San Francisco Health Plan

2016 Quality Improvement Program Evaluation
1. Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement (QI) Program is to assure high quality care and services for our members by proactively seeking opportunities to improve the performance of our internal operations and health care delivery system.

SFHP’s QI Program is detailed in the SFHP QI Program Description. The QI Program Description contains an annual Work Plan, outlined in Appendix I, representing the current year improvement activities and measure targets. The QI Work Plan is evaluated on an annual basis. The QI Evaluation provides a detailed review of progress toward the measures and goals set forth in the QI Work Plan. In this evaluation, the results are presented in six activity domains:

- Clinical Quality and Patient Safety
- Quality of Service & Access to Care
- Utilization Management
- Care Coordination and Services
- Delegation Oversight

At the time of this evaluation, not all data for the 2016 measures have been finalized. As such, only measures with finalized data are included. SFHP will publish an amendment in early 2017 with the remaining measures.

1.1 Executive Summary

Oversight

Under the leadership of SFHP’s Governing Board, the Quality Improvement Committee (QIC) oversees the development and implementation of the QI Program and annual QI Work Plan. The QIC is supported by multiple other committees detailed in the Quality Committees Structure (Appendix B). SFHP’s Quality Committees, under the leadership of the Chief Medical Officer, assure ongoing and systematic involvement of SFHP’s members, medical groups, practitioners, and other key stakeholders.

Impact of QI Program on Patient Safety

SFHP successfully influenced network-wide safe clinical practices through a multi-pronged approach including adopting clinical guidelines, implementing the pain management program, incentivizing primary care follow-up after acute hospital discharge, and incentivizing population health best practices through a pay-for-performance program.

SFHP has adopted two clinical practice guidelines related to chronic conditions (asthma and diabetes) and two additional clinical guidelines related to behavioral conditions (adult depression in primary care and ADHD in primary care). The guidelines help assure that clinical practices align with current best practices, providing safe and effective care to SFHP’s members.

SFHP continues to operate a comprehensive pain management program, driving to ensure safe opiate prescribing practices. SFHP convenes a safety-net pain management workgroup that advises SFHP on
pain management provider trainings, updating practice guidelines, ensuring safe opiate prescribing, and improving patient function while minimizing risk.

In addition, SFHP monitors timely assessment and follow up on Potential Quality Issues (PQI) through its quality program. PQIs can be sourced from a variety of mechanisms, including grievances, utilization management activities, and case management activities.

The Pay-For-Performance program reinforced patient safety activity through rewarding performance in pain management best practices, follow-up outreach after member discharge from the hospital and HEDIS clinical quality best practices.

SFHP launched and operates a discharge planning program in order to ensure members’ safe transition from the hospital and prevent possible readmission.

**Participation in the QI Program: Leadership, Practitioners, and Staff**

During 2016, senior leadership, including the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) provided key leadership for the QI program. The CEO championed SFHP’s NCQA journey and an organization-wide effort to improve member’s ability to access services in a timely manner within the provider network. This included instituting ‘NCQA Accreditation Preparation’ and ‘Access to Care’ as organizational strategic priorities. In addition, the CEO ensured there were regular reports at Board meetings on the QI program components.

The CMO provided day-to-day support for all quality improvement studies and activities, and was responsible for leading the Quality Improvement Committee, Physician Advisory and Peer Review, Credentialing Committee, the Pharmacy and Therapeutics Committee, and the Grievance Committees. The Medical Director provided clinical leadership for the Pain Management program, Case Management Program, and Disease Management Program.

Beyond SFHP Medical Directors, practitioner participation in the QI program was achieved through involvement of providers in the Quality Improvement Committee, the Practice Improvement Program Advisory Committee that advises on the pay-for-performance program (i.e. PIP), and the annual HEDIS/PIP review meetings during which health plan leadership meets with senior leadership in the network to review outcomes and solicit input on the health plan QI program. Overall, leadership and practitioner participation in the QI program in 2016 was sufficient to support the execution of quality objectives. Additionally, SFHP administered 19 member focus groups to better inform development of QI measures, targets, and barriers.

The staff accountable for implementing the annual QI Work Plan represents the cross-functional nature of quality improvement activities at SFHP. Staff monitor quality indicators and programs, and implement and evaluate SFHP’s QI work plan. For a detailed summary of all staff supporting the QI Program, please refer to the Quality Improvement Program Description.
1.2 Factors Influencing Implementation of QI Programs in 2016:
SFHP plans the QI Work Plan for the upcoming year prior to the start of the year. Throughout the year, expected and unexpected challenges may impact implementation of planned activities. Some of the factors that may have impacted the 2016 QI Program include:

- **Medi-Cal Expansion** - With the advent of Medi-Cal expansion in 2014, SFHP membership has grown significantly. This sustained growth introduced operational challenges for both SFHP and its providers, even though several years have passed. These challenges had an impact on the ability to establish, maintain, and meet the targets of the QI work plan throughout the year. For example, the Cervical Cancer Screening HEDIS rates dropped significantly due to the large increase in the eligible population for reporting year 2016. In addition, members recently gaining health care access have increased demand for services, making it difficult to ensure timely access to care.

- **Infrastructure Improvement: Essette Care Management System** - In 2014, SFHP implemented Essette, an enterprise-wide application, designed to strengthen its utilization management, care coordination, grievance management, and population health efforts. Each year, SFHP implements several enhancements to improve overall care coordination for our members. In 2016, SFHP implemented a significant upgrade contributing to greater stability and versatility, new assessments supporting discharge planning and decreased readmissions, and Potential Quality Issue documentation and tracking allowing for greater information sharing with utilization management and grievances. Essette use has increased staff efficiencies, but also impacted staff capacity as they participated in the implementation of new functionalities.

- **Implementation of Additional State Mandates and Benefits** - In 2016, SFHP has implemented or is implementing three state mandated benefits, including acupuncture, 12-month supply of contraceptives, Health Home program development, and adult immunizations. In addition, several major state mandates affected SFHP, including new provider directory requirements, and new pharmacy authorization requirements. While these benefits and mandates ultimately improve the care and services that SFHP members receive, these requirements impacted SFHP staff availability for other projects.

- **Network Operational Challenges** - Operational challenges in the network are typical for public health clinics, especially in times of sustained membership growth. For many, the additional membership increased demand significantly, causing workflow and access challenges for members. In addition, staff and provider turnover in public health clinics tend to be high, causing loss of QI knowledge, affecting overall sustainability of improvement activities. To address these challenges, SFHP implemented a QI collaborative in 2016. The collaborative trained over 35 staff across 12 San Francisco clinics.

- **NCQA** - SFHP committed to achieving interim NCQA accreditation. NCQA preparation requires significant SFHP resources as we initiated several new programs and overhauled many of our existing processes. While positively impacting health plan ongoing operations, NCQA preparation impacted staff time devoted to QI measures in the short term.
1.3 Highlights from the 2016 QI Program Measures
The San Francisco Health Plan had many positive outcomes during the 2016 QI Program Evaluation period. SFHP sets high stretch goals each year, ensuring that we are improving at an adequate pace. As such, many performance measures have demonstrated strong improvement even if the goal was not met. Of the 16 measures reported in the 2016 QI Program Evaluation, 8 met the target. SFHP is currently finalizing measurement for an additional 13 measures; these will be included in a QI Program Evaluation Amendment to be published in early 2017. SFHP will utilize lessons learned from 2016 to evolve the QI Program in 2017 and continue to strive for improvements in internal operations and outcomes.

In summary, SFHP identified the following areas from the QI Work Plan as either demonstrating effectiveness or as opportunities for improvement:

**Quality of Service and Access to Care:**

SFHP met 3 of the 4 measure targets impacting the quality of service and access to care domain. An additional three will be included in the amendment to be published in early 2017. Some notable improvements include:

- Demonstrated improvement in HP-CAHPS “Overall Rating of Health Plan” and “Getting Needed Care.”
- Demonstrated significant improvement in provider satisfaction with SFHP services.
- Developed systems to engage a broad group of SFHP stakeholders for improving member access.
- Incorporated member perception of specialty care access in SFHP’s Pay-for-Performance program.
- Secured resources for SFHP’s provider network to build needed infrastructure to improve access, offered in the form of the Strategic Reserve Grants.

Recommendations for continued improvement include:

- Continue to utilize annual member feedback through the CAHPS survey to develop targeted interventions to improve member experience when accessing care.
- Tailor access improvement interventions to meet the needs of individual provider groups, through Strategic Reserve Grants.
- Collaborate with Marketing and Customer Service departments to continue improvement in HP-CAHPS “Overall Rating of Health Plan.”

**Clinical Quality and Patient Safety:**

SFHP met 2 of the 7 measure targets impacting the clinical quality and patient safety domain. An additional one measure will be included in the amendment to be published in early 2017. Some notable improvements include:

- The provider network continues to provide exemplary clinical quality as demonstrated by 12 HEDIS measures meeting NCQA Medicaid 90th percentile.
- Member incentives are rated highly by the provider network and help continue to incentivize utilization of preventative care services.
• SFHP has evaluated its performance and prioritized resources for the additional HEDIS measures required for NCQA accreditation.

Recommendations for continued improvement include:
• Prioritize a subset of the HEDIS measures to ensure that improvement efforts are focused and targets are achievable.
• Validate the initial health assessment methodology to ensure that it accurately reflects SFHP’s performance.

Care Coordination:
SFHP met 4 of the 5 measure targets impacting the care coordination and services domain. Some notable improvements include:
• Demonstrated exceptional member satisfaction for the Complex Medical Case Management program.
• Demonstrated exceptional improvement in self-reported health as a result of the Community Based Case Management program.
• Successful implementation of a discharge planning program, in support of decreasing All Cause Readmissions.

Recommendations for continued improvement include:
• Continue focus on improving health outcomes by fully implementing the Disease Management and Complex Medical Case Management programs.
• Align Care Coordination efforts with other state and national programs, such as Health Homes and NCQA requirements.
• Continue to expand discharge planning activities, as resources allow.

Utilization Management:
Measures in this domain will be reported in the amendment published in early 2017.

Delegation Oversight:
Measures in this domain will be reported in the amendment published in early 2017.
2. Quality of Service and Access to Care

2.1 Rating of Health Plan

Measure Summary

The Rating of Health Plan measure from the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) survey assesses member perception of SFHP overall and is in the Quality of Service and Access to Care domain. This measure is important for SFHP’s NCQA accreditation, since Rating of Health Plan is worth two times that of the other seven composites when scored for NCQA accreditation. Therefore, SFHP will prioritize and focus on the performance of this measure in order to perform well in NCQA accreditation.

Measure Target, Results, & Barriers

The Rating of Health Plan performance is based off of one question from the HP-CAHPS survey: “Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?” The results for this rating represent the percentage of members responding 8, 9, or 10 out of the total responses to the above question.

The target of 2% improvement was determined by consulting with SFHP’s vendor, and is based on industry knowledge of achievable improvement from year to year. SFHP expected to meet this target by July 2016.

<table>
<thead>
<tr>
<th>Baseline performance: 64.16%</th>
<th>Final performance: 67.82%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 66.16%</td>
<td>☒ Target was met</td>
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<tr>
<td></td>
<td>☐ Target was not met</td>
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</tbody>
</table>

The main barrier in meeting this target was the timeline for fielding the survey. By the time many of the activities were implemented in January and February of 2016, members were already being re-surveyed due to the survey fielding period. Members are surveyed from January to March 2016 based on their experience in the prior 6 months. Therefore, the impact of activities implemented during 2016 will not likely appear in the survey results until the 2017 survey fielding period.

Accomplishments

The activity conducted to reach the target was an improvement project with SFHP’s Customer Service department to help improve performance in the HP-CAHPS regarding members needed information. The question is part of the Customer Service composite: “In the last 6 months, how often did your health plan’s customer service give you the information or help you needed?” SFHP’s Customer Service was chosen as SFHP’s CAHPS vendor listed it as a key driver for “Rating of Overall Health Plan.”

The performance improvement project identified key drivers to improve performance in the HP-CAHPS Customer Service question, such as member engagement, provider awareness and healthcare navigation. Additionally, the project identified interventions that would support improvement such as three-way phone calls with Medi-Cal and use of evidence-based practices in Customer Service.
Customer Service also implemented more regular measurement of member satisfaction by phone to help drive improvement by asking the HP-CAHPS customer service question to a sample of member callers. Survey administration lasts for one week each month. During this week Customer Service Representatives survey members after call questions are resolved for a systematic sampling of Medi-Cal members. The activity was a joint effort between Customer Service and Health Outcomes Improvement and fulfilled a requirement by DHCS to conduct a Performance Improvement Project. The next step will be to pilot different interventions through June 2017 and measure their effect on member satisfaction.

The success of this activity was the implementation of more regular measurement of member perception of the Customer Service representatives to provide members with the information they need. Additionally, Customer Service will be able to use this measurement to inform the piloting of the various interventions listed above to improve member perception.

The project is not yet complete as DHCS requires the project to continue through June 2017.

Recommended 2017 Interventions

The Rating of Health Plan measure is in the domain of Quality of Service and Access to Care. This measure is important as it represents member perception of SFHP overall and is important for SFHP’s NCQA accreditation strategy.

SFHP recommends increasing the target by 2% higher for a target of 69.82%, which is consistent with industry knowledge of realistic improvement from year to year.

2.2 Getting Care Quickly

Measure Summary

The Getting Care Quickly rating from the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) survey measures member perception of their ability to access care and is in the domain of Quality of Service and Access to Care. Measuring performance in HP-CAHPS allows SFHP the opportunity to assess member experience in accessing care and to benchmark against other health plans’ performance. Additionally, for the 2016-2017 fiscal year, SFHP’s performance in this composite is an organizational goal and strategic priority, due to low performance as compared to other Medicaid health plans. Improving access to care for members in HP-CAHPS is important as SFHP’s CAHPS vendor listed it as a key driver in improving performance in HP-CAHPS Rating of Health Plan, which is a key component of NCQA accreditation.

Measure Target, Results, & Barriers

The Getting Care Quickly Rating is composed of two questions from the HP-CAHPS survey: 1) “In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?” and
2) “In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?” The results for this composite represent the percentage of members responding “Usually” and “Always” out of the total responses to these two questions.

The target of 2% improvement was determined by consulting with our survey vendor, and is based on industry knowledge of achievable improvement from year to year. SFHP expected to meet the target by July 2016 when results of the re-survey of all adult Medi-Cal members were received.

<table>
<thead>
<tr>
<th>Baseline performance: 66%</th>
<th>Final performance: 65.3%</th>
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<tbody>
<tr>
<td>Target: 68%</td>
<td>☐ Target was met ☒ Target was not met</td>
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</table>

The main barrier in meeting this target was the timeline for fielding the survey. By the time many of the activities were implemented in January and February of 2016, members were already being re-surveyed due to the survey fielding period. Members are surveyed from January to March 2016 based on their experience in the prior 6 months. Therefore, the impact of activities implemented during 2016 will not impact survey results until the 2017 survey fielding period.

**Accomplishments**

The activities that were conducted to support improvement in this composite were: Inclusion of the Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey results in SFHP’s Pay for Performance program. Inclusion of the CG-CAHPS access composite incentivized provider groups to achieve improvement targets in member perception of access. Additionally, SFHP administered CG-CAHPS on behalf of SFHP’s network to assist providers in identifying opportunities for improvement. SFHP provided trainings on best practices for access improvement to the network and implemented targeted access interventions in collaboration with provider groups who serve the largest volume of SFHP’s membership. Finally, SFHP administered 19 member focus groups to better inform SFHP of members’ perception of access.

All activities were completed. The major successes of these activities included collaborating on interventions and further developing relationships with SFHP providers. Interventions included improved access measurement and training. SFHP also provided concrete tools and ideas to the network for improving access to care at the practice level. In addition, SFHP engaged multiple departments by creating a more cross-functional approach to addressing access to care.

Anecdotal evidence indicates that the primary issue impacting the completion of these activities is provider engagement and prioritization. While access may be a primary goal for SFHP, the broader network often has other priorities that may take precedence.

**Recommended 2017 Interventions**

Access to care is an organizational priority again this fiscal year, as well as an important component of SFHP’s NCQA accreditation strategy. Given the importance of the performance in this composite, as well as the fact that the goal was not achieved this year, SFHP recommends continuing to monitor and improve the measure.
To increase provider engagement, SFHP will execute grant funding to improve access, Strategic Use of Reserves. The Strategic Use of Reserve Grants and associated technical assistance provide the network with concrete resources to address access improvement. Rather than addressing access issues in specific parts of the network, it will hold all provider groups accountable for improving access.

2.3 Getting Needed Care

Measure Summary

The Getting Needed Care composite measure from the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) measures member perception of their ability to access care, tests and treatment and is in the domain of Quality of Service and Access to Care. Measuring performance in HP-CAHPS allows SFHP the opportunity to represent the voice of the member and to benchmark against other health plans' performance. Additionally, for the 2016-2017 fiscal year, SFHP's performance in this composite is an organizational goal and strategic priority, due to low performance as compared to other Medicaid health plans. Improving access to care for members in HP-CAHPS is important as SFHP's CAHPS vendor identified it as a key driver in improving performance in HP-CAHPS Rating of Health Plan, which is a key component of NCQA accreditation.

Measure Target, Results, & Barriers

The Getting Needed Care composite is composed of two questions from the HP-CAHPS survey: 1) “How often was it easy to get the care, tests, or treatment you needed?” and 2) “How often did you get an appointment to see a specialist as soon as you needed?” The results for this composite represent the percentage of members responding “Usually” and “Always” out of the total responses to these two questions.

The target of 2% improvement was determined by consulting with our vendor, and is based on industry knowledge of achievable improvement year over year. SFHP expected to meet this target by July 2016 when results of the re-survey Adult Medi-Cal members were received.

<table>
<thead>
<tr>
<th>Baseline performance: 62%</th>
<th>Final performance: 66.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 64%</td>
<td>☒ Target was met</td>
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</tbody>
</table>

The main barrier in meeting this target was the timeline for fielding the survey. By the time many of the activities were implemented in January and February of 2016, members were already being re-surveyed due to the survey fielding period. Members are surveyed from January to March 2016 based on their experience in the prior 6 months. Therefore, the impact of activities implemented during 2016 will not likely appear in the survey results until the 2017 survey fielding period.
Accomplishments

Activities planned included: Increased incentives for providers to improve specialty care access through the Pay-for-Performance (P4P) program. Coleman Associates, a well-known access consulting firm, worked with Zuckerberg San Francisco General Hospital (ZSFG) to improve clinic workflow and performance in key access metrics like no-show rate and third next available appointment.

Provider groups were newly incentivized in 2016 to improve perception of access to specialty care as measured by HP-CAHPS improvement. Due to the surveying schedule of January to March 2017, improvement will be assessed in the summer of 2017. Activities in 2016 included medical groups analyzing their survey results and submitting an improvement plan. In addition, SFHP added pay-for-performance incentives to improve third next available appointment for the majority of services offered by the specialty group serving approximately half of SFHP members.

Although Coleman Associates consultants worked with one specialty clinic, the Gastrointestinal Clinic, from August 2015 to March 2016, no change was seen in the specialty clinic’s access data. Some of the barriers included: competing priorities did not allow staff to focus solely on improvement work, lack of clear expectations for improvement making it difficult to assess progress of the project, and the consultant’s expertise did not align with specialty clinic operations.

Recommended 2017 Interventions

Access to care is an organizational priority again this fiscal year, as well as an important component of SFHP’s NCQA accreditation strategy. Given the importance of the performance in this composite, SFHP recommends continuing to monitor the measure and increase the target by another 2% from this year’s performance. This increase is consistent with industry knowledge of achievable improvement from year over year.

SFHP will execute Strategic Use of Reserves Grants to improve access. The Strategic Reserve Grants and technical assistance will be included as activities, for groups focusing on improving specialty care access. In addition, these grants will allow SFHP to hold all provider groups accountable for improving access by attaching access improvement project completion and outcomes to portions of the total grant amount.

2.4 Provider Satisfaction

Measure Summary

SFHP measures provider satisfaction annually to assess its network providers’ opinion of the services offered by SFHP. The activities tracked by this survey impact Quality of Service and Access to Care domain.
This measure is important because it is SFHP’s most comprehensive direct feedback from SFHP’s providers. Provider dissatisfaction with the plan may indicate problems such as burdensome plan processes, patient frustration, and other indications that plan processes and requirements interfere with, rather than facilitate, the provision of health care services.

**Measure Target, Results, & Barriers**

The survey pool of 750 is drawn from all contracted providers. The summary score is the percent of respondents indicating they are “somewhat satisfied” or “completely satisfied” with the three domains described below. They are in a section headed by “Please rate SFHP in the following service areas when compared to your experience with other health plans you work with.” The survey domains are:

1) Provider Relations representative’s ability to answer questions and resolve problems.
2) Quality of written communications, policy bulletins, and manuals.
3) Your overall satisfaction with Provider Relations.

SFHP aims to reach or maintain a high level of provider satisfaction. The target is a statistically-significant increase from the prior year, or the 90th national Medicaid percentile for each question.

Barriers to meeting the target are identified by the survey respondents’ comments in the 2015 survey and an analysis of the Provider Relations department’s customer service metrics and feedback. Maintaining proper functionality of SFHP’s secure provider portal was the primary barrier, because it is the main source of communication between providers and SFHP. When the provider portal does not work, providers contact SFHP via phone or email which demands more time of both Plan staff and the provider. The other main barrier was ensuring SFHP staffing levels and training to respond to any provider issue in order that all requests are efficiently addressed.

Results of the survey are as follows: For question #1, performance improved from 60.2% to 71.5%, achieving a statistically significant increase. For question #2, performance improved from 58.7% to 72.4%, achieving a statistically-significant increase and greater than 90th percentile (99th). For question #3, performance improved from 43.6% to 72.4%, achieving a statistically-significant increase. The target was met for each of the three questions.

**Accomplishments**

The Provider Relations department completed the following activities that helped contribute to these high scores: remediation of provider portal errors, communication related to pharmacy and prior authorizations, and implementation of a Provider Relations toolkit and training. In-person provider visits to all medium and large volume sites occurred during the winter holiday season to communicate the changes.
Recommended 2017 Interventions

SFHP recommends that this measure be continued for next year with the same target and activities. The target will be a statistically-significant increase from the prior year at 95% confidence interval, or the 90th national Medicaid percentile for each question.

Reference the three measures that will be reported in the QI Amendment.

3. Clinical Quality and Patient Safety

3.1 HEDIS Measure: Asthma Medication Ratio

Measure Summary

The Healthcare Effectiveness Data and Information Set (HEDIS) measure, Asthma Medication Ratio, was a priority for SFHP because this HEDIS rate fell below the HEDIS Medicaid 90th percentile during Measurement Year (MY) 2014. This measure is in the Clinical Quality and Patient Safety domain and evaluates the effectiveness of asthma management. Asthma is managed through the regular administration of controller medications, which can control chronic symptoms and prevent future exacerbation and progressive decline in lung function (or for children, reduced lung growth). The use of reliever medications helps to ease acute symptoms, but does not provide long-term asthma control; if used more than recommended, they can also cause long-term side effects. The measure is defined as the percentage of members with persistent asthma age 5-64 with a ratio of controller medications to total asthma medications of at least .50 or greater during the measurement year.

Measure Target, Results, & Barriers

The measurement methodology follows the HEDIS specifications and the results were calculated from MY 2015 administrative data (based on claims, encounters, and pharmacy data). The denominator of the measure is the eligible population (members identified as having persistent asthma who are 5-64 years old). The numerator is the number of members who have a medication ratio of 0.50 or greater during the measurement year. The target was determined by the Medicaid benchmarks provided by the National Committee on Quality Assurance (NCQA). SFHP projected to meet the target by June 1, 2016, when the HEDIS results were finalized and submitted to NCQA. The primary barrier to impacting the measure was related to SFHP’s Prior Authorization requirements, specifically pertaining to restrictions on the use of Advair. Another potential barrier to meeting the target was a delay in the launch of the disease management program due to competing priorities at SFHP and contracting challenges with the outside call center vendor.

<table>
<thead>
<tr>
<th>Baseline performance: 57.43% (MY 2013)</th>
<th>Final performance: 76.95% (MY 2015)</th>
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<tbody>
<tr>
<td>Target: 70.43%</td>
<td>☒ Target was met ☐ Target was not met</td>
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</table>
The disease management activity did not have a direct result on the Asthma Medication Ratio rate since the program did not launch until June 2016 and the results reflect 2015 performance.

Accomplishments

The activities conducted to reach the target included member outreach calls, a member incentive, and enhanced member health education materials which launched in May 2016. The rate increase may also have been impacted by SFHP extending the 90-day supply for non-generic prescriptions. This new process provided members a simpler way to fill non-generic asthma medications. In effect, the number of members with asthma medications ratio of 0.50 and greater sign increased over the past year.

Recommended 2017 Interventions

SFHP recommends that this measure be discontinued due to meeting the target. Monitoring to ensure performance is maintained will continue through HEDIS. Activities supporting maintenance of performance in 2017 will include the Disease Management Program and inclusion of this measure in SFHP’s pay-for-performance program.

3.2 Percentage of HEDIS Measures in the Medicaid 90th Percentile

Measure Summary

This measure focuses on SFHP’s performance in the Department of Health Care Services’ (DHCS) External Accountability Set (EAS), a subset of HEDIS measures that are calculated, audited, and reported annually as required by DHCS. SFHP has been using this performance measure for several years and it is in the Clinical Quality and Patient Safety domain.

In 2016, SFHP reported on the 27 HEDIS measures that were part of the EAS. These measures help SFHP evaluate the preventive and chronic care services delivered to its members. They serve as a useful accountability tool by giving SFHP the ability to benchmark against other health plans’ performance and make data-driven decisions about prioritizing improvement efforts. Additionally, HEDIS measures are an important component of NCQA accreditation, accounting for 37% of SFHP’s score.

Measure Target, Results, & Barriers

NCQA and DHCS provide guidance regarding data collection methodology, indicating whether measures will utilize administrative data only, or if they can be supplemented with chart review (hybrid method). 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. Populations that are targeted for each HEDIS measure are consistent with NCQA’s HEDIS specifications. Results for MY 2015 became available in June of 2016.
Baseline performance: 13/27 (48%) measures in the 90th percentile.

Final performance: 12/27 (44%) measures in the 90th percentile

Target: 13/27 (48%) measures in the 90th percentile (Table 1) ☐ Target was met  ☐ Target was not met

Key barriers to meeting SFHP’s goal for the measure included: 1) the large number of measures in the denominator, creating difficulty for SFHP to prioritize improvement, 2) changes in SFHP’s provider network’s data systems, and thus the ability for SFHP’s HEDIS team to collect all administrative data and to find all relevant member charts, and 3) in Measurement Year 2015, Medi-Cal expansion led to a large increase in eligible populations for key measures, many of whom had inadequate access to preventive care prior to implementation.
<table>
<thead>
<tr>
<th>Measure</th>
<th>SFHP 2014 Rate</th>
<th>SFHP 2015 Rate</th>
<th>2014-2015 Change</th>
<th>2015 Medicaid %ile</th>
<th>2016 Member &amp; Provider Incentives</th>
</tr>
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<tbody>
<tr>
<td>All Cause Readmissions - CA QIP Measure (ACR-A)</td>
<td>19.71%</td>
<td>19.87%</td>
<td>↑</td>
<td>NA**</td>
<td>PIP</td>
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<tr>
<td>All Cause Readmissions – CA QIP Measure (ACR-B)</td>
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<td>9.81%</td>
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<td>NA**</td>
<td>PIP</td>
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<tr>
<td>Ambulatory Care - ED Visits ***</td>
<td>34.32</td>
<td>34.77</td>
<td>↓ 90th**</td>
<td>None</td>
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<td>Ambulatory Care - Outpatient visits ***</td>
<td>369.4</td>
<td>356.17</td>
<td>↓ 75th**</td>
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<tr>
<td>Annual Monitoring for Patients on Persistent Medications - ACE Inhibitors or ARBs</td>
<td>86.47%</td>
<td>87.75%</td>
<td>↑ 50th</td>
<td>PIP</td>
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<tr>
<td>Annual Monitoring for Patients on Persistent Medications - Digoxin</td>
<td>51.02%</td>
<td>54.90%</td>
<td>↑ 50th**</td>
<td>PIP</td>
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<td>87.00%</td>
<td>↑ 25th</td>
<td>PIP</td>
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<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>45.34%</td>
<td>43.14%</td>
<td>↓ 90th</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening*</td>
<td>74.00%</td>
<td>61.56%</td>
<td>↓ 50th</td>
<td>Incentive Pilot/PIP</td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status*</td>
<td>82.87%</td>
<td>81.48%</td>
<td>↓ 90th</td>
<td>MI / PIP</td>
<td></td>
</tr>
<tr>
<td>Children &amp; Adolescents’ Access to PCPs - 12-24 Mos.</td>
<td>93.66%</td>
<td>93.39%</td>
<td>↓ 10th**</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Children &amp; Adolescents’ Access to PCPs - 25 Mos. - 6 Yrs.</td>
<td>90.01%</td>
<td>90.23%</td>
<td>↑ 50th**</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Children &amp; Adolescents’ Access to PCPs - 7-11 Yrs.</td>
<td>94.11%</td>
<td>93.01%</td>
<td>↓ 50th**</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Children &amp; Adolescents’ Access to PCPs - 12-19 Yrs.</td>
<td>91.05%</td>
<td>89.97%</td>
<td>↓ 25th**</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - BP&lt;140/90</td>
<td>75.41%</td>
<td>71.30%</td>
<td>↓ 75th</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exam</td>
<td>68.91%</td>
<td>74.07%</td>
<td>↑ 90th</td>
<td>MI / PIP</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care* - HbA1c Screening</td>
<td>91.42%</td>
<td>94.44%</td>
<td>↑ 90th</td>
<td>MI / PIP</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Control &lt;8%</td>
<td>62.41%</td>
<td>68.29%</td>
<td>↑ 90th</td>
<td>MI / PIP</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Poor Control &gt;9%***</td>
<td>25.06%</td>
<td>18.98%</td>
<td>↑ 90th</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – Nephropathy Monitoring</td>
<td>87.94%</td>
<td>89.58%</td>
<td>↑ 90th</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure*</td>
<td>72.19%</td>
<td>75.06%</td>
<td>↑ 90th</td>
<td>MI / PIP</td>
<td></td>
</tr>
<tr>
<td>Immunizations for Adolescents - Combo 1</td>
<td>79.40%</td>
<td>76.16%</td>
<td>↓ 50th</td>
<td>PIP</td>
<td></td>
</tr>
<tr>
<td>Medication Management for People with Asthma - 50% Control</td>
<td>55.69%</td>
<td>60.72%</td>
<td>↑ 75th</td>
<td>MI (DM)</td>
<td></td>
</tr>
<tr>
<td>Medication Management for People with Asthma - 75% Control</td>
<td>32.43%</td>
<td>37.07%</td>
<td>↑ 75th</td>
<td>MI (DM)</td>
<td></td>
</tr>
<tr>
<td>Prenatal and Postpartum Care - Postpartum Care</td>
<td>70.59%</td>
<td>74.23%</td>
<td>↑ 90th</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>Prenatal and Postpartum Care* - Timely Prenatal Care</td>
<td>90.12%</td>
<td>90.07%</td>
<td>↓ 75th</td>
<td>MI</td>
<td></td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>86.16%</td>
<td>81.58%</td>
<td>↓ 75th</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI</td>
<td>85.19%</td>
<td>86.57%</td>
<td>↑ 90th</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Nutrition</td>
<td>81.48%</td>
<td>85.42%</td>
<td>↑ 90th</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical Activity</td>
<td>77.78%</td>
<td>84.26%</td>
<td>↑ 90th</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*</td>
<td>85.42%</td>
<td>82.18%</td>
<td>↓ 75th</td>
<td>MI / PIP</td>
<td></td>
</tr>
</tbody>
</table>

Grey indicates administrative rate only; *DHCS auto assignment measure; **DHCS did not hold MCPs to min performance level; ***Lower is better; MI = member incentive; PIP = Practice Improvement Program measure; DM = Disease Management Program
Accomplishments

SFHP carried out a variety of activities in the areas of member outreach, provider outreach, internal infrastructure improvements, and data quality and capture improvement.

SFHP has 7 ongoing member outreach and incentive programs tied to SFHP’s priority HEDIS measures. In all relevant HEDIS measures, SFHP members who participated in the corresponding incentive program had a higher rate of HEDIS compliance than members who did not participate (Graph 1). Of particular interest is SFHP’s rate of hypertension incentive program participants who were compliant for the Controlling High Blood Pressure measure. Program participants were over 12% more likely to have met the measure’s blood pressure target than individuals who did not participate in the program (Graph 1).

In addition to impacts on member health outcomes, SFHP’s provider network is highly satisfied with SFHP’s incentive programs, indicated in responses from its 2016 Provider Satisfaction Survey (Table 2).

In Measurement Year 2015, SFHP made only one major modification to its incentive programs. It split the diabetes incentive program into separate incentives: 1) $25 for receiving an annual Hba1c test, blood pressure measurement, and nephropathy monitoring, and 2) $25 for receiving a retinal or dilated eye exam. Graph 2 demonstrates the strong improvement in SFHP’s diabetes eye exam rates associated with this incentive program modification.

SFHP provided outreach and education to its provider network in several ways to improve network-wide HEDIS performance. Activities continued from the prior year included:

1.) Financial incentives through SFHP’s pay-for-performance program (PIP)
2.) Annual meetings with medical groups to discuss their HEDIS results and collaborate on improvement opportunities
3.) Presentations to inform front-line staff at provider sites about SFHP’s member incentive programs
4.) Communication in SFHP’s monthly provider newsletter about HEDIS performance, incentive programs, and quality improvement training.

New provider outreach and education activities in 2016 included: 1.) SFHP’s Quality Improvement Collaborative, in which participants from the provider network conducted improvement projects on key HEDIS measures, received over 30 hours of training in quality improvement, and were coached by SFHP’s quality improvement staff, and 2.) a pilot member and provider outreach and incentive program to improve cervical cancer screening rates which resulted in overall improvement in self-reported rates from 69% to 74% over the course of one quarter.

In 2016, SFHP implemented two ongoing internal HEDIS committees. The HEDIS Clinical Oversight Committee is a group of clinical leaders and HEDIS subject matter experts who prioritize HEDIS measures for improvement activities. Prioritization is based on criteria such as clinical impact, DHCS/NCQA performance standards, SFHP population relevance, and disparities by race/ethnicity. The HEDIS
Interventions Committee is a cross-departmental work group that operationalizes improvement interventions for measures prioritized by the HEDIS Clinical Oversight Committee.

During 2016, SFHP’s HEDIS data quality team worked on a variety of activities. This group consists of Information Technology, Business Intelligence, Population Health, and Health Services Business Relationships staff. One major activity was the ongoing monitoring of supplemental data sources, in particular contracted lab submissions. During the course of the year, low volume counts from a few key submitters were identified. SFHP collaborated with submitters to request retroactive and corrected lab data files, and ensure that appropriate data is being included moving forward.

**Table 2: 2016 Provider Satisfaction Survey Question** - Please indicate if you think the following incentives help your patients' health care behaviors.

<table>
<thead>
<tr>
<th>Incentive Program</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
<th>Summary Score*</th>
<th>Valid n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood immunization gift card</td>
<td>31.5%</td>
<td>41.6%</td>
<td>25.8%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>n = 60</td>
<td>73.0%</td>
<td>89</td>
</tr>
<tr>
<td>Well Child gift card</td>
<td>37.5%</td>
<td>38.6%</td>
<td>22.7%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>n = 61</td>
<td>76.1%</td>
<td>88</td>
</tr>
<tr>
<td>Diabetes Care gift card</td>
<td>27.6%</td>
<td>45.7%</td>
<td>20.0%</td>
<td>4.8%</td>
<td>1.9%</td>
<td>n = 46</td>
<td>73.3%</td>
<td>105</td>
</tr>
<tr>
<td>Perinatal gift cards</td>
<td>23.2%</td>
<td>37.7%</td>
<td>34.8%</td>
<td>2.9%</td>
<td>1.9%</td>
<td>n = 80</td>
<td>60.9%</td>
<td>69</td>
</tr>
<tr>
<td>Hypertension gift card</td>
<td>26.7%</td>
<td>44.8%</td>
<td>22.9%</td>
<td>3.8%</td>
<td>1.9%</td>
<td>n = 48</td>
<td>71.4%</td>
<td>105</td>
</tr>
</tbody>
</table>

*Summary score represents the most favorable response options ("Strongly Agree" and "Agree")
Graph 1: MY15 HEDIS Compliance by Incentive Participation

*Only members included in the HEDIS sample are included due to lack of administrative data*

Graph 2: CDC Eye Exam Rates, MY 2012-2015

*Incentive implementation*

<table>
<thead>
<tr>
<th>Year</th>
<th>CDC-E</th>
<th>Medicaid 90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>67.59%</td>
<td>69.72%</td>
</tr>
<tr>
<td>2013</td>
<td>62.41%</td>
<td>67.64%</td>
</tr>
<tr>
<td>2014</td>
<td>68.91%</td>
<td>68.04%</td>
</tr>
<tr>
<td>2015</td>
<td>74.07%</td>
<td>67.74%</td>
</tr>
</tbody>
</table>
**Recommended 2017 Interventions**

SFHP recommends modifying this measure in 2017. Aggregating all publicly reported measures into one indicator poses a challenge to SFHP for a variety of reasons. First, SFHP’s publicly reported measures will change drastically in the coming years. There are several modifications to the 2017 EAS, and SFHP will also begin reporting on all NCQA Medicaid measures over the next several years. These changes modify this measure’s denominator significantly from year to year, creating a less meaningful measure to benchmark and trend. More importantly, it is counter to quality improvement principles to attempt to improve everything all at once, or all the time. Selecting a few priority measures that are lower-performing and clinically impactful as indicators creates more meaningful and attainable goals for SFHP. As such, in 2017 SFHP recommends replacing this indicator with three priority or lower performing HEDIS measures in the Clinical Quality and Patient Safety domain. Activities to support these measures will include member outreach, provider outreach, internal infrastructure improvement, and data quality improvement.

### 3.3 Initial Health Assessment (IHA)

**Measure Summary**

The Initial Health Assessment (IHA) measure is in the Clinical Quality and Patient Safety domain. It measures SFHP’s performance in meeting DHCS’ requirement that all newly-enrolled Medi-Cal members receive an IHA within 120 days of enrollment. The intent of the measure is to evaluate members’ engagement with primary care by measuring the rate of members who received an IHA within the required timeframes.

**Measure Target, Results, & Barriers**

This target is based on the DHCS requirement that 100% of IHAs are completed within the required timeframe (California Department of Health Services). SFHP’s rate for 2016 (1/1/16 – 9/30/16) was 21.7%.

The rate is calculated based on the number of newly-enrolled Medi-Cal members received an IHA out of the total newly-enrolled Medi-Cal members. The completion of an IHA is identified through specific Evaluation & Management (E&M) codes from claims and encounter data.

<table>
<thead>
<tr>
<th>Baseline performance: 28.5%</th>
<th>Final performance: 21.7% (1/1/16 – 9/30/16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 100%</td>
<td>☑ Target was met ☒ Target was not met</td>
</tr>
</tbody>
</table>

There were several barriers that affected performance in 2016. First, the IHA measurement methodology relies on providers to submit accurate claims and encounter data to identify that an IHA was completed. In addition, the target was set unrealistically high, making it near impossible to reach.
Lastly, the IHA requirement contradicts commonly known research for high-quality care, making it difficult to engage providers in improvement. For example, pediatric guidelines support an annual well visit whereas there is no such support from adult guideline. Moreover Choosing Wisely specifically suggests that an annual physical may do more harm than good.

Accomplishments

In 2016, SFHP mailed a welcome packet to all new members encouraging them to make an initial appointment with their PCP. SFHP also sent monthly reports to providers with demographic information for IHA-eligible members, requesting that providers outreach to them and conduct an IHA. With the member outreach lists, SFHP included the IHA rates from the prior two quarters to communicate the opportunity for improvement.

Recommended 2017 Interventions

SFHP recommends continuing this measure since it is a requirement from DHCS. In 2017, SFHP plans to validate that IHAs are being captured through billing data. To do this, SFHP will compare medical records collected during Facility Site Review audits to billing data. If the medical record indicates that an IHA occurred, SFHP will validate that an IHA-eligible code was submitted to and received by SFHP. If less than 80% of the codes are accurate, SFHP will re-examine the methodology and/or provide education to providers. In addition, SFHP may modify its IHA procedure pending modifications to Medicaid regulations, making IHA procedure more versatile.

3.4 QMED Compliance

Measure Summary

The Quality Measures for Encounter Data (QMED) Compliance measure is in the Clinical Quality and Patient Safety domain. It is a priority for SFHP as it supports comprehensive and accurate encounter data, which in turn impacts HEDIS data collection, performance, and improvements, as well as state reimbursement rates and the rates SFHP offers providers.

Measure Target, Results, & Barriers

This indicator was measured through participating clinic and medical group performance in three pay-for-performance program (PIP) measures: timeliness of electronic data submission, acceptance of electronic submissions, and accuracy between encounter and medical record data. The target was set at 30% of clinics and medical groups being in compliance with at least two of the three PIP measures, and was based on historical PIP performance.

In Quarter 1 2016, timeliness and acceptance were removed from PIP due to over 95% of participants hitting the stretch goal each quarter. As such, only one measure was used to measure performance. The
remaining PIP measure assessed accuracy between encounter and medical record data through an
SFHP-conducted audit. No PIP participants achieved the 80% compliance rate, resulting in 0% final
performance for this measure.

<table>
<thead>
<tr>
<th>Baseline performance: no baseline available</th>
<th>Final performance: 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 30%</td>
<td>☒ Target was met</td>
</tr>
<tr>
<td></td>
<td>☒ Target was not met</td>
</tr>
</tbody>
</table>

The results of the audit are aligned with expectations, as it was the first time such an audit had been
conducted. Barriers included lack of provider understanding of medical record documentation
requirements, as well as finding consultants qualified to advise on medical record documentation
standards and improvement.

Accomplishments

All planned activities are currently in progress: implementing the pay for performance measure which
supports the comprehensiveness of coding and provider data, administering provider data quality grants
to support infrastructural improvements, and providing technical assistance for medical record
documentation to providers.

Recommended 2017 Interventions

SFHP recommends that this measure be discontinued due to unspecified methodology from DHCS for
evaluating QMED performance. In 2017, stakeholder and data source research will be conducted to
identify a meaningful way to evaluate clinical data quality.

3.5 Influenza Vaccine Utilization

Measure Summary

The Influenza Vaccine Utilization measure is in the Clinical Quality and Patient Safety domain and is a
priority for SFHP because increased access to vaccines helps prevent influenza-related illness and health
care utilization. In addition, it was chosen for inclusion in the 2016 QI Plan as the influenza vaccine
became a pharmacy benefit in October 2015.

Measure Target, Results, & Barriers

The 2014-2015’s baseline was 15.4%. Final performance based on fiscal year 2015-2016 was 17.2%
California Immunization Registry (CAIR), medical, and pharmacy claims were used as data sources.

The measure target was 3% improvement from FY 2015-2016, as measured by:

\[
\text{Members in the denominator receiving a influenza vaccination} \quad \text{All Medi-Cal members age 19 and above}
\]
Baseline performance: 15.4%  
Final performance: 17.2%  
Target: 18.4%  
☐ Target was met  ☒ Target was not met

Barriers to meeting the target included member resistance to getting vaccinated due to perception of low efficacy, or the belief that the vaccine will cause influenza. The 2015-2016 influenza season had a lower impact than recent years, which may have led less members to prioritize getting vaccinated than SFHP predicted. Additionally, there are many places to get vaccinated for free, which will not be reflected in SFHP’s data.

Accomplishments

Activities supporting this measure included notifications in quarterly member newsletter (Your Health Matters) and monthly provider newsletters. Pharmacies were notified of the new benefit and flu vaccine utilization was monitored through pharmacy claims.

Recommended 2017 Interventions

SFHP recommends continuing this measure in 2017 as there continues to be room for improvement. The target will be improvement over the 2016 performance. Activities may include continuing to raise awareness of the pharmacy influenza vaccine benefit, exploring providing an influenza vaccine member incentive, promoting influenza vaccines to members involved in SFHP’s case management and discharge planning populations, and improving influenza vaccine data received.

3.6 Medical Record Review

Measure Summary

The Medical Record Review (MRR) measure is in the Clinical Quality and Patient Safety domain. It is a priority for SFHP since MRR scores help determine the level of safe, evidence-based care being delivered to members as per DHCS standards. This measure evaluates the overall average of Medical Record Review (MRR) scores. The MRR process helps ensure consistent compliance with clinical guidelines for preventive care and medical record documentation and help identify opportunities for improvement in the care being delivered to SFHP members in the primary care setting.

Measure Target, Results, & Barriers

SFHP 2013 and 2016 MRR scores were compared to find the average difference in percentage points. The total percentage point difference between 2013 and 2016 MRR scores was used as the numerator and the total number of MRRs conducted were used as the denominator.

The measure target was 2% average improvement from 2013-2016, as measured by:
The target was determined by the SFHP Facility Site Review (FSR) Master Trainer to help guide future measures and targets, as there was no baseline. The population targeted was all SFHP providers undergoing MRR. Measurements were reported quarterly, with the goal of reaching the overall target by the end of 2016. Barriers to meeting the target included: implementation of the “Staying Healthy Assessment” (SHA) in 2014, which was not seen as a priority by some providers. The new SHA requirement and lack of provider compliance in some PCP practices have resulted in slight decreases in MRR scores from 2013 to 2016.

<table>
<thead>
<tr>
<th>Baseline performance: N/A</th>
<th>Final performance: Average decrease in MRR score from 2013 to 2016 of 0.4 percentage points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: Average increase in MRR score from 2013 to 2016 of 2 percentage points</td>
<td>☐ Target was met ☒ Target was not met</td>
</tr>
</tbody>
</table>

**Accomplishments**

Activities conducted to reach the target included ongoing provider outreach and education, to include corrective actions, when necessary. These activities were conducted by SFHP Certified Nurse Reviewers. Successes included timely CAP completion by most provider offices and ongoing communication between nurse reviewers and provider offices. Issues impacting completion of these activities were delayed responses from some offices and challenges with staffing and collaboration with Anthem Blue Cross.

**Recommended 2017 Interventions**

The recommendation to discontinue this measure is based on the fact that the MMR/FSR aggregates many quality indicators; it is not a sufficient measure for quality improvement since it evaluates aspects of the medical record equally. For example, the IHA and correct spelling of the member’s name are scored equally in the MRR, despite the fact that IHA is a better indicator of care provided to the member. In addition, many components of the MRR are measured in other QI Plan measures, such as HEDIS clinical measures and IHA completion rate.

### 3.7 Pain Management/Opioid Safety

**Measure Summary**

The Pain Management/Opioid Safety measure is in the Clinical Quality and Patient Safety domain. This is a priority for SFHP as opioid use presents serious risks, including dependency and overdose. As such,
SFHP’s Pain Management Program remains committed to minimizing risks for members taking chronic opioids.

**Measure Target, Results, & Barriers**

Given that the risk of overdose and dependency increases with the amount and duration of opiate therapy, the measure’s target was to maintain the percentage of members with at least one opioid prescription. The 2015 baseline was 8.2%, down from 11% in 2014. Even though there was a substantial decline, SFHP still felt it was important to continue to monitor this measure given the risks associated with opioid prescribing.

<table>
<thead>
<tr>
<th>Baseline performance: 8.2%</th>
<th>Final performance: 7.74%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: Maintain baseline (8.2% or lower)</td>
<td>☒ Target was met ☐ Target was not met</td>
</tr>
</tbody>
</table>

**Accomplishments**

A number of activities were performed in support of this measure, primarily in the area of provider education. In 2016, SFHP launched a free online module open to all providers on the treatment of acute pain, which included best practices on how to discuss risks and realistic benefits of opiates. In addition, SFHP continued to communicate with providers about their SFHP members who had pharmacy claims indicating chronic opioid use. The pay-for-performance program (PIP) measure was continued in 2016, which incentivized following opioid safety best practices: documenting controlled substance agreements between providers and members, yearly urine toxicology screenings to ensure prescribed medications are being taken and non-prescribed contraindicated substances are not being taken, and annual interdisciplinary review of members with chronic opioid prescriptions.

Other activities supporting this measure’s success included expanding SFHP’s pharmacy formulary to include more non-opioid pain management modalities (e.g. anti-depressants and anti-convulsants and topical analgesics) without prior authorization and the reinstatement of the acupuncture benefit. Pain management treatment options were expanded within the network as well, such as a pilot integrative pain clinic and improved access at the pain management specialty clinic serving the majority of SFHP’s membership.

**Recommended 2017 Interventions**

Even though the target was exceeded, SFHP recommends continuation of this measure as opioid prescribing continues to carry great risks. The target of maintaining baseline should remain the same. Activities may include continued provider education, promotion of non-opioid treatment options, and monitoring of unintended possible consequences of continued improvement, such as diversion to opiate sources other than the primary care setting (such as the Emergency Department, heroin, and opioid medications obtained without a prescription).
4. Care Coordination and Services

4.1 CBCM Self-Efficacy

Measure Summary

SFHP’s CareSupport Community Based Care Management (CBCM) program’s self-efficacy measure is in the Care Coordination and Services domain. It calculates the percentage of engaged CBCM members who indicated higher self-efficacy based on their Initial and Closing Assessments. Clients must have consented to be in the program and have begun their initial assessment to be considered engaged. The self-efficacy assessment question was developed by program leadership as an important indicator of the member’s ability to navigate their own healthcare while in the CBCM program. The question is based on the First National Health and Nutrition Examination Survey that measured self-reported health as compared to medical conditions and risk behaviors. Baseline measurement for this question was not available since 2016 was the first year of measurement.

Improved self-efficacy can influence a member’s behavior, including adoption of new positive behaviors and reduction of existing harmful behaviors. Self-efficacy also affects the member’s effort towards their care plan goals. Members with low self-efficacy may reflect about their deficiencies rather than think about accomplishing their care plan goal. This can negatively impact the successful completion of the care plan goal.

The self-efficacy measure is important to SFHP as it aligns with the CBCM program’s overall goal to improve member health through in-person case management by working in parallel with the member to achieve care plan goals. By improving a member’s self-efficacy we can reduce reliance on urgent health care services (i.e. emergency department), increase adoption of preventive care, and increase self-management of chronic diseases.

Measure Target, Results, & Barriers

The target for this measure was 70% of members indicating higher self-efficacy based on responses to the self-efficacy question from the initial and closing assessments. Initial assessments are conducted in-person with the member once they have consented to participate in the program. A closing in-person assessment is completed when the member completes the program, which can be due to a variety of reasons (i.e. unable to contact member, care plans goals completed, or member declined services). The numerator is total engaged members with an initial and closing assessment who indicated higher self-efficacy and the denominator is total engaged members with an initial and closing assessment completed. Assessments were completed for 12 members.

<table>
<thead>
<tr>
<th>Baseline performance: No baseline available</th>
<th>Final performance: 85%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 70%</td>
<td>☑ Target was met ☐ Target was not met</td>
</tr>
</tbody>
</table>
Barriers to meeting the measure included the inability to retain a high engagement rate in the program. Some reasons included losing members to follow up (i.e. client is unable to contact, cannot be found, etc.), and systemic gaps in care that caused an inability to complete care plan goals. In addition, we encountered a delay in updating this question in our care management system as a standard part of our assessments. As a result, we included a small denominator of only 12 members. Analysis of the self-efficacy question shows an increase in members who felt “always” able to take the actions needed to maintain or improve their health. While we met our target, a larger denominator would be needed to gather more meaningful outcomes and better assess the true effect the program is having on our members.

Accomplishments

Over the course of the year the following activities were conducted and completed to ensure the measure was met:

- Outreach to program members to ensure members were engaged in the program and care plan goals
- In-person member assessments including completion of the initial and closing assessments

A significant barrier included the delay in adding the self-efficacy question to SFHP’s Care Management System assessments. Thus, we were only able to measure a small number of respondents, overall impacting the measure’s success.

Recommended 2017 Interventions

Care Management is discontinuing the self-efficacy measure and will implement a new Depression Screening QI measure that is standard among all Care Management programs and better aligned with requirements from the National Committee for Quality Assurance (NCQA), Health Homes Program (HHP), and SFHP organizational goals. The new measure will ensure all programs are aligned in their objectives and are subject to a standardized evaluation.

4.2 CBCM Self-Reported Health

Measure Summary

SFHP’s CareSupport Community Based Care Management (CBCM) program’s self-reported health measure is in the Care Coordination and Services domain. It calculates the percentage of engaged CBCM members who indicated higher self-reported health based on their Initial and Closing Assessments. Clients must have consented to be in the program and have begun their initial assessment to be considered engaged. The self-reported health question was developed by program leadership as a simple yet important indicator for monitoring the health of the member as perceived by the member over time in the program.
The self-reported health question measures the physical, emotional, and social aspects of the member’s health and well-being. It documents how members feel about their health which can provide a good indication of their overall disease burden. No baseline was available since 2016 was the first year of measurement. The overall goal is to demonstrate an increase in self-reported health from initial to closing assessment.

The self-reported health measure is important to SFHP as it aligns with the CBCM program’s overall goal to improve member health through in-person case management. The program provides members with connection to primary care and community resources.

**Measure Target, Results, & Barriers**

The target for this measure is 70% of members indicating higher self-reported health based on responses to the self-reported health question from the initial and closing assessments. Initial assessments are conducted in-person with the member once they have consented to participate in the program. A closing assessment is completed in-person when the member is closed out from the program, which can be due to a variety of reasons (i.e. unable to contact member, care plans goals completed, member declined services, or member deceased). The numerator is the total number of engaged members with an initial and closing assessment who indicated higher self-reported health and the denominator is the total engaged members with an initial and closing assessment. Assessments were completed for 127 members.

<table>
<thead>
<tr>
<th>Baseline performance: No baseline was set</th>
<th>Final performance: 76.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 70%</td>
<td>☒ Target was met</td>
</tr>
<tr>
<td></td>
<td>☐ Target was not met</td>
</tr>
</tbody>
</table>

There were no barriers to meeting the target. Analysis of the self-reported health question showed some members who originally stated “poor” in their Initial Assessment later reported “fair” or “good” in their Closing Assessment. Other members who originally reported “very good” in their Initial Assessment later reported “excellent” in their Closing Assessment.

**Accomplishments**

Over the course of the year the following activities were conducted and completed to ensure the measure was met:

- Outreach to program members to ensure members were engaged in the program and care plan goals.
- In-person member assessments including the completion of the initial and closing assessments.

No issues impacted the completion of these activities. SFHP was successful in achieving a high response rate, which can be attributed to the initial and closing assessment being provided in-person as a required process in the case management workflow.
Recommended 2017 Interventions

Care Management is discontinuing the self-reported health measure and will implement a new Depression Screening QI measure that is standard among all Care Management programs and better aligned with requirements from the National Committee for Quality Assurance (NCQA), Health Homes Program (HHP), and our SFHP organizational goals. The new measure will ensure all programs are aligned in their objectives and are subject to a standardized evaluation.

4.3 CMCM Client Satisfaction

Measure Summary

The Complex Medical Case Management (CMCM) program’s client satisfaction measure is in the Care Coordination and Services domain. It is a measure of how “helpful” clients find the CMCM case manager. The measure is important to SFHP because it helps monitor case manager performance and identify opportunities for program improvement.

Measure Target, Results, & Barriers

The Client Satisfaction survey has 5 question-statements. The first of which is “My case manager was helpful.” Clients may respond “Yes,” “No,” or “Not Sure.” The survey is administered at the time of the case closing. This measure calculates the number of survey respondents who answered “Yes” out of the total number of survey respondents for the question “my case manager was helpful.” Baseline data is not available since the CMCM program launched in 2015.

<table>
<thead>
<tr>
<th>Baseline performance: Not Available</th>
<th>Final performance: 100% (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 80%</td>
<td>☒ Target was met ☐ Target was not met</td>
</tr>
</tbody>
</table>

The 2016 target was established based on the plan’s experience with its Community Based Care Management (CBCM) program. The target population for the CMCM program is members with complex medical issues and high inpatient and/or Emergency Department utilization, combined with low utilization of outpatient services. There were no barriers to meeting the target. However, there were barriers in achieving an adequate amount of responses. Responses are collected during a client’s closing assessment. The closing assessment is completed when clients’ cases are closed and clients are able to be reached at the close of the case.

Accomplishments

The activities conducted for this measure included: 1) successful development of the client survey tool in collaboration with the SFHP Marketing department, 2) successful collaboration with the SFHP
Compliance department to secure Department of Health Care Services (DHCS) approval, and 3) successful hiring and training of three new case management staff members. There were no issues impacting completion of these activities.

**Recommended 2017 Interventions**

The Client Satisfaction measure is a useful tool for monitoring client satisfaction with their case manager. No target changes are recommended at this time. Activities for next year will include identifying ways to increase the total number and completion rate of Client Satisfaction surveys.

### 4.4 CMCM Engagement Rate

**Measure Summary**

The Complex Medical Case Management (CMCM) program’s engagement rate measure is in the Care Coordination and Services domain. It reflects the ability of the CMCM case manager to contact and engage a member identified as eligible for program participation. A member is considered to be engaged in the CMCM program when the member provides a response to at least one portion of the program’s intake assessment tool. This measure is important to SFHP because it helps identify issues with program performance and provides opportunities for program improvement.

**Measure Target, Results, & Barriers**

This measure calculates the percentage of engaged members out of all members identified for program participation, either through administrative data or active referral. Baseline data is not available given that the CMCM program launched in 2015. The 2016 target was established based on the plan’s experience with its Community Based Care Management (CBCM) program. The target population for the CMCM program is members with complex medical issues and high inpatient and/or Emergency Department utilization, combined with low utilization of outpatient services. There were no barriers to meeting the target.

<table>
<thead>
<tr>
<th>Baseline performance: Not Available</th>
<th>Final performance: 43%</th>
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</thead>
<tbody>
<tr>
<td>Target: 40%</td>
<td>☒ Target was met</td>
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<tr>
<td></td>
<td>☐ Target was not met</td>
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</tbody>
</table>

**Accomplishments**

The activities conducted include: 1) successful hiring and training of three new case management staff members, 2) successful development of an outreach report to identify members eligible for CMCM, successful development and implementation of a CMCM outreach workflow. There were no issues impacting completion of these activities.
**Recommended 2017 Interventions**

Care Management is discontinuing the engagement rate measure and will implement a new Depression Screening QI measure that is standard among all Care Management programs and better aligned with requirements from the National Committee for Quality Assurance (NCQA), Health Homes Program (HHP), and our SFHP organizational goals. The new measure will ensure all programs are aligned in their objectives and are subject to a standardized evaluation.

**4.5 All Cause Readmissions (ACR)**

**Measure Summary**

The All Cause Readmissions (ACR) measure is within the Care Coordination domain. This measure reflects the activities to prevent members from being readmitted within 30 days of discharge of an acute admission. Meeting this quality measure indicates that the discharge planning program and case management activities are keeping our members out of the hospital and in lower levels of care by reconnecting them to their Primary Care Provider and or needed specialty care. The ACR is measured monthly following the HEDIS All-Cause Readmission methodology.

**Measure Target, Results, & Barriers**

The ACR is measured by identifying acute inpatient admissions where a readmission occurred within 30 days of the discharge date. The target is a 14.43% readmission rate or less for UCSF and CHN members with a discharge from an acute hospital, excluding childbirth. This was chosen as both baseline and target as SFHP implemented a new discharge planning program for CHN members discharged from an out of medical group hospital. There are several barriers that SFHP encountered in tracking this metric. One barrier is that the discharge planning program was implemented in phases by facility so all CHN membership did not participate until Q3 2016. Another barrier is that the program is targeting only CHN out of medical group (OOMG) membership and not UCSF membership due to launching this program to focus first on CHN members. This decision was based on capacity and potential duplication of activities with UCSF-administered discharge planning.

<table>
<thead>
<tr>
<th>Baseline performance: 14.43%</th>
<th>Final performance: 22%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target: 14.43%</td>
<td>☐ Target was met ☒ Target was not met</td>
</tr>
</tbody>
</table>

**Accomplishments**

The readmission rate activities include the phased implementation of the discharge planning program that launched Q4 2015. Phase 1 included completing a discharge assessment that identified critical elements of transitioning care and setting primary care follow-up visits for CHN members discharged from an out of medical group hospital. The phase 2 activities will launch at a later date and will include
follow up phone calls to members. Other activities planned will be an on-site hospital nurse to discuss the discharge plan directly with the member and in coordination to hospital caregivers. Based on the implementation schedule and limited population served, the ACR metric does not adequately reflect the target population. Anecdotal feedback includes high satisfaction from primary care providers and providers reporting that the discharge summaries assisted with adjusting medication regimens based on the inpatient diagnosis.

**Recommended 2017 Interventions**

The recommendation is to change the measure to better represent the target population. In the next year the current measure represents ACR across SFHP’s network, while the activities generally support only the UCSF and CHN networks. Discharge planning activities will continue and based on resources, move into the second phase to include follow up phone calls, onsite discharge discussions with the member, and referrals to internal and external care coordination programs.

5. **Utilization Management**

Measures in this domain will be reported in the amendment published in early 2017 (see Appendix 1).

6. **Delegation Oversight**

Measures in this domain will be reported in the amendment published in early 2017 (See Appendix 1).
## Appendix I: 2016 Quality Improvement Work Plan

<table>
<thead>
<tr>
<th>Row</th>
<th>Area of Impact</th>
<th>Measure</th>
<th>Measure Summary</th>
<th>Target</th>
<th>Responsible Staff</th>
<th>Activities</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Quality of Service and Access to Care</td>
<td>Rating of Health Plan (HP-CAHPS)</td>
<td>Increase the rate of members who rate the health plan highly</td>
<td>66.16%</td>
<td>PM, Member Experience</td>
<td>• Improvement projects with internal departments DHCS Performance Improvement project with Customer Service to help members get the information they need</td>
<td>Target Met</td>
</tr>
</tbody>
</table>
| 2.2 | Quality of Service and Access to Care               | Getting Care Quickly Rating (HP-CAHPS)       | Increase the rate of members who report they get care quickly     | 68%     | PM, Member Experience      | • Coleman Associates DPI  
• CG-CAHPS PIP measure  
• Access trainings  
• NEMS & SFHN Improvement Projects                                                                 | Target Not Met    |
| 2.3 | Quality of Service and Access to Care               | Getting Needed Care Rating (HP-CAHPS)        | Increase the rate of members who report they get needed care      | 64%     | PM, Member Experience      | • Coleman Associates at SFGH Specialty  
• Specialty Access PIP Measures                                                                                           | Target Met        |
<table>
<thead>
<tr>
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</table>
| 2.4 | Quality of Service and Access to Care | Provider Satisfaction | Statistically increase the rate of provider satisfaction based on 3 provider survey questions | Statistically-significant increase at 95% confidence interval, OR 90th national Medicaid percentile | Supervisor, Provider Network Operations | • Analysis of survey responses  
• Provider Relations toolkit and training  
• Provider services metrics  
• Provider Update newsletter | Target Met |
| 3.1 | Clinical Quality and Patient Safety | Asthma Medication Ratio | Improve asthma medication ratio | 70.43% (90th percentile in MY 2014) | Manager, Clinical Quality | • Member outreach through disease management  
• Provider outreach | Target Met |
| 3.2 | Clinical Quality and Patient Safety | Percentage of HEDIS Measures in the 90th% | Maintain the rate of publicly reported HEDIS measures in the Medicaid 90th percentile | 13/27 (48%) measures in the 90th percentile in 2015 | PM, Population Health | • Member outreach  
• Provider outreach  
• Data quality improvement efforts  
• Comprehensive data capture | Target Not Met |
| 3.3 | Clinical Quality and Patient Safety | Initial Health Assessment Rate | Improve member engagement with primary care by increasing the IHA compliance rate | 100% | Grievance Analyst | • Include FSR results of the MRR for IHAs  
• Review methodology every two years & validity with other Health Plans | Target Not Met |
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</table>
| 3.4 | Clinical Quality and Patient Safety    | Compliance with QMED measures #2.3, 3.1, 5.2 and 4.7 as shown through PIP measures DQ1, DQ2 and DQ4 | Compare encounter data to key medical record data elements in support of DHCS data quality requirements | 30%      | Manager, Population Health       | • Implement PIP data quality domain  
  • Provide technical support in the form of trainings to providers on key medical record elements  
  • Implement a data quality improvement grant to PIP participants with the lowest compliance rates | Target Not Met |
| 3.5 | Clinical Quality and Patient Safety    | Influenza Vaccine Utilization | Increase in the rate of member flu vaccinations, measured by cumulative rate from previous seasonal period (July - June) | ≥ 3% increase | Care Coordination Pharmacist | • Informed members, providers and pharmacies  
  • Monitor utilization  
  • Update formulary (prn - when vaccines enter/exit market) | Target Not Met |
<table>
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<tr>
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</table>
| 3.6 | Clinical Quality and Patient Safety    | Primary Care Provider Site Medical Record Review | Increase MRR scores by 2 percentage points from 2013 score                       | Increase of 2 percentage points from 2013 MRR score | Nurse Specialist - Provider Quality and Outreach | • Conduct timely triennial FSRs and interim monitoring  
  • Provider outreach and training  
  • Timely and thorough CAP follow-up  
  • Participation in biannual DHCS Site Review Work Group meetings  
  • Hold trainings for Certified Nurse Reviewers at least biannually | Target Not Met |
| 3.7 | Clinical Quality and Patient Safety    | Pain Management Opioid Safety                 | SFHP Pain Management Program’s aim is to maintain the % of members with at least one opiate agonist prescription at 8.5% or less (across all lines of business, annually). | 8.5%       | Medical Director                       | • Provider and staff trainings  
  • PIP measure monitoring (includes part B CURES completion)  
  • Technical Assistance  
  • Alternative Treatment Options (Acu & Chiro) | Target Met    |
<table>
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</table>
| 4.1 | Care Coordination and Services | CMCM Program Self Efficacy | Increase the rate of members reporting increased self-efficacy based on member assessments (initial to closing). | 70% | Program Manager, CHAMP | • Conduct outreach to program members  
• Conduct & complete member assessments (initial and closing)  
• Conduct analysis of assessments | Target Met |
| 4.2 | Care Coordination and Services | CBCM Self-Reported Health | Increase the rate of members reporting increased self-reported health based on member assessments (initial to closing). | 70% | Program Manager, CHAMP | • Conduct outreach to program members  
• Conduct & complete member assessments (initial and closing)  
• Conduct analysis of assessments | Target Met |
<p>| 4.3 | Care Coordination and Services | CMCM Client Satisfaction | Increase the rate of CMCM satisfaction | 80% | Manager, Complex Medical Case Management | • CMCM Member Satisfaction Survey developed in October 2015. Approval of final copy sent to Marketing on 11/5/2015. | Target Met |
| 4.4 | Care Coordination and Services | CMCM Client Engagement | Increase the rate of CMCM engagement | 40% | Manager, Complex Medical Case Management | • Identified need to revise reporting process used to identify CMCM program candidates based on administrative data sets. Initial process contained large | Target Met |</p>
<table>
<thead>
<tr>
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<th>Activities</th>
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</tr>
</thead>
</table>
| 4.5 | Care Coordination and Services | All Cause Readmissions | Reduce the rate of all cause readmissions for UCS and CHN OOMG admissions. | 14.43% | Manager, Concurrent Review | • Launch phase 1 of the discharge planning program in December 2015  
• PIP primary care follow-up post discharge measure | Target Not Met |
|     | Quality of Service and Access to Care | Cultural and Linguistic Services | Increase the number of medical groups who meet the CLS audit requirement | 100% | PM, Population Health | • Annual medical group audits and corrective action plans when necessary | Results to be reported in amendment |
|     | Quality of Service and Access to Care | Member Grievances and Appeals | Increase the rate of member grievances and appeals resolved in a timely manner | 100% | Grievance Analyst | • Escalate grievances to Grievance Review Committee when the provider response is late. | Results to be reported in amendment |
|     | Quality of Service and Access to Care | Potential Quality Issues (PQI) | Increase the rate of PQIs resolved in a timely manner | 95% | Director, Clinical Operations | • Measure completion time of PQI receipt to PQI designation  
• Update systems to reflect 60 day TAT | Results to be reported in amendment |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
|     | Clinical Quality and Patient Safety    | Medication Therapy Management | Establish an enrollment metric that assess whether the program design meets the needs of the target population. | 30%    | Care Coordination Pharmacist | • 1st quarter - program design and budget submitted  
  • 2nd quarter - contracting, claim system and reporting developed  
  • 3rd quarter - implement tracking tool  
  • 4th quarter - member enrollment | Results to be reported in amendment |
|     | Utilization Management                  | Behavioral Health Penetration Rate | Increase the rate of NSMH utilization as seen through Beacon claims. Baseline is 0.55% for CY 2015. | 3%     | Chief Medical Officer     | • With Governing Board approval add telemedicine behavioral health vendor to NSMH network  
  • Increase rates paid to psychiatrist to enhance network participation  
  • Ensure that CBHS is submitting claims for NSMH services provided | Results to be reported in amendment |
<table>
<thead>
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<th>Responsible Staff</th>
<th>Activities</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utilization Management</td>
<td>Care Coordinator Utilization Management File Audits</td>
<td>Increase the rate of audit scores for UM coordinators</td>
<td>90%</td>
<td>Director, Clinical Operations</td>
<td>• Audit created by the Manager and Supervisor of the UM Coordinators and 5 cases are randomly selected to audit and any errors found are then addressed with the associate.</td>
<td>Results to be reported in amendment</td>
</tr>
<tr>
<td></td>
<td>Utilization Management</td>
<td>Interrater Reliability</td>
<td>Increase the rate of aggregate associate IRR scores</td>
<td>95%</td>
<td>Director, Clinical Operations</td>
<td>• Educate nurses and MD's on medical necessity criteria • Facilitate Interrater Reliability assessment</td>
<td>Results to be reported in amendment</td>
</tr>
<tr>
<td></td>
<td>Utilization Management</td>
<td>Pharmacy Prior Authorization Turnaround time</td>
<td>Increase the rate of authorizations approved/denied in a timely manner</td>
<td>90%</td>
<td>Supervisor, Pharmacy Operations</td>
<td>• Analysis of PA TAT reports • Lessons Learned summaries for PAs with noncompliant TAT. • Monitor PA TAT</td>
<td>Results to be reported in amendment</td>
</tr>
<tr>
<td></td>
<td>Utilization Management</td>
<td>UM Timeliness of Decision and Notification</td>
<td>Increase the rate of authorizations approved/denied in a timely manner</td>
<td>90%</td>
<td>Director, Clinical Operations</td>
<td>• Measure completion time of authorization from receipt to MD disposition</td>
<td>Results to be reported in amendment</td>
</tr>
<tr>
<td></td>
<td>Delegation Oversight</td>
<td>Delegation of CM Activities</td>
<td>Measure compliance with delegated CM activities</td>
<td>95%</td>
<td>Manager, Delegation Oversight</td>
<td>• Conduct annual oversight audit. Provider technical assistance to lowest performing providers from 2015 results.</td>
<td>Results to be reported in amendment</td>
</tr>
<tr>
<td>Row</td>
<td>Area of Impact</td>
<td>Measure</td>
<td>Measure Summary</td>
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<tr>
<td>1</td>
<td>Delegation Oversight</td>
<td>Delegation of Credentialing Activities</td>
<td>Measure compliance with delegated Credentialing activities</td>
<td>95%</td>
<td>Manager, Delegation Oversight</td>
<td>• Conduct annual oversight audit. Follow up on corrective action plans resulting from 2015 results.</td>
<td>Results to be reported in amendment</td>
</tr>
<tr>
<td>2</td>
<td>Delegation Oversight</td>
<td>Delegation of QI Activities</td>
<td>Measure compliance with delegated QI activities</td>
<td>95%</td>
<td>Manager, Delegation Oversight</td>
<td>• Conduct annual oversight audit. Provide technical assistance to lowest performing providers from 2015 results.</td>
<td>Results to be reported in amendment</td>
</tr>
<tr>
<td>3</td>
<td>Delegation Oversight</td>
<td>Delegation of UM Activities</td>
<td>Measure compliance with delegated UM activities</td>
<td>95%</td>
<td>Manager, Delegation Oversight</td>
<td>• Conduct annual oversight audit. Follow up on corrective action plans resulting from 2015 results.</td>
<td>Results to be reported in amendment</td>
</tr>
</tbody>
</table>