San Francisco Health Plan (SFHP)
Quality Improvement Program Evaluation 2007

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 2007 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 2007, we accomplished a great deal, but there are two things that we are particularly proud of.

- We made significant improvements in our HEDIS rates putting SFHP among the best health plans in the State.

- With our sponsorship, the eReferral project at San Francisco General Hospital dramatically reduced wait times for specialty appointments.

In addition to the accomplishments summarized in this report, we are also proud to have worked very hard in 2007 with the City of San Francisco to launch *Healthy San Francisco*, a new program to provide health care access to the uninsured. The program will provide a medical home and access to medical, pharmacy and behavioral health services to over 80,000 uninsured adults in San Francisco. The program launched in July 2007 and had over 8,000 participants by the end of the year. SFHP acts as a third-party-administrator for the program and will provide some quality improvement and quality monitoring functions. *Healthy San Francisco* gave us the opportunity to work closely

with our providers participating in the program and to expand our expertise in the area of adult quality of care issues.

While we achieved a great deal in 2007, we know that we still have areas where we can improve. In 2008, 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

Promoting Preventive Care

Promoting timely preventive care is a core component of our Quality Improvement Program. Our goal is to be among the top ten percent of health plans nationally in making sure that our members get the right care and the right time. We have programs for members to remind and encourage them to seek care. In addition, we have programs for providers to help them keep track and bring in patients due for services. Our efforts have been extremely successful as measured by our HEDIS results on key preventive care measures. While most of our programs have been in place for several years, we continue to look for ways to make our interventions more effective and find new opportunities for improvement. Below is a summary of our preventive health programs:

Preventive Care for Infants and Toddlers

- ***Immunization reminder card:*** Families with children turning 6, 12, 15 and 18 months of age receive an immunization reminder card with educational messages about vaccinations.
- ***Immunization member incentive:*** We mail families with children turning 13 months an offer for a $50 gift card for completing all immunizations on time. We reduced the amount of the gift card from $75 to $50 in July 2007 in order to keep the program financially sustainable.
- ***Immunization reminder phone blasts:*** Families receive three recorded telephone calls at 12, 13, and 22 months reminding them to bring their children in for well-checks and immunizations.
- ***Outreach to families for immunizations and well-baby check-ups:*** We call families with children under the age of two assigned to St. Luke's Pediatrics and Department of Public Health Clinics to remind them to take their children in for well-child checks and immunizations.
- ***Outreach lists for providers:*** We send PCPs monthly outreach lists of members due for well-checks and immunizations.
- ***Well-baby visit provider incentive:*** As part of a pilot program to increase well-baby visit rates we offered a $150 incentive to three provider sites for each child that received six well-baby visits by the age of 15 months.
- ***Support for the Bay Area immunization registry:*** We support the San Francisco Immunization Coalition in spreading the use of the Bay Area Immunization

Registry through outreach to provider sites and offering financial assistance to clinics that agree to use the registry.

- ***Targeted outreach to African American families:*** In response to data that shows that our African American members have lower than average well-baby and immunization rates, in April 2007, we began calling all new African American families with children under the age of two, to promote well-checks and immunizations.

Annual Check-ups for Children and Young Adults

- ***Well-adolescent visit member incentive:*** Our teen members receive a birthday card from SFHP, offering them movie tickets or a $15 gift card for getting an annual check-up.
- ***Well-adolescent visit phone blast:*** Along with the birthday card, teens receive a recorded telephone message encouraging them to see their doctor and take advantage of our member incentive.
- ***Well-adolescent "live" calls:*** In 2007, our HEDIS data showed that there were three clinics with very low teen visit rates and needed help with outreach. We called almost 900 families and encouraged them to get teen check-ups and reminded them about our member incentive.
- ***Well-adolescent visit provider incentive:*** We offer provider sites $20 for each well-adolescent visit. We also provide clinics with outreach lists of teens due for check-ups.
- ***Well-adolescent visit summer campaign:*** We worked with the San Francisco Unified School District to distribute posters encouraging all teens to see their doctor for a check-up over the summer.
- ***Well-adolescent visit raffle:*** As a part of our summer campaign we send out an additional mailer to all adolescents encouraging them to see their doctor for a check-up and informing them if they submit an incentive voucher they will be entered into a raffle for a laptop or an IPod.
- ***Targeted provider site support for adolescent outreach:*** Several of our clinics opened teen clinics in response to our provider incentive program. We provided additional support for these clinics by giving them movie tickets to distribute at visits and by making outreach calls to help fill appointment slots.
- ***Well-child visit member incentive:*** Families with a child between three and six receive a birthday card from SFHP, offering them $25 gift card for bringing their child in for an annual check-up.
- ***Well-child visit phone blast:*** Along with the birthday card, families receive a recorded telephone message encouraging them to take their child to the doctor and take advantage of our member incentive.
- ***Well-check periodicity schedule:*** We produced and distributed to our clinics a periodicity guide for front office staff that shows how often SFHP members should be seen for check-ups.

Preventive Health for Women

- ***Well-woman preventive health mailing:*** Upon enrollment and then once per year, our female members aged 27 and over receive a brochure with preventive health

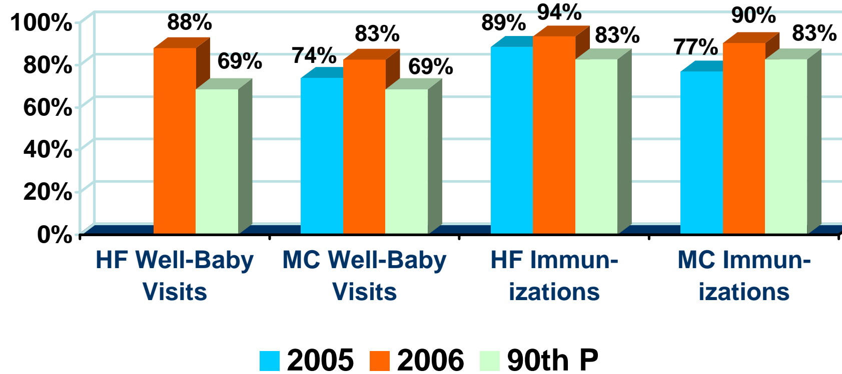
care guidelines for women and health education messages. The mailer also includes a promotion for our prenatal incentive program for members who may be pregnant.

- ***Young-woman preventive health mailing:*** Members between 16 and 26 years old receive a mailing similar to our well-woman mailing upon enrollment and annually thereafter. The mailing includes additional health information for younger women a promotion for our prenatal incentive program for members who may be pregnant.
- ***Pap smear reminder card:*** Members overdue for a Pap smear according to our encounter data, receive a reminder card encouraging them to check with their doctor about when they should be screened.
- ***Mammogram reminder card:*** Members overdue for a mammogram according to our encounter data receive a reminder card encouraging them to check with their doctor about when they should be screened.
- ***Timely prenatal care incentive program:*** We offer a $50 gift card to women who seek prenatal care early in their pregnancy. In addition to including a message about our prenatal incentive program in our well-woman and young-woman preventive health mailings, we distribute posters promoting the program to provider offices.
- ***Outreach lists for providers:*** We offer our providers lists of patients overdue for Pap smears and mammograms.

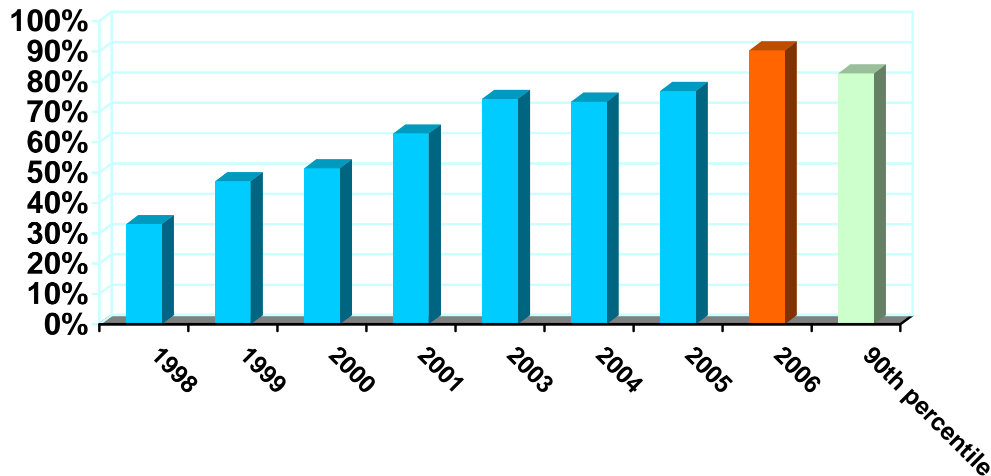
Analysis of HEDIS Results

Our preventive health programs made a measurable difference in the care that our members receive. All of our HEDIS rates for our Healthy Families Program are in the national Medicaid 90th percentile. Four of the preventive health HEDIS measures for our Medi-Cal program are in the national 90th percentile. While we have excellent results in some areas, we still have room for improvement in measures such as well-adolescent visits and prenatal and postpartum care. Every year, after finalizing our HEDIS results, we analyze our data to evaluate the interventions we put in place to improve. Below is a summary of our analysis.

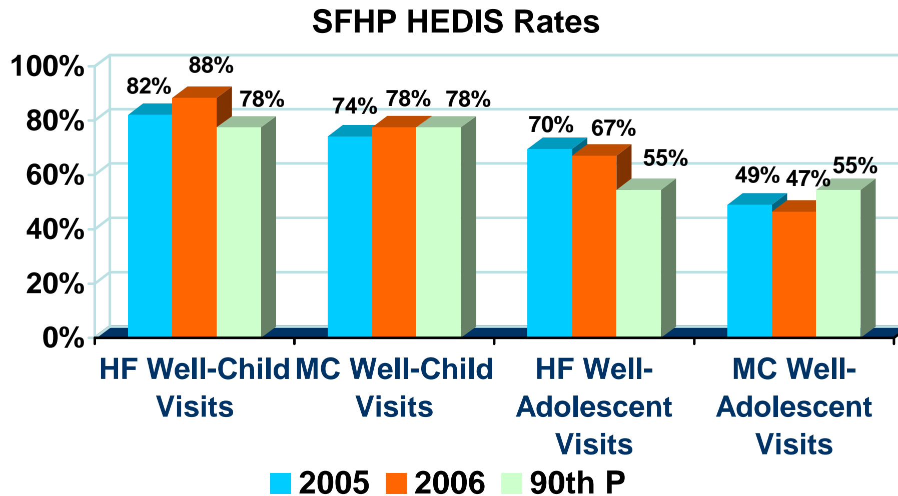
Well-baby visits and childhood immunizations



SFHP has the top immunization and well-baby visit rates among Medi-Cal health plans. Efforts to improve immunization rates began in 1999 and, as the graph below shows, we made improvements almost every year. Our rate is now above the 90th percentile nationally. In 2006, we integrated our efforts to promote immunizations and well-baby visits and we expanded our outreach to all children assigned to DPH clinics and to St. Luke's Pediatrics. The changes we made in 2006 helped us achieve the 17% increase in our immunization rates. In 2007, we hope to maintain our rates. Although we reduced the amount of our gift card from $75 to $50 in 2007, we think it will not impact our rates negatively. Additionally, we hope that the outreach initiated in 2007 to African American families will reduce disparities among groups and improve our overall score.

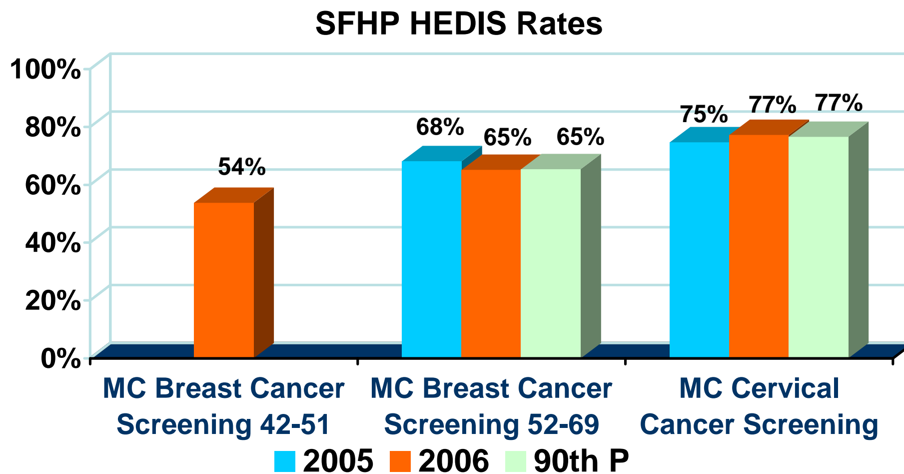


Well-Child and Well-Adolescent Visit Rates



Both our well-child and well-adolescent visit rates improved in 2006. Our well-child rates are back in the 90th percentile nationally, however our well-adolescent rates remain below the 90th percentile. We have very popular incentive programs in place for members in both age groups. We learned how effective our incentive programs were in 2005 when our well-child visit rates dropped. We were offering a $15 gift card to Toys R Us. The response rate to the incentive program dropped when Toys R Us closed its Bay Area stores. Our score dropped for both our Medi-Cal and Healthy Families populations. We redesigned our incentive, offering three store choices, and increased the amount. Now our rates are back up for both Healthy Families and Medi-Cal. We plan to continue these successful programs in 2008 and focus additional resources on outreach for teen visits.

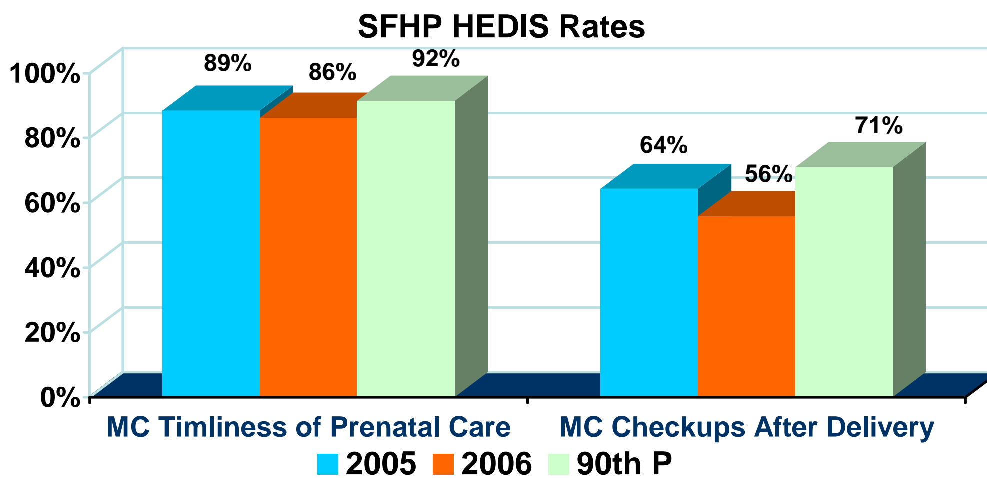
Breast Cancer and Cervical Cancer Screening Rates



Our cervical cancer screening rate is above the 90th percentile and our breast cancer screening rate is within one percentage point of the 90th percentile. We owe these excellent rates to our primary care and OB/Gyn providers who have excellent systems in place to track and remind patients of preventive health care screenings. Last year, we added an additional reminder program for women who are overdue for breast cancer or cervical cancer screening.

In 2007, the HEDIS measure for breast cancer screening was expanded to include 42-51 year olds. Our rate for that age cohort is 53.8%, more than ten percentage points lower than our rate for 52-65 year olds. When we shared these results with our provider network, we found differences among our providers on the age at which women should begin routine mammograms. We hope to bring more awareness to mammograms for women in this age group by giving our providers feedback on their clinics' HEDIS results and through dissemination of our preventive health care guidelines.

Prenatal and Postpartum Care



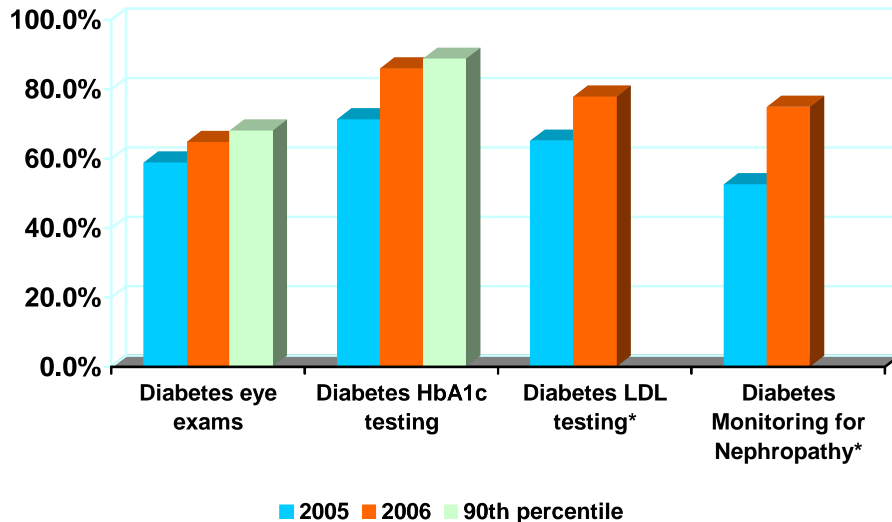
Our results for the timeliness of prenatal care and check-ups after delivery measures offer opportunities for improvement. They both fall below the 75th percentile nationally. Our timeliness of prenatal care rate declined slightly and as a result, in 2007 we devoted additional resources to promoting our prenatal incentive program in our provider offices. Our check-ups after delivery rate is low due to different guidelines among our OB/Gyns on when women should return for postpartum check-ups. The HEDIS timeframe requires a visit between three and eight weeks after delivery, however many of our providers bring patients back for check-ups at two weeks and for a second visit after eight weeks.

Improving Chronic Care

The Chronic Care Team at SFHP implemented a chronic disease management program to promote high quality of care for asthma, diabetes, hypertension, and hyperlipidemia.

Though we focused most of our efforts on diabetes and asthma in 2007, we started work on hypertension and hyperlipidemia.

Improving Diabetes Care
In 2006 we made significant improvements in diabetes care as measured by the four diabetes HEDIS measures we report, however we still have work to do to meet our goal of reaching the Medicaid 90th percentile.



Our highest priority was to improve our LDL screening rates, which were below the Medicaid 25th percentile in 2005 and required us to submit a corrective action plan to the Department of Health Care Services. We made a big improvement in LDL screening rates even after the specifications for the measure were tightened requiring a screening every year instead of every two years. New Medicaid benchmarks for the LDL measure and for the monitoring for nephropathy measure which also changed in 2006 have not yet been released.

We made improvements in all four measures and our eye exam and HbA1c rates are now above the 75th percentile. In 2007, we enhanced the programs we put into place in 2006 focusing on member and provider education and systems improvement. We developed materials and programs intended to help members and providers with all aspects of diabetes management including regular screenings, medication adherence, blood sugar monitoring, nutrition and physical activity. We accomplished a great deal in 2007 and are planning new interventions to further improve our diabetes care in 2008. Below is a summary of our interventions:

- ***Diabetes clinical guidelines:*** We developed clinical guidelines with the guidance of our Physician Advisory Committee and distributed to all adult primary care physicians in our network.

- ***Diabetes member reminder card:*** Every six months we send all of our diabetic members a reminder card encouraging them to complete the screening tests such as HbA1c, cholesterol, microalbumin, foot exam, blood pressure, and eye exam.
- ***Diabetes telephone case management:*** We called the moderate and high risk members and offered case management assistance. Our Nurse Case Managers had the opportunity to:
  - Educate members about management of the disease.
  - Identify barriers in accessing care
  - Remind members about the screening tests
  - Assess need for additional education
- ***Provider support:*** In 2006, we visited 15 provider offices to offer education and technical assistance to improve care for diabetic patients.

In 2007, we had the opportunity to improve upon the interventions quickly put into place in 2006 and look for new areas for improvement. In 2007, we expanded our interventions to include the following:

- ***Chronic disease registry support:*** When the Department of Public Health and the San Francisco Community Clinic Consortium partnered to purchase a chronic disease management registry, we supported the purchase financially and participated in the Advisory Committee for its implementation.
- ***Expanded provider feedback and education:*** This year we made focused visits to 28 of our providers to review charts and offer our support to improve care. Visits were productive and education was well received. We identified opportunities for improvement and made some interventions based on the findings:
  - Many providers expressed difficulty accessing ophthalmology services for their patients. They also had difficulty getting written consultation reports from ophthalmologists. Based on the findings, we provided the clinics with a list of VSP providers.
  - We gave providers who were interested in implementing the use of a diabetes flow sheet a supply to use for all of their members.
  - We found that many providers and office managers were unaware of our incentive program but were very enthusiastic about it. We gave clinics blank incentive forms to use with their patients.
  - DPH clinics had problems accessing the Eye Van in 2007 because it was not in service for several months during the year. Each clinic that utilized Eye Van services was provided a list of their diabetic members, who according to the record review, had not had an eye exam in 2007. The clinic managers were encouraged to conduct outreach to those members and give them an appointment for an Eye Van visit or a VSP provider visit prior to the beginning of 2008.
  - In our site visits we identified members in need of case management. Our Nurse Case Managers called the members and offered case management assistance.
- ***Eye exam reminder card:*** We sent a reminder card to diabetic members who did not have an eye exam in the past 12 months. Members were given a list of VSP

providers who spoke their language. The card included a "fax-back" form for the eye care provider to fill out and fax back to the PCP for their records.

- ***Diabetes incentive program:*** We sent an incentive offer to members identified as moderate and high risk diabetics. Members who completed all the required screening tests received a $50 gift certificate.

Next year we plan to continue working on improving care for our members with diabetes. We face new challenges in 2008 as we begin measuring the percent of our members with diabetes lab results in "good control" and "poor control." We will report on the percentage of members with HbA1c less than seven, (good control), HbA1c greater than ten (poor control) and the percentage of members with an LDL less than 100 (good control). Our focus will be on helping our members achieve good outcomes on their lab tests through effective self-management.

- We will collaborate with San Francisco General Hospital to implement the Automated Telephone Self Management (ATSM) program. Members enrolled in the program will receive an automated call each week for six months. The member will be prompted to key in their answers pertaining to blood sugar level, diet, exercise and medication. The calls are available in English, Spanish and Cantonese. The SFHP Nurse Case Manager will receive daily reports for members who have out of range responses and will make follow-up calls.

- Our data shows that many of our members who have diabetes also have hypertension and hyperlipidemia. In 2008, our Nurse Case Managers will call members who are diagnosed with all three diseases and then follow up in six months with members who still have not received their screenings.

- In order to encourage members to keep HbA1c and LDL at goal, we plan to expand our member incentive program to:
    - Offer an additional incentive to members whose lab values are in range or show significant improvement
    - Expand the incentive program to all diabetic members including members at low risk

- We plan to provide our members with tools such as pedometers, medication bags and organizers, educational material, measuring cups and spoons, and cookbooks to help improve diabetic control.

- In small practices, where patients do not have easy access to labs, we will distribute information on in-office diabetes lab tests to the physicians and office managers. The in-office lab tests, offer several advantages. Patients can complete diabetes lab tests at their doctor visit, eliminating the need to make a separate trip to another location. This will increase patient compliance and allow the provider to make on-the-spot treatment decisions as well as deliver more effective patient education sessions.

Improving Care for Members with Hypertension and Hyperlipidemia
Hypertension and hyperlipidemia affect a large number of our members. We have approximately 2,000 members with hypertension and 1,500 members with hyperlipidemia. In 2007, we created a member education flyer called "Know Your Numbers." It encourages members with diabetes, hypertension, hyperlipidemia and/or heart disease to know their blood pressure and cholesterol levels and provides helpful information on how to stay healthy. We plan to begin mailing this piece out in 2008. We also plan to begin calling our members with diabetes, hypertension and hyperlipidemia and offer case management assistance.

Promoting Healthy Weight
Obesity significantly increases a person's risk of diabetes, hypertension and hyperlipidemia. Though there is no HEDIS measure on weight management, we feel that by promoting healthy weight, we can prevent members from developing diabetes and other chronic diseases. In 2007, we started exploring healthy weight programs.

- We explored the option of offering Weight Watchers classes at three of our clinics. After further investigation we found that Weight Watchers was not a good option for us because they would market their products in the meetings and they were not able to offer classes in languages other than English.

- We explored two alternatives to Weight Watchers:
    - We met with YMCA and Medical Directors from several clinics to create a program that was suitable for our patient population. The program will include physical activity and nutrition programs such as dancing and cooking classes for adolescents.
    - Three clinics agreed to be the pilot sites for classes promoting healthy weight. We started our search for a Registered Dietician who could offer nutrition classes at the clinic sites.

Improving Asthma Care
The goal of the asthma disease management program is to help our members control their asthma. The use of appropriate medications for people with asthma HEDIS measure helps us monitor the percent of our members on controller medications. We scored 92.1% on the asthma HEDIS measure but missed the Medicaid 90th percentile by 0.4%. We will continue the interventions in 2008, but will make some improvements in order to reach the 90th percentile.

- ***Patient profiles for PCPs:*** We sent a packet to PCPs with a cover letter reviewing the percentage of their asthma patients who were on controller medications. A medication profile for each member who was not on a controller medication was also included in the mailing.
- ***Flu shot outreach lists:*** In the fall, we mailed flu vaccine rosters to all PCPs. The roster showed whether the member had received a prescription for a controller medication in 2007.

- ***Member health education:*** We mailed a letter and health education materials to asthma members who have not received controller medications. We encouraged members to talk to their providers about the disease and medications they might need.
- ***Case management for high risk members:*** The Nurse Case Managers called asthma members who had four medication-fills of asthma rescue medication but no controller medications and educated them about the disease, ways to avoid an exacerbation, and the importance of a flu shot. Members were encouraged to talk to their doctor about whether a controller medication was appropriate for them.
- ***Asthma supplies:*** We supplied provider practices with free aerochambers, peak flow meters, and hypoallergenic mattress cover sets in multiple sizes.
- ***Collaboration with HealthFirst asthma program:*** The HealthFirst Center at St. Luke's Hospital offers a unique program for patients with chronic conditions. The center offers intensive health education counseling and frequent follow-up calls from community health workers. Patients are followed closely and come in for regular visits to ensure their treatment program is working for them. We helped HealthFirst identify patients for the program by providing them with data on their patients and reports every six months on a set of quality indicators for asthma, diabetes and ER usage.

Our asthma program has been very successful and we plan to continue our interventions with a few improvements in 2008. Our asthma patient profiles deliver valuable information to most of our providers; however, clinic directors in one of our medical groups found that the PCP identified on the profile is often different than the PCP identified in their records. In 2008, we plan to set up a data exchange that will help us correctly identify PCPs.

II. Providing Excellent Member Services

One of SFHP's core goals is to provide our members with extraordinary customer service. Our Member Services Department helps members to understand and take full advantage of their health plan benefits. Members can get assistance by contacting SFHP Member Services by phone, fax, TDD/TTY, email, mail, or in person. By contacting us, members can get assistance with ID cards, change of PCPs, covered benefits, medical bills, grievances, access to doctors, enrollment, disenrollment, etc. We represent a safety net for any member who needs help.

Providing Excellent Telephone Services

By far, our members find the phone as the easiest way to reach us. As a result, we are committed to ensuring that we provide excellent customer service over the phone. We monitor our performance in several ways and continued to work on improving our processes in 2007.

Call Center Performance
We received 60,343 incoming calls through our telephone automated distribution system in 2007. We met or exceeded the performance standards we set for our department to handle incoming calls. We tracked the reasons that members called in order to improve our services and provide feedback to different departments for better customer services.

- Our 2007 average abandonment rate of member line was 1.7% which was 0.2% better than that of 2006, and well below the 5% maximum benchmark.

- We answered an average of 91.5% of member calls within 30 seconds exceeding our goal of 90%.

- Bilingual and bicultural member services representatives provided telephone service in English, Cantonese, Mandarin, Spanish, Russian, and Burmese.

In 2007, we continued to work on ways to improve service to members. In order to improve satisfaction and efficiency we continued to work toward "one-call-resolution.' We streamlined our processes between departments and began making more conference calls between departments so that members could get answers and assistance from Member Services Representatives in just one phone call. We also saw an increase in the number of Russian speaking callers. In response we hired a new bilingual representative who speaks Russian.

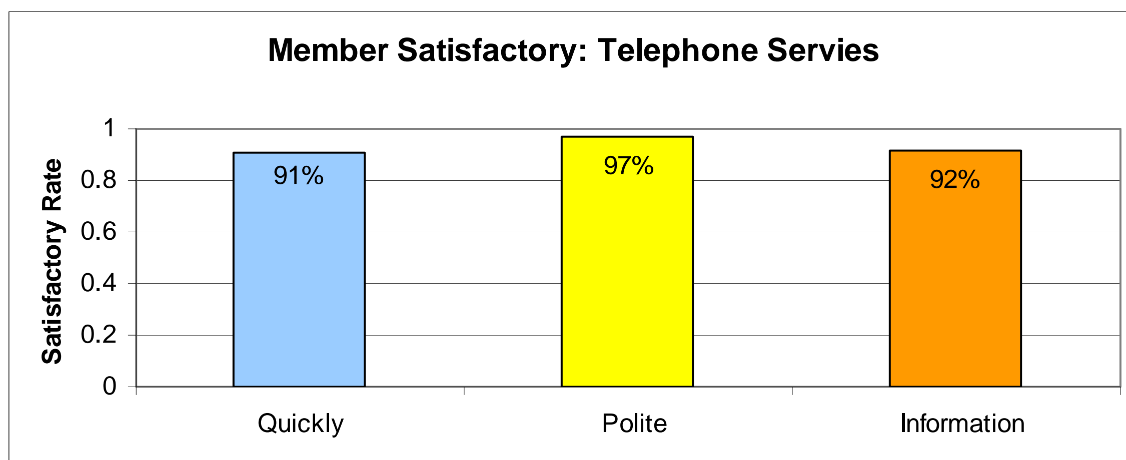
Telephone Satisfaction Survey
Member Services Call Center conducted the sixth annual satisfaction survey in the last quarter of 2007. The purpose of this survey was to assess satisfaction with the services provided by Member Services Department and improve our services based on the feedback from members.

The survey was conducted in English, Spanish and Chinese. Members responded to the following statements regarding the 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.

In the last quarter of 2007, we sent 4,379 survey cards to all members who contacted Member Services by phone recently. We increased our survey sample by 13% comparing with that of 2006. We received 590 cards in mail resulting in a 14% return rate.

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



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 Consumer Assessment of Health Plans Survey (CAHPS) 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 administer our own survey tool annually. The results from the HKYA survey and the Medi-Cal and Healthy Families CAHPS survey are summarized below.

Healthy Kids & Young Adults Satisfaction Survey
In April 2007, approximately 5,500 Healthy Kids & Young Adults households, with active program members between April 2005 and May 2007, were contacted by mail to participate in a satisfaction survey. Members contributed their time to share their experiences and opinions of the program. Their input is valuable in developing and improving future HKYA member benefits and services.

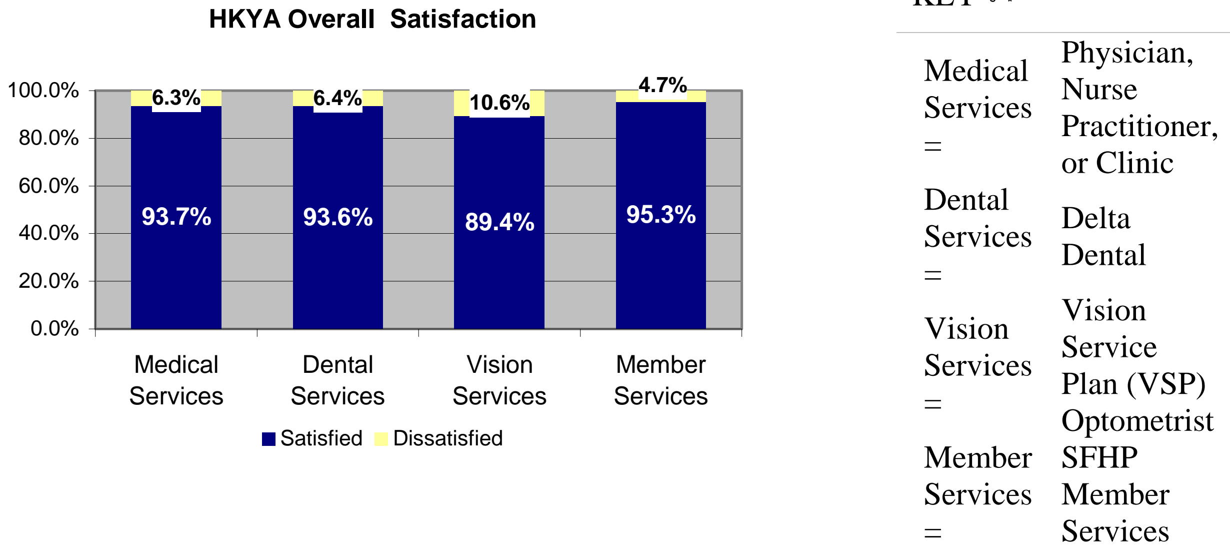
The survey asked about:

- member utilization of HKYA benefits and services
- member satisfaction with HKYA benefits and services
- perceived importance placed on HKYA benefits and services
- member experiences with SFHP advertising and outreach efforts
- member Internet use and capabilities

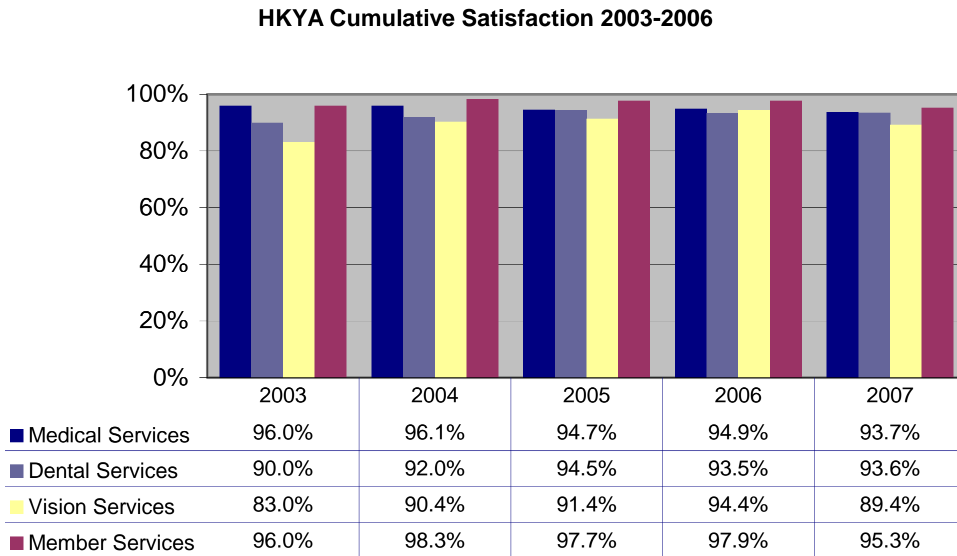
We surveyed 5,517 Healthy Kids & Young Adults households, asking if they had accessed four types of services: Medical, Dental, Vision, and SFHP Member Services. If so, we asked them to tell us if they were satisfied with the service they received. 1,129

members responded, garnering a 20.5% response rate. Feedback indicates a high rate of satisfaction with all services.[1]

Overall Program Satisfaction



Since 2006, satisfaction has decreased slightly in all but dental services; most notably in vision services by 5.0 percentage points.



	2003	2004	2005	2006	2007
Medical Services	96.0%	96.1%	94.7%	94.9%	93.7%
Dental Services	90.0%	92.0%	94.5%	93.5%	93.6%
Vision Services	83.0%	90.4%	91.4%	94.4%	89.4%
Member Services	96.0%	98.3%	97.7%	97.9%	95.3%

Over half of members (56%) who expressed dissatisfaction with medical services cite access and/or long wait times (in excess of one hour) as the reason for dissatisfaction.

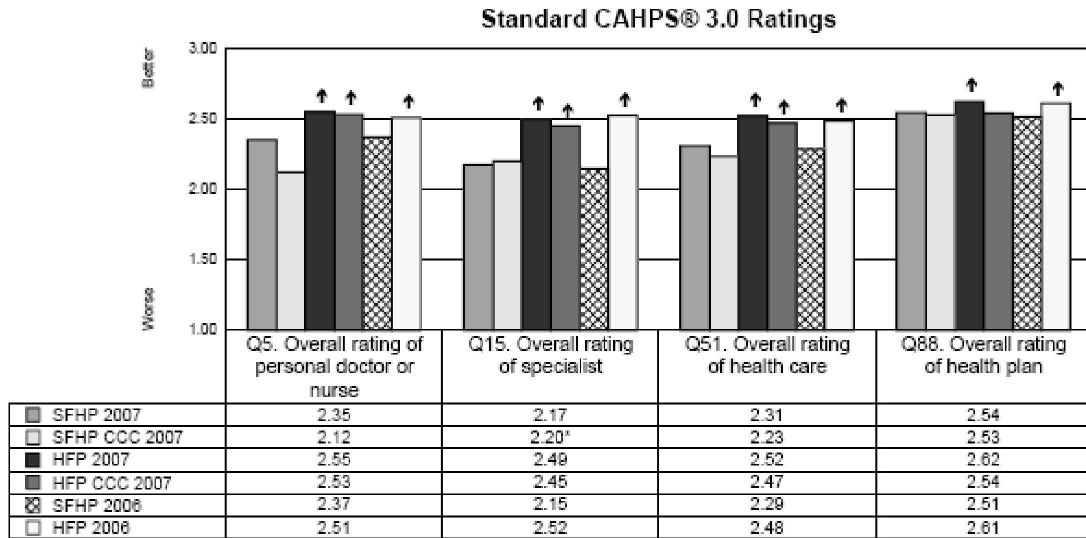
[1] For the purposes of reporting, it is assumed that the reporting entity of a child aged 0-18 is the parent or guardian, and not the actual child member.

Member comments revealed that some would consider not accessing services at all or opting to visit the emergency room for care instead of visiting their PCP office again.

Of all services experienced by members, SFHP Member Services consistently scores highest and this year is no different. Members cite the accommodation of member services, the friendliness of the staff, and the helpful information they provide as factors in their satisfaction. Only 4.7% cited dissatisfaction and of those few members provided detail on the reason for dissatisfaction, but those that did attributed their opinion to long waits on hold, or long waits for member materials such as ID cards.

CAHPS Results for Healthy Families

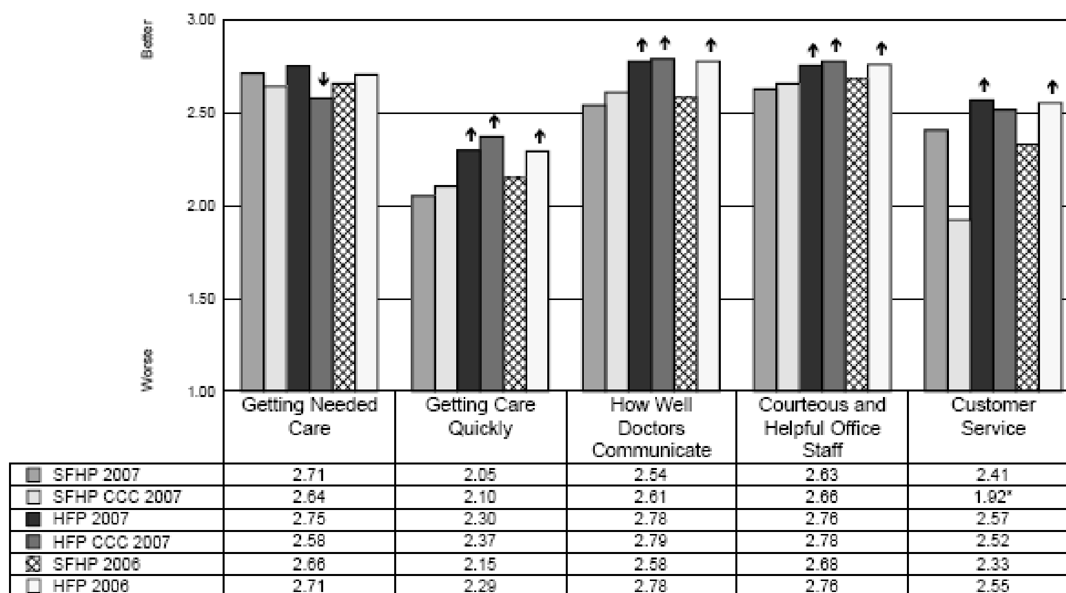
Since 2002, the Managed Risk Medical Insurance Board (MRMIB) surveys Healthy Families members using the CAHPS survey tool. The survey is administered statewide by an external vendor and results are reported back to Healthy Families participating health plans. In 2007, MRMIB added the Children with Chronic Conditions component of the CAHPS survey. An additional sample of SFHP members with chronic conditions was surveyed and results are displayed separately. The 2007 report we received shows that SFHP performs below the statewide average on the Overall and Composite Scores.



	Q5. Overall rating of personal doctor or nurse	Q15. Overall rating of specialist	Q51. Overall rating of health care	Q88. Overall rating of health plan
SFHP 2007	2.35	2.17	2.31	2.54
SFHP CCC 2007	2.12	2.20*	2.23	2.53
HFP 2007	2.55	2.49	2.52	2.62
HFP CCC 2007	2.53	2.45	2.47	2.54
SFHP 2006	2.37	2.15	2.29	2.51
HFP 2006	2.51	2.52	2.48	2.61

↑↓ Statistically significantly higher/lower than SFHP 2007

* Scores based on observations of less than 30 should be viewed with caution.



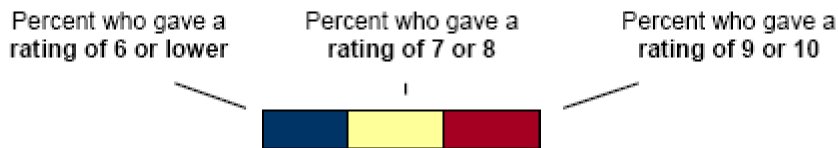
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Courteous and Helpful Office Staff	Customer Service
SFHP 2007	2.71	2.05	2.54	2.63	2.41
SFHP CCC 2007	2.64	2.10	2.61	2.66	1.92*
HFP 2007	2.75	2.30	2.78	2.76	2.57
HFP CCC 2007	2.58	2.37	2.79	2.78	2.52
SFHP 2006	2.66	2.15	2.58	2.68	2.33
HFP 2006	2.71	2.29	2.78	2.76	2.55

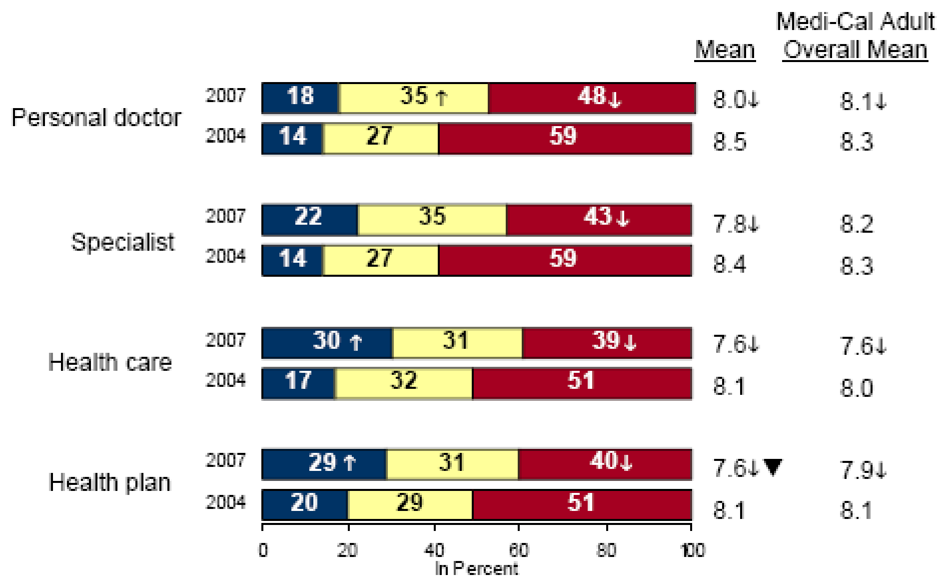
↑↓ Statistically significantly higher/lower than SFHP 2007
* Scores based on observations of less than 30 should be viewed with caution.

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 for our population. SFHP is the only health plan with a predominantly Chinese-speaking membership and 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.

CAHPS Results for Medi-Cal

The California Department of Health Care Services (DHCS) also assesses the satisfaction of its enrollment using the CAHPS survey. Like the Healthy Families Program, the survey is administered by an external vendor and results are reported back to each health plan. We received our results in December 2007 and began to evaluate them. We were very concerned to see decreases in satisfaction in several areas since the last survey was administered in 2004. In 2008, we will continue to analyze our results and look for opportunities to improve member satisfaction.

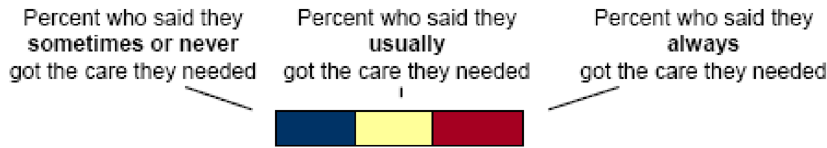




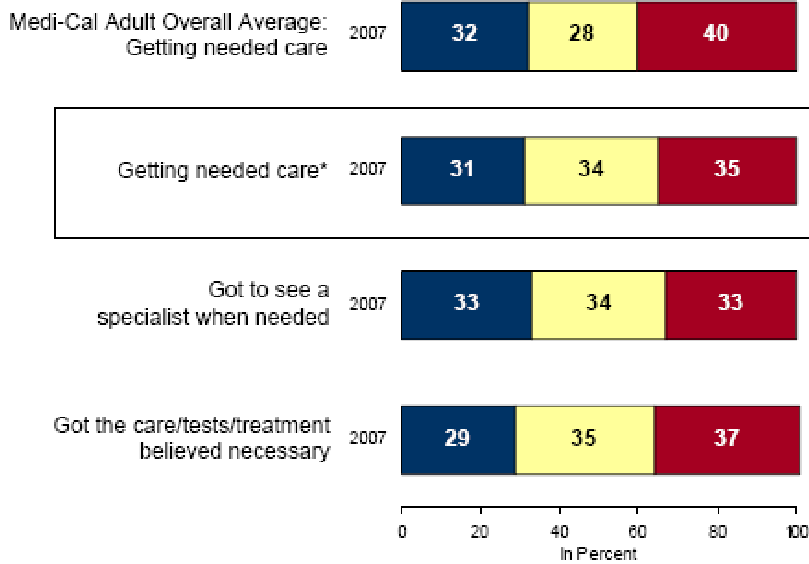
Adult members were asked to rate the following on a scale of "0 to 10," where a "0" means worst possible and a "10" means best possible:

- Their personal doctor (AQ21)
- The specialist they see most often (AQ25)
- The health care they've received in the past 6 months (AQ12)
- Their health insurance plan (AQ35)

↑ significant increase from 2004
↓ significant decrease from 2004
▲ significantly higher than Medi-Cal Adult Overall Average
▼ significantly lower than Medi-Cal Adult Overall Average



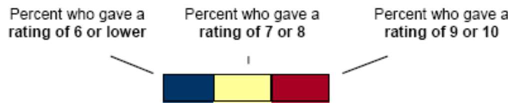
Adult Ratings



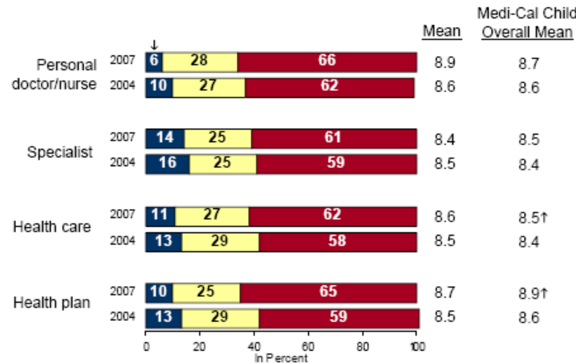
*To get the percentages shown for the composite score, we averaged the answers to two individual survey questions. These questions asked adult members to tell how often they:

- Got to see a specialist that they needed to see (AQ23)
- Got the care, tests, or treatment they or their doctor believed necessary (AQ27)

▲ significantly higher than Medi-Cal Adult Overall Average
▼ significantly lower than Medi-Cal Adult Overall Average



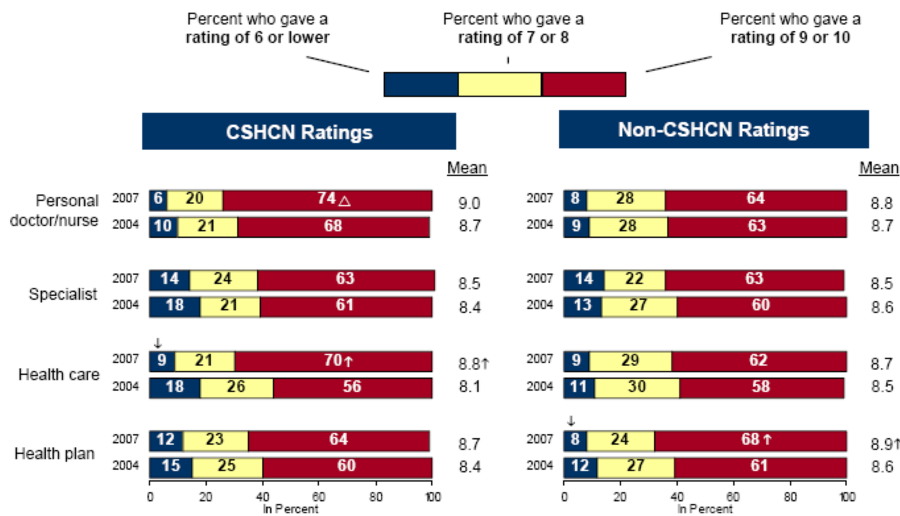
Child Ratings



Child members were asked to rate the following on a scale of "0 to 10," where a "0" means worst possible and a "10" means best possible:

- Their personal doctor or nurse (CQ5)
- The specialist they see most often (CQ15)
- The health care they've received in the past 6 months (CQ51)
- Their health insurance plan (CQ88)

↑ significant increase from 2004
↓ significant decrease from 2004
▲ significantly higher than Medi-Cal Child Overall Average
▼ significantly lower than Medi-Cal Child Overall Average



Child members were asked to rate the following on a scale of "0 to 10," where a "0" means worst possible and a "10" means best possible:

- Their personal doctor or nurse (CQ5)
- The specialist they see most often (CQ15)
- The health care they've received in the past 6 months (CQ51)
- Their health insurance plan (CQ88)

↑ significant increase from 2004
↓ significant decrease from 2004
△ significantly higher than CSHCN/non-CSHCN

Monitoring Member Grievances

SFHP monitors grievances on a quarterly basis to identify trends and problems. Our quarterly reports help us look for ways to improve the service to our members.
In addition to looking for trends in 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.

- **167** member grievances were processed by SFHP, Kaiser, VSP, and Delta Dental.
- **14%** of grievances (**16** 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 resolution letters sent within 30 days.
- **99%** of non-exempt grievances met requirements for timeliness of acknowledgement letters set within five days.

Tracking and Trending Grievances
In order to identify patterns and changes in our grievances, we report grievance rates by line of business, medical group and category. Trends in 2007 were similar to previous years. Below are the grievance statistics for 2007 and the highlights from our analysis.

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

  - Medi-Cal 3.4 G/1KM
  - Healthy Kids & Young Adults 3.3G/1KM
  - Healthy Workers 2.7 G/1KM
  - Healthy Families 1.0 G/1KM

- The **Medical Groups** as ranked by *grievances per thousand members* (G/1KM):

  - Kaiser Permanente (KSR) 17.4 G/1KM
  - University of California San Francisco (UCSF) 8.1 G/1KM
  - Physicians Integrated Medical Group (PIMG) 2.7 G/1KM
  - Chinese Community Health Care Association (CCHCA) 2.6 G/1KM
  - Community Health Network (CHN) 1.5 G/1KM
  - North East Medical Services (NEMS) 1.0 G/1KM

- Grievances handled by SFHP by grievance category

CATEGORY	Grievances	% of total
Denials/Refusals	37	32%
Access	28	24%
Quality of Service	24	21%
Billing	16	14%
Enrollment	7	6%
Quality of Medical Care	2	2%
Benefit/Coverage	1	1%
TOTAL	**115**	**100%**

Important Findings for 2007

- In 2007 the number of access related grievances increased particularly from CHN and UCSF members. The grievances pointed toward capacity issues in both Medical Groups. We alerted UCSF to this issue and shortly thereafter UCSF decided to close to new members. We began work with CHN to develop methods to increase capacity in primary care clinics.

- In 2005, we identified an upward trend of denial/refusal grievances from Physician's Integrated Medical Group (PIMG). We brought this to the attention of PIMG's leadership and saw a decrease in the number of grievances in 2006 and a further decrease in 2007.

- The quality of service category rose to the top three in 2007 while enrollment and eligibility decreased substantially and fell out of the top three. We saw far fewer grievances related to HKYA eligibility from members who were disenrolled

because they were attending schools outside of the nine Bay Area Counties. We believe that increased awareness of eligibility guidelines lead to the decrease in grievances.

- Further analysis of the increase in quality of service grievances did not uncover any systematic problems.

III. Ensuring Access to an Excellent 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 Joint Administrative Meetings (JAMs) conducted with the medical group administrative staff, SFHP staff also met with the clinical and administrative staff in our doctors offices to strengthen our collaboration on quality activities and improve access to health care.

Provider Outreach Activities

In 2007, 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 quality measurement results and in many cases helped them think of ways to improve. We also visited many 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. Similar to 2006, the survey was tailored to each medical group and to capture and eliminate questions that may not yield actionable feedback. Eighty-two out of 229 PCPs and clinics returned surveys. The response rate of 35.8% is higher than that of the 2006 survey (29.8%). No surveys were returned due to incorrect mailing addresses, reflective of the accuracy of our provider contact information. We excluded Kaiser and UCSF from the survey because we do not have direct relationships with PCPs in those two groups. After excluding UCSF and Kaiser, our survey covered providers serving 86.8% of our members. Below are response rates by medical group.

Medical Group	# of Responses	# of PCPs for MG	% of Response for MG
Chinese Community Health Care Association (CCHCA)	17	45	37.8%
Community Health Network (CHN)	41	107	38.3%
North East Medical Services (NEMS)	12	35	34.3%
Physicians Integrated Medical Group (PIMG)	12	42	28.6%

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

- DPH providers are concerned with clinic administration issues that surround the Healthy Worker program and managing member assignments in the community and hospital based clinics.

- A key concern for CHN providers continues to be access to specialists and diagnostic services, and by extension, some frustration with the SFHP utilization management process for out of network referrals.

- Comments on the SFHP formulary continue to attract some negative feedback from all medical groups but generally the responses were favorable. A clear area for improvement however, lies in our pharmacy denial appeal resolution process.

- 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 from our provider website. Consequently, SFHP is upgrading the provider site to offer more content.

Provider Education and Training

In response to feedback from our Provider Satisfaction Survey, we worked to make more resources available to our providers. In 2007, we improved the content for providers on our website, expanded our clinical guidelines, and sponsored two targeted provider trainings. Our website now includes information for providers on the following:

- CDC Immunization Guidelines and catch Up Schedule for 2007
- SF City Clinic's STD Prevention Guidelines
- SF TB Control Units Guidelines

- Type II Diabetes Care Guidelines
- Strep Test for Pharyngitis
- Avoiding Antibiotic Resistance
- JNC7 Guidelines for Hypertension
- ATPIII Guidelines for Hyperlipidemia

We also communicate with our providers via fax-blasts and our provider newsletter *Informed*. We use the newsletter and fax-blasts to keep our providers up-to-date on SFHP benefits and resources offered by SFHP. Information on upcoming events and trainings, like those described below, are also included in our newsletters.

Improving Care for Adolescents: Provider Training on Adolescent Health Toolkits
As part of the Medi-Cal Statewide Adolescent Health Quality Improvement Collaborative, we launched a series of trainings in 2007 for two high volume clinics. The trainings offered both clinicians and front office staff information and skills to help them improve care for teens. We used materials and curriculum developed by the Adolescent Health Working Group. The series included:

- Adolescent Health Care 101: The Basics
- Understanding Confidentiality and Minor Consent in California
- Sexual Health
- Body Basics
- Community Behavioral Health

Physicians and office staff attended from both clinics and responded that the training helped them feel more comfortable treating adolescents. After the training, we provided the clinics with:

- Pedometers, BMI wheels and Boys & Girls Club vouchers
- Adolescent Resource Guide (developed by AHWG)
- Wall posters, pocket cards, health education materials (developed by AHWG)

Adolescent Behavioral Health Provider Toolkit Trainings
In 2007, we partnered with Blue Cross to sponsor training for our providers on the Adolescent Health Working Group's (AHWG) Behavior Health Toolkit. Fifty-five providers attended the training. In the training, providers learned to:

- Assess practice for readiness to engage in behavioral health assessment and primary care interventions with youth and their families
- Complete a screening behavioral health assessment with adolescent clients/patients and their families
- Assess urgency of behavioral health issues in adolescents
- Make culturally sensitive community behavioral health referrals
- Assist youth and families with behavioral health referrals

In addition, SFHP developed with the Community Behavior Health Services (CBHS) staff a list of mental health and substance abuse programs throughout San Francisco: *2006-2007 Community Behavioral Health Directory* that was distributed through our website and at the training sessions.

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 2007, 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 approximately 54,000 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 2007:

Medical Group	#Members < age 18	# PCPs caring for children	# Members > age 18	# PCPs caring for adults
CCHCA	4,277	18	3,668	40
UCSF	2,695	44	1,828	58
NEMS	5,657	19	4,301	23
PIMG	3,508	46	1,748	52
CHN	9,550	77	14,663	157

Note: PCPs caring for children include physician and mid-level PCP's designated as adolescent medicine, family medicine, family practice, pediatric adolescent medicine, or pediatrics. PCPs caring for adults include physician and mid-level PCP's designated as family medicine, family practice, general practice, geriatric medicine, internal medicine, or OB/GYN.

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.

	CCHCA	UCSF	NEMS	PIMG	CHN
Obstetrics & Gynecology	13	55	8	19	30
Cardiology	9	10	1	6	6
Endocrinology	2	15	1	1	7
Gastroenterology	7	15	6	2	4
Radiology	4	84	1	2	17
Pulmonary	3	17	4	7	7
Ophthalmology	8	82	14	14	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:

Medical Group	# Chinese speaking PCPs	# Spanish speaking PCPs	# Vietnamese speaking PCPs	# Russian speaking PCPs
CCHCA	**44**	**2**	**2**	**0**
UCSF	**5**	**19**	**2**	**0**
NEMS	**24**	**3**	**4**	**1**
PIMG	**4**	**35**	**1**	**4**
CHN	**11**	**68**	**9**	**1**
Totals	**88**	**127**	**18**	**6**

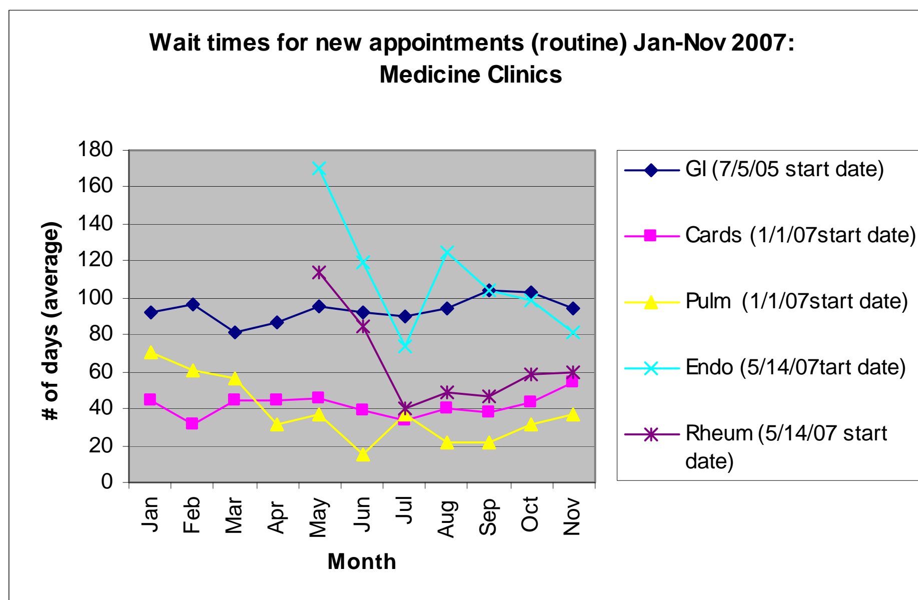
Wait Times for Key Specialty Areas at SFGH
In 2007 we collected data from our DPH clinics about wait times for appointments for specialty consults and diagnostic testing as a method of measuring access for CHN members. Each month data was collected through a telephone survey of specialty clinics and 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 has already decreased wait times for specialty appointments, diagnostic testing, and specialty interventions. This project is discussed below.

eReferral Spread Project

In 2006, the SFHP Governing Board elected to address the issue of improving access to specialists by launching the eReferral Spread Project. The Board elected to support the "spread" of the eReferral electronic referral system to four SFGH specialty clinics (Cardiology, Pulmonary, Endocrine and Renal) with the goal of eventual replication in multiple SFGH specialty clinics. The goal was to replicate the positive outcomes that had been generated by an electronic referral and triage system, piloted at San Francisco General Hospital's (SFGH) GI Clinic. Using an early version of eReferral at that clinic reduced wait times for appointments from 11 months to 3.5 months.

In 2007, the SFHP Governing Board approved additional funds for the spread of eReferral to eight surgical clinics and to the Department of Radiology at SFGH. In addition, monies were granted to the San Francisco Community Clinic Consortium to identify technological solutions that could improve access to eReferral for community clinics that refer patients to San Francisco General Hospital for specialist and diagnostic services.

To date, implementation of eReferral has resulted in an overall pattern of improvement of wait times, although the magnitude and stability of the improvement varies from clinic to clinic, and has shown a tendency to level-off once the system is in place for a few months.



A particular benefit of eReferral is shown by the number of "not initially scheduled" and "overbooked" referrals. "Not initially scheduled" are referrals that require additional history or additional diagnostic evaluation, are not appropriate referrals, or can be managed by the primary doctor with some guidance. These "saved" specialist appointments represent an opportunity for improved efficiency that frees up specialty

care appointments. Rates of "saved" appointments range from 13% of total appointment requests for Rheumatology and Cardiology to 47% for Endocrinology.

eReferral also allows a qualified specialty reviewer to systematically triage appointments. Patients with urgent need are given more immediate access (overbooked). Rates of "overbooked" appointments ranged from 12% for Orthopedics to 59% for Rheumatology. Higher overbook rates can be attributed to a combination of higher clinical urgency and wait times (e.g. a clinic whose wait time is only a month will need to overbook less frequently than a clinic whose wait time is nine months).

Data for June-November 2007				**May 14th start date**	**May 14th start date**	**July 16th start date**	**July 16th start date**
Clinic	**GI**	**Cardio**	**Pulm**	**Endo**	**Rheum**	**Ortho**	**NSU**
Total eReferrals received (1)	1100	463	209	210	222	909	108
Not initially scheduled (2)	273 (25%)	61 (13%)	38 (18%)	98 (47%)	29 (13%)	190 (20%)	27 (25%)
Routinely scheduled	625 (57%)	288 (62%)	138 (66%)	50 (24%)	59 (27%)	612 (67%)	63 (58%)
Overbooked (3)	177 (16%)	113 (24%)	30 (14%)	61 (29%)	132 (59%)	105 (12%)	18 (17%)

Sources: data query, contact with clinic

(1) Does not include discarded/duplicate eReferrals

(2) Number/percent of premature or unnecessary appointments that were initially not scheduled

(3) Number/percent of scheduled appointments that were expedited, i.e. clinically triaged

eReferral received the 2007 California Association of Public Hospitals and Healthcare Systems' top award for Improvement in System-Wide Care Integration. eReferral has proven to be a valuable platform to identify improvement opportunities both within the eReferral system and in the larger system of care that surrounds it. It has attracted the interest of other health systems and additional funders to support future innovations.

A formal evaluation is underway. At this point, a survey of primary care providers has been completed. Primary care providers were generally very enthusiastic about eReferral and its impact on clinical care. Overall, two-thirds (62%) felt that patient care has improved with eReferral; only 7% felt that care has worsened. Of note, providers at Consortium clinics tended to view eReferral less positively. The less enthusiastic (although still favorable) view of eReferral by these providers likely reflects difficulties with accessing eReferral due to connectivity problems. As noted, SFHP has provided funding to determine a method to address this issue.

eReferral has proven to be a powerful tool to drive access improvement in the SFHP provider network, a trend we hope will continue as eReferral spreads to additional clinics. We anticipate that a continuing evaluation process will identify additional access improvement options to magnify the gains that the eReferral system promises to achieve.

Disability Access Project:
Providing Access To Health Care (PATH)

SFHP 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.

Phase I of PATH Completed in 2006
The goal of Phase I was to pilot a survey to assess the architectural and programmatic capabilities of our provider offices. SFHP Provider Relations Department worked with DREDF to develop and administer a pilot survey tool. In 2006, SFHP completed surveys at 14 provider sites.

Phase II of PATH
The goals of Phase II are to complete surveys at all targeted primary care sites and to survey key specialist provider sites. Surveys of specialty provider sites are planned for 2008. In 2007, we completed surveys at 120 primary care provider sites. The survey results showed that there is adequate, if not fully compliant, access to buildings and most offices. However, specialized equipment, such as height-adjustable exam tables, wheelchair accessible scales, and TTY/TDD machines are not commonly available. Additionally, 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 III of PATH
The goals for Phase III are below and are planned for 2008-2009:

- 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, provider and SFHP staff education plan to create a knowledgeable and skilled network able to serve all members with disabilities

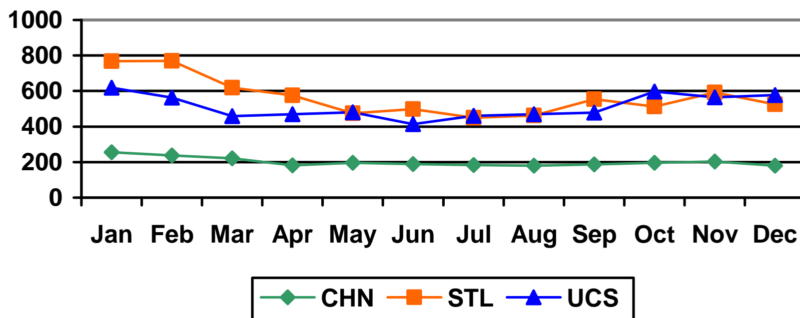
V. Medical Management

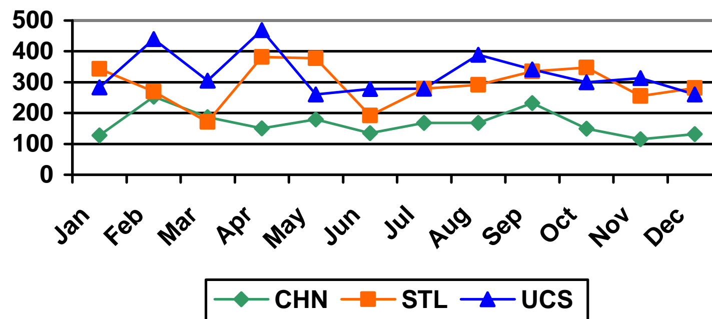
Utilization Management

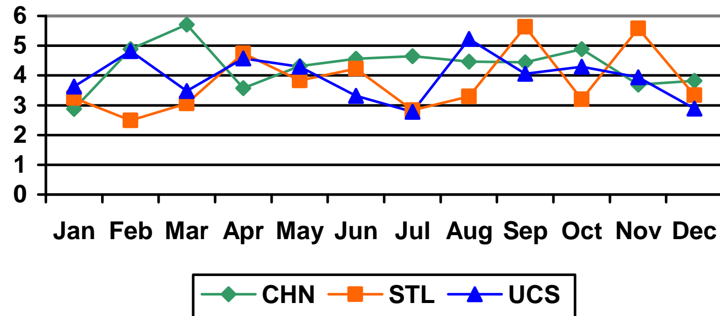
SFHP and its medical groups work under a Utilization Management Program and set of policies that assure that effective and appropriate health care services are delivered to our

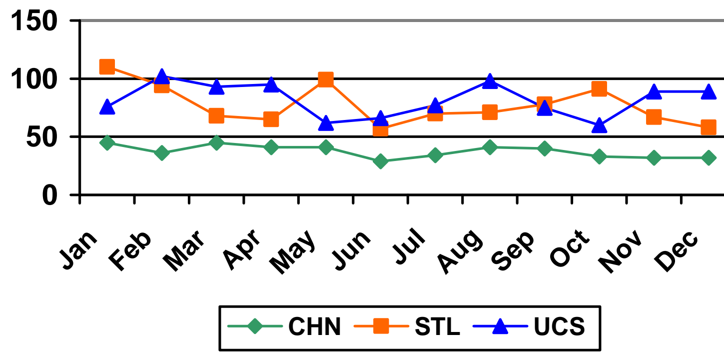
members based on sound clinical principles. Under our QI Program, we monitor under and over-utilization, and continuity and coordination of care. We comply with strict standards for issuing denials and responding to appeals to assure member rights are protected. Quality of care is monitored, and our Peer Review Committee addresses instances of poor quality.

SFHP provides utilization management services for three of our medical groups, University of California San Francisco (UCSF), Physician's Integrated Medical Group (PIMG), and Community Health Network (CHN). We monitor inpatient admissions and emergency room visits for these groups. The reports below show that our rates have remained fairly constant. PIMG and UCSF have higher ER visit rates and inpatient rates than CHN. We know from previous studies that patients assigned to UCSF tend to be sicker than members assigned to our other groups. In 2007, we began work with PIMG to reduce ER visit rates and a slight reduction was observed toward the end of 2007.









Utilization Management Denial Letter Audit

The Utilization Management Department conducts quarterly denial letter audits to ensure that members receive letters meeting regulatory guidelines and strict quality standards. A sample of denial letters is chosen every quarter and reviewed on nine quality standards. In 2007 the audit results showed 100% compliance with most standards. The only errors found were typos (one letter) and using the language "your" instead of "your child" in letters addressing services for members under the age of 18. Staff was reminded to review letters for appropriate language. We will continue to monitor denial letters quarterly.

Coordination of Care with Community Agencies and Waiver Programs

SFHP members who need specialty care are referred by their primary care practitioners to specialists and may also receive services from many agencies in the community with which SFHP has memorandums of understanding. These community programs include California Children's Services (CCS), Golden Gate Regional Center (GGRC), Early Start (ES), Women, Infants and Children (WIC), Community Behavioral Health Services, Sexually Transmitted Disease/Infections Services and the Tuberculosis-Direct Observed Therapy (TB-DOT) Assistance Program. SFHP members are also eligible for services from the federal waiver programs: HIV/AIDS Waiver Program, the Multipurpose Senior

Services Program, Nursing Facility/Acute Hospital Waiver, and Home and Community Based Services Waiver for the Developmentally Disabled. SFHP informs our members and practitioners about these services and how to access them through the SFHP Community Resource Guide, Joint Administrative Meetings with our Medical Groups, and featured articles in our Provider Newsletters. In addition, SFHP is responsible for assuring that there is comprehensive care coordination when PCPs make referrals.

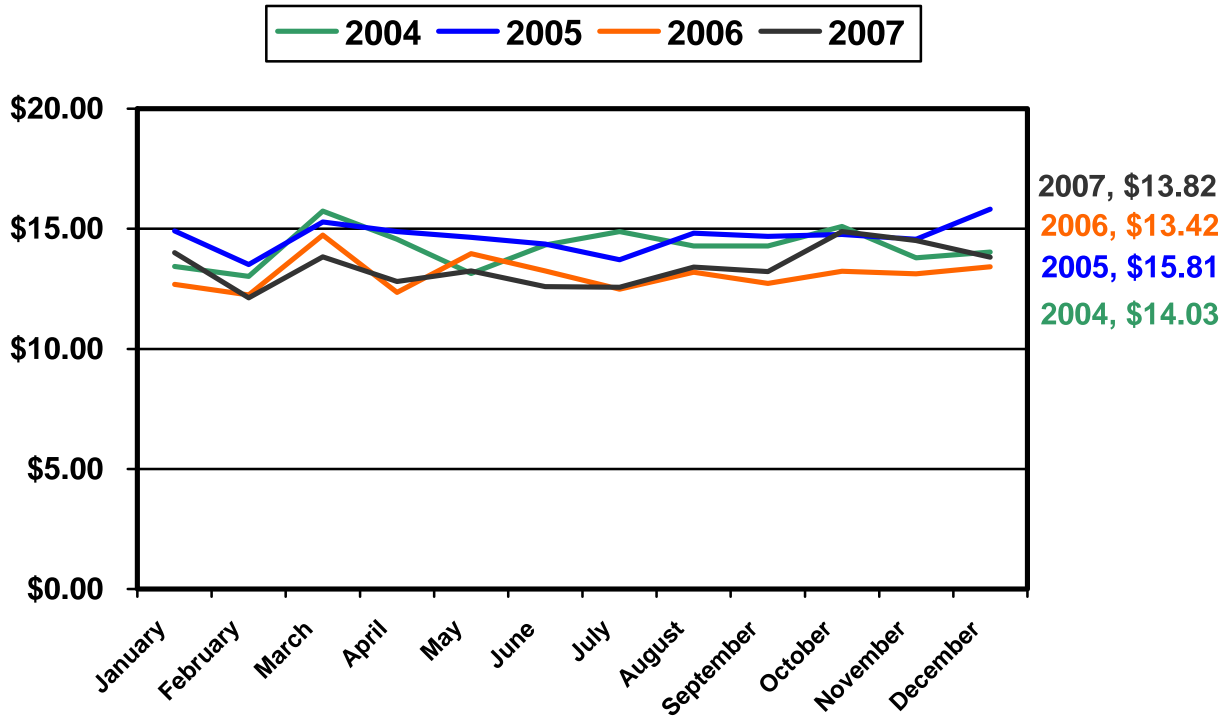
- We continued to work with PCPs and specialists to help refer children to CCS services. We maintained a CCS common member lists and sent monthly lists to providers and medical groups until October of 2007 when SFHP and its medical groups were able to obtain direct access to CCS lists on the Internet. This website is routinely updated and has the current information and authorization status on our members.

- In 2007, SFHP was a pilot site for the Department of Health Care Services in developing a common member list of Golden Gate Regional Center and Early Start members. Once the system was refined, DDS and DHCS implemented monthly common member lists in October 2007. We receive the list from DHCS monthly and distribute it to staff at Golden Gate Regional Center, Early Start and case managers at each of our delegated medical groups for care coordination.

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) remained stable in 2007, because the membership in our lines of business has been stable.

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



SFHP manages pharmacy costs through our generic-preferred formulary and prior authorization process. In 2007, over 80% of prescriptions were filled with generic medications and the average cost per prescription (all prescriptions, brand and generic) was $29.13. In 2007, less than two percent of paid prescriptions required a new prior authorization each month.

In 2007, our Pharmacy and Therapeutics (P&T) Committee met four times to maintain the SFHP formulary and to add new drugs as appropriate. The Committee completed the full three-year drug class rotation and reviewed medications and supplies in the ophthalmic, migraine, hypnotic, anticonvulsant, contraceptives, hormonal agents and dermatology 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.

The pharmacy department has maintained the electronic review and filing of pharmacy prior authorization requests. The percent of all authorizations processed in less than five days was almost 95% in 2007.

IV. Making Health Education and Cultural and Linguistic Services Available to Members

Health education and cultural and linguistic competency principles are fully integrated into our quality improvement activities. Each intervention takes into consideration the specific characteristics and needs of our subpopulations. In response to the Medi-Cal Group Needs Assessment completed in 2006, provider recommendations, and member input, we continued many existing projects and launched new projects in 2007. Our health education and cultural and linguistic initiatives are focused on addressing the health needs of our population and include: efforts to promote nutrition and physical activity, encourage regular preventive health screenings and check-ups, promote immunizations, timely prenatal care, promote management of chronic illness, improve access to cultural competency training and to reduce disparities in care among African Americans.

Health Education and Cultural and Linguistic Services Group Needs Assessment

Every five years, as part of its contractual requirements for both Medi-Cal and Healthy Families, 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 data from member and provider surveys, regional demographic data, as well as SFHP administrative and utilization data, our goal is to discover ways SFHP can meet the needs of our members and providers and set priorities for future projects. The data gathering for the Medi-Cal and Healthy Families Group Needs Assessments was completed in 2006. The results for Medi-Cal were completed and summarized in the 2006 Quality Improvement Annual Evaluation. The results for Healthy Families were completed in 2007 and were very similar to those for Medi-Cal. A full report from the Healthy Families GNA is available from SFHP and the major findings are summarized below.

Satisfaction with Health Care Services
Ninety percent of SFHP members are satisfied overall with the services they receive through the health plan and specifically are very satisfied with the care received from their doctors, the respect and courtesy received at the place where care is received, and with the quality of information provided by both the doctor and the health plan. Over 90% of all members report being treated respectfully when they go to their doctor and/or clinic. Drivers of SFHP member satisfaction included the quality of information that is disseminated by SFHP, the quality of information that is received from the provider, and the length of time it takes to see a doctor after an appointment is scheduled. One area for improvement is the wait time when visiting a specialist and the perceived quality of care received from specialists.

Language Access
Less than two percent of members indicated that their provider does not fluently speak the languages that they understand. Survey respondents without a doctor fluent in their native language or at signing were less likely to be comfortable with the suggestions and advice supplied by this provider. Of this member group, approximately 33% were unaware that San Francisco Health Plan will provide them with a free interpreter, if requested.

Cultural Competency
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 reported that they are able to appreciate and incorporate their patients' beliefs into their medical treatments and recommendations. They also reported being interested in more training around cultural competency.

Emergency Room Utilization and Access to Care
The majority of members reported receiving health care services when needed and visiting their primary care physician rather than seeking emergency room treatment. However, nearly one third of members reported a desire and/or need for weekend and evening medical services and that current medical scheduling represented a significant barrier to access.

A specific subset of questions for members that visited the emergency room revealed that one third of them first contacted their PCP or equivalent and were told to seek medical attention in the emergency room. The majority of SFHP members who visited the emergency room did so because they felt it was easier to get care in the emergency room than in a PCP office.

Health Education Needs
The health education topics identified as most important to members and providers were nutrition, exercise, and obesity. Members reported that they prefer to receive health education via postal mail or from their doctor's office. The majority of members had never attended a health education class and less than one half reported that they would consider doing so. The least favorable method for obtaining health information was via the internet.

The provider survey indicated an interest in learning more about how to access community health care resources for patients, how to incorporate cultural health beliefs into their practices, and increased access to patient education materials. Providers also reported that there was not one mode of relaying health information that was preferable to others; rather, they preferred being given multiple options to best suit an individual patient's needs.

Disparities in Utilization of Preventive Services
While we continue to show improvement for a majority of our HEDIS measures, when broken down by race/ethnicity, African Americans were least likely to receive preventive

health services including: well-visits, immunizations, breast cancer screening, and postpartum visits.

Opportunities for Improvement
In 2006, the results from the Medi-Cal GNA led us to identify the following opportunities for improvement:

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

We now have the benefit of the results of both the Medi-Cal and Healthy Families GNAs to help us set priorities for our Health Education and Cultural and Linguistic Services activities. In 2007 we identified three additional areas for improvement.

- Increase educational opportunities around nutrition and physical activity
- Increase access to education resources for members and providers on management of chronic conditions
- Improve availability of cultural competency trainings for providers and staff

Health Education for members and providers

Health education 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 paper and on-line formats which are used to respond to member and provider requests. Our redesigned website includes an easy-to-navigate repository of educational materials that providers, members, and visitors can access and print via their respective web pages. Currently, we have on-line materials in multiple languages that address topics not limited to but including: asthma, diabetes, breastfeeding, and weight management. We plan to extend to more content areas in 2008.

Targeted health education mailings
As part of our quality improvement initiatives to promote preventive care and management of chronic conditions, SFHP also proactively mails health education materials to members. We mail information and health reminders on the following health topics:

- Immunizations for 0-2 year-olds
- Well-checks for 3-6 year-olds
- Well-checks for 12-21 year-olds
- Cervical cancer screening
- Breast cancer screening
- General women’s health ages 27+

- General young-women's health ages 16-26
- General diabetes management including information on exercise and nutrition
- Diabetes eye exams
- General asthma management
- Asthma controller medications
- Initial health assessments
- Pregnancy education books

Our quarterly newsletter continues to be an important means for communication health education messages to our members. The newsletter, *Your Health Matters*, regularly includes articles on topics such as child safety, wellness tips, and SFHP's community partnerships.

Health Education Messages in Print Media

In 2007, we also began using print media to communicate on important health topics in our community. We initiated a social marketing campaign to address nutrition and women's health. Four newspaper ads were written and designed by SFHP Health Education and Cultural and Linguistic Services and Marketing Departments. The topics included:

- How to read a nutrition label
- Limiting portion sizes
- Taking folic acid
- General nutrition tips

These ads were translated into Spanish and Chinese and placed within local newspapers in the San Francisco area.

Health Education Compensation Program

In 2007, SFHP launched a program to make it easy for providers to receive reimbursement for health education classes. Our providers have always offered a wide variety of excellent health education classes, but they rarely submitted claims for reimbursement. Providers found our reimbursement form onerous to complete and the reimbursement too low to justify the expense of filling out the form. We made the following changes to our reimbursement program to increase provider participation:

- Released a new, simplified reimbursement form
- Increased reimbursement rates
- Offered an electronic submission option
- Implemented a process where clinic directors can designate where the reimbursement funds should be sent

The Manager of Health Education contacted all of our high-volume provider sites after the launch to offer support and training on our new reimbursement process.

Health Education Classes on the SFHP Website

As a part of our restructuring our health education reimbursement process, we collaborated with our medical groups to compile and post listings of health education

classes offered within our network. Providers and any other visitor to the website can search for classes by medical group, topic, and the languages in which they are offered.

Nutrition and physical activity resources

Healthy Weight Initiative
The Medi-Cal and Health Families GNAs revealed that both providers and members identify obesity as the primary issue in which further education and support services are needed. SFHP formed a Healthy Weight workgroup to identify means to fill service gaps. In response to provider requests, SFHP decided to sponsor nutrition education classes at three pilot clinics: Southeast Health Center, Maxine Hall Health Center, and Silver Avenue Family Health Center. Initial plans were to contract with Weight Watchers to provide a series of classes on healthy eating and food choices. After further investigation, we found that Weight Watchers would not be the best choice for our membership. SFHP remains committed to finding another option and the Healthy Weight workgroup has been researching alternatives. Our priority is to find weight management education that emphasizes affordable options for nutrition and exercise while taking into account the language and cultural needs of our members.

San Francisco CHDP Program Childhood Obesity Prevention Workgroup
In 2006, 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 San Francisco 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 2007, SFHP contributed to the development of the database and will assist with implementation and project evaluation in 2008.

Promoting Cultural Competency and Language Access

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 was well attended by a diverse group of providers serving the African American community including representatives from community based organizations, physicians, nurses, social workers, and mental health

professionals. SFHP will continue to be involved in the planning and implementation of this training on an annual basis.

Cultural Competency Trainings for Our Providers
In 2007, as part of our medical group oversight audits, we found that some of our groups needed assistance providing cultural competency trainings for their provider networks. In order to support our providers we initiated plans to sponsor a two day “Train the Trainers” Cultural Competency Workshop to be conducted by the UCSF Center for Health Professionals. Participants in the workshop will create a customized cultural competency training curriculum that they can then take and use for trainings in their provider network. We identified two medical groups with the greatest need for support in this area and invited them to send staff to the workshop. SFHP will also send three staff members to the training.

Cultural Competency Trainings for SFHP Staff
In 2007, SFHP staff had several opportunities for cultural competency training. The New Hire Orientation at SFHP added a new section called An Introduction to Cultural Competency, conducted by the Manager of Health Education and Cultural and Linguistic Services. We also held another Talk Story Brownbag in Spring 2007. The Talk Story Brownbags were a series of lunchtime meetings, open to all SFHP staff, devoted to discussions on the cultural diversity of our membership and its implications for our every-day work. The meeting held in the spring focused on the disparities in care among language and racial/ethnic groups found in our HEDIS rates. Staff had the opportunity to examine the data and offer suggestions for improvement.

Language Access
SFHP monitors language access through medical group oversight audits, grievances and provider network monitoring. In addition to our regular monitoring activities, we began work on compliance with SB853, new legislation around language services provided by managed care organizations. SB853 requires all Department of Managed Health Care (DMHC) licensed managed care organizations to provide language assistance services to enrollees with Limited English Proficiency (LEP). It specifies that health plans are required to 1) provide translation, interpreter, and culturally competent services for those with LEP and 2) collect specific demographic information (race **and** ethnicity, preferred written **and** spoken language) of their members. This bill does not include services provided to Medi-Cal members.

We currently meet most of the requirements, however we will have to collect additional demographic data on our members and modify some of our policies and procedures to comply fully with the regulation. We must also prepare an initial demographic profile of our membership in 2008.

Examining HEDIS Rates by Race/Ethnicity and Language
While we made impressive strides in improving our overall rates for almost all HEDIS measures in 2007, an analysis by race/ethnicity and language demonstrates significant disparities in the rates for some measures. In general, all racial and language groups

tended to score above average in comparison to 2006 national average rates; although there were some areas and groups that merit targeted improvement. Our findings are summarized below:

- African Americans and English speakers had the lowest scores on most preventive health and chronic care measures in particular immunization and well-baby visits.

- Asian/Pacific Islanders and Hispanics had the highest scores on most preventive health and chronic care measures.

- Asian/Pacific Islanders had the lowest Chlamydia screening rates.

- Monolingual Chinese and Spanish speaking members had low Chlamydia screening rates and significantly lower screening rates than English speaking members within the same ethnic groups.

- Although we have very few Tagalog speaking members, they consistently scored lower than average on most measures.

Reducing Disparities in Care

In April 2007, we began an outreach program to help African American families connect with Primary Care Practitioners and ensure that they have timely access to preventive care. Each month, we identify families with children under the age of two who recently enrolled in the health plan. We call the family to welcome them to the plan, and offer information on immunizations and well baby visits for their child. In the call we make sure the family is happy with the PCP they selected or were assigned to and offer help changing PCPs if necessary. We also send a folder containing information about how to keep their child healthy and other culturally competent parenting resources. We targeted 121 families in 2007, averaging approximately 13 per month. Although the volume is low, SFHP will continue this program in 2008.

Our analysis of HEDIS rates by race/ethnicity consistently shows that Asian/Pacific Islanders have lower Chlamydia screening rates than other groups. In 2006, we offered an incentive for our physicians serving the Asian community to participate in a CME training on Chlamydia screening and on how to talk to patients about the importance of being screened. Several of our key providers completed the training however our Chlamydia screening rate did not improve. The message may need to be delivered multiple times and in different formats before we see a change in practice around this issue.

VII. Quality Monitoring

Facility Site and Medical Record Reviews

SFHP collaborates with Blue Cross of California to review all provider sites to ensure compliance with criteria set forth by the California Department of Health Care Services (DHCS). Each primary care site is reviewed every three years using a tool designed by DHCS. 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 are summaries of the reviews conducted in 2007.

Summary of Facility Site Reviews

MEDICAL GROUP	# REVIEWS IN 2007	SCORES 90% - 100% SITE REVIEWS	SCORES 80% - 89% SITE REVIEWS	SCORES <80% SITE REVIEWS
CCHCA	9	5	4	0
CHN	4	2	1	0
PIMG	5	3	1	1
NEMS	1	1	0	0
UCSF	0	0	0	0
TOTALS	19	11	6	1

Summary of Medical Record Reviews

MEDICAL GROUP	# REVIEWS IN 2007	SCORES 90% - 100% MEDICAL RECORDS	SCORES 80% - 89% MEDICAL RECORDS	SCORES <80% MEDICAL RECORDS
CCHCA	13	3	10	0
CHN	2	0	2	0
PIMG	10	6	2	2
NEMS	1	1	0	0
UCSF	0	0	0	0
TOTALS	26	10	14	2

We work closely with providers that fail their initial review and conduct a follow-up reviews six months after a failed review. In 2007, only one provider failed the initial medical record review with a score below 80%. We are working with the provider and medical group to help the site fully implement the corrective action plan. The site is closed to new member assignments while the corrective action plan is implemented.

In cooperation with Blue Cross, we conduct targeted trainings and share materials to assist offices in improving their site review and medical record review scores. In 2008 we plan to conduct joint trainings with Blue Cross on the following topics:

- Advanced Health Care Directives for members 18 years of age and older
- Staying Healthy/IHEBA assessments
- Annual TB risk assessments
- Vaccine Information Sheet (VIS) whenever an adult or pediatric vaccine is given.

These topics were also highlighted in San Francisco Health Plan's winter issue of our provider newsletter.

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:

DELEGATED ENTITY	AUDIT RESULTS	ACTIONS TAKEN
Kaiser	100% on all areas of the audit except utilization management • UM: One out of the six denial/referral files did not have a decision within the appropriate timeframe.	• Staff was instructed to send 14-day extension letter when more information was needed to make the decision. Clinical staff and management will follow-up and provide oversight to ensure timeliness.
CCHCA	100% on all areas of the audit except credentialing and cultural and linguistic services • Credentialing: All nine initial credentialing files were reviewed because there was one Attestation Statement with a "yes" response to "reason or inability to perform with or without accommodations" that needed to be clarified prior to the approval by the Credentialing Committee. • Cultural and linguistic services: CCHCA's existing policy regarding Access and Availability of Interpreter Services/Bilingual Providers and Staff required additional language to be compliant.	• File was sent back for clarification. The "yes" was changed to "no" by the provider. Staff will review future files for items that need clarification before the file goes to Credentialing Committee. • Policy was accepted after revision.

NEMS	100% in all areas except utilization management and cultural and linguistic services: • Utilization management: One denial letter did not contain the Medi-Cal appeal State Fair Hearing language. • Cultural and linguistic services: "Interpreter Services and Bilingual Staff" policy must state that: 1. documents will be translated into threshold languages and 2. members may file a grievance if linguistic needs are not met.	• SFHP shared denial letter templates and NEMS implemented them • NEMS revised "Interpreter Services and Bilingual Staff" policy.
PIMG	100% on all areas of the audit	
SFGH Medical Staff Office - (Community Health Network)	100% initial credentialing 100% recredentialing	
St. Mary's Medical Staff Office (Sister Mary Philippa)	100% initial credentialing 100% recredentialing on all areas except four which scored 90% or greater	
UCSF Medical Staff Office	100% initial credentialing 100% recredentialing	

As a result of the findings above, SFHP made the following changes:

- In 2006, we implemented quarterly audits of Kaiser's grievances because Kaiser was not consistently meeting timeliness standards for sending acknowledgement and resolution letters and letters did not contain Medi-Cal appeal language. We offered Kaiser assistance with improving their process and monitored their progress. In 2007, Kaiser scored above 98% for two consecutive quarters and we chose to discontinue our audits. Going forward, we will monitor Kaiser grievances as part of the annual oversight audit.

- Interim reviews of St. Mary’s Hospital’s credentialing process showed that they made the necessary improvements and no longer require interim monitoring.

- In response to deficiencies found in the area of cultural competency training, SFHP will sponsor a cultural competency train-the-trainer training in spring 2008. Each medical group will be invited to send up to three potential trainers to the workshop. SFHP will support the dissemination of the training after the workshop.

VIII. 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 2007, the quality monitoring reports such as the grievance reports, HEDIS results, provider satisfaction survey results, were presented at this meeting for review and discussion. 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 2007. The committee is made up of SFHP physicians and members and met four times in 2007 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:

- Evaluating possible interventions to reduce avoidable emergency room visits in preparation for the DHCS Statewide Quality Improvement Collaborative
- Addressing disparities in chronic care and utilization of preventive health care services by race/ethnicity and language

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. Physician representatives from five of our medical groups participated as members of the committee.

In 2007, the committee provided guidance for our chronic care management efforts. This included advising us on the following issues:

- Developing a weight management program for our members
- Identifying guidelines for hypertension and hyperlipidemia
- Creating a member health education piece on hypertension and hyperlipidemia
- Improving our asthma patient profiles sent to PCPs annually