Santa Clara
Family Health Plan
The Spirit of Care

www.scfhp.com

Regular Meeting of the
Santa Clara County Health Authority
Quality Improvement Committee
Wednesday, February 08, 2017
6:00 PM - 7:30 PM
210 E. Hacienda Avenue
Campbell, CA 95008

AGENDA

1.	**Introduction**	Dr. Robertson	6:00	5 min.
2.	**Meeting Minutes**	Dr. Robertson	6:05	5 min.

Review minutes of the November 09, 2016 Quality Improvement Committee meeting.

Possible Action: Approve 11/09/2016 minutes

3.	**Public Comment**	Dr. Robertson	6:10	5 min.

Members of the public may speak to any item not on the agenda; two minutes per speaker. The Committee reserves the right to limit the duration of public comment period to 30 minutes.

4.	**CEO Update**	Ms. Tomcala	6:15	10 min.

Discuss status of current topics and initiatives.

5.	**Action Items**		6:25	10 min.

a. Review of Quality Improvement Policies — Ms. Liu
- i. CM.10 Early Start Program (Early Intervention Services)
- ii. QI.02 Clinical Practice Guidelines
- iii. Renumbering of CM policies

Possible Action: Approve Quality Improvement policies.

b. Review of QI Program Description

Possible Action: Approve QI Program Description

c. Review of Case Management Program Description

Possible Action: Approve Case Management Program Description

d. Review of Health Education Program Description

Possible Action: Approve Health Education Program Description

e. Review of Cultural and Linguistics Program Description and Evaluation

Possible Action: Approve Cultural and Linguistics Program Description and Evaluation

6.	**Discussion Items**		6:35	20 min.
	a. Access and Availability	Ms. Clements		
	b. Appeals and Grievances	Mr. Breakbill		
7.	**Committee Reports**			
	a. Credentialing Committee Review December 02, 2016 report of the Credentialing Committee. **Possible Action:** Accept December 02, 2016 Credentialing Committee Report as presented	Dr. Lin	6:55	5 min.
	b. Pharmacy and Therapeutics Committee Review minutes of the September 15, 2016 Committee Meeting. **Possible Action:** Accept September 15, 2016 Pharmacy and Therapeutics Committee minutes as presented	Dr. Lin	7:00	5 min.
	c. Utilization Management Committee Review minutes of the October 19, 2016 Committee Meeting. **Possible Action:** Accept October 19, 2016 Utilization Management Committee minutes as presented	Dr. Lin	7:05	5 min.
	d. Dashboard	Ms. Liu	7:15	10 min.
8.	**Adjournment**	Dr. Robertson	7:25	

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 Quality Improvement 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 Caroline Alexander 48 hours prior to the meeting at 408-874-1835.

To obtain a copy of any supporting document that is available, contact Caroline Alexander 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 210 E. Hacienda Avenue, Campbell.

This agenda and meeting documents are available at www.scfhp.com.

Meeting Minutes

SCCHA Quality Improvement Committee

Wednesday, November 09, 2016

Voting Committee Members	Specialty	Present Y or N
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	N
Jimmy Lin, MD	Internist	Y
Ria Paul, MD	Geriatric Medicine	Y
Jeff Robertson, MD, CMO	Managed Care Medicine	Y
Christine Tomcala, CEO	N/A	Y
Sara Copeland, MD	Pediatrics	N
Ali Alkoraishi, MD	Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Andres Aguirre	Quality Improvement Manager	Y
Lily Boris, MD	Medical Director	Y
Jennifer Clements	Director of Provider Operations	Y
Caroline Alexander	Administrative Assistant	Y
Johanna Liu, PharmD	Director of Quality and Pharmacy	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Chairman Ria Paul, MD called the meeting to order at 6:05 p.m. Quorum was established.			
Review and Approval of August 10, 2016 minutes	The minutes of the August 10, 2016 Quality Improvement Committee Meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the August 10, 2016 meeting were approved as presented.		
Public Comment	No attendees from public.			
CEO Update	Christine Tomcala reported Medi-Cal membership is currently at 271, 186. Healthy Kids membership is currently at 2,458. Cal MediConnect membership is at 7,583. Total membership is 281,334. There is new leadership at O'Connor Hospital and at Verity Health Systems. Will reach out to the new leadership and set up a meeting.			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Action Items A. Annual Review and Approval of Quality Improvement Policies	Three policies were presented to the committee: QI07 Physical Access Compliance QI08 Cultural and Linguistically Competent Services QI12 SBIRT	All policies were approved as presented.		
Discussion Items A. LTSS Overview	Dr. Robertson presented and overview of LTSS on behalf of Ms. Lori Andersen. As of October 2016 the breakdown of members in MLTSS programs was as follows: Medi-Cal SPD's • IHSS: 9, 177 members • CBAS: 491 members • MSSP: 223 members • Long Term Care: 981 Duals/Medi-Cal members Cal MediConnect • IHSS: 2,088 members • CBAS: 52 members • MSSP: 48 members • Long Term Care: 153 members Total LTSS referrals (from August to October 2016) • CBAS: 47 referrals • Other LTSS referrals: 60 referrals • LTC assessments: 146 referrals • LTC identified for Transition: 14 referrals			
B. Access and Availability	Mr. Aguirre presented the Access and Availability report. An analysis was done by network. The findings were as follows: • First three quarters, compared to other networks, Net 20 has the majority of access issues, they also have the largest number of delegated lives • Once the data is Normalized on a per 1000 basis, to the PQI's per 1,000 members in network, Network 20 is not an outlier.	Bring benchmarks to next meeting	Andres Aguirre	February 8, 2017

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	Will continue to track access by network on an ongoing basis internally and report outliers as needed. Continue education to all networks on the importance of access to care.			
C. Appeals and Grievances	Mr. Aguirre presented the Appeals and Grievances report for the 3rd Quarter. Breakdown of total grievances is as follows: • Healthy Kids: 3 • Cal Medi-Connect: 67 • Medi-Cal: 447 Cal MediConnect Appeals: • July: 15 • August: 37 • September: 10 • October: 15 Cal MediConnect Part D Trends from July through October 2016: Ambien, Vistaril, and Lidocaine patches were the top 3 number of appeals for Part D. Part C Trends were as follows: MRI: 4 appeals DME: 4 appeals Cardiac Stress Test: 2 appeals Part B injectable: 1 appeal Results consistent with baseline.			
D. Group Needs Assessment	Mr. Aguirre presented an overview of the Group Needs Assessment (GNA). The goal of the GNA is the evaluation and quantification of the members' health status and health risks, the evaluation of group-specific health education needs and the evaluation of any other specific cultural and linguistic service needs. Adults, Children, and Seniors and Persons with Disabilities are surveyed. HEDIS, CAHPS, membership demographic data and survey data are combined. Findings were as follows: • SPD and Medi-Cal Adults: Asian members were diagnosed more frequently with Type II diabetes, Hypertension, and Hyperlipidemia in both sub populations when compared to other ethnicities • Medi-Cal Children: Hispanic children were most			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	frequently diagnosed with Acute Upper Respiratory Infections, Cough, and Unspecified Fever when compared to other ethnicities Next steps include developing interventions that address chronic disease health education in a culturally appropriate manner, as well as promoting Nurse Advice Line in Spanish through website and in geographic areas with high proportion of Spanish speakers.			
E. CAHPS Results	Mr. Aguirre presented the CAHPS 2016 final results. Findings were as follows: • Low response rate at 15.6% (other MMP plans response rate was 22.2%) • A lot of responses of "Not applicable" attributed to either too few beneficiaries answered the questions to permit reporting or the score had very low reliability and were suppressed The following comparison data was used: • Getting appointment and Care Quickly • Rating of Health Plan • Rating of Drug Plan • Medicare Specific and HEDIS Measures (Annual Flu Vaccine and Pneumonia Vaccination) In Summary: • Missing data due to suppression • Room for improvement with provider member follow up • Educational opportunity for the plan • Strong Drug Plan performance • Exceptional Flu and Pneumonia performance			
F. Clinical Practice Guideline Evaluation	Mr. Aguirre presented the Clinical Practice Guidelines (CPG) evaluation for HEDIS year 2016 (2015 CY). SCFHP's selected CPG's coincide with HEDIS measures for each of the CPG's . Therefore, quantitative analysis of the CPG's performance is completed by evaluation of changes in the HEDIS measures. The HEDIS 2016 data will be the baseline for			

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
	CPG analysis. Measures looked at were as follows: • Comprehensive Diabetes Care HbA1c Test/Poor/Control • Comprehensive Diabetes Care Eye Exam/Med Attn Neph/BP <140/90 • Controlling High Blood Pressure • ADD Initiation Phase • ADD C&M Phase • Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Childhood Immunization Status • Immunizations for Adolescents • Prenatal Postpartum Care-Timeliness of Prenatal Care • Prenatal Postpartum Care-Post Partum Care			
Committee Reports A. Credentialing Committee	Dr. Lin presented the October 5, 2016 Credentialing Committee Report. No issues to report. It was moved, seconded to approve Credentialing Committee report as presented.	Credentialing Committee report was approved as presented.		
B. Pharmaceutical and Therapeutics Committee	Dr. Lin presented the 2nd Quarter 2016 Pharmacy and Therapeutics Committee minutes. Pharmacy Dashboard was presented. As of May 2016, percentage of expedited authorizations completed within one business day is 100% for Medi-Cal. For Cal MediConnect, percentage of standard prior authorizations completed within 72 hours is 100%. Committee Charter was presented with a recommendation to add information on how members are appointed to the Pharmacy and Therapeutics Committee. During Class Reviews, recommendations were made and approved for the following drug classes: • Growth Hormones	2nd Quarter 2016 Pharmaceutical and Therapeutics Committee minutes were approved as presented.		
C. Utilization Management Committee	Dr. Lin presented the 3rd Quarter 2016 Utilization Management Committee minutes. CEO presented an update on DMHC/DHCS audit results. Dr. Boris presented report for Inpatient Utilization, Inpatient Readmissions, as well as Frequency of Selected Procedures. 2016 Inter Rater Reliability Report was also presented by Dr. Boris.	3rd Quarter 2016 Utilization Management Committee minutes were approved as presented.		

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
D. Dashboard	Dr. Liu presented the 3rd Quarter Dashboard report, including data through October 2016. Quality Improvement department will develop a more in depth dashboard for presentation to the Quality Improvement Committee. Dashboard reports on Facility Site Reviews (FSR's), Membership, timeliness of Potential Quality Issues (PQI's) and Grievance timeliness.	Present Quarterly dashboard at Quality Improvement Committee	Johanna Liu/Andres Aguirre	Ongoing; Quarterly
Adjournment	Meeting adjourned by Dr. Ria Paul at 7:23 p.m.			
Next Meeting	Wednesday, February 08, 2017- 6:00 PM	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____

Ria Paul, MD
Quality Improvement Committee Chairperson

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Early Start Program (Early Intervention Services)**	**Policy No.:**	CM.10
Replaces Policy Title (if applicable):	Early Start Program (Early Intervention Services): Developmental Delay Identification, Referral and Care Coordination	**Replaces Policy No. (if applicable):**	CM.005_03
Issuing Department:	Health Services	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal ☒ Healthy Kids		☐ CMC

I. Purpose

To ensure that eligible members receive early screening, counseling and treatment for developmental delay or disabilities.

II. Policy

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

III. Responsibilities

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

IV. References

V. Approval/Revision History

First Level Approval	Second Level Approval
Sherry Holm LCSW	
Signature Sherry Holm, LCSW	Signature Jeff Robertson, MD
Name Behavioral Health Manager	Name Chief Medical Officer
Title January 25, 2017	Title January 25, 2017
Date	Date

Version	Change	Reviewing Committee	Committee Action/Date	Board Action/Date

POLICY

Number	(Original/ Reviewed/ Revised)	(if applicable)	(Recommend or Approve)	(Approve or Ratify)
V4	**Original**	**Pending Review by Quality Improvement Committee**		

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Clinical Practice Guidelines**	**Policy No.:**	QI.02
Replaces Policy Title (if applicable):	Development of Clinical Practice Guidelines	**Replaces Policy No. (if applicable):**	QM008_001
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To ensure a consistent process for development and revisions of Clinical Practice Guidelines.

II. Policy

Santa Clara Family Health Plan (SCFHP) adopts and disseminates Clinical Practice and Preventive Care Guidelines relevant to its members for the provision of preventive, acute and chronic medical services and behavioral health care services. These guidelines are adopted to help practitioners make appropriate decisions for specific clinical circumstances, preventive health and behavioral healthcare services.

A. These guidelines are based on up to date evidence 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.

B. SCFHP adopts at least two medical based and two behavioral health based clinical practice guidelines.

C. The guidelines are reviewed and updated at least every two years by the Quality Improvement Committee (QIC).

D. The guidelines are available for viewing on the provider web page of the health plan website, in the Provider Manual and upon request.

E. In addition to the clinical practice guidelines, SCFHP adopts preventive health guidelines for the following:
   1. Care for children up to 24 months old
   2. Care for children 2-19 years old
   3. Care for adults 20-64 years old
   4. Care for adults over 65 years old

F. SCFHP annually measures performance against at least two important aspects of the disease management programs

G. SCFHP annually evaluates provider adherence to CPGs and Preventive Health Guidelines through analysis demonstrating a valid methodology to collect data.
    a. The QI Department analyzes pertinent HEDIS scores and claims data. The analysis includes quantitative and qualitative analysis or performance.
    b. Member satisfaction and grievances are tracked and reported to the QIC at least annually and acted upon as recommended by the QIC.

III. Responsibilities

Health Services Department, Quality Improvement Department and plan providers develop and adhere to Clinical and Preventive Practice Guidelines which are reviewed / revised at least annually. Evaluation of the guidelines occurs every 2 years.

IV. References

CA.gov. (2016, February 11). Retrieved February 22, 2015, from California Department of Managed HealthCare: https://www.dmhc.ca.gov/

Medicare Coverage Data Base. (2016, February 07). Retrieved February 07, 2016, from CMS.gov: https://www.cms.gov/medicare-coverage-database/

NCQA Guidelines. 2016

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 2/2/2017	Title 2/2/2017
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**	
v**2**	**Revised**	**Quality Improvement**		

Santa Clara
Family Health Plan

The Spirit of Care

QUALITY IMPROVEMENT PROGRAM
2017 Executive Summary

SCFHP is committed to the provision of a well-designed and well-implemented Quality Improvement Program (QI Program). The Plan's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This 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.

In order to fulfill its responsibility to members, the community and other key stakeholders, regulatory agencies and accreditation organizations, the Plan's Quality Improvement Committee and the Board of Directors (BOD) reviews and approves the Quality Improvement Program on an annual basis. The 2017 updates to the Quality Improvement Program include changes needed to bring the Program into compliance with NCQA standards. The updates are:

- Addition of roman numeral numbering to table of contents and headings
- Updated SCFHP staff titles
- Highlighted where analytics support to the Program is provided
- Added clinical credentials of the Behavioral Health Program Manager
- Added section describing the program duties of the Quality Manager

Santa Clara Family Health Plan

Quality Improvement Program

2017

Table of Contents

I.	Introduction	3
II.	Mission Statement	3
III.	Authority and Accountability	4
IV.	Purpose	4
V.	Goals	5
VI.	Functions	6
VII.	Objectives	7
VIII.	Scope	8
IX.	QI Work Plan	9
X.	QI Methodology	10
XI.	QI Quality Issue Identification	12
XII.	QI Program Activities	16
XIII.	QI Organizational Structure	19
XIV.	Committee Structure	21
XV.	Role of Participating Practitioners	25
XVI.	Pharmacy Services	26
XVII.	Behavioral Health Services	28
XVIII.	Utilization Management	28
XIX.	Care of Members with Complex Needs	29
XX.	Cultural and Linguistics	32
XXI.	Credentialing Processes	33
XXII.	Facility Site Review, Medical Record and Physical Accessibility Review	34
XXIII.	Member Safety	35
XXIV.	Member Experience and Satisfaction	36
XXV.	Delegation Oversight	37
XXVI.	Data Integrity/Analytics	38
XXVII.	Conflict of Interest	42
XXVIII.	Confidentiality	42
XXIX.	Communication of QI Activities	43
XXX.	Annual Evaluation	43

I. Introduction

The Santa Clara County Health Authority, operating business 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). It is a public agency established to enter into a contract with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. In 2001, SCFHP commenced providing health care to children enrolling in the Healthy Kids Program. The Centers for Medicare and Medicaid Services (CMS) contracted with SCFHP from 2007 – 2009 to serve as a Special Needs Plan (SNP) in Santa Clara County. In 2014, CMS and the State of California contracted with SCFHP for the Managed Long Term Services and Supports (MLSS) programs. In 2015, CMS contracted with SCFHP for the Duel Demonstration Project.

SCFHP is dedicated to improving the health and well-being of the residents of our region. SCFHP continues to realize its vision of serving new enrollees, consistent with our mission and core values.

II. Mission Statement

The Mission of Santa Clara Family Health Plan (SCFHP) 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 select practitioners and 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 publicly funded, local health plan, we have a unique responsibility to work toward improving the health status of the community in which we are based. SCFHP continually promotes community health 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 Santa Clara Family Health Plan (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 Board of Directors assumes ultimate responsibility for the Quality Improvement Program and has established the Quality Improvement Committee to oversee this function. The Board passed a resolution defining the QI Program Description as an organization-wide commitment. This resolution 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.

IV. Purpose

SCFHP is committed to the provision of a well-designed and well-implemented Quality Improvement Program (QI Program). The Plan's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This 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 will foster 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 quality of care issues are identified and corrected.

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 will provide 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 will implement 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, and services received promoting patient safety at all levels of care.

In order to fulfill its responsibility to members, the community and other key stakeholders, regulatory agencies and accreditation organizations, the Plan's Board of Directors (BOD) has adopted the following Quality Improvement Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and Board of Directors.

V. Goals

Quality improvement goals and objectives are to monitor, evaluate and improve:

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 its demographics, high-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 to a network of providers with experience in providing care to the population
E. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service
F. Member and provider satisfaction, including the timely resolution of complaints and grievances
G. Risk prevention and risk management processes
H. Compliance with regulatory agencies and accreditation standards
I. The effectiveness and efficiency of the Medi-Cal and CMC internal operations
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 it's mission, vision, and values
L. Compliance with Clinical Practice Guidelines and evidence-based medicine
M. Compliance with regulatory agencies and for CMC the accreditation standards (NCQA)
N. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
O. Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers
P. Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals for patient safety and coordination of care

VI. Functions

The QI Program Description supports and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that our members receive.

The QI Program Description supports the QI Department functions, which include:

A. Implement a multidimensional and multi-disciplinary QI work plan that effectively and systematically monitors and evaluates the quality and safety of clinical care and quality of service rendered to members.
B. Monitor, evaluate and act on clinical outcomes for members
C. Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members
D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
    1. Drive improvement of quality of care received
    2. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Support the maintenance of quality standards across the continuum of care and all lines of business
F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)
G. Coordinate and drive improvements with HEDIS compliance and access to preventive care and management of chronic conditions to HEDIS standards
H. Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes an annual evaluation of the Quality Improvement Program
I. Support collaboration and quality processes and effectiveness of continuous quality improvement activities across the organization
J. Conduct effective oversight of delegated providers

All SCFHP members have timely access to health care that is delivered by qualified practitioners and delivery systems, which meets or exceeds standards determined by the Plan, the Centers for Medicare and Medicaid Services (CMS), the California Department of Managed Health Care (DMHC), the California Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA).

VII. Objectives

The objectives of the QI Program Description include to:

A. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
B. Support practitioners with participation in quality improvement initiatives of SCFHP and all governing regulatory agencies
C. Establish 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
D. Measure the compliance of contracted practitioners' medical records against SCFHP's medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance
E. Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improve performance and/or validate a problem or measure conformance to standards. Oversee delegated activities by:
    1. Establishing performance standards
    2. Monitoring performance through regular reporting
    3. Evaluating performance annually
F. Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include, but are not limited to, an annual evaluation of:
    1. Medical record review
    2. Rates of referral to specialists
    3. Hospital discharge summaries in office charts
    4. Communication between referring and referred-to physicians
    5. Analysis of member complaints regarding difficulty obtaining referrals
    6. Identification and follow-up of non-utilizing members
    7. Practice Pattern Profiles of physicians
    8. Rates of referrals per 1000 members
    9. Performance measurement of practice guidelines
G. Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from UM activities, and the identification and reporting of potential quality of care concerns through complaints and grievances collected through the Member Services Department.
H. Evaluate the QI Program Description and Work Plan at least annually and modify as necessary. The evaluation addresses:
    1. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    2. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
I. Analysis of 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)
J. Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals, and assessments of goals

K. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members
L. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VIII. Scope

The QIP provides for the review and evaluation of all aspects of health care, encompassing both clinical care and service provided to external and internal customers. External and internal customers are defined as Members, practitioners, providers, employers, governmental agencies, and SCFHP employees.

All departments participate and collaborate in the quality improvement process. The Chief Medical Officer and the Director of Quality integrate the review and evaluation of components to demonstrate the process is effective in improving health care. The measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

A. The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service
B. All activities will reflect the member population in terms of age groups, 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:
    1. Access to Preventive Care (HEDIS)
    2. Behavioral Health Services
    3. Continuity and Coordination of Care
    4. Emergency Services
    5. Grievances
    6. Inpatient Services
    7. Maintenance of Chronic Care Conditions (HEDIS)
    8. Member Experience and Satisfaction
    9. Minor Consent/Sensitive Services
    10. Perinatal Care
    11. Potential Quality of Care Issues
    12. Preventive Services for children and adults
    13. Primary Care
    14. Provider Satisfaction
    15. Quality of Care Reviews
    16. Specialty Care

D. Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:
    1. UM Metrics
    2. Prior authorization
    3. Concurrent review
    4. Retrospective review
    5. Referral process
    6. Medical Necessity Appeals
    7. Case Management
    8. Complex Case Management
    9. Disease Management
    10. California Children's Services (CCS)

IX. QI Work Plan

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

A. Quality of clinical care
B. Quality of Service
C. Safety of clinical care
D. QI Program scope
E. Yearly objectives
F. Yearly planned activities
G. Time frame for each activity's completion
H. Staff responsible for each activity
I. Monitoring of previously identified issues
J. Annual evaluation of the QI Program
K. Priorities for QI activities based on the specific needs of SCFHP's organizational needs and specific needs of SCFHP's populations for key areas or issues identified as opportunities for improvement
L. Priorities for QI activities based on the specific needs of SCFHP's populations, and on areas identified as key opportunities for improvement
M. Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified (PQI)
N. The Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures

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

X. QI Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be 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)
C. Measures required by the California DMHC, such as access and availability
D. Measures required by Medicare such as Quality Improvement Activities (QIAs)
E. Chronic Care Improvement Project (CCIP)

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services

A. Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
B. Case Management
C. Coordination and continuity of care for Seniors and Persons with Disabilities (in house)
D. Provisions of chronic and 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, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
B. Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
C. 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
D. Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
E. 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 will have at least one (and frequently more) quality indicator(s). 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 will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS measures are acceptable.

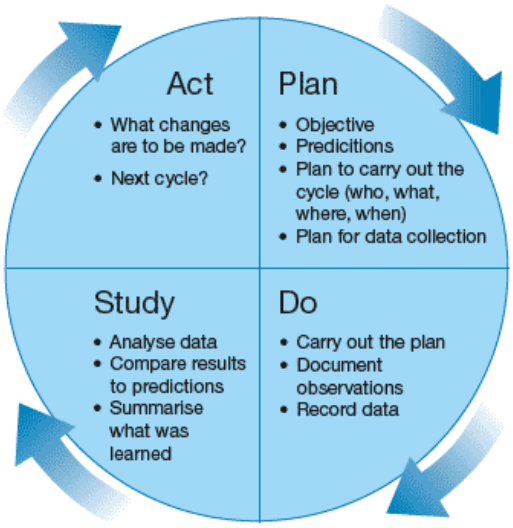
Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Data Warehouse will be utilized.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% 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 dependent 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

XI. QI Quality Issue Identification

SCFHP utilizes a full range of methods and tools of that program, including Sentinel Event monitoring. A sentinel 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.

Sentinel events can include:

A. Potential Quality Issues (PQI)
B. Potential Quality of Care Concern
C. Unexpected death during hospitalization
D. Complications of care (outcomes), inpatient and outpatient
E. Reportable events for long-term care (LTC) facilities include but are 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
F. Reportable events for community-based adult services (CBAS) centers include but are not limited to falls, injuries, medication errors, wandering incidents, emergency room transfers, and 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 will increase 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 Credentialing and Peer Review Committee to determine the appropriate course of action and/or evaluate the actions recommended by 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
D. Case Management
E. Pharmacy Data
F. Group Needs Assessments
G. Results of Risk Stratification
H. HEDIS Performance
I. Member and Provider Satisfaction
J. Quality Improvement Projects (QIPs)
K. Health Risk Assessment data

An example of identification of risk and quality potential or actual issues include:

A. Ambulatory setting
    1. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such an electric exam tables
    2. Annual blood-borne pathogen and hazardous material training
    3. Preventative maintenance contracts to promote that equipment is kept in good working order
    4. Fire, disaster, and evacuation plan, testing, and annual training
B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings
    1. Falls and other prevention programs
    2. Identification and corrective action implemented to address post-operative complications
    3. Sentinel events identification and appropriate investigation and remedial action

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

Case Management and Referrals 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 Utilization Management. 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 to have potential quality of care issues, the Quality Improvement RN Clinical Review staff will abstract the records and prepare the documents for review by the CMO or Medical Director. The case is routed back to the Quality staff who initiated the review for closure of the case.

When the Chief Medical Officer agrees that a quality of care problem exists, the CMO reviews the case, assigns a priority level, initiates corrective action, or recommends corrective action as appropriate. For case of neglect or abuse, follow-up or corrective action may include referrals to Child or Adult Protective Services.

In-Home Supportive Services (IHSS) Quality Monitoring

SCFHP will participate in the stakeholder workgroup established by the Department of Health Services, the State Department of Social Services, and the California Department of Aging to develop the universal assessment process, including a universal assessment tool, for home-and community-based services, as defined in subdivision (a) of Section 14186.1. The stakeholder workgroup shall include, but not be limited to, consumers of IHSS and other home- and community-based services and their authorized representatives, the county, IHSS, Multipurpose Senior Services Program (MSSP), and CBAS providers, and legislative staff. The universal assessment process will be used for all home-and community-based services, including IHSS. In developing the process, the workgroup shall build upon the IHSS uniform assessment process and hourly task guidelines, the MSSP assessment process, and other appropriate home- and community-based assessment tools.

In developing the universal assessment process, a universal assessment tool will be developed that will facilitate the development of plans of care based on the individual needs of the recipient. The workgroup shall consider issues including, but not limited to, how the results of new assessments would be used for the oversight and quality monitoring of home- and community-based services providers.

SCFHP will work closely with the local IHSS Agency to develop an appropriate monitoring and oversight plan to adhere to quality assurance provisions and individual data and other standards and requirements as specified by the State Department of Social Services including state and federal quality assurance requirements. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

Quality Improvement Activities – Long Term Care Facilities

Monitoring of the quality of care provided to SCFHP members, including those residing in LTC facilities, includes, but is not limited to, the following:

- Member complaint and/or grievance trends.
- Provider complaint and/or grievance trends.
- Case review of potential quality of care issue referrals triggered by quality monitors (sentinel events), or utilization management activities.
- Member satisfaction surveys.
- Focused review of topics, including those specifically related to special needs populations such as members residing in LTC facilities.

Topics for review are identified through the monitoring process. Proposed study indicators shall be reviewed by the QI Committee and approved prior to commencing the study. Initiation of quality improvement projects will be directed to the identified needs of members residing in LTC facilities. Focused quality improvement audits, as necessary, for members residing in LTC facilities are performed by the Concurrent Review Case Managers, or Quality Analysts, during on-site facility visits.

Results of quality improvement activities are presented to the Quality Department for review, analysis and summarizing. LTC facilities are notified if there is a need to execute corrective action plans (CAPs). Follow-up reviews will be conducted at LTC facilities when CAPs are executed. SCFHP assists in the identification and communication of potential quality of care issues with other agencies directly involved in coordination of services for SCFHP members in LTC facilities, including the local Regional Center, Licensing and Certification, Medi-Cal Operations Division and the Ombudsman's Office. Referrals will also be made to appropriate agencies for follow-up and/or referrals will be made to local Adult and Child Protective Services agencies or law enforcement agencies (when appropriate).

XII. QI Program Activities

The QI Program's scope includes implementation of QI activities or initiatives. The QI Committee and related committee and work groups select the activities that are designed to improve performance on selected 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 will be given 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 provides care resulting in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Board of Directors 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 and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken 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 (chronic 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 of the Clinical Quality Improvement, Utilization Management and Pharmacy and Therapeutics Committees. Guidelines will be reviewed and revised, as applicable, at least every two years.

Preventive Health/HEDIS® Measures

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

Disease Management Programs

The health care services staff, Clinical Quality Improvement Committee and network practitioners identify members with, or at risk for, chronic medical conditions. The Clinical Quality Improvement Committee is responsible for the development and implementation of disease management programs for identified conditions. Disease management programs are designed to support the practitioner-patient relationship and plan of care. The programs will emphasize the prevention of exacerbation and complications using evidence-based practice guidelines. The active disease management programs and their components will be identified in the annual UM work plan.

Complex case management and chronic care improvement are major components of the disease management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs. Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The case managers'/care coordinators help members navigate the care system and obtain necessary services in the most optimal setting.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

1. Primary care services
2. Behavioral health care services
3. Inpatient hospitalization services
4. Home health services
5. 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 are accomplished:

A. Information Exchange – 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 of 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 – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
E. Implementations of Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

XIII. QI Organizational Structure

The Quality Improvement Department

The Department support and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that are members receive.

A. Monitor, evaluate and act on clinical outcomes for members
B. Conduct review and investigations for potential or actual Quality of Care matters
C. Conduct review and investigations for clinical grievances, including Potential Quality Issues (PQIs).
D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
    1. Drive improvement of quality of care received
    2. Minimize rework and costs
    3. Minimize the time involved in delivering patient care and service
    4. Empower staff to be more effective
    5. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Support the maintenance of quality standards across the continuum of care and all lines of business
F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)

Chief Medical Officer (CMO)

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

Medical Director

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

The Medical Director(s) is required to supervise all medical necessity decisions and conducts medical necessity denial decisions. A Medical Director is the only Plan person authorized to make a clinical denial based on medical necessity. The Plan pharmacist(s) may make a denial based on medical

necessity regarding pharmaceuticals.

Director of Quality

The Director of Qualityis a registered nurse or other qualified person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Director of Quality reports to the Chief Medical Director and is responsible for directing the activities of the Plan's quality management staff in monitoring and auditing 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 senior executive staff, both clinical and non-clinical, 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 coordinates the Plan's QI Committee proceedings in conjunction with the CMO; report to the Board relevant QI activities and outcomes, support corporate initiatives through participation on committees and projects as requested; review statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

Quality Manager

The Quality Manager is a person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Quality Manager reports to the Director of Quality and is responsible for managing the activities of the Plan's quality management staff in monitoring and auditing 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 Quality Manager assists the Director of Quality 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 Quality Manager facilitates the Plan's QI Committee proceedings in conjunction with the CMO; supports corporate initiatives through participation on committees and projects as requested; reviews statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

QI Nurse, RN

The QI Nurse reports to the Quality Manager and oversees the investigations of member grievances, supports HEDIS reviews, investigates and prepares cases for potential quality of care (QOC) reviews and potential quality issues (PQI) for the 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 (PIP) and Chronic Care Improvement Projects (CCIP). The QI Nurse is also a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Evaluations (IHEs), and assists with other QI activities at the direction of the Quality Manager.

QI Project Manager

The QI Project Manager provides leadership, coordination, and management of quality improvement projects. Director of Quality his position is responsible for developing and maintaining processes that enhance the operationalization of QI processes, management of software applications(s), and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

HEDIS Project Manager

The HEDIS Project Manager provides leadership, coordination, and 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(s), and support reporting requirements to Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS) and achieving SCFHP goals of improved quality of care and service.

QI Health Educator

The Health Educator is responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance to state and federal regulatory requirements concerning health education and cultural and linguistic services. The QI Health Educator works under the general direction of the Quality Improvement Manager and works in cooperation with other departments.

Coordinator, QI

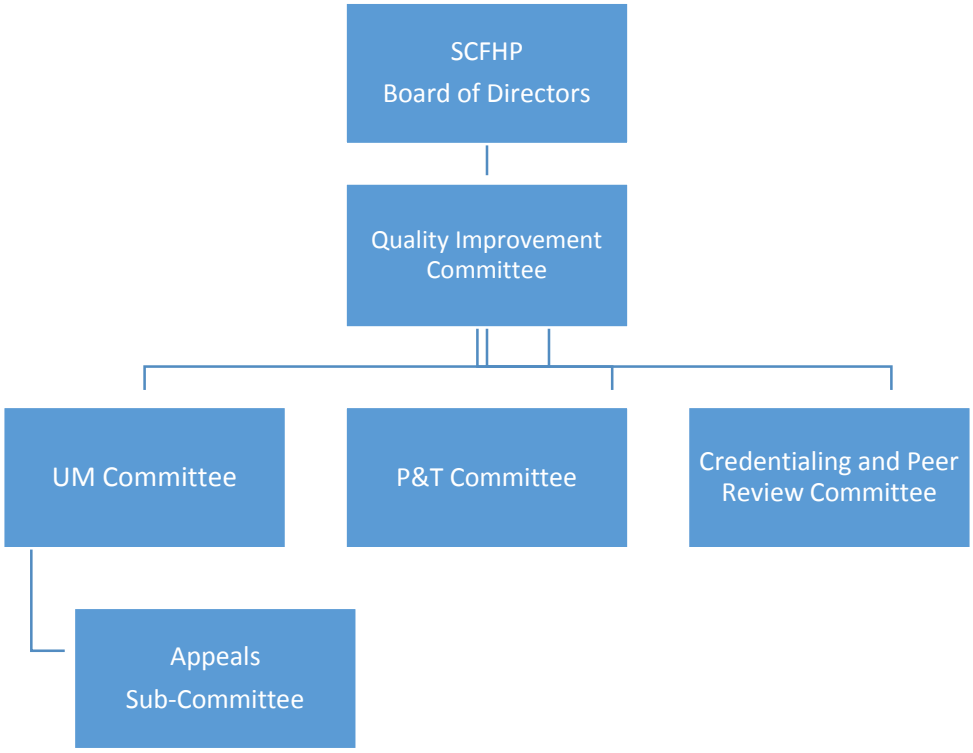
Quality Improvement Coordinators are highly trained clinical and non-clinical staff with significant experience in a health care setting; experience with data analysis and/or project management preferred. QI Coordinators report to the Quality Manager and their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and 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 action or improvement initiatives as identified through Plan's quality improvement activities and quality of care reviews. Committee Structure
Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the Board of Directors.

SCFHP involves a contracted network licensed behavioral specialist who is a psychiatrist or Ph.D. level psychologist to serve on the QI Committee and the UM Committee and as an advisor to the QI Program structure and processes. The designated behavioral health practitioner advises the Clinical Quality Improvement Committee 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.

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

A. Voting members
B. Plan support staff
C. Quorum

D. Meeting frequency
E. Meeting terms
F. Goals
G. Objectives



In addition the Grievance/Appeals Committee conducts analysis and intervention and reports to the QI Committee.

Board of Directors

The Board of Directors is responsible to review, act upon and approve the overall QI Program, Work Plan, and annual evaluation. The Board of Directors receives at least quarterly progress and status reports from the QI Committee describing interventions and actions taken, progress in meeting objectives, and improvements achieved. The Board shall also make recommendations additional interventions and actions to be taken when objectives are not met.

The Director of Quality is responsible for the coordination and distribution of all quality improvement related data and information. The Quality Improvement Committee reviews, analyzes, makes recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The Chief Executive or the Chief Medical Officer communicates the QI C 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.

XIV. Committee Structure

Quality Improvement Committee

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

The purpose of the QI Committee is to monitor and assess 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 QI Committee oversees the performance of delegated functions and contracted provider and practitioner partners. The composition of the QI Committee includes a participating Behavioral Health Practitioner 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 QI Committee provides overall direction for the continuous improvement process and evaluates for activities that are consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and interdepartmental approach and adequate resources for the program. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided the highest quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QI Committee.

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

The QI Committee shall develop, oversee, and coordinate member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QI Committee also recommends strategies for dissemination of all study results to SCFHP-contracted providers and practitioners, and contracted groups.

The QI Committee provides overall direction for the continuous improvement process and monitors that activities are consistent with SCFHP's strategic goals and priorities. It promotes efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

Utilization Management Committee

The Utilization Management Committee promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic

monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UM Committee actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. Plan's UM Committee is comprised of network physicians representing the range of practitioners within the network and across the regions in which it operates, including a BH practitioner. Plan executive leadership and UM/QI staff may also attend the UMC as appropriate.

The UM Committee (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 UM Work Plan.

The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as adoption of Evidence Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and 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 to medical care, continuity and coordination of medical and behavioral health care, as well as 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 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, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to SCFHP's members. The P&T Committee includes practicing physicians and the contracted provider networks. A majority of the members of the P&T Committee are physicians (including both Plan employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties including a Behavioral Health practitioner, in order to adequately represent the needs and interests of all plan members.

The P&T Committee involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacological drugs.

The P&T Committee also involves mental health prescribing practitioners 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

Peer Review is coordinated through the QI Department and communicated with the Credentialing process. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases will be presented to the Credentialing and Peer Review Committee to assess if documentation is complete, and no further action is required. The QI Department also 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 is based on referrals to the QI Department originated from multiple areas, which include, but are not limited to, the following: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

XV. Role of Participating Practitioners

Participating practitioners 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, disease management 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 levels of care and service
F. Are involved with policy setting
G. Participate with the following committees
    1. Quality Improvement Committee
    2. Pharmacy and Therapeutics Committee
    3. Utilization Management Committee
    4. Credentialing and Peer Review Committee
    5. Additional committees as requested by the Plan

XVI. Pharmacy Services

Pharmacy Services are overseen by the Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is two-fold, utilizing the Pharmacy Benefit Manager (PBM) national P&T Committee for the Medicare line of business and a Plan Based P&T Committee for the Medi-Cal line of business as well as to oversee QI monitoring of medication management outcomes, and approve applicable programs and policies and procedures. The P&T Committee oversees the development, maintenance, and improvement of SCFHP's formularies. The P&T Committee recommends policy on all matters related to the use of drugs to promote the clinically appropriate use of pharmaceuticals based on sound clinical evidence. The P&T Committee reports organizationally to SCFHP's Quality Improvement Committee. SCFHP has adopted its PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements.

SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state. SCFHP maintains a closed drug formulary for the Medi-Cal (Medicaid) line of business.

The Plan has adopted the PBM's Medicare Advantage formulary and associated prior authorization criteria, step edits and step criteria, and quantity limits. The maintenance and updating of the Medicare formulary has been delegated to the PBM based on Medicare requirements and guidelines. Therefore, SCFHP's P&T Committee is not charged with the review and maintenance of the formulary but rather the oversight of the delegation for the formulary review process.

The scope of coverage, classes of pharmaceuticals, co-payment policies, exclusions and limitations, policies and procedures may be affected by contractual and regulatory requirements. SCFHP's Medi-Cal Formulary is influenced by the state of California's Medi-Cal List of Contracted Drugs. The P & T Committee reviews additions, deletions, and changes to the Medi-Cal List of Contracted Drugs as they are announced in the Medi-Cal Provider Bulletins. The Committee may elect to adopt, modify, or reject the actions taken by the state.

Current versions of SCFHP's formularies are posted on the Plan's web site and are accessible to both members and practitioners. SCFHP pharmaceutical management procedures are included within the formulary as well as in the *Member Guide* (Combined Evidence of Coverage and Disclosure Form) and Provider Manual. Members, prescribers, and pharmacies may receive a printed copy of the formulary upon request.

SCFHP develops its own medical exception review criteria and/or adopts its PBM's criteria. The P&T Committee reviews and approves each set of criteria (both Plan developed and PBM-developed criteria) prior to use and performs an annual review of all criteria. When applying the criteria in a review of a request, SCFHP's criteria are applied when they exist. When Plan-developed criteria do not exist, the appropriate clinical references will be applied.

Member safety is integrated into all components of the Plan's QI Program, and is especially applicable to Pharmacy Services who conducts monitoring and evaluation and takes interventions when application while reviewing processes

SCFHP's pharmaceutical quality improvement process includes measures and reporting systems to address the identification and reduction of medication errors and adverse drug interactions. The PBM's utilization review (DUR) edits provide on-line messaging to dispensing pharmacists. The PBM identifies drug-drug interactions based on three severity levels supported by nationally recognized references (e.g., First Data Bank, NDDF Plus, and National Drug Data File). Eight (8) on-line DUR edits are used and send a message to the dispensing pharmacist when "triggered":

A. Drug Interaction
B. Drug dosage
C. Ingredient duplication
D. Age precaution
E. Pregnancy precaution
F. Gender conflict
G. Therapeutic duplication
H. Late refill

The PBM identifies and notifies SFHP of members and prescribers affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons. SCFHP uses these reports to notify affected physicians and members within 30 calendar days of the FDA notification. An expedited process is followed for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. When the FDA recalls a drug, the product is immediately removed from SCFHP's formularies and active prior authorizations are terminated.

SCFHP conducts retrospective drug utilization of pharmacy claims and other records, through computerized drug claims processing and information retrieval systems to identify patterns of inappropriate or medically unnecessary care among members or associated with specific drugs or groups of drugs.

SCFHP monitors and implements processes to prevent over-utilization and under-utilization of prescribed medications, including but not limited to the following elements:

A. Compliance programs designated to improve adherence/persistency with appropriate medication regimens
B. Monitoring procedures to discourage over-utilization through multiple prescribers or multiple pharmacies
C. Quantity versus time edits
D. Early refill edits

XVII. Behavioral Health Services

SCFHP will monitor and improve the quality of behavioral health care and services provided through and based on applicable contract requirements. The QI program includes services for behavioral health and review of the quality and outcome of those services delivered to the members within our 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 Clinical Director for Behavioral Health services shall be involved in the behavioral aspects of the QI Program. The Clinical Director shall be available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data, and follow-up on identified issues.

XVIII. Utilization Management

Utilization Management activities and related UM activities including Case Management, Disease Management, and Model of Care programs and processes as addressed in the Utilization Management Program Description.

The outcomes of UM activities are measured and reported to the UM Committee and are defined in the UM Work Plan.

Please refer to the Utilization Management Program and the Utilization Management Work Plan for QI activities related to the following:

11. UM Metrics
12. Prior authorization
13. Concurrent review
14. Retrospective review
15. Referral process
16. Medical Necessity Appeals
17. Case Management

18. Complex Case Management
19. Disease Management
20. California Children's Services (CCS)
21. Early and Periodic Screening, Diagnosis and Treatment (ESPDT)

Monitoring Utilization Patterns

To monitor and analyze that appropriate care and service to members, SCFHP's Utilization Management Committee performs an annual assessment of utilization data to identify potential under- and over-utilization issues or practices. Data analysis is conducted using various data sources such as medical service encounter data, pharmacy, dental and vision encounter reporting to identify patterns of potential or actual inappropriate utilization of services. The QI Department works closely with the UM Department, Chief Medical Officer Director of Health Care Services and Plan Medical Directors to identify problem areas and provide improvement recommendations to the QIC for approval. Once approved, the QI and UM Departments will implement approved actions to improve appropriate utilization of services.

The California DHCS also requires submission of selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures. These measures may be audited as part of the EAS/HEDIS Compliance Audit and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, SCFHP adheres to DHCS notification to the Plan of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

XIX. 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 promotion of 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. Standardized mechanisms for member identification through use of data
B. Documented process to assess the needs of member population
C. Multiple avenues for referral to case management and disease management programs
D. Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
E. Ability of member to opt out
F. Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education
G. Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

H. Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
I. Coordinating services for members for appropriate levels of care and resources
J. Documenting all findings
K. Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
L. Ongoing assessment of outcomes

The Interdisciplinary Care Teams (ICT) includes three (3) levels of ICTs that reflect the health risk status of members. Each are offered an ICT. All members are stratified using a plan-developed stratification tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. The members are stratified into high, moderate and low risk levels.

The low risk members are managed by the basic ICT at the PCP level. Moderate members may be managed by the primary ICT at the Medical Group level, if delegated. High risk members are managed by the Complex ICT at the Plan level or through a delegation agreement by an NCQA Certified organization.

For high risk members, the ICT includes the member if feasible, Medical Director, PCP/specialist as necessary, Case Management Team, Behavioral Health Specialist, and Social Worker. A treating Specialist may be invited to an ICT meeting if the need is identified. The teams are designed to see that members' needs are identified and managed by an appropriately composed team. Additional disciplines, such as the Clinical Pharmacist, Dietician, and/or Long Term Care Manager, may be included in the ICT based on the member's specific needs.

Interdisciplinary Care Teams process includes:

A. Basic ICT for Low Risk Members:

1. Basic CM by PCP in collaboration with the case manager
    a. Initial Health Assessment (IHA)
    b. Initial Health Behavioral Assessment (IHEBA)
    c. Identification of appropriate providers and facilities(such as medical, rehabilitation and support services)
    d. Direct communication between provider, member and family
    e. Member and family education
    f. Coordination of carved out/linked services
    g. Referral to appropriate community resources/agencies

B. Primary ICT for Moderate Risk Members:

1. Basic CM as above
2. Record of Medication History
3. Assessment of Health History
4. Development of ICP
    a. Specific to member needs
    b. Member and PCP input
    c. Updated at least annually
5. Identification of appropriate providers and facilities (such and medical, rehabilitation and support services) to meet member care needs
6. Direct communication between provider, member/family or caregiver and case manager/care coordinator
7. Member, family and/or caregiver education including healthy lifestyle changes as appropriate
8. Coordination of carved out and linked services, and referral to appropriate continuity resources and other agencies

C. Complex ICT for High Risk Members:

1. Basic CM as above
2. Record of Medication History
3. Assessment and Health History
4. Basic CM Services
5. Development of Care Plan (ICP)
    a. Specific to member needs
    b. Member and PCP input
    c. Updated at least annually
6. Management of acute/chronic illness(s)
7. Management of emotional/social support issues
    a. By multidisciplinary team
8. Intense coordination of resources
    a. Goal for member to regain optimal health or improved functioning
    b. Focused community based coordination of medical, BH and LTSS benefits and resources including IHSS, MSSP and CBAS.

D. Team Composition (As appropriate for identified needs): Member, Caregiver, or Authorized Representative, Medical Group Medical Director, Plan Clinical/Medical Group Case Manager, PCP and/or Specialist, Social Worker, and Behavioral Health Specialist
    1. Roles and responsibilities of this team
    2. Consultative for the PCP and Medical Group teams
    3. Encourages member engagement and participation in the IDT process
    4. Coordinating the management of members with complex transition needs and development of ICP
    5. Providing support for implementation of the ICP by the Medical Group
    6. Tracks and trends the activities of the IDTs
    7. Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
    8. Oversight of the activities of all transition activities at all levels of the delivery system
        a. Meets as often as needed until member's condition is stabilized.

XX. Cultural and Linguistics

SCFHP will monitor that services, both clinical and non-clinical, 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 needs and planned interventions involve member input and are vetted through the Customer Advisory Committee prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

A. Analysis of significant health care disparities in clinical areas
B. Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
C. Consider outcomes of member grievances and complaints
D. Conduct patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language specific risks
E. Identify and reduce a specific health care disparity with culture and race
F. Provide information, training and tools to staff and practitioners to support culturally competent communication

All individuals providing linguistic services to SCFHP members shall be 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 compliance ability to serve as an interpreter will be maintained by the Plan.

Interpreter services are provided to the member at no charge to the member.

SCFHP offers 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 patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity. And language specific risks to improve cultural competency in materials
C. Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs to improve cultural competency communications
D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy to meet the needs of underserved groups.

SCFHP has designated the Director of Quality 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 Spanish staff
D. Cultural competency trainings such as:
    1. Cultural Competency Workshops
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

XXI. Credentialing Processes

SCFHP conducts a Credentialing process that is in compliance withal regulatory and oversight requirements. SCFHP contracts with an NCQA Certified Vendor Organization (CVO). The Plan credentials all new applicants prior to executing a contract to see members and 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. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS, and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, allied health and midlevel practitioners, which include, but are not limited to practitioners who work independently including behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and Direct contracts.

Healthcare Delivery Organizations

SCFHP performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every 36 months thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies and as applicable, accreditation status.

Use of Quality Improvement Activities in the Re-credentialing Process

Findings from quality improvement activities are included in the Re-credentialing process. Should an egregious 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, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

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

SCFHP does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted groups. The Plan does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 02-02. SCFHP assumes responsibility and conducts and coordinates FSR/MRR for the non-delegated groups.

SCFHP collaborates with the delegated entities to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs. 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 02-02 and SCFHP policies.

Medical records of new providers shall be 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 Groups make certain that each member medical record is maintained 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 promote timely access by members to information that pertains to them.

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.

XXIII. 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 is a significant part our quality and risk management functions. Our member safety efforts are clearly articulated both internally and externally, and include strategic efforts specific to member safety. The QI Program Description is based on a needs assessment, and includes the areas:

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, and targets based on the risk assessment
C. Plans to conduct appropriate patient safety training and education are available to members, families, and health care personnel/physicians
D. Health Education and Promotion
E. Group Needs Assessment
F. Over- and under- Utilization monitoring
G. Medication Management
H. Case Management and Disease 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), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
B. Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
C. Utilizing facility site review, Physical Accessibility Review Survey (PARS), and medical record review results from practitioner and healthcare delivery organization 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
D. 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 identifying and remediate potential and actual safety issues, and to monitor ongoing staff education.

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

XXIV. Member Experience and Satisfaction

SCFHP supports continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction by monitoring member and provider complaints, member and provider satisfaction, and member and provider 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, depending upon the intervention.

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

Provider satisfaction is assessed annually using 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. Plan also uses another approach to obtain more real-time data related to new provider satisfaction. Provider Services

Member Grievances and Provider Complaints

The QI Department investigates and resolves all member 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 QI Committee. The QI Committee will recommend specific physician/provider improvement activities.

All administrative member grievances are tracked and resolution is facilitated by the Appeals and Grievance Coordinator. 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 QI Committee at least quarterly, along with recommendations for QI activities based on results.

All provider complaints are tracked and resolution is facilitated by the Provider Network Department. Data is reported to and analyzed by the QI Committee 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.

XXV. Delegation Oversight

The Delegation Oversight process and Delegation Oversight Committee are reviewed through the Plan's Compliance Committee. The Delegation Committee reports to compliance. The portion of Delegation Oversight specific to the QI Program are the reporting submitted by the delegated entities and the functional operational area overseeing corrective action plans.

Through Delegation Oversight, the Plan monitors include, but are not limited to, the following:

A. On-going monitoring via quarterly, semi-annual, and annual reports. Focus reviews are conducted when applicable
B. Annual site visits Annual Review of the delegates' policies and procedures
C. Annual review, feedback and approval of the delegates' Quality and Utilization Management Program Plans
D. Annual Review, approval, and feedback to the delegates on QI and utilization management work plans
E. Review and approval, by Compliance Committee, of sub-delegate's delegation agreement/s prior to implementation of such an agreement for sub-delegation
F. Sub-delegation reports
G. Review of case management program and processes Review of quality of care monitoring processes, results of QI Activities, and peer review processes
H. Review of credentialing and re-credentialing processes Working collaboratively with the delegates' staffs to review performance and develop strategies for improvement
I. Providing educational sessions
J. Evaluating and monitoring improvement
    1. Monthly and quarterly analysis of reports and utilization benchmarks by with results communicated to delegate, results reported on quarterly basis

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

A. Evaluation, oversight, and monitoring of the delegation agreement to determine what services can 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 its 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.

XXVI. Data Integrity/Analytics

The Clinical Data Warehouse aggregates data from SCFHP's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. 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 disease management population identification, risk stratification, process measures, and outcomes measures. SCFHP staff creates and maintains the data base with quarterly data updates.

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

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

<u>Identification and Stratification of Members</u>

Using clinical business rules, the database can identify members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect 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 will be available through UM Metrics such as 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 preventative 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 diabetic.

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 will be the primary conduit for targeting and prioritizing heath education, disease management, and HEDIS-related interventions.

By analyzing data that SCFHP currently receives (i.e. claims data, pharmacy data, and encounter data), the data warehouse will identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide SCFHP in not only targeting the members, but also the 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 will be utilized. Training for each data element (quality indicator) will be accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be coordinated by the Director of Quality or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, will be 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. Demonstrated Improvement
   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. Sustained Compliance with Improvement
   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 necessarily 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:

Clinical Care and Service:

A. Access and Availability
B. Continuity and Coordination of Care
C. Preventive care, including:
    1. Initial Health Risk Assessment
    2. Initial Health Education
    3. Behavioral Assessment
D. Patient Diagnosis, Care, and Treatment of acute and chronic conditions
E. Complex Case Management: 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.
F. Drug Utilization
G. Health Education and Promotion
H. Over- and Under- Utilization monitoring
I. Disease Management Outcomes

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.

XXVII. 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.

XXVIII. 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 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.

All records and proceedings of the Quality Improvement Committee 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.

All information is maintained in confidential files. The medical groups hold all information in strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement." This Agreement requires the member to maintain confidentiality of any

and all information discussed during the meeting.

XXIX.Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QI Committee quarterly in order to facilitate communication along the continuum of care. The QI Committee reports activities to the Board of Directors, through the CMO or designee, on a quarterly basis. QI Committee 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. Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on the Plan's website, in addition to the annual article in both practitioner and member newsletter.
D. The information to be shared with practitioners and members includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service.
E. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
F. Included in annual practitioner education through Provider Relations and the Provider Manual

XXX. Annual Evaluation

The QI Committee 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 Board of Directors.

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

1. A description of completed and ongoing QI activities that address quality of care and safety of clinical care and quality of service
2. Trending of measures to assess performance in the quality and safety of clinical care and quality of services
3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward

influencing network wide safe clinical practices
4. 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:

1. The adequacy of QI Program resources
2. The QI Committee structure
3. Amount of Practitioner participation in the QI Program, policy setting, and review process
4. Leadership involvement in the QI Program and review process
5. Identification of needs to restructure or revise the QI Program for the subsequent year

Practitioners and members are advised of the availability of a summary of the QIP posted on the Plan's web site and that the summary is also available upon request. This summary includes information about the QIP's goals, processes, and outcomes as they relate to member care and service.

Santa Clara Family Health Plan, Health Services

Comprehensive Case Management
Program Description
2017

_____	_____
Date	Jeff Robertson, MD Chief Medical Officer
_____	_____
Date	Bob Brownstein Chairperson, Board of Directors

Table of Contents

I. SCFHP Background 3
II. Purpose and Scope 4
III. Goals and Objectives 5
IV. Program Oversight and Staff Responsibility 6
V. Eligibility Criteria & Risk Stratification 10
VI. Case Management Clinical Systems 13
VII. Case Management Functions 14
VIII. Levels of Case Management 15
IX. Care Coordination and Case Management Services 18
X. Case Management Program Description 23
XI. Program Overview 26
XII. Case Management Programs Descriptions 27
XIII. Case Management Organizational Structure and Staffing 32
XIV. Staff Development and Training 33
XV. Program Evaluation and Assessment of Effectiveness 37
XVI. END NOTE 40

I. SCFHP Background

Santa Clara Family Health Plan (SCFHP) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Santa Clara County. Established in January 1996, SCFHP was created by the Santa Clara County Board of Supervisors for residents and reflects the cultural and linguistic diversity of the community. Our mission is to provide high quality, comprehensive health care 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, we act as a bridge between the health care system and those who need coverage. We do this by offering comprehensive, affordable medical, behavioral health, dental and vision coverage through our health insurance programs: Medi-Cal, Cal MediConnect and Healthy Kids. Medi-Cal is a public insurance program, Cal MediConnect is a program for people with both Medi-Cal and Medicare, and Healthy Kids is a locally funded insurance program.

Since 1997, SCFHP has partnered with providers to deliver high-quality health care to our members. 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. We currently serve over 250,000 residents of Santa Clara County. For the Cal MediConnect Line of Business we serve approximately 7,500 members.

SCFHP offers an array of care management services to support a collaborative patient and provider treatment process and to improve the health of the member population. Comprehensive case management is one such SCFHP service that assists members and providers in aligning effective healthcare services and appropriate community resources.

The activities of the comprehensive case management program support SCFHP members and providers to attain the highest level of functioning available to the member in relation to their overall health conditions. SCFHP oversees and maintains the following three case management service types in the comprehensive case management program: (1) Basic Case Management Services, (2) Moderate Case Management Services and (3) Complex Case Management.

The comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and individual program descriptions for each of the three case management categories that comprise the comprehensive case management program.

II. Purpose and Scope

The purpose of the Santa Clara Family Health Plan (SCFHP or the "Plan") Comprehensive Case Management Program Description is to define the goals and objectives of the program, the methods and processes of identifying and assessing members, managing member care, and measuring the impact of Case Management (CM) interventions. Case management is defined by the Case Management Society of America (CMSA) as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes." The Plan also abides by the principles of case management practice, as described in CMSA's Standards of Practice for Case Management, providing both episodic and complex case management, based on member needs and the intensity of service required.

The SCFHP Case Management Program has three categories: Basic Case Management, Moderate Case Management and Complex Case Management with multiple programs that address the unique needs of our members. All Case Management activities maintain the member's privacy, confidentiality and safety. The Case Manager advocates for the member and adheres to ethical, legal and accreditation/regulatory standards while reinforcing the member's Rights and Responsibilities as noted in the Member Handbook. The program provides case management processes and procedures that enable SCFHP to improve the health and health care of its membership.

Case management activities are performed telephonically or in-person depending upon the member's needs. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems, various payer sources and the community at large.

SCFHP promotes case management services through a multidisciplinary team that addresses member specific medical conditions, behavioral, functional, psychosocial issues in a single health care setting or during the member's transitions of care across the continuum of care. The fundamental components of SCFHP case management services encompass: member identification and screening; member assessment; individual care plan development, interdisciplinary team implementation and management; on-going management of the member care plan; and closure of the case upon successful achievement of established goals. 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.

The SCFHP Care Delivery Model for comprehensive case management provides coordinated care across the full continuum of care including Medical, Behavioral Health (BH) and Long Term

Services and Supports (LTSS). This model reflects a person-centered, outcome-based, community-centered approach. The focus is on providing care in the most appropriate, safe, and least restrictive setting for members including monitoring of nursing facility utilization and facilitating successful care transitions between facilities and community. SCFHP comprehensive case management services span Medical and LTSS systems, emphasizing coordination with county agencies, direct contractors for Behavioral Health and appropriate community resources. The CM Program focuses on the integration of the array of available services and proactively facilitates the communication and collaboration between them.

The SCFHP comprehensive case management program is aligned with the SCFHP Model of Care (MOC) specific to our CMC population per CMS requirements, and in compliance with all DCHS program requirements for the Medi-Cal and Healthy Kids population. Embracing the SCFHP guiding principle of "the Spirit of Care" the program embraces a Member-driven, whole person approach to care coordination that integrates a robust individual care plan with a multi-disciplinary team of professionals to address the needs of our members.

III. Goals and Objectives

A. Goals

The overall goal of the comprehensive case management program is to support the mission of making high quality health care services accessible and affordable to the SCFHP membership, to promote member health and well-being, and to offer quality accessible care coordination among medical care, behavioral health, and long term services and supports; and further the goals of the Olmstead Decision[1]. In doing so, more specific goals for the program include:

- Identification of the most vulnerable members;
- Interact with members as a "whole person," not as a condition or event;
- Provide support, education and advocacy to members;
- Identify barriers that may impede member's functionality;
- Work collaboratively with the member, family and caregivers to develop goals and assist member is achieving these goals;
- Enhance member health self-management skills and knowledge regarding their health;
- Promote early and timely interventions that prevent avoidable emergency room visits and hospitalizations;
- Help members achieve optimum health or regain functional capability;
- Treatment of the member in the least restrictive setting appropriate.
- Promote utilization of participating providers;
- Engage the providers and community as collaborative partners in the delivery of effective healthcare;

- Support the foundational role of the primary care physician and care team to achieve high-quality, accessible, efficient health care;
- Integrate seamlessly into the primary care office workflow to ease use of program by physicians and staff;
- Coordinate with community services to promote and provide member access to available resources in the Santa Clara County service area;
- Provide financial stewardship and diligence, while ensuring the provision of high quality, evidence-based health care services;
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards.

B. Objectives

The objectives of the comprehensive case management program is to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the SCFHP membership. The Chief Medical Officer, Director of Health Services and Manager of Case Management develop measurable goals and objectives and monitor them. The Quality Improvement Committee (QIC) reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Prevent and reduce hospital and facility readmissions as measured by admission and readmission rates
- Prevent and reduce emergency room visits as measured by emergency room visit rates
- Achieve and maintain member's high levels of satisfaction with case management services as measured by member satisfaction rates
- Improve functional health status and sense of wellbeing of comprehensive case management members as measured by member self-reports of health condition

The comprehensive case management program is a supportive and dynamic resource that SCFHP uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

IV. Program Oversight and Staff Responsibility

A. Quality Improvement Committee (QIC)

The QIC supports the objective and systematic monitoring and evaluation of the overall processes and procedures of the comprehensive case management program. The QIC is a standing committee of the SCFHP Board of Governors and meets a minimum of four times per year, and as often as needed to follow-up on findings and required actions. All meetings are open to the public, except when matters deal with peer review activities, contracting issues and other proprietary matters of

business. Signed and dated minutes are maintained that summarize committee activities and decisions. The elected Chair of the QIC and members are appointed for two-year terms and include the following representatives:

- SCFHP Chief Medical Officer
- SCFHP Chief Executive Officer (ex officio)
- SCFHP Contracted physicians (3)
- Behavioral Health Practitioner / Specialist

The QIC holds oversight and monitoring responsibility for clinical activities, services and programs provided by the SCFHP health plans. These responsibilities include:

- Oversight of the utilization, case and disease management, and quality management programs.
- Review and approval of annual QI (Quality Improvement), CM (Case Management), DM (Disease Management) and UM (Utilization Management) program descriptions, work plans, and evaluations.
- Annual Population Assessment for Case Management and Disease Management programs
- Review results and effectiveness of quality improvement, case and disease management and utilization management activities and measures, and provide recommendations for priorities and corrective action interventions.
- Review and approval of medical necessity criteria and clinical practice guidelines.
- Oversight of all delegation arrangements to include review of summary reports and evaluations.
- Monitor and review regulatory and accreditation compliance activities.
- Monitor and review member grievance and appeals information.
- Review reports from the Pharmacy and Therapeutics Committee.
- Provide summary reports of clinical activities, services and programs to the Board of Governors.

Specific to the comprehensive case management program, the QIC maintains the following responsibilities and functions:

- Oversight of development, implementation, administration, and management of program.
- Integration of program activities with other SCFHP functions, including utilization management, disease management, Behavioral Health and Long Term Services and Supports, quality and performance improvement, member services, and provider network services.
- Recommendations for coordination and promotion of program to provider, community and consumer stakeholders.
- Review of annual program evaluation that includes analysis of performance measures, review of policies, procedures and program description, analysis of member population characteristics, and evaluation of the resources to meet the case management needs of membership.
- Recommendations for program improvement and approaches to address barriers to care.
- Assure overall effectiveness, efficiency, quality and satisfaction with the program.

A. Staff Resources

1. Chief Medical Officer

The Chief Medical Officer (CMO) has ultimate responsibility for and provides support to the Plan's Case Management Programs. The Plan's CMO, Medical Director, Director of Health Services along with the Plan President and CEO are the senior executives responsible for implementing the Case Management Programs including cost containment, quality improvement monitoring, medical review activities, outcomes tracking, recommendation of guidelines, oversight of annual membership analysis with monthly stratification, and reporting relevant to case management. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services. The CMO provides guidance for all clinical aspects of the program. The CMO makes periodic reports to the QIC regarding comprehensive case management program activities and the annual program evaluation. The CMO works collaboratively with SCFHP network physicians to continuously improve the services that the comprehensive management program provides members and providers.
The CMO's responsibilities include in part, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Case Management Program
- Provides a point of contact for practitioners with questions about the case management process
- Communicates with practitioners as necessary to discuss case management issues
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.
- Reports case management activities to the Quality Improvement Committee and other relevant committees

2. Medical Director

The Medical Director, a licensed physician, provides clinical leadership and stewardship to the Health Services programs and staff. The Medical Director provides guidance to clinical program design and clinical consultation of members enrolled in the disease management programs, utilization management, transitions of care, and care coordination. The Medical Director works collaboratively with the SCFHP network physicians to continuously improve the services that the disease management program provides members and providers. The Medical Director's responsibilities include in part, coordination and oversight of the following activities:

- Assists in the development and revision of case management policies and procedures as necessary to meet state statutes and regulations
- Monitors compliance with the Case Management Program
- Provides clinical support to the case management staff in the performance of their case management responsibilities

- Provides a point of contact for practitioners with questions about the case management process
- Communicates with practitioners as necessary to discuss case management issues
- Assures there is appropriate integration of physical and behavioral health services for all members in case management as needed
- Educates practitioners regarding case management issues, activities, reports, requirements, etc.

3. Pharmacists

Pharmacists are an integral part of the Model of Care and the Interdisciplinary Care Team. SCFHP has an internal pharmacy director, clinical pharmacists and pharmacy technicians. The core functions of pharmacists are to ensure member access to appropriate medications, ensure safety, increase adherence, maximize medication outcomes, provide education and optimize medication therapy. SCFHP Pharmacists target those members most in need of pharmacy management, including:

- Recently hospitalized members
- Members on multiple medications or with multiple prescribers
- Members on anticoagulants and other high risk drugs
- Members referred by CMs, PCPs or other team members for medication reviews
- Perform Medication Reconciliation at points of transition of levels of care

4. Manager, Case Management

The Manager of Case Management oversees the comprehensive case management program. Under the supervision of the Director of Health Services, the scope of responsibilities of the Manager of Case Management includes management of daily operations, training of case management staff, tracking of program metrics, oversight of vendors and continuous quality and compliance reviews. The CM Manager is also involved in development of the operational plan; allocation and management of program resources, and accountability for quality of care and services.

5. Director of MLTSS Operations

The Director of Managed Long Term Services and Supports(MLTSS) serves as the point of contact within the Plan for Long Term Support Services (LTSS) and oversees planning, implementation and management of plan operations for LTSS programs and the provider network including In Home Supportive Services (IHSS), Multi Senior Services Program (MSSPC), BAS, Care Plan Options (CPO), Long Term Care and Home and Community Based Services (HCBS) waiver programs and other non-covered LTSS community-based providers.

6. Behavioral Services Manager

Reporting to the CMO, this position is responsible for oversight of all Behavioral Health care coordination for SCFHP including BH Utilization management, compliance reporting and BH staff supervision. The BH Manager will review all complex cases and provide consultation to the rest of the Health Services staff as needed. This position is responsible for all utilization management under the contract with the County

Behavioral Health Department. Any denials of Behavioral Health Service is reviewed first by the SCFHP CMO and then by the SCFHP consulting psychiatrist.

7. **Case Manager**
   SCFHP uses licensed California registered nurses, licensed vocational nurses, social workers, Behavioral Health and LTSS professionals in the role of the Case Managers. The Case Manager provides case management services for members with highly complex medical conditions where advocacy and coordination are necessary to help the member reach the optimum functional level and autonomy within the constraints of the member's disease conditions. Working within an interdisciplinary team, the Case Manager coordinates with the member, member caregiver(s), member primary care provider, specialist(s), Behavioral Health and LTSS and/or community resources, and health plan partners to assess member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes. SCFHP uses staffing guidelines to assign caseloads to each Case Manager. Caseload assignments are made with the following considerations: current case load size; acuity level of case load; characteristics of members, primary care provider, health plan product; and relevant case management responsibilities.

8. **Personal Care Coordinator (PCC)**
   The Personal Care Coordinator (PCC) is an unlicensed staff position available to provide care coordination services for members with basic non-clinical care management/care coordination needs. The PCC coordinates with the members of the interdisciplinary team to ensure appropriate and timely services are provided to members. The PCC acts as a bridge for the member between the health plan, health care providers, and community resources. They act as patient navigators and assist with referral to MLTSS and other services, patient educator and coordinator for the various care plans from community providers. The PCC is responsible for organizing needed ICT meetings, ensuring all members of the team are notified of a scheduled ICT meeting and providing all required documents and minutes are documented after the ICT. PCC are also responsible for development, and monitoring of programs and projects that support the case management department.

V. Eligibility Criteria & Risk Stratification

A. Criteria

Population Assessment includes annual review of the member population and program processes. In order to identify members who may benefit from Case Management services, the Plan annually assesses and maintains a defined set of case management population criteria for use with all members and including at a minimum:

- Children, adolescents, adults and seniors
- Children with special needs
- Individuals with disabilities, including the Developmentally disabled (DD)

- Individuals with serious and persistent mental illness (SPMI)
- Seniors and persons with disabilities (SPD)
- CalMediConnect (CMC)

At least annually, the population assessment will be reviewed and recorded by the Utilization Management and Quality Improvement Committees, which will include both the population assessment and a review of the complex case management processes with updates as necessary to meet member needs

SCFHP routinely assesses the characteristics and needs of the member population, including relevant subpopulations. SCFHP analyzes claims and pharmacy data, as well as enrollment and census data to obtain the population characteristics of its total membership. Population characteristics for member participation in the comprehensive case management program include:

- Product lines and eligibility categories
- Language and subpopulations
- Literacy
- Psycho-social needs
- Disabilities
- Social support
- Race and ethnicity
- Age
- Gender
- High volume diagnoses
- Chronic and co-morbid medical conditions
- Utilization

In order to effectively address member needs, subsequent to the collection of member population data, the Manager of Case Management, the Health Services Director, the Medical Director, and the Chief Medical Officer analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program. The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

- Department staffing – by analyzing the data SCFHP revises staffing ratios and roles, for example adding nurse case managers versus social workers when the level of higher risk members increases in the program.
- Evidence-based guidelines – as the mix of condition types increase the Medical Director assists in identifying clinical guidelines to be used in creating care plans for members.
- Member materials – SCFHP uses data, case manager feedback and patient satisfaction information to identify new types of materials or revise materials to support language and cultural needs.

B. Risk Stratification

The Plan or vendor uses internally established criteria to identify and stratify members for case management levels. No sooner than 60 calendar days prior to new member enrollment, DHCS and/or CMS electronically transmits historical Medicare and Medi-Cal FFS utilization and other

applicable data to the MMP for its use in the risk stratification process. This data may include, but is not limited to: Medicare Parts A, B, and D; Medi-Cal FFS; Medi-Cal In Home Supportive Services (IHSS); Multipurpose Senior Services Program (MSSP); Skilled Nursing Facility (SNF); Behavioral Health pharmaceutical utilization; outpatient; inpatient; emergency department; pharmacy; and ancillary services for the most recent 12 months. SCFHP has an established risk stratification mechanism designed for the purpose of identifying new members who are considered to be higher or lower risk. Higher risk for risk stratification purposes means a member who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive his or her initial contact by SCFHP within 45 calendar days of enrollment.

After analyzing the historical data, SCFHP identifies a member as **higher risk** if he or she, at a minimum, meets any one of the following criteria:

- Has been on oxygen within the past 90 calendar days;
- Has been hospitalized within the last 90 calendar days, or has had three or more voluntary and/or involuntary hospitalizations within the past year;
- Has had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases);
- Has In Home Supportive Services (IHSS) greater than or equal to 195 hours/month. Higher risk IHSS beneficiaries can be identified in the IHSS assessment files;
- Is enrolled in MSSP
- Is receiving Community Based Adult Services (CBAS);
- Has End Stage Renal Disease, Acquired Immunodeficiency Syndrome, and/or a recent organ transplant;
- Has cancer and is currently being treated;
- Has been prescribed anti-psychotic medication within the past 90 calendar days;
- Has been prescribed 15 or more medications in the past 90 calendar days; or
- Has other conditions as determined by SCFHP, based on local resources.

Diagnostic categories typically associated with high intensity of services and high cost of care may be in Basic, Moderate or Complex Case Management, depending of the member's individual needs, capabilities and resources. Typical conditions include:

- Newly diagnosed cancer;
- Sickle Cell Anemia;
- Tuberculosis;
- Hepatitis C;
- HIV / AIDS;
- Children with special needs;
- Life changing conditions.

Specific to Behavioral Health needs, conditions may include:

- Anxiety disorders and phobias;
- Bipolar Disorder;
- Major / Chronic Depression;

- Mood Disorder – other;
- Substance Abuse / Substance Use;
- Child Psychiatric Disorders;
- Autism Spectrum Disorders;
- Other Mental Health.

SCFHP has a health risk assessment survey (HRA) tool that is used to assess a member's current health risk within 45 calendar days of enrollment for those enrollees identified through the risk stratification as higher risk, and within 90 calendar days of coverage for those identified as lower risk.

VI. Case Management Clinical Systems

A. Clinical Information Systems

Delivery and documentation of case management services either directly provided by SCFHP staff or through a vendor is accomplished through a clinical information system. SCFHP uses a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with the use of algorithmic evidence based clinical guidelines or algorithms to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program.

Care plans are generated within the system and are individualized for each member and include short and long term goals, interventions and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; records actions or interactions with members, care givers and providers; and automatic date, time and user stamps. This feature automatically identifies the staff member, date and time of actions / interaction with member, practitioner or provider. To facilitate care planning and management, the clinical information system includes features to send automated prompts and reminders for next steps or follow-up contact as defined in the member's care plan.

B. Clinical Decision Support Tools

Evidence-based clinical guidelines are embedded into the clinical information system to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the SCFHP involves board certified specialists in the development of the appropriate guidelines. Assessment questions are based on evidence-

based guidelines from The National Guideline Clearinghouse (www.guideline.gov), medical and behavioral healthcare specialty societies and/or SCFHP guidelines of care. The clinical guidelines that are used by the SCFHP case manager and disease management program team are reviewed and approved by the QIC.

C. Integration of Case Management Services

Case Management services are integrated with the services of others involved in the member's care through a number of processes including, but not limited to:

- Communication of Integrated Care Team with the PCP;
- Case Management rounds;
- Medication reconciliation activities;
- Collaboration with the Disease Management program;
- Integration with the SCFHP's wellness programs including member self-management tools;
- Health Information line;
- Behavioral Health services;
- Hospice and palliative care programs.

VII. Case Management Functions

A. The Comprehensive Case Management Program supports processes and efforts of the organizational mission, strategic goals and objectives through the following functions:

- Early identification of members who have potential or actual CM needs
- Assessment of member's risk factors
- Development of an individualized plan of care in concert with the member and/or member's family and the Primary Care Provider (PCP)
- Identification of barriers to meeting goals included in the plan of care
- Referrals and assistance to support timely access to necessary providers
- Active coordination of care linking members to providers, medical services, residential, social and other support services where needed
- Ongoing monitoring and revision of the plan of care as required by the member's changing condition
- Continuity of care and coordination of services
- Ongoing monitoring, follow up, and documentation of all care coordination and case management activities
- Addressing the right of the member to decline participation in the case management program or dis-enroll at any time
- Accommodating member specific cultural, linguistic, literacy and disability needs

- Conducting all case management procedures in compliance with HIPAA regulations and state laws

VIII. Levels of Case Management

A. Basic Case Management

1. Characteristics

a. Typically has adequate family/caregiver support
b. Moderate/Minimal case management needs
c. Clinical needs for minor medical or behavioral health issues
d. Basic CM by PCP in collaboration with the case manager
    i. Initial Health Assessment (IHA)
    ii. Initial Health Behavioral Assessment (IHEBA)
    iii. Identification of appropriate providers and facilities (such as medical, rehabilitation and support services)
    iv. Identification of appropriate providers and facilities (such as medical, rehabilitation and support services) as needed to meet member needs
    v. Direct communication between provider, member and family
    vi. Member and family education; including healthy lifestyle changes as warranted
    vii. Coordination of carved out/linked services
    viii. Referral to appropriate community resources/agencies

2. Examples of Basic Case Management Services and Coordination of Care services are provided for members who may need support or interventions on a minimal basis, frequently once or twice a year. These members may have specific conditions requiring support but are generally self-managed with a strong understanding of their condition with sufficient support. These members may include but not be limited to the following:

a. Dental services that are the responsibility of SCFHP
b. Public Health Tuberculosis Services, including Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)
c. Women's, Infants, and Children (WIC) Supplemental Nutrition Program
d. Stable diabetics
e. Controlled hypertension
f. Post-operative procedures
g. Smoking cessation
h. Mild weight management conditions

i. Controlled asthma
j. Hospice cases
k. ER Diversion

3. Basic Case Management also supports member self-case management through on-line resources including interactive self-management tools developed through evidence-based resources to help members stay healthy and reduce risk. On-line interactive resources include tolls derived from available evidence that provide members with information on at least the following wellness and health promotion areas

a. Health weight (BMI) maintenance
b. Smoking and tobacco use cessation
c. Encouraging physical activity
d. Healthy eating
e. Managing stress
f. Avoiding at-risk drinking

B. Moderate Case Management

1. Characteristics

a. Chronic disease well managed and meeting goals
b. Chronic disease not well managed but have not developed complications
c. Moderate use of healthcare resources
d. Frequent Emergency Department use
e. Goal of treatment with avoidance of serious complications
f. Behavioral Health diagnosis that requires day treatment
g. Psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services.

2. Examples of Services and Coordination of Care include

a. Basic case management
b. Record of Medication History
c. Assessment and Health History
d. Development of Care Plan (ICP)
    1. Specific to member needs
    2. Member and PCP input
    3. Updated at least annually

e. Identification of appropriate providers and facilities (such as medical, rehabilitation, and support services) to meet Member care needs
f. Direct communication between provider, member/family or caregiver and case manager/care coordinator
g. Member/family or caregiver education, including healthy lifestyle changes as appropriate
h. Coordination of carved out and linked services, and referral to appropriate continuity resources and other agencies

C. Complex Case Management

1. Characteristics

i. Identified through stratification activities
    1. HRA
    2. UM/Clinical
j. Highest acuity requiring intensive CM
    1. Behavioral Health (BH) diagnosis with over 3 hospitalizations in a 12 month period
    2. BH conditions resulting in over 4 ED visits in a 12 month period
    3. Complex condition(s) or multiple co-morbidities generally well managed
    4. Members eligible for Home and Community Based Services (HCBS) waiver program or the Nursing Facility program
    5. Specialty CM members requiring
        i. Adaptive equipment
        ii. Adult day health services
        iii. Behavioral Services
        iv. Day Habilitation
        v. Emergency Home Response
        vi. Environmental Accessibility Adaptations
k. Record of Medication History
l. Assessment and Health History
m. Basic CM Services
n. Development of Care Plan (ICP)
    1. Specific to member needs
    2. Member and PCP input
    3. Updated at least annually
o. Management of acute/chronic illness(s)
p. Management of emotional/social support issues
    1. By multidisciplinary team
q. Intense coordination of resources

1. Goal for member to regain optimal health or improved functioning

r. Focused community based coordination of medical, BH and LTSS benefits and resources including IHSS, MSSP and CBAS.

2. Examples of Complex Case Management Services and Coordination of Care services are provided for members who may need more intense support to navigate the health care system, stabilize their condition or manage long term or terminal conditions. These members may include but not be limited to the following:

a. 3 or more hospital admissions within 6 months for the same or related diagnosis
b. Major or multiple system failure
c. Multiple Trauma
d. Med/Surg inpatient cases with extenuating complications
e. Head or spine injuries with potential residual deficits (includes CVA)
f. Severe burns over 20% of the body surface
g. Complicated coordination of care or discharge planning (any disease/condition)
h. Cancer with critical event or treatment requiring the extensive use of resources
i. Chronic diseases with co-morbidities or complications leading to high dollar claims or high utilization
j. High risk pregnancy
k. Transplant – solid organ or bone marrow (excludes corneal)
l. compliance with treatment plan or medications
m. Extensive use of health care and/or community resources
n. Newborn/Pediatric with critical event or diagnoses requiring the extensive use of resources
o. NICU babies with a length of stay greater than 10 days

An annual evaluation of the effectiveness of the program and member and provider satisfaction will be implemented. Based on findings the program will be adjusted to reflect the needs of the members and providers population-wide

IX. Care Coordination and Case Management Services

A. Discharge Planning and Care Coordination

1. Discharge Planning

SCFHP utilization management and case management staff ensure discharge planning when a member is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning activities ensure that necessary care, including Long Term Services and Supports (LTSS) and Behavioral Health (BH) Services are in place for the member once the member is discharged from a hospital or

institution. This includes scheduling an outpatient appointment, conducting follow-up with the member and/or caregiver, facilitating access to and coordination with other LTSS or community resources. Minimum elements for discharge planning include:

a. Documentation of pre-admission status, including living arrangements, physical and mental functioning, social support, durable medical equipment (DME), and other services received
b. Documentation of pre-discharge factors, including an understanding of the medical condition by the member or a representative of the member as applicable, physical and mental functioning, financial resources, and social supports and community case managers
c. Services needed after discharge, type of placement preferred by the member and/or caregiver and hospital/institution, type of placement agreed to by the member and/or caregiver, specific agency/home agreed to by the member and/or caregiver, and pre-discharge counseling recommended
d. Coordination, as appropriate with County agencies for In Home Supportive Services (IHSS) and Behavioral Health services, LTSS providers including, Multipurpose Senior Services Program (MSSP) provider, Community Based Adult Services (CBAS) Centers, nursing facilities, specialized providers and others community organizations as deemed appropriate. For IHSS, the coordination process must be developed jointly with county social service agencies and consider state requirements for counties regarding discharge planning
e. Summary of the nature and outcome of member and/or caregiver of the member involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action considered by the hospital or institution

2. Coordination of Care for Short Term Medical Needs

SCFHP Case Management staff maintains procedures to assist members who are unable to secure and coordinate their own care because of functional, cognitive, or behavioral limitations of the complexity of the community-based services. Members are assigned to a Case Manager or Personal Care Coordinator to assist with short term assistance with care coordination. Members, during the course of program enrollment, will also be assessed for longer term Complex Case Management and Disease Management.

3. Patient Safety

The SCFHP comprehensive case management process provides opportunities along the continuum of care to identify and address potential risks for medical errors and ensure patient safety. The complex case management program includes the following activities to ensure and enhance member safety

a. Completion of a comprehensive health risk assessment HRA that supports proactive prevention or correction of patient safety risk factors.
b. Active management of transitions of care to ensure that the member's health condition will not be placed at risk for an unsafe situation that may result in a negative outcome.
c. Care plan development that ensures individualized access to quality, safe, effective and timely care.
d. Monitoring of information exchanges across the provider continuum to ensure safety, prevent medical errors, and support effective continuity of care.
e. Review of medication regimen to monitor drug utilization, interactions and side-effects that compromise patient health and safety.
f. Appropriate setting assessments
g. Patient advocacy to ensure the care plan is followed by all providers.

h. Annual evaluation of satisfaction with the complex case management program.

4. Coordination of Care with Community Resources

SCFHP maintains procedures to identify and facilitate coordinated service delivery for members receiving comprehensive case management services. Case Managers provide appropriate referrals to carve out services, SCFHP Intensive Case Management to support access to community-based services and resources. SCFHP assists eligible members in obtaining access to the following services or programs:

a. Out-of-Plan Case Management and Coordination of Care
b. Specialty Mental Health
c. Alcohol and Substance Abuse Treatment Services
d. Dental services
e. Excluded Services Requiring Member Disenrollment
f. Home and Community Based Services Waiver Programs
g. Care Plan Options

B. Comprehensive Case Management

SCFHP oversees and maintains three case management services in the comprehensive case management program. These include Basic Case Management, Moderate Case Management and Complex Case Management. All three of these programs have the following case management elements:

a. Completion of a Health Risk Assessment (HRA)
b. Creation of an Individual Care Plan (ICP)
c. Formation of Interdisciplinary Care Team (ICT)
d. Care Plan implementation and care coordination

1. Basic Case Management Services

Basic Case Management services are made available to SCFHP members when appropriate and medically indicated. Basic Case Management services are provided by the primary care provider and or the SCFHP staff, in collaboration with SCFHP, and include the following elements:

a. Review of clinical information from the provider
b. Completion of the Health Risk Assessment
c. Creation of the Interdisciplinary Care Plan (ICP)
d. Identification and referral to appropriate providers and facilities (such as medical rehabilitation, support services, LTSS, Behavioral Health, Care Plan Option Services and for covered and non-covered services) to meet member needs
e. Direct communication between the provider and member, family and/or caregiver.
f. Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
g. Coordination of services outside of the CalMediConnect Plan such as referral to appropriate community social services or specialty mental health or Drug Medi-Cal services

2. Moderate Case Management Services

SCFHP facilitates and coordinates care for eligible members through Moderate Case Management services. SCFHP staff follows preset criteria and collaborates with community partners when necessary

to determine eligibility for Moderate Case Management services. SCFHP members may self-refer, or be referred to receive services through community partners, case managers, delegates and vendors.

SCFHP members eligible for Moderate CM services meet one or more of the following criteria:

a. Member is already served with case management by community partners
b. High utilizers of high cost services including multiple hospitalizations in the last three months, severely mentally ill, 10+ multiple medications
c. Already receiving case management services from a community provider (County Behavioral Health, New Directions, MSSP, etc.)
d. Care plan requires intensive coordination with a focus on local resources
e. Member in transition from acute or long term care to lower level of care or member wishes to transition to lower levels of care
f. Member is unable to be contacted

Once a member is identified and referred for Moderate case management, they are assigned to a lead Case Manager to take responsibility for screening, referrals, care planning, interdisciplinary care team management and communication and all other care coordination activities. Members are matched to a Case Manager that is specialized based on the prominence of medical, LTSS, or behavioral health needs. Though there is one assigned "lead," the support and expertise of other units may be harnessed in order to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those members who are multiple diagnosed with medical, functional, cognitive, and psychosocial conditions.

For Members who are already connected to services through a community social service, LTSS, or behavioral health provider, the responsibilities of lead Case Manager will fall to that agency. Generally, case management services performed by the external agency that demonstrates expertise in the area of the referred member's most pressing needs. For example, members who require primary support for housing assistance are referred to community partners for the provision of services.

Lead case manager, whether SCFHP -based or community-based, is responsible for the following services:

- Screening and enrollment
- Comprehensive clinical assessment that includes behavioral health
- Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan."
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon assessment and care plan.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

3. Complex Case Management Services

Complex Case Management services are made available to SCFHP members with chronic and complex medical conditions, across medical, LTSS and Behavioral Health domains. Complex case management

services are offered through SCFHP Complex Case Management program. Complex Case Management includes but is not limited to the following elements:

- Basic Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure member regains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline and avoids institutionalization when appropriate and possible.
- Interdisciplinary Care Teams creation prior to the ICP, training and communication with member and input from Interdisciplinary Care Team
- Development of Individual Care Plans (ICPs) specific to member needs and updated at least annually.
- Referral to Disease Management Program

4. Behavioral Health and MLTSS Services

Behavioral Health and MLTSS Case Management may fall into different levels of Comprehensive Case Management. Although they follow the same program requirements unique requirements and procedures exist as described below.

a. Behavioral Health Services

1. Assesses the characteristics and needs of its member population and relevant subpopulations
2. Assesses the needs of children and adolescents
3. Assesses the needs of individuals with disabilities
4. Assesses the needs of individuals with serious and persistent mental illness
5. Reviews its complex case management processes and updates them, if necessary to address member needs
6. Reviews its case management resources and updates them, if necessary to address member needs
7. The Plan selects collaborative data to analyze for improving coordination of care and determine areas to carry over, specific to meet the behavioral health needs of the Plan's membership.

b. Coordination of Care Management and Long Term Services and Supports (LTSS)

SCFHP has processes and models in place to coordinate with external organizations for provision of covered services including LTSS benefits, as appropriate for the member. This includes referral mechanisms, coordinated assessment, eligibility determination and intake activities, coordination of benefits, delineation of roles and responsibilities for care management and participation on the interdisciplinary care team with:

1. Multipurpose Senior Services Program (MSSP), a program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides complex care management as an alternative to nursing facility placement.

2. Community Based Adult Services (CBAS), an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services and transportation to eligible members.
3. In-Home Supportive Services (IHSS), a program for aged, blind and disabled persons who are unable to perform activities of daily living and cannot remain safely in their own homes without help.
4. Nursing Facilities - to coordinate care for residents including care transition plans and programs to move members back into the community to the extent possible.
5. Care Plan Options – for the purchase of services and supports that are not covered benefits for Cal MediConnect members that meet the criteria.
6. Examples of Complex Case Management Services and Coordination of Care services are provided for members specific to the Cal MediConnect (CMC) member population for behavioral health and Long Term Services and Supports (LTSS). These members may include but not be limited to the following:
    a. Dementia
    b. Community Based Adult Services (CBAS) or Adult day care health services
    c. Coordination of Medical, Behavioral Health and LTSS
    d. Major mental health (severe, persistent mental illness) or substance abuse disorder or critical event: may be characterized by suicidal or homicidal ideation or behaviors, inability to carry out activities of daily living independently, or persistent issues with
    e. Member treatment is referred to community resources

7. Specially designated case management staff in dementia care are trained in:
    a. Understanding dementia
        i. Symptoms and progression
        ii. Understanding and managing behaviors
        iii. Communication problems
        iv. Caregiver stress and management

X. Case Management Program Description

The SCFHP Case Management Program is a multi-tiered case management program aligned with the SCFHP MOC and meets DHCS regulatory requirements for Case Management. The program promotes the health and well-being of SCFHP members by actively coordinating services for those with high care needs, or complex medical conditions or providing population health services for our healthy members. The program utilizes existing risk stratification protocols and proactively identifies populations with, or at risk for, chronic medical conditions; emphasizing the prevention of exacerbations and complications. With a holistic approach to each member; the program emphasizes patient and caregiver engagement through shared goal setting and development of a multi-disciplinary care plan with support across the care continuum unique to each member's needs.

Eligible members are identified as candidates for case management or care coordination by the risk stratification process as outlined in the MOC and the findings from the member HRA responses. In addition, eligible candidates are identified by referrals from SCFHP PCP, Specialist or UM department. Using this information members are stratified into one of four case management classifications as outlined in the MOC. Each case management classification has unique programs to provide case management services as appropriate to the individual member.

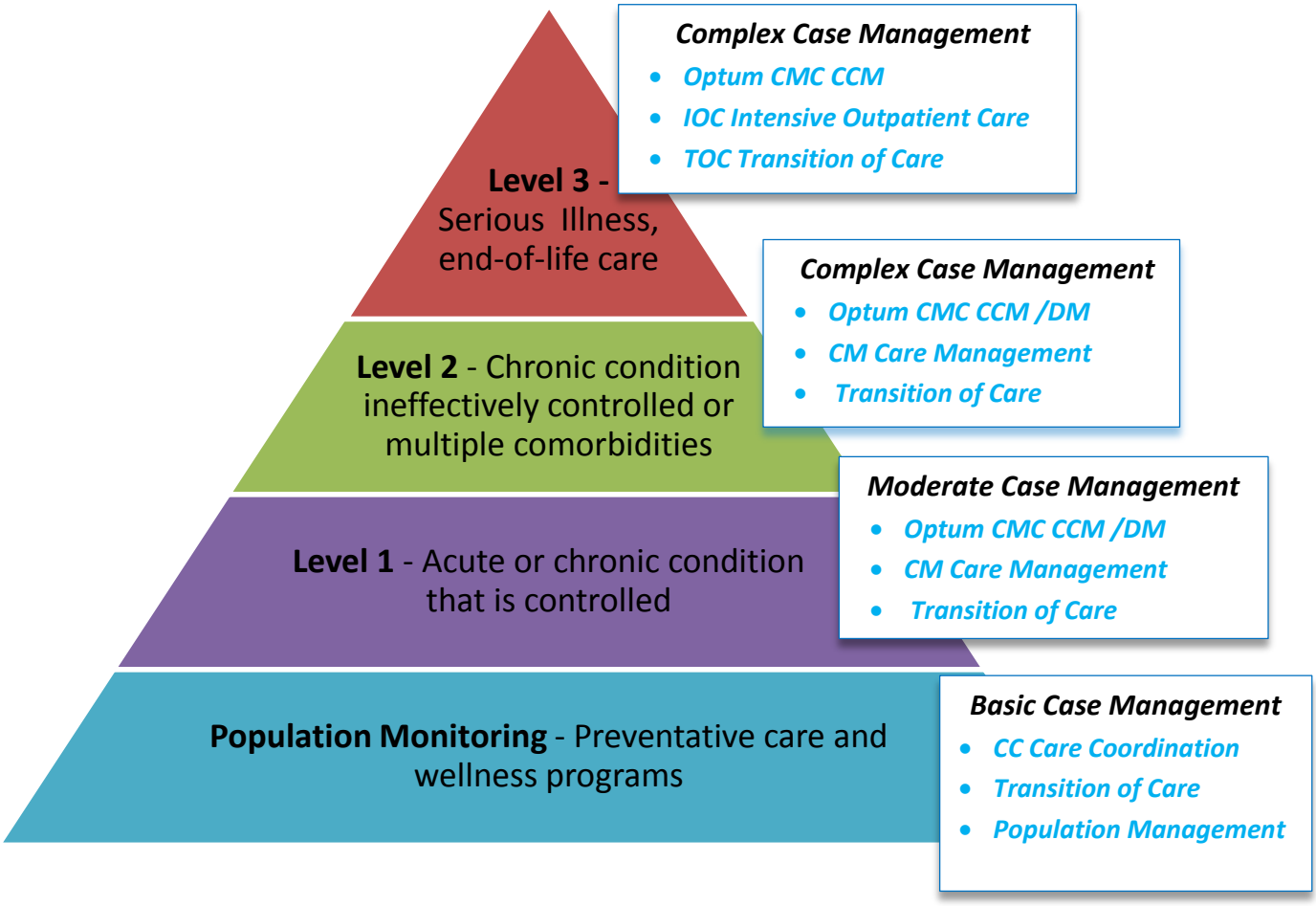
Enrollment to one of six unique programs is based on line of business, and RN Case Manager clinical assessment of available information including the SCFHP risk-stratification, HRA, case management classification and additional clinical assessments as available.

Program design supports assisting our members to access needed resources while promoting patient and family autonomy, and building trusting relationships with members, their families, and SCFHP providers. The program is geared toward the goal of achieving the triple-aim of better health, better care and, lower cost for all SCFHP members.

Key features of the program includes whole person care coordination toward high quality, appropriate medical care and access to services and support that are timely, cost-effective, and provides member and provider satisfaction.
Enrollment is voluntary.

Case Management Levels

Members are stratified in to one of four case management classification levels and eligible for enrollment in the case management programs as summarized in graphic below.



XI. Program Overview

A. Identifying Members for Case Management

SCFHP implements Case Management when utilization or case management staff identifies that a member's condition or diagnosis indicated the appropriateness and necessity for services. This identification may take place through admission review, concurrent review processes, provider referral, or at the request of the member.

B. Case Management Process

SCFHP maintains policies and procedures for Case Management services which include:

1. Intake
2. Health Risk Assessment, Initial Health Assessment and Behavioral Risk Assessment
3. Creation of an Individual Care Plan (ICP) with member and the Interdisciplinary Care Team (ICT) that takes into consideration the goals, preferences and desired level of involvement in the case management plan of the member.
4. The ICP includes:
    a. Identification of problems
    b. Prioritized goals
    c. Identification of barriers to established goals
    d. Identification of targeted interventions
    e. Development of member self-management plans
    f. Development of a schedule for follow-up
    g. Identification of start date and target date for each element in the ICP

C. Case Closure

The SCFHP case management staff terminates case management services for members based on case closure guidelines. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with member
- Member transferred to another setting and no longer require BCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the member
- Member not compliant with plan of care
- Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services

XII. Case Management Programs Descriptions

The SCFHP case management programs covers all SCFHP members across all lines of business, including: CalMediConnect (CMC), High Risk Medi-Cal Seniors and Persons with Disabilities (SPD), as well as the Non-High Risk SPD and Non-SPD Managed Medi-Cal (MMC) population.

A. Defined Case Management Functions, Services, and Processes

For the CMC line of business, SCFHP delegates to an NCQA-accredited entity (Optum) to provide the Complex Case Management services to CalMediConnect members. Delegated activities will be outlined in the Delegation Agreement and may include but not be limited to the following:

- Risk Stratification
- Individual Care Plan development telephonic Health Risk Assessment (HRA)
- Member communication & ICT development
- Individual Care Plan development with member
- Referrals to DM, and SCFHP for Moderate Case Management, Behavioral Health and LTSS benefits and services

Entry into case management occurs as follows: Based on SCFHP identified risk level as outlined in the MOC, a Health Risk Assessment (HRA) is completed by the outsourced vendor (Optum) within 45 or 90 calendar days of enrollment. Optum then creates an Individual Care Plan (ICP) based on plan risk assessment and HRA data. The ICP is customized, taking into account the member's healthcare goals and wishes for Individual Care Team (ICT) participants. The completed ICP is then shared with the member and the PCP, along with any other participants of the ICT. Upon completion of this initial assessment, members are further assessed for inclusion in one of the Optum case management or disease management programs. Members who are not included in one of Optum's case management programs are returned to SCFHP for on-going care coordination or population management. Members identified by SCFHP as High Risk who are returned to SCFHP without enrollment into a case management program are returned to Optum via direct referral from SCFHP RN Case Manager for inclusion in Optum complex case management or disease management as appropriate.

For the SPD line of business, entry into case management occurs as follows: Based on SCFHP identified risk level as outlined in the MOC, a Health Risk Assessment (HRA) is completed within 45 calendar days of enrollment. An Individual Care Plan (ICP) based on plan risk assessment and HRA data is then generated. The ICP is further customized, taking into account the member's healthcare goals and wishes for Individual Care Team (ICT) participants. The completed ICP is then shared with the member and the PCP, along with any other participants of the ICT. Upon completion of this initial assessment, high risk members are further assessed and assigned to one of the SCFHP Case Management Programs as detailed below.

For the MMC line of business, entry into case management occurs as follows: Based on sentinel events such as inpatient hospitalization, or referral from provider or direct referral from member, initial intake

assessment is completed by RN Case Manager, and assigned to one the SCFHP Case Management Programs as outlined below.

For all SCFHP lines of business, episodic case management in the ***Transition of Care*** or ***Intensive Outpatient Care*** program occurs when a member experiences a sentinel event such as an acute hospitalization, discharge from a long-term care facility, new diagnosis of a serious or terminal illness.

B. Description of Case Management Programs

***Optum CMC Complex Case Management and Disease Management (CMC CCM/DM*)**: SCFHP delegates to an NCQA-accredited entity (Optum) to provide the majority of Complex Case Management services to CMC members. Delegated activities are outlined in the Delegation Agreement and may include but not be limited to the following:

- Risk Stratification
- Individual Care Plan development telephonic Health Risk Assessment (HRA)
- Member communication & ICT development
- Individual Care Plan development with member
- Referrals to DM, and SCFHP for Moderate Case Management, Behavioral Health and LTSS benefits and services

Defined Case Management Functions, Services, and Processes

Provides case management services to the CMC population with risk stratification corresponding to level 1, 2 or 3 in the MOC. Members who are identified by SCFHP as High Risk and are not targeted or enrolled in Optum CCM or DM are referred in Optum PAD system as "Direct Referrals" by SCFHP RN Case Manager.

Optum CMC CCM/DM - Medium to long term (3 months – 1 + year) members with multiple chronic complex conditions resulting in high utilization that require coordination of care to avoid unnecessary exacerbations or hospitalization, and those members with low engagement in presence of a single chronic condition that require care coordination and/or education. The DM program focuses on specific disease management and assisting members to become more autonomous in the management of chronic conditions. Assessment tools used for this program include: HRA, and Optum proprietary CM assessment tool. The goal for Optum CCM/DM is to provide member education, care coordination and increase member engagement in personal health; shifting the focus of care to preventative in nature. Primary activities include: medication reconciliation, education about disease process, monitoring and treatment along with coordination of routine health maintenance and assuring preventative measures are met. Transition to CC or PM upon improvement in health status and IOC upon decline. Optum RN Case Manager responsible for management of these members.

Intensive Outpatient Care (IOC): Provides episodic case management services for all lines of business In the case of CMC members, it is possible that the member will be concurrently enrolled in this episodic program as well as Optum CCM/DM.

Short term (1-3 months) intensive care for members who have end-stage condition, or terminal diagnosis, and will most likely benefit from palliative care or hospice services. Assessment tools used for this program include: HRA, SCFHP Individual Risk Assessment*, and PHQ9. The goal for IOC is to capture those members with the highest risk for complications from serious chronic illness and provide care coordination, reducing or eliminating unnecessary hospitalizations due to end-stage disease process. Primary activities include: partnership with PCP to provide collaborative care planning to include evidence based therapeutic care, and assistance in completing Advanced Directives and POLST forms. Transition to CM or return to Optum CCM/DM upon improvement in health status. Transfer to hospice or palliative care upon decline in health status. SCFHP RN Case Manager responsible for management of these members.

Transition of Care (TOC): Provides episodic case management services for all lines of business. In the case of CMC members, it is possible that the member will be concurrently enrolled in this episodic program as well as Optum CCM/DM.

Short term (up to 30days) episodic care for those members who experience a sentinel event such as an acute hospitalization, or discharge from a long-term care facility who require coordination of care during transition to a lower acuity setting. Assessment tools used for this program include: HRA, TOC Assessment, and the PHQ9. The goal for TOC is to provide care coordination across care settings and avoid unnecessary disease exacerbation requiring re-hospitalization. Primary activities include: medication reconciliation, scheduling of necessary follow-up visits with healthcare providers, coordination of routine health maintenance and assuring that preventative measures are met. Transfer to CC or PM upon improvement in health status. Transition to either CM, Optum CCM/DM, or IOC upon decline in health status. SCFHP RN Case Manager responsible for management of these members.

Care Management (CM): Provides case management services to the MMC, and SPD populations with risk stratification corresponding to level 1 or 2 in the MOC.

Medium to long term (3 months – 1+ year) members with multiple chronic complex conditions resulting in high utilization that require coordination of care to avoid unnecessary exacerbations or hospitalization, and those members with low engagement in presence of a single chronic condition that require education. This program focuses on specific disease management and assisting members to become more autonomous in the management of chronic conditions. Assessment tools used for this program include: HRA, SCFHP Individual Risk Assessment*, PHQ9, and the Patient Engagement Assessment**. The goal for CM is to provide member education, care coordination and increase member engagement in personal health; shifting the focus of care to preventative in nature. Primary activities include: medication reconciliation, education about disease process, monitoring and treatment along with coordination of routine health maintenance and assuring preventative measures are met. Transition to CC or PM upon improvement in health status and IOC upon decline. SCFHP RN Case Manager responsible for management of these members.

Care Coordination (CC): Provides case management services to the MMC, SPD, and CMC populations with risk stratification corresponding to level 1 or Population Management in the MOC.

Medium-term (3 – 6 months) focused care for members with inappropriate ER utilization, missing quality measures, and continuation of care coordination for those members transferring in from TOC, or CM program who require longer term low acuity support to achieve goals. Assessment tools used for this program include: HRA, SCFHP Individual Risk Assessment*, and the PHQ9. The goal for CC is to provide care management to members with stable medical conditions, who require assistance with access to services or referrals to resources. The primary activities of this program are: care coordination, and assuring preventative measures are met. Transition to PH program when goals are met, transition to CM, Optum CCM/DM or IOC upon decline. SCFHP Personal Care Coordinator responsible for management of these members.

Population Management (PM): Provides case management services to members from all lines of business with case management stratification corresponding to level Population Management in the MOC.

Long-term (12+ months) population management focused on providing preventative care and education. Assessment tools used for this program include: the HRA. Goal for this population is healthy lifestyle and wellness. In partnership with the Health Education Department, primary activities for this population include: quarterly newsletter “Winning Health” that contains information about healthy lifestyle and important preventative activities to maintain wellness; as well as, monthly and quarterly reminders for missing preventative measures. SCFHP Health Education Coordinator responsible for management of these members.

Program Summary Table

Program	Assessment Tools	Population	Activities	Referral Source
Optum Complex Case Management for CMC (Optum CCM)	**HRA** **Optum proprietary CM assessment**	**CMC members**	• **Optum directed activities**	**Eligibility** **Direct RN CM referral** **Network Providers**
Intensive Outpatient Care (IOC)	**HRA*** ***STEADI* Fall Risk Assessment** **PHQ9**	**End-stage Illness or Terminal Diagnosis**	• **PRN Intake visit** • **Weekly phone** • **PCP Conference** • **PRN visits**	**UM Concurrent Review,** **PCP, Hospital or ER visit,** **TOC, CM & CC programs** **Network Providers** **IHSS, CBAS, MSSP**
Transition of Care (TOC)	**HRA*** **TOC Assessment** **PHQ-9** ***STEADI* Fall Risk Assessment**	**Discharge from inpatient setting**	• **PRN Intake visit** • **Twice weekly phone** • **PCP Conference**	**UM Concurrent Review**
Care Management (CM)	**HRA*** ***STEADI* Fall Risk Assessment** **PHQ-9** ***PAM-13* Patient Activation Measure**	**Medi-Cal and CMC Non-Optum CCM managed with One or more chronic conditions resulting in high utilization, or behavioral health diagnosis, or LTSS High Risk members**	• **PRN Intake visit** • **Monthly phone** • **PRN visits**	**PCP, UM, Claims, IOC, TOC, & CC programs** **Network Providers** **County or Community BH Providers** **IHSS, CBAS, MSSP**
Care Coordination (CC)	**HRA*** **PHQ-9** ***STEADI* Fall Risk Assessment** ***PAM-13* Patient Activation Measure**	**Inappropriate ER utilization** **High non-medical care coordination needs**	• **Telephonic** • **Frequency dependent on acuity** • **Non-SCFHP/Optum CM programs**	**All above**
Population Management (PM)	**HRA***	**Healthy Members for Wellness Support**	• **Quarterly Newsletters** • **Monthly and Quarterly mailings to encourage preventative measure completion**	**All above**

** HRA for CMC and SPD members only*

***SCFHP Individual Risk Assessment tool not yet developed for use in population that does not have regulatory requirement for HRA.*

XIII. Case Management Organizational Structure and Staffing

A. Interdisciplinary Team

SCFHP Lead Case Manager is responsible for leading an interdisciplinary team composed of:

- Member with complex healthcare needs and their families
- MD/DO, Primary Care Physician
- MD/DO, Specialist
- RN, Case Manager (acts as Lead CM)
- RN, Hospital Liaison
- RN, Skilled Nursing Facility Liaison (acts as Lead CM)
- BH LCSW/MSW, Social Worker (acts as Lead CM)
- MLTSS Team
- PCC Personal Care Coordinator (acts as Lead CM)
- Pharmacist

POD Structure

A Pod is a slice of the geographic coverage area for SCFHP (Santa Clara County). The RN Case Manager Team is organized into 3 Pods, with each pod having 2 RN's, and 1 PCC.

Of the three identified Pods at SCFHP, North Pod, Central Pod, and South Pod. Each pod is further divided into six sub-pods based on zip codes and language preference with responsibility for case management of the SCFHP population as follows:

Central Pod PCC	Jasmine Brooks	
Central-A	Dana Qamoos, RN	Spanish Language
Central-B	Rebecca Weaver, RN	
North Pod PCC	Elsa Wang	
North -A	Angela Kohn, RN	
North -B	Kathleen Reboton, RN	Tagalog (Illongo) Language
South Pod PCC	Mayra Tapia	
South-A	Angela Chen, RN	Mandarin Language
South-B	Oanh Nguyen, RN	Vietnamese Language

XIV. Staff Development and Training

Care Excellence CM Education

Care Excellence is a case management education program envisioned and managed by CSU Institute of Palliative Care with funding from California Health Care Foundation. The curriculum includes foundational, advanced, and leadership course tracks for professional case managers. The course work is directly applicable to the CCM exam.

Training for RN Case Managers includes:

Case Management Principles • Care Management Concepts • Principles of Practice • Healthcare Management and Delivery • Managed Care Principles • Face to Face vs. Telephonic Care Management • Care Management Teams, Ancillary Services, and Partnerships • Peer Support, Burnout Prevention, and Safety • Critical Thinking Fundamentals	**Palliative Care Theories and Principles** • Quality of Life • Advance Care Planning • Communicating Palliative Care as an Option • Top Diagnoses for Palliative Care • Psychological Factors of Palliative Care • Role of Spirituality • Understanding and Integrating Complimentary Therapies • Ethics of Palliative Care • Managing Cultural Differences • Transitions and Bereavement • Supporting the Palliative Care Network	**Care Planning** • Care Planning Concepts • Coordination of Medical and Behavioral Treatment • Coordination of Medical and long-term Services and Supports • Confirmation and Reconciliation of Medications • Provision of Resources: Community Support and Advocacy • Facilitating Patient Activation and Engagement • Establishing Care Planning Goals and Discharge Criteria
Getting the Whole Picture • Evaluating Mandatory Reporting Protocols • Completing Effective Home Visits	**Relationship Building** • Patient Activation Principles	**Motivational Interviewing w/Practicum** • Core Principles • Strategies and Techniques • Practicum

Training for Personal Care Coordinators includes:

Getting the Whole Picture	**Relationship Building**	**Motivational Interviewing w/Practicum**
• Trauma Informed Care • Evaluating Meaning in Communication and Documentation • Assessing Capacity and Literacy • Evaluating Mandatory Reporting Protocols • Psychosocial Aspects of Care • Managing Multiple Chronic Conditions • Special Populations Overview • Completing Effective Home Visits	• Interdisciplinary Care Teams • Member Relationships and Engagement • Community Partners • Patient Activation Principles • Transitions and Bereavement • Supporting the Palliative Care Network	• Core Principles • Strategies and Techniques • Practicum

Training for BH Social Workers includes:

Getting the Whole Picture	**Relationship Building**	**Motivational Interviewing w/Practicum**
• Trauma Informed Care • Evaluating Meaning in Communication and Documentation • Assessing Capacity and Literacy • Evaluating Mandatory Reporting Protocols • Psychosocial Aspects of Care • Managing Multiple Chronic Conditions • Special Populations Overview • Completing Effective Home Visits	• Interdisciplinary Care Teams • Member Relationships and Engagement • Community Partners • Patient Activation Principles • Transitions and Bereavement • Supporting the Palliative Care Network	• Core Principles • Strategies and Techniques • Practicum

Training for LTSS RNs and Social Workers includes:

Getting the Whole Picture	**Relationship Building**	**Motivational Interviewing w/Practicum**
• Trauma Informed Care • Evaluating Meaning in Communication and Documentation • Assessing Capacity and Literacy • Evaluating Mandatory Reporting Protocols • Psychosocial Aspects of Care • Managing Multiple Chronic Conditions • Special Populations Overview • Completing Effective Home Visits	• Interdisciplinary Care Teams • Member Relationships and Engagement • Community Partners • Patient Activation Principles • Transitions and Bereavement • Supporting the Palliative Care Network	• Core Principles • Strategies and Techniques • Practicum

Case Management All Staff Training as outline in 2017 SCFHP MOC

Page 46-47 2017 MOC Case Management Curriculum Includes:	**Plan**
Overview of the SCFHP Model of Care	in-house training
Compliance training: review of all regulatory standards and contractual requirements	in-house training
Review of clinical and quality policies and procedures including those most pertinent to implementation of the Model of Care	in-house training
Case Management processes, overview of components of case management program and workflows	in-house training
Health Risk Assessments	in-house training
Completion of nursing assessments: Fall risk assessment, geriatric depression scale and other clinical measurement tools	in-house training
Development of an Individual Care Plan and Interdisciplinary Care Team	CE Care Planning
cultural awareness & sensitivity training	CE
social determinants of health	CE
communication basics	CE
person centered care	CE
how to work with complex members	CE
motivational interviewing	CE
trauma informed care	CE
strength based care planning	CE
harm reduction practices	CE
understanding dementia	Alz assoc
self-management training	CE
privacy and confidentiality	in-house training
ltss operations including lstss benefits, eligibility, program limitations, referrals and interface with case mangement	in-house training
care transition case management; criteria for safe transitions	CE
coordination and communication with providers, community care service providers, and other members of the ICT	CE
resources for case management: housing, food and nutrition, HCBS waiver programs, public benefits, public services	in-house training

XV. Program Evaluation and Assessment of Effectiveness

The Chief Medical Officer/Medical Director and the Director of Health Services collaboratively conduct an annual evaluation of SCFHP complex case management program. The evaluation includes the following.

A. Measures/Process- The evaluation includes analysis of population characteristics and of the resources to meet the needs of the population. SCFHP selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. SCFHP annually measures the effectiveness of its complex case management program based on the following guidelines.

1. Measurement of effectiveness of Complex Case Management annually
    a. Minimum of three measures (annually defined). For each measure.
        1. Identify a relevant process/outcome
        2. Valid methods for quantitative results
            i. Numerator and denominator
            ii. Sampling methodology
            iii. Sample size calculation
            iv. Measurement periods and seasonality effects
        3. Setting a performance goal
            i. Explicit, quantifiable performance goal
        4. Using clearly identified measures
            i. Data source
            ii. Eligible population
            iii. Coding and other means
            iv. Adaptation of HEDIS if used
        5. Collecting data and analyzing results
            i. Quantitative and qualitative analysis with comparison against goals
                a. includes causal analysis as appropriate
        6. Identify opportunities for improvement as applicable
            i. Report to and follow through with QIC

B. Member Satisfaction/member experience

Objective: Achieve and maintain high levels of satisfaction with CM services
SCFHP measures member satisfaction and experience with the complex case management program. A satisfaction survey is mailed after case closure. The member is asked to rate experiences and various aspects of the program's services, including interactions with the Case Manager. The survey also collects information involving member complaints and inquiries about the program. Data is collected and reported within a secure clinical information system.
The Health Services staff systematically analyzes the feedback from member surveys at least annually.

1. Analyze member complaints
    a. This includes complaints about
        i. Access to Case Manager

ii. Dissatisfaction with Case Manager
iii. Timeliness of Case Management services

a. SCFHP tracks and trends complaints and grievances quarterly
i. Summarizes annually
ii. Compares with previous year

2. Satisfaction surveys
a. SCFHP focuses at minimum on
i. Complex Case Management
ii. Usefulness of information
iii. Member ability to adhere to recommendations

C. Performance measures

SCFHP maintains performance measures for the case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. Likewise, a needs assessment is conducted to identify gaps in care and community resources. These findings are brought to the QIC, when appropriate and other community forums. An annual report of the effectiveness of this program will be provided to the QIC and the Board of Directors. The following are measured.

a. Improve member outcomes , All-Cause Admission Rate
i. All-Cause Admission Rate

SCFHP measures admission rates for all causes for members in the complex case management program who had an admission within six months of being enrolled in the complex case management program. The Vendor's Healthcare Analytics department collects data and reports measurement results to the Health Services staff.

ii. Emergency Room Visit Rate

SCFHP measures emergency room visit rates of members enrolled in the complex case management program. The Healthcare Analytics department collects data and reports measurement results to the Health Services Staff.

b. Achieve optimal member functioning, Health Status

SCFHP measures the percentage of members who received complex case management services and responded that their health status improved as a result of complex case management services. A satisfaction survey that includes questions to assess health status is administered after case closure. SCFHP collects data and reports within a secure clinical information system. The Health Services Staff systematically analyses the feedback from member surveys at least annually.

c. Use of Appropriate Health Care Services, Use of Services

SCFHP measures enrolled members' office visit activity, to ensure members seek ongoing clinical care within SCFHP network. The Vendor's Healthcare Analytics department collects data and reports measurement results to the Health Services Staff.

D. Procedure

For each of the performance measures, SCFHP completes the following procedures to produce annual performance measurement reports:

a. Identify a relevant process or outcome

The measure is relevant to the target population so appropriate interventions result in a significant improvement to the care or health of the population.

b. Use valid methods that provide quantitative results

Performance measurement involves the use of quantitative information derived from a valid methodology that considers the numerator and denominator, sampling methodology, sample size calculation, and measurement period.

c. Set a performance goal

The Manager of Case Management in collaboration with the Chief Medical Officer/Health Services Director, establish a quantifiable performance goal for each measure that reflects the desired level of achievement or progress.

d. Clearly identify measure specifications

The Manager of Case Management in collaboration with analysts from the Healthcare Analytics department identifies measure specifications to ensure that reliable and valid measures can be produced with available analytic capabilities and data resources.

e. Analyze results

The Manager of Case and Management with data analytic support from the Healthcare Analytics Department complete an annual comparison of results against performance goals and an analysis of the causes of any deficiencies.

f. Identify opportunities for improvement, if applicable

The Director of Case and Disease Management in collaboration with the Chief Medical Officer/ Director of Health Services and feedback from the HCQC use qualitative and quantitative analysis to prioritize opportunities to improve performance on the measure.

g. Develops a plan for intervention and re-measurement

The Manager of Case Management in collaboration with the Chief Medical Officer/ Director of Health Services and feedback from the HCQC develop an intervention action plan to improve measurement performance and subsequently re-measure performance to assess effectiveness of the intervention. The Manager of Case Management coordinates with the Healthcare analytics department to report the results of the performance improvement intervention.

D. Evaluation Review/Follow-up

The results of the annual program evaluation are reported to the QIC for review and feedback. The QIC makes recommendations for corrective action interventions to improve program performance, as appropriate. The Manager of Case Management is responsible for implementing the interventions under the oversight of the Chief Medical Officer/Medical Director.

XVI. END NOTE

1. On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act. The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity.

Health Education Program

2017

Angela Sheu-Ma, CHES, MPH, RDH

Santa Clara
Family Health Plan

SANTA CLARA FAMILY HEALTH PLAN

2017 HEALTH EDUCATION PROGRAM

Executive Summary

As a community based health plan, Santa Clara County Health Authority, a public agency operating business as Santa Clara Family Health Plan (SCFHP), strives to provide high quality health care to those who cannot access affordable health care. A component to achieving this goal is **SCFHP's Health Education Program** which assists and engages the community to reach their wellness goals.

The Health Education Program is under the direction of a full-time health educator with a Master's degree in public health with specialization in health education. The program identifies the health education needs of its members and utilizes findings for continuous development and improvement of health education programs and services. As part of the Quality Improvement Department, Health Education Program activities will be coordinated and integrated with SCFHP's overall health care and quality improvement plan.

Implementation of the Health Education Program includes: 1) Providing programs, classes and/or materials free of charge to members, 2) Point of service education for members as part of their preventive and primary health care visits, 3) Practitioner education and training, 4) program evaluation, monitoring, and quality improvement, 5) Group Needs Assessment, and 6) The formation of a Community Advisory Committee (CAC).

Santa Clara
Family Health Plan

SANTA CLARA FAMILY HEALTH PLAN

2017 HEALTH EDUCATION PROGRAM

TABLE OF CONTENTS

I.	INTRODUCTION	Page 3
II.	MISSION	Page 3
III.	STATEMENT OF PURPOSE	Pages 3-4
IV.	SCOPE OF PROGRAM	Page 4
V.	PROGRAM GOALS AND OBJECTIVES	Pages 4-5
VI.	PROGRAM STRUCTURE AND ORGANIZATION	Page 4-5
VII.	PROGRAM IMPLEMENTATION	Pages 5-7
VIII.	PROGRAM EFFECTIVENESS AND ACOUNTABILITY	Page 7-8

I. INTRODUCTION

Santa Clara County Health Authority is a public agency which operates business as Santa Clara Family Health Plan (SCFHP) in order to provide medical coverage for persons with Medi-Cal Managed Care. Santa Clara Family Health Plan is licensed under the Knox Keene Act of 1975 and is subject to the regulations set forth by the State of California's Department of Managed Health Care (DMHC).

SCFHP is contracted with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. In 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program.

SCFHP then entered into a series of contracts which extended care to a broader range of the population. From 2007 to 2009 SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) to serve as a Special Needs Plan in Santa Clara County. In 2014, SCFHP contracted with CMS and the State of California for the Managed Long Term Services and Supports (MLTSS) programs. And most recently in 2015, SCFHP contracted with CMS for the Cal MediConnect (CMC) Dual Demonstration Project.

SCFHP is dedicated to improving the health and well-being of the community and continues to uphold its vision of serving new enrollees, consistent with its mission and its core values.

II. MISSION

As a community based health plan, we strive to provide consistently high quality health care to those who cannot access affordable health care.

With a richly diverse population residing in the area, it is crucial for information to be presented in a manner that takes into account the culture and linguistic capability of those we serve. Because of this we strive to develop procedures to ensure the materials are appropriately structured for maximum clarity and effectiveness. SCFHP is committed to delivering culturally and linguistically appropriate health care services.

III. Statement of Purpose

The goal of SCFHP's Health Education program is to assist and engage the community to reach their wellness goals and structure informational and educational materials in a manner all plan members can easily read and understand. In order to accomplish this, the following components are included in the program:

- Health Education
- Community Advisory Committee (CAC)

IV. SCOPE OF PROGRAM

The scope of the Health Education program is to identify the health education needs of its members and to utilize the findings for continuous development and improvement of health education programs and services. In order to accomplish this, multiple reliable data sources, methodologies, techniques, and tools will be used to identify these needs.

V. PROGRAM GOALS AND OBJECTIVES

Community Advisory Committee (CAC)

- A community advisory committee will be in place.

Health Education

- Health Education system provides organized programs, services, functions, and resources necessary to deliver health education, health promotion and patient education.
- Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and alternative care.
- Risk reduction and healthy lifestyles – 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.
- Self-care and management of health conditions – pregnancy, asthma; diabetes; and hypertension
- Members receive point of service education as part of preventive and primary health care visits.
    - Education, training, and program resources will be given to assist contracting medical providers in the delivery of health education services for Members.
- Provide provider education regarding the Initial Health Assessment (IHA) and the need for Members to have an IHA within 120 days of being eligible with the health plan.
- Ensure all written Member information is provided at a sixth grade reading level

VI. 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 with specialization in health education.
The Health Education program is part of the Quality Improvement Department. Health education program activities will be coordinated and integrated with SCFHP's overall health care and quality improvement plan.

VII. PROGRAM IMPLEMENTATION

The Health Education Department will provide programs, classes and/or materials free of charge to members including, but not limited to the following topics:

1. Nutrition and physical activity
2. Healthy Weight(BMI) Management
3. Healthy eating
4. Healthy weight maintenance
5. Encouraging physical activity
6. Managing stress
7. Parenting
8. Smoking and Tobacco use cessation
9. Alcohol and drug use
10. Injury prevention
11. Prevention of sexually transmitted diseases, HIV and unintended pregnancy
12. Management of chronic diseases or health conditions, including asthma, diabetes, and hypertension
13. Pregnancy care
14. Identifying depressive symptoms

Point of Service Education

Individual members will receive health education services 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 member's medical record.

Medical providers will use an Individual Health Education Behavioral Assessment tool and other relevant clinical evidence to identify member'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 members. (DHS PL 02-004)

Practitioner Education and Training

SCFHP will provide education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members. Practitioner training will cover: a) Group Needs Assessment findings, b) Individual Health Education Behavioral Assessment (IHEBA); c) Techniques to enhance effectiveness of provider/patient interaction, d) Educational tools, modules, materials and staff resources, e) Plan specific resource and referral information, and f) Health Education requirements, standards, guidelines, and monitoring.

SCFHP will ensure providers are trained and administering the IHAs (Initial Health Assessment) with the health education behavioral risk assessment for all members within 120 days of enrollment.

SCFHP will also implement a comprehensive risk assessment tool for all pregnant female members 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.

Program Standards, Evaluation, Monitoring, and Quality Improvement

The Health Education System 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 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) beneficiaries.
SCFHP will monitor the performance of providers contracted to deliver health education programs and services to members. Strategies will be implemented to improve provider performance and effectiveness. (DHCS PL 13-001)

Group Needs Assessment

A Group Needs Assessment will be conducted every 5 years to identify the health education and cultural and linguistic needs of our members. Multiple reliable data sources, methodologies, techniques, and tools will be used to conduct the group needs assessment. 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 Member population.

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.

VIII. CONFIDENTIALITY AND CONFLICT OF INTEREST

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

IX. PROGRAM EFFECTIVENESS AND ACCOUNTABILITY

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.

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

Training

Initial Health Assessment

The Provider Services Department educates new PCPs about the IHA and IHEBA within the first 10 days of their effective date, during the new provider orientation and annually thereafter (Provider services policy PS019_03)

1) A log will be kept of Initial Health Assessment (IHA) training which is included in the new Provider handbook given to new providers.
2) The provider services department administers training for new providers which include IHA requirements.
3) Providers who are found to be noncompliant with IHA requirements during periodic Facility Site Reviews (FSR's) will receive retraining.

Monitoring

Facility Site Reviews

The QI Department monitors PCP's IHA and IHEBA process during periodic site reviews.

Facility Site Reviews (FSR's) 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.

Santa Clara
Family Health Plan

The Spirit of Care

CULTURAL AND LINGUISTIC SERVICES PROGRAM
2017 Executive Summary

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, diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation or gender identity.

The Methodology used by SCFHP as a guiding principal of our C&L Service Program is the 14 National Culturally and Linguistically Appropriate Services (CLAS) Standards. The 14 standards are organized by the following themes:

- **Culturally competent care**
- **Language access services**
- **Organizational supports for cultural competence**

The overall 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 limited English proficiency, sensory impairment, diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation or gender identity.

The C&L Services Program is comprehensive, systematic and ongoing. It includes assessment, monitoring and enhancement of all services provided directly by the Health Plan, as well as all services provided by contracted providers, including pharmacies and ancillary services. Components of the program include:

- **Assessment of member Cultural and Linguistic needs**
- **Assessment of linguistic capabilities of SCFHP employees, providers, and subcontractors**
- **Access to interpreter services**
- **Availability of translated materials**
- **Staff and provider cultural competency and diversity training**
- **Monitoring, evaluation and enforcement**

Included as part of the program is Appendix A listing all Plan C&L oversight staff and Appendix B which is the 2017 C&L Work Plan.

Santa Clara
Family Health Plan

The Spirit of Care

CULTURAL AND LINGUISTIC SERVICES PROGRAM 2017

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 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program. In 2014, SCFHP contracted with the Centers for Medicare and Medicaid Studies (CMS) and the State of California for the Managed Long Term Services and Supports (MLTSS) program. Most recently in 2015, SCFHP contracted with CMS for the Cal MediConnect (CMC) Duals Demonstration Project. SCFHP is dedicated to improving the health and well-being of the community and continues to uphold its vision of serving new enrollees, consistent with its mission and its core values.

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, 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 members 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.

SCFHP is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible members with limited English proficiency (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 members, especially LEP and sensory impaired members 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,"[1] 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."[2]

At SCFHP, we have 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

1. 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.
2. 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.
3. 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).
4. 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

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.

6. 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.
7. 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 overall 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 limited English proficiency, 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 unique needs. It also ensures processes and procedures are designed to ensure that all medically necessary covered services are available and accessible to all members 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 rather than an attainable, finite goal, the C&L Services staff periodically identifies new objectives and activities based on the findings of the Health Education and C&L Group Needs Assessment (GNA) which is administered every 3 years. SCFHP also incorporates member, provider and staff feedback expressed at Consumer Advisory Committee 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 Cultural and Linguistic 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 enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. It also ensures SCFHP's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

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

The Provider Network Management Department is responsible for ensuring that the composition of the provider network continuously meets members' ethnic, cultural and linguistic needs. 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 Management is also responsible for conducting initial and periodic provider network C&L training.

The Pharmacy Department is responsible for ensuring that the pharmacy network composition continuously meets members' ethnic, cultural and linguistic needs and for conduction pharmacy network C&L training.

The Customer Service Department records members' cultural and linguistic capabilities and preferences upon enrollment, using data acquired from DHCS or CMS, including standing requests for material in alternate languages and formats. Members are informed they have access to free oral interpretation in their language and written materials translated into SCFHP's threshold languages or provided in alternative formats. Marketing and Communications is also responsible for supporting SCFHP's Consumer Advisory Committee (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 members 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 members, including seniors, persons with limited English proficiency (LEP), and disabilities. CAC reports directly to the SCFHP Governing Board.

Linguistic services are provided by SCFHP to monolingual, non-English speaking or LEP beneficiaries for population groups as determined by contract. Services include, but are not limited to, the following:

- No cost linguistic services:
    - Oral interpreters, signers or bilingual providers and provider staff at all points of contact are available in languages spoken by beneficiaries. Linguistic services are provided in all languages spoken by members, not just the threshold or concentration standards languages.
    - Written informational materials are fully translated into threshold languages, upon request:

        - 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)
        - Member surveys
        - Newsletters
    - California Relay Services for hearing impaired.
    - Telecommunications Device for the Deaf (TDD).
    - Documents translated into threshold languages within 90 days after the English version is approved by the State include:
        - Evidence of Coverage Booklet and/or Member 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

SCFHP regularly assesses member 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. Assessment and documentation activities include, but are not limited to:

- Documenting reported ethnicity, preferred language, and use of interpreters in SCFHP's information systems.
- Documenting a member's standing request to receive materials in another language or alternate format in SCFHP's information systems.
- Documenting member requests to change their reported ethnicity or preferred language.

- Instructing providers to record members' language needs in the medical record and documenting member requests or refusal of language/interpreter services.
- Utilizing the results of Facility Site and Medical Record Review audits to validate provider compliance with documentation requirements.
- Utilizing the findings and conclusions from the GNA, completed every 3 years with annual update, to continuously develop and improve the cultural and linguistic services program.

SCFHP continuously assesses the linguistic capabilities of its employees, providers and subcontractors to reduce language barriers increase the quality of care LEP members receive, and ensure the plan's ability to meet members' ethnic, cultural and linguistic needs. Activities that contribute to the assessment process include:

- Employees
    - Hire staff that demonstrates appropriate bilingual proficiency by passing a language professional test at time of hire.
    - Use of a contracted vendor to annually test SCFHP employee positions that require bilingual language proficiency.
    - 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 members through the provider's own certified 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 or self-assessment.
    - Report provider and office staff language capabilities for inclusion in the Provider Directory.
- Subcontractors
    - Execute agreements with subcontractors that include 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 department of community health resources throughout the counties we serve, including the language in which the programs are offered.

SCFHP ensures access to interpreter services for all LEP and sensory impaired members through several mechanisms:

- Inform new enrollees of available linguistic services in welcome packets.

- Provide a Quick Reference Guide for providers about accessing SCFHP's interpreter services.
- Provide an interpreter for scheduled appointments when requested by the provider or member.
- Ensure members 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 member or provider.
- Encourage the use of qualified interpreters rather than family members or friends. The member 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 Customer Service Department of languages available from the interpreter services.
- Translate all written member informational materials into SCFHP's threshold languages and make materials available in alternative formats as requested, such as Braille, large print, CD, or audio cassette.
- Maintain records in the Customer Service Department of translated member informational materials.
- Ensure members are made aware they have the right to file a complaint or grievance if their linguistic needs are not met.

SCFHP has internal systems to meet members' cultural and linguistic needs. Examples of activities that support these internal systems include:

- Initial and continuing training on cultural competency, sensitivity, or diversity for SCFHP staff, providers and subcontractors, including Interdisciplinary Care Team (ICT) members.
- Regular communication and/or training ensuring staff and providers are informed and aware of SCFHP's policies and procedures regarding provision of CLAS.
- Training, educational materials and tools regarding various cultures and CLAS are made available to SCFHP staff and network providers.
- Monitoring and evaluation of effectiveness of SCFHP's C&L Services in delivering CLAS is accomplished by review of:
    - Member satisfaction surveys
    - Member complaints and grievances
    - Reports of utilization of interpreter service by language
    - Provider satisfaction surveys
    - Provider assessments and site reviews

- Findings from the Health Education and Cultural and Linguistic GNA and annual updates.
- Feedback on services from the CAC, Quality Improvement Committee, SCFHP staff and network providers, community-based organization partners, and other sources.

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

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 the Health Plan, as well as all services provided by contracted providers, including pharmacies and ancillary services.

Assessment of Member Cultural and Linguistic Needs

In order to assess the cultural and linguistic appropriateness of its services, SCFHP recognizes that it is necessary to document and analyze members' C&L needs. SCFHP conducts regular assessments of these needs, including language preferences, reported ethnicity, use of interpreters, use of alternative medicines, traditional health beliefs and beliefs and practices regarding health and health care utilization. Specifically, SCFHP:

- Documents in the Health Plan's Information System the reported ethnicity and preferred language of eligible members provided by DHCS/CMS for Medi-Cal or Cal Mediconnect members, by Maximus for Healthy Families members and the internal application process for Healthy Kids members in the uploads of membership data.
- Documents member requests to change their reported ethnicity or preferred language.
- Documents a member'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 and document the member'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 GNA every three years to identify C&L needs, and periodically update the assessment based on additional member input through member surveys, focus groups and grievances.

- Elicits and documents input from the CAC regarding members' C&L needs (for detailed procedures (see Policy MS-07-05 *Consumer Advisory Committee*).

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

SCFHP acknowledges the role that language barriers can play in reducing the quality of care LEP members may receive. To reduce language barriers, SCFHP regularly assesses its employee base, provider network and subcontractors to ensure its ability to meet ethnic and C&L needs of SCFHP members. Additionally, SCFHP makes every effort to ensure that members are assigned to providers with the ability to meet members' C&L needs. SCFHP:

- Tests SCFHP employees in positions identified as requiring bilingual proficiency for specific language proficiency through a qualified contracted service. A high priority is placed on recruiting staff with cultural competence and linguistic skills specific to these positions.
- Assesses language proficiency of bilingual providers and provider office staff through language assessment or certification.
- Reports on provider and provider office staff language capabilities in the Provider Directory.
- Requires, through contractual agreements, that contracted translators and interpreters are tested for proficiency and experience.

Access to Interpreter Services

SCFHP ensures access to interpreter services for all LEP members. SCFHP provides 24-hour access to telephonic interpreter services for all medical and non-medical points of contact. SCFHP members can, with advance notice, utilize in-person language and sign language interpreter services. All interpreter services are provided at no charge to members. (For more detail please refer to Procedure QI.08.02 Language Assistance Program.)

Availability of Translated Materials

SCFHP translates member informing materials into all threshold languages identified by the Department of Health Care Services (DHCS). (For more detail please refer to Procedure QI.08.02 Language Assistance Program.)

Staff and Provider Cultural Competency and Diversity Training

SCFHP recognizes that the ability to provide services in a culturally and linguistically appropriate manner must be cultivated through training and experience. To increase C&L competency, 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 on culturally and linguistically appropriate care 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 members' C&L needs.

Monitoring, Evaluation and Enforcement

SCFHP recognizes that the provision of CLAS is challenging and requires a great deal of coordination. 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/member satisfaction surveys
- Review of member grievances
- Provider assessments and provider site-reviews
- Feedback on services from Consumer Affairs Committees, the Provider Advisory Council and Provider Office Staff Committee, Quality Improvement Committee, SCFHP staff and network providers, community-based organization partners, and other focus group reports
- Data from utilization reports
- Analysis of health outcomes

APPENDIX A

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

Christine Tomcala, Chief Executive Officer

Jeff Robertson, MD, Chief Medical Officer

Chris Turner, Interim Chief Operating Officer

Johanna Liu, Pharmacy and Quality Director

Beth Paige, Compliance Officer

Laura Watkins, Director of Marketing, Communications and Outreach

Jennifer Clements, Director of Provider Network Management

Tanya Nguyen, Director of Customer Service

Andres Aguirre, Quality Manager

Mariana Ulloa, Quality Improvement Project Manager

Angela Sheu-Ma, Health Educator

Divya Shah, Quality Improvement Coordinator

Pat Smith, Quality Improvement Nurse

Kim Englehart, 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 Management, Customer Service, Compliance, and Health Services Departments. The Quality Improvement Project Manager, Health Educator and Quality Improvement Nurses report to the Quality Manager. The Quality Manager reports to the Pharmacy and Quality Director, who in turn reports to the Chief Medical Officer. The Chief Medical Officer reports to the Chief Executive Officer. The Compliance Officer, Director of Marketing,

Communications and Outreach, Director of Provider Network Management and the Director of Customer Service report to the Interim Chief Operations Officer.

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

APPENDIX B

SANTA CLARA FAMILY HEALTH PLAN (SCFHP)
CULTURAL & LINGUISTICS (C&L) SERVICES WORKPLAN 2017

Program Objectives	Activities (Steps to measure compliance/ achieve objective)	Timelines
Comply with state and federal guidelines related to caring for LEP and sensory impaired members.	• GNA update for DHCS • Submit to DHCS one copy of materials provided to new members for each threshold language. • Language assistance program Policy & Procedure (Title 28, Sec.1300.67.04) has standards for: o Enrollee assessment o Providing language assistance services o Staff training o Compliance monitoring	1st quarter On-going On-going
Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact.	• Distribute "Quick Guide" for accessing interpreter services to all providers. • Promote interpreter services at no charge to members and providers. • Use the CAC for advice and feedback on CLAS and procedures. • Use available C&L member reports, e.g. grievance and appeals, to identify interventions to improve quality • Include C&L as agenda item at Joint Operation	On-going

Program Objectives	Activities (Steps to measure compliance/ achieve objective)	Timelines
	Committee meetings with delegates as appropriate. • Include C&L Compliance, including training, in all Delegation Oversight Audits. • Include C&L Training in new provider and sub-contractor orientations. • Include resources in training related to gender, sexual orientation or gender identity	4th Quarter
Promote a culturally competent health care and work environment for the SCFHP	• New employees complete an on-line training when hired • Culturally relevant materials and event notices made available to employees. • Review and revise staff training module to incorporate information related to disabilities, and regardless of gender, sexual orientation or gender identity.	On going 4th Quarter
Promote CLAS "best practices" for implementation by SCFHP, as well as network providers and subcontractors.	• Participate in CLAS focused plan, community, state/federal organizations, partnerships, and projects. • Use a strategy of interdepartmental collaboration to identify and promote CLAS best practices in all areas.	On going
Use outcome, process and structure measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities.	• Design oversight mechanisms that monitor for CLAS and cultural competency. • Use the delegated audit process to identify subcontractor compliance with CLAS; work with providers to improve compliance. • Monitor grievances and appeals to identify areas of improvement and forward data to appropriate department(s).	On going

Santa Clara Family Health Plan

The Spirit of Care

2016 CULTURAL AND LINGUISTICS PROGRAM EVALUATION

☑ Annual Evaluation

Executive Summary:

CULTURAL AND LINGUISTICS

Program Objectives:

1. **Promote and ensure culturally competent care and services are provided to SCFHP members at all medical and non-medical points of contact.**
2. **Use outcome, process and structure measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities.**
3. **Promote a culturally competent health care and work environment for SCFHP**

Objective 1: Promote and ensure culturally competent care and services are provided to SCFHP members at all medical and non-medical points of contact.

Interventions:

1. Ensure Cultural and Linguistics(C&L) Program includes and has standards for:
   - CLAS "best practices" for implementation by the SCFHP organization, network providers and subcontractors.
   - Member assessment
   - Providing language assistance services
   - Staff and Provider training
   - Compliance monitoring
   - Non-Discrimination as required by Section 1557 of ACA
2. Create and implement C&L Program Work plan
3. Create Policy and Procedures in support of C&L Program
4. Ensure members have access to member informing material in Braille, large print and audio CD
5. Distribute "Quick Guide" for accessing interpreter services to all providers
6. Promote interpreter services at no charge for members to providers
7. Include C&L as standing agenda item at all Joint Operation Committee meetings
8. Include C&L Training in new provider and sub-contractor orientations
9. Include training resources related to gender, sexual orientation or gender identity in Culturally Competency Tool Kit

Results: All interventions implemented.

Progress:

1. 2016 C&L Program updated and approved by DHCS on September 8, 2016
2. 2016 C&L Program Work plan updated and approved by DHCS on September 8, 2016
3. Policy QI 08 Linguistics Culture, approved on 11/09/2016. The following procedures created in support pf Policy QI 08:
   a. QI 08 01 Cultural and Linguistically Competent Services
   b. QI 08 02 Language Assistance Program

c. QI 08 03 Member Threshold Languages Ad Hoc Document Translations
d. QI 08 04 Standing Requests for Member Materials in Alternate Formats
e. QI 08 05 Ad Hoc Requests for Member Materials in Alternate Formats

4. Braille, audio CD and large print requests can be produced by Marketing or SCFHP's translation vendor per policy QI.08 Cultural and Linguistically Competent Services as of November 2016
5. Interpreter services "Quick Reference Guide" provided to delegates for distribution to providers in 3Q2016.
6. Interpreter services promoted and reviewed at 2016 JOC's with all providers and delegates
7. C&L staff and agenda item added to JOC agendas in September 2016
8. C&L covered at all new provider orientations in 2016
9. Provider Cultural Competency Tool Kit updated to include non-discrimination training resources related to ACA section 1557 requirements in December of 2016.

Objective 2: Use outcome, process and structure measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities.

.

Interventions:

1. Submit GNA results to DHCS.
2. Include C&L compliance, including training, in all Delegation Oversight Audits
3. Complete C&L audits of all providers and delegates
4. Use the CAC for advice and feedback on CLAS and procedures
5. Review GNA and CAHPS results for opportunities to improve culturally competent services
6. Review Provider and delegate audit results to identify C&L training needs

Results: All interventions implemented.

Progress:

1. GNA Update submitted to DHCS on 10/14/2016, next submission will be in October of 2017
2. Completed 12 provider and delegate audits in 2016
3. Delegate Audit Guidelines updated to include more robust auditing of interpreter and translation services provided by Delegates and Vendors in October 2016
4. Quality staff commenced CAC attendance in December 2016
5. GNA and CAHPS results received and review started in December 2016
6. Audit results resulted in additional C&L training provided to one delegated group ,in 4Q2016

Objective 3: Promote a culturally competent health care and work environment for SCFHP

Interventions:

1. New employees complete an on-line C&L training as part of new hire orientation and retake it on an annual basis as required by C&L Program
2. New bi-lingual employees are tested for language proficiency and retested on an annual basis as required by C&L Program

Results: All interventions implemented

Progress:

1. All staff completed annual C&L Training in December 2016
2. HR to update policies to commence annual language proficiency re testing for bi lingual staff in July of 2017

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: December 7, 2016

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Total number of practitioners in network (includes delegated providers) as of 11/30/16	3667	Threshold
Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	4	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	4	
Number practitioners recredentialed within 36-month timeline	4	
% 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	

	Stanford	LPCH	NT 20	NT 40	NT 50	NT 60
Total # of Initial Creds	56	53	41	16	11	2
Total # of Recreds	113	43	27	123	18	1
(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
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

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
September 15, 2016
CONFIDENTIAL

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD	Internist	Y
Hao Bui, BS, PharmD	Walgreens	Y
Minh Thai, MD	Family Practice	Y
Amara Balakrishnan, MD	Pediatrics	N
Peter Nguyen, MD	Family Practice	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, Pharm D	SCVMC Pharmacy Director	Y
Ali Alkoraishi, MD	Psychiatry	Y
Johanna Liu, PharmD	SCFHP Director of Quality and Pharmacy	Y
Jeff Robertson, MD	SCFHP Chief Medical Officer	Y

Non-Voting Staff Members	Title	Present Y or N
Lily Boris, MD	Medical Director	N
Caroline Alexander	Administrative Assistant	Y
Christine Tomcala	Chief Executive Officer	N
Tami Ogino, PharmD	Clinical Pharmacist	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Angelique Tran	Prior Authorization Supervisor	N
Dang Huynh, PharmD	Pharmacy Manager	Y
Andres Aguirre	Quality Improvement Manager	Y
Dan Johns	Appeals and Grievance Manager	Y

Item	Discussion	Follow-Up Action
	The meeting convened at 6:10 PM.	
I.	**REVIEW, REVISE, AND APPROVE MEETING MINUTES of June 16, 2016.** The minutes were reviewed by Committee as submitted.	Upon motion duly made and seconded, the P&T Committee minutes of **June 16, 2016** were approved as submitted and will be forwarded to the QI Committee and Board of Directors.

Item	Discussion	Follow-Up Action
II.	**REPORTS** **a. Health Plan Updates** Dr. Robertson reported that plan participated in joint Department of Health Care Services (DHCS)/Department of Managed Health Care (DMHC) audit. Received final report from DHCS. Plan is in the process of completing Corrective Action Plan. Santa Clara Family Health Plan membership is currently over 280,000. PBM is ending relationship with current specialty pharmacy Diplomat. Doing small abbreviated RFQ for specialty pharmacy. Will be revising for 1st Quarter of 2017. Launching Flu Shot campaign to go live in October. New Health Services Director has been hired and has a targeted start date of September 19th. New Pharmacy Manager Dang Huynh hired as of July 1st. **b. Appeals and Grievances** Mr. Johns presented the 2nd Quarter 2016 Pharmacy Appeals. 50 MediCal appeals were received during the 2nd Quarter of 2016. 9 State Fair Hearings were requested. No trends or changes were identified for MediCal appeals during the 2nd Quarter of 2016. 39 Cal MediConnect appeals were received during the 2nd Quarter of 2016. 26 Prior Authorization requests were sent from MedImpact. Since late Q1/early Q2, Grievance and Appeals Department no longer accepts these as valid appeal requests. Provider's office is now contacted and process for filing an appeal is explained. This has resulted in a reduction of the number of redeterminations processed. **c. Membership** Topic addressed during Health Plan Updates. **d. Pharmacy Dashboard** Dr. Ogino presented the Pharmacy Dashboard for MediCal and Cal Mediconnect. For MediCal, percentage of standard prior authorizations completed within 1 business day is 100% as of August 2016. Percentage of expedited prior authorizations completed within 24 hours is 100% as of August 2016. For Cal MediConnect, percentage of standard prior authorizations completed within 72 hours is 100% as of August 2016. Percentage of expedited prior authorizations completed within 24 hours is 100% as of August 2016. Goal for Medication Therapy Management (MTM) completion rate is 22% at year end. Currently at 12% completion rate as of July 2016.	

Item	Discussion	Follow-Up Action
	e. CAHPS *(Consumer Assessment of Healthcare Providers and Systems) Mr. Aguirre presented the CAHPS report. Final sample size for MediCal was 1,373 and for Cal MediConnect 800. Total response rate for MediCal was 27.8% and Cal MediConnect 20.05%. Part D Measures rated were as follows: • Rating of Drug Plan: SCFHP=87%; CMS National Data=85% • Willingness to Recommend: SCFHP=79%; CMS National Data=82% • Getting Needed Prescription Drugs: SCFHP=86%; CMS National Data=91% • Getting Information from Drug Plan: SCFHP=76%; CMS National Data=80%	
III.	**OLD BUSINESS/ DISCUSSION ITEMS** **a. Zolpidem restriction follow up** Recommend keep Zolpidem 10mg and 5mg on Formulary as is. **b. Epipen in the news** Price of Epipen has increased. Manufacturer will come out with a generic version that costs $300.	No action required.

Item	Discussion	Follow-Up Action
IV.	**NEW BUSINESS** **a. Formulary Modifications** Dr. Ogino presented Formulary Modifications made since interim from last Pharmacy and Therapeutics Committee meeting: • Add Zepatier and Epclusa to formulary with prior authorization • Remove Harvoni and Sovaldi from formulary • Change QL on Sertraline 25mg and 50mg from #1 tablet/day to #1.5 tablets/day • Update age limit on sodium fluoride products to ≤ 16 years old • Add QL to products containing acetaminophen • Remove 2nd generation antihistamine/pseudoephedrine combination products from formulary • Remove Desloratadine from formulary • Remove prior authorization from Pindolol, Betaxolol, Bisoprolol. Remove step therapy from Acebutolol. Remove brand Inderal XL and brand Innopran from formulary	Upon motion duly made and seconded, Formulary Modifications were approved as submitted.
	b. PA Guideline Review Project Dr. Huynh presented the proposed Non-formulary criteria and Reauthorization criteria. Standardize the way plan review non-formulary drugs. Provides transparency on criteria.	Upon motion duly made and seconded, Non-formulary and Reauthorization Criteria were approved as submitted.
	c. MedImpact P & T Minutes Dr. Liu and Dr. Ogino reviewed the MedImpact P&T Minutes and approved as written.	Upon motion duly made and seconded, MedImpact 2Q16 P&T Minutes were approved as submitted.
	d. New Drugs Dr. McCarty presented new drugs. i. Zinbryta-Presented as informational only ii. Ocaliva-Presented as informational only	Informational only. No action required.

Item	Discussion	Follow-Up Action
	e. Class Reviews Dr. McCarty presented class updates and recommendations. i. Diabetes Update Proposed items for discussion: Maintain Adlyxin, LixiLan, and Xultophy as non-formulary ii. Long Acting Opioids Proposed items for discussion: Maintain Troxyca ER and Xtampza ER as non-formulary Maintain Oxycontin as formulary with Prior Authorization restriction iii. Growth Hormone No discussion at this time. iv. Hepatitis C Update/Updates SCFHP Guidelines Proposed items for discussion: Add Zepatier and Epclusa to formulary with PA restriction Remove Harvoni and Sovaldi from formulary Maintain Daklinza, Technivie, Viekira, Sovaldi, Olysio, Ribavarin as non-formulary **f. 3Q2016 Drug Trend and Utilization Review** **g. Medi-Cal Formulary Drug Updates** **h. Generic Pipeline-Presented as informational only**	Upon motion duly made and seconded, recommendations were approved as presented. Upon motion duly made and seconded, recommendations were approved as presented. Upon motion duly made and seconded, guidelines were approved as presented. Informational only. No action required.
V.	**ADJOURNMENT** The meeting was adjourned at 7:55 PM.	

Santa Clara Family Health Plan
Pharmaceutical and Therapeutics Committee
September 15, 2016
CONFIDENTIAL

Submitted by:

Caroline Alexander Date: 12/15/16
Caroline Alexander
Administrative Assistant, SCFHP

Internal Approved By:

Date: 12/15/16
Johanna Liu, PharmD
Director of Quality & Pharmacy, SCFHP

External Approved by:

Date: 12/15/16
Jimmy Lin, MD
Pharmacy & Therapeutics Chair

Santa Clara
Family Health Plan

The Spirit of Care

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 19, 2016

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	N
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	N
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	Y
Lily Boris, MD	Medical Director	Y
Jana Alegre	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	Y

ITEM	DISCUSSION	ACTION REQUIRED
I. Introductions Review/Revision/Approval of Minutes	Meeting called to order by chair at 6:10 p.m. Introduced Sandra Carlson, Health Services Director to the group. The minutes of the July 20, 2016 meeting were approved as presented.	
II. CEO Update	Ms. Tomcala presented the update for Santa Clara Family Health Plan. Plan is busy preparing for NCQA accreditation and upcoming CMS audit. Opened the floor for questions.	
III. Old Business	Dr. Boris gave an update on the audit findings for the Utilization Management department, as well as the response to the corrective action plan. There were three findings for the Utilization Management Department. Findings included the following: • The Plan did not have a 2015 UM Program and Work Plan -- Corrected • The Plan did not demonstrate a consistent systemic process, such as inter-rater reliability (IRR) studies or other	

ITEM	DISCUSSION	ACTION REQUIRED
	methods, for ensuring consistent application of UM guidelines by all UM decision makers -- Corrected • The Plan did not have an established and systemic process to track all specialty referrals that require medical prior authorizations to their completion, including out of network referrals – In process in accordance to our current policy	
IV. Action Items	a. Final Medi-Cal Prior Authorization Grid for implementation January 1, 2017 Ms. Alegre presented a summary of changes to the Medi-Cal Prior Authorization Grid. Reformatted list to match MediCare list and make easier to read. Inpatient admissions, SNF, LTC will require prior authorization. Outpatient surgery section: removed Hemodialysis, which does not require prior authorization unless out of area. Added gender reassignment surgery. Non contracted providers require prior authorization. Organ transplants, Behavioral Health remained the same. In conjunction with Pharmacy Department, revised drug prior authorization list. Removed Oncology prior authorization requirement. Removed Oncology drugs from prior authorization list. New Grid will be effective January 1, 2017 and be published to the website. Will notify providers via FAX blast there is a new prior authorization grid. Discussion opened to the floor. Dr. Robertson clarified DME section of grid. After motion duly made, seconded, Medi-Cal Prior Authorization Grid was approved as presented.	

ITEM	DISCUSSION	ACTION REQUIRED
V. Standing Reports	a. Membership Dr. Robertson presented an update on membership. Of note between August and September, Healthy Kids population reduced by 1200 due to State slowly decreasing Healthy Kids population. This was due to rolling over Healthy Kids into Medi-Cal. 1300 went into Medi-Cal in September, 300 left Healthy Kids in October. Increased Medi-Cal enrollment in October. Gained 2400 Medi-Cal members in October. Medi-Cal membership is 274,000 and Cal Medi-Connect is 7,800 as of October. Grand Total as of October is 282,000 members. Growth is steady in membership. Distribution amongst networks has remained relatively constant. Working with providers to promote Cal Medi-Connect program. b. UM Reports 2016 – see attached PowerPoint i. Quarterly: CMC and Medi-Cal Dr. Boris presented the report on Inpatient Utilization for Medi-Cal Non-Seniors and Persons with Disabilities (SPD), Medi-Cal SPD, Cal MediConnect, as well as Inpatient Readmissions for the above mentioned populations, respectively. Will do more data analysis and trending, as well as analysis by network for future reporting. Also presented Frequency of Selected Procedures for Medi-Cal population, as well as Medi-Cal Behavioral Health Metrics. ii. Turn Around Time Dr. Boris presented the Dashboard for June 2016 through August 2016. For all Lines of Business, the goal in each area is 95%. For Cal MediConnect the non urgent pre-service requirement is review within 14 calendar days. Percent reviewed within 14 calendar days increased from 79% in June to 97% in August. Expedited requirement is review within 72 hours. Percent reviewed within 72 hours increased from 69% in June to 81% in August. Retrospective Review is to be reviewed within 30 calendar days. 100% were completed within this time frame. For Medi-Cal Standard non urgent requirement is review within 5 business days. Range from June to August has been 95 to 97%. For expedited review, the requirement is 72 hours turnaround. As of August, percentage reviewed in 72 hours is 94%, just slightly below the goal of 95%. Concurrent review not available currently because of our systems. Should be available once Medi-Cal is moved into QNXT system. Decision needs to be made within 24 hours of the request. Retrospective review is to be completed within 30 calendar days of request. As of August, 90% were reviewed within this timeframe. Volume is 1,000 requests per month for Medi-Cal. And CMC requests are also approximately 1000 / month for about 8000 patients.	

ITEM	DISCUSSION	ACTION REQUIRED
VI. Adjournment	Meeting adjourned at 7:05 p.m.	
NEXT MEETING	The next meeting is scheduled for Wednesday, January 18, 2017, 6:00 PM	

Prepared by:
Caroline Alexander
Administrative Assistant
Date 1/18/17

Reviewed and approved by:
Jimmy Lin, M.D.
Committee Chairperson
Date 1/18/17