



# San Francisco Health Plan (SFHP) Quality Improvement Program Evaluation 2006

## Introduction

The goal of SFHP's Quality Improvement Program is to assure that we provide high-quality care and services to members by aggressively seeking opportunities to improve the performance of our health care delivery system. This report is a summary of the activities that SFHP undertook in 2006 to monitor and improve the health care delivery system for our members. It highlights our successes, examines lessons learned, and outlines our next steps.

SFHP's strategic goals are *1) to improve quality of care our members receive 2) to improve access to services*, and *3) to expand coverage*. Our Quality Improvement Program is focused on achieving those goals, especially in the areas of quality care and access to care. In 2006, we accomplished a great deal, but there are four things that we are particularly proud of:

- We improved our scores on all HEDIS measures except one.
- We launched a disease management program for diabetes.
- We worked with the City of San Francisco to develop Healthy San Francisco (HSF), which, beginning in late 2007, will improve care for the City's uninsured population.
- We sponsored an innovative project to improve access to key specialty areas through eReferral.

While 2006 was a very productive year for SFHP, we know that we have areas where we can improve. In 2007, we will continue to work toward creating a health care delivery system that places us among the best health plans in the nation.

# I. Improving the Health Status of SFHP Members

## Quality Measurement

We worked very hard in 2005 to improve care for our members as measured by our HEDIS scores reported in 2006. Our focused efforts paid off: We reported improvements to the State in every measure, except one, well-child visits, for our Medi-Cal and Healthy Family lines of business.

Interestingly, in a natural experiment on the effectiveness of our member incentives, the one measure in which we declined was our well-child measure. Our member incentive – a Toys R Us gift certificate – became useless toward the end of the year when all the Toys R Us stores in San Francisco closed.

Where we improved, we had robust quality improvement efforts in place. All of the following projects are discussed in detail later in this report, but here is a summary of the programs that made a difference in our performance as reported in 2006:

Average % improvement by measure	SFHP efforts
5% - Prenatal Care 10% - Postpartum Care	<ul style="list-style-type: none"> <li>Member incentive for timely prenatal care and free pregnancy book for all pregnant women</li> </ul>
15% - Well-Adolescent Visits	<ul style="list-style-type: none"> <li>Movie tickets for members</li> <li>Provider incentive</li> <li>SFHP personal outreach calls</li> <li>Outreach to SF public schools</li> <li>Assistance to clinics opening teen clinics</li> </ul>
31% Well-Baby Visits	<ul style="list-style-type: none"> <li>On-site outreach assistance</li> <li>Provider incentive for selected sites</li> <li>SFHP personal outreach to families assigned to DPH clinics</li> </ul>
7% Childhood Immunizations	<ul style="list-style-type: none"> <li>SFHP personal outreach to families assigned to DPH clinics</li> <li>Onsite provider outreach assistance</li> <li>Member reminders</li> <li>Member incentives</li> <li>Automated calls to children due for shots</li> </ul>

24% - Cervical Cancer Screening	<ul style="list-style-type: none"> <li>Well-woman reminder mailings</li> </ul>
16% - Chlamydia Screening	
* Breast Cancer Screening	<ul style="list-style-type: none"> <li>Provider profiles accompanied by patient data on all patients with asthma</li> <li>Member reminders</li> <li>Personal calls to all high-risk asthma patients</li> <li>Assistance to practice sites to implement better processes to care for patients with chronic conditions</li> </ul>
* Use of Appropriate Medications for People with Asthma	

\*% improvement cannot be calculated because of specification change in measure from previous year

SFHP’s goal is to reach the national Medicaid 90<sup>th</sup> percentile for every measure. This year all of the measures we reported for Healthy Families are in the 90<sup>th</sup> percentile as are four of our Medi-Cal scores:

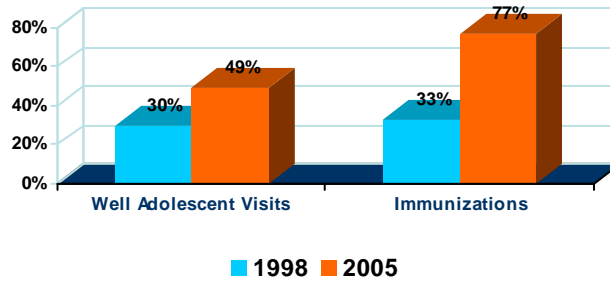
- Breast cancer screening
- Well-baby visits
- Chlamydia screening (21-26 yrs)
- Appropriate treatment for children with upper respiratory infections

We still have some work to do to reach the 90<sup>th</sup> percentile in some measures, especially in the new diabetes chronic care measures.

Our performance on HEDIS impacts the number of members assigned to SFHP by Medi-Cal. SFHP and Blue Cross’s results were extremely close on the five measures that determine the percentage of defaulting Medi-Cal members that will be assigned to each plan. We are pleased that the competition appears to be raising the quality of care for all Medi-Cal managed care members in San Francisco. Once again, the asthma measure was the only measure where there was a statistically significant difference between plans. SFHP outperformed Blue Cross by almost 13 percentage points for asthma.

The SFHP Governing Board made improving quality of care as measured by HEDIS a strategic priority for Plan and over the years it has paid off. Here are two examples of how far we have come in improving HEDIS rates, since the SFHP Governing Board made improving quality of care a priority:

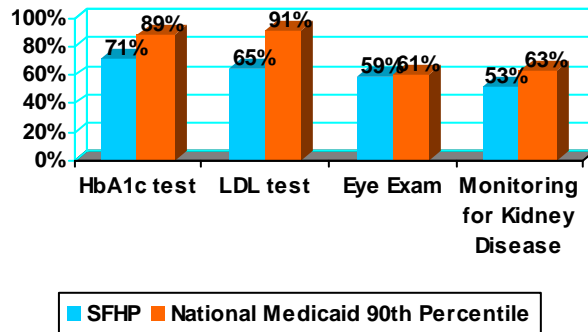
**SFHP HEDIS Rates 1998 vs 2005**



Our experience has shown us that keeping careful track of our members' preventive services and reminding (and incentivizing) members to schedule appointments make a significant difference in our HEDIS scores. In addition, supporting our doctors in making changes in their practices is another way SFHP can improve the systems that deliver care to our members.

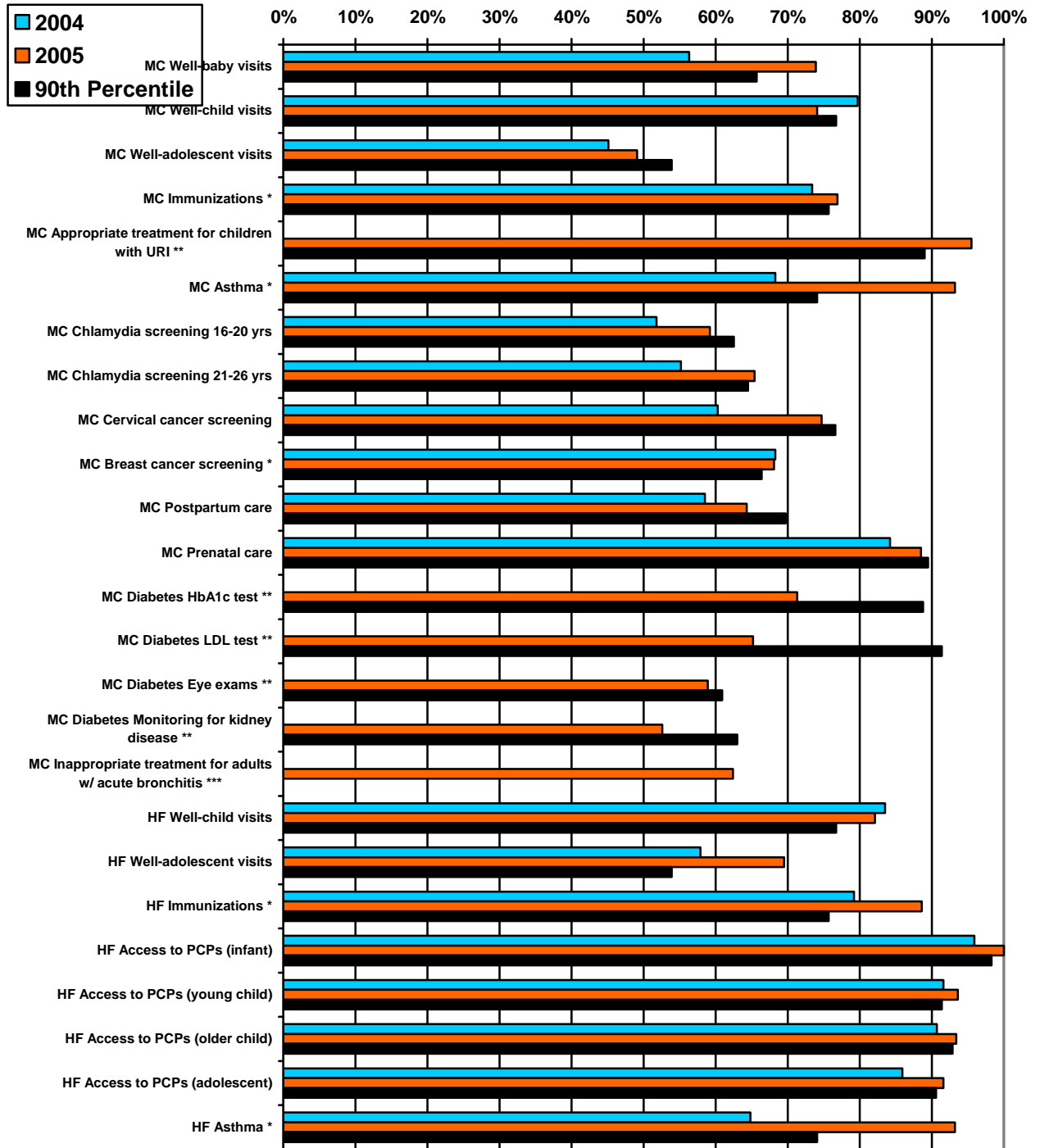
While we will continue to work on the long-established HEDIS rates measuring preventive care rates, our next challenge is improving care for our members with chronic conditions. We have already made a significant difference for our members with asthma. Over 90% of our members with asthma are receiving appropriate medications and we have helped several primary care sites implement procedures to take excellent care of their patients with asthma. We will continue to use our experience improving care for people with asthma to develop programs to improve care for people with other chronic conditions like diabetes. We are currently below the Medicaid 90<sup>th</sup> percentile in the diabetes HEDIS measures, which were reported for the first time in 2006:

**Comprehensive Diabetes Care Results**



On one measure, LDL screening, our score is in the bottom 25% of all Medicaid plans. As a result we were required to submit a corrective action plan to the State. A summary of our diabetes initiatives and development of our Chronic Care Team appears later in this report.

## 2005 SFHP HEDIS Results Compared to 2004 Results and National Medicaid 90<sup>th</sup> Percentile



\* Specifications for these measures changed between 2004 and 2005. It has not yet been determined whether comparisons of results between years or to established benchmarks (90<sup>th</sup> percentile) are valid.

\*\* New measure in 2005 for SFHP - no SFHP data available for 2004

\*\*\* New HEDIS measure - no national percentile data or SFHP data available for 2004

## **Targeted Quality Improvement Projects**

The improvements in our HEDIS scores were brought about by targeted quality improvement projects implemented by SFHP. The following is a summary of those projects, including an evaluation of our results and the challenges we faced.

### **Improving Well-Baby Visit Rates**

As part of the Local Initiative Rewarding Results (LIRR) collaborative, SFHP began a pilot provider incentive program to improve our well-baby visit rates towards the end of calendar year 2003. We offered three provider sites a financial incentive of \$150 for completing six well-baby visits by the child's 15-month birthday. In addition, we offered member outreach assistance to two other provider sites to help families make appointments for their baby's well-checks.

After implementing this intervention, our well-baby visit rate has fluctuated significantly. We saw a large initial improvement and then a substantial drop in the following year. Our goal was to bring our score back to what it was in 2004, and to eventually reach the national Medicaid 90<sup>th</sup> percentile. In 2006, we reached our goal and reported a score of 73.9%. We not only surpassed all of our previous rates, but scored well above the national Medicaid 90<sup>th</sup> percentile of 68.6%. Although we are pleased, we feel it is necessary to continue to refine and improve our interventions because we have not reported consistently high scores in this area.

#### ***Well-Baby Interventions***

- Well-Baby Provider Incentive Program, offering \$50 for four or five visits and \$150 for six visits by the child's 15-month birthday
- Monthly outreach lists mailed to providers
- SFHP outreach to children assigned to Children's Health Center and Family Health Center

#### ***New Interventions in 2006***

- Restructured Well-Baby Provider Incentive program rules, eliminating the incentive for four or five visits, and only offering the \$150 for six complete visits
- Redesigned monthly outreach provider lists to integrate well-baby and immunization outreach
- Began on-site monthly support visits at St. Luke's Pediatric Center
- Expanded appointment reminder outreach to all DPH clinics
- Redesigned well-baby visit reminder cards

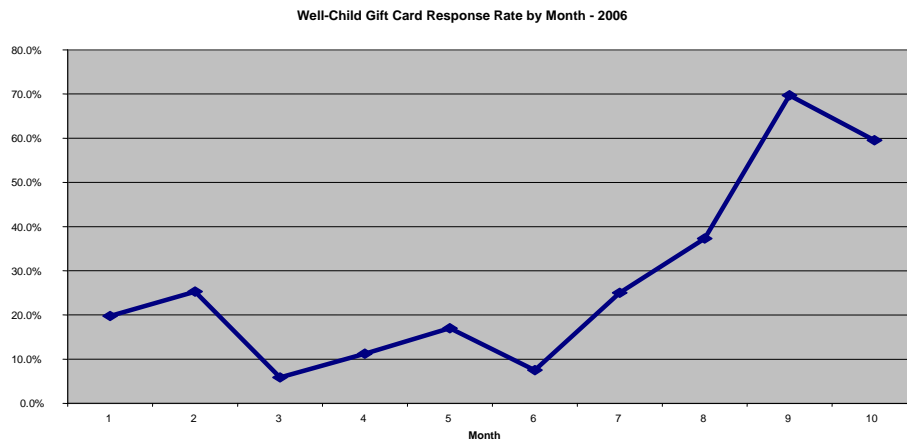
#### ***Plans for 2007***

The biggest challenge in improving well-baby visit rates is keeping provider sites engaged in doing outreach to members. Our plans for the coming year are to continue to use the Provider Incentive Program to encourage outreach to members who have not accessed care. In 2007, we will place an emphasis on outreach to African American

families with new infants. We found that African Americans have the lowest well-baby visit rates in our member population. The goal of our outreach will be to help families connect with Primary Care Practitioners and ensure that they have timely access to preventive care.

### **Improving Well-Child Visit Rates**

As reported, the well-child visit measure is the only measure SFHP's performance declined in for 2006. Toys R Us closed many of its Bay Area stores in 2005 and consequently the response rate for our incentive dropped significantly and our well-child rates dropped. To address this, we redesigned our incentive offer cards, increased the offer from \$15 to \$25, and offered gift cards at Target, Ross or Walgreens. In June 2006, we re-mailed this new offer to all parents and guardians who had not received Toys R Us gift cards since January, and then continued our monthly mailings. Our response rates increased sharply after the new card was released, and we hope to see a commensurate rise in our HEDIS rates when we report in June 2007. The graph below shows the response rate to our incentive program between January 2006 and October 2006.



One of the main barriers we encountered with well-child visit rates was communicating the SFHP periodicity schedule for well-checks to members and providers. In our visits to provider offices, we promoted our preventive health care guidelines, disseminated our periodicity charts and encouraged outreach to families with three to six year-olds who had not had a check-up in the last twelve months.

#### ***Well-Child Visit Interventions***

- Offered a \$15 gift card to Toys R Us member incentive for annual check-ups
- Conducted monthly phone blast following the mailing of the incentive offer

#### ***New Interventions in 2006***

- Redesigned the well-child incentive mailer, offering \$25 gift card to Target, Ross or Walgreens

- Distributed the *Recommended Periodicity for Pediatric Well-Checks* for posting at PCP offices
- Conducted two evenings of staff outreach calls in early November, encouraging families to make a well-check appointment before the end of the year

### ***Plans for 2007***

At this time, we plan to continue our current interventions. When rates are reported in June, we will closely analyze the results to see if there are further opportunities for improvement.

## **Improving Well-Adolescent Visit Rates**

Our well-adolescent visit rate improved for the seventh straight year. Our rate increased from 45.1% to 49.1%. We are still working towards the Medicaid 90<sup>th</sup> percentile at 54.5%. In order to reach the 90<sup>th</sup> percentile, we plan to refine our interventions to reach that goal.

### ***Well-Adolescent Interventions***

- Mailed teens an offer for two movie tickets for getting an annual check-up
- Called all members following the mailing of the incentive offer
- Conducted iPod raffle for all adolescents who were seen for an annual check-up
- Offered \$20 provider incentive for each teen visit, encouraging outreach and starting new teen clinics
- “Well-Adolescent Summer Campaign”
  - Worked with San Francisco middle and high schools to put up posters encouraging teens to go to the doctor for a check-up over the summer
  - Mailed flyers to teens at the end of the school year encouraging them to see their doctor over the summer
- Conducted special SFHP after-hours phone banks, calling members who were overdue for a well-check
- Worked to open an after-hours teen clinic and helped clinic staff call teens in for their annual check-ups

### ***Plans for 2007***

We received feedback from a few providers and members that movie tickets are not a compelling incentive to all teens. They suggested that some teens might find a gift card far more desirable than movie tickets. In 2007, we plan to make the following changes and additions to our interventions:

- Redesign birthday card and offer other incentives on suggestion from our providers and include a raffle
- Distribute well-check periodicity guidelines to PCP offices
- Implement monthly automated calls to teens encouraging them make an appointment for an annual check-up

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## **Statewide Collaborative to Improve Care for Teens**

*In 2006, SFHP continued our participation in a Statewide Adolescent Care Improvement Collaborative. The Collaborative aims to improve teen visit rates as measured by HEDIS, but also to improve the quality of health care delivered to teens. As a part of this project, adolescent champions from four of our clinics attended a California Department of Health Services (DHS) training. The training focused on confidentiality rules, how to discuss high-risk behavior, nutrition/physical activity counseling and mental health issues.*

*To measure the effect of the training, we asked teens assigned to the four clinics chosen for the project to fill out a survey. The surveys were administered at teen visits before and after the trainings. Each of the clinics received feedback from the surveys to help them with further improvement efforts.*

*SFHP also supported our providers caring for teens by making the following resources available:*

- *SFHP's Adolescent Behavioral Health Resources in San Francisco*
- *"Confidentiality" and "Youth Rights and Responsibilities" posters*
- *Dietician and obstetrician/family planning resources*
- *Multiple health education brochures on a variety of topics*
- *Help reorganizing patient flow for adolescents to allow private time with the provider*

*In 2007, SFHP will participate in Phase II of the Collaborative, spreading the training and resources to more clinics in our provider network.*

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## **Improving Childhood Immunization Rates**

Improving immunization rates was one of the first quality improvement projects SFHP engaged in and we have more than doubled our score on this measure since we first reported in 1999. Although we saw an increase in the HEDIS rate from 73.4% last year to 76.9% this year, it was not as much as we had hoped. New measure specifications should have resulted in a larger increase. We also did not reach the Medicaid 90<sup>th</sup> percentile, which is now at 82.7%.

### ***Immunization Interventions***

- Targeted outreach to members assigned to Family Health Center and Children's Health Center to remind them to get immunizations that were overdue

- Piloted a member incentive to a small group of members, offering a \$75 gift card to Target, Old Navy or Mervyns for members completing all immunizations on time
- Conducted automated monthly reminder phone calls to families of children turning one and two in the upcoming months
- Provided our PCPs with lists of members turning two in the upcoming year
- Made scheduling guides available for the new HEDIS criteria to front office staff at all pediatric primary care sites
- Performed a monthly chart-pull at St. Luke's Pediatric Center of those children turning 18 months, to identify children who are overdue for immunizations

#### ***New Interventions in 2006***

- Extended outreach to all DPH clinics in January 2006
- Extended pilot member incentive to all members
- Redesigned member incentive card in response to feedback from members
- Implemented monthly automated calls following the mailing of the incentive card
- Began sending a standard letter to families who submitted immunization records with missing shots listing the shots their child needs in order to qualify for the incentive

#### ***Plans for 2007***

- Continue to educate around new HEDIS immunization standards requiring four doses of Prevnar
- Reduce the dollar amount for the member incentive gift card
- Support the spread of the Bay Area Immunization Registry

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## **Spread of the Bay Area Immunization Registry**

*In the past few years SFHP has played a significant support role in the development and implementation of a citywide immunization registry. In 2006, of the 50,080 San Francisco children under the age of six, 10,096 or 23% were entered into the registry, up from 15% by the end of 2005. SFHP providers using the registry include:*

- *Mission Neighborhood Health Center*
- *North East Medical Services*
- *Valencia Health Services*

*Some of SFHP's largest pediatric provider sites announced plans to begin using the registry in 2007. Our goal is to support their efforts and work towards covering 100% of children in the immunization registry.*

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## **Improving Timeliness of Prenatal Care and Utilization of Women's Preventive Health Services**

SFHP's incentive program to promote timely prenatal care continues to demonstrate positive results. Our HEDIS rate for Medi-Cal climbed 4.3% from 2005 for a final rate of 88.5%. We are now only one percentage point away from the Medicaid 90<sup>th</sup> percentile.

The biggest challenge to improvement in this area continues to be the early identification of pregnant women. By the time we receive claims or pharmacy data indicating that a member may be pregnant, it is too late to intervene to make sure she has timely prenatal care. To address this barrier, we targeted our incentive promotional mailings and posters to all female members of childbearing age.

### ***Prenatal Care Interventions***

- Offered a \$50 gift card to members for a timely prenatal care visit
- Distributed posters and flyers to clinics and community organizations that encourage timely prenatal care and promote the incentive
- Mailed a flyer promoting the incentive to all new female members
- Mailed a flyer promoting the incentive to all female members twice per year
- Mailed a pregnancy health education book to all women who call SFHP and are pregnant

Our outreach efforts continue to make a difference. In 2006, we received 92 phone calls from pregnant women interested in participating in the program. Of these, 71 were eligible to receive both our free educational book and the \$50 gift card and 44 returned their coupon for a book and gift card, which translates into a 62% return rate.

### ***New for 2006***

In 2006, we decided to expand the mailing to include more women's health education material. Our mailer now includes information on mammograms, Pap smears, STD screenings and other preventive health care information for women, and is mailed to all women aged 15 and over.

### ***Plans for 2007***

In 2007, we will continue to expand our efforts to promote excellent health care for women. Our first step will be to implement a reminder system for women overdue for mammograms and Pap smears.

## **Improving Use of Controller Medications for People with Asthma**

SFHP's asthma disease management aims to improve asthma care and specifically to improve the use of appropriate medications for people with asthma. Unfortunately, changes in the HEDIS measure specifications for the use of appropriate medications for people with asthma made it impossible to compare results reported in 2005 to those

reported in 2006. A combination of our interventions and changes in the measure specifications helped our HEDIS rate to improve by more than 20 percentage points from 68.5% to 93.8%. SFHP's asthma HEDIS rate is better than most Medi-Cal plans and #1 among Local Initiative Health Plans. We attribute this success to several interventions:

### ***Asthma Interventions***

- Sent a packet to all PCPs with patients with asthma including:
  - a cover letter letting them know what percent of their patients with asthma were on controller medications,
  - a visit history and medication profile for each patient not on a controller medication
- Mailed letters to all of our members with asthma who did not have a fill for a controller medication, recommending that they talk to their doctor about a prescription for controller medication
- Called members with more than eight rescue medication fills and no controller medication, encouraging them to talk to their doctor about whether they may be a candidate for controller medications

One challenge we face with distributing data to our doctors in the asthma PCP packets is making sure that data on the patient profiles are accurate, timely and useful. We got feedback from PCPs that some of the profiles sent to them were for patients that they had not seen which occurs when members are defaulted to a PCP in our system. One way we addressed this problem in 2006 was by sending clinic medical directors a packet with patient profiles for all PCPs in their clinic and allowed them to distribute the profiles to the correct PCP.

### ***New Interventions for 2006***

- Grouped our PCP mailing by clinic and delivered a packet to each clinic medical director for their evaluation and distribution
- Included a clinic roster in each clinic packet of all the patients identified as having persistent asthma and whether they had a fill for a controller medication
- Mailed flu vaccination rosters in the fall and included an updated indication of whether the patient had yet received a controller medication in 2006
- Mailed asthma health education materials to ALL members with asthma regardless of controller status, including a flu shot reminder

### ***Plans for 2007***

- Mail provider packets again in Fall with updated patient profiles
- Discontinue entering LCR clinical alerts
- Cross-check PCP assignments with those in the clinic-specific medical record
- Revise the patient mailing to include more information about San Francisco asthma resources

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## Improving Asthma Care at the Practice Site

*In 2005, SFHP along with seven other California Medi-Cal health plans, entered into a quality improvement collaborative initiated by the State Department of Health Services to improve asthma care at the provider practice site. The goal of the collaborative, named Plan/Practice Improvement Project (PPIP), was to lead health plans and provider practices through the process of implementing the Chronic Care Model for asthma, and thereby reduce hospital and emergency room visits by half at participating practices. The PPIP also included a “spread” component where health plans were expected to spread the best ideas from the collaborative to other practices in their provider networks.*

*A unique collaboration developed when Blue Cross State Sponsored Business, our competitor, joined the collaborative and chose to focus on San Francisco. The environment for cooperating on this project with Blue Cross was not ideal because the State’s auto-assignment algorithm rewards us for outperforming Blue Cross on our quality scores, one of which is the asthma medication measure. We elected to put aside our competition to improve asthma care*

*Together, SFHP and Blue Cross issued a request for application to participate in the PPIP to all primary care sites. We accepted five practices and all five completed the collaborative:*

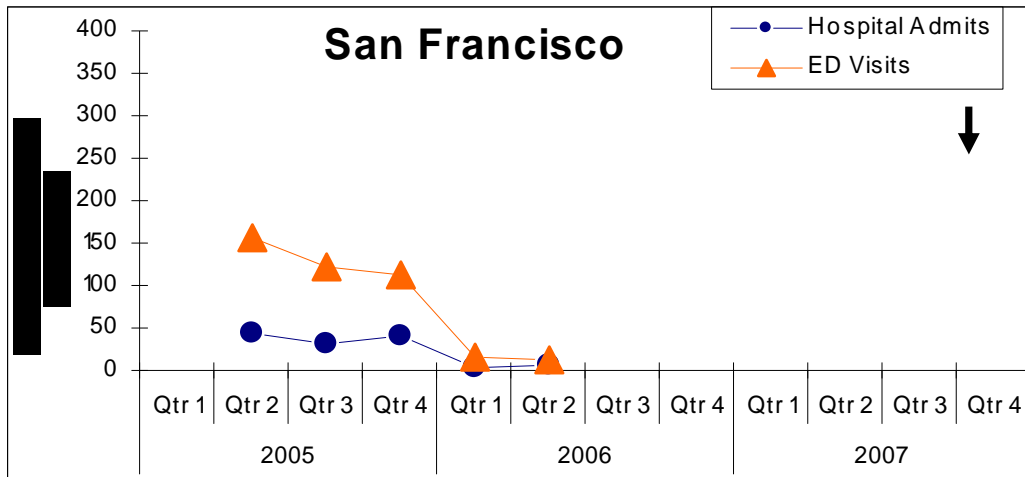
- *St. Luke’s Pediatrics*
- *UCSF Parnassus Pediatrics*
- *Family Health Center and SFGH*
- *South East Health Center*
- *North East Medical Services*

*They each participated in three Virtual Learning Sessions (VLS), led by the PPIP faculty. In the time between each VLS, the practices were expected to implement changes in clinic processes and monitor the effectiveness of those changes. In addition, they were expected to submit monthly reports and participate in monthly conference calls with practices from all over the State.*

*All five sites made significant changes in their practices and made progress toward reducing hospitalizations and emergency room visits. Below are some of their accomplishments:*

- After SFHP and Blue Cross provided each site with a laptop, printer, spirometer and spirometry training they began to perform severity assessments routinely at asthma visits.
- Three practices started using a registry.
- Three practices put a system in place to label all charts of patients with asthma.
- All practices sent at least one staff person to a San Francisco City and County sponsored program to train and certify asthma educators.
- After SFHP supplied practices with spacers in multiple sizes, clinicians began teaching patients how to use spacers at the asthma visit and making sure that patients went home with a spacer in the correct size.
- All practices started using structured encounter forms for asthma visits.
- All practices began systematically calling their patients with asthma to schedule focused asthma visits.

The data we reported to the collaborative on hospitalizations and ER visits appears to show that the PPIP made a big difference (see graph below). We questioned the validity of the data because the drop we saw was so dramatic; however, Blue Cross reported a similar drop in the exact same timeframe. We plan to continue monitoring both hospitalizations and ER visits to make sure that these statistics are not just temporary fluctuations.



Both Blue Cross and SFHP learned a great deal from the collaborative. We had many successes, but learned even more from our failures. The following are some of the lessons we drew from the collaborative:

- *Virtual learning sessions are not the most effective way of conducting a collaborative because faculty cannot interact with participants. To keep participants engaged, collaborative learning sessions should be in person.*
- *At a minimum, a basic disease registry must be in place before beginning a chronic disease collaborative otherwise tracking the effectiveness of changes is very difficult.*
- *Most practices need ongoing, in-person technical assistance to be successful in implementing and tracking changes.*
- *Reporting requirements for practice sites should be kept to a minimum.*

*Although the PPIP ended in October 2006, the health plan remains a resource to the five clinics who participated in the collaborative. We also hope to help spread the chronic care model for asthma to other clinics. We learned through the PPIP that with regard to improving chronic care, a health plan cannot make changes at the practice site, but we can support the physicians and clinic sites that want to make change.*

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## **Improving Diabetes Care**

In 2006, SFHP launched a diabetes disease management program to improve the quality of care and enhance the quality of life for our members with diabetes. Improving diabetes care became an increasing priority for SFHP in recent years. Our diabetes results show room for improvement. The percent of our members with diabetes who received their LDL screening was below the 25<sup>th</sup> percentile nationally. Also, the prevalence of diabetes among SFHP members has increased and now surpasses the number of members with asthma. In 2006, SFHP formed the Chronic Care Team, which sought to put processes in place to develop programs to improve chronic care. The diabetes disease management program was the first project of the Chronic Care Team.

Our approach to diabetes disease management is three-pronged and involves member, provider and health plan interventions. *Members* with diabetes need education and support to help them manage their disease. *Providers* need tools and information to help them manage their patients. And, finally, the *health plan* must develop systems to manage our diabetic population. The following summary shows what we accomplished in 2006 in these areas, including the lessons we learned and describes our plans for 2007.

### ***Improving Our Members' Ability to Manage Their Diabetes***

Education and self-management support are critical to helping patients manage their chronic disease. In 2006, we mailed a packet to members with diabetes. The packet included health education materials and a health record card to help keep track of the many exams and lab tests needed to monitor their diabetes. Using SFHP clinical and pharmacy data to stratify our members according to risk, we developed a tiered series of

interventions that promote appropriate self-care and provide educational resources to better manage their disease. The following will be implemented in 2007:

- **Tier 1:** quarterly reminders to all members with diabetes containing information about regular tests and screenings needed
- **Tier 2:** biannual “Live Your Life - Control Your Diabetes” mailing to all members classified as moderate and high-risk, offering a \$50 gift card incentive for completing the following tests/screenings: blood pressure, HbA1c, LDL, foot exam, eye exam, and microalbumin.
- **Tier 3:** for our high-risk members (beginning with two clinics) a nutrition or physical activity gift basket containing a variety of items to help support a healthy lifestyle including measuring cups and spoons, food scales, Weight Watchers or gym memberships, pedometers, exercise bands, etc. delivered upon completion of their required screening tests/exams as well as documentation of attendance at diabetic education classes and/or individual diabetic counseling appointments.

In addition to the mailings described above, our nurse case manager will call all members classified as moderate and high-risk. We started making these calls in 2006 and reached over 300 members. Our nurse case managers assisted patients with:

- Establishing a source of care
- Identifying sources for specialty referral
- Coordinating appointments for podiatry and ophthalmology
- Facilitating adherence to physician-directed medication and treatment plans
- Assessing need for additional learning (nutrition, health education classes)
- Assessing barriers to adherence, making appointments, etc.

Initial feedback showed that calls were well received by patients and appreciated by PCPs.

#### ***Giving Providers Tools and Information about Diabetes***

SFHP developed a comprehensive program to support and educate providers. We began by developing SFHP diabetes guidelines with guidance from our Physician Advisory Committee. In fall 2006, we distributed these guidelines to our PCPs along with standardized chart documentation forms and a diabetic patient teaching checklist. Following that mailing, we provided PCPs with a list of their diabetic members noting those who had not had a HbA1C, an LDL, a retinal exam or a urine exam for microalbumin during 2006 according to our data.

Our QI Nurse Manager followed up the mailings with visits to 15 provider sites. The sites were chosen because their members were stratified as high or moderate-risk and appeared not to have received their recommended screening tests and exams. The objective of these visits was to review member lists and previously mailed packet materials, to evaluate barriers to care, and to discuss ways in which SFHP might assist the provider to care for patients with diabetes. Additionally, through chart review the QI Nurse was able

to show clinic office staff which patients still needed to be called in for specific diabetes screening tests in 2006.

Briefly, the provider visits revealed the following opportunities for improvement:

- Our data is sometimes incomplete resulting in physicians being skeptical of its validity. Providers appreciate a simple list of their patients with diabetes. We should note where we have data showing completed diabetes screenings but refrain from penalizing providers if we do not have evidence that a test was completed.
- We found that reviewing charts at provider sites is an extremely valuable teaching tool. Providers discover a great deal about their patients and practice patterns that are often difficult to see in the midst of day-to-day practice. We also find members for case management.
- Many providers expressed difficulty accessing ophthalmology services for their patients. We helped them find providers through our vision service provider that were open to seeing Medi-Cal patients.
- Providers were having difficulty getting written consultation reports from ophthalmologists and/or optometrists. We offered referral-tracking forms to assist physicians in following up on eye exams.
- The majority of providers visited did not use standardized diabetic flow sheets but agreed to “give them a try.”
- Many providers seemed to send their patients for lab tests in a rather random fashion, which resulted in patients missing screenings that should occur annually. Most agreed that at least once a year, preferably at the start of the year, they would send each patient for *all* of the recommended screening tests at once.
- Examples of opportunities to improve microalbumin screening through provider education were:
  - one physician did not understand the importance of microalbumin testing in caring for patients with diabetes
  - one physician who was checking the wrong box on the lab slip for microalbumin
  - one physician who admitted to always forgetting to order the microalbumin

### ***Creating System Changes***

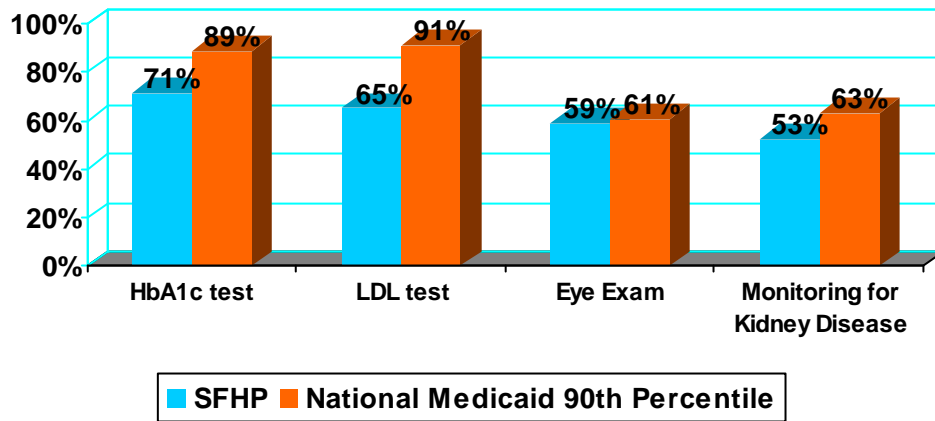
We used what we learned in developing our member and provider interventions to make system changes that facilitate better diabetes care. In 2006 we accomplished the following:

- We created a system to identify our members with diabetes, stratify them into three risk groups, and identify the screenings they had received. In 2007, reports will be run quarterly to facilitate our member and provider outreach efforts described above.
- SFHP actively encouraged providers to adopt chronic disease registries and has plans for 2007 to support the DPH in its implementation.

- SFHP called every provider on the VSP list to determine who took SFHP members. This revised list was then sent to all PCPs.

Measuring the success of such a multifaceted program will be difficult. At a minimum, we will continue to monitor the four diabetes HEDIS indicators we currently report to the State. As the graph below shows, we have opportunities for improvement in the monitoring for nephropathy and eye exam measures. Our LDL and HbA1c scores demonstrate an even greater need for improvement, although we know there were data collection problems that should be corrected in 2007. In addition to monitoring our HEDIS rates, we will continue to document feedback from member outreach and provider visits.

### Comprehensive Diabetes Care Results



## II. Providing Excellent Member Services

One of SFHP’s core values is to provide our members with extraordinary customer service. Our Member Services Department helps members understand and take full advantage of their health plan benefits. Members can contact SFHP Member Services by phone, fax, TDD/TTY, email, mail or in person. By contacting us, members find assistance with ID cards, changing primary care providers, understanding benefits, medical bills, registering grievances, accessing providers, as well as with enrollment and disenrollment and many other issues. We represent a safety net for any member who needs assistance.

### Providing Excellent Telephone Services

By far, our members find the phone to be the easiest way to reach us. That is why we are committed to ensuring we provide excellent customer service over the phone. We monitor our performance in several ways and implemented new processes to improve our performance in 2006. The following is a summary of our work.

We received 52,581 member-related calls through our telephone automated distribution system in 2006. Highlights include:

- Our 2006 abandonment rate was an average of 1.9%, well below our 5% benchmark and 39% lower than 2005's rate.
- We answered 90.2% of calls within 30 seconds and reached our 90% benchmark.
- Bilingual and bicultural member services representatives provided telephone service in English, Cantonese, Mandarin, Spanish, Vietnamese and Burmese.

### ***Telephone Service Satisfaction***

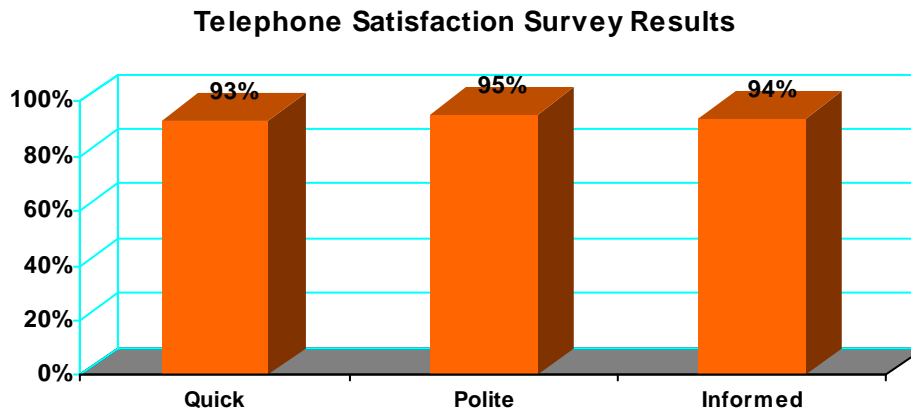
SFHP Member Services Department conducted its fifth annual Telephone Satisfaction Survey in the last quarter of 2006. The purpose of this survey was to assess the level of members' satisfaction with the services provided by our Member Services Department and improve our services based on their feedback.

Members responded to the following statements regarding their recent interactions with SFHP Member Services with a 'Yes', 'No', or 'Not Sure':

- My call was answered quickly.
- I received polite service.
- I received the information that I needed.

Over approximately two and a half months, we sent 3,865 survey cards to all members who had contacted Member Services by phone. We received 701 cards back, which was far more than the number of responses we collected in 2005.

The results were very consistent with those obtained in previous years. The positive responses of our members, displayed below, indicated that they were highly satisfied with the services they received from the staff in Member Services.



### ***Improved Call Tracking and One-Call Resolution***

Although the Member Services Department reached all of its telephone service performance goals, we found opportunities for further improvement in service. One was

in the area of categorizing reasons for incoming calls. The existing call-reason categories were not providing sufficient, actionable data. In October 2006, we revamped our call-reason categories to collect better data. The Member Services Department Manager will use the data to make decisions about call routing, staffing, and training to ensure our callers' needs are met in the best way possible.

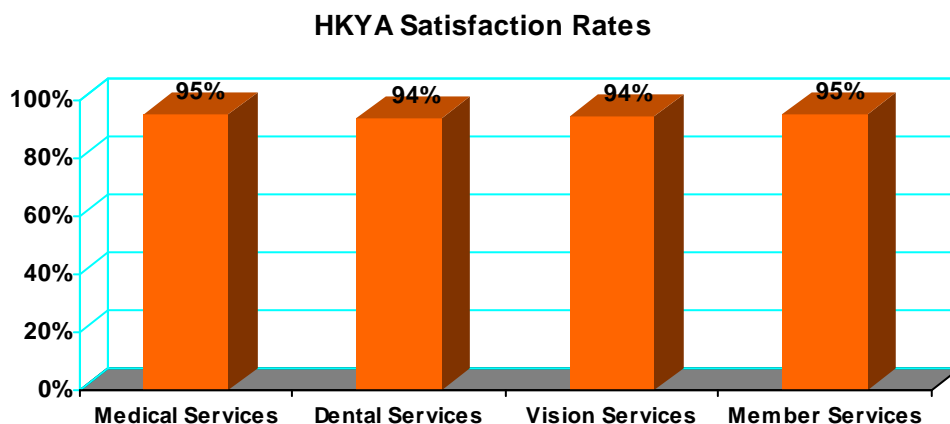
In addition to collecting better data on incoming calls, the Member Services Department also implemented a one-call resolution project. We found that many incoming calls required a call back or a transfer before the caller's concern could be resolved. Having the tools and training to address a caller's concern in one phone call improves both health plan efficiency and caller satisfaction. We streamlined processes and created shared data files between departments so that members could get answers and assistance with only one phone call.

## Ensuring Member Satisfaction

Member satisfaction surveys are one way we monitor members experience with SFHP and with our health care delivery system. For the Healthy Families and Medi-Cal lines of business, we participate in a State-sponsored member satisfaction survey using the CAHPS survey tool. The surveys are administered by an external vendor every two years for Medi-Cal and annually for Healthy Families. For the Healthy Kids & Young Adults (HKYA), we administered our own survey tool annually. The results from the HKYA survey and the Healthy Families CAHPS survey are summarized below. The biannual results for the next Medi-Cal survey will be included in the 2007 QI Annual Evaluation.

### *Healthy Kids & Young Adults Satisfaction Survey*

Since the inception of the program, satisfaction rates with the HKYA program have been very high and 2006 was no exception. We asked our members if they had accessed services in four areas and then asked if they were satisfied with their experience. Members were asked to respond "yes" or "no". The satisfaction results are displayed below:



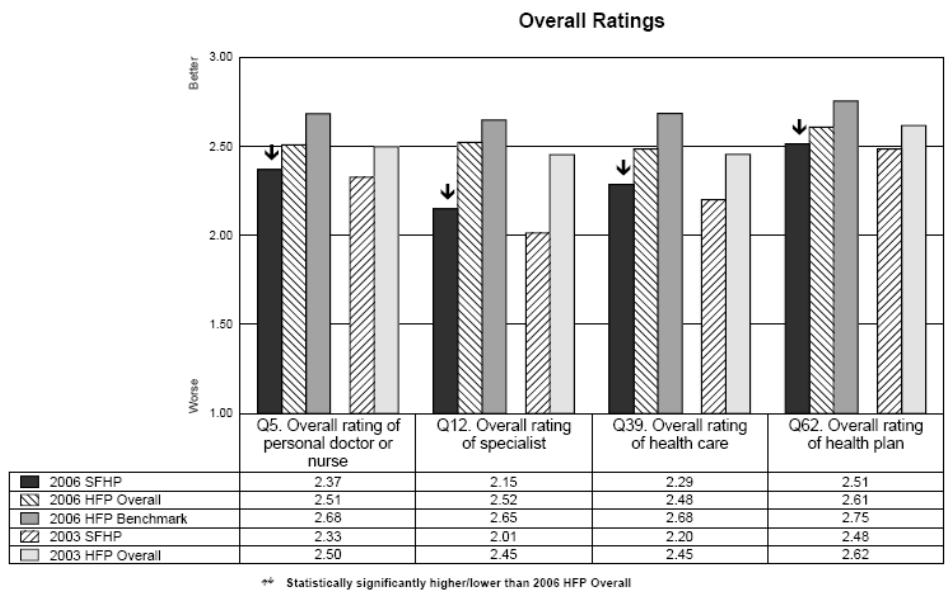
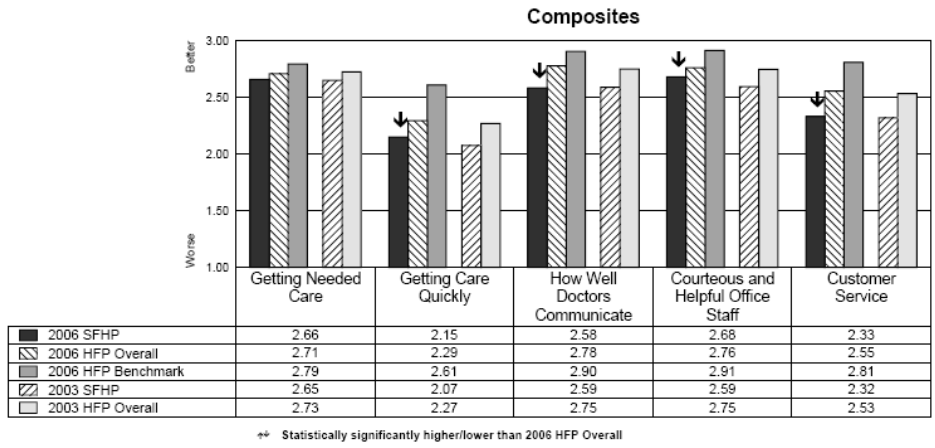
The survey also included questions about members' access to providers who speak their language. We found that language concordance is very high in the HKYA program. When asked if their PCP speaks their language:

- 97.1% of Chinese-speaking members said yes
- 97.4% of Spanish-speaking members said yes

Members who speak English and all other non-English languages were surveyed in English. Of that group, 83.4% responded that their PCP speaks their language.

**CAHPS Results for Healthy Families**

Since 2002, MRMIB, the State agency administering Healthy Families has surveyed enrollees using the CAHPS survey tool and reported results to the Healthy Families participating health plans. The 2006 annual reports show that SFHP performs below the statewide average on the Overall and Composite Scores.



Every year we look for information to help us understand these results. We reviewed our grievance reports, utilization reports, HEDIS results and access reports to find out more about our Healthy Families members experience. To date, we have not found any information that supports the poor performance reported on the CAHPS survey. Our own research led us to question the validity of the CAHPS instrument. SFHP is the only health plan with a predominantly Chinese-speaking membership and that the Chinese version of the CAHPS survey has not been field-tested. There may be significant differences in the way Chinese-speaking respondents score their answers on the CAHPS survey. We suspect that our results may have been impacted by those differences and requested that the State study the bias in the survey instrument.

## Monitoring Member Grievances

SFHP monitors grievances on a quarterly basis to identify trends and problems. Monitoring grievances is an excellent way to identify problems early and address them. Tracking grievances over time allows the plan to identify systematic problems in our service to our members and put appropriate solutions into place.

In addition to tracking and trending our grievances, we also monitor the way we handle grievances for timeliness and regulatory compliance. Our goal is to meet DMHC standards for responding to and resolving grievances.

- **154** member grievances were processed by SFHP, Kaiser, VSP, and Delta Dental.
- **10%** of grievances (**11** grievances) handled by SFHP were resolved by the next business day and were exempt from state regulations regarding acknowledgement letters.
- **100%** of non-exempt grievances met state regulatory requirements for timeliness of acknowledgement letters sent within 5 days and resolution letters sent within 30 days.

### *Tracking and Trending Grievances*

The 2006 grievance statistics showed very little change from previous years. We received a normal volume of grievances compared to previous years. There was little change in the number of grievances reported by line of business, medical group or grievance category.

- The **Lines of Business** as ranked by *grievances per thousand members (G/1KM)*:

○ Healthy Kids & Young Adults	2.8G/1KM
○ Healthy Workers	2.9 G/1KM
○ Medi-Cal	2.7 G/1KM
○ Healthy Families	1.5 G/1KM
- The **Medical Groups** as ranked by *grievances per thousand members (G/1KM)*:

- Kaiser Permanente (KSR) 10.4 G/1KM
- Physicians Integrated Medical Group (PIMG) 3.4 G/1KM
- Chinese Community Health Care Association (CCHCA) 1.8 G/1KM
- Community Health Network (CHN) 2.0 G/1KM
- University of California San Francisco (UCSF) 5.7 G/1KM
- North East Medical Services (NEMS) 0.9 G/1KM

- Grievances handled by SFHP by grievance category

<b>CATEGORY</b>	<b>Grievances</b>	<b>% of total</b>
Denials/Refusals	35	32%
Access	21	19%
Enrollment	20	18%
Quality of Service	10	9%
Billing	9	8%
Pharmacy	6	5%
Benefit/Coverage	4	4%
Quality of Medical Care	3	3%
Cultural/Linguistic	2	2%
<b>TOTAL</b>	<b>110</b>	<b>100%</b>

***Important Findings for 2006***

- We were pleased to see that the number of grievances in the quality of care and access to care categories decreased.
- In 2005, we reported that one of our medical groups, PIMG, had a much higher than average number of denial/refusal grievances. We brought this issue to PIMG administrative staff and worked with them to improve process for reviewing requests for authorization. The number of grievances in the denials/refusals category decreased for PIMG even while it increased for SFHP overall.
- In 2006, the proportion grievances in the enrollment/eligibility category increased. These are primarily related to annual eligibility reviews for Healthy Kids & Young Adults members. The Enrollment and Eligibility Department put several new processes into place that will improve members experience when reenrolling.

**III. Ensuring Excellence in Our Provider Network**

The Provider Relations Department focused on creating strong provider health plan partnerships to support our goal to improve quality of care and access to care. In addition to quarterly Joint Administrative Meetings (JAMs) conducted with the medical group administrative staff, staff met with the clinical and administrative staff in our doctors offices to strengthen our collaboration on quality activities and to access to health care.

## Provider Outreach Activities

In 2006, SFHP staff visited every site with more than 100 members and many of those with less than 100 members. Our goals in conducting these visits are to provide information, technical assistance and training to provider office staff. We gave providers feedback on their HEDIS results and in many cases helped them think of ways to improve. We also made visits in conjunction with the Chronic Care Team to 15 high-volume providers to help identify methods for improving care of our diabetic members. These visits provided SFHP staff with an invaluable opportunity to assess internal procedures in the clinic/office and to work directly with the providers on care improvement strategies.

## Provider Satisfaction Survey

Annually, SFHP conducts a Provider Satisfaction Survey to gather information about network providers' issues and concerns in working with SFHP and our members. This year, the survey was redesigned to tailor questions to each medical group and to capture and eliminate questions that may not yield actionable feedback. The response rate improved over last year, because the questions asked were more relevant and because of the closer relationship we now have with our providers.

Eighty-two of SFHP's network of 274 PCPs<sup>1</sup> and clinics returned surveys. The response rate of 29.8% is higher than that of the 2005 survey (18%). No surveys were returned due to incorrect mailing addresses, reflective of the increased accuracy of our provider contact information. We excluded Kaiser and UCSF from the survey because physicians in those two groups do not have as much interaction or awareness of SFHP. We plan to conduct focus groups with UCSF physicians in 2007. After excluding UCSF and Kaiser, our survey covered providers serving 85.8% of our members. Below are response rates by medical group

<b>Medical Group</b>	<b># of Responses</b>	<b># of PCPs for MG</b>	<b>% of Response for MG</b>
Chinese Community Health Care Association (CCHCA)	18	45	40.0%
Community Health Network (CHN)	35	122	28.6%
North East Medical Services (NEMS)	10	29	34.5%
Physicians Integrated Medical Group (PIMG)	12	55	21.8%

<sup>1</sup> The SFHP provider database (A3) reports more than 251 PCPs because primary care practice sites are counted as a provider, several PCPs practice at multiple sites, and duplicate records are automatically generated for select number of providers. For the purposes of this survey, the response rate was calculated against the actual number of individually distinct providers in the SFHP network.

Overall, providers are very satisfied with both their medical groups and with SFHP, with a few notable exceptions. The following is a summary of our key findings:

- CHN providers are concerned with access to specialists and diagnostic services, commenting on long wait-times for appointments and consultations.
- CHN providers are less satisfied than they were last year with the clarity and ease of SFHP's process for utilization management authorizations.
- Every year we receive some negative feedback on our formulary. In addition, this year we saw that a clear opportunity for improvement in our pharmacy denial appeal resolution process. Only 44% of all providers find that process easy to use.
- Our providers are highly satisfied with the courtesy and accuracy of the information supplied by our Member Services and Provider Relations Departments.
- Providers report that if they use our website, they use it primarily to check eligibility; however, they expressed interest in accessing community resources, clinical guidelines, and related patient education materials such as from our provider website. Consequently, SFHP is upgrading the provider site to provide a much richer content for to make it a vital communication and education tool.
- CCHCA providers responded that they are satisfied with the management of claims payment. (The start of the survey period marks a full year from when SFHP transferred responsibility for claims payment to CCHCA.)

## **Provider Network Access Monitoring**

SFHP closely monitors the adequacy of our provider network to ensure that our members have access to the care they need in a timely manner. We measure network access in a variety of ways to capture different aspects of network access including language capacity, wait times, availability of specialists in key areas, and PCP availability.

### ***Access to Primary Care Providers***

In 2006, as in previous years, there was very little change in the size and make-up of our primary care provider network. Our stable network of PCPs is more than adequate to care for our 52,000 members. Regulatory requirements set forth in our Knox Keene license guide our accessibility standards. State regulations require that a primary care physician panel should be no more than 2000 patients. While our ratio of members to PCPs falls well within those standards, we cannot accurately measure panel size because our PCPs see patients from several different payors as well as care for the uninsured. Below is a table that shows our PCP and member counts for 2006:

<b>Medical Group</b>	<b>#Members &lt; age 18</b>	<b># PCPs caring for children</b>	<b># Members &gt; age 18</b>	<b># PCPs caring for adults</b>
<b>CCHCA</b>	<b>3,903</b>	<b>23</b>	<b>3,346</b>	<b>39</b>
<b>UCSF</b>	<b>2,482</b>	<b>138</b>	<b>2,127</b>	<b>204</b>
<b>NEMS</b>	<b>5,086</b>	<b>32</b>	<b>4,359</b>	<b>35</b>
<b>PIMG</b>	<b>2,912</b>	<b>39</b>	<b>2,496</b>	<b>23</b>
<b>CHN</b>	<b>12,262</b>	<b>23</b>	<b>10,509</b>	<b>39</b>
<b>Total</b>	<b>28,085*</b>		<b>24,072*</b> <b>*includes KSR</b>	

***Access to Specialists***

We regularly monitor the number of physicians in our network in specialty areas that our members access the most. In San Francisco, UCSF provides the bulk of specialty care even for those members who are assigned to other medical groups. The table below shows that each of our medical groups has specialists in all of the key areas.

	<b>CCHCA</b>	<b>UCSF</b>	<b>NEMS</b>	<b>PIMG</b>	<b>CHN</b>
<b>Obstetrics &amp; Gynecology</b>	18	55	13	23	57
<b>Cardiology</b>	10	27	1	7	6
<b>Endocrinology</b>	3	12	1	2	7
<b>Gastroenterology</b>	10	15	6	3	4
<b>Radiology</b>	5	78	1	2	17
<b>Pulmonary</b>	5	17	4	5	7
<b>Ophthalmology</b>	9	79	14	15	7

***PCP Language Concordance***

SFHP works to ensure that our members have access to primary care providers that speak their language or have access to interpreter services. We monitor the number of PCPs who speak Chinese, Spanish, Vietnamese and Russian because they are the most common non-English languages spoken by our members. Members are encouraged to choose a PCP when they enroll, but if they do not choose a PCP, our systems help ensure that they are assigned to a PCP that speaks their language. The table below shows that the SFHP provider network has PCPs who speak each of the predominant languages:

<b>Medical Group</b>	<b># Chinese speaking PCPs</b>	<b># Spanish speaking PCPs</b>	<b># Vietnamese speaking PCPs</b>	<b># Russian speaking PCPs</b>
<b>CCHCA</b>	<b>39</b>	<b>3</b>	<b>3</b>	<b>0</b>
<b>UCSF</b>	<b>5</b>	<b>17</b>	<b>1</b>	<b>0</b>
<b>NEMS</b>	<b>35</b>	<b>2</b>	<b>3</b>	<b>2</b>
<b>PIMG</b>	<b>5</b>	<b>38</b>	<b>1</b>	<b>4</b>
<b>CHN</b>	<b>13</b>	<b>79</b>	<b>8</b>	<b>1</b>
<b>Totals</b>	<b>113</b>	<b>139</b>	<b>15</b>	<b>7</b>

***Wait Times for Key Specialty Areas at SFGH***

In 2006 we began collecting data from our DPH clinics about wait times for appointments for specialty consults and diagnostic testing as a method of measuring access for CHN members. Each month data was collected through a telephone survey of specialty clinics and diagnostic testing centers for CHN. As a result of the increased focus on extensive wait times for specialty care, SFHP is funding an expansion of the eReferral system which is anticipated to significantly decrease wait times for specialty appointments, diagnostic testing, and specialty interventions.

**eReferral Spread Project**

In 2006, the SFHP Governing Board requested a proposal that specifically targeted improving access to specialists. With this mandate, we investigated the positive outcomes that had been generated by an electronic consult and triage system, eReferral, that, when piloted at SFGH’s GI Clinic, successfully reduced appointment wait-times from 11 months to 3.5 months.

In September, the SFHP Governing Board approved a grant to “spread” the eReferral electronic referral system to four more SFGH specialty clinics (Cardiology, Pulmonary, Endocrine and Renal) with the goal of eventual replication in multiple SFGH specialty clinics. The grant also funds an evaluation of the eReferral approach to improving access to specialty care.

**Disability Access Project (PATH)**

SFHP has partnered with the Disability Rights and Education Defense Fund (DREDF) to assess and enhance our provider network’s capacity to serve members with disabilities. Our goal is to identify a network of primary care, specialty and ancillary services for

members with disabilities and functional limitations. “Providing Access to Healthcare,” or “PATH,” is the name chosen for this project, as it embodies the vision of a network in which members with a disability are able to navigate easily through the health care system. The three phases of the PATH project are described below.

*Phase I of PATH Completed in 2006:*

SFHP Provider Relations Department worked with DREDF to develop and administer a pilot survey tool to assess the architectural and programmatic capabilities of our provider offices. The survey revealed that there is adequate, if not fully compliant, access to buildings and within most offices. However, specialized equipment, such as adjustable exam tables, wheelchair accessible scales, and TTY/TDD machines are not commonly available. Additionally, though providers and their staff are eager to provide whatever services are needed in the most equitable way possible, there is a lack of awareness of how to get necessary resources, how to identify accessible specialists, and how to get the necessary training to improve staff’s ability to provide services for members with disabilities.

*Phase II of PATH:*

The goals of Phase II are to identify the necessary components of a fully accessible network and to begin to build a clearly defined path for members to access primary care, specialty and diagnostic services. This phase also involves mapping access to current specialist/diagnostic/ancillary services, pricing costs for equipment and training, and identifying funding for future activities.

*Phase III of PATH:*

The final phase of this project is estimated to begin in mid-2007. Our goals are to:

- Make resources available to providers to close the identified service gaps, including support for purchasing equipment
- Develop and provide training for providers to improve programmatic access
- Develop and implement a member and provider education plan to create a knowledgeable and skilled network able to serve all members with disabilities

## **Access Enhancement Fund**

In 2003, SFHP launched an Access Enhancement Fund by asking providers to propose strategies for improvement that they thought would be both achievable in their practices and meaningful to their patients. Using a competitive application process, the SFHP Governing Board funded ten Access Enhancement Fund (AEF) projects (see below), using \$800,000 from a lawsuit settled with the State of California.

1. UCSF/SFGH Children's Health Center for weekend & evening appointments
2. SFGH Dept. of Ophthalmology for equipment for a mobile program to provide eye services at community health centers
3. SFGH Asthma Clinic to hire a practitioner to make more appointments available

4. San Francisco General Hospital for equipment to expand their urgent care center
5. Ocean Park Health Center to implement the Chronic Care Model for its patients with diabetes
6. Los Portales Family Medical Center for a Spanish-speaking physician assistant to increase appointments for monolingual Spanish speakers
7. North East Medical Services (NEMS) for a new telephone system that will make it easier for members to reach their physicians, and will include a nurse advice line
8. Sunset Health Services for a nurse to provide telephone advice and same-day appointments
9. San Francisco Hearing & Speech Center for a bi-lingual speech therapist to assist Spanish-speaking children
10. Valencia Health Services for a nurse to provide telephone advice and triage demand for urgent and same-day appointments

In 2006, SFHP undertook an evaluation of each of these projects. Though the ten AEF-funded projects differed widely, the evaluation demonstrated a notable and positive impact on access to care for SFHP members and other patients served by the participating providers. They also provide instructive lessons for future initiatives.

Through expanded clinic hours, the addition of providers, and unique staffing models, seven grantees reported an increase in the number of appointments and visits they were able to offer patients. Four of these grantees increased access to specialty visits, two increased access to primary care, and one expanded urgent care services.

Four grantees also reported that the AEF grant led to improved medical practices and/or administrative operations that contributed to better quality of care and service. Successful strategies included the use of a telephone advice nurse, implementation of the Chronic Care Model, providing mobile ophthalmology services, and installing a telecommunications system. Four AEF projects also explicitly increased linguistic access for non-English speaking patients, primarily through the addition of bilingual providers.

A significant challenge for grant-funded projects is sustaining funded services after the expiration of initial funding. Our evaluation found that nine of ten grant-funded services will be sustained beyond the term of the grant, and in most cases resulting in a permanent expansion of medical services.

## **IV. Expanding Health Care Access in San Francisco to New populations**

### **Healthy San Francisco (HSF): Coverage for the Uninsured**

SFHP and the City of San Francisco Department of Public Health (DPH) have worked together to incrementally expand insurance coverage to the City's uninsured by creating the Healthy Kids & Young Adults and the Healthy Workers programs. In 2006, the City and SFHP turned to address the needs of the estimated 82,000 San Francisco residents who remain uninsured. The initiative that emerged is HSF, a program that for the first time expands coverage outside of an insurance-based model.

In June 2006, the San Francisco Board of Supervisors passed and Mayor Gavin Newsom signed the Health Care Security Ordinance. The ordinance created two new programs to address the needs of the uninsured: HSF and an employer spending requirement. The spending requirement provides a mechanism for medium and large employers to contribute toward the health care coverage of their uninsured employees.

When fully implemented, HSF will be the City's new safety-net program. It will offer the uninsured access to comprehensive health care services for income-based fees. Participants will have new access to primary and preventive care, as well as increased protection from the catastrophic costs of illness. Since August, HSF has been actively under construction, and is slated to launch in July 2007.

### **Options for Covering Taxi Drivers**

In response to requests from the San Francisco Board of Supervisors and the City Controller, SFHP and the San Francisco Department of Public Health undertook a detailed study to determine the cost of providing health insurance to taxi drivers, and to develop models for financing the coverage. The report, "Establishing a San Francisco Taxi Driver Health Plan: Plan Administration, Cost and Funding Options," was published in March 2006 and presented to the San Francisco Taxi Commission and other stakeholders. The report demonstrates how taxi drivers could get health insurance, if the various stakeholders in the taxi industry are each willing to contribute a part of the funds needed. Subsequent to the report's publication, the Taxi Commission formed a health care subcommittee to review options for coverage and make a final recommendation for how to provide for taxi drivers' health care.

## **V. Medical Management**

### **Utilization Management**

SFHP and its medical groups work under a Utilization Management Program and set of policies that assure that effective and appropriate health care services are delivered to our members based on sound clinical principles. Under our QI Program, we monitor under and over-utilization, and continuity and coordination of care. We comply with strict standards for issuing denials and responding to appeals to assure member rights are protected. Quality of care is monitored, and our Peer Review Committee addresses instances of poor quality. In 2006 our efforts included:

- Development of a report to monitor out-of-network costs utilization for CHN, UCSF and St. Luke's
- Development of new hospital and emergency room utilization monitoring reports from the SFHP Data Warehouse
- Quarterly auditing of pharmacy and UM Notice of Action letters assuring compliance with regulatory standards
- Writing new and revised policies to comply with DHS audit findings of December 2005
- Auditing of UM functions of delegated medical groups with corrective action plan submitted and accepted by SFHP

The new utilization reports from the Data Warehouse allow the Medical Management department to easily monitor hospitalization and emergency room visit rates for our members. The data shows variation between medical groups and lines of business on admissions, bed days, average length of stay and emergency room visit rates. Most of the variation is normal given the demographic characteristics of the population sub-groups. However, we saw significantly higher emergency room visit rates in our Medi-Cal line of business and in the PIMG medical group. We plan to use this data along with data from our 2006 Medi-Cal Health Education, Cultural and Linguistic Group Needs Assessment to develop programs to reduce unnecessary emergency room visits.

### **Coordination of Care with Community and Waiver Programs**

SFHP members who need specialty care are referred by their primary care practitioners to specialists, or may receive services from many agencies with which SFHP has memorandums of understanding. These include community programs like California Children's Services (CCS), Golden Gate Regional Center (GGRC), Early Start (ES), Women, Infants and Children (WIC), and Tuberculosis-Direct Observed Therapy (TB-DOT). SFHP members also are eligible for services from federal waiver programs such as the AIDS Waiver Program, the Multipurpose Senior Services Program, and Home and Community Based Services for the Developmentally Disabled. SFHP informs our members and practitioners about these services and how to access them. In addition,

SFHP is responsible for assuring that there is appropriate coordination of care when PCPs make referrals.

- We worked with PCPs and specialists to help refer children to CCS services. We worked closely with CCS to maintain a common member list of SFHP members and to send monthly lists to providers and medical groups who request them.
- We worked with Golden Gate Regional Center to implement a common list of members and to provide the list to our providers.
- SFHP updated and published a Community Resource Guide with descriptions and contact information for the community and waiver programs to assist provider with member referrals. The guide was distributed through provider site visits, Joint Administrative Meetings with our medical groups and facility site/medical record review visits throughout 2006 and is also posted on our website.

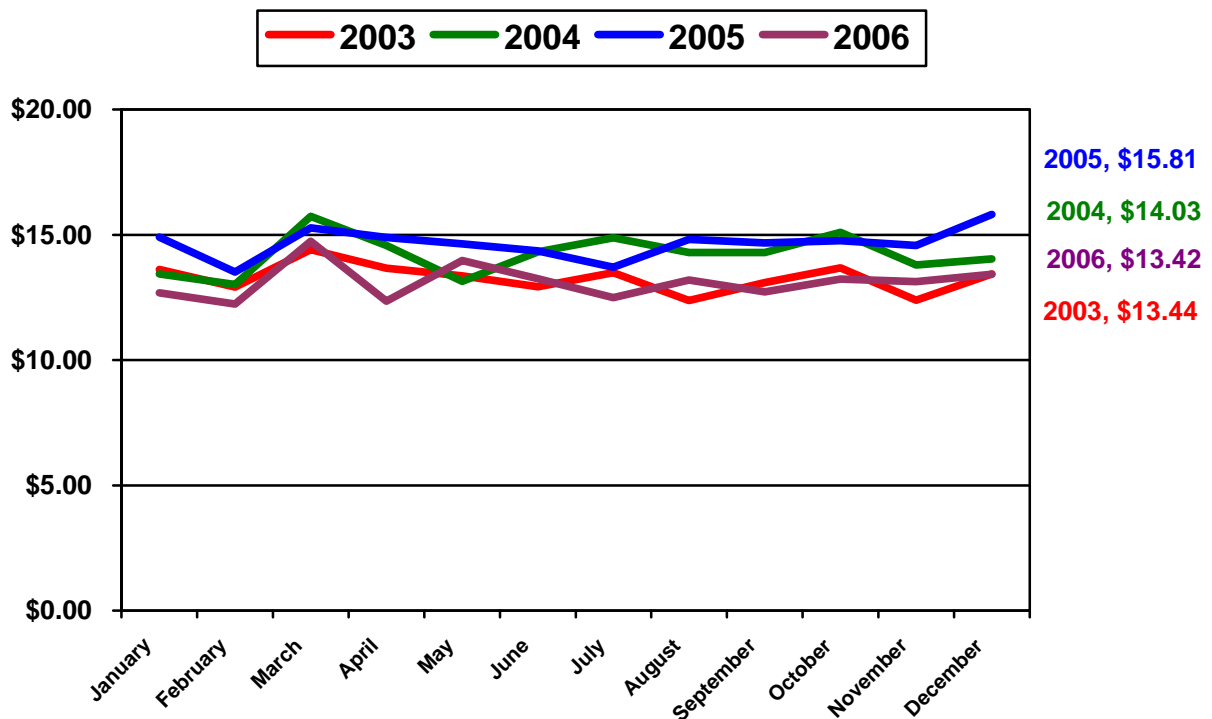
## **Management of Members with Chronic Conditions**

Members with chronic diseases are getting new level of assistance from SFHP. SFHP formed a Chronic Care Team (CCT) to develop programs to better manage our members with chronic illnesses. The CCT's efforts are guided by our Physician Advisory Committee who gives us input on diseases to address and strategies to improve care. The first program launched by the CCT aimed to improve care and quality of life for our members with diabetes. The interdisciplinary Chronic Care Team worked on developing member and provider materials, identifying barriers to care, and developing strategies to improve care. Our goal is to assist members and providers to optimally manage their disease.

## **Improving Pharmacy Services**

SFHP assures the quality of its pharmacy services by offering a generous formulary and maintaining a solid relationship with our pharmacy providers. Our pharmacy services and formulary are constantly reviewed and updated by our Pharmacy and Therapeutics Committee, a sub-committee of our Quality Improvement Committee. We monitor pharmacy usage monthly through cost and utilization reports. The trend for pharmacy cost per member per month (PMPM) decreased overall in 2006, because the members who are eligible for both Medicare and Medi-Cal started receiving the majority of their pharmacy benefit through Medicare.

*Pharmacy Cost per Member per Month (PMPM) for all Lines of Business (LOB)*



SFHP manages pharmacy costs through our generic-preferred formulary and prior authorization process. In 2006, over 80% of prescriptions were filled with generic medications and the average cost per prescription was \$11.87. In 2006, approximately less than two percent of paid prescriptions required a new prior authorization each month.

In 2006, our Pharmacy and Therapeutics (P&T) Committee met four times to maintain the SFHP formulary and to add new drugs as appropriate. The Committee reviewed medications and supplies in the asthma, allergy, diabetes, blood glucose monitoring, gastrointestinal, and ADHD categories. The committee has resolved to invite a medical specialist to the P&T meetings for specific expert opinion on medication related standards of care

In 2006, we engaged in an internal quality improvement project to evaluate and improve the prior authorization process. The review and filing of pharmacy prior authorization requests is now completely electronic, and pharmacy prior authorizations are resolved more quickly. The percent of authorizations processed at SFHP in less than five days increased from approximately 40% in 2005 to approximately 85% in 2006.

SFHP re-negotiated the contract with our pharmacy benefit management (PBM) company to ensure high-levels of pharmacy service for our providers and members and high-levels of customer service for our pharmacy partners. Included in the re-negotiation are higher

PBM performance standards, a fraud, waste and abuse program, and a formulary management software program.

## **Health Education and Cultural and Linguistic Services**

Since 2003, the Medical Management Department of SFHP has formally integrated health education and cultural and linguistic competency principles into its quality improvement activities. Each intervention takes into consideration the specific characteristics and needs of our subpopulations. In 2006 projects included efforts to improve asthma care, encourage well-child, well-baby and well-adolescent visits, promote immunizations, encourage timely prenatal care, and promote management of chronic illness, particularly diabetes.

Throughout 2006, we continued to focus our efforts in health education and cultural and linguistic services in two key areas: providing health education materials that support our clinical quality improvement activities and improving provider and staff access to cultural competency resources and training.

### ***Educational Opportunities for SFHP Members and Providers***

To support our clinical quality improvement programs, we offer educational materials to members who are identified through program outreach or who contact the health plan directly. We also give providers materials to use and distribute.

- We provide asthma education materials, including a patient tip sheet that describes the difference between controller and rescue medications as well as a pharmacy coverage hand-out for physicians.
- We provide diabetes education materials, including information on blood glucose monitoring, nutrition, and exercise in print and on our website.
- We provide health education materials focusing on childbirth, nutrition, and breastfeeding. Members receive low-literacy pregnancy education books in English, Spanish, Chinese, or Vietnamese as part of our prenatal member incentive program.
- We continue to:
  - Publish a member newsletter, “Your Health Matters”
  - Offer free health educational classes, support groups, and counseling services to members, that include topics such as smoking cessation, diabetes and asthma management
  - Offer lactation support services, including breast pumps for home use
  - Provide free asthma supplies such as mattress covers, spacers and educational videos.
  - Offer free membership to the SF Boys and Girls Clubs
- This year, we established a partnership with the SFGH Healthy Lifestyles Clinic to support its physical activity goals by rewarding two free movie tickets to patients who complete the 10,000 steps a day goals for one month.

### ***Health Education Materials on the Web***

Health Education and Cultural and Linguistic Services maintains a library of health education materials in a wide range of topic areas both in a paper and on-line format which is used to respond to both member and provider requests. Our redesigned website includes a repository of educational materials that providers and members can access and print out. Currently, we have on-line materials that address, asthma, diabetes, breastfeeding, prevention, and weight management in multiple languages. We also created links to national, state, and local resources for health education materials and plan to expand to more content areas in 2007.

### ***Staying Healthy Translations***

After several years of planning, the newly translated versions of the Staying Healthy Individual Health Education Behavioral Assessment Tool were released by the Department of Health Services. Bilingual forms are now available in English, Spanish, Chinese, Vietnamese, Russian, Hmong, and Lao. We made the new forms available to providers through our website. In addition, we sent a CD-ROM with the forms, training guide, and tip sheets for patients to all SFHP primary care providers. We also worked collaboratively with Blue Cross to set up trainings at St. Luke's, NEMS, and CCHCA to orient new providers to the use of the tools. Trainings for the CHN hospital and community-based clinics as well as UCSF are planned for 2007.

### ***Seven Principles Project***

#### ***Cultural Competency Training: Reducing African American Infant Mortality***

SFHP collaborated with the Seven Principles Project and the Maternal, Child, and Adolescent Health sections of SFDPH, Blue Cross of California State Sponsored Business, and the UCSF National Center of Excellence in Women's Health to plan, conduct and evaluate a provider training to explore the impact of culture, race, and racism, on health seeking behaviors, quality of care, and health outcomes of African American infants and mothers. The training provided tools and resources to improve their practice and reduce barriers to better outcomes. The training, held in November, was well attended by a diverse group of providers serving the African American community including physicians, nurses, social workers, and mental health professionals as well as representatives from community based organizations representing the African American community. SFHP will continue to be involved in the planning and implementation of this training on an annual basis.

### ***San Francisco CHDP Program Childhood Obesity Prevention Workgroup***

SFHP joined a citywide coalition of health care providers and managed care organizations to create a way for PCPs to help families find low-cost ways to engage their children in physical activity. The SFDPH Maternal, Child and Adolescent Health Referral line will be provided with a database of information on physical activity programs available throughout San Francisco. PCPs will be able to call the referral line and match families with programs that meet their needs by cost, neighborhood, activity type, age group etc. The Referral line will also conduct regular follow-up with families

and PCPs. In 2006, SFHP contributed to the development of the database and will assist with implementation in 2007

### ***Educational Opportunities for SFHP Staff***

In November 2005 we held the first of a four part series to explore cultural competency with our staff. Entitled “Talk Story – Getting to Know Your Neighborhood,” this event was an opportunity for staff members to use the Hawaiian tradition of oral history to share professional and personal experiences about San Francisco neighborhoods, and learn more about the people/SFHP members who live there. In March and July of 2006, we held two more staff trainings using the “Worlds Apart: A Four-Part Series on Cross-Cultural Healthcare.” We also make this video available to our providers and will assist with similar cultural competency trainings at our provider sites. The trainings were well-received and SFHP Staff had the opportunity to discuss issues related to cross-cultural medicine, racial/ethnic disparities in health care, and diversity. Subsequent discussions will focus on defining cultural competency and language access and its application to SFHP operations.

### ***Examining HEDIS Rates by Race/Ethnicity and Language***

While we made impressive strides in improving our overall rates for almost all HEDIS measures in 2006, an analysis by race/ethnicity and language demonstrates significant disparities in the rates for some preventive screenings.

- Both African Americans and Whites are less likely to receive preventive screenings for cervical cancer and breast cancer, childhood immunizations, well-adolescent and well-baby visits when compared to Hispanic-Latinos and Asian/Pacific Islanders.
- African Americans are least likely to receive timely prenatal care, post-partum check-ups, well-baby or well-child visits, cervical cancer screening, and diabetic screenings of LDL and HbA1C when compared to all other ethnic groups.
- Spanish speakers have the highest rates of breast cancer screening and cervical cancer screening.
- Chinese speakers had the highest rates of timely prenatal care and postpartum check-ups when compared to other ethnic groups.
- Chinese and Vietnamese speakers were least likely to receive chlamydia screening.
- Asian/Pacific Islanders were most likely to receive well-adolescent visits and to demonstrate appropriate use of controller medications for asthma.

SFHP focused on two areas for intervention in 2006: improving chlamydia screening rates among our Chinese-speaking members and improving preventive health care utilization for African American infants. SFHP targeted 88 providers serving our Asian/Pacific Islander community and offered a \$50 incentive to complete an online chlamydia screening CME course. Twenty-two providers responded to the incentive offer and completed the CME course. SFHP QI staff met with each medical group to discuss barriers to chlamydia screening and will continue to identify other educational opportunities to address this disparity. Work will begin on addressing low well-baby

visit and immunization rates for African Americans in 2007. We plan to increase our outreach to our African American members, and improve access and utilization of preventive services.

## **Medi-Cal Health Education and Cultural and Linguistic Services Group Needs Assessment 2006**

Every five years, as part of its contractual requirements with the California Department of Health Services Medi-Cal program, SFHP is required to prepare a Health Education, Cultural and Linguistic Services Group Needs Assessment (GNA). The assessment is a method to evaluate and define the specific health education and cultural and linguistic needs of our members and providers. Through an examination of quantitative and qualitative data from member and provider surveys as well as local and SFHP administrative and utilization data, our goal was to discover ways SFHP can be culturally responsive to the needs identified in the GNA and to set priorities for future projects. A full report is available from SFHP and the major findings are summarized below.

### ***Satisfaction with Health Care Services***

The majority of SFHP members are satisfied overall with the services they receive through the health plan and satisfied with the respect and courtesy they receive at the provider's office. One area for improvement is the wait time when visiting a specialist and the perceived quality of care received from specialists. Drivers of SFHP member satisfaction included the information disseminated by SFHP, the quality of the advice given by providers, the amount of available PCPs to choose from, and the understanding of members' cultural backgrounds.

Members reported receiving health care services when needed and a large majority of patients visit their primary care physician rather than seeking emergency room treatment. However, those members that stated not receiving treatment when needed – mostly adult members – are more likely to seek alternative treatment sources outside the health plan and those members frequently also feel they are not treated respectfully.

### ***Language Access***

While most of our members are assigned to PCPs who speak their language, for those who are not, the member survey identified a few issues with access to interpreters. A large percentage of SFHP providers reported that they have exam rooms without telecommunication equipment to allow access to telephonic interpreter services. Although the number is low, some providers still use family members or family friends to translate for some non-English speaking patients. The member survey results also showed that many of our members do not know that they have a right to an interpreter.

### ***Cultural Competency***

Findings of the provider survey indicated limited congruence between the provider ethnic and racial composition and that of the Medi-Cal population served. Hispanic and African American providers are underrepresented within our network.

SFHP providers reported that they encountered religious or cultural health beliefs in the course of treating their patients and are knowledgeable of these practices. Providers were able to appreciate and incorporate their patients' beliefs into their medical treatments and recommendations.

### ***Emergency Room Utilization***

A specific subset of questions for members that visited the emergency room revealed that only a third of them first contacted their PCP or equivalent and were told to seek medical attention in the ER. The majority of SFHP members visited the emergency room because they felt it was easier to get care in the ER than in a provider's office. These members also believed they would receive better personal attention in the emergency room than from their PCP. An analysis of SFHP encounter data mirrored the results of the member survey, showing that our members frequently use the ER for ambulatory care sensitive conditions. The most common are severe ear, nose, and throat infections, followed by cellulitis, asthma and kidney/urinary infections.

A significant proportion of SFHP members do not identify a single person as their health care provider or primary care physician. Health plan members without identified primary care provider were more likely to visit the emergency room and are also less satisfied with the health care services they receive.

### ***Health Education Needs***

Members prefer to receive health education from their doctor's office and feel more comfortable with the advice given from a provider when this provider speaks their language. A large majority also prefers a professional interpreter, although, as stated above, a significant proportion of these members are not aware of the current interpreter services available to them. The health education topics identified as most important to members were nutrition, exercise, obesity and dental health.

The surveyed providers have an interest in learning more about how to access community health care resources for their patients, incorporating cultural health beliefs into their practices, and using patient education materials. The most important health need identified by our providers was obesity.

Accessing health education resources around chronic illness is an increasing priority for our members and providers. Twenty-five percent of adult members reported being diagnosed with hypertension or high cholesterol. The majority of our members classified as Seniors and Persons with Disabilities (SPD) reported being diagnosed with a chronic condition in addition to their disability.

### ***Disparities in Utilization of Preventive Services***

An analysis of SFHP administrative and utilization data yielded interesting results. While we continue to show improvement for a majority of our HEDIS measures, when broken down by race and ethnicity, African Americans were least likely to receive preventive health services including: well-visits, immunizations, breast cancer screening, and postpartum visits.

### *Plans for 2007*

In response to the results of our GNA, SFHP has identified two areas for cross-departmental collaboration:

- Improving member understanding of appropriate emergency room use, as well as navigation of the health care system
- Improving outreach efforts to our African American community to address disparities in utilization of preventive health care services

## **VI. Quality Monitoring**

### **Facility Site and Medical Record Reviews**

SFHP works collaboratively with Blue Cross of California to review all provider sites to ensure compliance with criteria set forth by the California Department of Health Services (DHS). Each primary care site is reviewed every three years, alternately by Blue Cross and SFHP, using a tool designed by DHS. The site review portion evaluates 139 criteria in the areas of access and safety, personnel, office management, clinical services, preventive services, pharmacy, and infection control. The medical record review portion evaluates 32 criteria in the areas of chart format, documentation, continuity and coordination of care, and preventive care. Below is a summary of the full scope reviews conducted in 2006.

#### **Summary of Site Reviews**

MEDICAL GROUP	# REVIEWS IN 2006	SCORES 90% - 100% SITE/RECORDS	SCORES 80% - 89% SITE/RECORDS	SCORES <80% SITE/RECORDS
CCHCA	21	19	2	0
CHN	7	7	0	0
PIMG	17	15	2	0
NEMS	6	6	0	0
UCSF	5	5	0	0
<b>TOTALS</b>	56	52	4	0

## Summary of Medical Record Reviews

MEDICAL GROUP	# REVIEWS IN 2006	SCORES 90% - 100% SITE/RECORDS	SCORES 80% - 89% SITE/RECORDS	SCORES <80% SITE/RECORDS
CCHCA	21	14	5	1
CHN	7	3	2	1
PIMG	17	10	5	2
NEMS	6	3	2	1
UCSF	5	0	5	0
<b>TOTALS</b>	56*	30	19	5

\* There were 56 site reviews done in 2006 but record reviews were done at only 54 sites. In some cases, there are an insufficient number of members assigned to do a record review.

In cooperation with Blue Cross, we conduct follow-up reviews six months after a failed review (a score of less than 80%). Two of the five providers who failed their record review have had a follow-up review already. One provider's score increased to 90% and the other to 80%. For the other three providers, follow-up reviews will be conducted in 2007.

## Medical Group Oversight

Through reports and regular oversight audits, SFHP monitors all delegated functions of each of our six contracted medical groups. These functions are delineated annually in the Medical Group's Responsibilities and Reporting Requirement Grid. Depending on delegated functions the audit may include these areas: utilization management, coordination of care, credentialing and recredentialing, grievances and wait time studies. SFHP works collaboratively with all of our delegated entities to ensure excellent communication and to resolve problems as they arise.

The results of our monitoring are displayed below:

<b>DELEGATED ENTITY</b>	<b>AUDIT RESULTS</b>
<b>Kaiser</b>	100% on all areas of the audit except UM and grievances <ul style="list-style-type: none"> <li>• UM: Three out of ten files did not have the decision made within the appropriate timeframe.</li> <li>• Grievances: Timeliness of acknowledgment letters and resolution letters was not compliant and letters did not consistently use the Medi-Cal appeal language.</li> </ul>
<b>CCHCA</b>	100% on all areas of the audit except UM and primary care wait time study <ul style="list-style-type: none"> <li>• UM: Denial letters did not consistently contain Medi-Cal and DMHC appeal language or provide members with alternative direction for follow-up care when a denial is issued. In addition we found that members were sometimes forwarded claims denial letters.</li> <li>• Wait time study: 2006 results were not submitted on time. SFHP will work to ensure that reports are received in 2007.</li> </ul>
<b>NEMS</b>	100% on all areas of the audit
<b>PIMG</b>	100% on all areas of the audit
<b>SFGH Medical Staff Office - (Community Health Network)</b>	100% on all areas of the audit
<b>St. Mary's Medical Staff Office (Sister Mary Philippa)</b>	100% on all areas of the audit except recredentialing <ul style="list-style-type: none"> <li>• Recredentialing: Only 22 out of 30 recredentialing files passed (score = 73%) due to a process in place during 2004.</li> </ul>
<b>UCSF Medical Staff Office</b>	95% score on initial credentialing files 100% score on recredentialing files

As a result of the findings above, SFHP implemented interventions:

- In 2006, SFHP implemented quarterly audits of Kaiser's grievances and offered technical assistance in ensuring that Medi-Cal members consistently receive timely acknowledgement and resolution letters with the Medi-Cal appeal language. SFHP will continue to conduct quarterly audits until Kaiser reaches 98% compliance for two consecutive quarters.
- SFHP reviewed with CCHCA the Medi-Cal and DMHC appeal language required in denial letters and agreed on a plan to include the language in all future letters. In addition, we reminded CCHCA not to send claims denial letters to members as they are not financially responsible.
- The CCHCA 2006 wait time studies were available, but the report was pending analysis and committee input. We will make sure reports are submitted in 2007.
- SFHP will resume auditing credentialing annually at St. Mary's Medical Staff Office, dropping our six month technical assistance credentialing review, since they have had two credentialing audits that have scored 100% in 2006.

## **VII. Quality Leadership**

### **Quality Management at SFHP**

The SFHP Management Team, including representatives from every department, meets monthly and acts as the Quality Management Team for the health plan. In 2006, the following quality monitoring reports were presented at this meeting for review and discussion:

- Quarterly grievance reports
- Provider satisfaction survey results
- Provider network access reports
- Telephone satisfaction survey results
- Member satisfaction survey results
- Medi-Cal Group Needs Assessment
- HEDIS results

The Management Team is asked to give input and recommendations for interventions before these reports are presented to our Quality Improvement Committee.

### **Quality Improvement Committee**

The SFHP Quality Improvement Committee provided valuable guidance for our QI activities in 2006. The Committee is made up of SFHP physicians and members and met four times in 2006 to review quality monitoring reports and give input on our quality improvement projects. The committee also approved our QI Program and UM Program.

In addition to providing oversight for our QI activities, the Quality Improvement Committee helped us with the following:

- Implementation of a Pap smear and mammogram reminder system
- Development of SFHP Preventive Health Care Guidelines for Adults and Children
- Planning a way to address disparities in utilization of preventive health care services by race/ethnicity and language

### **Young Adults Quality Improvement Sub-Committee**

Since March 2005, a small subgroup of providers and advocates as well as SFHP staff members met bimonthly to discuss the progress and development of our Healthy Young Adult program. Committee members highlighted three focus areas for discussion:

- Preventive care guidelines/standards of care for the young adult population
- Evaluating access for young adults
- Outreach to encourage new membership

Discussions centered on the issue that while clear preventive care guidelines are available for children/adolescents, health needs of young adults are merged with care guidelines that apply to older adults, which may not be inclusive enough. Using the U.S. Preventive Services Task Force Guidelines as well as guidelines from the American Academy of Pediatrics and the American Academy of Family Physicians as sources, committee members developed a draft document of recommended services/areas for 18-24 year-old population. We will explore the implementation of the guidelines at two high-volume clinics in 2007 and keep the QIC informed.

### **Physician Advisory Committee**

To increase the involvement of our providers in our quality initiatives, SFHP created a Physician Advisory Committee, and combined the duties of the Peer Review and Credentialing Committee into it. This committee meets six times per year to conduct credentialing and peer review activities, as well as provide advice, comment and recommendations on SFHP's clinical and quality initiatives.

The first meeting was held in July 2006. Physician representatives from five of our medical groups participated as members of the committee. In 2006, the committee provided guidance for our chronic care management efforts and helped us to us to develop SFHP clinical guidelines for diabetes care. We plan to work on expanding our work on chronic care to other diseases in 2007 and will work with the Physician Advisory Committee to set priorities and develop programs.