San Francisco Health Plan

2019 Quality Improvement Program Evaluation
Table of Contents
1. Introduction........................................................................................................................................... 3
   1.1 Executive Summary ............................................................................................................................ 3
   1.2 Highlights from the 2019 QI Program Measures .............................................................................. 4
2. Quality of Service and Access to Care................................................................................................. 6
   2.1 Provider Appointment Availability Survey – Routine Appointment Availability in Specialty and Primary Care .................................................................................................................. 6
   2.2 Cultural & Linguistic Services (CLS) ................................................................................................. 8
   2.3 Member Grievances and Appeals ..................................................................................................... 9
   2.4 CAHPS Getting Care Quickly/Getting Needed Care ....................................................................... 9
3. Clinical Quality and Safety .................................................................................................................... 12
   3.1 Pain Management-Opioid Safety .................................................................................................... 12
   3.2 Hepatitis C Treatment .................................................................................................................... 14
   3.3 Medication Therapy Management (MTM) ..................................................................................... 15
   3.4 Cervical Cancer Screening ............................................................................................................ 16
   3.5 Chlamydia Screening .................................................................................................................... 17
   3.6 Opioid Safety ............................................................................................................................... 17
4. Care Coordination and Services ............................................................................................................ 18
   4.1 Care Management Client Satisfaction with Staff ............................................................................. 18
   4.2 Care Management Client Perception of Health .............................................................................. 19
   4.3 Screening for Clinical Depression ................................................................................................. 20
   4.4 Follow Up on Clinical Depression ............................................................................................... 21
   4.5 Community Health Network (CHN) Out Of Medical Group (OMG) All Cause Readmissions ...... 22
5. Utilization of Services............................................................................................................................ 23
   5.1 Percentage Of Members Utilizing The Non Specialty Mental Health Benefit With More Than Two NSMH Visits ........................................................................................................... 23
   5.2 Members with a Primary Care Visit in the Last Twelve Months ................................................... 24
6. Quality Oversight Activities .................................................................................................................. 26
1. Introduction

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

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

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

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

1.1 Executive Summary

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

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

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

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

The staff accountable for implementing the annual QI Work Plan work cross-functionally to oversee and carry out quality improvement activities at SFHP. Staff monitor quality indicators and programs and implement and evaluate SFHP’s QI work plan. For a detailed summary of all staff supporting the QI Program, please refer to the Quality Improvement Program Description.

1.2 Highlights from the 2019 QI Program Measures

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

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

Quality of Service and Access to Care:

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

Some notable improvements include:

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

Recommendations for continued improvement include:

- Investing in appointment scheduling improvements through Strategic Use of Reserves grant funds.
• Incentivizing clinics and provider groups to implement projects to improve access under SFHP’s Pay for Performance program.
• Launching a Cultural and Linguistic Services Program to develop a coordinated strategy to improve members’ experience of cultural and linguistic services.
• Conducting member focus groups to better understand member perception regarding access to care.

Clinical Quality and Safety:

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

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

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

Care Coordination and Services:

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

Some notable improvements include:
• Attained high member satisfaction with care management services provided by SFHP.
• Exceeded target of 70% for member clinical depression follow up with a final result of 77%.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Provider Appointment Availability Survey – Routine Appointment Availability in Specialty and Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
</tr>
<tr>
<td>Denominator</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>2018 Numerator</th>
<th>2018 Denominator</th>
<th>2018 Routine Appointment Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>127</td>
<td>177</td>
</tr>
<tr>
<td>Cardiology</td>
<td>36</td>
<td>51</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>26</td>
<td>54</td>
</tr>
<tr>
<td>Specialty</td>
<td>Count 1</td>
<td>Count 2</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>34</td>
<td>40</td>
</tr>
<tr>
<td>Gynecology</td>
<td>23</td>
<td>37</td>
</tr>
<tr>
<td>Oncology</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>261</td>
<td>374</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

2.2 Cultural & Linguistic Services (CLS)

<table>
<thead>
<tr>
<th>Measure: Cultural &amp; Linguistic Services (CLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
</tr>
<tr>
<td>165</td>
</tr>
<tr>
<td>Denominator</td>
</tr>
<tr>
<td>187</td>
</tr>
</tbody>
</table>

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

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

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

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

SFHP recommends retaining this measure to continue monitoring and improving member access to Cultural Linguistic Services. The target will increase to 90%. Activities to support this measure will include:
• Issuing and approving Corrective Action Plans to medical groups performing under 80% in the linguistic services portion of the previous survey year (2018).
• Launching a Cultural and Linguistic Services Program to leverage all of SFHP’s CLS resources and develop a coordinated strategy to address SFHP’s CLS priorities.
• Completing review of HECLS related grievances and quarterly trending reports.

2.3 Member Grievances and Appeals

| Measure: Member Grievances and Appeals |
|---------------------------|----------------|----------------|----------------|
| Numerator                | 288            | Baseline 78.0% | Final Performance 98.0% |
| Denominator              | 294            | Target 90.0%   | Evaluation Year 2019 |

The Member Grievances and Appeals measure is in the Quality of Service and Access to Care domain. It measures the rate of member grievances resolved within regulated timeframes (standard clinical and non-clinical grievances within 30 calendar days) and excludes 14 day extensions. Timely grievance resolution is important to member satisfaction and provides opportunities for improving individual members’ health care quality concerns. SFHP chose the target of 90% to achieve improvement over baseline of 78% from the previous measurement year.

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

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

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

2.4 CAHPS Getting Care Quickly/Getting Needed Care

<table>
<thead>
<tr>
<th>Measure: CAHPS Getting Care Quickly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline 73.0%</td>
</tr>
<tr>
<td>Target 75.0%</td>
</tr>
<tr>
<td>Final Performance 72.9%</td>
</tr>
<tr>
<td>Evaluation Year 2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure: CAHPS Getting Needed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline 68.4%</td>
</tr>
<tr>
<td>Target 70.4%</td>
</tr>
<tr>
<td>Final Performance 73.8%</td>
</tr>
<tr>
<td>Evaluation Year 2019</td>
</tr>
</tbody>
</table>

The Getting Care Quickly and Getting Needed Care composites from the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) survey assesses member experience of care and are in the Quality of Service and Access to Care domain. HP-CAHPS performance is important to SFHP for three reasons:

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

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

The Getting Care Quickly composite is comprised of two questions:

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

2) Got routine care as soon as needed – “In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?”

The Getting Needed Care composite is comprised of two questions:

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

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

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

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

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

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

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

3.1 Pain Management-Opioid Safety

<table>
<thead>
<tr>
<th>Measure: Pain Management-Opioid Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
</tr>
</tbody>
</table>

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

Activities completed to support this measure included:

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

○ Promotion of non-narcotic alternatives for pain management, including implementation of an acupuncture benefit for members with chronic pain.

○ Implementation of a pharmacy policy restricting members being started on short-acting opioids to a 7 day initial supply, to align with updated clinical evidence.

○ Grant opportunities funded by SFHP's Strategic Use of Reserves (SUR) program to support implementation of inpatient medically assisted treatment at three in-network hospitals.

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

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

<table>
<thead>
<tr>
<th>% of members with at least one opioid prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.01</td>
</tr>
<tr>
<td>8.28</td>
</tr>
<tr>
<td>7.14</td>
</tr>
</tbody>
</table>

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

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

### 3.2 Hepatitis C Treatment

<table>
<thead>
<tr>
<th>Measure: Hepatitis C Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>1,241</td>
</tr>
<tr>
<td>Denominator</td>
</tr>
<tr>
<td>4,023</td>
</tr>
</tbody>
</table>

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

Activities completed to support this measure included:

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

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

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

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

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

Barriers to achieving the target included:

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

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

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

### 3.3 Medication Therapy Management (MTM)

<table>
<thead>
<tr>
<th>Measure: Medication Therapy Management (MTM)</th>
<th>Numerator</th>
<th>Baseline</th>
<th>Final Performance</th>
<th>Evaluation Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>142</td>
<td>N/A</td>
<td>76%</td>
<td>2019</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

Activities to support this measure will include:

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

### 3.4 Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Measure: Cervical Cancer Screening</th>
<th>Numerator</th>
<th>237</th>
<th>Baseline</th>
<th>70%</th>
<th>Final Performance</th>
<th>68%</th>
<th>Denominator</th>
<th>348</th>
<th>Target</th>
<th>72%</th>
<th>Evaluation Year</th>
<th>2019</th>
</tr>
</thead>
</table>

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

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

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

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

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

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

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

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

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

4.1 Care Management Client Satisfaction with Staff

<table>
<thead>
<tr>
<th>Measure: Care Management Client Satisfaction with Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
</tbody>
</table>

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

The following activities were completed:

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

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

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

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

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

<table>
<thead>
<tr>
<th>Measure: Care Management Client Perception of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
</tbody>
</table>

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

The following activities were completed:

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

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

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

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

### 4.3 Screening for Clinical Depression

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

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

The following activities were completed:

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

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

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

### 4.4 Follow Up on Clinical Depression

<table>
<thead>
<tr>
<th>Measure: Follow Up on Clinical Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
</tbody>
</table>

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

The following activities were completed:

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

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

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

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

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

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

The CHN OMG All Cause Readmissions measure is in the Care Coordination and Services domain. This measure reflects activities to prevent members from being readmitted within 30 days of discharge of an acute admission. Meeting this measure indicates SFHP’s discharge planning program and case management activities are keeping our members out of the hospital and in lower levels of care by reconnecting them to their Primary Care Provider or needed specialty care. The ACR is measured quarterly using the HEDIS All-Cause Readmission methodology. The target for this measure was 17.72%. The target was chosen to align with the Medi-Cal state average.

The following activities were completed:

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

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

SFHP is addressing these barriers by:

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

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

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

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

| Measure: Percentage Of Members Utilizing The Non Specialty Mental Health Benefit With More Than Two NSMH Visits |
|--------|-------------|----------------|----------------|----------------|
| Numerator | 2,065 | Baseline | 54.3% | Final Performance | 43.8% |
| Denominator | 4,712 | Target | 55.9% | Evaluation Year | 2019 |

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

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

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

SFHP did not complete the following planned activities:

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

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

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

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

| Measure: Members with a Primary Care Visit in the Last Twelve Months |
|------------------------|-----------------|----------------|-------------------|---------------|
| Numerator              | 64,667          | Baseline       | 67.9%            | Final Performance| 68.0%         |
| Denominator            | 95,112          | Target         | 69.9%            | Evaluation Year  | 2019          |

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

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

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

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

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

These are quality oversight activities monitored and completed this year.

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