Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, February 9, 2021, 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	5 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 reserves the right to limit the duration of the public comment period to 30 minutes.	Dr. Paul	6:05	2 min
3.	**Meeting Minutes** Review minutes of the December 9, 2020 Quality Improvement Committee meeting. **Possible Action:** Approve minutes of the December 9, 2020 Quality Improvement Committee meeting	Dr. Paul	6:07	3 min
4.	**CEO Update** Discuss status of current topics and initiatives.	Ms. Tomcala	6:10	10 min
5.	**Assessment of Network Adequacy MY2020** Review the Network Adequacy Report for MY2020. **Possible Action:** Approve the Network Adequacy Report for MY2020	Ms. Switzer	6:20	10 min
6.	**Review of Quality Improvement (QI) Program Description 2021** Review the QI Program Description 2021. **Possible Action:** Approve the QI Program Description 2021	Ms. Baxter	6:30	5 min
7.	**Review of Health Education (HE) Program Description 2021, HE Work Plan 2021, and HE Evaluation 2020** Review the HE Program Description 2021, HE Work Plan 2021, and HE Evaluation 2020. **Possible Action:** Approve the HE Program Description 2021, HE Work Plan 2021, and HE Evaluation 2020	Mr. Hernandez	6:35	5 min

8. Review of Cultural and Linguistics (C&L) Program Description 2021, C&L Work Plan 2021, and C&L Evaluation 2020 Review the C&L Program Description 2021, C&L Work Plan 2021, and C&L Evaluation 2020. **Possible Action:** Approve the C&L Program Description 2021, C&L Work Plan 2021, and C&L Evaluation 2020	Ms. Shah	6:40	10 min
9. Review of Population Health Assessment Review the Population Health Assessment. **Possible Action:** Approve the Population Health Assessment	Dr. Liu	6:50	10 min
10. Review of Clinical, Behavioral, and Medical Preventative Practice Guidelines Review the Clinical, Behavioral, and Medical Preventative Practice Guidelines. **Possible Action:** Approve the Clinical, Behavioral, and Medical Preventative Practice Guidelines	Mr. Pascual	7:00	5 min
11. 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.13 Comprehensive CM **e.** QI.29 Nurse Advice Line **Possible Action:** Approve QI & CM Policies as presented	Dr. Liu & Ms. Singh	7:05	5 min
12. American with Disabilities Act (ADA) Work Plan 2021 Review the ADA Work Plan 2021	Ms. Patel	7:10	5 min
13. Initial Health Assessment (IHA): Q1 and Q2 Reports Review IHA Q1 and Q2 Reports	Ms. Patel	7:15	10 min
14. Grievance and Appeals Report Q4 2020 Review the Grievance and Appeals Report Q4 2020. **Possible Action:** Approve the Grievance and Appeals Report Q4 2020	Ms. Luong	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. Pharmacy and Therapeutics (P&T) Committee Review minutes of the 09/17/2020 P&T Committee meeting. **Possible Action:** Approve the 09/17/2020 P&T Committee meeting minutes	Dr. Lin	7:40	5 min
18. Pharmacy and Therapeutics (P&T) Committee Review minutes of the 12/17/2020 P&T Committee meeting. **Possible Action:** Approve the 12/17/2020 P&T Committee meeting minutes	Dr. Lin	7:45	5 min
19. Utilization Management Committee (UMC) Review minutes of the 10/14/2020 UMC meeting. **Possible Action:** Approve the 10/14/2020 UMC meeting minutes	Dr. Lin	7:50	5 min

20. Credentialing Committee Report Review 12/02/2020 Credentialing Committee Report. **Possible Action:** Approve the 12/02/2020 Credentialing Committee Report	Dr. Nakahira	7:55	5 min
21. Adjournment The next QIC meeting will be held on April 14, 2021.	Dr. Paul	8:00	

Notice to the Public—Meeting Procedures

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

Santa Clara Family Health Plan™

Quality Improvement Committee

Meeting Minutes

December 9, 2020

Regular Meeting of the

Santa Clara County Health Authority
Quality Improvement Committee

Wednesday, December 9, 2020, 6:00 PM – 8:00 PM
Santa Clara Family Health Plan, Teleconference
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Draft

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

Staff Present
Chris Turner, Chief Operating Officer
Laura Watkins, Vice President , Marketing and Enrollment
Tyler Haskell, Interim Compliance Officer
Johanna Liu, PharmD, Director, Quality & Process Improvement
Raman Singh, Director, Case Management
Tanya Nguyen, Director, Customer Service
Lucile Baxter, Manager, Quality & Health Education
Jamie Enke, Manager, Process Improvement
Jayne Giangreco, Manager, Administrative Services
Charlene Luong, Manager, Grievance and Appeals
Natalie McKelvey, Manager, Behavioral Health
Carmen Switzer, Manager, Provider Network Access
Theresa Zhang, Manager, Communications
Victor Hernandez, Grievance & Appeals Quality Assurance Program Manager
Tiffany Franke-Brauer, Social Work Case Manager Lead, Behavioral Health
Neha Patel, Quality Improvement, RN
Lan Tran, Quality Improvement, RN
Nancy Aguirre, Administrative Assistant

1. Roll Call

Laurie Nakahira, D.O., Chief Medical Officer, Santa Clara Family Health Plan (SCFHP), called the meeting to order at 6:03 pm, in Ria Paul's absence. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

Minutes of the October 21, 2020 Quality Improvement Committee (QIC) meeting were reviewed.

It was moved, seconded and the minutes of the October 21, 2020 meeting were **unanimously approved.**

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

4. CEO Update

Christine Tomcala, Chief Executive Officer, reported the current Plan membership is approximately 271,000 members. Of which, approximately 10,000 are Cal MediConnect (CMC) members and 261,000 are Medi-Cal members. This reflects an 11.8% increase from last year. However, a lot of these members are not new members, but rather members whose redeterminations are on hold due to the public health emergency.

Ms. Tomcala noted the SCFHP staff continue to primarily work remotely from home, as Santa Clara County is in the purple tier. Discussions regarding COVID-19 vaccine distributions are underway, and SCFHP is anxious to participate with the County as well as the State in terms of distribution plans to our members.

Ms. Tomcala briefly mentioned the Medi-Cal RX transition delay. The transition has been extended to April 1, 2021. The Pharmacy Team will discuss this further in the meeting.

This concludes Ms. Tomcala's update. No questions were asked.

5. Provider Accessibility Assessment

Carmen Switzer, Manager, Provider Network Access, reviewed the Provider Accessibility Assessment for 2020. Ms. Switzer noted Valley Health Plan (VHP) is included in the survey for 2020, but was not included in previous years.

Ms. Switzer reviewed SCFHP's survey goals, objectives, methodologies, and results of each of the following reporting sections: Provider Appointment Availability Survey, After Hours Survey, CAHPS, and Member Grievance. No questions were asked.

It was moved, seconded and the Provider Accessibility Assessment was **unanimously approved.**

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

6. QI.30 Private Duty Nursing Policy

Raman Singh, Director, Case Management, presented the QI.30 Private Duty Nursing Policy. Ms. Singh reviewed the eligibility for Private Duty Nursing, the responsibilities of the Case Management and Utilization Management Departments, as well as the APL expectations.

Dr. Dawood asked what the qualifications for a Private Duty Nurse are. Ms. Singh explained any Medi-Cal members under the age of 21, who are Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) eligible. Ms. Singh added Private Duty Nursing is utilized for Home Health Services, appropriate evaluations for vision and dental needs, as well as developmental screenings.

Dr. Lin asked who qualifies for Case Management. Dr. Nakahira clarified the criteria for eligibility for Case Management is separate from eligibility for Private Duty Nursing. Ms. Raman added within the organization, there is currently one (1) member who qualifies for Private Duty Nursing.

It was moved, seconded and the QI.30 Private Duty Nursing Policy was **unanimously approved.**

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

7. Annual Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis

Tiffany Franke-Brauer, Behavioral Health Social Work Case Manager Lead, presented the Annual Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis. Ms. Franke-Brauer noted the report measures 6 areas of collaboration between medical and behavioral health providers. Measures selected by SCFHP are Exchange of Information:

1. Medical Record Review has been replaced with a PCP Questionnaire/Survey to evaluate the exchange of information;
2. Depression is an area of concern for our membership and the HEDIS Antidepressant Medication Management measure is used to assess diagnosis, treatment and referral of behavioral health disorder commonly seen in primary care;
3. Use of adjunct therapy for members prescribed an anti-depressant medication by a PCP;
4. A1C testing for members with Schizophrenia and Diabetes;
5. Screening with the PHQ9; and
6. LDL screening for members with Severe and Persistent Mental Illness (SPMI) and Cardiovascular disease

Two of the six measures were selected for intervention: Appropriate use of psychotropic medications and LDL Screening for members with SPMI and Cardiovascular disease.

Ms. Franke-Brauer reviewed the methodologies, affected populations, goals, barriers, and results of Factors 1 -6. Interventions were identified and discussed in the BH Workgroup for Factor 4 and Factor 6. Two (2) interventions were implemented for Factor 4, Management of Co-Existing Medical and Behavioral Disorders. The first was a letter to providers, followed by (three) 3 outgoing calls to members to remind them of the need for an AIC test. At this time, it is inconclusive as to whether or not the implemented interventions were effective.

Ms. Franke-Brauer reviewed the two (2) interventions implemented for Factor 6 – Special Needs of Members with Severe and Persistent Mental Illness. The first intervention were three (3) outgoing calls to members who had not had an LDL C and needed to complete testing(s). The second intervention was a faxed letter to providers.

Although no effectiveness could be identified during analysis extending specifically from these interventions, SCFHP plans to improve timing of data collection and implementation of interventions.

It was moved, seconded and the Annual Continuity and Coordination between Medical Care and Behavioral Healthcare Analysis and recommendations were **unanimously approved.**

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

8. Annual Cal Medi-Connect (CMC) Continuity and Coordination of Medical Care Analysis (2020)

Neha Patel, Quality Improvement Nurse, reviewed the Annual CMC Continuity and Coordination of Medical Care Analysis (2020). Ms. Patel reviewed four (4) measures: Transition of Care – Medication Reconciliation, Comprehensive Diabetes Care (CDC) Eye Exam Rate, PCP Follow-up After 30 Days of Discharge, and Plan All-Cause Readmissions (PCR). Ms. Patel noted all measures compared measurement year 2019 with the baseline data from 2017 and 2018.

Ms. Patel explained a cross-functional work group comprised of representatives from Case Management (CM), Utilization Management (UM), Behavioral Health (BH), Long Term Services and Support (LTSS), and Quality Improvement (QI) Departments reviewed the barriers analysis of each measure. Ms. Patel reviewed the results and interventions implemented in the previous years and the plan for next year for each measure.

Ms. Patel explained the results of the interventions in previous years to the CDC Eye Exam Rate, PCP Follow-Up After 30 Days of Discharge, and Plan all-cause readmissions (PCR) measures. The recommendation to maintain performance goals that were met was due to the impact COVID-19 is expected to have on the metrics in 2020. Many members have postponed preventive services and the impact to the hospitals and readmissions is of concern.

It was moved, seconded, and the Annual CMC Continuity and Coordination of Medical Care Analysis (2020) and recommendations were **unanimously approved.**

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

9. Personalized Information on Health Plan Services

Tanya Nguyen, Director, Customer Service, presented Personalized Information on Health Plan Services. SCFHP has a responsibility to provide access to accurate, quality personalized health information via the SCFHP website and the telephone. Ms. Nguyen reviewed the methodology used, SCFHP goals, qualitative analysis, and the results.

Ms. Nguyen concluded all established measures applied to the website and telephone met the goal of 100% on accuracy and quality. No deficiencies were identified for this audit period.

It was moved, seconded, and the Annual CMC Continuity and Coordination of Medical Care Analysis (2020) was **unanimously approved.**

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

10. Pharmacy Benefit Information

Ms. Nguyen presented the Pharmacy Benefit Information. SCFHP has a responsibility to ensure that members can contact the organization via telephone and receive accurate, quality pharmacy benefit information such as, drugs, coverage, and cost.

Ms. Nguyen reviewed the results of the audit conducted from 07/01/19 through 06/30/20. For accuracy of information, SCFHP met the goal of 100% on all measures, with the exception of one, Factor 2 (Exceptions Process). The turn-around time for the Exception process was not provided to members. For quality of information, SCFHP met the goal of 100% on all measures, with the exception of Factor 2, measures 1 & 2 (Exceptions Process). Customer Service Representatives (CSR) did not fully explain the restrictions for a medication or the next step when an exception was submitted.

Refresher trainings will be provided to remind CSRs to take the appropriate actions in these areas of deficiency.

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

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

11. Grievance and Appeals Member Experience Analysis 2019

Victor Hernandez, Grievance and Appeals Quality Assurance Program Manager, reviewed the Grievance and Appeals Member Experience Analysis 2019. Mr. Hernandez noted the data in this analysis was captured in calendar year 2019 (January 1 – December 31).

The Grievance and Appeals (G&A) Department utilizes an internal code set to categorize G&As. The data collected for the entire SCFHP CMC population is aggregated into the following five (5) categories: Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site.

Mr. Hernandez reviewed the goals for each category as well as the Qualitative Analysis for two (2) categories: Attitude/Service and Billing/Financial. Corrective actions for the opportunities identified were discussed and agreed upon. SCFHP will monitor and follow up with individual transportation vendors as well as the two (2) identified hospitals to resolve the billing issues.

Further discussion of the Behavioral Health Member Satisfaction Survey was deferred to the next meeting.

12. Grievance and Appeals Report Q3 2020

Charlene Luong, Manager, G&A, and Mr. Hernandez presented the G&A Report Q3 2020. Mr. Hernandez noted there was a decrease in Grievances in 2020.

Mr. Hernandez reviewed the MC Grievances by Network, Categories, Subcategories, Provider Staff Attitude, Vendor (Transportation), and Reason. The greatest Grievance reason was transportation. Late Pick-Up followed by No Show and Driver Attitude were the top contributors. Ms. Luong reviewed the 270 MC Appeals by Network and Disposition. Ms. Luong noted about 70% of the MC Dispositions were upheld. The rationale for the majority of overturns was due to Medical Necessity.

Mr. Hernandez reviewed the top three (3) CMC Grievances: Access, Quality of Care, and Quality of Service. Also reviewed were the top three (3) CMC Grievance Subcategories: Inappropriate Provider Care, Access (Provider Telephone Access and Timely Access to PCP), and Billing/Balance Billing. Ms. Luong reviewed the CMC Appeals by Case Type. Ms. Luong noted the majority Case Type was Post-Service Part C. In terms of CMC Appeals by Disposition, data shows 62% of appeals were overturned. The rationale for the majority of overturns was due to Medical Necessity.

This concludes the presentation. No questions were asked.

13. Quality Dashboard

Johanna Liu, PharmD, Director, Quality and Process Improvement, presented the Quality Dashboard. Dr. Liu reviewed the Potential Quality of Care Issues (PQI) investigation and noted there was a 98.1% on-time closure rate from September – November, 2020.

Dr. Liu reviewed the Member Incentives for Wellness appointments related to Asthma, Breast Cancer Screening (BCS), Well Child Visits in the first 15 months of life (W15), Adolescent Well Care Visits (AWC), Cervical Cancer Screening (CCS), Well Child Visits (3-6 years of age), Comprehensive Diabetes Care (CDC), and Prenatal Care (PPC). Members who received service(s) became eligible for a gift card.

Dr. Liu highlighted the new Outreach Call Campaign, designed to close gaps in care by helping members schedule wellness appointments. Over 4,000 outreach calls were made to members. The Outreach Call Campaign focused on W15, Asthma Medication Ratio (AMR), Controlling High Blood Pressure (CBP), CDC, and AWC.

Dr. Liu shared a total of 680 members have verbally consented into Health Homes as of November 25, 2020. Dr. Liu noted Facility Site Reviews (FSR) were not conducted due to COVID-19. Extensions have been approved by DHCS. Virtual FSRs will be soon introduced to new sites.

14. Compliance Report

Tyler Haskell, Interim Compliance Officer, presented the Compliance Report. Mr. Haskell reviewed the recent and ongoing audit activity. Mr. Haskell announced SCFHP has officially closed out the CMS Program Audit Revalidation (Revalidation Audit). SCFHP received a letter from CMS which recognized SCFHP sufficiently corrected all 31 of the Program Audit findings.

Mr. Haskell noted SCFHP is currently in the Compliance Program Effectiveness (CPE) Audit, an annual CMS requirement for Medicare health plans. The CPE Audit evaluates the effectiveness of SCFHP's Medicare Compliance Program through an internal audit. A review session with auditors will take place next week.

Additionally, two (2) State regulatory agencies have reached out to SCFHP to schedule audits. Both audits will take place in March, 2021. The Entrance Conference for the annual DHCS Audit will take place on March 8, 2021. A follow-up audit for DMHC will also be taking place in March, 2021.

15. Credentialing Committee Report

Dr. Nakahira reviewed the Credentialing Committee Report for October 7, 2020. There were no questions asked.

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

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

16. Adjournment

The next QIC meeting will be held on February 9, 2021. The meeting was adjourned at 7:44 pm.

_____ _____

Ria Paul, MD, Chair Date

Santa Clara Family Health Plan™

Assessment of Network Adequacy 2020

Cal Medi-Connect

Prepared by: Carmen Switzer, Provider Network Access Manager

For review and approval by the Quality Improvement Committee

February 9, 2021

Introduction

At least annually, SCFHP conducts a quantitative analysis against availability and accessibility standards and a qualitative analysis on performance.

Provider types included in this assessment are primary care, high volume specialist(s), high impact specialist(s), and high volume behavioral health providers.

An analysis on member complaints/appeals and member requests for out-of-network services is also conducted to identify and monitor access issues.

Opportunities to improve network adequacy are identified and prioritized based on the outcome of access assessments.

Availability Assessment (NET 1)

Maximum Driving Time & Distance (MTD)

Provider to Member Ratios (PMR)

Table I: Primary Care Providers **Member Count = 7967**

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7525	442	94.4%	10 min and 5 miles	90%	Met

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 94.4%.
- The NET 1 report also showed that the Plan's PCP network met provider to member ratios at 1:42 – goal = 1:87.

Availability Assessment (NET 1)

Table II: Cardiology (HVP)

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7866	101	98.7%	20 min and 10 miles	90%	Met

* HVP = High Volume Provider

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 98.7%.
- The NET 1 report also showed that the Plan's Cardiology network met provider to member ratios at 1:57 – goal = 1:300.

Availability Assessment (NET 1)

Table III: Gynecology (HVP)

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7967	6	99.9%	30 min and 15 miles	90%	Met

* HVP = High Volume Provider

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 99.9%.
- The NET 1 report also showed that the Plan's Gynecology network met provider to member ratios at 1:55 – goal = 1:1200.

Availability Assessment (NET 1)

Table IV: Ophthalmology (HVP)

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7907	160	99.2%	20 min and 10 miles	90%	Met

* HVP = High Volume Provider

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 99.2%.
- The NET 1 report also showed that the Plan's Ophthalmology network met provider to member ratios at 1:74 – goal = 1:300.

Availability Assessment (NET 1)

Table V: Hematology/Oncology (HIP)

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7585	382	95.2%	20 min and 10 miles	90%	Met

* HIP = High Impact Provider

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 95.2%.
- The NET 1 report also showed that the Plan's Hematology/Oncology network met provider to member ratios at 1:76 – goal = 1:400.

Availability Assessment (NET 1)

Table VI: Psychiatry (HVP)

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7964	13	99.9%	20 min and 10 miles	90%	Met

* HVP = High Volume Provider

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 99.9%.
- The NET 1 report also showed that the Plan's Psychiatry network met provider to member ratios at 1:53 – goal = 1:600.

Availability Assessment (NET 1)

Table VII: Marriage/Family Therapy (HVP)

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7964	13	99.9%	20 min and 10 miles	90%	Met

* HVP = High Volume Provider

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 99.9%.
- The NET 1 report also showed that the Plan's Marriage/Family Therapy network met provider to member ratios at 1:53 – goal = 1:600.

Availability Assessment (NET 1)

Table VIII: Clinical Social Worker (HVP)

Provider Type	Members with Access	Members without Access	% with Access	Standard	Goal	Met/Not Met
All	7433	534	93.3%	20 min and 10 miles	90%	Met

* HVP = High Volume Provider

- As shown in the table, the NET 1 report (availability of network providers) showed that the standards for time and distance was met at 93.3%.
- The NET 1 report also showed that the Plan's Clinical Social Worker network met provider to member ratios at 1:137 – goal = 1:600.

Availability Assessment (NET 1)

Conclusion: MTD & PMR -

- The assessment showed that provider to member ratios were met at 100%.
- Year to year comparisons indicate that provider to member ratios remain steady.
- The assessment showed that maximum time and distance standards were met at 100%.
- Time and distance goals were exceeded at 93.3% (lowest) and 99.9% (highest).

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

Primary Care Provider – Appointment Availability

Table I: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=636)	187	90%	No	65%	-3

Table II: Standard - Non-Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
PCP (N=636)	194	90%	Yes	92%	+7

- As reported in the NET 2 analysis, the PCP network did not meet the urgent care appointment standard (65%), 25 percentage points below goal, and the non-urgent care appointment standard was met at 92%, 2 percentage points above goal.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

Specialist – Appointment Availability

Table III: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=109)	25	90%	No	67%	+9

Table IV: Standard - Non-Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Cardiology (N=109)	27	90%	No	88%	+16

- As reported in the NET 2 analysis, the Cardiology network did not meet the urgent care appointment standard (67%), 23 percentage points below goal, and the non-urgent care appointment was not met (88%), 2 percentage points below goal.

Accessibility Assessment (NET 2)

Table V: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Gynecology (N=170)	25	90%	No	51%	+4

Table VI: Standard - Non-Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Gynecology (N=170)	33	90%	No	83%	+24

- As reported in the NET 2 analysis, the Gynecology network did not meet the urgent care appointment standard (51%), 39 percentage points below goal, and the non-urgent care appointment was not met (83%), 7 percentage points below goal.

Accessibility Assessment (NET 2)

Table VII: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Ophthalmology (N=167)	23	90%	No	85%	+16

Table VIII: Standard - Non-Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Ophthalmology (N=167)	24	90%	No	80%	-1

- As reported in the NET 2 analysis, the Ophthalmology network did not meet the urgent care appointment standard (85%), 5 percentage points below goal, and the non-urgent care appointment was not met (80%), 10 percentage points below goal.

Accessibility Assessment (NET 2)

Table IX: Standard - Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Oncology (N=81)	15	90%	No	48%	+4

Table X: Standard - Non-Urgent Care

Provider Type	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Oncology (N=81)	16	90%	No	76%	-3

- As reported in the NET 2 analysis, the Oncology network did not meet the urgent care appointment standard (48%), 42 percentage points below goal, and the non-urgent care appointment was not met (76%), 14 percentage points below goal.

Accessibility Assessment (NET 2)

Santa Clara Family Health Plan

Behavioral Health – Appointment Availability

Table XI: Psychiatry (N=119) – Prescribers (HVP)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	17	90%	N	71%	+13
Urgent Care within 48-hours	10	90%	N	20%	-5
Non-Life Threatening Emergency within 6hrs	10	90%	N	0%	None
Follow-up Routine Care within 30-days	13	90%	N	70%	+12

- As reported in the NET 2 analysis, while the goal was not meet across all standards, as shown in the table accessibility improved in 2 areas. The only decrease in performance from 2019 was Urgent Care by 5 percentage points.

Accessibility Assessment (NET 2)

Table XII: Psychology (N=32) – Prescribers (HVP)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	2	90%	Y	100%	+67
Urgent Care within 48-hours	2	90%	Y	100%	+80
Non-Life Threatening Emergency within 6hrs	1	90%	N	0%	-25
Follow-up Routine Care within 30-days	1	90%	Y	100%	+33

- As reported in the NET 2 analysis, the goal was met across all metrics with the exception of non-life threatening emergency within 6hrs. Appointment access improved in 3 areas from 2019.

Accessibility Assessment (NET 2)

Table XIII: Non-Physician Mental Health (N=120) – Non-Prescribers (HVP)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	5	90%	Y	100%	+37
Urgent Care within 48-hours	5	90%	N	0%	-50
Non-Life Threatening Emergency within 6hrs	5	90%	N	0%	None
Follow-up Routine Care within 30-days	5	90%	Y	100%	+33

- As reported in the NET 2 analysis, the goal was met across 2 metrics (initial/routine & follow-up care) and not met across the other 2 metrics (urgent care and non-life threatening emergency within 6hrs). Appointment access increased from 2019 across 2 metrics - initial/routine and follow-up care.

Accessibility Assessment (NET 2)

Table XIII: Marriage/Family Therapy (N=34) – Non-Prescribers (HVP)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	3	90%	Y	100%	+25
Urgent Care within 48-hours	3	90%	N	0%	-63
Non-Life Threatening Emergency within 6hrs	3	90%	N	0%	None
Follow-up Routine Care within 30-days	3	90%	Y	100%	+33

- As reported in the NET 2 analysis, the goal was met across 2 standards (initial/routine & follow-up care) and not met across the other 2 standards (urgent care and non-life threatening emergency within 6hrs). Appointment access increased from 2019 across 2 standards - initial/routine and follow-up care.

Accessibility Assessment (NET 2)

Table XIII: Licensed Clinical Social Worker (N=28) – Non-Prescribers (HVP)

Standard	# Responded	Goal	Goal Met	Rate of Compliance	PY Change
Initial Routine Visit within 10-days	2	90%	Y	100%	None
Urgent Care within 48-hours	2	90%	N	0%	-75
Non-Life Threatening Emergency within 6hrs	2	90%	N	0%	None
Follow-up Routine Care within 30-days	2	90%	Y	100%	None

- As reported in the NET 2 analysis, the goal was met across 2 metrics (initial/routine & follow-up care) and not met across the other 2 metrics (urgent care and non-life threatening emergency within 6hrs). Appointment access decreased from 2019 across 1 metric – urgent care.

Accessibility Assessment (NET 1)

Conclusions – Appointment Access:

- The assessment showed that over a 3-year period specific provider types remain steady below goal on urgent appointment access.
- While appointment access surveys may show appointment access issues with specific provider types, other access assessments (listed below) were conducted and no trending against specific provider types were identified:
  - Review of letter of agreements
  - Member complaints/appeals
  - Percentage of providers open for new referrals
  - Member out of network requests
- It is important to note that the Provider Appointment Availability survey does not take into account other access opportunities such as other providers within a group and/or urgent care facilities that are available to see a patient within access standards.

Accessibility Assessment (NET 2)

After-Hours

Table I: PCP Network

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2020	Met
Access	640	601	141	29	91%	Y
Timeliness				57	42%	N

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

Aggregate access results:

- 2020: 91%
  --VHP omitted: 95% (+4)
- 2019: 80%

Aggregate timeliness results:

2020: 42%
--VHP omitted: 47% (+5)

2019: 40%

Aggregate results for PCP's rate of compliance increased by 11 percentage points on access and 2 percentage points on timeliness. Given that VHP was not included in the survey in 2019, for year to year comparisons, noted are results with VHP omitted. There are a total of 29 phone numbers that were non-complaint with after-hours messaging on access and 57 phone numbers on timeliness.

Accessibility Assessment (NET 2)

Table I: BH Network

Standard	# Providers	# Responded	# Phones	Non-Compliant Phone #'s	2020	Met
Access	158	143	52	15	89%	Y
Timeliness				17	36%	N

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

Aggregate access results:

- 2020: 89%

  --VHP omitted: 86% (-3)

- 2019: 78%

Aggregate timeliness results:

- 2020: 36%

  --VHP omitted: 42% (+6)

- 2019: 33%

Aggregate results for Behavioral Health Provider's rate of compliance increased by 11 percentage points on access and 3 percentage points on timeliness. Given that VHP was not included in the survey in 2019, for year to year comparisons, noted are results with VHP omitted. There are a total of 15 phone numbers that were non-complaint with after-hours messaging on access and 17 phone numbers on timeliness.

Accessibility Assessment (NET 2)

Conclusions – After Hours:

- Provider networks have made progress in meeting after-hours access and timeliness in the past 2-years. *The provider (including BH) network met and exceeded the "access" standard for the first time in 2020.*

- While survey results indicate that the provider network may be unaware of the "timeliness" standard (call back within 30min), this standard is difficult to assess. For example, provider's are marked as non-complaint if the after-hours message does not state that a call back will occur within 30-minutes, and while the after-hours message machines may not state the provider will call back within this timeframe, the majority of network providers are likely meeting this standard.

Member Experience

Overview

Santa Clara Family Health Plan (SCFHP) uses feedback from members and employs the following mechanisms to assess and improve the member experience -

- Track and trend member compliant and appeal activity to identify barriers to care and identify potential interventions.

- Behavioral health member satisfaction survey.

Member Behavioral Health Survey

Table I: Survey Sample Size

Category	Count
# to Survey	385
# of Respondents	104
% Completed	27%

Table II: Behavioral Health Survey Results – "Access"

Measures	# Responded	# Always/Usually	Rate of Compliance	Goal	Goal Met	PY Change
How often did you get an appointment as soon as you wanted? (Q7)	104	80	77%	90%	No	-9
How often did you see someone as soon as you wanted when you needed help right away? (Q8)	102	84	85%	90%	No	+12

- Overall, the majority of members reported positive or neutral experiences through their use of behavioral health care providers and services, and showed more positive responses than in 2019.

Member Complaints and Appeals

Standards and Thresholds:

SCFHP's goals are to:

Maintain a rate of complaints/appeals per 1000 members as shown below:

- Non-Behavioral Health – 5.0
- Behavioral Health – 5.0

- If complaints and/or appeals exceed the established thresholds, a root cause analysis will be conducted to identify the root cause and develop initiatives to address underlying issues.

Member Access Complaints Category

Table I: Non-Behavioral Providers

Member Count = 8051
January – December 2019

Access Compliant/Grievance	Q1	Q2	Q3	Q4		Total
# Complaints	10	11	17	28		66
Per 1,000 members	1.24	1.37	2.11	3.48		8.198

- Access complaints were below the threshold in all quarters (Q1-Q4) in 2019.
- Access complaints were above the threshold by 3.198 combined in 2019.

Table 2: Behavioral Providers

Access Compliant/Grievance	Q1	Q2	Q3	Q4		Total
# Complaints	0	0	0	0		0
Per 1,000 members	0	0	0	0		0

- No members complaints were filed.

Member Access Appeals Category

Table I: Non-Behavioral Providers

Member Count = 8051
January – December 2019

Access Appeals	Q1	Q2	Q3	Q4		Total
# Appeals	0	0	0	0		0
Per 1,000 members	NA	NA	NA	NA		NA

- No member appeals were filed.

Table 2: Behavioral Providers

Access Appeals	Q1	Q2	Q3	Q4		Total
# Appeals	0	0	0	0		0
Per 1,000 members	NA	NA	NA	NA		NA

- No member appeals were filed.

Member Complaints and Appeals

Conclusions:

- The Plan identified that the highest number of member complaints were regarding transportation (NMT).
- The Customer Service and Provider Network Operations departments agreed to work with network transportation vendors to establish interventions to ensure a decrease in member complaints.

Member Out of Network Requests

The Plan compiles data on member requests for out-of-network services and data on actual out-of-network utilization to identify and monitor issues with access to non-behavioral and behavioral health providers.

Standards and Thresholds:

Maintain a rate of out-of-network requests per 1000 members as shown below:

- Non-Behavioral Health – 5.0
- Behavioral Health – 2.0

Member OON Requests

Table I: Non-Behavioral Providers

Member Count = 8051
January – December 2019

Out-of-Network	Q1	Q2	Q3	Q4	Total
# Requests	22	25	23	30	100
Rates	2.732	3.105	2.856	3.726	12.420
# Approved	9	11	7	10	37
# Denied	13	14	16	20	63

- Quarterly results were under the 5.0 threshold and annual result were over the threshold by 7.420.
- Denials: Not medically necessary, not a covered benefit and/or available in-network.

A review of OON approved requests (n=37) were noted as follows:

- Continuity of Care - 68%
- Other – 32%
  - DME
  - ASC
  - Pharmacy

Member OON Requests

Table I: Behavioral Health Providers

Member Count = 8051
January – December 2019

Out-of-Network	Q1	Q2	Q3	Q4	Total
# Requests	0	2	0	1	3
Rates	NA	0.248	NA	0.124	0.372
# Approved	NA	2	NA	1	3
# Denied	NA	NA	NA	NA	NA

- Quarterly results were under the 2.0 threshold and annual result was under the threshold by 1.628.

A review of OON approved requests (n=3) were noted as follows:

- Continuity of Care - 100%

Conclusions – NET 1 - 3

NET 1:

- Overall, SCFHP is able to demonstrate that member cultural and linguistic needs are met.
- Provider to member ratios and maximum time and distance standards were met at 100%.

NET 2:

- Timely access appointment surveys showed some improvement in access across most provider types.

  Potential focus area(s):

  - BH appointment access –

    1. Urgent Care
    2. Non-life threatening appointment within 6hrs.

  - SPC appointment access

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

Conclusion – NET 1 - 3

- 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 2020.

  Potential focus area(s):

  - BH Providers – Overall satisfaction rating with SCFHP is 50%
  - Timely appointment access to non-urgent behavioral health care.

Conclusion – NET 1 - 3

NET 3:

Member complaints on transportations was identified as a potential issue. No member appeals were filed.

Member out-of-network requests appeared to be within normal limits and no trending was identified.

Focus area:

- Transportation complaints

*Transportation issues are currently being addressed by customer service and provider relations.

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 them to submit an action plan within 30-days.	Yes	Completed
		• Resurvey non-complaint providers within 60-days from the date on CAP letter.	Yes	Completed
		• Require provider's that show continued non-compliance to complete access training and submit in attestation.	Yes	In process
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.	Yes	Completed
		• CAP to include non-compliant phone numbers.		
In-office wait times exceed 15 minutes	• Educate providers on in-office wait times	• SCFHP's access matrix to be faxed to entire provider network.	Yes	March 2021

Santa Clara Family Health Plan

Quality Improvement Program 2021

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 263,093 Medi-Cal enrollees in Santa Clara County as of January 2021.
- 9807 members are enrolled in SCFHP's Cal MediConnect (CMC) plan as of January 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 15% 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

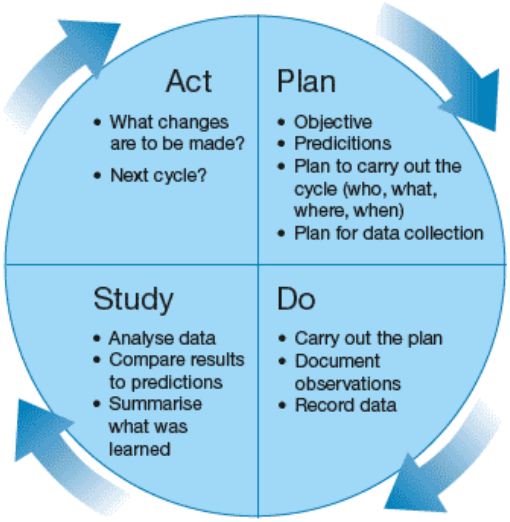
2) Implement change plan

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 priority level, initiates corrective action, and/or recommends corrective action as appropriate. For cases of neglect or abuse, follow-up or corrective actions may include referrals to Child or Adult Protective Services.

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, at least every two years.

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 multiple departments, but not limited to: Case Management, Utilization Management, Pharmacy, Grievances & Appeals, Customer Service 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, participating in and advising the QI Committee or a subcommittee that reports to QI Committeeand 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.

The Medical Director(s) is also the designee physican participating in or advising the QI Committee or a subcommittee that reports to the QI Committee when Chief Medical Officer (CMO) is not available.

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 CAHPS and Health Outcomes Survey (HOS) surveys, Health Homes Program 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.

Health Homes Program Manager

The Health Homes Program Manager provides coordination and program management of the Health Homes Program (HHP). This position is responsible for developing and maintaining processes related to the operationalization of Health Homes processes, supporting reporting requirements to DHCS, and contracting with Community-Based Care Management Entities (CB-CMEs) to achieve a collaborative and effective program for Plan members. This position implements the quality monitoring of the program and oversees contracted partner activities to ensure the quality of care and quality of service to HHP enrollees. The Health Homes Program Manager represents SCFHP, promotes the HHP in the community and conducts program training and education with local providers, associations and community-based organizations.

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 Certified Health Education Specialist (CHES) 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.

Social Work Case Manager

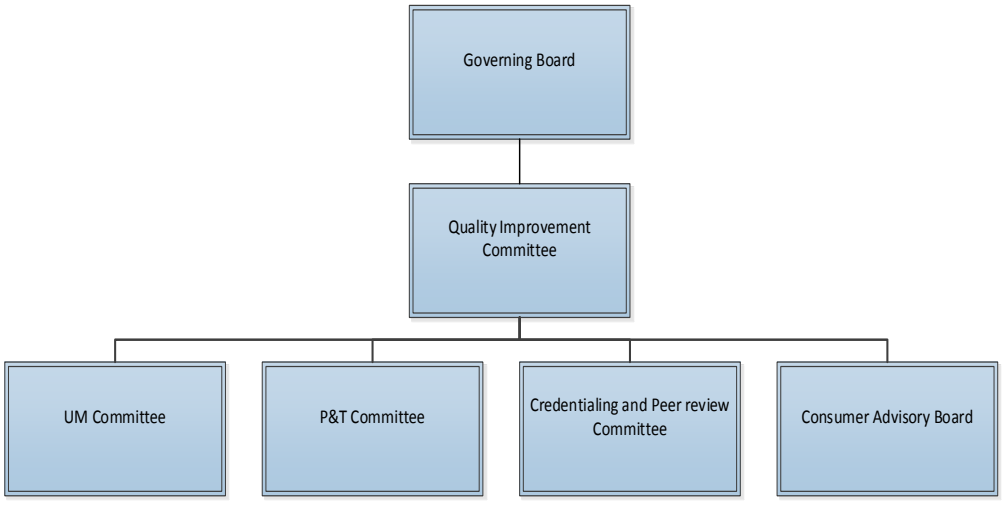
The Social Work Case Manager facilitates communication and coordination among interdisciplinary care team (ICP), to ensure member identified goals and needed services are provided to promote quality cost-effective outcomes. Through the development and implementation of member individualized care plans, the case manager provides medical and psychosocial case management support to help coorindate resources, services and needs but not limited to: physical, psychological, environment, safety, developmental, cultural and linguistic. The Case Manger reports to Clincal Quality and Safety Manager.

Medical Management Personal Care Coordinator

The Medical Management Personal Care Coordinator works with Case Manager to assist memebrs navigating the healthcare delivery system and home and community-based service and coordinates internal and external resources The Care Coorindator also outreaches members to facilitate timely completion of Health Risk Assessments (HRA's). The Care Coorinator reports to Clincal Quality and Safety Manager.

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. Compliance Committee provides reports and updates at QIC.

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 from the community 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 is a forum for an evidence-based formulary review process. The P&T Committee promotes clinically sound and cost effective pharmaceutical care for all members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program.

In addition, the P&T Committee reviews and evaluates current pharmacy-related issues that are interdisciplinary 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 behavioral health prescribing practitioners are involved in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step-therapy.

The Committee provides written decisions regarding all formulary development and revisions. The P&T Committee meets at least quarterly, and reports to the QIC.

Credentialing and Peer Review Committee

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 medical practitioners, including a behavioral health practitioner who is either a medical doctor specialized in psychiatry 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 CMO, 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.

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. 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.

XXI. 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.

XXII. 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.

XXIII. 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.

XXIV. 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

XXV. 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, 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.

<u>Member Grievances and Provider Complaints</u>

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.

XXVI. Delegation Oversight

The Delegation Oversight process and Delegation Oversight Committee are overseen by the Plan's Compliance Committee. The Delegation Oversight Committee reports to the Compliance department. Delegation Oversight activities that are specific to the QI Program include reports submitted by delegated entities and the functional operational area that has responsibility for overseeing corrective action plans.

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

A. On-going monitoring via quarterly, semi-annual, and annual reports
B. Focus reviews conducted when applicable
C. Annual site visits
D. Annual review of the delegates' policies and procedures
E. Annual review, feedback and approval of the delegates' Quality and Utilization Management Program Plans and Work Plans
F. Review and approval, by Compliance Committee, 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, and peer review processes
J. Review of credentialing and re-credentialing processes, working collaboratively with the delegates' staffs to review performance and develop strategies for improvement
K. Providing educational sessions
L. Evaluating and monitoring improvement
    a. Communication of monthly and quarterly analysis of reports and utilization benchmarks to delegates

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

A. Evaluation, oversight, and monitoring of the delegation agreement to determine what services may be delegated and how they can be delegated or not delegated
B. Providing input into contractual language necessary for delegation
C. Providing tools and designating appropriate measurement and reporting requirements for monitoring of delegated activities
D. Providing support in the analysis of data obtained from reporting and other oversight activities
E. Assisting in the development of corrective action plans and tracking of their effectiveness

F. Providing structure and methodology in the development and administration of incentives and sanction for delegate's performance.

When a delegate is determined to be deficient in an area or areas, the issue is referred to the Delegation Oversight Committee, which reports to the Compliance Committee, for review and discussion, with recommendations to the Compliance Department for action.

The Compliance Department presents the issue to the Plan's Compliance Committee for decisions and final recommendations, which could include de-delegation.

XXVII. 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.

XXVIII. 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.

XXIX. 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

XXX. 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

XXXI. 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:

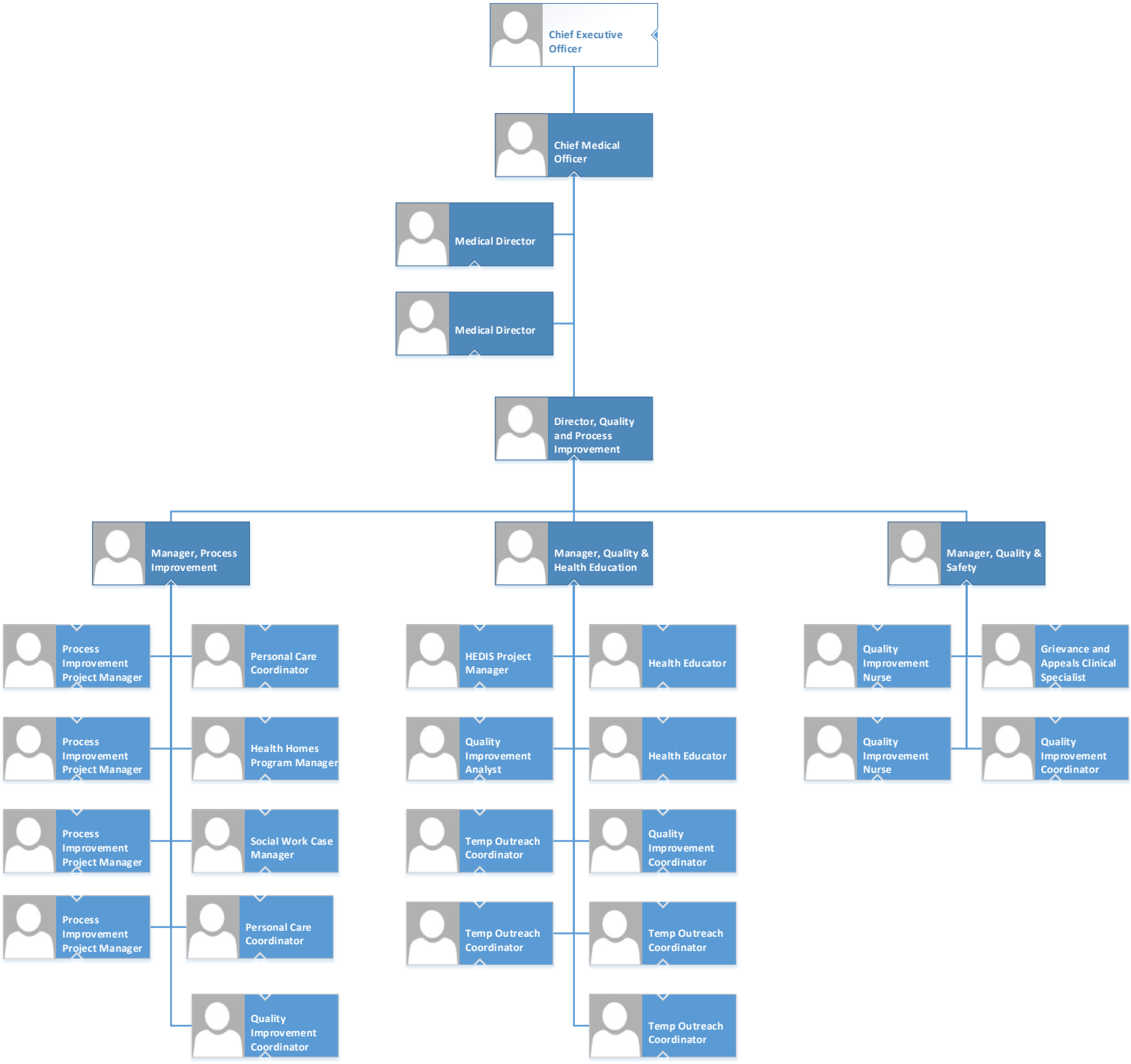
A. A description of completed and ongoing QI activities that address quality of care, safety of clinical care, quality of service and members' experience
B. Trending and monitoring of measures and previously identified issues to assess performance in the quality and safety of clinical care and quality 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 Program 2021

2021 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. 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 and contracted Vendors.

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 receive 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.
- Provide provider education regarding the Initial Health Assessment (IHA) and the need for beneficiaries to have an IHA within 120 days of being eligible with the health plan.

V. PROGRAM STRUCTURE AND ORGANIZATION

The Health Education Program is under the direction of a full-time Health Educator with a Master's degree in Public Health and specialization in health education.

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.

VI. PROGRAM IMPLEMENTATION

Health Education Classes

The Health Education Department 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

Medical providers will use the Staying Healthy Assessment (SHA) tool and other relevant clinical evidence to identify beneficiary's health education needs and conduct educational intervention. 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 are trained and administering the Initial Health Assessment (IHA) with the SHA for all beneficiaries within 120 days of enrollment.

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 beneficiares 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).

Facility Site Reviews

The Quality Improvement Department monitors PCP's IHA and SHA process during periodic site reviews. Facility Site Reviews (FSR) will include medical chart reviews to monitor if providers are compliant with IHA requirements. IHA requirements will be included in providers' corrective action plans (CAP) for providers not passing any section of their FSR's.

Population Needs Assessment

A population needs assessment (PNA) will be conducted annually to identify the health education and cultural and linguistic needs of our beneficiaries. 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. 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 Assessment

SCFHP annually assesses the characteristics and needs, including social determinants of health, of its CMC 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.

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.

HEALTH EDUCATION WORK PLAN 2021

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation
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	Continuous	
Services for All Members	Health Education	- Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	Pg. 73 Exhibit A, Attachment 10 Scope of Services 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.	Continuous	
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	Continuous	
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	Continuous	
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 12/31/2020 - 100% of vendors audited by 12/31/20	Health Educator	Annually	Continuous	Ask Gaya about these standards.
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	Continuous	

HEALTH EDUCATION WORK PLAN 2021

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation
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	Continuous	
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	Continuous	
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.	Continuous	
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	Continuous	
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	Continuous	
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	Continuous	Ask Gaya about these standards.
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	Continuous	
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	Pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	Ensure member medical records include health education behavioral assessment and referrals to health education services		- P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. - Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI Nurse	Annually	Continuous	
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	Continuous	
Quality of Services	Access and Availability	Create Health Ed Work plan	Pg. 61 Exhibit A, Attachment 9 Access and Availability DHCS APL 19-011		- 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	June '20	

HEALTH EDUCATION WORK PLAN 2021											
Scope	**Area**	**Objective**	**Contract Reference**	**Project Objectives**	**Activity**	**Final Deliverable(s)**	**Goals or Baseline**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed/Evaluation**
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	Continuous	
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	Continuous	

HEALTH EDUCATION WORK PLAN EVALUATION 2020

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation (Update)
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	Continuous	Marketing working on getting ACOG guidelines up on site. Pending PNO review.
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 through 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.	Continuous	Hanna amendment for VRI services effective August 2020. Health Trust (in progress) Edifying Lives (in progress) ACT (in progress) (update dates once contracts are signed effective) P&Ps updated May 2020. Working with existing partners to enhance partnerships and develop programming for CRC (Health Trust, Breathe California, Edifying Lives, American Heart Association, County Car Seat Safety Program, Healthier Kids Foundation) Established new partnership with County Black Infant Health Program in June 2020. Review HE library - in progress
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	Continuous	PNA completed June 2020.
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	Continuous	P&Ps updated May 2020.

HEALTH EDUCATION WORK PLAN EVALUATION 2020

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation (Update)
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 12/31/2020 - 100% of vendors audited by 12/31/20	Health Educator	Annually	Continuous	Completed class audits: Anger Management - ACT, Healthier Kids Foundation (part 1 of 3 class series). Breathe CA has no classes planned, Health Trust pending.
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 through other methods that ensure communication - P&P's regarding the development of 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	Continuous	QI.08.04 and QI.08.05 updated May 2020. (pending final approval) QI 09.02 Health Education Materials drafted completed in May 2020. (pending final approval) C&L audits for VSP, PCNC, Language Line, and Hanna completed in 2020.
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	Inform members in writing of their rights annually	Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.	All members informed	Marketing, Health Educator	Annually	Continuous	Rights and Responsibilites page updated January 2020.
Provider Training	Health Ed	Practitioner Education and Training	DHCS PL 02-004 DHCS PL 99-003 CMC 3-way contract 2.9.10.10	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	Continuous	Cultural Competency Toolkit finalized in May 2020.
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	Continuous	All incentives from 2019 have continued to 2020. No end of program evaluations submitted.

HEALTH EDUCATION WORK PLAN EVALUATION 2020

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation (Update)
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.	Continuous	PPC submitted in Feb 2020. DPP submitted in April 2020. CCS, BCS, and AMR submitted in May 2020. W15, W34, AWC, and CDC submitted on August 2020. HKF submitted on September 2020.
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	Continuous	All member newsletters and member incentive letters are at the 6th grade reading level or lower and translated into the threshold languages.
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) NA	Approved readability and suitability checklists with attached health ed materials	Health Educator	- For previously approved material, review every three years	Continuous	Readability and suitability checklist completed for materials, where applicable.
Health Education	NCQA	Evaluation of Plan's self-management tools for usefulness to members	NCQA 2020 Health Plan Accreditation Requirements PHM4	To ensure self-management tools through Optum 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	Continuous	Optum contract is terminating on 12/31/20. No longer will provide self-management tools.
Health Education	NCQA	Review plan's online web-based self-management tools.	NCQA 2020 Health Plan Accreditation Requirements PHM4	To ensure online Optum web-based self-management tools are up to date	- Review and update online web-based self-management tools including the plan website and portal	Updated web-based self-management tools	Baseline	Health Educator	Ongoing	Continuous	Optum contract is terminating on 12/31/20. No longer will provide self-management tools.
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	Continuous	Policy QI.10 approved by QIC April 2020. IHA audit avegage 29.5% YTD. All health education classes are listed on the provider portal. Reviewed November 2020. Health Education referral form listed on provider section of SCFHP website. Reviewed November 2020. Portal class list review reviewed October 2020.

HEALTH EDUCATION WORK PLAN EVALUATION 2020

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed/Evaluation (Update)
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 of 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	Continuous	Information included in the Medi-Cal Evidence of Coverage. Members can call California Family Planning Information and Referral Service at 1-800-942-1054 to learn more. EOC updated on January 2020.
Quality of Services	Access and Availability	Create Health Ed Work plan	Pg. 61 Exhibit A, Attachment 9 Access and Availability DHCS APL 19-011		- Incorporate PNA findings and annual and ongoing review of data into work plan - Approval of Health Ed work plan by QI Committee	Approved Health Ed Work Plan	Baseline	QI Manager and Health Educator	Annually	Annual	Health Education Work Plan 2020 and Evaluation 2019 approved by QIC in Feb. 2020.
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	Continuous	**YMCA Camp:** Outreach calls for WCC measure focusing on Hispanics, African American, and Native American populations. Encouraged members to sign up for YMCA Healthy Living Day Camp. 18 members of the 418 who were outreached attended the camp 4.3% success rate. **Camp SuperStuff:** Outreach calls for AMR measure focusing on asthmatic children, ages 6-12. Encouraged members to sign up for Breathe California Camp Superstuff. 1 member of 127 outreach attended, .7% success rate. Due to the COVID-19 pandemic, camp was provided virtually and members were not interested in attending a virtual camp.
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	Continuous	PNA findings reported to CAC on September 8, 2020. Key findings: SPDs have the highest Emergency room and in-patient utilization among all sub-populations. African Americans have the lowest rate for Controlling High Blood Pressure Caucasians have the lowest rate for Cervical Cancer Screening

Cultural and Linguistics Program 2021

Updated 12.28.2020

2021 CULTURAL & LINGUISTICS PROGRAM
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CULTURAL AND LINGUISTIC SERVICES PROGRAM 2021

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. 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 Mediconnect 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

o 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

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:

Christine Tomcala, Chief Executive Officer

Laurie Nakahira, DO, Chief Medical Officer

Chris Turner, Chief Operating Officer

Tyler Haskell, Interim Chief Compliance and Regulatory Affairs Officer

Laura Watkins, Vice President, Marketing and Enrollment

Johanna Liu, Director of Quality and Process Improvement
Chelsea Byom, Director of Marketing and Communications

Janet Gambatese, Director of Provider Network Operations

Tanya Nguyen, Director of Customer Service and Grievance and Appeals

Lucille Baxter, Quality and Health Education Manager

Jamie Enke, Process Improvement Manager

Mansur Zahir, Process Improvement Project Manager

Divya Shah, Health Educator

Zara Hernandez, Health Educator

Neha Patel, Quality Improvement Nurse

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, 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.

CULTURAL AND LINGUISTICS WORK PLAN 2021

Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion	Completed
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	Continuous	
	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	
	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	
	Exhibit A, Attachment 9 15	Use the CAC for advice and feedback on CLAS and procedures	CAC Agenda	QI, Marketing	Ongoing	Continuous	
	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	
	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	

CULTURAL AND LINGUISTICS WORK PLAN 2021							
Project Objectives	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed**
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	
	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	
	Exhibit A, Attachment 9,13.E	Provide ongoing training for all SCFHP staff members	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Continuous	

CULTURAL AND LINGUISTICS WORK PLAN 2021							
Project Objectives	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed**
	DHCS APL	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	
		Incorporate cultural focus into health education classes	Class materials	Health Educator, QI	Ongoing	Continuous	
	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	
	Exhibit A, Attachment 9,13.E	Review All Staff C&L Training Slides	C&L staff training slides	Health Educator, QI	Ongoing	Sep-20	
	Exhibit A, Attachment 9,13.E	Health Plan activities to raise cultural awareness	Copies of e-mails	Health Educator, QI	Ongoing	Quarterly	
	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	

CULTURAL AND LINGUISTICS WORK PLAN 2021

Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion	Completed
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	
	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	
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	
	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	
	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	
	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	
	Exhibit A, Attachment 9,13.F	Monitor language utilization reports for compliance with regulatory requirements.	Interpreter utilization report	Health Educator, QI	Ongoing	Monthly	

CULTURAL AND LINGUISTICS WORK PLAN 2021							
Project Objectives	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed**
	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	

CULTURAL AND LINGUISTICS EVALUATION 2020

Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion	Completed
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	Continuous	Completed Enrollee Assessment Dec. 2019. Findings: 1) The database (QNXT) accuracy of members' langauge preferences is very accurate. 2) Of those who have difficulty reading the benefits information, the majority is English speaking. 3) The stated preferred method of receiving health plan materials are physical mail and email, however, this accounts for 70% of members' preference. Almost a third of members od not read the outreach materials at all. Updated Policy QI.08 approved by QIC in April 2020.
	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	Added reference to the C&L Toolkit May 2020. Interpreter Quality Standards Memo included reference guide July 2020.
	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	Ongoing (newsletter blurb with language assistance and taglines in all newsletters, language assistance notice included in all mailings)
	Exhibit A, Attachment 9 15	Use the CAC for advice and feedback on CLAS and procedures	CAC Agenda	QI, Marketing	Ongoing	Continuous	Shared PNA results at CAC in Q3 2020.
	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	Used reports G&A reports, Langauge Line reports for PNA in Q2 2020.
	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	Ongoing

CULTURAL AND LINGUISTICS EVALUATION 2020

Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion	Completed
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	Hanna Interpretering audit completed in September 2020. Findings: A Hanna Spanish interpreter was audited over the phone. Interpreter was not engaged in the conversation and provided incorrect information Corrective action issues by Oversight. LL must conduct refresher training for all interpreters that work on the SCFHP LOB. Langauge Line audit completed in September 2020. Findings: A LL Spanish interpreter was audited over the phone. Interpreter was not engaged in the conversation and provided incorrect information Corrective action issues by Oversight. LL must conduct refresher training for all interpreters that work on the SCFHP LOB.
	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	Updated C&L Toolkit May 2020. Toolkit is included in new provider orientation slides.
	Exhibit A, Attachment 9,13.E	Provide ongoing training for all SCFHP staff members	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Continuous	Training completed December 2020.

CULTURAL AND LINGUISTICS EVALUATION 2020							
Project Objectives	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed**
	DHCS APL	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	APL has not been released yet.
	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
Promote a culturally competent health care and work environement for the SCFHP	28 CCR 1300.67.04(d)(9)	Bilingual staff completed language proficiency test	Log of staff that complete language proficiency test	Health Educator, QI, HR	Ongoing	Jul-20	No longer doing this.
	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 C&L training completed in November 2020.
	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 implemented November 2020.
	Exhibit A, Attachment 9,13.E	Implement All Staff Cultural Competency Training	Staff attestations	Health Educator, QI	Ongoing	Annually	All Staff C&L training completed in November 2020.

CULTURAL AND LINGUISTICS EVALUATION 2020							
Project Objectives	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed**
	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	Ongoing
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	Hanna Amendment for VRI implemented August 2020. Providers and internal staff notified November 2020. Working with member-facing departments on checking report and fulfilling requests.
	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
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
	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	Completed December 2020.
	Exhibit A, Attachment 6 13	Develop quarterly report for Provider Network Management to analyze languages spoken by contracted providers	Interpreter utilization log with provider data	Health Educator, QI, PNM	Ongoing	Quarterly	Ongoing
	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	Created C&L dashboard in September 2020.

CULTURAL AND LINGUISTICS EVALUATION 2020							
Project Objectives	**Contract Reference**	**Activity**	**Final Deliverables**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed**
	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	Ongoing

2021 Cal MediConnect (CMC) Population Health Assessment

Committee Review: February 9, 2021

Table of Contents

Background

Santa Clara Family Health Plan (SCFHP) is a not-for-profit organization established in 1997 that offers comprehensive and affordable health coverage for low-income residents in Santa Clara County, California. SCFHP currently services over 9,800 beneficiaries under its Cal MediConnect (CMC) line of business. In order to qualify for the optional program, beneficiaries must meeting the following criteria: live in Santa Clara County; be 21 years of age or older; have both Medicare Part A and B; and be eligible for full-scope Medi-Cal.

Introduction

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

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

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

1. Population Demographics

SCFHP serves a diverse CMC population, with women making up 59% of the population. Beneficiaries aged 65 and older represent 83% of the population. Hispanic beneficiaries made up 23% of the CMC population during calendar year 2020, with Caucasians representing 14%, and Vietnamese representing 14%. Over 40% of the population lists English as their primary language. Other languages that represent over 5% of the SCFHP population include: Spanish at 18%; Vietnamese at 15%; and Mandarin Chinese at 13%. Approximately 98% of SCFHP CMC enrollees have disabilities. Majority of these members (49%) were not in LTC, SMI and did not utilize LTSS during the measurement year. CMC enrollees utilizing LTSS have higher rate with disabilities compared to other subpopulation such as LTC and SMI.

The California Health Care Foundation found that seven in 10 dual-eligible enrollees are age 65 and over and nearly six in 10 dual –eligible enrollees are female (1). They cited that the overrepresentation of women and people of color in dual-eligible programs was due to lower incomes and less access to health care and other services, and the economic burdens of women's longer life span compared to males (1).

Gender

Gender	Member Count	Percentage
Female	6,382	58.91%
Male	4,452	41.09%
Total	**10,834**	**100.00%**

Table 1.1. Member Demographics: Gender.

Age

Age Group	Member Count	Percentage
<65 years	1,849	17.07%
65-74 years	4,664	43.05%
75+ years	4,321	39.88%
Total	**10,834**	**100.00%**

Table 1.2. Member Demographics: Age.

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

Ethnicity	Member Count	Percentage
Hispanic	2,550	23.54%
Caucasian	1,537	14.19%
Vietnamese	1,531	14.13%
Chinese	1,330	12.28%
Other	889	8.21%
Filipino	642	5.93%
All remaining ethnicities with less than 5%	2,355	21.74%
Total	**10,834**	**100.00%**

Table 1.3. Member Demographics: Ethnicity.

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

Primary Language	Member Count	Percentage
English	4,429	40.88%
Spanish	1,970	18.18%
Vietnamese	1,671	15.42%
Chinese *	1,429	13.19%
All remaining languages with less than 5%	1,335	12.32%
Total	**10,834**	**100.00%**

Table 1.4. Member Demographics: Primary Language

*Chinese includes Mandarin and Cantonese speakers.

Disabled Population

CMC Population	Member Count	Percentage
Disabled population	3,067	28.3%
Others	7,767	72.7%
Total	**10,834**	**100.00%**

Table 1.5. Member Demographics: Disabilities

CMC population	Total Subpopulation	Disabled subpopulation	Percentage
LTC	296	64	0.6%
SMI	1,320	721	6.7%
LTSS	2,575	812	7.5%
Non LTC, non SMI & non LTSS	6,643	1,470	13.6%
Total	**10,834**	**3,067**	**28.3%**

Table 1.6. CMC Beneficiaries with disabilities by sub-population (LTC, SMI, LTSS)

2. Social Determinants of Health

According to the World Health Organization (WHO), social determinants of health (SDOH) are the conditions in which people are born, grow, live, work, age, and play that impact a wide range of health, functioning, and quality-of-life outcomes and risks. These social and/or demographic characteristics of individuals, groups, communities, and societies have been shown to have powerful influences on health and well-being at the individual and population levels (2).Social determinants are also the root cause of health disparities, a measure of differences in health outcomes between populations. It is vital to address social determinants of health to decrease health disparities and move towards achieving health equity. Health equity implies that everyone should have a fair opportunity to attain their full potential wellness and that no one should be disadvantaged from achieving this potential.

In reviewing our CMC population, we opted to review the SDOH by utilizing the framework outlined by *Healthy People 2020* (3) and supported by the CDC:

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

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

Economic Stability

One of the vital indicators of economic instability is food insecurity and housing instability and therefore are social determinants of health. A healthy diet is key to having positive health outcomes. Not being able to access nutritious meals can create various health problems (4). According to the article "Housing and Health: An Overview of the Literature", people who are not chronically homeless, but face housing instability in the form of moving frequently, falling behind on rent, or couch surfing are more likely to experience poor health in comparison to their stably housed peers (5).

Three different data sources indicates that almost 30% of CMC members ran out of money for their food, rent, bills or medicines. Also 4% CMC members responded that they have to make decision between food, medication and other basic necessities because of financial instability. These figures, in conjunction with rates of members who report having problems writing checks, keeping track of money, or who need assistance managing money, potentially indicate a lack of financial knowledge.

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

It was also identified that 4.9% of CMC population delayed or did not fill the prescription because they felt they couldn't afford it which again indicate lack of knowledge about covered benefits and services along with community resources.

According to the Santa Clara County's Plan to End Homelessness report, there is an income disparity between the lowest and highest earner, with those families earning at the 10th percentile earned 12 times less than the highest earners (6). Workers in the lowest earning group also saw a decline in their income by 12 % from 2000 to 2015 (6).

Financial Resources

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Members who have to make choices between food, medication, heat, or other necessities because of financial concerns	4.0% (N=1,993)				2020 Signify SDOH Report – 12/2/2020
Members who delayed or did not fill a prescription because they felt they could not afford it	4.9%				2020 Santa Clara CAHPS Report Survey
Respondents who run out of money to pay for food, rent, bills, or medicine	28.5% (N=2,926)	9.4% (N=106)	28.5% (N=470)	29.5% (N=972)	HRA Results (2020)
Respondents with problems writing checks or keeping track of money	23.2% (N=2.920)	82.2% (N=118)	35.3% (N=476)	45.2% (N=984)	HRA Results (2020)
Respondents in need of assistance managing money	1.65% (N=1,993)				2020 Signify SDOH Report – 12/2/2020

Table 2.1. Economic Stability and Financial Resources.

Food Security

In 2017, in the San Jose-Sunnyvale-Santa Clara metro area, 12% of seniors were food insecure. This is 4 percentage points higher than the State and National rate (7).

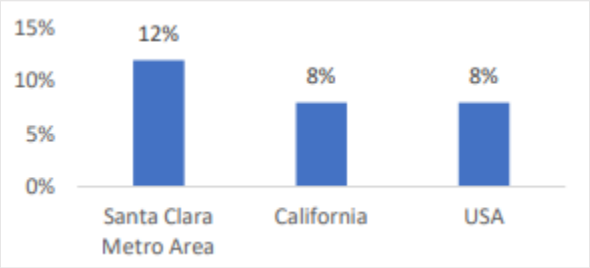


Figure 2.1 Food Security

Education

The level of education is highly important and increasingly recognized as a social determinant of health. Having a higher level of education plays vital role in opening doors for employment opportunities, improves one's ability to make better decision regarding health and increases awareness of available social and personal resources that are for physical and mental health. Post-secondary education is fast becoming a minimum requirement to be eligible for employment (8). CMC enrollees in Santa Clara County are more likely to have college degrees than CMC enrollees elsewhere in the state, but SCFHP still has higher rates of CMC enrollees without a high school diploma than those who opt-out of CMC with SCFHP.

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

Table 2.2. Level of education achieved.

Language and Health Literacy

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

Spanish (18%) and Vietnamese (15%) are most commonly spoken languages by SCFHP CMC members.

Measure	Santa Clara County Rate	Data Source
Respondents who said their health care provider did not speak their language and/or had no interpreter available	36%	SCAN (2019)

Table 2.3. Language

In 2020 Q1-Q4, SCFHP's primary language vendor, was utilized for over 18,850 calls for CMC beneficiaries. Top three request languages included: Spanish (5,545), Vietnamese (5,389) and Chinese (4,829). Table 2.5. Shows the breakdown of language services utilization by CMC beneficiaries in 2020 Q1-Q4.

Language	Number of Calls	Percentage
Spanish	5,545	29.4%
Vietnamese	5,389	28.6%
Chinese	4,829	25.6%
Tagalog	1,170	6.2%
Farsi	466	2.5%
Russian	417	2.2%
Punjabi	293	1.6%
Khmer	144	1%
Korean	136	1%
Hindi	64	1%
Other	397	2%
Total	**18,850**	**100%**

Table 2.4. Telephone Utilization of Interpretation Services by CMC Beneficiaries in 2020 Q1-Q4

Social and Community Context

Support System

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

CMC members with SMI report higher rates of no family members or people (no social support) to help when needed also no one to assist them if their primary caregiver is unavailable than the plan average and the LTC and LTSS populations.

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

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Respondents without family members or others willing and able to help when needed	11.5% (N=3,063)	14.5% (N=117)	16.0% (N=489)	11.2% (N=1,020)	HRA Results (2020)
Respondents in need of a ride to see the doctor or friends	50.4% (N=2,967)	93.2% (N=117)	66.0% (N=480)	81.4% (N=1,000)	HRA Results (2020)

Respondents in need of assistance to see family or friends	41.7% (N=2.875)	87.9% (N=116)	54.2% (N=474)	73.6% (N=965)	HRA Results (2020)
Respondents who have no one to assist them if their primary caregiver is unavailable	35.0% (N=2,783)	12.8% (N=117)	39.1% (N=468)	34.5% (N=996)	HRA Results (2020)

Table 2.5. Support System

Social Interactions

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

Measure	SCFHP Rate	LTC Rate	SMI Rate	LTSS Rate	Data Source
Living alone	24.4%				2020 Santa Clara CAHPS Report Survey
"Yes" response to the question: are you afraid of anyone or is anyone hurting you?	3.2% (N=3,062)	2.6% (N=115)	6.1% (N=489)	4.1% (N=1,011)	HRA Results (2020)
Members experiencing loneliness or social isolation	9.69% (N=1,992)				2020 Signify SDOH Report – 12/2/2020

Table 2.6. Social Interaction

Loneliness or Social Isolation

The high rates reported for CMC enrollees that they never feel lonely, although members utilizing LTSS services reported that they felt loneliness more than 15 days a month (7.1%) to most of the days (6.8%).

Question (from HRA 2020) Over the past month (30 days), how many times have you felt lonely?	All CMC N=2,825	LTC N=106	SMI N=448	LTSS N=951
<5 days	16.9%	32.1%	23.7%	20.9%
>15 days	4.6%	4.7%	6.9%	7.1%
Most Days(Always feel Lonely)	5.0%	7.5%	8.0%	6.8%
None(never feel Lonely)	73.5%	55.7%	61.4%	65.1%

Table 2.7. Loneliness or Social Isolation

Health and Health Care

Access to Care

CAHPS and SCAN reports/surveys indicate that there is still opportunity to improve access to care – less than 80% of respondents said that they were getting their needed care, or getting appointments and care quickly. SCFHP has lower rates of satisfaction than the statewide average for CMC enrollees with

the wait time to see a doctor when they need an appointment, while a higher rate of respondents report that the physician they were seeing is not available through the SCFHP provider network.

Measure	SCFHP Rate/Score	CA CMC Enrollees	SCFHP CMC Opt-Outs	Data Source
Getting needed care	81.3%			2020 Santa Clara CAHPS Report Survey
Getting appointments & care quickly	73.4%			2020 Santa Clara CAHPS Report Survey
Good communication from clinicians	92.0%			2020 Santa Clara CAHPS Report Survey
Respondents satisfied with the wait to see a doctor when they need an appointment	73%	78%	75%	SCAN (’15-’17)
Respondents who said the doctor they were seeing is not available through SCFHP	20%	18%	17%	SCAN (’15-’17)

Table 2.8. Access to Care

Health Literacy

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

Measure/Question	Santa Clara County Rate	Data Source
Respondents who had a misunderstanding about health care services or coverage	17%	SCAN (2019)

Table 2.9. Health Literacy

Health Status

SCFHP CMC enrollees have, based on claims data, higher prevalence of hyperlipidemia, diabetes, chronic kidney disease, and osteoporosis than the national average for the same conditions, as well as higher than Santa Clara County.

In 2020, California Health Care Foundation reported that 48% of CMC enrollees have three or more chronic conditions compared to 27% of Medicare-only enrollees (1). CMC enrollees were also more likely to have a condition resulting in a functional limitation or disability, including, for example, mobility impairments, intellectual disability, depression, anxiety, bipolar disorder, and schizophrenia. This report also found that Black and Latinx CMC enrollees were 2 and 1.5 times as likely to be hospitalized compared to white enrollees (1).

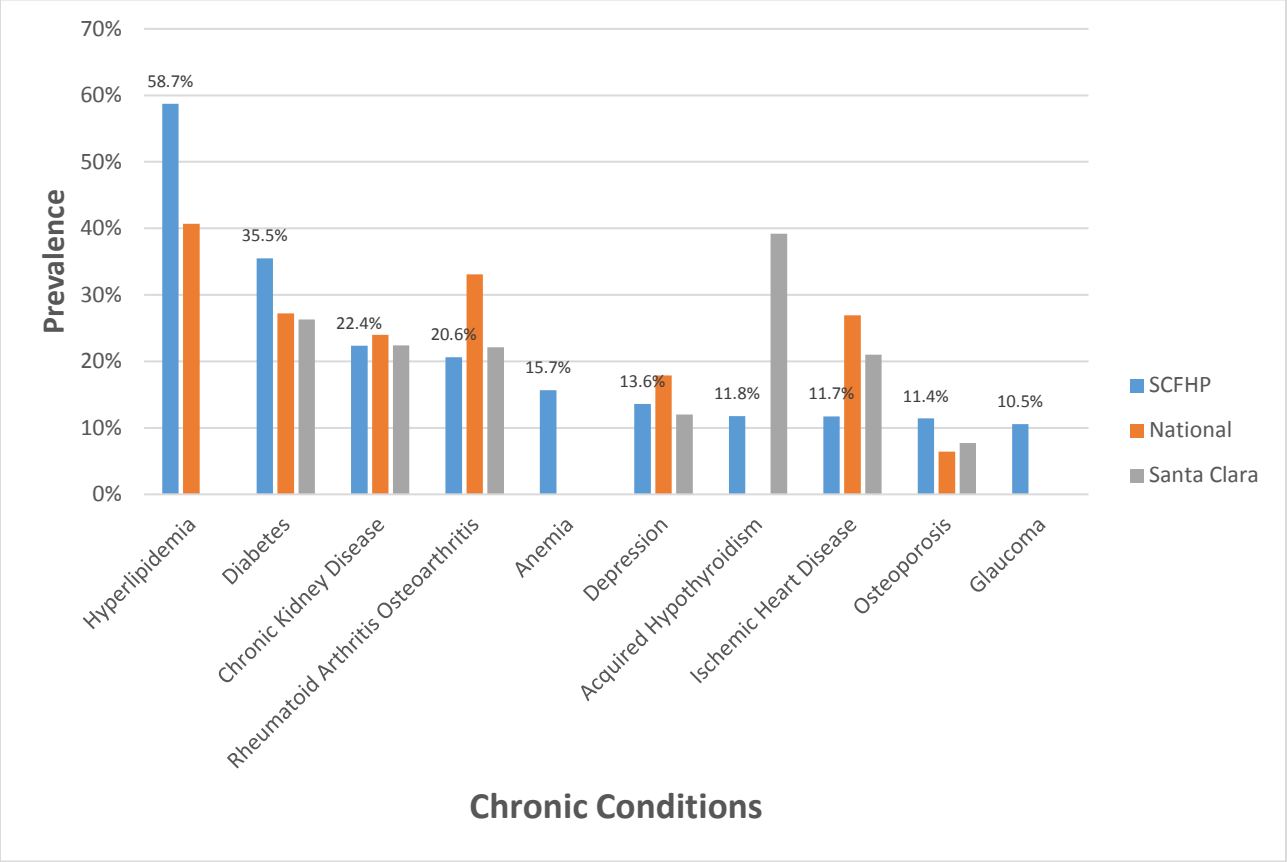


Table 2.10. Prevalence of chronic conditions at SCFHP (top 10)

Knowledge of Condition

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

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

Chronic Condition		SCFHP Prevalence	Knowledge of Condition[1]			
			CMC (N=2,928)	LTC (N=103)	SMI (N=471)	LTSS (N=991)
Hyperlipidemia	High Cholesterol	58.7%	51.0%	48.5%	50.3%	54.3%
Diabetes	Diabetes	35.5%	35.1%	43.7%	37.4%	38.6%
Chronic Kidney Disease	Kidney Problem	22.4%	9.8%	27.2%	18.0%	13.8%
Rheumatoid Arthritis Osteoarthritis	Arthritis/Arthritis-Rheumatoid	20.6%	47.6%	33.0%	47.1%	54.9%

Anemia		15.7%	11.9%	8.7%	15.7%	14.2%
Depression	Depression	13.6%	20.3%	39.8%	34.0%	24.3%
Acquired Hypothyroidism	Thyroid problems	11.8%	12.7%	22.3%	14.4%	13.6%
Ischemic Heart Disease	Heart Problems/Congestive Heart Failure (CHF)	11.7%	20.0%	41.7%	41.0%	28.7%
Osteoporosis	Osteoporosis	11.4%	19.5%	19.4%	15.3%	26.2%
Glaucoma	Limited Vision	10.5%	30.2%	32.0%	33.1%	37.6%

Table 2.11.Knowledge of condition

Quality of Care

Fewer SCFHP CMC Enrollees expressed satisfaction with their physicians working together than CMC enrollees across the state and then individuals who opted-out of the SCFHP CMC program.

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

Table 2.12. Quality of care

The HEDIS scores below are measures for which SCFHP is at less than or equal to the 10th percentile for CMC in 2020.

Measure/Question	Sub measure	SCFHP Rate/Score	2020 MPL	Data Source
BCS: Breast Cancer Screening		63.8%	74.1%	HEDIS 2020 YTD
COL: Colorectal Cancer Screening		54.3%	73.5%	HEDIS 2020 YTD
CDC: Comprehensive Diabetes Care	Eye Exam	65.5%	75.7%	HEDIS 2020 YTD
	HbA1c Testing	83.3%	95.0%	HEDIS 2020 YTD
	Medical Attention for Nephropathy	87.4%	96.0%	HEDIS 2020 YTD
OMW: Osteoporosis Management in Women Who Had a Fracture		34.3%	48.5%	HEDIS 2020 YTD
MRP: Medication Reconciliation Post-Discharge		2.8%	52.3%	HEDIS 2020 YTD
PBH: Persistence of Beta-Blocker Treatment After a Heart Attack		75.0%	87.3%	HEDIS 2020 YTD
Pharmacotherapy Management of COPD Exacerbation		91.3%	81.3%	HEDIS 2020 YTD

Statin Therapy for Patients with Cardiovascular Disease	Statin Adherence 80% - Total	81.8%	80.9%	HEDIS 2020 YTD
Statin Therapy for Patients with Diabetes	Statin Adherence 80% - Total	80.6%		HEDIS 2020 YTD

Table 2.12. HEDIS

Neighborhood and Built Environment

Access to Transportation

Despite transportation utilization and costs increasing rapidly for the plan, 16% of respondents to the SCAN survey reported issues with transportation that kept them from getting needed healthcare, while 29% of CMC respondents on a Risk Adjustment in Home Assessment report indicated that they need assistance with driving and/or arranging transportation.

The 2016 Santa Clara County's Livable Communities Survey reported that 90% of the survey's respondents indicated special transportation services for people with disabilities and older adults are extremely or very important. It was noted that as respondents' age increased, so did their opinion of the importance of specialized services (9).

Measure/Question	Santa Clara County Rate	Data Source
Respondents with transportation problems that kept them from getting needed healthcare	15%	SCAN (2019)
Members who need assistance with driving and/or arranging transportation	29.00% (N=1,400)	2019 Signify SDOH Report – 1/13/2020

Table 2.13. Access to Transportation

Housing

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

According to Santa Clara County's Community Plan to End Homelessness, there were only 34 affordable and available units for every 100 extremely low-income renter households in the San Jose metro area. This report found that people of color are more likely to become homeless in Santa Clara County, and poverty alone could not explain the disparities in homelessness (6).

Measure/Question	Rate/Score	Data Source
Members who need help with laundry and/or housekeeping	24.8% (N=1,400)	2020 Signify SDOH Report – 1/13/2020

Table 2.14. Housing

Quality of Air & Water

Air quality: According to Bay Area Air Quality Management District, there were 25 days where particulate matter of 2.5 exceeded the national standard compared to 1 day in 2019 (10).

Water quality: According to Santa Clara Valley Water District review there are no contaminants above maximum levels in 2020 (11).

3. Sub-population

This document looks at three sub-populations – members in Long Term Care (LTC), members with Severe Mental Illness (SMI), and members utilizing Long Term Support Services (LTSS).[*Appendix A* – Sub-Population Definitions 39% SCFHP CMC beneficiaries eligible for subpopulation. As these three groups are not mutually exclusive, a few combinations are also included. These combinations are made based on the one or more services utilized by subpopulation in measurement year (2020). Combinations such as members in LTC with SMI and who also utilized LTSS in measurement year; members in LTC with SMI who did not utilize LTSS; members in LTC who utilized LTSS but do not have SMI; members who have SMI and utilized LTSS.

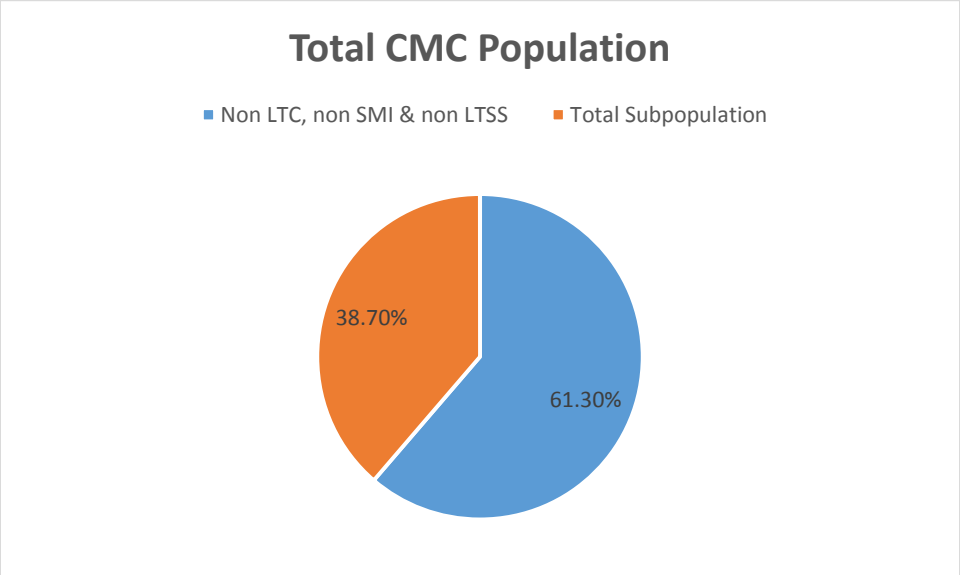


Figure 3.1. Total CMC population

Long Term Care

LTC is an institute who provides variety of services medical and non-medical needs of people with disabilities and/or chronic illness who cannot care for themselves for longer period. The goal of these services are to indorse independence, maximize quality of life and meet the need of patients. SCFHP CMC beneficiaries has a very small sub-population (1.8%) of members in LTC. However, these members experience many barriers in the form of social determinants of health. For example, 93% LTC members require a ride to see the doctor. 82% have difficulty writing checks or keeping track of money. Social determinants of health such as transportation and financial management needs have to be addressed in the case management of LTC members.

Serious Mental Illness

Approximately 1,300 (12.14%) CMC enrollees have a mental health diagnosis. SCFHP collaborates with the County Behavioral Health Services Department (CBHSD), which serves consumers ages 18 and above. The CBHSD Call Center screens individuals for functional impairments, such as homelessness, lack of support, and recent job loss, etc. and direct individuals based on diagnosis. Once the screening has been completed, CBHSD refers individuals who are identified as SMI to either a county mental health clinic or a community based organization (CBO) for services. These are considered specialty mental

health providers and may include: psychiatry, therapy, and case management. Please refer to the CBHSD screening tools in Appendix B.

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

Long Term Support and Services

A subset of the CMC population are beneficiaries living with multiple chronic conditions and limited functional capacity that makes it difficult for them to live independently without LTSS, SCFHP defines these members as the disabled population. These individuals require assistance with at least three activities of daily living, are in poor or fair health and may have cognitive impairments or behavioral health issues. These members frequently have needs related to transportations and financial insecurity. Eighty percent of LTSS members reported needed transportation help in order to see their doctor or family members. 29% reported running out of money and 45% reported having trouble tracking money. They can either be living in the community or a long-term care nursing facility, and a population at high risk for falls and isolation due to their impairments. Nearly 2,575 (23.54%) enrollees utilized LTSS in the measurement year. To meet the needs of SCFHP's members with disabilities the following LTSS programs are included for CMC beneficiaries:

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

Of the sub-populations and amalgamations reviewed, the largest population was those who utilize LTSS services (regardless of whether or not they have SMI or utilized LTC). On the other side, Only 44 SCFHP CMC enrollees have SMI and also utilized LTC and LTSS in the measurement year. In this report sub-populations with less than 150 member count are excluded from further utilization assessment as there is not enough data to study the need in emergency room and inpatient utilization.

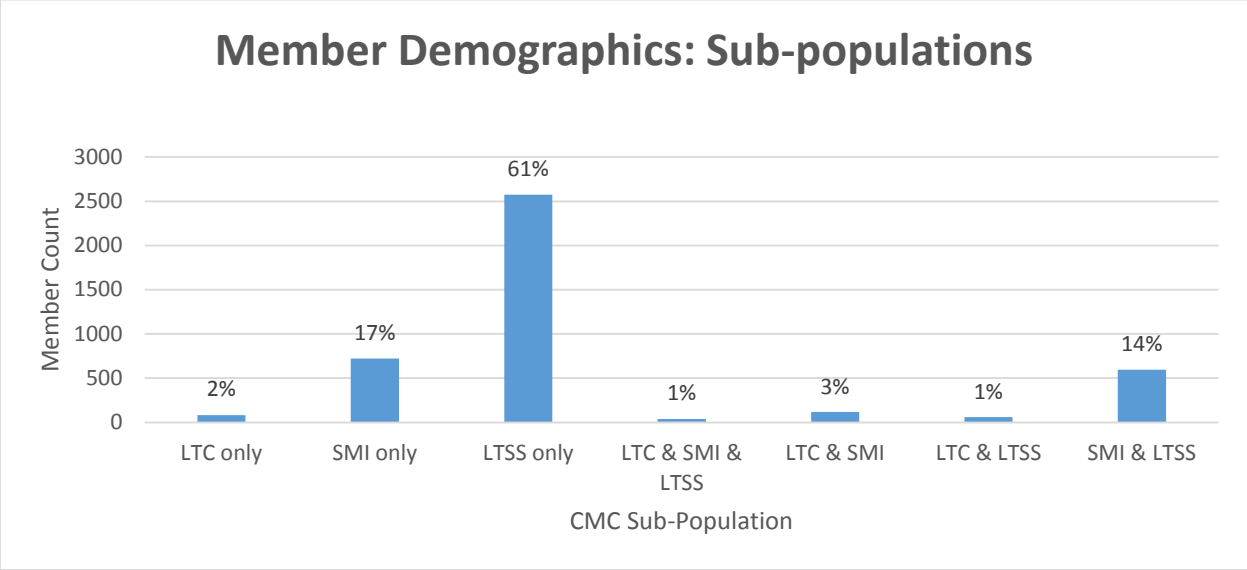


Chart 3.1. Member Demographics: Sub-Population

Utilization

The report below provides an overview of most common discharge diagnosis from emergency room(ER) visits and inpatient admissions for SCFHP CMC beneficiaries.

Inpatient Utilization

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

Reviewing programs separately, the most common inpatient admission diagnosis was sepsis, which accounted for nearly 11% of CMC enrollees in the BH program. This was followed by 4% having schizoaffective disorder. The other top diagnoses related to hypertension, health failure and chronic kidney disease. Similarly, 13% of inpatient diagnoses for CMC enrollees in the LTSS program was related to sepsis. Coronavirus accounted for 3% of the cases and health and kidney related diagnoses accounted for 7% of the most common diagnoses. A similar trend was observed in the members assigned to CM and those CM members who were categorized as high risk. Please refer to Appendix 4 for program specific data on inpatient utilization.

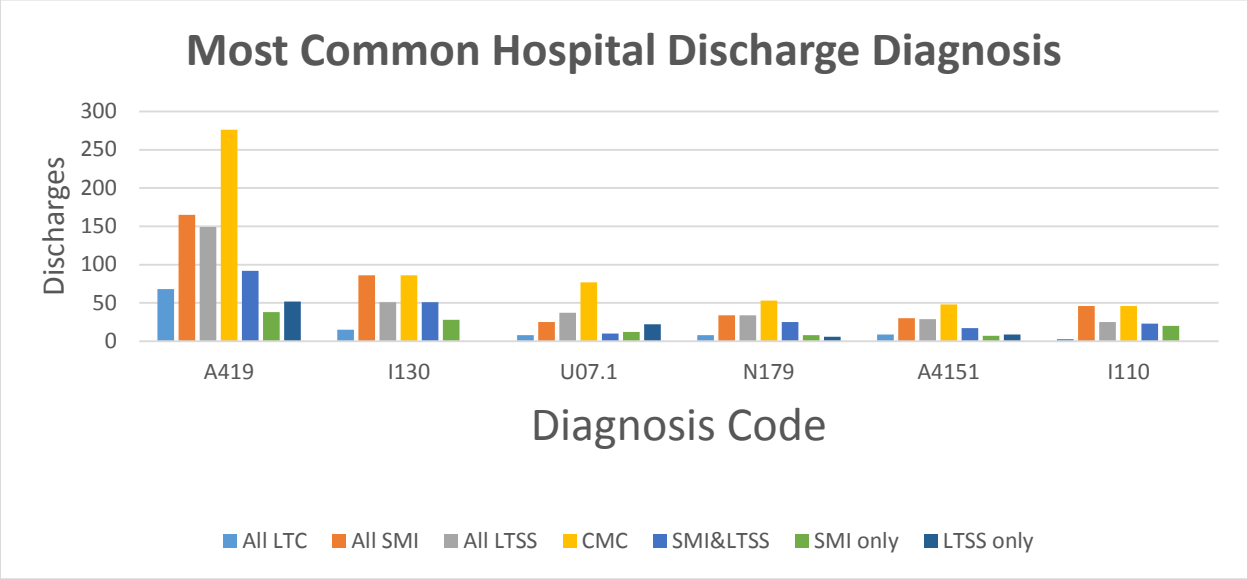


Table 3.1.1. Most common hospital discharge diagnosis

Diagnosis Code	Description
A419	SEPSIS, UNSP ORGISM
I130	HYP HRT & CHR KIDNEY DIS W/HRT FAIL & STG 1-4/UNSP
U07.1	2019-NCOV ACUTE RESPIRATORY DISEASE
N179	ACUTE KIDNEY FAILURE, UNSP
A4151	SEPSIS D/T ESCHERICHIA COLI [E. COLI]
I110	HYPERTENSIVE HRT DIS W/HRT FAILURE

Table 3.1.2. Description of diagnosis codes

Emergency Room Utilization

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

At the program level, schizoaffective disorder was the most common diagnosis for member in the BH program. Adjustment disorder accounted for 4% of ED visits by BH members while chest pain counted for 2%. In the LTSS program, chest pains and UTIs were the most common ED visit diagnoses. The 5th most common diagnosis was adjustment disorder for LTSS members. Dizziness & giddiness, chest pain and UTIs were the most common diagnoses for ED visits for CM program members.

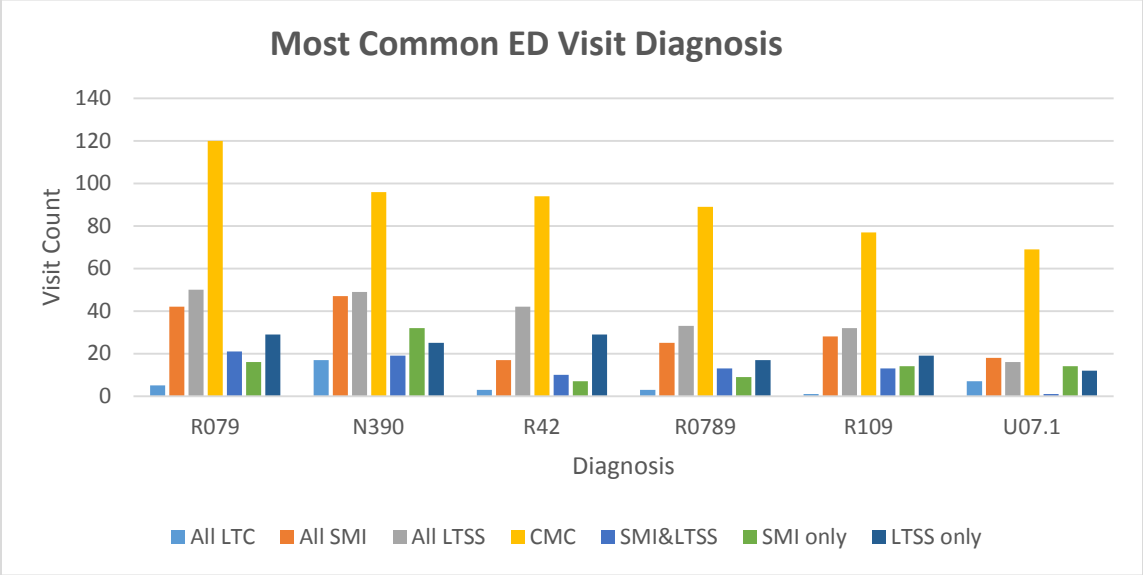


Table 3.1.2. Most common ED diagnosis

Diagnosis Code	Description
R079	CHEST PAIN, UNSP
N390	URINARY TRACT INFECT, SITE NOT SPEC
R42	DIZZINESS & GIDDINESS
R0789	OTH CHEST PAIN
R109	UNSP ABD PAIN
U07.1	2019-NCOV ACUTE RESPIRATORY DISEASE

Table 3.1.3. Description of diagnosis codes

COVID- 19 Pandemic

2020 has been an unprecedented year with the COVID-19 pandemic changing the way we interact with each other and our community. In Santa Clara County, there has been a total of nearly 100,000 cases and over 1300 deaths (12). As of January 2021, nearly 4,397 of SCFHP members tested positive for COVID-19 and cumulatively 1,600 members have been hospitalized. To date, 150 members have passed away (82 in Skilled Nursing Facilities (SNF) and 68 non-SNF), representing 15% of County-reported total (total membership equals about 12% of the County population).

4. CONCLUSION

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

- Nearly a third of respondents to the HRA said they ran out of money to pay for food, rent, bills, or medicine indicating a lack of economic stability; SMI and LTSS subpopulations were three times more likely to respond as having run out of money to pay for necessary bills. Interventions

should focus on financial resources availability to these subpopulations. Food insecurity is also higher in Santa Clara County compared to the state and national averages. Interventions aimed at finding options for members to access food, subsidize rent or utilities, and ensure members are aware of pharmacy benefits will be beneficial to all members.

- Santa Clara County had the worst score compared to other counties when asked whether respondents felt their health care provider did not speak their language or did not have an interpreter available. Interventions should focus on ensuring members are aware of interpreter services, including language lines, know how access these services and are able to access them when needed. SCFHP can also work with providers to ensure they are aware of available interpreter services for SCFHP members in order to address this need.
- HRA responses indicate that all sub-populations such as LTSS and SMI report issues arranging transportation to see their provider, family and/or friends. Over half of respondents stated they need a ride to see the doctor or friends. Interventions should aim to educate members about transportation benefits for medical appointments and connect members to community resources to aid their transportation needs.
- Sepsis was the most common inpatient admission diagnosis for CMC enrollees. There is a need for further exploration to assess the behavior of SMI sub-population that may lead to infectious disease and eventually to sepsis so case managers can provide education to members on preventative strategies.
- Schizoaffective disorder was the most common emergency department utilization diagnosis for members in the BH program. Interventions should focus on understanding this population and helping to address their needs to prevent ED visits.
- Coronavirus was the third most common diagnosis for inpatient hospitalization. California has one of the highest rates of daily new cases. As the pandemic continues, it will be important to educate members on how to protect themselves and their families, identify signs and symptoms of potentially contracting COVID-19 and how to access vaccines as they become available.

The data analyzed in this report provides key information about the CMC population's health care experience and barriers that may exist to obtaining care and maintaining optimal health. It also provides insight into social determinants of health and the role they plan in shaping an individual's health care experience and outcomes.

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

Appendix

Appendix A – Sub-Population Definitions

Long Term Care (LTC)

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

Severe Mental Illness (SMI)

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

Long Term Support & Services (LTSS)

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

Appendix B –Santa Clara County BHSD Screening Tool

Santa Clara County BHSD Screening Tool

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

Insurance Type_____ Medi-Cal Plan Name_____Provider Network_____

Preferred Language_____ Identified Culture_____

Address_____ City_____Zipcode_____ Phone(___)_____-_____

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

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

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

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

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

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

Referral Disposition_____

Symptom description/details_____

_____

_____

Brief summary of relevant history_____

_____

_____

Screener Signature_____

Screener Name_____ Screener title_____ Date_____/_____/_____

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

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

Revised Jan 6, 2017

Appendix C – Data Sources

Health Risk Assessment (HRA)

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

Questions:

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

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

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

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

Health Outcomes Survey (HOS)

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

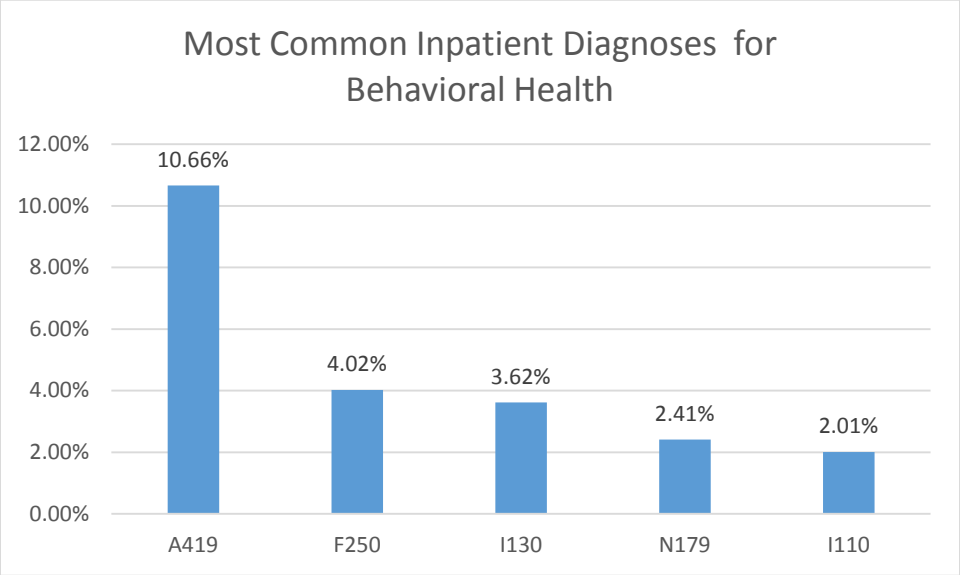
Signify Health – In Home Assessment (IHA)

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

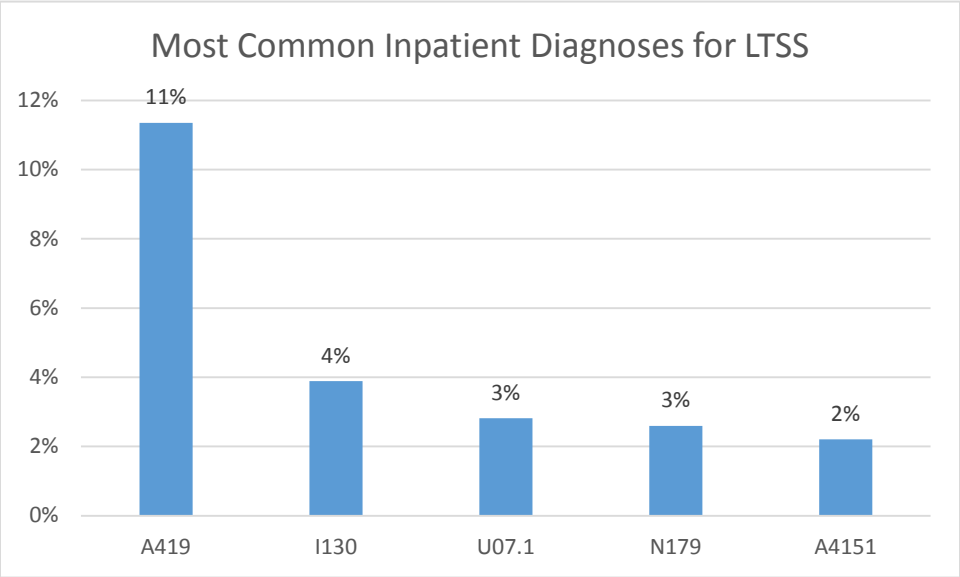
12. In the past 4 weeks, have you had too little energy to do the things you want to do? (Yes; No)
13. During the past 30 days, how many days did poor physical or mental health keep you from your usual activities, self-care, or recreation? (0-5; 6-10; 11-15; 16-20; 21-25; 26-30)
14. What is your current living situation? (Home, apt, condo; assisted living facility; senior/low income housing; long-term care facility; other)
15. Currently living alone? (Yes; No)
16. Are you a caregiver for someone else? (Yes; No)
17. Who else lives with you? (Spouse/domestic partner; child/children; long-term care setting; other family/friend; other)
18. Help needed to go out of the house? (Yes; No)
19. Because of financial concerns, does individual have to make choices between food, medication, heat, or other necessities? (Yes; No)
    a. Specify choices due to financial concerns (food; medications; electric/gas service; telephone; transportation; other)
20. Does individual have any special needs? (Yes; No)
21. Home safety could be improved to better support ADLs? (Yes; No)
22. Do you feel unsafe in your home? (Yes; No)
23. Does individual use Durable Medical Equipment (DME) on a regular basis? (Yes; No)
24. Is your caregiver providing adequate support for your needs? (Yes; No; N/A)
25. Difficulties with activities of daily living? (Yes; No)
26. Difficulties with instrumental activities of daily living? (Yes; No)
27. In the past 12 months, did you talk with a doctor or other health care provider about your level of exercise or physical activity? (Yes; No)
28. In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity? (Yes; No)
29. Do you regularly experience any of the following (stress; loneliness/social isolation; anger; anxiety, of such intensity, that it interferes with daily activities; current or recent hallucinations)

Appendix 4 – Program Specific Utilization Data

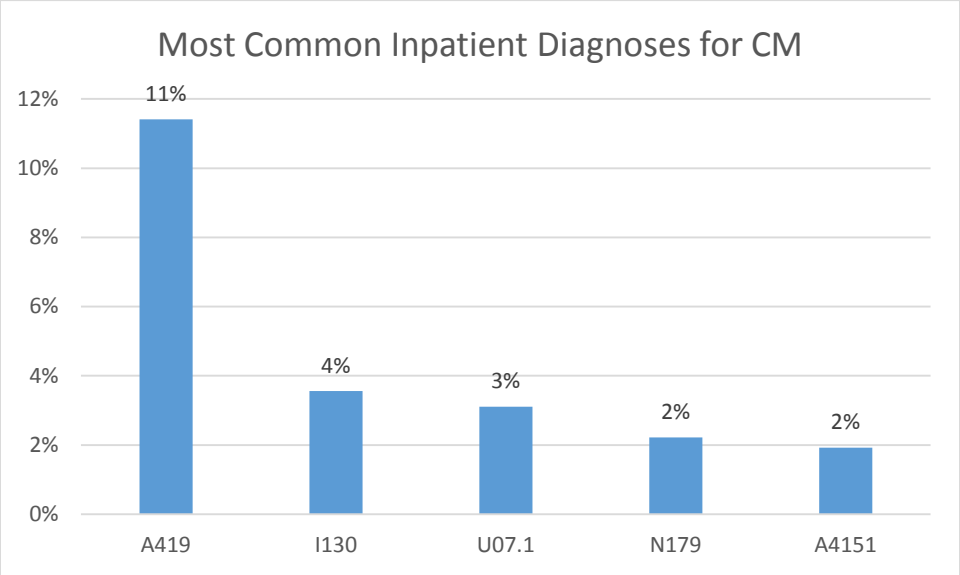
Inpatient



Diagnosis Code	Description
A419	SEPSIS, UNSP ORGISM
F250	SCHIZOAFFECTIVE DISORD, BIPOLAR TYPE
I130	HYP HRT & CHR KIDNEY DIS W/HRT FAIL & STG 1-4/UNSP
N179	ACUTE KIDNEY FAILURE, UNSP
I110	HYPERTENSIVE HRT DIS W/HRT FAILURE

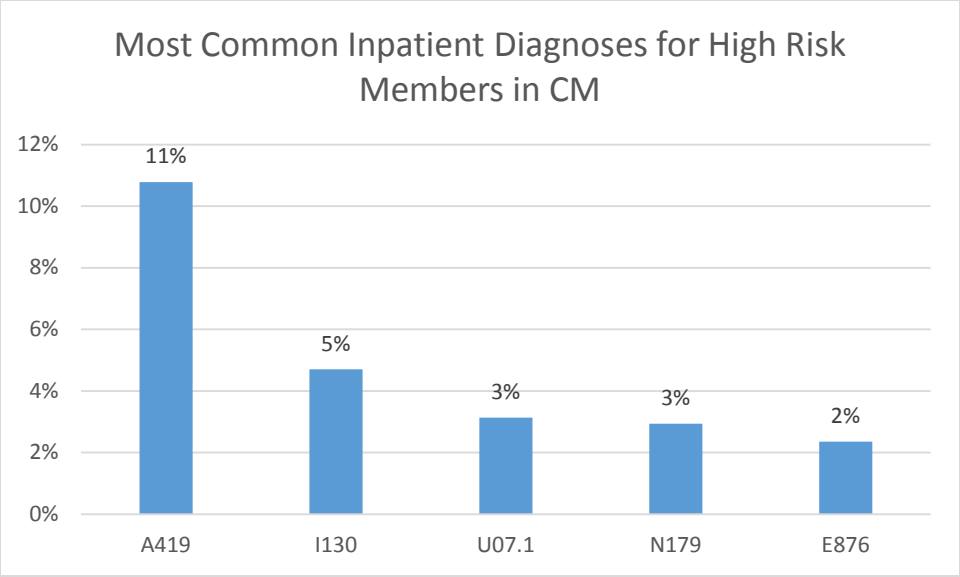


Diagnosis Code	Description
A419	SEPSIS, UNSP ORGISM
I130	HYP HRT & CHR KIDNEY DIS W/HRT FAIL & STG 1-4/UNSP
U07.1	2019-NCOV ACUTE RESPIRATORY DISEASE
N179	ACUTE KIDNEY FAILURE, UNSP
A4151	SEPSIS D/T ESCHERICHIA COLI [E. COLI]



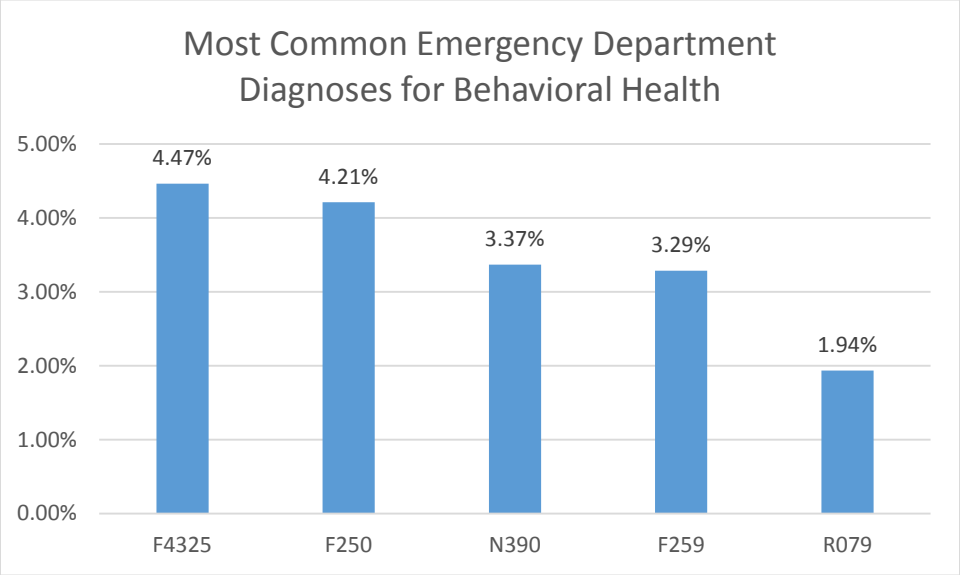
Diagnosis Code	Description
A419	SEPSIS, UNSP ORGISM

I130	HYP HRT & CHR KIDNEY DIS W/HRT FAIL & STG 1-4/UNSP
U07.1	2019-NCOV ACUTE RESPIRATORY DISEASE
N179	ACUTE KIDNEY FAILURE, UNSP
A4151	SEPSIS D/T ESCHERICHIA COLI [E. COLI]

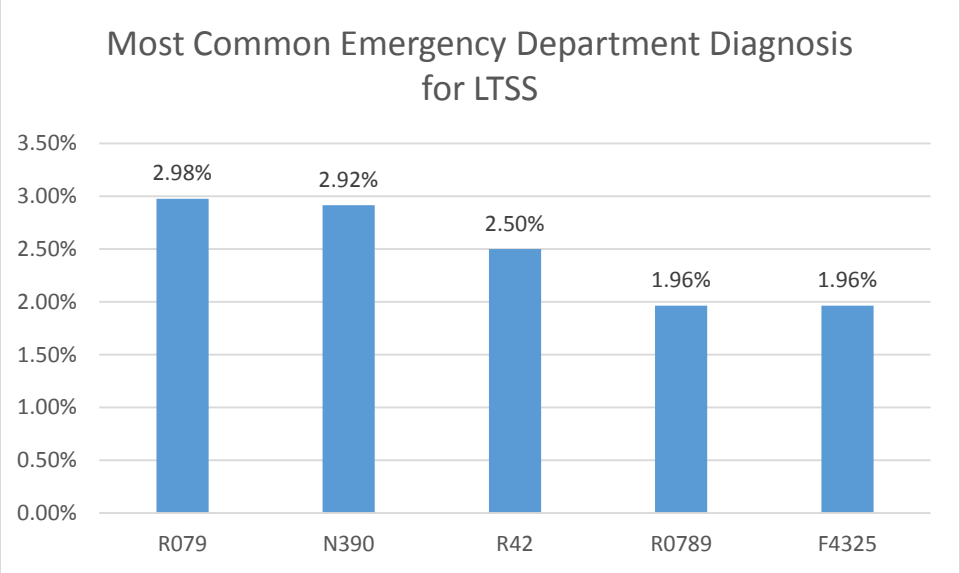


Diagnosis Code	Description
A419	SEPSIS, UNSP ORGISM
I130	HYP HRT & CHR KIDNEY DIS W/HRT FAIL & STG 1-4/UNSP
U07.1	2019-NCOV ACUTE RESPIRATORY DISEASE
N179	ACUTE KIDNEY FAILURE, UNSP
E876	HYPOKALEMIA

Emergency Room Utilization

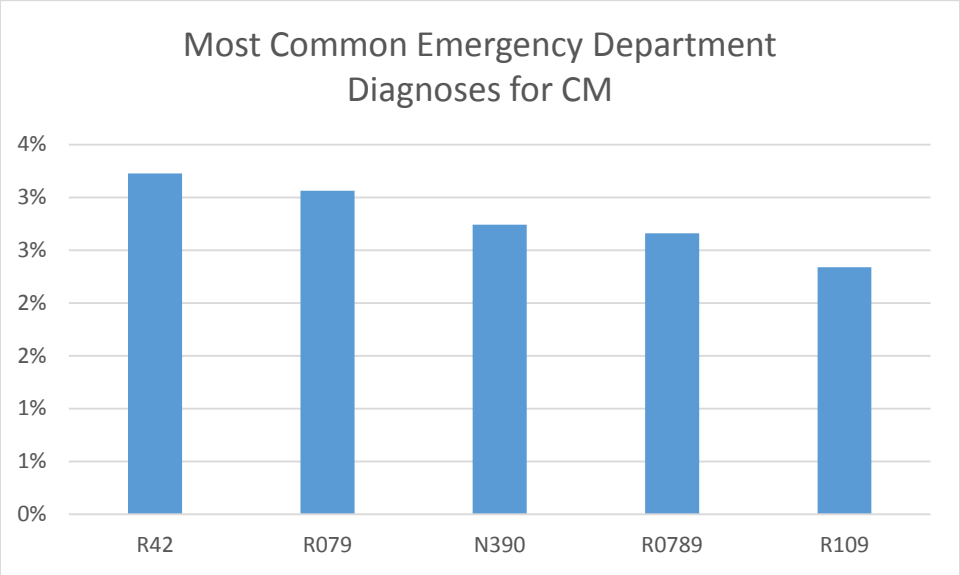


Diagnosis Code	Description
F4325	ADJUST DISORD W/MIXED DISTURB EMOTIONS & CONDUCT
F250	SCHIZOAFFECTIVE DISORD, BIPOLAR TYPE
N390	URINARY TRACT INFECT, SITE NOT SPEC
F259	SCHIZOAFFECTIVE DISORD, UNSP
R079	CHEST PAIN, UNSP

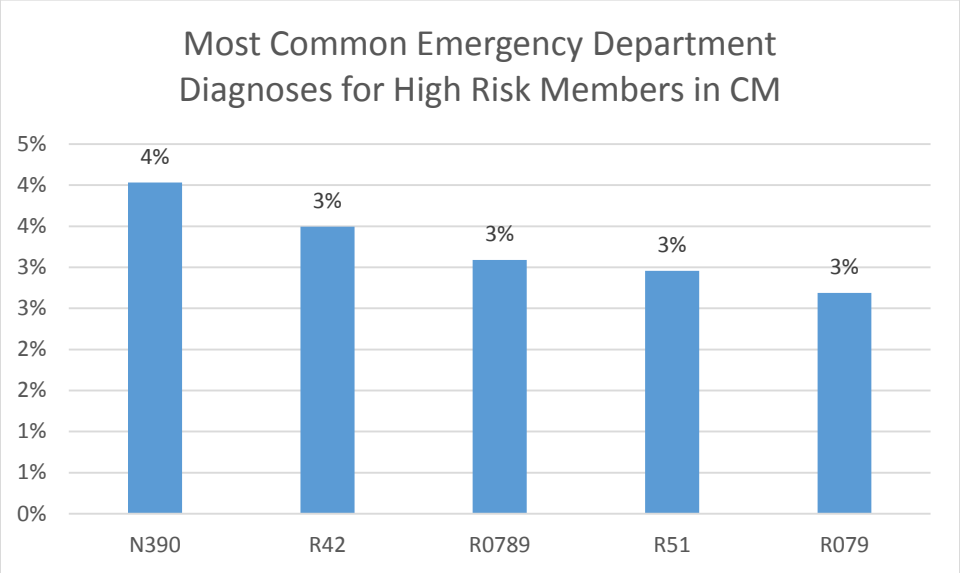


Diagnosis Code	Description
R079	CHEST PAIN, UNSP
N390	URINARY TRACT INFECT, SITE NOT SPEC
R42	DIZZINESS & GIDDINESS
R0789	OTH CHEST PAIN

F4325	ADJUST DISORD W/MIXED DISTURB EMOTIONS & CONDUCT



Diagnosis Code	Description
R42	DIZZINESS & GIDDINESS
R079	CHEST PAIN, UNSP
N390	URINARY TRACT INFECT, SITE NOT SPEC
R0789	OTH CHEST PAIN
R109	UNSP ABD PAIN



Diagnosis Code	Description

N390	URINARY TRACT INFECT, SITE NOT SPEC
R42	DIZZINESS & GIDDINESS
R0789	OTH CHEST PAIN
R51	HEADACHE
R079	CHEST PAIN, UNSP

REFERENCE

1. **Christ, Amber and Burke, Georgia.** *A Primer on Dual-Eligible Californians: How People Enrolled in Both Medicare and Medi-Cal Receive Their Care.* The California Health Care Foundation. 2020.

2. *Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016.* **Singh, Gopal K.** 2017, International Journal of MCH and AIDS.

3. **Healthy People.** *Social Determinants of Health | Healthy People 2020.* 2020.

4. **Mosier, Susan and Clayton, Paula.** *Economic Instatbility A Social Determinant of Health.* 2015.

5. **Taylor, Lauren.** *Housing and Health: An Overview of the Literature.* 2018.

6. **Santa Clara County.** *Santa Clara County Community Plan to End Homelessness (2020-2025).* 2020.

7. **Sourcewise.** *2020-2024 to Area Planning on Aging.* 2020.

8. **Shankar, Janki.** *Education as a Social Determinant of Health: Issues Facing Indigenous and Visble Minority Students in Postsecondary Education in Western Canada.* 2013. pp. 3908-3929.

9. **Santa Clara County Public Health.** *Older Adult Transportation and Traffic Safety Report 2018.* 2018.

10. **Spare the Air.** *Particulate Matter Historical Data.* 2021.

11. **Valley Water.** *Water Quality Reports | Santa Clara Valley Water.* 2021.

12. **Santa Clara County Public Health.** Santa Clara County COVID-19 Dashboard. [Online] January 2021. Data Source: California Reportable Disease Information Exchange. https://www.sccgov.org/sites/covid19/Pages/dashboard-cases.aspx.

13. **The Scan Foundation.** *2017 Findings from the Cal MediConnect Rapid Polling Project.* 2017.

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
American College of Cardiology/American Heart Association

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Hypertension Clinical Guidelines
American Academy of Family Physicians (AAFP)

Osteoporosis
American Academy of Family Physicians (AAFP)

Rheumatoid Arthritis Osteoarthritis
American College of Rheumatology

Acquired Hypothyroidism
American Thyroid Association (ATA)

Behavioral Health Guidelines

Adult Depression Clinical Guidelines
Institute for Clinical Systems Improvement

Children and Adolescents with ADHD Guidelines
American Academy of Pediatrics Guideline

Children and Adolescents with Depressive Disorder Clinical Guidelines
American Academy of Child and Adolescent Psychiatry Guideline

Adverse Childhood Experiences (ACES) Screening
ACES Aware

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

U.S. Preventive Health Services Task Force

CDC Immunization Guideline

Child and Adolescent (0 month to 21 years) Preventative Guidelines

U.S. Preventive Health Services Task Force

CDC Immunization Guideline

CDC Developmental Milestones

Prenatal Preventative Guidelines

ACOG Guidelines

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Seniors (65+ years) Preventive Guidelines

CDC's Advisory Committee of Immunization Practices

U.S. Preventive Health Services Task Force

Treating Tobacco Use and Dependence Guidelines

Agency for Healthcare Research and Quality

Review of Quality Improvement Policies

QI.05 Potential Quality of Care Issues

QI.07 Physical Access Compliance

QI.10 Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)

QI.13 Comprehensive Case Management

QI.29 Nurse Advice Line

POLICY

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

I. Purpose

To define Santa Clara Family Health Plan's (SCFHP) 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, medical groups and facilities. All service types, such as preventive care, primary care, specialty care, emergency care, transportation and ancillary services are considered and subject to disciplinary action. Availability of care, including case management for the Seniors and Persons with Disabilities (SPD) population, continuity of care, and coordination of care are also considered. The Plan monitors and analyzes data to determine if services meet professionally recognized standards of practice. Any grievance or PQI referral that involves quality of care or potential adverse outcome to a member is referred to a Medical Director.

III. Responsibilities

PQIs may initially be identified by providers, members, and 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)(1)(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

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 02/12/2020	Title 02/12/2020
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Quality Improvement	Approve 5/10/2016	
V1	Reviewed	Quality Improvement	Approve 5/10/2017	
V1	Reviewed	Quality Improvement	Approve 6/6/2018	
V1	Reviewed	Quality Improvement	Approve 2/13/2019	
V2	Revised	Quality Improvement	Approve 2/12/2020	
V2	Review	Quality 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:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal		☒ CMC

I. Purpose

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

II. Policy

SCFHP conducts a physical accessibility review at every contracted Primary Care Physician (PCP) office, defined high volume specialist, CBAS, and ancillary practice site listed in the Plan's provider directory.

SCFHP drives 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.

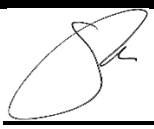
III. Responsibilities

SCFHP Quality Improvement Department (QI) performs site reviews and reports to the Quality Improvement Committee (QIC). 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

1. Access to Medical Care for Individuals with Mobility Disabilities, July 2010, U.S. Department of Justice, Civil Rights Division, Disability Rights Section
2. DPL14-005 – Facility Site Reviews/Physical Accessibility Reviews
3. APL15-023 – Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
4. PL 12-006 - Revised Facility Site Review Tool
5. Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
6. 2009 California Building Standards Code with California Errata and Amendments
7. State of California, Department of General Services, Division of the State Architect. Updated April 27, 2010
8. DHCS/SCFHP Contract:
   Exhibit A, Attachment 4 - QUALITY IMPROVEMENT SYSTEM
9. Quality Improvement Committee
10. Quality Improvement Annual Report
11. Site Review
12. Exhibit A, Attachment 7 – PROVIDER RELATIONS
13. Provider Training
14. Exhibit A, Attachment 9 – ACCESS AND AVAILABILITY
15. Access for Disabled Members

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
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Date	Date

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V1	Original	Quality Improvement	Approve 11/9/2016	
V1	Reviewed	Quality Improvement	Approve 05/10/2017	
V1	Reviewed	Quality Improvement	Approve 06/06/2018	
V1	Reviewed	Quality Improvement	Approve 02/13/2019	
V1	Reviewed	Quality Improvement	Approve 02/12/2020	
V1	Review	Quality Improvement		

POLICY

Policy Title:	**Initial Health Assessments (IHA) and Staying Healthy Assessment (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 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 SHAs.

II. Policy

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

III. Responsibilities

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

Santa Clara Family Health Plan™

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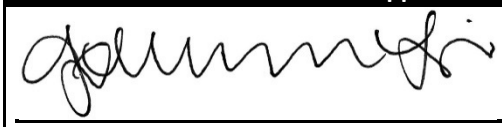
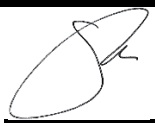
V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Laurie Nakahira, D.O.
Name Director, Quality and Process Improvement	Name Chief Medical Officer
Title 02/12/2020	Title 02/12/2020
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	Approved 08/10/2016	
V1	Reviewed	Quality Improvement	Approved 05/10/2017	
V2	Revised	Quality Improvement	Approved 06/06/2018	
V2	Reviewed	Quality Improvement	Approved 02/13/2019	
V2	Reviewed	Quality Improvement	Approved 02/12/2020	
V3	Revised	Quality Improvement		

POLICY

Policy Title:	**Comprehensive Case Management**	**Policy No.:**	QI.13 V2
Replaces Policy Title (if applicable):	Case Management	**Replaces Policy No. (if applicable):**	CM030_05
Issuing Department:	Health Services	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ CMC	

I. Purpose

To promote access to appropriate, coordinated services with the intent that members with case management needs may achieve optimal health and functionality.

II. Policy

A. The comprehensive case management program is established to provide case management processes and procedures that helps members with multiple or complex conditions to obtain access to care and services, and the coordination of appropriate care and resources. The structure of comprehensive case management is organized to promote quality case management, client satisfaction and cost efficiency through the use of collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

B. To define the fundamental components of SCFHP case management services which when appropriate for any given member, include:

- Initial assessment of members' health status, including condition specific issues
- Documentation of clinical history, including medications
- Initial assessment of the activities of daily living
- Initial assessment of behavioral health status, including cognitive functions
- Initial assessment of social determinants of health
- Initial assessment of life-planning activities
- Evaluation of cultural and linguistic needs, preferences or limitations
- Evaluation of visual and hearing need, preferences or limitations
- Evaluation of caregiver resources and involvement
- Evaluation of available benefits
- Evaluation of community resources
- Provider engagement

C. Referrals to SCFHP's case management team are accepted from members or their caregivers, practitioner's or other external providers, hospital discharge planners, SCFHP internal staff (including customer service and utilization management) and/or community partners. All referrals will initially be assessed by case management staff for the appropriate level of case management support needed to coordinate care and services for medical, behavioral health and other non-medical risk factors.

Successful completion of an initial assessment will determine member's placement in the most appropriate Population Health case management Tier for ongoing support.

D. A Case Management referral form is available on SCFHP's public website and all completed forms and supporting documentation may be submitted directly to the Case Management department via mail delivery or by secure email to: CaseManagementHelpDesk@scfhp.com. Case Management referrals may also be requested verbally through telephonic interaction by calling SCFHP's Customer Service department at 1-877-723-4795 (Medicare members) of 1-800-260-2055 (Medi-Cal members) and requesting case management support. Members can also call the Case Management Department directly at 1-877-590-8999. All Case Management referrals will receive an initial review within 72 business hours of receipt.

E. SCFHP's 2021 PHM Strategy description defines the process of how SCFHP coordinates services for the highest risk members with complex conditions and helps them access needed resources through intensive and comprehensive interactions.

III. Responsibilities

Health Services collaborates with other SCFHP departments (IT, claims, benefits, provider services) as well as providers and community services to identify, coordinate services, coordinate benefits and provide members with comprehensive case management.

IV. References

3 Way Contract. (2019). *Contract Between United States Department of Health and Human Services; Centers for Medicare and Medicaid Services and California Department of Health Care Services*.
Cal MediConnect Continuity of Care Technical Assistance Guide (TAG). (2015, October 27). California, USA.
NCQA Health Plan Accreditation Guidelines 2021 - Population Health (PHM) Element 5
DPL 17-001 and DPL 17-002

V. Approval/Revision History

First Level Approval	Second Level Approval
Raman Singh Director, Case Management	Laurie Nakahira, D.O. Chief Medical Officer
Date	Date

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

Santa Clara Family Health Plan™

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V1	Original	Quality Improvement	Approved 08/05/16	
V1	Reviewed	Quality Improvement	Approved 08/19/17	
V1	Reviewed	Quality Improvement	Approved 06/06/18	
V1	Reviewed	Quality Improvement	Approved 06/12/19	
V2	Revised 07/22/19	Quality Improvement	Approved 08/14/19	
V2	Reviewed	Quality Improvement	Approved 06/10/20	
V2	Review	Quality Improvement		

POLICY

Policy Title:	**Nurse Advice Line**	**Policy No.:**	QI.29 V2
Replaces Policy Title (if applicable):	Nurse Advice Line	**Replaces Policy No. (if applicable):**	HS.13
Issuing Department:	Health Services – Care 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 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

Multiple departments at SCFHP maintain responsibilities related to the Nurse Advice Line. Health Services and Customer Service 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

NCQA 2021
3-way Contract between CMS, DHCS and SCFHP

Santa Clara Family Health Plan™

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval
Raman Singh Director, Case Management	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	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		

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 2020		
Responsible Party	Identify responsible individual for ADA Compliance	Annual	February 2020	February 2020	Director of Quality and Process Improvement has oversight for ADA Compliance.
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: CBAS	Quarterly	3/31/2020- 0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: LTSS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: Nursing Home	Quarterly	3/31/2020-2 6/30/2020-0 9/30/2020-1 12/31/2020-1	Completed	
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: IHSS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Patient Safety	Number of *Potential* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Patient Safety	Number of *Potential* Quality of Care Issues identified at: IHSS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Patient Safety	Number of *Potential* Quality of Care Issues identified at: LTSS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Patient Safety	Number of *Potential* Quality of Care Issues identified at: Nursing Home	Quarterly	3/31/2020-8 6/30/2020-6 9/30/2020-7 12/31/2020-6	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: LTSS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: Nursing Home	Quarterly	3/31/2020-1 6/30/2020-0 9/30/2020-1 12/31/2020-3	Completed	
Patient Safety	Number of *Validated* Quality of Care Issues identified by: IHSS	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Completed	
Access	PAR Site Identification: Plan refreshes claims history to identify new high volume specialists and ancillary providers for review	Annual	1/31/2020	Completed	
Access	Physical Accessibility Review: Number of LTSS sites reviewed	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	none identified for 2020	

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Access	Physical Accessibility Review: Number of CBAS sites reviewed	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	Two providers identified for 2020. Postponed due to COVID-19 pandemic.	Golden Castle: identified CBAS for 2020 with an address change GRACE ADHC: Priousuly done in 2015.
Access	Number of referrals to: CBAS	Quarterly	3/31/2020 -201 6/30/2020 -208 9/30/2020- 213 12/31/2020 -220	Completed	
Access	Number of referrals to: MSSP	Quarterly	3/31/2020 -0 6/30/2020- 2 9/30/2020- 1 12/31/2020 -5	Completed	
Access	Number of referrals to: Nursing Home	Quarterly	3/31/2020 -124 6/30/2020- 131 9/30/2020-116 12/31/2020 - 99	Completed	
Access	Number of referrals to: IHSS	Quarterly	3/31/2020 -34 6/30/2020 -19 9/30/2020- 58 12/31/2020 -61	Completed	
Access	Physical Accessibility Review: Number of High Volume Specialists	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	One provider identified for 2020. Postponed due to COVID-19 pandemic.	TAI, EDMUND W Med Onc 795 El Camino Real Palo Alto
Access	Physical Accessibility Review: Number of Ancillary sites reviewed	Quarterly	3/31/2020-0 6/30/2020-0 9/30/2020-0 12/31/2020-0	none identified for 2020	
Preventive Care	HEDIS: Care of Older Adults - Functional Status Assessment	Annual	6/30/2020	Completed	HEDIS 2020 (MY 2019) 57.91%
Preventive Care	Medication Reconciliation Post-Discharge	Annual	6/30/2020	Completed	HEDIS 2020 (MY 2019) 67.88%

Domain	Measure	Reporting Frequency	Target Completion	Completed	Findings
Population Needs Assessment	Population Needs Assessment Report shared at: Consumer Advisory Committee Quality Improvement Committee	Annual	8/31/2020	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	3/31/2020- 0 6/30/2020-3 9/30/2020-1 12/31/2020-1	Completed	
Patient Safety	Plan monitors grievances for reasonable accommodations and access to services under ADA	Quarterly	3/31/2020- 7 6/30/2020- 6 9/30/2020 - 0 12/31/2020- 1	Completed	
Workplan	Plan will identify issues within its system that require improvement to promote access and ADA compliance	Annual	12/31/2020	Completed	No issues identified.

Santa Clara Family Health Plan™

Initial Health Assessment (IHA)

Quality Improvement Department

Neha Patel, QI RN

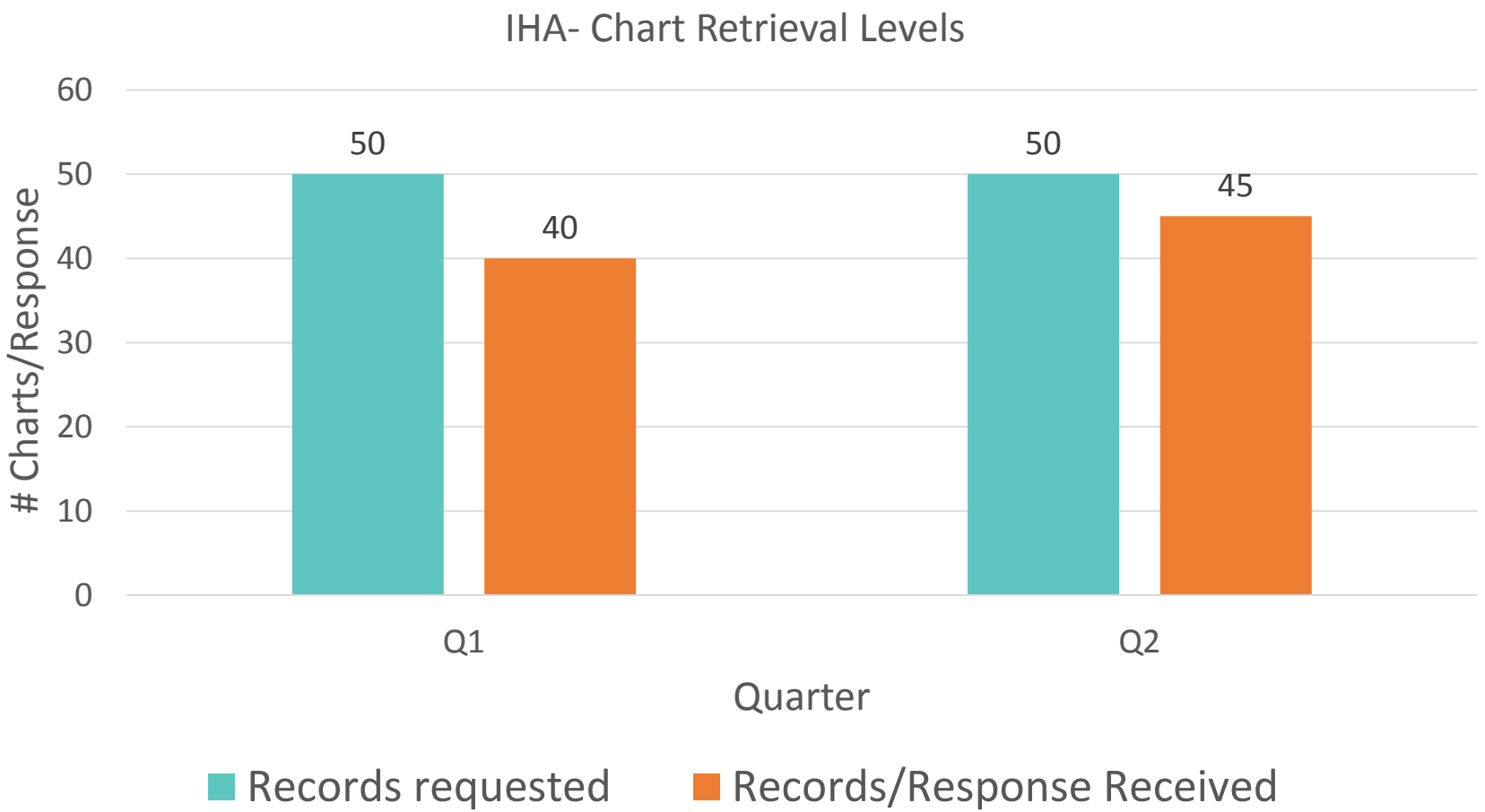
Initial Health Assessment (IHA)

Complete medical, social, and needs assessment in the first 120 days of plan enrollment

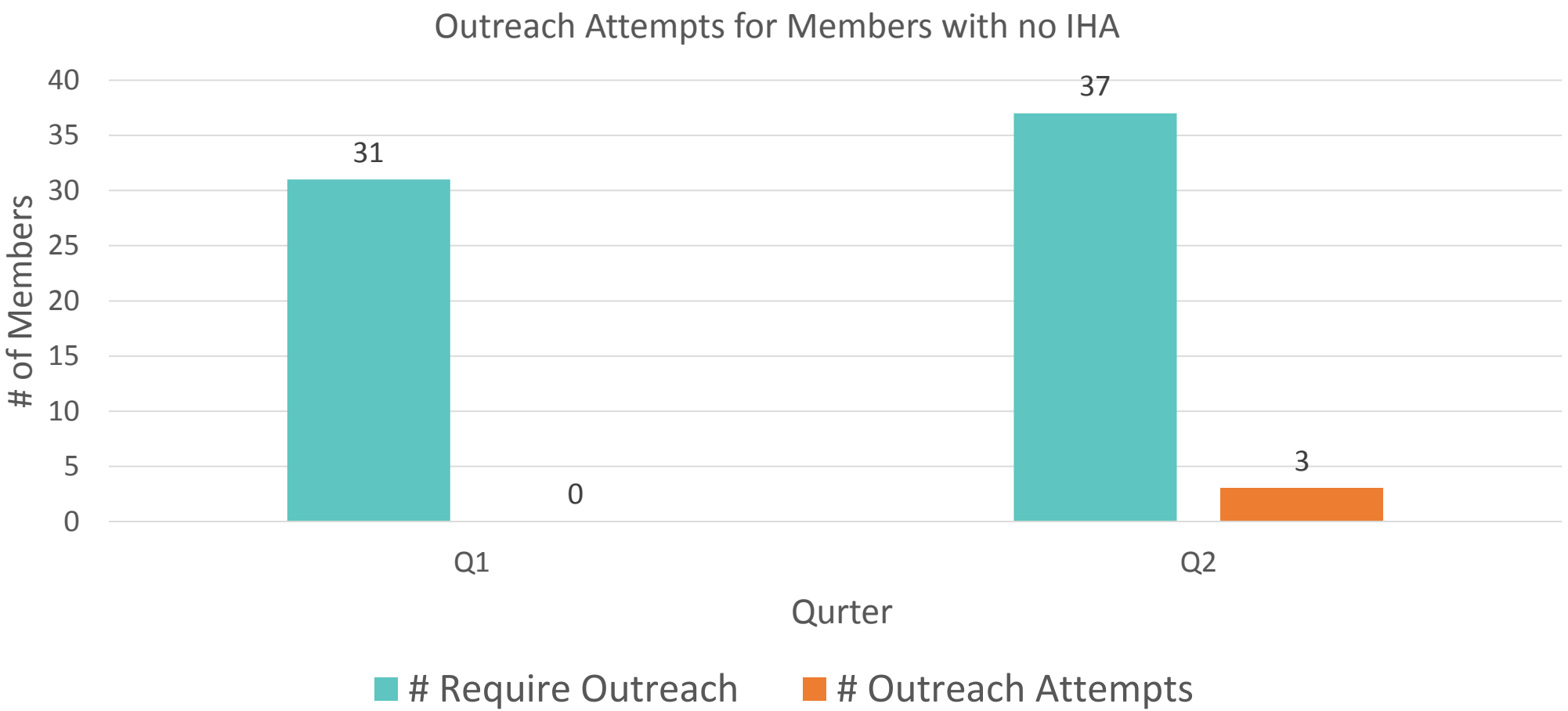
- **Five elements required for completion credit:**

1 - Comprehensive history
2 - Administration of preventive services (screenings, immunizations, etc.)
3 - Comprehensive physical and mental status exam
4 - Diagnosis and plan of care
5 - Staying Healthy Assessment (SHA) Questionnaire

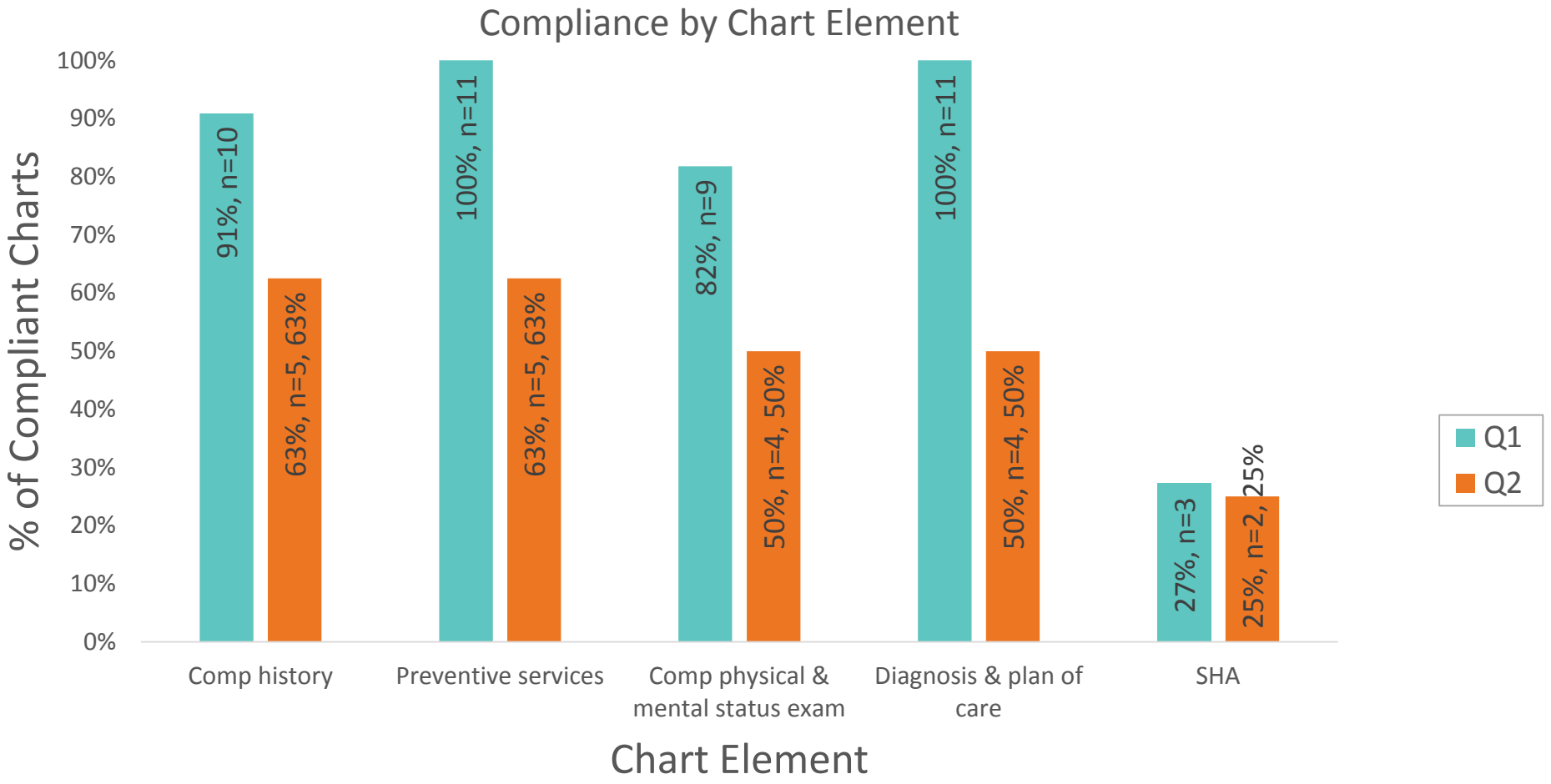
IHA – Chart Retrieval Levels



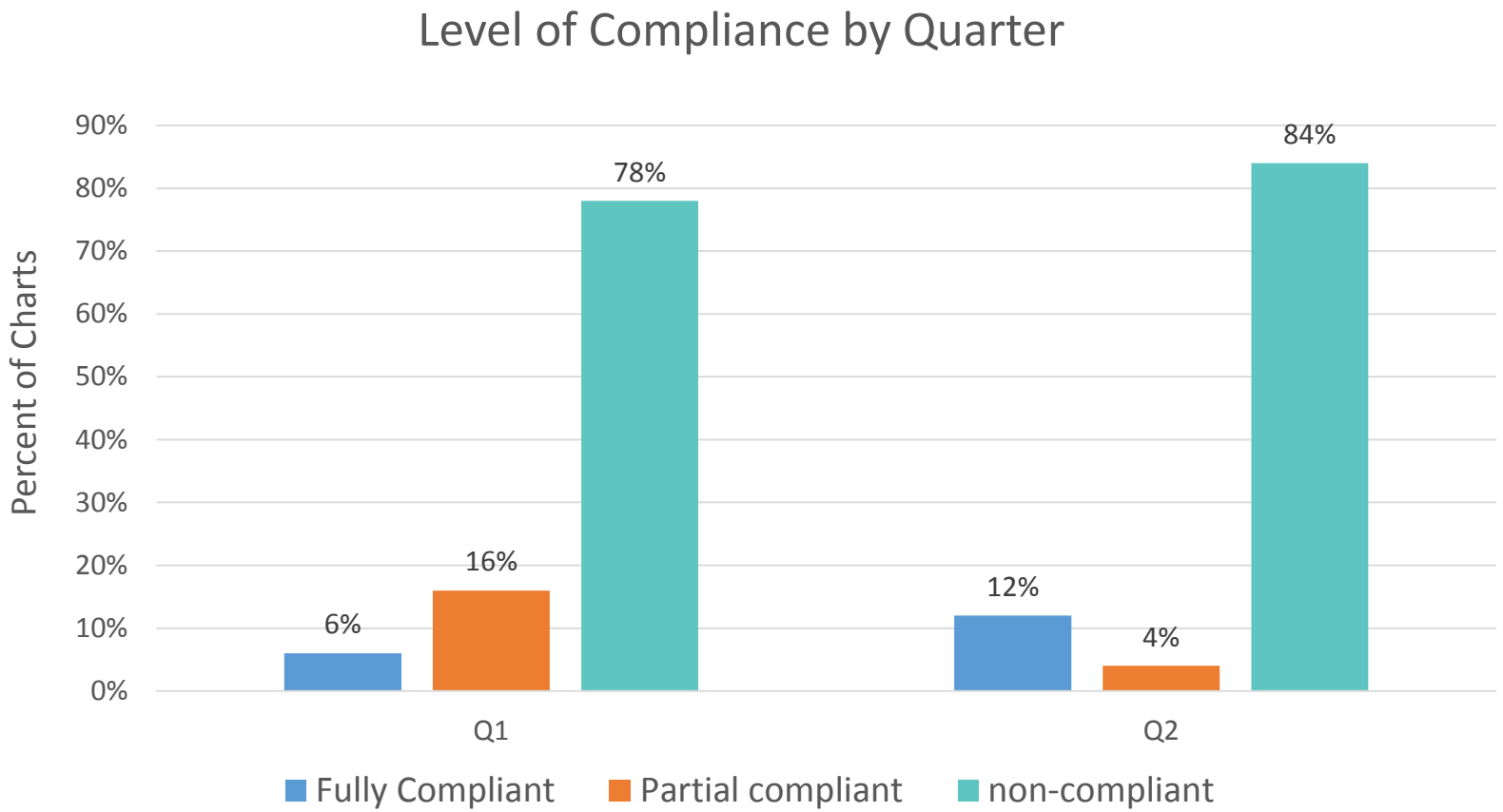
Outreach Attempts for Members with no IHA



IHA – Compliance by Chart Element



IHA – Level of Compliance by Quarter



IHA Findings

Except for SHA, all the IHA elements scores are above 50%

- SHA remains the element with the greatest opportunity for improvement.
- Education required for 20/20 providers, primarily due to missing SHAs.
- Adult visits are most consistently fully compliant records in Q1 and Q2.
  - Missing SHA makes pediatric charts partially compliant.
- Missing mental status still the most common reason for the incomplete physical criteria.
- Record retrieval remains problematic. 4 providers did not submit any record or documentation of outreach attempts.

IHA Findings

SHA, Outreach and Record Retrieval remain problematic

SHA

- Approximate 75% of charts do not have complete SHA.

Record retrieval

- Q1 - 60% provider charts not returned, Three providers did not return any medical records.
- Q2 - 55% of charts not returned, One provider did not return any medical records.

Outreach attempts

- Q1 and Q2 - 68 records in both quarters without IHAs, 3 charts had outreach attempt documented.

CAPs

- 1 previously educated Q4 – 2019 providers, with additional education materials will be provided.
- Health education material will be provided to all the providers. No CAPs issued.

IHA- Barriers

Provider	System	Member
Providers do not : Check the SCFHP portal on a regular basis for newly assigned members	Difficulty reaching Medi-Cal members to schedule appointments	Members are hesitant to schedule visit with PCP due to PHE
Document attempted contacts to schedule appointments for new members	Lack of provider training about all IHA requirements	Members change providers in the first 120 days
Use the required SHA questionnaires or other state approved forms during IHAs	Submit requested records for IHA review	Members may have other barriers including getting to appointments that are outside of SCFHP's control
	Limited staff in the clinic to support provider on IHA due to Public Health Emergency (PHE)	

IHA- Overcoming Barriers

Provider Education	System Improvement	Member Education
Provider Portal use	Provider News article published on 4/2020,5/2020 & 10/2020	Timely member education regarding need for IHA
Required documentation, including outreach	Trained PNO on IHA	Encourage members to be active participants in their health care
More efficient, effective use of the SHA	PNM included IHA & SHA information in the provider training packet	Member newsletter article published in Fall 2020
Ongoing support and education based on provider feedback	Continue working with IHA collaborative work group on quarterly basis	

Questions?

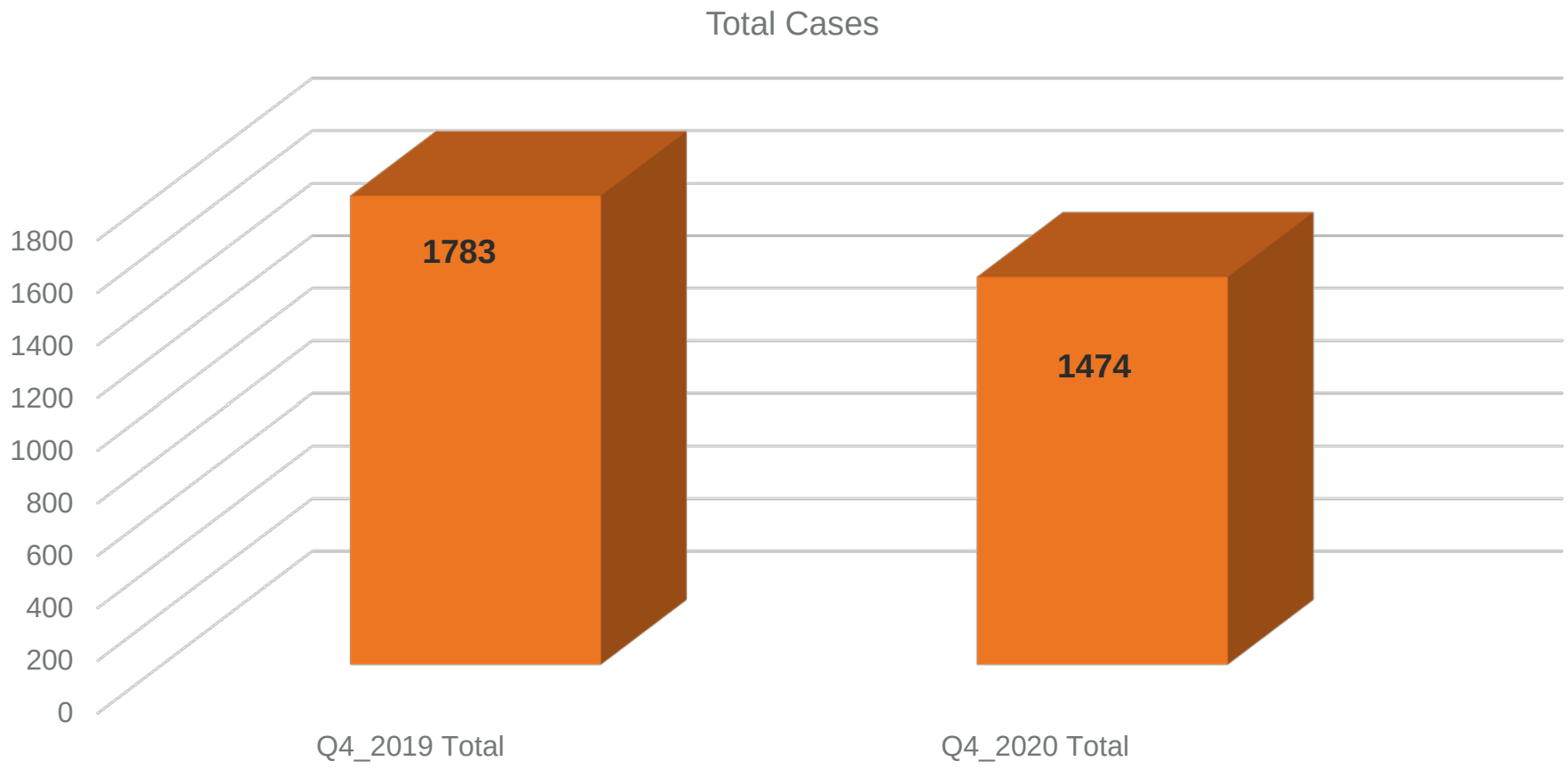
Santa Clara Family Health Plan™

Quality Improvement Committee

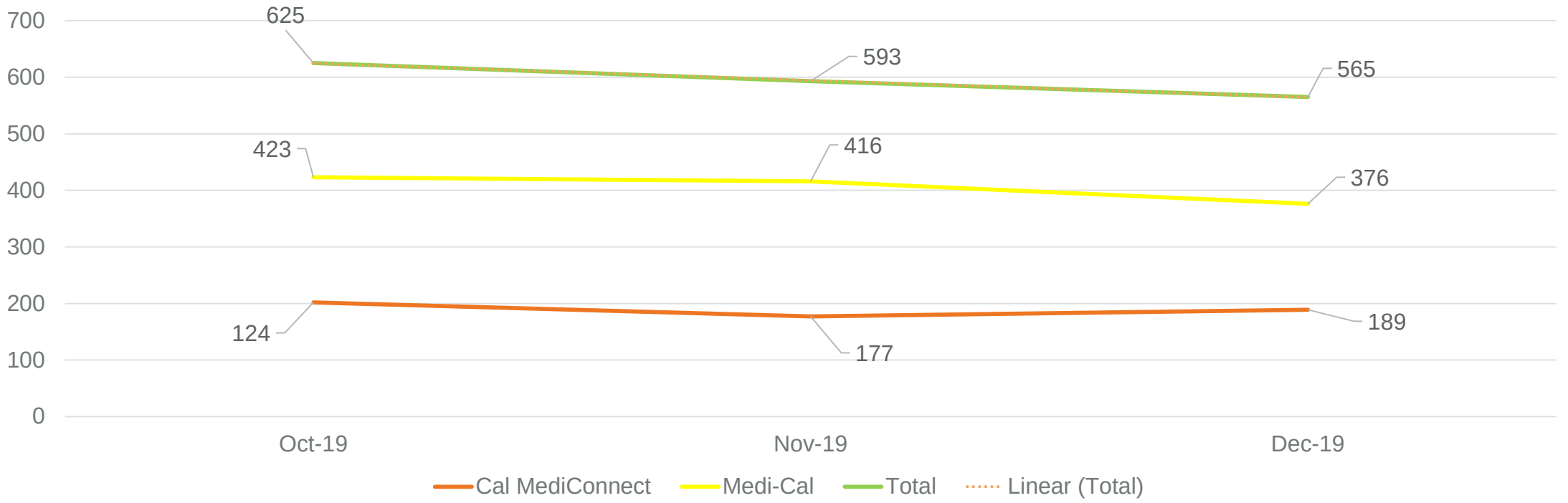
Q4 2020 Grievance & Appeals Data

February 9, 2021

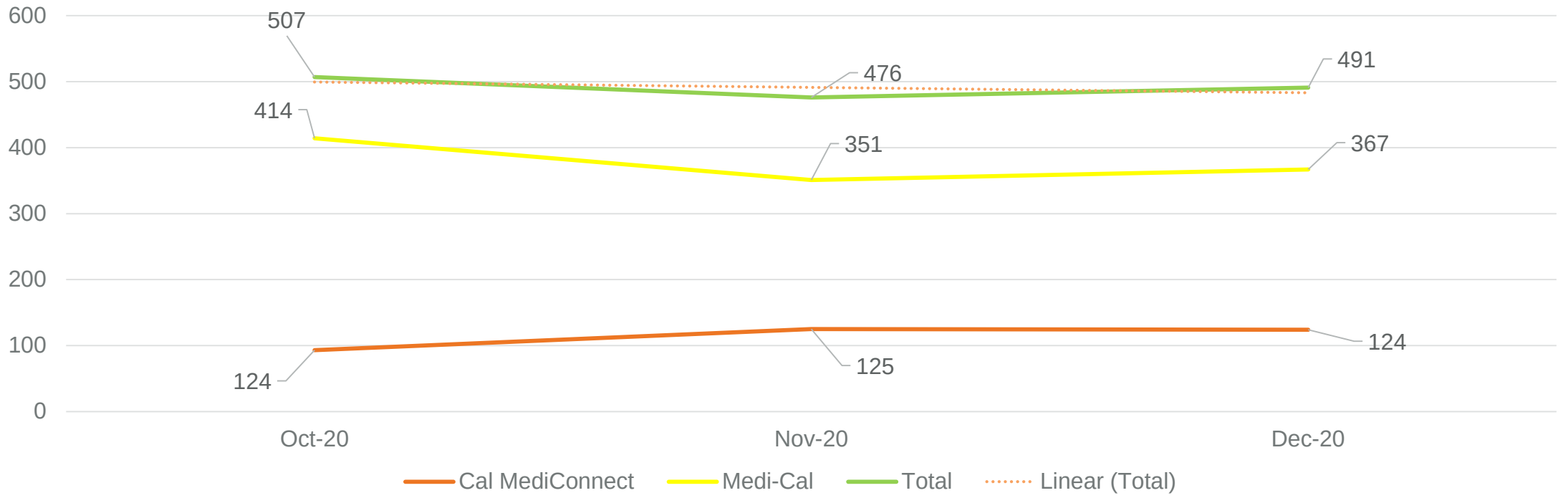
Total Grievance & Appeal Cases Received (All LOB)



Q4 2019 Total Grievance & Appeal Cases Received(All LOB)



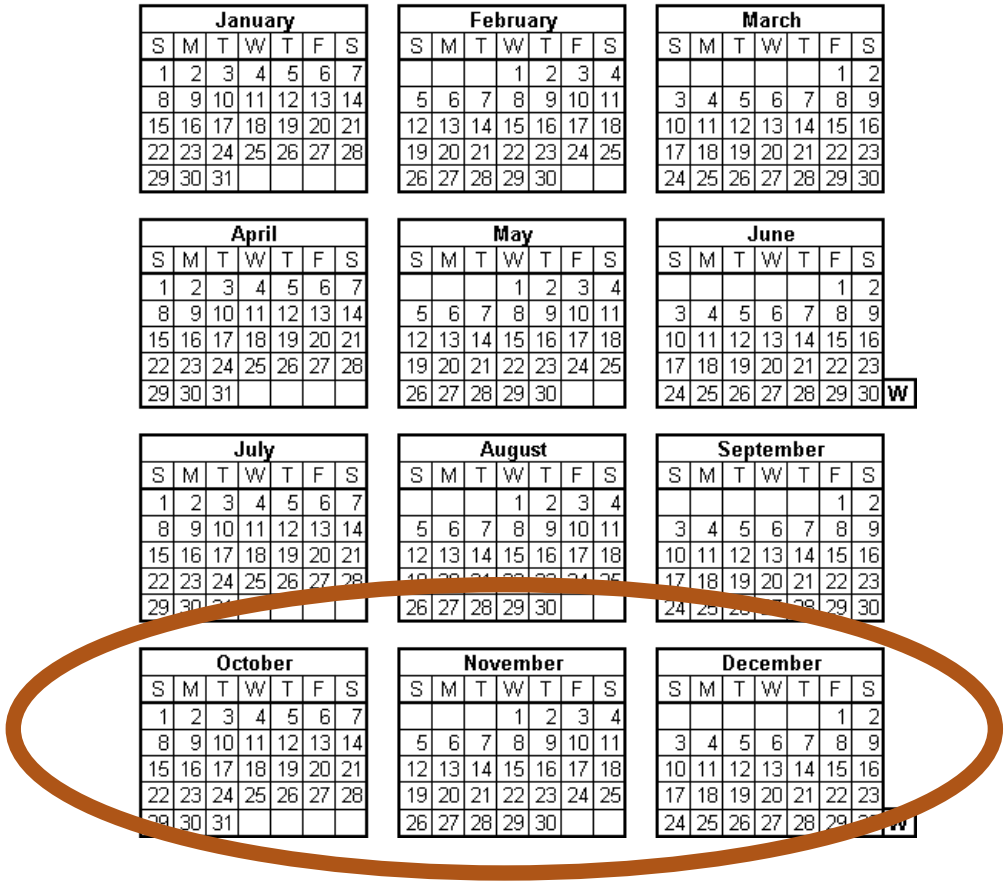
Q4 2020 Total Grievance & Appeal Cases Received(All LOB)



Q4 2020 Total Grievances
(*Rate per 1000 Members)*

		Oct-20	Nov-20	Dec-20
Total CMC Grievances		**18**	**30**	**3**
CMC Total Membership		**9,570**	**9,679**	**9,820**
Rate per 1,000		2	3	0
Total MC Grievances		274	257	253
MC Total Membership		**256,490**	**259,202**	**261,287**
Rate per 1,000		1.07	0.99	0.97

Medi-Cal



January						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

February						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

March						
S	M	T	W	T	F	S
					1	2
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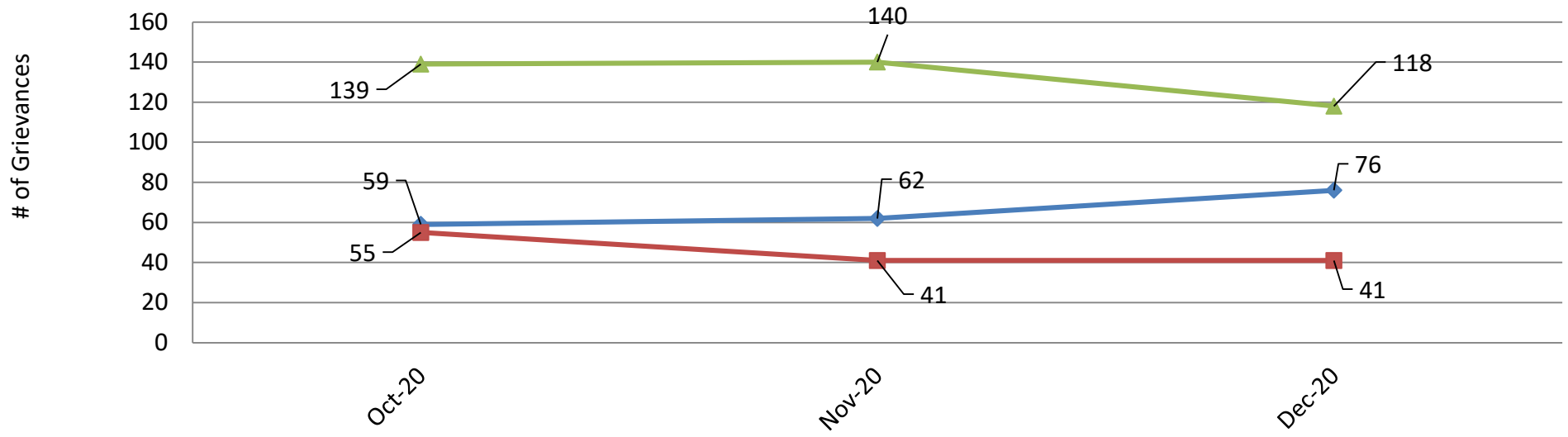
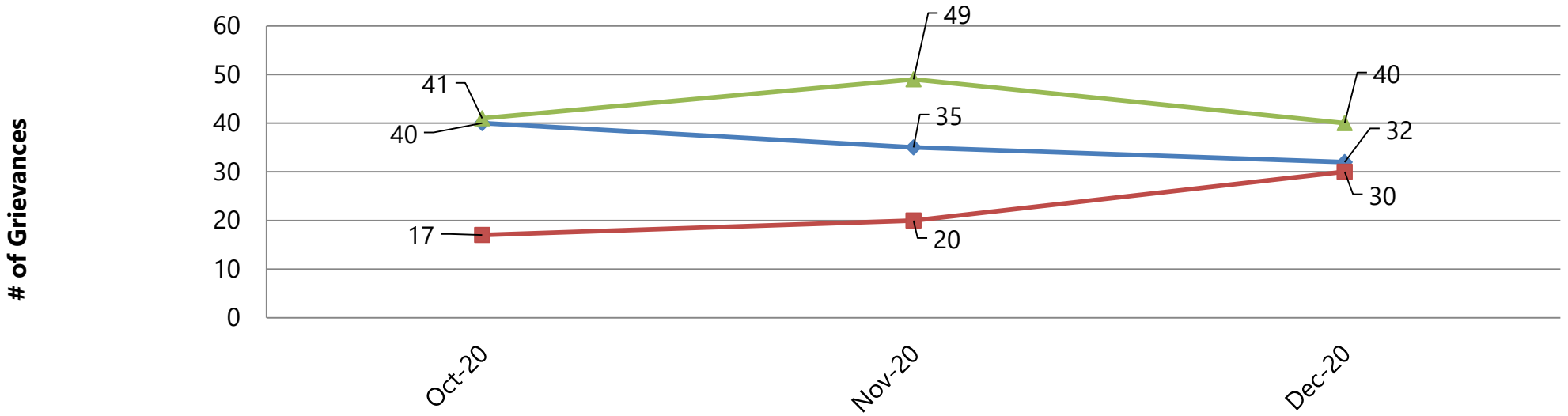
Q4 2020

Q4 2020:Top 3 Medi-Cal Grievance Categories



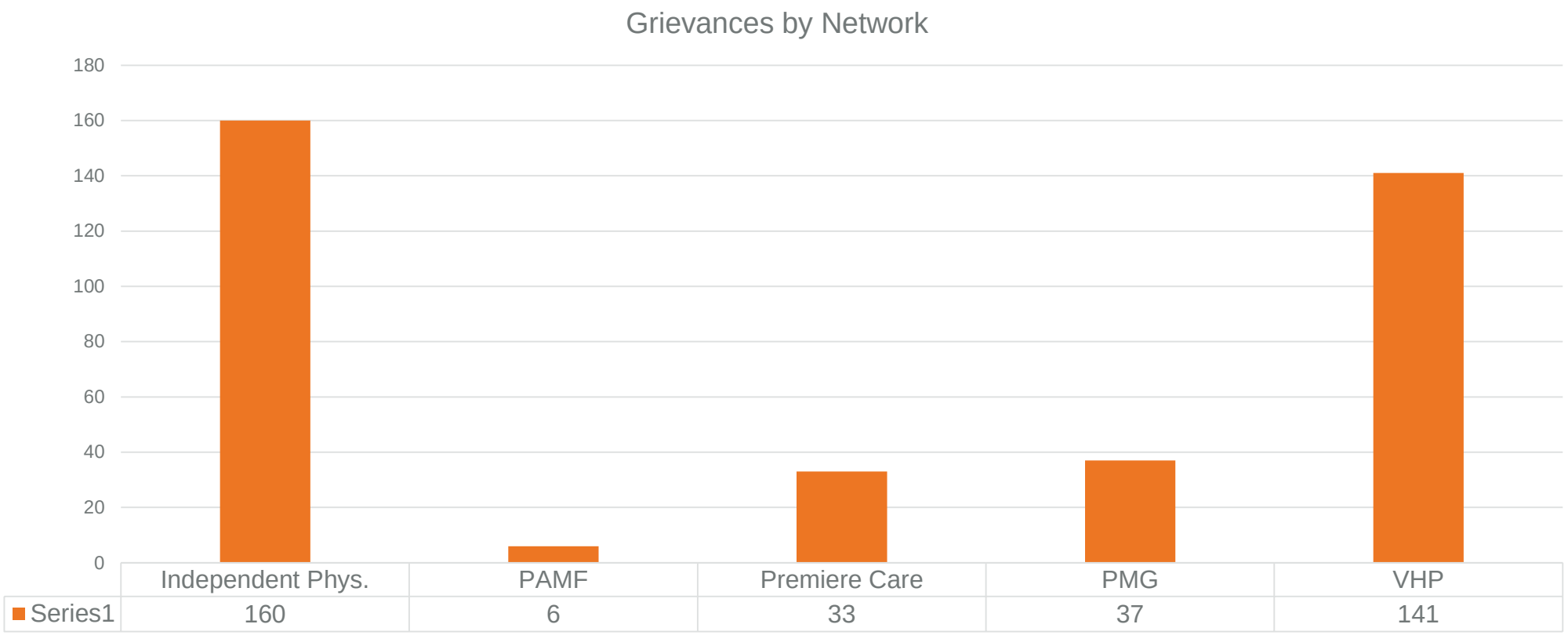
	Oct-20	Nov-20	Dec-20
Access	59	62	76
Quality of Care	55	41	41
Quality of Service	139	140	118

Q4 2020:Top 3 Medi-Cal Grievance Subcategories



	Oct-20	Nov-20	Dec-20
QOC- Inappropriate Provider Care	40	35	32
Access-Provider Telephone Access	17	20	30
QOS-Inappropriate Billing	41	49	40

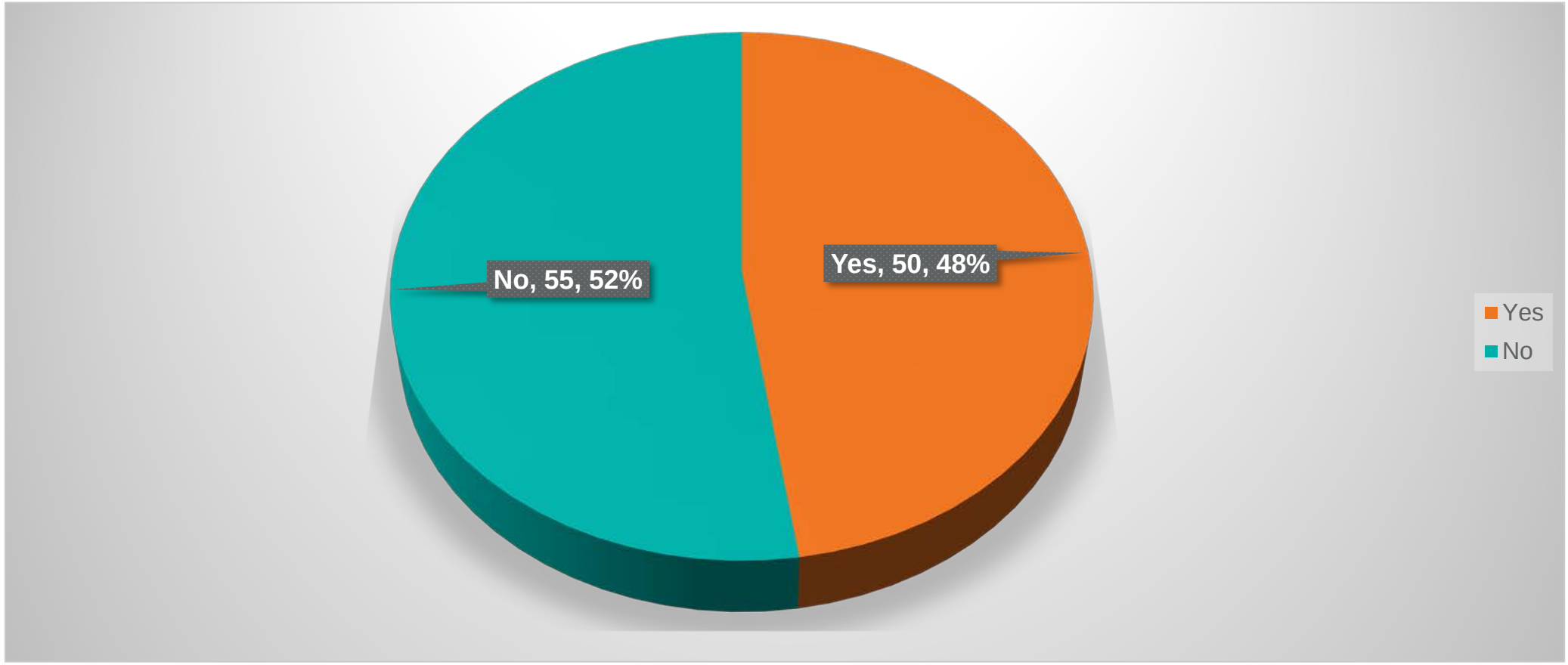
Q4 2020 MC Grievances by Network



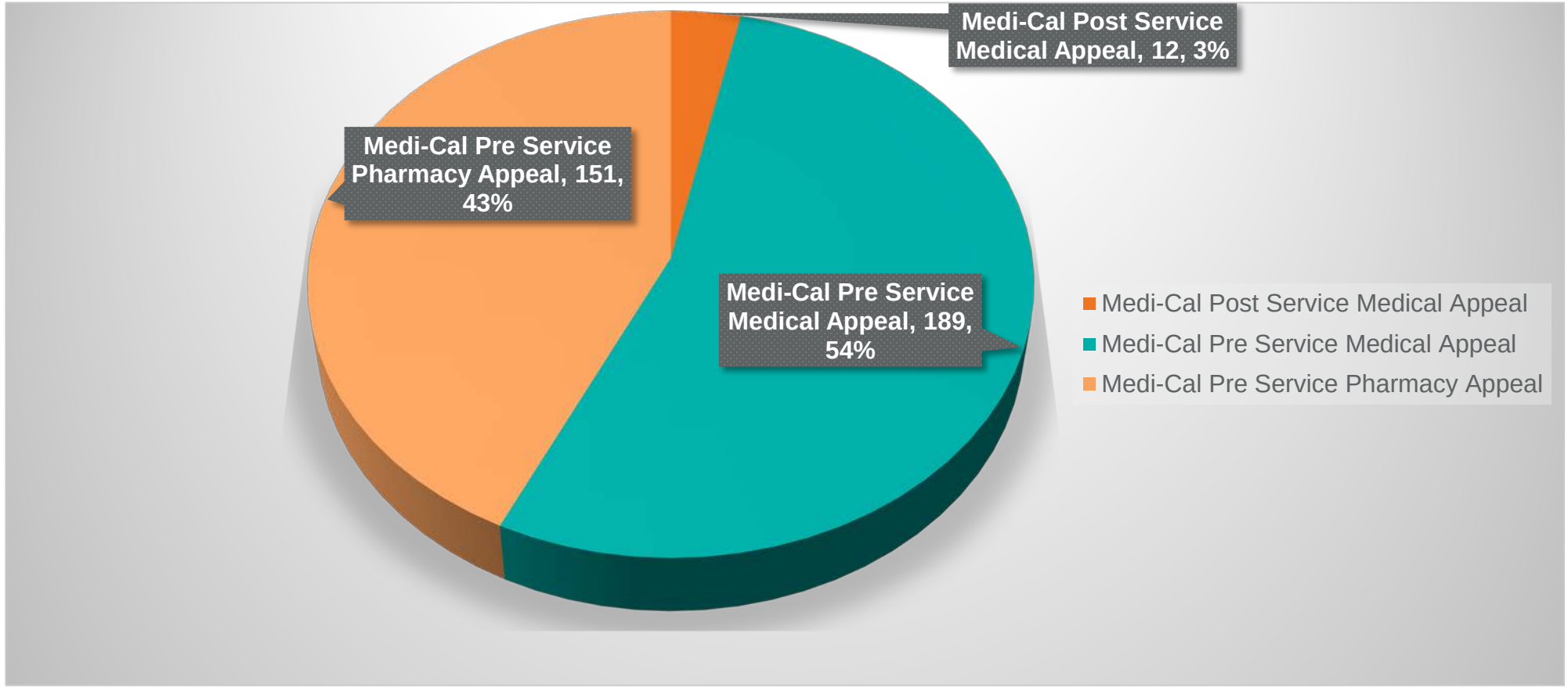
Q4 2020 MC Grievances by Network (*Rate per 1000 Members)*

Network	Oct-20	Nov-20	Dec-20	Total Grievance Q4 by Network	Rate per 1,000
INDEPENDENT PHYSICIANS	16,627	16,829	16,938	160	9.45
MEDICARE PRIMARY	15,742	15,830	16,002	34	2.12
PALO ALTO MEDICAL FOUNDATION	6,935	6,985	7,010	6	0.86
PHYSICIANS MEDICAL GROUP	44,223	44,560	44,861	37	0.82
PREMIER CARE	15,473	15,593	15,646	33	2.11
VHP NETWORK	128,622	130,068	131,124	141	1.08

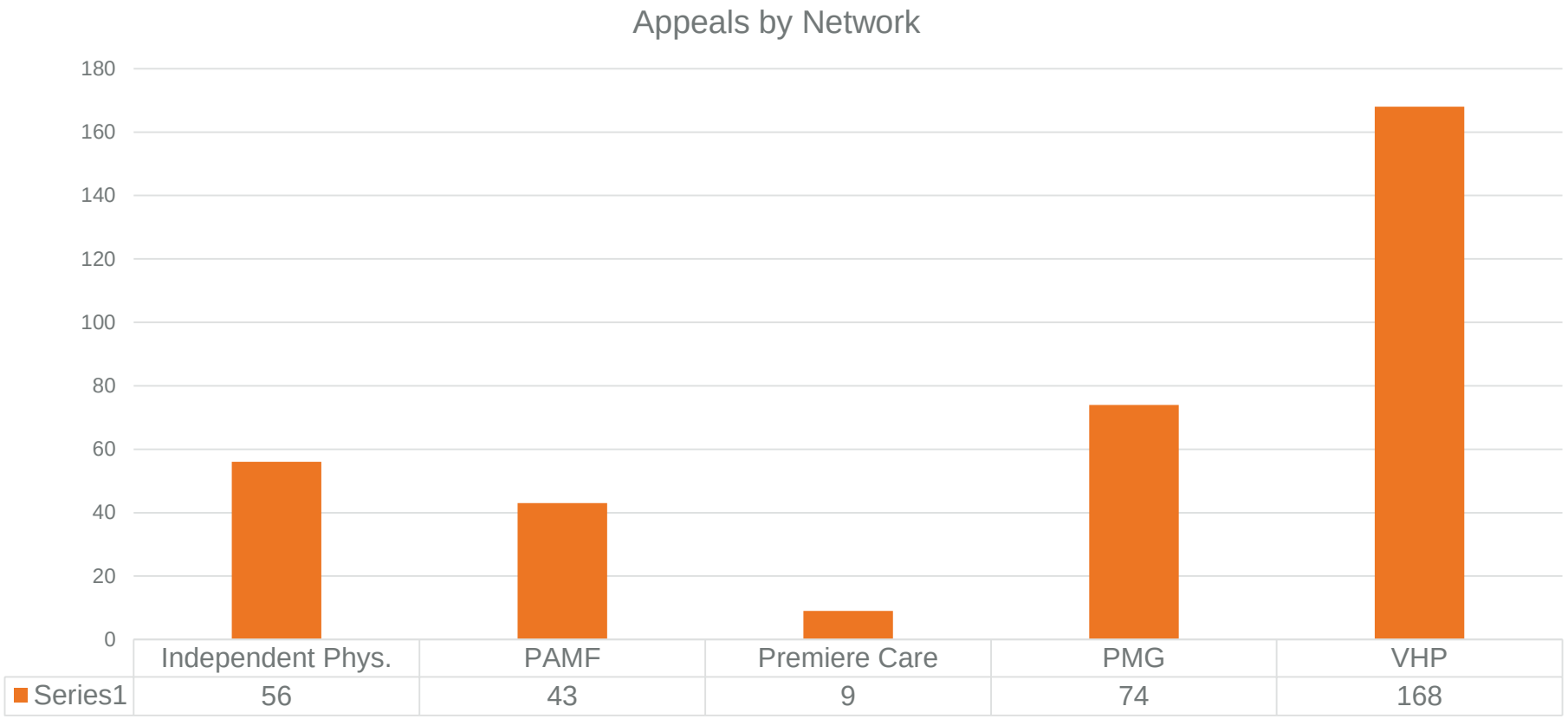
Q4 2020 MC Inappropriate Provider Care PQI Issues Flag



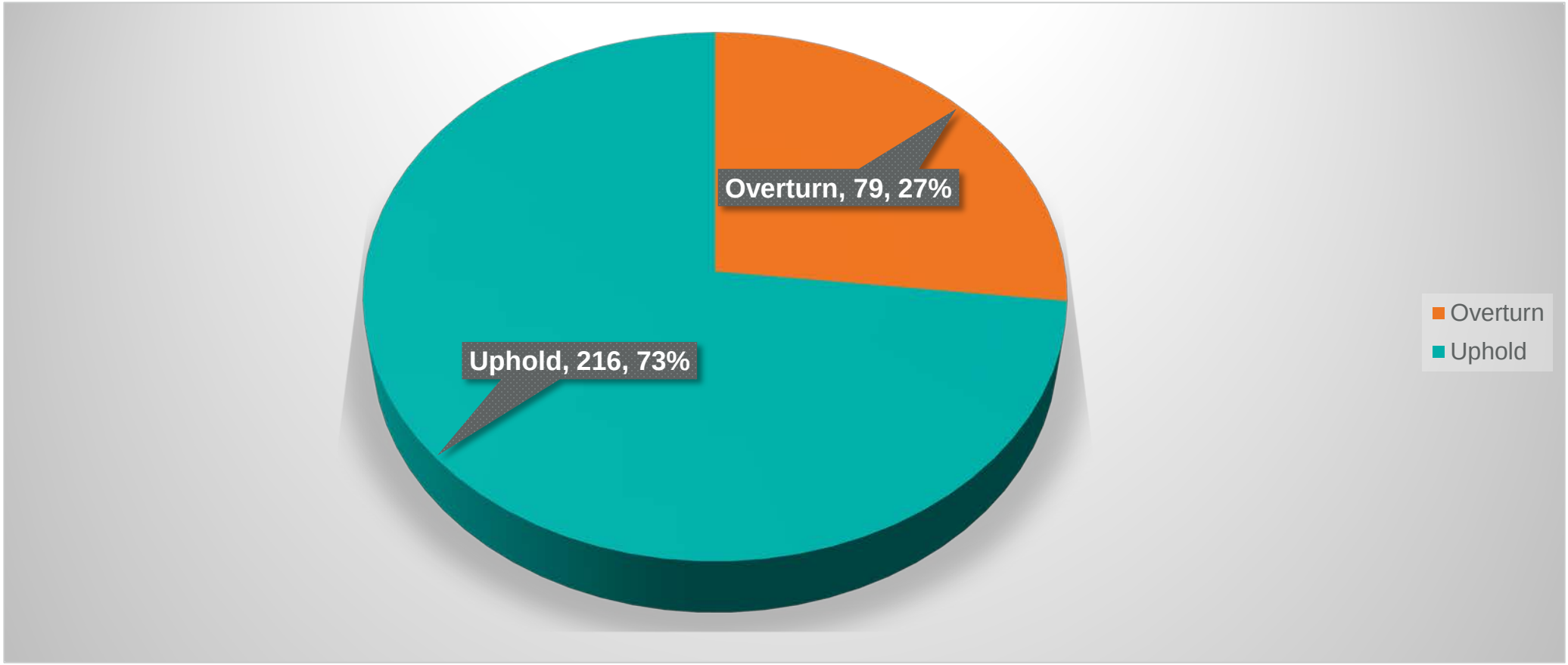
Q4 2020 Medi-Cal Appeals by Case Type



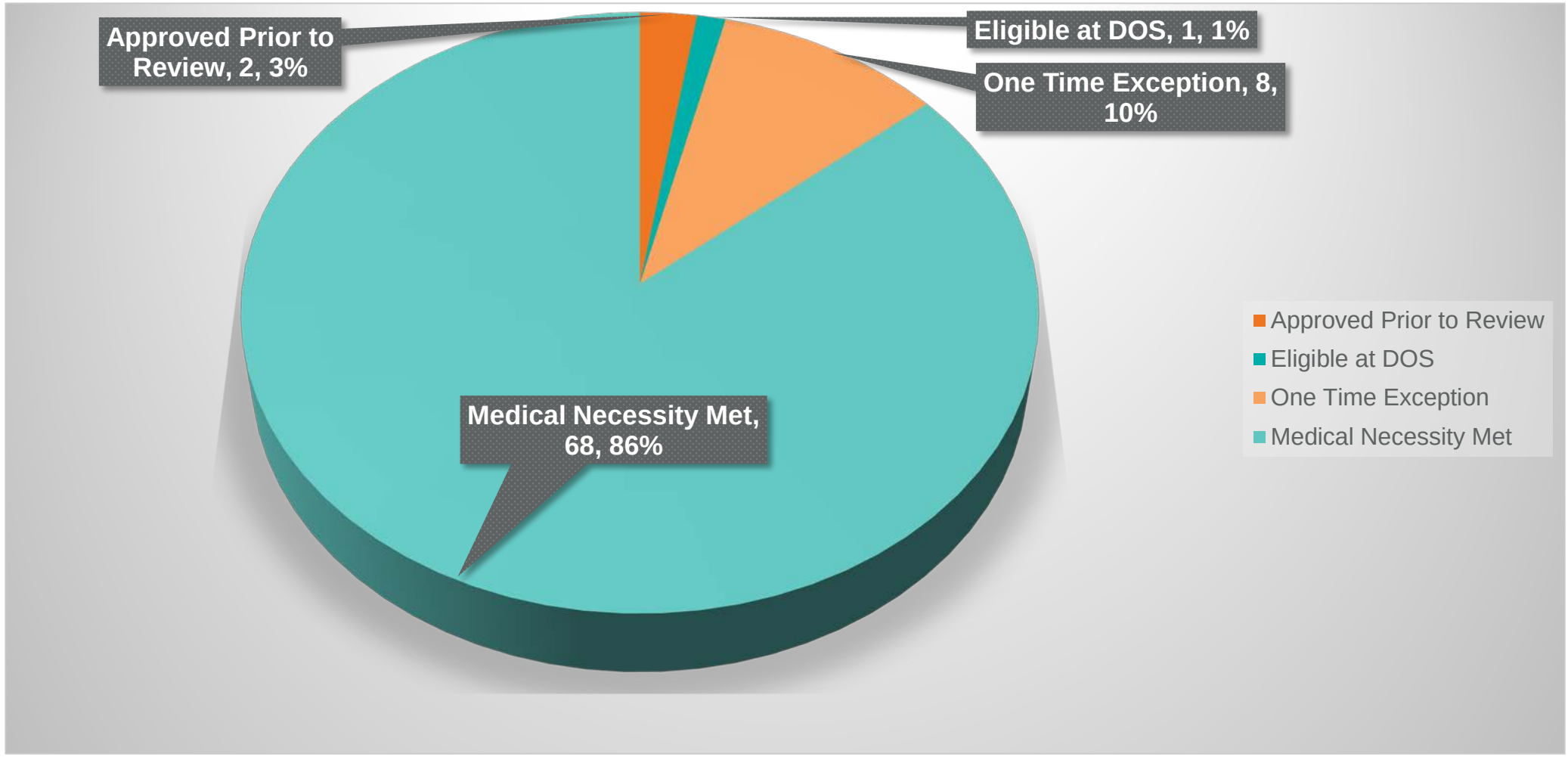
Q4 2020 MC Appeals by Network



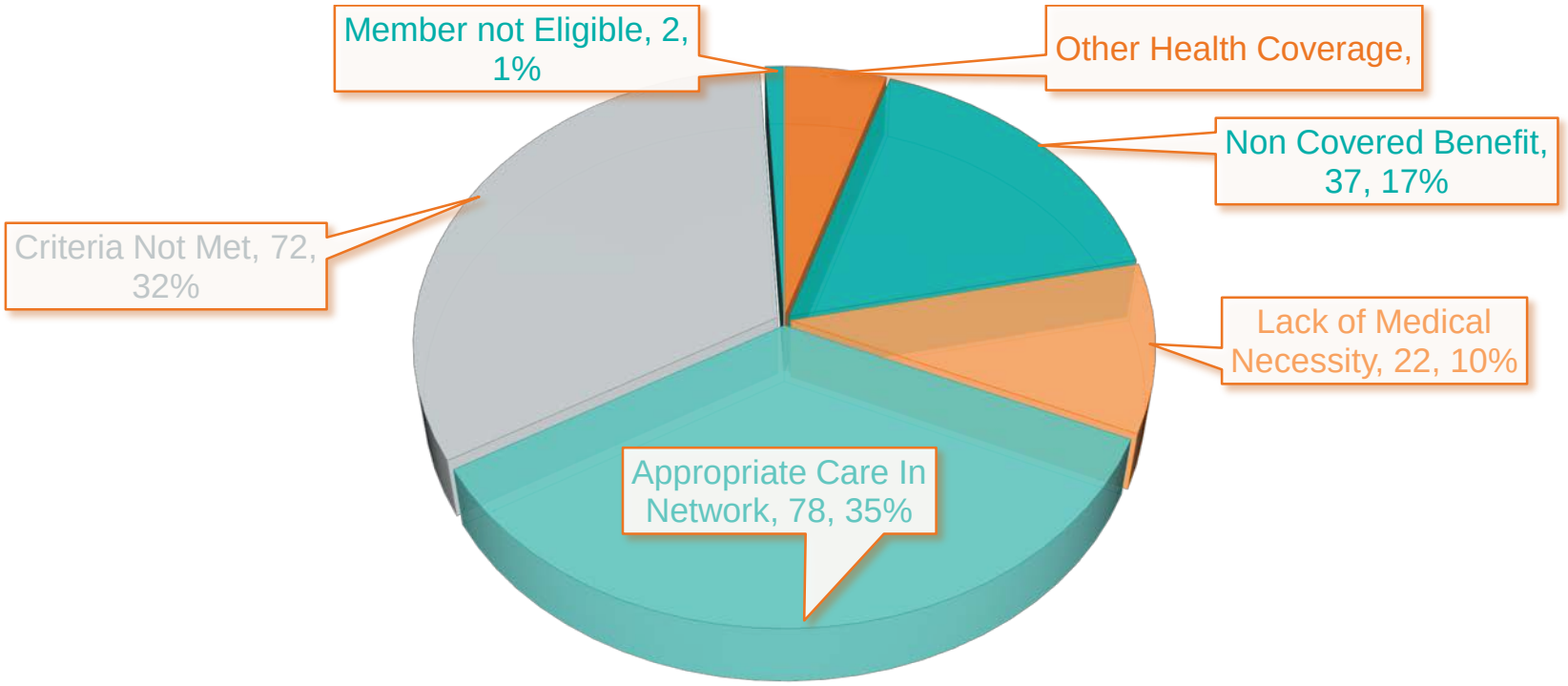
Q4 2020 MC Appeals by Disposition



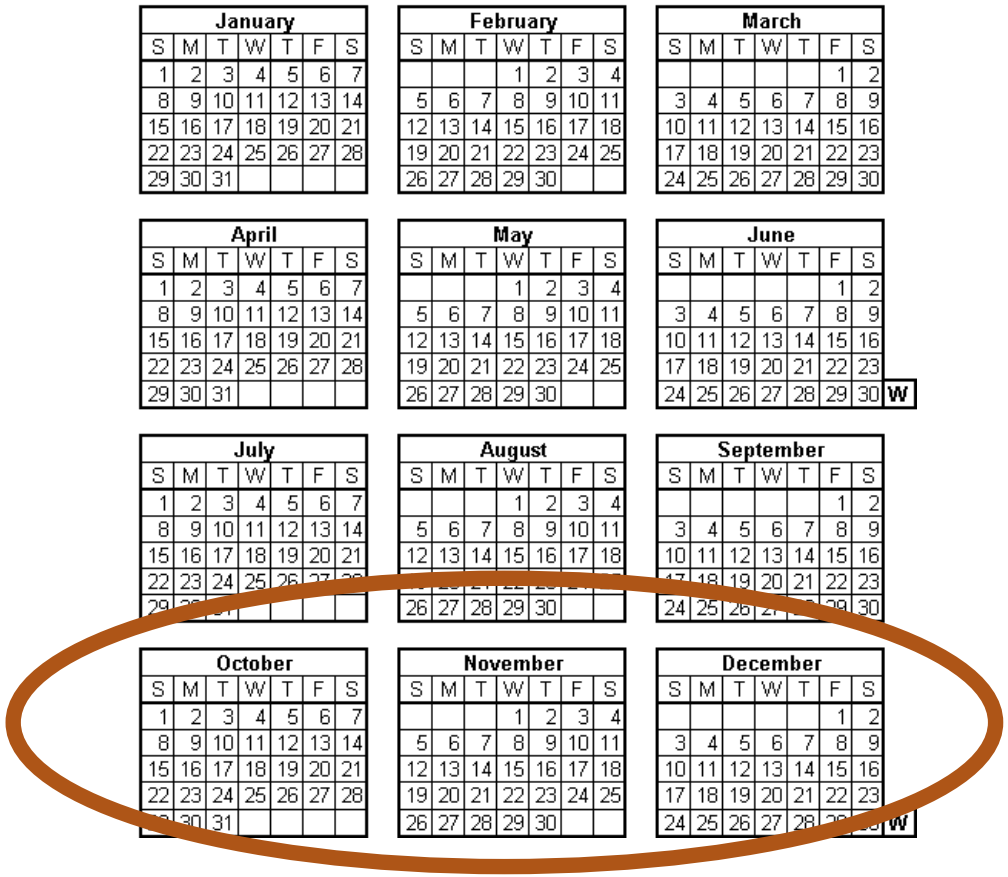
Q4 2020 MC Appeals: Overturn Rationale



Q4 2020 MC Appeals: Upheld Rationale



Cal MediConnect



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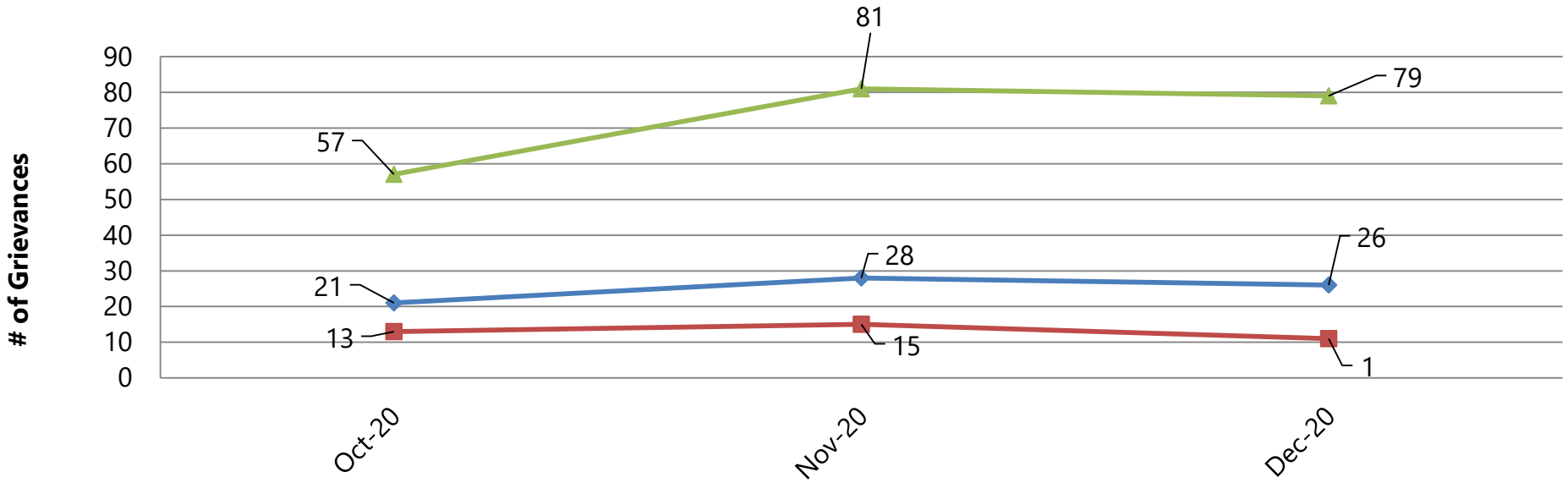
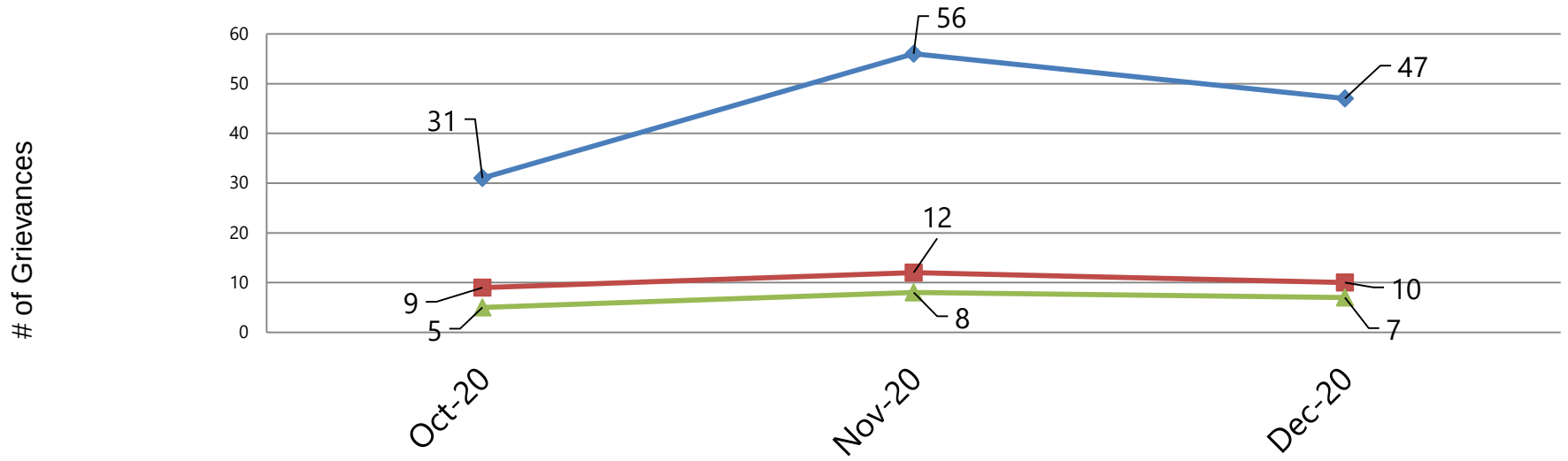
Q4 2020

Q4 2020:Top 3 Cal MediConnect Grievance Categories



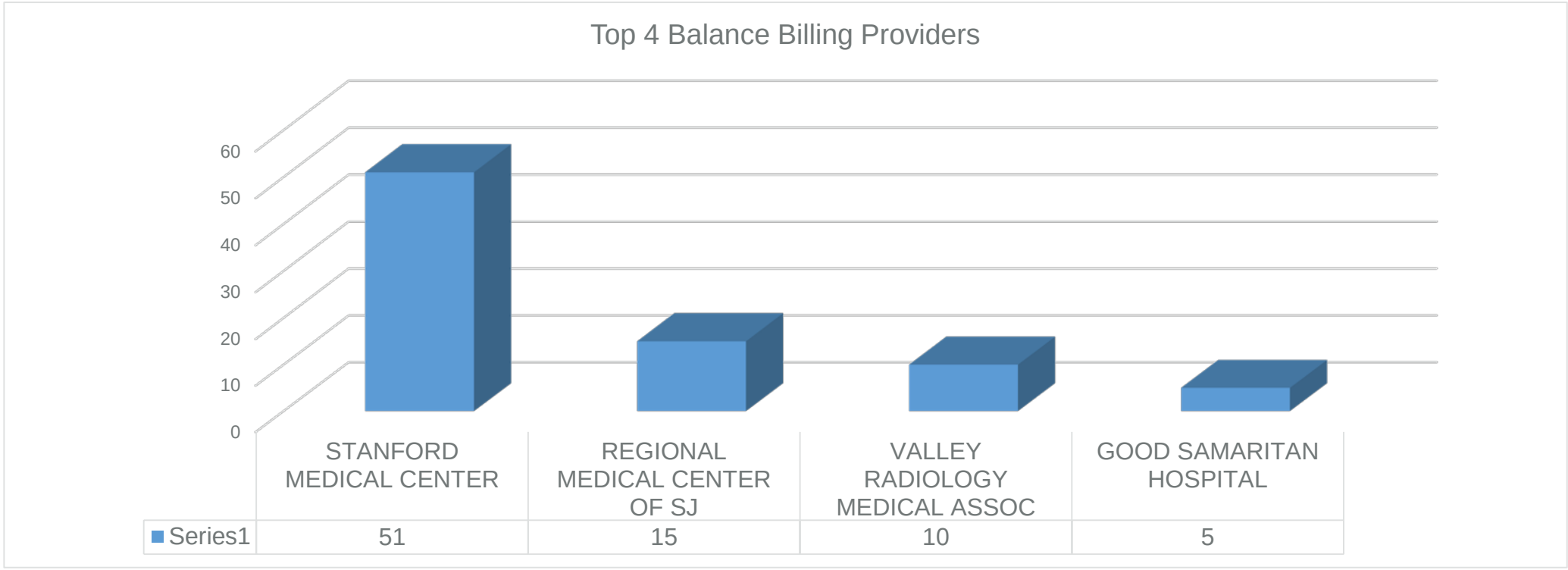
	Oct-20	Nov-20	Dec-20
Access	21	28	26
Quality of Care	13	15	11
Quality of Service	57	81	79

Q4 2020:Top 3 Cal MediConnect Grievance Subcategories

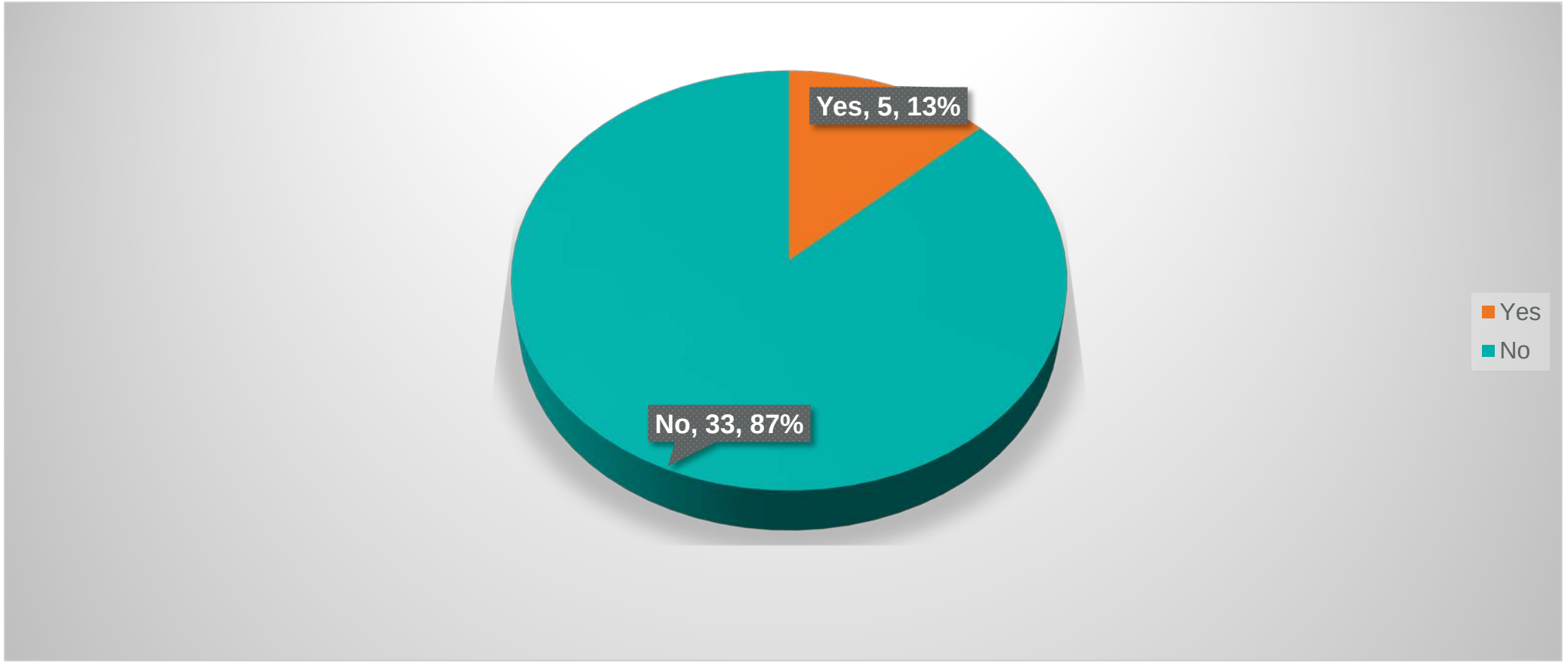


	Oct-20	Nov-20	Dec-20
QOS-Billing/Balance Billing	31	56	47
QOS-Inappropriate Provider Care	9	12	10
Access-Timely Access to Specialist	5	8	7

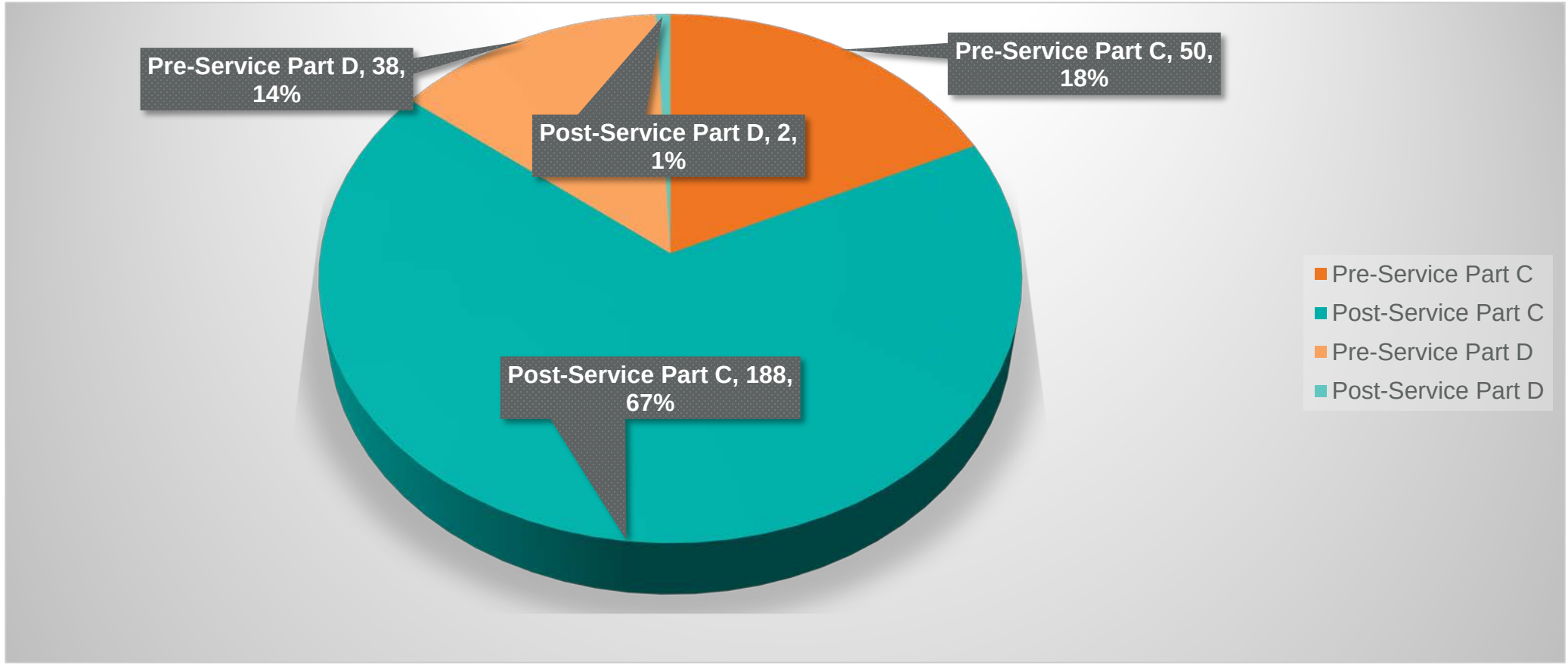
Q4 2020 CMC Balance Billing Grievances by Provider



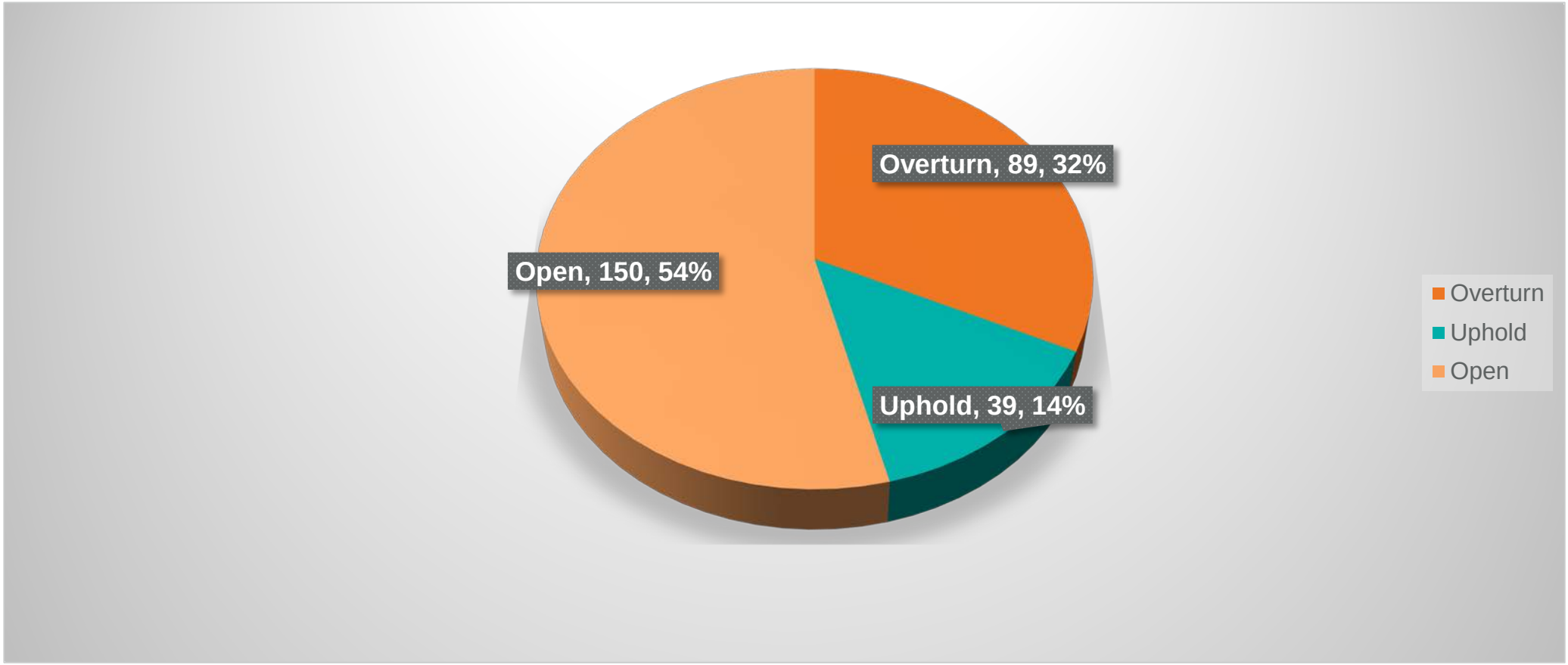
Q4 2020 CMC Inappropriate Provider Care PQI Issues Flag



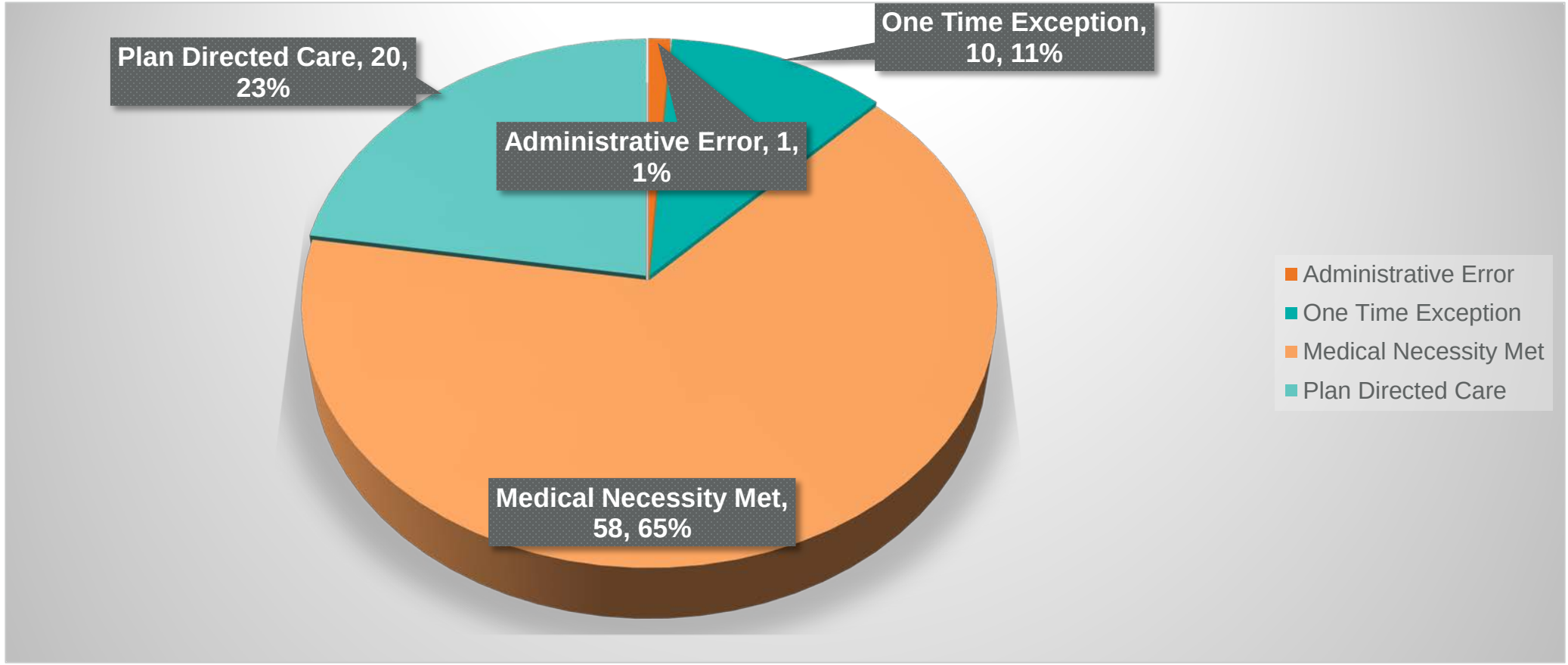
Q4 2020 CMC Appeals by Case Type



Q4 2020 CMC Appeals by Disposition



Q4 2020 CMC Appeal: Overturn Rationale



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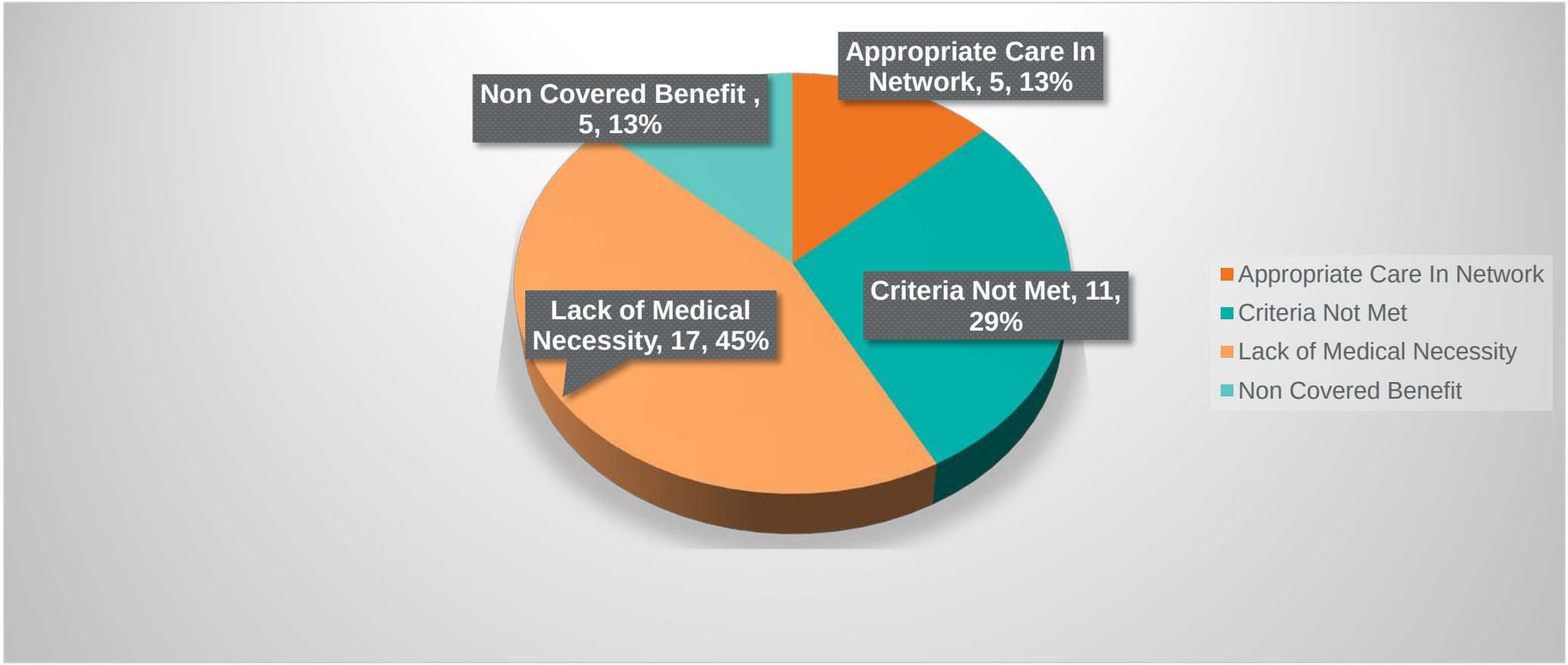


Santa Clara Family Health Plan™

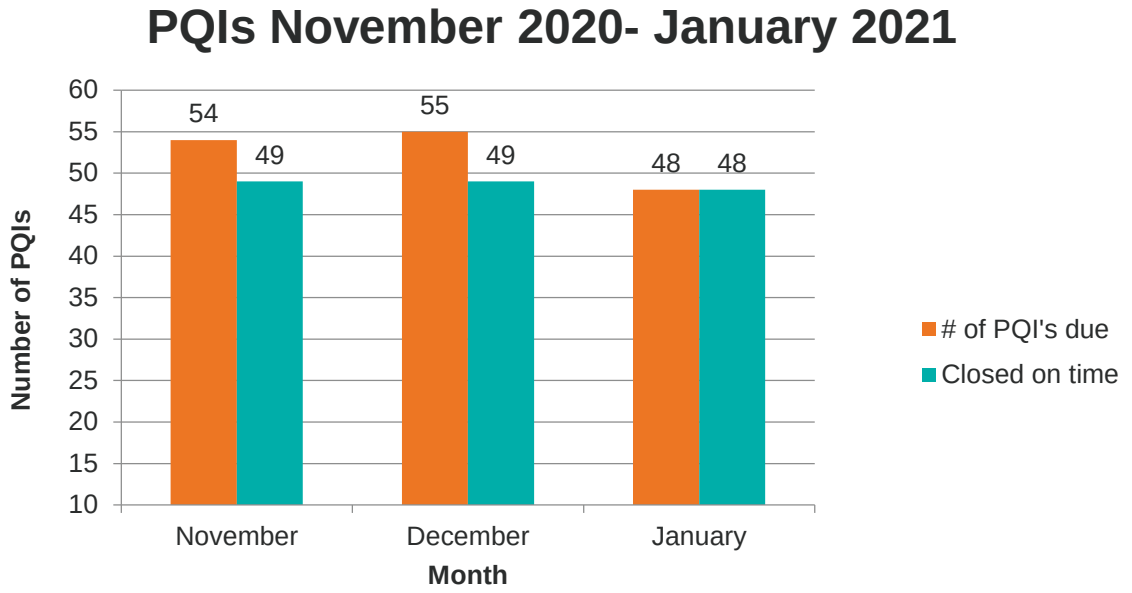
Quality Improvement Dashboard

November 2020- January 2021

Potential Quality of Care Issues

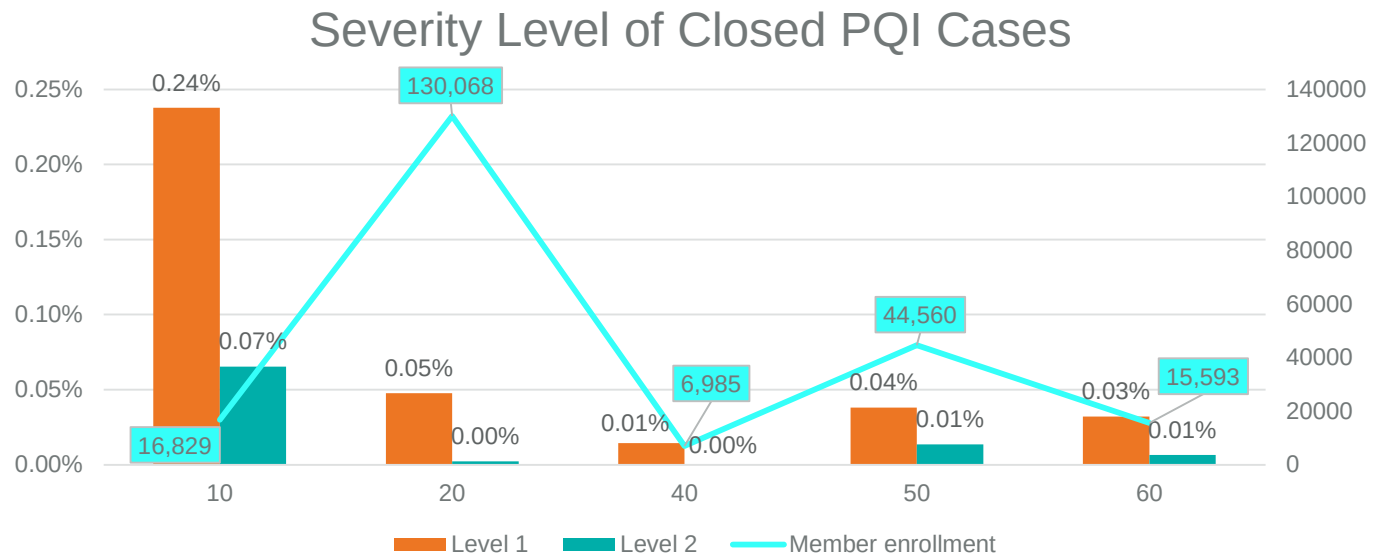
Santa Clara Family Health Plan

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



93%

Percentage of PQIs due from November 2020-January, 2021 closed on time within 60 days

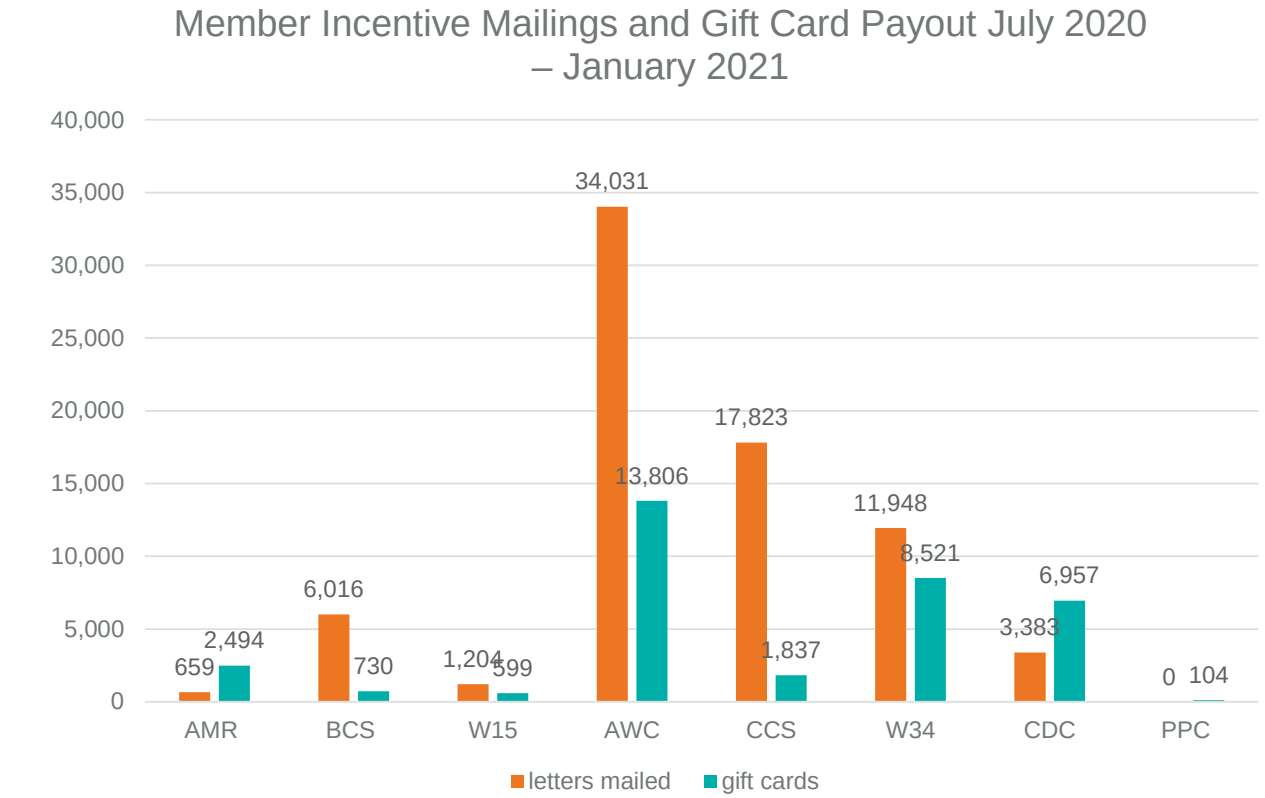


Member Incentives:
Wellness Rewards Mailing

Letters to non-compliant members started in July for: W15, W34, AWC, BCS, CCS, CDC, AMR

*PPC is referral based, no mailers

Total # of mailers sent since July 2020	75,064
Total # of gift cards mailed since July 2020	35,048



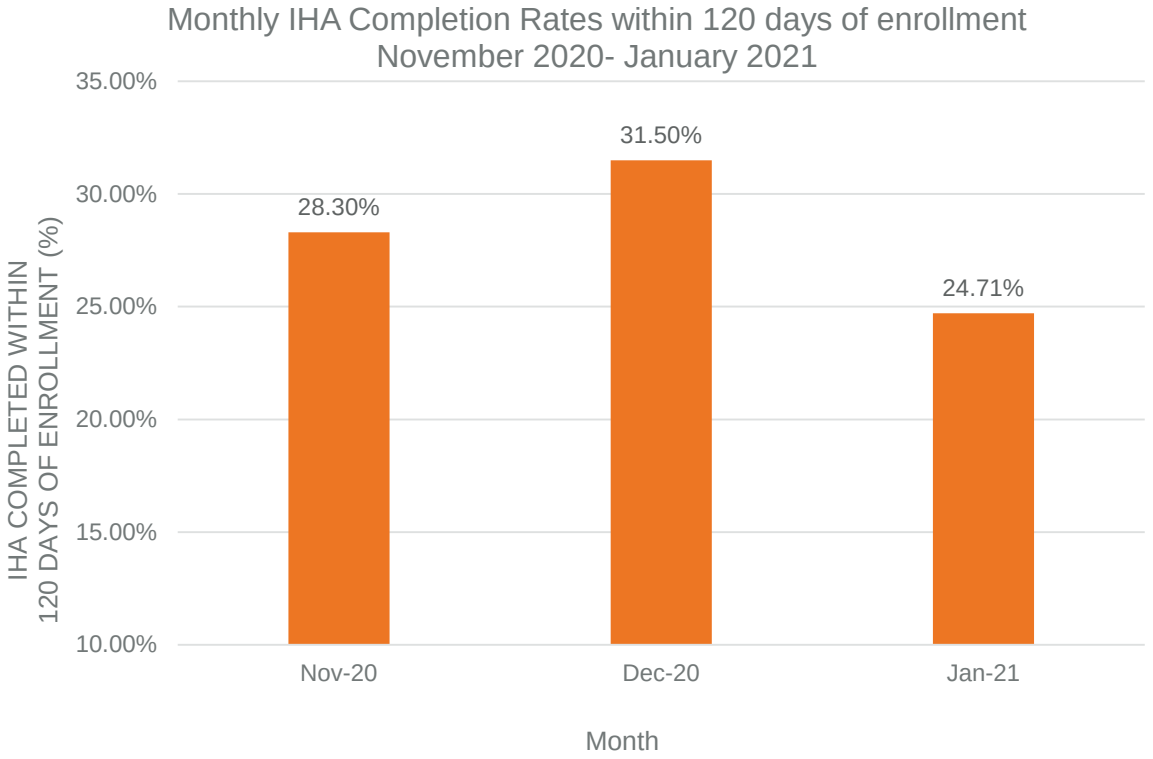
Initial Health Assessment (IHA)

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



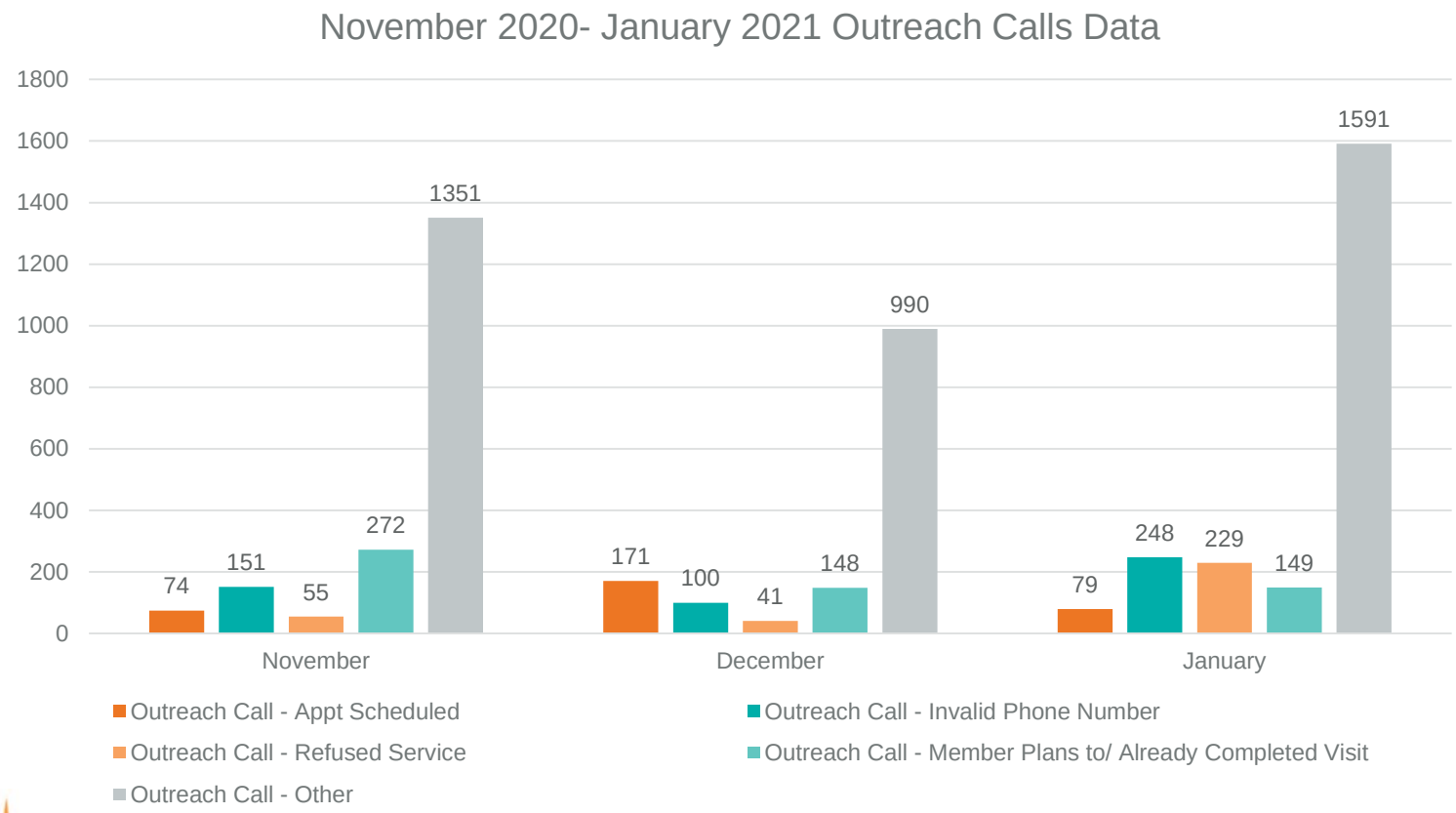
*DHCS has temporarily suspended the requirement to complete IHAs for members within 120 days of enrollment until the COVID-19 emergency declaration has ended. The IHAs will have to be completed once this emergency is over.

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

Outreach Call Campaign

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

Campaigns completed (October–November 2020)
Cervical Cancer Screening (CCS)
Asthma Medication Ratio (AMR)
Controlling High Blood Pressure (CBP)
Comprehensive Diabetes Care (CDC)
Breast Cancer Screening (BCS)



5,649

Total number of attempted outreach in November 2020-January 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

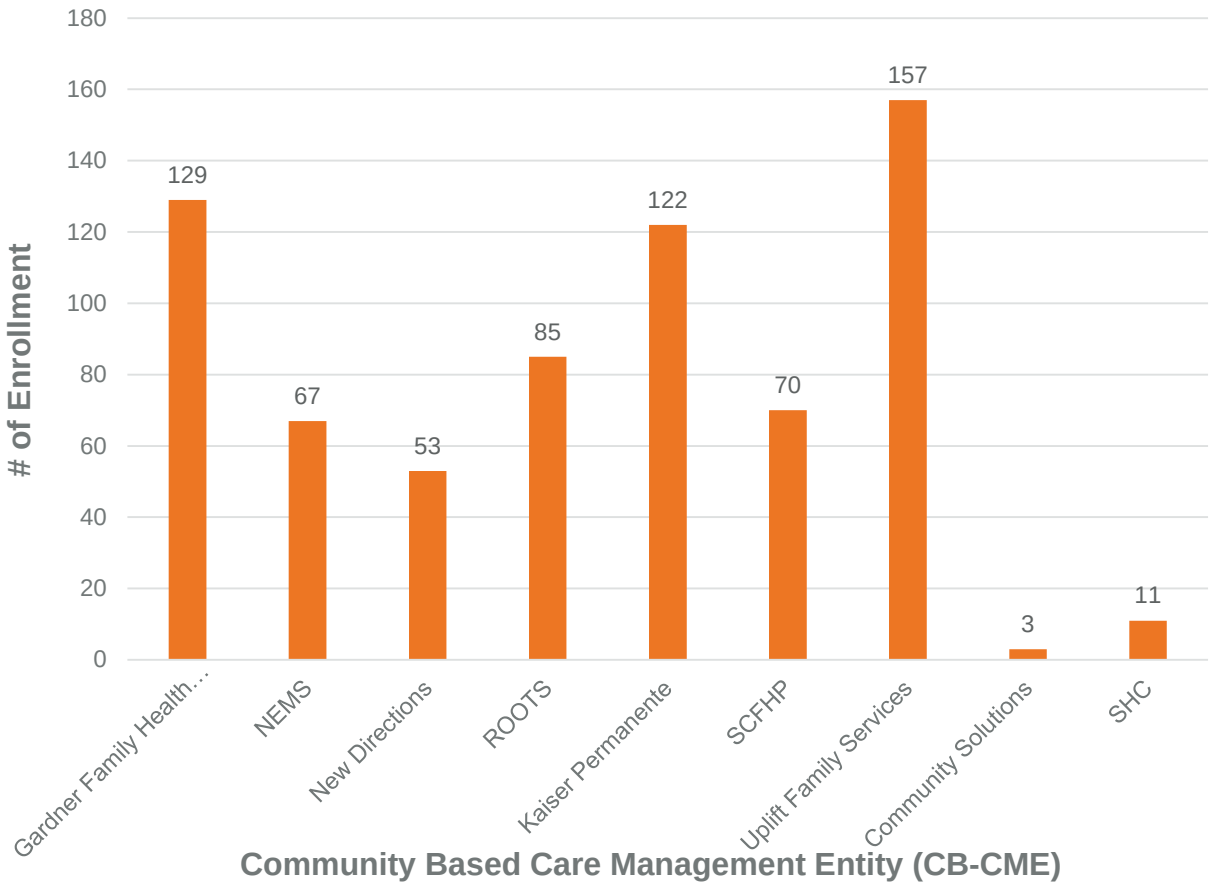
What is the Health Homes Program?

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

697

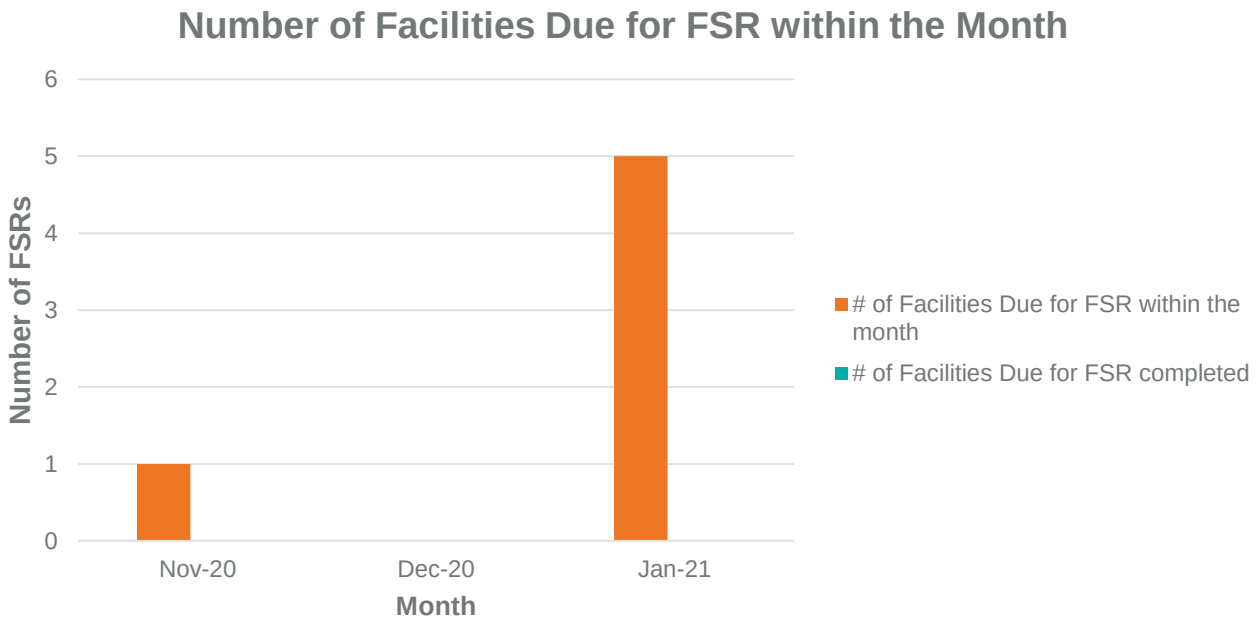
Members have verbally consented into Health Homes as of January 31, 2021

Number of Enrolled Members as of January 31, 2021



Facility Site Review (FSR)

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



FSRs were not conducted due to the **COVID-19 situation-** Extensions have been approved by DHCS

*DHCS has temporarily suspended the requirement to conduct FSRs until the COVID-19 emergency declaration is rescinded. The FSRs will have to be completed once this emergency is over
*There were no FSRs due in December 2020
*Virtual FSRs will be soon introduced for new sites

Compliance Report

February 9, 2021

AUDIT UPDATE

- **Compliance Program Effectiveness (CPE) Audit**

  In accordance with CMS requirements, the Plan recently completed its annual Compliance Program Effectiveness Audit (CPE), which was conducted by the audit firm, Medicare Compliance Solutions. The Compliance team is reviewing the final report and developing responses. The Compliance Committee will review the contents of report and proposed actions in response at its February 2021 meeting.

- **Department of Health Care Services (DHCS) Medi-Cal Managed Care Audit**

  Our 2021 annual DHCS audit, covering only Medi-Cal, will take place between March 8 and March 19 covering a review period of March 2020 through February 2021. Compliance has been gathering, reviewing, and submitting data requested by DHCS from internal operations and delegates.

- **Department of Managed Health Care (DMHC) Medi-Cal Managed Care Audit**

  Also in March, the Plan undergo a follow-up audit of our 2019 DMHC audit. The scope of this audit is limited to the outstanding deficiencies in our 2019 audit final report. Pre-audit documents covering the review period of February 2020 through October 2020 were submitted in December.

Santa Clara Family Health Plan™

Pharmacy & Therapuetics Committee

Meeting Minutes

September 17, 2020 &
December 17, 2020

Regular Meeting of the

Santa Clara County Health Authority

Pharmacy & Therapeutics Committee

Thursday, September 17, 2020, 6:00 PM – 8:00 PM

Santa Clara Family Health Plan

6201 San Ignacio Ave, San Jose, CA 95119

Minutes (Open) - Approved

Members Present
Ali Alkoraishi, MD
Amara Balakrishnan, MD
Hao Bui, BS, RPh
Xuan Cung, PharmD
Dang Huynh, PharmD, Director of Pharmacy and UM
Jimmy Lin, MD, Chair
Laurie Nakahira, DO, Chief Medical Officer
Peter Nguyen, DO
Jesse Parashar-Rokicki, MD
Narinder Singh, PharmD

Members Absent
Dolly Goel, MD

Staff Present
Duyen Nguyen, PharmD, Clinical Pharmacist
Tami Otomo, PharmD, Clinical Pharmacist
Jayne Giangreco, Manager, Administrative Services

Others Present
Amy McCarty, PharmD

1. **Roll Call**

   Jimmy Lin, MD, Chair, called the meeting to order at 6:09 pm. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The 2Q2020 P&T Committee Open meeting minutes were reviewed.

   It was moved, seconded and the open minutes of the June 18, 2020 P&T meeting were **unanimously approved.**

   Motion: Dr. Nguyen
   Second: Dr. Alkoraishi
   Ayes: Dr. Alkoraishi, Dr. Balakrishnan, Ms. Bui, Dr. Cung, Dr. Huynh, Dr. Lin, Dr. Nakahira, Dr. Nguyen, Dr. Parashar-Rokicki, Dr. Singh

Absent: Dr. Goel

4. Standing Agenda Items

a. Chief Medical Officer Health Plan Updates

Dr. Nakahira provided an update on the Plan's response to the two state of emergency orders for the wildfires and COVID-19. The Plan continues with outreach calls calls to our vulnerable population, which includes high-risk members and members over the age of 65 with comorbidities. The Plan also worked with Santa Clara County to ensure our vulnerable population is on the County's list for evacuation orders and power outages. The majority of SCFHP's staff continues to work from home, and it is anticipated this will continue until sometime in 2021, pending updates from the County and the state.

Dr. Nakahira continued with staff updates. She announced that Lucille Baxter is the new Manager of Quality and Health Education, Raman Singh is the new Case Management Director; and Dang Huynh accepted the position as Pharmacy and Utilization Management (UM) Director.

Dr. Nakahira provided an update on the Community Resource Center (CRC), which is projected to open in mid-October 2020. The CRC is located at North Capital and McKee. The CRC will offer health education classes. There will be some SCFHP staff working there. Members will be also be able to meet with Case Managers there if it is more convenient.

b. Medi-Cal Rx Update

Dr. Huynh presented an update on Medi-Cal Rx. Beginning January 1, 2021, the pharmacy benefit for Medi-Cal will be carved back into the state. Their claims processor will be Magellan. The Plan will continue to manage the clinical aspects of pharmacy adherence and providing disease and medication management. The call script was finalized and rolled out by the state, and Customer Service will receive training on how to answer member and provider questions. DHCS will be sending out 90 and 60 day notices before the transition. The Plan will be sending out the 30 day notice.

SCFHP will identify members who may require more assistance during this transition and will offer help with prescription transfers. This includes assisting members who receive mail order prescriptions from pharmacies outside of California to transition them to a pharmacy enrolled in Medi-Cal Rx . Members will need to take their new SCFHP ID card and their Medi-Cal Benefits Identification Card (BIC) to the pharmacy. Members can locate network pharmacies on the state's website. Dr. Huynh explained that if the state does not cover a medication that a member is currently taking, there will be a 180 day transition period for the member to continue getting that drug. The state will also honor active prior authorizations for up to one year; they are discussing the potential for extending those authorizations.

The Plan is updating all member and provider material with Medi-Cal Rx information. SCFHP will also be conducting additional provider and member communication. Training for providers is available on the Medi-Cal Rx website, and the Plan will be sending out a fax blast to providers to notify them of this training. Dr. Huynh explained that there are ongoing discussions to clarify coverage of certain items in the state's scope document. The Plan is evaluating care coordination strategies for items that may be partially carved out. SCFHP continues to work with plan partners and delegates to ensure that information from DHCS and Magellan is communicated in a timely manner.

c. Plan/Global Medi-Cal Drug Use Review (DUR)

Dr. Otomo stated that SCFHP participates in the state's Global Drug Use Review (DUR) Board quarterly meetings, then assesses DUR activities that need to be implemented at the plan. There were no actions for SCFHP from the last DUR meeting.

For the Plan's Drug Use Evaluation (DUE) program for 3rd quarter, the Plan targeted members who may have persistent asthma based on claims history and did not receive an asthma controller medication in a recent 12 month period. SCFHP will send out letters to impacted providers within our Cal MediConnect and Medi-Cal lines of business.

d. NCQA Member Portal Evaluation

Dr. Nguyen presented an overview of the NCQA Member Portal Evaluation, which is required by NCQA on an annual basis to ensure accuracy and quality of our website for our Cal MediConnect members. The 2020 analysis was just completed and the website met 100% of the NCQA criteria.

e. 2019 2nd and 3rd Quarter Report Emergency Supply Reports

i. 2019 2nd Quarter Report

Dr. Nguyen discussed the Emergency Prescription Access Report for 2Q2019, and there were no issues identified.

ii. 2019 3rd Quarter Report

Dr. Nguyen reviewed the results for 3Q2019. There was one issue identified regarding a member's prescription for cefpodoxime, which is a non-formulary drug. The member went to three different pharmacies to try to fill the prescription and did not receive the drug. The member was referred to Case Management for follow-up. To remedy this gap, SCFHP will implement a point-of-sale (POS) message on cefpodoxime informing pharmacies that cefdinir is our formulary alternative. Dr. Huynh stated the Plan will send out a fax blast to the pharmacy network reminding them that for our Medi-Cal patients, they can input an override to provide an emergency 3-day supply. Dr. Nguyen will provide an update on this case at the next meeting.

f. Appeals & Grievances Pharmacy Report

i. 2020 1st Quarter Report

ii. 2020 2nd Quarter Report

Dr. Huynh presented the Appeals & Grievances Pharmacy Reports on behalf of Ms. Luong. Data and descriptions in slide deck required additional clarification. Dr. Huynh stated that he would validate the information with the G&A team and send out the updated slides or provide an update at the next meeting.

Dr. Lin inquired if appeals are mainly submitted by members or providers, and Dr. Huynh replied that the majority of appeals are submitted by providers.

Adjourned to Closed Session at 6:38 p.m.
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

5. Closed Meeting Minutes

The 2Q2020 P&T Committee Closed meeting minutes were reviewed.

It was moved, seconded and the closed minutes of the June 18, 2020 P&T meeting were **unanimously approved**.

6. Metrics and Financial Updates

a. Membership Report

Dr. Nakahira presented the Plan's membership.

b. Pharmacy Dashboard

Dr. Otomo reviewed the Pharmacy Dashboard for April 2020 through August 2020.

c. Drug Utilization and Spend

Dr. McCarty presented the Drug Utilization and Spend.

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

a. Pharmacy Benefit Manager 2Q2020 P&T Minutes
Dr. McCarty reviewed the Pharmacy Benefit Manager 2Q2020 P&T Minutes.

b. Pharmacy Benefit Manager 3Q2020 P&T Part D Actions
Dr. McCarty reviewed the Pharmacy Benefit Manager 3Q2020 P&T Part D Actions.

It was moved, seconded and the Pharmacy Benefit Manager 2Q2020 and 3Q2020 Part D Actions were **unanimously approved**.

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

a. Old Business/Follow-Up

i. Dapagliflozin combinations
Dr. Huynh provided a follow-up from the last meeting regarding adding Farxiga and its combinations.

b. Formulary Modifications
Dr. Otomo presented the formulary changes made since the June 2020 meeting to the Committee.

It was moved, seconded and the Medi-Cal Formulary Modifications were **unanimously approved**.

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

It was moved, seconded and the Fee-for-Service Contract Drug List Comparability recommendations were **unanimously approved**.

d. Prior Authorization Criteria

i. <u>New or Revised Criteria</u>
1. Enablex – *revised*
2. Myrbetriq - *revised*
3. Retacrit - *revised*
4. Penlac - *revised*

ii. <u>Annual Review</u>
1. Brand Name – *no changes*
2. Compounded Medications – *no changes*
3. Duragesic – *no changes*
4. Emend – *no changes*
5. Enbrel – *no changes*
6. Humira – *no changes*
7. Insulin Pens – *no changes*
8. Nicotrol – *no changes*
9. Off-label – *no changes*
10. Opioid Safety Edits – *no changes*
11. Quantity Limit – *no changes*

12. Taltz – *no changes*
13. Trintellix – *no changes*
14. Xelpros – *no changes*
15. Zyvox – *no changes*

Dr. Nguyen reviewed the revised PA criteria.

It was moved, seconded and the Prior Authorization Criteria was **unanimously approved.**

9. New Drugs and Class Reviews

a. New and Expanded Indications
Dr. McCarty presented an overview of the following drugs with new and expanded indications: Taltz, Cosentyx, Lynparza, Rubraca, Crysvita, Ilaris.

It was moved, seconded and the New and Expanded Indications recommendations were **unanimously approved.**

b. Oriahnn (elagolix, estradiol, norethindrone) – Uterine fibroids
Dr. McCarty gave an overview of uterine fibroids and a new drug, Oriahnn.

It was moved, seconded and recommendation for Oriahnn was **unanimously approved.**

Reconvene in Open Session at 7:18 p.m.

10. Discussion Items

a. New and Generic Pipeline
Dr. McCarty reviewed the New and Generic Pipeline. She noted that the major drug of interest in 3Q2020 is ofatumumab (Kesimpta), which is for multiple sclerosis and can be self-administered. In 4Q2020, a drug of interest is roxadustat, an oral agent for the treatment of anemia in chronic kidney disease. In 1Q2021, a drug of interest is aducanumab, a monoclonal antibody treatment for early stage Alzheimer's disease, which would make it the first biologic for this condition.

Dr. McCarty stated that drugs of interest in the generic pipeline are Nexium packets for oral suspension and Kuvan powder for oral suspension and tablet. Dr. Lin inquired as to whether or not Oxytrol or Humalog Mix 75/25 have been released as generics. Dr. McCarty replied that neither are available as generic products yet.

11. Adjournment
The meeting adjourned at 7:25 p.m. The next P&T Committee meeting will be on Thursday, December 17, 2020.

_____ _____
Jimmy Lin, MD, Chair Date

Regular Meeting of the

Santa Clara County Health Authority
Pharmacy & Therapeutics Committee

Thursday, December 17, 2020, 6:00 PM – 8:00 PM

Santa Clara Family Health Plan

6201 San Ignacio Ave, San Jose, CA 95119

Minutes (Open) - Draft

Members Present
Jimmy Lin, MD, Chair
Ali Alkoraishi, MD
Amara Balakrishnan, MD
Hao Bui, BS, RPh
Xuan Cung, PharmD
Dang Huynh, PharmD, Director of Pharmacy and UM
Laurie Nakahira, DO, Chief Medical Officer
Peter Nguyen, DO

Members Absent
Dolly Goel, MD
Jesse Parashar-Rokicki, MD
Narinder Singh, PharmD

Staff Present
Duyen Nguyen, PharmD, Clinical Pharmacist
Tami Otomo, PharmD, Clinical Pharmacist
Kristine Zhang, PharmD, Clinical Pharmacist
Jayne Giangreco, Manager, Administrative Services
Nancy Aguirre, Administrative Assistant

Others Present
Amy McCarty, PharmD
Shelly Tausing, Pharmacy Student

1. **Roll Call**

   Jimmy Lin, MD, Chair, called the meeting to order at 6:09 pm. Roll call was taken and a quorum was established.

2. **Public Comment**

   There were no public comments.

3. **Meeting Minutes**

   The 3Q2020 P&T Committee Open meeting minutes were reviewed.

   It was moved, seconded and the open minutes of the September 17, 2020 P&T meeting were **unanimously approved.**

   Motion: Dr. Lin
   Second: Dr. Cung
   Ayes: Dr. Alkoraishi, Dr. Balakrishnan, Ms. Bui, Dr. Huynh, Dr. Nakahira,
   Absent: Dr. Goel, Dr. Nguyen, Dr. Parashar-Rokicki, Dr. Singh

4. Standing Agenda Items

a. Chief Medical Officer Health Plan Updates

Laurie Nakahira D.O., Chief Medical Officer (CMO), shared Santa Clara Family Health Plan (SCFHP) and Anthem Blue Cross collaborated to host 10 flu shot clinics. The clinics were free to everyone, including those without health insurance. Further information is available on the SCFHP website.

The current Plan membership is at a total of 250,000 members. Numbers have been increasing due to not disenrolling some of the Medi-Cal (MC) and Cal MediConnect (CMC) members.

Dr. Nakahira announced the DHCS and DMHC audits will be taking place in March, 2021. Touching base on the previously mentioned CalAIM, Dr. Nakahira was pleased to announce CalAIM will be brought back after being put on hold due to COVID-19 and the budget. The new start date for CalAIM with enhanced Case Management and In Liu of Services is January 2022.

Dr. Nakahira briefly mentioned MediCal's Pharmacy Carve Out was due to start on 01/01/2021, but has now been postponed to 04/01/2021. This postponement will allow the Plan to better prepare for the transition.

Dr. Nakahira reported, as of yesterday, SCFHP has approximately 3,400 members that are positive with COVID-19 and about 1,300 of those members have been hospitalized. Ninety-five (95) members have passed away from COVID-19; 50 of them have been at a Skilled Nursing Facility (SNF) and 45 have been outside of a hospital. This represents about 17% of deaths within the county.

Dr. Nakahira updated the committee with the latest news regarding the recently approved Pfizer vaccine. The county started to vaccinate, beginning with Phase 1A. Phase 1A includes frontline workers and long term care residents and workers. The State estimates California will receive approximately 1.8 million vaccines by the end of this year (2021). This reflect approximately 4.5% of the state's population. There are about 1.7 million healthcare workers in California and about 640,000 nursing home residents and workers.

Dr. Nakahira added SCFHP is working with the Public Health Department as well as the State to develop ways to message the population and the community about risks involved in taking/not taking the vaccine.

b. Medi-Cal Rx Update

Dang Huynh, PharmD, Director, Pharmacy & Therapeutics, presented the Medi-Cal Rx update. As mentioned by Dr. Nakahira, MediCal's Pharmacy Carve Out has been delayed to start on 04/01/2021. DHCS will communicate the delay with all beneficiaries, including our Managed Care members. There are minor formulary changes, in terms of SCFHP's authorization process, that will be discussed later in this meeting.

c. Policy Review

i. PH10 CMC Part D Transition

Dr. Huynh reviewed the Pharmacy Policy PH10 CMC Part D Transition (2021), specific to CMC. CMS requires annual submission of this policy.

It was moved, seconded and the Pharmacy Policy PH10 CMC Part D Transition was **unanimously approved**.

Motion: Dr. Lin
Second: Dr. Balakrishnan
Ayes: Dr. Alkoraishi, Ms. Bui, Dr. Cung, Dr. Huynh, Dr. Nakahira
Absent: Dr. Nguyen, Dr. Parashar-Rokicki, Dr. Singh

5. Plan/Global Medi-Cal Drug Use Review

a. Drug Use Evaluation Update

Tami Otomo, PharmD, Clinical Pharmacist, shared the results from SCFHP's quarterly retrospective Drug Use Evaluation (DUE). The clinical topics and data are chosen and provided by MedImpact. The first program reviewed was Asthma DUE. The success rate for Medi-Cal was 61% and 57% for CMC. The second program reviewed was the Polypharmacy DUE. This program was only made available for CMC, not Medi-Cal.

Dr. Otomo noted program letters for both Asthma DUE and Polypharmacy DUE were mailed on 11/03/2020. Follow up results will be shared next year. No questions were asked.

b. 2019 4TH Quarter Emergency Supply Report

Duyen Nguyen, PharmD, Clinical Pharmacist, reviewed the 2019 4th Quarter Emergency Supply Report. Dr. Nguyen noted the key diagnosis used was urinary tract infection (UTI) due to clinical determination that such a diagnosis will require a prescription. No readmissions for the same diagnosis were found for the sampled members from the previous quarter, 2019Q3.

Dr. Nguyen added SCFHP will continue the quarterly assessments of emergency prescription access with medical and pharmacy data.

c. Grievance & Appeals Pharmacy Report: 2020 1st – 3rd Quarter Reports

Dr. Huynh presented the G&A Pharmacy Report: 2020 1st – 3rd Quarter Reports in Charlene Luong's absence. While presenting this information at the previous P&T Committee meeting, two inconsistencies in reporting numbers were identified.

Dr. Huynh reviewed the updated data. For Q1 Medi-Cal February Overturns, the total number of overturns was changed from 18 to 19. For Q2 CMC, there was a rationale that was missing, which was non-covered benefit.

Dr. Huynh reviewed the Q3 2020 Medi-Cal Appeals Volume, Appeals by Decision, and Appeals by Rationale. Dr. Huynh also reviewed the Q3 2020 CMC Appeals Volume, Appeals by Decision, and Appeals by Rationale. No questions were asked.

Adjourned to Closed Session at 6:36 p.m.
Pursuant to Welfare and Institutions Code Section 14087.36 (w)

6. Closed Meeting Minutes

The 3Q2020 P&T Committee Closed meeting minutes were reviewed.

It was moved, seconded and the closed minutes of the September 17, 2020 P&T meeting were **unanimously approved**.

7. Metrics and Financial Updates

a. Membership Report

Dr. Nakahira presented the membership report during the CMO Health Plan Updates.

b. Pharmacy Dashboard

Dr. Otomo reviewed the Pharmacy Dashboard for August 2020 through November 2020.

c. Pharmacy Member Portal Stats

Dr. Huynh presented the Pharmacy Member Portal Stats.

d. **Drug Utilization & Spend**
Dr. McCarty presented the Drug Utilization and Spend for Q3 2020.

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

a. **Pharmacy Benefit Manager 3Q2020 P&T Minutes**
Dr. McCarty reviewed the Pharmacy Benefit Manager 3Q2020 P&T Minutes.

b. **Pharmacy Benefit Manager 4Q2020 P&T Part D Actions**
Dr. McCarty reviewed the Pharmacy Benefit Manager 4Q2020 P&T Part D Actions.

It was moved, seconded and the Pharmacy Benefit Manager 3Q2020 and 4Q2020 Part D Actions were **unanimously approved**.

c. **2021 Medical Benefit Drug Prior Authorization Grid**
Dr. Otomo reviewed the 2021 Medical Benefit Drug Prior Authorization Grid.

It was moved, seconded and the 2021 Medical Benefit Drug Prior Authorization Grid was **unanimously approved**.

9. **Discussion and Recommendations for Changes to SCFHP's Medi-Cal and Prior Authorization Criteria**

a. **Old Business/Follow-Up**

i. **Cefdinir Point-of-sale Message Update**
Dr. Nguyen provided a follow-up from the last meeting regarding the Q3 Emergency Supply Report.

b. **Formulary Modifications**
Dr. Otomo presented the changes made to the Medi-Cal formulary since the September 2020 P&T Committee meeting.

It was moved, seconded and the Medi-Cal Formulary Additions and Modifications were **unanimously approved**.

c. **Fee-for-Service Contract Drug List Comparability**
Dr. McCarty reviewed the Fee-for-Service Contract Drug List (CDL) Comparability for Medi-Cal.

It was moved, seconded and the Fee-for-Service CDL Comparability proposed actions were **unanimously approved**.

d. **2021 Medical Benefit Drug Prior Authorization Grid**
Dr. Otomo presented the 2021 Medical Benefit Drug Prior Authorization Grid.

It was moved, seconded and the Medi-Cal 2021 Medical Benefit Drug Prior Authorization Grid was **unanimously approved**.

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

i. **New or Revised Criteria**
1. Protopic ointment – *revised*
2. Non-Formulary – *revised*

ii. **Annual Review**
1. Norditropin Flexpro – *no changes*
2. Zarxio – *no changes*

It was moved, seconded and the Prior Authorization Criteria was **unanimously approved.**

Peter Nguyen joined the meeting at approximately 7:21 p.m.

10. New Drugs and Class Reviews

Kristine Zhang, PharmD, PGY-2 Administration Pharmacy Resident, presented the new drugs and class reviews.

a. Tardive Dyskinesia Review.

Dr. Zhang recommended to leave both drugs as non-formulary, as they are both very expensive. A review of patient's specific clinical data will be required.

b. COVID-19 Vaccines.

Ms. Bui asked which COVID-9 vaccine will be ordered. Dr. Zhang noted Pfizer is currently the only approved COVID-19 vaccine. Ms. Bui asked which vaccine would be most cost effective. Dr. Zhang explained the federal government is purchasing the vaccines, and SCFHP will be responsible for distribution, allocation, and administration of the vaccines. At this moment, there is not a fee associated with obtaining the vaccines.

Dr. McCarty asked if there is any data revealing the efficacy with 1 dose. Dr. Zhang replied the efficacy of 1 dose is about 52%, based on a study done.

c. Asthma Review

Dr. McCarty announced the Global Initiative for Asthma (GINA) no longer recommends treatment of asthma in adolescents and adults with SABA alone. Instead, to reduce their risk of serious exacerbations, all adults and adolescents with asthma should receive either symptom-driven or daily inhaled corticosteroid containing treatment. Dr. McCarty further reviewed this asthma treatment in depth, including the comparison of reliever treatments and inhalers.

Dr. McCarty noted the utilization for budesonide/formoterol (Symbicort) isn't truly reflected in the 3Q20 Utilization, as it was added to the formulary near the end of October.

d. Hereditary Angioedema (HAE) – Orladeyo

Dr. McCarty noted Orladeyo was recently approved in December, to treat long-term Hereditary Angioedema (HAE) prophylaxis. Dr. McCarty reviewed the epidemiology, clinical presentation, and diagnosis of HAE, as well as its pathophysiology. An overview of treatment options reflect Orladeyo as the only oral form of treatment.

Dr. McCarty noted the pricing for Orladeyo was just made available this week. The cost for a 28 day supply is $45,000/month. Although it is potentially not as effective as the other products, it is less expensive and it is oral. Experts expect Orladeyo to have about 1/3 of the market share by the end of 2021.

Dr. McCarty reviewed the proposed actions to remain as non-formulary and approve by exception only.

e. New & Expanded Indications – Epidiolex, Spravato, Tremfya, and Simponi Aria

Dr. McCarty reviewed the new & expanded indications – Expidiolex, Spravato, Tremfya, and Simponi Aria.

It was moved, seconded and the New & Expanded Indications were **unanimously approved.**

f. <u>Informational Only</u>

i. Anemia Chronic Kidney Disease – Roxadustat
ii. Systemic Lupus Erythematosus – Anifrolumab and Voclosporin
iii. Acne – Winlevi
iv. Duchenne Muscular Dystrophy – Viltepso
v. Pain from Osteoarthritis – Tanezumab
vi. Schizophrenia – Olanzapine/Samidorphan
vii. Fatty Acid Metabolism – Dojolvi
viii. Attention Deficit Hyperactivity Disorder – Viloxazine
ix. Overactive Bladder – Vibegron

x. Heart Failure – Vericiguat
xi. Chemo-induced Neutropenia – Rolontis
xii. Hyperlipidemia – Inclisiran
xiii. Ophthalmic NSAIDs

Reconvene in Open Session at 7:41 p.m.

11. Discussion Items

a. New and Generic Pipeline

Ms. McCarty reviewed the new and generic pipeline. Roxadustat, an oral for anemia of CKD, released in 4Q2020, will compete with the injectable drugs. Dr. McCarty noted teplizumab, a development designed to delay Type 1 Diabetes, is to be released in 3Q2021.

Dr. McCarty noted a generic product made available in 4Q2020, Vascepa.

Dr. Huynh noted a member from the public, Shelly Tausing, a Pharmacy student, joined the Open Session.

Dr. Balakrishnan announced her retirement from the Pharmacy & Therapeutics Committee.

12. Adjournment

The meeting adjourned at 7:58 p.m. The next P&T Committee meeting will be on Thursday, March 18, 2021.

_____ _____

Jimmy Lin, MD, Chair Date

Santa Clara Family Health Plan™

Utilization Management Committee

Meeting Minutes

October 14, 2020

Regular Meeting of the

Santa Clara County Health Authority
Utilization Management Committee

Wednesday, October 14, 2020, 6:00 – 7:30 PM
Santa Clara Family Health Plan
6201 San Ignacio Ave, San Jose, CA 95119

Minutes - Approved

Members Present
Jimmy Lin, MD, Internal Medicine, Chair
Ali Alkoraishi, MD, Psychiatry
Dung Van Cai, DO, Head & Neck
Ngon Hoang Dinh, OB/GYN
Laurie Nakahira, D.O., Chief Medical Officer
Indira Vemuri, Pediatric Specialist

Staff Present
Dang Huynh, Director, Utilization Management & Pharmacy
Lily Boris, MD, Medical Director
Natalie McKelvey, Manager, Behavioral Health
Amy O'Brien, Administrative Assistant

Members Absent
Habib Tobbagi, PCP, Nephrology

Staff Absent
Christine Tomcala, Chief Executive Officer
Angela Chen, Manager, Utilization Management
Luis Perez, Supervisor, Utilization Management

1. Roll Call

Jimmy Lin, MD, Chair, called the meeting to order at 6:05 p.m. Roll call was taken and a quorum was established.

2. Public Comment

There were no public comments.

3. Meeting Minutes

The minutes of the July 15, 2020 Utilization Management Committee (UMC) meeting were reviewed.

It was moved, seconded, and the minutes of the July 15, 2020 Utilization Management Committee meeting were **unanimously approved.**

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

4. Chief Executive Officer Update

This item was combined with the Chief Medical Officer Update.

5. Chief Medical Officer Update

a. General Update

Laurie Nakahira, D.O., Chief Medical Officer (CMO), Santa Clara Family Health Plan (SCFHP), delivered the Chief Executive Officer update on behalf of Christine Tomcala. Dr. Nakahira began with an update on the Plan's membership. The Plan's October 2020 membership for the Cal MediConnect line of business is 9,570 members, which is an increase of approximately 1,200 members over the last 12 months. The Plan's membership for the Medi-Cal line of business is 256,490 members, which is an increase over the last 12 months of approximately 20,000 members. This is largely attributable to the temporary disenrollment suspensions by the DHCS due to COVID.

Dr. Nakahira continued with an update on Santa Clara County's response to COVID and the impact on SCFHP. The County has now moved from the purple tier into the orange tier, and further information on the criteria and mandates under the orange tier is available on the Santa Clara County Public Health website. At this time, the majority of SCFHP's staff continues to work from home, and it is anticipated this will continue until approximately mid-2021, pending updates from the CDC and Public Health. Dr. Nakahira continued her update with the Plan's COVID statistics. The Plan's member population includes 2,343 members who tested positive for COVID, and 897 members hospitalized due to COVID. Approximately 63 members, or 17% of the Plan's member population, have died from COVID. As of October 5, 2020, SCFHP's overall call volume has decreased. Our nurse advice line has received over 333 members calling in for advice regarding COVID. Approximately, 924 members have created an MD Live account, and 775 members have completed an MD Live telehealth visit. Approximately, 54 members have filed grievances related to COVID. Hospitalizations have increased due to COVID, which includes skilled nursing homes. This situation is being closely monitored by Public Health. Dr. Nakahira continued with an overview of the Plan's member outreach calls which includes robo calls to our vulnerable population and high-risk members, as well as members over the age of 65 with co-morbidities.

Dr. Nakahira continued with an update on the Blanca Alvarado Community Resource Center (CRC), which is projected to open between late October and mid-November 2020. The CRC will offer virtual health education classes. There will be some SCFHP staff working there, such as Customer Service representatives, and members will be also be able to meet with Case Managers there if it is more convenient for them to do so.

b. Provider Relief Funds Information

Dr. Nakahira provided the committee with an update on the Department of Health and Human Services CARES Act for the provider relief fund. We are in phase 3 of the relief fund. The application period is from October 5, 2020 until November 6, 2020. Eligible providers include those who were in practice from January 1, 2020 through March 31, 2020, and who were seeing patients with Medi-Cal, Medicare, and CHIP insurance plans. Behavioral health providers and providers who treat patients in assisted living facilities and skilled nursing homes are also eligible for relief funds. Eligible providers may apply online, and Dr. Nakahira will send Committee members a link to the CARES Act website.

Dr. Dinh asked Dr. Nakahira if a provider who qualified for the first 2 rounds of relief funds will also qualify for the 3rd round. Dr. Nakahira referred Dr. Dinh to the CARES Act website for further details. Dr. Dinh asked about billing modifiers, and Dr. Nakahira advised she will research this and provide clarification of this along with the link to the CARES Act website. Dr. Lin inquired as to whether telehealth will continue in 2021. Dr. Nakahira responded that CMS would like to extend telehealth, however, she has no further details.

6. Old Business/Follow-Up Items

a. General Old Business

Dr. Boris reminded the Committee that the Pharmacy Benefit Manager for the Medi-Cal line of business will transition to DHCS from Managed Care applicable to services received after January 1, 2021. Enterals and supplies are included as part of this transition. Dr. Boris referred Committee members to the website for further details. Dr. Dinh expressed concerns with next steps for providers. Dr. Huynh gave an overview of the Medi-Cal Rx program and when training for providers, as well as additional program details, will be made available on the provider portal on the Medi-Cal Rx website.

7. Medical Covered Services Prior Authorization (PA) Grid

Dr. Boris advised the Committee that the Medical Covered Services PA Grid is brought to the Committee on an annual basis for review and approval. The PA Grid pertains to both the Medi-Cal and Cal MediConnect lines of business. Dr. Boris reviewed the minor changes that were made to the grid since the last annual review in 2019. Once the Committee has approved it, the grid will be published and forwarded to CMS. Dr. Boris highlighted the most significant changes to the Grid. For example, all forms of non-emergency transportation will now require prior authorization, with the exception of ground transportation from facility to facility. In addition, prior authorizations are no longer required for colonoscopies but continue to be required for endoscopies. Dr. Lin requested clarification in regards to prior authorizations for colonoscopies, and Dr. Boris clarified that no prior authorization is needed for colonoscopies. Dr. Dinh requested clarification on prior authorization for ground transportation, and Dr. Boris clarified that emergency transportation does not require prior authorization.

It was moved, seconded and the Medical Covered Services Prior Authorization (PA) Grid was **unanimously approved**.

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

Dr. Vemuri left the meeting at 6:35 pm.

8. 2021 CMC List of Durable Medical Equipment (DME) List

Dr. Boris presented an overview of the items on the 2021 CMC List of DME to the Committee. Dr. Boris advised the DME List is updated on an annual basis, and it is published on the SCFHP website.

It was moved, seconded and the 2021 CMC List of Durable Medical Equipment (DME) was **unanimously approved**.

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

9. UM Policies and Procedures

a. HS. 02 Medical Necessity Criteria

b. HS. 09 Inter-Rater Reliability

Dr. Huynh presented the Committee with an overview of the relatively minor changes to the HS.02 Medical Necessity Criteria and HS.09 Inter-Rater Reliability policies.

It was moved, seconded and the UM Policies and Procedures HS.02 Medical Necessity Criteria and HS.09 Inter-Rater Reliability were **unanimously approved**.

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

10. Reports

a. Membership

Dr. Boris gave a brief summary of the Membership Report from January 2020 through September 2020. The majority of our members are delegated to Valley Health Plan, with the remaining majority delegated to Physicians Medical Group, Premier Care, and Kaiser Care.

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

Dr. Boris presented the Committee with the UM objectives and goals. Dr. Boris summarized the results of the Medi-Cal SPD and non-SPD lines of business for the Q3 2020 12 month lookback period. Dr. Boris also summarized the Q3 2020 results of the Cal MediConnect line of business. These results resemble, but are typically higher than, the SPD results, and are attributable to a temporary claims lag. The number of discharges per thousand for the Medi-Cal population, including the SPD and non-SPD Medi-Cal population, is approximately 4-4.5 days, with the average length of stay approximately 4 days. The SPD population consists of approximately 30,000 members, and the rest are comprised of the non-SPD population. Dr. Lin asked if the average length of stay is normal, and Dr. Boris confirmed the average length of stay is normal, as is the number of discharges per thousand for the Medi-Cal population.

Dr. Boris next summarized the results for Medi-Cal and Cal MediConnect inpatient readmissions, which is an area of focus for the UM team for 2020. The lookback period ran from January through August 2020. The August numbers may be impacted by a claims lag. For our Medi-Cal population, there was a 30 day readmission rate at approximately 16% which is an area of improvement for the UM team. For our Cal MediConnect population, there was also a 30 day readmission rate at approximately 16%. These results align with the NCQA MediCare 50th percentile. Dr. Boris concluded with a summary of the ADHD Medi-Cal Behavioral Health metrics, and there are no significant changes from our July 2020 meeting.

c. Dashboard Metrics

- Turn-Around Time – Q3 2020

  Dr. Boris presented the Turn-Around Time metrics for Q3 2020 on behalf of Luis Perez. Approximately 100% of the UM staff continues to work from home. Dr. Boris summarized the Medi-Cal turn-around time results for the Committee. For July, August, and September of 2020, the turn-around times were compliant in all categories. Dr. Boris next summarized the results for the Cal MediConnect line of business. For July, August, and September of 2020, the turn-around times were also compliant in all categories.
- Call Center – Q3 2020

  Dr. Boris presented the Call Center metrics for Q3 2020 on behalf of Luis Perez. Dr. Boris reminded the Committee members these are provider calls, not member calls. The results for July, August, and September of 2020 for both the Medi-Cal and Cal MediConnect lines of business were compliant in all categories. Dr. Boris agreed with Dr. Lin that the team is very efficient.

d. Cal MediConnect and Medi-Cal Quarterly Referral Tracking – Q3 2020

Dr. Boris presented the Cal MediConnect and Medi-Cal Quarterly Referral Tracking report to the Committee. Dr. Boris explained that the UM team tracks the cycle of prior authorizations from the time the

prior authorization is issued through to claims payment. For the Cal MediConnect line of business, out of 2,700 authorization requests, 1,500 were paid within the first 90 days, and 1,200 outstanding claims remain. There are none that were received outside the 90 day period. This means approximately 44% received the service within the 90 day period. Overall, Cal MediConnect is at 60%. Dr. Lin advised that these numbers are low due to COVID-19 and Dr. Boris agreed.

For the Medi-Cal line of business, out of 4,000 authorization requests, 2,600 received services or were paid within 90 days, or 35%. There are none that were received outside the 90 day period. The UM team will call the 50 patients to find out why they did not get the authorized service.

e. Quality Monitoring of Plan Authorizations and Denial Letters (HS.04.01) – Q3 2020

Dr. Boris presented the Committee with the results of the Q3 2020 Quality Monitoring of Plan Authorizations and Denial Letters.

Dr. Vemuri rejoined the meeting at approximately 6:35 pm.

f. Behavioral Health UM

Ms. McKelvey gave the Behavioral Health UM presentation to the Committee. Ms. McKelvey highlighted the new behavioral health vendors currently under contract or pending contract. Ms. McKelvey also highlighted the fact that the Behavioral Health team implemented the new ACES and PEARLS trauma screenings, and 1,460 screenings have been completed, largely at Valley Health Plan. Dr. Vemuri asked if SCFHP pays for these screenings. Ms. McKelvey responded that the Plan does pay for these screenings. Ms. McKelvey explained the process for providers to receive reimbursement for ACES and PEARLS trauma screenings. Dr. Vemuri expressed concern that SCFHP does not pay their providers for these screenings. A discussion ensued amongst Dr. Vemuri, Dr. Nakahira, and Dr. Boris in regards to claims reimbursements and provider incentives. Dr. Boris advised the Committee there was an issue with the billing modifier, and she and Dr. Nakahira will research this issue and report back to the Committee. Dr. Alkoraishi asked Ms. McKelvey if the trauma screenings can be broken down by age group. Ms. McKelvey replied that the reimbursement is the same no matter the age. Members under 21 are eligible for an annual screening, and providers will receive an annual provider reimbursement. Providers who screen members over the age of 21 are eligible for a once a lifetime, per provider, reimbursement. Dr. Boris assured the Committee that Ms. McKelvey will forward all pertinent information on the ACES and PEARLS trauma screenings to all Committee members.

11. UMC Meeting Calendar – 2021

Dr. Boris reviewed the 2021 UMC meeting dates and times with the Committee members.

12. Adjournment

The meeting adjourned at 6:50 p.m. The next meeting of the Utilization Management Commitment is on January 20, 2021 at 6:00 p.m.

_____ _____

Jimmy Lin, MD, Chair Date

Santa Clara Family Health Plan™

Credentialing Committee Report

December 2, 2020

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

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

Credentialing Committee 12/02/2020

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	42	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	41	
Number practitioners recredentialed within 36-month timeline	41	
% 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 09/30/2020	231	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**VHP**	**PAMF**	**PMG**	**PCNC**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1094	965	689	831	328	71

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.