Santa Clara Family Health Plan

Quality Improvement Program 2018

Table of Contents

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. In 2015, Centers for Medicare and Medicaid Services (CMS) contracted with SCFHP for the Cal MediConnect (CMC)/Dual Demonstration Project Medicare-Medicaid Plan (MMP).

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

II. Mission Statement

The Mission of (SCFHP) is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase 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 local, public, not-for-profit health plan, we have a unique responsibility to continually improve the health status of the community by incorporating a comprehensive approach to health care and wellness. SCFHP maintains a comprehensive Quality Improvement (QI) Program that systematically monitors and continually drives improvements to the quality of care to our members, provides for culturally and linguistically appropriate services, identifies over- and under- utilization and substandard care, monitors member satisfaction and member safety and takes corrective actions and interventions when necessary.

III. Authority and Accountability

The Santa Clara County Health Authority is an independent public agency that governs 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 Governing Board assumes ultimate responsibility for the Quality Improvement Program and has established the Quality Improvement Committee to oversee this function as a Board committee. This supports the Board playing a central role in monitoring the quality of health care services provided to members and striving for quality improvement in health care delivery. The Board authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QI Program Description. The CEO has delegated oversight of the day-to-day operations of the QI Program to the Chief Medical Officer.

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 Governing Board has adopted the following Quality Improvement Program Description. The program description is reviewed and approved at least annually by the Quality Improvement Committee and Governing Board.

V. Goals

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

A. Quality of physical health care, including primary and specialty care.
B. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation.
C. Quality of Long Term Support Services(LTSS)
D. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS provides and services.
E. Continuity and coordination of care across all care and settings, and for transitions in care.
F. Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.\

Additional goals and objectives are to monitor, evaluate and improve:

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 network to deliver quality care and service
F. Member and provider satisfaction, including the timely resolution of grievances
G. Risk prevention and risk management processes
H. Compliance with regulatory agencies and accreditation standards
I. The effectiveness and efficiency of 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 its mission, vision, and values
L. Compliance with Clinical Practice Guidelines and evidence-based medicine
M. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
N. 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
O. 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. Objectives

The objectives of the QI Program Description include to:

A. Keeping members healthy
B. Managing members with emerging risk
C. Patient safety or outcomes across settings
D. Managing multiple chronic illnesses
E. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
F. Support practitioners with participation in quality improvement initiatives of SCFHP and all governing regulatory agencies
G. 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

H. 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
I. 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:
    a. Establishing performance standards
    b. Monitoring performance through regular reporting
    c. Evaluating performance annually
J. 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:
    a. Medical record review
    b. Rates of referral to specialists
    c. Hospital discharge summaries in office charts
    d. Communication between referring and referred-to physicians
    e. Analysis of member complaints
    f. Identification and follow-up of non-utilizing members
    g. Practice Pattern Profiles of physicians
    h. Performance measurement of practice guidelines
K. 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 grievances.
L. Evaluate the QI Program Description and Work Plan at least annually and modify as necessary. The evaluation addresses:
    a. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    b. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
M. 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)
N. 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
O. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve health outcomes. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members
P. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VII. 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:
    a. Access to Preventive Care (HEDIS)
    b. Behavioral Health Services
    c. Continuity and Coordination of Care
    d. Emergency Services
    e. Grievances
    f. Inpatient Services
    g. Maintenance of Chronic Care Conditions (HEDIS)
    h. Member Experience and Satisfaction
    i. Minor Consent/Sensitive Services
    j. Perinatal Care
    k. Potential Quality of Care Issues
    l. Preventive Services for children and adults
    m. Primary Care
    n. Provider Satisfaction
    o. Quality of Care Reviews
    p. Specialty Care
D. Refer to the Utilization Management Program and the Case Management Program for QI activities related to the following:
    a. UM Metrics
    b. Prior authorization
    c. Concurrent review
    d. Retrospective review
    e. Referral process

f. Medical Necessity Appeals
g. Case Management
h. Complex Case Management
i. Disease Management
j. California Children's Services (CCS)

VIII. QI Work Plan

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

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.

IX. QI Methodology

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

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

QI Project Selections and Focus Areas

Performance and outcome improvement projects 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 Centers for Medicare and Medicaid Services (CMS) such as Quality Improvement Activities (QIAs), Quality Improvement Projects (QIP's) or Performance Improvement Projects (PIP's)

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
D. Provisions of complex care management services
E. Access to and provision of preventive services

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

A. Staff, 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: Governing Board, 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.

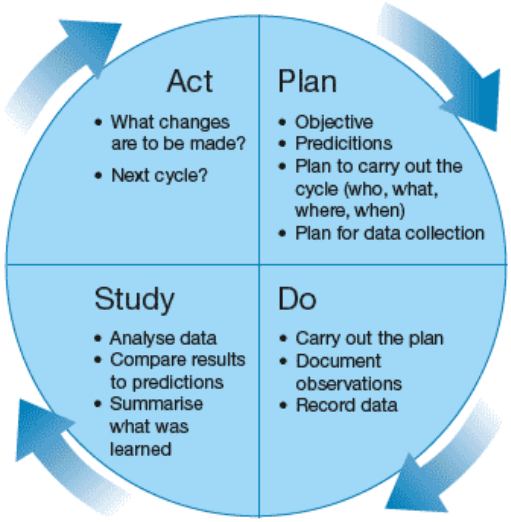
Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

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

X. QI Quality Issue Identification

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

Adverse events can include:

A. Potential Quality Issues (PQI)
B. Unexpected death during hospitalization
C. Complications of care (outcomes), inpatient and outpatient
D. Reportable events for long-term care (LTC) facilities 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
E. 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. Performance Improvement Projects (PIPs)
L. Health Risk Assessment data

M. Consumer Assessment of Healthcare Providers & Systems (CAHPS)
N. Health Outcomes Survey (HOS)
O. Regulatory Reporting

Protocol for Using Quality Monitors Screens

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 Medical 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.

XI. 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 Governing Board and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process 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 CMC. 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, Quality Improvement Committee (QIC) and network practitioners identify members with, or at risk for, chronic medical conditions. The QIC 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 CM 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.

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

The continuity and coordination of care received by members includes medical care in combination with behavioral health care. SCFHP collaborates with behavioral health practitioners to promote the following activities 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. Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

XII. QI Organizational Structure

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
    a. Drive improvement of quality of care received
    b. Minimize rework and costs
    c. Optimize the time involved in delivering patient care and service
    d. Empower staff to be more effective
    e. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. 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 is responsible to report to the Governing Board 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 Staff meetings, executive 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 improvement program, the utilization management program, and the grievance system. The Medical Directories 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, including resolving grievances related to medical quality of care. 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 Quality is a licensed clinician 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 improvement 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 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 QIC 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 Improvement Manager

The Quality Improvement 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 Improvement Manager reports to the Director of Quality and is responsible for managing the activities of the Plan's quality improvement 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 Improvement 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.

QI Nurse, RN

The QI Nurse reports to the Quality Improvement Manager and oversees the investigations of member grievances, supports HEDIS medical record reviews, investigates and prepares cases for 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), as well as supports the Health Education Program with clinical perspective. The QI Nurse can also be a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Assessments (IHAs), and assists with other QI activities at the direction of the Quality Improvement Manager.

QI Project Manager

The QI Project Manager provides leadership, coordination, and management of Quality Improvement Projects, PIPs, CAHPS and HOS Surveys. In addition this this position is responsible for developing and maintaining processes that enhance the operationalization of QI processes, , 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.

Health Educator

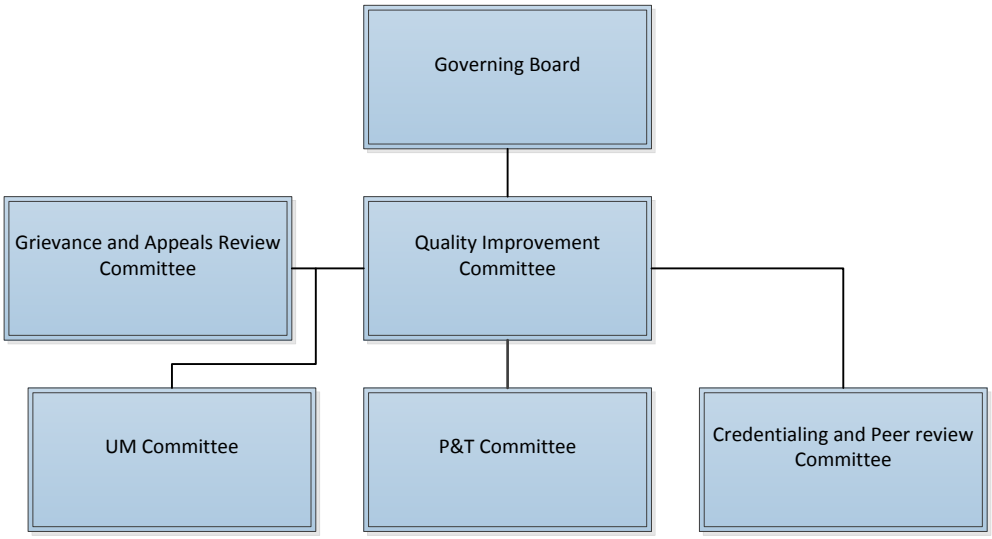
The Health Educator is a Certified Health Education Specialist (CHES) responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance to state and federal regulatory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

QI Coordinator

Quality Improvement Coordinators are 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.

XIII. Committee Structure Overview

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



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

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

XIV. Committee Structure

Governing Board

The Governing Board is responsible to review, act upon and approve the overall QI Program, Work Plan, and Annual Evaluation. The Governing Board routinely received reports from the QIC describing actions taken, progress in meeting quality objectives and improvements made. 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 QIC activities to the Board. The Board reviews the QI activities and any concerns of the Board are communicated back to the source for clarification or resolution.

Quality Improvement Committee

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.

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.

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.

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

Utilization Management Committee

The Utilization Management Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including 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 UMC 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 (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 (CPG) 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 Committee is coordinated through the Credentialing. 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, including a behavioral health practitioner who is either a medical doctor or PHD/PsyD, serve on the QI Program Committees as necessary to support each committee's function. Through these committees' activities, network practitioners:

A. Review, evaluate and make recommendations for credentialing and re-credentialing decisions
B. Review individual cases reflecting actual or potential adverse occurrences
C. Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, 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
    a. Quality Improvement Committee
    b. Pharmacy and Therapeutics Committee
    c. Utilization Management Committee
    d. Credentialing and Peer Review Committee
    e. Additional committees as requested by the Plan

XVI. Behavioral Health Services

SCFHP 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 Director for Behavioral Health services shall be involved in the behavioral aspects of the QI Program. The 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.

XVII. Utilization Management

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

XVIII. Care of Members with Complex Needs

Please refer to the Case Management program description for complete details on care of members with complex 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. Provide case management teams that focus on members who have had an organ transplant, with HIV/AIDS, progressive degenerative disorders and metastatic cancers.
B. Improve access to primary and specialty care to facilitate the receipt of appropriate services for members with complex health conditions
C. Coordinate care for members who receive multiple services.
D. Identify and reduce barrios to services for members with complex conditions.

XIX. 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 as determined by the plan's Health Educator.

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 as determined by the plan's Health Educator
D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy 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 staff
D. Cultural competency trainings such as:
    a. Cultural Competency annual online training for plan staff
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

XX. 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 MDs, DOs, 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.

<u>Healthcare Delivery Organizations</u>

SCFHP performs credentialing and re-credentialing of ancillary providers and health care delivery organizations (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.

XXI. 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 14-004. 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 14-004 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.

XXII. 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

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

XXIII. 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, HOS and (CAHPS) member satisfaction survey, monitoring member complaints and direct feedback from the Member Policy Committee. The Quality Department is responsible for coordinating the HOS and CAHPS surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the 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.

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.

XXIV. 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
    a. 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.

XXV. 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

Identification and Stratification of Members

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

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

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not 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:
    a. Initial Health Risk Assessment
    b. 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
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.

XXVI. 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.

XXVII. 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.

XXVIII. 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 Governing Board, 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

XXIX. 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 Governing Board.

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

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

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

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

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.