# AGENDA

## Quality Improvement Committee: Open Session

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Objective</th>
<th>Assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30</td>
<td>Follow Up Items (5 min)</td>
<td>Update</td>
<td>Dr. Glauber</td>
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<td></td>
<td><strong>QIC: quorum: 5 QIC members, 3 physicians, including committee chair</strong></td>
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<tr>
<td></td>
<td>- Public Comments/Questions</td>
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<tr>
<td></td>
<td>- Follow Up Items (p. 3)</td>
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<tr>
<td>7:35</td>
<td>Consent Calendar (5 min)</td>
<td>Update/Vote</td>
<td>Dr. Glauber</td>
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<td></td>
<td>- Review of October 2019 Minutes (p. 9)</td>
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<td></td>
<td>- UM Committee Minutes</td>
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<tr>
<td></td>
<td>o September 2019 (p. 15)</td>
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<td>o October 2019 (p. 23)</td>
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<td>- P&amp;T Member Reappointments and New Members (p. 31)</td>
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<td></td>
<td>- Q2 2019 ED Visits/Pharmacy Access Report (p. 33)</td>
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<td>- Q3 2019 Appeals Report (p. 37)</td>
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<td>- Q3 2019 PQI Report (p. 43)</td>
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<td>- Policies &amp; Procedures (P&amp;Ps)</td>
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<td></td>
<td>o CO-57 UM Clinical Criteria (p. 49)</td>
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<td>o QI-20 Comprehensive Perinatal Services (p. 55)</td>
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<td>- UM Criteria</td>
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<tr>
<td></td>
<td>o UM Criteria Genital Confirmation Services (p. 67)</td>
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<td></td>
<td>o UM Criteria Non-Genital Confirmation Services (p. 73)</td>
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<td></td>
<td>o UM Criteria Private Duty Nursing (p. 81)</td>
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<td></td>
<td>o InterQual (p. 87)</td>
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<td>7:40</td>
<td>Quality Improvement (70 minutes)</td>
<td>Update/Vote</td>
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<td></td>
<td>- 2018 Annual Grievance Report (p. 91)</td>
<td></td>
<td>Gabrielle Torres</td>
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<tr>
<td></td>
<td>- QI 2019 Program Evaluation (p. 95) and QI 2020 Program Description (p. 123)</td>
<td>Vote</td>
<td>Adam Sharma</td>
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<tr>
<td></td>
<td>- Policy &amp; Procedure Summary (p. 185)</td>
<td></td>
<td>Matija Cale</td>
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<tr>
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<td>o CO-59 Investigational or Experimental (p. 187)</td>
<td>Vote</td>
<td>Varun Shankar</td>
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<td>- Beacon 2019 Program Evaluation (p. 195)</td>
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<td>9:00</td>
<td>PAC</td>
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**NEXT MEETING THURSDAY, APRIL 9, 2020**
## Quality Improvement Committee Follow Up List

<table>
<thead>
<tr>
<th>QIC Meeting Date</th>
<th>Follow Up Item</th>
<th>Owner</th>
<th>Complete By</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 2019</td>
<td>Sean will send any comments from the open-ended portion of the survey for QIC to review and ask for other feedback from committee members.</td>
<td>Sean Dongre</td>
<td>8/30/19</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Oct 2019</td>
<td>Invite UM Team Representative to upcoming QIC to share improvements to the authorization process</td>
<td>Dr. Glauber</td>
<td></td>
<td>In progress</td>
<td></td>
</tr>
<tr>
<td>Oct 2019</td>
<td>Determine if PTSD falls under non-specialty mental health benefit</td>
<td>Dr. Glauber</td>
<td></td>
<td>In progress</td>
<td></td>
</tr>
<tr>
<td>Oct 2019</td>
<td>SFHP to meet with SFHN to review opportunities for provider and health plan to collaborate on outreach activities</td>
<td>Adam Sharma</td>
<td>11/22/19</td>
<td>Complete</td>
<td></td>
</tr>
<tr>
<td>Oct 2019</td>
<td>Include information regarding PHQ-2 and PHQ-9</td>
<td>Adam Sharma</td>
<td>11/25/19</td>
<td>Complete</td>
<td>See attachment in the packet</td>
</tr>
</tbody>
</table>
Patient Health Questionnaire-2 (PHQ-2)

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is to screen for depression in a “first-step” approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Over the **last 2 weeks**, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things
   - 0
   - +1
   - +2
   - +3

2. Feeling down, depressed or hopeless
   - 0
   - +1
   - +2
   - +3

PHQ-2 score obtained by adding score for each question (total points)

**Interpretation:**

- A PHQ-2 score ranges from 0-6. The authors identified a score of 3 as the optimal cutpoint when using the PHQ-2 to screen for depression.
- If the score is 3 or greater, major depressive disorder is likely.
- Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.

<table>
<thead>
<tr>
<th>Major Depressive Disorder (7% Prevalence)</th>
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<tbody>
<tr>
<td>PHQ-2 Score</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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<td>4</td>
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<td>5</td>
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<td>6</td>
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</table>

<table>
<thead>
<tr>
<th>Any Depressive Disorder (18% Prevalence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-2 Score</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>PHQ-2 Score</td>
</tr>
<tr>
<td>1</td>
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<td>6</td>
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</table>

Notes:
- *Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.

Sources
## Patient Health Questionnaire-9 (PHQ-9)

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.

Over the **last 2 weeks**, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things
   - 0
   - +1
   - +2
   - +3

2. Feeling down, depressed or hopeless
   - 0
   - +1
   - +2
   - +3

3. Trouble falling asleep, staying asleep, or sleeping too much
   - 0
   - +1
   - +2
   - +3

4. Feeling tired or having little energy
   - 0
   - +1
   - +2
   - +3

5. Poor appetite or overeating
   - 0
   - +1
   - +2
   - +3

6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down
   - 0
   - +1
   - +2
   - +3

7. Trouble concentrating on things, such as reading the newspaper or watching television
   - 0
   - +1
   - +2
   - +3

8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual
   - 0
   - +1
   - +2
   - +3

9. Thoughts that you would be better off dead or of hurting yourself in some way
   - 0
   - +1
   - +2
   - +3

PHQ-9 score obtained by adding score for each question (total points)

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https://www.hiv.uw.edu/page/mental-health-screening/phq-9
Interpretation:

- Total scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively.
- Note: Question 9 is a single screening question on suicide risk. A patient who answers yes to question 9 needs further assessment for suicide risk by an individual who is competent to assess this risk.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Depression Severity</th>
<th>Proposed Treatment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4</td>
<td>None-minimal</td>
<td>None</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild</td>
<td>Watchful waiting; repeat PHQ-9 at follow-up</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate</td>
<td>Treatment plan, considering counseling, follow-up and/or pharmacotherapy</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Moderately Severe</td>
<td>Active treatment with pharmacotherapy and/or psychotherapy</td>
</tr>
<tr>
<td>20 – 27</td>
<td>Severe</td>
<td>Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management</td>
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</table>

Sources:


This calculator operates entirely from your device.
No input variables or data is transmitted between your computer and our servers.
Date: October 10, 2019  
Meeting Place: San Francisco Health Plan, 50 Beale Street 13th floor, San Francisco, CA 94105  
Meeting Time: 7:30AM - 9:00AM  

Members Present: Edwin Batongbacal; LCSW; Ellen Chen, MD; Lukejohn Day, MD; Edward Evans; Jaime Ruiz, MD; Joseph Woo, MD; Ana Valdez, MD; Irene Conway; Jackie Lam, MD; James Glauber, MD, MPH (Chief Medical Officer, SFHP)  

Staff Present: Nicole Ylagan, Jesse Chairez, Adam Sharma, Amy Petersen, Lisa Ghotbi, Tammie Chau, Joel Nellis  

<table>
<thead>
<tr>
<th>Topic</th>
<th>Follow-up [if Quality Issue identified, Include Corrective Action]</th>
<th>Resolution, or Closed Date [for Quality Issue, add plan for Tracking after Resolution]</th>
</tr>
</thead>
</table>
| Call to Order          | • Meeting called to order at 7:35AM with a quorum.  
                         • No public comments or questions.                               | • No follow up needed.  
                                                                             | n/a                                                                 |
| Follow Up Items        | • August meeting request for Provider Satisfaction comment analysis. Dr. Glauber followed up on request from August and shared themes from Provider Satisfaction survey qualitative data and all provider comments were included in the meeting materials. Themes from provider comments were:  
                         o Streamline authorization process  
                         o Staff a pleasure to work with  
                         o Increase payment to providers  
                         o Challenges with behavioral health access  
                                                                             | • Dr. Glauber to invite UM team representative to upcoming QIC to share improvements to authorization process.  
                                                                             | •                                                                 |
| Consent Calendar       | • Ana Valdez motioned to approve Consent Calendar  
                         • Irene Conway seconded the motion  
                         • All in Favor                                                      | • No follow up needed.  
                                                                             | Approved:  
                                                                             o August QIC minutes  
                                                                             o UMC minutes July & August 2019  
                                                                             o Q2 2019 Grievance Report  
                                                                             o Q2 2019 Appeals                                                                 |
### Quality Improvement

<table>
<thead>
<tr>
<th>New Benefits Effective October 2019 (Dr. Glauber)</th>
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<tbody>
<tr>
<td>- Chiropractic Services</td>
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<tr>
<td>- Diabetes Prevention Program (DPP)</td>
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**Benefit Changes Expected in 2020**

- Pharmacy Carve Out to DHCS
- Transplants (carve-in)
- Long-Term Care (carve-in)
- Dually Eligible Members

Committee requested information on how members access new benefits. SFHP shared that both benefits are available via self-referral (no authorization required). Members can call DPP or chiropractic vendor directly or SFHP’s customer service dept.

**QI Scorecard (Adam Sharma)**

- The measure “Members with a primary care visit in last 12 months”, so-called PCP engagement rate, saw little improvement this year.
- A primary intervention was an Adult Wellness visit that incentivized preventive care for member not accessing primary care. Due to operational challenges, fewer incentives disseminated than expected. A second intervention is SFHP's Practice Improvement Program (PIP) wherein providers incentivized to create local interventions to increase PCP engagement.
- Committee shared work around outreach for well-child visits targeting low utilizers or those who never had a visit. Member contact information and current enrollment are challenges. Data quality issues related to being able to reach people where phone number or other contact information has changed.

- Adam Sharma to meet with SFHN to review opportunities for provider and health plan to collaborate on outreach activities.
- Adam Sharma to include PHQ-2 and PHQ-9 to understand indications of a positive depression screen
- Dr. Glauber to determine if PTSD falls under Non-Specialty Mental Health benefit.
SFHP found an error in the baseline calculation for non-specialty mental health utilization measure which has since been corrected.

SFHP’s Strategic Use of Reserves Program for FY 18/19 (SUR) (Nicole Ylagan)

- Funds come from SFHP operational surplus that exceeds Governing Board approved reserve limit. Funds in excess are directed towards (SUR).
- 2018-19 program split into three programs:
  - Hospital SUR – Example projects include improving patient experience, patient safety, staff burnout, ridesharing program, testing for penicillin allergy, virtual high-risk transitional program, and daytime hospitalist service. Presented video on improving communication and optimal resolution program (CANDOR).
  - Professional SUR – integrated into SFHP’s Pay-for-Performance program. Projects target improvement in Hepatitis C screening, ease in appointment scheduling, and streamlining specialty referral processes.
  - Addressing Social Determinants of Health – Projects include Advanced Primary Care, Medically Tailored Meals, Doula care for African American/Pacific Islander pregnant women.

- Committee asked questions about hospital ridesharing program. SFHP responded that services are comprehensive, assuring that frail members are safely settled into their home.
- Committee requested information on target population for medically tailored meals. SFHP is currently exploring the following populations: Uncontrolled Diabetes, Cardio-Obstructive Pulmonary Disease (COPD), high-risk patients’ post-hospital discharge, and gestational diabetes.
- Committee asked if meals are tailored to member’s cultural
preferences. SFHP explained that Project Open Hand (vendor for Medically Tailored Meals) currently has limited ability to tailor meals to member cultural preferences.

- Committee shared that some clinics are doing “Food Pharmacies”. Members have shared feedback about improvement opportunities including that recipes do not meet cultural preferences. Leah’s Pantry is collaborating with Project Open Hand to address this concern. SFHP responded that Project Open Hand is developing capacity to better serve Chinese members.

- Future SUR opportunities in this domain may include addressing social isolation. Health Plan of San Mateo has some emerging best practices in this area.

### Prescription Benefit Carve Out (Lisa Ghotbi)

- Governor Newsom California issued Executive Order to carve out pharmacy benefit from Health Plans to DHCS-administered benefit.

- SFHP is committed to mitigating any potential negative member impact by participating in state-wide workgroup initiatives.


- Local Health Plans of California (LHPC) issued request to slow down initiative as magnitude of change is unprecedented. Requested greater input from stakeholders and planning for continuity of clinical care management.

- California Association of Health Plan (CAHP) also issued request to reconsider approach.

- There has been significant opposition from various communities, including health plans, community clinics, and member groups. Legislators may address via legislation, since current advocacy to DHCS and the Governor to reconsider carve-out hasn’t been successful.
• Committee requested information on ability for SFHP to intervene if member has issue with prescription at pharmacy. SFHP responded that this is a significant biggest concern. As currently proposed they will have to call the state’s contracted PBM call center. The PBM will run the call center, which will be open 24/7, every day of the year.
• Committee asked about impact to 340B program. The carve-out to FFS Medi-Cal would eliminate 340B margins currently available via the managed care pharmacy program. SFHP responded that change may impact HSF members, as their pharmacy benefit is supplemented by 340B.
• Pharmacies are closing around SF; hope that DHCS will contract with all of the pharmacies that are open to the public.
• Committee expressed interest in gaining more access to pharmacy data to facilitate quality improvement. Requested information on DHCS commitment to provide data on a regular basis. SFHP responded that DHCS stated intent to provide daily claims data to health plans.
• Committee asked the extent to which the benefit will change. SFHP stated that we have been liberal with pharmacy benefit, including broad formulary and 90-day supplies. It is likely that benefit will be more limited than current benefit. DHCS will have a 3-month transition period where all formerly filled prescriptions will be honored without a requirement for a treatment authorization request.
• Committee asked how DHCS will build the formulary. SFHP said that DHCS currently maintains a formulary for the 2M members in fee for service Medi-Cal.
• Committee expressed appreciation for SFHP’s policy to fill 90-day prescriptions.

Minutes are considered final only with approval by the QIC at its next meeting.
### Utilization Management Committee (UMC)
26 September 2019

**LINK TO THE UMC SHAREPOINT SITE:** [UMC SharePoint Site](#)

<table>
<thead>
<tr>
<th>Meeting called by:</th>
<th>Matija Cale</th>
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<tbody>
<tr>
<td>Type of meeting:</td>
<td>Mandatory – Monthly Recurring</td>
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<tr>
<td>Recorder:</td>
<td>SeDessie Harris</td>
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<tr>
<td><strong>Present:</strong></td>
<td>Cornejo, Rebecca; Custodio, Ralph; Crowder, Ralph; Glauber, Jim; Nellis, Joel; Golubski, Nina; Sharief, Shimi; McDonald, Kirk; Tai, Tony; Ghotbi, Lisa; Harris, SeDessie; Nguyen, Jenny; Short, Jessica; Chairez, Jesse;</td>
</tr>
<tr>
<td><strong>Not Present:</strong></td>
<td>Clark, Betty DeLos Reyes (Extended OOO); Baldzikowski, Monica; Staniford, Tamsen; Crowder, Ralph; Nellis, Joel; Donald, Fiona; Garcia, Crystal; Kerr, Morgan, Kaitlin Hawkins</td>
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</tbody>
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#### Documents Presented:
- Draft_Minutes_August_UMC_v8.22.19
- Draft_Agenda_September_UMC_v9.12.19
- UM Director Dashboard_July 2019_8 28 19
- Appeals_September-2019_v9.16.19
- IMR_State Fair Hearings to Report to UMC_v9.16.19
- UMC ACTION ITEM F_UP-----FW_Project - Utilization on LARC codes - [P-251503]
- Utilization of LARC Codes 20190603_v9.16.19
- CO-57 UM Clinical Criteria_v8.29.2019

#### Agenda Notes / Minutes

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Brought By</th>
<th>Agenda Notes / Minutes</th>
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| 10:00-10:05 | Standing Items:  
- Minutes approval  
- Overview of Action Items  
- Parking Lot Items  
- Director’s Dashboard – Ad Hoc discussion | Matija | • August minutes approved  
• Updated various action items  
• Reviewed the parking lot items |
| 10:05-10:10 | Walk through the Director’s Dashboard | Matija | • Reviewed metric elements of dashboard, including data and definition tabs.  
• Shared with staff monthly in several Health Services departments. |
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<th></th>
<th>Good trending tool for DHCS and other audits.</th>
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|   | • Appeal for removal of body hair overturned upon further clinical information submitted by the transgender health consultant.  
|   | • NEMS Grievance regarding Denied Speech Therapy (ST) for elementary school child who was referred to school district instead.  
|   | o Determined SFHP/DMG should not redirect services; SFHP/DMG should be covering just for LEA capacity issues.  
|   | o Per DHCS’ APL 19-010, it is SFHP’s/DMG’s responsibility to ensure necessary therapy services are being provided and the managed care plan (MCP) should not rely on LEA.  
|   | o Should SFHP, or DMG, attempt to refer to school first?  
|   | • Both pharmacy appeals were in favor of the member and would have been approved upon receipt if adequate information was included.  
|   | o No recommended changes in process  
|   | • IMR submitted Monday 9/24 regarding Acupuncture Services investigation. IMR is still in progress. |   |
| 3. | • UM Appeals (Upheld and Overturned)  
|   | • IMR  
|   | • State Fair Hearings | R. Crowder  
|   | F. Donald  
|   | J. Glauber  
|   | Compliance Team et al. | 10:10 – 10:25 |
|   | • The LARC data sample is based is the % of SFHP’s total population (female and male), not % of women of child bearing age (15 – 44).  
|   | • Discussion around LARC studies (internally and externally) and national averages (4.2%).  
|   | Concluded the need to refine the current LARC report data.  
|   | o Sample will only include women between the ages of 15 – 44.  
|   | o The date range will be extended (5 years: 2014 – 2019).  
|   | • Potentially considering a new LARC utilization measure for HOI even though SFHP’s averages are tentatively appear to be double the national average. |   |
|   | Discussion and feedback for CO-57 UM Criteria additions | Kirk | 10:35 – 10:45 | • No discussion given the time constraints.  
  • Will submit the redline version of CO-57 by email to key UMC members for review. |
|---|---|---|---|---|
| 6. | Grievance – Travel Vaccinations | Nina G. / Tamsen / Shimi | 10:45 – 10:50 | • A recent member grievance revealed SFHP has no process for travel vaccinations and the information in the Member Handbook is misleading.  
  o Throughout the grievance process, it was confirmed SFHP should cover travel vaccinations if they are medically necessary.  
  o Travel vaccinations are in the Medi-Cal Manual and in the Fee Schedule as covered services (Typhoid and yellow Fever).  
  ▪ In QNXT these vaccination do not require a PA if obtained from in-network provider.  
  • AITC Immunization & Travel Clinic [San Francisco Dept. of Public Health (DPH)] does not take insurance payments and the only other travel clinic available is at CPMC or Kaiser. According to CPMC’s website information, the CPMC clinic does take Medi-Cal payments for the vaccines, but charges an out of pocket consultation fee at time of visit. PNO is currently following up with NEMS and/ or the CPMC clinic to discuss whether they would accept OOMG group referrals.  
  • Nina G. requested an opinion from UMC on whether SFHP should cover travel vaccines, noting it does come up in the Medi-Cal Fee schedule as covered services.  
  o Determined that although SFHP has no contract with an agency providing travel vaccinations, they should require a prior authorization.  
  • Lisa G. shared it’s required we cover all vaccines per SFHP’s pharmacy benefit.  
  • Currently, there is a nationwide shortage of  

Yellow Fever vaccines; the only manufacturer of YF-Vax announced total supply depletion as they move to a new production facility. Clinics and pharmacies can't even order. CPMC travel clinic and AITC currently have an IRB open to use an IND drug replacement called Stameril on an experimental basis.

- Per Nina G., SFHP’s Member Handbook is being updated regarding travel vaccines by Compliance & language services.

<table>
<thead>
<tr>
<th>OWNER</th>
<th>ACTION ITEMS</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>Ralph Custodio</td>
<td>• To disseminate updates on travel vaccinations to DMGs</td>
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<tr>
<td>Kirk</td>
<td>• Kirk (UM+pharm+BI) to connect w/Emily on re-running LARC data to look further back (up to 5-10 years) to include continuous eligibility,</td>
<td>• 10.4.19 – Meet with Jenny Nguyen/Pharmacy; discussed</td>
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<tr>
<td>OWNER</td>
<td>ACTION ITEMS</td>
<td>STATUS</td>
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<tr>
<td>Kirk / Jose</td>
<td>• Add a data point to the CHM OMG metric table in the Director’s Dashboard to show the number of redirections and to visually clarify why the low CHN OMG counts.</td>
<td>• 10.4.19 – followed up w/ Jose; awaiting response</td>
</tr>
<tr>
<td>Kirk / Monica</td>
<td>• Is there a way to distinguish OMG from OON requests? • Is there a way to track OMG specialty requests?</td>
<td>• 10.4.19 – followed up w/ Jose; awaiting response</td>
</tr>
<tr>
<td>Kirk / Monica</td>
<td>• UM Criteria for EPSDT Private Duty Nursing: review the scoring of this template in 6-months and provide an analysis</td>
<td>Follow-up: April 2020</td>
</tr>
<tr>
<td>Monica</td>
<td>• Will update the bi-annual report about acupuncture utilization to include massage therapy.</td>
<td>Completed. Added the Massage Therapy code 97124 to the monitoring report that Business Solutions is creating for Clin Ops to monitor acupuncture.</td>
</tr>
</tbody>
</table>

7.16.19 – Action Steps, Status and Final Decisions

<table>
<thead>
<tr>
<th>OWNER</th>
<th>ACTION ITEMS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ralph Crowder</td>
<td>• UM &amp; Pharmacy will establish alignment for use of CGM and bring to UMC. Any changes to the pharmacy “Blood Glucose Test Strips” PA</td>
<td>Awaiting new information from the manufacturer of Freestyle Libre. Discussion of UM &amp; Pharmacy</td>
</tr>
</tbody>
</table>
| Tamsen/Monica | • Research and evaluate the Massage Therapy questions posed by UMC. See questions above | Completed. Communication distributed (9.12.19) to East West included:
• Massage therapy is not in the contracts for acupuncture providers
• All requests would be reviewed for medical necessity, including practitioner scope of practice and Medi-Cal credentialing
• Massage therapy will not be payable to massage therapists or other non-Medi-Cal credentialed providers. |

| Linsay Shon-Nguyen/Sean PNO/Contracting Team | • Negotiate contracting rates with Option Care (aka Crescent aka Walgreens)
• If rates are agreeable, develop credentialing criteria for Ambulatory Treatment Sites and update policy CR-02 accordingly. | Linsay’s email (Thu 10/3/2019 3:35 PM) – “Rates for the Option Care contract were approved and it is currently with DHCS and DMHC for filing. The effective date of the contract is 12/1/2019 and it contains language allowing for services to be performed at ambulatory treatment sites (ATS). The ATS do not have a separate reimbursement rate that is different from the infusion done at home.”
Linsay will attend the October UMC to present her update. |

---

### 6.18.19 – Action Steps, Status, & Final Decisions

<table>
<thead>
<tr>
<th>Responsible Member</th>
<th>Action Item</th>
<th>Status and Final Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kirk</td>
<td>ALOS Readmission Data</td>
<td>Business Analytics (BA) team is requesting to defer Clarizen report request to Q4 2019</td>
</tr>
<tr>
<td>Kirk/Ralph</td>
<td>Integrate UMC feedback of DMG information workflow into process map</td>
<td>Ralph Custodio, Monica, and Kirk met 8.8.19; Ralph is in the process of updating the workflow</td>
</tr>
</tbody>
</table>
### 5.22.19 – Action Steps, Status, & Final Decisions

<table>
<thead>
<tr>
<th>Responsible Member</th>
<th>Action Item</th>
<th>Status and Final Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kirk</td>
<td>Initiate Benefit Exception process for CoCM services</td>
<td>In progress; waiting for BA UM data</td>
</tr>
<tr>
<td>Ralph Custodio</td>
<td>Add LARC utilization and/or barriers to accessing LARC as agenda item for JAMs</td>
<td>Pended. Upon review of the LARC utilization data, report requires refinement. See 9.17.19 action item update.</td>
</tr>
</tbody>
</table>

### 3.28.19 – Action Steps, Status, & Final Decisions

<table>
<thead>
<tr>
<th>Responsible Member</th>
<th>Action Item</th>
<th>Status and Final Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morgan</td>
<td>Add CMS criteria (case-by-case basis) into CO-57</td>
<td>Complete. Redline changes sent, via email, on 10/03/19 for review and comments.</td>
</tr>
</tbody>
</table>

### 1.24.19 – Action Steps, Status, & Final Decisions

<table>
<thead>
<tr>
<th>Responsible Member</th>
<th>Action Item</th>
<th>Status and Final Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tamsen</td>
<td>If QNXT can be configured, monitor BTL utilization and report data to UMC in six (6) months</td>
<td>In progress. Confirmed QNXT can be configured.</td>
</tr>
</tbody>
</table>

### Parking Lot

<table>
<thead>
<tr>
<th>Date</th>
<th>Responsible Member</th>
<th>Action Item</th>
<th>Status and Final Decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.20.18</td>
<td>Monica</td>
<td>• Will obtain metrics on Retrospective Utilization Reviews to guide Compliance on the effect of a 90 or a 180 day guideline.</td>
<td>• The current strategy is there will be no changes to CO-22 retrospective policy.</td>
</tr>
<tr>
<td>9.28.18</td>
<td>Tamsen/Monica</td>
<td>Develop Milliman Criteria and InterQual Criteria comparison presentation.</td>
<td>• Presentation on hold.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Confirmed the current InterQual contract is valid through June 2020.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• HSBR team is currently</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>researching InterQual’s newly developed modules (i.e. Care Transition Module)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Topic</th>
<th>Brought By</th>
<th>Time</th>
<th>Agenda Notes / Minutes</th>
</tr>
</thead>
</table>
| 1. Standing Items:  
  - Minutes Approval  
  - Overview of Action Items  
  - Parking Lot Items  
  - Director’s Dashboard – Ad Hoc discussion | Matija | 1:00 – 1:05 |  
  - See Action Step tables below  
  - Voted to approve September’s minutes  
    - 7/10 voting members present. 6 approved (60% approval).  
  - Director’s Dashboard  
    - Moving forward, to be inclusive of Pharmacy and Clinical Operations (Medical) departmental data, CMO Dashboard will be included in UMC document folder |
| 2. Appeals – Upheld and Overturned IMR / State Fair Hearings | Clin Ops Team Pharmacy Team | 1:05 – 1:20 |  
  - Appeals Medical: 1 – upheld appeal/ 2 – overturned appeals  
  - Upheld: No concerns identified for discussion. No change to UM process.  
  - Overturned: One recommended update/follow-up (see
1. SFHP denied authorization request for wheelchair using Medi-Cal DME criteria and an independent DME Evaluator’s denial recommendation. The denial was overturned because additional documentation demonstrated the member’s inability to safely ambulate in the community/accomplish Instrumental Activities of Daily Living (IADLs). Request meets medical necessity criteria pursuant to APL 15-018 (Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components) guidance.

- Re-educate DME Consulting Group and PA team on APL 15-018 requirements regarding IADLs,

2. Brown and Toland Medical Group (BTMG) denied authorization request for acupuncture for lack of medical necessity based on the member having chronic fatigue. BTMG using SFHP guidelines, in SFHP’s Member Handbook, specifies the intent of the acupuncture benefit is to alleviate chronic/severe pain; however, chronic fatigue is not covered. After the provider submitted additional information demonstrating member was experiencing chronic pain, in addition to chronic fatigue, the denial was overturned.

**Pharmacy:** 1 – upheld appeal  3 – overturned appeals

- Upheld: No concerns identified for discussion. No change to UM processes.

1. Overturned: Discussed continuity of care (COC) assessment methodology; however, because requesting providers did not indicate COC there were no recommended changes to UM processes. SFHP denied authorization request for Makena 275 MG/1.1 ML using “Makena” prior authorization criteria. The criteria requires treatment to be started between 16 weeks 0 days - 20 weeks 6 days gestation; the member was 29 weeks 2 days gestation. The denial was overturned based on additional information
demonstrating the member was receiving Mekena prior to SFHP enrollment. Approved for continuity of care.

2. SFHP denied authorization request for Phentermine 15MG capsule using “Anti-Obesity Medication” prior authorization criteria. The criteria requires documentation of at least one weight related comorbid condition, which was not indicated in the authorization request. The denial was overturned based on additional information demonstrating the member had an applicable comorbidity of fatty liver disease.

3. SFHP denied authorization request for Humira 40 MG/0.8 ML Syring using "Disease Modifying Biololgics” prior authorization criteria. The criteria requires the prescription dosage be FDA approved or supported by at least two published peer reviewed clinical studies, This denial was overturned based on additional information demonstrating the member was receiving, through Blue Shield, the requested dosage of Humira prior to SFHP enrollment . Approved for continuity of care.

State Fair Hearing

Behavioral Health: 1 – open

- Beacon denied request for a Non-Medi-Cal, out-of-network provider and redirected the member to alternate in-network providers. When attempting to schedule an initial appointment, the three alternate in-network providers were unavailable to accept the member. Beacon is currently investigating the grievance and is assisting the member with appointment scheduling.

Weighted Blankets: Benefit Exception Consideration

Monica

1:20 – 1:30

Jess Wiley, Children and Families Program Manager, received several inquiries about coverage and availability of weighted blankets for autistic members. Jess shared:

- There is no formal tracking of the number of members requesting weighted blanket; historically 2 members were
prescribed one by their provider.

- SFHP’s current vendors do not carry this item; this has been verified through polling by *Support for Families of Children with Disabilities* staff.

The UMC advised the following process, for SFHP staff to follow, when provider inquiries are received about weighted blankets:

- When a provider inquires if weighted blankets are a covered benefit, the provider will be informed that they are not a Medi-Cal benefit, but should submit a prior authorization request if they (the provider) deems the blanket medically necessary and would like the request considered as a benefit exception.
- An authorization request can be submitted by provider or DME vendor.
  - It is not the provider’s responsibility to research available DME vendors.
- If medically necessary, SFHP will investigate vendor options. If no vendor is found, member reimbursement is an available option.
  - Note: Member reimbursement cannot be classified under medical expense because there is no service code attached.

PA Team – next steps:

- To-date, PA team has not received an authorization request for a weighted blanket.
- If a request is received, the PA team will review for medical necessity applying the EPSDT benefit guidelines.
  - SFHP does not have criteria for weighted blankets, therefore, requests will be sent to MRiOA for evaluation if not approvable by the reviewing SFHP physician.
- If requests begin to be received, the UMC will need to discuss developing considered coverage through the benefit exception handling process.
| Case example: A Cisfemale member with Polycystic Ovary Syndrome (PCOS) experienced pathological concern/stress over excessive hair growth. | Reconstructive Surgery Statute • SFHP has applied the statute to Transgender member’s requests • Can/Should this statute be applied to Cisgender members experiencing dysharia regarding pathological facial hair for removal? o UMC unanimously agreed | Reviewed historical Cisfemale hair removal authorization details (see footnote below). • To standardize how utilization approvals/denials are determined, the UMC will: o Develop criteria for cis-females members highlighting EPSDT requirement considerations for members under 21 years of age. Next steps: ▪ Reviewing the MROIa overturn rationales for similarities. ▪ Confirming if MCG has established criteria. ▪ Confirming if Inland Empire Health Plan has established criteria. o Until criteria is developed, clinical reviewers should consistently send request to MROIa for expert evaluation. o Notify DMGs after criteria is finalized. |

| Hair Reduction for Cisgender Members | Jim | 1:30 – 1:45 |

| Status Update: • Rates for the Option Care contract were approved and are with DHCS and DMHC for filing. • Effective date of the contract is 12/1/2019. • Contract contains language allowing for services to be formatted as a table. | Option Care Contract | Lindsay Shon-Nguyen | 1:45 – 1:50 |
performed at ambulatory treatment sites (ATS).
  
  - The ATS do not have a separate reimbursement rate from infusion done at home
  - Delivery will be through the medical benefit versus pharmacy
  - ATS sites will expand access for members, especially SFHP’s homeless population
    - Which treatment cites are available?
      - Lindsay will confirm

---

### 10.15.19 – Action Steps, Status, and Final Decisions

<table>
<thead>
<tr>
<th>Tamsen</th>
<th>Power Chair (Group 1) overturn appeal f/up:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Review APL 15-018 requirements with DME Consulting Group (Jim Aguilar) regarding IADLs.</td>
</tr>
</tbody>
</table>

| Monica/Kirk | Advise CM staff on appropriate communication response to inquiries | Completed. Jess advised on |
about weighted blanket coverage 10/23/2019

<table>
<thead>
<tr>
<th>Owner</th>
<th>Action Items</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monica/Tamsen/Shimi</td>
<td>Develop Cis-female hair removal criteria and highlight ESPDT requirements</td>
<td></td>
</tr>
<tr>
<td>Ralph</td>
<td>Disseminate Cis-female hair removal criteria to DMGs</td>
<td>Pended until SFHP develops or adopts criteria. UMC to approve criteria prior to DMG dissemination</td>
</tr>
<tr>
<td>Lindsay</td>
<td>Confirm which ATS cites are available for infusion services</td>
<td></td>
</tr>
</tbody>
</table>

**9.17.19 – Action Steps, Status and Final Decisions**

<table>
<thead>
<tr>
<th>Owner</th>
<th>Action Items</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ralph Custodio</td>
<td>• To disseminate updates on travel vaccinations to DMGs</td>
<td>(10.10.19) - Pending. SFHP needs to have a solid process for travel vaccine first before disseminating info to DMGs</td>
</tr>
<tr>
<td>Kirk</td>
<td>• Kirk (UM+pharm+BI) to connect w/Emily on re-running LARC data to look further back (up to 5-10 years) to include continuous eligibility, age/gender (15-44yo)</td>
<td>10.4.19 – Meet with Jenny Nguyen/Pharmacy; discussed the data points; the Pharmacy Team will take the lead in obtaining the updated LARC data</td>
</tr>
<tr>
<td>Nina G</td>
<td>• To email Cynthia Lamond requesting agenda item for Joint Operations Committee (JOC) regarding PCP/clinic education on providing travel vaccinations.</td>
<td>10.11.19 - Completed.</td>
</tr>
</tbody>
</table>

**8.20.19 – Action Steps, Status and Final Decisions**

<table>
<thead>
<tr>
<th>Owner</th>
<th>Action Items</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kirk / Jose</td>
<td>• Add a data point to the CHM OMG metric table in the Director’s Dashboard to show the number of redirections and to visually clarify why the low CHN OMG counts.</td>
<td>10.17.19, 2PM: meeting to discuss</td>
</tr>
<tr>
<td>Kirk / Monica</td>
<td>• Is there a way to distinguish OMG from OON requests?</td>
<td>10.17.19, 2PM: meeting to discuss</td>
</tr>
<tr>
<td></td>
<td>• Is there a way to track OMG specialty requests?</td>
<td></td>
</tr>
<tr>
<td>Kirk / Monica</td>
<td>• UM Criteria for EPSDT Private Duty Nursing: review the scoring of this template in 6-months and provide an analysis</td>
<td>Follow-up: April 2020</td>
</tr>
</tbody>
</table>

**7.16.19 – Action Steps, Status and Final Decisions**
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<td>Ralph Crowder</td>
<td>• UM &amp; Pharmacy will establish alignment for use of CGM and bring to UMC. Any changes to the pharmacy “Blood Glucose Test Strips” PA criteria will be addressed at P&amp;T.</td>
<td>Awaiting new information from the manufacturer of Freestyle Libre. Discussion of UM &amp; Pharmacy alignment scheduled for Nov. ’19 UMC</td>
</tr>
</tbody>
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### 6.18.19 – Action Steps, Status, & Final Decisions

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<tbody>
<tr>
<td>Kirk</td>
<td>ALOS Readmission Data</td>
<td>Business Analytics (BA) team is requesting to defer Clarizen report request to Q4 2019</td>
</tr>
<tr>
<td>Dental Anesthesia Workgroup</td>
<td>Present recommendations and updates, as necessary</td>
<td>In progress</td>
</tr>
</tbody>
</table>

### 5.22.19 – Action Steps, Status, & Final Decisions

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<td>In progress; waiting for BA UM data</td>
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<td>The current strategy is there will be no changes to CO-22 retrospective policy.</td>
</tr>
<tr>
<td>First Name</td>
<td>Last Name</td>
<td>Degree</td>
<td>Company</td>
</tr>
<tr>
<td>------------</td>
<td>-----------</td>
<td>---------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Lisa</td>
<td>Ghotbi</td>
<td>Pharm. D</td>
<td>SFHP</td>
</tr>
<tr>
<td>James</td>
<td>Glauber</td>
<td>MD</td>
<td>SFHP</td>
</tr>
<tr>
<td>(Jerome)</td>
<td>Nichol</td>
<td>MD</td>
<td>Chinese Community Health Care Association</td>
</tr>
<tr>
<td>Ted</td>
<td>Li</td>
<td>MD</td>
<td>North East Medical Services</td>
</tr>
<tr>
<td>Lopez</td>
<td>Maria</td>
<td>Pharm. D</td>
<td>Mission Wellness Pharmacy</td>
</tr>
<tr>
<td>Joseph</td>
<td>Pace</td>
<td>MD</td>
<td>San Francisco Dept. of Public Health (SFDPH)</td>
</tr>
<tr>
<td>Ron</td>
<td>Ruggiero</td>
<td>Pharm. D</td>
<td>UCSF Department of Clinical Pharmacy-Retired</td>
</tr>
<tr>
<td>Jaime</td>
<td>Ruiz</td>
<td>MD</td>
<td>Mission Neighborhood Health Center</td>
</tr>
<tr>
<td>Linda</td>
<td>Truong</td>
<td>Pharm. D</td>
<td>San Francisco Health Network (SFHN)</td>
</tr>
<tr>
<td>Robert (Brad)</td>
<td>Williams</td>
<td>MD</td>
<td>Mission Neighborhood Health Center</td>
</tr>
<tr>
<td>Steven</td>
<td>Wozniak</td>
<td>MD</td>
<td>South of Market Mental Health</td>
</tr>
<tr>
<td>Jenna</td>
<td>Lester</td>
<td>MD</td>
<td>UCSF Department of Dermatology</td>
</tr>
<tr>
<td>Andrew</td>
<td>McDonald</td>
<td>Pharm. D</td>
<td>Walgreens</td>
</tr>
</tbody>
</table>

**first appointment 8/2019**
Emergency Room Visit / Prescription Access Report  
2nd Quarter 2019  
San Francisco Health Plan Medi-Cal LOB

Goal:
Evaluate access to medications prescribed pursuant to an emergency room visit and determine whether any barriers to care exist.

Methodology:
All claim and encounter records for an emergency room visit (without an admission) during a calendar quarter are evaluated and consolidated into a unique record of each emergency room (ER) visit date by member. These unique ER visits are analyzed by ER facility site and member count (see Tables 1A & 1B). Top diagnoses were evaluated for reason of ER visit (see Table 2). Selected key diagnoses with a high likelihood for ER discharge prescription are analyzed (see Table 3). A review of the pharmacy locations where members filled their prescriptions within 72 hours of discharge was assessed to reflect any medication barriers (see Table 4).

Findings:

Section 1 - ER Visits

In 2Q2019, 8,969 members had 14,386 ER visits, averaging 1.60 ER visits per member, which is slightly more than the previous quarter (1.59). This reflects an ER visit by approximately 7.7% of the SFHP Medi-Cal membership within the quarter, which increased from 7.3% previously. Visits by ER facility and the number of Member ER visits decreased compared to the previous quarter (15,512 and 9,742 respectively).

<table>
<thead>
<tr>
<th>ER Facility</th>
<th>ER Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZSFG – ACUTE CARE</td>
<td>5747</td>
</tr>
<tr>
<td>UCSF MEDICAL CENTER</td>
<td>2503</td>
</tr>
<tr>
<td>ST FRANCIS MEMORIAL HOSPITAL</td>
<td>1703</td>
</tr>
<tr>
<td>CPMC MISSION BERNAL CAMPUS</td>
<td>1375</td>
</tr>
<tr>
<td>CPMC PACIFIC CAMPUS</td>
<td>1287</td>
</tr>
<tr>
<td>ST MARYS MEDICAL CENTER</td>
<td>538</td>
</tr>
<tr>
<td>CPMC DAVIES CAMPUS</td>
<td>445</td>
</tr>
<tr>
<td>KAISER FOUNDATION HOSPITAL SF</td>
<td>245</td>
</tr>
<tr>
<td>CHINESE HOSPITAL</td>
<td>237</td>
</tr>
<tr>
<td>JADE HEALTH CARE – MEDICAL</td>
<td>135</td>
</tr>
<tr>
<td>Other ED Facilities</td>
<td>171</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>14,386</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># ER Visits</th>
<th>Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6476</td>
</tr>
<tr>
<td>2</td>
<td>1491</td>
</tr>
<tr>
<td>3</td>
<td>481</td>
</tr>
<tr>
<td>4</td>
<td>192</td>
</tr>
<tr>
<td>5</td>
<td>112</td>
</tr>
<tr>
<td>6</td>
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<tr>
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<td>21</td>
</tr>
<tr>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>11 - 46</td>
<td>65</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>8,969</strong></td>
</tr>
</tbody>
</table>

Table 1A: Visits by ER Facility

Prepared by SFHP Pharmacy Services – JLN & TJC 11/7/19
Section 2 - Top Diagnoses

Of the 14,386 ER visits in 2Q2019, 7,501 visits (52%) resulted in a medication (from ER or pharmacy) within 72 hours of the ER Visit and 6,885 (48%) did not. Not all ER visits warranted medication treatment (i.e. chest pain, abdominal pain or altered mental status). Overall, the distribution of top ER visits by diagnoses category is shown in Table 2. Compared to the previous quarter, abdominal pain, upper respiratory infection and cough decreased. The latter two may be attributable to the end of flu season. On the other hand, altered mental status and alcohol abuse increased.

Table 2: Percent ER Visits by Diagnoses (2Q2019)

<table>
<thead>
<tr>
<th>Top Diagnoses Categories</th>
<th>ICD10</th>
<th>ER Visits</th>
<th>% of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>R10.xx</td>
<td>779</td>
<td>5.4%</td>
</tr>
<tr>
<td>Chest pain</td>
<td>R07.xx</td>
<td>726</td>
<td>5.0%</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>F10.xx</td>
<td>418</td>
<td>2.9%</td>
</tr>
<tr>
<td>Nausea w/wo vomiting</td>
<td>R11.xx</td>
<td>301</td>
<td>2.1%</td>
</tr>
<tr>
<td>Altered mental status</td>
<td>R41.82</td>
<td>268</td>
<td>1.9%</td>
</tr>
<tr>
<td>Fever</td>
<td>R50.xx</td>
<td>223</td>
<td>1.6%</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>R06.02</td>
<td>207</td>
<td>1.4%</td>
</tr>
<tr>
<td>Headache</td>
<td>R51</td>
<td>206</td>
<td>1.4%</td>
</tr>
<tr>
<td>Upper Respiratory Infection</td>
<td>J06.9</td>
<td>196</td>
<td>1.4%</td>
</tr>
<tr>
<td>Cough</td>
<td>R05</td>
<td>179</td>
<td>1.2%</td>
</tr>
<tr>
<td>Dizziness and Giddiness</td>
<td>R42</td>
<td>174</td>
<td>1.2%</td>
</tr>
<tr>
<td>Low back pain</td>
<td>M54.5</td>
<td>173</td>
<td>1.2%</td>
</tr>
<tr>
<td>Asthma</td>
<td>J45.xx</td>
<td>171</td>
<td>1.2%</td>
</tr>
<tr>
<td>All Other Diagnoses</td>
<td></td>
<td>10,365</td>
<td>72.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>14,386</td>
<td>100%</td>
</tr>
</tbody>
</table>

Section 3 - Key Diagnoses Category

Selected key diagnoses with a high likelihood for ER discharge prescription are reported in Table 3. In 2Q2019, greater than 95% of ER visits for key diagnoses of asthma, pneumonia and COPD received medication treatment within 72 hours of the visit, however treatment for UTI decreased below 95% this quarter. Overall proportion of patients treated for UTI, asthma and pneumonia slightly decreased, while treatment for COPD slightly increased.

Table 3: ER Visit – Key Diagnoses Category

<table>
<thead>
<tr>
<th>Diagnoses Category</th>
<th>ICD10</th>
<th>RX Filled</th>
<th>ER Treated</th>
<th>No Rxs</th>
<th>Total</th>
<th>% Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTI</td>
<td>N39.0</td>
<td>64</td>
<td>21</td>
<td>6</td>
<td>94</td>
<td>90.4%</td>
</tr>
<tr>
<td>Asthma</td>
<td>J45.901,J45.909, J45.902</td>
<td>55</td>
<td>42</td>
<td>3</td>
<td>100</td>
<td>97.0%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>J18.9</td>
<td>42</td>
<td>11</td>
<td>2</td>
<td>55</td>
<td>96.4%</td>
</tr>
<tr>
<td>COPD</td>
<td>J40, J44.1, J44.9</td>
<td>34</td>
<td>37</td>
<td>1</td>
<td>72</td>
<td>98.6%</td>
</tr>
</tbody>
</table>
Section 4 - Pharmacy Location

For the members filling a prescription from a Pharmacy within 72 hours of their ER visit date, a further analysis evaluated the location of the pharmacy relative to where the member received emergency care and the hours of operation for these pharmacies. Of the 6,010 member visits to a pharmacy after an ER discharge, the top 16 most utilized pharmacies are reported in Table 4. One 24 hour pharmacy in San Francisco was top utilized. Last quarter an additional 24 hour pharmacy in the adjacent San Mateo County was highly utilized. Access to a pharmacy after an ER visit can occur throughout the day and would not be limited to only after-hours. In this analysis, member visits are defined as unique days that prescriptions are filled for a member per unique pharmacy.

Table 4. Pharmacies where Members obtained Rx within 72 hours of an ER Visit

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Hours of Operation</th>
<th>Mbr Visits</th>
<th>% of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF General (1001 Potrero Ave)</td>
<td>9AM – 8PM M-F, 9AM-1PM Sat</td>
<td>497</td>
<td>8.3%</td>
</tr>
<tr>
<td>Walgreens 3711 (1189 Potrero Ave)</td>
<td>8AM – 10PM M-F, 8AM – 9PM Sat-Sun</td>
<td>492</td>
<td>8.2%</td>
</tr>
<tr>
<td>Walgreens 5487 (5300 3rd St)</td>
<td>8AM – 9PM</td>
<td>254</td>
<td>4.2%</td>
</tr>
<tr>
<td>Walgreens 1327 (498 Castro St)</td>
<td>24 Hours</td>
<td>242</td>
<td>4.0%</td>
</tr>
<tr>
<td>Walgreens 4609 (1301 Market St)</td>
<td>8AM – 9PM</td>
<td>202</td>
<td>3.4%</td>
</tr>
<tr>
<td>Walgreens 2153 (790 Van Ness Ave)</td>
<td>8AM – 8PM</td>
<td>187</td>
<td>3.1%</td>
</tr>
<tr>
<td>Walgreens 1126 (1979 Mission St)</td>
<td>9AM – 9PM</td>
<td>158</td>
<td>2.6%</td>
</tr>
<tr>
<td>CVS Pharmacy 04770 (1101 Market St)</td>
<td>9AM – 8PM M-F, 10AM – 5PM Sat-Sun</td>
<td>154</td>
<td>2.6%</td>
</tr>
<tr>
<td>Walgreens 13668 (1496 Market St)</td>
<td>8AM – 9PM</td>
<td>149</td>
<td>2.5%</td>
</tr>
<tr>
<td>Chinese Hospital (845 Jackson St)</td>
<td>8AM – 7PM M-F, 9AM-5PM Sat-Sun</td>
<td>146</td>
<td>2.4%</td>
</tr>
<tr>
<td>Walgreens 1626 (2494 San Bruno Ave)</td>
<td>9AM – 9PM</td>
<td>146</td>
<td>2.4%</td>
</tr>
<tr>
<td>Walgreens 2244 (3601 3rd St)</td>
<td>9AM – 9PM</td>
<td>133</td>
<td>2.2%</td>
</tr>
<tr>
<td>Walgreens 7150 (965 Geneva Ave)</td>
<td>9AM – 9PM</td>
<td>126</td>
<td>2.1%</td>
</tr>
<tr>
<td>Walgreens 1120 (4645 Mission St)</td>
<td>9AM – 9PM</td>
<td>119</td>
<td>2.0%</td>
</tr>
<tr>
<td>Walgreens 15331 (500 Parnassus Ave)</td>
<td>8:30AM – 8:30PM M-F, 10AM – 6PM Sat-Sun</td>
<td>119</td>
<td>2.0%</td>
</tr>
<tr>
<td>Walgreens 3185 (825 Market St)</td>
<td>8AM – 9PM M-F, 9AM – 5PM Sat 10AM – 6PM Sun</td>
<td>117</td>
<td>1.9%</td>
</tr>
<tr>
<td>All Other Pharmacy Locations</td>
<td></td>
<td>2,769</td>
<td>46.1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>6,010</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Summary:

No barrier to pharmacy access during after-hours was identified in this quarter. ER utilization was lower in 2Q2019 compared to 1Q2019 (14,386 visits versus 15,512) with each member utilizing the ER at 1.60 visits, which is not a significant increase from previous quarter (1.59). About 52% of ER visits received a medication (from ER or pharmacy) within 72 hours of the ER visit, which did not change from the previous quarter. Appropriate prescription fills were seen in all four key diagnoses category, however UTI treatment fell below 95% in 2Q2019. Monitoring of member access to medication treatment after an ER visit will continue. If UTI treatment falls below 95% again in 3Q2019, we will evaluate for any barriers.
During Q3-19, there were a total of 26 appeals filed (medical 11, pharmacy 15)\(^1\). In Q3-19, there were a total of 5,878 authorizations (medical 4,411; pharmacy 1,467)\(^2\). On a per 1,000 authorization basis, this is 4.4 appeals per 1,000 authorizations; or 2.4 appeals per 1,000 medical authorizations and 10.2 appeals per 1,000 pharmacy authorizations.
Comparing appeal activity in Q3-19 to Q2-19:
- 26 appeals in Q3-19 vs. 27 appeals in Q2-19.
- 4.4 appeals/1000 in Q3-19 vs. 4.2 appeals/1000 in Q2-19.

Of the 26 appeals in Q3-19, 13 appeals were overturned (medical 4, pharmacy 9), which is a 50% overturn rate. This compares to a 44% overturn rate in Q2-19 (12 overturned out of 27 appeals).
Q3-UM Medical Appeal Activity by Medical Groups
The medical appeals by medical group appear representative of the distribution of membership.

<table>
<thead>
<tr>
<th>Medical Groups</th>
<th>BTP</th>
<th>CHI</th>
<th>CHN</th>
<th>Hill</th>
<th>JAD (2019)</th>
<th>NEMS</th>
<th>NMS</th>
<th>UCSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3-2016</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Q3-2107</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Q3-2018</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Q3-2019</td>
<td>5</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>
Analysis
Between Q4-2017 and Q3-2019, the medical denial rates varied by 1.53%. The denial rates ranged from 0.24% (Q4-2017) to 1.77% (Q3-2019):

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Medical Authorizations</th>
<th>Medical Denials</th>
<th>Medical Denial Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4-2017</td>
<td>3,766</td>
<td>9</td>
<td>0.24%</td>
</tr>
<tr>
<td>Q1-2018</td>
<td>4,875</td>
<td>50</td>
<td>1.03%</td>
</tr>
<tr>
<td>Q2-2018</td>
<td>4,637</td>
<td>18</td>
<td>0.39%</td>
</tr>
<tr>
<td>Q3-2018</td>
<td>4,303</td>
<td>13</td>
<td>0.30%</td>
</tr>
<tr>
<td>Q4-2018</td>
<td>4,026</td>
<td>22</td>
<td>0.55%</td>
</tr>
<tr>
<td>Q1-2019</td>
<td>4,450</td>
<td>52</td>
<td>1.17%</td>
</tr>
<tr>
<td>Q2-2019</td>
<td>4,734</td>
<td>71</td>
<td>1.50%</td>
</tr>
<tr>
<td>Q3-2019</td>
<td>4,411</td>
<td>78</td>
<td>1.77%</td>
</tr>
</tbody>
</table>

Between Q4-2017 and Q3-2019, the pharmacy denial rates varied by 5.2%. The denial rates ranged from 19.3% (Q2-2019) to 24.5% (Q3-2019):

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Pharmacy Authorizations</th>
<th>Pharmacy Denials</th>
<th>Pharmacy Denial Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4-2017</td>
<td>1,388</td>
<td>303</td>
<td>21.8%</td>
</tr>
<tr>
<td>Q1-2018</td>
<td>1,580</td>
<td>350</td>
<td>22.2%</td>
</tr>
<tr>
<td>Q2-2018</td>
<td>1,532</td>
<td>370</td>
<td>24.2%</td>
</tr>
<tr>
<td>Q3-2018</td>
<td>1,461</td>
<td>295</td>
<td>20.2%</td>
</tr>
<tr>
<td>Q4-2018</td>
<td>1,492</td>
<td>303</td>
<td>20.3%</td>
</tr>
<tr>
<td>Q1-2019</td>
<td>1,484</td>
<td>305</td>
<td>20.6%</td>
</tr>
<tr>
<td>Q2-2019</td>
<td>1,641</td>
<td>316</td>
<td>19.3%</td>
</tr>
<tr>
<td>Q3-2019</td>
<td>1,467</td>
<td>359</td>
<td>24.5%</td>
</tr>
</tbody>
</table>

Medical and pharmacy appeals and appeal rates combined, between Q4-2017 and Q3-2019, are:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Medical Appeals</th>
<th>Pharmacy Appeals</th>
<th>Medical + Pharmacy Appeal Rate / 1000 Authorizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4-2017</td>
<td>3</td>
<td>8</td>
<td>2.1</td>
</tr>
<tr>
<td>Q1-2018</td>
<td>2</td>
<td>15</td>
<td>2.6</td>
</tr>
<tr>
<td>Q2-2018</td>
<td>10</td>
<td>13</td>
<td>3.7</td>
</tr>
<tr>
<td>Q3-2018</td>
<td>3</td>
<td>8</td>
<td>1.9</td>
</tr>
<tr>
<td>Q4-2018</td>
<td>6</td>
<td>5</td>
<td>1.9</td>
</tr>
<tr>
<td>Q1-2019</td>
<td>7</td>
<td>9</td>
<td>2.7</td>
</tr>
<tr>
<td>Q2-2019</td>
<td>14</td>
<td>13</td>
<td>4.2</td>
</tr>
<tr>
<td>Q3-2019</td>
<td>11</td>
<td>15</td>
<td>4.4</td>
</tr>
</tbody>
</table>
Medical and pharmacy combined, overturned appeal rates, between Q4-2017 and Q3-2019 are:

<table>
<thead>
<tr>
<th>Medical + Pharmacy Overtum Appeal Rates</th>
<th>Med Overturned</th>
<th>RX Overturned</th>
<th>Total Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4-2017</td>
<td>82%</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Q1-2018</td>
<td>41%</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Q2-2018</td>
<td>35%</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Q3-2018</td>
<td>45%</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Q4-2018</td>
<td>45%</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Q1-2019</td>
<td>69%</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Q2-2019</td>
<td>44%</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Q3-2019</td>
<td>50%</td>
<td>4</td>
<td>9</td>
</tr>
</tbody>
</table>

**Actions**

The Utilization Management Committee’s (UMC) standing agenda item is to review and discuss upheld and overturned medical and pharmacy utilization management appeals. The discussion and decision highlights are reflected in the UMC minutes.

---

i Source: 0944ES A&G UM APPEALS REPORT, Case RECEIPT DATE: 7/1/2019 - 9/30/2019 as of 11/12/2019 8:22:29 AM. This is an aggregate number of medical and pharmacy appeals; members appealing were: 21 Medi-Cal members, 2 Healthy Workers HMO members, and 3 Healthy Kids HMO members.

ii UM Director Dashboard_September 2019_10 18 19
November 19, 2019

To: Quality Improvement Committee

From: Nina Golubski, RN
Quality Review Nurse
Health Outcomes Improvement

Regarding: Quarter 3, 2019
Potential Quality Issue Report

## Case Reviews

<table>
<thead>
<tr>
<th>Q3 2019 - Case types reviewed</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cases reviewed for PQI</td>
<td>166*</td>
</tr>
<tr>
<td>Appeals</td>
<td>27*</td>
</tr>
<tr>
<td>Decline to File Grievances (Clinical)</td>
<td>39*</td>
</tr>
<tr>
<td>Grievances (Clinical)</td>
<td>100*</td>
</tr>
<tr>
<td>Internal referrals (not including grievances)</td>
<td>5</td>
</tr>
<tr>
<td>External referrals</td>
<td>0</td>
</tr>
<tr>
<td>Provider Preventable Condition (PPC)</td>
<td>0</td>
</tr>
</tbody>
</table>

## Outcomes

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQI criteria met</td>
<td>2</td>
</tr>
<tr>
<td>Formal PQI investigation (PQI letter)</td>
<td>2</td>
</tr>
<tr>
<td>Cases requiring external physician review or peer review</td>
<td>0</td>
</tr>
<tr>
<td>Confirmed Quality Issue</td>
<td>0</td>
</tr>
<tr>
<td>PQI cases resulting in Corrective Action Plan (CAP)</td>
<td>0</td>
</tr>
<tr>
<td>Confirmed Provider Preventable Condition (PPC)</td>
<td>0</td>
</tr>
<tr>
<td>PQI cases closed within 60-day turnaround time</td>
<td>2</td>
</tr>
<tr>
<td>PQI cases closed outside 60-day turnaround time</td>
<td>0</td>
</tr>
</tbody>
</table>

*Data retrieved from Ramp 937 report
Turnaround times met for all PQI cases.
## PQI Final Determination
### PRACTITIONER PERFORMANCE AND SYSTEM RANKING

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Definition</th>
<th>Action/Follow-up</th>
<th>Final case status note in Essette</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P0/S0</strong></td>
<td>Care appropriate.</td>
<td>No action required. Resolution notification sent to provider as applicable.</td>
<td>P0/S0 - No confirmed quality issue</td>
</tr>
<tr>
<td><strong>P1/S1</strong></td>
<td>Minor opportunity for improvement. No actual adverse outcome to member.</td>
<td>Notification to provider confirming quality issue. Notification may include Improvement Opportunity recommendation.</td>
<td>P1/S1- Confirmed Minor Quality Issue (CQI)</td>
</tr>
<tr>
<td><strong>P2/S2</strong></td>
<td>Moderate improvement opportunity and/or care deemed inappropriate. Potential/actual minor or moderate adverse outcome to member.</td>
<td>Notification to provider confirming quality issue. Medical Director/designee may request peer review, offer Improvement Opportunity recommendation, and/or corrective action. Peer review outcome documented in case notes.</td>
<td>P2/S2–Confirmed Moderate Quality Issue (CQI)</td>
</tr>
<tr>
<td><strong>P3/S3</strong></td>
<td>Significant opportunity for improvement and/or care deemed inappropriate. Potential/actual significant adverse outcome to member.</td>
<td>Notification to provider confirming quality issue. Medical Director/designee may request peer review, offer Improvement Opportunity recommendation, and/or corrective action. Peer review outcome documented in case notes. Referral to Physician Advisory Committee (PAC) for review and/or recommendations.</td>
<td>P3/S3– Confirmed Significant Quality Issue (CQI)</td>
</tr>
</tbody>
</table>

**Analysis:** No trends identified during Q3 2019
<table>
<thead>
<tr>
<th>Policy</th>
<th>Summary of New Policy and Updates</th>
</tr>
</thead>
</table>
| **CO-57: UM Clinical Criteria** (approved at Oct PCC) | **Policy Update**  
  - **HEADER**  
    - Policy owner changed to CO (previously UM)  
  - **POLICY STATEMENT**  
    - Clarified UMC reviews and approves clinical criteria prior to QIC  
  - **PROCEDURE**  
    - Clarified that UM staff = CO Nurses and Medical Directors  
    - Added Medicare/CMS criteria may be consulted on a case by case basis, if Medi-Cal criteria does not exist  
    - Added Private Duty Nursing Criteria (SFHP Criteria)  
    - Specified the 2 Gender Confirmation Criteria: “Genital and Non-Genital”  
    - Removed DMG paragraph out of Criteria Hierarchy section as this is not the appropriate place for this information. Instead, merged this language into Application of Criteria and Monitoring sections  
    - Updated UMC abbreviations.  
    - Added section on Communication of UM Criteria from CO-22  
  - **MONITORING**  
    - Updated UMC abbreviations.  
    - Updated department names (HOI and CRA)  
    - Updated DMG oversight section with content taken from procedure section  
  - **DEFINITIONS**  
    - Updated “Medical Necessity” to specify EPSDT  
  - **AFFECTED DEPARTMENTS**  
    - Updated UM → CO  
    - Added CRA-Delegation Oversight, HOI, Medical Directors, UMC, and QIC  
  - **RELATED POLICIES/ DOCUMENTS**  
    - Updated CO’s P&P naming conventions  
    - Added specific links for UM Criteria  |
| **QI-20: Comprehensive Perinatal Services** (approved at Nov PCC) | **Policy Update (NCQA Update)**  
  - **POLICY STATEMENT**  
    - Removed “SFHP’s prenatal care and obstetrical providers and non-physician medical practitioners are exempt from the requirement of certification as Medi-Cal CPSP providers (22 CCR Sections 51249 and 51179.7),” to reflect what is stated currently in 22 CCR 51179.1 and 51249 (a) sections  
  - **PROCEDURE**  
    - Added licensed midwives and FBCs  
    - Added language about family planning care and immediate care for newborn  
    - Added Free Standing Birth Center to the list of qualified practitioners  
    - Added more detail to primary care responsibilities,  
    - Added LMs and FBCs  
    - Updated (Procedure, A, 6), to reflect what is stated in the Provider Manual.  
    - Added a statement about abortion services as required by APL 15-020  
    - Added language to this p/p regarding member participation in CPS, informed consent and information disclosure, privacy and respectful treatment of members, and continuation of care.  
    - “EAS” has been changed to “MCAS” to reflect the update from State. |
Update “Provider Handbook” to “Provider Manual”
Remove “Female” to “pregnant female members”
In step B.1, regarding “HEDIS postpartum care measure requires a visit between 3 and 7 weeks after delivery”, update to reflect “3 and 8 weeks”.
In step C.4, delete language regarding abortion services as it does not belong in this perinatal services policy; only include reference to CO-06 Abortion Services policy for information.

**MONITORING**
- Removed “Aggregate auth data” to align with current practices.
- Revised this sentence, “SFHP Health Outcomes Improvement Department monitors performance in perinatal care measures included in the Department of Health Care Services (DHCS) External Accountability Set (EAS),” because Health Outcomes Improvement (HOI) may not be the only department responsible for monitoring performance in perinatal care measures.
- Removed this sentence, “The SFHP UM Committee reviews appeals overturned for medical necessity to determine whether an appropriate assessment of the case was conducted in the initial review, as part of the UM Committee agenda (Monitoring, D),” because it does not reflect SFHP’s current practice. There is no authorization requirement as mentioned by Clinical Operations.

**AFFECTED DEPARTMENTS**
- Updated department name to “Clinical Operations”
- Added “Care Management”
- Updated department name to “Provider Network Operations”
- Updated department name to “Health Outcomes Improvement”
- Added “Compliance & Regulatory Affairs”
- Added “Marketing & Communications”
- Added “Claims” and “Pharmacy”

**DEFINITIONS**
- Added the following definitions:
  - “Certified Nurse Midwife (CNM)”
  - “Covered Services”
  - “Free Standing Birth Center (FBC)”
  - “Healthcare Effectiveness Data and Information Set (HEDIS)”
  - “Individualized Care Plan”
  - “Licensed Midwife (LM)”
  - “National Committee for Quality Assurance (NCQA)”
  - “Perinatal”
  - “Memorandum of Understanding (MOU)”
- Revised “Comprehensive Perinatal Services” definition to reflect what is stated in TITLE 22 CPSP Regulations Section 51179.7 “Comprehensive Perinatal Services”

**RELATED DOCUMENTS**
- Added the following:
  - PR-03: New Provider Training
  - CO-31: Lactation Support Services Breastfeeding and Lactation Management
  - CO-56: Potential Quality Issues
  - HE-02: Initial Health Assessment Education and Follow- Up
  - MC-02: New Member Materials
  - MC-03: Translation of Member Materials
  - QI-05: Access and Policy Standard
  - QI-18 Potential Quality Issues
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<th>REFERENCES</th>
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<td>o Added several DHCS contract &amp; CCR sections, MMCD APL, etc.</td>
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• C&RA 25: Minor Consent
POLICY STATEMENT

San Francisco Health Plan (SFHP) conducts utilization management (UM) to manage covered benefits through the consistent application of medical necessity criteria used in a systematic hierarchy. For services subject to Clinical Operations’ medical benefit, UM review is performed through the evaluation of a member’s relevant clinical information against established clinical criteria that meet professional standards of care.

SFHP uses external criteria State/Federal (Medi-Cal/CMS) and InterQual when available and, in limited circumstances, internally developed and approved criteria when external criteria are unavailable.

SFHP internally reviews and recommends changes to its clinical and level of care criteria through the UM Committee (UMC) to ensure they continue meeting professional standards of care. Annually, the UMC approves each set of clinical criteria with oversight and consensus from the Quality Improvement Committee (QIC).


PROCEDURE

I. Criteria Hierarchy

Resources are used to assist Clinical Operations Nurse and Medical Director staff (hereafter referred as UM staff) in determining the medical necessity of requested services. SFHP’s clinical criteria hierarchy in order includes:

A. State/Federal (Medi-Cal/CMS) criteria – (Medi-Cal only)
   a. If no Medi-Cal criteria is available, Medicare/CMS criteria can be consulted on a case by case basis.

B. SFHP internally developed and approved criteria – When external criteria are unavailable:
   1. Genital Gender Confirmation Services
   2. Non-Genital Gender Confirmation Services
   3. EPSDT Private Duty Nursing
C. McKesson’s InterQual® Criteria
D. Chief Medical Officer (CMO) or physician designee (MD) review of the evidence in consultation with relevant external, independent specialty expertise obtained from SFHP’s Independent Review Organization when there are no available external or internally developed and approved criteria.

II. Application of Criteria

A. SFHP and its Delegated Medical Group (DMG) UM staff, including Beacon for non-specialty mental health services, must use professionally accepted evidence-based criteria. UM staff is required to apply criteria in the order of the hierarchy. If a service is not addressed in the primary criteria, UM staff consults subsequent criteria in order until finding the relevant criteria.

B. Clinical information evaluated with reference to these criteria may include, but are not limited to:
   • Office and hospital records
   • History of the presenting problem
   • Physical examination results
   • Diagnostic testing results
   • Treatment plans and progress notes
   • Information on consultations with the treating practitioner
   • Evaluations from any other health care practitioners and providers
   • Any operative and pathological reports
   • Rehabilitation evaluations
   • Patient characteristics and information
   • Treating physician statements of medical necessity

C. Criteria must be applied in conjunction with consideration of the individual member needs and characteristics such as age, cultural and linguistic needs, comorbidities, complications, progress of treatment, psychosocial needs, and the home and/or work environment. In addition, characteristics of the local delivery system available to the individual, including aspects such as the availability of alternative levels of care, timely accessibility of covered services, cultural preferences for treatment modalities, availability of specialty providers, access to community resources, familial influences and supports, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the required access standards must also be considered.

III. Review and Approval of Criteria

A. The UMC review clinical criteria as needed, but at least annually to ensure that they are current. Information sources to gather data on potential changes to clinical criteria include, but are not limited to:
   1. Evaluation of member complaints, grievances, and appeals.
2. Frequent and consistent overturns of SFHP denials through Independent Medical Review (IMR).
3. New and/or revised statutory or regulatory requirements, including DHCS directives and All Plan Letter or Policy Letters.
4. Changes to guidelines or practice protocols.
5. Increased volume or rate of denied authorization requests.
6. Availability of new technologies and/or treatments.
7. Addition of new benefits or services.
8. Concerns raised through the Member Advisory Committee (MAC), Pharmacy and Therapeutics Committee (P&T), or QIC.
9. Provider or member input/feedback.

B. In considering the development of and/or changes to clinical criteria, the UMC considers the following:
1. New technologies (See CO-54 Evaluation of New Technology).
2. Other health plans’ criteria – reflecting community standards of care.
5. Benefit changes.
6. Statutory and regulatory changes.

C. The UMC and QIC both review and approve the criteria hierarchy and adopt SFHP-developed and vendor purchased criteria annually.

IV. Communication of UM Criteria
Practitioners and enrollees are informed how they may obtain copies of UM criteria utilized for decision-making, and are provided to them on request. SFHP also communicates with practitioners through the Network Operations Manual (NOM) and the SFHP website to ensure their awareness of prior authorization procedures and timeframes. The public may obtain the relevant UM criteria for specific medical procedures or conditions on request. If there is a charge, the charge may not exceed the cost of copying and postage. When disclosed to the public, the notice that accompanies the criteria says, “The materials provided to you are criteria used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.”

MONITORING
SFHP’s Clinical Operations Department performs inter-rater reliability (IRR) audits at least annually for both physicians and nurse reviewers to evaluate the consistency and accuracy with which its reviewers apply UM criteria. The assessment is a standard IRR tool created by McKesson InterQual using hypothetical case scenarios and multiple choice answers to assess the accurate and consistent application of patient clinical presentations against medical
necessity criteria. Reviewers are allowed two opportunities to reach the passing threshold of 90 percent. Reviewers who are unable to reach a 90 percent threshold are placed on an educational corrective action, which may include but is not limited to attendance of an internal InterQual training session, more frequent case review, supervisor feedback, and IRR reassessment.

SFHP’s Clinical Operations Department also audits ten randomly selected medical necessity denials per quarter utilizing a proprietary audit tool, which includes NCQA, DHCS, and DMHC requirements. These include administrative requirements (turnaround time, Notice of Action readability, inclusion of appropriate appeal and grievance rights language) and clinical requirements (accurate criteria selection, accurate application of clinical information).

Results of the IRR assessment and denial audit are presented to the UMC and discussed for potential improvements. Final versions are submitted to QIC for review and comment.

A. SFHP employs the following monitoring mechanisms to reevaluate an existing or identify the need to develop new UM criteria:
   1. Medical record audits by SFHP’s Clinical Operations Department.
   2. Review of member and provider satisfaction surveys, complaints, grievances, and appeals by SFHP’s Health Outcomes Improvement Department.
   3. Overturns of medical necessity denials, especially overturns in which additional clinical information was not needed to reach the alternative determination by SFHP’s UMC.
   4. Reports of cases sent for external medical review due to no criteria available by SFHP’s UMC.
   5. Review of Clinical Operations utilization reports by SFHP’s UMC.

B. When SFHP delegates UM to a contracted medical group, SFHP is accountable for assuring that the delegated medical group conducts UM according to SFHP’s standards, which incorporate applicable DMHC, DHCS, and NCQA requirements. For each delegated medical group, SFHP’s Clinical Operations and Compliance and Regulatory Affairs:
   1. Review the UM program to identify if the medical group is following the standards of application, approval, and evaluation of medical necessity criteria.
   2. Review a sample of UM denial files to evaluate compliance with the use of relevant criteria and clinical information, as well as, the availability of criteria to practitioners.

**DEFINITIONS**

**Medical Necessity:** The Medi-Cal definition of Medical Necessity is reasonable and necessary services to protect life, to prevent significant illness or significant disability, or
to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For members who are eligible for EPSDT services, services are determined to be medically necessary when needed to correct or ameliorate defects and physical and mental illnesses or conditions.

AFFECTED DEPARTMENTS/PARTIES

Clinical Operations
Compliance and Regulatory Affairs
Health Outcomes Improvement
Medical Directors
Utilization Management Committee (UMC)
Quality Improvement Committee (QIC)

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

2. CO-22: Authorization Requests
3. CO-33: EPSDT and EPSDT Supplemental Services
4. CO-54: Evaluation of New Technology
5. DO-04: Oversight of Delegated UM Functions
6. UM Criteria for Genital Gender Confirmation Services
7. UM Criteria for Non-Genital Gender Confirmation Services
8. UM Criteria for EPSDT Private Duty Nursing

REVISION HISTORY

Effective Date: August 20, 2015
Approval Date: August 20, 2015, February 17, 2017, April 20, 2017, September 21, 2017, April 19, 2018; November 21, 2019
Revision Date(s): January 5, 2017, April 1, 2017, September 15, 2017, March 28, 2018, October 29, 2019; November 21, 2019; December 3, 2019

REFERENCES

1. DHCS/SFHP Contract Exhibit A, Attachment 5, Provisions 1, 2
2. H&S Code §§1363.3, 1367.01
3. W&I Code §14059.5
POLICY STATEMENT

San Francisco Health Plan (SFHP) ensures that pregnant members' initiation of prenatal care first prenatal visit will be available within two weeks upon request as soon as possible and does not require prior authorization for basic prenatal care or preventive services. SFHP informs members of childbearing age of the availability of comprehensive perinatal services and how to access such services as soon as pregnancy is determined.

1. SFHP covers and ensures the provision of all medically necessary services for pregnant members. SFHP uses the most current American College of Obstetricians and Gynecologists (ACOG) guidelines to establish the standard of care.

2. SFHP requires that:
   a. Prenatal care providers utilize a comprehensive risk assessment tool for all pregnant members that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348.
   b. Results of this assessment shall be maintained as part of the obstetrical record.
   c. Risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit.
   d. Risks identified shall be followed up on by appropriate interventions, which must be documented in the medical record.
   e. Individualized care plans are developed and include obstetrical, nutrition, psychosocial, and health education interventions when indicated by identified risk factors.

3. SFHP applies its provider credentialing standards (CR-01 Credentialing Program) to all prenatal care providers.

4. SFHP's prenatal care and obstetrical providers and non-physician medical practitioners are exempt from the requirement of certification as Medi-Cal CPSP providers (22 CCR Sections 51249 and 51179.7).
5. SFHP ensures that pregnant members at high-risk of poor pregnancy outcomes are referred to appropriate specialists, including perinatologists, and that they have access to genetic screening with appropriate referrals. SFHP also ensures that appropriate hospitals are available within its provider network to provide necessary high-risk pregnancy services.

6. SFHP has executed a Memorandum of Understanding (MOU) with the San Francisco Department of Public Health (SFDHP) Maternal, Child, and Adolescent Health (MCAH) section regarding perinatal services.

**PROCEDURE**

**A. Member Communication and Services**

1. SFHP mails information to members about the availability of comprehensive perinatal services and how to access such services upon request by members or if a member is eligible for a perinatal member incentive, soon after pregnancy is verbally confirmed.

2. SFHP members may obtain pregnancy testing from any qualified practitioner in their medical group. No prior authorization or referral is required. A Medi-Cal member may self-refer for pregnancy testing within or outside of the SFHP network.

3. SFHP encourages its members to seek initiation of prenatal care as soon as pregnancy is confirmed.

4. SFHP members may obtain perinatal care from any qualified practitioner, including family planning care for the birther and immediate care for the newborn, from any qualified practitioner in their medical group. No prior authorization or referral is required. Qualified practitioners include:
   a. Certified family nurse practitioner
   b. Certified pediatric nurse practitioner
   c. Certified nurse midwife
   d. Licensed midwife

5. SFHP ensures that pregnant members at high-risk of poor pregnancy outcomes are referred to appropriate specialists, including perinatologists, and that they have access to genetic screening with appropriate referrals. SFHP also ensures that appropriate hospitals are available within its provider network to provide necessary high-risk pregnancy services.
6. SFHP has executed a Memorandum of Understanding (MOU) with the San Francisco Department of Public Health (SFDHP) Maternal, Child, and Adolescent Health (MCAH) section regarding perinatal services.

7. SFHP members have the option to obtain perinatal services at a hospital or free standing birthing center in their medical group. No prior authorization or referral is required. Members may also obtain services from an out-of-plan certified nurse-midwife.

4. If a member is not able to access Free Standing Birth Center, Licensed Midwife, or Certified Nurse Midwife services in-network, SFHP will reimburse out-of-network FBCs for services provided to its members. SFHP will ensure that staff assisting members through telephone inquiries inform members of their right to obtain services from out-of-network FBCs, CNMs, and LMs when access to these provider types is not available in-network. A perinatal practitioner may act as a primary care practitioner, making referrals and obtaining authorization for medically necessary specialty services.

7.3. SFHP uses its member materials and health education services to inform members about the services described in this policy, and provides non-monetary incentives to members who receive timely prenatal and postpartum care. Timeliness of care is determined by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS).

8.4. Minors have the right to control the disclosure of their medical records related to services for which they have the authority to consent. Minors of any age have the authority to consent to abortions, birth control (except sterilization), care for rape or sexual assault, and diagnosis and treatment for pregnancy. Guardian consent or notification for these services is not allowed or required. For more information, refer to SFHP Policy CRA-25, Minor Consent. Minors do not require parental consent to obtain confidential pregnancy services.

B. Provider Requirements

1. SFHP applies its provider credentialing standards (CR-01) to all prenatal care providers. Prenatal care or obstetrical providers and non-physician medical practitioners are not required to be CPSP-certified providers.

1. SFHP standards for access to perinatal care include:
   a. An initial prenatal visit is available within two (2) weeks of request and occurs in the first trimester.
   b. Same-day access for urgently needed care.
   c. A post-partum check that occurs between three (3) and seven-eight (78) weeks after delivery.
2. SFHP recommends that CPSP certified or practitioners who provide CPSP-like services coordinate perinatal care. This includes:
   a. Medi-Cal members must have access to CPSP or CPSP-like practitioners in their medical group.
   b. Practitioners undertake a risk assessment of all pregnant female members comparable to the ACOG standards and CPSP-like standards (22 CCR Section 51348). Results of the assessment are maintained as part of the obstetrical record and include medical/obstetrical, nutritional, psychosocial, and health education needs components. The risk assessment is administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified are appropriately addressed, and documented in the member’s medical record.
   c. CPSP certified or practitioners who provide CPSP-like services coordinate care and assure member access to CPSP or CPSP-like nutritional, health education and psychosocial services, and to other programs, including, but not limited to, Women, Infants and Children Supplemental Foods (WIC) and Child Health and Disability Prevention (CHDP).
   d. Pregnant members at high-risk of poor pregnancy outcomes are referred to appropriate specialists, including perinatologist, alfa-fetoprotein (AFP) testing, genetic testing and counseling. Testing services provided through the Genetic Disease Screening Program (GDSP), California Prenatal Screening Program at the California Department of Public Health (CDPH) are not the responsibility of SFHP and are billed through Medi-Cal Fee-for-Service.
   e. Members are referred to dental care and family planning services.
   f. Perinatal practitioners offer HIV education and testing, and, if needed, treatment to all pregnant members.

3. Comprehensive perinatal practitioners inform their patients of available services and how they may be accessed.

4. A perinatal practitioner may act as a primary care practitioner. Primary care incorporates all of the essential factors of primary care and case management that includes evaluation, assessment, treatment, referral and obtaining authorization for medically necessary specialty services as required.

C. SFHP Requirements

1. Services provided by certified nurse midwives, licensed midwives, and Free Standing Birth Centers, including services by an out-of-plan provider are covered for the care of the birmother and the newborn though the perinatal period and up to six weeks post-partum.

2. SFHP does not restrict maternity length of stays to less than 48 hours after a vaginal delivery, or 96 hours after a Cesarean section. When the treating practitioner in consultation with the birmother orders a discharge in less than 48
hours after a vaginal delivery, or in less than 96 hours after a Cesarean section, the practitioner informs the member that their benefit includes a physician-prescribed follow-up visit for the birthing and newborn within 48 hours of discharge.

3. SFHP has executed a Memorandum of Understanding (MOU) with the San Francisco Department of Public Health (SFDPH) Maternal, Child, and Adolescent Health (MCAH) section regarding perinatal services.

3. SFHP informs its staff, medical groups and practitioners of the benefits and services provided in this policy.

SFHP Medi-Cal members may self-refer to any provider for outpatient abortion services without prior authorization. Inpatient abortion services are available to all SFHP members and do require prior authorization. SFHP will assist any provider or member to access abortion services. 4. For more information on abortion services, refer to SFHP Policy CO-06, Abortion Services.

3. SFHP and its medical groups make benefit and medical necessity determinations and evaluate care based upon CPSP requirements and ACOG guidelines.

D. Member Rights

1. Member participation in the Comprehensive Perinatal Services Program (CPSP) shall be voluntary. Each eligible member shall be informed about the services available in the program, the potential risks and benefits of participation, and alternative obstetric care if they choose to not participate in the program.

2. Prior to the administration of any assessment, drug, procedure, or treatment the member shall be informed of potential risks or hazards which may adversely affect them or their unborn infant during pregnancy, labor, birth or postpartum and alternative therapies available to them. The member has a right to consent or refuse the administration of any assessment, drug, procedure or treatment.

3. Members have the right to be treated with dignity and respect, to have their privacy and confidentiality maintained, to review their medical treatment and record with their physician or practitioner, to be provided with explanations about tests and clinic procedures, to have their questions answered about their care, and to participate in the planning and decisions about their management during pregnancy, labor, and delivery.

4. Members who are being treated for their pregnancy, (including immediate postpartum care) are eligible to receive continued services from an SFHP
provider whose contract with the member’s medical group or SFHP terminates while the member is under treatment. Providers shall provide the completion of Covered Services through the duration of the pregnancy and the immediate postpartum period.

5. A member may request continued care from a provider, including a hospital, if at the time of enrollment, the member was receiving care from a non-contracted provider for any of the following conditions:

   - Pregnancy, except during the first and second trimester periods, but including immediate post-partum period.
   - A newborn child, in the first 30 days, under birther’s enrollment.

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**MONITORING**

A. **SFHP Health Outcomes Improvement Department** monitors performance in perinatal care measures included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS). This includes the Timeliness of Prenatal and Postpartum Care (PPC) measures. When gaps in perinatal care are identified, SFHP works with its provider network to address systems barriers and implement quality improvement strategies. For more information, refer to SFHP Policy QI-04, HEDIS and PIP Procedures.

B. **San Francisco Health Plan (SFHP)** SFHP complies with monitors appointment access and availability contract requirements set forth by the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS), as well as standards recommended for National Committee for Quality Assurance (NCQA) accreditation, as described in Policy QI-05.

C. **SFHP’s Health Outcome Improvement Department** evaluates monitors member grievances, as well as SFHP’s member satisfaction survey responses, to identify trends and potential opportunities for improvement in perinatal care patterns.

D. **SFHP’s Provider Network Operations Department** monitors SFHP’s provider satisfaction survey responses, to identify trends and potential opportunities for improvement in perinatal care.

E. **SFHP’s Chief Medical Officer, Medical Director, or physician designee** identifies any potential quality issues (PQI), and follows the PQI process as defined in the SFHP policy, Potential Quality Issues (QI-18).

A. Aggregate authorization data is subject to retrospective analysis by SFHP’s Clinical Operations Department in order to evaluate over- and under-utilization of
B. SFHP’s Health Outcomes Improvement Department evaluates member and provider grievances, as well as SFHP’s member and provider satisfaction survey responses, to identify patterns.

C. SFHP’s Chief Medical Officer, Medical Director, or physician designee identifies any potential quality issues (PQI), and follows the PQI process as defined in UM-56.

D. The SEHP UM Committee reviews appeals overturned for medical necessity to determine whether an appropriate assessment of the case was conducted in the initial review, as part of the UM Committee agenda.

E-F. Reports regarding SFHP’s Clinical Operations Department’s Health Outcomes Improvement monitoring activities are presented to the Quality Improvement Committee (QIC) at least annually for evaluation and corrective actions as needed.

F-G. The SFHP Provider Quality and Outreach Nurse Specialist ensures compliance with DHCS guidelines in compliance with PL 14-004 by conducting medical record reviews (MRRs), which includes OB/CPSP MRRs for physicians acting as primary care providers (PCSs). Deficiencies are addressed through the procedure contained in PR-10: Facility Site and Medical Record Review.

G. SFHP’s Health Outcomes Improvement Department monitors performance in perinatal care measures included in the Department of Health Care Services (DHCS) External Accountability Set (EAS). This includes the Timeliness of Prenatal and Postpartum Care (PPC) measures. When gaps in perinatal care are identified, SFHP works with its provider network to address systems barriers and implement quality improvement strategies.

DEFINITIONS

Certified Nurse Midwife (CNM) - a practitioner licensed as a registered nurse and certified as a nurse midwife by the California Board of Registered Nursing and authorized under state law to provide prenatal, intrapartum, and postpartum care, including family planning care for the birther and immediate care for the newborn. CNMs are permitted to attend cases of normal childbirth and are required

Comprehensive Perinatal Services – Obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by comprehensive perinatal practitioners or under the personal supervision of a physician during pregnancy and 60
days following delivery. The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal reimbursement program for enhanced perinatal services.

**Covered Services** - Covered services are services for which coverage benefits are available under SFHP. Under SFHP, covered services are free as long as they are medically necessary. Care is medically necessary if it is reasonable and necessary to protect life, keeps members from becoming seriously ill or disabled, or reduces pain from a diagnosed disease, illness or injury. Refer to the Member Handbook for a list of covered services. As a member of SFHP, covered services are free as long as they are medically necessary. Care is medically necessary if it is reasonable and necessary to protect life, keeps you from becoming seriously ill or disabled, or reduces pain from a diagnosed disease, illness or injury.

**SFHP offers these types of services:**
- Outpatient (ambulatory) services
- Emergency services
- Hospice and palliative care
- Hospitalization
- Maternity and newborn care
- Prescription drugs and related supplies
- Rehabilitative and habilitative services and devices, including physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings
- Laboratory services
- Preventive and wellness services and chronic disease management
- Mental health services
- Substance use disorder services
- Pediatric services
- Vision services
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)

**Free Standing Birth Center (FBC)** - FBC benefit category is considered both a service and a setting for services. FBC may also be referred to as Alternative Birth Centers (ABCs). Federal law defines an FBC as a health facility –

(i) that is not a hospital;
(ii) where childbirth is planned to occur away from the pregnant person’s residence
(iii) that is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and
(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall
Healthcare Effectiveness Data and Information Set (HEDIS) – A widely used set of health plan performance measures in the managed care industry developed and maintained by the National Committee for Quality Assurance (NCQA).

Individualized Care Plan - a document developed by a comprehensive perinatal practitioner(s) in consultation with the patient. The plan consists of 4 components: obstetrical, nutritional, health education, and psychosocial. Each component includes and identification of risk conditions, prioritization needs.

Licensed Midwife (LM) - is a practitioner licensed as a midwife by the Medical Board of California who are permitted to attend cases of normal pregnancy and childbirth, as defined in 24 CCR Sections 2505-2521 and provide prenatal, intrapartum, and postpartum care, including family-planning care, for the birther, and immediate care for the newborn. LMs must adhere to a detailed set of restrictions and requirements when a patient’s condition deviates from the legal definition of normal.

Memorandum of Understanding (MOU) - a type of agreement between two or more parties which expresses a convergence of will between the parties, indicating an intended common line of action. It is often used either in cases where parties do not imply a legal commitment or in situations where the parties cannot create a legally enforceable agreement.

National Committee for Quality Assurance (NCQA) – A private non-profit organization that works to improve health care through the administration of evidence-based standards, measures, program, and accreditation. NCQA operates on a formula of measure, analyze, and improve, and it aims to build consensus across the industry by working with policymakers, employers, doctors, patients, and health plans.

Perinatal - the period from the establishment of pregnancy to one month following delivery.

AFFECTED DEPARTMENTS/PARTIES

- Care Management
- Claims
- Compliance & Regulatory Affairs
- Customer Service
- Health Outcomes Improvement
- Marketing & Communications
- Pharmacy
- Provider Relations
- Network Operations
Utilization Management Clinical Operations
Utilization Management Clinical Operations

Care Management
Customer Service
Provider Relations Network Operations
Health Outcomes Improvement
Compliance & Regulatory Affairs
Marketing & Communications

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

C&RA-25: Minor Consent
CO-31: Lactation Support Services
CO-31: Breastfeeding and Lactation Management
CO-56: Potential Quality Issues
CR-01 Credentialing Program
CR-061: Initial Credentialing, Recredentialing, Screening, and Enrollment of Practitioners
Evidence of Coverage for Medi-Cal
HE-02 Initial Health Assessment Education and Follow-Up
HE-02: Initial Health Assessment Education and Follow-Up
MC-02 New Member Materials
MC-02: New Member Materials
MC-03 Translation of Member Materials
MC-03: Translation of Member Materials
Member Handbook (formerly EOC)
Member newsletter – “Your Health Matters”
Postpartum Care Member Incentive
PR-03: New Provider Training
PR-03 New Provider Training
PR-10: Facility Site and Medical Record Review
Prenatal Care Member Incentive
Provider Handbook Manual
QI-05: Access and Policy Standard
QI-05: Access and Policy Standard
QI-18: Potential Quality Issues
QI-18 Potential Quality Issues
SFHP Provider Directory
UM-31: Lactation Support Services Breastfeeding and Lactation Management
UM-56: Potential Quality Issues
CO-31 Lactation Support Services
CR-01 Credentialing Program
HE-02 Initial Health Assessment Education and Follow-Up
PR-03 New Provider Training
REVISION HISTORY

Effective Date: June 22, 2004, March 16, 2017
Approval Date: April 18, 2007, June 12, 2014, July 21, 2016, October 22, 2019

REFERENCES

1. DHCS Contract Exhibit A Attachment 4 Section 7H, and
2. DHCS Contract Exhibit A Attachment 9 Section 3
3. DHCS Contract Exhibit A Attachment 10 Section 7A-C,
4. DHCS Contract Exhibit A Attachment 10 Section 8A Provision 6A
5. DHCS Contract Exhibit A Attachment 11 Section 17A
6. DHCS Contract Exhibit A Attachment 18 Section 10G
7. DHCS Contract Exhibit E Attachment 1 and Exhibit A Attachment 10 Section 8A Provision 6A
8. DHCS State Plan Amendment (SPA) 11-022
9. 16 CCR 1379.1-1379.31
10. 17 CCR Section 6500 et seq. (Newborn Screening Regulations)
11. 22 CCR Sections 51179-51504.1 and 51249 (Comprehensive Perinatal Provider), 51345 (Nurse Midwife Services), 51345.1 (Certified Family Nurse Practitioners and Certified Pediatric Nurse Practitioners), 51348 and 51348.1 (Comprehensive Perinatal Services Program Regulations)
12. 24 CCR Sections 2505-2521 (Licensed Midwife Practice Act 1993)
13. 28 CCR 1300.67.2.2.(b)(5)
14. 28 CCR 1300.67.2.2.(b)(1), (c)(1) through (7), and (d)
15. 28 CCR 1300.67.2.2.(H)
16. California Code of Regulation Sections 1460-1466
2.-
3. 17 CCR Section 6500 et seq. (Newborn Screening Regulations)
17. Health and Safety Code, Section 123110(a), 123115(a)(1)
5.19. Health and Safety Code, Section 1367.54 and 1367.62 (Newborns’ and Mothers’ Health Act)
20. Health and Safety Code, Section 1367.695 (Direct Access to OB/GYNs)
6.  
7.21. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines for Perinatal Care
8.22. MMCD Policy Letter 08-003
9.23. MMCD Policy Letter 12-003
10.24. MMCD Policy Letter 14-004
25. MMCD All Plan Letter 15-017
26. MMCD DHCS, All Plan Letter 18-022 (Supersedes APL 16-017)
27. NPA, Business and Professions Code Sections §2746-2746.8
28. California Civil Code §§ 56.10, 56.11
29. California Penal Code § 11167 and 11167.5.
30. California Family Code § 6925
UM CRITERIA FOR GENITAL GENDER CONFIRMATION SERVICES

Examples of covered surgeries ................................................................. 1
Genital Surgery Consult ................................................................. 2
Genital Surgery Procedure ............................................................... 3
Penile Prosthesis ................................................................. 4
Surgical Revisions ................................................................. 4

Note: criteria pertains to adults members of SFHP and not those under the age of 18

COVERED GENITAL GENDER CONFIRMATION SURGERY PROCEDURES

Surgical procedures may include but not limited to the following:

1. MALE TO FEMALE (MtF)
   - Clitoroplasty
   - Orchietomy
   - Penectomy
   - Vaginoplasty

2. FEMALE TO MALE (FtM)
   - Hysterectomy/salpingo-oophorectomy
   - Metoidioplasty
   - Phalloplasty
   - Scrotoplasty
   - Urethroplasty
   - Vaginectomy
1. SURGICAL CONSULTATION:
All types of genital surgery require:

- For San Francisco Community Health Network members:
  a. Send consultation request and supporting documents to
     Transgender Health Services via eReferral
- Prior authorization from SFHP Utilization Management Department
- Documentation of Medical Evaluation
- Documentation of Behavioral Health Evaluation
- Documentation of Patient Education

Documentation of Medical Evaluation
- Comprehensive history and physical
  a. Dated within 3 months of the initial request for consult
  b. List of medical and psychiatric medications
  c. Lived as preferred gender for 12 continuous months
  d. Substance use well-controlled for at least 6 months prior to request date
  e. Received 12 continuous months of hormonal therapy; OR
  f. Viable medical contraindication to hormonal therapy
- Primary care provider states:
  a. Available for coordination of care
  b. Welcomes phone calls to establish care-coordination
  c. Recommendation for surgery
- List of significant medical and/or behavioral health conditions:
  a. Managed for at least 6 months preceding request for prior authorization
- Established care with Primary Care Provider and/or clinic for 12 months
- Completed “Medical Evaluation” form (available at sfhp.org)

Documentation of Behavioral Health Evaluation
- Two referrals for surgery by qualified behavioral health professionals:
  a. Behavioral health professionals must perform independent assessments
  b. Both dated within one year of prior authorization request
  c. Each assessment must include a statement that:
1. Behavioral health professional is available for coordination of care
2. Welcomes phone calls to establish care-coordination

- Referrals must appear in one of the following forms:
  a. Completed “Transgender Health Service Therapist Documentation Form” (available at sfhp.org); OR
  b. Narrative typewritten statement documenting responses to all items on the “Transgender Health Service Therapist Documentation Form”

Documentation of Patient Education
- “Transgender Health Patient Education” form (available at sfhp.org)
  a. Signed by member
  b. Surgery-specific

Note: gender confirmation surgery can have long waiting times. SFHP requires updated medical and behavioral health documentation for surgical clearance prior to surgery.

2. SURGICAL PROCEDURE:
All types of genital surgery require:
- Prior authorization from SFHP Utilization Management Department
- Completion of surgical consult
- Submission of request no sooner than 3 months prior to planned surgery date
- List of requested procedure(s)
- Updated medical and behavioral health clearance for surgery
- Statement from the surgeon recommending surgery

Updated Medical and Behavioral Health Clearance
- Updated H&P within 3 months of scheduled surgery date:
  a. No medical contraindications to surgery
- Behavioral Health attestation dated within 3 months of scheduled surgery:
  a. No behavioral contraindications to surgery
  b. The following providers can provide this statement:
    1. Primary care provider
    2. Behavioral Health Professional
    3. Transgender Health Services (THS)
GENDER CONFIRMATION PENILE PROSTHESIS

Medi-Cal does not cover penile prosthesis as a benefit; however, SFHP will review requests on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity.

Penile prosthesis requests require:
- Completion of genital surgical consult
- Status of phalloplasty:
  - Approved request for phalloplasty surgical procedure: OR
  - Completion of phalloplasty surgical procedure
- Statement from either the primary care provider or performing surgeon:
  - Cannot achieve insertive coitus
  - Tried and failed external penile rigidity device (e.g. penile splint)
- Statement from the surgeon recommending surgery

REVISIONS OF GENITAL GENDER CONFIRMATION SURGERY

SFHP authorizes requests for surgical revisions on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity. SFHP does not cover cosmetic surgery. Clinical documentation must support medical necessity.

Surgical revisions require:
- Medical and/or functional complications of prior gender confirmation procedure
- Measurements and/or photographs of deformity/asymmetry (if applicable)
- Statement from the performing surgeon recommending the procedure
DEFINITIONS

MEDICAL NECESSITY
Services reasonable and necessary to protect life, prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury

GENDER DYSPHORIA
Distress caused by conflict between a person's sex assigned at birth and the gender he/she/they currently identifies with

FEMALE TO MALE (FTM)
A person assigned female sex at birth and later adopts the identity, appearance, and gender role of a male, especially after gender confirmation surgery

MALE TO FEMALE (MtF)
A person assigned male at birth and later adopts the identity, appearance, and gender role of a female, especially after gender confirmation surgery

QUALIFIED MEDICAL PROFESSIONAL
The medical professional must have appropriate training (MD, DO, NP, PA):
- Up-to-date clinical license in the State of California
- Training, continuing education, and experience working with the diagnosis and treatment of Gender Dysphoria

QUALIFIED BEHAVIORAL HEALTH PROFESSIONAL
The behavioral health professional must have appropriate training:
- Master's degree or its equivalent in a clinical behavioral science field by an accredited institution
- Doctor of medicine or osteopathy, specializing in psychiatry and/or PhD in clinical behavioral science field by an accredited institution
- Licensed Psychiatrist
- Up-to-date clinical license
- Training, continuing education, and experience working with the diagnosis and treatment of Gender Dysphoria
GENDER CONFIRMATION SURGERY
Surgical procedure that changes a person’s physical appearance and function from his/her existing sex characteristics, including secondary sex characteristics, to resemble that of the opposite sex in order to affirm his/her gender identity. Gender confirmation surgery can meet medical necessity as an important part of treating gender dysphoria.

TRANSGENDER
Diverse group of individuals who cross or transcend culturally-defined categories of gender. Gender identity of transgender people differs to varying degrees from their sex or physical gender assigned at birth.

WORLD PROFESSIONAL ASSOCIATION OF TRANSGENDER HEALTH (WPATH)
Organization founded in 1979 and formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA). It devotes its resources to understanding the treatment of Gender Dysphoria and has developed internationally accepted Standards of Care (SOC).

REVISION HISTORY

Effective Date: April 10, 2014
Approval Date: April 10, 2014

REFERENCES

Criteria based on the following:
- 7th edition of the World Professional Association of Transgender Health, WPATH, Standards of Care
- Medi-Cal Provider Manual “Surgeries”
UM CRITERIA FOR NON-GENITAL GENDER CONFIRMATION SERVICES

Mammoplasty................................................................. 1
Mastectomy................................................................. 1
Facial Reconstruction...................................................... 3
Surgical Revisions........................................................... 4
Surgical Site Hair Reduction................................................. 4
Facial Hair Reduction....................................................... 5

Note: criteria pertains to adults members of SFHP and not those under the age of 18

GENDER CONFIRMATION MAMMOPLASTY AND MASTECTOMY

1. SURGICAL CONSULTATION:
Mammoplasty and Mastectomy with Male Chest reconstruction require:

- For San Francisco Community Health Network members:
  a. Send consultation request and supporting documents to Transgender Health Services via eReferral

- Prior authorization from SFHP Utilization Management Department

- Documentation of Medical Evaluation

- Documentation of Behavioral Health Evaluation

- Documentation of Patient Education

Documentation of Medical Evaluation

- Comprehensive history and physical dated within 3 months of request date

- Gender confirmation mammoplasty and mastectomy both require:
  a. Received 12 continuous months of hormonal therapy; OR
  b. Viable medical contraindication to hormonal therapy
  c. Lived as preferred gender for 12 continuous months
  d. Substance use well-controlled for at least 6 months prior to request date
e. No medical contraindications to surgery
f. Completed “Medical Evaluation” form (available at sfhp.org)

- Gender Confirmation Mammaplasty additionally requires:
  a. Documentation that 12 continuous months of estrogen therapy has failed to result in breast tissue growth of at least Tanner Stage 5 when hormonal therapy has no medical contraindication

Documentation of Behavioral Health Evaluation
- Referral for surgery from a qualified behavioral health professional who has assessed the member for mammaplasty/mastectomy
- Referral must include a statement that
  a. Behavioral health professional is available for coordination of care
  b. Welcomes phone calls to establish care-coordination
- Evaluation dated within one year of prior authorization request via EITHER:
  a. Completed “Transgender Health Service Therapist Documentation” form (available at sfhp.org); OR
  b. Narrative typewritten statement documenting responses to all items on the “Transgender Health Service Therapist Documentation Form”

Documentation of Patient Education
- “Transgender Health Patient Education” form (available at sfhp.org)
  a. Signed by member
  b. Surgery-specific

Note: gender confirmation surgery can have long wait times. SFHP requires updated medical and behavioral health documentation for surgical clearance prior to surgery.

2. SURGICAL PROCEDURE:
Mammaplasty and Mastectomy with Male Chest reconstruction require:
- Prior authorization from SFHP Utilization Management Department
- Completion of surgical consult
- List of requested procedure(s)
- Statement from the surgeon recommending surgery
GENDER CONFIRMATION FACIAL RECONSTRUCTIVE PROCEDURES

SFHP will review requests of this type when the medical referral and behavioral health evaluation support medical necessity.

1. SURGICAL CONSULTATION:
   Facial reconstruction requests require:
   - For San Francisco Community Health Network members:
     a. Send consultation request and supporting documents to Transgender Health Services via eReferral
   - Prior authorization from SFHP Utilization Management Department
   - Documentation of Medical Evaluation
   - Documentation of Behavioral Health Evaluation

Documentation of Medical Evaluation

- Comprehensive history and physical dated within 3 months of request date
- 12 continuous months of hormonal therapy; OR
- Viable medical contraindication to hormonal therapy
- Member has lived as the preferred gender for 12 continuous months
- Substance use well-controlled for at least 6 months prior to request date
- No medical contraindications to surgery

Documentation of Behavioral Health Evaluation

- Referral for surgery from a qualified behavioral health professional who has assessed the member for facial reconstruction and includes:
  a. Evaluation of facial feature(s) that cause persistent gender dysphoria
  b. How the presence of stated feature(s) impair function in relation to activities of daily living
  c. How the reconstruction of said features will improve quality of life and daily function
  d. Must include statement that:
1. Behavioral health provider is available for coordination of care
2. Welcomes phone calls to establish care-coordination

- Evaluation dated within one year of prior authorization request via **EITHER:**
  a. Completed “Transgender Health Service Therapist Documentation Form” (available at sfhp.org); **OR**
  b. Narrative typewritten statement documenting responses to all items on the “Transgender Health Service Therapist Documentation Form”

**2. SURGICAL PROCEDURE:**

Facial reconstruction requests require:
- Prior authorization from SFHP Utilization Management Department
- Completion of surgical consult
- List of requested procedure(s)
- Statement from the surgeon recommending surgery as part of the treatment for gender dysphoria
- Documentation of signed Patient Education

**REVISIONS OF NON-GENITAL GENDER CONFIRMATION SURGERY**

SFHP authorizes requests for surgical revisions on a case-by-case basis consistent with Medi-Cal guidelines for medical necessity. SFHP does not cover cosmetic surgery. Clinical documentation must support medical necessity.

Surgical revisions require:
- Medical and/or functional complications of prior gender confirmation procedure
- Measurements and/or photographs of deformity/ asymmetry (if applicable)
- Statement from the performing surgeon recommending the procedure

**HAIR REDUCTION PROCEDURES**

**1. SURGICAL SITE HAIR REDUCTION**

SFHP will cover electrolysis or laser hair reduction prior to gender confirmation surgery in order to prepare the surgical site
Surgical hair reduction requests require:
- Prior authorization from SFHP Utilization Management Department
- Completion of surgical consult
- Surgeon indicates member as an appropriate surgical candidate
- Authorization requests must come from the office of the consulting surgeon

2. FACIAL HAIR REDUCTION
SFHP will review requests of this type when the medical referral and behavioral health evaluation support medical necessity for MtF transgender individuals on a case-by-case basis.

Facial hair reduction requests require:
- Prior authorization from SFHP Utilization Management Department
- Documentation of Medical Evaluation
- Documentation of Behavioral Health Evaluation

Documentation of Medical Evaluation
- 12 continuous months of hormonal therapy; **OR**
- Viable medical contraindication to hormonal therapy
- Member has lived as the preferred gender for 12 continuous months

Documentation of Behavioral Health Evaluation
- Referral for procedure from a qualified behavioral health professional who has independently assessed the member and includes:
  a. Evaluation of gender dysphoria related to the presence of facial hair
  b. How the presence of facial hair impairs function in relation to activities of daily living
  c. How the reduction of facial hair will improve quality of life and daily function
  d. List of alternative methods of hair reduction and their results
  e. Ability to give informed consent
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Services reasonable and necessary to protect life; prevent significant illness and/or disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness, or injury

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MALE TO FEMALE (MtF)
A person assigned male at birth and later adopts the identity, appearance, and gender role of a female, especially after gender confirmation surgery

QUALIFIED MEDICAL PROFESSIONAL
The medical professional must have appropriate training (MD, DO, NP, PA):
- Up-to-date clinical license in the State of California
- Training, continuing education, and experience working with the diagnosis and treatment of Gender Dysphoria

QUALIFIED BEHAVIORAL HEALTH PROFESSIONAL
The behavioral health professional must have appropriate training:
- Master’s degree or its equivalent in a clinical behavioral science field by an accredited institution
- Doctor of medicine or osteopathy, specializing in psychiatry and/or PhD in clinical behavioral science field by an accredited institution
- Licensed Psychiatrist
- Up-to-date clinical license
- Training, continuing education, and experience working with the diagnosis and treatment of Gender Dysphoria
GENDER CONFIRMATION SURGERY

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REVISION HISTORY

Effective Date: April 10, 2014
Approval Date: April 10, 2014

REFERENCES

Criteria based on the following:

- 7th edition of the World Professional Association of Transgender Health, WPATH, Standards of Care
- Medi-Cal Provider Manual "Surgeries"
SFHP EPSDT Private Duty Nursing Medical Necessity Criteria

San Francisco Health Plan (SFHP) uses the following Private Duty Nursing (PDN) Acuity Grid to determine the medical necessity of PDN prior authorization requests for EPSDT services for Medi-Cal beneficiaries under the age of 21.

**Instructions:**

The Private Duty Nursing Acuity Grid indicates the average amount of skilled nursing treatment or services as documented by concurrent health records for each of the services listed below:
- For the first certification period, these skilled nursing services are estimated by the nurse per shift.
- For the recertification period(s), the average amount of skilled nursing services performed by the nurse per shift

### ASSESSMENT NEEDS

This is based on the severity of illness and the stability of the patient's condition(s).

(Choose one)

<table>
<thead>
<tr>
<th>ASSESSMENT NEEDS</th>
<th>POINTS</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial physical assessment per shift</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Second documented complete physical assessment per shift</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Three or more complete physical assessments per shift</td>
<td>3.0</td>
<td></td>
</tr>
</tbody>
</table>

(Choose one if at least 2 of the 4 assessment types are ordered and documented as medically necessary)

*Note: These assessments are incorporated in the physical assessment above. Select only if completed in addition to the physical assessment.*

<table>
<thead>
<tr>
<th>ASSESSMENT NEEDS</th>
<th>POINTS</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>VS/GLU/NEURO/RESP (Assess less often than daily)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>VS/GLU/NEURO/RESP (Assess less often than Q4, at least once per shift)</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>VS/GLU/NEURO/RESP (Assess Q 4 hr or more often per shift)</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>VS/GLU/NEURO/RESP (Assess Q 2 hr or more often per shift)</td>
<td>3.0</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**

### MEDICATION / IV DELIVERY NEEDS

(Choose one describing the medications provided by the nurse: Oral, Inhaler, Rectal, NJ, NG, G Tube. Does not include nebulizer or over-the-counter medications.)

<table>
<thead>
<tr>
<th>MEDICATION / IV DELIVERY NEEDS</th>
<th>POINTS</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented medication delivery less than 1 dose per shift</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Documented medication delivery 1 to 3 doses per shift</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Documented medication delivery 4 to 6 doses per shift</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Documented medication delivery 7 or more doses per shift</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Critical Medication (i.e. anticonvulsant, cardiac with hold parameters, etc)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>(Choose one)</td>
<td>Points</td>
<td>Score</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>No IV access</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Peripheral IV access</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Central line of port, PICC Line, Hickman, etc.</td>
<td>2.5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Choose one)</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No IV Medication Delivery</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Transfusion of IV medication less than daily but at least weekly</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>IV medication less often than Q 4 hrs (does not include hep flush)</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>IV medication Q 4 hrs or more often</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Choose one)</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No regular blood draws, or regular blood draws less than twice per week</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Regular blood draws / IV Peripheral Site - at least twice per week</td>
<td>4.5</td>
<td></td>
</tr>
<tr>
<td>Regular blood draws / IV Central line - at least twice per week</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Routine diagnostics - fingersticks, urine, stool, sputum, etc. (per days needed)</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Complicated routine diagnostics - fingersticks, urine, stool, sputum, etc. (complications must be documented.) (per day needed)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**

<table>
<thead>
<tr>
<th>FEEDING NEEDS</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No parenteral</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Partial parenteral nutrition</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total parenteral nutrition (TPN)</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Choose one)</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine oral feeding or no tube-feeding required</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Documented difficult prolonged oral feeding by nurse</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Tube feeding (routine bolus or continuous)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Tube feeding (combination bolus and continuous, does not include clearing tubing)</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>Complicated tube feeding (complications must be documented)</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Choose any that apply)</th>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented occasional reflux and/or aspiration precautions by a nurse</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>G-Tube, or Mic-key button</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>J-tube, GJ-tube, or tract &lt; 90 days old for any tube</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**
# Respiratory Needs

<table>
<thead>
<tr>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>(Choose one)</td>
</tr>
<tr>
<td>0</td>
<td>No trach, patent airway</td>
</tr>
<tr>
<td>4</td>
<td>No trach, unstable airway with desaturations and airway clearance issues</td>
</tr>
<tr>
<td>1</td>
<td>Trach (routine care)</td>
</tr>
<tr>
<td>4</td>
<td>Trach special care (wound or breakdown treatment, pull-out or replacement, stoma less than 90 days old) at least two documented events during shift (Choose one: instilling normal saline and resuctioning to break up secretions count as one suctioning session.)</td>
</tr>
<tr>
<td>0</td>
<td>No suctioning</td>
</tr>
<tr>
<td>4</td>
<td>Nasal and oral pharyngeal suctioning by a nurse &gt; 10 times per shift</td>
</tr>
<tr>
<td>1</td>
<td>Infrequent tracheal suctioning by a nurse during shift, less than Q 3 hrs but at least daily</td>
</tr>
<tr>
<td>4</td>
<td>Tracheal suctioning session by a nurse during shift, Q 3 hrs</td>
</tr>
<tr>
<td>6</td>
<td>Tracheal suctioning session by a nurse during shift, Q 2 hrs or more frequently</td>
</tr>
<tr>
<td>0</td>
<td>(Choose one)</td>
</tr>
<tr>
<td>0.5</td>
<td>Oxygen - daily use</td>
</tr>
<tr>
<td>1</td>
<td>Oxygen PRN based on pulse oximetry, oxygen needed at least weekly</td>
</tr>
<tr>
<td>3</td>
<td>Humidification and oxygen - direct (via mask or tracheostomy tube but not with ventilator)</td>
</tr>
<tr>
<td>0</td>
<td>(Choose one)</td>
</tr>
<tr>
<td>0</td>
<td>No ventilator, BiPap, or CPAP</td>
</tr>
<tr>
<td>9</td>
<td>Ventilator: rehab transition / active weaning; documented</td>
</tr>
<tr>
<td>6</td>
<td>Ventilator: weaning achieved, required monitoring, documented</td>
</tr>
<tr>
<td>8</td>
<td>Ventilator: at night, 1-6 hrs during shift, documented</td>
</tr>
<tr>
<td>10</td>
<td>Ventilator: 7-12 hours per day, documented</td>
</tr>
<tr>
<td>12</td>
<td>Ventilator: &gt; 12 hrs per day but not continuous, documented</td>
</tr>
<tr>
<td>14</td>
<td>Ventilator: no respiratory effort or 24 hr/day in assist mode, documented</td>
</tr>
<tr>
<td>4</td>
<td>BiPAP or CPAP by nurse during shift, up to 8 hours per day</td>
</tr>
<tr>
<td>6</td>
<td>BiPAP or CPAP by nurse during shift, &gt; 8 hrs per day</td>
</tr>
<tr>
<td>7</td>
<td>BiPAP ST by nurse during shift, spontaneous timed with rate used to ventilate at night</td>
</tr>
<tr>
<td>0</td>
<td>(Choose one)</td>
</tr>
<tr>
<td>0</td>
<td>No nebulizer treatments</td>
</tr>
<tr>
<td>1</td>
<td>Nebulizer treatments by nurse during shift, less than daily but at least Q week</td>
</tr>
<tr>
<td>1.5</td>
<td>Nebulizer treatments by nurse during shift, Q 4hrs or less frequently but at least daily</td>
</tr>
<tr>
<td>2</td>
<td>Nebulizer treatments by nurse during shift, Q 3 hrs</td>
</tr>
<tr>
<td>3</td>
<td>Nebulizer treatments by nurse during shift, Q 2 hrs or more frequently</td>
</tr>
</tbody>
</table>
(Choose one: must be physician ordered, medically necessary, by nurse during shift, and documented)

| Chest PT, HFCWO vest or Cough Assist Device at least Q week | 0.5 |
| Chest PT, HFCWO vest or Cough Assist Device / Q 4 hrs or less, but at least daily | 1.5 |
| Chest PT, HFCWO vest or Cough Assist Device / Q 3 hrs | 2 |
| Chest PT, HFCWO vest or Cough Assist Device / Q 2 hrs or more | 3 |

**TOTAL**

**ELIMINATION NEEDS**

<table>
<thead>
<tr>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose one that best applies to care nurse provided during the previous 60 days)</td>
<td></td>
</tr>
<tr>
<td>Continent of bowel and bladder</td>
<td>0</td>
</tr>
<tr>
<td>Uncontrolled incontinence &lt; 3 yrs of age</td>
<td>0</td>
</tr>
<tr>
<td>Uncontrolled incontinence, either bowel or bladder &gt; 3 yrs of age</td>
<td>1</td>
</tr>
<tr>
<td>Uncontrolled incontinence, both bowel and bladder, &gt; 3 yrs of age</td>
<td>2</td>
</tr>
<tr>
<td>Incontinence and intermittent straight catheterization, indwelling, suprapubic, or condom catheter</td>
<td>3.5</td>
</tr>
<tr>
<td>BOWEL OR BLADDER</td>
<td></td>
</tr>
<tr>
<td>Ostomy Care - at least daily</td>
<td>3</td>
</tr>
<tr>
<td>Ostomy Care - at least daily: complex or at risk, Documented</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
</tr>
</tbody>
</table>

**SEIZURES**

<table>
<thead>
<tr>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose One)</td>
<td></td>
</tr>
<tr>
<td>No seizure activity</td>
<td>0</td>
</tr>
<tr>
<td>Mild seizures - at least daily, no intervention</td>
<td>0</td>
</tr>
<tr>
<td>Mild seizures - at least 4 per week, each requiring minimal intervention</td>
<td>1</td>
</tr>
<tr>
<td>Mod seizures - at least daily, each requiring minimal intervention</td>
<td>2</td>
</tr>
<tr>
<td>Mod seizures - 2 to 4 times per day, each requiring minimal intervention</td>
<td>4</td>
</tr>
<tr>
<td>Mod seizures - at least 5 times per day, each requiring minimal intervention</td>
<td>4.5</td>
</tr>
<tr>
<td>Severe seizures - up to 10 per month, each requiring intervention</td>
<td>4.5</td>
</tr>
<tr>
<td>Severe seizures (requiring IM/IV/Rectal med administration - at least daily)</td>
<td>5</td>
</tr>
<tr>
<td>Severe seizures (requiring IM/IV/Rectal med administration - 2 to 4 times per day)</td>
<td>8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>92</td>
</tr>
</tbody>
</table>
### Therapies / Orthotics / Casting

<table>
<thead>
<tr>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose one)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>Fractured or casted limb</td>
<td>2</td>
</tr>
<tr>
<td>Passive ROM (at least Q shift)</td>
<td>2</td>
</tr>
<tr>
<td>Torso cast, torso splint, or torso brace</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose one)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>No splinting schedule or splint removed and replaced less frequently than once per shift</td>
<td>0</td>
</tr>
<tr>
<td>Splinting schedule requires nurse to remove and replace at least once per shift</td>
<td>1</td>
</tr>
<tr>
<td>Splinting schedule requires nurse to remove and replace at least twice per shift</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total**

### Wound Care

<table>
<thead>
<tr>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose one)</td>
<td></td>
</tr>
<tr>
<td>None of the options below apply</td>
<td>0</td>
</tr>
<tr>
<td>Wound Vac, JP drain, per site</td>
<td>2</td>
</tr>
<tr>
<td>Stage 1-2, wound care at least daily (does not include trach, PEG, IV site, J-tube, G-tube.</td>
<td>2</td>
</tr>
<tr>
<td>Stage 3-4, or multiple wound sites</td>
<td>3</td>
</tr>
<tr>
<td>Complex wound care, or multiple Stage 3-4, documented</td>
<td>6</td>
</tr>
</tbody>
</table>

**Total**

### Issues That Interfere With Care

<table>
<thead>
<tr>
<th>Points</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Choose all that apply)</td>
<td></td>
</tr>
<tr>
<td>None of the issues below interfere with care</td>
<td>0</td>
</tr>
<tr>
<td>2 or more parents/caregivers in home</td>
<td>0</td>
</tr>
<tr>
<td>1 or fewer parents/caregivers in home</td>
<td>4</td>
</tr>
<tr>
<td>2 or more children in home with special health care needs</td>
<td>6</td>
</tr>
<tr>
<td>Complications with parent/caregiver participation in care (documentation needed)</td>
<td>2</td>
</tr>
<tr>
<td>Weight &gt;100 pounds or immobility increases care difficulty</td>
<td>1</td>
</tr>
<tr>
<td>Mobility limitations: Ambulation (&gt;3yo)</td>
<td>2</td>
</tr>
<tr>
<td>Mobility limitation: Bed Mobility or total self-care deficit, documented (&gt;3yo)</td>
<td>6</td>
</tr>
<tr>
<td>Unable to express needs and wants creating a safety issue</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total**

93
**OTHER ISSUES**

<table>
<thead>
<tr>
<th>Requires isolation for infectious disease (i.e. tuberculosis, wound drainage) or protective isolation (nursing care activities for creating and maintaining isolation must be documented)</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any positive Score in three or more sections</td>
<td>6</td>
</tr>
<tr>
<td>Other issues or complications - documentation required</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Score from All Sections:**

- Medically appropriate skilled nursing shift care for clients up to age 21 years old, may be covered where it has been determined that skilled management by a licensed nurse is required

- The number of hours of private duty nursing a member may receive may be determined by the score on the Private Duty Nursing Acuity Grid. Family / Guardian / Caregivers are required to provide some of the nursing care. 20 to 22 hour care is only covered in certain circumstances described below. The banking, saving or accumulated of unused prior authorization hours to be used later for the convenience of the family or the home health agency is not covered.

- The scoring applies as follows:

  **20 points or less:** if the individual is being transitioned from 8 hrs/day, then 832 hours will be approved to the home health agency for the certification period. Otherwise, no Private Duty Nursing hours will be approved.

  *Note: when the member is decannulated up to 4 hours of nursing per day may be expected during the first 24-27 hours for the weaning process.*

  **21 - 35 points:** up to 8 hours per day for shift care
  **36 - 45 points:** up to 10 hours per day for shift care
  **46 - 55 points:** up to 12 hours per day for shift care
  **56 points and over:** up to 14 hours per day for shift care

  Client may receive up to 2-3 days of 20-22 hr shift care only under the following conditions:
  - After initial hospitalization discharge - family / caregiver(s) need supervision or training in home care procedures.
  - After subsequent hospitalization discharge - family / caregiver(s) need training in home care changes
  - Due to caregiver illness or temporary incapacity, an episode of supportive nursing care is needed.

  *Note: The Private Duty Nursing Grid may not accurately reflect the requirements of the member who remains in stable condition. Once 8 hours is reached, an increase in hours of service will require a change in the member's condition which meets the above criteria.*
InterQual Actionable Evidence-Based Criteria Portfolio

Enabling shared, clinical decision support

McKesson’s InterQual® content portfolio helps support better patient outcomes through integrated, streamlined care management processes and evidence-based appropriateness of care decision support. The InterQual content portfolio consists of four product sets:

• InterQual Level of Care Criteria
• InterQual Care Planning Criteria
• InterQual Behavioral Health Criteria
• InterQual Complex Case Management Content

Unmatched Clinical Integrity

Refined and proven over 35 years to provide exceptional credibility and integrity in all InterQual products, the InterQual development cycle combines systematic, critical appraisal of the medical literature by our highly trained clinical development team — including more than 30 physicians, registered nurses and allied health professionals — with feedback from our InterQual Clinical Panel of over 650 experts. InterQual contains more than 16,000 citations from a variety of acknowledged and authoritative sources including online databases such as PubMed, specialty society guidelines, accreditation organizations and national guidelines.
**InterQual Level of Care Criteria**

InterQual Level of Care Criteria help healthcare organizations assess the clinical appropriateness of patient services across the continuum of care: prospectively, concurrently or retrospectively. Robust clinical detail allows organizations to consider in real time the severity of illness, comorbidities and complications, as well as the intensity of services being delivered, guiding them to the most efficient, safest level of care. They also assist the care manager in discharge planning and transition to the most appropriate level of care.

<table>
<thead>
<tr>
<th>InterQual Level of Care Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>InterQual Acute Adult Criteria</strong></td>
<td>Help determine the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are age 18 or older. InterQual Acute Adult Criteria are organized by primary condition in this new 'condition specific' model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.</td>
</tr>
<tr>
<td><strong>InterQual Acute Pediatric Criteria</strong></td>
<td>Help determine the appropriateness of admission, continued stay and discharge at acute care facilities for patients who are less than 18 years of age. InterQual Pediatric Criteria also are organized by primary condition in a 'condition specific' model and include relevant complications, comorbidities and guideline standard treatments, all in one view. Addressing the individual patient rather than the typical patient, the criteria facilitate moving patients through the care continuum, based on their response to treatment. This integrated approach to utilization and case management is a powerful aid to decreasing inappropriate admissions, avoidable days and readmissions.</td>
</tr>
<tr>
<td><strong>InterQual Long-Term Acute Care Criteria</strong></td>
<td>Valuable for determining the appropriateness of admission, continued stay and discharge at long-term acute care facilities.</td>
</tr>
<tr>
<td><strong>InterQual Rehabilitation Criteria</strong></td>
<td>Valuable for determining the appropriateness of admission, continued stay and discharge at inpatient rehabilitation facilities for the adult and pediatric patient.</td>
</tr>
<tr>
<td><strong>InterQual Subacute &amp; SNF Criteria</strong></td>
<td>Valuable for determining the appropriateness of admission, continued stay and discharge at subacute and skilled nursing facilities.</td>
</tr>
<tr>
<td><strong>InterQual Home Care Criteria</strong></td>
<td>Support healthcare professionals in determining the appropriateness of initial and ongoing home care, hospice and palliative care services for the adult and pediatric patient.</td>
</tr>
<tr>
<td><strong>InterQual Outpatient Rehabilitation &amp; Chiropractic Criteria</strong></td>
<td>Aid in determining the appropriateness of initial and ongoing outpatient rehabilitation and chiropractic services for the adult, adolescent and pediatric patient.</td>
</tr>
</tbody>
</table>
**InterQual Care Planning Criteria**

InterQual Care Planning Criteria help to identify when imaging studies, procedures, molecular diagnostics, durable medical equipment, specialty referral consultations and specialty pharmaceuticals are medically appropriate based on the evidence. The criteria feature extensive informational notes and references that support clinical recommendations and offer guidance to the reviewer in a timely manner. The intuitive Q&A format, available in all of Care Planning Criteria except for Specialty Referral, supports efficient review workflows. In addition, where appropriate, the best evidence-based recommendation is suggested based on the clinical scenario presented (e.g., MRI being superior to CT of the head in cases of evaluation for primary brain tumor), driving more value from your criteria investment.

<table>
<thead>
<tr>
<th>InterQual Care Planning Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>InterQual Durable Medical Equipment Criteria</td>
<td>Address the most challenging, costly and time consuming equipment requiring authorization. They distinguish between senior and general populations (adult and pediatric), the former category being aligned with Medicare coverage guidelines. The criteria also include ICD-9 and HCPCS codes to facilitate the authorization process. <em>These criteria are updated quarterly to help ensure alignment with Centers for Medicare &amp; Medicaid Services (CMS) updates of local coverage determination (LCDs) and national coverage determination (NCDs).</em></td>
</tr>
<tr>
<td>InterQual Imaging Criteria</td>
<td>Address high-volume, high-cost imaging studies and includes ICD-9 diagnosis and CPT codes. In addition, the criteria help identify situations according to the best evidence in which additional diagnostic or therapeutic interventions should be undertaken. Covering more than 170 imaging studies, the criteria provide the most comprehensive coverage of imaging studies for pediatric, adolescent and adult populations in the industry, including Computed Tomography (CT), Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET).</td>
</tr>
<tr>
<td>InterQual Molecular Diagnostics Criteria</td>
<td>Help healthcare organizations determine whether a genetically based lab test is appropriate based on the evidence, so patients receive the right treatments based on their genetic makeup. The criteria also help you make more appropriate test utilization decisions, so treatment can be tailored to genetic make-up while allowing cost-effective allocation of medical resources. <em>These criteria cover over 650 tests, including more than 90% of high-volume molecular and genetic tests (MDx). The tests are organized into more than 120 test families, including the newest and most complex tests requiring authorization. These criteria also include lower cost, non-molecular tests that are often the most clinically appropriate. These criteria are updated quarterly to reflect the fast pace of change in the molecular diagnostics literature.</em></td>
</tr>
<tr>
<td>InterQual Procedures Criteria</td>
<td>Are evidence-based medical necessity guidelines for nearly 300 high-volume, high-cost procedures. The criteria help make documenting medical necessity easy while helping to improve the quality of care. Covering major categories of surgical and invasive procedures for all body systems for adults and children, the criteria include arthroscopy, hysterectomy, bariatric surgery and adenoidectomy.</td>
</tr>
<tr>
<td>InterQual Specialty Referral Criteria</td>
<td>Help identify when specialty care is appropriate and when care should remain in the hands of a generalist.</td>
</tr>
<tr>
<td>InterQual Specialty Rx Non-Oncology Criteria</td>
<td>Help guide the most appropriate use of a drug based on the latest medical evidence, providing clear guidance on step therapy, addressing both on-label and off-label indications. <em>Sample conditions include Crohn’s disease, factor deficiency, hepatitis, multiple sclerosis and rheumatoid arthritis. These criteria are updated quarterly.</em></td>
</tr>
<tr>
<td>InterQual Specialty Rx Oncology Criteria</td>
<td>Help guide the most appropriate use of an oncology drug based on the latest medical evidence, providing clear guidance on step therapy, addressing both on-label and off-label indications. The criteria incorporate content from the National Comprehensive Cancer Network® (NCCN®), the market leader in decision support for the use of drugs and biologics in treating cancer. The NCCN content is used for determining criteria for off-label (non-FDA approved) oncologic drug use. On-label indications are developed utilizing the InterQual criteria development process. Specialty Rx Oncology Criteria delivered via McKesson or McKesson-partner software are the only automated source for NCCN recommendations on appropriate use of off-label prescription drugs and biologics in patients with cancer. <em>These criteria are updated quarterly.</em></td>
</tr>
<tr>
<td>SIMplus™ Retrospective Monitoring Criteria</td>
<td>Enable healthcare organizations to assess the appropriateness of surgical and invasive procedures. Retrospective assessments can be performed to identify care delivery improvement opportunities which can increase quality and decrease risk.</td>
</tr>
</tbody>
</table>

---

1. Internal analysis based on 2008 HCPCS data.
**InterQual Behavioral Health Criteria**

*InterQual Behavioral Health Criteria* support initial and continued stay level of care decisions for patients. The depth of criteria enables care managers to consider behavior, symptoms, functions, social risks and social supports, while the comprehensive range of level of care alternatives allows for movement up and down the continuum of care.

<table>
<thead>
<tr>
<th>InterQual Behavioral Health Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>InterQual Child Psychiatry Criteria</td>
<td>For the review of patients who are age 4 to 12 years.</td>
</tr>
<tr>
<td>InterQual Adolescent Psychiatry Criteria</td>
<td>For the review of patients who are age 13 to 17 years.</td>
</tr>
<tr>
<td>InterQual Adult Psychiatry Criteria</td>
<td>For the review of patients who are age 17 to 65 years.</td>
</tr>
<tr>
<td>InterQual Geriatric Psychiatry Criteria</td>
<td>For the review of patients who are over age 65.</td>
</tr>
<tr>
<td>InterQual Substance Use Disorders and Dual Diagnosis Criteria</td>
<td>For the review of adult patients 17 years and older and adolescent patients age 13 to 17 years.</td>
</tr>
<tr>
<td>InterQual Residential &amp; Community-Based Treatment Criteria</td>
<td>For the review of child to adult residential and community based treatment (age 6 to 65 years) and adolescent and adult substance use treatment (age 13 and older).</td>
</tr>
</tbody>
</table>

**InterQual Complex Case Management Content**

*InterQual Complex Case Management Content* supports case management assessment of complex cases or high-risk members.

- **InterQual Coordinated Care Content** assessment blends multiple conditions or disease states and generates content for a patient-specific care plan. The assessment covers common barriers to care, case management and many specific conditions or disease states. In addition, there is a separate readmission reduction assessment to aid in mitigating avoidable readmissions within 30 days of hospital discharge.
MEMO

Date: April 30, 2019

To: Quality Improvement Committee

From: Gabrielle Torres, Grievance Analyst

Regarding: 2018 Annual Grievance and Appeals Report

The intent of this report is to monitor member grievances and appeals to identify areas of improvement. San Francisco Health Plan processes grievances and appeals for Medi-Cal members. Medi-Cal is a state sponsored health insurance program.

Table 1: Grievance Volume Report

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of grievances received in 2016</th>
<th>Grievance Rate per 1,000 Member Months 2016</th>
<th>Number of grievances received in 2017</th>
<th>Grievance Rate per 1,000 Member Months 2017</th>
<th>Number of grievances received 2018</th>
<th>Grievance Rate per 1,000 Member Months 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude/Service</td>
<td>130</td>
<td>0.78</td>
<td>99</td>
<td>0.60</td>
<td>104</td>
<td>0.66</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>103</td>
<td>0.62</td>
<td>136</td>
<td>0.82</td>
<td>96</td>
<td>0.61</td>
</tr>
<tr>
<td>Access</td>
<td>36</td>
<td>0.22</td>
<td>48</td>
<td>0.29</td>
<td>53</td>
<td>0.34</td>
</tr>
<tr>
<td>Quality of Practitioner Office Site</td>
<td>28</td>
<td>0.17</td>
<td>8</td>
<td>0.05</td>
<td>2</td>
<td>0.01</td>
</tr>
<tr>
<td>Billing/Financial</td>
<td>15</td>
<td>0.09</td>
<td>11</td>
<td>0.07</td>
<td>10</td>
<td>0.06</td>
</tr>
<tr>
<td>SFHP Total/Number per 1,000 Member Months</td>
<td>353</td>
<td>2.11</td>
<td>302</td>
<td>1.83</td>
<td>265</td>
<td>1.68</td>
</tr>
<tr>
<td>Department of Health Care Services (DHCS)</td>
<td>-</td>
<td>2.40</td>
<td>-</td>
<td>2.90</td>
<td>Currently not available</td>
<td>Currently not available</td>
</tr>
</tbody>
</table>

99
### Table 2: Appeal Volume Report

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Appeals received in 2016</th>
<th>Appeal Rate 2016 per 1,000 Member Months</th>
<th>Number of Appeals received in 2017</th>
<th>Appeal Rate 2017 per 1,000 Member Months</th>
<th>Number of Appeals received in 2018</th>
<th>Appeal Rate 2018 per 1,000 Member Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.02</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Access</td>
<td>65</td>
<td>0.39</td>
<td>57</td>
<td>0.35</td>
<td>61</td>
<td>0.39</td>
</tr>
<tr>
<td>Attitude/Service</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Billing/Financial</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Quality of Practitioner Office Site</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>SFHP Total/Number per 1,000 Member Months</td>
<td>65</td>
<td>0.39</td>
<td>57</td>
<td>0.35</td>
<td>61</td>
<td>0.39</td>
</tr>
</tbody>
</table>

**Data analysis:**

- A total of 265 grievances and 61 appeals were reported in 2018 in comparison to 302 grievances and 57 appeals in 2017. The grievance volume in 2018 decreased 12.2% from 2017. The appeal volume in 2018 increased 7% from 2017.
- SFHP’s performance threshold for each NCQA grievance category is < 1.00 per 1,000 members. If any category exceeds a rate of 1.00 for either grievances or appeals, SFHP determines appropriate improvement activities for SFHP and its broader provider network. For grievances and appeals in 2018, SFHP met performance threshold for all categories.

**Qualitative Analysis of Grievances 2018:**

In addition to reviewing the performance threshold, SFHP monitors clinical grievances throughout the year to identify opportunities of improvement within our provider network. On a monthly basis, SFHP reviews clinical grievance data to identify trends. A trend is identified when providers or clinics are named in three or more grievances from unique members within the same grievance category. Grievance trends trigger an analysis and discussion by SFHP’s Grievance Review Committee, Grievance Program Leadership Team, Joint Operations, and/or Access Compliance Committee. Committees will recommend further actions such as interventions or corrective action, if necessary.
SFHP’s committees made the following recommendations based on the review of 2018 trending grievances:

- In Q2 2018, SFHP identified instances where Zuckerberg San Francisco General Hospital Ophthalmology Clinic was non-compliant with the DMHC timely access standards for specialty care appointments. In June and October 2018, SFHP discussed these grievances at the Joint Administrative Meeting for San Francisco Health Network (SFHN) to support SFHN in improving access to care and overall member experience. SFHN reported some of the challenges they faced in meeting the access standard and set a goal to decrease wait times. SFHP provided information to SFHN leadership on the out of network referral process and how to initiate an out of network referral. SFHN has assigned someone to monitor wait times at the Ophthalmology clinic and will report back to the Joint Administrative Meeting.

- In Q3 2018, SFHP identified instances where the UCSF Primary Care Clinics were non-compliant with the DMHC timely access standard for primary care appointments. Enrollees complained of challenges scheduling primary care appointments at UCSF clinics. This access issue was discussed at Grievance Review Committee in October 2018 and then escalated to Access Compliance Committee (ACC) in February 2019. ACC decided to send UCSF a memo requesting a meeting with UCSF leadership to discuss panel management and access to primary care clinics. UCSF agreed to work toward improving access for members by reviewing their panel sizes and open/close status of clinic sites.

Other improvement opportunities identified through individual member grievances:

- In Q2 2018, an appeal was filed due to denial of acupuncture services from a member assigned to Brown and Toland Physicians (BTP). Acupuncture is a covered service for Medi-Cal members. Therefore, the appeal was overturned. BTP was educated about the acupuncture benefit. In addition, there was a member grievance regarding difficulty accessing acupuncture services in the BTP medical group. SFHP discussed access to acupuncture services at BTP’s Joint Operations Meeting in January 2019. BTP did a validation of their participating acupuncturists and SFHP provided a list of contracted acupuncturists for BTP to recruit.

**Qualitative Analysis of Appeals 2018:**

The UM program undergoes evaluation and monitoring in order to ensure SFHP members have access to medically necessary, cost effective high quality care. The main forum for this is the Utilization Management Committee (UMC). At each UMC monthly meeting, there is a standing agenda item to review all appeals, Independent
Medical Reviews (IMRs), and State Fair Hearings (SFHs) to determine if there are any opportunities for improvement to UM policies and procedures or processes. During 2018, the UMC conducted full committee discussions of appeals: medical / pharmacy.

UMC made the following recommendation based on the review of 2018 overturned appeals:

- In Q1 2018, two appeals were filed from members assigned to Chinese Community Health Care Association (CCHCA). One denial involved custodial care and the other denial involved diagnostic testing. The denials were overturned because they were incorrect determinations. SFHP met with CCHCA staff in February 2019 to discuss issues with CCHCA’s prior authorization process and criteria.
San Francisco Health Plan

2019 Quality Improvement Program Evaluation
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1. Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement (QI) Program is to ensure high quality care and services for its members by proactively seeking opportunities to improve the performance of its 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 a quarterly basis and consolidated annually. The QI Evaluation provides a detailed review of progress towards the measures and goals set forth in the QI Work Plan. In this evaluation, the results are presented for five activity domains:

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

At the time of this evaluation, some data for the 2019 measures have not been finalized. As such, only measures with finalized data are included. SFHP will include the remaining measures in subsequent QI Evaluations.

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 and the QI Program is supported by multiple committees including Utilization Management, Physician Advisory/Peer Review/Credentialing, Pharmacy and Therapeutics. The QI Program is also supported by multiple other committees including Access Compliance, Grievance Program Leadership, Grievance Review, Policy and Compliance, Practice Improvement Program and Provider Network Oversight. SFHP’s Quality Committees, under the leadership of the Chief Medical Officer, ensure ongoing and systematic involvement of SFHP’s staff, members, medical groups, practitioners, and other key stakeholders where appropriate.

Participation in the QI Program: Leadership, Practitioners, and Staff
Senior leadership, including the Chief Executive Officer (CEO) and Chief Medical Officer (CMO), provided key leadership for the QI program. The CEO champions SFHP’s NCQA accreditation journey as well as an organization-wide effort to improve member care and quality of service, namely by establish organizational strategic priorities and ensuring resources to support key initiatives. In addition, the CEO ensures that Board members received regular reports and involvement on components of the QI program.

The CMO provides ongoing support for all quality improvement studies and activities and was responsible for leading the Quality Improvement Committee; Physician Advisory/Peer Review/Credentialing Committee; Pharmacy and Therapeutics Committee; and Grievance Review...
Committee. The CMO leads key clinical improvement efforts, particularly prioritizing and designing interventions for clinical quality performance measures as represented in the QI Work Plan.

Beyond SFHP senior leadership, SFHP achieved stakeholder participation in the QI program through provider and member involvement in several key committees. Stakeholders participate 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 performance meetings during which health plan leadership meets with senior leadership in the network to review outcomes and solicit input on measures in the Clinical Quality and Safety domain of the QI Program. Additionally, SFHP’s Member Advisory Committee supported key QI activities by reviewing and providing feedback on existing programs and new initiatives including member incentives, health education, member perception regarding access to care, and service recovery mechanisms. Overall, leadership and practitioner participation in the QI program in 2019 was sufficient to support the execution of the QI Plan.

The staff accountable for implementing the annual QI Work Plan work cross-functionally to oversee and carry out 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 Highlights from the 2019 QI Program Measures

The San Francisco Health Plan had positive outcomes during the 2019 QI Program period. Of the 18 measures included in the 2019 QI Evaluation, 6 met the target. Of the 12 measures that did not meet the target, one improved from baseline. Two remaining measures are multi-year measures; these will be included in subsequent QI Program Evaluations. SFHP will utilize lessons learned from 2019 to inform the 2020 QI Program and to drive continuous improvement in 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 three of the five measure targets in this domain.

Some notable improvements include:

- Exceeded target of 70.4% in the HP-CAHPS composite “Getting Needed Care” with a final result of 73.8%.
- Exceeded target of 80% for compliance with Cultural and Linguistic standards with a final result of 88%.
- Exceeded target of 90% for turnaround times in member grievance resolution with a final result of 98%.

Recommendations for continued improvement include:

- Investing in appointment scheduling improvements through Strategic Use of Reserves grant funds.
Incentivizing clinics and provider groups to implement projects to improve access under SFHP’s Pay for Performance program.

Launching a Cultural and Linguistic Services Program to develop a coordinated strategy to improve members’ experience of cultural and linguistic services.

Conducting member focus groups to better understand member perception regarding access to care.

Clinical Quality and Safety:

SFHP met one of the six measure targets in this domain. One measure that did not meet target improved over baseline. Two other measures are multi-year measures and not yet finalized. They will be included in subsequent QI Evaluations.

Some notable improvements include:

- Exceeded target of 7.75% for reducing the percent of members with an opioid prescription with a final result of 7.14%.
- Increased by 10% over baseline total eligible members completing treatment for chronic Hepatitis C infection.
- Expanded population eligible for Medication Therapy Management to further improve member medication safety.

Recommendations for continued improvement include:

- Developing Hepatitis C member and provider outreach campaigns in target clinics and offices.
- Focusing on new pediatric HEDIS measures, particularly Well Child Visits for Infants and Well-Care Visits for Adolescents.
- Focusing on low-performing HEDIS measures, particularly Breast Cancer Screening.

Care Coordination and Services:

SFHP met two of the five measure targets in this domain.

Some notable improvements include:

- Attained high member satisfaction with care management services provided by SFHP.
- Exceeded target of 70% for member clinical depression follow up with a final result of 77%.

Recommendations for continued improvement include:

- Implementing new medical criteria guidelines software with a strong focus on member metrics and reporting that includes a Benchmark Statistics Dashboard and other data tools for inpatient, ambulatory, post-acute reporting, and 30 day readmission rates.
- Providing staff with mental health training focused on severe mental illness (SMI) to help address identified client safety concerns.
- Focusing on improving the health status of members who indicate poor self-reported health as well as maintaining the health status of members who indicate positive self-reported health.

Utilization of Services:
SFHP did not meet any of the two measure targets in this domain.

Some notable improvements include:
- Promotion of tele-health services to members and providers including tele-behavioral health.
- New contracting requirements for behavioral health therapists for timely response to member referrals.
- Incentivized providers to increase primary care visits by including measure in SFHP’s Pay for Performance Program.

Recommendations for continued improvement include:
- Exploring contracting incentives to provide timely follow-up to members with missed mental health appointments.
- Use of Strategic Use of Reserves grant funds for medical groups who improve appointment scheduling options for members.

2. Quality of Service and Access to Care

Quality of Service and Access to Care are measures that improve service to members. They may include service metrics (wait times), accessibility (ease of access), or member perception of care (Consumer Assessment of Healthcare Providers and Systems).

2.1 Provider Appointment Availability Survey – Routine Appointment Availability in Specialty and Primary Care

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<thead>
<tr>
<th>Provider Appointment Availability Survey – Routine Appointment Availability in Specialty and Primary Care</th>
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<tbody>
<tr>
<td><strong>Numerator</strong></td>
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<td><strong>Denominator</strong></td>
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The Routine Appointment Availability in Specialty and Primary Care measure is in the Quality of Service and Access to Care domain. Increasing appointment availability improves access and care for members. This measure demonstrates SFHP’s continued emphasis on connecting members to preventive care in order to better manage their health. Increasing appointment availability may also support other QI program measures such as HEDIS and CAHPS, as members with timely primary and specialty care visits are more likely to receive needed care. Members with a visit tend to score SFHP higher in CAHPS.

Routine Appointment Availability in Specialty and Primary Care is the total number of providers with appointments offered within 10 days for primary care visits and 15 days for specialty care visits out of the total number providers surveyed in the Provider Appointment Availability Survey. SFHP set a target of 90.7% based on 3% absolute improvement from baseline.

<table>
<thead>
<tr>
<th>2018 Numerator</th>
<th>2018 Denominator</th>
<th>2018 Routine Appointment Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCP</strong></td>
<td>127</td>
<td>177</td>
</tr>
<tr>
<td><strong>Cardiology</strong></td>
<td>36</td>
<td>51</td>
</tr>
<tr>
<td><strong>Endocrinology</strong></td>
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<table>
<thead>
<tr>
<th>Specialty</th>
<th>Count 1</th>
<th>Count 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>34</td>
<td>40</td>
<td>85.0%</td>
</tr>
<tr>
<td>Gynecology</td>
<td>23</td>
<td>37</td>
<td>62.0%</td>
</tr>
<tr>
<td>Oncology</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>261</td>
<td>374</td>
<td>69.8%</td>
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</table>

Data is based on returned surveys of the Provider Appointment Availability Survey created by DMHC. Performance decreased by 17.9% from the previous measurement year, thus not meeting the target. One barrier to meeting the target was a change in the survey methodology in 2018 from measurement year 2017 that established the baseline. In the 2017 survey, if a provider was not able to offer an appointment in the required time the survey asked an additional question. The question asked if there were any other providers available who could see that member. In 2017, compliance for appointment availability was calculated based on the additional question. However, in 2018 the second question was removed.

As a result, the 2018 appointment availability results are limited to a per-provider view instead of a per-site view. This change significantly impacted appointment availability as measured by the survey. If 2017 results were calculated based on the 2018 methodology the baseline would have been 71.3%, which SFHP still did not meet or exceed in 2018. In addition to the change in methodology, SFHP surveyed very few Federally Qualified Health Centers in 2018 due to a mistake in survey fielding. Federally Qualified Health Centers tend to have better appointment access than other SFHP providers.

Another barrier to reaching the target is that provider groups that were surveyed lacked the infrastructure critical to the provision of timely and efficient care. Infrastructure barriers negatively impact the volume of care that could otherwise be provided. Infrastructure needs include technological improvements (online appointment access, video visits, robust patient portals), ability to provide care beyond typical face-to-face visits, effective provider recruitment and retention strategies, and processes to inform/manage expectations with members. Finally, gynecology and endocrinology specialists, which performed the lowest in 2018, are two of a number of specialties where the current supply of providers does not meet demand. Growing patient demand and lower compensation for Med-Cal providers contribute to the current appointment availability challenges.

To improve performance, SFHP completed the activities listed below. There were no barriers to conducting the activities.

- SFHP communicated timeline, elements, and requirements of survey to network providers and provider network leadership.
- SFHP issued requests for Corrective Action Plans of provider groups performing under 80% compliance with appointment access.
- Groups who received a request for a Corrective Action Plan from SFHP's access monitoring surveys implemented activities to improve access to care. SFHP provided technical assistance to providers for their access Corrective Action Plans.

For the next evaluation period, the target will be set at 71.9% or 3% relative improvement over 2018 performance. Activities will include:

- Develop communication plan for survey fielding.
• Request Corrective Action Plans of provider groups performing under 80% compliance and under 50% response rate.
• Provide technical assistance with Corrective Action Plans.

2.2 Cultural & Linguistic Services (CLS)

<table>
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<tr>
<th>Measure: Cultural &amp; Linguistic Services (CLS)</th>
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<tbody>
<tr>
<td>Numerator</td>
</tr>
<tr>
<td>165</td>
</tr>
<tr>
<td>Denominator</td>
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<tr>
<td>187</td>
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The Cultural & Linguistic Services (CLS) measure is in the Quality of Service and Access to Care domain. This measure is calculated based on the number of providers who pass the linguistic services portion of the 2018 Provider Time to Answer Survey, out of the total number of providers surveyed. Assessing and improving the availability of linguistic services across SFHP’s provider network is important to ensure members have access to health care providers and services in the language of their choice. The target of 80% represents SFHP’s high performance benchmark.

All planned activities to support this measure were completed, including:

• Issuing and approving Corrective Action Plans to medical groups that did not pass the linguistic services portion of the previous survey year (2017).
• Provider and member education about linguistic services, including:
  o Presentation of SFHP’s Education and Linguistic Group Needs Assessment results to all contracted medical groups.
  o Published article in the Summer 2018 member newsletter to notify members of the availability of interpreter services to members enrolled in Medi-Cal, Healthy Kids, and Healthy Workers.
  o Articles published in the August and September 2018 provider newsletters, to inform providers of state required linguistic services and improve their readiness to respond to SFHP’s survey.
• Updating survey methodology to encourage a higher response rate. Traditionally, SFHP conducted the survey over the telephone. The new methodology included initially sending surveys to providers over fax or email, allowing providers two weeks to complete the survey, and collecting completed surveys back via fax or email.
• Launching a Cultural and Linguistic Services Program to leverage all of SFHP’s CLS resources and develop a coordinated strategy to address SFHP’s CLS priorities.

One potential barrier to achieving outcomes is turnover of provider site staff responsible for completing the survey. Turnover often results in lower response rates or staff answering the survey that may be less knowledgeable of their organization’s policies and procedures. To address this barrier SFHP will consider ways to strengthen provider knowledge of linguistic services requirements and survey readiness, in addition to the announcements in the SFHP provider newsletter. This may include developing more pre-survey outreach (calls and emails) and educational materials on CLS requirements.

SFHP recommends retaining this measure to continue monitoring and improving member access to Cultural Linguistic Services. The target will increase to 90%. Activities to support this measure will include:

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• Issuing and approving Corrective Action Plans to medical groups performing under 80% in the linguistic services portion of the previous survey year (2018).
• Launching a Cultural and Linguistic Services Program to leverage all of SFHP’s CLS resources and develop a coordinated strategy to address SFHP’s CLS priorities.
• Completing review of HECLS related grievances and quarterly trending reports.

2.3 Member Grievances and Appeals

<table>
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<tr>
<th>Measure: Member Grievances and Appeals</th>
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<tbody>
<tr>
<td>Numerator 288 Baseline 78.0% Final Performance 98.0%</td>
</tr>
<tr>
<td>Denominator 294 Target 90.0% Evaluation Year 2019</td>
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The Member Grievances and Appeals measure is in the Quality of Service and Access to Care domain. It measures the rate of member grievances resolved within regulated timeframes (standard clinical and non-clinical grievances within 30 calendar days) and excludes 14 day extensions. Timely grievance resolution is important to member satisfaction and provides opportunities for improving individual members’ health care quality concerns. SFHP chose the target of 90% to achieve improvement over baseline of 78% from the previous measurement year.

From July 1, 2018 to June 30, 2019, 98.0% of all grievances were resolved within 30 calendar days. To improve performance, SFHP completed the following activities:

- Conducted internal audits to monitor turnaround time and identify any barriers to resolving grievances within 30 days.
- Reported an SFHP multi-department shared metric goal for grievance turnaround time on a monthly basis. Monthly reporting promotes accountability among all staff involved in the grievance process.
- Improved efficiency of resolving grievances in a timely manner by creating nurse protocols to ensure timely clinical review.
- Developed a report that calculates provider response turnaround time to monitor for provider performance and identify any barriers.

The target was met. SFHP will retire this measure for 2020 due to meeting the target and sustained improvement. SFHP will continue internal monitoring of grievance turnaround time via daily operations.

2.4 CAHPS Getting Care Quickly/Getting Needed Care

<table>
<thead>
<tr>
<th>Measure: CAHPS Getting Care Quickly</th>
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<tbody>
<tr>
<td>Baseline 73.0% Final Performance 72.9%</td>
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<tr>
<td>Target 75.0% Evaluation Year 2019</td>
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<table>
<thead>
<tr>
<th>Measure: CAHPS Getting Needed Care</th>
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<tbody>
<tr>
<td>Baseline 68.4% Final Performance 73.8%</td>
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<tr>
<td>Target 70.4% Evaluation Year 2019</td>
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The Getting Care Quickly and Getting Needed Care composites from the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) survey assesses member experience of care and are in the Quality of Service and Access to Care domain. HP-CAHPS performance is important to SFHP for three reasons:

1) HP-CAHPS is the primary means by which members provide feedback about their satisfaction with SFHP and their overall health care. SFHP strives for high member satisfaction, in addition to high quality and affordability.
2) Improvement in the Getting Care Quickly and Getting Needed Care composites are the biggest contributors to SFHP members’ overall satisfaction with the health plan, and therefore remains an organizational priority.

3) NCQA Accreditation is partly dependent on a strong performance in HP-CAHPS.

The Getting Care Quickly composite is comprised of two questions:

1) Got urgent care as soon as needed – “In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?”

2) Got routine care as soon as needed – “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 Getting Needed Care composite is comprised of two questions:

1) Easy to get needed care – “How often was it easy to get the care, tests, or treatment you needed?”

2) Easy to see specialists – “How often did you get an appointment to see a specialist as soon as you needed?”

The results for these composites represent the percentage of members responding “Usually” and “Always” to each of the questions, then averaged to create the composite score. SFHP met the target and improved by over 2% in the Getting Needed Care composite. More members gave a “usually” or “always” response to getting needed care, test, or treatment (67.9% in 2018 to 79.0% in 2019). Within Getting Care Quickly, the question of getting an appointment for routine care increased as well (65.2% in 2018 to 67.3% in 2019). However, the Getting Care Quickly composite did not meet its target due to fewer members giving a “usually” and “always” response for the getting care as soon as needed question (80.8% in 2018 to 78.4% in 2019).
Member focus groups and SFHP appointment availability monitoring show that lack of clear and timely communication about how to get care as soon as needed (e.g. visits with other providers, telephonic or email options) is a barrier to Getting Care Quickly. To address this barrier, SFHP implemented several improvement projects to improve performance in HP-CAHPS access composites:

- Provided technical assistance and grant funding for access improvement through the Strategic Use of Reserves Grant program via the Service Recovery training series, which focused on repairing relationships with members dissatisfied with care because of communication, access, or clinical issues.
- Increased monitoring of access in the network and requests for corrective action when it had been determined that provider groups had not met access standards.
- Provided technical assistance to the network about best practices for improving access. This included coaching clinics and providers with the intention of improving appointment availability.
- Marketed Teladoc which provides members with an alternative to primary care or emergency care when primary care providers are not able to offer a timely or convenient appointment.
- Included performance in Clinic and Group CAHPS Access Composite in SFHP’s Pay for Performance Program.
- Conducted member focus groups to gain additional insight on member perception of access.
- Sent survey reminder postcards to members in an effort to increase responsiveness to CAHPS.
- Provided CAHPS presentations to SFHP departments and during joint standing meetings with provider groups to facilitate shared ownership of CAHPS.

For 2020, SFHP will modify this measure to focus on overall improvement in CAHPS measured by performance in Consumer Satisfaction of NCQA Health Plan Insurance Rating. This reflects SFHP’s shift in broader CAHPS improvement. Activities to continue improvement in CAHPS will include:

- Increase monitoring of network access and request Corrective Actions when needed.
• Identify access-related issues via the Access Compliance Committee and develop plans to address found issues.
• Develop a member-facing grid to include more information on the role of Medical Groups and post in more places.
• Include measures of performance in Clinic and Group CAHPS and implementing improvement projects in SFHP's Pay for Performance Program.
• Invest Strategic Use of Reserves Grant funds into improvements in appointment scheduling and specialty care coordination.
• Improve readability of Clinical Operations letters sent to members for approvals, denials, and appeal resolution.
• Maintain or improve CAHPS response rate through alternative survey methods and reminders.
• Conduct member focus groups.

3. Clinical Quality and Safety
These are measures that improve clinical based outcomes. Patient safety prevents adverse health outcomes, such as death or poor quality of life.

3.1 Pain Management-Opioid Safety

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<tr>
<th>Measure: Pain Management-Opioid Safety</th>
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<tr>
<td><strong>Numerator</strong></td>
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The Pain Management – Opioid Safety measure is in the Clinical Quality and Patient Safety domain. This measure calculates the percentage of SFHP members with at least one opioid prescription, out of the total number of SFHP members. This metric allows SFHP to monitor patterns and trends of opioid prescribing across the provider network. In addition, these data can be used to assess member safety related to opioid use and determine appropriate interventions to address chronic use and dependence. The target for this metric is to maintain the percentage of members receiving at least one opioid prescription at 7.75% or less. This target was set based on the metric’s historical data trends and 2017 baseline data.

Activities completed to support this measure included:

• Provider education about opioid prescribing best practices through:
  o 2018 Pain Day: “The Shift in Pain Management – A cultural transformation in how we view, treat, and manage Chronic Pain.” This event was open to SFHP’s provider network and members with topics focused on emerging evidence and treatment for chronic pain management, using data to inform population-level treatment strategies, and interventions to address gaps, disparities, and bias in pain management. SFHP hosted 171 guests of whom 86.5% were SFHP network providers and 13.5% SFHP members.
  o SFHP’s pay-for-performance program that incentivizes various opioid safety initiatives including creating and monitoring a registry of patients on chronic opioids, expanding the number of providers with X-licenses, conducting SBIRT screenings and increasing Naloxone prescribing. Thirteen SFHP providers participate in this program including medical groups and community clinics.
  o Participation in the San Francisco Safety Net Pain Management Workgroup.
Development of health education materials available on the SFHP Pain Management website including:

- 3 resources for pain management patient agreements and informed consent
- 5 resources on medication assisted treatment (MAT) for opioid use disorder
- 7 resources on overdose prevention
- 3 resources on opioid tapering
- 6 resources on patient consultation support

- Promotion of non-narcotic alternatives for pain management, including implementation of an acupuncture benefit for members with chronic pain.
- Implementation of a pharmacy policy restricting members being started on short-acting opioids to a 7 day initial supply, to align with updated clinical evidence.
- Grant opportunities funded by SFHP's Strategic Use of Reserves (SUR) program to support implementation of inpatient medically assisted treatment at three in-network hospitals.

SFHP was not able to implement a chiropractic benefit for members. Barriers to implementing this benefit was large delays in establishing mutually agreeable contract terms with a provider new to working in the Medicaid space. The new target date for the benefit implementation is August 2019, contingent on the contract being executed.

The final result of 7.14% met the target and improved from the baseline. SFHP has demonstrated a steady decline in the overall rate of members with an opioid prescription since 2016.

<table>
<thead>
<tr>
<th>% of members with at least one opioid prescription</th>
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<tbody>
<tr>
<td>2016</td>
</tr>
<tr>
<td>10.01</td>
</tr>
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</table>

SFHP will retire this metric from the QI Plan and replace it with a metric that is aligned with new opioid safety priorities to increase the percentage of members with opioid use disorder who have a buprenorphine prescription. The new target will be 12.0% based on SFHP baseline data. Activities will include:

- Provide grant opportunities through SFHP’s Strategic Use of Reserves to implement Opioid Safety initiatives that will increase the percentage of individuals within SFHP's network who are trained to provide inpatient addiction treatment services.
• Develop provider education opportunities to increase the number of buprenorphine prescribers in SFHP's network.

3.2 Hepatitis C Treatment

<table>
<thead>
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<th>Measure: Hepatitis C Treatment</th>
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<tr>
<td>Numerator</td>
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<td>Denominator</td>
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The Hepatitis C Treatment measure is in the Clinical Quality and Safety domain. The rate is based on the total number of SFHP members with any past history of Hepatitis C diagnosis who have completed the Hepatitis C treatment regimen. This measure benefits members because it can prevent the spread of Hepatitis C disease and because treatment eliminates risk of progression of liver disease. The target of 35% was based on SFHP’s preliminary population analysis.

Activities completed to support this measure included:

• A Strategic Use of Reserves (SUR) Grant opportunity to initiate a treatment program at HealthRIGHT360. As part of this project, HealthRIGHT360 hired a Hepatitis C care coordinator to support adherence to Hepatitis C treatment among patients receiving inpatient residential drug treatment. The goal for this program is to enroll 70 patients into a Hep C treatment program by the end of 2020.

• A Hepatitis C incentive measure was included in the Practice Improvement Program (PIP) in 2017.
  o As a result of the PIP measure and an SFHP grant program sourced from unearned PIP funds, 49% of current SFHP members are assigned to medical groups and community clinics who have implemented Hepatitis C screening and treatment improvement activities.

• Participation in San Francisco's city-wide "End Hep C" efforts. During these meetings the group discussed strategies to remove access barriers to treatment. Most recent accomplishments of the End Hep C group included:
  o Conducting provider outreach incentivizing adoption of Hepatitis C identification and treatment.
  o Implementing medication storage lockers available at needle exchange sites. This is a resource for members who lack a safe place to store medication and, as such, supports medication adherence.
  o Leading statewide advocacy; as a result, DHCS approved expansion of Hepatitis C treatment to all patients with any past history of Hepatitis C infection.
  o Creating provider education material including a Hepatitis C formulary guide that specifies which treatment each San Francisco insurance company prefers.

• Information gathering both internally and externally (i.e. CDC, DPH, End Hep C work group) to better identify new populations at-risk for Hepatitis C and determine effective strategies for screening and treatment for those populations.

• Creating more points of treatment access including:
  o Contracting US BioServices (SFHP’s primary specialty pharmacy) to provide treatment through medication delivery.
Expanding the number of local specialty pharmacies to include North East Medical Services, Mission Wellness, Mission Neighborhood Health Center for members who don’t have access to mail delivery or medication storage.

Barriers to achieving the target included:

- SFHP’s data is limited by ICD-10 codes that exist for diagnosis and prescription claim data. Because there are no procedure codes for Hepatitis C treatment and cure, SFHP may be missing data for members who were previously treated and cured or who spontaneously cleared the virus and are immune.
- There is a stigma related to Hepatitis C that prevents members from wanting to seek screening and treatment may impact the accuracy of the prevalence estimate. Members report not wanting a positive Hepatitis C screening to be in their medical record.
- Effective Hepatitis C Treatment requires 8-12 weeks of medication adherence which can be a barrier for members with difficulty with safe medication storage or are experiencing other barriers to completing treatment.
- The clinics and provider offices serving populations with a high prevalence of Hepatitis C infection have been aggressive to screen and treat infected members leaving the untreated members in clinics with a lower prevalence with less provider awareness and comfort.

The final result of 31% improved 10 percentage points from baseline but did not meet the target of 35%. SFHP recommends retaining this measure to continue monitoring and improving the percentage of members who complete Hepatitis C treatment. The target will remain at 35%. Activities to support this measure will include:

- Developing both a member-focused awareness campaign and provider education outreach campaign in target clinics and offices.
- Addressing stigma for Hepatitis C treatment with providers and members.
- Providing treatment support through SFHP’s Care Transitions or Care Management programs.
- Identifying and addressing potential data quality concerns to ensure an accurate denominator population count.

### 3.3 Medication Therapy Management (MTM)

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<th>Measure: Medication Therapy Management (MTM)</th>
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<td><strong>Numerator</strong></td>
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The Medication Therapy Management (MTM) measure is in the Clinical Quality and Safety domain. MTM is a clinical assessment by a pharmacist of all the medications a member is taking, identification of potential harmful medication combinations, recommendations to optimize the medication regimen, and provision of medication-related education and advice to the member and provider. This intervention improves medication safety among members with complex diseases.

The 2019 MTM rate is calculated based on the number of completed MTM assessments (numerator) divided by number of members engaged in SFHP’s Health Homes and NCQA Complex Medical Care Management programs who have a flagged need for MTM review (denominator).
The MTM target is set based on results from a similar program in 2018 where 90% MTM completion rate was obtained. Though, the 2019 program targeted an expanded population with potentially greater risk and competing health concerns.

All activities conducted to support this measure were completed, including:

- Pharmacy MTM workflow improved for efficiency and expanded to include the Health Homes Program.
- SFHP Pharmacists became active members of the care management team and participated in weekly meetings where care plans were discussed as a multi-disciplinary team.
- Five SFHP Pharmacists were trained to complete the new MTM workflow.
- Eighteen Care Coordinators and 3 Care Management Nurses were trained on the updated pharmacy workflow and tasking the pharmacist with an MTM assessment.
- System configurations were added to improve work flow and increase efficiency. A report (Health Homes Initial MTM Report) was created to track the numerator and denominator results for this measure. NCQA program results are manually tracked.
- Improvements to the Care Management module were implemented to make all medication reconciliation assessments reportable.

A barrier to meeting the 90% target was engaging members who had multiple chronic conditions, mental health conditions, and high acuity related to emergency department visits and/or inpatient admissions. As a result, these members are more likely to be lost-to-follow-up resulting in incomplete MTM assessments. Additionally, the development, training, and adoption of workflows that tasked MTM assessments to a pharmacist were slower to implement than expected representing an operational barrier that is now resolved.

The final rate was 76%. SFHP will retain this measure due to the benefits MTM adds to medication safety for members. Since the population in the next year is more complex and potentially difficult to engage, SFHP is adjusting the target to 80%. The Care Management team will continue their work with members to prioritize their health needs and MTM assessment will be tasked for members who agree to focus on their medications.

Activities to support this measure will include:

- Develop specialized intervention plans designed around the member’s preferences to prevent lost-to-follow-up.
- Update Pharmacy workflow for Health Homes Program to improve efficiency.
- Add configurations to the Care Management module to improve work flow including pharmacy technician support for some of the MTM activities.

### 3.4 Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Measure: Cervical Cancer Screening</th>
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<tr>
<td>Numerator</td>
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The Cervical Cancer Screening (CCS) measure is in the Clinical Quality and Safety domain. The rate is calculated from a sample derived from 29,948 SFHP members, between the ages of 21 to 64 with a female gender marker, who were eligible for cervical cancer using one of the following:

- Cervical cytology performed every 3 years for members between the ages of 21-64.
- Cytology/human papillomavirus co-testing every 5 years for members between the ages of 30-64.

Cervical cancer screenings reduce morbidity and mortality from cervical cancer; however, these screenings have historically been underutilized by SFHP members. Improvement in the cervical cancer screening rate benefits members because it helps to reduce cervical cancer morbidity and mortality by detecting atypical and dysplastic lesions that, if untreated, could develop into cervical cancer. The target of 71.88% was set to achieve NCQA’s National 90th percentile for Medicaid for cervical cancer screenings for reporting year 2019.

All activities conducted to support this measure were completed, including:

- Incentivized improvement of cervical cancer screenings through a pay-for-performance measure included in SFHP’s Practice Improvement Program (PIP).
  - Four out of 10 PIP participants included cervical cancer screening as a Clinical Quality priority measure in 2018
    - One out of the 4 PIP participants that included CCS as a priority measure in 2018 met the 90th percentile at 76.59%.
- During January 2018, SFHP promoted cervical cancer screening health education messaging on SFHP’s Customer Service main phone line.

A barrier to meeting the 71.88% target was the chosen methodology for outreach to members to engage them in health education. The methodology chosen allowed SFHP to reach a limited number of the intended members. SFHP is investigating other methods for member outreach and health education messaging including exploring how members can be contacted electronically or via cell phones.

The final result of 68.10% was 2.18% under the baseline and did not meet the target of 71.88%. SFHP recommends retiring this measure due to SFHP and DHCS shifting priority focus to new pediatric measures. SFHP will focus on lower-performing measures, such as Well Child Visits for Infants and Breast Cancer Screening. New measures will be added to the Clinical Quality and Safety domain to reflect the organization’s shift in priorities.

### 3.5 Chlamydia Screening
This is a multi-year measure to be evaluated in 2020.

### 3.6 Opioid Safety
This is a multi-year measure to be evaluated in 2022.
4. Care Coordination and Services
These are measures that improve care and hand-offs across multiple providers/facilities. They may also be defined as serving a specific population with complex medical needs.

4.1 Care Management Client Satisfaction with Staff

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<thead>
<tr>
<th>Measure: Care Management Client Satisfaction with Staff</th>
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<td><strong>Numerator</strong></td>
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The Care Management Client Satisfaction with Staff measure is in the Care Coordination and Services domain. This measure reflects activities to increase the percentage of clients enrolled in SFHP’s Care Management (CM) programs who respond “Yes” to the survey question “Was your experience with Care Management staff helpful?” The client satisfaction survey is conducted twice a year and is used to assess client experience with CM services and staff. The target for this measure was 80%, chosen based on results from previous versions of the survey. This target represents SFHP’s commitment to ensuring that Care Management programs are member-centered.

The following activities were completed:

- Revised the survey tool to measure specific satisfaction elements, including satisfaction with staff and an open-ended question requesting suggestions to improve the program to identify future interventions.
- Trained staff in best practices in survey administration to maximize response rate.
- Analyzed survey results for themes in dissatisfaction to identify improvement opportunities.
- Reported results of survey and dissatisfaction themes to staff.

The final result for this measure was 98%. The target was met. Response rates were consistent with previous years’ rates. Due to higher program enrollment in 2018, staff surveyed a record number of Care Management clients, including clients enrolled in the new Health Homes Program launched in July 2018. While the overall satisfaction rate was high, qualitative analysis indicates that clients who responded either “No” or “Not sure” felt that they had not been enrolled in the program long enough at the time of the survey to be able to assess their satisfaction. Suggestions to improve the program included:

- Allow clients more time with CM Coordinator (day-to-day as well as longer length of stay in the program).
- Increase outreach and education to providers about the program.

This measure will be retired due to sustained improvement the past few years. However, SFHP will continue to monitor client satisfaction with Care Management staff as part of regular operations via internal operational scorecards and member satisfaction reporting for NCQA and DHCS.

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td>Results</td>
<td>96%</td>
<td>100%</td>
<td>92%</td>
<td>98%</td>
</tr>
<tr>
<td>Target</td>
<td>85%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
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</table>
### 4.2 Care Management Client Perception of Health

<table>
<thead>
<tr>
<th>Measure: Care Management Client Perception of Health</th>
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<tr>
<td>Numerator</td>
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The Care Management Client Perception of Health measure is in the Care Coordination and Services domain. This measure reflects activities to improve adult Care Management (CM) clients’ perception of their health. This outcome is based on changes in their self-reported health status between initial and closing assessments. Clients self-report via a question on the SF-12; a health questionnaire used to capture self-reported health status for clients with chronic conditions. The target for this measure was 60%. The target was selected based on evaluation data from the Community Based Care Management program with a similar population. This target represents SFHP’s commitment to ensuring that Care Management programs are member-centered, support self-management of health conditions, and promote members feeling in control of their health.

The following activities were completed:

- CM nurses completed continuing education training to enhance health coaching skills.
- CM Clinical Supervisors worked with staff to ensure clients had a chronic condition self-management goal when appropriate and the staff had the health coaching skills needed to support the clients. CM Clinical Supervisors and the Medical Director reviewed self-management goal progress with CM nurses to identify and address gaps in members receiving health education.
- CM nurses provided health coaching and education to their clients. This contributed to the client's understanding of their health and capacity to manage their chronic conditions.
- CM staff monitored client connection to PCP via a report for clients enrolled in the Complex Care Management program. Staff discussed their cases in multidisciplinary rounds on a monthly basis. These rounds provided support with building the client’s care team and allowed a forum to troubleshoot barriers to PCP and other provider connections.
- Additional analysis of survey results was conducted to assess for trends in client responses.

The final result for this measure was 37%. Twenty-two out of 60 CM clients completed the SF-12 health questionnaire during their initial and closing assessments and indicated an improvement in their self-reported health status. The target was not met. Several barriers to meeting the target were identified. The measure relies on data from both the initial and closing assessment; many members do not complete the closing assessment due to being lost to follow up, deceased, or otherwise unable to answer the questions. In the reporting period, 101 clients were closed due to being lost to follow up and 23 were closed due to death. Of those members who did complete the closing assessment, 25% responded with “Don’t know” or “Decline to answer” for the self-reported health question, which impacted the sample size; these respondents were not included in the denominator.

SFHP will keep this measure for 2020 and refine to focus on improving the health status of those who indicate “Poor” or “Fair” health and maintaining the health status of those who indicate “Good,” “Very Good,” or “Excellent” during their initial assessment. Analysis found that 44% of those members who self-reported “Poor” health at intake improved at least one level by closing and the rate of improvement...
declined the higher the level of self-reported health at intake. Analysis also found that 50% of respondents reported the same health status from intake to closing. Those respondents with greater self-reported health at intake were more likely to stay the same. These results are consistent with programmatic goals of targeting members with serious health conditions and ensuring that they have the skills, connections, and resources to maintain or improve their health. Therefore, the revised measure will focus on improved self-reported health for those who report “Poor” or “Fair” health at intake and maintaining health status for those who report greater self-reported health. The target will be 55% as the baseline is 52%. Activities to support this measure will include:

- Coaching from Clinical Supervisors and Medical Director with the CM nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- Review of self-management goal report with CM nurses to ensure that members have chronic condition self-management goals as part of their care plans as indicated.
- Analysis of assessment results to address high rates of “declining to respond” to closing self-reported health status question.

### 4.3 Screening for Clinical Depression

| Measure: Screening for Clinical Depression |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Numerator       | Baseline        | Final Performance |
| Denominator     | Target          | Evaluation Year  |
| 48              | N/A             | 67%              |
| 72              | 70%             | 2019             |

The Screening for Clinical Depression measure is in the Care Coordination and Services domain. This measure reflects activities to increase the percentage of adult clients in SFHP's Care Management (CM) programs successfully screened for clinical depression using the Patient Health Questionnaire-9 (PHQ-9) when indicated by their responses to the Patient Health Questionnaire-2 (PHQ-2). The PHQ-2 is a brief series of questions used to screen for clinical depression and the PHQ-9 is an instrument used to screen, monitor, and measure the severity of depression. All adult clients enrolled in CM programs receive the PHQ-2 screening; the PHQ-9 is triggered based on the PHQ-2 score. The target for this measure was 70%. The target was selected based on results from past clinical measures.

The following activities were completed:

- CM Clinical Supervisors reviewed screening report with staff monthly and developed action plans when needed to ensure members had a depression screening.
- Staff participated in Motivational Interviewing and Trauma Informed Care training to ensure they were equipped to speak with clients about depression symptoms.
- CM leadership facilitated mental health training with staff to promote best practices around screening and follow up.
- Additional analysis of screening results was conducted to assess for trends in barriers.

The final result for this measure was 67%. Seventy-two CM clients screened positive for clinical depression using the PHQ-2. Forty-eight of those clients had a longer, more in-depth nine-question PHQ-9- completed to identify the severity of their depression and inform follow up. The 70% screening target was not met. The primary barrier to meeting the target is members declining the screening. In order to address this, the Clinical Supervisors started doing one-on-one coaching with the staff every month to address individual client barriers to completing the screening and additional training is planned.
SFHP will keep this measure for 2020 because the target was not met and screening for clinical depression is an important step in identifying and addressing depression symptoms. Analysis found that 24% (72/305) of all CM clients who received the PHQ-2 screened positive for depression. As of 2018, 4.5% of the overall SFHP Medi-Cal population had a depression diagnosis, though there is reason to believe that depression is underdiagnosed due to stigma, among other factors. Depression screening will continue to be a priority for the CM programs in order to connect clients to behavioral health services as clinically indicated and with the client’s consent. The target will remain at 70% and activities to support this measure will include:

- Coaching and role-playing activities to reduce the rate of members declining PHQ-9 screening.
- Mental health training for staff, particularly on severe mental illness (SMI), in order to ensure that staff is equipped to identify signs and symptoms of clinical depression and address client safety.
- Monthly report review with staff and coaching from Clinical Supervisors to ensure members are screened and receive appropriate follow up.
- Additional report tracking to monitor the rate of members declining the PHQ-9 screening.

### 4.4 Follow Up on Clinical Depression

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<th>Measure: Follow Up on Clinical Depression</th>
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The Follow Up on Clinical Depression measure is in the Care Coordination and Services domain. This measure reflects activities to increase the percentage of adult clients in SFHP’s Care Management (CM) programs who screen positive for clinical depression and receive follow up care. The target for this measure was 70%. The target was selected based on results from past clinical measures. This target represents SFHP’s commitment to ensuring that Care Management programs are member-centered and address follow up care for members with behavioral health needs.

The following activities were completed:

- CM Clinical Supervisors provided staff with one-on-one and role-based training that focused on coaching clients with behavioral health follow up.
- CM staff worked with Beacon Health Options to ensure timely follow up of referrals submitted. Beacon staff is co-located which provides the CM staff easy access to their Care Manager and Coordinator to help with linkage to services.
- CM staff attended a Beacon overview which provided updates on workflow and benefits as part of ongoing staff training.
- CM Clinical Supervisors reviewed follow up reporting with staff and developed action plans to connect members to behavioral health services.
- CM leadership facilitated mental health training with staff to promote best practices around screening and follow up.
- Additional analysis of screening results was conducted to assess for trends in barriers.

The final result for this measure was 77%. Forty-four CM clients had a positive score in the PHQ-9 completed to determine the severity of their depression. Thirty-four of those CM Clients had a care plan
goal completed, in progress, or had declined to connect to appropriate behavioral health services. Clients may decline services because they are already connected to behavioral health services or they are not ready to discuss or prioritize their mental health; 19 clients declined the goal for these reasons. Staff is trained to re-assess at a minimum every six months. Ultimately, 26% of clients who initially declined the “Connect to Behavioral Health” goal were re-engaged and connected to appropriate behavioral health services. The target was met.

SFHP will keep this measure for 2020 to ensure sustained high rates of follow up. The target will be increased to 80% to support continued improvement. Activities to support this measure will include:

- Mental Health training for staff, particularly on severe mental illness (SMI), in order to ensure that staff is equipped to identify signs and symptoms of major depressive disorder and address client safety.
- Updates to CM workflow to provide guidance to staff for triaging members with PHQ-9 scores indicating moderately severe or severe depression who are not connected to behavioral health and who decline a referral.
- Monthly report reviews with staff and coaching from Clinical Supervisors to ensure members at risk of clinical depression receive appropriate follow up.

4.5 Community Health Network (CHN) Out Of Medical Group (OMG) All Cause Readmissions

| Measure: Community Health Network (CHN) Out of Medical Group (OMG) All Cause Readmissions (ACR) |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Numerator       | 735             | Baseline        | 22.40%          | Final Performance| 23.05%          |
| Denominator     | 3,181           | Target          | 17.72%          | Evaluation Year  | 2019            |

The CHN OMG All Cause Readmissions measure is in the Care Coordination and Services domain. This measure reflects activities to prevent members from being readmitted within 30 days of discharge of an acute admission. Meeting this measure indicates SFHP’s 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 or needed specialty care. The ACR is measured quarterly using the HEDIS All-Cause Readmission methodology. The target for this measure was 17.72%. The target was chosen to align with the Medi-Cal state average.

The following activities were completed:

- Implemented follow up phone calls to members pre and post discharge.
- Launched onsite discharge planning including hospital visits for high risk members, home visits and health education.
- Hired a Care Navigator to support the Care Transitions Nurse with discharge planning activities.
- Conducted staff training including motivational interviewing and other case management best practices.

The final result for this measure was 23.11%. Out of 3,181 OMG admissions in our CHN network, 735 resulted in a readmission within 30 days after discharge. The target was not met. Barriers to meeting the target included:
• Member non-compliance with discharge instructions and condition management.
• Low member engagement rate in Care Transitions program.
• Lack of housing resources.

SFHP is addressing these barriers by:

• Implementing new medical criteria guidelines software that includes a Transitions of Care Module to better track and address member admission and readmission trends.
• Refining program criteria to expand target population to other networks.
• Hiring an additional Care Navigator to support discharge planning efforts.
• Hiring additional Care Transitions on-site staff to increase community engagement.

SFHP will retire this measure for 2019 and implement a new readmission measure that targets CHN members engaged in the Care Transitions program rather than all CHN members who go out of medical group. This refinement will help SFHP assess the true impact of its discharge planning activities on CHN members engaged in the program. SFHP will continue to monitor overall readmissions as part of daily UM operations.

5. Utilization of Services
These are measures that address appropriate utilization, i.e., decrease over-utilization or increase under-utilization.

5.1 Percentage of Members Utilizing the Non Specialty Mental Health Benefit with More Than Two NSMH Visits

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<thead>
<tr>
<th>Measure: Percentage Of Members Utilizing The Non Specialty Mental Health Benefit With More Than Two NSMH Visits</th>
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The Percentage of Members Utilizing the Non-Specialty Mental Health (NSMH) Benefit with More Than Two NSMH Visits is in the Utilization of Services domain. Increasing non-specialty mental visits reflects improved access for members with behavioral health conditions who do not consistently seek treatment. This measure reflects continued focus on enhancing member and provider awareness of the availability of the non-specialty mental health benefit and in sustaining engagement in care. The measure is the percentage of non-dual Medi-Cal members utilizing the NSMH benefit as defined by having two or more visits with a behavioral health provider from April 1, 2018 to March 31, 2019. SFHP set a target of 55.9%, based on previous SFHP performance.

Data is based on NSMH claims paid by Beacon Health Options and claims and encounters submitted from mental health providers directly to SFHP. The baseline rate of 54.3% was based on a broad set of claim codes and the target of 55.9% was based on this initial baseline. After setting the target, SFHP learned of inaccuracies in the initial code set. Upon re-measuring the baseline, SFHP’s rate was 41.1%. Having an incorrect baseline and target due to imprecise measurement represented a significant barrier to meeting the target. Despite SFHP not meeting the target, SFHP increased the rate from the new baseline by 2.7%.
To improve performance, SFHP completed the following activities:

- Promoted tele-behavioral health benefit to members through member communications and a registration incentive campaign.
- Assessed and identified barriers of follow up for members and referred any members with barriers to SFHP’s Care Management staff to assist with mitigating those barriers.
- New contracting requirements with several high volume therapists required them to be consistently available to new referrals and respond to new member requests within 48 hours.

SFHP did not complete the following planned activities:

- Share the measure rate with medical groups to promote the benefit and engage in mental health care utilization. This activity was not completed due to other priorities needing to be communicated to medical groups. SFHP focused on collaboration with Beacon Health Options to impact the measure’s success.
- Outreach to members who have not followed through on a referral. Three months pass before claims can be fully counted, meaning that three months would pass before being able to determine which members have not had follow-up visits. SFHP and Beacon worked to contract with more responsive providers, which served to be a more productive approach in engaging members.

For 2020, SFHP will modify this measure to focus on members newly initiating behavioral health treatment. The target will be set at 46.8% or 3% over the 2019 performance. Activities to support this measure will include:

- Survey engaged members and contracted therapists who have not received more than two NSMH visits regarding their barriers to receiving care.
- Explore provider incentives to provide timely follow-up with members who do not attend scheduled appointments.

### 5.2 Members with a Primary Care Visit in the Last Twelve Months

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<th>Measure: Members with a Primary Care Visit in the Last Twelve Months</th>
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The Members with a Primary Care Visit in the Last 12 Months measure is in the Utilization of Services domain. Increasing the percentage of members with a primary care visit reflects improved primary care utilization. This measure demonstrates SFHP’s continued emphasis on connecting members to preventive care in order to better manage their health. Increasing the rate of members with a primary care visit may also support other QI program measures such as HEDIS and CAHPS, as members with primary care visits are more likely to receive preventive care. Members with a primary care visit have higher satisfaction with their health care as reflected in CAHPS. Members with a Primary Care Visit in the Last 12 Months is the total number of SFHP adult members with at least one primary care visit from July 1, 2018 to June 30, 2019 out of the total number of SFHP Medi-Cal members with 12 months of continuous eligibility.

Data is based on primary care visit claims and encounters submitted by SFHP’s provider groups. SFHP set a target of 69.9%, based on improvement over baseline of 67.9%. SFHP did not meet the 2019 target. Barriers to meeting this target include ease of accessing care. In focus groups with SFHP members, barriers to care included having difficulty getting an appointment and accessing information regarding how to access care.
To improve performance, SFHP completed the following activities:

- Promoted tele-health services to members and providers. Tele-health visits contribute to the rate of members with a primary care visit. SFHP incentivized registering with Teladoc through a raffle incentive.
- Incentivized providers to increase primary care visits by including measure in 2019 Pay for Performance program.
- Provided a gift card incentive for adult members to have a primary care wellness visit. The incentive targeted members without a primary care visit who had an Emergency Department visit. This incentive increased to $50 from $25 in previous years. Over the measure period SFHP disseminated 11,018 incentive offers to members and completed 317 for members who had a wellness visit.

For the next evaluation period, the target will be set at 70.0% or 2% over 2019 performance. Activities will include:

- Promote tele-health services to members and provide incentives for registration of tele-health services.
- Inform members of the importance of primary care visits through marketing to members.
- Continue inclusion of the PCP visit rate in SFHP’s pay-for-performance program.
- Provide grant funds to medical groups who improve appointment scheduling options for patients.
6. Quality Oversight Activities

These are quality oversight activities monitored and completed this year.

<table>
<thead>
<tr>
<th>Oversight Activity</th>
<th>Summary</th>
<th>Responsible Staff</th>
<th>Activities</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Quality Improvement Committee</td>
<td>Ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan</td>
<td>CMO</td>
<td>6. Six meetings held in 2019</td>
<td>12/30/2019</td>
</tr>
<tr>
<td>B Pharmacy and Therapeutics Committee</td>
<td>Ensure oversight and management of the SFHP formulary and DUR initiatives</td>
<td>CMO</td>
<td>6. Quarterly and ad hoc P&amp;T Committee meetings</td>
<td>12/30/2019</td>
</tr>
<tr>
<td>C Physician Advisory/Peer Review/Credentialing Committee</td>
<td>Ensure oversight of credentialing and peer review by the Provider Advisory Committee</td>
<td>CMO</td>
<td>6. Six meetings held in 2019</td>
<td>12/30/2019</td>
</tr>
<tr>
<td>D Utilization Management Committee</td>
<td>Ensure oversight of SFHP Utilization Management program</td>
<td>Director, Clinical Operations</td>
<td>6. Twelve meetings held in 2019</td>
<td>12/30/2019</td>
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</tbody>
</table>
| E Annual Evaluation of the QI Program | Review Quality Improvement plan and determine efficacy of implemented plan based on outcomes | Director, Health Outcomes Improvement | 6. Evaluated each measure in the QI work plan  
   5. QIC reviewed QI evaluation  
   4. Governing Board reviewed QI Evaluation | 3/1/2019 |
| F QI Plan Approval for Calendar Year | Review and approve proposed Quality Improvement work plan | Director, Health Outcomes Improvement | 6. QIC reviewed QI work plan  
   5. Governing Board reviewed QI Work Plan | 3/1/2019 |
| G Delegation Oversight for QI | Ensure oversight of QI for all delegated entities | Director, Health Outcomes Improvement | 6. Followed delegation oversight procedures  
   5. QIC review of Delegated Oversight Audits for QI  
   4. All groups delegated for QI passed audit | 12/30/2019 |
| G DHCS Performance Improvement Projects | Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs) | Director, Health Outcomes Improvement | 6. Attended DHCS-led PIP calls  
   5. Adhered to process delineated by DHCS | 12/30/2019 |
Reviewed and Approved by:

Chief Medical Officer: James Glauber, MD, MPH Date: 10/29/19

Quality Improvement Committee Review Date:

Board of Directors Review Date:
San Francisco Health Plan
2020 Quality Improvement Program Description & Work Plan
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1. Introduction

San Francisco Health Plan (SFHP) is a community health plan that provides affordable health care coverage. As of July 2019, membership included 139,605 low and moderate-income individuals and families. Members have access to a range of medical benefits including preventive care, specialty care, hospitalization, prescription medicines, behavioral health and family planning services. SFHP was designed by and for the residents it serves and takes great pride in its ability to serve a diverse population that includes children, young adults, and seniors and persons with disabilities (SPDs).

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

To ensure high quality care and service, SFHP embarked on a journey to be accredited with the National Center for Quality Assurance (NCQA) in 2015. SFHP received interim accreditation status in 2016 and first survey accreditation in 2017, earning 48.3 of 50 possible points. SFHP will have to renew its accreditation in 2020.

SFHP’s products include Medi-Cal, Healthy Kids, and Healthy Workers:

- **Medi-Cal**
  Medi-Cal is California’s Medicaid program, which is a federal and state-funded public health insurance program for low-income individuals. As a managed care plan, SFHP manages the funding and delivery of health services for Medi-Cal members. As of June 2019, SFHP retained 87% (126,621 members) of the managed care market share in San Francisco County. ¹

- **Healthy Workers**
  Healthy Workers is a health insurance program offered to providers of In-Home Supportive Services or temporary exempt employees of the City and County of San Francisco. As of July 2019, 11,609 members are enrolled in this program.

2. QI Program Purpose, Scope and Goals

SFHP is committed to continuous quality improvement for both the health plan and its health care delivery system. The purpose of the SFHP QI Program is to establish comprehensive methods for systematically monitoring, evaluating, and improving the quality of the care and services provided to San Francisco Health Plan members. The QI Program is designed to ensure that members have access to quality medical and behavioral health care services that are safe, effective, accessible, equitable, and meet their unique needs and expectations. Delivery of these services must be in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

¹ Medi-Cal Managed Care Enrollment Report – June 2019, https://data.chhs.ca.gov/dataset/c6ceef54-e7a9-4ebd-b79a-850b72c4dd8c/resource/95358a7a-2c9d-41c6-a0e0-405a7e5e5f18/download/mcod-mc-mc-enrollment-report-june-2019.csv
SFHP contracts with medical and behavioral health care providers, including medical groups, clinics, independent physicians and their associated hospitals, ancillary providers, behavioral health clinicians, and pharmacies to provide care. SFHP maintains responsibility for communicating regulatory and contractual requirements as well as policies and procedures to participating network providers. SFHP retains full responsibility for its QI Program and does not delegate quality improvement oversight. In certain instances, SFHP may delegate some or all QI functions to accredited provider organizations.

Under the leadership of SFHP’s Governing Board, the QI Program is developed and implemented through the Quality Improvement Committee (QIC). The QIC structure, under the leadership of the SFHP Chief Medical Officer, ensures ongoing and systematic collaboration between SFHP and its key stakeholders: members, provider groups, and practitioners. The QI Program is also part of a broader SFHP improvement strategy that includes a Population Health Management Program. The Population Health Management Program develops SFHP’s strategic targets for addressing the needs of its members across the continuum and manages the effective execution of that strategy. Strategic targets from Population Health Management are incorporated into the QI program. A shared leadership team ensures accountability and collaboration between both programs.

The QI Program’s objectives and outcomes are detailed in the QI Work Plan (see Appendix A). Each program objective is monitored at least quarterly and evaluated at least once per year. Measures and targets are selected based on volume, opportunities for improvement, risk, organizational priorities, and evidence of disparities.

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

- Improving members’ health status, including reducing health disparities and addressing, where possible, the social determinants of health that adversely impact our members
- Ensuring continuity and coordination of care
- Ensuring access and availability of care and services, including parity between medical and behavioral health care services
- Ensuring member knowledge of rights and responsibilities
- Providing culturally and linguistically appropriate services
- Ensuring that health care practitioners are appropriately credentialed and re-credentialed
- Ensuring timely communication of Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) standards and requirements to participating medical groups and organizational providers
- Ensuring effective and appropriate utilization management of health care services, including medical, pharmaceutical, and behavioral health care services
- Providing health education resources
- Ensuring clinical quality and safety in all health care settings
- Ensuring excellent member care experience
- Ensuring that responsibilities delegated to medical groups meet plan standards
- Evaluating the overall effectiveness of the QI Program through an annual comprehensive program evaluation
- Using the annual evaluation to update the QI Program and develop an annual QI Work Plan
3. QI Program Structure

The following section describes the quality committees and staff of SFHP. Appendix B - Quality Improvement Committee Structure, includes details on committee reporting structure.

A. Quality Committees

The Quality Committees listed below report either to the Quality Improvement Committee (QIC), the Governing Board, or the Chief Medical Officer (CMO).

i. The Quality Improvement Committee

The SFHP QIC is comprised of network clinicians (physicians, behavioral health, and pharmacists) and two members of the Member Advisory Committee. The QIC is chaired by SFHP’s CMO. The QIC is a standing committee of the San Francisco Health Authority Governing Board that meets six times a year. It is the main forum for member and provider oversight, ensuring the quality of the healthcare delivery system. The committee is responsible for reviewing and approving the annual QI Program and QI Evaluation, and for providing oversight of the Plan’s quality improvement activities. SFHP brings new quality improvement programs to the QIC to ensure the committee members provide input into program planning, design, and implementation. SFHP maintains an annual calendar to ensure that key SFHP QI activities are brought to the QIC for ongoing review. This includes review and approval of policies and procedures related to quality improvement, utilization management, and delegation oversight. SFHP maintains minutes of each QIC meeting, submits them to the Governing Board for review and approval, and submits these to DHCS on a quarterly basis. The QIC meetings are open to the public and agendas and minutes are published on SFHP’s website.

ii. The Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is comprised of network physicians, including a psychiatrist, and pharmacists along with the SFHP Pharmacy Director and is chaired by SFHP’s CMO. The P&T Committee convenes at least quarterly to review, evaluate, and approve the SFHP Formulary revisions based on safety, comparable efficacy and cost and to adopt pharmaceutical management procedures including prior authorization criteria, quantity limits, and step therapy protocol for covered outpatient prescription medications. The P&T Committee is responsible for pharmaceutical and therapeutic treatment guidelines and an annual approval of the pharmacy clinical policies and procedures for formulary, prior authorization, monitoring of utilization rates, timeliness of reviews, and drug utilization review (DUR) processes. The committee meets quarterly and on an ad hoc basis, and meetings are open to the public. The P&T Committee reports to the QIC.

iii. The Physician Advisory/Peer Review/Credentialing Committee

The Physician Advisory/Peer Review/Credentialing Committee (PAC) provides comments and recommendations to SFHP on standards of care and peer review. The PAC Committee is chaired by SFHP’s CMO and consists of providers in SFHP’s network. The PAC Committee serves to review and provide recommendations regarding substantive quality of care concerns, in particular those related to credentialled provider performance. The Sanctions Monitoring Report is reviewed by SFHP monthly to ensure that any identified providers with investigations or actions are brought to the PAC Committee for review, including confirmed Potential Quality Issues and Facility Site Reviews. The PAC Committee also reviews credentials and approves practitioners for participation in the SFHP network as appropriate. The PAC Committee meets every two months and reports to the QIC in closed session.
iv. The Member Advisory Committee

The Member Advisory Committee (MAC) serves as the Public Policy Committee of SFHP as defined and required by the Knox-Keene Act. The MAC advises the Plan on issues of concern to SFHP’s service beneficiaries. The committee is made up of SFHP members and health care advocates. In this forum, members can voice concerns and give advice about what health services are offered and how services are delivered to members. It consists of at least 10 to no more than 30 members and is led by an SFHP member. The Committee meets monthly and reports to the Governing Board.

v. The Practice Improvement Program Advisory Committee

The Practice Improvement Program (PIP) Advisory Committee provides guidance to SFHP on pay-for-performance program development, implementation, and evaluation. Committee members review prior and current year PIP network performance, identify and predict barriers to success for participants, and problem-solve solutions. Membership is made up of representatives from all PIP-participating organizations. Meetings are held at least three times a year. The PIP Advisory Committee reports to the CMO.

B. Committees with Internal Membership Only

The Committees with Internal Membership Only listed below report either to the CMO, or the Compliance and Regulatory Affairs Officer, which in turn provide updates to the QIC or the Governing Board through minutes or representation as appropriate.

i. The Policy & Compliance Committee

The Policy and Compliance Committee (PCC) is comprised of SFHP staff and led by SFHP’s Compliance and Regulatory Affairs Officer. The PCC reviews and approves all new policies and procedures and changes to existing policies and procedures. Policies and procedures with clinical implications must be approved by the QIC before review by the PCC. The PCC also communicates regulatory updates and compliance issues to SFHP management. The PCC meets at least 11 times per year, and is chaired by the Compliance Programs Supervisor. Members include representatives from Health Services, Operations, Finance, Information Technology Services, Human Resources, and Marketing departments. PCC members include:

- Supervisor, Compliance Programs (Chair)
- Officer, Compliance and Regulatory Affairs
- Director, Policy Development and Coverage, or a delegate
- Director, Finance, or a delegate
- Director, Pharmacy, or a delegate
- Director, Clinical Operations, or a delegate
- Director, Human Resources, or a delegate
- Director, Systems Development Infrastructure, or a delegate
- Director, Claims and Customer Service, or a delegate
- Director, Marketing & Communications, or a delegate
- Director, Business Solutions, or a delegate
- Director, Provider Network Operations, or a delegate
- Director, Care Management, or a delegate
- Director, Health Outcomes Improvement, or a delegate
ii. The Provider Network Oversight Committee

The Provider Network Oversight Committee (PNOC) is comprised of SFHP staff and led by SFHP’s Compliance and Regulatory Affairs Officer. The PNOC provides a forum for evaluating providers’ compliance with DHCS, DMHC, and NCQA requirements and standards. This committee identifies issues and addresses concerns related to provider performance of their administrative responsibilities. The committee is responsible for making penalty recommendations when providers do not consistently meet performance standards according to federal and state requirements. The PNOC is chaired by the Manager of Delegate Oversight and is comprised of members from the following departments: Compliance and Regulatory Affairs, Operations, and Health Services. PNOC voting members include:

- Manager, Delegate Oversight (Chair)
- Officer, Compliance and Regulatory Affairs
- Provider Network Operations Director
- Director, Clinical Operations
- Director, Health Outcomes Improvement
- Director of Pharmacy
- Director, Care Management
- Supervisor, Compliance Programs

iii. The Grievance Review Committee

The Grievance Review Committee (GRC) is an internal SFHP committee that reviews all grievances and serves as an escalation point for trends identified from member grievances. If a grievance trend is identified or there is a particularly concerning grievance, the committee will recommend a Corrective Action Plan (CAP) or a notification to the Medical Group. The GRC also reviews individual member grievances through a collaborative process to ensure that all the components of the grievances have been resolved. The committee is led by the CMO with cross functional representation from Member Services, Provider Relations, Health Outcomes Improvement, Behavioral Health, and Compliance and Regulatory Affairs departments. The committee meets twice weekly. GRC members include:

- Chief Medical Officer (Chair)
- Officer, Compliance and Regulatory Affairs
- Associate Medical Director
- Manager, Customer Service
- Account Manager, Provider Network Operations
- Quality Review Nurse
- Manager, Access and Care Experience
- Supervisor, Regulatory Affairs Program
- Grievance Staff
- Pharmacy, Utilization Management, Care Management, and Cultural & Linguistics staff participate as needed.

iv. The Grievance Program Leadership Team

The Grievance PLT is an internal SFHP committee that provides oversight and monitoring of all grievance program functions such as process improvement opportunities, audits, reporting, regulatory requirements, operations, and grievance trends. Grievance PLT also ensures follow through of Grievance Review Committee recommendations for grievance trends and reviews for system issues. The Grievance PLT is led by the Manager of Access and Care Experience with cross functional representation from
Health Services, Member Services, Health Outcomes Improvement, and Compliance and Regulatory Affairs departments. Grievance PLT meets quarterly. PLT members include:

- Manager, Access and Care Experience (Chair)
- Chief Medical Officer
- Officer, Compliance and Regulatory Affairs
- Associate Medical Director
- Manager, Customer Service
- Quality Review Nurse
- Supervisor, Regulatory Affairs Program
- Grievance Analyst
- Director of Health Outcomes Improvement
- Director of Claims and Customer Service
- Manager, Provider Relations and/ or Account Manager, Provider Network Operations as needed.

v. The Access Compliance Committee

The Access Compliance Committee (ACC) coordinates the monitoring and improvement activities for the accessibility and availability of medical and behavioral health care services. The committee meets at least quarterly to review access data, monitor progress of access-related corrective action plans, and recommend and review actions based on non-compliance with timely access standards. The committee is cross-functional and comprised of representatives from Operations, Health Services, Compliance and Regulatory Affairs, and Business Analytics departments. The committee reports to the QIC. ACC members include:

- Supervisor, Regulatory Affairs Program (Chair)
- Manager, Access and Care Experience
- Manager, Provider Relations
- Clinical Pharmacist
- Manager, Delegation Oversight
- Network Manager, Provider Relations
- Program Manager, Access and Care Experience
- Program Manager, Credentialing
- Specialist, Access and Care Experience

vi. The Utilization Management Committee

The Utilization Management Committee (UMC) provides oversight to ensure effective and compliant implementation of SFHP’s Utilization Management Program and to support compliance with requirements from SFHP’s policies, the Medi-Cal contract, NCQA accreditation criteria, and DHCS/DMHC regulations. Discussions result in changes to medical policy and criteria, Prior Authorization requirements, and/or UM Process enhancements. The UMC reports to the QIC. The UMC meets monthly and provides monthly minutes, quarterly trend reports and annual reports to the QIC. UMC members include:

- Director, Clinical Operations (Chair)
- Chief Medical Officer
- Medical Director
- Senior Manager, Prior Authorization Nurses
- Manager, Care Transitions & Concurrent Review
• Manager, UM Authorizations
• Program Manager, Clinical Operations
• Director of Pharmacy

C. Quality Improvement Communications

i. Communication to members
SFHP updates members regularly regarding key QI activities. A summary of the QI work plan and evaluation is published and distributed to members annually by mail in the member newsletter “Your Health Matters,” and on SFHP’s website.

ii. Communication to providers
SFHP updates providers regularly regarding key QI activities, including:

- Disseminating the QI work plan and evaluation to providers via the SFHP Provider Newsletter and by posting on SFHP’s website
- Informing providers of new and revised policies and procedures, and legislative and regulatory requirements as they occur through the SFHP Provider Newsletter and the Network Operations Manual (NOM)
- Sharing preventive care and other clinical practice guidelines
- Distributing results of quality monitoring activities, audits and studies, including grievances that identify potential system issues and member experience and provider satisfaction survey results
- Providing training for new providers on SFHP’s NOM

D. Quality Improvement Staff

The Health Outcomes Improvement (HOI) department within Health Services has primary accountability for implementing the QI Program and corresponding QI Work Plan. The department is organized to provide interdisciplinary involvement in ensuring the quality of health care and services provided to SFHP’s membership. HOI staff monitors quality indicators and implements and evaluates the Plan’s quality improvement activities. HOI staff develop and comply with policies and procedures describing SFHP standards, legislative and regulatory mandates, contractual obligations and, as applicable, NCQA standards. HOI staff support management of QI studies and reports, including statistical analysis and interpretation of data. Based on the QI Work Plan activities, HOI staff provides summary data, analysis, and recommendations to the QIC.

i. Health Services Staffing Structure

The Health Services Leadership that supports the QI program are:

Chief Medical Officer – responsible for leading the Quality Improvement Committee, Physician Advisory/Peer Review/Credentialing Committee, and the Pharmacy and Therapeutics Committee, and for all quality improvement studies and activities. The CMO provides guidance and oversight for development of policies, programs, and projects that support all activities identified in the QI Program. The CMO carries out these responsibilities with support from direct reports, including Medical Director, Associate Medical Director, and Directors of Health Outcomes Improvement, Pharmacy, Clinical Operations, and Care Management. In addition, the CMO partners with the Officer of Compliance and Regulatory Affairs.
Medical Director and Associate Medical Director – report to the CMO and provide physician leadership to key quality activities, including complex case management, utilization management, grievances, potential quality issues, and clinical improvement programs.

ii. Health Outcomes Improvement Staffing Structure

Director, Health Outcomes Improvement – reports to the Chief Medical Officer, ensures the completion of the QI Program (including work plan and evaluation), and directs the execution of QI activities identified in the QI Work Plan. The Director, Health Outcomes Improvement, oversees teams focused on fostering quality for our members: Population Health, Access & Care Experience, and Health Services Product Management.

- Manager, Population Health – reports to the Director, Health Outcomes Improvement, and oversees activities related to the improvement and auditing of clinical HEDIS measures, health education & promotion programs, and pay-for-performance. Reporting to the Manager, Population Health, the following positions support SFHP’s QI efforts:
  - Program Managers, Population Health – project manages interventions to improve HEDIS measures, including pay-for-performance program, member incentives, medical record review, health disparities, and cultural linguistic services.
  - Program Manager, Population Health (Qualified Health Educator) – designs and implements interventions to improve HEDIS rates, ensures that members have access to low-literacy health education materials/classes, and ensures that members have access to services in their preferred language.
  - Lead Population Health Nurse – provides technical assistance to clinical practice sites to improve gaps in care and documentation opportunities.
  - Specialists – provide support to the above staff to execute their responsibilities, including HEDIS chart review, developing marketing materials, pay-for-performance data management, and coordinating with providers to report pay-for-performance data.

- Manager, Access & Care Experience – reports to the Director, Health Outcomes Improvement, and oversees grievance management, access monitoring, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) improvement (i.e. patient experience). Reporting to the Manager of Access & Care Experience, the following positions support SFHP’s QI efforts:
  - Program Managers, Access & Care Experience – project manages SFHP’s access monitoring requirements, measures CAHPS performance, develops and implements interventions to improve the care experience of SFHP members.
  - Grievance Analyst – manages member grievances, and ensures that grievances are appropriately classified and resolved, in conjunction with the Grievance Review Committee.
• **Specialists**– provide support to the above staff to execute their responsibilities, including grievance management, processing incentives, and event management.

• **Manager, Health Services Product Management** – reports to the Director, Health Outcomes Improvement and oversees internal applications supporting SFHP processes that impact member care. Reporting to the Manager of Health Services Business Relationships, the following positions support SFHP’s QI efforts:

  • **Program Managers** – responsible for operating quality improvement oversight and overseeing systems and applications affecting multiple departments within Health Services. Examples include Essette (care management software), PIPBase (Pay-for-Performance database), Cotiviti (HEDIS software), MARA (member risk measurement), and PreManage ED (Hospital Information Exchange).

  • **Specialist** – Provides support to the above staff to execute their responsibilities, including system support requests and processing incentives.

### iii. Health Services Departments that contribute to the QI Program

**Clinical Operations Department**
SFHP’s Clinical Operations Department conducts Utilization Management (UM) for both inpatient and outpatient referrals. In addition, they oversee delegated UM activities within the provider network to comply with all regulatory UM requirements. Activities are comprised of the following functional areas: Care Transitions, Inpatient Concurrent Review, Outpatient Prior Authorization, UM Delegation Oversight, and Provider Dispute Resolutions.

**Pharmacy Department**
SFHP’s Pharmacy Department coordinates and monitors all aspects of the pharmacy benefit for SFHP members. SFHP Pharmacy staff carry out daily pharmacy program operations including formulary management, oversight of the contracted Pharmacy Benefits Manager and the specialty pharmacy vendors. In addition, the Pharmacy Department leads initiatives to improve quality of care, including medication reconciliation and drug utilization reviews.

**Care Management Department**
SFHP’s Care Management Department supports high-risk members with navigating the health care system. The primary focus is to improve health status, medical and behavioral health care system access, and decrease hospitalization and emergency department use. Members are enrolled in various case management programs including Health Homes, NCQA, and Time Limited Coordination based on acuity, clinical criteria, and utilization of services.

### iv. External Agency that contributes to the QI program

**Beacon Health Options**
Beacon Health Options is delegated to provide non-specialty mental health care to SFHP’s members. Beacon’s Quality Director presents annually on their QI plan and participates in QIC meetings as needed. SFHP’s CMO provides oversight and strategic guidance of the NSMH benefit to Beacon Health Options. Beacon’s on-site clinical staff participates in Care Management rounds to ensure a smooth connection of our member to Beacon services. SFHP collaborates with Beacon’s Clinical Management Director on QI initiatives as needed.
4. Quality Improvement Method and Data Sources

A. Identification of Important Aspects of Care

SFHP identifies priorities for improvement based on regulatory requirements, NCQA standards, data review, and provider- and member-identified opportunities in the key domains of Clinical Quality & Safety, Quality of Service & Access to Care, Utilization Management, and Care Coordination & Services. Particular attention is paid to those areas that are high risk, high volume, high cost, or problem prone.

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

- Establish targets and/or benchmarks for key indicators within each domain
- Systematically collect data
- Analyze and interpret data at least annually
- Identify opportunities for improvement
- Identify barriers to improvement
- Prioritize opportunities
- Establish improvement objectives in support of priorities
- Design interventions based on best practices or previous interventions
- Implement and track progress of interventions
- Measure effectiveness of interventions based on progress toward standards or benchmarks

B. Data Systems and Sources

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<td>• Grievances</td>
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<td>• Consumer Assessment of Healthcare Providers and Systems</td>
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<td>• Health Information Form/Member Evaluation Tool</td>
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<td>• Health Risk Assessment</td>
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<td>• Eligibility</td>
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<td>• Member Predictive Risk Score (MARA)</td>
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<td>• Enterprise Data Warehouse</td>
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<td>• Essette (Care Management System)</td>
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<td>• QNXT (Claims Processing System)</td>
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<tr>
<td>• Cotiviti (HEDIS Vendor)</td>
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<td>• PreManage (Information Exchange)</td>
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<td>• Health Trio (Member and Provider Portal)</td>
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i. Data Monitoring and Reporting

SFHP monitors and improves data quality via the following mechanisms:

- **Data Governance Committee** - The Data Governance Committee consists of directors and managers from across the organization that oversees the creation and maintenance of high quality data. The committee is the deciding body for data definitions, establishing data quality procedures/guidelines and standards for the appropriate use of information.

- **Data Stewards** - The Data Stewards are a cross-functional team working to support San Francisco Health Plan’s vision of becoming an Analytical Organization. The team directly supports Data Governance by focusing on critical data-related topics. Data Stewards strive to identify, understand, standardize, and communicate key organizational business definitions and identify and correct data quality issues.

- **Encounter Data Monitoring** – SFHP measures the quality of encounter data monthly for completeness, accuracy, reasonability, and timeliness using methodology published in the DHCS Quality Measures for Encounter Data (QMED) document. SFHP works with its Trading Partners to ensure timely encounter submissions by reviewing error reports, reconciling and resubmitting rejected encounters.

- **HEDIS Data Quality Workgroup** – The HEDIS Data Quality Workgroup is an internal SFHP workgroup that sets the overall direction for HEDIS data quality improvement and monitoring efforts. The workgroup’s goals include improvement of data quality (lab, encounter/claim, pharmacy, and member data), regular and recurring monitoring of data quality, and vetting of new data sources (carve out, lab, EHR feeds, Medicare, etc.). The workgroup supports improvement of data that impacts NCQA Accreditation and the California Managed Care Accountability Set quality indicators.

C. Policies and Procedures

SFHP reviews and updates all of its quality and clinical policies and procedures (Utilization Management, Care Coordination, Pharmacy, Quality Improvement, Health Education, Cultural and Linguistic Services) biennially at a minimum. Clinical policies and procedures are also updated on an as-needed basis to reflect changes in federal and state statutory and regulatory requirements and/or NCQA standards. QIC and SFHP’s internal Policy and Compliance Committee approve new and updated policies and procedures.

5. QI Program

San Francisco Health Plan evaluates the overall effectiveness of the Quality Improvement Program through an annual evaluation process that results in a written report which is approved by the CMO, QIC, and Governing Board and then submitted to DHCS.

A. QI Work Plan

Results of the annual evaluation described above, in combination with information and priorities determined by the Health Services leadership and staff, are reviewed and analyzed in order to develop an annual QI Work Plan (see Appendix A). This comprehensive set of measures and indicators is divided into four domains:
1. Clinical Quality and Safety
2. Quality of Service and Access to Care
3. Utilization of Services
4. Care Coordination and Services

The QI Work Plan also includes a summary of Quality Improvement Committee Activities and updates are communicated to QIC via a scorecard each quarter.

B. QI Program Evaluation

Measures completed within the evaluation timeline are included in the evaluation for that calendar year. Measure completion is determined by the staff responsible for the measure and is indicated by either completion of planned activities, achievement of the stated target, or receipt of the required data for evaluation. Measure timelines are determined by the activities and the data frequency, and can be longer than a single calendar year. Each measure’s timeline is indicated in the Work Plan found in Appendix A. The evaluation includes an executive summary and a summary of quality indicators, identifying significant trends and areas for improvement. Each measure included in the evaluation includes the following elements:

- Brief description of the QI activity/intervention and how it aims to improve the domain in which it is included
- Measure target of the QI activity/intervention
- Measure definition
- Measure results, trended over at least three years when available
- Barriers that affected the effectiveness of the activity/intervention
- Recommended interventions/actions to overcome barriers in the following year

6. QI Activities

A. Clinical Quality and Safety

The domain of Clinical Quality and Safety involves QI activities related to clinical outcomes, including disease prevention, chronic condition care management, and preventing adverse health outcomes.

i. Preventive Care

SFHP monitors and reports on a subset of U.S. Preventive Services Task Force (USPSTF) clinical recommendations and preventive service guidelines as well as other preventive service HEDIS measures. These include:

- Adolescent Immunization Status
- Adolescent Well-Care Visits
- Adult BMI Assessment
- Ambulatory Care
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status
- Children and Adolescents Access to Primary Care
- Chlamydia Screening in Women
- Contraceptive Care: All Women Ages 15-44
- Contraceptive Care: Postpartum Women Ages 15-44
- Depression Screening and Follow-Up for Adolescents and Adults
- Developmental Screening
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life
- Well-Child Visits in the First 15 Months of Life

SFHP promotes pediatric and adult preventative health care guidelines to providers through the monthly provider newsletter and by publishing links to established guidelines on SFHP’s public website. These guidelines include:

- Recommended immunization schedules (e.g. HPV, Influenza)
- Required screenings (e.g. Initial Health Assessment, Colon Cancer)
- Pediatric laboratory/diagnostic studies (e.g. Newborn Blood Screening)
- Recommended counseling (e.g. violence, tobacco use/cessation)

To encourage members to receive high priority services, SFHP offers incentives for completing the following preventative care services: a $50 gift card for childhood immunizations and a $25 gift card for a prenatal screening, postpartum visit, and well-child visit.

ii. DHCS Performance Improvement Projects (PIP)

SFHP implements DHCS PIPs at any given time. PIP measures aim to understand key drivers of poor performance and conduct improvement activities based on the key drivers. One of SFHP’s PIPs for 2019-2021 targets the large disparities in breast cancer screening rates seen among the SFHP member population by race/ethnicity. SFHP aims to improve the rate of African American members who receive a breast cancer screening within the HEDIS timeframe. The second PIP aims to improve the rate of well-child visits for infants up to the age of fifteen months. This is a new measure for SFHP so there is significant improvement opportunity for the entire SFHP member population.

iii. Chronic Condition Management

SFHP monitors and reports on a variety of HEDIS measures focused on recommended interventions for members with chronic conditions. These include:

- Antidepressant Medication Management
- Asthma Medication Ratio
- Comprehensive Diabetes Care
- Concurrent Use of Opioids and Benzodiazepines
- Controlling High Blood Pressure
- Depression Screening and Follow-Up for Adolescents and Adults Annual Monitoring for Patients on Persistent Medications
• Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications
• HIV Viral Load Suppression
• Medical Assistance with Smoking and Tobacco Use Cessation
• Pharmacotherapy Management of COPD Exacerbation
• Statin Therapy for Patients with Cardiovascular Disease
• Statin Therapy for Patients with Diabetes
• Use of Opioids at High Dosage in Persons Without Cancer

SFHP promotes chronic condition management guidelines to providers through the quarterly provider newsletter and by publishing guidelines on SFHP’s public website. These guidelines include:

• American Diabetes Association: Clinical Practice Guidelines
• National Institutes of Health (NIH) Guidelines for the Diagnosis and Management of Asthma
• Joint National Committee Guidelines for Hypertension
• American College of Cardiology Guidelines for Hypercholesterolemia

SFHP offers incentives to encourage members to manage their chronic conditions. Members with diabetes receive a $25 gift card for completing screenings (HbA1C, nephropathy, and blood pressure screenings) and a $25 gift card for completing retinopathy screening. Members with asthma receive a $25 gift card for completing the Asthma Control Test and reviewing it with a provider. Members with hypertension receive a $25 gift card for completing a blood pressure check and heart healthy action plan.

iv. Health Education

SFHP ensures that members have access to low-literacy health education and self-management resources in all threshold languages mandated by DMHC and DHCS. These resources are available on the SFHP website, and through SFHP providers. Select materials are also mailed to members as part of SFHP’s population health campaigns.

Health topics covered by these tools and fact sheets include smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, asthma and diabetes control, parenting, and perinatal care, among others. SFHP’s member newsletter, “Your Health Matters,” features emerging health education topics prioritized by SFHP’s clinical leadership. In addition, the SFHP website includes a sortable listing of free group wellness classes offered by SFHP’s provider network on a variety of topics.

SFHP’s member portal prompts members to complete the Health Trio Health Appraisal tool to identify risk factors and health concerns. Based on the Health Appraisal results, members are provided with a risk and wellness profile, along with prevention strategies. In addition, the Health Trio online platform provides members with access to dynamic and evidence-based self-management tools based on their individual areas of risk or interest. These include topics such as healthy weight, healthy eating, promotion of physical activity, managing stress, tobacco use cessation, avoiding at-risk drinking, and identifying symptoms of depression.

v. Patient Safety

SFHP is committed to the safety of its members. Current patient safety initiatives include the following:

Medication Therapy Management (MTM) Program – SFHP Clinical Pharmacists review medication needs for members identified by the Care Management program. The goal is to optimize medication
regimen by promoting safe and effective use of medications. Achieving the goal and completing interventions is a multidisciplinary effort between Pharmacy services, the Care Management team, Medical Director, and primary care providers. Educational medication resources for targeted members will also increase adherence and knowledge of their drug regimen.

**SFHP Pain Management Program** – SFHP conducts trainings for providers and clinic staff on multiple aspects of pain management, including safe opiate prescribing. SFHP works with external and internal experts to provide clinical and non-clinical pain management resources to the community. SFHP’s pay-for-performance program (PIP) also supports best practices in opiate prescribing and pain management. SFHP co-leads the San Francisco Safety Net Pain Management Workgroup and has pain management as a standing topic on the SFHP Pharmacy & Therapeutics Committee.

**Potential Quality Issues (PQIs)** – SFHP Clinical Operations, Care Management, and Pharmacy staff are trained to identify PQIs and refer them to the Quality Review Nurse. PQIs are incidents outside the standard of care that put member safety at risk of harm, or when medical errors cause harm. SFHP ensures that PQIs are evaluated first by the Quality Review Nurse for initial review and investigation and then reviewed with an SFHP Medical Director. Confirmed PQIs involving individual provider departures from care standards are brought to the Provider Advisory Committee (PAC) for peer review and next step recommendations.

**Drug Utilization Review (DUR):** The DUR program consists of a Prospective DUR Program, a Retrospective DUR Program, and an Educational Program promoting optimal medication use to prescribers, pharmacists, and members. The SFHP DUR Program coordinates with the Medi-Cal DUR Board on retrospective DUR and educational activities for the Med-Cal line of business. The Pharmacy DUR Program activities may focus on identifying medication use patterns to reduce fraud, abuse, waste, inappropriate, unsafe or unnecessary care and develop education programs to optimize medication use.

**B. Quality of Service and Access to Care**

The domain of Quality of Service and Access to Care incorporates all aspects of the services provided to members including customer service, language access, appointment access, and wait times.

i. **Monitoring Member Access**

SFHP monitors members’ access to care, following regulations delineated by DMHC and DHCS as well as accreditation standards set by NCQA. DMHC monitoring requirements are met by the annual Timely Access Regulations submission in March. DHCS monitoring requirements are met via the annual contract oversight audit performed by DHCS. These access monitoring measures, among others, are reviewed quarterly by SFHP’s Access Compliance Committee. Based on monitoring and survey results, the committee identifies issues and requests a response when performance thresholds are not met. Data are comprehensive, addressing core areas such as member and provider experience with access, appointment availability, after hours care, wait times, as well as indicators of network adequacy to meet members’ needs.

ii. **Financial Incentives to Support Improvement**

The Practice Improvement Program (PIP) is SFHP’s pay-for-performance program. PIP incentive funds are sourced from approximately an 18.5% withholding of provider payments. Providers are eligible to earn 100% of these funds back if they meet program requirements. Supporting the goals of the triple aim, PIP has four domains: Clinical Quality, Patient Experience, Systems Improvement, and Data Quality. Participants have opportunities to gain incentive funds both from meeting benchmarks and from relative
improvement. Unearned funds are reserved to support improvement of performance measures via technical assistance and provider-level grants.

In addition to the pay-for-performance program, SFHP’s governing board caps financial reserves equal to two months of member capitation. Reserves in excess of these amounts are allocated to the Strategic Use of Reserves (SUR). SFHP then reviews quality indicators (HEDIS, CAHPS, utilization, etc.) and recommends projects to improve quality for SFHP members, using funds from SUR.

iii. Customer Service Trainings
SFHP collaborates with the Studer Group, a patient experience consulting firm, to offer trainings to provider network staff on improving customer service to patients. Trainings either occur at the clinic site or a centralized location. This year’s trainings include the following evidence-based practices for improving customer service for SFHP members:

- AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank you)
- Patient Rounding
- Service Recovery

iv. Provider Satisfaction
On an annual basis, SFHP conducts a Provider Satisfaction Survey to gather information about network-wide provider issues and concerns with SFHP’s services. The survey is administered by an outside vendor, and targets primary care and high-volume specialty care providers and office staff. It measures their satisfaction with the following SFHP functions:

- Finance Processes
- Utilization Management and Care Support
- Network/Coordination of Care
- Timely Access to Non-Emergency Health Care Services
- Pharmacy
- Health Plan Customer Service Staff
- Provider Relations
- Ancillary Provider Network
- Member Incentives

Results are distributed to the impacted SFHP departments and the QIC to identify and implement improvement activities. Applicable improvements are integrated into QI Program activities.

v. Provider Credentialing
SFHP ensures that health care practitioners are qualified to perform the services for which they are contracted by credentialing, re-credentialing all network providers. This process includes:

- Bi-annual review of credentialing policies and procedures for compliance with legislative and regulatory mandates, contractual obligations, and NCQA standards
- Peer review of credentialing and re-credentialing recommendations, potential quality of care issues, and disciplinary actions through the Physician Advisory Committee (PAC)
- Providing a mechanism for due process for practitioners who are subject to adverse actions
- Reviewing licensing and accreditation documentation of organizational providers, or reviewing for compliance with industry standards
• Conducting frequent provider monitoring through the Medical Board of California, List of Excluded Individuals/Entities (LEIE), DHCS’ Suspend & Ineligible List (S&I), the System for Award Management (SAM), National Plan and Provider Enumeration System (NPPES), and the Social Security Death Master File (SSADMF).

vi. Member Grievances and Appeals

SFHP ensures that member grievances and appeals are managed in accordance with Managed Care and Medi-Cal guidelines. SFHP manages and tracks complaints and grievances and provides a quarterly analysis, identifying trends and addressing patterns when evident, to the QIC. To identify patterns and trends in grievances, grievance reports are generated to report rates by line of business, medical group, and grievance category. When a grievance pattern has been identified, SFHP works with clinics or medical groups to develop strategies for improvement or request corrective action as appropriate. SFHP’s Utilization Management Committee (UMC) reviews all member appeals for issues and trends.

vii. Member Rights and Responsibilities

SFHP works to ensure that members are aware of their rights and responsibilities. This includes the annual review, revision, and distribution of SFHP’s statement of member rights and responsibilities to all members and providers for compliance with SFHP standards and legislative mandates. SFHP also implements specific policies that address the member rights to confidentiality and minor’s rights. On at least a semi-annual basis, SFHP conducts a review of grievance and appeal policies and procedures to ensure compliance with SFHP standards, legislative mandates, DHCS contractual obligations, and NCQA standards. In addition, SFHP analyzes member grievances and appeals that specifically concern member rights and responsibilities.

viii. Cultural and Linguistically-Appropriate Services and Anti-Discrimination Procedures

SFHP’s Cultural and Linguistic Services program is informed by regular assessment of the cultural and linguistic needs of its members via the Medi-Cal Group Needs Assessment (GNA). All SFHP member materials are available in Medi-Cal threshold languages. All SFHP health education materials are written at a sixth-grade reading level. Alternative formats for member materials, such as large text and braille, are available to members upon request.

All non-English monolingual and Limited English Proficient (LEP) SFHP members have access to confidential, no-cost linguistic services at all SFHP and medical points of contact. SFHP informs members about the availability of linguistic services through its Member Handbook, Evidence of Coverage, member newsletters and through other member contacts. The SFHP identification card also indicates the right to interpreter services. Linguistic services may be provided by bilingual providers and staff, or via interpreter services. Interpreter services are provided by a face-to-face interpreter, telephone language line, or Video Monitoring Interpretation (VMI). Interpreter services include sign language interpreters and/or TTY/TDD.

Most SFHP members have the option to select a primary care provider that speaks their preferred language. The SFHP Provider Directory indicates languages spoken by providers and at clinic sites. SFHP conducts member and provider language concordance studies each year.

SFHP contracts the responsibility for providing interpreter services at all medical points of contact to its medical groups. All medical groups must have language access policies and procedures that are consistent with SFHP’s policy and meet all legal and regulatory requirements. The SFHP Program Manager, Population Health, conducts an audit of linguistic services and anti-discrimination policies as
part of the annual Medical Group Compliance Audit. The Program Manager, Population Health, also assists in addressing grievances related to cultural and linguistic issues and discrimination at both medical and non-medical points of contact, systemically investigating and intervening as needed. In addition, SFHP publishes anti-discrimination notices on member and provider-facing materials, including Evidence of Coverage and Provider Network Operations Manual.

C. Utilization of Services
The domain of Utilization of Services addresses quality of care through the lens of appropriate utilization (i.e. monitoring and improving both overused and underused services).

i. Over and Under Utilization of Services
SFHP monitors service utilization, including inpatient, outpatient, Emergency Department, non-specialty mental health, and ancillary services, to identify patterns of under or overutilization of services and create actionable steps to promote medically appropriate utilization of services. Inpatient and Emergency Department Utilization data are compared to HEDIS and NCQA benchmarks as appropriate. Overutilization is identified through monthly inpatient and emergency room trend reporting. Underutilization is reported through post-discharge follow-up visit reports. Outpatient and ancillary service utilization is trended over time and compared to internal network performance. In addition, utilization patterns are shared with senior leadership in the network. Adverse patterns are discussed for root-cause identification and corrective action as needed.

ii. Pharmacy Services Drug Utilization Review (DUR)
The DUR program consists of a Prospective DUR Program, a Retrospective DUR Program, and an Educational Program promoting optimal medication use to prescribers, pharmacists, and members. The SFHP DUR Program coordinates with the Medi-Cal DUR Board on retrospective DUR and educational activities for the Med-Cal line of business. The Pharmacy DUR Program activities may focus on identifying medication use patterns to reduce fraud, abuse, and waste, inappropriate, unsafe or unnecessary care and develop education programs to optimize medication use.

- **Prospective DUR Program** consists of claim system screens, audits, edits, and messaging conducting before each prescription is filled or delivered to the member at the point-of-sale (POS) or point of distribution. Prospective DUR includes screening and audits for drug-disease contraindications, drug-drug interactions, appropriate dosing and duration of treatment, therapeutic duplication and other safety and formulary management requirements used to determine formulary and prior authorization criteria and treatment algorithms

- **Retrospective DUR Program** consists of reporting and analysis for prescription claims data and other records to identify patterns of fraud, abuse, gross overuse, inappropriate or medically unnecessary care and other formulary management requirements. Regularly reviews drug utilization reports for trends in prescription over and under use and potential outlier cases. Utilization reports include member compliance reports, controlled substance overutilization reports, doctor-drug reports, asthma drug utilization reports, pharmacy outlier reports, etc.

- **Educational Program** consists of verbal and written communication outreach activities developed by the Medi-Cal DUR team and by SFHP to educate prescribers, pharmacists and members on common drug therapy problems with the aim of improving prescribing and dispensing practices.
iii. Care Transitions
SFHP manages members from the Community Health Network (CHN) who are admitted at an out of medical group hospital setting and assists in creating a plan of action to create a medically safe and effective transition to an alternate level of care. The SFHP Utilization Management Nurses and Coordinators collaborate internally and with the acute care and SNF facilities to ensure that safe transitions are completed. These include medically necessary services and supportive services in the community for the member upon discharge. SFHP also conducts pre and post discharge calls or in-person visits with the member and coordinates timely post-discharge follow-up appointments as part of the discharge planning process. These activities help to coordinate care with the goal of reducing avoidable admissions or emergency department visits by ensuring the member’s discharge needs are met and the appropriate follow-up through the continuum of care is in place.

D. Care Coordination and Services
The Care Coordination and Services domain encompasses QI activities that improve coordination across multiple providers and facilities and focuses on members with more complex medical and psychosocial needs.

i. Care Management Programs
SFHP’s Care Management department administers case management programs aimed at improving care for members who may be high risk, high-utilizing, and/or experiencing challenges when trying to effectively engage the health care system. Care Management provides a wide range of services from basic telephonic care coordination to intensive, in-person case management. The goals of Care Management’s programs are to improve member health, support members’ self-management of chronic conditions, improve connection with and utilization of primary care, and reduce inpatient admissions and ED visits. As part of these goals, the program works to address psychosocial stability (e.g. housing, access to healthy food, clothing, and in-home supportive services) when needed. All programs include comprehensive assessments and member-driven care plans. Through a collaborative process with primary care providers, behavioral health providers, community agencies, and the member, Care Management staff work to improve coordination of services. Staff identify and address barriers to care and enhance and support members’ self-care knowledge and skills.

ii. Care Coordination with External Agencies
SFHP’s Care Management and Utilization Management teams ensure coordination of care for members per Medi-Cal contractual requirements. These coordination activities include executed MOUs with key agencies such as California Children Services (CCS), Golden Gate Regional Services (GGRC), Early Start (ES) and Community Behavioral Health Services (BHS) that outline coordination activities. These coordination activities are designed to ensure members are aware of non-plan benefits and programs available to them and confirm coordination of care across agencies and services. As part of the Health Homes Program, SFHP addresses the needs of members living in supportive housing and those experiencing homelessness. Through collaboration with the Department of Homelessness and Supportive Housing, supportive housing providers, and various community partners, SFHP enhances the scope of care coordination to create a more unified and effective service system.

iii. Children and Transitional Aged Youth
The Children and Transitional Aged Youth (CATY) care coordination program is designed to serve SFHP members aged 0-21 and their families and/or caregivers. Evidence-based assessment tools, consent documents, and care plan goals and interventions have been developed to meet the needs of this population. This program has specific workflows outlining program eligibility, policies, procedures, and
outcome metrics. Dedicated Care Management staff have been hired and trained on workflows and California consent laws and policies pertaining to case management with children and transitional aged youth.

iv. Health Risk Assessment (HRA)

All new Seniors and Persons with Disabilities (SPDs) members complete Health Risk Assessments. Members are then reassessed annually. Members are stratified as either high or low risk based on their responses to the HRA questionnaire or the reassessment report data. Members who are high risk receive outreach both by phone and mail, while low risk members receive outreach by mail. HRA telephonic care management is provided for 30 days to members who receive services within the non-delegated medical groups (CHN and UCSF). Members receiving care within delegated medical groups in the network receive follow-up from their assigned medical group.

E. Delegation Oversight

i. Standards and Process for Delegated Medical Groups

SFHP oversees functions and responsibilities delegated to subcontracted medical groups, health plans and behavioral health organizations (Delegated Entities). These Delegated Entities must comply with laws and regulations stated in 42 CFR 438.230 and Title 22 CCR § 53867, the DHCS contract, and NCQA Health Plan Standards. SFHP ensures that delegated functions are in compliance with these laws, regulations, and standards through an annual audit process and monthly and quarterly monitoring activities.

As a prerequisite to enter into a delegation agreement, SFHP conducts a pre-delegation audit of the prospect’s delegated functions. Subject to approval from the Provider Network Oversight Committee, SFHP may waive the pre-delegation audit in lieu of current and in good standing documented evidence of NCQA Accreditation or Certification.

Once the pre-delegation audit is complete, a Delegation Agreement and Responsibilities and Reporting Requirements (R3) Grid is executed. The R3 Grid describes the specific responsibilities that are being delegated, and provides the basis for oversight. The R3 Grid indicates which activities are to be evaluated through annual audits, and which activities are to be evaluated through more frequent monitoring.

Six to twelve months past execution of the Delegation Agreement, SFHP conducts an audit of all delegated functions. The audit scope and review period are determined by the Provider Network Oversight Committee.

Delegated Entities are required to demonstrate compliance with applicable requirements and standards by achieving a passing score of 95%. A Corrective Action Plan (CAP) is required if:

- A critical element is missed.
- The overall audit score is lower than 95%.
- There are inappropriate UM denials.
- There are incorrectly paid or denied claims.

Audit results are communicated to the Delegated Entity within 60 days from the completion of the audit. When a CAP is submitted by the Delegated Entity, the SFHP Delegate Oversight team will evaluate the response and issue either an approval or a request for additional information.
Annually, the Provider Network Oversight Committee, the UM Committee, and the Quality Improvement Committee review a summary of delegated groups audit results, provide feedback or request additional information or corrections from the delegate as needed.

ii. Delegated Functions

Credentialing – The following groups are delegated to conduct credentialing activities on behalf of the plan:

- American Specialty Health
- Beacon Health Options
- Brown and Toland
- Chinese Community Health Care Association
- Hill Physicians Medical Group
- Jade HealthCare Medical Group
- Kaiser Foundation Health Plan
- North East Medical Services
- San Francisco Health Network
- University of California, San Francisco Medical Center (UCSF)
- Teladoc

Utilization Management – The following groups are delegated to conduct UM activities on behalf of the Plan:

- American Specialty Health
- Beacon Health Options
- Brown and Toland
- Chinese Community Health Care Association
- Hill Physicians Medical Group
- Jade HealthCare Medical Group
- Kaiser Foundation Health Plan
- North East Medical Services.

Pharmacy Services – Kaiser Health Plan Foundation and PerformRx are delegated to manage pharmaceutical services on SFHP’s behalf.

Complex Case Management – The following groups are delegated to conduct Complex Case Management on behalf of the plan:

- Brown and Toland
- Chinese Community Health Care Association
- Hill Physicians Medical Group
- Jade HealthCare Medical Group
- North East Medical Services
- Kaiser Foundation Health Plan

Non-Specialty Mental Health – Kaiser Foundation Health Plan is delegated to provide behavioral health services to all of its SFHP Medi-Cal members. Beacon Health Options provides non-specialty mental health services to all other SFHP Medi-Cal members. Community Behavioral Health Services (BHS) provides all non-specialty and specialty behavioral services to SFHP Healthy Workers members.
Quality Management – Kaiser Foundation Health Plan and Beacon Health Options are delegated for QI.

Member Appeals and Grievances – Kaiser Foundation Health Plan and Beacon Health Options are delegated for Appeals and Grievances.
Reviewed & Approved by:

Chief Medical Officer: James Glauber, MD, MPH  Date: 11/25/19

Quality Improvement Committee Review Date:

Board of Directors Review Date:
## Appendix A: Work Plan

### Care Coordination and Services

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<th>Measure Name</th>
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| Screening For Clinical Depression  | Total clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-2 and, if positive, Patient Health Questionnaire-9 screening is conducted | Total clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-2 | 70%    | Quality Program Manager, Care Management                           | • Staff coaching and role-playing activities to reduce the rate of members declining Patient Health Questionnaire-9 screening.  
• Mental health training for staff to ensure that staff is equipped to identify signs and symptoms of clinical depression and address client safety.  
• Monthly report indicating depression screening rates by Care Management staff. Follow-up coaching as necessary.  
• Monitor the rate of members declining the Patient Health Questionnaire-9 screening.                                                                 | 6/30/2020                                                                 |
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| Follow Up On Clinical Depression         | Total clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-9 with a "Connect to Behavioral Health" care plan goal | Total clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-9 | 80%    | Quality Program Manager, Care Management                              | • Mental Health training for staff, particularly on severe mental illness (SMI), in order to ensure that staff is equipped to identify signs and symptoms of major depressive disorder and address client safety.  
• Updates to Care Management workflow to provide guidance to staff for triaging members with Patient Health Questionnaire-9 scores indicating moderately severe or severe depression who are not connected to behavioral health and who decline a referral.  
• Monthly report indicating depression screening rates by Care Management staff. Follow-up coaching as necessary. | 6/30/2020                       |
| Care Management Client Perception Of Health | Total clients who responded to self-reported health question of SF-12 on both the intake and closing assessments and:  
- Increased at least one box in rating their health if "Poor" or "Fair" indicated  
- Maintained or increased at least one | Total clients who responded to self-reported health question of SF-12 on both the intake and closing assessments | 55%    | Quality Program Manager, Care Management                              | • Coaching from Clinical Supervisors and Medical Director with the RNs and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.  
• Review of self-management goal report with RNs to ensure that members have chronic condition self-management goals as part of their care plans as indicated. | 6/30/2020                       |
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| % of Members who completed Hepatitis C Treatment | Total number of members with any past history of Hepatitis C infection who have completed the Hepatitis C treatment regimen | Total number of members with any past history of Hepatitis C diagnosis       | 35%    | Clinical Pharmacist, Pharmacy | • Developing both a member-focused awareness campaign and provider education outreach campaign in the target clinics and offices.  
• Addressing stigma for Hepatitis C treatment with providers and members through dissemination of health education materials and clinic site “roadshows”.  
• Providing treatment support through Care Transitions or Care Management.  
• Identifying and addressing potential data quality concerns to ensure an accurate denominator population count. | 1/25/2020 |
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| Chlamydia Screening (CHL)          | Total number of members 16-24 years of age with a female gender marker identified as sexually active and had at least one screening test for chlamydia during the measurement year | Total number of members 16-24 years of age with a female gender marker identified as sexually active                                                                                                                | 40.5%  | Associate Program Manager, Health Services Product Management      | • Include pay-for-performance measure in SFHP's Practice Improvement Program (PIP).  
• Meetings with medical groups to review 2017 data and identify improvement opportunities.  
• Complete a root cause analysis to identify potential data and clinical quality issues; make recommendations for improvement; implement at least one recommendation.                                                                                                    | 6/30/2020                          |
| Medication Therapy Management (MTM)| Total number of SFHP members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation to be completed with initial medication reconciliation completed | Total number of SFHP members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation to be completed | 80%    | Clinical Pharmacist, Pharmacy                                        | • Develop specialized intervention plans designed around the member’s preferences to prevent lost-to-follow-up.  
• Update Pharmacy workflow for Health Homes Program to improve efficiency.  
• Add configurations to the Care Management module to improve work flow including pharmacy technician support for some of the MTM activities.                                                                                                                       | 6/30/2020                          |
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| Opioid Safety - Benzodiazepine    | Total number of SFHP members with Opioid Use Disorder with at least one  | Total number of SFHP members with Opioid Use Disorder                         | 12.0% | Medical Director| • Create educational materials for providers and members on the risks of concomitant opioid and benzodiazepine prescribing.  
  • Maintain the soft edit on members’ concomitantly prescribed opioid and benzodiazepine medications.  
  • Outreach to providers with members concomitantly on opioid and benzodiazepine medications | 12/31/2021                                                                  |
| Prescription                      | buprenorphine prescription in the last year                              |                                                                               |        |                |                                                                                                                                                                                                            |                                 |
| Opioid Safety - Opioid and       | Total number of SFHP members with Opioid Use Disorder with co-prescribed | Total number of SFHP members prescribed opioids                              | 8%     | Medical Director| • Analysis of benzodiazepine prescribing for all SFHP Medi-Cal members in order to create a more complete picture of trends for Central Nervous System suppressant use.  
  • Create educational materials for providers on the risks of benzodiazepine and opioid co-prescribing and long-term benzodiazepine use.  
  • Outreach to primary care providers through joint meetings to address utilization and concerns. | 12/31/2021                                                                  |
<p>| Benzodiazepine Co-prescribing     | opioid and benzodiazepine medications                                    |                                                                               |        |                |                                                                                                                                                                                                            |                                 |</p>
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| Well-Child Visits in the First 15 Months of Life (W15)    | Total number of members who turned 15 months of age during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life | Total number of members who turned 15 months of age during the measurement year | 15.8%  | Manager, Population Health                | • Participate in the 0-5 year developmental screening and referral workgroup.  
• Identify opportunities to improve or expand the Well-Child member incentive.  
• Include pay-for-performance measure in DHCS or SFHP Practice Improvement Program (PIP).  
• Provider funding via DHCS value-based payment disbursement program. | 6/30/2021                      |
| Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) | Total members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year. | Total number of members 3–6 years of age                                   | 85.8%  | Manager, Population Health                | • Participate in the 0-5 year developmental screening and referral workgroup with other network providers.  
• Identify opportunities to improve or expand the Well-Child member incentive.  
• Include pay-for-performance measure in DHCS or SFHP Practice Improvement Program (PIP).  
• Provider funding via DHCS value-based payment disbursement program. | 6/30/2021                      |
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| Adolescent Well-Care Visits (AWC)                | Total number of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year | Total number of members 12–21 years of age                               | 56.1%  | Manager, Population Health   | • Develop Adolescent Well-Care member incentive.  
• Include pay-for-performance measure in DHCS or SFHP Practice Improvement Program (PIP).                                                       | 6/30/2021                       |
| Diabetes Prevention Program - Weight Loss         | Total number of members 18 years or older at high risk for developing diabetes completing the program and achieving a 5% weight loss | Total number of members 18 years or older at high risk for developing diabetes completing the program | 25%    | Associate Program Manager, Population Health | • Identify eligible members via lab data, self-referral, or PCP referral.  
• Develop targeted marketing materials to inform members of their eligibility.                                                                     | 6/30/2020                       |
## Quality of Service and Access to Care

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| Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) | *N/A - Plans are given a rating on a scale from 0 – 5 for CAHPS overall performance | *N/A - Plans are given a rating on a scale from 0 – 5 for CAHPS overall performance | 3.5    | Program Manager, Access & Care Experience | • Identify access-related issues via the Access Compliance Committee and develop plans to address found issues.  
• Develop a member-facing grid to support easier navigation of Medi-Cal benefits.  
• Include pay-for-performance measures in Clinic and Group CAHPS and implement improvement projects in SFHP's Practice Improvement Program (PIP).  
• Invest Strategic Use of Reserves Grant funds into improvements in appointment scheduling and specialty care coordination.  
• Improve readability of letters sent to members for approvals, denials, and appeal resolution.  
• Maintain or improve CAHPS response rate through alternative survey methods and reminders.  
• Conduct member focus groups.                                                                 | 5/31/2020                                                                  |
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| Provider Appointment Availability Survey (PAAS) - Routine Appointment Availability In Specialty And Primary Care | Total PCPs and non-behavioral health specialists surveyed in PAAS with eligible survey responses that indicate routine appointment availability compliant with Department of Managed Health Care standards | Total PCPs and non-behavioral health specialists surveyed in PAAS with eligible survey responses                                                                                                                                 | 71.9%  | Program Manager, Access & Care Experience                           | • Develop communication plan for survey fielding.  
• Request Corrective Action Plans of provider groups performing under 80%.  
• Provide technical assistance with Corrective Action Plans.                                                                                                               | 3/31/2020                    |
| Cultural and Linguistic Services (CLS) | Total number of SFHP provider sites surveyed in the SFHP Daytime Survey who pass the linguistic services portion | Total number of SFHP provider sites surveyed in the SFHP Daytime Survey                                                                                                                                                                                                  | 90%    | Program Manager, Population Health                                 | • Issuing and approving Corrective Action Plans to medical groups performing under 80% in the linguistic services portion of the previous survey year (2018).  
• Launching a Cultural and Linguistic Services Program to leverage all of SFHP’s CLS resources and develop a coordinated strategy to address SFHP’s CLS priorities.  
• Completing review of related grievances and quarterly trending reports.                                                                                                           | 12/31/2019                   |
## Utilization of Services

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<th>Measure Name</th>
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<th>Denominator</th>
<th>Target</th>
<th>Title</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Members With a Primary Care Visit in Last 12 Months                        | Medi-Cal members continuously enrolled for 12 months who have at least one primary care or urgent care visit in the reporting period | Medi-Cal members continuously enrolled for 12 months                      | 70.0% | Program Manager, Access & Care Experience                              | • Promote tele-health services to members and provide incentives for registration of tele-health services.  
• Inform members of the importance of primary care visits through marketing to members.  
• Continue inclusion of the PCP visit rate in SFHP’s Practice Improvement Program (PIP).  
• Provide grant funds to medical groups who improve appointment scheduling options for patients.  
• Administer member incentive to encourage members to seek preventive care. |
| Percentage Of Members Utilizing The Non Specialty Mental Health (NSMH) Benefit With More Than Two NSMH Visits | Total unique non-dual members who utilize the NSMH benefit with more than two NSMH services | Total unique non-dual members who utilize the NSMH benefit                  | 46.8% | Chief Medical Officer                                                  | • Survey engaged members who have not received more than two NSMH visits regarding their barriers to receiving care.  
• Explore provider incentives to provide timely follow-up with members who do not attend scheduled appointments. |

<table>
<thead>
<tr>
<th>Date Activities to be Completed</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Members With a Primary Care Visit in Last 12 Months</td>
<td>6/30/2020</td>
</tr>
<tr>
<td>Percentage Of Members Utilizing The Non Specialty Mental Health (NSMH) Benefit With More Than Two NSMH Visits</td>
<td>6/20/2020</td>
</tr>
</tbody>
</table>
### iii. Quality Oversight Activities

<table>
<thead>
<tr>
<th>Oversight</th>
<th>Summary</th>
<th>Resp. Staff</th>
<th>Activities</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement Committee</td>
<td>Ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan</td>
<td>CMO</td>
<td>• Six meetings to be held in 2020</td>
<td>12/30/2020</td>
</tr>
<tr>
<td>Pharmacy and Therapeutics Committee</td>
<td>Ensure oversight and management of the SFHP formulary and DUR initiatives</td>
<td>CMO</td>
<td>• Quarterly and ad hoc P&amp;T Committee meetings</td>
<td>12/30/2020</td>
</tr>
<tr>
<td>Provider Advisory, Peer Review, and Credentialing Committee</td>
<td>Ensure oversight of credentialing and peer review by the Provider Advisory Committee</td>
<td>CMO</td>
<td>• Six meetings to be held in 2019</td>
<td>12/30/2020</td>
</tr>
<tr>
<td>Annual Evaluation of the QI Program</td>
<td>Review Quality Improvement plan and determine efficacy of implemented plan based on outcomes</td>
<td>Director, Health Outcomes Improvement</td>
<td>• Evaluate each measure in the QI work plan</td>
<td>3/1/2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• QIC review of QI evaluation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Governing Board review of QI Evaluation</td>
<td></td>
</tr>
<tr>
<td>QI Plan Approval for Calendar Year</td>
<td>Review and approve proposed Quality Improvement work plan</td>
<td>Director, Health Outcomes Improvement</td>
<td>• QIC review of QI work plan</td>
<td>3/1/2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Governing Board review of QI Work Plan</td>
<td></td>
</tr>
<tr>
<td>Delegation Oversight for QI</td>
<td>Ensure oversight of QI for all delegated entities</td>
<td>Director, Health Outcomes Improvement</td>
<td>• Follow delegation oversight procedures</td>
<td>12/30/2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• QIC review of Delegated Oversight Audits for QI</td>
<td></td>
</tr>
<tr>
<td>DHCS Performance Improvement Projects</td>
<td>Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs)</td>
<td>Director, Health Outcomes Improvement</td>
<td>• Attend DHCS-led PIP calls.</td>
<td>12/30/2020</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Adhere to process delineated by DHCS.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Quality Improvement Committee Structure

Quality Committees Reporting to Governing Board

- SFHP Governing Board (GB)
  - Quality Improvement Committee (QIC)
  - Member Advisory Committee (MAC)
    - Physician Advisory/Peer Review/Credentialing Committee (PAC)
    - Pharmacy and Therapeutics Committee (P&T)
    - Utilization Management Committee (UMC)
Operational Quality Committees Reporting to Chief Medical Officer

- Chief Medical Officer
  - Grievance Program Leadership Team (PLT)
  - Access Compliance Committee (ACC)
  - Practice Improvement Program (PIP) Advisory Committee
  - Grievance Review Committee (GRC)
San Francisco Health Plan
Clinical Operations and Pharmacy
Utilization Management Programs

2019
Overview
The San Francisco Health Plan (SFHP) Clinical Operations (CO) and Pharmacy Services (PS) Utilization Management (UM) program description details the scope, structure, and processes guiding utilization management decisions supporting membership in accessing plan appropriate, and evidence-based, health and behavioral health care services. The UM program’s mission is to:

- Improve health outcomes of the diverse San Francisco communities through successful partnerships.

Supporting this mission is the UM program’s commitment to the principle that the UM decision-making process is transparent. UM decisions are based on medical necessity within the scope of the SFHP benefit structure. Tools to support medical necessity include: industry standard UM guidelines (Medi-Cal, Provider Handbook, InterQual); peer reviewed SFHP guidelines grounded in current, scientifically sound, medical evidence; and independent medical review as needed. [UM medical necessity decisions are not unduly influenced by fiscal or administrative factors] The UM program undergoes evaluation and monitoring internally, and by DHCS/DMHC, in order to ensure SFHP members have access to medically necessary, cost effective high quality care. The integrity of this principle is grounded on a continual evaluation of, and the evolvement of, the UM program through monitoring multiple sources of medical information and metrics. The objective is to provide SFHP’s members equitable access to efficient, effective health and behavioral health care throughout the delivery system.

UM Program Scope
The UM program is responsible for reviewing and evaluating provider requests for authorization to perform certain services for three SFHP health plans: Medi-Cal and Healthy Workers (Healthy Kids was terminated October 2019). Each plan provides members with a distinct set of benefits and is guided by plan specific UM criteria. Therefore, SFHP’s UM program is structured to accommodate and execute multiple utilization requirements. All authorization decisions are based on written UM policies and procedures. The policies and procedures are reviewed by the Chief Medical Officer (CMO), the SFHP UM Committee (UMC), the Quality Improvement Committee (QIC) and/or the SFHP Pharmacy and Therapeutics (P&T) Committee and derived from scientifically sound, medical evidence to ensure the latest clinical principles and processes are driving the UM decision-making process.

UM Program Functions
The UM program ensures effective utilization management practices, regulatory compliance, alignment with National Committee for Quality Assurance (NCQA) accreditation guidelines, and network oversight. UM program responsibilities are to ensure:
- Improvement of our members health status
- Continuity and coordination of care
- Access and availability of care and services, including parity between medical and behavioral health.
- Transparency of members’ rights and responsibilities
- Parsimonious, yet holistic approach toward utilization management of health care services, including medical, pharmaceutical, and behavioral health care services.

Utilization Management Structure
Prior Authorization
The UM Prior Authorization Team receives pre-/post-authorization requests for outpatient services and planned admissions. UM Coordinators are responsible for processing incoming authorization requests and creating authorization records so that a UM Prior Authorization Nurse may review the requested services for medical necessity and benefits coverage. The review goals and priorities are:
- Medical Necessity:
  - Patients are receiving timely, medically appropriate services.
- Coordination of benefits:
  - Identification of other primary payers
SFHP is not responsible for prior authorizations covered by other health insurance or carved out of the SFHP benefit package.

- **Care Coordination:**
  - Care is provided in medical group, and within network, when appropriate.
  - Identifying members for care management services and community services and eligible benefits.
  - Ensuring the safety of SFHP’s members through the Potential Quality Incident (PQI) process.

**Concurrent Review Authorization**
The Concurrent (CCR) Team receives concurrent authorization requests. UM Coordinators are responsible for processing incoming authorization requests and creating authorization records so a CCR Nurse may review the requested services. The review goals and priorities are:

- **Medical Necessity:**
  - Acute hospital admissions are reviewed to determine medical necessity and appropriateness of hospitalization and treatment plans, and to engage in early discharge planning, and if appropriate, provide referrals for care management intervention.
  - Observation admissions are reviewed to identify if the admission meets acute inpatient medical necessity criteria. Medi-Cal does not reimburse observation stays; however, SFHP evaluates observation admissions against inpatient InterQual criteria to determine if appropriate for acute inpatient classification.

- **Proper level of care:**
  - Patients are receiving an appropriate level of care.
  - Administrative Days are reviewed for difficult to place patients requiring Skilled Nursing Facility (SNF) level of care.

- **Care Coordination:**
  - Care is provided in medical group, and within network, when appropriate.
  - Identifying members for care management services and community services and eligible benefits.
  - Ensuring the safety of SFHP’s members through the PQI process.

- **Coordination of benefits:**
  - Identification of other primary payers.
  - SFHP is not responsible for prior authorizations covered by other health insurance or carved out of the SFHP benefit package.

- **Screening eligibility for the Care Transitions Program:**
  SFHP’s Care Transitions Program (CTP) supports the coordination of care as members move from one level of care to another with the objective of improving quality and reducing hospital and emergency department readmissions. The CTP Team conducts patient outreach through pre- and post-discharge calls and onsite visits. The CTP Team collaborates with various SFHP cross-functional teams and hospital staff to ensure safe discharge planning.

**Oversight of Delegated UM Activities**
SFHP delegates the responsibility to manage UM services, UM reporting to the following medical groups:

- American Specialty Health (ASH)
- Beacon Value Options
- Brown & Toland Physicians (BTP)
- Chinese Community Health Care Association (CCHCA)
- Hill Physicians (HIL)
- Institute of Aging (CBAS)
- JADE (JADE)
- Kaiser (KSR)
- North East Medical Services (NEMS) & SFHN (NEMS)
- VSP Vision Care (VSP)

Additionally, SFHP delegates the responsibility of Quality Improvement (QI) activities to:
When UM activity is delegated to a contracted medical group, SFHP is fully accountable for how the delegated medical group (DMG) conducts UM decision making according to the standards of SFHP's UM program and applicable Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) regulations, and NCQA accreditation guidelines. A separate policy (DO-04: Oversight of Delegated UM Functions) and annual delegation agreements describe how SFHP oversees the functions delegated to the DMGs. To ensure each DMG is compliant, SFHP:

- Reviews the DMG’s UM Program description.
- Reviews a sample of a DMG’s UM denial files to evaluate compliance with policies and procedures; including review by appropriate professionals, timeliness of UM decisions, use of relevant clinical information, adherence to denial letter standards, and handling of emergency services. SFHP’s CMO/Medical Director review the denial logs of the DMGs to ensure denials were handled appropriately.
- Monitors coordination of care transition and continuity of care
- Reviews the DMG’s UM work plans, specialty referral reports, Inter-rater Reliability (IRR) results.
- Performs annual audits of the DMGs, including semi-annual CMO review of DMG’s denials. This yearly audit includes review of policies and procedures, case files, notice of action (NOA) correspondence, and reports. Findings of deficiencies in delegated UM programs are addressed through Joint Operations Committee/Joint Administrative Meetings and may result in implementation of a corrective action plan (CAP).
- Educates the DMGs to inform their practitioners, staff, and patients that UM decisions are based on the appropriate use of care and services, and there are no financial or other rewards for denying, modifying, or reducing care.

Program Management

The UM Program is required to prepare and write a variety of reports to meet the administrative requirements for the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), and the NCQA accreditation guidelines. The reports are reviewed and discussed through the monthly UMC meetings. The UMC provides monthly minutes and annual reports to the QIC. The QIC, in turn, submits reports and minutes, which includes UM Program activity, to the SFHP Governing Board.

Discharge Planning

SFHP’s Concurrent Review (CCR) and Care Transitions Program (CTP) Team provides discharge planning services for SFHP members admitted to out-of-medical-group (OOMG) hospitals. The CCR and CTP Team manages members in acute or Skilled Nursing Facility (SNF) care settings and assists in the creation of a discharge plan to create a medically safe and effective transition to an alternate level of care for all out-of-medical-group Community Health Network (CHN) members. The CCR and CTP Team collaborate with various SFHP cross-functional teams, and with the acute care and SNF facilities, to ensure discharge needs are met. The CCR and CTP Team collaborate with hospital staff to ensure safe discharge planning; and conduct patient outreach through pre- and post-discharge calls, as well as, onsite and home visits. These include medically necessary care services, and support services in the community for the member upon discharge. In collaboration with the San Francisco Health Network (SFHN), SFHP coordinates timely post discharge follow-up for CHN members.

Scope of UM Reviews

Benefit authorization requests are approved, deferred, partially denied/modified, or denied by appropriately qualified UM staff. Utilization review may be prospective, concurrent, or retrospective depending on when the services are to be, or were, performed.

1 The 2019/2020 UMC Reportage Calendar is in located in Appendix A.
UM staff use standard criteria (e.g., Medi-Cal, InterQual, SFHP peer reviewed criteria) to determine whether or not the requested services meets medical necessity criteria. Specific levels of staff engagement with the approval review of health care services have been set. Using these standard criteria, Prior Authorization Nurses and CCR Nurses may approve health care services based on medical necessity. If a request does not meet medical necessity criteria, the UM nursing staff will route the request to an SFHP Medical Director, or physician designee, for review.

Concurrent review uses patient-specific clinical information to determine the medical necessity of hospital admission, and to confirm discharge planning is performed with each admission. The reviewer may consult with the treating provider and arrange a mutually agreed upon alternative care plan before referring the review to the SFHP Medical Director, or physician designee, to determine the appropriateness of the admission at the current level of service.

Only the CMO, a SFHP Medical Director, or physician designee, can deny health care services based on medical necessity. Physicians can make denials of coverage of health and behavioral health care services based on failure to meet established medical necessity criteria. Beacon Health Options does not require prior authorization for their contracted, non-specialty mental health (NSMH) services, therefore, will be no NSMH service denials requiring SFHP oversight review. However, Beacon’s provision of Applied Behavioral Analysis (ABA) through their behavioral health therapy (BHT) service does require prior authorization, medical necessity review; denials will be reviewed by SFHP’s CMO, SFHP Medical Director, or physician designee.

The Director of Clinical Operations oversees SFHP UM staff and conducts compliance activities for SFHP UM and for UM delegated to medical groups. The Director of Pharmacy oversees SFHP pharmacy staff that makes denials for coverage of medications based on lack of medical necessity as outlined by the authorization criteria approved by the P&T Committee.

Pharmacy benefit authorization requests are approved, denied, or deferred for more information by the Prior Authorization Teams at SFHP’s Pharmacy Benefits Manager (PBM) and the SFHP’s Prior Authorization Pharmacy Team. SFHP Pharmacists can make denials for coverage of medications based on failure to meet established medical necessity criteria as outlined by the authorization criteria approved by the Pharmacy & Therapeutics (P&T) Committee for formulary and non-formulary medications including behavioral health medications. The P&T committee is comprised of network physicians and pharmacists of diverse specialties including a psychiatrist. The reviewer may consult with an SFHP Medical Director and/or an external medical specialist to determine the appropriateness of the requested medication and may also consult with the prescriber to arrange mutually agreed alternative medications Utilization review may be prospective or retrospective depending on if the services are to be, or were performed. Retrospective reviews may be conducted to evaluate, for example, on-hand supply of therapy, emergency care, out-of-network, and out-of-area care when a prospective review was not performed.

The Medical Directors, nurses, pharmacists, and other professional providers, and independent medical consultants who perform utilization review services for the plans are not compensated or given incentives based on their coverage review decisions. Medical Directors, pharmacists, and nurses are salaried employees of SFHP, and contracted external physicians and other professional consultants are compensated on an hourly or per-case-reviewed basis, regardless of the coverage determination. SFHP does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for UM staff or independent medical consultants to encourage utilization review decisions that result in underutilization.

Sources of Plan Benefits and UM Decision Criteria

DHCS mandates the scope of benefits to be offered to Medi-Cal members. The City and County of San Francisco Department of Public Health (DPH), SFHP’s CMO, and SFHP’s Chief Executive Officer (CEO) developed the scope of benefits offered by the Healthy Workers HMO and Healthy Kids HMO. The UM Prior Authorization and Concurrent Review nurse managers collaborate with the CMO and Director of Clinical Operations to implement clinical criteria for each plan to ensure adherence to evidence-based care in alignment with current regulations and applicable SFHP health and behavioral health care
policies. Pharmacists collaborate with the CMO and the Director of Pharmacy to implement clinical criteria for each plan to ensure alignment with current medical practices, current regulations, applicable SFHP policies, and SFHP P&T Committee approved policies. Because each of these plans (Medi-Cal, Healthy Workers HMO, Healthy Kids HMO) provide members with a distinct benefits, there are multiple, plan specific UM criteria.

**Process Overview of the Medical UM Decision Process**

Pharmacy authorization requests go through a first level review, using member eligibility information, plan specific formulary, and criteria, approved by SFHP’s Pharmacy and Therapeutics Committee. For PBM decisions to deny, requests are forwarded to the Pharmacy team at SFHP for a secondary review where approved, partially approved, deferred, or denied decisions are made by the SFHP Pharmacy team.

**Process Overview of the Pharmacy UM Decision Process**

Pharmacy authorization requests go through a first level review, using member eligibility information, plan specific formulary, and criteria, approved by SFHP’s Pharmacy and Therapeutics Committee. For PBM decisions to deny, requests are forwarded to the Pharmacy team at SFHP for a secondary review where approved, partially approved, deferred, or denied decisions are made by the SFHP Pharmacy team.

**Process Overview of the Behavioral Health Referral Process**

The behavioral health referral process involves the UM Prior Authorization and Concurrent Teams reviewing various databases (e.g., CCMS, Pre-Manage, EPIC) for information identifying members potentially eligible for care coordination with non-specialty mental health services (NSMH) or specialty mental health services (SMH). The assessed member is not directly linked to behavioral health services, but is referred to either Beacon Value Options for NSMH services or to the consultative services of the SFHP Intake Officer of the Day for a potential case management referral for SMH services.

**Principles Guiding UM Decisions**

- UM decision making is based only on appropriateness of medical necessity of care and service and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Therefore, all UM decisions are made by qualified professionals who are unhindered by fiscal or administrative considerations.

**Source for Determining Medical Necessity and Plan Information**

Essette, operable since June 2014, is the centralized IT services (ITS) tool housing all data and plan information related to medical utilization management (including carved-out services), care management, appeals, and grievances. Essette is the master repository for all resources used to determine medical necessity for each of SFHP’s health plans (Medi-Cal and Healthy Workers). Additionally, the resources are weighted by hierarchy when referenced to establish medical necessity for a certain prior authorization (PA).

The PBM claim system, IPNS™, houses all medication data and plan information related to pharmacy utilization management. Prior authorization documentation including supporting medical record documentation is stored in the associated PBM PerformPA™ system. Reviewers use information provided with the request, claims history of previous therapy and dosage, and P&T Committee approved criteria to determine the medical necessity for the requested medication or product. The reviewer may
also consult with the treating provider and arrange an alternative care plan before determining the medical necessity of the service.

**Source of UM Decision Criteria**

UM inpatient and outpatient decisions are based on multiple, hierarchically ranked, data based, clinically focused resources. Within Essette, the resources range from Federal/State Medi-Cal criteria, InterQual, and national evidence-based criteria to proprietary [criteria developed by SFHP’s CMO](#). UM decision criteria also reference plan specific benefit libraries to confirm DHCS mandated benefits are provided to members and are being appropriately administered. Additionally, SFHP’s various written and web-based membership collateral materials provide information about the UM decision process and criteria and document which benefits are covered for each health plan.

**UM and Clinical Criteria**

Resources are available to assist in determining review decisions. SFHP’s clinical criteria hierarchy in order include: specified Federal/State (Medi-Cal) criteria, SFHP internally developed and approved criteria, InterQual, and Chief Medical Officer or MD review of the evidence in consultation with relevant, external specialty expertise obtained from SFHP’s Independent Review Organization. The Utilization Management Committee and the Pharmacy and Therapeutics Committee, both subcommittees of the QIC, review and annually approve each set of clinical criteria. If services are not addressed in the primary criteria, UM staff consults subsequent criteria in the order of the hierarchy.

The criteria must be applied in conjunction with [consideration of:](#)

- **The local delivery system.**
- **The following individual characteristics:**
  - Age
  - Comorbidities
  - Complications
  - Progress of treatment
  - Psychosocial situation
  - Home environment, when applicable
- **Availability of alternative levels of care.**
- **Specialty providers, access to community resources, familial influences and supports, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the estimated length of stay must also be considered.**

SFHP adopts those benefits mandated by DHCS for Medi-Cal beneficiaries and DMHC for Healthy Worker HMO members (until October 2019 when Healthy Kids was terminated). Covered benefits are documented in the Evidence of Coverage, and authorization will be denied if the requested service is not a covered benefit or that exceed the limitations or restrictions stated in the benefits plan.

SFHP requires the treating provider to submit relevant clinical information and/or medical records to ensure the appropriate review decisions are being made. SFHP’s CMO, or Medical Directors, are available for a peer-to-peer review of the submitted authorization request. Practitioners and members are informed how they may obtain copies of UM criteria utilized for decision-making, and are provided to them on request. SFHP also communicates with practitioners through the Provider Manual, monthly Provider Newsletter, and the SFHP website to ensure their awareness of prior authorization procedures and timeframes.

SFHP utilizes physician consulting services of the [Medical Review Institute of America, Inc. (MROIa)](#) for medical necessity determinations outside the expertise of SFHP’s internal medical directors. MROIa utilizes a nationwide network of board-certified physician specialists and professionals in over 133 specialties and sub-specialties of medicine. MROIa reviews cases prospectively, concurrently and retrospectively for: Medical Necessity, Appropriate Treatment, Experimental Procedures, Appropriate Hospitalization, Formulary Criteria Review, Pre-Existing Conditions, Injury Causation, and all Diagnostic Testing. MROIa holds dual accreditation with URAC with certificates in Health Utilization Management Processes and information sources used to make determinations.
and as an Independent Review Organization. In addition, MRIoA is NCQA accredited in Utilization Management.

**Behavioral Health Services**

SFHP members can access non-specialty mental health (NSMH) services, behavioral health therapy (BHT) services, specialty mental health (SMH), and substance use disorder (SUD) services by either working with their network primary care practitioners to obtain a referral or a member can self-refer. Regardless, of the method of referral the primary care provider, when appropriate, will coordinate care with behavioral health practitioners.

**BHT**
- Youth members, diagnosed with autism spectrum disorder (ASD), and youth members with behaviorally challenging conditions without an autism diagnosis, have access to medically necessary Applied Behavioral Analysis (ABA) BHT services through Beacon Value Options. Members may access the medically necessary ABA BHT services when prior authorization is obtained and eligibility is confirmed.
- Once a member has been identified as eligible for ABA BHT services, Beacon’s Member Services will coordinate the member care with local providers.
- Member’s behavioral health diagnoses have access to outpatient prescription medications from their SFHP Formulary, governed by the SFHP P&T committee.

**NSMH**
- Members with mild to moderate mental health impairment have access to NSMH services through Beacon Value Options (Beacon). Members are able to:
  - Directly access Beacon services, without obtaining a PCP referral or prior-approval, by calling Beacon to complete a screening and register for services.
  - Directly access Behavioral Health (BH) clinicians co-located in their primary care practice without having to contact Beacon services directly. These co-located BH clinicians are contracted and credentialed by Beacon to provide NSMH services at these care sites. Members can also be referred to Beacon services by their PCP or case manager, as appropriate.
- Once a member has been identified as experiencing a mild to moderate impairment, Beacon’s Member Services will offer the member referrals to local providers; Beacon also may refer to tele-behavioral providers who may not be local. A member can also self-refer to a provider using Beacon’s online Provider Directory. SFHP UM Teams may also refer members to Beacon for services.
- Members with mental health diagnoses of mild to moderate impairment have access to outpatient prescription medications from their SFHP Formulary, governed by the SFHP P&T committee.

**SMH**
- Members with moderate to severe mental health diagnoses and severe functional impairment receive specialty mental health services from the Community Behavioral Health Services (CBHS), administered by the San Francisco Department of Public Health (DPH). Specialty mental health, as well as, medications treating serious mental illness, are carved out benefits. Members access CBHS services by calling the CBHS Access Hotline for triage or members may also self-refer to any mental health facility within the CBHS network. SFHP UM Teams also refer members who meet specialty mental health criteria to CBHS for services.

**SUD**
- Medi-Cal eligible members with substance use disorders are eligible for services from the Drug Medi-Cal Treatment Program, a carve-out benefit for all Medi-Cal members.

**UM Policies and Procedures**

UM policies and procedures confirm:
- Preventive services are available without referral or prior authorization when obtained in medical group.

2 MRIoA participates in ongoing NCQA renewal surveys.
• Emergency services and Urgent Care Services are available without prior authorization, to screen and stabilize a member for signs and symptoms that a member, acting reasonably, given the member's age, personality, education, background, and other similar factors, believes to be emergent in nature, or if the member is referred by any SFHP representative or physician, regardless of final diagnosis.

• For family planning services, HIV testing and the treatment of sexually transmitted diseases, Medi-Cal members may see any provider who accepts Medi-Cal without referral or authorization. Non-Medi-Cal members in the Healthy Workers HMO and Healthy Kids HMO programs may self-refer to any provider who is contracted with their medical group for outpatient sensitive services.

• Abortion services
  o Outpatient Services
    • Medi-Cal members may self-refer to any Medi-Cal provider for an outpatient abortion without a prior authorization. It is not required for that provider to be contracted with SFHP.
    • Healthy Kids HMO and Healthy Workers HMO members must stay within medical group for outpatient abortions. Prior authorization is not required. If services are not available in medical group, SFHP will approve out-of-medical group, and if necessary, out-of-network. Medical necessity review is not required.
  o Inpatient Services
    • For Medi-Cal members, abortions while in an inpatient facility require prior authorization, and must be performed within the member's assigned medical group. If the service is not available within the medical group, SFHP will approve an authorization request within the SFHP network.
    • For Healthy Kids HMO and Healthy Workers HMO members, abortions while in an inpatient facility require prior authorization, and must be performed within the member's assigned medical group. If the service is not available within the medical group, SFHP or the delegated medical group will approve an authorization request within the SFHP network.

• Obstetrical and gynecological services, including basic prenatal care and support services, are available to members from practitioners associated with their medical group without prior authorization or referral.

• The length of a hospital stay associated with mastectomy and lymph node dissection is determined by the attending physician and surgeon in consultation with the patient. SFHP and its medical groups do not require a treating physician and surgeon to receive prior approval in determining the length of hospital stay following these procedures.

• Members with chronic, life threatening, degenerative, or disabling conditions have the right to obtain standing referral to specialists.

• Members have access to second opinions within the SFHP network.

• Members’ denial notices describe all means of appeal and related member rights and responsibilities, including how to expedite the authorization and appeal process.

• Members have full access to DMHC’s independent medical review (IMR). Members are encouraged to resolve a grievance using SFHP’s grievance process, but this does not prevent a member for accessing DMHC’s IMR process. A member can access DMHC’s IMR if a member’s grievance involving an emergency, a grievance not resolved satisfactorily, or a grievance unresolved for more than 30-days. The form for requesting an IMR, including instructions, is provided with the NOA, as well as, being available from DMHC through their internet site.

• Members and providers are informed about waiver and community-based programs such as, California Children Services (CCS) and Golden Gate Regional Center (GGRC), and how to coordinate care between SFHP and these services.

Disenrollment for Medi-Cal Members
Medi-Cal and Medicare members admitted to Long Term Care, approved for Transplant Services, other than kidney and cornea, or members with an out-of-area (OOA) address are submitted to Health Care Options for disenrollment.
Grievances, Denials, and Appeals
SFHP encourages its members, or the member’s representative, to voice their dissatisfaction with SFHP’s and/or its providers’ services through the Grievances and Appeals process. The grievance process is designed to address and resolve members’ concerns in a manner that is timely, fair, and thorough.

Providers may appeal on behalf of members as their authorized representative. Additionally, SFHP has a policy for member grievances and appeals, and for provider dispute resolutions (PDR).

The UM program monitors grievances, denials, appeals, and overturned appeals to ensure the prior-approval (PA) criteria were correctly applied and are aligned with current evidence based standards of care.

Engagement with the SFHP Quality Improvement Program
The purpose of the Quality Improvement (QI) Program is to establish comprehensive methods for systematically monitoring, evaluating, and improving the quality of the care and services provided to members. Under the leadership of the SFHP Governing Board, the QI Program is developed and implemented through a QI committee structure. The QI committee structure, with the central involvement of the Chief Medical Officer, provides ongoing and systematic interaction between the health plan and its key stakeholders: members, medical groups, and practitioners.

The UM program collaborates with the Quality Improvement program, the Pharmacy & Therapeutics Committee, and the QIC committee, to support the QI initiative and commitment to the continuous quality improvement of SFHP’s health care delivery system. UM provides a quarterly report to the QIC committee trending and evaluating UM grievances, denials, appeals, and overturned appeals as a means of maintaining the medical soundness of the PA criteria and processes.

Quality Monitoring and Improvement
The objectives of the UM program are primarily measured through the SFHP Quality Improvement Program using, for example, indicators for over- and under-utilization, timeliness of UM decisions, member (CAHPS) and annual provider satisfaction survey with the UM process, PQIs, and UM reviewer IRR scores. When emergent problems are identified, corrective actions are implemented to achieve the proper outcome results.

The Quality Improvement Program includes these mechanisms for monitoring over-utilization and under-utilization:
- Medical record audits
- Review of CAHPS and provider satisfaction surveys, complaints, grievances, and appeals concerning denials, deferments, or modifications of care.
- UM reports
- Pharmacy utilization reports
- The Healthcare Effectiveness Data and Information Set (HEDIS) effectiveness of care measures

At least annually, SFHP or its delegated medical groups gather information from members, through CAHPS, and practitioners about their satisfaction with Clinical Operations processes and reports the results in an annual Member and Provider Satisfaction Report. SFHP then focuses on addressing trends indicative of dissatisfaction. At least annually, SFHP or its delegated medical groups conduct an IRR evaluation to ensure the consistency with which SFHP or delegated reviewers apply UM criteria in decision-making and to determine if a reviewer requires a remediation plan.

Accountability
SFHP and its delegated medical groups convene committees to monitor, evaluate, and optimize the delivery of health care services and the implementation of the UM Program.
The Utilization Management Committee (UMC) provides oversight of SFHP’s utilization activities and initiatives. The UMC works to assure effective implementation of SFHP’s UM Program and to support compliance and alignment with:

- SFHP policy and procedures
- Medi-Cal contract requirements
- NCQA accreditation requirements
- California Department of Health Care Services (DHCS) regulatory requirements
- California Department of Managed Health Care (DMHC) regulatory requirements
- Applicable Federal and State laws and regulations
- Evaluates and recommends for the Executive Committee, as appropriate, ad hoc and ongoing benefit exceptions.

The UMC provides monthly minutes, quarterly, and annual reports to the Quality Improvement Committee (QIC).

The UMC membership, with voting rights on all motions (parliamentary procedure as defined in Robert’s Rules of Order), consists of:

- Chief Medical Officer, MD
- Director, Clinical Operations, RN
- Medical Director, MD
- Associate Medical Directors, MD
- Senior Manager, Prior Authorizations, RN
- UM Nurse Manager, Prior Authorizations, RN
- Manager, Concurrent Review and Care Transitions, RN
- Program Manager, Clinical Operations, PhD
- Director, Pharmacy, Pharm.D
- Manager, Pharmacy Operations, RPh.

The UMC membership, with voting rights limited to behavioral health and mental health motions consists of:

- Director of Clinical Services (MPH) – Beacon Health Options (ad hoc)
- Medical Director (MD/ Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)

Additionally, the UMC, on an ad hoc basis, and required by the UMC Charter, will include the Director of Clinical Services from Beacon Value Options and the Medical Director of College Health IPA (Beacon Value Options) to participate in the UMC meeting(s) when discussions and decisions related to behavioral health are on the agenda.

The QIC is charged with monitoring oversight of SFHP’s UM program. The QIC includes SFHP’s CMO, and Medical Director(s), primary care practitioners, specialists, SFHP member representatives from the Member Advisory Committee, and other provider representatives. The QIC:

- Provides a venue for medical issues to be resolved by a committee or subcommittee of practitioners, with three physician members serving as a quorum;
- Meets at least quarterly; and
- Allows SFHP representatives, as well as the general public, to attend.
- Conducts an:
  - Annual evaluation and, when appropriate, revision of the UM program policies, and criteria. UM criteria are required to be updated at least annually or more frequently if necessary.
  - Provide oversight of the UM program and annually approve, and if needed, update the UM program description.

The SFHP Chief Medical Officer is responsible for ensuring compliance with the SFHP UM program policies and requirements.
SFHP UM Program Structure
A high-level view of the UM organizational structure:

**Clinical Operations Teams**

SFHP’s UM Program consists of the following functional individuals/teams (refer to the organization chart above):

- **Chief Medical Officer**
  - M.D. degree from an accredited medical school. Board certified, preferably in a primary care field.
  - Licensed to practice medicine without restriction in the State of California or eligible to obtain an unrestricted license in California.
Develops, implements, and evaluates the Quality Improvement and Utilization Management Programs for SFHP. Reports to the Governing Board on progress on the programs.

- Directs and monitors utilization management activities of the Plan.
- Directs and monitors health education/cultural and linguistic (HECLS) activities of the Plan.
- Directs and monitors pharmacy services of the Plan, including monitoring and enforcing SFHP’s contractual relationship with its pharmacy benefit management company.
- Directs and monitors non-specialty behavioral health services delivery to SFHP members, including negotiating and executing SFHP’s contractual relationship with its behavioral health management vendor.
- Establishes and maintains strong strategic partnerships with clinical leaders from SFHP’s contracted Medical Groups Oversight and performance of the plans clinical grievance process, including active participation in Grievance Review Committee.
- Ensures that medical decisions at the Plan are rendered by qualified medical personnel, unhindered by fiscal or administrative direction.
- Chairs the Quality Improvement, Pharmacy and Therapeutics, SFHP-SFHN Joint Operations, and Peer Review Committees.
- Develops implements, evaluates, and improves programs to improve the Plan’s HEDIS scores and other quality initiatives.
- Monitors delegated IPAs and delegated medical groups/clinics’ compliance with contractual responsibilities in utilization management and facility site and medical record reviews.
- Works with DHCS and other regulators to facilitate compliance with regulatory requirements for the Plan and SFHP providers. Actively participates in the annual DHCS Medical Audit and triennial DMHC Medical Audit. Responsible for successful development and execution of corrective actions plans pertaining to activities under the scope of Health Services.
- Responsible for NCQA accreditation readiness with regard to Quality, Population Health, and Utilization Management standards.

- **Medical Director**
  - MD/DO degree from an accredited program, with active, unrestricted California medical license. Board certified required.
  - A current CA license to practice medicine without restriction.
  - **Utilization Management**
    - Provides clinical guidance on medical necessity and transfer decisions to support UM staff. Responsibilities include contacting attending and ED physicians to discuss patients when appropriate.
    - Shares responsibility for utilization management and pharmacy decisions: determining medical necessity based on established criteria, interpreting benefits and limitations, and consulting with providers as appropriate. Actively participates in Utilization Management Committee.
    - Calls physicians at his/her discretion to discuss management of members related to pharmacy and UM authorizations, inpatient care, and/or high-dose pain management focusing on evidence, best practices, and medical necessity.
    - Assists in developing and revising policies to support utilization management activities, including criteria and guidelines for appropriate use of services, clinical practice guidelines, and treatment guidelines.
  - **Quality**
    - Investigates and resolves potential quality incidents and determines their appropriateness for review by the Physician Advisory Committee.
    - Reviews appeals and provides second opinions regarding medical necessity.
    - Reviews clinical grievances and is an active participant in Grievance Review Committee.
    - Provides clinical input for programs.

- **Pharmacy**
- Participates in formulary criteria development.
  - Clinical Quality
    - Provides clinical support for program development of disease management and practice improvement.
    - May serve on Quality Improvement Committee, Pharmacy and Therapeutics Committee, or the Practice Improvement Program Advisory Group.

- Associate Medical Director
  - MD/DO degree from an accredited program, with active, unrestricted California medical license. Board certified required.
  - A current CA license to practice medicine without restriction.
  - Provides clinical decision-making and support.
  - Assumes primary responsibility for utilization management and pharmacy decisions: determining medical necessity based on established criteria, interpreting benefits and limitations, consulting with providers as appropriate. Actively participates in Utilization Management Committee.
  - Reviews appeals and provides second opinions regarding medical necessity.
  - Reviews clinical grievances and active participant in Grievance Review Committee.
  - Calls physicians to discuss management of members, related to pharmacy and UM authorizations, inpatient care, and/or high-dose pain management, focusing on evidence, best practices and medical necessity.
  - Provides clinical input for programs:
    - Works with Director of Pharmacy to ensure an appropriate formulary (addressing safety, choice, and cost-containment) and improve quality of pharmacy reporting.
    - Assists in developing and revising policies to support utilization management activities, including criteria and guidelines for appropriate use of services, clinical practice guidelines, and treatment guidelines.

- Director, Clinical Operations
  - Current unrestricted California RN license.
  - A current RN CA license to practice without restriction.
  - Provide tactical and strategic leadership as a member of the Health Services Leadership team, ensuring integration of clinical operations, care management, pharmacy, and health outcomes improvement.
  - Integration of UM process with and referral of high risk members to new mandated benefits (Health Homes, Palliative) to eligible high risk members.
  - Contribute to the evolving integration of clinical operations with other Health Services departments: care management, pharmacy, and health outcomes improvement; establishes department objectives and metrics in alignment with organizational goals, and support management in reaching these goals.
  - Manage and continuously improve the Utilization Management process to maintain full compliance with state regulatory requirements and relevant NCQA accreditation standards. Maintain the department in a perpetual state of audit readiness.
  - Develop and implement UM process redesign and programmatic improvements to improve efficiency, quality, performance, and reduce administrative expense without compromising results and customer service.
  - Provide oversight of the quality management team, which includes dedicated RN for UM delegation oversight, provider dispute resolutions, and clinical grievance review/potential quality incident investigation.
  - Provider strategic guidance of UM prior authorization and concurrent review strategy to balance reduction of avoidable costs and administrative burden to the provider community.
  - Oversee the UM components of the annual medical group oversight audits conducted by SFHP, develop corrective action plans (CAP) if needed, and monitor CAP to ensure implementation, appropriate resolution and the reporting of such to Medical Director and QI Committee.
• Senior Manager, Prior Authorizations
  o Current unrestricted Registered Nurse or Nurse Practitioner license in the state of California.
  o A current CA license to practice without restriction.
  o Manage Prior Authorization team, including Nurses and Nurse Supervisor.
  o Manage and serve as a resource for the Quality Review program to include being a resource for Potential Quality Incidents, Provider Dispute Resolutions, and UM Delegation Oversight.
  o Managing the Gender Affirmation program which includes criteria development and relationship with Gender Health Services.
  o Analysis of prior authorization trends and development/implementation of appropriate action plans.
  o Management of clinically related authorization and claims issues.
  o Act as interim prior auth and quality review lead for escalating concerns when the Director, Clinical Operations is not available.
  o Prior Authorization utilization management including review of clinical requests, and coordination with the Medical Director(s) to ensure members receive appropriate services within their medical group.
  o Collaboration with Medical and CO Director to develop and implement clinical criteria to ensure evidence-based care that reflects current regulations and SFHP policy.

• UM Nurse Manager, Prior Authorization
  o Current unrestricted Registered Nurse or Nurse Practitioner license in the state of California.
  o A current CA RN license to practice without restriction.
  o Manage the Prior Authorization team.
  o Work with Sr. Manager, Prior Authorizations, Director, Clinical Operations, and Medical Director(s) and other key stakeholders to ensure appropriate UM criteria are developed and practiced.
  o Conduct analysis of prior authorization trends and develop/implement appropriate action plans.
  o Manage clinically related authorization and claims issues.
  o Utilization management including review of prior authorization requests and coordination with the Medical Director(s) to ensure members receive medically necessary services within their medical group.

• Manager, Concurrent Review and Care Transitions
  o Current unrestricted Registered Nurse or Nurse Practitioner license in the state of California.
  o A current CA RN license to practice without restriction.
  o Manage Concurrent Review team, including remote nurses and on-site care transitions nurse.
  o Develop and manage the care transitions program.
  o Ensure NCQA, DHCS, and DMHC regulatory compliance in concurrent review and care transitions.
  o Review utilization management metrics and provide analysis and action plans for over and underutilization, readmission rates, and trending.
  o Act as interim concurrent review and care transitions lead for escalating concerns when the Director, Clinical Operations is not available.
  o Work with Director, Clinical Operations and Medical Director(s) to ensure appropriate clinical criteria are developed and practiced.
  o Inpatient utilization management including review of clinical requests, and coordination with the Medical Director(s) to ensure members receive appropriate services within their medical group.
  o Collaboration with Medical Director, Director, Clinical Operations and Prior Authorizations Senior Manager to develop and implement clinical criteria to ensure evidence-based care that reflects current regulations and SFHP policy.
• **UAT, Analyst**
  o Create high level performance test plans, detailed test cases and performance testing scripts.
  o Critically evaluates information gathered from multiple sources, reconciles conflicts, decomposes high-level information into details, abstract up from low-level information to a general understanding, and distinguishes user requests from the underlying true needs.
  o Develop and update testing scenarios that support requirements for operational systems including but not limited to QNXT.
  o Maintain all related user test cases
  o Supports tracking of defects that are related to integrations user test scenarios.

• **Program Manager, Clinical Operations**
  o Substantively contributes to the preparation for DHCS, DMHC, NCQA audits and coordinates development and submission of Corrective Action Plans (CAPs).
  o Participation in work plan development, timely completion of work, mid-term and long-term strategic planning.
  o Planning and ensuring new project requirements remain in compliance with all DHCS regulatory requirements.
  o Review current business processes and devise improvement strategies.
  o Participates in DHCS, DMHC, and NCQA audits.

• **Clinical Operations Analyst**
  o Baccalaureate degree, master’s degree in a healthcare field preferred.
  o Independently review and resolve provider dispute resolutions. Monitor trends and implement process improvements to the provider dispute resolution process to ensure deliverables and deadlines are met.
  o Serve as a Subject Matter Expert (SME) in the provider dispute resolutions process when collaborating with internal and external stakeholders.
  o Independently develop and revise Clinical Operations policies, and present these policies to UM Committee and the Policy and Compliance Committee for review and approval.
  o Support Quality Review Nurse in provider dispute resolution activities.
  o Support Clinical Quality and Outreach Nurse in delegated oversight activities
  o Collaborate with primary care physicians and specialists as appropriate.

• **Supervisor, UM Coordinators**
  o Bachelor’s degree in business management or health care administration or a related field; three years of supervising and managing people, at least a year experience in project management, and three years of managed care experience.
  o Supervises Inpatient and Outpatient UM coordinators.
  o Works collaboratively with UM nurses, UM Managers and Medical Directors.
  o Demonstrates expertise in researching and trouble-shooting medical authorizations.
  o Provides assistance to Inpatient and Outpatient UM coordinators to resolve issues.
  o Ensures staff is handling provider inquiries properly and effectively, and promptly following up on provider issues.
  o Continuously improves the managed care process and pipeline of new opportunities for Utilization Management.

• **UM Nurse, Clinical Quality & Outreach**
  o LVN or active Registered Nurse license in the State of California.
  o A current CA RN license to practice without restriction.
  o Acts as a liaison between SFHP Utilization Management Department and the delegated provider groups.
  o Provides assistance to other Clinical Operations Team members to resolve delegated group-related issues. Ensures staff is handling delegated provider inquiries properly and effectively, and promptly following up on delegated provider issues.
  o Using medical group data prepare and track program performance, utilization and quality review reports for delegated groups and SFHP and follows up on corrective actions.
  o Conducts quarterly review of delegated groups’ work plan, denial logs, and case management reports, and provides feedback as needed.
Completes delegated medical group oversight audit for utilization management and case management, and follows up on corrective actions.

- Participates in DHCS, DMHC, and NCQA audits.
- Audits SFHP authorization determinations against NCQA standards and SFHP policies and procedures and adheres to and understands SFHP Policy and Procedures, our Network Operations Manual, and our agreements with our delegated groups. Performs audits and addresses audit findings, such as on authorization determinations.
- Coordinates the UM Delegation Oversight Sub-Committee to continuously evaluate delegates compliance with the UM and process.
- Actively contributes toward Program, Utilization and Process improvements and goals and continuously improves the managed care process and pipeline of new opportunities.
- Works closely with the Medical director to resolve Potential Quality Issues (PQI).

- **Care Transitions Nurse**
  - Bi-cultural, bi-lingual language skills preferred.
  - Current California RN license from an accredited school of nursing.
  - Conduct in-person discharge planning assessments upon admission for hospitalized/SNF members to help early identification of discharge needs and provide feedback to discharge planning staff regarding coordination of covered services.
  - Contact primary healthcare provider to facilitate notification of admission.
  - Re-evaluate discharge needs throughout hospitalization to anticipate any new or changing needs.
  - Identify members for various clinical programs (including care management, disease management, palliative care etc.).
  - Serves as health plan’s point of contact for member, family and hospital/SNF for discharge planning needs.
  - Promotes timely access to appropriate care.
  - Facilitates member access to appropriate medical and specialty providers upon discharge from hospital or SNF.
  - Promotes utilization of preventative services.
  - Increases continuity of care by assisting in managing relationship with primary care provider upon discharge.
  - Conducts post discharge follow-up phone calls or home visits to ensure discharge needs are met.
  - Identify potential candidates for care management and refer and coordinate with care management, utilization management and pharmacy as appropriate.
  - Support individuals in medication management, and adherence, health care system navigation and other health topics.
  - Assist in developing the Care Transitions program (including training, appropriate documentation, measurement tools, tracking systems, etc.).
  - Participate in development of inter-departmental workflow to support collaboration with SFHP Health Outcomes Improvement, Pharmacy, Care Management and Utilization Management teams.

- **Care Transitions Navigator**
  - Bi-cultural, bi-lingual language skills preferred, but not required
  - Bachelor’s Degree preferred
  - Associate’s degree, or Community Health Worker certificates considered
  - Experience working as a medical assistant or pharmacy technician preferred.
  - Assisting clinical staff to conduct in-person or telephonic discharge planning assessments for hospitalized members to help identify his/her discharge needs.
  - Assists clinical staff in identifying members for various programs (including care management, health homes, palliative care etc.)
  - Serves as one of the health plan’s point of contact for member, family and hospital/SNF for discharge planning needs.
  - Contact primary healthcare provider to facilitate notification of admission.
  - Promotes timely access to appropriate care as directed by clinical staff.
• Facilitates member access to appropriate medical and specialty providers upon discharge from hospital or SNF in conjunction with clinical staff
• Promotes utilization of preventative services
• Increases continuity of care by assisting in managing relationship with primary care provider upon discharge
• Conducts post discharge follow-up phone calls to ensure discharge needs are met and prescribed follow-up services are occurring
• Support individuals in medication management, adherence, health care system navigation and other health topics as directed by or in conjunction with the clinical staff.

• Quality Review Nurse
  - Nursing Degree (Associates Degree, Bachelor of Science in Nursing, Master of Science in Nursing, etc.)
  - Licensed in the State of California without restriction.
  - Reviews, tracks, documents, and manages clinical appeals and grievances.
  - Reviews clinical appeal records and applies SFHP-approved medical necessity criteria and policies.
  - Works closely with the Medical director to rank and respond to Potential Quality Issues (PQI). Complies with clinical appeal and grievance accreditation and regulatory standards.
  - Participates in case conferences. Provides clinical information and assessment of care during Grievance Review Committee (GRC).
  - Participates in DHCS, DMHC, and NCQA audits.
  - Performs audits and addresses audit findings.
  - Appropriately utilizes relevant clinical guidelines to determine medical necessity and benefit coverage criteria for appeals.

• Concurrent Review Nurse II
  - Current unrestricted Registered Nursing License in the state of California.
  - Able to collect patient information and utilize clinical assessment skills to make decisions regarding medical necessity of services.
  - Able to determine which cases should be referred to the Medical Director for evaluation.
  - Able to apply clinical criteria and guidelines to ensure appropriate administration of benefits and optimum medical outcomes based on the use of relevant SFHP policies, InterQual criteria and Medicaid/Medicare guidelines.
  - Works closely with hospital case managers to repatriate members back to member’s designated home hospital.
  - Collaboration with Medical Directors to ensure quality and cost-effective care.
  - Meet departmental review and documentation standards for work assignments including compliance with mandated turnaround times for decisions and provider/member communication.
  - Coordination of care and referrals to services and facilities such as home health, skilled nursing, intermediate care, infusion center, PT/OT, and speech therapy.
  - Coordination of care for members requiring services from community agencies, the department of public health, and Medi-Cal carve-out and waiver programs.

• Prior Authorization Nurse II
  - Current unrestricted Registered Nurse license in the state of California.
  - A current license to practice without restriction.
  - Utilization management, including review of 15-30 clinical requests per day. Coordination with the medical director to ensure members receive appropriate services within their medical group as medically appropriate.
  - Collaboration with Medical Director.
  - Coordination of care for members as appropriate.
  - Coordination of the preauthorization process for medical group services including second opinions, independent medical review, and experimental and investigational services.
• UM Lead Coordinator
  o A Bachelor’s degree in Social Sciences, Life Sciences, Business or equivalent work experience.
  o Current Medical Assistant Certification or California Pharmacy Technician License or equivalent experience in a health care field with familiarity with medical terminology and concepts, a plus.
  o Assist the Supervisor of Utilization Management with daily management of authorization processing, including tracking and reporting of metrics, and leading daily huddle.
  o Demonstrates expertise in researching and trouble-shooting medical authorizations.

• UM Specialist
  o A Bachelor’s degree in Social Sciences, Life Sciences, Business or a related field, preferred.
  o Current Medical Assistant Certification or California Pharmacy Technician License or equivalent experience in a health care field with familiarity with medical terminology and concepts.
  o Researches medical utilization requests using a variety of resources including SFHP evidence of coverage, policies and procedures, and electronic resources.
  o Refers cases to a clinician, including the Medical Director, for clinical review, potential denial or modification and physician provider education.
  o Provides administrative and clerical support for utilization management and other clinical service’s activities.
  o Troubleshoots questions and resolves issues promptly from providers, office staff, delegated groups, and other staff pertaining to authorization requests and determinations.
  o Proven aptitude for telephonic outreach to members according to SFHP utilization, and other clinical service’s program protocols.

• Utilization Management Coordinator
  o A Bachelor’s degree in Social Sciences, Life Sciences, Business or a related field, preferred or equivalent work experience.
  o Current California Medical Assistant Certification or California Pharmacy Technician License without restriction or equivalent experience in a health care field with familiarity with medical terminology and concepts, a plus.
  o Researches utilization management requests using a variety of resources including SFHP evidence of coverage, policies and procedures, and electronic resources.
  o Refers cases to a UM nurse, for clinical review, potential denial or modification and physician provider education.
  o Provides administrative and clerical support for utilization management activities.
  o Answers questions and resolves issues promptly from provider, office staff and delegated groups about authorization requests and determinations.
  o Works closely with providers to obtain accurate information regarding authorization requests.
  o Works closely with clinicians to generate Notice of Action (NOA) letters to providers and members.
  o Enters required data in various computer programs and databases.
  o Coordinates activities with the other members of the UM and Medical Management departments and the company as a whole.
  o Participates in making member phone calls working from a script, and identifying when calls need to be referred to a clinician for review.
Appendix A: Utilization Management Committee Reportage Calendar

<table>
<thead>
<tr>
<th>NCOQA, Regulatory, SFHP Reportage</th>
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<tbody>
<tr>
<td><strong>Monthly &amp; Standing Agenda Items</strong></td>
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<tr>
<td>- Review and documented discussions about:</td>
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<tr>
<td>o Overturned medical and pharmacy appeals</td>
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<tr>
<td>o California Department of Managed Health Care (DMHC) State Fair Hearings and Independent Medical Reviews (IMRs)</td>
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<tr>
<td>o Review of policies and procedures requiring renewal (ad hoc)</td>
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<tr>
<td>o Review of Clinical Operations operational dash board</td>
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<tr>
<td>- UM Trending Report (over/underutilization review)</td>
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<tr>
<td><strong>Quarterly</strong></td>
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<tr>
<td>- QIC consent calendar, and ad hoc agenda discussions:</td>
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<tr>
<td>o Updated UM policies and procedures</td>
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<tr>
<td>o Appeals Report</td>
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<td>o UMC quarterly minutes</td>
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<tr>
<td>- Department of Health Care Services (DHCS) reportage suite:</td>
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<tr>
<td>o Specialty Referral Report</td>
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<tr>
<td>o Clinical Operations Internal File Audit</td>
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<tr>
<td>o Turn-Around-Time</td>
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<tr>
<td>o CMO DMG Denial File Review</td>
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<tr>
<td><strong>Semi-Annual (2x/year)</strong></td>
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<tr>
<td>- Assessment of Delegated Medical Groups’ (DMG) reportage suite</td>
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<tr>
<td>o Specialty Referral</td>
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<tr>
<td>o Work Plans</td>
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<tr>
<td><strong>Annual</strong></td>
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<tr>
<td>- Clinical Operations UM Program Description</td>
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<tr>
<td>- IRR Results and Action Steps</td>
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<tr>
<td>- Medical Necessity Criteria Review</td>
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<tr>
<td>- Program Metric Benchmarks Review</td>
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<td>- Delegated Medical Groups’ annual R3 document audits</td>
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NCQA UM1, Element B
Annual UM Program Evaluation

Annually, the UM program prepares an assessment of members’ and providers’ experience with the UM process. The process for obtaining the assessment data is:

**Process for Acquiring Member Assessment Data**
SFHP conducts a CAHPS survey between February and May for the current measurement year. The CAHPS survey is fielded by the Center for Study of Services (CSS). CSS conducts its survey using the CAHPS 5.0H Adult Medicaid Member Satisfaction Survey. The survey is focused on SFHP’s Medicaid adult population enrolled as of the end of December of the year prior to the survey. The CAHPS survey questions are scored on a Likert scale: Never, Sometimes, Usually, and Always. The results are then benchmarked against CSS’ national Adult Medicaid Average. Based on this data, the UMC will review the data, and as needed, will develop and execute an action plan for improving the member experience.

**Process for Acquiring Provider Assessment Data**
SFHP conducts a Provider Satisfaction Survey, between April and June, which is fielded by SPH Analytics (SPHA). Each January the survey’s content is developed, reviewed, and finalized. The final content is given to SPHA. SPHA then produces the survey and administers the Provider Satisfaction Survey through a two-wave email blast and a one-wave mail with phone follow-up survey methodology. The Survey monitors provider satisfaction levels and provides data applicable to NCQA Health Plan Accreditation Standards. The Survey questions are scored on a Likert scale: Well above Average, Somewhat above Average, Average, and Well/Somewhat below average. Based on this
The annual Clinical Operations UM Program Evaluation is the core report for the UM program. The primary purpose of the report is to confirm SFHP’s UM program remains current and appropriate. The evaluation covers:

- The program structure.
- The program scope, processes, information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program.
- The organization considers members’ and practitioners’ experience data when evaluating its UM program.

Using the evaluation’s outcomes, SFHP will execute the program changes and updates to the UM program.

The UMC annually reviews the UM Program Evaluation. The UMC membership consists of:

- Chief Medical Officer, MD
- Director, Clinical Operations, RN
- Medical Director, MD
- Consultant Medical Directors, MD
- Senior Manager, Prior Authorization, RN
- UM Nurse Manager, Prior Authorizations
- Manager, Concurrent Review and Care Transitions, RN
- Program Manager, Clinical Operations, PhD
- Director, Pharmacy, Pharm.D
- Manager, Pharmacy Operations, RPh.
- Director of Clinical Services (MPH) – Beacon Health Options (ad hoc)
- Medical Director (MD/ Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)

The Quality Improvement Committee discusses and approves the annual UM Program Description. The QIC membership consists of:

- Representative from the Governing Board (1)
- Pharmacist from non-delegated medical groups (1)
- Pharmacist from delegated medical group (1)
- Member Advisory Committee (MAC) members (2)
- Physicians from delegated medical groups (3)
- Physicians from non-delegated medical groups (10)
- The physicians’ specialties include:
  - Emergency Medicine
  - Family Medicine (4)
  - Gastroenterology
  - Internal Medicine (3)
  - Internal Medicine, Cardiology
  - Internal Medicine, Rheumatology
  - Pediatrics (2)
  - Pharmacy

**Member Notifications January / June**

- UM3, Element A: Access to Staff
  - Factor 1: Staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
  - Factor 2: Staff can receive inbound communication regarding UM issues after normal business hours.
### Provider / Practitioner Notifications

**January / June**

- **UM2, Element B: Availability of Criteria**
  - Factor 1: States in writing how practitioners can obtain UM criteria.

- **UM3, Element A: Access to Staff**
  - Factor 1: Staff is available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
  - Factor 2: Staff can receive inbound communication regarding UM issues after normal business hours.
  - Factor 4: TDD/TTY services for members who need them.
  - Factor 5: Language assistance for members to discuss UM issues.

### NCQA Accreditation Analyses Renewal Survey

- **UM1: Program Structure**
  - Element A: Written Program Description
  - Element B: Annual Evaluation
  - Element C: Consistency in Applying Criteria

- **UM 2: Clinical Criteria for UM Decisions**
  - Element A: UM Criteria
  - Element B: Availability of Criteria

- **UM 4: Appropriate Professionals**
  - Element A: Licensed Health Professionals
  - Element B: Use of Practitioners for UM Decisions
  - Element C: Practitioner Review of Nonbehavioral Healthcare Denials
  - Element F: Use of Board-Certified Consultants; 3 cases can be a report / files

- **UM 5, Element D– Renewal Survey**
  - Element A: Licensed Health Professionals Review
  - TAT report

- **MEM 5: Personalized Information on Health Plan Services**
  - Element A: Quality and Accuracy of Information
    - Factor 1: Collecting data on quality and accuracy of information provided.
    - Factor 2: Analyzing data against standards or goals.
    - Factor 3: Determining causes of deficiencies, as applicable.
    - Factor 4: Acting to improve identified deficiencies, as applicable.

- **QI 3: Continuity and Coordination of Medical Care**
  - Element A: Identifying Opportunities
  - Element B: Acting on Opportunities
  - Element C: Measuring Effectiveness
<table>
<thead>
<tr>
<th>Policy</th>
<th>Summary of New Policy and Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO-59: Investigational or Experimental Services (approved at Sept PCC)</td>
<td><strong>New Policy</strong>&lt;br&gt; New Policy. Encompasses procedure for services determined to be Investigational or Experimental in nature. Policy includes definition, procedure for evaluation, required documents (from requesting provider) including appropriate medical/scientific literature as defined in HSC 1370.4. Additionally, the policy describes the distinction between SFHP appeal processes (which will include MRIoA external review) versus DMHC’s IMR processes. All regulatory components included and verified with Compliance.</td>
</tr>
</tbody>
</table>
POLICY STATEMENT

San Francisco Health Plan (SFHP) does not cover investigational or experimental services. Investigational or experimental services do not meet the criteria for "medically necessary services" because these services are not standard medical practice. This exclusion does not apply to services that are related to a cancer clinical trial outlined in CO-47: Clinical Cancer Trials.

SFHP has an external, independent review process for decisions regarding experimental or investigational therapies. SFHP members may also seek an Independent Medical Review by contacting the Department of Managed Health Care (DMHC).

This policy pertains to the Clinical Operations Department’s process for evaluating medical services as investigational or experimental in nature; please refer to Pharm-02 for the Pharmacy Department’s evaluation of pharmaceuticals.

PROCEDURE

Services are investigational or experimental if any of the following apply:

1. The requested services do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
2. There is insufficient or inconclusive medical and scientific evidence to permit SFHP to evaluate the therapeutic value of the service. (Adequate evidence is defined as at least two documents of medical and scientific evidence that indicate that the proposed treatment is likely to be beneficial to the member.)
3. There is inconclusive medical and scientific evidence in peer-reviewed medical literature that the service, procedure, medical supply or durable medical equipment has a beneficial effect on health outcomes.
4. The service, procedure, medical supply or durable medical equipment under consideration is not as beneficial as any established alternatives.
5. There is insufficient information or inconclusive scientific evidence that, when used in a non-investigational setting, the service has a beneficial effect on health outcomes or is as beneficial as any established alternatives.

This exclusion does not apply to services that are related to a cancer clinical trial outlined in CO-47: Clinical Cancer Trials.
Authorization Procedure

1. Clinical Operations (CO) Prior Authorization team evaluates authorization requests for services that may be investigational or experimental in nature.

2. If a Prior Authorization Nurse determines the request to be investigational or experimental, it is documented in the applicable authorization assessment (in Essette) and routed to a SFHP Medical Director to evaluate whether it is investigational or experimental in nature. If the request is determined not to be investigational or experimental, the regular review process described in CO-22 will proceed.

3. The reviewing SFHP Medical Director may choose to consult with the Medical Review Institute Of America Inc. (MRIoA) to assist in their decision making about whether the request is investigational or experimental in nature.

4. If the request is determined to be investigational or experimental, supporting documentation is required from the requesting physician. Acceptable supporting documentation includes:
   i. A statement that the member has a condition or disease for which standard health service or procedures have been ineffective or would be medically inappropriate; or that there does not exist a more beneficial standard health service or procedure covered by the health care plan.
   ii. A statement of why the standard therapy available would not be beneficial, would be ineffective or would be inappropriate, including an assessment of the risks and benefits of the proposed treatment, specific goals and criteria for patient selection.
   iii. Copies of two published studies from the available peer-reviewed Medical and Scientific Evidence upon which the attending physician based their recommendation for the proposed treatment and an explanation why, in the opinion of the physician, these documents establish that the treatment or procedure is likely to be more beneficial to the member than any covered standard health service or procedure or would provide a positive effect on the member's condition or illness and that the benefits outweigh the harmful effects of the treatment.
   iv. Documentation that the attending physician is a board certified or board eligible physician qualified to practice in the area of practice appropriate to treat the member's condition.
   v. A copy of the Member's informed consent form, when appropriate.
   vi. A copy of the Member's relevant medical and treatment records, including results of tests or studies, establishing the member's current condition and any treatment the member has received for the condition;
   vii. Any other relevant data that indicates the requested treatment’s effectiveness.

5. If the reviewing SFHP Medical Director decides not to authorize the treatment, SFHP will issue a Notice of Adverse Benefit Determination (NOA) letter specifically stating the medical and scientific reasons for the denial and any alternative treatment covered by SFHP. SFHP will provide the NOA letter to the member within five business days of denial decision.
   a. The NOA letter will include instructions on SFHP's Appeal process.
   b. The NOA letter will also include instructions on DMHC's Independent Medical Review (IMR) process, an application and envelope addressed to DMHC, the physician certification form, and DMHC's toll-free information number.
c. DMHC IMR instructions and forms are available in threshold languages for members who requests materials in their preferred language.

6. If SFHP denies a service to a member with a Terminal Illness, SFHP provides a NOA within five (5) business days which includes or attaches all of the following:
   a. A statement with the specific medical and scientific reasons for denying authorization.
   b. A description of alternative treatment, services, or supplies that are covered by SFHP, if any.
   c. A copy of SFHP’s Grievance Form and instructions for how to request an appeal (“Your Rights” attachment)
   d. Instructions for how to request a DMHC IMR (“Your Rights” attachment) and the DMHC IMR form
   e. An offer to the member to request a conference with SFHP.

Member Appeals of Decisions to Deny an Experimental/Investigation Service

1. If a member disagrees with SFHP’s decision to deny authorization for a service, procedure, medical supply or durable medical equipment because SFHP has determined it is experimental or investigation, the member may appeal the decision pursuant to QI-17.

2. SFHP has an external, independent review process for decisions regarding experimental or investigational therapies for members who meet all of the following criteria:
   a. Member has a Life-Threatening or Seriously debilitating condition; and
   b. The member’s physician certifies that the member has a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving the condition of the member, for which standard therapies would not be medically appropriate for the member, or for which there is no more beneficial standard therapy covered by SFHP than the therapy proposed; and
   c. Either
      i. The member’s physician, who is contracted with SFHP, has recommended a service, procedure, medical supply or durable medical equipment that the physician certifies in writing is likely to be more beneficial to the member than any available standard therapies, or
      ii. The member, or the member’s physician who is a licensed, board certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat the member’s condition, has requested a therapy that, based on two published studies from Medical and Scientific Evidence, is likely to be more beneficial for the member than any available standard therapy.
   d. The physician’s certification must include a statement of the Medical and Scientific Evidence relied upon by the physician in certifying the recommendation; and
   e. SFHP denied coverage of the recommended drug, device, procedure, or other therapy; and
   f. The specific service recommended would be a covered service, except for the SFHP’s determination that the therapy is experimental or investigational.

2. If a member meets all of the above criteria, SFHP forwards the case to its external independent medical review organization (MRIoA) for review.
   a. Written notification to eligible members of the opportunity to request the external independent review within five business days of the decision to deny coverage.
   b. If the requesting physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the MRIoA experts on the panel shall be rendered within seven days of the request for expedited review. At the request of the MRIoA expert, the deadline shall be extended by up to three days for a delay in providing the documents required.
c. Each MRIoA expert’s analysis and recommendation is in written form and states the reasons the requested therapy is or is not likely to be more beneficial for the enrollee than any available standard therapy, and the reasons that the MRIoA expert recommends that the therapy should or should not be provided by SFHP, citing the member’s specific medical condition, the relevant documents provided, and the relevant medical and scientific evidence, including, but not limited to, the medical and scientific evidence to support the MRIoA expert’s recommendation.

3. If the member has a Terminal Illness, the member may appeal a decision to deny an experimental/investigation service by attending a conference:
   a. SFHP’s representative at the conference is a staff member with authority to determine the resolution of the appeal.
   b. The member and member’s representative may attend the conference telephonically or in person. The member is given the opportunity to attend the conference within 30 calendar days of the denied authorization.
      i. If the member’s treating physician determines, after consultation of SFHP’s Medical Director and based on standard medical practice, that the effectiveness of the proposed treatment would be materially reduced if not provided at the earliest possible date, the conference is held within five (5) business days.

DMHC Independent Medical Review

1. Members may seek an Independent Medical Review by contacting DMHC.
2. SFHP does not require the member to participate in SFHP’s grievance and appeal process prior to seeking a DMHC IMR.
3. To directly access DMHC Independent Medical Review process, the member, member’s representative, or physician may submit application to DMHC for IMR review. The application documents are included in SFHP’s denial NOA as described above.
4. When SFHP is notified of an IMR request, SFHP Compliance and Regulatory Affairs staff respond to the IMR request pursuant to CRA-24.

MONITORING

A. SFHP’s Clinical Operations Department performs inter-rater reliability audits at least annually for both physician and nurse reviewers.

B. SFHP Health Outcomes Improvement Department evaluates member grievances and appeals, as well as, SFHP’s member and provider satisfaction survey responses, to identify patterns.

C. On a monthly basis, the Utilization Management Committee (UMC) reviews Appeals, IMRs, and State Fair Hearings resulting from an authorization decision made by SFHP or one of its delegated medical groups. The UMC recommends corrective action and/or identifies where the Clinical Operations Department can revise the authorization process, if necessary, to improve the member experience, to address any barriers, and ensure the utilization management criteria are consistent with current industry and evidence-based practices. The Quality Improvement Committee reviews an Appeals Report (overturned and upheld appeals) every quarter regarding the activity of pharmacy and medical authorizations.
D. Reports regarding SFHP’s Clinical Operations Department’s monitoring activities are reviewed at the Utilization Management Committee (UMC) on a monthly basis and are presented to the Quality Improvement Committee (QIC) at least annually for evaluation and corrective actions as needed.

E. The policies of medical groups that are delegated to perform utilization management are reviewed though annual audits performed by the Clinical Operations and Delegation Oversight Teams. In the event a medical group is non-compliant, the Delegation Oversight Team or designee notifies the medical group in writing that corrective action is required. The medical group has 30 calendar days from the date of receipt to submit a corrected policy to SFHP.

DESKTOPIONS

**Appeal:** A request by a member for review of an Adverse Benefit Determination, including, delay, modification or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit.

**Experimental/Investigational Therapy:** Any treatment, device, or procedure that is not currently approved as an accepted standard of practice, but is subject to rigorous ethical and scientific investigative methods in a controlled setting.

**Grievance:** An expression of dissatisfaction by a member about an issue other than an Adverse Benefit Determination, including but not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employees, and the member’s right to dispute an extension to make an authorization decision.

**Independent Medical Review (IMR):** The expert review of disputed health care services by an outside organization that contracts with the Department of Managed Health Care (DMHC).

**Life-Threatening:** Means either or both of the following:
   1. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
   2. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

**Medical/Scientific Evidence:** As defined in HSC 1370.4(d):
   (1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
   (2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR).
   (3) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.
   (4) Either of the following reference compendia:
      (A) The American Hospital Formulary Service’s Drug Information.
      (B) The American Dental Association Accepted Dental Therapeutics.
Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
   (A) The Elsevier Gold Standard’s Clinical Pharmacology.
   (B) The National Comprehensive Cancer Network Drug and Biologics Compendium.
   (C) The Thomson Micromedex DrugDex.

Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

Peers-reviewed abstracts accepted for presentation at major medical association meetings.

**Notice of Action (NOA):** A formal letter telling members that a medical service has been denied, deferred, or modified.

**Notice of Adverse Benefit Determination (NABD):** same definition of NOA. DHCS has retained use of NOA for ease of understanding by members.

**Terminal Illness:** Refers to an incurable or irreversible condition that has a high probability of causing death within one year or less.

**Seriously Debilitating:** Diseases or conditions that cause major irreversible morbidity.

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**AFFECTED DEPARTMENTS/PARTIES**

Clinical Operations
Delegated Groups
Medical Directors
Network Providers

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**RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS**

CO-03 Organ Transplants Prior Authorization and Disenrollment
CO-38 Durable Medical Equipment (DME)
CO-47 Cancer Clinical Trials
CO-54 Evaluation of New Technology
CO-55 Exception Handling of Medi-Cal Non-Covered Services
CO-57 UM Clinical Criteria
CRA-24 Responding to State Inquiries about Member Complaints
Pharm-02 Pharmacy Prior Authorization
QI-06 Clinical Member-Grievances
QI-17 Member Appeals
Member Handbook (Medi-Cal LOB)
Evidence of Coverage (Healthy Workers and Healthy Kids LOB)
Provider Manual

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**REVISION HISTORY**

**Effective Date:** October 8, 2019
REFERENCES

1. CA Health and Safety Code 1370.4.
2. CA Health and Safety Code § 1300.70.4. Independent Medical Reviews Experimental and Investigational Therapies
3. CA Health and Safety Code 1368.1
4. DMHC Technical Assistant Guide
Draft Annual Evaluation
2019
San Francisco Health Plan

Beacon Health Options
Western Region

PROPRIETARY AND CONFIDENTIAL
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INTRODUCTION

Overview

Western Region has accepted and adopted the 2019 Beacon Health Options (Beacon) Corporate Quality Management Program Description and Work Plan. The mission of the Beacon Quality Program, in collaboration with the Clinical Program, is to help people live their lives to the fullest potential by transforming the lives of those we serve through promotion, support and facilitation of high quality, cost effective, evidence-based care and service known to improve health outcomes.

Scope

The scope of the Beacon Western Region Quality program encompasses the ongoing assessment, monitoring and improvement of all aspects of care and service delivered to members, including member safety. The population served is diverse, representing multiple cultural and linguistic groups and includes pediatric, adult and geriatric individuals in the Western region. The lines of business managed out of this region include Commercial, Exchange (marketplace), Medicare and Medicaid (Medi-Cal).

The membership for the Western Region as of October 2019 was approximately 4,057,752. The Western Region has maintained the NCQA MBHO accreditation for Commercial, Exchange (marketplace), Medicare and Medicaid lines of business under Beacon Health Strategies, LLC. The Quality Program evaluation serves to assess the overall effectiveness of the Quality Program, including the effectiveness of the committee structure, the adequacy of the resources, practitioner and leadership involvement, the strengths and accomplishments of the program, and the Service Center’s performance in quality of clinical care and quality of service initiatives.

The preliminary Draft Annual Evaluation of Beacon’s Quality Programs for San Francisco Health Plan (SFHP) is presented in this report. The information presented includes results from clinical and service quality improvement activities for the Medi-Cal line of business. Please note that claims based measures presented in this report reflect data run through October 31, 2019, and will be updated in July 2020 to reflect claims run out for Service Year 2019. Additionally, claims data reported in this report include BH claims only and do not include medical or pharmacy claims.
EVALUATION OF CLINICAL QUALITY IMPROVEMENT INITIATIVES

Western Region clinical and service quality improvement initiatives are discussed below.

Depression

Goal
Improve the percentage of members 18 years of age and older with a diagnosis of major depression who are newly treated with antidepressant medication, and who remain on antidepressant medication treatment (HEDIS Antidepressant Medication Management (AMM) measures and American Psychiatric Association (APA) Clinical Practice Guideline (CPG) measures).

Background
Beacon Health Options (Beacon) aims to improve the quality of clinical care of members prescribed antidepressants for the treatment of major depressive disorders through programs designed to improve medication adherence.

The National Alliance on Mental Illness (NAMI) estimates that almost 7% of American adults had at least one major depressive episode in the past year. There are wide varieties of symptoms associated with the illness. Symptoms include a sad mood, diminished interest in activities once considered enjoyable, weight loss or gain, psychomotor retardation or agitation, fatigue, inappropriate guilt, difficulty concentrating, and in more serious depression, recurrent thoughts of death. The American Psychiatric Association (APA) requires that five (5) or more previously mentioned symptoms to be present for two weeks or more for someone to be diagnosed with depression.

Depression not only affects persons suffering from the illness, but also those around them. Research shows that interpersonal relationships tend to suffer for those experiencing symptoms of depression. Very few families or friend groups are not affected by their loved one’s depression. Relationships outside of the home, such as at school or in the workplace, can also be affected. Effective treatment of depression can help improve the health of a Member who is suffering, as well as repair broken interpersonal relationships.

Measures
1. Claims based CPG Measures
   a. Percent of members ages 18 years and older with depressive diagnoses who received two or more outpatient therapy visits within 12 weeks of their diagnoses
   b. Percent of members ages 18 years and older with depressive diagnoses who received one or more medication visits within 84 days of the diagnosis
   c. Percent of members ages 18 years and older with depressive diagnoses who received one or more medication visits within 84 days of the diagnosis and received additional follow up visit within 84 days of the initial medication visit

2. HEDIS Measure
   a. Percent of newly diagnosed and treated members who remained on antidepressant medications for at least 84 days – HEDIS® AMM Effective Acute Phase Treatment
   b. Percent of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months) – HEDIS® AMM Effective Continuation Phase Treatment

Methodology

For CPG Measures, claims data is used to identify members who had two or more visits within 12 weeks of their initial diagnoses, members who had one medication visit within 84 days of their initial diagnoses, and members who received an additional follow up visit within 84 days of the initial medication visit. Chart Review data is currently pending for 2019 and will be updated for the July 2020 Annual Evaluation submission.

HEDIS® Antidepressant Medication Management (AMM) measures are reported directly by individual health plans. Beacon does not produce AMM HEDIS® rates. Beacon antidepressant medication management activities are designed to support the AMM rates that are reported by the health plan partners.

The Antidepressant Medication Management (AMM) sub-measure Effective Acute Phase Treatment measures the percentage of members that meet the following criteria:
- 18 years and older on April 30, 2019
- Were diagnosed with major depression
- Were prescribed an anti-depressant medication
- Were adherent with their medications for at least 84 days of the 115 days after initial prescription fill date

The Antidepressant Medication Management (AMM) sub-measure Effective Continuation Phase Treatment measures the percentage of members that meet the following criteria:
- 18 years and older on April 30, 2019
- Were diagnosed with major depression
- Were prescribed an anti-depressant medication
- Were adherent with their medications for at least 180 days of the 232 days after initial prescription fill date

Interventions implemented
- Continue to review, approve and disseminate guidelines on depression as part of the guideline review process.
- Ensure that Beacon providers and PCPs are informed annually about information and updates to all depression management tools that are available on the website via postcard and Provider Bulletin. Supply documents to health plan for distribution to PCPs. (Annual)
- Present provider profiler to the providers:
  - Quarterly data for member utilization, average therapy visits, initial assessment rate, engagement rate
- Create strategic plan for every provider to improve clinical and operational performance.
- Through Provider Bulletin, educate providers regarding HEDIS AMM measures and the importance of antidepressant medication.
- Continue to educate providers on the importance of PCP support and “peer-to-peer” support. Providers can call Beacon psychiatrists for advice on members and medication.

Results

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<tr>
<td>1. Clinical Practice Guideline Measure: The percentage of members (18+)</td>
<td>50%</td>
<td>52.8%* (163/309)</td>
<td>41.3%* (104/252)</td>
<td>51.1%* (146/286)</td>
</tr>
<tr>
<td>newly diagnosed with depressive disorder who received two (2) or more</td>
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<tr>
<td>Behavioral Health (BH) visits within 84 days of diagnosis. (Claims)</td>
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2.

a. The percentage of members (18+) newly diagnosed with depressive disorder who received one (1) or more medication visits within 84 days of diagnosis. (Claims)

<table>
<thead>
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<th>Percentage</th>
<th>2020</th>
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<tr>
<td></td>
<td>20%</td>
<td>20.4%</td>
<td>18.7%</td>
<td>23.4%</td>
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<td></td>
<td>(63/309)</td>
<td>(47/252)</td>
<td>(67/286)</td>
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</table>

b. The percentage of members (18+) newly diagnosed with depressive disorder who received one (1) or more medication visits within 84 days of the first medication visit. (Claims)

<table>
<thead>
<tr>
<th>Percentage</th>
<th>2020</th>
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<tbody>
<tr>
<td></td>
<td>95%</td>
<td>93.7%</td>
<td>93.6%</td>
<td>95.5%</td>
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<tr>
<td></td>
<td>(59/63)</td>
<td>(44/47)</td>
<td>(64/67)</td>
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*Statistically significant change from the previous reporting period using z-test for proportions at p<0.05

Result Analysis
The percent of members ages 18 years and older with depressive diagnosis who received two or more visits within 12 weeks of initial diagnostic visit met the established goal at 51.1% in 2019. It is important to note that 2019 data contains claims lag and final data without claims lag will be provided in the next submission of this report in July 2020.

The target for measure 2a met the established goal at 23.4% in 2019. Of members receiving one or more medication visit, 95.5% had another follow up appointment within 84 days of their first medication visit indicating strong medication adherence.

Barrier Analysis
As Beacon has access to BH claims only, Beacon is unable to capture members that may have received BH services from their PCP; consequently, measurement estimates may be artificially low. Below are additional barriers believed to affect members’ depression treatment:

- Providers may not be aware of best practices for prescribing antidepressant medications
- Providers may give samples to supplement prescriptions which could hinder refills in a timely manner
- Providers may not educate patients about the importance of outpatient behavioral health visits and medication adherence.
- Providers may have inadequate follow up plans for newly prescribed members.
- Providers are not regularly informed of their HEDIS AMM performance, specifically when there are opportunities to improve their rates.
- Members may be resistant to treatment due to social stigma or cultural barriers.
- Members may not adhere to instructions for treating depression.
- Members may not be aware that it takes time for medication to take effect and may discontinue use if they do not experience changes or if they experience side effects.
- Members may discontinue therapy sessions if they do not experience immediate changes.
- Members may have chronic co-morbid medical conditions that make accessing outpatient care for depression difficult.
- Members have difficulty with transportation, childcare, and other resources that prevent them from keeping scheduled appointments.
- Deductibles and co-payments may impact member adherence.
- Generic medications may be cheaper to buy outright than to pay a co-payment.

Opportunities for Improvement
- Increase network in regions where there are prescriber deficiencies
- Improve member and provider education strategies regarding best practices

Next Steps
• Explore opportunities to promote best practices for treatment of members with chronic medical and BH conditions, such as complex care management models and initiatives for members with dual eligibility (Ongoing).
• Continue the efforts to collaborate with the health plan around exchange of Medical and Pharmacy data for production of HEDIS® AMM and accurate production of CPG measures. Additionally, access to real time data will ensure real time and effective interventions.
• Continue to educate Beacon providers and PCPs about information and updates to all depression management tools that are available on Beacon’s website via postcard and Provider Bulletin (Annual).
• Promote use of online resources to members and providers through plan newsletters Beacon Provider Bulletins, site visits and Provider Advisory Councils.
• Ensure depression materials and screening tools on website are up-to-date and easily available (Ongoing).

Attention Deficit Hyperactivity Disorder (ADHD)

Goal
Improve the rate with which children are screened and treated for attention-deficit/hyperactivity disorder (ADHD) (American Academy of Pediatrics (AAP) CPG measures). Improve the rate with which children newly prescribed ADHD medication have at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed (HEDIS® Follow-Up Care for Children Prescribed ADHD Medication (ADD) measures).

Background
The National Survey of Children’s Health (NSCH), funded by the Centers for Disease Control (CDC) found that more than 1 in 10 (11%) US school-aged children had received an ADHD diagnosis by a health care provider by 2011, as reported by parents with higher prevalence, almost 2 to 1 of diagnosis in boys than girls.

• The percentage of US children 4-17 years of age with an ADHD diagnosis by a health care provider, as reported by parents, continued to increase 42% between 2003 and 2011, with an average annual increase of 5% per year:
  o 7.8% had ever had a diagnosis in 2003
  o 9.5% had ever had a diagnosis in 2007
  o 11.0% had ever had a diagnosis in 2011
• The percentage of children aged 4-17 taking medication for ADHD, as reported by parents, increased by 28% between 2007 and 2011, with an average annual increase of 7% per year:
  o 4.8% in 2007
  o 11% in 2011

In 2011, the CDC researchers looked at data from a national sample of children with special health care needs, ages 4-17 years, collected in 2009-10. They found that most children with ADHD received either medication treatment or behavioral therapy; however, many were not receiving treatment as outlined in the 2011 best practice guidelines. Current AACAP guidelines recommend that for school-aged children (6-18 years of age) with ADHD, treatment include ADHD medication with or without behavioral therapy, with both medication and behavioral therapy as the preferred treatment. Behavioral therapy is recommended first for preschoolers (4-5 years of age) with ADHD.

• Less than 1 in 3 children with ADHD received both medication treatment and behavioral therapy, the preferred treatment approach for children ages 6 and older.
• Only half of preschoolers (4-5 years of age) with ADHD received behavioral therapy, which is now the recommended first-line treatment for this group.
• About half of preschoolers with ADHD were taking medication for ADHD, and about 1 in 4 was treated only with medication.
All evidence supports that early diagnosis can play an important role in the efficacy of treatment and offset of risks. Since the associated behaviors can interfere with a child’s ability to perform well in school, complete homework assignments, follow rules, or develop and maintain relationships with peers, intervening at the onset of symptoms can help to minimize behavioral and social issues in adolescents and adulthood. The evidence continues to support that children are not consistently receiving evidenced based best practice care for ADHD and Beacon needs to continue to champion for greater consistency in care and treatment. Further, the majority of Beacon’s child members receive some form of public support through Medicaid, Child Health Plus and other funding streams for the lower socioeconomic groups who have higher rates of ADHD and accompanying sequelae.

Beacon first disseminated a clinical practice guideline in 2002 for the treatment of ADHD for children 6-12 years and based on expert consensus adopted the AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorders in 2008. In order to address the gaps in ADHD care and treatment, the ADHD Quality Improvement program was developed in 2008 to operationalize best practice, educate providers and monitor adherence to evidence based best practice.

**Measures**

**Chart Reviews/ Claims Data (California Only)**

1. The percentage of members aged 6-12 years with a diagnosis of ADHD, who had an outpatient psychopharmacology visit within 30-90 days following the initial diagnostic visit. (Claims)
2. The percentage of members aged 6-12 years with a diagnosis of ADHD, who had an outpatient psychopharmacology visit within 30-90 days following the initial diagnostic visit and had additional follow up visit within 30-90 days following the qualifying psychopharmacology visit. (Claims)
3. Is there evidence the member was screened for ADHD when relevant? (Chart Review)
4. If Member screened positive for ADHD, was there a referral for a medication evaluation? (Chart Review)
5. If Member screened positive for ADHD, was family involved in treatment? (Chart Review)

**Methodology**

Claims data is used for the first two measures, and chart review data is used for measures 3, 4 and 5 for the eligible population. The eligible population for all five measures encompasses all members 6 – 12 years of age having a new ADHD diagnosis and received interventions during 2019. Beacon conducts clinical chart reviews of high volume providers and practitioners on an annual basis. High volume providers are defined as those treating 100 or more unique members per year. High volume practitioners are defined as those treating 50 or more unique members per year. Beacon maintains a goal of reviewing 10 provider sites each year; the number of charts reviewed for each site depends on overall volume of members. Beacon’s Outpatient Clinical Chart Review Tool has been modified over time to capture data for quality improvement activities such as Alcohol and Other Drugs and Attention Deficit Hyperactivity Disorder, as well as for reporting requirements (ex. BH/PCP Coordination). Chart reviews are generally conducted through desktop review. To ensure consistency and accuracy in the data collection process, inter-rater reliability (IRR) is measured prior to beginning each review.

After the chart review is complete and the results entered into the database, each provider receives an individualized feedback letter with information regarding their performances on each question (comparable to a report card). Providers may receive overall ratings of “excellent” (80% - 100%), “acceptable” (65% - 79%) or “other” (0% - 65%). If a provider receives a failing score, the Outpatient Department completes a site visit, and the provider site is certain to be one of the sites receiving a chart review the following year. If a provider fails the chart review two years in a row, the provider is placed under a Corrective Action Plan (CAP). The Outpatient Department reports that providers frequently call for verbal feedback after receiving their “report cards,” regardless of how well they may have done on the review.

The 2019 Outpatient provider chart reviews will occur as follows:
1. The Quality Department will generate a random pull of member names and send the list of names to the provider sites at least two weeks in advance of each review.

2. An Outpatient Clinician will complete the entire tool for each chart reviewed.

3. Administrative staff or Quality staff will enter chart review results into the database periodically at points throughout the year.

Note: 2019 Chart Review data is currently being pulled. An updated copy of results will be shared in the July 2020 Annual Evaluation submission.

In addition to Outpatient Chart Review data, Beacon uses Behavioral Health (BH) claims data to measure the impact of the ADHD program and provider adherence to ADHD guidelines. No pharmacy claims were utilized and assumptions are made about the association between an initial psychopharmacology visit with an ADHD diagnosis that an ADHD stimulant is being prescribed. BH claims data was used to examine performance for measures 1 and 2. However, all Beacon members, when delegated by contracted health plans, receive the interventions described below.

For HEDIS measures, Beacon uses HMSA behavioral health claims, pharmacy claims, and Verisk Sightlines data to measure the effectiveness of programs and interventions. ADD eligible members were identified using the NCQA specifications for the HEDIS® 2019 ADD measure (including NCQA’s comprehensive list of ADHD medications and NDC codes) and HMSA’s provider specialty code sets for both commercial and QUEST line of business. There are two sub-measures.

- **Initiation Phase.** The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

- **Continuation and Maintenance (C&M) Phase.** The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

In addition to providing basic demographic information about the ADD eligible population, the following information was extracted from HMSA medical and pharmacy claims:

- IPSD
- Name of Prescribing Provider
- Prescribing Provider Specialty
- ADHD Medication Name
- # of Supply of ADHD Medication
- ADD Initiation Date of Service
- ADD Initiation Provider
- ADD Initiation Provider Specialty

**Interventions completed**

- Continue to review, approve and disseminate Clinical Practice Guidelines on ADHD as necessary.
- Promote and promulgate use of online resources by members and providers, including the PCP Toolkit that includes new screening tools and ADHD rating scales.
- Continue to educate providers on Beacon’s Quality Program through the distribution of Inpatient, Outpatient, and PCP “Quality Packets”. Collaborate with the health plan on dissemination of similar materials to plan BH providers and PCPs.
- Based on chart review results, continue to provide feedback on provider’s performance and documentation. Send letters to providers with tips for improving performance.
- Present provider profiler to the providers:
  - Quarterly data for member utilization, average therapy visits, initial assessment rate, engagement rate
- Create strategic plan for every provider to improve clinical and operational performance.
• Through monthly provider bulletin, educate providers on HEDIS ADD measures, how it is measured, relevance of the measure and the best practices.
• Continue to educate providers on the importance of PCP support and “peer-to-peer” support. Providers can call Beacon psychiatrists for advice on members and medication.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The percentage of members ages 6-12 years old with a diagnosis of ADHD, who had an OP psychopharmacology visit within 30-90 days following the initial diagnostic visit. (Claims)</td>
<td>20%</td>
<td>18.1%</td>
<td>20.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2/11)</td>
<td>(2/10)</td>
<td>(2/5)</td>
</tr>
<tr>
<td>2. The percentage of members ages 6-12 years old with a diagnosis of ADHD, who had an OP psychopharmacology visit within 30-90 days following the initial diagnostic visit and had an additional follow up visit within 30-90 days following the qualifying psychopharmacology visit. (Claims)</td>
<td>70%</td>
<td>NA</td>
<td>100%</td>
<td>50.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0/0)</td>
<td>(2/2)</td>
<td>(1/2)</td>
</tr>
<tr>
<td>3. Is there evidence the member was screened for ADHD when relevant? (Chart Review**) (2017: If the member is 6-12, was the member assessed for ADHD?)</td>
<td>95%</td>
<td>0.0%</td>
<td>87.5%</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0/4)</td>
<td>(7/8)</td>
<td></td>
</tr>
<tr>
<td>4. If Member screened positive for ADHD, was there a referral for a medication evaluation? (Chart Review**) (2017: If the member is 6-12 and diagnosed with ADHD, is there evidence that s/he was referred to or participated in a medication evaluation?)</td>
<td>95%</td>
<td>NA</td>
<td>50.0%</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0/0)</td>
<td>(3/6)</td>
<td></td>
</tr>
<tr>
<td>5. If Member screened positive for ADHD, was family involved in treatment? (Chart Review**) (2017: If the member is 6-12 and screened positive for ADHD, was there family involvement in treatment?)</td>
<td>90%</td>
<td>NA</td>
<td>85.7%</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0/0)</td>
<td>(6/7)</td>
<td></td>
</tr>
</tbody>
</table>

**Note: Starting 2018, Beacon has added new questions, as well as, removed age range from Treatment Record Review process in order to broaden the scope of the reviews. Most of the questions have been rephrased as indicated by the inclusion of previous year questions.

**Result Analysis**

Based on the claims data, only five (5) members between the ages 6-12 were diagnosed with ADHD in 2019. Of the five (5) members identified as having initial diagnosis of ADHD, two (2) demonstrated evidence of having an OP psychopharmacology visit within 30-90 days of initial diagnostic visit.

Chart Review data for 2019 are currently being collected and will be available in the July 2020 submission.

**Barrier Analysis**
Currently pending 2019 Chart Review data for analysis.

**Next Steps**
Currently pending 2019 ADHD data for analysis.
CONTINUITY AND COORDINATION OF CARE MONITORING ACTIVITIES

Continuity and Coordination of Care (COC)

Goal
Improve the Continuity and Coordination between BH providers, both acute and ambulatory, and primary medical care providers.

Background
Behavioral health (BH) problems often co-occur with chronic medical conditions. When BH problems are not addressed, there may be a negative impact on self-care and adherence to medical and behavioral health treatments. An integrated approach in which primary care and behavioral health providers work together to address medical and BH needs of a patient is therefore necessary to improve overall health of patients.

The high rate of co-occurrence of BH illnesses and general medical conditions brings awareness to the gap between the BH and primary care systems. Over about half of the care for BH disorders is administered in a primary care setting. This leads to the majority of patients not being treated effectively. Low rates of effective BH treatment can cause an increase in issues occurring from physical illnesses. Without coordination of care between the PCP and the BH provider, the patient may not receive proper treatment for all illnesses.

The majority of those with severe mental and behavioral health conditions are seen primarily by mental health specialists. However, some are solely seen by primary care practitioners. Many cases have been shown that those who are primarily treated by BH providers die prematurely due to the lack of general medical care. Their illness makes it difficult for them to pursue and receive primary care. This can be a cause of social stigmas, financial reasons, or few available community resources.

The inadequate level of care given to BH patients can be attributed to the lack of knowledge on behalf of both BH providers and PCPs. The providers of BH and primary care services are not usually trained to treat disorders or illnesses in the other field. PCPs did not know how to adequately treat many behavioral or mental health disorders. This leads to the importance of separate treatment for those with BH illnesses. Since most BH providers do not possess the skill set to work in a primary care setting, the coordination between the two sectors becomes extremely important.

The integration of treatments for BH and physical health conditions results in a coordinated system of care that supports the multifaceted needs of members, ensuring continuity of care, improved outcomes for patients, and an effective health care system. An integrated system improves the overall health of a patient by allowing for comprehensive care in the most effective and efficient manner possible. Communication between BH providers and medical healthcare providers such as PCPs, allows for comprehensive care, improves patient safety through collaboration, and reduces the negative consequences of disjointed care, such as risk of medication contraindications or medication errors.

Beacon initiated PCP/BH coordination efforts in 1997 and has since undertaken numerous initiatives to facilitate improved communication between BH providers and PCPs as well as BH providers and other mental health and substance use disorder (MH/SUD) providers and practitioners. Beacon monitors continuity of care between BH providers and PCPs and BH providers and other MH/SUD providers and practitioners by measuring BH provider compliance with Beacon’s communication tools and standards and analyzing the exchange of information.
Measures
1. Is there a signed release of information in the chart to release information to the primary care practitioner (PCP)? (N/A if there is documentation of the member’s refusal)
2. Is there a signed release of information in the chart to release information for other practitioners/stakeholders?
3. Is there evidence that the treatment provider contacted, collaborated, received clinical information from or communicated in any way with the PCP?
4. Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated in any way with the other BH providers and/or prescribers of medication?
5. Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated with EAP, schools and other agencies as applicable?

Methodology
Beacon conducts clinical chart reviews of high volume providers and practitioners on an annual basis. High volume providers are defined as those treating 100 or more unique members per year. High volume practitioners are defined as those treating 50 or more unique members per year. Beacon maintains a goal of reviewing 10 provider sites each year in some markets, but the number of charts reviewed at each site depends on overall volume of members. In other markets, where these thresholds are not met, Beacon audits charts from the top 10 percent of providers. Beacon’s Outpatient Clinical Chart Review Tool has been modified over time to capture data for quality improvement activities such as Alcohol and Other Drugs and Attention Deficit Hyperactivity Disorder, as well as for reporting requirements (ex. BH/PCP Coordination).

Chart reviews are generally conducted through desktop reviews. To ensure consistency and accuracy in the data collection process, inter-rater reliability (IRR) is measured prior to beginning each review.

After the chart review is complete and the results entered into the database, each provider receives an individualized feedback letter with information regarding their performances on each question (comparable to a report card). Providers may receive overall ratings of “excellent” (80 - 100 percent), “acceptable” (65 - 79 percent) or “other” (0 - 65 percent). If a provider receives a failing score, the provider may be audited again the following year. If a provider fails the chart review two years in a row, the provider is placed under a Corrective Action Plan (CAP). Providers frequently call for verbal feedback after receiving their “report cards,” regardless of how well they may have done on the review.

The 2019 Outpatient provider chart reviews will occur as follows:
1. The Quality Department will generate a random pull of member names and send the list of names to the provider sites at least two weeks in advance of each review.
2. An Outpatient Clinician will complete the entire tool for each chart reviewed.
3. Administrative staff or Quality staff will enter chart review results into the database periodically at points throughout the year.

Note: 2019 Chart Review data is currently being pulled. An updated copy of results will be shared in the July 2020 Annual Evaluation submission.

Data from FlexCare (Beacon’s proprietary information system) is used to monitor measure three. Clinicians elicit this information from concurrent review forms in FlexCare. The percent of episodes where consent to release information was given by the member and where the IP provider forwarded information to the member’s PCP is calculated for the measure.

Interventions completed
• Continue mandatory annual Beacon training for all Beacon Clinicians regarding documentation standards.
• Continue to emphasize during the New Provider Orientation Beacon’s expectation that providers work collaboratively with PCP’s, other BH providers, and community based organizations.
- Monitor provider performance using chart review process and send providers the results of their 2019 audits with suggestions to improve their scores on measures regarding communication with other BH provider and with PCPs.
- Continue to educate providers on the importance of PCP support and “peer-to-peer” support. Providers can call Beacon psychiatrists for advice on members and medication.
- Collaborate with the health plan to educate PCPs on collaborating with the member’s BH providers as well as availability of PCP Toolkit and other tools on Beacon website.
- Through provider bulletin, educate providers regarding importance of continuing and coordinating care between BH providers and PCPs and best practices to support continuity and coordination of care. The integration of treatments for BH and physical health conditions results in a coordinated system of care that supports the multifaceted needs of members, ensuring continuity of care, improved outcomes for patients, and an effective healthcare system.

### Results

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a signed release of information in the chart to release information to the primary care practitioner (PCP)? (N/A if there is documentation of the member’s refusal) (Chart Review**) (2017: Is there evidence in the chart that a Release of Information was obtained to communicate with the PCP?)</td>
<td>80%</td>
<td>50.0% (2/4)</td>
<td>85.7%* (12/14)</td>
<td>TBD</td>
</tr>
<tr>
<td>2. Is there a signed release of information in the chart to release information for other practitioners/stakeholders? (Chart Review**) (2017: Is there evidence in the chart that at least one Release of Information, Authorization, or Consent was obtained to speak with at least one other OP mental health or OP substance abuse treatment provider?)</td>
<td>80%</td>
<td>80.0% (4/5)</td>
<td>92.3%* (12/13)</td>
<td>TBD</td>
</tr>
<tr>
<td>3. Is there evidence that the treatment provider contacted, collaborated, received clinical information from or communicated in any way with the OP treatment provider received information, communicated with the PCP?)</td>
<td>80%</td>
<td>0.0% (0/3)</td>
<td>69.2% (9/13)</td>
<td>TBD</td>
</tr>
<tr>
<td>4. Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated in any way with the other BH providers and/or prescribers of medication? (Chart Review**) (2017: Is there evidence that the OP treatment provider received clinical information, communicated with the PCP?)</td>
<td>80%</td>
<td>50.0% (2/4)</td>
<td>53.8% (7/13)</td>
<td>TBD</td>
</tr>
</tbody>
</table>


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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>5. Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated with EAP, schools and other agencies as applicable? (Chart Review</strong>)**</td>
<td>TBD</td>
<td>100.0% (2/2)</td>
<td>36.4% (4/11)</td>
</tr>
<tr>
<td><strong>(2017: Is there evidence that the OP treatment provider contacted, collaborated, received clinical information from or communicated in any way with any state agencies or schools, community outlets, etc.?)</strong></td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note: Starting 2018, Beacon has added new questions, as well as, removed age range from Treatment Record Review process in order to broaden the scope of the reviews. Most of the questions have been rephrased as indicated by the inclusion of previous year questions.**

**Result Analysis**

2019 Chart Review data is currently being collected. Beacon will be providing an updated 2019 Annual Evaluation for SFHP by July 2020 submission.

**Barrier Analysis**

Currently pending Chart Audit data for 2019.

**Next Steps**

Currently pending Chart Audit data for 2019.

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**SERVICE IMPROVEMENT ACTIVITIES**

**Appointment Accessibility and Availability**

**Goal**
To improve member accessibility to medically necessary behavioral health ambulatory care that meets timeliness standards for the individual’s perceived urgency of the situation and physical access standards as well.

**Interventions Implemented**

- Develop corporate wide A&A QIA focusing on designing and implementing improvements in areas that Beacon identifies as key thus improving quality of care and services for our members, providers and health plan.
- Outpatient team identifies appointment for member and instructs member to contact provider directly to secure appointment. To ensure member was able to obtain appointment, Outpatient team will contact provider’s office to confirm member has scheduled appointment.
- Continue to educate members through Appointment Assistance Checklist training Guide. This guide contains information on transportation options through the health plans, interpreter services and psych testing request (linkage to a therapist).
- Create Access and Availability weekly workgroup involving Outpatient Department, Appointment Assistance team, and Network Development team to discuss and address any barriers the teams may be facing.
- Continue quarterly analysis of geographic and specialty needs to inform network recruitment strategies.
- Implemented Access and Availability weekly workgroup involving Outpatient Department, Appointment Assistance team, and Network Development team to discuss and address access concerns and where to focus recruiting efforts.
- Recruited new staff to increase efforts in assisting members with timely appointments. New staff is currently being trained and transitioned to assist with appointment scheduling. (Q1 2019)
- Live calls will be transferred from member services to outpatient services team to provide appointment assistant to members, hence assisting more members with urgent, emergent and routine appointments.
- Continue quarterly provider survey to capture providers’ availability to see members within 6 hours, 48 hours and 10 business days as well as provider and staff language/cultural capability and specialty.
- Create new workflow in regards to appointment assistance. Live calls will be transferred from member services to outpatient services team to provide appointment assistant to members, hence assisting more members with urgent, emergent and routine appointments.
- Training of Beacon staff in capturing telehealth (when appropriate) in order to report on accurate timeliness within full network.
- Ongoing workgroup with PR/Contracting to discuss access issues and where to focus recruiting efforts.
- Contacting providers on “HOLD” who appear to be accepting referrals but were not lifted from the HOLD – exhausting network options.
- [Targeting Providers] Using NetMinder to pull data from provider directories of other health plans. Compare list of providers form NetMinder with our Network.

**Results**

a. Appointment Assistance Data:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
b. Member Satisfaction Data:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was Beacon able to refer you to the care you needed within 6 hours?</td>
<td>85%</td>
<td>54.0% (27/50)</td>
<td>N/A</td>
<td>TBD</td>
</tr>
<tr>
<td>2. Was Beacon able to refer you to the care you needed within 48 hours?</td>
<td>85%</td>
<td>60.4% (32/53)</td>
<td>76.0% (19/25)</td>
<td>TBD</td>
</tr>
<tr>
<td>3. Were you offered your first appointment within 10 business days of your call?</td>
<td>85%</td>
<td>78.2% (93/119)</td>
<td>88.5% (46/52)</td>
<td>TBD</td>
</tr>
</tbody>
</table>

Number of complaints regarding access to care per 1,000 members

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints regarding access to care per 1,000 members</td>
<td>&lt;1/1,000</td>
<td>4 (0.032/1,000 members)</td>
<td>4 (0.025/1,000 members)</td>
<td>9 (0.058/1,000 members)</td>
</tr>
</tbody>
</table>

d. Provider Availability through GeoAccess analysis:

See GeoAccess report (Miles and Minutes)

Result Analysis

Appointment Assistance data:
In 2019, there were no non-life-threatening Emergent (6 hour) or Urgent (48 hours) requests received. Overall, 100.0% of the Routine (10 Business days) appointment assistance requests were met for 2019, an improvement since 2016 and 2017. For non-prescriber requests, twenty-five (25) out of twenty-five (25) members were able to receive therapist services within 10 business days.

Member Satisfaction Survey:
The 2019 Member Satisfaction Survey results will be available by July 2020 submission.

Member Complaints:
In 2019, there were nine (9) grievances received by Beacon regarding Access to Care which meets the target of less than 1 grievance per 1,000 members.

GeoAccess data:
Detailed provider availability data based on GeoAccess data is available in a separate GeoAccess report, which will be available for the July 2020 submission.

Barrier Analysis

- Providers’ availability in providing appointments within 10-business day timeframe.
- Provider not returning voicemails on timely basis.
- Providers’ availability to accept new members due to members cancelling appointments or “no show”.
- Lack of accurate and timely information regarding provider availability
- Provider insufficiency in certain service areas that meet specific prescribing, cultural, or language needs
- Members may be unaware that Beacon staff can assist with procuring appointments
- Members refusing 1st available appointment within 10 business day due to their unavailability
- Members accepting appointments outside of 10 business day timeframe
- Ensuring providers understand their contractual obligations in regards to appointment availability timeframes
- Improving appointment accessibility information in FlexCare
- Members who are not able to obtain a timely appointment may forgo treatment

Next Steps

- Continue to educate members through Appointment Assistance Checklist training Guide. This guide contains information on transportation options through the health plans, interpreter services and psych testing request (linkage to a therapist).
- Continue quarterly provider access and availability survey to ensure providers are available to take members within the 6-hour, 48-hour, and 10 business day time frames and Beacon directory is updated with real time data.
- Review criteria for admitting providers to the network, and updating as warranted.
- Analyze out of network utilization data to identify specialty, cultural, and linguistic recruitment needs and bring providers in network.
- Active recruitment of prescribers, child psychiatrists, and other providers based on specialty, cultural/linguistic, and geographic needs
- Ensure that members are aware of Beacon’s availability to assist in obtaining appointments when member is unable to secure an appointment
- Continue to conduct targeted follow up with providers who are non-responsive to quarterly provider access surveys through email software.
- Continue to explore various means of capturing appointment accessibility data such as through complaints, claims, appointment request and survey.
- Analyze data from the Aftercare Module regarding emergent, urgent, and routine appointment assistance requests, to allow for real time analysis of appointment availability
- In addition to corporate wide A&A QIA, continue local workgroup to discuss and address California specific access issues.
- Continue publishing articles in the Provider Bulletin around Beacon’s access standards.

Telephone Access

Goal
To maintain the rate at which member and provider calls are answered in a timely manner and reduce the rate that calls are abandoned.

Background
The key challenge of a call center in the United States healthcare industry is balancing the business needs of the plan and healthcare needs of the patient. In the rapidly changing landscape of American healthcare and in the call center industry, key performance indicators were identified as telephone call abandonment rates, percent of calls answered within 30 seconds and average speed to answer. Total call volume is also tracked in order to identify trends and areas for improvement regarding staffing and training.

Maintaining appropriate staffing ratios, including employing enough full-time and back-up staff for times of increased call volume, is a major contributor in ensuring easy telephone access, thus improving patient outcomes. Focusing on staff retention as a method for minimizing service disruption also contributes to easy telephone access. Due to staff turnover, it is important that Beacon maintains organized, on-going training programs. The necessity in mental health for call center staff to be seen as knowledgeable is paramount to effectiveness.

**Measures**

1. Percent of calls abandoned
2. Percent of calls answered within 30 seconds
3. Average speed of answer in seconds (ASA)
4. Total call volume

**Methodology**

Beacon uses the Avaya Phone System to capture all data for the Telephone Access measures.

**Interventions Implemented**

- Continue to audit Member Service Representatives to ensure call accuracy and documentation accuracy in FlexCare.
- Through Member Services Claims Resolution team, continue addressing claims related calls in order to resolve all issues in timely manner and continue to improve member and provider satisfaction.

**Results**

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Call Abandonment Rate</td>
<td>≤ 5%</td>
<td>0.1%*</td>
<td>0.16%</td>
<td>0.86%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2/2,838)</td>
<td>(4/2,528)</td>
<td>(17/1,979)</td>
</tr>
<tr>
<td>2. % Answered Within 30 Seconds</td>
<td>≥ 80%</td>
<td>96.3%*</td>
<td>96.2%</td>
<td>85.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2,734/2,838)</td>
<td>(2,432/2,528)</td>
<td>(1,687/1,979)</td>
</tr>
<tr>
<td>3. Average Seconds To Answer</td>
<td>≤ 30 Seconds</td>
<td>3.9*</td>
<td>3.8</td>
<td>12.7</td>
</tr>
<tr>
<td>4. Call Volume</td>
<td>NA</td>
<td>2,838</td>
<td>2,528</td>
<td>1,979</td>
</tr>
</tbody>
</table>

*Statistically significant change from the previous reporting period using z-test for proportions at p<0.05

**Result Analysis**

Interventions implemented throughout the year continue to demonstrate improvement in performance metrics. Targets for call abandonment rate, percent of calls answered within 30 seconds and average seconds to answer exceeded established goals as of October 2019. It is important to note that percent of calls answered within 30 seconds was around 85.3% in 2019. Telephone data only includes counts from Quarter 1 to Quarter 3 (January to September) of 2019.

**Barrier Analysis**

- No barriers identified.
Opportunities for Improvement
- Ensure all MSRs are cross trained on all lines of business.

Next Steps
- Continue to train MSRs on all lines of business to act as back-up to health plan specific teams.
- Ensure that Call Center Representatives are consistently providing professional, courteous customer service by regularly monitoring their calls in the areas of customer service skills (i.e., proper greeting and closing), telephone skills (i.e., proper call transfer and hold procedures), accuracy of information given, and proper documentation.
- Continue vigorous training process, incorporating quality topics, and developing new training materials as necessary. Evaluations will continue as part of the training process.
- Continue to provide quarterly workflow refresher trainings to member services (Ongoing).
- Continue MSR auditing process to ensure call accuracy and documentation accuracy in operating systems.

Cultural and Linguistic Program

Goal
To assess and improve healthcare quality and equity by reducing health care disparity, and to deliver culturally and linguistically appropriate health care services to its member population.

Background
The Beacon Cultural & Linguistic Program was developed in accordance with National Standards for Culturally and Linguistically Appropriate Services in Health Care, as published by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH); the Federal Plain Language Guidelines, published by PlainLanguage.gov; Measuring Knowledge and Health Literacy Among Medicare Beneficiaries, published by the Centers for Medicare and Medicaid Services Office of Research; Section 1300.67.04 of Title 28 California Code of Regulations and 2010 NCQA Multicultural Health Care Standards and Guidelines.

The C&L Program assesses the ethnicity and language profiles of Beacon’s membership in addition to provider and practitioner networks Member satisfaction regarding cultural and linguistic needs and preferences is measured through questions related to the topic on the annual Member Satisfaction Survey and satisfaction improvement is determined by Member Satisfaction Survey rate trending from year to year. Survey results illustrate whether or not Beacon staff and network resources meet members’ cultural and linguistic needs and preferences.

Measures/Methodology/Data Sources
The following data sources were used to assess practitioner, provider, and Beacon’s cultural and linguistic profile:

1. FlexCare provider module in which providers’ languages and ethnicities are documented as reported by providers on their network applications, by phone, or the provider directory questionnaire, if available. This information is voluntary; therefore, self-reported demographic data may not accurately represent the cultural and linguistic characteristics of the provider network.

2. Beacon staff languages are captured on the day of hire through the human resources department, if staff choose to report.

Interventions Implemented
- Continue annual training for Beacon staff on Cultural and Linguistic program.
- Continue mandatory annual training for providers on Cultural and Linguistic program.
- Continue to update and distribute the Cultural and Linguistic Provider Toolkit with resources for providers such as summary of Beacon’s Cultural and Linguistic program, provider language skills self-assessment tool and other educational materials.
- Continue to update and distribute the Cultural and Linguistic Staff Toolkit with resources for staff such as summary of Beacon's Cultural and Linguistic program, employee language skills self-assessment tool and other educational materials.
- Administer Member Satisfaction Survey to assess member satisfaction with Beacon staff and network provider’s cultural sensitivity and implement interventions when needed.
- Perform cultural linguistic analysis of the Beacon provider network. Based on the analysis, identify opportunities for improvement, and implement interventions to improve the Beacon network.
- As indicated by analysis of provider network, conduct direct recruitment of providers to address gaps, and consider opportunities for expedited credentialing to meet critical needs.

### Results

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utilization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Number and percentage of calls (SFHP) to Beacon that used language interpreter services</td>
<td>NA</td>
<td>33.1%</td>
<td>32.7%</td>
<td>34.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(939/2838)</td>
<td>(826/2,528)</td>
<td>(609/1,754)</td>
</tr>
<tr>
<td>2. The rate of members who requested written translation services</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0)</td>
<td>(0)</td>
<td>(0)</td>
</tr>
<tr>
<td>3. The percentage of Beacon staff that are bilingual</td>
<td>NA</td>
<td>21.1%</td>
<td>23.3%</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(84/399)</td>
<td>(81/348)</td>
<td></td>
</tr>
<tr>
<td><strong>Turnaround Time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The percentage of time that the TTY/TTD services and foreign language interpretation were available when needed by members who called the Beacon’s customer service phone line (CMS measure)</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>2. The percentage of time member materials were made available to members in the language they requested within 21 calendar days of request</td>
<td>95%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0/o)</td>
<td>(0/o)</td>
<td>(0/o)</td>
</tr>
<tr>
<td><strong>Member Satisfaction Survey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The percentage of members that responded “Yes or No” to member satisfaction question: Do you feel your counselor has met your cultural, religious, or language needs?</td>
<td>85%</td>
<td>89.7%</td>
<td>86.6%</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(104/116)</td>
<td>(97/112)</td>
<td></td>
</tr>
<tr>
<td>2. The percentage of members that responded “Yes or No” to member satisfaction question: In getting mental health services, did you need interpreter or translation services?</td>
<td>NA</td>
<td>9.3%</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(12/129)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2a. The percentage of members that responded “Yes or No” to member satisfaction survey question: Did Beacon have these services immediately available for you?</td>
<td>85%</td>
<td>88.5%</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(54/61)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Complaints and Grievances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Number of grievances per 1,000 members that are around cultural and linguistic issues | <1/1,000 members | NA (o) | NA (o) | NA (o)

*Statistically significant change from the previous reporting period using z-test for proportions at p<0.05

Note: Member Satisfaction survey for 2018 had many questions that could not be trended for 2016 and 2017.

**Result Analysis**

**Utilization:**
The rate that SFHP members utilized language interpreter services in 2019 was 34.7% of all SFHP callers, an increase of two percentage points from 2017. This increase can be attributed to education of members, providers and Beacon staff around the availability to provide interpreter services.

**Turnaround Time:**
There were no requests for materials to be translated into another language in 2019 by SFHP members.

**Member Satisfaction:**
The 2019 Member Satisfaction Survey results will be available summer of 2020.

**Grievances/Complaints:**
There were no grievances related to Cultural and Linguistic issues in 2019.

**Barrier Analysis**
- Members may not be aware of interpretative service offered by Beacon.
- Members may not be aware that they can have materials translated by Beacon.

**Next Steps**
- Continue to review and distribute the Cultural and Linguistic Toolkit for providers and staff.
- Continue to update and distribute the Cultural and Linguistic Provider Toolkit with resources for providers such as summary of Beacon’s Cultural and Linguistic program, employee language skills self-assessment tool and other educational materials (Semi-annually).
- Continue annual training for Beacon staff on Cultural and Linguistic Program.
- Continue conducting monthly training for network providers on Beacon’s requirement around program.
- Field Member Satisfaction Survey quarterly.
- Continue to track and trend grievances and complaints for cultural and linguistic concerns.
- Continue to share articles with providers regarding the importance of providing culturally and linguistically appropriate services.
PATIENT SAFETY

Timeliness of Handling Member Complaints

Goal
To ensure member needs are met and grievances are resolved in a timely manner.

Background
As part of the overall effort to assess and improve member and practitioner satisfaction with its health plans, Beacon collects and analyzes data from the complaint and appeals processes. This data is included in Beacon’s Core Performance Indicator System and is reviewed monthly and annually by senior management.

Measures
1. Number of complaints by category:
   a. Quality of Care
   b. Access to Care
   c. Beacon Internal Process
   d. Billing and Financial Issues
   e. Attitude and Service
   f. Quality of Office Site
2. Percent of complaints resolved within timeframe (30 calendar days for Routine; 72 hours for Urgent)

Methodology
Complaints and appeals data is analyzed from the universe of complaints and appeals received by Beacon during the measurement period. Complaints and appeals resolution times are tracked on a continuous basis for each complaint and appeal received.

Interventions Implemented
- Continue to provide training to Member Services staff, Clinical, and co-located teams regarding the grievance process.
- Educated and trained all Western Region staff regarding grievances (September 2018).
- Initiate corporate-wide member complaints/ grievances/ inquiries QIA to better track and resolve member inquiries that continues to be a challenge.
- Continue expanding Telehealth program, both site based as well as home based.
- Continued network expansion including working with out of network providers to encourage them to join the network.

Results

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of complaints by category:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Quality of Care</td>
<td>1/1,000</td>
<td>7 (0.056)</td>
<td>6 (0.038)</td>
<td>13 (0.084)</td>
</tr>
<tr>
<td>b. Access to Care</td>
<td></td>
<td>a. 0</td>
<td>a. 0</td>
<td>a. 0</td>
</tr>
<tr>
<td>c. Beacon Internal Process</td>
<td></td>
<td>b. 4 (0.032)</td>
<td>b. 4 (0.025)</td>
<td>b. 9 (0.058)</td>
</tr>
<tr>
<td>d. Billing and Financial Issues</td>
<td></td>
<td>c. 2 (0.016)</td>
<td>c. 1 (0.006)</td>
<td>c. 3 (0.019)</td>
</tr>
<tr>
<td>e. Attitude and Service</td>
<td></td>
<td>d. 0</td>
<td>d. 0</td>
<td>d. 0</td>
</tr>
<tr>
<td>f. Quality of Office Site</td>
<td></td>
<td>e. 1 (0.008)</td>
<td>e. 1 (0.006)</td>
<td>e. 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. 0</td>
<td>f. 0</td>
<td>f. 0</td>
</tr>
<tr>
<td>2. Percent of complaints resolved within timeframe (30 CD for</td>
<td>95%</td>
<td>100% (7/7)</td>
<td>83.3% (5/6)</td>
<td>100.0% (13/13)</td>
</tr>
</tbody>
</table>
Results Analysis
There were thirteen (13) member complaints that Beacon received in 2019, all were resolved within 30 day timeframe.

Barrier Analysis
- Provider lack of understanding regarding the importance of timely and accurate reporting.
- Internal process barriers at provider sites that result in reporting delays or lack of reporting.
- Difficulty obtaining investigative details or resources needed to conclude investigations.

Next Steps
- Continue to provide quarterly education to Beacon’s member services team as well as clinical staff to offer grievances to members.
- Continue presenting grievances to the SFHP GRC as they are received.
- Continue to monitor provider performance related to complaints and report to credentialing committee for review as needed.

Timeliness of Incident Reporting

Goal
To enhance member safety and quality of clinical care by tracking and reporting on Adverse Incidents (AIs) and Quality of Care (QOC) issues.

Background
In the United States, an AI occurs in every 2.9 to 3.7 percent of hospital admissions. The estimated number of deaths associated with these incidents is between 44,000 to 98,000 per year. Reporting AIs can help target major medical errors that might be taking place on a regular basis. However, many incidents go unreported and estimates of the total number can be much lower than what is conveyed. This could lead to more injuries and deaths that could have been prevented.

Measures
1. Total number of adverse incidents reported during the year
2. Number of adverse incidents by type
3. Adverse Incident rates per 1,000 members
4. Timeliness of incident reporting

Methodology
Beacon Ombudspersons monitor and track the safety and well-being for members in active behavioral health facilities (ex. inpatient, partial hospitalization, and residential treatment) by investigating concerns through the adverse incident reporting process. Beacon becomes aware of incidents through a variety of mechanisms, including internal Utilization Management and Case Management reviews, and directly from providers that are contractually required to report such incidents to Beacon. Once an incident has occurred, Beacon collaborates with providers to understand why and how the incident occurred, where it occurred, and what measures were taken to improve safety and prevent reoccurrence. Incidents could include, but are not limited to:

- Absence without authorization (AWA) of an unstable/at risk member
- Any serious injury in a treatment setting resulting in urgent/emergent interventions
- Falls with serious consequences
- Human Rights Violations
- Illegal activity
- Medication/treatment errors
- Others occurrences
- Potential Compensatory Event (PCE)
• Property damage
• Self-inflicted harm
• Serious adverse reaction to BH treatment
• Significant sexual behavior
• Suicide attempt
• Tarasoff (CA law)
• Unanticipated death – Accident (motor vehicle/work/home)
• Unanticipated death - Accidental overdose
• Unanticipated death – Natural causes/Disease process
• Unanticipated death – Suicide
• Unanticipated death – Unable to determine
• Unplanned transfers to a medical unit
• Unscheduled event that results in the evacuation of a program or facility
• Violent/assaultive behavior with physical harm to self or others

Interventions Implemented

• Continue to educate new providers on timely notification of AI’s and QOC’s through the new provider orientation training.
• Continue to educate and train Member Services, Clinical, and co-located staff regarding AI reporting and QOC concerns including the need for timely notification to external agencies and Quality Department.
• Continue to produce analysis of AI and QOC trends.
• Continue to review, investigate, track, and trend all AIs and potential QOC issues and act on identified patterns of patient safety violations.

Results

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of reportable events that are reported and reviewed within specified time frames (reported to plan within 24 hours)</td>
<td>95%</td>
<td>NA (0/0)</td>
<td>NA (0/0)</td>
<td>NA (0/0)</td>
</tr>
<tr>
<td>Percentage of Quality of Care concerns that are resolved within 30 days</td>
<td>95%</td>
<td>NA (0/0)</td>
<td>NA (0/0)</td>
<td>NA (0/0)</td>
</tr>
</tbody>
</table>

Results Analysis

There were no reportable events or QOC concerns reported for SFHP members by October 2019.

Barrier Analysis/ Opportunities for Improvement

• Provider lack of understanding regarding the importance of timely and accurate reporting.
• Internal process barriers at provider sites that result in reporting delays or lack of reporting.
• Difficulty obtaining investigative details or resources needed to conclude investigations.
• Varied state regulations and plan requirements regarding the reporting of adverse incidents

Next Steps

• Continue current activities and monitoring.
• Continue to produce analysis of AI and QOC trends.
• Continue to provide ongoing training and support to Beacon staff regarding the reporting and investigation of AIs and other reportable incidents (Quarterly).
• Educate providers regarding patient safety and reporting timeframe standards for AIs and other reportable incidents.
• Continue to educate new providers on timely notification of AI’s and QOC’s through the new provider orientation training.

EVALUATION OF THE EFFECTIVENESS OF THE QUALITY PROGRAM

Summary of Strengths include:

Beacon implemented several targeted interventions in 2019. As a result, Beacon demonstrated improvements in some areas and identified areas for improvement in others.

Clinical Quality Improvement Initiatives

Depression:
For 2019, the rate at which members ages 18 years and older received two or more outpatient therapy visits within 84 days of their diagnoses met the goal of 50%. The medication visit scores in comparison were met. These scores will be further impacted due to claims lag and unavailability of data from remainder of the year.

In addition, the data would not capture those members who are receiving antidepressant medication from their PCPs. Beacon does not manage these benefits and therefore is unable to track whether or not these members had a visit within the measure timeframe.

Service Improvement Initiatives

Telephone Access:
During 2019, call metrics including Abandonment Rate, Average Speed to Answer and Percent of Calls Answered within 30 Seconds met and exceeded established goals. Beacon attributes the improvement to the interventions implemented by Member Services throughout the year including investments in technology, health plan specific teams, and four team leads added to improve efficiency and increase knowledge of membership specific needs.

Appointment Accessibility and Availability:
Appointment accessibility is measured through five areas: Appointment Assistance, claims based Follow-up Routine Care, Member Satisfaction Survey, Member Complaints, and GeoAccess. According to appointment accessibility data, 100.0%% of members requesting Routine appointments (within 10 business days) were able to see a non-prescribing provider exceeding the 85% target. Complaints data regarding access and availability was also below the threshold.

Cultural and Linguistic Program:
The effectiveness of the Cultural and Linguistic Program is measured through utilization of interpreter services, turnaround time of translated document requests, Member Satisfaction survey results, and Grievance and Complaints related to cultural and linguistic services. To meet the cultural and linguistic needs of non-English speaking members, Beacon increased the number of bi-lingual staff to 81 in Cypress office that work directly with members in 2018. It is noteworthy to mention that an increased percent of members calling Beacon used language assistance interpreter services during 2018 compared to 2017. 2019 data is currently pending and further analysis will be provided in the July 2020 Annual Evaluation.

Patient Safety

Member Complaints:
In 2019, there were nine (9) grievance received by Beacon regarding Access to Care which meets the target of less than 1 grievance per 1,000 members. The Beacon Quality team continues to provide quarterly training regarding grievances to all member facing staff, including Member Services and Clinical teams.
Priorities for the 2020 Quality Program include:

Depression:
Beacon will continue collaborating with health plans on sharing of HEDIS rate including member level details. Efforts toward making providers aware of the AMM measures and encouraging the use of the PHQ-9 assessment tool will be continued in 2020. Additionally, Beacon will also focus on depression screening and monitoring for adolescents and post-partum members.

Attention Deficit Hyperactivity Disorder (ADHD):
Beacon will select high volume providers who specifically treat children ages 6-12 to gather sufficient chart review based ADHD metrics. This data will be used to identify poor performers and provide feedback and education as needed. Beacon will also collaborate with the health plan on HEDIS ADD rate and possible real time interventions. Beacon will also identify newly diagnosed or prescribed members through behavioral health claims, then track and remind them of the follow-up appointments, as well as send educational material to treating providers.

Continuity and Coordination of Care:
Beacon will continue to focus on collaborating and expanding the local Continuity and Coordination of Care QIA with other Beacon Regional Offices to share best practices and develop new member centered interventions between BH providers and medical professionals as BH to BH and community based services.

Appointment Accessibility:
Efforts in 2019 will be focused on educating providers regarding standards for non-life threatening Emergent, Urgent, and Routine appointments. Beacon will continue to capture provider availability through quarterly provider surveys and update the provider directory with current availability, language and specialty in real time. Beacon will continue to utilize the company wide and local QIA around Access Availability to address California specific access issues. In addition, efforts will be made to continue adherence to access standards via the appointment assistance provided by Beacon staff. Beacon will continue to work towards expanding the Telehealth program.
**ATTACHMENT 1**

Note: 2019 Treatment Record Review data is currently being collected. Beacon will be providing an updated 2019 Annual Evaluation for SFHP once Chart Audit data is available.

### Treatment Record Review

<table>
<thead>
<tr>
<th>Measure**</th>
<th>Goal</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Intake and/or Assessments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Is the reason for admission/beginning of treatment documented?</td>
<td>NA</td>
<td>100.0% (14/14)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>2 Is there consent or refusal from member, either verbal or written, to participate in treatment?</td>
<td>95.0% (19/20)</td>
<td>85.7% (12/14)</td>
<td>95.0% (19/20)</td>
<td>TBD</td>
</tr>
<tr>
<td>(2017: Appropriate informed treatment consent form(s); parent or guardian consent for treatment of minor; include office policies regarding scheduling and financial responsibility)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Cultural and linguistic needs addressed?</td>
<td>NA</td>
<td>90.0% (9/10)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>4 Medical history and current conditions are indicated?</td>
<td>65.0% (13/20)</td>
<td>90.9% (10/11)</td>
<td>65.0% (13/20)</td>
<td>TBD</td>
</tr>
<tr>
<td>(2017: Is past medical history easily identified? If not significant medical history, is this noted?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B</strong> Medication Safety (when prescribed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Medications are documented to the standard in the provider manual including allergies?</td>
<td>60.0% (12/20)</td>
<td>88.9% (8/9)</td>
<td>60.0% (12/20)</td>
<td>TBD</td>
</tr>
<tr>
<td>(2017: Are medication allergies and adverse reactions prominently noted in the record? If the member has no known allergies or adverse reactions, are these noted?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Monitoring adherence to medication is evident?</td>
<td>NA</td>
<td>100.0% (4/4)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>C</strong> General Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Adequate risk assessment is completed?</td>
<td>50.0% (10/20)</td>
<td>71.4% (5/7)</td>
<td>50.0% (10/20)</td>
<td>TBD</td>
</tr>
<tr>
<td>(2017: Mental Status Exam includes affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 When risks are identified, interventions are prompt and appropriate?</td>
<td>55.0% (11/20)</td>
<td>78.6% (11/14)</td>
<td>55.0% (11/20)</td>
<td>TBD</td>
</tr>
<tr>
<td>(2017: All risk factors (SI, H/I, CD, History of non-compliance) noted with appropriate intervention and care plan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Was a formal tool used to complete risk assessments?</td>
<td>20.0% (4/20)</td>
<td>85.7% (12/14)</td>
<td>20.0% (4/20)</td>
<td>TBD</td>
</tr>
<tr>
<td>Measure**</td>
<td>Goal</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>(2017: Is there evidence that an outcome tool was utilized in determining the member’s treatment plan?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>For Outpatient services, when applicable, there are outreach attempts when a member misses an appointment?</strong></td>
<td>NA</td>
<td>66.7% (8/12)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Comprehensiveness of Record (Age at Intake)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence the member was screened for Alcohol or other substance use? (2017: Is there documentation that the member was screened for alcohol or other drug abuse or dependence? (15+))</td>
<td>68.8% (11/16)</td>
<td>72.7% (8/11)</td>
<td>68.8% (11/16)</td>
<td>TBD</td>
</tr>
<tr>
<td>Is the member engaged in ongoing substance treatment?</td>
<td>NA</td>
<td>66.7% (6/9)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>If the member screened positive for substance use, was this addressed on an ongoing basis? (2017: If the member screened positive, was treatment for AOD included in the treatment plan?)</td>
<td>25.0% (1/4)</td>
<td>0.0% (0/3)</td>
<td>25.0% (1/4)</td>
<td>TBD</td>
</tr>
<tr>
<td>If member screened positive for SU, was member educated on Medication Assisted Treatment (MAT) services as applicable?</td>
<td>NA</td>
<td>0.0% (0/1)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>If member screened positive for SU- was family involved in treatment? (2017: If the member screened positive for alcohol or other substance abuse/dependence, was there family involvement in the treatment?)</td>
<td>25.0% (1/4)</td>
<td>42.9% (3/7)</td>
<td>25.0% (1/4)</td>
<td>TBD</td>
</tr>
<tr>
<td>For OP services- Is there evidence the member was screened for Depression using the PHQ-9 or PHQ-9A?</td>
<td>NA</td>
<td>8.3% (1/12)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>For OP services-When required, if the member is age 18 or older, diagnosed with depression or dysthymia, was the PHQ-9 tool used to monitor progress of treatment? (2017: For members age 18 or older diagnosed with depression or dysthymia: Was the PHQ-9 tool used to monitor progress of treatment?)</td>
<td>0.0% (0/3)</td>
<td>40.0% (2/5)</td>
<td>0.0% (0/3)</td>
<td>TBD</td>
</tr>
<tr>
<td>Is there evidence the member was screened for ADHD when relevant? (2017: If the member is 6-12, was the member assessed for ADHD?)</td>
<td>0.0% (0/4)</td>
<td>87.5% (7/8)</td>
<td>0.0% (0/4)</td>
<td>TBD</td>
</tr>
<tr>
<td>If Member screened positive for</td>
<td>NA (o/o)</td>
<td>50.0% (3/6)</td>
<td>NA (o/o)</td>
<td>TBD</td>
</tr>
<tr>
<td>Measure**</td>
<td>Goal</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
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</tr>
<tr>
<td>ADHD, was there a referral for a medication evaluation? (2017: If the member is 6-12 and diagnosed with ADHD, is there evidence that s/he was referred to or participated in a medication evaluation?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Member screened positive for ADHD, was family involved in treatment? (2017: If the member is 6-12 and screened positive for ADHD, was there family involvement in treatment?)</td>
<td>NA (0/0)</td>
<td>85.7% (6/7)</td>
<td>NA (0/0)</td>
<td>TBD</td>
</tr>
<tr>
<td>Other Screenings if applicable are identified?</td>
<td>NA</td>
<td>72.7% (8/11)</td>
<td>NA</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**F Clinical Formulation**

<p>| | | | | |</p>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1 Member meets level of care criteria throughout treatment?</td>
<td>NA</td>
<td>91.7% (11/12)</td>
<td>NA</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**G Treatment Plans**

<p>| | | | | |</p>
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<tr>
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</thead>
<tbody>
<tr>
<td>1 Member has been involved in the treatment planning.</td>
<td>NA</td>
<td>85.7% (12/14)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>Is treatment consistent with presenting symptoms and diagnosis? (2017: The DSM-IV Diagnosis is documented that is consistent with the presenting problems, history, mental stats examination and/or other assessment data.)</td>
<td>NA</td>
<td>70.0% (14/20)</td>
<td>85.7% (12/14)</td>
<td>70.0% (14/20)</td>
</tr>
<tr>
<td>Are objectives and goals measurable? (2017: Treatment plans demonstrate objective and measurable goals?)</td>
<td>NA</td>
<td>70.0% (14/20)</td>
<td>64.3% (9/14)</td>
<td>70.0% (14/20)</td>
</tr>
<tr>
<td>Are there timeframes for goal attainment or problem resolution? (2017: Does the treatment plan include short term time frames for goal attainment or problem resolution?)</td>
<td>NA</td>
<td>70.0% (14/20)</td>
<td>42.9% (6/14)</td>
<td>70.0% (14/20)</td>
</tr>
<tr>
<td>When applicable, the record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the individuals unless contraindicated? (contraindications must be noted)</td>
<td>NA</td>
<td>80.0% (8/10)</td>
<td>NA</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**H Discharge**

<p>| | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1 Barriers to discharge were addressed timely?</td>
<td>NA</td>
<td>62.5% (5/8)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>2 Medical follow up is included in discharge when applicable?</td>
<td>NA</td>
<td>100.0% (2/2)</td>
<td>NA</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**I Progress Notes (PN)**

<p>| | | | | |</p>
<table>
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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1 Include skilled clinical interventions or techniques used by provider?</td>
<td>NA</td>
<td>62.5% (5/8)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>2 Are goals directed &amp; focused on</td>
<td>70.0%</td>
<td>85.7%</td>
<td>70.0%</td>
<td>TBD</td>
</tr>
<tr>
<td>Measure**</td>
<td>Goal</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
</tr>
<tr>
<td>-----------</td>
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<td>------</td>
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<td>------</td>
</tr>
</tbody>
</table>
| treatment objectives?  
(2017: Progress notes are goal directed and focused on treatment objectives?) | (14/20) | (12/14) | (14/20) | |
| There is adherence to best practices in documentation (e.g. patient name on each page/electronic form, all notes are signed, signatures of staff include credentials etc.)? | NA | 50.0% (7/14) | NA | TBD |
| **J Coordination of Care** | | | | |
| Is there a signed release of information in the chart to release information to the primary care practitioner (PCP)? (N/A if there is documentation of the member's refusal)  
(2017: Is there evidence in the chart that a Release of Information was obtained to communicate with the PCP?) | 50.0% (2/4) | 85.7% (12/14) | 50.0% (2/4) | TBD |
| Is there a signed release of information in the chart to release information for other practitioners/stakeholders?  
(2017: Is there evidence in the chart that at least one Release of Information, Authorization, or Consent was obtained to speak with at least one other OP mental health or OP substance abuse treatment provider?) | 80.0% (4/5) | 92.3% (12/13) | 80.0% (4/5) | TBD |
| Is there evidence that the treatment provider contacted, collaborated, received clinical information from or communicated in any way with the PCP?  
(2017: Is there evidence that the OP treatment provider received information, contacted, collaborated, or in any way, communicated with the PCP?) | 0.0% (0/3) | 69.2% (9/13) | 0.0% (0/3) | TBD |
| Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated in any way with the other BH providers and/or prescribers of medication?  
(2017: Is there evidence that the OP treatment provider received clinical information, contacted, collaborated, or in any way, communicated with another OP provider regarding member's clinical care?) | 50.0% (2/4) | 53.8% (7/13) | 50.0% (2/4) | TBD |
<p>| Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated | 100.0% (2/2) | 36.4% (4/11) | 100.0% (2/2) | TBD |</p>
<table>
<thead>
<tr>
<th><strong>Measure</strong></th>
<th><strong>Goal</strong></th>
<th><strong>2017</strong></th>
<th><strong>2018</strong></th>
<th><strong>2019</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>with EAP, schools and other agencies as applicable?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2017: Is there evidence that the OP treatment provider contacted, collaborated, received clinical information from or communicated in any way with any state agencies or schools, community outlets, etc.?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>K Measurement Based Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Measurement-based care is evident?</td>
<td>NA</td>
<td>42.9% (6/14)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>Is there evidence of a scale to measure changes in function and or improvements?</td>
<td>NA</td>
<td>35.7% (5/14)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td>The treatment includes the use of appropriate measurement based tools?</td>
<td>NA</td>
<td>42.9% (6/14)</td>
<td>NA</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>L Fraud Waste Abuse</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Is there any indication that services are misrepresented/duplicated?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2017: Is there any indication that the provider is misrepresenting any services provided, i.e. patterns of duplicate billing?)</td>
<td>0.0% (0/20)</td>
<td>42.9% (6/14)</td>
<td>0.0% (0/20)</td>
<td>TBD</td>
</tr>
<tr>
<td>Are there treatment notes to match claims submitted when part of audit?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2017: Are there treatment notes to match the claims submitted?)</td>
<td>100.0% (20/20)</td>
<td>28.6% (4/14)</td>
<td>100.0% (20/20)</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>M State Mandates and/ or Contract Requirements</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State mandated requirements are included when applicable?</td>
<td>NA</td>
<td>100.0% (8/8)</td>
<td>NA</td>
<td>TBD</td>
</tr>
</tbody>
</table>

*Statistically significant change from the previous reporting period using z-test for proportions at p<0.05

**Note: Starting 2018, Beacon has added new questions, as well as, removed age range from Treatment Record Review process in order to broaden the scope of the reviews. Most of the questions have been rephrased as indicated by the inclusion of previous year questions.
ATTACHMENT 2
Geographic and Numeric Availability Assessment Report

Note: Please see GeoAccess (Miles and Minutes) report for details. Will be provided in July 2020 submission.

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Quality Program
Member Satisfaction 2018

Beacon Health Options
San Francisco Health Plan (SFHP)
Beacon Health Options
Annual Trend Analysis
2018 Member Satisfaction Report

Background

In 2018, Beacon Health Options (Beacon) changed its survey vendor from FactFinders to Morpace to administer the Behavioral Health Member Satisfaction survey for the service year 2018. The change in survey vendor lead to a review and modification of Beacon’s survey process that included a redesigned survey. As the review resulted in changes to the survey (i.e. the question phrasing and response scales for survey questions), questions that experienced:

- Minimal question phrasing changes in service year 2018: data from previous years are presented for trending.
- Major question phrasing and/or change in response scale in 2018: data from previous years’ questions with similar content are shown. These comparisons are for reference only. These results cannot necessarily be trended, due to changes in question or response scale modification.

This report summarizes results derived from the Member Satisfaction Survey as applied to a random sample of San Francisco Health Plan, Medi-Cal members. In general, member satisfaction is presented by Summary Rate Scores, which represent the percent of respondents who chose the most positive responses.

Methodology

Members were randomly selected to be in the sample from based on a data file that Beacon provided to Morpace. The data file comprised of behavioral health claims data from quarter 4 2017, quarter 1 2018, and quarter 2 2018. Once the data file was received by Morpace, it was deduped to ensure that no more than one member per household was included in the sample. The sample size was defined by Morpace based on market proportions by line of business, age, and gender.

The survey administration (which was offered in both English and Spanish) consisted of:

- First mailing: mailing a cover letter, a survey, and a return envelope to all members in the sample.
- Second mailing: mailing a cover letter, a survey, and a return envelope to all members who did not respond in the first mailing.
- Telephone: calling all members (on different days and at different times, up to three attempts) who did not respond in the second mailing.

Measures

In survey years 2017 and 2018, the performance goal set by Beacon is a Summary Rate Score of 85 percent for each question in all domains; for overall satisfaction with Beacon, the benchmark is 90 percent.

In service year 2018, the performance goal set by Beacon is 85 percent for select questions identified in the tables due to the nature of the question and how it is phrased (i.e. perception of care rather than just access and/or utilization of identified service). Due to the previously mentioned modifications to the core survey tool, the overall satisfaction and net promoter questions were removed.
For this report, the response rate was calculated as the proportion of completed surveys divided by the total sample minus the ineligible surveys. The calculations are detailed below:

\[
\frac{161 \text{ (Total Response)}}{1333 \text{ (Total Sample)}} = 12.1\% \text{ (Response Rate)}
\]

**Interventions implemented**

**Provider Focused Interventions:**
- Continue to educate providers on the importance of PCP support and “peer-to-peer” support. Providers can call Beacon psychiatrists for advice on members and medication (Quarterly).
- Continued to emphasize during the New Provider Orientation Beacon’s expectation that providers work collaboratively with PCP’s, other BH providers, and community based organizations (multiple training sessions held quarterly).
- Continued quarterly provider survey to capture providers’ availability to see members within 6 hours, 48 hours and 10 business days as well as provider and staff language and cultural capability and specialty (January, April and July 2018).
- Through Provider Bulletin, educated providers regarding importance of Treatment Record Documentation standards and key components of documentation. Treatment record documentation standards are established to assure that records are maintained in organized format, which permits effective and confidential patient care and quality review. These standards facilitate communication, coordination and continuity of care, and promote efficient and effective treatment (January 2018).
- Through provider bulletin, educated providers regarding importance of continuing and coordinating care between BH providers and PCPs and best practices to support continuity and coordination of care. The integration of treatments for BH and physical health conditions results in a coordinated system of care that supports the multifaceted needs of members, ensuring continuity of care, improved outcomes for patients, and an effective health care system (February 2018).
- Through provider bulletin, educated providers regarding access and availability standards (March 2018).
- Provided Suicide Prevention & Awareness training to all health plans and PCPs (June 28, 2018 and July 08, 2018).
- Continued mandatory annual training for providers on Cultural and Linguistic program (Trainings are offered during credentialing, credentialing and upon request).
- Continued to update and distribute the Cultural and Linguistic Provider Toolkit with resources for providers such as summary of Beacon’s Cultural and Linguistic program, employee provider language skills self-assessment tool and other educational materials (Updated in June 2018; Distributed via Provider Bulletin in July 2018, December 2018).
- Informed providers via provider bulletin regarding C&L Rights Signage Requirements in various languages ensuring providers have proper understanding of the notice (Q2 2018).
- Through provider bulletin, educated providers regarding improving care coordination as an essential component to member care. Coordination of care between healthcare providers is an important and necessary process for optimal client health and wellness. This includes coordination of care between behavioral health providers and medical providers. Barriers to this vital communication may include: (October 2018)
  - Time issues
  - Concerns over protection of personal health information (PHI)
  - Client concerns and fears
- Continued to promote the use of online resources to providers, Beacon Provider Bulletins, site visits and Provider Advisory Councils.
In collaboration is Provider Quality Managers (PQMs) (formally known as Managers of Provider Partnership), continued to promote the PCP Toolkit which now links interactively with Achieve Solutions; Beacon’s health and wellness information library on Beacon website.

Staff Focused Interventions:
- Trained Beacon staff on 2018 HEDIS BH measures, which includes FUH measures, measure rational, and changes for 2018 (January 09 and January 10, 2018).
- Created Access and Availability weekly workgroup involving Outpatient Department, Appointment Assistance team, and Network Development team to discuss and address any barriers the teams may be facing (Weekly; February 2018).
- Continued to update and distribute the Cultural and Linguistic Staff Toolkit with resources for staff such as summary of Beacon’s Cultural and Linguistic program, employee language skills self-assessment tool and other educational materials (Updated and distributed in June 2018, December 2018).
- Initiated weekly workgroup with Aftercare leads and CM leads to review and strategies on improvement plan for members not reached or were no show to the scheduled appointment (August 2018)
- Redesigned Interdepartmental Inpatient workflow where Aftercare team, Case Management team, UM, and Provider Quality Managers (PQMs) collaborate in order to widen scope and quality of clinical service during transition of care following inpatient care, improve HEDIS FUH rates, and reduce abrasion with facilities (August 28, 2018)
- Continued weekly rounds with aftercare staff to discuss any barriers to scheduling aftercare appointments or members attending their appointment. Individual QI Programs are created for each staff member to identify barriers and areas of opportunity, successful plans are shared with the rest of the team.
- Continued educating staff (clinicians and member services staff) on the availability and location of triage and referral manual that outlines procedures for Emergent, Urgent and Routine calls.

Member Focused Interventions:
- Continued to implement Beacon Aftercare Program, including activities such as:
  - Initiated discharge plan at the time of admission
  - Appointment reminder calls
  - Successful appointment verification, including carve out services
  - Follow up letters to members
  - Tracking and trending data
  - Send appointment reminder card to all members
  - Send aftercare educational letter and brochure to all members who do not keep appointment
  - Send "we are trying to reach you" slips when unable to reach member
  - Meet members in the acute hospital when possible
- Continue corporate wide FUH QIA focused on designing and implementing improvements in areas that Beacon identifies as key thus improving quality of care and services for our members, providers and health plans developed (Bi-weekly).
- In collaboration with Case Management, FUH team uses coaching referral process that is used when a member is non-responsive or declining aftercare services. CM team reaches out to members after hours/weekends and uses motivational coaching techniques to engage members.
- Outpatient team identifies appointment for member and instructs member to contact provider directly to secure appointment. To ensure member was able to obtain appointment, Outpatient team will contact provider’s office to confirm member has scheduled appointment (Ongoing; Q1 2018).
- Conducted joint clinical rounds with the plan to discuss any intervention or barriers in regards to patient care (Bi-weekly).
- Transition of Care Clinicians (TOC) conducted face to face visits at designated facilities for commercial members. These face to face visits will help Beacon TOCs encourage members to attend
their appointments. Best practice/recommendation will also be shared with members with SUD as well as providers (January 08, 2018)

- Initiate ADD Member Outreach Initiative where parents/guardians of members with ADHD diagnosis are outreached. These calls will emphasize the need for follow up with a prescriber and importance of medication adherence. (Q3 and Q4 2018)

- Enhanced Beacon’s website to include link to Achieve Solutions health library, which includes articles, quizzes, resources and interactive self-assessment tools related to depression on member pages.

**Results**

SFHP results are provided below by product line.

There were a total of 161 members surveyed in the service year 2018.

Demographic information from the survey showed that:

- Adult members equated to 85.7 percent (138/161) of the sample and child members equated to 14.3 percent (23/161) of the sample.
- Male members equated to 43.5 percent (70/161) of the sample and female members equated to 56.5 percent (91/161) of the sample.
- White members equated to 48.3 percent (70/145) of the sample, Latino or Hispanic members equated to zero percent of the sample, Black or African-American members equated to 15.2 percent (22/145) of the sample, Asian members equated to 10.3 percent (15/145) of the sample, Native Hawaiian or other Pacific Islander members equated to 1.4 percent (2/145) of the sample, American Indian or Alaskan Native members equated to 2.8 percent (4/145) of the sample, members that identified their race as Other equated to 20.7 percent (30/145) of the sample.
- Members who preferred to speak English in their home equated to 80.1 percent (113/141) and members who preferred to speak another language in their home equated to 19.9 percent (28/141).
As it relates to services provided by a provider defined as a prescriber or non-prescriber based on credential to prescribe medication, information from the survey showed that:

- Services provided to members by prescribers equated to 25.5 percent (41/161) of the sample and services provided to members by non-prescribers equated to 74.5 percent (120/161) of the sample.

Product line information from the survey showed that:
- Members with Medi-Cal equated to 100 percent of the sample.

SFSJ results are provided below by product line.
### Member Satisfaction Survey - Aggregate

<table>
<thead>
<tr>
<th>Measures</th>
<th>Goal</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appointment Access</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>As a result of calling Beacon Health Options, were you able to set a</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>82.9%</td>
</tr>
<tr>
<td>meeting time with a provider? (answer key: yes)</td>
<td></td>
<td></td>
<td></td>
<td>(29/35)</td>
</tr>
<tr>
<td>When you needed Urgent Care, when was the earliest appointment that was</td>
<td></td>
<td>85%</td>
<td>71.4%</td>
<td>60.4%</td>
</tr>
<tr>
<td>offered to you? (answer key: within 1 or 2 days)</td>
<td></td>
<td></td>
<td></td>
<td>76.0%</td>
</tr>
<tr>
<td>(2017 and 2018 question: Were you able to get the care you needed within</td>
<td></td>
<td></td>
<td></td>
<td>(19/25)</td>
</tr>
<tr>
<td>48 hours?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you had a first-time appointment, when was the earliest appointment</td>
<td></td>
<td>85%</td>
<td>78.0%</td>
<td>78.2%</td>
</tr>
<tr>
<td>that was offered to you? (answer key: within 14 calendar days)</td>
<td></td>
<td></td>
<td></td>
<td>88.5%</td>
</tr>
<tr>
<td>(2017 and 2018 question: Were you offered your first appointment within 10</td>
<td></td>
<td></td>
<td></td>
<td>(46/52)</td>
</tr>
<tr>
<td>business days of your call?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, thinking about those you have seen for</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>89.6%</td>
</tr>
<tr>
<td>counseling or treatment, how often were you seen within 15 minutes of</td>
<td></td>
<td></td>
<td></td>
<td>(95/106)</td>
</tr>
<tr>
<td>your appointment time? (answer key: always or usually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the ease of getting needed mental health or</td>
<td>85%</td>
<td>81.6%</td>
<td>82.4%</td>
<td>87.0%</td>
</tr>
<tr>
<td>substance use care in the last 12 months? Please use any number from 0</td>
<td></td>
<td></td>
<td></td>
<td>(94/108)</td>
</tr>
<tr>
<td>to 10, where 0 is very difficult to get needed care and 10 is very</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>easy to get needed care? (answer key: 6-10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2017 and 2018 question: Was it easy or difficult to get the care you</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>thought you needed?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appointment Availability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After you called Beacon Health Options, did you have a hard time</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>finding a provider for any of the following reasons? Select all that</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>apply.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Did not have hard time finding a provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outdated provider listing</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Reason</td>
<td>Always</td>
<td>Usually</td>
<td>Mostly</td>
<td>Never</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------</td>
<td>---------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>Provider is not a good fit for your needs</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Provider is not taking new patients</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Provider no longer takes your insurance</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Provider is not close enough to where you live or work</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Other reasons</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>In the last 12 months, how often were treatment locations close enough for you? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**Acceptability**

<table>
<thead>
<tr>
<th>Question</th>
<th>Always</th>
<th>Usually</th>
<th>Mostly</th>
<th>Never</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 12 months, how often did counseling or treatment meet your language, religious or cultural needs? (answer key: always or usually)</td>
<td>85%</td>
<td>90.7%</td>
<td>89.7%</td>
<td>86.6% (97/112)</td>
<td></td>
</tr>
<tr>
<td>(2017 and 2018 question: Do you feel your counselor met your cultural, religious, or language needs?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, how often were those you saw for counseling or treatment just right for your needs? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>In the last 12 months, were you given as much information as you wanted about what you could do to manage your condition? (answer key: yes)</td>
<td>85%</td>
<td>84.2%</td>
<td>86.3%</td>
<td>86.5% (96/111)</td>
<td></td>
</tr>
<tr>
<td>(2017 and 2018 question: Do you feel your counselor provided all the information or resources you needed to manage your condition?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Please use any number from 0 to 10, where 0 is the worst counseling or treatment possible, and 10 is the best counseling or treatment possible. What number would you use to rate all your counseling or treatment in the last 12 months? (answer key: 6-10)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>93.7% (104/111)</td>
<td></td>
</tr>
<tr>
<td>What number would you use to rate the treatment you got from this facility? Please use any number from 0 to 10, where 10 is</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>75.0% (3/4)</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
<td>NA</td>
<td>%</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>-------</td>
<td>-----</td>
</tr>
<tr>
<td>the best treatment possible? (answer key: 6-10)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>80.0%</td>
<td>(4/5)</td>
</tr>
<tr>
<td>Do you feel the number of days approved for your stay was enough? (answer key: yes)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>87.4%</td>
<td>NA</td>
</tr>
<tr>
<td>How satisfied are you with services you get from Beacon Health Options? (answer key: very satisfied or somewhat satisfied)</td>
<td>90%</td>
<td>91.0%</td>
<td>87.4%</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>(2017 and 2018 question: Overall, how satisfied are you with the mental health services of Beacon?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you called, how often was it easy to get through the list of choices to speak with a staff member? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>69.8%</td>
<td>(30/43)</td>
</tr>
<tr>
<td>How many calls to a Beacon staff member did it take to get all the information you needed? (1 to 2 calls)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>88.4%</td>
<td>(38/43)</td>
</tr>
<tr>
<td>How often were Beacon staff member(s) as polite and respectful as you thought they should be? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>83.7%</td>
<td>(36/43)</td>
</tr>
<tr>
<td>How often did Beacon staff member(s) explain things in a way you could understand? (answer key: always or usually)</td>
<td>85%</td>
<td>94.4%</td>
<td>92.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2017 and 2018 question: Did the staff explain things in a way you could understand?)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you feel the staff member(s) wanted to be sure you got the information or help you needed? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>And how often were Beacon staff member(s) able to give all the information or help you needed? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>79.1%</td>
<td>(34/43)</td>
</tr>
<tr>
<td>Please use any number from 0 to 10, where 0 is the worst service possible and 10 is the best service possible. What number would you use to rate the quality of services you got from Beacon staff member(s)? (answer key: 6-10)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>83.3%</td>
<td>(35/42)</td>
</tr>
<tr>
<td>When you called for help to find a provider, were you directly handed over to someone who could help you right away?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>83.3%</td>
<td>(35/42)</td>
</tr>
<tr>
<td>Question</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>When you called for help to find a provider, were you given a list of providers to call?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>How would you rate the Beacon staff member for their work to help you find a provider that is best for your needs? (answer key: Excellent or Very Good or Good)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>77.1% (27/35)</td>
<td></td>
</tr>
<tr>
<td>Please use any number from 0 to 10, where 0 is the worst service possible and 10 is the best service possible. What number would you use to rate the quality of service you got when you called Beacon Health Options to find a provider? (answer key: 6-10)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Now please consider everything with Beacon Health Options in the last 12 months. Please use any number from 0 to 10, where 0 is the worst service possible and 10 is the best service possible. What number would you use to rate the quality of services you got from Beacon Health Options? (answer key: 6-10)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>83.0% (127/153)</td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, as far as you know, do you feel those you see for counseling or treatment protect private information? (answer key: yes) (2017 and 2018 question: Do you feel your counselor Protected confidential information?)</td>
<td>85%</td>
<td>95.7%</td>
<td>95.0%</td>
<td>97.3% (107/110)</td>
<td></td>
</tr>
<tr>
<td>Your Beacon Health Options benefits include a website for members called beaconhealthoptions.com. The website includes helpful articles on everyday life issues. Before today, did you know about this website?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, did you visit this website?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>In the last 12 months, how often did you find the information on the website to be useful?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Experience of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did those you saw for counseling or treatment tell you what side effects of those medicines to watch for? (answer key: yes)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>
Statistically significant change from the previous reporting period using z-test for proportions at p<0.05

<table>
<thead>
<tr>
<th>Question</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often are you following your provider’s treatment plan (including medicine)?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>(answer key: always or usually)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compared to 12 months ago, how would you rate your ability to deal with daily problems?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>(answer key: much better or a little better)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compared to 12 months ago, how would you rate your ability to deal with social situations?</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>(answer key: much better or a little better)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compared to 12 months ago, how would you rate your ability to do the things you want to do? (answer key: much better or a little better)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Compared to 12 months ago, how would you rate your problems or symptoms? (answer key: much better or a little better)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>In the last 12 months, how much were you helped by the counseling or treatment you had? (answer key: a lot or somewhat)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>In the last 12 months, how often did your personal doctor seem to know about the counseling or treatment you had? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>57.3% (63/110)</td>
</tr>
<tr>
<td>In the last 12 months, how often did those you have seen for counseling and treatment seem to know about the care you had from medical doctors? (answer key: always or usually)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>69.4% (75/108)</td>
</tr>
</tbody>
</table>

*Statistically significant change from the previous reporting period using z-test for proportions at p<0.05

**Result Analysis**

Due to the sample size of 161, reliability of the survey is present due to response rate for most questions; however, as some questions are focused on inclusiveness of intended audience, reliability for those specific questions in the survey is absent and should not be generalized. Those questions will be identified in the broken out analysis by categorization (i.e. Appointment Access, Appointment Availability, Acceptability, Scope of Services, and Experience of Care).

Being that the survey timeframe is Q4 2017 and Q1 and Q2 2018 and the interventions identified above were started and/or completed in Q3 or Q4 2018, the interventions would not have had a direct impact on any of the results in service year 2018.

**Appointment Access:**
This category had three questions that could be trended for 2016, 2017, and 2018, due the modification of the survey tool described above:
• Of the 25 members surveyed, 19 were able to get an urgent care appointment within two days (48 hours) which equated to 76.0 percent in service year 2018, which fell short of the 85 percent goal but was 15.6 percentage point increase from service year 2017. The results for this question are not reliable due to the sample size of 25 as compared to 42 in 2016 and 53 in 2017 and should not be generalized.
• Of the 52 members surveyed, 46 had their first-time appointment within 14 calendar days (10 business days) which equated to 88.5 percent in 2018, which met the 85 percent goal and was a 10.3 percentage point increase from 2017.
• Of the 108 members surveyed, 94 rated the ability to get needed mental health or substance use care as very easy which equated to 87.0 percent in 2018, which met the 85 percent goal and increased by 4.6 percentage points in 2018.

This category had two newly formulated questions that could be not trended for 2016, 2017, and 2018, due the modification of the survey tool described above.
• Of the 29 members surveyed, 35 were able to set a meeting time with a provider when calling Beacon which equated to 82.9 percent 2018.
• Of the 106 members surveyed, 95 were seen for their counseling appointment with 15 minutes of appointment time which equated to 89.6 percent in 2018.

Appointment Availability:
This category did not have any questions that could be trended for 2016, 2017, and 2018, due the modification of the survey tool described above.

This category had two newly formulated question that could be not trended for 2016, 2017, and 2018, due the modification of the survey tool described above. Of the two questions, only one had member data. It is listed as follows:
• Of the 109 members surveyed, 95 identified that treatment locations were always or usually close enough for them which equated to 87.2 percent in 2018.

Acceptability:
This category had two questions that could be trended for 2016, 2017, and 2018, due the modification of the survey tool described above:
• Of the 112 members surveyed, 97 identified that their counseling or treatment always or usually met their language, religious or cultural needs which equated to 86.6 percent in 2018, which met the 85 percent goal.
• Of the 111 members surveyed, 96 were given as much information as wanted to manage their condition which equated to 86.5 percent in 2018, which met the 85 percent goal.

This category had five newly formulated questions that could be not trended for 2016, 2017, and 2018, due the modification of the survey tool described above. Of the five questions, only three had member data. They are listed below:
• Of the 111 members surveyed, 104 rated that their counseling or treatment was satisfactory which equated to 93.7 percent in 2018.
• Of the 4 members surveyed, 3 rated that the treatment they received from the facility was satisfactory equated to 75.0 percent in 2018. Due to a sample size of 4, the results for this question are not reliable and should not be generalized.
• Of the 5 members surveyed, 4 felt the number of days approved for hospital or facility stay was enough which equated to 80.0 percent in 2018. The results for this question are not reliable due to a sample size of 5 and should not be generalized.

Scope of Services:
This category had three questions that could be trended for 2016, 2017, and 2018, due the modification of the survey tool described above. Of the three questions, only two had member data. They are listed below:
• Of the 43 members surveyed, 36 identified that Beacon staff member(s) always or usually explained things in a way they could understand which equated to 83.7 percent in 2018, which did meet the 85 percent goal. This score was also a six percentage point decrease from 2017.
• Of the 110 members surveyed, 107 felt that those they see for counseling or treatment protected their private information which equated to 97.3 percent in 2018, which exceeded the 85 percent goal.

This category had fourteen newly formulated questions that could be not trended for 2016, 2017, and 2018, due the modification of the survey tool described above. Of the fourteen questions, only six have member data. They are listed below:
• Of the 43 members surveyed, 30 were able to get all the information they needed in one or two calls when they called Beacon Health Options which equated to 69.8 percent in 2018.
• Of the 43 members surveyed, 38 thought Beacon staff members(s) were always or usually as polite and respectful as they thought which equated to 88.4 percent in 2018.
• Of the 43 members surveyed, 34 thought that Beacon staff member(s) were always or usually able to give all the information or help they needed which equated to 79.1 percent in 2018.
• Of the 42 members surveyed, 35 were directly handed over to someone who could help them right away, which equated to 83.3 percent in 2018.
• Of the 35 members surveyed, 27 rated Beacon staff’s ability to help find a provider that is best for their need as satisfactory which equated to 77.1 percent in 2018.
• Of the 153 members surveyed, 127 rated quality of services provided by Beacon as satisfactory which equated to 83.0 percent in 2018.

Experience of Care:
This category did not have any questions that could be trended for 2016, 2017 and 2019, due the modification of the survey tool described above.

This category had nine newly formulated questions that could be not trended for 2016, 2017 and 2019, due the modification of the survey tool described above. Of the nine, only two had member data. Those are listed below:
• Of the 110 members surveyed, 63 stated that those the personal doctor seemed to know about the counseling or treatment they had, which equated to 57.3 percent in 2018.
• Of the 108 members surveyed, 75 stated that those they were seeing for counselling and treatment seem to know about the care they had from medical doctors, which equated to 69.4 percent in 2018.

Barrier Analysis
Modification of question phrasing and response scales for survey questions made an impact on the trended results as there were no questions that equated to a one-to-one. This modification altered the previously established survey question constructs due to the fact that the questions were asked in a slightly different manner. The sample size is also considerably smaller for two analyses listed above (i.e. CMC, and commercial), which would have also had an impact on the results. This could be in part due to utilization of a new survey vendor (i.e. Morpace) and/or use of a new survey methodology (i.e. survey administration and sample plan based on market proportions by line of business).

Other Barriers and Opportunities for Improvement
• Member’s perception of Emergent and Urgent needs may be different from the clinical judgments of providers and Beacon staff.
• Lack of accurate and timely information regarding provider’s availability.
• Lack of providers in certain service areas that meet specific prescribing and cultural needs.
• Certain prescribers in FQHCs may not be willing to see the members unless members switch their PCP to FQHC also, this may result in member dissatisfaction and delay of services.
• Providers requesting for members to call to schedule appointment
• Member lack of awareness that Beacon staff can assist with procuring appointments.
• Members may be confusing their county access experience (especially around emergent) with Beacon.
• Members non-responsive after submitting initial Routine with Assistance (RWA) request
• Members may not be aware of interpretative service offered by Beacon.
• Members may not be aware that they can have materials translated by Beacon.
• Provider need for understanding that communication between BH providers and PCPs is a contractual obligation.

Next Steps/Interventions
• Continue to educate providers on Beacon’s Quality Program through the distribution of Inpatient, Outpatient, and PCP “Quality Packets” (Ongoing).
• UM clinicians to continue collaboration with the facility discharge planner to ensure discharge plan is a solid and viable plan and member’s willingness to follow through with the plan.
• Continue to utilize the Transition of Care Clinicians to go to meet the members at the acute hospital setting prior to discharge and then again post discharge to educate members on the importance of attending their follow-up appointments.
• When feasible, case managers will meet the members face-to-face in the hospital setting to encourage continuity of care between the acute unit and the outpatient provider.
• Based on chart review results, continue to provide feedback on provider’s performance and documentation. Send letters to providers with tips for improving performance.
• Continue to educate providers through trainings on specific topics, Provider Advisory Council, Provider Bulletins and articles.
• Continue to leverage the PQMs to work closely with providers on building highly collaborative relationships with providers, driving provider performance improvement year-over-year through education and data, and identifying top-performing providers for innovative programs/pilots.
• The PQMs will continue to be informed by the Aftercare team if there is need for provider education around discharge planning and follow up appointment scheduling.
• Continue to monitor provider performance using chart review process and send providers the results of their 2018 audits with suggestions to improve their scores on measures regarding communication with other BH provider and with PCPs.
• Continue mandatory annual Beacon training for all Beacon Clinicians regarding documentation standards.
• Collaborate with the health plan to educate PCPs on collaborating with the member’s BH providers as well as availability of PCP Toolkit and other tools on Beacon’s website.
• Share results of survey with providers along with tools targeted towards barriers identified through survey.
• Ensure all coordination of care materials on website are up-to-date, easily available and consistent across all plans (Ongoing).
• Continue to educate members through Appointment Assistance Checklist training Guide. This guide contains information on transportation options through the health plans, interpreter services and psych testing request (linkage to a therapist).
• Continue quarterly provider access and availability survey to ensure providers are available to take members within the 6-hour, 48-hour, and 10 business day time frames and Beacon directory is updated with real time data.
• Review criteria for admitting providers to the network, and updating as warranted.
• Analyze out of network utilization data to identify specialty, cultural, and linguistic recruitment needs and bring providers in network.
• Active recruitment of prescribers, child psychiatrists, and other providers based on specialty, cultural/linguistic, and geographic needs
• Ensure that members are aware of Beacon’s availability to assist in obtaining appointments when member is unable to secure an appointment
• Continue to conduct targeted follow up with providers who are non-responsive to quarterly provider access surveys through email software.