Agenda Item 1:

Action Item

Approval of Consent Calendar

a. Minutes from March 4, 2015 Board Meeting

b. Minutes from the February 12, 2015 Quality Improvement Committee

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Date: April 27, 2015

To	**SFHP Governing Board**
From	**John F. Grgurina, Jr.**
Regarding	**Consent Calendar Items for Approval**

Consent Calendar
All matters listed hereunder constitute a Consent Calendar and are considered to be routine by the Governing Board of the San Francisco Health Authority and San Francisco Community Health Authority Board and will be acted upon by a single vote of the Board. There will be no separate discussion of these items unless a member of the Board so requests, in which event the matter shall be removed from the Consent Calendar and considered as a separate item.

Item 1a

Recommendation to Approve Board Minutes
It is recommended that the Governing Board approve the minutes from the Governing Board meeting held on March 4, 2015. The minutes are attached for review.

Item 1b

Recommendation of the Quality Improvement Committee (QIC) Minutes
It is recommended that the Governing Board approve the attached minutes from the February 12, 2015 QIC meeting, as recommended by the QIC.

Agenda Item 1a:

Action Item

Approval of Consent Calendar

a. Minutes from March 4, 2015 Board Meeting

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Joint San Francisco Health Authority/San Francisco Community Health Authority
Governing Board
March 4, 2015
Meeting Minutes

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

Members Present: Dale Butler, Edwin Batongbacal, Sue Currin, RN, Irene Conway, Reece Fawley, John Gressman, Elena Tinloy, PharmD, Maria Luz Torre, and Brenda Yee

Members Absent: Eddie Chan, PharmD, Steve Fields, Steven Fugaro, MD, Barbara Garcia, and Belle Taylor-McGhee

Sue Currin, chaired the meeting and called the meeting to order. Ms. Currin asked if there was anyone from the public in attendance that wanted to make any comments. There were none.

1. Approval of Consent Calendar

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

a. Review and Approval of Quality Improvement Committee Minutes
b. Review and Approval of Member Advisory Committee Appointment

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

The minutes from the January 7, 2015 Board meeting were removed from the consent calendar to discuss a revision to the minutes. James Glauber, MD, Chief Medical Officer, stated that in the Medical Director's report he would like to revise the statement regarding the Department of Health Care Services' (DHCS) rate reduction for Express Scripts. He stated that it should state that Express Scripts is a PBM contracted by DHCS, with an exclusive arrangement for their Hepatitis C drug. A rate reduction for health plans has not been formally communicated by DHCS. The Board approved the revision to the minutes.

The Governing Board adjourned to Closed Session.

2. Approval of Year-To-Date Unaudited Financial Statements and Investment Income Reports

This item was discussed in closed session.

3. Review and Approval of Contingency Succession Planning

This item was discussed in closed session.

4. Review of Items that May Impact Provider Rates and Administrative Expenses

This item was discussed in closed session.

The Governing Board resumed in Open Session.

5. Report on Closed Session

Sue Currin reported that the Board approved the following action items.

a. Approved the Year-To-Date Unaudited Financial Statements and Investment Reports.
b. Approved the Contingency Succession Planning.

6. Review and Approval of Board Contract Approval Process

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

John F. Grgurina, Jr., CEO, reviewed the background of the contract approval process with the Board. 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 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 that case, the Board authorized the CEO to execute the agreement as long as the contract was within the approved parameters provided by the Board.

Mr. Grgurina stated the Finance Committee recommended approval, but with a slight modification for contract renewals. The Finance Committee recommended that Board approvals for annual contract renewals would not be required for up to five years. After

five years, the contract would be reviewed by the Board. With this change, the Board unanimously approved the Board contract approval process.

Mr. Grgurina also stated that after one year of experience with this policy, we will revisit the policy and determine whether any revisions would be required by the Board, as well as explore establishing a policy regarding a threshold for requests for proposals for vendor services.

7. Member Advisory Committee (MAC) Report

a. Review and Approval of 2015 MAC Goals

Maria Luz Torre and Irene Conway reported that the Member Advisory Committee met in February and reviewed their 2015 goals for forwarding to the Governing Board for approval. Ms. Torre and Ms. Conway briefly reviewed the proposed MAC goals.

After a discussion of issues and concerns about a goal regarding medicinal cannabis, the Board approved the Member Advisory Committee's 2015 goals with the removal of the goal related to medical cannabis.

Ms. Conway stated that the Committee is now at capacity of 30 members.

Ms. Torre also mentioned that Dr. Glauber, CMO, attended the meeting in February to discuss super viruses and how it is important to get flu shots. Dr. Glauber answered several questions from the Committee. The Committee was appreciative of Dr. Glauber' s presentation.

8. Chief Medical Officer's Report

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

Recommendation: San Francisco Health Plan (SFHP) recommends approval of the Evaluation of the 2014 Quality Improvement Program.

Dr. Glauber briefly reviewed 2014 QI Program Evaluation. The 2014 Evaluation successes and opportunities for improvement were a crucial input in development of the 2015 Quality Improvement Program and work plan. 2015 has an enhanced focus on outcome measures and has been structured to meet NCQA accreditation standards. (PowerPoint presentation summarizing the QI Program was provided in the Board packet.)

The Governing Board unanimously approved the Evaluation of the 2014 Quality Improvement Program.

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

Recommendation: San Francisco Health Plan (SFHP) recommends approval of the 2015 Quality Improvement Program and Work plan.

Dr. Glauber also reviewed the highlights of the 2015 Quality Improvement Program and Work Plan to the Board. (PowerPoint presentation showing highlights and work plan was provided in the Board packet.)

After some discussion regarding how much work was being required of primary care providers, Dr. Glauber said he will come back in May with additional clarification on

the work plan activities required by NCQA accreditation, DHCS audit corrective actions, DHCS contract requirements, and the impact on the provider network. The item was moved to the May Board meeting, pending receipt of the additional information.

9. CEO Report

John F. Grgurina, Jr., CEO, briefly highlighted the State budget, default assignment rate, and Form 700. (Please see the March 2015 CEO Report, incorporated as a reference document.)

Mr. Grgurina also thanked and congratulated Board members, Maria Luz Torre, Susan Currin, John Gressman, Steven Fugaro, MD, and Elena Tinloy for their reappointments from the Board of Supervisor Rule Committee for another term on the Board. In addition, Mr. Grgurina also mentioned Dr. Lawrence Cheung was also appointed to the Board and will be joining us in May. Lastly, Mr. Grgurina announced that Emily Webb, who was a former San Francisco Health Plan employee, will be joining the Board as well. Ms. Webb will be filling the seat left vacant by Grant Davies, Executive Director of California Pacific Medical Center.

10. Semi-Annual Compliance Report

Nina Maruyama, Officer, Compliance and Regulatory Affairs, reviewed the SFHP annual Compliance, Fraud & Abuse Report. The report is also submitted to the Department of Managed Health Care (DMHC). The enclosed summary in the Bard packet provides an overview of the report, as well as other updates related to compliance, fraud and abuse activities.

Ms. Maruyama also met with the Finance Committee, who suggested that the annual mandatory training be tied to the employee bonus for next fiscal year. Mr. Grgurina, Jr., will bring this item back in June or September.

11. Adjourn

The meeting was adjourned.

_____

Reece Fawley, Secretary

Agenda Item 1b:

Action Item

Approval of Consent Calendar

b. Minutes from the February 12, 2015 Quality Improvement Committee

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Quality Improvement Committee Minutes

Date: February 12, 2015
Meeting Place: San Francisco Health Plan, 201 Third Street, San Francisco, CA 94103
Meeting Time: 7:30-8:30am
Present: Irene Conway, Shawna Lamb, Dexter Louie, MD; Todd May, MD; Elena Tinloy, PharmD; Albert Yu, MD
Staff Present: James Glauber, MD; Collin Elane, Anna Jaffe, Kirk McDonald, Sunshine Middour, Jim Soos, Gabrielle Torres, Sari Weis, Nicole A. Ylagan

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 7:40 am • There were no public comments	•	•
Follow Up Items	• N. Ylagan informed the committee that SFHP's pharmacy dept does not have a formal review process for pharmacy dissatisfaction. They are able to resolve the complaints immediately. And they receive approximately one complaint per month. • A handout was included with the QIC binder of the infant mortality rates for African Americans and Caucasians.	•	•

Consent Calendar	• QIC minutes January 22, 2015 • CMO Report • January Membership Report • P&T minutes October 17, 2014 • CLS-06 Cultural Awareness • Pharm-04 Pharmaceutical Grants Consent Calendar was approved with no additional comments.	•	• QIC minutes January 22, 2015 - approved • CMO Report • January Membership Report • P&T minutes October 17, 2014 - approved • CLS-06 Cultural Awareness - approved • Pharm-04 Pharmaceutical Grants - approved
Policies and Procedures	• CARE-04 Complex Case Management SFHP should work with the Medical Group's Case Managers to help integrate this Program with their internal care coordination strategies. • CARE-05 Coordination of Care (previously UM-09) • UM-54 Evaluation of New Technology • UM-56 Potential Quality Issues The requirement for medical records should mirror hospital's policy regarding the investigation of PQIs. • SFHP Criteria Transgender Services Policies were approved.	• UM-48 Repatriation will be brought back to the committee on 4/9/15 per Dr. May's request.	• CARE-04 - approved • CARE-05 - approved • UM-54 - approved • UM-56 - approved • SFHP Criteria Transgender Services - approved
Quality Improvement	• Q4 2014 Grievance report was presented with new analysis of	•	• QI/UM Evaluation 2014 approved

	UM & Pharmacy appeals, identifying Access grievances, stratifying the number of grievances by Medical Group and clinic. Could you add an observation regarding trending of grievances from Q3-Q4, both by number and type? We need to demonstrate more robust consideration of grievances in the minutes. <u>QI/UM Evaluation 2014</u> • Written & structured to meet NCQA requirements • Assessed goal attainment as per 2014 Work Plan • Summarized key results with supporting metrics • Identified opportunities for improvement to be addressed in 2015 • 69% (20/29) of QI projects met their stated goals. <u>QI/UM Program Plan 2015</u> • Quality Committee Infrastructure Enhancements • Establishment of: Grievance Committee • Member Access to Care Committee		• QI/UM Plan 2015 - approved

	• Delegated Network Oversight Committee • Interdisciplinary Grand Rounds to review complex medical/psychosocial cases managed byour care coordination programs • Integration of additional UM and Pharmacy activities, such as MTM • Greater emphasis on outcome rather than process measures • Focus on 56 measures & indicators associated with clinical quality, patient safety, quality of service , access to care, utilization management, care coordination and services for members with complex health needs and delegation oversight. Both the QI evaluation 2014 and QI/UM Work Plan 2015 were approved with no additional comments.		
Utilization Management	The UM report Q3 2014 was presented. For the next UM report, the data will be presented quarterly rather than monthly.	•	•

QI Committee Chair's Signature & Date___ 2/24/15__

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

Agenda Item 4:
Discussion Item

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

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Agenda Item 5:

Action Item

Review and Approval of 2015-16 Employee Benefit Contracts

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MEMO

Date: April 27, 2015

To	**SFHP Finance Committee and Governing Board**
From	**John F. Grgurina, Jr., CEO**
Regarding	**Review and Approval of 2015-16 Employee Benefit Contracts**

Recommendation

San Francisco Health Plan (SFHP) recommends the following employee benefits for benefit year 2015-16 for Finance Committee and Governing Board approval:

- Replace Blue Shield of CA HMO and PPO with Aetna HMO and PPO.
- Renew Kaiser HMO, with an ER copay increase to $100 (matches Aetna HMO).
- Provide $0 contribution for employees with a salary of $75,000 or more, for either Kaiser or Aetna, to meet the requirement to have at least 50% participation in the non-Kaiser option. (Employees with a salary under $75,000 already pay $0 for Kaiser HMO and the non-Kaiser option.)
- Renew with Principal Dental.
- Replace Blue Shield Basic Life/ Accidental Death & Dismemberment (AD&D) with Principal Basic Life/AD&D.
- Change vision plan from EyeMed to VSP.
- Renew existing Employee Assistance Program (EAP), Voluntary Life, Short-Term Disability, and Long-Term Disability.

Background:

SFHP proposes changes to the employee benefits for benefit year 2015-16 to provide savings and overall improvements for employees' benefits. The change to Aetna HMO and PPO is proposed because the Aetna network would be a 99% match to the Blue Shield of CA HMO network and Aetna's PPO network would be a very close to the PPO network, with all major hospitals being in-network. There would also be premium savings compared to Blue Shield premiums. Although there would be an HMO $35 copay for urgent care and $15 copay for chiropractic care, there would be no deductibles for prescriptions. For the PPO network, there would be a 20% cost share after meeting the deductible and an additional inpatient copay of $150, but there would be better coverage for specialty drugs.

We recommend approval of the employee benefits contracts, as stated above, for benefit year 2015-16.

Agenda Item 6:

Action Item

Review and Approval of Payment of CalPERS Unfunded Liability

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Finance Committee & Governing Board

MEMO

Date:	**April 27, 2015**
To:	**Finance Committee and Governing Board**
From:	**John F. Grgurina Jr., Chief Executive Officer and John A. Gregoire, Chief Financial Officer**
Regarding:	**Review and Approval of Payment of CalPERS Unfunded Liability**

Recommendation:
San Francisco Health Plan (SFHP) recommends approval to pay the entire amount of SFHP's CalPERS pension unfunded accrued liability of $2,659,313 by June 30, 2015.

Background:
The Government Accounting Standards Board (GASB) Statement number 27 (GASB 27) is in reference to an accounting standard for pension by State and Local Government Employers. It specifies that an employer's fiscal year ending in 2015 must begin accruing for unfunded pension liability.

SFHP is a government employer in the CalPERS Miscellaneous Pooled Plans for the defined benefit pension plan known as 2% @ 55 for employees with hire dates prior to January 1, 2013 and 2% @ 62 for employees with hire dates after December 31, 2012. According to the most recent CalPERS statement in October 2014, SFHP's unfunded accrued liability as of June 30, 2014 is $2,659,313.

SFHP has "booked" the unfunded accrued liability amount of $2,659,313 in our February/March 2015 monthly financials statements. This means that it counted as an administrative cost to SFHP in this current year.

CalPERS is offering the following options to pay off the unfunded accrued liability:

1) Pay it back over a 30-year period with annual interest payments of 7.5% (this is the assumed annual investment rate of return CalPERS is using for all pension funds). This would mean total payments of $7,122,049 over 30 years (interest payments would be $4.5 million of this total amount).

2) Pay it back over a 25-year or 20-year period, or whatever shortened time period the organization selects.
3) Pay it all back now.

SFHP is recommending to the Finance Committee and the Governing Board to pay off the entire amount now. The reasons are:

1) It is financially advantageous to pay the entire amount to avoid the annual 7.5% interest payments (totaling $4.5 Million over 30 years) versus keeping the cash at our current annual investment return of 1.32%.
2) Because of SFHP's strong financial balance sheet, we currently have the cash to pay off the entire amount now.
3) Paying off the unfunded accrued liability would place SFHP's CalPERS pension funding level at approximately 100% (currently at 84%).

Included in the "Additional Background Information" section, for anyone interested in more details, is the letter from the CalPERS actuarial office on this issue.

Agenda Item 7:
Action Item

Review and Approval of FY15-16 Organizational Goals and Success Criteria

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Governing Board Meeting

MEMO

Date	**April 27, 2015**
To	**Governing Board**
From	**John F. Grgurina, Jr., Chief Executive Officer**
Regarding	**FY 2015-16 Organizational Goals and Success Criteria**

Recommendation

San Francisco Health Plan (SFHP) recommends the Board approve the annual organizational performance goals and success criteria for FY 2015-16. Depending on the financial results at the end of the fiscal year 2016, the Board will determine whether staff bonuses are appropriate, and if so, will use the performance criteria and results to determine the bonus amount. In addition, we recommend approval to require staff to complete four mandatory training sessions during the fiscal year in order to be eligible for a staff bonus.

Background

The Governing Board approved the following organizational goals for FY 14-15:

Goal 1: Strengthen Our Core (65%) –Strengthen our People, Processes and Technology

- **Develop and implement strategies to strengthen our People**
  Objective 1: Build and Maintain High Morale and High Performing Work Force Management and Staff training.
  Objective 2: Improve staff morale, performance, and retention through the Organizational Health Model, focused on improving cross-functional teamwork and institutionalizing meeting norms.

- **Develop and implement strategies to strengthen our Processes**
  Objective 1: NCQA
  Strengthen our ability to serve our members and providers through completing a mock interim NCQA accreditation survey, without complex case management. SFHP will pursue interim NCQA accreditation by July 2016.
  Objective 2: Eligibility - Improve member eligibility data processing and reconciliation. Procure and implement an "Other Health Coverage" Vendor; Minimize discrepancies among systems; and Reduce manual interventions.

Objective 3: Data Quality - Improve processes to support increased data quality and quantity.

- **Develop and implement strategies to strengthen our Technology**
  Objective 1: Roll out On Demand Ad Hoc Reporting capabilities to key users.
  Objective 2: Implement FY 2014-15 Technology Move - Prepare servers, network, desktops & other technology related infrastructure for the facility move.
  Objective 3: Maintain Healthy Applications and Data Warehouse.

Goal 2: Achieve Board-Approved FY14-15 Budget (15%)
Achieve a financial surplus equal to or greater than the Board-approved FY14-15 budget.

Goal 3: Comply and Respond to External Mandates (20%)
- Comply with State Encounter Data Modernization initiatives by the mandated date.
- Comply with numerous rates changes, report submissions, legislative and grant mandates received throughout the year.

Proposed FY15-16 Goals

SFHP's FY14-15 goals to strengthen the operational core met the needs of the organization as our membership grew to over 130,000 members. We believe the goal to "Strengthen our core," will continue to be appropriate for SFHP through 2016. For FY15-16, we propose to continue the focus on objectives and strategies that will further strengthen how we provide services to our members, providers and external agencies. Board-approved organizational goals and success criteria provide SFHP management with the foundation for establishing priorities and making resource decisions during the fiscal year.

After several years of establishing organizational goals and success criteria, it is clear that SFHP has been, and will continue to be in the near future, an organization with priorities that are heavily dictated by the Medi-Cal contract with the Department of Health Care Services, regulatory requirements as a health plan, and programmatic requirements of its third party administrative agreements, as well as grant agreements. In order to manage workload and resources effectively and realistically, SFHP proposes that the organizational goal to "Strengthen our Core," be measured in the following structure:

1. Strategic Priorities - 30% (30 points)
2. External Mandates – 70% (70 points)
3. Fundamental health plan functions to "keep the lights on" that are measured through department metrics

Strategic Priorities – 30% (30 points)
Goal 1: Access (15 points)
With the recent increase in health plan membership, SFHP identified a need to focus attention on improving access to services for our plan membership. The access improvement strategy includes an Access to Care Committee to oversee the monitoring of access and the development of provider interventions, ensuring network compliance with timely access requirements, and implementation of corrective actions, either directly as a Committee or through designated subgroups.

Goal 2: NCQA Interim Medicaid Accreditation (15 points)
As a continuation of the FY14-15 goal, SFHP will strengthen our ability to serve our members and providers through achieving NCQA Interim Medicaid accreditation status by July 2016.

Goal 3: External Mandates – 70%
SFHP is a mandate-driven organization. SFHP is required by the Department of Health Care Services, Department of Managed Health Care, City and County of San Francisco and grant program to complete many projects related to regulatory, contractual, programmatic, or grant requirements. As of today there are close to forty projects that we will be expected to completed in FY15-16 related to this category of external mandates. Failure to complete the projects timely or accurately may result in monetary or administrative fines and penalties, including termination of the grant or contracts. Each project will be measured against deadlines and completion of project success criteria.

Goal 4: Department metrics – 0%
Each department is responsible for implementing and monitoring measurable and effective metrics for the key functions of the department that ensure health plan operations are meeting the needs and expectations of the members, providers, and external agencies. The staff will be measured against their department metrics, as well as individual goals. Department metrics will not have an additional organizational score to avoid double counting toward the staff bonus, as the metrics will be counted toward the department score.

In addition, as recommended by the Governing Board and Finance Committee, we recommend that starting in FY15-16, in order to qualify to receive a staff bonus, employees will be required to complete the following four online compliance training courses that are either mandated by state law or regulatory agencies:

- HIPAA Privacy & Security Overview
- Health Care Fraud & Abuse Awareness
- Effective Cross-Cultural Communication
- California Harassment Prevention for Supervisors

All of these online courses will be available to the employee at any time during the fiscal year to ensure ample opportunity to reach our 100% completion rate, with the expectation that the courses will be completed by June 30 of the fiscal year. Employees will be reminded of due dates and that non-compliance will disqualify them for bonus payments and may also result in disciplinary action up to and including termination. The training requirements may change depending on new legislation. The Board and employees will be notified annually of any changes.

Please see the attached details for the proposed organizational goals and success criteria for FY 15-16 for the Board's review and approval.

FY 15-16 Organizational Goals and Success Criteria

Organizational Goal: "Strengthen Our Core"

Goal	OBJECTIVE	SUCCESS CRITERIA	POINTS
Strategic Priorities (30%)			
Goal 1	**Access:** SFHP shall establish an access improvement strategy that includes an Access to Care Committee to oversee the monitoring of access and the development of provider interventions, to ensure network compliance with timely access requirements, and to implement corrective actions, either directly as a Committee or through designated subgroups.	CAHPS Access Domain Improvement (50%) – 5 pts Improvement in Access Domain from 2015 Baseline results (available June 2015 and weighted by membership) • Stretch: 3% (5 points) • Meets: 2% (4 points) • Minimum: 1% (3 points) Accomplishment of Project Work Plan Milestones (50%)– 10 pts • Stretch: 100% (10 points) • Meets: 90-99% (9 points) • Min: 80-89% (8 points) **References:** Access to Care Work Plan	**15**
Goal 2	**NCQA:** Strengthen our ability to serve our members and providers through achieving NCQA Interim Medicaid accreditation status by July 2016.	***Meets:*** Achieve interim accreditation status by July 2016. The NCQA goal is an all or nothing measurement. All points will be awarded if interim accreditation is achieved; zero points will be awarded if it is not achieved.	**15**
Mandates (70%)			
Goal 3	**Comply with requirements mandated by state legislation, regulations, program contracts and grant agreements.** In FY 2015-16, SFHP will have at least 40 projects related to rate changes, DHCS and DMHC projects, legislative mandates and grant requirements. The list of these mandates will continue to expand and change throughout the year. The following are some of the larger projects: • Encounter data modernization • Medi-Cal Rate Changes and Pass-throughs • State ad hoc reports, e.g., mental health utilization • DHCS and DMHC corrective actions related to audit reports	***Stretch:*** Meet >= 90% of projects' deadlines or success criteria (70 pts) ***Meets:*** Meet 85-89.9% of deadlines or success criteria (60 to 69 pts) ***Minimum:*** Meet 80-84.9% of deadlines or success criteria (50 to 59 pts) Each project related to a mandate has a deadline or project plan with success criteria, depending on the scope of the mandate. Each project will be measured and scored for meeting the deadline or success criteria. At the end of the fiscal year, the results of all mandates	**70**

FY 15-16 Organizational Goals and Success Criteria

Goal	OBJECTIVE	SUCCESS CRITERIA	POINTS
	• Legislative mandates • Grant and Program Mandates (Healthy Kids, HSF)	will be compiled and scored against the stretch, meets and minimum measurements.	
Keeping the Lights On			
Goal 4	**Department Metrics** Each SFPH department implements and monitors metrics to track and score the departments' performance against measurements that align with the organizations' goals and ensure departments provide services to meet the health plans' obligations to members, providers and external parties.	All departments' metrics are defined and measurable. All departments' results are used as a factor in the calculation of employees' bonuses. To avoid double counting toward bonuses, department metrics are not awarded any points related to organizational goals.	**0**

Agenda Item 8:
Discussion Item

Member Advisory Committee Report

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201 Third Street, 7th Floor
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MEMO

Date: April 13, 2015

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

Enclosed are the minutes and agendas for the March and April0 2015 Member Advisory Committee meetings.

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

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

Meeting Agenda
March 6, 2015
1:00PM- 3:00PM
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: Mollie Tobias MS, MFT Program Director, SteppingStome, to Discuss the Organization

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:	April 3, 2015 (1pm -3pm)
Quality Improvement Committee:	April 9, 2015 (7:30am-9am)
Finance Committee:	May 6, 2015 (11am-12pm)
Governing Board:	May 6, 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.

March 6, 2015
Member Advisory Committee
Meeting Minutes

Members Present: Lourdes Alarcon, Starr Gul, Ed Evans, Raquel Cárdenas, Irene Conway, Charles Conway, Elia Fernandez, June Lynn Kealoha-Hall, Diana Jerome, Willow Lancaster, Vivian Lee, Ching Suk Lam, Chin Hong Lou, Un Un Che, Liu Zhong Chen, Anh Le, Shaowei Luo, Diane Maluia, A. Jon Martinelli, Gene Porfido, Merlin Nw, Lee Rogers, Linda Ross, Libah Sheppard, Maria Luz Torre, Kwai Fong Tsui, James Walker, and Idell Wilson

Members Absent: Nancy Rodríguez and Stacey Robledo

Excused: None

Guests: Mollie Tobias, MS, MFT Program Director, SteppingStone

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 two corrections to add the correct Member Advisory Committee meeting date for April and the guest speaker.

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 March 4, 2015.

   Ms. Conway and Ms. Torre reported that Lee Rogers nomination was approved by the Board and that Nina Maruyama will present the staff report in John Grgurina absence.

   The next Board meeting is scheduled for May 6, 2015.

   Quality Improvement Committee Report-Ed Evans and Irene Conway
   Irene Conway and Ed Evans reported that the Quality Improvement Committee (QIC) met on February 12, 2015.

   Ms. Conway mentioned the Committee only discussing and reviewing UM policies and procedures and the Care Support Program.

   Lastly, Ms. Conway and Mr. Evans 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. Two Members experienced the concern of not

receiving any follow-up care at home was discharged from the hospital. Both members left the meeting before giving details of their experience.

The next QIC meeting is scheduled for April 9, 2015.

Staff Report-Nina Maruyama, Officer of Compliance and Regulatory Affairs
Nina Maruyama attended the Members Advisory Committee meeting to discuss one of the Committees goals and why the Governing Board voted to remove that specific goal from their list. Ms. Maruyama explained that Ms. Torre and Ms. Conway did a great job of representing the Committee and wanted to thank them, however San Francisco Health Plan being a public agency we have to be careful what we put out there as an education item that may be interpreted the wrong way.

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

4. **Discussion:** Mollie Tobias, MS, MFT Program Director, SteppingStone
Mollie Tobias attended the Committee to introduce SteppingStone and present a short presentation about the organization.

SteppingStone is the largest independent provider of Adult Day Health Care (ADHC) in San Francisco; SteppingStone plays a critical role in meeting the healthcare needs of San Francisco's most vulnerable seniors. Founded in 1983, our primary objective is to help seniors and adults with disabilities improve their health and quality of life, and maintain their independence in the community.

SteppingStone (formerly North & South of Market Adult Day Health), is a 501(c)(3) non-profit organization that operates four Adult Day Health Care Centers that serve residents throughout San Francisco. SteppingStone is licensed by the State Department of Health Services and is certified as a MediCal provider with the California Department of Aging. Since 1983, the organization has worked tirelessly to help seniors overcome the obstacles to independent living by providing a cost-effective, stimulating, and comprehensive set of services that that are all available under one roof.

At each of our four Centers in San Francisco, we provide an array of services including nursing and personal care; medical social work services; meals and nutritional services; medication management; physical, occupational, and speech therapies; and social and recreational activities. We also offer round trip transportation to and from our four Centers via our wheelchair accessible vans. Presently, we serve over 300 ethnically diverse seniors and adults with disabilities each month.

Ms. Tobias was able to answered most of the Committee's questions. The Committee thanked Ms. Tobias for attending their meeting.

5. **Public Comment**
   The Co-Chairs continues to remind 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 were no prospective members in the audience this

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 4-3-15

Maria Luz Torre and Irene Conway, Co-Chairs

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

Meeting Agenda
April 3, 2015
1:00PM- 3:00PM
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: Open

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:	April 9, 2015 (7:30am-9am)
Finance Committee:	May 6, 2015 (11am-12pm)
Governing Board:	May 6, 2015 (12pm-2pm)
Member Advisory Committee:	May 8, 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.

April 3, 2015
Member Advisory Committee
Meeting Minutes

Members Present: Lourdes Alarcon, Ed Evans, Raquel Cárdenas, Irene Conway, Charles Conway, Elia Fernandez, June Lynn Kealoha-Hall, Diana Jerome, Vivian Lee, Ching Suk Lam, Chin Hong Lou, Un Un Che, Anh Le, Diane Maluia, A. Jon Martinelli, Gene Porfido, Lee Rogers, Linda Ross, Maria Luz Torre, Kwai Fong Tsui, James Walker, and Idell Wilson

Members Absent: Willow Lancaster, Merlin Nw, Nancy Rodríguez, Stacey Robledo, and Libah Sheppard,

Excused: Liu Zhong Chen, Starr Gul, and Shaowei Luo

Guests: None

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 and the minutes were approved as written.

3. **Committee Reports:**
   Chair & Governing Board Report-Maria Luz Torre
   Irene Conway and Maria Luz Torre co-chaired the meeting reported that the Governing Board was not scheduled to meet this month. The next meeting is scheduled for May 6, 2015.

   Directions were handed out to the new retail space on Kearny Street where the next Member Advisory Committee meeting will be held. Members were reminded to arrive on time, as the meeting will end 20 to 30 minutes early, in order to give the members a tour of the new facility. Valerie mentioned that goody bags will be distributed.

   Quality Improvement Committee Report-Ed Evans and Irene Conway
   Irene Conway and Ed Evans reported that the Quality Improvement Committee (QIC) did not meet. The next scheduled meeting is April 9, 2015.

   Staff Report-John F. Grgurina, Jr., CEO
   John F. Grgurina, Jr., CEO announced the opening of our new Service Center where we will be enrolling our members located at 7 Springs Street off of Kearny. In addition to this, Mr. Grgurina mentioned that the Members Advisory Committee will be having their Committee meetings right upstairs in a big conference room

located in the United Way building. In addition to this, Mr. Grgurina mentioned that San Francisco Health Plan will start enrolling members in Medi-Cal soon.

Mr. Grgurina briefly spoke about the move to 50 Beale Street, and 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:**
The Committee briefly discussed member absences and what are the steps to be taken. A copy of the bylaws will be provided at the next Committee meeting.

The scheduled guest presenters did not make it.

5. **Public Comment**
The Co-Chairs continues to remind 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 were no prospective members in the audience at this time. Membership seats are all filled up.

8. **Announcements**
Maria Luz Torre announced Joint Senate and Assembly Budget Hearing on CalWORKs and Child Care, April 14th and 16th at 10am, and the Stand for Children Rally in Sacramento on May 6 The Week of the Young Child starts on April 13. There will be a Walk Around the Block at City Hall on April 17 at 10 am. Un Un Che will speak at the rally.

Several other announcements were made by members.

The next Member Advisory Committee meeting will be at the new Service Center at 550 Kearny Street, San Francisco, Ca.

9. **Adjournment**
The meeting adjourned at 2.30pm.

Date Approved _____

_____
Maria Luz Torre and Irene Conway, Co-Chairs

Agenda Item 9:

Action and Discussion Items

Chief Medical Director's Report

- Review and Approval of 2015 Quality Improvement Work Plan
- 2014 Practice Improvement Program Preliminary Summary

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Governing Board Meeting

MEMO

Date: April 27, 2015

To **Governing Board**

From **James Glauber, MD, MPH**

Regarding **Review and Approval of the 2015 Quality Improvement Work Plan**

Recommendation

San Francisco Health Plan (SFHP) recommends the Governing Board approve the proposed 2015 Quality Improvement Work Plan. While there are a total of 57 measures or indicators, only 10 are new measures or indicators. We believe that of these 10 new measures, only two will have a significant impact on our provider network.

Background

Each year, the Governing Board reviews and approves the quality improvement program for the calendar year. In 2015, we propose a total of 57 measures or indicators for the year. Many of the measures are existing and are required by HEDIS, NCQA, Department of Health Care Services (DHCS), or Department of Managed Health Care (DMHC). Of the 57 measures in 2015, there are 10 new measures and indicators. Only the following two new measures, however, are tied to the practice improvement program (PIP) payments and therefore, may have a significant impact on the network:

1) Improve the rate of members who report that they “get care quickly” by 2% (DHCS and DMHC requirement).
2) Improve the rate of members who report they “get needed care” by 2% (DHCS and DMHC requirement).

While impacting the provider network, these are priorities of the medical groups as well. The other eight new measures are not tied to PIP measures and payments and are not likely to have a significant impact on the provider network. Most only impact SFHP staff workload.

We recommend Board approval of the 2015 Quality Improvement Work Plan. The detailed 2015 Quality Improvement Work Plan and summary grid of the measures, or indicators, are attached.

Clinical Quality and Patient Safety

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
1	Percentage of HEDIS Measures in the 90th%	Maintain the rate of publicly reported HEDIS measures in the Medicaid 90th percentile	• Member outreach • Provider outreach • Data quality improvement efforts • Comprehensive data capture	No	Yes	No
2	Cervical Cancer Screening (HEDIS)	Increase cervical cancer screening rates in members marked as female age 21-65 to the Medicaid 90th percentile	• Member outreach with incentive TBD • Ongoing monitoring • Pay-for-Performance (PIP) Measure	No	Yes	No
3	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	• Targeted member outreach with $25 • Ongoing monitoring • Pay-for-Performance (PIP) Measure	No	Yes	No
4	Childhood Immunization Status – Combo 3 (HEDIS)	Increase the rate of children age 2 and below with all Combo 3 immunizations	• Member outreach with $50 incentive • Ongoing monitoring • Pay-for-Performance (PIP) Measure	No	Yes	No
5	Immunizations in Adolescents – Combo 1 (HEDIS)	Increase the rate of adolescents age 11-13 with all Combo 1 immunizations to the 90th percentile	• Ongoing monitoring • Pay-for-Performance Measure	No	Yes	No
6	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	• Member outreach with $25 incentive • Ongoing monitoring • Pay-for-Performance (PIP) Measure	No	Yes	No
7	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	• Ongoing monitoring	No	Yes	No
8	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (HEDIS)	Reduce the treatment of adults with acute bronchitis with antibiotics	Ongoing monitoring	No	Yes	No
9	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	• Targeted member outreach with • Asthma texting	No	Yes	No

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
10	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	• Provider outreach • Ongoing monitoring • Pay-for-Performance (PIP) measure •	No	Yes	No
11	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	• Targeted member outreach with $25 • Ongoing monitoring • Pay-for-Performance (PIP) Measure • Diabetes texting	No	Yes	No
12	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	• Member outreach with $25 incentive • Ongoing monitoring • Pay-for-Performance (PIP) Measure	No	Yes	No
13	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	• Ongoing monitoring	No	Yes	No
14	Initial Health Assessment Rate	Improve member engagement with primary care by improving the IHA rate by at least 5 percentage points	• Monthly provider mailings • Analysis by medical group and clinic site	No	Yes	No
15	Pain Management	Ensure that 50% of patients in PIP participant pain registries have a both UTOX and Pain Agreement in the last 12 months	• Pay-for-Performance (PIP) Measure • Technical assistance offered • Education for providers, patients and staff (clinical and non-clinical)	No	No	No
16	Medication Therapy Management	Implementation of MTM program one provider group and performance guarantee in place for 1:1 ROI on drug cost savings interventions	• Identify site for implementation	Yes	No	No

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
	Quality of Service and Access to Care					
1	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	• Member outreach with raffle incentive • Ongoing monitoring	No	Yes	No
2	Timely Access Regulations (DMHC)	100% of provider network have no patterns of non-compliance	• Measure access compliance per recommended methodology • Implement corrective action plans for network with patterns of non-compliance.	No	Yes	Yes; if out of compliance, but not tied to PIP
3	Getting Care Quickly Rating (HP-CAHPS)	Improve the rate of members who report that they "get care quickly" by 2%	• Pay-for-Performance (PIP) Measure • Access Learning Initiative • CG-CAHPS for network • Coleman Rapid Dramatic Process Improvement	Yes	Yes	Yes
4	Getting Needed Care Rating (HP-CAHPS)	Improve the rate of members who report that they "get needed care" by 2%	• Pay-for-Performance (PIP) Measure for Specialists	Yes	Yes	Yes
5	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)	• IHC Communication Trainings • Customer Service trainings	No	Yes	No
6	Cultural Awareness Training for SFHP Staff	Increase the percentage of SFHP staff who participate in a cultural awareness training to 95%	• Online interactive module to be implemented 2014-2016	No	Yes	No
7	Member Grievances and Appeals	Resolve 100% of grievances within 30 days	• Quarterly Reports	No	Yes	No
8	Potential Quality Issues (PQI)	100% of PQIs resolved within timeframe	• Developing criteria and P&P for PQI • Monitoring report	No	Yes	No
9	Provider Alignment with the Practice Improvement Program (PIP)	Measure alignment of SFHP's P4P program with provider priorities	• PIP Advisory Committee Meetings • Subject Matter Expert (SME) meetings	No	No	No
10	PIP Block Funding (improve at least one outcome measure)	66% of PIP Block Funding Participants that demonstrate improvement in at least one measure	• Quarterly check-in call with • Financial incentive for reaching target	No	No	No

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
11	Practice Improvement Program	35% of participants that improve or meet top threshold in at least 75% of quantitative measures	• PIP Orientation • Training/Technical Assistance • Financial Incentive for meeting targets • ABCs of QI	No	No	No
12	Improve leadership capacity in provider network	75% of training participants report that the QCS training improved their effectiveness as a leader	• Identify key leadership topics needing improvement • Provide two leadership QCS trainings to providers	No	No	No
13	Primary Care Third Next Available (TNAA)	Improve TNAA in SFHN and NEMS by 5 days	• Implement access to care improvement strategy customized for San Francisco Health Network and North East Medical Services	No	Yes	No
14	Specialty Care Third Next Available (TNAA)	Improve TNAA in 3 specialty clinics by 5 days	• Implement access to care improvement strategy customized for Clinical Practice Group	Yes	Yes	Yes, for CPG only
15	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 --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	• 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 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	No	No	No

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
			• Secure more provider subscriptions to our monthly newsletter, used to proactively disseminate changes to Medi-Cal programs and other relevant info.			
	Utlization Management					
1	UM Timeliness of Decision and Notification	Ensure 90% of all prior authorization and concurrent review decisions are made within specified turnaround times	• 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 possible	No	Yes	No
2	Utilization Among Members in CareSupport's CBCM Program	Reduce inpatient admissions, acute inpatient days and ED visits	• Review average pre/post engagement utilization of 1) acute inpatient stays, 2) acute inpatient day, and 3) ED visits	No	No	No
3	Member Satisfaction with UM Processes	Conduct member satisfaction survey of UM processes	• Member survey	Yes	No	No
4	Provider Satisfaction with UM Processes	Conduct provider satisfaction survey of UM processes	• Provider survey	No	No	No
5	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	• Five cases per care coordinator, quarterly • Annual cumulative score	Yes	No	No
6	Interrater Reliability	Improve utilization management decision making by improving the nurses' and medical directors' clinical skill set by achieving an 80% or greater score using Interrater Reliability Assessment	• Yearly InterQual Interrater Reliability Assessment	No	Yes	No
7	Delegation of UM Activities	Ensure that BTP, HIL, NEMS and CCHCA medical groups are providing 100% of delegated utilization management functions	Annual Delegation Oversight UM Audit	No	Yes	No
8	Nurse Advice Line	Improve Nurse Advice Line to link clinical guidelines to level of care disposition	• 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.	Yes	No	No

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
9	UM Overutilization and Underutilization	Identify patterns of under or overutilization to create actionable steps to promote medically appropriate utilization of services	• Establish overutilization/underutilization review process • Establish utilization benchmarks for comparison • Development an action plans to remediate deviations from utilization benchmarks	Yes	Yes	No
10	Pharmacy Prior Authorization Turnaround time	Provide a decision to pharmacy prior authorization requests in 24 hours or one business day	Pharmacy and PBM reengineered process to managed more condensed TAT	No	Yes	No
11	ED Visits (HEDIS)	Reduce the number of ED visits by 2%	Pay-for-Performance (PIP) Measure	No	Yes	No
12	All Cause Readmissions (State QIP)	Reduce the rate of hospital readmissions by members to 16.4%	Pay-for-Performance (PIP) Measure	No	Yes	No

Care Coordination

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
1	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 "helpful"	• Mailing to members who are closed twice during the year • Hand delivered surveys to active members twice during the section year	No	Yes	No
2	CareSupport Client Engagement	Increase the percentage of members referred to CareSupport that are "engaged" to 85%	• Quarterly monitoring	No	No	No
3	Complex Medical Case Management Client Satisfaction	Measure client satisifaction with new Complex Medical Case Management Program	• Pending final development of program	Yes	Yes	No
4	Complex Medical Case Management Client Engagment	Track engagement rate of new Complex Medical Case Management Program	• Pending final development of program • Quarterly monitoring	Yes	No	No

Delegation and Oversight

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
1	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 requirements, and applicable NCQA standards	• Timely approval of policies and procedures by QIC and PCC	No	Yes	No

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
2	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	• Six meetings to be held in 2015	No	Yes	No
3	Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary is conducted in the 4 annual meetings	• Quarterly and ad hoc P&T Committee meetings	No	Yes	No
4	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	• Six meetings to be held in 2015	No	Yes	No
5	Credentialing and Delegation of Credentialing Activities	Implement a Credentialing Program that is in accordance with NCQA Standards.	• Execute 2015 Credentialing Program • Develop the schema for a credentialing system in QNXT. • Ensure all non-delegated providers' licenses and accreditation are up-to-date. • Provide oversight of delegated groups' credentialing activities through the annual audits, and periodic review of credentialing reports.	No	Yes	No
6	Delegation of QI Activities	Ensure that Kaiser is providing 100% of delegated Quality Improvement activities	• Annual Delegation Oversight Audit	No	Yes	No
7	Delegation of CM Activities	Ensure that BTP, HIL, NEMS and CCHCA medical groups are providng 100% of	• Annual Delegation Oversight Audit	No	Yes	No
8	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 the end of the calendar year.	• 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 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	No	Yes	No
9	Beacon Health Strategies QIC Plan	Ensure Beacon QI Plan is submitted ontime and is approved by SFHP QIC	• Beacon QI Plan to be reviewed annually in June (pending DHCS approval of delegation agreement)	Yes	Yes	No

	Measure/Indicator	Goals	Activities	New Program?	NCQA/DHCS/CAP requirement?	Require Additional Work from Network?
10	% of encounter data that match medical records	Set baseline for Data Quality per DHCS Data Quality requirements	• Audit primary care medical records consistency with encounter data	No	Yes	No

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

Agenda Item 9b:

Action and Discussion Items

Chief Medical Director's Report

- 2014 Practice Improvement Program Preliminary Summary

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Highlights of 2014 PIP Performance

Alignment

Patient Experience domain

Systems Improvement domain

James Glauber, MD, MPH

Governing Board

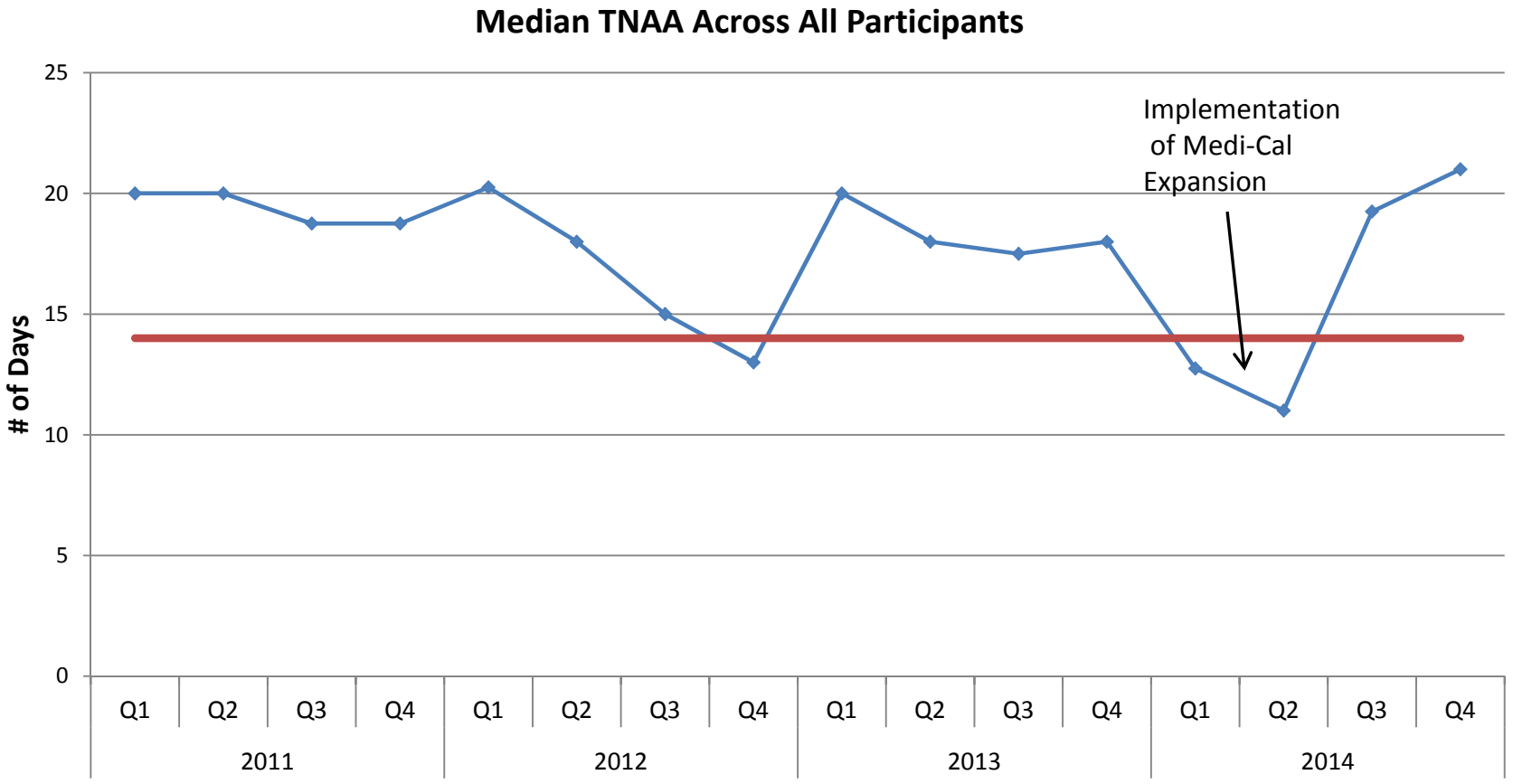
PIP is Relevant to Organizations' QI Efforts

Q: To what extent is SFHP's Practice Improvement Program (PIP) relevant to your organization's improvement priorities?

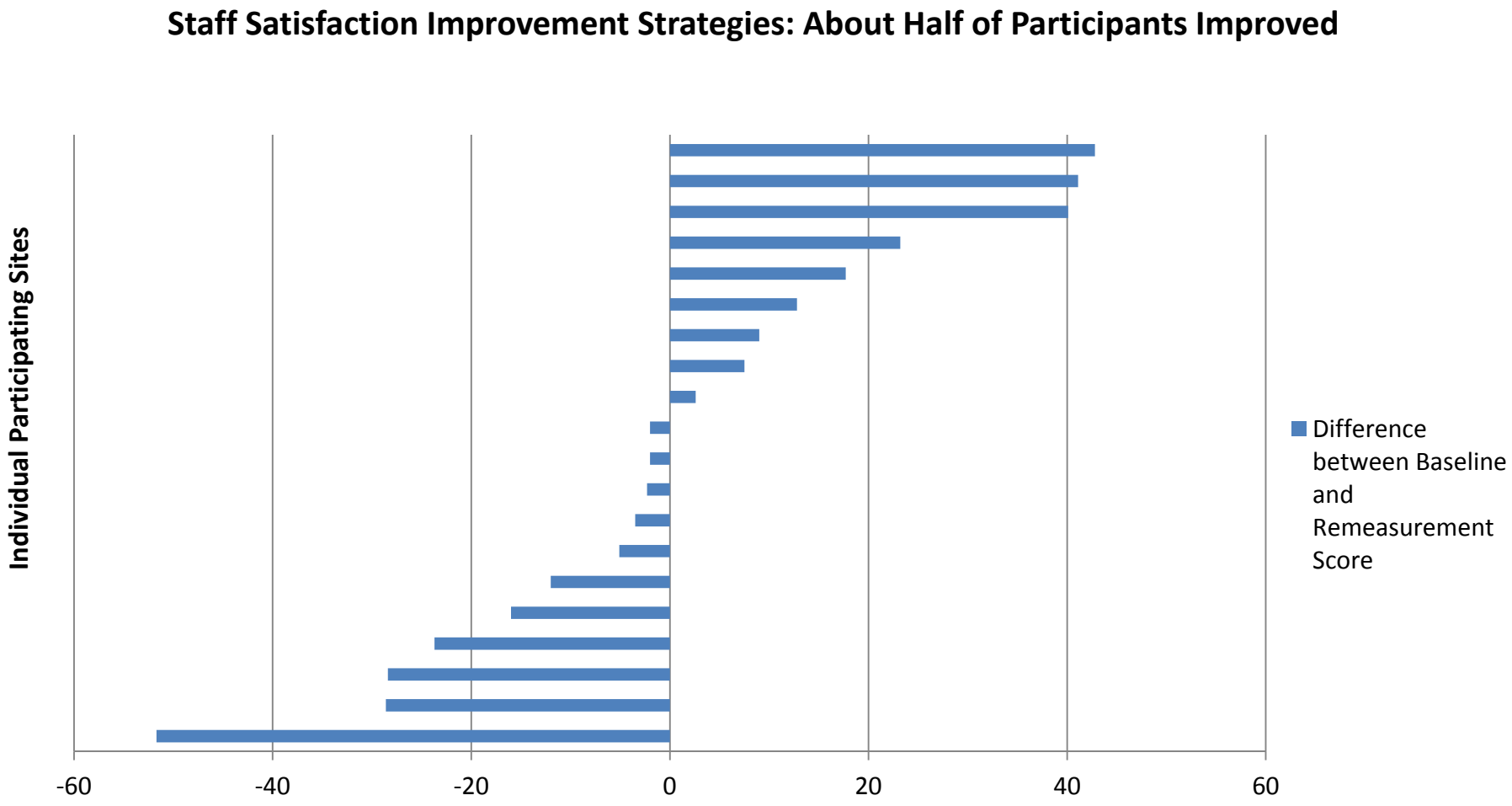
Surveys conducted in January 2015 at PIP Orientation and on 2015 Enrollment form

- n=44
- 77% gave top box scores (9-10)
- 9% gave low box scores (1-6)
- The average score was 9 out of 10

Patient Experience Domain

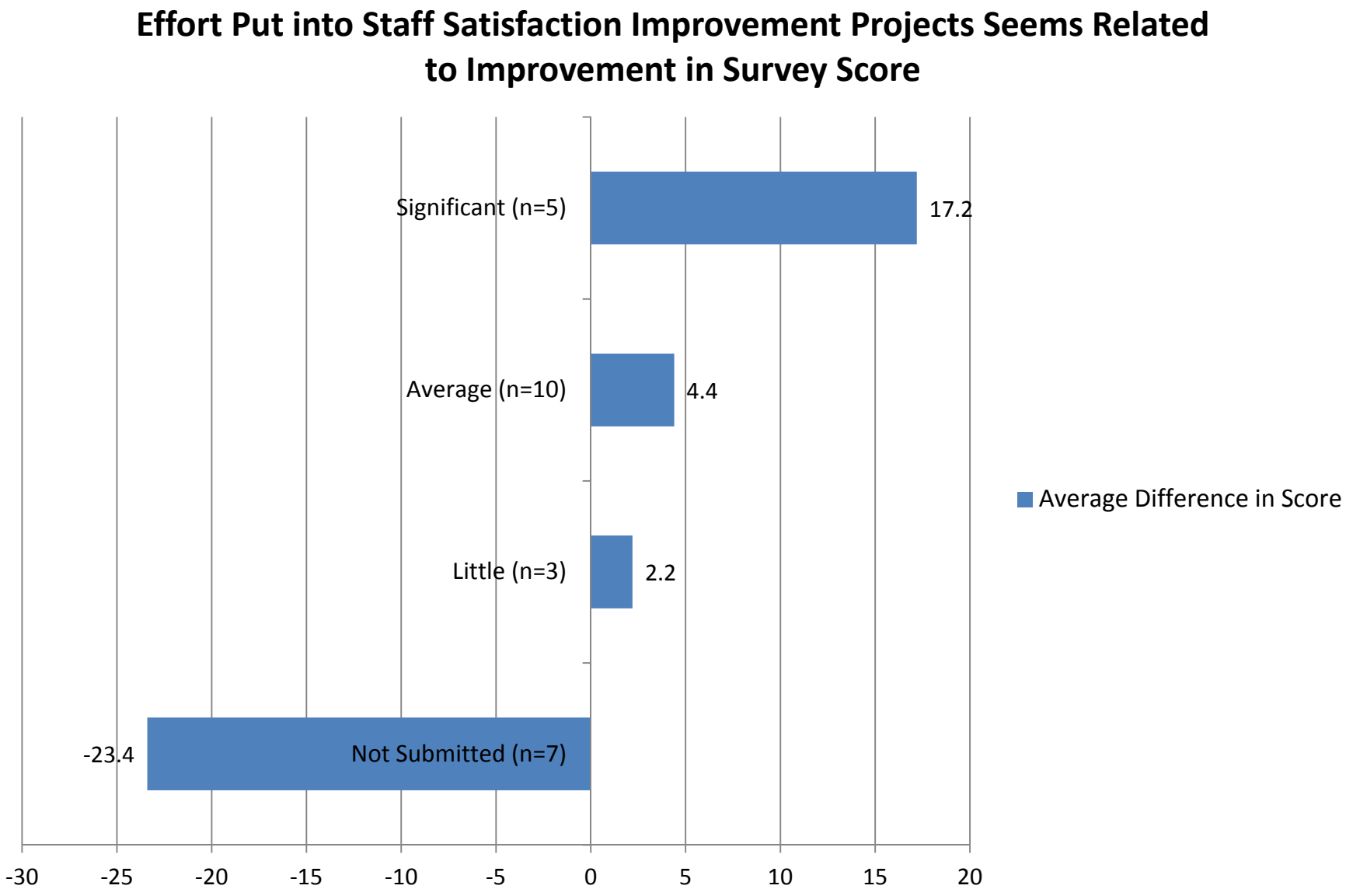


Patient Experience Domain

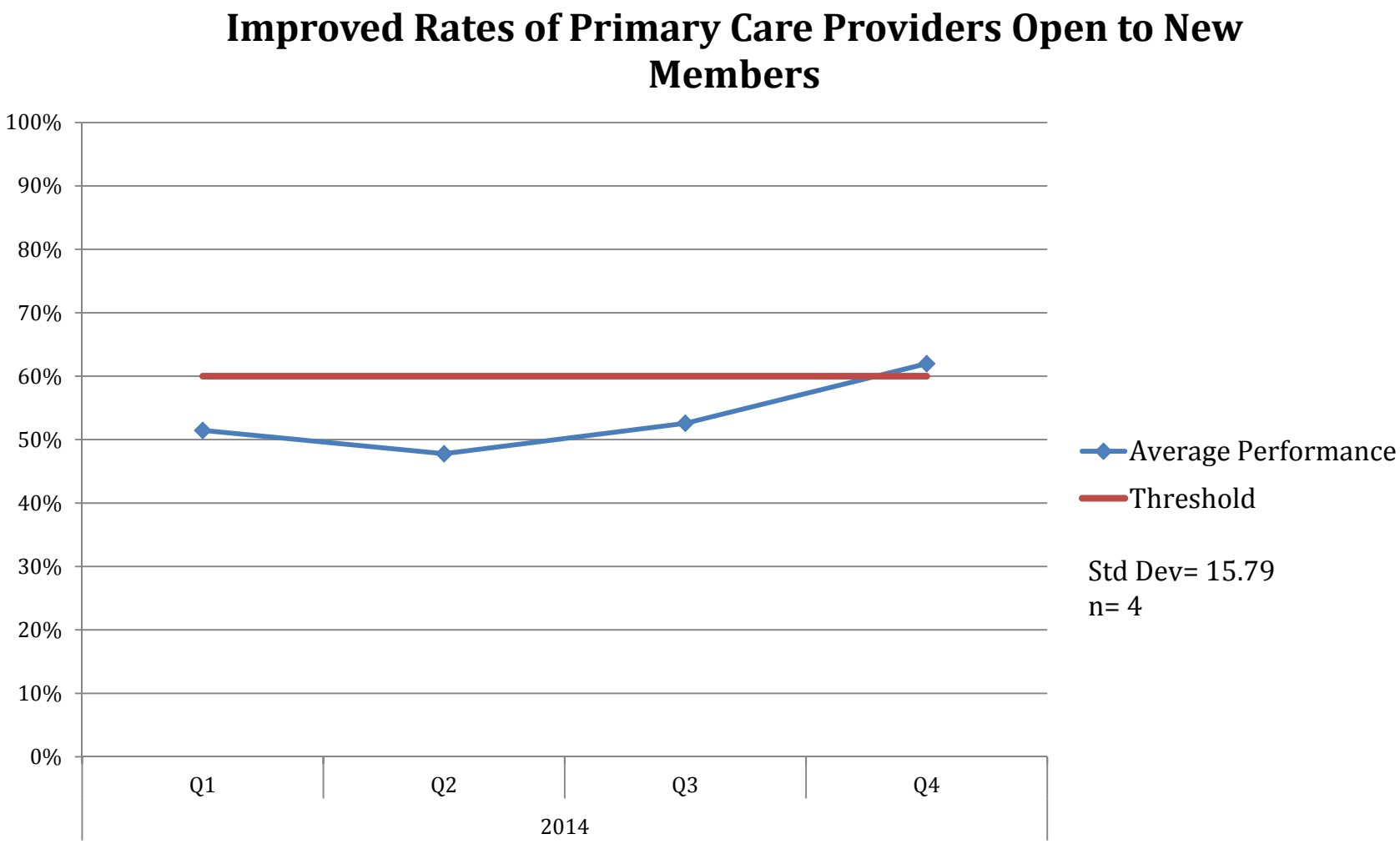


Average response rate was 81%, with an average improvement of 21.5 between baseline and re-measurement scores.

Patient Experience Domain

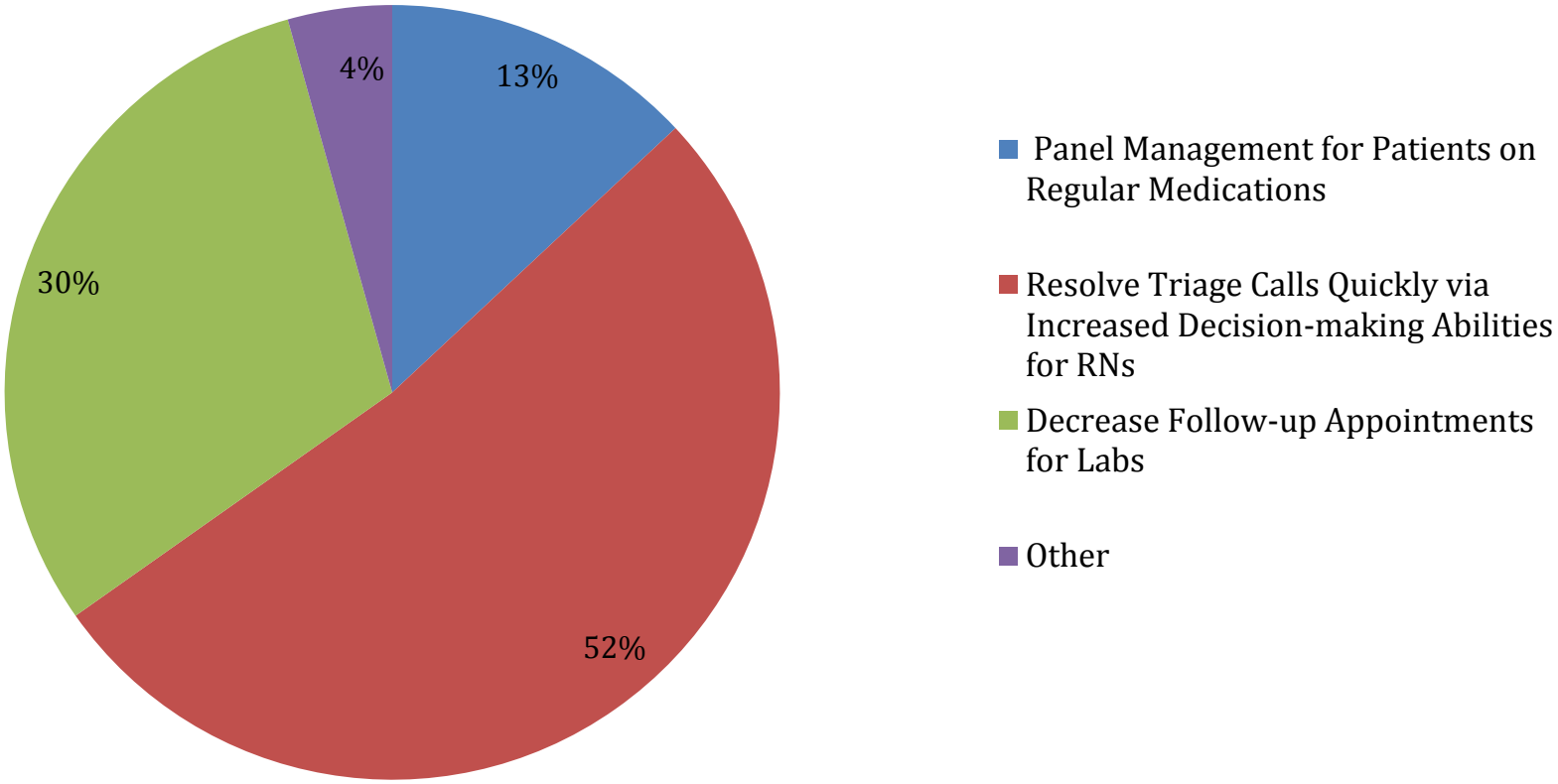


Systems Improvement Domain



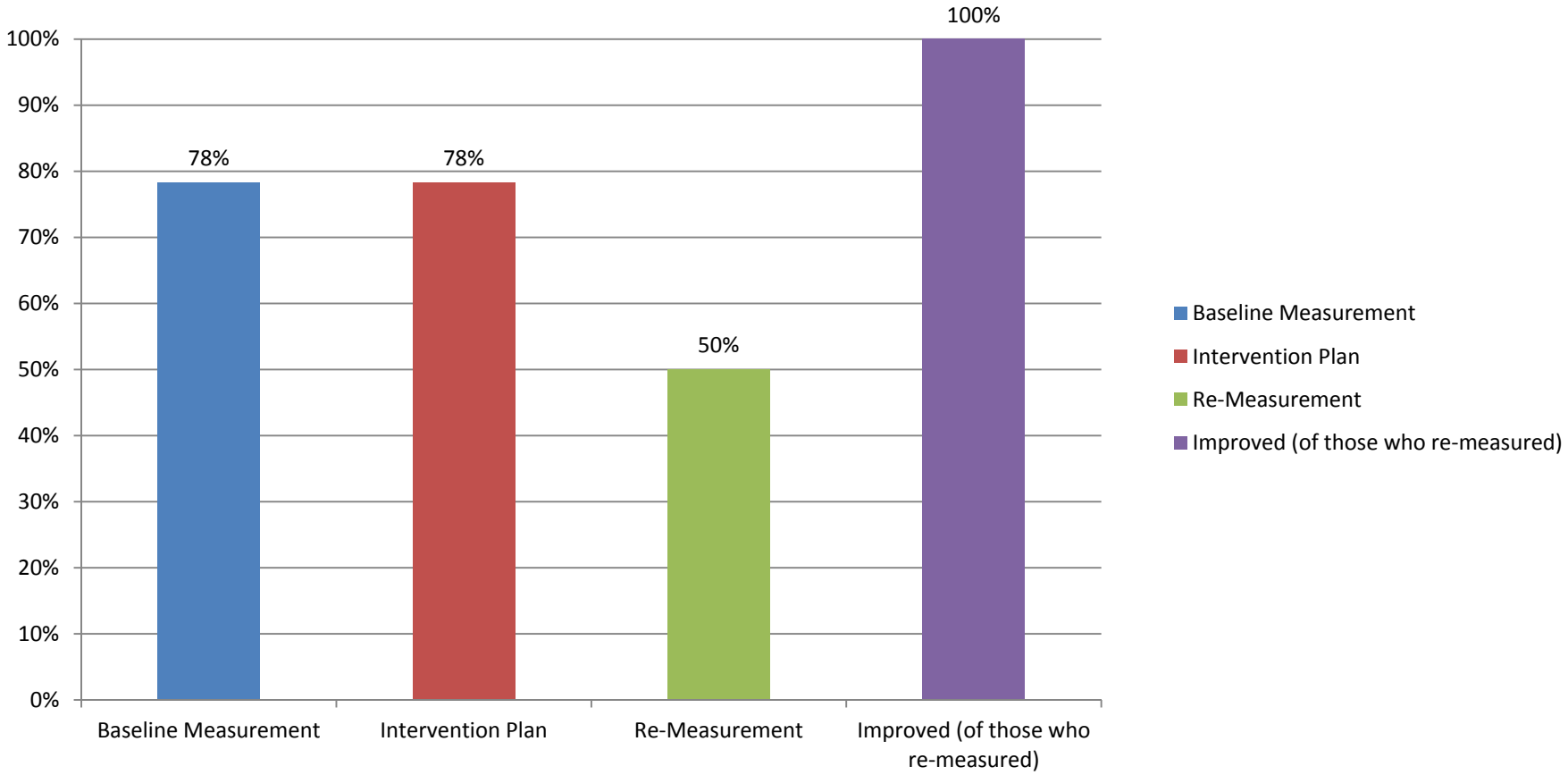
Systems Improvement Domain

Interventions to Reduce the Demand for Provider Visits: Majority of Participants Chose to Implement Standing Orders (n=23)



Systems Improvement Domain

Interventions to Reduce the Demand for 1:1 Provider Visits: Majority Started Project, Half Finished. Those That Finished, Improved. (n=23)



What's New in 2016?

- Inclusion of Specialty Measures
- Domains: Patient Experience and Timely Access

Agenda Item 10:
Discussion Item

CEO Report

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Governing Board

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

MEMO

Date: **April 27, 2015**

To: **Governing Board**

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

Regarding: **CEO Report for May 2015 Governing Board Meeting**

State & Federal Update

Section 1115 Waiver Proposal Submitted by DHCS to CMS

The Department of Health Care Services (DHCS) submitted its Section 1115 Medicaid Waiver Renewal proposal "Medi-Cal 2020" to the Centers for Medicare and Medicaid Services (CMS) on March 27, 2015. California's current "Bridge to Reform Waiver", approved in November 2010, which authorized key initiatives such as the Low-Income Health Program, mandatory enrollment of Seniors and Persons with Disabilities (SPDs) into managed care and the Delivery System Reform Incentive Pool (DSRIP), expires this year. The DHCS proposes to continue some of these 1115 waiver programs, such as the mandatory enrollment of SPDs in managed care, DSRIP, the Community Based Adult Services Program, and matching of state only programs (such as the Genetically Handicapped Person Program) in its new waiver request.

Several new, ambitious proposals are included in the Medi-Cal 2020 proposal, with a focus on coordination and alignment of care and delivery systems, including:

- **Coordination of behavioral health and physical health** between managed care plans, providers and county specialty mental health plans with an incentive pool available for demonstration of improved patient outcomes

- **Whole Person Care Pilots** for high utilizing, high need members at the county and regional level, which may be in coordination with the Section 2703 Health Homes Proposal

- **Improved care delivery in Medi-Cal Fee for Service**, particularly maternity and dental services, with incentive payments available to providers meeting quality and access metrics

- **Housing and Supportive Services** where a federal match would be provided for housing subsidies and intensive case management/housing supports for homeless Medi-Cal members

- **DSRIP** with five domains of quality improvement and population health advancement, such as patient safety measures and care coordination for high risk, high utilizing populations

- **Workforce Development and Capacity**, including financial incentives to increase the supply of Medi-Cal providers and access, training in mental health, substance use, and long term services and supports for non-clinical care team members, increased use of telehealth, and permitting non-physicians to be trained and certified for Screening, Brief Intervention and Referral to Treatment (SBIRT)

- **Shared Savings** where the state, managed care plans and providers would be allowed to maintain a portion of the federal Medi-Cal savings resulting from improved health outcomes and lower costs from coordination of care

The DHCS waiver submission is still very high level, with many more financial, timeline, and key operational details and decisions that must be made. For example, managed care plans play a central administrative and financing role in most aspects of the waiver, but the plan's actual operational responsibilities, ability to control or reach utilization decrease targets and meet care improvement metrics (which have not been detailed but generally referred to) within likely resource limitations are unclear and must be determined.

The DHCS has commenced discussions related to this proposal with CMS, which are anticipated to last through the fall. Legislation is likely required to enact some of the waiver proposals and the first year of the legislative session ends September 11.

The Local Health Plans of CA and CA Association of Health Plans continue to monitor the waiver process closely, given the significant potential responsibility, lack of financial details, and short implementation timelines. We will continue to keep you updated on development in the coming months.

Health Homes Concept Paper Released

Section 2703 of the ACA authorizes states to establish the Medicaid Health Home State Plan Option, which would provide Medicaid members with chronic conditions a full-

range of team-based, physical and behavioral health services and community-based long-term services and supports. The goals are to improve care coordination and health outcomes and result in net cost avoidance. Section 2703 provides a 90% federal match for eight quarters to states implementing this state option. Additionally, legislation signed by Governor Brown in 2013 authorizes the California Endowment to match the remaining 10% of the cost, up to $25 million annually, subject to an evaluation after two years and a finding of General Fund neutrality.

On April 7, the DHCS released a second draft concept paper for comment and review of its Health Homes for Patients with Complex Needs (Health Home Project or HHP). The DHCS' HHP is similar in goals and complementary in structure to what is currently an SFHP Care Support team initiative supported by a grant from the California Health Facilities Financing Authority. If approved, the SFHP grant funded initiative would be eligible for at least 2 years of Medi-Cal funding, with the potential for permanent Medi-Cal funding should the HPP show state General Fund neutrality.

The DHCS proposes to structure the HHP as an entitlement program that is voluntary for Medi-Cal members but mandatory for Medi-Cal managed care plans. The HHP would be operated through Medi-Cal managed care plans, which would establish networks of community based providers to offer services such as comprehensive care management, care coordination and health promotion, transitional care, individual and family support services, and referral to community and social supports. The DHCS must certify readiness by the Medi-Cal managed care plan prior to implementation, which is currently proposed for January 2016 or July 2016, depending upon eligibility criteria.

The HPP payment would be directed to Medi-Cal managed care plans, which would be responsible for negotiating contracts and setting rates with community based providers. There would be a health plan specific rate that would need to be developed with the DHCS based on the acuity of the patients enrolled. In addition, there would be an enhanced member engagement reimbursement rate for the first three months to pay for required initial assessments, contacting and enrolling members and developing a member's individualized health action plan (HAP). An HAP is required for future payment. Lastly, health homes must provide at least one core health home service each quarter for payment to occur.

The DHCS is beginning a stakeholder process for comments on its concept paper with the hope of submitting a state plan amendment to CMS by August. SFHP and its trade associations will be participating in these discussions and SFHP will seek to align this program with its current grant funded initiative.

Covered CA Releases Preliminary Results of Second Open Enrollment

On April 16, Covered CA released preliminary results through April 15 of its second open enrollment for the 2015 plan year for Sacramento and the Greater Bay Area, including San Francisco (Region 4). This special second open enrollment, which ends on April 30, is available for Californians who certify they were unaware of the tax penalty implications of the ACA. Normally, only qualifying events, such as birth, marriage or

loss of employment would trigger the ability to enroll outside of open enrollment. For tax year 2015, the tax penalty rises from $95 per person or 1% of income, whichever is greater, to $325 per person or 2% of income, whichever is greater.

For San Francisco, the second open enrollment period has resulted in an additional 25,456 individuals enrolling, a more than 62% increase above the 40,825 that enrolled in the 2015 first open enrollment that ended February 15. 11,393 have chosen a carrier, and the vast majority of those choosing a carrier, chose Kaiser. Over 14,000 San Franciscans still need to choose a carrier. Not surprisingly, over 54% in both open enrollment periods enrolled in silver tier plans, given the link to the federal subsidy.

Please see the table below for these preliminary results. We will provide further updates for 2015 once Covered CA releases the final results of 2015 two open enrollments.

San Francisco (Region 4)

2015 Open Enrollment (Results through April 15)

Metal Level of Individuals Enrolled*

Metal Level	First Open Enrollment		Second Open Enrollment	
Minimum Coverage	914	2.2%	298	1.2%
Bronze	13,288	32.5%	9,416	37.0%
Silver	22,363	54.8%	13,860	54.4%
Gold	2,079	5.1%	1,026	4.0%
Platinum	2,181	5.3%	856	3.4%
Total	**40,825**	100.0%	**25,456**	100.0%

Carrier Selected of Individuals Enrolled*

Carrier	First Open Enrollment		Second Open Enrollment	
Anthem Blue Cross of California	7,212	17.7%	1,489	13.1%
Blue Shield of California	9,085	22.3%	2,535	22.3%
Chinese Community Health Plan	11,550	28.3%	2,063	18.1%
Health Net	2,354	5.8%	227	2.0%
Kaiser Permanente	10,613	26.0%	5,079	44.6%
Total	**40,814**	100.0%	**11,393**	100.0%

May Revision to Be Released Next Week

The Governor's May Revision, where he updates major revenue and expenditures from his January 2015-16 Proposed State Budget, will be released May 12. While the Assembly and Senate budget subcommittees have been reviewing the Governor's January budget proposal over the last month, most actions are taken by the Legislature once the May Revision is released. The May Revision is expected to reflect California's revenue growth, which is currently several hundred million dollars above January's levels. Much of this revenue growth will be directed to K-12 and community colleges

under the Proposition 98 minimum funding guarantee. California's constitutional deadline for passage of the state budget by the Legislature is June 15, and the 15-16 fiscal year begins July 1. Last year, the state budget passed the Legislature on time, and was signed by Governor Brown on June 20. The Department of Health Care Services (DHCS) has informed health plans that capitation payments to health plans will not be released until after the budget is signed. SFHP, however, does not foresee any delays in provider payments.

We will provide a summary of the Governor's May Revision to the Board once it is released.

SAN FRANCISCO HEALTH PLAN STRATEGIC ANCHORS

Strategic Anchor 1: Universal Coverage

Healthy San Francisco Program Enrollment (as of March 31, 2015)

Total Enrollment
A total of 16,192 participants were enrolled in Healthy San Francisco as of March 31, 2015.

City Option Program, As of March 31, 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. April is typically a high dollar volume month for employers participating in the City Option program, as it is a quarter end. The results of April 2015 will be available for the June board meeting.

City Option Program Data – As of March 31, 2015

	Program-to-Date (PTD)	March 2015
Employers		
Employers Participating in City Option Program	2,240	
Employers with Contributions Within the Past 12 Months	n/a	1,471
New Participating Employers	n/a	12
Total City Option Program Contributions	$337.2M	$3.1M
Contributions Assigned to HSF	$113.9M	$0.5M

	Program-to-Date (PTD)	March 2015
Contributions Assigned to MRA	$223.2M	$2.6M
Employees		
Employees Receiving City Option Employer Contributions	163,467	
Employees Enrolled in HSF	15,047	1,506
Number of Medical Reimbursement Accounts with Deposits	110,981	4,822
MRA Claims Paid	$101.1M	$3.6M
MRA Dollars Available	$108.3M	

Medi-Cal Expansion Updates

As of April 1, 2015, SFHP active enrollment in the Medi-Cal expansion-related aid codes, L1, M1, and 7U, is 47,113 members. This number includes 2,678 new members and 1,514 disenrollments in April. 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

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)
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 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 members; 143 did not choose	1,240 members of 1,653 non-choosers (75%) were defaulted to DPH
March	21 members	2,273 M1 members; 1,315 did not choose	126 members; 100 did not choose	1,415 members of 1,887 non-choosers (75%) were defaulted to DPH
April	10 members	2,268 M1 members; 1,769 did not choose	126 L1 members; 116 did not choose	1,457 members of 1,887 non-choosers (75%) were defaulted to DPH

SFHP MEMBERSHIP UPDATE

In April 2015, the total SFHP enrollment for all lines of health plan business was 134,447 members. Global membership was relatively flat, with an increase of 0.1% (15 members) from March 2015, but increased by 33% (36,088 members) since April 2014.

Overall Medi-Cal membership was also relatively flat, with a 0.02% increases (3 members) from March to April 2015. Compared to April 2014, Medi-Cal enrollment increased by 38% (33,492 members). **Please see Attachment 1** for SFHP Membership and HSF Participant reports.

STRATEGIC ANCHOR 2: QUALITY CARE & ACCESS

HEALTH SERVICES

Health Improvement

Practice Improvement Program (PIP)
The PIP Advisory Committee reviewed the performance of the 2014 PIP program. There were notable improvements in a variety of measures, including staff satisfaction, team-based care, and chronic pain management. While there have been improvements in third next available appointments, thresholds continue to be below the state requirement of 10 business days for non-urgent primary care and 15 business days for non-urgent specialty appointments. The 2015 measure set has an enhanced emphasis on access.

PIP participants were asked the extent to which the PIP is relevant to their improvement priorities. Overall, 77% of participants rated PIP's relevance a 9 or 10 (out of 10). SFHP attributes this high rating to provider engagement, benchmarking PIP to ensure relevance, and flexing some measures to suit the San Francisco medical community.

Access Improvements
In response to findings in SFHP's 2014 DHCS Audit (and expected findings in the 2015 DHCS/DMHC audit), SFHP is focusing access improvement efforts on the two largest segments of SFHP's network (NEMS and SFHN). Knowing that together these groups care for approximately 71% of SFHP's Medi-Cal membership, SFHP hopes to see significant improvement in member satisfaction as measured via CAHPS. SFHP will continue to support other parts of SFHP's network with their access improvements, including offering Coleman Rapid DPIs and technical assistance.

HEDIS
Last fall, SFHP received the 2014 HEDIS Bronze Quality Award from the Department of Health Care Services (DHCS) based on its HEDIS Measurement Year (MY) 2012 results. As a result of SFHP's award-winning performance in HEDIS, SFHP's auto assignment default rates increased as of February 2015 to its highest rates yet, with 100% for Seniors and Persons with Disabilities, and 95% for all others.
Currently, SFHP is engaged in meticulous data collection for MY 2014. HEDIS data collection concludes on May 15, 2015, at which time SFHP will have its preliminary HEDIS rates. SFHP's goal for HEDIS MY 2014 is to achieve 46% of publicly reported measures in the 90th percentile, and no measures in the 25th percentile.

Population Health Management

In response to DHCS' designation of "Controlling High Blood Pressure" as a new auto-assignment measure, SFHP launched a new member incentive program for members with hypertension in November 2014. The program encouraged members to get a blood pressure check from their PCP by the end of 2014, and to write a "Healthy Heart Action Plan" in order to receive a $25 gift card. Information about the incentive was sent out to over 7,000 members, with 1,057 successfully fulfilling requirements for the incentive.

Currently SFHP is finalizing the development of its new Disease Management (DM) program. SFHP has identified asthma and diabetes as the two chronic conditions relevant to its membership and in need of improvement based on MY2013 HEDIS rates. The program stratifies members into four disease categories based on diagnosis, acuity and encounter history. Each stratified group will receive targeted interventions appropriate for its level of disease acuity. A suite of new health education material has also been developed for both chronic conditions. SFHP is contracting with CareNet Healthcare Services to provide live outreach and assessment calls to members in the program. For both diabetes and asthma, the new DM program will align with SFHP's existing interventions (e.g. HEDIS incentives and the DMTxt Diabetes Texting and Asthma Texting program). The DM program is projected to launch prior to the end of the 2014-2015 Fiscal Year.

Care Coordination

Effective March 2015, the CareSupport team was re-named Care Coordination. This team encompasses three Care Coordination programs including CareSupport (SFHP's name for Community-Based Care Management), Complex Medical Case Management *(*coming soon for our medical complex members*),* and Time-Limited Coordination (shorter-term interventions to help members with key coordination of care needs).

The CareSupport Community-Based Care Management (CBCM) CHAMP Demonstration Project submitted the 2nd Quarter Status Report to the California Health Facilities Financing Authority (CHFFA) and continued successful progression of Phase 1 activities of the Project Schedule.

Pharmacy

The Pharmacy Department implemented the DHCS-mandated 24-hour turnaround time January 1, 2015 and is successfully at a 99% compliance rate. This required a huge shift in our daily operations and we are proud to report our success to date.

SFHP's total cost of new Hepatitis C drugs (Harvoni, Solvaldi and Olysio) to date is $5.9 million (M), with $1.7M (28.8%) incurred from January 1, 2015 to March 31, 2015. Hepatitis C continues to drive our pharmacy spending and operation workload. From January 1 –March 31 2015, 145 prior authorizations have been received for the new Hepatitis C drugs for 70 unique members. SFHP received 90 appeals for Hepatitis C

treatment from January 1, 2014 – March 31, 2015. Supplemental reimbursement, "kick-payment," from DHCS alleviates some of the financial burden of these agents experienced by the plan. SFHP has received DHCS payments for all Hep C payments submitted to DHCS.

SFHP has been partnering with OutcomesMTM since November 1, 2014 to provide a medication therapy management program for Medi-Cal Seniors and Persons with Disabilities (SPD) members. Since implementation, we have provided MTM services to 292 members.

The SFHP post-graduate year one (PGY1) managed care pharmacy residency program is in American Society of Health Systems Pharmacists (ASHP) pre-accreditation status. ASHP informed SFHP that our accreditation survey dates have been moved to October 22-23, 2015.

STRATEGIC ANCHOR 3: EXEMPLARY SERVICE

SERVICE CENTER UPDATE

SFHP's Service Center opened on March 31st as scheduled. Through the first three weeks of operations, the Service Center staff have scheduled 273 appointments, serving Medi-Cal, Healthy San Francisco and Healthy Kids members. The Service Center has experienced one to three walk-in appointments per day. Comments from visitors have been positive, although a few had some difficulty finding the new office. We have implemented a satisfaction survey and have received 174 responses to date. We will provide a report of responses in the June Board report. The first member Advisory Committee meeting will be held at the new location on May 8th. Please see **Attachment 2** for photos of the Service Center.

Community Relations staff, who are also located at the Service Center will participate in the annual Cinco de Mayo celebration in the Mission district. The event will be held on May 2nd on Valencia St., between 21st and 24th Streets. We will be scheduling appointments to meet requests for enrollment assistance.

OPERATIONS UPDATE

<u>Operations Update</u>
Operations, which is comprised of the departments of Business Solutions, Claims, Customer Service, Enterprise Project Management, Member Eligibility Management, Provider Network Operations and Continuous Improvement, continues to work collaboratively with other departments to improve health plan operations and also to implement initiatives and mandates, such as ICD10 implementation and NCQA.

Key projects and tasks in-process include: Office relocation, implementing the new administrator (Beacon) to manage the non-specialty mental health (NSMH) benefit and the autism benefit, and implementation of a project management and tracking tool.

Department metrics for 2015-16 are being finalized. The team continues to work on tasks and projects to strengthen core operations. We are preparing to embark on the upgrade of one of our core administrative systems, QNXT.

Claims

1. Claims Department continues to process claims for non-specialty mental health services until Beacon is approved by the Department of Managed Health Care (DMHC).
2. February 2015 Claims turnaround time (TAT) was at 99.6% under 30-days and 100% within the mandated 45-day TAT. The auto-adjudication rate goal was met at 78.1% for February 2015.
3. Provider dispute resolution (PDR) rate was at 0.97% which is under the target of 1.02%; PDR Acknowledgement and Determination letters met the mandated TAT at 100% and 99.6% respectively for February 2015.

Customer Service (CS)

1. Finalized the new Kaiser permission-to-enroll process proposed by Kaiser.
2. Trained and implemented the new Medi-Cal application appointment-scheduling features in TimeTrade to help the Enrollment Department with Medi-Cal enrollments.
3. Created user acceptance testing (UAT) scenarios for data center and main office move; executed successful UAT for the data center cutover.
4. Completed training of Customer Service staff to take Claims calls.

Member Eligibility Management (MEM)

1. Outreached all existing Medi-Cal and HW members who will turn 65 years old in the following month but had no Medicare coverage, and assisted them to apply for Medicare.
2. Researched about 600 member records for other health coverage and updated necessary information to coordinate benefits for members.
3. Reported 200 cases of Medi-Cal members with other health coverage to DHCS electronically within 10 calendar days.
4. Reconciled over 1,600 Active/Term member records to ensure accuracy of members' eligibility.

Performance and Process Improvement

Through process efficiencies and continuous improvement, the Performance & Process Improvement team has realized cost savings of $584,000 year-to-date. These cost savings are good examples of the internal collaborative efforts of many people across SFHP and an example of how we "Strive to Excel" by keeping our costs as low as possible for our Members and Providers.

Provider Network Operations

1. Implemented new contract with All City Sleep Center (requested by SFHN)
2. Finalized re-negotiation with skilled nursing provider SF Health Care thereby reestablishing referral stream from SFHP.
3. Coordinated delivery and submission of medical records submission via face-to-face office visits with 24 different provider offices in preparation for last minute DHCS audit.
4. FSR Nurse instituted new collaboration with Children, Health and Disability Prevention (CHDP) agency to streamline provider site review process.
5. In negotiations to expand ancillary provider network in the areas of: Home Infusion, Home Health, Acute Rehab, Dialysis.

STRATEGIC ANCHOR 4: FINANCIAL VIABILITY

ENCOUNTER 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 successfully submitting in the new format since January 2, 2015. Since our last update, the following key accomplishments have been achieved:

1. Identified and tested remediation options for submission of Brown & Toland encounters to DHCS since DHCS requires an National Provider Identifier (NPI) for the billing provider, but Brown & Toland refuses to obtain an NPI because it is not required to do so as an independent physician association.
2. Successfully tested Kaiser 837 inpatient and professional files submission to SFHP and are preparing to receive all historical Kaiser encounters from October 2014 to present for processing & submission to DHCS. The remainder of the work entails successful conversion of Kaiser pharmacy encounter from proprietary to NCPDP format.

Performance below encounter data quality standards may result in health plan financial and administrative penalties.

CAQH COMMITTEE ON OPERATING ROLES FOR INFORMATION EXCHANGE (CORE)

CAQH CORE is a federal mandate for all health plans to provide timely electronic responses to our trading partners as it relates to eligibility & benefit inquiries, claims status and EFT/ERA transmission. All health plans must be certified by December 31, 2015, in order to avoid substantial financial penalties on a per member per day basis. As part of this effort, SFHP engaged a consulting firm, Edifecs, to complete an internal gap assessment to determine current areas of non-compliance, along with various remediation options. The next step is for SFHP to decide on a remediation option with a target to test our remediation effort by August 2015.

TECHNOLOGY MOVE PROJECT

The Technology Move Project is comprised of three major parts.

1. The move of SFHP's Enrollment staff to the new facility know known as the Service Center, located at Kearny and Spring Streets.
2. The Data Center Move which is the move of SFHP's computing infrastructure to a dedicated data center facility located in Santa Clara.
3. The move to the new SFHP headquarters location at 50 Beale Street.

SFHP's Enrollment staff was successfully relocated to the Service Center. The Service Center was open for business on Monday, March 30th as scheduled. All supporting technology was available as planned.

The move of SFHP's computing infrastructure to the Santa Clara data center was completed successfully on April 10th. This was the project to move the bulk of our servers to an offsite, secure location as part of our plan to facilitate business continuity in the event of disaster. After comprehensive systems and user testing, all systems were then made immediately available and returned to service for production access.

MAIN OFFICE RELOCATION

The Main Office project at Beale Street is on schedule. Construction phase was completed on time and under budget. The furniture has also been installed. The space is designed to provide maximum natural light and to foster collaboration across the organization. ITS is currently working on connectivity. The Move Team, with representatives from ITS, Facilities/Finance, Marketing/Communications and Operations has worked diligently to ensure a smooth transition to the new space. Targeted last day of business at 201 Third Street is May 22nd. First day of business at the new Main Office is May 26th. Testing of systems will occur on Monday, May 25th.

The exit from 201 Third Street offices entails the removal of all furniture, fixtures and equipment and will be completed by June 30th.

MEDIA ROUNDUP

Please see **Attachment 3** for the Media Roundup with articles related to the SFHP Service Center, Covered CA and Medi-Cal expansion.

GOVERNING BOARD MEMBER UPDATES

As reported at the last meeting, we welcome our new Board member, Lawrence Cheung, MD, who replaces Dr. Randall Low. We also welcome Emily Webb, a former SFHP employee, as a new Board member. She fills the seat left vacant by Grant Davies, representing California Pacific Medical Center. Both are expected to attend the May Board meeting.

NEXT BOARD MEETING LOCATION

We are excited to host the June 10, 2015 Finance Committee and Board meetings at our new Main Office at 50 Beale Street. We will provide detailed directions and parking instructions prior to the June meeting.