## Quality Improvement Committee Meeting

**Thursday, February 8, 2018**  
7:30 – 9:00 AM  
50 Beale Street, 13th Floor

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Trouble Joining? Try Skype Web App  
Conference Call Number +1 (628) 220-4855 Access Code: 1744672

### AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Objective</th>
<th>Assigned</th>
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</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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<tr>
<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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<td></td>
<td>• Follow Up Items (p. 2)</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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<tr>
<td></td>
<td>• Review of Minutes – December 14, 2017 (p. 4)</td>
<td>Vote</td>
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<tr>
<td></td>
<td>• Q4 2017 Grievance Report (p. 13)</td>
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<td></td>
<td>• Q4 2017 Appeals Report (p. 21)</td>
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<td>• Q4 2017 Potential Quality Issue Report (p. 24)</td>
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<td>• Q4 2017 QI Scorecard (p. 25)</td>
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<td>• Q3 2017 Emergency Room Visit/Prescription Access Report (p. 26)</td>
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<tr>
<td>7:40</td>
<td>Policy &amp; Procedures (5 min.)</td>
<td>Vote</td>
<td>J. Soos</td>
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<tr>
<td></td>
<td>• HE-06: Alcohol Misuse Screening and Counseling (AMSC) – 5 min. (p. 29)</td>
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<td>7:45</td>
<td>Quality Improvement (60 minutes)</td>
<td>Vote</td>
<td>J. Soos/M. Cale</td>
</tr>
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<td>• Palliative Care – 20 min.</td>
<td>Vote</td>
<td>J. Soos</td>
</tr>
<tr>
<td></td>
<td>o Implementation of the Medi-Cal Palliative Care Benefit Memo (p. 33)</td>
<td></td>
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<td></td>
<td>o UM-58: Palliative Care (p. 36)</td>
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<td></td>
<td>• Facility Site Review 2017 Results – 20 min. (p. 43)</td>
<td>Vote</td>
<td>J. Hagg</td>
</tr>
<tr>
<td></td>
<td>• Delegated Medical Group QI Audit Results – 20 min. (p. 49)</td>
<td>Vote</td>
<td>O. Leon</td>
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<td>9:00</td>
<td>PAC</td>
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</table>

**NEXT MEETING THURSDAY, APRIL 5, 2018**
<table>
<thead>
<tr>
<th>QIC Meeting Date</th>
<th>Follow Up Item</th>
<th>Owner</th>
<th>Complete By</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>October 2017</td>
<td>Explore if sister plans give monetary incentives to members for completing the Health Risk Assessment tool.</td>
<td>F. Donald</td>
<td>2/8/18</td>
<td>Completed Fiona asked the Medical Directors in the Local Initiative Health Plans and County Organized Health Systems (LI-COHS) distribution group and did not receive a response. It is assumed that sister plans do not give monetary incentives to members for completing the HRA Tool.</td>
</tr>
<tr>
<td>December 2017</td>
<td>Create slides on the Pharmacotherapy Management of COPD measure describing measure specification.</td>
<td>A. Sharma</td>
<td>2/8/18</td>
<td>Completed The slides describing the Pharmacotherapy Management of COPD measure is included in the February 2018 QIC packet.</td>
</tr>
<tr>
<td>December 2017</td>
<td>Research and inform QIC of the baseline for the measure &quot;improve client's perception of their health.&quot;</td>
<td>A. Sharma</td>
<td>2/8/18</td>
<td>Completed The baseline for self-reported health is 78%. This is based on SFHP's previous CareSupport Program population. Due to changes in our Care Management population with our current programs, we have set a conservative target of 60% for year one for the self-reported health measure within the QI Workplan.</td>
</tr>
<tr>
<td>December 2017</td>
<td>Present the Pain and Opiate Safety Coalition to QIC in Spring 2018.</td>
<td>F. Donald</td>
<td>4/5/18</td>
<td>In Progress</td>
</tr>
</tbody>
</table>
Pharmacotherapy Management of COPD Exacerbation

Members 40 years and older with an acute inpatient discharge or ED visit for a COPD exacerbation and who were dispensed appropriate medication.

Two Rates Reported:

• Dispensed a systemic corticosteroid within 14 days of event
• Dispensed a bronchodilator within 30 days of the event
Date: December 14, 2017
Meeting Place: San Francisco Health Plan, 50 Beale Street 13th floor, San Francisco, CA 94105
Meeting Time: 7:30AM - 9:00AM

Members Present: Edwin Batonbacal; LCSW; Jeanette Cavano, PharmD; Daniel Chan, MD; Ellen Chen, MD; Irene Conway; Jeffrey Critchfield, MD; Edward Evans; Jaime Ruiz, MD; Kenneth Tai, MD; Joseph Woo, MD; Albert Yu, MD; James Glauber, MD, MPH (Chief Medical Officer, SFHP)

Staff Present: Grace Dadios; Fiona Donald, MD; Jose Mendez; Adam Sharma; Jim Soos; Chris Forshee; Laura Grossmann; Michelle Hernandez, Beacon Health Options

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion [including Identification of Quality Issue]</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 was called to order at 7:30AM with a quorum.  
• No public comments or questions. | • No follow up needed.                                              | • n/a                                                                                 |
| Follow Up Items  | Follow-Up Items from October 2017                     |                                                                   |                                                                                      |
|                  | • There are no follow up items from October 2017.     |                                                                   |                                                                                      |
| Jim Glauber      |                                                      |                                                                   |                                                                                      |
|                  | • SFHP underwent the final phase of the National      |                                                                   |                                                                                      |
|                  | Commission for Quality Assurance (NCQA) audit in     |                                                                   |                                                                                      |
|                  | early December. NCQA audited SFHP’s Utilization      |                                                                   |                                                                                      |
|                  | Management, Credentialing, and Complex Case          |                                                                   |                                                                                      |
|                  | Management files.                                    |                                                                   |                                                                                      |
|                  | • SFHP projects it may lose two out of the 50        |                                                                   |                                                                                      |
|                  | eligible points. 32.5 points are needed to pass.     |                                                                   |                                                                                      |
|                  | • The final determination will be sent in late       |                                                                   |                                                                                      |
|                  | December.                                             |                                                                   |                                                                                      |
|                  | • QIC members will receive notification of elective   |                                                                   |                                                                                      |
|                  | reappointment to QIC in February 2018.               |                                                                   |                                                                                      |
| Consent Calendar | • Review of Minutes – October 12, 2017  
• Health Services Update – November 2017  
• Pharmacy & Therapeutics Committee Minutes – July 2017  
  • SFHP updated the Hepatitis C criteria to maximize the use of Mayvret when appropriate. Mayvret offers significant cost savings as it is half the price of the next lowest cost Hepatitis C medication.  
  • Starting January 2018, DHCS is reducing the Hep C kick payment by 23%  
• UM Committee – October 2017  
• Q3 2017 Grievance and Appeals Report  
• Q3 2017 Potential Quality Issues Report  
• UM Clinical Criteria  
  o Interqual  
  o Hayes  
  o SFHP Criteria for Genital Gender Confirmation Services | Approved:  
• Review of Minutes – October 12, 2017  
• Health Services Update – November 2017  
• Pharmacy & Therapeutics Committee Minutes – July 2017  
• UM Committee – October 2017  
• Q3 2017 Grievance and Appeals Report  
• Q3 2017 Potential Quality Issues Report  
• UM Clinical Criteria  
  o Interqual  
  o Hayes  
• SFHP Criteria for Genital Gender Confirmation Services |
| Quality Improvement | Policy and Procedures QI-06 & QI-05  
Jim Soos, Medical Policy Administrator, presented Policy and Procedures QI-06, Member Grievances and Appeals, and QI-15, Quality Improvement Program.  
• QI-06 – Member Grievances & Appeals  
  o Per SB-282 (Health Care Coverage: Prescription Drugs), SFHP is required to forward Healthy Worker (HW) and Healthy Kids (HK) non-formulary drug denial appeals to SFHP’s external review organization (Medical Review Institute of America) for review.  
• QI-15 Quality Improvement Program  
  o QI-15 is a new policy that defines SFHP’s Quality Improvement (QI) Program including requirements for the QI Description, QI Work Plan, and QI Program Evaluation. | Approved: Policy and Procedures QI-06 & QI-05 |
### 2017 Quality Improvement Program Evaluation

Adam Sharma, Director of Health Outcomes Improvement, presented the 2017 QI Program Evaluation and the 2018 QI Work Plan.

- **QIC’s role in the QI Program include:**
  - Providing leadership for SFHP’s ongoing QI Program.
  - Providing oversight of SFHP’s annual work plan through quarterly monitoring (through the QI Scorecard).
  - Reviewing and approving the annual QI Evaluation and subsequent year’s Work Plan.

- **SFHP’s evaluation process includes:**
  - Determining measures and targets.
  - Developing activities to support measures.
  - Executing activities.
  - Evaluating impact of activities.
  - Recommending future measures and activities that influence next year’s measures and targets.

- **The 2017 QI Program Evaluation:**
  - Analyzed the QI Program structure, including provider, leadership, and staffing support.
  - Assessed target attainment.
  - Summarized key results.
  - Summarized recommendations for continuous improvement.

- At the time of this evaluation, not all the data for the 2017 measures have been finalized. These measures will be included in the 2018 QI Program Evaluation.

- Fifty-six percent (14/25) of QI measures met targets or improved from baseline.

- Five Quality of Service and Access to Care measures met the target.
  - Successes include:
specifically in the Rating of Health Plan, Getting Care Quickly, and Getting Needed Care measures.

- Improvements in provider satisfaction with SFHP services and improvement in turnaround times in Potential Quality Issue (PQI) resolution.
  - Recommendations include:
    - Review of both clinical and non-clinical grievances at Grievance Oversight Committee to address incomplete responses from providers.
    - Providing technical assistance for providers and grant funding for access improvement through Strategic Use of Reserves.
    - Increasing CAHPS measurement frequency to help evaluate improvement activities.
      - SFHP is required to administer CAHPS through written mailed surveys and understands the issue of administering too many member surveys.
  - In the Clinical Quality and Patient Safety area, one measure met the target while two measures improved from baseline.
    - Notable improvements include:
      - 7.2% absolute improvement in Cervical Cancer Screening.
      - 17% decrease in members receiving opiate prescriptions.
      - While the percentage of members receiving an opiate prescription has decreased, the number of hospitalizations related to overdose events is increasing. This is consistent with the national experience.
      - SFHP established a Pain and Opiate Safety Coalition to discuss and address pain related issues. Fiona Donald,
Medical Director, will present the workgroup to QIC in spring 2018.

- Exemplary clinical quality as demonstrated by 9 HEDIS measures meeting the NCQA Medicaid 90th percentile.
  - Recommendations include:
    - Adding a chiropractic benefit to SFHP’s Pain Management program strategy.
    - Utilizing Strategic Use of Reserves (SUR) to increase availability of inpatient addiction services.
      - The largest monetary commitment in SUR this year is directed to hospitals to increase the capacity and availability of inpatient and ER services to start people on medication assisted therapy when in an acute facility for overdose or substance misuse related complications.

- Four Utilization Management (UM) measures met the target while two UM measures improved from baseline.
  - Successes include:
    - Increase in the adult non-specialty mental health (NSMH) penetration rate.
  - Recommendations include:
    - Outreach and education to providers and members on how to refer to/access the non-specialty mental health penetration rate.
    - Implementation of a provider Pay for Performance depression screening measure to increase identification of members who may benefit from behavioral health treatment.

- No Care Coordination measures were evaluated in 2017. These measures will be evaluated in early 2018.

- None of the measures for Delegation Oversight met the target or improved from baseline.
  - SFHP set a 95% target for the Delegation
Oversight measures. In retrospect these targets proved unrealistic given the scope of delegated activities.

- SFHP is proposing to remove Delegation Oversight as a discrete domain. This will still be reported but as a Quality Oversight activity.

2018 Quality Improvement Work Plan

- SFHP’s 2018 QI Work Plan has fewer measures, moves all delegation oversight to the Quality Oversight domain, and is focused on outcomes.

- The Clinical Quality and Patient Safety domain has 6 measures including Medication Therapy Management and Pharmacotherapy Management of COPD Exacerbation.
  - The Medication Therapy Management measure is focused on identifying the population for the program.
  - Adam to create slides on the Pharmacotherapy Management of COPD measure describing measure specification.

- In the Quality of Service and Access to Care domain, SFHP combined the two HP-CAHPS measures into one measure and again includes the Member Grievances and the PQI measures.
  - Additional measures will be included in early 2018.

- The UM domain has two measures including adult members with primary care visit rate in the last 12 months (64% baseline with a stretch target of 67%) and NSMH penetration rate (3.2% baseline and a stretch target of 4.5%).

- The Care Coordination and Services domain contain 4 new measures including screening for Clinical Depression (10% baseline with a target of 70%), follow up on Clinical Depression (0% baseline with a target of 70%), improve SFHP’s Care Management clients’ perception of their health (baseline unknown with a target of 60%), and client satisfaction with SFHP Care Management staff (92% baseline with a target of 80%).
  - The denominator is members who are already engaged in the SFHP Care Management program.

- Adam to create slides on the Pharmacotherapy Management of COPD measure detailing what is being measured.
Adam to research and inform QIC of the baseline for the measure “improve client’s perception of their health.”

The Quality Oversight domain does not contain measures and instead includes activities including delegation oversight for QI.

2017 Beacon Quality Program Evaluation
Laura Grossmann, AVP, Account Partnerships, West of Beacon Health Options presented the 2017 Beacon Quality Program Evaluation and the 2016 Member Satisfaction Survey Results.

- The Quality Program Evaluation serves to assess the overall effectiveness of the Quality Program, including the performance in clinical and service improvement initiatives.
- The report covers SFHP’s Medi-Cal lines of business.
- The data presented in the report includes behavioral health (BH) claims only (medical and pharmacy claims are not included) and reflects data as of October 31, 2017. An evaluation amendment will be presented to QIC in April 2018.

Clinical improvement activities/results include:
- Depression (HEDIS Antidepressant Medication Management)
- Continuity and Coordination of Care
  - The goal is to improve the continuity and coordination between behavioral health (BH) providers and primary or medical care providers. The target for these measures was 80%.
  - None of the records indicated evidence of communication between treating BH provider and member’s PCP or the use of a standardized communication form.
- Timeliness of Handling Member Complaints
  - Beacon received six member complaints in 2017. All were resolved within the timeframe.

Service Improvement activities and results include:
Telephone Accessibility

- The call abandonment rate, the percent of calls answered within 30 seconds, and average seconds to answer exceeded established goals in 2017.

2016 Member Satisfaction Survey Results

- Beacon contracted with Fact Finders, an independent research company, to conduct the survey.
  - The survey was administered in Quarter 2 2017 to members who received Beacon services in calendar year 2016.
- The survey contained 27 questions and focused on Overall Satisfaction, Satisfaction with Providers, Access to and Utilization of Care, and Outcomes.
- One hundred and seventy surveys were completed with a response rate of 13.2%.
- The survey questions were categorized in four domains and the goal was greater or equal to 85%.
  - Results related to Appointment Access and Availability include:
    - 78.9% percent of members were offered a first appointment within 10 business days of the member’s call.
    - 67.5% of members responded they can get to a Beacon counselor’s office in less than 30 minutes.
    - 80% of members indicated that Beacon has interpreter services immediately available to them.
  - Three out of five questions in the Acceptability of Services domain exceeded the goal.
    - 90% of members responded very satisfied or somewhat satisfied with the services received from their Beacon counselor.
    - 76.9% and 87.9% of respondents felt their counselor included them in their planning.
• Treatment goals and felt their counselor has met members’ cultural, religious, and language needs, respectively.
  • 87.8% and 71.4% of members reported they were satisfied with the behavioral health services from Beacon and that it was easy or difficult to get the care from Beacon they thought they needed, respectively.
    o In the Scope of Services domain, 92.5% of members indicated they felt their provider protected confidential information while 45.8% felt their counselor sent information or discussed their care with their primary care provider.
    o 85.7% and 77.1% of members reported they were able to handle problems and were better able to get along with others as a result of the services provided by their counselor, respectively.
• Opportunities for improvement include continuing to assist members to obtain emergent appointments, continue education on Beacon’s availability expectations, and continued education and outreach via the Provider Bulletin.

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

Date: January 19, 2018

<table>
<thead>
<tr>
<th>To</th>
<th>Quality Improvement Committee</th>
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<tbody>
<tr>
<td>From</td>
<td>Nicole A. Ylagan – Grievance Analyst</td>
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<tr>
<td>Regarding</td>
<td>Q4 2017 Grievance Report</td>
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A total of 86 grievances and appeals were reported in the fourth quarter of 2017 (October 1st – December 31st). The overall volume decreased by 7.52% from the previous quarter (Q3 2017) when the total number of grievances filed was 93.

A total of 4 grievances deliverables were not closed within the required timeframes in the fourth quarter of 2017. One out of 86 acknowledgement letters was not sent out within five calendar days. An SFHP internal department did not notify the grievance team and therefore delayed the acknowledgement of the grievance.

Three out of 86 grievances were not closed within the required timeframe of 30 calendar days, as mandated by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS). However, all three grievances had an approved 14 calendar day extension and were closed within the timelines stated in the letter sent to the member.

![Graph showing Q1 2017 - Q4 2017 closed in 30 days]

- Q1 2017: 88.3%
- Q2 2017: 89.2%
- Q3 2017: 100.0%
- Q4 2017: 100.0%

Performance Target: 100.0%
Met requirement
Since Q4 2015, SFHP’s grievance rate has decreased each quarter. In comparison, SFHP’s rate from Q1 – Q2 2017 is lower than DHCS’ rate because DHCS received more grievances for these two quarters.

*DHCS data is two quarters behind*
**Grievances filed by members who are Seniors and Persons with Disabilities (SPD):**

SFHP continues to monitor grievances filed by members who are part of the SPD population. In Q4 2017, 41 grievances were filed by SPD members. This quarter, the number of grievances filed by SPDs increased by 5.12% compared to the prior quarter (Q3 2017). The types of grievances received vary quarter by quarter. However, a consistent pattern of issues related to quality of service, quality of care and denials are filed by both SPD and non-SPD members.

In comparison, SFHP’s rate is consistently lower than DHCS’ SPD rate because the DHCS rate is inclusive of all Medi-Cal health plans.

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*DHCS data is two quarters behind*
Grievance Rate by Medical Group:

Q1 - Q4 2017 Grievance Rate by Medical Group

<table>
<thead>
<tr>
<th></th>
<th>UCS</th>
<th>BTP</th>
<th>NMS</th>
<th>CHI</th>
<th>CHN</th>
<th>HIL</th>
<th>KSR</th>
<th>NEM</th>
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<tbody>
<tr>
<td>Q1 2017</td>
<td>1.69</td>
<td>0.79</td>
<td>0.50</td>
<td>0.09</td>
<td>0.72</td>
<td>1.64</td>
<td>0.33</td>
<td>0.26</td>
</tr>
<tr>
<td>Q2 2017</td>
<td>1.68</td>
<td>1.85</td>
<td>0.46</td>
<td>0.71</td>
<td>0.63</td>
<td>0.41</td>
<td>0.11</td>
<td>0.09</td>
</tr>
<tr>
<td>Q3 2017</td>
<td>2.44</td>
<td>0.77</td>
<td>0.21</td>
<td>0.27</td>
<td>0.55</td>
<td>1.01</td>
<td>0</td>
<td>0.2</td>
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<tr>
<td>Q4 2017</td>
<td>1.60</td>
<td>1.00</td>
<td>0.81</td>
<td>0.65</td>
<td>0.58</td>
<td>0.44</td>
<td>0.11</td>
<td>0.09</td>
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</table>
**Source of the grievances:**

The graph below shows who was involved in the grievance i.e. the member’s PCP, the clinic staff, specialist etc. In Q4 2017, there was a trending grievance identified with Tom Waddell Urban Health Clinic (TWUHC). SFHP reviewed the grievance responses and felt the clinic took appropriate steps and SFHP will monitor the grievances for this clinic.
Access to Care Grievances:

SFHP’s Member Experience Dashboard shows all grievances (exempt, decline to file, clinical and non-clinical) associated with access from Q4 2016 – Q2 2017. There was a trend identified for Q3 2017. The trend will be reviewed by SFHP’s internal committee to determine next steps.
Access Grievances per Thousand Member Months

<table>
<thead>
<tr>
<th>Medical Group</th>
<th>Metrics Quarter</th>
<th>2016 Q4</th>
<th>2017 Q1</th>
<th>2017 Q2</th>
<th>2017 Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHN-DPH</td>
<td></td>
<td>0.11</td>
<td>0.38</td>
<td>0.15</td>
<td>0.15</td>
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<tr>
<td>CHN-CCC</td>
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<td>0.26</td>
<td>0.16</td>
<td>0.13</td>
<td>0.25</td>
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<tr>
<td>CHN-OTHER</td>
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<td>0.00</td>
<td>0.90</td>
<td>0.00</td>
<td>0.78</td>
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<tr>
<td>BTP</td>
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<td>0.00</td>
<td>0.41</td>
<td>0.21</td>
<td>0.59</td>
</tr>
<tr>
<td>CHI</td>
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<td>0.16</td>
<td>0.00</td>
<td>0.08</td>
<td>0.00</td>
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<td>HIL</td>
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<td>0.42</td>
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<td>0.00</td>
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<td>UCS</td>
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<td>0.48</td>
<td>0.55</td>
<td>0.23</td>
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<td>0.00</td>
<td>0.50</td>
<td>0.00</td>
<td>0.21</td>
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*Includes Exempt, Denied to File and Clinical and Non-Clinical Grievances*
**Beacon:**
Beacon Health Options is SFHP’s non-specialty mental health provider. Grievances are semi-delegated. In Q4 2017, there was not a trend identified with Beacon grievances.

![Q1 2017 - Q4 2017 Beacon Grievances](chart)

**Kaiser:**
Kaiser is fully delegated to investigate and resolve grievances. At the time this report was created, the data for Q4 2017 was not available. This information will be reported in next quarter’s grievance report.
MEMO

Date: January 29, 2018

To: SFHP Quality Improvement Committee
From: Kirk McDonald, UM Program Manager
Regarding: Q4-2017 UM Medical and Pharmacy Appeals

Q4-2017 UM Medical and Pharmacy Appeals Activity

**UM Medical and Pharmacy Appeals Activity – Overview**
During Q4-17, there were a total of 11 appeals filed (medical 3, pharmacy 8). In Q4-17, there were a total of 5,159 authorizations (medical 3,771, 1,388 pharmacy). On a per 1,000 authorization basis, this is 2.1 appeals per 1,000 authorizations; or .79 appeals per 1,000 medical authorizations and 5.7 appeals per 1,000 pharmacy authorizations.

**Medical Appeals Activity**
Q4 Year-over-Year
2015 - 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Denials</th>
<th>Total Appeals</th>
<th>Appeals Overturned</th>
<th>Appeals Upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>31</td>
<td>29</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>2016</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>2017</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>2</td>
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</tbody>
</table>

Pharmacy Appeals Activity
Q4 Year-over-Year
2015 - 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Denials</th>
<th>Total Appeals</th>
<th>Appeals Overturned</th>
<th>Appeals Upheld</th>
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<tbody>
<tr>
<td>2015</td>
<td>545</td>
<td>327</td>
<td>303</td>
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</tr>
<tr>
<td>2016</td>
<td>21</td>
<td>5</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>2017</td>
<td>12</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>
Comparing appeal activity in Q4-17 to Q3-17:
- 18 appeals in Q3-17 vs. 11 appeals in Q4-17.
- 4.0 appeals/1000 in Q3-17 vs. 2.1 appeals/1000 in Q4-17.

Of the 11 appeals in Q4-17, 9 appeals were overturned (medical 3, pharmacy 6), which is an 82% overturn rate. This compares to a 67% overturn rate in Q3-17 (12 overturned out of 18 appeals).

**UM Medical Out-of-Medical-Group (OOMG) / Out-of-Network Appeals (OON) Activity**

There were a total of 0 OOMG / OON medical appeals. Q4-17 compared to Q4-15/16:

**Medical Appeals OOMG/OON Activity**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Appeals</th>
<th>Appeals Overtled</th>
<th>Appeals Upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2016</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2017</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**UM Medical and Pharmacy Appeal Activity by Medical Groups**

The medical and pharmacy appeals by medical group appear representative of the distribution of membership.

**Medical Appeals Activity by Medical Groups**

<table>
<thead>
<tr>
<th>Year</th>
<th>BTP</th>
<th>CHI</th>
<th>CHN</th>
<th>Hill</th>
<th>NEMS</th>
<th>NMS</th>
<th>UCSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4-2015</td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4-2016</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4-2017</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pharmacy Appeals Activity by Medical Groups**

<table>
<thead>
<tr>
<th>Year</th>
<th>BTP</th>
<th>CCHCA</th>
<th>CHN</th>
<th>Hill</th>
<th>KAI</th>
<th>NEMS</th>
<th>NMS</th>
<th>UCSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4-2015</td>
<td>1</td>
<td></td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4-2016</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Q4-2017</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>
Analysis
- The average quarterly membership decreased by 9.7% from Q3-17 (148,813) to Q4-17 (134,392)\(^3\).
- Total authorization denials remained relatively flat year-over-year:
  - 356 denials/5,831 authorizations, which represents 61 denials/1000 authorizations in Q4-16.
  - 312 denials/5,159 authorizations, which represents 60 denials/1000 authorizations in Q4-17.
- Total appeals per 1000/authorizations also remained relatively flat year-over-year: 10 appeals/1000 authorizations in Q4-16 versus 11 appeals/1000 authorizations in Q4-17.
- Overturned appeal rate was:

<table>
<thead>
<tr>
<th>Year</th>
<th>Overturn Appeal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>47%</td>
</tr>
<tr>
<td>Q2</td>
<td>39%</td>
</tr>
<tr>
<td>Q3</td>
<td>67%</td>
</tr>
<tr>
<td>Q4</td>
<td>82%</td>
</tr>
</tbody>
</table>

Actions
- The Utilization Management Committee (UMC) has standing agenda items to review and discuss overturned medical and pharmacy utilization management appeals. The discussion and decision highlights are reflected in the UMC minutes.

\(^1\) Source: 0944ES A&G UM APPEALS REPORT: Case RECEIPT DATE: 10/1/2017 - 12/31/2017 as of 1/23/2018 11:00:44 AM. This is an aggregate number of medical and pharmacy appeals; members appealing were 11 MediCal members.

\(^2\) The data for Q4 in the report 0944ES A&G UM APPEALS REPORT: Case RECEIPT DATE: 10/1/2017 - 12/31/2017 as of 1/23/2018 11:00:44 AM does not distinguish between the categories of OOMG and OON.

MEMO

Date: January 14 2018

To Quality Improvement Committee
From Derek Malley
UM Nurse Supervisor/Quality Review
Clinical Operations

Regarding Quarter 4 2017
Potential Quality Issue Report

Case reviews

<table>
<thead>
<tr>
<th>Quarter 4 2017</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cases Reviewed for PQI</td>
<td>116</td>
</tr>
<tr>
<td>#of cases of 116 which required additional Documentation and medical peer review</td>
<td>2</td>
</tr>
<tr>
<td>Formal PQI investigation</td>
<td>0</td>
</tr>
<tr>
<td>Confirmed PQI</td>
<td>0</td>
</tr>
<tr>
<td>Provider Preventable Condition</td>
<td>0</td>
</tr>
<tr>
<td>Grievances (Clinical/Non-Clinical)</td>
<td>102</td>
</tr>
<tr>
<td>UM referrals</td>
<td>0</td>
</tr>
<tr>
<td>Provider Preventable Condition reporting</td>
<td>0</td>
</tr>
<tr>
<td>Appeals</td>
<td>14</td>
</tr>
</tbody>
</table>

All PQI cases were reviewed within the 45 day time frame as outlined in UM56. No confirmed Clinical Quality Issues within this quarter.

**Analysis:** No identified PQI trends during Q4 2017.
### All QI Workplan Measures Status

- **Total Red**: 2, 8%
- **Total Yellow**: 0, 0%
- **Total Green**: 4, 16%
- **Total N/A**: 19, 76%

### QI Workplan Measures Status by Domain

#### Care Coordination and Services

**Community Health Network (CHN) Out of Medical Group (OMG) All Cause Readmissions**
- **Measure**: Reduce the rate of All Cause Readmissions for CHN OMG admissions.
- **Final Due Date**: 12/31/2017
- **Target**
  - 2017: 14.43%
  - 2016: 22.75%
- **Q2 YTD Results**: 14.43%
- **Update on Activities**
  - The following activities were completed:
    - Completion of discharge assessment.
    - QIC Summaries sent to PCP.
    - POP or Specialist follow-up appointments.
- **Data Analysis**
  - The following activities were not completed due to staffing resource barriers:
    - Follow-up phone calls to members post discharge.
    - Onsite discharge planning.
- **Status**: Target was not met. These are the final 2017 results. Reporting period is Oct 2016 - Sept 2017. Barriers included staffing resource issues for follow-up phone calls and onsite discharge planning.

#### Care Coordination and Services

**Screening for Clinical Depression and Follow up**
- **Measure**: Increase the percentage of clients in SFHP’s Case Management (CM) programs successfully screened for clinical depression including a follow-up plan documented, if positive.
- **Final Due Date**: 12/31/2017
- **Target**
  - 2017: 70.00%
  - 2016: 36.00%
- **Q2 YTD Results**: 70.00%
- **Update on Activities**
  - The following activities were completed:
    - A report/process will need to be developed to capture PHQ-2 screenings and care plan goals currently part of the Care Management Interview tool.
    - Conduct analysis of depression screening results and corresponding care plan documentation.
    - Staff trained to self-audit for adding goal to positive depression screenings.
- **Data Analysis**
  - The following activities were not completed due to system issues being resolved at the end of Q3 2017.
- **Status**: Target was not met. These are the final 2017 results. Barriers to meeting target included members declining services, however, there was an increase in Q4 2017 in total goals completed due to system issues being resolved at the end of Q3 2017.

#### Care Coordination and Services

**Complex Medical Case Management (CMCM) Client Satisfaction**
- **Measure**: Increase the rate of CMCM satisfaction with their case manager.
- **Final Due Date**: 12/31/2017
- **Target**
  - 2017: 80.00%
  - 2016: 90.00%
- **Q2 YTD Results**: 80.00%
- **Update on Activities**
  - Survey completed in August 2017 for NCQA cases. Next survey to be completed at the end of Q1 2017.
- **Data Analysis**
  - Target met. These are the Final 2017 results.
- **Status**: Green

#### Delegation Oversight

**Utilization Management (UM) Delegation Improvements**
- **Measure**: Implement new Notice of Action (NOA) across all medical groups.
- **Final Due Date**: 12/31/2017
- **Target**
  - 2017: 100.00%
  - 2016: 100.00%
- **Q2 YTD Results**: 100.00%
- **Update on Activities**
  - All medical groups have implemented new NOA letter.
  - The following activities were completed:
    - Provide the delegated medical groups with a new, compliant Notice of Action.
    - Feedback to medical groups via 2016 UM audit.
    - Annual NOA denial file review (Annual Oversight Audit).
    - Check-in of progress during Joint Administrative Meetings - not completed during JAMs, progress check was made during Annual Oversight Audit.
- **Data Analysis**
  - Target met. These are the Final 2017 results.
- **Status**: Green

#### Quality of Service and Access to Care

**Member Grievances**
- **Measure**: Increase the rate of member grievances resolved in a timely manner.
- **Final Due Date**: 6/30/2018
- **Target**
  - 2017: 100.00%
  - 2016: 100.00%
- **Q2 YTD Results**: 100.00%
- **Update on Activities**
  - The following activities were completed:
    - Grievance team finalizing program charter. High level document that defines structure, processes, and responsibilities.
    - Charters also set up a grievance PLT that meets quarterly. The PLT assists the grievance team in making regulatory requirements and ensures departmental collaboration for grievances that identify systemic issues.
    - Process improvement with customer service to improve the grievance process, including ongoing quarterly meeting with Customer Service Leadership.
- **Data Analysis**
  - No trends in grievance turnaround time found, target met.
- **Status**: Green

#### Quality of Service and Access to Care

**Potential Quality Issues (PQI)**
- **Measure**: Increase the rate of PQIs resolved in a timely manner.
- **Final Due Date**: 6/30/2018
- **Target**
  - 2017: 100.00%
  - 2016: 100.00%
- **Q2 YTD Results**: 100.00%
- **Update on Activities**
  - The following activities were completed:
    - Triage of Care Management case referrals by QI Review Nurse.
    - Identification and monitoring of Provider Preventable Conditions.
    - Refine PQI workflow in Essette to maximize functionality.
- **Data Analysis**
  - Target met.
- **Status**: Green

### 2017 QI Plan Measure

#### 2018 QI Plan Measure
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 SFHP, 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 3Q2017, 9,254 members had 15,017 ER visits, averaging 1.62 ER visits per member. This reflects an ER visit by approximately 7% of the SFHP Medi-Cal membership within the quarter. The distribution of ER visits by ER facility and by member is consistent with previous quarters and is reported in Table 1A and Table 1B respectively.

<table>
<thead>
<tr>
<th>ER Facility</th>
<th>ER Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZSFG - ACUTE CARE</td>
<td>5778</td>
</tr>
<tr>
<td>UC SAN FRANCISCO MEDICAL CENTER</td>
<td>2338</td>
</tr>
<tr>
<td>ST FRANCIS MEMORIAL HOSPITAL</td>
<td>2033</td>
</tr>
<tr>
<td>CPMC ST LUKES CAMPUS</td>
<td>1665</td>
</tr>
<tr>
<td>CPMC PACIFIC CAMPUS</td>
<td>1133</td>
</tr>
<tr>
<td>ST MARYS MEDICAL CENTER</td>
<td>604</td>
</tr>
<tr>
<td>CPMC DAVIES CAMPUS</td>
<td>499</td>
</tr>
<tr>
<td>CHINESE HOSPITAL</td>
<td>268</td>
</tr>
<tr>
<td>KAISER FOUNDATION HOSPITAL SAN FRANCISCO</td>
<td>257</td>
</tr>
<tr>
<td>CHINESE COMMUNITY HEALTH CARE ASSOCIATION</td>
<td>92</td>
</tr>
<tr>
<td>Other ED Facilities</td>
<td>350</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15,017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># ER Visits</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6,602</td>
</tr>
<tr>
<td>2</td>
<td>1,631</td>
</tr>
<tr>
<td>3</td>
<td>469</td>
</tr>
<tr>
<td>4</td>
<td>213</td>
</tr>
<tr>
<td>5</td>
<td>110</td>
</tr>
<tr>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td>9 - 11</td>
<td>15</td>
</tr>
<tr>
<td>11 - 29</td>
<td>75</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9,254</td>
</tr>
</tbody>
</table>
Section 2 - Top Diagnoses

Of the 15,017 ER visits in 3Q2017, 9,876 visits (66%) resulted in a medication (from ER or pharmacy) within 72 hours of the ER Visit and 5,141 (34%) did not. This distribution is consistent with previous quarters. Not all ER visits warranted medication treatment (ie. chest pain, abdominal pain or altered mental status). The distribution of top ER visits by diagnoses category is consistent with previous quarters with no changes ≥1% since 2Q2017. The top 15 diagnoses categories for ER Visits are reported below in Table 2.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Top Diagnoses Categories</th>
<th>ICD10</th>
<th>ER Visits</th>
<th>% of Visits</th>
<th>Change in % visits 3Q vs 2Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Abdominal Pain</td>
<td>R10.xx</td>
<td>864</td>
<td>5.8%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>2</td>
<td>Chest pain</td>
<td>R07.xx</td>
<td>718</td>
<td>4.8%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>3</td>
<td>Alcohol abuse/dependence</td>
<td>F10.xx</td>
<td>534</td>
<td>3.6%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>4</td>
<td>Fever</td>
<td>R50.xx</td>
<td>267</td>
<td>1.8%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>5</td>
<td>Headache</td>
<td>R51</td>
<td>247</td>
<td>1.6%</td>
<td>0.2%</td>
</tr>
<tr>
<td>6</td>
<td>Asthma</td>
<td>J45.xx</td>
<td>198</td>
<td>1.3%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>7</td>
<td>Nausea w/wo Vomiting</td>
<td>R11.xx</td>
<td>189</td>
<td>1.3%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>8</td>
<td>Shortness of Breath</td>
<td>R06.02</td>
<td>170</td>
<td>1.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>9</td>
<td>Dizziness and giddiness</td>
<td>R42</td>
<td>169</td>
<td>1.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>10</td>
<td>Altered Mental Status</td>
<td>R41.82</td>
<td>164</td>
<td>1.1%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>11</td>
<td>Low Back Pain</td>
<td>M54.5</td>
<td>157</td>
<td>1.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>12</td>
<td>UTI unspecified</td>
<td>N39.0</td>
<td>154</td>
<td>1.0%</td>
<td>0.2%</td>
</tr>
<tr>
<td>13</td>
<td>Acute Pharyngitis Unspecified</td>
<td>J02.9</td>
<td>133</td>
<td>0.9%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>14</td>
<td>Cough</td>
<td>R05</td>
<td>131</td>
<td>0.9%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>15</td>
<td>Acute Upper Respiratory Infection Unspecified</td>
<td>J06.9</td>
<td>108</td>
<td>0.7%</td>
<td>-0.6%</td>
</tr>
<tr>
<td></td>
<td>All Other Diagnoses</td>
<td></td>
<td>10,814</td>
<td>72%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td></td>
<td>15,017</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Table 3: ER Visit – Key Diagnoses Category

Selected key diagnoses category with a high likelihood for ER discharge prescription is reported in Table 3. In 3Q2017, >96% of ER visits for Asthma, UTI, and Pneumonia received medication treatment within 72 hours of the visit. The number of prescriptions filled for bronchitis remained less than 90% for the second consecutive quarter and lower than other diagnoses at 85%.

<table>
<thead>
<tr>
<th>Diagnoses Category</th>
<th>ICD10</th>
<th>RX Filled</th>
<th>ER Treated</th>
<th>No Rxs</th>
<th>Total Rxs</th>
<th>%Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>UTI</td>
<td>N39.0</td>
<td>101</td>
<td>29</td>
<td>5</td>
<td>135</td>
<td>96%</td>
</tr>
<tr>
<td>Asthma</td>
<td>J45.901,J45.909</td>
<td>85</td>
<td>51</td>
<td>5</td>
<td>141</td>
<td>96%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>J18.9</td>
<td>38</td>
<td>19</td>
<td>1</td>
<td>58</td>
<td>98%</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>J20.8, J20.9, J21.9, J40, J44.1</td>
<td>13</td>
<td>9</td>
<td>4</td>
<td>26</td>
<td>85%</td>
</tr>
</tbody>
</table>
Due to the consecutive low percentage of prescriptions filled for bronchitis, an ad hoc analysis was performed to investigate if members had an ER visit for the same diagnosis within 7 days of the initial visit. In 3Q2017, there were a total of 10 unique members who had at least 2 consecutive ER visits with primary diagnosis of COPD within 7 days.

Section 4 - Pharmacy Location

For the members that did fill a prescription from a Pharmacy within 72 hours of their ER visit date, a further analysis evaluated the location of the pharmacy in relation to where the member received emergency care and the hours of operation for these pharmacies. SFHP has one 24 hour pharmacy in our San Francisco network and 50% of our pharmacies are open until 9pm. 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. Of the 5,687 member visits to a pharmacy after an ER discharge, the top 12 most utilized pharmacies are reported in Table 4.

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>Walgreens 3711 (1189 Potrero Ave)</td>
<td>8AM – 10PM</td>
<td>503</td>
<td>8.8%</td>
</tr>
<tr>
<td>SF General (1001 Potrero Ave)</td>
<td>9AM – 8PM M-F, 9AM-1PM Sat</td>
<td>434</td>
<td>7.6%</td>
</tr>
<tr>
<td>Walgreens 1327 (498 Castro St)</td>
<td>24 Hours</td>
<td>260</td>
<td>4.6%</td>
</tr>
<tr>
<td>Walgreens 5487 (5300 3rd St)</td>
<td>7AM – 9PM</td>
<td>216</td>
<td>3.8%</td>
</tr>
<tr>
<td>Walgreens 4609 (1301 Market St)</td>
<td>6AM – 9PM</td>
<td>215</td>
<td>3.8%</td>
</tr>
<tr>
<td>Walgreens 1126 (1979 Mission St)</td>
<td>7AM – 10PM</td>
<td>173</td>
<td>3.0%</td>
</tr>
<tr>
<td>Walgreens 13668 (1496 Market St)</td>
<td>7AM – 10PM</td>
<td>152</td>
<td>2.7%</td>
</tr>
<tr>
<td>Walgreens 7150 (965 Geneva Ave)</td>
<td>7:30AM – 10PM</td>
<td>150</td>
<td>2.6%</td>
</tr>
<tr>
<td>Walgreens 2153 (790 Van Ness Ave)</td>
<td>7AM – 10PM</td>
<td>144</td>
<td>2.5%</td>
</tr>
<tr>
<td>Walgreens 2244 (3801 3rd St)</td>
<td>9AM – 10PM</td>
<td>131</td>
<td>2.3%</td>
</tr>
<tr>
<td>Walgreens 15331 (500 Parnassus J Level)</td>
<td>8:30AM – 8:30PM</td>
<td>125</td>
<td>2.2%</td>
</tr>
<tr>
<td>Walgreens 1626 (2494 San Bruno)</td>
<td>7:30AM – 10PM</td>
<td>124</td>
<td>2.2%</td>
</tr>
<tr>
<td>All Other Pharmacy Locations</td>
<td></td>
<td>3,060</td>
<td>53.8%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>5,687</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Summary:

ER utilization was lower in 3Q2017 compared to 2Q2017 (15,017 visits vs 15,497) with each member utilizing the ER at 1.62 visits. The number of prescriptions filled for bronchitis remained less than 90% for the second consecutive quarter. An ad hoc analysis on bronchitis readmission showed 10 unique members were readmitted within 7 days, with only 1 member not receiving medical treatment. Since 2Q2017, there was an overall 15% reduction in number of pharmacies where members obtained a prescription within 72 hours of an ER visit with no specific pharmacies disproportionately affected. No barrier to pharmacy access during after-hours was identified in this quarter. Monitoring of member access to medication treatment after an ER visit will continue.
SFHP POLICY AND PROCEDURE

Alcohol Misuse Screening and Counseling (AMSC)

Policy and Procedure number: HE-06
Department Owner: Health Outcomes Improvement
Lines of Business Affected: Medi-Cal

POLICY STATEMENT

Providers in primary care settings must offer and document Alcohol Misuse Screening and Counseling (AMSC) services for any member 18 years of age and older who answers “yes” to the alcohol question in the Staying Healthy Assessment (SHA), or at any time the PCP identifies a potential alcohol misuse problem.

PROCEDURE

1. Materials
   A. SFHP informs Medi-Cal members about the availability of AMSC in the Medi-Cal Member Handbook.
   B. SFHP informs providers about the AMSC requirements in the Network Operations Manual.
   DHCS provides electronic copies of the Alcohol Use Disorder Identification Test (AUDIT) and the Alcohol Use Disorder Identification Test – Consumption (AUDIT-C) (Attachments A and B, respectively) via SAMHSA-HRSA Center for Integrated Health Solutions.

2. Requirements
   A. SFHP covers and pays for an expanded alcohol screening for members 18 years of age and older who answer “yes” to the alcohol question in the SHA, or at any time the PCP identifies a potential alcohol misuse problem. Youth aged 18-21 are eligible for additional screening benefits under EPSDT (refer to UM-33 for EPSDT-related procedures). SFHP also covers and pays for behavioral counseling intervention(s) for members who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder. Capitated providers are covered through their capitation payments and non-capitated providers are covered through claims submissions. SFHP allows each member at least three (3) behavioral counseling interventions per year. SFHP requires that PCPs document the SHA and expanded screening.

   B. All licensed providers, as well as non-licensed providers who meet the requirements below, may offer AMSC services in the primary care setting.
Non-licensed health care providers must provide AMSC under the supervision of a licensed health care provider (Licensed Physician, PA, NP, Psychologist).

C. At least one supervising licensed provider per clinic or practice may take four (4) hours of AMSC training. SFHP offers information about trainings on its website and in provider communications. Rendering licensed providers are highly encouraged, but not required, to take training in order to provide the services.

D. When a member answers “yes” to the SHA alcohol pre-screen question, the PCP must offer the members an expanded, validated alcohol screening questionnaire (AUDIT or AUDIT-C). PCPs must document having done this expanded screening. SFHP must allow each member at least one expanded screening, using AUDIT or AUDIT-C, every year. Additional screenings can be provided in a calendar year if medical necessity is documented by the member’s provider.

E. Providers must offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use when a member responds affirmatively to the alcohol question in the SHA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified. Behavioral counseling interventions typically include one (1) to three (3) sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities, and do not require Prior Authorization. Providers may refer offsite for behavioral counseling interventions; however, SFHP encourages PCPs and their teams to offer the service within the primary care clinic, to increase the likelihood of members following through on the interventions. Providers may combine these visits in one (1) or two (2) visits, or administer the sessions as three (3) separate visits. Additional sessions can be provided if medical necessity has been determined by the member’s provider.

F. When a member transfers to another PCP, the receiving PCP must obtain prior records. If no documentation is found, the new PCP must provide and document this service. Updated Healthcare Common Procedure Codes (HCPC) are provided in the DHCS Provider Manual.

G. Members who, upon screening and evaluation, meet criteria for an alcohol use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), or whose diagnosis is uncertain, must be referred for further evaluation and treatment, without requiring Prior Authorization, to the County Department for alcohol and substance use disorder treatment services or DHCS-certified treatment program.

H. Member grievances and appeals regarding AMSC services are processed per the procedures in QI-06.
MONITORING

The Manager of Population Health and the Facility Site Review Nurse are responsible for monitoring, oversight and reporting of SHA compliance. The Facility Site Review nurse monitors compliance with SHA and AMSC requirements as part of the medical record review during facility site review audits.

DEFINITIONS

Alcohol Misuse Screening and Counseling (AMSC): Screening for alcohol misuse and providing persons engaged in risky or hazardous drinking and brief behavioral counseling interventions to reduce alcohol misuse.

Alcohol Use Disorder: A patient who meets the criteria in the Diagnostic and Statistical Manual (DSM) for a substance use disorder resulting from alcohol use.

Alcohol Abuse Disorder Identification Test (AUDIT) and Alcohol Abuse Disorder Identification Test – Consumption (AUDIT-C): Screening instruments for alcohol misuse that are downloadable from the SAMHSA-HRSA Center for Integrated Health Solutions. Although instruments are available there, a complete guide to clinical implementation of the AUDIT screening instrument is available by the World Health Organization.

Behavioral Counseling Interventions for Alcohol Misuse: activities delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including appropriate alcohol use.

Staying Healthy Assessment (SHA): The new DHCS MMCD IHEBA, revised in 2013.

AFFECTED DEPARTMENTS/PARTIES

Health Outcomes Improvement
Provider Network Operations
Marketing and Communications

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

HE-01: Staying Healthy Assessment (SHA)/Individual Health Education and Behavioral Assessment (IHEBA)
QI-06: Member Grievances and Appeals
UM-33: Early Periodic Screening, and Diagnosis and Treatment (EPSDT) and EPSDT Supplemental Services—Alcohol Use Disorders Identification Test (AUDIT)
(https://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf)
Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)

REVISION HISTORY

Effective Date:
Approval Date:
Revision Date(s):

REFERENCES

DHCS/SFHP Contract Exhibit A, Attachment 18, Section 19, Paragraph K
MMCD Policy Letter 14-004
MMCD Policy Letter 17-016
Effective January 1, 2018, San Francisco Health Plan (SFHP) implemented a palliative care benefit for Medi-Cal members in compliance with California Senate Bill (SB) 1004 (2014) and the subsequent All Plan Letter (APL) 15-015 issued by the Department of Health Care Services (DHCS) on October 19, 2017.

I. SB 1004 Requirements

SB 1004 required that Medi-Cal managed care plans (MCPs) provide palliative care, including:
- Specialized medical care and emotional and spiritual support for people with serious advanced illnesses.
- Relief of symptoms, pain and stress of serious illness.
- Improvement of quality of life for both the patient and the family.
- Appropriate care for any age and for any stage of serious illness, along with curative treatment.

II. APL 17-015 Requirements

The bill requires that covered services include at least those services covered by the Medi-Cal hospice benefit:
- Hospice services that are provided at the same time that curative treatment is available to the extent that services are not duplicative.
- Hospice services provided to individuals whose conditions may result in death, regardless of the estimated length of the member’s remaining life.
- Any other services DHCS determines to be appropriate.

On October 19, 2017 DHCS issued APL 17-015 providing guidance to Medi-Cal MCPs on implementation of the palliative care benefit. Specific elements include:

A. Eligibility Requirements
To be eligible, a member must meet general eligibility requirements:

- The member is likely to or has begun using the hospital or emergency department (ED) as a means to manage the advanced disease.
- The member has a specified advanced illness (below) and is not eligible for or has declined hospice services. Members may not be enrolled in both hospice and palliative care.
- The member’s death within a year would not be unexpected.
- The member has received appropriate medical care or medical care is no longer effective. Member may not be in reversible acute decompensation.
- The member and any member-designated family or caregiver agree to attempt appropriate in-home, residential, or outpatient palliative care instead of relying on the ED and agree to participate in advance care planning discussions.

A member must also meet disease-specific eligibility criteria:

- Congestive Heart Failure (CHF), including hospitalization due to CHF as a primary diagnosis without further invasive procedures planned; OR meets criteria for the New York Heart Association heart failure classification III or higher; AND has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.
- Chronic Obstructive Pulmonary Disease (COPD), including a Forced Expiratory Volume 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; OR a 24-hour oxygen requirement of at least three liters per minute.
- Advanced Cancer, including stage III or IV solid organ cancer, lymphoma, or leukemia; AND a Karnofsky Performance Scale score less than or equal to 70 or failure of two lines of standard care therapy.
- Liver Disease, including evidence of irreversible liver damage and a Model for End Stage Liver Disease score of greater than 19; OR evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio greater than 1.3; AND ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices.

B. Palliative Care Services

Palliative care must include at a minimum the following services:

- Advance Care Planning, including advance directives.
- Palliative Care Assessment and Consultation, including collection of medical and additional personal data not regularly included in a medical history:
  - Treatment plans for both palliative care and curative care
  - Pain and medication side effects
  - Emotional and social challenges
  - Spiritual concerns
o Patient goals
o Advance directives, including POLST forms
o Legally recognized decision maker

• A Plan of Care developed with the patient and any representatives, including palliative care and curative care plans and goals.
• Palliative Care Team, including all team members providing authorized palliative care. Recommended team members include a physician (may be a PCP), a nurse (RN, LVN, or NP – may be PCP if NP), a social worker, and a chaplain, although chaplain services are not Medi-Cal reimbursable.
• Care Coordination, through implementation and assessment of the plan of care.
• Pain and Symptom Management, through prescription drugs, physical therapy, and other medically necessary pain management services.
• Mental Health and Medical Social Services, including psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate.

C. Providers

Palliative care may be provided in a variety of settings, including inpatient, outpatient, and community-based settings. MCPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care.

D. Policy and Procedure

MCPs are required to submit a policy and procedure to DHCS for approval to meet the requirements for the palliative care benefit. SFHP developed UM-58: Palliative Care in response, which DHCS approved on December 6, 2017.
POLICY STATEMENT

San Francisco Health Plan offers palliative care as a benefit to members who qualify for and choose palliative care. SFHP ensures that all members who elect that and meet criteria are provided the scope of services as defined by Senate Bill (SB) 1004 (Hernandez, Chapter 574, Statutes of 2014).

PROCEDURE

I. Eligibility Criteria

Palliative care does not require the beneficiary to have a life expectancy of six (6) months or less and may be provided concurrently with curative care. A member with a serious illness who is receiving palliative care may choose to transition to hospice care if he/she meets the hospice eligibility criteria (see UM-32 Hospice Care). A member may not be concurrently enrolled in hospice care and palliative care.

A member under 21 years-of-age may be eligible for palliative care and hospice services concurrently with curative care through other existing programs such as the Section 1915 (c) Home and Community Based Services waiver, known as Pediatric Palliative Care waiver or concurrent care under Section 2302 of the Patient Protection and Affordable Care Act (ACA).

A member is required to meet all the requirements for the general eligibility criteria and at least one (1) of the four (4) disease-specific eligibility requirements.

A. General Eligibility Criteria:

1. A member must not be a Medicare-Medi-Cal dual eligible.
2. The member is likely to or has started to use the hospital or emergency department as a means to manage his/her advanced disease. This refers
to unanticipated decompensation and does not include elective procedures.

3. The member has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.

4. The member's death within a year would not be unexpected based on clinical status.

5. The member has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective. The patient is not in reversible acute decompensation.

6. The member and, if applicable, the family/patient-designated support person, agrees to:
   a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
   b. Participate in Advance Care Planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
   a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association’s (NYHA) heart failure classification III or higher; and
   b. The member has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
   a. The member has a Forced Expiratory Volume (FEV1) less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
   b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
   a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b. The member has a Karnofsky Performance Scale (KPS) score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).
4. Liver Disease: Must meet (a) and (b) combined or (c) alone
   a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
   b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

If a member continues to meet the above minimum eligibility criteria, he or she may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

II. Identification/Referral Process

A. The primary care provider, SFHP and medical group staff may refer members to palliative care services.
B. SFHP informs staff, network providers and other relevant programs/non-network providers of the importance of timely recognition of a member's eligibility for palliative care services and their election of palliative care services.
C. SFHP UM Coordinator(s) will receive the referral information.
D. SFHP UM Coordinator will work with appropriate clinical staff to review the referral and determine eligibility for palliative care.
E. If eligible, UM Coordinator will complete the referral process and ensure palliative care services are coordinated within the appropriate prior authorization turnaround standards.
F. Upon approval, SFHP will ensure palliative care providers adhere to timely access standards to provide services within 15 calendar days of requesting the service.

III. Notice of Action

A. If a request for palliative care is deferred, denied, or modified, SFHP UM staff will send the member and provider a Notice of Action, following the timeframes for prior authorization requests (outlined in UM-22 – Authorization Requests)
B. A member or provider may appeal the decision, as outlined in QI-06 Member Grievances and Appeals.

IV. Palliative Care Benefits

SFHP assures that the following seven (7) services are provided at minimum when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions.
A. Advance Care Planning: Advance care planning for members enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified health care professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms. Please refer to the section on Advanced Care Planning in the Medi-Cal Provider Manual for further details.

B. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
   - Treatment plans, including palliative care and curative care
   - Pain and medicine side effects
   - Emotional and social challenges
   - Spiritual concerns
   - Patient goals
   - Advance directives, including POLST forms
   - Legally recognized decision maker

C. Plan of Care: A plan of care should be developed with the engagement of the member and/or his or her representative(s) in its design. If a member already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A member’s plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program.

D. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of members and their families and are able to assist in identifying sources of pain and discomfort of the member. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. The palliative care team should include, but is not limited to the following team members, a doctor of medicine or osteopathy (Primary Care Provider if MD or DO), a registered nurse, licensed vocational nurse or nurse practitioner (Primary Care Provider if NP), or and a social worker. Chaplain Services: It is recommended that
members have access to chaplain services as part of the palliative care team, but not required.

E. Care Coordination: A member of the palliative care team should provide coordination of care, ensure continuous assessment of the member’s needs, and implement the plan of care.

F. Pain and Symptom Management: Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy, and other medically necessary services may be needed to address the member’s pain and other symptoms. The member’s plan of care must include all services authorized for pain and symptom management.

G. Mental Health and Medical Social Services: Counseling and social services must be available to the member to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services shall not duplicate specialty mental health services (SMHS) provided by Community Behavioral Health Services (CBHS) and does not change the SFHP’s responsibilities for referring to, and coordinating with, CBHS as delineated in APL 13-021.

V. Palliative Care Provider Network

A. SFHP ensures it has a qualified network of providers to offer palliative care services.

B. SFHP may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings.

C. SFHP contracts with and utilizes only qualified providers for palliative care based on the setting and needs of a member.

D. SFHP ensures that its providers comply with existing Medi-Cal contracts and/or APLs.

E. SFHP uses providers with current palliative care training and/or certification to conduct palliative care consultations or assessments, if possible.

VI. Provider Education

A. SFHP ensures that its provider network is informed and educated regarding the availability of palliative care services and the network of palliative care providers through the SFHP Network Operations Manual and newsletters.

B. SFHP informs its provider network of the free training available for a limited time through the California State University. Providers are directed to apply
for the training at this Web site: https://csupalliativecare.org/education/sb1004/

**MONITORING**

A. SFHP utilize its grievance and appeals process to address any disputes related to the provision of palliative care services (QI-06 Member Grievances and Appeals).

B. Aggregate data is subject to retrospective analysis by SFHP’s UM Department, with the following goals:
   1. Identify individual provider practice patterns relative to medical standards
   2. Evaluate over and underutilization of services
   3. Evaluate palliative care enrollment
   4. Evaluate palliative care network

C. SFHP monitors turnaround times of internal processing for compliance with standards.

D. SFHP performs inter-rater reliability audits at least annually for both physician and nurse reviewers.

E. SFHP evaluates member and provider grievances, as well as SFHP’s member and provider satisfaction survey responses, to identify patterns.

F. SFHP Medical Director identifies any potential quality issues (PQI), including provider preventable conditions (PPCs) and follows the PQI process as defined in UM-56 (Potential Quality Issues).

G. Reports regarding SFHP’s UM Departments’ monitoring activities are presented to the Quality Improvement Committee (QIC) at least annually for evaluation and corrective actions as needed.

**DEFINITIONS**

**Palliative Care:** Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice¹.

**POLST (Physician Orders for Life-Sustaining Treatment):** A form that gives seriously-ill patients more control over their end-of-life care, including medical treatment, extraordinary measures (such as ventilator or feeding tube) and CPR².

**AFFECTED DEPARTMENTS/PARTIES**

Clinical Operations  
Care Management  
Provider Network Operations  
Claims
RELATED POLICIES AND PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

QI-06 Member Grievances and Appeals
UM-22 Authorization Requests
UM-56 Potential Quality Issues
UM-32 Hospice Care

REVISION HISTORY

Effective Date: January 1, 2018
Approval Date: 
Revision Date(s): 

REFERENCES

¹http://www.dhcs.ca.gov/provgovpart/Documents/SB1004PallCarePolicyDoc090116.pdf
²http://capolst.org/
DHCS All Plan Letter (APL): Palliative Care and Medi-Cal Managed Care
DHCS All Plan Letter (APL) -13-014: Hospice Services and Medi-Cal Managed Care
DHCS All Plan Letter (APL) -13-021: Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services
Medi-Cal Provider Manual
MEMO

Date: January 31, 2018

<table>
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<tr>
<th>To</th>
<th>SFHP Quality Improvement Committee</th>
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<tr>
<td>From</td>
<td>Jackie Hägg, RN, MSN, LNC, Nurse Specialist, Provider Quality and Outreach</td>
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<tr>
<td>Regarding</td>
<td>2017 Facility Site Review Results</td>
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**Background:** The California Department of Health Care Services (DHCS) requires Medi-Cal Managed Care Plans to conduct a Full Scope Facility Site Review (FSR) for every Primary Care Provider (PCP) site as part of the initial credentialing process and at least every 36 months thereafter. The Full Scope FSR consists of two scored components that help ensure consistent compliance with DHCS administrative and clinical guidelines:

1. Site Review Survey (SRS) evaluates 139 criteria in the areas of access and safety, personnel, office management, clinical services, preventive services, and infection control.
2. Medical Record Review (MRR) evaluates 32 criteria in the areas of chart format, documentation, continuity and coordination of care, and preventive care.

Both FSR components are scored by Certified Nurse Reviewers (CNRs) using standardized audit tools developed by DHCS. Scoring guidelines are as follows:

**Site Review Survey**
- 90-100%* - Exempted Pass
- 80-89% - Conditional Pass with Corrective Action Plan (CAP)
- Less than 80% - Non-pass
*Regardless of overall score, CAP is required for any deficiencies in Infection Control, Pharmaceutical Services, or Critical Elements

**Medical Record Review**
- 90-100%* - Exempted Pass
- 80-89% - Conditional Pass with CAP
- Less than 80% - Non-pass
*Regardless of overall score, CAP is required if any individual section score is below 80%
San Francisco Health Plan (SFHP) works collaboratively and has an active Memorandum of Understanding (MOU) with Anthem Blue Cross of California to review all primary care providers and sites that are jointly contracted with the Plans in order to ensure compliance with criteria set forth by the California Department of Health Care Services (DHCS). In addition, SFHP delegates and conducts ongoing oversight of these full scope (facility site and medical record) reviews and the interim monitoring activities to its medical groups. Each medical group identifies internal staff or contracts with a nurse who contracts each type of review and is certified by SFHP’s Master Trainer as a Site Review Trainer. Each contracted primary care site is reviewed every three years with tools implemented by the DHCS in Policy Letter 14-004 (2014).

FSRs are conducted by SFHP and Anthem Blue Cross in the City and County of San Francisco. Per DHCS guidelines, FSR results are shared between the two Health Plans to avoid over-auditing PCP sites. The following SFHP Medical Groups are delegated to perform FSRs: Brown and Toland (BTP), Chinese Community Health Care Association (CCHCA), Hill Physicians Medical Group (HPMG), Kaiser, and North East Medical Services (NEMS).

The following tables summarize all FSR scores from Calendar Year 2017. Many PCPs participate in more than one medical group; however, providers are only listed once, by medical group that performed the FSR. It is also important to note that the SRS and MRR are sometimes conducted separately. For instance, an initial SRS is conducted for new sites as part of the initial credentialing process, but the MRR will be delayed by approximately six months to allow providers time to see new Managed Medi-Cal patients. Therefore, the number of SRS reviews may differ from the number of MRR reviews for a specified time period.

### 2017 Site Review Scores Summary

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<th># of Reviews in 2017</th>
<th>Review Scores 90% - 100%</th>
<th>Review Scores 80% - 89%</th>
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### 2017 Medical Record Review Scores Summary

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</table>

**Summary:** There were 49 SRS and 47 MRR completed in calendar year 2017. Within San Francisco Health Plan’s network, eight initial reviews were conducted with new providers and/or clinic locations during the year. Of these eight reviews, six were providers who had moved their office locations.

Three network providers received facility site or medical record review scores that were below 80%. The Department or Health Care Services (DHCS) standards do not pass a provider/clinic with scores below 80%. These providers were in Chinese Community Health Care Association’s (CCHCA) network, Hill Physician Medical Group (HPMG), and San Francisco Health Plan (SFHP):

- One CCHCA provider scored 72% on his periodic MRR in February 2017. DHCS considers any scores below 80% as “not passed”. His medical record corrective action plan (CAP) was approved and signed off on April 13, 2017. 100% of the corrective actions were signed off by the PCP. The Certified Nurse Reviewer (CNR) re-visited the clinic to ensure all corrections were implemented. A Focused MRR is planned for February 2018. Providers with failed office or medical record scores below 80% are taken to that medical group’s Quality Improvement/Peer Review Committee for appropriate action and the provider’s panel is closed to new members until a score of 80% or above is documented.

- One HPMG provider scored 77% on their initial MRR in April 2017. DHCS considers any scores below 80% as “not passed”. His medical record corrective action plan (CAP) was approved and signed off on June 9, 2017. This PCP was brought to the PAC on August 3, 2017 and approved of the plan to conduct a follow-up medical record review January, 2018 to ensure corrective actions are being practiced. Providers with failed office or medical record scores below 80% are taken to that medical group’s Quality Improvement/Peer Review Committee for appropriate action and the provider’s panel is closed to new members until a score of 80% or above is documented.
One SFHP affiliated with HPMG provider scored 77% on her periodic MRR on November 30, 2017. A considerable amount of support was provided to the clinic Medical Director (MD) due to high staff turnover, a mixed paper/EHR documentation system, and the member demographic. A Facility Site Review (FSR) binder was prepared and given to the MD with guidelines for each corrective action item including sample policies and/or templates. This MD’s circumstances were brought before the PAC in December 2017 with approval of the approach and pending CAP due late January 2018. DHCS considers any scores below 80% as “not passed”. A follow-up medical record review will be determined after the CAP is returned and reviewed, scheduled in 6 months (April 2018) allowing time to fully implement all items on the CAP.

In addition, there were a total of 77 Interim Monitoring/Focused (IM) reviews in 2017 that were conducted at approximately 18 months following their last facility site review. The purpose of the IM review is to monitor that the facility site critical elements, medical record standards and any corrective action plans from their last review have been maintained. Evaluation of the important patient safety critical elements is conducted at all IM reviews.

### 2017 Interim Monitoring (IM) Reviews Summary

<table>
<thead>
<tr>
<th>Medical Group</th>
<th># Interim Monitoring Reviews by Medical Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>BTP</td>
<td>8</td>
</tr>
<tr>
<td>CCHCA</td>
<td>20</td>
</tr>
<tr>
<td>CHN</td>
<td>9</td>
</tr>
<tr>
<td>HPSM</td>
<td>1</td>
</tr>
<tr>
<td>HPMG</td>
<td>8</td>
</tr>
<tr>
<td>NEMS</td>
<td>3</td>
</tr>
<tr>
<td>SFHP</td>
<td>22</td>
</tr>
<tr>
<td>UCSF</td>
<td>6</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>77</strong></td>
</tr>
</tbody>
</table>

### 2017 Inter-Rater Reliability Nurse Reviewers Summary:

All four of SFHP’s certified nurse Site Review Trainers participated in the October 26, 2017 Northern California DHCS Inter-rater Reliability (IRR) chart review process re-certification and conference. The delegated nurses and this writer scored six medical records (Two pediatric, two adult, and two obstetrical charts). The scores for each reviewer are compiled and graphed. All nurses in Northern California scored within ten percentage points of the control score of 85%. The SFHP delegated nurses reviewers scored within 7 (seven) percentage points of the control score.

Nurse Reviewer Comprehensive IRR Scores – October 26, 2017

<table>
<thead>
<tr>
<th>Reviewer</th>
<th>Overall Score</th>
<th>Difference from Control</th>
<th>Format</th>
<th>Documentation</th>
<th>Continuity and Coordination of Care</th>
<th>Pediatric Preventive</th>
<th>Adult Preventive</th>
<th>OB/CPSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hagg, Jackie</td>
<td>87%</td>
<td>2%</td>
<td>93%</td>
<td>73%</td>
<td>88%</td>
<td>94%</td>
<td>76%</td>
<td>83%</td>
</tr>
<tr>
<td>Ho, Liza</td>
<td>83%</td>
<td>-2%</td>
<td>100%</td>
<td>81%</td>
<td>87%</td>
<td>80%</td>
<td>55%</td>
<td>85%</td>
</tr>
<tr>
<td>Kwong, Amy</td>
<td>92%</td>
<td>7%</td>
<td>95%</td>
<td>92%</td>
<td>88%</td>
<td>91</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>Lau, Olin</td>
<td>92%</td>
<td>7%</td>
<td>97%</td>
<td>96%</td>
<td>89%</td>
<td>91%</td>
<td>81%</td>
<td>94%</td>
</tr>
<tr>
<td>Levinson, Jean</td>
<td>84%</td>
<td>-1%</td>
<td>97%</td>
<td>83%</td>
<td>81%</td>
<td>87%</td>
<td>77%</td>
<td>65%</td>
</tr>
</tbody>
</table>
SFHP and its delegated nurse reviewers educate providers and their staff about the facility site, critical elements and medical record standards when conducting site audits. A corrective action plan is required for scores below 90% or with an infectious disease or pharmacy deficiency. In addition, SFHP highlighted topics for focus from either SRS or MRR audits in the “Provider Update” eNewsletter eight times in 2017. In 2017, the following topics were published in the newsletter:

- SHA - Staying Healthy Assessment
- TB Risk Assessment
- Adult Preventive Criteria – Overview
- Medical Record Release Forms
- Engineered Sharps Injury Protection (ESIP)
- Adult Immunizations
- How are multi-dose medication vials and multi-test diagnostic supply bottles (e.g. glucose and urine strips) handled?
- Immunization Practices

To date, SFHP is assisting Lyon-Martin Health Services (HealthRight360) with an Alternative IHEBA (DHCS) Request Form so that the clinic can tailor their behavioral assessments to their unique population. The Medical Director will be sending information to SFHP by the end of January, 2018, so that the application can be completed and sent to DHCS.

In 2018, San Francisco Health Plan is anticipating that the DHCS will be reviewing Policy Letter 14-004 (2014) for needed updates with a release date to be determined.
Of the 49 SRS and 47 MRR completed in calendar year 2017, the below charts demonstrate the areas of opportunity throughout San Francisco Health Plan sites. A 2017 calendar-year audit of the Medical Record Review Surveys showed Critical Element: Adult Preventive Vaccines with the highest percentage of non-compliance at 55.7%. A 2017 calendar-year audit of the Site Review Surveys showed Critical Element: Access/Safety Airway Management with the highest percentage of non-compliance at 14.2%. From these findings, interventions will be problem-solved to address these areas of opportunity for 2018 goals.

SFHP was responsible for creating, forwarding and reviewing all corrective action plan responses. These signed-off CAPS are forwarded to the State.

### Site Review Survey (SRS) Individual Question Audit
**Critical Elements**
**January 1, 2017 to December 31, 2017**

<table>
<thead>
<tr>
<th>Site Review Survey Category</th>
<th>Site Review Survey Element</th>
<th># of SRS Audits</th>
<th># Total Physicians</th>
<th>SRS Yes Points</th>
<th>SRS No Points</th>
<th>SRS N/A Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access/Safety</td>
<td>D.4. Airway management: Oxygen delivery system, oral airways, nasal cannula or mask, ambu bag.</td>
<td>42</td>
<td>191</td>
<td>85.70%</td>
<td>14.20%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>B.2. Needle-stick safety precautions are practiced on site.</td>
<td>42</td>
<td>191</td>
<td>88.00%</td>
<td>11.90%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Access/Safety</td>
<td>C.4. Exit doors and aisles are unobstructed and egress (escape) accessible.</td>
<td>42</td>
<td>191</td>
<td>97.60%</td>
<td>2.38%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Personnel</td>
<td>C.1. Only qualified/trained personnel retrieve, prepare or administer medications.</td>
<td>42</td>
<td>191</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Office Management</td>
<td>E.2. Physician reviewer and follow-up of referral/consultation reports and diagnostic test results.</td>
<td>42</td>
<td>191</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Clinical Services</td>
<td>C.4. Only lawfully authorized persons dispense drugs to patients.</td>
<td>42</td>
<td>191</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>B.1. Personal protective equipment is readily available for staff use.</td>
<td>42</td>
<td>191</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>B.4. Blood, other potentially infectious material and regulated waste are placed in appropriate, leak-proof, labeled containers.</td>
<td>42</td>
<td>191</td>
<td>100.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>D.6. Spore testing of autoclave/steam sterilizer with documented results (at least monthly)</td>
<td>42</td>
<td>191</td>
<td>30.90%</td>
<td>69.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

### Medical Record Review (MRR) Individual Question Audit
**January 1, 2017 to December 31, 2017**

<table>
<thead>
<tr>
<th>Site Review Survey Category</th>
<th>Site Review Survey Element</th>
<th># of MRR Audits</th>
<th># MRR Indv. Records</th>
<th>MRR Yes Points</th>
<th>MRR No Points</th>
<th>MRR N/A Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Preventive</td>
<td>E - 1. Given according to AAP Guidelines</td>
<td>25</td>
<td>174</td>
<td>36.70%</td>
<td>55.70%</td>
<td>7.47%</td>
</tr>
<tr>
<td>Adult Preventive</td>
<td>E - G. Tuberculosis Screening</td>
<td>27</td>
<td>240</td>
<td>63.70%</td>
<td>36.20%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Documentation</td>
<td>B - E. Advanced Health Care Directive Information is offered*</td>
<td>26</td>
<td>237</td>
<td>51.80%</td>
<td>48.20%</td>
<td>19.40%</td>
</tr>
<tr>
<td>Adult Preventive</td>
<td>E - 2. Individual Health Education Behavioral Assessment (IHEBA)</td>
<td>27</td>
<td>250</td>
<td>47.20%</td>
<td>52.80%</td>
<td>10.00%</td>
</tr>
<tr>
<td>Adult Preventive</td>
<td>E - K. Colorectal Screening</td>
<td>27</td>
<td>250</td>
<td>38.80%</td>
<td>61.20%</td>
<td>10.00%</td>
</tr>
<tr>
<td>Adult Preventive</td>
<td>E - L. Cervical Screening</td>
<td>27</td>
<td>250</td>
<td>42.40%</td>
<td>57.60%</td>
<td>10.00%</td>
</tr>
<tr>
<td>Pediatric Preventive</td>
<td>D - 2. Individual Health Education Behavioral Assessment (IHEBA)</td>
<td>14</td>
<td>41</td>
<td>48.70%</td>
<td>9.70%</td>
<td>41.40%</td>
</tr>
<tr>
<td>Adult Preventive</td>
<td>E - M. Breast Screening</td>
<td>27</td>
<td>250</td>
<td>30.80%</td>
<td>69.20%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>C - F. There is evidence of practitioner review of consult/referral reports and diagnostic results</td>
<td>27</td>
<td>257</td>
<td>86.50%</td>
<td>13.50%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Note:
Advanced Health Care Directive - Only for Adults 2 or Emancipated Minors
Excluded Format Category due to EHR use that largely leads to high compliance scores in this domain.
MEMO

Date: January 25, 2018

To
Quality Improvement Committee (QIC)
Physician Advisory/Peer Review/Credentialing Committee (PAC)

From
Odalis Leon, Manager, Delegation Oversight and Credentialing

CC
Provider Network Oversight Committee (PNOC)

Regarding
Delegated Groups 2017 Audit Results

Oversight of delegated activities is a requirement of the Department of Health Care Services (DHCS) contract, as established under Exhibit A, Attachment 4, Quality Improvement System; Provision 6, and the National Committee for Quality Assurance (NCQA).

2017 RESULTS: Below you will find Audit Dashboard by delegated group by area of review.

<table>
<thead>
<tr>
<th>Function</th>
<th>BTP</th>
<th>CHCCA</th>
<th>Hill</th>
<th>NEMIS</th>
<th>Redox</th>
<th>Kaiser</th>
<th>UCHI</th>
<th>SFHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>QI</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Passed</td>
<td>Passed</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>UM</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Credentialing</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>Not Passed 1 Open CAP</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Claims and PDRs</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>Not Passed 1 Open CAP</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>HE and CLS</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
<td>n/a</td>
<td>n/a</td>
<td>Passed</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>CM</td>
<td>Passed</td>
<td>Not passed 1 Open CAP</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Compliance</td>
<td>n/a</td>
<td>Passed after GAPs</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Passed 2 Open CAPs</td>
<td>n/a</td>
</tr>
<tr>
<td>Appeals and Grievances</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Passed</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Passed 2 Open CAPs</td>
<td>n/a</td>
</tr>
<tr>
<td>Mental Health and DIT</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Provider Training</td>
<td>Passed</td>
<td>n/a</td>
<td>Passed</td>
<td>n/a</td>
<td>n/a</td>
<td>Passed</td>
<td>Passed</td>
<td>Passed</td>
</tr>
</tbody>
</table>

ANALYSIS:

1. **Brown and Toland (BTP):**
   - On August 16, 2017 SFHP conducted an audit of BTP’s UM, Credentialing, Claims, Case Management, and Provider Training files.
   - BTP received a passing score for Credentialing, Claims & PDRs, and Provider Training.
   - BTP also received a passing score for the UM audit; however, SFHP identified the following two deficiencies:
• In four of the cases reviewed the Notice of Action (NOA) letters did not include a reference to the benefit provision. On 12/27/2017, BTP submitted, and SFHP accepted, evidence that training had been conducted with the UM staff. This CAP is closed.
• In ten of the cases reviewed non-English NOA’s did not include a statement indicating that the member can (upon request) obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion, in which the denial was based. On 10/13/2017, BTP submitted, and SFHP accepted, a revised NOA template. This CAP now closed.
  o SFHP shared with the group the results of the Language Accessibility Survey conducted from October to December of 2016. The survey results were provided as an addendum to the annual audit. The results were not favorable, and BTP was asked to provide a plan for corrective action. The response submitted by the group was insufficient. This CAP remains open.
  o NEXT STEPS:
    ▪ SFHP is currently in the process of scheduling a meeting with BTP to further discuss the plan for corrective action for the Language Access deficiency and others open CAPs related to appointment availability.
    ▪ BTP’s next audit is scheduled for 08/16/2018
  • Chinese Community Health Care Association (CCHCA):
    o SFHP conducted three (3) audits of CCHCA in 2017:
      ▪ 03/15/2017: UM, Claims & PDRs, and Credentialing files. CCHCA did not have any Case Management files for review.
      ▪ 04/20/2017: UM and Credentialing programs, policies, and procedures.
      ▪ 09/19/2017: UM, Claims & PDRs, and Credentialing files; and QI, Claims, Cultural Linguistic Services, Case Management, and Compliance policies and procedures. CCHCA did not have any Case Management files for review.
      ▪ The results presented above are from the audits conducted in April and September
    o Audit results indicate that CCHCA has made some significant improvements in the areas reviewed. However, CCHCA continues to have a general problem with required documentation of some procedures.
    o SFHP granted CCHCA a passing score for Compliance after providing evidence of corrective action. There are no open CAPs in this area.
    o Although CCHCA received a 99% score in the UM audit, post audit, a few severe irregularities have been identified with the group’s application of the UM criteria. SFHP is further investigating these issues and will be requesting a plan for corrective action.
    o QI Open CAPs (2): Access policies and procedures do not fully comply with DMHC requirements. The edits required to make the policies compliant are minimal; however CCHCA failed to complete them during the CAP response period. This CAP remains open.
    o Credentialing Open CAP (1): Twenty nine (29) recredentialing files did not include the Previous Approval date making it impossible for SFHP to evaluate compliance with recredentialing timelines. This CAP remains open.
    o Claims & PDRs Open CAP (1): Seven out of 30 PDR cases were not resolved timely. CCHCA’s response to this CAP was not approved by SFHP. This CAP remains open.
    o SFHP shared with the group the results of the Language Accessibility Survey conducted from October to December of 2016. The survey results were provided as an addendum to the annual audit. The results were not favorable, and CCHCA was asked to provide a plan for corrective action. The response submitted by the group was partially approved by SFHP. This CAP remains open.
    o CM Open CAPs (1): Policies for coordination and continuity of care do not fully meet requirements for coordination of care when a provider terminates. The group provided a response, which was not
accepted by SFHP. This CAP remains open. In addition to the deficiencies identified during the audit, it is important to note that CCHCA has not identified any members eligible for CM. This is of concern for SFHP and will be addressing the issue with CCHCA.

**NEXT STEPS:** SFHP is planning to meet with CCHCA on 01/12/2018 to discuss:
- the current problems with the application of UM criteria,
- a plan for correcting all open CAPs identified through the audits and surveys, and
- a plan for identifying members eligible for CM.

CCHCA’s next audit is scheduled for 09/11/2018; however, SFHP plans to conduct a series of UM monitoring activities during 2018.

### 2. Hill Physicians Medical Group (Hill):

- On May 17, 2017 SFHP conducted an audit of Hill’s UM, Credentialing, Claims, Case Management, and Provider Training files.
- Hill received a passing score for UM, Credentialing, CM, and Provider Training. There are no open CAPs in these areas.
- Hill received a passing score for the Claims audit, but failed the PDR audit.
  - SFHP found that interests were not paid on 10 out of 14 overturned PDR cases. Hill agreed with this finding during the onsite audit interview; however, retracted its agreement, and did not provide an acceptable reason for the retraction. This CAP remains open.
- SFHP shared with the group the results of the Language Accessibility Survey conducted from October to December of 2016. The survey results were provided as an addendum to the annual audit. The results were not favorable, and Hill was asked to provide a plan for corrective action. The response submitted by the group was accepted by SFHP. This CAP remains open until evidence of implementation is provided by the group.

**NEXT STEPS:**
- On 01/11/2018, SFHP held a meeting with Hill’s Claims staff to review and discuss audit findings, and SFHP’s expectations regarding corrective action. A response from the group is expected by 02/12/2018.
- Hill’s next audit is scheduled for 05/02/2018.

### 3. North East Medical Services (NEMS):

- On April 26, 2017 SFHP conducted an audit of NEMS’s UM, Credentialing, Claims, Case Management, and Provider Training files.
- At the time of the audit, NEMS received a passing score for UM, CM, Claims and PDRs, and Provider Training. SFHP granted NEMS a passing score for Credentialing after providing evidence corrective action. There are no open CAPs in these areas.
- SFHP shared with the group the results of the Language Accessibility Survey conducted from October to December of 2016. The survey results were provided as an addendum to the annual audit. The results were favorable for NEMS. No CAP was required.

**NEXT STEPS:** NEMS next audit is scheduled for 04/17/2018.

### 4. Beacon:

- On June 29, 2017 SFHP conducted an audit of Beacon’s UM, Claims & PDRs, Credentialing, Grievances, and Provider Training files; and a review of the QI and UM programs.
- Except for Provider Training, Beacon received a passing score in all areas reviewed.
- New Provider Training Open CAP: SFHP eight files and found that two did not include evidence that the Medi-Cal training and Cultural Sensitivity training had been completed by the providers. Beacon’s CAP response included a plan to configure the New Provider Orientation as a requirement in the
credentialing system. SFHP approved Beacon’s CAP. This CAP will remain open until the training attestations are received.

- **NEXT STEPS:** Beacon’s next audit is scheduled for 06/07/2018.

5. **Kaiser:**
   - Annual oversight of Kaiser was conducted by Health Plans (Partner Plans) located in the San Francisco Bay Area.
   - In 2017 the Partner Plans below participated in the Kaiser Shared-Audit. The work of evaluating policies and procedures was distributed among the Partner Plans:
     - Alameda Alliance for Health (AAH): QI and Network Management
     - Health Plan of San Joaquin (HPSJ): Pharmacy and Credentialing (included files)
     - Health Plan of San Mateo (HPSM): Compliance, Appeals, and Grievances
     - Partnership Health Plan (PHP): Claims and Medi-Cal Addendum
     - San Francisco Health Plan (SFHP): UM and Health Education Cultural and Linguistic Services (HECLS)
     - Santa Clara Family Health Plan (SCFHP): Mental Health and New Provider Training
   - On October 25, 2017 each Partner Plan conducted its own review of utilization management, appeals and grievances, case management, and claims files.
   - Kaiser received a passing score for QI, UM, HECLS, Appeals and Grievances, and Provider Training. There are no open CAPs in these areas.
   - Kaiser also received a passing score for Compliance, Pharmacy, and Mental Health; however, the Partner Plans identified the following deficiencies:
     - Compliance Open CAPs (2): policies and procedures do not indicate that Kaiser reports (1) breaches of PHI, and (2) incidences of Fraud, Waste, and Abuse to contracting Plans. SFHP’s Compliance Officer reported that SFHP has received reports of breaches of PHI within the required timeframe; SFHP has not received any notifications regarding incidences of Fraud, Waste, and Abuse. This is a repeat finding.
     - Pharmacy Open CAPs (2): policies for member communication do not meet DHCS APL 17-011 requirements for providing members with the options of materials available in the threshold of languages outlined by DHCS. Policy did not provide a policy describing the process for dispensing prescribed drugs in an emergency situation.
     - Mental Health and BHT Open CAPs (3): Triage and Referral Protocols were last updated two years ago; DHCS requires this document to be updated every two years. In addition, the Triage and Referral Protocol does not clearly describe the process for referring members to non-specialty mental health providers and to County Behavioral Health Services. Kaiser did not provide policies and procedures indicating the timeframe for providing Initial Appointment with a Qualified Autism Services (QAS) provider.
   - Kaiser did not receive a passing score for the Credentialing audit. Kaiser did not provide a complete set of credentialing policies and procedures. The auditor requested the missing documentation and received partial information.
   - **NEXT STEPS:**
     - Kaiser CAP responses are due to the Partner Plans on February 5, 2018. Lead Plan for the audit will review and provide a report to all participating plans.
     - Kaiser’s next audit will be for October of 2018.

6. **UCSF:**
   - On November 1, 2017 SFHP conducted an audit of UCSF’s Credentialing and Provider Training files.
   - UCSF received a passing score in all areas reviewed.
   - **NEXT STEPS:** UCSF’s next audit will be for November of 2018.
7. **SFHN:**
   - On December 15, 2017 SFHP conducted an audit of SFHN’s Credentialing and Provider Training files.
   - SFHN received a passing score in all areas reviewed.
   - **NEXT STEPS:** SFHN’s next audit will be for December of 2018.
DELEGATES:

<table>
<thead>
<tr>
<th>Health Plans</th>
<th>Medical Groups</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Beacon – Behavioral Health</td>
<td>• Brown and Toland Physicians (BTP)</td>
<td>• San Francisco Health Network (SFHN)</td>
</tr>
<tr>
<td>• Kaiser – Medical and</td>
<td>• Chinese Community Health Care Association (CCHCA)</td>
<td>• University of California San Francisco (UCSF)</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>• North East Medical Services (NEMS)</td>
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<tr>
<td></td>
<td>• Hill Physicians Medical Group (Hill)</td>
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AUDIT METHODOLOGY:

- SFHP uses industry-accepted audit tools.
- SFHP conducts a review of policies, procedure, reports, and case files.
- File review sampling methods:
  - Credentialing and CM – NCQA 8/30 Rule
  - UM – 5% of the total universe, 50 files, or the total files available, whichever is less.
- A passing score for each area of review is 95% of the total points available for that area.

AREAS OF REVIEW AND SCORING SYSTEM:

Each area of review is divided into categories; for example, the QI audit is divided into three categories: 1.1) QI Program; 1.2) Access; and 1.3) IHA and IHEBA. This breakdown helps SFHP identify categories that need improvement.

Each category is further divided into requirements; the delegate’s documentation must show that it meets each requirement. If the requirement is met, the delegate receives one point; if it’s not met, the delegate receives no points. All points are added to produce the Category Score (presented in percentage form); all category points are also added to produce the Audit Score (presented in percentage form).

The chart below shows the number of categories and the number of requirements per area of review:

<table>
<thead>
<tr>
<th>SFHP Areas of Review</th>
<th>Number of Categories</th>
<th>Number of Requirements (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Quality Improvement (QI)</td>
<td>2 - 3</td>
<td>27 - 36</td>
</tr>
<tr>
<td>2.0 Utilization Management (UM)</td>
<td>11 - 14</td>
<td>47 - 66</td>
</tr>
<tr>
<td>3.0 Credentialing</td>
<td>10 - 12</td>
<td>39 - 46</td>
</tr>
<tr>
<td>5.0 Health Education and Cultural and Linguistics (HECLS)</td>
<td>2</td>
<td>12 - 21</td>
</tr>
<tr>
<td>6.0 Case Management and Coordination of Care (CM &amp; COC)</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>8.0 Grievances</td>
<td>3</td>
<td>41</td>
</tr>
<tr>
<td>10.0 Non-Specialty Mental Health</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>11.0 New Provider Training</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

(*) also number of available points
PROVIDER NETWORK OVERSIGHT COMMITTEE (PNOC):
The Provider Network Oversight Committee (PNOC) is comprised of internal SFHP stakeholders. The PNOC provides a forum for evaluating providers’ compliance with the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the National Committee for Quality Assurance (NCQA) requirements. This committee identifies issues and addresses concerns related to providers’ performance of their administrative responsibilities. The Committee addresses specific cases of non-compliance with requirements, and assures that appropriate corrective actions are taken.

OTHER OVERSIGHT ACTIVITIES:
In addition to annual audits, SFHP monitors delegates’ performance through the review of member grievances, annual provider access surveys, and others:

- **Member Grievances**: SFHP consults and engages delegates as well as their contracted providers when resolving member grievances. Occasionally grievances provide an opportunity for identifying areas for improvement at the delegate or provider level.

- **Appointment and Language Access Surveys**: SFHP conducts a Provider Appointment Availability Survey (PAAS) and an After-hour Survey. These surveys have allowed SFHP to identify practices where access requirements are not being met. SFHP has begun working with some clinics, provider practices, and delegated groups where access requirements are not being met.

- **Others**: SFHP also use encounter data and provider complaints to evaluate delegates’ performance. These occur rarely; however, they provide a good opportunity for improving performance and processes.