purpose of this policy is to define a consistent process and define reasons to deny or disenroll members from the Enhanced Care Management (ECM) benefit.

II. Overview

Enhanced Care Management (ECM) is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals that is community-based, high touch, and person-centered. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

If a member does not meet the ECM program eligibility or a member is currently enrolled in an excluded program, the member is not eligible for ECM services and denied the ECM benefit. Members eligible for ECM are able to decline enrollment into ECM or terminate ECM services at any time throughout the duration of their enrollment.

III. ECM Benefit Exclusions

A. Duplicative Services

i. The Department of Health Care Services (DHCS) established a list of programs that members are (1) excluded from enrollment into ECM due to members receiving similar services, (2) unable to enroll in both ECM and another program to prevent duplication of services, and (3) able to enroll in ECM as a "wrap" when also enrolled in the other program as long as SCFHP ensures that duplicative services are not provided. They are as follows:

a. Members are excluded from enrollment in both ECM and one of the following programs:
   1. Cal MediConnect (CMC)
   2. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
   3. Program for All-Inclusive Care for the Elderly (PACE)
   4. Mosaic Family Services
   5. Hospice

b. Members are able to enroll in either ECM or one of the following programs, but not both at the same time:
   1. Multipurpose Senior Services program (MSSP)
   2. Assisted Living Waiver (ALW)

3. Home and Community Based Alternatives (HCBA) Waiver
4. HIV/AIDS Waiver
5. HCBS Waiver for Individuals with Developmental Disabilities (DD)
6. Self-Determination Program for Individuals with I/DD
7. Basic Case Management
8. Complex Case Management
9. California Community Transitions (CCT) Money Follows the Person (MFTP)
10. 1915 (C) Waiver

c. Members are able to enroll in both ECM and one of the following programs to serve as a "wrap" with SCFHP ensuring there is not any duplication of services:
   1. California Children's Services (CCS)
   2. Genetically Handicapped Person's Program (GHPP)
   3. County-based Targeted Case Management (TCM
   4. Specialty Mental Health (SMHS) TCM
   5. SMHS Intensive Care Coordination for children (ICC)
   6. Drug Medi-Cal Organized Delivery Systems (DMC-ODS)
   7. CCS Whole Child Model
   8. Community-Based Adult Services (CBAS)
   9. Dual Eligible Special Needs Plans (D-SNPs) [from 2023]
   10. D-SNP look-alike plan
   11. Other Medicare Advantage Plans
   12. Medicare FFS
   13. AIDS Healthcare Foundation Plans
   14. In Home Support Services (IHSS)

B. Reasons for Denying or Disenrolling Members
   i. Does Not Meet the Eligibility Criteria
      a. Members must have certain chronic medical conditions and experience complex social factors that influence their health. If documentation does not indicate a member meets the ECM program eligibility, the member is denied ECM services.
   ii. Unsuccessful Engagement
      a. If an ECM provider is unable to contact a member and/or a member is not actively engaged in ECM services, the ECM provider may recommend that the member is disenrolled from ECM. Members are considered disengaged if they meet at least one of the following:
         1. Member has missed three consecutive appointments with care team within the last 60 days.
         2. Member has not completed a care plan within 90 days of enrolling in ECM.
         3. Member has not followed their care plan.
         4. Care team could not reach member within 90 days of providing outreach on three different days and time, utilizing different forms of outreach methods (i.e. phone, mail, in-person, etc.).
   iii. Unsafe Behavior
      a. Members are considered unsafe if one of the following occurs:
         1. Member displays disruptive behavior that keeps the ECM provider from delivering ECM services.
         2. Member creates a situation where ECM services are delivered in an unsafe environment and leads to the ECM provider not being able to continue providing services.
   iv. Well Managed
      a. Members are considered well managed if once of the following occurs:

1. Member has met all care plan goals and the ECM provider and/or member has determined the member does not have any additional goals.
2. Member has met all care plan goals and has determined that they do not have any additional goals.
3. Member continues to meet their care plan goals and the ECM Provider has determined the member is able to self-manage their care needs.
4. Member continues to meet their care plan goals and has determined they are able to self- manage with care needs.

v. Transition to Lower Level of Care

a. Members who have been in tier 3 for at least 6 months may be eligible to transition to a lower level of care. To reduce a member's acuity level, the ECM provider follows a tier assessment that may consist of the following elements:
   1. Care adherence
   2. Current health status
   3. Medication adherence
   4. Health literacy
   5. Sexual/reproductive health promotion
   6. Mental health
   7. Drug and alcohol use
   8. Housing
   9. Living situation/support systems
   10. Legal
   11. Income/personal finance
   12. Transportation
   13. Nutrition

b. SCFHP and the ECM provider should work collaboratively to recommend an alternative program that is better suited for the member's needs if care management services are still needed or requested by the member.

c. Members are considered ready to transition to a lower level of care if they meet one of the following:
   1. Member has met all care plan goals and the ECM provider or member has determined the member does not have any additional goals.
   2. Member continues to meet their care plan goals and the ECM provider or member is able to self-manage the member's care needs.

vi. Member Request

a. Member notifies the ECM provider that they have elected to disenroll and discontinue ECM services.

b. Member requests to discontinue services are not mailed a Notice of Action (NOA) letter denying the member the ECM benefit.

vii. Medi-Cal Termed

a. Member is not actively enrolled in SCFHP's Medi-Cal plan.

b. Member termed from Medi-Cal are not mailed an NOA letter

IV. **SCFHP Responsibilities**

A. SCFHP is responsible for reviewing relevant information pertaining to members who refer into ECM or ECM enrolled members who meet the criteria for disenrollment. When members cannot be provided the ECM benefit and must be denied the ECM benefit, members undergo a review process. If it is determined the member cannot receive the ECM benefit, the member is issued an NOA letter.

B. Referring into ECM

i. When a member self-refers into ECM or is referred by a provider for ECM services, the member must meet specific eligibility criteria

1. If member does not meet ECM eligibility criteria or has been identified as meeting one of the program exclusions, the member is denied the ECM benefit and SCFHP will proceed with the denial process
2. When the member is denied the ECM Medi-Cal benefit, the member is issued an NOA

C. ECM Provider may recommend members for disenrollment
   i. If an ECM provider identifies a member as meeting the exclusion criteria or is ready to "graduate" from ECM services, the ECM provider may recommend the member for disenrollment.
   ii. ECM providers are required to submit supporting documentation to SCFHP for review.
   iii. The member undergoes a review process, in which SCFHP reviews the submitted documentation and determines if the member meets the graduation criteria or meets one of the program exclusions.
   iv. If it is determined the member should be disenrolled from the ECM benefit, the member is mailed an NOA letter, which denies the member from continuing the ECM benefit.
   v. If SCFHP determines the member should remain enrolled, SCFHP will communicate the determination to the member's ECM provider services will continue.

D. Claims and encounter data
   i. Each month, SCFHP generates a Member Information File (MIF) to identify new members who may be eligible, as well as members enrolled in ECM who may meet one of the program exclusions.
   ii. Enrolled ECM members who are no longer eligible for the ECM benefit are systematically identified and disenrolled from ECM.
   iii. Enrolled members who meet one of the exclusions will be processed for disenrollment by SCFHP and mailed an NOA letter.

E. Notice of Action (NOA) Letter
   i. All members that are denied and/or excluded from receiving ECM services undergo a review process by SCFHP.
   ii. Upon completion of the review process and a determination that the member should be denied the ECM benefit or disenrolled from ECM services, the member is mailed an NOA letter.
   iii. An NOA letter is sent to the disenrolled or denied member, the member's PCP, if a fax number is available, and the ECM provider, if applicable.
   iv. The member disenrollment date is documented in SCFHP's systems, as applicable.
   v. If the member was enrolled in ECM, the member will remain on the MIF for 60 days with a disenrollment attribute, then will be removed off the MIF

V. **ECM Provider Responsibilities**

A. ECM providers are required to notify SCFHP of members who may no longer qualify for ECM or wish to discontinue ECM services.

B. ECM providers are required to submit documentation that supports a recommendation for disenrolling a member from ECM.
   i. Required documentation may include:
      1. Care plan
      2. Recent chart notes
      3. Outreach log
      4. Alternate program attestation
      5. Other materials, as applicable
   ii. Upon request, SCFHP may request additional documentation to ensure a determination can be made.
   iii. ECM providers must report disenrollments using SCFHP's ECM Disenrollment Reporting template.
   iv. ECM providers may recommend a case management program that better suits the members' needs.

v. ECM providers must document the member disenrollment date in the member's ECM care plan, if applicable.

VI. **Reference**

A. Department of Health Care Services. (2022). *California Advancing & Innovating Medi-Cal (CalAIM) Enhanced Care Management Policy Guide.* Sacramento, CA: Unknown

VII. **Approval/Revision History**

First Level Approval	Second Level Approval
Signature Lori Andersen, MPA	Signature Laurie Nakahira, MD
Name Director, Long Term Services and Supports (LTSS)	Name Chief Medical Officer (CMO)
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
1	Original	N/A		

Santa Clara Family Health Plan™

Quality Improvement Committee

Q1 2022 Grievance & Appeals Data

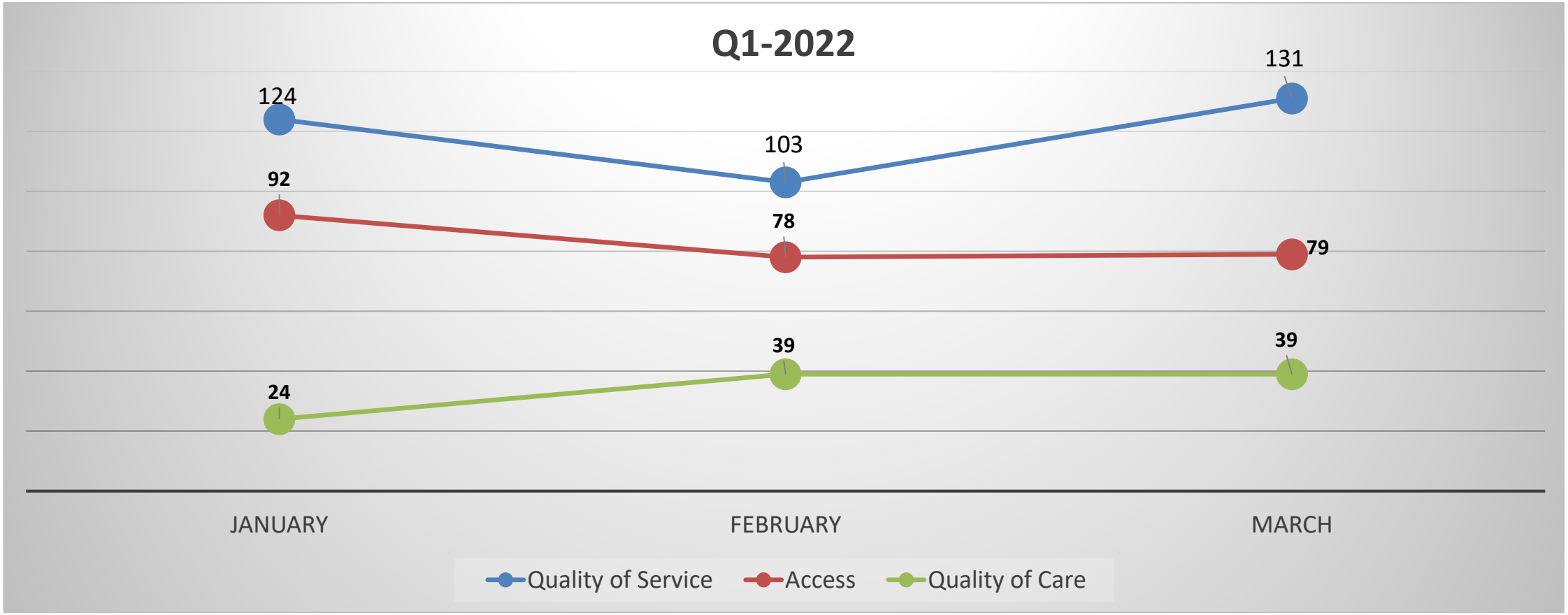
Q1 2022 Medi-Cal Grievances & Appeals Received

Case Type/Month	January	February	March
Medi-Cal Medical Grievance	290	276	326
Medi-Cal Pharmacy Grievance	3	0	0
Medi-Cal Post Service Medical Appeal	7	2	3
Medi-Cal Pre Service Medical Appeal	50	48	43
Medi-Cal Pre Service Pharmacy Appeal	5	2	0
Total Received	**355**	**328**	**372**
Received p/1000 Members	**1.25**	**1.15**	**1.30**

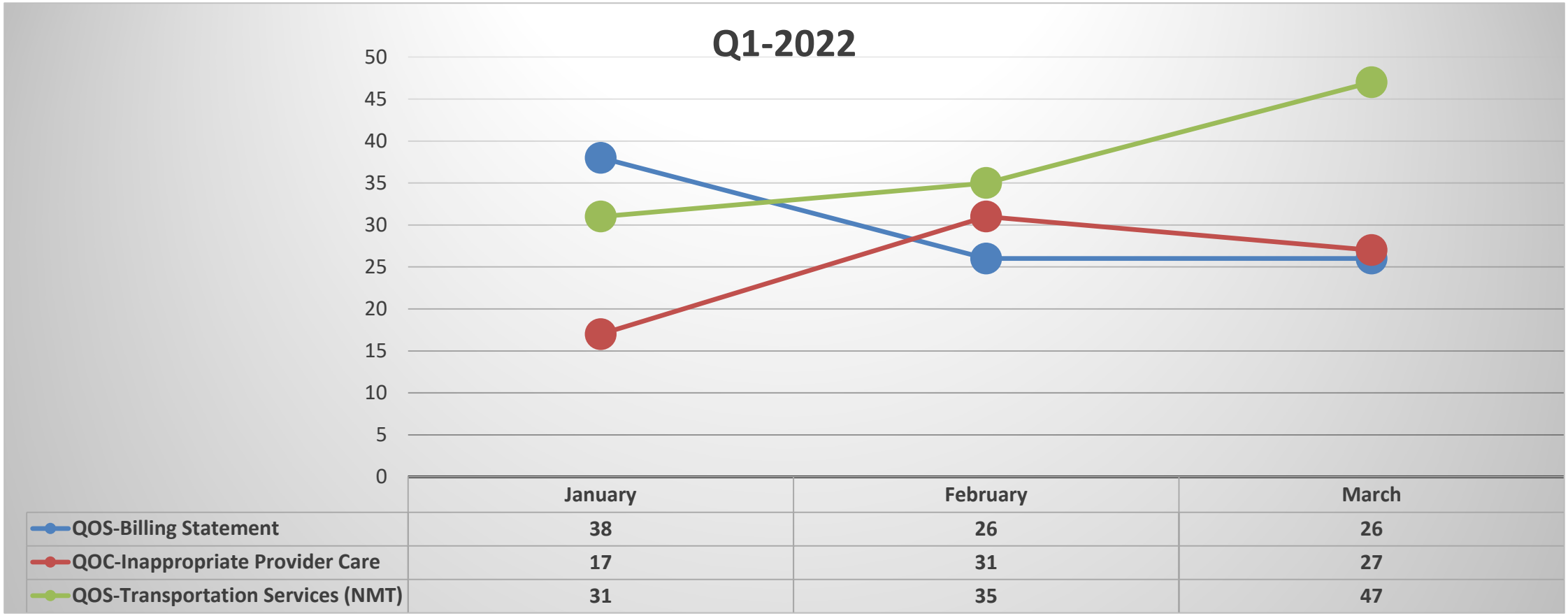
Q1 2022 Cal MediConnect Grievances & Appeals Received

Case Type/Month	January	February	March
Cal MediConnect Part C Grievance	92	79	130
Cal MediConnect Part D Grievance	2	9	3
Cal MediConnect Post Service Part C Appeal	43	54	71
Cal MediConnect Post Service Part D Appeal	1	0	1
Cal MediConnect Pre-Service Part B Appeal	0	0	1
Cal MediConnect Pre-Service Part C Appeal	16	12	17
Cal MediConnect Pre-Service Part D Appeal	3	10	11
Total Received	**157**	**164**	**234**
Received p/1000 Members	**15.36**	**15.99**	**22.72**

Q1 2022:Top 3 Medi-Cal Grievance Categories

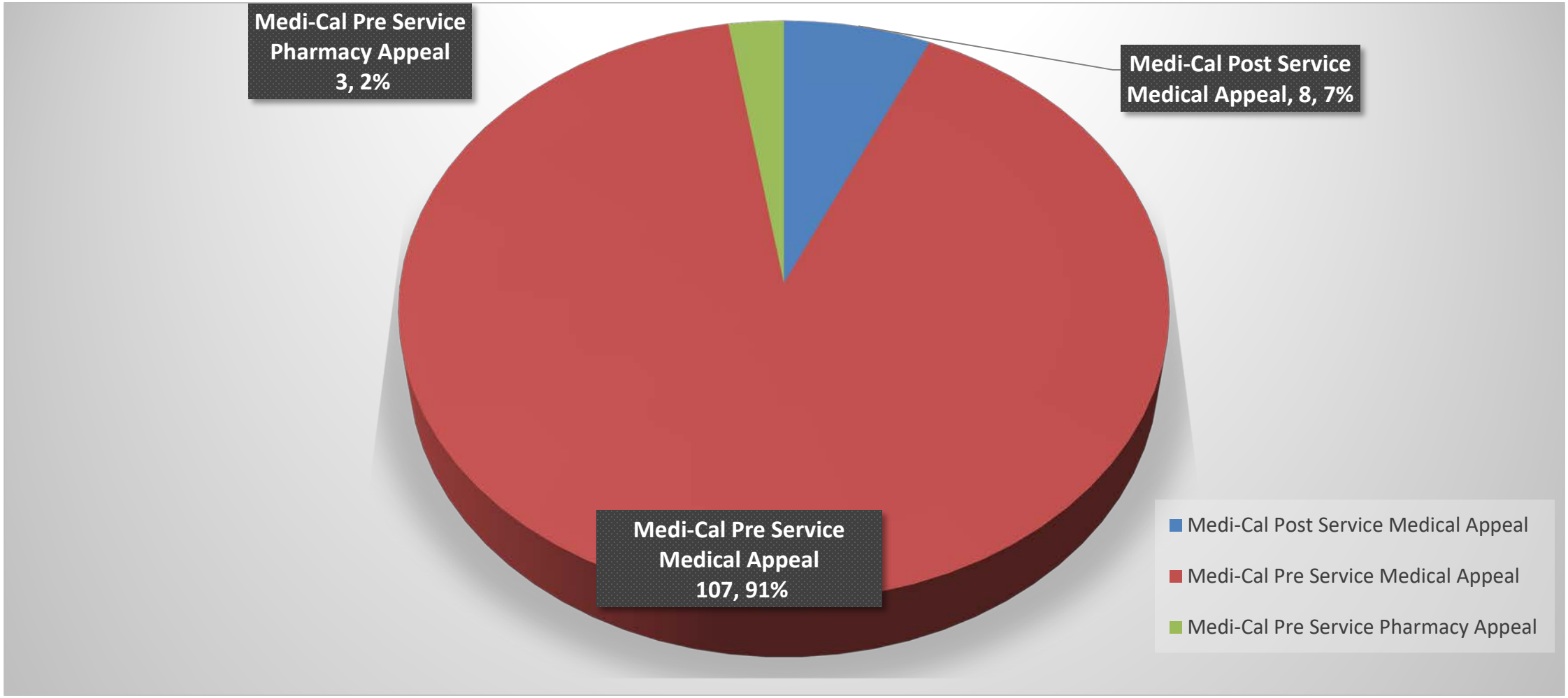


Q1 2022:Top 3 Medi-Cal Grievance Subcategories

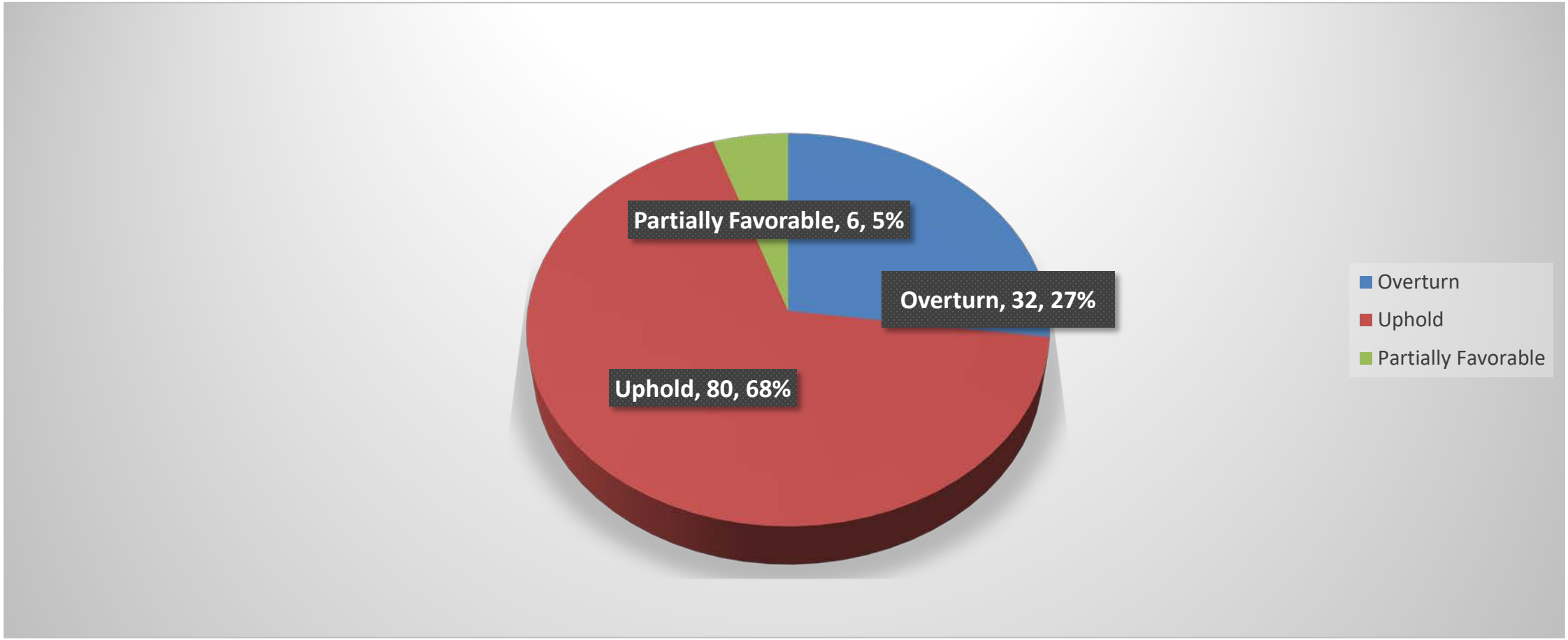


	January	February	March
QOS-Billing Statement	38	26	26
QOC-Inappropriate Provider Care	17	31	27
QOS-Transportation Services (NMT)	31	35	47

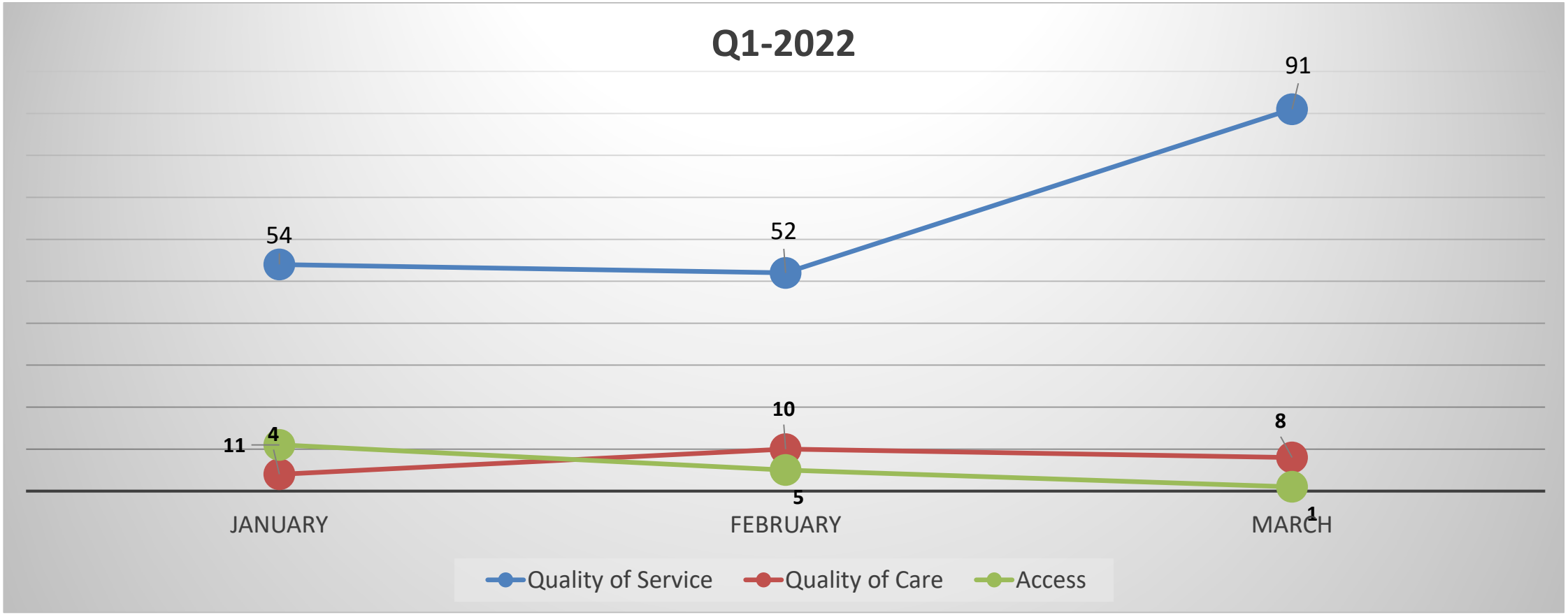
Q1 2022 Medi-Cal Appeals by Case Type



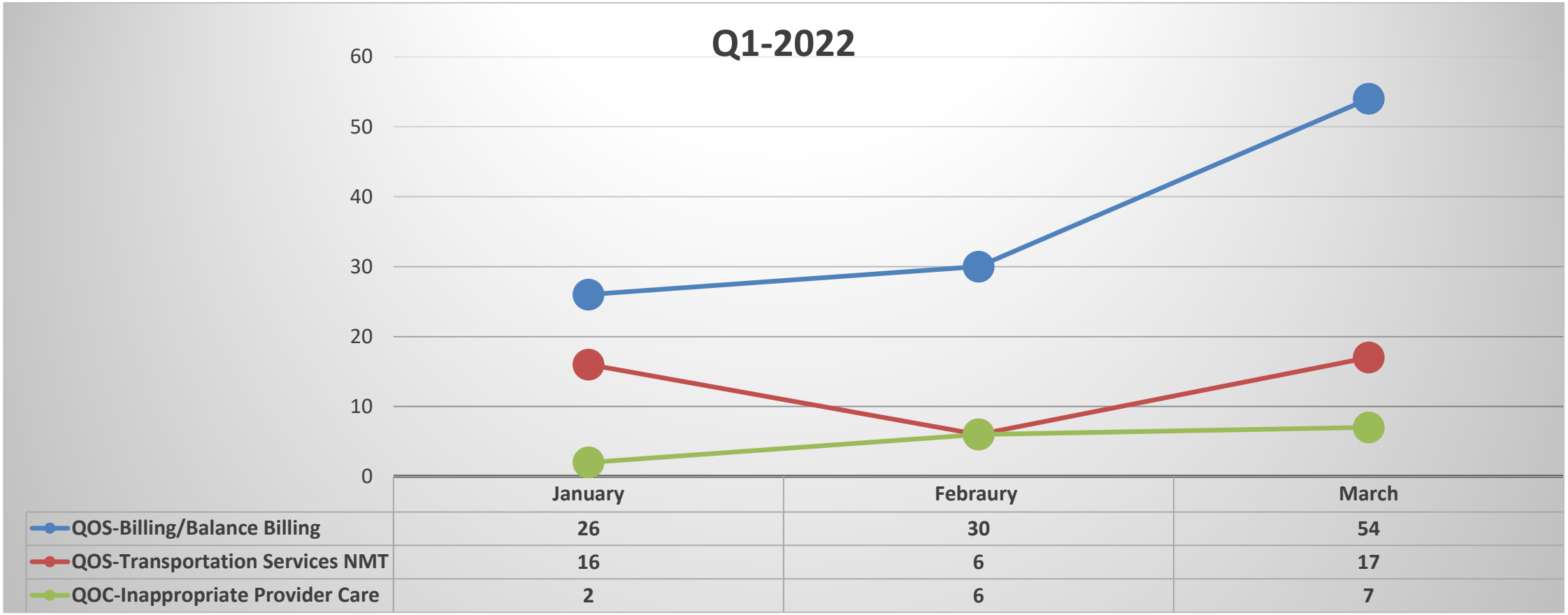
Q1 2022 MC Appeals by Disposition



Q1 2022:Top 3 Cal MediConnect Grievance Categories

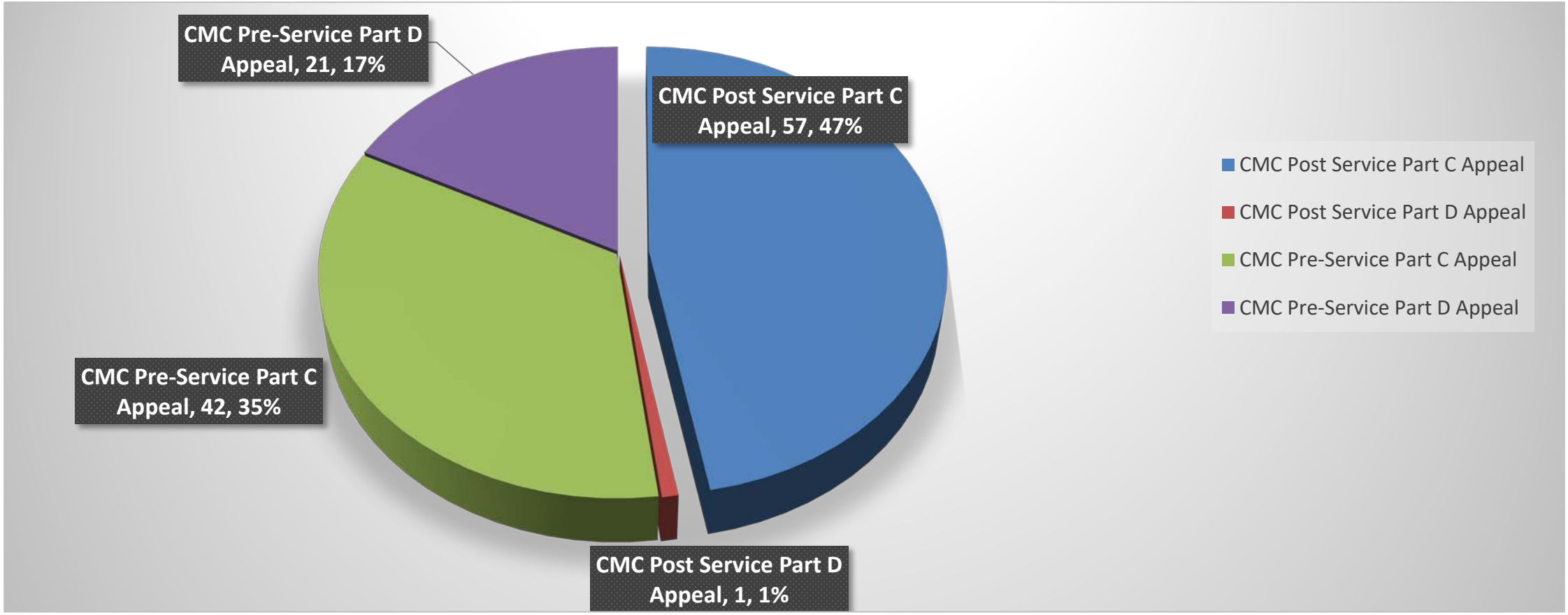


Q1 2022:Top 3 Cal MediConnect Grievance Subcategories

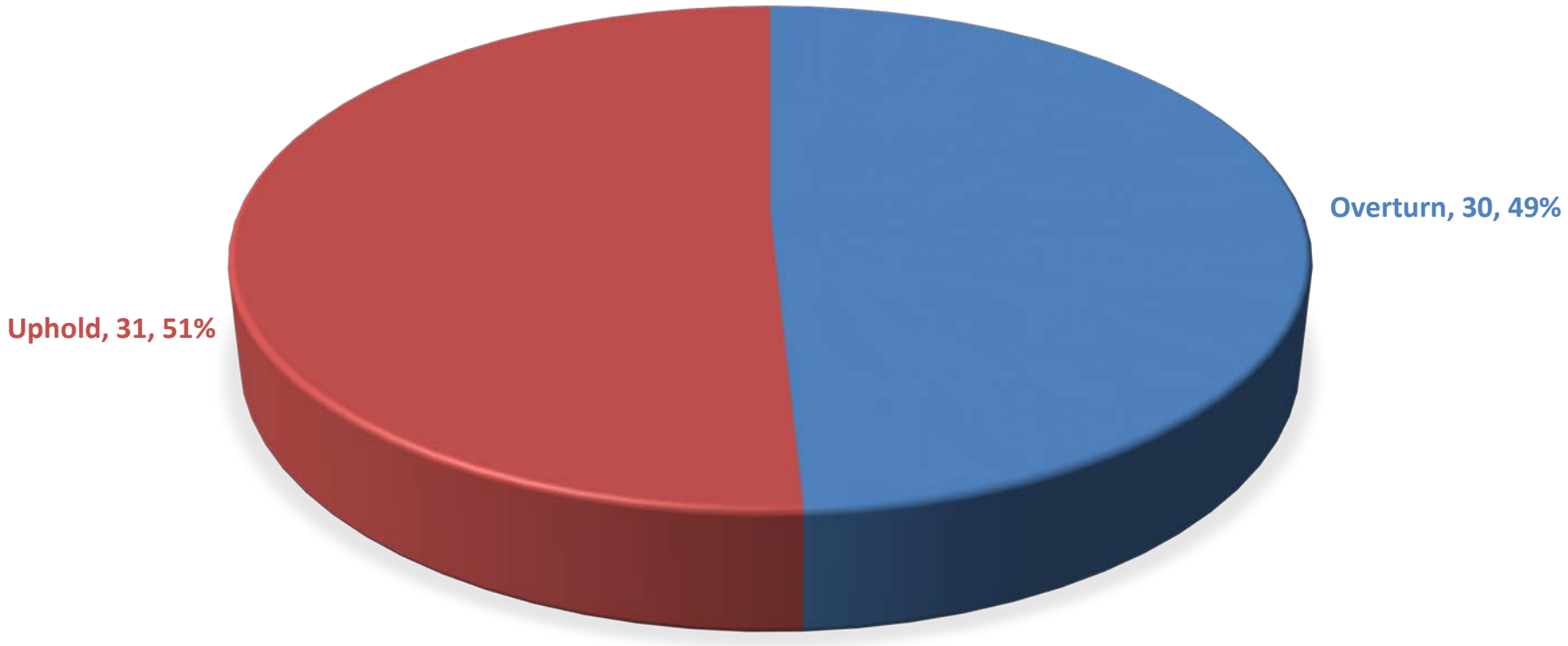


	January	Febraury	March
QOS-Billing/Balance Billing	26	30	54
QOS-Transportation Services NMT	16	6	17
QOC-Inappropriate Provider Care	2	6	7

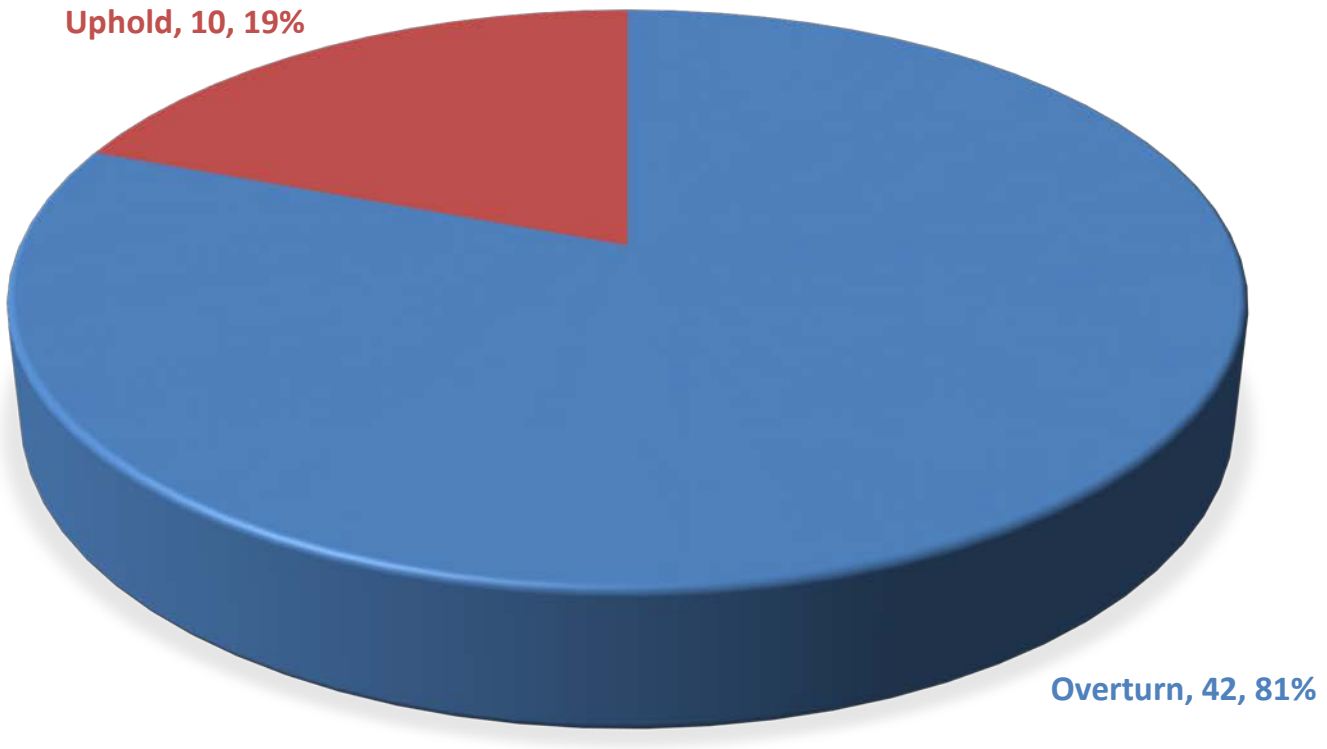
Q1 2022 CMC Appeals by Case Type



Q1 2022 CMC Pre-Service Appeals by Disposition



Q1 2022 CMC Post-Service Appeals by Disposition



Santa Clara Family Health Plan™

Quality Improvement Committee

Q1 2022 Grievance and Appeals Data

Santa Clara Family Health Plan™

Quality Improvement Dashboard

April & May 2022

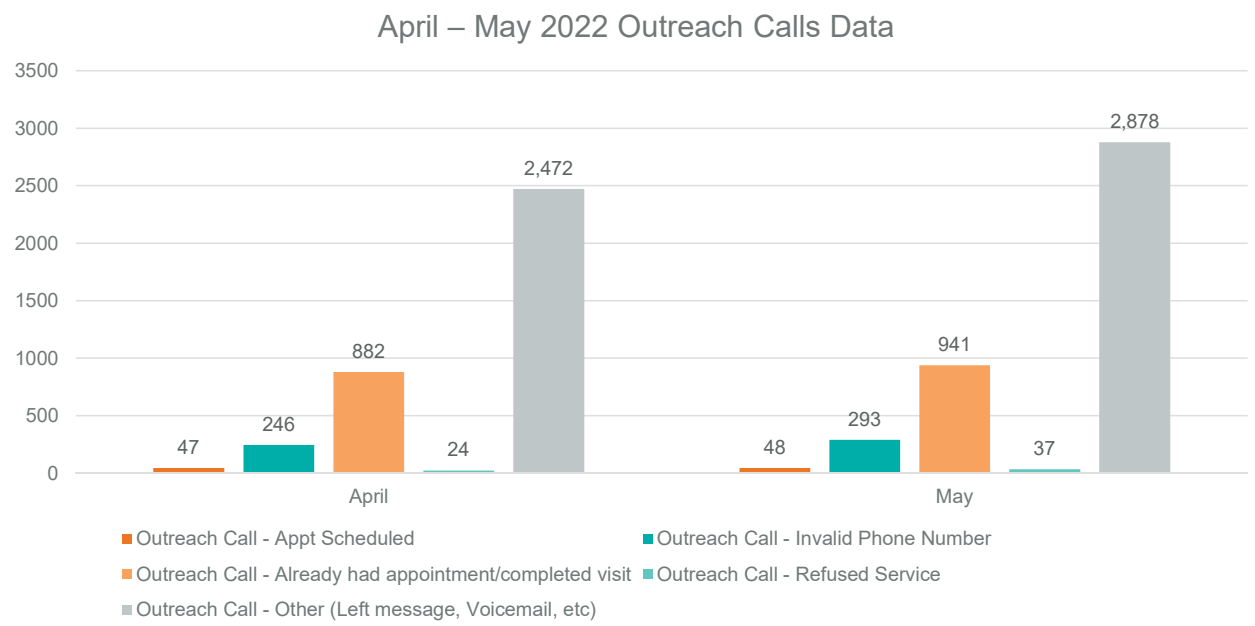
Outreach Call Campaign

Santa Clara Family Health Plan

Dedicated outreach call staff conduct calls to members for health education promotion, to help schedule screenings and visits while offering Wellness Rewards

Campaigns completed (April – May 2022)

Ambulatory Visit (CMC)	**Well-Child Visit (W30)**
	Well-Visit – Adolescent (WCV)



7,868

Total number of attempted outreach in April – May 2022

*Outreach call - Other include member demographic change requests, dis-enrollment requests, specific questions from members, calls that go to voicemails and other miscellaneous requests

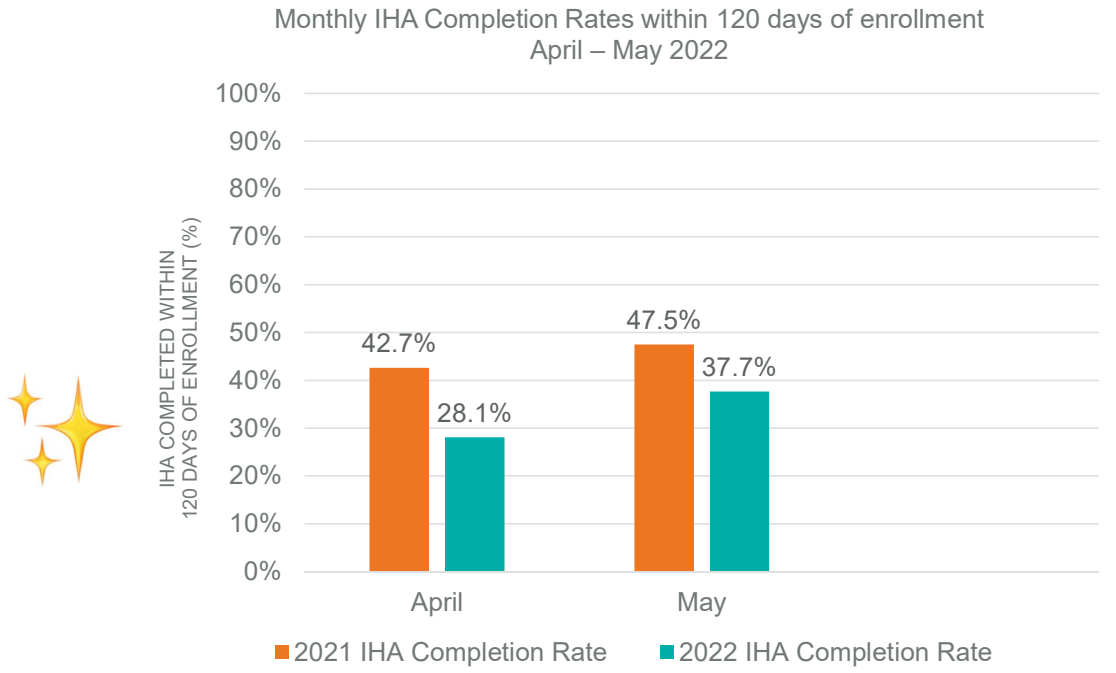
Initial Health Assessment (IHA)

Santa Clara Family Health Plan™

What is an IHA?

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

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



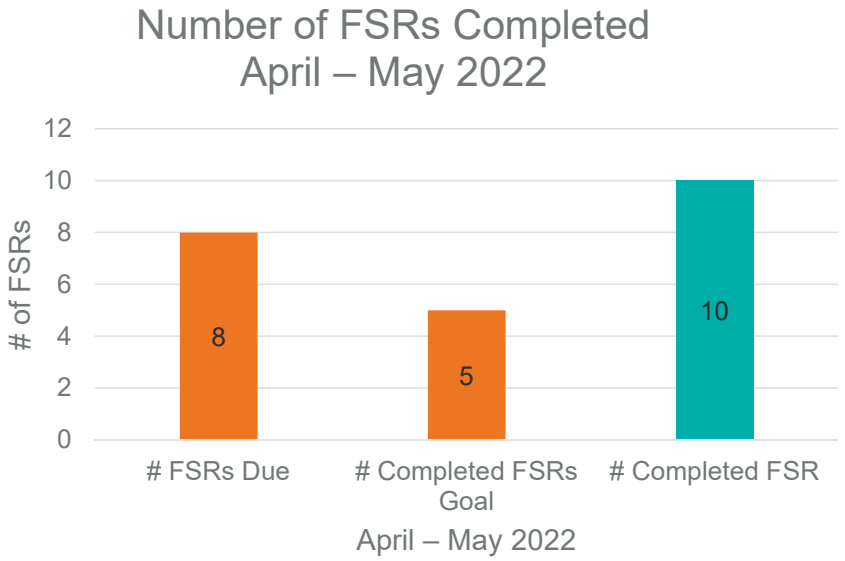
*DHCS had temporarily suspended the requirement to complete IHAs for members within 120 days of enrollment until the COVID-19 emergency declaration is rescinded. Starting October 1, 2021, DHCS required all primary care providers to resume IHA activities.

*These IHA rates may change in the future months owing to the 90-day claims lag

Facility Site Review (FSR)

Santa Clara Family Health Plan

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



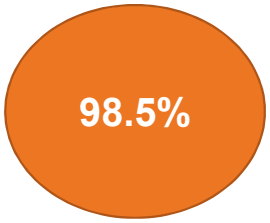
*FSR Certified Master Trainer (CMT) and QI Nurses have continued to conduct the audit to ensure sites operate in compliance with all applicable local, state, and federal laws and regulations.

# Periodic FSRs Completed	10
# Initial FSRs Completed	1

Potential Quality of Care Issues

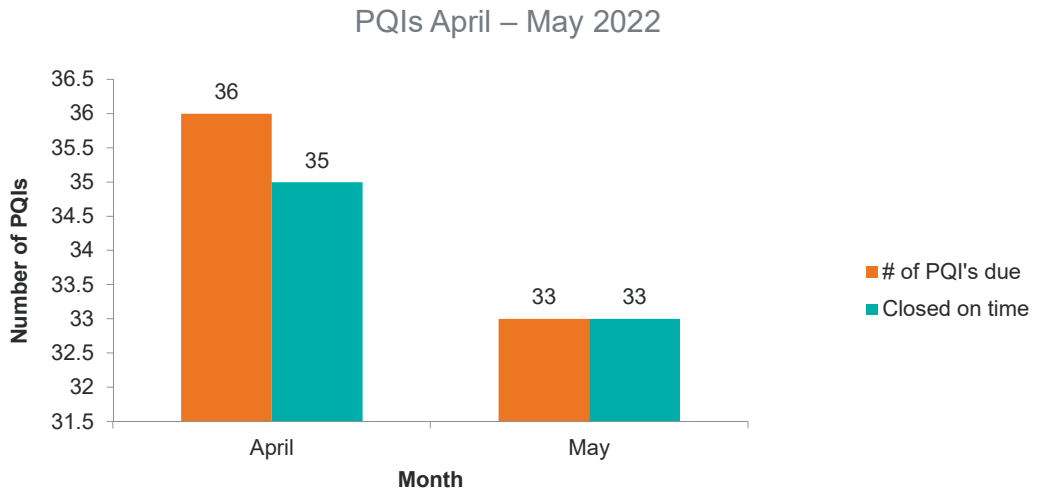
Santa Clara Family Health Plan

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



Percentage of PQIs due from April – May 2022 closed on time within 90* days

PQI Levels: April – May 2022
Level 0: 6 Cases
Level 1: 56 Cases
Level 1A: 1 Case
Level 2: 5 Cases
Level 3: 1 Case
Level 4: 0 Case



Network	Case Identified Level 0	Case Identified Level 1	Case Identified Level 1A	Case Identified Level 2	Case Identified Level 3	Case Identified Level 4
Admin – Medicare Primary	5	0	0	1	1	0
Direct SCFHP (Net 10)	0	16	0	1	0	0
North East Medical Services/NEMS (Net 15)	0	1	0	0	0	0
VHP Network	1	28	1	1	0	0
PAMF (Net 40)	0	1	0	1	0	0
Physicians Medical Group (Net 50)	0	9	0	0	0	0
Premier Care (Net 60)	0	1	0	1	0	0

QNXT Gaps In Care Alerts

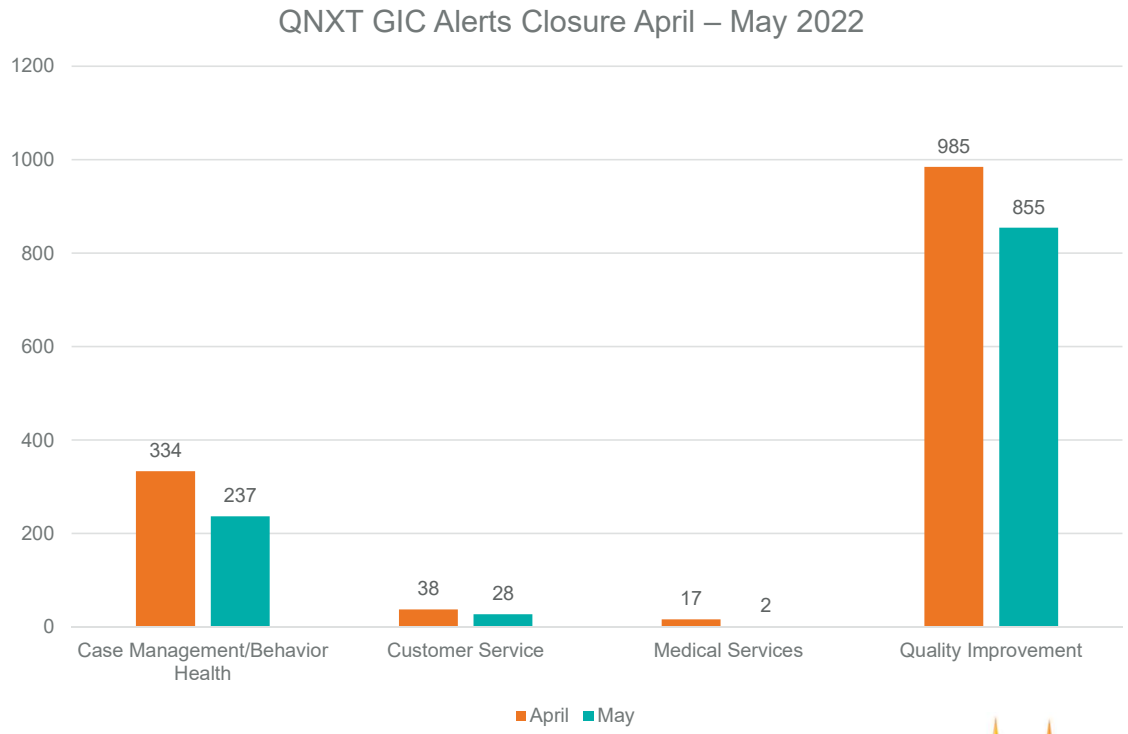
Santa Clara Family Health Plan

What are QNXT GIC Alerts?

In an effort to improve our company-wide HEDIS MC and CMC rates, alerts have been loaded into QNXT in order for internal staff to remind members about the screenings and/or visits they are due for.

2,496

Total number of QXNT GIC alerts terminated in April – May 2022



Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, April 20, 2022, 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present
Jimmy Lin, M.D., Internal Medicine, Chair
Ali Alkoraishi, M.D., Psychiatry
Ngon Hoang Dinh, D.O., Head & Neck Surgeon
Laurie Nakahira, D.O., Chief Medical Officer
Habib Tobbagi, MD, PCP, Nephrology
Indira Vemuri, MD, Pediatric Specialist

Staff Present
Christine Tomcala, Chief Executive Officer
Dang Huynh, Director, Pharmacy and Utilization Management
Jessica Bautista, Manager, Community Based Case Management
Luis Perez, Supervisor, Utilization Management
Ashley Kerner, Manager, Administrative Services
Robyn Esparza, Administrative Assistant
Amy O'Brien, Administrative Assistant

1. **Roll Call**

   Jimmy Lin, MD, Chair, called the meeting to order at 6:02 p.m. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The minutes of the January 20, 2022 Utilization Management Committee (UMC) meeting were reviewed.

   It was moved, seconded, and the minutes of the January 20, 2022 UMC meeting were **unanimously approved**.

   Motion: Dr. Alkoraishi
   Second: Dr. Nakahira
   Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira
   Abstain: Dr. Tobbagi
   Absent: Dr. Vemuri

4. **CEO Update**

   Christine Tomcala, Chief Executive Officer, announced that the Plan successfully completed its National Committee for Quality Assurance (NCQA) accreditation renewal survey for the Cal MediConnect (CMC) Medicare product. Congratulations were offered to the medical management team and all staff members who ensured the audit was a success.

   It was noted the Plan is actively preparing for implementation of a Dual Eligible Special Needs Plan (D-SNP). The D-SNP is a requirement of California Advancing and Innovating Medi-Cal (CalAIM), and it will replace the current CMC plan in 2023. The Plan's preparation includes, among other things, re-contracting with our provider network.

5. Chief Medical Officer Update

Dr. Laurie Nakahira, Chief Medical Officer, began with an update on the Department of Health Care Services (DHCS) audit. The audit took place over a 2 week period in March 2022. The Plan currently awaits the results of the audit. In addition, the Plan has begun preparation for next year's NCQA interim accreditation audit for our Medi-Cal (MC) line of business.

6. Old Business/Follow-Up Items

a. NCQA Cardiovascular Monitoring of People with Cardiovascular Disease and Schizophrenia

Dr. Huynh presented the summary of changes from Healthcare Effectiveness Data and Information Set (HEDIS) for Measure Year (MY) 2022. Dr. Huynh noted that members who receive hospice care anytime during the measurement year are excluded. The full data set will be reported to the NCQA. Please refer to the complete UMC agenda packet for the handout that outlines these changes.

7. UM Program Evaluation - 2021

Dr. Nakahira presented an overview of the UM Program Evaluation for 2021. The Program Evaluation pertains to both the Plan's CMC and MC lines of business. It is also necessary for NCQA MC accreditation purposes.

It was moved, seconded, and the UM Program Evaluation - 2021 was **unanimously approved**.

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Dinh, Dr. Vemuri

8. UM Work Plan - 2022

Dr. Nakahira presented an overview of the UM Work Plan for 2022. Dr. Nakahira advised that lines one through twenty-two are the standard measures used for prior years, and lines twenty-three and twenty-four were added to meet regulatory requirements.

It was moved, seconded, and the UM Work Plan - 2022 was **unanimously approved**.

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Alkoraishi, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Dinh, Dr. Vemuri

9. Prior Authorization Grid for Medi-Cal and Dual SNP - 2023

Dr. Huynh presented an overview of the Prior Authorization Grid for Medi-Cal and Dual SNP for 2023. Currently, there are no changes for 2022. The UM department is in the process of updating the grid to reflect the implementation of the D-SNP in 2023. Revisions to the Prior Authorization Grid will be brought to either the July 2022 or October 2022 UMC meetings. The current grid was approved by the Pharmacy and Therapeutics committee during the January 2022 meeting.

It was moved, seconded, and the Prior Authorization Grid for Medi-Cal and Dual SNP - 2023 was **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Dinh
Ayes: Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Vemuri

10. UM 1B Annual Assessment of Senior Level Practitioners for NCQA - 2021

Dr. Nakahira presented an overview of the UM 1B Annual Assessment of Senior Level Practitioners for NCQA 2021 to the committee. This annual review occurs as a result of NCQA requirements. The assessment illustrates the Plan's activities related to oversight of senior level practitioners within their provider networks.

11. Delegation Oversight

Dr. Huynh gave an overview of the Plan's Delegation Oversight Program Description. Kaiser Permanente is excluded from this Program Description. Dr. Huynh's summary included some of the changes pending from North East Medical Services (NEMS), Valley Health Plan (VHP), Physicians' Medical Group of San Jose, and Premier Care of Northern California. Dr. Huynh explained that the Program Description is approximately 350 pages in length, and includes all of the UM Program Descriptions. During the annual review, the UM department will take a deeper dive into the Program Description and bring their findings and recommendations to the UMC at the end of the year. Please refer to the complete UMC agenda packet for the handouts that outline these Program Descriptions.

It was moved, seconded, and Delegation Oversight was **unanimously approved**.

Motion: Dr. Dinh
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira, Dr. Tobbagi
Absent: Dr. Vemuri

12. Enhanced Care Management (ECM)

a. ECM Denial and Disenrollment Policy

Dr. Huynh gave a brief summary of the ECM Denial and Disenrollment Policy. The purpose of the policy is to clearly define the Plan's ECM Denial and Disenrollment process. The policy falls under the Quality Improvement department, but it is a UM function. Dr. Huynh explained that this process is similar to the prior authorization process. The main difference is that when an ECM member or beneficiary no longer meets the requirements, disenrollment occurs and the member or beneficiary is sent a notice of action.

b. ECM Care Coordinator Guidelines

Dr. Huynh next provided an overview of the ECM Care Coordinator Guidelines. These guidelines outline how members or beneficiaries meet the eligibility requirements for ECM. These guidelines are utilized by non-medical clinical staff members. In cases where it is deemed that a member or beneficiary no longer meets the criteria, a medical director reviews the case to determine if medical necessity still exists and they can remain in the ECM program.

It was moved, seconded, and the ECM Denial and Disenrollment Policy and the ECM Care Coordinator Guidelines were **unanimously approved**.

Motion: Dr. Tobbagi
Second: Dr. Dinh
Ayes: Dr. Alkoraishi, Dr. Dinh, Dr. Lin, Dr. Nakahira
Absent: Dr. Vemuri

13. Reports

a. Membership

Dr. Nakahira gave a summary of the Membership Report from April 2021 through April 2022. The Plan's current CMC membership includes 10,333 members. The Plan's total MC membership includes 288,485 members. As of April 2022, our total membership includes 298,818 members.

b. Over/Under Utilization by Procedure Type/Standard UM Metrics

Dr. Nakahira gave an overview of the UM objectives and goals. Dr. Nakahira advised that these metrics cover the period from April 1, 2021 through March 31, 2022. Dr. Nakahira gave a summary of the data for the Plan's MC SPD line of business. Dr. Nakahira then gave a summary of the data for the Plan's MC non-SPD line of business. She continued with her summary of the data for the Plan's CMC line of business.

Dr. Nakahira continued with a comparison of the inpatient and outpatient utilization rates for the Plan's MC non-SPD and SPD populations. Her summarization included the outpatient utilization rates for our MC SPD and non-SPD populations, and for our CMC population.

Dr. Nakahira discussed the inpatient readmissions rates for the MC line of business, and she included a comparison of the data from 2020 versus 2021. Next, she discussed the inpatient readmissions rates for our CMC line of business.

Dr. Tobbagi asked for a more detailed breakdown of the specific types of readmissions and their causes. Dr. Huynh replied that there could be several diagnoses that could lead to patients' readmissions. The UM department is developing a process which enables staff to share all hospitalization discharges and transfers with our provider networks on a timely basis. Dr. Huynh agreed that there should be a transparent process in place to notify providers when a patient is admitted to the hospital, along with the cause of admission. The UM department can put together some additional metrics, and/or conduct a random sampling of the causes of patients' readmissions, and bring these results to either the July 2022 or October 2022 UMC meeting.

Dr. Nakahira gave an overview of the ADHD MC BH metrics. The UM department hopes to increase the rankings in the category of 'Follow-up Care for Children Prescribed ADHD Medication' through increased follow-up measures and services, such as telehealth, primary care, and behavioral health care visits. The category of 'Antidepressant Medication Management' was on track for 2021. In the category of 'Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia' the 2021 ranking has shown improvement.

Dr. Huynh presented a summary of the discussion points from the UM department's medical deep dive meeting on April 7, 2022. Dr. Lin asked for the eligibility requirements for Community-Based Adult Services (CBAS). Dr. Huynh advised he will discuss the Department of Managed Health Care (DMHC) eligibility requirements with Dr. Lin in a separate discussion outside of this meeting. Dr. Huynh then gave an overview of the California Children's Services (CCS) Utilization Review, which was also a part of the deep dive discussion. Please refer to the complete UMC agenda packet for the handouts that address the specifics pertaining to these two topics.

c. Dashboard Metrics

- Turn-Around Time – Q1 2022

  Dr. Huynh summarized the CMC and MC Turn-Around Time metrics for Q1 2022. The turn-around times in almost all categories are compliant at 98% or better, with many categories at 100%. Due to an IT glitch, however, approximately 750 letters were not mailed out on a timely basis and member notification was non-compliant. This is not reflected on the CMC and MC dashboards. Dr. Huynh advised that the updated numbers will be reviewed and brought to the July 2022 meeting.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q1 2022

Mr. Perez summarized the data from the Q1 2022 CMC and MC Quarterly Referral Tracking reports. Mr. Perez explained the purpose of the quarterly referral tracking reports. At the end of the year, the Plan analyzes the members who did not receive authorized services to determine why those services were not rendered. This is a requirement of the DHCS. Mr. Perez explained that these numbers are affected by claims lag times. The UM department regularly reviews authorizations where no services were rendered to determine why the members did not receive the services.

Dr. Lin asked why only 43.8% of authorized services were received in March 2022. Mr. Perez replied that the UM department will conduct some research and bring the results to the July 2022 meeting.

e. Cal MediConnect and Medi-Cal Annual Referral Tracking – 2021 Annual Assessment

Mr. Perez summarized the results of the CMC and MC Annual Referral Tracking Assessments for 2021. Mr. Perez explained the purpose of the annual referral tracking reports. At the end of the year, the Plan analyzes the members who did not receive authorized services to determine why those services were not rendered. This is a requirement of the DHCS. Mr. Perez explained that these numbers are affected by claims lag times.

f. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q1 2022

Dr. Huynh presented the results of the Quality Monitoring of Plan Authorizations and Denial Letters for Q1 2022. Dr. Huynh reported that 96% of the standard authorizations were compliant with regulatory turnaround times. There was one case that was completed on the 15th day rather than the 14th day, and the UM department is working to identify if this was due to user error or increased volume during that timeframe. All findings are reviewed on a quarterly basis, with oversight by the Plan's medical directors.

g. Behavioral Health (BH) UM

Dr. Huynh presented the BHT (Behavioral Health Treatment) program overview to the committee. Dr. Huynh highlighted the developmental and trauma screenings that were completed in 2021 and, so far, in Q1 2022. These screening numbers may be affected by a data lag. Dr. Huynh highlighted the CMC and MC BHT utilization rates for members in 2019, 2020, 2021, and currently for 2022. The number of BHT services for 2022 will increase as we progress through the year. These utilization rates include our CMC Unique Members. Kaiser Permanente and Palo Alto Medical Foundation (PAMF) continue to lead among our provider networks for the highest utilization rates from 2019 through Q1 2022.

Ms. Tomcala asked if the numbers for the MC Outpatient Mild to Moderate Unique Members would be better reflected as percentages. Dr. Huynh agreed, and a discussion ensued in regards to tracking the data for any members who have progressed from the mild to moderate stage to the severe stage. In addition, information on patients' actual diagnoses would help determine who should receive mild to moderate services versus who might qualify for more intensive services.

Dr. Huynh continued with his presentation. Dr. Lin would like to see the UM department take a deeper dive into why Valley Health Plan's numbers are so much higher than Kaiser's in the MC Outpatient Mild to Moderate Unique Members category. Dr. Huynh will do some research and bring the results to our July 2022 meeting.

Dr. Huynh concluded with his summary of the data for BHT per/1000 and BHT Unique Members for 2019, 2020, 2021, and thus far for 2022. Dr. Huynh will ensure all BHT data will be presented in a more digestible format for future UMC meetings.

14. Adjournment

The meeting adjourned at 7:40 p.m. The next meeting of the Utilization Management Commitment is on July 20, 2022 at 6:00 p.m.

_____

Jimmy Lin, M.D, Chair
Utilization Management Committee

Regular Meeting of the

Santa Clara County Health Authority

Cal MediConnect Consumer Advisory Board (CAB)

Thursday, June 2, 2022 11:30 AM – 1:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

Members Present
Laurie Nakahira, DO, Chief Medical Officer, Chair
Andy Le, Ombudsperson, Supervising Staff Attorney, Bay Area Legal Aid
Narendra Pathak

Members Absent
Charles Hanks
Dennis Schneider

Guest
John B. Henley, Jr.

Staff Present
Chelsea Byom, Vice President, Marketing, Communications, and Outreach
Angela Chen, Director, Case Management
Mike Gonzalez, Director, Community Engagement
Thien Ly, Director, Medicare Outreach
Carole Ruvalcaba, Director, Marketing and Communications
Lucille Baxter, Manager, Quality and Health Education
Charla Bryant, Manager, Clinical Quality and Safety
Shawna Cagle, Manager, Case Management
Cristina Hernandez, Manager, Marketing and Public Relations
Jocelyn Ma, Manager, Community Outreach
Zara Ernst, Health Educator
Jeanette Montoya, Health Educator
Rita Zambrano, Executive Assistant
Amy O'Brien, Administrative Assistant

Others Present
Rita Cruz Gallegos, Aurrera Health Group
Mary Haughey, Chief Operating Officer, YMCA of Silicon Valley
Lesa Honick, Marketing Consultant, Jensen-Honick
Shari Jensen, Marketing Consultant, Jensen-Honick

1. Roll Call

Dr. Laurie Nakahira, DO, Chief Medical Officer, and Chair called the meeting to order at 11:32 a.m., roll call was taken, and a quorum was established. Dr. Nakahira welcomed John B. Henley, Jr. as a guest and new member to the Consumer Advisory Board. Mr. Pathak noted that our thoughts and condolences are with all the victims of the recent mass shootings.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the March 3, 2022 Cal MediConnect (CMC) Consumer Advisory Board Committee meeting were reviewed.

4. Health Plan Update

Dr. Nakahira presented the Health Plan update. She began with an enrollment update. As of May 1, 2022, SCFHP has 301,262 members. This is a 7.1% increase since May 2021. The Plan's total Cal MediConnect (CMC) membership includes 10,334 members, which is a 3.5% increase since May 2021. Dr. Nakahira gave an update on the status of the recent National Committee for Quality Assurance (NCQA) audit. The Plan successfully completed this routine audit and is now re-accredited for the CMC line of business.

Dr. Nakahira continued with a general overview of Plan updates that are in the works. It is anticipated that the COVID-19 public health emergency (PHE) will be extended until at least October 15, 2022, with all board and committee meetings to remain virtual throughout that time. If the PHE continues, the "pause" on Medi-Cal (MC) redeterminations will remain in effect. Effective July 1, 2022, the Plan has a new CMC fitness provider, YMCA of Silicon Valley. The Governor's May budget was revised, and Dr. Nakahira summarized the changes made to some of the benefits covered under this budget.

5. COVID-19 Update

Dr. Nakahira provided the committee with an overview of the Plan's COVID-19 vaccination data and clinics. She discussed the various organizations the Plan has partnered with to increase testing and vaccination rates throughout the community. She gave an overview of the vaccination rates for SCFHP members, as compared to the residents of Santa Clara County who are non-members. Her presentation included the data for vaccination rates by age groups and ethnicities. She also provided data that compared SCFHP's MC membership vaccination rates with other managed care and Fee-for-Service health plans.

6. Cal MediConnect Transition to Dual Eligible Special Needs Plan (D-SNP)

Thien Ly, Director, Medicare Outreach, gave an overview of the upcoming CMC transition to the Dual Eligible Special Needs Plan (D-SNP). This transition is part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative by the Department of Health Care Services (DHCS). Mr. Ly provided a link to the DHCS website. Mr. Ly defined D-SNP for the committee members, and he explained all of the elements of the transition. As of January 1, 2023, current SCFHP CMC members do not need to take any action, and they will automatically transition to the D-SNP.

At this time, Cristina Hernandez, Manager, Marketing and Public Relations, presented the committee members with 3 options for D-SNP messaging that will be rolled out later this year. She asked for the members' feedback on which option they prefer and feel is the most clear and concise.

Mr. Pathak asked if the prescription drug benefit of up to $75 for OTC items every 3 months will be increased to $100 or $150, which is a better benefit for our members. Ms. Hernandez will relay this feedback to the staff members who work on our benefits packages.

Mr. Henley likes the compactness of the messaging in Option 1. Mr. Pathak likes both Options 1 and 2, however, he feels strongly that Option 3's messaging is not beneficial.

7. Member Orientation

Jocelyn Ma, Manager, Community Outreach, provided an overview of the Plan's Member Orientation pilot program. Ms. Ma highlighted the accomplishments of the pilot program. She discussed the number of orientation sessions to date, offered both virtually and in-person. Sessions are conducted in English and 3 threshold languages. She discussed the number of registrants and attendees since the pilot program's implementation in 2021. Ms. Ma also discussed the results of the member orientation feedback survey sent to

all attendees. Ms. Ma concluded with an overview of some of the challenges SCFHP has experienced in the implementation of the Member Orientation program.

Ms. Ma asked the committee members for their feedback on how SCFHP can increase attendance for member orientations. Mr. Henley commented that the member newsletter is a good resource for information on events at SCFHP. Mr. Pathak suggested that the Plan send the newsletter to our various non-profit organizations, community partners, and Santa Clara County elected officials so they can publish it on their message boards and websites in the threshold languages.

8. Standing Items

a. Community Resource Center

Mike Gonzalez, Director, Community Engagement, presented an overview of the recent activities at the Blanca Alvarado Community Resource Center. Mr. Gonzalez introduced Daisy Montoya, Community Resource Center Coordinator, and the newest member of the team. Mr. Gonzalez shared the monthly calendar of activities, which can be found on our website at www.crc.scfhp.com and through our social media account @CRC_SCFHP. He also shared the hours the Center is open.COVID-19 safety protocols remain in place. Mr. Gonzalez highlighted the services, programs, and events on offer at the Center. He also shared the number of visitors and the types of services provided to them since the Center opened in 2021.

Mr. Gonzalez discussed the impact of the CRC on the community. Members can receive in-person application assistance for enrollment into Covered California and MC. The Center also provides members with resource navigation assistance. Mr. Gonzalez discussed the goals of the process roadmap and the members of the Resident Advisory Group. He also discussed the Center's vision and purpose, which is in alignment with the vision of SCFHP. Mr. Gonzalez introduced the Center's 'Welcome Statement'. He concluded his presentation with an announcement about the 'Community Celebration Event' on Saturday, June 25, 2022 from 10:00 a.m. to 2:00 p.m. The topics for discussion include the conclusion of the CRC planning process, and the launch of a community health framework.

b. Member Communications

Chelsea Byom, Vice President, Marketing, Communications, and Outreach discussed the member communications completed since the March 2022 meeting. Member communications included the spring newsletter, and updated Welcome Kits that include information about the current fitness benefit. Her presentation highlighted the SCFHP website which is updated with materials such as the Formulary, the Provider directory, our newsletters, and the PHE Homepage banner. The PHE Homepage includes a link to County websites. Ms. Byom also discussed the SCFHP PHE communication strategy once the PHE ends. Ms. Byom concluded with a list of the events the Plan participated in since our March 2022 meeting, as well as upcoming events.

c. Behavioral Health

Angela Chen, Director, Case Management, discussed Mental Health Awareness Month. Ms. Chen explained that mental health includes our emotional, psychological, and social well-being. It affects how people think, feel, act, handle stress, relate to others, and make good choices. Mental health is important from childhood through adulthood. Mental illness can cause psychological and behavioral problems that are not uncommon, yet are largely treatable. Ms. Chen shared that 1 in 5 Americans will be affected by a mental health condition at some point in their lifetime. She also shared key points related to Mental Health Awareness month and how to take action to fight the stigma of mental illness and raise awareness.

d. Case Management Update

Shawna Cagle, Manager, Case Management, provided an overview of the Case Management Care Coordination and In-Home Supportive Services (IHSS) programs. Ms. Cagle's overview included details such as who qualifies for IHSS, what services are included and how to apply for them, and the overall timeline from the start of the application process until the start of IHSS. It is possible to expedite applications for individuals

with critical care or hospice care needs. Ms. Cagle also explained the scenarios in which IHSS reassessment is required. Ms. Cagle provided contact information for the IHSS registry list and the care coaching referral process. Ms. Cagle also provided contact information for the Care Coordinator Case Management Help Desk and their hours of operation.

e. Health Education and Cultural Linguistics – Overview of the YMCA Diabetes Prevention Program

Dr. Nakahira introduced Mary Haughey, Chief Operating Officer, YMCA of Silicon Valley, who presented an overview of the Diabetes Prevention Program (DPP). Ms. Haughey explained that the DPP program model is a structured intervention with the goal of Type 2 Diabetes prevention in individuals with an indication of pre-diabetes. Ms. Haughey provided the details of the year-long program which consists of at least 16 intensive "core" sessions which follow a curriculum approved by the Centers for Disease Control and Prevention (CDC). The program provides practical training in long-term dietary changes, increasing physical activity, and behavior change strategies for weight management. Upon completion of the core sessions, monthly follow-up meetings are conducted to ensure the continuation of the new behaviors. The primary goals are to reduce body weight by 5-7% and increase physical activity.

Ms. Haughey further explained that the National DPP is based on the results of a study funded by the National Institutes of Health (NIH) which showed that these strategies sharply reduced the onset of Type 2 Diabetes in people at high risk for the disease. The program is virtual at this time, with limited availability of Chromebooks and scales and internet hot spots. In-person classes will resume within the next year, with a virtual option available if allowed to do so by the CDC. Classes are currently in English, Spanish, and, after July 1, 2022, Vietnamese. The YMCA is currently recruiting for lifestyle coaches who speak Mandarin and Cantonese. They also have the capacity to deliver the program in Russian, Hindi, and Portuguese.

Ms. Haughey continued with an overview of the program reach and impact. She discussed the eligibility requirements and instructions on how to register for the program. The YMCA works with enrollees' insurance plans and with medical offices for direct referrals.

f. Cal MediConnect Ombudsperson Program Update

Andy Le, Ombudsperson and Supervising Staff Attorney for Bay Area Legal Aid, gave an overview of the services available for our CMC members. Members who experience difficulty with CMC health plan enrollment, disenrollment, or access to healthcare are encouraged to call Bay Area Legal Aid. Oftentimes, disenrollment occurs when the premium has not been paid, when the individual has enrolled within the wrong county, one of the MC or Medicare programs is inactive or has been terminated, or when there is a gap in coverage.

Mr. Le included his contact information in the 'Chat'. He encouraged committee members to contact him with any healthcare access or eligibility issues, as well as instructions on how to file an appeal of disenrollment. He can also assist with redetermination letters or questions about share of cost.

Bay Area Legal Aid has seen an increase in phone calls related to emergency health plan enrollment. They are short-staffed at this time, so please be patient and leave a voicemail if you call after 1:00 p.m. Your calls will be returned within 24 hours.

g. Future Agenda Items

Dr. Nakahira asked for suggestions on topics of interest for our September 1, 2022 meeting. At this time, there were no suggestions.

9. Adjournment

The meeting adjourned at 1:04 p.m. The next Cal MediConnect Consumer Advisory Board meeting is scheduled for Thursday, September 1, 2022 at 11:30 a.m.

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Laurie Nakahira, DO, Chairperson
Cal MediConnect Consumer Advisory Board Committee

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee 04/06/2022

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

DIRECT NETWORK		
Initial Credentialing		
Number initial practitioners credentialed	20	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	5	
Number practitioners recredentialed within 36-month timeline	5	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 01/31/2022	669	

DELEGATED NETWORS							
(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**	**NEMS**
Total # of Suspension	0	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0	0
Total # of practitioners	1354	908	754	800	1224	488	1040

Total counts for some Networks have increased due to Provider Adds for Full Delegate Network Reporting.

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.