Santa Clara Family Health Plan

Medi-Cal (MC) and DualConnect (DC)

Quality Improvement and Health Equity Transformation Program 2024

Quality Improvement and Health Equity Committee Approval on: 9th January 2024

2024 Quality Improvement and Health Equity Transformation Program Description

Contents

I.   Introduction

The Santa Clara County Health Authority, operating as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975 and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). SCFHP is a public agency contracted with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. Since 2015, SCFHP has held a three-way contract with DHCS and the Centers for Medicare and Medicaid Services (CMS) to offer a Cal MediConnect Plan (Medicare-Medicaid Plan). Beginning in 2023, SCFHP's Cal Mediconnect Plan transitioned to DualConnect (a Medicare Advantage Plan) as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative Dual Eligible Special Needs Plan (D-SNP).

- SCFHP serves 307,608 Medi-Cal enrollees in Santa Clara County as of December 2023.
- 10,757 members are enrolled in SCFHP's DualConnect plan as of December 2023.

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

II.   Mission Statement

The mission of SCFHP is to 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.

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

III.   Authority and Accountability

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

SCFHP's Governing Board assumes ultimate responsibility for the QIHETP and has established the Quality Improvement and Health Equity Committee (QIHEC) to oversee this function as a Board committee. In preparation for the implementation of DHCS' 2024 contract, the QIHEC may be referenced as the Quality

4

Improvement Committee (QIC) in other SCFHP documents. This supports the Board playing a central role in monitoring the quality of health care services provided to members and striving for quality improvement and health equity in health care delivery. The Board authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QIHETP. The CEO has delegated oversight and supervision of the QIHETP to the Chief Medical Officer (CMO) in collaboration with the Chief Health Equity and Strategies Officer (CHESO).

IV. Purpose

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

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

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

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

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

V.   Goals

SCFHP implements a Quality Improvement and Health Equity Transformation Program (QIHETP) that includes, at a minimum, the standards set forth in 42 CFR sections 438.330 and 438.340, 28 CCR section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy. SCFHP monitors, evaluates, and takes timely action to address necessary improvements in the quality of care delivered by all its Providers in any setting, and takes appropriate action to improve upon Health Equity. SCFHP is responsible for the quality and health equity of all Covered Services regardless of whether or not those services have been delegated to a Subcontractor, Downstream Subcontractor, or Network Provider.

VI.   Program Structure

Functional Areas and Responsibilities

A. SCFHP delivers quality care that enables all Members to maintain health, improve, or manage a chronic illness or disability. SCFHP ensures quality of care in each of the following areas:
1. Clinical quality of physical health care, including access to primary and specialty care;
2. Clinical quality of behavioral health services focused on prevention, recovery, resiliency and rehabilitation;
3. Availability and regular engagement with primary care providers (PCP);
4. Continuity and coordination of care across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships; and
5. Member experience and access to high quality, coordinated and culturally competent clinical care and services, across the care continuum.

B. SCFHP applies the principles of continuous quality improvement (CQI) to all aspects of service delivery system through analysis, evaluation, and systematic enhancements of the following:
1. Quantitative and qualitative data collection and data-driven decision-making;
2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
3. Feedback provided by Members and Network Providers in the design, planning, and implementation of its CQI activities;
4. Other issues identified by SCFHP or DHCS.

C. SCFHP develops Population Health Management (PHM) interventions designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by:

1. Developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services; and
2. Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

D. SCFHP ensures that the QIHETP requirements are applied to the delivery of both physical and behavioral health services

VII. Objectives

The objectives of the QIHETP Description include:

A. Keeping members healthy
B. Managing members with emerging risk
C. Ensuring health equity, patient safety or outcomes across settings
D. Overseeing programs dedicated to helping members manage multiple chronic conditions through case management and the coordination of services and supports
E. Leading the processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
F. Supporting practitioners with participation in quality improvement and health equity initiatives of SCFHP and its governing regulatory agencies
G. Establishing clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation
H. Measuring the compliance of contracted practitioners' medical records against SCFHP's medical record standards at least once every three years; taking steps to improve performance and re-measure to determine organization-wide and practitioner specific performance.
I. Developing studies or quality activities for member populations using demographic data to identify barriers to improve performance, reduce disparities, including Social Determinants of Health, validate a problem, and/or measure conformance to standards
J. Overseeing delegated activities by:
    1. Establishing performance standards;
    2. Monitoring performance through regular reporting; and
    3. Evaluating performance annually
K. Evaluating under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon member need. These methods include, but are not limited to, an annual evaluation of:
    1. Medical record review;
    2. Rates of referral to specialists;

3. Hospital discharge summaries in office charts;
4. Communication between referring and referred-to physicians;
5. Member complaints;
6. Non-utilizing members, including identification and follow-up;
7. Practice pattern profiles of physicians; and
8. Performance measurement of adherence to practice guidelines.

L. Coordinating QI and health equity activities with other activities, including, but not limited to, the identification and reporting of risk situations, adverse occurrences from UM activities, and potential quality of care concerns through grievances

M. Evaluating the QIHETP Description and Work Plan at least annually and modifying as necessary. The evaluation includes:
   1. A description of completed and ongoing QI and health equity activities that address the quality and safety of clinical care and the quality of services; and
   2. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data.

N. Analyzing the results of QI and health equity initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality of services)

O. Developing recommendations to inform the QI and Health Equity Work Plan for the upcoming year to include a schedule of activities for the year, measurable objectives, plan for monitoring previously identified issues, explanation of barriers to completion of unmet goals, and assessments of the completed year's goals

P. Implementing and maintaining health promotion activities and population health management programs linked to QI and health equity actions to improve health outcomes. These activities include, at a minimum, identification of and outreach to of high-risk and/or chronically ill members, education of practitioners, and outreach and education programs for members, and

Q. Maintaining accreditation through the National Committee for Quality Assurance (NCQA)

VIII. Scope

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

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

A. The scope of quality review is reflective of the health care delivery systems, including quality of clinical care and quality of service

B. Activities reflect the member population in terms of age groups, cultural and linguistic needs, disease categories and special risk status

C. The scope of the QIHETP includes the monitoring and evaluation and driving improvements for key areas, including but not limited to the following:
   a. Healthcare Effectiveness Data and Information Set (HEDIS)
      i. Access to Preventive Care
      ii. Maintenance of Chronic Care Conditions
   b. Behavioral health services
   c. Continuity and coordination of care
   d. Emergency services
   e. Grievances
   f. Inpatient services
   g. Member experience and satisfaction
   h. Minor consent/sensitive services
   i. Perinatal care
   j. Potential quality of care issues
   k. Preventive services for children and adults
   l. Primary care
   m. Provider satisfaction
   n. Quality of care reviews
   o. Specialty care
   p. Health equity and health disparity
   q. Social Determinants of Health

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

IX.   QI and Health Equity Work Plan

The QIHETP guides the development and implementation of an annual QI and Health Equity Work Plan that includes:

2024 Quality Improvement and Health Equity Transformation Program Description

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

Quarterly review and updates to the Work Plan are documented and presented to QIHEC, highlighting areas with findings and/or needing improvement. The QI and Health Equity Work Plan is available to regulatory agencies by request.

X.   QI Methodology

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

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

QI and Health Equity Project Selections and Focus Areas

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

A. Areas for improvement identified through continuous delegated and internal monitoring activities, including, but not limited to, (a) potential quality concern review processes, (b)

provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes

B. Measures required by DHCS for Medi-Cal members such as Strength, Weakness, Opportunity and Threat (SWOT) Analysis, Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs)

C. Measures required by the California Department of Managed Health Care (DMHC), such as access and availability

D. Measures required by Centers for Medicare and Medicaid Services (CMS) such as Quality Improvement Activities (QIAs), Performance Improvement Projects (PIPs), or Chronic Care Improvement Projects (CCIPs)

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

A. Access to and availability of services, including appointment availability, as described in policy and procedure

B. Case Management

C. Coordination and continuity of care for Seniors and Persons with Disabilities.

D. Provision of complex care management services

E. Access to and provision of preventive services

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

A. Staff and physicians provide vital information necessary to support continuous improvement in work processes

B. Individuals and department stakeholders initiate improvement projects within their area of authority, which support the strategic goals of the organization

C. Specific performance improvement projects may be initiated by the state or federal government

D. Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes

E. Project coordination occurs through the various leadership structures: Governing Board, Management, QIHEC and UM Committees, etc., based upon the scope of work and impact of the effort

F. These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

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

QI Project Measurement Methodology

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

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes are a minimum of 411 (with 3 to 20% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on SFCHP's previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

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

Plan   1) Identify opportunities for improvement

2) Define baseline

3) Describe root cause(s)

4) Develop an action plan

Do   1) Communicate change/plan

2) Implement change plan

Study   1) Review and evaluate result of change

2) Communicate progress

Act   1) Reflect and act on learning

2) Standardize process and celebrate success

2024 Quality Improvement and Health Equity Transformation Program Description
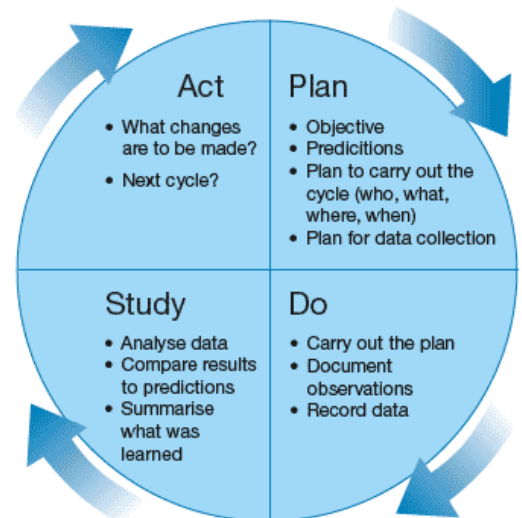
XI.   QI Quality Issue Identification

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

Adverse events can include:

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

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

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

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

A. Claims information/activity
B. Encounter data
C. Utilization data
D. Case management data, such as notes, care plans, tasks and assessments
E. Pharmacy data
F. Population needs assessments

13

G. Results of risk stratification
H. HEDIS performance
I. Member and provider satisfaction surveys
J. Quality Improvement Projects (QIPs)
K. Performance Improvement Projects (PIPs)
L. Chronic Care Improvement Projects (CCIPs)
M. Health Risk Assessment data
N. Consumer Assessment of Healthcare Providers & Systems (CAHPS)
O. Health Outcomes Survey (HOS)
P. Regulatory reporting

Protocol for Using Quality Monitor Screens

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

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

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

XII.   Quality Improvement and Health Equity Program Activities

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

Prioritization

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

A. The annual analysis of member demographic and epidemiological data
B. Those aspects of care which occur most frequently, affect large numbers of members or identified with disparity gaps
C. Those diagnoses in which members are at risk for serious consequences or deprivation of substantial benefit if care does not meet community standards or is not medically indicated

D. Those processes involved in the delivery of care or service that, through process improvement interventions, could achieve a higher level of performance

E. Activities required to achieve and maintain and fortify NCQA Plan and Health Equity Accreditation

Use of Committee Findings

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

Clinical Practice Guidelines

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

Preventive Health/HEDIS Measures

The Quality Improvement and Health Equity Committee (QIHEC) determines aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators are monitored annually for Medicaid (aka Medi-Cal) or Medicare/Dual-Special Needs Plan (aka DualConnect). Initiatives are put in place to encourage member compliance with chronic illnesses, preventive cares, such as for screenings, education and compliance.

Continuity and Coordination of Care

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

workgroups. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

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

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

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

XIII.   QI Organizational Structure

Quality Improvement Department [See Appendix 1]

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

A. Monitoring, evaluating and acting on clinical outcomes for members
B. Conducting reviews and investigations for clinical grievances, including Potential Quality Issues (PQIs)
C. Designing, managing and improving work processes to:
    a. Drive improvement of quality of care received
    b. Minimize rework and costs
    c. Optimize the time involved in delivering patient care and service
    d. Empower staff to be more effective

2024 Quality Improvement and Health Equity Transformation Program Description

     e. Coordinate and communicate organizational information, both division and department-specific, and system-wide

D. Supporting the maintenance of quality standards across the continuum of care and all lines of business
E. Leading cross-functional Process Improvement projects to improve efficiency across the organization
F. Maintaining company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)
G. Collaborating with multi-departments, but not limited to: Health Services Depatrments, Provider Network Operations, Grievance & Appeals, and Customer Services to coordinate QI and health equity activities for all line of business (DC & MC)

The QI Department is led by CMO and Vice President of Health Service; and overseen by Director of Quality and Process of Improvement. The CHESO collaborates with the CMO regarding oversight and supervision of the QIHEC and QIHETP activities.

Chief Medical Officer (CMO)

The CMO has an active and unrestricted medical license in the state of California. The CMO is responsible to report to the Governing Board at least quarterly on the QIHETP, in collaboration with the Chief Health Equity and Strategies Officer, including reports, outcomes, opportunities for improvement, corrective actions, and communicating feedback from the Board to the committees as applicable. The CMO is responsible for day to day oversight and management of quality improvement, health care services and peer review activities. The CMO, in collaboration with the CHESO, is also responsible for communicating information and updates regarding the QIHETP to SCFHP leadership and staff via Staff meetings, executive team meetings, and other internal meetings. The CMO serves as a voting member of the Quality Improvement Health Equity Committee (QIHEC), the Utilization Management Committee (UMC), the Pharmacy and Therapeutics Committee (P&T) and the Credentialing Committee. The CMO also participates in consumer advisory board discussions and other standing and ad hoc committees, as needed.

Chief Health Equity and Strategies Officer (CHESO)

The Chief Health Equity and Strategies Officer (CHESO) provides leadership, strategy and program development across the organization ensuring that health equity is addressed throughout the organization, including the QIHETP. The CHESO, in collaboration with the CMO, is responsible to report to the Governing Board at least quarterly on the QIHETP. The CHESO, in collaboration with the CMO, is also responsible for communicating information and updates regarding the QIHETP to SCFHP leadership and staff via Staff meetings, executive team meetings, and other internal meetings. The CHESO serves as a voting member of the QIHEC.

Medical Director

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

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

VP, Health Services

The Vice President of Health Services shall provide leadership to the following Health Services departments: Quality and Process Improvement, Case Management, Behavioral Health, Utilization Management, Community Based Programs, and Pharmacy. The VP, Health Services shall report directly to the Chief Medical Officer. The VP, Health Services shall be responsible for optimizing the quality and value of care health received by the Plan's members by providing consistent, leadership and direction to design, implement, analysis, monitoring and reporting of effective and efficient health management services within the Plan. The VP, Health Services shall ensure best practices within the plan and delegates to maximize appropriate utilization and quality of health care services while maintaining regulatory requirements and accreditation standards.

Director of Quality and Process Improvement

The Director of Quality and Process Improvement provides leadership to the Quality and Process Improvement Department and is a qualified person with experience in data analysis, barrier analysis, and project management as it relates to improving the clinical quality of care and quality of service provided to Plan members. The Director of Quality and Process Improvement reports to the VP, Health Services and is responsible for directing the activities of the Plan's quality improvement staff in monitoring the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Director of Quality assists the Plan's executive staff, in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Director of Quality and Process Improvement coordinates the Plan's QIHEC proceedings in conjunction with the CMO and CHESO; reports to the Board relevant QI and health equity activities and outcomes, supports organization initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data and recommends performance improvement initiatives while incorporating best practices as applicable.

Quality and Health Education Manager

The Quality and Health Education Manager provides leadership, and coordination to the HEDIS and Health Education Team and is a person with experience in data analysis, barrier analysis, and project management as it relates to improving the quality of service provided to Plan members. The Quality and Health Education Manager reports to the Director of Quality and Process Improvement and is responsible for managing the activities of the Plan's quality improvement staff in monitoring the Plan's health care delivery system relating to quality improvement and health equity, including but not limited to, Health Education (HE), Cultural & Linguistic (C&L) programs and Healthcare Effectiveness Data and Information Set (HEDIS) operation and reporting. The Quality and Health Education Manager assists the Director of Quality and Process Improvement in overseeing the day to day operations of Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members.

Clinical Quality and Safety Manager

The Clinical Quality and Safety Manager provides leadership, and coordination to the QI clinical Team and is a person with experience in clinical as it relates to improving the clinical quality of care provided to Plan members. This includes oversight of the Potential Quality of Care Issue (PQI) investigation process, Facility Site Review (FSR), Initial Health Assessment (IHA) audits. The Clinical Quality and Safety Manager reports to the Director of Quality and Process Improvement and works cross-functionally to support all projects to improve clinical quality of care and quality of service at the plan and is responsible for leading and managing the staff who perform those activities.

Process Improvement Manager

The Process Improvement Manager provides leadership, coordination and management to the Process Improvement Team as it relates to improving internal processes impacting the quality of care and quality of service provided to Plan Members. The Process Improvement Manager reports to the Director of Quality and Process Improvement and is responsible for managing the Process Improvement team in reviewing the Plan's internal delivery systems, managing activities of the Plan's Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) surveys, and overseeing NCQA accreditation activities. The Process Improvement Manager is also responsible for ensuring that Project Management methods are consistently applied towards the goal of quality outcomes for internal projects.

QI Nurse, RN

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

2024 Quality Improvement and Health Equity Transformation Program Description

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

Grievance & Appeals Clinical Specialist, RN

The Grievance & Appeals Clinical Specialist reports to Clinical Quality & Safety Manager and acts as a clinical resource to provide clinical review of all appeals and grievances in accordance with applicable regulatory and professional standards using clinical experience and skills to assess, plan, implement, coordinate and evaluate to ensure appropriate clinical decision making. The Specialist is responsible for the clinical screening for quality of care and assisting the research and review PQI.

HEDIS Project Manager

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

Quality Improvement Program Manager

The Quality Improvement Program Manager develops and executes a strategy to improve the quality performance of Medi-Cal. This role partners with internal teams, external vendors and healthcare providers to serve as critical resource and subject matter expert in supporting, monitoring, managing and driving strategic projects, intervention, and initiatives for Medicaid quality measures, including Medi-cal Accountability Set for Health Care Delivery System (MCAS) and NCQA Healthcare Effectiveness Data Information Set (HEDIS), CAHPS measures for QIHETP to ensure health equity. The Quality Improvement Program Manager reports to Quality and Health Education Manager.

Stars Program Manager

The Stars Program Manager develops and executes strategy to improve the quality performance of CMS Medicare Star Rating. This role partners with internal teams, external vendors and healthcare providers to serve as critical role and subject matter expert in supporting, monitoring, managing and driving strategic projects, intervention, and initiatives for Medicare Star Rating (Part C and D) measures, including but not limited to HEDIS, CAHPS, HOS. The Stars Program Manager reports to Quality and Health Education Manager.

Process Improvement Project Manager

The Process Improvement (PI) Project Manager provides coordination and project management of Plan process improvement projects, PIPs, CCIPs, and NCQA accreditation. The PI Project Manager is

responsible for working collaboratively and cross-functionally with internal and external stakeholders, including staff, consultants, auditors and surveyors to create efficiencies and quality improvements, as well as applying six sigma principals to processes at SCFHP. Additionally, this position is responsible for developing and maintaining processes that enhance the operationalization of Quality Improvement processes and support reporting requirements to DHCS, CMS and achievement of SCFHP goals of improved quality of care and service.

<u>Health Educator</u>

The Health Educator is a qualified health educator/health education specialist either being a Certified Health Education Specialist (CHES) or qualified with Master of Public Health (MPH), who is responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance with state and federal regulatory requirements concerning health education and cultural and linguistic services. The Health Educator works under the direction of the Quality and Health Education Manager and works in cooperation with other departments.
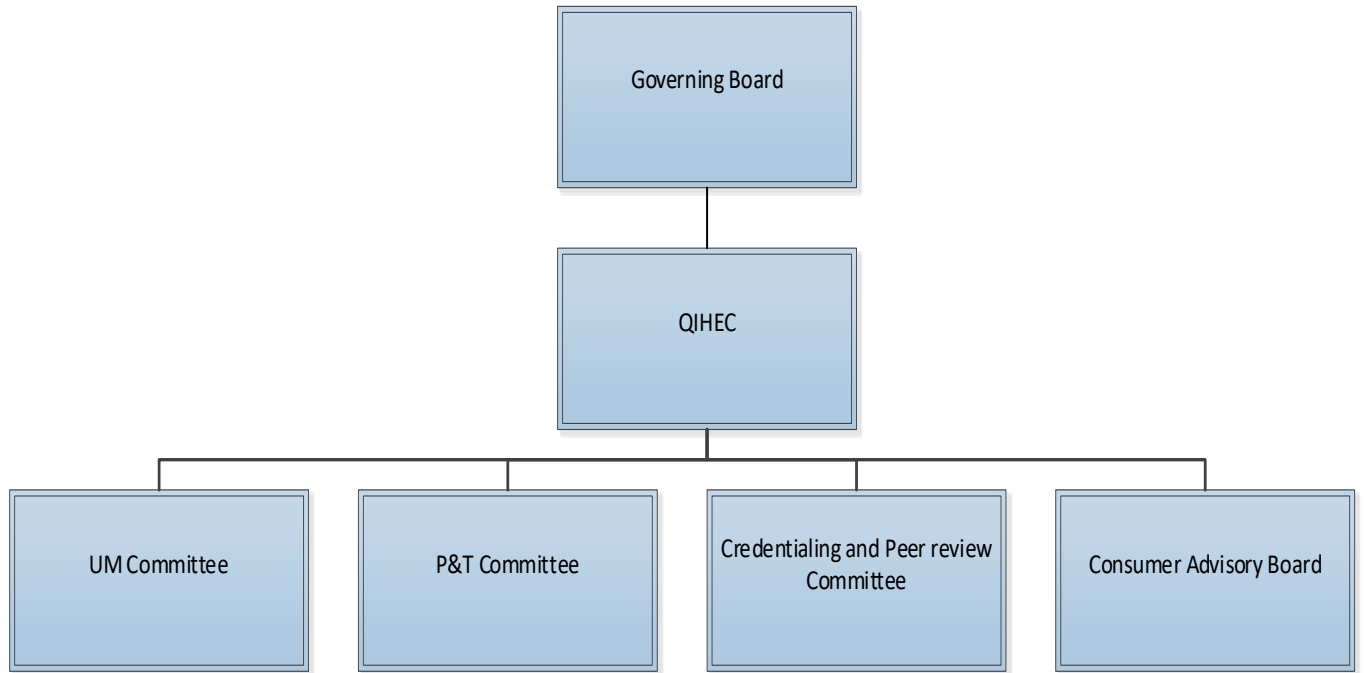
<u>Quality Improvement Coordinator</u>

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

<u>Quality Improvement Outreach Coordinator</u>

The QI Outreach Coordinator has experience in health care setting and customer services. The QI Outreach Coordinator is mainly responsible for conducting outreach calls to coordinate services of care for members and providers to close care gaps and any related quality improvement and health equity activities, in addition to providing health education and cultural & linguistic resources. This position reports to the Quality and Health Education Manager.

XIV. Committee Structure Overview

Oversight of the Quality Improvement Health Equity TransformationProgram (QIHETP) is provided through a committee structure, which allows for the flow of information to and from the Governing Board.

2024 Quality Improvement and Health Equity Transformation Program Description

```
┌─────────────────────────────┐
│      Governing Board        │
└─────────────────────────────┘
              │
┌─────────────────────────────┐
│           QIHEC             │
└─────────────────────────────┘
              │
   ┌──────────┼──────────┬──────────────┐
   │          │          │              │
┌─────────┐ ┌─────────┐ ┌──────────────┐ ┌──────────────┐
│   UM    │ │   P&T   │ │Credentialing │ │  Consumer    │
│Committee│ │Committee│ │and Peer review│ │Advisory Board│
│         │ │         │ │  Committee   │ │              │
└─────────┘ └─────────┘ └──────────────┘ └──────────────┘
```

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

A. Goals
B. Objectives
C. Voting members
D. Plan support staff
E. Quorum
F. Meeting frequency
G. Meeting terms

XV.   Committee Structure

Governing Board

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

The Director of Quality and Process Improvement is responsible for the coordination and distribution of all quality improvement related data and information. The QIHEC reviews, analyzes, makes

recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The CEO, CMO or CHESO communicates the QIHEC activities to the Board. The Board reviews the QIHEC activities and any concerns of the Board are communicated back to the source for clarification or resolution.

<u>Quality Improvement and Health Equity Committee (QIHEC)</u>

The QIHEC is the foundation of the QI and Health Equity Transformation program. The QIHEC assists the CMO, CHESO and SCFHP administration in overseeing, maintaining, and supporting the QIHETP and Work Plan activities.

The purpose of the QIHEC is to monitor and ensure that all QI and health equity activities are performed, integrated, and communicated internally and to the contracted network and partners to achieve the end result of improved care and services for members. Although Delegation Oversight is overseen by the Plan's Compliance Committee, the QIHEC oversees the performance of delegated functions (*See Appendix 2)* and contracted provider and practitioner partners including but not limited to quality of care, quality of service, and access and availability. The Chief Compliance Officer, or designee, participates in QIHEC meetings and provides regular updates on Compliance activities, including delegation oversight.

The composition of the QIHEC includes a broad range of Network providers, including but not limted to contracted providers from a range of specialties as well as other representatives from the community, contracted hospitals, clinics, Medical Directors from contracted IPAs, county partners, Subcontractors, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, a designated behavioral health practitioner, who is a psychiatrist or Ph.D. level psychologist, to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care. The designated behavioral health practitioner participates in the network and advises the QIHEC to support efforts that goals, objectives and scope of the QIHETP are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members. The Subcontractors, Downstream Subcontractors, and Network Providers that are part of QIHEC must be representative of the composition of the SCFHP's Provider Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, Limited English Proficiency (LEP) Members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs) and persons with chronic conditions.

The QIHEC provides overall direction for the continuous improvement process and evaluation of activities, consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and interdepartmental approach. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, it strives to ensure that members are provided the highest quality of care, that the plan adopts evidence based clinical practice guidelines (CPG), completes an annual review and

23

updates the CPGs to make certain they are in accordance with recognized clinical organizations. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIHEC.

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

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

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

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

Utilization Management Committee

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

The UMC actively involves participating network practitioners in utilization review activities to the extent that there is not a conflict of interest. The Plan's UMC is comprised of the CMO and network physicians representing the range of practitioners within the network and across the service area in which it operates, including a Behavioral Health practitioner. The UMC chair is a participating practitioner. Plan executive leadership and Utilization Management/Quality Improvement staff may also attend the UMC, as appropriate. The UMC monitors the under-/over- utilization of health care services by SCFHP and through delegated entities to that may adversely impact member care as well as practice patterns of network practitioners and other QI monitors as defined by the Utilization Management Program and Utilization Management Work Plan.

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

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

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee provides oversight of the SCFHP pharmacy program to promote the delivery of quality patient care through review of policies and clinical programs. This would include pharmacy care coordination, oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management, and providing retrospective drug utilization review (DUR) services. For the Medi-Cal line of business, pharmacy services are carved out to the California Department of Health Care Services including developing, implementing and maintaining all Medi-Cal pharmacy policy, formulary drug coverage, and prior authorization/utilization management.

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

The P&T Committee meets quarterly and reports to the QIHEC.

Credentialing and Peer Review Committee

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

ranging from among the multidisciplinary specialties and an SCFHP Chief Medical Officer and/or Medical Director. The CMO, or a participating practitioner, may chair the Credentialing Committee.

XVI. Role of Participating Practitioners

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

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

XVII. Behavioral Health Services

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

A. Access to care
B. Availability of practitioners
C. Coordination of care
D. Medical record and treatment record documentation
E. Complaints and grievances
F. Appeals
G. Utilization metrics
     a. Timeliness
     b. Application of criteria
     c. Bed days

      d.   Readmissions

      e.   Emergency department utilization

      f.   Inter-rater reliability

  H. Compliance with evidence-based clinical guidelines

  I.   Language assistance

The Behavioral Health department, overseen by the Director of Case Management & Behavioral Health, assists with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, providing behavioral health QI statistical data, and follow-up on identified issues. The Director of Case Management & Behavioral Health represents SCFHP and acts as liaison between the Managed Care Plan and the County Mental Health Plan by collaborating and coordinating services for members, participating in County Behavioral Health Services quality efforts and audits.

XVIII. Utilization Management

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

XIX. Population Health Management

The Population Health Management (PHM) program is developed, implemented and evaluated by the Health Services team with input and oversight by the QI Team and QIHEC. SCFHP's PHM program seeks to improve the health outcomes of all Members, including Members less than 21 years of age, and ensuring all Members have equitable access to necessary wellness and prevention services, care coordination and care management. The Health Services Department annually conducts a population health assessment to identify the needs and characteristics of SCFHP's member population. The Health Services Team reviews the results of the assessment and identifies programs that would be beneficial to SCFHP's sub populations. The PHM Program has four areas of focus, as outlined by NCQA:

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

The QI Team works with other Health Services departments to identify and set goals as part of the PHM Strategy. The PHM Strategy also outlines how SCFHP provides PHM services to Members less than 21 years of age, including but not limited to, Basic PHM, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, Care Coordination services, Early Intervention Services and a Wellness and Prevention Program. SCFHP will collaborate with local health jurisdictions and other Managed Care Plans in Santa Clara County on a Population Needs Assessment (PNA) every three years, or as per DHCS requirement, and provide meaningful participation. Findings from the PNA will be incorporated into SCFHP's PHM Strategy.

The PHM Strategy is brought to the QIHEC for review and approval annually.

XX.   Health Equity

SCFHP is committed to providing equitable, appropriate care to our members by implementing a comprehensive health equity program. The program is overseen by the CHESO and strives to create a system whereby care does not vary in quality because of personal characteristics such as sexual orientation, gender identity, race, ethnicity, language, socioeconomic status, and geographic location. The program seeks to:

- Develop and implement policies and procedures aimed at improving Health Equity and reducing Health Disparities;
- Develop training programs focused on sensitivity, diversity, cultural competency, and health equity;
- Engage and collaborate with Contractor staff, Subcontractors, Downstream Subcontractors, Network Providers, and entities included, but not limited to local community-based organizations, local health department, behavioral health and social services, child welfare systems and Members in Health Equity efforts and initiatives[
- Implement strategies designed to identify and address root causes of Health Inequities, which includes but is not limited to systemic racism, Social Drivers of Health, and infrastructure barriers;
- Develop targeted interventions designed to improve Health Equity and reduce Health Disparities; and
- Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to improve Health Equity and reduce Health Disparities.

XXI.   Care of Members with Complex Needs

Refer to the QIHETP Description and the Population Health Management Strategy document for complete details on care of members with complex needs. SCFHP is committed to serving the needs of all members and places with additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is to promote the delivery of effective quality health care to members with special health care needs, including, but

2024 Quality Improvement and Health Equity Transformation Program Description

not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

A. Providing care coordination support to reduce unplanned hospital readmissions
B. Improving access to primary and specialty care to facilitate the receipt of appropriate services for members with complex health conditions
C. Coordinating care for members who receive multiple services
D. Identify and reducebarriers to services for members with complex conditions

XXII. Community Based Programs (CBP) & Social Determinants of Health (SDOH)

The CBP Department develops and leads strategies, initiatives and programs that address members' social needs and supports their ability to thrive in the community while reducing utilization of higher levels of care and institutionalization. This includes building and managing an adequate provider network and community partnerships for the delivery of the Enhanced Case Management (ECM) and Community Health Worker benefits,as well asCommunity Supports (CS) services. Designated CBP staff oversee pre-identification of target populations, referrals and eligibility determination for these benefits and services, as well as coordination and training with Long-Term Services and Supports (LTSS) providers including Community Based Adult Services (CBAS) In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) and the network of contracted nursing facilities. SCFHP is committed to the coordination and leveraging of community resources, and education to provide adequate access and availability to members needing LTSS and to address member's social conditions.

Training on LTSS needs, benefits, Enhanced Care Management (ECM) and Community Supports (CS) services is provided upon hire and annually to all case management staff and included in the initial training for the provider network. A focus of the training is how LTSS benefits and services support member's ability to remain living in the community and to support transitions of care for members residing in long term care nursing facilities.

The SDOH team educates providers on how ICD-10 codes can be used to report members' social needs by providing information in tips sheets, the provider manual, and education sessions. This information will allow the health plan to understand members' social needs and adequately train staff and partner with community providers to provider better care.

The SDOH team is responsible for implementing a social needs screening process to help identify members who require assistance addressing said needs. The team will work cross-departmentally with member facing programs on the collection, storage and analysis of this data. The process will define action steps based on the department completing the screening and include both benefits, services and community resources appropriate for the member based on the needs identified. This data along with social needs risk scores will be used to provide aggregated information on Santa Clara

County geographies, highlighting the emerging needs of members and communities SCFHP serves. This will inform future program planning and resource mapping as well as assist in the evaluation of community investments and pilot programs.

The Housing Services team is responsible for the development, implementation and ongoing management of an integrated homeless and housing strategy for SCFHP's membership. This includes managing housing and homelessness initiatives, programs and special projects, coordination of housing strategies with SCFHP's Community Supports and SDOH goals and working collectively with internal and external housing/homeless service providers and advocacy groups.

XXIII. Enhanced Care Management, Community Health Workers and Community Supports

Enhanced Care Management (ECM) is a Medi-Cal benefit delivered by community-based providers for members who meet specific eligibility criteria for one of the eight identified ECM Populations of Focus. These include children with complex health needs, homeless individuals, high utilizers, individuals who are at risk of long-term care institutionalization, justice-involved individuals and nursing facility residents transitioning to the community, individuals with Serious Mental Illness and/or Substance Use Disorder, and pregnant and post-partum individuals. Eligible members are assigned a Lead Care Manager to work with the member and family support individuals to manage and coordinate the member's care. ECM serves as the central point for coordinating patient-centered care to improve member outcomes through coordination of primary care, physical and developmental health, mental health, substance use disorder treatment (SUD), community-based LTSS, oral health, palliative care, and community-based and social services. ECM creates an infrastructure to support multi-system coordination and care delivery, including connecting members to Community Supports; ECM looks to reduce healthcare costs, including hospital admissions/ readmissions and ED visits, and extends to reduce costs related to expensive community systems such as long term care settings, nursing home residencies, and jails or prison systems.

Community Health Worker (CHW) is a Medi-Cal benefit delivered by community based providers known as Supervising Providers, who employee or contract with community health workers (CHWs) to provide preventive health services. CHWs are members of the community they are serving and a larger component to linking health and social services for Members with an overall improvement in quality of services delivered. CHWs may assist with a variety of concerns impacting Medi-Cal-eligible members, including but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services. Additionally, CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

Community Supports are flexible wrap-around services that are available to members and integrated into our case management programs for members at medium-to-high levels of risk and may fill gaps in Medi-Cal benefits to address medical or other needs that may arise due to social determinants of health. These services are medically-appropriate and cost-effective substitutes or settings that are provided as an alternative to services covered under Medi-Cal, such as hospital care, nursing facility care stays, and emergency department (ED) use. SCFHP launched 13 of the 14 DHCS-approved Community Supports, with the final one expected to be launched on July 1, 2024. Referrals can be made by providers and members; eligibility criteria are reviewed and if approved, the member is linked to a community- based provider to deliver the Community Supports services. Community Supports providers update ECM providers and SCFHP on the member's care.

ECM, CHW, and Community Supports programs are reflected in the Population Health Management Strategy. Updates and changes to these programs are reported to the Quality Improvement Committee for review, feedback and approval.

XXIV. Cultural and Linguistics

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

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

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

The goal of the SCFHP C&L Services Program is to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with LEP, sensory impairment, diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation or gender identity.

Interpreter services are provided to the member at no charge.

To ensure that SCFHP employees and providers adhere to its C&L services policies and procedures, and that these policies and procedures result in services that are effective in providing CLAS, SCFHP conducts regular monitoring and enforcement activities regarding staff, provider, and interpreter performance that include, but are not limited to:

- Member satisfaction surveys

- Review of member grievances
- Provider assessments and provider site reviews
- Provider satisfaction surveys
- Feedback on services from Consumer Advisory Committee (CAC), Consumer Advisory Board (CAB), the Provider Advisory Council (PAC), provider office staff, QIHEC, SCFHP staff and network providers, community-based organization partners, and other focus group reports
- Audits of delegated provider groups
- Data from utilization reports
- Analysis of health outcomes

If gaps in the provision of cultural and linguistic services are identified, SCFHP takes immediate action to identify such gaps and take immediate action to improve the delivery of such C&L services. SCFHP also reviews the C&L Program work plan, evaluation, and description on an annual basis. Updates and changes are submitted to the QIHEC for approval on an annual basis. Health disparities and utilization patterns by race, ethnicity, and language are investigated by SCFHP's Quality Improvement Department and appropriate interventions are implemented as needed.

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

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

Please refer to Cultural and Linguistic Services Program Description for details.

XXV. Health Education

Health Education Program is an organized program, service, functions and resources necessary to deliver general health education, health promotion, and patient education to assist SCFHP beneficiaries to maintain and improve their health and manage their illnesses. The Health Education Program supports SCFHP's Population Health Management (PHM) strategy under the direction of Health Educator.

Please refer to Health Education Program Description.

XXVI. Nurse Advice Line and Telehealth

SCFHP's Nurse Advice Line is available 24 hours a day, seven days a week with immediate telephonic access to medical support for a multitude of varying member health care needs. Members have access to support for a broad range of health-related questions, including acute and chronic disease triage, education or prevention. Members are advised regarding accessing care and the most appropriate level of care, based on their inquiries. Depending on need, members can speak to a Registered Nurse or Physician after being triaged for the reason of the call. Follow-up with members is recommended and arranged as needed. Nurse Advice Line services include the use of TTY/TDD equipment to handle the needs for deaf/hard of hearing individuals, and also Language Line Interpretation services for member languages other than English.

XXVII.   Credentialing Processes

SCFHP conducts a credentialing process that is in compliance with the NCQA, DHCS, DMHC, and CMS. SCFHP contracts with a Credentials Verification Organization (CVO) who performs primary source verification. The Plan credentials new applicants prior to the effective date of the practitioner's agreement and in advance of the practitioner delivering care to members, and re-credentials network practitioners at least every 36 months.

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

Healthcare Delivery Organizations

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

Use of Quality Improvement Activities in the Re-credentialing Process

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

Monitoring for Sanctions and Complaints

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

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

SCFHP does not delegate Primary Care Provider (PCP) site and medical records review to its contracted groups. SCFHP assumes responsibility and conducts and coordinates Facility Site Review (FSR) and Medical Record Review (MRR) in accordance with standards set forth by MMCD APL 22-017.

SCFHP collaborates with other health plan partners to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for PCPs contracted with health plan partners. Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD APL 22-017 and SCFHP policies.

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

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

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

Medical Record Documentation Standards

SCFHP requires that its contracted practitioners maintain medical records in an accurate and timely manner that is current, detailed, organized, and easily accessible to treating practitioners. All member data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation

notes, etc.). The medical record should also indicate timely access by members to information that is pertinent to them, such as health education materials.

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

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

XXIX. Initial Health Appointment

SCFHP ensure contracted providers are trained and administering the Initial Health Appointment (IHA) within 120 days of enrollment (DHCS APL 22-030) and preriodically readministered according to the requirements in DHCS' PHM Policy Guide and DHCS contractual requirement. The IHA is conducted in a culturally and linguistically appropriate manner for all members, including those with disabilities using relevant clinical evidence to identify beneficiary's health education needs and conduct educational intervention.

XXX. Member Safety

The monitoring, assessment, analysis and promotion of member safety matters are integrated into all components of member enrollment and health care delivery organization continuum oversight and are a significant part the Plan's quality and risk management functions. Member safety efforts are clearly articulated both internally and externally, via newsletter, email, fax, web and verbal communications. Member safety efforts include:

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

Member Safety prevention, monitoring and evaluation include:

A. Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), to allow the practitioner to correct the issue

B. Ensuring timely and accurate communication between sites of care, such as hospitals and skilled nursing facilities, to improve coordination and continuity of care utilizing Facility Site Review (FSR), Physical Accessibility Review Survey (PARS), and Medical Record Review (MRR) results from practitioner and healthcare delivery organizations at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act), and SPD (Seniors and Persons with Disabilities) site review audits into the general facility site review process

C. Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

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

A. Ambulatory setting
   a. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
   b. Annual blood-borne pathogen and hazardous material training
   c. Preventative maintenance contracts to promote that equipment is kept in good working order
   d. Fire, disaster, and evacuation plan, testing, and annual training

B. Institutional settings (including Long-Term Care (LTC) and Long-Term Services and Supports (LTSS)
   a. Falls and other prevention programs
   b. Identification and corrective action implemented to address post-operative complications
   c. Sentinel events identification and appropriate investigation and remedial action
   d. Administration of Flu/Pneumonia vaccine

C. Administrative offices
   a. Fire, disaster, and evacuation plan, testing, and annual training

XXXI. Member Experience and Satisfaction

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

SCFHP solicits feedback from members, medical centers, and caregivers to assess satisfaction using a range of approaches, such as NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS) and member satisfaction survey, monitoring member complaints and direct feedback from grievances and appeals. The Quality and Process Improvement Department is responsible for coordinating the HOS and CAHPS surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the QIHEC with specific recommendations for performance improvement interventions or actions. The CAHPS survey is conducted annually for both Medicare and Medicaid (aka Medi-Cal) members. The HOS is following CMS Medicare Star Rating guidelines.

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

Member Grievances and Provider Complaints

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

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

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

XXXII. Delegation Oversight

The Delegation Oversight process is within the Plan's Compliance Department and overseen by the Plan's Compliance Committee. The Compliance Officer participates in the QIHEC and regularly reports on Compliance activities, including delegation oversight. Delegation Oversight activities includes but is not limited to the following:

A. On-going monitoring via quarterly, semi-annual, and annual reports
B. Focused review that may include case file monitoring when applicable
C. Annual review of the delegates' policies and procedures
D. Annual Oversight Audits

2024 Quality Improvement and Health Equity Transformation Program Description

E. Annual review to provide feedback of the delegates' Quality and Utilization Management Program Plans and Work Plans

F. Review and approval of sub-delegate's delegation agreement(s) prior to implementation of such an agreement

G. Sub-delegation reports

H. Review of case management program and processes

I. Review of quality of care monitoring processes, results of QI Activities,

J. Review of credentialing and re-credentialing processes, working collaboratively with the delegates' staffs to review performance and develop strategies for improvement

    a. Communication monthly and quarterly analysis of reports and utilization benchmarks to delegates

Oversight activity results are shared with delegates during Joint Operating Committees or other applicable workgroups and committees. When a delegate is found to be non-compliant with contractual or regulatory standards, SCFHP may issue the delegate a corrective action plan. Further disciplinary actions may include sanctions, freezing enrollment, financial penalties, and contract termination.

Delegate monitoring and auditing activities, including corrective action plan monitoring and recommendations are presented and discussed in the Plan's Oversight Workgroup. All oversight activities and recommendations are also presented to the Compliance Committee for review, discussion, and approval, when applicable.

XXXIII.   Data Integrity/Analytics/Improvement Activities

The data warehouse aggregates data from SCFHP's core business systems and processes, such as member eligibility and demographics, provider data, utilization, and pharmacy data. The NCQA HEDIS engine data table provides status on each member and metric at a point in time. Other data tables include health risk assessments, in home assessments, case management outcomes and care plan progress. Using these various data tables, SCFHP is able to apply queries and logic to do the following and conduct quality activities in a manner that embeds health equity and health disparity in focus:

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

A. Identify and stratify members

B. Identify over/under utilization of services, including non-engagement

C. Identify gaps in care using HEDIS evidenced based care guidelines

D. Identify members for targeted interventions, e.g., uncontrolled diabetes

Identification and Stratification of Members

Criteria are developed for risk segmentation and stratification (RSS) for high risk, medium-emerging risk, and low risk members using data from the data tables. A menu of services are mapped to each

38

RSS that includes Complex Care Management, Basic Population Health Management, Wellness and Prevention, Self Management, Chronic Disease Management and/or Transition of Care Services. The RSS can be presented by race/ethnicity, age, geography and other demographic views with goal of reducing bias and exacerbating disparities.

Identify Potential of Over- and Under- Utilization of Services

Using clinical business rules, the database can identify inappropriate utilization which can be over or underutilization ofmedical services. For example, frequent ED utilization for ambulatory care senstive condition, potentially preventable (re)admission, chronic condition prescriptions filled without a primary care encounter, or non engagement with the PCP. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

Identify Missing Preventive Care Services

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

Identify Members for Targeted Interventions

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

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

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation. Validation is done through a minimum 10% sampling of abstracted data for rate to standard reliability, and is coordinated by the Director of Quality and Process

Improvement, or designee. If validation is not achieved on all records samples, a further 25% sample is reviewed. If validation is not achieved, all records completed by the individual are re-abstracted by another staff member.

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

Interventions

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

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

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

Improvement Standards

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

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

Documentation of QI Projects

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

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

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

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

- Primary care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

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

A. Clinical care and service
B. Access and availability
C. Continuity and coordination of care
D. Preventive care, including:
    a. Initial health appointment (IHA)
    b. Behavioral assessment

E. Patient diagnosis, care, and treatment of acute and chronic conditions
F. Complex case management:
   a. SCFHP coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the utilization and case management department, which details this process in its utilization management and case management programs and other related policies and procedures
G. Drug Utilization
H. Health Education
I. Over- and Under- Utilization monitoring
J. Population health program outcomes and performance against program goals

Administrative Oversight:

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

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

XXXIV.   Conflict of Interest

Network practitioners serving on any QI and Health Equity program-related committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues.

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

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

XXXV. Confidentiality

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

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

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

XXXVI. Communication of QI and Health Equity Activities

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

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

A. Practitioner participation in the QIHEC and its subcommittees
B. Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
C. Practitioner and member newsletters regarding relevant QI program topics
D. The QIHETP description, available to providers and members on the SCFHP website. This includes QIHETP goals, processes and outcomes as they relate to member care and service. Members and/or providers may obtain a paper copy by contacting Customer Service.
E. Included in annual practitioner education through provider relations and the Provider Manual

XXXVII. Annual Evaluation

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

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

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

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

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

Appendix 1

Quality Improvement Department Organization Structure

2024 Quality Improvement and Health Equity Transformation Program Description
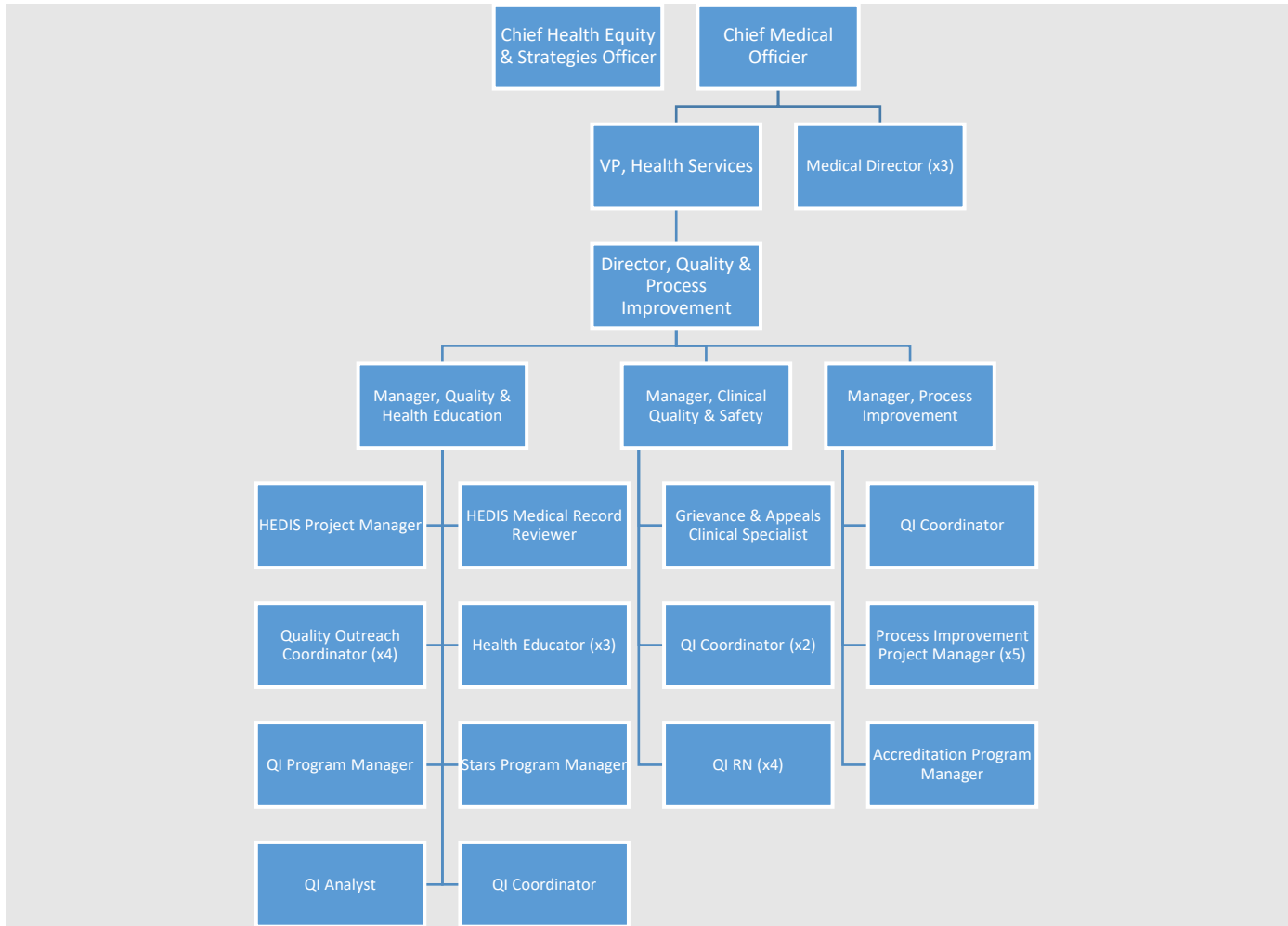
Appendix 2

Delegated Activities Grid

Entity	Delegate/Vendor	Type of Delegate	M-Cal	QI	PHM	NET	UM	CR	ME	HE	Description of delegation	M-Care	QI	PHM	NET	UM	CR	ME	HE	Description of delegation
Delegates																				
Valley Health Plan (VHP) - Current	Delegate	Health Plan	X	X	X		X	X			QI: Health Services Contracting, UM: Clinical Criteria (Behavioral),Clinical Criteria (Non-Behavioral),Communication Services,New Technology Evaluation,Pharmaceutical Management,Program Structure (Behavioral),Program Structure (Non-Behavioral),System Controls (UM Denials),UM Denials (Behavioral),UM Denials (Medical),UM Denials (Pharmacy) CR: Credentialing/Recredentialing (Full Delegation)									
Valley Health Plan (VHP) - Future/Not Signed	*Delegate*	*Health Plan*	X	X	X	X	X	X	X	X	*QI: Fully delegated PHM: Fully delegated NET: Accessibility (Behavioral), Accessibility (Non-Behavioral), Availability/Accessibility (Behavioral), Availability/Accessibility (Non-Behavioral), Continued Access to Care UM: Clinical Criteria (Behavioral), Clinical Criteria (Non-Behavioral), Communication Services, New Technology Evaluation, Pharmaceutical Management, Program Structure (Behavioral), Program Structure (Non-Behavioral), System Controls (UM Denials), UM Denials (Behavioral), UM Denials (Medical), UM Denials (Pharmacy) CR: Fully delegated ME: Other (Interpreter Services, Customer Service Experience Reports) HE: Fully delegated*									
Premier Care of Northern California (PCNC)	Delegate	Provider Network	X				X	X			UM: Clinical Criteria (Non-Behavioral),Communication Services,New Technology Evaluation,Pharmaceutical Management,Program Structure (Non-Behavioral),System Controls (UM Denials),UM Denials (Medical),UM Denials (Pharmacy) CR: Credentialing/Recredentialing (Full Delegation)									
Physician's Medical Group (PMG)	Delegate	Provider Network	X				X	X			UM: Clinical Criteria (Non-Behavioral),Communication Services,New Technology Evaluation,Pharmaceutical Management,Program Structure (Non-Behavioral),System Controls (UM Denials),UM Denials CR: Credentialing/Recredentialing (Full Delegation)									
North East Medical Services (NEMS)	Delegate	Provider Network	X				X	X			UM: Clinical Criteria (Non-Behavioral),Communication Services,New Technology Evaluation,Pharmaceutical Management,Program Structure (Non-Behavioral),System Controls (UM Denials),UM Denials (Medical),UM Denials (Pharmacy) CR: Credentialing/Recredentialing (Full Delegation)									
Vision Service Provider	Delegate	Vision Provider	X					X			CR: Credentialing/Recredentialing (Full Delegation)	X					X			CR: Credentialing/Recredentialing (Full Delegation)
VerifPoint	Delegate	CVO	X					X			CR: Credentialing/Recredentialing (Full Delegation)	X					X			CR: Credentialing/Recredentialing (Full Delegation)
Stanford/LPCH	Delegate	Provider Network	X					X			CR: Credentialing/Recredentialing (Full Delegation)	X					X			CR: Credentialing/Recredentialing (Full Delegation)
Palo Alto Medical Foundation	Delegate	Provider Network	X					X			CR: Credentialing/Recredentialing (Full Delegation)	X					X			CR: Credentialing/Recredentialing (Full Delegation)
Harte Hankes	Delegate	Customer Service										X						X		ME: Complaint Handling, Customer Contact Center
MedImpact	Delegate	Pharmacy Benefits										X		X		X		X		PHM: Informs Members (for MTM program) UM: Performs prior authorization review for Part D pharmacy benefit. ME: Call Center Other: Provides single-sign on access to members' Pharmacy Benefit Information
Arvato	Delegate	Mail Service/Communications Fulfillment	X						X		ME: Other (Provider Termination Letters)	X						X		ME: Other (Provider Termination Letters)