Performance Evaluation Report

Santa Clara Family Health Plan

July 1, 2008–June 30, 2009

Medi-Cal Managed Care Division
California Department of
Health Care Services

December 2010

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1. Executive Summary

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 3.6 million beneficiaries (as of June 2009) in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Plan-specific reports are issued in tandem with the technical report and include findings for each plan regarding its organizational assessment and structure, performance measures, and QIPs as they relate to the quality, access, and timeliness domains of care. This report is unique to the MCMC Program's contracted plan, Santa Clara Family Health Plan ("SCFHP" or "the plan"), for the review period July 1, 2008, to June 30, 2009. Actions taken by the plan subsequent to June 30, 2009, regarding findings identified within this report will be included in the next annual plan-specific evaluation report.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses performance measures and QIP results to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

To create a uniform standard for assessing plans on MCMC-required performance measures, MCMC established a minimum performance level (MPL) and a high performance level (HPL) for each measure. Rates below the MPL indicate low performance, rates at or above the HPLs indicate high performance, and rates at the MPLs or between the MPLs and HPLs demonstrate average performance.

HSAG found that SCFHP demonstrated average performance for the quality of care domain. This was based on the plan's 2009 performance measure rates (which reflected 2008 measurement data), QIP outcomes, and compliance review standards related to measurement and improvement. For example:

- Most of SCFHP's performance measure rates fell between the established MPLs and HPLs. The plan performed above the HPL on the *Use of Appropriate Medications for People With Asthma (ASM)* measure and showed a statistically significant increase over the previous year. The plan had no below-average performance for any of its rates.
- The plan demonstrated strength in its diabetes performance measure rates. Five of these measures had statistically significant increases over the previous year.
- While no performance measure rates fell below the MPLs, the plan had a statistically significant decrease for its breast cancer screening measure.
- For its obesity QIP, the plan documented several interventions that were ongoing; however, the plan may need to initiate new, targeted interventions to improve low performance.
- HSAG noted that the plan has an opportunity to improve its documentation of both QIPs to comply with federal requirements for conducting a QIP.

- The joint audit found that the organizational structure of the plan supported its quality improvement program. The plan tracked and trended data across quality activities, identified opportunities for improvement, implemented interventions, and assessed effectiveness as part of its quality improvement evaluation.
- Joint audit findings showed that the plan did not have documentation showing review of all quality of care grievances.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members.

The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The Department uses monitoring processes, including audits, to assess plans' compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services. Many performance measures fall under more than one domain. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

SCFHP demonstrated average performance for the access domain of care based on its 2009 performance measure rates related to access, QIP outcomes addressing access, and compliance review standards related to the availability of and access to care. For example:

- SCFHP's 2009 performance measures related to access all fell between the MPLs and HPLs.
- Joint audit findings showed that the plan had good procedures in place to coordinate care for its members.
- As part of the statewide collaborative QIP focused on reducing avoidable emergency room visits, the plan noted results of a 2006 SCFHP Geographic Needs Assessment Member Survey. The plan identified that 37 percent of members had a difficult time accessing evening/weekend care and 25 percent had difficulty contacting or making appointments with a PCP. Additionally, 60 percent of members found going to the ER was easier. SCFHP did not propose any interventions to address these access barriers.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, minimize any disruptions to care, and provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified.

Based on 2009 performance measure rates for providing timely care and compliance review standards related to timeliness, SCFHP demonstrated average performance in the timeliness domain of care. The plan performed within the MCMC-established thresholds for well-child visits, prenatal and postpartum care, and childhood immunizations. The plan did not have below-average performance measure rates for any of the performance measures that fall under the timeliness domain of care.

Based on the joint audit findings, SCFHP has an opportunity to improve the low rate of provider compliance with the required initial health education behavioral assessments. The audit findings also showed that the plan lacked a process to ensure delegated grievance reporting within the quality improvement program. In a review of grievance files, not all members received member rights information with notice of action letters.

Conclusions and Recommendations

Overall, SCFHP demonstrated average performance in providing quality, accessible, and timely health care services to its MCMC members. The plan's performance measure rates fell primarily between the established MPLs and HPLs. SCFHP exceeded the HPL for its *Use of Appropriate Medications for People With Asthma (ASM)* measure. The plan also demonstrated strength in its diabetes performance measure rates with four statistically significant increases and rates that were very close to the HPLs.

SCFHP demonstrated compliance with many DHCS standards for access to care, structure and operations, availability and accessibility, and quality measurement and improvement. Opportunities for improvement related to member rights and the grievance system.

Based on the overall assessment of SCFHP in the areas of quality and timeliness of and access to care, HSAG recommends the following:

- Explore factors that contributed to the decreased *Breast Cancer Screening (BCS)* rate to prevent further decline.
- Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.
- Analyze obesity QIP interventions to determine whether additional targeted efforts are needed to achieve improvement.
- Address access-related barriers to evening and weekend availability for members to increase the likelihood of decreasing avoidable ER visits.
- Implement a process to ensure delegated entity member grievances are included in the reporting of grievances within the quality improvement program.
- Develop a process to review all clinical grievances for potential quality of care issues.
- Implement internal monitoring to ensure that member rights information is included with notice of action letters to members.
- Implement interventions to improve the rate of initial health education behavioral assessments (IHEBA) and monitor the effectiveness of the interventions.
- Determine if successful strategies used to improve initial health assessment rates can be applied to increasing IHEBA rates.

In the next annual review, HSAG will evaluate SCFHP's progress with these recommendations along with its continued successes.

Plan Overview

Santa Clara Family Health Plan (SCFHP) is a full-scope managed care plan in Santa Clara County. SCFHP became operational with the MCMC Program in February 1997 and as of June 30, 2009, SCFHP had 90,155 MCMC members.[1]

SCFHP serves members as a local initiative (LI) plan under a Two-Plan model. In a Two-Plan model county, the DHCS contracts with two managed care plans to provide health care services to members. In most Two-Plan model counties, Medi-Cal beneficiaries in both mandatory and voluntary aid codes can choose between a local initiative plan and a nongovernmental commercial health plan.

[1] *Medi-Cal Managed Care Enrollment Report, June 2009*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process to assess plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about SCFHP's performance in providing quality, accessible, and timely health care services to its MCMC members. Compliance monitoring standards primarily fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Joint Audit Review

The DHCS's Audits and Investigations Division (A&I) works in conjunction with the California Department of Managed Health Care (DMHC) to conduct routine medical surveys (joint audits) of MCMC plans. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A joint audit is conducted for each MCMC plan approximately once every three years. In addition, A&I periodically conducts non-joint medical audits of five MCMC plans; however, SCFHP is not among those plans designated for a non-joint medical audit.

For this report, HSAG reviewed the most current audit reports available as of June 30, 2009, to assess plans' compliance with State-specified standards. A joint audit for SCFHP was conducted in May 2007 covering the review period of May 1, 2006, through April 30, 2007. The audit covered the areas of utilization management, continuity of care, availability and accessibility, member

rights, quality management, and administrative and organizational capacity. Results from this audit identified strengths as well as opportunities for improvement as explained below.

Under the utilization management (UM) category of review, SCFHP had a UM program that used written criteria to determine medical necessity. The UM program tracked under- and over-utilization of services, timeliness of UM decisions, and referrals. It also was responsible for delegated UM oversight. Findings under this category showed that the notice of action for denied, deferred, or modified claims did not include the required language notifying members of their right to contact the DHCS.

For continuity of care, the plan had policies and procedures in place for in- and out-of-network care coordination for members. The plan had a memorandum of understanding in place with community agencies to ensure care coordination for early intervention and developmental disability services. Audit findings in this area showed a low rate of provider compliance with administering the initial health education behavioral assessment. The DHCS *Medical Audit Close Out Report* from March 2008 indicated that the plan outlined promising interventions to improve assessment completion rates; however, the plan did not confirm that the interventions had been implemented.

Under the availability and accessibility of services category, SCFHP had policies and procedures for access and availability of routine care, urgent care, emergency care, routine specialty care, and prenatal care. Findings under this category included lack of verifying credentials for HIV/AIDS specialists and lack of oversight of delegated medical groups for verifying credentials of its providers. The plan did not monitor telephone waiting time and call-return times of its providers. The plan did not perform annual audits of subcontracted providers for payment of emergency department claims. A review of denied emergency service claims showed that some claims were denied due to late submission; however, they were received within a year. The DHCS *Medical Audit Close Out Report* noted that the plan corrected deficiencies related to verifying specialist credentials for HIV/AIDS. However, the plan needs to demonstrate implementation of proposed telephone monitoring processes and document its verification of timely and appropriate payment of emergency services to adequately address the outstanding deficiencies.

The audit had several findings related to the grievance system. Not all medical grievance files were reviewed for quality of care issues. Not all files had appropriate notification to the member and some acknowledgement letters did not include the date the plan received the grievance. Delegated grievances were not included in the report to the Quality Improvement Committee. The DHCS *Medical Audit Close Out Report* noted that the plan had taken appropriate action by having a manager and a nurse provide oversight of the grievance process. However, the plan was unable to demonstrate implementation of an effective method for resolving all member grievances.

Under its Health Insurance Portability and Accountability (HIPAA) policies and procedures, the plan lacked reporting requirements to notify the DHCS of a data breach. The *Medical Audit Close Out Report* noted an opportunity for the plan to further revise its policy and procedures to include the specific time frames for reporting breaches to the DHCS.

SCFHP was fully compliant with the requirements for administrative and organizational capacity.

Member Rights and Program Integrity Monitoring Review

The Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These reviews are done before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2009.

MRPIU conducted an on-site review of SCFHP in December 2008, covering the review period of January 1, 2007, through June 30, 2008. The scope of the review included grievances, prior authorization notifications, cultural and linguistic services, and marketing.

MRPIU found the plan fully compliant with requirements for cultural and linguistic services and marketing. For member grievances, the review showed that SCFHP's policies and procedures did not include language regarding the continuation of services pending the resolution of the grievance process. Under prior authorization notifications, one of the 32 files reviewed did not contain a citation that supported the action taken by the plan. In 13 of 32 files reviewed, the "Your Rights" attachment was not included with the notice of action to the members.

Strengths

SCFHP demonstrated adequate administrative and organizational capacity to support its quality improvement program. The plan tracked and trended data across quality activities, identified opportunities for improvement, implemented interventions, and assessed effectiveness as part of its quality improvement evaluation.[2]

The plan had good processes in place for care coordination for its members, including care for early intervention and developmental disability services. The plan was fully compliant with cultural and linguistic services requirements.

Opportunities for Improvement

SCFHP has an opportunity to improve the rate of initial health education behavioral assessments. The plan may consider monitoring and tracking and trending these data consistent with its monitoring initial health assessments.

The plan needs to demonstrate implementation of:

- An effective mechanism for resolving member grievances.
- A process to monitor that member rights information is included with notice of action letters to members.
- Interventions to improve initial behavioral health education assessments.
- A process to monitor telephone waiting times and the call-return times of its providers.
- Timely and appropriate payment of emergency services.

[2] Santa Clara Family Health Plan. 2008 Quality Improvement Program Evaluation. March 2009.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provides a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about SCFHP's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Performance Measure Validation

HSAG performed a HEDIS® Compliance Audit™ [3] of SCFHP in 2009. HSAG found all measures to be reportable with the exception of the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)* measure. This measure had significant methodology revisions that resulted in the plan having to exclude a large number of members from the medical record review sample. As a result of these exclusions, the sample did not achieve the required size to produce a valid rate. The plan chose not to report this measure due to the added cost to resample and abstract the additional medical records needed to produce a valid rate.

[3] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS Compliance Audit™ is a trademark of the NCQA.

SCFHP's information systems (IS) supported accurate HEDIS reporting. The plan was fully compliant with IS standards, and the auditors identified no corrective actions.

Recommendations from the audit included implementing a formal audit process for data entry of PM 160 forms. The plan should explore increasing the volume of auto-adjudication rates, which would increase efficiencies and timely processing of claims data.

Performance Measure Results

The table below presents a summary of SCFHP's county-level HEDIS 2009 performance measure results (based on calendar year 2008 data) compared to HEDIS 2008 performance measures results (based on calendar year 2007 data). In addition, the table shows the plan's HEDIS 2009 performance compared to the MCMC-established MPLs and HPLs.

For all but one measure, the MCMC Program bases its MPLs and HPLs on the National Committee for Quality Assurance (NCQA)'s national Medicaid 25th percentile and 90th percentile, respectively. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* measure, NCQA inverted the rate—a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

Due to significant methodology changes for the *Comprehensive Diabetes Care—HbA1c Control (<7.0 Percent)* measure for 2009, the MCMC Program was unable to compare 2008 and 2009 performance results for this measure.

Appendix A includes a performance measure name key with abbreviations contained in the following table.

Table 4.1—2008–2009 Performance Measure Results for Santa Clara Family Health Plan Santa Clara County

Performance Measure[1]	Domain of Care[2]	2008 HEDIS Rates[3]	2009 HEDIS Rates[4]	Performance Level for 2009	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	27.4%	25.1%	★★	↔	20.6%	35.4%
ASM	Q	87.9%	96.5%	★★★	↑	86.1%	91.9%
AWC	Q,A,T	39.4%	42.2%	★★	↔	35.9%	56.7%
BCS	Q,A	57.8%	55.2%	★★	↓	44.4%	61.2%
CCS	Q,A	73.5%	74.4%	★★	↔	56.5%	77.5%
CDC –E	Q,A	56.3%	59.0%	★★	↔	39.7%	67.6%
CDC–H7 (<7.0%)	Q	33.6%	NR	Not Comparable	Not Comparable	†	†
CDC–H9 (>9.0%)	Q	45.3%	38.7%	★★	↑	52.5%	32.4%
CDC–HT	Q,A	80.3%	85.7%	★★	↑	74.2%	88.8%
CDC–LC (<100)	Q	29.8%	42.1%	★★	↑	25.1%	42.6%
CDC–LS	Q,A	70.0%	78.2%	★★	↑	66.7%	81.8%
CDC–N	Q,A	71.4%	77.7%	★★	↑	67.9%	85.4%
CIS–3	Q,A,T	78.5%	75.0%	★★	↔	59.9%	78.2%
PPC–Pre	Q,A,T	84.3%	83.2%	★★	↔	76.6%	91.4%
PPC–Pst	Q,A,T	61.9%	66.4%	★★	↔	54.0%	70.6%
URI	Q	91.3%	92.6%	★★	↑	79.6%	94.1%
W15	Q,A,T	59.0%	60.0%	★★	↔	44.5%	73.7%
W34	Q,A,T	73.1%	73.1%	★★	↔	59.8%	78.9%

[1] DHCS-selected HEDIS performance measures developed by NCQA. See Appendix A for the full name of each HEDIS measure.
[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).
[3] HEDIS 2008 rates reflect measurement year data from January 1, 2007, through December 31, 2007.
[4] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.
[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.
[6] The MMCD's minimum performance level (MPL) is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile.
[7] The MMCD's high performance level (HPL) is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.
†The MMCD's MPL and HPL are not applied to this measure due to significant methodology changes between 2008 and 2009.
★ = Below-average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the Medicaid 75th percentile.
★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th and 75th percentiles.
★★★ = Above-average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, performance is relative to the national Medicaid 10th percentile.
↓ = Statistically significant decrease.
↔ = Nonstatistically significant change.
↑ = Statistically significant increase.
Not Comparable = Performance could not be compared due either to significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, SCFHP demonstrated average performance, falling between the MPLs and HPLs for most of its reported performance measures in 2009. The plan exceeded the MCMC goal, which reflects the national Medicaid 90th percentile for *Use of Appropriate Medications for People With Asthma (ASM)*. The plan did not have below-average performance in any area.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. Plans that have rates below these minimum levels must submit an improvement plan to the DHCS for each area of deficiency, outlining the steps they will take to improve care.

SCFHP did not have any measures in 2008 or 2009 that were below the MPLs. Therefore, the DHCS did not require SCFHP to submit improvement plans for any measure for either year.

Strengths

SCFHP performed above the HPL on the *Use of Appropriate Medications for People With Asthma (ASM)* measure and showed a statistically significant increase over the previous year. The *Appropriate Treatment for Children With Upper Respiratory Infection (URI)* measure also had statistically significant improvement, which demonstrated the plan's efforts to improve the quality of care related to the appropriate prescribing of medications consistent with practice guidelines.

In addition, five comprehensive diabetes measures showed statistically significant improvement in performing retinal eye exams, testing and controlling HbA1c and low-density lipoprotein cholesterol (LDL-C) levels, and monitoring for nephropathy, which demonstrated the plan's efforts to provide quality care and good management of a chronic condition.

Opportunities for Improvement

Between 2008 and 2009 SCFHP had a statistically significant decrease in the HEDIS rate for the *Breast Cancer Screening (BCS)* measure, which presents an opportunity for improvement. SCFHP's declining performance in this area may point to issues with health care quality and/or access.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas.

HSAG reviews each QIP using CMS' validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about SCFHP's performance in providing quality, accessible, and timely care and services to its MCMC members. The *Medi-Cal Managed Care Program Technical Report, July 1, 2008–June 30, 2009*, scheduled for release in early 2011, will provide an overview of the objectives and methodology for conducting the EQRO review.

Quality Improvement Projects Conducted

SCFHP had two clinical QIPs in progress during the review period of July 1, 2008, through June 30, 2009. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. SCFHP's second project, an internal QIP, aimed to increase the screening for obesity, thereby improving the health of members 12 to 18 years of age. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

Childhood obesity is often an indicator of reduced overall health and a risk factor for many chronic conditions. SCFHP's QIP, *Adolescent Health and Obesity Prevention*, attempted to improve the quality of care delivered to adolescents by increasing the obesity screening rate and appropriate counseling.

Quality Improvement Project Validation Findings

The DHCS contracted with HSAG as its new EQRO in the second half of 2008. HSAG began validation for QIPs submitted by the plans after July 1, 2008.

The table below summarizes the validation results for both of SCFHP's QIPs across CMS protocol activities during the review period.

Table 5.1—QIP Validation Results for Santa Clara Family Health Plan (N=2 QIPs)
Santa Clara County

Activity		Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
I.	Appropriate Study Topic	92%	8%	0%
II.	Clearly Defined, Answerable Study Question(s)	0%	50%	50%
III.	Clearly Defined Study Indicator(s)	54%	38%	8%
IV.	Correctly Identified Study Population	0%	67%	33%
V.	Valid Sampling Techniques (if sampling was used)	50%	0%	50%
VI.	Accurate/Complete Data Collection	19%†	44%†	38%†
VII.	Appropriate Improvement Strategies	25%	75%	0%
VIII.	Sufficient Data Analysis and Interpretation	31%	23%	46%
IX.	Real Improvement Achieved	50%	25%	25%
X.	Sustained Improvement Achieved	‡		
	Percentage Score of Applicable Evaluation Elements *Met*	**40%**		
	Validation Status	***Not Applicable****		

‡The QIP did not progress to this activity during the review period and could not be assessed.
* QIPs were not given an overall validation status during the review period.
† The sum may not equal 100 percent due to rounding.

SCFHP submitted baseline data for both projects during the review period; therefore, the QIPs had not progressed to the point of remeasurement and HSAG could not assess for real and sustained improvement.

During the period covered by this report, HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the MCMC plans. As a result, many plans had difficulty complying fully with these requirements during the first cycle of QIP validations by HSAG. This was the case with SCFHP's QIPs, neither of which fully met the new validation criteria. As directed by the DHCS, HSAG provided SCFHP, as well as other plans, with an overall validation status of "Not Applicable" for both QIPs. This allowed time for plans to receive technical assistance and training with HSAG's validation requirements without holding up the ongoing progress of QIPs that were already underway.

Quality Improvement Project Outcomes

Table 5.2 shows SCFHP's baseline data for its QIPs. The plan submitted its first remeasurement data in late 2009, after the time period covered by this report. The results of HSAG's assessment for statistically significant improvement will be included in SCFHP's next performance evaluation report.

For the ER statewide collaborative QIP, SCFHP set a goal to reduce the rate of avoidable ER visits from 1 to 5 percent annually, with a 10 percent total reduction from baseline over the QIP duration.

For the *Adolescent Health and Obesity Prevention* QIP, SCFHP set a goal that, by the conclusion of the QIP, it would increase to between 55 to 65 percent both the percentage of members who had at least one body mass index (BMI) calculated and documented and the percentage of members who had at least one documented counseling session and/or nutrition referral.

Table 5.2—QIP Outcomes for Santa Clara Family Health Plan—Santa Clara County

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement Period 1 1/1/08–12/31/08	Remeasurement Period 2 1/1/09–12/31/09	Sustained Improvement
Percentage of ER visits that were avoidable	17.1%	‡	‡	‡

‡ The QIP did not progress to this phase during the review period and could not be assessed.

QIP #2—Adolescent Health and Obesity Prevention			
QIP Study Indicator	Baseline Period 1/1/07–12/31/07	Remeasurement 1 1/1/08–12/31/08	Sustained Improvement
1) Percentage of enrolled members who were 12 to 18 years of age who had at least one BMI calculated and documented by a primary care practitioner or an OB/GYN during the measurement year	23.4%	‡	‡
2) Percentage of enrolled members who were 12–18 years of age who had at least one documented counseling and/or referral with a primary care practitioner, OB/GYN practitioner, endocrinologist, weight management specialist, and/or nutritionist during the measurement year	33.6%	‡	‡

‡The QIP did not progress to this phase during the review period and could not be assessed.

Strengths

SCFHP demonstrated a good understanding of documenting support for its QIP topic selections and providing plan-specific data.

Opportunities for Improvement

SCFHP has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan comply with the DHCS requirement to document QIPs using HSAG's QIP Summary Form, which will help the plan document all required elements within the CMS protocol activities.

For the ER statewide collaborative QIP, SCFHP reported the results of a 2006 SCFHP Geographic Needs Assessment Member Survey. The plan identified that 37 percent of members had a difficult time accessing evening/weekend care and 25 percent had difficulty contacting or making appointments with a PCP. Additionally, 60 percent of members found that going to the ER was easier. SCFHP did not propose any interventions to address these access barriers and may need to further explore if members have difficulty accessing care.

SCFHP acknowledged that it has been collecting information on providers' documentation of BMI and obesity referrals/counseling since 2004 and initiating ongoing provider interventions to improve in this area. The plan may need to initiate new, targeted interventions to improve its low performance on the obesity QIP to increase the likelihood of success.

The table below provides abbreviations of HEDIS performance measures used throughout this report.

Table A.1—HEDIS® Performance Measures Name Key

Abbreviation	Full Name of HEDIS® Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
ASM	*Use of Appropriate Medications for People With Asthma*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–E	*Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed*
CDC–H7	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 7.0 Percent)*
CDC–H9	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC	*Comprehensive Diabetes Care—LDL-C Control*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W15	*Well-Child Visits in the First 15 Months of Life (Six or More Visits)*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*