Agenda Item 1:

Action Item

Approval of Consent Calendar

a. Minutes from January 7, 2015 Board Meeting
b. Minutes from the January 22, 2015 Quality Improvement Committee
c. Appointment to the Member Advisory Committee

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Agenda Item 1:

Action Item

Approval of Consent Calendar:

a. Minutes from
   January 7, 2015
   Board Meeting

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Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board
January 7, 2015
Meeting Minutes

Chair:	Susan Currin, RN
Vice-Chair:	Steven Fugaro, MD
Secretary-Treasurer:	Reece Fawley

Members Present: Edwin Batongbacal, Barbara Garcia, Eddie Chan, Irene Conway Reece Fawley, Steve Fields, Steven Fugaro, MD, Maria Luz Torre, and Brenda Yee

Members Absent: Dale Butler, Sue Currin, RN, John Gressman, Belle Taylor-McGhee, and Elena Tinloy, PharmD

Steven Fugaro, MD chaired the meeting and called the meeting to order. Dr. Fugaro asked if there was anyone from the public in attendance that wanted to make any comments. John Logan, National Account Executive, from Pharmacyclics was one guest in the audience for the open session.

John F. Grgurina, Jr., CEO, announced Irene Conway's nomination has been approved by the Board of Supervisor Office and signed by the Mayor. The Board welcomed Ms. Conway to the Governing Board. Mr. Grgurina also mentioned Belle Taylor-McGhee, Health Commissioner, is in the hospital. He will provide the hospital information for those who would like to send her well wishes after the Board meeting.

Mr. Grgurina announced that Lawrence Cheung, MD, has been nominated to replace Dr. Randall Low from the San Francisco Medical Society. We hope to have him approved by the Board of Supervisors Rules Committee soon and to have him join the Board by the March or May Board meeting.

In a related matter, Mr. Grgurina mentioned that several of our Board members' terms will be expiring in January 2015. The process to reappoint our Board members is underway and we are waiting to be placed on the agenda of the Rules Committee. Board members may continue to serve on the Board until the new appointment or reappointment is approved.

1. Election of Officers for San Francisco Health Authority and San Francisco Community Health Authority

Steven Fugaro, MD, stated it was time for the annual election of officers. John F. Grgurina, Jr., CEO, opened the floor for nominations for the Board Chairperson. Reece Fawley

nominated Sue Currin, RN, to serve as Chair. Her nomination was seconded and unanimously approved. Mr. Grgurina then opened the floor for nominations for the Vice-Chair. Reece Fawley nominated Steven Fugaro, MD. Dr. Fugaro was the sole nominee. He was unanimously approved as well. Mr. Grgurina then opened the floor for nominations for the position of Secretary/Treasurer. Steve Fields nominated Reece Fawley. Mr. Fawley was re-elected unanimously.

2. Approval of Consent Calendar

The following Board items were on the consent calendar for the Board's approval:

a. Minutes from November 5, 2014 Meeting
b. Review and Approval of Finance Committee Appointment
c. Review and Approval of Member Advisory Committee Appointment

The Board unanimously approved the consent calendar as presented without any issues.

3. Finance Committee Report

The following items were discussed in closed session:

a. Review and Approval of Year-To-Date Unaudited Financial Statements and Investment Reports
b. Review and Approval of Provider Medi-Cal Expansion Rates
c. Financial Discussion Items with Impact on Provider Rates

4. Review and Approval of Recommendation for Qualified Health Plan Potential 2016 Bid

5. Review Chief Executive Officer's Contingency Succession Planning

The Governing Board adjourned to Closed Session.

The Governing Board resumed in Open Session.

6. Report on Closed Session

Dr. Steven Fugaro reported that the Board approved the following action items.

a. Approved the Year-To-Date Unaudited Financial Statements and Investment Reports
b. Approved the Provider Medi-Cal Expansion Rates
c. Approved the Recommendation for SFHP's Covered CA Qualified Health Plan 2016 bid

7. Member Advisory Committee Report

Maria Luz Torre and Irene Conway reported that the Member Advisory Committee met in November 2014. At the November meeting the Committee finalized their 2015 goals. There was no meeting in December as the Committee had their end of the year holiday party.

8. Review and Approval of Revisions to Employee Handbook

Recommendation: San Francisco Health Plan recommends (SFHP) the Governing Board approve the proposed revisions to the SFHP Employee Handbook for calendar year 2015.

Peggy McCrea, Chief Human Resources Officer, mentioned each year the Employee Handbook is revised as needed and presented to the Governing Board for review and

approval. Changes include policy changes, as well as required legal updates, slight revisions to existing policies for clarity, and stylistic or grammatical changes. The following is a summary of the significant changes made to the Handbook for the Board's approval. (Please see detailed memo provided in the Board packet.)

Based on staff and external counsel review, several changes were recommended to provide additional clarity to an existing policy, add a new policy or to update policies as required by law. The following changes were recommend for the 2015 Employee Handbook:

- Cash Out Policy was revised to be in compliance with IRS tax guidelines. This topic was also discussed and approved during the January 2014 Board meeting, with an effective date of January 1, 2015.
- Floating holiday policy was changed to be a floating holiday tied to the birthday month of the employee. The policy changes the ability to use the floating holiday from any time during the year to only during the employee's birthday month. Tying the floating holiday to an employee's birthday month limits our financial exposure. This policy was also presented and approved during the January 2014 Board meeting, with an effective date of January 1, 2015.
- We increased the Employee Referral Award Amounts to encourage more employee participation.
- Added a provision to our Employee Review Policy to include guidance on handling internal transfers.
- Added language to exclude certain employees that work an alternative schedule and already receive holiday pay, from being eligible to receive a floating holiday if scheduled to work on an SFHP observed holiday.
- Removed option for employees to use only 50% of their available PTO during a leave of absence. Our current practice requires employees to exhaust all of their PTO before being able to take an unpaid leave.
- The revision also clarifies that employees must exhaust all PTO before being able to take an unpaid leave of absence.
- Added legally-required language regarding exempt employees and rest/meal breaks.

After some discussion, the Board unanimously approved the revisions to the San Francisco Health Plan Employee handbook for calendar year 2015.

9. <u>CEO Report</u>

John F. Grgurina, Jr., CEO, briefly highlighted the State budget, non-specialty mental health implementation and provider contract updates. Regarding the non-specialty mental health contract with Beacon Health Strategies, Barbara Garcia stated her department has received questions from community providers about how Beacon would work with community organizations that provide help to children that require trauma services. Coordination of services is one of Beacon's requirements, so we will monitor how well they fulfill this obligation. (Please see the January 7, 2015 CEO Report, incorporated as a reference document.)

10. Chief Medical Officer's Report

a. Practice Improvement Program (PIP) Update

Dr. Jim Glauber, Chief Medical Officer gave an update on the Practice Improvement Program (PIP). The PIP is SFHP's provider pay-for-performance program that incentivizes SFHP's providers to achieve improvements in system and health

outcomes. The primary objectives of PIP are aligned with the Quadruple Aim: improving patient experience, improving population health, reducing the per capita cost of health care, and improving provider staff satisfaction. Performance is measured on a calendar year and encompasses clinical quality, patient experience, system improvements, and data quality. This year, SFHP will begin sharing unblinded data with PIP participants to assist participants with benchmarking and sharing best practices. (Please see detailed memo provided in the Board packet.) Eddie Chan mentioned that his staff at North East Medical Services would like to include more clinical measures in the PIP. This would help providers reach more PIP measures.

Dr. Glauber also provided a brief update on the DHCS hepatitis C drug treatment guidelines and payment methodology, including a new reduction in rates DHCS obtained with Express Scripts. It is unclear whether this will trickle down to health plans.

11. Adjourn

The meeting was adjourned.

Reece Fawley, Secretary

Agenda Item 1:

Action Item

Approval of Consent Calendar:

b. Minutes from January 22, 2015 Quality Improvement Committee Meeting

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Quality Improvement Committee Minutes

Date: January 22, 2015
Meeting Place: San Francisco Health Plan, 201 Third Street, San Francisco, CA 94103
Meeting Time: 7:30-9:00am
Present: Daniel Chan, MD; Irene Conway, Edward Evans, Shawna Lamb, Dexter Louie, MD; Todd May, MD; Jaime Ruiz, MD; Richard Zercher, MD
Staff Present: James Glauber, MD

Topic	Discussion [including Identification of Quality Issue]	Follow-up [if Quality Issue identified, Include Corrective Action]	Resolution, or Closed Date [for Quality Issue, add plan for Tracking after Resolution]
Call to Order	• Meeting was called to order with a quorum at 7:35am • There were no public comments	•	•
Follow Up Items	Exception handling process • Committee needs to only advise on medical necessity on exceptions • An example would be the Transgender policy / facial hair removal / penile prosthesis status post-phalloplasty / both are not Medi-Call benefits, but are medically necessary under specific circumstances and will ask the committee to weigh in on the medical necessity only.	•	•

	• Another example that the committee might review are Ambulatory blood pressure monitoring – new draft grade A USPSTF recommendation o Not currently a covered Medi-Cal benefit o Federal gov is a draft recommendation, but if formalized need to make a member benefit o Medi-Cal is evaluating this o ET will make the final decision of the financial impact & volume before the final decision is made to include as a benefit. <u>Pain Management Update</u> • On pause o Original plan rolling out sequential dosage limits o This plan is on hold ▪ Pharmacy Director has left and awaiting for the new Pharmacy Director to be in place to participate in the discussion o PA process might not be the most efficacious and look at identifying upstream patients who are approaching dose limit rather than after their prescribed opioid regimen exceeds it o We will be evaluating Develop a performance metric for opioid prescribing at the practice level		

Consent Calendar	• Oct 9, 2014 QIC minutes
	• Membership Report
	• P&T Minutes – Jul 16, 2014
	• CMO Update
	• Policies Summary
	  o HE-01 SHA/IHEBA
	  o Pharm-02 Pharmacy Prior Auth
	  o QI-05 Access Policy & Standards
	  o QI-06 Member Grievances & Appeals
	  o UM-01 UM Notice of Action Letters
	  o UM-06 Abortion Services
	  o UM-11 Direct Access to OB/GYNs
	  o UM-14 Mastectomy Coverage
	  o UM-16 LEA Services in the SFUSD
	  o UM-20 CCS
	  o UM-21 Human Breast Milk Coverage for Infants
	  o UM-22 Authorization Requests
	  o UM-29 Behavioral Health Services
	  o UM-44 GGRC
	
	E. Evans – (unrelated to agenda item) why his SNF was not available in SF.
	
	Dr. May- many times there aren't enough beds for each patient, and we have to use any beds as soon as they become when it's available in order to transition patients from inpatients to a more appropriate level of care.
		•	• Oct 9, 2014 minutes approved
			• P&T Jul 16, 2014 minutes approved
			• HE-01 SHA/IHEBA
			• Pharm-02 Pharmacy Prior Auth
			• QI-05 Access Policy & Standards
			• QI-06 Member Grievances & Appeals (
			• UM-01 UM Notice of Action Letters
			• UM-06 Abortion Services
			• UM-11 Direct Access to OB/GYNs
			• UM-14 Mastectomy Coverage
			• UM-16 LEA Services in

	No additional comments and the consent calendar were approved.		the SFUSD • UM-20 CCS • UM-21 Human Breast Milk Coverage for Infants • UM-22 Authorization Requests • UM-29 Behavioral Health Services • UM-44 GGRC
Policies & Procedures	J. Soos presented the P&Ps: • CARE-01 Care Coordination and Case Management o Describes the new care support program, complex case management and care coordination program • CARE-03 Client and Staff Safety o Describes that all staff (licensed & unlicensed) are responsible for 3rd party potential harm, 5150, confidentiality & mandate reporting on child or adult abuse.	•	• CARE-01 • CARE-03
Quality Improvement	<u>Performance Improvement Program (PIP)</u> V. Pratt presented the update for PIP. There are three changes (1) reduced the overall number of measures, (2) the total number of points have decreased (3)	• Follow up with the rate of infant mortality rate between African Americans and Caucasians	•

	primary care measures – narrowed down to five measures based on participants lowest performance in 2014. <u>Health Disparities</u> S. Weis reviewed the Health Disparities. The data enables to see the idea of PCP protocols or member understanding that affects i.e. diabetic, hypertension and asthma rates. We discussed that the Tagalog language issue as a "barrier" to hypertension control/maintenance and to ensure follow-up directly with this population. Tagalog is not considered a Medi-Cal threshold language. <u>Q3 2014 Grievance & (UM) Appeals Reports</u> N. Ylagan & K. McDonald presented the data for Q3 2014 regarding grievances and appeals. Overall, the number of grievances increased 85% from 2013 to 2014, which is due to the increased Medi-Cal expansion population. In future, we will be giving a more detailed report of grievances associated by clinics, more analysis of UM & pharmacy appeals and access grievances which fulfill the CAP criteria for DHCS 2014 audit. No additional comments and questions for Quality		

	Improvement		
Utilization Management	Q2 2014 UM Report K. McDonald updated the committee with the latest data. No additional comments or questions for Utilization Management.	•	•

QI Committee Chair's Signature & Date: _____ _____2/3/15_____

Minutes are considered final only with approval by the QIC at its next meeting.

Agenda Item 1:

Action Item

Approval of Consent Calendar:

c. Appointment to the Member Advisory Committee

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201 Third Street, 7th Floor
San Francisco, CA 94103
www.sfhp.org

MEMO

Date: February 17, 2015

To	**Governing Board**
From	**Valerie Huggins** **(415) 615-4235** **Fax: (415) 615-6435** **Email: vhuggins@sfhp.org**
Regarding	Biography of Member Advisory Committee Member; Lee Rogers

As requested, we are providing you with biographies of all new members joining the Member Advisory Committee. Enclosed is the biography for Lee Rogers for your review.

Please direct any questions to Maria Luz Torre or Irene Conway, co-chairs of the Member Advisory Committee.

February 17, 2015

To: San Francisco Health Plan (SFHP) Member Advisory Committee (MAC),

My name is Lee s and I've been a member of the San Francisco Health Plan since 2011 and I am currently looking for work in the Information Technology Field.

I am a Veteran of the US Military and served in the Navy for six years with honorable discharge. I do not get VA benefits and I have to rely on Medi-Cal. This experience in navigating the Healthcare System has motivated me to want to make Healthcare more accessible and to improve the treatment of Veteran patients.

I would be grateful for the opportunity to sit on the SFHP MAC to be a voice for US Veterans who are not service connected.

Thank you for this opportunity to introduce myself.
Sincerely,

Lee

Agenda Item 5:
Discussion Item

Chair Report on Closed Session Action Items
(Verbal report only)

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Agenda Item 6:

Action Item

Review and Approval of Board Contract Approval Process

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201 Third Street, 7th Floor
San Francisco, CA 94103
www.sfhp.org

Governing Board Meeting

MEMO

Date	**February 23, 2015**
To	**Finance Committee and Governing Board**
From	**John F. Grgurina, Jr., CEO**
Regarding	**Review and Approval of Governing Board Contract Approval Policy**

Recommendation

San Francisco Health Plan (SFHP) recommends establishing a one million dollar threshold for contracts to be approved by the Board of Governors.

Background

SFHP proposes to establish a one million dollar threshold for contracts that would be required to be presented to the Governing Board for review and approval, within the following framework:

- SFHP holds a contract with the City and County of San Francisco as the third party administrator (TPA) for Healthy Workers, Healthy Kids and Healthy San Francisco. Through these programs there may be subcontracts that are required to fulfill our obligations as the TPA. We believe that since the Department of Public Health (DPH) reviews and approves the TPA services and budget for the program contracts, any subcontracts for the TPA businesses would not require approval by the Governing Board.
- Vendor contracts are often renewed on an annual basis. We propose that the policy for Board approval would not include review and approval of annual renewals of contracts.
- Due to having only six Board meetings per year, we would also recommend that the policy would allow some flexibility regarding exceptions when there are short timeframes and other parameters, e.g. employee health insurance benefits when we have to decide in two to three weeks among the bids and reinsurance, which requires decisions with less than one month. Flexibility could include the parameters of a deal that the Board would provide to the CEO, as was the case with the building leases. In this case, the Board authorized the CEO to execute the agreement as long as the contract was within the approved parameters provided by the Board.

We recommend approval of the contract threshold policy, with the above parameters. After one year of experience with this policy, we will revisit the policy and determine whether any revisions would be required, as well as explore establishing a policy regarding a threshold for requests for proposals for vendor services.

Agenda Item 7:

Action and Discussion Items

Action:

Member Advisory Committee CY2015 Goals

Member Advisory Committee Report

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201 Third Street, 7th Floor
San Francisco, CA 94103
www.sfhp.org

Governing Board Meeting

MEMO

Date: February 23, 2015

To	**Governing Board**
From	**Valerie Huggins** **(415) 615-4235** **Fax: (415) 615-6435** **Email: vhuggins@sfhp.org**
Regarding	**Member Advisory Committee Goals for Calendar Year 2015**

Attached are the Member Advisory Committee goals for your approval for calendar year 2015.

We are pleased the Member Advisory Committee continues to set goals for themselves and for the Plan. This year's goals are both reasonable and appropriate in our opinion and we request the Board's approval.

Maria Luz Torre and Irene Conway will present more detail at the meeting and respond to any questions.

MEMBER ADVISORY COMMITTEE
GOALS
2015

	Goal	Responsible/Timeline	Status
Goal #1:	Inform SFHP members on the "new" supervirus that causes epidemics, like ebola (article in the SFHP newsletter) how they spread and how to prevent it	**Jin Glauber, MD: SFHP Chief Medical Officer - February**	
Goal #2:	A presentation on GOUT, what causes it and how to prevent or manage i	**Val/Elia - March**	
Goal #3:	Pain Management – educate SFHP members about pain management	**Emily Coriale, Pharm.D.- April**	
Goal #4:	Mental Health Access – update info of providers, resources, other approaches to manage or cure depression, trauma (indicate language capacity of providers)	**Libah/Starr/Idell - May**	
Goal #5:	Teenagers - health care services specific to teenagers, also how to talk to teenagers about healthy lifestyle choices	**Maria/Libah - June**	
Goal #6:	Program to address and reduce obesity – example: free access to exercise programs	**James/Starr/Irene - August**	

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MEMBER ADVISORY COMMITTEE
SAN FRANCISCO HEALTH AUTHORITY
www.sfhp.org
(415) 615-4235
Maria Luz Torre & Irene Conway, Co-Chairs
415-722-6229

Meeting Agenda
January 9, 2015
1:00PM- 3:00PM
4 San Francisco Health Plan
201 3rd Street, 7th Floor, San Francisco, CA 94103

1. Welcome, Introductions & Roll Call

2. Adopt Agenda/Approve Minutes

3. Reports
   - Chairs & Governing Board: Maria Luz Torre & Irene Conway
   - Quality Improvement: Edward Evans & Irene Conway
   - Staff Report: John Grgurina, Jr. CEO
   - Health Education & Cultural Linguistic Services Update: Anna Le Mon, MSW, MPH, Project Manager, HECLS

4. Discussion: Dori Martini, Health Coverage Programs Training Specialist; Update on the Covered California and Medi-Cal Expansion Enrollments

5. Public Comment:

6. Calendar Items for Next Meeting:

7. Prospective Members:

8. Announcements:

9. Adjournment:

Please Note These Upcoming SFHA Meetings:

Member Advisory Committee:	February 6, 2015 (1pm -3pm)
Quality Improvement Committee:	February 12, 2015 (7:30am-9am)
Finance Committee:	March 4, 2015 (11am-12pm)
Governing Board:	March 4, 2015 (12pm-2pm)

The Committee meetings are public and wheelchair accessible. The Committee requests accommodations for those with allergies or chemical sensitivity. Please refrain from the wearing of scented products. Also, during the meeting please make sure all cell phones and pagers are off. Thank you for your cooperation.

January 9, 2015
Member Advisory Committee
Meeting Minutes

Members Absent: Willow Lancaster and Nancy Rodrigues

Excused: Raquel Cárdenas

Guests: Dorothy Barton and Lee Rogers

Staff: Valerie Huggins and John F. Grgurina, Jr. CEO

1. **Welcome, Introductions and Roll Call:**
   The meeting was called to order at 1:00pm.

2. **Approval of Agenda & Minutes:**
   The agenda was approved with one amendment to add the Committees goals as a discussion item. The minutes from the November 7, 2014 meeting were approved as written.

3. **Committee Reports:**
   Chair & Governing Board Report-Maria Luz Torre
   Irene Conway and Maria Luz Torre co-chaired the meeting. The Governing Board met on Wednesday, January 7, 2015.

   Ms. Conway and Ms. Torre mentioned that the health plan is doing well financially. We are now at 135k members. In addition to this Ms. Conway mentioned that the Health Plan will not participate in Covered California in 2015 and 2016 but will review it again for 2017. It is not economically feasible at this time and the potential number of transitioning SFHP members moving on to the Exchange is too low to justify the move. We have to compete with the lowest rate which would result to a financial loss considering the high upfront cost.

   Quality Improvement Committee Report-Ed Evans and Irene Conway
   Irene Conway and reported that the Quality Improvement Committee (QIC) did not meet. The next scheduled meeting is February 12, 2015.

   Ms. Conway and I continue to encourage the Committee to let them know if they are experiencing any issues so it can be brought up at the Quality Improvement Committee.

   Staff Report-John F. Grgurina, Jr., CEO
   John F. Grgurina, Jr., CEO, mentioned Irene Conway being an official Govening Board member. Also, Mr. Grgurina reviewed a few highlights from the Board

meeting. The Board approved the Year-To-Date Unaudited Financial Statements and Investment Reports and Provider Medi-Cal Expansion Rates recommendation to not participate in Covered CA Qualified Health Plan 2016 bid.

Mr. Grgurina also discussed the Plan's upcoming moves. All of our servers' offsite to San Jose housed by an expert as it's much safer. The main office will be 50 Beale and we hope to move in May no later than August 2015.In addition we will have a satellite office on Spring Street off Kearny. We will be enrolling our members there as well as hosting the Member Advisory Committee meetings.

Mr. Grgurina answered most of the Committee's questions.

Anna LeMon, Project Manager, HECLS

Anna LeMon attended the meeting with our new Chief Medical Director, Dr. Jim Glauber to discuss that the Plan is working with the Thumbs Up organization to see if we can use their health ed materials. Ms. LeMon passed around some materials for the Committee review and asked for feedback. The Committee had some great feedback and suggestions. Ms. LeMon and Dr. Glauber thanked the Committee and will follow up at a future Committee meeting.

Lastly, Ms. LeMon announced this will be her last meeting for a while as she will be on maternity leave.

4. **Discussion: Wendy Li, San Francisco Health Plan , Supervisor, Enrollment Services**
   Wendy Li attended the Committee to discussed some of the services we provide at the Enrollment Services and our effort to outreach to our members who just termed with their Medi-Cal coverage and providing assistance to their renewal process.

5. **Discussion: Goals**
   The Committee goals are finalized and will be discussed at the March Governing Board meeting. In addition to this, the Committee reviewed the six set goals and made sure they're assigned to the members who will be handling that particular goal.

6. **Public Comment**
   The Co-Chairs reminded the Committee to arrive on time and stay for the full two hours to receive a stipend.

7. **Calendar Items for Next Meeting**
   There were no items calendared at this time.

8. **Prospective Members**
   Maria Luz Torre announced that the Governing Board approved
   nomination to the Members Advisory Committee. The Committee welcomed Mr.
   ɔ the Committee.

9. **Announcements**
   Several announcements were made and printed copies were passed on the table for the Committees review.

10. **Adjournment**

The meeting adjourned at 3pm.

Date Approved _____

_____

Maria Luz Torre and Irene Conway, Co-Chairs

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MEMBER ADVISORY COMMITTEE
SAN FRANCISCO HEALTH AUTHORITY
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Meeting Agenda
February 6, 2015
1:00PM- 3:00PM
4 San Francisco Health Plan
201 3rd Street, 7th Floor, San Francisco, CA 94103

1. Welcome, Introductions & Roll Call

2. Adopt Agenda/Approve Minutes

3. Reports
   - Chairs & Governing Board: Maria Luz Torre & Irene Conway
   - Quality Improvement: Edward Evans & Irene Conway
   - Staff Report: John Grgurina, Jr. CEO
   - Health Education & Cultural Linguistic Services Update: Anna Le Mon, MSW, MPH, Project Manager, HECLS

4. Discussion: Dr. Jim Glauber; SFHP's Chief Medical Officer - Super Virus

5. Public Comment:

6. Calendar Items for Next Meeting:

7. Prospective Members:

8. Announcements:

9. Adjournment:

Please Note These Upcoming SFHA Meetings:

Quality Improvement Committee:	February 12, 2015 (7:30am-9am)
Finance Committee:	March 4, 2015 (11am-12pm)
Governing Board:	March 4, 2015 (12pm-2pm)
Member Advisory Committee:	March 6, 2015 (1pm -3pm)

The Committee meetings are public and wheelchair accessible. The Committee requests accommodations for those with allergies or chemical sensitivity. Please refrain from the wearing of scented products. Also, during the meeting please make sure all cell phones and pagers are off. Thank you for your cooperation.

February 6, 2015
Member Advisory Committee
Meeting Minutes

Members Absent:

Excused:
Guests:

Staff: Valerie Huggins and John F. Grgurina, Jr. CEO

1. **Welcome, Introductions and Roll Call:**
   The meeting was called to order at 1:00pm.

2. **Approval of Agenda & Minutes:** The agenda was approved with and the minutes from the January 9, 2015 meeting were approved with two corrections, 1) name was misspelled, and 2) was excused)

3. **Committee Reports:**
   Chair & Governing Board Report-Maria Luz Torre
   Irene Conway and Maria Luz Torre co-chaired the meeting. The Governing Board met in January and updates were reported at the January meeting. There were questions from members about Affordable Care Act and Covered California.

   Maria Luz Torre explained that the deadline to enroll by Feb 15 does not apply to most San Francisco Health Plan members considering that they are already covered and that it applies mainly to those applying for Covered California (our CA version of the ACA). We deferred the question to staff regarding the penalty if someone does not have health insurance.

   The next Board meeting is scheduled for March 4, 2015.

   Quality Improvement Committee Report-Ed Evans and Irene Conway
   Irene Conway and reported that the Quality Improvement Committee (QIC) met in December. The next scheduled meeting is February 12, 2015.

   Ms. Conway mentioned the Committee only discussing and reviewing policy and procedures. Ms. Conway stated that Dr. Glauber mentioned having focus groups at the Satellite office when we move.

   reminded the Committee to get their kids vaccinations updated.

Lastly, Ms. Conway and continue to encourage the Committee to let them know if they are experiencing any issues so it can be brought up at the Quality Improvement Committee.

Staff Report-John F. Grgurina, Jr., CEO
John F. Grgurina, Jr., CEO, gave a few updates on the State level. The Governor's proposed 15-16 budget are pretty good news for Medi-Cal managed care plans. There's no major cuts to Medi-Cal program, no new major programs given to managed care. Fully funds projected 15-16 caseloads of 12.2 million and 30% of total state population will be enrolled in Medi-Cal.

Lastly, Mr. Grgurina reported that the State's auto assignments rates are at 95% which means for every 100 members who do not make a choice, 95 members will come to San Francisco Health Plan and five will go to Anthem Blue Cross.

Mr. Grgurina answered most of the Committee's questions.

Anna LeMon, Project Manager, HECLS
Ms. LeMon was not present as she is currently on maternity leave.

4. **Discussion: Dr. Jim Glauber; SFHP's Chief Medical Officer – Super Virus**
Dr. Jim Glauber, SFHP's Chief Medical Officer attended the meeting to discuss the Super Virus such as Ebola. Previously known as Ebola hemorrhagic fever, is a rare and deadly disease caused by infection with one of the Ebola virus strains. Ebola can cause disease in humans and nonhuman primates.

How an infectious disease is transmitted – whether through direct contact with bodily fluids, through air, or other means, as well as whether human-to-human transmission is possible – is important for understanding how to prevent and track the disease. Ebola is transmitted only through direct contact with bodily fluids, as are HIV and Hepatitis C. Other diseases, such as measles, flu and SARS, are transmitted through airborne means. Human- to-human transmission occurs for all of the diseases included in this profile except for malaria, which is transmitted by mosquitoes to humans.

Ebola is one of the most deadly infectious diseases, causing death in approximately 50-90 percent of those who become infected. This is much higher than almost every other infectious disease included.

Currently, there is no vaccine to prevent Ebola, no treatment for the disease (other than treatments for its symptoms and some experimental treatments), and no cure. Other diseases have treatments but no vaccine and no cure (such as HIV), while still others have vaccines, but cannot be treated or cured (such as measles).

Dr. Glauber answered most of the Committees questions. Most of the discussion focused on vaccines and their pros and cons.

5. **Public Comment**
The Co-Chairs reminded the Committee to arrive on time and stay for the full two hours to receive a stipend. In addition to this, the Co-Chairs also reminded guest that the Committee is at capacity; however, the meetings are open to the public.

6. **Calendar Items for Next Meeting**
   There were no items calendared at this time.

7. **Prospective Members**
   There was one member, who nomination was voted on by the Committee as this was his second consecutive meeting. His nomination will go before the full Board at the March 4th Governing Board meeting.

   The Committee and prospective members were informed that the Membership Advisory Committee will be at capacity of 30 members once s membership is confirmed. Prospective members were informed that they are welcome to attend because the Member Advisory Committee meetings are open to the public. But in fairness to them, and so as not to keep up their hopes, it was reiterated that there are no vacant seats at this time.

8. **Announcements**
   Several announcements were made and printed copies were passed on the table for the Committees review.

9. **Adjournment**
   The meeting adjourned at 3pm.

Date Approved _____

_____
Maria Luz Torre and Irene Conway, Co-Chairs

Agenda Item 8:

Chief Medical Officer's Report

Action Item

a. Review and Approval of Evaluation of CY 2014 Quality Improvement (QI) Program

b. Review and Approval of CY 2015 Quality Improvement Program and Work Plan

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SFHP's Quality Improvement Program:
2014 Evaluation & 2015 Work Plan

Presentation to the Governing Board

James Glauber, MD, MPH
Chief Medical Officer

Action Requested

- Review and approval of the 2014 Quality Improvement (QI) Program Evaluation (CMO Report Attachment 1)*.
- Review and approval of the 2015 QI Program and Work plan (CMO Report Attachment 2)*.

*See “Additional Board Packet Documents” folder

Highlights

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- 2014 Evaluation successes and opportunities for improvement were a crucial input in development of the 2015 Quality Improvement Program and work plan.
- 2015 has enhanced focus on outcome measures.
- Structured to meet NCQA accreditation standards.

2014 QI Program Evaluation

- Written and structured to meet NCQA's annual evaluation standard
- Evaluated efficacy of 29 quality improvement projects:
  - Assessed goal attainment as per 2014 work plan
  - Summarized key results with supporting metrics
  - Identified opportunities for improvement to be addressed in 2015

Key Influencers During 2014

- Medi-Cal Expansion: nearly 60% membership increase
- Essette: deployment of resources and significant learning curve
- New State Mandates: non-specialty mental health services & behavioral health treatment for autism spectrum disorders

Results

- 69% (20/29) of QI projects met their stated goals
- Highlights:
  - Awarded Bronze Award for Quality based on HEDIS performance
  - Achieved Practice Improvement Program (PIP) successes
  - Enhanced clinical quality, patient safety, and care management programs
  - Received CHAMP $1.5M grant to expand and evaluate the CareSupport Program
  - Launched Essette, an enterprise-wide Care Management System
  - Strengthened our oversight by forming a new Grievance Committee and Grand Rounds

Improvement Opportunities

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- Compliance with regulatory requirements (e.g., Initial Health Assessments (IHA), Access to Care)
- Patient experience
- Coaching program
- Grievance resolution
- Utilization management decision turn-around times
- Quality Improvement Committee (QIC) focus on quality and peer review

2015 QI Program Highlights

- Health Improvement Infrastructure Enhancements
  - Grievance Committee
  - Member Access to Care Committee
  - Delegated Network Oversight Committee
  - Grand Rounds
- Integration of additional utilization management and pharmacy activities
- Emphasis on outcome rather than process measures

2015 QI Workplan

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Focus on 56 measures and indicators associated with five domains:

Domain	# of Measures / Indicators
Clinical Quality and Patient Safety	16
Quality of Service and Access to Care	13
Utilization Management	12
Care Coordination and Services for Members with Complex Health Needs	4
Delegation and Oversight	11

2015 Priorities

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Clinical Quality and Patient Safety

- HEDIS
- Compliance requirements (e.g., Initial Health Assessments, Appeals &Grievances)

Quality of Service and Access to Care

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Access Improvements

Utilization Management

- Prior Authorizations

Care Coordination

- Disease Management Program, Expansion of Complex Medical Case Management

Delegation Oversight

- Enhanced coordination of Delegation Oversight

QIC Approval

- On February 12, 2015, the SFHP Quality Improvement Committee approved both the Evaluation of the 2014 Quality Improvement Program and the 2015 Quality Improvement Program and Work Plan

Board Action Requested

- We recommend approval of the Evaluation of the 2014 Quality Improvement Program.
- We recommend approval of the 2015 Quality Improvement Program and Work plan.

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Questions?
Comments?

Agenda Item 9:
Discussion Item

CEO Report

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Governing Board

MEMO

Date: **February 23, 2015**

To: **Governing Board**

From: **John F. Grgurina, Jr., Chief Executive Officer**

Regarding: **CEO Report for March 2015 Meeting**

State & Federal Update

Governor's 15-16 Proposed Budget Released

On January 9, 2015 Governor Brown released his $164.7 billion proposed FY2015-16 State budget. The Governor's budget reflects an improved State economic climate and avoids prior year reductions to State programs such as Medi-Cal and K-14 education. The Governor projects FY 15-16 state General Fund (GF) revenues of $114.6 billion that would be a healthy 4.5% above FY 14-15 adjusted levels.

Of significant interest and importance to the Medi-Cal program and Medi-Cal managed care plans are the following proposals:

- **Continued Growth in Federal Support for the Medi-Cal Program.** The Governor proposes $95.4 billion ($18.6 billion State GF) in total Medi-Cal expenditures, with roughly $800 million in additional State GF expenditure in FY 15-16 over FY 14-15. The $18.6 billion in State GF is dwarfed by the level of federal support for the Medi-Cal program, particularly the costs assumed by the federal government for the optional Medi-Cal expansion. The projected cost to the federal government in FY 15-16 for just the optional Medi-Cal expansion is $14.3 billion.

- **Medi-Cal Grows to 12.2 Million Californians.** The Governor estimates the FY 15-16 Medi-Cal caseload will increase 2.1% to 12.2 million Californians, which represents a slowing of the unprecedented caseload growth from FYs 13-14 and 14-15 as a result of the implementation of the Affordable Care Act. Medi-Cal enrollment grew from 7.9 million in 2012-13 to 11.5 million in 2014-15, and by 2015-16, 32% of the total population of California is projected to be enrolled in the Medi-Cal program.
- **Managed Care Organization (MCO) Tax.** California has enhanced federal support for the Medi-Cal program through a 3.975% sales tax on the gross receipts of Medi-Cal managed care plans such as SFHP. The MCO tax offsets $803 million in State GF spending in FY 14-15 and an estimated $1.1 billion in State GF in 15-16. However, the Centers for Medicare and Medicaid Services has notified California that the current structure of its tax is out of compliance with federal rules and must end by 2016 when the tax expires. The Governor proposes a new, federally compliant MCO tax for all health plans regulated by the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) and would be based on enrollees. The new proposed MCO tax would be intended to offset the same amount of GF expenditures as the current tax, as well as fund a restoration of prior 7% reduction of In-Home Supportive Services (IHSS) hours.
- **Coordinated Care Initiative (CCI) Potentially to End in 2017.** The Governor's Coordinated Care Initiative has been the subject of three years of intensive work to coordinate care delivery through managed care for those individuals dually eligible for Medi-Cal and Medicare. However, the current overall opt-out rate in pilot counties is 69%, and nearly 80% amongst IHSS beneficiaries. As a result, the Governor indicates that in the absence of the MCO tax, the CCI would have a GF cost of $399 million in 2015-16. Should the CCI's continue to have high opt-out rates and should the MCO tax not be extended by January 2016, the CCI will be discontinued effective January 2017.
- **Annual Open Enrollment.** The Governor dusted off a prior budget proposal that would establish an annual 90-day open enrollment period in Medi-Cal managed care that aligns with Covered CA's open enrollment period. Currently, Medi-Cal managed care enrollees can change their health plan in any month, from month to month. This proposal would apply to children and adults in the Temporary Aid to Needy Families category and would limit these changes to an annual open enrollment period to promote continuity of care. The proposal would garner GF savings of $1.6 million in 2015-16. This proposal would not change the ability of anyone to apply and enroll in Medi-Cal at any time of the year.
- **No Extension of the Enhanced Payment for Primary Care Services in Medicaid.** The Governor does not fund a state-only continuation of the enhanced payment to physicians providing primary care services to Medi-Cal enrollees. Federal support for the enhanced payment under the ACA commenced in January 1, 2012 and ended December 31, 2014.
- **Pediatric Palliative Care Pilot Extension.** The budget proposes to expand the current 11 county pediatric palliative care pilot project that provides access to in-home palliative care for children with life threatening illnesses to an additional

seven counties. It is likely San Francisco will be one of the 7 counties. This proposal is currently the subject of a DHCS work group. The Administration estimates GF savings of $1.4 million in 2015-16.

New DHCS Director Appointed; New Medi-Cal Director Appointed

On January 26, Governor Brown appointed Jennifer Kent as the new Director of the Department of Health Care Services. Jennifer was most recently the Executive Director of the Local Health Plans of California, the trade association for public Medi-Cal managed care plans such as SFHP. She has a long history with the DHCS, previously serving as the Associate Director and the Deputy Director for Legislative and Government Affairs. Additionally, she served as Deputy Legislative Secretary under Governor Schwarzenegger, handling his health and human services legislation, as well as Associate Secretary to the Health and Human Services Agency. We are extremely fortunate to have a new DHCS Director with such a strong foundation in the Medi-Cal program, workings of state government and knowledge of public managed care plans.

Marianne Cantwell, the Chief Deputy Director of Health Care Programs for the DHCS has been appointed the Medi-Cal Director for the DHCS. Mari was previously the Vice President of Finance Policy for the California Association of Public Hospitals and Health Systems. She is an expert in hospital financing and will be a strong asset to the department in its upcoming 1115 Waiver renewal negotiations with the Centers for Medicare and Medicaid Services.

Update on Covered CA Enrollment Assistance by Public Medi-Cal Managed Care Plans

SFHP is currently in the process of becoming certified by Covered CA as an enrollment site. SFHP is awaiting the final regulatory approval by Covered CA at its March 2015 board meeting of the Certified Medi-Cal Managed Care Enrollment Assistance Program. Once that is completed, Covered CA will issue the MOU and necessary documents for our staff to complete for criminal background and fingerprint checks and commence training and final certification for our staff.

While open enrollment for Covered CA has ended, SFHP will be able to enroll the public in Medi-Cal throughout the year, which is an SFHP priority, as well as individuals eligible for special enrollment periods through Covered CA. This means that enrollment staff from SFHP will provide the full spectrum of enrollment services for San Francisco residents, including Healthy San Francisco, Healthy Kids, Medi-Cal, and Covered CA on an ongoing basis.

Covered CA and DHCS Report Strong New Enrollment In Qualified Health Plans and Medi-Cal

Covered CA and the Department of Health Care Services reported over 1.2 million Californians newly enrolling into private health insurance through Covered CA or Medi-Cal for the period of November 15 – February 15.

Nearly 474,000 Californians selected health plans through Covered CA and over 779,000 Californians enrolled in Medi-Cal.

SAN FRANCISCO HEALTH PLAN STRATEGIC ANCHORS

Goal 1: Universal Coverage

Healthy San Francisco Program Enrollment (as of January 30, 2015)

Total Enrollment

A total of 15,567 participants are enrolled in Healthy San Francisco as of January 30, 2015.

City Option Program, As of January 30, 2015

Employers can choose to meet the employer spending requirement of the San Francisco Health Care Security Ordinance (HCSO) by participating in the City Option Program. Employees of participating employers may enroll in the Healthy San Francisco Program if they meet HSF eligibility requirements, or are provided a Medical Reimbursement Account (MRA) to pay for eligible health care expenses if they do not qualify for HSF.

The City Option Program continues to grow and recent DPH policy and HCSO changes will spur further growth.

City Option Program Data – January 2015

	Program-to-Date (PTD)	January 2015
Employers		
Employers Participating in City Option Program	2,196	
Employers with Contributions within the past 12 months (active employers)		1,459
New Participating Employers	n/a	16
Total City Option Program Contributions	$317.1M	$4.6M
Contributions Assigned to HSF	$111.8M	$1.2M
Contributions Assigned to MRA	$205.3M	$3.4M
Employees		
Employees Receiving City Option Employer Contributions	154,584	
Employees Enrolled in HSF	14,847	1,758

	Program-to-Date (PTD)	January 2015
Number of Medical Reimbursement Accounts with Deposits	75,013	4,828
MRA Claims Paid	$95.0M	$3.0M
MRA Dollars Available	$95.7M	

Medi-Cal Expansion Updates

As of February 1, 2015, SFHP active enrollment in the Medi-Cal expansion-related aid codes, L1, M1, and 7U, is 54,935 members. This number does not include the disenrollments. SFHP remains compliant with the requirement mandated by AB 85 to default 75% of non-choosing M1 and L1 aid code members to primary care providers within the public hospital system.

Month of Enrollment	L1 Aid Code (SF PATH transition members)	M1 Aid Code (Optional Expansion members)	7U Aid Code (CalFresh-related Optional Expansion members)	AB 85 Default Requirement to Public Hospital System (M1 and 7U only)
January	10,795 members	101 members; 88 did not choose a PCP	n/a	66 members (75%) were defaulted to DPH clinics
February	53 members	977 members; 580 did not choose a PCP	n/a	440 members (75.9%) were defaulted to DPH clinics
March	239 members	1,802 members	597 members	
		1,489 did not choose a PCP (combined M1 and new 7U aid codes)		1,119 members (75.15% were defaulted to DPH clinics)
April	462 members	1,671 members; 1,159 members did not choose a PCP	759 members; 570 did not choose a PCP	1,306 members (75.5%) were defaulted to DPH clinics
May	252 members	1,709 members; 997 did not choose	367 members; 299 did not choose	972 members of 1,296 non-choosers (75%) were defaulted to DPH
June	171 members	3,588 members; 1,949 did not choose	169 members; 132 did not choose	1,559 members of 2,079 non-choosers (75%) were defaulted

Month of Enrollment	L1 Aid Code (SF PATH transition members)	M1 Aid Code (Optional Expansion members)	7U Aid Code (CalFresh-related Optional Expansion members)	AB 85 Default Requirement to Public Hospital System (M1 and 7U only)
				to DPH
July	149 members	3,421 members; 2,195 did not choose	231 members; 213 did not choose	1,808 members of 2,411 non-choosers (75.8%) were defaulted to DPH
August	114 members	3,529 members; 2,200 did not choose	85 members; 74 did not choose	1,703 members of 2,272 non-choosers (75%) were defaulted to DPH
September	1,500 members	5,393 members; 3,833 did not choose	105 members 59 did not choose	2,917 members of 3,892 non-choosers (75%) were defaulted to DPH
October	1,082 members	2,987 members; 2,240 did not choose	116 members 79 did not choose	2,319 members of 3,103 non-choosers (75%) were defaulted to DPH
November	28 members	2,365 members; 2,264 did not choose	109 members; 105 did not choose	2,369 Of 3,158 non-choosers (75%)
December	30 members	1,616 members; 1,563 did not choose	85 members; 84 did not choose	1,647 members of 2,084 non-choosers (79%) were defaulted to DPH
January	30 members	2,176 M1 members; 1,357 did not choose	220 members; 139 did not choose	1,495 members of 1,993 non-choosers (75%) were defaulted to DPH
February	22 members	1,916 M1 members; 1,510 did not choose	149 L1 members;143 did not choose	1,240 members of 1,653 non-choosers (75%) were defaulted to DPH

SFHP MEMBERSHIP UPDATE

In February 2015, the total SFHP enrollment for all lines of health plan business was 133,193 members. Global membership decreased by 1.46% (1,917 members) from

January 2015, but increased by 39.7% (39,058 members) since February 2014. The decrease in membership was in both Medi-Cal expansion members as well as non-Medi-Cal Expansion members.

Overall Medi-Cal membership decreased by 1.6% (1,901 members) from January to February 2015. Compared to February 2014, Medi-Cal enrollment increased by 46.9% (38,058 members). Medi-Cal Expansion enrollment decreased by 973 members (2.2%) and non-Medi-Cal Expansion decreased by 928 members (1.2%). SFHP had over 7,000 members on hold, which contributed to the decline in membership. Statewide, there was an unusually high decrease in the number of members that were placed on hold by Medi-Cal. SFHP will continue to monitor these members and expects some of the members to become active members. SFHP will also send letters to these members on hold to encourage them to renew their Medi-Cal. SFHP continues to retain 84% of Medi-Cal market share in SF County. Of individuals who selected a plan during this period, 82.3% (4,087 members) chose SFHP over Anthem Blue Cross. Medi-Cal membership is above goal 6.46% (7,232 members). **Please see Attachment 1** for SFHP Membership Reports. HSF Participant report data was not available at the time of this report**.**

STRATEGIC ANCHOR 2: QUALITY CARE & ACCESS

HEALTH SERVICES

Health Improvement

HEDIS/Population Management

Healthcare Effectiveness Data Information Set (HEDIS) chart pursuit season started in January 2015 and will end on May 15, 2015. SFHP hired a temporary staff of four medical record abstractors and two administrative coordinators, who will be reviewing thousands of charts throughout the network from services performed during the Measurement Year (MY) 2014, which spans the period January 1, 2014-December 31, 2014. Preliminary results for MY 2014 are comparable to the preliminary results from MY 2013. The final results will be reported to the Department of Health Care Services (DHCS) and the National Committee on Quality Assurance (NCQA) in June 2015.

Health Education

SFHP's Health Education program provided Cultural Humility training in December 2014 for all SFHP staff from a new vendor, Quality Interactions, which was well received by SFHP staff and will be offered to SFHP's providers in spring of 2015.

Member Grievances

SFHP implemented a new internal Grievance Committee in December 2014. The purpose of this cross-departmental committee is to improve the member experience by enhancing SFHP's internal grievance processes. The committee will meet quarterly to review grievance trends and process improvements. While a good business process, this was also the result of findings from the March 2014 DHCS medical audit.

Practice Improvement Program (PIP)
SFHP finalized and disseminated measure sets for both PIP Primary Care and PIP Specialty. Notable changes this year include: 1) increased focus on patient access (including CAHPS performance, avoidable ED visits, and after hours care), 2) tailoring participant clinical quality measures to area in greatest need of improvement, and 3) decreasing the number of measures overall in order to focus improvements. SFHP has begun planning for the 2016 measure set; the first advisory committee will be in March.

Clinic Patient Satisfaction Surveys
Initial results for Clinical and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) were returned to SFHP early February. SFHP conducts CG-CAHPS for CCHCA, Hill Physicians, NEMS, Mission Neighborhood Health Center, and South of Market Health Center. These results will serve as the baseline for PIP and provide meaningful information for targeting improvement efforts. In March, SFHP will field its first ever Health Plan CAHPS and will have comparable results for every part of SFHP's provider network. These results will allow SFHP to target improvement efforts appropriately.

CareSupport Grant Site Visit
In January, CareSupport staff and SFHP leadership successfully hosted the grantors for the $1.5 million grant awarded to SFHP to expand and study the CareSupport program. Attendees of the one-day site visit included California Health Facilities Financing Authority staff and board members, including the California State Treasurer, John Chiang. CareSupport staff provided an update on the progression of the project and provided insight into the "day in the life" of the Care Coordinators and member clients. The site visit included a community visit to St. Anthony's Clinic to demonstrate our coordinated approach with community agencies to provide member care through collaboration of services and resources.

Health Plan Default Rate
SFHP received the new Medi-Cal auto-assignment default rates for the period from February 2015 to January 2016.

We are very proud to announce that our rates have increased to the highest rates in the history of SFHP. Last year, our auto assignment rate was 91% for Seniors and Persons with Disabilities (SPDs) and 86% for non-SPDs. This year the rate has increased to 100% for SPDs and 95% for non-SPDs.

The auto assignment rates are very important because they determine the percentage of Medi-Cal enrollees, who did not choose a health plan, who are then automatically assigned to SFHP or Anthem Blue Cross. A better auto assignment default rate means we receive and serve a larger percentage of San Francisco residents and increases our overall Medi-Cal market share, which is currently 84%.

Our outstanding auto-assignment rates are due in large part to our scores in five Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as two safety-net measures. These are a national set of measures for clinical care delivered to health plan members developed by the National Committee for Quality Assurance (NCQA).

The State reviews our rates in these measures and compares them to Anthem Blue Cross' rates. Our HEDIS rates were significantly higher than Anthem Blue Cross' rates. Please see **Attachment 2** for auto-assignment rates for all of the Medi-Cal managed care plans. At this time, no other health plan has an auto-assignment rate as high as SFHP.

STRATEGIC ANCHOR 3: EXEMPLARY SERVICE

OPERATIONS UPDATE

Operations Update

Key projects and tasks in progress include: Office relocation, implementing the new administrator (Beacon) to manage the non-specialty mental health (NSMH) benefit and the autism benefit; preparing for the March DMHC/DHCS audit; and implementing a project management and tracking tool. Planning and budgeting for fiscal year 2015-16 is well underway as well.

Claims

1. Claims staff retention has been at 100% for 2 years.
2. We have started to process claims for mental health in February. We have received 40 claims to date.
3. We also processed claims for administrative days starting 2/1/15.
4. Claims adjudicated all claims within 45 working days and 99.9% of claims within 30 working days.
5. The goal to reduce the provider dispute rate has been met for 6 consecutive months.
6. The auto-adjudication rate metric was met in December at 78.23%.

Customer Service

1. Customer Service received 600 City Option Medical Reimbursement Account transfer requests in January.
2. Customer Service achieved a 93.84% service level for HSF program and 95.88% for SFHP lines of business.
3. The abandonment rate goal was met in January - 1.08% for HSF program and 0.81% for SFHP lines of business.
4. Customer Service has is helping HSF participants that have Brown and Toland Physicians (BTP) as their medical home choose a new medical home since BTP will no longer participate in HSF, effective 3/1/15.

Member Eligibility Management (MEM)

1. MEM staff outreached to 1,481 existing Medi-Cal members who will turn 65 years old in the next month to help them in applying for Medicare coverage.
2. MEM corrected almost 1,000 member records with eligibility and PCP assignment issues and updated 735 Medi-Cal member records manually with proper Medicare information.

Performance and Process Improvement

1. Improved the authorization matching to claims in QNXT and redesigned the Medi-Cal fee schedule upload process. These improvements will help process providers' claims in a timelier manner.
2. Created and implemented a Non-Specialty Mental Health validation process to supports correct payment and oversight of new provider NSMH provider, Beacon.

Provider Network Operations

1. Finalized delegation agreements with all delegated medical groups.
2. Developed and implemented the Delegated Network Oversight Committee.
3. Abby Wolf, RN, represented SFHP at the SF Health Improvement Partnership's Children's Oral Health Strategic Plan. This is a citywide initiative led by Dr. Susan Fisher-Owens to address children's oral health disparities and eliminate early childhood caries in San Francisco.
4. Notified provider network of upcoming DHCS Facility Site reviews in February, which will be in addition to the March Medical Review.
5. Notified provider network of the new Administrative Day reimbursement policy (effective 2-1-2015).
6. Added new hospice, sexual reassignment surgery (SRS) services, and diagnostic radiology providers to the network.
7. Distributed contract amendments to provider network to address 3/1/15 rate change approved by the Governing Board in January 2015.
8. Initiated Ancillary Provider re-contracting process to update contract terms.
9. Hosted SFHP's provider seminar regarding the Network Operations Manual, SFHP's website and secure portal.

COMPLIANCE AND REGULATORY AFFAIRS UPDATE

The business unit of Compliance and Regulatory Affairs also includes Marketing and Communications, Community Relations and Outreach and Enrollment Services.

- Compliance and Regulatory Affairs staff has been working closely with the DHCS and DMHC auditors on all of their pre-onsite audit requests, as well as working with all SFHP staff that will be involved with the audit file reviews and interviews.
- Marketing and Communications has been working on hundreds of updates and communications required for the upcoming move, in addition to designing the artwork for both sites. Marketing and Communications has developed templates for staff to use with providers, members and vendors to communicate with them about the move in stages. They are also preparing materials for the annual

member mailing, as well as working projects for other departments, most involving communications with members and providers.

- Enrollment Services and Community Relations staff members are preparing for the move to the Service Center. The staff will stop scheduling appointments for March 27th and 30th, and will resume operations and appointments at the new center on March 31st. They will use the time that they are closed to move to the center and test systems.
- Enrollment staff have been trained on Medi-Cal applications and have been assisting individuals with new Medi-Cal applications and renewals. They utilize the CalWin system, with the individual's consent, and submit the application to the Medi-Cal office for processing.
- We also are recruiting for a vacancy left by Adrian Nunez, our former Director, Enrollment Services and Community Relations. Valerie Miller, our Director, Marketing and Communications, has been serving as the interim Director.

STRATEGIC ANCHOR 4: FINANCIAL VIABILITY

DHCS Encounter Data Modernization

As reported in the previous board meetings, DHCS required that all Managed Care Plans (MCPs) transition from monthly submission of Medi-Cal Encounter data in the DHCS Proprietary format to HIPAA 5010 compliant format effective October 1, 2014. SFHP has been working on the Encounter Modernization project since April 2014. Since our last update, the following key accomplishments have been achieved:

1. Successfully submitted production 837I, 837P and NCPDP files to DHCS on January 2nd upon receipt of production cut-over from DHCS on December 23rd. First set of files achieved a 99.2% acceptance rate overall. The set entails 3 months' worth of data dating back to October 2014 which were held at DHCS's behest.
2. Subsequent files were submitted in regular production mode every 2 weeks without any major issues.
3. Completed DHCS historical conversion with a 92% successful conversion rate for all file types.

At this juncture, the remainder of the work is to complete testing with Kaiser using the new HIPAA-compliant format and target to convert Kaiser by end of March for inclusion of regular submission to DHCS. We will also refine existing processes and make adjustments as needed based on DHCS feedback.

MEDIA ROUNDUP

Please see **Attachment 3** for the Media Roundup with articles related to Healthy San Francisco, Covered CA and Medi-Cal expansion.

Governing Board Member Updates

We are pleased to announce that on February 12th, the San Francisco Board of Supervisors Rules Committee approved all seven of SFHP's Governing Board member nominees and passed their nominations on to the full Board Supervisors. The Rules Committee members are Supervisors John Avalos, Katy Tang, London Breed and Malia Cohen.

We welcome our new Board member, Lawrence Cheung, MD, who replaces Dr. Randall Low. We welcome back Sue Currin, John Gressman, Dr. Steven Fugaro, Maria Luz Torre, Steve Fields and Elena Tinloy, Pharm.D.

Both Supervisor Avalos and Supervisor Tang expressed how impressed they were with the quality of our candidates and their passion to bring quality care to the low income residents in San Francisco.

Form 700

As you may recall, members of our Governing Board are required by the San Francisco County Ethics Commission to submit the Statement of Economic Interest Form each year by April 1st. The forms are completed for the Commission using an electronic filing process. Valerie Huggins, Mr. Grgurina's Executive Assistant, will contact each Board member the week of February 23rd with instructions on completing the process electronically. (Please see **Attachment 4.**)

All members of our board are required to complete and file the Form 700 with the San Francisco County Ethics Commission by April 1, 2015. The County will assess a fine to individuals of $10 per day, and up to $100, for late filings. Individuals may be assessed a fine of up to $5,000 per violation for failure to file. If you have any questions about this process, please contact Valerie Huggins, Executive Assistant to the CEO, at **vhuggins@sfhp.org**, or (415) 615-4235.

Agenda Item 10:
Discussion Item

Semi-Annual Compliance Report

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MEMO

Date	**February 23, 2015**
To	**Finance Committee and Governing Board**
From	**Nina Maruyama, Officer, Compliance & Regulatory Affairs, and John F. Grgurina, Jr., Chief Executive Officer**
Regarding	**Compliance Report to the Finance Committee and Governing Board**

Summary of Compliance Report to the Finance Committee and Governing Board

San Francisco Health Plan's (SFHP) Compliance and Regulatory Affairs Department submitted the annual Fraud, Waste and Abuse report to the Department of Managed Health Care (DMHC) on January 31, 2015. The report was accepted and is under review. The following summary provides an overview of the report that was submitted, as well as other updates related to compliance activities.

Reports of Potential Fraud

During the calendar year 2014, SFHP experienced one incident that was investigated for potential fraud involving a contracted SFHP durable medical equipment provider. In August 2014, SFHP received a call from a provider asking why their May, June and July claims were denied. At that time, SFHP determined that the member died in April 2014 and the claims for oxygen supplies in May, June and July were denied. The Compliance Officer contacted the provider and informed the provider about the member's death. The provider stated that they did not know the member was deceased and stated they would withdraw their claims. There was no pattern by the provider of submitting claims for deceased members. The case was closed with a finding that the provider did not submit the claims with a fraudulent intent.

SFHP experienced one incident of suspected fraud involving a SFHP Medi-Cal member. However, before the case could be investigated, the member was disenrolled. The member's name will be monitored to see if the member returns to the plan and tries to repeat potentially fraudulent behavior.

Summary of Annual Independent Audit

San Francisco Health Plan is audited annually by a certified public accounting firm to ensure that adequate financial controls are in place. For the fiscal year 2013-14, there

were no audit findings that indicated any inappropriate practices or controls. The audit firm gave the SFHP its "unmodified opinion" stating SFHP's combined financial statements were fairly presented in accordance with generally accepted accounting principles.

2014 Compliance Program Key Activities

The following describes a few of the key compliance program's activities in 2014:

1. Similar to last year, the total completion rate for all employees by the deadline was 85%. The employees that did not complete the online training and test module on time were given additional time, resulting in 92% completion by the end of July 2014. All employees, temporary staff and contractors are required to take two online training modules on Fraud, Waste and Abuse and HIPAA, which include a test at the end. Our goal for the 2015 training will be to obtain 95% completion by the initial deadline.

2. SFHP's anonymous, 24-hour compliance hotline for employee was utilized by three staff, but the calls were not fraud related. One was related to an anonymous report by an employee that staff may be using a SFHP credit card for personal use. After investigation by Finance, there was no finding of inappropriate use. The other two calls were inquiries about the phone line, without any reports. Rather than use the anonymous hotline, staff directly email or report issues to Compliance and Regulatory Affairs in person. The most frequent issue is sending an email with protected health information in an unsecure manner, or to the wrong individual at a covered entity. These cases did not resulted in any breaches in 2014. Staff members are reminded of taking the appropriate steps to send data securely.

3. During 2014, the Policy and Compliance Committee met ten times to review, revise and approve policies and procedures, discuss trending issues in privacy and security, review state policies that were new or revised and monitored the results of the Department of Health Care Services (DHCS) medical audit in March 2014, including the corrective action plan. In 2015, there will be a continued effort to monitor implementation of corrective action plans from the State audits and increased oversight of auditing and monitoring activities.

Compliance and Regulatory Affairs Staff Changes

Compliance and Regulatory Affairs Program Manager resigned effective July 2014 to pursue a compliance position closer to her home. As a result, we now have Crystal Garcia, Compliance Program Manager, and Betty DeLos Reyes, Esq., Regulatory Affairs Program Manager. They both have extensive experience with state audits, fraud and abuse monitoring and investigation, state license filings, and HIPAA compliance. Ms. Garcia has compliance experience from Alameda Alliance for Health and Blue Shield in Utah. Ms. DeLos Reyes also has experience from Alameda Alliance for Health, and most recently from the Department of Managed Health Care.

Summary of 2014 and Highlights for 2015

During the calendar year of 2014, SFHP maintained an adequate system of appropriate internal and external anti-fraud controls, designed to detect and prevent fraudulent activities. In the coming year, our goal will include continued implementation of corrective action plans from State audits, updating the annual staff training, business continuity planning and testing, and implementation of a comprehensive internal monitoring and auditing plan.

CEO Report

- Attachment 1 – Membership Reports
- Attachment 2 – DHCS Auto-Assignment Rates for All Plans
- Attachment 3 – SFHP Media Report
- Attachment 4 – Filing the Electronic Annual Form 700

CMO Report

- Attachment 1 - Evaluation of CY 2014 Quality Improvement Program
- Attachment 2 - CY2015 Quality Improvement Program and Work Plan

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CEO Report

Attachment 1 – Membership Reports

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Membership Report - January 2014

Department: Marketing & Communications

Global membership decreased by 1.46% (1,971 members) from January 2014 to February 2015; and increased by 39.7% (37,842 members) since February 2014. The rise in year-to-year membership growth is due in large part to Medi-Cal expansion. Global membership is 6.63% above goal (8,279 members).

Medi-Cal (MC): Membership decreased by 1.57% (1,901 members) from January 2014 to February 2015, and increased by 46.9% (38,058 members) since February 2014. SFHP retains 84.3% (120,070 members) of MC market share in SF County. Of individuals who selected a plan during this period, 82.3% (4,087 members) chose SFHP over Anthem Blue Cross. Membership is above goal by 6.46% (7,232 members).

Healthy Workers (HW): HW membership decreased 0.33% (39 member) from January 2014 to February 2015, and increased 1.09% (130 members) since February 2014. Membership is above goal by 0.03% (3 members).

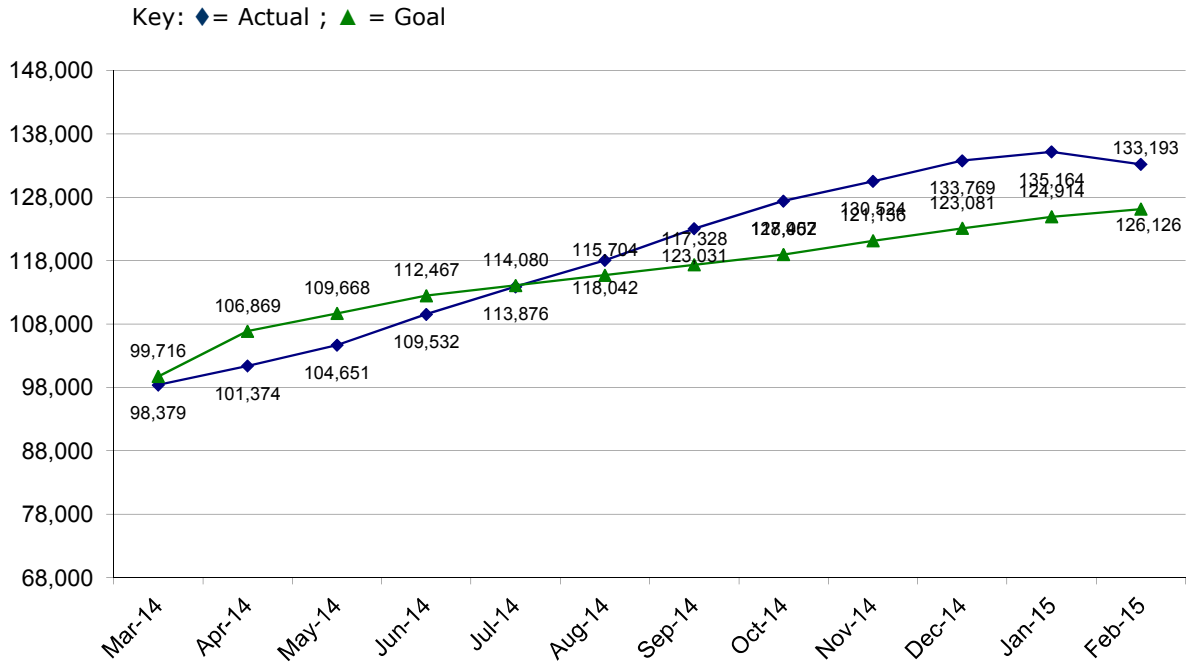
Healthy Kids (HK): Membership decreased by 1.46% (31 members) from January 2014 to February 2015, and decreased by 4.74% (104 members) since February 2014. Membership is below goal by 7.07% (159 members). San Francisco continues to have a small and decreasing population of families and children which reflects in the low overall numbers. SFHP is developing a marketing/outreach strategy for new ways to reach out to potential members and increase the annual renewal rates of existing members through internal outreach efforts.

* Source:
www.dhcs.ca.gov/dataandstats/reports
http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptJan2015.pdf
http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_EnrollDisenroll_Rpts/2014/September/COPS-11_09-14.pdf

HEALTH PLAN
Here for you

Global Membership

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
MC	84,143	87,052	90,257	95,119	99,413	103,588	108,577	112,968	116,154	119,412	121,166	119,265
HW	12,088	12,164	12,223	12,242	12,283	12,283	12,283	12,265	12,192	12,191	11,876	11,837
HK	2,148	2,158	2,171	2,171	2,180	2,171	2,171	2,174	2,178	2,166	2,122	2,091
Total	**98,379**	**101,374**	**104,651**	**109,532**	**113,876**	**118,042**	**123,031**	**127,407**	**130,524**	**133,769**	**135,164**	**133,193**
Net New	-580	2,995	3,277	4,881	4,344	4,166	4,989	4,376	3,117	3,245	1,395	-1,971
% New	-0.74%	3.04%	3.23%	4.66%	3.97%	3.66%	4.23%	3.56%	2.45%	2.49%	1.04%	-1.46%



Annual Growth		
Feb-15	133,193	
Feb-14	95,351	
Change	**37,842**	**39.7%**

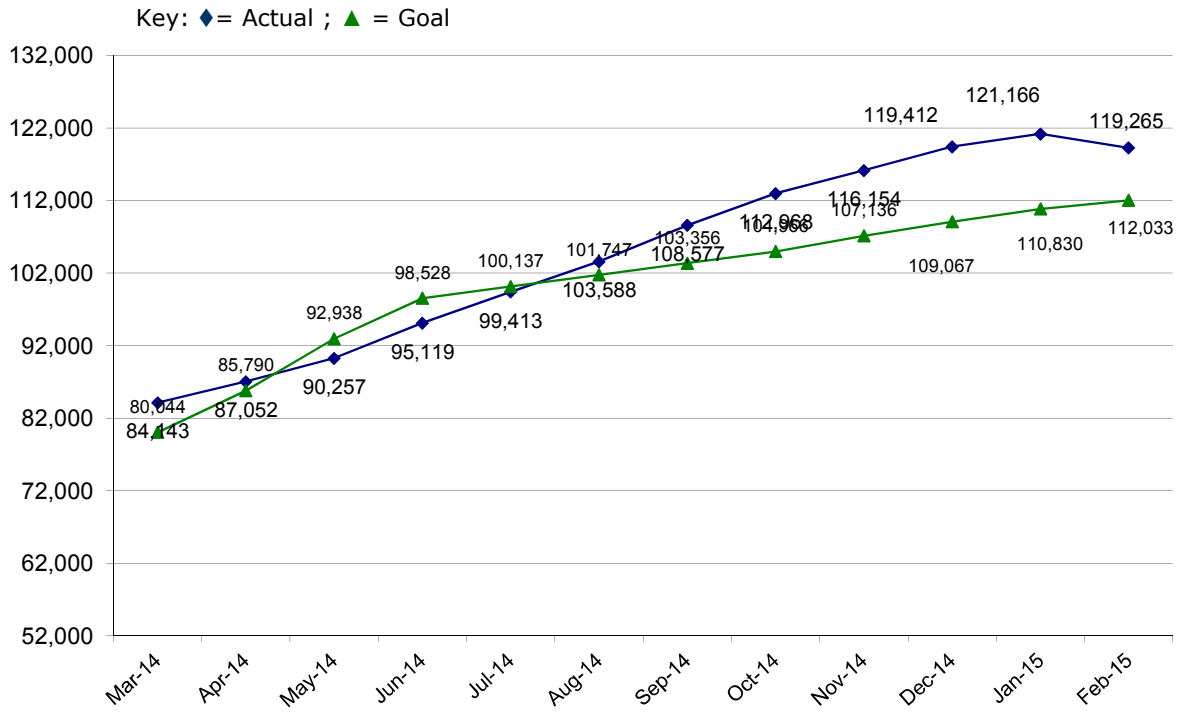
Medical Group	#	%
SFCCC + DPH	65,235	49.0%
NEMS	30,925	23.2%
NMS	507	0.4%
CCHCA	10,795	8.1%
UCSF	9,851	7.4%
HILL	4,714	3.5%
KAISER	7,123	5.3%
BTP	4,040	3.0%
Unassigned	3	0.0%
Total	**133,193**	**100.0%**

Language	#	%
English	62,552	47.0%
Chinese	43,142	32.4%
Spanish	18,230	13.7%
Other	3,835	2.9%
Russian	2,411	1.8%
Vietnamese	3,023	2.3%
Total	**133,193**	**100.0%**

Medi-Cal

Medi-Cal (MC) Membership

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
	84,143	87,052	90,257	95,119	99,413	103,588	108,577	112,968	116,154	119,412	121,166	119,265
Net New	6,799	2,909	3,205	4,862	4,294	4,175	4,989	4,391	3,186	3,258	1,754	-1,901
% New	11.89%	3.46%	3.68%	5.39%	4.51%	4.20%	4.82%	4.04%	2.82%	2.80%	1.47%	-1.57%



Annual Growth		
Feb-15	119,265	
Feb-14	81,207	
Change	38,058	46.9%

Medical Group	#	%
SFCCC+ DPH (aka CHN)	51,914	43.53%
NEMS	30,782	25.81%
NMS	505	0.42%
CCHCA (aka CHI)	10,687	8.96%
UCSF	9,775	8.20%
Hill	4,520	3.79%
Kaiser	7,123	5.97%
BTP	3,956	3.32%
Unassigned	3	0.00%
Total	119,265	100.0%

Language	#	%
English	59,795	50.14%
Chinese	37,775	31.67%
Spanish	15,856	13.29%
Other	2,446	2.05%
Vietnamese	2,865	2.40%
Russian	528	0.44%
Total	119,265	100.0%

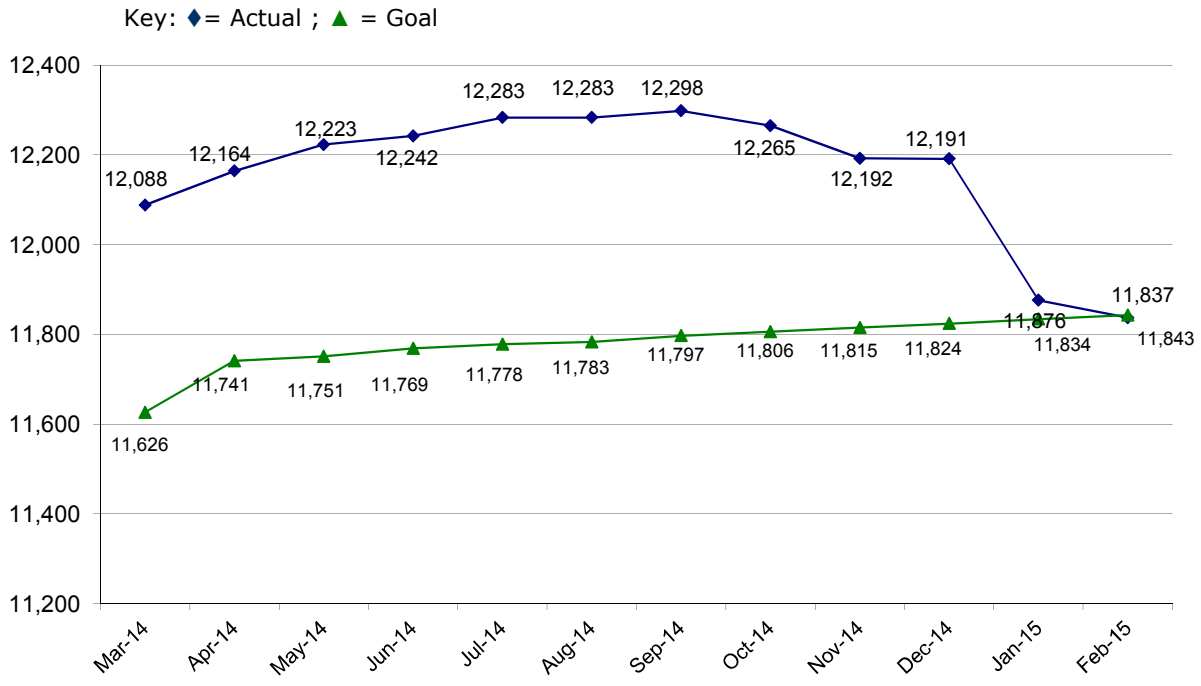
	Market Share*		Member Choice*		Auto-Assign (AA)*		Prior Plan (PP)*		AA + PP*	
	#	%	#	%	#	%	#	%	#	%
SFHP	120,070	84.3%	4,087	82.3%	2,309	86.2%	205	79.5%	79.5%	79.5%
Anthem Blue Cross	22,403	15.7%	876	17.7%	369	13.8%	53	20.5%	20.5%	20.5%
Total	142,473	100.0%	4,963	100.0%	2,678	100.0%	258	100.0%	100%	100.0%

** Source: http://www.dhcs.ca.gov/dataandstats/reports (http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptJan2015.pdf)(http://www.dhcs.ca.gov/dataandstats/reports/Docu*

HealthyWorkers

Healthy Workers (HW) Membership

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
	12,088	12,164	12,223	12,242	12,283	12,283	12,298	12,265	12,192	12,191	11,876	11,837
Net New	74	76	59	19	41	0	15	-33	-73	-1	-315	-39
% New	0.64%	0.63%	0.49%	0.16%	0.33%	0.00%	0.12%	-0.27%	-0.60%	-0.01%	-2.58%	-0.33%



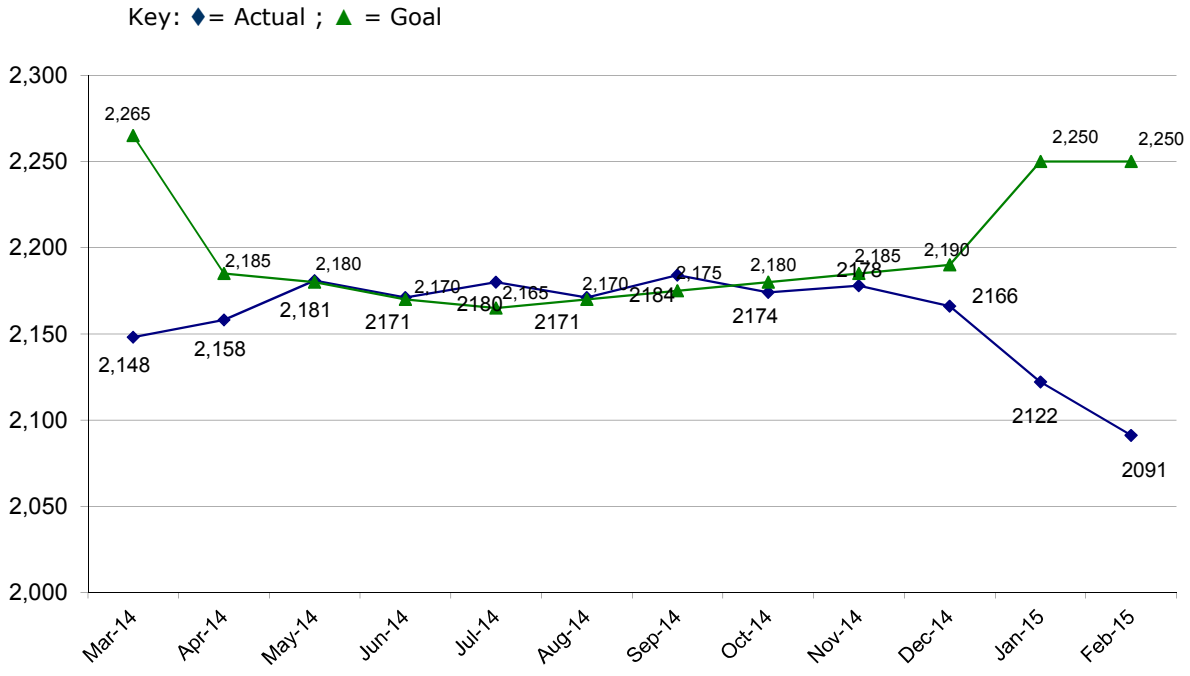
Annual Growth		
Feb-15	11,837	
Feb-14	11,967	
Change	**-130**	**-1.09%**

Medical Group	#	%
SFCCC + DPH	11,837	100.0%
Total	**11,837**	**100.0%**

Language	#	%
Chinese	5,183	43.8%
English	2,608	22.0%
Russian	1,879	15.9%
Other	1,371	11.6%
Spanish	643	5.4%
Vietnamese	153	1.3%
Unassigned	0	0.0%
Total	**11,837**	**100.0%**

Healthy Kids (HK) Membership

	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
	2,148	2,158	2,181	2171	2180	2171	2184	2174	2178	2166	2122	2091
Net New	-53	10	23	-10	9	-9	13	-10	4	-12	-44	-31
% New	-2.09%	0.47%	1.07%	-0.46%	0.41%	-0.41%	0.60%	-0.46%	0.18%	-0.55%	-2.03%	-1.46%



Annual Growth		
Feb-15	2,091	
Feb-14	2,195	
Change	-104	-4.74%

Medical Group	#	%
SFCCC + DPH	1,484	70.97%
HILL	194	9.28%
CCHCA	108	5.16%
NEMS	143	6.84%
NMS	2	0.10%
UCSF	76	3.63%
BTP	84	4.02%
Unassigned	0	0.00%
Total	2,091	100.00%

Language	#	%
Spanish	1,731	82.78%
Chinese	184	8.80%
English	149	7.13%
Vietnamese	5	0.24%
Other	18	0.86%
Russian	4	0.19%
Total	2,091	100.00%

CEO Report

Attachment 2 –
DHCS Auto-Assignment Rates for All Plans

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Year 10 Auto Assignment Default Rates

(Effective for MOE February 2015 - December 2015)

Plan Model Type	County Code	County Name	Plan Code	Plan Name	Non-SPD Members	SPD Members
Two Plan	01	Alameda	300	Alameda Alliance for Health	75%	70%
			340	Anthem Blue Cross	25%	30%
	07	Contra Costa	301	Contra Costa Health Plan	67%	72%
			344	Anthem Blue Cross	33%	28%
	10	Fresno	315	CalViva	55%	60%
			362	Anthem Blue Cross	45%	40%
	15	Kern	303	Kern Family Health Systems	67%	62%
			360	Health Net	33%	38%
	16	Kings	316	CalViva	53%	58%
			363	Anthem Blue Cross	47%	42%
	19	Los Angeles	304	LA CARE Health Plan	44%	49%
			352	Health Net	56%	51%
	20	Madera	317	CalViva	52%	57%
			364	Anthem Blue Cross	48%	43%
	33	Riverside	305	Inland Empire Health Plan	74%	79%
			355	Molina Health Care	26%	21%
	36	San Bernardino	306	Inland Empire Health Plan	81%	86%
			356	Molina Health Care	19%	14%
	38	San Francisco	307	San Francisco Health Plan	95%	100%
			343	Anthem Blue Cross	5%	0%
	39	San Joaquin	308	Health Plan of San Joaquin	45%	50%
			354	Health Net	55%	50%
	43	Santa Clara	309	Santa Clara Family Health Plan	71%	76%
			345	Anthem Blue Cross	29%	24%
	51	Stanislaus	312	Health Plan of San Joaquin	45%	50%
			361	Health Net	55%	50%
	54	Tulare	311	Anthem Blue Cross	25%	20%
			353	Health Net	75%	80%
GMC	34	Sacramento	190	Anthem Blue Cross	3%	8%
			150	Health Net	29%	24%
			170	Kaiser Permanente: North	47%	47%
			130	Molina Health Care	21%	21%
	37	San Diego	167	Care First Health Plan	4%	9%
			029	Community Health Group	25%	25%
			068	Health Net	6%	1%
			079	Kaiser Permanente: South	33%	33%
			131	Molina Health Care	32%	32%

Year 10 Auto Assignment Default Rates

(Effective for MOE February 2015 - December 2015)

Plan Model Type	County Code	County Name	Plan Code	Plan Name	Non-SPD Members	SPD Members
Regional & Imperial	02	Alpine	100	Anthem Blue Cross	50%	50%
			118	California Health & Wellness	50%	50%
	03	Amador	101	Anthem Blue Cross	50%	50%
			119	California Health & Wellness	50%	50%
			177	Kaiser	0%	0%
	04	Butte	102	Anthem Blue Cross	50%	50%
			120	California Health & Wellness	50%	50%
	05	Calaveras	103	Anthem Blue Cross	50%	50%
			121	California Health & Wellness	50%	50%
	06	Colusa	104	Anthem Blue Cross	50%	50%
			122	California Health & Wellness	50%	50%
	09	El Dorado	105	Anthem Blue Cross	50%	50%
			123	California Health & Wellness	50%	50%
			178	Kaiser	0%	0%
	11	Glenn	106	Anthem Blue Cross	50%	50%
			124	California Health & Wellness	50%	50%
	13	Imperial	145	Molina Health Care	50%	50%
			143	California Health & Wellness	50%	50%
	14	Inyo	107	Anthem Blue Cross	50%	50%
			128	California Health & Wellness	50%	50%
	22	Mariposa	108	Anthem Blue Cross	50%	50%
			129	California Health & Wellness	50%	50%
	26	Mono	109	Anthem Blue Cross	50%	50%
			133	California Health & Wellness	50%	50%
	29	Nevada	110	Anthem Blue Cross	50%	50%
			134	California Health & Wellness	50%	50%
	31	Placer	111	Anthem Blue Cross	50%	50%
			135	California Health & Wellness	50%	50%
			179	Kaiser	0%	0%
	32	Plumas	112	Anthem Blue Cross	50%	50%
			136	California Health & Wellness	50%	50%
	46	Sierra	113	Anthem Blue Cross	50%	50%
			137	California Health & Wellness	50%	50%
	51	Sutter	114	Anthem Blue Cross	50%	50%
			138	California Health & Wellness	50%	50%
	52	Tehama	115	Anthem Blue Cross	50%	50%
			139	California Health & Wellness	50%	50%
	55	Tuolumne	116	Anthem Blue Cross	50%	50%
			141	California Health & Wellness	50%	50%
	58	Yuba	117	Anthem Blue Cross	50%	50%
			142	California Health & Wellness	50%	50%

CEO Report

Attachment 3 –
SFHP Media Report

SAN FRANCISCO HEALTH PLAN™
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CEO MEDIA SUMMARY REPORT

December 2014 to February 2015

Contents

News Presence by Categories

HEALTHY SAN FRANCISCO

S.F. Man Gets to Thank Obama for the Care in Person

SFGATE

By David McCumber | February 3, 2015

WASHINGTON — San Franciscan Derrick Benn is known to his friends as "D.C." On Tuesday, that's exactly where he was — hanging out at the house of the most famous resident of Washington, D.C., President Obama, talking health care.

"Nobody back home is going to believe this," Benn said with a huge grin. "It's fantastic to be here." Benn had written Obama a few months ago, telling him about the difference the Affordable Care Act had made in his life. On Friday, he learned that the president's staff wanted him to come to Washington to tell his story personally. He was one of 10 letter-writers from around the country selected to join a health care panel at the White House.

Benn, 46, formerly an engineer, is now a tutor — helping "good students get better at math, chemistry and physics, so they can get into great schools," he said.

It's important work, but he's a contractor, so it doesn't come with health care. That's a problem for Benn, who is a Type 2 diabetic.
"I appreciate the Healthy SF plan," he said of the city's health-access program. "But it takes a long time to get prescriptions filled, or blood drawn, and it's frustrating."

Benn said that now, with his health insurance purchased through the Affordable Care Act, he can get his health care needs met much more quickly — and the care he gets is better. "It has taken so much stress out of my life," he said. "It's made me better at what I do."

It's no accident that Obama convened the meeting with 10 people who are Affordable Care Act success stories. On Tuesday, the House passed a bill by Republicans to repeal the law, the 56th time the GOP has voted either to gut or abolish the act. Republican leaders concede they have no chance of overriding a certain veto.

White House officials said another reason for the timing of Tuesday's event was to stress that open enrollment for this year continues only through Feb. 15.
"I just don't have to worry any more about my health care," Benn said.

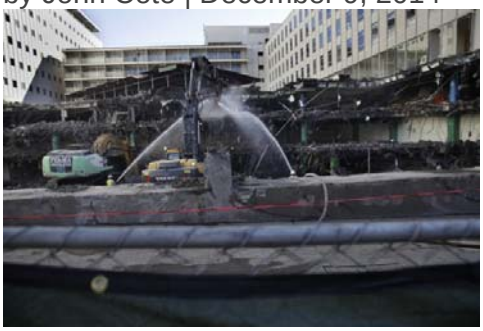
http://www.sfgate.com/nation/article/S-F-man-gets-to-thank-Obama-for-the-care-in-6060056.php

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

CPMC Falls Short of Hiring Target – But Still in Compliance with City Agreement

SFGATE

by John Cote | December 9, 2014



The old Jack Tar Hotel, which later became the Cathedral Hill Hotel, was demolished to make way for new California Pacific Medical Center hospital.

California Pacific Medical Center fell short of a first-year local hiring target it had agreed to as part of a deal with the city for a $2 billion overhaul of its medical facilities in San Francisco, including building two new hospitals, a city report shows.

The Sutter Health-affiliated hospital group had a target of hiring 19 entry-level workers last year from economically disadvantaged backgrounds — 40 percent of its entry hires in San Francisco. It only hired six, according to the report from the city's Office of Economic and Workforce Development.

The report also found CPMC has not yet come through on its commitment to provide hospital and specialty care to 1,500 residents of the Tenderloin, a dense, relatively poor neighborhood near the site of a new hospital and medical office facility CPMC is building on Van Ness Avenue.

Still, the report found CPMC was in compliance with the wide-ranging development agreement, which was hammered out over months of sometimes-tense negotiations with city officials and approved by the Board of Supervisors in July 2013.

While CPMC, the city's fourth largest employer with over 6,000 employees, hadn't met one of several job targets, the agreement doesn't require perfection. The shortfall in entry-level hiring — 13 jobs — is rolled over and added to the next year's target in the 10-year requirement.

CPMC also has more time to deal with the Tenderloin health care issue. The agreement requires CPMC to contract with what's known as a management services organization, often a group of physicians, in the Tenderloin to provide care for 1,500 residents through Medi-Cal. However, there is no such medical group in the Tenderloin, the report found. If one is not created, CPMC can contract with one outside the Tenderloin, subject to the approval Department of Public Health Director Barbara Garcia.

A coalition of housing, jobs and health care advocacy groups, including the California Nurses Association, disputed the city's decision to find CPMC in compliance with the agreement.

"When CPMC doesn't do its part by holding up its end of the agreement, not only does it impact the community, it also has a ripple effect on the city budget when people can't get jobs or access to promised health care," said Gordon Mar, director of Jobs with Justice, which advocates for employment for the working class.

http://blog.sfgate.com/cityinsider/2014/12/09/cpmc-falls-short-of-hiring-target-but-still-in-compliance-with-city-agreement/

MEDI-CAL

Court Orders State to Give Medi-Cal Benefits Within 45 Days

The Fresno Bee

By Barbara Anderson | January 22, 2015

A court decision this week could help thousands of central San Joaquin Valley consumers who have been waiting months for Medi-Cal cards.

An Alameda County Superior Court judge has ordered California to determine Medi-Cal eligibility within 45 days — the legal time limit for making most Medi-Cal eligibility decisions — if the applicants appear to be eligible. And others whose eligibility is less clear must be notified of the right to a hearing.

The decision also says the state likely may not be able to comply, and so at its discretion, may provide provisional benefits to those who are eligible but whose applications have not been processed within 45 days.

Thousands of Californians have been stuck in a kind of Medi-Cal limbo while their health deteriorated, according to attorneys for plaintiffs who sued the state. The state-federal insurance program provides mostly free care to low-income families and individuals.

One of the plaintiffs in the case, Frances Rivera, 68, of Visalia, has said her son, Robert Cribbs, waited five months for a Medi-Cal card that did not arrive until two months after his death of a pulmonary embolism in April 2014.

Thursday, Rivera said in a written statement: “I am just thrilled that the people who need Medi-Cal will be able to get it in a timely manner. Hopefully somebody’s life will be saved because of this decision.”

County welfare workers were overwhelmed by Medi-Cal applications that coincided with the first open enrollment for the Affordable Care Act from October 2013 to April 1, 2014. More than 1 million enrolled in Affordable Care Act health plans offered through Covered California, the state’s health insurance exchange. But even more — 2.7 million — enrolled in Medi-Cal, and at one point, the Medi-Cal application backlog reached 900,000 statewide.

Anthony Cava, a spokesman for the California Department of Health Care Services, said the department already has undertaken actions. Since Jan. 1, the department has given coverage to people prior to their cases reaching the 45-day limit, he said. And the state has “virtually cleared the number of pending individuals, reducing it by more than 95%.”

The state is processing the remaining pending applications this week, Cava said. But multiple factors affect processing, he said. For example, many people have yet to provide information needed to verify their eligibility, and many other applications are duplicates that have to be be removed from the system.

In the court ruling issued Jan. 20 by Alameda County Judge Evelio M. Grillo, the state's latest estimate was that the backlog had been reduced to approximately 44,143. And in his ruling, Grillo said the reduction demonstrated the state "is capable of significantly reducing the backlog" and that the department had not "established that there is an administrative or other emergency that continues to be 'beyond the Department's control.'"

Donna Ortiz, deputy director of TulareWORKs, which signs residents up for Medi-Cal, said Tulare County. had a backlog of about 11,600 applications, but has worked to reduce that number. "Today we have about 275 applications that have been pending 45 days," she said.

She encouraged Tulare County residents people who have applied for Medi-Cal and need immediate coverage to contact her office at (800) 540-6880. Anyone who has waited 45 days or longer for a Medi-Cal eligbility confirmation should also contact the office, she said.

Fresno County has processed nearly 58,000 Medi-Cal applications and about 2,800 remain to be processed that are older than 45 days. Some of the pending applications were held up by the state, said Linda Duchene, a Fresno County program manager. County workers are processing the claims to give the clients interim coverage, she said.

The county has been told that the state will be processing batches of applications that are nearing 45 days to give consumers temporary approval until their Medi-Cal eligibility can be confirmed, Duchene said.

A new wave of Medi-Cal applications began hitting county offices Nov. 15, the start of the second year of open enrollment for Covered California. It's expected that Medi-Cal applications will continue to be received at a fast clip until the open enrollment ends Feb. 15.

Gillian Sonnad, an attorney for Central California Legal Services in Fresno, said the hope is that Tuesday's court decision "means there won't be a backlog from this most recent open enrollment period."

http://www.fresnobee.com/2015/01/22/4342677_court-orders-state-to-give-medi.html?rh=1

California Takes Different Path on Insuring Immigrants Living in U.S. Illegally

By Amma Gorman | January 22, 2015

Guadalupe Carrera, 36, with her daughter Eva Maqueda, 9, and son Jose Maqueda, 5, fills out an application for health insurance assistance at El Proyecto Del Barrio Family Health Care Clinic on Thursday January 8, 2015 (Photo by Heidi de Marco/KHN).

PASADENA, Calif. - Angel Torres hasn't been to the doctor since coming to the United States illegally more than two decades ago. But now, his vision is getting blurry and he frequently feels tired. Torres, 51, worries he might have diabetes like his brothers.

"Time is passing," he said in Spanish. "I need to get checked out."

Torres is in luck. He lives in California, which has a dramatically different approach than most other states to health care for immigrants without authorization to live here.

Several counties - including Los Angeles, where Torres lives - offer these immigrants free coverage allowing them to receive care at local clinics. In addition, as many as 500,000 low-income immigrant parents eligible for President Barack Obama's new deportation relief likely will qualify for Medi-Cal, California's version of Medicaid. Already, young adults who were brought here as children and have been granted similar immigration relief can receive the state-funded insurance.

And in December, legislation was proposed to extend state-subsidized health insurance to everyone, including those barred from getting covered through the Affordable Care Act. Federal dollars could not be used.

The push to offer health insurance to all Californians regardless of immigration status is the latest in a series of immigrant-friendly state policies over the past few years. Already, immigrants here illegally can obtain licenses to practice medicine, law or other professions, and as of this month, they can apply for driver's licenses.

There is no guarantee that other states will follow California's lead, but the size and demographic makeup of the state ensure it a prominent role in the national debate over coverage of people living in the country illegally.

"If California goes out on a limb on this, it could have an impact on other states," said Randy Capps, director of research for the Migration Policy Institute, a nonpartisan think tank based in Washington, D.C. "It is a really big thing."

California has been a leader on immigration issues in the past. For instance, it was one of the first states to offer in-state tuition to students living in the state illegally. Now, about 20 states do so.

Still, some states are unlikely to consider offering them health coverage in the near future. In the South, for example, advocates for expanded coverage say they are still trying to convince officials to expand Medicaid programs to include more U.S. citizens and legal residents. The federal law allowed states to extend Medicaid to include people at slightly higher incomes and without children.

"We are having a very different conversation," said Cindy Zeldin, executive director of Georgians for a Healthy Future. "I think we are really far away as a state from where California is."

California, however, is very far from where it used to be.

In 1994, voters passed an initiative, Proposition 187, that sought to deny education, health care and other benefits to immigrants living here illegally.

"It is really an important development that California - 21 years after Prop. 187 - is where it is," said Thomas A. Saenz, president of the Mexican American Legal Defense and Educational Fund, or MALDEF. "That change, in less than a full generation, is what we are going to see increasingly across the country."

Saenz attributes California's transformation in part to the growth of the immigrant population and Latino electorate. He also believes people have come to understand that issues like health affect everyone - one person's inability to get treatment can sicken others in the community.

In addition, Saenz and others say immigrant youths brought illegally into to the country by their parents, when they were too young to make choices, have put a human face on the issue.

"We have to credit … the young undocumented activists who have come out and said, ‘I am unafraid and I am here,'" said Gabrielle Lessard, health policy attorney with the National Immigration Law Center.

U.C. Berkeley graduate Jose Flores, 23, is one of them. His face is on billboards around the state as part of a campaign for universal health coverage. Flores received temporary legal status through the Obama administration's plan for undocumented youth and can now apply for Medi-Cal, though his parents are still in the country illegally and uninsured.

"I have always thought the best way to receive support is through being open about our status," he said.

Not everyone is so thrilled with the push for expanded coverage. Tim Donnelly, a former state assemblyman said covering any immigrants here without authorization is fiscally irresponsible and threatens to "erase the line between legal and illegal."

"We've finally gotten the seesaw of the California budget under control," said Donnelly, who was a leader in the Minuteman citizen border patrol group. "It's the wrong time to open up a can of entitlement worms."

In the meantime, local initiatives in California are paving the way for broader change, said Anthony Wright, executive director of the consumer group Health Access.

"We think that these county efforts, whether they be in San Francisco, Alameda or Los Angeles, provide momentum," he said. They could be "bridges to a statewide solution."

Los Angeles County rolled out its $61 million program last fall called My Health LA, which provides free coverage to immigrants living in the country illegally and pays community clinics to care for them.

Angel Torres signed up at Community Health Alliance of Pasadena this month. Patricia Monroy, a clinic employee who helped him apply, told him that he could seek care at certain clinics and publicly-funded hospitals in the county but that he should avoid private facilities. "It's a county program," she reminded him. "It's not insurance."

At another clinic participating in My Health LA, El Proyecto del Barrio in the San Fernando Valley, Maria Lara signed up, along with her 11-year old daughter. Her son, born several months ago in the U.S., receives Medi-Cal, she said.

Lara said that just a few weeks before his birth, her husband was deported. Now she lives off the support of her church. A friend told her she could get free health coverage at a local clinic. She was nervous but anxious to get treatment for a thyroid condition identified during her pregnancy, when she had coverage under the emergency Medi-Cal program.

"Now I can make an appointment and not wait for hours in the emergency room," she said.

Another patient, Aldo Corado, said he has relied on public hospitals and clinics with sliding scales since a car accident five years ago left him paralyzed and in a wheelchair. When he heard about My Health LA, Corado eagerly enrolled.

On a recent January morning he came to El Proyecto because of a lingering cough. Corado said he can't work so appreciates the free coverage. But the father of two U.S.-born children said he is hopeful that he will get on Medi-Cal.

"It would be practically a dream for immigrants to have Medi-Cal," he said, adding that it could enable him to have more access to specialists and physical therapy.

The bill, proposed by Sen. Ricardo Lara, would allow low-income immigrants to receive Medi-Cal and those with higher incomes to purchase plans with state subsidies. He proposed a similar bill last year but it stalled in committee.

A U.C. Berkeley study issued in May said that covering all immigrants in California illegally would increase Medi-Cal spending by 2 percent in 2015 while increasing enrollment by 7 percent. The cost of about $360 million would be significantly offset by a drop in health-care costs for the uninsured as well as an increase in sales tax revenue from managed care health plans, the study by the U.C. Berkeley Labor Center wrote.

When Gov. Jerry Brown issued his spending plan this month, he didn't include an estimate for how much it would cost to extend Medi-Cal to the immigrant population granted deportation relief under the Obama order. The deportation relief applies to certain parents of U.S. citizen or legal resident children. Health officials said it was too early to tell how many people would apply.

About 1.85 million immigrants living in California illegally are uninsured, Capps of the Migration Policy Institute said. He estimated that Obama's new policy could bring forward between 450,000 and 500,000 people who could qualify for Medi-Cal.

Meanwhile, the campaign to cover everyone in California is continuing. The California Endowment is promoting the coverage through billboards, social media and radio ads. Daniel Zingale, senior vice president at the organization, said Obamacare should have included this immigrant population.

"In California, that is a real problem," he said. "We have to find a way to finish the job."

Kaiser Health News (KHN) is a national health policy news service. It is an editorially independent program of the Henry J. Kaiser Family Foundation.

http://kaiserhealthnews.org/news/immigrant/

New Applications for Covered California, Medi-Cal top 1 Million

SACRAMENTO BUSINESS JOURNAL
EL DORADO PLACER SACRAMENTO YOLO

By Kathy Robertson | January 13, 2015

More than 1 million Californians have applied for health insurance throughCovered California or Medi-Cal since the second annual open enrollment began on Nov. 15, program officials announced Tuesday.

This includes 304,394 consumers deemed eligible for Covered California and 217,146 who went on to pick a plan through the state health benefit exchange by Jan. 11. Another 466,776 people signed up for Medi-Cal by Jan. 11 and 110,913 more appear eligible for the program.

"We've seen strong interest and continued momentum in Covered California," executive director Peter Lee said in a media call Tuesday morning. "'But hundreds of thousands of Californians appear to be waiting."

While more than 73,000 consumers have signed up for coverage since Dec. 15, the clock is ticking. Those who want coverage to begin Feb. 1 must sign up by Thursday. Those who want to buy insurance through Covered California for 2015 — and to avoid rising tax penalties — have to do it by the close of open enrollment Feb. 15.

Almost nine out of 10 Covered California customers receive some kind of assistance to pay premiums and lower out-of-pocket costs, Lee said.

It looks like Covered California is well on its way toward a goal of 500,000 new members in 2015, but sign-ups have to remain high due to folks falling off the rolls between application and payment of their first premium.

The 217,000 to pick a plan so far are less than half the number needed, but more than half paid their first premium when they signed up — an option not available last year, Lee said. The other 300,000 to apply so far will have to pick a plan and pay a their first premium before they are considered fully enrolled.

How renewals are going for the 1.2 million Californians who signed up for the program in 2014 remains unclear. Those who did nothing were automatically re-enrolled in the same plan for 2015. "A big percentage did this," Lee said, but numbers will not be available until next month.

http://www.californiahealthline.org/capitol-desk/2014/11/medical-jumps-to-11-3-million

Medi-Cal Ranks Grow by Nearly 500K

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

By David Gorn | January 9, 2015

About 413,000 Californians have been newly enrolled into Medi-Cal in less than two months, and an additional 100,000 have been determined likely eligible for the program during that time, state health officials said.

Approximately half a million Californians will likely be added to Medi-Cal between Nov. 15, 2014, and Jan. 7, officials said.

Covered California launched its second open enrollment period on Nov. 15, 2014. The Medi-Cal program doesn't have an open enrollment period -- eligible Californians can sign up at any time. Many of the people interested in Covered California may have incomes low enough to qualify for Medi-Cal, though, and are referred to that program during open enrollment.

It turns out that's a lot of referrals.

Anthony Cava, information officer for the Department of Health Care Services that oversees Medi-Cal, said roughly 80% of the applicants who apply through the Covered California web portal and qualify for Medi-Cal are immediately enrolled into coverage.

In all, Cava said, "Medi-Cal enrolled more than 2.2 million consumers in 2014."

That number likely will continue growing. There are an additional 100,000 individuals who have been deemed to be likely eligible for Medi-Cal and are going through the enrollment process now, Cava said.

Covered California's open enrollment period ends Feb. 15.

Exchange officials said they have enrolled approximately 144,000 Californians into policies through Covered California from Nov. 15, 2014, to Dec. 15, 2014, with almost 600,000 applications received.

New enrollment numbers from Covered California for the rest of December will be released next week, exchange officials said, before the exchange board meets Jan. 15.

http://www.californiahealthline.org/capitol-desk/2015/1/medical-ranks-grow-nearly-half-a-million

State Has No Plans to Maintain Rate Increase for Medi-Cal Physicians

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

January 2, 2015

California officials do not have plans to maintain a recently expired federal incentive program used to encourage physicians to treat Medi-Cal beneficiaries, the *Los Angeles Times* reports. Medi-Cal is California's Medicaid program.

Background

Under the Affordable Care Act, the "Medicaid fee bump" program allotted more than $5 billion in federal funding to bring primary care reimbursement rates in line with those under Medicare.

According to the *Times*, California has one of the lowest Medicaid reimbursement rates in the U.S. Specifically, data from the California Medical Association show that:

Medicare in April 2014 paid $45.69 for a traditional office visit for a returning patient; and
Medicaid in April 2014 paid a standard rate of $18.10 for a traditional office visit for a returning patient.

The two-year Medicaid federal rate increase expired with the start of 2015.

According to California Department of Health Care Services spokesperson Anthony Cava, it would cost $1.8 billion annually to maintain the rate increases -- $700 million of which would come from the state.

Effect of Rate Program Unclear

An Urban Institute analysis estimated that the expiration of the fee bump would result in a 58.8% drop in payments for California doctors.

However, Anthony Wright, executive director of Health Access California, said, "People didn't see the [original] increases until months and months after the fact," adding that the program was not implemented well.

In addition, the Urban Institute analysis stated that it is "unclear whether the increase ... has had an effect on the number of physicians accepting Medicaid or the number of Medicaid patients that physicians are willing to see."

According to the *Times*, advocates say the sate lacks such data. California Medical Association spokesperson Molly Weedn said, "Nobody knows how many physicians are out there seeing new Medi-Cal patients."

Meanwhile, Wright and Christopher Perrone of the California HealthCare Foundation -- which publishes *California*

Healthline -- said that the effects of the rate increases could have been weakened by the high number of physicians working under managed-care plans, which pay doctors a flat rate for patient care. According to the DHCS, about 9 million of the 11.3 million Medi-Cal beneficiaries are enrolled in managed-care plans.

Further, Del Morris, president of the California Academy of Family Physicians, said the program "got mixed into a lot of uncertainty about whether doctors should or should not participate in caring for those patients who were newly insured," adding, "Two years is a pretty short time to change the patterns of your practice

http://www.californiahealthline.org/articles/2015/1/2/state-has-no-plans-to-maintain-rate-increase-for-medical-physicians

Half of Listed Medicaid Doctors Unavailable, OIG Report Finds

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

December 9, 2014

Many physicians listed in plans under contract with Medicaid are unavailable to treat beneficiaries, according to an HHS Office of Inspector General report released Tuesday, the *New York Times*reports.

Medicaid enrolled about nine million new beneficiaries in the last year, with the program growing by about 16%. Many new beneficiaries are covered through managed care plans that feature a list of available physicians.

For the report, researchers contacted about 1,800 providers included on such lists for about 200 Medicaid managed care plans in 32 states.
Report Findings

Overall, the researchers found that half of the listed providers were unable to offer beneficiaries appointments.

Specifically:

- More than one-third of providers could not be found at the locations listed;
- 8% were at the listed location but did not participate in the plan under which they were listed; and
- 8% were at the listed location and participated in the plan, but were not accepting new patients.
-

The report also gathered information about wait times among providers who offered appointments. It found:

A median wait time of two weeks;

- More than one-quarter of providers had wait times longer than one month; and
- 10% had wait times that longer than two months.
- Wait times were longer among specialists than general practitioners, but specialists were more likely to offer appointments.
-

CMS Response

CMS Administrator Marilyn Tavenner agreed with report recommendations to correct errors and ensure Medicaid beneficiaries are able to access care. "Inaccurate provider directory data may unnecessarily delay an enrollee from selecting a provider," she said.

In addition, CMS Division of Managed Care Plans Director James Golden said he is in the process of creating rules and standards to improve timely access to care for beneficiaries (Pear, *New York Times*, 12/8).

http://www.californiahealthline.org/articles/2014/12/9/half-of-listed-medicaid-doctors-unavailable-oig-report-finds

DENTI-CAL

State Program Leaves Poorest Kids Short of Dental Care

San Francisco Chronicle

by Victoria Colliver | Decmeber 11, 2014

California's dental program for low-income children is leaving many of the kids it is intended to serve at high risk of developing lifelong dental diseases because it has failed to provide adequate services, a state audit released Thursday has found.

The 92-page report described a system that serves fewer than half the children enrolled in the program, attributing that mainly to a lack of dentists willing to accept the rates the state is willing to pay them for their services. Those rates, which haven't increased since 2000, were cut by 10 percent last year.

Problems with the program, known as Denti-Cal, have persisted for years, but health advocates worry that the migration last year of more than 865,000 kids into Medi-Cal from the state's Healthy Families program under the federal health law will make matters worse. More than 5.1 million children are now covered by Medi-Cal, the state health program for the poor.

"While the state has taken some steps to increase the number of children in Medi-Cal who get needed dental care, more needs to be done, and this audit clearly demonstrates that," said Jenny Kattlove, director of strategic health initiatives for the Children's Partnership, an advocacy group that pushed for the audit.

The state's report found that the state as a whole appeared to have enough dentists in its Denti-Cal program, but that access to them varied by geography. As of January 2014, the state found, as many as five of California's 58 counties may not have a single dentist who accepts Denti-Cal. In addition, dentists in 11 counties weren't willing to accept new patients and 16 counties had an inadequate number of dental providers in the program.

The problem is worse in rural and far Northern California counties than in urban areas like San Francisco. The report ranked counties such as Alpine, Amador, Del Norte, Sierra, Inyo and Mono the lowest in terms of access to Denti-Cal services for kids.

The report criticized the California Department of Health Care Services for failing "to adequately monitor the program" and comply with state law that requires it to review the reimbursement rates each year to ensure that Medi-Cal recipients have reasonable access to services.

The auditor also chided the department for not enforcing terms with Delta Dental of California, the private company the state contracts with to provide services, that required it to make sure that at least

mobile services were available in underserved areas.

Delta Dental, located in San Francisco and the state's largest dental insurer, declined to comment.

The auditor recommended a series of changes for improvement, and the Department of Health Care Services agreed to all of them except one because it says it's not required by state law, agency officials said. The agency said in a statement that it will provide updates to the auditor throughout the year.

"The department is committed to ensuring that all of our beneficiaries in California have appropriate access to high-quality care," the department said.

Despite the dismal findings, health advocates were encouraged by the report.

"Dental has finally been getting the attention it needs," said Eileen Espejo, director of media and health policy for Children Now, an advocacy group in Oakland. "Reports like these are really saying we can't be silent anymore. If a child is in pain, they're not concentrating on lessons going on in school. We know the mouth cannot be separated from the body."

http://www.sfchronicle.com/news/article/State-program-leaves-poorest-kids-short-of-dental-5951472.php

SAN FRANCISCO SAFETY NET HEALTH CARE

280,000 Sutter Health Members Spared From Loss of Their Doctors

SFGATE

by Victoria Colliver | January 30, 2015

The public battle between Blue Shield of California and Sutter Health came to an end Friday, with the two sides announcing they'd reached a two-year contract agreement that keeps more than 280,000 Northern and Central California consumers from having to find new doctors and hospitals.

While the terms of the contract are confidential, both the health insurer and the large network of hospitals and physicians said they were pleased to reach an agreement and apologized to their customers for the potential disruption. The new contract ends Dec. 31, 2016.

"We sincerely regret the frustration our patients experienced as the negotiations took longer than necessary — especially when the final agreement is extremely close to the reasonable offer we made to Blue Shield several months ago," Dr. Steve Lockhart, Sutter Health's chief medical officer, said in a statement.

The showdown started when the two nonprofit health companies were unable to reach a new agreement before their contract expired at the end of last year. The insurer, which is headquartered in San Francisco, began informing its customers that they would have to find hospitals and doctors not affiliated with Sutter by April 1 or July 1, depending on the type of coverage they had.

The deadlines caused widespread angst for many patients. They were upset about the potential of having to find new doctors and losing access to their local hospital. Some said they felt like pawns in the negotiations between two large health care businesses.
Stevanne Auerbach, of Berkeley, was thrilled that she could now continue seeking care at Sutter Health's Alta Bates Summit Medical Center in Berkeley and visit the doctor she has seen for two decades.

"It's awesome negotiations can work to overcome barriers and keep from putting up roadblocks to the health of the community and putting patients through chaos and anxiety," said Auerbach, a child-development specialist on a Blue Shield Medicare plan.

Other Sutter entities affected by the negotiations were California Pacific Medical Center in San Francisco, Castro Valley's Eden Medical Center and the Palo Alto Medical Foundation.
Blue Shield said it was pleased with the outcome.
"The principles Blue Shield fought for in this negotiation with Sutter have been preserved," the company said.
http://www.sfgate.com/bayarea/article/280-000-Sutter-Health-members-spared-from-loss-of-6051921.php

Bill Would Require Insurers to Improve Provider Network Lists

January 26, 2015

State Sen. Ed Hernandez (D-West Covina) has introduced a bill (SB 137) that would require insurers to improve and frequently update their provider network directories, the *Los Angeles Times* reports.

Background

The bill was introduced in response to complaints of narrow networks among insurers selling plans through Covered California, the state's health insurance exchange (Terhune, *Los Angeles Times*, 1/23).

Several California insurers have been sued over inadequate networks. In addition, a Department of Managed Health Care reportin November 2014 said that Anthem Blue Cross and Blue Shield of California violated state law by misleading consumers about the size of their provider networks (*California Healthline*, 11/19/14).

Details of SB 137

SB 137 would require insurers to:

- Update their provider lists weekly and make that information available online for consumers;
- Post online whether in-network physicians are accepting new patients; and
- Publicize what languages their in-network providers speak.

It also would require state regulators to develop a standard format for provider directories.

The bill is sponsored by:

- The California Pan-Ethnic Health Network;
- Consumers Union; and
- Health Access (*Los Angeles Times*, 1/23).

The Senate Health Committee will consider the bill in April.

In a release, Hernandez said, "In a world where we compel people to purchase health insurance, we must empower consumers to make accurate and informed decisions about the plans and policies they are choosing" (Hernandez release, 1/23).

Reaction

Anthony Wright, executive director of Health Access, said, "We don't allow other products to be sold with an inaccurate listing of ingredients," adding, "We can't have consumers spending significant

dollars on premiums for plans with inaccurate listings of their providers."

However, Charles Bacchi, president of the California Association of Health Plans, said, "Health plans and providers have a shared responsibility in ensuring directories are updated in a timely manner," noting that the association will work with lawmakers on the bill

http://www.californiahealthline.org/articles/2015/1/26/bill-would-require-insurers-to-improve-provider-network-lists

Why Kaiser Psych Workers Are Striking

The Examiner SAN FRANCISCO
sfexaminer.com

by Sal Rosselli | January 12, 2015

Even after state regulators fined Kaiser Permanente $4 million for systemically understaffing its psychiatry department, California's largest health insurer continues to put the lives of thousands of its members at risk by forcing mental health patients to wait weeks, even months, for treatment. Kaiser simply does not staff its psychiatry department with enough psychologists, therapists, social workers and psychiatric nurses to provide timely, quality care to the ever-growing number of patients seeking our help.

After having exhausted all other measures to persuade Kaiser officials to bring its psychiatric services into compliance with state laws governing timely access and parity for mental health care, Kaiser's 2,600 California mental health clinicians, along with more than 700 Kaiser Northern California Optical workers and Southern California Healthcare Pros, are on strike this week, here in The City and the greater Bay Area and throughout the state. Kaiser has left them nop choice. These clinicians have an ethical obligation to advocate for their patients to ensure that they get the care they need in Kaiser's increasingly corporatized and impersonal healthcare system.

Even after the California Department of Managed Health Care (DMHC) fined Kaiser $4 million in 2013, Kaiser did not staff its clinics appropriately but instead merely shifted its resources, directing clinicians to see more first-time patients to give the illusion of timely access to care. After an initial appointment for diagnosis, Kaiser patients here in San Francisco are forced to wait weeks or months for follow-up appointments, making consistent, effective treatment difficult if not impossible.

And the problem is getting worse as more and more patients come into the Kaiser system under the Affordable Care Act. Kaiser has enrolled 250,000 new members in California but its staffing levels have not kept pace.

Meanwhile, the violations have continued:

• On Jan. 2, in anticipation of the tens of thousands of new patients coming into the Kaiser system following 2014 open enrollment, Kaiser Fremont knowingly ordered its clinicians to break the law by delaying all non-urgent patients well beyond the legal 10-day waiting period. And they're closing their Intensive Outpatient Program to new patients, meaning patients deemed at risk are being knocked down to a lower priority level because there isn't enough staff to see them.

• According to Kaiser's own records from September, pediatric patients requiring neuropsychological testing waited 22 weeks before receiving a phone call from Kaiser's San Francisco psychiatry department to schedule an appointment, according to Kaiser's records.

• In August, Kaiser's San Francisco psychiatry department was so severely understaffed that dozens

of patients' calls to the triage team languished in the voicemail system for more than a week before staffers could even listen to them, let alone respond to them, according to internal Kaiser emails.

• In May of last year, Kaiser failed to provide timely mental health appointments to more than 60 percent of the patients seeking care at Kaiser's Oakland and Richmond facilities, according to data supplied by Kaiser.

Thankfully the DMHC held Kaiser accountable and forced the HMO to pay the fine. But $4 million is a slap on the wrist for this massive corporation. While Kaiser shortchanges its mental health patients, the company is scoring record profits year after year -- "nonprofit" Kaiser had made more than $14 billion in the past five years, and this year's profits are up 40 percent over last year's record -- and pleading poverty with workers. By imposing significant cuts to healthcare and retirement benefits, Kaiser is reneging on commitments made to its clinicians when they were hired and undermining its recruitment of much needed new clinicians, who have to wonder: If this is how Kaiser treats its employees in good times, how does it treat them in bad times?

In bargaining last month, we proposed that Kaiser establish clinician-management committees in each facility to determine staffing levels and outsourcing needs with help from a mediator if the two sides couldn't reach an agreement. Other healthcare systems already used this approach.

It's very simple: too many patients, not enough staff. Clinicians call that gap a patient care crisis. Kaiser calls it a profit margin.

Kaiser is a leader in the healthcare industry. As Kaiser goes, the industry goes. With its huge profits, Kaiser can well afford to provide the timely, quality care the law requires and that its members pay for with their premiums.

Sal Rosselli is president of the National Union of Healthcare Workers, a democratic, member-led union that represents more than 10,000 healthcare workers throughout California

http://www.sfexaminer.com/sanfrancisco/why-kaiser-psych-workers-are-striking/Content?oid=2916458

Kaiser Permanente Give $5.5 Million to San Francisco Nonprofits to Helpt “at-risk populations”

BAY AREA | BizTalk

By Chris Rauber | December 17, 2014

Kaiser Permanente is making $5.5 million in grants to seven San Francisco nonprofits that work with "at-risk populations," the Oakland-based health care giant and San Francisco Mayor Ed Lee announced Wednesday morning.

That total includes a $3 million grant to HOPE SF, a city-backed initiative to revitalize distressed public housing sites. The program's goal is to transform the often-dangerous public housing sites "into mixed-income communities without displacing existing residents," officials said.

Lee lauded Kaiser for its generosity, calling such "public-private partnerships" critical to the city's efforts.
Kaiser's chairman and CEO, Bernard Tyson, said the grants "demonstrate our commitment to creating communities that support the physical, emotional and spiritual well-being on those who live, work and thrive in San Francisco."
(Nice way to work Kaiser's ubiquitous "Thrive" advertising tag line into the conversation, Mr. Tyson.)

The $3 million grant to HOPE SF will be used to improve residents' health and wellness at four sites serving 4,000 "of San Francisco's most vulnerable residents," officials said Dec. 17.
Other portions of Kaiser's holiday gift package will be distributed as follows:

The Bayview HEAL Zone, part of the San Francisco Public Health Foundation, gets $1 million to help reduce domestic violence, make neighborhoods safer, as well as to enhance social and emotional health.

- HealthRight 360, a nonprofit health care safety net organization that helps 50,000 uninsured and often homeless clients, will receive $500,000 to help it build a new campus.

- PHASE, a Kaiser program that aims to provide evidence-based care to people at risk for heart attack and strokes, will be expanded by nearly a third using a $400,000 grant to the San Francisco General Hospital Foundation.

- The UCSF Center for Excellence in Primary Care will receive $250,000 to assess clinical readiness, develop ways to become more effective, provide coaching and enhance other efforts.

- The San Francisco Community Clinic Consortium, which represents 11 safety net clinics, gets $250,000 to support core services and advocacy on behalf of poor patients in the city.

- The California Center for Youth Wellness, a Bayview-Hunters Point health clinic, will receive $100,000 to develop a statewide effort to prevent childhood experiences that lead to chronic disease later in life.

Kaiser has 9.5 million enrollees in eight states and the District of Columbia. Nearly 80 percent of them reside in California.
In early November, Kaiser reported that its net income during the first nine months of 2014 had soared 41 percent to $3.1 billion, and 57 percent in the third quarter to nearly $1 billion, at its hospital and health plan subsidiaries.

http://www.bizjournals.com/sanfrancisco/blog/2014/12/kaiser-gives-5-5-million-to-sf-nonprofits.html?page=all

COVERED CALIFORNIA

Obamacare Penalities, Payouts Ahead for Many Tax Filers

Los Angeles Times

by Chad Terhune | January 9, 2015

Client Paul Chirico of L.A. works with H&R Block tax preparer Erika Arbulante to see how the Affordable Care Act will affect his taxes. Many Americans miscalculated their income last year, affecting their subsidy levels. (Gina Ferazzi / Los Angeles Times)

Uncle Sam could take a bigger bite at tax time for consumers who received too much government help last year with their Obamacare premiums.

That may be just one of several surprises for millions of Americans in advance of the first tax deadline involving the Affordable Care Act.

The majority of Americans who get their health insurance at work should see few changes when filing their taxes. Most will just need to check a box on their tax return indicating they had coverage in 2014.

It stands to be more complicated for those individuals who purchased a private health plan in government-run exchanges or went without insurance at some point last year.

Obamacare launched a year ago, but it's only now that people will incur tax penalties for being uninsured. Others will realize their federal premium subsidy was incorrect.

Experts project that 40% to 50% of families that qualified for financial assistance might have to repay some portion because their actual household income for 2014 was higher than what they estimated during enrollment.

Those repayments could range from a relatively small amount to thousands of dollars in some cases. In California, some of the first clues may emerge later this month when the state issues tax notices to 1 million consumers.

About 85% of the roughly 7 million Americans who signed up last year through government-run

exchanges paid discounted premiums thanks to subsidies.

"This could flip people from having a refund to not," said John Graves, an assistant professor of health policy at Vanderbilt University in Nashville. "Nobody can project their income down to the last dollar. It could be a huge deal."

The Obama administration, state health officials and tax preparers are gearing up to help consumers make sense of it all and respond to the potential anger that may arise.

"We are still in the first steps of a historic change, and the challenge we all have is educating Californians and all Americans on how this works," said Peter Lee, executive director of the Covered California exchange. "The individual mandate is really kicking in and some people will find out, 'Oh I actually received more of a tax credit than I should have.'"

Covered California is sending tax notices to its more than 1 million policyholders starting Jan. 20. This new form, called 1095-A, will serve as proof of insurance and specify how much federal assistance customers received last year.

Obamacare policyholders can then use that information to fill out another new tax form, 8962, that will help them calculate the actual amount of subsidy they were eligible for based on their 2014 income.

It could cut both ways. Some people may get additional money from the federal government because their income came in lower than expected, while others will owe money.

As part of his research at Vanderbilt, Graves analyzed household income data and estimated that the average subsidy is $208 too high.

All this comes at an already busy time because Covered California is trying to sign up several hundred thousand new people before open enrollment closes Feb. 15. Officials say they have increased the service center staff in anticipation of these tax-related questions.

In its marketing and outreach, the state had reminded consumers about the need to update their income if they changed jobs or hours, got a bonus or had another change that affected their finances or household size.

Individuals earning up to $46,000 annually and families of four making up to $94,000 can qualify for

subsidies.

About two-thirds of consumers didn't know that their 2014 tax return would be used to reconcile their subsidy amount, according to a survey by the H&R Block Tax Institute.

More than 80% of tax filers typically get a refund, and the average amount is about $2,800, according to Kathy Pickering, the tax institute's executive director. Many families depend on that infusion of cash to pay off bills, get out of debt or splurge on a big purchase.

"That money is so important to so many people," Pickering said. "Anything that affects their tax refund negatively can really impact their financial situation."

Lee notes that the health law has caps in place to protect lower-income people from owing a significant amount and that repayments can also be extended into future tax years.

For instance, people earning less than 200% of the federal poverty line, about $23,000 for an individual, won't owe more than $300. That cap increases to $1,250 for an individual who makes less than four times the federal poverty line. There is no cap for those with higher incomes.

"There are people that might owe more than $2,500 as a family," Lee said. "There will be a very small amount of them, and I worry they become the headline."

During tax season, the uninsured will get an opportunity to seek an exemption from the mandate to buy health insurance. There are more than 30 potential exemptions available to them, ranging from financial hardship to religious reasons.

For the 2014 tax year, the penalty for being uninsured is $95 per adult or 1% of modified adjusted gross income, whichever is greater.

For instance, Pickering said, a couple making $65,000 a year could be penalized $447 on their tax return for lacking coverage.

Public awareness of the penalties is very low. A survey published last month by the Kaiser Family Foundation found that 72% of people didn't know what the fines are in the health law.

Those penalties are increasing for future tax years. For 2015, they rise to $325 per adult or 2% of income, whichever is higher.

During the final weeks of open enrollment this year, California officials will be emphasizing the financial toll of skipping coverage.

"We don't want consumers to be surprised," Lee said. "They have the opportunity to avoid far bigger penalties that will be hitting them a year from now."

http://www.latimes.com/business/la-fi-obamacare-taxes-20150110-story.html

Covered California Prepares for Changes to Board of Directors

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

December 30, 2014

Covered California is preparing to make the first major changes to its board of directors since the state-run insurance exchange was created four years ago, the *AP/San Francisco Chronicle* reports.

Background on Covered California Board

Under the bill (SB 972) that created the state exchange, the governor is required to appoint two members to the board, while the Assembly and state Senate appoint one member each. The California Health and Human Services Agency secretary is automatically instated as a voting member of the board.

According to the *AP/Chronicle*, board members must have some health care experience, but they also can qualify as:

- Enrollment counselors;
- IT experts; or
- Health insurance marketers (Lin, *AP/San Francisco Chronicle*, 12/29/14).

Changes to Covered California Board

Diana Dooley, chair of the exchange and California HHS secretary, has announced that:

- Board member Robert Ross, CEO of the California Endowment, will step down Dec. 31 so that the new Senate President Pro Tempore Kevin de León (D) can appoint a new director; and
- The terms of board members Susan Kennedy and Kim Belshé are set to expire, and Gov. Jerry Brown (D) will decide whether to reappoint them or name replacements (*California Healthline*, 12/16/14).

As a result, Brown will have a greater influence on Covered California's five-member board as it continues to work to reduce the number of uninsured Californians and reduce health care costs.

Rep.-Elect Norma Torres (D-Calif.), who authored SB 972 as a state senator, said, "With three board seats open, the governor and [state] Senate now have an opportunity to implement SB 972 in the way it was intended: by appointing a new majority to the board that is more representative of California's population, particularly those who need insurance" (*AP/San Francisco Chronicle*, 12/29/14).

http://www.californiahealthline.org/articles/2014/12/30/covered-california-prepares-for-changes-to-board-of-directors

144K Sign Up for Covered Calif. During First Month of Enrollment

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

December 18, 2014

During the first month of Covered California's second open enrollment period, more than 144,000 state residents signed up for a health plan through the exchange, the Los Angeles Times reports. The open enrollment period runs from Nov. 15 to Feb. 15, 2015 (Terhune, Los Angeles Times, 12/17/14).

Details of Enrollment

As of Dec. 15, the exchange received 301,539 applications for private coverage during its second open enrollment period (Robertson, Sacramento Business Journal, 12/17). Of those applicants, 144,178 also selected a health plan.

About half of the individuals who selected a plan have already paid their first monthly premium online. Meanwhile, 216,423 state residents since Nov. 15 have signed up for Medi-Cal, the state's Medicaid program.

Reasons for High Enrollment

Yolanda Richardson, chief deputy executive director at Covered California, attributed the high number of sign-ups to the exchange's outreach at storefront locations and clinics, and other initiatives (Los Angeles Times, 12/17/14).

According to a release, about 31% of new enrollees signed up for health coverage on their own, compared with 41% who did so during the exchange's first open enrollment period (Covered California release, 12/17/14).

http://www.californiahealthline.org/articles/2014/12/18/144k-sign-up-for-covered-calif-during-first-month-of-enrollment

CEO Report

Attachment 4 –

Filing the Electronic Annual Form 700

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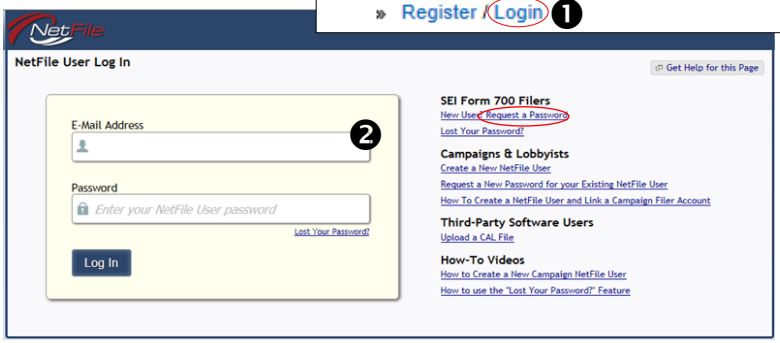
How to File a Form 700 Using NetFile

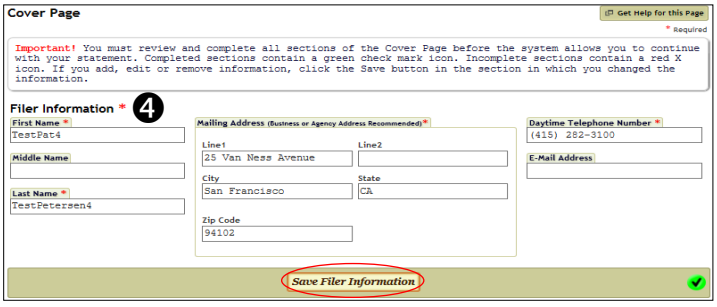
Effective January 1, 2014, elected officials, department heads, and members of decision-making boards or commissions must file the assuming, annual, and leaving office Statement of Economic Interests electronically.

❶ Go to the Ethics Commission website (sfethics.org). Under "E-File Statements," "Statement of Economic Interests," click "**Login**."

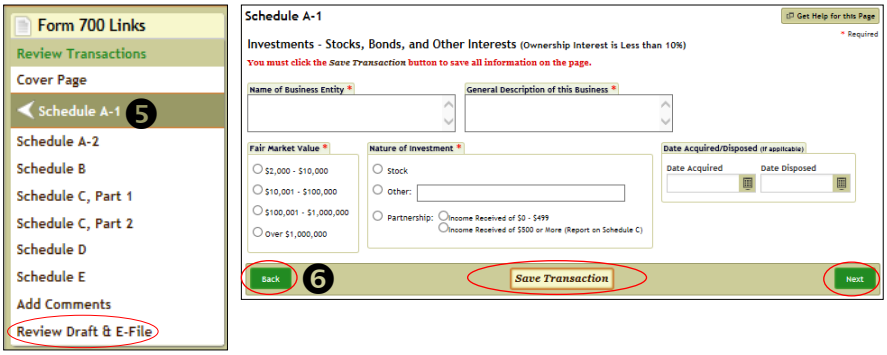


❷ Log in to NetFile using the e-mail address provided to the Ethics Commission. (If you're a new user, click "**Request a Password**.")

❸ Select the filing that you want to complete, and click "**Start Selected 700 Document**."

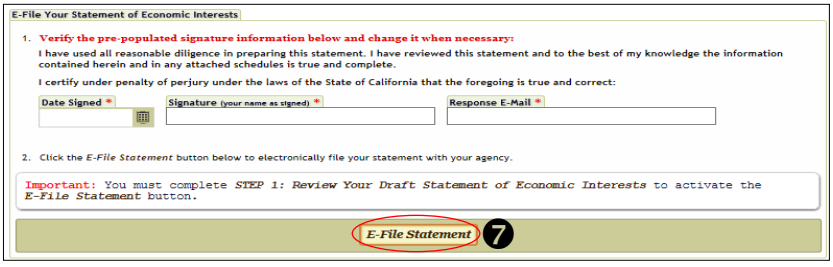


❹ Fields with a red asterisk must be completed. Click "**Save Filer Information**" as you proceed.



❺ Select and fill out Schedules A-1 through E, as appropriate. Comments can be added if needed. When finished, click "**Review Draft & E-File.**"

❻ ***IMPORTANT:*** *Use the "**Back**" and "**Next**" buttons to navigate the schedules. Using your browser's back arrow won't work.*



❼ Review the draft, sign it, and click "**E-File Statement**."

How to Request A NetFile Password

Whether you're a new user or you've simply forgotten your password, here's how to obtain a new system-generated password.

❶ Click "**New User? Request a Password**."

❷ Enter your e-mail Address.

❸ NetFile will e-mail you a link.

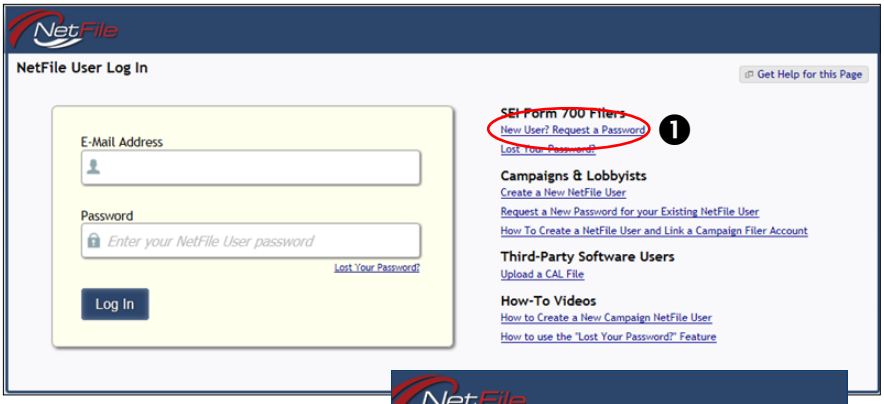
❹ Click on the link.

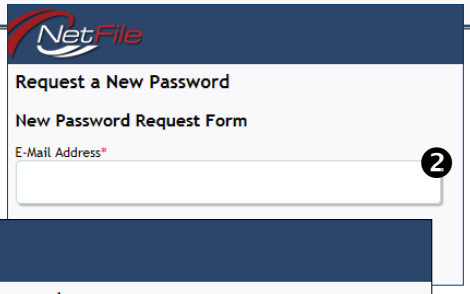
❺ NetFile will generate a new password for you.

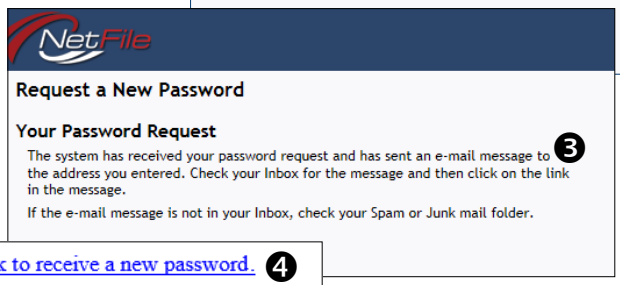
❻ Go back to the NetFile User Log In page, and log in using your new password.

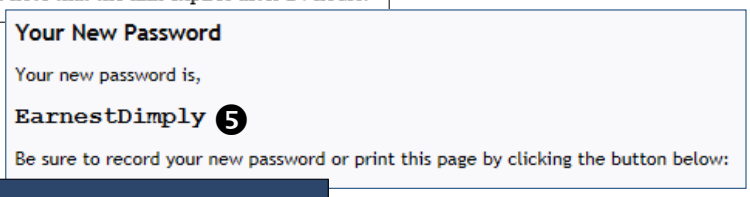
❼ Once you log in, you have the option to change your system-generated password. (The link is on the right, at the bottom)

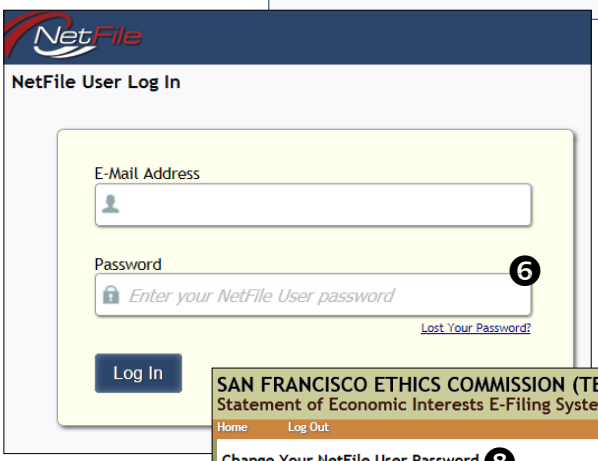
❽ Enter and confirm your new password.

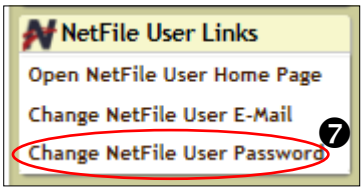


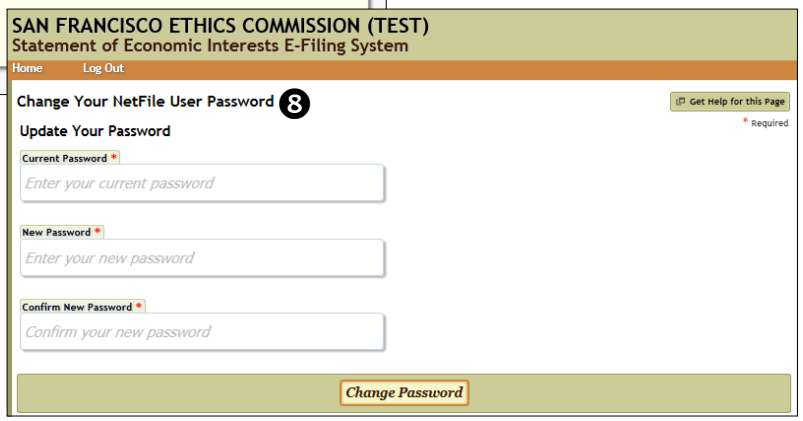












CMO Report

- Attachment 1- Evaluation of CY 2014 Quality Improvement Program

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San Francisco Health Plan

2014 Quality Improvement and Utilization Management Program Evaluation

Table of Contents

1 Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement Program (QIP) is to assure high quality care and services for our members by proactively seeking opportunities to improve the performance of our health care delivery system. SFHP's QIP and all program elements are detailed in the SFHP QI program description and Workplan. The Evaluation of the QI Program reviews the QI goals specified in Appendix I, the 2014 QI Workplan. In this summary, the results of these QI activities are presented in four activity domains: clinical care quality, service quality & access to care, utilization management, and patient safety & coordination of care.

1.1 Executive Summary

Under the leadership of SFHP's Governing Board, the Quality Improvement Program is developed and implemented through a Quality Improvement Committee (QIC). The QIC structure, under the leadership of the SFHP Chief Medical Officer, assures ongoing and systematic interaction between SFHP and its key stakeholders: members, medical groups, and practitioners. SFHP's extensive Quality Improvement Committee Structure (Appendix II) includes leadership within the health plan and its provider network to ensure oversight of SFHP QI Activities.

Leadership and Practitioner Participation in the QI Program

During 2014, senior leadership, including the CEO, Chief Medical Officer, and Associate Medical Director were very involved in the QI program. The CEO championed the initiation of SFHP's NCQA journey, supported the proposal for California Health Care Financing Authority's CHAMP grant, and advocated for enhanced funding for the Practice Improvement Program, Block Funding Program, data quality improvement efforts, and an additional health improvement incentive for hypertension. In addition, the CEO ensured there were regular reports at Board meetings on these programs. The Chief Medical Officer provided day to day support to the QI staff and was responsible for leading the Quality Improvement Committee, Physician Advisory and Peer Review, Credentialing Committee, and the Pharmacy and Therapeutics Committee, and for all quality improvement studies and activities. The Associate Medical Director provided leadership for a pain management initiative.

Practitioner participation in the QI program beyond the Chief Medical Officer and Associate Medical Director was achieved through involvement of providers in the Quality Improvement Committee, the Practice Improvement Advisory Committee that advises on the pay for performance program, the Quality Culture Series that engages providers in key improvement efforts, the clinic coaching program that partners improvement coaches with clinic leaders, and annual HEDIS/PIP review meetings during which QI leadership at the health plan meets with senior leadership in the network to review outcomes and solicit input on the health plan QI program. Overall, leadership and practitioner participation in the QI program in 2014 was appropriate to support execution of quality objectives.

The Health Services (HS) staff is accountable for implementing the annual QI Work Plan. It is organized to provide inter-disciplinary involvement in assuring the quality of medical care and services provided to SFHP's membership. It monitors quality indicators and plans, and implements and evaluates the Plan's QI activities. The HS staff also develops policies and procedures to assure compliance with SFHP

standards, legislative and regulatory mandates, contractual obligations and, as applicable NCQA standards. Based on its activities, the HS staff provides summary data, analysis and recommendations to the QIC. For a detailed summary of all staff supporting the QI Program, please refer to the Quality Improvement Program Description.

2014 Highlights

In 2014, SFHP focused on 24 areas for either improving current programs or developing new ones with specific goals. Five additional areas were added to meet identified needs and are explained in footnotes as appropriate. There were some notable accomplishments and gains over the course of the year. Over the last three years, the Practice Improvement Program (PIP) has realized significant gains in improving patient experience. PIP, in conjunction with other provider communication and training programs like the Coleman Rapid Dramatic Performance Improvement Program (DPI), contributed to a 9.3 point increase in SFHP's CAHPS scores in the Global Ratings for Overall Health Care and Rating of a Personal Doctor since the last measurement period (2012). For the 7th consecutive year, DHCS recognized SFHP for excellence in quality care. In September 2014, DHCS awarded SFHP the Bronze Award for Quality based on our HEDIS performance. In measurement year 2012 (reporting year 2013), SFHP scored within the top 10% of all Medicaid plans nationwide in 12 out of 26 measures.
Based on surveys distributed during the year, SFHP members participating in our health improvement programs like text messaging, health education and the diabetes incentive program generally feel enhanced confidence in their ability manage their health conditions. SFHP members who received dedicated care coordination services from the CareSupport department reported high levels of satisfaction with the program with an 88% endorsement rate.

Based on recommendations for the Interim Chief Medical Officer, SFHP adopted two clinical practice guidelines related to chronic conditions (asthma and diabetes) and two additional clinical guidelines related to behavioral conditions (adult depression in primary care and ADHD in primary care). The guidelines help assure that clinical practices align with current best practices and provide safe and effective care to SFHP's members. Additionally, SFHP implemented a refill policy to define standards for the use of opioids.

Factors Influencing Implementation of QI Programs in 2014:

- **Medi-Cal Expansion**
  With the advent of Medi-Cal expansion during 2014**, SFHP membership grew by 59.7%** which represented an average of 4.4% increase each month. This unprecedented growth introduced operational challenges for SFHP and for its providers. These challenges had an impact on the ability to establish, maintain and meet the goals of our QI initiatives throughout the year.

- **Infrastructure Improvement: Essette Care Management System**
  In 2014, SFHP implemented an enterprise-wide application designed to strengthen its utilization management, care coordination, and population health management efforts. The Essette Care Management System was launched in January 2014 in a phased approach, starting with modules related to care management and member grievances. Subsequent modules supported resolution of provider disputes, utilization management and a health incentive program designed for members

with diabetes. Essette's implementation, which also included significant modification to business workflows, impacted SFHP staffing resources. HS staff played a major role in customizing Essette for SFHP needs, participating in User Acceptance Testing (UAT), and designing and conducting staff training.

- **Implementation of Additional Benefits per State Mandate**
  In 2014, SFHP faced two new benefit requirements mandated by the State. For members with mental health disorders that result in mild to moderate impairment of mental, emotional or behavioral functioning, SFHP was required to provide non-specialty mental health services and selected Beacon Health Strategies as its provider. The other mandated benefit by DHCS was the provision of Behavioral Health Treatment (BHT) services for the treatment of Autism Spectrum Disorders. Beacon Health Strategies was also selected to provide these services. Both benefit mandates required extensive program design. The contract with Beacon has been executed and responsibilities have been defined, but as of late January 2015, the implementation is pending DMHC approval.

Infrastructure, Staffing, and Resource Adequacy for the QI Program

Despite several factors influencing SFHP and the QI Program, the QI Program staffing was sufficient to support program objectives. Some goals were not met due to the establishment of stretch goals to drive a higher bar on improvement, and operational challenges in the health plan and provider network during Medi-Cal expansion. The challenges within the health plan include data quality and lack of documented processes or process maturity typical for a period of organizational growth.

Data quality improvements are being addressed in the broader organization through the establishment of a Data Governance Committee. In addition, in 2014 SFHP established a Grievance Committee to better understand drivers of expressed member dissatisfaction in the provider network. Documented processes are being developed in concordance with improved policies.

The QIC structure has been refined to mature with additional requirements. While the QIC has engaged participation by network providers, the structure did not allow for sufficient time for discussion and review of quality data. For 2015, the QIC is being modified to allow more time for discussion of quality goals and peer review. Finally, enhancing the monitoring and improvement of member access to care has been identified as a priority for the health plan. As a result, SFHP formed an Access to Care Committee that will meet quarterly starting in January 2015 to review access data, expand access measures and monitors, and evaluate the success of access improvement initiatives both within the plan and the network.

Operational challenges in the network are typical for public health clinics in a time of growth. The implementation of Electronic Medical Record systems by many clinics and enhanced patient panels resulted in the need to develop new operational processes. These process improvements took time and resources. To address these challenges in 2015, SFHP is redesigning its technical assistance programs to best support current challenges in the clinics. This redesign includes refining SFHP's Quality Culture Series leadership training program to address current priorities, revising the Clinic Coaching Program to

focus efforts on the Practice Improvement Program priorities, and enhancing the Practice Improvement Program Pay for Performance Program to focus on access and member experience.

1.2 Quality Improvement Initiatives Not Launched During 2014

As part of SFHP's strategic objective to gain NCQA Interim Accreditation in 2014, disease management programs for diabetes and asthma were planned for implementation. Additionally, a Complex Medical Case Management program for members with complex medical conditions and significant care coordination challenges was planned. However, due to SFHP's Board of Directors decision to delay the accreditation application, both programs were delayed with planned launches in 2015.

2 2014 Results

2.1 Quality Leadership

Quality Improvement Committee (QIC)

The SFHP Quality Improvement Committee (QIC) is a standing committee of the San Francisco Health Authority Governing Board. The QIC is the main forum for oversight of SFHP's health care delivery system and for member and provider participation in assuring the quality of the delivery system. It is responsible for reviewing and approving the annual QI Program and Quality Improvement and Utilization Management Program Evaluation, and for providing oversight of the Plan's quality improvement activities.

Goal:

Throughout 2014, ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan in the six QIC meetings of the year.

Major Accomplishments / Results:

The goal was met. All six meetings met with a quorum and all scheduled QI topics were discussed.

Issues & Barriers:

The QIC reviews a multitude of policies and quality issues. Time spent on policies diminished the committee's capacity to review quality data in depth. While meetings occurred on schedule, SFHP identified an opportunity to better leverage the committee through enhanced focused on quality outcomes and less discussion of policies as appropriate.

Recommended 2015 Interventions:

For 2015, the SFHP Policy Committee will review all policies that do not require QIC approval or review. This change will allow more time at the QIC for discussion of quality goals and opportunities.

Physician Advisory, Peer Review & Credentialing Committee (PAC)

The Physician Advisory, Peer Review & Credentialing Committee provides comments and recommendations to SFHP on standards of care, clinical programs and guidelines, and quality initiatives.

Goal:

Throughout 2014, ensure oversight of credentialing and peer review in the six Provider Advisory Committee meetings of the year.

Major Accomplishments / Results:

The goal was met. All six meetings met with a quorum.

Issues & Barriers:

None identified.

Recommended 2015 Interventions:

The PAC is convened at the conclusion of the QIC: Reducing the number of policies reviewed at QIC will increase the time dedicated to quality issue and peer review in the PAC.

Pharmacy & Therapeutics Committee

The Pharmacy & Therapeutics (P&T) Committee assures that the Plan administers its pharmacy benefit in a manner that is consistent with sound clinical principles and processes, and that it complies with current standards of practice. It reviews and makes recommendations about SFHP's formulary and its pharmaceutical and therapeutic treatment guidelines.

Goal:[1]

Throughout 2014, meet four times. By March 1, 2014, implement a 30 day supply limit on all opioids.

Major Accomplishments / Results:

The goals were met. All four meetings met with a quorum. In 2014, the committee implemented a 30 day supply limit on all opioids. In addition, P&T approved implementation of a Medication Therapy Management contracted service for SFHP.

Issues & Barriers:

None identified.

Recommended 2015 Interventions:

None identified.

[1] The goal was revised from the internal QI Workplan to include the meeting frequency for the committee in order to stay consistent with the goals for all other committees.

2.2 QI / UM Program Evaluation

Results of the annual QI program description and Workplan from the previous year, in combination with information and priorities determined by the HS leadership and staff, are reviewed and analyzed in order to develop an annual QI evaluation.

Goal:

By March 31, 2015 evaluate 2014 QI Plan Annual Work Plan to determine if goals for SFHP's quality improvement and utilization management programs are met.

Major Accomplishment / Results:

The goal was met. The 2014 QI Plan Annual Program Description and Work Plan were evaluated and submitted as per scheduled.

Issues & Barriers:

For 2014, SFHP adopted a new evaluation format to enhance the rigor of program evaluation processes at SFHP.

Recommended 2015 Interventions:

Utilize 2014 evaluation format and schedule on an ongoing basis.

3 Quality Clinical Care

3.1 Initial Health Assessment (IHA)

Per DHCS regulations, SFHP requests providers to complete an Initial Health Assessment (IHA) for new members. IHAs must be completed for adult members within 120 days and within 60 days for members younger than 18 months. New members receive a mailer in their primary language encouraging them to call their providers and make an appointment to receive this service. To improve IHA rates, SFHP also sends monthly reports to providers that outline all of their patients yet to receive an IHA. Providers are then able to follow up with patients as needed to conduct the IHA.

Goal:

To improve member engagement with primary care by increasing the 2013 IHA rate by 3%.

Major Accomplishments / Results:

The goal was not met. The overall IHA rate declined by 10.2 percentage points.

The following table shows the 2014 performance compared to 2013:

Measure	Total Members 2014	Total IHA Completed 2014	IHA Rate 2014	Total Members 2013	Total IHA Completed 2013	IHA Rate 2013
Members 0 - 18 months	2,189	1,271	58.1%	2,656	1,799	67.7%
Members > 18 months	58,946	20,417	34.6%	17,649	7,489	42.4%
Total Members	**61,135**	**21,688**	**35.5%**	**20,305**	**9,288**	**45.7%**

Issues & Barriers:

SFHP determined that the lower compliance rate may be due to the following factors:

- In cases where newly enrolled members had previously received an IHA under another health plan or another SFHP line of business, the PCP would be less likely to administer another IHA.
- In addition, any new members meeting the following criteria would not be considered in compliance, but would not have received the IHA due to reasonable timing challenges:
    - New members continuously enrolled in the plan for the required number of days.
    - New members disenrolled from SFHP during the IHA period.
    - New members' or a member's parent/guardian refuses to complete an IHA and this refusal is documented in the chart. This is not an exclusion from the measure.
    - New member misses a scheduled appointment with the PCP and at least two additional documented attempts were made to reschedule the appointment, without success.

Recommended 2015 Interventions:

- Previous IHA reporting was done by Medical Group only. For 2015, SFHP will improve annual reporting to identify specific clinics within medical groups not in compliance.
- Work collaboratively with SFHP's Provider Network Operations team, Health Improvement teams, and low performing medical groups to develop recommendations on how to improve performance for those not in compliance.

3.2 Health Text Messaging Program

SFHP aims to improve the health status of its members with chronic conditions by offering a health text messaging program for those diagnosed with diabetes. Messages are available in English, Spanish, Chinese, and Vietnamese.

Participating members receive three to four health-related text messages per week on topics related to HEDIS diabetes screening measures, stress reduction, healthier eating, physical activity and weight control, and self-management. About 50% of the messages invite a response from the member. In 2014, SFHP launched an on-line program registration option designed to increase enrollment.

Goal:
By December 31, 2014, enroll at least 280 members with diabetes into the health text messaging program.

Major Accomplishments / Results:
The goal was met. As of December 31, 2014, 303 members were enrolled in the program.

- Currently enrolled members represent SFHP's threshold languages with the following distribution:
  - Chinese: 47%
  - English: 39%
  - Spanish: 11%
    Vietnamese: 3%
- Members responded extremely positively to texted surveys about their satisfaction with and utility of the program for helping them to manage their diabetes. In a December 2014 survey, respondents provided the comments such as these regarding the texting program:
  - "Talking to me, helping me keep up with my health. Keep me up with my BP, my weight, and how to eat right. Thanks."
  - "I now keep better track of my diabetes and other health issues."
  - "This program has helped me to remember to check everything that is right for my health."
- Members who responded to texted surveys about diabetes management self-efficacy and communication with their provider regarding their diabetes showed improvement in 2014 versus 2013:
  - Self-efficacy: *How confident are you that you can control your diabetes?* (69% versus 57% rated 8, 9, or 10 confidence level).
  - Self-management: *In the last 12 months, how often did you & your health provider talk about specific things you can do to prevent illness?* (76% vs. 63% talked with their provider "usually" or "always" instead of "sometimes" or "never").

Issues & Barriers:
The overall low levels of enrollment compared to size of patient population in the program may be due to the following factors:

- There seems to be a strong preference for registration by mail. It appears that switching to an exclusively online registration option for a period of months led to a drop in new enrollments by eligible members.
- Some members who requested enrollment did not have a cell phone or provided non-working cell phone numbers and could not be enrolled in the program.
- Some members were disenrolled from SFHP at the time of their health texting enrollment request so were not added to the texting program.

Recommended 2015 Interventions:
Offer mail-in registration for this program in addition to keeping the online registration open.

3.3 Healthier Living (Chronic Disease Self-Management Program)

SFHP sustained its membership in the San Francisco Healthier Living Coalition, a group of San Francisco agencies that have joined together to schedule, promote, and lead workshops in the Healthier Living. This program utilizes an evidence-based curriculum developed by Stanford University designed to empower people with chronic conditions to self-manage their care. The six-week peer education program builds knowledge and self-management skills in order to increase participants' self-efficacy.

SFHP and coalition partners conducted extensive outreach through targeted onsite presentations and through provider referrals to promote the program at clinic sites.

Goal:
By December 31, 2014, SFHP will work with two community sites and/or clinics to offer the Healthier Living Program to members with chronic conditions.

Major Accomplishments / Results:
The goal was met. Two sites (one clinic and one community site) conducted the Healthier Living Program for clients.

- The community site conducted the program twice, in January and October. The clinic site conducted the program in October. These sites received recruitment tools and reimbursement for their expenses.
- Of the 32 participants in the three workshops, 17 were SFHP members. Of these 17 members, 12 (71%) fully met the requirement for completion (attending 4/6 sessions).
- SFHP Project Manager completed training to become certified as a Master Trainer, in order to increase SFHP's capacity to train new program leaders.
- SFHP Project Manager conducted a leader training for 22 new leaders in partnership with a SFDPH/CBHS staff member
- 100% of participants in the Healthier Living Program reported that as a result of the workshop, they now have a self-management plan and planned to share it with their primary care provider at their next visit.

Issues & Barriers:
Additional leaders at other sites expressed interest in running the program, but were unable to execute the program due to competing site priorities and commitments.

Recommended 2015 Interventions:
- Continue to regularly promote the program to clinics and community sites.
- Offer technical assistance and financial reimbursement to sites with staff resources to conduct the program.
- Collaborate with SFHP's Care Coordination team to promote the program to members who receive services at participating sites.

3.4 HEDIS Pursuit & Related QI Activities

SFHP participates annually in the pursuit of administrative and/or hybrid data for measures included in the DHCS 2015 Required Performance Measures for Full Scope Medi-Cal Plans.

Goal:

By June 30, 2014, achieve 14 HEDIS measures in the national Medicaid 90th percentile and no measures in the 25th percentile.

Major Accomplishments / Results:

The goal was met. SFHP achieved Medicaid 90th percentile in 14 HEDIS measures with no measures in the 25th percentile.

Below are the 14 measures:

- Annual Monitoring for Patients on Persistent Medications – Digoxin
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Childhood Immunization Status – Combo 3
- Comprehensive Diabetes Care – BP Control <140/90
- Comprehensive Diabetes Care – HbA1c Control <8
- Comprehensive Diabetes Care – Poor Control >9
- Comprehensive Diabetes Care – LDL Control <100
- Comprehensive Diabetes Care – Monitoring for Nephropathy
- Prenatal and Postpartum Care – Timeliness of Prenatal Care
- Use of Imaging Studies for Low Back Pain
- Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents – BMI Percentile
- Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents – Counseling for Nutrition
- Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents – Counseling for Physical Activity
- Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life

SFHP distributed individual HEDIS results to each medical group within the provider network

The following pursuit activities were achieved:

- Configured HEDIS software (Verisk Quality Engine & Quality Reporter) and loaded all available data.
- Hired and trained temporary HEDIS pursuit staff (2 coordinators, 4 RN abstractors).
- Acquired and reviewed medical charts for 2710 SFHP members included in the HEDIS samples for each of the 8 hybrid measures specified in the DHCS measure set.
- Conducted oversight on at least 10% of randomly selected chart entries.

All audit & data submission milestones were achieved:

- Successfully submitted NCQA HEDIS Roadmap.
- Completed onsite audit with Health Services Advisory Group (HSAG) on 04/01/14.
- Responded to all audit follow-ups and rate review inquiries within 7 days.
- Passed HSAG source code review.
- Passed Medical Record Review Validation (MRRV).
- Submitted final rates submitted via NCQA's Interactive Data Submission System (IDSS) tool.
- Successfully submitted Data Submission Template to DHCS.

Issues & Barriers:

- Quality gaps in claims, encounter, and supplemental data.
- Difficulty obtaining EHR access for portions of SFHP's provider network.
- Imprecise pull list algorithm resulting in excessive time spent researching member encounter history and duplicative requests to providers.

Recommended 2015 Interventions:

Data quality barriers:

- Analyze preliminary rates by medical group to uncover gaps in data submissions.
- Integrate data quality measures in SFHP's Practice Improvement Program.
- Pursue acquisition of more complete supplemental data sources (e.g. lab tests and lab results).
- Implement data quality block funding initiative to improve administrative data rates and thus HEDIS performance.
- Collaborate with SFHP's Information Technology Systems and Business Intelligence departments to improve data flow in SFHP's Enterprise Data Warehouse (EDW).
- Collaborate with DHCS on data quality monitoring.

EHR access:

- Leverage contract negotiations to secure EHR remote access.
- Collaborate with SFHP's Compliance department to ensure adherence with HIPAA and compliance standards.
- Continue to share individual HEDIS results with each medical group in SFHP's provider network.

Pull list algorithm:

- Collaborate with SFHP's Business Intelligence department to develop a more comprehensive and precise algorithm
- Improve SharePoint site development prior to launching 2015 HEDIS pursuit process in order to improve data collection efficiency.

3.5 HEDIS Incentives and Outreach

SFHP provides member level interventions in order to incentivize SFHP member to receive the priority preventive screenings included in the DHCS HEDIS auto assignment measure set. DHCS's auto-assignment of newly enrolled Medi-Cal members to SFHP is achieved, in part, by SFHP's success in fulfilling outreach and incentive program goals.

The following are outreach and incentive milestones for each of the HEDIS auto assignment measures:

- *Diabetes outreach and incentive program*
  - Mail Disease Management (DM) passport and incentive information twice per year to members with diabetes.
  - Provide live outreach calls to members with diabetes twice per year.
  - Provide a $25 gift card to qualifying members who get the appropriate diabetes screenings in 2014 (HbA1c test, eye exam, foot exam, BP check, kidney protection).
- *Prenatal and postpartum care outreach and incentive program: "Your Body, Your Baby"*
  - Provide a live outreach call to members who are pregnant or have recently delivered.
  - Mail "Your Body, Your Baby" health education and incentive packet to pregnant and postpartum women (for prenatal member must give verbal confirmation of pregnancy) on a monthly basis.
  - Provide a $25 gift card to qualifying members (who have a prenatal visit in their first trimester or within 42 days of enrollment; who have a postpartum visit between 3-8 weeks after delivery).
  - Provide a health education book to members who respond to the incentive mailing (What To Do When You're Having a Baby; What To Do When Your Child Gets Sick).
- *Cervical Cancer Screening outreach program*
  - Provide a live outreach call to members who are due for a cervical cancer screening – members are informed that if they get a cervical cancer screening in 2013 they will be entered in an iPad raffle.
  - For clinics in SFHP's provider network with the largest access barriers, provide a drop-in pap clinic alternative to members.
- *Well-Child outreach and incentive program*
  - Mail well-child incentive information to members once per year.
  - Provide an automated reminder call to members once per year.
  - Provide a $25 gift card to members who get a well-child visit in their 3rd, 4th, 5th, or 6th year of life.
- *Childhood Immunization outreach and incentive program*
  - Mail immunization incentive information to members four times prior to their 2nd birthday (5mos, 8mos, 13mos, 17mos).
  - Provide an automated reminder call to members four times prior to their 2nd birthday (12mos, 13mos, 17mos, 22mos).
  - Provide a $50 gift card to members who receive the all immunizations in the HEDIS measure, Childhood Immunizations Combo 3 series prior to their 2nd birthday.
- *Pilot hypertension outreach and incentive program*

- Mail hypertension and incentive information to members who have had a hypertension diagnosis prior to 06/30/14.
- Provide an automated reminder call to members with hypertension.
- Provide a $25 gift card to members who get a BP check prior to 12/31/14 and complete a "Healthy Heart Action Plan."
- Partner with San Francisco Health Network (SFHN) clinics to provide "drop in" blood pressure clinics and distribute gift cards to qualifying members.

Goal:
By December 31st, 2014, carry out one outreach and/or incentive program for each of the 6 DHCS HEDIS auto assignment measures.

Major Accomplishments / Results:
The goal was met. SFHP successfully provided outreach to members in each of the 6 programs as detailed below:

Program	Target Population	Outreach Results	Incentive Results
Diabetes	2953 members targeted in March, 3745 members targeted in October	1251 members successfully reached via outreach calls in March (42%), 1583 members in October (42%)	144 members received a gift card (69 members did not qualify)
Your Body, Your Baby	114 members were sent prenatal packets, 749 members were sent postpartum packets in 2014	100 members successfully reached via prenatal outreach calls (data not available for postpartum calls)	84 members received a prenatal gift card (11 members did not qualify); 154 received a postpartum gift card (13 members did not qualify)
Cervical Cancer Screening	NA	178 members successfully reached via outreach calls (11% of 1634 members targeted)	The raffle occurred in March 2014
Well-Child Visits	8338 members targeted in 2014	8338 members targeted for automated calls (no successful call rate available)	1606 members received a gift card
Childhood Immunizations	1913 members targeted in 2014	1913 members targeted for automated calls (no successful call rate available)	586 members received a gift card (117 members responded but did not qualify)
Hypertension Pilot	6994 targeted in 2014	6994 members targeted for automated calls (no successful call rate available)	No gift cards have been distributed yet

- SFHP Clinical Quality staff provided presentations to clinic staff regarding member incentives at the following sites:
  - North East Medical Services Stockton
  - SFGH Women's Clinic
  - Silver Avenue Family Health Center
  - Family Health Center at SFGH
  - Mission Neighborhood Health Center
  - St. Luke's Women's Health Center
- Baseline evaluation of 2013 incentive program participation and corresponding HEDIS measure compliance:
  - Diabetes: Of members in the HEDIS eligible population (n=3,061), 16% (n=477) submitted an incentive card, and of those, 52% qualified for incentive.
  - Prenatal: Of members in the HEDIS eligible population who had a prenatal packet sent to them (n=19), 95% had a prenatal visit in the required timeframe.
  - Cervical Cancer Screening: Of members in the HEDIS eligible population who were due for a test successfully received an outreach call (n=635), 35% had a cervical cancer screening in 2013 (10 percentage points higher than members that were not reached because of a disconnected number or no answer).
  - Well-Child: Of members in the HEDIS eligible population who had incentive information sent to them (n=6,777), 60% received a Well Child visit.
  - Childhood Immunizations: Of members in the eligible population who had incentive information mailed to them (n=1,717), 43% received required immunizations in the required time period (when encounter data only is analyzed).
- Assessed health disparities using HEDIS data:
  - Analyzed HEDIS data with a disparities lens to develop a baseline and distribute a disparities "scorecard" to medical groups.
  - Convened a disparities workgroup among SFHP staff, with each participant working on an intervention to address health disparities in SFHP's network and/or address social determinants of health impacting members.
  - Researched best practices for reducing health disparities and addressing the social determinants of health, utilizing Community Health Workers (CHWs).

Issues & Barriers:

- Incorrect member contact information.
- Manual tracking systems for HEDIS member incentives.
- Underutilization of member incentive programs.
- Short turnaround time to implement an incentive program for the new auto assignment measure: Controlling High Blood Pressure.

Recommended 2015 Interventions:

- Member Contact Information:
  - Track returned mail and disconnected numbers.

- Utilize Essette as a repository for member contact information.
- Research best practices for collecting member-reported contact information (outside of what is received in monthly state enrollment file).

- Incentive Tracking Systems:
  - Develop and utilize Essette to automate and manage all HEDIS incentive programs.
- Underutilization of Incentive Programs:
  - Continue to collaborate with SFHP's CareSupport Department to promote incentive programs among CareSupport clients (SFHP members considered high utilizers).
  - Continue to improve disparities data and analysis and convene a cross-departmental disparities workgroup.
  - Continue to provide incentive program presentations to staff at safety net clinics.
- New Incentives:
  - Collaborate with SFHP stakeholder areas (Marketing and Communication, Finance, Compliance, Customer Service, Provider Relations) to successfully implement incentives with short turnaround times.
  - Begin materials development with as much lead time as possible.

3.6 Clinical Practice Guidelines Update

In 2014, the Clinical Quality team established a process to monitor SFHP's clinical guidelines to ensure that the adopted guidelines are up to date with current practice and meet NCQA Accreditation QI-9 Standard requirements.

Goal:

By December 31, 2014, ensure that SFHP practice guidelines are compliant with NCQA Accreditation QI-9 Standard.

Major Accomplishments / Results:

The goal was met. The NCQA Accreditation consultant approved new guidelines, policies and procedures designed to meet NCQA Accreditation requirements. For 2014, four new guidelines were added to SFHP's existing list of clinical guidelines, two related to chronic conditions (asthma and diabetes) and two related to behavioral conditions (adult depression in primary care and ADHD in primary care).

- SFHP provided an updated policy and procedure to the Quality Improvement Committee (QIC) in order to comply with the NCQA Accreditation standards
- The QIC and CEO approved the new policy and procedure.
- SFHP created a desktop procedure outlining the new process.
- SFHP's Marketing and Communications department posted the new guidelines on SFHP's website: http://www.sfhp.org/providers/provider-resources/clinical-guidelines/
- Clinical Quality provided information about the new guidelines in the monthly provider newsletter
- Provider Network Development staff distributed information about the new guidelines to the delegated medical groups

Issues and Barriers:
Webpage statistics reveal that our guidelines are rarely utilized (less than 1 web page hit per day on average).

Recommended 2015 Interventions:
In addition to the QIC approval process, request additional feedback from targeted clinical leadership in the network when providing new guidelines to increase utilization.

4 Quality of Services & Access to Care

4.1 Improving Patient Experience Quality Improvement Program (QIP)

Current survey results show that SFHP lags behind the state and national averages in provider communication, shared decision making, and timely access to appointments. SFHP's plan-specific QIP is designed to improve SFHP's CAHPS results, particularly the rating of overall health care and the rating of personal doctor.

Goal:

- To improve the CAHPS global measure *Rating of Overall Health Care* by 25% (43.6% to 54.5%) by the end of two re-measurement periods.
- To improve the CAHPS global measure *Rating of Personal Doctor* by 25% (54.7% to 68.4%) by the end of two re-measurement periods.

In response to this QIP priority, SFHP continued its focus on two primary initiatives: Coleman's Rapid Dramatic Process Improvement and Provider Communication Trainings.

Coleman Associates Rapid Dramatic Improvement (DPI) Initiative:
SFHP sponsors clinics to participate in Coleman Associates' Rapid Dramatic Performance Improvement (DPI) program. In this intensive program, 3 to 5 consultants work side-by-side with clinic staff for one week, redesigning clinic processes to improve teamwork, patient experience, access, and patient visit efficiency. This week is followed by two months of coaching, monitoring and reporting of performance measures. This intervention is useful for primary care clinics that wish to improve patient experience and access through QI, team based care, and improved productivity.

Provider Communication Trainings:
SFHP collaborates with the Institute for Healthcare Communications (IHC) to offer trainings to care providers (MDs, NPs, PAs, LCSWs, etc.) aimed at improving their one-on-one interactions with patients and shared decision making. Past topics include difficult clinician-patient relationships and using EHR in the exam room.

Major Accomplishments / Results:

The goals were not met. CAHPS global measure *Rating of overall health care* improved by 21% (43.6% to 52.9%) compared to the goal of 25% CAHPS global measure *Rating of personal doctor* improved by 19% (54.7% to 64.1%) compared to the goal of 25%.

Below are results related to the Coleman DPI Program and Provider Communication Trainings:

- Five Rapid DPI participants reported in clinic exit interviews that there was an overall positive impact on clinic flow especially with appointment scheduling and overall office visit cycle time[2].
- Nine clinics that underwent Rapid DPI decreased on average no-show rate by two percentage points and reduced cycle time by 17 minutes.

[2] As per the Institute for Healthcare Improvement (IHI), cycle time is the time in minutes that a patient spends during an office visit, excluding time spent in laboratory or radiology during a primary care visit.

Out of the 157 in attendance and surveyed, 100% of survey respondents from the provider-patient communication training reported that they use at least two new communication techniques as a result of the training.

Issues & Barriers:

- Clinics participating in Rapid DPI have struggled with sustaining progress.
- DHCS conducts HP-CAHPS every three years making it difficult to evaluate and modify programs.

Recommended 2015 Interventions:

- Conduct HP-CAHPS annually for each medical group in SFHP's network.
- Develop an optional sustainability program for clinics that have participated in a Rapid DPI.
- Continue to host trainings focused on improving customer service, quality improvement, and provider communication.

4.2 Timely Access Requirements (TAR)

SFHP complies with access regulations, as defined by DMHC and DHCS. DMHC Timely Access Regulations are submitted in March each year. SFHP's Timely Access Monitoring follows DMHC's recommended methodology, including randomized appointment availability telephone surveys, provider satisfaction surveys, member satisfaction surveys, review of after-hours advice calls, and access-related grievances. This ongoing monitoring provides SFHP with perspective on satisfaction with access, timeliness of various appointments, and access to afterhours care. In addition, SFHP monitors specific access measures required by DMHC, including timeliness of prenatal appointments, telephone wait times, and nurse advice line wait times. SFHP also reviews a suite of other access measures for a comprehensive picture on member access. Examples include providers open to new members and member transfer rate from one part of the network to another or one provider to another. Providers that are not in

compliance with regulations are required to participate in either a quality improvement plan or a corrective action plan.

Goals:

By March 31, 2014, measure 2013 compliance with member access for each of SFHP's six networks, including primary care, specialty care, and ancillary care per the DMHC requirements:

- Availability of urgent care within 48 hours of request
- Availability of urgent specialty care within 98 hours of request
- Availability of non-urgent primary care appointments within 10 business days of request
- Availability of non-urgent appointments with specialist physicians within 15 business days of the request
- Availability of a non-urgent appointment with a non-physician mental health care provider within 10 business days of request
- Availability of non-urgent ancillary services within 15 business days of request
- Percent of telephone triage or screening wait time that do not exceed 30 minutes (See Nurse Advice section for details)

By June 2014, develop improvement plans for all networks with a trend of non-compliance.

Major Accomplishments / Results:

The goals were met. Based on a review of the monitoring measures, the six networks did not demonstrate a pattern of non-compliance. Therefore, no improvement plans were developed. Below are the monitoring results:

Provider Appointment Availability Survey Results (conducted August – October 2013):

Standards	Provider Network A	Provider Network B	Provider Network C	Provider Network D	Provider Network E
Advanced access[3]	100%	100%	54%	100%	46%
Urgent appointments for services that require prior authorization, offered within 96 hours	100%	100%	80%	100%	79%
Urgent appointments, no prior authorization required, offered within 48 hours.	100%	100%	91%	100%	100%
Non-urgent appointments for primary care offered within 10 business days.	100%	100%	71%	100%	96%

[3] Definition: The provision, by an individual provider, or by the medical group or independent practice association to which an enrollee is assigned, of appointments with a primary care physician, or other qualified primary care provider such as a nurse practitioner or physician's assistant, within the same or next business day from the time an appointment is requested, and advance scheduling of appointments at a later date if the enrollee prefers not to accept the appointment offered within the same or next business day.

Provider Satisfaction Survey Results:

Composite and Key Questions	2013	
	Valid N	Summary Rate Scores
Timely Access to Non-Emergency Health Care Services Composite	Overall	82%
5A. The referral and/or prior authorization process necessary for your patients to obtain covered services.	104	77%
5B. Your patients' access to urgent care.	95	88%
5C. Your patients' access to non-urgent primary care.	96	87%
5D. Your patients' access to non-urgent specialty services.	94	73%
5E. Your patients' access to non-urgent ancillary diagnostic and treatment services.	94	83%

Member Survey Results (Member Satisfaction) from CG-CAHPS (2013):

Enrollee Survey – Adult Members		2012	2013
Survey Population		1,351	6,865
Responded to All Questions		320	1,873
Response Rate		24%	27%
Q04: In the last 12 months, how many times did you visit this doctor to get care for yourself?	Total Responses	327	1,544
	No visits	13%	6%
	1 visit	15%	18%
	2 visits	15%	22%
	3 visits	16%	17%
	4 visits	17%	15%
	5-9 visits	16%	19%
	10 or more visits	7%	4%
Q06: In the last 12 months, when you phoned this doctor's office to get an appointment, how often did you get an appointment for care you needed right away?	Total Responses	320	564
	Never	14%	6%
	Sometimes	27%	42%
	Usually	32%	27%
	Always	27%	25%
Q23: Using any number from 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate this doctor?	Total Responses	327	1398
	Average Provider Rating (Scale: 1-10)	8.3	8.3
Q27: In the past 12 months, have you seen a doctor or other health provider three or more times for the same condition or problem?	Total Responses	328	1384
	Yes	56%	41%
	No	44%	59%

Issues & Barriers:

- Meaningful ongoing access monitoring is challenging due to resource requirements.
- DMHC changed their survey methodology in October 2013, adding 30 additional completed surveys for each provider which affected compliance rate.

Recommended 2015 Interventions:

- Collaborate with SFHP's Provider Network Operations (PNO) department to improve provider data.
- Implement quality improvement plans for sites with identified non-compliance.
- Develop access measurement dashboard with automated data.

4.3 10 Building Blocks Practice Coaching Program

In January 2013, SFHP, in collaboration with UCSF's Center for Excellence in Primary Care (CEPC), launched a three year program focused on guiding clinics' primary care transformation using the "10 Building Blocks of High-Performing Primary Care." The building blocks outline critical elements found in multiple high-performing primary care practices around the country.

Participating clinics are assigned a coach from SFHP or CEPC, free of charge, to implement the 10 Building Blocks program. Coaches focus on building clinic capacity to ensure that changes are sustainable through training and facilitation. Each clinic is allocated approximately three hours per week of coaching resources over three years, including both on-site and off-site support. 2014 focused on ensuring sustainability of coaching efforts across safety net clinics in San Francisco.

Goal:

By December 31, 2014, engage a minimum of 15 safety net clinics with ongoing practice coaching focused on practice transformation.

Major Accomplishments / Results:

The goal was not met. SFHP engaged with 13 safety net clinics.

The following are program milestones and results:

- Drafted a toolkit focused on the 10 Building Blocks of Primary Care. SFHP will send out the toolkit to providers in 2015.
- Administered an annual Building Blocks Primary Care Assessment to all participating practices.
- Developed a structure to collect data and evaluate clinic participation.
- As of November 2014, 12 of the 13 participating clinics have defined objective series (n=29) for two or more building blocks.
- Of the 29 objective series, 41% are focused on team-based care, 10% on engaged leadership, 7% on data driven improvement, and 3% on prompt access to care.

- As of September 2014, 27% of defined structures are in progress and 20% have been completed; 20% of operational processes and 18% of performance measures are trending toward improvement goals.

Issues & Barriers:

- San Francisco clinics may be experiencing change fatigue as a result of the numerous initiatives implemented within the primary care network (e.g., Lean, Coleman Rapid DPI, and other training programs).
- Clinic evaluation interviews reveal that clinic expectations for the coaching program do not match coach expertise; clinics want subject matter experts to serve as coaches.

Recommended 2015 Interventions:

- In order to sustain coaching program beyond current funding, the program should be transitioned into a coaching program focusing on the Practice Improvement Program priorities.
- In conjunction with UCSF's Center for Excellence in Primary Care (CEPC), create individual transition plans for each participating clinic prior to the end of the program.
- Transition SFHP coaching to focus on the Practice Improvement Program priorities.

4.4 San Francisco Quality Culture Series (SFQCS)

Studies on high-performing organizations frequently name leadership commitment and alignment as the foundations for success. Redwood Community Health Coalition, a consortium of clinics in four North Bay counties, created the Quality Culture Series and saw a dramatic acceleration of improvements in the areas of chronic care, access, EHR, and patient experience, after 100% of their clinic leadership teams went through the training together. They attribute their success to the fact that the entire leadership team attended all sessions, and then spread the training to their clinic staff.

San Francisco's Quality Culture Series (SFQCS) was based on this model. The initial year-long program consisted of eight full-day interactive sessions, focusing on leadership and management skills, quality improvement, and project management. Each clinic was assigned a practice coach, and all clinics participated with their senior leadership teams. The series has been credited with increasing the pace of improvement in safety net clinics related to access, chronic care, and patient experience. In addition, clinic leaders had the opportunity to network and share best practices. Based on this success, SFHP planned to continue its sponsorship in 2014.

Goal:

By December 31, 2014, 20% of clinics will improve clinic staff satisfaction via training and coaching to clinic management teams.

Major Accomplishments / Results:
The goal was met. 35% (7/20) of clinics improved staff satisfaction based on the PULSE survey results. [4]

71% (17 out of 24) of eligible clinics received credit for their pay-for-performance incentive measure by participating in the QCS gallery walk for improving staff satisfaction.

Issues & Barriers:
- There are many factors influencing staff satisfaction. SFHP cannot assert that QCS or Clinic Coaching is the primary factor.
- Change in clinic leadership, staff turnover, lack of resources, and various clinic-specific access interventions hinder efforts to improve staff satisfaction.
- Strong leadership coaching is needed to assist management teams with applying tools to their unique environments. Finding leadership coaches with clinical operations knowledge is challenging.

Recommended 2015 Interventions:
Staff Satisfaction improvement is a measure in the 2015 Practice Improvement Program; participants will be scored on improvement over baseline of staff satisfaction.

4.5 Practice Improvement Program (PIP)

The Practice Improvement Program (PIP) is SFHP's pay-for-performance program. PIP is equivalent to approximately 18.5% of provider payments, proving to be a strong motivator for provider groups. Supporting the goals of the triple aim, PIP has four domains: Clinical Quality, Patient Experience, Systems Improvement, and Data Quality. Participants have opportunities to gain incentive funds both from meeting benchmarks and from relative improvement. Unearned funds are reserved to support improvement of performance measures via technical assistance and provider-level grants.

Goal:
By December 31, 2014, meet program milestones and apply measure set developed in 2013.

Major Accomplishments / Results:
The goal was met. SFHP achieved the key program milestones and successfully applied the measure set developed in 2013.

The following are program milestones and results:
- Consolidated two pay-for-performance programs into PIP.
- Stronger focus on outcomes-based measures.
- Data quality measures became applicable to all participant types.

[4] This improvement was based on the PULSE survey question related to staff & clinicians' feeling about their clinic as a place to work.

- Measures developed in conjunction with key stakeholders through Advisory Board and Content Expert Workgroups.
- SFHP surveyed other managed pay-for-performance programs to compare and strengthen SFHP's program.
- Monitored participants' submissions for potential quality issues, and provided technical assistance as needed.
- Further aligned Clinical Quality measures with HEDIS specifications to strengthen PIP's impact.
- Began planning participant survey regarding program relevance and data sharing plan.

Issues & Barriers:

- Database containing PIP performance data had some technical difficulties, making it difficult to track performance.
- Participants expressed challenges with a large measure set, making it difficult to prioritize improvement work.

Recommended 2015 Interventions:

- Develop a more focused measure set to enhance improvement prioritization.
- Improve/revise database containing participant performance data.

4.6 PIP Block Funding Initiative

At the end of 2013, SFHP netted an operational surplus of $8,000,000 due to a variety of factors that included revised reimbursement rates for Seniors and Persons with Disabilities (SPDs), low SFPH administrative costs, and retroactive payment for programs and services provided in '11-'12 but not paid until '12-'13. A new PIP block funding initiative was designed during 2014 to distribute this surplus to support infrastructure improvements specifically focused on the PIP goals of access to care, data quality, and ensuring appropriate utilization of services. The funds were intended to support improvement initiatives and infrastructure that could be sustained over time.

Unlike PIP, the program's goal was not to hold these funds in reserve, but to be distributed to participants after they met goals. 80% of the money was released to the providers early, so the funds can support improvement efforts. When goals are met, then the remaining funds will be released to participating providers.

Goal:

By December 31, 2014, develop and administer a program to provide financial incentives for SFHP's network to engage in activities related to systems improvement, patient experience, clinical quality and data quality.

Major Accomplishments / Results:

The goal was met. SFHP successfully developed and administered a block grant program.

The following are program milestones and results:

- Program guide developed that outlined participation requirements.
- Statements of Interests were received and reviewed for project scoping.
- Subject Matter Experts (SMEs) followed up with participating organizations on a quarterly basis to review data and completion of work plan tasks.
- 88% (eight of nine) of participating organizations have submitted a final approved application.
- Remaining metrics have yet to be calculated as current quarter check-ins are due by the end of the 2014 calendar year.

Issues & Barriers:
The San Francisco Health Network (SFHN) is the only PIP Block Funding Initiative participant that has not submitted a final application. The delay was agreed to by both parties.

Recommended 2015 Interventions:
Continue administration of the funding as sites meet stated goals.

4.7 Member Grievances and Appeals

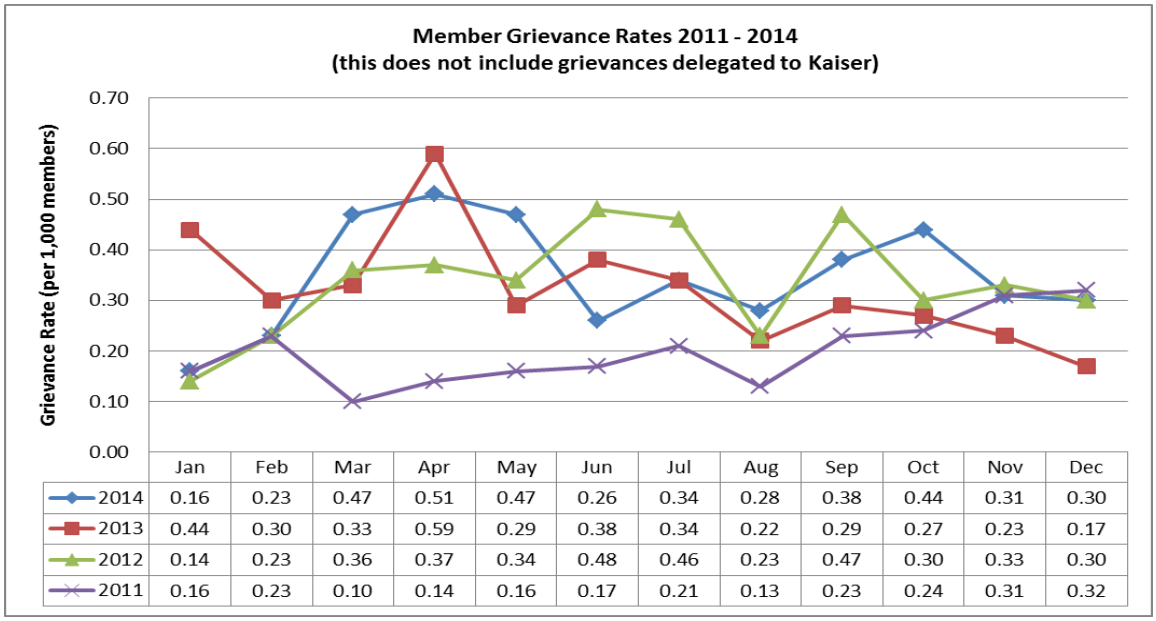
SFHP strives to improve service to our members and monitors grievances each quarter to identify trends and challenges with the health system. To identify patterns and trends in our grievances, SFHP reports grievance rates by line of business, medical group and grievance category. When a pattern has been identified, SFHP will work with clinics or medical groups to provide recommendations on how to improve on the specific issue.

Goal:
For 2014, resolve 100% of grievances within 30 days.

Major Accomplishments / Results:
The goal was not met. Ninety-eight percent (436/ 445) of non-delegated grievances were resolved within 30 days of receipt. Nine non-delegated grievances were not resolved within the 30-day period and required an additional six days.[5] Six of the nine grievances that required the additional resolution time were due to delayed provider responses. The remaining three were due to delays related to internal challenges.

[5] In 2014, 530 member grievances were processed by SFHP and Kaiser Permanente (the one medical group in SFHP's network that is delegated for grievance processing and resolution). Of those, 445 are non-delegated and is the basis of this performance goal.

The following chart shows the grievance rate (1,000 / PMPM):



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2014	0.16	0.23	0.47	0.51	0.47	0.26	0.34	0.28	0.38	0.44	0.31	0.30
2013	0.44	0.30	0.33	0.59	0.29	0.38	0.34	0.22	0.29	0.27	0.23	0.17
2012	0.14	0.23	0.36	0.37	0.34	0.48	0.46	0.23	0.47	0.30	0.33	0.30
2011	0.16	0.23	0.10	0.14	0.16	0.17	0.21	0.13	0.23	0.24	0.31	0.32

- SFHP experienced a 51% increase in grievances due to Medi-Cal expansion (530 grievances were filed in 2014 in comparison to 350 grievances filed in 2013). The grievance rate did not increase due to the increase of members.

Grievance Categories

The top categories across all lines of business were Denials/Refusals, Quality of Service, Quality of Medical Care. Denials/Refusals remained the top category (171) which increased by 16% from 2013. However, both Quality categories experienced significant increases over their 2013 levels. Quality of Service grievances increased by 84% and Quality of Medical Care grievances increased by 55%. SFHP attributed these increases to the fact that a rise in patient population typically impacts service and quality as the clinics adjust their operations to meet additional demands.

Grievances handled by SFHP, by category, 2011 - 2014
Sorted by percentage of total, highest to lowest

Grievance Category	2014		2013		2012		2011	
	#	%	#	%	#	%	#	%
Denials, Refusals	171	42%	147	47%	189	62%	64	40%
Quality of Service	138	34%	75	24%	55	18%	53	33%
Quality of Medical Care	73	18%	47	15%	17	6%	9	6%
Access	26	6%	19	6%	17	6%	10	6%
Billing	12	3%	11	4%	7	2%	5	3%
Benefits/Coverage	12	3%	10	3%	14	5%	6	4%
Cultural and Linguistic	1	0%	2	1%	2	1%	1	1%
Enrollment	6	1%	2	1%	1	0%	13	8%

Other	6	1%	0	0%	2	1%	0	0%
Total	**445**	**------**	**313**	**------**	**304**	**------**	**161**	**------**

Implementation of Essette: Appeals & Grievances Module

- The implementation of Essette, SFHP's new care management system, provided a more efficient system to process grievances and appeals.
- Processing grievances in Essette enables all staff that work on grievances, may review the status of specific grievances.

Grievance Committee

- SFHP developed a grievance committee in order to help improve member experience, improve SFHP's internal grievance process and respond to recommendations in the DHCS Corrective Action Plan.
- The committee is a multidisciplinary committee composed of the Chief Medical Officer, and representatives from Member Services, Provider Relations, Health Improvement, Care Support, Pharmacy, Clinical Operations and State and Regulatory Affairs.

Issues & Barriers:

- Many of the grievances that could not be closed timely were due to the untimely response from providers.
- There were two non-clinical grievances that were not closed timely due to the internal operational challenges.
- Due to Medi-Cal expansion and the increase in the number of grievances received, resolving and closing grievances appropriately within the 30 calendar day timeframe is challenging.

Recommended 2015 Interventions:

- Improve quarterly reporting to demonstrate clinic-specific grievances related to access issues.
- Work collaboratively with SFHP's Provider Network Operations department and Practice Improvement team in order to track and trend grievances related to specific clinics and provide recommendations on how to improve their access issues.
- Develop a grievance escalation process when providers do not give a response timely.
- Create a process flow to help improve internal operations.

4.8 Providing Cultural and Linguistic Services (Health Education)

SFHP regularly assesses the cultural and linguistic needs of its members, and maintains appropriate services, including providing member materials that are written at a sixth grade reading level in English and in threshold languages. These resources are available for viewing and download on the SFHP website.

SFHP also disseminates health education messages and topics through its quarterly distribution of a member newsletter, *Your Health Matters*. Articles in this newsletter adhere to DHMC's literacy requirements.

Goal:
By December 31, 2014 ensure that all health education fact sheets are available in SFHP's Medi-Cal threshold languages (English, Spanish, Vietnamese, Chinese) and Russian.

Major Accomplishments / Results:
The goal was met with the following results:

- 100% (38/38) of health education fact sheets were available in SFHP's threshold languages.

In addition,

- 100% (38/38) of all links to health education fact sheets had working links on the SFHP website.
- 100% (21/21) of *Your Health Matters* articles complied with DMHC literacy requirements and were clinically accurate.

Issues & Barriers:
None identified.

Recommended 2015 Interventions:
None identified.

4.9 Annual Cultural Awareness Training for SFHP Staff

All SFHP regular full-time employees must participate in an annual cultural humility and SPD sensitivity training in order to comply with State recommended best practices. This training consists of two components: 1) Reviewing a "Serving Seniors and Persons with Disabilities" presentation, and 2) Completing a web-based, interactive cultural humility training session.

Goal:
By December 31, 2014, review cultural awareness principles with all SFHP employees through participation in a mandatory training.

Major Accomplishments / Results:
The goal was not met. As of December 31, 2014, 89% (231/260) of SFHP employees completed the training.

The following are program milestones and results:

- Performed thorough search for a consultant to provide cultural awareness training; consulted experts in the field for recommendations
- Executed contract in early November 2014
- Launched training in mid-November 2014
- Facilitated completion of annual staff training by all staff through providing information and instructions for participating in training

Issues & Barriers:
Short timeframe for completing the training resulted in reduced completion rates.

Recommended 2015 Interventions:
Offer longer training period to balance competing priorities.

5 Utilization Management

5.1 Effective and appropriate utilization management

The goal of the Utilization Management program is to optimize members' health status by ensuring that they receive appropriate type and level of medical services while actively managing cost trends. 2014 focused on two key areas: Timeliness of UM decisions and Managing Out of Medical Group (OOMG) costs.

Turnaround Time:
2014 improvements to UM operations were expected to improve timeliness of utilization management decisions. The implementation of the UM module in Essette was expected to play a key role in increasing and expediting decision-making and monitoring capabilities.

Goal:
Each month SFHP will render a decision for more than 90% of:

- Expedited prior authorizations within three calendar days.
- Routine prior authorizations within five calendar days.

Major Accomplishments / Results:
The goal was not met. For routine authorizations, the last two months of 2014 did not meet the goal of having more than 90% of the requests be determined within 5 calendar days. For expedited authorizations, only 50% of the time (6 months), was SFHP able to reach the > 90% goal.

The following are program milestones and results:

- Essette UM module was successfully launched in June 2014. This implementation also included monitoring reports regularly used by the staff.
- These 2014 results for routine authorizations suggest that requests are being accepted, triaged, and dispositioned in a timely manner to avoid delays in care.

OBJECTIVE	METRIC	MONTHLY GOAL	Dec-14	Nov-14	Oct-14	Sep-14	Aug-14	Jul-14	Jun-14	Essette Go-Live	May-14	Apr-14	Mar-14	Feb-14	Jan-14
Monitor Expedited Authorization TAT Compliance	% Expedited Auths in Compliance *	> 90%	77%	86%	89%	92%	89%	82%	86%		94%	100%	98%	94%	96%
Monitor Routine Authorization TAT Compliance	% Routine Auths in Compliance **	> 90%	79%	90%	97%	99%	99%	99%	99%		99%	100%	99%	100%	99%
* Total Expedited Auths finalized within 3 calendar days/Total Expedited Auths Received															
** Total Routine Auths finalized within 5 calendar days/Total Routine Auths Received															

Issues & Barriers:

- Increase in membership higher than originally projected had an impact on staffing. Throughout 2014, SFHP experienced minimal staffing during holiday season, many open staff positions, and intensive time involved in training of new associates.
- The implementation of the new care management system, Essette, introduced a steep learning curve for staff that had to adapt to the new operational workflows.

Recommended 2015 Interventions:

- Increase staffing model threshold to account for greater membership variances and trend seasonal influx of authorization to provide greater work capacity.
- Provide ongoing training to staff on the use of Essette.

Out of Medical Group Costs (OOMG):

On a monthly basis, SFHP generates, disseminates, and reviews utilization management reports with SFGH leadership to identify over and underutilization of out of medical group inpatient and outpatient services. By moving members back into their medical group, they receive more consistent and continuous medical care. Inpatient repatriation was initiated in 2013 with minimal service level agreements and workflows. In 2014, SFHP partnered with SFGH and the referring hospitals to streamline process, agree to timeframes, and create workflows that move members from the ED to their "home" hospitals in three hours or less. This minimizes disruption to member care and enhances their healthcare experience. Every month, SFHP and SFGH partners to review the OOMG utilization reports and discusses how to impact utilization. The inpatient OOMG reports drive the repatriation workflow and help to identify opportunities for improvement. The prior authorization OOMG reports drive identification of gaps in services available in network and where steerage is possible.

Goals: [6]

The following program goals and milestones were identified:

- Transition members in-medical-group to facilitate continuous care with providers already familiar with their care.
- Promote relationships between members and their in-network hospitals.
- Establish OOMG leadership meetings with SFGH, Office of Managed Care, DPH, and referring facilities.
- Develop and agree on standardized workflows for ED to IP repatriations to create a seamless process for transitioning members.
- Create reporting mechanisms to track OOMG costs.

Major Accomplishments / Results:

The goals were met. SFGH and SFHP joint leadership meetings were established to discuss OOMG concurrent review and prior authorization services. These resulted in identified areas of provider education to assist in steerage of members from OOMG providers to in-medical group providers. A list was developed in collaboration between SFGH and SFHP to quickly triage when services are available within the SFGH and when it is appropriate to authorize service OOMG, decreasing the time it takes for members to receive an answer where care can be received. In addition, standardized workflows for ED to IP repatriations were also developed.

- Ongoing collaboration with SFGH and SFHP to decrease OOMG utilization.
- Continued relationship building of SFHN, DPH, and Office of Managed Care.
- Inpatient OOMG initiatives resulted in cost savings to SFGH.

Issues & Barriers:

- SFHN has 70% more SFHP members as of October 2014 compared to October 2013.
- Increased membership and corresponding claims have driven up prior authorization OOMG costs by 38%.
- Inpatient repatriations are partially contingent on the availability of beds and resources at SFGH.
- Prior authorization OOMG costs are partially contingent on services available within the SFHN network.

Recommended 2015 Interventions:

- Continue to partner with referring hospitals and SFGH to streamline the repatriation process by creating Service Level Agreements between all entities to provide an expeditious and safe transfer of members.
- Continue to collaborate with the Office of Managed Care, DPH, and SFGH on identifying where services can be made available within medical group.

[6] These goals were added to the QI Internal Workplan after a process improvement opportunity was identified for the Clinical Operations Department.

- Explore provider contracting options.
- Continue to analyze claims and UM data to facilitate changes in the OOMG prior authorization process.
- Transition focus to broader trends in overutilization and underutilization.

5.2 All Cause Readmissions QIP

SFHP is mandated by DHCS to participate in a statewide collaborative focused on decreasing all-cause readmissions through the Quality Improvement Project (QIP). The collaborative provides an opportunity for participants to collect data, share knowledge and best practices, and implement changes that will reduce readmission rates for the Medi-Cal population. The QIP requires SFHP to focus on an intervention that supports the QIP goal. SFHP selected the Practice Improvement Program (PIP) as the QIP's intervention. In 2013, PIP included a new optional measure focused on SFHP member hospital readmissions. The measure focused on follow up with members within seven days of initial hospital discharge to identify gaps in patient care needs. [7]

Goal:

To improve SFHP's network 30-day acute all cause readmission (ACR) rate from 15.8% to 15%. (Based on HEDIS 2013 Reporting/2012 Measurement Year validated data).[8]

Major Accomplishments / Results:

The goal was met. SFHP had a 13.9% (318/2294) 30-day ACR rate for calendar year 2013, which reflects a 2% absolute improvement over 2012's ACR rate.[9]

- The ACR QIP received an overall "Met" validation status and was approved and validated by HSAG on behalf of the California DHCS.
- Four clinics/medical groups opted into reporting for the hospital readmissions PIP measure and fully participated by submitting plans and corresponding data to obtain credit.
- Prior to the intervention (2012), these four participating clinics/medical groups had an overall ACR rate of 14% (42/300). Their ACR rate during 2013 was 9.2% (38/411). This 4.8% absolute improvement in their ACR rate was statistically significant (x^2= 3.9254, df = 1, p=0.0476, α= 0.05).

Issues & Barriers:

The specified PIP measure was optional and resulted in participation from only four clinics/medical groups. One contributing factor on the low participation rate could have been that the measure was optional.

[7] As per QIP reporting requirements, results for 2014 reflect performance based on 2013 calendar year and HEDIS data. Baseline was based on 2012 calendar year.
[8] This goal was modified from the internal QI Workplan due to change request from DHCS on the QIP goal.
[9] 2% is a rounded value of 1.95%.

Recommended 2015 Interventions:
Based on the success of the participant clinics/medical groups, the 2015 PIP Program Guide will include the intervention measure focused on follow-up with patients post hospital discharge as a required measure instead of an optional one.

6 Patient Safety and Continuity of Care

6.1 Care Management

SFHP's CareSupport team supports focuses on members who receive services with the SFHN and UCSF medical groups. The primary program, Community Based Care Management (CBCM), is focused on SFHP members who are high utilizers of acute inpatient and ED visits. In June 2014, the program was awarded the California Health Access Model Program (CHAMP) grant from the California Health Facilities Financing Authority (CHFFA). The grant lead to an expansion of the team and began the process of a more robust evaluation plan that will be continued in 2015. In 2014, one major focus of the CareSupport teams was to automate processes and standardize case management through development and implementation of Essette. SFHP maintained its focus on measuring client satisfaction and engagement with the program.

Goals:[10]
The following program goals were identified:

- Hire program staff
- Implement Essette Care Management Module to automate and standardize the care management process
- Measure member satisfaction and engagement with the program

Major Accomplishments / Results:
The goals were met. Essette's Care Management Module was successfully implemented along with the hiring of six new team members. Member satisfaction and engagement with the program was also measured and assessed through the CareSupport Satisfaction Survey.

- Successful implementation of Essette during Q1 2014 led to the following results:
  - Creation of standards prescribed for outreach, assessment and care planning of all members referred to CareSupport
  - Staff is able to follow uniform note formats to capture all work done with or on behalf of clients
  - Additional reporting functionality for both the Community Care Coordinators and management
- In 2014, execution of the CHAMP grant began with the hiring and onboarding of a new team; including a clinical supervisor, four community care coordinators and a program manager. The new team has built near full caseloads of SFHP's most vulnerable members.

[10] These goals were added to the internal QI Workplan due to receipt of the CHAMP grant in June 2014.

- The CareSupport team participated in a number of trainings to ensure quality skill building. These trainings included: suicide prevention, health coaching, motivational interviewing, and end of life planning.

Issues & Barriers:
Survey distribution challenges resulted in low response rate for the CareSupport Satisfaction Survey (7% response rate).

Recommended 2015 Interventions:
Increase the frequency of survey distribution to twice per year to increase the likelihood of a higher response rate.

6.2 Pain Management Initiative

The SFHP Pain Management Program was designed to implement pharmaceutical management best-practices with required safeguards to enhance patient safety.

Goals:
The program goals included the following milestones to be completed by October 2014:

- Identify members taking high-dose opioids (≥200mg Morphine Equivalents) and require prescriber to submit documentation of adequate monitoring and safeguard to reduce overdose risk.
- Implement dose ceilings in a staged fashion to safely taper members to lower doses if appropriate, and to identify members who meet medical necessity exemptions for tapers.
- Implement a Pain Management policy and procedure creation.
- Implement new refill policy.
- Implement new dose limit policy.
- Develop provider communication, trainings and website updates for provider resources.
- Provide support with staff communication and trainings.
- Organize at least 1 provider training (annual pain management training/conference).
- Develop reporting for PIP Pain Management Measure and refine reporting for regular panel management (and PIP ongoing).

Major Accomplishments / Results:
The goals were partially met. SFHP did not meet the originally set project timeline of dose ceiling. Prior Authorization requirements and targeted intervention implementation due to changes in leadership. The project team did meet all provider training and education goals.

The following goals were met during 2014:

- Provider communications and updates to website complete.
- Staff communication complete; trainings/talking points for Customer Service & Pharmacy drafted
- Member communication paused; educational materials developed, translated and approved by state; ready for future deployment.

- Annual provider trainings held (SCOPE of Pain and Tapering Best-Practices Trainings).
- Pharm-10 P&P was drafted and reviewed by QIC & P&T committees and received favorable feedback. The policy was developed into the SFHP Chronic Non-Cancer Pain Management program document, but was not made as an official policy and procedure. Decisions regarding future P&P for pain management forthcoming.
  - SFHP refill policy was implemented
  - SFHP dose limit policy milestones deferred
- Internal strategic planning for ongoing program direction scheduled for January 2015 with Stakeholder Advisory planning in February 2015; new program to be developed by March/April 2015.

Issues & Barriers:

- Leadership transitions and program management transitions.
- Original program set aggressive timelines for opiate ceiling implementation; leadership decision to strengthen community stakeholder buy-in prior to implementation of dose ceilings and additional Prior Authorization (PA) requirements.

Recommended 2015 Interventions:

- Schedule internal strategic planning and Stakeholder Advisory meetings.
- Establish 2015 program plan.

6.3 Nurse Advice Line

The Nurse Advice Line is a service for all SFHP members that provides 24/7 telephonic access to health care professionals. During a call, nurses assess members' symptoms, determine the appropriate level of care needed, and suggest a self-care plan (if appropriate) or direct the members to a physician, urgent care, or emergency care if necessary.

Goal:[11]

Provide member access to nurse triage service 24 hours a day.

Major Accomplishments / Results:

The goals were met. Nurse triage service was available 24 hours a day with 832 calls answered within 30 seconds and triaged appropriately.

- In Q3 2014 the Nurse Advice Line vendor achieved 94% (n=832) of all calls answered within 30 seconds and a 1.7% abandonment rate (n=14).
  - 146 of the calls were classified as crisis calls and directed to the ED for expeditious treatment.
  - 78 calls were dispositioned to other levels of care.

[11] This goal was added to the internal QI Workplan since monitoring Nurse Advice Line is a contractual requirement.

- 68 calls were dispositioned as emergent situations requiring emergency level of care.
- In October 2014, 53% of member calls were potentially deferred from ED usage to other more appropriate levels of care.

Issues & Barriers:
Current reports showing breakdown of where members sought care were not tied to recommended level of care given by the nurse to the member (e.g., E.D., urgent care, office visit, etc.). This disconnect limited SFHPs ability to pursue robust improvement efforts since it was unknown whether members adhered to nurses' advice.

Recommended 2015 Interventions:
Build report specifications with Nurse Advice Line to link disposition with recommended level of care and conduct analysis to identify opportunities for improvement.

6.4 Delegation Oversight Activities

SFHP contracts with medical groups to provide health care services to plan members. SFHP delegates certain functions and activities to some contracted medical groups. SFHP further delineates the functions delegated to the medical groups in an annual Responsibilities and Reporting Requirement (R3) Grid.

SFHP fully and/or partially delegates the following functions:
- Credentialing (CR) and New Provider Orientation
- Pharmacy Management
- Member Appeals and Grievances
- Health Education (HE) and Cultural and Linguistic Services (CLS)
- Utilization Management (UM)

SFHP uses industry-accepted audit tools to measure Delegates' compliance with delegated functions – audits are conducted annually. Delegates are expected to achieve an overall audit score of 95%. Corrective Action Plans are required in the following cases:
- A category score lower than 75%
- The overall audit score lower than 95%

Goal:[12]
By December 31, 2014, complete annual delegation audits and quarterly reports to evaluate medical groups' compliance with their delegation agreements.

Major Accomplishments / Results:
The goal was met. All annual delegation audits and quarterly reports were completed and evaluated for medical groups' compliance.

[12] This goal was added to the internal QI Workplan to more robustly reflect the delegation oversight activities.

Audit details are confidential; however, SFHP evaluates written requests to release this information to Federal or State Agencies, or NCQA.

- Credentialing
  - Seven groups are delegated to conduct credentialing and re-credentialing activities.
  - Six out of seven scored 100% in this audit.
  - One out of seven scored 99% in this audit.
- Utilization Management
  - Five groups are delegated to conduct utilization management activities.
  - One out of five delegated scored in the high range (90-100%).
  - Four out of five delegates scored in the medium range (60-89%).
- Appeals and Grievances
  - One group is delegated to resolve members' appeals and grievances.
  - This group scored 97% in this audit.
- Pharmacy Services
  - One group is delegated to manage pharmacy services.
  - This group scored 100% in this audit.
- Health Education and Cultural and Linguistic Services
  - SFHP delegates Health Education and Cultural and Linguistic at various levels.
  - One group is fully delegated to provide health education materials and cultural and linguistic services.
  - This group scored 100% in this audit.
- Other Medi-Cal requirements
  - Five groups are required to meet compliance with other Medi-Cal requirements.
  - Five out of five delegates scored in the medium range (60-89%).

Issues & Barriers:

- The 2014 audit identified issues regarding compliance with utilization management requirements for the Medi-Cal population, as well as compliance with other Medi-Cal requirements. This is primarily because delegates' operations are set up to meet Commercial and Medicare requirements rather than Medi-Cal ones. Meeting Medi-Cal requirements through modification of systems and business workflows require a long lead time for SFHP Delegates.
- The audits uncovered opportunities for Delegates' staff and practitioners training.

Recommended 2015 Interventions:

- Continue to develop informational documents that will help Delegates' staff and practitioners better understand how to execute Medi-Cal requirements.
- Distribute revised SFHP Responsibilities and Reporting Requirement (R3) Grid, which now provides more details regarding the different requirements and Delegates' expectation.
- Offer additional staff and practitioners' training.

6.5 Delegation Agreement with Kaiser Permanente for QI Activities

As of 2013, an agreement with Kaiser Permanente to conduct QI activities for SFHP members had not been established. Establishing this delegation agreement was part of fulfilling NCQA accreditation goals.

Goals:

- By December 31, 2014, draft a delegation agreement of QI activities with Kaiser Permanente.
- Participate in Kaiser Permanente's annual shared audits.
- Review Kaiser Permanente's quarterly QI reports of delegated activities.

Major Accomplishments / Results:

The goals were partially met. As of December 31, 2014, the delegation agreement had not been finalized; however, the following project milestones were achieved:

- Revised Delegation Agreement & Delegation Grid was sent to Kaiser Permanente for review in October 2014. Kaiser Permanente is in the process of revising the agreement.
- SFHP participated in a shared Kaiser Permanente annual and quarterly audit of QI activities. The audit was conducted by Contra Costa Health Plan. Kaiser Permanente met all QI requirements and achieved a 100% score in the audit.

Issues & Barriers:

Revising the delegation agreement was tied to SFHP's NCQA accreditation timeline. The planned delay of NCQA accreditation resulted in delaying finalization of the agreement.

Recommended 2015 Interventions:

- Continue to work with Kaiser Permanente to finalize and execute the delegation agreement.
- Continue to follow up on required improvement activities.

6.6 Implementation of Non-Specialty Mental Health Benefit

As part of Medi-Cal expansion, starting 1/1/2014, San Francisco Health Plan (SFHP) became responsible for providing non-specialty mental health services for Medi-Cal managed care members. During 2014, SFHP contracted with nine different entities to provide these services. In July 2014, SFHP issued a Request for Proposal (RFP) to identify one entity to provide non-specialty mental health services for all of its Medi-Cal members. Specialty Mental Health is a Medi-Cal carved-out service, therefore CBHS (Community Behavioral Health Services) continues to provide these services. Beacon Health Strategies, was selected as the vendor that will be providing non-specialty mental health services on behalf of SFHP.

Goal:[13]

To implement new non-specialty mental health network with Beacon Health Strategies to begin providing access to non-specialty mental health services starting January 1, 2015.

Major Accomplishments / Results:

The goal was not met. As of January 1, 2015, Beacon Health Strategies has not started providing non-specialty mental health services due to DMHC requiring additional time to review SFHP's filing. Although SFHP did not receive approval to implement a new network, services to members will not be impacted. Members will continue to receive care from their current providers.

The following program milestones and results were achieved:

- Administrative Services Contract and Delegation Agreement with Beacon Health Strategies were executed on November 1, 2014 with an effective date of January 1, 2015.
- 75% completion of business and system changes.

Issues & Barriers:

- As of December 31, 2014, the DMHC had not issued its approval of the new non-specialty network. The Department requires more time to review SFHP's filing.
- Final implementation of the new network will be on hold until approval is received.

Recommended 2015 Interventions:

SFHP will work with currently contracted providers to ensure continuity and coordination of care, and will issue Letters of Agreement (LOA) as necessary.

6.7 Policies and Procedures

Policies and procedures are the documentation that defines the standards for program operations. They provide clear guidelines for staff, ensure program effectiveness and consistency, and provide a target for continuous quality improvement. Clinical policies and procedures are approved by the QIC and Policy & Compliance Committee (PCC) biennially.

Goal:

To ensure that 100% of SFHP clinical policies and procedures are up to date, in alignment with contractual, statutory, and regulatory requirements, and applicable NCQA standards.

Major Accomplishments / Results:

The goal was met with the following results:

- 100% (71/71) clinical policies and procedures approved by QIC and PCC in 2014.
- 100% (71/71) policies and procedures were in compliance with SFHP's standard of biennial review.

[13] This goal was added to the internal QI Workplan after the non-specialty mental health benefit was mandated starting January 1, 2014.

Issues & Barriers:
Policies & Procedures' goal in 2014 QI Workplan was too broad in scope and therefore, the goal required slight modification:

- To clarify that it only applies to clinical policies and procedures. Other SFHP departments (Finance, IT, Claims, etc.) have policies and procedures that are outside the quality program.
- To clarify that "required protocols" mean contractual, statutory, and regulatory requirements and applicable NCQA standards.
- To delete reference to "corresponding desktop procedures" as not all policies and procedures have corresponding desktop procedures.

Recommended 2015 Interventions:
Use 2014 modified goal for 2015.

7 Summary / Conclusion

SFHP's focus in its Quality Improvement Program was on primarily strengthening its core through improved program monitoring and identification of outcome and efficiency measures. These improvement efforts enabled SFHP to better evaluate programs and make informed decisions for goal expansion or restructuring. In 2014, SFHP also faced three challenges: unprecedented growth in membership due to Medi-Cal expansion, implementing previously carved out benefits (non-specialty mental health and autism services) and the deployment of Essette, SFHP's enterprise-wide care management system. While Essette helped many of the areas to achieve their goals, there was a considerable learning curve and Health Services staff heavily participated in its design, testing, and deployment. In 2015, SFHP will continue to sustain its 2014 gains and will expand improvement efforts in Utilization Management, Behavioral Health, oversight of delegated groups, achievement of HEDIS measures above the 90% for Medicaid, an enhanced focus on outcomes measures, and will work towards NCQA interim accreditation by participating in a mock survey.

Reviewed & Approved by:

Chief Medical Officer: _____ Date: _____
James Glauber, MD, MPH

Quality Improvement Committee: Date: _____

Appendix I: 2014 Quality Improvement Work Plan

		RESPONSIBLE PARTY	GOALS	ACTIVITIES	DUE DATES	STATUS
Compliance Related Activities						
A	Annual Cultural Awareness Training for SFHP Staff	Anna Le Mon	By December 31, 2014, review cultural awareness principles with all SFHP employees through participation in a mandatory training.	Facilitate annual staff training	October 2014	Completed
B	Providing Cultural and Linguistic Services	Anna Le Mon	December 31, 2014 ensure all health fact sheets are posted in Medi-Cal threshold languages (English, Spanish, Vietnamese, Chinese and Russian).	Review website and health education materials	Ongoing	Completed
C	Improving Patient Experience QIP	Llendl Aquino	By December 31, 2014, improve this indicator by 25% to a 54.5% rating overall health care as a "9" or "10." By December 31, 2014, improve this indicator by 25% to a 68.4% rating their doctor as a "9" or "10."	1. Plan initiatives 2. Activity implementation 3. Validate data 4. Submit QIP report	March 2014 Ongoing Ongoing August 2014	Completed Completed Completed Completed
D	All-Cause Readmissions QIP	Candy Magaña	By December 31, 2014, improve SFHP's ACR rate from 17.3% to 16.4%.	1. Plan initiatives 2. Activity implementation 3. Validate data 4. Submit QIP report	March 2014 Ongoing Ongoing September 2014	Completed Completed Completed Completed
E	Timely Access Regulations	Adam Sharma	By March 31, 2014, measure 2013 compliance for each of SFHP's six networks. Develop improvement plans for all non-compliant networks.	1. 2013 DMHC Submission 2. 2013 Appointment Availability Survey 3. Member Survey 4. Provider Satisfaction Survey	March 2014 November 2013 December 2013 December 2013	Completed Completed Completed Completed

		RESPONSIBLE PARTY	GOALS	ACTIVITIES	DUE DATES	STATUS
F	Policies and Procedures	Jim Soos	Throughout 2014, ensure SFHP clinical policies and procedures are up to date, in alignment with contractual, statutory, and regulatory requirements, and applicable NCQA standards.	Review and update policies and procedures	Ongoing	Completed
G	Grievances and Appeals Reports	Nicole Ylagan	Throughout 2014, resolve 100% of grievances within 30 days.	Quarterly reports	Ongoing	Completed
H	QI Delegation Activities	Odalis Bigler (Audits and Delegation Agreement) Anna Jaffe (Reporting and Opportunities for Improvement)	By December 31, 2014, draft a delegation agreement of QI activities with Kaiser. Participate in Kaiser annual shared audit. Review quarterly reports.	1. Draft Delegation Agreement to include QI activities 2. Provision of Member Data to the Delegate 3. Provisions for PHI 4. Pre-delegation Evaluation 5. Review of QI Program 6. Opportunities for Improvement	Dec 2014 Dec 2014 Dec 2014 Oct 2014 Oct 2014 Dec 2014	Completed Completed Completed Completed Completed Q1-2015
I	Effective and appropriate utilization management	Collin Elane	Monthly, utilization management will authorize greater than 90% of all medically appropriate care within 3 calendar days (2014 and 2015). Monthly, SFHP generates, disseminates, and reviews utilization management reports with SFGH leadership to identify over and underutilization of out of medical group inpatient and outpatient services (2014 and 2015).	1. Complete UM function in Essette for management and tracking 2. Generate reports 3. Monitor performance, review with stakeholders, establish improvement thresholds as needed	June 18th, 2014	Completed Completed Completed

		RESPONSIBLE PARTY	GOALS	ACTIVITIES	DUE DATES	STATUS
Quality Improvement Programs						
A1	Practice Improvement Program (PIP)	Vanessa Pratt	By December 31, 2014, manage program and apply measure set developed in 2013.	1. Program Scope 2. Quarterly data collection 3. Performance review	January 2014 April, July & November 2014 May, August, December 2014	Completed Completed Completed
A2	Practice Improvement Program (PIP) Block Funding Program	Candy Magaña	By December 31, 2014, develop and administer program to provide incentives for SFHP's network to engage in activities related to systems improvement, patient experience, clinical quality and data quality.	1. Initial program Statements of Interest collected from eligible participants 2. Approve final project submissions and budgets 3. Pay out initial block funding payment 4. Quarterly check-ins with program participants	January 2014 Apr, Jul, Nov 2014 May, Aug, Oct 2014 June 2014	Completed Completed Completed Completed
B	Health Text Messaging Program	Anna Le Mon	By December 31, 2014, increase program members' potential for self-management of their diabetes through receipt of health-related text messages to at least 280 members with diabetes.	1. Maintain diabetes program 2. Spread program to members with asthma; enrollment	Ongoing April 2014	In progress Completed
C	Ten Building Blocks Practice Coaching Program	Candy Magaña	By December 31, 2014, engage a minimum of 15 safety net clinics with ongoing practice coaching focused on practice transformation.	1. Weekly or bi-weekly coaching to approximately 12 clinics. 2. Quarterly operations meetings with partners 3. Annual reporting to funder	Ongoing Ongoing November 2014	Completed Completed Completed

		RESPONSIBLE PARTY	GOALS	ACTIVITIES	DUE DATES	STATUS
D	Healthier Living (Chronic Disease Self-Management Program)	Anna Le Mon	By December 31, 2014, spread Healthier Living Program to two sites to empower members with chronic conditions with self-management tools.	1. Plan workshops 2. Implement workshops	March 2014 Ongoing	Completed Completed
Quality Improvement Reporting/Activities						
A	HEDIS Pursuit & Related QI Activities	Sari Weis	By June 30, 2014, achieve 14 measures in the 90th percentile and no measures in the 25th percentile.	1. HEDIS Pursuit Process 2. Data submission	May 2014 June 2014	Completed Completed
B	HEDIS Incentives and Outreach	Sari Weis	By December 31, 2014 carry out one outreach and/or incentive program for each of the 6 auto assignment HEDIS measures.	1. Diabetes outreach and incentive program 2. Your Body, Your Baby prenatal and postpartum care outreach and incentive program 3. Cervical Cancer Screening outreach program 4. Well-Child outreach and incentive program 5. Childhood Immunization outreach and incentive program 6. Hypertension outreach and incentive program	December 2014 December 2014 December 2014 December 2014 December 2014 December 2014	Completed Completed Completed Completed Completed Completed
C	SF Quality Culture Series	Adam Sharma	By December 31, 2014, improve staff satisfaction in SFHP's provider network by 5% via training and coaching to clinic management teams.	1. Plan March 2014 session 2. Plan September 2014 session	March 2014 September 2014	Completed Completed
D	QI/UM Program Evaluation	Anna Jaffe	By March 31, 2015 evaluate 2014 QI Plan Annual Work Plan to determine if goals for SFHP's quality improvement and utilization management programs are met.	1. Plan evaluation 2. Develop QI/UM report 3. Submit evaluation	January 2014 March 2014 April 2014	Completed Completed Completed

		RESPONSIBLE PARTY	GOALS	ACTIVITIES	DUE DATES	STATUS
E	Initial Health Assessment	Sari Weis	By December 31, 2014, improve member engagement with primary care by improving the IHA rate by 3%.	1. Member outreach mailings 2. Provider outreach mailings 3. Improvement in access in clinics	Ongoing Ongoing Ongoing	In progress In progress In progress
Committees						
A	Quality Improvement Committee	Scott Endsley	Throughout 2014, ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan in the six QIC meetings of the year.	1. Convene February QIC 2. Convene April QIC 3. Convene June QIC 4. Convene August QIC 5. Convene October QIC 6. Convene December QIC	February 2014 April 2014 June 2014 August 2014 October 2014 December 2014	Completed Completed Completed Completed Completed Completed
B	Provider Advisory, Peer Review, and Credentialing Committee	Scott Endsley	Throughout 2014, ensure oversight of credentialing and peer review in the six Provider Advisory Committee meetings of the year.	1. Convene February committee 2. Convene April committee 3. Convene June committee 4. Convene August committee 5. Convene October committee 6. Convene December committee	February 2014 April 2014 June 2014 August 2014 October 2014 December 2014	Completed Completed Completed Completed Completed Completed

		RESPONSIBLE PARTY	GOALS	ACTIVITIES	DUE DATES	STATUS
C	Pharmacy and Therapeutics Committee	Elizabeth Sampsel	By March 1, 2014, implement a 30 day supply limit on all opioids.	1. Convene January meeting 2. Convene April meeting 3. Convene July meeting 4. Convene September meeting	January 2014 April 2014 July 2014 September 2014	Completed Completed Completed Completed

		RESPONSIBLE PARTY	GOALS	ACTIVITIES	DUE DATES	STATUS
Patient Safety						
A	Pain Management Initiative	Mimi Zou	By October 15, 2014, complete pain program action items per timeline.	1. Develop SFHP pain management policies	January 2014 – April 2014	Completed
					April 2014	Completed
				2. QIC approval	April 2014	Completed
				3. P&T approval	May 2014	Completed
				4. Communication of policy to provider network		
				5. Implement new refill policy	July 2014	Completed
				6. Implement new dose limit policy	October 2014	Not Completed – dose limits paused
				7. Reporting	August 2014	Not completed – Reporting in progress
				8. Talking Points for Customer Service (and Pharmacy) re: Pain Program	August 2014	Talking points drafted
				9. Website updates for Provider resources	August 2014	Completed & ongoing
				10. Provider training	October 2014	Completed & ongoing

Appendix II: Quality Improvement Committee Structure

External Committees:

Governing Board Membership

- Member Advisory Committee (2 seats)
- Individual Provider (1)
- Provider Network (5)
- Labor Representative (1)
- San Francisco Community Clinic Consortium
- San Francisco Department of Public Health (1)
- San Francisco Health Commission (1)
- Medical Society (1)
- Community Behavioral Health Services (1)
- Progress Foundation (1)

QIC Membership

- Member Advisory Committee (2 seats)
- Labor Representative (1)
- Provider Network (15)
- SFHP Staff:
    - CMO (Chair)
    - Director, Health Improvement

  As needed:
    - Associate Medical Director

MAC Membership

- SFHP CEO
- Health Plan members (28)

PAC Membership

- Provider Network (11 seats)
- SFHP Staff:
    - CMO (Chair)

  As needed:
    - Associate Medical Director
    - Provider Relations Staff

The following specialties are represented on our Physician Advisory Committee:

- Family Medicine
- Internal Medicine
- Pediatrics
- Rheumatology

P&T Membership

- Provider Network (13)
- SFHP Staff:
    - CMO (Chair)
    - Director of Pharmacy

Practice Improvement Program (PIP) Advisory Committee

- Provider Network (16)
- SFHP Staff:
    - Manager, Practice Improvement (Co-Chair)
    - Director, Health Improvement (Co-Chair)
    - CMO
    - PIP Program Manager
    - PIP Program Coordinator

Internal Committees Supporting the Work of External Committees:

Policy & Compliance Committee Membership

- SFHP Staff:
  - Compliance Officer (Chair)
  - Director, Finance
  - Sr. Manager, Human Resources
  - Manager, Claims
  - Director, Operations
  - Director, Clinical Operations
  - Administrator, Clinical Policies
  - Director, Provider Network Operations

Grievance Committee

- SFHP Staff:
  - Manager, Clinical Quality (Co-Chair)
  - Grievance Coordinator (Co-Chair)
  - CMO
  - Director, Health Improvement
  - Manager, Compliance & Regulatory Affairs
  - Compliance Officer
  - Director, Provider Network Operations
  - Director, Clinical Operations
  - Sr. Manager, Care Coordination
  - Manager, Customer Service
  - Director, Pharmacy

Delegated Network Oversight Committee Membership

- SFHP Staff:
  - Provider Network Operations Director (Chair)
  - Compliance Officer
  - Director, Clinical Operations
  - Manager, Delegated Member Group Oversight
  - Dir, Health Improvement
  - Dir, Pharmacy

Access to Care Committee Membership

- SFHP Staff:
  - Director of Health Improvement (Chair)
  - CMO
  - Chief Operations Officer
  - Manager, Practice Improvement
  - Dir, Clinical Operations
  - Dir, Enrollment
  - Dir, Provider Network Operations

CMO Report

- Attachment 2- CY2015 Quality Improvement Program and Work Plan

SAN FRANCISCO HEALTH PLAN™
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1. Introduction

San Francisco Health Plan (SFHP) is a community health plan that provides affordable health care coverage to over 100,000 low- and moderate-income individuals and families. Members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription medicines, non-specialty mental health and family planning services. SFHP was designed by and for the residents it serves and takes great pride in its ability to accommodate a diverse population that includes children, young adults, seniors, and persons with disabilities.

SFHP is a unique public-private partnership established by the San Francisco Health Authority, as a public agency distinct from the county and city governments. A nineteen-member Governing Board directs SFHP. The Governing Board includes physicians and other health care providers, beneficiaries, health and government officials, and labor representatives. The Board is responsible for the overall direction of SFHP, including its Quality Improvement (QI) Program. The Governing Board meetings are open for public participation.

SFHP's products include Medi-Cal, Healthy Kids, Healthy Workers, Healthy San Francisco, and City Option programs.

- **Medi-Cal** is California's Medicaid program, which is a federal and state-funded public health insurance program for low-income individuals. As a managed care plan, SFHP manages the funding and delivery of health services for Medi-Cal members. As of December 2014 SFHP retained 84.0% 119,412 members) of the managed care market share in San Francisco County. After accounting for market share, member choice auto-assignment and prior plans, SFHP has a total of 133,769 members enrolled in this program.
- **Healthy Kids** is a health insurance program funded by the City and County of San Francisco and administered exclusively by SFHP to eligible children up to 18 years of age in San Francisco. The program provides medical, dental and vision coverage for children in San Francisco who are ineligible for other publicly funded health coverage programs and who are uninsured. As of December 2014, 2,166 members are enrolled in this program.
- **Healthy Workers** is a health insurance program offered to providers of In-Home Support Services or temporary exempt employees of the City and County of San Francisco. As of December 2014, 12,190 members are enrolled in this program.
- SFHP is the Third Party Administrator for the **Healthy San Francisco** and **City Option** programs. Healthy San Francisco is a health access program for uninsured adults in San Francisco with 17,809 participants as of December 2014. The City Option program is an optional program designed for employers in San Francisco to comply with the Health Care Security Ordinance (HCSO) and allows employees to access Healthy San Francisco or a Medical Reimbursement Account through their employer contributions.

2. QI Program Purpose, Scope and Goals

SFHP is committed to continuous quality improvement for both the health plan and its health care delivery system. The purpose of the SFHP Quality Improvement (QI) Program is to establish comprehensive methods for systematically monitoring, evaluating and improving the quality of the care and services provided to San Francisco Health Plan members. The overall goal of the QI Program is to ensure that members have access to quality health care services that are safe, effective, and meet their needs.

SFHP contracts with health care providers, including organized medical groups and their associated hospitals, to provide members with medical services. SFHP utilizes the medical group structure to facilitate the communication of standards, contractual requirements, and policies and procedures to participating practitioners. SFHP retains full responsibility for its QI Program, and does not delegate quality improvement oversight. In certain instances, SFHP may partially or fully delegate authority for some activities described in this program to medical groups.

Under the leadership of SFHP's Governing Board, the Quality Improvement Program is developed and implemented through a Quality Improvement Committee (QIC). The QIC structure, under the leadership of the SFHP Chief Medical Officer, assures ongoing and systematic interaction between SFHP and its key stakeholders: members, medical groups, and practitioners.

The QI Program is organized to meet overall program objectives as described below and as directed each year by the QI Work Plan (Appendix I). Settings and types of care to examine are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

The scope and goals of the QI Program are comprehensive and encompasses major aspects of care and services in the SFHP delivery system, and the clinical and non-clinical issues that affect its membership. These include:

- Improving the health status of our members
- Ensuring continuity and coordination of care
- Assuring access and availability of care and services
- Ensuring member knowledge of rights and responsibilities
- Assuring that health care practitioners are appropriately credentialed and re-credentialed, and all organizational providers meet accreditation standards
- Ensuring timely communication of standards and requirements to participating medical groups and organizational providers
- Assuring effective and appropriate utilization management of health care services, including medical, pharmaceutical, and behavioral health care services
- Providing complex case management
- Providing culturally and linguistically appropriate services
- Providing a disease management program

- Providing health education resources
- Ensuring patient safety
- Ensuring excellent member experience of care
- Ensuring the delivery of behavioral health services
- Assuring that responsibilities delegated to medical groups meet plan standards
- Evaluating the overall effectiveness of the QI Program through an annual, comprehensive evaluation process
- Using the annual evaluation to update the QI Program and develop an annual QI Work Plan

3. QI Program Structure

A. Committee Structure

The following section describes the Quality Improvement Committees of SFHP. Appendix II includes details on committee membership.

Committees with Membership Both Internal and External to SFHP Include:
The SFHP **Quality Improvement Committee (QIC)** is a standing committee of the San Francisco Health Authority Governing Board that meets six times a year. It is the main forum for oversight of SFHP's health care delivery system and for member and provider participation in assuring the quality of the delivery system. It is responsible for reviewing and approving the annual QI Program and Quality Improvement and Utilization Management (QI/UM) Evaluation, and for providing oversight of the Plan's quality improvement activities. SFHP brings new QI programs to the QIC to ensure the committee members contribute to the planning, design, and implementation of new programs. SFHP maintains an annual calendar to ensure that key SFHP QI activities are brought to the QIC for ongoing review. This includes review and approval of policies and procedures related to quality improvement, utilization management, pharmacy, and delegation oversight. SFHP maintains minutes of each Quality Improvement Committee meeting, brings them to the Governing Board for review and approval, and submits these to DHCS on a quarterly basis.

The **Pharmacy and Therapeutics Committee (P & T)** assures that the Plan administers its pharmacy benefit in a manner that is consistent with sound clinical principles and processes, and compliant with current standards of practice. The P & T reviews and makes recommendations about the Plan's formulary and its pharmaceutical and therapeutic treatment guidelines. The committee meets quarterly and ad hoc as needed.

The **Physician Advisory/Peer Review/Credentialing Committee (PAC)** provides comments and recommendations to SFHP on standards of care, clinical programs and guidelines, and quality initiatives. The PAC serves to address concerns or identify problems related to quality of medical care and provider/practitioner safety. The Medical Board Hot Sheet is reviewed monthly to ensure that any identified providers with investigations or actions are brought to the PAC for review. The PAC also reviews credentials and approves practitioners for participation in the SFHP network, and reviews the credentialing policies and activities of entities delegated for credentialing. The Peer Review Committee meets every two months. All participating practitioners are required to comply with QI activities and protect the confidentiality of member information; these responsibilities are reviewed with all practitioners on joining SFHP, and are outlined in all provider contracts. This committee reports to the QIC.

The Member Advisory Committee (MAC) serves as the Public Policy Committee of SFHP as defined and required by the Knox-Keene Act. The MAC advises the Plan on issues of concerns to the recipients of services from SFHP. The committee is made up of health plan members and health care advocates. In

this forum, members can voice concerns and give advice about what health services we offer, and how we deliver them to members. The Committee consists of at least ten (10) and no more than thirty (30) members. The Committee meets the first Friday of every month.

Committees with Internal Membership Only:

The Policy and Compliance Committee (PCC) reviews and approves all changes to and new policies and procedures with approval from QIC as required per regulation. In 2014, the QIC dedicated substantial time to policy review. In an effort to alleviate that burden and focus QIC efforts on the QI Program, the PCC will complete the primary review of policies and procedures and then submit appropriate documents to QIC for approval. The PCC meets 6 times per year, reports to the QIC, and is chaired by the Compliance Officer. Members include representatives from Health Services, Operations, Finance, Human Resources, and Marketing.

The Delegated Network Oversight Committee provides oversight for delegated activities. This committee identifies issues and addresses concerns related to delegates' performance of delegated activities and is responsible for making penalty recommendations when delegates do not consistently perform according to industry standards and federal and state requirements. The Delegated Network Oversight Committee is chaired by the Director, Provider Network and is composed of Directors and Managers from the Health Services and Operations departments. The committee meets bi-monthly and reports to the Policy and Compliance Committee (PCC).

The Grievance Committee was developed at the end of 2014 in order to improve the member experience and improve SFHP's internal grievance process. The committee is multidisciplinary, composed of the Chief Medical Officer and representatives from Member Services, Provider Relations, Health Improvement, Care Support, Pharmacy, Clinical Operations, and State and Regulatory Affairs. The committee meets quarterly and reports to the QIC as needed.

The Member Access to Care Committee was convened in 2015 to ehance the monitoring and improvement activities of the health plan. The committee meets at least quarterly to review access data, expand access measures and monitors, and evaluate the success of access improvement initiatives both within the plan and the network. The committee is chaired by the Director, Health Improvement and is attended by prepresenatives from Operations, Health Services, Compliance and Regulatory Affairs, and Business Intelligence. The committee reports to the QIC as needed.

B. QI Communications

SFHP informs its participating providers and members of its QI program and ongoing QI activities through the SFHP provider newsletter, the Network Operations Manual, and annual member mailing.

Please refer to Appendix II for reporting diagram and committee membership. Policies and procedures that govern all SFHP Quality Committees are included in Appendix III.

C. Quality Improvement Staff

The Health Services (HS) department has primary accountability for implementing the annual QI Work Plan. It is organized to provide inter-disciplinary involvement in assuring the quality of medical care and services provided to SFHP's membership. It monitors quality indicators and plans, and implements and evaluates the Plan's QI activities. The HS staff also develop policies and procedures to assure compliance with SFHP standards, legislative and regulatory mandates, contractual obligations and, as applicable NCQA standards. Based on the Quality program activities, staff provide summary data, analysis and recommendations to the QIC.

San Francisco Health Plan staff responsible for implementing the QI Program includes:

- The SFHP **Chief Executive Officer (CEO)** is accountable to the Governing Board for the QI Program.
- The SFHP **Chief Medical Officer (CMO)** is responsible for leading the Quality Improvement Committee, Physician Advisory and Peer Review, Credentialing Committee, and the Pharmacy and Therapeutics Committee, and for all quality improvement studies and activities. The CMO provides guidance and oversight for development of policies, programs, and projects that support all activities identified in the QI Program. The CMO carries out these responsibilities with support from at least the following staff: Associate Medical Director, and Director of Health Improvement, Provider Network Operations Director, Pharmacy, Clinical Operations, and their teams.
- SFHP will delegate non-specialty mental health services for Medi-Cal members to Beacon Health Strategies in 2015 pending approval from DHCS. At that time, **Beacon Health Strategies' designated Behavioral Health Services practitioner** will have involvement in the QI program.
- The SFHP **Director, Health Improvement** ensures the completion of the annual QI Plan and corresponding evaluation, and directs the QI activities required by state agreement and identified as opportunities for improvement within the provider network. The Director, Health Improvement oversees four teams focused on fostering quality and coordinated care for our members: Clinical Quality, Practice Improvement, Care Coordination, and Clinical Improvement Programs.
- The SFHP **Manager, Clinical Quality** reports to the Director, Health Improvement, and oversees member grievance staff and all activities related to improvement and auditing of clinical HEDIS measures and health promotion programs as well as provides oversight of the Disease Management program. Reporting to the Manager, Clinical Quality, the following positions support SFHP's QI efforts:
    - **Coordinator, Clinical Quality** - manages member incentive and outreach programs aimed at improving preventive care and care of chronic conditions, and manages Healthy San Francisco participants' complaints and SFHP member grievances.
    - **Specialist, Clinical Quality -** manages member incentive and outreach programs aimed to improve preventive care and care of chronic conditions as well as supports HEDIS project management.
    - **Project Manager, Clinical Quality** - designs interventions to improve clinical quality, and provides project management of the HEDIS data collection and audit process.
    - **Specialist, Quality Management -** manages member grievances, and ensures that grievances are appropriately classified and resolved in a timely manner, tracked

appropriately, and reported quarterly to the Grievance Oversight Committee and to QIC.

- **Project Manager, Health Education and Cultural and Linguistic Services -** designs interventions to improve outcomes for members with chronic conditions identified as high priority through the SFHP Disease Management Program, ensures that members have access to low-literacy health education materials and classes in all threshold languages, and ensures that members have access to services in their own language.

- The SFHP **Manager, Practice Improvement** reports to the Director , Health Improvement, and oversees SFHP's provider incentive bonus program, the Practice Improvement Program. This manager also oversees all practice improvement activities, including technical assistance efforts with clinics and medical groups to improve access to care and patient experience. Reporting to the Manager of Practice Improvement, the following positions support SFHP's delivery system improvement efforts:
    - **Project Manager, Care Experience** - accountable for developing and managing interventions to improve the experience of care for our members, particularly focusing on access and patient/doctor communication in the safety net clinics.
    - **Project Manager, Practice Improvement** - responsible for project management of the Practice Coaching program, which delivers coaching to safety net clinics in areas relevant to the Practice Improvement Program. This position also manages PIP Block Funding Grants, which provide opportunities for clinics and medical groups to complete targeted efforts to improve timely access to care.
    - **Project Manager, Practice Improvement Program** - responsible for project management of SFHP's pay-for-performance/incentive bonus program, the Practice Improvement Program. This program aims to improve clinical quality, data quality, systems improvement, and patient experience through incentive bonuses and technical assistance.
    - **Specialists, Practice Improvement** - responsible for day-to-day management of practice improvement projects including database management, DHCS/DMHC access monitoring, and event coordination.
- The SFHP **Manager, Clinical Improvement Programs** reports to the Director, Health Improvement and oversees internal programs to improve health services processes impacting member care. Reporting to the Manager of Clinical Improvement Programs, the following positions support SFHP's QI efforts:
    - **Reporting Data Analyst** - coordinates new reports needed to assess QI activities.
    - **Project Managers, Clinical Improvement Programs -** responsible for overseeing systems and projects affecting multiple departments within Health Services. Examples include:
        i. Essette (SFHP's care management software) implementation and improvement efforts; and
        ii. Lead cross-functional projects within Health Services including Prior Authorizations and QI Program Evaluation efforts.

- The **Senior Manager, Care Coordination** reports to the Director, Health Improvement and oversees case management and care coordination programs including: CareSupport's community based care management (CBCM); complex medical case management (CMCM); care coordination; and health risk assessment (HRA) follow-up for members. In addition, the Senior Manager, Care Coordination is responsible for execution of the California Health Access Model Program (CHAMP) grant funded by California Health Facilities Financing Authority. These Care Coordination programs target our high risk, high cost members with the aim of reducing avoidable ED and hospital utilization and improving health outcomes. The following positions support SFHP's Care Coordination improvement efforts:
    - **Supervisors, CareSupport** - responsible for clinical and administrative oversight of the Community Care Coordinators.
    - **Community Care Coordinator, CareSupport -** who provide case management, care coordination, assessment and referrals to our highest utilizing members.
    - **Supervisor, Complex Medical Case Management** - responsible for oversight of both nurse and CMCM coordinators.
    - **Complex Medical Case Management Nurse (CMC RN)** - responsible for providing direct service to medically complex members by virtue of multiple chronic conditions and psychosocial challenges.
    - **Coordinators, Complex Medical Case Management** - responsible for support work done by the CMCM RN, completing initial outreach and referrals to members.
    - **Program Manager, CHAMP Grant** - responsible for quarterly deliverables to funders, tracking of ongoing program expenses and evaluation planning.
    - **Coordinator, Project Management** - responsible for follow-up or triage to delegated medical groups of completed HRAs for our SPD members.
- The SFHP **Director, Pharmacy** and pharmacy team are responsible for ensuring that SFHP has evidence-based, cost-effective medication coverage. The pharmacy team provides oversight of pharmacy vendors (e.g. pharmacy benefit manager, specialty pharmacy and medication therapy management) and provides daily operations for pharmacy prior authorization reviews. The pharmacy team also works closely with Health Improvement on clinical quality programs to improve HEDIS scores and to provide support to the UM and Care Coordinations teams for medication related initiatives. The pharmacy team is composed two **Clinical Pharmacists**, three **Pharmacy Technicians**, and one **Pharm.D. Resident**.
- The SFHP **Director, Clinical Operations** ensures the completion of UM activities that support the QI initiatives and directs the UM activities required by state agreement and within the provider network. The Director, Clinical Operations supervises four functional areas that manage various responsibilities that support effective utilization management practice, compliance and oversight. These areas include Concurrent Review and Prior Authorization, UM Delegation Oversight, Policies and Procedures, and Program Management. The following positions support SFHP's Utilization Management activities:
    - **Manager, Concurrent Review** - reports directly to Director, Clinical Operations and manages concurrent review daily operations. Ensures that concurrent review turnaround times are compliant with regulations that assure expeditious care to SFHP members and response to SFHP hospital partners. Has oversight over the Repatriation

process to support consistent, quality continuity of care by facilitating transfers of hospitalized members to their "home" hospital.

- **Nurses, Concurrent Review** - report directly to either Supervisor, Concurrent Review or the Manager of Concurrent Review. Responsible for evaluating medical necessity of inpatient stays and evaluating for potential quality concerns.
- **Manager, Prior Authorization** - reports directly to Director, Clinical Operations and manages the inpatient and outpatient prior authorization team and daily operations. The scope of these services includes pre-service requests and their medical appropriateness based on member's clinical presentation and the use of industry standard or Medi-Cal medical necessity criteria. Also has oversight of the steerage of members to the appropriate providers within their medical group to support continuous and consistent care to SFHP members.
- **Nurse, Prior Authorization** - reports directly to the Manager, Prior Authorizations and responsible for the direct engagement with providers to evaluate specific pre-service authorization requests with reference to the appropriate medical necessity criteria. Also evaluates potential quality concerns and escalates to leadership as appropriate.
- **Manager, UM Authorizations** - reports directly to the Director, Clinical Operations and responsible for leading the non-clinical staff that support the concurrent review and prior authorization process. Has oversight over phone Service Level Agreements, claims edits, and productivity standards over the non-clinical staff.
- **Coordinators, UM** - report directly to the Manager, UM Authorizations or Supervisor of UM Coordinators. Responsible for triaging authorization type and creating authorization shells in care management system. UM Coordinators also manage census, perform outbound phone calls, and maintain timelines of designated work flows.
- **Program Manager, UM -** reports directly to the Director, Clinical Operations and has a multi-faceted role to program manage several overarching UM initiatives to include NCQA accreditation, DHCS compliance, DMHC compliance, Memorandums of Understanding with clinical services provided to SFHP members outside the purview of the plan, and Quality Improvement Initiatives. Creates analysis and trend reports for compliance requirements such as over/under utilization, overturned appeals, and out of network referrals.
- **Nurse, Clinical Outreach** - reports directly to the Director, Clinical Operations and is responsible for the UM Delegation Oversight of the Delegated Medical Groups. In collaboration with Provider Network Operations, the Clinical Outreach nurse performs the state and NCQA required delegation oversight audits to ensure that functions provided by the delegated medical groups are complaint with regulatory standards. The audit results are provided to the delegated medical groups and, when indicated, Corrective Action Plans are developed with the Oversight Nurse and the Medical Group.
- **Administrator, Clinical Policies -** reports directly to the Director, Clinical Operations and is responsible for assuring that Health Services Policies remain compliant with Federal, State, and NCQA requirements. This role provides direction on upcoming All Plan Letters (APL) and the impact on operations. All Plan Letters (APLs) are the means by

which the state of California conveys information or interpretation of changes in policy or procedure at the Federal or State levels, and provides instruction to contractors, if applicable on how to implement these changes on an operational basis. The Administrator, Clinical Policies also is the primary associate that presents policies to the Quality Improvement Committee.

In addition to the above, the CMO and the Health Services Department are also responsible for:

- Coordinating all clinical analyses, programs and activities;
- Facilitating quality improvement efforts and providing the skills needed to analyze data and interpret the significance of trends;
- Conducting needs assessments that guide the design and implementation of the Plan's health education and health promotion initiatives;
- Proposing the QI Program, Work Plan and Evaluation, providing regular reports, and assuming other functions that assist the QI committees to meet their objectives;
- Assures the timely resolution of complaints and appeals and maintains tracking logs that allow trending of member and provider concerns;
- Reviewing and approving all policies and procedures related to QI activities, and ensuring review and approval by the SFHP Policy and Compliance Committee;
- In conjunction with the Customer Service Department, ensures full compliance with all policies concerning member rights; and
- In conjunction with Provider Network Operations , monitoring and where indicated improving member access to and availability of care.

The Provider Network Operations (PNO) Department is responsible for those aspects of the QI Program that relate to evaluation of provider qualifications and performance. It coordinates oversight of all delegated activities and monitors the implementation of corrective action plans. It is also responsible for new provider orientation and education, facility site reviews and conducting and analyzing provider satisfaction surveys.

The PNO staff whom support the QI Program include:

- **Manager, Delegation Oversight and Credentialing** – reports directly to the Director, Provider Network Operations. Manages and coordinates delegation oversight and provider credentialing processes.
- **The Facility Site Review (FSR) Master Trainer –** report directly to the Director, Provider Network Operations. A Registered Nurse who conducts tri-annual FSRs, using standardized DHCS guidelines and audit tools, for all non-delegated Primary Care Physician (PCP) sites in SFHP's network. The Master Trainer also oversees the FSRs completed by Certified Nurse Reviewers for our Delegated Medical Groups.
- **Supevisor, Provider Relations** – reports directly to the Director, Provider Network Operations. Coordinates the provider satisfaction survey administration. Faciliates organizational review of the provider satisfaction survey and appropriate action plan development.

4. Methods and Processes for QI

A. Identification of Important Aspects of Care

SFHP identifies priorities for improvement based on regulatory requirements, data review, and provider and member identified opportunities in the key domains of Clinical Quality & Patient Safety, Quality of Service & Access to Care, Utlization Management, Care Coordination & Services for Members with Complex Health Needs, and Delegation & Oversight. Particular attention is paid to those areas which are high risk, high volume, high cost or problem prone.

The QI Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. The QI Program uses the following strategies to improve performance:

1. Establish standards and/or benchmarks
2. Collect data
3. Analyze and interpret data
4. Identify opportunities for improvement
5. Prioritize opportunities
6. Establish improvement objectives
7. Design interventions
8. Implement interventions
9. Measure effectiveness

B. Data Systems and Sources

Health Effectiveness Data and Information Set (HEDIS)
The External Accountability Set Performance Measures, a subset of HEDIS, are calculated, audited and reported annually as required by DHCS. Depending on the measure and per DHCS mandate, measures utilize administrative data (claims, encounters, supplemental lab sources) and data collected via chart review. HEDIS Compliance Audit services are provided by the Health Services Advisory Group (HSAG) per DHCS mandate. Final results are reported to DHCS, and submitted to NCQA via the Interactive Data Submission System (IDSS).

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
SFHP evaluates member experience annually through CAHPS survey. Primary care clinics and medical groups are rewarded for improvement in CG-CAHPS (CAHPS Clinician & Group Surveys) via SFHP's Practice Improvement Program (PIP). Provider groups either conduct their own CG-CAHPS survey or SFHP conducts the survey on their behalf. Additionally, Health Plan CAHPS is conducted every three years by DHCS and, as of 2014, annually by SFHP.

Practice Improvement Program (PIP)
Medical groups and primary care clinics participating in the PIP program may select to self-report data for some of the measures included in the measure set. From the PIP 2015 Program Guide, these measures include:

- Clinical Quality Domain: Diabetes HbA1c Test, Diabetes HbA1c <8, Diabetes Eye Exam, Routine Cervical Cancer Screening, Routine Colorectal Cancer Screening, Labs for Patients on Persistent Medications, Smoking Cessation Intervention, Controlling High Blood Pressure, Adolescent Immunizations, Childhood Immunizations, Well Child Visits for Children 3-6 Years of Age
- Patient Experience Domains that are impacted by Clinic Operations: Third Next Available Appointment, Show Rate, Office Visit Cycle Time, Staff Satisfaction
- Systems Improvement Domain: After Hours availability, Outreach to Patients Recently Discharged from Hospital, Comprehensive Chronic Pain Management

State of California Measures
Per DHCS mandate, SFHP reports on and evaluates additional measures developed specifically for Medi-Cal Managed Care plans.

Utilization Management
Utilization Management data are captured from the authorization process and include:

- Prior Authorizations
- Concurrent Review Authorizations
- Appeals and Grievances
- Claims
- Member clinical information
- Provider reported data

Pharmacy
Pharmacy data are captured from Pharmacy Benefits Manager and authorization process and include:

- Pharmacy encounter data from pharmacy benefit manager
- Specialty pharmacy
- Pharmacy prior authorization
- Appeals and grievances
- Member clinical information
- Provider reported data

Others
In addition to the data sources listed above, SFHP utilizes the following data sources to inform its QI activities:

- Medical records
- Enrollment data
- Lab data

- Behavioral health data from Community Behavioral Health Services and Beacon Health Strategies
- Key external agencies including Golden Gate Regional Services, California Children Services, and Early Start
- California Immunization Registry (CAIR)

C. QI Program Evaluation

San Francisco Health Plan evaluates the overall effectiveness of the Quality Improvement Program through an annual, comprehensive evaluation process that results in a written report, which is submitted to DHCS. The report includes an executive summary and a summary of all quality indicators, identifying significant trends and areas for improvement. For each item in the QI Work Plan, the evaluation includes the following elements:

- Brief description of the QI activity/intervention and how it purports to improve care or service quality.
- Goal(s) of the QI activity/intervention
- Measures / Metrics used to demonstrate the efficacy of the QI activity/intervention
- Results
- Barriers that impeded the QI activity from demonstrating effectiveness
- Recommended interventions/actions to overcome barriers in the following year

D. QI Work Plan

Results of the annual evaluation described above, in combination with information and priorities determined by the HS leadership and staff, are reviewed and analyzed in order to develop an annual QI Work Plan (Appendix I). This comprehensive set of measures and indicators is divided into five domains:

1. Clinical Quality and Patient Safety
2. Quality of Service and Access to Care
3. Utilization Management
4. Care Coordination and Services for Members with Complex Health Needs
5. Delegation and Oversight

5. QI Activities

The following QI activities are completed annually or are planned for 2015. The activities are arranged by Work Plan domain and further describe the activities referred to under each measure/indicator within the Work Plan (Appendix I).

A. Clinical Quality and Patient Safety

Preventive Care

As a DHCS requirement, San Francisco Health Plan (SFHP) oversees the implementation of preventive health assessments across its provider network, including the Initial Health Assessment (IHA) and the Individual Health Education Behavior Assessments/Staying Healthy Assessments (IHEBA/SHA).

SFHP also monitors and reports on a variety of HEDIS measures focused on preventive services for women and pediatric populations. These include:

- Cervical Cancer Screenings
- Prenatal and Postpartum Care
- Childhood Immunization Status – Combo 3
- Immunizations for Adolescents – Combo 1
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents

Refer to the annual Work Plan for current goals specific to these measurements.
To encourage members to receive high priority services, SFHP offers the following incentives: $50 gift card for childhood immunizations; $25 gift card for a prenatal screening, postpartum visit, and well-child visit, and aniPad raffle for cervical cancer screening.

Initial Health Assessment and Staying Healthy Assessment

All newly-enrolled Medi-Cal members are expected to receive an Initial Health Assessment. SFHP sends monthly reports to its providers with demographic information about these new members. SFHP asks providers to outreach to these members to conduct an Initial Health Assessment within 120 days, as mandated by DHCS (60 days for members 0-18 months). New members receive a mailing in their primary language encouraging them to call their provider and make an appointment to receive this service. SFHP monitors performance against this requirement by analyzing claims and encounter data to calculate the percentage of new members who receive an IHA visit within the DHCS-recommended periods. These results are then analyzed by medical group and Icinica. As needed, SFHP requires a performance improvement plan for underperforming sites with a clear opportunity for process improvement.

Providers are also required to administer the age-appropriate Staying Healthy Assessments, with state-approved questions designed to identify behavioral and other significant risk factors to be addressed by the PCP. SFHP ensures compliance with this requirement through facility site reviews and medical record reviews, in compliance with Medi-Cal guidelines. SFHP provides training to providers about these assessments, and facilitates deeming of equivalent tools upon provider request.

All members over eighteen are required to have an annual screening for alcoholism, based on recommendations from the U.S. Preventive Services Task Force, with follow-up detailed assessment questions and brief interventions, when appropriate.

Data Quality and Capture Initiatives

HEDIS performance cannot be evaluated without accurate information. This requires aggressive data capture and improvement efforts. Some data capture and data quality improvement strategies are year-round pursuits, while some occur during the HEDIS audit season. Monthly, the Clinical Quality teams closely tracks HEDIS administrative rates, so the team can act quickly if the rates are trending lower than previous years. Where there is a difference of 3% or more, the team investigates this discrepancy through detailed analysis of provider submissions, to identify if there is a data problem or a care delivery problem. This analysis informs our action plan, so we can target the solution to the appropriate problem, either focused on a particular medical group, or a SFHP department.

SFHP also analyzes trended claims and encounter volume monthly, by provider group, to identify any specific data issues well in advance of HEDIS season. When problems are identified, our Information Technology Services Department contacts data submitters to facilitate improved data quality and timeliness.

Every year, SFHP adds new strategies to ensure that we get credit for all clinical care that is done, as data quality issues lead to incomplete administrative data. Examples of strategies include:

- Integrate data quality measures in SFHP's Practice Improvement Program
- Pursue acquisition of more complete supplemental data sources (e.g. lab tests and lab results)
- Implement data quality block funding initiative to improve administrative data rates and thus HEDIS performance
- Collaborate with SFHP's Information Technology Systems and Business Intelligence departments to improve data flow in SFHP's Enterprise Data Warehouse (EDW)
- Collaborate with DHCS on data quality monitoring

Disease Management

SFHP monitors and reports on a variety of HEDIS measures focused on recommended interventions for members with chronic conditions. These include:

- Medication Management for People with Asthma – 50% and 75% Compliance
- Annual Monitoring for Patients on Persistent Medications – ACE/ARBs, Diuretics, Digoxin

- Comprehensive Diabetes Care – Eye Exam, HbA1c Testing and Control, Nephropathy Monitoring, BP Control
- Controlling High Blood Pressure

Refer to the annual Work Plan for current goals specific to these measurements.
To encourage members to receive priority interventions, SFHP offers the following incentives: $25 gift card for a diabetes screenings (A1C, lipid, nephropathy screening, retinal and foot exams), and blood pressure check for members with hypertension.

SFHP's DMTxt program is a health text messaging program for members with diabetes. The program's goal is to improve program participants' self-management and diabetes control. Since 2012, more than 250 members elected to participate in the program. Fewer than 25% have dropped out, and based on periodic surveys, members indicate both a high level of satisfaction with the program and relay that it has helped them to gain better control of their diabetes. SFHP will continue to utilize the texting reminders in coordination with the new Disease Management program for members with asthma and diabetes to improve program participants' self management and disease control for both conditions.

SFHP's Disease Management (DM) program, which is planned to be fully implemented April 2015, will build on current health education and incentive efforts and target members with asthma and diabetes. The program is designed to address self-management, patient adherence to the treatment plans, medical and behavioral health co-morbidities and health behaviors, psychosocial issues, and depression screening. The program provides information about the member's condition to caregivers who have the member's consent, and encourages members to communicate with their practitioners about their health conditions and treatment. SFHP facilitates access to community resources to assist members with comorbidities and psychosocial issues.

The DM program systematically identifies members who qualify for each program on a monthly basis through SFHP's Care Management system, Essette. SFHP informs eligible members about the DM program through its Member Handbook, Evidence of Coverage, member newsletters, outreach letters, and through other member contacts. This information includes how to use the services, how members become eligible to participate, and how to opt out. The DM program provides interventions to members based on risk stratification and is aligned with nationally recognized evidence-based clinical practice guidelines.

SFHP ensures that all member communication related to DM is culturally and linguistically appropriate, reading-level appropriate, and approved by all regulating bodies as needed prior to dissemination. SFHP ensures that a member's Protected Health Information (PHI) is protected according to regulations.

Health Education
SFHP ensures that members have access to low-literacy health education and self-management resources in all threshold languages. These resources are available on the SFHP website, and through SFHP providers. Health topics covered by these tools and fact sheets include healthy weight maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating,

managing stress, improving mental health, and substance use referral resources. The SFHP website also includes a listing of clinic-based health-related classes, numerous health education fact sheets (available in five languages), tips for enhancing provider-patient communication, and videos in multiple languages and on myriad topics.

SFHP supports the development and dissemination of the Healthier Living Program, an evidence-based peer-led program that teaches self-management skills to members who are living with chronic conditions. To this end, SFHP financially reimburses sites that run the program for expenses such as snacks and small incentives for program participants.

Behavioral Health Services

Specialty mental health services are not a SFHP benefit and are provided by county run Community Behavioral Health Services (CBHS). Starting January 1, 2014, non specialty mental health services was added as a new Medi-Cal benefit and was delegated to San Francisco Department of Public Health (SFDPH) and a handful of our FQHC clinics. As of January 1, 2015, San Francisco Health Plan (SFHP) has executed a contract with Beacon Health Strategies to deliver both the non-specialty mental health benefit, and the recent (9/14) behavioral health benefit for children diagnosed with Autism Spectrum disorders. This agreement is awaiting final approval from DHCS. As of now, this benefit is managed by the health plan.

As part of this new agreement, Beacon will be responsible for providing the following:

- SFHP members have the right to file grievances related to behavioral health services and SFHP assures that these grievances are managed in accordance with Medi-Cal guidelines. Grievances will initially be managed through Beacon Health Strategies. All resolution letters will be translated and distributed by Beacon within thirty days of receipt if a member files a non-urgent grievance, and 72 hours of receipt if a member files an urgent grievance. SFHP will notify Beacon within four calendar days of receipt if they receive a Beacon-related grievance.
- Beacon Health Strategies will provide SFHP with their QI Plan early in 2015 and will provide reports throughout the year on utilization, case management, grievances, and annually on member and provider satisfaction. This information will be presented to SFHP's QIC.
- Beacon Health Strategies will co-locate staff at the SFHP offices to ensure coordination of care with SFHP Care Coordination and Utilization Management teams.

Note: Goals for Behavioral Health Services are included in the workplan under Delegation and Oversight)

Patient Safety

SFHP is committed to the safety of its members. Current patient safety initiatives include the following:

- **SFHP Pain Management Program**: SFHP conducts trainings to providers focused on improving knowledge of safe opioid management and sharing best practices. SFHP is working with external and internal experts to provide clinical and non-clinical pain management resources to the community. SFHP also participates in the San Francisco Safety Net Pain Management workgroup and has pain management as a standing topic on the SFHP Pharmacy & Therapeutics Committee.

- **Medication Therapy Management (MTM) Program**: In FY 2014-15, SFHP launched a MTM program for Medi-Cal SPD members, working with a vendor to reimburse pharmacists for providing comprehensive medication reviews to members who are identified as high-risk and to provide targeted clinical interventions focused on clinical quality initiatives, such as HEDIS measures.
- SFHP UM and Pharmacy staff are trained to identify **Potential Quality Incidents (PQIs)** and refer them to the Chief Medical Officer (CMO) or physician designee for review. PQIs are incidents outside the standard of care that put members at risk of harm, or when medical errors caused harm. SFHP has a process that ensures that PQIs are evaluated first by the CMO or physician designee, and then brought to the PAC for peer review and next step recommendations.

B. Quality of Service and Access to Care

Monitoring Member Access

SFHP follows DMHC Timely Access Regulations and submits monitoring results to DMHC in March each year. These data provide SFHP with perspective on member and provider satisfaction with access, timeliness of various appointments, and after hours care. In addition, SFHP monitors specific access measures required by DMHC, including timeliness of prenatal appointments, telephone wait times, and SFHP's Nurse Advice Line wait times. SFHP is currently designing additional reporting for a suite of other access measures in order to develop a more comprehensive picture on member access. These additional measures will be available in March 2015. Providers that are not in compliance with regulations are required to participate in either a quality improvement plan or a corrective action plan.

Customized Access Improvement Strategies

Member access to the right care at the right time is a crucial component of SFHP's core purpose to improve health outcomes. Access is a challenge within San Francisco due to recent EMR implementations, primary care provider recruitment challenges, and lack of infrastructure within safety net clinics. SFHP is engaged in a multi-prong strategy working in collaboration with the largest provider groups in the network to support access to care improvements (San Francisco Health Network, Clinical Practice Group and North East Medical Services). This will include a combination of leadership and quality improvement training and coaching. All program components will focus on access improvements and require leadership champions at network sites.

To evaluate the success of access improvement efforts the Director, Health Improvement and Manager, Practice Improvement will analyze the access measures within the practice improvement program (PIP, SFHP's pay-for-performance program) on a quarterly basis and identify trends for opportunities for improvement. These data will be presented to the Access to Care Improvement Committee.

Financial Incentives to Support Improvement

The Practice Improvement Program (PIP) is SFHP's pay-for-performance program. PIP is equivalent to approximately 18.5% of provider payments, proving to be a strong motivator for provider groups. Supporting the goals of the triple aim, PIP has four domains: Clinical Quality, Patient Experience,

Systems Improvement, and Data Quality. Participants have opportunities to gain incentive funds both from meeting benchmarks and from relative improvement. Unearned funds are reserved to support improvement of performance measures via technical assistance and provider-level grants.

Practice Improvement Program Coaching Program

Clinic coaching is an effective tool to apply best practices to a clinic's unique context, create urgency and accountability, as well as provide a valuable outside perspective. In 2015, SFHP will complete a grant for the 10 Building Blocks Practice Coaching program, a 3-year coaching program in collaboration with UCSF's Center for Excellence in Primary Care (CEPC). At the completion of the grant period, SFHP will redesign coaching efforts to align with the Practice Improvement Program (PIP).

Patient Experience Quality Improvement Project (QIP)

SFHP's plan-specific QIP is designed to improve SFHP's CAHPS results, particularly the rating of overall health care and the rating of personal doctor. Goals for CAHPS measurements are found in the annual Work Plan. In response to this QIP priority, SFHP is focusing on two primary interventions, Coleman's Rapid Dramatic Process Improvement and Provider Communication Trainings. Both are described below.

Coleman's Rapid Dramatic Process Improvement

SFHP sponsors clinics to participate in Coleman Associates' Rapid Dramatic Performance Improvement (DPI) program. In this intensive program, 3 to 5 consultants work side-by-side with clinic staff for one week, redesigning clinic processes to improve teamwork, patient access, patient experience, and visit efficiency. This week is followed by two months of coaching, monitoring and reporting of performance measures. This intervention is useful for primary care clinics that wish to improve access and patient experience through QI methodology, team based care, and improved productivity.

Provider Communication Trainings

SFHP collaborates with the Institute for Healthcare Communications (IHC) to offer trainings to care providers (MDs, NPs, PAs, LCSWs, etc.) aimed at improving their one-on-one interactions with patients. Past topics include difficult clinician-patient relationships and using EHR in the exam room.

Customer Service Trainings

SFHP collaborates with Sullivan-Luallin to offer trainings to all clinic staff on improving customer service to patients. Trainings either occur at the clinic site or in a centralized location. Topics may vary, including general customer service, phone customer service, de-escalation, and manager training for building customer service accountability.

Quality Culture Series

SFHP supports the concept of the "patient-centered medical home," and believes that reaching peak performance in quality will require real transformation in how care is delivered in the safety net. Practices that have successfully transformed themselves have three key elements in common:

- The will to change (the classic business-critical burning platform, or at least recognition that the current system is not working)
- High-performing leadership teams, who communicate the vision and lead the transformation
- Core skills in quality improvement (creating small tests of change, measuring, spreading), people management (accountability, delegation, creating high-performing staff teams) and operations (creating lasting functional and efficient systems – not leaping from project to project)

San Francisco's Quality Culture Series serves to support clinic leadership and staff in strengthening these three elements. SFHP offers 2-4 full-day sessions each year. Sessions focus on enhancing leadership competency and operational excellence with near-universal participation of San Francisco safety net clinics.

Provider Satisfaction

On an annual basis, SFHP conducts a Provider Satisfaction Survey to gather information about network provider issues and concerns with SFHP's services. The survey is administered by an outside vendor, and targets primary care and high-volume specialty care providers and office staff. It measures their satisfaction with the following SFHP functions:

- Finance Processes
- Utilization Management and Care Support
- Network/Coordination of Care
- Timely Access to Non-Emergency Health Care Services
- Pharmacy
- Health Plan Customer Service Staff
- Provider Relations
- Ancillary Provider Network
- Health Improvement

Results are distributed to the impacted SFHP departments for the identification and implementation of improvement activities. Applicable improvements are integrated into the QI Program activities.

Timely Communication to Providers

SFHP provides timely communication of standards and requirements to participating medical groups and organizational providers via the following activities:

- Distributing SFHP operations manuals that are revised and updated at least annually.
- Informing providers of new and revised policies and procedures, and legislative and regulatory requirements as they occur through the SFHP Provider Newsletter and the Network Operations Manual.
- Distributing preventive care and other clinical practice guidelines.
- Distributing results of quality monitoring activities, audits and studies, including grievances that identify potential system issues and member experience and provider satisfaction survey results.
- Providing training of new providers on SFHP policies and procedures.

Provider Credentialing

SFHP ensures that health care practitioners are appropriately credentialed and re-credentialed, and all organizational providers meet accreditation standards. This process includes:

- Bi-annual review of credentialing and re-credentialing policies and procedures for compliance with SFHP standards, legislative and regulatory mandates, contractual obligations and, NCQA standards.
- Peer review of credentialing and re-credentialing recommendations, potential quality of care issues and disciplinary actions through the Physician Advisory Committee (PAC).
- Providing a mechanism for due process for practitioners who are subject to adverse actions.
- Conducting facility site and medical record reviews on all primary care practitioners prior to credentialing and re-credentialing in accordance with SFHP standards, legislative mandates, contractual obligations and, NCQA standards.
- Requiring accreditation of institutional providers, or reviewing for compliance with industry standards.
- Conducting provider monitoring through Medical Board of California, List of Excluded Individuals/Entities (LEIE) database, and Medi-Cal no pay list.

Member Grievances and Appeals

SFHP ensures that members' grievances are managed in accordance with Medi-Cal guidelines. SFHP manages and tracks complaints and grievances, and provides a quarterly analysis to the Quality Improvement Committee, identifying trends and addressing patterns when evident. To identify patterns and trends in grievances, grievance reports are generated to report rates by line of business, medical group, and grievance category. When a pattern has been identified, SFHP will work with clinics or medical groups to develop strategis for improvement.

To formalize the above processes, a Grievance Committee has been developed in order to improve the member experience and improve SFHP's internal grievance process. The committee is multidisciplinary, composed of the Chief Medical Officer and representatives from Member Services, Provider Relations, Health Improvement, Care Support, Pharmacy, Clinical Operations, and Compliance and Regulatory Affairs.

Any grievance that poses a Potential Quality Incident (PQI) is referred to the Chief Medical Officer or physician designee to review. PQIs are incidents outside the standard of care that put members at risk of harm, or when medical errors caused harm. SFHP has a PQI process that ensures that PQIs are evaluated first by the CMO or designee, and then brought to the Physician Advisory Committee for peer review and next step recommendations.

Member Rights and Responsibilities

SFHP works to ensure that members are aware of their rights and responsibilities. This includes the annual review, revision, and distribution of SFHP's statement of member rights and responsibilities to all members and providers in compliance with SFHP standards and legislative mandates. The Plan also implements specific policies that address the member's right to confidentiality and minor's rights. SFHP conducts a bi-annual review of the process for a formal complaint, grievance and appeal to ensure

compliance with SFHP standards, legislative mandates, contractual obligations and, National Committee for Quality Assurance (NCQA) standards. In addition, member grievances and appeals that specifically concern member rights and responsibilities are analyzed for trends. Corrective action plans are implemented as necessary in order to address specific or systemic issues in providing members rights and responsibilities.

Cultural and Linguistically-Appropriate Services

SFHP regularly assesses the cultural and linguistic needs of its members, and maintains appropriate services, including providing member materials that are written at a sixth-grade reading level in English and in threshold languages. SFHP also provides interpreters and bilingual staff where members rely on face-to-face or telephonic contact with the Plan.

All non-English monolingual and Limited English Proficient (LEP) SFHP members have confidential, no-cost linguistic services available to them for all member service inquiries and medically related visits. Interpreter services include sign language interpreters and/or TTY/TDD. When bilingual providers or staff is not available, interpreter services are provided at no cost to the member when accessing health services. Interpreter services are provided by a face-to-face interpreter, telephone language line, or Video Monitoring Interpretation (VMI). SFHP informs members about the availability of linguistic services through its Member Handbook, Evidence of Coverage, member newsletters and through other member contacts. The SFHP identification card also indicates the right to interpreter services.

SFHP members are discouraged from asking a friend, neighbor, spouse, relative or a child under the age of 18 to interpret for them. However, a member may choose to ask such an individual to accompany them to a medical visit and serve as their interpreter if this is requested by the LEP individual after being informed he/she has the right to use free interpreter services. Providers must document preferred language and requests for language and/or interpretation services by a non-English or LEP person in the medical record. Providers must also document member's refusal to accept the services of a qualified interpreter.

Providers are required to coordinate interpreter services during appointment scheduling in order to ensure that an interpreter is available at the time of the appointment. SFHP delegates the responsibility for providing interpreter services at all medical points of contact to its medical groups. All delegated medical groups must have language access policies and procedures that are consistent with SFHP's policy and meet all legal and regulatory requirements. The SFHP Project Manager, Health Education and Cultural and Linguistic Services (HECLS) conducts an audit of linguistic services as part of the annual Medical Group Compliance Audit. The Project Manager, HECLS also assists in addressing grievances related to cultural and linguistic issues at both medical and non-medical points of contact, systemically investigating and intervening as needed. SFHP provides interpreter services at all health plan points of contact. SFHP also provides linguistic services to members who call or visit the health plan and who participate in health plan related committees, such as the SFHP Member Advisory Committee (MAC).

Most SFHP members have the option to select a primary care provider or clinic that speaks his/her language. The SFHP Provider Directory indicates languages spoken by providers and at clinic sites.

C. Utilization Management

Utilization Management

In order to ensure appropriate utilization management, SFHP engages in the following activities:

- Monitoring of denials and modifications of care
- Annual approval of the utilization management program, policies and procedures for compliance with SFHP standards, legislative and regulatory mandates, and applicable NCQA standards
- Annual review of utilization management criteria and policies to assure they are current, based on sound clinical principles, and are consistently applied
- Annual prior authorization review
- Quarterly monitoring of utilization rates, coordination and continuity of care indicators, quality of care issues and risk management activity
- Tracking of open prior authorization specialty referrals for completion of services
- Monitoring California Children Services (CCS) and Golden Gate Regional Services (GGRC) coordinated care
- Monitoring the timeliness of utilization management decisions, including expedited appeals
- Monitoring utilization reports for evidence of over-utilization and under-utilization
- Medical record audits from Delegated Medical Groups
- Reviewing member grievances and appeals and provider satisfaction surveys concerning denials, delays or modifications of care
- Implementing corrective actions that address specific or systemic deviations from sound utilization management practice

Ambulatory Care and Readmissions

SFHP monitors the use of services using the HEDIS Ambulatory Care measure, which tracks outpatient and ED visits by the number of visits per 1000 member months. As part of a statewide collaborative Quality Improvement Plan (QIP), hospital All Cause Readmissions are also measured and monitored. The primary intervention for this QIP is a pay-for-performance measure that incentivizes providers to follow-up with patients within seven days of initial discharge. SFHP then compares the follow up rates with the readmission rates to determine the association between the two measures.

Pharmacy Services

In order to ensure appropriate pharmacy prior authorization, SFHP engages in the following activities:

- Quarterly Pharmacy and Therapeutics Committee meetings to review and approve criteria
- Annual approval of the pharmacy policies and procedures for compliance with SFHP standards, legislative and regulatory mandates, and applicable NCQA standards
- Annual review of pharmacy prior authorization criteria and policies to assure they are current, based on sound clinical principles, and are consistently applied
- Annual prior authorization review

- Monthly monitoring of utilization rates and timeliness of reviews
- Quarterly interraterreliability review

D. Care Coordination and Services for Members with Complex Health Needs

Care Coordination

SFHP's Care Coordination and Utilization Management teams ensure coordination of care for members per Medi-Cal contractual requirements. These coordination activities include executed MOUs with key agencies such as California Children Services (CCS), Golden Gate Regional Services (GGRC), Early Start (ES) and Community-Behavioral Health Services (CBHS) that outline coordination activates. These coordination activities are designed to ensure members are aware of non-plan benefits and programs available to them and confirm coordination of care across agencies and services.

CareSupport

SFHP's CareSupport team supports three programs that are focused on members who receive services within the non-delegated medical groups (SFHN and UCSF). Members receiving care within delegated Medical Groups in the network receive case management from their Medical Group. The primary program, Community Based Care Management (CBCM), is focused on our members who are high utilizers of acute inpatient and ED visits. The goal of CBCM is to improve member health, improve connection with and utilization of primary care, and reduce avoidable inpatient admissions and ED visits.

The inclusion criteria for CBCM are the following: 2 inpatient admissions in prior 12months; or 1 inpatient admission and 5 ED visits in prior 12months; or 6 ED visits in prior 12 months. Bachelor-level prepared Community Care Coordinators, with the oversight of Clinical Supervisors, work with approximately 25-30 members at any given time. This program is supported by additional funding from California Health Facilities Financing Authority (CHFFA)'s California Health Access Model Program (CHAMP) grant. This grant supports additional staffing, evaluation and a focus on replication across the state of California. The key components of the CBCM model include:

1. In person outreach and engagement
2. Initial holistic psychosocial assessment
3. Ongoing reassessment of needs and motivation
4. Member driven care plans
5. Primary Care Provider engagement
6. Wraparound care coordination
7. Referrals to community resources and programs

The second program supported by CareSupport is the Time Limed Coordination (TLC) program. The TLC program is a short-term (less than 6 months) care coordination program for members who don't meet the high utilizer criteria of the CBCM program but are referred to the Care Coordination department for coordination assistance. Only members of the CHN and UCSF medical groups are eligible for this program and the member must have at least one stated coordination need. The focus of this program is to provide members with coordination, referral, and support services to meet their identified needs. The

TLC program has all of the same key components of CBCM, however the cases are addressed in a shorter time-frame and focuses on select coordination opportunities.

CareSupport also supports follow-up with new SPD members who complete their Health Risk Assessment (HRA). These members are stratified as complex or basic, based on their HRA responses. If members are identified as complex they receive up to three phone calls and a letter attempting to engage them in services. If they are identified as basic, they receive a letter explaining how to access limited care coordination services if needed. Once a member engages with our Project Management Coordinator, he or she receives assistance with community referrals, navigating their health plan benefits, or connection to primary care. The goal of this program is to ensure that new SPD members with identified needs receive timely and appropriate care.

Complex Medical Case Management

In 2015, SFHP is implementing a Complex Medical Case Management (CMCM) program aligned with NCQA standards and Medi-Cal contractual requirements. Members receiving care in most medical groups (all except Kaiser) who have complex medical conditions, and are at high risk, are eligible for this program. This program will complement the efforts in the Community Based Care Management (CBCM) and provide new services to medically complex members who qualify for the program.

Care Coordination Highlights

- All SFHP care management programs are developed based on evidence and patient-centered principles, and are revised annually based on evaluation of impact and analysis of member satisfaction.
- SFHP utilizes an automated care management system, Essette, to manage workflow, and ensure standardization and inter-rater reliability in terms of member assignment, assessment, care plan development, and management. Management oversight and audits are conducted to ensure adequate documentation.
- The impact of SFHP care management programs is assessed annually at a minimum based on several pre-identified indicators.

Nurse Advice Line

The Nurse Advice Line is a service that provides members with 24/7 telephonic access to a health care professional. During a call, a nurse assesses the caller's symptoms, determines the appropriate level of care needed, suggests a self-care plan, if appropriate, or directs the members to a physician, or if necessary, urgent or emergency care. The service is available to all SFHP members, with interpretation services available as needed.

E. Delegation and Oversight

Standards for Delegated Medical Groups

SFHP oversees any functions and responsibilities delegated to subcontracted medical groups and behavioral health organizations. The delegated entity must comply with laws and regulations as stated in 42 CFR 438.230(B)(3), (4) and Title 22 CCR § 53867 and the Department of Health Care Services

contract. SFHP ensures that delegated functions are in compliance with these laws and regulations through an annual audit process and monthly and quarterly monitoring activities.

Delegated Functions:

- Credentialing –
  - All activities related to Credentialing verification of individual practitioners are fully delegated to the medical group with which the practitioners have a contract.
    - Brown and Toland, Chinese Community Health Care Association, Hill Physicians Medical Group, Kaiser Foundation Health Plan, North East Medical Services, San Francisco Health Network, and UCSF.
  - SFHP conducts Credentialing verification of all clinics affiliated with SFCCC and other independent clinics.
- Utilization Management –
  - The following groups are delegated to conduct UM activities on behalf of the Plan:
    - Brown and Toland, Chinese Community Health Care Association, Hill Physicians Medical Group, Kaiser Foundation Health Plan, and North East Medical Services.
- Pharmacy Services – Kaiser Health Plan Foundation and Perform Rx are delegated to manage pharmaceutical services on SFHP's behalf
- Nurse Advice Line – NurseWise is the SFHP vendor for this function
- Complex Case Management – Kaiser Foundation Health Plan is delegated to provide CCM services to all of its members. SFHP provides CCM to all other Plan members.
- Non-Specialty Mental Health – Kaiser Foundation Health Plan is delegated to provide behavioral health services to all of its members. SFHP provides non-specilaty mental health services to all other Plan members. DMHC is considering a request for SFHP to delegate this function to Beacon Health Strategies.
- Quality Management – Kaiser Foundation Health Plan will be delegated for 2015 to fulfill QI obligations for all of its members.

As a prerequisite to enter into a delegation agreement, SFHP conducts a pre-delegation evaluation of the prospect delegated functions. Dependent upon the scope of the delegated functions, SFHP requires specific documents and performs a pre-delegation audit. SFHP may waive the pre-delegation audit in lieu of appropriately documented evidence of NCQA Accreditation or Certification.

Once the pre-delegation audit is complete, a Delegation Agreement and Responsibilities and Reporting Requirements (R3) Grid is executed. The R3 describes the specific responsibilities that are being delegated, and provides the bases for the required delegate oversight. The R3 indicates which activities are to be evaluated through annual audits, and which activities are to be evaluated through more frequent monitoring.

Six to twelve months post execution of the Delegation Agreement, SFHP conducts an audit of all delegated functions. The audit scope and review period are determined by the Delegated Network Oversight Committee. The Provider Network Operations Department coordinates the audit process. The audit team is comprised of subject matter experts from the delegated functional areas. SFHP uses NCQA

and DHCS approved audit tools as well as tools developed in-house and in conjunction with other Local Initiative Health Plans.

Audit results are communicated to the Delegate within 30 days from the completion of the audit. If deficiencies are identified, a corrective action plan (CAP) is requested. When a CAP is submitted by Delegate, the SFHP audit team will evaluate the response and issue either an approval or a request for additional information.

Upon execution of the Delegation Agreement, SFHP retains the authority to:

- Conduct a full-scope review at any time.
- Annually review key program or policy documents.
- Accept or reject the qualifications of all network providers, approve new practitioners and sites, terminate or sanction practitioners, and report serious quality deficiencies or access issues to appropriate authorities.
- Accept or reject all UM decisions to deny, defer, or modify care, review new technologies, and provide additional member benefits.
- Conduct all member appeals and respond to any complaint or grievance the member elects to address directly to the Plan.

SFHP may participate in joint audits with other DHCS Managed Care Health Plans. In lieu of conducting an oversight audit, SFHP may accept a Delegate's NCQA Accreditation or Certification if it is in good standing. SFHP does not waive the right to conduct monitoring activities. SFHP delegation audit committees are overseen by the Delegation Oversight Committee and the QIC.

Policies and Procedures

SFHP reviews and updates all of its clinical policies and procedures (Utilization Management, Care Coordination, Pharmacy, Quality Improvement, Health Education, Cultural and Linguistic Services) biennially at a minimum. Clinical policies and procedures are also updated on an as-needed basis to reflect changes in federal and State statutory and regulatory requirements and/or NCQA standards. QIC and SFHP's internal Policy and Compliance Committee review and approve all changes to and new clinical policies and procedures.

Reviewed & Approved by:

Chief Medical Officer: _____ Date: _____

James Glauber, MD, MPH

Quality Improvement Committee: Date: _____

Appendix I: Work Plan

1. Clinical Quality and Patient Safety

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Time Frame	Status
A.	Percentage of HEDIS Measures in the 90th%	Maintain the rate of publicly reported HEDIS measures in the Medicaid 90th percentile	14/29 measures in the 90th percentile in 2014	Manager, Clinical Quality; PM, Clinical Quality	• Member outreach • Provider outreach • Data quality Improvement effforts • Comprehensive data capture	Final rates available 06/15/15	On track
B.	Cervical Cancer Screening (HEDIS)	Increase cervical cancer screening rates in members marked as female age 21-65 to the Medicaid 90th percentile	SFHP 2014 - 90th 74.74% - 78.51%	Manager, Clinical Quality; PM, Clinical Quality	• Member outreach with incentive TBD • Ongoing monitoring • Pay-for-Performance (PIP) Measure	Final rates available 06/15/15	On track
C.	Prenatal and Postpartum Care (HEDIS)	Increase the rate of pregnant and postpartum members who have a visit in the required timeframe to the Medicaid 90th percentile in both indicators	SFHP 2014 - 90th Prenatal: 93.24% - 93.33% Postpartum: 70.40% - 74.73%	Manager, Clinical Quality; PM, Clinical Quality	• Targeted member outreach with $25 incentive for timely prenatal and postpartum care • Ongoing monitoring • Pay-for-Performance (PIP) Measure	Final rates available 06/15/15	On track
D.	Childhood Immunization Status – Combo 3 (HEDIS)	Increase the rate of children age 2 and below with all Combo 3 immunizations	SFHP 2014 - 90th 85.42% - 82.48%	Manager, Clinical Quality; PM, Clinical Quality	• Member outreach with $50 incentive • Ongoing monitoring • Pay-for-Performance (PIP) Measure	Final rates available 06/15/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Time Frame	Status
E.	Immunizations in Adolescents – Combo 1 (HEDIS)	Increase the rate of adolescents age 11-13 with all Combo 1 immunizations to the 90th percentile	SFHP 2014 - 90th 81.71% - 80.91%	Manager, Clinical Quality; PM, Clinical Quality	• Ongoing monitoring • Pay-for-Performance Measure	Final rates available 06/15/15	On track
F.	Well-Child Visits in the 3rd, 4th, 5th and 6th years of Life (HEDIS)	Increase the rate of children age 3-6 who receive a well-child visit	SFHP 2014 - 90th 86.81% - 83.04%	Manager, Clinical Quality; PM, Clinical Quality	• Member outreach with $25 incentive • Ongoing monitoring • Pay-for-Performance (PIP) Measure	Final rates available 06/15/15	On track
G.	Weight Assessment and Counseling for Nutrition & Physical Activity in Children and Adolescents – BMI, Nutrition Counseling, PA Counseling (HEDIS)	Increase the rate of members age 3-17 who receive BMI monitoring and counseling for nutrition and physical activity	SFHP 2014 - 90th BMI: 86.81% - 77.13% Nutrition: 82.41% - 77.61% Phys Activity: 79.17% - 64.87%	Manager, Clinical Quality; PM, Clinical Quality	• Ongoing monitoring	Final rates available 06/15/15	On track
H.	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (HEDIS)	Reduce the treatment of adults with acute bronchitis with antibiotics	SFHP 2014 - 90th 44.01% - 33.33%	Manager, Clinical Quality; PM, Clinical Quality	Ongoing monitoring	Final rates available 06/15/15	On track
I.	Medication Management for People with Asthma – 50% and 75% Compliance (HEDIS)	Increase the rate of members age 5-65 with asthma who are using their controller medications as recommended to the 90th percentile	SFHP 2014 - 90th 50% Compliance: 52.10% - 62.39% 75% Compliance: 32.87% - 40.17%	Manager, Clinical Quality; PM, Clinical Quality	• Targeted member outreach with Pharmacy Resident • Asthma texting	Final rates available 06/15/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Time Frame	Status
J.	Annual Monitoring for Patients on Persistent Medications – ACE Inhibitors or ARBs, Digoxin, Diuretics (HEDIS)	Increase the rate of monitoring for members on ACE/ARBs, Digoxin, Diuretics to the Medicaid 90th percentile in all indicators	SFHP 2014 - 90th ACE/ARBs: 87.32% - 91.33% Digoxin: 95.92% - 95.56% Diuretics: 86.31% - 91.30%	Manager, Clinical Quality; PM, Clinical Quality	• Provider outreach • Ongoing monitoring • Pay-for-Performance (PIP) measure •	Final rates available 06/15/15	On track
K.	Comprehensive Diabetes Care – Eye Exam, HbA1c Testing and Control, Nephropathy Monitoring, BP Control (HEDIS)	Increase the rate of adults age 18-75 with diabetes who receive all recommended screenings to the Medicaid 90th percentile in all indicators	SFHP 2014 - 90th Eye Exam: 62.41% - 69.72% HbA1c Test: 89.33% - 91.13% HbA1c Control: 63.57% - 59.37% Nephropathy: 86.77% - 86.93% BP Control: 76.57% - 75.44%	Manager, Clinical Quality; PM, Clinical Quality	• Targeted member outreach with $25 incentive • Ongoing monitoring • Pay-for-Performance (PIP) Measure • Diabetes texting	Final rates available 06/15/15	On track
L.	Controlling High Blood Pressure (HEDIS)	Increase the rate of adults age 18-85 with hypertension whose BP is considered in control to the Medicaid 90th percentile	SFHP 2014 - 90th 63.42% - 69.11%	Manager, Clinical Quality; PM, Clinical Quality	• Member outreach with $25 incentive • Ongoing monitoring • Pay-for-Performance (PIP) Measure	Final rates available 06/15/15	On track
M.	Use of Imaging Studies for Low Back Pain (HEDIS)	Increase the rate of members age 18 and older who did not have an imaging study performed	SFHP 2014 - 90th 84.86% - 82.04%	Manager, Clinical Quality; PM, Clinical Quality	• Ongoing monitoring	Final rates available 06/15/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Time Frame	Status
N.	Initial Health Assessment Rate	Improve member engagement with primary care by improving the IHA rate by at least 5 percentage points	35% in 2014	Grievance Coordinator	• Monthly provider mailings • Analysis by medical group and clinic site	Final rate available 12/31/15	On track
O.	Pain Management	Ensure that 50% of patients in PIP participant pain registries have a both UTOX and Pain Agreement in the last 12 months	2014 baseline available in 05/2015	PM, Practice Improvement Program	• Pay-for-Performance (PIP) Measure • Technical assistance offered • Education for providers, patients and staff (clinical and non-clinical)	11/30/15	On track
P.	Medication Therapy Management	Implementation of MTM program one provider group and performance guarantee in place for 1:1 ROI on drug cost savings interventions	NA in 2014	Director, Pharmacy	• Identify site for implementation	12/31/15	On track

2. Quality of Service and Access to Care

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
A.	Children and Adolescents' Access to Primary Care Practitioners (HEDIS)	Increase the rate of members age 1-19 who have a visit with a PCP to the Medicaid 90th percentile in all age groups	SFHP 2014 - 90th 1-2 years: 97.01 – 98.49% 2-6 years: 92.55% - 93.60% 7-11 years: 94.70 - 95.25% 12-19 years: 91.04% - 93.77%	Manager, Clinical Quality; PM, Clinical Quality	• Member outreach with raffle incentive • Ongoing monitoring	Final rates available 06/15/15	On track
B.	Timely Access Regulations (DMHC)	100% of provider network have no patterns of non-compliance	100% in 2013	Practice Improvement Specialist	• Measure access compliance per recommended methodology • Implement corrective action plans for network with patterns of non-compliance.	03/31/15	On track
C.	Getting Care Quickly Rating (HP-CAHPS)	Improve the rate of members who report that they "get care quickly" by 2%	43% in 2013	Project Manager, Member Experience	• Pay-for-Performance (PIP) Measure • Access Learning Initiative • CG-CAHPS for network • Coleman Rapid Dramatic Process Improvement	Final report available in July 2015	On track
D.	Getting Needed Care Rating (HP-CAHPS)	Improve the rate of members who report that they "get needed care" by 2%	39% in 2013	Project Manager, Member Experience	• Pay-for-Performance (PIP) Measure for Specialists	Final report available in July 2015	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
E.	How Well Doctors Communicate Rating (HP-CAHPS)	Improve the rate of members who rate their doctor as a "9" or "10" to 68.4% (NCQA QI Plan)	64% in 2013	Project Manager, Member Experience	• IHC Communication Trainings • Customer Service Strainings • Pay-for-Performance (PIP) Measure	Final report available in July 2015	On track
F.	Cultural Awareness Training for SFHP Staff	Increase the percentage of SFHP staff who participate in a cultural awareness training to 95%	91% in 2013	PM, Health Education	• Online interactive module to be implemented 2014-2016	06/30/15	On track
G.	Member Grievances and Appeals	Resolve 100% of grievances within 30 days	100% in 2013	Quality Management Specialist	• Quarterly Reports	12/31/15	On track
H.	Potential Quality Issues (PQI)	100% of PQIs resolved within timeframe	No baseline available	AMD	• Developing criteria and P&P for PQI • Monitoring report	6/1/2015	On track
I.	Provider Alignment with the Practice Improvement Program (PIP)	Measure alignment of SFHP's P4P program with provider priorities	No baseline, 2015 first year of measurement	PM, Practice Improvement Program	• PIP Advisory CommitteeMeetings • Subject Matter Expert (SME) meetings	08/30/15	On track
J.	PIP Block Funding (improve at least one outcome measure)	66% of PIP Block Funding Participants that demonstrate improvement in at least one measure	No baseline	Project Manager, Practice Improvement	• Quarterly check-in call with participants • Financial incentive for reaching target	12/31/15	On track
K.	Practice Improvement Program	35% of participants that improve or meet top threshold in at least 75% of quantitative	31% in 2014	PM, Practice Improvement Program	• PIP Orientation • Training/Technical Assistance • Financial Incentive for meeting targets	6/31/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
		measures			• ABC's of QI		
L.	Improve leadership capacity in provider network	75% of training participants report that the QCS training improved their effectiveness as a leader	No baseline	PM, Practice Improvement	• Identify key leadership topics needing improvement • Provide two leadership QCS trainings to providers	12/31/15	On track
M.	Primary Care Third Next Available (TNAA)	Improve TNAA in SFHN and NEMS by 5 days	SFHN – 31 days NEMS – 20 days	Dir, HI Mgr. Practice Improvement	• Implement access to care improvement strategy customized for San Francsico Health Network and North East Medical Services	12/31/15	On track
N.	Specialty Care Third Next Available (TNAA)	Improve TNNA in 3 specialty clinics by 5 days	TBD	Dir, HI Mgr. Practice Improvement	• Implement access to care improvement strategy customized for Clinical Practice Group	12/31/15	On track
O.	Provider Satisfaction	Observe statistically significant improvements upon prior year, or 90th national percentile, in each of three measures on Provider Satisfaction Survey --Overall satisfaction with the Provider Relations department - 74.8% for January 2014 survey	Statistically significant improvement from 2014	Dir. Provider Network Operations	• Enhance and standardize processes to improve staff competency and proactivity • Continue to develop existing Provider Relations ACD toolkit to answer questions in common topics authoritatively and completely • Initial basic customer service training with refreshers and "secret	2/1/16	On Track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
		--Question 8A: (Satisfaction with) Provider Relations representative's ability to answer questions and resolve problems. - 80.7% for January 2014 survey --Question 8C: (Satisfaction with) Quality of written communications, policy bulletins, and manuals. - 75.8% for January 2014 survey			shopper" evaluation for PR staff • Use ACD and email patterns to dedicate more PR staff at times when providers are actually reaching out to us • Secure more provider subscriptions to our monthly newsletter, used to proactively disseminate changes to Medi-Cal programs and other relevant info.		

3. Utilization Management

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
A.	UM Timeliness of Decision and Notification	Ensure 90% of all prior authorization and concurrent review decisions are made within specified turnaround times	2013: 90%	Director, Clinical Operations	• Monthly TAT reports to identify delays in SFHP auth processing and medical necessity reviews • Yearly review of authorization workflow to identify non-value added processes and streamline, where	06/30/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
					possible		
B.	Utilization Among Members in CareSupport's CBCM Program	Reduce inpatient admissions, acute inpatient days and ED visits	No baseline, 2015 first year of measurement	Sr. Manager, Care Coordination	• Review average pre/post engagement utilization of 1) acute inpatient stays, 2) acute inpatient day, and 3) ED visits	Measurement ends 12/31/15	On track
C.	Member Satisfaction with UM Processes	Conduct member satisfaction survey of UM processes	No baseline, 2015 first year of measurement	Director, Clinical Operations	• Member survey	06/30/15	To be developed
D.	Provider Satisfaction with UM Processes	Conduct provider satisfaction survey of UM processes	No baseline, 2015 first year of measurement	Director, Clinical Operations	• Provider survey	06/30/15	To be developed
E.	Care Coordinator Utilization Management File Audits	Deploy a tool and maintain a schedule to audit care coordinator auth-related activity within core UM system to improve authorization data quality to enhance reporting and trending analysis.	No baseline, 2015 first year of measurement	Director, Clinical Operations	• Five cases per care coordinator, quarterly • Annual cumulative score	06/30/15	On track
F.	Interrater Reliability	Improve utilization management decision making by improving the nurses' and medical directors' clinical skill set by achieving an 80% or greater	No baseline, 2015 first year of measurement	Director, Clinical Operations	• Yearly InterQual Interrater Reliability Assessment	06/30/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
		score using Interrater Reliability Assessment					
G.	Delegation of UM Activities	Ensure that BTP, HIL, NEMS and CCHCA medical groups are providing 100% of delegated utilization management functions outlined in the 2015 R3 agreements	No baseline, 2015 first year of measurement	Director, Clinical Operations Clinical Outreach Nurse	Annual Delegation Oversight UM Audit	(Per audit schedule)	On track
H.	Nurse Advice Line	Improve Nurse Advice Line to link clinical guidelines to level of care disposition	Enhanced reporting	Director, Clinical Operations	• Build report specifications with Nurse Advice Line to add clinical guideline dimension • Review enhanced report and identify if specific diagnosis are being triaged as ED level of care or if inappropriately not dispositioned to ED level of care.	06/30/15	On track
I.	UM Overutilization and Underutilization	Identify patterns of under or overutilization to create actionable steps to promote medically	NA	Director, Clinical Operations	• Establish overutilization/underutilization review process • Establish utilization benchmarks for comparison	06/30/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff	Activities	Timeframe	Status
		appropriate utilization of services			• Development an action plans to remediate deviations from utilization benchmarks		
J.	Pharmacy Prior Authorization Turnaround time	Provide a decision to pharmacy prior authorization requests in 24 hours or one business day	No baseline (interpretation of guidance was updated with 2014 CAP)	Director of Pharmacy	Pharmacy and PBM reengineered process to managed more condensed TAT	Ongoing in 2015	On track
K.	ED Visits (HEDIS)	Reduce the number of ED visits by 2%	SFHP 2013-2014 ED: 33.03-35.34	Practice Improvement Specialist	Pay-for-Performance (PIP) Measure	Final rates available 06/15/15	On track
L.	All Cause Readmissions (State QIP)	Reduce the rate of hospital readmissions by members to 16.4%	2013: 17.3%	PM, Practice Improvement	Pay-for-Performance (PIP) Measure	Final rates available 06/15/15	On track

4. Care Coordination and Services for Members with Complex Health Needs

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff Title	Activities	Timeframe	Status
A.	CareSupport Program Client Satisfaction	Increase the percentage of respondents to 10% and retain a rate of at least 85% of respondants who who rate CareSupport as	6% response rate in 2013; 87% "helpful" rating in 2013	Sr. Manager, Care Coordination	• Mailing to members who are closed twice during the year • Hand delivered surveys to active memebrs twice during thesection year	03/15/15 06/30/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff Title	Activities	Timeframe	Status
		"helpful"					
B.	CareSupport Client Engagement	Increase the percentage of members referred to CareSupport that are "engaged" to 85%	74% in 2014	Sr. Manager, Care Coordination	• Quarterly monitoring	Final report available 07/10/15	On track
C.	Complex Medical Case Management Client Satisfaction	Measure client satisifaction with new Complex Medical Case Management Program	No baseline, 2015 first year of measurement	Sr. Manager, Care Coordination	• Pending final development of program	Final report available 07/10/15	On track
D.	Complex Medical Case Management Client Engagment	Track engagmenet rate of new Complex Medical Case Management Program	No baseline, 2015 first year of measurement	Sr. Manager, Care Coordination	• Pending final development of program • Quarterly monitoring	Final report available 07/10/15	On track

5. Delegation and Oversight

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff Title	Activities	Timeframe	Status
A	Review of Policies and Procedures	Ensure that 100% of SFHP clinical policies and procedures are up to date, in alignment with contractual, statutory, and regulatory	No baseline available	Clinical Policy Administrator	• Timely approval of policies and procedures by QIC and PCC	12/31/15	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff Title	Activities	Timeframe	Status
		requirements, and applicable NCQA standards					
B	Quality Improvement Committee	Ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan in the six QIC meetings held in 2015	NA	CMO	• Six meetings to be held in 2015	12/31/15	On track
C	Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary is conducted in the 4 annual meetings	NA	CMO	• Quarterly and ad hoc P&T Committee meetings	12/31/15	On track
D	Provider Advisory, Peer Review, and Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee is conducted in the 6 annual meetings	NA	CMO	• Six meetings to be held in 2015	12/31/15	On track
E	Credentialing and Delegation of Credentialing Activities	Implement a Credentialing Program that is in accordance with NCQA Standards.	NA	Manager, Delegation Oversight	• Execute 2015 Credentialing Program • Develop the schema for a credentialing system in QNXT. • Ensure all non-delegated providers' lincenses and accreditation are up-	Ongoing in 2015	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff Title	Activities	Timeframe	Status
					to-date. • Provide oversight of delegated groups' credentialing activities through the annual audits, and periodic review of credentialing reports.		
F	Delegation of QI Activities	Ensure that Kaiser is providing 100% of delegated Quality Improvement activities outlines in the 2015 R3	No baseline, 2015 first year of measurement	Director, Health Improvement	• Annual Delegation Oversight Audit	Ongoing in 2015	On track
G	Delegation of CM Activities	Ensure that BTP, HIL, NEMS and CCHCA medical groups are providng 100% of delegated Case Management and Care Coordination activities outlined in the 2015 R3 agreements	No baseline, 2015 first year of measurement	UM Delegation Oversight Project Manager	• Annual Delegation Oversight Audit	Ongoing in 2015	On track
H	Provider Site Reviews	Ensure at least 90% of all PCP facility, medical record, and ADA-accessability (FSR-C) reviews due in 2015 are completed before	No baseline available	FSR Coordinator	• Ensure all SFHP PCP FSRs are up-to-date • Manage FSR work plan for SFHP, all delegated RN reviewers, and ABC RN reviewer • Lead quarterly FSR	Ongoing in 2015	On track

	Measure/Indicator	Goals	Benchmark/ Target	Responsible Staff Title	Activities	Timeframe	Status
		the end of the calendar year.			MOU meetings with ABC • Provide oversight of delegated groups' FSRs , including QA, IRR, and training • Implentation of using QNXT for FSR data for improved organization and accurate reporting		
J	Beacon Health Strategies QIC Plan	Ensure Beacon QI Plan is submitted ontime and is approved by SFHP QIC	No baseline	Director, Health Improvement	• Beacon QI Plan to be reviewed annually in June (pending DHCS approval of delegation agreement)	7/1/15	On track
K	% of encounter data that match medical records	Set baseline for Data Quality per DHCS Data Quality requirements	No baseline	Practice Improvement Specialist	• Audit primary care medical records consistency with encounter data	7/1/15	On track

Appendix II: Quality Improvement Committee Structure

External Committees:

Governing Board Membership

- Member Advisory Committee (2 seats)
- Individual Provider (1)
- Provider Network (5)
- Labor Representative (1)
- San Francisco Community Clinic Consortium
- San Francisco Department of Public Health (1)
- San Francisco Health Commission (1)
- Medical Society (1)
- Community Behavioral Health Services (1)
- Progress Foundation (1)

QIC Membership

- Member Advisory Committee (2 seats)
- Labor Representative (1)
- Provider Network (15)
- SFHP Staff:
    - CMO (Chair)
    - Director, Health Improvement

    As needed:
    - Associate Medical Director

MAC Membership

- SFHP CEO
- Health Plan members (28)

PAC Membership

- Provider Network (11 seats)
- SFHP Staff:
    - CMO (Chair)

    As needed:
    - Associate Medical Director
    - Provider Relations Staff

The following specialties are represented on our Physician Advisory Committee:

- Family Medicine
- Internal Medicine
- Pediatrics
- Rheumatology

P&T Membership

- Provider Network (13)
- SFHP Staff:
    - CMO (Chair)
    - Director of Pharmacy

Practice Improvement Program (PIP) Advisory Committee

- Provider Network (10)
- SFHP Staff:
    - Manager, Practice Improvement (Co-Chair)
    - Director, Health Improvement (Co-Chair)
    - CMO
    - PIP Program Manager
    - PIP Program Coordinator

Internal Committees Supporting the Work of External Committees:

Policy & Compliance Committee Membership

- SFHP Staff:
  - Compliance Officer (Chair)
  - Director, Finance
  - Sr. Manager, Human Resources
  - Manager, Claims
  - Director, Operations
  - Director, Clinical Operations
  - Administrator, Clinical Policies
  - Director, Provider Network Operations

Grievance Committee

- SFHP Staff:
  - Manager, Clinical Quality (Co-Chair)
  - Grievance Coordinator (Co-Chair)
  - CMO
  - Director, Health Improvement
  - Manager, Compliance & Regulatory Affairs
  - Compliance Officer
  - Director, Provider Network Operations
  - Director, Clinical Operations
  - Sr. Manager, Care Coordination
  - Manager, Customer Service
  - Director, Pharmacy

Delegated Network Oversight Committee Membership

- SFHP Staff:
  - Provider Network Operations Director (Chair)
  - Compliance Officer
  - Director, Clinical Operations
  - Manager, Delegated Member Group Oversight
  - Dir, Health Improvement
  - Dir, Pharmacy

Access to Care Committee Membership

- SFHP Staff:
  - Director of Health Improvement (Chair)
  - CMO
  - Chief Operations Officer
  - Manager, Practice Improvement
  - Dir, Clinical Operations
  - Dir, Enrollment
  - Dir, Provider Network Operations

Appendix III: SFHP Quality Committees' Policies and Procedures

QI-01 Quality Improvement Committee
Pharm-01 Pharmacy and Therapeutics Committee
QI-11 Physician Advisory Peer Review Credentialing Committee
QI-12 Peer Review Process
QI-10 Governing Board's Role in QI Programs
CLS-03 Member Advisory Committee

Other Patient Safety Policies and Procedures:
Pharm-03 Credentialing and Recredentialing of Pharmacy Providers
Pharm-07 Emergency Medication Supply
Pharm-09 Pharmaceutical Patient Safety
Pharm-13 After-Hours Pharmacy Access
QI-05 Access Policy & Standards
QI-07 Independent Medical Review