Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

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

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

AGENDA

1.	**Roll Call**	Dr. Paul	6:00	3 min
2.	**Public Comment** Members of the public may speak to any item not on the agenda; two minutes per speaker. The Quality Improvement Committee (QIC) reserves the right to limit the duration of the public comment period to 30 minutes.	Dr. Paul	6:03	2 min
3.	**Meeting Minutes** Review draft minutes of the 2/8/2022 QIC meeting. **Possible Action:** Approve draft minutes of the 2/8/2022 QIC meeting	Dr. Paul	6:05	5 min
4.	**Chief Executive Officer (CEO) Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:10	15 min
5.	**Medi-Cal (MC) & Cal MediConnect (CMC) Quality Improvement (QI) Work Plan 2022** Review the MC & CMC QI Work Plan 2022. **Possible Action:** Approve the MC & CMC QI Work Plan 2022	Ms. Baxter	6:25	15 min
6.	**MC & CMC QI Program Evaluation 2021** Review the MC & CMC QI Program Evaluation 2021. **Possible Action**: Approve the MC & CMC QI Program Evaluation 2021	Ms. Baxter	6:40	15 min
7.	**Pharmacy Benefit Information Analysis** Review the Pharmacy Benefit Information Analysis. **Possible Action:** Approve the Pharmacy Benefit Information Analysis	Dr. Nguyen	6:55	15 min
8.	**Quality Dashboard** Review of the Quality Dashboard.	Ms. Baxter	7:10	15 min
9.	**Compliance Report** Review of the Compliance Report.	Mr. Haskell	7:25	10 min

10. Annual Review of QI Policies **a.** QI.03 Distribution of QI Information **b.** QI.04 Peer Review Process **c.** QI.06 QI Study Design/Performance Improvement Program Reporting **d.** QI.08 Cultural and Linguistically Competent Services **e.** QI.09 Health Education Program and Delivery System **f.** QI.11 Member Non-Monetary Incentives **g.** QI.15 Transitions of Care **h.** QI.16 Managed Long Term Services and Support Care Coordination **i.** QI.19 Care Coordination Staff Education and Training **j.** QI.23 SABIRT Misuse of Alcohol and Substances **k.** QI.28 Health Homes Program **l.** QI.30 Health Risk Assessment **m.** QI.31 Community Supports (CS) **n.** QI.32 Enhanced Care Management (ECM) **Possible Action:** Approve the QI policies as presented.	Dr. Nakahira & Ms. Baxter	7:35	10 min
11. Consumer Advisory Board (CAB) Review draft minutes of the 3/3/2022 CAB meeting. **Possible Action:** Approve the 3/3/2022 CAB draft meeting minutes	Dr. Nakahira	7:45	5 min
12. Pharmacy & Therapeutics (P&T) Committee Review draft minutes of the 3/17/2022 P&T Committee meeting. **Possible Action:** Approve the 3/17/2022 P&T draft meeting minutes	Dr. Lin	7:50	5 min
13. Credentialing Committee Report Review 2/23/2022 Credentialing Committee Report. **Possible Action:** Approve the 2/23/2022 Credentialing Committee Report	Dr. Nakahira	7:55	5 min
14. Adjournment The next QIC meeting will be held on June 14, 2022.	Dr. Paul	8:00	

Notice to the Public—Meeting Procedures

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

Santa Clara Family Health Plan™

QIC Draft Meeting Minutes

February 8, 2022

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

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

Minutes – Draft

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

Members Absent
None

Staff Present
Chris Turner, Chief Operating Officer
Ngoc Bui-Tong, Vice President, Strategy & Analytics
Tyler Haskell, Interim Compliance Officer
Lori Andersen, Director, Long Term Services and Support
Johanna Liu, PharmD, Quality and Process Improvement
Desiree Funches, Quality Improvement RN
Lucille Baxter, Manager, Quality & Health Education
Mauro Oliveira, Manager, Grievance and Appeals
Byron Lu, Process Improvement Project Manager
Amber Tran, Process Improvement Project Manager
Karen Fadley, Provider Database Analyst
Claudia Graciano, Provider Network Associate Lead
Tu Le, Medical Management Care Coordinator
Zara Hernandez, Health Educator
Nancy Aguirre, Administrative Assistant

1. **Roll Call**

   Ria Paul, MD, Chair, called the meeting to order at 6:02 pm. Roll call was taken and quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   Meeting minutes of the 12/7/2021 Quality Improvement Committee (QIC) meeting were reviewed.

It was moved, seconded and the minutes of the 12/7/2021 QIC meeting were **unanimously approved.**

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

4. Network Adequacy Assessment 2021

Karen Fadley, Provider Database Analyst, presented the Network Adequacy Assessment 2021 for the Cal Medi-Connect (CMC) line of business. On an annual basis, Santa Clara Family Health Plan (SCFHP) conducts a quantitative analysis against availability and accessibility standards, and a qualitative analysis on performance. Provider types included in this assessment are primary care, high volume specialist(s), high impact specialist(s), and high volume behavioral health providers.

Ms. Fadley reviewed the results for Appointment Availability for each provider type. Also reviewed were the contributing factors to the results and opportunities for improvement.

It was moved, seconded and the Network Adequacy Assessment 2021 was **unanimously approved.**

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

5. Clinical, Behavioral, & Medical Preventative Practice Guidelines

Johanna Liu, PharmD, Director, Quality and Process Improvement, presented the Clinical, Behavioral, & Medical Preventative Practice Guidelines, in place of Lan Tran, Quality Improvement Nurse. These clinical practice guidelines are intended to assist providers in clinical decision-making.

Practice guidelines are reviewed and updated at least every two (2) years and more frequently when updates are released. SCFHP monitors compliance and member outcomes related to these clinical guidelines for quality improvement initiatives.

It was moved, seconded and the Clinical, Behavioral, & Medical Preventative Practice Guidelines were **unanimously approved.**

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

6. Quality Improvement (QI) Program Description 2022

Lucille Baxter, Manager, Health and Education, presented an overview of the contents included within the QI Program Description 2022.

It was moved, seconded and the QI Program Description 2022 was **unanimously approved.**

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

7. Health Education (HE) Evaluation 2021, HE Program Description 2022, HE Work Plan 2022

Zara Hernandez, Health Educator, presented the HE Evaluation 2021 and noted item 3B (Evaluation of Plan's self-management tools for usefulness to members) and 3C (Review of Plan's online web-based self-management tools) are still in progress. The Plan is in need of a solution to meet Medicaid requirements by 12/2023, as both items are part of the NCQA 2020 Health Plan Accreditation Requirements. Also in progress

is item 4D (Comprehensive Tobacco Prevention and Cessation Services).

Ms. Hernandez reviewed the overall changes made to the HE Program Description 2022. Changes include the specification that the HE Program Description 2022 includes Medicaid and Medicare. Additionally, modifications to the HE Program Description 2022 is permitted, and is subject to change, based on NCQA requirements. Furthermore, Initial Health Assessment (IHA) and Facility Site Review (FSR) were removed.

Ms. Hernandez reviewed the HE Work Plan 2022. Items 5C and 5D were added to the HE Work Plan 2022 to lead improvement in the health of communities impacted by disparities.

It was moved, seconded and the HE Evaluation 2021, HE Program Description 2022, and HE Work Plan 2022 were **unanimously approved.**

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

8. Cultural and Linguistics (C&L) Evaluation 2021, C&L Program Description 2022, C&L Work Plan 2022

Ms. Hernandez presented the C&L Evaluation 2021 and noted SCFHP fulfilled all requirements and goals. Ms. Hernandez highlighted items 3A and 3B. Goals for both items were met by focusing on disparate groups.

Ms. Hernandez reviewed the overall changes made to the C&L Program Description 2022. Changes include the specification that the C&L Program Description 2022 includes Medicaid and Medicare, and that the C&L Program Description 2022 can be modified and is subject to change based on DHCS requirements.

Ms. Hernandez noted item 3C was added to the C&L Work Plan 2022.

It was moved, seconded and the C&L Evaluation 2021, C&L Program Description 2022, and C&L Work Plan 2022 were **unanimously approved.**

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

9. Grievance and Appeals (G&A) Report Q3 and Q4 2021

Mauro Oliveira, Manager, Grievance and Appeals presented the G&A Report for Q3 2021. Mr. Oliveira reviewed the correction made to the Q3 2021 report, specific to the total G&As per 1000 members, for both MC and CMC.

Mr. Oliveira presented the G&A Report for Q4 2021. The top 3 MC Grievance Categories and the top 3 MC Grievance Subcategories were reviewed, as well as the MC Appeals by Case Type, and Disposition. In addition, the Top 3 Cal MediConnect (CMC) Grievance Categories and the top 3 CMC Grievance Subcategories were reviewed, as well as the CMC Appeals by Case Type, and Disposition.

It was moved, seconded and the G&A Report Q3 and Q4 2021 were **unanimously approved.**

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

10. SCFHP Equity Steering Committee

Ngoc Bui-Tong, Vice President, Strategy & Analytics, presented the SCFHP Equity Steering Committee. The purpose of this committee is to align, develop, coordinate, strengthen, and/or expand organization-wide efforts, as well as raise health equity for our members and create an equitable and inclusive workplace. Additionally, the SCFHP Equity Steering Committee serves as an advisory body to the executive team in support of the Strategic Plan and Plan Objectives.

Ms. Bui-Tong reviewed the structure of this committee, reflecting a support of three (3) councils. The councils include: The Member Equity Council, The Provider and Vendor Equity Council, and The Staff Council. Ms. Bui-Tong reviewed the focus of each Council.

11. Health Outcomes Survey (HOS) 2021

Byron Lu, Process Improvement Project Manager, presented the HOS 2021 Cohort21 results. Mr. Lu noted there were 121 respondents, reflecting a 66.5% response rate, the rate is on par with the National HOS response rate at 66.8%. Mr. Lu reviewed the HOS questions, results, and trends over a 3 cohorts.

Also reviewed were the findings for the Cohort 21 Performance Measurements, and the top chronic conditions at SCFHP. Mr. Lu noted the top three (3) reported chronic conditions for all 3 cohorts (19, 20, 21) have remained the same.

Mr. Lu reviewed the Star Ratings for each measure, informing improving or maintaining physical health and mental health will be moved to display measure, and the interventions to improve the HOS outcome.

12. American with Disabilities Act (ADA) Work Plan 2022

Desiree Funches, Quality Improvement RN, presented the ADA Work Plan 2022. The ADA Work Plan 2022 is comprised of different metrics, measuring patient safety, access, delivery of preventive care, health education, and grievance monitoring.

Ms. Funches reported a total of 15 Potential Quality Issues (PQI) cases against nursing homes that were identified in the Patient Safety domain for 2021. Out of these 15 cases, four (4) cases were validated to be PQI cases upon investigation.

13. Annual Review of QI Policies

- **a.** QI.05 Potential Quality of Care Issues
- **b.** QI.07 Physical Access Compliance
- **c.** QI.10 Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)
- **d.** QI.14 Disease Surveillance
- **e.** QI.23 Alcohol and Drug Screening Assessment, Brief Intervention, and Referral to Treatment (SABIRT)
- **f.** QI.29 Nurse Advice Line
- **g.** QI.31 Community Supports (CS)
- **h.** QI.32 Enhanced Care Management (EMC)

Lori Andersen, Director, Long Term Services and Support, presented the two (2) new policies, QI.31 and QI.32. Ms. Andersen noted Community Supports is not a benefit, but rather a program that is being offered under the CalAIM initiative. Additionally, ECM is a new Medi-Cal (MC) benefit. The intent of ECM is that community based organizations provide these services to members.

It was moved, seconded and policies QI.31 and QI.32 were **unanimously approved** with addendum**.**

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

Dr. Liu reviewed policies QI.05, QI.07, QI.10, QI.14, QI.23, and QI.29. There were no significant changes.

It was moved, seconded and policies QI.05, QI.07, QI.10, QI.14, QI.23, and QI.29 were **unanimously approved.**

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

14. QIC Charter

Dr. Liu presented the QIC Charter and noted the minor administrative edits made. No questions were asked.

It was moved, seconded and the QIC Charter was **unanimously approved.**

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

15. Quality Dashboard

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

Dr. Liu reviewed the completion rates for the Initial Health Assessment (IHA). Reports indicate an increase in completion rates from November 2021 – December 2021. Also reviewed was the Outreach Call Campaign, an internal program where staff conduct calls to members for health education promotion. A total of 5,350 calls were made from November 2021 – December 2021.

Dr. Liu noted the Health Homes Program (HHP), launched with Community Based Care Management Entities (CB-CME) on July 1, 2021 for Chronic Conditions and on January 1, 2020 for Serious Mental Illness. HHP is designed to coordinate care for MC beneficiaries with chronic conditions and/or substance use disorders. A total of 788 members have verbally consented into Health Homes as of December 31, 2021.

Dr. Liu announced Facility Site Reviews (FSR) have resumed. In November 2021 and December 2021, there were six (6) FSRs that were completed.

16. Compliance Report

Tyler Haskell, Interim Compliance Officer, presented the Compliance Report. Mr. Haskell provided an update to CMS's Compliance Program Effectiveness (CPE) audit. SCFHP received results from Piedmont in January 2022, and is working to address a few findings related to Production Services and Provider Network Operations (PNO).

The 2022 Department of Health Care Services (DHCS) Annual Audit will take place between March 7 and March 18, covering a review period of March 2021 through February 2022. Unlike previous DHCS audits, which covered only the MC line of business, this audit will cover both MC and Cal MediConnect (CMC).

Mr. Haskell noted in January 2022, SCFHP received notice of the Department of Managed Health Care (DMHC) Financial Audit that will be conducted by June 2022. This audit occurs every three years and examines the financial health and sustainability of the health plan. It is expected that DMHC will begin requesting documents in March 2022.

17. Consumer Advisory Board (CAB)

Dr. Nakahira reviewed the draft minutes of the 12/2/2021 CAB meeting.

It was moved, seconded and the 12/2/2021 draft CAB meeting minutes were **unanimously approved.**

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

18. Pharmacy & Therapeutics Committee (P&T)

The draft minutes of the 12/16/2021 P&T Committee meeting were reviewed by Dr. Lin, Chair, Pharmacy and Therapeutics Committee.

It was moved, seconded and the 12/16/2021 draft meeting minutes were **unanimously approved.**

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

19. Utilization Management Committee (UMC)

The draft minutes of the 1/19/2022 UMC meeting were reviewed by Dr. Lin, Chair, UMC.

It was moved, seconded and the 1/19/2022 draft meeting minutes were **unanimously approved.**

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

20. Credentialing Committee Report

Laurie Nakahira, D.O., Chief Medical Officer, reviewed the Credentialing Committee Report.

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

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

21. Adjournment

The next regular QIC meeting will be held on April 12, 2022. The meeting was adjourned at 8:02PM.

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Ria Paul, MD, Chair Date

Santa Clara Family Health Plan™

Chief Executive Officer Update

April 12, 2022

Santa Clara Family Health Plan™

Medi-Cal (MC) & Cal MediConnect (CMC)

Quality Improvement (QI) Work Plan 2022

Medi-Cal (MC) 2022 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Clinical Care	QI Program	QI Work Plan	Development of a QI Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	May 2022	N/A	Annual Completion		
Quality of Clinical Care	QI Program	QI Work Plan Evaluation	Subsequent tracking of implementation of the QI Work Plan	QI & Health Education Manager	May 2022	N/A	Annual Completion		
Members' Experience	CAHPS	CAHPS Survey Results Report	Develop Improvement Plans based on results areas for improvement identified in the CAHPS 2021 survey	Process Improvement Manager or Designee	December 2022	N/A	Annual Completion		
Quality of Clinical Care	Health Education	Health Education Work Plan and Evaulation	Development of a HE Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	- limited availability of classes	Expansin of virtual classes		
Quality of Clinical Care	Cultural & Linguistics	Cultural and Linguistics Work Plan and Evaluation	Development of a C&L Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	N/A	Annual Completion		
Quality of Service	Access/Availability	Provider Accessibility Report	Access to needed medical services in a timely manner is maintained	Provider Services Director or Designee	August 2022	- Timely appointment access - After-hours timeliness (call back within 30min) - In-office wait times not to exceed 15-minutes.	One hundred percent (100%) of network providers will meet appointment access standards established by SCFHP, CMS, and NCQA.		

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Service	Access/Availability	Provider Availability Report	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Provider Services Director or Designee	August 2022	- Rural communities in the southeast area of Santa Clara County	Meet performance goal of 90% for relevant to provider to member ratios and maximum time and distance across all in network primary care providers, high volume/impact specialists, and behavioral health providers.		
Quality of Service	Access/Availability	Credentialing Report	Credentialing file reviews - New applicants processed within 180 calendar days of receipt of application - Recredentialing is processed within 36 months	Provider Services Director or Designee	February 2022 April 2022 August 2022 December 2022	N/A	100%		
Quality of Clinical Care	HEDIS Reporting	HEDIS Submission	Report HEDIS successfully by 6/15/2020	QI & Health Education Manager	June 2022	N/A	Annual Completion		
Quality of Clinical Care	Quality (MCAS/HEDIS) Measures	Quality Measures Intervention Workbook	Report on specific HEDIS and CMS core set measures	QI & Health Education Manager	June 2022 December 2022	N/A	Annual Completion		
Quality of Clinical Care	Statewide Quality Improvement Plan	DHCS Modules	PDSA Cycle - Quality Improvement Plan	QI & Health Education Manager	December 2022	N/A	Submit by deadline indicated by DHCS		
Quality of Clinical Care	Statewide Quality Improvement Plan	DHCS Modules	COVID-19 Quality Improvement Plan	QI & Health Education Manager, CM & BH Director	December 2022	N/A	Submit by deadline indicated by DHCS		
Quality of Clinical Care	Statewide Disparity Performance Improvement Projects	DHCS Modules	Increase rate of adolescent well care visits	QI & Health Education Manager	December 2022	Improve rate of adolescent well care visits	5.8% increase over baseline rate of 16.7% for Network 20		
Quality of Clinical Care	Statewide Child and Adolescent Performance Improvement Projects	DHCS Modules	Blood lead screening in children	QI & Health Education Manager	December 2022	Children under the age of 3 need blood lead screening completed	8% increase over baseline rate of 65.14% for all target population (goal: 73.13%)		

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Safety of Clinical Care	Project: 120 Initial Health Assessment	IHA Report	Initial Health Assessment and Staying Health Assessment	Quality & Clinical Safety Manager or designee	February 2022 December 2022	Low compliance rate	100%		
Safety of Clinical Care	Facility Site Review	FSR/MMR Report	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	Quality & Clinical Safety Manager or designee	Ongoing - Monthly	COVID-19 has prevented completion	N/A		
Safety of Clinical Care	Quality of Care	PQI Report	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	QI Nurse	Ongoing - Monthly	N/A	- Close 80% cases with in 60 days - Review PQI referral with in 5 calendar days from a day referral was recieved		
Members' Experience	Grievance and Appeal	Grievance and Appeal Annual Report	Grievance and Appeal	Director, Customer Service or Designee	May 2022	Expedited grievances and appeals	Increase member satisfaction by addressing member grievances within mandated timelines.		
Quality of Service	Delegation Oversight Audit Results	Semi-Annual Report	Delegation Oversight Audit Results	Compliance Officer or Designee	June 2022 December 2022	N/A	Annual Completion		

Medi-Cal (MC) 2022 Quality Improvement Work Plan

Cal-Medi-Connect (CMC) 2022 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring
Quality of Clinical Care	QI Program	QI Work Plan	Development of a QI Work Plan each year and subsequent	QI & Health Education Manager	May 2022	N/A	Annual Completion	
Quality of Clinical Care	QI Program	QI Work Plan Evaluation	Subsequent tracking of implementation of the QI Work	QI & Health Education Manager	May 2022	N/A	Annual Completion	
Members' Experience	CAHPS	CAHPS Survey and Work Plan	Develop Improvement Plans based on results areas for	Process Improvement Manager or Designee	August 2022	- low response rate	Annual Completion	
Members' Experience	HOS	HOS Survey and Work Plan	Develop Improvement Plans based on results areas for	Process Improvement Manager or Designee	Third quarter Quality Improvement	N/A - only completed every 2 years	Annual Completion	
Quality of Clinical Care	Health Education	Health Education Work Plan and	Development of a HE Work Plan each year and subsequent	QI & Health Education Manager	February 2022	- limited availability of classes	Expansion of virtual classes	
Quality of Clinical Care	Cultural & Linguistics	Cultural and Linguistics Work	Development of a C&L Work Plan each year and subsequent	QI & Health Education Manager	February 2022	N/A	Annual Completion	
Quality of Service	Access/Availability	Provider Accessibility Report	Access to needed medical services in a timely manner is maintained	Provider Services Director or Designee	August 2022	- Timely appointment access - After-hours timeliness (call back within 30min) - In-office wait times not to exceed 15-minutes.	One hundred percent (100%) of network providers will meet appointment access standards established by SCFHP, CMS, and NCQA.	
Quality of Service	Access/Availability	Provider Availability Report	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Provider Services Director or Designee	August 2022	- Rural communities in the southeast area of Santa Clara County	Meet performance goal of 90% for relevant to provider to member ratios and maximum time and distance across all in network primary care providers, high volume/impact specialists, and behavioral health providers.	
Quality of Service	Access/Availability	Credentialing Report	Credentialing file reviews - New applicants processed within 180 calendar days of receipt of application - Recredentialing is processed within 36 months	Provider Services Director or Designee	February 2022 April 2022 August 2022 December 2022	N/A	100%	
Quality of Clinical Care	HEDIS Reporting	HEDIS Submission	Report HEDIS successfully by 6/15/2022	QI & Health Education Manager	June 2022	N/A	Annual Submission	
Quality of Clinical Care	Quality Measures	Quality Measures Intervention	Report on MMP, Star Rating and Accreditation Measures	QI & Health Education Manager	April 2022	N/A	Annual Submission	

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring
Quality of Clinical Care	Chronic Clinical Performance Improvement Projects (CCIP) CMC	PDSA Modules	Target Chronic Condition: Behavorial Health Condition - Mental Illness	Behavioral Health Manager	There is no required submission deadline. SCFHP internally tracks the project. Third year cycle ends on February 2022	Plan will develop and implement a 3 year project to increase the percentage of members who had a follow-up visit with a mental health practitioner within 30 days of discharge, specifically from an acute psychiatric facility and for members age of 21 and older, who were hospitalized for treatment of mental illness. Targeting members who are discharged home and from Valley Medical Center.	By December 31, 2021, increase measure rate from 43.18 % to 53.18%.	
Safety of Clinical Care	Facility Site Review	FSR/MMR	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	QI Nurse	Ongoing - Monthly	COVID-19 has prevented completion	N/A	
Safety of Clinical Care	Potential Quality Issues	PQI Report	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	QI Nurse	Ongoing - Monthly	N/A	- Close 80% cases with in 60 days - Review PQI referral with in 5 calendar days from a day referral was received	
Members' Experience	Grievance and Appeal	Grievance and Appeal Annual Report	Grievance and Appeal	Director, Customer Service or Designee	April 2022	Expedited grievances and appeals	Increase member satisfaction by addressing member grievances within mandated timelines.	
Quality of Service	Delegation Oversight Audit Results	Semi-Annual Report	Delegation Oversight Audit Results	Compliance Officer or Designee	June 2022	N/A	Annual Completion	

Cal-Medi-Connect (CMC) 2022 Quality Improvement Work Plan

Santa Clara Family Health Plan™

Medi-Cal (MC) & Cal MediConnect (CMC)

Quality Improvement (QI) Program Evaluation 2021

SCFHP Medi-Cal (MC) 2021 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Clinical Care	QI Program	QI Work Plan	Development of a QI Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	May 2022	N/A	Annual Completion	Approved by QIC: 2/8/22	
Quality of Clinical Care	QI Program	QI Work Plan Evaluation	Subsequent tracking of implementation of the QI Work Plan	QI & Health Education Manager	May 2022	N/A	Annual Completion	Approved by QIC: 2/8/22	
Members' Experience	CAHPS	CAHPS Survey Results Report	Develop Improvement Plans based on results areas for improvement identified in the CAHPS 2021 survey	Process Improvement Manager or Designee	October 2021 (report is provided by DHCS)	N/A	Annual Completion	Approved by QIC: 12/7/21	
Quality of Clinical Care	Health Education	Health Education Work Plan and Evaluation	Development of a HE Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	- limited availability of classes	Expansion of virtual classes	Approved by QIC: 2/8/22	X
Quality of Clinical Care	Cultural & Linguistics	Cultural and Linguistics Work Plan and Evaluation	Development of a C&L Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	N/A	Annual Completion	Approved by QIC: 2/8/22	
Quality of Service	Access/Availability	Provider Accessibility Report	Access to needed medical services in a timely manner is maintained	Provider Services Director or Designee	August 2021	- Timely appointment access - After-hours timeliness (call back within 30min) - In-office wait times not to exceed 15-minutes.	One hundred percent (100%) of network providers will meet appointment access standards established by SCFHP, CMS, and NCQA.	Approved by QIC: 2/8/22 Assessment/findings: Rate of compliance for PCPs relevant to urgent care appt and non-urgent/routine appt access was 59% and 83%, respectively, in 2021, and did not meet the goal. In the past survey cycles, the Plan established interventions in an effort to assist providers with improving PCP urgent/non-urgent appointment access and survey participation. SCFHP's Provider Network Access Mgr worked directly with compliance officers and/or office admins and issued a corrective action plan (CAP) for providers who were non-compliant with access standards. All non-compliant providers are resurveyed within 30 days from the date of the CAP.	
Quality of Service	Access/Availability	Provider Availability Report	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Provider Services Director or Designee	August 2021	- Rural communities in the southeast area of Santa Clara County	Meet performance goal of 90% for relevant to provider to member ratios and maximum time and distance across all in network primary care providers, high volume/impact specialists, and behavioral health providers.	Approved by QIC: 2/8/22 Assessment/findings: Overall, providers have made a significant amount of progress in trending upward in meeting after-hours and timeliness in the past 3 years. Aggregate access results increased from 78% to 95.7%, respectively, from 2019 to 2021. Aggregate timeliness results increased from 33% to 82.6%, respectively, from 2019 to 2021. The Plan believes that the efforts made in partnership with the providers through notifications of non-compliant and access training increased awareness on after-hours standards, thus both PCPs and BH providers showed improved results on access (911) and timeliness (30 mins).	
Quality of Service	Access/Availability	Credentialing Report	Credentialing file reviews - New applicants processed within 180 calendar days of receipt of application - Recredentialing is processed within 36 months	Provider Services Director or Designee	February 2021 April 2021 August 2021 December 2021	N/A	100%	Approved by QIC: 2/8/22 for Dec 21	
Quality of Clinical Care	HEDIS Reporting	HEDIS Submission	Report HEDIS successfully by 6/15/2021	QI & Health Education Manager	June 2021	N/A	Annual Completion	HEDIS Reporting submitted to NCQA & CMS on 6/14/2021.	
Quality of Clinical Care	Quality (MCAS/HEDIS) Measures	Quality Measures Intervention Workbook	Report on specific HEDIS and CMS core set measures	QI & Health Education Manager	June 2021 December 2021	N/A	Annual Completion	Approved by QIC: 8/10/21	

SCFHP Medi-Cal (MC) 2021 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Clinical Care	Statewide Quality Improvement Plan	DHCS Modules	PDSA Cycle - Quality Improvement Plan	QI & Health Education Manager	December 2021	N/A	Submit by deadline indicated by DHCS	Have Ivy run data monthly to check for increase or decrease of compliance and input into run chart provided in Module.	
Quality of Clinical Care	Statewide Quality Improvement Plan	DHCS Modules	COVID-19 Quality Improvement Plan	QI & Health Education Manager	December 2021	N/A	Submit by deadline indicated by DHCS	Completed December 2021.	
Quality of Clinical Care	Statewide Disparity Performance Improvement Projects	DHCS Modules	Increase rate of adolescent well care visits	Process Improvement Project Manager	Module 1 Due Date: March 1, 2021	Improve rate of adolescent well care visits	5.8% increase over baseline rate of 16.7% for Network 20	Have Ivy run data monthly to check for increase or decrease of compliance and input into run chart provided in Module.	X
Quality of Clinical Care	Statewide Child and Adolescent Performance Improvement Projects	DHCS Modules	Blood lead screening in children	Process Improvement Project Manager	Status: Submitted, pending validation	Children under the age of 3 need blood lead screening completed	8% increase over baseline rate of 65.14% for all target population (goal: 73.13%)	Goal was 9,500 to complete. 7,221 were completed. That is 76% completion rate	X
Safety of Clinical Care	Project: 120 Initial Health Assessment	IHA Report	Initial Health Assessment and Staying Health Assessment	QI Manager or designee	February 2021 December 2021	Low compliance rate	100%	Approved by QIC: 12/7/21 Assessment/Findings: Based off the quarterly audit that was conducted in 2021, SHA remains the element with the greatest opportunity for improvements. Physical exams were incomplete often due to the limitation of tele-visits. Providers or Clinic who scored less than 80% were issued letter to educate about IHA Elements and the importance of completing an IHA visit. Correction Action Plans (CAPs) were not issued from December 1, 2019 to September 30, 2021 due to DHCS' temporarily suspending the requirement to complete an IHA within 120 days for any newly enrolled members within that timeframe. This was lifted October 1, 2021 by DHCS and Providers were advised to review their member roster to identify and outreach members newly enrolled since December 1, 2019 to present who are still currently enrolled who have not received an IHA. .	X
Safety of Clinical Care	Facility Site Review	FSR/MMR Report	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	QI Nurse	Ongoing - Monthly	COVID-19 has prevented completion	N/A	DHCS terminated the flexibilities outlined in APL 20-011 effective June 30th, 2021 per EO N-08-21 issued by Governor on June 11th, 2021. Therefore, effective July 1st MCPs were required to begin resumption of these activities and return to standard program operations, policies, and procedures in place before the COVID-19 public health emergency. The QI department and DHCS CMT started working on virtual FSRs for providers/offices. DHCS MT and QI Nurses resumed on-site audits starting October 12, 2021. SCFHP and DHCS CMT completed 14 Initial FSRs with 3 CAPs issued, 7 Periodic FSRs with 2 CAPs issued, 2 Initial MRR with 2 CAPS issued, 5 Periodic MRR with 3 CAPS issued in 2021. CAPs were issued, monitored, verified, closed, and pending closure in 2021. 3 PARs were conducted in 2021, one was for a Primary Care Provider (PCP) site and 2 were from High Volume Specialist Site (HVS).	X
Safety of Clinical Care	Quality of Care	PQI Report	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	QI Nurse	Ongoing - Monthly	N/A	-Close 90% cases within 90 days from receipt date -Review PQI referral within 7 calendar days of receiving the referral	Assessment/Findings: SCFHP investigated total 424 PQI cases in 2021. Of those 424 closed cases, 11 cases were closed at a level 0; 363 cases closed at Level 1; 14 cases closed at Level 1A; 29 cases closed at Level 2; and 7 cases closed at Level 3. A total of 14 PQI notification letters were issued. A total of 4 CAPS were issued, monitored, validated, and closed in 2021. Out of the 4 CAPS issued: 2 were against an acute hospital; 1 was against a Skilled Nursing Facility (SNF); and 1 against a transportation vendor.	

SCFHP Medi-Cal (MC) 2021 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Members' Experience	Grievance and Appeal	Grievance and Appeal Annual Report	Grievance and Appeal	Director, Customer Service or Designee	May 2022	Expedited grievances and appeals	Increase member satisfaction by addressing member grievances within mandated timelines.	Assessments/Findings: A total of 5,613 grievances and appeals were received in 2021 (1,411 grievances and 698 appeals from CMC and 2,401 grievances and 1,103 appeals from Medi-Cal). Transportation service (non-medical transportation - NMT) was the top subcategory for all medical grievances under quality of service in which comprised of 28% (350 cases). SCFHP meets with the transportation vendor regularly to determine the specific solutions to decrease overall grievances. Timely access to primary care provider and specialist were the highest in Access category with 190 cases and 176 cases respectively. In 2021, appointment availability and timely access was due to the COVID-19 pandemic. All cases are reviewed and determined whether required Potential Quality of Care review. Some cases could be withdrawn or had one or more related cases which PQI was reviewed on the "mother case". 1633 cases (80.17%) were resolved in favor member and 6 cases were partially resolved in favor of member. 172 cases were resolved in favor of plan. 165 cases and 56 cases were withdrawn and dismissed respectively. And 5 cases were closed	
Quality of Service	Delegation Oversight Audit Results	Semi-Annual Report	Delegation Oversight Audit Results	Compliance Officer or Designee	June 2021 December 2021	N/A	Annual Completion	Delegation Oversight Audit Results is estimated to be avaialable by end of April 2022. Preliminary results will be shared with Oversight Workgroup by 4/21/22	

2021 Quality Improvement Work Plan

SCFHP Cal-Medi-Connect (CMC) 2021 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Clinical Care	QI Program	QI Work Plan	Development of a QI Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	May 2022	N/A	Annual Completion	Approved by QIC: 2/8/22	
Quality of Clinical Care	QI Program	QI Work Plan Evaluation	Subsequent tracking of implementation of the QI Work Plan	QI & Health Education Manager	May 2022	N/A	Annual Completion	Approved by QIC: 2/8/22	
Members' Experience	CAHPS	CAHPS Survey and Work Plan	Develop Improvement Plans based on results areas for improvement identified in the CAHPS 2021 survey	Process Improvement Manager or Designee	August 2021	N/A	Annual Completion	Presented to QIC: 12/7/21 Monitor and plan: Based on the result of 2021, the Plan will focus on the following measures: Customer Service, Getting needed care and getting needed prescription drugs. The Plan will have 3 projects to focus on these 3 areas. CS- Enhanced call handling training, Rx- Increase MTM rate to 4star, and PNO/Operations team will work on PCP panel review to ensure PCP have manageable load.	X
Members' Experience	HOS	HOS Survey and Work Plan	Develop Improvement Plans based on results areas for improvement identified in the HOS 2021 survey	Process Improvement Manager or Designee	Third quarter Quality Improvement Committee	N/A - follow up only completed every 2 years	Annual Completion	Presented to QIC: 2/8/22 Monitor and plan: Continue to monitor cohort results. Case Management team will continue to provide CM services (HRA,ICP,ICT,TOC and CCM) to our members. Health education and physical activities will continue be provided to our members.	X
Quality of Clinical Care	Health Education	Health Education Work Plan and Evaluation	Development of a HE Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	- limited availability of classes	Expansion of virtual classes	Approved by QIC: 2/8/22	X
Quality of Clinical Care	Cultural & Linguistics	Cultural and Linguistics Work Plan and Evaluation	Development of a C&L Work Plan each year and subsequent tracking of implementation	QI & Health Education Manager	February 2022	N/A	Annual Completion	Approved by QIC: 2/8/22	
Quality of Service	Access/Availability	Provider Accessibility Report	Access to needed medical services in a timely manner is maintained	Provider Services Director or Designee	August 2021	- Timely appointment access - After-hours timeliness (call back within 30min) - In-office wait times not to exceed 15-minutes.	One hundred percent (100%) of network providers will meet appointment access standards established by SCFHP, CMS, and NCQA.	Approved by QIC: 2/8/22 Assessment/findings: Rate of compliance for PCPs relevant to urgent care appt and non-urgent/routine appt access was 59% and 83%, respectively, in 2021, and did not meet the goal. In the past survey cycles, the Plan established interventions in an effort to assist providers with improving PCP urgent/non-urgent appointment access and survey participation. SCFHP's Provider Network Access Mgr worked directly with compliance officers and/or office admins and issued a corrective action plan (CAP) for providers who were non-compliant with access standards. All non-compliant providers are resurveyed within 30 days from the date of the CAP.	X

SCFHP Cal-Medi-Connect (CMC) 2021 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Quality of Service	Access/Availability	Provider Availability Report	Measure and analyze availability of practitioners in order to maintain an adequate network of PCPs, BH and specialty care practitioners.	Provider Services Director or Designee	August 2021	- Rural communities in the southeast area of Santa Clara County	Meet performance goal of 90% for relevant to provider to member ratios and maximum time and distance across all in network primary care providers, high volume/impact specialists, and behavioral health providers.	Approved by QIC: 2/8/22 Assessment/findings: Overall, providers have made a significant amount of progress in trending upward in meeting after-hours and timeliness in the past 3 years. Aggregate access results increased from 78% to 95.7%, respectively, from 2019 to 2021. Aggregate timeliness results increased from 33% to 82.6%, respectively, from 2019 to 2021. The Plan believes that the efforts made in partnership with the providers through notifications of non-compliant and access training increased awareness on after-hours standards, thus both PCPs and BH providers showed improved results on access (911) and timeliness (30 mins).	
Quality of Service	Access/Availability	Credentialing Report	Credentialing file reviews - New applicants processed within 180 calendar days of receipt of application - Recredentialing is processed within 36 months	Provider Services Director or Designee	February 2021 April 2021 August 2021 December 2021	N/A	100%	Approved by QIC: 12/7/21	
Quality of Clinical Care	HEDIS Reporting	HEDIS Submission	Report HEDIS successfully by 6/15/2021	QI & Health Education Manager	June 2021	N/A	Annual Submission	HEDIS Reporting submitted to NCQA & CMS on 6/14/2021.	
Quality of Clinical Care	Quality Measures	Quality Measures Intervention Workbook	Report on MMP, Star Rating and Accreditation Measures	QI & Health Education Manager	April 2021	N/A	Annual Submission	Approved by QIC: 8/10/21	
Quality of Clinical Care	Chronic Clinical Performance Improvement Projects (CCIP) CMC	PDSA Modules	Target Chronic Condition: Behavioral Health Condition - Mental Illness	Behavioral Health Manager	There is no required submission deadline. SCFHP internally tracks the project. Third year cycle ends on February 2022	Plan will develop and implement a 3 year project to increase the percentage of members who had a follow-up visit with a mental health practitioner within 30 days of discharge, specifically from an acute psychiatric facility and for members age of 21 and older, who were hospitalized for treatment of mental illness. Targeting members who are discharged home and from Valley Medical Center.	By December 31, 2021, increase measure rate from 43.18 % to 53.18%.	The number of psychiatric discharges in the final measurement year increased to 8. Seven of those 8 had successful TOC outreaches, resulted in 87.5%. We reached the target goal of 56% in the final year. During the final year, improvements were made in the TOC process, case managers were notified within Essette via automatic task notification when an authorization was created for admission. This allowed staff to initiate communication with in-patient staff prior to discharge and to schedule outreach to the member within a small timeframe after discharge. The plan will continue to provide enhanced training to staff on the importance and purpose of a transition of care activity occurred.	

SCFHP Cal-Medi-Connect (CMC) 2021 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Safety of Clinical Care	Facility Site Review	FSR/MMR	Perform Facility Site Review Part A, B and C for all PCP offices and High Volume Specialists offices	QI Nurse	Ongoing - Monthly	COVID-19 has prevented completion	N/A	DHCS terminated the flexibilities outlined in APL 20-011 effective June 30th, 2021 per EO N-08-21 issued by Governor on June 11th, 2021. Therefore, effective July 1st MCPs were required to begin resumption of these activities and return to standard program operations, policies, and procedures in place before the COVID-19 public health emergency. The QI department and DHCS CMT started working on virtual FSRs for providers/offices. DHCS MT and QI Nurses resumed on-site audits starting October 12, 2021. SCFHP and DHCS CMT completed 14 Initial FSRs with 3 CAPs issued, 7 Periodic FSRs with 2 CAPs issued, 2 Initial MRR with 2 CAPS issued, 5 Periodic MRR with 3 CAPS issued in 2021. CAPs were issued, monitored, verified, closed, and pending closure in 2021. 3 PARs were conducted in 2021, one was for a Primary Care Provider (PCP) site and 2 were from High Volume Specialist Site (HVS).	**X**
Safety of Clinical Care	Potential Quality Issues	PQI Report	- Identify potential quality of care (PQI) - Identify and Report Provider Preventable Conditions	QI Nurse	Ongoing - Monthly	N/A	-Close 90% cases within 90 days from receipt date -Review PQI referral within 7 calendar days of receiving the referral	Assessment/Findings: SCFHP investigated total 107 PQI cases in 2021. Of those 107 closed cases, 1 case was closed at a level 0; 93 cases closed at Level 1; 2 cases closed at Level 1A; 8 cases closed at Level 2; 2 cases closed at Level 3 and 1 case closed at a Level 4. However, the level 4 was recently downgraded to a level 3 in 2022 after further investigation. A total of 2 PQI notification letters were issued. A total of 3 CAPS were issued, monitored, validated, and closed in 2021. Out of the 3 CAPS issued: 1 was against a Skilled Nursing Facility (SNF); 1 against a Long Term Care Facility (LTC); and 1 against a Home Health Agency.	

SCFHP Cal-Medi-Connect (CMC) 2021 Quality Improvement Work Plan

QI Activity	Area	Deliverable	Objective	Staff Responsible	Timeframe	Previous Barrier/Issue	Goal	Evaluate/Monitoring	Impact of COVID-19
Members' Experience	Grievance and Appeal	Grievance and Appeal Annual Report	Grievance and Appeal	Director, Customer Service or Designee	April 2022	Expedited grievances and appeals	Increase member satisfaction by addressing member grievances within mandated timelines.	Assessment/Findings: Balance Billing Statement was the top subcategory for all Part C & D grievances under quality of service in which comprised of 27.42% (387 cases). Same as Medi-Cal, Transportation service (NMT) was also on the top subcategory for Part C & D grievances under quality of service in which comprised of 12.97% (183 cases). The third top subcategory was Inappropriate Provider Care under the category of Quality of Care. There were total 124 cases, 117 from Part C, and 7 from Part D. All cases are reviewed and determined whether required Potential Quality of Care review. 1,095 cases (89.39%) were resolved in favor member and 7 cases were partially resolved in favor of member. 28 cases were resolved in favor of plan. 91 cases and 2 cases were withdrawn and dismissed respectively. Two cases were closed. SCFHP tracks and trends all member appeals for each of the five categories: including Post Services and Pre-Services for Part B, C and D.	
Quality of Service	Delegation Oversight Audit Results	Semi-Annual Report	Delegation Oversight Audit Results	Compliance Officer or Designee	June 2021 December 2021	N/A	Annual Completion	Delegation Oversight Audit Results is estimated to be avaialable by end of April 2022. Preliminary results will be shared with Oversight Workgroup by 4/21/22	

2021 Quality Improvement Work Plan

Santa Clara Family Health Plan

2021 QUALITY IMPROVEMENT PROGRAM

Medi-Cal & Cal-Medi-Connect

ANNUAL EVALUATION

QIC Approval Date: mm/dd/yyyy

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I. INTRODUCTION

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

- SCFHP served 280,666 Medi-Cal enrollees in Santa Clara County at the end of December, 2021.
- 10,431 members were enrolled in SCFHP's Cal MediConnect (CMC) plan at the end of December, 2021.

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.

SCFHP is committed to the provision of a well-designed and well-implemented Quality Improvement Program. The Plan's culture, systems and processes are structured to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods for monitoring, analysis, evaluation and improvement of the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, administrative and network services, and member satisfaction. Most of the activities are led by Quality and Process Improvement Department, collaborated with cross-functional departments including: Utilization Management, Medical Management, Long Term Services and Support, Pharmacy, Provider Network and Behavioral Health.

II. CLINICAL IMPROVEMENT

A. QUALITY MEASURES & PERFORMANCE IMPROVEMENT

Medi-Cal

In 2021, SCFHP reported 33 Managed Care Accountability Set (MCAS) measures following directions from the California Department of Health Care Services (DHCS). MCAS measures consisted of the Healthcare Effectiveness Data Information Set (HEDIS) measures developed by the National Committee of Quality Assurance (NCQA) and CMS Adult and Child Core Sets. The calendar year of these 10 hybrid and 23 administrative measures was 2020 and the reporting year was 2021.

https://www.dhcs.ca.gov/dataandstats/reports/Documents/RY2021-MCAS-%282021-05-07%29.pdf

DHCS sets a Minimum Performance Level (MPL) and a High Performance Level (HPL) for each quality measure. The MPL and HPL are the 50th and 90th percentiles of the national benchmarks, respectively. SCFHP sets a goal to meet MPL and strive to reach HPL for all measures. In addition, SCFHP also monitored the utilization and overutilization measures for quality improvement.

The goal was to exceed MPL for all MCAS measures. Below are the results of all MCAS measures reported in measurement year 2020 and reporting year 2021:

#	Measure Acronym	Measure	Measure Type Methodology	MY 2020 Final Rate	MPL	HPL
1	AMM-Acute	Antidepressant Medication Management: Acute Phase Treatment	Admin	64.15%	53.57%	64.29%
2	AMM-Cont	Antidepressant Medication Management: Continuation Phase Treatment	Admin	50.40%	38.18%	49.37%
3	AMR	Asthma Medication Ratio aged 5-64 years	Admin	64.25%	62.43%	73.38%
4	BCS	Breast Cancer Screening	Admin	59.78%	58.82%	69.22%
5	CCS	Cervical Cancer Screen	Hybrid	59.85%	61.31%	72.68%
6	WCV	Child and Adolescent Well-Care visits	Admin	43.92%	NA	NA
7	CIS-10	Childhood Immunization Status: Combination 10	Hybrid	57.91%	37.47%	52.07%
8	CHL	Chlamydia Screening in Women for aged 16-24 years	Admin	57.43%	58.44%	71.42%

#	Measure Acronym	Measure	Measure Type Methodology	MY 2020 Final Rate	MPL	HPL
9	CDC-H9	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Hybrid	34.31%	37.47%	27.98%
10	CBP	Controlling High Blood Pressure	Hybrid	57.42%	61.80%	72.75%
11	SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Admin	74.08%	82.09%	87.91%
12	IMA-2	Immunizations for Adolescents: Combination 2	Hybrid	43.31%	36.86%	50.85%
13	APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Admin	45.15%	35.43%	56.34%
14	PPC-Pst	Prenatal and Postpartum Care: Postpartum C are	Hybrid	84.67%	76.40%	84.18%
15	PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Hybrid	92.70%	89.05%	95.86%
16	WCC-BMI	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment	Hybrid	80.54%	80.50%	90.77%
17	WCC-N	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	Hybrid	74.21%	71.55%	85.16%
18	WCC-PA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	Hybrid	72.26%	66.79%	81.02%
19	W30-6	Well-Child Visits in the First 15 Months of Life - 6 or more visits	Admin	33.89%	NA	NA
20	W30-2	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	Admin	76.73%	NA	NA

#	Measure Acronym	Measure	Measure Type Methodology	MY 2020 Final Rate	MPL	HPL
21	AMB-ED	Ambulatory Care: Emergency Department (ED) Visits	Admin	28.91%	NA	NA
22	COB	Concurrent Use of Opioids and Benzodiazepines	Admin	12.45% (18-64) 7.23% (65+)	NA	NA
23	CCW-LARC	Contraceptive Care—All Women: Long Acting Reversible Contraception	Admin	2.28% (15-20) 4.98% (21-44)	NA	NA
24	CCW-MMEC	Contraceptive Care—All Women: Most or Moderately Effective Contraception	Admin	14.81% (15-20) 26.05% (21-44)	NA	NA
25	CCP-LA RC3	Contraceptive Care—Postpartum Women: LARC—3 Days	Admin	18.86% (15-20) 13.95% (21-44)	NA	NA
26	CCP-LA RC60	Contraceptive Care—Postpartum Women: LARC—60 Days	Admin	32.57% (15-20) 23.33% (21-44)	NA	NA
27	CCP-MMEC3	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days	Admin	27.43% (15-20) 24.52% (21-44)	NA	NA
28	CCP-MMEC60	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days	Admin	52.57% (15-20) 46.90% (21-44)	NA	NA
29	DEV	Developmental Screening in the First Three Years of Life	Admin	22.85%	NA	NA
30	ADD-C&M	Follow-Up Care for Children Prescribed Attention-Deficit / Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase	Admin	49.28%	42.95%	55.33%
31	ADD-Init	Follow-Up Care for Children Prescribed Attention-Deficit /	Admin	45.26%	54.73%	67.98%

#	Measure Acronym	Measure	Measure Type Methodology	MY 2020 Final Rate	MPL	HPL
		Hyperactivity Disorder (ADHD) Medication: Initiation Phase				
32	PCR	Plan All-Cause Readmissions	Admin	9.55%	NA	NA
33	CDF	Screening for Depression and Follow-Up Plan	Admin	0.85% (12-17) 2.22% (18-64) 1.36% (65+)	NA	NA
34	OHD	Use of Opioids at High Dosage in Persons Without Cancer	Admin	0.00%	NA	NA

In summary, SCFHP met 13 of the 17 MCAS measures which were held to MPL. 4 measures, Controlling Blood Pressure (CBP), Cervical Cancer Screening (CCS), Chlamydia Screening (CHL), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD) did not meet MPL.

Other than the above 7 focus measures, SCFHP monitored other measure performance monthly and shared results at the Quality & Strategy Workgroup. Immediate quality activities and interventions were created to maintain the quality clinic service standards as needed.

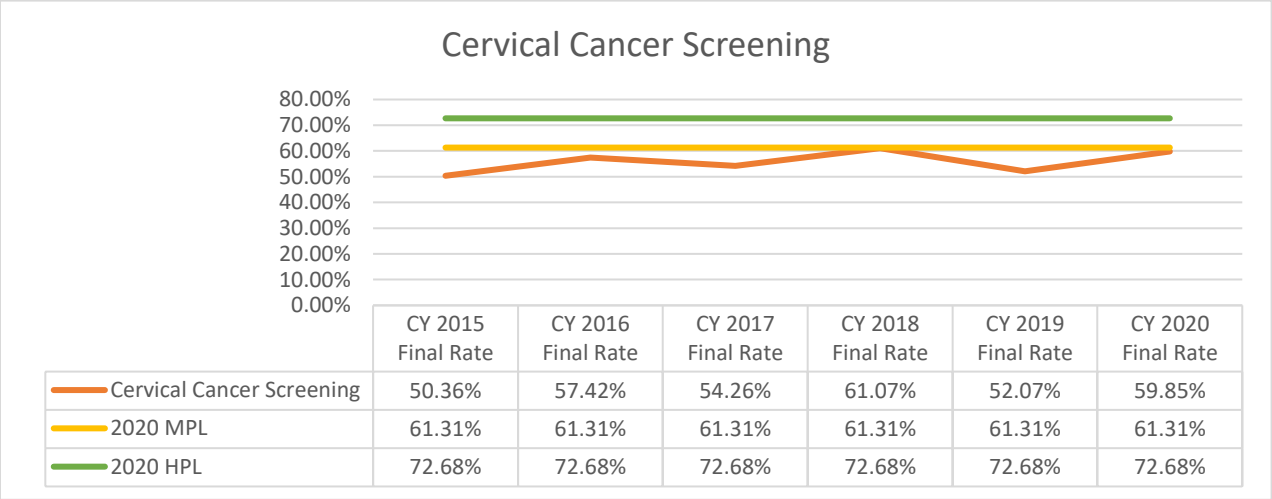
In addition, SCFHP developed a work plan and implemented quality interventions. Quality Improvement (QI) Work Plan was approved at the Quality Improvement Committee and was implemented in February 2021. SCFHP used the results in 2020 to conduct barrier analyses and focus on the following measures. Detailed documentation is included in the Quality Measure Workbook in 2021:

1. Cervical Cancer Screening (CCS)
2. Breast Cancer Screening (BCS)
3. Child and Adolescent Well-Care Visits (WCV)
4. Childhood Immunization Status: Combination 10 (CIS-10)
5. Chlamydia Screening in Women (CHL)
6. Comprehensive Diabetes Care – HbA1c Poor Control (>9%)
7. Controlling Blood Pressure <140/90 mmHg (CBP)
8. Immunizations for Adolescents: Combination 2 (IMA-2)
9. Prenatal & Postpartum Care – Timeliness of Prenatal Care (PPC-Pre) and Postpartum Care (PPC-Pst)
10. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Assessment (WCC-BMI), Nutrition (WCC-N) and Physical Activity (WCC-PA)
11. Well-Child Visits in the First 30 Months of Life (W30)
12. Trauma, Developmental and Blood Lead Screenings

1. Cervical Cancer Screening (CCS)

Women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria:

- Aged 21 - 64 years of age who had cervical cytology performed within the last 3 years (2018 – 2020)
- Aged 30 – 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years (2016 – 2020)
- Aged 30 – 64 years of age who had cervical cytology/high-risk papillomavirus (hrHPV) testing performed within the last 5 years (2016-2020)

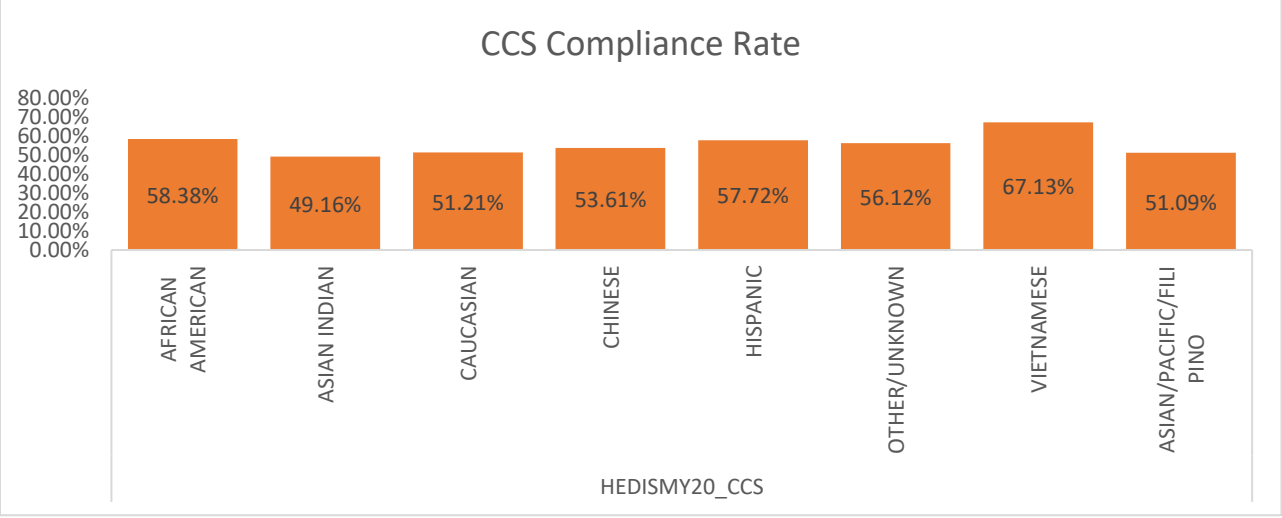


	CY 2015 Final Rate	CY 2016 Final Rate	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Cervical Cancer Screening	50.36%	57.42%	54.26%	61.07%	52.07%	59.85%
2020 MPL	61.31%	61.31%	61.31%	61.31%	61.31%	61.31%
2020 HPL	72.68%	72.68%	72.68%	72.68%	72.68%	72.68%

CY 2020 Goal: Meet Cervical Cancer Screening MPL (61.31%)

CY 2020 Rate: 59.85%

Analysis:
The CCS rate increased by 7% compared to the previous calendar year 2019 but still missed the SCFHP goal of meeting the MPL by 2%. SCFHP struggled with meeting MPL.



As can be seen in the chart above, the Asian Indian, Caucasian, and Asian/Pacific/Filipino groups had the lowest compliance rates. The compliance rates for these three groups were statistically significantly lower than for other ethnicity groups with $p < .005$ for all three ethnicities. Vietnamese group had the best compliance rate (67.13%), in which was the same as previous year. As a result of this analysis, targeted outreach was conducted for Asian Indian, Caucasian, and Asian/Pacific/Filipino members.

355 outreach calls were conducted to remind 165 Caucasians, 61 Asian Indians and 29 Asian Pacific members the importance of cervical cancer screening and assisting members to schedule well woman visit with PCP or GYN in April 2021. 37 members (10.42%) were scheduled an appointment. However, 17 out of 61 (28.54%) Asian Indian either declined the services or had invalid phone numbers. SCFHP learnt that Asian Indians would avoid discussion on the topic deeply influenced of cultural beliefs.

3596 letters were also sent to remind members who were still missing both cervical cancer screening and breast cancer screening in October 2021. An incentives $15 were offered who completed the screening.

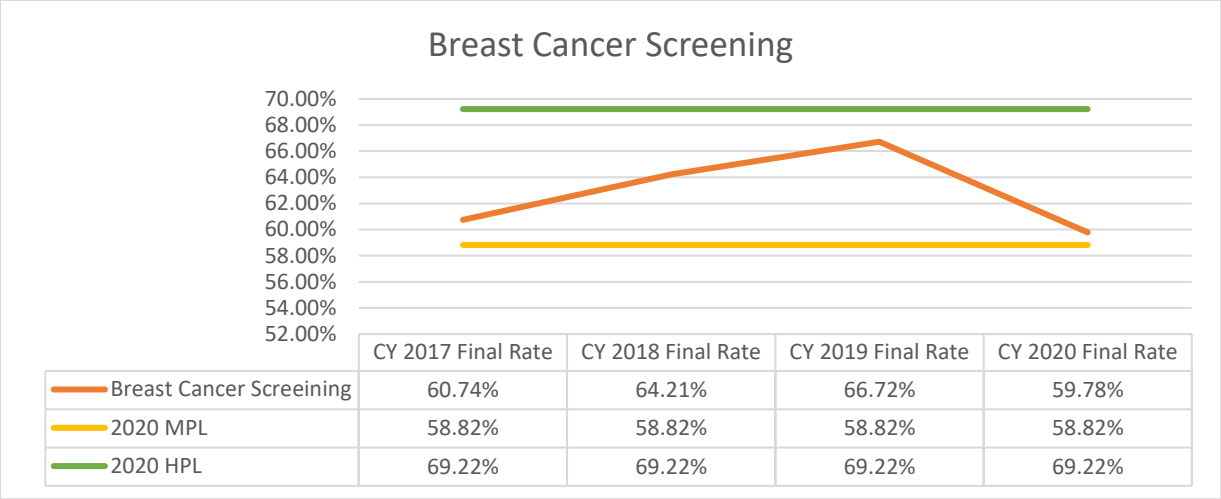
In addition, SCFHP educated PCPs and OBGYN through multiple channels and identified couple barriers. Some PCPs who are specialized in Internal Medicine or other specialties would not perform cervical cancer screening during visit. Therefore, members would be referred to GYN but members never made to the GYN appointment. Or OBGYN limited the appointment availability during COVID-19 pandemic and prioritized patients for obstetrical needs, instead of preventive services.

Follow-up & Strategies to be considered for future years:

- Focus on disparity groups by conducting focus group of Asian Indians, Caucasian and Asian/Pacific/Filipino to identify root causes
- Strengthen communication and education with PCPs on importance of cervical cancer screening for both PCPs and OBGYN providers. Encourage clinics to follow-up members on appointments once referral is received.

2. Breast Cancer Screening (BCS)

Percentage of women 50–74 years of age who had one or more mammograms any time on or between October 1, 2018 to December 31, 2020.

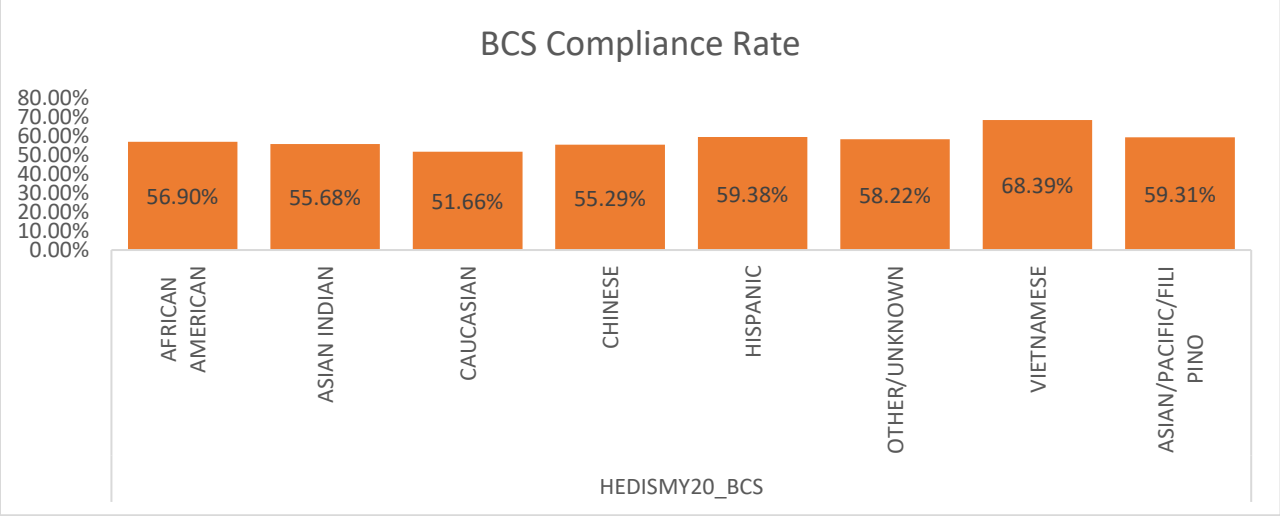


	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Breast Cancer Screeining	60.74%	64.21%	66.72%	59.78%
2020 MPL	58.82%	58.82%	58.82%	58.82%
2020 HPL	69.22%	69.22%	69.22%	69.22%

CY 2020 Goal: Meet Breast Cancer Screening MPL (58.82%)

CY 2020 Rate: 59.78%

Analysis:
From CY 2017 to 2019, there was a steady increase in the breast cancer screening rate. However, there was a drop of 7% from CY 2019 to CY 2020. This decrease in screening is likely due to the COVID-19 pandemic, as many mammography centers were closed and not performing screenings for members. Despite this drop, the plan was still able to meet the MPL of 58.82%.



From the chart above, it can be seen that the Caucasian, Asian Indian, and Chinese ethnicities were the lowest performing. The lower performance of these three ethnicity groups was statistically significant at $p < .005$.

3,596 letters were sent to remind members who were missing both cervical cancer screening and breast cancer screening in October 2021. $15 Incentives were offered to those who completed the screening.

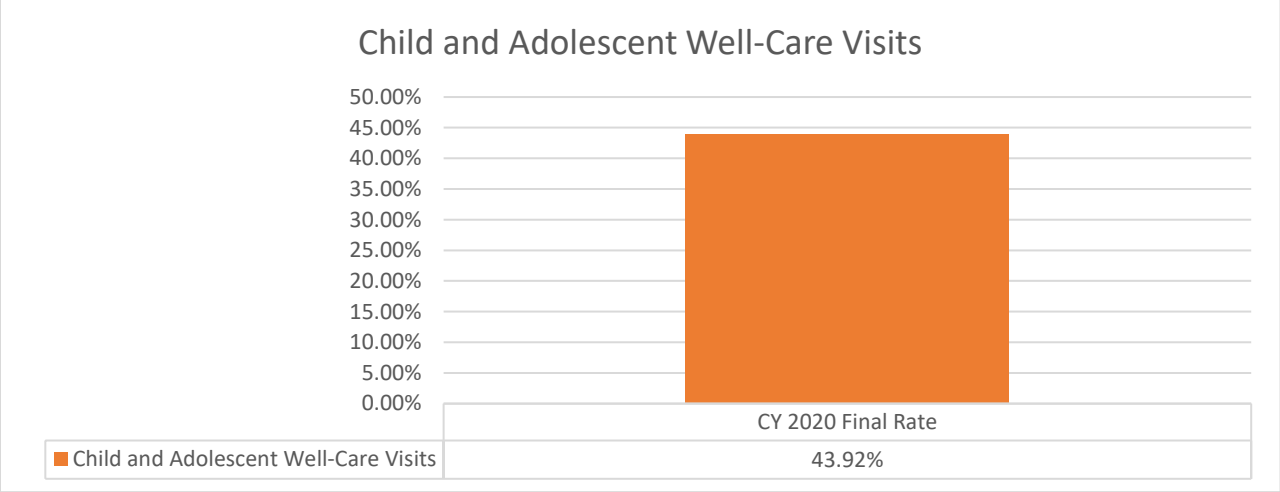
504 warm outreach calls were made to remind the importance of breast cancer screening. However, mammogram appointment availability was limited during the COVID-19 pandemic. Therefore, SCFHP also partnered with Bay Area Community Healthcare (BACH) and Alinea Medical Imaging to host a Mobile Mammogram event in October 2021. 22 members completed the mammogram on that event.

Follow-up & Strategies to be considered for future years:

- Focus on disparity groups by conducting focus group of Asian Indians, Caucasian and Chinese to identify root causes
- Continue to partner with clinics for mobile mammogram events

3. Child and Adolescent Well-Care Visits (WCV)

Percentage of members 3- 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner in 2020.

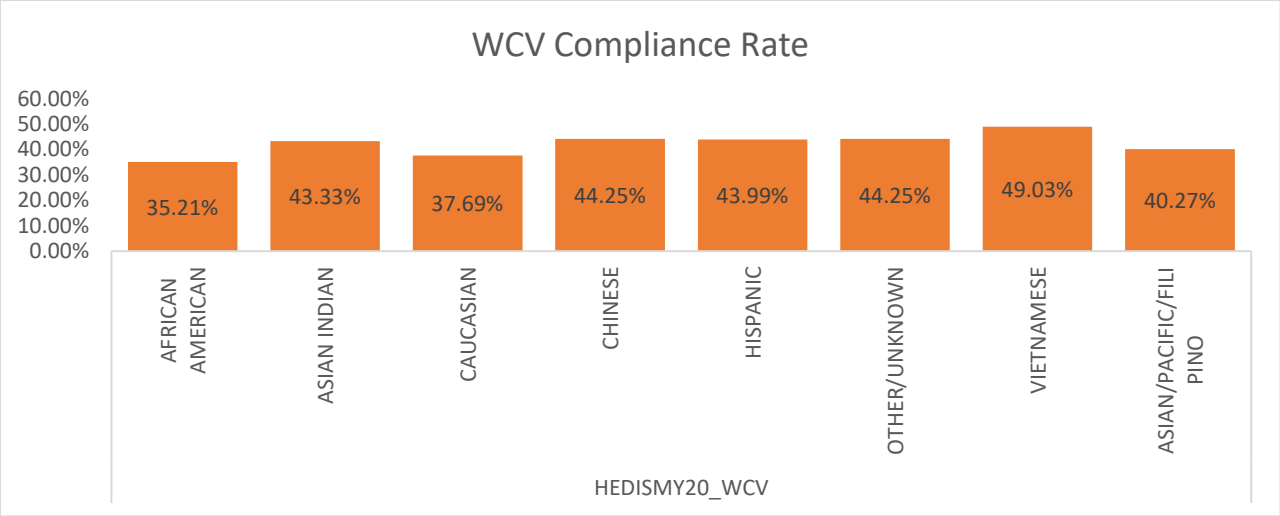


CY 2020 Goal: N/A (This was a new measure for CY 2020 so there were no benchmarks)

CY 2020 Rate: 43.92%

Analysis:
As WCV was a new measure for CY 2020, there were no benchmarks to set as the goal. However, comparing the rate to Adolescent Well Child Visit (WCV) (51.82%) and Well Child Visit in the Third, Fourth, Fifth and Sixth years of Life (W34) (77.13%) from CY 2019, we can see that performance in CY 2020 was lower. Similar to the other decreases in CY 2020, this is likely due to COVID-19 and members' reluctance to go to the doctor's office for their well-visits. In addition, this measure was used to hybrid measure. Coding opportunities may be missed.

SCFHP stratified the performance of WCV. Age 3-11 performed at 51.94%, Age 12-17 performed at 43.86% and 18-21 poorly performed at only 22.72%.



The African American, Caucasian, and Asian/Pacific/Filipino ethnicity groups were the lowest performing. All three of these ethnicity groups had statistically significantly lower performance than the others with $p < .005$ for all three groups.

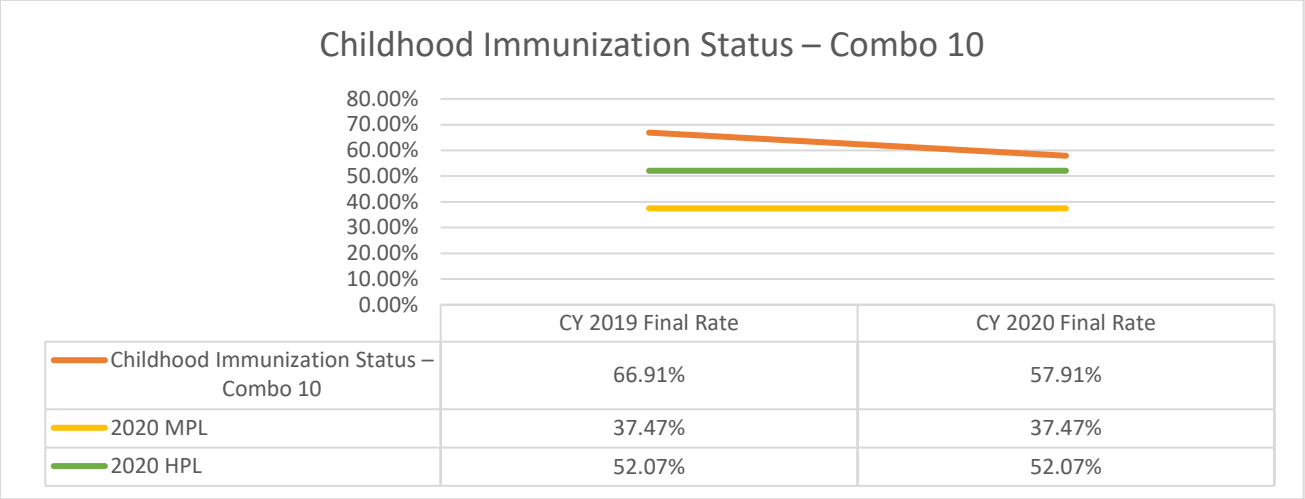
15,982 parents/guardians were received well-child visit reminder letters from July to November and incentives for $50 gift card. WCV was also one of the Provider Pay for Performance measure. SCFHP fully supported DHCS efforts to implement a comprehensive member outreach campaign to increase children utilization of preventive services through live calls to member for whom had landline and direct mail to those had wireless numbers in July. Live calls made to 1373 unique household for 1690 members and successfully scheduled PCP appointments on 62 calls. 19,624 direct member mailing sent to under age 7 who have not received a check-up or well-visit for preventive care services within the last six (6) months. It covered developmental screening, blood lead screening, well visit, physical exam, nutrition screening, mental health screening, immunizations, dental, hearing, and vision screenings.

Follow-up & Strategies to be considered in future years:
W34 retired and combined with Adolescent Well Care Visit (AWC) into measure Child and Adolescent Well Care Visit (WCV)

- Continue to strengthen the member's parents and members. Communication. Look for opportunity to communicate with members who are aged 18-21 in different technology communication channels like app or text
- Provide provider education on appropriate coding of services on claims and encounter
- Focus on African American and Asian Pacific groups to have root cause analysis on barriers for further improvement

4. Childhood Immunization Status: Combination 10 (CIS-10)

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

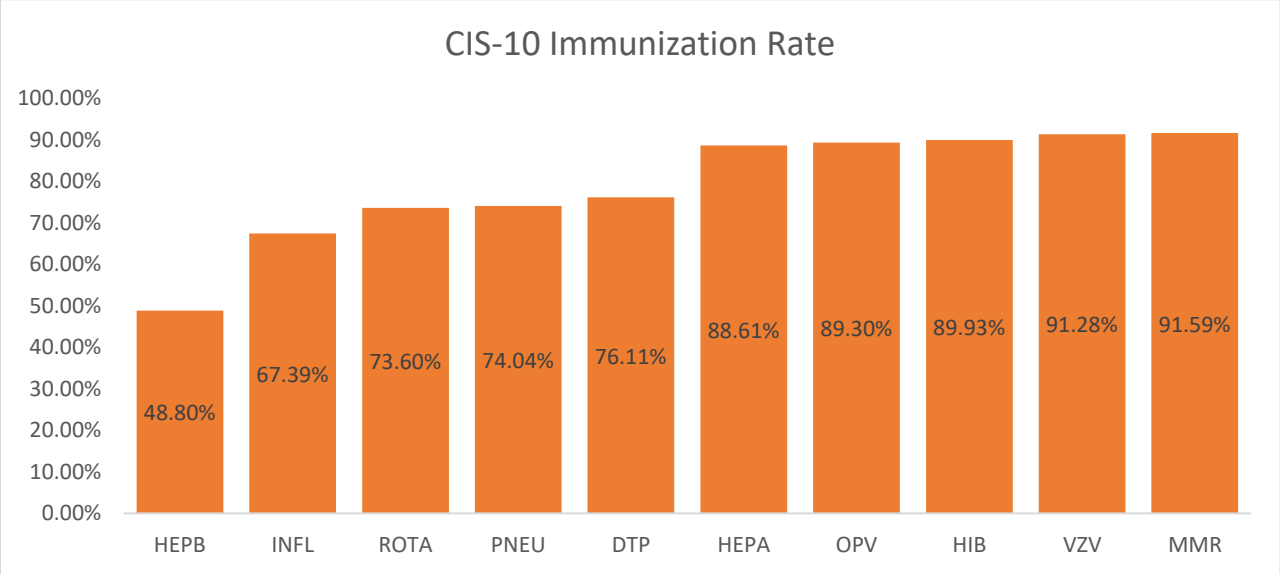


	CY 2019 Final Rate	CY 2020 Final Rate
Childhood Immunization Status – Combo 10	66.91%	57.91%
2020 MPL	37.47%	37.47%
2020 HPL	52.07%	52.07%

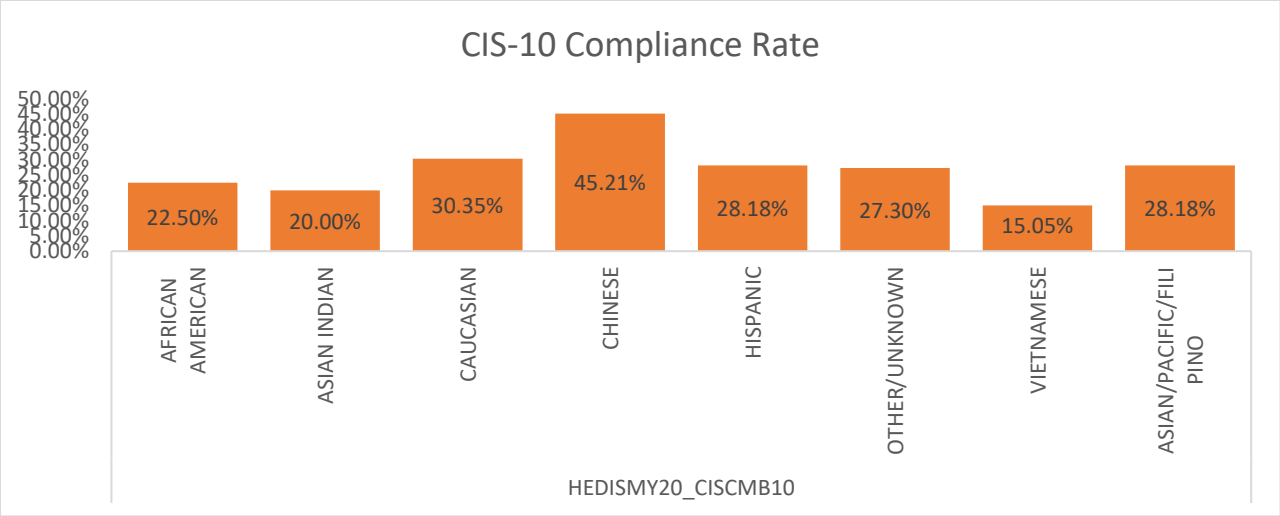
CY 2020 Goal: 37.47%

CY 2020 Rate: 57.91%

Analysis:
The MPL (37.47%) for this measure was exceeded by 20% in CY 2020, with a final rate of 57.91%. However, this was lower than the CY 2019 final rate of 66.91%. It was consistent with the county data of 0-2 years old with lower immunization total doses given in CY2020 (342,732 doses) compared to CY2019 (358,065 doses).



From the graph above, it can be seen that the Hepatitis B immunization has the lowest rate, followed by the influenza immunization.



The Vietnamese ethnicity group had the lowest performance at 15.05%. This rate was statistically significantly lower than the other ethnicities with $p < .005$. There were no other statistically significant low performers for this measure.

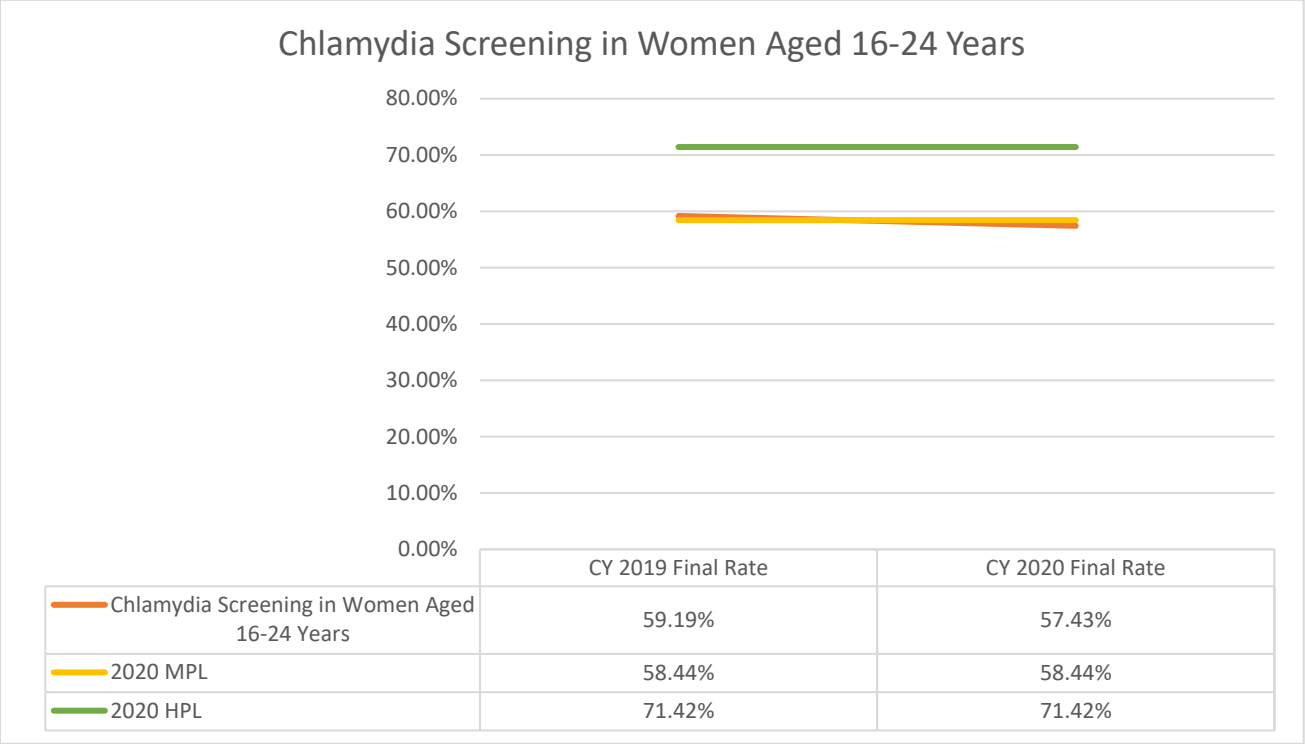
SCFHP realized COVID-19 pandemic is significantly affecting the immunization rates due to limited in-person appointment availability and were afraid of visiting clinics where could be high risk area. Though some clinics have implemented drive-through clinics, it was still a concern by the parents. Besides, SCFHP also identified there was gap from CAIR data monthly feed during medical records review. Any name spelling or format is difference from health plan member ID, data would not be extracted to plan.

Follow-up & Strategies to be considered in future years:

- Emphasize to the provider and clinic staff of the importance of data entry into California Immunization Registry (CAIR), including Hep B at birth given in hospital and member's demographics matching health plan information
- Maximize supplemental data submission for immunized vaccines

5. Chlamydia Screening in Women (CHL)

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia in 2020.

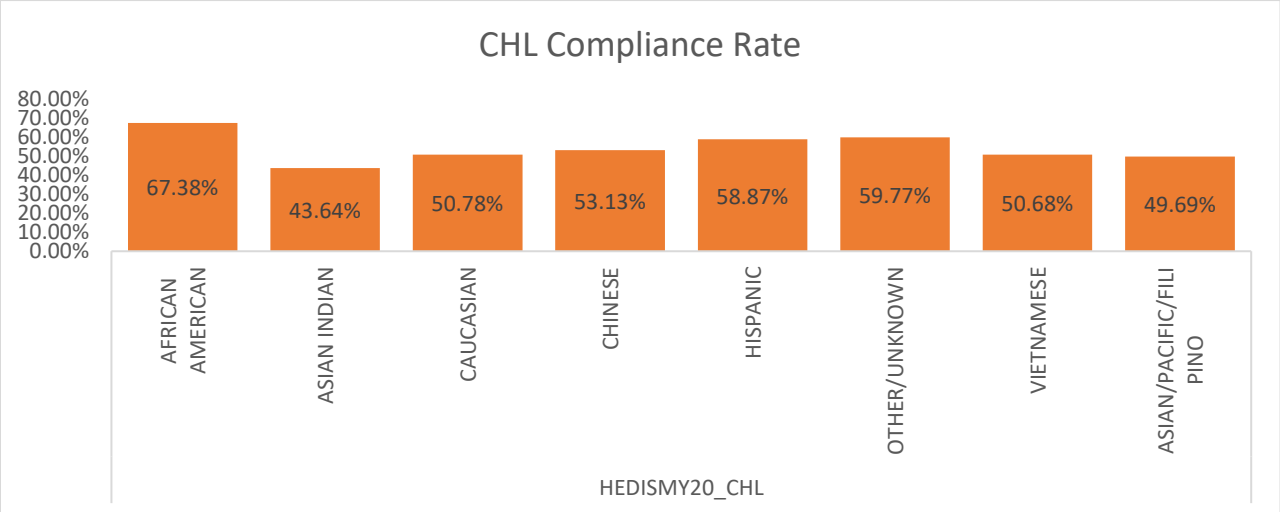


	CY 2019 Final Rate	CY 2020 Final Rate
Chlamydia Screening in Women Aged 16-24 Years	59.19%	57.43%
2020 MPL	58.44%	58.44%
2020 HPL	71.42%	71.42%

CY 2020 Goal: Meet the Chlamydia Screening MPL (58.44%)

CY 2020 Rate: 57.43%

Analysis:
In CY 2020, the CHL rate was missed by 1% (MPL as 58.44% while the final rate was 57.43%). Performance was worse in CY 2020 than it was in CY 2019 by about 2%.



Analysis comparing the performance of different ethnicity groups was conducted, but there were no statistically significant lower performers identified.

Age was analyzed by stratified into Age 16 -20 which performed at 52.85% and Age 21 -24 performed at 63.37%. Screening at age 16-20 was mostly missed. SCFHP has implemented Plan, DO, Study, Act (PDSA) Performance Improvement Plan (PIP) in 2021.

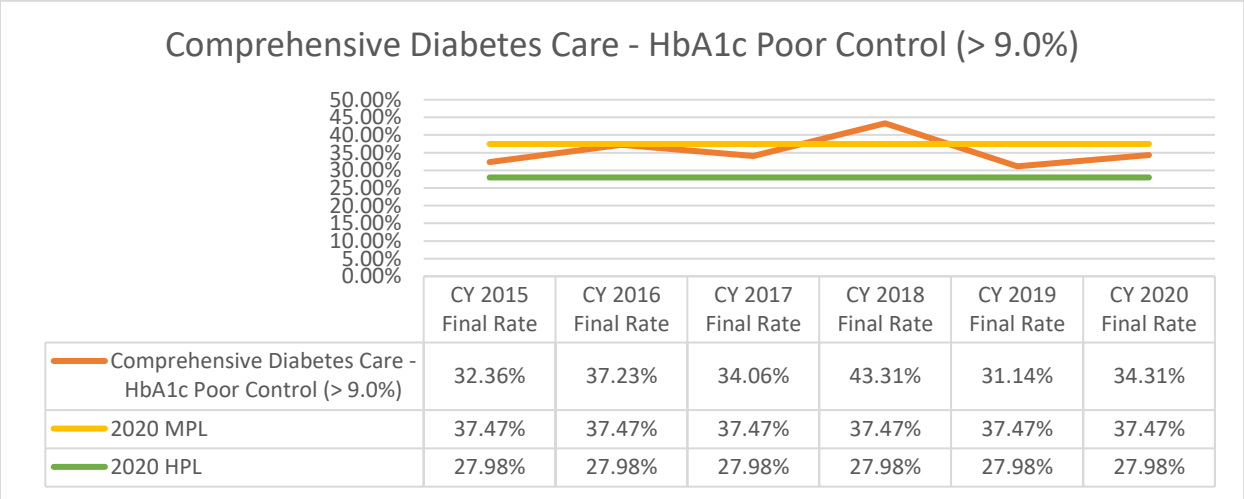
302 warm outreach calls were made to members ages 18-24 to remind them of the importance of chlamydia screening and educate that it can be done during well women exam. Overall, the feedback was good without embarrassment because of sensitive a topic. This measure was chosen to be part of short cycle PSDA Quality Improvement Plan with Cervical Cancer Screening. See PIP section for details.

Follow-up & Strategies to be considered in future years:

- Continue implementing Chlamydia PDSA PIP
- Offer incentive reward for completing screening and continue warm outreach calls
- Consider focusing on specific provider network to isolate members with low-compliance

6. Comprehensive Diabetes Care – HbA1c > 9% Poor Control

Members 18 – 75 years of age with Diabetes who had Hemoglobin A1C (HbA1c) > 9% in 2020.

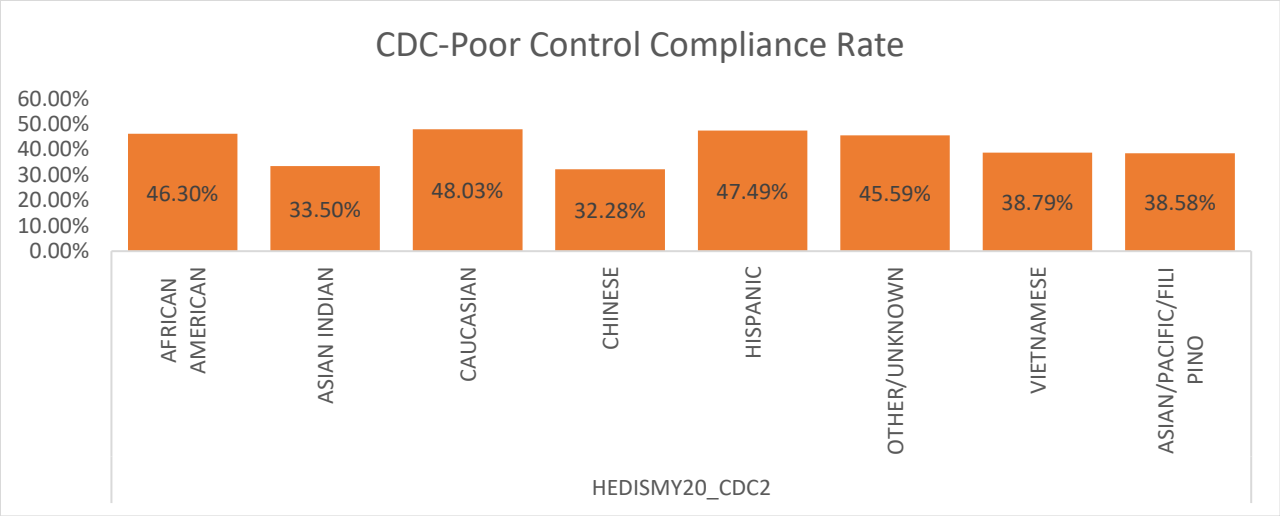


	CY 2015 Final Rate	CY 2016 Final Rate	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Comprehensive Diabetes Care - HbA1c Poor Control (> 9.0%)	32.36%	37.23%	34.06%	43.31%	31.14%	34.31%
2020 MPL	37.47%	37.47%	37.47%	37.47%	37.47%	37.47%
2020 HPL	27.98%	27.98%	27.98%	27.98%	27.98%	27.98%

CY 2020 Goal: Meet the Comprehensive Diabetes Care HbA1C >9% Poor Control MPL (37.47%)

CY 2020 Rate: 34.31%

Analysis:
CDC Poor Control is a reverse measure where lower rates indicate better performance. Although the CDC Poor control rate increased in CY 2020 compared to CY 2019, the MPL of 37.47% was met with a final rate of 34.31%.



The chart above shows that the Caucasian and Hispanic ethnicity groups had the lowest performance compared to the other ethnicities. Statistical testing revealed that these differences were statistically significant for the Caucasian and Hispanic groups with $p < .005$.

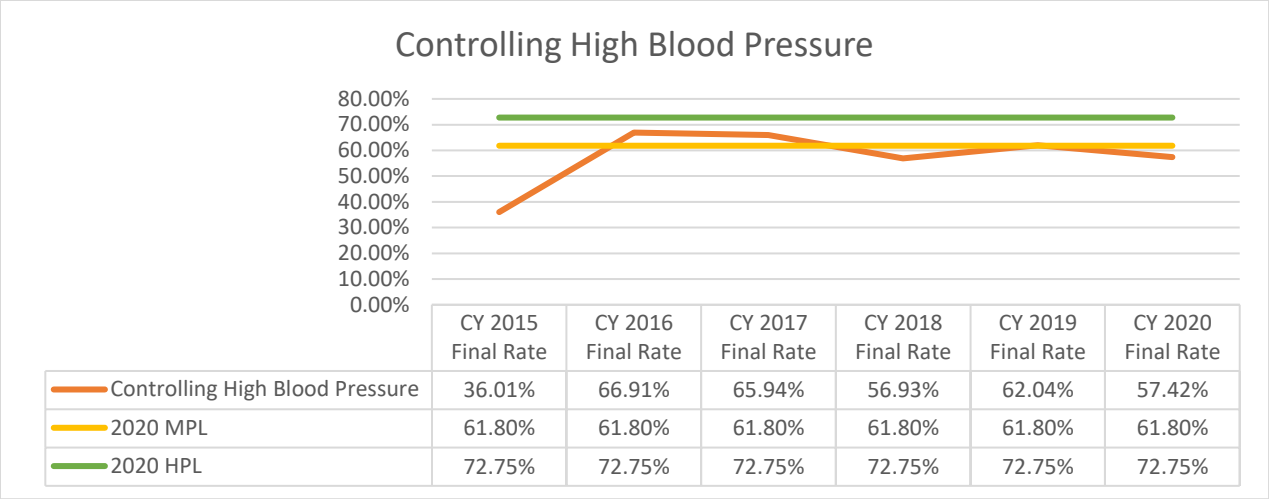
SCFHP mailed letter to 973 members to complete a health education class with certified diabetes educator from July to November 2021. $20 incentive given to 15 eligible members from January to December. QI Outreach team conducted 2784 warm outreach calls to members assisting in scheduling appointments with PCP to follow-up Diabetes in September to December. Through outreach calls, SCFHP identified some barriers - members are not aware of their HbA1C result and do not check their levels often. Members are non-compliant with medication and lack understanding of the disease process. CDC- HbA1c Member Newsletters on Smoking and Diabetes was published in fall.

Follow-up & Strategies to be considered in future years:

- Focus on younger age groups specifically those Ages 18 – 49
- Strengthen communication and education regarding importance of managing diabetes to members
- Continue to improve administrative data on HbA1C testing and attain result from various laboratories

7. Controlling Blood Pressure <140/90 mmHg (CBP)

Members 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled under 140/90 mmHg in 2020.

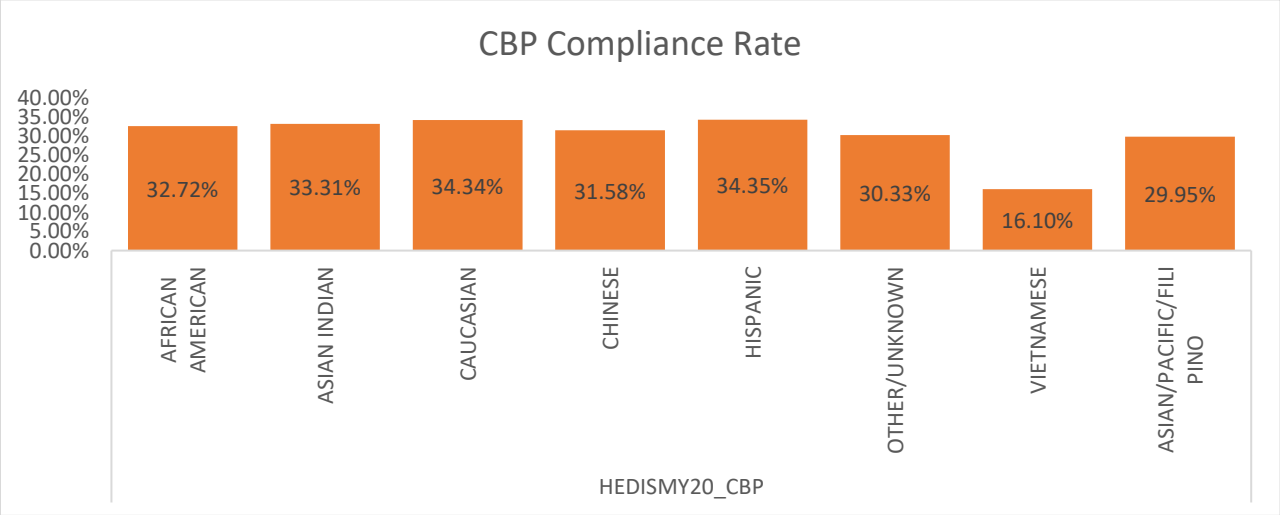


	CY 2015 Final Rate	CY 2016 Final Rate	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Controlling High Blood Pressure	36.01%	66.91%	65.94%	56.93%	62.04%	57.42%
2020 MPL	61.80%	61.80%	61.80%	61.80%	61.80%	61.80%
2020 HPL	72.75%	72.75%	72.75%	72.75%	72.75%	72.75%

CY 2020 Goal: Meet Controlling Blood Pressure MPL (61.80%)

CY 2020 Rate: 57.42%

Analysis:
The goal of meeting the MPL at 61.80% was not met, with the plan performing at 57.42%. Although there was more supplemental data provided by delegates in CY 2020 compared to previous years, the overall rate for CBP decreased compared to CY 2019.



After performing an analysis on performance by ethnicity, the Vietnamese, Asian/Pacific/Filipino, and Other/Unknown groups were determined to have statistically significantly lower compliance rates with $p < .05$.

QI Outreach team conducted 5860 warm outreach calls to members with a diagnosis of hypertension from February to December 2021. Members were three-way connected to their PCP if found of not having a recent office visit. SCFHP launched a health education class in August 2021 for hypertensive members to educate them on their condition, learn how to use BP monitor, diet considerations, and ways to control their BP. Of 5860 members called, 2113 were invited to health education class and 34 members attended.

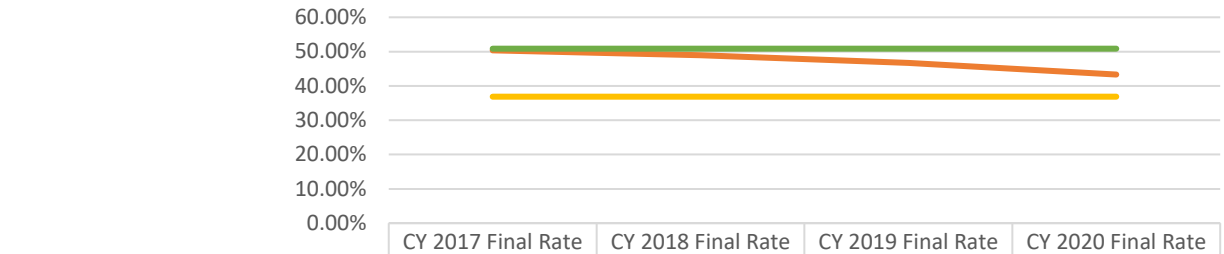
Barriers found during outreach calls: members are not aware of their current BP reading, member unknown when last visited PCP, and members were unware that blood pressure monitor is SCFHP benefit and can be redeemed at no-cost. SCFHP encouraged providers to submit supplemental data for BP reading for better analysis and intervention all year long. Member & Provider Newsletters were published on Hypertension in July.

Follow-up & Strategies to be considered in future years:
Focus on younger age groups specifically those Ages 30 – 49

- Reinforce the importance of BP control and self-management/accountability
- Advocate to ensure each hypertensive member for home monitoring BP
- Strategize ways to increase enrollment in health education class

8. Immunizations for Adolescents: Combination 2 (IMA-2)

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday in 2020.

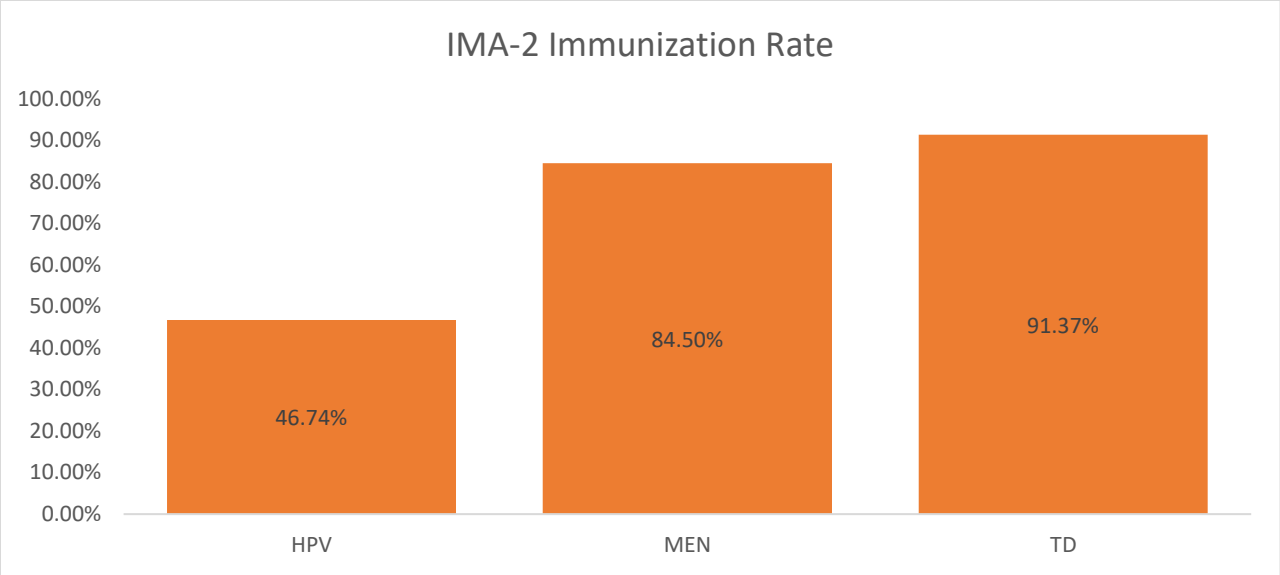


	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Immunizations for Adolescents - Combo 2	50.36%	48.91%	46.72%	43.31%
2020 MPL	36.86%	36.86%	36.86%	36.86%
2020 HPL	50.85%	50.85%	50.85%	50.85%

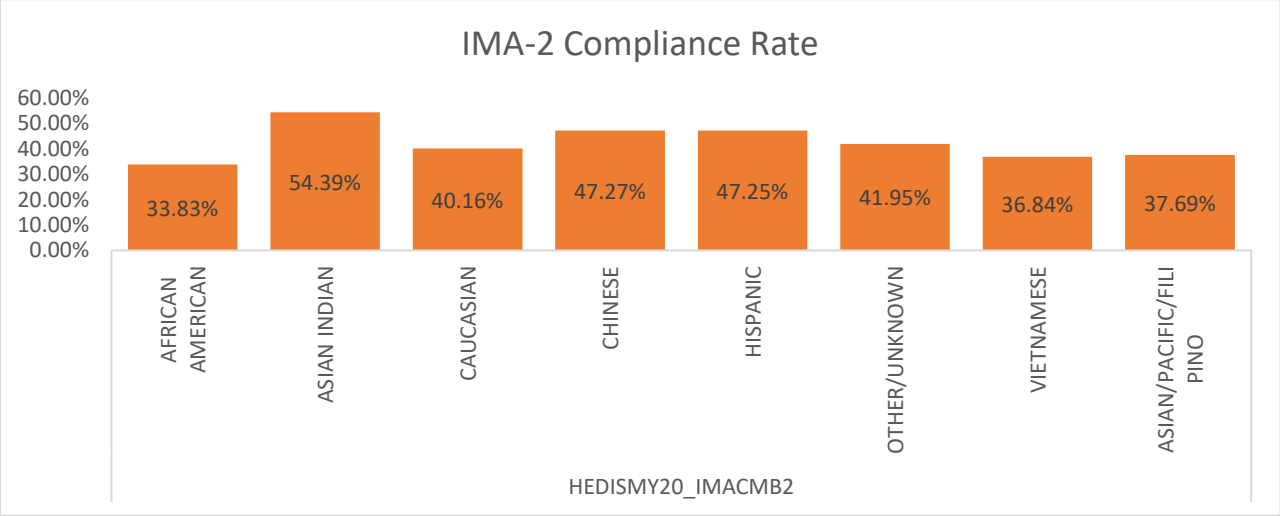
CY 2020 Goal: Meet Immunizations for Adolescents – Combo 2 MPL (36.86%)

CY 2020 Rate: 43.31%

Analysis:
The goal of meeting the MPL (36.86%) was exceeded by 7%. However, the IMA-2 rate continues to decrease each year, going from 50.36% in CY 2017 to 43.31% in CY 2020.



Looking at the immunizations individually, the HPV immunization has a much lower rate than the other two immunizations.



An analysis was conducted looking into performance by ethnicity group, and the African American and Vietnamese groups were determined to have statistically significantly lower performance than the other ethnicities with $p < .05$.

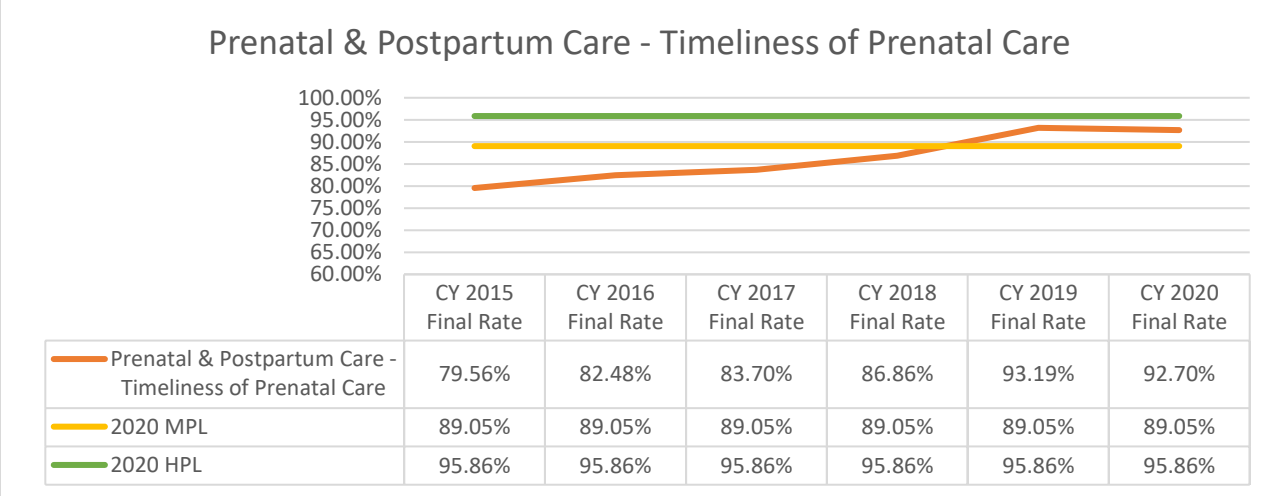
SCFHP realized COVID-19 pandemic is significantly affecting the immunization rates due to limited in-person appointment availability and were afraid of visiting clinics where could be high risk area. Though some clinics have implemented drive-through clinics, it was still a concern by the parents. Besides, SCFHP also identified there was gap from CAIR data monthly feed during medical records review. Any name spelling or format is difference from health plan member ID, data would not be extracted to plan.

Follow-up & Strategies to be considered in future years:

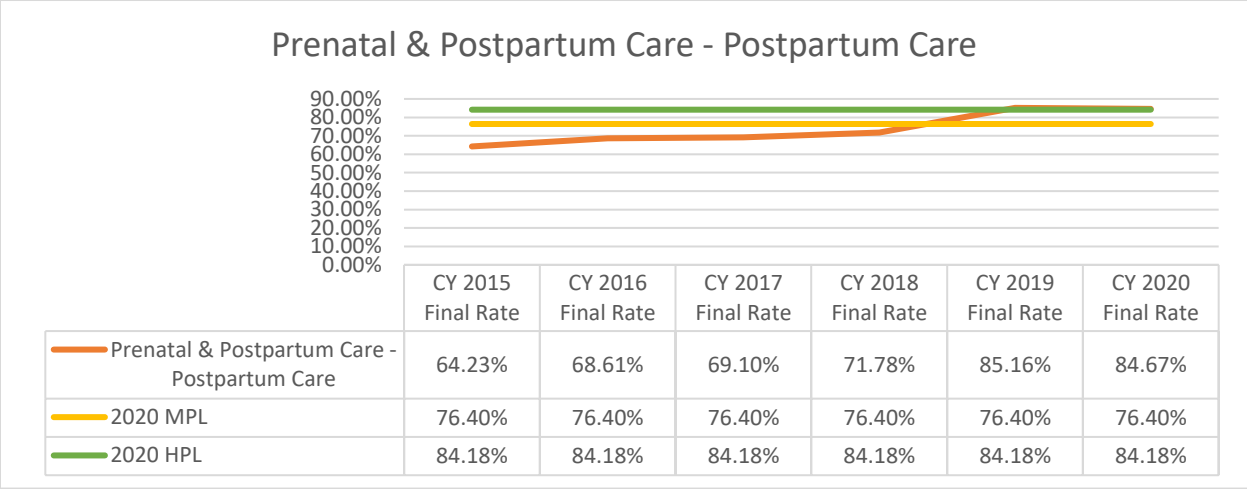
- Emphasize to the provider and clinic staff of the importance of data entry into California Immunization Registry (CAIR), and member's demographics matching health plan information
- Maximize supplemental data submission for immunized vaccines

9. Prenatal & Postpartum Care – Timeliness of Prenatal Care (PPC-Pre)

Pregnant women with live birth on or between October 8, 2019 and October 7, 2020 who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment.



	CY 2015 Final Rate	CY 2016 Final Rate	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Prenatal & Postpartum Care - Timeliness of Prenatal Care	79.56%	82.48%	83.70%	86.86%	93.19%	92.70%
2020 MPL	89.05%	89.05%	89.05%	89.05%	89.05%	89.05%
2020 HPL	95.86%	95.86%	95.86%	95.86%	95.86%	95.86%

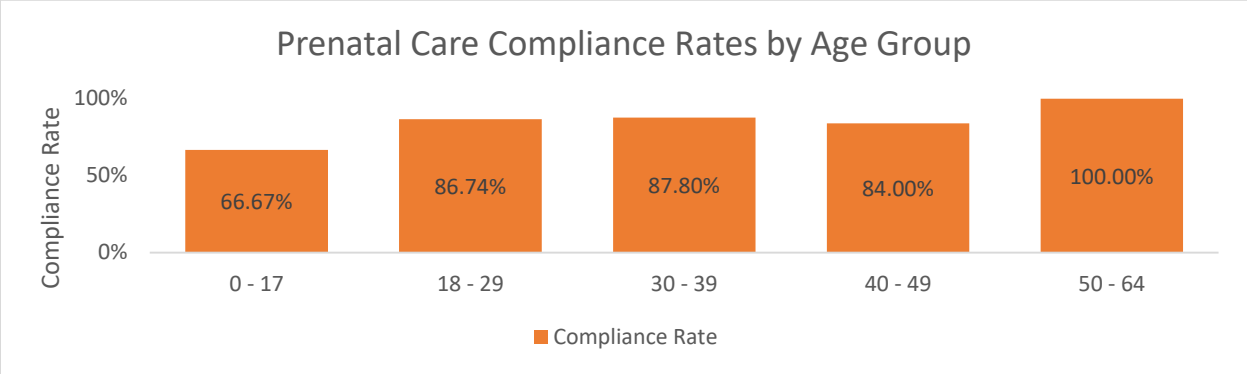


	CY 2015 Final Rate	CY 2016 Final Rate	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Prenatal & Postpartum Care - Postpartum Care	64.23%	68.61%	69.10%	71.78%	85.16%	84.67%
2020 MPL	76.40%	76.40%	76.40%	76.40%	76.40%	76.40%
2020 HPL	84.18%	84.18%	84.18%	84.18%	84.18%	84.18%

CY 2020 Goal: Meet Timeliness of Prenatal Care MPL (89.05%) and Postpartum Care MPL (76.40%)

CY 2020 Rate: Prenatal - 92.70%; Postpartum – 84.67%

Analysis:
The goal for this measure was exceeded by 3% for the Timeliness of Prenatal Care measure and 8% for the Postpartum Care measure. However, even though the performance exceeded the goal for both measures, SCFHP found opportunities to better serve our members under the age of 18.



For members ages 17 or below, the compliance rate of having prenatal visit in first trimester or within 42 days of enrollment was lower than all other age groups. Members in this group had a compliance rate of 66.67% compared to the other age groups which performed at 80% or above. Teenage pregnancy carries extra health risks to both the mother and the baby, including premature birth and low birth weight, so it is important that members complete their prenatal visits.

Upon further analysis, SCFHP found the rate for postpartum visits continues to trend lower than prenatal visits in the last few years. In CY 2018 the rate was 71.78%, increasing to 85.16% in CY 2019 and slightly decreasing to 84.67% in CY 2020. This tells us that members may not have postpartum visits after delivery and further work is needed to increase these rates. Analysis looking at ethnicity groups was also conducted, but no statistically significant differences were found.

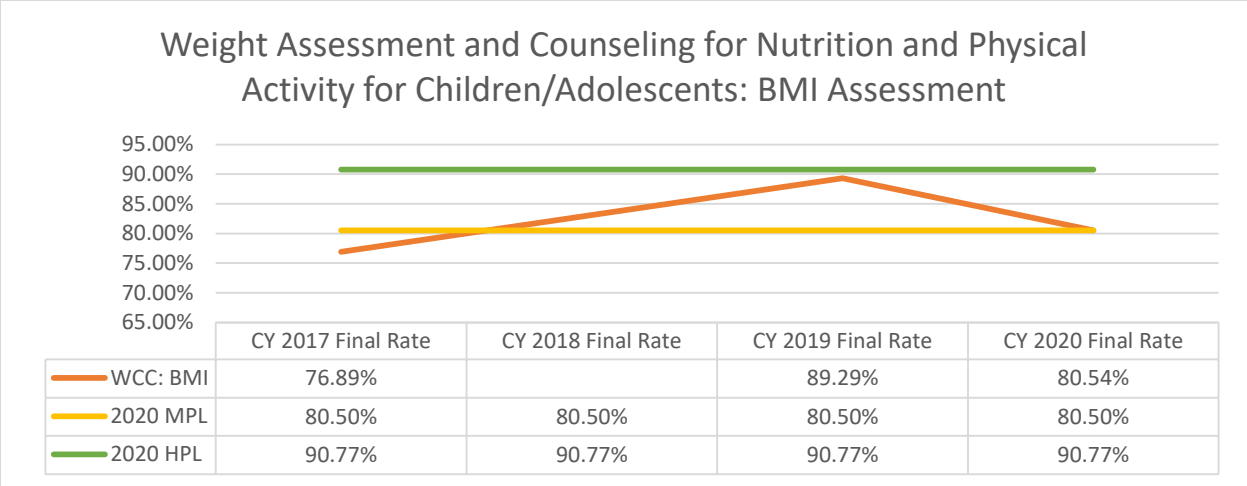
Healthy Mom Healthy Babies program was implemented with incentives to encourage pregnant women to receive prenatal and postnatal care. Program was mainly by provider referral. The participation was relatively low. 185 referrals received. As part of the program, a health education class "Virtual Baby Shower" was hosted. Topics included prenatal and postpartum care, SCFHP health education classes available, SCFHP benefits, mental health. 84 pregnant members participated in virtual baby shower. SCFHP continued to partner with community organizations, including Black Infant Health to offer community outreach and support for members during pregnancy. PPC-Pre is a Provider Pay for Performance measure.

Follow-up & Strategies to be considered in future years:

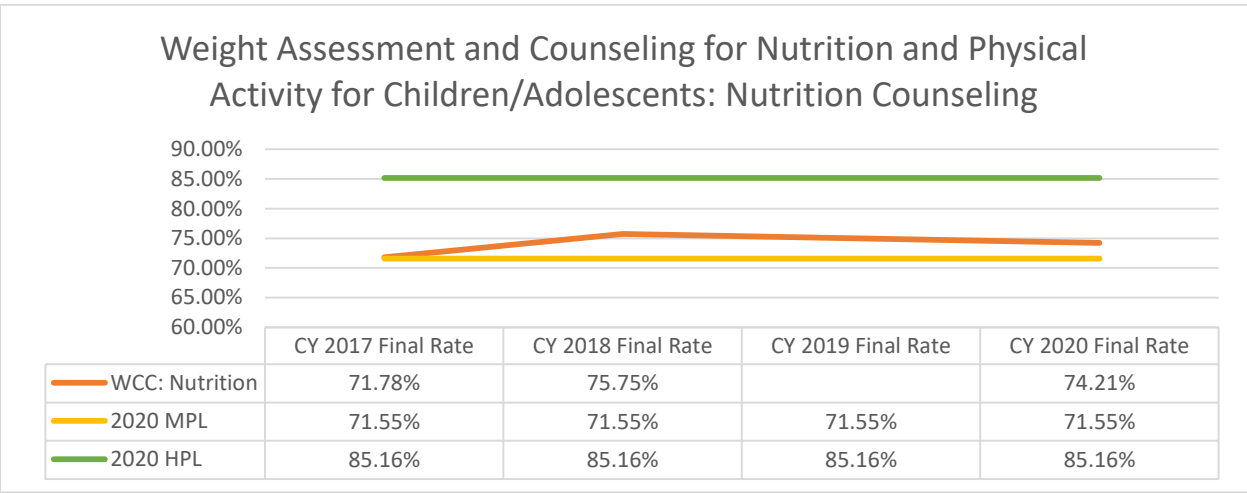
- Continue offering Virtual Baby Shower, hosting in-person option when
- Early identification of teenage pregnancy through claims data for coordination of care and to analyze any disparities.
- Conduct postpartum outreach calls educating member on importance of visit and connecting member to local resources (breastfeeding, doula support, etc.).

10. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Assessment (WCC-BMI), Nutrition (WCC-N) and Physical Activity (WCC-PA)

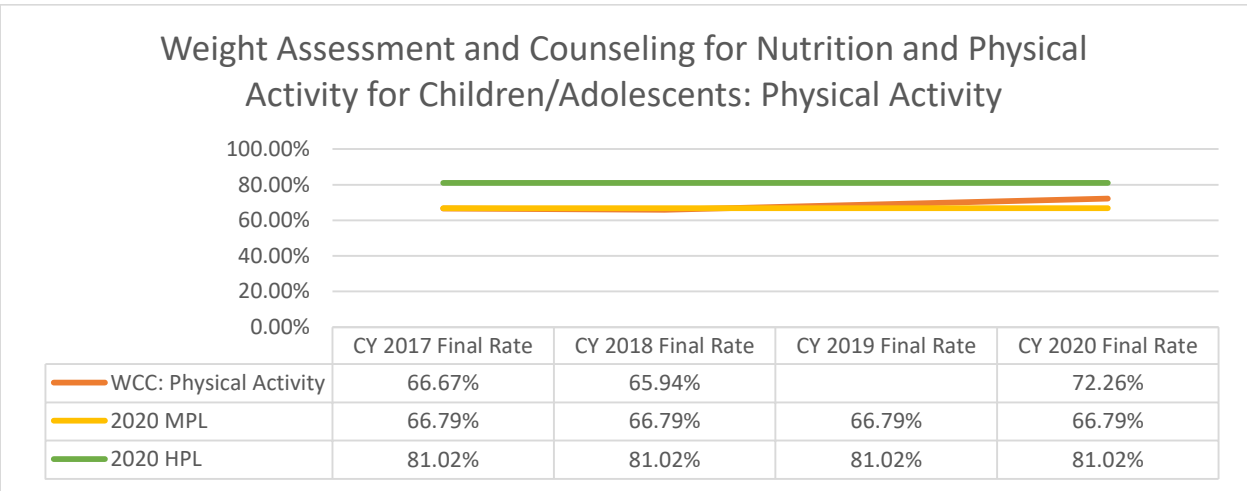
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following in 2020: BMI percentile documentation, counseling for nutrition, and counseling for physical activity.



	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
WCC: BMI	76.89%		89.29%	80.54%
2020 MPL	80.50%	80.50%	80.50%	80.50%
2020 HPL	90.77%	90.77%	90.77%	90.77%



	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
WCC: Nutrition	71.78%	75.75%		74.21%
2020 MPL	71.55%	71.55%	71.55%	71.55%
2020 HPL	85.16%	85.16%	85.16%	85.16%

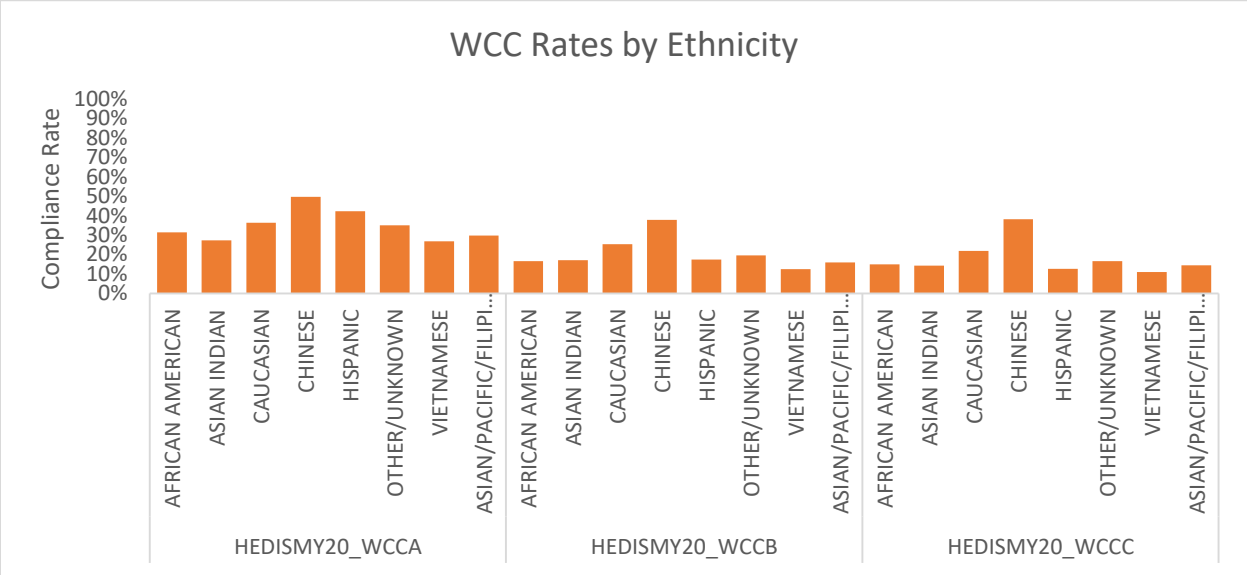


	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
WCC: Physical Activity	66.67%	65.94%		72.26%
2020 MPL	66.79%	66.79%	66.79%	66.79%
2020 HPL	81.02%	81.02%	81.02%	81.02%

CY 2020 Goal: Meet the MPL for BMI (80.50%), Nutrition Counseling (71.55%), and Physical Activity Counseling (66.79%)

CY 2020 Rate: BMI—80.54%; Nutrition Counseling—74.21%; Physical Activity Counseling—72.26%

Analysis: The MPL was met for all three of the WCC sub measures, with slight decreases in the BMI and Nutrition Counseling compared to previous years, and an increase in Physical Activity Counseling compared to previous years.



As can be seen in the graph above, the Chinese ethnicity group tends to perform higher than other groups, while the Vietnamese group tends to be one of the lower-performing groups across all three sub measures. SCFHP further analyzed the relationships among age, delegates and gender with Ethnicity. There were no significance difference.

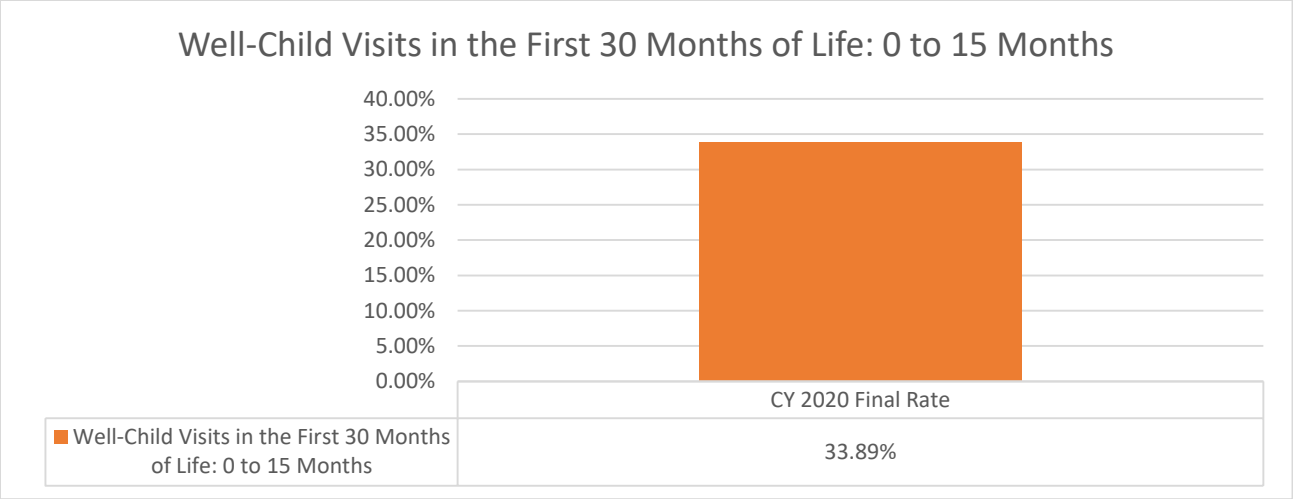
During medical record review, SCFHP found that documentation is the contributing factor for members who completed well visits, especially to those providers who are still using paper charts.

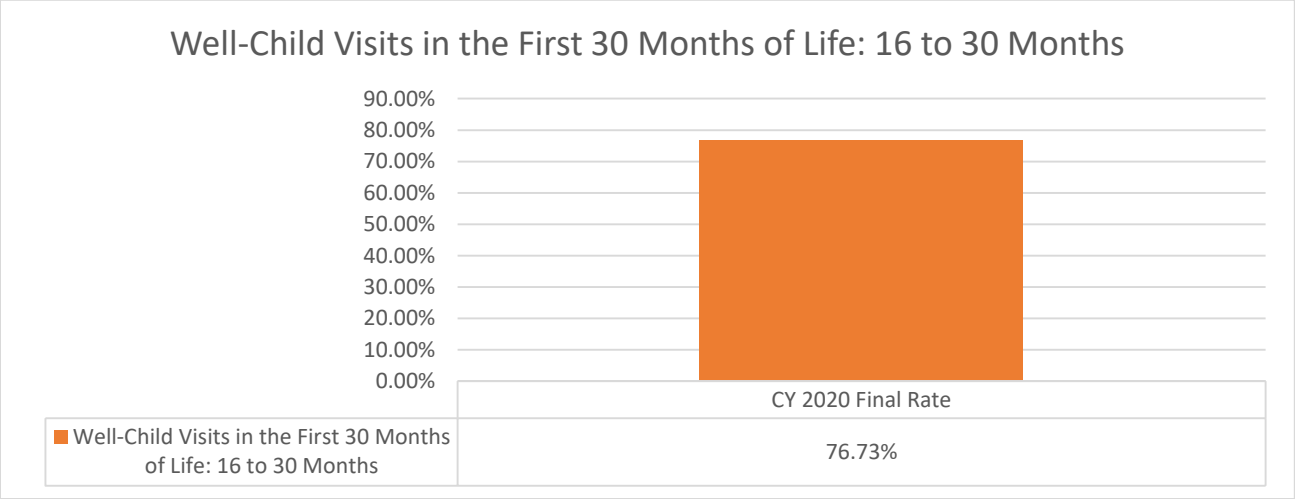
Follow-up & Strategies to be considered in future years:

- Educate providers on documentation requirement
- Continue for member communication the importance of well visits

11. Well-Child Visits in the First 15 months of life – 6 Visits (W30-6) and 2 Visits (W30-2)

Well-Child Visits in the First 15 Months: Children who turned 15 months old in 2020 and had six or more well-child visits. Well-Child Visits for Age 15 Months–30 Months: Children who turned 30 months old in 2020 and had two or more well-child visits.

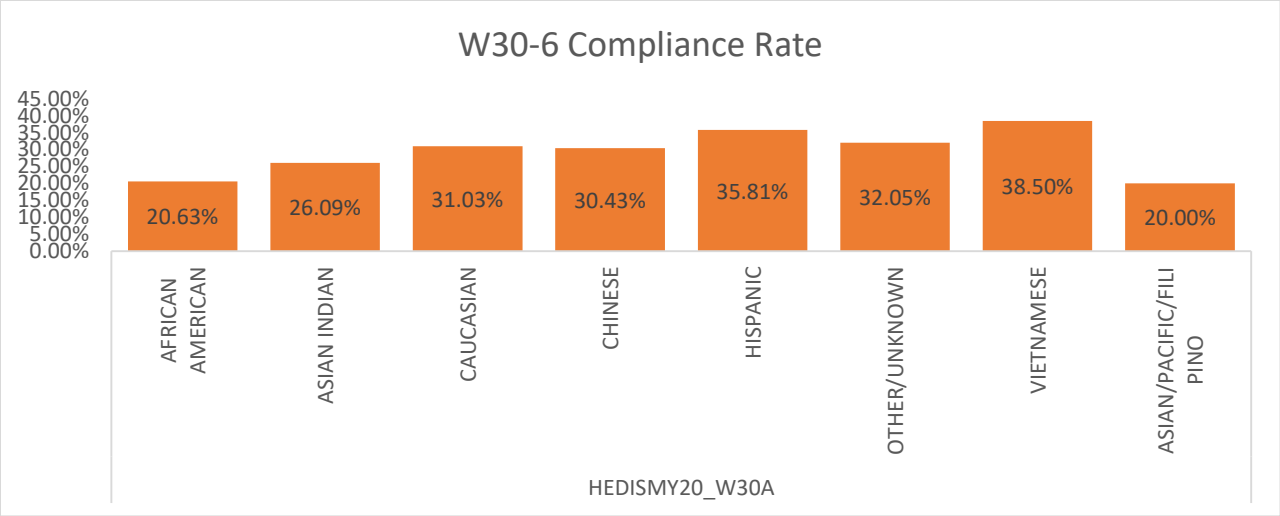




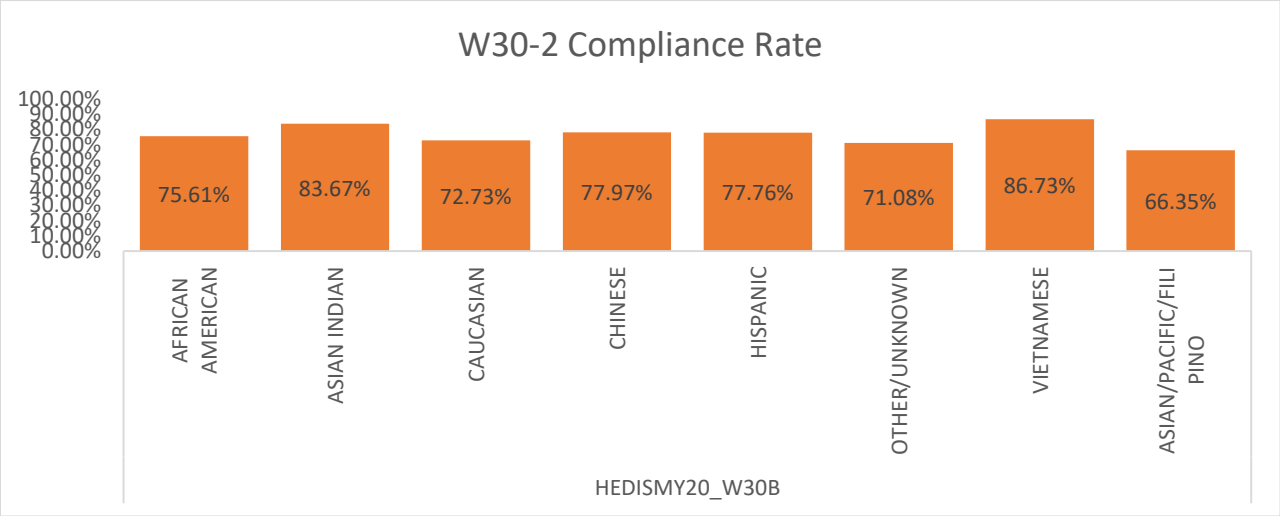
CY 2020 Goal: N/A (This was a new measure for CY 2020 so there were no benchmarks)

CY 2020 Rate: W30-6—33.89%; W30-2—76.73%

Analysis:
As W30 was a new measure for CY 2020, there were no benchmarks to set as the goal. It also became an administrative measure after being a hybrid measure in CY 2019. However, comparing to the W15 administrative rate in CY 2019 (33.25%) to the W30-6 rate in CY 2020 (33.89%), we can see that the score slightly increased by .6%.



Looking at the chart above, the African American, Asian Indian, and Asian/Pacific/Filipino ethnicity groups were the lowest performing. However, only the African American group was statistically significantly lower than the other ethnicities with $p < .05$.



For W30-2, the Asian/Pacific/Filipino ethnicity group had the lowest performance. This was statistically significantly lower than the other ethnicities with $p < .05$.

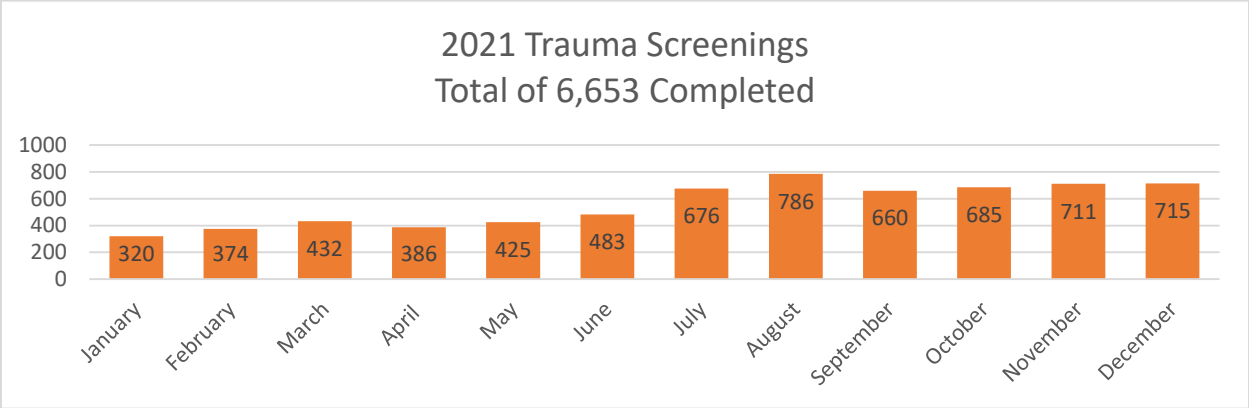
SCFHP realized COVID-19 pandemic was affecting the well visits rates due to limited in-person appointment availability and were afraid of visiting clinics where could be high risk area.

Follow-up & Strategies to be considered in future years:

- Continue to strengthen the member's parents and members. Communication.
- Provide provider education on appropriate coding of services on claims and encounter
- Focus on Asian Pacific Filipino groups to have root cause analysis on barriers for further improvement

12. Trauma, Developmental and Blood Lead Screenings

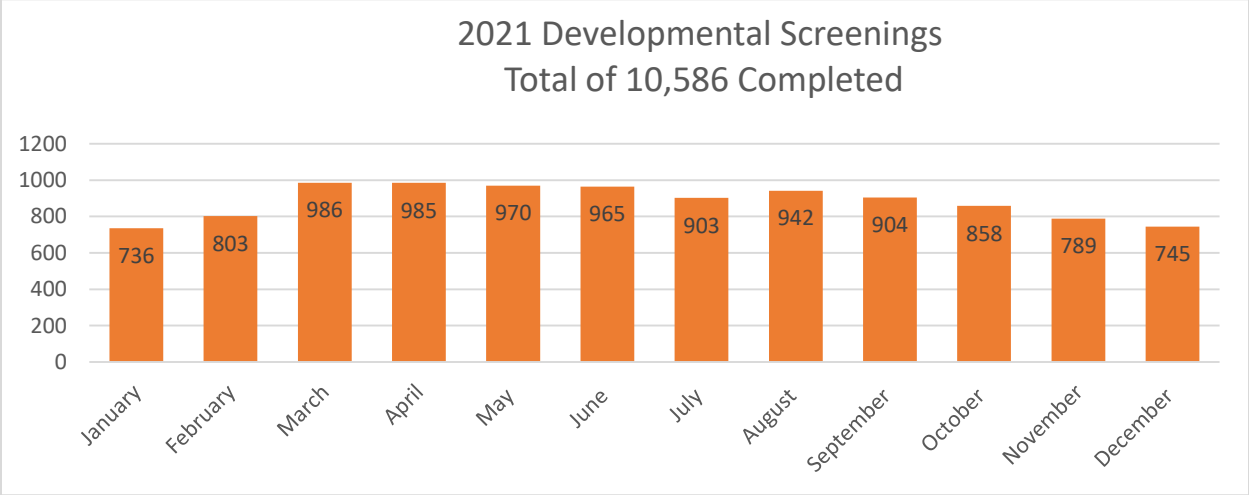
A. Trauma Screening



For 2021 the SCFHP QI goal for the year for Trauma Screenings was to increase screenings completed for eligible Members 65 year of age and under to 5,000 screenings. The outcome for the year was 6,653 screenings completed. In order to increase the number of completed trauma screenings for our eligible Members, SCFHP worked to educate our providers and meet their individualized network needs. Our Performance Provider Program staff review and discuss the Provider Performance Report card at provider monthly quality meetings to increase focus on this initiative. Topics of discussion include the trauma screening goal and outcomes, review of any gaps in care with root cause analysis, the tracking and monitoring of progress, and discussion of outcomes and any actionable items.

Actionable items include review of tip sheets, coding education, staff education and training, communicating best practices for trauma screening, and including the screening guidelines in the Provider Manual. In addition, providers were encouraged with a monetary incentive to attend an ACES Training on the ACEs Aware website for ACEs certification, and attest to training certification on the DHCS website by December 31, 2021. Transformation Consultants aligned with offices as appropriate to incorporate the screening as best practice into in their clinical workflow. Our Member education has included a social media campaign through Facebook posts, in addition to member newsletters on the importance of trauma screenings, as well as the guidelines for testing.

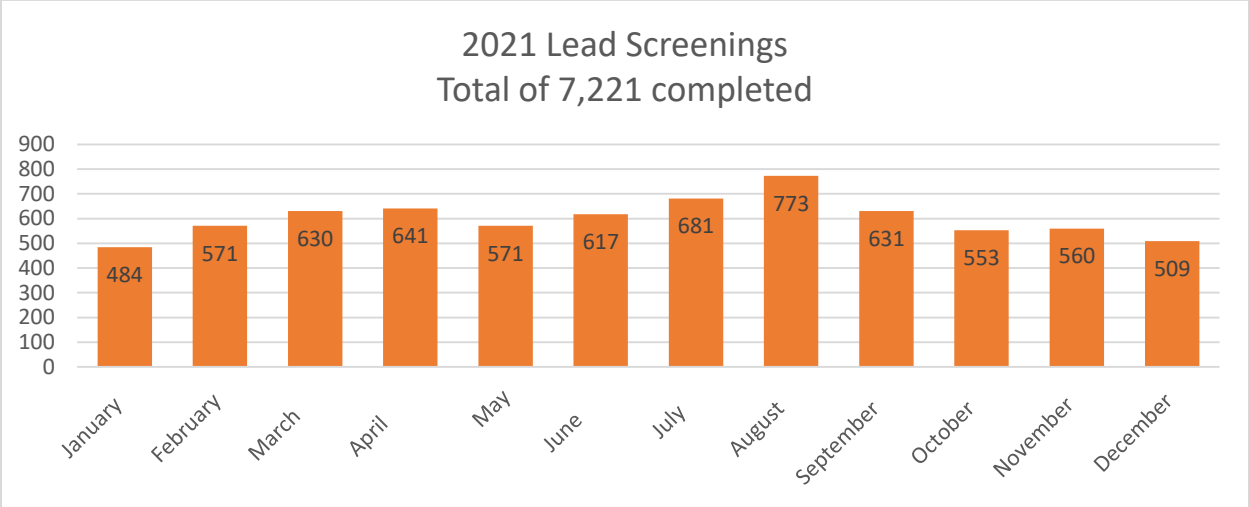
B. Developmental Screenings



For 2021 the SCFHP QI goal for the year for Developmental Screenings was to increase screenings completed for Members 3 years of age and under to 11,000 screenings. The outcome for the year was 10,586 screenings completed. In order to increase the number of completed developmental screenings for our eligible Members, SCFHP worked to educate our providers and meet their individualized network needs as our Performance Provider Program staff review and discuss the Provider Performance Report card at provider monthly Quality meetings. Topics of discussion include the developmental screening goal and outcomes, review of any gaps in care with root cause analysis, the tracking and monitoring of progress, and discussion of outcomes and any actionable items.

Actionable items include review of tip sheets, coding education, staff education and training, communicating best practices for developmental screening, and including the screening guidelines in the Provider Manual. Provider education involved incorporating the Developmental Screening as part of the well child visit at the 9 month, 18 month and 30 month milestone visits following a best practice algorithm. Providers were invited to attend our 2021 Provider Performance Program meeting to review the initiative, and increase knowledge about the importance of developmental screenings. Transformation Consultants aligned with offices as appropriate to incorporate the screening as best practice into in their clinical workflow. Our Member education has included a social media campaign through Facebook posts, in addition to member newsletters on the importance of developmental screenings as well as the age expectations for testing.

C. Lead Screenings



For 2021 Lead Screenings, the SCFHP QI goal for the year was is to increase lead screenings to >/= 9500 for children 3 years and under. Outcome for the year was 7,221 screenings completed. In order to increase lead screenings for our eligible members, SCFHP worked to educate our providers and meet their individualized network needs by discussion at monthly quality meetings to review the Provider Performance Report card that included lead screening outcomes, review of any gaps in care with root cause analysis, the tracking and monitoring of progress, and discussion of outcomes and any actionable items.

Actionable items included collectively working with providers on the development of a standing order in their Electronic Health Record, educating on the importance of following -up and closing the loop on Member outstanding lead screening lab orders, providing various resources for lead prevention and trainings from the California Lead Prevention Program, review of tip sheets, coding education, staff education and training, communicating best practices for lead screening, and including screening guidelines in the Provider Manual. Our Member education has included a social media campaign through Facebook posts, in addition to member newsletters on the importance of lead screenings as well as the age expectations for testing. Customer Service Representatives provide reminders to parents of child Members who call in on whether they should have a lead screening test completed for their child.

Cal-Medi-Connect

CMS and the State establish a set of quality withhold measures with established thresholds which MMPs are required to meet. Due to impacts from the Coronavirus Disease (COVID-19) public health emergency, SCFHP (MMP) is not required to submit HEDIS CY 2020 data covering the 2020 measurement year. However, SCFHP continued to monitor the quality withhold measure performance. Detailed documentation of interventions is included in the Quality Measure Workbook in 2021:

Rates of the measures are reflected for calendar year 2020:

#	Measure Acronym	Measure	Measure Type Methodology	Rate in CY 2020 (Reporting year 2021)	Withhold Threshold
1	CW6	Plan All-Cause Readmission	Administrative HEDIS	1.02	Did not meet 1.0
2	CW7	Annual Flu Vaccine	CAHPS	83.1%	Met 69%
3	CW8	Follow-up After Hospitalization for Mental Illness	HEDIS	32.14%	Did not meet 56% (Not reported due to small denominator)
4	CW11	Controlling blood pressure (CBP)	HEDIS	59.85%	Did not meet 71%
5	CW12	Medication Adherence for Diabetes Medications	PDE	87.3%	Met 80%
6	CW13	Encounter Data	Encounter Data	98.4%	Met 80%
7	CAW7	BH shared accountability outcome measure	Compliance Reporting	85.3	Met 78.3
8	CAW8	Documentation of care goals	Compliance Reporting	99.5%	Met 95%
9	CAW9	Interaction with care team	Compliance Reporting	40.5%	Did not meet 95%
10	CAW10	Care Plan Completion	Compliance Reporting	94.9%	Met 80%

SCFHP met 7 of the 10 quality withhold measures by collaborating cross-functionally across departments, including but not limited to: Quality, Medical Management, Behavioral Health, Pharmacy, Case Management and Marketing to implement interventions. One of the measures, CW8 had a small denominator so the rate was not reported.

Other than the Quality Withhold measures, SCFHP also reported HEDIS Medicare measures for NCQA Accreditation and Medicare-Medicaid Plan (MMP). National Percentiles and Star Rating cut points are used as benchmarks and goals for improvement and comparison.

In addition, HEDIS measures are also required reporting for NCQA Accreditation and CMS Medicare Star Ratings. These measures are highlighted as follows:

#	Measure Acronym	Measure	Measure Type Methodology	Final Rate	National 50th Percentile	3-Star Cut Point
1	AHUT	AHUT: Acute Hospital Utilization- Total	Admin	10.49%	N/A	N/A
2	AMM3	AMM3: Continuation Phase	Admin	61.57%	56.6	N/A
3	BCS	BCS: Breast Cancer Screening	Admin	65.01%	74.11	61%
4	CBP	CBP: Controlling High BP	Hybrid	59.85%	70.8	N/A
5	CDC10	CDC: HbA1c <8	Hybrid	62.53%	69.1	N/A
6	CDC2	CDC: HbA1c >9 Poor Control	Hybrid	28.71%	18.62	40%
7	CDC4	CDC: Eye Exam	Hybrid	77.13%	75.67	62%
8	CDC7	CDC: Nephropathy	Hybrid	88.08%	96	88%
9	CDC9	CDC: BP Control	Hybrid	55.96%	70.13	N/A
10	COA1	COA: Care Planning	Hybrid	20.92%	70.03	N/A
11	COA2	COA: Med Review	Hybrid	84.67%	95.73	71%
12	COA3	COA: Functional Assessment	Hybrid	43.07%	94.12	N/A
13	COA4	COA: Pain Assessment	Hybrid	82.97%	96.84	76%
14	COL	COL: Colorectal Screen	Hybrid	60.34%	73.48	62%
15	COUB	COU: Risk of Continued Use 31 aged 18 years and older	Admin	10.29%	N/A	N/A
16	DAE1	DAE1: Use of High Risk Medications to Avoid	Admin	N/A	N/A	N/A
17	DDE4	DDE : Total rate	Admin	30.68%	40.22	N/A
18	EDU	EDU: Emergency Department Utilization	Admin	19.41%	N/A	N/A
19	FMC	FMC: 7 days Post ED Mult High Risk CC aged 18 years and older	Admin	58.49%	54.85	N/A
20	FUA7	FUA: 7 day FUP post SU ED visit aged 13 years and older	Admin	8.33%	7.38	N/A
21	FUH7	FUH: 7 Day FUP post discharge	Admin	21.43%	24.68	N/A
22	FUI7	FUI: 7 Day FUP Post SU Event	Admin	15.38%	N/A	N/A
23	FUM7	FUM: 7 day FUP post MI ED visit	Admin	92.31%	29.65	N/A
24	HDO	HDO: Use of High Dose Opioids	Admin	6.18%	4.28	N/A
25	HFSA	HFSA: Hospitalization Following Discharge From a Skilled Nursing Facility with 30 days	Admin	12.10%	10.62	N/A

#	Measure Acronym	Measure	Measure Type Methodology	Final Rate	National 50th Percentile	3-Star Cut Point
26	HPCT	HPCT: Hospitalization for Potentially Preventable Complications-Total ACSC	Admin	1.94%	33.38	N/A
27	IETBT	IET: Engagement: Total	Admin	7.33%	3.88	N/A
28	OMW	OMW: Osteoporosis Management	Admin	42.86%	48.48	40%
29	PCE1	PCE: COPD Corticosteroids	Admin	75.00%	72.8	N/A
30	PCE2	PCE: COPD Bronchodilator	Admin	88.46%	81.32	N/A
31	PCR	PCR: Plan All-Cause Readmissions	Admin	10.50%	N/A	N/A
32	POD	POD: Pharmacotherapy Opioid Use	Admin	N/A	N/A	N/A
33	PSA	PSA: Non-Recommended PSA	Admin	13.46%	27.6	N/A
34	SAA	SAA: Antipsychotic Med Adherence	Admin	88.24%	N/A	N/A
35	SPCA	SPC: Statin Therapy for CAD	Admin	83.19%	80.94	81%
36	SPCB	SPC: Statin Adherence for CAD	Admin	88.83%	81.08	N/A
37	SPDA	SPD: Statin Therapy	Admin	81.83%	74.12	N/A
38	SPDB	SPD: Statin Adherence	Admin	87.42%	78.17	N/A
39	TRCD	TRC: Receipt of discharge information	Hybrid	45.26%	2.59	N/A
40	TRCE	TRC: Patient Engagement	Hybrid	83.94%	82.08	N/A
41	TRCI	TRC: Notification of Inpatient Admission	Hybrid	54.26%	7.39	N/A
42	TRCM	TRC: Medication Reconciliation	Hybrid	54.99%	52.31	N/A
43	UOPC	UOP: Opioid Use-Multi Presc & Pharms	Admin	2.43%	1.02	N/A
44	FRM	Fall Risk Management	HOS	70.44%	N/A	55%
45	PNU	Pneumococcal Vaccination Status for Older Adults	CAHPS	64.85%	N/A	N/A
46	FVO	Flu Vaccinations for Adults Ages 65 and Older	CAHPS	76.13%	N/A	N/A

SCFHP tracked and trended the HEDIS measures to identify barriers for quality improvement to reach the national benchmark 50th percentile.

Besides providing education to members on the importance of managing diseases, preventive health, and well-being through newsletters, providers were also educated on proper documentation and coding. In

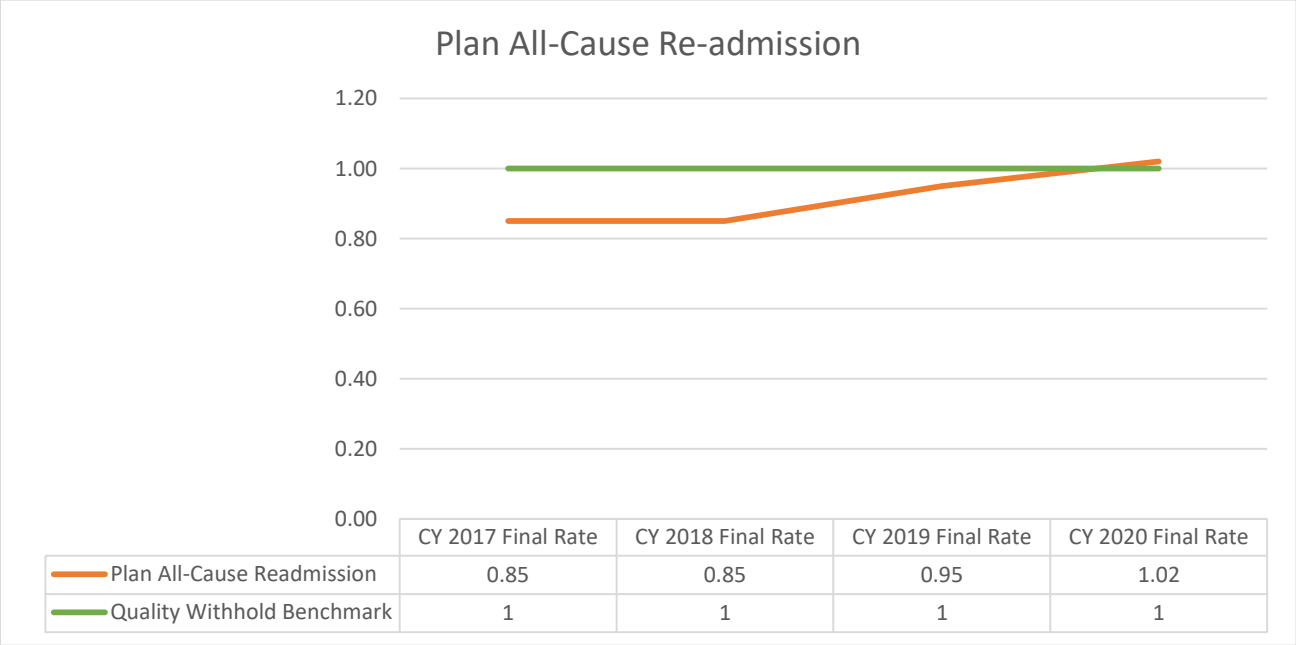
2021, SCFHP conducted 1620 in-home assessments to provide clinical assessment and health services by physician or nurse practitioner to member's home. It was lower than planned as many members were reluctant or refused due to COVID-19 pandemic.

During in-home assessment, physician or nurse practitioner assess member's health and safety, including but not limited to functional status, preventives services, physical and mental screenings, and medication review. The assessment is shared with member's assigned PCP for coordination of care.

In addition, care gap lists were provided to PCPs for follow-up to address missing services via provider portal.

1. Plan All-Cause Re-Admission

The table below shows the ratio of the plan's observed readmission rate to the expected readmission rate in 2020. The readmission rate is based on the percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.



	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Plan All-Cause Readmission	0.85	0.85	0.95	1.02
Quality Withhold Benchmark	1	1	1	1

** Methodology changed in CY 2019 to remove outlier members from the final rate*

CY 2020 Goal: 1.0

CY 2020 Rate: 1.02

Analysis:
The PCR rate in CY 2020 did not meet the goal of having a ratio of observed to expected visits below 1, with a final rate of 1.02. The main barrier for this measure is lack of timeliness of notification of discharge.

HEDIS Measure	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
PCR - Plan All-Cause Readmissions - Observed-to-Expected Ratio (Ages 18-64)*	0.90	0.86	0.83	0.79	N/A	1.00
PCR - Plan All-Cause Readmissions - Observed-to-Expected Ratio (Ages 65+)*	0.98	0.81	0.79	0.75	N/A	1.06

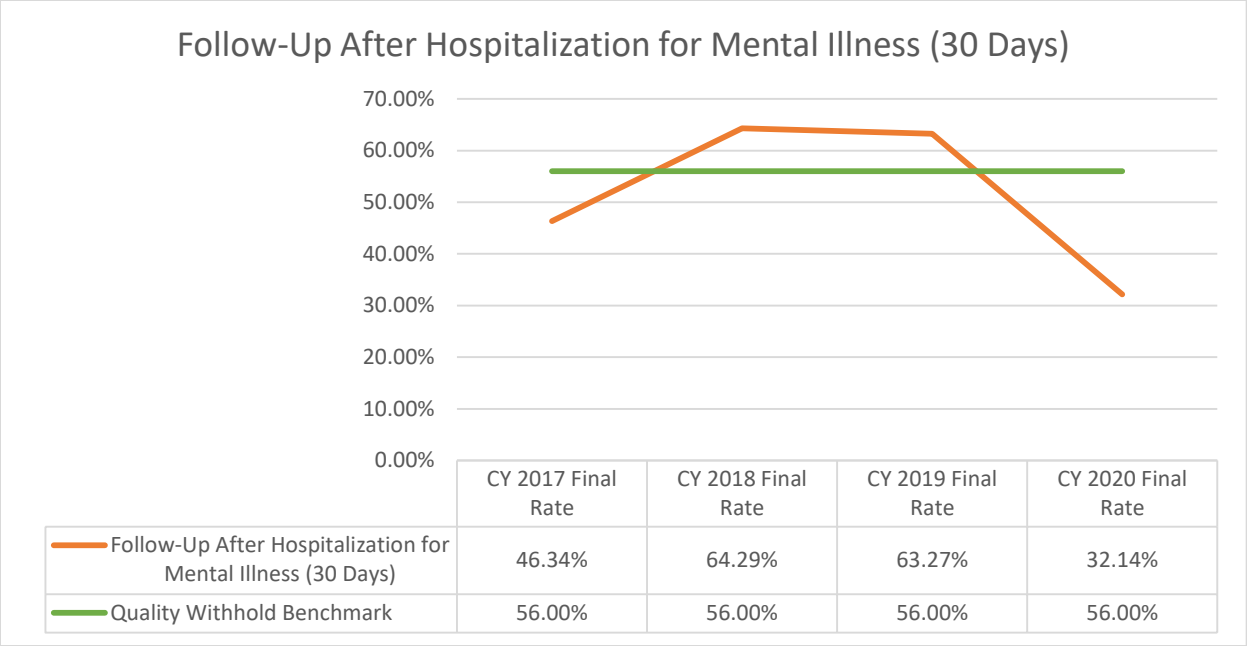
Comparing the PCR rates to statewide performance from CMS in the table above, the increase in rates in CY 2020 aligns with the increase seen statewide.

A cross-functional work group was set up, comprised of representatives from Utilization Management (UM), Case Management (CM), Quality, and Information Technology (IT) departments for barrier analysis. Transitions of Care (TOC) work was continued to complete follow up calls to members within 72 hours post discharge. These calls were redistributed from the Case Management team to the Utilization Management team due to limited staff resources to accommodate the TOC task in April 2020. Notification letters were sent to PCPs with discharge information in an SBAR format for post discharge follow-up. IT infrastructure was built obtaining census data on admission and discharge from a majority of the contracted hospitals.

Follow-up & Strategies to be considered for future years:
SCFHP continues 2020 interventions and improve the census data on admission and discharge from contracted hospitals to address the barriers for this measure.

2. Follow-up after Hospitalization for Mental Illness

Discharges for plan members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge in 2020.



CY 2020 Goal: 56%

CY 2020 Rate: 32.14%

The rate for this measure dropped by 30% compared to the previous calendar year, resulting in the plan not meeting the Quality Withhold benchmark. However, due to the small denominator for this measure, the rate was not reported.

HEDIS Measure	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
FUH - Follow-Up After Hospitalization for Mental Illness- 30 Days	31.2	46.6	47.7	48.3	N/A	46.4

Comparing SCFHP's performance in this measure to the statewide average, the plan's rate dropped much more dramatically in CY 2020 compared to the state, which only dropped 2% between 2018 and 2020.

SCFHP selected this measure as Chronic Care Performance Improvement Project in 2020.

SCFHP realized that inconsistent data and communication received from Santa Clara County Behavioral Health Department. The efforts made by SCFHP behavioral health team, including keeping track of admission and discharges to Santa Clara Valley Medical Center, collaboration with acute social work staff on the barriers to follow up care prior discharge, and completing the transition of care (TOC) outreach once discharged, have shown to be successful. The outcomes were as follows:

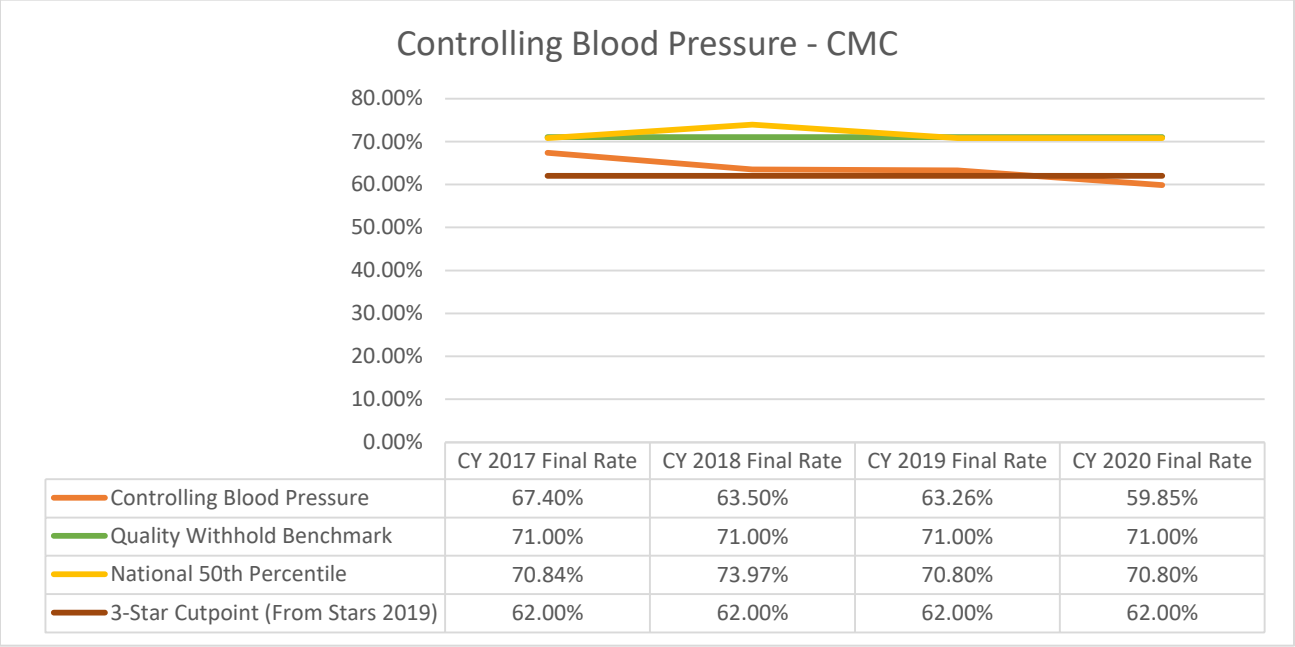
	Baseline 11/01/2017- 10/31/2018	Year 1 2/15/2019-2/14/2020	Year 2 2/15/2020-3/14/2021
Numerator	19	7	2
Denominator	44	9	2
Result	46.18%	77.78%%	100%

In measurement year 2 (2/15/2020 – 3/14/2021), there were 2 eligible members and both cases received completed TOC outreach. The number of discharges to home from SCVMC was smaller in 2020 than previous measurement year. Assuming that COVID-19 pandemic has changed the health care access and process, members who may have increased symptoms either do not present to services out of fear or there are no community/family available to witness the current unstable symptomology requiring an admission. Another factor may be that symptoms are more severe due to the pandemic that less are discharged to home and instead transferred to a lower level of care such as crisis residential or IMD setting.

The plan has identified the best practice by developing coordination between the health plan behavioral health worker and the acute psychiatric social worker at the facility. Post discharge communication with the outpatient behavioral health treatment team has benefited the TOC transition process. The best practices has impacted smooth transition and communication for successful TOC. Although the admission rate is low, the practices of addressing barriers to care, coordination of discharge, maximizing current health plan benefits such as transportation and PCP appointments will continue to be practiced going forward.

3. Controlling Blood Pressure

Members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled in 2020.



	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Controlling Blood Pressure	67.40%	63.50%	63.26%	59.85%
Quality Withhold Benchmark	71.00%	71.00%	71.00%	71.00%
National 50th Percentile	70.84%	73.97%	70.80%	70.80%
3-Star Cutpoint (From Stars 2019)	62.00%	62.00%	62.00%	62.00%

CY 2020 Goal: 71%

CY 2020 Rate: 59.85%

Analysis:
CBP did not meet any of the three benchmarks (Quality Withhold, National 50th percentile, 3-Star cut point) in CY 2020. CBP is a hybrid measure and data is obtained for the sample during the HEDIS medical record review period. It is challenging to monitor and identify whether members have controlled blood pressure. During chart review, SCFHP identified that BP was not rechecked even if the first reading was >140/90 mmgHg. Secondly, the care team did not initiate or intensify treatment during office visits if member's BP was not at goal. Thirdly, there was poor patient participation in self-management behaviors.

HEDIS Measure	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
CBP - Controlling High Blood Pressure	60.0	62.7	66.4	69.0	N/A	61.6

The plan's performance was 2% lower than the statewide MMP average and did not see as drastic of a drop between CY 2018 and 2019.

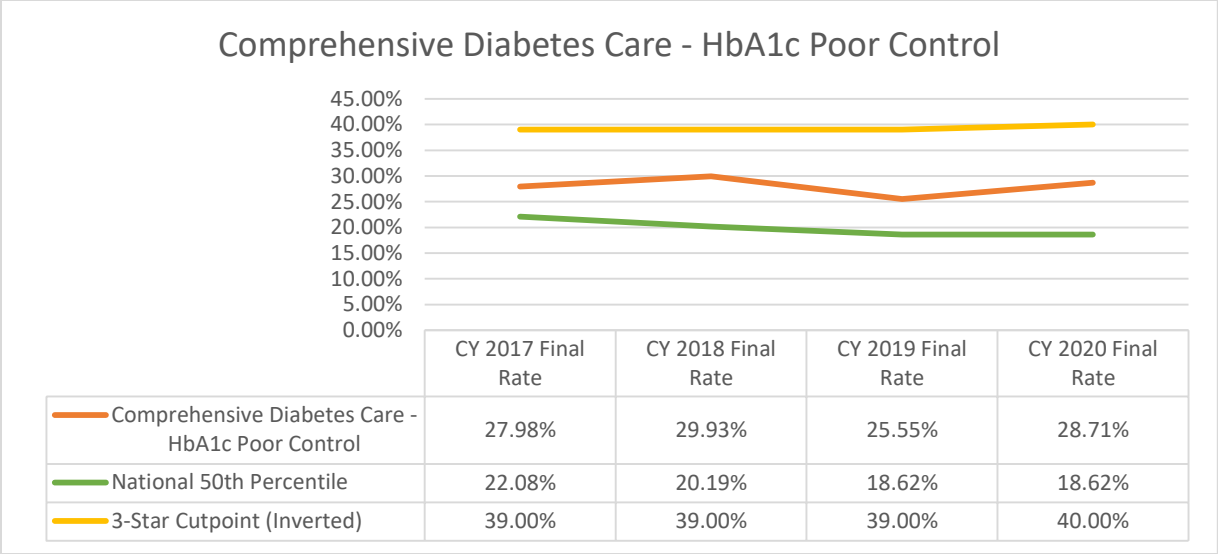
Providers were encouraged to utilize telehealth for hypertension follow-up. They were also educated on proper coding and how to prescribe home blood pressure monitor to hypertensive member in order to submitting BP readings as supplemental data. Member newsletters about high blood pressure were published in Spring and Winter newsletters. SCFHP launched health education class focusing on controlling blood pressure July 2021. Please see Health Education section (D) for more information.

Follow-up & Strategies to be considered for future years:

- Ensure members have blood pressure monitors for home monitoring and reporting BP result to their PCP during telehealth follow-ups
- Continue conducting health education class for members on how to use BP monitors at home so they know their BP reading

4. Comprehensive Diabetes Care – HbA1C Poor Control

Percentage of members 18-75 years of age with Diabetes (type 1 and type 2) who had had HbA1C poor control (>9%) in 2020.



	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Comprehensive Diabetes Care - HbA1c Poor Control	27.98%	29.93%	25.55%	28.71%
National 50th Percentile	22.08%	20.19%	18.62%	18.62%
3-Star Cutpoint (Inverted)	39.00%	39.00%	39.00%	40.00%

CY 2020 Goal: 18.62%

CY 2020 Rate: 28.71%

Analysis:
CDC – HbA1C Poor Control (<9%) is a hybrid inverted rate measure. It scored 28.71% in CY 2020 and met the CMS Star Rating 3-star cut point (40%). However, the rate was 10% below the national 50th percentile. The rate for this measure worsened by 3% compared to the previous year. CDC is a hybrid measure. Though SCFHP improved the data and received HbA1C results from a majority of laboratories, the data are still incomplete, with many members being flagged as having HbA1c > 9% due to missing lab values.

HEDIS Measure	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
CDC - Comprehensive Diabetes Care - Poor HbA1c Control*	39.6	29.9	24.9	25.6	N/A	28.8

SCFHP's rate for this measure was very similar to the statewide average in CY 2020 and saw a slight improvement compared to the plan's rate in CY 2018.

Member education on the importance of HbA1C testing through was published in the member newsletter. Providers were encouraged to offer standing orders for HbA1C test. Member and provider newsletters on the importance of diabetes care were sent out in the fall. Providers were also encouraged to submit HbA1C results and coding in encounters and/or supplemental data. Member incentive was offered to those who complete Medical Nutrition Therapy (MNT) with Registered Dietician or Diabetic Self-Management (DSME) with a Certified Diabetic Educator. 973 letters were mailed to members with offer of an incentive for completing MNT/DSME. In all, 15 members were compliant and awarded the gift card.

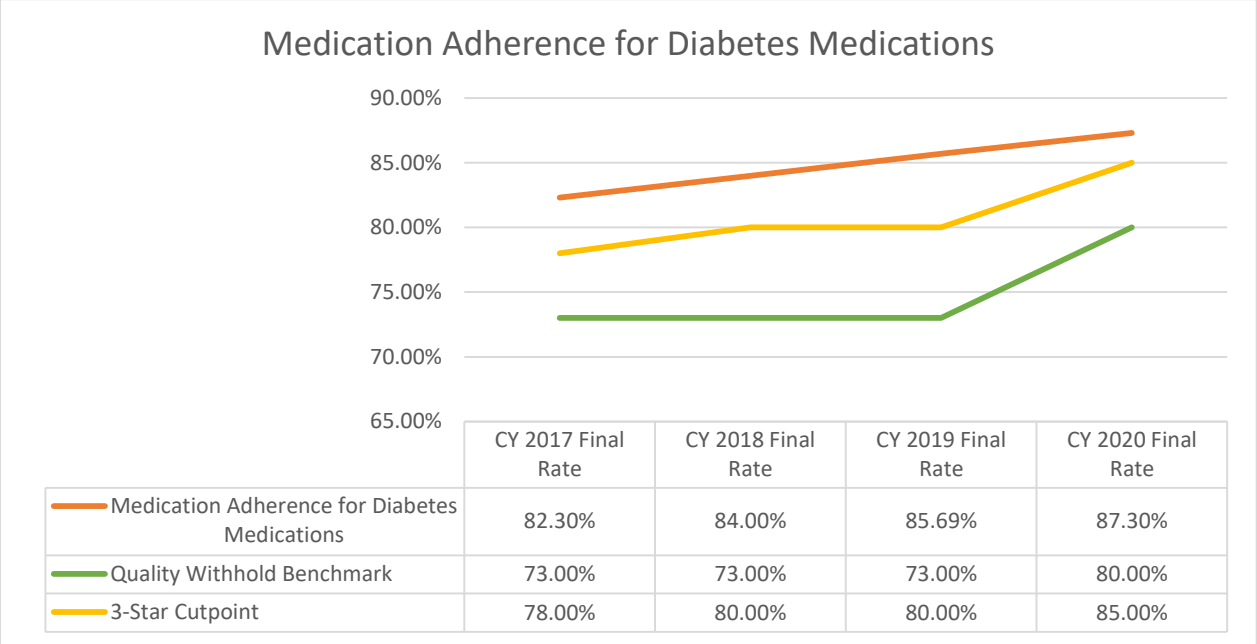
Follow-up & Strategies to be considered for future years:

- Improve supplemental data for HbA1C results

- Promote Diabetes Self-Management Education and Medical Nutrition Therapy to members with uncontrolled diabetes

5. Medication Adherence for Diabetes Medications

Members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication in 2020.



	CY 2017 Final Rate	CY 2018 Final Rate	CY 2019 Final Rate	CY 2020 Final Rate
Medication Adherence for Diabetes Medications	82.30%	84.00%	85.69%	87.30%
Quality Withhold Benchmark	73.00%	73.00%	73.00%	80.00%
3-Star Cutpoint	78.00%	80.00%	80.00%	85.00%

CY 2020 Goal: 85%

CY 2020 Rate: 87.30%

Analysis:
The rate for medication adherence for diabetes medications improved by 1.61% compared to the previous year. The Quality Withhold benchmark and the 3-Star cut point were both met for this measure.

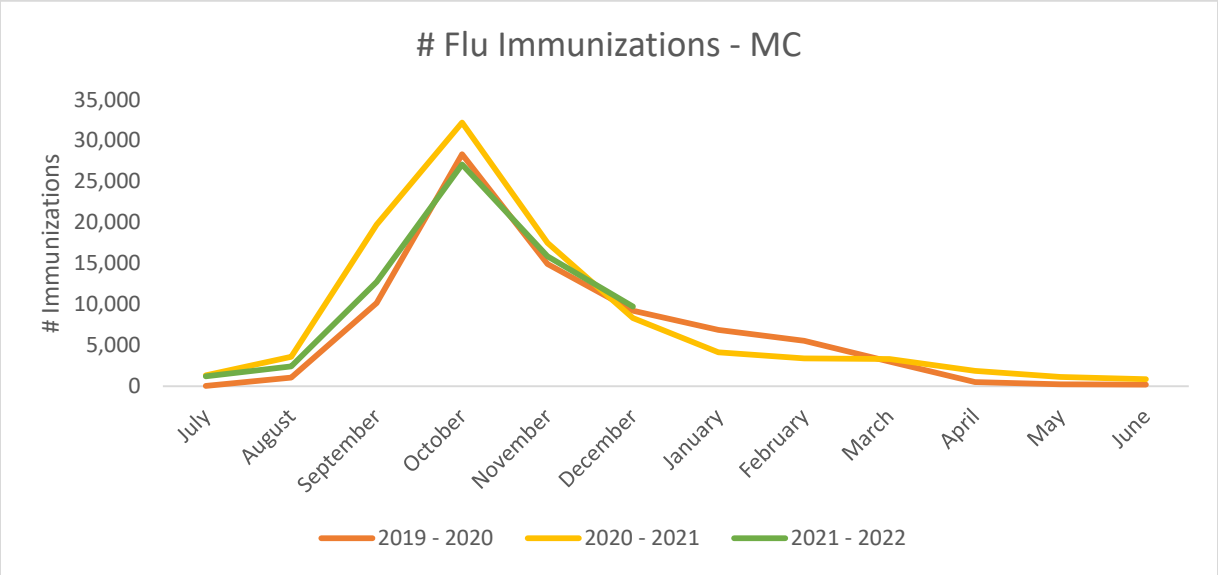
Providers are encouraged to prescribe mail order and 90-days' supply of hypoglycemic medication to members, especially during the COVID-19 pandemic.

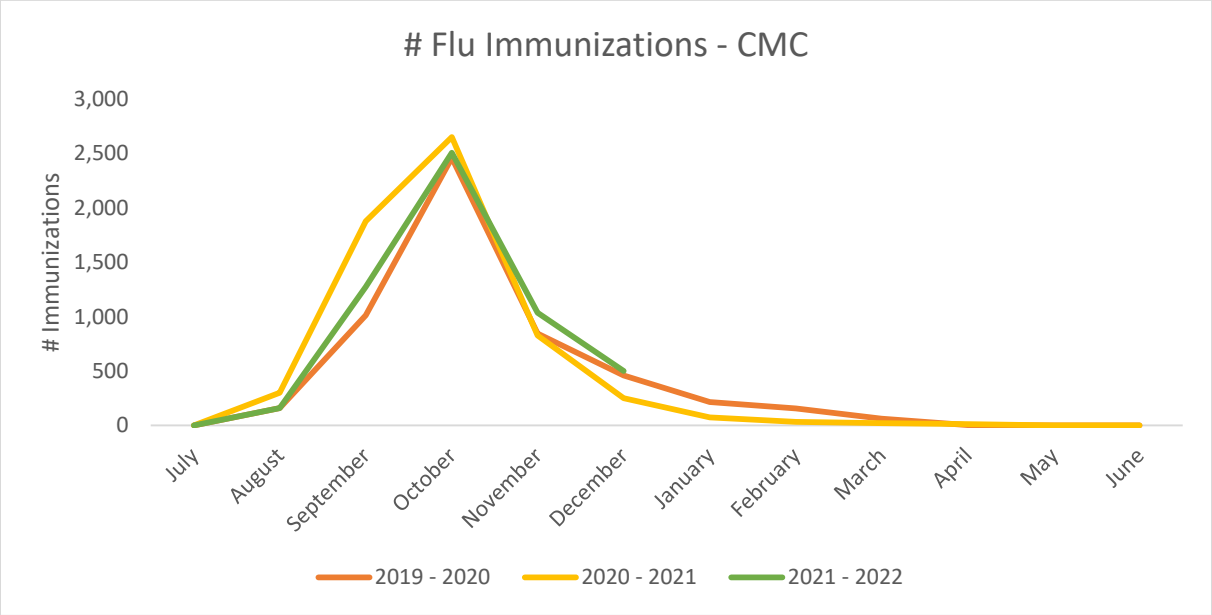
Follow-up & Strategies to be considered for future years:

- Continue to encourage the 90-days' supply and mail order

Both Medi-Cal and Cal-Medi-Connect

1. Influenza Vaccine





Analysis:

As the tables above indicate, the number of flu immunizations for both LOBs for flu season 2021-2022 are lower compared to the previous 2 years. There are several barriers that explain this drop compared to

previous years. Due to competing information around the COVID and flu vaccine, the flu may be trivialized by COVID. Confusion also exists regarding the timing of COVID and flu vaccines, and the possibility of co-administering both vaccines. This may cause people to underestimate the importance of getting their annual flu vaccination, due to the overpowering COVID public health crisis.

Interventions:

SCFHP hosted a health fair at our Blanca Alvarado Community Resource Center (CRC) in October 2021, where free flu vaccines, as well as other health screenings, were available to the public. The CRC is located in East San Jose, where a majority of SCFHP's members reside. The event was promoted via social media, outreach with SCFHP community partners, and shared with all member-facing staff to share with members.

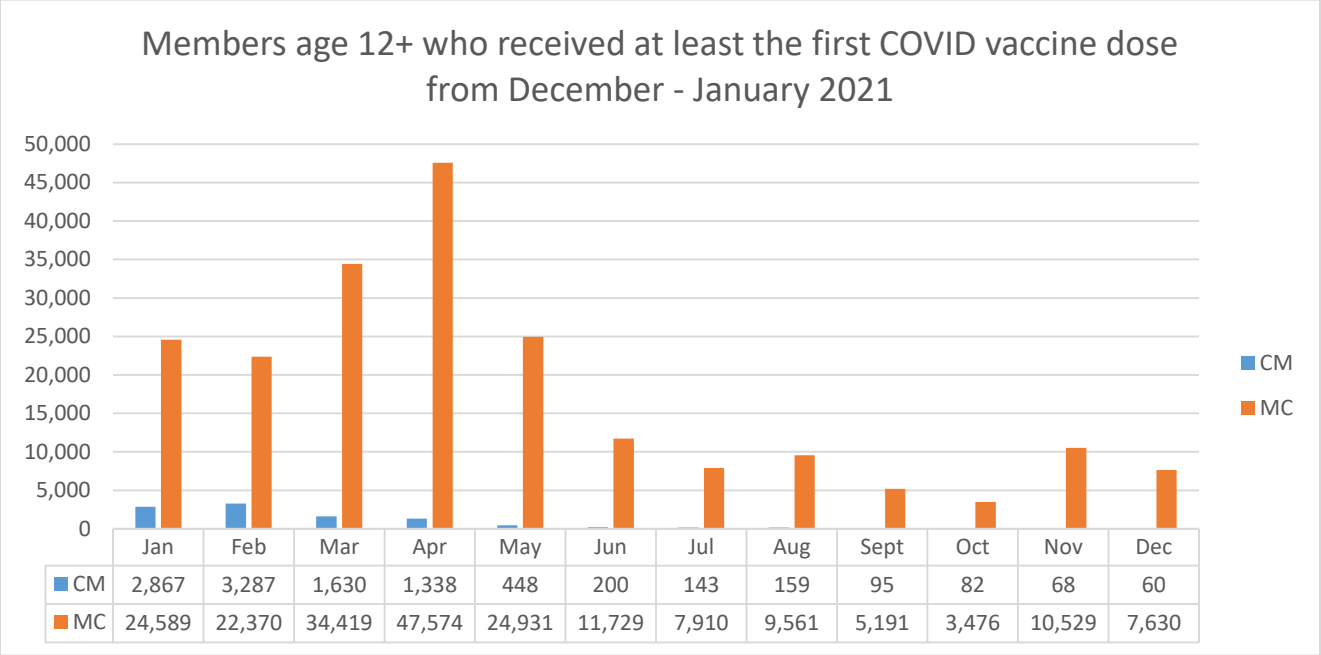
SCFHP also released several member communication via newsletters, on-hold phone messages, social media, and SCFHP's member-facing website, to inform and remind members to get the flu shot. The website also offers a dedicated Flu Homepage, where members can view a Google Maps Flu Vaccine Locator, to find nearby flu vaccine locations. All communications remind members they can get the free flu shot at any retail pharmacy and can also schedule for free transportation services to their appointment by calling SCFHP's Customer Service.

Additionally, Case Management staff remind members to get their flu shots during Health Risk Assessment (HRA) outreach. SCFHP holds an internal flu shot reminder campaign for all member-facing teams, including Customer Service, Case Management, Behavioral Health, MLTSS, Health Homes Program, and Medicare Outreach. The campaign incentivizes all member-facing staff to remind members to get their flu shot at the end of member phone calls. Teams are provided with a flu FAQ and script to ensure members are appropriately informed about the flu shot and where they can go to get the flu shot. A Quality Alert for flu vaccines is provided in the internal QNXT system to identify members who have not received their flu shot yet to notify member-facing staff to make the reminder. In total, SCFHP staff gave 8,267 flu reminders to un-vaccinated members.

Follow-up & Strategies to be considered in future years:

- Engage community partners early in the planning process to learn about barriers their patients face to getting the flu vaccine and develop strategies to address those barriers
- Host more flu vaccine drive-through clinics with expanded hours (evening and weekends) to accommodate different schedules and availabilities

2. COVID-19 Vaccine



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
CM	2,867	3,287	1,630	1,338	448	200	143	159	95	82	68	60
MC	24,589	22,370	34,419	47,574	24,931	11,729	7,910	9,561	5,191	3,476	10,529	7,630

Interventions and Outcomes:

SCFHP is dedicated to providing evidence-based information to members, providers, CBOs, and other local partners about the COVID vaccine to encourage vaccine uptake. Information strategies included:

- Community Resource Center Outreach - Offer one-stop shop for COVID vaccine information, resources, testing, and vaccination at SCFHP's Community Resource Center (CRC). In CY 2021, the CRC hosted 7 COVID vaccination clinics and administered 1,163 COVID vaccines.
- Social media and ad campaign - Expand COVID social media advertising campaign on Facebook and Instagram. Plan ran Spanish and English digital and social media ads starting in November 2021 and targeted county zip codes with the lowest vaccination rates.
- Member outreach –
    - Robocall campaign: 114,417 robocalls were made to members to share information about the COVID vaccine and where and how to schedule appointments,
    - Mail campaign: 25,130 letters and flyers were mailed to identified vulnerable populations and target groups to share information about the COVID vaccine and where and how to schedule appointments
    - Call campaign: a call campaign was strategized in four different phases throughout CY 2021, based on priority vulnerable groups. A total of 16,048 members were contacted.

B. QUALITY IMPROVEMENT PROJECT (QIP), PERFORMANCE IMPROVEMENT PROJECT (PIP) & Chronic Condition Improvement Plan (CCIP)

SCFHP conducted Performance Measure Plan-Do-Study-Act (PDSA) PIP, COVID-19 QIP, Health Equity PIP, Priority PIP, Chronic Condition Improvement Plan (CCIP), and Diabetes PIP in 2021.

1. Performance Measure Plan-Do-Study Act (PDSA) Process QIP 2021

For 2021, SCFHP implemented a Plan Do Study Act (PDSA) rapid cycle project that focuses on preventive care of chlamydia (CHL) screening. The first cycle of the PDSA was implemented from October 1, 2021 to December 31, 2021. The global aim for the PDSA was to increase CHL measure to meet minimum performance level at 58.44% for the measurement year 2021.

280 members were identified as non-compliant for CHL belonging to Independent Network (directly contracted providers), Community Health Partnership (CHP), and Premier Care (PCNC). The SMART objective for this cycle is that SCFHP will increase Chlamydia Screening in Women (CHL) rate by completing the lab test for 40% of the 280 members, or 112 members who had completed at least one chlamydia screening between measurement years 2018 to 2020 and are assigned to directly contracted providers, Community Health Partnership (CHP) Clinics, or Premier Care (PCNC) Network within Santa Clara County.

SCFHP identified a barrier as providers needing assistance in identifying members with CHL screening gaps in care. SCFHP added CHL screening dates from three measurement years: MY18, MY19, and MY20 who were assigned to the provider groups listed above. By adding these screening dates on the member list, SCFHP is able to facilitate a conversation with each provider group during a one-one-one call. The call will consist of:

i. Sharing the list of non-compliant members including the most recent chlamydia screening date for each member
ii. Reminding the provider/provider group the importance of having members complete the chlamydia screening annually
iii. Strongly recommending the provider/provider groups to put in a standing order at the lab for the list of non-compliant members
iv. Sharing the provider tool kit

This PDSA cycle continues into 2022 and will run from January 1st 2022 – April 30th, 2022.

2. COVID-19 Quality Improvement Plan (QIP) for 2021

Due to the COVID-19 pandemic in 2020, DHCS required managed care plans to develop strategies and conduct interventions that support efforts to improvement member accessibility to preventive health services. As a part of the requirement, SCFHP was required to submit an initial description of interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care to members amidst COVID-19. An initial submission outlining the three (3) strategies and rationale were required to be submitted to DCHS. A 6-month follow-up and progress submission is required in early 2022.

The first strategy focused on behavioral health. The goal is to monitor members' adherence for newly prescribed antidepressant medication with regular follow up for 12 weeks post physician's order. Due to the strains and effects of the COVID pandemic, SCFHP wants to focus on antidepressant medication adherence was chosen to provide targeted support and assistance to those newly diagnosed with depression. The start date of this intervention was Oct 3, 2021. Current progress on this intervention includes developing logic to identify target population through encounter data, a letter template drafted for provider and member outreach, and warm outreach calls to members.

The second strategy was focused on women's health. The goal is to promote order for screening mammogram by PCP for SCFHP Quality Improvement Coordinator outreach and assisting in appointment scheduling. SCFHP selected White, Chinese, and Asian Indians as the focus of this intervention as these three groups are significantly lower in compliance for breast cancer screenings compared to other ethnic backgrounds. The start date of this intervention was October 1, 2021. Current progress on this intervention includes 786 warm outreach calls made to members promoting mammogram screenings and assisting in appointment scheduling. From October 2021 – December 2021, a total of 986 members completed mammograms. SCFHP also partnered with a local community clinic for mobile mammogram day in October 2021. 19 members registered for this event and 12 completed their screenings on-site.

The third strategy was focused on chronic disease self-management. Members' management on high blood pressure by providers was interrupted during COVID pandemic. Therefore, the goal is to promote home monitoring for hypertension self-management by (1) assisting member to obtain home BP monitor and (2) offering SCFHP health education class for Controlling High Blood Pressure. The start date of this intervention was October 1, 2021. Current progress on this intervention includes 2008 calls made to members promoting in health education class. 142 members registered for classes held monthly from August – December 2021 and total 43 members attended. A post-class survey was conducted after each class. 83% of members who attended reported they learned something about the chronic condition they did not know before. 369 members have since received at home BP monitor.

QIP continues to be in the strategies and interventions until 2022.

3. Health Equity Performance Improvement Project

Health Equity PIP focused on an identified health disparity based on, but not limited to, age, gender, race or ethnicity, language spoken, income, educational attainment, sexual orientation or gender identity, occupation, provider or geographic area.

SCFHP has identified Adolescent Well Care Visit (AWC) aged 18 – 21 to be the Health Equity Improvement Project.

In Module 1, the SMART aim goal was defined as "By December 31, 2022 use key driver diagram interventions to increase the percentage of adolescent well-care visits among members' aged 18-21 assigned to Gardner Health, Asian Americans for Community Involvement (AACI), Saint James Health

Center, School Health Clinics, and Planned Parenthood clinics from a 19.53% compliance rate to a 25.0% compliance rate."

The SMART aim goal's baseline 19.53% identified 932 eligible members assigned to the clinics listed. The goal was established based on the 2020 HEDIS 25th percentile. Module 1 was validated on May 26, 2021.

During module 2, process map, FMEA and key drivers were developed and identified. The key drivers were to increase low participation rate in AWC visits, improve member awareness, and member's appointment coordination. The plan developed gift card incentive program to promote the participation rate, clinic days to increase member awareness and educate the members on the importance of the visits. Module 2 was completed and validated on August 6, 2021.

PIP continues to be in the intervention testing phase until December 31, 2022.

4. Childhood Health – Blood Lead Screening in Children (LSC) Priority PIP

SCFHP has identified that Blood Lead Screening in Children (LSC) is a measure that needed additional focus as it had a low compliance rate and was a priority measure for the Plan.

Module 1 of LSC Priority PIP, the SMART aim goal was "by December 31st, 2022, use health education and incentive member mailings, monthly provider Care Gap Report, and quality calls to increase the percentage of children two years of age, assigned to Valley Health Plan (VHP) and Physicians Medical Group (PMG), who had one or more capillary or venous lead blood test by their second (2nd) birthday, from 69.08%to 73.13%."

The SMART aim baseline 69.08%, is comprised of 2613 total eligible members assigned to Valley Health Plan and Physicians Medical Group. This baseline was calculated from our HEDIS certified vendor for the LSC measure, following NCQA HEDIS 2020 technical specifications. Claims, encounter, and supplemental data using lead test value set were used in order to determine if members 2 years of age in 2020 had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. Module 1 was validated on April 28, 2021.

Module 2 process map was developed and failure modes and effects analysis (FMEA) was identified as well as the key driver diagram. The key drivers were to increase the AWC visit rates within the two selected networks, increase member awareness and to inform members of their scheduled visits and getting appointments scheduled. The plan developed incentive program to increase the visit rates, visit coordination to ensure members attend the scheduled visit as well as scheduling the appropriate time. Module 2 was completed and validated on June 29, 2021.

PIP continues to be in the intervention phase until December 31, 2022.

5. Chronic Condition Improvement Plan (CCIP)

In the 2021 the number of psychiatric discharges increased to a total of 8 in the final measurement year. Seven of those 8 had successful transition of care (TOC) outreaches, resulting in 87.5% result. The plan successfully reached the target goal of 56% in the final year. Over the last three years, SCFHP's efforts to track and monitor the follow up after psychiatric admission have resulted in updates to processes and workflows that aid in successful coordination of care for a vulnerable population. During the baseline year, SCFHP met with County Behavioral Health Services Department to clarify how to identify a Cal-Medi-Connect (CMC) member so that claims are sent correctly and timely.

Annually SCFHP trained internal staff on the importance of this measure and their role for a successful follow up appointment within 30 days. Training focused on not only the process, but also the importance of quality assessment. The TOC process was enhanced over the course of the three years to include easier notification and documentation of the assessment and TOC. Once the Behavioral Health (BH) Case Manager is notified of the admission, collaboration with the acute inpatient staff commenced with the goal of coordination of the after-care treatment recommended. If the member did not have a scheduled appointment, the SCFHP BH case manager assisted with scheduling and addressing barriers addressed during the assessment to getting to that appointment.

The COVID-19 pandemic had forced our entire community to address the needs of members after a psychiatric admission in a different manner. Due to the pandemic, SCFHP was unable to complete face to face visits with members, or visit them in the hospital prior to discharge. Staff relied on telephone communication only. SCFHP learned that we must remain flexible in approaches to outreach and interventions that focus not only barriers to getting to that one follow-up appointment, but also assess the overall needs, specifically Social Determinants of Health that may contribute to readmission and instability. Within the SCFHP BH Case Management team, there is consistency of case assignments. This specialized population requires skills to build rapport and trust that may take longer than the average member. The Behavioral Health Case Manager not only addresses the follow up needs after discharge, but also takes the opportunity to assess the medical, behavioral, and social needs and over time reduces the rate of hospitalizations and creates a plan for maximum health and well-being.

6. Comprehensive Diabetes Care PIP

The Comprehensive Diabetes Care PIP is aimed to improve diabetes status of our members. Goal is to decrease the percentage of the poor HbA1c poor control >9% within the poor control population. The Hispanic population in CY2020 was at 44.44%, ranking the highest non-compliant population. The national benchmark (MPL) is at 37.47%. SCFHP worked with Arkray USA and Advanced Pharmacy Solutions (APS) to provide English and Spanish talking glucose meter to our Medi-Cal Hispanic members that were HbA1c poor control >9% in CY2019 and CY2020. In 2021, the distribution count of Arkray Glucose monitors was at 24 units. SCFHP will continue to monitor the distribution of glucose monitors until the end of June 2022 and further analysis if the bilingual glucose monitor contributes to improvement in the HbA1c poor control >9% Hispanic population.

C. Health Education

SCFHP offered Health Education classes and resources for members in 2021 under topics including nutrition and weight management, fitness and exercise, chronic disease self-management, smoking

cessation, prenatal education, counseling and support services, parent education, and sexual health. The Plan also offers written resource materials on a variety of topics if requested by the member. A total of 626 members attended various health education classes in 2021. SCFHP is highlighting three classes:

Prenatal Education – SCFHP launched a health education class for expecting mothers as part of the incentive program in 2021. Members who attended a first prenatal visit were invited to attend a Virtual Baby Shower. Held monthly, the class is led by a Certified Health Education Specialist. Topics include prenatal and postnatal health, mental health, SCFHP benefits such as breast pump and transportation to appointments, health education offerings through local partners such as breastfeeding classes, infant and child safety, and newborn prep. Members were also awarded a diaper bag for attending the baby shower. In 2021, 84 members attended the shower virtually. SCFHP will continue offering this class and update the content in order to continue engaging the target population. SCFHP will continue this offering in 2022.

Chronic Disease Self-Management – SCFHP launched a health education class for members diagnosed with high blood pressure (hypertension) in July 2021. A total of 34 members attended. Held monthly, this class is led by a Certified Health Education Specialist. Topics discussed include overview of what high blood pressure is, how to manage the condition, diet and exercise, health education offerings such as stress and anger management, weight control, and smoking cessation. SCFHP benefits are also reviewed including at-home BP monitor and services such as transportation and translation for appointments. Members who attend the class are also awarded a $15 gift card as an incentive. Follow-up is done to ensure members understand how to receive BP monitor. SCFHP will continue this offering in 2022.

Nutrition and Weight Management – Nutrition and healthy eating class focused on parents and caregivers of children at SCFHP are offered as part of health education. Because healthy eating habits start in the home, the class is critical to educating parents on how to raise a happy, healthy child. Topics include addressing picky eater, grocery shopping tips, meal preparation, sugary snacks and alternatives. In 2021, a total of 159 members attended the class hosted by a local partner in Santa Clara County. The Plan will continue to promote this class in 2022.

For details, refer to Health Education Work Plan 2022.

D. Cultural & Linguistics

The Plan offers interpreters and written translation services at no charge to members. The Plan promoted these services on member newsletters Spring, Summer, Fall, and Winter. Education for providers during monthly collaboration calls, as well as SCFHP's Cultural Competency & Disability Toolkit outlines the services and provides clinics with one-page guide on how to connect with translation for members who request them at medical appointments. 22,542 calls to interpreter services were made on behalf of members in 2021. Calls can be initiated from provider offices or through SCFHP staff. Interpreters attended 1,048 in-person appointments with SCFHP members in 2021. Interpreter requests can be made through SCFHP. The Plan will continue to promote these services in future years and work with provider offices to utilize the service. Additionally, the Plan will also offer these services during warm outreach calls made to members.

For details, refer to Cultural & Linguistics Work Plan 2022.

E. INITIAL HEALTH ASSESSMENT (IHA)

The Department of Health Care Services (DHCS) requires all new Medi-Cal members complete their comprehensive Initial Health Assessments with their selected or assigned primary care provider within 120 days from Santa Clara Family Health Plan enrollment and it must be documented in the medical record. The IHA consists of a comprehensive history, physical exam, mental status exam, preventive care services, diagnosis and plan of care, and the Staying Healthy Assessment (SHA). The intent is to evaluate members' engagement with Providers by measuring the rate of members who received an IHA within the required timeframe.

Santa Clara Family Health Plan's providers are required to use and administer the SHA to all Medi-Cal beneficiaries as part of the Initial Health Assessment (IHA) and periodically re-administer it according to contract requirements. The Staying Healthy Assessment (SHA) is the Department of Health Care Services' (DHCS's) version of the Individual Health Education Behavior Assessment (IHEBA). Providers may use an alternative IHEBA tool with prior approval of the Medi-Cal Managed Care Division (MMCD). It is a valuable tool for early detection of possible risks to patients' health and well-being. After reviewing the completed form, PCPs may refer patients to health education classes through SCFHP, or provide them with copies of their own educational materials. SCFHP offers health education classes and programs to all of our members at no charge.

SCFHP recognizes the importance of promoting Initial Health Assessments (IHA) within 120 days of enrollment into the health plan. Quarterly medical record audits are performed for each of the required elements of an IHA, including the SHA. Each quarter, the Quality Improvement Nurse randomly selects 5 members from 10 randomly selected providers, including members who did and did not have a claim for an IHA. Santa Clara Family Health Plan reviews 50 charts for IHA components each quarter. Our list of providers comes from claims and/or encounter data.

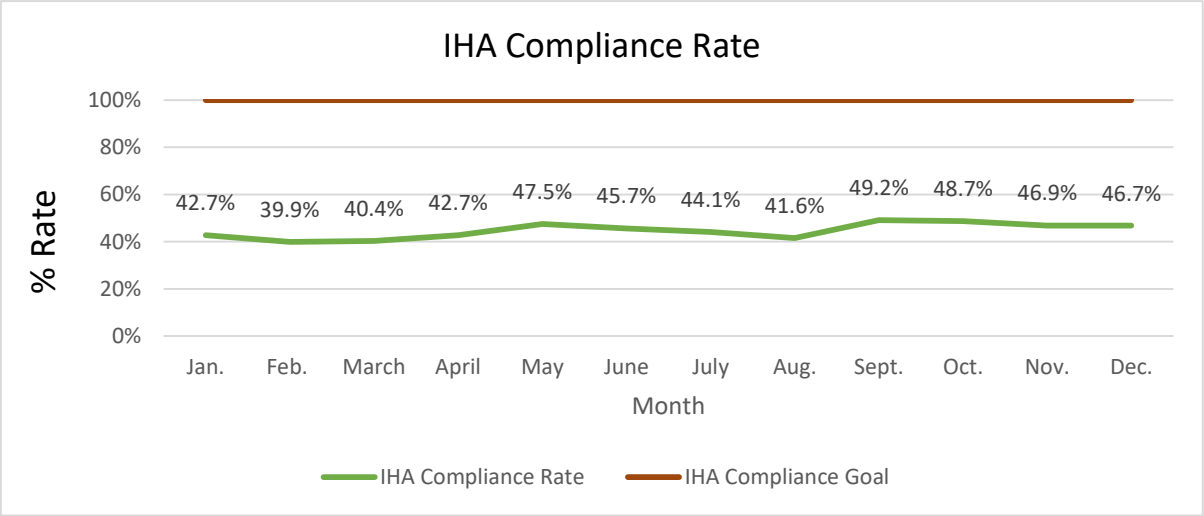
Charts are scored for presence or absence of the elements of the IHA, including the SHA and outreach attempts. A provider who scores 80% or less on the individual chart score or the overall score, will be considered a fail. For providers who scored 80% or less, the QI Department coordinated with the Provider Network Operations Department to educate the provider about the requirements for completing an IHA and SHA. If the Provider continues to fail after education has been provided, then a Corrective Action Plan is issued. The Quality Improvement Committee is provided a report of results and analysis.

Based off the quarterly audit that was conducted in 2021, SHA remains the element with the greatest opportunity for improvements. Physical exams were incomplete often due to the limitation of tele-visits. SCFHP identified provider, member, and system level barriers. Lack of documentation of outreach attempts and provider knowledge on IHA requirements contributes to the provider of being non-compliant. There are limited staff in the clinic to support providers on IHA outreach due to COVID. Members are hesitant to schedule visits with their Providers or do not come in for visits due to COVID. Members who change their PCP within 120 days do not allow enough time for Providers to schedule and conduct IHA visit. Member may have other barriers including getting to an appointment that is outside SCFHP's control.

Providers or Clinic who scored less than 80% were issued letter to educate about IHA Elements and the

importance of completing an IHA visit. Correction Action Plans (CAPs) were not issued from December 1, 2019 to September 30, 2021 due to DHCS' temporarily suspending the requirement to complete an IHA within 120 days for any newly enrolled members within that timeframe. This was lifted October 1, 2021 by DHCS and Providers were advised to review their member roster to identify and outreach members newly enrolled since December 1, 2019 to present who are still currently enrolled who have not received an IHA.

SCFHP runs a report based on claims and encounter data on a monthly basis to identify IHA compliance rates and reports this to the Compliance Dashboard to monitor. The measurement relies on Providers to submit accurate claims and encounter data to identify an IHA was completed. The rate is calculated based on the number of newly-enrolled Medi-Cal members who received an IHA out of the total newly-enrolled Medi-Cal members. Based on the rates each month listed in the table below, the IHA Compliance rates were consistently above 40% in 2021 except for February. These rates are presented to the Quality Improvement Committee. The rates are lower likely due to COVID and members' reluctance to go to the doctor's office for their visits.



Follow-up & Strategies to be considered in future years:

SCFHP continues to promote the importance of completing an IHA and DHCS IHA requirements to its delegates and independent network providers. SCFHP provides a list of new or re-enrolled members each month to Primary Care Providers to help them meet these timelines. Provider Network Operation representatives continues to educate Providers on how to download their member list in the Provider Portal. SCFHP incorporates IHA requirements in the provider packet to educate the provider on the importance of completing an IHA. To help PCPs fulfill the IHA requirements, Santa Clara Family Health Plan provide copies of various professional standards, guidelines, and age-appropriate screening/assessment tools, IHA information in provider newsletters, and on our website. A training manual and presentation was created to educate providers on the requirement and benefit of outreach to their new members. SCFHP annually reviews the IHA Policy and Procedure to incorporate any new changes to improve overall IHA performance.

Quality Improvement (QI) Nurse continues to audit medical records to validate IHA compliance and reports the results to the Quality Improvement Committee. SCFHP follows DHCS established Facility Site Review and Medical Record Review guidelines for scoring of the IHA and SHA. Certified Site Review Nurses and DHCS Master Trainer educates providers on importance of conducting IHA during the audit and

instructions on how to complete an IHA if there are any deficiencies or gaps in knowledge.

Santa Clara Family Health Plan continues to inform members of the availability and importance of an IHA through the Evidence of Coverage (EOC) booklets, which are mailed to each member shortly after enrollment. Santa Clara Family Health Plan also mails a welcome letter to each new member on behalf of our PCPs, which mentions the value of an IHA.

SCFHP initiated a new pilot April 2021 to help School Health Clinics (SHC) with outreach attempts by sending letters to selected members to remind them of the importance and to schedule an IHA visit. The letters for all new members who either selected or were assigned to School Health Clinic were mailed on 4/9/2021. A report listing all members who were mailed a letter was sent to School Health Clinics on 4/12/2021. SCFHP has established a process where letters will be sent around the first of each month with a monthly report to be sent to the School Health Clinic contact to improve IHA visit rates.

F. Health Outcomes Survey (HOS)

SCFHP participates in the Medicare Health Outcomes Survey (HOS) to gather valid and reliable clinically meaningful data that have many uses, such as targeting quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping beneficiaries make informed health care choices; and advancing the science of functional health outcomes measurement.

Each year a random sample of Medicare beneficiaries is drawn and surveyed from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees. In 2021, SCFHP received the 2018 -2020 Cohort 21 performance measurement response rate of 66.5%, with 252 eligible samples and 121 respondents. Compared to HOS follow up response rate of 66.8% the plan's response rate is about the same.

In 2020 the change of survey administration changed due to the impact of the COVID-19 Public Health Emergency (PHE), administration of the 2020 HOS took place from August to November 2020 in accordance with the revised 2020 HOS Program Timeline, in 2021 the survey timeline continued.

The 2021 survey administration used the HOS 3.0 that was implemented in 2015. The HOS 3.0 uses the Veterans RAND 12-Item Health Survey (VR-12) as the core physical and mental health outcomes measures, and the four HEDIS Effectiveness of Care measures, those measures are Management of Urinary Incontinence in Older Adults, Physical Activity in Older Adults, Fall Risk Management, and Osteoporosis Testing in Older Women. Outcomes would be available in Cohort 22 follow up report in 2022.

The trends in Physical Health results and Mental Health results performance was as expected in Cohort 20.

Trends in Physical Health Results over Three Cohorts are as below:

	Percent Better	Percent Same	Percent Worse	Percent Better + Same	Performance Result
2018-2020 Cohort 21	18.91%	51.92%	29.18%	70.82%	As expected (same as national average)

2017-2019 Cohort 20	12.95%	60.40%	26.65%	73.35%	As expected (same as national average)
2016-2018 Cohort 19	15.20%	61.97%	22.83%	77.17%	As Expected (same as national average)

Trends in Mental Health Results over Three Cohorts are as below:

	Percent Better	**Percent Same**	**Percent Worse**	**Percent Better + Same**	**Performance Results**
2018-2020 Cohort 21	19.20%	58.83%	21.97%	78.03%	As expected (same as national average)
2017-2019 Cohort 20	21.62%	61.73%	16.65%	83.35%	As expected (same as national average)
2016-2018 Cohort 19	15.21%	79.93%	10.86%	89.14%	Performed Better

The general health performance in the follow up group decreased 3.2% in the fair or poor condition compared the baseline. This year's result did not see an increase when compared to California overall performance at 1.2% increase and 1.9% increase in HOS total. Comparative physical health performance in slightly worse or much worse compared to baseline, the Plan saw a decrease of 7.6%. Compared to California and HOS total at 3.5% and 4.2% increase. In the comparative mental health performance the plan saw 0.5% decrease when compared the baseline in slightly worse and much worse condition. California increased 6.8% and 6% in HOS total. The category can provide assumption of greater risk in mortality.

	General Health Fair or Poor		**Comparative Physical Slightly Worse or Much Worse**		**Comparative Mental Slightly Worse or Much Worse**	
	Baseline	**Follow Up**	**Baseline**	**Follow Up**	**Baseline**	**Follow Up**
SCFHP	53.8%	49.6%	44.7%	37.1%	25.7%	25.2%
California	30.2%	31.4%	26.5%	30.0%	13.3%	20.1%
HOS Total	22.5%	24.9%	22.6%	26.8%	10.0%	16.0%

The higher percentage of multiple (2 or more) chronic medical conditions table members can indicate the increase risk of the following outcomes: mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests and conflicting medical advice. The plan had very small increase at 0.2% when compared to California and HOS total performance with 1.9% and 2.3% increase.

	Multiple Chronic Medical Conditions	
	Baseline	**Follow Up**
SCFHP	86.2%	86.4%
California	74.1%	76.0%
HOS Total	75.2%	77.5%

The Healthy Days Measures served as indicators of populations with greater risk for disease or injury. In the 14 or more days of poor physical health, mental health, or activity limitations are considered indicative of poor well-being, the plan saw 2.8% decrease compared to the baseline. When compared to slight increased percentage in California and HOS Total performance with 0.5% and 1.0% increase. The plan had 0.4% decreased in 14 or More Days of Poor Mental health while California and HOS Total had slight increase at 0.9% and 1.5% respectively. In the 14 or More Days of Activity Limitations the plan had 0.2% decrease while California had 1% increase and 1.4% increase in HOS Total. The performance can be used to identify beneficiaries in poor health who may have undiagnosed conditions or are having difficulty managing stress or chronic diseases.

	14 or More Days of Poor Physical Health		14 or More Days of Poor Mental health		14 or More Days of Activity Limitations	
	Baseline	**Follow Up**	**Baseline**	**Follow Up**	**Baseline**	**Follow Up**
SCFHP	33.0%	29.2%	11.8%	20.2%	27.5%	27.2%
California	19.6%	20.1%	12.0%	12.9%	14.1%	15.1%
HOS Total	16.9%	17.9%	9.3%	10.8%	11.3%	12.7%

The Body Mass Index (BMI) chart can identify the unhealthy weight range and are associated with increased chronic diseases, and in the case of the underweight, increased mortality for the elderly. The plan has a higher increase in underweight group at 3.9%, when compared to 0.7% increase in California and HOS Total. The percentage of overweight increased 0.6% and in California and HOS total had 1.4% and 1.2% decrease. The obese group decreased 2.2%. Both California and HOS Total had 1.5% and 1.4% decrease.

	Underweight		Overweight		Obese	
	BMI<18.5		**BMI 25 to 29.99**		**BMI > 30**	
	Baseline	**Follow Up**	**Baseline**	**Follow Up**	**Baseline**	**Follow Up**

SCFHP	1.9%	5.8%	31.1%	31.7%	26.2%	24.0%
California	2.5%	3.2%	36.9%	35.5%	25.3%	23.8%
HOS Total	1.6%	2.3%	38.1%	36.9%	31.6%	30.2%

SCFHP identified opportunities for our Cal-Medi-Connect members to reduce health disparities and explore potential programmatic interventions aimed at maintaining or improving the overall health of the population. Quality Department track and trend patient outcomes and experiences of care to address ongoing improvement. Cross-functional departments work closely to implement innovate care management approach. Health education team find extensive variety of resources to enhance patient education and care, offering health classes whose subjects range from physical activity, to wellness program; provide weight loss program; distribute newsletters to discuss topics important to a specific segment of the population and ensure that education is culturally appropriate. The case management team will continue to provide comprehensive care through annual health risk assessment, individual care plan, interdisciplinary care team meeting, and transition of care follow up and complex case management.

III. Safety of Clinical Care

A. FACILITY SITE REVIEW (FSR) & MEDICAL RECORDS REVIEW (MRR)

All contracted SCFHP Primary Care Providers (PCP's) receive Part A Facility Site Review (FSR), Part B Medical Records Review (MRR), and Part C Physical Accessibility Survey (PAR) evaluation every three years. All newly contracted SCFHP PCP's must complete and pass FSR Part A and C before being contracted with the Plan. FSR Part B is completed within 90 days of the effective date. SCFHP PCPs who move office locations are reviewed within 30 days of the date QI is notified of the move.

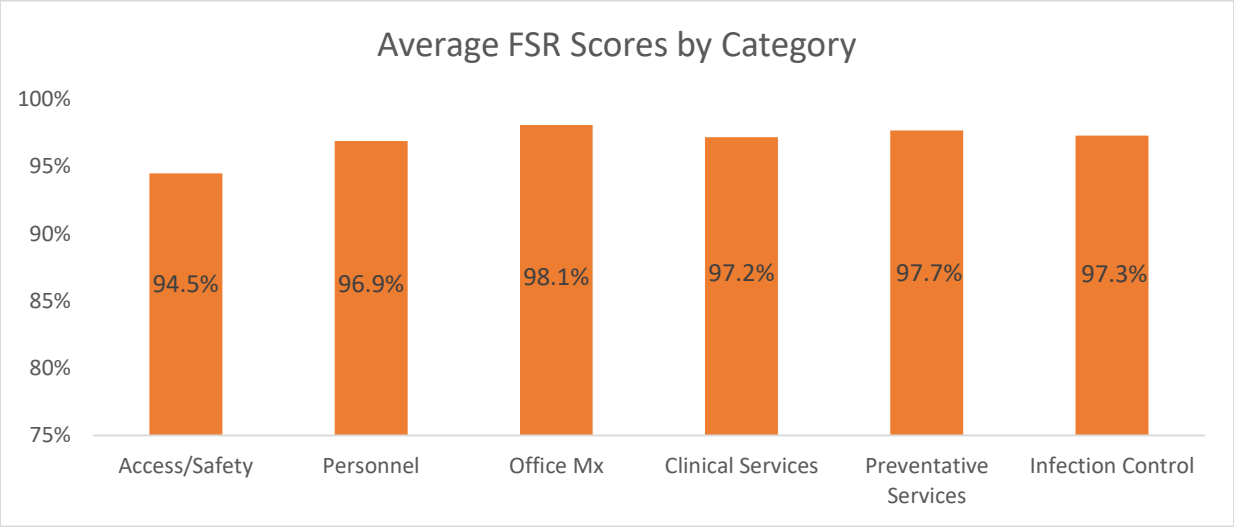
PCPs that score below 80% are monitored more frequently. If critical elements of deficiencies are identified, a score in any section of the site or medical record review below 90%, or there is a deficiency in Pharmacy or Infection Control or an overall score below 90%, then a Corrective Action Plan (CAP) is required to be completed by the providers. SCFHP reviews the sites more frequently when determined necessary based on monitoring, evaluation, or CAP follow-ups needs. CAPs are monitored by QI Nurses.

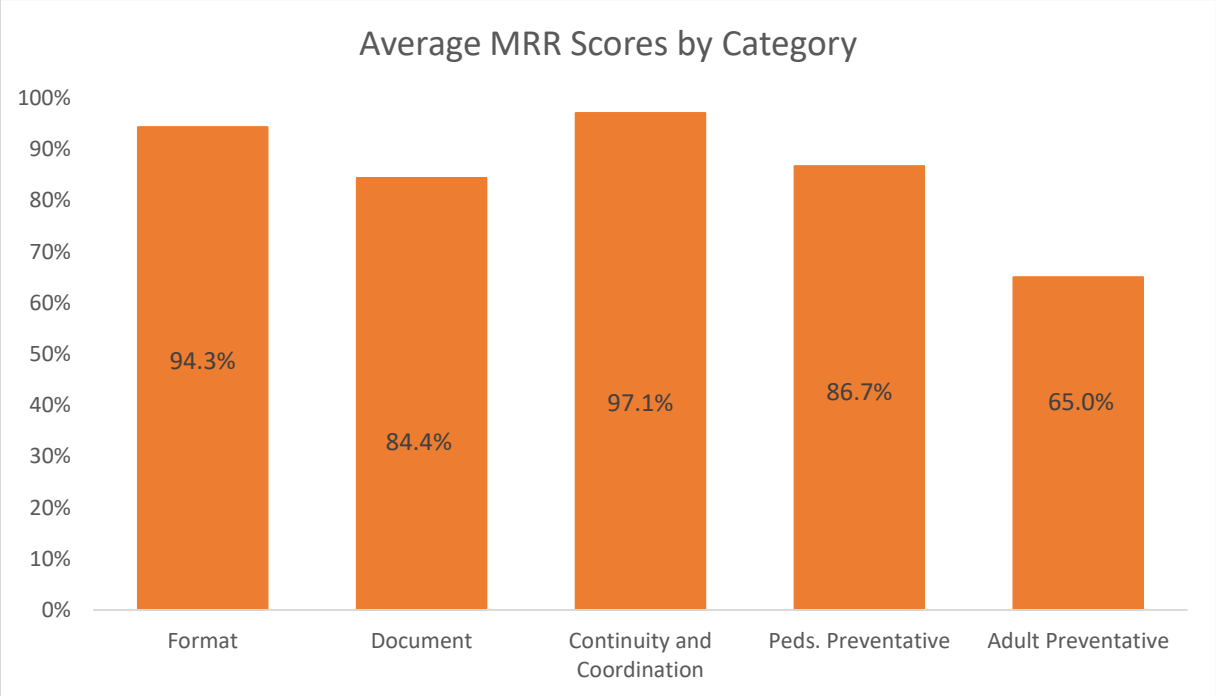
SCFHP works collaboratively with Anthem Blue Cross, on shared primary care provider facilities to minimize duplicated audits and support consistency of reviews in Primary care facilities.

The QI department and DHCS CMT started working on virtual FSRs for providers/offices. DHCS MT and QI Nurses resumed on-site audits starting October 12, 2021. SCFHP and DHCS CMT completed 14 Initial FSRs with 3 CAPs issued, 7 periodic FSRs with 2 CAPs issued, 2 Initial MRR with 2 CAPs issued, 5 Periodic MRR with 3 CAPs issued in 2021. CAPs were issued, monitored, verified, closed and pending closure in 2021. Of the 21 Facility Site Reviews completed in 2021, the average Facility Site Review (FSR) score was 97%. Of the 7 Medical Record Reviews completed in 2021, the average Medical Record Review (MRR) was 87%.

3 PARs were conducted in 2021, one was for a Primary Care Provider (PCP) site and 2 were from High Volume Specialist Site (HVS).

2 providers with exempted passes for FSR and MRR requirements. 2 FSR and MRR corrective action plan issued, monitored, validated, and closed. The facility site review deficiencies were mainly identified among access/safety, personnel and clinical services criteria. The most common medical record review deficiencies were identified among document, adult, and pediatric prevention criteria.





Common Deficiencies identified in Facility Site Review:

- A written policy on referrals are not available
- Lack of Emergency medical supplies and emergency medication
- Blood, other potentially infectious materials, and Regulated Wastes are not appropriately placed in leak proof, labeled containers for collection, handling, processing, storage, transport, or shipping.
- Specialized equipment such as scales, EKG's is not always calibrated.
- No evidence that staff has received training and/or information on different topics such as infection control, biohazard waste handling, child/elder/domestic violence abuse, Patient confidentiality, etc.

Common Deficiencies identified in Adult Medical Record Review:

- Staying Healthy Assessments as well as subsequent Staying Health Assessments are not completed
- TB risk assessments are not always documented
- Advance care directives are not documented in the medical record
- Adult immunizations are not administered
- Vaccine Information Statement documentation is not complete or evidence of publication date is not noted
- Completion of Initial Health Assessment within 120 days of enrollment
- Referral for breast and cervical cancer screening are not documented in the medical record

Common Deficiencies identified in Pediatric Medical Record Review:

- Staying Healthy Assessments as well as subsequent Staying Health Assessments are not completed
- Hearing screenings or vision screenings are not always performed
- Blood lead screening test is not completed
- VIS documentation is not completed

SCFHP collaborated with Anthem Blue Cross to obtain results of site reviews as to not duplicate site reviews of the same providers. There were 17 periodic FSRs and MRRs, 1 initial FSR and 2 initial MRRs performed.

QI nurses continue to work on FSR/MRR/PAR database software for use by reviewers in the office via the web interface. FSR staff attends mandated DHCS Site review workgroup meetings to stay connected with new changes from DHCS. SCFHP published a provider news article on the new FSR and MRR tool in June 2020. The new tool and the guideline are available on the SCFHP's website.

SCFHP contracted with a DHCS Certified Master Trainer (CMT) Consultant to conduct pending site reviews and certified 1 nurse.

DHCS terminated the flexibilities outlined in APL 20-011 effective June 30th, 2021 per EO N-08-21 issued by Governor on June 11th, 2021. Therefore, effective July 1st MCPs were required to begin resumption of these activities and return to standard program operations, policies, and procedures in place before the COVID-19 public health emergency.

B. PROVIDER PREVENTABLE CONDITIONS (PPCs)

SCFHP tracked Provider Preventable Conditions by number of cases each month, number of cases per hospital to see any trends. There were a total 48 cases in 2021: 36 were Medi-Cal and 15 were Medi-Cal-Connect.

Hospital	Number of Cases
EL CAMINO HOSPITAL-MOUNTAIN VIEW CAMPUS	1
GOOD SAMARITAN HOSPITAL	5
KAISER HOSITAL- SANTA CLARA	1
O'CONNOR HOSPITAL	5
PROTECION A LA INFANCIA, A.C. HOSPITAL 'LA LUZ'	1
REGIONAL MEDICAL CENTER OF SAN JOSE	6
ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL, INC	1
ST. LOUISE REGIONAL HOSPITAL	3
SANTA CLARA VALLEY MEDICAL ACUTE CARE HOSPITALS	10
SANTA CLARA VALLEY MEDICAL CENTER REHABILITATION UNITS	3
STANFORD MEDICAL CENTER HOSPITAL	9
UNIVERSITY MEDICAL CENTER	1
WASHINGTON HOSPITAL	1
WHITE BLOSSOM CARE CENTER	1

SCFHP also tracked the count of cases by Provider Preventable Conditions. The top conditions were Catheter-associated urinary tract infection with 41 cases, comprised of 85.42% of 48 cases.

Condition	Number of cases
Catheter-associated urinary tract infection	41
Stage III or IV pressure ulcers	2
Falls/trauma	4
Iatrogenic pneumothorax with venous catheterization	1

QI nurses are to investigate cases as PQI, including but not limited to: wrong surgery/invasive procedure, surgery/invasive procedure on the wrong body part and wrong patient. Out of the 39 PPC cases investigated: 36 cases were closed at a level 1- no quality of care issue identified; 3 cases were closed at a level 0.

C. POTENTIAL QUALITY CARE OF ISSUES (PQI)

The Potential Quality Issue (PQI) is a suspected deviation from the standard performance, clinical care, or outcome of care, which requires further investigation to determine whether the issue is substantiated to quality of care or opportunity for improvement exist.

The goal of the SCFHP PQI process is to identify, address, investigate, report, and resolve any potential quality of care issues (PQI) to ensure that services provided to members meet established professional quality of care standards and improve member outcomes. This includes Critical Incidents (CI) and Provider Preventable Conditions (PPC's).

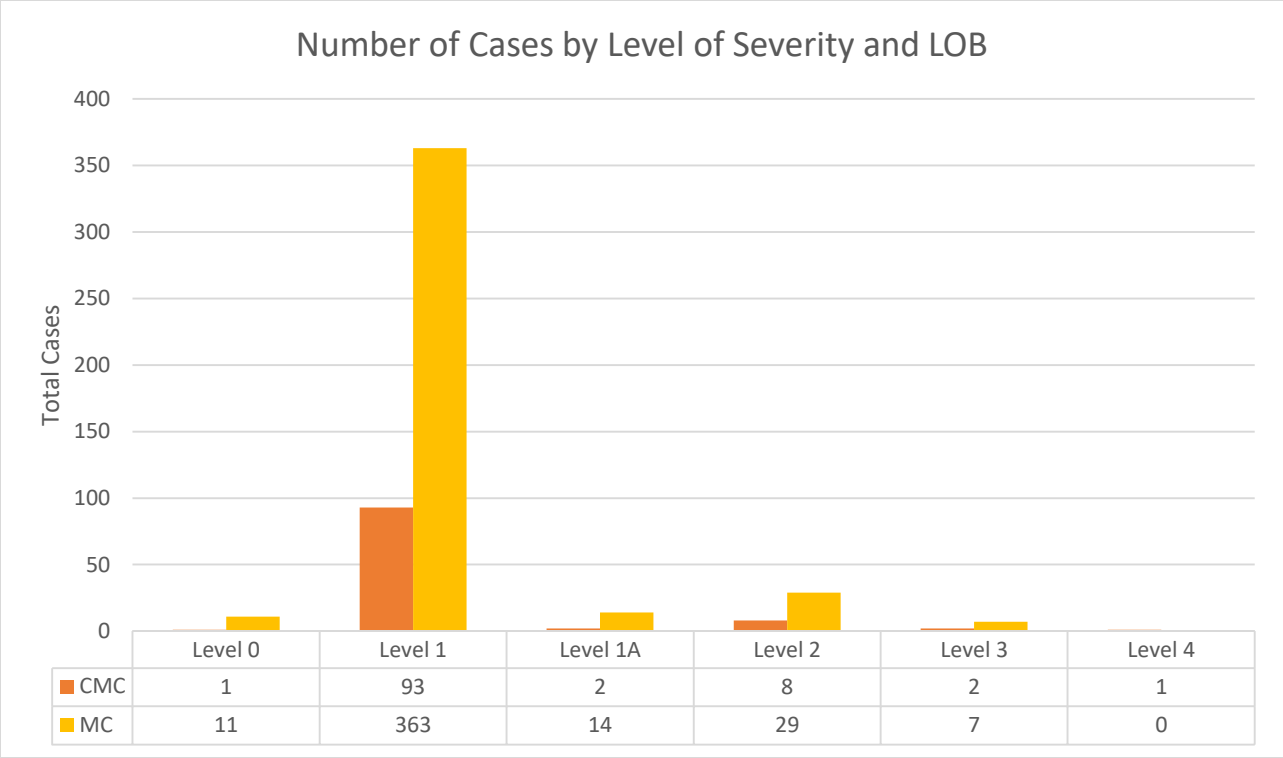
The Grievance and Appeal (G&A) Clinical Specialist reviews PQI referrals and all the grievances to identify PQI. If the referral or grievance is identified as a PQI, the G&A Clinical Specialist will notify QI coordinators to request medical records for investigation. The QI Nurses review each PQI and CI case with Medical Director. QI Nurses provide annual PQI training to all the member-facing departments at the health plan. QI nurses submit quarterly PQI reports to the credentialing and peer review committee. QI nurses also report PQI cases to the health plan's delegate network for re-credentialing purposes. The Medical Director makes the final determination and assigns a severity level to each PQI case.

Description of each severity level:

- Level 0: Not our member/Not our provider/Not a covered benefit
- Level 1: No quality of care issue identified. Quality of Care is Acceptable
- Level 1A: No quality of care issue identified (ie., Quality of Service issue)
- Level 2: Opportunity for Improvement; No adverse occurrence
- Level 3: Opportunity for Improvement; No adverse occurrence
- Level 4: Immediate Jeopardy

SCFHP investigated a total of 531 cases in 2021. Of those 531 cases closed, 12 cases were closed at a level 0; 456 cases closed at a level 1; 16 cases closed at a level 1A; 37 cases closed at a level 2; 9 cases closed at a level 3; and 1 case was closed at a level 4. However, the level 4 case was recently downgraded to a level 3 in Quarter 1 of 2022 after further investigation.

A total of 16 PQI notification letters were issued. A total of 6 corrective action plans (CAPs) were issued, monitored, validated, and closed in 2021. Out of the 6 CAPS issued: 2 were against Acute Hospitals; 2 against Skilled Nursing Facility (SNF); 1 against a Long Term Care Facility (LTC); 1 against a Transportation Vendor; and 1 against a Home Health Agency.



	Level 0	Level 1	Level 1A	Level 2	Level 3	Level 4
CMC	1	93	2	8	2	1
MC	11	363	14	29	7	0

There was a decrease in the number of PQIs in 2021 compared to 2020. The majority of PQIs reviewed were unsubstantiated or closed as level 1-Quality of Care is Acceptable. The health plan defined the process to temporarily hold PCP auto-assignment based on the PQI cases closed at levels 2, 3, and 4 with CAP. Two PCP's auto-assignments were paused in 2021 by SCFHP.

The plan identified 10 PQIs with Critical Incidents in 2021. Of those PQIs identified as Critical Incidents, 4 involved non-emergency medical transportation/cab vendors, 3 occurred at a skilled nursing facility (SNF), and 3 involved providers. Critical incidents are identified as high-priority cases.

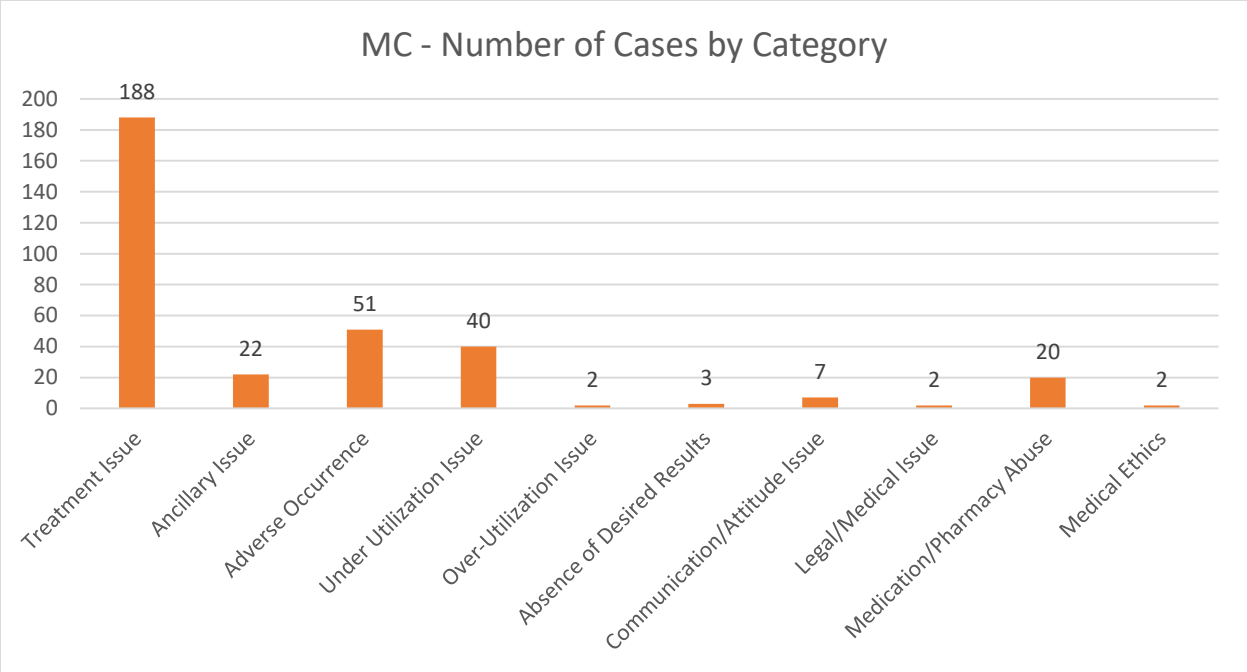
The 3 Critical Incident cases against the SNFs were reported to the California Department of Public Health (CDPH) Licensing and Certification office in San Jose for investigation. Two Critical Incident cases against providers were closed at a level 2 and PQI notification letters were sent. One out of the 3 Critical Incident cases against the SNFs was closed at a level 3 with a corrective action plan requesting the facility's policies and procedures in regards to carrying out physician orders (i.e., written, telephone, etc.). One transportation-related critical incident PQI case was closed at a level 3 with a CAP requesting the vendor's policy and procedures in regards to operational vehicle and equipment inspection, basic operations and maneuvering, boarding and aligning passengers, safety and operation of wheelchair/gurney and other special equipment along with driving condition, passenger assistance and securement. One Critical incident PQI case identified in Quarter 4 is still currently under investigation. The following severity levels were assigned to the identified Critical Incident cases:

Level 0- 0
Level 1- 5; No CAP
Level 2-2; PQI Notification Letter sent

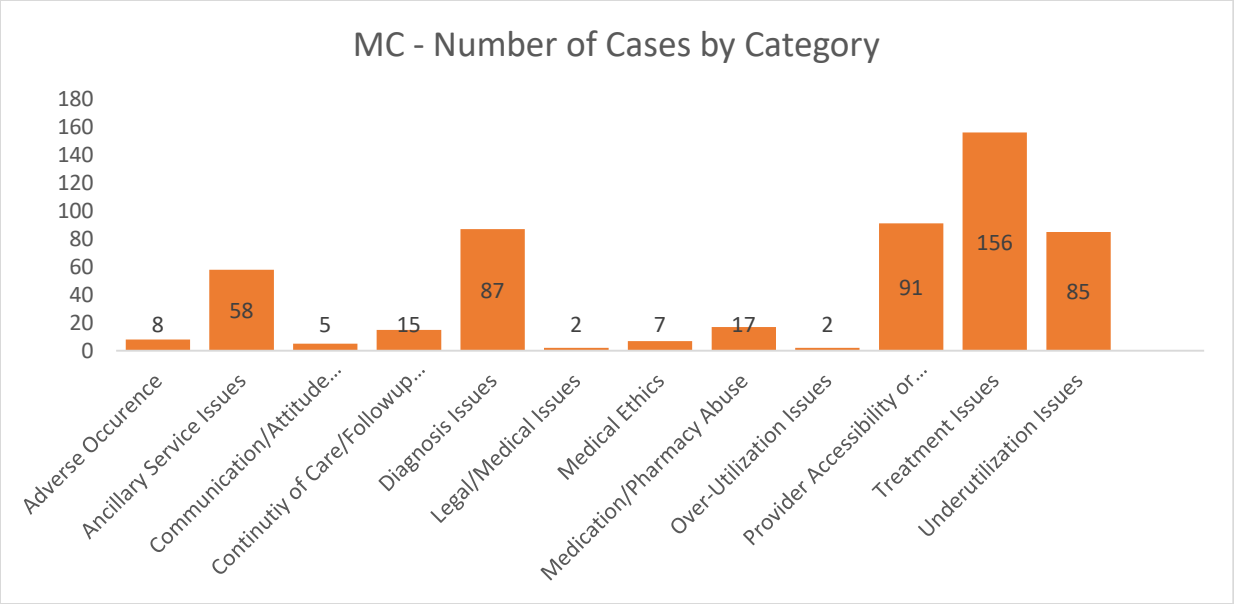
Level 3- 2; CAPs sent
Level 4- 0

QI Nurses assign a quality indicator to each PQI cases to determine the type of PQI.

The chart below shows the number of Medi-Cal PQIs by category. Treatment, adverse occurrence, and underutilization-related PQIs were mostly identified among the Medi-Cal LOB.



The chart below showed the number of 3 represents the number of Cal MediConnect PQIs by category. The most common type of PQI among Cal- MediConnect LOB were treatment issues, provider accessibility, and diagnosis issues.



SCFHP continues to monitor the numbers and categories of PQI to improve our member safety and satisfaction.

IV. QUALITY OF SERVICE

A. ACCESS & AVAILABILITY

SCFHP makes every effort to ensure that its members receive timely access to appointments, medical services and after-hours care. When appointment and after-hours access is not being met, an analysis of findings is conducted and a corrective action plan is required (when applicable). Access reporting monitoring activities are reviewed in the Timely Access & Availability (TAA) Work Group and Quality Improvement Committee (QIC). The Work Group is represented by the following departments: Provider Network Operations, Quality, Utilization Management, Customer Service, Behavioral Health, Compliance, Grievance/Appeals, Contracting, and Marketing. The TAA work group and QIC reviews, evaluates, and makes recommendations as needed.

Appointment Standards

Provider Type	Urgent Appointment	Non-Urgent/ Routine Appointment	Non-Life Threatening Appointment	Follow-up Care
Primary Care Providers (All)	48 hours	10-days	NA	NA
Specialists (All)	96 hours	15-days	NA	NA
BH/MH – (All)	48 hours	10-days	6-hours	30-days

Results

PCP Urgent Care Appointment within 48-hours

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	PCP (N=725)	268	387	158	59%	90%	No
2021	PCP – Telehealth (N=61)	36	23	33	92%	90%	Yes

PCP Non-Urgent/Routine Appointment within 10-days

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	PCP (N=725)	278	92	231	83%	90%	No
2021	PCP – Telehealth (N=61)	38	23	33	87%	90%	No

Specialists Urgent Care Appointment within 96 hours

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Specialists (N=286)	52	227	21	40%	90%	No
2021	Specialists Telehealth (N=47)	11	19	8	73%	90%	No

Specialists Non-Urgent Care Appointment within 15-days

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Specialists (N=286)	59	227	34	58%	90%	No
2021	Specialists Telehealth (N=47)	11	19	7	64%	90%	No

Psychiatry Urgent Care Appointment within 48-hours

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Psychiatrists (N=178)	6	171	3	50%	90%	No
2021	Psychiatrists Telehealth (N=9)	0	9	0	0%	90%	No

Psychiatry Non-Urgent/Routine Care Appointment within 10-days

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Psychiatrists (N=178)	7	171	5	71%	90%	No
2021	Psychiatrists Telehealth (N=9)	1	8	1	100%	90%	Yes

Non-Physician Mental Health Urgent Appointment within 48-hours

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Non-Physician Mental Health(N=125)	11	113	7	70%	90%	No
2021	Non-Physician Mental Health Telehealth (N=21)	5	16	5	100%	90%	Yes

Non-Physician Mental Health Non-Urgent/Routine Appointment within 10-days

Year	Provider Type	# Responded	# Refused/Non-Response	# Providers Meet AA	Rate of Compliance	Goal 90%	Goal Met Yes/No
2021	Non-Physician Mental Health(N=125)	12	1	7	64%	90%	No
2021	Non-Physician Mental Health Telehealth (N=21)	7	16	7	100%	90%	Yes

SCFHP administers Cal MediConnect (CMC); a dual eligible plan for members who qualify for both Medicare and Medi-Cal.

CMC enrollees receives Medicare and Medi-Cal benefits from one plan, such as, medical care, prescription medications, mental/behavioral health care, long-term services and supports (LTSS), and connection to social services. Other important benefits include vision care, transportation and hearing tests and aids.

Medi-Cal enrollees receive accessible, and cost-effective health care through managed care delivery systems. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

At least annually, SCFHP conducts a quantitative analysis against availability standards and a qualitative analysis on performance. SCFHP's performance measures are used to assess provider availability for primary care, high volume specialist(s), high impact specialist(s), and high volume behavioral health providers. SCFHP's goal is to maintain an adequate network and to monitor how effectively the network meets the needs and preferences of its members.

For line of business CMC, SCFHP identifies at least three (3) high-volume specialists (at minimum to include gynecology), two (2) high-volume behavioral health providers and one (1) high impact provider (oncology), all of which are included in this assessment. Encounter data collection to identify high volume/impact providers is through QNXT; a claims management system. SCFHP's Internal Systems & Technology (IS&T) department extracts encounter data for a twelve (12) month period. The reports are used to identify high volume/impact specialists and behavioral health providers by highest total of unique members seen. Network Access (Geo Access) reports are generated through the Quest Analytics system and are used to assess if provider availability meets SCFHP standards.

Provider to Member Ratio Standards

Primary Care Provider

Provider Type (PCP)	Measure	Standard	Performance Goal
Family/General Practice	Family/General Provider to Member	1:87	90%
Internal Medicine (IM)	IM Provider to Member	1:87	90%

Table II. High Volume / High Impact Specialists

Provider Type	Measure:	Standard	Performance Goal
Cardiology (HVS)	Cardiology Provider to Member	1:300	90%
Gynecology (HVS)	Gynecology Provider to Member	1:1200	90%
Ophthalmology (HVS)	Ophthalmology Provider to Member	1:300	90%
Hematology/Oncology (HIS)	Oncology Provider to Member	1:400	90%

Table III: Behavioral Health Provider

Provider Type	Measure:	Standard	Performance Goal
Psychiatry (HVBH)	Psychiatry Provider to Member	1:600	90%
Licensed Clinical Social Worker (LCSW) (HVBH)	LCSW Provider to Member	1:600	90%
Marriage/Family Therapy (LCMFT) (HVBH)	LCMFT to Member	1:600	90%

Results

Provider Type	Provider #	Member #	Standard	Result	Goal	Met/Not Met
Primary Care Provider						
Family/General Practice	258	10,148	1:87	1:39	90%	Met
Internal Medicine	259	10,148	1:87	1:39	90%	Met
Total (PCP's combined)	517	10,148	1:87	1:20	90%	Met

High Volume Specialists						
Cardiology	125	10,148	1:300	1:81	90%	Met
Gynecology	245	10,148	1:1200	1:41	90%	Met
Ophthalmology	190	10,148	1:300	1:53	90%	Met
High Impact Specialist						
Hematology - Oncology	90	10,148	1:400	1:113	90%	Met
High Volume Behavioral Health Providers						
Psychiatry	151	10,148	1:600	1:67	90%	Met
Marriage/Family Therapy	17	10,148	1:600	1:597	90%	Met
Clinical Social Worker	48	10,148	1:600	1:211	90%	Met

Maximum Tine and Distance Standards

Primary Care Provider

Provider Type	Measure: Driving Time and Distance	Performance Goal
Family/General Practice	10 minutes and 5 miles	90%
Internal Medicine	10 minutes and 5 miles	90%

Table II: High Volume / High Impact Specialists

Provider Type	Measure: Driving Time and Distance	Performance Goal
Cardiology	20 minutes and 10 miles	90%
Gynecology	30 minutes and 15 miles	90%
Ophthalmology	20 minutes and 10 miles	90%
Hematology/Oncology	20 minutes and 10 miles	90%

Table III: Behavioral Health Provider

Provider Type	Measure: Driving Time and Distance	Performance Goal
Psychiatry	20 minutes and 10 miles	90%
Licensed Clinical Social Worker (LCSW)	20 minutes and 10 miles	90%
Marriage/Family Therapy (LCMFT)	20 minutes and 10 miles	90%

*SCFHP follows HSD maximum driving time/distance standards published via the MMPHSD Criteria Reference Table and LCSW's and LCMFT's are not included, thus the Plan uses Medicaid standards for these provider types.

Results

Maximum Driving Time & Distance (MTD)

Provider Type	Members with Access	Members without Access	Standard (Time and Distance)	% of Members with Access	*Goal	Met/Not Met
Primary Care (PCP)	10,088	42	10 min and 5	99.5%	90%	Met
Cardiology	10,060	70	20 min and 10	99.3%	90%	Met
Gynecology	10,130	0	30 min and 15	100%	90%	Met
Ophthalmology	9,977	153	20 min and 10	98.5%	90%	Met

Hematology -	9,923	207	20 min and 10	98.0%	90%	Met
Psychiatry	10,130	0	20 min and 10	100%	90%	Met
Marriage/Family	9,256	878	20 min and 10	91.4%	90%	Met
Clinical Social	9,432	702	20 min and 10	93.1%	90%	Met

***Goal:** 90% of members will have access

For line of business MC, SCFHP follows the annual network certification procedure.

V. MEMBER EXPERIENCE

A. CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

Medi-Cal

The NCQA HEDIS Consumer Assessment of Healthcare Providers & Systems (CAHPS) 5.0H Child and Adult Medicaid survey follows the DHCS direction of a 2-year cycle. The last CAHPS was conducted in MY2020, and the result was released in 2021.

Adult Medicaid Survey's total response rate is 18.6%.

CAHPS 5.0 Adult Medicaid Health Plan Survey

Measure	Rate (8+9+10)	Rate (9+10)
Rating of Health Plan	71.18%	53.31%
Rating of All Health Care	79.8%	58.59%
Rating of Personal Doctor	83.14%	66.67%%
Rating of Specialist Seen Most Often	83.47%	71.9%
Measure	**Rate (Always)**	**Rate (Always + Usually)**
Getting Needed Care	47.13%	77.13%
Getting Care Quickly	44.36%	70.57%
How Well Doctors Communicate	69.2%	89.2%
Customer Service	63.02%	90.43%

Child Medicaid Survey's total response rate is 21.87%

CAHPS 5.0 Child Medicaid Health Plan Survey

Measure	Rate (8+9+10)	Rate (9+10)
Rating of Health Plan	88.4%	72.85%
Rating of All Health Care	91.11%	74.44%
Rating of Personal Doctor	91.1%	76.26%
Rating of Specialist Seen Most Often	NA	NA
Measure	**Rate (Always)**	**Rate (Always + Usually)**
Getting Needed Care	51.94%	84.62%
Getting Care Quickly	61.38%	79.89%
How Well Doctors Communicate	72.92%	91.1%
Customer Service	60.76%	86.92%

SCFHP continues to review the results of CAHPS 5.0 Medicaid survey for both children and adult and aim at continuous improvement. In 2021, SCFHP developed customer service education and up to date Medi-Cal call handling. Utilize marketing material inform our members regarding access and availability during the Covid-19 public health emergency. Many routine visits and non-elective procedures were affected by Covid-19 public health emergency, SCFHP continued to provide customer service and transportation arrangements for our members to ensure the quality and comprehensive care was provided. SCFHP worked on developing disaster management plan to ensure the continuous care was provided in a timely matter. The next Medicaid CAHPS survey will be conducted in 2023.

Cal Medi-Connect

SCFHP utilizes Consumer Assessment of Healthcare Providers & Systems (CAHPS) results to improve member satisfaction and use results to compare to Medicare Medicaid Plan's (MMP) National Data Benchmark average scores in all categories to reach health plan improvement and increase member satisfaction annually.

In 2021, the response rate was 33.5%, a 4.3% increase over the prior year. 27.4% of surveys were completed by mail and 5.9% were completed by phone call. In 2021, data submission to CMS resumed. Overall there were no significant changes compared to 2020. However there were moderate improvements and the gaps compared to 2019 results were closed in the following areas: Rating of Health Plan and Rating of Health Care Quality. The ease of filling prescriptions by mail showed a 5 point increase between 2019 and 2021.

Below is the rate of each survey measure in 2021:

Measure	Rate
Getting Care Easily	77.4%
Getting Care Quickly	79.2%
Rating of Primary Care Doctor	67.1%
Rating of Specialists	65.0%
Rating of Care	50.6%
Coordination of Care	87.1%
Rating of Health Plan	59.9%

SCFHP had the highest increase year over year in the Getting Care Quickly measure, improving from 67.7% in 2020 to 79.2% in 2021.

The top three performing measures were the Coordination of Care, Getting Care Quickly, and Getting Care Easily measures. The lowest three performing measures were the Rating of Care, Rating of Health Plan, and Rating of Specialists measures.

SCFHP's response rate increased in 2021 to 33.5%, the highest response rate since the plan conducted the first CAHPS survey in 2016. The plan continued the implementation of 2 new languages (Chinese and Vietnamese) for the survey. The number of surveys completed in Chinese continued to grow in 2021. The Chinese survey rate increased from 0.65% in 2019 to 11.07% in 2021. The plan will continue to use this opportunity to improve response rates. There were 33 survey language barriers in 2021, which was less than the 2019 and 2018 surveys with 55 and 116 barriers reported, respectively. The plan will look into potentially adding Tagalog as an additional language.

SCFHP saw improvement projects implemented successfully in 2020 and 2021 with the focus of improving customer service, mainly targeting Question 37 of the survey. After making health plan forms easier to fill, the score improved from 3.56 in 2019 to 3.68 in 2021. A successful marketing campaign also increased the overall response rate to 33.5%.

SCFHP is looking into opportunities to stratify reporting on provider groups. The stratified provider groups will provide better understanding for the plan to better work with our network partners. This will allow the plan to provide the best care to our members through provider education and have our provider network operations team develop strategies with our providers on providing timely access to care and getting needed care in time. SCFHP is working on developing enhanced customer service training and education to ensure the customer service representatives have all the tools to provide the information requested by members and explain the information clearly for members to understand. SCFHP will also work on primary care physician (PCP) panel review to ensure the loading for PCPs are manageable.

B. GRIEVANCES & APPEALS (G&A)

SCFHP's goal is to increase member satisfaction by addressing member grievances within mandated timeliness. Appeal and grievance data is reported on the company compliance dashboard and offers ongoing monitoring to rapidly identify variances and address the variances in a timely manner. SCFHP's

G&A Clinical Specialist also conducts expedited review for any imminent and serious threat to health including but not limited severe pain, or potential loss of life, limb, or major body function for Medi-Cal line of business.

A total of 5,613 grievances and appeals were received in 2021 (1,411 grievances and 698 appeals from CMC and 2,401 grievances and 1,103 appeals from Medi-Cal). The cases are classified in 3 categories: Access, Quality of Care, and Quality of Service.

Medi-Cal

SCFHP monitors Medi-Cal grievances by category and subcategory from medical and pharmacy grievances.

Category	Medical Grievance	Pharmacy Grievance	Total	Percentage
Quality of Service	1,150	32	1,182	49.23%
Access	621	1	622	25.91%
Quality of Care	364	1	365	15.20%
Referral	108	0	108	4.50%
Compliance	59	0	59	2.46%
Enrollment/Disenrollment	27	3	30	1.25%
Other	20	0	20	0.83%
Language Access	8	0	8	0.33%
Plan Benefits	5	0	5	0.21%
Marketing	2	0	2	0.08%
Grand Total	2,364	37	2,401	100%

Transportation service (non-medical transportation - NMT) was the top subcategory for all medical grievances under quality of service in which comprised of 28% (350 cases). It is consistently the highest subcategory. SCFHP meets with the transportation vendor regularly to determine the specific solutions to decrease overall grievances.

Timely access to primary care provider and specialist were the highest in Access category with 190 cases and 176 cases respectively. In 2021, appointment availability and timely access was due to the COVID-19 pandemic.

Third top category of medical grievances quality of care received the most grievance on inappropriate provider care which comprised of 10% of all grievances (243 cases). That also the most referred cases for PQI.

All cases are reviewed and determined whether required Potential Quality of Care review. Some cases could be withdrawn or had one or more related cases which PQI was reviewed on the “mother case”. 1633 cases (80.17%) were resolved in favor member and 6 cases were partially resolved in favor of member. 172 cases were resolved in favor of plan. 165 cases and 56 cases were withdrawn and dismissed respectively. And 5 cases were closed.

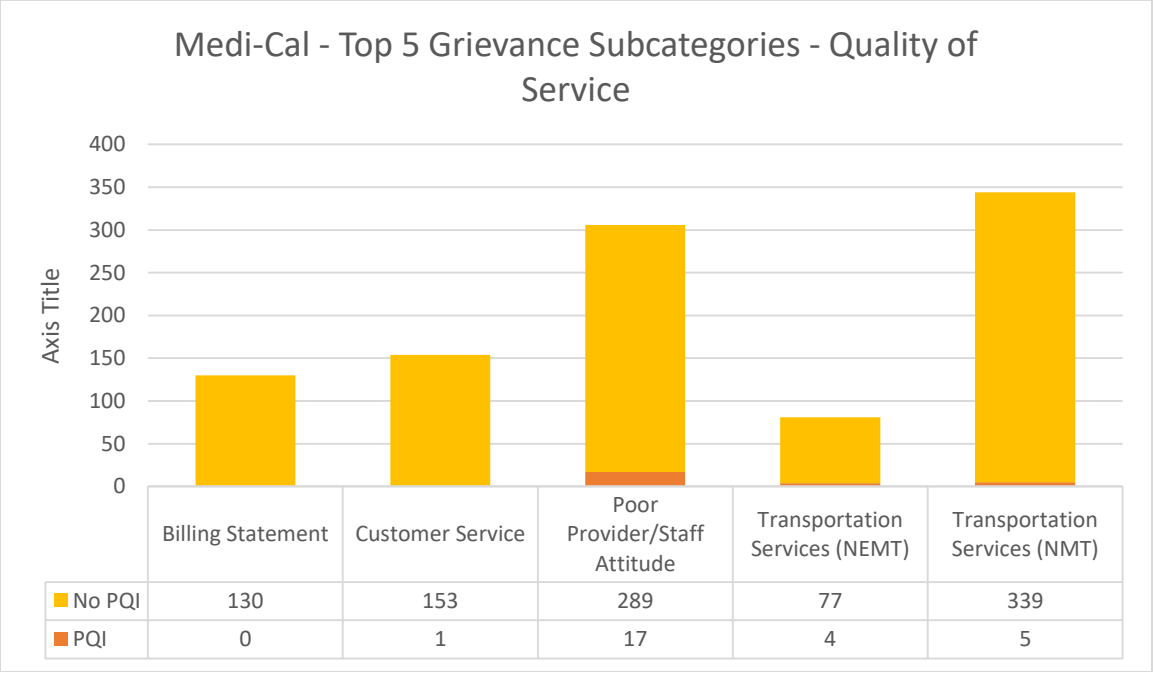
SCFHP tracks and trends all member appeals for each of the five categories including: Authorization – covered service, Authorization – medical necessity, Continuity of Care, Covered Service, and Medical Necessity. The data below representative of total 1,103 member appeals in 2021.

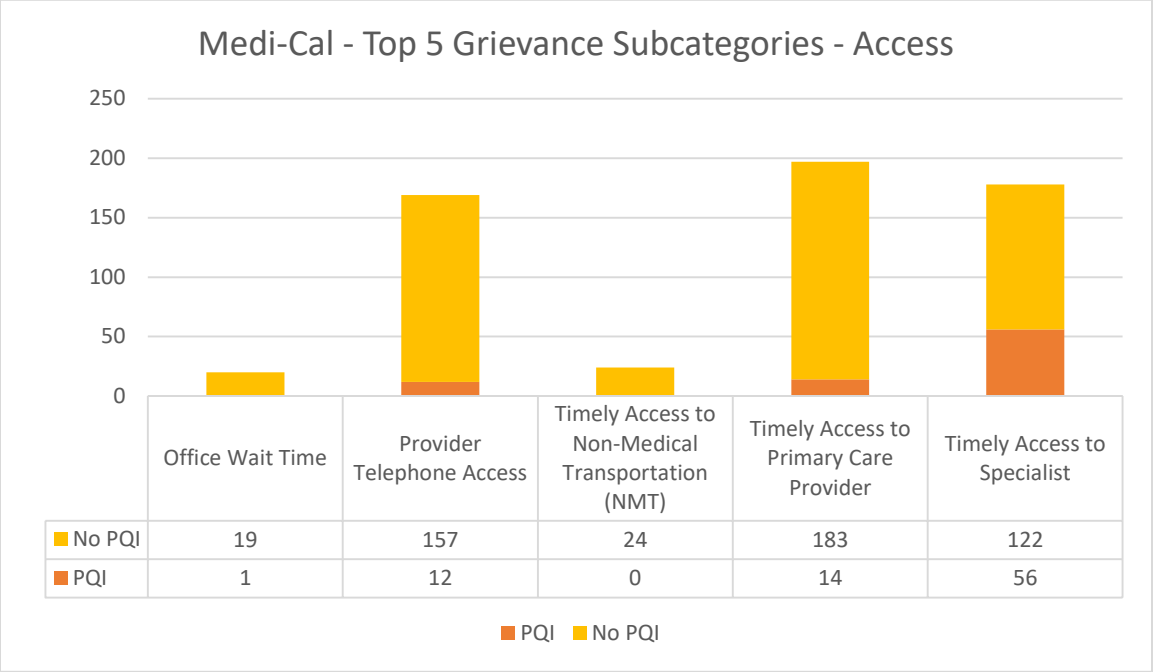
Case Type	Category Name	Grand Total

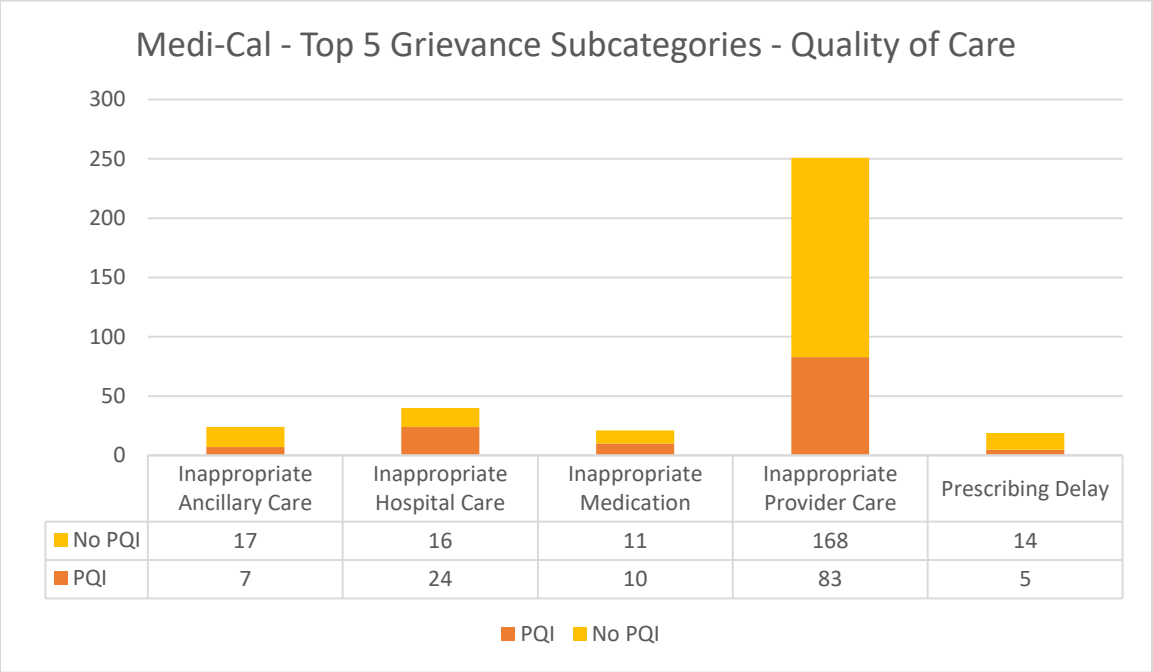
Medi-Cal Pre Service Pharmacy Appeal	Authorization (Medical Necessity)	474
	Authorization (Covered Service)	45
Pre Service Pharmacy Appeal		***519***
Medi-Cal Pre Service Medical Appeal	Authorization (Medical Necessity)	377
	Authorization (Covered Service)	164
	Continuity of Care	1
Pre Service Medical Appeal		***542***
Medi-Cal Post Service Medical Appeal	Medical Necessity	25
	Covered Service	14
	Direct Member Reimbursement Appeal	1
Post Service Medical Appeal		***40***
Medi-Cal Post Service Pharmacy Appeal	Medical Necessity	2
Post Service Pharmacy Appeal		***5***
Grand Total		**1,103**

262 cases were overturn, 8 were partially favorable, 691 were uphold, and 15 were withdrawn by Plan/Medical Direction Disposition.

Case Status Name	Overturn	Partially Favorable	Uphold	Withdrawn	Other	Grand Total
Resolved in Favor of Plan			762		11	773
Resolved in Favor of Member	266	2	2		2	272
Dismissed					43	43
Partially Resolved in Favor of Member		15				15
Grand Total	**266**	**17**	**764**		**56**	**1,103**







Cal Medi-Connect (CMC)

SCFHP monitored CMC grievances by category and subcategory from Part C and Part D grievances.

Grievance Category	Part C	Part D	Grand Total	Percentage
Quality of Service	875	29	904	64.07%
Access	186	3	189	13.39%

Quality of Care	176	11	187	13.25%
Compliance	47	3	50	3.54%
Plan Benefits	15	9	24	1.70%
Service Authorization and Plan Level Appeals Process	24	0	24	1.70%
Other	13	2	15	1.06%
Enrollment/Disenrollment Coverage Determination/Redetermination Process	7	0	7	0.50%
Language Access	4	0	4	0.28%
Marketing	4	0	4	0.28%
Coverage Determination/Redetermination Process	0	2	2	0.14%
Expedited	1	0	1	0.07%
Grand Total	1,352	59	1,411	100%

Balance Billing Statement was the top subcategory for all Part C & D grievances under quality of service in which comprised of 27.42% (387 cases). Same as Medi-Cal, Transportation service (NMT) was also on the top subcategory for Part C & D grievances under quality of service in which comprised of 12.97% (183 cases).

The third top subcategory was Inappropriate Provider Care under the category of Quality of Care. There were total 124 cases, 117 from Part C, and 7 from Part D.

All cases are reviewed and determined whether required Potential Quality of Care review. 1,095 cases (89.39%) were resolved in favor member and 7 cases were partially resolved in favor of member. 28 cases were resolved in favor of plan. 91 cases and 2 cases were withdrawn and dismissed respectively. Two cases were closed.

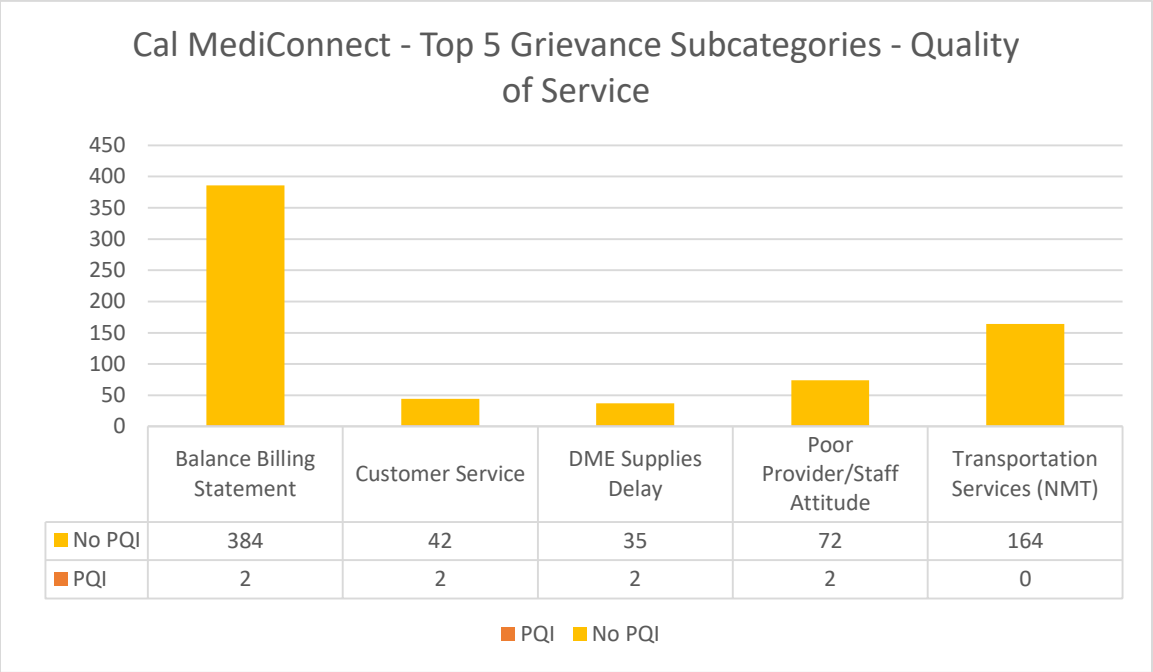
SCFHP tracks and trends all member appeals for each of the five categories: including Post Services and Pre-Services for Part B, C and D. The data below representative of total 698 member appeals in 2021.

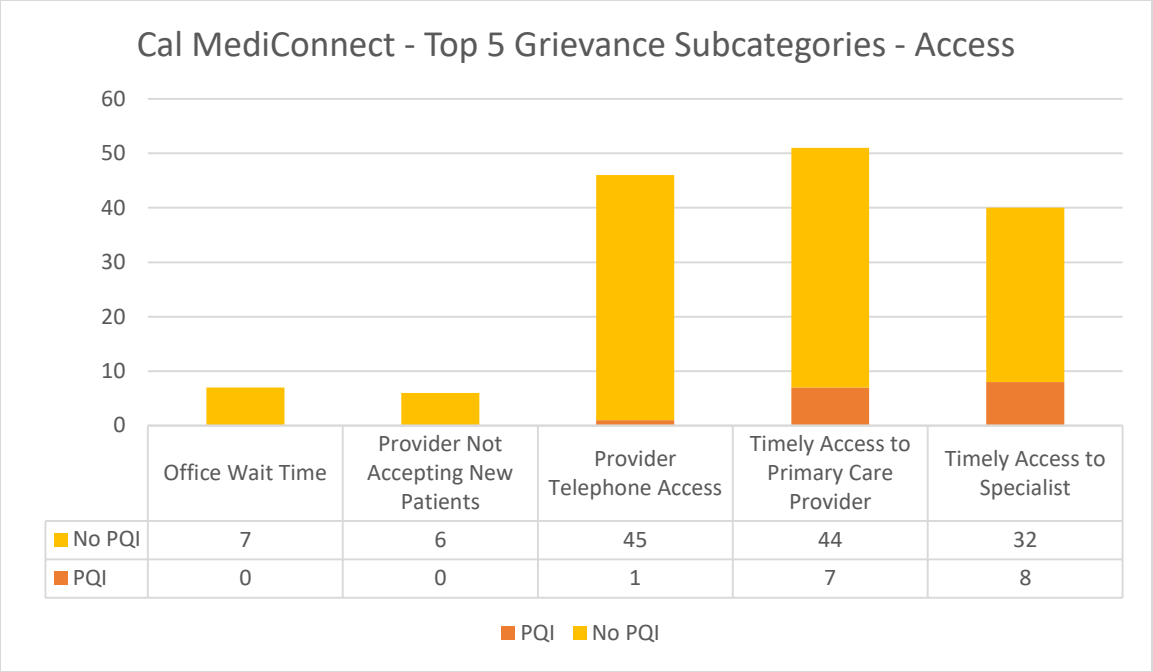
Appeal Case Type	Category Name	Grand Total
Cal Medi-Connect Post Service Part C		***331***
	Post-Service Reconsideration (Claims)	331
Cal MediConnect Post Service Part D		***12***
	Direct Member Reimbursement Redetermination	3
	Post-Service Redetermination (Claim)	9
Cal MediConnect Pre-Service Part C		***213***
	Expedited	19
	Pre-Service Reconsideration (Authorization)	194
Cal MediConnect Pre-Service Part D		***142***
	Expedited	31
	Pre-Service Reconsideration (Authorization)	111

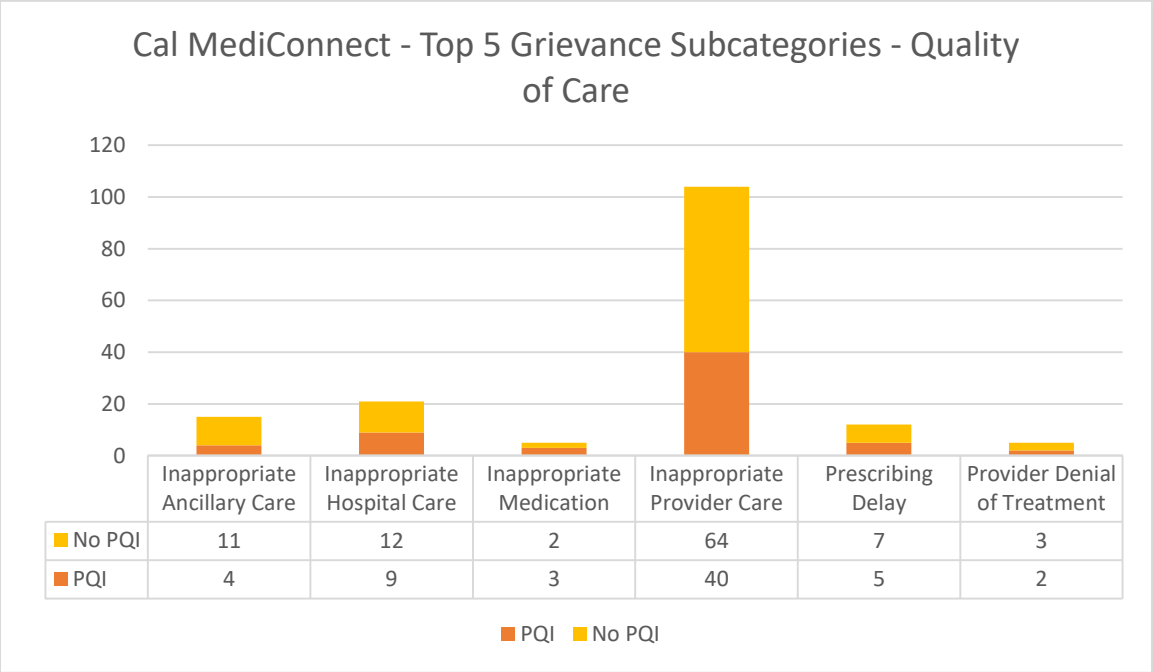
Grand Total		**698**

328 cases were overturn, and 211 were uphold by Plan/Medical Direction Disposition.

Case Status	Overturn	Uphold	Other	Grand Total
Resolved in Favor of Member	325	4	48	377
Dismissed			14	14
Resolved in Favor of Plan	1	206	15	222
Withdrawn	2	1	82	85
Grand Total	**328**	**211**	**159**	**698**







G&A management provides daily review of oversight monitoring reports to flag staff for potential untimely cases; Regular monitoring of company holiday schedule and ensure proper holiday coverage; provide reminders to staff about the upcoming holiday and promote compliance on their cases prior to departing for the scheduled holidays. Refresher training is also provided to staff on notification requirements for expedited grievance and appeal cases. SCFHP always seeks to identify opportunities to enhance member experience by identifying sources of abrasion to resolve grievances and appeals in a timely manner.

VI. CONCLUSION

In summary, SCFHP was able to complete Quality Improvement Interventions as planned in Quality Improvement Work Plan.

The COVID-19 pandemic has reflected a number of strengths of the plan. The collaboration efforts and dedication of leading by Quality Department and other departments, including but not limited to: Grievance & Appeals, Pharmacy, Medical Management, Provider Network continued to focus on providing best possible quality clinical care and safety of care services to our Medi-Cal and Medi-Connect members in Santa Clara County. Besides, plan has good relationship with provider networks to maintain coordination of care and enhance data collection and sharing process. Plan continued to strive and minimize the impact of our quality services in 2022.

Plan will follow the analysis, identify barriers, and track and trend data in 2020-2021 to develop the 2022 Quality Improvement Work Plan and obtain approval from Quality Improvement Committee (QIC) in April 2022.

Santa Clara Family Health Plan™

Pharmacy Benefit Information Analysis

April 12, 2022

SANTA CLARA FAMILY HEALTH PLAN

ME 5C Pharmacy Benefit Information: 2022 Accuracy and Quality Analysis (Web)

I: Overview

Pharmacy benefits and pharmaceutical costs are of concern to all members with any chronic or acute condition treatment. Santa Clara Family Health Plan (SCFHP) has a responsibility to provide accurate, quality information on pharmacy benefits to Cal MediConnect (CMC) members through the website.

In an effort to make this information readily available, the website allows the member to self - serve and find information on drugs, coverage, cost and effectiveness. The member may also obtain this information from Customer Service or the Pharmacy Department.

Pharmaceutical benefits and drugs change periodically throughout the year; therefore, SCFHP has an obligation to be sure the information displayed on the web site is accurate and current. SCFHP audits pharmacy information annually to identify any opportunities to improve pharmacy benefit interactions with the members.

II: Methodology: Web

Annually, Santa Clara Family Health Plan audits the information on the website that is available to CMC members. The auditor randomly selects a drug in each of the 4 formulary tiers, one excluded drug, and one newly added drug (6 total). The selected drugs are tested through 5 test members at each LIS levels from 0 to 4. There was no LIS 4 member at SCFHP for this audit, therefore, LIS 4 was excluded. The selected drugs are tested through 4 test members at each LIS levels from 0 to 3 instead.

- The drugs are checked for accurate reflection of financial responsibility per LIS level (copays).
- The drugs are checked for availability of a generic substitution.
- For each test member, pharmacy search is conducted for 3 different types of pharmacies (choice 90 retail, long term care, home infusion) to locate an in-network pharmacy.
- A pharmacy proximity search is conducted based on 3 random zip codes in Santa Clara County.
- For the exception request validation, 3 actual members' completed coverage determinations are audited to make sure MedImpact was able to receive the requests and all the fields populate correctly.

The audit is performed on an annual basis by collecting data on the quality and accuracy of the pharmacy benefit information (see Appendix A for Audit Sheet).

Definitions

Accuracy: Information provided is correct.

Quality: Information is understandable to the member.

Goal:

Accuracy: 100%

Quality: 100%

III: Data

Table 1: Accuracy of Pharmacy Benefit Information on the Website: Information is correct and members can access in one session

Measure	Total sample	Accuracy Goal Met	% Goal Accuracy Goal Met
1. Determine financial responsibility for a drug, based on pharmacy benefit	24	24	100%
2. Initiate the exceptions process	3	3	100%
3. Order a refill for an existing, unexpired mail-order prescription*	N/A	N/A	N/A
4. Find the location of an in-network pharmacy	12	12	100%
5. Conduct a Pharmacy proximity search based on zip codes	12	12	100%
6. Determine the availability of generic substitution	24	24	100%
Total	**75**	**75**	**100%**

* Members are able to use any mail order service that is offered by any of our contracted, in-network pharmacies. Thus, testing of the mail order service is N/A for SCFHP.

Table 2: Quality of the Website: Information is understandable to the member.

Measure	Total Sample	Quality Goal Met	%Goal Quality Goal Met
1. Their financial responsibility for a drug, based on pharmacy benefit	24	24	100%
2. How to initiate the exceptions process	3	3	100%
3. How to order a refill for an existing, unexpired mail-order prescription*	N/A	N/A	N/A
4. How to find the location of an in-network pharmacy	12	12	100%
5. How to conduct a Pharmacy proximity search based on zip codes	12	12	100%
6. How to determine the availability of generic substitution	24	24	100%
Total	**75**	**75**	**100%**

***** Members are able to use any mail order service that is offered by any of our contracted, in-network pharmacies. Thus, testing of the mail order service is N/A for SCFHP.

IV: Accuracy and Quality Analysis

Both Accuracy and Quality measures met goal at 100%. There were no deficiencies identified.

This population is more likely to call into the Member Services Department for this type of information, but SCFHP will continue to monitor the accuracy and quality of web information provided to members.

SCFHP did not test the quality and accuracy of the ability for members to order a refill on an existing, mail-order prescription because SCFHP does not offer a mail order service. Members are able to use any mail order service that is offered by any of our contracted, in-network pharmacies. Thus, testing of the mail order service is N/A for SCFHP.

V. Conclusion

There were no significant changes to the CMC pharmacy member portal since the previous report in August 2020. From 2020 to this year, there was a 19.4% decrease in the number of samples (93 vs. 75) for both accuracy and quality measures because there was no LIS 4 member for this year's analysis. Should any LIS 4 members arise in the future prior to 2023 report, we will conduct an interim analysis to make sure information for LIS 4 members meet all measures for accuracy and quality. The accuracy and quality measures continued to meet goals of 100%

and no deficiencies were identified. Compared to August 2020 report, there was no change in the % of meeting accuracy and quality measures because for both reports 100% of goals were met.

APPENDIX A

Audit Sheet

Test member:

LIS level:

Accuracy and Quality of Pharmacy Benefit Information on the Website (circle Y=YES OR N=NO where indicated).

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy Benefit Information on the Website (factors 1-11 below) **Accuracy:** Members can access the following in one session without the need to sign in again or contact the organization. **Quality**: Information is legible, complete and allows the member to understand.		
1. Determine financial responsibility for a drug, based on pharmacy benefit. **Accuracy:** Allow members to enter a drug name, the National Drug Code (NDC) or another identifier. Co-pay matches with LIS level and formulary tier (see table 1 for reference). **Quality:** Easy to find co-pay information.		
Tier 1 Drug:	Y / N	Y / N
Tier 2 Drug:	Y / N	Y / N
Tier 3 Drug:	Y / N	Y / N
Tier 4 Drug:	Y / N	Y / N
Excluded Drug:	Y / N	Y / N
New Drug:	Y / N	Y / N
2. Initiate the exceptions process (audit 3 actual member's history). **Accuracy:** MedImpact (PBM) is able to receive the request and all fields on exception request form populate correctly. **Quality:** Explanation of the exception process is written in a member-friendly manner.	See Appendix B	See Appendix B
3. Order a refill for an existing, unexpired mail-order prescription.	N/A	N/A

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
4. Find the location of an in-network pharmacy (randomly pick 3 types of in-network pharmacies): **Accuracy:** Pharmacy name, pharmacy label, address, phone number, hours of operation, national provider identifier, map and direction are accurate. **Quality:** Includes easy to understand instructions on use of search feature.		
Pharmacy 1 (Choice 90 Retail):	Y / N	Y / N
Pharmacy 2 (Long Term Care):	Y / N	Y / N
Pharmacy 3 (Home Infusion):	Y / N	Y / N
5. Conduct a Pharmacy proximity search based on zip codes (randomly pick 3 zip codes in Santa Clara County). **Accuracy:** All pharmacies populate correctly within certain miles. Pharmacy name, address, phone number, hours of operation, national provider identifier are accurate. **Quality:** Includes easy to understand instruction on use of search feature.		
Zip code 1 (search within 1 mile):	Y / N	Y / N
Zip code 2 (search within 2 miles):	Y / N	Y / N
Zip code 3 (search within 3 miles):	Y / N	Y / N
6. Determine the availability of generic substitutes. **Accuracy:** Search using brand names of chosen drugs to retrieve a list of available generic substitutes. If no generics available, then generics should not be listed. **Quality:** Easy to search for available generic substitutes.		
Tier 1 Drug:	Y / N	Y / N
Tier 2 Drug:	Y / N	Y / N
Tier 3 Drug:	Y / N	Y / N
Tier 4 Drug:	Y / N	Y / N
Excluded Drug:	Y / N	Y / N
New Drug:	Y / N	Y / N

Reviewer's name: **Date reviewed:**

APPENDIX B

Audit Sheet

Accuracy and Quality of Pharmacy Benefit Information on the Website (circle Y=YES OR N=NO where indicated).

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
1. Initiate the exceptions process (audit 3 member's history). **Accuracy:** Members can initiate the exceptions process on their own behalf. MedImpact is able to receive the request and all fields on exception request form populate correctly. **Quality:** Explanation of the exception process is written in a member-friendly manner.		
Member #1 Drug:	Y / N	Y / N
Member #2 Drug:	Y / N	Y / N
Member #3 Drug:	Y / N	Y / N

Reviewer's name: **Date reviewed:**

Table 1: LIS Level and Copays for 2020

Formulary Tier	Formulary Tier Description	LIS	Copay Range
1	Generic drugs	Any LIS	$0
2	Brand drugs	0, 1, 4	$0 - $9.85
		2	$0 - $4.00
		3	$0
3	Non-Medicare prescription drugs	Any LIS	$0
4	Non-Medicare over-the-counter (OTC) drugs	Any LIS	$0

APPENDIX A

Audit Sheet

Test member: #1
LIS level: 0
Accuracy and Quality of Pharmacy Benefit Information on the Website (circle Y=YES OR N=NO where indicated).

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy Benefit Information on the Website (factors 1-11 below) **Accuracy:** Members can access the following in one session without the need to sign in again or contact the organization. **Quality**: Information is legible, complete and allows the member to understand.		
1. Determine financial responsibility for a drug, based on pharmacy benefit. **Accuracy:** Allow members to enter a drug name, the National Drug Code (NDC) or another identifier. Co-pay matches with LIS level and formulary tier (see table 1 for reference). **Quality:** Easy to find co-pay information.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N
2. Initiate the exceptions process (audit 3 actual member's history). **Accuracy:** MedImpact (PBM) is able to receive the request and all fields on exception request form populate correctly. **Quality:** Explanation of the exception process is written in a member-friendly manner.	See Appendix B	See Appendix B
3. Order a refill for an existing, unexpired mail-order prescription.	N/A	N/A
4. Find the location of an in-network pharmacy (randomly pick 3 types of in-network pharmacies): **Accuracy:** Pharmacy name, pharmacy label, address, phone number, hours of operation, national provider identifier, map and direction are accurate. **Quality:** Includes easy to understand instructions on use of search feature.		

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy 1 (Choice 90 Retail): Walgreens #1179 1795 E Capitol Expy, San Jose, CA 95121 Phone#408-238-5890, opening hours Su 10am-6pm, M-F 8am-9pm, Sat 9am-6pm. NPI#1013922301	Y / N	Y / N
Pharmacy 2 (Long Term Care): Garcia Pharmacy, 25 N 14th St STE 110, San Jose, CA 95116. Phone#408-294-3219, opening hours M-F 9am - 5:30pm Sat 9am - 2:30pm Su closed. NPI#1023660875	Y / N	Y / N
Pharmacy 3 (Home Infusion): Tully Medical Clinic Pharmacy, 1693 Flanigan Dr STE 104, San Jose 95121, (408) 274-6698, opening hours M-F 9am - 6:30pm Sat 9am - 1:30pm Su closed, NPI#1689139735	Y / N	Y / N
5. Conduct a Pharmacy proximity search based on zip codes (randomly pick 3 zip codes in Santa Clara County). **Accuracy:** All pharmacies populate correctly within certain miles. Pharmacy name, address, phone number, hours of operation, national provider identifier are accurate. **Quality:** Includes easy to understand instruction on use of search feature.		
Zip code 1 (search within 5 miles): 95014	Y / N	Y / N
Zip code 2 (search within 10 miles): 95117	Y / N	Y / N
Zip code 3 (search within 5 miles): 94040	Y / N	Y / N
6. Determine the availability of generic substitutes. **Accuracy:** Search using brand names of chosen drugs to retrieve a list of available generic substitutes. If no generics available, then generics should not be listed. **Quality:** Easy to search for available generic substitutes.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N

APPENDIX B

Audit Sheet

Accuracy and Quality of Pharmacy Benefit Information on the Website (circle Y=YES OR N=NO where indicated).

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
1. Initiate the exceptions process (audit 3 member's history). **Accuracy:** Members can initiate the exceptions process on their own behalf. MedImpact is able to receive the request and all fields on exception request form populate correctly. **Quality:** Explanation of the exception process is written in a member-friendly manner.		
Member #1 Drug: SC0436179 (zolpidem tartrate 5mg tab)	Y / N	Y / N
Member #2 Drug: SC0431918 (lidocaine 5% patch)	Y / N	Y / N
Member #3 Drug: SC0410778 (colchicine 0.6mg tab)	Y / N	Y / N

Reviewer's name: Duyen Nguyen, PharmD **Date reviewed: 2/14/2022**

Table 1: LIS Level and Copays for 2020

Formulary Tier	Formulary Tier Description	LIS	Copay Range
1	Generic drugs	Any LIS	$0
2	Brand drugs	0, 1, 4	$0 - $8.95
		2	$0 - $3.90
		3	$0
3	Non-Medicare prescription drugs	Any LIS	$0
4	Non-Medicare over-the-counter (OTC) drugs	Any LIS	$0

Test member: #2
LIS level: 1
Accuracy and Quality of Pharmacy Benefit Information on the Website (circle Y=YES OR N=NO where indicated).

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy Benefit Information on the Website (factors 1-11 below) **Accuracy:** Members can access the following in one session without the need to sign in again or contact the organization. **Quality**: Information is legible, complete and allows the member to understand.		
1. Determine financial responsibility for a drug, based on pharmacy benefit. **Accuracy:** Allow members to enter a drug name, the National Drug Code (NDC) or another identifier. Co-pay matches with LIS level and formulary tier (see table 1 for reference). **Quality:** Easy to find co-pay information.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N
2. Initiate the exceptions process (audit 3 actual member's history). **Accuracy:** MedImpact (PBM) is able to receive the request and all fields on exception request form populate correctly. **Quality:** Explanation of the exception process is written in a member-friendly manner.	See Appendix B	See Appendix B
3. Order a refill for an existing, unexpired mail-order prescription.	N/A	N/A
4. Find the location of an in-network pharmacy (randomly pick 3 types of in-network pharmacies): **Accuracy:** Pharmacy name, pharmacy label, address, phone number, hours of operation, national provider identifier, map and direction are accurate. **Quality:** Includes easy to understand instructions on use of search feature.		

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy 1 (Choice 90 Retail): Walgreens #1179 1795 E Capitol Expy, San Jose, CA 95121 Phone#408-238-5890, opening hours Su 10am-6pm, M-F 8am-9pm, Sat 9am-6pm. NPI#1013922301	Y / N	Y / N
Pharmacy 2 (Long Term Care): Garcia Pharmacy, 25 N 14th St STE 110, San Jose, CA 95116. Phone#408-294-3219, opening hours M-F 9am - 5:30pm Sat 9am - 2:30pm Su closed. NPI#1023660875	Y / N	Y / N
Pharmacy 3 (Home Infusion): Tully Medical Clinic Pharmacy, 1693 Flanigan Dr STE 104, San Jose 95121, (408) 274-6698, opening hours M-F 9am - 6:30pm Sat 9am - 1:30pm Su closed, NPI#1689139735	Y / N	Y / N
5. Conduct a Pharmacy proximity search based on zip codes (randomly pick 3 zip codes in Santa Clara County). **Accuracy:** All pharmacies populate correctly within certain miles. Pharmacy name, address, phone number, hours of operation, national provider identifier are accurate. **Quality:** Includes easy to understand instruction on use of search feature.		
Zip code 1 (search within 5 miles): 95014	Y / N	Y / N
Zip code 2 (search within 10 miles): 95117	Y / N	Y / N
Zip code 3 (search within 5 miles): 94040	Y / N	Y / N
6. Determine the availability of generic substitutes. **Accuracy:** Search using brand names of chosen drugs to retrieve a list of available generic substitutes. If no generics available, then generics should not be listed. **Quality:** Easy to search for available generic substitutes.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N

Reviewer's name: Duyen Nguyen, PharmD **Date reviewed: 2/14/2022**

Test member: #3
LIS level: 2
Accuracy and Quality of Pharmacy Benefit Information on the Website (circle Y=YES OR N=NO where indicated).

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy Benefit Information on the Website (factors 1-11 below) **Accuracy:** Members can access the following in one session without the need to sign in again or contact the organization. **Quality**: Information is legible, complete and allows the member to understand.		
1. Determine financial responsibility for a drug, based on pharmacy benefit. **Accuracy:** Allow members to enter a drug name, the National Drug Code (NDC) or another identifier. Co-pay matches with LIS level and formulary tier (see table 1 for reference). **Quality:** Easy to find co-pay information.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N
2. Initiate the exceptions process (audit 3 actual member's history). **Accuracy:** MedImpact (PBM) is able to receive the request and all fields on exception request form populate correctly. **Quality:** Explanation of the exception process is written in a member-friendly manner.	See Appendix B	See Appendix B
3. Order a refill for an existing, unexpired mail-order prescription.	N/A	N/A
4. Find the location of an in-network pharmacy (randomly pick 3 types of in-network pharmacies): **Accuracy:** Pharmacy name, pharmacy label, address, phone number, hours of operation, national provider identifier, map and direction are accurate. **Quality:** Includes easy to understand instructions on use of search feature.		

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy 1 (Choice 90 Retail): Walgreens #1179 1795 E Capitol Expy, San Jose, CA 95121 Phone#408-238-5890, opening hours Su 10am-6pm, M-F 8am-9pm, Sat 9am-6pm. NPI#1013922301	Y / N	Y / N
Pharmacy 2 (Long Term Care): Garcia Pharmacy, 25 N 14th St STE 110, San Jose, CA 95116. Phone#408-294-3219, opening hours M-F 9am - 5:30pm Sat 9am - 2:30pm Su closed. NPI#1023660875	Y / N	Y / N
Pharmacy 3 (Home Infusion): Tully Medical Clinic Pharmacy, 1693 Flanigan Dr STE 104, San Jose 95121, (408) 274-6698, opening hours M-F 9am - 6:30pm Sat 9am - 1:30pm Su closed, NPI#1689139735	Y / N	Y / N
5. Conduct a Pharmacy proximity search based on zip codes (randomly pick 3 zip codes in Santa Clara County). **Accuracy:** All pharmacies populate correctly within certain miles. Pharmacy name, address, phone number, hours of operation, national provider identifier are accurate. **Quality:** Includes easy to understand instruction on use of search feature.		
Zip code 1 (search within 5 miles): 95014	Y / N	Y / N
Zip code 2 (search within 10 miles): 95117	Y / N	Y / N
Zip code 3 (search within 5 miles): 94040	Y / N	Y / N
6. Determine the availability of generic substitutes. **Accuracy:** Search using brand names of chosen drugs to retrieve a list of available generic substitutes. If no generics available, then generics should not be listed. **Quality:** Easy to search for available generic substitutes.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N

Reviewer's name: Duyen Nguyen, PharmD **Date reviewed: 2/14/2022**

Test member: #4
LIS level: 3
Accuracy and Quality of Pharmacy Benefit Information on the Website (circle Y=YES OR N=NO where indicated).

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy Benefit Information on the Website (factors 1-11 below) **Accuracy:** Members can access the following in one session without the need to sign in again or contact the organization. **Quality**: Information is legible, complete and allows the member to understand.		
1. Determine financial responsibility for a drug, based on pharmacy benefit. **Accuracy:** Allow members to enter a drug name, the National Drug Code (NDC) or another identifier. Co-pay matches with LIS level and formulary tier (see table 1 for reference). **Quality:** Easy to find co-pay information.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N
2. Initiate the exceptions process (audit 3 actual member's history). **Accuracy:** MedImpact (PBM) is able to receive the request and all fields on exception request form populate correctly. **Quality:** Explanation of the exception process is written in a member-friendly manner.	See Appendix B	See Appendix B
3. Order a refill for an existing, unexpired mail-order prescription.	N/A	N/A
4. Find the location of an in-network pharmacy (randomly pick 3 types of in-network pharmacies): **Accuracy:** Pharmacy name, pharmacy label, address, phone number, hours of operation, national provider identifier, map and direction are accurate. **Quality:** Includes easy to understand instructions on use of search feature.		

Measure	Accuracy Goal Met Y/N	Quality Goal Met Y/N
Pharmacy 1 (Choice 90 Retail): Walgreens #1179 1795 E Capitol Expy, San Jose, CA 95121 Phone#408-238-5890, opening hours Su 10am-6pm, M-F 8am-9pm, Sat 9am-6pm. NPI#1013922301	Y / N	Y / N
Pharmacy 2 (Long Term Care): Garcia Pharmacy, 25 N 14th St STE 110, San Jose, CA 95116. Phone#408-294-3219, opening hours M-F 9am - 5:30pm Sat 9am - 2:30pm Su closed. NPI#1023660875	Y / N	Y / N
Pharmacy 3 (Home Infusion): Tully Medical Clinic Pharmacy, 1693 Flanigan Dr STE 104, San Jose 95121, (408) 274-6698, opening hours M-F 9am - 6:30pm Sat 9am - 1:30pm Su closed, NPI#1689139735	Y / N	Y / N
5. Conduct a Pharmacy proximity search based on zip codes (randomly pick 3 zip codes in Santa Clara County). **Accuracy:** All pharmacies populate correctly within certain miles. Pharmacy name, address, phone number, hours of operation, national provider identifier are accurate. **Quality:** Includes easy to understand instruction on use of search feature.		
Zip code 1 (search within 5 miles): 95014	Y / N	Y / N
Zip code 2 (search within 10 miles): 95117	Y / N	Y / N
Zip code 3 (search within 5 miles): 94040	Y / N	Y / N
6. Determine the availability of generic substitutes. **Accuracy:** Search using brand names of chosen drugs to retrieve a list of available generic substitutes. If no generics available, then generics should not be listed. **Quality:** Easy to search for available generic substitutes.		
Tier 1 Drug: pravastatin 10mg tablet	Y / N	Y / N
Tier 2 Drug: Lucemyra 0.18mg tablet	Y / N	Y / N
Tier 3 Drug: benzonatate 100mg capsule	Y / N	Y / N
Tier 4 Drug: arthritis pain reliever 1% gel	Y / N	Y / N
Excluded Drug: Cranberry 500mg capsule	Y / N	Y / N
New Drug: Welireg 40mg tablet	Y / N	Y / N

Reviewer's name: Duyen Nguyen, PharmD **Date reviewed: 2/14/2022**

Santa Clara Family Health Plan™

Quality Improvement Dashboard

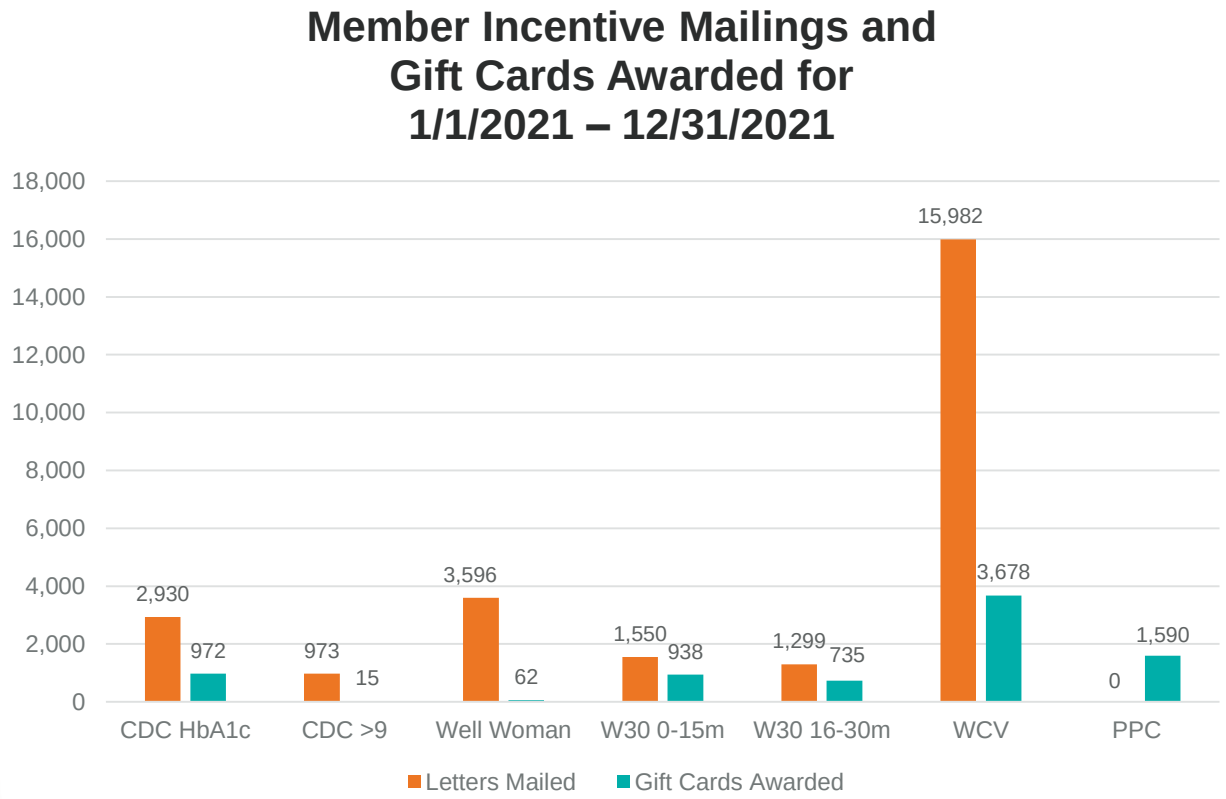
January – February – March 2022

Member Incentives:
Wellness Rewards Program

A calendar year rewards program offered to members who complete preventative screenings and close gaps in care

- **Breast Cancer Screening**
- **Cervical Cancer Screening**
- **Well Child 0-15m**
- **Well Child 16-30m**
- **Adolescent Well Care (18-21y)**
- **Prenatal Care – Postpartum Visit**
- **Comprehensive Diabetes Care (Poor Control)**
- **Comprehensive Diabetes Care (HbA1c Testing)**

Total # of **letters** mailed	26,330
Total # of **gift cards** mailed	7,990



*PPC program does not mail out letters. This is a clinic referral program

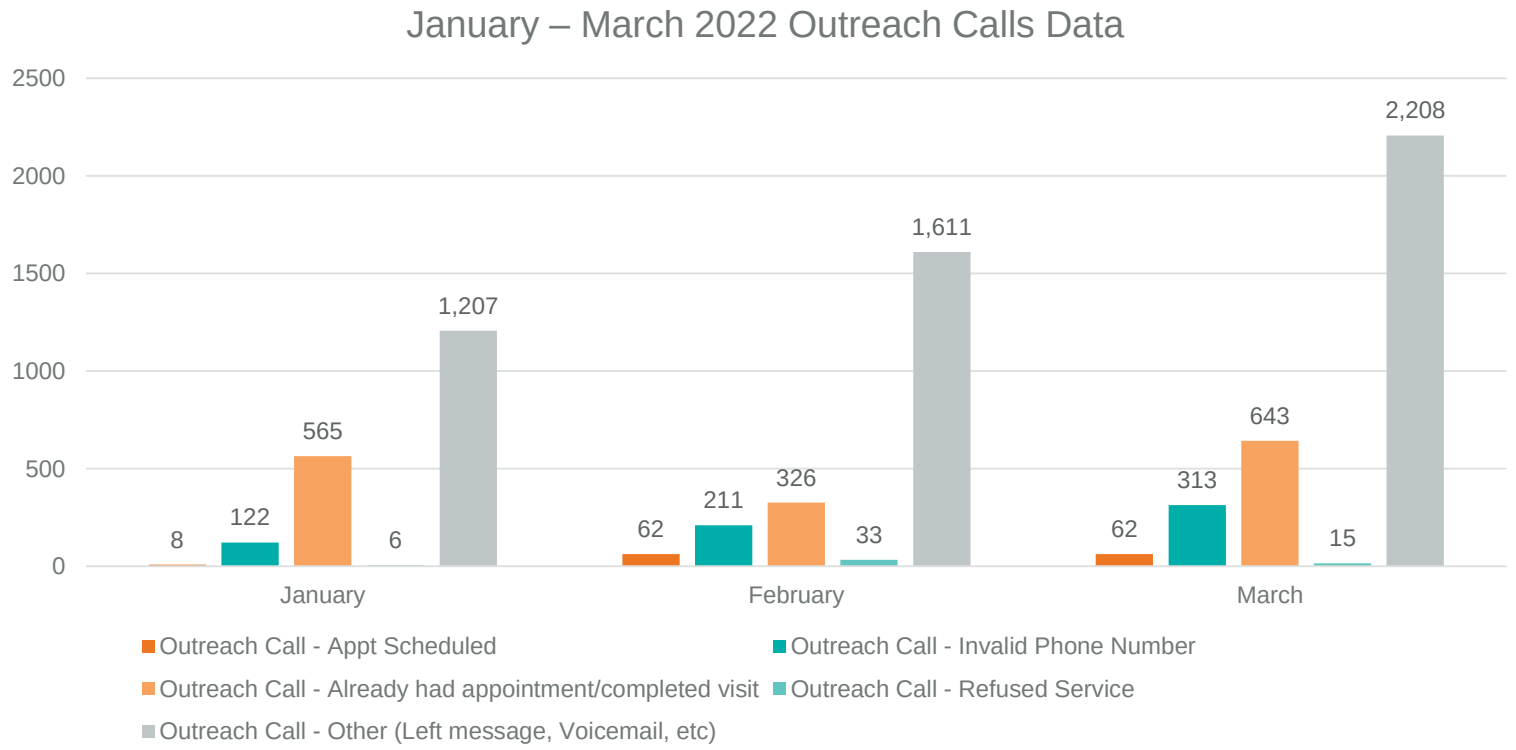
There are no changes and that the final CY2021 numbers will be reported in the next QIC dashboard.

Outreach Call Campaign

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

Campaigns completed (January – March 2022)

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



7,422

Total number of attempted outreach in January – March 2022

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

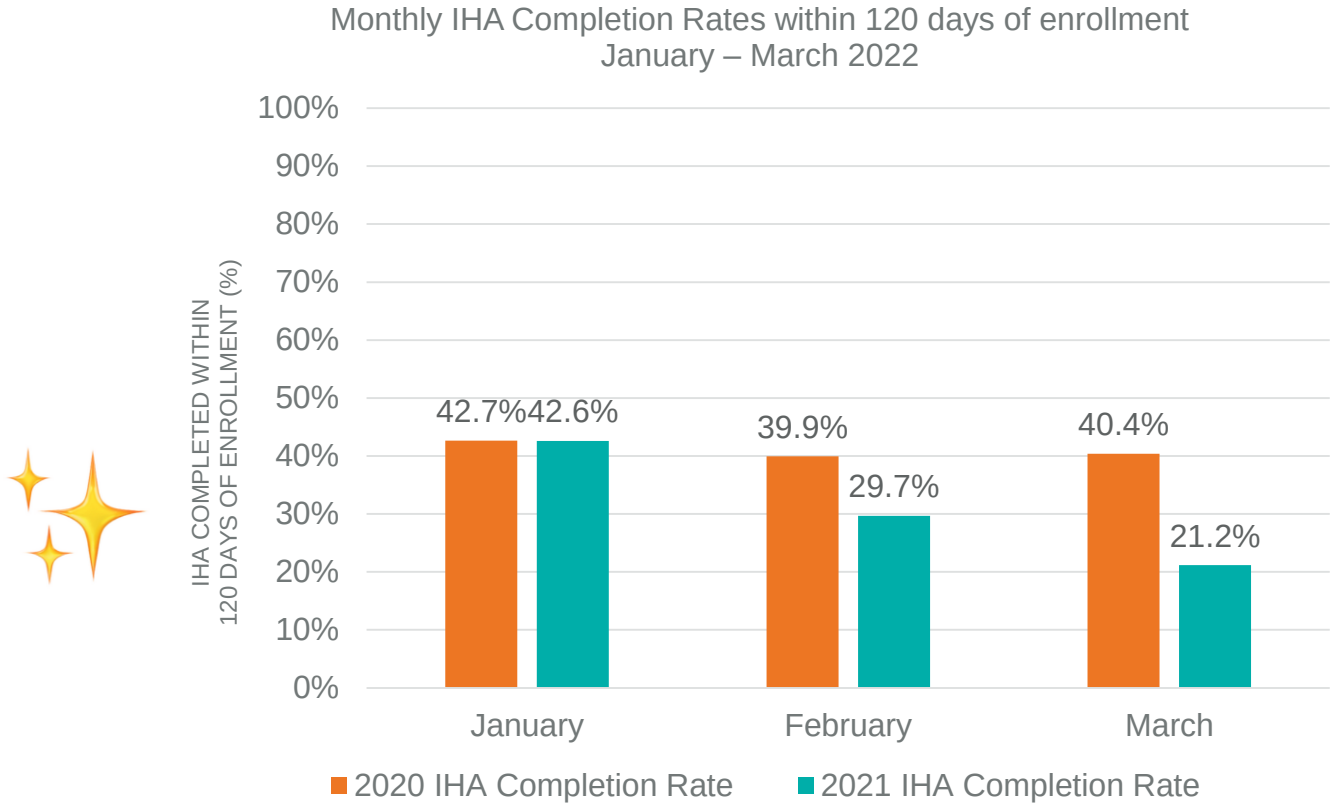
Initial Health Assessment (IHA)

Santa Clara Family Health Plan™

What is an IHA?

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

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



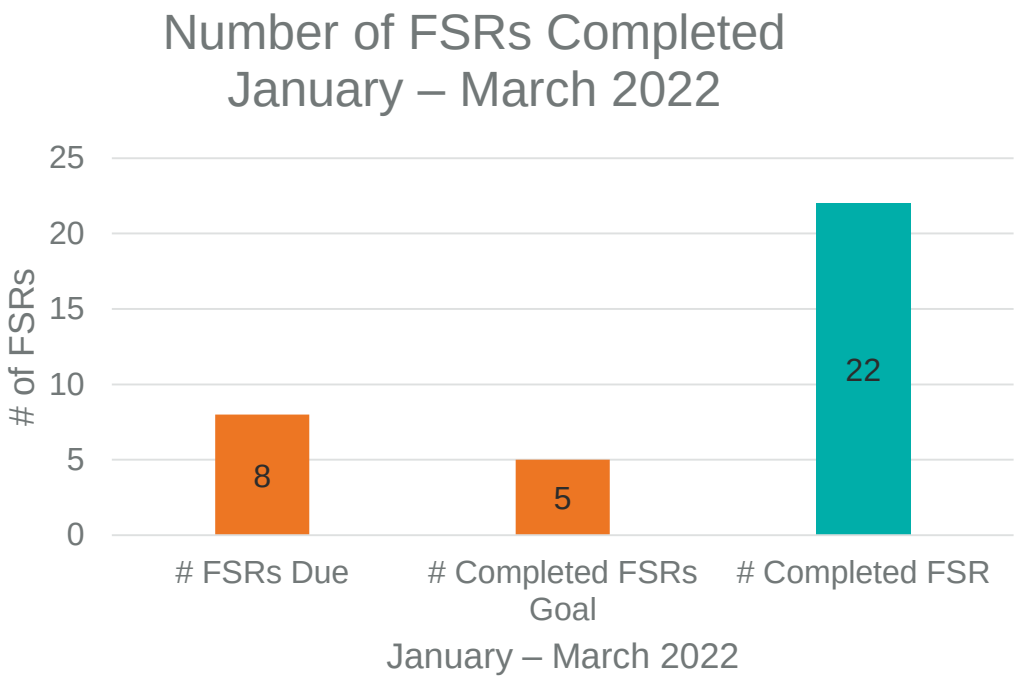
*DHCS had temporarily suspended the requirement to complete IHAs for members within 120 days of enrollment until the COVID-19 emergency declaration is rescinded. Starting October 1, 2021, DHCS required all primary care providers to resume IHA activities.

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

Facility Site Review (FSR)

Santa Clara Family Health Plan

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



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

# Periodic FSRs Completed	22
# Initial FSRs Completed	0

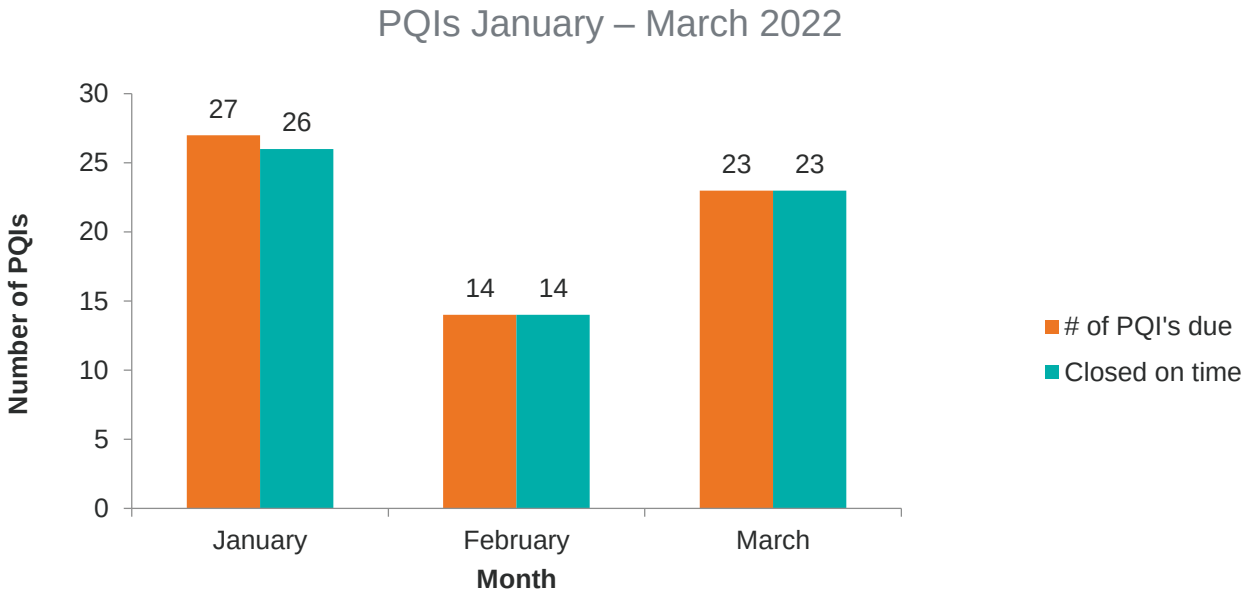
Potential Quality of Care Issues

Santa Clara Family Health Plan

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

98.4%

Percentage of PQIs due from January - March 2022 closed on time within 90* days



PQI Levels: January – March 2022
Level 0: 2 Cases
Level 1: 56 Cases
Level 1A: 1 Case
Level 2: 5 Cases
Level 3: 0 Case
Level 4: 0 Case

Network	Case Identified Level 0	Case Identified Level 1	Case Identified Level 1A	Case Identified Level 2	Case Identified Level 3	Case Identified Level 4
Admin – Medicare Primary	1	2	0	0	0	0
Direct SCFHP	0	10	0	1	0	0
VHP Network	1	36	0	2	0	0
Palo Alto Medical Foundation	0	4	0	0	0	0
Physicians Medical Group	0	3	1	2	0	0
Premier Care	0	1	0	0	0	0

QNXT Gaps In Care Alerts

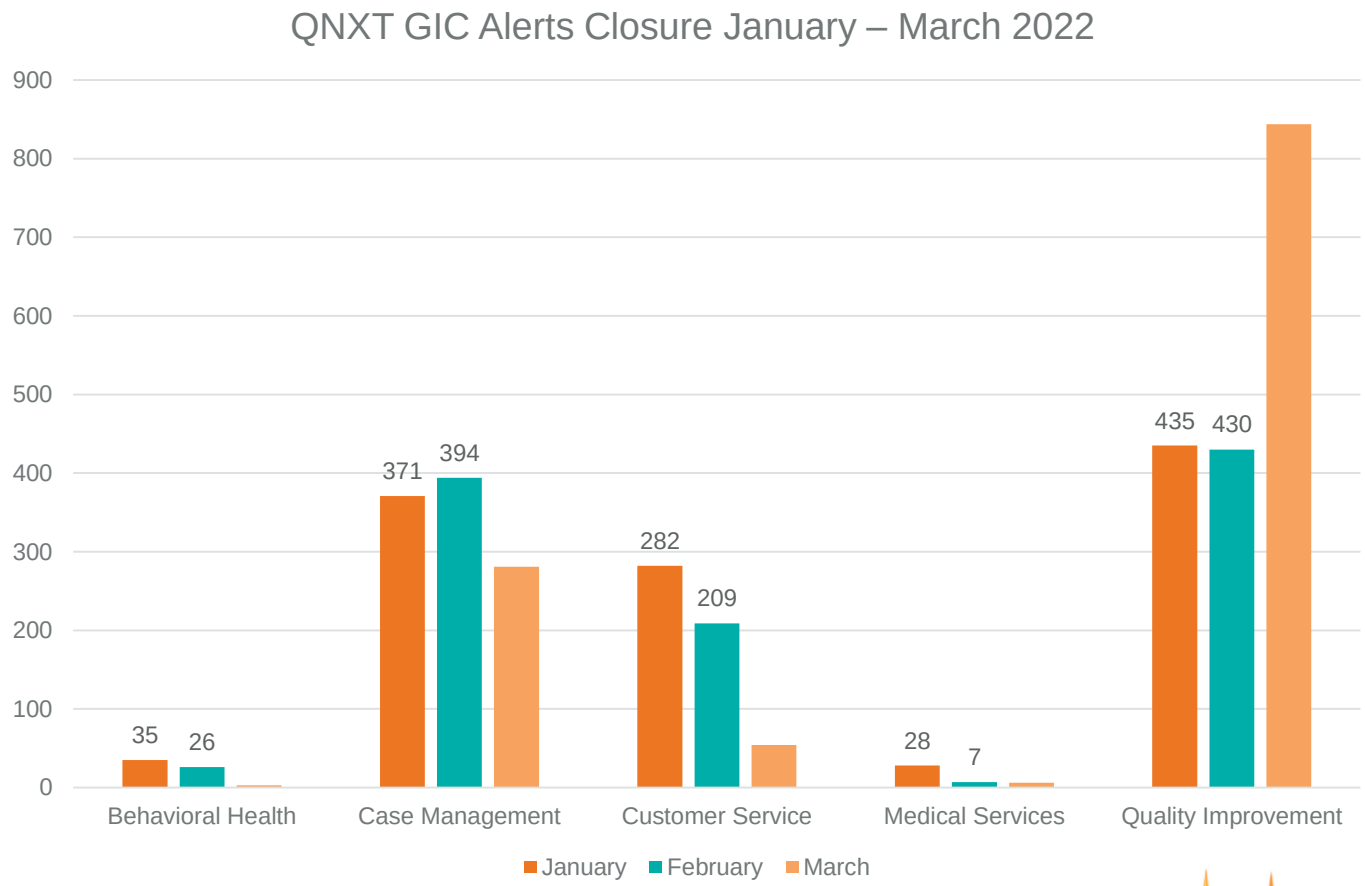
Santa Clara Family Health Plan™

What are QNXT GIC Alerts?

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

3,341

Total number of QXNT GIC alerts terminated in January – March 2022



Santa Clara Family Health Plan™

Compliance Report

April 12, 2022

Compliance Activity Report

April 12, 2022

- **CMS Notices of Noncompliance**
  The Plan recently received two notices of non-compliance from CMS in February for late submissions of attestations and policies and procedures related to the use of a formulary for the Medicare Part D program, which are required to be submitted annually. The Pharmaceutical and Therapeutics Committee attestation, Prior Authorization/Step Therapy attestation, and Transition Policy were due on June 7, 2021. We submitted them on June 8. There are no penalties or corrective actions required by CMS, and we have taken steps to ensure future timely submissions.

- **Department of Health Care Services (DHCS) Annual Audit**
  The Plan recently completed its annual 2022 DHCS audit, covering both Medi-Cal and Cal MediConnect with a review period of March 2021 through February 2022. During the audit exit conference, DHCS verbally indicated potential findings in several areas (including utilization management, grievances and appeals, initial health assessments, transportation, quality improvement, and fraud, waste, and abuse), with other areas still under review. It could be several months before we receive a preliminary audit report.

- **Department of Managed Health Care (DMHC) Financial Audit**
  In January, we received notice of a routine financial audit that will be conducted by DMHC in June. This audit occurs every three years and examines the financial health and sustainability of the health plan, including cash, investments, liabilities, billing processes, claims data, and provider disputes. Finance is responding to document requests from DMHC.

Santa Clara Family Health Plan™

Quality Improvement Policies

Annual Review

Santa Clara Family Health Plan™

Santa Clara Family Health Plan™

POLICY

Policy Title:	**Distribution of Quality Improvement Information**	**Policy No.:**	QI.03~~v2~~
Replaces Policy Title (if applicable):	Dissemination of Approved Information Following Quality Improvement Committee	**Replaces Policy No. (if applicable):**	QM007_01
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

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

II. Policy

a. At least annually, SCFHP communicates Quality Improvement (QI) program information to practitioners, providers and members. Information about QI program processes, goals, and outcomes are shared, as they relate to member care and services, in language that is easy to understand.

b. SCFHP may distribute information through regular mail, e-mail, fax, the Web or mobile devices. If posted on the Web, practitioners, providers and members are notified of the posting and given the opportunity to request the information by mail.

III. Responsibilities

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

IV. References

NCQA ~~2020~~2022, MED 8, Element D

V. Approval/Revision History

First Level Approval	Second Level Approval

Santa Clara Family Health Plan™

POLICY

Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Quality Improvement	Approve 5/10/2016	
v1	Reviewed	Quality Improvement	Approve 5/10/2017	
v1	Reviewed	Quality Improvement	Approve 06/06/2018	
v2				

POLICY

Policy Title:	**Peer Review Process**	**Policy No.:**	QI.04 ~~v2~~
Replaces Policy Title (if applicable):	Peer Review Process	**Replaces Policy No. (if applicable):**	QM009_02
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

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

II. Policy

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

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

III. Responsibilities

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

IV. References

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

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Quality Improvement	Approve 5/10/2016	
v1	Reviewed	Quality Improvement	Approve 5/10/2017	
v1	Reviewed	Quality Improvement	Approve 06/06/2018	
v2				

POLICY

Policy Title:	**Quality Improvement Study Design/Performance Improvement Program Reporting**	**Policy No.:**	QI.06 ~~v2~~
Replaces Policy Title (if applicable):	Quality Improvement Study Design/Performance Improvement Program Reporting	**Replaces Policy No. (if applicable):**	QM005_02
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

SCFHP's Quality Improvement (QI) department continuously works to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program. SCFHP clearly defines its QI program structure and processes, assigns responsibility to appropriate individuals and operationalizes its QI program.

II. Policy

Santa Clara Family Health Plan (SCFHP) continuously monitors and develops ways to improve quality of care for plan members. This is achieved through a variety of measures including, quality of clinical care, safety in clinical care, quality of service, members' experience, trends in potential quality of care issues, chronic care improvement projects, and quality improvement activities. Annually, SCFHP develops a QI Work Plan to track these measures and activities, and conducts a QI Program Evaluation at the close of each calendar year. SCFHP uses findings from the QI Program Evaluation to make adjustments to the QI Program as needed.

SCFHP utilizes sound statistical techniques, measurable and quantitative data and reporting techniques that produce reliable and timely data. Procedure details are documented in the associated Procedure Document QI.06.01 Quality Improvement Study Design/Performance Improvement Program Reporting.

III. Responsibilities

Health Services, Customer Service, Provider Network Operations, Claims, Appeals and Grievance, and IT provide data to QI for quality monitoring and reporting. QI then develops a work plan and further monitors and reports on progress and further actions.

IV. References

The Centers for Medicare and Medicaid Services (CMS). (2014). Quality Assessment, *Medicare Managed Care Manual*.
NCQA ~~2020~~ Health Plan Accreditation (HPA) Standards, QI
Elements A-C
NCQA HEDIS Specifications~~. (2018).~~

V. Approval/Revision History

Santa Clara Family Health Plan™

POLICY

First Level Approval	Second Level Approval
Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Quality Improvement	Approve 5/10/2016	
v1	Reviewed	Quality Improvement	Approve 05/10/2017	
v1	Reviewed	Quality Improvement	Approve 06/06/2018	
v2				

POLICY

Policy Title:	**Cultural and Linguistically Competent Services**	**Policy No.:**	QI.08 ~~v2~~
Replaces Policy Title (if applicable):	Cultural and Linguistic Services Program Policy	**Replaces Policy No. (if applicable):**	CU 002_02
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

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

II. Policy

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

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

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

III. Responsibilities

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

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

POLICY

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

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

IV. References

CMS.gov; Managed Care Manual, Chapter 13
NCQA ~~2018~~2022
California Code of Regulations (28 CCR 1300.67.04) (d) (9) (A) (B) (C)
DHCS Contract
Title 22 CCR Section 53876
Title 22 CCR 53853 (c)
CA Health and Safety Code Sections 1367.04 (b)(1)(a), (b)(4) and (b)(5)
Section 1367.04(h)(1)
Civil Rights Act of 1964, (42 U.S.C. Section 2000d, and 45 C.F.4. Part 80)
PL – 99-003
APL 99-005
APL 17-011
CFR 42 § 440.262
APL 19-011

V. Approval/Revision History

First Level Approval	Second Level Approval
Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Quality Improvement Committee	Approved 06/06/2018	
v2	Revised	Quality Improvement Committee		

POLICY

POLICY

Policy Title:	**Health Education Program and Delivery System**	**Policy No.:**	QI.09 ~~v3~~
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

The purpose of this policy is to describe Santa Clara Family Health Plan's (SCFHP) Health Education Program and its functions. Health Education at SCFHP is operationalized within the Quality Improvement Department.

II. Policy

The Health Education Program provides organized programs, services, functions, and resources necessary to deliver health education, health promotion, and patient education. It includes assessment, monitoring, and evaluation of all services provided by SCFHP and contracted Vendors.

A. The Health Education Program will provide classes and/or materials free of charge to beneficiaries including, but not limited to, the following topics:
   1. Nutrition
   2. Healthy weight maintenance and physical activity
   3. Individual and group counseling and support services
   4. Parenting
   5. Smoking and tobacco use cessation
   6. Alcohol and drug use
   7. Injury prevention
   8. Prevention of sexually transmitted diseases, HIV, and unintended pregnancy
   9. Self-care and chronic disease management, including asthma, diabetes, and hypertension
   10. Pregnancy care

B. SCFHP also offers self-management tools through the Member Portal.

C. All SCFHP members are eligible to receive Health Education classes through SCFHP and/or their assigned network where applicable.

D. All programs are voluntary and opt-in process. Member can choose to opt-out/no longer participate even after signing up or enrolling for a class or program at any time. To opt-out, members should contact the vendor or organizer directly.

III. Responsibilities

The Quality Department and Health Educator will do the following:

POLICY

A. Ensure all programs and services are provided at no cost to members.
B. Ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for members and effective in achieving behavioral change for improved health outcomes.
C. Ensure that health education materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for the intended audience.
D. Maintain a program that provides educational interventions addressing the topics listed above.
E. Ensure that members receive point of service education as part of preventive and primary health care visits. Health Education shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for members.
F. Maintain policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and monitor the performance of providers that are contracted to deliver health education services to ensure effectiveness.
G. Periodically review the health education program to ensure appropriate allocation of health education resources and maintain documentation that demonstrates effective implementation of the health education requirements.
H. Ensure online self-management tools are useful and up-to-date and meet the language, vision, and hearing needs of members.
I. Oversight health education programs provided by contracted vendors.
J. Track and trend the referrals and the utilization of health education programs.

IV. References

3-Way Contract, SCFHP, CMS and DHCS
NCQA ~~2020~~2022 Health Plan Accreditation Requirements PHM 4A-K (Wellness and Prevention), PHM 1B (Informing Members)

V. Approval/Revision History

First Level Approval	Second Level Approval
Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original			
v2	Revised	Quality Improvement Committee	Approve; 6/6/2018	
v3				

Santa Clara Family Health Plan™

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POLICY

Policy Title:	**Member Non-Monetary Incentives**	**Policy No.:**	QI.11 ~~v2~~
Replaces Policy Title (if applicable):	None	**Replaces Policy No. (if applicable):**	None
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

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

II. Policy

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

A. SCFHP obtains approval by DHCS prior to offering any type of member incentive for a member incentive (MI) program, focus group, or survey.
B. SCFHP will submit annual updates to DCHS through the Member Incentives Evaluation Form to justify the continuation of an ongoing MI program and an end of program evaluation to describe whether or not the MI program was successful.
C. For Focus Group Incentives (FGIs), SCFHP will submit an evaluation that incudes recruitment, participation methodology, and results summary. The FGI evaluation will also indicate if policy and program changes are warranted. For Survey Incentives (SI), SCFHP will submit a copy of the survey, along with an evaluation that includes findings and recommendations.
D. SCFHP obtains approval from CMS for incentives for CMC members. Incentives in the form of cash or monetary rebates are not offered. SCFHP ensures that the monetary value of the incentive does not exceed the value of the health related service or activity (§422.134(C)(1)(iii)). (Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives).

III. Responsibilities

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

IV. References

Santa Clara Family Health Plan™

POLICY

MMCD APL 16-005, February 25, 2016
AB 915 (Chapter 500., Statutes of 2007): Welfare and Institutions(W&I) Code 14407.1
Title 28. CCR. Section 1300.46
Medicare Managed Care Manual, Chapter 4, Section 100 Rewards and Incentives, pg. 72.

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Johanna Liu Director, Quality & Process Improvement	Laurie Nakahira Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Quality Improvement Committee	Approve; 08/10/2016	
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v1	Reviewed	Quality Improvement Committee	Approve: 06/06/2018	
v2				

POLICY

Policy Title:	**Transitions of Care**	**Policy No.:**	QI.15
Replaces Policy Title (if applicable):	n/a	**Replaces Policy No. (if applicable):**	n/a
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal ☒ CMC		

I. Purpose

To outline Santa Clara Family Health Plan's process for managing Cal Medi-Connect (CMC) and non-delegated Medi-Cal High Risk Seniors and Persons with Disabilities (SPD) members at risk for planned and unplanned transitions across the care continuum.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) supports and promotes appropriate transitions between care settings which is critical to improving member quality of care and health outcomes.

B. SCFHP's Transitions of Care program is focused on identifying members at risk for transitions and facilitating the transitions between settings to the most appropriate and safe level of care for that member. This includes, but is not limited to:
   a. Acute hospitals;
   b. Inpatient psychiatric hospitals;
   c. Skilled Nursing Facilities (SNFs);
   d. Assisted living and residential care facilities;
   e. Rehabilitation facilities; and
   f. Member's home

C. SCFHP will implement evidence-based interventions to ensure safe and coordinated care across the Care Continuum and to prevent readmissions.

D. SCFHP will ensure members are in the least restrictive and most appropriate setting that meets the members' health care needs

E. The Transition of Care program is the combined responsibility of SCFHP and the member's assigned Primary Care Provider (PCP).

F. The Transition of Care program consists of, but is not limited to:
   a. Identification and management of members at risk for planned and unplanned transitions;
   b. Communication with the member and/or the member's authorized representative, PCPs, and specialists, if appropriate;
   c. Reduction of unplanned transitions;
   d. Support member preferences and choice through the ICP process;
   e. Promote the exchange of information across care settings; and
   f. Analyzing and monitoring data for process improvement

G. SCFHP implements processes that coordinate services and care needed for members including, but not limited to, ensuring access to necessary medical and behavioral health care, medications, durable medical equipment, supplies, transportation, Long Term Support Services (LTSS) benefits, and community based resources.

III. Responsibilities

Health Services collaborates with other SCFHP departments as well as providers and community partners to identify member risks and gaps, and to coordinate services and benefits for positive member outcome and optimum health.

IV. References

Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (2019)

Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 16-002: Continuity of Care

Department of Health Care Services (DHCS) Duals Plan Letter (APL) 16-003: Discharge Planning for Cal MediConnect

National Committee on Quality Assurance: Population Health Management (2021)

V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen Interim Director, Case Management	Laurie Nakahira, D.O. Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	**Original**	**Quality Improvement**	**Approve**	08/05/2016
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V1	**Reviewed**	**Quality Improvement**	**Approve**	06/06/2018
V2	**Revised**	**Quality Improvement**	**Approve**	04/14/2021

Santa Clara
Family Health Plan

Policy Title:	**Managed Long Term Services and Supports (MLTSS) Care Coordination**	**Policy No.:**	QI.16
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services	**Policy Review Frequency:**	
Lines of Business (check all that apply):	☒ Medi-Cal	☐ Healthy Kids	☒ CMC

I. Purpose

Santa Clara Family Health Plan (SCFHP) identifies members that are possibly at risk for institutional placement, that are currently placed in nursing facilities or those that want to move to a lower level of care. The Plan promotes coordination of services with the goal of achieving optimal well-being and functionality at the least restrictive level of care most beneficial to individual members.

II. Policy

A. In addition to following the Comprehensive Case Management policy, the Plan coordinates and monitors access, availability, continuity and coordination of care to Managed Long Term Services and Supports (MLTSS) for members. Additional procedures are specific to this form of care coordination.

B. <u>The Plan defines MLTSS procedures to include</u>:

- LTSS Assessment Review
- Community Based Adult Services (CBAS): Eligibility/Determination and Coordination, Referrals
- Referrals and Coordination for Multipurpose Senior Services Program
- LTC Case Management and Care Transitions
- Home and Community Services (HCBS) Coordination
- Individual Care Team (ICT): Specific providers required
- Individual Care Plan (ICP): Specific requirements
- Training: Additional needs for providers and staff

C. The Plan maintains procedures specific to the above mentioned areas as well as Comprehensive Case Management and Utilization Management procedures that provide details.

III. Responsibilities

Health Services collaborates with internal departments (IT, Claims) to identify members for MLTSS Care Coordination and to coordinate services as well as contracted providers, community resources and facilities.

IV. References

3 Way Contract. (2018). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.

APL 17-012 Care Coordination Requirements for Managed Long-Term Care Services and Supports
APL 17-013 Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities

DPL 15-001 Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans

Cal MediConnect Continuity of Care Technical Assistance Guide (TAG). (2015, October 27). California, USA.

DPL 16-002 Continuity of Care

DPL 16-003 Discharge Planning for Cal MediConnect

DPL 17-001 Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect

All Call Center Letters, CA Department of Aging 20-08, 10, 11 and 12 (CBAS COVID)

All Plan Letter 20-007, 009 (COVID)

SCFHP Procedures: QI 16.02-IHSS, QI 16.03-MSSP and QI 16.04-CBAS

NCQA Guidelines 2019

SCFHP NCQA Population Health Management Strategy (2019)

V. Approval/Revision History

First Level Approval	Second Level Approval
 Signature Lori Andersen Name Director of LTSS Title Date	 Signature Laurie Nakahira, MD Name Chief Medical Officer Title Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1.0	**Original**			
v1.1	**Revised**			
v1.2	**Revised**			

POLICY

Policy Title:	Care Coordination Staff Training	**Policy No.:**	QI.19
Replaces Policy Title (if applicable):	n/a	**Replaces Policy No. (if applicable):**	n/a
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal ☒ CMC		

I. Purpose

To outline Santa Clara Family Health Plan's consistent processes for providing initial and ongoing education and training to all Care Coordination staff who have responsibilities related to serving members and the skills to meet member needs related to care coordination principles.

II. Policy

A. Santa Clara Family Health Plan (SCFHP) Care Coordination staff will receive initial and on-going education and training to provide members with access to quality health care that is delivered in a cost-effective and compassionate manner

B. Training will be provided in a variety of educational formats including, but not limited to, the distribution of documents, classroom, informational sessions, and virtual learning modules as appropriate

C. Care Coordination Staff training includes, but is not limited to, the following:

1. Overview of regulatory and contractual requirements
2. Organizational objectives
3. SCFHP policies and procedures
4. Member eligibility and benefits
5. Member rights and responsibilities
6. Health Insurance Portability and Accountability Act (HIPAA)
7. Seniors and Persons with Disabilities (SPD)
8. Disability Awareness and Sensitivity
9. Population Health Management
10. Interdisciplinary Care Teams (ICTs) role and responsibilities
11. Long Term Services and Supports (LTSS) eligibility, referrals and operations
12. Behavioral Health services and coordination
13. Grievance and appeals process
14. Pharmacy management
15. Care Coordination and care transitions
16. Cultural Competency and available Cultural and Linguistic Services
17. Community resources and services
18. Person centered planning process
19. Wellness principles

20. Understanding Dementia

D. Training content is reviewed and updated as needed to meet state and federal regulatory requirements as well as other best practices. Staff training is completed upon hire, reviewed annually and as needed.

III. Responsibilities

Health Services management works with internal departments, external partners and providers to provide staff training to prepare Care Coordination to best assist and support our members.

IV. References

Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect (2019)

Department of Health Care Services (DHCS) All Plan Letter (APL) 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities

Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans

V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen Interim Director, Case Management	Laurie Nakahira, D.O. Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve	08/05/2016
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V1	Reviewed	Quality Improvement	Approve	06/06/2018
V2	Revised	Quality Improvement	Approve	04/14/2021

POLICY

Policy Title:	**Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)**	**Policy No.:**	QI.23
Replaces Policy Title (if applicable):	**Alcohol and Drug Misuse: Screening, Assessment, Brief Interventions, and Referral to Treatment in Primary Care**	**Replaces Policy No. (if applicable):**	QI.23 v3
Issuing Department:	Health Services – Behavioral Health	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To outline Santa Clara Family Health Plan's process for providing required Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) to members ages 11 years and older, including pregnant women.

II. Policy

A. The US Preventative Services Task Force (USPSTF) uses the term "unhealthy alcohol use" to define a spectrum of behaviors, from risky drinking to Alcohol Use Disorder (AUD) (e.g., harmful alcohol use, abuse, or dependence). Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for health consequences, but not meeting criteria for AUD. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "heavy use" as exceeding the recommended limits of 4 drinks per day or 14 drinks per week for adult men or 3 drinks per day or 7 drinks per week for adult women. The term "unhealthy drug use" is defined as the use of illegally obtained substances, excluding alcohol and tobacco products, or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual.

B. SCFHP's policy is to support the contracted network in screening, assessment, brief interventions, and referral to treatment for members over the age of 11, including pregnant women, in the primary care setting. AAP/Bright Futures Initiative recommends screening, assessment, and follow up action should begin at 11 years of age for tobacco, alcohol, and drug use. The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years and older, and providing persons engaged in risky and hazardous drinking with brief behavioral counseling intervention to reduce unhealthy alcohol use. It is the policy of SCFHP to meet the Department of Health Care Services (DHCS) expanded contractual requirements for all preventative services for members who are 21 years of age or older consistent with USPSTF Grade A&B recommendations.

   a. <u>Screening</u>

      Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. Validated screening tools include, but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults o The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population.

b. Brief Assessment
When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use disorder (AUD) or substance use disorder (SUD) is present. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

c. Brief Interventions and Referral to Treatment
For recipients with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD. SCFHP must make good faith efforts to confirm whether members receive referred treatments and document when, where, and any next steps following treatment. If a member does not receive referred treatments, the SCFHP must follow up with the member to understand barriers and make adjustments to the referrals if warranted. MCPs should also attempt to connect with the provider to whom the member was referred to facilitate a warm hand off to necessary treatment. Brief interventions must include the following: Providing feedback to the patient regarding screening and assessment results; Discussing negative consequences that have occurred and the overall severity of the problem; Supporting the patient in making behavioral changes; and Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated.

d. Documentation Requirements
SCFHP will ensure that PCPs maintain documentation of SABIRT services provided to members. Member medical records must include the following: The service provided (e.g., screen and brief intervention); The name of the screening instrument and the score on the screening instrument (unless the screening tool is embedded in the electronic health record); The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record); and If and where a referral to an AUD or SUD program was made.

C. Providers in SCFHP primary care settings must offer and document SABIRT services are offered. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's

prior medical records, including those pertaining to the provision of preventive services. SCFHP will continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and SUD treatments and coordinate services between Primary Care Providers (PCP) and treatment programs.

D. SCFHP will not limit behavioral counseling interventions. Beneficiaries who meet criteria for an alcohol or substance use disorder or whose diagnosis is uncertain, are to be referred for further evaluation to the Santa Clara County Substance Use Treatment Services Gateway Call Center at 1-800-488-9919.
E. SCFHP will arrange referral to Gateway Call Center when indicated, or to other community resources when services are not available through the county substance abuse treatment services program, and to outpatient heroin detoxification providers available through the Medi-Cal Fee-For-Service program for appropriate services.
F. SABIRT services may be provided by providers within their scope of practice, including, but not limited to:
    a. Physicians
    b. Physician assistants
    c. Nurse practitioners
    d. Certified nurse midwives
    e. Licensed midwives
    f. Licensed clinical social workers
    g. Licensed professional clinical counselors
    h. Psychologists
    i. Licensed marriage and family therapists.

III. Responsibilities

A. SCFHP's Behavioral Health Department is responsible for monitoring compliance with the policy.
B. SCFHP's Health Services Department coordinates with the Quality Improvement Department to collaborate with the assistance of the Health Education, Provider Services and Behavioral Health Departments to train/educate providers in the provision of the SABIRT.
C. SCFHP must comply with all applicable laws and regulations relating to the privacy of SUD records, as well as state law concerning the right of minors over 12 years of age to consent to treatment, including, without limitation, Title 42 Code of Federal Regulations (CFR) Section 2.1 et seq., 42 CFR Section 2.14, and Family Code Section 6929.
D. SCFHP can provide linkage to treatment and may assist members in locating treatment service facilities. SCFHP will pursue placement outside of the county if treatment slots are not available within the county substance abuse treatment services program.
E. SCFHP must include information about SABIRT services in member-informing materials.

IV. References

Department of Health Care Services (DHCS) All Plan Letter 21-014 – Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment
Title 42 Code of Federal Regulations (CFR) Section 2.1 et seq.
Family Code Section 6929

POLICY

Bright Futures Periodicity Schedule and Guidelines for Pediatric Preventive Care
The US Preventative Services Task Force (USPSTF) Guidelines

V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen, RN Director, Case Management & Behavioral Health	Laurie Nakahira, DO Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement Committee	Approve	02/21/2018
V2	Reviewed	Quality Improvement Committee	Approve	06/03/2019
V3	Revised	Quality Improvement Committee		

POLICY

Policy Title:	Health Homes Program	Policy No.:	QI.28 v2
Replaces Policy Title (if applicable):		Replaces Policy No. (if applicable):	
Issuing Department:	Health Services – Care Management	Policy Review Frequency:	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

The Health Homes Program (HHP) offers coordinated care to individuals with multiple chronic health conditions, including mental health, substance use disorders and those experiencing homelessness. The HHP is a team-based clinical approach that includes the member, their providers, and family members (when appropriate). The HHP builds linkages to community supports and resources, as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

The Medi-Cal HHP offers comprehensive, high quality health care for eligible Santa Clara Family Health (SCFHP) Plan Medi-Cal members. The purpose of this policy is to identify all of the HHP requirements for SCFHP and selected Community-Based Care Management Entities (CB-CMEs). SCFHP will work with selected CB-CMEs to facilitate care planning, care coordination, care transitions, and housing navigation services. SCFHP will utilize communication and reporting capabilities to perform health promotion, encounter reporting, and quality of care reporting. Selected CB-CMEs will serve as the community-based entity with responsibilities that will ensure members receive access to HHP services.

II. Policy

SCFHP will be responsible for the overall administration of the HHP. SCFHP will have oversight of the CB-CMEs and their performance. CB-CMEs will provide all members with access to the same level of HHP service, in accordance with the tier/risk grouping that is appropriate for members' needs and HHP service requirements. SCFHP will perform regular auditing and monitoring activities to ensure that all HHP services are delivered according to the contract signed by the selected CB-CMEs and SCFHP. SCFHP will select and assess the readiness of community organizations to serve as CB-CMEs. Selected entities will need to provide all core services of the HHP, including:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports
- Housing Navigation

III. Responsibilities

A. SCFHP

POLICY

1. Maintain the HHP infrastructure with contracted CB-CMEs and ensure that the roles and division of responsibility between the CB-CME and SCFHP are clearly identified
2. Ensure that the CB-CME has the capacity to provide assigned HHP members with a multi-disciplinary care team
    a. SCFHP will encourage participation of member care team members who are not on the multi-disciplinary care team (such as a member's PCP or Specialist)
3. Share information with CB-CMEs to assist with identifying patients and providing HHP services; data sharing agreements will be established with selected CB-CMEs and SCFHP:
    a. SCFHP will notify CB-CME of inpatient admissions and ED visits/discharges
    b. SCFHP will share each member's health history with assigned CB-CMEs
    c. Data will be exchanged between CB-CME and SCFHP to better track CMS-required quality measures and state-specific measures, including health status and outcomes data for the DHCS evaluation process
4. Identify, review and prioritize HHP eligible members by tier/risk grouping and assign members to CB-CMEs
    a. Identify members through the DHCS-provided Targeted Engagement List (TEL), internal TEL, and member/provider referrals
    b. Group members according to a tier structure, which should correlate with the member's risk grouping and intensity of services needed
5. Reduce the duplication of services to the member by verifying eligible members' involvement in other case management programs (e.g., Whole Person Care)
6. Develop CB-CME training tools as needed, as well as coordinate trainings to strengthen skills for CB-CMEs in conjunction with HHP
7. Develop and administer payment structure for CB-CMEs
    a. Payment structure may consider the payments received from DHCS, member's tier/risk grouping and any other supplemental funding
8. Prepare SCFHP's Customer Service, Nurse Advice Line, and other staff as necessary to ensure HHP members' needs can be addressed

B. CB-CME Responsibilities
1. CB-CMEs retain overall responsibility for all duties that the CB-CME has agreed to perform for SCFHP, as defined in the contract between the CB-CME and SCFHP
    a. CB-CME will perform all seven core services to the HHP-eligible member, as defined in the DHCS HHP Program Guide
2. Complete a readiness assessment as developed by SCFHP
    a. If services are insufficient, CB-CME will work with SCFHP to fulfill the readiness gaps prior to enrolling members
3. Ensure that providers with experience servicing frequent utilizers of health services and those experiencing homelessness, are available as needed per AB 361 requirements
4. Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate
5. Ensure assigned HHP members receive access to HHP services including completing a patient-centered health action plan (HAP) within 90 days of enrollment
    a. Maintain a strong and direct connection to the PCP and ensure PCP's participation in HAP development and ongoing coordination

b. Assess the HHP member's physical, behavioral, substance use, palliative, trauma-informed care, and social services need using screenings and assessments with standardized tools

6. Maintain a multi-disciplinary care team to provide outreach and enrollment
   a. CB-CME will utilize assigned member lists provided by SCFHP to complete outreach and enrollment
   b. Ensure needs are met based on the member's HAP and the tiered structure outlined by SCFHP
7. Utilize existing health information technology (HIT) to collect and share data to SCFHP
   a. If CB-CME does not have adequate technology, CB-CME will work with SCFHP to determine how information will be shared for HHP services and reporting purposes
8. CB-CME will attend required trainings for the HHP
9. CB-CME may utilize community health workers to conduct outreach and other services as appropriate

IV. References

Department of Health Care Services. (2018). *Medi-Cal Health Homes Program-Program Guide.* Sacramento, CA

Department of Health Care Services. (2018). *All Plan Letter 18-012.* Sacramento, CA: Managed Care Quality and Monitoring Division.

Legislative Counsel's Digest. (2013). *AB-361 Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Population with Chronic and Complex Conditions.* Sacramento, CA: Marjorie Swartz.

V. Approval/Revision History

First Level Approval	Second Level Approval
Lori Andersen Director, Managed Long Term Supports and Services	Laurie Nakahira Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement Committee	12/05/2018	
V2	Revised	Quality Improvement Committee		

POLICY

Policy Title:	**Health Risk Assessment**	**Policy No.:**	QI.30
Replaces Policy Title (if applicable):	n/a	**Replaces Policy No. (if applicable):**	n/a
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal ☒ CMC		

I. Purpose

To outline Santa Clara Family Health Plan's process for identifying potential health risks of Cal MediConnect (CMC) and Medi-Cal only Seniors and Persons with Disabilities (SPD) members based on the responses provided by the member in the Health Risk Assessment (HRA) that is to be used for development of a member's Individualized Care Plan (ICP).

II. Policy

A. Santa Clara Family Health Plan (SCFHP) shall identify the health risk of each newly enrolled CMC and Medi-Cal only SPD members using a proprietary Risk Stratification Algorithm to identify members who have High Risk and more complex health needs and those who have Low Risk.

B. The Risk Stratification Algorithm shall incorporate member-specific utilization data for the most recent 12 months to identify members who are High Risk and have more complex healthcare needs. These data sources may include, but not limited to:
   a. Medicare Parts A, B, and D;
   b. Medi-Cal FFS;
   c. Medi-Cal In Home Supportive Services (IHSS);
   d. Multipurpose Senior Services Program (MSSP);
   e. Skilled Nursing Facility (SNF);
   f. Behavioral health pharmacy;
   g. Outpatient, inpatient, emergency department, pharmacy, and ancillary services; and
   h. Results of previously administered assessments

C. SCFHP identifies higher risk members for meeting any one of the following criteria:
   a. Has been on oxygen within the past 90 days;
   b. Has been hospitalized within the last 90 days, or has had three or more voluntary and/or involuntary hospitalizations within the past year;
   c. Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases);
   d. Has IHSS greater than or equal to 195 hours/month. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files;
   e. Is enrolled in MSSP;
   f. Is receiving Community Based Adult Services;

g. Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant;
h. Has cancer and is currently being treated;
i. Has been prescribed anti-psychotic medication within the past 90 days;
j. Has been prescribed 15 or more medications in the past 90 days; or
k. Has other conditions as determined by the SCFHP, based on local resources.

D. Members stratified as High Risk shall be assessed using the HRA within forty-five (45) days of enrollment with SCFHP.
E. Members stratified as Low Risk shall be assessed using the HRA within ninety (90) days of enrollment with SCFHP.
F. All communications, whether by phone, mail, or in-person, shall be provided in a linguistically and culturally appropriate manner.
G. SCFHP shall use the completed HRA to develop an ICP to meet the member's medical, functional, cognitive, psychosocial, social support, and access to care needs as appropriate.
H. Members shall be reassessed, using the HRA, as appropriate, as follows:
   a. Annually, for all active members, within twelve (12) months of completing the last HRA, or before the enrollment anniversary date of the member if no HRA was obtained in the prior measurement year, or
   b. As often as the medical, functional, cognitive, psychosocial, and social needs of the member requires based on clinical review of the SCFHP Care Coordination staff
I. SCFHP shall ensure a process for incorporating member and stakeholder input in the development and update of the HRA for the CMC population that includes, but is not limited to, reviewing the tool and process at:
   a. Member Advisory Committee (MAC) meeting or other member events
   b. Quality Improvement Committee (QIC) meeting, and
   c. Provider Advisory Committee (PAC) meeting

III. Responsibilities

Health Services collaborates with other SCFHP departments as well as providers and community partners to identify member risks and gaps, and to coordinate services and benefits for positive member outcome and optimum health.

IV. References

Santa Clara Family Health Plan Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-001: Health Risk Assessment and Risk Stratification Requirements for Cal MediConnect
Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 15-001: Interdisciplinary Care Team and Individual Care Plan Requirements for Medicare-Medicaid Plans
Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements (2018)
Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements (2021)

POLICY

Department of Health Care Services (DHCS) All Plan Letter (APL) 17-013: Requirements for Health Risk Assessment of Medi-Cal Seniors and Persons with Disabilities (2017)

V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen Interim Director, Case Management	Laurie Nakahira, D.O. Chief Medical Officer
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	**Original**	**Quality Improvement**	**Approve**	**04/14/2021**

POLICY

Policy Title:	**Community Supports (CS)**	**Policy No.:**	QI.31
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services, Long Term Services and Supports (LTSS)	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐Healthy Kids	☐CMC

I. Purpose

The purpose of this policy is to define Community Supports (CS) and distinguish the responsibilities for delivering CS between SCFHP and CS providers.

II. Definition

CS are medically-appropriate and cost-effective substitutes or settings for more costly Medi-Cal health care services. CS are not Medi-Cal benefits, but supplemental services paid by SCFHP that focus on addressing combined medical and social determinants of health needs to avoid higher levels of care and are typically delivered by a different provider or in a different setting than traditional Medi-Cal benefits. CS is one of many initiatives of the Department of Health Care Services (DHCS)'s California Advancing and Innovating Medi-Cal (CalAIM).

III. Policy

SCFHP is responsible for the overall administration of CS, including providing oversight and monitoring of all contracted CS providers, ensuring providers adhere to all requirements as set forth by DHCS and SCFHP, evaluating provider performance on quality measures and metrics, and submitting reporting to DHCS. SCFHP ensures that members are determined eligible and authorized for CS and are aligned with an Enhanced Care Management (ECM) Population of Focus. Once authorized for CS, SCFHP assigns members to CS providers for the delivery of the CS in accordance with guidelines and requirements defined in the *CS Vendor Agreement* and the *CS Provider User Guide*. SCFHP monitors the processes for member identification, referral intake, eligibility determination, authorization, provider assignment, service delivery, closed-loop notification to referring entity, claim and invoice submission, reporting, and quality assurance. SCFHP works collaboratively with member care teams to integrate services with ECM or other case management programs to help members live independently and address social determinants of health (SDOH) or other social needs. SCFHP maintains a 'no wrong door' policy for those members who do not meet the eligibility criteria for CS to ensure warm handoffs to community-based entities for the provision of CS-equivalent services.

IV. Responsibilities

A. SCFHP Responsibilities
   1. CS Provider Network
      a. Network Development

i. SCFHP identifies providers who have experience, expertise, and capacity to deliver CS to SCFHP members. LTSS staff distribute a CS readiness assessment to all interested CS providers and require providers to complete it within a specified timeframe, participate in meetings to address any concerns with the assessment, and respond to follow-up questions.
ii. SCFHP considers all qualified providers by each offered CS to determine overall provider capacity based on pre-determined estimates of eligible members, geographical representation (if applicable), and specialties or strengths of particular providers that may impact specific member needs.
iii. SCFHP ensures that providers understand the terms, requirements, payment rates, and claim and invoice process for any CS that they are interested in providing to SCFHP members. SCFHP requires CS providers to adhere to the eligibility criteria, restrictions and/or limitations, and program models for the delivery of CS.
iv. SCFHP engages interested providers in the contracting process, which includes a credentialing process and execution of a *CS Vendor Agreement*.
v. Upon launch of a CS, SCFHP ensures that it has an adequate network of providers to ensure that all eligible members will have access to the CS after being authorized. As such, SCFHP will adhere to its implementation plan to ensure that the network is not only adequate for newly launched CS, but also for ongoing CS should the demand for the services increase resulting in a need to expand the networks.

b. Provider Training and Technical Support
i. SCFHP is responsible for providing its standard Network Provider training to all CS providers, as well as an initial training to support the launch of CS.
ii. SCFHP hosts ongoing trainings and distributes materials to ensure consistency for delivering the CS to SCFHP members.
iii. SCFHP hosts provider meetings to provide technical support to providers by discussing challenges and issues, clarifying requirements, discussing best practices, and creating a forum for general communication among CS providers.

2. Member Identification
a. SCFHP identifies Members eligible for offered CS by working with Enhanced Care Management (ECM) providers to identify members receiving ECM who could benefit from and be eligible for CS and encouraging referrals for CS from internal case managers.
b. SCFHP promotes the self-referral process for members, their authorized representatives, and/or family supports for submitting referrals for CS.
c. SCFHP provides trainings and materials to network primary care physicians (PCPs), Enhanced Care Management (ECM) providers, internal SCFHP and external case managers, CS providers, community-based organizations (CBOs), and other providers on offered CS, general eligibility for CS, and how to refer their patients/clients to CS.

3. Referral Process

a. SCFHP accepts referrals or requests for CS electronically via online provider portal, fax, secure email, or U.S. mail using procedures that address required functions that support equitable and cost-effective use of services.
b. SCFHP manages and provides all oversight for the referral intake, eligibility determination, timelines, accuracy of data, and assignment to a contracted CS provider for the delivery of the CS.
c. SCFHP ensures that the referring entity is notified of the receipt of a referral, status of the referral, and completion of the delivered CS through a closed-loop referral process.

4. Eligibility Determination and Authorization
   a. SCFHP staff uses all information available to determine eligibility for CS referrals and authorizes or denies based on strict adherence to the eligibility criteria as defined by DHCS.
   b. SCFHP assigns to an appropriate CS provider that has capacity to accept new CS referrals.
   c. SCFHP makes a concerted effort to ensure that if a referring member does not meet the eligibility criteria for the CS that other documentation is acquired from the referring entity, ECM provider, case manager, PCPs, CBOs, and others before denying the request for CS. In addition, SCFHP must review internal data (utilization, claims, case management notes, etc.) and incorporate it into the decision to deny the request.
   d. SCFHP adheres to criteria set forth in its procedures for situations that warrants expediting authorization for members needing immediate access to CS.
   e. SCFHP adheres to the timelines as set forth in its procedures to ensure that CS are authorized in a timely manner.
   f. SCFHP assigns members for authorized CS to CS providers within specified timeframes as designed by DHCS for timely access to services.
   g. SCFHP sends written notifications to members, assigned CS providers, and the referring entities related to the authorization of CS and to members and the referring entity for denied CS.

5. Discontinuation
   a. SCFHP provides access to health plan eligibility information to all CS providers.
   b. SCFHP requires all CS providers to review health plan eligibility prior to delivering a service.
   c. Members who no longer have coverage under SCFHP are not authorized to receive CS services.
   d. Members who are no longer interested in continuing a CS can notify the CS provider or SCFHP to discontinue. CS providers direct member to SCFHP to discontinue.
   e. SCFHP reviews all requests for discontinuation and applicable documentation and processes the discontinuation with 3 business days of receipt
   f. SCFHP provides written notification to members, the referring entity, and the assigned provider for any discontinuation of service.
   g. Members who discontinue from CS are able to request CS at another time by contacting SCFHP or a referring entity can submit a new referral for CS.

6. Data Systems and Data Sharing
   a. SCFHP maintains appropriate systems for collecting and maintaining data for tracking CS referrals, determining eligibility, assigning to CS providers, providing status on the delivery of CS,

documenting submitted claims and invoices, documenting payments released to providers, providing status on filed grievances and appeals, and tracking performance on quality measures and metrics.

b. Consistent with all federal, state, and local privacy and confidentiality laws, SCFHP shares data with CS providers via a secure system (e.g., SFTP). Data that SCFHP provides is member demographics, utilization, SDOH and other social needs, and performance on quality measures.
c. SCFHP uses defined federal and state standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with CS providers, to the extent practicable.

7. Claims and Payment
   a. SCFHP ensures that all CS providers understand the requirements for submitting claims or invoices for payment after CS has been rendered.
   b. If CS providers are not able to submit claims, SCFHP must convert the invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.
   c. SCFHP releases payment for rendered CS only when the CS was authorized prior to the start of the delivery of the services.
   d. SCFHP adheres to the timelines set forth by DHCS for the release of payment for clean claims.
   e. SCFHP collects, maintains, and monitors CS expenditures for reporting and evaluation purposes.

8. CS Network Oversight
   a. SCFHP provides oversight of all CS providers, holding them accountable to all CS requirements as set forth by the DHCS and SCFHP, and are subject to change based on updated guidance from DHCS.
   b. SCFHP ensures that CS providers adhere to the processes as defined in the *CS Provider User Guide* and the services are delivered in accordance with SCFHP's CS program models.
   c. SCFHP requires all CS providers to adhere to the same reporting requirements as those that DHCS requires of SCFHP.
   d. SCFHP provides ongoing monitoring of the provider network capacity for each CS and will expand the capacity of current providers and/or engage additional providers to meet the demand. With sufficient monitoring, SCFHP avoids placing members on waiting lists for any CS that does not have any restrictions. SCFHP anticipates that for those CS that will launch with restrictions, SCFHP will place members on a waiting list with CS services provided on a first referred, first authorized basis to ensure that SCFHP is equitable and non-discriminatory.
   e. SCFHP provides ongoing monitoring of CS providers, which includes meetings, trainings and technical assistance, data sharing on cost-effectiveness and the outcome of the provision of the CS, and other activities.
   f. SCFHP adheres to requirements set forth by DHCS on reporting and outcome monitoring and evaluation of performance measures and metrics.
   g. SCFHP adheres to its procedure on evaluating whether an elected CS is a cost-effective alternative to a State Plan service or setting.

B. CS Provider Responsibilities

POLICY

1. Vetting and Contracting
   a. CS providers must submit a completed CS readiness assessment and supporting evidence to illustrate their experience and expertise in providing the CS, and the capacity and ability to meet all of the service requirements.
   b. CS providers are required to complete the CS credentialing process as defined in the *CS Vendor Agreement.*
   c. CS providers must understand the terms, requirements, payment rates, and claim and invoice process for any CS that they are providing to SCFHP members. In addition, CS providers must adhere to the eligibility criteria, restrictions and/or limitations, and program models for the delivery of the CS.
   d. CS providers must hold their subcontractors accountable to the same standards and requirements as SCFHP requires of CS providers.
   e. CS providers must participate in trainings, technical assistance sessions, meetings, and other forums related to the launch of CS and the ongoing support to ensure consistent and effective delivery of CS.
   f. CS providers must execute a *CS Vendor Agreement* prior to delivering any services to SCFHP members.

2. Patient Identification and Referral Submission
   a. CS providers must share details on CS with their patients/clients, have the ability to screen for basic qualifications and need for CS, and submit a referral to SCFHP on behalf of members if deemed appropriate.
   b. CS providers must adhere to SCFHP's requirements for submitting a referral for CS.
   c. CS providers must formally accept the referral for authorized CS before providing services to members.
   d. CS providers must regularly update the SCFHP with outcomes on the delivery of the authorized CS.

3. Service Delivery
   a. CS providers are required to adhere to the service definitions and requirements for each CS they are contracted to deliver as defined in the *CS Provider User Guide*.
   b. CS providers are required to adhere to the designated program model for each of the CS they are contracted to provide in order to standardize the delivery services among all CS providers.
   c. CS providers are required to maintain appropriate staffing who is experienced and skilled in the delivery of the CS. Should staffing decrease below an appropriate level, CS providers need to restructure their current staffing and/or hire new staff to increase staffing to an appropriate level to ensure effective and efficient delivery of the CS.
   d. CS providers must accept and act upon CS referrals, conduct initial and ongoing outreach, and respond to related communication in accordance to the timelines set forth by DHCS and SCFHP.
   e. CS providers must coordinate the delivery of CS with members' care teams, PCPs, CBOs, and other providers; and assist with the transition to other services should members discontinue CS.
   f. CS providers are encouraged to identify additional CS that members may benefit from whether they are or are not contracted to provide them and submit referrals to SCFHP.

4. Data System and Data Sharing
   a. CS providers must accept and/or make referrals using SCFHP's stated process. CS providers must be able to receive CS assignments, update others on the status of the delivery of the CS, and report outcomes after CS are rendered in a mutually-agreed upon timeframe and method.
   b. CS providers must submit the required reporting as defined in the *CS Vendor Agreement* by the specified submission dates. Reported data must be accurate and properly monitored, and is subject to auditing by SCFHP and DHCS.

5. Claim Submission
   a. CS providers must submit claims using specifications based on national standards and code sets as defined by DHCS. For CS providers that submit invoices, they must include the minimum necessary data elements defined by DHCS. Claims and invoices must be submitted within the designated timeframe as specified by DHCS and defined in the *CS Vendor Agreement*.
   b. CS providers may not submit claims or invoices for rendered CS that were not authorized prior to the start of delivering the CS.

C. CS Implementation
   1. SCFHP has established a timeline for launching all 14 of the DHCS-approved CS between 1/1/2022 and 7/1/2023 in six-month increments.
   2. When launching a CS, SCFHP ensures that it has a sufficient provider network to minimize any restrictions on providing the CS and ensure that all eligible members are able to access the services.
   3. For all launched CS, SCFHP will expand the provider networks over time to ensure their capacity increases to accommodate all members who are determined eligible for CS services.

V. References

- CalAIM-Proposal-Updated-1-8-21
- MCP-ECM-and-CS-Contract-Template-Provisions-05282021
- ECM-and-CS-Standard-Provider-Terms-and-Conditions-05282021
- ECM-CS-Model-of-Care-Template-05282021

VI. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
Lori Andersen, Director, LTSS		
[Manager/Director Name] [Title]	[Compliance Name] [Title]	[Executive Name] [Title]
Date	Date	Date

POLICY

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1		QIC		

POLICY

Policy Title:	**Enhanced Care Management (ECM)**	**Policy No.:**	QI.32
Replaces Policy Title (if applicable):	N/A	**Replaces Policy No. (if applicable):**	N/A
Issuing Department:	Health Services, Long Term Services and Supports (LTSS)	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

The purpose of this policy is to define Enhanced Care Management (ECM) and distinguish the responsibilities for delivering ECM between SCFHP and contracted ECM providers.

II. Definitions

A. ECM: A whole person care approach that addresses the clinical and non-clinical needs of high-need, high-cost Medi-Cal members through systematic coordination of services. ECM is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals that is community based, interdisciplinary, high touch, and person centered. The goals of ECM are to improve care coordination, integrate services, facilitate community resources, address social determinants of health (SDOH), improve health outcomes, and decrease inappropriate utilization and duplication of services.

B. ECM Providers: Contracted community-based entities with the experience and expertise to provide intensive, in-person care management services to individuals who meet the eligibility criteria for one or more of the ECM Populations of Focus (POF).

C. Lead Care Manager: A member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be SCFHP staff). The Lead Care Manager operates as part of the member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Services (CS). To the extent a member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services.

D. Populations of Focus (POF): To be eligible for ECM, members must be enrolled in Medi-Cal Managed Care and meet the eligibility criteria for one or more of the ECM POF. The seven POF are:

1. Adults and families experiencing homelessness, chronic homelessness, or who are at risk of homelessness
2. High utilizers adults with frequent hospital admissions, short-term skilled nursing facility stays or emergency room visits
3. Adults with Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)

4. Individuals transitioning from incarceration and have significant complex health needs
5. Individuals at-risk for institutionalization and are eligible for long term care (LTC)
6. Nursing facility residents who are willing and able to transition to the community
7. Children with complex health needs

III. Responsibilities

A. SCFHP Responsibilities

1. ECM Provider Network
   a. Network Development
      i. SCFHP identifies providers who have experience, expertise, and capacity to deliver ECM to members. LTSS staff distribute an ECM readiness assessment to all interested providers and require providers to complete it within a specified timeframe, participate in meetings to address any concerns with the assessment, and respond to follow-up questions.
      ii. SCFHP considers all qualified providers and determines overall provider capacity based on pre-determined estimates of eligible members, special focus on ECM POF, geographical representation (if applicable), and specialties or strengths of particular providers that may impact specific member needs.
      iii. SCFHP ensures that providers understand the terms, requirements, payment rates, and claim and invoice process for ECM. SCFHP requires ECM providers to adhere to the expectations and requirements set forth by DHCS and SCFHP.
      iv. SCFHP engages interested providers in the contracting process, which includes a credentialing process and execution of an *ECM Agreement*.
      v. Upon initial implementation, SCFHP ensures that it has an adequate network of providers to ensure that all eligible members have access to ECM services. After initial implementation, SCFHP ensures that it will expand its provider network to account for newly implemented POF and an overall increase in the number of members enrolled in ECM over time.

   b. Provider Training and Technical Support
      i. SCFHP is responsible for providing its standard provider network training to all ECM providers, as well as an initial training to support the launch and ongoing delivery of ECM.
      ii. SCFHP hosts ongoing trainings and distributes materials to ensure consistency for delivering ECM to members.
      iii. SCFHP hosts provider meetings to provide technical support which may include discussing challenges and issues, clarifying requirements, discussing best practices, and creating a forum for general communication among ECM providers.

2. Member Identification and Referral Process

a. SCFHP proactively identifies members who may benefit from ECM and who meet the eligibility criteria for one or more of the ECM POF. When identifying such members, SCFHP considers members' health care utilization, health risks and needs due to SDOH, and LTSS needs.
b. SCFHP identifies members for ECM using such data as enrollment, claims/utilization, pharmacy, lab, screening or assessment, clinical information on physical and/or behavioral health, SMI/SUD, ICD-10 codes, and other cross-sector data (e.g., housing, social services, foster care, criminal justice history, etc.)
c. SCFHP encourages ECM providers to identify members who meet the eligibility criteria for ECM and submit referrals to SCFHP for ECM.
d. SCFHP disseminates information and provides details on its referral process to primary care physicians (PCPs) and other provider groups to encourage them to submit referrals to SCFHP for members who may benefit from and be eligible for ECM.
e. SCFHP promotes the self-referral process for members, their authorized representatives, and/or family supports for submitting referrals for ECM.

3. Eligibility Determination and Authorization
   a. SCFHP staff adheres to the eligibility set forth by DHCS to determine whether members are eligible for ECM. SCFHP authorizes or denies based on strict adherence to the eligibility criteria as defined by DHCS and further refined by SCFHP.
   b. For transitioned members from Health Homes Program (HHP) and Whole Person Care (WPC), SCFHP adheres to DHCS requirements for transitioning them into ECM as outlined in its procedures.
   c. SCFHP adheres to its process as stated in its procedures for authorizing members for ECM in an equitable and non-discriminatory manner and within an appropriate timeline that ensures members access services in a timely manner.
   d. SCFHP adheres to criteria set forth in its procedures for situations that warrants presumptive authorization or preauthorization of ECM.
   e. SCFHP adheres to its standard notice process for denying ECM services when members do not meet the eligibility criteria, voluntarily discontinue, or meet one or more of the exclusion criteria.

4. Assignment to an ECM Provider
   a. SCFHP assigns to an appropriate contracted ECM provider that has the capacity and appropriate expertise to serve members based on the POF for which they are eligible. To the extent practicable, SCFHP takes into consideration member preference for assignment.
   b. If a member's assigned PCP is a contracted ECM provider, SCFHP assigns the member to the PCP as the ECM provider, unless the member expresses a different preference or SCFHP identifies a more appropriate ECM provider given the member's individual needs and health conditions.
   c. If a member receives services from a Specialty Mental Health provider for Serious Emotional Disturbance (SED), SUD, and/or SMI; or enrolled in California Children's Services (CCS); SCFHP

adheres to its procedures to assign the member to the appropriate ECM provider in accordance with DHCS requirements.

d. SCFHP assigns members to an ECM provider within ten business days of authorization.
e. SCFHP permits members to change ECM providers at any time and implements such change within thirty days.

5. Outreach and Engagement and Delivery of ECM
   a. SCFHP requires ECM providers to adhere to its requirements for conducting outreach and engagement into ECM in accordance with its procedures.
   b. SCFHP does not require verbal or written member authorization for ECM-related data sharing as a condition for initiating the delivery of ECM.
   c. SCFHP ensures that a Lead Care Manager is assigned to each member receiving ECM. The Lead Care Manager has the responsibility for interacting directly with the member and/or family, authorized representative, caretakers, and/or other authorized support person(s) as appropriate.
   d. SCFHP establishes and defines acuity levels for ECM. Upon determining members are eligible for ECM, SCFHP assigns the initial acuity level (i.e., tier) and communicates such to the assigned ECM provider.

6. Discontinuation
   a. SCFHP allows members to decline or end ECM upon initial outreach and engagement, or at any other time.
   b. SCFHP allows ECM providers to discontinue ECM for members when any of the circumstances are met as outlined in its procedures.
   c. SCFHP maintains processes to determine if a member is no longer authorized to receive ECM and notifies the assigned ECM provider to initiate the discontinuation of services in accordance with the Notice of Action (NOA) process as described in its procedures.
   d. SCFHP notifies the member when ECM is discontinued and provides information on their right to appeal and the appeal process by way of the NOA process.

7. Data Systems and Data Sharing
   a. SCFHP maintains an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to consume and use claims and encounter data, assign members to ECM providers, maintain records for members receiving ECM and authorizations for sharing member-specific data with ECM and other providers (if necessary), securely share data with ECM providers and others members of the care team, receive and process reports from ECM providers, manage referrals, and submit data to DHCS.
   b. SCFHP maintains and provides oversight of a Health Information Technology (HIT) platform jointly utilized by SCFHP and ECM providers.

c. SCFHP adheres to DHCS guidance on data sharing and provides the required information to all ECM providers, including inpatient admissions stays and discharges, emergency department (ED) use, medical history as needed.
d. SCFHP uses defined federal and state standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM providers and DHCS.

8. Claims and Payment
   a. SCFHP ensures that all ECM providers understand the requirements for submitting claims or invoices for payment.
   b. If ECM providers are not able to submit claims, SCFHP must convert the invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.
   c. SCFHP adheres to the timelines set forth by DHCS for the release of payment for clean claims and approved invoices.

9. Network Oversight
   a. SCFHP provides oversight of all ECM providers, holding them accountable to all ECM requirements as set forth by the DHCS and SCFHP, and are subject to change based on updated guidance from DHCS.
   b. SCFHP ensures that ECM providers adhere to the processes as defined in the *ECM Provider User Guide* and the core services are provided in accordance with member needs.
   c. SCFHP requires all ECM providers to adhere to the same reporting requirements as those that DHCS requires of SCFHP.
   d. SCFHP provides ongoing monitoring of the ECM provider network capacity and will expand the capacity of current providers and/or engage additional providers to meet the demand.
   e. SCFHP provides ongoing support to ECM providers, which includes meetings, trainings and technical assistance, best practices on outreach and engagement strategies, and other activities.
   f. SCFHP adheres to requirements set forth by DHCS on reporting and outcome monitoring and evaluation of performance measures and metrics.

B. ECM Provider Responsibilities

1. Vetting and Contracting
   a. ECM providers must submit a completed ECM readiness assessment and supporting evidence to illustrate their experience and expertise in providing the ECM core services and the capacity and ability to meet all of the service requirements.
   b. ECM providers are required to complete SCFHP's credentialing process as defined in the *ECM Agreement.*
   c. ECM providers must understand the requirements, payment rates, and claim and invoice process for ECM services they are providing to members.

d. ECM providers must hold their subcontractors accountable to the same standards and requirements as SCFHP requires of ECM providers.
e. ECM providers must participate in trainings, technical assistance sessions, meetings, and other forums related to the launch of ECM and the ongoing support to ensure consistent and effective delivery of ECM.
f. ECM providers must actively participate in semi-annual audits, provide documentation as requested by SCFHP and/or DHCS, and work to resolve any findings within the specified timeline that is outlined in the ECM audit process.

2. Member Identification and Referral Submission
   a. ECM providers identify members who may benefit from and are eligible for ECM and submit referrals to ECM for eligibility determination and authorization.
   b. ECM providers must adhere to SCFHP's requirements for submitting a referral to SCFHP for ECM.

3. Outreach and Engagement
   a. ECM providers utilize the Member Information File (MIF) to track and monitor their assigned members for ECM.
   b. ECM providers are required to conduct outreach to newly assigned members as identified on the monthly MIF and engage them into ECM in accordance with the required attempts and timeline as stated in the *ECM Provider User Guide*.
   c. ECM providers must track and monitor the enrollment status and the enrollment date of each assigned member and report changes in enrollment status on the monthly Return Transmission File (RTF) in adherence with DHCS and SCFHP requirements.
   d. ECM providers must submit outreach data on assigned members monthly to SCFHP as outlined in the *ECM Provider User Guide*.

4. Service Delivery
   a. ECM providers are required to maintain appropriate staffing who is experienced and skilled in the delivery of the ECM. Should staffing decrease below an appropriate level, ECM providers need to restructure their current staffing and/or hire new staff to increase staffing to an appropriate level to ensure effective and efficient delivery of ECM.
   b. ECM providers must provide all assigned and enrolled members all seven ECM core services, which include outreach and engagement, comprehensive assessment and care management plan, enhanced care management, health promotion, comprehensive transitional care, member and family supports, and coordination of and referral to community and social support services (includes Community Supports).
   c. ECM providers must deliver services primarily through in-person interaction in settings that are most appropriate for the member, such as where the member lives, seeks care, or prefers to access services; and in a culturally-appropriate and timely manner.

d. ECM providers must adhere to all federal laws and regulations and all ECM requirements as stated in *ECM Agreement* and the *ECM Provider User Guide*.
e. If a member is receiving duplicative services from other sources that are similar to ECM, ECM provider must notify SCFHP as part of their monthly reporting.

5. Data System and Data Sharing
   a. ECM providers must have and maintain a care management system or process that supports the documentation of member information, member needs, member care plan, and other relevant data that assists with the effective delivery of ECM to members.
   b. ECM providers must submit the required reporting as defined in the *ECM Agreement* and the *ECM Provider User Guide,* adhering to the specified data elements and in accordance with the submission dates. Reported data must be accurate and properly monitored, and is subject to auditing by SCFHP and DHCS.

6. Claim Submission
   a. ECM providers must submit claims using specifications based on national standards and code sets as defined by DHCS. For ECM providers that submit invoices, they must include the minimum necessary data elements defined by DHCS. Claims and invoices must be submitted within the designated timeframe as specified by DHCS and defined in the *ECM Agreement*.

C. ECM Implementation

1. SCFHP will go live with the seven POF in accordance with the timeline set forth by DHCS.
2. As SCFHP goes lives with each POF, SCFHP ensures that it has a sufficient provider network to deliver services to all members determined as eligible for ECM.
3. SCFHP will expand its ECM provider network over time to ensure its capacity increases to accommodate more members being determined as eligible for and in need of ECM.

IV. References

- CalAIM-Proposal-Updated-1-8-21
- MCP-ECM-and-CS-Contract-Template-Provisions-05282021
- ECM-and-CS-Standard-Provider-Terms-and-Conditions-05282021
- ECM-CS-Model-of-Care-Template-05282021

I. Approval/Revision History

First Level Approval	Second Level Approval

POLICY

Lori Andersen Director, Long Term Services and Supports	Dr. Laurie Nakahira Chief Medical Officer
Date	Date

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

Santa Clara Family Health Plan™

Consumer Advisory Board (CAB) Draft Minutes

March 3, 2022

Regular Meeting of the

Santa Clara County Health Authority
Cal MediConnect Consumer Advisory Board (CAB)

Thursday, March 3, 2022 11:30 AM – 1:00 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

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

Members Absent
Luis Gova Gonzalez
Charles Hanks
Verna Sarte
Dennis Schneider

Staff Present
Chelsea Byom, Vice President, Marketing, Communications, and Outreach
Laura Watkins, Vice President, Marketing and Enrollment
Mike Gonzalez, Director, Community Engagement
Johanna Liu, Director, Quality and Process Improvement
Thien Ly, Director, Medicare Outreach
Lucille Baxter, Manager, Quality and Health Education
Charla Bryant, Manager, Clinical Quality and Safety
Cristina Hernandez, Manager, Marketing and Public Relations
Jocelyn Ma, Manager, Community Outreach
Natalie McKelvey, Manager, Behavioral Health
Liz Sullivan, Manager, Communications
Andrea Smith, Supervisor, Case Management
Sherry Anne Faphimai, Graphic Design Project Manager
Byron Lu, Process Improvement Project Manager
Lynette Topacio, Marketing Project Manager
Zara Ernst, Health Educator
Jeanette Montoya, Health Educator
Ashley Kerner, Manager, Administrative Services
Amy O'Brien, Administrative Assistant

Others Present
Rita Cruz Gallegos, Aurrera Health Group

1. Roll Call

Dr. Laurie Nakahira, DO, Chief Medical Officer, and Chair called the meeting to order at 11:32 a.m., and roll call was taken. There was no quorum. Mr. Pathak noted that our thoughts are with the people of Ukraine. Dr. Nakahira introduced Rita Cruz Gallegos with Aurrera Health Group as a guest.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the December 2, 2021 Cal MediConnect (CMC) Consumer Advisory Board Committee meeting were reviewed.

4. Health Plan Update

Dr. Nakahira presented the Health Plan update. She began with an update on audit season. The National Committee for Quality Assurance (NCQA) re-accreditation audit for the Plan's CMC line of business occurred from March 1, 2022 through March 2, 2022. The audit went well and concluded after 1 day. The Plan is pending the written results. The Department of Health Care Services (DHCS) audit is scheduled to occur from March 7, 2022 through March 18, 2022. These are both routine audits.

As of January 1, 2022 the Plan implemented the Medi-Cal (MC) Enhanced Care Management (ECM) and Community Supports programs. As of December 31, 2021, the County's Whole Person Care and Health Homes programs were discontinued. The CMC program has begun its transition to the Dual Eligible Special Needs Plan (D-SNP), which will go into effect on January 1, 2023.

5. COVID-19 Update

Dr. Nakahira provided the committee with a COVID-19 update. Dr. Nakahira discussed the vaccination rates for SCFHP members, as compared to the residents of Santa Clara County. She also discussed the COVID-19 vaccine incentive program campaign goals. The Plan has partnered with Anthem Blue Cross to cobrand materials and increase vaccination rates. The Plan has held several vaccination clinics at both the Blanca Alvarado Community Resource Center and the Children's Discovery Museum.

6. Consumer Assessment of Healthcare Providers and Systems (CAHPS)/Health Outcome Survey (HOS)

Byron Lu, Process Improvement Project Manager, presented an overview of the CAHPS and HOS surveys. Mr. Lu began with an explanation of the purpose of the CAHPS survey, which is a requirement of the Centers for Medicare and Medicaid Services (CMS). The Plan achieved a 33.5% response rate, which is the highest response rate since 2016. Mr. Lu summarized the results of the survey. He also discussed the CAHPS strategy and goals for 2022.

Next, Mr. Lu gave an overview of the HOS survey. The HOS survey is mandatory for all Medicare Advantage plans and Medicaid-Medicare contracts. He discussed the purpose of the HOS survey, and he summarized the 2021 results. Mr. Lu also discussed the interventions that the Plan offers our members for comprehensive care. The Plan has formed internal workgroups to include the participation of our Provider networks.

7. 2022 Wellness Rewards Program

Lucille Baxter, Manager, Quality and Health Education, provided an overview of the 2022 Wellness Rewards program. Ms. Baxter outlined the various types of medical visits and screenings that qualify for wellness rewards. She also discussed the eligibility requirements, and the specific rewards members will receive for completion of screenings and visits. All screenings must be completed by December 31, 2022. These services do not require a doctor's authorization. Upon completion of any eligible screening, SCFHP will receive a claim from the rendering Provider, and a gift card will be mailed to the member.

Ms. Baxter introduced Sherry Anne Faphimai, Graphic Design Project Manager. Ms. Faphimai discussed the various direct mailing photo concepts under consideration that emphasize the importance of preventive screenings. Mr. Pathak provided her with feedback on how these images make him feel, and whether or not certain images speak to him more than others.

8. Standing Items

a. Community Resource Center

Mike Gonzalez, Director, Community Engagement, presented an overview of the recent activities at the Center. Mr. Gonzalez introduced Elizabeth Gonzales, the newest member of the Customer Service team. Mr. Gonzalez shared the monthly calendar of activities, which can be found on our website at www.crc.scfhp.com and through our social media account @CRC_SCFHP. He also shared the hours the Center is open.COVID-19 safety protocols remain in place. Mr. Gonzalez highlighted the services, programs, and events on offer at the Center.

Mr. Gonzalez discussed the impact of the CRC on the community. Members can receive in-person application assistance for enrollment into Covered California and Medi-Cal. The Center also provides members with resource navigation assistance. Mr. Gonzalez discussed the member orientation program. Members can sign up via our website, or by calling Customer Service. The CRC has hosted numerous COVID-19 vaccination clinics, in partnership with local school districts. He also highlighted the various cultural events hosted at the Center.

Mr. Gonzalez discussed the elements and strategies of the community-led CRC Planning Process and the process roadmap. He also spotlighted the members of the Resident Advisory Group. This planning process included a CRC Resident Survey targeted to residents within 6 specific zip codes in East San Jose. There were 770 respondents, and he summarized the key findings based on the respondents' feedback.

Mr. Gonzalez concluded his presentation with an outline of next steps and future plans for the CRC. He will finalize the CRC framework with the stakeholders, and he hopes to share this framework with the community in either late April or early May 2022.

b. Member Communications

Chelsea Byom, Vice President, Marketing, Communications, and Outreach discussed the member communications completed since the December 2021 meeting. Member communications included the winter newsletter, the CAHPS survey awareness postcard, and the COVID-19 vaccine rewards program. Her presentation highlighted the SCFHP website which is updated with meeting materials, and member materials such as the Formulary, Provider directory, newsletters, and COVID-19 vaccine information. Ms. Byom concluded with a list of the events the Plan participated in since our December 2021 meeting.

c. Behavioral Health

Natalie McKelvey, Manager, Behavioral Health, presented an overview of the Behavioral Health program. She discussed the California incentive and Grant programs. She also discussed the elements of the Student Behavioral Health Incentive Program and the Behavioral Health Continuum Infrastructure Program (BHCIP). The Governor has announced a multi-year plan to create infrastructure to support the homeless population and those with severe mental illness. Ms. McKelvey discussed the CalHOPE program. Ms. McKelvey concluded with an update on the new 988 hotline. The 988 hotline goes into effect on July 16, 2022, and is specifically for those experiencing a mental health crisis.

d. Case Management Update

Andrea Smith, Supervisor, Case Management, provided an overview of the Case Management and Care Coordination programs. She discussed the steps members can take in order to access care coordination. Ms. Smith also included contact information for members interested in case management and care coordination.

e. Health Education and Cultural Linguistics

Jeanette Montoya, Health Educator, presented an overview of the Health Education classes available at SCFHP. Available programs and classes include asthma education and an in-home assessment by Breathe California. Members can enroll in a wide range of classes, with topics such as chronic disease management, stress and anger management, nutrition and weight management, and smoking cessation programs. She also provided details on how to sign up for classes. Wellness and health education materials are available on our website at no cost to members. Ms. Montoya also discussed some of the new classes that SCFHP will roll out in 2022. Ms. Montoya's presentation also included a brief overview of how to access translation services.

f. Cal MediConnect Ombudsperson Program Update

Andy Le, Ombudsperson and Supervising Staff Attorney for Bay Area Legal Aid, gave an overview of the services available for our CMC members. Members with issues such as health plan enrollment, disenrollment, or healthcare access are encouraged to call Bay Area Legal Aid. There has been an increase in phone calls related to emergency health plan enrollment. The public health emergency is scheduled to end on April 16, 2022. As a result, the pause on MC redeterminations will be lifted, and more people may be terminated from MC for failure to renew their annual application. Members with concerns are encouraged to call Bay Area Legal Aid.

Mr. Le highlighted some of the changes to expect for 2022. As of May 2022, MC coverage expands to include undocumented older adults 50 years of age and over regardless of their immigration status. As of July 1, 2022, the state will raise the asset limit for MC recipients to $130,000 for an individual, and $65,000 for each additional family member, up to a maximum of 10 individuals. These asset limit increases also apply to participants in the Medicare Savings Program. This is part of the state's goal to eliminate the asset test requirement, which may be completely phased out in 2024.

Mr. Le advised the committee that an additional four COVID-19 tests are now available at www.covidtests.gov. Mr. Le also discussed the new Medi-Cal Rx program which took effect in 2022. Members who purchased COVID tests between March 11, 2021 and January 31, 2022 can request reimbursement by the state through the Medi-Cal Rx program.

g. Future Agenda Items

Dr. Nakahira asked for suggestions on topics of interest for our June 2, 2022 meeting. Mr. Pathak took the opportunity to express his gratitude for SCFHP, and the wonderful job the Plan has done with their COVID-19 vaccination outreach efforts.

9. Adjournment

The meeting adjourned at 1:05 p.m. The next Cal MediConnect Consumer Advisory Board meeting is scheduled for Thursday, June 2, 2022 at 11:30 a.m.

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

Santa Clara Family Health Plan™

Pharmacy & Therapeutics Committee Draft Minutes

March 17, 2022

Regular Meeting of the

Santa Clara County Health Authority

Pharmacy & Therapeutics Committee

Thursday, March 17, 2022, 6:00 PM – 8:00 PM

Santa Clara Family Health Plan

6201 San Ignacio Ave, San Jose, CA 95119

Minutes (Closed) - Draft

Members Present
Jimmy Lin, MD, Chair
Ali Alkoraishi, MD
Xuan Cung, PharmD
Dang Huynh, PharmD, Director of Pharmacy and UM
Laurie Nakahira, DO, Chief Medical Officer
Jesse Parashar-Rokicki, MD

Members Absent
Judy Ngo, PharmD
Peter Nguyen, DO

Staff Present
Kathy Le, PharmD, Pharmacy Resident
Duyen Nguyen, PharmD, Clinical Pharmacist
Caroline Tambe, PharmD, Clinical Pharmacist
Nancy Aguirre, Administrative Assistant

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:06 pm. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Open Meeting Minutes

The 4Q2021 P&T Committee open meeting minutes were reviewed.

It was moved, seconded and the open minutes of the 4Q2021 P&T meeting minutes were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Nakahira
Ayes: Dr. Alkoraishi, Dr. Cung, Dr. Huynh, Dr. Parashar-Rokicki
Absent: Dr. Ngo, Dr. Nguyen

4. Standing Agenda Items

a. Chief Medical Officer Health Plan Updates

Laurie Nakahira, D.O., Chief Medical Officer (CMO), presented the CMO Health Plan Updates. Dr. Nakahira noted the 2022 Department of Health Care Services (DHCS) Annual Audit will take place between March 7 and March 18, covering a review period of March 2021 through February 2022. Unlike previous DHCS audits, which covered only the MC line of business, this audit will cover both MC and Cal MediConnect (CMC).

Dr. Nakahira noted in January 2022, SCFHP received notice of the Department of Managed Health Care (DMHC) Financial Audit that will be conducted by June 2022. This audit occurs every three years and examines the financial health and sustainability of the health plan. It is expected that DMHC will begin requesting documents in March 2022.

b. Medi-Cal Rx Update

Dang Huynh, PharmD, Director, Pharmacy and Therapeutics and Utilization Management, provided an Medi-Cal (MC) Rx Update. Dr. Huynh noted, the state has suspended a lot of Prior Authorization requirements. As a result, the turnaround time for PAs reduced from 7 days to 1 day or less.

Dr. Huynh also noted call time has dramatically been reduced as there is no longer a 4-6 hour wait to speak to someone. Working with state to expand the state with clinical liaisons. Access has improved as restrictions have been removed.

c. Policy Review

i. PH.01 Pharmacy and Therapeutics Committee
ii. PH.02 Formulary Development and Guideline Management
iii. PH.03 Prior Authorization
iv. PH.04 Pharmacy Clinical Programs and Quality Monitoring
v. PH.05 Continuity of Care for Pharmacy Services
vi. PH.06 Pharmacy Communications
vii. PH.07 Drug Recalls
viii. PH.08 Pain Management Drugs for Terminally Ill
ix. PH.09 Medications for Members with Behavioral Health Conditions
x. PH.10 Cal MediConnect Part D Transition
xi. PH.11 340B Program Compliance
xii. PH.12 Drug Management Program
xiii. PH.14 Medications for Cancer Clinical Trial
xiv. PH.15 Diabetic Supplies

Dr. Huynh reviewed the policies due for annual review.

It was moved, seconded and the SCFHP Pharmacy Policies were **unanimously approved.**

Motion: Dr. Lin
Second: Dr. Cung
Ayes: Dr. Alkoraishi, Dr. Huynh, Dr. Nakahira, Dr. Parashar-Rokicki
Absent: Dr. Ngo, Dr. Nguyen

d. Plan/Global Medi-Cal Drug Use Review

i. **Annual DHCS Global DUR Submission**
Caroline Tambe, PharmD, Clinical Pharmacist, presented the annual DHCS Global DUR Submission.

ii. **Drug Utilization Evaluation Update**
Dr. Tambe reviewed the results from SCFHP's quarterly retrospective Drug Use Evaluation (DUE) program.

e. Emergency Supply Report – 1Q 2021

Duyen Nguyen, PharmD, Clinical Pharmacist, reviewed the Emergency Supply Report for Q1 2021. Dr. Nguyen reported in Q1 2021, SCFHP had a total of 16,302 ER visits from claims and encounter data. Approved claims were appropriate. There were no inappropriate denied claims. For no claims, there were no issues with the completed charts that were reviewed.

f. NCQA Member Portal Evaluation

Dr. Nguyen presented the NCQA Member Portal Evaluation and reviewed the results. Dr. Nguyen noted both accuracy and quality measures met goal at 100%. There were no deficiencies identified.

Adjourned to Closed Session at 6:31p.m.
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5. Closed Meeting Minutes

The 4Q2021 P&T Committee closed meeting minutes were reviewed.

It was moved, seconded and the closed minutes of the 4Q2021 P&T meeting minutes were **unanimously approved**.

Motion: Dr. Huynh
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Cung, Dr. Nakahira, Dr. Parashar-Rokicki
Absent: Dr. Ngo, Dr. Nguyen

6. Metrics and Financial Updates

a. Membership Report
The Membership Report was presented by Dr. Nakahira.

b. Pharmacy Dashboard
Dr. Nguyen reviewed the Pharmacy Dashboard.

c. Pharmacy Member Portal Stats – 2H 2021
Dr. Tambe reviewed the Pharmacy Member Portal Stats – 2H 2021.

d. Drug Utilization & Spend – 4Q 2021
Dr. Huynh presented the Drug Utilization & Spend 4Q 2021.

7. Discussion and Recommendations for Changes to SCFHP's Cal MediConnect Formulary & Coverage Determination Criteria

a. Pharmacy Benefit Manager 4Q 2021 P&T Minutes
Dr. Huynh referenced the Pharmacy Benefit Manager 4Q 2021 P&T Minutes included in the meeting packet.

b. Pharmacy Benefit Manager 1Q 2022 P&T Part D Actions
Dr. Huynh reviewed the Pharmacy Benefit Manager 1Q 2022 P&T Part D Actions.

It was moved, seconded and the MedImpact Minutes and Actions were **unanimously approved**.

Motion: Dr. Lin
Second: Dr. Alkoraishi
Ayes: Dr. Cung, Dr. Huynh, Dr. Nakahira, Dr. Parashar-Rokicki

Absent: Dr. Ngo, Dr. Nguyen

c. 2023 Medical Benefit Drug Prior Authorization Grid

Dr. Huynh reviewed the proposed changes to the 2023 Medical Benefit Drug PA Grid.

It was moved, seconded and the 2023 Medical Benefit Drug PA Grid was **unanimously approved**.

Motion: Dr. Huynh
Second: Dr. Lin
Ayes: Dr. Alkoraishi, Dr. Cung, Dr. Nakahira, Dr. Parashar-Rokicki
Absent: Dr. Ngo, Dr. Nguyen

8. Discussion and Recommendations for Changes to SCFHP's Medi-Cal Formulary & Prior Authorization Criteria

a. Diabetes Management Program

Dr. Tambe reviewed the Diabetes Management Program.

9. New Drugs and Class Reviews

a. COVID-19 Updates

Dr. Tambe reviewed the COVID-19 updates.

b. Ryzneuta (benegrastim): Chenotherapy-induced Neutropenia

Dr. Nguyen reviewed Ryzneuta (benegrastim): Chenotherapy-induced Neutropenia.

c. Vadadustat: Anemia in CKD

Dr. Nguyen reviewed Vadadustat:Anemia in CKD.

d. Informational only:

Dr. Nguyen reviewed the following:

i. *HIV Disease State Review – Ienacapavir, Apretude*
ii. *Gefapixant – chronic cough*
iii. *Vitrisiran – hATTR-polyneuropathy*
iv. *Oteseconazole – Recurrent vulvovaginal candiasis*
v. *Tavneos – ANCA-associated vasculitis*
vi. *Adlarity – Alzheimer's disease*
vii. *Skyrizi – psoriasis arthritis*

***e.* New and Generic Pipeline**

Dr. Huynh reviewed the new and generic pipeline.

Reconvene in Open Session at 7:16 p.m.

10. Adjournment

The meeting adjourned at 7:19p.m. The next P&T Committee meeting will be on Thursday, June 16, 2022.

_____ _____

Jimmy Lin, MD, Chair Date

Santa Clara Family Health Plan™

Credentialing Committee Report

February 23, 2022

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee 02/23/2022

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

DIRECT NETWORK		
Initial Credentialing		
Number initial practitioners credentialed	17	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	18	
Number practitioners recredentialed within 36-month timeline	18	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 01/31/2022	628	

DELEGATED NETWORS							
(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**	**NEMS**
Total # of Suspension	0	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0	0
Total # of practitioners	1342	907	723	791	1229	449	1041

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

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.