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
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 12/7/2021 QIC meeting. **Possible Action:** Approve draft minutes of the 12/7/2021 QIC meeting	Dr. Paul	6:05	3 min
4.	**Network Adequacy Assessment 2021** Review the Network Adequacy Assessment 2021. **Possible Action:** Approve the Network Adequacy Assessment 2021	Ms. Fadley	6:08	10 min
5.	**Clinical, Behavioral, & Medical Preventative Practice Guidelines** Review the Clinical, Behavioral, & Medical Preventative Practice Guidelines. **Possible Action:** Approve the Clinical, Behavioral, & Medical Preventative Guidelines	Ms. Tran	6:18	5 min
6.	**Quality Improvement (QI) Program Description 2022** Review the QI Program Description 2022. **Possible Action**: Approve the QI Program Description 2022	Ms. Baxter	6:23	10 min
7.	**Health Education (HE) Evaluation 2021, HE Program Description 2022, HE Work Plan 2022** Review the HE Evaluation 2021, HE Program Description 2022, and HE Work Plan 2022. **Possible Action**: Approve the HE Evaluation 2021, HE Program Description 2022, and HE Work Plan 2022	Ms. Hernandez	6:33	10 min

8. Cultural and Linguistics (C&L) Evaluation 2021, C&L Program Description 2022, C&L Work Plan 2022 Review the C&L Evaluation 2021, C&L Program Description 2022, and C&L Work Plan 2022. **Possible Action**: Approve the C&L Evaluation 2021, C&L Program Description 2022, and C&L Work Plan 2022	Ms. Hernandez	6:43	10 min
9. Grievance and Appeals (G&A) Report Q3 and Q4 2021 Review the G&A Report Q3 and Q4 2021. **Possible Action:** Approve the G&A Report Q3 and Q4 2021	Mr. Oliveira	6:53	10 min
10. SCFHP Equity Steering Committee Review new structure for organization-wide focus on diversity, equity, and inclusion.	Ms. Bui-Tong	7:03	5 min
11. Health Outcomes Survey (HOS) 2021 Review results from the HOS 2021.	Mr. Lu	7:08	7 min
12. American with Disabilities Act (ADA) Work Plan 2022 Review the ADA Work Plan 2022.	Ms. Funches	7:15	5 min
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 (ECM) **Possible Action:** Approve the QI policies as presented	Dr. Liu	7:20	5 min
14. QIC Charter Review of the QIC Charter. **Possible Action**: Approve the QIC Charter	Dr. Liu	7:25	5 min
15. Quality Dashboard Review of the Quality Dashboard.	Dr. Liu	7:30	5 min
16. Compliance Report Review of the Compliance Report.	Mr. Haskell	7:35	5 min
17. Consumer Advisory Board (CAB) Review draft minutes of the 12/2/21 CAB meeting. **Possible Action:** Approve the 12/2/21 CAB meeting minutes	Dr. Nakahira	7:40	5 min
18. Pharmacy & Therapeutics Committee (P&T) Review draft minutes of the 12/16/2021 P&T meeting. **Possible Action:** Approve the 12/16/2021 P&T draft meeting minutes	Dr. Lin	7:45	5 min
19. Utilization Management Committee (UMC) Review draft minutes of the 1/19/2022 UMC meeting. **Possible Action:** Approve the 1/19/2022 UMC draft meeting minutes	Dr. Lin	7:50	5 min

20. Credentialing Committee Report Review 12/1/2021 Credentialing Committee Report. **Possible Action:** Approve the 12/1/2021 Credentialing Committee Report	Dr. Nakahira	7:55	5 min
21. Adjournment The next QIC meeting will be held on April 12, 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.

Quality Improvement Committee

Draft Meeting Minutes

December 7, 2021

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Tuesday, December 7, 2021, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes – Draft

Members Present
Ria Paul, MD, Chair
Ali Alkoraishi, MD
Nayyara Dawood, MD
Jennifer Foreman, MD
Jimmy Lin, MD
Laurie Nakahira, D.O., Chief Medical Officer

Members Absent
Christine Tomcala, Chief Executive Officer

Specialty
Emergency Medicine
Adult & Child Psychiatry
Pediatrics
Pediatrics
Internist

Staff Present
Chris Turner, Chief Operating Officer
Janet Gambatese, Director, Provider Network Operations
Chelsea Byom, Director, Marketing and Communications
Lucille Baxter, Manager, Quality & Health Education
Mauro Oliveira, Manager, Grievance and Appeals
Daniel Quan, Manager, Medicare Compliance
Lan Tran, Interim Manager, Clinical Quality & Safety
Byron Lu, Process Improvement Project Manager, QI
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 11/16/2021 Quality Improvement Committee (QIC) meeting were reviewed.

It was moved, seconded and the minutes of the 11/16/2021 QIC meeting were **unanimously approved.**

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

4. Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) 2021

Byron Lu, Process Improvement Project Manager, Quality and Process Improvement, reviewed the results from the CMC CAHPS 2021 on behalf of Johanna Liu, PharmD, Director, Quality and Process Improvement. CAHPS is an annual consumer satisfaction survey, required by the Centers for Medicare and Medicaid Services (CMS).

Mr. Lu noted COVID-19 has had a significant impact on CAHPS survey methodology and reporting for 2021. The CAHPS objectives, timeline, response rate, 2021 updates, overall performance on providers and the health plan based on SPH Analytics boob of business, CMS' National benchmark, and estimated NCQA health plan rating and CMS Medicare star ratings were reviewed. Also reviewed were the opportunities for improvement and next steps in improving the work plan and CAHPS 2022 strategy development.

5. Initial Health Assessment (IHA) – Q3, Q4 2020 and Q1 2021

Lan Tran, Quality Improvement Nurse, reviewed the results of the IHA for Q3, Q4 2020 and Q1 2021. IHA is a comprehensive assessment, required to be completed within 120 days of enrollment, during a new member's initial encounter with a PCP. There are five (5) elements required for completion credit: 1) Comprehensive history; 2) Administration of preventive services; 3) Comprehensive physical and mental status exam; 4) Diagnosis and plan of care; and 5) IHA Questionnaire.

Ms. Tran noted DHCS issued a temporary suspension from 12/01/19 – 9/30/21, due to the Public Health Emergency (PHE), to complete IHA within 120 days. IHA activities were required to resume on 10/1/21.

Ms. Tran reviewed the IHA compliance rates and findings. Also reviewed were barriers, plans to overcome said barriers, and opportunities for improvement.

A question regarding specific Staying Healthy Assessment (SHA) requirements was asked. Ms. Tran provided the link to the SHA periodicity timeline per DHCS guidelines and where to locate forms on the DHCS website.

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

Mauro Oliveira, Manager, Grievance and Appeals presented the G&A Report Q3 2021. Mr. Oliveira reviewed the Q3 2021 top 3 MC Grievance Categories and the top 3 MC Grievance Subcategories. Also reviewed were 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.

A motion to approve was deferred, as parts of the data presented require recalculation. Revisions will be presented at the following QIC meeting for approval.

7. Quality Dashboard

Lucille Baxter, Manager, Quality and Health Education, reviewed the Quality Dashboard on behalf of Dr. Liu. Ms. Baxter presented an overview of the Wellness Rewards Program – a calendar year program offered to members who complete preventative screenings and close gaps in care. YTD, a total of 5,993 gift cards have been mailed to members.

Ms. Baxter reviewed the completion rates for the Initial Health Assessment (IHA). Reports indicate an increase in completion rates from August 2021 – October 2021. Also reviewed was the Outreach Call Campaign, an internal program where staff conduct calls to members for health education promotion. A total of 12,837 calls were made from August 2021 – November 2021.

Ms. Baxter 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.

Ms. Baxter noted Facility Site Reviews (FSR) were not conducted due to COVID-19. However, extensions have been approved by DHCS. Ms. Baxter provided an overview of Potential Quality of Care Issues (PQI) and reported 99.34% of PQIs, due from August 2021 – September 2021, closed on time (within 90 days).

Ms. Baxter explained in an effort to improve the 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 due.

DRAFT

8. Compliance Report

Daniel Quan, Manager, Medicare Compliance, presented the Compliance Report on behalf of Tyler Haskell, Interim Compliance Officer. Mr. Quan noted, in October 2021, the Department of Managed Health Care (DMHC) assessed SCFHP an administrative penalty in the amount of $10,000 for two (2) deficiencies in the 2017 Timely Access and Network Adequacy Compliance Report.

Mr. Quan announced the Plan has partnered with Piedmont Community Health Plan (Piedmont) to conduct peer-review audits of the respective compliance programs to meet the CMS required Compliance Program Effectiveness (CPE) Audit for CY 2021. SCFHP and Piedmont began the audits in early November and expect to conclude them in January 2022.

Mr. Quan noted the Compliance Department recently disclosed to CMS an issue the Plan discovered that was preventing providers from receiving information about transitions of care, interdisciplinary care team (ICT) meetings, and individual care plans (ICP). CMS recently notified SCFHP that CMS will not take any compliance or enforcement actions on this matter.

Mr. Quan reported the Plan has been selected by CMS's external quality review organization to participate in the 2021 Performance Measure Validation Audit. All requested documents have been submitted in advance of a scheduled review session on August 19, 2021. The Plan recently received a draft report indicating that both data sets were deemed "reportable", meaning the data was compliant with CMS specifications.

9. Utilization Management Committee (UMC)

The draft minutes of the 10/20/2021 UMC meeting were reviewed.

It was moved, seconded and the 10/20/2021 draft meeting minutes were **unanimously approved.**

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

10. Credentialing Committee Report

It was moved, seconded and the 10/06/2021 Credentialing Committee Report was **unanimously approved.**

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

11. 2022 Board and Committee Meeting Calendar

Laurie Nakahira, D.O., Chief Medical Officer, reviewed the 2022 QIC meeting dates. No questions were asked.

12. Adjournment

The next regular QIC meeting will be held on February 8, 2022. The meeting was adjourned at 7:04PM.

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Ria Paul, MD, Chair Date

DRAFT

Santa Clara Family Health Plan
Accessibility of Provider Network
MY2021

Cal-MediConnect

Prepared by: Karen Fadley, Manager, Provider Data, Credentialing and Reporting

November 16, 2021 – Updated 2/1/2022

I. INTRODUCTION

Cal MediConnect is a program that integrates medical care, long-term care, mental health and substance use programs and social services under a coordinated care plan for people who are dually eligible for Medicare and Medi-Cal.

Santa Clara Family Health Plan (SCFHP) conducts an annual performance analysis on provider network accessibility against its standards. The Plan's access standards are established by SCFHP, CMS, DMHC, DHCS and NCQA.

SCFHP makes every effort to ensure that at least 90% of 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.

II. TERMS AND DEFINITIONS

Primary Care Providers PCP(s) are defined as physicians of Family Medicine and Internal Medicine.

High **Volume** Specialists (HVS) are identified by claims submitted for a 12-month period, excluding non-physician specialists and hospital-based specialists (i.e. radiologists). The high volume analysis includes cardiology, ophthalmology and gynecology.

High **Impact** Specialists (HIS) are defined as specialists who treat conditions that have high mortality and morbidity rates and where treatment requires significant resources**.** High impact specialists are identified by claims submitted for a 12-month period, excluding non-physician specialists and hospital-based specialists (i.e. radiologists). The high-impact analysis includes hematology/oncology.

High **Volume** Behavioral Health (HVBH) providers are defined as providers who are located in a high-volume geographic area or in a high-volume specialty (or both), and are likely to provide services to a large segment of members. Behavioral health providers are defined Psychiatry (prescribing) and Psychology (non-prescribing), Licensed Clinical Social Workers and Marriage/Family Therapists. High volume behavioral health providers are identified by analyzing claims and encounter data for a 12-month period.

This report provides an overview and analysis of SCFHP's timely access survey results. SCFHP survey goals, objectives, methodologies and results are included in each reporting section.

The following survey assessments are included in this report:

1. Provider Appointment Availability Survey
2. After Hours Survey
3. CAHPS
4. Provider Satisfaction Survey
5. Member Grievances

The provider types included in this report:

- Primary Care Provider's (PCPs)
- High Volume Specialists (HVS)
- High Impact Specialist (HIP)
- Behavioral Health Providers (BHP) -- prescribers and non-prescribers.

III. Provider Appointment and Availability Survey (PAAS)

A. GOALS

- Ninety percent (90%) of providers will meet appointment access standards established by SCFHP, CMS, and NCQA.

B. OBJECTIVES

- Measure rate of compliance with timely access standards, at least annually.
- Evaluate SCFHP's timely access performance in comparison to goals.
- Identify areas to improve timely appointment access.
- Develop interventions as appropriate/applicable to address deficiencies and/or gaps in timely access to care.

C. METHODOLOGY

The Provider Appointment Availability Survey (PAAS) Methodology is developed by the Department of Managed Health Care (Department), pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The PAAS Methodology, published under the authority granted in Section 1367.03 is a regulation in accordance with Government Code section 11342.600. For measurement year 2020 (MY 2020), all reporting health plans must adhere to the PAAS Methodology when administering the PAAS and reporting rates of compliance for timely access appointment standards, pursuant to Rule 1300.67.2.2.

The Plan uses the Department's PAAS Templates, which include:

- Contact List Template
- Raw Data Template
- Results Data Template

Each contact list will include the provider types to satisfy the DMHC and NCQA compliance formats and each list is de-duplicated to ensure providers are only surveyed one time.

SCFHP sends outreach communications that inform network providers of the following:

- Who is administering the survey
- Information about the importance of participating in the survey
- What the survey is, why it is being done, how it is administered and the types of questions that will be asked
- The date range during which the survey is likely to occur

SCFHP uses an "all provider network" (census) where sixty percent (50%) of providers are surveyed in the first wave and the 2nd wave starts following the 3-week DMHC mandatory break and covers the remaining forty percent (50%) of providers.

The surveys are initiated by fax and email (email included a personalized URL to take the survey online; the fax directed providers to www.cssresearch.org/Appointment and a unique login code is provided) with a telephone follow-up. Three call attempts are made during business hours (9:00 am – 4:30 pm Pacific Time) and within a 48-hour time period from the first attempt. The timeframe to complete the survey online or by fax is limited to 48 hours from the time of the message.

D. MEASURES

Table I: 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

E. Results – Provider Appointment/Availability Survey

Table I: Aggregate 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
2020	PCP (N=545)	226	319	161	73%	90%	No
2019	PCP (N=509)	285	224	189	66%	90%	No

Quantitative Analysis (Table I)**:** Rate of compliance for PCP's relevant to the urgent care appointment access fell short of goal by 30.9 percentage points at 59% for year 2021, 17 percentage points for year 2020 and 24 percentage points for year 2019.

Table II: Aggregate 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
2020	PCP (N=545)	141	131	128	90%	90%	Yes
2019	PCP (N=509)	326	183	276	85%	90%	No

Quantitative Analysis (Table II): Rate of compliance for PCP's relevant to the Non-Urgent/Routine appointment access fell short of goal by 7 percentage points at 83% for year 2021, goal was met for year 2020 at 90.4% and fell short 5 percentage points for year 2019.

Review on PCPs performance relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care: 66%
- Non-Urgent Care: 86%

The analysis also revealed that urgent appointment access remains steady at 66%, 24 percentage points below goal and that non-urgent appointment access is also remaining steady at 86%, 4 percentage points below goal.

Qualitative Analysis: In the past survey cycles the Plan established interventions in an effort to assist provider with improved PCP urgent/non-urgent appointment access and survey participation. It appears that the pandemic had an impact on PCP respondents to the survey; reduction in staff, closed offices, staff turnover, training and the surge of patient care impacted the PCPs survey participation and appointment availability.

SCFHP's Provider Network Access Manager worked directly with compliance officers and/or clinic administrators and issued a corrected action letter to each of them with a report listing each provider that was non-complaint with access standards. All non-compliant providers are resurveyed within 30-days from the date on the corrective action letters. Providers who show continued non-compliance from the resurveys receive notice from the Plan and are required to complete SCFHP's access training and submit an attestation within 60-days from the date of notice.

Specialists - High Impact and High Volume

Below includes tables that shows the number of high volume/impact providers were surveyed, the number that responded and the rate of compliance broken down by each network. The Direct network represents the Plan's individually contracted providers. With the exception of Gynecology, the majority of the Plans specialists included in this report are available through Stanford. While SCFHP is very pleased to have Stanford in its network to serve CMC members, as they are well known for their international reputation for excellence, it is important to point out that Stanford's access survey participation rates have historically been low, therefore meaningful conclusions on appointment access through the PAAS survey has been difficult to achieve. Discussions with this group to improve participation has occurred, and a "manual/electronic extraction" of provider schedules are being explored as a method to increase data collection for measurement year 2021. Also included below are charts that show results against goals and/or benchmarks trended over time.

Table I: - Urgent Care Access – Appointment within 96 Hours
Cardiology, Gynecology, Ophthalmology – High Volume Provider, Oncology – High Impact Provider

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
2020	Specialists (N=308)	103	205	54	56%	90%	No
2019	Specialists (N=300)	102	198	40	48%	90%	No

Quantitative Analysis (Table I) Rate of compliance for Specialists on urgent appointment access fell short of goal by 50 percentage points for year 2021, a 34 percentage point decrease short of goal in 2020, and a 42 percentage point decrease from goal in 2019.

Table II: - Non - Urgent/Routine Care Appointment within 15 days
Cardiology, Gynecology, Ophthalmology – High Volume Provider, Oncology – High Impact Provider

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
2020	Specialists (N=308)	103	205	82	79%	90%	No
2019	Specialists (N=300)	102	198	58	59%	90%	No

Quantitative Analysis (Table II) Rate of compliance for Specialists on Non-Urgent Care appointment access fell short of goal by 32 percentage points for year 2021, an 11 percentage point decrease short of goal in 2020, and a 31 percentage point decrease from goal in 2019.

Review on Specialists performance relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care: 48%
- Non-urgent Care: 65%

The 3-year (2019-2021) analysis on Specialists urgent appointment access revealed that results remain steady at 48%,42 percentage points below goal; and non-urgent appointment access is currently 65%, 25 percentage points below goal.

Behavioral Health Providers – Prescribers/Non-Prescribers (HVBH)

Psychiatry – Prescribers (High Volume Provider)

Table I: Psychiatrists Urgent Care Appointment 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
2020	Psychiatrists (N=104)	15	89	7	54%	90%	No
2019	Psychiatrists (N=82)	14	68	4	33%	90%	No

Quantitative Analysis (Table I) Rate of compliance for Psychiatrists Urgent Care Appointment fell short of goal by 50 percentage points for year 2021, 36 percentage points decrease short of goal in 2020, and 57 percentage points for year 2019.

Table II: Psychiatrists 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
2020	Psychiatrists (N=104)	15	89	10	67%	90%	No
2019	Psychiatrists (N=82)	14	68	8	58%	90%	No

Quantitative Analysis (Table II) Rate of compliance for Psychiatrists Non-Urgent/Routine Care appointment fell short of goal by 19 percentage points for year 2021, 23 percentage points for year 2021, and 32 percentage points for year 2019.

Review on Psychiatrists performance relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care 48 hours: 46%
- Non-urgent Care: 65%

It appears that meeting appointment access with initial and routine visits is trending upward, therefore the Plan is confident that access to timely routine care is improving results have remained steady for the past 3-years.

Table I: Non-Physician Mental Health – Non-Prescribers Urgent Appointment 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

2020	Non-Physician Mental Health (N=79)	14	64	11	79%	90%	No
2019	Non-Physician Mental Health (N=83)	19	64	11	61%	90%	No

Quantitative Analysis (Table I): Rate of compliance for Non Physician Mental Health Providers Urgent Appointment fell short of goal by 30 percentage points for year 2021, 11 percentage points for year 2021, and 29 percentage points for year 2019.

Table II: Non-Physician Mental Health – Non-Prescribers Non-Urgent/ Routine Appointment 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
2020	Non-Physician Mental Health (N=79)	15	64	14	93%	90%	Yes
2019	Non-Physician Mental Health (N=83)	19	64	12	63%	90%	No

Quantitative Analysis (Table II) Rate of compliance for Non-Physician Mental Health provider's Non-Urgent/routine Appointment fell short of goal by 26 percentage points for year 2021, 2020 the Plan Met performance standards, and fell short by 27 percentage points for year 2019.

Review on performance by Non-Physician Mental Health Providers relevant to appointment access against standards across a 3-year period (2019-2021) revealed the following average ratings:

- Urgent Care: 70%
- Non-Urgent: 73%

Given that the 3-year analysis indicates that the behavioral health network collectively is holding steady further review within this review cycle to identify barriers was conducted as follows:

- Member Complaints: None were filed against the Behavioral Health network.
- Open for New Referrals: 100%.
- Out of Network Requests: None

In conjunction with the reviews bulleted above and other components included in this analysis, such as the assessments on time/distance and provider to member ratios, all of which were met for behavioral health, this may indicate that there is not an access issue. The barriers to consider are as follows:

- Appointment access survey participation has been historically low across the BH network, which may skew access results. Provider feedback concerning lack of participation is mostly due to practice operations where solo practitioners do not staff front desk or schedulers, thus while in session with patients, survey calls are not captured.

SCFHP educates its providers by submitting the timely access grid bi-annually via fax blast to network behavioral health providers which advises them to include the following message on automated systems, office, or exchange/answering services to:

"Hang up and dial **911** or go to the nearest emergency room or call Santa Clara County Behavioral Health at **1-800-704-0900**."

The same information is included in the Plan's access training offered on-line or via webinar. This action item by the Plan and its BH network ensures that patients needing non-life threatening and/or urgent care are directed to the Santa Clara County BH system, where access to triage/screening and referrals for care are established as needed are available. The Santa Clara County BH system is available to SCFHP members 24hrs a day/7-days a week.

F. AFTER HOURS SURVEY

Santa Clara Family Health Plan (SCFHP) conducts an annual After-Hours survey to ensure that telephone triage or screening services are provided in a timely manner. The survey also identifies if emergency 911 instructions are provided. The provider types included in the survey are:

- Primary Care Providers
- Behavioral/Mental Health Providers

A. GOAL

To ensure that Plan network providers meet after-hours access and timeliness standards at 90%.

B. METHODOLOGY

The after-hours survey was administrated by CSS survey vendor. The survey was conducted during non-business hours Pacific Standard Time (6:00 pm - 8:00 am on weekdays, and all day on weekends). The survey sample included all contracted primary care providers. SCFHP provided CSS a provider contact list, which was de-duplicated to ensure each provider was surveyed once. Providers who share the same phone numbers are combined into one group and survey results are attributed to all the providers.

When a live person (provider or answering service) is reached, the surveyor announces that they are calling on behalf of SCFHP to conduct a survey and the respondents are asked the same questions from the after-hours survey tool, and if the call is answered by an automated recording, the interviewer collects the response based on the message. If the automated recording provides an option to connect to a live person (by pressing a button or staying on the line), the interviewer selects that option and records the answers the person provides. The interviewer does not leave a voice message during any telephone attempts.

C. MEASURES

Table I: After Hours Standards

Provider Type	After-Hours Care
PCP (All)	24-hours / 7-days a week
BH/MH - Prescribers	24-hours / 7-days a week
BH/MH – Non-Prescribers	24-hours / 7-days a week

Table II: After Hours Access and Timeliness Standards

Service	Standard access requirement
Automated systems, office, or exchange/answering services	Must inform the patient that the provider will call back within 30 minutes.
Life-threatening situation	Automated systems must provide emergency 911 instructions, such as: • "Hang up and dial **911** or go to the nearest emergency room." Behavioral health providers should include the number to the Santa Clara County Behavioral Health: • "Hang up and dial **911** or go to the nearest emergency room or call Santa Clara County Behavioral Health at **1-800-704-0900**."
Urgent need to speak with a provider	Automated systems, office, or exchange/answering services must connect the patient with an on-call provider or should direct the patient on how to contact a provider after hours.

D. Aggregate After-Hours Data Results

Table I: Primary Care Providers

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2021	Met
Access	786	679	286	10	94.7%	Yes
Timeliness				17	71.7%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2020	Met
Access	640	601	141	29	91%	Yes
Timeliness				57	42%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2019	Met
Access	505	455	183	22	80%	No
Timeliness				18	40%	No

*Access = 911 messaging
*Timeliness = 30min call back messaging

Aggregate access results:
- 2021: 94.7%
- 2020: 91%
- 2019: 80%

Aggregate timeliness results:
* 2021: 71.7%
* 2020: 42%
* 2019: 40%

Aggregate results for PCP's rate of compliance increased by 3.7 percentage points on access and 29.7 percentage points on timeliness for year 2021, increased 11 percentage points on access and 2 percentage points on timeliness for year 2020. There is a total of 1 phone number that were non-complaint with after-hours messaging on access and 1 phone number on timeliness which shows a significant decrease in SCFHP conducted an after-hours review of each network as follows -

--Aggregate results for **Behavioral Health Providers**:

Table I: Behavioral Health Providers

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2021	Met
Access	335	279	235	11	95.7%	Yes
Timeliness				22	82.6%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2020	Met
Access	350	316	52	26	89%	No
Timeliness				41	36%	No

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2019	Met
Access	329	300	83	30	78%	No
Timeliness				65	33%	No

*Access = 911 messaging
*Timeliness = 30min call back messaging

Aggregate access results:
- 2021: 95.7%
- 2020: 89%
- 2019: 78%

Aggregate timeliness results:
* 2021: 82.6%
* 2020: 36%
* 2019: 33%

Aggregate results for Behavioral Health Provider's rate of compliance increased by 6.7 percentage points on access and 46.6 percentage points on timeliness in year 2021, 11 percentage points on access and 3 percentage points on timeliness in year 2020. There are a total of 11 phone numbers that were non-complaint with after-hours messaging on access and 22 phone numbers on timeliness.

Analysis (Tables I &X)

The PCP network showed an increase in compliance with access and timeliness in 2021. The PCP network also showed a total of 10 phone numbers that were non-compliant with after-hours messaging on access and 17 phone numbers for timeliness.

The BH network showed an increase in compliance with access and timeliness in 2021. The BH network also showed a total of 11 phone numbers that were non-compliant with after-hours messaging on access and 22 phone numbers for timeliness.

The Plan believes that the efforts made in partnership with the providers through notifications of non-compliance and access training increased awareness on after-hours standards, thus both PCP's and BH providers showed improved results on access (911) and showed improved timeliness (30min). The Plan also believes that monitoring after-hours timeliness (30min call back messaging) can be a challenge because the surveyors do not follow through with prompts to contact the after-hours

provider to avoid interference with patient care, thus if the message does not state that the provider will call back or get on the line within 30minutes or less, the provider is marked non-compliant. Following receipt of corrective action letters, several providers contact the Plan each year to report that they meet after-hours timeliness requirements by calling patients back with 30mintues or less.

The Plan and Providers are working to ensure front line messaging states that the provider will call back within 30 minutes or less. Monitoring member complaints is another avenue used by the Plan to identity issues with after-hours access

PCPs and Behavioral Health providers that were deemed non-complaint as a result of the 2021 survey, received a corrective action letter, and or the networks (PMG, PC, VHP, PAMF) received a corrective action letter and a report highlighting all phone numbers that were deemed non-compliant on access and/or timeliness.

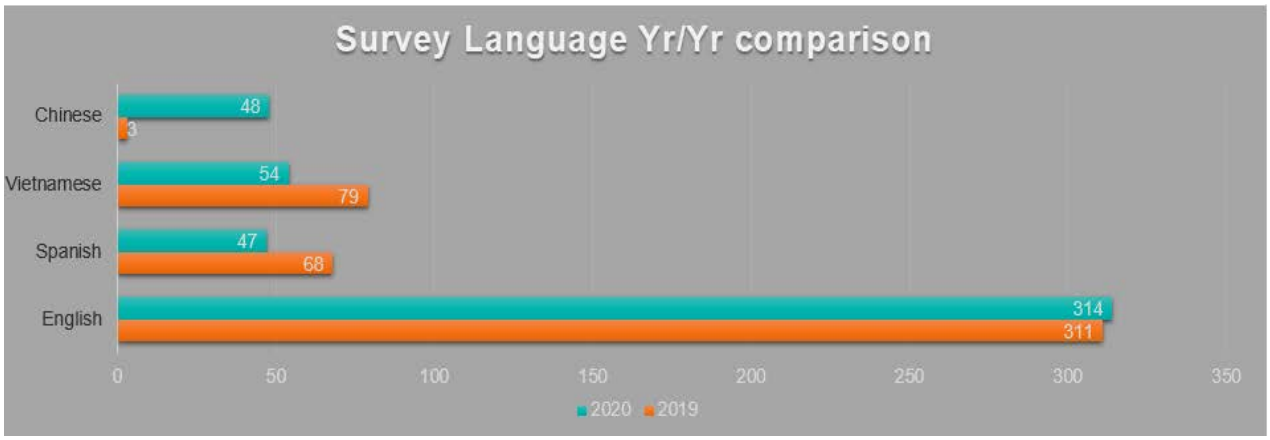
Conclusions:

- The PCPs and Behavioral Health providers combined have 21 phone numbers that show non-compliance with access (911 messaging) and 39 phone numbers that showed non-compliance with timeliness (30min call back messaging).
- Providers deemed non-compliant with after-hours access/timeliness standards receive a corrective action letter from the Plan, and are expected to submit a corrective action plan within 30-days.
- Overall Providers have made a significant amount of progress in trending upward in meeting after-hours access and timeliness in the past 3-years.

G. MEMBER EXPERIENCE SURVEY (CAHPS)

METHODOLOGY

- CAHPS is a consumer satisfaction survey that the health plan is required to administer annually by the Centers for Medicare and Medicaid Services (CMS)
- SCFHP contracts with a vendor-SPH Analytics to conduct the survey
- Respondents were given the option of completing the survey in a language other than English. Survey Language 2020/2019 comparisons are as follows:



- Due to COVID-19, changes were made to the methodology and no follow up phone calls to non-respondents were made in 2020.

Data Collection:

Survey Protocol	Date
SCFHP postcard notification #1	1/31/2020
SCFHP postcard notification #2	2/28/2020
Pre-notification letter mailed	3/5/2020
First survey mailed	3/11/2020
Second survey mailed	4/11/2020
Last day to accept completed surveys	6/14/2020

Note: CMS recommended to cease telephone outreach due to COVID-19

Item	Volume
Total mailed	1600
Ineligibles	11
Total completed surveys	463
Mail completes	461
Phone completes	2

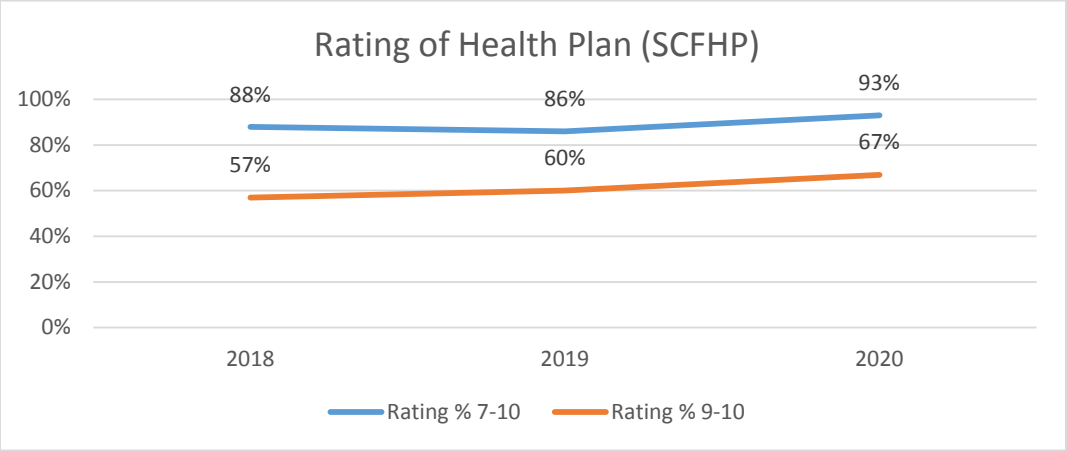
RESULTS

Table I: 2020 Medicare CAHPS Survey

Composite Rating & Questions	# of Respondents	Goal	Goal Met	Always and Usually (2020)	Always and Usually (2019)	PY Change
Rating of Health Plan (Q38)	375	90%	Y	93%	86%	+6
Getting tests results when needed (Q21)	318	90%	N	82%	83%	-1
Getting appointments with specialists (Q29)	246	90%	N	75%	75%	-.4
Getting needed care, tests or treatment (Q10)	445	90%	N	83%	80%	+3

Getting care needed right away (Q4)	134	90%	N	81%	82%	-.7
Getting appointments (Q6)	338	90%	N	73%	76%	-3
Getting seen within 15min of your appt (Q8)	335	90%	N	58%	54%	-4

Chart I: Rating of Health Plan



Quantitative Analysis (Tables I)**:**
Table I shows that 3 out of 7 measures indicate a marked improvement from 2019. While Getting seen within 15min of your appointment" did not meet goal, 2020 ratings showed a marked improvement by 4 percentage points. In 2020, overall "access" results showed the Plan's performance improved by 7.66 percentage points, also improved from 2019's 7.02 percentage points.

Chart 1 shows that approximately 7 in 10 (67.10%) gave the Plan a rating of 9 or 10, which an improvement from the past two years. On a 0 to 10 scale about 9 in 10 (92.90%) gave the Plan a rating of 7, 8, 9 or 10 which is a continuous improvement from the past two years.

The response rate in "Always" and "Usually" is combined to compare the member/enrollee satisfaction in timely appointment access and rating of health plan measures between 2019 and 2020. As shown in the Table I above, the goal was not met for any measures; however, member satisfaction improved in 4 out of 7 measures, which is a marked improvement from 2019. The measure most improved was "getting care needed right away" (Q4) with an increase of 7.78 percentage points from 2019. The measure for "getting seen within 15min of your appointment" (Q8), showed the greatest decrease in satisfaction by 6.41 percentage points from 2019.

As shown in Table II, SCFHP performed similar to last year on the rating of the health plan and performed similar to two years ago. About 9 in 10 (84.41%) gave their health plan a rating of 7, 8, 9 or 10 on a 0 to 10 scale, which is not significantly different from two years ago. About six in 10 (59.91%) gave a rating of 9 or 10, which is not significantly different from last year and not significantly different from two years ago.

Qualitative analysis: Overall results showed no significant improvements compared to 2019; however, there was a significant improvement compared to two years ago on the composite score relevant to Customer Service. SCFHP performed similar to last year on the rating of the health plan and performed similar to two years ago. About 9 in 10 (84.41%) gave their health plan a rating of 7, 8, 9 or 10 on a 0 to 10 scale, which is not significantly different from two years ago. About six in 10 (59.91%) gave a rating of 9 or 10, which is not significantly different from last year and not significantly different from two years ago.

SCFHP recognizes that "getting care needed right away" (Q4) has a relatively high impact on members and is pleased that satisfaction ratings showed an improvement of 7.78 percentage points in 2020. The assessment on member grievances showed that 34% of complaints were associated with timely appointments; therefore, survey results combined has helped SCFHP identify factors that may affect member satisfaction, such as:

- Providers do not have an adequate understanding of regulatory requirements for timely access to care.
- Longer wait times for urgent and non-urgent/routine care could be due to inefficient scheduling procedures.
- Provider offices are not communicating in office wait times with members at check in or contacting them ahead of time to allow member to come in at a later time.

Conclusion - CAHPS:
SCFHP is pleased to acknowledge 4 out of 7 measures showed a marked improvement from 2019. Overall results showed that the Plan improved by 7.02 percentage points, which may be attributed to the Plans on-going efforts to improve operational procedures and member/provider communications. One example of SCFHP's initiatives is the recent development of a Pay for Performance (P4P) program to improve quality, efficiency, and overall healthcare outcomes. This program along with other efforts show that SCFHP has taken a more active role working with network providers in support of plan initiatives that are aimed toward meeting regulatory requirements and improving overall access and quality of care. SCFHP's Provider Network Management, Quality Management, Provider Relations, Customer Service and Contracting departments will continue to develop and improve initiatives to meet member needs.

H. PROVIDER SATISFACTION SURVEY

Santa Clara Family Health Plan (SCFHP) conducts an annual Provider Satisfaction Survey (PSS) to assess provider satisfaction with specific areas of services.

GOALS AND OBJECTIVES

A. Goals:

- To ensure that SCFHP providers have a positive experience with health plan services.

B. Objectives:

- Measure provider experience (satisfaction) at least annually.
- Evaluate provider's satisfaction with performance measures.
- Identify any areas for improving contracted provider's experience with the health plan.
- Develop interventions as appropriate to address gaps in service.

C. Performance Standards for Provider Satisfaction:

- Eighty percent (80%) of provider's will be satisfied (Q1-8 & 10)
- One hundred percent (100%) of provider's will be satisfied (Q9)

METHODOLOGY

A. Sample

SCFHP provided CSS with lists of 1,726 providers to be surveyed using a fax-only methodology. CSS drew a sample of all unique fax numbers (N=486) associated with providers in SCFHP's network. This was done to reduce the burden on offices where multiple providers share a single fax number, especially since it is often office staff who complete these surveys, not the provider to whom the survey is addressed. Each fax number was assigned a unique 8-digit identification number to track responses.

B. Survey Instrument

In 2021, one version of the survey instrument was used to help SCFHP assess provider satisfaction with services delegated to provider networks as well as those provided directly by the plan. The measures (27) were included in the version of the survey.

C. Timeline

The entire sample was included in the first wave of fax outreach.

D. Data Capture

Returned surveys were captured using manual data entry with double key verification. Each returned survey was identified by the original tracking ID and the date the survey was received. Returned surveys with missing responses for every question were eliminated. Thus, any survey with a valid response to at least one question was retained. If two completed surveys with the same tracking ID were received, the most complete survey (based on the total number of questions appropriately answered) was retained. In the event of a tie, the survey with the earliest return date was retained.

E. Sample

The original sample was comprised of 486 unique fax numbers. Of the original sample, 34 fax numbers were undeliverable or determined to be ineligible and were removed from the final sample size in following exhibits.

A total of 83 responses were received at the close of data collection resulting in an overall response rate of 17.1%. This was down from MY2020, when 18.3% of fax numbers resulted in a returned survey. Responses for a fax number were attributed to all providers in the sample associated with that fax number. Therefore, collected fax responses were associated with 196 out of 1,513 eligible providers (13.0%).

IV: Rate of Response

Table A: Responses by Provider Types

Provider Type	# Surveyed	Response #	2021	2020	2019
PCP	721	126	18%	20%	27%
SPC	477	57	12%	8%	7%
BH	308	10	3%	11%	12%
Total	1,508	193	13%	11%	10%

- Provider participation increased in 2021 by 2 percentage point.

V. Provider Satisfaction Results

Survey results that are calculated based on sample data and compared to a benchmark score (such as the plan's prior-year rate), the question is whether the observed difference is real or due to chance. A test of statistical significance uses the difference in scores as well as the number of respondents in both groups (in this case, the number of current-year and prior-year respondents) to determine the likelihood that the observed difference is real.

Scores marked with an asterisk are statistically significant at a 95% confidence level, meaning there is a 95% probability that the observed difference is not due to chance. Questions with larger changes in scores and a larger number of respondents are more likely to be statistically significant.

The following tables reflect the responses to the survey on access categories:

Table I: Patient Timely Access to Appointments (Q5a)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Urgent Care	86.7%	-11.6%	100.0%	15.4%	100.0%	0.0%	94.4%	-2.7%	80%	YES
MY2020										
Urgent Care	98.0%	-4.0%	85.0%	-4.0%	100.0%	0.0%	97.0%	2.0%	80%	Yes

Goal: Met - 2021

- Urgent Care:
  - ❑ All provider networks rated satisfaction above goal – VHP and Premier Care rated the highest at 100%,
    followed by Direct at 94.4%, and PMG at 86.7%.
  - ❑ PMG had a decrease in satisfaction from 2020 by -11.6 percentage points and Direct showed a decrease in satisfaction from 2020 by -2.7 percentage points.

Table II: Timely Access to Appointments (Q5b)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Primary Care	96.3%	-3.7%	100.0%	15.4%	100.0%	0.0%	90.0%	-6.9%	80%	YES
MY2020										
Non-Urgent Primary Care	100.0%	0.0%	85.0%	-6.0%	100.0%	0.0%	97.0%	-1.0%	80%	Yes

Goal: Met - 2021

- Non-urgent primary care:

- ❑ All provider networks rated satisfaction above goal – Premier Care and VHP rated the highest at 100%, followed by PMG at 96.3% and Direct at 90.0%
- ❑ PMG showed a decrease in satisfaction from 2020 by 3.7 percentage points and Direct showed a decrease of 6.9 percentage points.

Table III: Timely Access to Appointments (Q5c)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Specialists Care	89.3%	-7.8%	100.0%	21.4%	100.0%	21.9%	92.9%	-0.8%	80%	Yes
MY2020										
Non-Urgent Specialists Care	97.0%	-2.0%	79.0%	-8.0%	59.0%	0.0%	94.0%	1.0%	80%	No

Goal: Met - 2021

- Non-urgent specialists care:
  - Premier Care and VHP rated satisfaction above goal – 100%, followed by Direct at 92.9 and PMG at 89.3 percentage points.
  - PMG rated satisfaction at 89.3% and showed a decrease in satisfaction from 2020 by -7.8 percentage points a Direct showed a decrease in satisfaction by .8 percentage points.

Table VIII: Timely Access to Appointments (Q5d)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Ancillary diagnostic and treatment services	100.0%	0.0%	100.0%	14.3%	72.7%	4.0%	92.2%	-4.0%	80%	No
MY2020										

Non-Urgent Ancillary diagnostic and treatment services	100.0%	2.0%	86.0%	-4.0%	69.0%	0.0%	96.0%	8.0%	80%	No

Goal: Not met - 2021

- Non-urgent ancillary diagnostic and treatment services:
  - ❑ PMG, PC and Direct rated satisfaction above goal – PMG and Premier Care rated the highest at 100%,followed by Direct at 92.2%
  - ❑ VHP rated satisfaction at 72.7% - goal was not met by 7.3 percentage points.

Table IV: Timely Access to Appointments (Q5e)

MY2021										
Patient's Timely Access to-	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Non-Urgent Behavioral Health Care	76.9%	-4.7%	88.9%	8.9%	81.3%	4.6%	83.7%	28.9%	80%	No
MY2020										
Non-Urgent Behavioral Health Care	82.0%	-13.0%	80.0%	-9.0%	77.0%	0.0%	55.0%	-8.0%	80%	No

Goal: Not met.

- Non-urgent behavioral health care:
  - ❑ VHP, Direct and PC rated satisfaction above goal – Premier Care rated the highest with 88.9 percentage points, followed by Direct with 83.7 percentage points, and VHP with 81.3 percentage points. PMG rated the lowest with 76.9 percentage points.

Table V: Customer Service Staff (Q6a-c)

MY 2021										
Customer Service Staff	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met

Ability to answer calls promptly	96.6%	3.6%	84.6%	-15.4%	83.3%	-16.7%	92.2%	-2.7%	80.0%	Yes
Ability to resolve my concerns/issues	96.6%	6.3%	92.3%	4.8%	100.0%	0.0%	92.1%	-0.6%	80.0%	Yes
Friendliness and helpfulness	96.6%	3.7%	92.3%	-7.7%	100.0%	3.7%	95.1%	1.5%	80.0%	Yes
MY 2020										
Ability to answer calls promptly	93.0%	2.0%	100.0%	0.0%	100.0%	0.0%	95.0%	0.0%	80.0%	Yes
Ability to resolve my concerns/issues	90.0%	-3.0%	88.0%	-4.0%	100.0%	0.0%	93.0%	0.0%	80.0%	Yes
Friendliness and helpfulness	93.0%	-3.0%	100.0%	4.0%	96.0%	0.0%	94.0%	-2.0%	80.0%	Yes

Goal: Met across all metrics -2021

- "Ability to answer calls promptly" – PMG showed an increase from 2020 of 3.6 percentage points and the other networks showed decreases with VHP having the largest decrease -16.7 percentage points, followed by PC with -15.4 percentage points and Direct with -2.7 percentage points.
- "Ability to resolve my concerns/issues" – PMG and PC showed an increase in satisfaction from 2020 by 6.3 and 4.8 percentage points. VHP had no change in 2021 while Direct had a slight decrease of .6 percentage points.
- "Friendliness/helpfulness" – PMG, VHP and Direct network showed an increase in satisfaction by 3 – 2 percentage points. PC rated satisfaction at 92.3 percentage points with a decrease of -7.7 percentage points from 2020.

Table VI: Provider Relations Staff (Q7a-c)

MY 2021										
Provider Relations Staff	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met

Ability to answer calls promptly	100.0%	7.0%	69.2%	-19.0%	83.3%	-5.1%	94.1%	1.6%	80.0%	No
Ability to resolve my concerns/issues	100.0%	9.3%	69.2%	-19.0%	83.3%	-5.1%	94.1%	2.2%	80.0%	No
Friendliness and helpfulness	96.4%	3.5%	76.9%	-10.6%	100.0%	11.5%	95.1%	0.8%	80.0%	No
MY 2020										
Ability to answer calls promptly	93.0%	-3.0%	88.0%	-8.0%	88.0%	0.0%	92.0%	-4.0%	80.0%	Yes
Ability to resolve my concerns/issues	91.0%	-3.0%	88.0%	-3.0%	88.0%	0.0%	93.0%	-1.0%	80.0%	Yes
Friendliness and helpfulness	93.0%	-4.0%	87.0%	-12.0%	88.0%	0.0%	94.0%	1.0%	80.0%	Yes

Goal: Not Met - 2021

- "Ability to answer calls promptly" – PMG rated the highest with 100 percentage points and a 7 percentage point increase, while Direct also showed an increase of 1.6 percentage points from year 2020.VHP and PC showed a decrease in satisfaction from 2020. PC fell below the satisfaction rate of 80% with a 69.2 percentage point and the largest decrease of 19 percentage points.
- "Ability to resolve my concerns/issues" – PMG rated the highest with 100 percentage points and a 9.3 percentage point increase. VHP, Direct and PC showed a decrease in satisfaction from 2020. PC fell below the satisfaction rate of 80% with a 69.2 percentage point and the largest decrease of 19 percentage points.
    - "Friendliness/helpfulness" – PMG, VHP and Direct rated above goal for year 2021, while PC rated below goal with 76.9% and the largest decrease of -10.6 percentage points.

Table VII: Provider Network (Q8a-c)

MY 2021

Provider Network	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Quality of Provider Network	82.1%	-12.9%	92.3%	12.3%	100.0%	17.2%	93.4%	10.5%	80.0%	Yes
Availability of Medical Health Providers	74.1%	-22.1%	91.7%	-1.7%	72.7%	0.3%	93.0	-2.3%	80.0%	No
Availability of Behavioral Health Providers	57.1%	-22.5%	63.6%	-9.7%	72.7%	0.3%	48.9%	-19.7%	80.0%	No
MY 2020										
Quality of Provider Network	95.0%	-2.0%	80.0%	-16.0%	83.0%	0.0%	83.0%	-6.0%	80.0%	Yes
Availability of Medical Health Providers	96.0%	-4.0%	93.0%	-2.0%	72.0%	0.0%	95.0%	7.0%	80.0%	No
Availability of Behavioral Health Providers	80.0%	-13.0%	73.0%	-13.0%	72.0%	0.0%	67.0%	3.0%	80.0%	No

Goal: Q8a met. Q8b-c not met.

- "Quality of provider network" – PMG, showed a decrease in satisfaction of -12.9 percentage points from 2020 but maintained goal along with PC, VHP and Direct met the satisfaction goal of 80%.

- "Availability of medical health providers" – PMG showed the largest decrease in satisfaction overall with a -22.1 percentage point, followed by PC showed a decrease in satisfaction from 2020 of 1.7 percentage points, VHP fell below the goal of 80% with a 72.7 percentage points and Direct showed a decrease in satisfaction of 2.3 percentage points...

- "Availability of behavioral health providers" –

- Direct rate the lowest with a 48.9%, followed by PMG at 57.1%, PC rated satisfaction at 63.6% And VHP rated below the goal at 72.7 percentage points.

Table XIII: SCFHP's Language Assistance Program (Q9a-c)

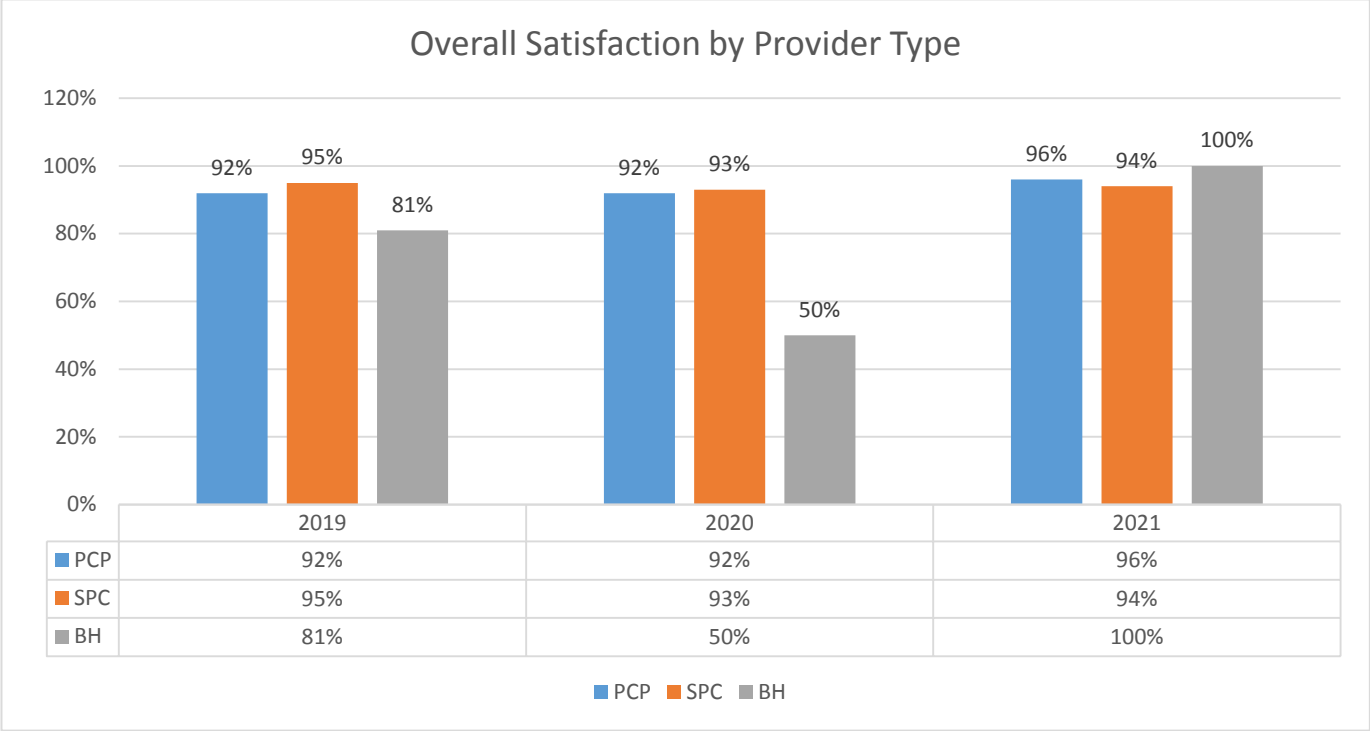
MY 2021										
SCFHP's Language Assistance Program	PMG	PY Change	PC	PY Change	VHP	PY Change	Direct	PY Change	Goal	Met
Coordination of Appointments with an interpreter	100.0%	8.3%	100.0%	0.0%	100.0%	0.0%	94.7%	-1.9%	80.0%	Yes
Availability of an appropriate range of interpreters	100.0%	8.3%	100.0%	0.0%	100.0%	0.0%	94.6%	-2.1%	80.0%	Yes
Training and competency of interpreters	100.0%	8.6%	100.0%	0.0%	100.0%	0.0%	94.6%	-1.9%	80.0%	Yes
MY 2020										
Coordination of Appointments with an interpreter	92.0%	-3.0%	100.0%	0.0%	100.0%	0.0%	97.0%	-1.0%	80.0%	Yes
Availability of an appropriate range of interpreters	92.0%	-3.0%	100.0%	0.0%	100.0%	0.0%	97.0%	-2.0%	80.0%	Yes
Training and competency of interpreters	92.0%	-3.0%	100.0%	0.0%	100.0%	0.0%	97.0%	-1.0%	80.0%	Yes

Goal: Met - 2021

- PMG, PC and VHP rated satisfaction at 100% across all metrics, while Direct rated 94.7 and 94.6 with a decrease of -2.1 percentage points and -1.9 percentage points.

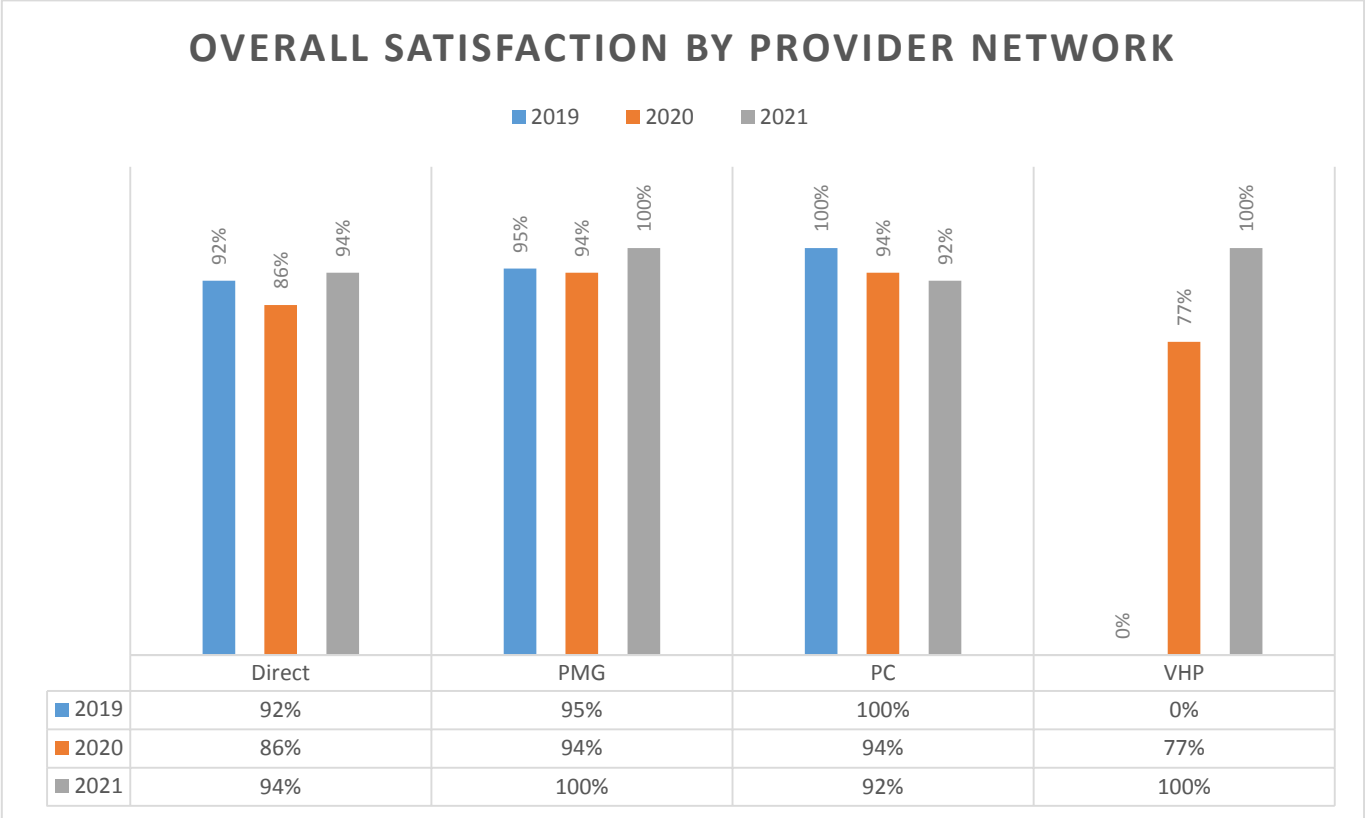
A. Overall Provider Satisfaction with SCFHP (Q10)

Chart A: Overall Satisfaction by Provider Type



- BH providers rated satisfaction the highest at 100% - a 50 point increase from 2020, and 11 point increase from 2019.
- PCP providers rated satisfaction at 96% - an increase of 4 points from 2020 and from 2019.
- Specialist providers rated satisfaction the lowest at 94% - 1 point increase from 2020, and 1 point decrease from 2019.

Chart B: Overall Satisfaction by Provider Network



	Direct	PMG	PC	VHP
2019	92%	95%	100%	0%
2020	86%	94%	94%	77%
2021	94%	100%	92%	100%

- Direct rated satisfaction at 94% 2021- a 6 point increase from 2020.
- PMG rated satisfaction at 100% 2021 - a 6 point increase from 2020.
- PC rated satisfaction at 92% 2021 - a 2 point drop from 2020.
- VHP rated satisfaction at 100% 2021 - 13 points increase from 2020.

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B. Conclusion:

While the Plan is pleased that most measures met the Plan's performance goals, and overall results indicate strengths in most operational areas, SCFHP business units will collaborate internally on specific areas, and if operational issues are identified, a correction plan will be established.

SCFHP values its network providers and will continue to improve operations to satisfy and meet provider needs and expectations.

I. MEMBER ACCESS GRIEVANCES

Table I: Access Complaint Record **Jan 2020 – Dec 2020**

Provider/Service Type	Totals	Resolved In Favor of Member	Resolved In Favor of Plan	Withdrawn
Interpreter Services	2	2		
Office Wait Time	4	4		
Physical Access to Facility	1	1		
Provider Directory Error	1	1		
Provider Not Accepting New Patients	5	2	3	
Provider Telephone Access	30	25		5
SCFHP Telephone Access	1	1		
Specialist Telephone Access	2	1		1
Timely Access to Non-Medical Transportation	3	2	1	
Timely Access to Primary Care Provider	35	30	1	4
Timely Access to Specialist	26	23		3
Totals	**110**	**92**	**5**	**13**

Quantitative Analysis (Table I): As shown in the table, there were a total of 110 member complaints relevant to access. The three highest percentage of member complaints was at 32% relevant to

Timely Access to Primary Care Provider, followed by Provider Telephone Access at 27%, and Timely Access to Specialist 24%.

Provider Network Operations department is currently monitoring complaints and is working directly with specific transportation vendors to ensure that member complaints are addressed.

Qualitative Analysis: The review showed that member complaints are resolved expeditiously and no barriers appear to be present in resolving member access complaints. No trending or concerns with specific provider types and/or geographic areas were identified in the member complaint assessment. As noted, the increase in transportation complaints initiated an action plan to closely monitor complaints and to work directly with transportation vendors specifically to improve services and decrease member complaints.

Conclusion

Overall member complaints were within normal limits.

Overall Conclusions:

- Appointment surveys showed improvement in access across most provider types. However, there are potential areas that may need to be addressed.

  Potential focus area(s):

  - BH appointment access –

    1. Urgent Care

  - SPC appointment access

    1. Gynecology – Urgent Care
    2. Oncology – Urgent Care

- After-hours survey – PCP and BH providers exceeded goal on “access” (911 messaging) and fell short of goal on “timeliness”.

  Potential focus area(s):

  - Messaging on timeliness (call back within 30min or less)

- Member experience survey (CAHPS) showed marked improvements in several areas, specifically the rating of the Plan, which increased by 6 percentage points in 2020.

  Potential focus area(s):

- Getting seen within 15min of appointment

- Provider experience survey indicated a reasonable overall satisfaction rating in 2021.

Potential focus area(s):

- Specialist Providers – Overall satisfaction rating with SCFHP is 94%.
- Timely appointment access to non-urgent behavioral health care.

The assessments in this report revealed potential barriers in access, therefore the Plan established opportunities and interventions for 2020/2021 as outlined in the grid below --

OPPORTUNITIES

Barrier	Opportunity	Intervention	Selected for 2020/2021	Date Initiated
Timely appointment access	• Notify providers of non-compliance.	• Submit a CAP to non-compliant providers and require an action plan within 30-days.	Yes	11/2020
After-hours timeliness (call back within 30min)	• Notify providers of non-compliance.	• Submit a CAP to non-compliant providers and require them to submit an action plan within 30-days. • CAP to include non-compliant phone numbers.	Yes Yes	11/2020 11/2020
In-office wait times not to exceed 15-minutes.	• Educate providers on in-office wait times.	• Submit SCFHP's access matrix to the entire provider network via fax blast.	Yes	03/2021

Santa Clara Family Health Plan™

PO Box 18880, San Jose, CA 95158
1.408.874.1788 | TTY 711
www.scfhp.com

Adopted Clinical and Preventative Guidelines

Santa Clara Family Health Plan uses clinical practice guidelines to help providers make decisions about appropriate care for specific clinical circumstances. These clinical practice guidelines are also used in related programs such as disease and population management.

Practice guidelines are developed from scientific evidence or a consensus of health care professionals in the particular field.

Practice guidelines are reviewed and updated at least every two years and more frequently when updates are released by the issuing entity. Santa Clara Family Health Plan monitors compliance and member outcomes related these clinical guidelines for quality improvement initiatives.

These clinical practice guidelines are intended to assist providers in clinical decision-making, and attempt to define clinical practices that apply to most patients in most circumstances.

The guidelines are not intended to replace clinical judgment but are provided to assist our practitioners with making decisions about a range of clinical conditions. The treating practitioner should make the ultimate decision in determining the appropriate treatment for each patient.

Preventative Guidelines

Clinical Practice Guidelines

Anemia
American Academy of Family Physicians (AAFP)

Antithrombotic Guidelines
American College of Chest Physicians

Asthma Clinical Guidelines
National Institute of Health Guideline on Asthma

Chronic Kidney Disease
National Kidney Foundation

Diabetes Clinical Guidelines
American Diabetes Association Guideline

Glaucoma
U.S. Preventative Services Task Force

Hyperlipidemia Guidelines
Guidelines from UpToDate

Hypertension Clinical Guidelines
American College of Cardiology
American College of Cardiology Guidelines

Osteoporosis
American Association of Clinical Endocrinologists/ American College of Endocrinology
Screening Guidelines from UpToDate

Rheumatoid Arthritis Osteoarthritis
American College of Rheumatology

Acquired Hypothyroidism
American Thyroid Association (ATA)

Behavioral Health Guidelines

Adult Depression Clinical Guidelines
American Psychological Association (APA) Guidelines

Children and Adolescents with ADHD Guidelines
American Academy of Pediatrics Guideline
Centers of Disease Control and Prevention

Children and Adolescents with Depressive Disorder Clinical Guidelines
American Academy of Pediatrics

Adverse Childhood Experiences (ACES) Screening
ACES Aware

Mental Health and Substance Abuse Guidelines
Substance Abuse and Mental Health Services Administration

Lead Screening

Childhood Lead Poisoning Prevention Branch – Guidance for Health Care Providers
California Department of Health Care Services Blood Lead Test and Anticipatory Guidance

Preventative Care Guidelines

Adult (22-64 year) Preventative Guidelines
American Association of Family Physicians
U.S. Preventive Health Services Task Force
CDC Advisory Committee Immunization Practices

Child and Adolescent (0 month to 21 years) Preventative Guidelines
American Academy of Pediatrics
American Academy of Pediatrics Periodicity Schedule
CDC Advisory Committee of Immunization Practices
U.S. Preventive Health Services Task Force

Prenatal Preventative Guidelines
ACOG Guidelines

Seniors (65+ years) Preventive Guidelines
CDC Advisory Committee of Immunization Practices
U.S. Preventive Health Services Task Force

Treating Tobacco Use and Dependence Guidelines
US Preventive Services Task Force A and B Recommendations
U.S. Department of Health and Human Services

Santa Clara Family Health Plan™

Medi-Cal (MC)
and
Cal-Medi-Connect (CMC)
Santa Clara Family Health Plan

Quality Improvement Program 2022

Quality Improvement Committee Approval on: mm/dd/yy

Santa Clara Family Health Plan™

Table of Contents

I. Introduction

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

- SCFHP serves 280,666 Medi-Cal enrollees in Santa Clara County as of December, 2021.
- 10,431 members are enrolled in SCFHP's Cal MediConnect (CMC) plan as 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.

II. Mission Statement

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

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

III. Authority and Accountability

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

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

Executive Officer (CEO) as the individual responsible for the implementation of the QI Program Description. The CEO has delegated oversight of the day-to-day operations of the QI Program to the Chief Medical Officer (CMO).

IV. Purpose

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

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

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

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

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

V. Goals

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

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

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

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

O. The provision of quality monitoring and oversight of contracted facilities, per DHCS requirements, to continuously assess that the care and service provided satisfactorily meet quality goals for patient safety and coordination of care.

VI. Objectives

The objectives of the QI Program Description include:

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

L. Coordinating QI activities with other activities, including, but not limited to, the identification and reporting of risk situations, adverse occurrences from UM activities, and potential quality of care concerns through grievances.
M. Evaluating the QI Program Description and Work Plan at least annually and modifying as necessary. The Work Plan is updated quarterly. The evaluation includes:
    a. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    b. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
N. Analyzing the results of QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality of services)
O. Developing recommendations to inform the QI Work Plan for the upcoming year to include a schedule of activities for the year, measurable objectives, plan for monitoring previously identified issues, explanation of barriers to completion of unmet goals, and assessments of the completed year's goals
P. Implementing and maintaining health promotion activities and population health management programs linked to QI actions to improve health outcomes. These activities include, at a minimum, identification of and outreach to of high-risk and/or chronically ill members, education of practitioners, and outreach and education programs for members
Q. Maintaining accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VII. Scope

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

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

A. The scope of quality review is reflective of the health care delivery systems, including quality of clinical care and quality of service.
B. Activities reflect the member population in terms of age groups, cultural and linguistic needs, disease categories and special risk status.
C. The scope of the QI Program includes the monitoring and evaluation and driving improvements for key areas, including but not limited to the following:
    a. Healthcare Effectiveness Data and Information Set (HEDIS)
        i. Access to Preventive Care
        ii. Maintenance of Chronic Care Conditions
    b. Behavioral health services
    c. Continuity and coordination of care

d. Emergency services
e. Grievances
f. Inpatient services
g. Member experience and satisfaction
h. Minor consent/sensitive services
i. Perinatal care
j. Potential quality of care issues
k. Preventive services for children and adults
l. Primary care
m. Provider satisfaction
n. Quality of care reviews
o. Specialty care

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

VIII. QI Work Plan

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

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

K. Comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures

Quarterly review and updates to the Work Plan are documented. It is available to regulatory agencies by request.

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

IX. QI Methodology

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

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

QI Project Selections and Focus Areas

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

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

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

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

B. Case Management.
C. Coordination and continuity of care for Seniors and Persons with Disabilities.
D. Provision of complex care management services.
E. Access to and provision of preventive services.

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

A. Staff and physicians provide vital information necessary to support continuous improvement in work processes
B. Individuals and department stakeholders initiate improvement projects within their area of authority, which support the strategic goals of the organization.
C. Specific performance improvement projects may be initiated by the state or federal government.
D. Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes.
E. Project coordination occurs through the various leadership structures: Governing Board, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort.
F. These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Quality Indicators

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

QI Project Measurement Methodology

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

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

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

Plan 1) Identify opportunities for improvement

2) Define baseline

3) Describe root cause(s)

4) Develop an action plan

Do 1) Communicate change/plan

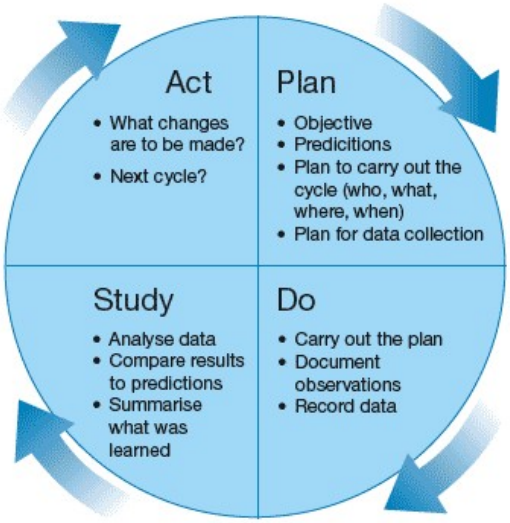
2) Implement change plan

Study 1) Review and evaluate result of change

2) Communicate progress

Act 1) Reflect and act on learning

2) Standardize process and celebrate success



X. QI Quality Issue Identification

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

Adverse events can include:

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

Sentinel event monitoring includes patient safety monitoring across the entire continuum of SCFHP's contracted providers, delegated entities, and health care delivery organizations. The presence of a sentinel event is an indication of possible quality issues, and the monitoring of such events increases

the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

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

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

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

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

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

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

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

XI. QI Program Activities

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

Prioritization

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

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

Use of Committee Findings

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

Clinical Practice Guidelines

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

Preventive Health/HEDIS Measures

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

Continuity and Coordination of Care

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

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

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

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

XII. QI Organizational Structure

Quality Improvement Department [Appendix 1]

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

A. Monitoring, evaluating and acting on clinical outcomes for members.

B. Conducting reviews and investigations for potential or actual Quality of Care matters.
C. Conducting reviews and investigations for clinical grievances, including Potential Quality Issues (PQIs).
D. Designing, managing and improving work processes to:
    a. Drive improvement of quality of care received
    b. Minimize rework and costs
    c. Optimize the time involved in delivering patient care and service
    d. Empower staff to be more effective
    e. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Supporting the maintenance of quality standards across the continuum of care and all lines of business.
F. Leading cross-functional Process Improvement projects to improve efficiency across the organization
G. Maintaining company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA).
H. Collaborating with multi-departments, but not limited to: Medical Management, Pharmacy, Grievance & Appeals, Customer Services and Utilization to coordinate QI activities for all line of business (CMC & MC).

Chief Medical Officer

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

Medical Director

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

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

Director of Quality and Process Improvement

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

Quality and Health Education Manager

The Quality and Health Education Manager provides leadership, and coordination to the HEDIS and Health Education Team and is a person with experience in data analysis, barrier analysis, and project management as it relates to improving the quality of service provided to Plan members. The Quality and Health Education Manager reports to the Director of Quality and Process Improvement and is responsible for managing the activities of the Plan's quality improvement staff in monitoring the Plan's health care delivery system relating to quality improvement, including, Health Education (HE), Cultural & Linguistic (C&L) programs and Healthcare Effectiveness Data and Information Set (HEDIS) reporting. The Quality and Health Education Manager assists the Director of Quality and Process Improvement in overseeing the day to day operations of Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members.

Clinical Quality and Safety Manager

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

Process Improvement Manager

The Process Improvement Manager provides leadership, coordination and management to the Process Improvement Team as it relates to improving internal processes impacting the quality of care and quality of service provided to Plan Members. The Process Improvement Manager reports to the Director of Quality and Process Improvement and is responsible for managing the Process Improvement team in reviewing the Plan's internal health care delivery systems, managing activities of the Plan's Consumer

Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) surveys, and overseeing NCQA accreditation activities.

QI Nurse, RN

The QI Nurse reports to the Clinical Quality & Safety Manager and oversees investigations of member grievances related to PQI, supports HEDIS medical record reviews, and investigates and prepares cases for PQIs for Medical Director or CMO review. The QI Nurse also assists with ongoing QI studies and reviews which include but are not limited to Performance Improvement Projects (PIPs) and Chronic Condition Improvement Projects (CCIPs), and supports the Health Education Program team with a clinical perspective. The QI Nurse can also be a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, and medical record reviews, monitors compliance with Initial Health Assessments (IHAs), and assists with other QI activities at the direction of the Clincal Quality and Safety Manager.

Grievance & Appeals Clinical Specialist, RN

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

HEDIS Project Manager

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

Process Improvement Project Manager

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

QI Analyst

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

Process Improvement and Quality and Health Edcuation Manager and works in collaboration with other departments.

Health Educator

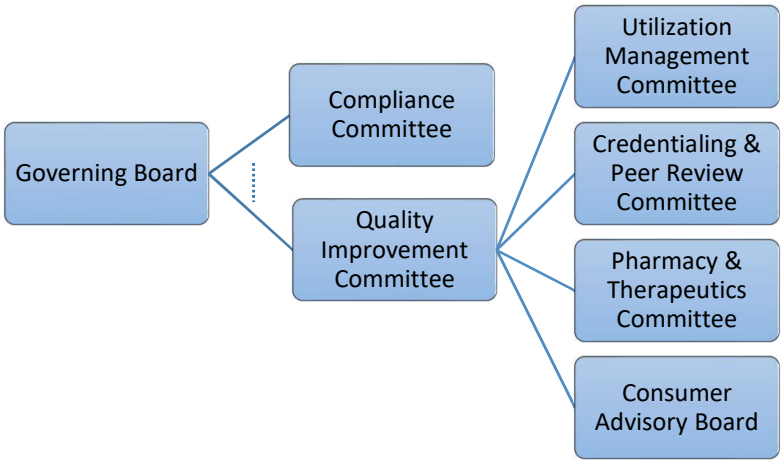
The Health Educator is a qualified health educator/health education specialist either being a Certified Health Education Specialist (CHES) or qualified with Master of Public Health (MPH), who responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education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

Quality Improvement Coordinator

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

XIII. Committee Structure Overview

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



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

A. Goals

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

XIV. Committee Structure

Governing Board

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

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

Quality Improvement Committee (QIC)

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

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

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

scope of the QI Program are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

The QIC provides overall direction for the continuous improvement process and evaluation of activities, consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and interdepartmental approach. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, it strives to ensure that members are provided the highest quality of care, that the plan adopts evidence based clinical practice guidelines (CPG), completes an annual review and updates the CPGs to make certain they are in accordance with recognized clinical organizations. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

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

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

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

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

Utilization Management Committee

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

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

The UMC monitors the utilization of health care services by SCFHP and through delegated entities to identify areas of under- or over- utilization that may adversely impact member care as well as practice

patterns of network practitioners and other QI monitors as defined by the Utilization Management Program and Utilization Management Work Plan.

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

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

Pharmacy and Therapeutics Committee

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

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

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

Credentialing and Peer Review Committee

SCFHP's Credentialing and Peer Review Committee uses a peer review process to make decisions regarding health plan credentialing and recredentialing of its contracted practitioners and those applying to contract with the Plan, and to serve as the Peer Review Committee when quality review is requested by the Quality Improvement Committee (QIC). Medical staff triages potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to the Credentialing and Peer Review Committee to assess if documentation is complete, and whether further action is required. The QI Department tracks, monitors, and trends service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the Credentialing and Peer Review Committee at time of re-credentialing. Quality of care case referral to the QI Department originating from

multiple activities, which include, but are not limited to: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

XV. Role of Participating Practitioners

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

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

XVI. Behavioral Health Services

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

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

f. Inter-rater reliability

H. Compliance with evidence-based clinical guidelines

I. Language assistance

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

XVII. Utilization Management

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

XVIII. Population Health Management

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

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

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

XIX. Care of Members with Complex Needs

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

A. Providing case management teams focusing on members who have had an organ transplant, or are diagnosed with HIV/AIDS, progressive degenerative disorders and/or metastatic cancers.

B. Improving access to primary and specialty care to facilitate the receipt of appropriate services for members with complex health conditions.
C. Coordinating care for members who receive multiple services.
D. Identifying and reducing barriers to services for members with complex conditions.

XX. Long Term Services and Supports (LTSS) & Social Determinants of Health (SDOH)

The LTSS Team develops and leads strategies, initiatives and programs that address members' LTSS needs and Social Determinants of Health (SDOH). This includes building and managing an adequate provider network and community partnerships for the delivery of Enhanced Case Management (ECM) benefits and the Community Supports program. Designated LTSS staff oversee referrals and eligibility determination for these benefits as well as coordination and training with LTSS providers including Community Based Adult Services (CBAS) In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) and the network of contracted nursing facilities. SCFHP is committed to coordination and leveraging of community resources, and education to provide adequate access and availability to members needing LTSS and to address member's social conditions.

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

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

XXI. Enhanced Care Management and Community Supports

Enhanced Care Management (ECM) is a Medi-Cal benefit delivered by community-based providers for members who meet specific eligibility criteria for one of the seven identified ECM Populations of Focus. These include children with complex health needs, homeless individuals, high utilizers, individuals at risk of institutionalization, justice involved individuals and nursing facility residents transitioning to the community. Eligible members are assigned a Lead Care Manager to work with the member and family support individuals to manage and coordinate the member's care. ECM serves as the central point for coordinating patient-centered care to improve member outcomes through coordination of primary care, physical and developmental health, mental health, substance use disorder treatment (SUD), community-based Long Term Services and Supports (LTSS), oral health, palliative care, and community-based and social services. ECM creates an infrastructure to support multi-system coordination and care delivery, including connecting member to Community Supports; ECM looks to reduce healthcare cost,

including hospital admissions/ readmissions and ED visits, and extends to reduce cost in expensive community systems such as, long term care setting, nursing home residency, and prision systems.

Community Supports are flexible wrap-around services that are integrated into our case management programs for members at medium-to-high levels of risk and may fill gaps in Medi-Cal benefits to address medical or other needs that may arise due to social determinants of health. These services are medically-appropriate and cost-effective substitutes or settings and will be provided as an alternative to services covered under Medi-Cal, such as hospital care, nursing facility care, and emergency department (ED) utilization. The health plan will launch all 14 of the DHCS-approved Community Supports in six-month increments between January 1, 2022 and July 1, 2023. Referrals can be made by all providers and members, eligibility criteria are reviewed and if approved, the member is linked to a community based-provider to provide the community support. Community support providers provide updates on the member to ECM providers and the health plan which can be communicated to those in the care circle.

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

XXII. Cultural and Linguistics

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

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

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

Interpreter services are provided to the member at no charge.

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

A. Using practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved to reduce health care disparities in clinical areas.
B. Conducting member-focused interventions using culturally competent education materials that focus on race, ethnicity and language specific risks.

C. Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs and how to improve the cultural competency of communications, as determined by the plan's Health Educator
D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy, and to meet the needs of underserved groups.

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

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

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

XXIII. Health Education

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

Please refer to Health Education Program Description.

XXIV. Credentialing Processes

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

The comprehensive credentialing process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status, and judgment, thus ensuring the competency of practitioners working within the SCFHP contracted delivery system. The scope of the credentialing program includes all licensed Physicians (MD), Oral Surgeons, Dentists (DDS), Podiatrists (DPM), Doctors of Osteopathy (DO), Nurse

Practitioners (NP), Physician Assistants (PA), Certified Nurse Mid-Wife (CNM), Clinical Nurse Specialists (CNS), Chiropractors (DC), Optometrists (OD), Clinical Psychologists (Ph.D.), Behavioral Health Practitioners such as Marriage Family Therapists (LMFT), Licensed Clinical Social Workers (LCSW), and other ancillary, allied health professionals or mid-level practitioners, as applicable, both in the delegated and direct contracts.

Healthcare Delivery Organizations

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

Use of Quality Improvement Activities in the Re-credentialing Process

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

Monitoring for Sanctions and Complaints

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

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

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

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

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

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

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

Medical Record Documentation Standards

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

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

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

XXVI. Initial Health Assessment

SCFHP ensure contracted providers are trained and administering the Initial Health Assessment (IHA) with the Staying Healthy Aessment (SHA) for all memebrs within 120 days of enrollment. (DHCS APL 08-003) The IHA is conducted in a culturally and linguistically appropriate manner for all memebrs, including those with disabitilies. The Goals Medical providers will use the SHA tool and other relevant clinical evidence to identify beneficiary's health education needs and conduct educational intervention.

XXVII. Member Safety

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

A. Identification and prioritization of patient safety-related risks for all SCFHP members, regardless of line of business and contracted health care delivery organizations
B. Operational objectives, roles and responsibilities

C. Ensuring appropriate patient safety training and education are available to members, families, and health care personnel/physicians
D. Health Education
E. Population Needs Assessment
F. Over- and Under- Utilization monitoring
G. Medication Management
H. Case Management and Population Health Management outcomes
I. Operational Aspects of Care and Service

Member Safety prevention, monitoring and evaluation include:

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

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

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

XXVIII. Member Experience and Satisfaction

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

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

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

Member Grievances and Provider Complaints

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

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

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

XXIX. Delegation Oversight

The Delegation Oversight process is within the Plan's Compliance Department and overseen by the Plan's Compliance Committee. Delegation Oversight activities that are specific to the QI Program include reports submitted by delegated entities and reviewed by SCFHP's functional operational areas.

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

A. On-going monitoring via quarterly, semi-annual, and annual reports

B. Focused review that may include case file monitoring when applicable
C. Annual review of the delegates' policies and procedures
D. Annual Oversight Audits
E. Annual review to provide feedback of the delegates' Quality and Utilization Management Program Plans and Work Plans
F. Review and approval of sub-delegate's delegation agreement(s) prior to implementation of such an agreement
G. Sub-delegation reports
H. Review of case management program and processes
I. Review of quality of care monitoring processes, results of QI Activities,
J. Review of credentialing and re-credentialing processes, working collaboratively with the delegates' staffs to review performance and develop strategies for improvement
    a. Communication monthly and quarterly analysis of reports and utilization benchmarks to delegates

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

Delegate monitoring and auditing activities, including corrective action plan monitoring and recommendations are presented and discussed in the Plan's Oversight Workgroup. The Plan's Oversight Workgroup is comprised of representatives from all functional areas. Representatives are invited and encouraged to present their oversight activities with delegated entities. Delegation Oversight activities related to this QI Program, including quality of care, quality of service and access and availability is also presented in QIC by functional area representatives or Compliance representative as part of additional monitoring. All oversight activities and recommendations are also presented to the Compliance Committee for review, discussion, and approval, when applicable. The Compliance Committee is comprised of members from the Governing Board and SCFHP's Executive Leadership Team. The Compliance Committee reports to the Governing Board.

XXX. Data Integrity/Analytics

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

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

A. Identify and stratify members with certain disease states
B. Identify over/under utilization of services

C. Identify missing preventive care services
D. Identify members for targeted interventions

Identification and Stratification of Members

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

Identify Potential of Over- and Under- Utilization of Services

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

Identify Missing Preventive Care Services

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

Identify Members for Targeted Interventions

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

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

Medical Record Review

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

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

Interventions

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

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

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

Improvement Standards

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

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

Documentation of QI Projects

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

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

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

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

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

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

A. Clinical care and service
B. Access and availability
C. Continuity and coordination of care
D. Preventive care, including:
    a. Initial risk assessment (IHA)
    b. Behavioral assessment
E. Patient diagnosis, care, and treatment of acute and chronic conditions

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

Administrative Oversight:

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

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

XXXI. Conflict of Interest

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

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

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

XXXII. Confidentiality

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

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

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

This

XXXIII. Communication of QI Activities

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

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

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

XXXIV. Annual Evaluation

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

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

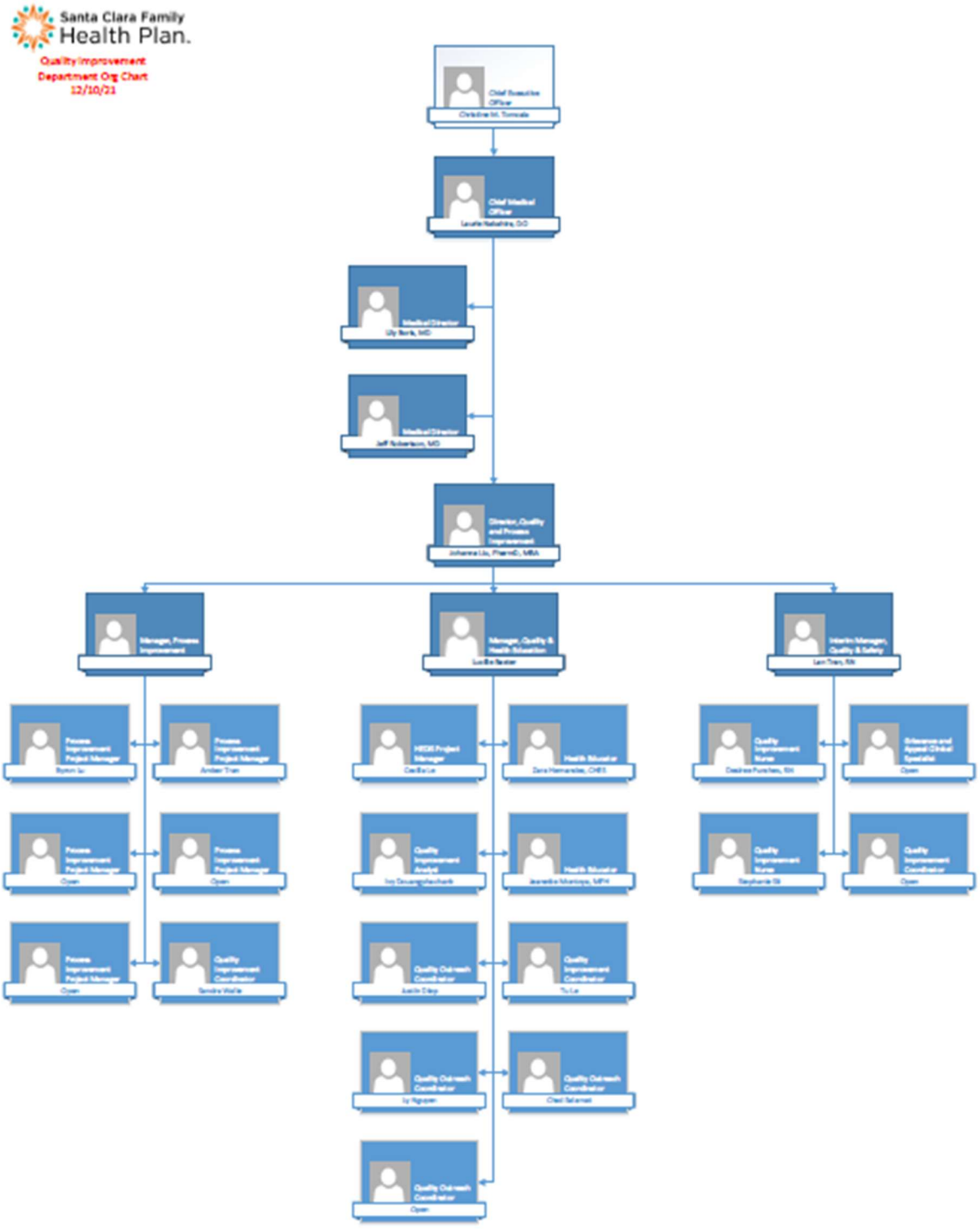
A. A description of completed and ongoing QI activities that address quality of care, safety of clinical care, quality of service and members' experience
B. Trending and monitoring of measures and previously identified issues to assess performance in the quality and safety of clinical care and quality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

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

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

Appendix 1

Quality Improvement Department Organization Structure



Santa Clara Family Health Plan™

Health Education Work Plan Evaluation 2021

HEALTH EDUCATION WORK PLAN EVALUATION 2021

Item	Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation
1A	Scope of Services	Scope of Services	Pregnant Women	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS APL 18-016	- Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components - Health Education including breastfeeding, language, cultural competence and education needs must be assessed. Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for education materials distributed to Medi-Cal member (APL 18-016)	- Chart audits and provider training	- Provider Training and FSR results	All providers trained	QI & Health Educator, Provider Services	Annually	Ongoing	Clinical nurse team audit have risk assessment tool for pregnant members during FSR/MRR Implemented virtual baby shower for pregnant women, education, health education during pregnancy, appointments with OB doctor
1B	Services for All Members	Health Education	- Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS PL 02-004	- Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - - Contact community organizations for potential health ed partnerships - Develop patient education materials library -	- P&P's for health education system - List of health ed classes that cover all required health ed topic areas. - Provider/Vendor Contracts/MOU's - Comprehensive patient education library	Baseline	Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Ongoing	P&Ps updated and approved by QIC Feb. 2021. List of health ed classes reviewed July 2021. Contracts inventory reviewed June 2021. Comprehensive library reviewed August 2021.
1C	Services for All Members	Health Education	Ensure effective health ed program	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS APL 19-011 (superseeds APL 17-002)	- Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	- Use findings from PNA to select educational strategies and methods - Measure pre- and post- educational intervention behavior	- P&P's for delivery of health ed program using educational strategies appropriate for Members. -Health Education Program	Organized delivery of health ed program	Health Educator	Annually	Ongoing	P&Ps updated and approved by QIC Feb. 2021. Post class surveys developed for Health Moms, Healthy Babies Virtual Baby Shower (May 2021) and Controlling High Blood workshop (July 2021).
1D	Services for All Members	Health Education		DHCS APL 18-016	- Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	- Test reading materials using flesch readability formula, etc., - Field test material at CAC meetings - Adhoc committee for field testing materials	- P&P's that define appropriate reading levels - Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to Plan-developed health education materials) - Adhoc field testing committee sign-in sheets	100%	Health Educator	Ongoing	Ongoing	Policy QI.09 Health Education Program and Delivery System updated and approved by QIC Feb. 2021. R&S checklist completed for the following items: 1. Blood pressure log 2. Well-child visits, age 0-30 months 3. Well-child visits, age 3-21 4. CDC Poor Control 5. Well Woman Exam Adhoc field testing completed for preventive care campaign. Screenshots with feedback available (no sign-in sheets since all staff are working from home) completed March 2021.
1E	NCQA	Health Ed		Pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004 NCQA 2020 Health Plan Accreditation Requirements PHM4	- Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions - Alcohol and drug use, including avoiding at risk drinking - Identifying depressive symptoms	- Contract with health education vendors to provide classes to meet requirement	- Health Ed courses/activities - Health Educator or designee to audit all health education classes -	- 100% of vendors to have signed contracts (new or renewed) by 12/31/2021 - 100% of vendors audited by 12/31/21	Health Educator	Annually	Ongoing	Vendors with signed contracts Audits completed: 1. ACT - July 2021 2. Breathe California - August 2021 3. HKF - June and July 2021 4. IHC - not completed. No group classes offered in 2021. 6. Health Trust - Not completed. No longer providing services to SCFHP as of 6/30/21.
2A	Member Services	Health Ed	Member Services	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials.	- Written Member informing materials will be translated into identified threshold and concentration languages.	- P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication - P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing, Health Educator	Annually	Ongoing	Policy QI.09 Health Education Program and Delivery System updated and approved by QIC Feb. 2021.
2B	Provider Training	Health Ed	Practitioner Education and Training	DHCS PL 02-004 DHCS PL 99-003 CMC 3-way contract 2.9.11.7	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services and culturally competent care for members. Training content shall include: language access requirements, tips for working with interpreters, cross-cultural communications, strategies to address health literacy, health beliefs, strategies for working with LEP members and SPDs, and disability sensitivity.	- Practitioner education and training by provider services - Health ed updates during JOC's	- Sign in sheet of provider training - JOC minutes	All providers trained	Health Educator, Provider Services, QI	Ongoing	Ongoing	Provider newsletter article about health education services January 2021. C&L Toolkit for Providers reviewed for updates 2021

Santa Clara Family Health Plan™

Health Education Work Plan Evaluation 2021

HEALTH EDUCATION WORK PLAN EVALUATION 2021

Item	Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation
2C	Incentives	Health Ed	MMCD on-going monitoring activities	DHCS APL 16-005	Evaluation summary	- Plans must submit a brief description of evaluation results within 45 days after the incentive program ends	- Brief description of evaluation results indicating whether the program was successful. -	All MI incentives with evaluation/update summary	Health Educator	45 days after end of program incentive	Ongoing	Evaluations completed: 1. PPC - February 2021 2. CDC HT - March 2021 3. W15 - March 2021 4. BCS/CCS - March 2021 5. AWC - March 2021 6. DPP (YMCA) - August 2021 7. HKF - October 2021
2D	Incentives	Health Ed	- Justify continuation of on-going incentive program	DHCS APL 16-005	Justify continuation of MI program	- Provide brief explanation (update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded in the previous year.	-Update submission to DHCS	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the desired start date listed on the MI form.	Ongoing	No programs continued from 2020
2E	Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials	- Ensure member informing resources are at sixth grade level or lower and translated into threshold languages	- Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower	Health Educator and Marketing	Ongoing	Ongoing	Newsletter dates: Winter 2021 MC/CMC Spring 2021 MC/CMC Summer 2021 MC/CMC Fall 2021 MC/CMC
3A	Health Education		Written Health Education Materials	DHCS APL 18-016	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	- Approve written member health ed materials using readability and suitability checklist by qualified health educator	- Approved readability and suitability checklists with attached health ed materials.(Only applies to materials developed by the plan)	Approved readability and suitability checklists with attached health ed materials	Health Educator	- For previously approved material, review every three years	Ongoing	CDC A1C - reviewed 10/13/21 CDC >9 - reviewed 7/27/21 W30A - reviewed 7/28/21 W30B - reviewed 7/28/21 WCV - reviewed 10/13/21 Well Woman - reviewed 10/13/21
3B	Health Education		Evaluation of Plan's self-management tools for usefulness to members	NCQA 2020 Health Plan Accreditation Requirements PHM4	To ensure self-management tools are useful to members and meets the language, vision, and hearing needs of members	- Develop an evaluation tool/survey	- Evaluation results summary	Baseline	Health Educator	Every 36 months	Ongoing	CMC - currently meet thru WebMD via Healthx, our portal vendor. *In Progress* - MC - Need solution to meet requirement by 12/2023. Purchase through NCQA certified vendor (WebMD) or work with IT to develop HA and self-management tool
3C	Health Education		Review plan's online web-based self-management tools.	NCQA 2020 Health Plan Accreditation Requirements PHM4	To ensure online web-based self-management tools are up to date	- Review and update online web-based self-management tools including the plan website and portal	Updated web-based self-management	Baseline	Health Educator	Ongoing	Ongoing	CMC - currently meet thru WebMD via Healthx, our portal vendor. *In Progress* - MC - Need solution to meet requirement by 12/2023. Purchase through NCQA certified vendor (WebMD) or work with IT to develop HA and self-management tool
3D	Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	Pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	Ensure member medical records include health education behavioral assessment and referrals to health education services		- P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. - Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI Nurse	Annually	Ongoing	See P&Ps Q.10, QI.10.01, QI.10.02, QI.10.04 in PolicyTech. Provider newsletter with list of Health Ed classes/programs published 1/25/22
3E	Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	Pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	- Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide	- Written information in Evidence of Coverage	All members of childbearing age informed of right to access to qualified family planning provider	Marketing and Health Educator	Annually	Ongoing	2021 Evidence of Coverage (EOC) released/updated April 2021
4A	Quality of Services	Access and Availability	Updated Health Ed Work plan	Pg. 61 Exhibit A, Attachment 9 Access and Availability DHCS APL 19-011	Update work plans	- Incorporate PNA findings and annual and ongoing review of data into work plan - Approval of Health Ed Workplan by QI Committee	Approved Health Ed Work Plan -	Baseline	QI Manager and Health Educator	Annually	Ongoing	PNA approved by DHCS on 8/4/21.
4B	Quality of Services	Access and Availability	Health Disparities	Pg. 73 Exhibit A, Attachment 10 Scope of Services	Develop interventions based on identified health disparities	Implement at least 2 new projects outside of required DHCS PIPs and other government mandated projects.	- DHCS member incentive form submissions - Intervention work plan - intervention materials	Baseline	QI Manager, Health Educator	Annually	Ongoing	Implemented internal PIP for adolescent well-care visits (AWC) for ages 18-21 Outreach calls to close gaps among ethnic groups including: *Hispanics and Vietnamese groups for CCS/BCS in January 2021. *African American and Hispanic groups for CBP in February 2021.

Santa Clara Family Health Plan™

Health Education Work Plan Evaluation 2021

HEALTH EDUCATION WORK PLAN EVALUATION 2021

Item	Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation
4C	Community Advisory Committee	Access and Availability	Community Advisory Committee	Pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01, DHCS APL 19-011	- Have a Community Advisory Committee in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	- Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues from PNA findings.	- CAC Meeting minutes - Report PNA findings to CAC.	Baseline	QI, Health Educator, and Marketing	Quarterly	Ongoing	PNA findings presented at CAC - September 2021.
4D	Consumer Advisory Board	Access and Availability	Consumer Advisory Board	Pg. 115 CMS 3-way contract 2.16.3.2.4.5.	- Have a Community Advisory Board in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	- Ensure CAB is included in policy decisions for QI educational, operational and cultural competency issues.	- CAB Meeting minutes	Baseline	QI, Health Educator, and Marketing	Quarterly	Ongoing	Health Education and C&L information presented at CAB meetings: - American Heart Association Healthy Hearts - March '21 - SCFHP Health Education - June '21 - SCFHP High blood pressure class Sept '21
4D	Scope of Services	Access and Availability	Comprehensive Tobacco Prevention and Cessation Services	APL 16-014	To develop a system to identify tobacco users and track utilization data of tobacco cessation interventions.	Develop a system to track individual utilization data of tobacco cessation interventions. Utilization report of No Butts web-based referrals by providers. Educate providers on documenting tobacco users in medical records.	Annual report summarizing claims to track utilization of tobacco interventions. Annual report summarizing tobacco users.	Baseline	QI, Health Educator	Annually	Ongoing	*In Progress -* Pending contract with CA through UC SD. Once agreement is in place with Smoker's Helpline we will have a report to track utilization. Contract Breathe CA still in place as backup referrrals.
4E	Scope of Services	Provider Education	Comprehensive Tobacco Prevention and Cessation Services	APL 16-014	Utilization of Initial Health Assessment (IHA) and Provider Education for pregnant woman and children and adolescent who use or who are at risk of exposure to tobacco smoke.	Ensure providers are completing the IHA and are referring members to appropriate smoking cessation programs.	Provider training FSR/MRR results IHA audit results	All providers trained/informed	Qi, Health Educator, PNO	Annually	Ongoing	Smoking cessation included in provider onboarding training FSR/MRR - Jan - Dec 2021 Initial FSR - 11 (99% average score) Period FSR - 5 (94%) MRR Initial - 2 (84%) MRR Periodic - 2 (84%)
5A	Scope of Services	Health Education	Comprehensive Tobacco Prevention and Cessation Services	APL 16-014	Availability of tobacco cessation programs for SCFHP members	Member and provider education through newsletters and website/social media. Collaboration with local and statewide smoking cessation organizations; stay abreast of updates to better inform members.	Member newsetters, various social media posts. SCFHP registration through No Butts Referral webportal.	All members informed	QI, Health Educator, Marketing	Annually	Ongoing	Smoker's CA Provider Web portal registered and went live in Q4 2020. Smoking content included in Winter 2021 member newsletter.
5B	Scope of Services	Health Education	Incorporate Health Education information into member mailers	N/A	Member outreach to include messaging around preventive care, health promotion, screenings, disease managmenet, and healthy living.	Add health education messaging to member mailers and call scripts.	Outreach Call Scripts Member Mailers	All members in target population informed	QI, Health Educator, Marketing	Annually	Ongoing	Outreach calls scripts included health education messaging from January - December 2021 including well-care visits, controlling high blood pressure, asthma, prenatal visits, and diabetes. All member incentive letters mailed from July - December 2021 included health education messaging. Letter topics included well-care visits, diabetes care (A1c and poor control), breast and cervical cancer screenings.
5C	Scope of Services	Health Education	Implement Health Education Classes at Community Resource Center	N/A	Availability of health education classes at CRC for SCFHP members	Work with Health Education vendors to launch classes at CRC by third quarter 2021*.	Schedule of health education classes Utilization report from classes	All member informed	QI, Health Educator, Marketing	Annually	Ongoing	Delayed due to COVID.
5D	Scope of Services	Health Education	Establish new partnerships with community-based organization	N/A	Availability of health education classes provided by community-based organization.	Establish relationships with organizations focused on chronic conditions (such as American Heart Association, American Diabetes Association, etc.) to implement classes for SCFHP members. Establish partnership with YMCA by end of fiscal year.	Signed ASA and BAA Utilization report from classes	All members informed.	QI, Health Educator, Marketing	Annually	Ongoing	CA Smoker's Helpline - MOU pending signature with vendor, AHA Check. Change. Control - Established adhoc referral process for workshops. YMCA - DPP contract for CMC effective 09/01/21 YesHealth - DPP contract for MC in contracting phase AACI - Established relationships for senior programs. OnLok MOU - Aging Mastery program in contracting phase.
5E	Scope of Services	Health Education	Increase virtual health education options	N/A	Availability of virtual health education classes.	Work with Health Education vendors to add virtual class options to SCFHP health education offerings.	Class schedule.	All members informed.	QI, Health Educator, Marketing	Annually	Ongoing	List of available virtual classes provided to Customer Services. SCFHP virtual baby shower and high blood pressure class availability listed on "Events" page on SCFHP website. SCFHP Blood Pressure class availability listed on "events" page on SCFHP website. Health Education landing page has a banner with general messaging about availability of virtual classes.

Santa Clara Family Health Plan

Medi-Cal (MC) and Cal Medi-Connect (CMC)

Health Education Program 2022

2022 HEALTH EDUCATION PROGRAM

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I. INTRODUCTION

Santa Clara County Health Authority, dba Santa Clara Family Health Plan (SCFHP), is a county public health agency. SCFHP's primary mission is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with providers and community partners, SCFHP acts as a bridge between the health care system and those who need coverage.

SCFHP is a fully licensed health care service plan, which began operations in February 1997. SCFHP initially served the County's Medi-Cal population, as a Medi-Cal managed care plan in the State's "Two Plan Model Program". SCFHP continues to serve as the county local initiative in that program. In 2015, SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) for the Cal MediConnect (CMC) Duals Demonstration Project.

Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families.

II. STATEMENT OF PURPOSE

The purpose of the Health Education Program is to deliver general health education, health promotion, and patient education to assist SCFHP beneficiaries to maintain and improve their health and manage their illnesses. This includes helping SCFHP beneficiaries understand SCFHP and the benefits of the plan. SCFHP's Health Education Program complies with the Health Education requirements outlined in the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and CMS. The Health Education Program supports SCFHP's Population Health Management (PHM) strategy.

III. METHODOLOGY

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 directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services.

IV. GOALS, STRATEGIES AND OBJECTIVES

Health Education

- Keeping beneficiaries healthy through appropriate use of health care services, including: preventive and primary health care, obstetrical care, health education services, and complementary and alternative care.
- Managing beneficiaries with emerging risk through risk reduction and healthy lifestyles, including: tobacco use and cessation, alcohol and drug use, injury prevention, prevention of sexually transmitted diseases, HIV and unintended pregnancy, nutrition, weight control, and physical activity, and parenting.
- Managing multiple chronic illnesses through self-care and management of health conditions, including: pregnancy, asthma, diabetes, and hypertension.
- Beneficiaries receiving point of service education as part of preventive and primary health care visits.
    - Education, training, and program resources will be given to assist contracted medical providers in the delivery of health education services for beneficiaries.
- Expand the health education offerings and increase the participation and utilization for members and community to address the needs of culturally diverse and ethnic beneficiary.

V. PROGRAM STRUCTURE AND ORGANIZATION

The Health Education Program is part of the Quality Improvement Department and the Health Educator will report to the Manager of Quality and Health Education. Health Education Program activities will be coordinated and integrated with SCFHP's overall PHM strategy and quality improvement plan.

The Health Education Program is under the administrative oversight by at least a qualified full-time Health Educator who with one of the qualification: (1) Master of Public Health (MPH) degree with a specialization in health education or health promotion, from a program of study accredited by the Council on Education for Public Health, sanctioned by the American Public Health Association or (2) MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.

VI. PROGRAM IMPLEMENTATION

Health Education Classes

The Health Education Program will provide programs, classes and/or materials at no cost to beneficiaries including, but not limited to, the following topics:

1. Nutrition
2. Healthy weight maintenance and physical activity
3. 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. Chronic disease management, including asthma, diabetes, and hypertension
10. Pregnancy care

SCFHP also offers other self-management tools through the Member Portal. A library of Health Education materials and resources is available on the SCFHP website.

Point of Service Beneficiary Education

Individual beneficiaries will receive point of service health education as part of their preventive and primary health care visits. Health risk behaviors, health practices and health education needs related to health conditions are identified. Educational intervention, including counseling and referral for health education services will be conducted and documented in the beneficiary's medical record (DHCS PL 02-004).

Provider Education and Training

SCFHP will provide education, training, and program resources to contracted medical providers and other allied health care providers to support delivery of effective health education services for beneficiaries.

Provider training will cover:
1. Population Needs Assessment findings
2. Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) requirements
3. Tobacco use and cessation resources
4. Techniques to enhance effectiveness of provider/patient interaction
5. Educational tools, modules, materials and staff resources
6. Plan-specific resource and referral information
7. Health Education requirements, standards, clinical practice guidelines, and monitoring

SCFHP will provide resource information, educational material and other program resources to assist contracting medical providers to provide effective health education services for beneficiaries. (DHCS PL 02-004)

SCFHP will ensure contracted providers have the preventative care disease-specific and plan services information necessary to support beneficiary education in an effort to promote compliance with treatment directives and to encourage self-directed care.

SCFHP will also implement a comprehensive risk assessment tool for all pregnant female beneficiaries that is comparable to the ACOG standard and Comprehensive Perinatal

Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record. (DHCS PL 08-003)

SCFHP will ensure contracted providers are trained on tobacco cessation treatments using the USPHS "Clinical Practice Guidelines, Treating Tobacco Use and Dependence: 2008 Update". SCFHP will also ensure that contracted providers identify and track all tobacco use (both initially and annually) and do the following:

- Complete the IHA for all new beneficiaries within 120 days of enrollment and review the SHA's questions on tobacco with the beneficiary.
- Annually access tobacco use status for every beneficiary based on the SHA's periodicity schedule, unless an assessment needs to be re-administered (SHA should be re-administered annually).
- Ask tobacco users about their current tobacco use and document in their medical record at every visit.
- Offer individual, group, and telephone counseling to beneficiaries who wish to quit smoking, whether or not those beneficiaries opt to use tobacco cessation medications. Inform them that counseling is available at no cost.
- Refer beneficiaries who use tobacco to the California Smokers' Helpline or other comparable quit-line service.
- Ask all pregnant beneficiaries if they use tobacco or are exposed to tobacco smoke.
- Offer all pregnant beneficiaries who use tobacco at least one face-to-face tobacco cessation counseling session per quit attempt.
- Ensure pregnant beneficiaries who use tobacco are referred to a tobacco cessation quit line.
- Refer to tobacco cessation guidelines by ACOG before prescribing tobacco cessation medications during pregnancy.
- Provide interventions, including education or counseling, in an attempt to prevent initiation of tobacco use in school-aged children and adolescents. (DHCS APL 16-014)

VII. PROGRAM EFFECTIVENESS AND ACCOUNTABILITY

Program Standards, Evaluation, Monitoring, and Quality Improvement

SCFHP shall ensure the organized delivery of Health Education Programs using educational strategies and methods that are appropriate for beneficiaries and effective in achieving behavioral change for improved health.

The Health Education Program will be conducted according to the highest standards/guidelines supported by professional experts or peers, best practices, and/or published research findings. Appropriate levels of training, evaluation, e.g. formative, process, impact and outcome evaluation will be conducted to ensure effectiveness in achieving Health Education Program goals and objectives. Policies and procedures will be in place for ensuring providers receive training on a continuing basis regarding DHCS developed cultural awareness and sensitivity instruction for Senior and Persons with Disability (SPD) and limited English proficient (LEP) beneficiaries.

Monitoring

SCFHP will monitor the performance of providers contracted to deliver Health Education Programs and services to beneficiaries. Strategies will be implemented to improve provider performance and effectiveness (SCFHP/Medi-Cal contract Exhibit A, Attachment 10 Scope of Services).

Population Needs Assessment

A population needs assessment (PNA) will be conducted annually to identify the health education and cultural and linguistic needs of the Medi-Cal beneficiary population. Multiple reliable data sources, methodologies, techniques, and tools will be used to conduct the PNA. The findings will be utilized for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Relevant PNA findings will be shared with Community Advisory Committee (CAC) as well as Quality Improvement Committee to illicit feedback and to progress made towards PNA goals. Documentation will be maintained of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the beneficiary population (DHCS APL 19-011).

Population Health Assessment

A population health assessment (PHA) will be conducted annually to assess the characteristics and needs, including social determinants of health, of the Cal-Medi-Connect beneficiary population. This includes review of relevant beneficiary sub-populations, beneficiaries with disabilities, and beneficiaries with serious and persistent mental illness.

SCFHP annually uses the population assessment to review and update its Population Health Management activities, resources, and community resources for integration into program offerings to address beneficiary needs. Relevant PHA findings will be shared with Consumer Advisory Board (CAB) as well as Quality Improvement Committee to illicit feedback and to progress made towards PHA goals

Annual Evaluation and Work Plan

SCFHP monitors and reviews the Health Education work plan, evaluation, and program description on an annual basis. All changes are submitted and approved by the Quality Improvement Committee.

Community Advisory Committee

SCFHP shall form a Community Advisory Committee (CAC) pursuant to Title 22 CCR Section 53876(c) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers. SCFHP will ensure CAC is included and involved in policy decisions related to Quality Improvement educational, operational, and cultural competency issues affecting groups who speak a primary language other than English.

Consumer Advisory Board

SCFHP shall form a Cal MediConnect Consumer Advisory Board (CAB) as required by the California Coordinated Care Initiative. SCFHP will ensure the CAB engages consumers and caregivers in the implementation and evaluation of operations and policies of SCFHP Cal MediConnect Plan. SCFHP shall regularly update CAB members on key changes to the SCFHP Cal MediConnect operations or mission. (CMC 3-Way Contract, p. 115, 2.16.3.2.4.5)

VIII. CONFIDENTIALITY AND CONFLICT OF INTEREST

Confidentiality of practitioner, provider, and beneficiary identifying information is ensured in the administration of Health Education Services.

Santa Clara Family Health Plan™

Medi-Cal (MC) and Cal Medi-Connect (CMC)
HEALTH EDUCATION WORK PLAN 2022

Medi-Cal (MC) and Cal Medi-Connect (CMC) HEALTH EDUCATION WORK PLAN 2022											
Item	**Scope**	**Area**	**Objective**	**Contract Reference**	**Project Objectives**	**Activity**	**Final Deliverable(s)**	**Goals or Baseline**	**Responsible Position**	**Reporting Frequency**	**Target Completion**
1A	Scope of Services	Scope of Services	Pregnant Women	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS APL 18-016	- Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components - Health Education including breastfeeding, language, cultural competence and education needs must be assessed. Materials must be available in the appropriate threshold languages and must meet readability and suitability requirements for education materials distributed to Medi-Cal member (APL 18-016)	- Chart audits and provider training	- Provider Training and FSR results	All providers trained	QI & Health Educator, Provider Services	Annually	Ongoing
1B	Services for All Members	Health Education	- Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS PL 02-004	- Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - - Contact community organizations for potential health ed partnerships - Develop patient education materials library	- P&P's for health education system - List of health ed classes that cover all required health ed topic areas. - Provider/Vendor Contracts/MOU's - Comprehensive patient education library	Baseline	Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Ongoing
1C	Services for All Members	Health Education	Ensure effective health ed program	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS APL 19-011 (superseeds APL 17-002)	- Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	- Use findings from PNA to select educational strategies and methods - Measure pre- and post- educational intervention behavior	- P&P's for delivery of health ed program using educational strategies appropriate for Members. -Health Education Program	Organized delivery of health ed program	Health Educator	Annually	Ongoing
1D	Services for All Members	Health Education	Readability and Suitability of Health Education Materials	DHCS APL 18-016	- Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	- Test reading materials using flesch readability formula, etc., - Field test material at CAC meetings - Adhoc committee for field testing materials	- P&P's that define appropriate reading levels - Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to Plan-developed health education materials) - Adhoc field testing committee sign-in sheets	100%	Health Educator	Ongoing	Ongoing
1E	NCQA	Health Ed	Ensure effective health ed program	Pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004 NCQA 2020 Health Plan Accreditation Requirements PHM4	- Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions - Alcohol and drug use, including avoiding at risk drinking - Identifying depressive symptoms	- Contract with health education vendors to provide classes to meet requirement Readability Suitability Checklist Final Oct2018.docx	- Health Ed courses/activities - Health Educator or designee to audit all health education classes -	- 100% of vendors to have signed contracts (new or renewed) by 12/31/2020 - 100% of vendors audited by 12/31/20	Health Educator	Annually	Ongoing
2A	Member Services	Health Ed	Member Services	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing/health education materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials.	- Written Member informing materials will be translated into identified threshold and concentration languages.	- P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication - P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing, Health Educator	Annually	Ongoing
2B	Provider Training	Health Ed	Practitioner Education and Training	DHCS PL 02-004 DHCS PL 99-003 CMC 3-way contract 2.9.11.7	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services and culturally competent care for members. Training content shall include: language access requirements, tips for working with interpreters, cross-cultural communications, strategies to address health literacy, health beliefs, strategies for working with LEP members and SPDs, and disability sensitivity.	- Practitioner education and training by provider services - Health ed updates during Quality Delegate meetings (if applicable) - Provider fax memo or provider newsletter	- Sign in sheet of provider training -Quality Delegate minutes - Copy of memo or provider newsletter	All providers trained	Health Educator, Provider Services, QI	Ongoing	Ongoing
2C	Non Monetary Incentives	Health Ed	MMCD on-going monitoring activities	DHCS APL 16-005	Use non-monetary incentives to enhance health education program efforts to increase member participation, learning, and motivation to: 1) effectively use managed health care services, including preventive and primary care services, obstetric care, and health education services; 2) modify personal health behaviors, achieving and maintaining healthy lifestyles and treatment therapies and positive health outcomes; and 3) follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases, or health conditions.	Submit MI Program Request Form and have approved by DCHS before implementing any new incentive program Submit a End of Program Evaluation, within 45 days after the incentive program ends to DHCS. For ongoing programs, submit Annual Update of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded in the previous year to justify continuation of incentive program.	-Copy of submitted forms	All MI incentives	Health Educator	Ongoing	Ongoing
2D	Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials	- Ensure member informing resources are at sixth grade level or lower and translated into threshold languages	- Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower	Health Educator and Marketing	Ongoing	Ongoing
2E	Health Education		Written Health Education Materials	DHCS APL 18-016	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	- Approve written member health ed materials using readability and suitability checklist by qualified health educator	- Approved readability and suitability checklists with attached health ed materials.(Only applies to materials developed by the plan)	Approved readability and suitability checklists with attached health ed materials	Health Educator	- For previously approved material, review every three years	Ongoing
3A	Health Education		Evaluation of Plan's self-management tools for usefulness to members	NCQA 2020 Health Plan Accreditation Requirements PHM4	To ensure self-management tools are useful to members and meets the language, vision, and hearing needs of members	- Develop an evaluation tool/survey	- Evaluation results summary	Baseline	Health Educator	Every 36 months	Ongoing

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HEALTH EDUCATION WORK PLAN 2022

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Item	**Scope**	**Area**	**Objective**	**Contract Reference**	**Project Objectives**	**Activity**	**Final Deliverable(s)**	**Goals or Baseline**	**Responsible Position**	**Reporting Frequency**	**Target Completion**
3B	Health Education		Review plan's online web-based self-management tools.	NCQA 2020 Health Plan Accreditation Requirements PHM4	To ensure online web-based self-management tools are up to date	- Review and update online web-based self-management tools including the plan website and portal	Updated web-based self-management Zara to look into this (not sure)	Baseline	Health Educator	Ongoing	Ongoing
3C	Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	Pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	Ensure member medical records include health education behavioral assessment and referrals to health education services	- Monitoring of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. - Health ed classes and/or programs to providers	- P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. - Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI Nurse	Annually	Ongoing
3D	Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	Pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	- Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide	- Written information in Evidence of Coverage	All members of childbearing age informed of right to access to qualified family planning provider	Marketing and Health Educator	Annually	Ongoing
3E	Quality of Services	Access and Availability	Create Health Ed Work plan	Pg. 61 Exhibit A, Attachment 9 Access and Availability DHCS APL 19-011	Develop annual Population Needs Assessment annually to identify the health education and cultural and linguistic needs of our beneficiaries	- Incorporate PNA findings and annual and ongoing review of data into work plan - Approval of Health Ed Workplan by QI Committee	Approved Health Ed Work Plan	Baseline	QI Manager, Health Educator	Annually	Ongoing
4A	Quality of Services	Access and Availability	Health Disparities	Pg. 73 Exhibit A, Attachment 10 Scope of Services	Develop interventions based on identified health disparities	Implement at least 2 new projects outside of required DHCS PIPs and other government mandated projects.	- DHCS member incentive form submissions - Intervention work plan - intervention materials	Baseline	QI Manager, Health Educator	Annually	Ongoing
4B	Community Advisory Committee	Access and Availability	Community Advisory Committee	Pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01, DHCS APL 19-011	- Have a Community Advisory Committee in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	- Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues from PNA findings.	- CAC Meeting minutes - Report PNA findings to CAC.	Baseline	QI, Health Educator, and Marketing	Quarterly	Ongoing
4C	Consumer Advisory Board	Access and Availability	Consumer Advisory Board	Pg. 115 CMS 3-way contract 2.16.3.2.4.5.	- Have a Community Advisory Board in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	- Ensure CAB is included in policy decisions for QI educational, operational and cultural competency issues.	- CAB Meeting minutes	Baseline	QI, Health Educator, and Marketing	Quarterly	Ongoing
4D	Scope of Services	Access and Availability	Comprehensive Tobacco Prevention and Cessation Services	APL 16-014	To develop a system to identify tobacco users and track utilization data of tobacco cessation interventions.	Develop a system to track individual utilization data of tobacco cessation interventions. Utilization report of No Butts web-based referrals by providers. Educate providers on documenting tobacco users in medical records.	Annual report summarizing claims to track utilization of tobacco interventions. Annual report summarizing tobacco users.	Baseline	QI, Health Educator	Annually	Ongoing
4E	Scope of Services	Provider Education	Comprehensive Tobacco Prevention and Cessation Services	APL 16-014	Utilization of Initial Health Assessment (IHA) and Provider Education for pregnant woman and children and adolescent who use or who are at risk of exposure to tobacco smoke.	Ensure providers are completing the IHA and are referring members to appropriate smoking cessation programs.	Provider training FSR/MRR results IHA audit results PPC medical records review from HEDIS	All providers trained/informed	Qi, Health Educator, PNO	Annually	Ongoing
5A	Scope of Services	Health Education	Comprehensive Tobacco Prevention and Cessation Services	APL 16-014	Availability of tobacco cessation programs for SCFHP members	Member and provider education through newsletters and website/social media. Collaboration with local and statewide smoking cessation organizations; stay abreast of updates to better inform members.	Member newsetters, various social media posts. SCFHP registration through No Butts Referral webportal.	All members informed	QI, Health Educator, Marketing	Annually	Ongoing
5B	Scope of Services	Health Education	Incorporate Health Education information into member mailers	N/A	Member outreach to include messaging around preventive care, health promotion, screenings, disease managmenet, and healthy living.	Add health education messaging to member mailers and call scripts.	Outreach Call Scripts Member Mailers	All members in target population informed	QI, Health Educator, Marketing	Annually	Ongoing
5C	Performance Objective FY22	Health Education	Lead improvement in the health of communities impacted by disparities	N/A	Partner with clinics/CBOs/recognized health organizations to offer health education classes and workshops in person at the CRC, virtually, or in the community (including for non-members) Expand health ed program offerings in community, focusing on areas of disparity not limited to South County, seniors, specific chronic conditions, and language in which classes are offered (directly or partner) Expand health education offerings, outreach and participation for members and community	Create P&P on CRC/Health Education collaboration Source additional health ed class options focused on seniors, South County, and chronic disease management Develop method to track and report health ed utilization, referrals, offer/outreach (QI)	P&P Finalized Calendar listing with health ed vendors and classes sent to providers and posted live by 6/30/22 Dashboard for health education utilization updated monthly; Dashboard for SalesForce	Baseline	QI, Health Educator	Ongoing	6/30/2022
5D	Performance Objective FY22	Health Education	Lead improvement in the health of communities impacted by disparities	N/A	Implement new NCQA compliant Health Library and Self-Assessment Maximize Aunt Bertha for community resources and health education, including reporting.	Implement solution for MCAL LOB by purchasing NCQA certified vendor or develop in-house by IT. Source at least two (2) additional health ed classes/programs from Aunt Bertha	NCQA compliant Health Library and Self-Assessment live by 6/30/22 2 classes/programs listed on SCFHP.com and all health ed collateral promoting classes	Baseline	QI, Health Educator	Ongoing	6/30/2022

CULTURAL AND LINGUISTICS WORK PLAN EVALUATION 2021

CULTURAL AND LINGUISTICS WORK PLAN EVALUATION 2021								
Item	**Project Objectives**	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed/Evaluation**
1A	Comply with state and federal guidelines related to caring for limited English proficient (LEP) and sensory impaired members	DMHC TAG - Language Assistance Program 28 CCR 1300.67.04(c)	Language assistance program Policy and Procedures (Title 28, Sec. 1300.67.04) has standards for: 1) enrollee assessment, 2) providing language assisstance services, 3) staff training, 4) Compliance monitoring	Policy and Procedures	Health Educator, QI Dept.	Ongoing	Ongoing	Policy QI.08 approved at QIC on February 2021.
1B	Comply with state and federal guidelines related to caring for limited English proficient (LEP) and sensory impaired members	2.9.7.4.	Distribute "Reference Guide" for accessing interpreter services to all providers	Interpreter Reference Guide for Providers	Health Educator, PNM, Delegation Oversight	Ongoing	Continuous	Included with annual training PNO Q1 2021
1C	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9 9.14.b (p. 63)	Promote interpreter services at no charge to members and providers	EOC, Language Assistance Services document included in member mailings, SCFHP Website	QI, Marketing, Customer Service	Ongoing	Continuous	EOC released April 2021, public website updated August 2021. Health Education/ Wellness rewards mailings (June - November 2021) included taglines with language assistance Member informing mailings (sent by Mkting) included taglines with language assistance MCAL Newsletters : Spring, Summer, Fall, Winter 2021 CMC Newsletters: Spring Summer, Fall, Winter 2021
1D	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9 15	Use the CAC for advice and feedback on CLAS and procedures	CAC Agenda	QI, Marketing	Ongoing	Continuous	PNA findings shared at CAC in September 2021. Field testing for Preventive Care campaign completed in March 2021.
1E	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 14.3.B.2	Use available C&L member reports, e.g. grievances and appeals, to identify interventions to improve quality	Reports from G&A, Language vendor utilization reports	Health Educator, QI, Grievance and Appeals	Quarterly	Continuous	Monthly review of C&L dashboard data to monitor interpreter utilization and determine action, including remediation. Ongoing review and investigation to address grievances related to interpreter services, including remediation.
2A	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	2.9.7.4.	Include C&L as agenda item at Joint Operation Committee meetings with delegates as appropriate	JOC Agenda	Health Educator, QI, Delegation Oversight	Ongoing	Continuous	C&L discussed PCNC QI Meeting 3/18/21 VRI Services for ASL promoted via phone via PNO team October 2021

CULTURAL AND LINGUISTICS WORK PLAN EVALUATION 2021								
Item	**Project Objectives**	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed/Evaluation**
2B	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact		Include C&L Compliance, including training, in all Delegation Oversight Audits	Audit tools	Health Educator, QI, Delegation Oversight	Ongoing	Annually	PMG audit completed January 2021. Findings: N/A PCNC completed March 2021. Finding 1: Matrix of Health Plan Contacts info for interpretation services outdated Finding 2: PCNC does not utilize a valid method for assessing language capacity of interpreters and bilingual staff VHP completed March 2021. Findings: N/A Kaiser completed April 2021 Findings: N/A
2C	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9,13.E	Include C&L Training in new provider and sub-contactor orientations. Training content shall include: language access requirements, tips for working with interpreters, cross-cultural communications, strategies to address health literacy, health beliefs, strategies for working with LEP members and SPDs, and disability sensitivity.	Provider Training Slides	Health Educator, QI, PNM	Ongoing	Continuous	C&L toolkit reviewed in August 2021. Toolkit is included in new provider orientation slides.
2D	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9,13.E	Provide ongoing training for all SCFHP staff members	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Continuous	All staff training completed on November 2021
2E	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	DHCS APL 21-004	Implement Farsi as new threshold language	Update all vital documents, E-mails informing all staff	Health Educator, QI	Ongoing	3 Months after APL is released	New APL 21-004 was released in 2021. Farsi is not a threshold language.
3A	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	N/A	Incorporate cultural focus into health education classes	Class materials	Health Educator, QI	Ongoing	Continuous	AHA Check. Change. Control - target Vietnamese population in January 2021. CBP calls to African American population in January 2021.
3B	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9,13.E	New employees complete an online training when hired	Log of new staff who completed C&L Trainings	Health Educator, QI, HR	Ongoing	Continuous	Ongoing evaluation based on dates of new hires
3C	Promote a culturally competent health care and work environment for the SCFHP	Exhibit A, Attachment 9,13.E	Review All Staff C&L Training Slides	C&L staff training slides	Health Educator, QI	Ongoing	Sep-20	All staff trainings slides reviewed and updated August 2021. Minor changes to include updated SCFHP demographics

CULTURAL AND LINGUISTICS WORK PLAN EVALUATION 2021								
Item	**Project Objectives**	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed/Evaluation**
3D	Promote a culturally competent health care and work environment for the SCFHP	Exhibit A, Attachment 9,13.E	Health Plan activities to raise cultural awareness	Copies of e-mails	Health Educator, QI	Ongoing	Quarterly	Holiday/observances e-mails sent out monthly to all staff: January 4 2021 Feb 2 2021 March 1 2021 April 1 2021 May 3 2021 June 1 2021 August 4 2021 July 2 2021 September 1 2021 October 1 2021 November 1 2021 December 3 2021 Completion of Management training Diversity, Equity, and Inclusion workshop series April 2021
3E	Promote a culturally competent health care and work environment for the SCFHP	Exhibit A, Attachment 9.13.A.1	Participate in CLAS focused plan, community, state/federal organizations, partnerships, and projects	Participation in quarterly HECLW and ICE Collaborative calls	Health Educator, QI	Ongoing	Continuous	ICE Meeting dates joined: 05/10/21 09/13/21
4A	Promote CLAS "best practices" for implementation by SCFHP, as well as network providers and subcontractors.	Exhibit A, Attachment 9.13.A.1	Use a strategy of interdepartmental collaboration to identify and promote CLAS best practices in all areas	Training materials provided to departments	Health Educator, QI	Ongoing	Continuous	Annual training for member-facing departments on C&L interpreter services and best practices completed 07/14/21 C&L reviews member requests for alternate format and langauges on an ongoing basis.
4B	Promote CLAS "best practices" for implementation by SCFHP, as well as network providers and subcontractors.	Exhibit A, Attachment 9.13.A.1	Design oversight mechanisms that monitor for CLAS and cultural competency	Completed C&L Audit tools	Health Educator, QI	Ongoing	Continuous	See line 9.
4C	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9.13.A.5	Monitor interpreter issues identifed by internal staff, e.g. no-show interpreters	Log of identified interpreter issues	Health Educator, QI	Ongoing	Continuous	Ongoing monitoring and reporting of interpreter issues reported by SCFHP staff and members to language vendor to improve quality.
4D	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	2.17.5.9.4.	Train all member-facing departments on updated QNXT process for logging alternate language and format (braille, audio, large print) requests	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Continuous	C&L refresher training completed 11/17/21
4E	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 6 13	Develop quarterly report for Provider Network Operations to analyze languages spoken by contracted providers.	Interpreter utilization log with provider data	Health Educator, QI, PNM	Ongoing	Quarterly	Quarterly reports shared with PNM with interpretation utilization data for telephone and in-person
5A	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9,13.F	Develop monthly interpreter service reports to ensure compliance with regulatory requirements and for tracking and trending purposes.	Interpreter utilization log	Health Educator, QI	Ongoing	Monthly	No major issues identified in 2021 regarding language utilization SCFHP CAP'd Hanna 7/20 - (in progress) updated amendment related to CAP findings.

CULTURAL AND LINGUISTICS WORK PLAN EVALUATION 2021								
Item	**Project Objectives**	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed/Evaluation**
5B	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9,13.F	Monitor language utilization reports for compliance with regulatory requirements.	Interpreter utilization report	Health Educator, QI	Ongoing	Monthly	No major issues identified in 2021 regarding language utilization
5C	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9,13.F	Review Language Line Portal for appropriate turnarond times for translated materials.	Report from Langauge Line Translations Portal	Health Educator, QI	Ongoing	Continuous	No major issues identified in 2021 regarding turnaround times for translation materials.

Medi-Cal (MC) and Cal Medi-Connect (CMC)

Cultural and Linguistics Program 2022

2022 CULTURAL & LINGUISTICS PROGRAM
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CULTURAL AND LINGUISTIC SERVICES PROGRAM 2022

I. INTRODUCTION

The Santa Clara County Health Authority, dba Santa Clara Family Health Plan (SCFHP), is a county public agency. SCFHP's primary mission is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with providers, SCFHP acts as a bridge between the health care system and those who need coverage.

SCFHP is a fully licensed health care service plan, which began operations in February 1997. SCFHP initially served the County's Medi-Cal population, as a Medi-Cal managed care plan in the State's "Two Plan Model Program". SCFHP continues to serve as the county local initiative in that program. In 2015, SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) for the Cal MediConnect (CMC) Duals Demonstration Project.

Through dedication to integrity, outstanding service, and care for our community, SCFHP works to ensure that everyone in our county can receive the care they need for themselves and their families.

II. STATEMENT OF PURPOSE

The Cultural and Linguistic (C&L) Services Program is designed to improve access and eliminate disparities in quality of care for individuals with Limited English Proficiency (LEP), diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation or gender identity. It also ensures that all medically necessary covered services are available and accessible to all beneficiaries regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner. (DHCS Medi-Cal Contract Exhibit A, Attachment 4, 7.F)

SCFHP is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries with LEP or sensory impairment. SCFHP's Cultural and Linguistic Services comply with 42, C.F. R. Section 440.262; Title VI of the Civil Rights Act of 1964; (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) and the Cultural and Linguistic Services requirements in accordance to the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and CMS. The goal of the C&L Services Program is to ensure that SCFHP beneficiaries, especially LEP and sensory impaired beneficiaries receive equal access to health care services that are culturally and linguistically appropriate.

III. METHODOLOGY

Culturally and Linguistically Appropriate Services (CLAS) Standards

The Office of Minority Health (OMH) in the U.S. Department of Health & Human Services (DHHS) require that health care professionals and organizations take responsibility for providing culturally and linguistically appropriate services (CLAS) as a means to improve health care access, quality of care and health outcomes. Defining CLAS as "health care services that are respectful of and responsive to cultural and linguistic needs," the OMH has issued a set of 14 CLAS standards that include "mandates, guidelines and recommendation intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate services." [1]

SCFHP has chosen the 14 National CLAS Standards as the guiding principles of our C&L Services Program.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (4-7) and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: federal mandates, guidelines (recommended by OMH to be federal mandates) and recommendations. Standards 4-7 are mandates, Standards 1-3 and 8-13 are guidelines and Standard 14 is a recommendation. The CLAS standards are:

Culturally Competent Care

1. Health care organizations should ensure that patients/consumers receive from all staff effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

[1] DHHS, OMH, National Standards for CLAS, 2001.

2. Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate services delivery.

Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports for Cultural Competence

8. Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
11. Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to

accurately plan for and implement services that respond to the cultural and linguistic characteristics of the area.

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

IV. GOALS, STRATEGIES AND OBJECTIVES

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

The Program ensures that beneficiaries have access to covered services delivered in a manner that meets their needs. It also ensures processes and procedures are designed to ensure that all medically necessary covered services are available and accessible to all beneficiaries regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. The program formalizes ongoing efforts to provide CLAS at all clinical and administrative points of contact in a consistent and measurable fashion. Since the effort to provide culturally and linguistically competent care is an on-going process, the C&L Services staff periodically identifies new objectives and activities based on the findings of the Health Education and C&L Population Needs Assessment (PNA) which is administered annually. SCFHP also incorporates beneficiary, provider and staff feedback expressed at Consumer Advisory Committee (CAC), Consumer Advisory Board (CAB), Provider Advisory Committee (PAC), and Quality Improvement Committee (QIC) meetings, area demographic research and organizational priorities into the development of its C&L Services Program.

An illustration of the reporting relationships for SCFHP identifies key staff with overall responsibility for the operation of the C&L Services Program (Appendix A).

SCFHP's Executive Team and Compliance Departments are responsible for promoting a culturally competent health care and work environment for SCFHP. They ensure that all Plan policies and procedures for eligible beneficiaries or potential beneficiaries do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. They also ensure SCFHP's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

The Quality Improvement Department is responsible for developing, implementing and evaluating SCFHP's C&L Services Program in coordination with the Provider Network Operations, Customer Services, Marketing and Communications, Health Services and Compliance Departments.

The Provider Network Operations Department is responsible for ensuring that the composition of the provider network continuously meets beneficiaries' ethnic, cultural and linguistic needs of its beneficiaries on an ongoing basis (DHCS Medi-Cal Contract, Exhibit A, Attachment 6, 13). Language capabilities of clinicians and other provider office staff are identified during the credentialing process and through periodic surveys to update SCFHP's provider directory. Provider Network Operations is also responsible for conducting initial and periodic provider network C&L training, as well as the PAC.

The Customer Service Department records updates to beneficiaries' cultural and linguistic capabilities and preferences, including standing requests for material in alternate languages and formats. Beneficiaries are informed they have access to no cost oral interpretation in their language and written materials translated into SCFHP's threshold languages or provided in alternative formats. Written materials translation is available in non-threshold languages upon request.

Marketing and Communications is also responsible for supporting SCFHP's CAC in accordance with Title 22, CCR, Section 53876 (c). The purpose of the CAC is to provide a link between SCFHP and the community. Meetings are chaired by designated SCFHP staff and composed of SCFHP beneficiaries and community advocates. The CAC advises SCFHP on the development and implementation of its cultural and linguistic accessibility standards and procedures. Committee responsibilities include advising on cultural competency, educational and operational issues affecting beneficiaries, including seniors, persons with LEP and disabilities. CAC reports directly to the SCFHP Governing Board.

Quality Improvement is responsible for supporting SCFHP's CAB in accordance with the DHCS Coordinated Care Initiative (CCI). The purpose of CAB is to provide a link between SCFHP and the Cal MediConnect population. Meetings are chaired by designated SCFHP staff and composed of SCFHP beneficiaries and community advocates. Committee responsibilities include advising on cultural competency, educational and operational issues affecting beneficiaries, including seniors, persons with LEP and disabilities. CAB is a subcommittee of the QIC.

Health Services (including Case Management, Managed Long Term Support Services, Behavioral Health, Utilization Management, Quality Improvement and Pharmacy) is responsible for ensuring cultural competent care coordination for all beneficiaries.

V. PROGRAM SCOPE

The C&L Services Program is comprehensive, systematic and ongoing. The program is modified and is subject to change based on the most recent All Plan Letter (APL) as released by Department of Health Care Services (DCHS). It includes assessment, monitoring and enhancement of all services provided directly by SCFHP, as well as all services provided by contracted providers, including pharmacies and ancillary services.

Assessment of Beneficiary Cultural and Linguistic Needs

SCFHP regularly assesses beneficiary cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. Specifically, SCFHP:

- Documents in the Health Plan's Information System the reported ethnicity and preferred language of eligible beneficiaries provided by DHCS/CMS for Medi-Cal or Cal-Medi-Connect beneficiaries.
- Documents beneficiary requests to change their reported ethnicity or preferred language.
- Documents a beneficiary's standing request for materials in another language or in an alternate format in the Health Plan's Information Systems.
- Instructs providers to offer no cost interpreter services by a qualified interpreter and document the beneficiary's preferred language in addition to requests for, and refusals of, interpreter services in the patient chart.
- Tracks and analyzes utilization of telephone and face-to-face interpreter services at all points of contact.

- Conducts a Cultural & Linguistic and Health Education PNA annually to identify C&L needs, and periodically update the assessment based on additional beneficiary input through beneficiary surveys, focus groups and grievances.
- Elicits and documents input from the CAC regarding beneficiaries' C&L needs (for details see Consumer Advisory Committee Charter).
- Elicits and documents input from the CAB regarding beneficiaries' C&L needs (for details see Consumer Advisory Board Charter).
- SCFHP makes reasonable changes to policies, procedures, and practices to provide equal access for individuals with disabilities.

Assessment of linguistic capabilities of SCFHP employees, providers, and subcontractors

SCFHP continuously assesses the linguistic capabilities of its employees, providers and subcontractors to reduce language barriers increase the quality of care LEP beneficiaries receive, and ensure the plan's ability to meet beneficiaries' ethnic, cultural and linguistic needs. SCFHP makes every effort to ensure that providers are assigned with the ability to meet beneficiaries' C&L needs. Activities that contribute to the assessment process include:

- Employees
    - Hire staff that demonstrates appropriate bilingual proficiency as needed for their role by passing a language professional test at time of hire.
    - Maintain Human Resource records on staff linguistic skills and relevant training, certification and/or proficiency results.
    - Assess the performance of employees who provide linguistic services.
- Providers
    - PCP and Specialists are required to ensure access to care for LEP speaking beneficiaries through the provider's own multilingual staff or through cultural and linguistic services facilitated by SCFHP.
    - Identify language proficiency of bilingual providers and office staff through documentation of certification of proficiency.
    - Report provider and office staff language capabilities for inclusion in the Provider Directory.
- Subcontractors
    - Execute agreements with subcontractors that are in compliance with the business requirements for all lines of business.
    - Execute agreements with contracted translators and interpreters that require staff to be tested for proficiency and experience.

- Maintain records in the Health Education Program of community health resources throughout the counties we serve, including the language in which the programs are offered.

Access to Interpreter Services and Availability of Translated Materials
Linguistic services are provided by SCFHP to non-English speaking or LEP beneficiaries for population groups. Services include, but are not limited to, the following:

- No cost linguistic services are provided to beneficiaries accurately and timely and protect the privacy and independence of the individual with LEP.
    - Oral interpreters, signers or bilingual providers and provider staff at all key points of contact are available in languages spoken by beneficiaries. Linguistic services are provided in all languages spoken by beneficiaries, not just the threshold or concentration standards languages. Key points of contact include:
        - Medical care settings
        - Telephone, Nurse Advice Line, urgent care transactions, and outpatient encounters with healthcare providers, including: pharmacists.
        - Non-medical care settings: Customer Services, orientations, and appointment scheduling.
    - Written informational materials are fully translated into all threshold languages within 90 days after the English version is approved by the state. Materials in non-threshold languages are made available upon request within 21 days of the request. (Refer to Policy QI.08.02 for more information on translation into non-threshold languages) Materials include:
        - Evidence of Coverage Booklet and/or Beneficiary Handbook and Disclosure Forms. The contents of these documents includes:
            - Enrollment and disenrollment information
            - Information regarding the use of health plan services, including access to screening and triage, after-hours emergency, and urgent care services
            - Access and availability of linguistic services

- Primary care provider (PCP) selection, auto-assignment, and instructions for transferring to a different PCP
- Process for accessing covered services requiring prior authorizations
- Process for filing grievances and fair hearing requests

- Provider listings or directories
- Formulary/Prescription Drug List
- Marketing materials
- Form letters (i.e. authorization notice of action letters, grievance and appeals, including resolution letters)
- Plan-generated preventive health reminders (i.e. appointments and immunization reminders, initial health examination notices, and prenatal care follow-up)
- Beneficiary surveys
- Newsletters

- California Relay Services for hearing impaired.

SCFHP ensures access to interpreter services for all LEP beneficiaries. SCFHP provides 24-hour access to telephonic interpreter services for all medical and non-medical points of contact. SCFHP beneficiaries can, with advance notice, utilize in-person language and sign language interpreter services. All interpreter services are provided at no charge to beneficiaries. SCFHP requires, through contractual agreement, that contracted interpreters are tested for proficiency and experience. (For more detail please refer to Procedure QI.08.02 Language Assistance Program). SCFHP ensures access to interpreter services for all LEP and sensory impaired beneficiaries through several mechanisms:

- Inform new beneficiaries of available linguistic services in welcome packets.
- Provide an Interpreter Reference Guide to providers about accessing SCFHP's interpreter services.
- Provide an interpreter for scheduled appointments when requested by the provider or beneficiary.
- Ensure beneficiaries can use face-to-face language and sign language interpreters with advance notice.
- Make 24-hour/7 days a week access to telephonic interpreter services available for all medical and non-medical points of contact as defined in the contract or regulations.

- Monitor the interpreter request process to avoid unreasonable or unnecessary delays when the service is requested by the beneficiary or provider.
- Encourage the use of qualified interpreters rather than family beneficiaries or friends. The beneficiary may choose an alternative interpreter at his/her cost after being informed of the no cost service.
- Discouraging the use of minors as interpreters except in extraordinary circumstances.
- Maintain records in the Marketing and Communications Department of translated beneficiary informational materials. SCFHP translates beneficiary informing materials into all threshold languages identified by the Department of Health Care Services (DHCS). Translation into non-threshold languages is available upon request. Alternate formats, such as braille, large print, and audio are available upon request.
- Ensure beneficiaries are made aware they have the right to file a complaint or grievance if their linguistic needs are not met.

SCFHP complies with the non-discrimination requirement set forth under Section 1557 of the Affordable Care Act (ACA). SCFHP does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (APL 17-011). This includes:

- Posting of the Notice of Non-Discrimination, including Non-Discrimination Statements, in all beneficiary communications and publications, including written notices requiring a response from an individual and written notices to an individual such as those pertaining to rights or benefits.
- Posting the Notice on-site at SCFHP and on the SCFHP website in a conspicuous location and conspicuously visible font size.
- Posting taglines in a conspicuously visible font size in English and at least the top 16 non-English languages spoken by individuals with LEP in California. These taglines inform individuals with LEP of the availability of language assistance services in all beneficiary communications and publications.
    - Languages include: Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese.

Staff and Provider Cultural Competency and Diversity Training

SCFHP provides cultural competency, sensitivity, or diversity training for staff, Network Providers, and First Tier, Downstream and Related Entities with direct beneficiary interaction.

SCFHP conducts annual cultural competency trainings for SCFHP employees. Network providers receive C&L training as part of Provider Orientation. SCFHP also provides regular training and information sessions to ensure employees and providers are informed and aware of SCFHP's policies and procedures regarding the provision of CLAS. Training includes DHCS-developed cultural awareness and sensitivity instruction for Seniors and Persons with Disabilities or chronic conditions. (DHCS Medi-Cal Contract, Exhibit A, Attachment 7, 5.B). Training on culturally and linguistically appropriate care and care coordination is made available to SCFHP staff. Specifically, SCFHP offers:

- Department-specific periodic trainings on C&L issues on topics such as health literacy, utilization of interpreter services, identifying and handling C&L grievances, customer service to a diverse membership, etc.
- New provider orientations that cover the Culturally Competency Toolkit and SCFHP C&L policies and procedures, specifically addressing provider responsibilities for providing CLAS and utilization of interpreter services.
- One-on-one provider and provider office staff training on C&L issues when a need is identified to improve provider effectiveness in meeting beneficiaries' C&L needs.
- Training, educational materials and tools regarding various cultures and CLAS are made available to SCFHP staff and network providers.

VI. PROGRAM EFFECTIVENESS AND ACCOUNTABILITY

Monitoring, Evaluation and Enforcement

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

- Consumer/beneficiary satisfaction surveys
- Review of beneficiary grievances
- Provider assessments and provider site reviews
- Provider satisfaction surveys
- Feedback on services from CAC, CAB, the Provider Advisory Council and Provider Office Staff Committee, QIC, SCFHP staff and network providers, community-based organization partners, and other focus group reports
- Audits of delegated provider groups
- Data from utilization reports
- Analysis of health outcomes

SCFHP also reviews the C&L Program work plan, evaluation, and description on an annual basis. Updates and changes are submitted to the Quality Improvement Committee for approval.

Health disparities and utilization patterns by race, ethnicity, and language are investigated by SCFHP's Quality Improvement Department and appropriate interventions are implemented as needed.

APPENDIX A

Santa Clara Family Health Plan- Cultural and Linguistic Oversight and Staff:

Chief Executive Officer

Chief Medical Officer

Chief Operating Officer

Chief Compliance and Regulatory Affairs Officer

Chelsea Byom, Vice President, Marketing and Enrollment

Director of Quality and Process Improvement

Director of Provider Network Operations

Director of Customer Service and Grievance and Appeals

Quality and Health Education Manager

Health Educator

The Quality Department staff is responsible for developing, implementing and evaluating SCFHP's Cultural and Linguistic Services in coordination with Provider Network Operations, Customer Service, Compliance, Marketing and Health Services Departments.

The Director of Marketing and Communications has oversight of the Consumer Advisory Committee.

The Director of Quality and Process Improvement has oversight of the Consumer Advisory Board.

All Plan Letter (APL)

Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (Supersedes APL 17-011 and Policy Letters 99-003 and 99-004)

Cultural Competency in Health Care - Meeting the Needs of a Culturally and Linguistically Diverse Population (APL 99-005)

CULTURAL AND LINGUISTICS WORK PLAN 2022
Medi-Cal (MC) and Cal Medi-Connect (CMC)

Item	Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion
1A	Comply with state and federal guidelines related to caring for limited English proficient (LEP) and sensory impaired members	DMHC TAG - Language Assistance Program 28 CCR 1300.67.04(c)	Language assistance program Policy and Procedures (Title 28, Sec. 1300.67.04) has standards for: 1) enrollee assessment, 2) providing language assisstance services, 3) staff training, 4) Compliance monitoring	Policy and Procedures	Health Educator, QI Dept.	Ongoing	Ongoing
1B	Comply with state and federal guidelines related to caring for limited English proficient (LEP) and sensory impaired members	2.9.7.4.	Distribute "Reference Guide" for accessing interpreter services to all providers	Interpreter Reference Guide for Providers	Health Educator, PNM, Delegation Oversight	Ongoing	Ongoing
1C	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9 9.14.b (p. 63)	Promote interpreter services at no charge to members and providers	EOC, Language Assistance Services document included in member mailings, SCFHP Website	QI, Marketing, Customer Service	Ongoing	Ongoing
1D	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9 15	Use the CAC for advice and feedback on CLAS and procedures	CAC Agenda	QI, Marketing	Ongoing	Ongoing
1E	Improve the quality of health care services for all SCFHP members at medical and non-medical points of	Exhibit A, Attachment 14.3.B.2	Use available C&L member reports, e.g. grievances and appeals, to identify interventions to improve quality	Reports from G&A, Language vendor utilization reports	Health Educator, QI, Grievance and Appeals	Quarterly	Ongoing

CULTURAL AND LINGUISTICS WORK PLAN 2022
Medi-Cal (MC) and Cal Medi-Connect (CMC)

Item	Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion
2A	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	2.9.7.4.	Include C&L as agenda item at Joint Operation Committee meetings with delegates as appropriate	JOC Agenda	Health Educator, QI, Delegation Oversight	Ongoing	Ongoing
2B	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact		Include C&L Compliance, including training, in all Delegation Oversight Audits	Audit tools	Health Educator, QI, Delegation Oversight	Ongoing	Annually
2C	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9,13.E	Include C&L Training in new provider and sub-contactor orientations. Training content shall include: language access requirements, tips for working with interpreters, cross-cultural communications, strategies to address health literacy, health beliefs, strategies for working with LEP members and SPDs, and disability sensitivity.	Provider Training Slides	Health Educator, QI, PNM	Ongoing	Ongoing
2D	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9,13.E	Provide ongoing training for all SCFHP staff members	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Ongoing
2E	Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	Exhibit A, Attachment 9,13.E	New employees complete an online training when hired	Log of new staff who completed C&L Trainings	Health Educator, QI, HR	Ongoing	Ongoing

CULTURAL AND LINGUISTICS WORK PLAN 2022
Medi-Cal (MC) and Cal Medi-Connect (CMC)

Item	Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion
3A	Promote staff training and awareness and increase knowledge	Exhibit A, Attachment 9,13.E	Review All Staff C&L Training Slides	C&L staff training slides	Health Educator, QI	Ongoing	Annually
3B	Promote staff training and awareness and increase knowledge	Exhibit A, Attachment 9,13.E	Health Plan activities to raise cultural awareness Provide unconscious bias training to all staff, and diversity & sensitivity training to management	Copies of e-mails	Health Educator, QI	Ongoing	Quarterly
3C	Promote staff training and awareness and increase knowledge	Exhibit A, Attachment 9.13.A.1	Participate in CLAS focused plan, community, state/federal organizations, partnerships, and projects	Participation in quarterly HECLW and ICE Collaborative calls	Health Educator, QI	Ongoing	Ongoing
3D	Promote CLAS "best practices" for implementation by SCFHP, as well as network providers and subcontractors.	Exhibit A, Attachment 9.13.A.1	Use a strategy of interdepartmental collaboration to identify and promote CLAS best practices in all areas	Training materials provided to departments	Health Educator, QI	Ongoing	Ongoing

CULTURAL AND LINGUISTICS WORK PLAN 2022
Medi-Cal (MC) and Cal Medi-Connect (CMC)

Item	Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion
3E	Promote CLAS "best practices" for implementation by SCFHP, as well as network providers and subcontractors.	Exhibit A, Attachment 9.13.A.1	Design oversight mechanisms that monitor for CLAS and cultural competency	Completed C&L Audit tools	Health Educator, QI	Ongoing	Ongoing
4A	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9.13.A.5	Monitor interpreter issues identifed by internal staff, e.g. no-show interpreters	Log of identified interpreter issues	Health Educator, QI	Ongoing	Ongoing
4B	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	2.17.5.9.4.	Train all member-facing departments on updated QNXT process for logging alternate language and format (braille, audio, large print) requests	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Ongoing
4C	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 6 13	Develop quarterly report for Provider Network Operations to analyze languages spoken by contracted providers.	Interpreter utilization log with provider data	Health Educator, QI, PNM	Ongoing	Quarterly
4D	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9,13.F	Develop monthly interpreter service reports to ensure compliance with regulatory requirements and for tracking and trending purposes.	Interpreter utilization log	Health Educator, QI	Ongoing	Monthly

CULTURAL AND LINGUISTICS WORK PLAN 2022
Medi-Cal (MC) and Cal Medi-Connect (CMC)

Item	Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion
4E	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9,13.F	Monitor language utilization reports for compliance with regulatory requirements.	Interpreter utilization report	Health Educator, QI	Ongoing	Monthly
5A	Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9,13.F	Review Language Line Portal for appropriate turnarond times for translated materials.	Report from Langauge Line Translations Portal	Health Educator, QI	Ongoing	Ongoing

Santa Clara Family Health Plan™

Quality Improvement Committee

Q3 2021 Grievance & Appeals Data

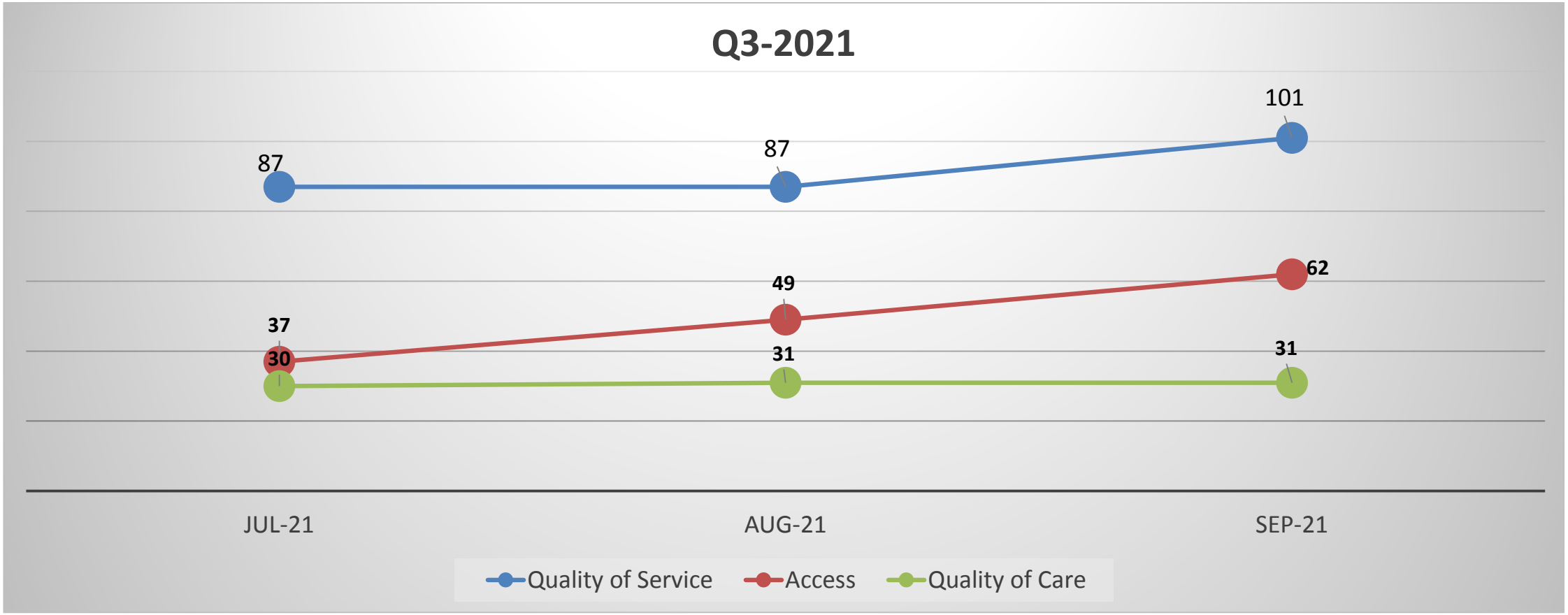
Total Grievances & Appeals

(*Rate per 1000 Members*)

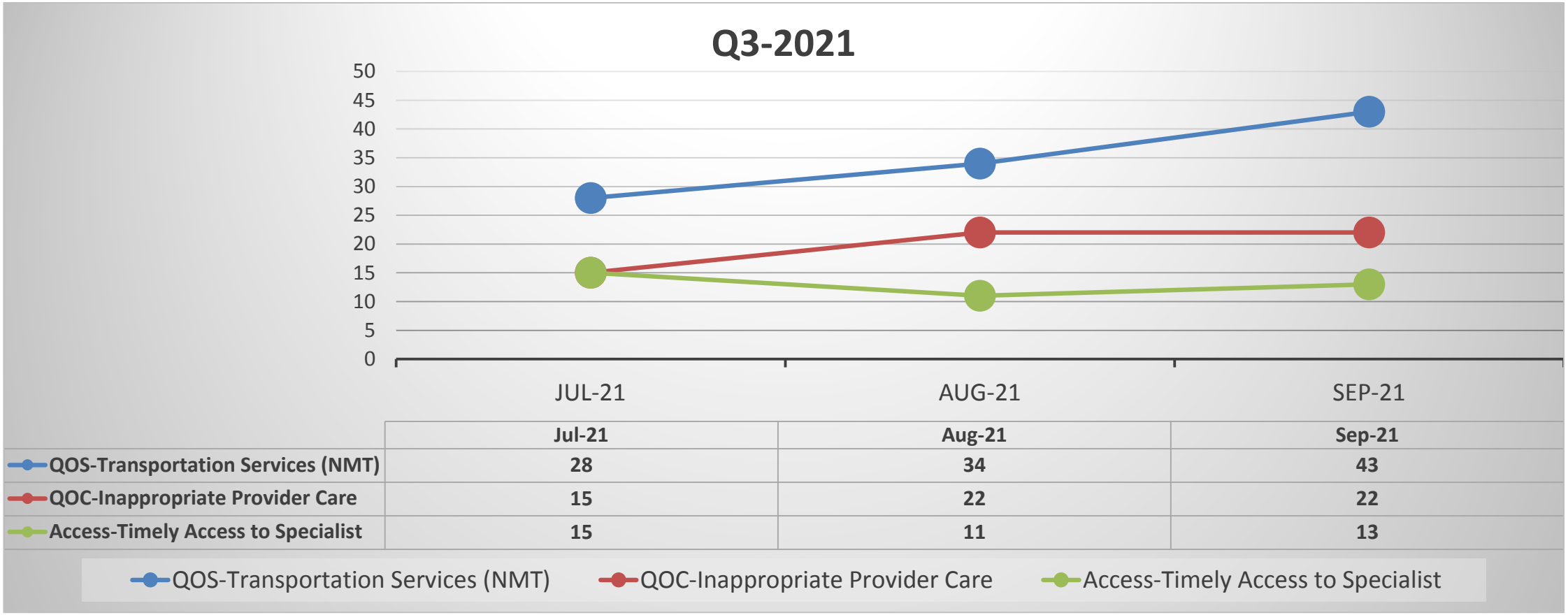
	Jul-20	Aug-20	Sep-20	Jul-21	Aug-21	Sep-21
Total Appeals	**45**	**53**	**53**	**45**	**41**	**36**
CMC Total Membership				**10,148**	**10,245**	**10,325**
Rate per 1,000				4.43437	4.00195	3.48668
Total Grievances	**104**	**94**	**95**	**106**	**102**	**127**
CMC Total Membership				**10,148**	**10,245**	**10,325**
Rate per 1,000				10.4454	9.95607	12.3002

	Jul-20	Aug-20	Sep-20	Jul-21	Aug-21	Sep-21
Total Appeals	86	77	83	85	79	98
MC Total Membership				**274,030**	**275,227**	**276,227**
Rate per 1,000				0.31018	0.28703	0.35478
Total Grievances	126	133	156	174	187	211
MC Total Membership				**274,030**	**275,227**	**276,227**
Rate per 1,000				0.63496	0.67943	0.76386

Q3 2021:Top 3 Medi-Cal Grievance Categories

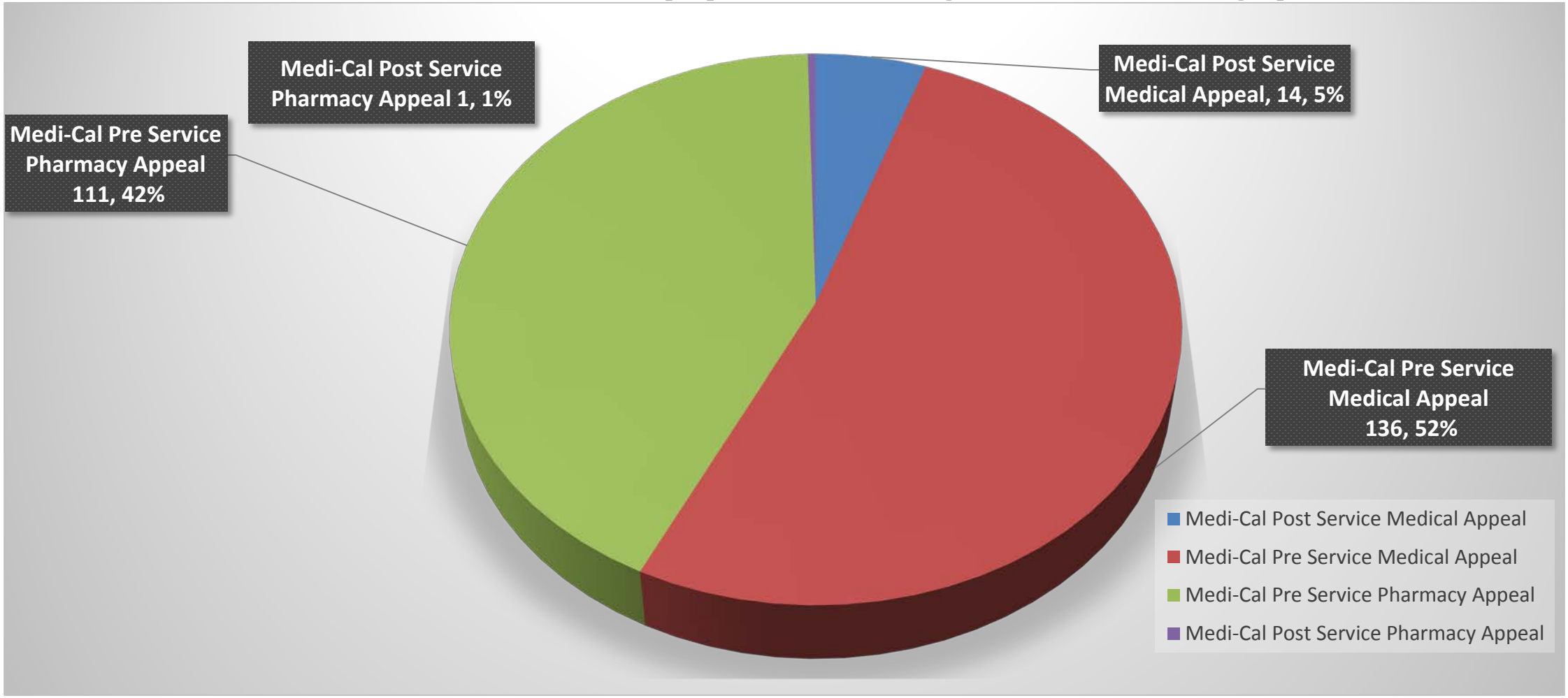


Q3 2021:Top 3 Medi-Cal Grievance Subcategories

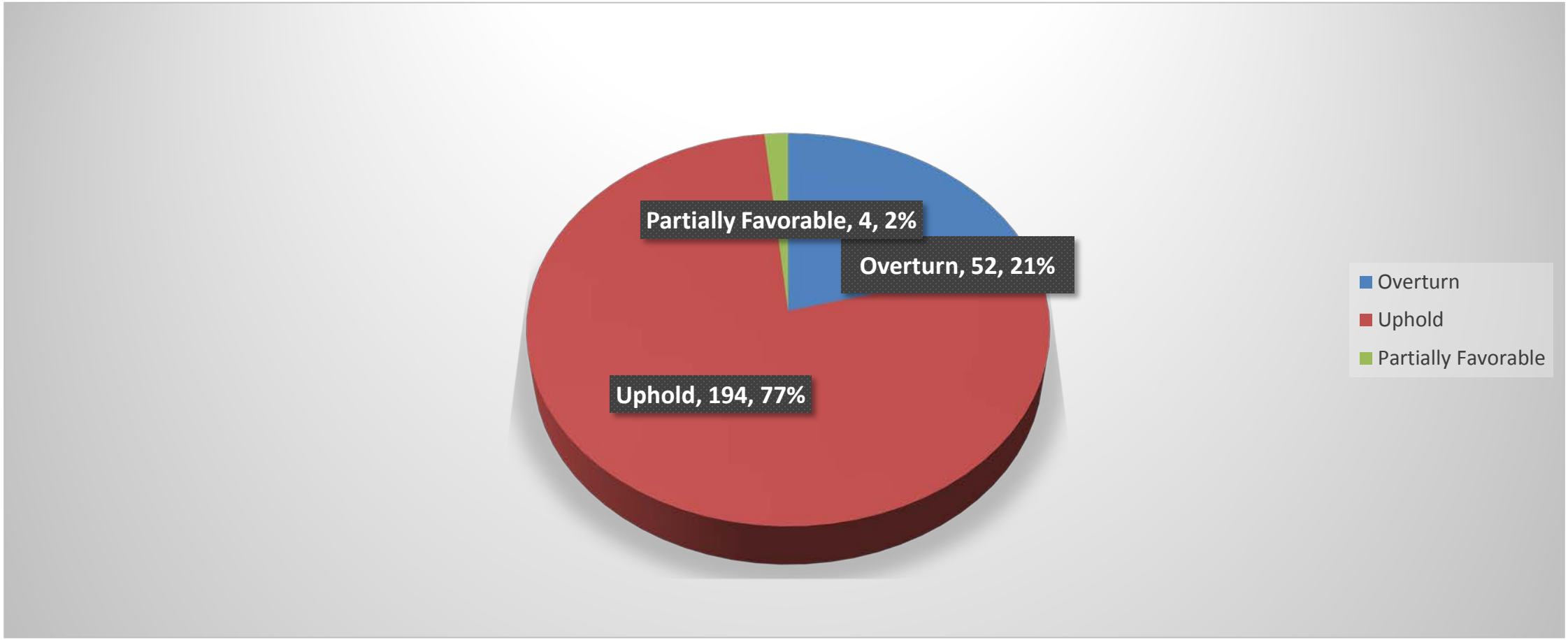


	Jul-21	Aug-21	Sep-21
QOS-Transportation Services (NMT)	28	34	43
QOC-Inappropriate Provider Care	15	22	22
Access-Timely Access to Specialist	15	11	13

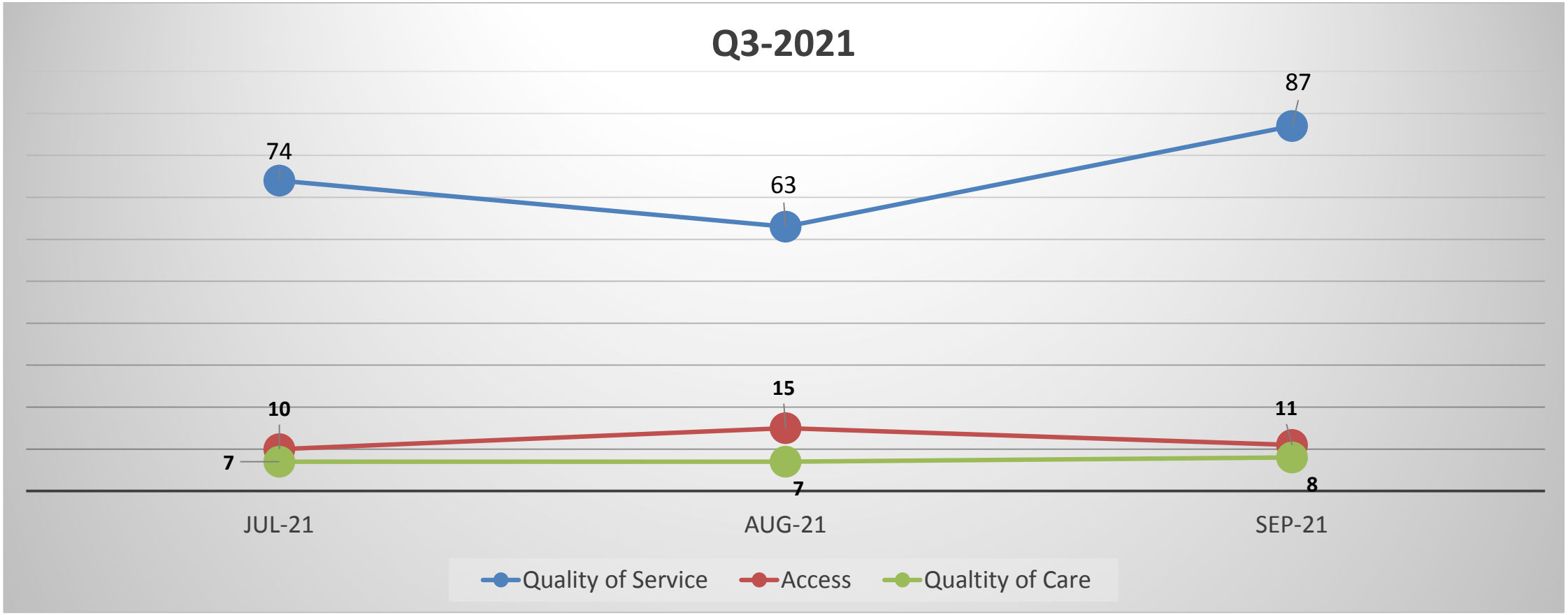
Q3 2021 Medi-Cal Appeals by Case Type



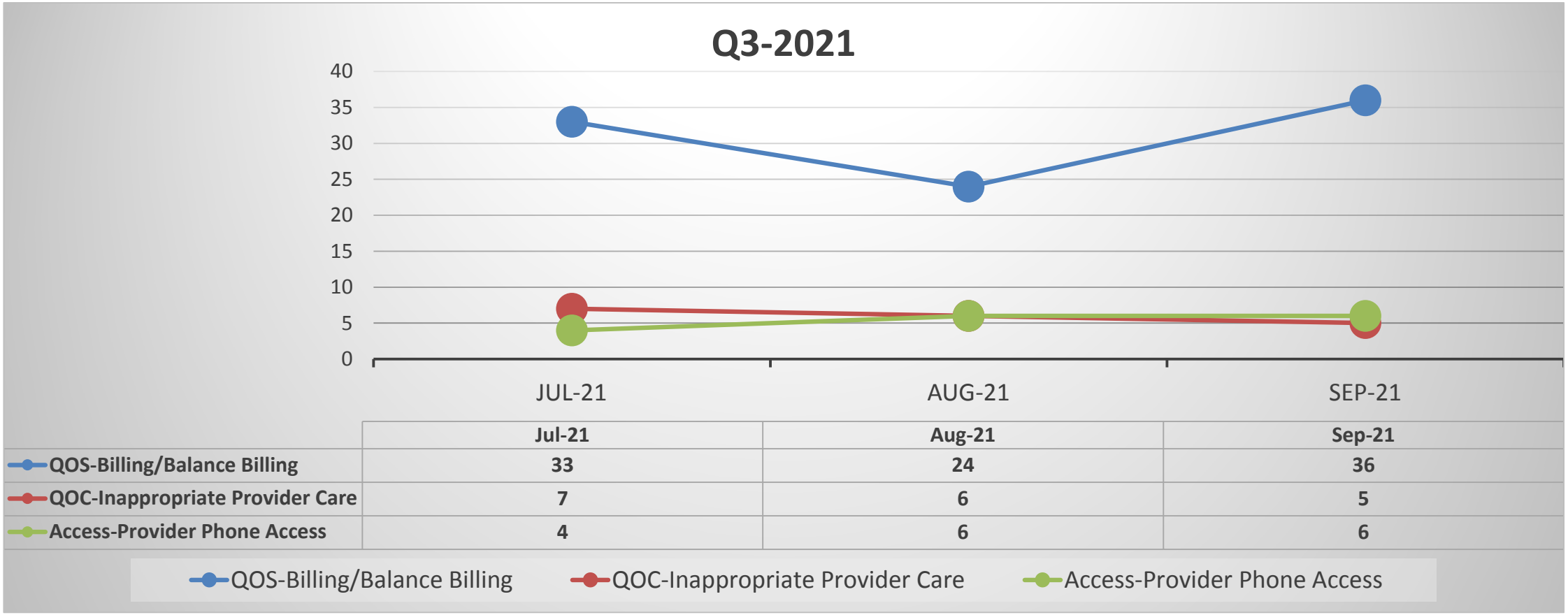
Q3 2021 MC Appeals by Disposition



Q3 2021:Top 3 Cal MediConnect Grievance Categories

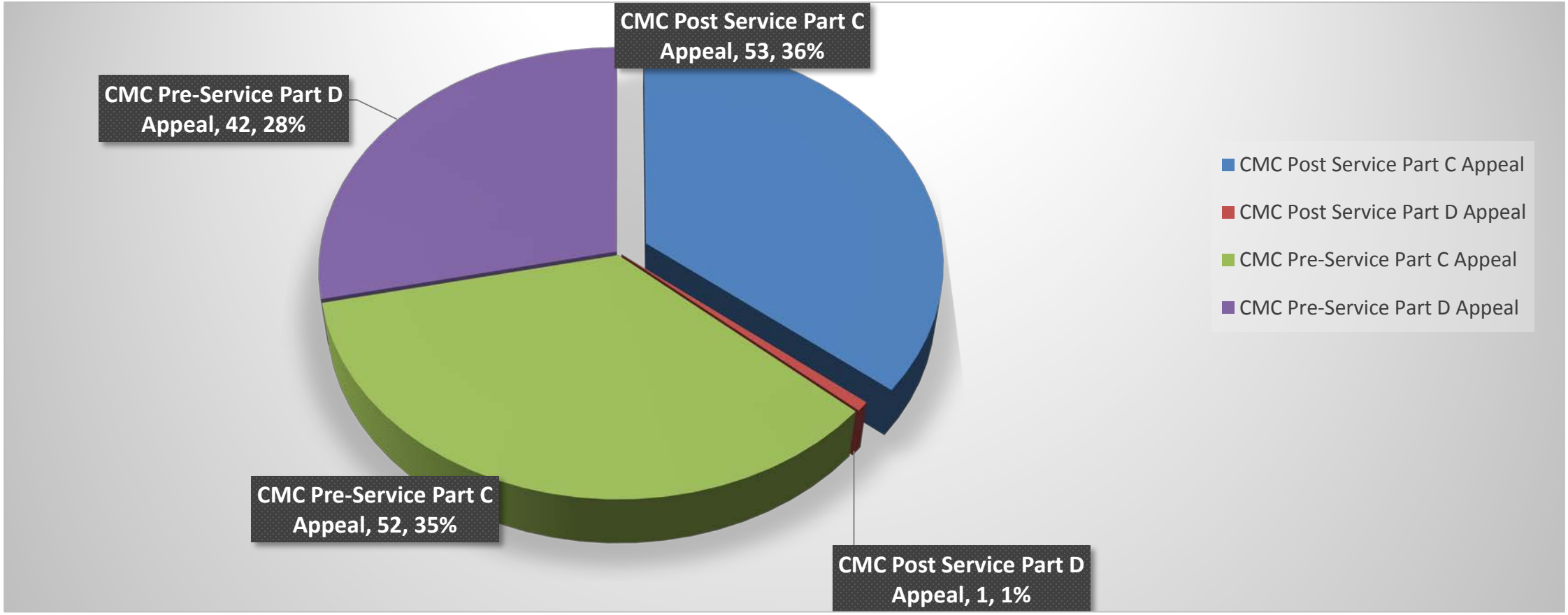


Q3 2021:Top 3 Cal MediConnect Grievance Subcategories

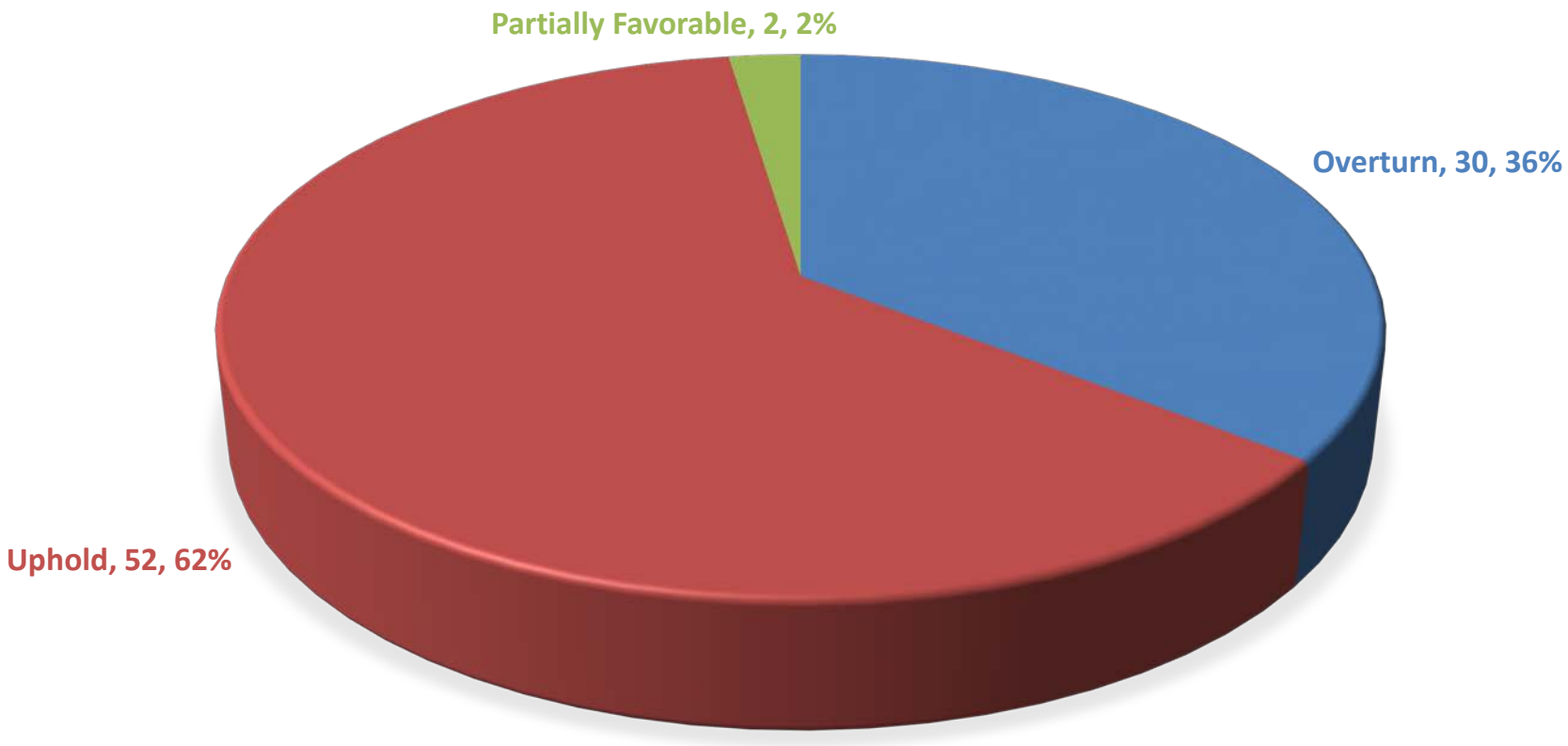


	Jul-21	Aug-21	Sep-21
QOS-Billing/Balance Billing	33	24	36
QOC-Inappropriate Provider Care	7	6	5
Access-Provider Phone Access	4	6	6

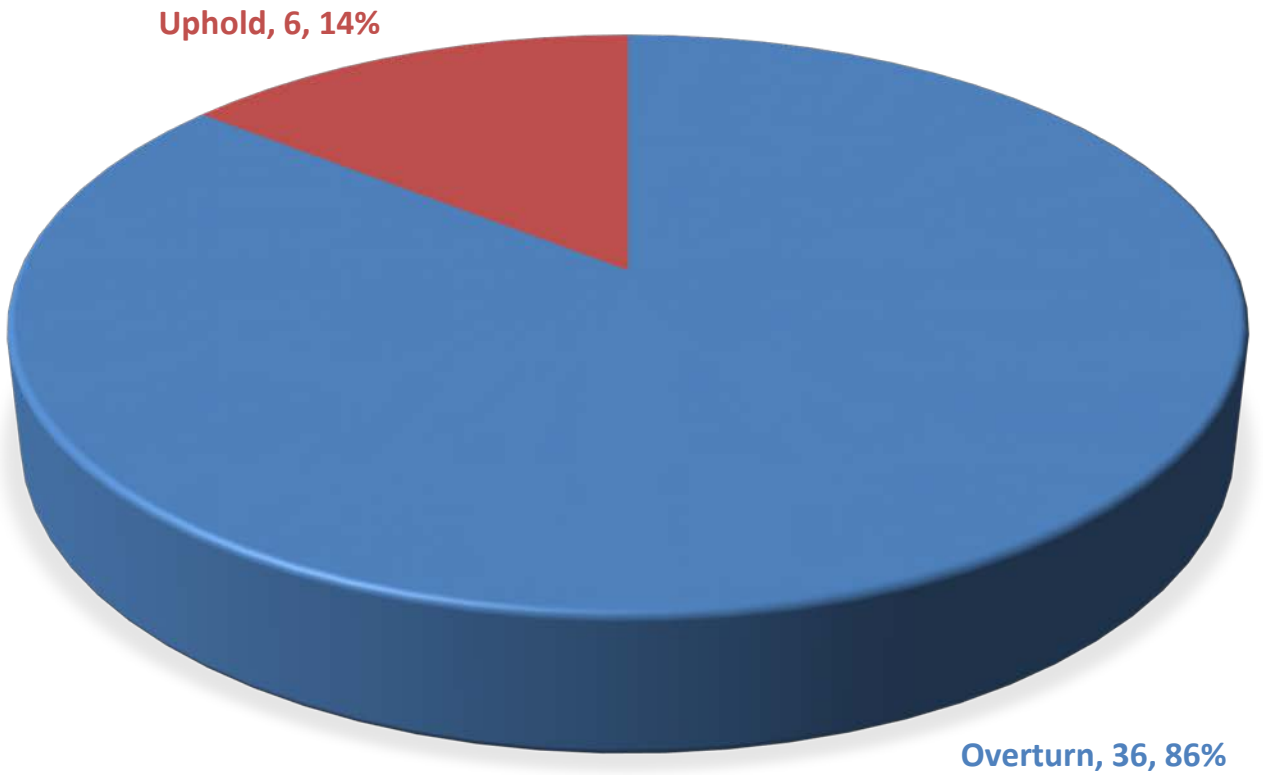
Q3 2021 CMC Appeals by Case Type



Q2 2021 CMC Pre-Service Appeals by Disposition



Q2 2021 CMC Post-Service Appeals by Disposition



Santa Clara Family Health Plan™

Quality Improvement Committee

Q3 2021 Grievance & Appeals Data

Santa Clara Family Health Plan™

Quality Improvement Committee

Q4 2021 Grievance & Appeals Data

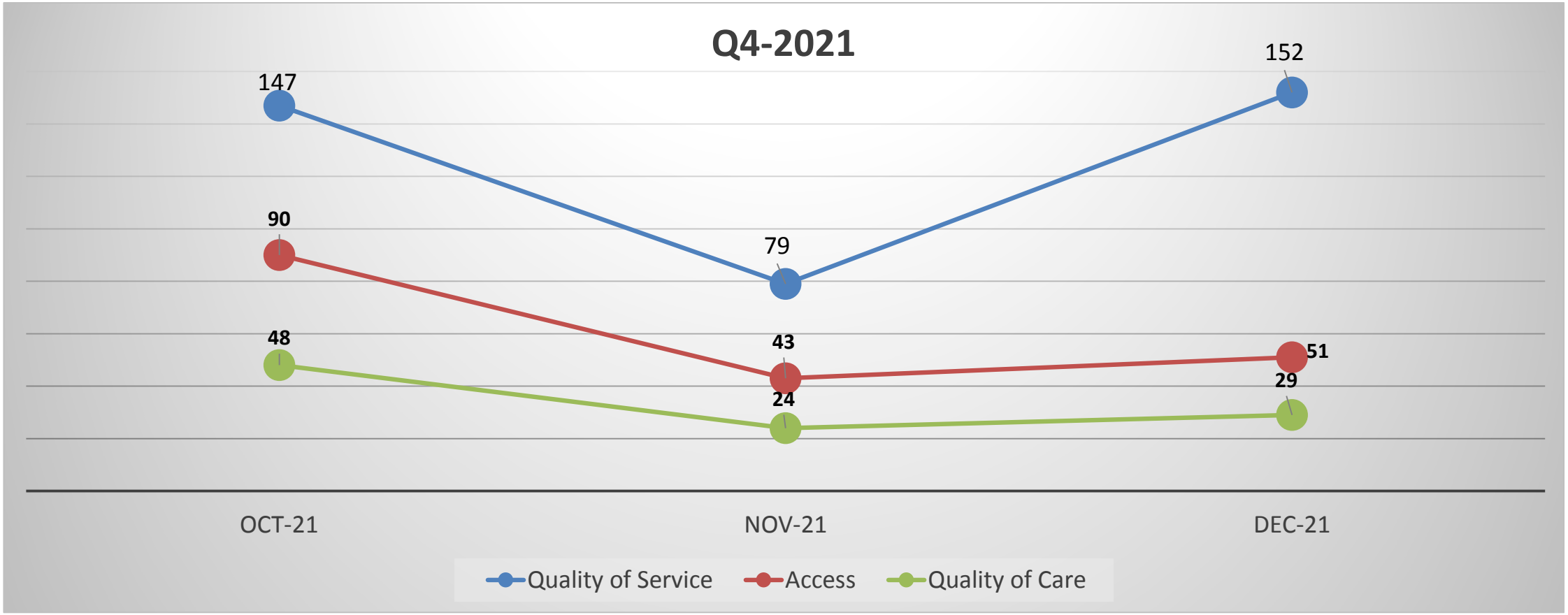
Total Grievances & Appeals

(*Rate per 1000 Members)*

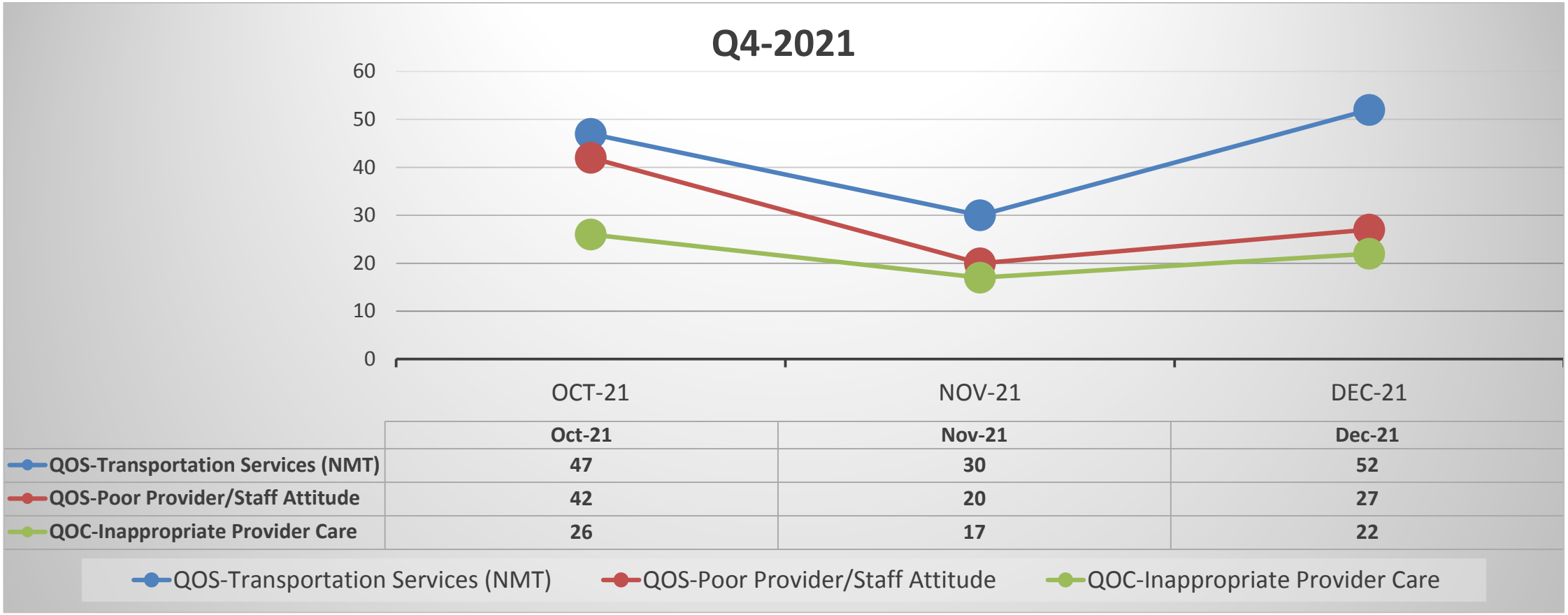
	Oct-20	Nov-20	Dec-20	Oct-21	Nov-21	Dec-21
Total Appeals	**40**	**42**	**49**	**39**	**22**	**40**
CMC Total Membership				**10,368**	**10,415**	**10,431**
Rate per 1,000				3.76157	2.11233	3.83472
Total Grievances	**96**	**93**	**117**	**120**	**110**	**140**
CMC Total Membership				**10,368**	**10,415**	**10,431**
Rate per 1,000				11.5740	10.5616	13.4215

	Oct-20	Nov-20	Dec-20	Oct-21	Nov-21	Dec-21
Total Appeals	127	108	96	67	91	91
MC Total Membership				**277,198**	**278,873**	**280,666**
Rate per 1,000				0.24170	0.32631	0.32422
Total Grievances	185	185	186	323	169	249
MC Total Membership				**277,198**	**278,873**	**280,666**
Rate per 1,000				1.16523	0.60601	0.88717

Q4 2021:Top 3 Medi-Cal Grievance Categories

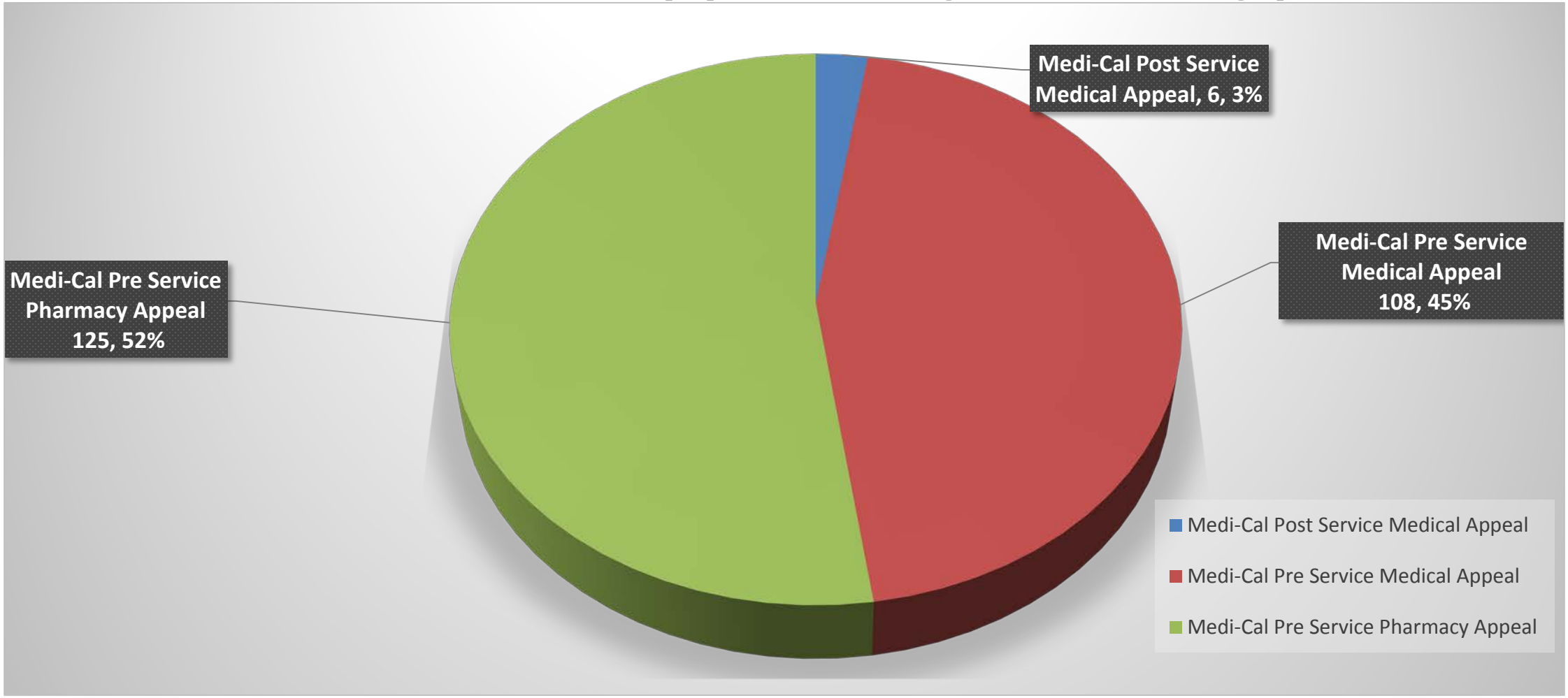


Q4 2021:Top 3 Medi-Cal Grievance Subcategories

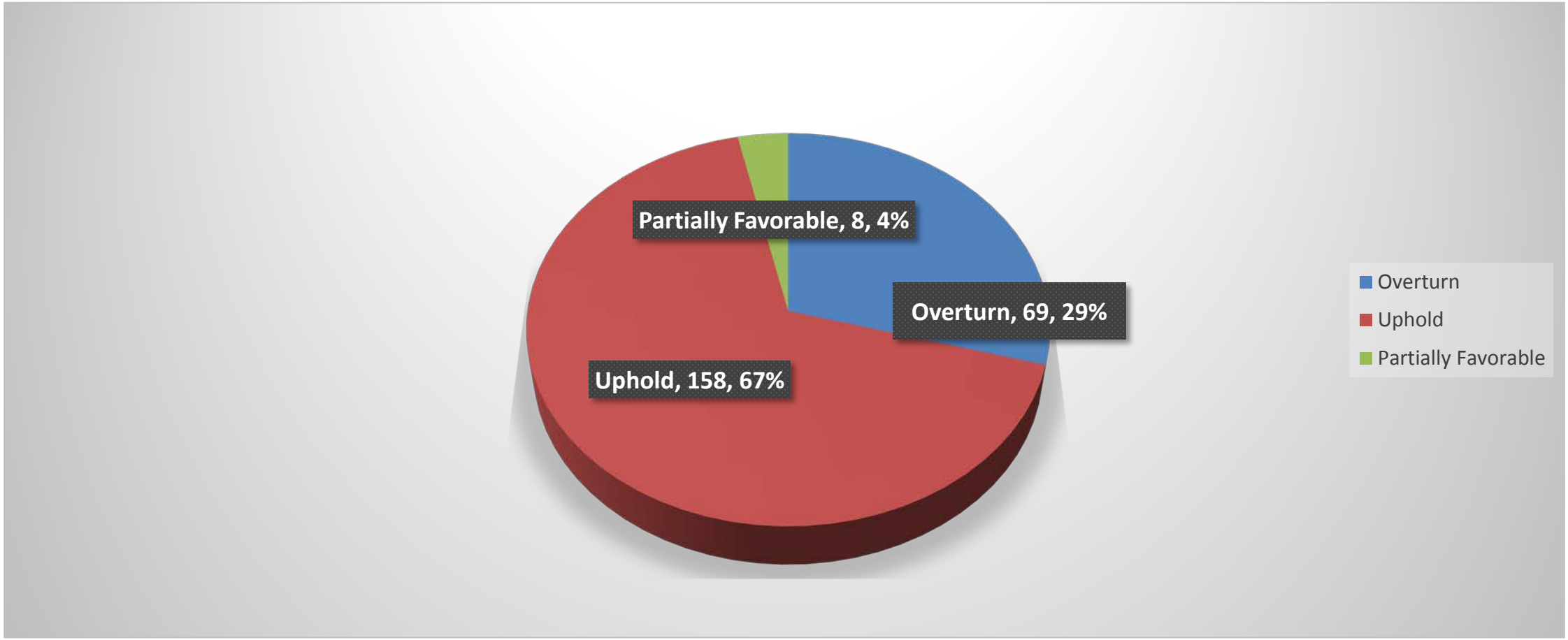


	Oct-21	Nov-21	Dec-21
QOS-Transportation Services (NMT)	47	30	52
QOS-Poor Provider/Staff Attitude	42	20	27
QOC-Inappropriate Provider Care	26	17	22

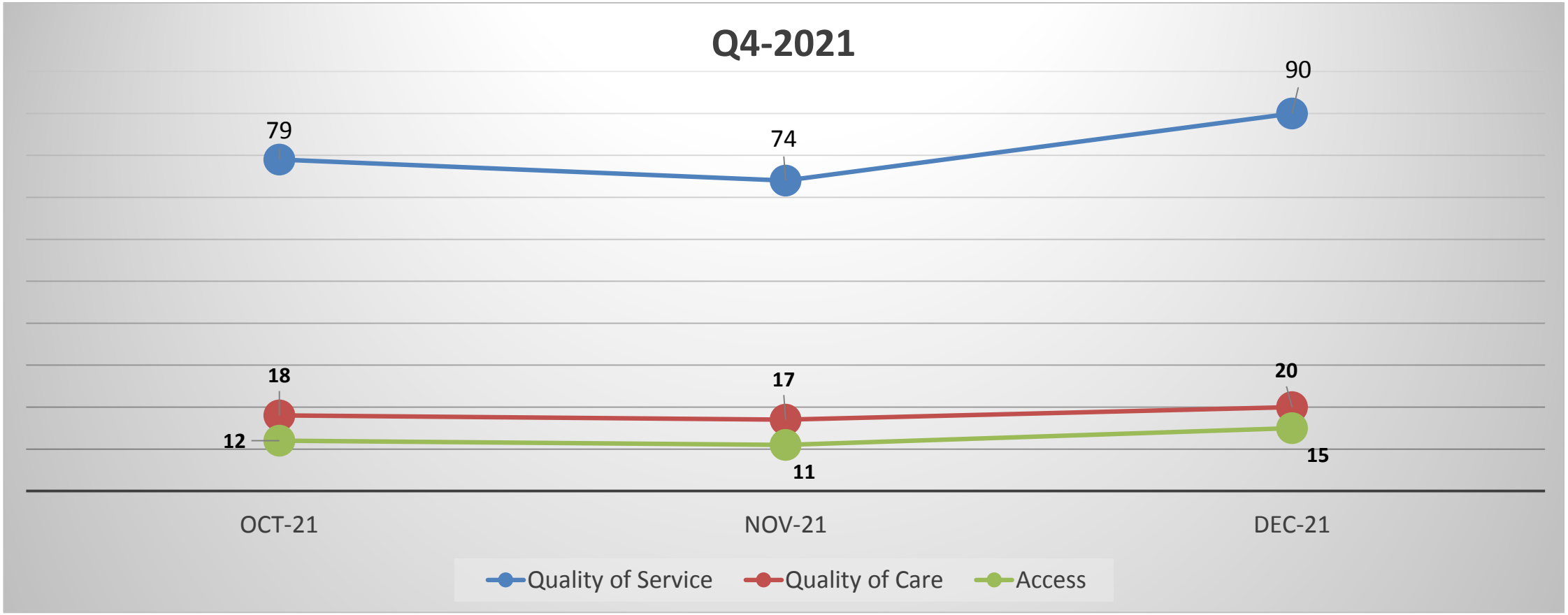
Q4 2021 Medi-Cal Appeals by Case Type



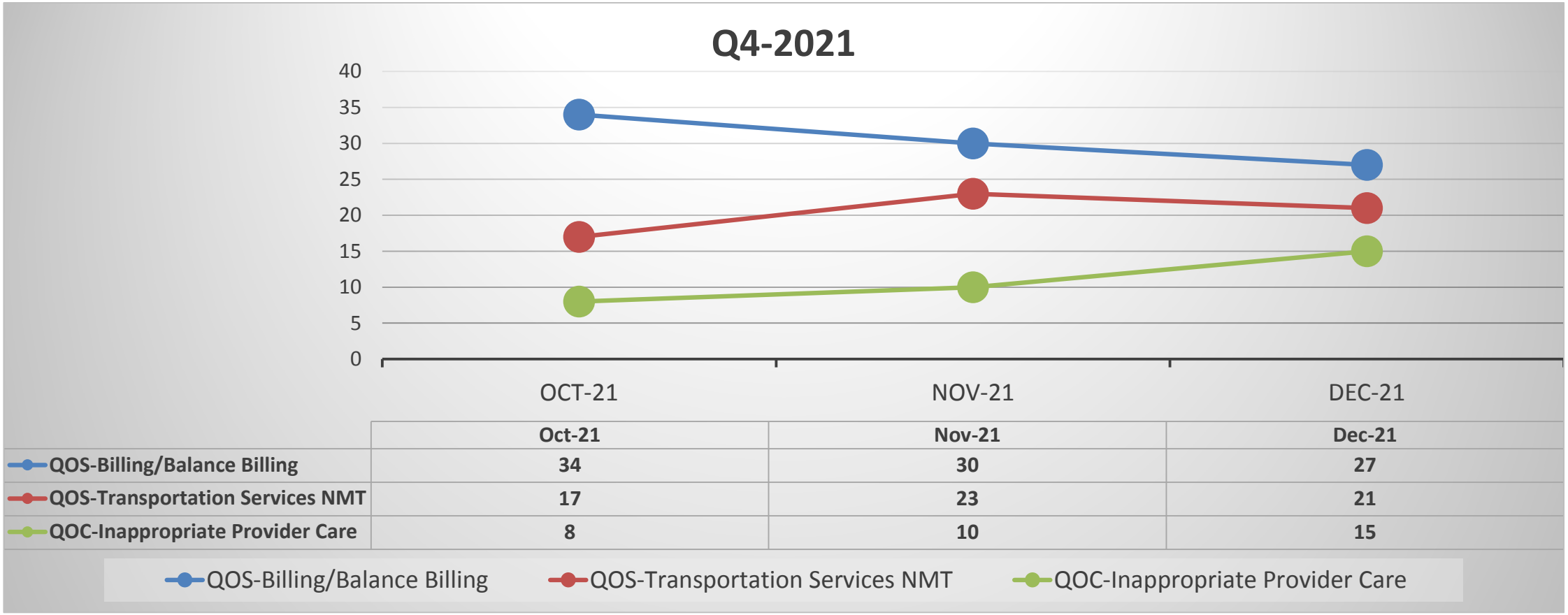
Q4 2021 MC Appeals by Disposition



Q4 2021:Top 3 Cal MediConnect Grievance Categories

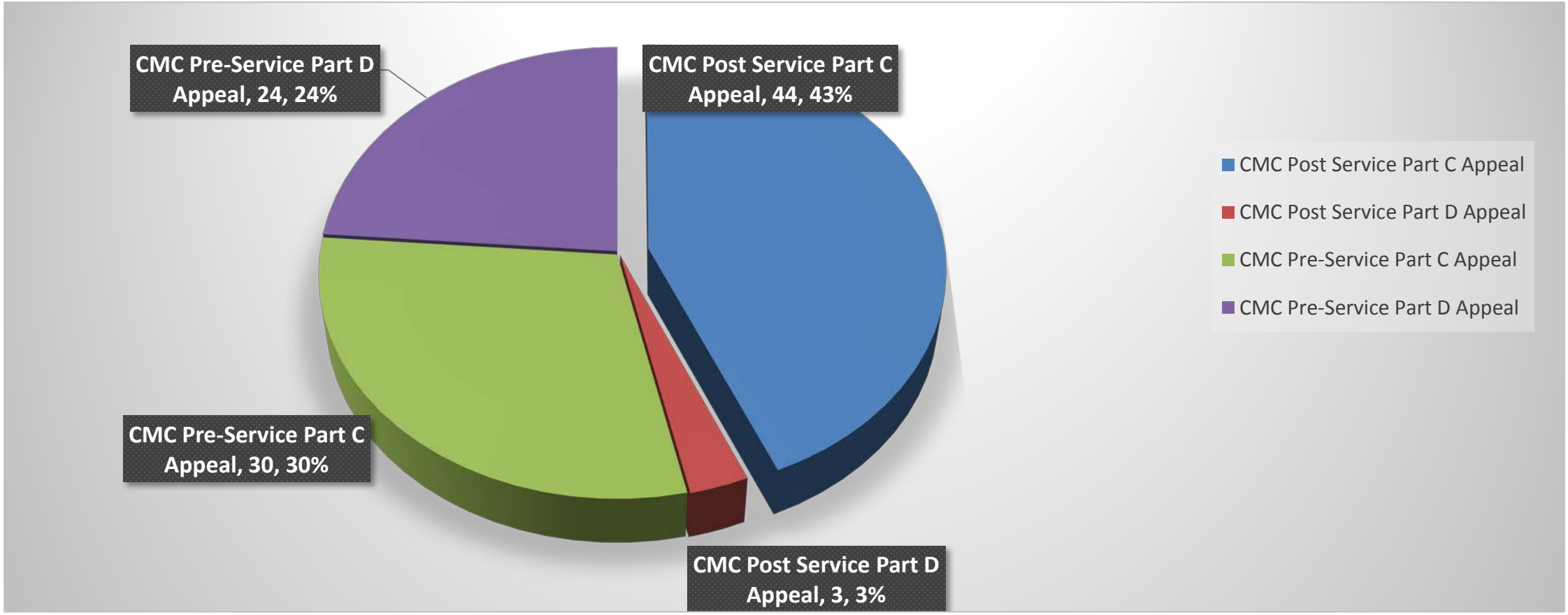


Q4 2021:Top 3 Cal MediConnect Grievance Subcategories

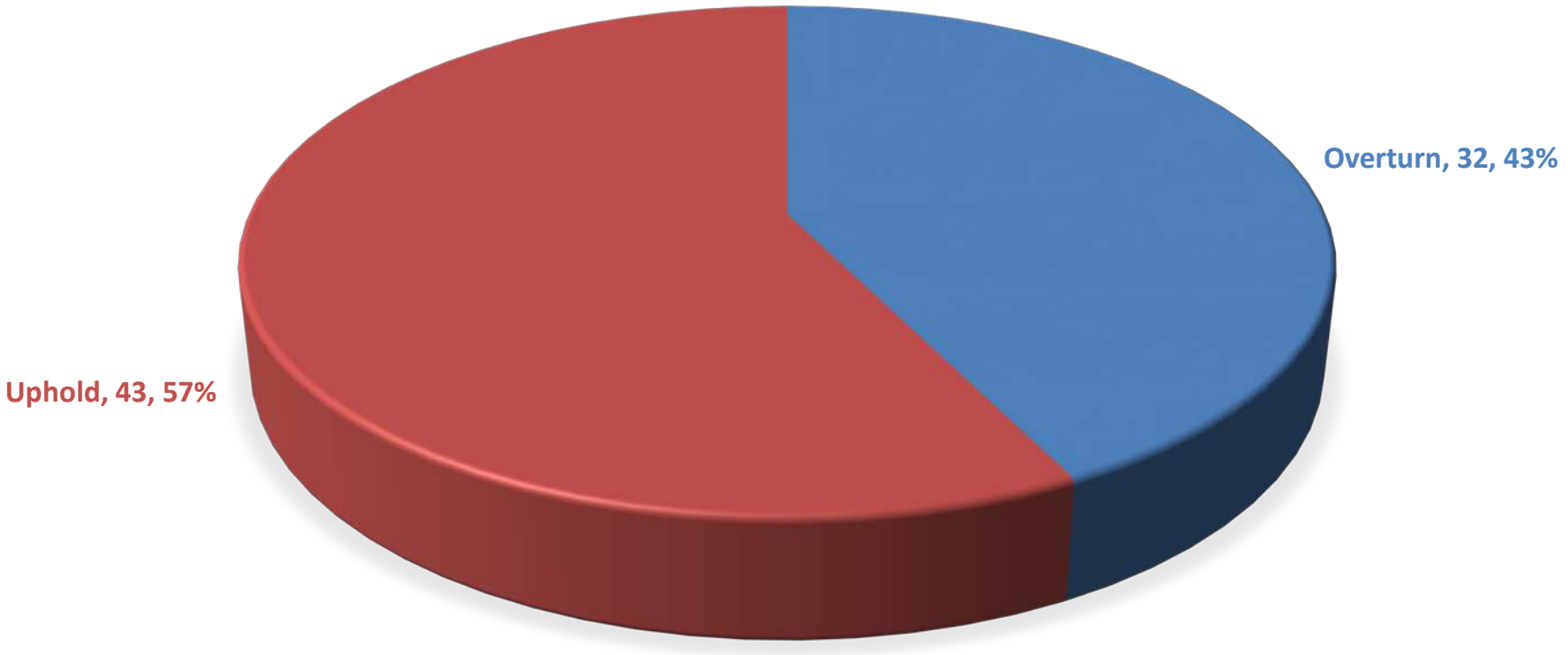


	Oct-21	Nov-21	Dec-21
QOS-Billing/Balance Billing	34	30	27
QOS-Transportation Services NMT	17	23	21
QOC-Inappropriate Provider Care	8	10	15

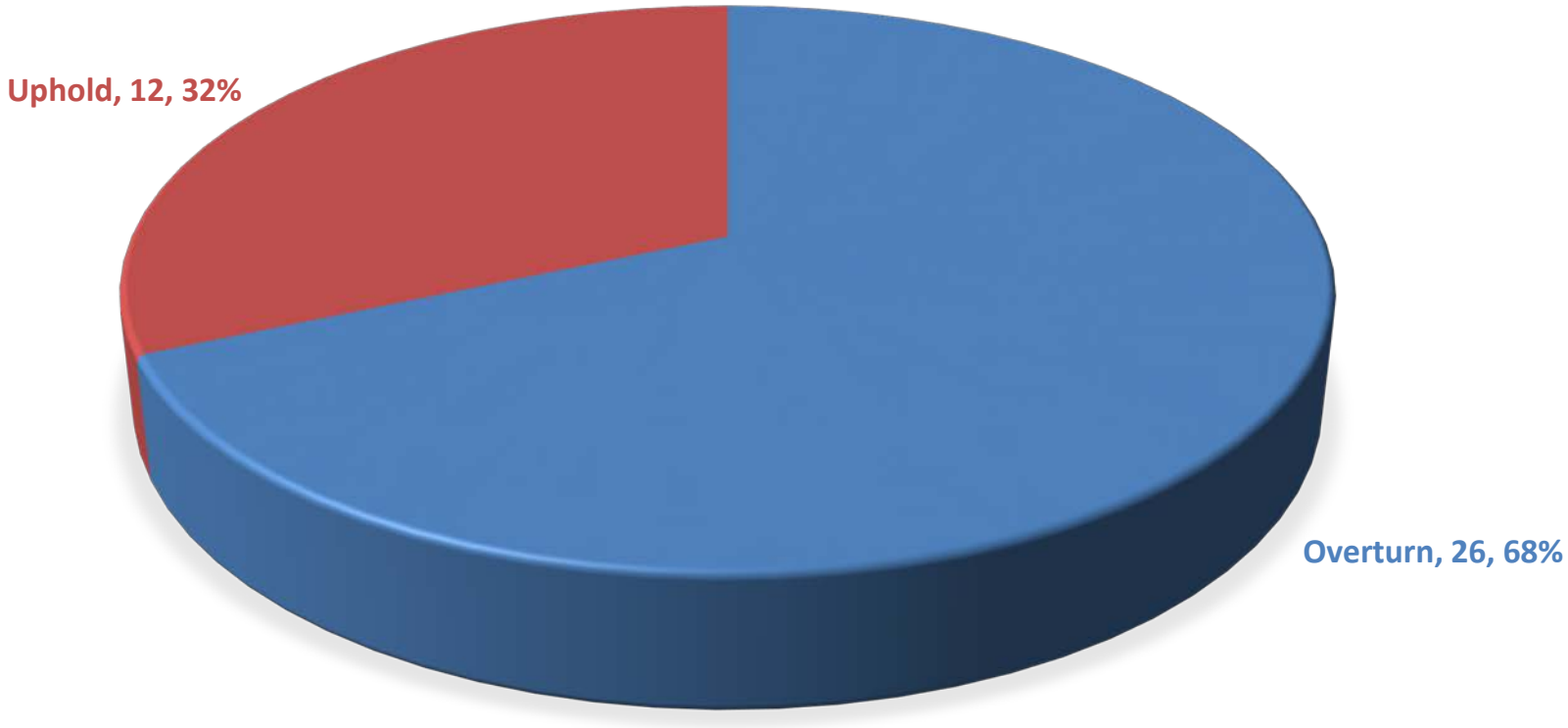
Q4 2021 CMC Appeals by Case Type



Q4 2021 CMC Pre-Service Appeals by Disposition



Q4 2021 CMC Post-Service Appeals by Disposition



Santa Clara Family Health Plan™

Quality Improvement Committee

Q4 2021 Grievance & Appeals Data

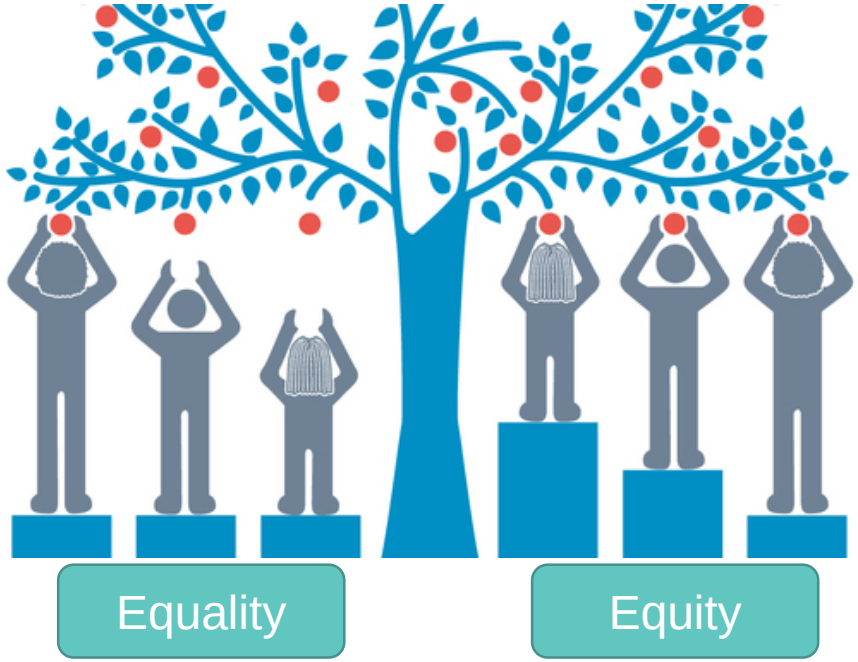
Santa Clara Family Health Plan™

SCFHP Equity Steering Committee

Vision

Health for all – a fair and just community where everyone has access to opportunities to be healthy.

Health Equity!



Common Terminology

- **Health equity:** everyone has a fair and just opportunity to be as healthy as possible.
- **Health disparity:** a health difference and pattern among specific patient populations with outcomes being more or less for a specific group
  - *Examples: difference in health, burden of illness, injury, disability or mortality*
- **Social Determinants of Health (SDOH):** economic and social conditions where people are born, live, learn, work, play and age that affect their health, functioning and quality of life
  - *Examples: safe housing, local food markets, access to education and jobs, social support*
- **Social needs:** immediate necessities based on the individual's preferences and priorities
  - *Examples: lack of adequate housing, not able to pay for utilities, not able to modify diet to combat diabetes*

Understanding the Relationship

Santa Clara Family Health Plan

Health Equity

Social Determinants of Health (SDOH)

Economic Stability	Education Access and Quality	Health Care Access and Quality	Neighborhood and Build Environment	Social and Community Context
• Employment • Income • Expenses • Debt • Medical Bills • Support	• Literacy • Language • Vocational training • Higher Education	• Health Coverage • Provider Linguistic and Cultural Competency • Quality of Care	• Housing • Transportation • Safety • Food Insecurity • Walkability • Zip Code	• Social Integration • Support Systems • Community Engagement • Discrimination

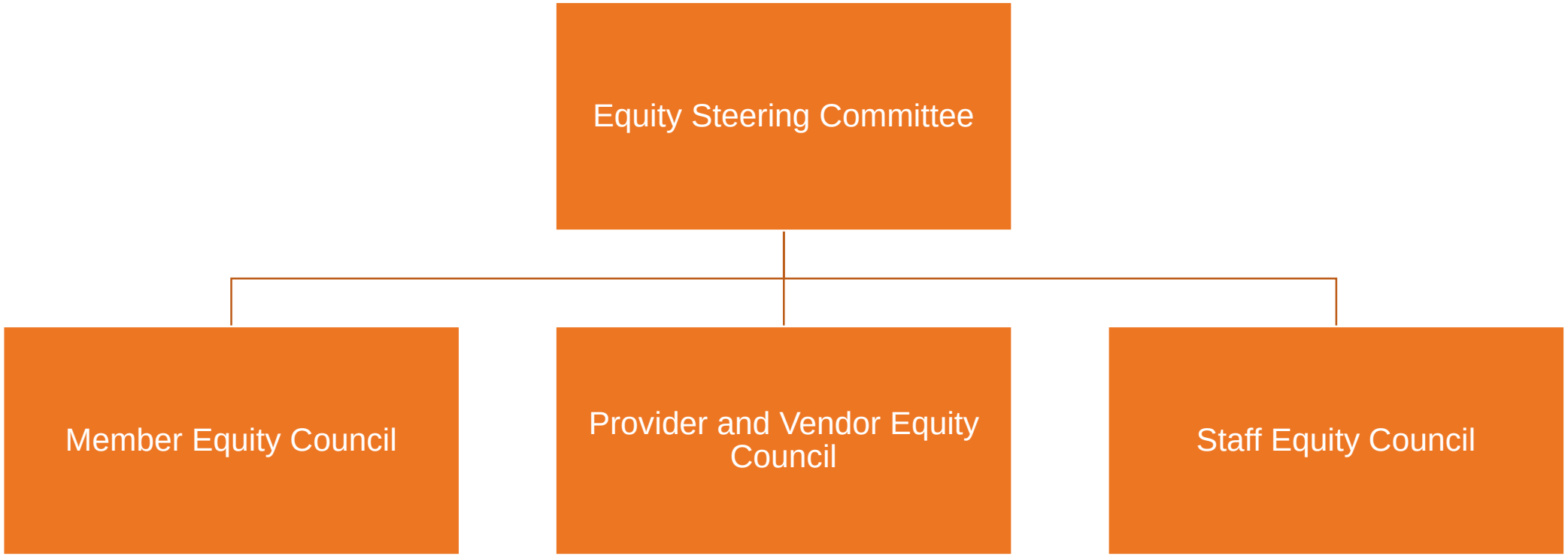
Health Disparities

Equity Steering Committee

Purpose

- To align, develop, coordinate, strengthen, and/or expand organization-wide efforts
  - to raise health equity for our members and
  - to create an equitable and inclusive workplace
- To serve as an advisory body to the executive team in support of the Strategic Plan and Plan Objectives

Equity Steering Committee



Membership: Executive Sponsor, Council Chairs, Project Manager, Staff Members (2)

Three Councils

Focus is to develop, strengthen, and/or expand activities that…

- **Member Equity Council**: promote health equity and reduce health disparities among members
  - Department Representatives: QI (Chair), Community Engagement, Customer Service, Grievance & Appeals, Case Management, LTSS
  - Work closely with Consumer Advisory Committee (Medi-Cal), Consumer Advisory Board (CMC), and the Blanca Alvarado Community Resource Center Resident Advisory Group
- **Provider and Vendor Equity Council**: promote culturally and linguistically appropriate standards of care for our members, and promote diversity of and opportunity for vendors
  - Department Representatives: PNO (Chair), Operations, Medical Director, IT, Compliance
  - Work closely with the Provider Advisory Council
- **Staff Equity Council**: promote a culture of inclusion and belonging at SCFHP, making it an employer of choice
  - Folds current Diversity Committee into organization-wide focus on equity
  - Membership: HR, Strategies and Analytics, 10-15 Staff members with Chair elected by Council

Santa Clara Family Health Plan™

Medicare Health Outcomes Survey (HOS) 2021
2018-2020 Cohort 21 Results

Byron Lu, Process Improvement Project Manager

February 2022

Health Outcomes Survey

- Background
  - What is Health Outcomes Survey (HOS)
    - *“The Medicare HOS is the first patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is 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. ” – www.HOSonline.org*
- Mandatory for all Medicare Advantage contracts (including Medicaid-Medicare Plans (MMP))
- Multi year survey
  - Baseline survey
  - Follow up survey two years later
- Data sources
  - Survey response
  - HEDIS rates

Medicare HOS Survey Administration and Star Ratings Timeline

Year	Baseline Data Collection	Follow Up Data Collection	Baseline Report	Follow Up Reports	2-yr PCS/MCS Change for Star Ratings	HEDIS Measures for Star Ratings	Star Rating Year
2023	Cohort 26	Cohort 24	Cohort 25	Cohort 23	2019-2021 Cohort 22	2021 Cohort 234Baseline & 2021 Cohort 22 Follow Up	2023
2022	Cohort 25	Cohort 23	Cohort 24	Cohort 22	2018-2020 Cohort 21	2020 Cohort 23 Baseline & 2020 Cohort 21 Follow Up	2022
2021	Cohort 24	Cohort 22	Cohort 23	Cohort 21	2017-2019 Cohort 20	2019 Cohort 22 Baseline & 2019 Cohort 20 Follow Up	2021
2020	Cohort 23	Cohort 21	Cohort 22	Cohort 20	2016-2018 Cohort 19	2018 Cohort 21 Baseline & 2018 Cohort 19 Follow Up	2020
2019	Cohort 22	Cohort 20	Cohort 21	Cohort 19	2015-2017 Cohort 18	2017 Cohort 20 Baseline & 2017 Cohort 18 Follow Up	2019

Reporting Details

- **Findings**
  - 2021 Results
    - 2018-2020 Cohort 21 Follow up Report
    - 2019 Cohort 23 Baseline report for HEDIS/HOS measures

- **By the numbers**
  - Sample size (Baseline report)
    - 1,200
  - Analytic sample after exclusion (Follow up report)
    - 121 in Cohort 21

HOS Cohort 21 Respondents

252

Less:
Disenrolled: 43
Death: 24

185

Less:
Ineligible Survey: 3
Non-Respondents: 61

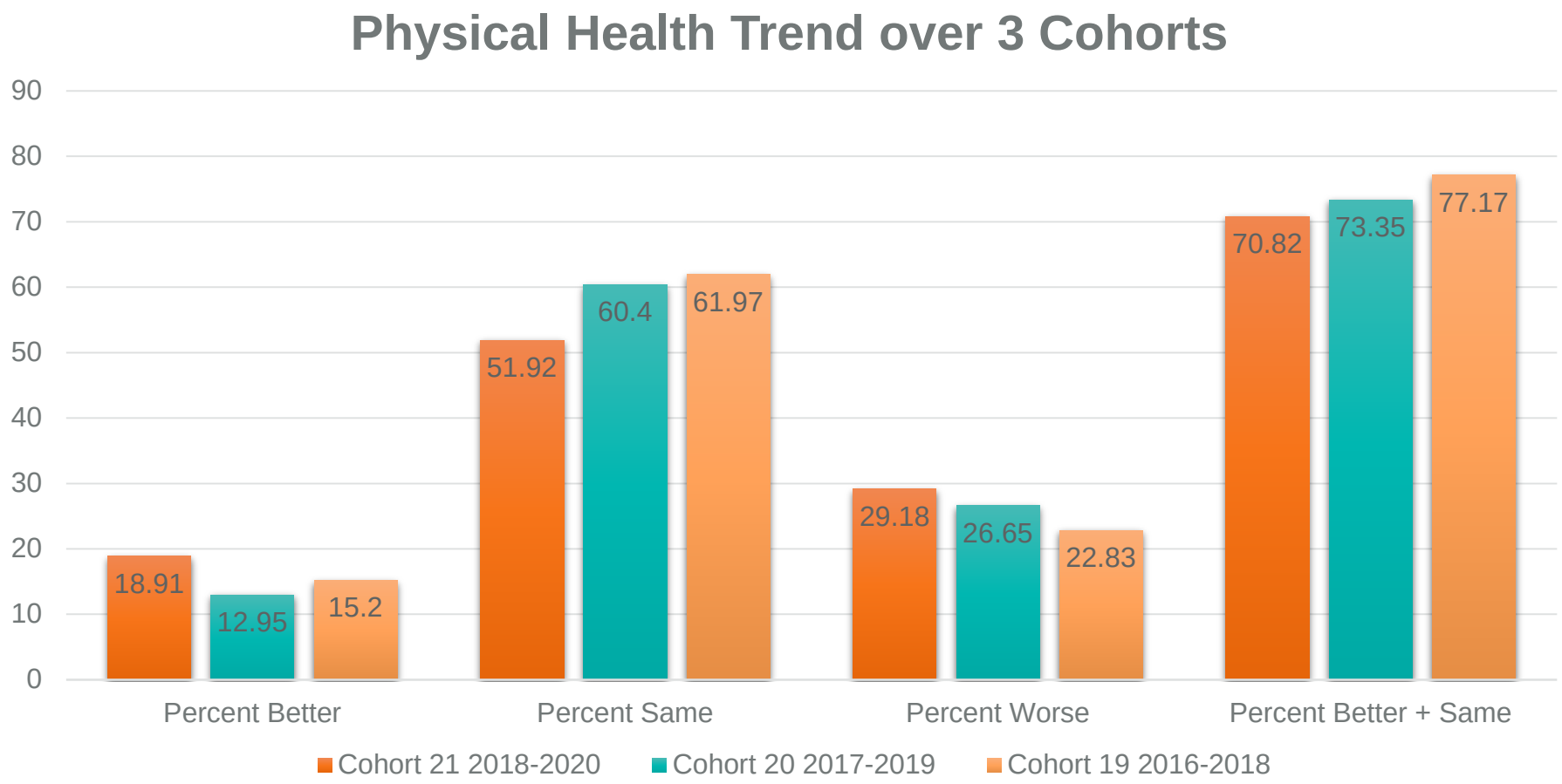
121

2021 SCFHP Response rate: 66.5%
2020 SCFHP Response Rate: 59.1%

2021 Overall HOS Response Rate: 66.8%
2020 Overall HOS Response Rate: 67.4%

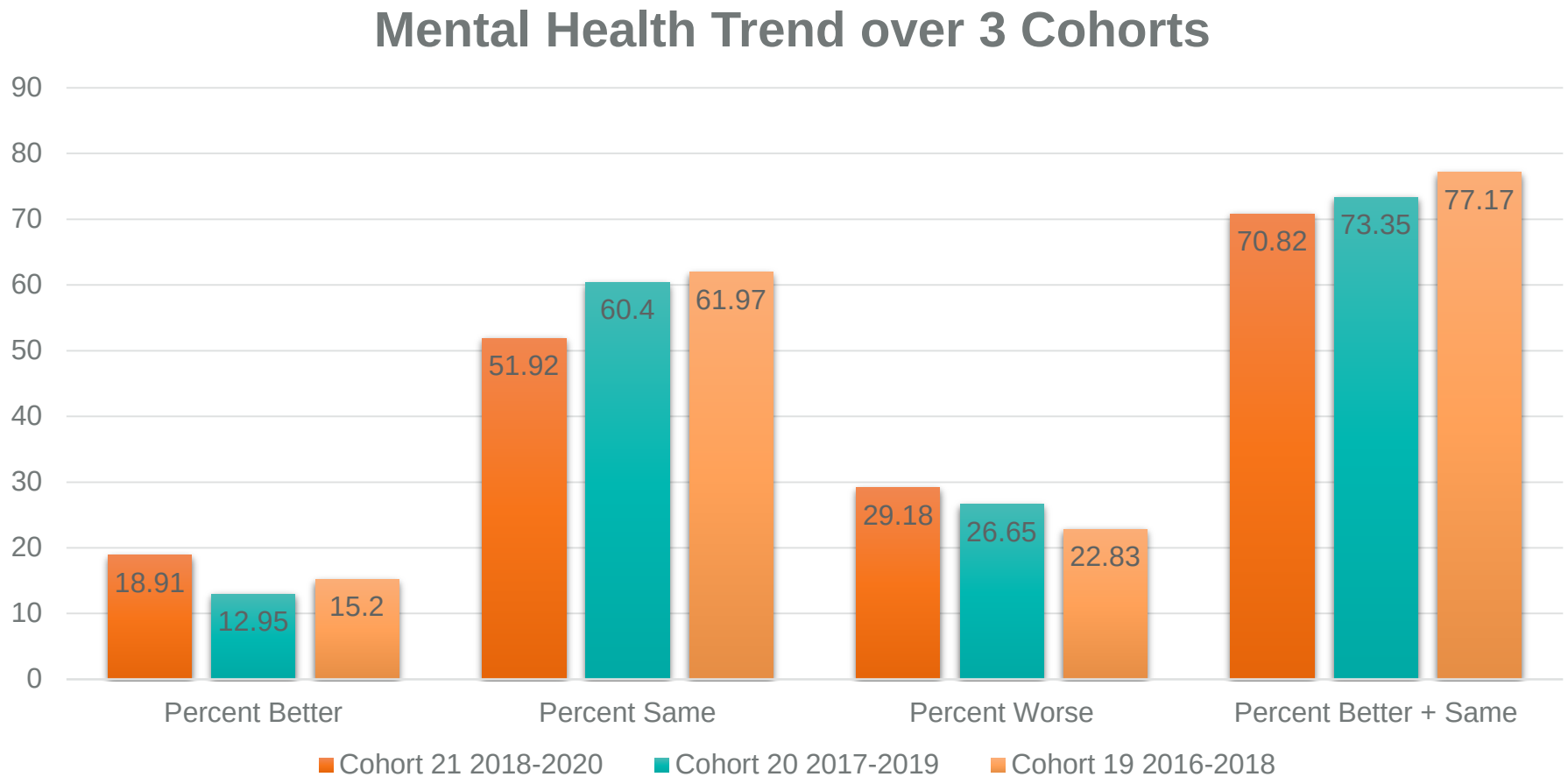
Physical Health Results over Three Cohorts

HOS Question- In general, would you say your health is?

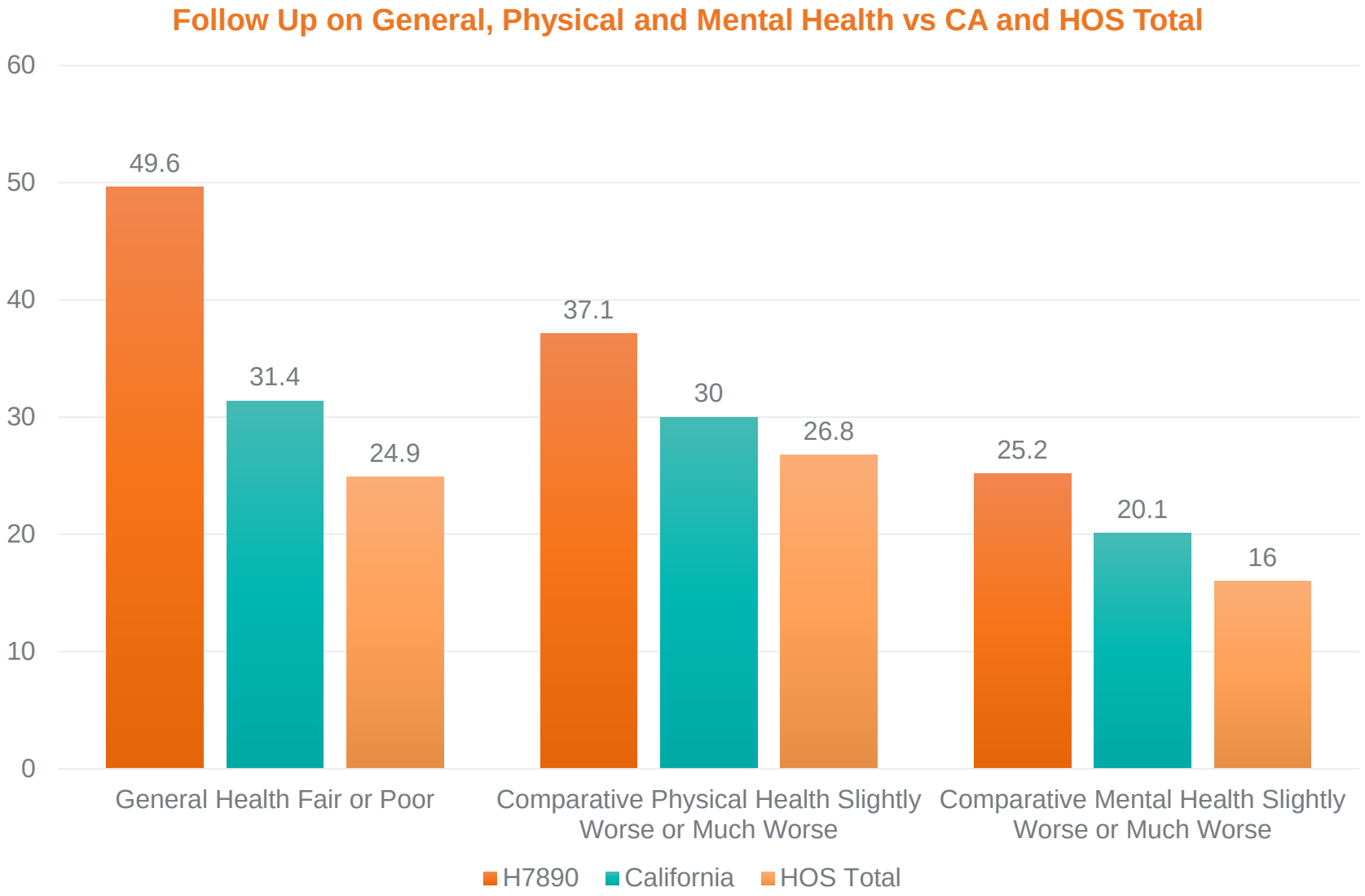


Mental Health Results over Three Cohorts

HOS Question- Findings- During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as result of any emotional problem (such as feeling depressed or anxious)?



General Health and Comparative Health



Performance Measurement: Multiple Chronic Condition

Findings

Cohort 21 Follow Up vs Cohort 20 Follow Up

	Multiple Chronic Medical Conditions			
	2020 Baseline	2020 Cohort Follow Up	2021 Baseline	2021 Cohort Follow Up
SCFHP	79.7%	77.0%	86.2%	86.4%
California	75.1%	76.9%	74.1%	76%
HOS Total	76.1%	77.8%	75.2%	77.5%

Performance Measurement: BMI

Findings

	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%

Cohort 21 Performance Measurement Prevalence of Chronic Medical Conditions

Findings

	MAO H7890 SCFHP		HOS Total	
	Baseline	Follow Up	Baseline	Follow Up
	N (%)	N (%)	N (%)	N(%)
Hypertension	91 (80.5%)	95 (80.5%)	48,615 (65.7%)	49,013 (66.9%)
Arthritis- Hip or Knee	65 (56.0%)	62 (53.4%)	31,655 (42.9%)	32,800 (45.0%)
Arthritis- Hand or Wrist	47 (40.5%)	50 (43.1%)	26,405 (35.8%)	27,155 (37.3%)
Diabetes	47 (40.5%)	46 (39.0%)	19,245 (26.0%)	19,818 (27.1%)
Sciatica	42 (39.5%)	47 (40.5%)	18,677 (25.4%)	18,708 (25.7%)

Top Chronic Conditions at SCFHP

TOP 3

Top three reported chronic conditions for all 3 cohorts (19, 20, 21):

- Hypertension
- Arthritis (Hip/Knee + Hand/Wrist)
- Diabetes

TOP 10

- Sciatica, other heart conditions, osteoporosis, pulmonary disease, depression and any caner rounded out the top 10 chronic conditions.
- Cohort 21: Pulmonary Disease increased significantly from 13.9% in baseline to 17.1% the largest increase in all chorionic conditions (3.2% increase vs HOS reported 1.2% increase)

HOS and Star Rating

Star Ratings Component	HOS Questions
Improving or Maintaining Physical Health	Q1: In general, would you say your health is?
Improving or Maintaining Mental Health	Q6: During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
Improving Bladder Control- MUI	Q45: There are many ways to control or manage the leaking of urine, including bladder training exercises, medication and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches?
Monitoring Physical Activity- PAO	Q46: In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity? Q47: In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?
Reducing the Risk of Falling- FRM	Q49: Did you fall in the past 12 months? Q50: In the past 12 months have you had a problem with balance or walking?

Star Rating

Measure Name	Source	Description	Final Rate	Projected Star (2022 Estimated Cut Points)	Projected Star (2021 Cut Points)	Previous Year Star (2021)
Improving or Maintaining Physical Health	HOS	Percent of plan members whose physical health was the same or better than expected after two years.	70.82%	4	4	4
Improving or Maintaining Mental Health	HOS	Percent of plan members whose mental health was the same or better than expected after two years.	78.03%	3	4	4
Improving Bladder Control (MUI Treat Rate)	HEDIS/HOS	Treatment of Urinary Incontinence: The percentage of Medicare members 65 years of age and older who reported having urine leakage in the past six months and who discussed treatment options for their urinary incontinence with a health care provider.	NA	N/A	5	5
Monitoring Physical Activity (PAO Advise Rate)	HEDIS/HOS	Advising Physical Activity: Advising Physical Activity- The percentage of Medicare members 65 years of age and older who had a doctor's visit in the past 12 months and who received advice to start, increase, or maintain their level of exercise or physical activity.	61.98%	5	5	5
Reducing the Risk of Falling (FRM Manage Rate)	HEDIS/HOS	Managing Fall Risk: The percentage of Medicare members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking from their current practitioner.	70.44%	4	5	5

Interventions

Health Plan

- Offer health education classes and Physical Activities class
  - Silver & Fit Fitness Center Program
  - Home Fitness Program
  - Healthy Aging Coaching Program
- Case Management
  - Annual Health Risk Assessment (HRA)
  - Individual Care Plan (ICP)
  - Conduct Interdisciplinary Care Team (ICT) meeting
  - Transition of Care (TOC) follow up
  - Complex Case Management (CCM)
- Provider Intervention
  - Planning in progress with internal workgroups

Santa Clara Family Health Plan™

Thank You

SCFHP Americans with Disabilities Act Workplan

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

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Workplan	ADA Workplan is reviewed and evaluated on an annual basis	Annual	February 2021		
Responsible Party	Identify responsible individual for ADA Compliance	Annual	February 2021	February 2021	Director of Quality and Process Improvement has oversight for ADA Compliance.
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: CBAS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: LTSS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: Nursing Home	Quarterly	3/31/2021-0 6/30/2021-1 9/30/2021-1 12/31/2021-0	Completed	
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: IHSS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Patient Safety	Number of *Potential* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-1 12/31/2021-0	Completed	

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Patient Safety	Number of *Potential* Quality of Care Issues identified at: IHSS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Patient Safety	Number of *Potential* Quality of Care Issues identified at: LTSS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Patient Safety	Number of *Potential* Quality of Care Issues identified at: Nursing Home	Quarterly	3/31/2021-3 6/30/2021-6 9/30/2021-4 12/31/2021-2	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: LTSS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: Nursing Home	Quarterly	3/31/2021-1 6/30/2021-1 9/30/2021-1 12/31/2021-1	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: IHSS	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-0	Completed	
Access	PAR Site Identification: Plan refreshes claims history to identify new high volume specialists and ancillary providers for review	Annual	1/31/2020	2/10/2021	PAR site identified on 2/10/2021.
Access	Physical Accessibility Review: Number of LTSS sites reviewed	Quarterly	3/31/2021 6/30/2021 9/30/2021 12/31/2021	None Identified	

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Access	Physical Accessibility Review: Number of CBAS sites reviewed	Quarterly (only required once every three years)	3/31/2021- 0 6/30/2021-0 9/30/2021-0 12/31/2021-1	Grace ADHC 2nd PAR Survey completed prior to 12/31/2021. Contacted Golden Castle's 2nd PAR Survey requesting to sign attestation if no changes to facility site since initial survey in 2018	2 sites Identified in 2021. 1. Golden Castle ADHC (3803 E Bayshore Rd, PA 94303) - previously done in 2015, needs only attestation 2. Grace ADHC(3010 Olcott St, Santa Clara, 95054) previously done in 2015. Needs only attestation.
Access	Number of referrals to: CBAS	Quarterly	3/31/2021-8 6/30/2021-11 9/30/2021-21 12/31/2021-12	Completed	
Access	Number of referrals to: MSSP	Quarterly	3/31/2021-2 6/30/2021-5 9/30/2021-2 12/31/2021-2	Completed	
Access	Number of referrals to: Nursing Home	Quarterly	3/31/2021-81 6/30/2021-106 9/30/2021-144 12/31/2021-134	Completed	
Access	Number of referrals to: IHSS	Quarterly	3/31/2021-71 6/30/2021-60 9/30/2021-34 12/31/2021-75	Completed	

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Access	Physical Accessibility Review: Number of High Volume Specialists	Quarterly	3/31/2021-0 6/30/2021-0 9/30/2021-0 12/31/2021-2	PAR completed for PAMF Medical Oncology (Dr. Edmund Tai) and PAMF Laboratory (Dr. Jon Keller) on 12/17/2021. PAR for Veronica Gonzalez at Maxim Healthcare Services was not completed prior to 12/31/2021 as we were awaiting response from DHCS to see if PAR needed to be completed as Maxim Healthcare ABA providers only provide service in the member's home, not at their facility	3. Identified in 2021 1. Tai Edmund W - Medical Oncology (795 El Camino Real PA 94301) 2. Gonzalez, Veronica M - Applied Behavioral Analyst (631 River Oaks Parkway, SJ, 95134) 3. Keller, Jon L- Anatomic/clinical pathology (795 El Camino Real, PA 94301)
Access	Physical Accessibility Review: Number of Ancillary sites reviewed	Quarterly	3/31/2021 6/30/2021 9/30/2021 12/31/2021-1	PARS completed for PAMF Laboratory (under Dr. Jon Keller) on 12/17/21	
Preventive Care	HEDIS: Care of Older Adults - Functional Status Assessment	Annual	6/30/2021	Completed	HEDIS 2021 (MY 2020) 43.07%
Preventive Care	Medication Reconciliation Post-Discharge	Annual	3/31/2021 6/30/2021 9/30/2021 12/31/2021	Completed	HEDIS 2021 (MY 2020) 54.99%

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Population Needs Assessment	Population Needs Assessment Report shared at: Consumer Advisory Committee Quality Improvement Committee	Annual	9/14/2021: Medi-Cal Population Needs Assessment shared at Consumer Advisory Committee 2/9/2021: CMC Population Needs Assessment shared with Quality Improvement Committee	Completed	
Health Education	Plan monitors health education referrals for CMC members: Number of referrals from members who are also in CBAS, LTSS, IHSS or Nursing Homes	Quarterly	3/31/2021-2 6/30/2021-0 9/30/2021-1 12/31/2021-1	Completed	
Patient Safety	Plan monitors grievances for reasonable accommodations and access to services under ADA	Quarterly	3/31/2021-1 6/30/2021-1 9/30/2021-1 12/31/2021-1	Completed	
Workplan	Plan will identify issues within its system that require improvement to promote access and ADA compliance	Annual	12/31/2021	Completed	

POLICY

Policy Title:	**Potential Quality of Care Issue (PQI)**	**Policy No.:**	QI.05 v2
Replaces Policy Title (if	Potential Quality of Care Issues	**Replaces Policy No. (if applicable):**	QM002_02
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that	☒ Medi-Cal	☒ CMC	

I. Purpose

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

II. Policy

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

Potential Quality of Care issues are considered for all providers and provider types such as individual practitioners, groups and facilities. All service types, such as preventive care, primary care, specialty care, emergency care, transportation and ancillary services are considered and are subject to disciplinary action. Availability of care, including case management for the SPD population, continuity of care and coordination of care are also considered. The Plan monitors and analyzes data to determine if services meet professionally recognized standards of practice. A Medical Director or Chief Medical Officer reviews all the PQIs and makes the final decision.

III. Responsibilities

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

IV. References

California Code and Regulations:

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

California Health and Safety Code section 1367.1

NCQA Health Plan Accreditation (HPA) Standards 2021, Credentialing (CR) 5, Element A

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	Approve 5/10/2016	
v1	Reviewed	Quality Improvement	Approve 05/10/2017	
v1	Reviewed	Quality Improvement	Approve 06/06/2018	
v2				

Business Title

Santa Clara Family Health Plan

Title	Version	Reference #
Potential Quality of Care Issue (PQI)	1	QI.05

Date Created	Date Submitted
06/22/2020	12/27/2020

Date Approved	Publication Date
01/10/2021	01/10/2021

Next Review Date	Review Interval
01/31/2023	12 month(s)

Reviewed with no changes	Date
SCFHP: Liu, Johanna (Director, Quality and Process Improvement)	01/31/2022

Owner

SCFHP: Liu, Johanna (Director, Quality and Process Improvement)

POLICY

Policy Title:	**Physical Access Compliance**	**Policy No.:**	QI.07
Replaces Policy Title (if applicable):	Physical Access Compliance Policy	**Replaces Policy No. (if applicable):**	QM107
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To define the processes Santa Clara Family Health Plan (SCFHP) follows to monitor that ADA requirements and quality are assessed and compliance is maintained at practice sites and facilities for primary care practices, high volume specialists, Community-Bases Adult Services (CBAS), ancillary practices and other organizational providers.

II. Policy

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

For contracted organizational providers that are unaccredited, SCFHP conducts an onsite quality assessment or accepts a CMS or state quality review, assuming it is no more than three years old. SCFHP obtains a survey report or letter from CMS or the state certifying completion of the review. SCFHP will limit the review to one main facility if there are multiple satellite locations that follow the same policies and procedures.

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

III. Responsibilities

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

IV. References

DPL14-005 – Facility Site Reviews/Physical Accessibility Reviews
APL15-023 – Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
PL 12-006 - Revised Facility Site Review Tool
Title 24, Part 2 California Building Standards Code, Sections 1133B.4.4 and 1115B-1

POLICY

DHCS/SCFHP Contract, Exhibit A, Attachments 4 , 7 and 9
NCQA 2021 Health Plan Accreditation (HPA) Standards, Credentialing (CR) 7 Element A, Factor 3

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:11/9/2016	
v1	Reviewed	Quality Improvement	Approve: 5/10/2017	
v1	Reviewed	Quality Improvement	Approve: 06/06/2018	
v2				

Business Title

Santa Clara Family Health Plan

Title	Version	Reference #
Physical Access Compliance	3	QI.07

Date Created	Date Submitted
01/13/2022	01/24/2022

Date Approved	Publication Date
01/27/2022	01/27/2022

Next Review Date	Review Interval
01/27/2023	12 month(s)

POLICY

Policy Title:	**Initial Health Assessments (IHAs) and Staying Healthy Assessments (SHA)**	**Policy No.:**	QI.10 v3
Replaces Policy Title (if applicable):	Initial Health Assessments (IHAs) and Behavioral Assessment (HEBA)	**Replaces Policy No. (if applicable):**	HE004_05
Issuing Department:	Quality & Process Improvement	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☐ CMC	

I. Purpose

1. To describe the required completion of the Initial Health Assessments (IHAs) and the Staying Healthy Assessments (SHA).
2. To define the process that Santa Clara Family Health Plan (SCFHP) will oversee to the completion of the IHAs and Staying Healthy Assessment (SHA).

II. Policy

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

III. Responsibilities

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

IV. References

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

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	
V1	Reviewed	Quality Improvement Committee	Approve: 05/10/2017	
V2	Revised	Quality Improvement Committee	Approve 06/06/2018	
V3	Revised			

Business Title

Santa Clara Family Health Plan

Title	Version	Reference #
Initial Health Assessments (IHAs) and Individual Health Education Behavior Assessment (IHEBA)	4	QI.10

Date Created	Date Submitted
01/13/2022	01/17/2022

Date Approved	Publication Date
01/25/2022	01/25/2022

Next Review Date	Review Interval
01/25/2023	12 month(s)

POLICY

Policy Title:	**Disease Surveillance**	**Policy No.:**	QI.14 v1
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

Santa Clara Family Health Plan is required to implement and maintain policies and procedures to ensure contracted network providers are reporting reportable disease or condition to the Department of Public Health as required and outlined by Title 17, California Code of Regulation (CCR) § 2500, §2593, §2641.5-2643.20, and §2800-2812.

II. Policy

Contracted Network Providers are to report reportable disease or condition to public health authorities to help public health agencies monitor several high-threat diseases on an ongoing basis as required by state law. Reporting disease or condition helps public health agencies identify outbreaks before they become epidemics and guide public health decision-making. Providers will report the case to the local health officer for the jurisdiction where the member resides by the required timeframe in accordance with California Code of Regulation (CCR) § 2500, §2593, §2641.5-2643.20, and §2800-2812.

III. Responsibilities

1. Compliance will add Disease Surveillance training in Delegate audit: E.g. Follow-up questions during audit to ensure Provider/Clinic has a policy and procedure for reporting to public health authorities.
2. Quality Improvement Nurse will work with Provider Network Operations to add and update Provider manual.
3. Quality Improvement Nurse will work with Provider Network Operations to add Disease Surveillance in Annual Provider Training Packet, where annually Providers review Disease Surveillance requirements and signs an attestation.

IV. References

1. California Code and Regulation (CCR):
    - Title 17, CCR § 2500, § 2593, § 2641.5-2643.20, §2800-2812
2. DHCS Medi-Cal Contract Exhibit 4, Attachment 4

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Johanna Liu Director, Quality & Process Improvement	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)

Business Title

Santa Clara Family Health Plan

Title	Version	Reference #
Disease Surveillance	2	QI.14

Date Created	Date Submitted
12/09/2021	12/10/2021

Date Approved	Publication Date
12/14/2021	12/14/2021

Next Review Date	Review Interval
12/14/2022	12 month(s)

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. 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. 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 11 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.

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

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Angela Chen, RN Director, Case Management & Behavioral Health Date	Laurie Nakahira, DO Chief Medical Officer 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:	**Nurse Advice Line**	**Policy No.:**	QI.29
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Health Services – Case Management	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒CMC	

I. Purpose

To describe Santa Clara Family Health Plan's (SCFHP) Nurse Advice Line services.

II. Policy

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

Nurse Advice Line summary reports are monitored and reported to the Quality Improvement Committee (QIC) on a quarterly basis.

III. Responsibilities

Health Services provides member follow-up as appropriate. Marketing maintains information regarding the Nurse Advice Line on the SCFHP website. Case Management and Delegation Oversight tracks and monitors the Nurse Advice Line for trends, performance and member satisfaction.

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)

Santa Clara Family Health Plan™

POLICY

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/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	Original	Utilization Management	Approve	7/19/2017
v1	Reviewed	Utilization Management	Approve	1/17/2018
v1	Reviewed	Utilization Management	Approve	1/16/2019
v2	Revised	Quality Improvement		

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 ~~v1~~
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

SantaANTA ClaraLARA CountyOUNTY Health EALTH AuthorityUTHORITY

QUALITY IMPROVEMENT COMMITTEE CHARTER

Purpose

The Quality Improvement Committee (QIC) is created as a standing Committee. Pursuant to the Bylaws, the Governing Board shall establish a QIC to provide expertise to the Santa Clara Family Health Plan (SCFHP) relative to their professional experience. The QIC shall oversee SCFHP's Quality Improvement Program, which is an organization-wide commitment to utilize a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided to all members, including those with special needs. This approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute, and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

Stakeholders Members

Pursuant to the Bylaws, the Governing Board shall establish a QIC to provide expertise to the Health Plan relative to their professional experience. The QIC shall have a sufficient number of members to provide the necessary expertise and to work effectively as a group. The QIC shall include contracted providers from a range of specialties, as well as other representatives from the community, including, but not limited to, representatives from contracted hospitals, Medical Directors from contracted IPAs, non-physician representatives who possess knowledge regarding the initiatives and issues facing the patient and provider community, and representation from the behavioral health community.

All QIC members, including the Chairperson, shall be appointed by the Health Plan's Chief Executive Officer (CEO). All QIC members, including the Chairperson, can serve up to three two-year terms. Additional terms may be appointed at the discretion of the CEO, provided that the member is in compliance with the requirements set forth in this charter.

Appointment and Term Limits

All QIC members, including the Chairperson, shall be appointed by the Health Plan's Chief Executive Officer (CEO). All QIC stakeholders, including the Chairperson, can serve up to three (3) two (2)-year terms. Additional terms may be appointed at the discretion of the CEO, provided that the member is in compliance with the requirements set forth in this Charter.
No person who holds a direct financial interest in an affiliated health care entity is eligible for appointment. QIC members stakeholders shall annually sign a "Confidentiality, Conflict of Interest, and Non-Discrimination Agreement."". Failure to sign the Aagreement, or abide by the terms of the Aagreement, shall result in removal from the Committee.

MeetingMeeting Time and Frequency

DRAFT

Regular meetings of the QIC shall be held ~~scheduled~~ quarterly, from 6:~~3~~00 p.m. to 8:00 p.m. Additional special meetings, or meeting cancellations, may occur as circumstances dictate. Special ad-hoc meetings that require decision(s) between regularly scheduled meetings may be held at any time and place, as ~~may be~~ designated by the Chairperson, the CEO, or a majority of the members of the Committee, in real-time or virtually (through video/web conference), but shall not be conducted through e-mail (NCQA CR2A2). Ad-hoc discussions will be documented and reported in the same manner as regularly scheduled meetings. Committee recommendations and reports shall be regularly and timely reported to the Governing Board.

Attendance

Committee members must attend at least two (2) meetings per year. Attendance may be in person or via teleconferencing. Teleconferencing shall be conducted pursuant to California Government Code section 54953(d). ~~The presence of a majority of the Committee members shall constitute a quorum for the transaction of business.~~
The Committee may invite other individuals, such as members of management, auditors, or other technical experts to attend meetings and provide pertinent information relating to an A~~a~~genda item, as necessary.

Meetings of the QIC shall be open and public, except such meetings or portions thereof that may be held in closed session to the extent permitted by applicable law, pursuant, but not limited to, the Ralph M. Brown Act (Government Code section 54950 *et seq.*) and Section 14087.38.

The Director of Quality Improvement is responsible for notifying members of the dates and times of meetings and for preparing a record of the Committee's meetings.

Quorum

The presence of a majority of the voting stakeholders of the Committee shall constitute a Quorum for the transaction of business.

Minutes

The Minutes of all meetings of the Committee shall be recorded.

Stipend

Per leadership's review

Roles and Responsibilities

The following functions shall be the common, recurring activities of the QIC. These functions ~~goals and objectives below~~ shall serve as a guide, with the understanding that the Committee may carry out additional functions as may be appropriate in light of changing business, regulatory, legal, or other conditions. The QIC also oversees the Utilization Management Committee, Credentialing and Peer Review Committee, the Pharmacy and Therapeutics

Committee, and the Consumer Advisory Board. The Committee is responsible for the review and approval of health services, credentialing, pharmacy, and quality policies. The QIC shall also carry out any other responsibilities delegated to it by the Governing Board from time to time.

Quality Iimprovement Program goals and objectives are to monitor, evaluate, and improve the following elements:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the plan population;
- The important clinical and service issues facing the Medi-Cal and CMC populations relevant to its demographics, high-risks, and disease profiles for both acute and chronic illnesses, and preventive care;
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners;
- The accessibility and availability of appropriate clinical care among a wide ~~and to a~~ network of providers with experience in providing care to the population;
- The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service;
- Member and provider satisfaction, including the timely resolution of complaints and grievances;
- Compliance with regulatory agencies and accreditation standards;
- Compliance with Clinical Practice Guidelines and evidence-based medicine;
- Design, measure, assess, and improve the quality of the organization's governance, management, and support processes;
- Monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers;
- Provide oversight of quality monitors from the contracted facilities to continuously assceess and ensure that the levels of care and service provided satisfactorily meet quality goals.

Santa Clara Family Health Plan™

Quality Improvement Dashboard

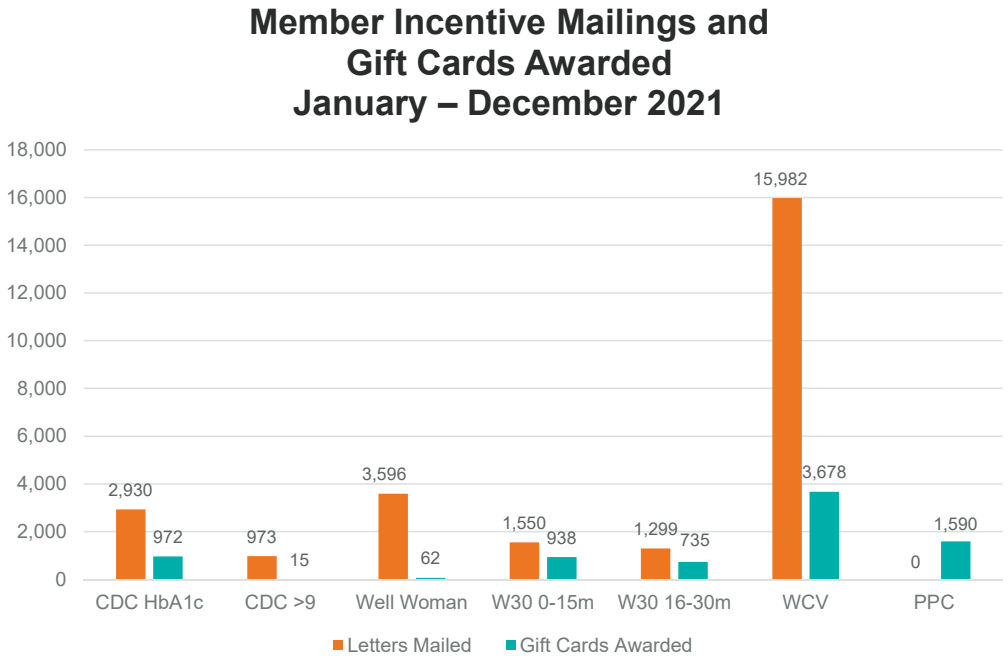
November 2021 – December 2021

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

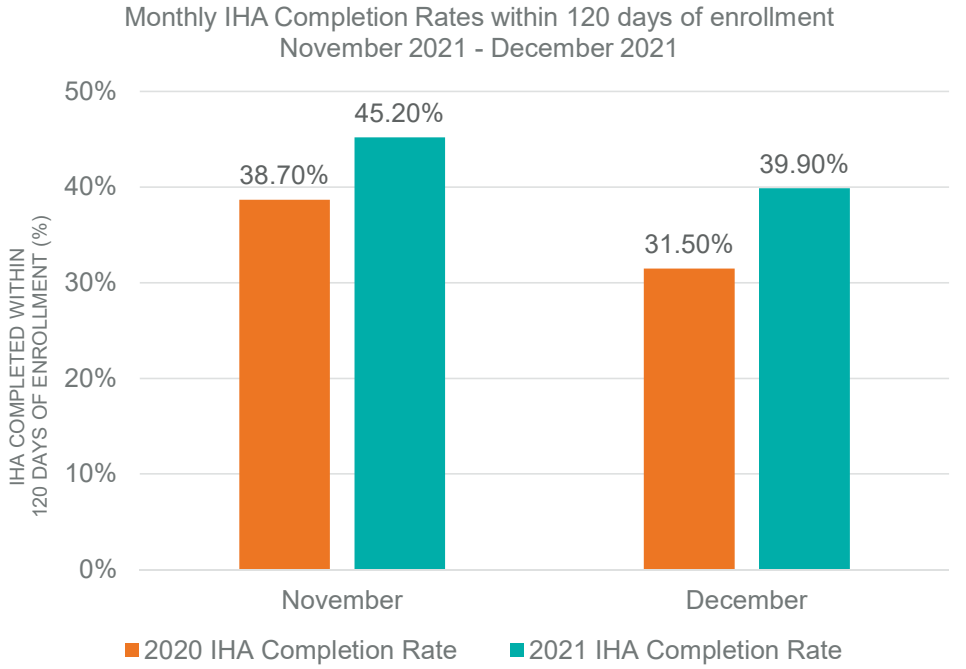
Initial Health Assessment (IHA)

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

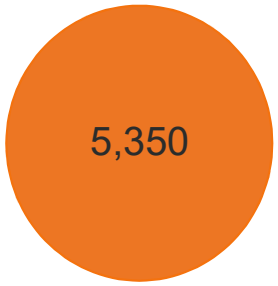
Outreach Call Campaign

Santa Clara Family Health Plan

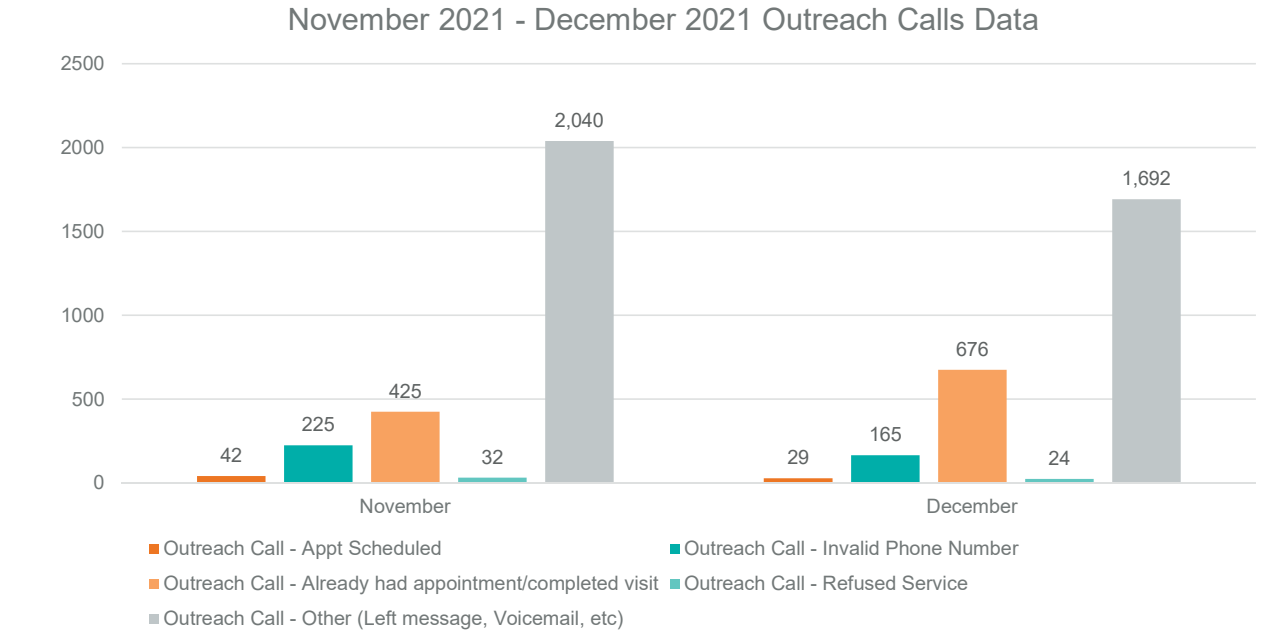
Dedicated outreach call staff conduct calls to members for health education promotion, to help schedule screenings and visits while offering Wellness Rewards

Campaigns completed (November 2021 – December 2021)

Cervical Cancer Screening (CCS)	Breast Cancer Screening (BCS)
Comprehensive Diabetes Care (CDC)	Blood Lead Screening (LSC)
Colorectal Cancer Screening (COL)	Prenatal Visit (PPC)
Engaged in Healthcare & Annual Wellness Visit	Chlamydia Screening (Ages 21 – 24 Only)
Well-Child Visit (W30)	Well-Visit – Adolescent (WCV)



Total number of attempted outreach in November 2021- December 2021



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

Health Homes Program (HHP)

Santa Clara Family Health Plan

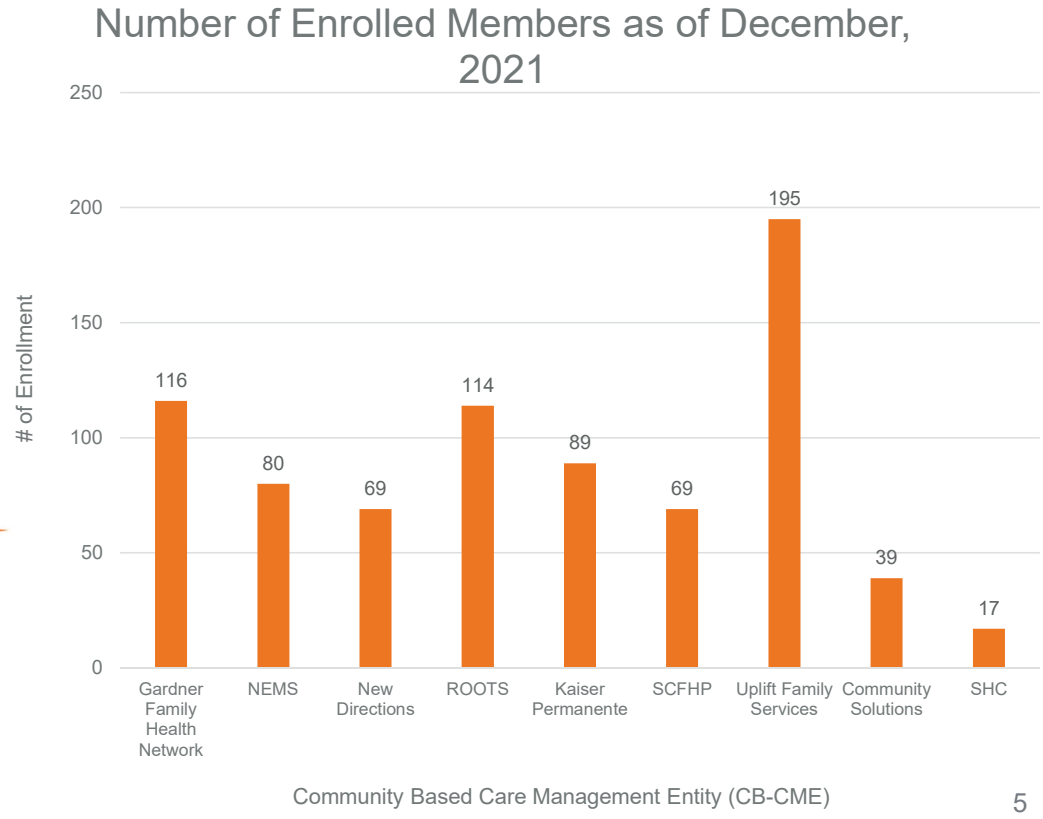
HHP launched with Community Based Care Management Entities (CB-CMEs) on July 1, 2019 for Chronic Conditions and on January 1, 2020 for Serious Mental Illness

What is the Health Homes Program?

HHP is designed to coordinate care for Medi-Cal beneficiaries with chronic conditions and/or substance use disorders

788

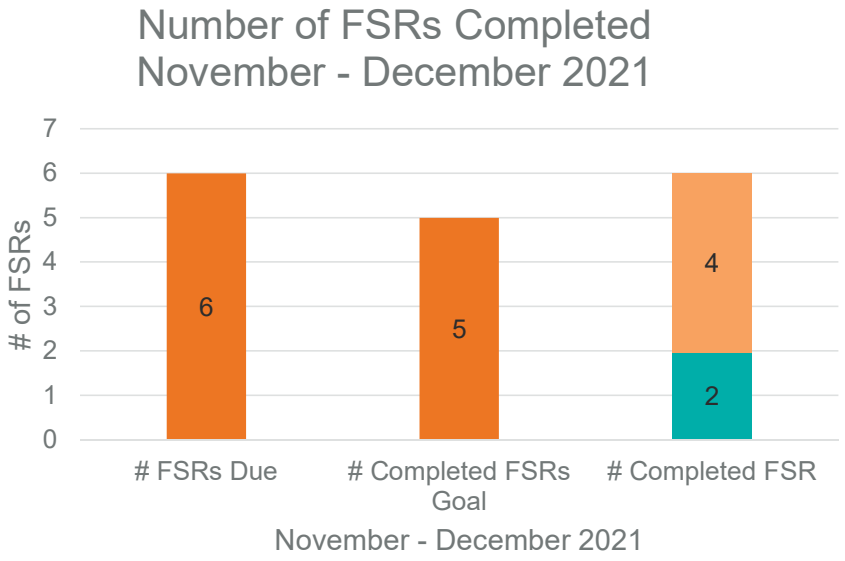
Members have verbally consented into Health Homes as of December 31, 2021



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	2
# Initial FSRs Completed	4

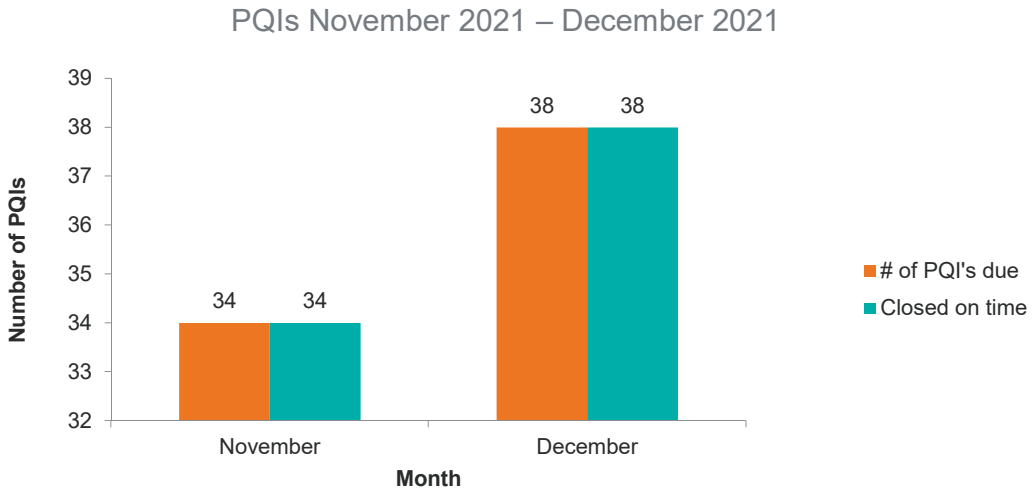
Potential Quality of Care Issues

Santa Clara Family Health Plan

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

100%

Percentage of PQIs due from November 2021 - December 2021 closed on time within 90* days



PQI Levels: November – December 2021
Level 2: 5 Cases
Level 3: 3 Cases
Level 4: 0 Case

Network	Case Identified Level 2	Case Identified Level 3	Case Identified Level 4
Direct SCFHP	1	1	0
VHP Network	3	2	0
Palo Alto Medical Foundation	0	0	0
Physicians Medical Group	1	0	0
Premier Care	0	0	0

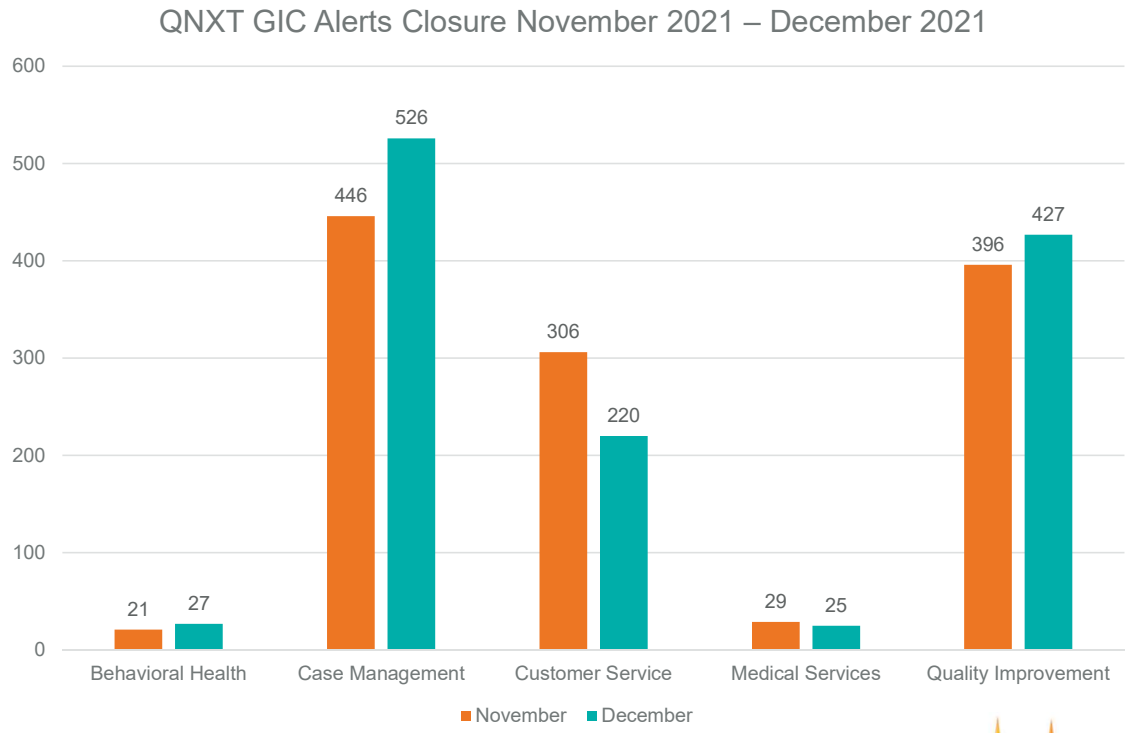
QNXT Gaps In Care Alerts

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.

Total number of QXNT GIC alerts terminated in November – December 2021



Compliance Activity Report

February 8, 2022

- **Compliance Program Effectiveness (CPE) Audit**
  CMS requires Medicare plans to have an independent review of the effectiveness of its compliance program each year. In collaboration with Health Plan Alliance, SCFHP partnered with Piedmont Community Health Plan (Piedmont) to conduct peer-review audits of our respective compliance programs to meet CMS's CPE requirement for CY 2021. The audit process is based on recently approved Medicare Part C and D Program Audit Protocols which CMS will begin using for 2022 program audits. SCFHP received results from Piedmont in January and is working to address a few findings related to Production Services and Provider Network Operations.

- **Department of Health Care Services (DHCS) Annual Audit**
  The Plan recently received notice for the annual 2022 DHCS audit, which will take place between March 7 and March 18, covering a review period of March 2021 through February 2022. Compliance has submitted all information requested by DHCS from internal operations and delegates. Unlike previous DHCS audits, which covered only the Medi-Cal line of business, this audit will cover both Medi-Cal and Cal MediConnect.

- **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. We expect DMHC to begin requesting documents starting in March.

- **Performance Measure Validation**
  The Plan was selected by CMS's external quality review organization to participate in the 2021 performance measure validation audit. The audit focused on 2020 reporting of data sets used to demonstrate compliance with two Cal MediConnect requirements: members with an initial health risk assessment and members with an initial care plan completed within 90 days of enrollment. A review session took place on August 19 and the Plan recently received a final report in December indicating that both data sets were deemed "reportable," meaning the data were valid compliant with CMS specifications.

Consumer Advisory Board

Draft Meeting Minutes

December 2, 2021

Regular Meeting of the

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

Thursday, December 2, 2021 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
Laura Watkins, Vice-President, Marketing and Enrollment
Chelsea Byom, Vice-President, Marketing, Communications, and Outreach
Tanya Nguyen, Director, Customer Service
Lucille Baxter, Manager, Quality and Health Education
Mike Gonzalez, Director, Community Engagement
Cristina Hernandez, Manager, Marketing and Public Relations
Thien Ly, Director, MediCare Outreach
Jocelyn Ma, Manager, Community Outreach
Amber Tran, Process Improvement Project Manager
Lynette Topacio, Marketing Project Manager
Amy O'Brien, Administrative Assistant

DRAFT

1. **Roll Call**

   Dr. Laurie Nakahira, DO, Chief Medical Officer, and Chair called the meeting to order at 11:35 a.m., and roll call was taken. There was no quorum.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The minutes of the September 2, 2021 Cal MediConnect (CMC) Consumer Advisory Board Committee meeting were reviewed. Dr. Nakahira pointed out that she has one minor correction to the minutes. For item #8, the contract for the CMC line of business is not yet complete and is still in process.

4. **Health Plan Update**

   Dr. Nakahira presented the Health Plan update. Dr. Nakahira began with an update on the National Committee for Quality Assurance (NCQA) re-accreditation for the Plan's CMC line of business. The accreditation period will run from January 31, 2022 through February 1, 2022, and the purpose is to ensure the Plan has appropriate quality measures in place. In addition, the Department of Health Care Services

(DHCS) audit will occur in March 2022. This is an annual audit. The audit will be conducted onsite over a 2 week period.

Mr. Pathak asked for an update on any changes to members' benefits for 2022. Dr. Nakahira responded that this topic will be discussed today by Thien Ly, Director, Medicare Outreach, as part of the update on CMC Benefits Changes for 2022.

5. COVID-19 Update

a. Vaccination Outreach and Vaccination Rate

Amber Tran, Process Improvement Project Manager, discussed the Plan's vaccination outreach efforts. She presented a summary of the current vaccination rates for our members. Approximately 68% of the Plan's total members are fully vaccinated, with 2% partially vaccinated, and 30% unvaccinated. By comparison, Ms. Tran explained that approximately 90% of Santa Clara County residents who are 12 and over are fully vaccinated.

Ms. Tran continued with an overview of the Plan's Member Outreach campaign efforts to increase vaccination rates, including the Plan's vaccine rewards program. Additional member outreach activities include vaccine events at the Blanca Alvarado Community Resource Center (CRC), with a one-stop-shop, and 'Ask the Doctor' services offered during various SCFHP-sponsored events. The 'Ask the Doctor' services are staffed by our medical directors and pharmacists who are available to answer questions and discuss any concerns about COVID and the vaccines. SCFHP has also partnered with various community organizations, such as Catholic charities, to establish trusted community messengers who can help strengthen the message of the importance of vaccination.

Mr. Pathak asked if SCFHP offers in-home vaccination services to our members. Ms. Tran replied that SCFHP does not offer these services; however, as a result of our partnership with Santa Clara County, the County will provide in-home vaccination services to homebound residents.

Mr. Pathak asked for an update on the new Omicron variant. Dr. Nakahira replied that, at this time, there is very little information available on this new strain. Dr. Nakahira advised that there is currently 1 case reported in San Francisco. The current recommendations are to get a booster shot. Research is being conducted as to how the vaccines will fight against this, and additional, variants.

b. Vaccination Availability and Boosters

Dr. Nakahira provided an update on vaccine availability and eligibility. Booster shots are now available for anyone 18 years of age and over. You can receive either the Pfizer, Moderna, or the J&J booster shot, as long as your booster occurs 6 months after your 2nd dose of the Pfizer or Moderna vaccine, or 2 months after your J&J vaccine. Booster shots of either the Pfizer, Moderna, or J&J vaccines can be administered, and are not dependent upon the brand of vaccine you received during your 1st vaccine series.

Our SCFHP provider network contains a list of which primary care physicians offer vaccinations, as well as additional vaccination locations and the names of the pharmacies where vaccinations are available.

6. Update on Cal MediConnect Benefits Changes for 2022

Thien Ly gave an overview of the upcoming CMC Benefits Changes for calendar year 2022. There is a minor change to the Hearing services benefit specific to the replacement of hearing aids that are lost, stolen, or severely damaged beyond the member's control. Replacement under these conditions is no longer included in the $1,510.00 maximum coverage amount. Prior authorization may now be required. In addition, the MSSP is no longer a covered benefit; and will be carved-out to the Medi-Cal (MC) program.

Mr. Ly also discussed changes to Part D coverage pertaining to catastrophic coverage, and increases to Tier 2 brand name drugs copays.

Mr. Pathak asked if it is possible to waive the 3 days advance notice that is required to arrange transportation to and from appointments. Mr. Ly replied that the Plan does need 3 days advance notice to arrange for transportation. Mr. Ly advised that members should still call Customer Service regarding upcoming

appointments that are less than 3 days away, and Customer Service will do everything possible to assist with transportation to and from appointments.

Mr. Pathak asked if the Plan will increase the number of covered acupuncture appointments per year. Mr. Ly replied that members are currently eligible for 2 acupuncture appointments per month. Members who require additional appointments can submit a prior authorization for approval. Mr. Pathak responded that seniors need more than 24 yearly acupuncture appointments to assist with pain management. Mr. Ly responded that prior authorization requests for additional acupuncture appointments will be reviewed and approved on the basis of medical necessity.

7. Standing Items

a. Community Resource Center

Mike Gonzalez, Director, Community Engagement, presented the Committee with an update on the recent activities at the Center. Mr. Gonzalez introduced the new Supervisor of the CRC, Trinh Nguyen. Mr. Nguyen began in October 2021, and his background includes extensive prior experience with supervising and developing programming for community centers, with a particular emphasis on senior programming. Mr. Gonzalez advised that there are currently Medicare Outreach team members working at the CRC, and the plan is to also staff the center with Customer Service Representatives and Case Management representatives. Mr. Gonzalez highlighted the current and upcoming programming schedule, including monthly Open Houses. COVID-19 safety protocols remain in place.

Mr. Gonzalez discussed the impact the CRC has already had on the community. He shared the number of monthly visitors from July 2021 through October 2021. Though the CRC's doors continued to remain locked until November 8, 2021 due to COVID, no residents who knocked on the door were turned away. The CRC has also provided many services regarding Covered California and MC application assistance, along with resource navigation regarding food, housing, healthcare, and COVID-19. These numbers are expected to grow now that the CRC is fully open. Mr. Gonzalez also shared the monthly calendar of activities, including Dia de Los Muertos, for November 2021.

Mr. Gonzalez highlighted the elements and strategies of the community-led CRC Planning Process and the process roadmap. This planning process included a community survey targeted to residents within 6 specific zip codes in East San Jose. There was a great response to the survey, with 770 respondents, all with valuable feedback on their vision of the CRC's purpose. A special thanks goes to our CRC Resident Advisory group who play a major role in developing the CRC, with their grassroots approach to community-led engagement. The next Open House is on Saturday, December 18, 2021 from 10:00 a.m. to 2:00 p.m., and includes a staff meet-and-greet, a tour, an overview of programs and services, and a Health Fair.

Mr. Pathak shared that he has received good feedback from residents on the programs and services on offer. Mr. Pathak asked if there are any future plans to provide medical services at the Center. Mr. Gonzalez replied that the Center is not a medical clinic; however, medical staff may be invited to provide community services such as flu shots or other vaccines. Dr. Nakahira added that there are currently no plans to provide medical care at the Center, but there will be an emphasis on health education. Mr. Gonzalez also added that all residents are encouraged to take advantage of opportunities to connect with onsite Case Managers. As always, the Plan welcomes feedback from all members.

b. Member Communications

Chelsea Byom, Director, Marketing, Communications, and Outreach gave an overview of the member communications completed since the September 2021 meeting. Ms. Byom discussed the 2022 Annual Member Mailing which included the CMC Annual Notice of Changes for the upcoming plan year. Ms. Byom reminded the committee that, during open enrollment, members with no changes to their current coverage will continue their same coverage through 2022. Member communications included the fall newsletter, with a large feature on our Reddit blog pertaining to the CRC. Ms. Byom highlighted the SCFHP website which is updated with meeting

materials, 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 as of September 2, 2021.

c. Health Education Overview

Ms. Tran gave an overview of the Plan's flu campaign. Events include a flu reminder incentive raffle. Members can use our flu shot locator tool to help them find the nearest locations where they can receive their flu shot. The member newsletter and the Plan's website also include free health education information on the flu.

d. Cal MediConnect Ombudsman Program Update

Andy Le, Ombudsperson and Supervising Staff Attorney for Bay Area Legal Aid, gave an update on changes to the CMC plan and Medicare/Medi-Cal (Medi-Medi) plans since the September 2021 meeting. The CMC redeterminations process has begun, and Bay Area Legal Aid has received calls from many individuals who were disenrolled due to share of cost and are trying to spend down their income and assets to continue to qualify for free MC. Mr. Le encouraged the committee to refer their friends and neighbors to Bay Area Legal Aid for assistance.

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. Adults who wish to take advantage of this benefit must meet all financial eligibility requirements. In addition, as of July 1, 2022, the state will raise the asset limit for non-MC programs to $130,000.00 per person, with $65,000.00 for each additional person, up to a maximum of 10 individuals. This is part of the asset limitation elimination process. The state foresees an expansion of MC eligibility, with the intent to guard against loss of MediCare eligibility in the future.

e. Future Agenda Items

Dr. Nakahira solicited ideas for future topics. Mr. Pathak took this opportunity to express his gratitude for the CAB committee and for the wonderful service provided by SCFHP. Dr. Nakahira thanked Mr. Pathak, and she also thanked her staff for all their hard work and dedication throughout the year.

8. Adjournment

The meeting adjourned at 12:35 p.m. The next Cal MediConnect Consumer Advisory Board meeting is scheduled for Thursday, March 3, 2022 at 11:30 a.m.

_____ _____

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

Pharmacy & Therapuetics Committee

Draft Meeting Minutes

December 16, 2021

Regular Meeting of the

Santa Clara County Health Authority

Pharmacy & Therapeutics Committee

Thursday, December 16, 2021, 6:00 PM – 8:00 PM

Santa Clara Family Health Plan

6201 San Ignacio Ave, San Jose, CA 95119

Minutes (Open) - Draft

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
Judy Ngo, PharmD
Peter Nguyen, DO
Jesse Parashar-Rokicki, MD

Members Absent
Dolly Goel, MD

Staff Present
Duyen Nguyen, PharmD, Clinical Pharmacist
Tami Otomo, PharmD, Clinical Pharmacist
Nancy Aguirre, Administrative Assistant

Others Present
Amy McCarty, PharmD, MedImpact

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 3Q2021 P&T Committee open meeting minutes were reviewed.

It was moved, seconded and the open minutes of the 3Q2021 P&T meeting minutes were **unanimously approved.**

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

4. Standing Agenda Items

a. Chief Medical Officer Health Plan Updates

Laurie Nakahira, DO, Chief Medical Officer (CMO), presented the CMO Health Plan Updates. Dr. Nakahira reported the current Plan membership is approximately 286,552 members, reflecting a 9.1% increase over the last year, September 2020. This increase is largely attributable to a hold on disenrollment of Medi-Cal members. When the Department of Health Care Services (DHCS) reactivates disenrollment, there will likely be a decrease in membership.

Dr. Nakahira announced the National Committee for Quality Assurance (NCQA) Cal MediConnect (CMC) Resurvey is coming up on January 31, 2022 to February 2, 2022. In addition, CalAIM, Enhanced Care Management (ECM), and In Lieu of Services (ILOS) will begin on January 1, 2022.

Currently, the Plan has placed a hold on returning to office due to concerns about the COVID-19 delta variant. All committee meetings will continue to be held via teleconference.

DHCS has initiated a COVID incentive program to address vaccine disparities. Out of SCFHP's Medi-Cal (MC) membership, approximately 56.9% are fully vaccinated and 5.7% are partially vaccinated. Out of SCFHP's CMC membership, approximately 75.8% are fully vaccinated and 4.5% are partially vaccinated. SCFHP will be participating in this incentive program to aid in closing gaps by offering MC members and providers incentives, partnering with community leaders, and conducting outreach to vulnerable populations. SCFHP will also be hosting COVID vaccine administration events at the Community Resource Center (CRC).

Dr. Nakahira noted that the CRC will be doing an opening kick-off on October 2, 2021.

Judy Ngo joined the meeting at 6:12p.m.

b. Grievance & Appeals 2Q 2021 and 3Q 2021 Pharmacy Reports

Mauro Oliveira, Manager, Grievance and Appeals, presented the Grievance & Appeals (G&A) 2Q 2021 and 3Q 2021 Pharmacy records.

c. Medi-Cal Rx Update

Tami Otomo, PharmD, Clinical Pharmacist, noted the Medi-Cal Rx Carve Out will be implemented on January 1, 2022. Starting on this date, the pharmacy benefit for MC members will be carved back into the state. SCFHP will be identifying members who may require more assistance during this transition and work with pharmacy partners to ease the transition. DHCS will send a 60-day notice to members, and the Plan will send a 30-day notice to members. The Plan is also working on updating member and provider material and will be conducting additional provider communication. Provider training and portal enrollment is available on the Medi-Cal Rx website.

d. Policy Review – PH.12 Drug Management Program

Dang Huynh, PharmD, Director, Pharmacy and Utilization Management, presented the updates to the PH.12 Drug Management Program.

e. Plan/Global Medi-Cal Drug Use Review

i. Drug Utilization Evaluation Update

Dr. Otomo shared the results from SCFHP's quarterly retrospective Drug Use Evaluation (DUE) program. For Q3 2021, the focus was Asthma for both lines of business. This program identified members receiving four or more prescriptions for an asthma medication over a 12-month period and are not on a controller medication. For MC, there were 662 impacted members, and 324 providers were mailed letters on August 18, 2021. For CMC, there were 88 impacted members, and 68 providers were emailed letters on August 18, 2021.

f. Emergency Supply Report – 3Q 2020, 4Q 2020

DRAFT

Adjourned to Closed Session at 6:21p.m.
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5. Closed Meeting Minutes

The 3Q2021 P&T Committee closed meeting minutes were reviewed.

It was moved, seconded and the closed minutes of the 3Q2021 P&T meeting minutes were **unanimously approved**.

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

6. Metrics and Financial Updates

a. Membership Report
The Membership Report was presented by Dr. Nakahira during the CMO Update.

b. Pharmacy Dashboard
Dr. Otomo reviewed the Pharmacy Dashboard.

c. Drug Utilization & Spend – 3Q 2021
Amy McCarty, PharmD, MedImpact, presented the Drug Utilization and Spend for 3Q 2021.

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

a. Pharmacy Benefit Manager 3Q 2021 P&T Minutes
Dr. McCarty referenced the Pharmacy Benefit Manager 3Q 2021 P&T Minutes included in the meeting packet.

b. Pharmacy Benefit Manager 4Q 2021 P&T Part D Actions
Dr. McCarty reviewed the Pharmacy Benefit Manager 4Q 2021 P&T Part D Actions.

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

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

c. 2022 Medical Benefit Drug Prior Authorization Grid
Dr. Otomo reviewed the 2022 Medical Benefit Drug PA Grid for CMC.

It was moved, seconded and the **2022 Medical Benefit Drug PA Grid** was **unanimously approved**.

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

8. Discussion and Recommendations for Changes to SCFHP's Medi-Cal Formulary & Prior Authorization Criteria

a. Old Business/Follow-Up
- **i. PCSK9 Inhibitors**
- **ii. Trijardy XR**

b. Formulary Modifications

DRAFT

Dr. Otomo presented the changes made to the Medi-Cal formulary since the last P&T Committee meeting.

It was moved, seconded and the Formulary Modification were **unanimously approved**.

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

c. Fee-for-Service Contract Drug List Comparability
Dr. McCarty reviewed the Fee-for-Service (FFS) Contract Drug List (CDL) Comparability for MC.

It was moved, seconded and the FFS Contract Drug List Comparability was **unanimously approved**.

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

d. 2022 Medical Benefit Drug Prior Authorization Grid
Dr. Otomo reviewed the 2022 Medical Benefit Drug PA Grid for Medi-Cal.

It was moved, seconded and the **2022 Medical Benefit Drug PA Grid** was **unanimously approved**.

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

e. Prior Authorization Criteria
Dr. Nguyen reviewed the PA Criteria.

g. <u>New or Revised Criteria</u>

1. Stromectol – *new criteria*
2. Zeposia – *new criteria*

h. <u>Annual Review</u>

1. Non-formulary – *no changes*
2. Norditropin Flexpro – *no changes*
3. Protopic Ointment – *no changes*
4. Zarxio – *no changes*

It was moved, seconded and the PA Criteria Recommendations were **unanimously approved.**

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

9. New Drugs and Class Reviews

a. COVID-19 Updates
Dr. McCarty reviewed the COVID-19 updates.

b. Inhaled tobramycin
Dr. McCarty reviewed Inhaled Tobramycin.

c. Dificid
Dr. McCarty reviewed Dificid.

d. New and Expanded Indications – Nucala, Facenra, Xywav

DRAFT

Dr. McCarty reviewed Nucala, Facenra, and Xywav.

e. New Entities, Derivatives & Formulations – Tyrvaya, Myrbetriq granules, Trudhesa
Dr. McCarty reviewed Tyrvaya, Myrbetriq granules, and Trudhesa.

f. Informational only:

i. Myelofibrosis – pacritinib
ii. Presbyopia – Presbysol
iii. Acute agitation – dexmedetomidine
iv. Pulmonary hypertension
v. Weight loss agents
vi. Continuous glucose monitors
vii. Drugs: Pennsaid, Santyl, Kuvan, Upneeq,Cosentyx, omidenepag, isopropyl, maribavir, daridorexant, tezepelumad

It was moved, seconded and the recommendations for New Drugs and Class Reviews were **unanimously approved.**

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

Reconvene in Open Session at 7:51 p.m.

10. Discussion Items

a. New and Generic Pipeline
Dr. McCarty reviewed the New and Generic Pipeline. There were no notable new or generic drugs.

11. Adjournment
The meeting adjourned at p.m. The next P&T Committee meeting will be on Thursday, March 17, 2022.

_____ _____
Jimmy Lin, MD, Chair Date

DRAFT

Utilization Management Committee

Draft Meeting Minutes

January 19, 2022

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, January 19, 2022, 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

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

Members Absent
Habib Tobbagi, PCP, Nephrology
Dung Van Cai, D.O., OB/GYN

Staff Present
Christine Tomcala, Chief Executive Officer
Lily Boris, M.D., Medical Director
Natalie McKelvey, Manager, Behavioral Health
Luis Perez, Supervisor, Utilization Management
Ashley Kerner, Manager, Administrative Services
Amy O'Brien, Administrative Assistant

Note: Items were discussed in a different order than as shown on the agenda.

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:08 p.m. Roll call was taken and a quorum was not established. Ashley Kerner, Manager, Administrative Services, introduced herself to the committee members.

2. Public Comment

There were no public comments.

3. Chief Executive Officer Update

Christine Tomcala, Chief Executive Officer, presented an update on 2 new programs which took effect on January 1, 2022. Ms. Tomcala began with the status of the CalAIM Medi-Cal (MC) reform program. The rollout of Enhanced Case Management (ECM) and community supports programs will continue over the next several years. Ms. Tomcala acknowledged the hard work of the UM team as they prepare for the implementation of these new programs. So far, the transition is going well. Ms. Tomcala also gave an update on the MC Rx program. This transition has been more of a challenge with reported long wait times for members trying to contact Magellan, the prescription provider.

Ms. Tomcala also gave an update on COVID. Due to the Omicron variant, the public health emergency has been extended. The SCFHP main office is not officially open yet; however, the Blanca Alvarado Community Resource Center is open to the public. SCFHP's efforts to increase members' vaccination rates continue.

Dr. Lin asked for the vaccination rate of SCFHP staff. Ms. Tomcala replied that approximately 90% of SCFHP staff are vaccinated. Dr. Lin remarked that the majority of patients hospitalized with COVID are unvaccinated. Ms. Tomcala concurred and stated that vaccination helps relieve some of the more severe symptoms, in

addition to keeping people out of the hospital. Dr. Lin also noted that COVID treatment options are better now than when the pandemic started and Ms. Tomcala agreed. She also discussed the possibility that a 4th booster shot may be necessary.

4. Chief Medical Officer Update

a. General Update

Dr. Laurie Nakahira, Chief Medical Officer, began with an update on the rollout of the Medi-Cal Rx program. Members did experience extended wait times when trying to reach Magellan regarding their prescriptions. Fortunately, the UM/Pharmacy team has a back line to Magellan to help members connect and receive their prescriptions. A Magellan representative reached out to the UM department regarding prior authorizations for controlled substances. These prior authorizations may require resubmission. The UM team was not previously aware of this requirement, and they are in the process of confirming this expectation in order to notify our provider network.

Dr. Nakahira advised the committee that the Plan is currently preparing for the National Committee for Quality Assurance (NCQA) reaccreditation audit for our Cal MediConnect (CMC) line of business. The onsite portion of the audit runs from January 31, 2022 through February 1, 2022. The Department of Health Care Services (DHCS) audit occurs mid-March of 2022, and will take place over a 2 week period.

Dr. Nakahira also discussed the student behavioral health incentive program. Over the next 3 years, the Plan will partner with the County Office of Education, Anthem, and the County Behavioral Health Department to work with the school districts to develop programs to support students' behavioral health. The Plan has received money to help implement these new incentive programs throughout the school districts.

Dr. Lin discussed the fact that the Medi-Cal Rx program will not accept any handwritten prescriptions for narcotics. Dr. Lin was dismayed to find out that it is actually all prescriptions that must be submitted via e-prescribe. Dr. Nakahira confirmed that, prior to the Medi-Cal Rx rollout, the medical board sent email notifications to all individual providers to notify them of this change.

b. Annual Confidentiality Agreements

Dr. Nakahira reminded the committee to promptly sign and return the Annual Confidentiality Agreement to Amy O'Brien.

5. Old Business Update

a. COVID-19 Reporting

Dr. Boris gave an update on the number of COVID-related deaths within the Plan's member populations for 2020, 2021, and 2022.

6. Reports

a. Membership

Dr. Boris gave a brief summary of the Membership Report from January 2021 through January 2022. Our CMC membership continues to grow with 10,219 members as of January 2022. Due to changes in CMC eligibility requirements, approximately 200 members were dis-enrolled as of January 1, 2022. The Plan's total MC membership is 284,439 members, an increase of approximately 21,346 members. The majority of these members are with Valley Health Plan. The Plan's direct membership includes 18,367 members. The Plan also manages the Admin. MC only and Admin. Medicare primary groups. NEMS is a new network provider group which began in October of 2021.

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

Dr. Boris presented the Committee with the UM goals and objectives, as well as our Over/Under Utilization and Standard UM Metrics. Dr. Boris advised that these metrics cover the period from January 1, 2021 through December 31, 2021. Dr. Boris gave a summary of the data for the Plan's MC SPD line of business.

The number of discharges per thousand is 14.32, with an average length of stay of 5.36 days. There does not appear to be a significant increase due to COVID. Dr. Boris continued with a summary of the data for the Plan's MC non-SPD line of business. The number of discharges per thousand is 3.91, with an average length of stay of 4.32 days. This population does not include our seniors or persons with disabilities.

Dr. Boris then gave a summary of the data for the Plan's CMC line of business. The number of discharges per thousand is 19.14, with an average length of stay of 5.82 days. This line of business includes the Plan's more high risk population.

Dr. Boris continued with a comparison of the inpatient utilization rates for the Plan's MC non-SPD and SPD populations. Dr. Boris also summarized the inpatient readmissions rates for the MC line of business. MC readmissions rates are monitored closely, as per Medicare performance standards and the SCFHP goal to reduce the likelihood of patient treatment errors and morbidity and mortality rates. Dr. Lin remarked that the 10% readmission rate for our CMC population is not out of line, however, he wants to know why the younger MC population readmission rate is so high. Dr. Boris explained that the MC program covers members in the 18-64 age group but, for the purposes of this report, the younger members have been omitted. Dr. Boris advised Dr. Lin that the number of chronic illnesses within the MC-SPD population is higher than you think. Ms. Tomcala asked if this presentation includes the HEDIS benchmarks. Dr. Boris replied that they were inadvertently left out of this presentation.

Dr. Vemuri joined the meeting at 6:27 p.m.

Dr. Boris continued with an overview of the ADHD MC BH metrics. The 2021 rankings for the Initiation Phase and Continuation Phase are not yet finalized. For purposes of the NCQA standards, the UM department prefers these fall within the 50th percentile. Dr. Boris discussed the UM department's ranking for cardiovascular monitoring of people with cardiovascular disease and schizophrenia. As always, it is a challenge to achieve more than a 10th percentile ranking. Dr. Lin remarked that he would expect a higher number of patients in this category would be more diligent in taking their medications. Dr. Boris explained that, due to their behavioral health diagnosis, they are at higher risk for cardiovascular disease. Dr. Alkoraishi added that it is a Food and Drug Administration (FDA) requirement that patients in this category have a lipid blood panel and fasting blood sugar every 6 months. Dr. Boris advised she will research the NCQA requirements and bring the results to the April 2022 meeting.

Dr. Dinh joined the meeting at 6:34 p.m.

7. Meeting Minutes

The minutes of the October 20, 2021 Utilization Management Committee (UMC) meeting were reviewed. Dr. Lin noted a correction to Dr. Dinh's specialty. Dr. Dinh is a head and neck specialist, rather than an OB/GYN as is currently shown. Dr. Boris confirmed that the minutes will be edited to reflect this change.

It was moved, seconded, and the minutes of the October 20, 2021 UMC meeting were **unanimously approved** with the change noted.

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

8. UM Program Description - 2022

Dr. Boris presented an overview of the UM Program Description for 2022. Dr. Boris advised this program description is a mandatory requirement for all of the Plan's regulators. Dr. Boris highlighted any significant changes, such as on page 11, item e) Pharmacy Director, and an internal error on page 22, E. Transplants, and the verbiage 'Renal and corneal transplants are excluded from SCFHP review' which will be stricken from the Program Description.

It was moved, seconded, and the UM Program Description - 2022 was **unanimously approved** with the change as noted.

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

9. BHT Program Description - 2022

Natalie McKelvey, Manager, Behavioral Health, presented an overview of the BHT Program Description – 2022. This program description is an NCQA requirement and includes an update to some of the codes. There has been no update to the criteria for the treatment plan or goals. Ms. McKelvey highlighted the changes to the codes for H0032 – Supervision (Direct) and H0032 – Supervision (Indirect).

Dr. Vemuri asked if, as a Pediatrician, she is authorized to make a diagnosis of autism. Ms. McKelvey advised that a pediatrician is authorized to make this diagnosis, and to address specific behaviors that may lead to a diagnosis of autism. Dr. Vemuri advised she has made this diagnosis in the past and it has been denied because she is not a psychologist. Ms. McKelvey suggested she address specific behaviors in her referral that would lead to a recommendation of ABA therapy. Ms. McKelvey will reach out to Dr. Vemuri outside of this meeting to further discuss. Dr. Alkoraishi suggested Dr. Vemuri consult the DSM V or ICD-10 codes. Dr. Boris advised that the UM team will review and target their reporting to search for ABA therapy denials for children and confirm they are SCFHP members and should receive ABA therapy.

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

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

10. Annual Review of UM Policies

a. HS. 01 Prior Authorization
b. HS. 02 Medical Necessity Criteria
c. HS.03 Appropriate Use of Professionals
d. HS.04 Denial of Services Notification
e. HS.05 Evaluation of New Technology
f. HS.06 Emergency Services
g. HS.07 Long-Term Care Utilization Review
h. HS.08 Second Opinion
i. HS.09 Inter-Rater Reliability
j. HS.10 Financial Incentive
k. HS.11 Informed Consent
l. HS.12 Preventive Health Guidelines
m. HS.13 Transportation Services
n. HS.14 System Controls

Dr. Boris presented the Committee with the annual review of UM Policies. Dr. Boris summarized the purpose of these policies. There were no changes to these policies since the January 2021 meeting.

It was moved, seconded, and the Annual Review of UM Policies was **unanimously approved**.

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

11. Care Coordinator Guidelines

a. Review of New Care Coordinator Guidelines

Luis Perez, Supervisor, Utilization Management, presented the committee with an overview of the new care coordinator guidelines. Dr. Lin asked how many of our members are in long-term care. Dr. Boris replied that she will research this information and bring the results to the April 2022 meeting. Dr. Boris believes the number is stable since our October 2021 meeting.

Mr. Perez continued his presentation. Dr. Lin asked for clarification of the guidelines for hospice room and board for non-contracted providers. Dr. Boris advised that these guidelines are specific to hospice care conducted within a Skilled Nursing Facility (SNF), which is a rare circumstance.

b. Community Based Adult Services (CBAS)

Mr. Perez gave an update on CBAS. Dr. Lin asked if CBAS was once run by the County, and Dr. Boris replied that, prior to 2015, management of this benefit was transferred to SCFHP. Dr. Boris and Mr. Perez agreed that there were no changes to the Care Coordinator Guidelines specific to CBAS.

It was moved, seconded, and the Care Coordinator Guidelines were **unanimously approved.**

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

12. Reports

c. Dashboard Metrics

- Turn-Around Time – Q4 2021

Mr. Perez summarized the CMC Turn-Around Time metrics for Q4 2021. The turn-around times in almost all categories are compliant at 98.4% or better, with many categories at 100%. In the category of Part B Drugs Expedited Prior Authorization Requests, Q4 2021 fell short at 92%. Mr. Perez continued with a summarization of the MC Turn-Around Time metrics for Q4 2021. The turn-around times in the majority of MC categories are compliant at 98.0%, with many categories at 100%.

Dr. Vemuri left the meeting at 6:40 p.m.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q4 2021

Dr. Boris summarized the data from the Q4 2021 CMC Quarterly Referral Tracking reports for the Committee. Dr. Boris explained the purpose of the quarterly referral tracking reports. At the end of the year, the Plan analyzes the members who did not receive authorized services to determine why those services were not rendered. This is a requirement of the DHCS. Dr. Boris explained that these numbers are affected by claims lag times.

Dr. Boris continued and summarized the data from the Q4 2021 MC Quarterly Referral Tracking report. Dr. Boris reiterated that these numbers are affected by the expected claims lag times. Dr. Lin and Dr. Boris agreed that many services were likely not rendered due to COVID.

e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q4 2021

Dr. Boris presented the results of the Q4 2021 Quality Monitoring of Plan Authorizations and Denial Letters from October 1, 2021 through December 31, 2021. Dr. Boris reported that the UM department received a 100% score in all categories. All findings are reviewed on a quarterly basis, with oversight by the Plan's medical directors. The Plan also continues to review our delegated letters, as those pertain to delegates with corrective action plans.

f. Delegation Oversight Dashboard

Dr. Boris presented a snapshot of the Delegation Oversight Dashboard to the committee. Dr. Boris explained the purpose and goal of the delegation dashboard. Dr. Boris highlighted the process the Plan follows to monitor their delegated groups. The Plan's auditors also require that the Plan show compliance with corrective action plans.

g. Annual Physician Peer-to-Peer (HS.02.02) – 2021

Dr. Boris next presented an overview of the Annual Physician Peer-to-Peer review. This process was initially in response to a prior DHCS request; however, the Plan chose to continue with this process. Dr. Boris explained the purpose and goal of Peer-to-Peer review, as well as the process to track Peer-to-Peer requests. The process begins when either she, Dr. Robertson, or Dr. Nakahira issue a denial letter. All denial letters clearly state physicians' and medical groups' peer-to-peer review rights, along with the telephone number to call to start the process. In cases where the initial denial was upheld, physicians and medical groups are advised to appeal.

h. Behavioral Health (BH) UM

Ms. Natalie McKelvey, Manager, BH, gave an overview of the BHT program for the committee. Ms. McKelvey highlighted the screenings that the BH team completed. These screening numbers may be affected by a claims lag. Ms. McKelvey highlighted the fact that outpatient utilization for our CMC line of business appears to have decreased, and she will research why this is the case. It may be attributable to a billing issue. Ms. Tomcala pointed out that our CMC population may be less comfortable using telehealth. Ms. McKelvey agreed, and she also advised that the County has a back log of residents who request services. Dr. Lin advised that, for the mild-to-moderate cases, primary care physicians should be able to render treatment. Ms. McKelvey advised that these claims are specific to our psychotherapists and BH treatment providers. Dr. Alkoraishi remarked that his patient no show rate has decreased which he attributes to the ease and convenience of appointments via telehealth and FaceTime.

Ms. McKelvey continued with her presentation. Kaiser continues to do a good job with getting their mild-to-moderate patients in treatment. Ms. Tomcala circled back to the low outpatient utilization rate, and she suggests we ask our Independent Practitioner Association (IPAs) for their thoughts on why utilization is so much lower per thousand. Ms. McKelvey replied that feedback from our IPAs suggests they are unaware of the resources available to connect patients with outpatient treatment. Ms. McKelvey will continue to meet with IPA leadership to try to close this gap.

Dr. Nakahira advised this may be attributable to a cultural difference. Ms. McKelvey responded that it may also be due to capitation, as BH is not included. Ms. McKelvey continued with her presentation on BH treatment, which is specific to ABA, and does not include supplemental treatments. Kaiser continues to have the highest rate of patients in treatment. Dr. Lin asked why Kaiser is able to see so many patients. Ms. McKelvey replied that Kaiser has a good developmental screenings process, in conjunction with a smooth referral process. Ms. McKelvey concluded with a discussion of the projects she is working on for 2022.

13. Adjournment

The meeting adjourned at 7:44 p.m. The next meeting of the Utilization Management Commitment is on April 20, 2022 at 6:00 p.m.

_____ _____

Jimmy Lin, M.D, Chair
Utilization Management Committee

Date

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: 12/01/2021

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	8	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	7	
Number practitioners recredentialed within 36-month timeline	7	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 11/30/2021	634	

(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	1344	922	729	804	394	455	978

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.