SAN FRANCISCO HEALTH PLAN™

Here for you

Our Journey to Improve Quality and the Health of Our Population

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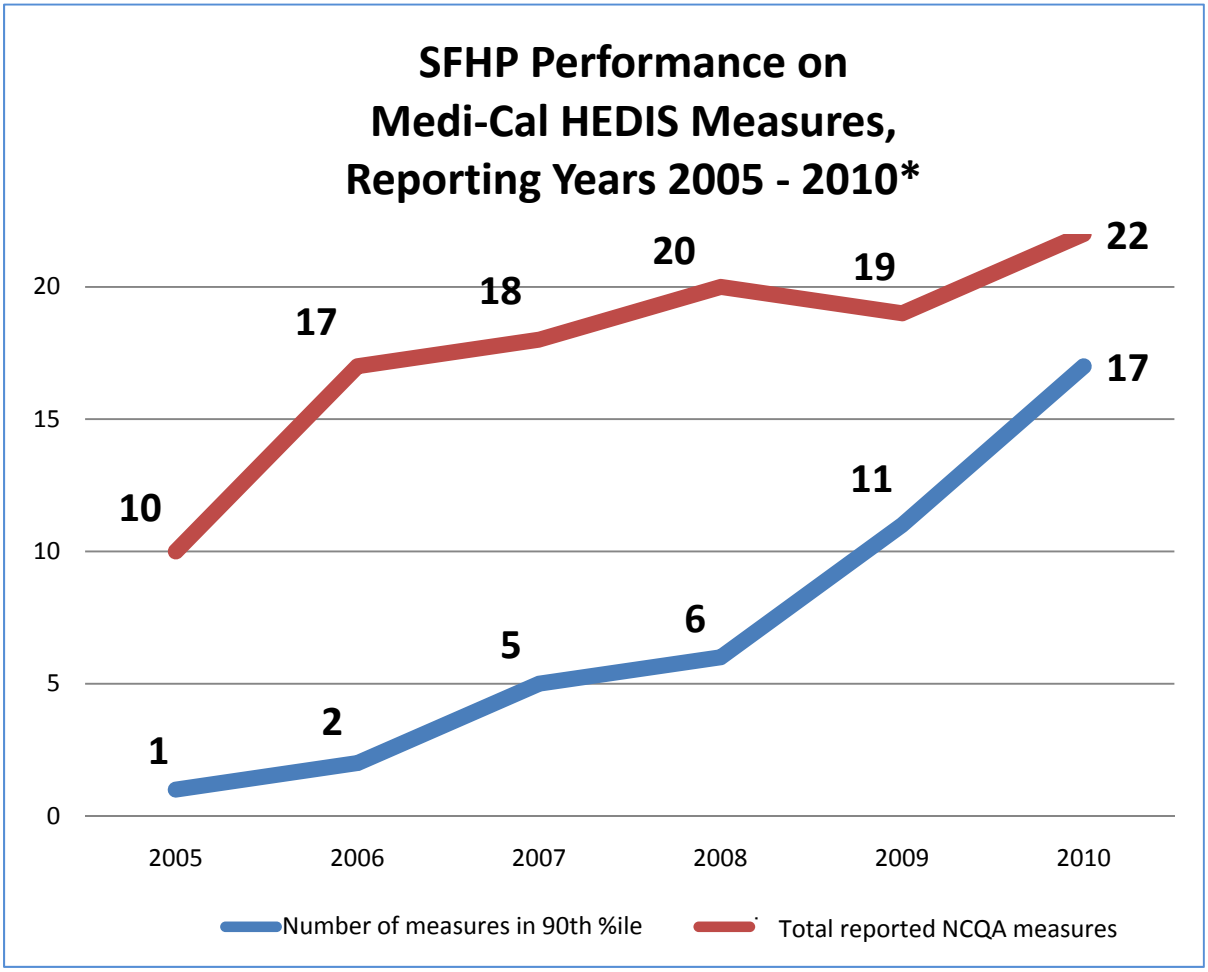
Introduction

We at San Francisco Health Plan (SFHP) are often asked "How do you do it?" by colleagues who want to hear how we score so well on HEDIS (Health Effectiveness Data and Information Set) quality measures. This white paper is a response to that question. Our hope is that by sharing information about our activities and our plans for continued improvement, we will participate in a community of learning that can drive improvements in healthcare across our country.

San Francisco Health Plan won the California Department of Health Care Services' Gold Award for HEDIS rates for three years running: 2008, 2009, and 2010. Including test measures, SFHP achieved the national Medicaid 90th percentile or better for 17 of 22 measures.* (See chart below.)

We also achieved the highest rate nationally among Medicaid plans for Childhood Immunizations for the reporting years 2008 and 2009 (data from 2007 and 2008), and Well-baby Visits for reporting year 2010 (data from 2009). For Childhood Immunizations, we are #2 nationally in reporting year 2010, falling behind our neighbor, the Health Plan of San Mateo, by 0.25%.



*** Of the total 22 publicly reported measures for 2010, 16 measures were used in California for benchmarking among Medi-Cal health plans. (The 6 new measures were excluded.) Within this subset of 16 measures, SFHP scored in the 90th percentile or greater on 11.**

In this white paper, we will describe our three-part strategy to improve HEDIS scores:

1. **Supporting population management in practices through performance improvement interventions**
2. **Directly engaging our health plan members and providers through HEDIS incentives**
3. **Aggressively capturing data during the HEDIS audit season and on an ongoing basis**

We will also describe in more detail our growing partnership with the San Francisco safety net providers to create a data-driven culture of quality improvement. Finally, we will share our plans for the future.

One more note about SFHP's quality journey: SFHP benefits from the great ideas and successes of other health plans and improvement beacons, such as CareOregon, Partnership HealthPlan of California, and L.A. Care Health Plan. We are grateful to these and other peers for their generous sharing of strategies and information.

Sincerely yours,

John F. Grgurina, Jr., CEO
San Francisco Health Plan

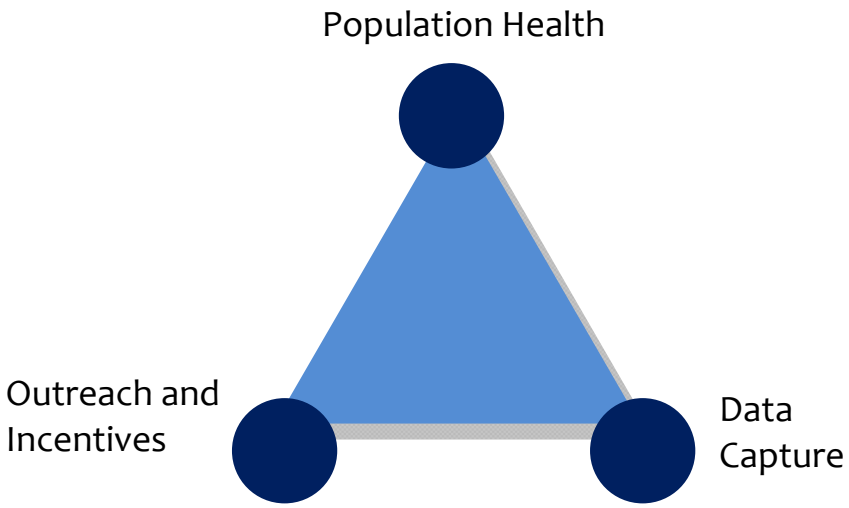
Kelly Pfeifer, MD
Medical Director
San Francisco Health Plan

SFHP strategies for improving HEDIS performance

San Francisco Health Plan uses a combination of activities to support our provider network in its journey towards reliable, evidence-based primary care for SFHP members:

- **Supporting providers in population management work**
- **Encouraging members to get recommended care through direct outreach and incentive programs**
- **Pursuing clinical data aggressively**

Our work in these three domains continues to evolve, as detailed in the "Future Plans" section below.



Supporting population management in the medical home

Compared to traditional episode-based primary care, accountability for the health of a population of patients requires a redesign of how providers deliver care. SFHP is exploring new ways to partner with our provider network to transform a visit-based model to a population health-based model. This section describes some of our efforts to support population management through providing training, consultation, incentives, and project funding.

Strength in Numbers

In March 2009, San Francisco Health Plan launched a new program called Strength in Numbers, with funding from San Francisco's universal access program Healthy San Francisco (HSF), California HealthCare Foundation, and Metta Fund. The program aims to support panel management and the use of clinic registries through standardized measures, incentives, and technical assistance. Strength in Numbers started with four diabetes care measures (testing and control levels for hemoglobin A1c and LDL cholesterol), reported quarterly by 18 safety net clinics. Through the end of 2010, clinics achieved significant improvements in these four diabetes measures.

After the first quarter of the program, Strength in Numbers allowed clinics to add more measures of their choice, based on their patient population. These additional conditions include depression, HIV, chronic pain management, and Hepatitis B. Clinics earned modest incentive payments through improvements on measures over their own baseline. By 2010, the program grew to include 24 clinics, representing 95% of Healthy San Francisco participants and 72% of SFHP-insured adult members.

To support the integration of registries and data-driven clinical work into the daily work of the clinic (as opposed to considering registry use a special QI project), Strength in Numbers offered trainings and resources to build panel management skills and registry use expertise for front-line staff. Topics

of trainings and technical assistance have included trainings on automated disease registry software and patient self-management "health coaching" trainings from Dr. Tom Bodenheimer and the Center for Primary Care Excellence at the University of California – San Francisco.

From its inception, Strength in Numbers achieved the following as of June 30, 2010:

- Medical Homes' self-reported data (n=18) showed improvement from baseline in all four diabetes measures.
- A robust data analysis was completed for participating clinics of the Department of Public Health (n=10). The analysis showed statistically significant results in three out of the four diabetes measures: HbA1c Testing, HbA1c Poor Control, and LDL Testing over the past year.

Strength in Numbers 2011 has an expanded set of measures that target high priority areas in clinical and patient experience: prevention and screening (breast and colon cancer screening), timely access (third next available appointment), meaningful use (electronic documentation of smoking status and blood pressure), and efficiency (continuity and patient show rates). Whereas previously Strength in Numbers was a program entirely supported by Healthy San Francisco, Strength in Numbers 2011 is co-sponsored by HSF and SFHP, reflecting that efforts to improve panel management in the safety net support the care of all patients, regardless of payer source.

With the expanded measures set and further development of technical assistance resources, Strength in Numbers 2011 has an ambitious set of objectives:

- Improve chronic care and prevention in the safety net
- Improve access to timely care
- Promote team-based care through teaching panel management health coaching, and other related skills to medical assistants and nurses
- Improve continuity of care for primary care teams
- Invest in the effective use of chronic care registries
- Create standardized measures and a shared data-driven culture of quality across the San Francisco safety net, supporting sharing of best practices across systems
- Align with other local and statewide safety net chronic care initiatives

One of the core lessons of Strength in Numbers was that salaried clinic medical directors were tremendously motivated by relatively small amounts of money – often about $15,000 per clinic per year (incentive amounts were based on total number of patients in the program). Medical directors used funds in a variety of ways to support their clinic projects, such as paying for staff or VISTA volunteers to do outreach to patients overdue for diabetes interventions, supporting team-building lunches for staff QI teams, buying health education supplies (such as TVs to screen educational videos), or purchasing incentive gift cards for patients with diabetes to encourage group medical visit attendance. Because clinic medical directors rarely have discretionary funds, small amounts of money for top clinic priorities turned out to be very motivating, allowing all 18 clinics to agree to focus on the same set of standardized measures and share results.

Patient Experience Pilots

Although SFHP has prided itself on high HEDIS scores and gold medals for quality, we have not fared well in measurement of patient experience: our patient satisfaction scores are among the lowest in California (see sidebar). Based on analysis of problem areas in our scores on the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey, and on input from SFHP's Performance Improvement Advisory Group, we decided to focus on two key areas of patient experience: **access to care** and **communication between patients and provider care teams**. In January, 2010, SFHP launched two small-scale learning collaboratives, based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series model. These two pilot programs were collaboratively funded by SFHP, Healthy San Francisco, California HealthCare Foundation, Metta Fund, and the University of California – San Francisco Center for the Health Professions.

The access collaborative, "**Optimizing the Primary Care Experience** (OPCE)," aimed to improve both access to appointments and office efficiency during appointments. Four clinics participated. Our expert faculty for the program was Dr. Mark Murray, with SFHP staff providing quality improvement coaching support to the improvement teams throughout the program. The program had the following goals:

- Reduce waiting times both *for* and *at* appointment services.
- Optimize health outcomes by improving clinical care, including continuity of care, defined as providers seeing their own panel of patients.

In summary, "See your own, and don't make them wait."

In 2009 and 2010, SFHP conducted extensive research and data analysis on the issue of language and cultural bias in the CAHPS surveys of patient experience.

We found that, all other things being equal,

- **Latino members** tend to score their experience higher.
- **Asian members** tend to score their experience lower.

In the results of the 2010 Department of Health Care Services CAHPS survey (administered by the Health Services Advisory Group), SFHP found that our poor showing was largely accounted for by responses from our large Asian population. Of SFHP members who responded to the adult survey, 56.5% were Asian (compared to 18.0% in Medi-Cal managed care statewide). On the children's survey, SFHP's respondents were 37.4% Asian; statewide, respondents were 9.6% Asian.

SFHP was able to successfully advocate to state agencies (MRMIB for Healthy Families, Department of Managed HealthCare for Medi-Cal) that language bias may account for some of the differences seen in scores comparing health plans. We encouraged these organizations to add disclaimers to public reporting of health plan scores stating this potential cultural difference in responses.

In addition, SFHP is launching our own survey this year to further evaluate disparities and identify potential future areas for improvement work.

Our overall CAHPS scores showed clear problems in the area of access and communication, and SFHP remains committed to addressing these problems. SFHP can share our detailed analysis of this issue upon request.

In two day-long OPCE Learning Sessions, clinics learned skills and techniques to work down visit backlogs, decrease delays, and improve efficiencies:

- **How to accurately measure supply,** demand and activity, plan for predictable variation and define a manageable panel size per full-time provider equivalent
- **How to increase visit capacity** ("supply") through optimizing provider schedules, teaming up part-time providers, simplifying scheduling templates, creating effective staff teams, and teaching access-maximizing scheduling practices to front-office staff
- **How to decrease or moderate demand** through extending visit intervals, "max-packing" visits, and decreasing no-show rates
- **How to create efficient work-flows** to decrease wait times during the visit

The second collaborative, "**Patient-Centered Communication** (PCC)," focused on improving the effectiveness of provider-patient and staff-patient communication. Five clinics participated. Expert faculty were trainers from the Institute for Healthcare Communication Dan O'Connell and Sandy Reifsteck. SFHP staff provided quality improvement coaching support. The program had the following primary goals:

- **Optimize** health outcomes by improving communication and shared decision-making
- **Improve** provider, staff and patient satisfaction

PCC trainings featured key communications techniques for providers and staff: agenda setting, staff huddles, warm greetings for patients, and teamwork techniques.

SFHP believes that a core component of our success in these collaboratives was the intensive, customized clinic coaching provided by two IHI-trained Improvement Advisors on the SFHP staff, and monthly teleconferences to cover specific content and allow sharing of successes and challenges among the clinics.

Final results will be available in May 2011. Preliminary results demonstrate significant improvement in both the OPCE and PCC projects. For OCPE (access), all four sites cut their average wait time for a routine return appointment by over half in the first six months of the collaborative (examples: one site went from 42 days to 20 days; another site went from 10 days to less than one day). For PCC (communication), the first round of results from the patient experience surveys demonstrated that four out of the five clinics improved over baseline in more than 50% of the survey measures.

SFHP is committed to continuing to improve our HEDIS scores, and we believe that we cannot achieve our goal unless patients have access to timely care, and are satisfied with the care they receive. Therefore we will continue to work on improving the patient experience for our members.

The Foundation of SFHP's Quality Partnership with Providers: The SLIM Network

SFHP's programs to improve chronic care, access and communications stand on the foundation of shared learning that began with a quality improvement conference in May 2009, funded by the California HealthCare Foundation. This conference established the San Francisco SLIM Network (SLIM stands for "Sharing Learning Improving Measuring") and featured breakout sessions with Northern California clinical leaders on the topics of disease registry use, chronic pain management, and improving access to care.

Since the initial SLIM conference, SFHP has used the SLIM network to promote, host, and co-sponsor fifteen additional trainings and conferences for all levels of clinic staff. Events have included a training session on primary care health coaching for frontline non-provider clinic staff, chronic pain management training, childhood obesity prevention training, and a site visit to CareOregon for 26 safety net executives and physician leaders, to learn from their Primary Care Renewal experience.

Member outreach and incentives

SFHP credits part of our HEDIS success to our direct outreach to our members. Among the most long-standing and effective interventions are the member incentive programs, where SFHP members receive gift cards for completing recommended care services such as annual well child visits or recommended tests for diabetes. Other interventions include live and automated phone call reminders for overdue care, and our ongoing work to provide health education materials and support for providers to teach patients how to manage their health and receive recommended care.

Member Incentives

Our member incentive programs began with incentives for well-adolescent visits (2002) and well-child visits (2003). Like other community health plans, we continue to redesign our incentives to accommodate new measures and address measures we want to improve.

The incentives are working, according to our provider network. In February 2011, SFHP's annual survey of our provider network found that 80% of our providers agree with a statement that SFHP member incentives are useful for their practice. This is a large jump from the 2010 survey, where only 44% of respondents stated that they found the incentives useful. We attribute the increase in part to our efforts to educate providers about the incentive programs.

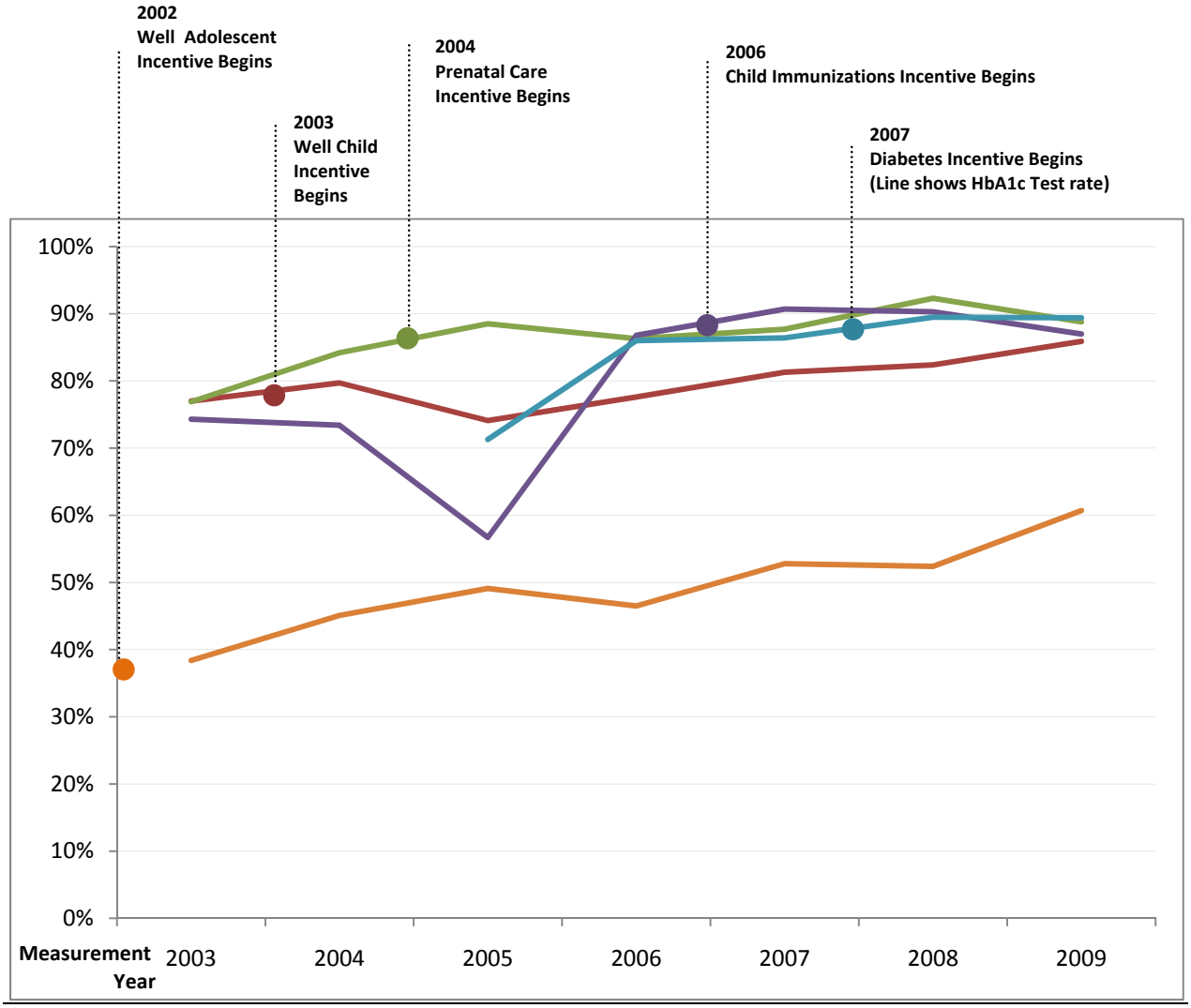
The two pages that follow give more detail on SFHP HEDIS incentives. Page 10 provides detail about each incentive. The chart on page 11 shows SFHP performance data on HEDIS measures for which we have incentive programs, with the year the corresponding incentive program started.

SFHP HEDIS Measure Incentives

HEDIS Measure	Eligible Members, Required Services	SFHP Incentive Program	2009 Member Response Rate
Prenatal Care	Expectant mothers. Must attend a prenatal medical visit during first trimester, or within 42 days of SFHP enrollment.	Women's health mailer includes description of incentive. Interested members call SFHP for incentive card. If provider signs, member gets incentive. $25 gift card.	35% of members who request incentive info submit a card that qualified for incentive gift.
Postpartum Care (New for 2011)	New mothers. Must attend a postpartum medical visit within 3 to 8 weeks of delivery.	Women's health mailer includes description of incentive. Members may call for incentive card. SFHP also does live outreach calls to postpartum women. $25 gift card.	NEW! This incentive will launch in 2011.
Childhood Immunizations	Children up to their second birthday. Must receive all doses for 10 immunizations: DTaP, Flu, HepA, HepB, HiB, MMR, Polio, Pneumococcal, Rotavirus, Varicella.	Incentive-specific mailer to all eligible member-parents includes card for provider to sign for completed immunizations. Live and automated reminder calls to member-parents reminding them to make/keep appointments and reminder of incentive. $50 gift card.	23% of all eligible members returned fully completed cards that qualified for incentive gift.
Well-child Visits	Children between ages of 3 and 6. Must attend a well-child medical visit within the calendar year.	Mailer to all eligible member-parents each year at child's birthday. Automated phone call reminders go out just prior to mailing. $25 gift card.	41% of eligible members returned fully completed cards that qualified for incentive gift.
Well-adolescent Visits - **SFHP Members** - **SFHP Providers**	Adolescents between ages of 12 to 21. Must attend a well-adolescent medical visit within the calendar year.	Mailer and automated reminder calls to all eligible members at birthday. $15 gift card or 2 movie tickets; entered in annual raffle of iPod Nano and laptop. Providers can receive $20 for each patient with a complete annual visit.	26% of eligible members returned an incentive card that qualified for the incentive gift.
Comprehensive Diabetes Care	Members with diabetes, ages 18 to 75. Must receive six screening tests in the year: hemoglobin A1c, blood pressure, cholesterol (LDL-C), neuropathy, eye exam, diabetic foot exam.	Mailer to all eligible members includes card for provider to sign attesting to the completion of the six required screening tests. $25 gift card.	8% of all eligible members returned an incentive card. Of these, 46% qualified for the incentive gift.

SFHP HEDIS Rates:

Association of Measure Performance with Member Incentives (Medi-Cal only)



Notes on data chart above:

1. Percentages above are for the measurement year, not the reporting year.
2. Incentives are one of many factors that contribute to success on these measures; significant credit, of course, goes to our providers for ongoing improvements.
3. In 2009, SFHP scored in the 90th Percentile statewide for Medi-Cal in four of the five HEDIS measures for which we have incentives. (Timeliness of Prenatal Care fell short.)
4. In the chart, the HEDIS rate for HbA1c testing serves as a proxy for SFHP's comprehensive diabetes care incentive (which requires members to receive six tests annually, of which HbA1c is one).
5. The number of immunizations that are included in the comprehensive Childhood Immunizations measure has grown significantly since the first data point above in 2005, from 7 immunizations to 10 immunizations (with a combined total of 25 doses) in Measurement Year 2010.
6. The dip in the Childhood Immunizations measure results in measurement year 2005 is attributed to a change in the immunizations required for completion in that year.

Additional HEDIS Measures Outreach

To support and supplement the HEDIS incentives programs detailed above, SFHP engages in targeted interventions for many more HEDIS measures. Some of these activities are described below.

Comprehensive Diabetes Care: In addition to the Diabetes Care incentive program, we hold after-hours HEDIS Push calls in the fall. SFHP customer service representatives call members who are missing recommended tests and screenings, according to our HEDIS administrative data. The staff uses talking points to educate members about the importance of diabetes preventive care, and remind them about the incentive programs. Call lists are sorted by member language and by SFHP priorities (for example, in 2010 we focused on eye exams). SFHP also provides "diabetes bags" (containing health education supplies including water bottles, exercise bands, measuring cups & spoons, medicine bags, "Living with Diabetes" guides in English and Spanish, and a healthy cookbook in English, Spanish, and Cantonese) to clinics who host comprehensive "Diabetes Days," where patients with diabetes complete annual diabetes screening and tests while benefiting from peer support, group health education, and other care services and self-management activities.

Automated Outreach Calls: SFHP reaches out to members to remind them of needed care and of incentive programs through automated calls throughout the year. In 2010, as part of our HEDIS year-end push, we used automated calls to patients that needed one of the following: Well-baby Visit, Well-child Visit, Well-adolescent Visit, and Cervical Cancer Screening (following HIPAA privacy regulations).

Population Outreach Lists: Along with the automated calls, lists of SFHP members who have not received care are provided to clinics and providers, to encourage them to call their patients directly. Providers are asked to provide feedback on how they use these lists, to allow us to tailor these lists by site or by provider in the future.

Well-adolescent Visit: SFHP provides outreach lists and patient education supplies for providers who host special adolescent clinic days. To encourage teens to see their provider for a well visit during the summer, we mail a flyer to eligible members in May, promoting the annual visit, our incentive program, and the annual gift raffle. Also in the spring, we distribute posters to schools to remind students of the importance of their annual visit.

Leveraging a Vendor Relationship to Improve Chronic Care

In 2010, our optometry vendor offered to do direct outreach to members who are overdue for an eye exam. The vendor has also worked with optometry offices to institute diabetic screening, to capture undiagnosed diabetics and refer them to primary care.

Member Health Education and Cultural and Linguistic Services

SFHP develops health education materials tailored to our members, in English, Spanish, Cantonese, and Russian, among other languages, often in response to provider requests. We mail these educational materials directly to members, and we also distribute materials to provider practices. A recent example of this work was the translation of existing pertussis (whooping cough) education materials for parents of infants and young children into Vietnamese. The SFHP member newsletter is distributed quarterly, with topics identified by our Member Advisory Committee and our provider network Quality Improvement Committee.

Aggressive data capture

Performance cannot be evaluated without accurate information. Optimum scores cannot be achieved without exploiting all data sources, and encounter data from our capitated network is often incomplete. Aggressive data capture is SFHP's third strategy for achieving high HEDIS scores. Some of these are year-round pursuits, while some occur during the HEDIS audit season.

Monthly Metrics Review of HEDIS Data

Each month, the management team of SFHP's Medical Management Department meets to review the latest administrative rates in each of the HEDIS measures as part of our monthly metrics review. We compare these rates to those of the same month for the previous 3 years. Where there is a difference of 3% or more, the team investigates this discrepancy through detailed analysis of provider submissions, to identify if it 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.

We also analyze 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 Clinical Informatics team works with the Information Technology Services Department to contact data submitters to facilitate improved data quality and timeliness.

This ongoing analysis is important, as it is one way to act on data issues within the HEDIS measurement year. We can uncover any problems with data submissions or care delivery and act quickly to correct them. We don't have to play wait-and-see until the annual HEDIS audit to know where to improve.

Annual Data Capture Efforts during HEDIS Season

As part of HEDIS data collection efforts in 2010 (measurement year 2009), SFHP identified new strategies that we believe helped add six new measures to the 90th percentile.

First, we identified new data sources to minimize chart pursuits. We sought and received approval to use three additional databases for HEDIS data: the California Immunization Registry, the San Francisco Department of Public Health's electronic record (used by 15 primary care clinics and some additional non-DPH clinics) and the disease registry program used by the majority of the health centers in our network. We also identified seven additional, under-utilized data sources that helped us locate paper records during physical chart pursuits, including our own member incentive program databases.

Second, as has been our practice in the past, SFHP hired a HEDIS team of nurses and a medical assistant to work in-house at SFHP during the HEDIS season. The team leader deliberately cultivated a culture of team cohesion, passion, inventiveness, and resourcefulness. Their mission-driven enthusiasm was infectious, and they built strong relationships with staff in the provider practices, which translated into improved cooperation with chart pulls. They also cultivated an attitude of "we will go to the end of the earth to find a positive hit," and there was almost a sports-like team spirit to every successful find. Staff called Indonesia and China looking for confirmation of completed immunizations. We also have been experimenting with the ideal team composition, such as training medical assistants to perform chart reviews that had formerly been done by nurses.

The third effective practice we used during the 2010 HEDIS audit was to include the SFHP Medical Director on the HEDIS team. The medical director was often able to convert a negative to a positive hit through interpretation of arcane abbreviations or "doctor scribble," or through a call to an optometrist to confirm that a retinal exam was actually performed.

What's next for SFHP HEDIS improvements

SFHP is engaged in three new endeavors to continue our efforts to push more measures into the 90th percentile.

Quality is a top organizational priority: staff communications and bonuses

SFHP attributes its success to the fact that there is consistent CEO and executive support for making quality a top priority at SFHP. Review of our four organizational goals is a part of all staff and manager communications, and is emphasized at all staff meetings:

- **Universal coverage**
- **Quality and Access to care**
- **Exemplary Service**
- **Financial Viability of the Plan and the Safety Net**

The importance of HEDIS scores as a measure of quality is a consistent message to all SFHP staff.

For many years, all SFHP staff received a modest incentive bonus based on HEDIS results. In 2009, this program was phased out and replaced with a broader staff incentive program that emphasizes results on metrics for a broader set of goals. In the current program (2011), SFHP staff members receive an annual bonus based on performance in three areas:

- **Organizational goals and metrics**
  HEDIS scores always are included in these goals, reviewed and approved annually by our Governing Board.
- **Department goals and metrics**
  HEDIS performance is included in the annual goals of the Medical Management department.
- **Individual goals**
  Every staff member establishes three to five specific individual goals with her manager each year.

SFHP believes the careful selection of goals and metrics, and ongoing communication to ensure they remain visible and meaningful for all staff, have contributed to our continually improving organizational performance.

San Francisco Quality Culture Series: Improving Clinic Leadership and Change Capacity

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 to achieve high performance in the triple aim (population health, patient experience, and cost containment) have three key elements in common:

- The will to change (or at least recognition that the current system is not working)
- High-performing leadership teams that 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)

The San Francisco Quality Culture Series (SFQCS) launched in January 2011, and aims to train 25 clinic leadership teams with tools and skills needed to transform their clinics. These clinics must adapt to the new era of health care reform where, for the first time, market competition will come to poorly funded delivery systems. The program provides intensive leadership training to address the three elements of success above. SFQCS is a collaboration between SFHP and the San Francisco Community Clinic

Consortium, the San Francisco Department of Public Health, and the University of California-San Francisco Center for Health Professions, and is funded by the Gordon and Betty Moore Foundation. SFQCS is a train-the-trainer program that will provide clinic leaders with tools to bring back to their clinic and help achieve a culture of quality, to accelerate their ability to implement new initiatives effectively.

Redwood Community Health Coalition, a consortium of clinics in four Northern California counties, began the Quality Culture Series in 2006, building on similar leadership development training at Intermountain Health Care in Utah that began in 1992. Redwood Community Health Coalition saw improvements in the areas of chronic care, access, EHR, and patient experience after the launch of its Quality Culture Series. SFQCS is adapted from this program.

Program activities include eight day-long training workshops spread over one year. During this time, SFQCS teams will work on an improvement project, with individualized technical assistance from a quality improvement coach. Each leadership team has chosen one of the following topics for their improvement project:

- **Improving Access to Appointments**. Among other quality and regulatory drivers, a new California timely access regulation requires primary care appointments for managed care patients within 10 days of request, starting January 2011.
- **Improving the Patient Experience**. Nationally, there is increased agreement on the importance of patient experience in achieving positive healthcare outcomes.
- **Integrating Behavioral Health in Primary Care.** Many clinics in San Francisco have added behavioral health professionals to their care teams. Complete integration is a major initiative of the San Francisco Department of Public Health, and is being pursued by several non-profit health centers as well.
- **Preparing for or Implementing Electronic Health Records**. The federal "Meaningful Use" measures and the industry-wide migration from paper to electronic records make this one of the most important changes for any health care organization to act on, and to get right.

In 2012, SFQCS will make available an evaluation of its impact and outcomes.

Practice Improvement Program

San Francisco Health Plan's Practice Improvement Program (PIP) launched in January 2011, and aims to be a pay-for-performance program that supports the infrastructure to create meaningful and lasting change in our broad provider network. Where the Strength in Numbers program focuses on the population health efforts of front-line staff in safety net clinics, PIP targets the data infrastructure of the clinic or practice, and includes our entire network, including private medical groups. PIP's goal is to reward system improvements and drive better outcomes in clinical care and patient experience, in preparation for healthcare reform. While the long-term objective of PIP is to reward performance-based outcome measures, PIP will initially focus on reporting and process measures, in the areas of clinical care, patient experience, data quality, and systems improvement.

The PIP structure and measurements were developed by the PIP Advisory Group, a group of physicians and administrators representing our entire provider network. 2011 measures focus on the following:

- **Data quality**. Medical groups and clinics will receive incentive payments based on timeliness and completeness of data submissions. SFHP was concerned that the quality of our data was not adequate to reward providers based on individual HEDIS measure outcomes, so our first priority is to improve the quality of our data.
- **Clinical quality.** Incentive payments will be based on the development of a QI project focusing on one of SFHP's six top HEDIS priorities. There is no payment for improvement for the first year; rather the payment is simply for developing a QI intervention, and submitting an

evaluation of that intervention. The advisory group believed that to start payments based on outcomes, without adequate data quality, would jeopardize support for the program.

- **Patient Experience.** SFHP will fund a network-wide patient experience survey, and will provide medical groups and clinics with comparative results. Incentives will be paid on submitting an improvement plan, based on the specific survey results.
- **Systems Improvement.** SFHP is convinced that change only occurs with high-performing leadership teams, creating a data-driven culture of quality (see above for a description of the SF Quality Culture Series). Incentives will be paid if medical group and clinic leaders complete QI and leadership training (at least 20 hours per person); SFQCS counts for this measure. Incentives are also paid for medical groups and clinics to share comparative clinical reports with providers so that providers receive meaningful data about their performance compared to their peers.

The measures will be adapted each year by the Advisory Group, to ensure that PIP aligns with other improvement efforts and to allow us to move over time to outcomes measures. SFHP plans to provide technical assistance to help medical groups and clinics improve performance through these measures.

Summary

At San Francisco Health Plan, we take pride in the many ways we partner with our provider network to improve quality and access to care. We follow the Model for Improvement; since it is not always clear what is the best way to achieve a goal, we frequently pilot interventions, measure the outcomes, and then revise our approach. We have benefitted greatly from learning from other health plans and providers, so we hope this paper is helpful in demonstrating what we have learned, and what we are continuing to learn. Please let us know if you would like any more detailed information on any of the programs we describe.

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