Quality Improvement and Health Equity Committee

SAN FRANCISCO HEALTH PLAN℠
Here for you

Thursday, March 7, 2024

8:30—10:00am

Agenda

- Welcome/ Roll Call
  - Announcements
    - NCQA Accreditation Status
  - Consent Calendar
  - Previous Action Items
- Carelon Provider Experience Survey (MY 2022)
- QIHETP
- MY 2023 HEDIS Analysis
- 2023 QI Program Evaluation
- 2024 QIHETP Program Description & Workplan
- UM Criteria

NCQA Accreditation Update

Nina Maruyama

Chief Compliance & Regulatory Affairs Officer

Consent Calendar

- November 2023 QIC Minutes
- Q3 2023 ER Access Report
- Q4 2023 Grievance Report
- Q4 2023 Appeals Report
- UM Committee Minutes and supporting documentation
    - October 2023
    - December 2023
- UM Program Description
- Health Services Policies & Procedures (P&P) Updates Summary
- 2023 Facility Site Review Report
- 2023 PQI Report
- QI Access Monitoring Annual Update

Previous Action Items

2022 Carelon Provider Experience Survey

Andrea Champagne-Small
Clinical Quality Program Manager—West Region, Carelon

Vanessa Aranda, MSW
Manager, Behavioral Health

QIHETP

Edwin Poon, PhD

Health Services Officer/ Interim Chief Health Equity Officer

Quality Improvement vs. Health Equity*

Quality Improvement – systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for members

Health Equity – the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations

*Source: DHCS 2024 Contract, Exhibit A, Attachment I, Section 1.0 Definitions

DHCS 2024 Contract – Quality Improvement and Health Equity Transformation Program, Section 2.2

Program Structure: New Requirements

- ❑ Hire a Chief Health Equity Officer
- ✓ Create a Quality Improvement and Health Equity Committee (QIHEC) to replace existing Quality Improvement Committee (QIC)
- ✓ Establish process for supervision of activities by the Chief Health Equity Officer and Medical Director
- ❑ Engage network providers, including community health workers and other non-clinical providers in the QIHEC
- ✓ Create policies and procedures for the Governing Board to approve the overall QIHETP program and annual work plan, receive written reports demonstrating progress of meeting objectives

DHCS 2024 Contract – Quality Improvement and Health Equity Transformation Program, Section 2.2

Quality Improvement and Health Equity Committee: New Requirements

- Committee must be led by a Medical Director in collaboration with the Chief Health Equity Officer (current QIHEC is led by the Chief Medical Officer)
- Review **health equity** activities in addition to **quality improvement** activities
- Plans must make written summaries of the QIHEC activities publicly available on its website at least quarterly

DHCS 2024 Contract – Quality Improvement and Health Equity Transformation Program, Section 2.2

Provider Participation: New Requirements

- Network providers must participate in both the QIHETP *and* the Population Needs Assessment (PNA)
- Plans must regularly update providers on activities, findings, and recommendations of the QIHETP and PNA results

MY 2023 HEDIS Analysis

José Méndez

Manager, Health Services Product Management

2024 Opportunities: MCAS/ NCQA

*Dedup of Pharmacy Carveout data and removal of adjustments reduced the days supply calculation

ADD

Follow Up Care for Children Prescribed ADHD Medication- Continuation and Maintenance Phase

- MY 23 Rate: 46.43%*
- MY 23 Denom: 28
- 10th Percentile
- NCQA QI 4
- 2023 HPR Pts. 3 → 2

AMM

Antidepressant Médication Management-Effective Continuations Phase Tx

- MY 23 Rate: 50.88%*
- MY 23 Denom: 1,254
- 75th Percentile
- NCQA QI 4
- 2023 HPR Pts. 5 → 4

APM

Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total

- MY 23 Rate: 45.71%*
- MY 23 Denom: 35
- 75th Percentile
- NCQA QI 4
- 2023 HPR Pts. 5 → 4

PCR

Plan All Cause Readmissions

- MY 23 Rate: 1.4618
- MY 23 Denom: 4,219
- <5th Percentile
- NCQA QI 3
- 2023 HPR Pts. 3 → 1

2024 Opportunities: MCAS Only - Depression

DRR-E

Depression Remission or Response for Adolescents and Adults - Follow-Up PHQ-9

- MY 23 Rate: 45.39%
- MY 23 Denom: 661
- Will be held to MPL for MY2025.
- No benchmarks

DRR-E

Depression Remission or Response for Adolescents and Adults - Depression Remission

- MY 23 Rate: 5.30%
- MY 23 Denom: 661
- Will be held to MPL for MY2025.
- No benchmarks

DRR-E

Depression Remission or Response for Adolescents and Adults - Depression Response

- MY 23 Rate: 12.10%
- MY 23 Denom: 661
- Will be held to MPL for MY2025.
- No benchmarks

DSF-E

Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening

- MY 23 Rate: 32.64%
- MY 23 Denom: 83,411
- Will be held to MPL for MY2025.
- No benchmarks

DSF-E

Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screening

- MY 23 Rate: 68.96%
- MY 23 Denom: 2,484
- Will be held to MPL for MY2025.
- No benchmarks

2024 Opportunities: MCAS Only

*Dedup of Pharmacy Carveout data and removal of adjustments reduced the days supply calculation

ADD

Follow Up Care for Children Prescribed ADHD Medication-Initiation Phase

- MY 23 Rate: 40%*
- MY 23 Denom: 80
- 25th Percentile
- NCQA QI 4

AMM

Antidepressant Medication Management-Acute Phase Tx

- MY 23 Rate: 70.65%*
- MY 23 Denom: 1,254
- 75th Percentile
- NCQA QI 4

HFS

Number of Outpatient ED Visits Per 1,000 Long Stay Resident Days

- Available in QR in March 2024
- NCQA QI 3

2024 Opportunities: NCQA Only

*Dedup of Pharmacy Carveout data and removal of adjustments reduced the days supply calculation

SPC

Statin Therapy for Patients with Cardiovascular Disease-Statin Adherence 80%

- MY 23 Rate: 69.59%*
- MY 23 Denom: 444
- 33rd Percentile
- NCQA QI 3
- 2023 HPR Pts. 5 → 3

SPD

Statin Therapy for Patients with Diabetes - Statin Adherence 80%

- MY 23 Rate: 74.82%*
- MY 23 Denom: 4443,518
- 33rd Percentile
- NCQA QI 3
- 2023 HPR Pts. 5 → 4

SFHP QIHET Program

2023 Evaluation + 2024 Program Description & Workplan

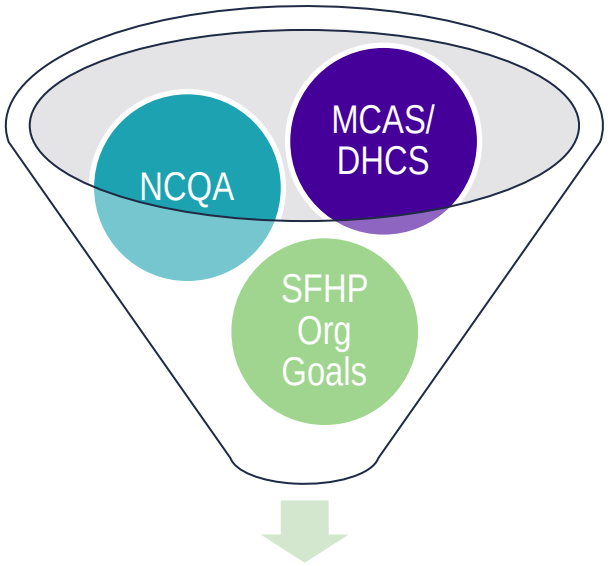
Yves Gibbons
Supervisor, Quality Improvement

QIHEC Role in QIHET Program

- Leadership for SFHP's ongoing QIHET Program
- Oversight of SFHP's annual work plan through standing QIHEC updates
- Review and approve the annual QI Evaluation and subsequent year's Work Plan

Measure Identification & Evaluation Process

Planning



QI Workplan

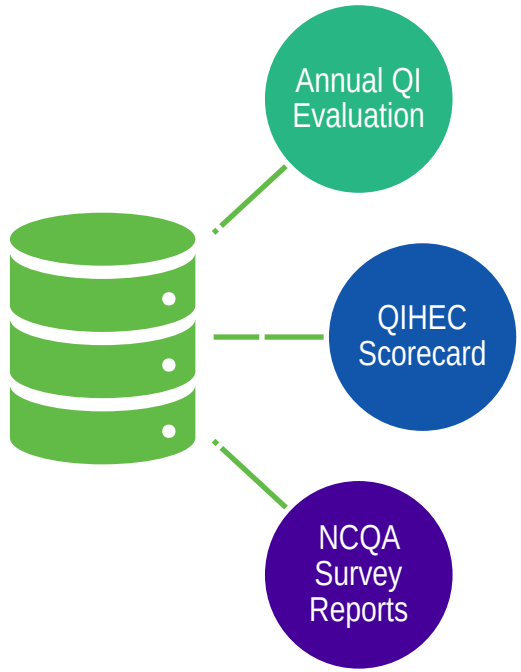
Data Collection

Monthly

+

Quarterly

Analysis & Reporting



2023 Measure Performance Summary

Quality of Service & Access to Care

- Out of 6 total measures, 3 met their targets

Patient Safety or Outcomes Across Settings

- Out of 6 total measures, 2 met their targets

Managing Members with Emerging Risk

- Out of 8 total measures, 3 met their targets

Keeping Members Healthy

- Out of 3 total measures, 1 met their target

Managing Multiple Chronic Conditions

- Out of 3 total measures, 1 met their targets

Utilization of Services

- Out of 2 total measures, 2 met their targets

2023 Successes

- Quality Oversight, Implementation
- Provider Engagement & Collaboration
- Care Experience Initiatives
- Timely HEDIS Reporting (Monthly Proactive Runs)
- New and growing benefits and services

Key Opportunities & Recommendations

- Challenges with DHCS measures held to minimum performance level
- Need for agility and expediency in improving coordination of care
- Increased partnership with providers
- Staffing needed for implementing programs
- Better analysis of barriers and root causes to enhance evaluations

2023 Measure Performance

Quality of Service & Access to Care

Measure Name	Baseline	Target	2023 Performance
CAHPS: Getting Needed Care	66.48%	68.48%	69.80%
CAHPS: Rating of Personal Doctor	64.29%	66.86%	64.54%
CAHPS: Rating of a Specialist	60.00%	62.79%	64.38%
Cultural & Linguistic Services: Provider Language Data	23.90%	25.00%	32.24%
Provider Directory: Race & Ethnicity	2.50%	5.00%	1.59%
Routine Appointment Availability in Specialty Care	57.90%	59.90%	48.20%

2023 Measure Performance

Patient Safety or Outcomes Across Settings

Measure Name	Baseline	Target	2023 Performance
Buprenorphine Prescription	22.50%*	30%	18.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day	9.90%	21.24%	22.30%
Follow-up after ED visit for Mental Illness: 30-Day	12.18%	54.51%	52.80%
High Dose Opioid Prescriptions	5.2*	4.0	4.53%
Medication Therapy Management Follow-Up Care	72.60%	70.00%	41.86%
SFHN Plan All-Cause Readmissions (18-64 years of age)	16.50%	13.50%	10.59%

*Reflects corrected baseline

2023 Measure Performance

Managing Members with Emerging Risk

Measure Name	Baseline	Target	2023 Performance
Asthma Medication Ratio	55.47%	59.94%	55.30%
Eye Exam for Patients with Diabetes	54.50%	56.51%	60.64%
Hemoglobin A1c Control for Patients with Diabetes: Poor HbA1c Control (>9.0%)	34.79%	30.90%	33.99%
Hepatitis C Treatment	37.00%	40.00%	35.97%
Postpartum Depression Follow-Up for Black & Native American Members	0.00%	38.89%	40.00%
Project Open Hand Member Satisfaction	95.70%	96.00%	89.01%
Postpartum Care for Black & Native American Members	57.14%	60.14%	88.89%
Prenatal Care for Black & Native American Members	92.86%	95.86%	88.89%

2023 Measure Performance

Keeping Members Healthy

Measure Name	Baseline	Target	2023 Performance
Well-Child Visits in the First 30 Months of Life: 15-30 Months	69.33%	72.24%	75.97%
Well-Child Visits in the First 30 Months of Life: 0-15 Months	41.63%	55.72%	49.11%
Breast Cancer Screening for Black and African American Members	42.00%	50.00%	47.16%

2023 Measure Performance

Managing Multiple Chronic Conditions

Measure Name	Baseline	Target	2023 Performance
Care Management Client Perception of Health	54.40%	60.00%	68.06%
Care Management Client Satisfaction	75.00%	80.00%	62.79%
Care Management Follow Up on Clinical Depression	85.71%	90.00%	85.71%

2023 Measure Performance

Utilization of Services

Measure Name	Baseline	Target	2023 Performance
Antidepressant Medication Management— Continuation Phase Treatment	51.98%	56.24%	61.96%
Adherence to Antipsychotic Medication	59.20%	61.59%	62.64%

QIHET Workplan

2024 QIHET Program Workplan

Official Workplan Measures (DHCS)

Access to Primary and Specialty Care

- Appointment Availability - Routine Specialty
- Provider Directory - Accuracy

Care Coordination & Continuity of Care

- Complex / Care Management Follow Up on Clinical Depression
- Depression Screening & Follow-Up (DSF-E)*
- Follow-up After ED for Mental Illness (FUM)
- Follow-Up After Emergency Department for SUD (FUA)

Clinical Quality – Behavioral Health

- Adherence to Antipsychotic Medication (SAA)
- Mental Health Utilization Rate

Clinical Quality – Medical

- Asthma Medication Ratio (AMR)*
- Hepatitis C Treatment

Engagement with Primary Care

- Initial Health Appointment
- PCP Engagement
- Postpartum Care (PPC-Post)*
- Topical Fluoride for Children (TFL)
- Well-Child Visits in the First 30 Months of Life*

Member Experience

- CAHPS: Getting Needed Care*
- CAHPS: Rating of a Specialist
- CAHPS: Rating of PCP
- Complex / Care Management Client Satisfaction
- Provider Directory: Race & Ethnicity

*Health Equity Measure

QIHET Program Workplan

Access to Primary & Specialty Care

Measure Name	Population	Baseline	Target
Appointment Availability - Routine Specialty	Total number of specialists responding to PAAS with a routine appointment within 15 business days	47.00%	50.0%
Provider Directory - Accuracy	Total number of provider data points confirmed accurate	88.70%	90.50%

QIHET Program Workplan

Care Coordination & Continuity of Care

*Health Equity Measure

Measure Name	Population	Baseline	Target
Care Management Follow Up on Clinical Depression	Total clients 18 years or older who screened positive for clinical depression with PHQ-9 with a "Connect to Behavioral Health" care plan goal	85.70%	90.00%
Complex Care Management Follow Up on Clinical Depression		67.70%	85.00%
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)*	The percentage of members who received follow-up care within 30 days of a positive depression screen finding.	68.96%	85.00%
Follow-up After ED visit for Mental Illness: 30-Day (FUM-30)	Members (aged 6 and older) who received a follow-up visit for mental illness within 7 or 30 days of an emergency department visit with a diagnosis of mental illness or intentional self-harm	22.04%	54.87%
Follow-up After ED visit for Mental Illness: 7-Day (FUM-7)		39.00%	40.59%
Follow-Up After Emergency Department Visit for SUD: 30-Day (FUA-30)	Follow up visit by members 13 years of age and older for alcohol or other drug (AOD) within 7 or 30-days of an emergency department (ED) visit with a principal diagnosis of AOD abuse or dependence	21.03%	36.34%
Follow-Up After Emergency Department Visit for SUD: 7-Day (FUA-7)		11.00%	24.51%

QIHET Program Workplan

Clinical Quality – Behavioral Health

Measure Name	Population	Baseline	Target
Adherence to Antipsychotic Medication (SAA)	Number of members on antipsychotic with 80% adherence (PDC)	58.08%	61.39%
Mental Health Utilization Rate	Number of unique Medi-Cal members with a mental health visit	3.00%	4.50%

QIHET Program Workplan

Clinical Quality – Medical

*Health Equity Measure

Measure Name	Population	Baseline	Target
Asthma Medication Ratio (AMR)*	Number of controller meds	66.33%	69.41%
Hepatitis C Treatment	Number of members who completed Hep C treatment regimen	37.00%	40.00%

QIHET Program Workplan

Engagement with Primary Care

*Health Equity Measure

Measure Name	Population	Baseline	Target
Initial Health Appointment	Number of members who had a comprehensive PCP visit during first 120 days of Medi-Cal enrollment	21.30%	35.00%
PCP Engagement	Medi-Cal members without a provider visit from the previous year who have a visit in the subsequent year	TBD	+2.0%
Prenatal and Postpartum Care: Postpartum Care (PPC-Post)*	Number of people with a live birth during the measurement period who had a postpartum check between 7-84 days after delivery.	81.40%	84.59%
Topical Fluoride for Children: Dental or Oral Health Services Total (TFL)	Number of members one to 20 years of age who receive at least two topical fluoride varnish applications in the measurement year.	6.51%	19.30%
Well-Child Visits in the First 30 Months of Life: 0-15 Months (W30 6+)*	Infants with six or more well visits by 15 months of age	53.14%	58.38%
Well-Child Visits in the First 30 Months of Life: 15-30 Months (W30 2+)*	Children with two or more well visits between 15 and 30 months of age	72.34%	77.78%

QIHET Program Workplan

Member Experience

*Health Equity Measure

Measure Name	Population	Baseline	Target
CAHPS: Getting Needed Care*	Total number of members responding with ‘usually’ or ‘always’ to the Getting Needed Care HP-CAHPS composite	69.80%	72.80%
CAHPS: Rating of a Specialist	Total number of members rating 9 or 10 to the Rating of Specialist HP-CAHPS question	64.38%	67.38%
CAHPS: Rating of PCP	Total number of members rating 9 or 10 to the Rating of Personal Doctor HP-CAHPS question	64.54%	67.54%
Care Management Client Satisfaction	Number of satisfaction survey respondents who respond “Yes” to Question 2: Has the Care Management program helped you reach your health goals? and who respond “Always” or “Often" to Question 6: After receiving information from the Care Management staff, I feel confident I can take the actions needed to maintain or improve my health.	63.00%	65.00%
Complex Care Management Client Satisfaction		100.00%	100.00%
Provider Directory: Race & Ethnicity	Number of physicians with race/ethnicity data submitted	2.59%	8.00%

NCQA QI 3 and QI 4 Planning

Ongoing Data Collection for Potential NCQA QI 3 and QI 4 Measures

QI 3

- Streamlining Authorizations/ Specialty Referral Tracking
- SFHP Provider Satisfaction Survey
- Eye Exam for Patients with Diabetes
- Transitions of Care
- Follow-Up After Hospitalization for Mental Illness
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Plan All-Cause Readmissions (18-64 years of age)
- Prenatal and Postpartum Care: Postpartum Care
- Use of Opioids From Multiple Providers

QI 4

- Carelon Provider Satisfaction Survey
- Follow-Up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- Adherence to Antipsychotic Medication
- Complex Care Management Follow Up on Clinical Depression
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Diabetes Monitoring for People With Cardiovascular Diseases and Schizophrenia
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Developmental Screening in the First Three Years of Life
- Depression Screening and Follow-Up for Adolescents and Adults
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Opioid Abuse Total
- Pharmacotherapy for Opioid Use Disorder

Quality & Health Equity Oversight Activities

- Quality Improvement & Health Equity Committee
- Pharmacy and Therapeutics Committee
- Provider Advisory, Peer Review, and Credentialing Committee
- Annual Evaluation of the QIHET Program
- QIHET Plan Approval for Calendar Year
- Delegation Oversight for QI
- DHCS Performance Improvement Projects
- Governing Board approval of QIHET Plan and Evaluation

Next Steps

- ➢ Approve 2023 Evaluation and 2024 Program Description & Workplan
- ❑ QIHEC Scorecard – May, July, and October 2024
- ❑ NCQA QI 3 & 4 Resurvey Measure Discussion – Q3 2024

UM Criteria

SeDessie Harris, RN MHA

Senior Manager, Clinical Operations

Questions?

SFHP

sfhp.org


@sanfranciscohealthplan


@SFHealthPlan


@SFHealthPlan

SAN FRANCISCO HEALTH PLAN
Here for you

Quality Improvement and Health Equity Committee Meeting

Thursday, March 7, 2024
8:30 – 10:00 AM

50 Beale St
13th Floor, Conference Room – City Hall
San Francisco, CA 94119

To arrange for public building access, please contact Stephanie MacAller at 415-615-4240

MS Teams Meeting
Meeting ID: 289 998 974 444
Passcode: QfxYLU
Download Teams | Join on the web
Or call in (audio only)
+1 323-475-1528,,599923137# United States, Los Angeles
Phone Conference ID: 599 923 137#
Find a local number | Reset PIN

AGENDA

Quality Improvement Committee: Open Session				
Time	**Topic**	**Page**	**Objective**	**Assigned**
8:30	Welcome / Roll Call (10 min)	1	Inform	Shenita Hurskin, MBA
	QIHEC quorum: 6 QIHEC members, 3 physicians, including Committee Chair · NCQA Accreditation	 2	Inform	Shenita Hurskin, MBA Nina Maruyama
8:40	Consent Calendar (5 mins)	22	Vote	Shenita Hurskin, MBA
	· November 2023 QIC Minutes · Q3 2023 ER Access Report · Q4 2023 Grievance Report · Q4 2023 Appeals Report · UM Committee Minutes and supporting documentation o October 2023 o December 2023 o UM Program Description · Health Services Policies & Procedures (P&P) Updates Summary · 2023 Facility Site Review Report · 2023 PQI Report · QI Access Monitoring Annual Update	22 27 31 39 44 44 56 77 115 118 122 127	Action: Vote	
8:45	Previous Action Items (5 mins)		Inform	Stephanie MacAller
8:50	2022 Carelon Provider Experience Survey (10 mins)	202	Inform	Vanessa Aranda, MSW Andrea Champagne-Small (Carelon)
9:00	Quality Improvement Updates (60 mins)		Inform/ Vote	
9:00	QIHETP Overview (5 mins)		Inform	Edwin Poon, PhD Shenita Hurskin, MBA
9:05	Measurement Year 2023 HEDIS Analysis (10 mins)		Inform	José Méndez
9:15	2023 QI Program Evaluation (10 mins)	219	Action: Vote	Yves Gibbons
9:25	2024 QIHETP Annual Plan (20 mins)	269	Action: Vote	Yves Gibbons
9:45	Utilization Management Criteria (10 mins)	154	Inform	SeDessie Harris, RN, MHA

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
sfhp.org

MEMO

To	San Francisco Health Plan (SFHP) Quality Improvement and Health Equity Committee (QIHEC)
From	Nina Maruyama, Chief Officer, Compliance and Regulatory Affairs
Regarding	Change in NCQA Health Plan Accreditation Status

San Francisco Health Plan (SFHP) underwent its NCQA Health Plan Accreditation Renewal Survey for Medi-Cal from October 2023 to January 2024. NCQA reviewed the SFHP's documentation for the six NCQA categories: 1) Quality Improvement, 2) Population Health Management, 3) Utilization Management, 4) Network Management, 5) Credentialing and Recredentialing, and 6) Member Experience. Documentation included hundreds of pieces of evidence, such as policies and procedures, reports, screenshots/materials, and presentation and review of case files.

On January 22, 2024, NCQA issued its final report regarding SFHP's Health Plan Accreditation Renewal Survey for Medi-Cal. Unfortunately, the result is not what we had hoped for and SFHP's Health Plan Accreditation status is now changed to Provisional, Under Corrective Action. SFHP will work closely with the QIHEC and provider network to remove the "Provisional, Under Corrective Action" status.

With the Provisional, Under Corrective Action status, SFHP will undergo a Resurvey for the two Quality Improvement (QI) requirements in which we fell short, 1) QI 3 A, B & C (Coordination of Medical Care) and 2) QI 4 B & C (Coordination Between Medical and Behavioral Health Care), on January 21, 2025. During the Resurvey of these areas, we must show evidence that SFHP and its provider network collaborate to care for members when they transition between providers or settings and when they have both medical and behavioral health care needs.

We will also undergo a File Review Resurvey for UM 9 D (Notification of Appeal Rights) on March 10-11, 2025, to demonstrate correction of the letters sent to members regarding the results of an appeal. The letter template has already been corrected and implemented for use.

SFHP will submit a detailed corrective action plan to NCQA by February 22nd. We have already implemented process improvements, including updating guidance for staff and implementing a rigorous review process for the appeal notification letters. The Quality team is developing the workplan for NCQA QI 3 and 4 requirements throughout 2024.

6279X 0515

SFHP's NCQA Health Plan Rating for Medicaid of 4 (out of 5) remains. SFHP's status of "Provisional, Under Corrective Action" remains until the Resurvey has concluded in April 2025. We are working diligently to ensure SFHP's accreditation status will be restored to "Accredited."

NCQA Update: Provisional Status, Under Corrective Action

- NCQA's Final Report reflected that SFHP fell below the minimum point threshold for the QI category and SFHP did not pass a must-pass element (UM 9 D Notification of Appeal Decision)
- SFHP's NCQA accreditation status is "Provisional."
    - Provisional status is different from Denied in that SFHP still has NCQA Health Plan Accreditation
    - SFHP's accreditation is still 4 out of 5.
    - SFHP's accreditation status is at risk, pending the outcome of the Resurvey 2025.
    - Resurvey will begin in January 2025, with results in April 2025.
- By February 15, 2024, NCQA will update its health plan report card website to reflect Provisional, Under Corrective Action.
- This status will not change until the completion of SFHP's Resurvey in April 2025.

Resurvey – QI 3 Coordination of Medical Care and QI 4 Coordination Between Medical and Behavioral Health Care

- To maintain “Accredited” status, plans must receive at least 80% of the points available in each of the six categories
- SFHP exceeded the points needed in all categories except Quality Improvement and Management, where it received 71% of the available points due analytical and narrative gaps in its annual reports for QI 3 and QI 4.
- We request QIHEC’s feedback on the proposed measures within the 2024 QI workplan, which will support our efforts to comply with QI 3 and QI 4.
- Throughout the year, we will be coming back to QIHEC for input on the process, outcomes analyses, including the results, barriers and opportunities for the next year.

Resurvey – January and March 2025

SFHP will undergo a Resurvey for NCQA Health Plan Accreditation in 2025, consisting of two events:

- January 21, 2025 - Submission of non-file evidence
  - All report evidence for QI 3 A-C and QI 4 A-C with a 6-month lookback
  - File universe for appeals
- March 10-11, 2025 - File review of the appeal files NCQA selects from the universe
  - SFHP staff will present case file evidence for UM 9 D Notification of Appeal Decision/Rights (NAR), focused on the contents of the Notice of Appeal Resolution letters sent to members.
  - Surveyors will assess performance with all factors for UM 9 D, not just Factor 5, the single factor we missed.
  - SFHP has already corrected the NAR letter template; high level of confidence this is corrected.

1100 13th Street NW, Third Floor
Washington, DC 20005
phone 202.955.3500
fax 202.955.3599
www.ncqa.org

January 19, 2024

Yolanda Richardson
Chief Executive Officer
San Francisco Health Authority DBA San Francisco Health Plan
PO Box 194247
San Francisco**,** CA 94119-4247

Dear Ms. Richardson:

We are pleased to inform you that based on the information gathered during your recent HP survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded **San Francisco Health Authority DBA San Francisco Health Plan** the accreditation status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting https://irt.ncqa.org. The final results are available by selecting your organization's project on the Dashboard and going to "View Final Report" from the actions menu. If this section does not appear, please follow the instructions in the attached documents entitled "Log In and Dashboard" and "User Management" and update your user rights.

Product Line/ Product	**Accreditation Status**	**Effective Date**	**Expiration Date**
Medicaid-HMO	Provisional, Under Corrective Action	January 18, 2024	April 18, 2025

The NCQA Health Plan Report Card will be updated to reflect this status by no later than the 15th of February. A certificate reflecting your accreditation status(es) can be downloaded from my.ncqa.org. .

Resurvey, Under Corrective Action (CAP)
The organization scored less than 80 percent for the Quality Management and Improvement (QI) standards category during the recent Renewal survey. If an organization's score is below 80 percent and above 55% in any standards category following a Full Survey, it must undergo a Resurvey within 12 months of the Accreditation decision. At a minimum, the scope of the Resurvey includes all elements scored 'Partially Met' or 'Not Met' in the standards category scored less than 80 percent. The organization also has the option to be re-evaluated on any other 'Partially Met' or 'Not Met' elements in any other standards category where the 80 percent threshold was met. Your organization will receive a 'Provisional' status until successful completion of the Resurvey. At a minimum, the organization's Resurvey must include QI 3A, QI 3B, QI 3C, QI 4B and QI 4C.

Additionally, your organization failed one (1) must-pass element requirement – UM 9D (Notification of Appeal Decision/Rights). Per the 2023 HPA Policies and Procedures, if an organization does not

score "Met" on any must-pass element, an 'Under Corrective Action' status modifier is applied to the organization's status and the organization must undergo corrective action.

Given your organization must undergo a Resurvey in 12 months due to not meeting the minimum 80 percent threshold for one standards category, NCQA will not require a separate Corrective Action (CAP) Survey in 6 months. Please note that the failed must-pass element will be included in the scope of the required Resurvey in 12 months to confirm implementation of corrective action. The organization will need to submit a detailed corrective action plan to NCQA within 30 days of this letter. Please complete the Corrective Action Summary Form and return to Avani Bharucha (bharucha@ncqa.org) and Candice Costello (costello@ncqa.org) within the 30-day deadline. A copy of the Corrective Action Summary Form can be found in your survey tool, under Organization Background, under Corrective Action. Upon receipt of the CAP plan, NCQA will advise the organization if it is approved. The organization must provide sufficient detail on the CAP Summary Form how it will address the identified deficiencies and how it will ensure the evidence will be compliant any failed must-pass elements (meeting the full element requirement – all factors and sub-components) at time of the Resurvey. The CAP Form only needs to cover the failed must-pass element requirements outlined in the form and not all other elements in scope of the Resurvey.

Please note the following regarding NCQA Resurveys:

- A Resurvey IRT tool will be created and assigned to you. You do not need to purchase an IRT License for the Resurvey.
- Your Resurvey tool will be linked to your previous survey tool for all requirements not in scope of the Resurvey. Your ASC will work with you to finalize the scope of the Resurvey.
- The Resurvey will be against the same Standards and Guidelines reviewed during the organization's full survey (HP2023).
- A new application and contract are required for Resurveys.
- Survey fee invoices are generally sent out 60 days prior to survey start date. Please contact applications & scheduling for invoice and payment information.
- The fee for a Resurvey is detailed in NCQA's pricing methodology - Survey fee calculated using Full Survey methodology and applying 25% discount.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or accreditation outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2023 *Standards and Guidelines for the Accreditation of Health Plans*. This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for HP Accreditation Survey, "Pricing Methodology and Cancellation Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

We have tentatively reserved **January 21, 2025**, as the submission date of the completed Survey Tool to NCQA. NCQA has tentatively set **March 10 - 11, 2025** for your onsite survey. If the proposed dates present a problem for you or if you have any questions regarding these dates, please submit a PCS question via our my.ncqa.org system.

If you have questions about the IRT, please contact NCQA Customer Support at (888) 275-7585 or via my.ncqa.org. You can also visit www.ncqa.org for additional information.

While it is our understanding that the results of this accreditation survey may satisfy a state regulatory requirement, NCQA assumes no responsibility for transmitting copies of this report to relevant state agencies.

We wish to acknowledge your quality improvement efforts, which were evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

Sue Matthiesen
Assistant Vice President, Accreditation

Organization: San Francisco Health Authority DBA San Francisco Health Plan
Standards Year: 2023
Evaluation Option: Renewal Survey
Unit of Assessment: Medicaid HMO

Element level scoring is unique. Some elements require all factors to be met, while others may have a range of factors required to meet 100%.

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
QI1A	QI Program Structure	Met				
QI1B	Annual Work Plan	Met				
QI1C	Annual Evaluation	Met				
QI1D	QI Committee Responsibilities	Met				
QI1E	Promoting Organizational Diversity, Equity and Inclusion	Met	✔			
QI2A	Practitioner Contracts	Met				
QI3A	Identifying Opportunities	Not Met	✔			
QI3B	Acting on Opportunities	Not Met	✔			

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
QI3C	Measuring Effectiveness	Not Met	✔			
QI3D	Transition to Other Care	Met				
QI4A	Data Collection	Met	✔			
QI4B	Collaborative Activities	Not Met	✔			
QI4C	Measuring Effectiveness	Not Met	✔			
QI5A	Delegation Agreement	Met				
QI5B	Predelegation Evaluation	NA				
QI5C	Review of QI Program	Met				
QI5D	Opportunities for Improvement	Met				
PHM1A	Strategy Description	Met				
PHM1B	Informing Members	Met	✔			
PHM2A	Data Integration	Met				
PHM2B	Population Assessment	Met				
PHM2C	Activities and Resources	Met				
PHM2D	Segmentation	Met				
PHM3A	Practitioner or Provider Support	Met	✔			

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
PHM3B	Value-Based Payment Arrangements	Met				
PHM4B	Topics of Self-Management Tools	Met				
PHM5A	Access to Case Management	Met	✔			
PHM5B	Case Management Systems	Met				
PHM5D	Initial Assessment	Met				
PHM5E	Case Management—Ongoing Management	Met				
PHM6A	Measuring Effectiveness	Not Met	✔			
PHM6B	Improvement and Action	Not Met	✔			
PHM7A	Delegation Agreement	Met				
PHM7B	Predelegation Evaluation	NA				
PHM7C	Review of PHM Program	Met	✔			
PHM7D	Opportunities for Improvement	Met				
NET1A	Cultural Needs and Preferences	Partially Met	✔			
NET1B	Practitioners Providing Primary Care	Met				
NET1C	Practitioners Providing Specialty Care	Met				
NET1D	Practitioners Providing Behavioral	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
	Healthcare					
NET2A	Access to Primary Care	Met				
NET2B	Access to Behavioral Healthcare	Met				
NET2C	Access to Specialty Care	Met				
NET3A	Assessment of Member Experience Accessing the Network	Met				
NET3B	Opportunities to Improve Access to Nonbehavioral Healthcare Services	Met				
NET3C	Opportunities to Improve Access to Behavioral Healthcare Services	Met				
NET4A	Notification of Termination	Met				
NET4B	Continued Access to Practitioners	Met				
NET5A	Physician Directory Data	Met				
NET5B	Physician Directory Updates	Met				
NET5C	Assessment of Physician Directory Accuracy	Met				
NET5D	Identifying and Acting on Opportunities	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
NET5E	Searchable Physician Web-Based Directory	Met				
NET5F	Hospital Directory Data	Met				
NET5G	Hospital Directory Updates	Met				
NET5H	Searchable Hospital Web-Based Directory	Met				
NET5I	Usability Testing	Not Met	✔			
NET5J	Availability of Directories	Met				
NET6A	Delegation Agreement	Partially Met	✔			
NET6B	Predelegation Evaluation	NA				
NET6C	Review of Delegated Activities	Met				
NET6D	Opportunities for Improvement	Met				
UM1A	Written Program Description	Met				
UM1B	Annual Evaluation	Met				
UM2A	UM Criteria	Met				
UM2C	Consistency in Applying Criteria	Met				
UM3A	Access to Staff	Met				
UM4A	Licensed Health Professionals	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
UM4B	Use of Practitioners for UM Decisions	Met				
UM4C	Practitioner Review of Nonbehavioral Healthcare Denials	Met		✔	100	
UM4D	Practitioner Review of Behavioral Healthcare Denials	Met		✔	100	
UM4E	Practitioner Review of Pharmacy Denials	Met		✔	100	
UM4F	Use of Board-Certified Consultants	Met				
UM5A	Notification of Nonbehavioral Healthcare Decisions	Met		✔	100	
UM5B	Notification of Behavioral Healthcare Decisions	Met		✔	100	
UM5C	Notification of Pharmacy Decisions	Met		✔	100	
UM5D	UM Timeliness Report	Met				
UM6A	Relevant Information for Nonbehavioral Healthcare Decisions	Met				
UM6B	Relevant Information for Behavioral Healthcare Decisions	Met				
UM6C	Relevant Information for Pharmacy	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
	Decisions					
UM7A	Discussing a Denial With a Nonbehavioral Healthcare Reviewer	Met				
UM7B	Written Notification of Nonbehavioral Healthcare Denials	Met		✔	100	
UM7C	Written Notification of Nonbehavioral Healthcare Appeal Rights/Process	Met		✔	100	
UM7D	Discussing a Behavioral Healthcare Denial With a Reviewer	Met				
UM7E	Written Notification of Behavioral Healthcare Denials	Met		✔	100	
UM7F	Written Notification of Behavioral Healthcare Appeal Rights/Process	Met		✔	100	
UM7G	Discussing a Pharmacy Denial With a Reviewer	Met				
UM7H	Written Notification of Pharmacy Denials	Met		✔	100	
UM7I	Written Notification of Pharmacy Appeal Rights/Process	Met		✔	100	
UM8A	Internal Appeals	Met	✔			

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
UM9A	Preservice and Postservice Appeals	Met				
UM9B	Timeliness of the Appeal Process	Met		✔	100	
UM9C	Appeal Reviewers	Met				
UM9D	Notification of Appeal Decision/Rights	Not Met	✔	✖	100	**Must Pass**
UM9E	Final Internal and External Appeal Files	NA				
UM9F	Appeals Overturned by the IRO	NA				
UM10A	Written Process	Met				
UM10B	Description of the Evaluation Process	Met				
UM11A	Pharmaceutical Management Procedures	Met				
UM11B	Pharmaceutical Restrictions/Preferences	Met				
UM11C	Pharmaceutical Patient Safety Issues	Met				
UM11D	Reviewing and Updating Procedures	Met				
UM11E	Considering Exceptions	NA				
UM12A	UM Denial System Controls	Met		✔	100	
UM12B	UM Denial System Controls Oversight	Met				
UM12C	UM Appeal System Controls	Met		✔	100	

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
UM12D	UM Appeal System Controls Oversight	Met				
UM13A	Delegation Agreement	Met	✔			
UM13B	Predelegation Evaluation	Met				
UM13C	Review of the UM Program	Partially Met	✔			
UM13D	Opportunities for Improvement	Met				
CR1A	Practitioner Credentialing Guidelines	Met				
CR1B	Practitioner Rights	Met				
CR1C	Credentialing System Controls	Met		✔	100	
CR1D	Credentialing System Controls Oversight	Met				
CR2A	Credentialing Committee	Met				
CR3A	Verification of Credentials	Met		✔	100	
CR3B	Sanction Information	Met		✔	100	
CR3C	Credentialing Application	Met		✔	100	
CR4A	Recredentialing Cycle Length	Met		✔	100	
CR5A	Ongoing Monitoring and Interventions	Met	✔			
CR7D	Assessing Medical Providers	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
CR7E	Assessing Behavioral Healthcare Providers	Met				
CR8A	Delegation Agreement	Met				
CR8B	Predelegation Evaluation	NA				
CR8C	Review of Delegate's Credentialing Activities	Partially Met	✔			
CR8D	Opportunities for Improvement	Met				
ME1A	Rights and Responsibilities Statement	Met				
ME1B	Distribution of Rights Statement	Met				
ME2A	Subscriber Information	Met				
ME2B	Distribution of Subscriber Information	Met				
ME2C	Interpreter Services	Met				
ME3A	Materials and Presentations	NA				
ME3B	Communicating With Prospective Members	NA				
ME3C	Assessing Member Understanding	NA				
ME5C	QI Process on Accuracy of Information	NA				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
ME5D	Pharmacy Benefit Updates	NA				
ME6A	Functionality: Website	Met				
ME6B	Functionality: Telephone	Met				
ME6C	Quality and Accuracy of Information	Met				
ME6D	Email Response Evaluation	Met				
ME7A	Policies and Procedures for Complaints	Partially Met	✔			
ME7B	Policies and Procedures for Appeals	Met	✔			
ME7C	Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals	Met				
ME7D	Nonbehavioral Opportunities for Improvement	Met				
ME7E	Annual Assessment of Behavioral Healthcare and Services	Met				
ME7F	Behavioral Healthcare Opportunities for Improvement	Met				
ME8A	Delegation Agreement	Partially Met	✔			
ME8B	Predelegation Evaluation	NA				
ME8C	Review of Performance	Met				

ELEMENT	TITLE	CURRENT	ISSUES NOT MET	MUST PASS	MUST PASS THRESHOLD	ELEMENTS SUBJECT TO CORRECTIVE ACTION
ME8D	Opportunities for Improvement	Met				

Date: November 2, 2023
Meeting Place: 50 Beale Street, 12th Floor
San Francisco, CA 94119

Microsoft Teams Meeting
+1 323-475-1528,,519741547#

Meeting Time: 8:00AM – 10:00AM

QIC Members Present:

In person: Dr. Kathleen Chung, Medical Director, Value Based Care, *SFHN*; Ed Evans, community member; Dr. Blake Gregory, Primary Care Director of Population Health and Quality; Medical Director, Complex Care Program, SFHN; Dr. Jackie Lam, Medical Director/QI/QA Director, *NEMS;* Dr. Amy Lu, Chief Quality Officer, *UCSF;* Alecia Martin, Director of Quality Management, *SF BHS;* Dr. David Ofman, Chief Medical Officer, San Francisco Consortium of Community Clinics (SFCCC); Idell Wilson, community member

Not present: Irene Conway, community member; Dr. Luke Day, Chief Medical Officer, *ZSFGH*; Dr. Jaime Ruiz, Chief Medical Officer, *MNHC*; Dr. Kenneth Tai, Chief Health Officer, *NEMS*; Dr. Ana Valdes, Chief Healthcare Officer, *HealthRight360*; Dr. Albert Yu, Chief Health Information Officer, *SFHN*

SFHP Staff Present:

In person: Shenita Hurskin, Director, Quality Improvement; Stephanie MacAller, Associate Program Manager, Quality Improvement; Yves Gibbons, Supervisor, Quality Improvement; Kaitlin Hawkins, Pharmacy Operations Manager; David Ries, Director of Behavioral Health and Housing; Hilary Gillette-Walch, Director of Population Health; Eddy Ang, Chief Medical Officer, Jose Mendez, Manager, Health Services Product Management; Leslie Mulhern, Nurse Supervisor, Quality Review

Topic		Follow-up [if Quality Issue identified, Include Corrective Action]	Resolution, or Closed Date [for Quality Issue, add plan for Tracking after Resolution]
Call to Order	Meeting called to order at 8:05am		
Welcome/ Updates	• SH introduced the name change for the committee to Quality Improvement and Health Equity Committee to align with DHCS requirements.		

Consent Calendar	• SM noted an update needed to the UMC meeting minutes item, stating the program description would be presented in January rather than December.		Approved • Sept 2023 QIC Minutes • Q2 2023 ER Access Report • UM Committee Minutes and supporting documentation o August 2023 o September 2023 • Health Services Policies & Procedures (P&P) Updates Summary • Q2 2023 PQI Report
Previous Action Items	• SM provided an update on previous action items, including outreach to schedule a discussion on provider recruitment strategies with EA. • KH noted work being done to better identify provider demographics. EA shared SFHP is analyzing telehealth utilization. • DR commented on state efforts to increase behavioral health provider reimbursement rates and allow billing for supervised clinician hours to attract more mental health clinicians. • EA proposed exploring telehealth vendor Teladoc utilization further to help expand provider access.	• SFHP to explore telehealth vendor Teladoc utilization further to help expand provider access.	
Proposed change to PQI reporting calendar	• LM presented the proposed changes to the PQI reporting calendar for 2024, noting reports currently don't capture completed cases due to long resolution times.		
2024 Potential Priority Quality Measures Discussion	POD • KH highlighted the measure requires being on OUD treatment for 180 days with no more than 8 days interruption, which stakeholders feel is very stringent. • KH noted the denominator includes anyone with OUD, so organizations won't be penalized for starting treatment if it's not maintained for 180 days. • BG shared UCSF is focusing on strengthening OUD services in primary care, including expanded navigation programs with an addiction specialist, navigator, clinical pharmacist and nurse at some clinics. The navigator proactively follows up with patients. • KL raised a concern that the measure definition could discourage screening for OUD in some clinics that don't currently ask about it regularly. PCE Systemic Corticosteroid • KH suggests focusing on optimal inhaled therapy given manageable denominator and potential for improved outcomes • Measure focuses on steroid dispensing within 14 days of IDI/inpatient discharge • Stakeholders identify issues with metric not capturing inpatient prescriptions	• POD: EA will send feedback to DHCS on concerns with the strict POD measure specifications. • PCE: Draft feedback from providers on concerns to send to NCQA (Assigned to EA) • SAA: Research measure methodology/specs and determine feedback (Assigned to EA) • PCR: Connect with ECM program on bulk referrals (Assigned to EA)	

	SPC Received Statin Therapy • KH finds measure accessible from primary care perspective with appropriate exclusions • JM discusses performance levels and data lag issues • Focus on statin therapy and cardiovascular disease SAA • Measure relies on prescription claims data accessibility • Challenges with measuring adherence through claims alone • Potential value in connecting with federal government to build metrics • EA asked if the treatment period is defined for the antipsychotic medication management measure (KH described how it is defined based on outpatient visits or acute inpatient visit) COL-E • Barriers include access issues for homeless patients • Partnerships like SFC help address barriers and reduce cancer burden PCR • Strategies discussed include improving hospital handoffs and follow up care • Concerns raised about new social risk factor screening increasing patient complexity weights • BG asked a question about whether the O/E ratio for readmissions takes into account factors like anticipated length of stay (ALS) when weighting discharges. (JM provided context about how discharges are weighted) • BG asked about the potential impact of new CMS requirements to screen for social determinants of health, wondering if diagnoses like homelessness could increase patient complexity weights (JM said this would need further looking into)	• Final 2024 Workplan will be brought to next QIHEC for approval	
2023 Priority Quality Measures Updates	AMR • Current rate of 67.95%, improvement from last year's 55% • Efforts from provider teams and committees contributed to progress • Rate has plateaued after data cleaning • Key efforts o Cleaning up asthma data through additional coding and identification of members with asthma o Developing clinical guidelines on asthma management and sharing them across partners o Partnering with pharmacies to promote medication adherence and management o Conducting home visits and environmental assessments to address triggers		

	• Launching an asthma alert program to notify providers of gaps in care • Providing asthma education to members and families • Collaborating with community health workers for outreach and education • Barriers and focus areas • Connecting with pharmacies like Walgreens and CVS given changes to payments • Additional data refinement with provider groups • Next 60 days • Continue engaging pharmacies and pharmacy leadership • Share data and performance with provider groups • Finalize NEMS presentation by end of year (Follow up meeting scheduled) • Thanks to partners like BG for insights and progress made through collaboration DEV • Current rate of 42.98%, above MPL • Key efforts • Conversations with providers to ensure coding during well visits • Pursuing supplemental data from SF Health Network • Barriers • Screenings not always coded with time allocated • Delay in recall report to identify missing screens • Next 60 days • Continue partnership with Department of Early Childhood (Assigned to HG) • Collect additional screening data and initiate data sharing • Distribute infant milestone map to stimulate follow up W30 • Current rate of 42.98%, above MPL • Supplemental data being collected to address gaps • Key efforts • Coding guidance provided to ensure visits coded during well checks • Developed infant wellness map to support families • Partnership with Department of Early Childhood on Sparkler app • Barriers • Screenings not always coded with time • Delay in recall report to identify missing visits • Challenges capturing first visits done under mom's ID • Next 60 days • Continue partnership and data collection • Distribute wellness maps and provide training		

	○ Make follow up calls to patients needing 1-2 visits TFL • Current rate very low • Key efforts ○ Providing fluoride varnish training to partners • Barriers ○ Low rates of application during pandemic ○ Metric does not fully align with USPSTF recommendations FUA/FUM • Key efforts ○ Identifying patients for follow up via hospitals, EDDs, clinics ○ Conducting follow up calls for patients who need encouragement • Barriers ○ Data gaps between substance use treatment providers and health plans ○ Low success of follow up calls long after ED or inpatient discharge • Next 60 days ○ Seeking supplemental data from DPH to address gaps ○ Researching follow up services provided by DPH and potential supplemental data		
Meeting Adjourned	Meeting adjourned at 10:05am		

QIHE Committee Chair's Signature & Date:

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

Emergency Room Visit / Prescription Access Report
3rd Quarter 2023
San Francisco Health Plan Medi-Cal LOB

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

Methodology:
All claim and encounter records for an emergency room visit (without an admission) during a calendar quarter are evaluated and consolidated into a unique record of each emergency room (ER) visit date by member. These unique ER visits are analyzed by ER facility site and member count (see Tables 1A & 1B). Top diagnoses were evaluated for the 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 3Q2023,13,017 members had 20,236 ER visits, averaging 1.55 ER visits per member, which is lower than the previous quarter (1.53). This reflects an ER visit by approximately 7.4% of the SFHP Medi-Cal membership within the quarter, which is lower than the previous quarter. Visits by ER facility and the number of Member ER visits decreased compared to the previous quarter (20,943 and 13,662 respectively).

Table 1A: Visits by ER Facility

ER Facility	ER Visits
ZSFG - ACUTE CARE 2	3,925
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER	3,745
UC SAN FRANCISCO MEDICAL CENTER	3,041
ST FRANCIS MEMORIAL HOSPITAL	1,838
CPMC MISSION BERNAL - ACUTE	1,730
CPMC VAN NESS CAMPUS - ACUTE CARE	1,534
CPMC PACIFIC CAMPUS – OUTPATIENT & ER	904
ST MARYS MEDICAL CENTER	786
CHINESE HOSPITAL	688
CPMC DAVIES CAMPUS - ACUTE	592
KAISER FOUNDATION HOSPITAL SF	438
Other ED Facilities	1,015
TOTAL	**20,236**

Table 1B: Member ER Visits

# ER Visits	Member
1	8,364
2	2,657
3	918
4	420
5	215
6	117
7	94
8	41
9	47
10	35
11+	109
TOTAL	**13,017**

Section 2 - Top Diagnoses

Of the 20,236 ER visits in 3Q2023 8,690 visits (43%) resulted in a medication (from ER or pharmacy) within 72 hours of the ER Visit and 10,139 (50%) did not. Not all ER visits warranted medication treatment (i.e. chest pain, abdominal pain or altered mental status). COVID-19 visits increased by 28% compared to the previous quarter. The distribution of top ER visits by diagnoses category is shown in Table 2.

Table 2: Percent ER Visits by Diagnoses (2Q2023)

Top Diagnoses Categories	ICD10	ER Visits	% of Visits
Chest pain	R07.xx	1,598	7.9%
Abdominal pain	R10.xx	901	4.5%
Shortness of breath	R06.02	381	1.9%
Alcohol Use	F10.xx	306	1.5%
Head Injury Unspecified	S09.90	265	1.3%
Headache	R51.9	265	1.3%
Dizziness and Giddiness	R42	229	1.1%
Abnormal Electrocardiogram	R94.31	221	1.1%
COVID-19	U07.1	208	1.0%
Altered mental status	R41.82	202	1.0%
Acute Upper Respiratory Infection Unspecified	J06.9	170	0.8%
Syncope and Collapse	R55	155	0.8%
Urinary Tract Infection Not Specified	N39.0	153	0.8%
Fever Unspecified	R50.9	149	0.7%
Low Back Pain, Unspecified	M54.50	145	0.7%
Cough	R05	136	0.7%
Suicidal Ideations	R45.851	125	0.6%
Acute Pharyngitis Unspecified	R11.10	120	0.6%
All Other Diagnoses		14,507	71.7%
TOTAL		**20,236**	100.0%

Further analysis of diagnoses include 108 ER visits for substance use disorder with 38 of the visits (35%) resulted in a pharmacy intervention. Opioid abuse resulted in 74 ER visits, overdose/poisoning was included in 27 ER visits, and alcohol abuse resulted in 13 ER visits.

- F19 substance abuse : 108 visits , 38 resulted in a pharmacy intervention.
- T50 overdose poison: 27 visits, 10 resulted in a pharmacy intervention.
- F11 opioid abuse : 74 visits, 40 resulted in a pharmacy intervention.
- F12 alcohol abuse: 13 visits, 7 resulted in a pharmacy intervention.

Section 3 - Key Diagnoses Category

Selected key diagnoses with a high likelihood for ER discharge prescription are reported in Table 3. In 3Q2023, more than 90% of ER visits for all key diagnoses received medication treatment within 72 hours of the visit.

Table 3: ER Visit – Key Diagnoses Category

Diagnoses Category	ICD10	RX Filled	ER Treated	No Rxs	ER Visit Total	% Treatment
COPD	J44, J44.1, J44.9	20	37	1	58	98%
UTI	N39.0	68	47	7	122	94%
Asthma Exacerbation	J45.901, J45.909, J45.902	63	38	5	108	94%
Pneumonia	J18.9	31	19	5	55	91%

Section 4 - Pharmacy Location

For the members filling a prescription from a Pharmacy within 72 hours of their ER visit date, a further analysis evaluated the location of the pharmacy relative to where the member received emergency care and the hours of operation for these pharmacies. Of the 7,417 member visits to a pharmacy after an ER discharge, the top 15 most utilized pharmacies are reported in Table 4. Access to a pharmacy after an ER visit can occur throughout the day and would not be limited to only after-hours. In this analysis, member visits are defined as unique days that prescriptions are filled for a member per unique pharmacy.

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

Pharmacy	Hours of Operation	Mbr Visits	% of Visits
SF General (1001 Potrero Ave)	9AM – 8PM M-F, 9AM-1PM Sat	778	10.49%
Walgreens 3711 (1189 Potrero Ave)	8AM – 10PM M-F,8AM – 9PM Sat-Sun	519	7.00%
Walgreens 5487 (5300 3rd St)	8AM – 9PM	352	4.75%
Walgreens 1327 (498 Castro St)	24 Hours	325	4.38%
Walgreens 7150 (965 Geneva Ave)	9AM – 9PM	298	4.02%
Chinese Hospital (845 Jackson St)	8AM – 7PM M-F, 9AM-5PM Sat-Sun	283	3.82%
Walgreens 4609 (1301 Market St)	8AM – 9PM	280	3.78%
Walgreens 4231 (2690 Mission St)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	231	3.11%
Daniels Pharmacy (943 Geneva Ave)	9AM-6:30PM	225	3.03%
Walgreens 1626(2494 San Bruno Ave)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	222	2.99%
Walgreens #3558 (1301 Franklin St)	9AM-9PM M-F, 9AM-1:30PM, 2PM-5PM Sat, 10AM-1:30PM, 2PM-6PM Sun	173	2.33%
Walgreens 1054(3398 Mission St)	9AM-9PM M-F, 9AM-1:30PM, 2PM-5PM Sat, 10AM-1:30PM, 2PM-6PM Sun	160	2.16%
Walgreens 3185 (825 Market St)	8AM – 9PM M-F, 9AM – 5PM Sat, 10AM – 6PM Sun	143	1.93%
Scriptsite Pharmacy (870 Market St #1028)	9:30AM-5:30PM M-F	135	1.82%
Walgreens 1283 (500 Geary St)	9AM to 1:30PM, 2PM to 7PM M-F, 9AM to 1:30PM, 2PM to 5PM Sat	125	1.69%
Walgreens 1393 (1630 Ocean Ave)	9AM-9PM M-F, 9AM-1:30PM, 2PM-5PM Sat, 10AM-1:30PM, 2PM-6PM Sun	112	1.51%

CVS 9577 (7191 Warner Avenue, Huntington Beach, CA) Mail Order	10AM to 1:30PM, 2PM to 8PM M-F, 10AM to 1:30PM, 2PM to 6PM Sat, 11AM to 1:30PM, 2PM to 5PM Sun	110	1.48%
All Other Pharmacy Locations		2,946	39.72%
TOTAL		**7,417**	**100.00%**

Summary:
No barrier to pharmacy access during after-hours was identified in this quarter. ER utilization was lower in 3Q2023 compared to 2Q2023 (20,236 visits versus 20,946) with each member utilizing the ER at 1.55 visits. About 43% of ER visits received medication (from ER or pharmacy) within 72 hours of the ER visit, which was slightly lower compared to last quarter (44%). Appropriate prescription fills were seen in all four key diagnoses category. Monitoring of member access to medication treatment after an ER visit will continue.

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

MEMO

Date: January 26, 2024

To	**Quality Improvement Committee**
From	**Phoebe Tong, Associate Program Manager, Grievances and Appeals**
Regarding	**Q3 2023 Grievance Report**

- SFHP received a total of 219 grievances in Q3 2023. Overall grievance volume decreased by 4% from 228 total grievances in Q2 2023.
- In Q3 2023, 2 out of 219 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). None of the expedited grievances were not closed within the required timeframe of 72 hours, as mandated by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS).
- In Q3 2023, 3 acknowledgement letters were not sent out within five calendar days, as mandated by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS).

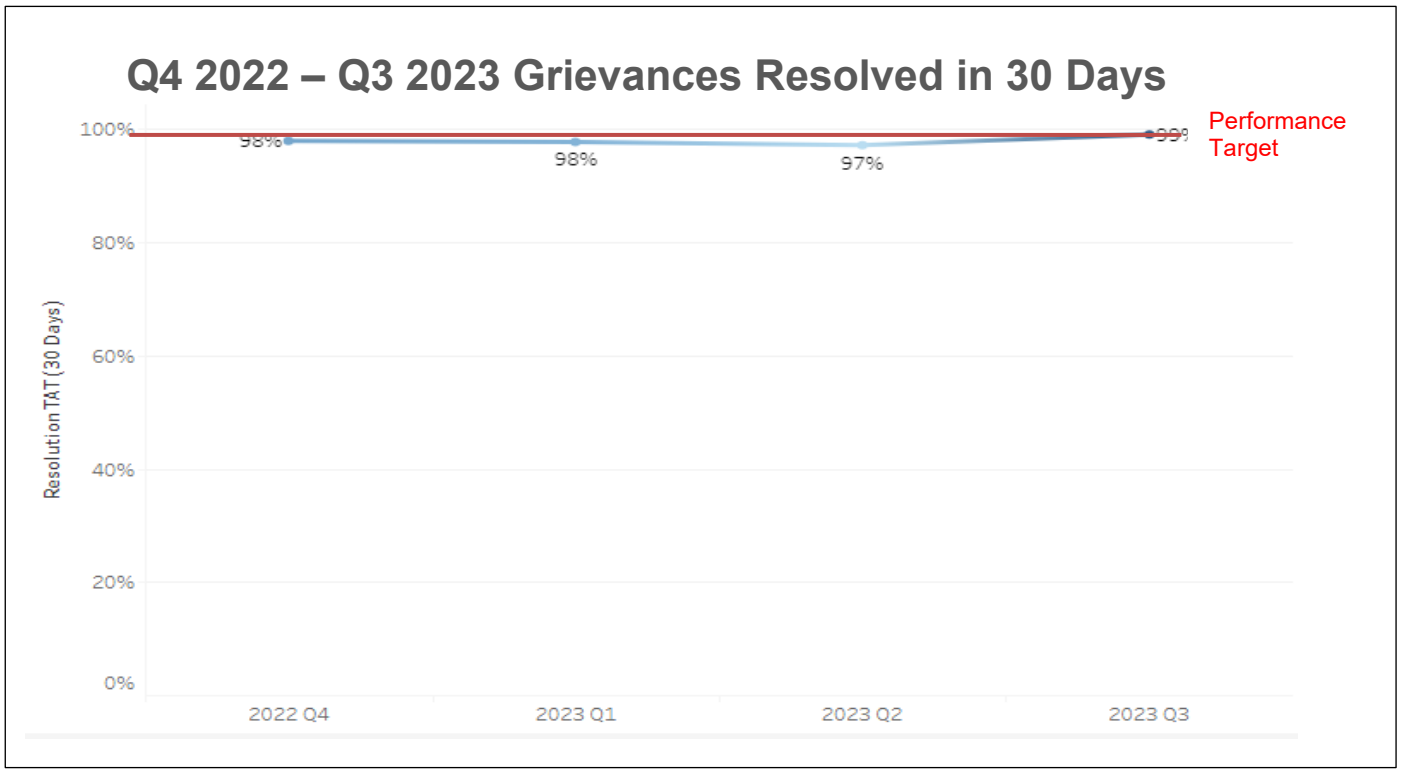
SFHP's performance threshold for closing grievances within the required timeframe of 30 days is 99%. In Q3 2023, the percentage of grievances resolved within 30 calendar days was 99%. SFHP did not send out two resolution letters within the 30-calendar day timeframe due to the following reasons:

- One resolution letter was due to concerns not being resolved timely.
- One resolution letter was due to lack of sufficient response from the provider.

In Q3 2023, the percentage of acknowledgement letters sent out within five calendar days was 98.6%. SFHP did not send out 3 acknowledgement letters within five calendar days due to the following reasons:

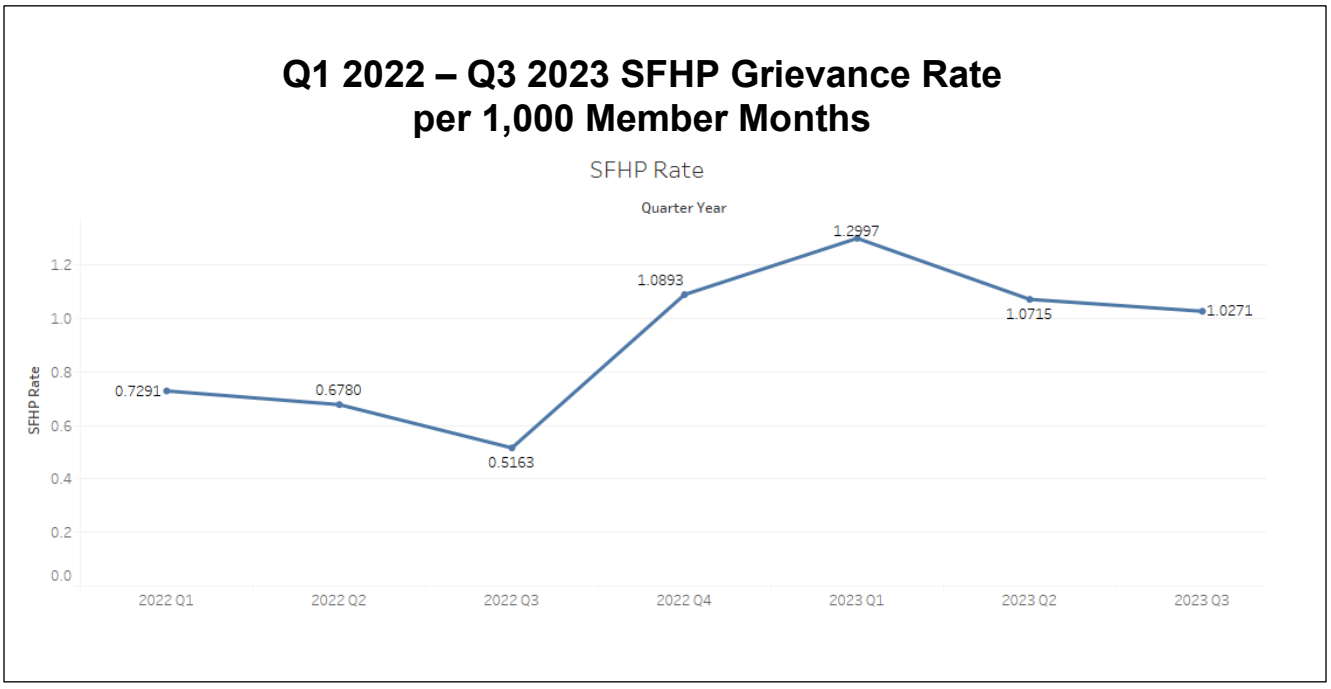
- Two acknowledgement letters were due to delay in the processing of the grievance intake.
- One acknowledgement letter was due to staff oversight.

As of 07/10/2023, the processing of non-clinical grievances was transitioned from the Customer Service team to the Grievance and Appeals team. This transition allows an additional layer of oversight to all grievance cases.



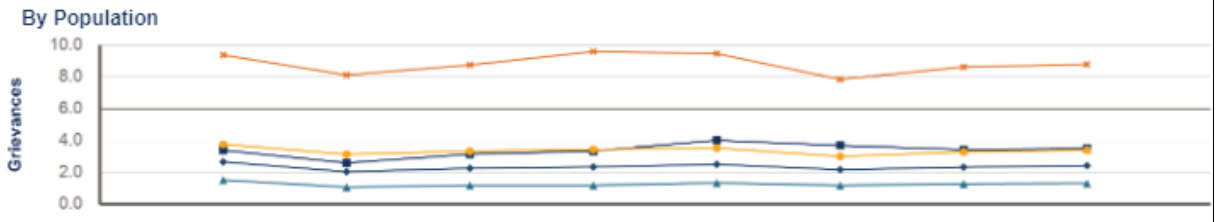
SFHP Grievance Rate

SFHP's grievance rate decreased from Q1 2022 to Q3 2022. The rate then started increasing from Q3 2022 through Q1 2023. The rate decreased again from Q2 2023 through Q3 2023.



SFHP's grievance rate continues to be lower than the DHCS grievance rate. Please see the graph below titled "DHCS Grievance Rates per 1,000 Member Months" for DHCS' grievance rates. Please note DHCS data is typically one quarter behind.

DHCS Grievance Rates per 1,000 Member Months



	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3	2022Q4	2023Q1	2023Q2
Dual	3.4	2.6	3.2	3.3	4.0	3.7	3.4	3.5
MO-ACA	3.8	3.1	3.3	3.5	3.5	3.0	3.3	3.4
MO-OTLIC	1.5	1.1	1.2	1.2	1.3	1.2	1.3	1.3
MO-SPD	9.4	8.1	8.8	9.6	9.5	7.9	8.6	8.8
MO-Other	2.7	2.1	2.3	2.3	2.5	2.2	2.3	2.4
Total	3.3	2.7	2.9	3.1	3.2	2.8	3.0	3.1

*MO-ACA: Medi-Cal Only Affordable Care Act
*MO-OTLIC: Medi-Cal Only Optional Targeted Low-Income Children
*MO-SPD: Medi-Cal Only Seniors and Persons with Disabilities

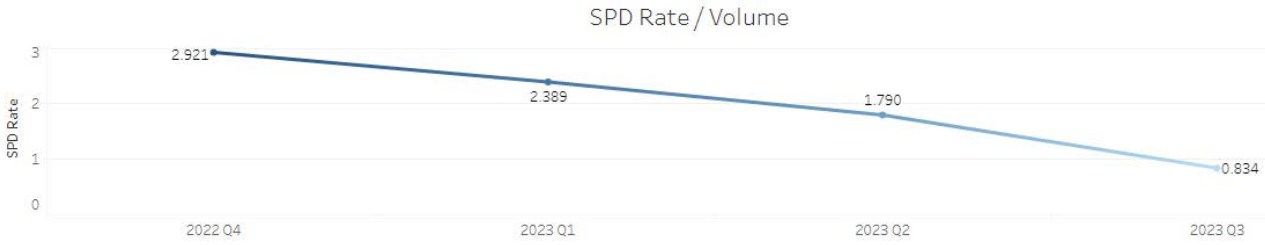
Grievances Filed by Seniors and Persons with Disabilities (SPD):

SFHP monitors grievances filed by members who are part of the SPD population.

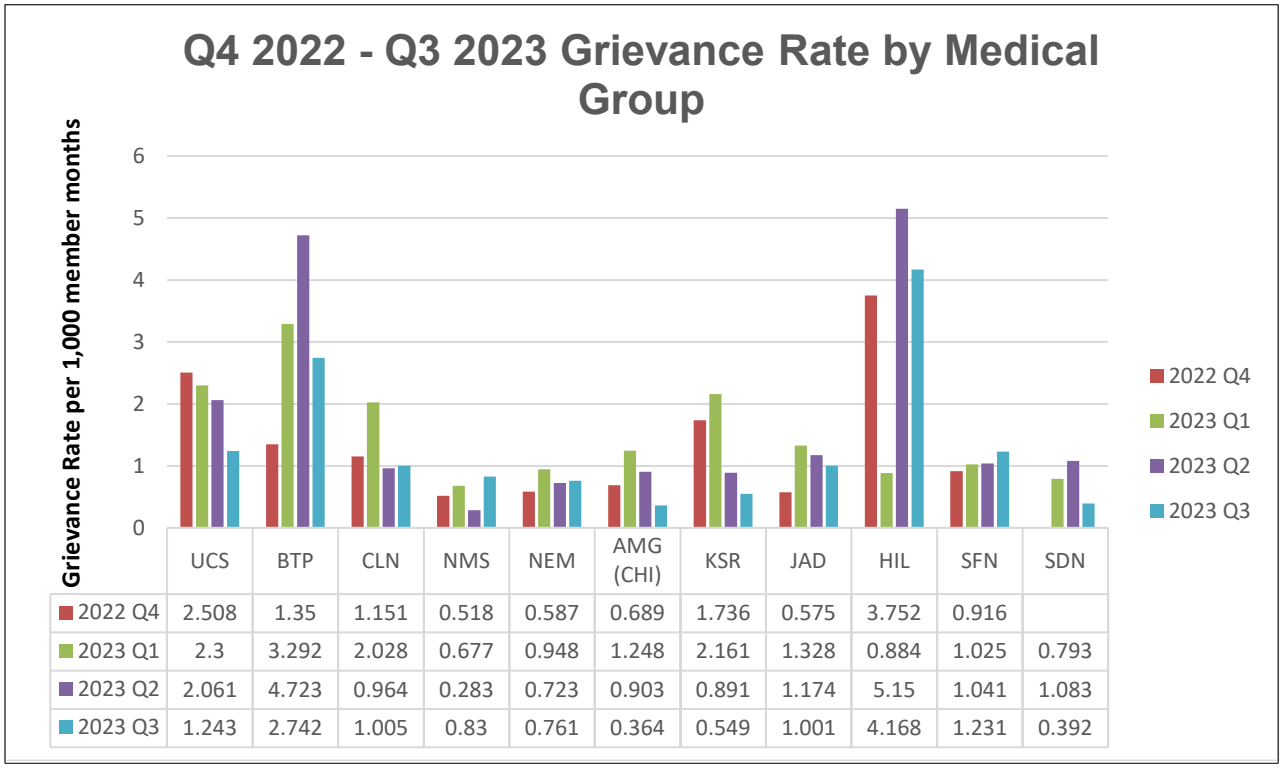
- In Q3 2023, 53 grievances were filed by SPD members. The number of grievances filed by SPDs decreased by 39% compared to Q2 2023 when a total of 87 grievances were filed by SPD members.
- Grievances involving quality of service and quality of care continue to be the most common grievance categories for SPD members.

In comparison, SFHP's SPD grievance rate remains lower than DHCS' SPD grievance rate. Please see the graph above for DHCS' SPD grievance rate.

Q4 2022 – Q3 2023 SFHP SPD Grievance Rate



Grievance Rate by Medical Group:



	UCS	BTP	CLN	NMS	NEM	AMG (CHI)	KSR	JAD	HIL	SFN	SDN
2022 Q4	2.508	1.35	1.151	0.518	0.587	0.689	1.736	0.575	3.752	0.916	
2023 Q1	2.3	3.292	2.028	0.677	0.948	1.248	2.161	1.328	0.884	1.025	0.793
2023 Q2	2.061	4.723	0.964	0.283	0.723	0.903	0.891	1.174	5.15	1.041	1.083
2023 Q3	1.243	2.742	1.005	0.83	0.761	0.364	0.549	1.001	4.168	1.231	0.392

*Includes clinical and non-clinical grievances only.

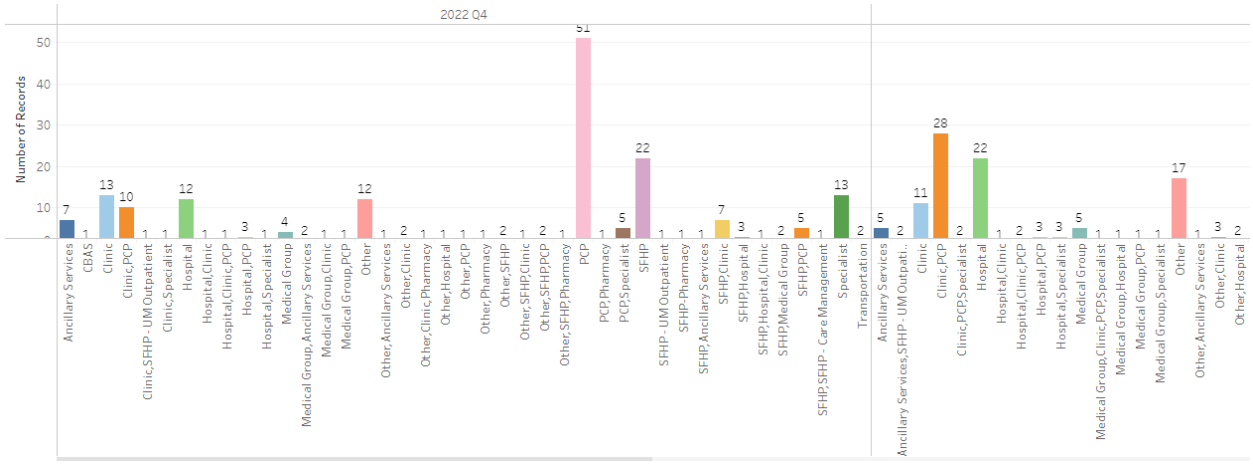
All American Medical Group (AMG) took over Chinese Community Health Care Association (CHI) effective July 1, 2023. The data for CHI is listed as AMG in this report.

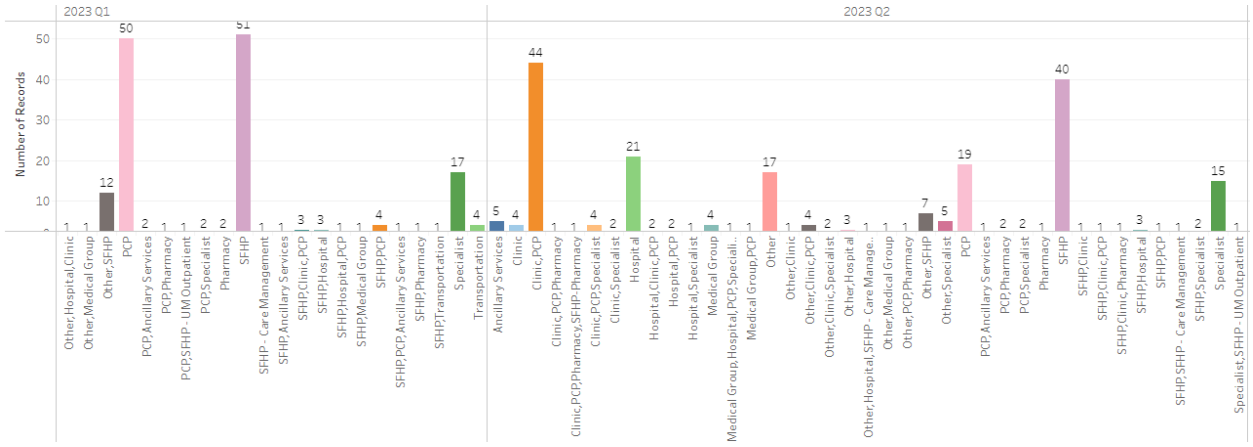
Seven of the medical groups' grievance rates decreased, while four medical groups' grievance rates increased compared to Q2 2023.

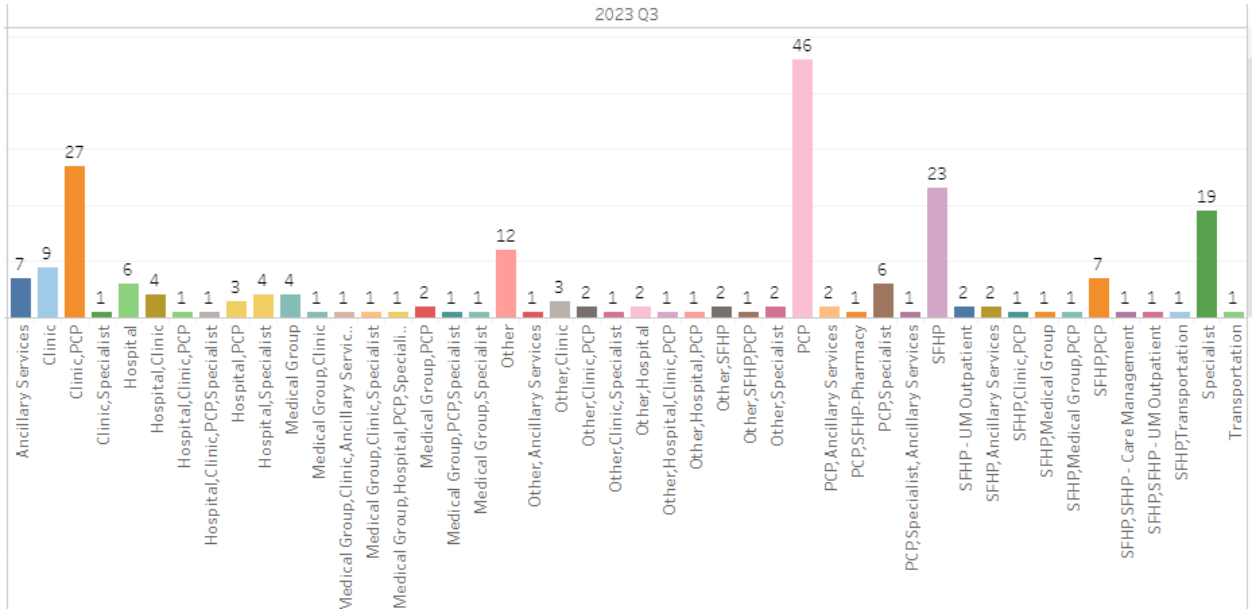
Source of the grievances:

The graph below shows who was involved in the grievance e.g., member's Primary Care Provider (PCP), clinic staff, or hospital. The source of most grievances received in Q3 2023 were those involving services provided by the member's PCP and clinic followed by SFHP.

Q4 2022 – Q3 2023 Grievance Source

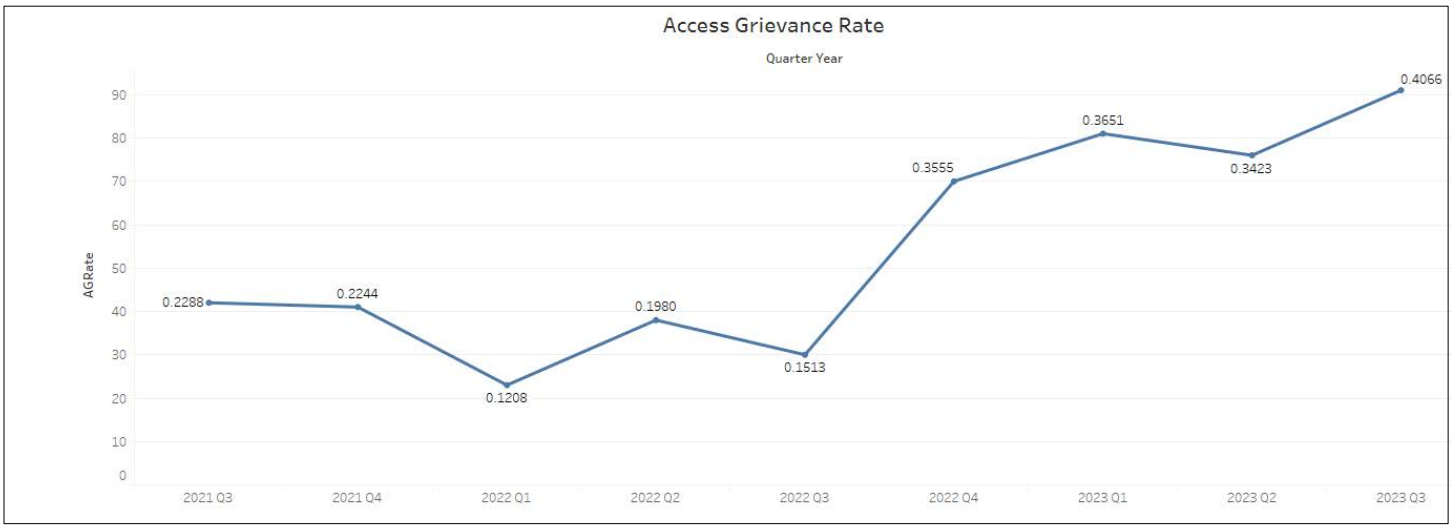






Access to Care Grievances:

The access grievance rate decreased from Q3 2021 to Q1 2022. The rate increased in Q2 2022 and decreased in Q3 2022. The rate increased significantly from Q4 2022 to Q1 2023 and decreased again in Q2 2023. In Q3 2023, the rate increased again.



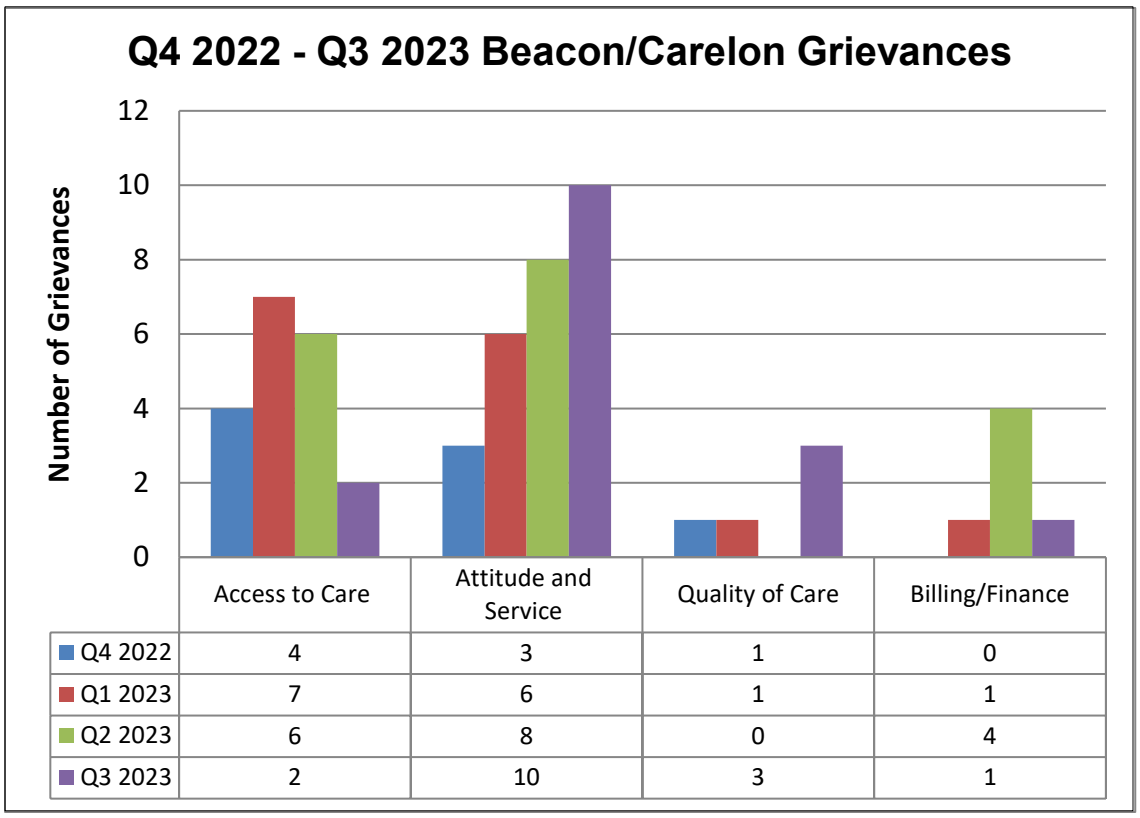
Access Grievances per 1,000 Member Months

Access Grievance Rate By Medical Group

	Quarter Year			
	2022 Q4	2023 Q1	2023 Q2	2023 Q3
AMG	0.52	0.71	0.18	0.18
BTP	1.35	1.97	3.37	2.06
CLN	0.42	0.86	0.41	0.35
ECM				
HIL	1.41	0.00	2.15	1.67
JAD	0.19	0.19	0.98	0.20
KSR	0.18	0.06	0.06	0.05
NEM	0.23	0.26	0.26	0.39
NMS	0.10	0.19	0.09	0.37
SDN		0.05	0.25	0.20
SFN	0.35	0.41	0.38	0.59
UCS	0.94	0.81	0.44	0.31

Beacon/Carelon:

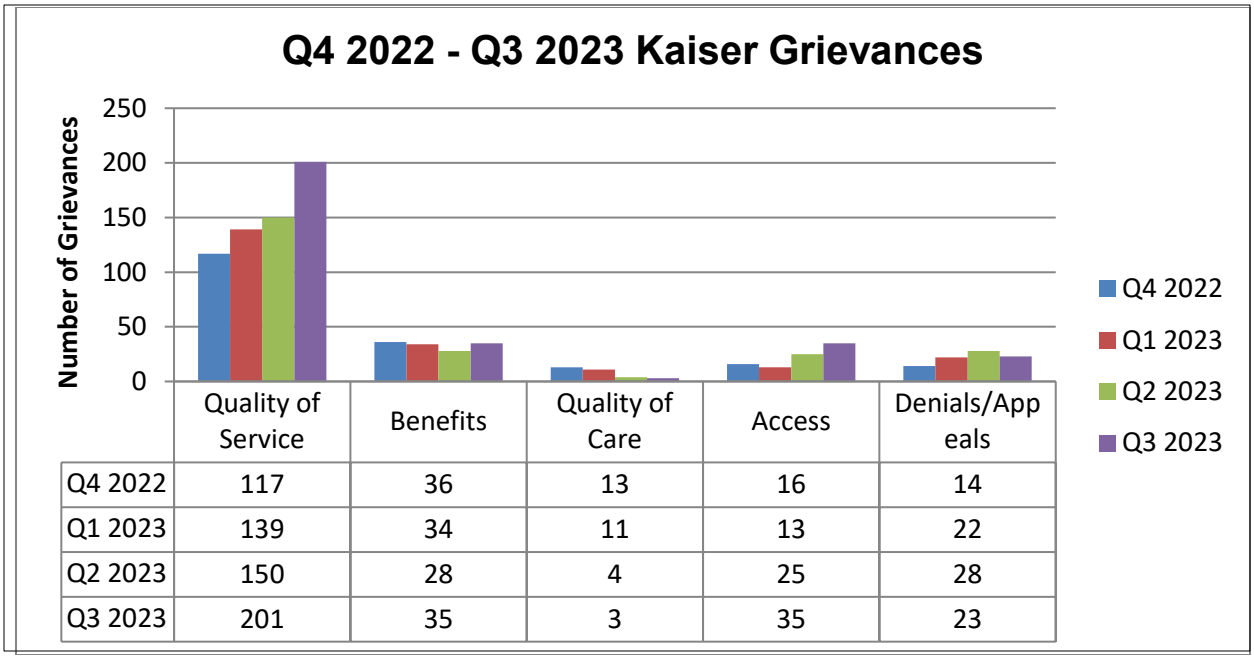
As of 03/01/2023, Beacon Health Options name was changed to Carelon. Carelon is SFHP's non-specialty mental health provider. Carelon is partially delegated to process grievances. Grievances received in Q3 2023 involved Attitude and Service followed by Quality of Care, Access to Care, and Billing/Finance.



	Access to Care	Attitude and Service	Quality of Care	Billing/Finance
Q4 2022	4	3	1	0
Q1 2023	7	6	1	1
Q2 2023	6	8	0	4
Q3 2023	2	10	3	1

Kaiser:

Kaiser is fully delegated to investigate and resolve grievances. There was an increase in the number of grievances received in Q3 2023. Most grievances received in Q3 2023 were grievances involving Quality of Service, which is consistent with previous quarters. In Q3 2023, grievances involving Access and Benefits increased compared to Q2 2023 while grievances involving Quality of Care and Denials/ Appeals decreased.



	Quality of Service	Benefits	Quality of Care	Access	Denials/Appeals
Q4 2022	117	36	13	16	14
Q1 2023	139	34	11	13	22
Q2 2023	150	28	4	25	28
Q3 2023	201	35	3	35	23

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

MEMO

Date: January 24, 2024

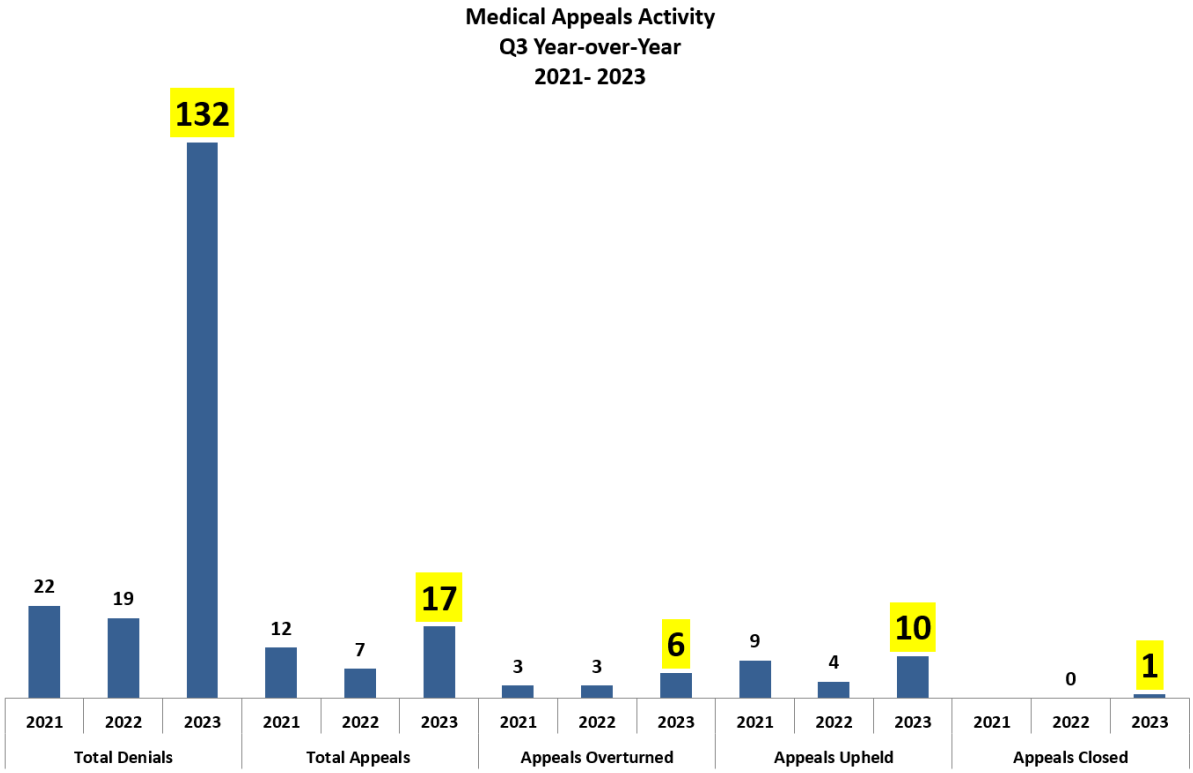
To	**Quality Improvement and Health Equity Committee**
From	**Grace Cariño, MPH** **Supervisor, Grievances and Appeals**
Regarding	**Q3 2023 UM Medical and Pharmacy Appeals Activity**

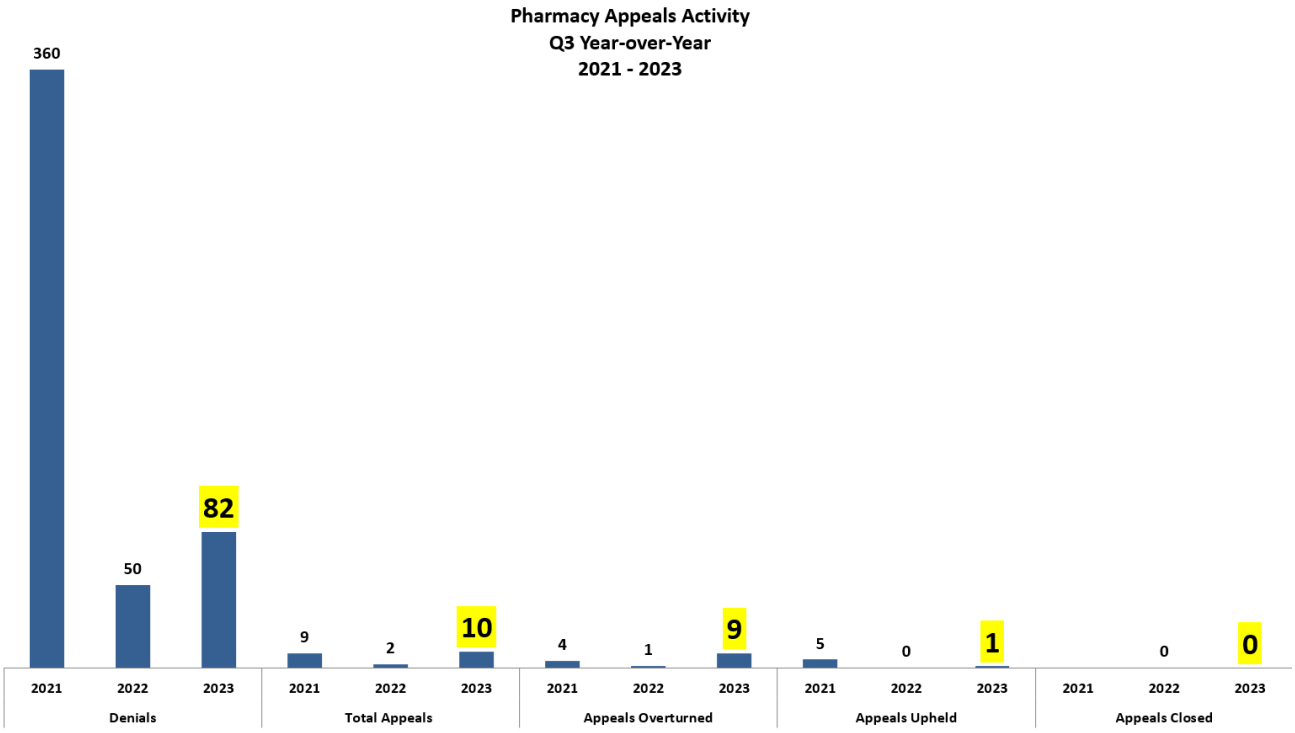
Q3-2023 Appeals Activity – Overview
During Q3-2023, there were a total of 27 appeals filed (medical – 17/pharmacy – 10)[i]. In Q3-2023, there were a total of 5,415 authorization[ii] requests (medical – 5,124/pharmacy – 291) and a total of 214 denials (medical – 132/pharmacy – 82).

On a per 1,000 total authorization basis:
- 4.99 total appeals per 1,000 total authorizations
- 3.14 medical appeals per 1,000 total authorizations
- 1.85 pharmacy appeals per 1,000 total authorizations

Comparing appeal activity in Q3-2023 to Q2-2023:
- 27 appeals in Q3-2023 vs. 13 appeals in Q2-2023
- 4.99 appeals/1000 in Q3-2023 vs. 2.25 appeals/1000 in Q2-2023

Of the 27 appeals in Q3-2023, 15 appeals were overturned (medical – 6/pharmacy – 9), which is a 56% overturn rate. This compares to a 62% overturn rate in Q2-2023 (8 overturned out of 13 appeals).





Analysis

Q3-2022 – Q3-2023 Medical Denial Rates

Between Q3-2022 and Q3-2023, the medical denial rates ranged from 0.35% (Q3-2022) to 2.57% (Q3-2023):

	Medical Authorizations	Medical Denials	Medical Denial Rate
Q3-2022	5,383	19	0.35%
Q4-2022	4,409	30	0.68%
Q1-2023	5,003	21	0.42%
Q2-2023	5,567	139	2.50%
Q3-2023	5,124	132	2.57%

Q3-2022 – Q3-2023 Pharmacy Denial Rates

Between Q3-2022 and Q3-2023, the denial rates ranged from 25.5% (Q2-2023) to 34.24% (Q3-2022):

	Pharmacy Authorizations	Pharmacy Denials	Pharmacy Denial Rate
Q3-2022	146	50	34.24%
Q4-2022	198	60	30.30%
Q1-2023	200	68	34.00%
Q2-2023	200	51	25.5%
Q3-2023	291	82	28.2%

Q3-2022 – Q3-2023 Collective Medical & Pharmacy Appeal Rates per 1000 Denials

Between Q3-2022 and Q3-2023, the collective medical and pharmacy appeal rates per 1000 denials ranged from 6.84 (Q2-2023) to 16.16 (Q3-2022):

	Medical + Pharmacy Denials	Medical + Pharmacy Appeals	Medical + Pharmacy Appeals / 1000 Denials
Q3-2022	99	16	16.16
Q4-2022	69	9	13.04
Q1-2022	90	11	12.22
Q2-2023	190	13	6.84
Q3-2023	214	27	12.62

Q3-2023 Collective Medical & Pharmacy Appeal Adjudication Turn-Around-Time

Ninety-six percent of the standard medical and pharmacy appeals were adjudicated within 30-days in Q3-2023 compared to 100% in Q2-2023.

	Q3-2023		
	Total (Med + Pharm)	**Medical**	**Pharmacy**
Number (#) of Appeals	27	17	10
Percentage (%) of Appeals Adjudicated within 30-days	96%	16	10

Q3-2023 Member and Provider Appeal Activity

Of all appeals filed in Q3-2023, 56% were member initiated and 44% were provider initiated.

Two appeals were expedited in Q3 2023.

		Q3-2023		
		Total (Med + Pharm)	**Medical**	**Pharmacy**
Member	**# of Initiated Appeals**	15	14	1
	% of Total Appeals	56%	52%	4%
Provider	**# of Initiated Appeals**	12	3	9
	% of Total Appeals	44%	11%	33%
Member	**# of Expedited Appeals**	2	2	0
	% of Initiated Appeals	7%	7%	0%
Provider	**# of Expedited Appeals**	0	0	0
	% of Initiated Appeals	0%	0%	0%

Q3-2023 Basis for Overturned Appeals

One hundred percent of overturned appeals in Q3-2023 were based on additional clinical information submitted.

	Q3-2023		
	Total (Med + Pharm)	**Medical**	**Pharmacy**
# of Overturned Appeals	15	6	9
% of Total Appeals	55%	22%	33%
# of Appeals overturned due to additional clinical information offered	15	6	9
% of Appeals overturned due to additional clinical information offered	100%	40%	60%
# Appeals overturned due to decision based on the same submitted clinical information	0	0	0
% Appeals overturned due to decision based on the same submitted clinical information	0%	0%	0%

Actions

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

---

[i] 0937ES Essette Grievance Report, Case Receipt Date 7/1/2023 - 9/30/2023 as of 1/24/2024 7:37AM.
ii Source for Medical data: Original_Q3-2023_AllAuthorizationsData. As of 5.2020, the following data classes are no longer counted in the authorization (auth) total:

- D Class auths - created in error;
- I Class auths - closed cases;
- O Class auths: Authorization Not Required; Duplicate Authorization; Medi-Medi Members; Other Payer; QNXT Failure; Created in Error.
- Additionally, any A Class auths (medical) and pharmacy auths associated with the following statuses were not counted: voids, retrospective, approved by PDRs, closed, pending, received, and early closed.

Source for Pharmacy Data: E-mail from 1/19/2024

SAN FRANCISCO HEALTH PLAN	**Utilization Management Committee (UMC)** **20 October 2023** **10:00 – 11:30AM** **Meeting Invite / Conference connection through Microsoft Teams**	
Meeting called by:	Matija Cale	
Type of meeting:	Mandatory – Monthly meeting. Meeting frequency is a maximum of 12 times per year or a minimum of 6 times per year depending on the priorities of the agenda for a given month.	**Recorder:** Christopher Ball
Present:	**Clinical Operations** Matija Cale, SeDessie Harris, April Tarpey, Tony Tai, Tamsen Staniford, Chris Ball, Traci Jovancevic, Juan Dunn, Susan Porter **Pharmacy** Kaitlin Hawkins, Eileen Kim **Physicians** Eddy Ang, Monique Yohanan	**Compliance** Crystal Garcia, Monica Fong, John Bhambra **Quality Review Team** Jenna Colin-Arriola **Optional Attendees** Courtney Spalding (Clinical Operations) Charles Aguilar (Clinical Operations) Amyn Nathoo (Care Management) Tammie Chau (Pharmacy) Jessica Shost (Pharmacy) Rudy Wu (Business Analytics) Grace Carino (Appeals & Grievances) Hilary Gillette-Walch (Population Health) Wayne Pan, MD (Medical Director) **Guests**
Not Present (NP):	Morgan Kerr, Traci Jovancevic, Stephanie Penrod (LOA)	
Quorum	• Chief Medical Officer, MD (Eddy Ang; official date of hire as the CMO 2.3.23) • Senior Medical Director (Monique Yohanan) • Director, Clinical Operations, RN (Matija Cale)	

	• Senior Manager, Concurrent Review and Post-Acute Care, RN (SeDessie Harris) • Manager, Long Term Care Nurses (Susan Porter, RN) • Manager, Clinical Operations (Morgan Kerr, MBA) • UM Nurse Manager, Prior Authorizations, RN (Tamsen Staniford) • Manager, Pharmacy Operations, PharmD (Kaitlin Hawkins) • Program Manager, Clinical Operations (Juan Dunn, MBA)

Documents Presented:	• CO_Authorization_Productivity_KPI_Dashboard_September_2023_V.10.18.2023 • UM_Trending_Dashboard_V.10.18.2023 • UM Director Dashboard_Sep 2023_10 18 23 • UMC Resolved Appeal Cases for Oct 2023 • Copy of SFH.IMR.CC_UMC Report_2023. 10.18 - 1 • 2024_Benchmarks_10.12.23 • FluorideVarnishBenefitExpansion • Summary of Changes MCG 27th Edition • Job_Aid_27th_Edition_Summary_of_Changes • UM DMG CAP Summary 2023

Consent Calendar – January 2023 to December 2023

ITEM #	Document	Review Schedule	Outcome	Comments	Meeting notes
1.	Quarterly Varis/APRDRG	• Dec 2022 • March 2023 • June 2023 • September 2023 • December 2023	•	•	• Compliance Team / 1.23 presented • Compliance Team / 9.20 presented
2.	UM Criteria for Non-Genital Gender Confirmation Services UM Criteria for Genital Gender Confirmation Services UM Criteria for EPSDT Private Duty Nursing	• Gender Affirming Services (Jan 2023 UMC) • QIC February 2023 • September/October 2023 (All criteria)	• Jan 2023: Gender Affirming Services criteria approved. • Feb 2023: QIC approved all criteria (reference the document *QIC_Annual_ClinicalCriteriaReview_Feb-23_Mtg_v2.15.23*).	•	• Annual review due Dec 2023

	MCG 25th edition; and 26th Edition (6.22) PP CO-57				
3.	Annual (CY2022) benchmark updates for the utilization trending tableau report	• Annual (Q3)		•	• 2024 Benchmarks presented in October 2023
4.	Internal Audit of Authorization Requests Report Q3-2022 Report (April UMC) Q4-2022 Report Q1-2023 Report Q2-2023 Report Q3-2023 Report	•	• No vote required. • Documenting review and discussion by the UMC.	• Q3-2022; this includes the UAT results of the new audits for: PAD Audit Tool; NEMT Audit Tool; Major Organ Transplant Audit Tool; State TAT Audit Tool; NCQA TAT Audit Tool. • Q4-2022; This includes the inaugural audits of PAD Audit Tool; NEMT Audit Tool; Major Organ Transplant Audit Tool; State TAT Audit Tool; NCQA TAT Audit Tool.	• April UMC: Q3-2022 Internal audit reviewed. • June UMC: Q4-2022 Internal Audit reviewed. • Q1 2023 to be reviewed in October UMC. Delayed to Nov/Dec 2023
5.	2022 Utilization Program Evaluation Annual Review and Approval	• June 2023 UMC Meeting	•	•	• FINAL_Draft_2022_UMProgEval_v3.9.23 • June UMC • 2023 Evaluation to be completed by January/Feb 2024
6.	Updated UMC Charter and Reports/Documents Review Calendar	•	• Added 2 new quorum members. • UMC voted, quorum met, to approve.	•	• January 2023 UMC • June 2023 UMC
7.	2023 Specialty Referral Reports	•	• No vote required. • Documenting review and discussion by the UMC.	• Q1-2023 Report (May UMC) • Q2-2023 • Q3-2023	• Q4-2022 / Annual 2022 Report – June 2023 UMC • Q1 2023 presented in September UMC • Q2 2023 to be presented in Dec 2023

8.	2022 UM Program Description 2023 UM Program Description	• UMC Q1-2023 (Final version) • UMC (Nov 2023) • QIC (Dec 2023)	•	• Oct 2022 UMC meeting. Reviewed the 2022 Interim UM Program Description with the PAD/LTC/Pharmacy updates. • 2023 version UMC (Nov) & QIC (Dec)	• 10/13/2023: Annual Review in progress. Final draft to be presented in Dec 2023

	Topic	Brought By	Time	Agenda	Meeting Notes
1.	Standing Items: • Approval of minutes • Action Items review • Parking lot review • Medical/Pharmacy Directors' Dashboards	Matija	10:00 AM – 10:20	• Agenda reviewed. • Action Items • Approval of draft minutes • CO Director Dashboard • Clinical Operations – KPI Dashboard • Clinical Operations – UM Trending Report Review (inpatient Admissions) • Pharmacy Dashboard (will be providing the quarterly dashboard the second month of the quarter (we need the first month of the quarter to compile last quarter's data). o Q4-2022 (April UMC) o Q1-2023 (May UMC) o Q2-2023 (August UMC) o Q3-2023 (December ~~November~~ UMC)	• Minutes Approval o The September 2023 minutes were approved by the quorum vote. • Action Items Review o See updates in the Action Items table below. • Parking Lot Review o No updates. • Dashboards o UM Trending ▪ Separate sub-committee meeting monthly to discuss dashboards. Reviewed ED utilization and plan to ask BA for a more detailed breakdown. ▪ High ED utilization in the Tenderloin neighborhood. ▪ Are there sufficient alternative resources available - primary care and urgent care clinics? ▪ What is causing members in certain areas to go to the ED more often ▪ Conduct a member campaign intervention.

Formatted Table

Formatted: Font: +Body CS (Arial), 10 pt

					Send educational pamphlets to members about when primary or urgent care is more appropriate than the ED.. ▪ Chest pain and COVID remain the top diagnoses. • Clinical Operations (CO) Authorization Productivity KPI Dashboard ▪ PA TATs- 99.82% ▪ CCR TATs- 100% ▪ LTC TATs- 100% o Long Term Care KPI dashboard ▪ New dashboard. ▪ 1096 LTC members. Half have the LTC Aid Code. 87% are in Contracted Facilities. ▪ Auth Volume (per month): 145 ▪ Average time to auth: 18.7 hours ▪ Average time to place: 11.7 days ▪ Suggestion made to add median values. Outliers greatly impact averages. . Bring request to BA. • Pharmacy Dashboard Highlights o Present in December UMC.
2.	• Medical/Pharmacy Appeals (RAMP 0937ES): Upheld and Overturned • Independent Medical Review (IMR); State Fair Hearings (SFH). Consumer Complaints	• April – DMG appeal cases • Leslie Mulhern; Michelle	10:20 AM – 10:35	• Appeals (See appendix for brief summary of overturned appeals.) o UM – Appeals - ▪ Upheld appeals – 4 ▪ Overturned appeals – 0	• UM Appeals o No overturned UM appeals. • Pharmacy Appeals o MA230911001

		Faust – CHN/UCSF cases • Eileen – Pharmacy Appeals Monica – Compliance		o Pharmacy – Appeals - ▪ Upheld appeals – 0 ▪ Overturned appeals – 3 • Compliance o IMR – 2 September & 0 October o SFH – 2 September & 0 October o Consumer Complaints – 2 September & 3 October	▪ Refer to table below for details. ▪ It was appropriate to re-authorize this member for Wegovy for an additional 6 months. o Given shortage issues, advise Magellan to review claims data, and if the prescribed supply was insufficiently filled, Magellan can approve. MA230921001 ▪ Refer to table below for details. ▪ Due to the member having diabetes and heart failure, the requested Jardiance meets our criteria. Appeal overturned and approved for the member. ▪ More information obtained on appeal. No changes to process. o MA230928002 ▪ Refer to table below for details. ▪ It was appropriate to re-authorize this member for Wegovy for an additional 6 months because of their progress of at least 5% weight loss after 6 months. • Compliance o See report for details.
3.	• Fluoride Varnish Benefit Exception Request	• Hilary	10:35 AM – 10:45		• Fluoride Varnish Benefit Exception Request o Recommending benefit expansion to include children ages 6-20. o DHCS recommends this but has not made it a formal benefit. o See PowerPoint for additional details.

					o Approved by quorum vote. ▪ Next Steps: Add BenEx request to Clarizen, finance and claims to complete an assessment, CMO brings information to ET for approval. o
4.	• DMG UM Audit/CAP Report	• April	10:45 AM – 11:00		• DMG UM Audit/CAP Report o A new quarterly audit process started. Auditing approvals and denials. o See report for details.
5.	• MCG Changes	• Tamsen	11:00 AM – 11:15		• MCG Changes o We went live with 27th edition on Monday October 9th. o MCG provides training modules on the updates. Nurses completed the modules. o Summary of changes and job aide have been included in the UMC documents. o Detailed changes accessible via the CareWeb QI or Static version of MCG. o Gender Affirmation Surgeries general recovery guideline updated. However, it is more restrictive/not aligned with WPATH SOC. Share criteria discrepancy feedback with MCG rep. o See report for details. o MCG updated criteria approved by quorum vote.
6.	• Annual Benchmarks	• Matija	11:15 AM – 11:30		• Annual Benchmarks o Every year benchmarks are reviewed to align with HEDIS, CG, and DHCS reporting. Benchmarks are submitted to BA and added into UM Trending. o Benchmarks include ALOS, Bed Days Per 1000MM, Admit Per

					1000MM, ED Visits 1000MM, Readmissions. o See report for details. o Benchmarks approved by quorum vote.

Action Items October 2023

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Matija	• Request BA add median data to LTC Dashboard, specifically for 1) ~~Average~~ time to auth, and 2) ~~Average~~ time to place.	
2.	Eileen	• In response to 2 Wegovy appeals - Advise Magellan to review claims data, given shortages, and if the prescribed supply was insufficiently filled, approve.	
3.	Tamsen	• Add approved fluoride varnish benefit expansion details into Clarizen	
4.	Tamsen/Matija	• Share discrepancies between WPATH SOC and MCG's Gender Affirmation Surgeries general recovery guideline with MCG rep.	
5.		•	

Formatted Table

Formatted: Font: (Default) +Body CS (Arial), 9.5 pt

Legend

1	= Need Update
2	= In progress
3	= Completed
4	= On Hold

UMC Meeting Date	Owner(s)	Action Item(s)	Comments	Status

Formatted Table

10.5.22	Tamsen/Tony	• PA TAT Compliance Rate in the CO KPI Dashboard needs to be adjusted to provide a more accurate rate. • Total Pre-Auth metrics in the CO KPI Dashboard needs to be adjusted to provide a more accurate rate.	1.9.23 - Jan 2023- relying on manual check implemented for Health Services KPI spreadsheet until Tableau KPI report logic updates can be prioritized into BA work. Tamsen to follow up with Tony and Jay for new timeline. 2.24.23- oh hold through March while focusing on processing SDN and preparing for SFN FFS auth volume. 4.18.23-On hold in April for same reason 6.16.23-Relying on manual check for accurate monthly count & plans to fix dashboard are on hold until Jiva implementation. 7.19.23-Tamsen confirmed this remains on hold until Jiva implementation.	4
1.11.23	Crystal/Matija	• The PMPM costs are strictly related to inpatient acute. • The overall PMPM rate is lower. • Is Varis doing a better job following up?	5.16.23 - VARIS recommended combining existing DRG Review service with their new Clinical Validation and Readmissions programs. 5.19.23-VARIS on hold until there are updates that can be presented to UMC. Next steps - Presentation to be scheduled with VARIS to learn more about these added services. 7.18.23-Meeting occurred Wednesday 6/14. Follow-up communication regarding pricing details is pending. 8.8.23- Pricing & details are still being reviewed. 8.16.23-Matija requested to take over ownership of action item and will review information with Eddy to decide if moving forward with VARIS's Clinical Validation and Readmissions programs. 9.8.23-Review in progress. 9.20.23- Matija to review	2
6.21.23	Morgan	• Confirm HIL MG high utilization for CBAS services is accurate. If accurate, reach out to HIL to understand their strategies for connecting members to CBAS services to increase utilization for all SFHP members.	6.29.23-Morgan is working with Tony Tai. to confirm data accuracy. 7.18.23- Initial analysis indicates data is accurate. Membership assigned to Hill is approx. 1.3%. However, Hill members make up	2

			8% of total CBAS population. In addition, Hill members are attending CBAS more frequently than groups with comparable (i.e., CHI) or slightly greater (i.e., UCS) total CBAS members. This pattern continues in Q1 2023. 7.19.23-Committee requested a deeper analysis on why delegated medical groups have low utilization of CBAS services and develop strategies to work with delegate medical groups to increase CBAS utilization. 8.03.23-Morgan sent email to cross functional SFHP teams to collaborate on how SFHP can work with network providers and delegated medical groups to develop strategies to increase CBAS utilization. Discussions in process. 8.16.23-Efforts in process to increase utilization: Post recorded CBAS webinar to the SFHP Website, CBAS Dashboard enhancements, & develop a system to identify CBAS eligible members and share information with Primary Care Providers to encourage referrals for CBAS services. 9.8.23-CBAS webinar posting has been completed and it is available on SFHP.org. Will be creating an article for the October provider newsletter. Due to competing BA priorities, CBAS Dashboard won't be final for several more months. 10.9.23 - Provider newsletter article complete. BA completed dashboard - will share in Nov/Dec UMC. Presented underutilization data at UCSF JOM 10/16.	
7.19.23	Leslie/Traci	• Discuss and develop an internal community site to store UM process changes that cross functional teams can access.	8.23.23- Not started but will plan to meet soon.	2
8.16.23	Leslie	• Check if UCSF hospitals participate in Sepsis registry.		2
8.16.23	Tamsen/Crystal/Morgan	• Crystal-Submit request in Clarizen & develop data analysis to present to UMC on Adult Preventative Service Codes exception. • CO-55 Exception Handling Process review & update.	9.20.23- Tamsen needs to go into Clarizen and add the codes for the exception process. For CO-55 Exception Handling Process policy review & update, Tamsen, and Morgan to meet with Matija. 10.20.23 – Crystal and Hilary confirmed this can be removed because preventative service codes are being added as a Medi-Cal benefit.	3

8.16.23	April	• Remind BTP Medical Group appeals are processed by SFHP only.	9.20.23- Talked with all the BTP Medical Groups at the DMG Work Group about delegation oversight. April to create an attestation to confirm that groups have been told. Crystal to work with Suzanna on verbiage. 10.20.23 – April confirmed this was completed via DMG workgroup meeting.	3
8.16.23	April/Crystal/Leslie/Wayne	• Discuss Continuity of Care with NEMS Medical Group and provide more guidance on handling Continuity of Care requests.	9.8.23-Will be discussed with NEMS at next JOC meeting. 9.20.23- Waiting for Leslie (unavailable due to PTO) to weigh in. Crystal proposes a two-fold approach: continuity of care update to all delegates and get NEMS specific information about where they were not doing what they were supposed to do.	2
9.20.23	Tamsen	• Continue monitoring PMPM for medical supplies and hearing aids.	10.20.23 Tamsen will present updates quarterly	2

Parking Lot

ITEM #	DATE	OWNER	ACTION ITEMS	STATUS
1.	4.06.22	SeDessie / Eddy Ang	• • Work w/ Eddy Ang on OBS metrics. • Need to be consistent in how OBS rules are applied.	• 5.4.22: SeDessie, Matija, Eddy working on priorities--medium category

Formatted Table

Appeals / Overturned – October 2023

Grievance ID	Case Type	Medical Group	Decision	Case Category	Name of Service Or Medication	Description	Resolution
MA230911001	Member Appeal	SFN	Overturned	SFHP-Pharmacy	WEGOVY 0.25MG/0.5	4.2% weight loss since starting Wegovy. Per our Anti-Obesity Medications Criteria, we require at least a 5% weight loss after 6 months. However, member only filled 3 Rxs in 6 months so wt loss likely impacted by non-adherence likely due to shortage. Has made other	Provider appealed the denial of Wegovy 0.25mg/0.5. Wegovy for weight loss. (SFHP) has decided to overturn the original denial decision. This request is now approved because SFHP got more information showing that Wegovy is medically needed for you. SFHP made an exception to the SFHP Anti-Obesity Medications Criteria to approve this medication

						lifestyle changes, will approve for additional 6months for now.	after reviewing your pharmacy refill history of Wegovy.
MA230921001	Member Appeal	SFN	Overturned	SFHP-Pharmacy	Jardiance 10 MG tablets	The member was prescribed both of these medications by his previous Cardiologist for coronary artery disease with previous myocardial infarction (NSTEMI) requiring stenting and heart failure with mid-range ejection fraction. The member also has a diagnosis of type 2 diabetes though his a1c has always been well controlled <7.5 from my review of his previous labs. Per our SGLT-2 Inhibitors criteria: For formulary SGLT-2 inhibitor or combination, approve if cardiovascular reduction due to comorbid heart failure	Provider appealed the denial of Jardiance 10 mg. Jardiance is a medication that treats for Type 2 Diabetes.SFHP has decided to overturn the original denial decision. This request is now approved because SFHP got more information showing that Jardiance is medically needed for you. SFHP made an exception to the SFHP Healthy Workers HMO formulary criteria to approve this medication.
MA230928002	Member Appeal	SFN	Overturned	SFHP-Pharmacy	WEGOVY 1.7MG/0.75	3.9% wt loss. Per our Anti-Obesity Medications Criteria, we require at least a 5% weight loss after 6 months. However, during the last 6 months, there was only 4 fills for 28-day supply of Wegovy: 3/9/23, 5/2/23, 5/15/23, 8/31/23. However, member only filled 3 Rxs in 6 months so wt loss likely impacted by non-adherence likely due to shortage. Has made other lifestyle changes, will approve for additional 6months for now.	Provider appealed the denial of Wegovy 1.7MG/0.75 for weight loss.SFHP has reviewed your appeal and decided to overturn the original denial decision. This request is now approved because SFHP got more information showing that Wegovy is medically needed for you. SFHP reviewed your medical condition and made an exception to the SFHP Anti-Obesity Medication Criteria to approve this medication for an additional six months.

SAN FRANCISCO HEALTH PLAN	**Utilization Management Committee (UMC)** **20 December 2023** **1:30 – 3:00PM** **Meeting Invite / Conference connection through Microsoft Teams**	
Meeting called by:	Matija Cale	
Type of meeting:	Mandatory – Monthly meeting. Meeting frequency is a maximum of 12 times per year or a minimum of 6 times per year depending on the priorities of the agenda for a given month.	**Recorder:** Christopher Ball
Present:	**Clinical Operations** Matija Cale, SeDessie Harris, April Tarpey, Tony Tai, Tamsen Staniford, Chris Ball, Traci Jovancevic, Juan Dunn, Susan Porter **Pharmacy** Kaitlin Hawkins, Eileen Kim **Physicians** Monique Yohanan	**Compliance** Crystal Garcia, Monica Fong, John Bhambra **Quality Review Team** Jenna Colin-Arriola **Optional Attendees** Courtney Spalding (Clinical Operations) Charles Aguilar (Clinical Operations) Amyn Nathoo (Care Management) Tammie Chau (Pharmacy) Jessica Shost (Pharmacy) Rudy Wu (Business Analytics) Grace Carino (Appeals & Grievances) Hilary Gillette-Walch (Population Health) Wayne Pan, MD (Medical Director) **Guests**
Not Present (NP):	Stephanie Penrod (LOA), Eddy Ang	
Quorum	• Chief Medical Officer, MD (Eddy Ang; official date of hire as the CMO 2.3.23) • Senior Medical Director (Monique Yohanan) • Director, Clinical Operations, RN (Matija Cale)	

	• Senior Manager, Concurrent Review and Post-Acute Care, RN (SeDessie Harris) • Manager, Long Term Care Nurses (Susan Porter, RN) • Manager, Clinical Operations (Morgan Kerr, MBA) • UM Nurse Manager, Prior Authorizations, RN (Tamsen Staniford) • Manager, Pharmacy Operations, PharmD (Kaitlin Hawkins) • Program Manager, Clinical Operations (Juan Dunn, MBA)

Documents Presented:	• SFH.IMR.CC_UMC Report_2023. 12.18 • Over and Underutilization Dashboard • 2023_UM_Program_Description_v12.19.23 • CO_Authorization_Productivity_KPI_Dashboard_November_2023_V.12.19.2023 • Lactation Benefit Expansion • LongTermCareCriteria_12.18.23 • Overturned Appeal Cases October and November 2023 • Pharmacy_Operations_Dashboard_2023Q3 • Q2-2023_SpecialtyReferralReport-UMC_11.16.23 • UM Clinical Criteria_12.18.23 • UM Director Dashboard_Nov 2023_12 15 23 • UM_Trending_Dashboard_V.12.19.2023

Consent Calendar – January 2023 to December 2023

ITEM #	Document	Review Schedule	Outcome	Comments	Meeting notes
1.	Quarterly Varis/APRDRG	• Dec 2022 • March 2023 • June 2023 • September 2023 • December 2023	•	•	• Compliance Team / 1.23 presented • Compliance Team / 9.20 presented • Due to present – Jan 2024
2.	UM Criteria for Non-Genital Gender Confirmation Services	• Gender Affirming Services (Jan 2023 UMC) • QIC February 2023 • September/October 2023 (All criteria)	• Jan 2023: Gender Affirming Services criteria approved. • Feb 2023: QIC approved all criteria (reference the document *QIC_Annual_ClinicalCriteriaReview_Feb-23_Mtg_v2.15.23*).	•	• Annual review due Dec 2023

	UM Criteria for Genital Gender Confirmation Services UM Criteria for EPSDT Private Duty Nursing MCG 25th edition; and 26th Edition (6.22) PP CO-57				
3.	Annual (CY2023) benchmark updates for the utilization trending tableau report	• Annual (Q3)		•	• 2024 Benchmarks to be presented in October 2023
4.	Internal Audit of Authorization Requests Report Q3-2022 Report (April UMC) Q4-2022 Report Q1-2023 Report Q2-2023 Report Q3-2023 Report	•	• No vote required. • Documenting review and discussion by the UMC.	• Q3-2022; this includes the UAT results of the new audits for: PAD Audit Tool; NEMT Audit Tool; Major Organ Transplant Audit Tool; State TAT Audit Tool; NCQA TAT Audit Tool. • Q4-2022; This includes the inaugural audits of PAD Audit Tool; NEMT Audit Tool; Major Organ Transplant Audit Tool; State TAT Audit Tool; NCQA TAT Audit Tool.	• April UMC: Q3-2022 Internal audit reviewed. • June UMC: Q4-2022 Internal Audit reviewed. • December UMC: Q1-2023 Internal Audit reviewed. • Feb UMC: Q2-2023 Internal audit – to be reviewed
5.	2023 Utilization Program Evaluation Annual Review and Approval	•	•	•	• 2023 Evaluation to be completed by Feb 2024
6.	Updated UMC Charter and Reports/Documents Review Calendar	•	• Added 2 new quorum members. • UMC voted, quorum met, to approve.	•	• January 2023 UMC • June 2023 UMC

7.	2023 Specialty Referral Reports	•	• No vote required. • Documenting review and discussion by the UMC.	• Q1-2023 Report (May UMC) • Q2-2023 • Q3-2023	• Q4-2022 / Annual 2022 Report – June 2023 UMC • Q1 2023 to be presented in September UMC • Q2 2023 to be presented in Jan 2024
8.	2022 UM Program Description 2023 UM Program Description	• UMC Q1-2023 (Final version) • UMC (Nov 2023) • QIC (Dec 2023)	•	• Oct 2022 UMC meeting. Reviewed the 2022 Interim UM Program Description with the PAD/LTC/Pharmacy updates. • 2023 version UMC (Nov) & QIC (Dec)	• Final draft presented in Dec 2023

	Topic	Brought By	Time	Agenda	Meeting Notes
1.	Standing Items: • Approval of minutes • Action Items review • Parking lot review • Medical/Pharmacy Directors' Dashboards	Matija	1:30 PM – 1:50	• Agenda reviewed. • Action Items • Approval of draft minutes • CO Director Dashboard • Clinical Operations – KPI Dashboard • Clinical Operations – UM Trending Report Review (inpatient Admissions) • Pharmacy Dashboard (will be providing the quarterly dashboard the second month of the quarter (we need the first month of the quarter to compile last quarter's data). o Q4-2022 (April UMC) o Q1-2023 (May UMC) o Q2-2023 (August UMC) o Q3-2023 (December UMC)	• Minutes Approval o The October 2023 minutes were approved by the quorum vote. • Action Items Review o See updates in the Action Items table below. • Parking Lot Review • Dashboards • Clinical Operations (CO) Authorization Productivity KPI Dashboard ▪ PA TATs- 99.8% ▪ CCR TATs- 99.9% ▪ LTC TATs- 100% • Pharmacy Dashboard Highlights o Medication Therapy Management Tasks ▪ Spike in tests in Q3 to support pilot medication adherence program. ▪ Continuing effort in 2024. ▪ Goal met for interventions ▪ JIVA implementation issues with the pharmacy

					program which will result in limitations in early 2024. o Prior Authorizations have gone up in volume driven by weight loss and diabetes medication. o Approval rates staying around 70-80% o Appeals and Overturn Rates of Denied PA ▪ Appeals are often overturned. ▪ Driven by new information included on appeal. o Phone Service Levels ▪ Volume has gone up in Q3 due to Medicare Rx benefit support external partners and helping members navigate that benefit.
2.	• Medical/Pharmacy Appeals (RAMP 0937ES): Upheld and Overturned • Independent Medical Review (IMR); State Fair Hearings (SFH). Consumer Complaints	• Leslie Mulhern – UM Appeal Cases • Eileen – Pharmacy Appeals • Monica – Compliance	1:50 PM – 2:05	• Appeals (See appendix for brief summary of overturned appeals.) o UM – Appeals - ▪ Upheld appeals – 0 ▪ Overturned appeals – 6 o Pharmacy – Appeals - ▪ Upheld appeals – 0 ▪ Overturned appeals – 3 • Compliance o IMR – 0 November & 0 December o SFH – 2 November & 1 December o Consumer Complaints – 1 November & 1 December	• UM Appeals o MA231012001 ▪ Refer to table below for details. ▪ Appeal overturned due to standard of care so the member could follow up with the OON surgeon who performed the surgery. In-network Orthopedic surgeons rarely accept members they did not perform surgery on. ▪ NEMS UM staff should better investigate OON requests prior to issuing a denial. ▪ Feedback was given to NEMS appeals contacts;

					however, it is unclear if this feedback is shared with NEMS UM team considering this has happened before. ▪ SFHP will utilize the grievance trending process – bundling similar cases together to get a better response from NEMS. o MA231031001 ▪ Refer to table below for details. ▪ Overturned due to MRIoA determination that continued Proton Beam Therapy was medically necessary. ▪ Without prior approval, member went to Seventh-Day Adventists Loma Linda Medical Center for the treatment. Once the Proton Beam Therapy has started, it has to be continued. However, had a request been received prior to treatment, it would have been denied for not meeting criteria. ▪ Concern about Loma Linda doing a procedure for a Medi-Cal member without authorization, potentially knowing that once the treatment starts it becomes medically necessary.

					▪ Davis is the nearest facility with Proton Beam Therapy for cancer treatment. Given SFHP's responsibility for transportation costs, evaluate getting the member switched from Loma Linda to Davis. o CPSA231117001 ▪ Refer to table below for details. ▪ Overturned due to NEMS not providing support for transitioning out of CCS. CCS covers up to 21 years old. ▪ PQI opened to follow up with NEMS. o MA231107001 ▪ Refer to table below for details. ▪ Overturned. Unclear why AMG denied. Leslie/April will follow up during DMG workgroup in January. o MA231110001 ▪ Refer to table below for details. ▪ Overturned due to additional information based on the EPSTD criteria. o MA231205001 ▪ Refer to table below for details. ▪ Overturned due to additional information. • Pharmacy Appeals

					o MA231018001 ▪ Refer to table below for details. ▪ Overturned due to member's intolerance for preservative based eye drops. o MA231024001 ▪ Refer to table below for details. ▪ Overturned due to member meeting continuation of therapy from Medi-Cal Rx. ▪ Provider did not provide continuation information in their initial request. o MA231109001 ▪ Refer to table below for details. ▪ Overturned due to member's inability to use phototherapy due to work schedule/financial burden to miss work. ▪ Could have been approved on initial request. Magellan educated that work schedule/financial burden qualifies as inability reason phototherapy cannot be used. • Compliance o See report for details. o UMC to adopt categories for compliance appeals common occurrences as well as a year-end-review.

3.	• 2023 UM Program Description – Annual Update (Requires a vote)	• Morgan/Juan	2:05 PM – 2:10		• See UM Program Description for details. • Changes approved by quorum vote.
4.	• UM Criteria (Requires a Vote - UMC prior to QIC)	• Tamsen / SeDessie / Courtney	2:10 PM – 2:20		• See UM Clinical Criteria for details. • UM Criteria approved by quorum vote.
5.	• Benefit Exception Request	• Hillary / Anh	2:20 PM – 2:30		• See Lactation Benefit Expansion for details. • Recommendation for expansion to current Lactation Benefit. • Expansion to include Lactation consultant visit, Initial nurse home visit, postpartum, and Follow-up nurse home visit for identified breastfeeding problems. • Impacted Stakeholders: Provider Relations, Clinical Operations, Population Health, and Claims.
6.	• Q1-2023 Internal Audit Report	• Traci	2:30 PM – 2:35		• See Q1-2023 Internal Audit Results for details. • Denial Files: 28 out of 30 files were fully compliant. 2 CCR files non-compliant. • PA Files: 27 out of 30 files were fully compliant. • Post-Acute Files: 28 out of 30 files were fully compliant. • LTC Files: 28 out of 30 files were fully compliant.
7.	• Q2-2023 Specialty Referral Report	• Juan	2:35 PM – 2:45		• Postponed to January UMC.
8.	• UM Over and Under Dashboard	• Morgan	2:45 PM – 2:55		• New approach to three services we want to focus on. o Underutilized: CBAS o 11,591 total eligible members (Oct 2022-Oct 2023) o Only 196 members approved for CBAS services. o 179 total CBAS utilizers o Alternative to going into a SNF. o Begin taking steps to close gaps in benefit awareness.

Action Items December 2023

ITEM #	OWNER	ACTION ITEMS	STATUS
1.	Tamsen	• Initiate process for Lactation Benefit Expansion	
2.		•	
3.		•	
4.		•	
5.		•	

Legend

1	= Need Update
2	= In progress
3	= Completed
4	= On Hold

UMC Meeting Date	Owner(s)	Action Item(s)	Comments	Status
10.5.22	Tamsen/Tony	• PA TAT Compliance Rate in the CO KPI Dashboard needs to be adjusted to provide a more accurate rate. • Total Pre-Auth metrics in the CO KPI Dashboard needs to be adjusted to provide a more accurate rate.	1.9.23 - Jan 2023- relying on manual check implemented for Health Services KPI spreadsheet until Tableau KPI report logic updates can be prioritized into BA work. Tamsen to follow up with Tony and Jay for new timeline. 2.24.23- oh hold through March while focusing on processing SDN and preparing for SFN FFS auth volume. 4.18.23-On hold in April for same reason. 6.16.23-Relying on manual check for accurate monthly count & plans to fix dashboard are on hold until Jiva implementation. 7.19.23-Tamsen confirmed this remains on hold until Jiva implementation.	4

1.11.23	Crystal/Matija	• The PMPM costs are strictly related to inpatient acute. • The overall PMPM rate is lower. • Is Varis doing a better job following up?	5.16.23 - VARIS recommended combining existing DRG Review service with their new Clinical Validation and Readmissions programs. 5.19.23-VARIS on hold until there are updates that can be presented to UMC. Next steps - Presentation to be scheduled with VARIS to learn more about these added services. 7.18.23-Meeting occurred Wednesday 6/14. Follow-up communication regarding pricing details is pending. 8.8.23- Pricing & details are still being reviewed. 8.16.23-Matija requested to take over ownership of action item and will review information with Eddy to decide if moving forward with VARIS's Clinical Validation and Readmissions programs. 9.8.23-Review in progress. 9.20.23- Matija to review	2
6.21.23	Morgan	• Confirm HIL MG high utilization for CBAS services is accurate. If accurate, reach out to HIL to understand their strategies for connecting members to CBAS services to increase utilization for all SFHP members.	6.29.23-Morgan is working with Tony Tai. to confirm data accuracy. 7.18.23- Initial analysis indicates data is accurate. Membership assigned to Hill is approx. 1.3%. However, Hill members make up 8% of total CBAS population. In addition, Hill members are attending CBAS more frequently than groups with comparable (i.e., CHI) or slightly greater (i.e., UCS) total CBAS members. This pattern continues in Q1 2023. 7.19.23-Committee requested a deeper analysis on why delegated medical groups have low utilization of CBAS services and develop strategies to work with delegate medical groups to increase CBAS utilization. 8.03.23-Morgan sent email to cross functional SFHP teams to collaborate on how SFHP can work with network providers and delegated medical groups to develop strategies to increase CBAS utilization. Discussions in process.	2

			8.16.23-Efforts in process to increase utilization: Post recorded CBAS webinar to the SFHP Website, CBAS Dashboard enhancements, & develop a system to identify CBAS eligible members and share information with Primary Care Providers to encourage referrals for CBAS services. 9.8.23-CBAS webinar posting has been completed and it is available on SFHP.org. Will be creating an article for the October provider newsletter. Due to competing BA priorities, CBAS Dashboard won't be final for several more months. 10.9.23 - Provider newsletter article complete. BA completed dashboard - will share in Nov/Dec UMC. Presented underutilization data at UCSF JOM 10/16.	
7.19.23	Leslie/Traci	• Discuss and develop an internal community site to store UM process changes that cross functional teams can access.	8.23.23- Not started but will plan to meet soon. 12.20.23- Met and discussed. On hold until post-Jiva implementation.	4
8.16.23	Leslie/Traci	• Check if UCSF hospitals participate in Sepsis registry.	7.19.23 Leslie/Traci * Discuss and develop an internal community site to store UM process changes that cross functional teams can access. 8.16.23- Leslie * Check if UCSF hospitals participate in Sepsis registry 8.23.23- Leslie/Traci * Not started but will plan to meet soon.- 12.20.23- Leslie/Traci * Have met and discussed options. Implementation postponed until after Jiva go-live. 12.20.23- Leslie * Sepsis registry not fully deployed yet, unknown whether UCSF or other providers will participate but could be helpful resource if any opt in.	4

8.16.23	Tamsen/Crystal/Morgan	• Crystal-Submit request in Clarizen & develop data analysis to present to UMC on Adult Preventative Service Codes exception. • CO-55 Exception Handling Process review & update.	9.20.23- Tamsen needs to go into Clarizen and add the codes for the exception process. For CO-55 Exception Handling Process policy review & update, Tamsen, and Morgan to meet with Matija. 10.20.23 – Crystal and Hilary confirmed this can be removed because preventative service codes are being added as a Medi-Cal benefit.	3
8.16.23	April	• Remind BTP Medical Group appeals are processed by SFHP only.	9.20.23- Talked with all the BTP Medical Groups at the DMG Work Group about delegation oversight. April to create an attestation to confirm that groups have been told. Crystal to work with Suzanna on verbiage. 10.20.23 – April confirmed this was completed via DMG workgroup meeting.	3
8.16.23	April/Crystal/Leslie/Wayne	• Discuss Continuity of Care with NEMS Medical Group and provide more guidance on handling Continuity of Care requests.	9.8.23-Will be discussed with NEMS at next JOC meeting. 9.20.23- Waiting for Leslie (unavailable due to PTO) to weigh in. Crystal proposes a two-fold approach: continuity of care update to all delegates and get NEMS specific information about where they were not doing what they were supposed to do. 12.20.23 – Crystal to confirm if this is planning for upcoming JOM agenda.	2
9.20.23	Tamsen	• Continue monitoring PMPM for medical supplies and hearing aids.	10.20.23 Tamsen will review claims data quarterly and report back 12.20.23- Tamsen to connect with Morgan to get analyst support.	2
10.20.23	Matija	• Request BA add median data to LTC Dashboard, specifically for 1) time to auth, and 2) time to place.	12.20.23- Matija will put a ticket in to get median data added to LTC Dashboard.	2
10.20.23	Eileen	• In response to 2 Wegovy appeals - Advise Magellan to review claims data, given shortages, and if the prescribed supply was insufficiently filled, approve.	12.20.23 – Discussed with Magellan. Complete.	3
10.20.23	Tamsen	• Add approved fluoride varnish benefit expansion details into Clarizen	12.20.23 – Tamsen awaiting more information from PNO/Finance. Tamsen to follow-up.	2
10.20.23	Matija/Tamsen	• Share discrepancies between WPATH SOC and MCG's Gender Affirmation Surgeries general recovery guideline with MCG rep.	12.20.23 – Tamsen shared details with MCG rep; however, he was unaware and requested time to research. Tamsen to follow-up	2

Parking Lot

ITEM #	DATE	OWNER	ACTION ITEMS	STATUS
1.	4.06.22	SeDessie / Eddy Ang	• Work w/ Eddy Ang on OBS metrics. • Need to be consistent in how OBS rules are applied.	• 5.4.22: SeDessie, Matija, Eddy working on priorities--medium category

Appeals / Overturned – December 2023

Grievance ID	Case Type	Medical Group	Decision	Case Category	Name Of Service Or Medication	Description	Resolution
MA231012001	Member Appeal	NEM	Overturned	Medical Group	Pediatric Orthopedic Surgery Follow-up Visits at Children's Hospital Oakland	The member's mom requested to file an appeal regarding the follow up appointment that was denied by NEMS. The PA was for the Children's Hospital Oakland. The member's mother stated the member broke their arm on 10/02/23. The school principal called 911 and the member was taken to the ER at CPMC Vanness. Due to there being no doctor, the member was transferred to the Children's Hospital in Oakland. The member had hand surgery and was admitted for 1 day. The member had a follow up appointment with Dr. Ishann Swarup on 10/09/2023 at UCSF Mission Bay SF. There was another follow up appointment, on 10/27/2023, at the Children's Hospital Oakland to remove the arm cast. The PA was denied, and the mother would like for the member to be seen by the same doctor because they know the wound and where the screw is. It was denied on 10/11/2023 due to the services being out of network. The PA is #20231010700122800013. NEMS UM stated the PA will not be approved for services in	You appealed the denial of pediatric orthopedic (bone) surgery follow-up visits at University of California, San Francisco (UCSF) Children's Hospital Oakland. San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved. This is because it is medically necessary for your son to get care at UCSF Children's Hospital Oakland. • SFHP confirmed that your son received care at UCSF. His condition meets the requirement for continuity of care.

						Oakland because it's out of the area. The PA may be approved for services at UCSF.	
MA231018001	Member Appeal	SFN	Overturned	SFHP-Pharmacy	DORZOLAMIDE-TIMOLOL 2 %-0.5 %	Appeal pf the denial of preservative-free dorzolamide-timolol eye drops to treat my ocular hypertension and prevent progression to glaucoma. The reason for denial stated that I did not meet step therapy requirements to try and fail preservative-containing dorzolamide and preservative-containing dorzolamide-timolol. I have congenital aniridia, a rare genetic eye condition. One of my ocular comorbidities is bilateral limbal stem cell deficiency (LSCD), a diagnosis consistently documented in all of my ophthalmology clinic notes dating back to at least 2014. Chronic use of preservative containing eye products is contraindicated for me because BAK and other preservatives are cytotoxic to my corneal epithelium and would exacerbate my ocular surface disease, hastening visual decline. The two preservative-containing medications listed in the denial letter are not appropriate for me due to my LSCD diagnosis.	You appealed the denial of Dorzolamide-Timolol 2 %-0.5 %. Dorzolamide-Timolol is an eye drop that treats increased eye pressure. San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved. This is because SFHP got more information showing that Dorzolamide-Timolol is medically needed for you. Your condition meets the SFHP Healthy Workers HMO formulary criteria as follows: • Your provider submitted information to show that you cannot tolerate a type of preservative in eye drops. Dorzolamide-Timolol is preservative free.
MA231024001	Member Appeal	SFN	Overturned	SFHP-Pharmacy	RYBELSUS 7 MG	Appeal from provider:Continuation of Therapy for NEW Members (within the last 6 months), approve if: • : Prescriber attests that member has been on this medication continuously before joining SFHP AND • Request is for generic or single source brand AND • The diagnosis and dosage provided meets FDA labeling and/or drug-specific criteria or off-label criteria He was prescribed both of these medications by his	You appealed the denial of Rybelsus 7 mg. Rybelsus is a medicine that treats type 2 diabetes.San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved. This is because SFHP got more

						previous cardiologist for coronary artery disease with previous myocardial infarction (NSTEMI) requiring stenting and heart failure with mid-range ejection fraction. He also has a diagnosis of type 2 diabetes though his a1c has always been well controlled <7.5 from my review of his previous labs. Studies that support this medical decision: Marx N, Husain M, Lehrke M, Verma S, Sattar N. GLP-1 Receptor Agonists for the Reduction of Atherosclerotic Cardiovascular Risk in Patients With Type 2 Diabetes. Circulation. 2022 Dec 13;146(24):1882-1894. doi: 10.1161/CIRCULATIONAHA.122.059595. Epub 2022 Dec 12. PMID: 36508493. Anker SD, Butler J, Filippatos G, Ferreira JP, Bocchi E, Böhm M, Brunner-La Rocca HP, Choi DJ, Chopra V, Chuquiure-Valenzuela E, et al; EMPEROR-Preserved Trial Investigators. Empagliflozin in heart failure with a preserved ejection fraction. N Engl J Med. 2021; 385:1451–1461. doi: 10.1056/NEJMoa2107038 Rybelsus 7MG tablets	information showing that Rybelsus is medically needed for you. • SFHP got information that you have been on Rybelsus via Medi-Cal Rx since April 2023. Your condition is eligible for continuity of therapy.
MA231031001	Member Appeal	SFN	Overturned	SFHP - UM Outpatient	Proton Beam Therapy	DESCRIBE THE PROBLEM: The member stated he has prostate cancer and needs treatments. The member doesn't understand why he was only approved for one session at Seventh-Day Adventists Loma Linda University Medical Center. It doesn't make sense to the member. The member stated, "This is why I need to speak to a manager at the UM department. It's a matter of incompetence." The member stated he had to stay at a hotel and spend money just to go to Seventh-Day	You and provider Jennifer Fisk from Loma Linda University Radiation Medicine appealed the denial of a type of radiation for cancer using protons to kill cells called "Proton Beam Therapy". San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved.

						Adventists Loma Linda University Medical Center, and now the new PA is denied.	This is because the external reviewer who specializes in Urology at the Medical Review Institute of America (MRIoA) found that it is medically needed for you to get proton beam therapy. • Based on National Comprehensive Cancer Network (NCCN) and American Urological Society guidelines, proton beam therapy is considered an option. • You already began proton beam therapy treatment. It was determined that you needed to continue the course of treatment that has already begun. You requested to be compensated for traveling to Seventh-Day Adventists Loma Linda University Medical Center and having to spend money on flight and hotel to get your cancer treatment. Please note that this appeal decision does not pertain to your compensation/ reimbursement request. If you paid for services that you believe SFHP should cover, please contact SFHP Customer Service at (415) 547-7800 for billing assistance.
CPSA231117001	Clinical Post-Service Appeal	NEM	Overturned	Medical Group	Out-of-Network Visit at University of California, San Francisco (UCSF)	The member's mother requested to appeal a denied Prior Authorization (PA). Denial from NEMS saying the PA was denied for a UCSF specialist visit on 11/03/2023. When explained that a specialist visit would need a referral from the PCP, the member's mother said the member did not need a referral from Primary Care Provider (PCP) since age	You appealed the denial of Endocrinology (study of hormones) follow-up visits at University of California, San Francisco (UCSF). San Francisco Health Plan (SFHP) has reviewed your appeal and decided to

						five. The member's mother said they do not know how much they need to pay but they could not afford to pay for the service on Date of Service (DOS) 11/03/2023. 2.) Per Joey, PA was denied from 11/08/2023 - 04/30/2024 with UCSF Endo due to the provider is out of network from NEMS. Informed Joey that the member's mother mentioned the member did not need a PA or referral to see UCSF, Joey said it was true because the member had CCS before, but CCS covers the member up to 21 years old. NEMS did not provide support for transitioning out of CCS, issue should have been anticipated and prevented.	overturn the original denial decision. This request is now approved. This is because it is medically necessary for you to get services at UCSF for care transitions. • You had been seen at UCSF Pediatric Endocrinology under California Children's Services (CCS), and you have now aged out of CCS. (CCS is a Medi-Cal program that treats children under 21 years of age with certain health conditions, diseases, or chronic health problems and who meet the CCS program rules.) • SFHP is approving two visits (one retrospective visit on 11/03/2023 and one future visit) to UCSF Pediatric Endocrinology.
MA231107001	Member Appeal	AMG	Overturned	Medical Group	Non-Emergency Transportation Wheelchair Van	"My Primary Care Provider's (PCP) request for the Non-Emergent Medical Transportation was declined twice to Medichair Transportation LLC. I am bedridden and my house has stairs. I need to have eye injection every three months. The same request was previously approved on 07/17/2023 and I used it on 07/27/2023. It is no reason for the exact same request to be declined. I left a message with All American Medical Group but no one returned my call. My PCP submitted the request a second time, but it was denied again.	You appealed the denial of Non-Emergency Medical Transportation (NEMT). NEMT is a medical transportation service with easy wheelchair entry and exit. San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved. This is because it is medically necessary for you to get NEMT. • SFHP has considered your medical condition and that your home has stairs. You also need to have an eye injection

							every three months. • The same service was previously approved.
MA231109001	Member Appeal	SFN	Overturned	SFHP-Pharmacy	Humira 40 mg/0.8 ml Syringe	Magellan forwarded the appeal from provider. “Patient is employed and unable to attend multiple phototherapy sessions multiple times per week. Skipping work for phototherapy sessions will create substantial financial burden for this patient. Patient has severe psoriasis affecting >10% BSA (??) who already tried topicals and acitretin. Already experienced severe adouse (??) event with acitretin (severe itching, peeling in hands and feet). Sincerely requesting a reconsideration on this Humira request."	Your provider, Dr. Robert Ricardo Gonzalez, appealed the denial of Humira. Humira is a medicine that treats inflammatory conditions. San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved. This is because SFHP got more information showing that Humira is medically needed for you. Your condition meets the SFHP Healthy Workers HMO formulary criteria as follows: • Your provider submitted information to show you have an inability to use methotrexate (a type of medication that helps reduce inflammation). The information also showed that you tried other medications that did not work for you. • SFHP also considered that you could not attend phototherapy sessions due to your work and financial situation.
MA231110001	Member Appeal	NEM	Overturned	SFHP - UM Outpatient	Whole Exome Sequence Analysis	Appeal from Provider at Stanford. “This is an appeal request for the previously denied prior authorization for genetic testing exome sequence (ES) analysis. Please see attached Letter of Medical Necessity	You appealed the denial of a whole exome sequence (WES) analysis for your son. It is a lab test to study the part of his gene that tells the cells in the body what to do.

						and clinicals. If you have any questions, please contact SHC Financial Counselor (Contractor) Karissa Naone at 650-725-9126."	San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved. This is because SFHP made an exception to approve this service. • Your son was seen by a provider at Stanford Medical Center who requested WES for diagnostic purposes, which is covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
MA231205001	Member Appeal	NEM	Overturned	Transportation	Non-Emergency Medical Transportation (NEMT) Wheelchair Van Services by MediChair Transportation LLC	The member stated this has been going around in circle with North East Medical Services (NEMS) and SFHP. NEMS denied the member's NEMT and was told to call SFHP. The medical transportation/NEMT with UCSF had been wonderful and had no problems. The driver would bring her wheelchair to the door. However, with NEMS, they denied the member's prior authorization (PA) for NEMT. The member does not understand why. The member has a handicap placard and gets her bathroom retro due to disability. The member said her limbs are swollen, both feet and right hand are swollen. Only the left hand is somewhat better. The member is not sure if the swelling is from the chemo that the member is getting. The member mentioned that new her PCP changed was effective 11/01/2023 but she has not seen the new PCP Dr.	You appealed the denial of Non-Emergency Medical Transportation (NEMT) wheelchair van services by MediChair Transportation LLC. NEMT is a medical transportation service with easy wheelchair entry and exit. San Francisco Health Plan (SFHP) has reviewed your appeal and decided to overturn the original denial decision. This request is now approved. This is because it is medically necessary for you to get NEMT. • SFHP has considered your medical condition and determined that you need NEMT to get to your appointments. • Regular transport is unable to assist

						Julia Nath, because the member couldn't get to the appointment. The member needs to see a doctor and needs medications because she is running low on medications.	with wheelchair/ walker entry and exit.

San Francisco Health Plan
Health Services
Clinical Operations
Utilization Management Programs

2023

Table of Contents

Overview
The San Francisco Health Plan (SFHP) Clinical Operations (CO) Utilization Management (UM) program description details the scope, structure, and processes guiding utilization management decisions to support membership in accessing the appropriate evidence-based, health and behavioral health care services. The UM program supports the Health Services' vision and mission statements.

Vision
Health Services Department's work supports core aspects of SFHP's vision and its activities across its departments directly while supporting the Institute for Healthcare Improvement (IHI) Triple Aim:

- Improve the health of the population.
- Improve patient experience of care.
- Improve affordability of healthcare

Mission
The mission of San Francisco Health Plan is to improve health outcomes of the diverse San Francisco communities through successful partnerships.

San Francisco Health Plan's Guiding Principles

- Educate, inspire, and assist our Members to lead healthy lifestyles.
- Maintain strong, collaborative relationships between our members, community-based organizations, and health care providers throughout the City.
- Recognize the cultural and linguistic diversity of San Franciscans.
- Lead with innovation, continually creating new ways to make health care more accessible and affordable.
- Create a team-oriented environment based on respect that supports personal and professional integrity and encourages employee growth.

SFHP Pillars

- Quality Care & Access
- Exemplary Service to Members
- Financial Viability
- Universal Coverage

Supporting this vision and mission is the UM program's commitment to the principle that the UM decision-making process is transparent. UM decisions are based on medical necessity within the scope of the SFHP benefit structure. Tools to support medical necessity include industry standard UM guidelines (Medi-Cal, Member Handbook, MCG criteria), peer reviewed SFHP guidelines (Gender Affirmation Services, Private Duty Nursing, Custodial Long-Term Care) grounded in current, scientifically sound, medical evidence; and independent medical review as needed. UM medical necessity decisions are not unduly influenced by fiscal or administrative factors. The UM program undergoes evaluation and monitoring internally, and by the State of California agencies Department of Health Care Services (DHCS); Department of Managed Health Care (DMHC), to ensure SFHP members have access to medically necessary, cost-effective, high-quality care. The integrity of this principle is grounded on a continual evaluation and evolution of the UM program through monitoring multiple sources of medical information and metrics. The objective is to provide SFHP's members equitable access to efficient, effective health and behavioral health care throughout the delivery system.

UM Program Scope
The UM program is responsible for reviewing and evaluating provider requests for authorization to perform certain services for two SFHP lines of business: Medi-Cal and Healthy Workers HMO. Each line of business provides members with a distinct set of benefits and is guided by line of business specific UM criteria. Therefore, SFHP's UM program is structured to accommodate and execute multiple utilization requirements. All authorization decisions are based on written UM policies and procedures. The policies and procedures are reviewed by the Chief Medical Officer (CMO), the SFHP UM Committee (UMC), the

Quality Improvement Committee (QIC); and derived from scientifically sound, medical evidence to ensure the latest clinical principles and processes are driving the UM decision-making process.

UM Program Functions
The UM program ensures effective utilization management practices, regulatory compliance, alignment with National Committee for Quality Assurance (NCQA) accreditation guidelines, and network oversight. UM program responsibilities are to ensure:

- Continuity and coordination of care.
- Access and availability of health care services, including parity between medical and behavioral health.
- Transparency of members' rights and responsibilities.
- Parsimonious, yet holistic approach toward utilization management of health care services, including medical, pharmaceutical, and behavioral health care services.

Review of Utilization Data: Detecting Over-/Underutilization
SFHP utilizes a variety of methods to monitor and track service utilization to identify patterns of over-/underutilization. The range of reports reviewed are, for example:

- Member satisfaction surveys
- Member complaints, grievances, and appeals reports.
- Tableau utilization trending reports and dashboards
- Ad Hoc business analytical reports
- HEDIS
- DHCS Medi-Cal Managed Care External Quality Review (EQR) Technical Reports (Benchmark Reports)

The range of data types reviewed are, for example:

- Outpatient Services (including Physician Administered Drugs [PADs])
- Preventive Care Services
- Inpatient Services
- Emergency Department Services
- Long-Term Care Services (as of 1/1/23)
- Medical and pharmaceutical claim/encounter data analysis

The Utilization Management Committee (UMC) is responsible for the monthly monitoring of utilization data to identify potential services being over- or underutilized. If a service is identified, the UMC will conduct further discussions and analysis to identify opportunities for improvement. Examples of the types of action steps the UMC might take are:

- If certain cases of inappropriate over-utilization are identified (e.g., ED visits, medications, diagnostic testing), they may be referred to the appropriate cross-functional team.
- If quality issues are identified, they are handled through the potential quality issue (PQI) process (refer to the Policy and Procedure QI-18 Potential Quality Issues).
- If any potential fraud, waste and/or abuse issues are identified, these will be referred to the Program Integrity Workgroup (refer to Policy and Procedure CRA-08 Fraud and Abuse Prevention and Investigation).
- If an opportunity for provider improvement is identified, Provider Network Operations (PNO) and UMC staff will collaborate with the provider to develop intervention strategies.

Utilization Management Structure
Prior Authorizations
The UM Prior Authorization Team receives pre-/post-authorization requests for outpatient services and planned admissions. UM Prior Authorization Coordinators are responsible for processing incoming authorization requests and creating authorization records so a UM Prior Authorization Nurse may review the requested services for medical necessity and benefits coverage. The authorization review goals and priorities are:

- Medical Necessity
    - Patients receive timely, medically appropriate services.
- Coordination of benefits
    - Identification of other primary payers.
    - SFHP is not responsible for prior authorizations covered by other health insurance or carved out of the SFHP benefit package.
- Care Coordination
    - Care is provided in medical group, and within network, when appropriate.
    - Care coordination redirects authorizations for behavioral health services to Carelon Behavioral Heath for SFHP Medi-Cal members and San Francisco Behavioral Health Services (SFBHS) for SFHP Healthy Workers members.
    - Identifying members for care management services and community services and eligible benefits.
    - Ensuring the safety of SFHP's members through the Potential Quality Issue (PQI) process.

Concurrent Review Authorizations

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

- Medical Necessity
    - Acute hospital admissions are reviewed to determine medical necessity and appropriateness of hospitalization and treatment plans, and to engage in early discharge planning, and if appropriate, provide referrals for care management intervention.
- Proper Level of Care
    - Patients receive an appropriate level of care.
    - Administrative Days are reviewed by request from the hospital for difficult to place patients requiring Skilled Nursing Facility (SNF) level of care.
- Care Coordination
    - Care is provided in medical group, and within network, when appropriate.
    - Identifying members for care management services and community services and eligible benefits.
    - Care coordination redirects authorizations for behavioral health services to:
        - Carelon Behavioral Heath for SFHP Medi-Cal members.
        - San Francisco Behavioral Health Services (SFBHS) for SFHP Healthy Workers members.
    - Ensuring the safety of SFHP's members through the PQI process.
    - Discharge Planning support
        - SFHP's supports the coordination of care as members move from one level of care to another with the objective of improving quality and reducing hospital and emergency department readmissions.. CCR Nurses collaborate with various SFHP cross-functional teams and hospital staff to ensure safe discharge planning.
- Coordination of Benefits
    - Identification of other primary payers.
    - SFHP is not responsible for services covered by other health insurance or carved out of the SFHP benefit package.

Long-Term Care Authorizations

The LTC Team receives preauthorization requests for LTC admissions and outpatient services. UM LTC Coordinators are responsible for processing incoming authorization requests and creating authorization records so an LTC Nurse may review the requested services. The review goals and priorities are:

- Medical Necessity
    - LTC admissions are reviewed to determine medical necessity and appropriateness of continued residency and treatment plan.
    - Patients receive timely, medically appropriate services.

- Proper Level of Care
    - Patients receive an appropriate level of care.
- Care Coordination
    - Care is provided in medical group, and within network, when appropriate.
    - Identifying members for care management services and community services and eligible benefits.
    - Ensuring the safety of SFHP's members through the PQI process.
- Discharge Planning support
    - SFHP's supports the coordination of care as members move from one level of care to another with the objective of improving quality and reducing LTC readmissions. LTC Nurses refer members with the potential to discharge to our care management team for enhanced care management.
- Coordination of Benefits
    - Identification of other primary payers.
    - SFHP is not responsible for services covered by other health insurance or carved out of the SFHP benefit package.

Oversight of Delegated UM Activities

SFHP delegates the responsibility to manage UM services and UM reporting to the following entities:

- American Specialty Health (ASH)
- Carelon Behavioral Heath
- Brown & Toland Physicians (BTP)
- All American Medical Group (AAMG)
- Hill Physicians (HIL)
- JADE (JADE)
- Kaiser (KSR) – Termination effective 1/1/24
- North East Medical Services (NEMS) & NEMS with SFHN (NMS)

Additionally, SFHP delegates the responsibility of Quality Improvement (QI) activities to:

- Carelon Behavioral Heath
- Kaiser – Termination effective 1/1/24

When UM activity is delegated to a contracted medical group, SFHP is fully accountable for how the delegated medical group (DMG) conducts UM decision making according to the standards of SFHP's UM program and applicable DHCS and DMHC regulations, and NCQA accreditation guidelines. A separate policy (DO-02 – Oversight of Delegated Functions) and annual delegation agreements describe how SFHP oversees the functions delegated to the DMGs. To ensure each DMG is compliant, SFHP:

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

Program Management[1]
The UM Program is required to prepare and write a variety of reports to meet the administrative requirements for DMHC, DHCS, and the NCQA accreditation guidelines. The reports are reviewed and discussed through the UMC meetings. The UMC provides minutes and annual reports to the QIC. The QIC, in turn, submits their quarterly meeting minutes, which includes UM Program activity, to the SFHP Governing Board.

Discharge Planning
SFHP's Concurrent Review Team provides discharge planning services for applicable members assigned to either the San Francisco Health Network (SFN) Medical Group, Community Clinic Network (CLN) Medical Group, UCSF (UCS) Medical Group, or SFHP Direct Network [SDN; limited to duals and LTC resident's]. These members may be admitted to either an in-plan or an out-of-plan hospital depending on a member's medical group/network assignment and eligibility.

The CCR Team focus is to manage members in acute and post-acute care settings; and provide assistance to facility staff with discharge planning efforts to ensure a medically safe and effective transition to an alternate level of care. The Team participates in:

- Working collaboratively with various SFHP cross-functional teams to ensure members' discharge needs are met. This includes assisting in coordinating medically necessary care services, and support services in the community for members upon discharge.
- Coordinating timely post discharge follow-up care.

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

UM staff use standard criteria (e.g., Medi-Cal, MCG, SFHP internally developed criteria) to determine whether the requested services meet medical necessity criteria. Specific levels of staff engagement with the approval review of health care services have been set. Using these standard criteria, Prior Authorization (PA) Nurses and CCR Nurses may approve health care services based on medical necessity. If a request does not meet medical necessity criteria, the UM nursing staff will route the request to an SFHP Medical Director, or physician designee, for review. The MD will review evidence with specialty consult if necessary.

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

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

The Director of Clinical Operations oversees SFHP UM staff and conducts compliance activities for SFHP UM and for UM delegated to medical groups.

[1] The UMC Reportage Calendar is in located in Appendix A.

Physician Administered Drugs (PADs)
Clinical Operations Prior Authorization Team is responsible for Medi-Cal/Healthy Workers members' medications administered at the physician's office or hospital and billed through SFHP's medical benefit. These drugs are excluded from the federal definition of "covered outpatient drug" as stated in SSA 1927(k)(3)[i] as these medications are provided as part of, or as incident to and in the same setting as, any of the following: inpatient hospital services, physicians' services, or outpatient hospital services.

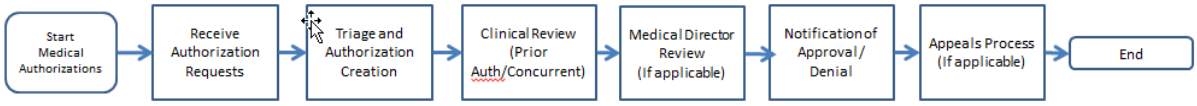
DHCS defines "a physician-administered drug is any covered outpatient drug provided or administered to a recipient and billed by a provider and not self-administered by a patient or caregiver. Such providers include, but are not limited to, physician offices, clinics, and hospitals. A covered outpatient drug is broadly defined as a drug that may be dispensed only upon prescription and is approved for safety and effectiveness as a prescription drug under the Federal Food, Drug and Cosmetic Act. Physician-administered drugs include both injectable and non-injectable drugs."[2].

DHCS always considers PADs – including chemotherapeutic agents, anti-rejection medications for organ transplants, and long-acting contraceptives – as a medical benefit. PADs remain a medical benefit even when they are also available as a pharmacy benefit on a case-by-case basis.[3]

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

Sources of Line of Business Benefits and UM Decision Criteria
DHCS mandates the scope of benefits to be offered to Medi-Cal members[4]. The City and County of San Francisco Department of Public Health (DPH), SFHP's CMO, and SFHP's Chief Executive Officer (CEO) developed the scope of benefits offered by the Healthy Workers HMO. The UM Prior Authorization and Concurrent Review Nurse Managers collaborate with the CMO and Director of Clinical Operations to implement clinical criteria for each line of business to ensure adherence to evidence-based care in alignment with current regulations and applicable SFHP health and behavioral health care policies.

Process Overview of the Medical UM Decision Process



[2] Department of Health Care Services (DHCS*). Physician-Administered Drugs – NDC* (DHCS Publication). CA.gov, DHCS. https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/physicianndc.pdf
[3] Department of Health Care Services (DHCS). (2022, March 18). *Medi-Cal Rx Billing Policy for Physician Administered Drugs* [Press Release]. https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/bulletins/2022.03_A_Medi-Cal_Rx_Billing_Policy_for_PADs.pdf
[4] "Covered Services are those services set forth in Title 22 CCR Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, and provided in accordance 42 CFR 438.210(a) and 42 CFR 440.230". Source: DHCS Medi-Cal contract (v12.17.2019), Exhibit A, Attachment 10, Scope of Services, p. 72.

Process Overview of the Behavioral Health Referral Process

The behavioral health referral process involves the UM Prior Authorization and Concurrent Teams, through various workflows, identifying members who are potentially eligible for care coordination with non-specialty mental health services (NSMH) or specialty mental health services (SMH). The assessed member is not directly linked to behavioral health services but is referred to either Carelon Behavioral Health for NSMH services or to the consultative services of the SFHP Intake Coordinator of the Day for a potential case management referral for SMH services.

Principles Guiding UM Decisions

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

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

Source for Determining Medical Necessity and Plan Information

Essette, operable since June 2014, is the core technology platform housing all data and line of business information related to medical utilization management (including PADs, and carved-out services), care management, appeals, and grievances. Essette is the primary repository for all resources used to determine medical necessity for each of SFHP's line of business (Medi-Cal and Healthy Workers). Additionally, the resources are weighted by hierarchy when referenced to establish medical necessity for a certain prior authorization (PA) request.

Effective February 2024, SFHP will sunset Essette and be operable with a new care management system, JIVA.

Source of UM Decision Criteria

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

Clinical Operations Nurses and Medical Directors use UM and clinical criteria resources to assist in determining the medical necessity of requested services. SFHP's clinical criteriaincludes:

1. SFHP internally developed and approved criteria:
    a. Gender Affirming Services
    b. EPSDT Private Duty Nursing
    c. Custodial Long-Term Care (effective 1/1/23)
2. MCG Care Guidelines
3. State/Federal (Medi-Cal/CMS) criteria
    a. If no Medi-Cal Criteria is available, Medicare/CMS criteria can be consulted on a case-by-case basis.
4. Chief Medical Officer (CMO) or physician designee (MD) review of the evidence in consultation with relevant external, independent specialty expertise obtained from SFHP's Independent Review Organization when there are no available external or internally developed and approved criteria.

The Utilization Management Committee (UMC), a subcommittee of the QIC, reviews and annually approves clinical criteria.

The criteria must be applied in conjunction with consideration of:[5]

- The member's needs and characteristics, such as:
  - Age.
  - Cultural and linguistic needs.
  - Comorbidities, complications, progress of treatment.
  - Psychosocial needs.
  - Home and/or work environments.
- In addition, characteristics of:
  - The local delivery system is available to the individual.
  - The availability of alternative levels of care.
  - Timely accessibility of covered services.
  - Cultural preferences for treatment modalities.
  - Availability of specialty providers.
  - Access to community resources.
  - Familial influences and supports.
  - Benefit coverage for the available alternatives.
  - Ability of local providers to provide all recommended services within the required access standards.

SFHP adopts those benefits mandated by DHCS for Medi-Cal beneficiaries and DMHC for Healthy Worker HMO members. Covered benefits are documented in the Member Handbook (Medi-Cal) or Evidence of Coverage (Healthy Workers HMO). An authorization will be denied if the requested service is not a covered benefit or exceeds the limitations or restrictions stated in the benefits plan.

SFHP requires the treating provider to submit relevant clinical information and/or medical records to ensure the appropriate review decisions are being made. Clinical information evaluated with reference to the criteria may include, but are not limited to[6]:

- Office and hospital records
- History of the presenting problem
- Physical examination results
- Diagnostic testing results
- Treatment plans and progress notes
- Information on consultations with the treating practitioner
- Evaluations from any other health care practitioners and providers
- Any operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Treating physician statements of medical necessity

SFHP's CMO, or Medical Directors, are available for a peer-to-peer review of the submitted authorization request. Practitioners and members are informed how they may obtain copies of UM criteria utilized for decision-making, and on request, the UM criteria are provided. SFHP also communicates with practitioners through the Provider Network Operations Manual, monthly Provider Newsletter, and the SFHP website and Provider Portal to ensure their awareness of prior authorization procedures and timeframes.

SFHP utilizes physician consulting services of MRIoA for medical necessity determinations outside the expertise of SFHP's internal medical directors. MRIoA utilizes a nationwide network of board-certified physician specialists and professionals in over 133 specialties and sub-specialties of medicine. MRIoA reviews cases prospectively, concurrently, and retrospectively for:

- Medical Necessity

[5] Sources are NCQA standard, UM-2: Clinical Criteria for UM Decisions and CO-57 UM Clinical Criteria.

[6] Refer to policy and procedure CO-57 UM Clinical Criteria.

- Appropriate Treatment
- Experimental Procedures
- Appropriate Hospitalization
- Formulary Criteria Review
- Pre-Existing Conditions
- Injury Causation
- Diagnostic Testing

MRIoA is dually accredited with URAC; certified in Health Utilization Management and as an Independent Review Organization. In addition, MRIoA is NCQA accredited in Utilization Management[7].

Behavioral Health Services
Specialty mental health, as well as, medications treating serious mental illness, are carved out.
SFHP members can access non-specialty mental health (NSMH) services, behavioral health therapy (BHT) services, specialty mental health (SMH), and substance use disorder (SUD) services by self-referral, referral by their network primary care practitioner, or referral by their care manager. Regardless of the method of referral, the primary care provider, when appropriate, will coordinate care with behavioral health practitioners. Members can access any of the listed behavioral health services, even if they are already receiving another of the listed behavioral health services.

BHT

- Youth members have access to medically necessary Applied Behavioral Analysis (ABA) Behavioral Health Therapy (BHT) services through Carelon Behavioral Health. These services are available based on whether BHT services will correct or ameliorate any physical and/or behavioral conditions a youth may have, such as a diagnosis of autism spectrum disorder. Members may access medically necessary ABA/BHT services when prior authorization is obtained, and eligibility is confirmed.
- Once a member is identified as eligible for ABA/BHT services, Carelon's Member Services will coordinate member care with local providers.

NSMH

- For Healthy Workers HMO members, SFHP contracts with San Francisco Behavioral Health Services (SF-BHS) to deliver comprehensive NSMHS, SMHS, BHT, and SUD services.
- Medi-Cal members with mild to moderate mental health impairment have access to NSMH services through Carelon Behavioral Health. Members are able to:
    - Directly access Carelon services, without obtaining a PCP referral or prior approval, by calling Carelon to complete a screening and register for services.
    - Directly access Behavioral Health (BH) clinicians co-located in their primary care practice without having to contact Carelon services directly. These co-located BH clinicians are contracted and credentialed by Carelon to provide NSMH services at these care sites. Members can also be referred to Carelon services by their PCP or case manager, as appropriate.
- Once a member has been identified as experiencing a mild to moderate impairment, Carelon's Member Services will offer the member referrals to local providers; Carelon also may refer to tele-behavioral health providers who may not be local. A member can also self-refer to a provider using Carelon's online Provider Directory. SFHP Care Management and/or Clinical Operations Teams may also refer members to Carelon for services.
- Healthy Workers members with mental health diagnoses have access to outpatient prescription medications from their SFHP Formulary governed by the SFHP P&T committee. Medi-Cal members with mental health diagnosis of mild to moderate impairment have access to outpatient prescription medication from Medi-Cal RX.

SMH

[7] MRIoA participates in ongoing NCQA renewal surveys.

- For Healthy Workers HMO members, SFHP contracts with San Francisco Behavioral Health Services (SF-BHS) to deliver comprehensive NSMHS, SMHS, BHT, and SUD services.
- Medi-Cal members with moderate to severe mental health diagnoses and severe functional impairment receive specialty mental health services from the San Francisco Behavioral Health Services (SF-BHS), administered by the San Francisco Department of Public Health (DPH). Specialty mental health, as well as, medications treating serious mental illness, are carved out benefits. Members access SF-BHS services by calling the SF-BHS Access Hotline for triage or members may also self-refer to any mental health facility within the SFCBHS network. SFHP UM Teams also refer members who meet specialty mental health criteria to SFCBHS for services.

SUD

- Members receive SUD screening and brief counseling from PCPs.
- For Healthy Workers HMO members, SFHP contracts with San Francisco Behavioral Health Services (SF-BHS) to deliver comprehensive NSMHS, SMHS, BHT, and SUD services.
- Healthy Workers members with behavioral health and/or substance use disorder (SUD) diagnoses have access to outpatient prescription medications from their SFHP Formulary governed by the SFHP P&T committee. Medi-Cal members with SUD diagnoses have access to outpatient prescription medication from SFBHS.
- Med-Cal eligible members with substance use disorders are eligible for services from the Drug Medi-Cal Treatment Program, a carve-out benefit for all Medi-Cal members through SF-BHS.
- Members can self-refer for SUD services by calling the Treatment Access Program (TAP) Voluntary Unit.
- PCPs refer members to TAP who need a higher level of care.

UM Policies and Procedures

UM policies and procedures confirm:

- Preventive services are available without referral or prior authorization when obtained in medical group.
- Emergency services and Urgent Care Services are available without prior authorization, to screen and stabilize a member for signs and symptoms that a member, acting reasonably, given the member's age, personality, education, background, and other similar factors, believes to be emergent in nature, or if the member is referred by any SFHP representative or physician, regardless of final diagnosis.
- For family planning services, HIV testing and the treatment of sexually transmitted infections, Medi-Cal members may see any provider who accepts Medi-Cal without referral or authorization. Non-Medi-Cal members in the Healthy Workers HMO program may self-refer to any provider who is contracted with their medical group for outpatient sensitive services.
- Abortion services
    - Outpatient Services
        - Medi-Cal members may self-refer to any Medi-Cal provider for an outpatient abortion without prior authorization. It is not required for that provider to be contracted with SFHP.
        - Healthy Workers HMO members must stay within medical group for outpatient abortions. Prior authorization is not required. If services are not available in-medical group, SFHP will approve out-of-medical group, and if necessary, out-of-network. Medical necessity review is not required.
    - Inpatient Services
        - For Medi-Cal members, abortions while in an inpatient facility require prior authorization, and must be performed within the member's assigned medical group. If the service is not available within the medical group, SFHP will approve an authorization request within the SFHP network.
        - Healthy Workers HMO members, abortions while in an inpatient facility, require prior authorization, and must be performed within the member's assigned medical group. If the service is not available within the medical group, SFHP or

the delegated medical group will approve an authorization request within the SFHP network.

- Obstetrical and gynecological services, including basic prenatal care and support services, are available to members from practitioners associated with their medical group without prior authorization or referral.
- The length of a hospital stay associated with mastectomy and lymph node dissection is determined by the attending physician and surgeon in consultation with the patient. SFHP and its medical groups do not require a treating physician and surgeon to receive prior approval in determining the length of hospital stay following these procedures.
- Members with chronic, life threatening, degenerative, or disabling conditions have the right to obtain standing referral to specialists.
- Members have access to second opinions within the SFHP network.
- Members' denial notices describe all means of appeal and related member rights and responsibilities, including how to expedite the authorization and appeal process.
- Members have full access to DMHC's independent medical review (IMR). Members are encouraged to resolve a grievance using SFHP's grievance process, but this does not prevent a member from accessing DMHC's IMR process. A member can access DMHC's IMR if a member's grievance involving an emergency, a grievance not resolved satisfactorily, or a grievance unresolved for more than 30-days. The form for requesting an IMR, including instructions, is provided with the NOA, as well as being available from DMHC through their internet site.
- Members and providers are informed about waiver and community-based programs such as, California Children Services (CCS) and Golden Gate Regional Center (GGRC), and how to coordinate care between SFHP and these services.

Long-Term Care

Effective January 1, 2023, SFHP assumes responsibility of the skilled nursing facility (SNF) Long-Term Care (LTC) benefit, previously managed by Fee-For-Service (FFS) Medi-Cal. Non-dual and dual LTC residents (including those with a Share of Cost), covered by FFS Medi-Cal, will enroll in SFHP. On January 1, 2024, the remaining LTC residents receiving the Subacute LTC benefit and Intermediate Care Facility for the Developmentally Disabled LTC benefit will be enrolled.

LTC is defined as Custodial Care in a facility for longer than the month of admission and month after. LTC SNF and Subacute admissions must meet SFHP's Custodial Care Criteria Guidelines. LTC ICF-DD admissions must meet the Regional Centers guidelines. For SNF and Subacute admissions, SFHP is responsible for medical necessity authorization review. For ICF-DD admissions, authorization responsibility is shared between SFHP and the Regional Center. The Regional Center is responsible for conducting medical necessity placement reviews for eligible members.. The Regional Center shares the placement decision with SFHP using the Certification for Special Treatment Program Services (form HS 231). SFHP is responsible for providing administrative authorization, a notice of determination, and claim payment for approved services. Members requiring LTC placement in a SNF, Subacute or ICF-DD Home will remain enrolled in managed care, instead of being disenrolled and transferred to FFS Medi-Cal. SFHP will be responsible for all administrative aspects of LTC. SNF and Subacute admissions that do not exceed the month of admission and month after, do not have a long-term disposition, or that do not meet SFHP's Custodial Care criteria will remain the responsibility of the delegated group to which the member is assigned. When the admission meets SFHP's Custodial Care criteria and exceeds the month of admission and month after, members who are eligible and pre-authorized for LTC, are reassigned to the SFHP Direct Network (SDN). The effective date of reassignment will be the first day of the third month of admission. ICF-DD admissions authorized by the Regional Center are reassigned to the SDN Network immediately upon admission. Members will remain assigned to SDN through the entirety of their LTC admission.

Disenrollment for Medi-Cal Members

Medi-Cal members with an out-of-area (OOA) residential address are submitted to Health Care Options for disenrollment.

Grievances, Denials, and Appeals
SFHP encourages its members, or the member's representative, to voice their dissatisfaction with SFHP's and/or its providers' services through the Grievances and Appeals process. The grievance process is designed to address and resolve members' concerns in a manner that is timely, fair, and thorough.

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

The UM program monitors grievances, denials, appeals, upheld and overturned appeals to ensure the prior-approval (PA) criteria were correctly applied and are aligned with current evidence-based standards of care. The UMC reviews all upheld and overturned appeals to determine if a policy or operational change is required to improve a member's health status or to improve a member's access to medically necessary, cost-effective, high-quality care.

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

The UM program collaborates with the QIHETP and the QIHEC to support the quality improvement and health equity initiatives and commitment to the continuous quality improvement of SFHP's health care delivery system. UM provides a quarterly report to the QIHEC trending and evaluating UM grievances, denials, appeals, and overturned appeals as a means of maintaining the medical soundness of the PA criteria and processes. Additionally, UM provides quarterly reportage related to UM activities integrated into the QIHETP. The reports focus on key UM activities and metrics that are relevant, meaningful, and add value to the QIHETP initiatives. The activities and metrics include information on the number and types of service utilization; authorization denials; and upheld/overturned appeals.

Quality Monitoring and Improvement
The objectives of the UM program are primarily measured through the SFHP Quality Improvement and Health Equity Transformation Program using indicators for over- and under-utilization. When emergent problems are identified, corrective actions are implemented to achieve the proper outcome results.

The Quality Improvement and Health Equity Transformation Program includes these mechanisms for monitoring over-utilization and under-utilization:

- Review of CAHPS
- Pharmacy utilization reports
- The Healthcare Effectiveness Data and Information Set (HEDIS) effectiveness of care measures.

At least annually, SFHP or its delegated medical groups gather information from members, through CAHPS, and practitioners about their satisfaction with Clinical Operations processes and the pharmacy benefits and reports the results in an annual *Member and Provider Satisfaction Report*. SFHP then focuses on addressing trends indicative of dissatisfaction.

At least annually, Clinical Operations, and its delegated medical groups, conduct separate interrater reliability assessments (IRR) to ensure the consistency with which the Clinical Operation's Teams, or the delegated reviewers, apply UM criteria in decision-making and to determine if a reviewer requires a remediation plan.

Accountability
SFHP and its delegated medical groups convene committees to monitor, evaluate, and optimize the delivery of health care services and the implementation of the UM Program.

The Utilization Management Committee (UMC) provides oversight of SFHP's utilization activities and initiatives. The UMC works to assure effective implementation of SFHP's UM Program and to support compliance and alignment with:

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

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

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

- Chief Medical Officer, MD
- Senior Medical Director, MD
- Director, Clinical Operations, RN
- Associate Medical Director, MD
- UM Nurse Manager, Prior Authorizations, RN
- Senior Manager, Concurrent Review RN
- Nurse Manager, Concurrent Review, RN
- Program Manager, Clinical Operations, MBA
- Manager, Pharmacy Operations, PharmD
- Manager, Long Term Care Nurses, RN
- Clinical Operations Manager, MBA

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

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

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

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

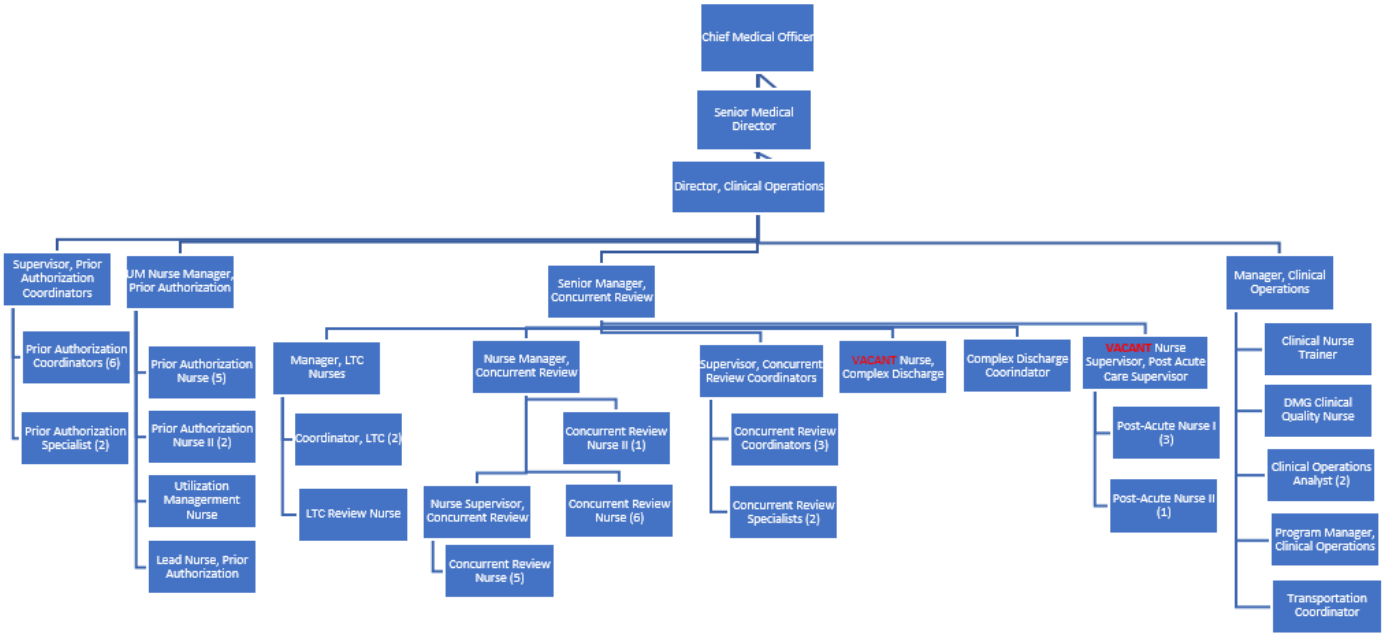
- Provides a venue for medical issues to be resolved by a committee or subcommittee of practitioners, with three physician members serving as a quorum.
- Meets at least quarterly; and
- Allows SFHP representatives, as well as the general public, to attend.
- Discusses any updates related to:
    - The UM Program Description (through the consent calendar) and, when appropriate, revisions of the UM program, policies, and criteria. UM criteria are required to be updated at least annually or more frequently if necessary.

- Provide oversight of the UM program and annually approve, and if needed, update the UM program description.

The SFHP Chief Medical Officer is responsible for ensuring compliance with the SFHP UM program policies and requirements.

SFHP UM Program Structure

A high-level view of the UM organizational structure:



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

	Provide day-to-day supervision of assigned UM staff	Participate in staff training	Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.	Monitor documentation for adequacy.	Are available to UM staff on site or by telephone.
Chief Medical Officer	X	X	X	X	X
Senior Medical Director	X	X	X	X	X
Medical Director	----	X	X	X	X
Director, Clinical Operation	X	X	X	X	X
UM Nurse Manager, Prior Authorization	X	X	X	X	X
Supervisor, Prior Authorization Coordinators	X	X	----	X	X
Senior Manager, Clinical Operations, CCRT	X	X	X	X	X
Nurse Manager Concurrent Review & Care Transitions	X	X	X	X	X
Supervisor, Concurrent Review Coordinators	X	X	----	X	X
Manager, LTC Nurses	X	X	X	X	X

- Chief Medical Officer
    - M.D. degree from an accredited medical school. Board certified, preferably in a primary care field.
    - Licensed to practice medicine without restriction in the State of California or eligible to obtain an unrestricted license in California.
    - Develops, implements, and evaluates programs within Health Services including:
        - Utilization Management
        - Quality Management Improvement Activities including HEDIS improvement strategies.
        - Population Health management activities including initiative/mandates intended to enhance care delivery aligned with Triple Aim (improve quality, lower cost and support member and provider satisfaction).
        - Reports to the Governing Board on progress on the programs.
    - Directs and monitors Behavioral Health activities.
    - Directs and monitors Health Services operations and programs designed to support Health Services activities including utilization management, quality management and improvement activities, and population health.
    - Directs and monitors pharmacy services of the Plan.
    - Directs and monitors non-specialty behavioral health services delivery to SFHP members.
    - Establishes and maintains strong strategic partnerships with clinical leaders from SFHP's contracted Medical Groups:
        - Provide clinical leadership in the oversight of delegated IPAs and delegated medical groups/clinics' compliance with contractual responsibilities in delegated activities including utilization, care management and quality management activities.
        - Provides clinical leadership to SFHP Facility Site Review (FSR) team and facility site and medical record reviews.
    - Ensures that medical decisions at the Plan are rendered by qualified medical personnel, unhindered by fiscal or administrative direction.
- Senior Medical Director
    - 5 years of post-residency experience in a recognized medical specialty, which must have included at least (3) years of medical administrative experience. Preferred experience is in adult primary care, such as family practice or internal medicine.
    - Experience working with clinical practice guidelines and evidenced based criteria sets.
    - Develop and implement clinical programs to align with SFHP's strategic priorities in order to improve quality of care and outcomes for members.
    - Provide leadership in developing and implementing UM Strategy and Program.
    - Lead the clinical team and provide clinical oversight, direction, and mentoring.
    - Develop and increase collaborative relationships with external partners and stakeholders evidenced by improved clinical performance metrics.
    - Monitor network performance proactively to ensure adherence to health plan standards and execute initiatives to address issues affecting performance.
    - Assure interdepartmental collaboration and communication with provider contracts, provider relations and claims and others resulting in a quality network of providers.
    - Identify areas of risk and opportunities to optimize utilization management.
    - Participate in a formal Utilization Management Program for the Plan and its Providers.
    - Develop and execute solutions to monitor Utilization Management.
    - Consult and advise on the development of protocol, procedures, oversight, and training in the following areas:
        - Pharmacy

        - Pre-admission authorization
        - Prospective, concurrent (inpatient) and retrospective review
        - Long Term Care Services and Support including Skilled Nursing and Subacute care.
        - Inpatient claims review
        - Utilization/Medical Management review reporting and evaluation
        - SFHP led Member Case Management
        - Potential Clinical Quality Issues
        - Grievance resolution
    - Actively Participates and provides physician leadership in the following SFHP Committees:
        - Utilization Management Committee
        - Grievance Review Committee
        - Pharmacy and Therapeutics Committee
        - Quality Improvement Committee
        - NCQA Accreditation
    - Provide physician leadership and clinical support for the following areas: Grievance and Appeals, Care Management, Potential Quality Issues.
    - Provide physician leadership and clinical support for NCQA activities of the Plan.
    - Provide physician leadership for UM and CM Delegation oversight activities of the Plan, including Behavioral Health.
    - May perform utilization reviews when required.

- Medical Director
    - MD/DO degree from an accredited program, with active, unrestricted California medical license. Board certified required.
    - A current CA license to practice without restriction.
    - 5+ years of clinical experience.
    - Clinical Decision Making and Support - Utilization Management
        - Provides clinical guidance on medical necessity and transfer decisions to support UM staff.
        - Responsibilities include contacting attending and ED physicians to discuss patients when appropriate.
        - Shares responsibility for utilization management and pharmacy decisions: determining medical necessity based on established criteria, interpreting benefits and limitations, and consulting with providers as appropriate.
        - Actively participates in Utilization Management Committee.
    - Clinical Decision Making and Support - Quality
        - Investigates and resolves potential quality incidents and determines their appropriateness for review by the Physician Advisory Committee.
        - Reviews appeals and provides second opinions regarding medical necessity.
        - Reviews clinical grievances and is an active participant in Grievance Review Committee.
    - Provides clinical input for programs:
        - Pharmacy
        - Participates in formulary criteria development.
        - Utilization Management
        - Assists in developing and revising policies to support utilization management activities, including criteria and guidelines for appropriate use of services, clinical practice guidelines, and treatment guidelines.
        - Clinical Quality
        - Provides clinical support for program development of disease management and practice improvement.
        - May serve on Quality Improvement Committee, Pharmacy and Therapeutics Committee, or the Practice Improvement Program Advisory Group.

- Represents SFHP with our external community partners, including giving presentations related to SFHP priorities as needed.
- Leads special projects and assignments as requested by the Sr. Medical Director and/or Chief Medical Officer.
- Provides clinical guidance related to systems implementations (such as care management IT integration systems).

Clinical Operations Teams

- Director, Clinical Operations
  - Current unrestricted California RN license
  - Provide tactical and strategic leadership as a member of the Health Services Leadership team, ensuring integration of clinical operations, care management, pharmacy, and health outcomes improvement.
  - Continued evolution of a team-based model of care management for at-risk members identified by UM and providers (e.g., care transitions hospital-to-home).
  - Integration of UM process with and referral of high-risk members to new mandated benefits (Health Homes, Palliative) to eligible high-risk members.
  - Contribute to the evolving integration of clinical operations with other Health Services departments: care management, pharmacy, and health outcomes improvement; establishes department objectives and metrics in alignment with organizational goals, and support management in reaching these goals.
  - Manage and continuously improve the Utilization Management process to maintain full compliance with state regulatory requirements and relevant NCQA accreditation standards. Maintain the department in a perpetual state of audit readiness.
  - Develop and implement UM process redesign and programmatic improvements to improve efficiency, quality, performance, and reduce administrative expense without compromising results and customer service.
  - Provide oversight of the dedicated RN for UM delegation oversight
  - Provide leadership to support the continued evolution of an effective discharge planning/care transitions program, specifically the development of an on-site staff model and key hospital partners.
  - Provide strategic guidance of UM prior authorization and concurrent review strategy to balance reduction of avoidable costs and administrative burden to the provider community.
  - Support all managers to create high-performing teams, including coaching staff to meet and exceed individual and department goals; manage conflict constructively within the department and promote a healthy team atmosphere.
  - Interface directly with the Plan IPAs/medical groups, community programs, state programs and hospitals to ensure coordinated, continuous cost-effective quality health care for members.
  - Oversee the UM components of the annual medical group oversight audits conducted by SFHP, develop corrective action plans (CAP) if needed, and monitor CAP to ensure implementation, appropriate resolution, and the reporting of such to Medical Director and QI Committee.
  - Ensure the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
  - Maintain an awareness of trends and regulations in the industry. Use data to modify programs to reflect customer, corporate and market changes. Ensure advance input from and communications to all stakeholders regarding policy/program changes.
  - Maintain collaborative ongoing relationships in support of the managed care organization with internal and external entities and partners.
  - Ensure managed care programs are compliant with all regulatory and accreditation requirements.

Clinical Operations Administrative Team

- Manager, Clinical Operations
  - Bachelor's degree or equivalent work experience.
  - Maximizes staff performance on efficiency and productivity, oversees tasks and projects, ensuring they are completed timely and accurately.
  - Trains, coaches, motivates, and updates staff. Provides positive and constructive feedback to staff and acts when appropriate.
  - Serve as a strategic and educational support to designated team members in CO processes as well as organizational initiatives.
  - Mentors, develops, and maintains a team of CO analysts, program managers, trainers, DMG clinical quality and administrative support staff.
  - Analyzes team composition and adequacy for the needs of the department and develops and implements strategies to address any deficiencies.
  - Recruits quality employees for CO and updates job descriptions.
  - Builds and executes effective strategies to preserve and optimize existing internal and external relationships while aligning with SFHP strategic goals.
  - Ensures metrics and goals of both SFHP and the department are achieved.
  - Ensures accurate and effective management of department data in accordance with all regulatory and NCQA requirements.
  - Ensures that confidentiality of member information is maintained, and that staff maintains compliance with HIPAA regulations.
  - Maintains ongoing knowledge of developing trends in department data and its impact on those who utilize it.
  - Updates SFHP policies and procedures and desk-top procedures pertaining to designated Clinical Operations areas.
  - Evaluates, streamlines, and redesigns processes. Implements new procedures in the operational process when needed.
  - Enhances department operations continuously by contributing information and recommendations for strategic planning and reviews, implements productivity, quality, and customer-service standards, trends, and determines system improvements.
  - In a prompt and efficient manner: investigate, trouble shoot and solve both standard and non-standard requests.
  - Detects and diagnoses issues and collaborates with other departments to resolve problems.
  - Represents CO Department and provides internal and external presentations as required.
  - Works closely with other departments on cross functional projects and provides timely updates.
  - Organizes and prioritizes the department's workload.
  - Performs applicable cost-benefit and comparative analysis.
  - Prepares budget and manages expenses for designated department areas.
  - Provides timely updates to Director, Clinical Operations
  - Performs additional duties as assigned.
- Clinical Operations Analyst (Reporting)
  - Bachelor's degree or equivalent work experience.
  - 3 or more years Business User Experience Testing (UAT) experience working with all phases of technical user testing development with a focus on integrations to produce efficiencies and improvements.
  - Creates high level performance test plans, detailed test cases and performance testing scripts.
  - Critically evaluates information gathered from multiple sources, reconciles conflicts, decomposes high-level information into details, abstract up from low-level information to a general understanding, and distinguishes user requests from the underlying true needs.
  - Ability to develop, execute and update test cases for User Acceptance Testing (UAT) that supports requirements for operational systems including but not limited to QNXT and Essette while understanding the upstream and downstream impacts.

  - Maintains all related user test cases.
  - Supports tracking of defects that are related to integrations user test scenarios.
  - Identifies business process improvements that are aligned with and supportive of SFHP business goals and objectives. Provides thoughtful analyses and recommendations.
  - Supports the Clinical Operations team by working to define, understand and document report requirements, translating business needs into defined report requirements.
  - Responds to ad-hoc requests for data from Clinical Operations leadership and other team members.
  - Conducts and continuously improves reporting to ensure reliability, validity and integrity of the data used in management reporting and analysis.
  - Responsible for maintaining accurate monthly Clinical Operation's Director and CMO dashboards.
  - Demonstrates expertise in researching and trouble-shooting medical authorizations and claims.
  - Ability to create, analyze, and report on UM Trends, patterns, and potential impacts.
- Clinical Operations Analyst (Policy and Programs)
  - Bachelor's degree or equivalent work experience.
  - Develops and revises Clinical Operations policies and presents these policies to UM Committee and the Policy and Compliance Committee for review and approval.
  - Conducts basic compilation, organization, and analysis of data to evaluate current projects and inform the development of new projects.
  - Develops work plans for achieving strategic goals and implementing projects impacting the Clinical Operations team.
  - Assists in developing reports and conducting analysis to identify and manage Clinical Operations process improvements and quality efforts.
  - Works with UM Program Manager and Clinical Operations leadership to facilitate Clinical Operations regulatory and accreditation audit processes.
  - Creates and maintains Clinical Operations documents such as Desk Top Processes and reference materials.
  - Maintains databases as needed for reporting requirements.
  - Ensures the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
  - Manages relationships with relevant stakeholders as needed to ensure successful outcomes.
  - Supports Project/Program Managers with implementation and enhancement projects.
- Program Manager, Clinical Operations
  - Bachelor's degree in health care administration or a related field or equivalent experience. Master's degree in healthcare field is desired.
  - Minimum 2 years of experience working in health care delivery system and/or employment at a health plan; experience with Medi-Cal or Department of Health Service regulations.
  - Leadership in a number of high-performing project teams, to ensure that project work is measurable, impactful, and consistent with organizational goals and objectives.
  - Participation in work plan development, timely completion of work, mid-term, and long-term strategic planning.
  - Create project and communication plans and schedules to include mapping, workflow diagrams and timetables.
  - Planning and ensuring that new project requirements remain in compliance with all DHCS regulatory requirements.
  - Manage projects from inception to completion and meet those requirements.
  - Review current business processes and devise improvement strategies.
  - Oversight and leadership of updates to departmental policies and procedures to include business and some technical writing.
  - Train Clinical Operations staff on core processes and system changes.
- Clinical Quality and Delegated Medical Group Oversight Nurse
  - A current State of California RN license to practice without restriction.

  - At least 2 years of clinical experience is required.
  - Acts as a liaison between SFHP Clinical Operations team and the delegated medical groups.
  - Provides assistance to other Clinical Operations Team members to resolve delegated group-related issues. Ensures delegated provider inquiries are properly and effectively handled, and promptly followed up on.
  - Utilizes medical group data to prepare and track program performance, utilization, and quality review reports for delegated medical groups and SFHP and follows up on corrective actions.
  - Conducts monthly review of delegated groups' work plans, denial logs, and reports, and provides feedback as needed.
  - Conducts the clinical review of SFHP's internal audits on a quarterly basis and assists in addressing any findings.
  - Conducts ad hoc trainings for the delegated medical groups on SFHP policies.
  - Completes annual delegated medical group oversight audits for utilization management and follows up on corrective actions.
  - Participates in the review of the Delegation Grid.
  - Participates in all Provider Network Outreach Committee (PNOC) and Utilization Management Committee (UMC) meetings.
  - Actively contributes toward program goals, process improvements, and continuously improves the managed care processes.
  - May review the clinical administration of all SFHP delegates, e.g., the Institute on Aging (IOA), Carelon Behavioral Health, and American Specialty Health (ASH) to ensure utilization management requirements and quality standards are met.
  - Participates in the development and review of policies and procedures.
- UM Clinical Nurse Auditor and Trainer
  - Develops and implements staff training for new and existing employees along with internal findings.
  - Trains Clinical Operations staff as appropriate regarding use of all platforms and core systems as it relates to UM processes (Essette, QNXT, Jiva, MCG etc.)
  - Provides one-on-one training to improve staff efficiency.
  - Works with Clinical Operations management to certify learners and maintain training records.
  - Subject matter expert/trainer on the implementation of any new software or processes.
  - Performs audits on clinical and non-clinical staff performance and summarizes and reports results to Clinical Operations management for process improvements.
  - Performs regular internal audits on all UM files to ensure compliance with all NCQA, DHCS and DMHC requirements.
  - Performs periodic audits of UM decision making assessing for appropriateness and accuracy of documentation.
  - In coordination with Clinical Operations Analyst identifies opportunities for improvements and trains staff on process changes and policy updates.
  - Maintains knowledge of SFHP policies and procedures as it related the UM processes.
  - Keeps current with all new and existing regulatory requirements.
  - Shares information with other departments as necessary.
  - Collaborates with all Clinical Operations staff and Medical directors as needed to ensure quality and cost-effective care.
  - This position does not directly manage personnel but requires teamwork with licensed and non-licensed staff.
  - Other job duties as assigned.
- Transportation Coordinator
  - Coordinates the authorization and documentation processes associated with non-emergency medical transportation for eligible SFHP members, with duties including but not limited to:
    - Answering phone calls from vendors, providers, and members through the department's Automatic Call Distribution line.

        - Conducting telephone interviews with members, family members and/or significant others to determine members' transportation needs.
        - Preparing transportation requests and distributing to appropriate team member for review.
        - Obtaining and entering authorization requests for services.
        - Utilizing case management system to complete authorizations, document, and update transportation case information, and ensure that transportation requests are entered and assigned appropriately.
        - Performing administrative duties to track, organize, monitor and follow-up on current and new transportation requests.
        - Making recommendations and implementing program improvements that strengthen members' access to transportation services.
        - Ensuring that all requests for Non-Emergency Medical Transportation are completed according to the state mandated guidelines.
    - Works with members, transportation vendors, provider offices, and SFHP staff to ensure effectiveness of transportation services, with duties including but not limited to:
        - Working with provider offices to determine the date and time of members' appointments.
        - Scheduling urgent and non-urgent NEMT requests from providers and members
        - Communicating issues and concerns related to transportation services to the relevant vendor in a timely manner.
        - Working with SFHP staff to gather information and resolve issues related to transportation cases.
        - Ensuring that transportation cases are routed appropriately.
        - Seeking guidance and direction from clinical staff regarding appropriateness of requested transportation service, as needed.
        - Assessing member satisfaction with transportation arrangements.
        - Identifying opportunities for improvement and making recommendations to improve member care.

Clinical Operations / Prior Authorization Team

- UM Nurse Manager, Prior Authorization
    - Valid unrestricted Registered Nurse or Nurse Practitioner license in the state of California.
    - Manage Prior Authorization team.
    - Serve as liaison to medical and ancillary providers to ensure SFHP members receive appropriate care.
    - Work with Sr. Manager, Prior Authorizations, Director, Clinical Operations, Medical Director(s), and other key stakeholders to ensure appropriate UM criteria are developed and practiced.
    - Conduct analysis of prior authorization trends and develop/implement appropriate action plans.
    - Manage clinically related authorization and claims issues.
    - Ensure effective collaboration between UM functions and care management and care coordination pharmacy programs.
    - Utilization management includes review of prior authorization requests and coordination with the Medical Director(s) to ensure members receive medically necessary services within their medical group.
    - Oversee quality initiatives and metrics for the Prior Authorizations Team.
    - Ensure appropriate documentation of Prior Authorization UM processes and procedures.
    - Service as Subject Matter Expert/Business Lead in organization-wide Clinical Operations initiatives.
- Lead Nurse, Prior Authorization
    - Current Registered Nurse license in the State of California without restriction.
    - Nursing and general business experience.

  - Designated backup for managerial work in manager absence.
  - Identifying areas of improvement and working independently on solutions.
  - Ability to lead Prior Authorization Nurses in applying clinical criteria to ensure appropriate administration of benefits based on the relevant SFHP policies, MCG criteria and Medicaid/Medicare policy.
  - Ability to lead Prior Authorization Nurses in coordination of care as appropriate.
  - Ability to lead Prior Authorization Nurses in coordination of care for members requiring services from community agencies, the department of public health, and Medi-Cal carve-out and waiver programs.
  - Ability to lead Prior Authorization Nurses in coordination of the preauthorization process for critical services including second opinions, independent medical review, and experimental and investigational services.
  - Serves as a subject matter expert on initiatives.
  - Utilization management, including review of 15-30 clinical requests per day.
  - Coordination with the medical director to ensure members receive appropriate services within their medical group as medically appropriate.
- UM Nurse
  - Current Registered Nurse license in the State of California without restriction.
  - Two to five years of acute clinical experience in a hospital.
  - Primary responsibility will be reviewing prior and retrospective authorization requests for elective procedures, specialty and ambulatory services, and medical supplies and equipment.
  - Back-up concurrent review responsibilities include reviewing acute admission authorization requests and working closely with hospitals on discharge planning and care coordination.
  - Back-up long-term care review responsibilities include working closely with facilities to perform pre-authorization, concurrent, and post-service review for members in Long Term Care (LTC) facilities, ensuring appropriate placement and care planning, and facilitating discharge planning and care coordination.
  - Back-up post-acute responsibilities include determining appropriate post-acute placement, ensuring appropriate care was implemented upon admission, and facilitating care coordination.
- Prior Authorization Nurse I
  - Current Registered Nurse license in the State of California without restriction.
  - Nursing and general business experience.
  - Utilization management, including review of 15-30 clinical requests per day. Coordination with the medical director to ensure members receive appropriate services within their medical group as medically appropriate.
  - Collaboration with Medical Director.
  - Coordination of care for members as appropriate.
  - Coordination of the preauthorization process for medical group services including second opinions, independent medical review, and experimental and investigational services.
  - Collaboration with team members on cross-departmental improvement efforts: quality improvement projects, member satisfaction improvement, and decreasing avoidable ER use.
- Prior Authorization Nurse II
  - Valid unrestricted Registered Nurse license in the state of California.
  - Mix of nursing and general business experience.
  - May serve as a subject matter expert on initiatives.
  - Assist Nurse Manager and Senior Manager in hiring and ongoing training of staff.
  - Utilization management, including review of 15-30 clinical requests per day. Coordination with the medical director to ensure members receive appropriate services within their medical group as medically appropriate.
  - Collaboration with Medical Director.
  - Coordination of care for members as appropriate.

    - Coordination of the preauthorization process for medical group services including second opinions, independent medical review, and experimental and investigational services.
    - Collaboration with team members on cross-departmental improvement efforts: quality improvement projects, member satisfaction improvement, and decreasing avoidable ER use.
- Supervisor, Prior Authorizations Coordinators
    - Bachelor's degree in business management or health care administration or equivalent combination of education and experience.
    - Supervises PA Coordinators.
    - Trains, develops, and coaches PA Coordinators.
    - Assists in hiring PA Coordinators.
    - Works collaboratively with PA Nurses and Managers, Medical Directors, and all Health Services Staff.
    - Responsible for daily operational work planning and organization to ensure operational efficiency and effectiveness of the department.
    - Demonstrates expertise in researching and trouble-shooting issues that arise.
    - Provides assistance to PA coordinators to resolve issues.
    - Ensures that staff handle provider inquiries properly and effectively, and promptly follows up on provider issues.
    - Ability to lead staff in applying critical thinking skills.
    - Works with Clinical Operations Managers and Director to set up departmental goals. Communicates goals to PA coordinators and motivates staff to achieve goals.
    - Evaluates performance and addresses performance issues of PA coordinators.
    - Develops, maintains and is responsible for effective new hire onboarding and ongoing training needs.
    - Participates in the identification and execution of operational performance improvement opportunities and activities.
    - Fosters and maintains relationships with providers and associated staff.
    - Assists in developing reports and conducts analysis to help improve processes to meet provider and regulatory requirements.
    - Conducts staff auditing to improve processes and ensures regulatory compliance.
    - Develops, updates, and maintains policies and desk top procedures development and maintenance as applicable.
    - Works to ensure software systems continues to meet business needs and provides guidance and training of enhancements. Creates and tracks turnaround time, performance, and utilization reports.
    - Ensures the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
    - Organizes, facilitates, and attends direct report huddles at established times, and contributes to regular team meetings.
    - Participates in tactical and strategic department and organizational initiatives.
    - Contributes to fiscal year budget assessments and ongoing budget analysis.
    - Escalates issues to manager when necessary.
    - Other related duties as assigned.
- Prior Authorizations Specialist
    - One year of experience with state and federal insurance programs, either from a provider or payer setting.
    - One year of experience in customer service, call center setting.
    - A Bachelor's degree or equivalent work experience.
    - Knowledge of medical terminology and familiarity with diagnosis and service codes (ICD/CPT/HCPCS).
    - Assist the UM Nurse Manager, Prior Authorizations with daily management of authorization processing, including scheduling PA Coordinator daily assignments.
    - Demonstrates expertise in researching and trouble-shooting authorizations.
    - Troubleshoot and resolve problems resulting from operational inefficiencies and quality issues.

    - Manages incoming coverage authorization requests, entering them into the Essette care management software or re-directing them to appropriate entities outside SFHP.
    - Processes authorization requests using SFHP policies and procedures and electronic resources and refers cases to the Prior Authorization Nurse as appropriate for medical necessity and/or benefit review within mandated regulatory timeframes.
    - Works closely with provider, facility and vendor office and delegated group staff to promptly answer questions and resolve issues related to authorizations.
    - Ensures the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
    - Maintains accurate and timely documentation of provider calls within authorization records.
    - Maintains databases as needed for reporting requirements.
- Prior Authorization Coordinator
    - One year of experience with state and federal insurance programs, either from a provider or payer setting.
    - One year of experience in a customer service, call center setting.
    - A bachelor's degree in social sciences, life sciences, business, or a related field, preferred or equivalent work experience.
    - Knowledge of medical terminology and familiarity with diagnosis and service codes (ICD/CPT/HCPCS).
    - Manages incoming coverage authorization requests, entering them into the Essette care management software or re-directing them to appropriate entities outside SFHP.
    - Processes authorization requests using SFHP policies and procedures and electronic resources and refers cases to the Prior Authorization Nurse as appropriate for medical necessity and/or benefit review within mandated regulatory timeframes.
    - Works closely with provider, facility and vendor office and delegated group staff to promptly answer questions and resolve issues related to authorizations.
    - Ensures the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
    - Maintains accurate and timely documentation of provider calls within authorization records.
    - Maintains databases as needed for reporting requirements.

Clinical Operations / Concurrent Review Teams

- Senior Manager, Clinical Operations, Concurrent Review
    - Valid unrestricted Registered Nurse or Nurse Practitioner license in the state of California
    - Manage Concurrent Review and Post-Acute team, including remote nurses .
    - Serve as liaison to acute care and post-acute care hospitals to ensure SFHP members are receiving appropriate care.
    - Responsible for the monitoring and oversight of Inpatient UM management activities and hospital relationship management
    - Ensure NCQA, DHCS, and DMHC regulatory compliance in concurrent review and discharge planning.
    - Review utilization management metrics and provide analysis and action plans for over and underutilization, readmission rates, and trending.
    - Assure effective collaboration between UM functions and care management and care coordination pharmacy programs.
    - Act as interim concurrent review and care transitions lead for escalating concerns when the Director, Clinical Operations is not available.
    - Work with Director, Clinical Operations and Medical Director(s) to ensure appropriate clinical criteria are developed and practiced.
    - Inpatient utilization management includes review of clinical requests, and coordination with the Medical Director(s) to ensure members receive appropriate services within their medical group.

    - Collaboration with hospital leadership staff to build quality, cost-effective care transition processes.
    - Primary oversight of quality initiatives and metrics for Concurrent Review Team.
    - Primary oversight of appropriate documentation of Concurrent Review and Care Transitions processes and procedures.
    - Ensures the privacy and security of PHI (Private Health Information) as outlined in SFHPs policies and procedures relating to HIPAA compliance.
    - Collaboration with Medical Director, Director, Clinical Operations and Prior Authorizations Manager to develop and implement clinical criteria to ensure evidence-based care that reflects current regulations and SFHP policy.
- Manager, Concurrent Review and Care Transitions
    - Valid unrestricted Registered Nurse or Nurse Practitioner license in the state of California
    - Manage Concurrent Review team, including remote nurses and on-site care transitions nurse.
    - Serve as liaison to acute care and post-acute care hospitals to ensure SFHP members are receiving appropriate care.
    - Trains, coaches, and assists in hiring CCR/C Nurses
    - Develop and manage the care transitions program.
    - Leads staff in applying critical thinking skills utilizing clinical assessment skills, SFHP policies and knowledge of patient care to make decisions on level of care or medical necessity of services and determines which cases need to be escalated to the medical director.
    - Ensure NCQA, DHCS, and DMHC regulatory compliance in concurrent review and care transitions discharge planning.
    - Review utilization management metrics and provide analysis and action plans for over and underutilization, readmission rates, and trending.
    - Assure effective collaboration between UM functions and care management and care coordination pharmacy programs.
    - Act as interim concurrent review and care transitions lead for escalating concerns when the Senior Manager Director, Clinical Operations is not available.
    - Work with Director and Senior Manager, Clinical Operations and Medical Director(s) to ensure appropriate clinical criteria are developed and practiced.
    - Inpatient utilization management including review of clinical requests, and coordination with the Medical Director(s) to ensure members receive appropriate services within their medical group.
    - Collaboration with hospital leadership staff to build quality, cost-effective care transition processes.
    - Oversee quality initiatives and metrics for Concurrent Review Team.
    - Ensure appropriate documentation of Concurrent Review and Care Transitions processes and procedures.
    - Collaboration with Medical Director, Director, Clinical Operations, Concurrent Review Senior Manager and Prior Authorizations Senior Manager to develop and implement clinical criteria to ensure evidence-based care that reflects current regulations and SFHP policy.
- Nurse Supervisor, CCR
    - A valid unrestricted Registered Nurse license in the state of California
    - A Bachelor’s degree in business or a health care related field preferred but not required
    - 2-5 years of acute clinical experience in a hospital required.
    - At least 2 years of managed care experience in case management, resource management or utilization review preferred.
    - Supervises Concurrent Review and Care Transitions (CCR/CT) Nurses
    - Trains, coaches and assists in hiring CCR/CT Nurses
    - Maintains CCR/CT Nurse Schedule
    - Works collaboratively with the CCR/CT Nurses, UM Coordinators, all Health Services staff, Managers and Medical Directors.

- Concurrent Review Nurse
    - Valid unrestricted Registered Nurse or Licensed Vocational Nurse license in the state of California.
    - Two to five years of acute clinical experience in a hospital.
    - Able to collect patient information and utilize clinical assessment skills to make decisions regarding medical necessity of services.
    - Able to determine which cases should be referred to the Medical Director for evaluation.
    - Able to apply clinical criteria and guidelines to ensure appropriate administration of benefits and optimum medical outcomes based on the use of relevant SFHP policies, MCG criteria and Medi-Cal guidelines.
    - Conducts discharge planning assessments upon admission for hospitalized members to help identify those at high risk for readmission and to facilitate early discharge planning.
    - Re-evaluates discharge needs throughout hospitalization to anticipate any new or changing needs.
    - Identifies members for various clinical programs (including care management, palliative care, and advanced primary care etc.).
    - Conducts post discharge follow-up phone calls to ensure discharge needs are met.
    - Works closely with hospital case managers to repatriate qualifying members back to member's designated home hospital.
    - Collaboration with Medical Directors to ensure quality and cost-effective care.
    - Coordination of care to help facilitate services such as home health, skilled nursing, DME, transportation etc.
    - Coordination of care for members requiring services from community agencies, the department of public health, and Medi-Cal carve-out and waiver programs.
    - Collaborates with team members on cross-departmental improvement efforts: quality improvement projects, optimization of cost management, member satisfaction improvement, and decreasing out of medical group hospital admissions.
- Concurrent Review Nurse II
    - Valid unrestricted Registered Nursing License in the state of California.
    - Two to five years of acute clinical experience in a hospital required.
    - Able to collect patient information and utilize clinical assessment skills to make decisions regarding medical necessity of services.
    - Able to determine which cases should be referred to the Medical Director for evaluation.
    - Able to apply clinical criteria and guidelines to ensure appropriate administration of benefits and optimum medical outcomes based on the use of relevant SFHP policies, InterQual criteria and Medi-Cal guidelines.
    - Conducts discharge planning assessments upon admission for hospitalized members to help identify those at high risk for readmission and to facilitate early discharge planning.
    - Re-evaluates discharge needs throughout hospitalization to anticipate any new or changing needs.
    - Identifies members for various clinical programs (e.g., care management, palliative care, and advanced primary care etc.).
    - Conducts post-discharge follow-up phone calls to ensure discharge needs are met.
    - Works closely with hospital case managers to repatriate qualifying members back to member's designated home hospital.
    - Collaboration with Medical Directors to ensure quality and cost-effective care.
    - Meets departmental review and documentation standards for work assignments including compliance with mandated turnaround times for decisions and provider/member communication.
    - Coordination of care to help facilitate services such as home health, skilled nursing, subacute, LTAC, infusion center, PT/OT, and speech therapy.
    - Coordination of care for members requiring services from community agencies, the department of public health, and Medi-Cal carve-out and waiver programs.
- Supervisor, Concurrent Review (Coordinators
    - Bachelor's degree in business management or health care administration or a related field

  - Previous supervisory experience strongly preferred.
  - 2-3 years of managed care experience preferred
  - Supervises CCR Coordinators
  - Trains, develops and coaches CCR coordinators
  - Assists in hiring CCR coordinators.
  - Works collaboratively with CCR Nurses and CT team nurses, PA Managers, Medical Directors, and all Health Services Staff
  - Plans and organizes daily operational work to ensure operational efficiency and effectiveness of the department.
  - Demonstrates expertise in researching and trouble-shooting issues that arise. Provides assistance to CCR coordinators to resolve issues. Ensures that staff handle provider inquiries properly and effectively, and promptly follows up on provider issues.
  - Works with CCR and PA Nurse Managers and Director to set up departmental goals. Communicates goals to CCR coordinators and motivates staff to achieve goals.
  - Develops and maintains training programs for new hires and ongoing training needs
  - Participate in the identification of operational performance improvement opportunities and in performance improvement activities
  - Fosters and maintains relationships with providers and associated staff.
  - Assists in developing reports and conducts analysis to help improve processes to meet provider and regulatory requirements.
  - Conducts ad hoc auditing to improve processes and ensures regulatory compliance
  - Develops, updates, and maintains policies and procedures as applicable
  - Works to ensure software systems continues to meet business needs and provides guidance and training of enhancements. Creates and tracks census, performance, and utilization reports.
  - Continuously improves the managed care process and pipeline of new opportunities to support Utilization Management.
  - Ensures the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
  - Participates in tactical and strategic department and organizational initiatives.
  - Reviews and approves policies and standard desktop procedures that may affect the department, workflows, and resources.
- Concurrent Review Coordinator
  - One year of experience with state and federal insurance programs.
  - One year of experience in a customer service, call center setting.
  - A Bachelor's degree in Health, Social or Life Sciences, Business, or a related field, preferred or equivalent work experience.
  - Research utilization management requests using a variety of resources including SFHP evidence of coverage, policies and procedures, and electronic resources.
  - Compiles data for utilization management review and submits the data to the Concurrent Review & Care Transitions nurse team for clinical decision-making.
  - Maintains ongoing tracking and appropriate documentation to facilitate the determination process within the regulatory timeframes for standard and urgent authorization requests.
  - Assists in discharge planning efforts for members requiring post discharge follow-up care through telephonic coordination with primary care providers.
  - Communicates effectively and timely to answer questions and resolve issues pertaining to providers, office staff, and delegated groups about authorization requests and determinations.
  - Responds to calls, emails, and other inquiries regarding the status of outstanding clinical requests and utilization management processes Ensures the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
  - Maintains an accurate census of SFHP members.
  - Works closely with providers to obtain accurate information regarding authorization requests.

  - Ensures correspondence distribution compliance by working closely with designated clinicians to generate Notice of Action (NOA) letters for the requesting providers and members.
  - Utilize and operate multiple software applications systems. Enters required data in various computer programs and databases.
  - Maintains designated databases as needed for reporting requirements.
  - Participates in making member phone calls working from a script and identifying when calls need to be referred to a clinician for review.
- Concurrent Review Specialist
  - Baccalaureate degree or equivalent work experience.
  - At least three years of experience in health plan operations, health care clinical quality improvement, or other experience directly related to position duties and knowledge.
  - Serves as a subject matter expert (SME) in concurrent review requests using a variety of resources including SFHP evidence of coverage, policies and procedures, and electronic resources.
  - Conducts monthly audits to ensure team concordance as well as identify trends and opportunities for enhancements, reporting results to supervisor.
  - Assists in upkeep of all CCR team training documentation.
  - Assists the Supervisor, Concurrent Review & Care Transitions Coordinators with daily management of authorization processing, including tracking and reporting of metrics, and leading weekly huddle. Transcribes huddle discussions and actions.
  - Manages SFHN and SFCCC post-discharge appointment processes and acts as lead communication liaison between Clinical Operations and its contracted clinics, hospitals, post-acute facilities, and community partners regarding post-discharge appointments.
  - Serves as an SME in Maternity Kick reporting.
  - Compiles data for utilization management review and submits the data to the Concurrent Review & Care Transitions nurse team for clinical decision-making.
  - Maintains ongoing tracking and appropriate documentation to promote decision accuracy.
  - Serves as SME for concurrent review coordinator responsibilities in the Essette system.
  - Completes hospital authorization status reports as well as primary care clinic admission reports.
  - Answers questions and resolves issues promptly from provider, office staff and delegated groups about authorization requests and determinations.
  - Communicates efficiently, effectively, and timely to answer questions and resolves issues pertaining to insurance payer verification, utilization management processes and authorization determination statuses.
- Post-Acute Nurse I
  - Collects pertinent patient medical/social information and utilizes clinical assessment skills to make decisions regarding medical necessity of services, in order to determine appropriate post-acute placement.
  - Works closely with hospital case managers and admission coordinators to facilitate transfer from hospital setting to appropriate post-acute setting. Provides similar facilitation for members admitting from the home, board and care or similar setting.
  - Applies clinical criteria and guidelines to ensure appropriate administration of benefits and optimum medical outcomes based on the use of relevant SFHP policies, InterQual or MCG criteria and Medi-Cal guidelines
  - Authorizes placement and manages process of care coordination for members requiring services from community agencies, the department of public health, and Medi-Cal carve-out and waiver programs.
  - Conducts review of clinical data after admission to ensure appropriate care was implemented by post-acute facility and makes determination of care days based on application of InterQual or MCG criteria.
  - Follows-up with facility as needed or requested to ensure member needs are met based on medical necessity.
  - Identifies and refers members for various clinical programs within SFHP.

  - Determines which cases should be referred to the Medical Director for evaluation of appropriate placement to ensure quality and cost-effective care.
  - Collaborates with team members on cross-departmental improvement efforts, such as quality improvement projects, optimization of cost management, care transition planning and decreasing hospital readmissions.
  - Manages large workload, requiring frequent evaluation of priorities within a given workday.
  - Maintains business hours availability to respond to both internal and external customer inquiries, questions, discussions, issues, and resolutions, as it relates to post-acute.
  - Meets departmental review and documentation standards for work assignments including compliance with mandated turnaround times for decisions and provider/member communication.
  - Assists in ongoing development of the Post-Acute Placement program and re-evaluates as needed.
  - Represents the Post-Acute Placement program to internal and external customers.
  - Serves as health plan's point of contact for outside agencies, hospitals, and post-acute facilities for post-acute placement.
  - Maintains privacy and confidentiality practices in accordance with regulation standards.
  - Participates in scheduled staff meetings or trainings.
  - This position does not directly manage personnel but requires extensive teamwork with licensed and non-licensed staff within SFHP.
  - It is not intended that the above listed duties and responsibilities reflect every job duty, responsibility, or task that the employee may be called upon to perform. The employee is expected to perform all job-related duties and tasks assigned by his/her manager or other authorized employees. SFHP management retains the right, in its sole discretion, to add, to delete, change or modify the duties and responsibilities of this position at any time in accordance with its business needs.
  - Other duties as assigned.
- Post-Acute Care Nurse II
  - Valid unrestricted Registered Nursing License in the state of California.
  - Collects pertinent patient medical/social information and utilizes clinical assessment skills to make decisions regarding medical necessity of services, in order to determine appropriate post-acute placement.
  - Works closely with hospital case managers and admission coordinators to facilitate transfer from hospital setting to appropriate post-acute setting. Provides similar facilitation for members admitting from the home, board and care or similar setting.
  - Authorizes placement and manages process of care coordination for members requiring services from community agencies, the Department of Public Health, and Medi-Cal carve-outs.
  - Conducts review of clinical data after admission to ensure appropriate care was implemented by post-acute facility and makes determination of care days based on application of MCG criteria guidelines.
  - Applies clinical criteria and guidelines to ensure appropriate administration of benefits and optimum medical outcomes based on the use of relevant SFHP policies, MCG criteria and Medi-Cal guidelines.
  - Follows-up with facility as needed or requested to ensure member needs are met based on medical necessity.
  - Determines which cases should be referred to the Medical Director for evaluation of appropriate placement to ensure quality and cost-effective care.
  - Collaborates with team members on cross-departmental improvement efforts, such as quality improvement projects, optimization of cost management, care transition planning and decreasing hospital readmissions.
  - Meets departmental review and documentation standards for work assignments including compliance with mandated turnaround times for decisions and provider/member communication.
  - Maintains privacy and confidentiality practices in accordance with regulation standards.

    - Serves as health plan's point of contact both internally and for outside agencies, hospitals, and post-acute facilities for post-acute placement.
    - Assists in ongoing development of the Post-Acute Placement program and re-evaluates as needed.
    - Represents the Post-Acute Placement program to internal and external customers.
    - Maintains business hours availability to respond to both internal and external customer inquiries, questions, discussions, issues, and resolutions, as it relates to post-acute care.
    - Assists in ongoing development of the Post-Acute Placement program and re-evaluates as needed.
- Complex Discharge Coordinator
    - One year of experience in a customer service, call center setting preferred
    - A Bachelor's degree in Health, Social or Life Sciences, Business or a related field, preferred or equivalent work experience.
    - Experience working as a medical assistant or pharmacy technician with medical terminology and concepts preferred.
    - Two years or more experience working in a clinical or community resource setting; Care Coordination skills desirable.
    - Compiles pertinent medical/social information and other data collection efforts at the direction of clinical staff.
    - Works closely with hospital case managers and admission coordinators to obtain accurate information regarding placement requests to facilitate transfer from hospital setting to appropriate post-acute setting. May provide similar facilitation for members admitting from home, board and care or similar settings.
    - Follows-up w/post-acute facility referrals made by hospitals to obtain any changes in bed availability or acuity capacity changes per the direction of clinical staff. Facilitates provision of additional clinical information needed or questions about member that post-acute facilities may have to determine acceptance.
    - Supports placement and care coordination efforts for identified members with complex needs requiring services from community agencies, the department of public health, and Medi-Cal carve-out and waiver programs.
    - Supports clinical staff in department and provider case conferences regarding members with complex discharge needs to identify and address placement barriers.
    - Meets departmental review and documentation standards for work assignments including compliance with mandated turnaround times for decisions, regulatory timeframes, and provider/member communication.
    - Assists in ongoing development of complex placement processes and provides required data for metrics and tracking purposes.
    - Supports efforts in collaboration with team members on cross-departmental improvement efforts, such as quality improvement projects, care transitions planning and decreasing hospital readmissions.

Clinical Operations / Long-Term Care

- Manager, Long Term Care Nurses
    - Builds a robust, multidisciplinary LTC team.
    - Oversight and performance of LTC team (remote and on-site LTC staff) including adherence to department standards of documentation and auditing.
    - Acts as an escalation point for clinical and operational issues from staff, members, and providers.
    - Serves as liaison to skilled nursing facilities (SNF), sub-acute and intermediate care facilities (ICF) to ensure SFHP members are receiving appropriate care.
    - Develops strong relationships with hospitals and community partners to ensure safe and effective transitions for our members.
    - Collaborates with SNF, sub-acute and ICF staff and leadership to build quality, cost-effective care transition processes.
    - Develops and manages the eligibility, operational, and transitional aspects of the LTC benefit (both utilization and care management components).

  - Ensures partnership with cross functional efforts specifically other CalAIM benefits (Enhanced Care Management and Community Supports).
  - Ensures effective collaboration between UM and CM functions.
  - Actively works with Health Services management to integrate departmental workflows and care provided to our members.
  - Collaborates effectively with other departments including, but not limited to: Care Management, Provider Network Operations, Information Technology, Business Analytics, Customer Services, Compliance, Appeals and Grievances, Claims, Pharmacy and Marketing.
  - Ensures NCQA, DHCS, and DMHC regulatory compliance in LTC are met.
  - Reviews utilization and case management metrics and provide analysis and action plans
  - Monitors over and underutilization of LTC services and develops an action plan.
  - Oversees quality initiatives and metrics for LTC.
  - Develops, monitors, and ensures LTC Key Performance Indicators (KPIs) are met.
  - Ensures appropriate documentation of LTC processes and procedures.
  - Collaborates with Medical Director, and Director, Clinical Operations to develop and implement clinical criteria to ensure evidence-based care that reflects current regulations and SFHP policy.
  - Responsible for development and management of LTC budget.
  - Periodically present to both internal and external stakeholders on Care Management program updates and outcomes.
- Long Term Care Review Nurse
  - Valid unrestricted Registered Nurse or Licensed Vocational Nurse license in the state of California
  - Able to collect patient information and utilize clinical assessment skills to make decisions regarding medical necessity of services.
  - Able to define issues, conduct research, collect and review data and contribute to the evaluation of options and individualized interventions.
  - Able to apply clinical and non-clinical criteria and guidelines to ensure appropriate administration of benefits and optimum medical outcomes based on the use of relevant SFHP policies, MCG criteria and Medi-Cal guidelines.
  - Performs pre-authorization, concurrent and post-service review for members in Long Term Care (LTC) facilities using established criteria and protocols, to ensure needs are being met and in alignment with SFHP policies. At times this may require on-site review for major in-the-area facilities or remote review for out-of-area facilities.
  - Conducts intake admission assessments for members admitted to a long-term care (LTC) environment to ensure appropriate placement and plan of care established.
  - Works closely with hospital or post-acute facility staff to evaluate transition requirements throughout hospitalization or post-acute stay to anticipate any new or changing needs.
  - Identifies members for various Health Services programs, completing, submitting and following-up on referrals as applicable (including care management, disease management, chronic conditions, palliative care etc.)
  - Meets departmental review and documentation standards for work assignments including compliance with mandated turnaround times for decisions and provider/member communication.
  - Coordinating members transition planning from LTC to skilled nursing facility placements, home or other supported housing situations including home health or DME needs.
  - Coordination of care for members requiring services from community agencies, The Department of Public Health, and Medi-Cal carve-out and waiver programs
  - Work collaboratively with an interdisciplinary team, including attending and contracting physicians, ancillary providers, County services, and institutional staff to facilitate transition planning.
  - Assist in planning and executing appropriate interventions, evaluating outcomes and adjusting the members individual plan of care as needed.
  - Recognizing barriers to compliance and alterations in a member’s condition in a timely manner and taking appropriate actions to address issues.

  - Educating members and their authorized representatives on UM and CM Care Programs
  - Assisting SFHP staff in other departments with the resolution and quality of coordination of care issues for members
  - Able to determine which cases should be referred to the Medical Director for evaluation.
  - Collaboration with Medical Directors to ensure quality and cost-effective care.
  - Collaborates with team members on cross-departmental improvement efforts: quality improvement projects, optimization of cost management, member satisfaction improvement, and decreasing out of medical group placements.
  - Protecting confidentiality of utilization review, quality management information and beneficiary identification
  - This position does not directly manage personnel but requires teamwork with licensed and non-licensed staff.
- Long-Term Care Coordinator
  - Research utilization management requests using a variety of resources including SFHP evidence of coverage, policies and procedures, and electronic resources.
  - Compiles data for utilization management review and submits the data to the LTC nurse team for clinical decision-making.
  - Maintains ongoing tracking and appropriate documentation to facilitate the determination process within regulatory timeframes for standard and urgent authorization requests.
  - Assists in transition planning efforts for members requiring post discharge follow-up care through telephonic coordination with post-acute provider staff.
  - Provides administrative and clerical support for utilization management activities.
  - Communicates effectively and timely to answer questions and resolve issues pertaining to providers, office staff, and delegated groups about authorization and medical group requests and determinations.
  - Responds to calls, emails and other inquiries regarding the status of outstanding clinical requests and utilization management processes Ensures the privacy and security of PHI (Protected Health Information) as outlined in SFHP's policies and procedures relating to HIPAA compliance.
  - Maintains an accurate census of SFHP members.
  - Works closely with providers to obtain accurate information regarding authorization requests.
  - Ensures correspondence distribution compliance by working closely with designated clinicians to generate Notice of Action (NOA) letters for the requesting providers and members.
  - Utilize and operate multiple software applications systems. Enters required data in various computer programs and databases accurately and timely.
  - Maintains designated databases as needed for reporting requirements.
  - Coordinates activities with the other members of the Clinical Operations Management departments and the company as a whole.
  - Participates in making provider and/or member phone calls working from a script and identifying when calls need to be referred to a clinician for review.

Appendix A: Clinical Operations Reportage Calendar (High Level)

SFHP UMC Internal/External Reportage Calendar			
Item #	**Reports**	**Frequency**	**Distribution**
1	UM Trending (This is an evolving/live document)	Monthly/Quarterly/Ad Hoc	Monthly: UMC Quarterly: QIC Ad Hoc: DHCS, DMHC, NCQA
2	UM Trending by Service Category	Monthly/Quarterly/Ad Hoc	Monthly: UMC Ad Hoc: QIC, DHCS, DMHC, NCQA
3	SFHP Clinical Operations Dashboard (This is an evolving/live document)	Monthly/Quarterly/Ad Hoc	Monthly: UMC Quarterly: QIC Ad Hoc: DHCS, DMHC, NCQA
4	A&G Appeals Report (RAMP report 0937ES)	Monthly/Quarterly/Ad Hoc	Monthly: UMC Quarterly: QIC Ad Hoc: DHCS, DMHC, NCQA
5	A&G Grievances (RAMP report 0937ES)	Ad Hoc - if relevant to UM procedures and policies	Monthly: UMC Quarterly: QIC Ad Hoc: DHCS, DMHC, NCQA
6	SFH.IMR.CC_UMC Report	Monthly	Monthly: UMC Quarterly: QIC Ad Hoc: DHCS, DMHC, NCQA
7	Specialty Referral Report (RAMP report 0943ES)	Quarterly/Ad Hoc	Monthly: UMC Quarterly: QIC Ad Hoc: DHCS, DMHC, NCQA
8	Internal Audit -Authorizations, and as of 1.23, the following ancillary audits: • PAD Audit Tool • NEMT Audit Tool • Major Organ Transplant Audit Tool • State TAT Audit Tool • NCQA TAT Audit Tool	Quarterly	Quarterly: UMC/QIC/Compliance Ad Hoc: DHCS, DMHC, NCQA
9	IRR Annual Report (DHCS/DMHC/NCQA)	Annual	Annual: UMC/QIC/Compliance Ad Hoc: DHCS, DMHC, NCQA

[i] SSA 1927(k):

(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term "covered outpatient drug" means—

(A) of those drugs which are treated as prescribed drugs for purposes of section 1905(a)(12), a drug which may be dispensed only upon prescription (except as provided in paragraph (4)[340]), and—

(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act[341] or which is approved under section 505(j) of such Act;

i. (ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations[342]) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a "new drug" (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act[343]) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

ii. (iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling; and

(B) a biological product, other than a vaccine which—

(i) may only be dispensed upon prescription,

(ii) is licensed under section 351 of the Public Health Service Act, and

(iii) is produced at an establishment licensed under such section to produce such product; and

(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

(3) LIMITING DEFINITION.—The term "covered outpatient drug" does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

(A) Inpatient hospital services.

(B) Hospice services.

(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

(D) Physicians' services.

(E) Outpatient hospital services.

(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

(G) Other laboratory and x-ray services.

(H) Renal dialysis.

Policies and Procedures (P&Ps) Updates and Monitoring

November & December

Below are all of the new and recently revised Policies and Procedures that have been approved and uploaded to Square1. The summary of changes describes the latest version of the P&P. Current versions of P&Ps, desktop procedures, process maps, and supporting documents are all on Square1.

P&P Updates:

November:

Policy (For Consent)	Summary of New Policy and Updates
CRA-29: Healthy Workers HMO Enrollment Terminations	**Policy Update Biennial Review** • Policy remains unchanged
CRA- 36: EVV	**New Policy, APL 22-014 approval** • New policy outlining that all PCS and HHCS providers enroll in and utilize SFHP's Electronic Visit Verification (EVV) system to verify in-home service visits
FI-10: Prop 56 Private Services Policy	**New Policy, DHCS APL 22-015 approval** • Supplemental payment to qualified providers either directly or through their Subcontractors, must pay the individual rendering Providers that are qualified to provide and bill for medical pregnancy termination.
IS-31: Administrative Access Controls for Trading Partner and Transaction	**Policy Update Biennial Review** • Section 4 revised to now include trading partner along with New employees
Pharm-02 Pharmacy Prior Authorization	**Policy Update Annual Review** • Page 2, PA TAT Requirements, removed Healthy workers • Page 3, PA review, added prior auth exceptions
Pharm-03 Pharmacy Network Credentialing	**Policy Update Annual Review** • Policy remains unchanged
Pharm-14 Pharmacy DUR Program	**Policy Update Annual Review** • Page 6, under educational program, added title f Qualified Health Educator • Added MC-02 and MC-03 as related policies
PR-29: COC Data Sharing	**New Policy, DHCS APL 23-018 approval** • New policy developed per the 2024 MCP Transition Policy guide • SFHP is minimally impacted
PR-30: Transition for	**New Policy, DHCS APL 23-018 approval**

Community Supports	• New policy developed per the 2024 MCP Transition Policy guide • SFHP is minimally impacted • Consistent with the 2024 MCP Transition Policy guide, a Receiving MCP must honor all of the Previous MCP's authorizations for Community Supports when both MCPs offer the same Community Supports
PR-31: Transition Policy for ECM	**New Policy, DHCS APL 23-018 approval** • New policy developed per the 2024 MCP Transition Policy guide • SFHP is minimally impacted • Receiving MCP will maintain all authorizations for no less than the length of time originally authorized by the Previous MCP, regardless of whether Members are actively receiving ECM
Policy (For Discussion)	**Summary of New Policy and Updates**
MC-08: Providing Informing Materials to Medi-Cal Members in Electronic Form	**Policy Update Biennial Review** • Procedure section updated to remove items in the member welcome kits and include additional not included items before.

December:

Policy (For Consent)	**Summary of New Policy and Updates**
CO-63: Health Plan Physician Availability for Access Assistance	**New Policy** • Policy approved for DHCS contract readiness R.0182 • Policy that ensures a health plan medical director or licensed Physician acting on behalf of SFHP's medical director, is available 24 hours a day, seven days a week to assist with access issues.
FI-01: SFHP Investment Policy	**Policy Update Biennial Review** • Policy remains unchanged
FI-04: Changing Accounts at Financial Institutions	**Policy Update Biennial Review** • Policy remains unchanged
IS-16: Change and Integrity Control	**Policy Update Biennial Review** • Policy remains unchanged • CRA-01 removed, now includes IS-29
IS-19: Automated Eligibility Verification Systems	**Policy Update Biennial Review** • Policy remains unchanged • Provider relations changed to Provider Network Operations • IVR system, spelled out under definitions
PHM-05: Clinical Practice Guidelines	**Policy Update Biennial Review** • Policy will now be housed under PHM as PHM-05

	• Policy statement revised to remove "upto 24 months, preventive care, etc. • Procedure section updated from health services to Population Health management • Under definitions, added California Tuberculosis controllers association
Policy (For Discussion)	**Summary of New Policy and Updates**
N/A	

SAN FRANCISCO HEALTH PLAN
Here for you

MEMO

DATE: 01/26/2024

TO	Quality Improvement and Health Equity Committee
FROM	Jackie Hägg, RN, MSN, DHCS-CMT, Facility Site Review Nurse Manager Eugenia Correa, RN, BSN, DHCS-CSR, Facility Site Review Senior Nurse Specialist Edward Cho, MPH, CPH, Facility Site Review Program Manager
REGARDING	2023 Facility Site Review Report

BACKGROUND

Facility Site Reviews (FSR) are conducted to ensure that all contracted Primary Care Provider (PCP) sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices per the Department of Health Care Services (DHCS) All Plan Letter 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review. The FSR confirms the PCP site operates in compliance with all applicable local, state, and federal laws and regulations before opening provider panels to members. The FSR team assists SFHP in other site review compliance activities as specified in DHCS APL 22-017, PL 12-006, APL 15-023, and APL 16-015.

DHCS requires Medi-Cal Managed Care Plans (MCP) to conduct an FSR for every PCP site as part of the initial credentialing process and at least every 36 months thereafter (APL 22-017). The Full Scope FSR consists of two scored components that ensure consistent compliance with DHCS administrative and clinical guidelines:

1. Site Review Survey (SRS) evaluates 156 criteria in the areas of Access & Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control
2. Medical Record Review (MRR) evaluates up to 92 criteria in the areas of Format, Documentation, Continuity & Coordination of Care, and Preventive Care (Pediatric, Adult, OB/CPSP)

FSR components are scored by a Certified Master Trainer (CMT) or Site Reviewer (CSR) using standardized audit tools developed by DHCS. DHCS defines “Not Pass” as any score under 80%. The three compliance levels for DHCS FSR Reviews:

Exempted Pass	90% of above without a critical element deficiency
Conditional Pass	80-89% or 90% and above with a critical element deficiency
Not Pass	Below 80%

The FSR team is responsible for ensuring compliance with PL 12-006 and APL 15-023, which covers physical accessibility for primary care, high volume specialty, ancillary, and community based adult services (CBAS) facilities. Each January, the FSR team collaborates with Business Analytics and submits a report to DHCS documenting benchmarks, methodology, and supporting Work Plans. High volume specialty PARS (FSR-C and FSR-D) and CBAS PARS (FSR-E) results are available on the current print and web versions of the SFHP Provider Directory, where they are searchable by members, providers, and the public.

San Francisco Health Plan (SFHP) has Memorandums of Understanding (MOUs) with Anthem Blue Cross of California (ABC) and Health Plan of San Mateo (HPSM) to review all PCP sites that are jointly contracted in the City and County of San Francisco or San Mateo County to ensure compliance with criteria set forth by DHCS. Per APL 22-017 and the MOUs with collaborating sister plans, FSR results are shared between MCPs to avoid duplication of auditing efforts.

SFHP maintains an annual FSR Work Plan for ~200 unique sites. The external FSR data system, Healthy Data Systems (HDS), continues to be customized and all site review information, scores, and action items are contained in this application. The FSR data is available to the Plan and Delegated Medical Groups for credentialing and quality assessment.

SAN FRANCISCO HEALTH PLAN
Here for you

SUMMARY STATEMENTS

PUBLIC HEALTH EMERGENCY SUMMARY

On March 16, 2020, the San Francisco Department of Public Health issued Order C19-07 directing all businesses and governmental agencies to cease nonessential operations at physical locations in the County in response to the COVID-19 Pandemic. FSR team worked closely with network providers, statewide FSR collaborative, and DHCS partners throughout the COVID-19 public health emergency (PHE) to ensure that FSR operations continued. SFHP Facility Site Review team returned to the field for all FSRs beginning July 1, 2022. MRRs completed virtually via electronic medical record (EMR) access continue to be accepted by DHCS. On February 15, 2023, DHCS presented the COVID-19 PHE Transition Roadmap and verbally communicated with the DHCS FAQ Meeting that the COVID-19 PHE plans to transition out of the emergency phase by May 11, 2023.

SFHP's FSR backlog strategy and status were reported quarterly to the Compliance and Site Review Section of the Managed Care Quality and Monitoring Division. As a result of the COVID-19 PHE, SFHP had a backlog of sixty (60) full-scope site reviews at the beginning of CY2023. As of this report, all backlogged FSRs have been completed and SFHP FSR team submitted the final quarterly metrics to DHCS on 1/3/2024. The submission was accepted and approved 1/3/2024.

2023 FSR ACTIVITIES SUMMARY

FSR team completed the site review backlog created by the COVID-19 public health emergency as of 12/31/2023. All FSRs were completed on-site during the report year. MRRs were completed via electronic medical record (EMR) access or on-site. The tables below shows the review volume, composite score, and section scores.

SITE REVIEW SURVEY (SRS) SCORE DISTRIBUTION

Review Type	No. of Reviews	Overall	AS	PE	OM	CS	PS	IC
FSR (Initial & Periodic)	43	96	94	96	99	94	95	97

Note: Includes shared PCP sites audited by sister plans (ABC & HPSM)

MEDICAL RECORD REVIEW (MRR) SCORE DISTRIBUTION

Review Type	No. of Reviews	Overall	FO	DO	CO	PE	AD	OB
MRR (Initial & Periodic)	63	86	96	91	97	88	75	--

Note: Includes shared PCP sites audited by sister plans (ABC & HPSM)

PROVIDER OUTREACH & EDUCATION

The SFHP Provider Newsletter Update includes monthly articles written by the FSR team, focusing on FSR/MRR audit criteria, standards, or trends. The following topics were covered in 2023:

Month	Topic(s)
January	Suicide Risk Screening, Vaccine Storage Survey
February	2023 Changes to Screening and Assessment and the Initial Health Appointment

April	Intimate Partner Violence Screening for Women of Reproductive Age Medical Record Review of EPSDT for Medi-Cal Members Under the Age of 21
May	Hepatitis B & C
June	Autism Screening
July	Skin Cancer Prevention Counseling
September	Obesity Screening Drug Disorder Screening and Assessment Including Overdose Awareness
October	Sudden Cardiac Arrest & Sudden Cardiac Death Screening Lead Poisoning Prevention Training (CME)
November	Lung Cancer Screening
December	Sexually Transmitted Infections (STI) Screening & Counseling

PROJECTS & UPDATES

1. FSR team partnered with several clinics and clinic groups to complete Medical Record Reviews remotely though remote electronic medical records (EMR) access. We continue to pursue additional remote EMR access collaboration.
    a. All American Medical Group (Solo providers), Elation
    b. North East Medical Services, NextGen
    c. Chinese Hospital Clinics, Cerner
    d. San Francisco Health Network, CareLink
2. FSR site reviewers participated in state-wide and local health plan collaborative meetings
    a. DHCS Site Review Work Group (SRWG)
    b. Public Health Emergency Plan Work Group
        i. FSR Backlog
    c. FSR Database Collaborative
        i. Technical Subgroups
    d. Site Review Data System Technical Questions and Discussion
        i. SFHP will submit FSR data to DHCS through JSON file exchanges beginning 2024
    e. FSR FAQ Committee (clarifications regarding new Standards and Tools)
    f. Inter-Rater Reliability (IRR) Work Group
    g. Northern California Local Health Plan Collaborative (Contra Costa, San Francisco, San Mateo, Santa Clara)
3. Partnered with UCSF administration to update
    a. Intimate partner violence screening questionnaire in Epic
    b. All emergency medications kit across UC to comply DHCS FSR emergency medication/anaphylactic reaction management standards
4. FSR team participates in internal cross functioning work groups
    a. Alcohol Use Disorder & Drug Use Disorder Screenings
    b. CCS Collaboration
    c. CHDP Transition (EPMO Project)
    d. CPSP Transition
    e. GGRC Collaboration
    f. Grievance Committee
    g. Maternal Mental Health Screening
    h. Population Health & Provider Network Operations
5. Oversight of increased provider training requirements (30+) due to CalAIM initiative that impacted the CHDP program and existing boilerplate (delegation grid)
    a. SFHP is working with Litmos to develop training modules

6. Maintenance of 100+ provider resource documents and tools on the SFHP website to help provider successfully pass their full scope FSRs

UPCOMING OPPORTUNITIES

1. FSR team will continue to collaborate with FSR teams across California at Site Review Work Group Meetings to discuss issues and quality improvement opportunities
2. FSR team will partner with NMM to update and standardize Elation (EMR) wellness templates for primary care providers
3. Provider training topics, including CHDP training modules, will be transitioned into Litmos so that the required trainings can completed electronically for network providers
    a. Litmos can offer training tracking for credentialing/recredentialing
    b. CHDP trainings will include:
        i. Anthropometric, BMI & Growth Charts
        ii. Audiometric Screening
        iii. Dental – Fluoride Varnish (Oral Health Assessment)
        iv. Lead Screening Training
        v. Presumptive Eligibility (retired Gateway)
        vi. Vision Health Assessment
4. With the retirement of Staying Healthy Assessment on January 1, 2023, and the replacement APL 22-030: Initial Health Appointment, the FSR team is exploring best practices to score this criteria with collaboration from Health Services and Claims
    a. See CalAIM: Population Health Management (PHM) Policy Guide, page 9
5. FSR team will continue to explore opportunities to improve data quality and monitoring through
    a. Pulling FSR data from external FSR vendor system into internal data warehouse to create a quality dashboard
        i. Anticipated implementation: June 30, 2024
    b. MRR coding project for hybrid MRR abstraction
    c. Develop provider coding tip sheets specific to MRR criteria
    d. Pulling FSR data from external FSR vendor system into internal data warehouse to create a quality dashboard

Appendix A: Abbreviations Key

Key			
FSR	Facility Site Review	MRR	Medical Record Review
AS	Access/Safety	FO	Format
PE	Personnel	DO	Documentation
OM	Office Management	CO	Continuity/Coordination of Care
CS	Clinical Services	PE	Pediatric Preventive
PS	Preventive Services	AD	Adult Preventive
IC	Infection Control	OB	OB/CPSP Preventive

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
sfhp.org

MEMO

To	QIC
From	Leslie Mulhern RN, Nurse Supervisor Quality Review
Regarding	Proposed change to PQI reporting calendar

Current Reporting Calendar: QR reports on the previous quarter's PQIs. This is presented quarterly to QIC

Proposed Reporting Calendar: QR reports on PQI results from 2 quarters prior. This will continue to be done on a quarterly basis

Rationale: Current reporting schedule doesn't allow for case closure and thus the reports are incomplete. QIC does not have an accurate overview of the PQI process and results of the related investigations or corrective action plans.

If approved, schedule for 2024 will be as follows:

QIC Meeting Month	Quarter Reported
February	Q3 2023
May	Q4 2023
July	Q1 2024
October	Q2 2024

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

Date: Feb 15, 2024

To	**Quality Improvement Committee**
From	**Leslie Mulhern, RN** **Nurse Supervisor, Quality Review** **Appeals & Grievances**
Regarding	**Quarter 1, 2023** **Potential Quality Issue Report** **UPDATED FOR REVISED REPORTING SCHEDULE**

Case Reviews

Q1 2023 - Case types reviewed	Count
Total cases reviewed for PQI	**423**
Appeals	22
Decline to File Grievances (Clinical and Non-clinical)/Exempt	129
Grievances (Clinical and non-clinical)	272
Internal referrals (not including GRC)	31
External referrals	0
Provider Preventable Condition (PPC)	0

Outcomes	Count
Opened for PQI investigation	26
Formal PQI investigation (PQI letter)	26
Cases requiring external physician review or peer review	2
Confirmed Quality Issue	10
PQI cases resulting in Corrective Action Plan (CAP)	0
Confirmed Provider Preventable Condition (PPC)	0
PQI cases closed within 180-day turnaround time	19
PQI cases closed outside 180-day turnaround time	7

*Data retrieved from Ramp 937 Case Reports

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

Date: February 15, 2024

To	**Quality Improvement Committee**
From	**Leslie Mulhern, RN** **Nurse Supervisor, Quality Review** **Appeals & Grievances**
Regarding	**Quarter 2, 2023** **Potential Quality Issue Report** **UPDATED FOR REVISED REPORTING SCHEDULE**

Case Reviews

Q2 2023 - Case types reviewed	Count
Total cases reviewed for PQI	**365**
Appeals	25
Decline to File Grievances (Clinica and Non-clinicall)	108
Grievances (Clinical and non-clinical)	227
Internal referrals (not including GRC)	16
External referrals	1
Provider Preventable Condition (PPC)	0

Outcomes	Count
Opened for PQI investigation	23
Formal PQI investigation (PQI letter)	23
Cases requiring external physician review or peer review	1
Confirmed Quality Issue	10
PQI cases resulting in Corrective Action Plan (CAP)	1
Confirmed Provider Preventable Condition (PPC)	0
PQI cases closed within 180-day turnaround time	10
PQI cases closed outside 180-day turnaround time	10

*Data retrieved from Ramp 937 and 0390ES PQI Case Reports

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

Date: February 15, 2024

To	**Quality Improvement Committee**
From	**Leslie Mulhern, RN** **Nurse Supervisor, Quality Review** **Appeals & Grievances**
Regarding	**Quarter 3, 2023** **Potential Quality Issue Report:** **UPDATED FOR REVISED REPORTING SCHEDULE**

Case Reviews

Q3 2023 - Case types reviewed	Count
Total cases reviewed for PQI	**392**
Appeals	30
Decline to File Grievances (Clinical and Non-clinical)	112
Grievances (Clinical and non-clinical)	219
Internal referrals (not including GRC)	38
External referrals	0
Provider Preventable Condition (PPC)	0

Outcomes	Count
Opened for PQI investigation	38
Formal PQI investigation (PQI letter)	38
Cases requiring external physician review or peer review	7
Confirmed Quality Issue	17
PQI cases resulting in Corrective Action Plan (CAP)	10
Confirmed Provider Preventable Condition (PPC)	0
PQI cases closed within 180-day turnaround time	35
PQI cases closed outside 180-day turnaround time	0

*Data retrieved from Ramp 937 Case Reports

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
www.sfhp.org

Date: 02/27/2024

To	**Quality Improvement Committee**
From	**Leslie Mulhern, RN** **Nurse Supervisor, Quality Review** **Appeals & Grievances**
Regarding	**Quarter 4, 2023** **Potential Quality Issue Report** **PRELIMINARY**

Case Reviews

Q4 2023 - Case types reviewed	**Count**
Total cases reviewed for PQI	**322**
Appeals	26
Decline to File Grievances (Clinical and Non-clinical)/Exempt	91
Grievances (Clinical and non-clinical)	184
Internal referrals (not including GRC)	21
External referrals	0
Provider Preventable Condition (PPC)	0

Outcomes	**Count**
Opened for PQI investigation	23
Formal PQI investigation (PQI letter)	23
Cases requiring external physician review or peer review	2
Confirmed Quality Issue	pending
PQI cases resulting in Corrective Action Plan (CAP)	pending
Confirmed Provider Preventable Condition (PPC)	pending
PQI cases closed within 180-day turnaround time	pending
PQI cases closed outside 180-day turnaround time	pending

*Data retrieved from Ramp 937 Case Reports

2022-23 Access Monitoring

Successes

- Increased survey response from non-behavioral health providers

Opportunities

- Most provider types did not reach 80% in appointment availability, including PCPs, the high-volume specialty gynecology and the high-impact specialty oncology
- Most specialties decreased in urgent & routine appointment availability
- Low response rate for behavioral health providers obfuscates appointment availability
- As a network SFHP did not reach 80% in availability of triage

Corrective Action

SFHP issues 228 findings to nine groups and four clinics, 83% of which have been closed by March 2024

Current & Next Steps

Improvement Work

- Implementation of specialty access improvement work with ZSFG

Access Monitoring

- Measurement year 2023 surveys are complete. SFHP receiving final data 3/8/2024 and beginning analysis
- Next access update: Q2 QIHEC

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

2022 APPOINTMENT AVAILABILITY REPORT

Date: July 6, 2023

Provider Appointment Availability

San Francisco Health Plan (SFHP) administers the Provider Appointment Availability Survey and the Daytime Survey to evaluate appointment availability. The Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), and the National Committee for Quality Assurance (NCQA) require SFHP to monitor appointment availability in order to ensure that health care services are provided to patients in a timely manner appropriate for the nature of the patient's condition and consistent with professional practice.

Executive Summary of Results

Accomplishments:

- SFHP reached 80% compliance in routine psychiatry and MRI appointments. (Table 5, page 6).
- There were increases in response rates from primary care, all specialties, and ancillary providers (Table 6, page 7). In addition to issuing corrective action to groups not meeting compliance rates of 80%, SFHP will issue corrective action to provider groups not reaching a 50% response rate by provider type (Table 4, page 6).

Opportunities for Improvement:

- Of SFHP medical groups meeting the 80% compliance requirement for each appointment standard, 82% (31/38) of standards remained the same or decreased from 2021 to 2022 for providers that SFHP previously surveyed in 2020 (table 3, page 4). SFHP will continue to request corrective action from each group that did not meet the 80% compliance requirement and provide technical assistance to the groups when requested.

Barriers:

Provider groups face a number of barriers providing timely access to care. Some barriers are more prevalent in safety net settings while others are specific to smaller practices with fewer resources to leverage.

Barriers include:

- Supply of providers – some provider groups' supply of appointments with providers is fixed due to resident and attending schedules or the number of part time providers working in a specific system or clinic.
- Variation in use of emerging appointment reminders, self-scheduling technology, and alternative visits – provider groups demonstrate uneven uptake or implementation of technologies such as telemedicine, electronic appointment reminders, and member self-scheduling. Provider groups also show uneven uptake of alternative visits such as nurse visits or group visits. Electronic tools are less optimized for low literacy or non-English speaking member and may require customizations or additional investments to fully leverage.
- Team based care – some clinics and health systems effectively utilize care team members to ensure good access while other settings may not be able to employ or as effectively utilize other licensed providers (e.g. health educator, pharmacist, behavioral health clinician).
- Electronic consult for specialty care – with the right technology in place, many consults can be managed without the need for a face-to-face visit. Different specialty care arrangements and coordination efforts as well as very recent changes in reimbursement options impact access to and timeliness of specialty care.
- Private behavioral health practitioners – SFHP's behavioral health network include both public and private providers. While private providers are contracted, they may not have availability to accept new clients.

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Depending on their caseload they may close their practice or limit the number of new clients they accept based on their ability to provide timely initial and ongoing appointments.

- High-impact and high-volume providers – oncology, gynecology. Overall compliance rates for all SFHP's high volume gynecology providers (table 5 page 6) decreased for urgent appointments from 64% in 2021 to 38% in 2022 and decreased for routine appointments from 70% in 2021 to 56% in 2022. Despite the decrease in routine appointment availability, more medical groups reached the minimum 80% compliance in 2022 than in 2021 for appointment availability for gynecology routine appointment availability (table 3, page 5). SFHP's high impact oncology providers decreased in urgent appointment availability (table 5 page 7) from 44% in 2021 to 30% in 2022 and increased for urgent availability and from 66% in 2021 to 72% in 2022 for routine appointment availability. A potential barrier for oncology appointment availability is in the low response rate from 2021 to 2022 (table 3, page 5).
- Social determinants of health – transportation, housing and employment related barriers can impact members' ability to make and keep appointments. Missed appointments that go unused can contribute poorer access.
- Survey limitations – SFHP uses a vendor, Sutherland, to conduct PAAS. Sutherland reaches out to providers over email and then by phone with Indian call centers. In 2022, most providers responded to the survey over the phone. There might be a communication barrier between survey respondents and survey recorders. Moreover, another potential barrier is that the survey respondents, usually receptionists, might not be aware of PAAS and therefore might not understand PAAS definitions for urgent vs routine.

Infrastructure needs to include technological improvements (member self-scheduling, robo-call appointment reminders), ability to provide care beyond typical face-to-face visits, effective provider recruitment and retention strategies, and processes to inform/manage expectations with members. Overall, SFHP's strategy is to work with each medical group individually to address appointment availability, clinic capacity and scheduling techniques.

Notable barriers from 2021 Appointment availability report:

- In 2021, Oncology and Gynecology were also identified a high-impact and high-volume providers. SFHP shares yearly PAAS compliance rates and findings with medical groups in a Corrective Action Plan (CAP). A finding is defined as a group not reaching 80% compliance for the access standard. SFHP reviews and approves plans and evidence to try to improve each plan compliance rate the following year.
    - Gynecology trends observed in Table A.1:
        - 7/8 medical group findings were repeat findings in 2022. Of the repeat findings, 2/7 showed improvements (Brown and Toland Physicians urgent, Hill Physicians urgent).
        - Northeast Medical Services with SFHN and Brown and Toland Physicians improved their 2021 rates to reach compliance in 2022.
        - SFHP overall rates improved for routine appointments by 12% and decreased for urgent appointments by 26%.
    - Oncology trends observed in Table A.2:
        - 7/12 medical group findings were repeat findings in 2022. Of the repeat findings, 2/7 showed improvements (Jade Healthcare routine, University of California San Francisco routine).
        - Chinese Community Healthcare Association improved their 2021 urgent rate to reach compliance in 2022.

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

- SFHP overall rates improved for routine appointments by 6% and decreased for urgent appointments by 14%.

- Barriers for improvements after Corrective Action Plans:
  - In 2022, SFHP did not have sufficient staff resources follow-up on CAP closures and evidence. PAAS and CAP main responsibilities are now the responsibility of one staff member.
  - Larger medical groups like University of California San Francisco and San Francisco Health Network have their own methodology to assess appointment availability access and have grieved about the PAAS methodology. These medical groups submitted their own data to close findings where they found themselves to be compliant.

Table A.1: Gynecology Yearly Comparison of Rates and Compliance
The purpose of this table is to enhance qualitative discussion for high-impact and high-volume providers rates not meeting goal year over year. Trends can be observed at network and group level. The table shows repeat vs new findings in descending order by worse performance year over year.

Medical Group	Gynecology Compliance Element	2021 Compliance	2022 Compliance	Difference	Repeat or New Finding	Newly Compliant
Northeast Medical Services	Urgent	78%	51%	-27%	Repeat	N
Chinese Community Healthcare Association	Urgent	75%	50%	-25%	Repeat	N
University of California San Francisco	Routine	32%	13%	-19%	Repeat	N
University of California San Francisco	Urgent	20%	10%	-10%	Repeat	N
Jade Healthcare	Routine	57%	54%	-3%	Repeat	N
Brown and Toland Physicians	Urgent	54%	64%	10%	Repeat	N
Jade Healthcare	Urgent	62%	76%	14%	Repeat	N
Hill Physicians	Urgent	100%	67%	-33%	New	N
SFHP Overall	Urgent	64%	38%	-26%	N/A	N
Northeast Medical Services	Routine	91%	80%	-11%	N/A	N
Chinese Community Healthcare Association	Routine	88%	88%	0%	N/A	N
Hill Physicians	Routine	100%	100%	0%	N/A	N
Northeast Medical Services with SFHN	Routine	100%	100%	0%	N/A	N
San Francisco Health Network	Routine	100%	100%	0%	N/A	N
Northeast Medical Services with SFHN	Urgent	75%	86%	11%	N/A	Y
SFHP Overall	Routine	63%	75%	12%	N/A	N

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Brown and Toland Physicians	Routine	79%	100%	21%	N/A	Y

Table A.2: Oncology Yearly Comparison of Rates and Compliance

The purpose of this table is to enhance qualitative discussion for high-impact and high-volume providers rates not meeting goal year over year. Trends can be observed at network and group level. The table shows repeat vs new findings in descending order by worse performance year over year.

Medical Group	Oncology Compliance Element	2021 Compliance	2022 Compliance	Difference	Repeat or New Finding	Newly Compliant
Northeast Medical Services with SFHN	Routine	67%	0%	-67%	Repeat	N
Northeast Medical Services with SFHN	Urgent	50%	0%	-50%	Repeat	N
University of California San Francisco	Urgent	41%	30%	-11%	Repeat	N
Jade Healthcare	Urgent	33%	26%	-7%	Repeat	N
San Francisco Health Network	Urgent	0%	0%	0%	Repeat	N
University of California San Francisco	Routine	56%	79%	23%	Repeat	N
Jade Healthcare	Routine	43%	78%	35%	Repeat	N
San Francisco Health Network	Routine	100%	0%	-100%	New	N
Brown and Toland Physicians	Urgent	100%	33%	-67%	New	N
Brown and Toland Physicians	Routine	100%	33%	-67%	New	N
Northeast Medical Services	Urgent	100%	33%	-67%	New	N
Northeast Medical Services	Routine	83%	50%	-33%	New	N
SFHP Overall	Urgent	44%	30%	-14%	N/A	N
Chinese Community Healthcare Association	Routine	100%	100%	0%	N/A	N
SFHP Overall	Routine	66%	72%	6%	N/A	N
Chinese Community Healthcare Association	Urgent	0%	100%	100%	N/A	Y

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Member Grievances:

Table B.1: SFHP Grievance Volume Report
The purpose of this table is to show access grievance data as compared to SFHP overall grievance data.

Category	Number of grievances received in 2020	Grievance rate per 1,000 members 2020	Number of grievances received in 2021	Grievance rate per 1,000 members 2021	Number of grievances received in 2022	Grievance rate per 1,000 members 2022
Access	**45**	**0.31**	**63**	**0.42**	**143**	**0.72**
SFHP Total	**259**	**1.81**	**308**	**2.04**	**445**	**2.73**

SFHP's performance threshold for each NCQA grievance category is < 1.00 per 1,000 members. If any category exceeds a rate of 1.00 for either grievances or appeals, SFHP determines appropriate improvement activities for SFHP and its broader provider network. SFHP met the performance threshold for all categories in 2022.

Access grievances did not exceed the NCQA grievance threshold in 2022.

Planned Actions:

- SFHP requested Corrective Action Plans (CAP) for any group that falls below the 80% compliance rate and/or the 50% response rate. SFHP will provide technical assistance and coaching to provide best practices for improving access to care, survey responsiveness, and instructions on how to accurately submit a CAP.
- SFHP requested improved Corrective Action Plans (CAP) for repeat findings in 2022.

Survey Methodology:

SFHP utilizes two surveys to assess appointment availability for each regulation as described in Table 1: the Provider Appointment Availability Survey (PAAS) and the Daytime Survey. SFHP implemented PAAS through survey vendor Sutherland Healthcare from September 2022 to January of 2023 and reported the results in April 2023. This methodology ensures that an appropriate number of providers for each county and network are surveyed to produce statistically reliable and comparable results across all health plans. Provider types included in PAAS as required by the DMHC include cardiologists, endocrinologists, gastroenterologists, non-physician mental health care provider, psychiatrists, and ancillary providers. SFHP surveys additional provider types as required by DHCS: dermatologists, general surgeons, hematologists, HIV & infectious disease provider, nephrologists, neurologists, ophthalmologists, orthopedic surgeons, otolaryngologists, physical medicine & rehabilitation providers, and pulmonologists. Finally, SFHP also surveys provider types to meet NCQA standards: oncologists, identified by SFHP as the top high-impact provider type and obstetrics & gynecologists as the top high-volume provider type. The number of providers to be surveyed for each county and network is determined separately for each of the provider survey types. Ancillary providers included those delivering MRI and physical therapy services. SFHP selected a random sample of provider type for each medical group. SFHP determined sample sizes from DMHC's Measurement Year 2019 PAAS methodology which DMHC calculated to produce confidence limits of plus or minus 5% for an expected compliance rate of 85% with a 95% confidence level.

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

SFHP utilized the 2019 PAAS methodology recommended by DMHC. Provider sites had five business days to respond to the faxed or e-mailed survey. Non-responsive providers received follow-up phone calls after the initial five business days to collect survey responses over the phone. Providers had two business days to respond to follow-up phone calls. Calls in which the respondent refused to respond to the survey or failed to return the phone call within the allotted time were categorized as non-responsive. Responses to the survey where respondents did not provide a compliant answer for the appointment wait time elements described in Table 1 were categorized as non-compliant. SFHP aggregated results of individual providers from completed surveys to obtain a compliance rate for each medical group. SFHP requires 80% compliance rate for each access standard and a 50% response rate by provider type. A plan for corrective action is required when a group or clinic does not meet the 80% compliance requirement and/or the 50% response requirement.

SFHP conducted the Daytime Survey from December 2022 to February 2023. SFHP surveyed contracted providers and clinic sites that provide routine primary care (including internal medicine, pediatrics, and family/general medicine). Each provider group's survey population is an audit of primary care and therefore contains sites for primary care providers within the medical group. As this survey is a census, the results of the survey provide a true measure of the population and thus no sampling error.

For each unique site surveyed, SFHP sent faxes or emails containing or linking to the Daytime Survey. SFHP requested information regarding access to the first available urgent and primary care appointments at the entire site. Additionally, SFHP requested if the provider office site offered prenatal care appointments; those that provided prenatal appointments were further surveyed regarding the next available prenatal care appointment available at that provider site. Provider sites had ten business days to respond to the faxed or e-mailed Daytime Survey. Responses that did not provide a compliant answer for the appointment wait time elements described in Table 1 were categorized as non-compliant. SFHP aggregated results of individual primary care sites to obtain a compliance rate for each medical group. SFHP requires 80% compliance rate for urgent, routine, prenatal care appointment availability in primary care and a 50% survey response rate. A plan for corrective action is required when a group or clinic does not meet the 80% compliance requirement and/or the 50% response requirement.

Table 1: Appointment Requirements

Provider Appointment Type	Urgent Appointment	Routine Appointment	Corresponding Survey
Primary Care Appointments	Within 48 hrs. without prior authorization	Within 10 business days	Daytime Survey
Prenatal Care Appointment	N/A	Within 10 business days	Daytime Survey
Specialty Care Appointments	Within 96 hrs. with prior authorization	Within 15 business days	Provider Appointment Availability Survey
Non-Physician Behavioral Health Appointments	Within 96 hrs. with prior authorization	Within 10 business days	Provider Appointment Availability Survey
Ancillary Appointments	N/A	Within 15 business days	Provider Appointment Availability Survey

Survey Analysis:

Overall results as shown in table 5, page 5, indicate that SFHP reached 80% compliance in urgent and routine primary care appointments, prenatal care appointments, routine psychiatry, physical therapy, and MRI appointments. SFHP did not meet 80% compliance for all other appointment types. For the specialty types cardiology, endocrinology, gastroenterology, obstetrics & gynecology, oncology, significant non-responsiveness to the survey contributed to

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

smaller than intended sample sizes, resulting in imprecise assessment of appointment availability. In comparison to 2020, 2021 results indicate that primary care, dermatology, ENT/otolaryngology, general surgery, hematology, HIV/infectious diseases, nephrology, neurology, ophthalmology, orthopedic surgery, physical medicine, pulmonology, and behavioral health provider types were more responsive to the survey. Sutherland Healthcare fielded PAAS on behalf of SFHP for all non-primary care provider types. Sutherland Healthcare contracts with many other California health plans for PAAS and shares survey results between them. This method conducted by the vendor lowers survey fatigue from providers, resulting in the increase in responsiveness for non-behavioral provider specialties.

Survey Limitations:

Some medical groups' sample sizes significantly varied between 2020 and 2021. One contributor to sample size change is due to the timing of the survey. SFHP determined sample frames for the Appointment Availability Surveyed from the December 2020 SFHP annual network provider roster, with surveying from September 2021 to January 2022, and reporting of results in March 2022. In the time lapse of 15 months, some providers may terminate with medical groups and become ineligible for reporting in medical groups samples. Additionally, the sample size is dependent on survey responses. As shown in Table 6, pages 7, since specialty types were more responsive to the provider survey in 2021, their sample sizes increased.

Self-Reported Member Access Data

Please note that no opportunities for improving network adequacy emerged from access complaints and appeals for 2021 which is demonstrated by a less than one complaint and appeal per 1,000 member threshold for each category. Please refer to the report entitled 2021 Annual Grievance Report in Appendix B in the Annual Access Report.

Table 2: Results Key

Green	Scores marked in green indicate higher scores in 2021 from 2020
Red	Scores marked in red indicate lower scores in 2021 from 2020
Yellow	Scores highlighted in yellow indicate that the group did not reach 80% compliance for the access standard
Blue	Scores highlighted in blue indicate that the group did not reach 50% compliance for the provider type

Table 3: Aggregate of Medical Group and Clinic Compliance (80%)

The purpose of this table is to demonstrate the aggregate compliance for all medical groups for each provider type by compliance element. For example, in 2021 two out of eight medical groups reached 80% compliance with urgent cardiology appointments, which equates to 25% of medical groups reaching 80% compliance.

Provider Type	Compliance Element	MY 2021 Medical groups and clinics achieving 80% compliance	MY 2022 Medical groups and clinics achieving 80% compliance
Primary Care	Urgent	69%	38%
	Routine	100%	50%
Cardiology	Urgent	25%	13%
	Routine	38%	25%
Dermatology	Urgent	0%	0%
	Routine	38%	0%
Endocrinology	Urgent	88%	13%
	Routine	25%	13%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Provider Type	Compliance Element	MY 2021 Medical groups and clinics achieving 80% compliance	MY 2022 Medical groups and clinics achieving 80% compliance
Gastroenterology	Urgent	25%	0%
	Routine	38%	25%
General Surgery	Urgent	25%	13%
	Routine	50%	25%
Gynecology	Urgent	13%	13%
	Routine	63%	75%
Hematology	Urgent	20%	0%
	Routine	71%	17%
Infectious Disease	Urgent	40%	25%
	Routine	33%	50%
Nephrology	Urgent	25%	25%
	Routine	38%	25%
Neurology	Urgent	0%	0%
	Routine	14%	0%
Oncology	Urgent	14%	14%
	Routine	71%	14%
Ophthalmology	Urgent	13%	0%
	Routine	25%	0%
Orthopedics	Urgent	13%	0%
	Routine	38%	25%
Otolaryngology	Urgent	0%	20%
	Routine	14%	67%
Physical Medicine & Rehabilitation	Urgent	14%	0%
	Routine	43%	29%
Pulmonology	Urgent	0%	0%
	Routine	0%	20%
Non-Physician Behavioral Health Providers	Urgent	0%	50%
	Routine	0%	50%
Psychiatry	Urgent	38%	0%
	Routine	78%	50%
MRI	Routine	100%	100%
Physical Therapy	Routine	100%	0%

Table 4: Aggregate of Medical Group and Clinic Response (50%)
The purpose of this table is to demonstrate the aggregate compliance for all medical groups for each provider type by response rate. For example, in 2021 five out of eight medical groups reached 50% survey response for oncology and obstetrics & gynecology providers, which equates to 63% of medical groups 50% survey response.

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Provider Type	MY 2021 Medical groups and clinics achieving 50% response rate	MY 2022 Medical groups and clinics achieving 50% response rate
Primary Care	69%	100%
Cardiology, Endocrinology, Gastroenterology	100%	100%
Obstetrics & Gynecology , Oncology	63%	75%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	75%	88%
Psychiatry	100%	0%
Non-Physician Behavioral Health providers	100%	0%
Ancillary	100%	100%

Table 5: Appointment Availability Compliance Rates

The purpose of this table is to demonstrate the appointment availability compliance for all providers across SFHP by provider type and by compliance element. For example, in 2021 81 out of 111 cardiologists were able to provide a routine specialty care appointment within 21 business days, which equates to 73% of cardiologists being compliant with the routine appointment standard.

SFHP		**MY 2021**			**MY 2022**		
Overall		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	150	17%	83%	195	38%	62%
	Routine	152	0%	100%	204	24%	76%
Cardiology	Urgent	107	50%	50%	109	75%	25%
	Routine	111	27%	73%	131	55%	46%
Dermatology	Urgent	63	87%	13%	47	91%	9%
	Routine	67	75%	25%	49	78%	22%
Endocrinology	Urgent	56	59%	41%	44	91%	9%
	Routine	68	43%	57%	63	73%	27%
Gastroenterology	Urgent	64	56%	44%	71	90%	10%
	Routine	78	37%	63%	82	72%	28%
General Surgery	Urgent	64	58%	42%	98	61%	39%
	Routine	82	32%	68%	106	45%	55%
Gynecology	Urgent	148	36%	64%	149	62%	38%
	Routine	175	30%	70%	183	44%	56%
Hematology	Urgent	17	76%	24%	23	100%	0%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

	Routine	39	62%	38%	25	52%	48%
Infectious Diseases	Urgent	15	87%	13%	11	45%	55%
	Routine	17	71%	29%	14	36%	64%
MRI	Routine	30	0%	100%	30	3%	97%
Nephrology	Urgent	30	50%	50%	51	69%	31%
	Routine	33	30%	70%	53	53%	47%
Neurology	Urgent	73	73%	27%	95	89%	11%
	Routine	92	49%	51%	121	74%	26%
Non-MD Behavioral	Urgent	212	55%	45%	128	38%	63%
	Routine	247	30%	70%	142	27%	73%
Oncology	Urgent	43	56%	44%	111	70%	30%
	Routine	47	34%	66%	111	28%	72%
Ophthalmology	Urgent	80	56%	44%	96	57%	43%
	Routine	114	49%	51%	121	38%	62%
Orthopedics	Urgent	80	67%	33%	98	81%	19%
	Routine	94	43%	57%	118	42%	58%
Otolaryngology	Urgent	23	57%	43%	42	69%	31%
	Routine	35	54%	46%	51	61%	39%
Physical Medicine and Rehabilitation	Urgent	14	71%	29%	10	100%	0%
	Routine		50%	50%	14	50%	50%
Physical Therapy	Routine	1	0%	100%	2	50%	50%
Psychiatry	Urgent	237	43%	57%	123	44%	56%
	Routine	240	8%	92%	131	20%	80%
Pulmonology	Urgent	22	77%	23%	16	63%	38%
	Routine	24	58%	42%	19	53%	47%

Table 5 Summary: We reached 80% compliance rates for the following areas: routing psychiatry and routine MRI.

Table 6: Appointment Availability Response Rates

The purpose of this table is to demonstrate the appointment availability survey response rate by provider type. Specialty provider types are further grouped by the specialties required by each regulatory or accrediting body: Cardiology, Endocrinology, and Gastroenterology for the DMHC, Obstetrics & Gynecology and Oncology for NCQA, and Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology for the DHCS.

SFHP Overall	**MY 2021 sample size**	**MY 2021 response**	**MY 2022 sample size**	**MY 2022 response**
All Provider Types	2,604	68%	3036	59%
Primary Care	160	95%	212	96%
Cardiology, Endocrinology, Gastroenterology	295	88%	311	89%
Gynecology & Oncology	381	58%	403	74%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

SFHP Overall	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	1,184	52%	1,088	64%
Psychiatry	256	94%	381	34%
Non-Physician Mental Health	294	84%	608	23%
Ancillary Providers	34	91%	33	97%

Table 7: Appointment Availability Compliance Rates

The purpose of odd-numbered tables seven through 27 is to demonstrate the appointment availability compliance for providers within each medical group by provider type and by compliance element. For example, in 2021 39 out of 42 psychiatrists contracted with Beacon Health Options for SFHP were able to provide a routine specialty care appointment within 21 business days, which equates to 93% of psychiatrists being compliant with the routine appointment standard.

Carelon		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Non-MD Behavioral	Urgent	57	42%	58%	51	20%	80%
	Routine	67	25%	75%	57	18%	82%
Psychiatry	Urgent	41	54%	46%	38	45%	55%
	Routine	42	7%	93%	39	15%	85%

Table 8: Appointment Availability Response Rates

The purpose of even-numbered tables eight through 28 is to demonstrate the appointment availability survey response rate by provider type. Specialty provider types are grouped by the specialties required by each regulatory or accrediting body: Cardiology, Endocrinology, and Gastroenterology for the DMHC, Obstetrics & Gynecology and Oncology for NCQA, and Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology for the DHCS.

Carelon	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	124	88%	214	45%
Non-MD Behavioral	81	83%	156	37%
Psychiatry	43	98%	58	67%

Table 9: Appointment Availability Compliance Rates

Brown and Toland Physicians		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	15	33%	67%	19	32%	68%
	Routine		7%	93%		11%	89%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Brown and Toland Physicians		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Cardiology	Urgent	5	0%	100%	2	100%	0%
	Routine		0%	100%	3	33%	67%
Dermatology	Urgent	2	50%	50%	2	100%	0%
	Routine		0%	100%		50%	50%
Endocrinology	Urgent	3	33%	67%	1	100%	0%
	Routine	4	0%	100%		100%	0%
Gastroenterology	Urgent	7	14%	86%	4	100%	0%
	Routine		0%	100%		50%	50%
General Surgery	Urgent	8	37%	63%	5	40%	60%
	Routine		0%	100%		20%	80%
Gynecology	Urgent	24	46%	54%	11	36%	64%
	Routine		21%	79%		0%	100%
Hematology	Urgent	No Data in 2021			1	100%	0%
	Routine	2	0%	100%		0%	100%
Infectious Disease	Urgent	1	0%	100%	1	100%	0%
	Routine		0%	100%		100%	0%
Nephrology	Urgent	5	100%	0%	3	67%	33%
	Routine		80%	20%		100%	0%
Neurology	Urgent	5	40%	60%	3	67%	33%
	Routine		40%	60%		67%	33%
Oncology	Urgent	3	0%	100%	3	67%	33%
	Routine		0%	100%		67%	33%
Ophthalmology	Urgent	10	60%	40%	5	100%	0%
	Routine	18	61%	39%	11	55%	45%
Orthopedics	Urgent	8	37%	63%	5	60%	40%
	Routine		0%	100%	6	0%	100%
Otolaryngology	Urgent	4	25%	75%	2	50%	50%
	Routine		0%	100%		0%	100%
Physical Medicine & Rehabilitation	Urgent	3	67%	33%	4	100%	0%
	Routine		33%	67%		50%	50%
Pulmonology	Urgent	2	67%	33%	2	50%	50%
	Routine		33%	67%	3	67%	33%
MRI	Routine	6	0%	100%	6	17%	83%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Table 10: Appointment Availability Response Rates

Brown and Toland Physicians	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	148	84%	93	94%
Primary Care	15	100%	19	100%
Cardiology, Endocrinology, Gastroenterology	16	100%	8	100%
Gynecology & Oncology	30	90%	17	82%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	79	75%	43	95%
Ancillary Providers	7	86%	6	100%

Table 11: Appointment Availability Compliance Rates

Chinese Community Healthcare Association		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	29	21%	79%	32	12%	88%
	Routine		10%	90%		3%	97%
Cardiology	Urgent	3	0%	100%	2	50%	50%
	Routine	2	0%	100%		0%	100%
Dermatology	Urgent	2	50%	50%	3	100%	0%
	Routine		0%	100%		67%	33%
Endocrinology	Urgent	3	33%	67%	2	0%	100%
	Routine		67%	33%		0%	100%
Gastroenterology	Urgent	5	20%	80%	3	33%	67%
	Routine		0%	100%		0%	100%
General Surgery	Urgent	3	0%	100%	4	25%	75%
	Routine		0%	100%		25%	75%
Gynecology	Urgent	8	25%	75%	8	50%	50%
	Routine		12%	88%		13%	88%
Hematology	Routine	1	0%	100%	1	100%	0%
Nephrology	Urgent	2	0%	100%	3	0%	100%
	Routine		0%	100%		0%	100%
Neurology	Urgent	2	50%	50%	4	50%	50%
	Routine	3	33%	67%		50%	50%
Oncology	Urgent	1	100%	0%	3	0%	100%
	Routine		0%	100%		0%	100%
Ophthalmology	Urgent	3	67%	33%	8	63%	38%
	Routine	7	14%	86%	10	40%	60%
Orthopedics	Urgent	4	25%	75%	9	67%	33%
	Routine		25%	75%		22%	78%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Chinese Community Healthcare Association		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Otolaryngology	Urgent	2	50%	50%	2	50%	50%
	Routine	3	33%	67%		0%	100%
Physical Medicine & Rehabilitation	Routine	1	0%	100%	1	0%	100%
Pulmonology	Urgent	1	100%	0%	1	100%	0%
	Routine		100%	0%		0%	100%

Table 12: Appointment Availability Response Rates

Chinese Community Healthcare Association	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	90	86%	96	93%
Primary Care	29	100%	32	100%
Cardiology, Endocrinology, Gastroenterology	12	92%	8	100%
Gynecology & Oncology	9	100%	13	85%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	39	69%	43	88%

Table 13: Appointment Availability Compliance Rates

Hill Physicians		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	26	31%	69%	31	23%	77%
	Routine	27	4%	96%		6%	94%
Cardiology	Urgent	4	25%	75%	3	0%	100%
	Routine	5	20%	80%		0%	100%
Dermatology	Urgent	2	50%	50%	2	100%	0%
	Routine		0%	100%		50%	50%
Endocrinology	Urgent	3	33%	67%	2	0%	100%
	Routine	4	50%	50%		100%	0%
Gastroenterology	Urgent	3	67%	33%	3	67%	33%
	Routine		0%	100%		0%	100%
General Surgery	Urgent	3	0%	100%	5	20%	80%
	Routine	4	0%	100%		20%	80%
Gynecology	Urgent	5	0%	100%	3	33%	67%
	Routine		0%	100%		0%	100%
Nephrology	Urgent	5	0%	100%	10	80%	20%
	Routine	6	0%	100%		60%	40%
Ophthalmology	Urgent	11	45%	55%	16	63%	38%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

	Routine	18	28%	72%	18	28%	72%
Orthopedics	Urgent	4	25%	75%	7	86%	14%
	Routine	5	0%	100%		14%	86%
Physical Medicine & Rehabilitation	Urgent	1	100%	0%	1	100%	0%
	Routine		0%	100%		0%	100%
MRI	Routine	14	0%	100%	12	0	100%

Table 14: Appointment Availability Response Rates

Hill Physicians	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	110	85%	111	87%
Primary Care	29	93%	32	97%
Cardiology, Endocrinology, Gastroenterology	13	92%	8	100%
Ancillary Providers	24	93%	12	100%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	48	75%	53	81%
Gynecology & Oncology	24	93%	6	50%

Table 15: Appointment Availability Compliance Rates

Jade Healthcare		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	19	17%	83%	18	33%	67%
	Routine	20	11%	89%	19	21%	79%
Cardiology	Urgent	17	65%	35%	24	87%	13%
	Routine	16	44%	56%	31	71%	29%
Dermatology	Urgent	12	83%	17%	17	88%	12%
	Routine		58%	42%		76%	24%
Endocrinology	Urgent	11	82%	18%	10	100%	0%
	Routine	14	57%	43%	19	68%	32%
Gastroenterology	Urgent	7	71%	29%	8	87%	13%
	Routine	11	46%	64%	11	45%	55%
General Surgery	Urgent	10	70%	30%	27	63%	37%
	Routine	19	26%	74%	30	43%	57%
Obstetrics & Gynecology	Urgent	29	38%	62%	41	76%	24%
	Routine	37	43%	57%	54	54%	46%
Hematology	Urgent	4	100%	0%	8	100%	0%
	Routine	10	80%	20%	7	43%	57%
Nephrology	Urgent	8	0%	100%	17	76%	24%
	Routine	19	89%	11%	18	50%	50%
Neurology	Urgent	19	89%	11%	35	94%	6%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Jade Healthcare		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
	Routine	24	58%	42%	46	78%	22%
Oncology	Urgent	6	67%	33%	39	74%	26%
	Routine	7	57%	43%	37	22%	78%
Ophthalmology	Urgent	23	57%	43%	31	45%	55%
	Routine	29	48%	52%	39	38%	62%
Orthopedics	Urgent	11	100%	0%	28	82%	18%
	Routine	13	54%	46%	36	47%	53%
Otolaryngology	Urgent	3	67%	33%	16	81%	19%
	Routine	8	62%	38%	19	79%	21%
Physical Medicine & Rehabilitation	Urgent	1	100%	0%	1	100%	0%
	Routine		100%	0%	2	50%	50%
Pulmonology	Urgent	5	80%	20%	3	33%	67%
	Routine	6	67%	33%	4	50%	50%
Psychiatry	Urgent	4	0%	100%	3	100%	0%
	Routine		50%	50%		67%	33%
MRI	Routine	3	0%	100%	3	0	100%
Physical Therapy	Routine	1	0%	100%	2	50%	50%

Table 16: Appointment Availability Response Rates

Jade Healthcare	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	384	64%	542	74%
Primary Care	20	100%	20	95%
Cardiology, Endocrinology, Gastroenterology	46	91%	65	95%
Gynecology & Oncology	72	61%	114	82%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	237	55%	330	66%
Psychiatry	4	100%	7	43%
Ancillary Providers	5	80%	6	83%

Table 17: Appointment Availability Compliance Rates

Northeast Medical Services		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	22	18%	82%	36	50%	50%
	Routine	29	5%	95%	37	24%	76%
Cardiology	Urgent	29	59%	41%	25	76%	24%
	Routine	30	30%	70%	29	55%	45%
Dermatology	Urgent	7	57%	43%	3	100%	0%
	Routine		29%	71%	4	75%	25%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Northeast Medical Services		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Endocrinology	Urgent	11	73%	27%	9	89%	11%
	Routine	13	38%	62%	10	60%	40%
Gastroenterology	Urgent	8	37%	63%	9	89%	11%
	Routine	13	31%	69%	11	55%	45%
General Surgery	Urgent	13	23%	77%	17	47%	53%
	Routine	20	10%	90%	18	44%	56%
Gynecology	Urgent	55	22%	78%	49	49%	51%
	Routine		9%	91%	51	20%	80%
Infectious Diseases	Urgent	1	0%	100%	1	100%	0%
	Routine		0%	100%	3	0%	100%
Nephrology	Urgent	12	0%	100%	3	0%	100%
	Routine	13	0%	100%	3	0%	100%
Neurology	Urgent	8	37%	63%	12	83%	17%
	Routine	11	27%	73%	15	87%	13%
Oncology	Urgent	5	0%	100%	6	67%	33%
	Routine	6	17%	83%		50%	50%
Ophthalmology	Urgent	13	37%	63%	17	65%	35%
	Routine	15	7%	93%	24	33%	67%
Orthopedics	Urgent	3	67%	33%	8	75%	25%
	Routine	6	33%	67%	9	22%	78%
Otolaryngology	Urgent	5	20%	80%	5	20%	80%
	Routine	6	0%	100%	5	0%	100%
Physical Medicine & Rehabilitation	Urgent	1	100%	0%	2	100%	0%
	Routine		0%	100%	3	33%	67%
Pulmonology	Urgent	3	67%	33%	4	75%	25%
	Routine		33%	67%		50%	50%
MRI	Routine	8	0%	100%	9	0%	100%

Table 18: Appointment Availability Response Rates

Northeast Medical Services	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	284	86%	266	91%
Primary Care	22	100%	37	100%
Cardiology, Endocrinology, Gastroenterology	59	95%	51	98%
Obstetrics & Gynecology, Oncology	68	91%	61	93%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	127	76%	108	81%
Ancillary Providers	8	100%	9	100%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Table 19: Appointment Availability Compliance Rates

Northeast Medical Services with SFHN		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	10	0%	100%	9	0%	100%
	Routine		0%	100%		0%	100%
Cardiology	Urgent	4	75%	25%	3	33%	67%
	Routine		25%	75%		33%	67%
Endocrinology	Urgent	6	17%	83%	4	75%	25%
	Routine		17%	83%		75%	25%
Gastroenterology	Urgent	9	78%	22%	8	100%	0%
	Routine	10	60%	40%	9	100%	0%
General Surgery	Urgent	7	100%	0%	9	89%	11%
	Routine		71%	29%		78%	22%
Gynecology	Urgent	4	25%	75%	7	14%	86%
	Routine	5	0%	100%		0%	100%
Hematology	Urgent	4	25%	75%	2	100%	0%
	Routine	5	0%	100%		50%	50%
Nephrology	Urgent	1	100%	0%	2	100%	0%
	Routine		100%	0%		100%	0%
Oncology	Urgent	6	50%	50%	2	100%	0%
	Routine		33%	67%	3	100%	0%
Orthopedics	Urgent	1	0%	100%	6	67%	33%
	Routine		0%	100%		33%	67%
Otolaryngology	Urgent	8	62%	38%	1	0%	100%
	Routine	10	50%	50%	2	0%	100%
Psychiatry	Urgent	18	28%	72%	10	30%	70%
	Routine		0%	100%	11	27%	73%

Table 20: Appointment Availability Response Rates

Northeast Medical Services with SFHN	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	156	58%	139	48%
Primary Care	10	100%	9	100%
Cardiology, Endocrinology, Gastroenterology	24	83%	23	70%
Gynecology & Oncology	32	22%	25	40%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	72	49%	48	44%
Psychiatry	18	100%	34	32%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

Table 21: Appointment Availability Compliance Rates

SF Behavioral Health Services		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Non-MD Behavioral	Urgent	155	59%	41%	77	49%	51%
	Routine	180	31%	69%	85	34%	66%
Psychiatry	Urgent	95	34%	66%	32	38%	63%
	Routine	97	8%	92%	33	12%	88%

Table 22: Appointment Availability Response Rates

SF Behavioral Health Services	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	318	87%	580	20%
Non-MD Behavioral	213	85%	452	19%
Psychiatry	105	92%	128	26%

Table 23: Appointment Availability Compliance Rates

San Francisco Consortium of Community Clinics		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	6	0%	100%	3	33%	67%
	Routine		0%	100%		0%	100%

Table 24: Appointment Availability Response Rates

San Francisco Consortium of Community Clinics	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
Primary Care	12	50%	3	100%

Table 25: Appointment Availability Compliance Rates

San Francisco Health Network		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	13	0%	100%	7	14%	86%
	Routine		0%	100%	8	25%	75%
Cardiology	Urgent	2	50%	50%	3	67%	33%
	Routine		50%	50%		33%	67%
Endocrinology	Urgent	6	50%	50%	4	100%	0%
	Routine		33%	67%		100%	0%
Gastroenterology	Urgent	10	70%	30%	8	100%	0%
	Routine	11	55%	45%	9	100%	0%
General Surgery	Urgent	7	100%	0%	10	90%	10%
	Routine		71%	29%		80%	20%
Gynecology	Routine	4	0%	100%	2	0%	100%
Hematology	Urgent	1	100%	0%	2	100%	0%

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

	Routine		0%	100%		50%	50%
Infectious Diseases	Urgent	4	100%	0%	2	0%	100%
	Routine		100%	0%		0%	100%
Nephrology	Urgent	3	67%	33%	2	100%	0%
	Routine		67%	33%		100%	0%
Oncology	Urgent	2	100%	0%	2	100%	0%
	Routine		0%	100%	3	100%	0%
Ophthalmology	Urgent	2	50%	50%	1	100%	0%
	Routine		50%	50%		100%	0%
Orthopedics	Urgent	11	73%	27%	11	82%	18%
	Routine	13	62%	38%		64%	36%
Otolaryngology	Routine	1	100%	0%	1	0%	100%
Physical Medicine & Rehabilitation	Urgent	3	100%	0%	1	100%	0%
	Routine		100%	0%		100%	0%
Psychiatry	Urgent	7	57%	43%	22	32%	68%
	Routine		0%	100%	25	16%	84%

Table 26: Appointment Availability Response Rates

San Francisco Health Network	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	186	59%	186	45%
Primary Care	13	100%	14	57%
Cardiology, Endocrinology, Gastroenterology	25	76%	25	64%
Gynecology & Oncology	29	21%	20	25%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	97	52%	71	42%
Psychiatry	22	100%	56	45%

Table 27: Appointment Availability Compliance Rates

University of California San Francisco		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
Primary Care	Urgent	11	0%	100%	40	78%	23%
	Routine		9%	91%	46	63%	37%
Cardiology	Urgent	43	47%	53%	46	76%	24%
	Routine	47	23%	77%	56	54%	46%
Dermatology	Urgent	28	100%	0%	20	90%	10%
	Routine	32	97%	3%	21	86%	14%
Endocrinology	Urgent	13	69%	31%	9	100%	0%
	Routine	18	50%	50%	17	82%	18%
Gastroenterology	Urgent	15	67%	33%	20	90%	10%
	Routine	18	50%	50%	23	83%	17%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

University of California San Francisco		MY 2021			MY 2022		
		Sample size	Non-compliant	Compliant	Sample size	Non-compliant	Compliant
General Surgery	Urgent	13	77%	23%	21	67%	33%
	Routine	14	57%	43%	25	36%	64%
Gynecology	Urgent	20	80%	20%	30	90%	10%
	Routine	37	68%	32%	47	87%	13%
Hematology	Urgent	10	70%	30%	10	100%	0%
	Routine	23	70%	30%	12	58%	42%
Infectious Disease	Urgent	8	100%	0%	7	43%	57%
	Routine	9	67%	33%	8	50%	50%
Nephrology	Urgent	3	100%	0%	11	73%	27%
	Routine		33%	67%	12	50%	50%
Neurology	Urgent	16	81%	19%	41	93%	7%
	Routine	25	52%	48%	53	70%	30%
Oncology	Urgent	22	59%	41%	56	70%	30%
	Routine	25	44%	56%	56	21%	79%
Ophthalmology	Urgent	14	64%	36%	18	50%	50%
	Routine	17	88%	12%	18	39%	61%
Orthopedics	Urgent	26	85%	15%	24	92%	8%
	Routine	33	52%	48%	40	53%	47%
Otolaryngology	Urgent	6	83%	17%	16	81%	19%
	Routine	11	73%	27%	20	80%	20%
Physical Medicine & Rehabilitation	Urgent	2	100%	0%	1	100%	0%
	Routine		100%	0%	2	100%	0%
Pulmonology	Urgent	7	71%	29%	6	67%	33%
	Routine	8	50%	50%	7	57%	43%
Psychiatry	Urgent	55	58%	42%	10	100%	0%
	Routine		13%	87%	11	45%	55%

Table 28: Appointment Availability Response Rates

University of California San Francisco	MY 2021 sample size	MY 2021 response	MY 2022 sample size	MY 2022 response
All Provider Types	793	49%	392	55%
Primary Care	11	100%	46	100%
Cardiology, Endocrinology, Gastroenterology	100	83%	101	96%
Gynecology & Oncology	135	46%	147	71%
Dermatology, ENT/Otolaryngology, General Surgery, Hematology, HIV/Infectious Diseases, Nephrology, Neurology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Pulmonology	485	37%	392	55%
Psychiatry	62	90%	64	17%

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821
FAX www.sfhp.org

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
www.sfhp.org

2022 ACCESS TO TRIAGE SERVICES

Date: August 28, 2023

Access Monitoring Requirements

The Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) require SFHP to monitor accessibility requirements for telephonic triage. DMHC and DHCS require primary care and behavioral health providers offer 24-hour coverage with the ability to access a clinician within 30 minutes of the member's request. In addition, DMHC and DHCS require that providers inform members on how to access emergency care when calling a provider.

Executive Summary of Results

Accomplishments:

- SFHP's network reached 90% compliance in providing accurate emergency instructions (Table D, page 4).

Quantitative Summary:

- 70% of SFHP providers provide after-hours triage within 30 minutes, which fell short of the goal of 80% (Table D, page 4).
- 78% of SFHP providers provide business-hours triage within 30 minutes, which fell short of the goal of 80% (Table D, page 4).
- The number of groups reaching 80% compliance in triage within 30 minutes after business hours decreased (Table C, page 4).
- Only four of twenty-seven compliance rates improved from last year while eighteen worsened (Table D).

Barriers:

- SFHP identified three barriers to meeting 80% compliance in providing triage within 30 minutes after business hours.
    - When new providers or clinics join SFHP, they may not be updating after-hours recorded messages to include language that communicates to members how to reach their provider after-hours and when they can expect to hear from a provider.
    - Additionally, for providers and clinics already contracted with SFHP, they may be altering their after-hours recorded message and removing either the description of how to reach a provider and/or removing the description that a member can expect to hear back from a provider within 30 minutes.
    - Moreover, there is high turnover rate in front-desk staff positions and there is need of training on telephone triage compliance requirements.

Qualitative Analysis:

- Only four of the yellow highlights were repeat instances in 2022 (Table D). These are all for after hours triage for the following provider groups BTP, CCHCA, HILL, and UCSF. The 2021 corrective

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
www.sfhp.org

action plans these groups made for this measure were not successful and SFHP will ensure 2022 corrective action plans are more elaborative than 2021.

- There were eight new medical group yellow highlights in 2022 (Table D). These new non-compliance rates were spread across our provider network. Providers have shared there is a staff resource issue, and this is likely to have contributed to these results.
- There were less results for day-time triage in 2021 than 2022. SFHP will work with our vendor, Sutherland, to ensure the survey user interface is easy to navigate and understand.

Planned Actions:

- SFHP has requested plans for corrective action for any group that falls below the 80% compliance rate (Table D).
- SFHP will provide technical assistance and coaching to provide best practices for improving access to care, survey responsiveness, and instructions on how to accurately submit a corrective action plan.

Survey Methodology

SFHP conducted the Daytime and After-Hours triage surveys from December 2021 through January 2022 during and after business hours. SFHP surveyed contracted providers and clinic sites that providing routine primary care (including internal medicine, pediatrics, and family/general medicine). Additionally, SFHP surveyed SFHP's contracted behavioral health care call centers. Each medical group's survey population is a census of primary care sites and therefore contains all phone numbers for primary care providers within the medical group.

For each unique site surveyed, SFHP sent faxes or emails linking to the Daytime Survey. SFHP requested information regarding the amount of time to hear back from a provider in the event of a member expressing an urgent need to speak with a clinician during business hours. Provider sites had ten business days to respond to the survey. Providers which refused to respond to the survey or failed to return the phone call within the allotted time were categorized as non-responsive. SFHP requires a 50% response rate for the Daytime Survey. A plan for corrective action is required when a group or clinic does not meet the 50% response requirement.

SFHP assessed access to triage after business hours and emergency instructions through the 2021 After-Hours Survey. For each unique phone number surveyed, SFHP relayed that SFHP was conducting an access compliance survey. SFHP requested information regarding the amount of time to hear back from a provider in the event of a member expressing an urgent need to speak with a clinician after hours and what instructions members are given in the event of an emergency.

Responses that did not provide a compliant answer for access elements described in Table A were categorized as non-compliant. SFHP aggregated results to obtain a compliance rate for each medical group and clinic. SFHP requires 80% compliance rate for emergency instructions, daytime and after-hours triage. A plan for corrective action is required when a group or clinic does not meet the 80% compliance requirement.

Table A: Triage Requirements

Survey Element	Definition

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
www.sfhp.org

Emergency Instructions	Correct emergency instructions to go to nearest hospital or call 911 if members experience an emergency.
Daytime Triage	Triage call from a licensed clinician within 30 minutes of request during operating hours when members have an urgent (not emergency) medical need.
After-Hours Triage	Triage return call from a licensed clinician within 30 minutes of request after operating hours when members have an urgent (not emergency) medical need.

Table B: Results & Provider Group Key

Green	Scores marked in green indicate higher scores in 2022 than in 2021
Red	Scores marked in red indicate lower scores in 2022 than in 2021
Yellow	Scores highlighted in yellow indicate that the group did not reach 80% compliance for the access standard
BHO	Beacon Health Options
BTP	Brown and Toland Medical Group
CCHCA	Chinese Community Health Care Association
HILL	Hill Physicians Medical Group
JADE	Jade Health Care Medical Group
NEMS	North East Medical Services
NMS	North East Medical Services with SFHN
SFBHS	San Francisco Behavioral Health Services
SFCCC & IC	San Francisco Community Clinic Consortium & Independent Clinics
SFHN	San Francisco Health Network
UCSF	University of California San Francisco Medical Group
SFHP	San Francisco Health Plan Overall

Table C: Aggregate of Medical Group Compliance (80%)

Compliance Element	Medical groups and clinics achieving 80% compliance (MY 2021)	Medical groups and clinics achieving 80% compliance (MY 2022)
Emergency Instructions	100%	90%
Daytime Triage	67%	67%
After-Hours Triage	58%	11%

Table D: Measurement Year 2021 – 2022 Telephone Triage Compliance Rates

Medical Group	Survey Element	MY 2021 Survey *n*	MY 2021 Compliance Rate	MY 2022 Survey *n*	MY 2022 Compliance Rate
BTP	**Emergency Instructions**	**12**	**100%**	**19**	**79%**
	Daytime Triage	**6**	**50%**	**5**	**80%**
	After-Hours Triage	**13**	**77%**	**19**	**63%**
CCHCA	**Emergency Instructions**	**23**	**100%**	**35**	**89%**

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
www.sfhp.org

	Daytime Triage	9	89%	8	88%
	After-Hours Triage	23	74%	35	74%
HILL	Emergency Instructions	25	100%	38	92%
	Daytime Triage	11	91%	9	78%
	After-Hours Triage	25	52%	38	68%
JADE	Emergency Instructions	14	86%	21	95%
	Daytime Triage	7	100%	16	81%
	After-Hours Triage	14	93%	21	76%
NEMS	Emergency Instructions	21	100%	18	83%
	Daytime Triage	12	100%	6	83%
	After-Hours Triage	22	91%	18	78%
NMS	Emergency Instructions	9	100%	1	100%
	After-Hours Triage	11	100%	10	100%
SFBHS	Emergency Instructions	1	100%	1	100%
	After-Hours Triage		100%		0%
SFCCC & IC	Emergency Instructions	6	100%	10	90%
	Daytime Triage		100%	2	50%
	After-Hours Triage	3	100%	10	70%
SFHN	Emergency Instructions	13	100%	10	100%
	After-Hours Triage		92%		70%
UCSF	Emergency Instructions	8	100%	10	90%
	After-Hours Triage	10	40%		60%
SFHP	Emergency Instructions	139	98%	165	90%
	Daytime Triage	80	85%	49	78%
	After-Hours Triage	144	77%	165	70%

NOTE: Kaiser Permanente is a fully delegated medical group and was not included in the survey. Kaiser submits their access reports directly to DHCS and DMHC.

UM Clinical Criteria

Presented by

SeDessie Harris, RN, MHA

- General UM criteria overview
- SFHP internally developed criteria
- MCG Criteria (top 3 guidelines used) and Physician Administered Drugs (PADs)

UM Clinical Criteria

1. SFHP internally developed and approved criteria
   - Gender Affirming Services
   - EPSDT Private Duty Nursing
   - Long-Term Care (LTC)
2. MCG Care Guidelines
3. State/Federal (Medi-Cal/CMS) criteria – (Medi-Cal only)

   If no Medi-Cal Criteria is available, Medicare/CMS criteria can be consulted on a case-by-case basis.
4. Chief Medical Officer (CMO) or physician designee (MD) review of the evidence in consultation with relevant external, independent specialty expertise obtained from SFHP's Independent Review Organization when there are no available external or internally developed and approved criteria.

Top 3 MCG Guidelines

#1: Cellulitis

- Inpatient and Surgical Care Guideline
- Frequently used due to the number of skin infections in our patient population
- Clinical Indications for Admission to Inpatient Care:
  - Hemodynamic instability
  - Failure of outpatient therapy
  - Bacteremia
  - Surgical procedure needed

Top 3 MCG Guidelines

#2: Substance-Related Disorders

- Inpatient and Surgical Care Guideline
- Clinical Indications for Admission to Inpatient Care:
  - Withdrawal signs related to alcohol, sedative, or opioid with high risk indicators, as indicated by:
    - Signs of withdrawal:
      - Heart rate >100, Nausea or vomiting, Tremor, Increased perspiration
    - Elevated risk due to historical or comorbid factors:
      - History of delirium due to alcohol or sedative withdrawal, history of repetitive seizures, epilepsy, pregnancy
- Acute toxicity or instability from substance use requiring inpatient care for which lower level of care is not feasible or inappropriate

Top 3 MCG Guidelines

#3: Sepsis and Other Febrile Illness

- Inpatient and Surgical Care Guideline
- Clinical Indications for Admission to Inpatient Care:
  - Hemodynamic instability
  - Bacteremia
  - Hypoxemia
  - Altered mental status that is severe or persistent
  - Tachypnea
  - Evidence of end organ dysfunction

PAD (Physician Adminstered Drugs) MCG Guidelines

- #1: OnabotulinumtoxinA
  - Top 3 indications: Migraine headache prophylaxis, Spasticity, Axillary Hyperhidrosis
  - Link to OnabotulinumtoxinA MCG criteria
- #2: Gonadotropin-Releasing Hormone (GnRH) Agonists
  - Top 3 indications: Breast or Prostate Cancer, Uterine leiomyomas, Central precocious puberty
  - Link to GnRH Agonists MCG criteria
- #3: Aflibercept
  - Top 3 indications: Diabetic retinopathy, Neovascular age-related macular degeneration, Diabetic macular edema
  - Link to Aflibercept MCG criteria

SFHP Gender Affirming Services Criteria

- QIC approved current version in February 2023 (no changes)
- Criteria and terminology matches World Professional Association for Transgender Health's Standards of Care- Version 8, DHCS's reconstructive surgery statue, and California Health and Safety Code fertility preservation law
- Gender Affirming Criteria

SFHP EPSDT Private Duty Nursing Criteria

- No updates since previous QIC approval (February 2023)
- Acuity grid for determining approvable hours
- Developed by Utah Medicaid program
- Chosen over MCG Care Guideline's criteria given small request volume
- EPSDT PDN Criteria

SFHP Long-Term Care (LTC) Criteria

- Adult and pediatric subacute criteria added in preparation for LTC Phase 2 carve in.
- Criteria is aligned with California Code of Regulations, Title 22.
- Custodial Care Criteria

Aflibercept

ACG: A-0680 (AC)
Link to Codes

MCG Health
Ambulatory Care
27th Edition

Clinical Indications

- Aflibercept may be indicated when **ALL** of the following are present(1)(2):
  - Age 18 years or older
  - Clinical diagnosis of **1 or more** of the following:
    - Diabetic macular edema[A](13)(14)(15)(16)(17)(18)N
    - Diabetic retinopathy[B](30)(31)N
    - Macular edema following central or branch retinal vein occlusion[C](34)(35)(36)(37)N
    - Metastatic colorectal cancer[D] with progression of disease on initial therapy(46)(47)(48)N
    - Neovascular (wet, or exudative) age-related macular degeneration[E](14)(37)(55)(56)(57)N
  - No active intraocular inflammation(67)
  - No concurrent ocular or periocular infection(67)

Evidence Summary

Background

Aflibercept acts as a decoy receptor that binds vascular endothelial growth factor, which inhibits its role in promoting neovascularization and vascular permeability.(1)(3)(4) **(EG 2)**

Criteria

For diabetic macular edema, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Meta-analyses and systematic reviews have demonstrated that all vascular endothelial growth factor inhibitors appear to have some activity against diabetic macular edema,(19) with some clinical trial evidence suggesting that aflibercept may improve best-corrected visual acuity (measured by Early Treatment Diabetic Retinopathy Study (ETDRS) letters) significantly compared with bevacizumab, without a statistically significant difference compared with ranibizumab.(20) **(EG 1)** A multicenter randomized double-masked study of 221 patients with diabetic macular edema reported significant improvement with aflibercept in mean best-corrected visual acuity after 24 weeks and 52 weeks.(21)(22) **(EG 1)** A randomized study of 872 eyes of patients with central involvement of diabetic macular edema found that intravitreal administration of aflibercept, as compared with laser photocoagulation, produced significantly greater improvement in both visual acuity and central retinal thickness after 52 weeks.(23) **(EG 1)** Follow-up studies showed that incremental visual acuity benefits were maintained at 100 weeks to 148 weeks.(24)(25) **(EG 1)** A randomized study of 660 adults with diabetic macular edema who received either intravitreal aflibercept, ranibizumab, or bevacizumab found that, after 1 year, visual acuity improvement was comparable among all 3 drugs in those with mild initial visual acuity loss; however, for those with worse initial levels of visual acuity, aflibercept was more effective at improving vision.(26) **(EG 1)** A follow-up study for up to 2 years found that all 3 groups showed continuing improvement in visual acuity, with similar improvement across all 3 drugs in eyes with better baseline acuity. However, among eyes with poorer baseline acuity, aflibercept had significantly better acuity improvement after 2 years as compared with bevacizumab.(27)(28) **(EG 1)** A secondary analysis also found, in eyes with proliferative diabetic retinopathy at baseline, that aflibercept therapy for diabetic macular edema was associated with a higher rate of diabetic retinopathy improvement compared with bevacizumab at both 1-year (75.9% vs 31.4%, respectively) and 2-year (70.4% vs 30.3%, respectively) follow-up; bevacizumab was also associated with a higher rate of improvement compared with ranibizumab at both 1-year (75.9% vs 55.2%, respectively) and 2-year (70.4% vs 37.5%, respectively) follow-up.(29) **(EG 1)** Review articles indicate that aflibercept use was found to be associated with improvement in the severity of diabetic retinopathy in patients with diabetic macular edema as a secondary outcome during clinical trials.(17)(18) **(EG 2)**

For diabetic retinopathy, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A multicenter phase III randomized trial of 402 adult patients with severe nonproliferative diabetic retinopathy without macular edema compared treatment with either intravitreal aflibercept (at 1 of 2 dosing regimens) or sham injection and found, at 52-week and 100-week follow-up, that aflibercept at either dose was associated with more patients achieving a 2-step or greater improvement in Diabetic Retinopathy Severity Scores (DRSS), fewer vision-threatening complications, and a lower rate of development of center-involved diabetic macular edema compared with sham injection.(32) **(EG 1)** A phase II noninferiority trial of 221 patients with active proliferative diabetic retinopathy compared treatment with aflibercept or panretinal laser photocoagulation and found, at 52-week follow-up, that aflibercept was noninferior to laser photocoagulation for best-corrected visual acuity change from baseline.(30) **(EG 1)** A review article notes that patients with diabetic retinopathy who are treated with vascular endothelial growth factor inhibitors may have less visual field loss, less development of diabetic macular edema, and less need for vitrectomy surgery compared with patients treated with panretinal photocoagulation.(31) **(EG 2)**

For macular edema following central or branch retinal vein occlusion, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Meta-analyses and systematic reviews have confirmed the efficacy and safety of vascular endothelial growth factor inhibitors for treatment of central and branch retinal vein occlusions for up to 26 to 52 weeks.(38)(39)(40)(41) **(EG 1)** The gains in visual acuity with aflibercept were maintained at 52-week and 76-week follow-up.(42) **(EG 1)** A randomized noninferiority trial of 463 patients with macular edema due to central retinal vein occlusion compared treatment with ranibizumab, aflibercept, or bevacizumab and found, at 100-week follow-up, mean gains in best-corrected visual acuity letter scores of 12.5, 15.1, and 9.8 in patients treated with ranibizumab, aflibercept, and bevacizumab, respectively. The authors found that aflibercept was noninferior compared with ranibizumab; however, bevacizumab was not noninferior compared with ranibizumab.(43) **(EG 1)** Specialty society guidelines state that aflibercept is an effective treatment for macular edema due to retinal vein occlusion.(44)(45) **(EG 2)**

For metastatic colorectal cancer with progression of disease on initial therapy, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A randomized phase III trial of 1226 patients with metastatic colorectal cancer previously treated with an oxaliplatin-based regimen reported that the addition of aflibercept to standard fluoropyrimidine-based chemotherapy resulted in an improved mean overall survival of 13.5 months, as compared with 12.1 months in the group receiving standard chemotherapy.(49) **(EG 1)** Longer-term follow-up analysis of safety and efficacy of this phase III study indicated the following probabilities of survival for those receiving aflibercept vs placebo: 38.5% vs 30.9% at 18 months, 28% vs 18.7% at 24 months, and 22.3% vs 12% at 30 months; the majority of the most severe adverse events occurred within earlier cycles of treatment.(50) **(EG 1)** A post hoc analysis of this study suggested that inclusion of some patients who had rapidly relapsed within 6 months of oxaliplatin-containing adjuvant chemotherapy may have resulted in understating the treatment benefit of aflibercept in patients who did not belong to this poor prognosis subgroup.(51) **(EG 2)** A technology assessment stated that the impact of aflibercept on overall survival of patients with metastatic colorectal cancer that has progressed following prior oxaliplatin-based chemotherapy was statistically significant but clinically small.(52) **(EG 1)** A meta-analysis of the use of aflibercept for treating various solid tumors found a significantly higher rate of fatal drug-related adverse events in treated patients as compared with controls, with an overall incidence of fatal events of 5.1%.(9) **(EG 1)** A meta-analysis stated that the incidence of severe infections in patients with solid tumors who were treated with aflibercept was 7.3%, and the mortality rate was 2.2%.(53) **(EG 1)** Expert consensus guidelines state that aflibercept, when given in conjunction with other chemotherapeutics (such as irinotecan or the folinic acid, fluorouracil, and irinotecan (FOLFIRI) regimen), may be appropriate for patients with metastatic colorectal cancer who have progressed on initial therapy. Aflibercept plus FOLFIRI is only appropriate for those patients who have not yet been exposed to any other treatment regimen containing FOLFIRI.(46)(47) **(EG 2)**

For neovascular age-related macular degeneration, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A meta-analysis and systematic review identified 2 randomized trials with a total of 2457 patients with neovascular age-related macular degeneration who received either intravitreal aflibercept or ranibizumab and found that patients achieved comparable improvement in visual acuity with either drug up to 1 year after initiation of treatment.(58) **(EG 1)** However, other authors have found that intraocular pressure is higher in patients who receive ranibizumab as compared with aflibercept.(59) **(EG 1)** Follow-up studies of patients treated with either ranibizumab or aflibercept for neovascular age-related macular degeneration indicate continued comparable effectiveness in improving visual acuity and preventing further vision loss for up to 96 weeks.(60)(61) **(EG 1)** A randomized trial of 278 patients with neovascular age-related macular degeneration compared treatment with intravitreal aflibercept or ranibizumab and found, at 24-month follow-up, no difference in development or growth of macular atrophy or change in best-corrected visual acuity between the groups.(62) **(EG 1)** A randomized trial of 127 patients with intermediate nonexudative age-related macular degeneration compared prophylactic treatment with either intravitreal aflibercept or sham injection and found, at 24-month follow-up, no difference in rates of conversion to exudative macular degeneration between groups.(63) **(EG 1)** Critical reviews of studies have found some evidence that switching from either ranibizumab or bevacizumab to aflibercept in refractory patients may further improve visual acuity outcomes. However, the authors caution that additional confirmatory randomized controlled trials are necessary.(64)(65) **(EG 2)** A specialty society guideline recommends aflibercept as a management option for patients with neovascular age-related macular degeneration.(66) **(EG 2)**

Inconclusive or Non-Supportive Evidence

For non-small cell lung cancer, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A multicenter double-blind placebo-controlled trial of 913 patients with advanced or metastatic nonsquamous non-small cell lung cancer reported that the addition of aflibercept to standard docetaxel therapy did not improve overall survival and was associated with increased toxicities.(5)(6) **(EG 1)** Several cases of reversible posterior

leukoencephalopathy syndrome have been observed in a phase II study of non-small cell lung cancer patients receiving a combination of aflibercept, pemetrexed, and cisplatin.(7) **(EG 2)**

For ovarian cancer, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A randomized phase II study of 84 patients with platinum-resistant advanced ovarian cancer found that while the drug was well tolerated, the desired efficacy endpoints were not achieved.(8) **(EG 1)** A meta-analysis of the use of aflibercept for treating various solid tumors found a significantly higher rate of fatal drug-related adverse events in treated patients as compared with controls, with an overall incidence of fatal events of 5.1%.(9) **(EG 1)**

For pancreatic cancer, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A phase III randomized study assigned 546 patients with metastatic pancreatic cancer to gemcitabine with or without aflibercept. The study was terminated when it was noted that the addition of aflibercept failed to significantly improve overall survival.(10) **(EG 1)** A meta-analysis of the use of aflibercept for treating various solid tumors found a significantly higher rate of fatal drug-related adverse events in treated patients as compared with controls, with an overall incidence of fatal events of 5.1%.(9) **(EG 1)**

For prostate cancer, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A phase III randomized study of 1224 patients with metastatic castration-resistant prostate cancer found that adding aflibercept to docetaxel and prednisone as first-line therapy resulted in no improvement in overall survival and incurred additional adverse effects. The authors indicated that docetaxel plus prednisone remains the standard treatment.(11) **(EG 1)** A meta-analysis of the use of aflibercept for treating various solid tumors found a significantly higher rate of fatal drug-related adverse events in treated patients as compared with controls, with an overall incidence of fatal events of 5.1%.(9) **(EG 1)**

For retinopathy of prematurity (ROP), evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review and meta-analysis of 6 studies (all cohort studies or case series) including 218 eyes in patients with ROP evaluated intravitreal aflibercept injection at half the adult dose as initial therapy for prethreshold type 1 ROP, threshold ROP, and aggressive posterior ROP and found that aflibercept therapy resulted in a 97% average regression rate and a 16% average recurrence rate. However, the authors noted that randomized controlled trials are needed to compare outcomes for the various anti-vascular endothelial growth factor agents and evaluate safety in this population.(12) **(EG 1)**

References

1. Eylea (aflibercept) injection, for intravitreal use. Physician Prescribing Information [Internet] Regeneron Pharmaceuticals, Inc. 2022 Aug Accessed at: https://www.eylea.us/. [created 2011; accessed 2022 Nov 11] [Context Link 1, 2, 3, 4, 5, 6, 7, 8]
2. Zaltrap (ziv-aflibercept) injection, for intravenous use. Physician Prescribing Information [Internet] sanofi-aventis U.S. LLC. 2020 Dec Accessed at: https://www.zaltrap.com/. [created 2012; accessed 2022 Nov 13] [Context Link 1, 2]
3. Ohr M, Kaiser PK. Intravitreal aflibercept injection for neovascular (wet) age-related macular degeneration. Expert Opinion on Pharmacotherapy 2012;13(4):585-91. DOI: 10.1517/14656566.2012.658368. [Context Link 1] View abstract...
4. Ferrara N, Adamis AP. Ten years of anti-vascular endothelial growth factor therapy. Nature Reviews. Drug Discovery 2016;15(6):385-403. DOI: 10.1038/nrd.2015.17. [Context Link 1] View abstract...
5. Ramlau R, et al. Aflibercept and Docetaxel versus Docetaxel alone after platinum failure in patients with advanced or metastatic non-small-cell lung cancer: a randomized, controlled phase III trial. Journal of Clinical Oncology 2012;30(29):3640-7. DOI: 10.1200/JCO.2012.42.6932. [Context Link 1] View abstract...
6. Neal JW, Wakelee HA. Aflibercept in lung cancer. Expert Opinion on Biological Therapy 2013;13(1):115-20. DOI: 10.1517/14712598.2013.745847. [Context Link 1] View abstract...
7. Chen H, et al. A phase II multicentre study of ziv-aflibercept in combination with cisplatin and pemetrexed in patients with previously untreated advanced/metastatic non-squamous non-small cell lung cancer. British Journal of Cancer 2014;110(3):602-8. DOI: 10.1038/bjc.2013.735. [Context Link 1] View abstract...
8. Tew WP, et al. Intravenous aflibercept in patients with platinum-resistant, advanced ovarian cancer: results of a randomized, double-blind, phase 2, parallel-arm study. Cancer 2014;120(3):335-43. DOI: 10.1002/cncr.28406. [Context Link 1] View abstract...
9. Qi WX, Tang LN, Shen Z, Yao Y. Treatment-related mortality with aflibercept in cancer patients: a meta-analysis. European Journal of Clinical Pharmacology 2014;70(4):461-7. DOI: 10.1007/s00228-013-1633-2. [Context Link 1, 2, 3, 4] View abstract...
10. Rougier P, et al. Randomised, placebo-controlled, double-blind, parallel-group phase III study evaluating aflibercept in patients receiving first-line treatment with gemcitabine for metastatic pancreatic cancer. European Journal of Cancer 2013;49(12):2633-42. DOI: 10.1016/j.ejca.2013.04.002. [Context Link 1] View abstract...
11. Tannock IF, et al. Aflibercept versus placebo in combination with docetaxel and prednisone for treatment of men with metastatic castration-resistant prostate cancer (VENICE): a phase 3, double-blind randomised trial. Lancet Oncology 2013;14(8):760-8. DOI: 10.1016/S1470-2045(13)70184-0. [Context Link 1] View abstract...
12. Chen PJ, Rossin EJ, Vavvas DG. Aflibercept for retinopathy of prematurity: a systematic review and meta-analysis. Ophthalmic Surgery, Lasers & Imaging Retina 2021;52(12):673-681. DOI: 10.3928/23258160-20211124-01. [Context Link 1] View abstract...
13. Stewart MW. Anti-VEGF therapy for diabetic macular edema. Current Diabetes Reports 2014;14(8):510. DOI: 10.1007/s11892-014-0510-4. [Context Link 1] View abstract...

14. VEGF inhibitors for AMD and diabetic macular edema. Medical Letter on Drugs and Therapeutics 2015;57(1464):41-42. [Context Link 1, 2] View abstract...
15. Harkins KA, Haschke M, Do DV. Aflibercept for the treatment of diabetic macular edema. Immunotherapy 2016;8(5):503-10. DOI: 10.2217/imt.16.5. [Context Link 1] View abstract...
16. Ashraf M, Souka A, Adelman R, Forster SH. Aflibercept in diabetic macular edema: evaluating efficacy as a primary and secondary therapeutic option. Eye (London, England) 2016;30(12):1531-41. DOI: 10.1038/eye.2016.174. [Context Link 1] View abstract...
17. Akiyode O, Major J, Ojo A. Aflibercept: a review of its use in the management of diabetic eye complications. Journal of Pharmacy Practice 2017;30(5):534-40. DOI: 10.1177/0897190016647232. [Context Link 1, 2] View abstract...
18. Dhoot DS, Avery RL. Vascular endothelial growth factor inhibitors for diabetic retinopathy. Current Diabetes Reports 2016;16(12):122. DOI: 10.1007/s11892-016-0825-4. [Context Link 1, 2] View abstract...
19. Virgili G, Parravano M, Evans JR, Gordon I, Lucenteforte E. Anti-vascular endothelial growth factor for diabetic macular oedema: a network meta-analysis. Cochrane Database of Systematic Reviews 2018, Issue 10. Art. No.: CD007419. DOI: 10.1002/14651858.CD007419.pub6. [Context Link 1] View abstract...
20. Veritti D, Sarao V, Soppelsa V, Lanzetta P. Managing diabetic macular edema in clinical practice: systematic review and meta-analysis of current strategies and treatment options. Clinical Ophthalmology (Auckland, N.Z.) 2021;15:375-385. DOI: 10.2147/OPTH.S236423. [Context Link 1] View abstract...
21. Do DV, et al. The DA VINCI Study: phase 2 primary results of VEGF Trap-Eye in patients with diabetic macular edema. Ophthalmology 2011;118(9):1819-26. DOI: 10.1016/j.ophtha.2011.02.018. [Context Link 1] View abstract...
22. Do DV, et al. One-year outcomes of the DA VINCI Study of VEGF Trap-Eye in eyes with diabetic macular edema. Ophthalmology 2012;119(8):1658-65. DOI: 10.1016/j.ophtha.2012.02.010. [Context Link 1] View abstract...
23. Korobelnik JF, et al. Intravitreal aflibercept for diabetic macular edema. Ophthalmology 2014;121(11):2247-54. DOI: 10.1016/j.ophtha.2014.05.006. [Context Link 1] View abstract...
24. Brown DM, et al. Intravitreal aflibercept for diabetic macular edema: 100-week results from the VISTA and VIVID studies. Ophthalmology 2015;122(10):2044-52. DOI: 10.1016/j.ophtha.2015.06.017. [Context Link 1] View abstract...
25. Heier JS, et al. Intravitreal aflibercept for diabetic macular edema: 148-week results from the VISTA and VIVID studies. Ophthalmology 2016;123(11):2376-2385. DOI: 10.1016/j.ophtha.2016.07.032. [Context Link 1] View abstract...
26. The Diabetic Retinopathy Clinical Research Network. Aflibercept, bevacizumab, or ranibizumab for diabetic macular edema. New England Journal of Medicine 2015;372(13):1193-1203. DOI: 10.1056/NEJMoa1414264. [Context Link 1] View abstract...
27. Wells JA, et al. Aflibercept, bevacizumab, or ranibizumab for diabetic macular edema: two-year results from a comparative effectiveness randomized clinical trial. Ophthalmology 2016;123(6):1351-1359. DOI: 10.1016/j.ophtha.2016.02.022. [Context Link 1] View abstract...
28. Cai S, Bressler NM. Aflibercept, bevacizumab or ranibizumab for diabetic macular oedema: recent clinically relevant findings from DRCR.net Protocol T. Current Opinion in Ophthalmology 2017;28(6):636-643. DOI: 10.1097/ICU.0000000000000424. [Context Link 1] View abstract...
29. Bressler SB, et al. Change in diabetic retinopathy through 2 years: secondary analysis of a randomized clinical trial comparing aflibercept, bevacizumab, and ranibizumab. JAMA Ophthalmology 2017;135(6):558-568. DOI: 10.1001/jamaophthalmol.2017.0821. [Context Link 1] View abstract...
30. Sivaprasad S, et al. Clinical efficacy of intravitreal aflibercept versus panretinal photocoagulation for best corrected visual acuity in patients with proliferative diabetic retinopathy at 52 weeks (CLARITY): a multicentre, single-blinded, randomised, controlled, phase 2b, non-inferiority trial. Lancet 2017;389(10085):2193-203. DOI: 10.1016/S0140-6736(17)31193-5. [Context Link 1, 2] View abstract...
31. Sun JK, Jampol LM. The Diabetic Retinopathy Clinical Research Network (DRCR.net) and its contributions to the treatment of diabetic Retinopathy. Ophthalmic Research 2019;62(4):225-230. DOI: 10.1159/000502779. [Context Link 1, 2] View abstract...
32. Brown DM, et al. Evaluation of intravitreal aflibercept for the treatment of severe nonproliferative diabetic retinopathy: results from the PANORAMA randomized clinical trial. JAMA Ophthalmology 2021;139(9):946-955. DOI: 10.1001/jamaophthalmol.2021.2809. [Context Link 1] View abstract...
33. Ashraf M, Souka AA, Singh RP. Central retinal vein occlusion: modifying current treatment protocols. Eye (London, England) 2016;30(4):505-514. DOI: 10.1038/eye.2016.10. [Context Link 1] View abstract...
34. Yang LP, McKeage K. Intravitreal aflibercept (eylea): a review of its use in patients with macular oedema secondary to central retinal vein occlusion. Drugs and Aging 2014;31(5):395-404. DOI: 10.1007/s40266-014-0176-2. [Context Link 1] View abstract...
35. Yeh S, et al. Therapies for macular edema associated with central retinal vein occlusion: A report by the American Academy of Ophthalmology. Ophthalmology 2015;122(4):769-778. DOI: 10.1016/j.ophtha.2014.10.013. (Reaffirmed 2022 Jul) [Context Link 1] View abstract...
36. Scott IU, et al. Effect of bevacizumab vs aflibercept on visual acuity among patients with macular edema due to central retinal vein occlusion: the SCORE2 randomized clinical trial. Journal of the American Medical Association 2017;317(20):2072-2087. DOI: 10.1001/jama.2017.4568. [Context Link 1] View abstract...
37. Anguita R, Tasiopoulou A, Shahid S, Roth J, Sim SY, Patel PJ. A review of aflibercept treatment for macular disease. Ophthalmology and Therapy 2021;10(3):413-428. DOI: 10.1007/s40123-021-00354-1. [Context Link 1, 2] View abstract...
38. Macular Oedema (Central Retinal Vein Occlusion) - Aflibercept Solution for Injection. NICE Technology Appraisal Guidance TA305 [Internet] National Institute for Health and Care Excellence. 2014 Feb (NICE reviewed 2017) Accessed at: https://www.nice.org.uk/guidance/. [accessed 2022 Oct 22] [Context Link 1]
39. Ford JA, et al. Treatments for macular oedema following central retinal vein occlusion: systematic review. BMJ Open 2014;4(2):e004120. DOI: 10.1136/bmjopen-2013-004120. [Context Link 1] View abstract...

40. Ho M, Liu DT, Lam DS, Jonas JB. Retinal vein occulsions, from basics to the latest treatments. Retina 2016;36(3):432-448. DOI: 10.1097/IAE.0000000000000843. [Context Link 1] View abstract...
41. Shalchi Z, Mahroo O, Bunce C, Mitry D. Anti-vascular endothelial growth factor for macular oedema secondary to branch retinal vein occlusion. Cochrane Database of Systematic Reviews 2020, Issue 7. Art. No.: CD009510. DOI: 10.1002/14651858.CD009510.pub3. [Context Link 1] View abstract...
42. Ogura Y, et al. Intravitreal aflibercept for macular edema secondary to central retinal vein occlusion: 18-month results of the phase 3 GALILEO study. American Journal of Ophthalmology 2014;158(5):1032-8. DOI: 10.1016/j.ajo.2014.07.027. [Context Link 1] View abstract...
43. Hykin P, et al. Clinical effectiveness of intravitreal therapy with ranibizumab vs aflibercept vs bevacizumab for macular edema secondary to central retinal vein occlusion: a randomized clinical trial. JAMA Ophthalmology 2019;137(11):1256-1264. DOI: 10.1001/jamaophthalmol.2019.3305. [Context Link 1] View abstract...
44. Schmidt-Erfurth U, et al. Guidelines for the management of retinal vein occlusion by the European Society of Retina Specialists (EURETINA). Ophthalmologica 2019;242(3):123-162. DOI: 10.1159/000502041. [Context Link 1] View abstract...
45. Flaxel CJ, et al. Retinal Vein Occlusions. Preferred Practice Pattern [Internet] American Academy of Ophthalmology. 2019 Accessed at: https://www.aao.org/. [accessed 2022 Aug 25] DOI: 10.1016/j.ophtha.2019.09.029. [Context Link 1] View abstract...
46. Benson AB III, et al. Colon Cancer. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v. 1.2022; 2022 Feb Accessed at: https://www.nccn.org/. [accessed 2022 Aug 10] [Context Link 1, 2]
47. Benson AB III, et al. Rectal Cancer. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v. 1.2022; 2022 Feb Accessed at: https://www.nccn.org/. [accessed 2022 Aug 10] [Context Link 1, 2]
48. Lee JJ, Sun W. Options for second-Line treatment in metastatic colorectal cancer. Clinical Advances in Hematology and Oncology 2016;14(1):46-54. [Context Link 1] View abstract...
49. Van Cutsem E, et al. Addition of aflibercept to fluorouracil, leucovorin, and irinotecan improves survival in a phase III randomized trial in patients with metastatic colorectal cancer previously treated with an oxaliplatin-based regimen. Journal of Clinical Oncology 2012;30(28):3499-506. DOI: 10.1200/JCO.2012.42.8201. [Context Link 1] View abstract...
50. Ruff P, et al. Time course of safety and efficacy of aflibercept in combination with FOLFIRI in patients with metastatic colorectal cancer who progressed on previous oxaliplatin-based therapy. European Journal of Cancer 2015;51(1):18-26. DOI: 10.1016/j.ejca.2014.10.019. [Context Link 1] View abstract...
51. Van Cutsem E, et al. Aflibercept plus FOLFIRI vs. placebo plus FOLFIRI in second-line metastatic colorectal cancer: a post hoc analysis of survival from the Phase III VELOUR study subsequent to exclusion of patients who had recurrence during or within 6 months of completing adjuvant oxaliplatin-based therapy. Targeted Oncology 2016;11(3):383-400. DOI: 10.1007/s11523-015-0402-9. [Context Link 1] View abstract...
52. Aflibercept in Combination With Irinotecan and Fluorouracil-Based Therapy for Treating Metastatic Colorectal Cancer That Has Progressed Following Prior Oxaliplatin-Based Chemotherapy. NICE Technology Appraisal Guidance TA307 [Internet] National Institute for Health and Care Excellence. 2014 Mar (NICE reviewed 2016) Accessed at: https://www.nice.org.uk/guidance/. [accessed 2022 Oct 22] [Context Link 1]
53. Zhang X, Ran Y, Shao Y, Wang K, Zhu Y. Incidence and risk of severe infections associated with aflibercept in cancer patients: a systematic review and meta-analysis. British Journal of Clinical Pharmacology 2016;81(1):33-40. DOI: 10.1111/bcp.12758. [Context Link 1] View abstract...
54. McKibbin M, et al. Aflibercept in wet AMD beyond the first year of treatment: recommendations by an expert roundtable panel. Eye (London, England) 2015;29 Suppl 1:S1-S11. DOI: 10.1038/eye.2015.77. [Context Link 1] View abstract...
55. Schmidt-Erfurth U, et al. Guidelines for the management of neovascular age-related macular degeneration by the European Society of Retina Specialists (EURETINA). British Journal of Ophthalmology 2014;98(9):1144-1167. DOI: 10.1136/bjophthalmol-2014-305702. [Context Link 1] View abstract...
56. Santarelli M, Diplotti L, Samassa F, Veritti D, Kuppermann BD, Lanzetta P. Advances in pharmacotherapy for wet age-related macular degeneration. Expert Opinion on Pharmacotherapy 2015;16(12):1769-1781. DOI: 10.1517/14656566.2015.1067679. [Context Link 1] View abstract...
57. Hassan M, et al. The role of Aflibercept in the management of age-related macular degeneration. Expert Opinion on Biological Therapy 2016;16(5):699-709. DOI: 10.1517/14712598.2016.1167182. [Context Link 1] View abstract...
58. Sarwar S, et al. Aflibercept for neovascular age-related macular degeneration. Cochrane Database of Systematic Reviews 2016, Issue 2. Art. No.: CD011346. DOI: 10.1002/14651858.CD011346.pub2. [Context Link 1] View abstract...
59. Freund KB, Hoang QV, Saroj N, Thompson D. Intraocular pressure in patients with neovascular age-related macular degeneration receiving intravitreal aflibercept or ranibizumab. Ophthalmology 2015;122(9):1802-10. DOI: 10.1016/j.ophtha.2015.04.018. [Context Link 1] View abstract...
60. Scott AW, Bressler SB. Long-term follow-up of vascular endothelial growth factor inhibitor therapy for neovascular age-related macular degeneration. Current Opinion in Ophthalmology 2013;24(3):190-196. DOI: 10.1097/ICU.0b013e32835fefee. [Context Link 1] View abstract...
61. Gerding H. Functional and anatomic efficacy of a conversion to aflibercept in eyes with age-related macular degeneration after long-term ranibizumab treatment. Klinische Monatsblatter fur Augenheilkunde 2015;232(4):560-563. DOI: 10.1055/s-0035-1545775. [Context Link 1] View abstract...
62. Gillies MC, et al. Macular atrophy in neovascular age-related macular degeneration: a randomized clinical trial comparing ranibizumab and aflibercept (RIVAL study). Ophthalmology 2020;127(2):198-210. DOI: 10.1016/j.ophtha.2019.08.023. [Context Link 1] View abstract...
63. Heier JS, et al. Intravitreal aflibercept injection vs sham as prophylaxis against conversion to exudative age-related macular degeneration in high-risk eyes: a randomized clinical trial. JAMA Ophthalmology 2021;139(5):542-547. DOI: 10.1001/jamaophthalmol.2021.0221. [Context Link 1] View abstract...

64. Lazzeri S, et al. Aflibercept administration in neovascular age-related macular degeneration refractory to previous anti-vascular endothelial growth factor drugs: a critical review and new possible approaches to move forward. Angiogenesis 2015;18(4):397-432. DOI: 10.1007/s10456-015-9483-4. [Context Link 1] View abstract...

65. Seguin-Greenstein S, Lightman S, Tomkins-Netzer O. A meta-analysis of studies evaluating visual and anatomical outcomes in patients with treatment resistant neovascular age-related macular degeneration following switching to treatment with aflibercept. Journal of Ophthalmology 2016;4095852. DOI: 10.1155/2016/4095852. [Context Link 1] View abstract...

66. Flaxel CJ, et al. Age-Related Macular Degeneration. Preferred Practice Pattern [Internet] American Academy of Ophthalmology. 2019 Accessed at: https://www.aao.org/. [accessed 2022 Aug 25] [Context Link 1]

67. Kitchens JW, et al. Comprehensive review of ocular and systemic safety events with intravitreal aflibercept injection in randomized controlled trials. Ophthalmology 2016;123(7):1511-20. DOI: 10.1016/j.ophtha.2016.02.046. [Context Link 1, 2] View abstract...

Footnotes

[A] For diabetic macular edema, aflibercept is administered by intravitreal injection every 4 weeks for the first 5 injections, and then continued by intravitreal injection every 4 to 8 weeks. Patients should be monitored for postinjection complications, including increased intraocular pressure, endophthalmitis, and retinal detachment.(1) [A in Context Link 1]

[B] For diabetic retinopathy, aflibercept is administered by intravitreal injection every 4 weeks for the first 5 injections, and then continued by intravitreal injection every 4 to 8 weeks. Patients should be monitored for postinjection complications, including increased intraocular pressure, endophthalmitis, and retinal detachment.(1) [B in Context Link 1]

[C] For macular edema following central or branch retinal vein occlusion, aflibercept is administered by intravitreal injection every 4 weeks.(1) Patients should be monitored for postinjection complications, including increased intraocular pressure, endophthalmitis, and retinal detachment.(1)(33) [C in Context Link 1]

[D] For metastatic colorectal cancer, aflibercept is administered by intravenous infusion over 1 hour every 2 weeks.(2) [D in Context Link 1]

[E] For neovascular (wet, or exudative) age-related macular degeneration, aflibercept is administered by intravitreal injection every 4 weeks for the first 3 months of treatment, then continued by intravitreal injection every 4 to 8 weeks(1); after 1 year of therapy, the dosing frequency may be extended by 2 weeks in eyes with inactive disease until a dosing frequency of every 12 weeks is reached, assuming the disease remains inactive.(54) Patients should be monitored for postinjection complications, including increased intraocular pressure, endophthalmitis, and retinal detachment.(1) [E in Context Link 1]

Codes

HCPCS: J0178, J9400

Last Update: 2/1/2023 1:42:37 AM
Build Number: 27.0.20230131232627.008841

Gonadotropin-Releasing Hormone (GnRH) Agonists

MCG Health
Ambulatory Care
27th Edition

ACG: A-0304 (AC)
Link to Codes

Clinical Indications

- Gonadotropin-releasing hormone (GnRH) agonists may be indicated for **1 or more** of the following:
  - Assisted reproductive technology (eg, female patient undergoing in vitro fertilization)(18)(19)(20)(21)(22)N
  - Cancer, as indicated by **1 or more** of the following:
    - Breast cancer, with **1 or more** of the following(27)(28):N
      - Adjuvant therapy needed,[A] and **ALL** of the following(30)(31)(44):
        - Administered in combination with tamoxifen or an aromatase inhibitor (eg, exemestane)
        - Patient is premenopausal.
        - Tumor is estrogen receptor positive or progesterone receptor positive.
      - Advanced disease,[B] and **ALL** of the following(1):
        - Palliative treatment
        - Patient is premenopausal or perimenopausal.
      - Prevention of premature ovarian failure needed, and **ALL** of the following(33)(37)(38)(39)(40):
        - Patient is receiving cytotoxic agent associated with premature ovarian failure (eg, cyclophosphamide).
        - Patient is premenopausal.
    - Prostate cancer, as indicated by **1 or more** of the following[C](1)(45)(47)(48)(49)(50):N
      - Intermediate-risk, high-risk, or very high-risk disease, as indicated by **1 or more** of the following(57)(58)(59)(60):
        - International Society of Urological Pathology (ISUP) Grade Group 2 to 5 (Gleason score of 7 to 10)(61)
        - Pretreatment PSA of 10 ng/mL (mcg/L) or greater
        - Stage T2b/T2c, stage T3a/T3b, or stage 4 prostate cancer
      - Metastatic prostate cancer (ie, bone or other metastasis)[D](62)(63)(64)(66)(67)(68)
  - Central precocious puberty, as indicated by **1 or more** of the following[E](2)(5)(70)(73)(76)(79)(80):N
    - Initial course, as indicated by **ALL** of the following:
      - Advanced bone age or accelerated growth velocity[F](90)
      - Clinical signs or symptoms of precocious puberty, as indicated by **1 or more** of the following(91)(92)(93):
        - Female with **ALL** of the following:
          - Age between 2 and 8 years when signs or symptoms of precocious puberty appear
          - Tanner stage 2 or greater clinical findings (ie, breast and pubic hair development)
          - No pregnancy
          - No undiagnosed abnormal vaginal bleeding
        - Male with **ALL** of the following:
          - Age between 2 and 9 years when signs or symptoms of precocious puberty appear
          - Testicular volume 4 mL or greater
      - Laboratory confirmation of diagnosis, as indicated by **1 or more** of the following(90)(92)(94):
        - Pubertal basal level of luteinizing hormone (based on pediatric reference ranges)
        - Pubertal basal level of sex hormones (based on pediatric reference ranges)
        - Pubertal response of luteinizing hormone or sex hormone to stimulation by GnRH
      - Other causes of precocious puberty ruled out by appropriate hormonal and imaging studies (eg, congenital adrenal hyperplasia, CNS tumor)
    - Subsequent course, with favorable response to prior administration of GnRH agonist[G](90)

- Dysfunctional uterine bleeding, as indicated by **ALL** of the following[H](1)(96):N
  - Prior to planned endometrial ablation for definitive treatment
  - No current breast-feeding
  - No pregnancy currently or anticipated while receiving medication
  - Other causes of symptoms or bleeding ruled out (eg, by endometrial biopsy)
- Endometriosis, as indicated by **1 or more** of the following[I](1)(2)(97)(98)(99)(100)(101):N
  - Initial course, as indicated by **ALL** of the following:
    - Age 18 years or older
    - Endometriosis symptoms, as indicated by **1 or more** of the following(104):
      - Dysmenorrhea
      - Dyspareunia
      - Pelvic pain
    - Failure of or contraindication to **ALL** of the following(105):
      - Oral contraceptive pills or medroxyprogesterone acetate injection
      - Nonsteroidal anti-inflammatory drugs (NSAIDs)
    - No current breast-feeding
    - No pregnancy currently or anticipated while receiving medication
    - No vaginal bleeding of unknown cause
  - Subsequent course, as indicate by **ALL** of the following:
    - Age 18 years or older
    - Concurrent use of medication to counter anti-estrogen effects of GnRH agonist (eg, norethindrone acetate or bisphosphonate add-back therapy), unless contraindicated(104)(105)(106)(107)
    - Patient has not received more than one previous 6-month course of GnRH agonist for treatment of endometriosis.
    - Recurrence of endometriosis symptoms following initial course of therapy
- Gender incongruence, as indicated by **1 or more** of the following[J](108)(109)(110)(111):N
  - Initial course, as indicated by **ALL** of the following:
    - Marked and sustained gender incongruence[K] as assessed and documented by clinician experienced in care of transgender and gender diverse people
    - Pubertal development of Tanner stage 2 or greater
  - Subsequent course, as indicated by **ALL** of the following:
    - Marked and sustained gender incongruence[K] as assessed and documented by clinician experienced in care of transgender and gender diverse people
    - Favorable response to initial course of GnRH agonist
- Uterine leiomyomas (fibroids), as indicated by **ALL** of the following[L](97)(98)(119):N
  - Age 18 years or older
  - Goal to reduce leiomyoma (fibroid) size or bleeding prior to operative intervention(122)
  - Leiomyoma symptoms, as indicated by **1 or more** of the following:
    - Abnormal uterine bleeding
    - Bulk-related symptoms (eg, pelvic pain or pressure, dyspareunia, urinary symptoms)
    - Iron deficiency anemia
  - No current breast-feeding
  - No pregnancy currently or anticipated while receiving medication
  - Other causes of symptoms or bleeding ruled out (eg, by endometrial biopsy)

Evidence Summary

Background

GnRH agonists initially stimulate the release of the pituitary gonadotropins LH and FSH, resulting in a temporary increase in gonadal steroidogenesis, followed after repeated administration by longer-term abolition of the stimulatory effects of the pituitary gland.(1) **(EG 2)** This leads to decreased gonadal steroidogenesis, with reduction in functionality of tissues and processes dependent upon such steroids.(1)(2) **(EG 2)** Side effects are often significant, ranging from effects on libido and sexual function to increased risk of metabolic syndrome, osteoporosis and associated fractures, diabetes, and cardiovascular disease.(3) **(EG 2)**

Criteria

For assisted reproductive technology, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A systematic review reported that when long (ie, for at least 14 days prior to ovarian stimulation) and short GnRH agonist protocols were compared, there was no conclusive evidence of differences in live birth and ongoing pregnancy rates; however, there was moderate-quality evidence of higher clinical pregnancy rates in the long-protocol group.(19)(23) **(EG 2)** Another systematic review and meta-analysis indicated that GnRH agonists were successful in significantly improving pregnancy rates when administered for 3 months in

women with endometriosis who were undergoing assisted reproduction.(24)(25) **(EG 1)** An open-label randomized trial of 1344 patients undergoing in vitro fertilization compared luteal progesterone with luteal triptorelin (given as multiple injections or a single bolus injection) and found that triptorelin was associated with increased clinical pregnancy and delivery rates as compared with progesterone.(26) **(EG 1)**

For breast cancer, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A randomized controlled trial randomized 3066 premenopausal women with hormone receptor-positive breast cancer to tamoxifen alone, tamoxifen plus ovarian suppression, or exemestane plus ovarian suppression for 5 years; ovarian suppression was achieved by either triptorelin intramuscular injection every 28 days, bilateral oophorectomy, or bilateral ovarian irradiation. There was no significant difference in disease-free survival between tamoxifen alone and tamoxifen plus ovarian suppression at 67-month follow-up. However, a subgroup analysis of 1628 women who had received prior chemotherapy found that ovarian suppression was associated with improved rates of freedom from breast cancer at 5 years (78% with tamoxifen alone, 82.5% with tamoxifen and ovarian suppression, and 85.7% with exemestane and ovarian suppression).(29) **(EG 1)** An extension of this study found, at 8 years of follow-up, that tamoxifen combined with ovarian suppression was associated with higher rates of disease-free and overall survival compared with tamoxifen alone.(30) **(EG 1)** A specialty society guideline recommends ovarian suppression in addition to adjuvant endocrine therapy for higher-risk premenopausal patients with estrogen receptor-positive tumors; however, risk is not clearly defined.(31) **(EG 2)** Expert consensus guidelines recommend tamoxifen, either with or without ovarian suppression, as adjuvant therapy for premenopausal women with lymph node-positive disease; treatment with an aromatase inhibitor plus ovarian suppression is an alternate option for premenopausal women who are at increased risk of recurrence due to young age, high-grade tumor, or lymph node involvement. Guidelines recommend ovarian suppression with a luteinizing hormone-releasing hormone agonist for premenopausal women with metastatic disease.(27)(28) **(EG 2)** A systematic review and meta-analysis evaluating the use of GnRH agonists for gonadal protection in women undergoing gonadotoxic chemotherapy included 10 studies of breast cancer and found that GnRH agonists were associated with increased rates of return of spontaneous menstruation as compared with controls.(32) **(EG 1)** A systematic review evaluating the use of GnRH agonists for the prevention of chemotherapy-induced ovarian failure (defined as a combination of amenorrhea and postmenopausal FSH levels) in premenopausal women that included 4 studies (780 patients with breast cancer) comparing treatment with chemotherapy alone or combined with GnRH agonists found moderate-quality evidence that patients treated with GnRH agonists plus chemotherapy had a lower incidence of chemotherapy-related premature ovarian failure compared with patients treated with chemotherapy alone (10.7% and 25.3%, respectively).(33) **(EG 1)** A meta-analysis of individual patient-level data from 873 premenopausal participants with a diagnosis of breast cancer evaluated the use of GnRH agonists during chemotherapy for the preservation of ovarian function and fertility and found that treatment with GnRH agonists was associated with a lower incidence of chemotherapy-induced premature ovarian insufficiency and amenorrhea and a higher incidence of post-treatment pregnancy compared with chemotherapy alone; no difference in the incidence of disease-free survival or overall survival was noted between the 2 treatment groups.(34) **(EG 1)** Long-term follow-up of an open-label phase III randomized trial of 281 premenopausal patients with breast cancer evaluating the safety of GnRH agonist therapy during chemotherapy for ovarian protection found, at a mean follow-up of 12.4 years, no difference in disease-free or overall survival in the GnRH agonist plus chemotherapy group compared with the chemotherapy-only group.(35) **(EG 1)** Another long-term follow-up of a randomized trial of 218 premenopausal patients with stage I to IIIA hormone receptor-negative breast cancer treated with either chemotherapy plus GnRH agonists or chemotherapy alone found, at a mean follow-up of 5.1 years, that more patients treated with chemotherapy plus GnRH agonists reported at least one post-treatment pregnancy compared with patients treated with chemotherapy alone. There was no statistical difference in disease-free survival or overall survival between the treatment groups.(36) **(EG 2)** An expert consensus guideline states that, regardless of hormone receptor status, ovarian suppression with GnRH agonists administered with adjuvant chemotherapy in premenopausal patients with breast cancers may preserve ovarian function and reduce the likelihood of chemotherapy-induced amenorrhea.(28) **(EG 2)** Multiple specialty society practice guidelines recommend the use of GnRH agonists during chemotherapy in premenopausal patients with breast cancer as an option for ovarian function protection; however, the evidence is insufficient to recommend the use of GnRH agonists as a replacement for standard fertility preservation methods (ie, cryopreservation techniques).(37)(38)(39)(40) **(EG 2)** An expert consensus guideline on male breast cancer management states that GnRH agonists combined with aromatase inhibitors are an option for adjuvant treatment of men with hormone receptor-positive cancer who are not candidates for tamoxifen, and for men with hormone receptor-positive, HER2-negative cancer without rapidly progressive disease or visceral crisis.(41) **(EG 2)**

For prostate cancer, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Studies indicate effectiveness of GnRH agonists in substantially reducing serum testosterone levels for palliation of signs and symptoms of advanced cancer.(51)(52)(53)(54) **(EG 2)** A meta-analysis of 16 studies of different GnRH agonists used for prostate cancer treatment concluded that there is insufficient evidence to directly compare efficacy and safety between these medications; further studies are recommended to determine comparative survival and toxicity among these treatments.(55) **(EG 1)** A specialty society guideline recommends the use of androgen deprivation therapy in patients who have developed castration-resistant disease, as the androgen receptor remains active in most patients.(56) **(EG 2)**

For central precocious puberty, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A specialty guideline consortium statement and review articles have concluded that GnRH agonists should be considered for children with progression of pubertal development in the setting of confirmatory diagnostic evaluation, including assessment of bone age and growth velocity, hormone levels, hormone stimulation testing, and central nervous system imaging.(81)(82)(83) **(EG 2)** A meta-analysis identified 8 studies of girls with precocious puberty and determined that treatment with GnRH agonists may have a positive effect on final adult height, but the results were not conclusive.(84) **(EG 1)** A prospective open-label study of 36 children with central precocious puberty suggested that histrelin implant

may significantly improve predicted adult height in girls.(75) **(EG 2)** A meta-analysis of 5 studies involving 153 children with central precocious puberty found that triptorelin was effective in significantly suppressing the luteinizing hormone peak and other gonadal hormones and in slowing disease progression.(85) **(EG 1)** A phase III single-arm trial of 62 untreated pediatric patients with central precocious puberty treated with subcutaneous leuprolide every 6 months found, at 24-week follow-up, that 87% of patients had suppression of peak luteinizing hormone levels, and 57.4% had a decrease in growth velocity.(86) **(EG 2)** An open-label noncomparative phase III trial of 44 children with central precocious puberty found that the 6-month formulation of triptorelin suppressed serum luteinizing hormone levels in 97.7% of patients at 12 months, and the Tanner stage was stable or reduced in 88.6% at 12 months.(87) **(EG 2)** A review article states that GnRH agonists likely improve adult height in girls diagnosed before age 6 years but suggests that long-term studies should be performed to evaluate the effects of GnRH agonists on patients' reproductive health.(79) **(EG 2)**

For dysfunctional uterine bleeding, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** GnRH agonists are indicated for endometrial thinning prior to endometrial ablation.(1) **(EG 2)** A systematic review and meta-analysis found evidence supporting the effectiveness of GnRH agonists, as compared with no treatment, in significantly reducing postoperative dysmenorrhea as well as bleeding for up to 24 months after ablation, although the authors indicated that most studies suffer from methodological issues such as lack of blinding, heterogeneity, and lack of long-term follow-up.(96) **(EG 2)**

For endometriosis, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A systematic review and meta-analysis, and other review articles and guidelines, indicate effectiveness of GnRH agonists in relieving symptoms such as pelvic pain, dysmenorrhea, dyspareunia, pelvic tenderness, and induration in patients who fail first-line therapy with NSAIDs and oral contraceptives.(24)(99)(100)(102)(103) **(EG 1)** A systematic review of randomized trials reported that leuprolide was equally effective for treatment of endometriosis as compared with continuous oral contraceptives.(101) **(EG 1)** Treatment with GnRH agonists is associated with hypoestrogenic side effects, including accelerated bone loss. The use of add-back therapy, such as low-dose combined oral contraceptive pills, progestins only, or bisphosphonates, may reduce these adverse effects, and allows the use of GnRH agonists for longer than 6 months.(104) **(EG 2)**

For gender incongruence, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** GnRH agonists may be administered at the time of onset of puberty in youths who are transgender or gender diverse in order to delay further development of secondary sexual characteristics of the individual's sex assigned at birth.(109)(112)(113) **(EG 2)** Puberty suppression reversibly suppresses development of secondary sexual characteristics that are not consistent with an individual's experienced gender, which may improve gender dysphoria and allow additional time for the individual to live in the experienced gender before making a decision about any additional irreversible therapy (eg, surgery).(108)(112)(114)(115) **(EG 2)** GnRH agonists may be used as part of gender-affirming hormone therapy in postpubertal patients (eg, for suppression of uterine bleeding in transgender males and as antiandrogen therapy in transgender females).(108)(116)(117)(118) **(EG 2)**

For uterine leiomyomas (fibroids), evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A meta-analysis and systematic review states that GnRH agonists are effective in reducing uterine and fibroid volume, increasing preoperative hemoglobin level, and reducing intraoperative blood loss, operation time, and complication rates.(120) **(EG 1)** A comparative effectiveness review concludes that GnRH agonists reduce the size of leiomyomas and the overall size of the uterus, with decreased bleeding symptoms and fibroid-related pain; there is a dearth of long-term follow-up after discontinuation of this treatment.(121) **(EG 1)** A practice bulletin suggests effectiveness of GnRH agonists in temporarily alleviating symptoms, such as abnormal uterine bleeding, due to the presence and size of the leiomyomas.(119) **(EG 2)** Case series suggest effectiveness of GnRH agonists in reducing leiomyoma size prior to laparoscopic myomectomy.(122)(123) **(EG 2)** A systematic review and meta-analysis of 23 studies found that administration of GnRH agonists prior to myomectomy was significantly associated with decreased blood loss and need for transfusion, and possibly less significantly associated with decreased formation of uterine adhesions.(124) **(EG 1)**

Inconclusive or Non-Supportive Evidence

For chronic pelvic pain in women, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review and meta-analysis found only a single study with 47 women with chronic pelvic pain (not due to endometriosis, primary dysmenorrhea, acute pelvic inflammatory disease, or irritable bowel syndrome), which suggested that pelvic pain scores were incrementally improved after 1 year of treatment with goserelin as compared with those who took medroxyprogesterone acetate; however, the authors indicated that confirmatory studies are required.(4) **(EG 1)**

For idiopathic short stature, evidence demonstrates a lack of net benefit; additional research is recommended. **(RG C1)** An international consensus statement and review articles conclude that GnRH agonists show a variable effect on adult height gain and are generally not recommended.(5)(6)(7) **(EG 2)**

For male infertility, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** Case series suggest that pulsatile use of GnRH agents may increase testicular volume(8) and induce fertility in males with hypogonadotropic hypogonadism, but such drugs are currently not approved for this indication.(9)(10) **(EG 2)** Pulsatile administration of GnRH agonist requires portable pumps and presents no incremental advantage as compared with gonadotropin therapy.(11) **(EG 2)** A randomized trial of 220 men with hypogonadotropic hypogonadism compared treatment with either

pulsatile GnRH or the combination of human chorionic gonadotropin plus human menopausal gonadotropin (HCG/HMG) and found, at 6-month follow-up, that GnRH was associated with higher rates of spermatogenesis as compared with HCG/HMG. However, the authors noted that heterogeneity of prior endocrine treatments and genetic variance among included patients may have limited the results, and further studies were recommended.(12) **(EG 1)**

For menorrhagia prevention in premenopausal women with anticipated chemotherapy-induced thrombocytopenia, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A review found limited evidence on the role of leuprolide for menorrhagia prevention in premenopausal women with thrombocytopenia but noted that more research with large-scale trials is warranted.(13) **(EG 2)** While a practice guideline endorsed the use of leuprolide in this setting, it acknowledged that available evidence includes only uncontrolled cohort studies or case control studies.(14) **(EG 2)**

For undescended testes, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of 14 studies addressing various types of hormonal therapy for undescended testes found that while testicular descent occurred in some actively treated patients, studies were generally of poor quality, and descent rates seldom exceeded those of patients treated with placebo by more than 10%.(15) **(EG 1)** A systematic review and meta-analysis of 10 case control or randomized controlled studies found that while some boys with undescended testes may benefit from an adjunctive GnRH agonist with orchidopexy in terms of improved fertility index, further studies are necessary to determine and confirm which patients are the optimal candidates for treatment.(16) **(EG 1)** A review article found that GnRH agonists have been investigated as an alternative to human chorionic gonadotropin, but results are both incomplete and conflicting, and do not suggest high efficacy. Surgery is still considered the preferred treatment for this condition.(17) **(EG 2)**

References

1. Zoladex (goserelin acetate implant) 3.6 mg. Physician Prescribing Information [Internet] AstraZeneca Pharmaceuticals LP. 2020 Dec Accessed at: https://www.zoladex.com/. [created 1989; accessed 2022 Nov 13] [Context Link 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12]
2. Synarel - nafarelin acetate spray, metered. Physician Prescribing Information [Internet] G.D. Searle LLC. 2022 Apr Accessed at: https://www.pfizer.com/products. [accessed 2022 Nov 13] [Context Link 1, 2, 3, 4, 5, 6]
3. Phillips JL, Wassersug RJ, McLeod DL. Systemic bias in the medical literature on androgen deprivation therapy and its implication to clinical practice. International Journal of Clinical Practice 2012;66(12):1189-96. DOI: 10.1111/ijcp.12025. [Context Link 1] View abstract...
4. Cheong YC, Smotra G, Williams AC. Non-surgical interventions for the management of chronic pelvic pain. Cochrane Database of Systematic Reviews 2014, Issue 3. Art. No.: CD008797. DOI: 10.1002/14651858.CD008797.pub2. [Context Link 1] View abstract...
5. Carel JC, et al. Consensus statement on the use of gonadotropin-releasing hormone analogs in children. Pediatrics 2009;123(4):e752-e762. DOI: 10.1542/peds.2008-1783. (Reaffirmed 2022 May) [Context Link 1, 2] View abstract...
6. Cohen P, et al. Consensus statement on the diagnosis and treatment of children with idiopathic short stature: a summary of the Growth Hormone Research Society, the Lawson Wilkins Pediatric Endocrine Society, and the European Society for Paediatric Endocrinology Workshop. Journal of Clinical Endocrinology and Metabolism 2008;93(11):4210-7. DOI: 10.1210/jc.2008-0509. (Reaffirmed 2022 May) [Context Link 1] View abstract...
7. Eugster EA. The use of gonadotropin-releasing hormone analogs beyond precocious puberty. Journal of Pediatrics 2015;167(2):481-5. DOI: 10.1016/j.jpeds.2015.05.031. [Context Link 1] View abstract...
8. Gong C, Liu Y, Qin M, Wu D, Wang X. Pulsatile GnRH Is superior to hCG in therapeutic efficacy in adolescent boys with hypogonadotropic Hypogonadodism. Journal of Clinical Endocrinology and Metabolism 2015;100(7):2793-9. DOI: 10.1210/jc.2015-1343. [Context Link 1] View abstract...
9. Dwyer AA, et al. Trial of recombinant follicle-stimulating hormone pretreatment for GnRH-induced fertility in patients with congenital hypogonadotropic hypogonadism. Journal of Clinical Endocrinology and Metabolism 2013;98(11):E1790-5. DOI: 10.1210/jc.2013-2518. [Context Link 1] View abstract...
10. Zhang L, et al. The pulsatile gonadorelin pump induces earlier spermatogenesis than cyclical gonadotropin therapy in congenital hypogonadotropic hypogonadism men. American Journal of Men's Health 2019;13(1):1557988318818280. DOI: 10.1177/1557988318818280. [Context Link 1] View abstract...
11. Rastrelli G, Vignozzi L, Maggi M. Different medications for hypogonadotropic hypogonadism. Endocrine Development 2016;30:60-78. DOI: 10.1159/000439332. [Context Link 1] View abstract...
12. Lin J, Mao J, Wang X, Ma W, Hao M, Wu X. Optimal treatment for spermatogenesis in male patients with hypogonadotropic hypogonadism. Medicine 2019;98(31):e16616. DOI: 10.1097/MD.0000000000016616. [Context Link 1] View abstract...
13. Pradhan S, Gomez-Lobo V. Hormonal contraceptives, intrauterine devices, gonadotropin-releasing hormone analogues and testosterone: menstrual suppression in special adolescent populations. Journal of Pediatric and Adolescent Gynecology 2019;32(5S):S23-S29. DOI: 10.1016/j.jpag.2019.04.007. [Context Link 1] View abstract...
14. Kirkham YA, Ornstein MP, Aggarwal A, McQuillan S. Menstrual suppression in special circumstances. No. 313. Journal of Obstetrics and Gynaecology Canada 2019;41(2):e7-e17. DOI: 10.1016/j.jogc.2018.11.030. (Reaffirmed 2022 Jul) [Context Link 1] View abstract...
15. Penson D, Krishnaswami S, Jules A, McPheeters ML. Effectiveness of hormonal and surgical therapies for cryptorchidism: a systematic review. Pediatrics 2013;131(6):e1897-907. DOI: 10.1542/peds.2013-0072. [Context Link 1] View abstract...
16. Chua ME, Mendoza JS, Gaston MJ, Luna SL, Morales ML. Hormonal therapy using gonadotropin releasing hormone for improvement of fertility index among children with cryptorchidism: a meta-analysis and systematic review. Journal of Pediatric Surgery 2014;49(11):1659-67. DOI: 10.1016/j.jpedsurg.2014.06.013. [Context Link 1] View abstract...

17. Kollin C, Ritzen EM. Cryptorchidism: a clinical perspective. Pediatric Endocrinology Reviews: PER 2014;11 Suppl 2:240-50. [Context Link 1] View abstract...
18. Dubourdieu S, Freour T, Dessolle L, Barriere P. Prospective, randomized comparison between pulsatile GnRH therapy and combined gonadotropin (FSH+LH) treatment for ovulation induction in women with hypothalamic amenorrhea and underlying polycystic ovary syndrome. European Journal of Obstetrics, Gynecology, and Reproductive Biology 2013;168(1):45-8. DOI: 10.1016/j.ejogrb.2012.12.016. [Context Link 1] View abstract...
19. Sunkara SK, Coomarasamy A, Faris R, Braude P, Khalaf Y. Long gonadotropin-releasing hormone agonist versus short agonist versus antagonist regimens in poor responders undergoing in vitro fertilization: a randomized controlled trial. Fertility and Sterility 2014;101(1):147-53. DOI: 10.1016/j.fertnstert.2013.09.035. [Context Link 1, 2] View abstract...
20. Youssef MA, et al. Gonadotropin-releasing hormone agonist versus HCG for oocyte triggering in antagonist-assisted reproductive technology. Cochrane Database of Systematic Reviews 2014, Issue 10. Art. No.: CD008046. DOI: 10.1002/14651858.CD008046.pub4. [Context Link 1] View abstract...
21. Kamath MS, Maheshwari A, Bhattacharya S, Lor KY, Gibreel A. Oral medications including clomiphene citrate or aromatase inhibitors with gonadotropins for controlled ovarian stimulation in women undergoing in vitro fertilisation. Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD008528. DOI: 10.1002/14651858.CD008528.pub3. [Context Link 1] View abstract...
22. Wu HM, Chang HM, Leung PCK. Gonadotropin-releasing hormone analogs: Mechanisms of action and clinical applications in female reproduction. Frontiers in Neuroendocrinology 2021;60:Online. DOI: 10.1016/j.yfrne.2020.100876. [Context Link 1] View abstract...
23. Siristatidis CS, Gibreel A, Basios G, Maheshwari A, Bhattacharya S. Gonadotrophin-releasing hormone agonist protocols for pituitary suppression in assisted reproduction. Cochrane Database of Systematic Reviews 2015, Issue 11. Art. No.: CD006919. DOI: 10.1002/14651858.CD006919.pub4. [Context Link 1] View abstract...
24. Brown J, Farquhar C. Endometriosis: an overview of Cochrane Reviews. Cochrane Database of Systematic Reviews 2014, (verified by Cochrane 2014 Aug), Issue 3. Art. No.: CD009590. DOI: 10.1002/14651858.CD009590.pub2. [Context Link 1, 2] View abstract...
25. Brown J, Farquhar C. An overview of treatments for endometriosis. Journal of the American Medical Association 2015;313(3):296-297. DOI: 10.1001/jama.2014.17119. [Context Link 1] View abstract...
26. Fusi FM, Brigante CM, Zanga L, Mignini Renzini M, Bosisio C, Fadini R. GnRH agonists to sustain the luteal phase in antagonist IVF cycles: a randomized prospective trial. Reproductive Biology and Endocrinology 2019;17(1):103. DOI: 10.1186/s12958-019-0543-2. [Context Link 1] View abstract...
27. Coleman RE, et al. UK guidance document: treatment of metastatic breast cancer. Clinical Oncology 2012;24(3):169-76. DOI: 10.1016/j.clon.2011.10.004. [Context Link 1, 2] View abstract...
28. Gradishar WJ, et al. Breast Cancer. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v. 4.2022; 2022 Jun Accessed at: https://www.nccn.org/. [accessed 2022 Aug 10] [Context Link 1, 2, 3]
29. Francis PA, et al. Adjuvant ovarian suppression in premenopausal breast cancer. New England Journal of Medicine 2015;372(5):436-46. DOI: 10.1056/NEJMoa1412379. [Context Link 1] View abstract...
30. Francis PA, et al. Tailoring adjuvant endocrine therapy for premenopausal breast cancer. New England Journal of Medicine 2018;379(2):122-137. DOI: 10.1056/NEJMoa1803164. [Context Link 1, 2, 3] View abstract...
31. Burstein HJ, Lacchetti C, Griggs JJ. Adjuvant endocrinet therapy for women with hormone receptor-positive breast cancer: American Society of Clinical Oncology clinical practice guideline update on ovarian suppression summary. Journal of Oncology Practice 2016;12(4):390-3. DOI: 10.1200/JOP.2016.011239. [Context Link 1, 2] View abstract...
32. Sofiyeva N, Siepmann T, Barlinn K, Seli E, Ata B. Gonadotropin-releasing hormone analogs for gonadal protection during gonadotoxic chemotherapy: a systematic review and meta-analysis. Reproductive Sciences 2019;26(7):939-953. DOI: 10.1177/1933719118799203. [Context Link 1] View abstract...
33. Chen H, Xiao L, Li J, Cui L, Huang W. Adjuvant gonadotropin-releasing hormone analogues for the prevention of chemotherapy-induced premature ovarian failure in premenopausal women. Cochrane Database of Systematic Reviews 2019, Issue 3. Art. No.: CD008018. DOI: 10.1002/14651858.CD008018.pub3. [Context Link 1, 2] View abstract...
34. Lambertini M, et al. Gonadotropin-releasing hormone agonists during chemotherapy for preservation of ovarian function and fertility in premenopausal patients with early breast cancer: a systematic review and meta-analysis of individual patient-level data. Journal of Clinical Oncology 2018;36(19):1981-1990. DOI: 10.1200/JCO.2018.78.0858. [Context Link 1] View abstract...
35. Lambertini M, et al. Long-term outcomes with pharmacological ovarian suppression during chemotherapy in premenopausal early breast cancer patients. Journal of the National Cancer Institute 2022;114(3):400-408. DOI: 10.1093/jnci/djab213. [Context Link 1] View abstract...
36. Moore HCF, et al. Final analysis of the prevention of early menopause study (POEMS)/SWOG intergroup S0230. Journal of the National Cancer Institute 2019;111(2):210-213. DOI: 10.1093/jnci/djy185. [Context Link 1] View abstract...
37. Paluch-Shimon S, et al. ESO-ESMO 5th international consensus guidelines for breast cancer in young women (BCY5). Annals of Oncology 2022;33(11):1097-1118. DOI: 10.1016/j.annonc.2022.07.007. (Reaffirmed 2022 Aug) [Context Link 1, 2] View abstract...
38. ESHRE Guideline Group on Female Fertility Preservation, et al. ESHRE guideline: female fertility preservation. Human Reproduction Open 2020;2020(4):hoaa052. DOI: 10.1093/hropen/hoaa052. (Reaffirmed 2022 Aug) [Context Link 1, 2] View abstract...
39. Lambertini M, et al. Fertility preservation and post-treatment pregnancies in post-pubertal cancer patients: ESMO Clinical Practice Guidelines. Annals of Oncology 2020;31(12):1664-1678. DOI: 10.1016/j.annonc.2020.09.006. (Reaffirmed 2022 Jul) [Context Link 1, 2] View abstract...
40. Oktay K, et al. Fertility preservation in patients with cancer: ASCO clinical practice guideline update. Journal of Clinical Oncology 2018;36(19):1994-2001. DOI: 10.1200/JCO.2018.78.1914. (Reaffirmed 2022 Aug) [Context Link 1, 2] View abstract...

41. Hassett MJ, et al. Management of male breast cancer: ASCO guideline. Journal of Clinical Oncology 2020;38(16):1849-1863. DOI: 10.1200/JCO.19.03120. [Context Link 1] View abstract...
42. Huerta-Reyes M, et al. Treatment of breast cancer with gonadotropin-releasing hormone analogs. Frontiers in Oncology 2019;9:943. DOI: 10.3389/fonc.2019.00943. [Context Link 1] View abstract...
43. Pelizzari G, et al. An Italian Delphi study to evaluate consensus on adjuvant endocrine therapy in premenopausal patients with breast cancer: the ERA project. BMC Cancer 2018;18(1):932. DOI: 10.1186/s12885-018-4843-2. [Context Link 1] View abstract...
44. Conte B, Del Mastro L. Gonadotropin-releasing hormone analogues for the prevention of chemotherapy-induced premature ovarian failure in breast cancer patients. Minerva Ginecologica 2017;69(4):350-356. DOI: 10.23736/S0026-4784.17.04067-9. [Context Link 1] View abstract...
45. Zoladex (goserelin acetate implant) 10.8 mg. Physician Prescribing Information [Internet] TerSera Therapeutics. 2020 Dec Accessed at: https://www.zoladex.com. [created 1996; accessed 2022 Nov 13] [Context Link 1, 2]
46. Ishizuka O, et al. Comparison of efficacy and safety of 1- and 3-month luteinizing hormone-releasing hormone agonist depots as initial therapies for prostate cancer. International Journal of Clinical Oncology 2013;18(3):524-30. DOI: 10.1007/s10147-012-0413-9. [Context Link 1] View abstract...
47. Schaeffer EM, et al. Prostate Cancer. NCCN Clinical Practice Guidelines in Oncology [Internet] National Comprehensive Cancer Network (NCCN). v. 4.2022; 2022 May Accessed at: https://www.nccn.org/. [accessed 2022 Aug 10] [Context Link 1]
48. Zhao S, Urdaneta AI, Anscher MS. The role of androgen deprivation therapy plus radiation therapy in patients with non-metastatic prostate cancer. Expert Review of Anticancer Therapy 2016;16(9):929-42. DOI: 10.1080/14737140.2016.1218279. [Context Link 1] View abstract...
49. Droz JP, et al. Management of prostate cancer in elderly patients: recommendations of a task force of the International Society of Geriatric Oncology. European Urology 2017;72(4):521-531. DOI: 10.1016/j.eururo.2016.12.025. (Reaffirmed 2022 Aug) [Context Link 1] View abstract...
50. Cornford P, et al. EAU-EANM-ESTRO-ESUR-SIOG guidelines on prostate cancer. part II-2020 update: treatment of relapsing and metastatic prostate cancer. European Urology 2021;79(2):263-282. DOI: 10.1016/j.eururo.2020.09.046. [Context Link 1] View abstract...
51. Hoda MR, Kramer MW, Merseburger AS, Cronauer MV. Androgen deprivation therapy with Leuprolide acetate for treatment of advanced prostate cancer. Expert Opinion on Pharmacotherapy 2017;18(1):105-113. DOI: 10.1080/14656566.2016.1258058. [Context Link 1, 2] View abstract...
52. Breul J, et al. Efficacy of testosterone suppression with sustained-release triptorelin in advanced prostate cancer. Advances in Therapy 2017;34(2):513-523. DOI: 10.1007/s12325-016-0466-7. [Context Link 1] View abstract...
53. Ostergren PB, et al. Luteinizing hormone-releasing hormone agonists are superior to subcapsular orchiectomy in lowering testosterone Levels of Men with Prostate Cancer: Results from a Randomized Clinical Trial. Journal of Urology 2017;197(6):1441-1447. DOI: 10.1016/j.juro.2016.12.003. [Context Link 1] View abstract...
54. Shore ND, Guerrero S, Sanahuja RM, Gambus G, Parente A. A new sustained-release, 3-month leuprolide acetate formulation achieves and maintains castrate concentrations of testosterone in patients with prostate cancer. Clinical Therapeutics 2019;41(3):412-425. DOI: 10.1016/j.clinthera.2019.01.004. [Context Link 1] View abstract...
55. Bolton EM, Lynch T. Are all gonadotrophin-releasing hormone agonists equivalent for the treatment of prostate cancer? A systematic review. BJU International 2018;122(3):371-383. DOI: 10.1111/bju.14168. [Context Link 1] View abstract...
56. Saad F, et al. 2021 Canadian Urological Association (CUA)-Canadian Uro Oncology Group (CUOG) guideline: Management of castration-resistant prostate cancer (CRPC). Canadian Urological Association Journal 2021;15(2):E81-E90. DOI: 10.5489/cuaj.7074. (Reaffirmed 2022 Aug) [Context Link 1] View abstract...
57. Jones CU, et al. Radiotherapy and short-term androgen deprivation for localized prostate cancer. New England Journal of Medicine 2011;365(2):107-18. DOI: 10.1056/NEJMoa1012348. [Context Link 1] View abstract...
58. Sasse AD, Sasse E, Carvalho AM, Macedo LT. Androgenic suppression combined with radiotherapy for the treatment of prostate adenocarcinoma: a systematic review. BMC Cancer 2012;12:54. DOI: 10.1186/1471-2407-12-54. [Context Link 1] View abstract...
59. Braeckman J, Michielsen D. Efficacy and tolerability of 1- and 3-month leuprorelin acetate depot formulations (Eligard/Depo-Eligar) for advanced prostate cancer in daily practice: a Belgian prospective non-interventional study. Archives of Medical Science 2014;10(3):477-83. DOI: 10.5114/aoms.2014.43743. [Context Link 1] View abstract...
60. Luo HC, et al. Long-term quality of life outcomes in patients with locally advanced prostate cancer after intensity-modulated radiotherapy combined with androgen deprivation. Medical Oncology 2014;31(6):991. DOI: 10.1007/s12032-014-0991-7. [Context Link 1] View abstract...
61. Gordetsky J, Epstein J. Grading of prostatic adenocarcinoma: current state and prognostic implications. Diagnostic Pathology 2016;11:25. DOI: 10.1186/s13000-016-0478-2. [Context Link 1] View abstract...
62. Lupron depot (leuprolide acetate for depot suspension) URO. Physician Prescribing Information [Internet] AbbVie Inc. 2019 Mar Accessed at: https://www.lupron.com/. [created 1989; accessed 2022 Sep 07] [Context Link 1, 2]
63. Eligard (leuprolide acetate) for injectable suspension, for subcutaneous use. Physician Prescribing Information [Internet] Tolmar Pharmaceuticals, Inc. 2019 Apr Accessed at: https://eligard.com/. [created 2002; accessed 2022 Nov 11] [Context Link 1, 2]
64. Trelstar (triptorelin pamoate for injectable suspension), for intramuscular use. Physician Prescribing Information [Internet] Verity Pharma. 2021 Dec Accessed at: https://www.trelstar.com/. [created 2000; accessed 2022 Nov 13] [Context Link 1, 2]
65. Tunn UW, Gruca D, Bacher P. Six-month leuprorelin acetate depot formulations in advanced prostate cancer: a clinical evaluation. Clinical Interventions in Aging 2013;8:457-64. DOI: 10.2147/CIA.S27931. [Context Link 1] View abstract...
66. Desai K, McManus J, Sharifi N. Hormonal therapy for prostate cancer. Endocrine Reviews 2021;42(3):354-373. DOI: 10.1210/endrev/bnab002. [Context Link 1] View abstract...
67. Virgo KS, et al. Initial management of noncastrate advanced, recurrent, or metastatic prostate cancer: ASCO guideline update. Journal of Clinical Oncology 2021;39(11):1274-1305. DOI: 10.1200/JCO.20.03256. (Reaffirmed 2022 Aug) [Context Link 1] View abstract...

68. Lowrance W, et al. Advanced Prostate Cancer. AUA/ASTRO/SUO Guideline [Internet] American Urogynecologic Society. 2020 Jun Accessed at: https://www.auanet.org/. [accessed 2022 Oct 12] [Context Link 1]
69. Lupron depot-ped (leuprolide acetate for depot suspension) for intramuscular use. Physician Prescribing Information [Internet] AbbVie Inc. 2022 Aug Accessed at: http://www.lupron.com/. [created 1985; accessed 2022 Nov 11] [Context Link 1]
70. Lee PA, et al. Efficacy and safety of leuprolide acetate 3-month depot 11.25 milligrams or 30 milligrams for the treatment of central precocious puberty. Journal of Clinical Endocrinology and Metabolism 2012;97(5):1572-80. DOI: 10.1210/jc.2011-2704. [Context Link 1, 2] View abstract...
71. Lee PA, Klein K, Mauras N, Lev-Vaisler T, Bacher P. 36-month treatment experience of two doses of leuprolide acetate 3-month depot for children with central precocious puberty. Journal of Clinical Endocrinology and Metabolism 2014;99(9):3153-9. DOI: 10.1210/jc.2013-4471. [Context Link 1] View abstract...
72. Fensolvi (leuprolide acetate) for injectable suspension, for subcutaneous use. Physician Prescribing Information [Internet] Tolmar Pharmaceuticals, Inc. 2022 Apr Accessed at: https://fensolvi.com/hcp/. [created 1985; accessed 2022 Nov 11] [Context Link 1]
73. Supprelin LA (histrelin acetate) subcutaneous implant. Physician Prescribing Information [Internet] Endo Pharmaceuticals Solutions, Inc. 2022 Apr Accessed at: https://www.supprelinla.com/. [accessed 2022 Oct 10] [Context Link 1, 2]
74. Rosati S, et al. Histrelin for central precocious puberty-a single surgeon experience. Journal of Surgical Research 2015;198(2):355-9. DOI: 10.1016/j.jss.2015.03.071. [Context Link 1] View abstract...
75. Silverman LA, et al. Long-term continuous suppression with once-yearly histrelin subcutaneous implants for the treatment of central precocious puberty: A final report of a phase 3 multicenter trial. Journal of Clinical Endocrinology and Metabolism 2015;100(6):2354-63. DOI: 10.1210/jc.2014-3031. [Context Link 1, 2] View abstract...
76. Triptodur (triptorelin) for extended-release injectable suspension. Physician Prescribing Information [Internet] Arbor Pharmaceuticals, LLC. 2022 Apr Accessed at: http://triptodur.com/. [created 2000; accessed 2022 Nov 13] [Context Link 1, 2]
77. Triptorelin (Triptodur) for central precocious puberty. Medical Letter on Drugs and Therapeutics 2018;60(1537):7-8. [Context Link 1] View abstract...
78. Bertelloni S, Mucaria C, Baroncelli GI, Peroni D. Triptorelin depot for the treatment of children 2 years and older with central precocious puberty. Expert Review of Clinical Pharmacology 2018;11(7):659-667. DOI: 10.1080/17512433.2018.1494569. [Context Link 1] View abstract...
79. Guaraldi F, Beccuti G, Gori D, Ghizzoni L. Management of endrocrine disease: Long-term outcomes of the treatment of central precocious puberty. European Journal of Endocrinology 2016;174(3):R79-87. DOI: 10.1530/EJE-15-0590. [Context Link 1, 2] View abstract...
80. Bereket A. A critical appraisal of the effect of gonadotropin-releasing hormon analog treatment on adult height of girls with central precocious puberty. Journal of Clinical Research in Pediatric Endocrinology 2017;9(Suppl 2):33-48. DOI: 10.4274/jcrpe.2017.S004. [Context Link 1] View abstract...
81. Bangalore Krishna K, et al. Use of gonadotropin-releasing hormone analogs in children: update by an International Consortium. Hormone Research in Pediatrics 2019;91(6):357-372. DOI: 10.1159/000501336. [Context Link 1] View abstract...
82. Soriano-Guillen L, Argente J. Central precocious puberty, functional and tumor-related. Best Practice & Research. Clinical Endocrinology & Metabolism 2019;33(3):101262. DOI: 10.1016/j.beem.2019.01.003. [Context Link 1] View abstract...
83. Cantas-Orsdemir S, Eugster EA. Update on central precocious puberty: from etiologies to outcomes. Expert Review of Endocrinology & Metabolism 2019;14(2):123-130. DOI: 10.1080/17446651.2019.1575726. [Context Link 1] View abstract...
84. Li P, Li Y, Yang CL. Gonadotropin releasing hormone agonist treatment to increase final stature in children with precocious puberty: a meta-analysis. Medicine 2014;93(27):e260. DOI: 10.1097/MD.0000000000000260. [Context Link 1] View abstract...
85. Durand A, Tauber M, Patel B, Dutailly P. Meta-analysis of paediatric patients with central precocious puberty treated with intramuscular triptorelin 11.25 mg 3-month prolonged-release formulation?. Hormone Research in Pediatrics 2017;87(4):224-232. DOI: 10.1159/000456545. [Context Link 1] View abstract...
86. Klein KO, et al. Phase 3 trial of a small-volume subcutaneous 6-month duration leuprolide acetate treatment for central precocious puberty. Journal of Clinical Endocrinology and Metabolism 2020;105(10):e3660-e3671. DOI: 10.1210/clinem/dgaa479. [Context Link 1] View abstract...
87. Klein K, et al. Efficacy and safety of triptorelin 6-month formulation in patients with central precocious puberty. Journal of Pediatric Endocrinology and Metabolism 2016;29(11):1241-1248. DOI: 10.1515/jpem-2015-0376. [Context Link 1] View abstract...
88. Creo AL, Schwenk WF. Bone age: a handy tool for pediatric providers. Pediatrics 2017;140(6):e20171486. DOI: 10.1542/peds.2017-1486. [Context Link 1] View abstract...
89. De Sanctis V, Di Maio S, Soliman AT, Raiola G, Elalaily R, Millimaggi G. Hand X-ray in pediatric endocrinology: Skeletal age assessment and beyond. Indian Journal of Endocrinology and Metabolism 2014;18(Suppl 1):S63-71. DOI: 10.4103/2230-8210.145076. [Context Link 1] View abstract...
90. Garibaldi LR, Chemaitilly W. Disorders of pubertal development. In: Kliegman RM, St. Geme JW, Blum NJ, Shah SS, Tasker RC, Wilson KM, editors. Nelson Textbook of Pediatrics. 21st ed. Philadelphia, PA: Elsevier; 2020:2899-2912.e1. [Context Link 1, 2, 3]
91. Pienkowski C, Tauber M. Gonadotropin-releasing hormone agonist treatment in sexual precocity. Endocrine Development 2016;29:214-29. DOI: 10.1159/000438893. [Context Link 1, 2] View abstract...
92. Kaplowitz P, Bloch C, Section on Endocrinology, American Academy of Pediatrics. Evaluation and referral of children with signs of early puberty. Pediatrics 2016;137(1):e20153732. DOI: 10.1542/peds.2015-3732. [Context Link 1, 2, 3] View abstract...
93. Styne DM. Physiology and disorders of puberty. In: Melmed S, Auchus RJ, Goldfine AB, Koenig RJ, Rosen CJ, editors. Williams Textbook of Endocrinology. 14th ed. Philadelphia, PA: Elsevier; 2020:1023-1164.e25. [Context Link 1]
94. Cheuiche AV, da Silveira LG, de Paula LCP, Lucena IRS, Silveiro SP. Diagnosis and management of precocious sexual maturation: an updated review. European Journal of Pediatrics 2021;180(10):3073-3087. DOI: 10.1007/s00431-021-04022-1. [Context Link 1, 2] View abstract...

95. Eugster EA. Treatment of central precocious puberty. Journal of the Endocrine Society 2019;3(5):965-972. DOI: 10.1210/js.2019-00036. [Context Link 1] View abstract...
96. Tan YH, Lethaby A. Pre-operative endometrial thinning agents before endometrial destruction for heavy menstrual bleeding. Cochrane Database of Systematic Reviews 2013, Issue 11. Art. No.: CD010241. DOI: 10.1002/14651858.CD010241.pub2. [Context Link 1, 2] View abstract...
97. Lupron depot 3.75 mg (leuprolide acetate for depot suspension). Physician Prescribing Information [Internet] AbbVie Inc. 2022 Jul Accessed at: https://www.lupron.com/. [accessed 2022 Nov 11] [Context Link 1, 2, 3, 4, 5]
98. Lupron depot 11.25 mg (leuprolide acetate for depot suspension). Physician Prescribing Information [Internet] AbbVie Inc. 2020 Mar Accessed at: https://www.lupron.com/. [created 1985; accessed 2022 Nov 11] [Context Link 1, 2, 3, 4, 5]
99. Management of endometriosis. ACOG practice bulletin no. 114. Obstetrics & Gynecology 2010 (ACOG reaffirmed 2020);116(1):223-36. DOI: 10.1097/AOG.0b013e3181e8b073. (Reaffirmed 2022 May) [Context Link 1, 2] View abstract...
100. Dysmenorrhea and endometriosis in the adolescent: ACOG Committee Opinion No. 760. Obstetrics & Gynecology 2018 (ACOG reaffirmed 2021);132(6):e249-e258. DOI: 10.1097/AOG.0000000000002978. (Reaffirmed 2022 Jul) [Context Link 1, 2] View abstract...
101. Jeng CJ, Chuang L, Shen J. A comparison of progestogens or oral contraceptives and gonadotropin-releasing hormone agonists for the treatment of endometriosis: a systematic review. Expert Opinion on Pharmacotherapy 2014;15(6):767-73. DOI: 10.1517/14656566.2014.888414. [Context Link 1, 2] View abstract...
102. Ferrero S, Evangelisti G, Barra F. Current and emerging treatment options for endometriosis. Expert Opinion on Pharmacotherapy 2018;19(10):1109-1125. DOI: 10.1080/14656566.2018.1494154. [Context Link 1] View abstract...
103. Vercellini P, Buggio L, Frattaruolo MP, Borghi A, Dridi D, Somigliana E. Medical treatment of endometriosis-related pain. Best Practice and Research. Clinical Obstetrics and Gynaecology 2018;51:68-91. DOI: 10.1016/j.bpobgyn.2018.01.015. [Context Link 1] View abstract...
104. Vannuccini S, Clemenza S, Rossi M, Petraglia F. Hormonal treatments for endometriosis: The endocrine background. Reviews in Endocrine & Metabolic Disorders 2022;23(3):333-355. DOI: 10.1007/s11154-021-09666-w. [Context Link 1, 2, 3] View abstract...
105. Della Corte L, et al. Tolerability considerations for gonadotropin-releasing hormone analogues for endometriosis. Expert Opinion on Drug Metabolism & Toxicology 2020;16(9):759-768. DOI: 10.1080/17425255.2020.1789591. [Context Link 1, 2] View abstract...
106. DiVasta AD, et al. Hormonal add-back therapy for females treated with gonadotropin-releasing hormone agonist for endometriosis: a randomized controlled trial. Obstetrics & Gynecology 2015;126(3):617-27. DOI: 10.1097/AOG.0000000000000964. [Context Link 1] View abstract...
107. Anastasilakis AD, et al. The effect of pharmacological cessation and restoration of menstrual cycle on bone metabolism in premenopausal women with endometriosis. Bone 2022;158:Online. DOI: 10.1016/j.bone.2022.116354. [Context Link 1] View abstract...
108. Hembree WC, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society Clinical Practice guideline. Journal of Clinical Endocrinology and Metabolism 2017;102(11):3869-3903. DOI: 10.1210/jc.2017-01658. (Reaffirmed 2022 Jul) [Context Link 1, 2, 3, 4] View abstract...
109. Coleman E, et al. Standards of care for the health of transgender and gender diverse people, Version 8. International Journal of Transgender Health 2022;23(Su 1):S1-S259. DOI: 10.1080/26895269.2022.2100644. (Reaffirmed 2022 Oct 10) [Context Link 1, 2, 3]
110. Skordis N, Kyriakou A, Dror S, Mushailov A, Nicolaides NC. Gender dysphoria in children and adolescents: an overview. Hormones (Athens, Greece) 2020;19(3):267-276. DOI: 10.1007/s42000-020-00174-1. [Context Link 1] View abstract...
111. Rew L, Young CC, Monge M, Bogucka R. Review: Puberty blockers for transgender and gender diverse youth-a critical review of the literature. Child and Adolescent Mental Health. 2021;26(1):3-14. DOI: 10.1111/camh.12437. [Context Link 1] View abstract...
112. Hembree WC. Management of juvenile gender dysphoria. Current Opinion in Endocrinology, Diabetes, and Obesity 2013;20(6):559-64. DOI: 10.1097/01.med.0000436193.33470.1f. [Context Link 1, 2] View abstract...
113. Radix A, Davis AM. Endocrine treatment of gender-dysphoric/gender-incongruent persons. Journal of the American Medical Association 2017;318(15):1491-1492. DOI: 10.1001/jama.2017.13540. [Context Link 1] View abstract...
114. Mahfouda S, et al. Gender-affirming hormones and surgery in transgender children and adolescents. Lancet. Diabetes & Endocrinology 2019;7(6):484-498. DOI: 10.1016/S2213-8587(18)30305-X. [Context Link 1] View abstract...
115. Nos AL, et al. Association of gonadotropin-releasing hormone analogue use with subsequent use of gender-affirming hormones among transgender adolescents. JAMA Network Open 2022;5(11):Online. DOI: 10.1001/jamanetworkopen.2022.39758. [Context Link 1] View abstract...
116. Health care for transgender and gender diverse individuals: ACOG Committee Opinion, number 823. Obstetrics & Gynecology 2021;137(3):e75-e88. DOI: 10.1097/AOG.0000000000004294. (Reaffirmed 2022 Aug) [Context Link 1] View abstract...
117. Safer JD, Tangpricha V. Care of the transgender patient. Annals of Internal Medicine 2019;171(1):ITC1-ITC16. DOI: 10.7326/AITC201907020. [Context Link 1] View abstract...
118. Safer JD, Tangpricha V. Care of transgender persons. New England Journal of Medicine 2019;381(25):2451-2460. DOI: 10.1056/NEJMcp1903650. [Context Link 1] View abstract...
119. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins-Gynecology. Management of symptomatic uterine leiomyomas: ACOG practice bulletin, number 228. Obstetrics & Gynecology 2021;137(6):e100-e115. DOI: 10.1097/AOG.0000000000004401. (Reaffirmed 2022 Aug) [Context Link 1, 2] View abstract...
120. Lethaby A, Puscasiu L, Vollenhoven B. Preoperative medical therapy before surgery for uterine fibroids. Cochrane Database of Systematic Reviews 2017, Issue 11. Art. No.: CD000547. DOI: 10.1002/14651858.CD000547.pub2. [Context Link 1] View abstract...
121. Hartmann KE, et al. Management of Uterine Fibroids. Comparative Effectiveness Review #195 AHRQ Publication No. 17(18)-EHC028-EF [Internet] Agency for Healthcare Research and Quality Effective Health Care Program. 2017 Dec Accessed at: https://www.effectivehealthcare.ahrq.gov/. [accessed 2022 Oct 16] DOI: 10.23970/AHRQEPCCER195. [Context Link 1]

122. Walid MS, Heaton RL. Laparoscopic myomectomy: an intent-to-treat study. Archives of Gynecology and Obstetrics 2010;281(4):645-9. DOI: 10.1007/s00404-009-1154-5. [Context Link 1, 2] View abstract...

123. Sancho JM, Delgado VS, Valero MJ, Soteras MG, Amate VP, Carrascosa AA. Hysteroscopic myomectomy outcomes after 3-month treatment with either Ulipristal Acetate or GnRH analogues: a retrospective comparative study. European Journal of Obstetrics, Gynecology, and Reproductive Biology 2016;198:127-30. DOI: 10.1016/j.ejogrb.2016.01.014. [Context Link 1] View abstract...

124. de Milliano I, Twisk M, Ket JC, Huirne JA, Hehenkamp WJ. Pre-treatment with GnRHa or ulipristal acetate prior to laparoscopic and laparotomic myomectomy: A systematic review and meta-analysis. PLoS ONE 2017;12(10):e0186158. DOI: 10.1371/journal.pone.0186158. [Context Link 1] View abstract...

Footnotes

[A] For adjuvant treatment of breast cancer, GnRH agonists (eg, goserelin acetate by subcutaneous implant, or leuprolide or triptorelin by intramuscular injection) are administered every 28 days.(30)(42)(43) [A in Context Link 1]

[B] For palliative treatment of breast cancer, goserelin acetate is administered as a subcutaneous implant every 28 days.(1) [B in Context Link 1]

[C] For clinically localized, advanced, or metastatic prostate cancer, goserelin acetate may be administered as a subcutaneous implant every 28 days or every 12 weeks, depending on dose formulation.(1)(45)(46) [C in Context Link 1]

[D] For palliative treatment of advanced prostate cancer, slow-release GnRH formulations (eg, leuprolide, triptorelin pamoate) may be administered as a subcutaneous injection every 1, 3, 4, or 6 months, depending on dose formulation.(51)(62)(63)(64)(65) [D in Context Link 1]

[E] For precocious puberty, nafarelin acetate is administered as 2 intranasal sprays in each nostril twice daily or 3 sprays in alternating nostrils 3 times daily (a total of 8 or 9 sprays a day), and continued until resumption of puberty is desired.(2) Leuprolide may be administered every 1 or 3 months as an intramuscular injection, with careful subsequent monitoring of hormonal levels, bone age, and Tanner staging to confirm downregulation.(69)(70)(71) Leuprolide may be administered every 6 months as a subcutaneous injection, with careful monitoring of hormonal levels and height.(72) Histrelin is administered as a subcutaneous implant of a small capsule in the upper arm every 12 months.(73)(74)(75) Triptorelin is administered every 24 weeks as an intramuscular injection, with careful subsequent monitoring of hormonal levels, bone age, and height to confirm downregulation.(76)(77)(78) [E in Context Link 1]

[F] Bone age is determined by comparison of a left hand and wrist x-ray with a standardized reference.(88)(89) [F in Context Link 1]

[G] There is no consensus about when to stop therapy for central precocious puberty; discontinuation is dependent on a number of patient-specific characteristics as well as family preference.(91)(92)(94)(95) [G in Context Link 1]

[H] For dysfunctional uterine bleeding, goserelin acetate may be administered as a subcutaneous implant for endometrial thinning prior to endometrial ablation 4 weeks later, or as 2 subcutaneous implants 4 weeks apart followed by endometrial ablation 2 to 4 weeks after the second administration.(1) [H in Context Link 1]

[I] For endometriosis, goserelin acetate may be administered as a subcutaneous implant every 28 days.(1) Intranasal nafarelin acetate may be administered via one spray into one nostril in the morning and one spray into the other nostril in the evening. If the patient is still menstruating after 2 months, the dose may be increased to one spray in each nostril twice daily.(2) The recommended duration of therapy for both goserelin acetate implants and intranasal nafarelin acetate is 6 months; retreatment is not recommended.(1)(2) Alternatively, leuprolide may be administered in depot form as a monthly or every-3-month intramuscular injection for up to 6 months.(97)(98) If symptoms recur, only one additional 6-month course of leuprolide (with concomitant norethindrone acetate unless contraindicated) may be given.(97)(98) [I in Context Link 1]

[J] For gender incongruence in peripubertal individuals, a specialty society guideline recommends initiation of a GnRH agonist from the time of starting puberty until the individual elects to initiate additional gender-affirming hormone therapy, if desired, after the individual has demonstrated persistent gender incongruence and is able to provide informed consent, typically at approximately age 16 years.(108) [J in Context Link 1]

[K] Gender incongruence is a difference between an individual's experienced gender and the gender expected of them based on sex assigned at birth. Gender-affirming medical and surgical treatments, including puberty suppression, hormone therapy, surgery, or a combination, may play a role in supporting the development and expression of a person's experienced gender identity by allowing them to live and be accepted as the experienced gender. Gender diversity is not pathologic, and gender incongruence is not defined by the presence of distress. However, gender incongruence may be associated with clinically significant distress and impairment (ie, gender dysphoria), and gender-affirming medical therapy may reduce the likelihood of gender dysphoria. Individuals seeking gender-affirming interventions should be evaluated by a healthcare professional with experience caring for transgender and gender diverse individuals and the ability to identify coexisting mental health or psychosocial conditions and conditions that can be mistaken for gender incongruence. Individuals seeking gender-affirming medical interventions should have demonstrated a marked and persistent gender incongruence, which includes incongruence that has not previously been disclosed to others.(109) [K in Context Link 1, 2]

[L] For uterine leiomyomas, leuprolide may be administered in depot form as a monthly or every-3-month intramuscular injection for up to 3 months prior to operative intervention.(97)(98) [L in Context Link 1]

Codes

HCPCS: C9399, J1950, J1951, J1952, J1954, J3315, J3316, J3490, J9202, J9217, J9218, J9219, S9560

Last Update: 2/1/2023 1:42:05 AM
Build Number: 27.0.20230131232627.008841

OnabotulinumtoxinA

ACG: A-0296 (AC)
Link to Codes

MCG Health
Ambulatory Care
27th Edition

Clinical Indications

- OnabotulinumtoxinA may be indicated for **1 or more** of the following(1)(2)(3)(4)(5)(6)(7):
  - Achalasia, as indicated by **1 or more** of the following(76)(77):N
    - Initial course, as indicated by **ALL** of the following:
      - Achalasia confirmed by esophageal manometry
      - Failure of or patient not candidate for pneumatic dilation or surgical myotomy (eg, elderly patient)(80)(82)
      - No response to pharmacologic treatment (eg, long-acting nitrates, calcium channel antagonists)
      - Other causes of dysphagia (eg, peptic stricture, carcinoma, lower esophageal ring or extrinsic compression) ruled out by upper gastrointestinal endoscopy
      - Progressive dysphagia for liquids and solids
    - Subsequent course, with favorable response to prior administration of onabotulinumtoxinA
  - Anal fissure, as indicated by **1 or more** of the following(83)(84)(85):N
    - Initial course, as indicated by **ALL** of the following:
      - At least 2 months of symptoms, including **1 or more** of the following:
        - Nocturnal pain and bleeding
        - Postdefecation pain
      - Failure of or intolerance to topical nitrates or topical calcium channel blockers
      - No anal fistula
      - No HIV disease
      - No inflammatory bowel disease
      - No perianal cancer
      - No previous perianal surgery
      - Patient not surgical candidate or has refused surgery
    - Subsequent course, with favorable response to prior administration of onabotulinumtoxinA
  - Blepharospasm, as indicated by **1 or more** of the following[A](89)(90)(91)(92):N
    - Initial course, as indicated by **ALL** of the following:
      - Age 12 years or older
      - Blepharospasm, as indicated by **1 or more** of the following:
        - Benign essential blepharospasm
        - Blepharospasm associated with dystonia
        - Blepharospasm associated with facial nerve (cranial nerve VII) disorder such as Bell palsy
      - No infection at proposed injection site
      - No neuromuscular disease (eg, myasthenia gravis)
    - Subsequent course, as indicated by **ALL** of the following:
      - Age 12 years or older
      - Favorable response to prior administration of onabotulinumtoxinA
  - Cervical dystonia (spasmodic torticollis), as indicated by **1 or more** of the following[B](89)(91)(99)(100)(101)(102):N
    - Initial course, as indicated by **ALL** of the following:
      - Age 16 years or older
      - Neck pain or abnormal head position causing adverse effect on daily functioning
      - No fixed contractures causing decreased neck range of motion
      - No infection at proposed injection site
      - No neuromuscular disease (eg, myasthenia gravis)

- Subsequent course, as indicated by **ALL** of the following:
  - Age 16 years or older
  - Favorable response to prior administration of onabotulinumtoxinA

− Hemifacial spasm, as indicated by **1 or more** of the following(91)(92)(112)(113)(114):N
- Initial course
- Subsequent course, with favorable response to prior administration of onabotulinumtoxinA

− Hyperhidrosis (axillary), as indicated by **1 or more** of the following[C](118)(119)(120)(122)(123)(124)(125)(126):N
- Initial course, as indicated by **ALL** of the following:
  - Age 18 years or older
  - Axillary hyperhidrosis, with Hyperhidrosis Disease Severity Scale (HDSS) score of 2 or more[D]
  - Inadequate response to 1 or more months of topical treatment (eg, aluminum chloride), as evidenced by no improvement in HDSS score, or patient intolerant to topical treatment due to unacceptable skin irritation[E]
  - No infection at proposed injection site
  - Secondary causes of hyperhidrosis (eg, hyperthyroidism) have been evaluated and, if necessary, treated.(134)
  - Significant effect of hyperhidrosis upon daily activities
- Subsequent course, with favorable response to prior administration of botulinum toxin A

− Laryngeal dystonia (ie, adductor spasmodic dysphonia), as indicated by **1 or more** of the following(100)(104)(135):N
- Initial course, as indicated by **ALL** of the following:
  - Adductor-type spasmodic dysphonia confirmed by fiberoptic laryngoscopy
  - Moderate to severe difficulty in phonation
- Subsequent course, with favorable response to prior administration of onabotulinumtoxinA

− Migraine headache prophylaxis needed, as indicated by **1 or more** of the following[F](142)(143)(144)(145)(146)(147):N
- Initial course, as indicated by **ALL** of the following:
  - Age 18 years or older
  - Migraine headache lasting 4 hours to 72 hours, as indicated by 5 or more attacks with **ALL** of the following(160)(161):
    - Headache symptoms, as indicated by **2 or more** of the following:
      - Aggravation by or causing avoidance of routine physical activity
      - Moderate or severe pain intensity
      - Pulsating quality
      - Unilateral location
    - Migraine-associated symptoms, as indicated by **1 or more** of the following:
      - Nausea or vomiting
      - Photophobia and phonophobia
    - Other potential causes of headaches have been excluded.
  - Migraine headache frequency occurring 15 or more days per month for 3 or more months(160)
  - Use of preventive medication (eg, beta-blocker, tricyclic antidepressant, anticonvulsant) has been ineffective or not tolerated for trial of at least 3 months.(162)(163)(164)(165)(166)
  - No neuromuscular disease (eg, myasthenia gravis)
- Subsequent course, as indicated by **ALL** of the following:
  - Age 18 years or older
  - Favorable response to prior administration of onabotulinumtoxinA

− Motor tics, as indicated by **1 or more** of the following(167)(168):N
- Initial course, as indicated by **ALL** of the following:
  - Age 16 years or older
  - Patient unable to adequately suppress tics
  - Tics causing interference with daily functioning
- Subsequent course, as indicated by **ALL** of the following:
  - Age 16 years or older
  - Favorable response to prior administration of onabotulinumtoxinA

− Overactive bladder with or without urgency urinary incontinence, as indicated by **1 or more** of the following[G](170)(171)(172)(173)(174)(175):N
- Initial course, as indicated by **ALL** of the following:
  - Age 18 years or older
  - Failure of or intolerance to anticholinergic medication
  - No acute urinary retention
  - No acute urinary tract infection
- Subsequent course, as indicated by **ALL** of the following:
  - Age 18 years or older
  - Favorable response to prior administration of onabotulinumtoxinA

- Sialorrhea (excessive salivation), as indicated by **1 or more** of the following[H](120)(191)(192)(193)(194):N
  - Initial course
  - Subsequent course, with favorable response to prior administration of onabotulinumtoxinA
- Spasticity, as indicated by **1 or more** of the following[I](202)(203)(204)(205):N
  - Initial course, as indicated by **1 or more** of the following:
    - Child with cerebral palsy receiving rehabilitation(207)(223)(229)(230)
    - Upper or lower extremity spasticity in individual age 2 years or older(231)(232)(233)
  - Subsequent course, with favorable response to prior administration of onabotulinumtoxinA
- Strabismus, as indicated by **1 or more** of the following[J](1)(234)(235):N
  - Initial course, as indicated by **ALL** of the following:
    - Age 12 years or older
    - Deviation of 50 prism diopters or less
    - No infection at proposed injection site
    - Strabismus not due primarily to Duane syndrome with lateral rectus weakness
    - Strabismus not due primarily to restrictive strabismus
    - Strabismus not due primarily to secondary strabismus caused by prior surgical over-recession of antagonist muscle
  - Subsequent course, as indicated by **ALL** of the following:
    - Age 12 years or older
    - Favorable response to prior administration of onabotulinumtoxinA
- Upper extremity focal dystonia (eg, writer's cramp), as indicated by **1 or more** of the following(100)(104)(240)(241):N
  - Initial course, as indicated by **ALL** of the following:
    - Age 16 years or older
    - Extremity pain or abnormal hand or forearm position causing adverse effect on daily functioning
    - No infection at proposed injection site
    - No prior surgical treatment
  - Subsequent course, as indicated by **ALL** of the following:
    - Age 16 years or older
    - Favorable response to prior administration of onabotulinumtoxinA
- Urinary incontinence due to neurogenic detrusor overactivity, as indicated by **1 or more** of the following(172)(173)(243):
  - Adult and **1 or more** of the following[K](244):N
    - Initial course, as indicated by **ALL** of the following:
      - Age 18 years or older
      - Condition secondary to spinal cord injury, spinal dysraphism, or neurologic disease (eg, multiple sclerosis)(254)(255)
      - Failure of or intolerance to pharmacologic therapy including anticholinergic medication
      - No acute urinary retention unless patient receiving regular clean intermittent catheterization
      - No acute urinary tract infection
    - Subsequent course, as indicated by **ALL** of the following:
      - Age 18 years or older
      - Favorable response to prior administration of onabotulinumtoxinA
  - Child or adolescent and **1 or more** of the following[L]:N
    - Initial course, as indicated by **ALL** of the following:
      - Age 5 years to younger than 18 years
      - Condition secondary to spinal cord injury, spinal dysraphism, or transverse myelitis
      - Failure of or intolerance to pharmacologic therapy including anticholinergic medication
      - No acute urinary tract infection
    - Subsequent course, as indicated by **ALL** of the following:
      - Age 5 years to younger than 18 years
      - Favorable response to prior administration of onabotulinumtoxinA

Evidence Summary

Background

OnabotulinumtoxinA is a purified form of botulinum toxin A, prepared by extraction of the toxin from cultures of the type A strain of *Clostridium botulinum*.(1) **(EG 2)** Botulinum toxins are potent neurotoxins; injection into striated muscles results in paralysis within 2 to 5 days, lasting for 2 to 3 months. Botulinum toxin has inhibiting effects on dystonia and spasticity, and it blocks autonomic activity to smooth muscle and exocrine glands. There are 7 different serotypes (A to G), each with varying potencies and characteristics of action.(8) **(EG 2)** OnabotulinumtoxinA has been the most-studied agent; other commercially available products include 2 botulinum toxin A agents (abobotulinumtoxinA and incobotulinumtoxinA) and rimabotulinumtoxinB (purified botulinum toxin B).(9) **(EG 2)** The

commercially available agents differ in synthesis and purification processes, potency, duration of action, and tendency toward clinically relevant systemic spread due to migration from the injection site.(2)(8)(10)(11)(12)(13) **(EG 2)**

Criteria

For achalasia, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** Expert consensus guidelines have reported that studies of endoscopic injection of botulinum toxin A into the lower esophageal sphincter demonstrated symptomatic benefit that diminishes over time, with sustained response in approximately 32% of patients at 12 months and nearly universal relapse at 2 years.(76)(78)(79) **(EG 2)** Additional reviews have also concluded that botulinum toxin A may be an effective therapeutic option for patients who are not candidates for or who have failed pneumatic dilation or surgical myotomy.(77)(80) **(EG 1)** A specialty society guideline recommends botulinum toxin injections for patients with achalasia who are unable to undergo definitive treatment (eg, pneumatic dilation, laparoscopic Heller myotomy), but notes that the duration of symptom relief associated with botulinum toxin treatments is limited.(81) **(EG 2)**

For anal fissure, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** Systematic reviews and meta-analyses of randomized trials have concluded that medical therapy, including botulinum toxin A, is less effective than surgical sphincterotomy, which has higher healing rates and lower rates of recurrence.(83)(86)(87) **(EG 1)** Botulinum toxin may be an effective treatment option for patients who fail topical nitrate therapy and for whom surgery presents a high risk for incontinence.(84)(85)(88) **(EG 2)**

For blepharospasm, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A systematic review and meta-analysis of 3 randomized placebo-controlled trials concluded that botulinum toxin A treatment was associated with improvements in blepharospasm-specific severity and disability.(93) **(EG 1)** A split-face, double-blind, randomized controlled trial comparing incobotulinumtoxinA with onabotulinumtoxinA in 48 patients with benign essential blepharospasm found no significant differences in subjective and objective outcome measures between the 2 treatments.(94) **(EG 1)** Expert evidence reviews on the use of botulinum toxin in movement disorders found high-level evidence supporting use of onabotulinumtoxinA for blepharospasm.(90)(95) **(EG 2)** A specialty society evidence-based guideline recommends onabotulinumtoxinA as being probably effective for treatment of blepharospasm.(96) **(EG 2)** A specialty society technology assessment report concluded that onabotulinumtoxinA was effective for treating benign essential blepharospasm.(92) **(EG 2)**

For cervical dystonia (spasmodic torticollis), evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review of 9 randomized controlled trials with 1144 patients found that a single treatment session of botulinum toxin A injections yielded significant and clinically relevant improvements in cervical dystonia pain, disability, and severity, as compared with placebo; onabotulinumtoxinA was used in 2 trials with 225 patients, while abobotulinumtoxinA and incobotulinumtoxinA were used in the other 7 trials.(103) **(EG 1)** Expert evidence-based guidelines and a network meta-analysis have concluded that all 4 commercially available botulinum toxins are effective as first-line treatment for this condition.(96)(104)(105)(106)(107) **(EG 1)** Systematic and other reviews of long-term case series of patients with cervical dystonia reported sustained benefit of botulinum toxin A over the course of multiple treatment sessions without serious adverse events.(108)(109)(110) **(EG 2)** A systematic review of 3 randomized studies with 270 patients found that there is low-quality evidence that botulinum toxin A and botulinum toxin B have comparable efficacy for cervical dystonia.(111) **(EG 1)**

For hemifacial spasm, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review did not identify any randomized controlled trials evaluating botulinum toxin A for hemifacial spasm that met the study's inclusion criteria but noted that observational studies suggest that botulinum toxin A is associated with symptom improvements in hemifacial spasm and is safe.(115) **(EG 1)** An expert evidence-based review and case series have found that onabotulinumtoxinA and abobotulinumtoxinA are possibly effective, with minimal side effects and possible equivalence in efficacy.(112)(113)(114)(116)(117) **(EG 2)** A specialty society technology assessment report concluded that onabotulinumtoxinA was effective for treating hemifacial spasm.(92) **(EG 2)**

For hyperhidrosis (axillary), evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A systematic review and meta-analysis of 23 studies found moderate-quality evidence to support botulinum toxin injections to control symptoms of axillary hyperhidrosis for up to 16 weeks compared with placebo.(123) **(EG 1)** Review articles and observational trials support the use of botulinum toxin A for the treatment of axillary hyperhidrosis if a trial of a topical agent (eg, aluminum chloride) is unsuccessful.(118)(119)(120)(121)(122)(124)(127)(128)(129)(130)(131) **(EG 2)**

For laryngeal dystonia (ie, adductor spasmodic dysphonia), evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A randomized double-blind placebo-controlled trial including 22 patients with adductor spasmodic dysphonia found that a single injection of onabotulinumtoxinA into the thyroarytenoid muscle was associated with improvements in speech production accuracy at 4 weeks of follow-up compared with placebo.(136) **(EG 1)** A systematic review and meta-analysis of 17 studies (3 clinical trials and 14 cohort studies) evaluating voice-related quality of life after botulinum toxin injection for adductor spasmodic dysphonia reported improvements in Voice Health Index voice-related quality-of-life scores after botulinum toxin therapy.(137) **(EG 1)** Expert consensus guidelines and review articles indicate that botulinum toxin is effective for treating this disorder based on limited evidence from randomized controlled trials.(104)(138)(139)(140) **(EG 2)** A retrospective analysis of 548 patients concluded that onabotulinumtoxinA injections into the thyroarytenoid or lateral

cricoarytenoid muscle complex was an effective treatment for adductor spasmodic dysphonia, lateral laryngeal tremor, or a combination of these vocal disorders, with the greatest effectiveness noted in patients with tremor-free adductor spasmodic dysphonia.(141) **(EG 2)**

For migraine headache prophylaxis, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review and meta-analysis of 28 randomized controlled trials (4190 patients) concluded that prophylaxis treatment with botulinum toxin A, as compared with placebo, was associated with 2 fewer migraine days per month in patients with chronic migraines (chronic being defined as 15 or more migraines per month). Botulinum toxin A was not associated with fewer episodic migraines (episodic being defined as less than 15 migraines per month), and the evidence was considered inadequate in this population.(148) **(EG 1)** A randomized controlled study with 904 patients suggests that onabotulinumtoxinA also may be effective in limiting medication overuse in chronic migraine patients.(149) **(EG 1)** Observational studies and review articles support the use of onabotulinumtoxinA for migraine prophylaxis in appropriately selected patients with chronic migraine headaches.(150)(151)(152)(153)(154)(155)(156) **(EG 2)** An industry-sponsored, randomized, double-blind, placebo-controlled trial including 125 adolescents age 12 to 18 years with chronic migraine found that treatment with onabotulinumtoxinA was not associated with reductions in the frequency of headache days or severe headache days at 12 weeks post treatment, as compared with placebo. The authors note that the study may have been underpowered and that additional studies in the pediatric population are needed.(157) **(EG 1)** A specialty society guideline recommends the use of onabotulinumtoxinA for chronic migraine prophylaxis, as it was found to be established and effective in increasing headache-free days and probably effective in improving health-related quality of life.(96) **(EG 2)** A practice guideline recommends botulinum toxin type A for the prophylaxis of headache in adults with chronic migraines (defined as at least 15 days of headache per month and at least 8 days of migraine) who have not responded to at least 3 prior pharmacologic prophylaxis therapies and whose condition is appropriately managed for medication overuse.(158) **(EG 2)** A specialty society guideline recommends that for chronic migraines, patients should have tried 2 to 3 other migraine prophylactics before initiating treatment with onabotulinumtoxinA.(159) **(EG 2)**

For motor tics, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review found one very low-quality randomized controlled trial employing onabotulinumtoxinA injections in 18 patients with muscle tics; the review authors were unable to conclude if the active treatment offered any therapeutic benefit as compared with placebo.(169) **(EG 1)** A specialty society guideline indicates that onabotulinumtoxinA injections are a treatment option for reducing tic severity in adolescents and adults.(167)(168) **(EG 2)**

For overactive bladder with or without urgency urinary incontinence, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** A randomized placebo-controlled dose-ranging study of 313 patients reported improvement in urinary incontinence with onabotulinumtoxinA as compared with placebo.(176) **(EG 1)** Another randomized placebo-controlled trial of 240 women with refractory detrusor overactivity reported higher rates of urinary continence with onabotulinumtoxinA therapy; however, urinary tract infection and voiding difficulties requiring self-catheterization were more common.(177) **(EG 1)** A randomized trial comparing onabotulinumtoxinA with anticholinergic therapy in 249 women reported that the group receiving onabotulinumtoxinA was more likely to have complete resolution of urgency urinary incontinence but had higher rates of transient urinary retention and urinary tract infections.(178) **(EG 1)** An industry-sponsored, randomized, double-blind, placebo-controlled trial including 250 adult patients with overactive bladder refractory to anticholinergics and/or beta-3 adrenergic agonists found that at 12 weeks post treatment, onabotulinumtoxinA was associated with a greater decrease in daily urinary incontinence episodes compared with placebo.(179) **(EG 1)** A systematic review and meta-analysis of 7 randomized controlled trials and 2 retrospective studies (1649 patients) comparing onabotulinumtoxinA with sacral neuromodulation found that patients receiving onabotulinumtoxinA were more likely to have a reduction in urgency urinary incontinence but had higher rates of urinary tract infections.(180) **(EG 1)** A randomized study of 557 patients with overactive bladder and urinary incontinence found that onabotulinumtoxinA decreased the daily frequency of incontinence episodes and improved health-related quality-of-life scores as compared with placebo.(181) **(EG 1)** A randomized study of 28 patients with overactive bladder and urge incontinence after prostate surgery found significant improvement in quality of life after administration of botulinum toxin A.(182) **(EG 1)** A systematic review and network meta-analysis concluded that onabotulinumtoxinA provided the greatest relief of overactive bladder symptoms compared with oral or transdermal anticholinergic medications, mirabegron, and placebo.(183) **(EG 1)** A systematic review and network meta-analysis of 19 trials concluded that botulinum toxin A was associated with fewer incontinence episodes and fewer micturitions per 24 hours as compared with mirabegron. However, botulinum toxin A was associated with a greater risk of urinary tract infections than mirabegron.(184) **(EG 1)** Review articles support the use of onabotulinumtoxinA due to significant improvement in measured frequency, urgency, and incontinence in the management of lower urinary tract disorders.(174)(185)(186)(187)(188) **(EG 2)**

For sialorrhea, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** Systematic reviews of randomized controlled trials investigating sialorrhea in children with cerebral palsy reported that all trials of intrasalivary injection of botulinum toxin demonstrated a statistically significant reduction in drooling; however, authors have concluded that there was insufficient evidence to fully inform clinical practice for this condition.(195)(196)(197) **(EG 1)** Expert reviews and consensus guidelines recommend intrasalivary injection of botulinum toxin, primarily botulinum toxin type A, to reduce drooling in patients with cerebral palsy, Parkinson disease,(191)(198) amyotrophic lateral sclerosis, and other neurodegenerative conditions.(193)(199)(200)(201) **(EG 2)**

For spasticity, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Systematic reviews and meta-analyses have found evidence in support of botulinum toxin A for the management of spasticity when it is administered with concomitant rehabilitation therapy,(203) particularly in children.(206)(207)(208) **(EG 1)** A systematic review and meta-analysis of 31 randomized trials evaluating type A botulinum neurotoxins for lower limb spasticity in children with cerebral palsy found moderate-

quality evidence that type A botulinum neurotoxin improves gait scores in the short term and medium term, compared with placebo or sham treatment, and low-quality evidence that type A botulinum neurotoxin improves gait scores and functioning in the medium term, compared with usual care or physical therapy.(209) **(EG 1)** A phase III randomized controlled trial of 235 patients (age 2 to 17 years) with single-arm upper limb spasticity due to cerebral palsy compared treatment with occupational therapy combined with either onabotulinumtoxinA (at 1 of 2 doses) or placebo and found, at 4-week and 6-week follow-up, that both doses of onabotulinumtoxinA were associated with greater improvements from baseline in spasticity in the affected limb (measured with the Modified Ashworth Scale-Bohannon score) compared with placebo.(210) **(EG 1)** A similarly designed phase III randomized controlled trial of 384 patients (age 2 to 17 years) with lower limb spasticity due to monoplegic or hemiplegic cerebral palsy compared treatment with physical therapy combined with either onabotulinumtoxinA (at 1 of 2 doses) or placebo and found, at 4-week and 6-week follow-up, that both doses of onabotulinumtoxinA were associated with greater improvements from baseline in ankle spasticity (measured by the Modified Ashworth Scale-Bohannon score at the ankle) compared with placebo.(211) **(EG 1)** Guidelines recommend botulinum toxin A for treating children with spasticity due to cerebral palsy.(205)(212)(213)(214)(215) **(EG 2)** However, a systematic review indicates that industry-sponsored studies of cerebral palsy patients are significantly more likely to have favorable conclusions as compared with nonsponsored studies.(216) **(EG 1)** A systematic review of use in children younger than 2 years indicates that evidence is lacking with regard to improvement in general motor development, even though there appears to be an advantage in avoiding contractures, reducing spasticity, and delaying need for surgery.(217) **(EG 1)** An industry-sponsored systematic review and network meta-analysis of studies evaluating type A botulinum neurotoxins for lower limb spasticity in children reported that, compared with placebo, onabotulinumtoxinA was associated with improved scores on some spasticity scales, depending on the dose used. However, the study did not find improvements in functional goal attainment with onabotulinumtoxinA. The authors noted that a sparsity of studies and small sample sizes impacted the reliability of the conclusions.(218) **(EG 2)** Systematic reviews and meta-analyses have concluded that botulinum toxin A is effective for treatment of upper extremity spasticity in adults due to stroke, with improvement in functionality.(202)(219) **(EG 1)** A multicenter randomized controlled trial of 333 patients reported that the addition of botulinum toxin to an upper limb therapy program did not improve active upper limb function; however, significant differences were seen in favor of the intervention group for basic functional tasks involving hand hygiene and facilitation of dressing.(220) **(EG 1)** With regard to lower extremity functional improvement in patients with stroke, a meta-analysis and systematic review found that studies on the injection of botulinum toxin A into the rectus femoris, while associated with significant improvement in knee flexion, have yet to confirm significant improvement in functional outcomes.(221) **(EG 1)** In a randomized study of 273 poststroke patients with focal or multifocal upper or lower limb spasticity, administration of botulinum toxin A along with standard rehabilitation care was not associated with significant improvement in patients' principal and secondary active functional goals, as compared with placebo and standard care.(222) **(EG 1)** A randomized double-blind study of 52 adults with spastic pes equinovarus after stroke, traumatic brain injury, or diffuse hypoxia compared treatment with botulinum toxin A or placebo and found, at 24-week follow-up, that the botulinum toxin A group had decreased muscle tone, as measured by the Modified Ashworth score.(223) **(EG 1)** A 12-week, double-blind, randomized, placebo-controlled trial with 450 patients, followed by a 48-week open-label extension study with 413 patients, found that onabotulinumtoxinA significantly improved symptoms of poststroke ankle spasticity during both phases of the trial.(224) **(EG 1)** A specialty society guideline indicates that onabotulinumtoxinA is an appropriate treatment for either upper or lower limb spasticity in adults.(96) **(EG 2)** Systematic and expert evidence-based reviews have found that botulinum toxin A is effective in improving muscle tone and range of motion in patients with spasticity due to multiple sclerosis and other neurologic conditions; however, the authors noted that evidence confirming active functional improvement has not yet been demonstrated.(96)(225)(226)(227)(228) **(EG 2)**

For strabismus, evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A systematic review comparing extraocular muscle botulinum toxin A injection with eye muscle surgery in nonparalytic, nonrestrictive horizontal strabismus identified 13 studies of onobotulinumtoxinA (only 2 of which were randomized controlled trials) and concluded that botulinum toxin A is associated with a similar rate of successful motor outcomes compared with surgery for small-angle to moderate-angle strabismus, although multiple treatments may be required.(236) **(EG 1)** A systematic review found comparable success rates between surgery and use of botulinum toxin A, with the advantage that adverse effects such as diplopia and ptosis are short-lived in the latter scenario.(234) **(EG 2)** A systematic review of botulinum toxin A for congenital and acquired strabismus (misalignment) found only 6 randomized controlled trials that showed no effect in preventing medial rectus contracture in sixth nerve palsy, poor effect in adult horizontal strabismus (esotropia and exotropia) when binocular vision is not present, and no difference in response for retreatment (initial treatment: surgery) of infantile esotropia or acute-onset esotropia.(237) **(EG 1)** Review articles support the use of botulinum toxin A as either the primary treatment or as an adjunct to surgery for strabismus.(238)(239) **(EG 2)**

For upper extremity focal dystonia (ie, writer's cramp, other occupational hand dystonias, non-task-specific hand dystonia), evidence demonstrates a net benefit, but of less than moderate certainty, and may consist of a consensus opinion of experts, case studies, and common standard care. **(RG A2)** A randomized controlled trial of 30 patients with focal brachial dystonia with dystonic tremor compared treatment with either onabotulinumtoxinA or placebo and found, at 6-week and 12-week follow-up, that onobotulinumtoxinA was associated with lower tremor severity (measured by the Fahn-Tolosa-Marin Tremor Rating Scale) compared with placebo.(242) **(EG 1)** Expert evidence-based guidelines recommend that botulinum toxin A formulations should be considered as a treatment option for this condition.(104) **(EG 2)**

For urinary incontinence due to neurogenic detrusor overactivity in adults, evidence demonstrates at least moderate certainty of at least moderate net benefit. **(RG A1)** Systematic reviews and randomized controlled trials concluded that cystoscopically guided injection of the detrusor with onabotulinumtoxinA improved quality-of-life scores(245)(246)(247) and daily urinary incontinence frequency,(246)(248) as well as catheter use and bladder pressures.(247)(248)(249)(250) **(EG 1)** Practice guidelines and review articles recommend

bladder wall injection of botulinum toxin A for patients with symptomatic neurogenic bladder unresponsive to antimuscarinic medication.(225)(243)(244)(251)(252)(253)(254) **(EG 2)**

For urinary incontinence due to neurogenic detrusor overactivity in children and adolescents, evidence demonstrates an incomplete assessment of net benefit vs harm; the drug is currently approved by a federal regulatory agency. **(RG A3)** An industry-sponsored randomized trial of 114 patients age 5 to 17 years with urinary incontinence related to detrusor overactivity due to spinal cord injury, spinal dysraphism, or transverse myelitis (all with symptoms inadequately controlled with anticholinergic agents) compared intra-detrusor injections of onabotulinumtoxinA at 3 doses (50 units, 100 units, or 200 units) and found, at 6 weeks of follow-up, that patients in all 3 groups had improvement from baseline in the number of daytime urinary incontinence episodes, with no significant difference seen between groups. Adverse events occurred in 58% of patients over 12 weeks of follow-up, including urinary tract infections in 19.5% of all patients.(256) **(EG 1)** A systematic review of 12 studies (293 patients) evaluating intra-detrusor botulinum toxin A in pediatric patients with spina bifida and neurogenic detrusor overactivity found resolution of incontinence in 23% to 100% of patients. The authors noted that the small number of patients, short-term follow-up, and lack of placebo control in the included studies limited the results.(257) **(EG 1)** A retrospective cohort study of 53 patients age 16 years or younger with spina bifida and detrusor overactivity or poor bladder compliance found that 30% of patients had global success (as defined by both urodynamic improvement and clinical improvement, including no incontinence episodes between clean intermittent catheterizations, fewer than 8 clean intermittent catheterizations per 24 hours, and absence of urinary urgency) after one intra-detrusor botulinum toxin A injection.(258) **(EG 2)** A specialty society guideline states that intra-detrusor botulinum toxin may improve urodynamic parameters in children with neurogenic bladder and detrusor overactivity.(259) **(EG 2)**

Inconclusive or Non-Supportive Evidence

For anal sphincter achalasia, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A meta-analysis of 16 nonrandomized studies of patients with internal anal sphincter achalasia reported that after botulinum toxin A injection, rates of transient fecal incontinence, nonresponse, and subsequent surgical procedures were significantly higher as compared with patients who underwent myectomy.(14) **(EG 2)**

For back pain, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review found only 3 randomized trials, with significant heterogeneity present, and concluded that current evidence does not support the use of botulinum toxin for low back pain and sciatica.(15) **(EG 1)**

For benign prostatic hyperplasia with lower urinary tract symptoms, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A review article found studies suggesting efficacy of either abobotulinumtoxinA or onabotulinumtoxinA for treatment of male lower urinary tract symptoms, but the author concluded that the overall level of evidence is low, and additional clinical trials are required.(16) **(EG 2)** A systematic review and meta-analysis of 3 randomized controlled trials with 522 patients with benign prostatic hyperplasia found that treatment with botulinum toxin A produced a slightly greater improvement in International Prostate Symptom Scores when compared with placebo; however, there were no differences in maximum urinary flow, prostate volume, and postvoid residual volume between the botulinum toxin A and placebo groups. The authors concluded that these trials did not support the use of botulinum toxin A for men with lower urinary tract symptoms due to benign prostatic hyperplasia.(17) **(EG 1)**

For chronic idiopathic constipation in children, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A randomized trial assigned 42 patients to onabotulinumtoxinA or to myectomy of the internal anal sphincter and reported comparable improvement after 1 year in both groups; however, larger, randomized studies are needed.(18) **(EG 1)** A retrospective study of 141 children with severe constipation unresponsive to medication management found that treatment with botulinum toxin injections into the internal anal sphincter was associated with a decrease in defecatory pain or an increase in frequency of bowel movements in 70% of patients. The authors note that a prospective randomized placebo-controlled trial is needed.(19) **(EG 2)**

For chronic pain, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review and meta-analysis of randomized controlled trials found preliminary but not confirmatory evidence that either abobotulinumtoxinA or onabotulinumtoxinA may be effective for a variety of painful conditions, as well as convincing evidence of lack of effectiveness for myofascial pain syndrome.(20) **(EG 1)** Systematic reviews of randomized trials reported that evidence is inconclusive to support the use of botulinum toxin for myofascial pain.(21)(22)(23) **(EG 1)** Systematic reviews and meta-analyses of randomized controlled trials found that intra-articular injections of botulinum toxin A significantly improved joint pain; however, the clinical effect was small and the authors recommended further studies assessing the benefit of this therapy.(24)(25) **(EG 1)** A systematic review and meta-analysis of 10 randomized placebo-controlled trials (2 of which were unpublished) including 530 patients evaluated botulinum toxin A for neuropathic pain and found, at 1-month and 3-month follow-up, that botulinum toxin A was associated with improvement in visual analog pain scale scores. However, the results were limited by small study sizes and variability in botulinum toxin A used, doses, and areas of the body treated.(26) **(EG 1)** A multicenter double-blind trial randomly allocated 176 patients with nociceptive pain from knee osteoarthritis to treatment with a single intra-articular injection of onabotulinumtoxinA (at 2 different doses) or saline. At 8-week follow-up, all 3 groups noted significant pain relief that was sustained throughout the 24-week study; however, there were no between-group differences when comparing onabotulinumtoxinA vs placebo.(27) **(EG 1)** For various types of chronic pain, including inflammatory pain, musculoskeletal pain, neuropathic pain, and postoperative pain, evidence-based reviews (involving primarily onabotulinumtoxinA) reported that the role of this therapy is not well established.(22)(28) **(EG 2)** A

randomized placebo-controlled trial with 30 patients with postherpetic neuralgia found that botulinum toxin A was significantly more effective than placebo in reducing postherpetic pain over a period of 16 weeks, but the authors indicated that further confirmatory studies are needed.(29) **(EG 1)** Review articles on evidence for the effectiveness of botulinum toxin A for various types of neuropathic pain found 2 randomized studies supporting use for postherpetic neuralgia; however, one study involved a formulation not available in the United States, and the second had only 15 patients per treatment arm with 24-week follow-up.(30)(31)(32) **(EG 2)**

For chronic pelvic pain in men, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of interventions for chronic prostatitis and chronic pelvic pain in men identified 3 studies evaluating botulinum toxin A. The authors concluded that there is low-quality evidence that intraprostatic botulinum toxin A injection may be associated with reduction of prostatitis symptoms, while pelvic floor muscle botulinum toxin A injection was not associated with symptom reduction in men.(33) **(EG 1)** A randomized double-blind controlled trial of 64 patients with chronic scrotal pain and an incomplete response to prior therapies compared further treatment with local anesthetic alone or combined with onabotulinumtoxinA and found, 1 month after injection, no significant difference in patient-reported scrotal pain between groups.(34) **(EG 1)**

For clubfeet, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of interventions for congenital clubfoot found insufficient evidence to draw conclusions about the incremental efficacy of adding botulinum toxin A to serial manipulation and casting. The review identified one randomized study of 20 newborns with 32 clubfeet who received onabotulinumtoxinA or placebo in addition to standard serial manipulation or casting; no significant incremental benefit was demonstrated for onabotulinumtoxinA in terms of reducing cast time, need for tenotomy, or risk for relapse.(35) **(EG 1)** A double-blind randomized controlled trial of 62 infants with congenital idiopathic clubfoot who were treated at the time of hindfoot stall found no difference in response rates (defined as obtaining 15 degrees or more of dorsiflexion) between treatment with onabotulinumtoxinA and placebo at 6 weeks after the injection.(36) **(EG 1)** A retrospective case series of 361 affected feet in 239 eligible patients younger than 2 years found that botulinum toxin appeared to be safe, but the authors cautioned that properly controlled prospective outcome studies are necessary to better assess efficacy.(37) **(EG 2)**

For depression, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A randomized double-blind crossover study of 30 patients with depression followed over 24 weeks found significant improvement in depressive symptoms with botulinum toxin A, but the authors stated that larger confirmatory studies with longer-term follow-up are essential.(38) **(EG 1)** In a randomized controlled study, 74 patients with major depression received onabotulinumtoxinA or placebo injections in corrugator and frown muscles. After 6 weeks, 52% of actively treated patients, as compared with 15% of those receiving placebo, achieved at least 50% improvement in a major depression rating scale; the authors indicated that larger, longer-term study is needed.(39) **(EG 1)**

For essential tremor, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** Expert evidence-based reviews found limited evidence to suggest that botulinum toxins may be helpful for disabling essential tremor of the hands in those patients who fail treatment with oral agents and prior to consideration of thalamic deep brain stimulation; however, existing evidence was insufficient to draw a conclusion on the use of botulinum toxins in the treatment of head and voice tremor.(40)(41)(42)(43)(44)(45) **(EG 2)**

For focal dystonias of the lower extremity, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A review and specialty society guideline summary indicated that evidence for effectiveness of botulinum toxin in focal lower limb dystonia is at the lowest level of consideration.(46) **(EG 1)** A review article on use of botulinum toxin for treatment of primary focal dystonias makes no recommendations for use in lower limb dystonias.(47) **(EG 2)**

For gastroparesis, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review and review articles have concluded that there is no evidence of effectiveness of botulinum toxin for this condition.(48)(49)(50) **(EG 2)** Expert consensus guidelines on the management of gastroparesis state that additional randomized controlled trials evaluating intrapyloric botulinum toxin for gastroparesis are needed.(51)(52) **(EG 2)**

For gustatory sweating (Frey syndrome), evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review found only uncontrolled case series and concluded that there is insufficient evidence to support the use of botulinum toxin for this condition.(53) **(EG 1)**

For idiopathic toe walking, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of conservative and surgical treatments for idiopathic toe walking in children identified a single randomized controlled trial in 47 children with idiopathic toe walking that showed no significant improvement in parent-reported toe walking time with below-the-knee walking casts with botulinum toxin A injected into the calf muscles, as compared with casting alone.(54) **(EG 1)**

For masseter hypertrophy, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review found a lack of relevant randomized controlled trials or other robust evidence to support or refute the effectiveness of botulinum toxins for treatment of masseter hypertrophy.(55) **(EG 1)**

For obesity, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review and meta-analysis of 4 randomized controlled trials with 108 obese patients concluded that gastric injections of botulinum toxin A were not effective for reducing weight.(56) **(EG 1)**

For Parkinson disease tremor, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A randomized trial compared the effects of onabotulinumtoxinA injection vs placebo in 12 patients with limb pain and advanced Parkinson disease and found no significant differences between the 2 treatments. (57) **(EG 1)**

For pelvic floor pain syndrome, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of 16 studies evaluating botulinum toxin A for chronic pelvic pain (ie, bladder pain syndrome, gynecologic pain syndrome, prostate pain syndrome, chronic anal pain, and myofascial pelvic pain) included 4 studies (194 patients) of onabotulinumtoxinA for gynecologic pelvic pain and one study (59 patients) of onabotulinumtoxinA for myofascial pelvic pain. In a pooled analysis, onabotulinumtoxinA was not associated with significant improvement in pain scores at 6-month follow-up compared with placebo; reporting on quality-of-life and functional outcomes was limited. In a single randomized placebo-controlled trial, onabotulinumtoxinA was not associated with significant improvements in pain scores at 3-month follow-up compared with placebo. The authors noted that the included studies were at high risk of bias and confounding and stated that additional multicenter trials evaluating botulinum toxin A for chronic pelvic pain are needed.(58) **(EG 1)** A literature review of the use of onabotulinumtoxinA for vaginismus found primarily case reports and case series suggesting but not confirming benefit in some patients. The authors suggest that further study is needed.(59) **(EG 2)** A subsequent review article found significant gaps in supporting evidence for use of onabotulinumtoxinA for high-tone pelvic floor dysfunction or anismus.(60) **(EG 2)** Another review article concluded that significantly more study is needed to evaluate the effectiveness of botulinum toxin A for anismus.(61) **(EG 2)**

For plantar fasciitis, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review evaluating minimally invasive nonsurgical management of plantar fasciitis included 3 randomized controlled trials (144 patients) comparing botulinum toxin A injection with placebo or corticosteroids and found that botulinum toxin A was associated with improved patient-reported visual analog pain scores compared with other interventions. However, the authors noted that heterogeneity among included studies limited the results, and further studies were recommended.(62) **(EG 1)** A randomized controlled trial of 71 patients with plantar fasciitis compared treatment with injected anesthetic (ropivacaine), corticosteroid, or botulinum toxin A and found, at 24-week follow-up, that all groups had improvement in patient-reported visual analog pain scores and Maryland Foot Score results, as well as improvement in ultrasound-measured plantar fascia thickness, with no differences seen between treatment groups.(63) **(EG 1)**

For postnatal brachial plexus injury, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of studies including use of either abobotulinumtoxinA or onabotulinumtoxinA found only a low level of promising but not confirmatory evidence, and the authors indicated that multicenter randomized trials are needed.(64) **(EG 2)**

For refractory interstitial cystitis, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review of 16 studies evaluating botulinum toxin A for chronic pelvic pain (ie, bladder pain syndrome, gynecologic pain syndrome, prostate pain syndrome, chronic anal pain, and myofascial pelvic pain) identified 7 studies (374 patients) of botulinum toxin A for bladder pain syndrome (interstitial cystitis), including 2 studies evaluating onabotulinumtoxinA, one study each evaluating abobotulinumtoxinA and incobotulinumtoxinA, and 3 studies evaluating unspecified botulinum toxin A. The review found that although half of the included studies reported significant improvements in pain at 3 to 12 months post treatment, the available evidence was limited by heterogeneity in intervention and control treatments, including the type and dose of botulinum toxin A, sites of injection, outcome measures, and follow-up periods. The authors stated that additional multicenter trials evaluating botulinum toxin A for chronic pelvic pain are needed.(58) **(EG 1)** A systematic review and network meta-analysis of 16 randomized controlled trials concluded that among 7 intravesical treatments for refractory interstitial cystitis, botulinum toxin A had the highest probability of being the best in terms of global response assessment and improved bladder capacity; however, the authors suggested further research to improve understanding of the disease and its treatment.(65) **(EG 1)**

For shoulder pain, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** Systematic reviews and meta-analyses found some evidence that intramuscular botulinum toxin A injection may reduce pain, but due to small sample sizes and significant study heterogeneity, the authors cautioned that more study is needed.(66)(67) **(EG 1)**

For thoracic outlet syndrome, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A meta-analysis and systematic review stated that there is moderate evidence suggesting that botulinum toxin injections to the scalene muscles for treatment of thoracic outlet syndrome resulted in no greater improvement than placebo injection of saline.(68) **(EG 1)**

For trigeminal neuralgia, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A meta-analysis of 4 randomized controlled trials (178 patients) found that treatment with botulinum toxin A had a favorable effect on pain compared with placebo in patients with trigeminal neuralgia; the authors cautioned that the findings should be interpreted with caution due to the limited number of patients and trials and the need for longer

follow-up. The authors recommended future randomized controlled trials to evaluate this intervention.(69) **(EG 1)** An uncontrolled study of 87 patients with trigeminal neuralgia showed that injection of botulinum toxin in the pain area had an effective rate of 48% at 1 week and 80% at 8 weeks.(70) **(EG 2)** Review articles of the use of botulinum toxin A for trigeminal neuralgia found evidence consisting only of small studies with limited follow-up; some studies suggested a possible favorable response, but the authors indicated that larger, randomized studies are needed.(30)(71)(72) **(EG 2)** A specialty society guideline notes that botulinum toxin A may have an effect as adjunctive therapy for treating patients with trigeminal neuralgia, acknowledging that the evidence supporting this conclusion is of very low quality.(73) **(EG 2)**

For upper esophageal sphincter dysfunction, evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended. **(RG B)** A systematic review to assess the efficacy and safety of botulinum toxin for improving upper esophageal sphincter dysfunction in patients with dysphagia did not identify any relevant randomized controlled trials and stated that there was insufficient evidence to inform clinical practice.(74) **(EG 1)** A subsequent systematic review found only case series describing the use of botulinum toxin for cricopharyngeal dysfunction; the authors noted that the treatment appears to be associated with a high recurrence rate but may be suitable in patients with multiple comorbidities or who are elderly, and they recommended future studies to better evaluate the efficacy of this intervention.(75) **(EG 1)**

References

1. Botox® (onabotulinumtoxinA) for injection, for intramuscular, intradetrusor, or intradermal use. Physician Prescribing Information [Internet] Allergan, Inc. 2022 Aug Accessed at: https://www.botoxone.com/. [created 1989; accessed 2022 Nov 11] [Context Link 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11]
2. Camargo CHF, Teive HAG. Use of botulinum toxin for movement disorders. Drugs in Context 2019;8:212586. DOI: 10.7573/dic.212586. [Context Link 1, 2] View abstract...
3. Safarpour Y, Jabbari B. Botulinum toxin treatment of movement disorders. Current Treatment Options in Neurology 2018;20(2):4. DOI: 10.1007/s11940-018-0488-3. [Context Link 1] View abstract...
4. Orsini M, et al. Botulinum neurotoxin type A in neurology: update. Neurology International 2015;7(2):5886. DOI: 10.4081/ni.2015.5886. [Context Link 1] View abstract...
5. Tater P, Pandey S. Botulinum toxin in movement disorders. Neurology India 2018 Mar-Apr;66(Supplement):S79-S89. DOI: 10.4103/0028-3886.226441. [Context Link 1] View abstract...
6. Zakin E, Simpson D. Evidence on botulinum toxin in selected disorders. Toxicon 2018;147:134-140. DOI: 10.1016/j.toxicon.2018.01.019. [Context Link 1] View abstract...
7. Pirazzini M, Rossetto O, Eleopra R, Montecucco C. Botulinum neurotoxins: biology, pharmacology, and toxicology. Pharmacological Reviews 2017;69(2):200-235. DOI: 10.1124/pr.116.012658. [Context Link 1] View abstract...
8. Ferrari A, Manca M, Tugnoli V, Alberto L. Pharmacological differences and clinical implications of various botulinum toxin preparations: a critical appraisal. Functional Neurology 2018;33(1):7-18. [Context Link 1, 2] View abstract...
9. Jankovic J. Botulinum toxin: State of the art. Movement Disorders 2017;32(8):1131-1138. DOI: 10.1002/mds.27072. [Context Link 1] View abstract...
10. Brin MF, James C, Maltman J. Botulinum toxin type A products are not interchangeable: a review of the evidence. Biologics 2014;8:227-241. DOI: 10.2147/BTT.S65603. [Context Link 1] View abstract...
11. Fraint A, Vittal P, Comella C. Considerations on patient-related outcomes with the use of botulinum toxins: is switching products safe? Therapeutics and Clinical Risk Management 2016;12:147-154. DOI: 10.2147/TCRM.S99239. [Context Link 1] View abstract...
12. Dashtipour K, Chen JJ, Espay AJ, Mari Z, Ondo W. OnabotulinumtoxinA and abobotulinumtoxinA dose conversion: a systematic literature review. Movement Disorders Clinical Practice 2016;3(2):109-115. DOI: 10.1002/mdc3.12235. [Context Link 1] View abstract...
13. Scaglione F. Conversion ratio between Botox, Dysport, and Xeomin in clinical practice. Toxins (Basel) 2016;8(3):E65. DOI: 10.3390/toxins8030065. [Context Link 1] View abstract...
14. Friedmacher F, Puri P. Comparison of posterior internal anal sphincter myectomy and intrasphincteric botulinum toxin injection for treatment of internal anal sphincter achalasia: a meta-analysis. Pediatric Surgery International 2012;28(8):765-771. DOI: 10.1007/s00383-012-3123-5. [Context Link 1] View abstract...
15. Waseem Z, Boulias C, Gordon A, Ismail F, Sheean G, Furlan AD. Botulinum toxin injections for low-back pain and sciatica. Cochrane Database of Systematic Reviews 2011, Issue 1. Art. No.: CD008257. DOI: 10.1002/14651858.CD008257.pub2. [Context Link 1] View abstract...
16. Chung E. Botulinum toxin in urology: a review of clinical potential in the treatment of urologic and sexual conditions. Expert Opinion on Biological Therapy 2015;15(1):95-102. DOI: 10.1517/14712598.2015.974543. [Context Link 1] View abstract...
17. Shim SR, Cho YJ, Shin IS, Kim JH. Efficacy and safety of botulinum toxin injection for benign prostatic hyperplasia: a systematic review and meta-analysis. International Urology and Nephrology 2016;48(1):19-30. DOI: 10.1007/s11255-015-1153-3. [Context Link 1] View abstract...
18. Keshtgar AS, Ward HC, Sanei A, Clayden GS. Botulinum toxin, a new treatment modality for chronic idiopathic constipation in children: long-term follow-up of a double-blind randomized trial. Journal of Pediatric Surgery 2007;42(4):672-680. DOI: 10.1016/j.jpedsurg.2006.12.045. [Context Link 1] View abstract...
19. Zar-Kessler C, Kuo B, Belkind-Gerson J. Botulinum toxin injection for childhood constipation is safe and can be effective regardless of anal sphincter dynamics. Journal of Pediatric Surgery 2018;53(4):693-697. DOI: 10.1016/j.jpedsurg.2017.12.007. [Context Link 1] View abstract...
20. Zhang T, et al. The efficacy of botulinum toxin type A in managing chronic musculoskeletal pain: a systematic review and meta analysis. Inflammopharmacology 2011;19(1):21-34. DOI: 10.1007/s10787-010-0069-x. [Context Link 1] View abstract...

21. Soares A, Andriolo RB, Atallah AN, da Silva EM. Botulinum toxin for myofascial pain syndromes in adults. Cochrane Database of Systematic Reviews 2014, Issue 7. Art. No.: CD007533. DOI: 10.1002/14651858.CD007533.pub3. [Context Link 1] View abstract...
22. Safarpour Y, Jabbari B. Botulinum toxin treatment of pain syndromes -an evidence based review. Toxicon 2018;147:120-128. DOI: 10.1016/j.toxicon.2018.01.017. [Context Link 1, 2] View abstract...
23. Khalifeh M, Mehta K, Varguise N, Suarez-Durall P, Enciso R. Botulinum toxin type A for the treatment of head and neck chronic myofascial pain syndrome: A systematic review and meta-analysis. Journal of the American Dental Association 2016;147(12):959-973.e1. DOI: 10.1016/j.adaj.2016.08.022. [Context Link 1] View abstract...
24. Courseau M, Salle PV, Ranoux D, de Pouilly Lachatre A. Efficacy of intra-articular botulinum toxin in osteoarticular joint pain: a meta-analysis of randomized controlled trials. Clinical Journal of Pain 2018;34(4):383-389. DOI: 10.1097/AJP.0000000000000538. [Context Link 1] View abstract...
25. Wu T, Song HX, Dong Y, Ye Y, Li JH. Intra-articular injections of botulinum toxin a for refractory joint pain: a systematic review and meta-analysis. Clinical Rehabilitation 2017;31(4):435-443. DOI: 10.1177/0269215516644951. [Context Link 1] View abstract...
26. Hary V, Schitter S, Martinez V. Efficacy and safety?of?botulinum A toxin?for the treatment of chronic peripheral neuropathic?pain: A systematic review of randomized controlled trials and meta-analysis. European Journal of Pain 2022;26(5):980-990. DOI: 10.1002/ejp.1941. [Context Link 1] View abstract...
27. McAlindon TE, et al. Efficacy and safety of single-dose onabotulinumtoxinA in the treatment of symptoms of osteoarthritis of the knee: results of a placebo-controlled, double-blind study. Osteoarthritis and Cartilage 2018;26(10):1291-1299. DOI: 10.1016/j.joca.2018.05.001. [Context Link 1] View abstract...
28. Sandrini G, De Icco R, Tassorelli C, Smania N, Tamburin S. Botulinum neurotoxin type A for the treatment of pain: not just in migraine and trigeminal neuralgia. Journal of Headache and Pain 2017;18(1):38. DOI: 10.1186/s10194-017-0744-z. [Context Link 1] View abstract...
29. Apalla Z, Sotiriou E, Lallas A, Lazaridou E, Ioannides D. Botulinum toxin A in postherpetic neuralgia: a parallel, randomized, double-blind, single-dose, placebo-controlled trial. Clinical Journal of Pain 2013;29(10):857-864. DOI: 10.1097/AJP.0b013e31827a72d2. [Context Link 1] View abstract...
30. Brown EA, Schutz SG, Simpson DM. Botulinum toxin for neuropathic pain and spasticity: an overview. Pain Management 2014;4(2):129-151. DOI: 10.2217/pmt.13.75. [Context Link 1, 2] View abstract...
31. Mittal SO, Safarpour D, Jabbari B. Botulinum toxin treatment of neuropathic pain. Seminars in Neurology 2016;36(1):73-83. DOI: 10.1055/s-0036-1571953. [Context Link 1] View abstract...
32. Shackleton T, Ram S, Black M, Ryder J, Clark GT, Enciso R. The efficacy of botulinum toxin for the treatment of trigeminal and postherpetic neuralgia: a systematic review with meta-analyses. Oral Surgery, Oral Medicine, Oral Pathology and Oral Radiology 2016;122(1):61-71. DOI: 10.1016/j.oooo.2016.03.003. [Context Link 1] View abstract...
33. Franco JV, et al. Pharmacological interventions for treating chronic prostatitis/chronic pelvic pain syndrome. Cochrane Database of Systematic Reviews 2019, Issue 10. Art. No.: CD012552. DOI: 10.1002/14651858.CD012552.pub2. [Context Link 1] View abstract...
34. Dockray J, Aljumaily A, Lau S, Jarvi KA. A randomized, double-blind, controlled trial shows that onabotulinum toxin A nerve blocks do not provide improved pain control in men with chronic scrotal pain. Journal of Urology 2020;203(4):767-772. DOI: 10.1097/JU.0000000000000658. [Context Link 1] View abstract...
35. Bina S, Pacey V, Barnes EH, Burns J, Gray K. Interventions for congenital talipes equinovarus (clubfoot). Cochrane Database of Systematic Reviews 2020, Issue 5. Art. No.: CD008602. DOI: 10.1002/14651858.CD008602.pub4. [Context Link 1] View abstract...
36. Alvarez CM, Wright JG, Chhina H, Howren A, Law P. Botulinum toxin type A versus placebo for idiopathic clubfoot: a two-center, double-blind, randomized controlled trial. Journal of Bone and Joint Surgery. American Volume 2018;100(18):1589-1596. DOI: 10.2106/JBJS.17.01652. [Context Link 1] View abstract...
37. Chhina H, Howren A, Simmonds A, Alvarez CM. Onabotulinumtoxin A injections: A safety review of children with clubfoot under 2 years of age at BC Children's Hospital. European Journal of Paediatric Neurology 2014;18(2):171-175. DOI: 10.1016/j.ejpn.2013.11.002. [Context Link 1] View abstract...
38. Magid M, et al. Treatment of major depressive disorder using botulinum toxin A: a 24-week randomized, double-blind, placebo-controlled study. Journal of Clinical Psychiatry 2014;75(8):837-844. DOI: 10.4088/JCP.13m08845. [Context Link 1] View abstract...
39. Finzi E, Rosenthal NE. Treatment of depression with onabotulinumtoxinA: A randomized, double-blind, placebo controlled trial. Journal of Psychiatric Research 2014;52:1-6. DOI: 10.1016/j.jpsychires.2013.11.006. [Context Link 1] View abstract...
40. Zesiewicz TA, et al. Evidence-based guideline update: treatment of essential tremor: report of the Quality Standards subcommittee of the American Academy of Neurology. Neurology 2011 (AAN reaffirmed 2014);77(19):1752-1755. DOI: 10.1212/WNL.0b013e318236f0fd. (Reaffirmed 2022 May) [Context Link 1] View abstract...
41. Zappia M, et al. Treatment of essential tremor: a systematic review of evidence and recommendations from the Italian Movement Disorders Association. Journal of Neurology 2013;260(3):714-740. DOI: 10.1007/s00415-012-6628-x. [Context Link 1] View abstract...
42. Ferreira JJ, et al. MDS evidence-based review of treatments for essential tremor. Movement Disorders 2019;34(7):950-958. DOI: 10.1002/mds.27700. [Context Link 1] View abstract...
43. Lotia M, Jankovic J. Botulinum toxin for the treatment of tremor and tics. Seminars in Neurology 2016;36(1):54-63. DOI: 10.1055/s-0035-1571217. [Context Link 1] View abstract...
44. Mittal SO, Lenka A, Jankovic J. Botulinum toxin for the treatment of tremor. Parkinsonism and Related Disorders 2019;63:31-41. DOI: 10.1016/j.parkreldis.2019.01.023. [Context Link 1] View abstract...
45. Picillo M, Munhoz RP. Medical management of movement disorders. Progress in Neurological Surgery 2018;33:41-49. DOI: 10.1159/000480747. [Context Link 1] View abstract...

46. Jankovic J. Medical treatment of dystonia. Movement Disorders 2013;28(7):1001-1012. DOI: 10.1002/mds.25552. [Context Link 1] View abstract...
47. Truong D. Botulinum toxins in the treatment of primary focal dystonias. Journal of the Neurological Sciences 2012;316(1-2):9-14. DOI: 10.1016/j.jns.2012.01.019. [Context Link 1] View abstract...
48. Bai Y, et al. A systematic review on intrapyloric botulinum toxin injection for gastroparesis. Digestion 2010;81(1):27-34. DOI: 10.1159/000235917. [Context Link 1] View abstract...
49. Pasricha TS, Pasricha PJ. Botulinum toxin injection for treatment of gastroparesis. Gastrointestinal Endoscopy Clinics of North America 2019;29(1):97-106. DOI: 10.1016/j.giec.2018.08.007. [Context Link 1] View abstract...
50. Ukleja A, Tandon K, Shah K, Alvarez A. Endoscopic botox injections in therapy of refractory gastroparesis. World Journal of Gastrointestinal Endoscopy 2015;7(8):790-798. DOI: 10.4253/wjge.v7.i8.790. [Context Link 1] View abstract...
51. Schol J, et al. United European Gastroenterology (UEG) and European Society for Neurogastroenterology and Motility (ESNM) consensus on gastroparesis. Neurogastroenterology and Motility 2021;33(8):e14237. DOI: 10.1111/nmo.14237. (Reaffirmed 2022 Apr) [Context Link 1] View abstract...
52. Lacy BE, Tack J, Gyawali CP. AGA clinical practice update on management of medically refractory gastroparesis: expert review. Clinical Gastroenterology and Hepatology 2022;20(3):481-500. DOI: 10.1016/j.cgh.2021.10.038. [Context Link 1] View abstract...
53. Xie S, Wang K, Xu T, Guo XS, Shan XF, Cai ZG. Efficacy and safety of botulinum toxin type A for treatment of Frey's syndrome: evidence from 22 published articles. Cancer Medicine 2015;4(11):1639-50. DOI: 10.1002/cam4.504. [Context Link 1] View abstract...
54. Caserta AJ, Pacey V, Fahey M, Gray K, Engelbert RH, Williams CM. Interventions for idiopathic toe walking. Cochrane Database of Systematic Reviews 2019, Issue 10. Art. No.: CD012363. DOI: 10.1002/14651858.CD012363.pub2. [Context Link 1] View abstract...
55. Fedorowicz Z, van Zuuren EJ, Schoones J. Botulinum toxin for masseter hypertrophy. Cochrane Database of Systematic Reviews 2013, Issue 9. Art. No.: CD007510. DOI: 10.1002/14651858.CD007510.pub3. [Context Link 1] View abstract...
56. Bustamante F, et al. Obesity treatment with botulinum toxin-A Is not effective: a systematic review and meta-analysis. Obesity Surgery 2017;27(10):2716-2723. DOI: 10.1007/s11695-017-2857-5. [Context Link 1] View abstract...
57. Bruno V, Freitas ME, Mancini D, Lui JP, Miyasaki J, Fox SH. Botulinum toxin type A for pain in advanced Parkinson's disease. Canadian Journal of Neurological Sciences 2018;45(1):23-29. DOI: 10.1017/cjn.2017.245. [Context Link 1] View abstract...
58. Parsons BA, et al. The benefits and harms of botulinum toxin-A in the treatment of chronic pelvic pain syndromes: a systematic review by the European Association of Urology Chronic Pelvic Pain Panel. European Urology Focus 2022;8(1):320-338. DOI: 10.1016/j.euf.2021.01.005. [Context Link 1, 2] View abstract...
59. Ferreira JR, Souza RP. Botulinum toxin for vaginismus treatment. Pharmacology 2012;89(5-6):256-259. DOI: 10.1159/000337383. [Context Link 1] View abstract...
60. El-Khawand D, Wehbe S, Whitmore K. Botulinum toxin for conditions of the female pelvis. International Urogynecology Journal 2013;24(7):1073-1081. DOI: 10.1007/s00192-012-2035-1. [Context Link 1] View abstract...
61. Emile SH, et al. Efficacy and safety of botulinum toxin in treatment of anismus: A systematic review. World Journal of Gastrointestinal Pharmacology and Therapeutics 2016;7(3):453-462. DOI: 10.4292/wjgpt.v7.i3.453. [Context Link 1] View abstract...
62. Al-Boloushi Z, Lopez-Royo MP, Arian M, Gomez-Trullen EM, Herrero P. Minimally invasive non-surgical management of plantar fasciitis: A systematic review. Journal of Bodywork and Movement Therapies 2019;23(1):122-137. DOI: 10.1016/j.jbmt.2018.05.002. [Context Link 1] View abstract...
63. Elizondo-Rodriguez J, Simental-Mendia M, Pena-Martinez V, Vilchez-Cavazos F, Tamez-Mata Y, Acosta-Olivo C. Comparison of botulinum toxin A, corticosteroid, and anesthetic injection for plantar fasciitis. Foot and Ankle International 2021;42(3):305-313. DOI: 10.1177/1071100720961093. [Context Link 1] View abstract...
64. Gobets D, Beckerman H, de Groot V, Van Doorn-Loogman MH, Becher JG. Indications and effects of botulinum toxin A for obstetric brachial plexus injury: a systematic literature review. Developmental Medicine and Child Neurology 2010;52(6):517-528. DOI: 10.1111/j.1469-8749.2009.03607.x. [Context Link 1] View abstract...
65. Zhang W, Deng X, Liu C, Wang X. Intravesical treatment for interstitial cystitis/painful bladder syndrome: a network meta-analysis. International Urogynecology Journal 2017;28(4):515-525. DOI: 10.1007/s00192-016-3079-4. [Context Link 1] View abstract...
66. Singh JA, Fitzgerald PM. Botulinum toxin for shoulder pain. Cochrane Database of Systematic Reviews 2010, (verified by Cochrane 2011 Jan), Issue 9. Art. No.: CD008271. DOI: 10.1002/14651858.CD008271.pub2. [Context Link 1] View abstract...
67. Wu T, Fu Y, Song HX, Ye Y, Dong Y, Li JH. Effectiveness of botulinum toxin for shoulder pain treatment: a systematic review and meta-analysis. Archives of Physical Medicine and Rehabilitation 2015;96(12):2214-20. DOI: 10.1016/j.apmr.2015.06.018. [Context Link 1] View abstract...
68. Povlsen B, Hansson T, Povlsen SD. Treatment for thoracic outlet syndrome. Cochrane Database of Systematic Reviews 2014, Issue 11. Art. No.: CD007218. DOI: 10.1002/14651858.CD007218.pub3. [Context Link 1] View abstract...
69. Morra ME, et al. Therapeutic efficacy and safety of Botulinum Toxin A therapy in Trigeminal Neuralgia: a systematic review and meta-analysis of randomized controlled trials. Journal of Headache and Pain 2016;17(1):63. DOI: 10.1186/s10194-016-0651-8. [Context Link 1] View abstract...
70. Xia JH, et al. Botulinum toxin A in the treatment of trigeminal neuralgia. International Journal of Neuroscience 2016;126(4):348-353. DOI: 10.3109/00207454.2015.1019624. [Context Link 1] View abstract...
71. Kowacs PA, Utiumi MA, Nascimento FA, Piovesan EJ, Teive HA. OnabotulinumtoxinA for trigeminal neuralgia: a review of the available data. Arquivos de Neuro-psiquiatria 2015;73(10):877-84. DOI: 10.1590/0004-282X20150109. [Context Link 1] View abstract...
72. Oh HM, Chung ME. Botulinum toxin for neuropathic pain: a review of the literature. Toxins (Basel) 2015;7(8):3127-54. DOI: 10.3390/toxins7083127. [Context Link 1] View abstract...

73. Bendtsen L, et al. European Academy of Neurology guideline on trigeminal neuralgia. European Journal of Neurology 2019;26(6):831-849. DOI: 10.1111/ene.13950. (Reaffirmed 2022 Jul) [Context Link 1] View abstract...
74. Regan J, Murphy A, Chiang M, McMahon BP, Coughlan T, Walshe M. Botulinum toxin for upper oesophageal sphincter dysfunction in neurological swallowing disorders. Cochrane Database of Systematic Reviews 2014, Issue 5. Art. No.: CD009968. DOI: 10.1002/14651858.CD009968.pub2. [Context Link 1] View abstract...
75. Ashman A, Dale OT, Baldwin DL. Management of isolated cricopharyngeal dysfunction: systematic review. Journal of Laryngology and Otology 2016;130(7):611-615. DOI: 10.1017/S0022215116007994. [Context Link 1] View abstract...
76. Stefanidis D, et al. SAGES guidelines for the surgical treatment of esophageal achalasia. Surgical Endoscopy 2012;26(2):296-311. DOI: 10.1007/s00464-011-2017-2. (Reaffirmed 2022 May) [Context Link 1, 2] View abstract...
77. Schlottmann F, Herbella F, Allaix ME, Patti MG. Modern management of esophageal achalasia: From pathophysiology to treatment. Current Problems in Surgery 2018;55(1):10-37. DOI: 10.1067/j.cpsurg.2018.01.001. [Context Link 1, 2] View abstract...
78. Mari A, Patel K, Mahamid M, Khoury T, Pesce M. Achalasia: insights into diagnostic and therapeutic advances for an ancient disease. Rambam Maimonides Medical Journal 2019;10(1):e0008. DOI: 10.5041/RMMJ.10361. [Context Link 1] View abstract...
79. Ramzan Z, Nassri AB. The role of Botulinum toxin injection in the management of achalasia. Current Opinion in Gastroenterology 2013;29(4):468-473. DOI: 10.1097/MOG.0b013e328362292a. [Context Link 1] View abstract...
80. Leyden JE, Moss AC, MacMathuna P. Endoscopic pneumatic dilation versus botulinum toxin injection in the management of primary achalasia. Cochrane Database of Systematic Reviews 2014, Issue 12. Art. No.: CD005046. DOI: 10.1002/14651858.CD005046.pub3. [Context Link 1, 2] View abstract...
81. Vaezi MF, Pandolfino JE, Yadlapati RH, Greer KB, Kavitt RT. ACG clinical guidelines: diagnosis and management of achalasia. American Journal of Gastroenterology 2020;115(9):1393-1411. DOI: 10.14309/ajg.0000000000000731. (Reaffirmed 2022 Jul) [Context Link 1] View abstract...
82. Dobrowolsky A, Fisichella PM. The management of esophageal achalasia: from diagnosis to surgical treatment. Updates in Surgery 2014;66(1):23-29. DOI: 10.1007/s13304-013-0224-1. [Context Link 1] View abstract...
83. Nelson RL, Thomas K, Morgan J, Jones A. Non surgical therapy for anal fissure. Cochrane Database of Systematic Reviews 2012, Issue 2. Art. No.: CD003431. DOI: 10.1002/14651858.CD003431.pub3. [Context Link 1, 2] View abstract...
84. Stewart DB, Gaertner W, Glasgow S, Migaly J, Feingold D, Steele SR. Clinical practice guideline for the management of anal fissures. Diseases of the Colon and Rectum 2017;60(1):7-14. DOI: 10.1097/DCR.0000000000000735. [Context Link 1, 2] View abstract...
85. Steinhagen E. Anal fissure. Diseases of the Colon and Rectum 2018;61(3):293-297. DOI: 10.1097/DCR.0000000000001042. [Context Link 1, 2] View abstract...
86. Yiannakopoulou E. Botulinum toxin and anal fissure: efficacy and safety systematic review. International Journal of Colorectal Disease 2012;27(1):1-9. DOI: 10.1007/s00384-011-1286-5. [Context Link 1] View abstract...
87. Chen HL, et al. Botulinum toxin injection versus lateral internal sphincterotomy for chronic anal fissure: a meta-analysis of randomized control trials. Techniques in Coloproctology 2014;18(8):693-698. DOI: 10.1007/s10151-014-1121-4. [Context Link 1] View abstract...
88. Brady JT, et al. Treatment for anal fissure: Is there a safe option? American Journal of Surgery 2017;214(4):623-628. DOI: 10.1016/j.amjsurg.2017.06.004. [Context Link 1] View abstract...
89. Thenganatt MA, Jankovic J. Treatment of dystonia. Neurotherapeutics 2014;11(1):139-152. DOI: 10.1007/s13311-013-0231-4. [Context Link 1, 2] View abstract...
90. Hellman A, Torres-Russotto D. Botulinum toxin in the management of blepharospasm: current evidence and recent developments. Therapeutic Advances in Neurological Disorders 2015;8(2):82-91. DOI: 10.1177/1756285614557475. [Context Link 1, 2] View abstract...
91. Jabbari B. History of botulinum toxin treatment in movement disorders. Tremor and Other Hyperkinetic Movements 2016;6:394. DOI: 10.7916/D81836S1. [Context Link 1, 2, 3] View abstract...
92. Bilyk JR, Yen MT, Bradley EA, Wladis EJ, Mawn LA. Chemodenervation for the treatment of facial dystonia: a report by the American Academy of Ophthalmology. Ophthalmology 2018;125(9):1459-1467. DOI: 10.1016/j.ophtha.2018.03.013. [Context Link 1, 2, 3, 4] View abstract...
93. Duarte GS, et al. Botulinum toxin type A therapy for blepharospasm. Cochrane Database of Systematic Reviews 2020, Issue 11. Art. No.: CD004900. DOI: 10.1002/14651858.CD004900.pub3. [Context Link 1] View abstract...
94. Saad J, Gourdeau A. A direct comparison of onabotulinumtoxina (Botox) and IncobotulinumtoxinA (Xeomin) in the treatment of benign essential blepharospasm: a split-face technique. Journal of Neuro-Ophthalmology 2014;34(3):233-6. DOI: 10.1097/WNO.0000000000000110. [Context Link 1] View abstract...
95. Hallett M, et al. Evidence-based review and assessment of botulinum neurotoxin for the treatment of movement disorders. Toxicon 2013;67:94-114. DOI: 10.1016/j.toxicon.2012.12.004. [Context Link 1] View abstract...
96. Simpson DM, et al. Practice guideline update summary: Botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache: Report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology 2016;86(19):1818-1826. DOI: 10.1212/WNL.0000000000002560. [Context Link 1, 2, 3, 4, 5] View abstract...
97. Marsh WA, Monroe DM, Brin MF, Gallagher CJ. Systematic review and meta-analysis of the duration of clinical effect of onabotulinumtoxinA in cervical dystonia. BMC Neurology 2014;14:91. DOI: 10.1186/1471-2377-14-91. [Context Link 1] View abstract...
98. Dressler D, Tacik P, Adib Saberi F. Botulinum toxin therapy of cervical dystonia: duration of therapeutic effects. Journal of Neural Transmission 2015;122(2):297-300. DOI: 10.1007/s00702-014-1253-8. [Context Link 1] View abstract...
99. Skogseid IM. Dystonia--new advances in classification, genetics, pathophysiology and treatment. Acta Neurologica Scandinavica Supplementum 2014;(198):13-19. DOI: 10.1111/ane.12231. [Context Link 1] View abstract...

100. Fasano A, Bove F, Lang AE. The treatment of dystonic tremor: a systematic review. Journal of Neurology, Neurosurgery, and Psychiatry 2014;85(7):759-769. DOI: 10.1136/jnnp-2013-305532. [Context Link 1, 2, 3] View abstract...

101. Mills RR, Pagan FL. Patient considerations in the treatment of cervical dystonia: focus on botulinum toxin type A. Patient Preference and Adherence 2015;9:725-731. DOI: 10.2147/PPA.S75459. [Context Link 1] View abstract...

102. Bledsoe IO, Comella CL. Botulinum toxin treatment of cervical dystonia. Seminars in Neurology 2016;36(1):47-53. DOI: 10.1055/s-0035-1571210. [Context Link 1] View abstract...

103. Rodrigues FB, et al. Botulinum toxin type A therapy for cervical dystonia. Cochrane Database of Systematic Reviews 2020, Issue 11. Art. No.: CD003633. DOI: 10.1002/14651858.CD003633.pub4. [Context Link 1] View abstract...

104. Albanese A, et al. EFNS guidelines on diagnosis and treatment of primary dystonias. European Journal of Neurology 2011;18(1):5-18. DOI: 10.1111/j.1468-1331.2010.03042.x. (Reaffirmed 2022 May) [Context Link 1, 2, 3, 4, 5] View abstract...

105. Contarino MF, et al. Clinical practice: evidence-based recommendations for the treatment of cervical dystonia with botulinum toxin. Frontiers in Neurology 2017;8:35. DOI: 10.3389/fneur.2017.00035. [Context Link 1] View abstract...

106. Han Y, Stevens AL, Dashtipour K, Hauser RA, Mari Z. A mixed treatment comparison to compare the efficacy and safety of botulinum toxin treatments for cervical dystonia. Journal of Neurology 2016;263(4):772-780. DOI: 10.1007/s00415-016-8050-2. [Context Link 1] View abstract...

107. Albanese A, et al. Practical guidance for CD management involving treatment of botulinum toxin: a consensus statement. Journal of Neurology 2015;262(10):2201-13. DOI: 10.1007/s00415-015-7703-x. [Context Link 1] View abstract...

108. Jochim A, et al. Treatment of cervical dystonia with abo- and onabotulinumtoxinA: long-term safety and efficacy in daily clinical practice. Journal of Neurology 2019;266(8):1879-1886. DOI: 10.1007/s00415-019-09349-2. [Context Link 1] View abstract...

109. Patel S, Martino D. Cervical dystonia: from pathophysiology to pharmacotherapy. Behavioural Neurology 2013;26(4):275-282. DOI: 10.3233/BEN-2012-120270. [Context Link 1] View abstract...

110. Jankovic J, et al. Primary results from the Cervical Dystonia Patient Registry for Observation of OnabotulinumtoxinA Efficacy (CD PROBE). Journal of the Neurological Sciences 2015;349(1-2):84-93. DOI: 10.1016/j.jns.2014.12.030. [Context Link 1] View abstract...

111. Duarte GS, et al. Botulinum toxin type A versus botulinum toxin type B for cervical dystonia. Cochrane Database of Systematic Reviews 2016, Issue 10. Art. No.: CD004314. DOI: 10.1002/14651858.CD004314.pub3. [Context Link 1] View abstract...

112. Ababneh OH, Cetinkaya A, Kulwin DR. Long-term efficacy and safety of botulinum toxin a injections to treat blepharospasm and hemifacial spasm. Clinical and Experimental Ophthalmology 2014;42(3):254-261. DOI: 10.1111/ceo.12165. [Context Link 1, 2] View abstract...

113. Batisti JP, Kleinfelder AD, Galli NB, Moro A, Munhoz RP, Teive HA. Treatment of hemifacial spasm with botulinum toxin type a: effective, long lasting and well tolerated. Arquivos de Neuro-psiquiatria 2017;75(2):87-91. DOI: 10.1590/0004-282X20160191. [Context Link 1, 2] View abstract...

114. Sorgun MH, Yilmaz R, Akin YA, Mercan FN, Akbostanci MC. Botulinum toxin injections for the treatment of hemifacial spasm over 16 years. Journal of Clinical Neuroscience 2015;22(8):1319-25. DOI: 10.1016/j.jocn.2015.02.032. [Context Link 1, 2] View abstract...

115. Duarte GS, et al. Botulinum toxin type A therapy for hemifacial spasm. Cochrane Database of Systematic Reviews 2020, Issue 11. Art. No.: CD004899. DOI: 10.1002/14651858.CD004899.pub3. [Context Link 1] View abstract...

116. Karp BI, Alter K. Botulinum toxin treatment of blepharospasm, orofacial/oromandibular dystonia, and hemifacial spasm. Seminars in Neurology 2016;36(1):84-91. DOI: 10.1055/s-0036-1571952. [Context Link 1] View abstract...

117. Gutierrez SAS, Yu JRT, Yalung PM, Jamora RDG. Real-world experience with botulinum toxin A for the treatment of hemifacial spasm: A study of 1138 injections. Clinical Neurology and Neurosurgery 2021;205:106632. DOI: 10.1016/j.clineuro.2021.106632. [Context Link 1] View abstract...

118. de Almeida AR, Montagner S. Botulinum toxin for axillary hyperhidrosis. Dermatologic Clinics 2014;32(4):495-504. DOI: 10.1016/j.det.2014.06.013. [Context Link 1, 2, 3] View abstract...

119. McConaghy JR, Fosselman D. Hyperhidrosis: management options. American Family Physician 2018;97(11):729-734. [Context Link 1, 2, 3, 4] View abstract...

120. Hosp C, Naumann MK, Hamm H. Botulinum toxin treatment of autonomic disorders: Focal hyperhidrosis and sialorrhea. Seminars in Neurology 2016;36(1):20-28. DOI: 10.1055/s-0035-1571214. [Context Link 1, 2, 3, 4] View abstract...

121. Glaser DA, et al. A prospective, nonrandomized, open-label study of the efficacy and safety of onabotulinumtoxinA in adolescents with primary axillary hyperhidrosis. Pediatric Dermatology 2015;32(5):609-17. DOI: 10.1111/pde.12620. [Context Link 1, 2, 3] View abstract...

122. Hosp C, Hamm H. Safety of available and emerging drug therapies for hyperhidrosis. Expert Opinion on Drug Safety 2017;16(9):1039-1049. DOI: 10.1080/14740338.2017.1354983. [Context Link 1, 2, 3] View abstract...

123. Wade R, et al. Interventional management of hyperhidrosis in secondary care: a systematic review. British Journal of Dermatology 2018;179(3):599-608. DOI: 10.1111/bjd.16558. [Context Link 1, 2] View abstract...

124. Sammons JE, Khachemoune A. Axillary hyperhidrosis: a focused review. Journal of Dermatological Treatment 2017;28(7):582-590. DOI: 10.1080/09546634.2017.1309347. [Context Link 1, 2] View abstract...

125. Singh S, Davis H, Wilson P. Axillary hyperhidrosis: A review of the extent of the problem and treatment modalities. Surgeon 2015;13(5):279-85. DOI: 10.1016/j.surge.2015.03.003. [Context Link 1] View abstract...

126. Kurta AO, Glaser DA. Emerging Nonsurgical Treatments for Hyperhidrosis. Thoracic Surgery Clinics 2016;26(4):395-402. DOI: 10.1016/j.thorsurg.2016.06.003. [Context Link 1] View abstract...

127. Fujimoto T. Pathophysiology and treatment of hyperhidrosis. Current Problems in Dermatology 2016;51:86-93. DOI: 10.1159/000446786. [Context Link 1, 2] View abstract...

128. Mirkovic SE, Rystedt A, Balling M, Swartling C. Hyperhidrosis substantially reduces quality of life in children: a retrospective study describing symptoms, Consequences and Treatment with Botulinum Toxin. Acta Dermato-Venereologica 2018;98(1):103-107. DOI: 10.2340/00015555-2755.

[Context Link 1] View abstract...

129. Rosen R, Stewart T. Results of a 10-year follow-up study of botulinum toxin A therapy for primary axillary hyperhidrosis in Australia. Internal Medicine Journal 2018;48(3):343-347. DOI: 10.1111/imj.13727. [Context Link 1] View abstract...
130. Grabell DA, Hebert AA. Current and emerging medical therapies for primary hyperhidrosis. Dermatology and Therapy 2017;7(1):25-36. DOI: 10.1007/s13555-016-0148-z. [Context Link 1, 2] View abstract...
131. Nawrocki S, Cha J. The etiology, diagnosis and management of hyperhidrosis: a comprehensive review. part II. therapeutic options. Journal of the American Academy of Dermatology 2019;81(3):669-680. DOI: 10.1016/j.jaad.2018.11.066. [Context Link 1, 2] View abstract...
132. Pariser DM, Ballard A. Topical therapies in hyperhidrosis care. Dermatologic Clinics 2014;32(4):485-90. DOI: 10.1016/j.det.2014.06.008. [Context Link 1, 2] View abstract...
133. Wechter T, Feldman SR, Taylor SL. The treatment of primary focal hyperhidrosis. Skin Therapy Letter 2019;24(1):1-7. [Context Link 1] View abstract...
134. Nawrocki S, Cha J. The etiology, diagnosis, and management of hyperhidrosis: A comprehensive review: Etiology and clinical work-up. Journal of the American Academy of Dermatology 2019;81(3):657-666. DOI: 10.1016/j.jaad.2018.12.071. [Context Link 1] View abstract...
135. Marchese MR, D'Alatri L, Bentivoglio AR, Paludetti G. OnabotulinumtoxinA for adductor spasmodic dysphonia (ADSD): Functional results and the role of dosage. Toxicon 2018;155:38-42. DOI: 10.1016/j.toxicon.2018.10.006. [Context Link 1] View abstract...
136. Hyodo M, et al. Botulinum toxin injection into the intrinsic laryngeal muscles to treat spasmodic dysphonia: A multicenter, placebo-controlled, randomized, double-blinded, parallel-group comparison/open-label clinical trial. European Journal of Neurology 2021;28(5):1548-1556. DOI: 10.1111/ene.14714. [Context Link 1] View abstract...
137. Faham M, Ahmadi A, Silverman E, Harouni GG, Dabirmoghaddam P. Quality of life after botulinum toxin injection in patients with adductor spasmodic dysphonia; a systematic review and meta-analysis. Journal of Voice 2019;Online. DOI: 10.1016/j.jvoice.2019.07.025. [Context Link 1] View abstract...
138. van Esch BF, Wegner I, Stegeman I, Grolman W. Effect of botulinum toxin and surgery among spasmodic dysphonia patients. Otolaryngology Head and Neck Surgery 2017;156(2):238-254. DOI: 10.1177/0194599816675320. [Context Link 1] View abstract...
139. Simonyan K, et al. Laryngeal dystonia: multidisciplinary update on terminology, pathophysiology, and research priorities. Neurology 2021;96(21):989-1001. DOI: 10.1212/WNL.0000000000011922. [Context Link 1] View abstract...
140. Lin J, Sadoughi B. Spasmodic dysphonia. Advances in Oto-Rhino-Laryngology 2020;85:133-143. DOI: 10.1159/000456693. [Context Link 1] View abstract...
141. Patel PN, et al. Outcomes of onabotulinum toxin A treatment for adductor spasmodic dysphonia and laryngeal tremor. JAMA Otolaryngology--Head & Neck Surgery 2018;144(4):293-299. DOI: 10.1001/jamaoto.2017.3088. [Context Link 1] View abstract...
142. Frampton JE, Silberstein S. OnabotulinumtoxinA: a review in the prevention of chronic migraine. Drugs 2018;78(5):589-600. DOI: 10.1007/s40265-018-0894-6. [Context Link 1] View abstract...
143. Chiang CC, Starling AJ. OnabotulinumtoxinA in the treatment of patients with chronic migraine: clinical evidence and experience. Therapeutic Advances in Neurological Disorders 2017;10(12):397-406. DOI: 10.1177/1756285617731521. [Context Link 1] View abstract...
144. Grazzi L, Usai S. Botulinum toxin A: a new option for treatment of chronic migraine with medication overuse. Neurological Sciences 2014;35 Suppl 1:37-39. DOI: 10.1007/s10072-014-1739-z. [Context Link 1] View abstract...
145. Silberstein SD. The use of botulinum toxin in the management of headache disorders. Seminars in Neurology 2016;36(1):92-98. DOI: 10.1055/s-0036-1571443. [Context Link 1] View abstract...
146. Gooriah R, Ahmed F. OnabotulinumtoxinA for chronic migraine: a critical appraisal. Therapeutics and Clinical Risk Management 2015;11:1003-1013. DOI: 10.2147/TCRM.S76964. [Context Link 1] View abstract...
147. Ailani J, Burch RC, Robbins MS, Board of Directors of the American Headache Society. The American Headache Society Consensus Statement: Update on integrating new migraine treatments into clinical practice. Headache 2021;61(7):1021-1039. DOI: 10.1111/head.14153. [Context Link 1] View abstract...
148. Herd CP, et al. Botulinum toxins for the prevention of migraine in adults. Cochrane Database of Systematic Reviews 2018, Issue 6. Art. No.: CD011616. DOI: 10.1002/14651858.CD011616.pub2. [Context Link 1] View abstract...
149. Silberstein SD, et al. OnabotulinumtoxinA for treatment of chronic migraine: PREEMPT 24-week pooled subgroup analysis of patients who had acute headache medication overuse at baseline. Journal of the Neurological Sciences 2013;331(1-2):48-56. DOI: 10.1016/j.jns.2013.05.003. [Context Link 1] View abstract...
150. Lenaerts ME, Green TH. OnabotulinumtoxinA in migraine and other headaches: review and update. Current Treatment Options in Neurology 2019;21(4):21. DOI: 10.1007/s11940-019-0561-6. [Context Link 1] View abstract...
151. Ahmed F, Gaul C, Garcia-Monco JC, Sommer K, Martelletti P, REPOSE Principal Investigators. An open-label prospective study of the real-life use of onabotulinumtoxinA for the treatment of chronic migraine: the REPOSE study. Journal of Headache and Pain 2019;20(1):26. DOI: 10.1186/s10194-019-0976-1. [Context Link 1] View abstract...
152. Alpuente A, Gallardo VJ, Torres-Ferrus M, Alvarez-Sabin J, Pozo-Rosich P. Early efficacy and late gain in chronic and high-frequency episodic migraine with OnabotulinumtoxinA. European Journal of Neurology 2019;26(12):1464-1470. DOI: 10.1111/ene.14028. [Context Link 1] View abstract...
153. Castrillo Sanz A, et al. Experience with botulinum toxin in chronic migraine. Neurologia 2018;33(8):499-504. DOI: 10.1016/j.nrl.2016.09.004. [Context Link 1] View abstract...
154. Vikelis M, Argyriou AA, Dermitzakis EV, Spingos KC, Makris N, Kararizou E. Sustained onabotulinumtoxinA therapeutic benefits in patients with chronic migraine over 3 years of treatment. Journal of Headache and Pain 2018;19(1):87. DOI: 10.1186/s10194-018-0918-3. [Context Link 1]

View abstract...

155. Mimeh H, Fenech Magrin AM, Myers S, Ghanem AM. A critical review of botulinum toxin type A in the prophylactic treatment of chronic migraine in adults. Aesthetic Surgery Journal 2019;39(8):898-907. DOI: 10.1093/asj/sjy224. [Context Link 1] View abstract...

156. Tassorelli C, et al. Botulinum toxin for chronic migraine: Clinical trials and technical aspects. Toxicon 2018;147:111-115. DOI: 10.1016/j.toxicon.2017.08.026. [Context Link 1] View abstract...

157. Winner PK, Kabbouche M, Yonker M, Wangsadipura V, Lum A, Brin MF. A randomized trial to evaluate onabotulinumtoxinA for prevention of headaches in adolescents with chronic migraine. Headache 2020;60(3):564-575. DOI: 10.1111/head.13754. [Context Link 1] View abstract...

158. Botulinum Toxin Type A for the Prevention of Headaches in Adults With Chronic Migraine. NICE Technology Appraisal Guidance TA260 [Internet] National Institute for Health and Care Excellence. 2012 Jun (NICE reviewed 2016) Accessed at: https://www.nice.org.uk/guidance/. [accessed 2022 Oct 22] [Context Link 1]

159. Bendtsen L, et al. Guideline on the use of onabotulinumtoxinA in chronic migraine: a consensus statement from the European Headache Federation. Journal of Headache and Pain 2018;19(1):91. DOI: 10.1186/s10194-018-0921-8. [Context Link 1] View abstract...

160. Headache Classification Committee of the International Headache Society (IHS) the international classification of headache disorders, 3rd edition. Cephalalgia 2018;38(1):1-211. DOI: 10.1177/0333102417738202. (Reaffirmed 2022 Jul) [Context Link 1, 2] View abstract...

161. Luvisetto S, Gazerani P, Cianchetti C, Pavone F. Botulinum toxin type A as a therapeutic agent against headache and related disorders. Toxins (Basel) 2015;7(9):3818-3844. DOI: 10.3390/toxins7093818. [Context Link 1] View abstract...

162. Pharmacological Management of Migraine. National Clinical Guideline #155 [Internet] Scottish Intercollegiate Guidelines Network. 2022 Sep Accessed at: https://www.sign.ac.uk/. [created 2018; accessed 2022 Oct 20] [Context Link 1]

163. Silberstein SD, et al. Evidence-based guideline update: pharmacologic treatment for episodic migraine prevention in adults: report of the Quality Standards Subcommittee of the American Academy of Neurology and the American Headache Society. Neurology 2012 (AAN reviewed 2015);78(17):1337-45. DOI: 10.1212/WNL.0b013e3182535d20. (Reaffirmed 2022 Jun) [Context Link 1] View abstract...

164. Pringsheim T, et al. Canadian Headache Society guideline for migraine prophylaxis. Canadian Journal of Neurological Sciences 2012;39(2 Suppl 2):S1-59. (Reaffirmed 2022 Jun) [Context Link 1] View abstract...

165. Headaches in Over 12s: Diagnosis and Management. NICE Clinical Guideline CG150 [Internet] National Institute for Health and Care Excellence. 2021 Dec Accessed at: https://www.nice.org.uk/guidance/. [created 2012; accessed 2022 Oct 22] [Context Link 1]

166. Mulleners WM, McCrory DC, Linde M. Antiepileptics in migraine prophylaxis: An updated Cochrane review. Cephalalgia 2015;35(1):51-62. DOI: 10.1177/0333102414534325. [Context Link 1] View abstract...

167. Pringsheim T, et al. Practice guideline recommendations summary: Treatment of tics in people with Tourette syndrome and chronic tic disorders. Neurology 2019;92(19):896-906. DOI: 10.1212/WNL.0000000000007466. [Context Link 1, 2] View abstract...

168. Pringsheim T, et al. Comprehensive systematic review summary: Treatment of tics in people with Tourette syndrome and chronic tic disorders. Neurology 2019;92(19):907-915. DOI: 10.1212/WNL.0000000000007467. [Context Link 1, 2] View abstract...

169. Pandey S, Srivanitchapoom P, Kirubakaran R, Berman BD. Botulinum toxin for motor and phonic tics in Tourette's syndrome. Cochrane Database of Systematic Reviews 2018, Issue 1. Art. No.: CD012285. DOI: 10.1002/14651858.CD012285.pub2. [Context Link 1] View abstract...

170. Gormley EA, et al. Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) in Adults. AUA/SUFU Guideline [Internet] American Urological Association. 2019 Apr Accessed at: https://www.auanet.org/guidelines/. [accessed 2022 Oct 13] [Context Link 1]

171. Harding CK, et al. EAU Guidelines on Non-neurogenic Female LUTS. [Internet] European Association of Urology. 2022 Mar Accessed at: https://uroweb.org. [accessed 2022 Sep 27] [Context Link 1]

172. Chermansky CJ, Chancellor MB. Use of botulinum toxin in urologic diseases. Urology 2016;91:21-32. DOI: 10.1016/j.urology.2015.12.049. [Context Link 1, 2] View abstract...

173. Moore DC, Cohn JA, Dmochowski RR. Use of botulinum toxin A in the treatment of lower urinary tract disorders: a review of the literature. Toxins (Basel) 2016;8(4):88. DOI: 10.3390/toxins8040088. [Context Link 1, 2] View abstract...

174. White N, Iglesia CB. Overactive bladder. Obstetrics and Gynecology Clinics of North America 2016;43(1):59-68. DOI: 10.1016/j.ogc.2015.10.002. [Context Link 1, 2] View abstract...

175. Duthie JB, Vincent M, Herbison GP, Wilson DI, Wilson D. Botulinum toxin injections for adults with overactive bladder syndrome. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD005493. DOI: 10.1002/14651858.CD005493.pub3. [Context Link 1] View abstract...

176. Fowler CJ, et al. OnabotulinumtoxinA improves health-related quality of life in patients with urinary incontinence due to idiopathic overactive bladder: a 36-week, double-blind, placebo-controlled, randomized, dose-ranging trial. European Urology 2012;62(1):148-157. DOI: 10.1016/j.eururo.2012.03.005. [Context Link 1] View abstract...

177. Tincello DG, et al. Botulinum toxin a versus placebo for refractory detrusor overactivity in women: a randomised blinded placebo-controlled trial of 240 women (the RELAX study). European Urology 2012;62(3):507-514. DOI: 10.1016/j.eururo.2011.12.056. [Context Link 1] View abstract...

178. Visco AG, et al. Anticholinergic therapy vs. onabotulinumtoxina for urgency urinary incontinence. New England Journal of Medicine 2012;367(19):1803-1813. DOI: 10.1056/NEJMoa1208872. [Context Link 1] View abstract...

179. Yokoyama O, et al. OnabotulinumtoxinA (botulinum toxin type A) for the treatment of Japanese patients with overactive bladder and urinary incontinence: Results of single-dose treatment from a phase III, randomized, double-blind, placebo-controlled trial (interim analysis). International Journal of Urology 2020;27(3):227-234. DOI: 10.1111/iju.14176. [Context Link 1] View abstract...

180. Niu HL, Ma YH, Zhang CJ. Comparison of OnabotulinumtoxinA versus sacral neuromodulation for refractory urinary urge incontinence: A systematic review and meta-analysis of randomized controlled trials. International Journal of Surgery 2018;60:141-148. DOI: 10.1016/j.ijsu.2018.10.041. [Context Link 1] View abstract...

181. Nitti VW, et al. OnabotulinumtoxinA for the treatment of patients with overactive bladder and urinary incontinence: results of a phase 3, randomized, placebo controlled trial. Journal of Urology 2013;189(6):2186-2193. DOI: 10.1016/j.juro.2012.12.022. [Context Link 1] View abstract...

182. Chughtai B, et al. Randomized, double-blind, placebo controlled pilot study of intradetrusor injections of onabotulinumtoxinA for the treatment of refractory overactive bladder persisting following surgical management of benign prostatic hyperplasia. Canadian Journal of Urology 2014;21(2):7217-7221. [Context Link 1] View abstract...

183. Drake MJ, et al. Comparative assessment of the efficacy of onabotulinumtoxinA and oral therapies (anticholinergics and mirabegron) for overactive bladder: a systematic review and network meta-analysis. BJU International 2017;120(5):611-622. DOI: 10.1111/bju.13945. [Context Link 1] View abstract...

184. Lozano-Ortega G, et al. The relative efficacy and safety of mirabegron and onabotulinumtoxinA in patients with overactive bladder who have previously been managed with an antimuscarinic: a network meta-analysis. Urology 2019;127:1-8. DOI: 10.1016/j.urology.2019.02.005. [Context Link 1] View abstract...

185. Mangera A, et al. An updated systematic review and statistical comparison of standardised mean outcomes for the use of botulinum toxin in the management of lower urinary tract disorders. European Urology 2014;65(5):981-990. DOI: 10.1016/j.eururo.2013.10.033. [Context Link 1] View abstract...

186. Raju R, Linder BJ. Evaluation and treatment of overactive bladder in women. Mayo Clinic Proceedings 2020;95(2):370-377. DOI: 10.1016/j.mayocp.2019.11.024. [Context Link 1] View abstract...

187. Cox L, Cameron AP. OnabotulinumtoxinA for the treatment of overactive bladder. Research and Reports in Urology 2014;6:79-89. DOI: 10.2147/RRU.S43125. [Context Link 1] View abstract...

188. Lopez Ramos H, Torres Castellanos L, Ponce Esparza I, Jaramillo A, Rodriguez A, Moreno Bencardino C. Management of overactive bladder with OnabotulinumtoxinA: systematic review and meta-analysis. Urology 2017;100:53-58. DOI: 10.1016/j.urology.2016.10.026. [Context Link 1] View abstract...

189. Calim OF, Hassouna HNH, Yildirim YS, Dogan R, Ozturan O. Pediatric sialorrhea: submandibular duct rerouting and intraparotid botulinum toxin A injection with literature review. Annals of Otology, Rhinology and Laryngology 2019;128(2):104-112. DOI: 10.1177/0003489418808305. [Context Link 1] View abstract...

190. Lungren MP, Halula S, Coyne S, Sidell D, Racadio JM, Patel MN. Ultrasound-guided botulinum toxin type A salivary gland injection in children for refractory sialorrhea: 10-year experience at a large tertiary children's hospital. Pediatric Neurology 2016;54:70-5. DOI: 10.1016/j.pediatrneurol.2015.09.014. [Context Link 1] View abstract...

191. Seppi K, et al. Update on treatments for nonmotor symptoms of Parkinson's disease-an evidence-based medicine review. Movement Disorders 2019;34(2):180-198. DOI: 10.1002/mds.27602. (Reaffirmed 2022 Jul) [Context Link 1, 2] View abstract...

192. Sridharan K, Sivaramakrishnan G. Pharmacological interventions for treating sialorrhea associated with neurological disorders: A mixed treatment network meta-analysis of randomized controlled trials. Journal of Clinical Neuroscience 2018;51:12-17. DOI: 10.1016/j.jocn.2018.02.011. [Context Link 1] View abstract...

193. Banfi P, Ticozzi N, Lax A, Guidugli GA, Nicolini A, Silani V. A review of options for treating sialorrhea in amyotrophic lateral sclerosis. Respiratory Care 2015;60(3):446-54. DOI: 10.4187/respcare.02856. [Context Link 1, 2] View abstract...

194. Heikel T, Patel S, Ziai K, Shah SJ, Lighthall JG. Botulinum toxin A in the management of pediatric sialorrhea: a systematic review. Annals of Otology, Rhinology and Laryngology 2022;Online. DOI: 10.1177/00034894221078365. [Context Link 1] View abstract...

195. Porte M, Chaleat-Valayer E, Patte K, D'Anjou MC, Boulay C, Laffont I. Relevance of intraglandular injections of Botulinum toxin for the treatment of sialorrhea in children with cerebral palsy: a review. European Journal of Paediatric Neurology 2014;18(6):649-57. DOI: 10.1016/j.ejpn.2014.05.007. [Context Link 1] View abstract...

196. Walshe M, Smith M, Pennington L. Interventions for drooling in children with cerebral palsy. Cochrane Database of Systematic Reviews 2012, Issue 11. Art. No.: CD008624. DOI: 10.1002/14651858.CD008624.pub3. [Context Link 1] View abstract...

197. Rodwell K, Edwards P, Ware RS, Boyd R. Salivary gland botulinum toxin injections for drooling in children with cerebral palsy and neurodevelopmental disability: a systematic review. Developmental Medicine and Child Neurology 2012;54(11):977-987. DOI: 10.1111/j.1469-8749.2012.04370.x. [Context Link 1] View abstract...

198. Gomez-Caravaca MT, et al. The use of botulinum toxin in the treatment of sialorrhea in parkinsonian disorders. Neurological Sciences 2015;36(2):275-279. DOI: 10.1007/s10072-014-1950-y. [Context Link 1] View abstract...

199. Ruiz-Roca JA, Pons-Fuster E, Lopez-Jornet P. Effectiveness of the botulinum toxin for treating sialorrhea in patients with Parkinson's disease: a systematic review. Journal of Clinical Medicine 2019;8(3):317. DOI: 10.3390/jcm8030317. [Context Link 1] View abstract...

200. Squires N, Humberstone M, Wills A, Arthur A. The use of botulinum toxin injections to manage drooling in amyotrophic lateral sclerosis/motor neurone disease: a systematic review. Dysphagia 2014;29(4):500-8. DOI: 10.1007/s00455-014-9535-8. [Context Link 1] View abstract...

201. Petracca M, et al. Botulinum Toxin A and B in sialorrhea: Long-term data and literature overview. Toxicon 2015;107(Pt A):129-140. DOI: 10.1016/j.toxicon.2015.08.014. [Context Link 1] View abstract...

202. Andringa A, van de Port I, van Wegen E, Ket J, Meskers C, Kwakkel G. Effectiveness of botulinum toxin treatment for upper limb spasticity after stroke over different ICF domains: a systematic review and meta-analysis. Archives of Physical Medicine and Rehabilitation 2019;100(9):1703-1725. DOI: 10.1016/j.apmr.2019.01.016. [Context Link 1, 2] View abstract...

203. Kinnear BZ, Lannin NA, Cusick A, Harvey LA, Rawicki B. Rehabilitation therapies after botulinum toxin-a injection to manage limb spasticity: a systematic review. Physical Therapy 2014;94(11):1569-1581. DOI: 10.2522/ptj.20130408. [Context Link 1, 2] View abstract...

204. Schramm A, et al. Spasticity treatment with onabotulinumtoxin A: data from a prospective German real-life patient registry. Journal of Neural Transmission 2014;121(5):521-530. DOI: 10.1007/s00702-013-1145-3. [Context Link 1] View abstract...

205. Strobl W, et al. Best clinical practice in botulinum toxin treatment for children with cerebral palsy. Toxins (Basel) 2015;7(5):1629-1648. DOI: 10.3390/toxins7051629. [Context Link 1, 2] View abstract...

206. Sakzewski L, Ziviani J, Boyd RN. Efficacy of upper limb therapies for unilateral cerebral palsy: a meta-analysis. Pediatrics 2014;133(1):e175-e204. DOI: 10.1542/peds.2013-0675. [Context Link 1] View abstract...

207. Hoare BJ, Wallen MA, Imms C, Villanueva E, Rawicki HB, Carey L. Botulinum toxin A as an adjunct to treatment in the management of the upper limb in children with spastic cerebral palsy (UPDATE). Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD003469. DOI: 10.1002/14651858.CD003469.pub4. [Context Link 1, 2] View abstract...

208. Yana M, Tutuola F, Westwater-Wood S, Kavlak E. The efficacy of botulinum toxin A lower limb injections in addition to physiotherapy approaches in children with cerebral palsy: A systematic review. NeuroRehabilitation 2019;44(2):175-189. DOI: 10.3233/NRE-182581. [Context Link 1] View abstract...

209. Blumetti FC, Belloti JC, Tamaoki MJ, Pinto JA. Botulinum toxin type A in the treatment of lower limb spasticity in children with cerebral palsy. Cochrane Database of Systematic Reviews 2019, Issue 10. Art. No.: CD001408. DOI: 10.1002/14651858.CD001408.pub2. [Context Link 1] View abstract...

210. Dimitrova R, et al. Efficacy and safety of onabotulinumtoxinA with standardized occupational therapy for treatment of pediatric upper limb spasticity: Phase III placebo-controlled randomized trial. NeuroRehabilitation 2021;49(3):469-479. DOI: 10.3233/NRE-210071. [Context Link 1] View abstract...

211. Dimitrova R, et al. Efficacy and safety of onabotulinumtoxinA with standardized physiotherapy for the treatment of pediatric lower limb spasticity: A randomized, placebo-controlled, phase III clinical trial. NeuroRehabilitation 2022;50(1):33-46. DOI: 10.3233/NRE-210070. [Context Link 1] View abstract...

212. Practice parameter: pharmacologic treatment of spasticity in children and adolescents with cerebral palsy (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology and the Practice Committee of the Child Neurology Society. Neurology 2010 (AAN reaffirmed 2019);74(4):336-343. DOI: 10.1212/WNL.0b013e3181cbcd2f. (Reaffirmed 2022 May) [Context Link 1] View abstract...

213. Love SC, et al. Botulinum toxin assessment, intervention and after-care for lower limb spasticity in children with cerebral palsy: international consensus statement. European Journal of Neurology 2010;17 Suppl 2:9-37. DOI: 10.1111/j.1468-1331.2010.03126.x. [Context Link 1] View abstract...

214. Fehlings D, et al. Botulinum toxin assessment, intervention and follow-up for paediatric upper limb hypertonicity: international consensus statement. European Journal of Neurology 2010;17 Suppl 2:38-56. DOI: 10.1111/j.1468-1331.2010.03127.x. [Context Link 1] View abstract...

215. Spasticity in Under 19s: Management. NICE Clinical Guideline CG145 [Internet] National Institute for Health and Care Excellence. 2016 Nov Accessed at: https://www.nice.org.uk/guidance. [created 2012; accessed 2022 Oct 22] [Context Link 1]

216. Sung KH, et al. Conflict of interest in the assessment of botulinum toxin A injections in patients with cerebral palsy: a systematic review. Journal of Pediatric Orthopedics 2013;33(5):494-500. DOI: 10.1097/BPO.0b013e318288b42a. [Context Link 1] View abstract...

217. Druschel C, Althuizes HC, Funk JF, Placzek R. Off label use of botulinum toxin in children under two years of age: a systematic review. Toxins (Basel) 2013;5(1):60-72. DOI: 10.3390/toxins5010060. [Context Link 1] View abstract...

218. Guyot P, Kalyvas C, Mamane C, Danchenko N. Botulinum toxins type A (Bont-A) in the management of lower limb spasticity in children: a systematic literature review and Bayesian network meta-analysis. Journal of Child Neurology 2019;34(7):371-381. DOI: 10.1177/0883073819830579. [Context Link 1] View abstract...

219. Dong Y, Wu T, Hu X, Wang T. Efficacy and safety of Botulinum Toxin type A for upper limb spasticity after stroke or traumatic brain injury: a systematic review with meta-analysis and trial sequential analysis. European Journal of Physical and Rehabilitation Medicine 2017;53(2):256-267. DOI: 10.23736/S1973-9087.16.04329-X. [Context Link 1] View abstract...

220. Shaw LC, et al. Botulinum Toxin for the Upper Limb after Stroke (BoTULS) Trial: effect on impairment, activity limitation, and pain. Stroke 2011;42(5):1371-1379. DOI: 10.1161/STROKEAHA.110.582197. [Context Link 1] View abstract...

221. Tenniglo MJ, Nederhand MJ, Prinsen EC, Nene AV, Rietman JS, Buurke JH. Effect of chemodenervation of the rectus femoris muscle in adults with a stiff knee gait due to spastic paresis: a systematic review with a meta-analysis in patients with stroke. Archives of Physical Medicine and Rehabilitation 2014;95(3):576-587. DOI: 10.1016/j.apmr.2013.11.008. [Context Link 1] View abstract...

222. Ward AB, et al. Functional goal achievement in post-stroke spasticity patients: the BOTOX Economic Spasticity Trial (BEST). Journal of Rehabilitation Medicine 2014;46(6):504-513. DOI: 10.2340/16501977-1817. [Context Link 1] View abstract...

223. Fietzek UM, Kossmehl P, Schelosky L, Ebersbach G, Wissel J. Early botulinum toxin treatment for spastic pes equinovarus--a randomized double-blind placebo-controlled study. European Journal of Neurology 2014;21(8):1089-1095. DOI: 10.1111/ene.12381. [Context Link 1, 2] View abstract...

224. Wein T, Esquenazi A, Jost WH, Ward AB, Pan G, Dimitrova R. OnabotulinumtoxinA for the treatment of poststroke distal lower limb spasticity: a randomized trial. PM & R : the Journal of Injury, Function, and Rehabilitation 2018;10(7):693-703. DOI: 10.1016/j.pmrj.2017.12.006. [Context Link 1] View abstract...

225. Cameron MH, Bethoux F, Davis N, Frederick M. Botulinum toxin for symptomatic therapy in multiple sclerosis. Current Neurology and Neuroscience Reports 2014;14(8):463. DOI: 10.1007/s11910-014-0463-7. [Context Link 1, 2] View abstract...

226. Santamato A, et al. Botulinum toxin type A for the treatment of lower limb spasticity after stroke. Drugs 2019;79(2):143-160. DOI: 10.1007/s40265-018-1042-z. [Context Link 1] View abstract...

227. Campbell E, Coulter EH, Mattison PG, Miller L, McFadyen A, Paul L. Physiotherapy rehabilitation for people with progressive multiple sclerosis: A systematic review. Archives of Physical Medicine and Rehabilitation 2016;97(1):141-151.e3. DOI: 10.1016/j.apmr.2015.07.022. [Context Link 1] View abstract...

228. Baker JA, Pereira G. The efficacy of Botulinum Toxin A for limb spasticity on improving activity restriction and quality of life: A systematic review and meta-analysis using the GRADE approach. Clinical Rehabilitation 2016;30(6):549-558. DOI: 10.1177/0269215515593609. [Context Link 1] View abstract...

229. Sewell MD, Eastwood DM, Wimalasundera N. Managing common symptoms of cerebral palsy in children. British Medical Journal 2014;349:g5474. [Context Link 1] View abstract...

230. Copeland L, et al. Botulinum toxin A for nonambulatory children with cerebral palsy: a double blind randomized controlled trial. Journal of Pediatrics 2014;165(1):140-146.e4. DOI: 10.1016/j.jpeds.2014.01.050. [Context Link 1] View abstract...

231. Moeini-Naghani I, Hashemi-Zonouz T, Jabbari B. Botulinum toxin treatment of spasticity in adults and children. Seminars in Neurology 2016;36(1):64-72. DOI: 10.1055/s-0036-1571847. [Context Link 1] View abstract...

232. Kaku M, Simpson DM. Spotlight on botulinum toxin and its potential in the treatment of stroke-related spasticity. Drug Design, Development and Therapy 2016;10:1085-99. DOI: 10.2147/DDDT.S80804. [Context Link 1] View abstract...

233. Wissel J, et al. OnabotulinumtoxinA improves pain in patients with post-stroke spasticity: findings from a randomized, double-blind, placebo-controlled trial. Journal of Pain and Symptom Management 2016;52(1):17-26. DOI: 10.1016/j.jpainsymman.2016.01.007. [Context Link 1] View abstract...

234. Joyce KE, Beyer F, Thomson RG, Clarke MP. A systematic review of the effectiveness of treatments in altering the natural history of intermittent exotropia. British Journal of Ophthalmology 2015;99(4):440-450. DOI: 10.1136/bjophthalmol-2013-304627. [Context Link 1, 2] View abstract...

235. Mahan M, Engel JM. The resurgence of botulinum toxin injection for strabismus in children. Current Opinion in Ophthalmology 2017;28(5):460-464. DOI: 10.1097/ICU.0000000000000408. [Context Link 1] View abstract...

236. Binenbaum G, et al. Botulinum toxin injection for the treatment of strabismus: a report by the American Academy of Ophthalmology. Ophthalmology 2021;128(12):1766-1776. DOI: 10.1016/j.ophtha.2021.05.009. [Context Link 1] View abstract...

237. Rowe FJ, Noonan CP. Botulinum toxin for the treatment of strabismus. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD006499. DOI: 10.1002/14651858.CD006499.pub4. [Context Link 1] View abstract...

238. Escuder AG, Hunter DG. The role of botulinum toxin in the treatment of strabismus. Seminars in Ophthalmology 2019;34(4):198-204. DOI: 10.1080/08820538.2019.1620795. [Context Link 1] View abstract...

239. Gomez de Liano R. The use of botulinum toxin in strabismus treatment. Journal of Binocular Vision and Ocular Motility 2019;69(2):51-60. DOI: 10.1080/2576117X.2019.1601973. [Context Link 1] View abstract...

240. Karp BI, Alter K. Muscle selection for focal limb dystonia. Toxins (Basel) 2017;10(1):20. DOI: 10.3390/toxins10010020. [Context Link 1] View abstract...

241. Lungu C, Ahmad OF. Update on the use of botulinum toxin therapy for focal and task-specific dystonias. Seminars in Neurology 2016;36(1):41-6. DOI: 10.1055/s-0035-1571211. [Context Link 1] View abstract...

242. Rajan R, et al. Assessment of botulinum neurotoxin injection for dystonic hand tremor: a randomized clinical trial. JAMA Neurology 2021;78(3):302-311. DOI: 10.1001/jamaneurol.2020.4766. [Context Link 1] View abstract...

243. Drake MJ, et al. Neurogenic lower urinary tract dysfunction: Clinical management recommendations of the Neurologic Incontinence committee of the fifth International Consultation on Incontinence 2013. Neurourology and Urodynamics 2016;35(6):657-665. DOI: 10.1002/nau.23027. [Context Link 1, 2] View abstract...

244. Ginsberg DA, et al. AUA/SUFU Guideline on Adult Neurogenic Lower Urinary Tract Dysfunction. [Internet] American Urogynecologic Society and the Society for Urodynamics, Female Pelvic Medicine and Urogenital Reconstruction. 2021 Sep Accessed at: https://www.auanet.org/. [accessed 2022 Oct 28] [Context Link 1, 2] View abstract...

245. Sussman D, Patel V, Del Popolo G, Lam W, Globe D, Pommerville P. Treatment satisfaction and improvement in health-related quality of life with onabotulinumtoxinA in patients with urinary incontinence due to neurogenic detrusor overactivity. Neurourology and Urodynamics 2013;32(3):242-249. DOI: 10.1002/nau.22293. [Context Link 1] View abstract...

246. Kennelly M, et al. Efficacy and safety of onabotulinumtoxinA therapy are sustained over 4 years of treatment in patients with neurogenic detrusor overactivity: Final results of a long-term extension study. Neurourology and Urodynamics 2017;36(2):368-375. DOI: 10.1002/nau.22934. [Context Link 1, 2] View abstract...

247. Li GP, Wang XY, Zhang Y. Efficacy and safety of OnabotulinumtoxinA in patients with neurogenic detrusor overactivity caused by spinal cord injury: a systematic review and meta-analysis. International Neurourology Journal 2018;22(4):275-286. DOI: 10.5213/inj.1836118.059. [Context Link 1, 2] View abstract...

248. Yuan H, Cui Y, Wu J, Peng P, Sun X, Gao Z. Efficacy and adverse events associated with use of onabotulinumtoxinA for treatment of neurogenic detrusor overactivity: a meta-analysis. International Neurourology Journal 2017;21(1):53-61. DOI: 10.5213/inj.1732646.323. [Context Link 1, 2] View abstract...

249. Zhou X, Yan HL, Cui YS, Zong HT, Zhang Y. Efficacy and safety of onabotulinumtoxinA in treating neurogenic detrusor overactivity: a systematic review and meta-analysis. Chinese Medical Journal 2015;128(7):963-968. DOI: 10.4103/0366-6999.154318. [Context Link 1] View abstract...

250. Utomo E, Groen J, Blok BF. Surgical management of functional bladder outlet obstruction in adults with neurogenic bladder dysfunction. Cochrane Database of Systematic Reviews 2014, Issue 5. Art. No.: CD004927. DOI: 10.1002/14651858.CD004927.pub4. [Context Link 1] View abstract...

251. Eldred-Evans D, Sahai A. Medium- to long-term outcomes of botulinum toxin A for idiopathic overactive bladder. Therapeutic Advances in Urology 2017;9(1):3-10. DOI: 10.1177/1756287216672180. [Context Link 1] View abstract...

252. Weckx F, Tutolo M, De Ridder D, Van der Aa F. The role of botulinum toxin A in treating neurogenic bladder. Translational Andrology and Urology 2016;5(1):63-71. DOI: 10.3978/j.issn.2223-4683.2016.01.10. [Context Link 1] View abstract...

253. Urinary Incontinence in Neurological Disease: Management of Lower Urinary Tract Dysfunction in Neurological Disease. NICE Clinical Guideline CG148 [Internet] National Institute for Health and Care Excellence. 2012 Aug (NICE reviewed 2019) Accessed at:

https://www.nice.org.uk/guidance. [accessed 2022 Oct 22] [Context Link 1] View abstract...

254. Kaviani A, Khavari R. Disease-specific outcomes of botulinum toxin injections for neurogenic detrusor overactivity. Urologic Clinics of North America 2017;44(3):463-474. DOI: 10.1016/j.ucl.2017.04.012. [Context Link 1, 2] View abstract...

255. Tradewell M, Pariser JJ, Nimeh T, Elliott SP, Neurogenic Bladder Research Group. Systematic review and practice policy statements on urinary tract infection prevention in adults with spina bifida. Translational Andrology and Urology 2018;7(Suppl 2):S205-S219. DOI: 10.21037/tau.2018.04.21. [Context Link 1] View abstract...

256. Austin PF, et al. OnabotulinumtoxinA for the treatment of neurogenic detrusor overactivity in children. Neurourology and Urodynamics 2021;40(1):493-501. DOI: 10.1002/nau.24588. [Context Link 1] View abstract...

257. Hascoet J, et al. Outcomes of intra-detrusor injections of botulinum toxin in patients with spina bifida: A systematic review. Neurourology and Urodynamics 2017;36(3):557-564. DOI: 10.1002/nau.23025. [Context Link 1] View abstract...

258. Hascoet J, et al. Intradetrusor injections of botulinum toxin type A in children with spina bifida: a multicenter study. Urology 2018;116:161-167. DOI: 10.1016/j.urology.2018.02.033. [Context Link 1] View abstract...

259. Stein R, et al. EAU/ESPU guidelines on the management of neurogenic bladder in children and adolescent part II operative management. Neurourology and Urodynamics 2020;39(2):498-506. DOI: 10.1002/nau.24248. [Context Link 1] View abstract...

Footnotes

[A] For blepharospasm, onabotulinumtoxinA is injected into the orbicularis oculi muscle, without necessity for electromyographic guidance. Initial effects are seen within 3 days, with peak effectiveness after 1 to 2 weeks. Each treatment lasts approximately 3 months, after which treatment may be repeated, with slight dosing adjustments made, if necessary, based on prior response.(1) [A in Context Link 1]

[B] For cervical dystonia (spasmodic torticollis), onabotulinumtoxinA is injected into affected muscles, with or without electromyographic guidance, with dosing tailored to head and neck position, location of pain, muscle hypertrophy, and history of prior response and adverse events. Clinical improvement usually begins within 2 weeks, with maximal improvement after about 6 weeks.(1) Most patients return to pretreatment status after about 3 to 4 months.(97)(98) [B in Context Link 1]

[C] For axillary hyperhidrosis, botulinum toxin A is administered intradermally into affected areas as determined by standard iodine-starch testing. Repeated doses may be administered when the clinical effectiveness of the most recent dose has diminished.(118)(119)(120)(121)(122) [C in Context Link 1]

[D] The Hyperhidrosis Disease Severity Scale (HDSS) is used to evaluate the severity of hyperhidrosis and how it affects the individual's daily activities and is based on the patient answering a single statement. A score of 1 reflects mild disease severity, while a score of 2 reflects moderate disease severity. A score of 3 or 4 reflects severe disease severity.(119)(121)(132) [D in Context Link 1]

[E] Topical aluminum chloride hexahydrate may initially be applied using a concentration of 10% to 12% to minimize skin irritation; a concentration of 35% may be required to achieve euhidrosis.(127)(130)(131)(132)(133) [E in Context Link 1]

[F] For chronic migraine, onabotulinumtoxinA is injected into 31 sites across 7 specific muscle areas in the head and neck. Injections may be repeated every 12 weeks.(1) [F in Context Link 1]

[G] For overactive bladder, onabotulinumtoxinA is injected across 20 sites into the detrusor.(1) [G in Context Link 1]

[H] For sialorrhea, onabotulinumtoxinA is injected directly into the parotid and submandibular glands.(189)(190) [H in Context Link 1]

[I] For upper or lower extremity spasticity, onabotulinumtoxinA is injected as a divided dose among affected muscles, taking into account the number and location of muscles involved, the spasticity severity, the presence of local muscle weakness, the response to previous treatment, and any history of adverse reactions to botulinum toxins. Electromyography, electrical stimulation, or ultrasound guidance is recommended to target the injection sites. Treatment may be readministered after 12 weeks, if needed.(1) [I in Context Link 1]

[J] For strabismus, onabotulinumtoxinA is injected into extraocular muscles, after instillation of topical anesthetic and decongestant drops, and while monitoring electrical activity recorded from the needle tip as a guide to placement, or via surgical exposure. Blind injection without electromyographic monitoring and/or surgical exposure should not be attempted. Paralysis of the injected muscle(s) begins within 1 to 2 days and increases during the first week. Paralysis lasts for 2 to 6 weeks and resolves over a similar period. About half of such patients will require subsequent doses due to inadequate response, failure of binocular fusion, or other factors.(1) [J in Context Link 1]

[K] For neurogenic detrusor overactivity in adults, onabotulinumtoxinA is injected across 30 sites into the detrusor.(1) [K in Context Link 1]

[L] For neurogenic detrusor overactivity in children and adolescents, onabotulinumtoxinA is injected across 20 sites into the detrusor.(1) [L in Context Link 1]

Codes

CPT®: 31573, 64616, 64617, 64642, 64643, 64644, 64645, 64646, 64647

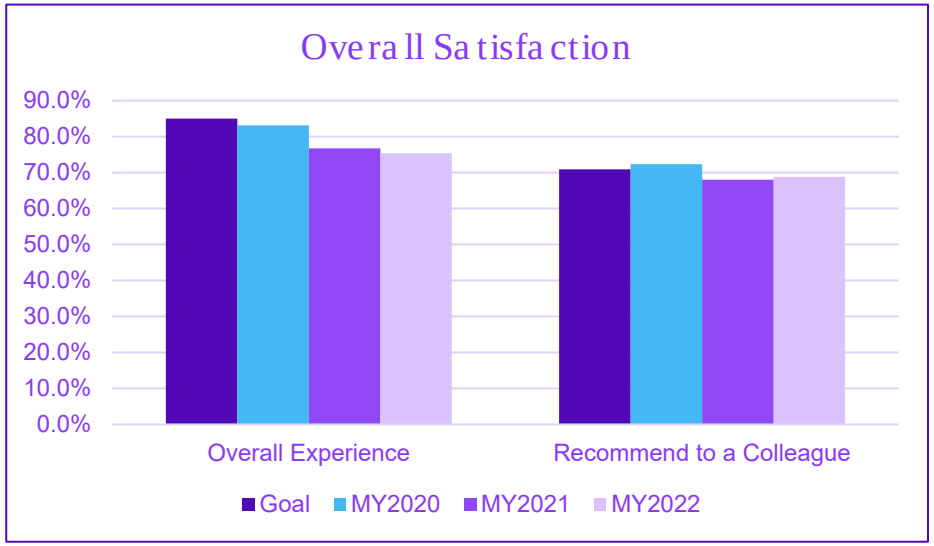
HCPCS: J0585

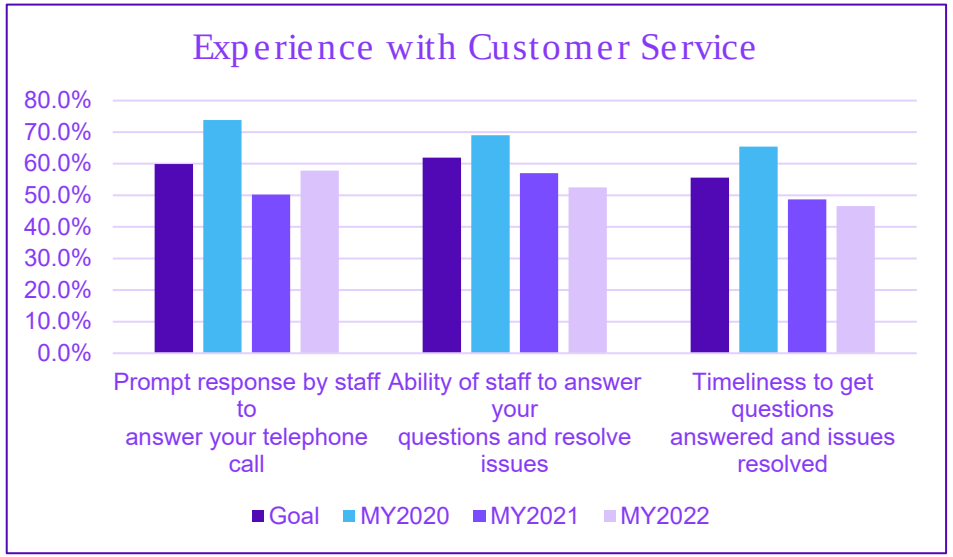
Last Update: 2/1/2023 1:47:18 AM
Build Number: 27.0.20230131232627.008841

MY 2022
Provider Experience Results

West Region

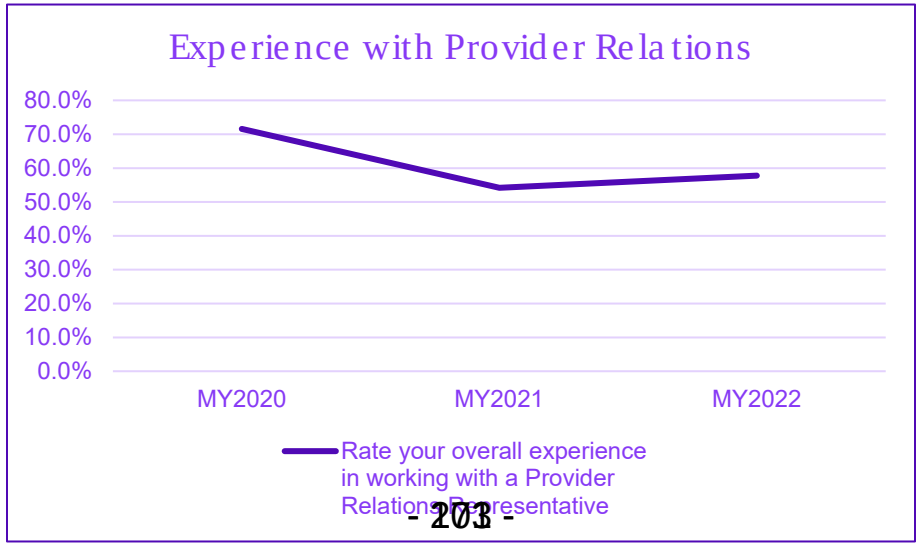
Overall Satisfaction, Customer Service and Provider Relations





Improvements in 2022

- Recommend to a colleague
- Prompt response by staff to answer your call
- Experience with Provider Relations

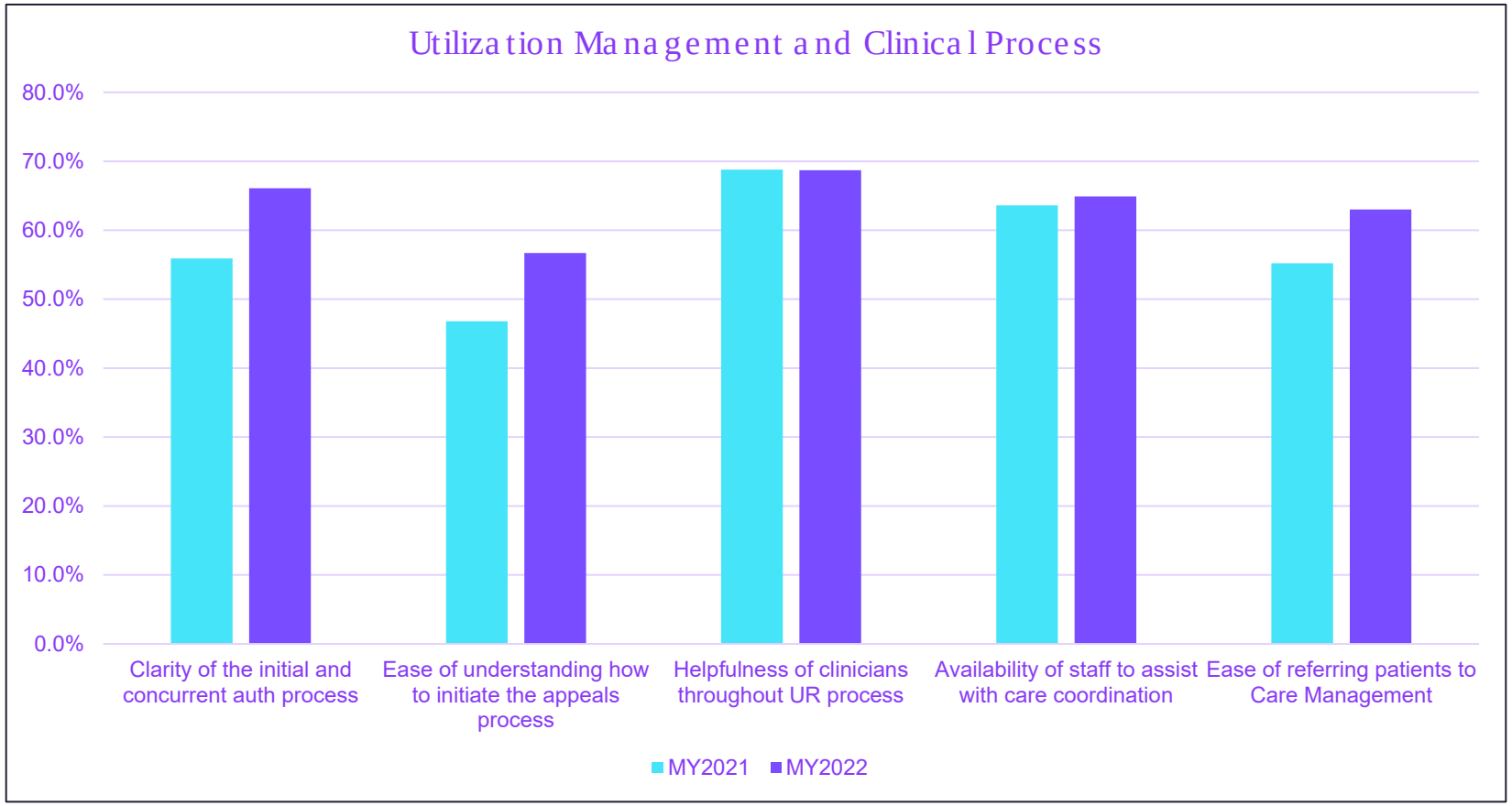


Opportunities for 2023

- Overall Satisfaction
- Customer Service ability to answer questions and resolve issues
- Timeliness in answering questions and resolving issues

Clinical Processes

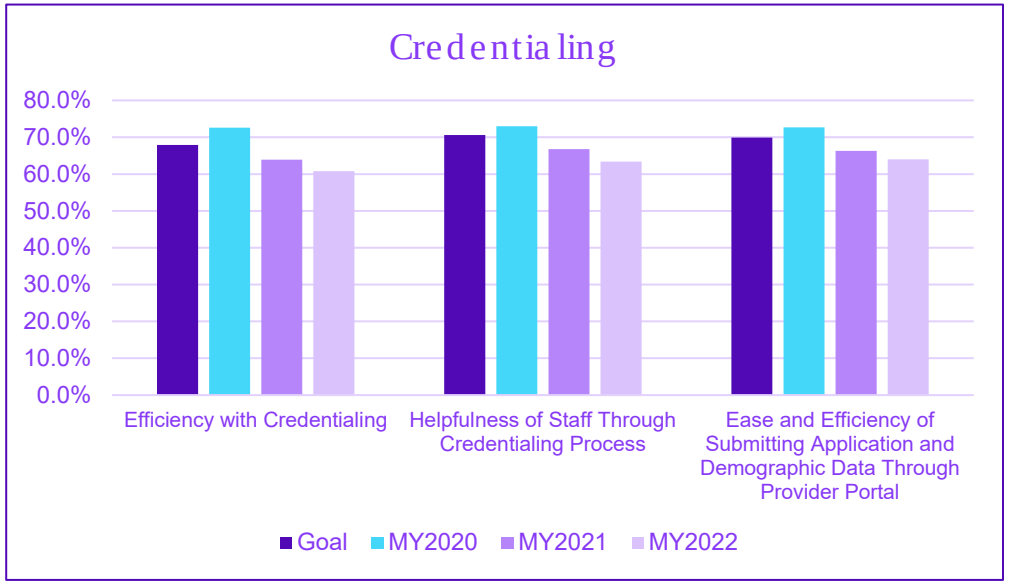
Improvement shown on 4 out of 5 questions from 2021 to 2022

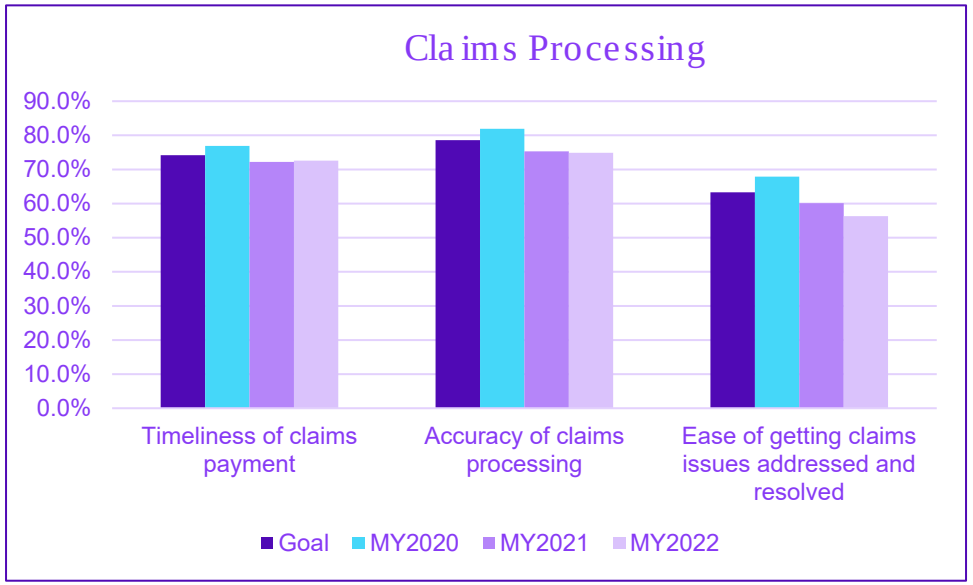


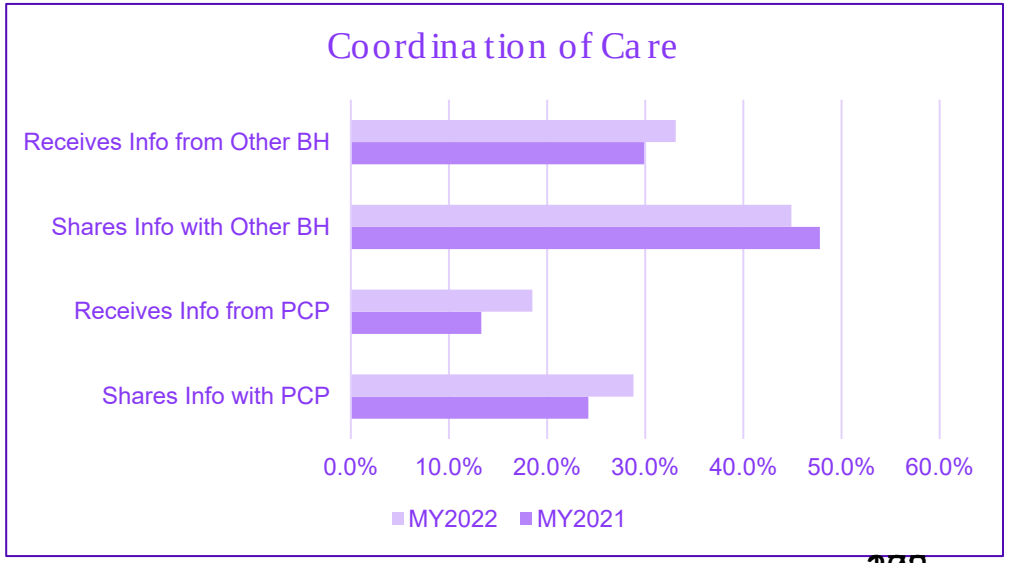
Credentialing, Claims, Coordination and Communications

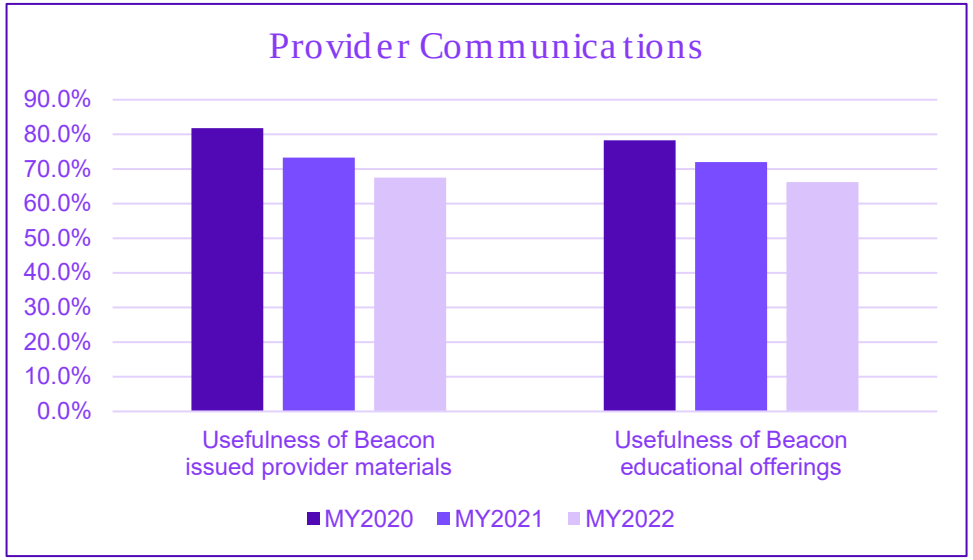
Improvements in 2022
- Receives Info from Other BH
- Receives Info from PCP
- Shares Info with PCP

Opportunities for 2023
- Credentialing
- Claims Accuracy and Issue resolution
- Provider Communication

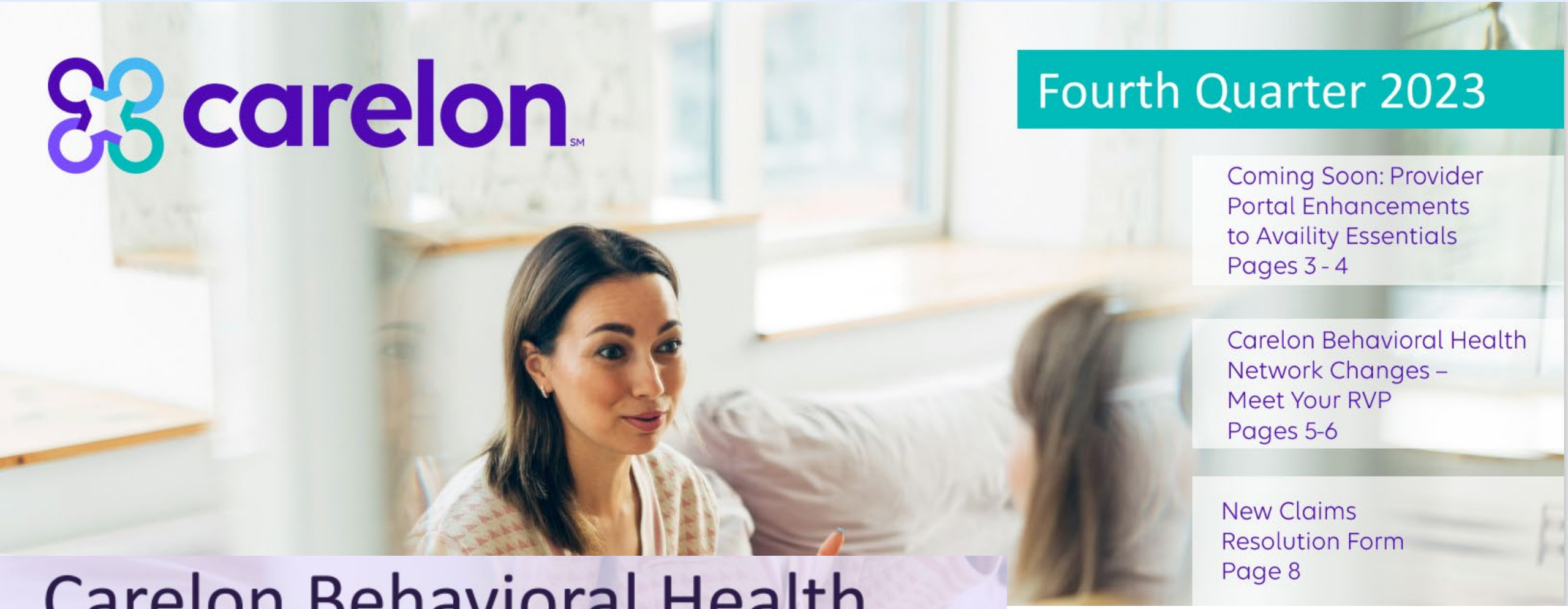




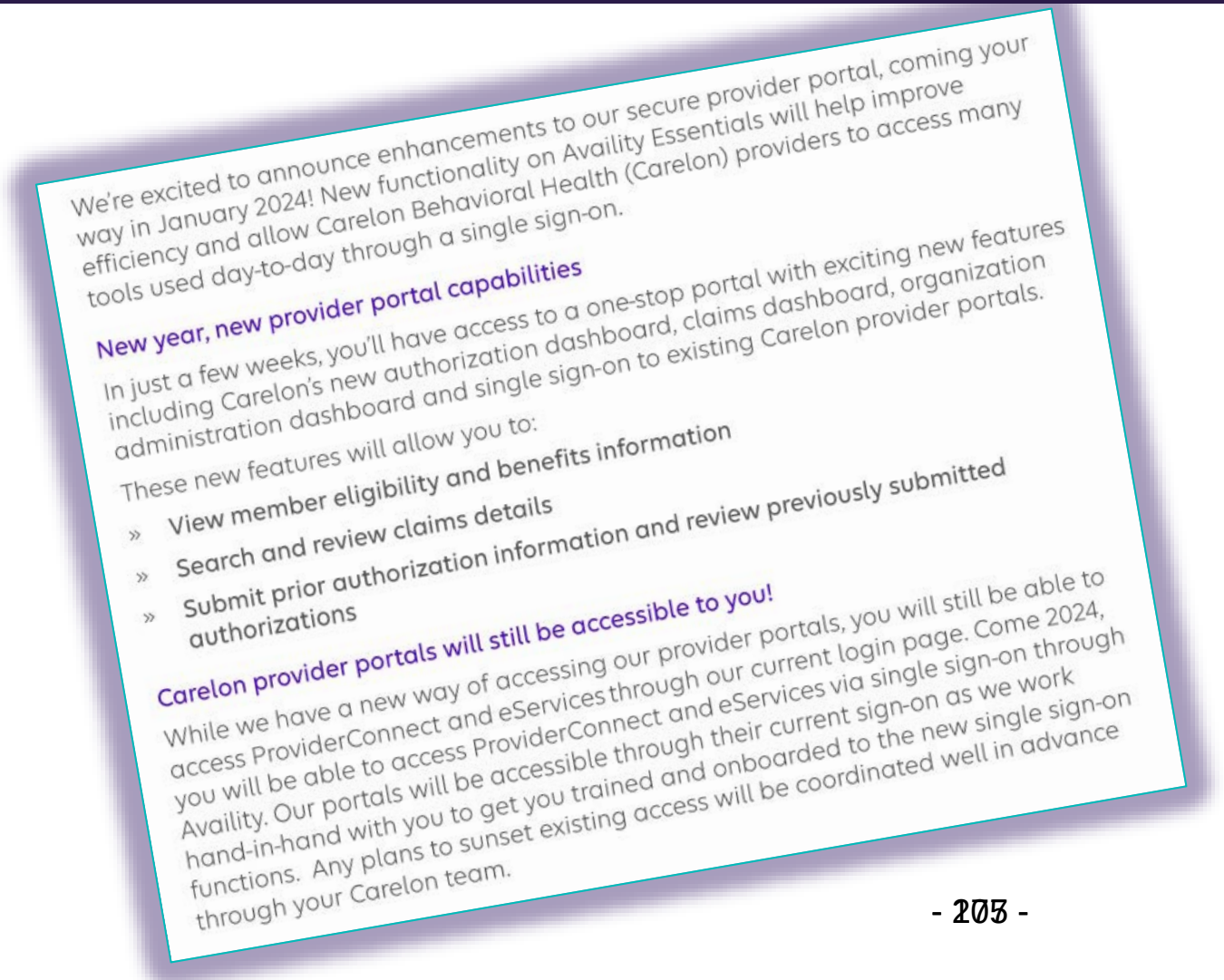




Q4 2023 Provider Newsletter



COMING SOON: PROVIDER PORTAL ENHANCEMENTS TO AVAILITY ESSENTIALS



We're excited to announce enhancements to our secure provider portal, coming your way in January 2024! New functionality on Availity Essentials will help improve efficiency and allow Carelon Behavioral Health (Carelon) providers to access many tools used day-to-day through a single sign-on.

New year, new provider portal capabilities

In just a few weeks, you'll have access to a one-stop portal with exciting new features including Carelon's new authorization dashboard, claims dashboard, organization administration dashboard and single sign-on to existing Carelon provider portals.

These new features will allow you to:

- View member eligibility and benefits information
- Search and review claims details
- Submit prior authorization information and review previously submitted authorizations

Carelon provider portals will still be accessible to you!

While we have a new way of accessing our provider portals, you will still be able to access ProviderConnect and eServices through our current login page. Come 2024, you will be able to access ProviderConnect and eServices via single sign-on through Availity. Our portals will be accessible through their current sign-on as we work hand-in-hand with you to get you trained and onboarded to the new single sign-on functions. Any plans to sunset existing access will be coordinated well in advance through your Carelon team.

Carelon Behavioral Health New Functionality to Availity Essentials Provider Portal [Frequently Asked Questions (FAQ)]

Provider Training – January 2024

Gender-Affirming BH 101

Wednesday, January 31st at 3 P.M. Eastern Standard Time

Gender-affirming behavioral healthcare involves range of social, psychological and behavioral interventions designed to support and affirm an individual's gender identity when it conflicts with the gender they were assigned at birth. In this introductory-level, 1.5 hour long training, learners will explore terminology and definitions, barriers and risks experienced by members of the transgender non-binary (TNGB) community, and ways that providers and staff can offer supportive, high quality, gender-affirming care. No CE credit or certification is associated with this training.

Disease Self-Management

Thursday, January 4th at 12 P.M. Eastern Standard Time

Self-Management refers to ways an individual can deal with the symptoms and challenges that come with living with a chronic illness diagnosis. This 1.5 hour training will discuss the rise of chronic disease in the U.S., theories and framework related to self-management, strategies to assist patients/members with chronic conditions and behavioral health needs to be involved in their own disease management. There is no CE credit or certification associated with this training.

Youth BH 101

Wednesday, January 17th at 1 P.M. Eastern Standard Time

This 2-hour long training will provide a high-level overview of Behavioral Health in Children & Adolescents. Topics discussed include childhood development, risk & protective factors, special population considerations, and an overview of common childhood diagnoses such as ADHD, Oppositional Defiant Disorder & Attachment Disorders. This training is intended for healthcare professionals who are not already knowledgeable and/or experienced in child behavioral healthcare. Experienced child behavioral health providers are welcome to attend as a content refresher. No CE Credit or certification is associated with this training.

Carelon Behavioral Health, Inc.:

Beacon Health Options, Inc. transitioned to the Carelon Behavioral Health name on March 1, 2023. This means that our name changed from Beacon Health Options, Inc. to Carelon Behavioral Health, Inc. Carelon (Care-ah-lon) is derived of "care" and "lon", meaning full and complete. Together, the name stands for the importance of providing full and complete care.

Elevance Health is the name of our holding company. As part of Elevance Health, Carelon is a new healthcare services brand dedicated to solving the industry's most complex challenges. Carelon integrates physical, behavioral, social and pharmacy services to deliver whole health affordably. The Carelon healthcare model puts people first. Its family of companies create value through proven-effective capabilities, powered by analytics and delivered with empathy. The Carelon companies offer advanced technology, data and clinical expertise to improve outcomes, streamline processes, manage risk and advance value-based care.

The transition of Beacon Health Options, Inc. to the Carelon brand is a name change; our commitment to you is unchanged. We exist to ensure access to whole health services across the health continuum and to deliver innovative solutions that advance better care and enhance efficiencies system wide in our partnership.

Background:

Carelon Behavioral Health, Inc. (Carelon Behavioral Health) annually administers an experience survey to request provider feedback about Carelon Behavioral Health's performance as a partner in delivering care to members, and uses the data toward process improvement and managing clinical outcomes. The provider experience survey also offers insight into the ways in which system characteristics affect the quality of care and services delivered to members. Further, the analysis helps to identify and prioritize opportunities for improvement. Carelon Behavioral Health has contracted with SPH Analytics to administer the survey on our behalf.

This 2022 provider experience survey report covers the plans in West Region under Carelon Behavioral Health. Plan(s) under Carelon Behavioral Health of California, Inc. are not included in this report due to the delegation structure.

Measures:

The provider experience survey measures are broken into the following categories:

- Overall Satisfaction and Experience with Carelon Behavioral Health
- Experience with Credentialing
- Customer Service and Provider Relations
- Utilization Management and Clinical Processes
- Claims Processing
- Provider Quality Management Team
- Carelon Behavioral Health Communications
- Coordination and Continuity of Care

Methodology:

1. Carelon Behavioral Health provides SPH Analytics with a database of active in-network providers (individual practitioners, group practices, and facilities) who have had at least 10 behavioral health claims (regardless of status) within the specified time period. Measurement year 2022 is comprised of the lookback period beginning Q3 2021 through the end of Q2 2022. The data is reported in calendar year 2023.
2. The database is cleaned by selecting the most recent date of service for each listed provider and deduping by National Provider Identifier (NPI).
3. The mode(s) of communication that were used for the 2022 survey distribution included email. All providers in the sample (22,025) with an email address on file were sent an email invitation to complete the survey online. Up to 3 email reminders to non-responders from the email invitation. Data collection was completed in mid-October through November 2022.

In 2022, Carelon Behavioral Health redesigned the provider survey. For measurement year 2022, the following updates were made:

1. Discontinuation of questions related to telehealth, duplicative questions, questions no longer applicable throughout the various categories listed above, and questions focused on the comparison to other MBHOs
2. Addition of questions related to the various categories listed above, which will be considered baseline
3. Discontinuation of regulatory questions related to provider access and availability

In measurement year 2022, the performance goal set by Carelon Behavioral Health is 85% for overall satisfaction. Overall satisfaction is measured using the Top-2 Box measure of satisfaction, which takes into account only those responses that are the highest ratings of satisfaction.

Studies have shown that the two highest values on feedback surveys are the most accurate measures at accurately measuring satisfaction and predicting retention.

Goal methodology for the individual questions consists of adding one standard deviation of the last three yearly results (MY2019-MY2021) to the prior year's results (MY2021).

In cases where three yearly results are not available, 'P' is used until the baseline is established and no longer pending; for any low denominator results, 'LD' is used as the volume is not statistically significant; for cases where the goal is not applicable to the specific question 'NA' is used.

Interventions Implemented:

Based on the opportunities for improvement identified in 2021, following interventions were implemented in 2022:

Date Implemented (MM/YY or Quarter/YY)	Check if Ongoing	Interventions
03/01/2022		Provider Experience initiatives include the launch of Carelon Behavioral Health's Alliance Partnership Strategy in March 2022, the development of new and improved provider facing materials, and redesigning the provider website to create a more user-friendly experience. Carelon Behavioral Health Alliance Partners have direct contact to their PR account manager for all their needs including claims issues, credentialing, authorization, and any other provider related concerns. A card including Carelon Behavioral Health contact information will be provided to each partner.
01/01/2022	√	Carelon Behavioral Health enhanced the PCP toolkit. The Carelon Behavioral Health Quality team in collaboration with Medical, Clinical, Peers, Provider Relations and other stakeholders across the organization revised the online resource. The PCP toolkit is intended to support primary care clinicians by providing a quick guide to behavioral health references. The toolkit is also a great resource for behavioral health providers and our health plan partners. The toolkit is useful for managing populations with co-occurring disorders. The toolkit promotes an integrated healthcare approach encouraging whole person health by providing PCPs and other practitioner's resources they can use with the members they serve. The toolkit includes resources for the management of depression, substance use disorders, anxiety, and schizophrenia; all have been updated to reflect most recent resources. Enhancements include the addition of four new topic areas: Social Determinants of Health, Autism Spectrum Disorder, COVID 19, and Medication. All sections include resources that the provider can use with the member including screening tools.
01/01/2022	√	Improve telephone performance by implementing a daily stand-up meeting with Call Center leadership and Workforce Management team to review prior day performance and agent productivity, make skilling and schedules adjustments as needed, and identify and address additional issues as needed. Additionally, maximized available resources including reducing the number of approved PTO allotted per day, offering overtime daily, cancelling or postponing off phone activities, and scheduling supervisors and support staff to assist with handling phone calls.
01/01/2022	√	Streamline provider engagement to decrease call volume providers are experiencing.

Carelon Behavioral Health, Inc.
2022 Provider Experience Survey
West Region

Results

Aggregate results are provided below. Results are broken out by categories (i.e. Overall Satisfaction and Experience with Carelon Behavioral Health, Experience with Credentialing, Customer Service and Provider Relations, Provider Quality Management Team, Carelon Behavioral Health Communications, Utilization Management and Clinical Processes, Coordination and Continuity of Care and Claims Processing.

There were a total of 22,025 providers surveyed in survey year 2023 (measurement year 2022).

Overall Response Rate (RR)
For survey year 2022, out of 22,025 eligible Carelon Behavioral Health providers outreached, 1,095 responded to the survey resulting in response rate of 4.97%. This is an increase of provider responses compared to 820 in MY2021.

Provider Experience Survey – Overall Satisfaction and Experience with Carelon Behavioral Health

Measures	Response Breakdown (if applicable)	Goal	Survey Year 2021 (MY 2020)	Survey Year 2022 (MY 2021)	Survey Year 2023 (MY 2022)	Trend
Q01. How would you rate your overall satisfaction with Beacon services? (answer key: very satisfied or somewhat satisfied)	N/A	85%	83.1% (1146/1379)	76.7%* (621/810)	75.4% (801/1062)	↓
Q03. How likely is it that you would recommend Beacon to a colleague as a managed care behavioral health organization partner based on your experiences during the past year? (6-10 ratings on a scale of 0-10)	N/A	70.9%	72.3% (1007/1393)	68.0% (570/838)	68.8% (738/1072)	↑

Provider Experience Survey – Experience with Credentialing

Measures	Response Breakdown (if applicable)	Goal	Survey Year 2021 (MY 2020)	Survey Year 2022 (MY 2021)	Survey Year 2023 (MY 2022)	Trend
How would you rate the following related to credentialing:						
Q4. Efficiency of credentialing and recredentialing process at Beacon (answer key: excellent or good)	N/A	67.9%	72.6% (928/1278)	63.9%* (472/739)	60.8% (546/898)	↓
Q5. Helpfulness of staff throughout the credentialing process at Beacon (answer key: excellent or good)	N/A	70.6%	73.0% (823/1128)	66.8%* (442/662)	63.4% (534/842)	↓
Q6. Ease and efficiency of submitting application and demographic data online via the Provider Portal at Beacon (answer key: excellent or good)	N/A	69.9%	72.7% (806/1108)	66.3%* (436/658)	64.0% (519/811)	↓

Provider Experience Survey – Customer Service and Provider Relations

Measures	Response Breakdown (if applicable)	Goal	Survey Year 2021 (MY 2020)	Survey Year 2022 (MY 2021)	Survey Year 2023 (MY 2022)	Trend
Q7. In the last 12 months, did you call Beacon Customer Service? (answer key: yes)	N/A	N/A	68.8% (958/1393)	73.7%* (604/820)	71.8% (781/1088)	↓
Q8. For what reason(s) did you call Beacon Customer Service? Select all that apply. (answer key: response breakdown selected)	a. Claims issues	N/A	63.0% (604/958)	68.7%* (415/604)	62.7% (490/781)	↓
	b. Benefits	N/A	28.9% (277/958)	26.8% (162/604)	21.5% (168/781)	↓
	c. Eligibility	N/A	38.5% (369/958)	38.6% (233/604)	32.7% (255/781)	↓
	d. Contracting	N/A	16.3% (156/958)	23.7%* (143/604)	26.9% (210/781)	↑
	e. Credentialing	N/A	20.8% (199/958)	27.5%* (166/604)	24.6% (192/781)	↓
	f. Demographic Updates	N/A	14.2% (136/958)	18.2%* (110/604)	14.0% (109/781)	↓
	g. Electronic Claims	N/A	14.5% (139/958)	19.9%* (120/604)	17.8% (139/781)	↓
	h. Website Support	N/A	8.6% (82/958)	11.4% (69/604)	9.3% (73/781)	↓
	i. Utilization Management	N/A	5.6% (54/958)	2.8% (17/604)	3.7% (29/781)	↑
	j. Other (specify)	N/A	11.3% (108/958)	11.1% (67/604)	10.2% (80/781)	↓
How would you rate the following related to customer service:						
Q10. Prompt response by staff to answer your telephone call at Beacon Health Options (answer key: excellent or good)	N/A	59.9%	73.8% (698/946)	50.2% (300/598)	57.8% (445/770)	↑
Q11. Ability of staff to answer your questions and resolve issues at Beacon Health Options (answer key: excellent or good)	N/A	61.9%	69.0% (653/946)	57.0%* (340/596)	52.5% (405/771)	↓
Q12. Timeliness to get questions answered and issues resolved at Beacon Health Options (answer key: excellent or good)	N/A	55.6%	65.4% (616/942)	48.7%* (289/594)	46.6% (359/770)	↓
Q13. In the last 12 months, have you worked with a Beacon Provider Relations Representative? (answer key: yes)	N/A	N/A	48.2% (672/1393)	47.9% (393/820)	56.3% (556/987)	↑
How would you rate the following related to engaging with a Beacon Provider Relations Representative:						
Q15. Rate your overall experience in working with a Provider Relations Representative at	N/A	P	71.6% (476/665)	54.2%* (208/384)	57.8% (321/555)	↑

Beacon Health Options (answer key: excellent or good)						

Provider Experience Survey – Carelon Behavioral Health Communications

Measures	Response Breakdown (if applicable)	Goal	Survey Year 2021 (MY 2020)	Survey Year 2022 (MY 2021)	Survey Year 2023 (MY 2022)	Trend
How would you rate the following at Beacon:						
Q18a. Usefulness of Beacon issued provider materials (written communications and manuals) (answer key: excellent or good)	N/A	P	81.8% (1013/1238)	73.3%* (532/726)	67.5% (564/835)	↓
18b. Usefulness of Beacon educational offerings (answer key: excellent or good)	N/A	P	78.3% (763/974)	72.0%* (404/561)	66.2% (494/746)	↓

Provider Experience Survey – Utilization Management and Clinical Processes

Measures	Response Breakdown (if applicable)	Goal	Survey Year 2021 (MY 2020)	Survey Year 2022 (MY 2021)	Survey Year 2023 (MY 2022)	Trend
How would you rate the following related to utilization management and clinical processes:						
Q20. Clarity of the initial and concurrent authorization processes at Beacon Health Options (answer key: excellent or good)	N/A	P	N/A	55.9% (320/572)	66.1% (563/852)	↑
Q21. Ease of understanding of how to initiate the appeals process at Beacon Health Options (answer key: excellent or good)	N/A	P	N/A	46.8% (146/312)	56.7% (301/531)	↑
Q22. Helpfulness of clinicians throughout the utilization review process at Beacon Health Options (answer key: excellent or good)	N/A	P	N/A	68.8% (216/314)	68.7% (347/505)	→
Q23. Availability of staff to assist with care coordination (i.e. medication reconciliation, discharge planning, etc.) at Beacon Health Options (answer key: excellent or good)	N/A	P	N/A	63.6% (154/242)	64.9% (268/413)	↑
Q24. Ease of referring your patients to Care Management and Intensive Case Management	N/A	P	N/A	55.2% (112/203)	63.0% (233/370)	↑

Services at Beacon Health Options (answer key: excellent or good)						

Provider Experience Survey – Coordination and Continuity of Care

Measures	Response Breakdown (if applicable)	Goal	Survey Year 2021 (MY 2020)	Survey Year 2022 (MY 2021)	Survey Year 2023 (MY 2022)	Trend
If my patient has a Primary Care Physician:						
Q25a. I communicate (verbal and/or written) about our mutual patient's care (answer key: always or usually) (2021 Question: If my patient has a Primary Care Physician, I communicate about our mutual patient's care (answer key: always or usually))	N/A	P	33.8% (421/1244)	24.2* (166/686)	28.8% (244/846)	↑
Q25b. I receive communication (verbal and/or written) about our mutual patient's care (answer key: always or usually)	N/A	P	N/A	13.3% (91/686)	18.5% (157/847)	↑
If my patient is currently treated by another behavioral health practitioner:						
Q26a. I communicate (verbal and/or written) about our mutual patient's care (answer key: always or usually) (2021 Question: If my patient is currently treated by another behavioral health practitioner, I communicate about our mutual patient's care (answer key: always or usually))	N/A	P	59.3% (677/1142)	47.8%* (291/609)	44.9% (315/701)	↓
Q26b. I receive communication (verbal and/or written) about our mutual patient's care (answer key: always or usually)	N/A	P	N/A	29.9% (180/607)	33.1% (232/701)	↑

Provider Experience Survey – Claims Processing

Measures	Response Breakdown (if applicable)	Goal	Survey Year 2021 (MY 2020)	Survey Year 2022 (MY 2021)	Survey Year 2023 (MY 2022)	Trend
How would you rate the following related to prompt and accurate claims payment:						
Q27. Timeliness of claims payment at Beacon Health Options (answer key: excellent or good)	N/A	74.2%	76.9% (1041/1354)	72.2% (575/796)	72.6% (763/1051)	→

Q28. Accuracy of claims processing at Beacon Health Options (answer key: excellent or good)	N/A	78.6%	81.9% (1105/1349)	75.3% (594/789)	74.9% (780/1042)	→
Q29. Ease of getting claims issues addressed and resolved at Beacon Health Options (answer key: excellent or good)	N/A	63.3%	67.9% (812/1195)	60.1% (424/705)	56.3% (530/941)	↓

* Statistically significant change from the previous reporting period chi-square test of independence at p<0.05

** ↓ = trending down compared to prior year; ↑ = trending up compared to prior year; → = trend within 1 percentage point of prior year; red result text = did not meet goal

Result Analysis

Quantitative Analysis:

Net Promoter Score (NPS)
Of the 1,072 survey responses in 2022, 35.5% were promoters (answer key 9, 10) and 38.0% were detractors (answer key 0-6). NPS score is calculated as the percent of promoters minus the percent of detractors (35.5% - 38.0% = -2.5). Compared to 2021, this is an improvement from the score of -6.2.

Overall Satisfaction & Experience with Carelon Behavioral Health
Providers were asked to rate their satisfaction with Carelon Behavioral Health services based on their experience in 2022. 75.4% of the providers surveyed were "somewhat satisfied" or "very satisfied" with Carelon Behavioral Health's overall services. This fell short of the 85% goal by 9.6 percentage points and is a decrease of 1.3 percentage points compared to 2021 (76.70%).

Likelihood to recommend Carelon Behavioral Health
Overall, 68.8% of the providers were likely to recommend Carelon Behavioral Health as a managed care behavioral health organization to a colleague. This missed the 70.9% goal by 2 percentage points and was the same results when compared to 2021 (68.8%).

Experience with Credentialing
In regards to the credentialing process at Carelon Behavioral Health in 2022, 60.8% rated the efficiency of credentialing and re-credentialing process as "good or excellent". This missed the 67.9% goal by 7 percentage points and is a decrease of 3 percentage points compared to 2021 (63.9%). 63.4% of providers indicated "good or excellent" in regards to finding the staff at Carelon Behavioral Health to be helpful. This missed the target goal by 7 percentage points and is a decrease of around 3 percentage points when compared to 2021 (66.8%). 64.0% of providers indicated "good or excellent" with the ease and efficiency in submitting application and demographic data online through the Provider Portal. This missed the 69.9% goal by 6 percentage points, and is a decrease of around 2 percentage points compared to 2021 (66.3%).

Experience with Customer Service and Provider Relations
In 2022, 71.8% of Providers indicated they called Carelon Behavioral Health customer service. This is a decrease of around 2 percentage points compared to 2021 (73.7%). The highest number of providers called Carelon Behavioral Health customer service for claims issues at 62.7%. 32.7% of the calls related to Eligibility and 21.5% related to Benefits. 52.5% of the providers rated Carelon Behavioral Health's ability to answer question and resolve issues as "good or excellent" a decrease of 4.5 percentage points compared to 2021 (57.0%) and missing the 61.9% goal by 9 percentage points. Promptness of call rated in at 57.8% and was a substantial increase of 7.6 percentage points compared to 2021 (50.2%), this missed the 59.9% goal by 2 percentage points. Timeliness to get questions answered or issues resolved

rated 46.6%, which was a decrease of 2 percentage points compared to the 2021 (48.7%) and missed the 55.6% goal by 9 percentage points.

Providers were also asked about provider relations at Carelon Behavioral Health. In 2022, 56.3% of Providers indicated they worked with a Carelon Behavioral Health provider relations representative. This is a substantial increase of 8.4 percentage points compared to 2021 (47.9%). 57.8% of the providers rated their overall experience working with a provider relations representative as "Excellent" and "Good." This is an increase of 3.6 percentage points compared to 2021 (54.2%). There is no goal set for these questions as the baseline is pending three consecutive yearly results.

Carelon Behavioral Health Communications
Specific to Carelon Behavioral Health communications, providers were asked to rate the following: Usefulness of Carelon Behavioral Health issued provider materials (written communication, policy bulletins, and manuals) and the usefulness of Carelon Behavioral Health educational offerings. Providers rated 67.5% and 66.2%, respectively. This is a decrease of 5.8 percentage points (73.3% and 72.0%). There is no goal set for these questions as the baseline is pending three consecutive yearly results.

Utilization Management and Clinical Processes
These questions gauge the utilization management and clinical processes at Carelon Behavioral Health ("Excellent" or "Good"). The clarity of the initial and concurrent authorization processes at Carelon Behavioral Health came in at 66.1%, which is a substantial increase of 10.2 percentage points compared to 55.9% in 2021. The ease of understanding how to initiate the appeals process came in at 56.7%, a 9.9 percentage point increase compared to 46.8% in 2021. The helpfulness of clinicians throughout the utilization review process came in at 68.7%, comparable results of 68.8% in 2021. The availability of staff to assist with care coordination came in at 64.9%, a 1.3 percentage point increase compared to 63.6% in 2021. There is no goal set for these questions as the baseline is pending three consecutive yearly results.

Coordination and Continuity of Care
These questions determine the Primary Care Physician and Behavioral Health Practitioner communication patterns (Usually and Always). When asked if a patient has a Primary Care Physician, 28.8% indicated that they communicate verbal and/or written regarding the mutual patients care and 18.5% indicated they receive communications verbal and/or written regarding the mutual patients care. This is an increase of around 5 percentage points respectively when compared to 2021 (24.2% and 13.3%). For instances when a patient is currently treated by another behavioral health practitioner, 44.9% indicated they communicate verbal and/or written regarding the mutual patients care, and 33.1% indicated they receive communications verbal and/or written regarding the mutual patients care. For communicating about mutual patient's care, this is a decrease of around 3 percentage points compared to 47.8% in 2021 and receiving communication about a mutual patient's care is an increase of 3.2 percentage points compared to 29.9% in 2021. There is no goal set for these questions as the baseline is pending three consecutive yearly results.

Claims Processing
There are three key components to the claims process that can positively impact the NPS score when considering provider satisfaction. These components are: timeliness of claims payment, accuracy of claims processing, and ease of getting claims issues addressed and resolved. According to the 2022 survey, 72.6% of providers rated the timeliness of claims payment as "good or excellent." This is a similar result when compared to 72.2% in 2021 and misses the 74.2% goal by 1.6 percentage points. 74.9% of respondents positively assessed the accuracy of claims processing, this is a similar results when compared to 75.3% in 2021 and misses the 78.6% goal by over 3 percentage points. In regards to experiencing ease when getting claims issued addressed and resolved by Carelon Behavioral Health staff, 56.3% of providers rated "good or excellent" compared to 60.1% in 2021, which is a 3.8 percentage point decrease and misses the 63.3% goal by over 6 percentage points.

Qualitative Analysis:

In 2022, several interventions were implemented to support Carelon Behavioral Health's activities around Provider Satisfaction, including an increased focus on provider communication, timeliness of issue resolution, and clinical staff training. Overall satisfaction and the likelihood to recommend Carelon Behavioral Health did not meet the goals and the overall results were comparable to the prior year. However, the overall NPS rating has improved when compared to the prior years.
Compared to the prior year, there has been a slight decrease in overall Customer Service call volume, as well as a decrease in each specific reason for the Customer Service calls, with the exception of calls related to Contracting and Utilization Management, where these categories increased compared to prior years. Carelon Behavioral Health will continue to implement strong and focused interventions to further improve our performance going into 2023.

Barrier Analysis, Opportunities for Improvement and Next Steps

Barrier	Opportunity	Next Steps
Primary Care providers may not have access to current and vetted out materials related to BH diagnoses which would impact their ability to identify the signs and symptoms in order to make appropriate referrals for care. There is a continued gap between primary and behavioral health care providers concerning coordination of care.	Create and maintain a resource library for vetted out materials on common BH diagnoses, which includes information such as: screening tools, guidelines for diagnosis and treatment, HEDIS tip sheets, and member materials.	Continuous updated review of materials.
Staffing deficits impacted the ability to meet established performance goals in Q3 and Q4 2021.	Continue filling open positions in a timely manner to ensure adequate staffing coverage. Additional new hires completing onboarding and training at the beginning of 2022 will further improve our ability to meet phone metrics	Continue to work with Human Resources team to ensure the recruiting and onboarding of qualified representatives with previous customer service experience to ensure better quality of service to members. All monthly metrics were met as of the month of December 2021.
Providers are struggling with the credentialing application and may require assistance from various Carelon Behavioral Health representatives (Credentialing, PR, Contracting and NPSL line) which may burden the already resource constrained teams.	Establish dedicated support for credentialing applications	Modifications to the credentialing and re-credentialing application.

SAN FRANCISCO HEALTH PLAN

50 Beale St. 12th Floor
San Francisco, CA 94105

www.sfhp.org

San Francisco Health Plan

2023 Quality Improvement Program Evaluation

Table of Contents

Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement and Health Equity Transformation (QIHET) 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. Before 2024, SFHP's QIHET Program was titled the Quality Improvement (QI) Program.

SFHP's QI Program is detailed in the SFHP 2023 QI Program Description. The QI Program Description contains an annual Work Plan, outlined in Appendix A, representing the previous year improvement activities and measure targets. The Work Plan is reviewed twice a year as well as 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 seven activity domains:

- Quality of Service & Access to Care
- Keeping Members Healthy
- Patient Safety or Outcomes Across Settings
- Managing Members with Emerging Risk
- Managing Multiple Chronic Illnesses
- Utilization of Services
- Quality Oversight

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 are 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 (CMO), 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 CMO, provided key leadership for the QI program. SFHP's Chief Executive Officer (CEO) participates in the QI program by championing SFHP's NCQA accreditation journey as well as an organization-wide effort to improve member care and quality of service, namely by establishing organizational strategic priorities and ensuring resources to support key initiatives. In addition, the CEO ensures that Governing Board members receive 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 Program Leadership. The CMO leads key clinical improvement efforts, particularly prioritizing

and recommending 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 and the Practice Improvement Program (PIP) Advisory Committee that advises on the pay-for-performance program (PIP). SFHP QI staff also meet with QI representatives from the provider in monthly and bimonthly quality collaborative meetings. Overall, leadership and practitioner participation in the QI program in 2023 was sufficient to support the execution of the QI Plan. In 2024, SFHP seeks to engage provider network leadership in quality committees and collaboratives to work together on quality activities and align QI priorities. Starting in 2024, the QI Program will henceforth be called the Quality Improvement & Health Equity Transformation (QIHET) Program and the QIC will be called the Quality Improvement & Health Equity Committee (QIHEC).

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. In 2023, based on the challenges assessed as part of the 2022 QI Program, staff convened a Quality Strike Team to provide a comprehensive evaluation of the QI program and in what ways the program needs to expand and change to incorporate health equity and be more agile in responding to gaps and disparities in health outcomes and management of resources devoted to quality. An outcome of the Quality Strike Team was the formation of the Quality Oversight Team and Quality Implementation Teams which are comprised of cross-functional groups of leaders from across SFHP. While the existing committees outlined in the QI Program Description met regularly as scheduled, had sufficient attendance, and completed action items, SFHP identified that the oversight of quality was not sufficient in tracking the completion of quality activities and data monitoring, as several areas had challenges with staffing and associated resources. In 2024, SFHP seeks to improve staff collaboration via committees and workgroups to maintain and improve quality measures and activities. For a detailed summary of all staff supporting the QI Program, please refer to the 2024 Quality Improvement & Health Equity Transformation Program Description.

1.2 Highlights from the 2023 QI Program Measures

SFHP had positive outcomes during the 2023 QI Program period. Of the 28 measures included in the 2023 QI Evaluation, 12 met the target. SFHP utilizes lessons learned from 2023 QI Evaluation to inform the 2024 QIHET Program and Work Plan 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 six measure targets in this domain.

Notable improvement:

- Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Specialist increased by 4.38%, exceeding the target with a final rate of 64.38%.

Recommendation for continued improvement:

- HP-CAHPS – Getting Needed Care: while this measure exceeded its target, it continues to perform below the 10th percentile compared to other Medicaid plans. SFHP will implement three organizational initiatives to improve the member care experience which include interventions focused on access to primary and specialty care, telehealth, and members engaged in SFHP member-facing programs and services.

Keeping Members Healthy:

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

Notable improvement:

- Well Child Visits in the First 15—30 Months exceeded its target by 3.73% for a final result of 75.97%. SFHP reached the 75th percentile for this measure, moving up from performing below the 50th percentile in the previous year compared to other Medicaid plans.

Recommendation for continued improvement:

- Well Child Visits in the First 15 Months. SFHP did not meet its target and performs below the 50th percentile in this area. In 2024 SFHP will conduct a Maternal Child Health Gap Analysis, collaborate with the SF Department of Public Health and other health plans on coordinated improvement. Additionally, SFHP will incentivize providers through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting well-child quality improvement activities for the measure for members who are Hispanic or Latino or Black or African American.

Patient Safety or Outcomes Across Settings:

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

Notable improvement:

- Follow up After Emergency Department for Substance Use increased by 12.40% exceeding the target of 21.24% by 1.06%. This achievement resulted in SFHP reaching the 50th percentile compared to other Medicaid plans.

Recommendation for continued improvement:

- Follow up After Emergency Department for Mental Health did not reach its target, falling short by 1.71%. SFHP will incentivize providers through inclusion of a Follow-up After ED Visit for Mental Illness measure within 30 days in SFHP's primary care pay-for-performance program.

Managing Members with Emerging Risk:

SFHP met three out of eight measure targets in this domain.

Notable improvement:

- Postpartum Care for Black & Native American Members: SFHP exceeded the target, improving by 31.75% for a final result of 88.89%.

Recommendation for continued improvement:

- Asthma Medication Ratio: this measure did not meet its target and achieved 10th percentile compared to other Medicaid plans. SFHP will work to improve this measure by incentivizing providers through inclusion of an Asthma Medication Ratio measure in SFHP's primary care pay-for-performance program.

Managing Multiple Chronic Illnesses:

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

Notable improvement:

- SFHP exceeded its target for Care Management Client Perception of Health by 8.06% from a target of 60.00%.

Recommendation for continued improvement:

- The measure Care Management Follow-Up on Clinical Depression did not reach its goal. Care Management staff will work to initiate a weekly behavioral health office hour between SFHP Care Management, SFHP Behavioral Health, and Carelon clinical teams to staff cases and ensure timely connection to behavioral health services.

Utilization of Services:

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

Notable improvement:

- Antidepressant Medication Management — Effective Continuation achieved 90th percentile compared to other Medicaid plans across the country.

Recommendation for continued improvement:

- While Antipsychotic Medication Adherence met the 2023 target, the measure achieved 50th percentile compared to other Medicaid plans; SFHP will continue to prioritize this measure and collaborate with behavioral health providers to ensure continued adherence.

2. Quality of Service & 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 Routine Appointment Availability in Specialty Care

Overview & Performance

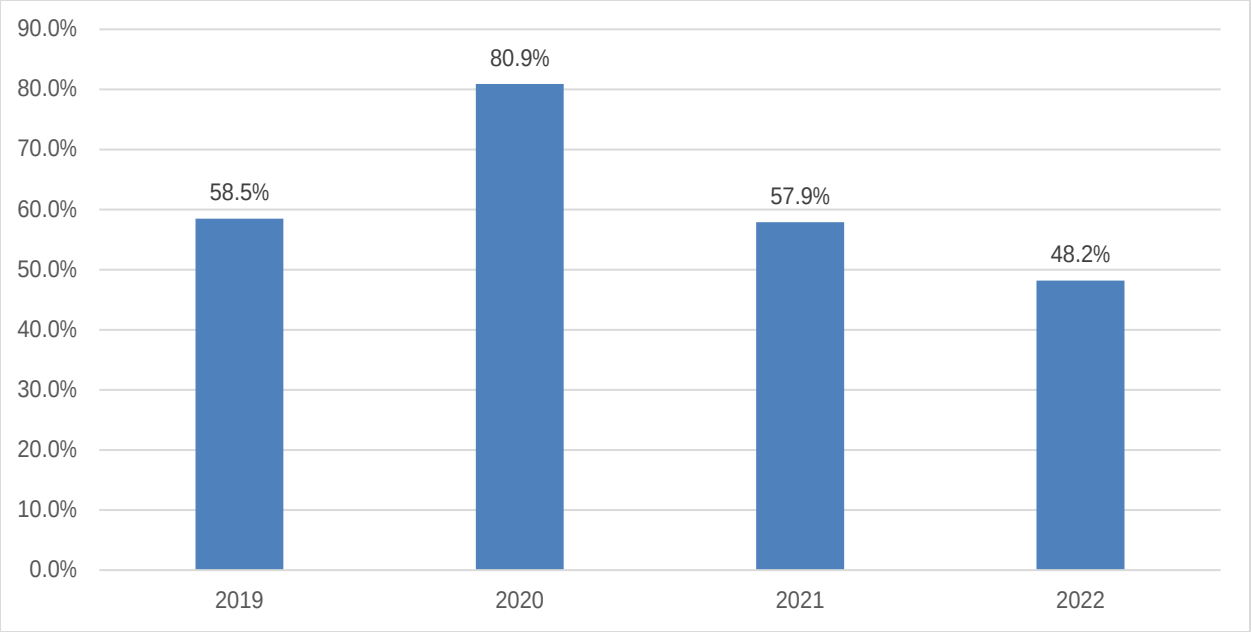
Measure: Routine Appointment Availability in Specialty Care					
Numerator	608	Baseline	57.9%	Final Performance	48.22%
Denominator	1261	Target	59.9%	Evaluation Year	2023

The Routine Appointment Availability in Specialty Care measure is in the Quality of Service & Access to Care domain. Increasing timely appointment availability improves access to care for members. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care and chronic disease management 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 specialty care visits are more likely to receive recommended care and members with a physician visit tend to score SFHP higher in CAHPS.

Routine Appointment Availability in Specialty Care is the total number of providers with appointments offered within 15 business days out of the total number providers surveyed in the Provider Appointment Availability Survey in 2022, set by the Department of Managed Health Care. SFHP set a target of 59.9% based on 2.0% absolute improvement from baseline.

Data is based on returned surveys of the Provider Appointment Availability Survey created by DMHC. The following chart demonstrates the four-year trend in routine specialty appointment availability. The table below that shows the appointment availability broken down by specialty type.

Specialty Appointment Availability 2019 – 2022



Specialty Appointment Availability Survey Denominator & Results by Provider Type

	2021 Denominator	2021 Routine Appointment Availability	2022 Denominator	2022 Routine Appointment Availability
Cardiology	111	73.0%	131	45.8%
Dermatology	67	25.4%	49	22.4%
Endocrinology	68	57.4%	63	30.0%
Gastroenterology	78	62.8%	82	28.0%

	2021 Denominator	2021 Routine Appointment Availability	2022 Denominator	2022 Routine Appointment Availability
General Surgery	82	68.3%	106	54.7%
Gynecology & Obstetrics	175	70.3%	183	55.7%
Hematology	39	38.5%	25	48.0%
HIV/Infectious Diseases	17	29.4%	14	64.3%
Nephrology	33	69.7%	53	47.1%
Neurology	92	51.1%	121	25.6%
Oncology	47	66.0%	111	72.1%
Ophthalmology	114	50.9%	121	62.0%
Orthopedics	94	57.4%	118	58.5%
Otolaryngology	35	45.7%	51	39.2%
Physical Medicine & Rehabilitation	14	50.0%	14	50.0%
Pulmonology	24	41.7%	19	47.4%
Total	**1,304**	**57.9%**	**1261**	**48.2%**

Activities

To improve performance, SFHP completed the activities listed below.

- Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
- Provide technical assistance with Corrective Action Plans.

Analysis

Quantitative

Performance decreased by 9.7% from the previous measurement year, thus not meeting the target.

Qualitative

SFHP faced a number of barriers providing timely access to care. Some barriers are more prevalent in safety net settings while others are specific to smaller practices with fewer resources to leverage.

Barriers include:

- Supply of providers – some provider groups' supply of appointments with providers is fixed due to resident and attending schedules or the number of part time providers working in a specific system or clinic.
- Variation in use of emerging appointment reminders, self-scheduling technology, and alternative visits – provider groups demonstrate uneven uptake or implementation of technologies such as telemedicine, electronic appointment reminders, and member self-scheduling. Provider groups also show uneven uptake of alternative visits such as nurse visits or group visits. Electronic tools are less optimized for low literacy or non-English speaking member and may require customizations or additional investments to fully leverage.
- Team based care – some clinics and health systems effectively utilize care team members to ensure good access while other settings may not be able to employ or as effectively utilize other licensed providers (e.g. health educator, pharmacist, behavioral health clinician).
- Electronic consult for specialty care – with the right technology in place, many consults can be managed without the need for a face-to-face visit. Different specialty care arrangements and coordination efforts as well as very recent changes in reimbursement options impact access to and timeliness of specialty care.
- Overall compliance rates for all SFHP's high volume gynecology providers decreased for routine appointments from 70.3% in 2021 to 55.7% in 2022.
- Social determinants of health – transportation, housing and employment related barriers can impact members' ability to make and keep appointments. Missed appointments that go unused can contribute poorer access.
- Barriers related to the planned activity of Corrective Action Plans:
    - In 2022, SFHP did not have sufficient staff resources follow-up on CAP closures and evidence. PAAS and CAP main responsibilities are now the responsibility of one staff member.
    - Larger medical groups like University of California San Francisco and San Francisco Health Network have their own methodology to assess appointment availability access and have grieved about the PAAS methodology. These medical groups submitted their own data to close findings where they found themselves to be compliant.

Recommendations

For the next evaluation period SFHP will retain this measure. The target for this revised measure will be set at 50.2%. Activities will include:

- Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
- Provide technical assistance with Corrective Action Plans.
- Provide funding to ZSFG Specialty Care providers to implement appointment access interventions.
- Incentivize ZSFG providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.

2.2 – 2.3 Cultural & Linguistic Services – Provider Data

Overview & Performance

Measure: Cultural & Linguistic Services: Provider Data					
Numerator Non-English Language	2,289	Non-English Language Baseline	23.9%	Final Performance Non-English Language	32.2%
Numerator Race or Ethnicity	113	Race or Ethnicity Baseline	2.5%	Final Performance Race or Ethnicity	1.6%
Denominator	7,100	Non-English Language Target	25.0%	Evaluation Year	2023
		Race or Ethnicity Target	5.0%		

The Cultural & Linguistic Services – Provider Data measure is in the Quality of Service & Access to Care domain. The goal of these measures is to ensure the organization's use provider data to determine the race/ethnicity of providers and languages spoken. SFHP chose the target of 25.0% for collecting provider non-English languages based on incremental improvement from 2022's 23.9% baseline and a target of 5.0% for provider race or ethnicity based on 2.5% absolute improvement from 2022.

Activities

SFHP completed the activities listed below:

- Collected information about providers' race/ethnicity identity and languages in which a provider is fluent when communicating about medical care via the credentialing process.
- Explored ways to collect practitioner race/ethnicity and practitioner language data.
- Published individual practitioner languages and race/ethnicities in the provider directory that is viewable to members.

Analysis

Quantitative

Data is based on provider information collected during the credentialling process. SFHP exceeded the 25.0% target for provider non-English languages with a final rate of 32.2%. SFHP did not meet the 5.0% target for collecting provider race/ethnicity data with a final rate of 1.6%.

Qualitative

The barrier to meeting the race/ethnicity data target is due to this information not being routinely collected through the credentialling process. SFHP collected 113 providers' race/ethnicity information via the providers' voluntary reporting. The number of credentialed clinicians who provided their race/ethnicity declined most likely due to providers leaving SFHP's network.

Recommendations

Due to meeting its goal, SFHP will discontinue the goal of collecting more data on non-English languages spoken by providers. To address the racial, ethnic, and cultural needs and preferences of our members, SFHP will continue the measure to collect race/ethnicity of individual practitioners with a target of 8.0%.

Activities to support this measure will include:

- Engage provider groups in collecting data from their clinicians.
- Conduct communication campaign to network providers to encourage providers to volunteer race and ethnicity information.
- Explore offering a provider incentive for collecting race and ethnicity information
- Integrate race and ethnicity data collection with credentialing data.

2.4 – 2.6 HP-CAHPS

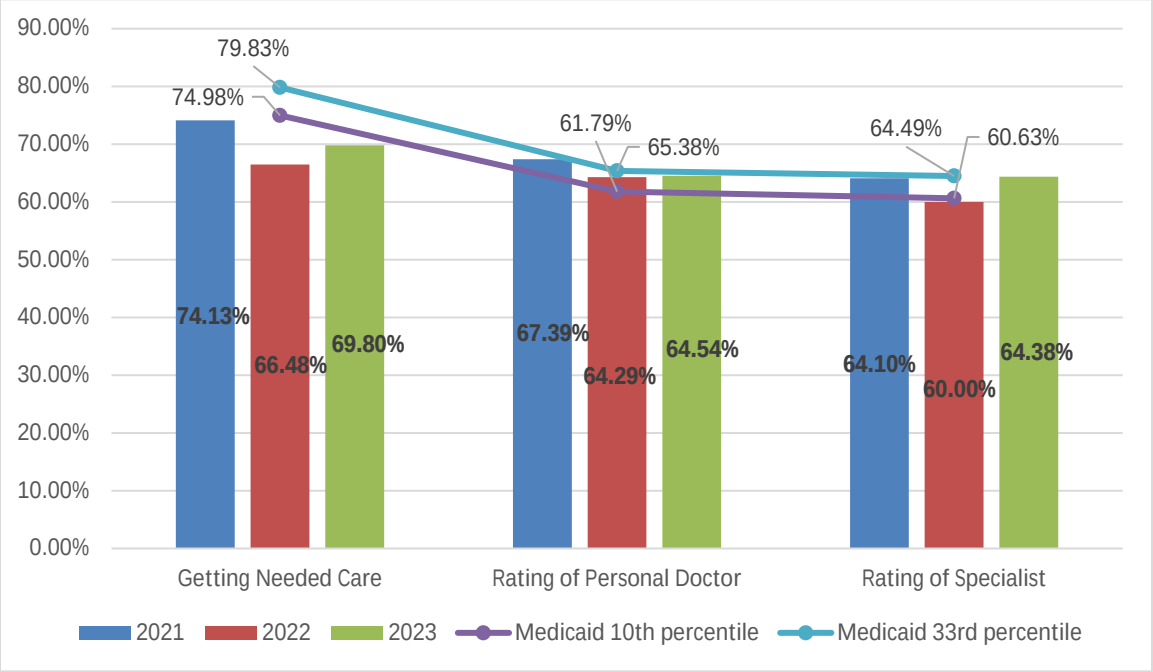
Overview & Performance

Measure: HP-CAHPS – Getting Needed Care					
Numerator	162	Baseline	66.48%	Final Performance	69.80%
Denominator	232	Target	68.48%	Evaluation Year	2023
Measure: HP-CAHPS – Rating of Personal Doctor					
Numerator	233	Baseline	64.29%	Final Performance	64.54%
Denominator	361	Target	66.86%	Evaluation Year	2023
Measure: HP-CAHPS – Rating of Specialist					
Numerator	94	Baseline	60.00%	Final Performance	64.38%
Denominator	146	Target	62.79%	Evaluation Year	2023

Getting Needed Care, Rating of Personal Doctor, and Rating of Specialists represent questions within the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) survey, which assesses member experience of care and is in the Quality of Service and Access to Care domain. HP-CAHPS performance is important to SFHP because 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.

HP-CAHPS – Getting Needed Care is the total number of members who responded to the Getting Needed Care composite responding with ‘usually’ or ‘always’ to the composite of two questions: “In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?” and “In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?”. SFHP set a target of 68.48% based on 2.0% absolute improvement from baseline. HP-CAHPS – Rating of Personal Doctor is the total number of members who responded to the Rating of Personal Doctor question responding with ‘9’ or ‘10’ to the question: “Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?”. HP-CAHPS – Rating of Specialist is the total number of members who responded to the Rating of Specialist question responding with ‘9’ or ‘10’ to the question: “We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?”. The following chart demonstrates the three-year trend in HP-CAHPS scores with comparison Medicaid percentile benchmarks.

HP-CAHPS Rating of Health Plan 2021 – 2023



Activities

The following activities were completed:

- Launched an organizational cross-functional work group to plan and implement member and provider-facing improvement projects involving assessments of members’ needs, identification of disparities in access to care and care experience, designing of member communication tools, and implementing interventions for the provider network.
- Identified provider network member experience champions and launched a CAHPS provider workgroup to develop shared goals, outline strategies and shared lessons learned on ways to improve SFHP member experience.

- SFHP's Marketing Team launched a digital ad campaign on website and social media channels educating and informing members on Access to Care, such as when and where to get care, who to contact, and average appointment wait times.
- Enhanced Care Management launched in 2022 as a new benefit for multiple member populations and provided mobile education events (online and in-person) to inform providers, members, and the community of the benefit, encouraged provider and self-referral; and collaborated with partners to streamline and simplify referral processes to track member-patient utilization and outcomes.
- The Grievance and Appeals department implemented a new weekly meeting with the Quality Review Nurses to discuss complex cases, work together to resolve grievances in a timely manner, discuss process improvement initiatives, and share best practices to solve system-related challenges around Access.
- Promoted response to the survey through member mailer for members with lower response rates: Black members and Spanish speaking members.

The following activities were not completed:

- Promote translation services and a process for Spanish-speaking members to connect with physicians and clinical leaders that speak Spanish.
- Implement member focus groups and a supplemental member experience survey to identify specific actions to drive improvement.

Analysis

Quantitative

- Getting Needed Care: Performance increased by 3.32% from the previous measurement year, exceeding the target. However, despite achieving the target, SFHP's Getting Needed Care composite score continued to perform below the 10th percentile compared to other Medicaid plans.
- Rating of Personal Doctor: Performance increased by 0.25% from the previous measurement year, not meeting the target. SFHP's Rating of Personal Doctor score achieved the Medicaid 10th percentile, missing the 33rd percentile by 0.84%.
- Rating of Specialist: Performance increased by 4.38% from the previous measurement year, exceeding the target. SFHP's Rating of Specialist score achieved the Medicaid 10th percentile, missing the 33rd percentile by 0.11%.

Qualitative

The main barriers to meeting the Rating of Personal Doctor target for this measure were:

- Members experience difficulty accessing primary care, in particular for those who do not have a PCP.
- The quality of interpreter services for members whose primary language is not English is not consistent in primary care or other care settings.
- Inability to schedule an appointment within a reasonable amount of time is a consistent issue.

Recommendations

SFHP will continue these three measures in 2024 with the following targets:

- Getting Needed Care – 72.80%
- Rating of Personal – 67.38%
- Rating of Specialist – 67.54%

Activities to support this measure will include:

- Implement three organizational initiatives to improve the member care experience which include interventions focused on access to primary and specialty care, telehealth, and members engaged in SFHP member-facing programs and services.
- Implement a telehealth initiative that increases awareness and utilization, with a focus on African Americans and Spanish-speaking members
- Incentivize providers through inclusion of a Rating of Personal Doctor measure in SFHP's primary care pay-for-performance program.
- Reduce gaps in care utilization through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting telehealth quality improvement activities for the measure for members who are Hispanic or Latino or Black or African American.
- Provide funding to ZSFG Specialty Care providers to implement appointment access interventions.
- Incentivize ZSFG providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.
- Collaborate with network providers who work in care experience to align priorities & strategy, and work on shared initiatives.
- Create a specialty referral guide by medical group for members.

3. Keeping Members Healthy

These are measures that improve clinical outcomes involving preventative care.

3.1 Breast Cancer Screening

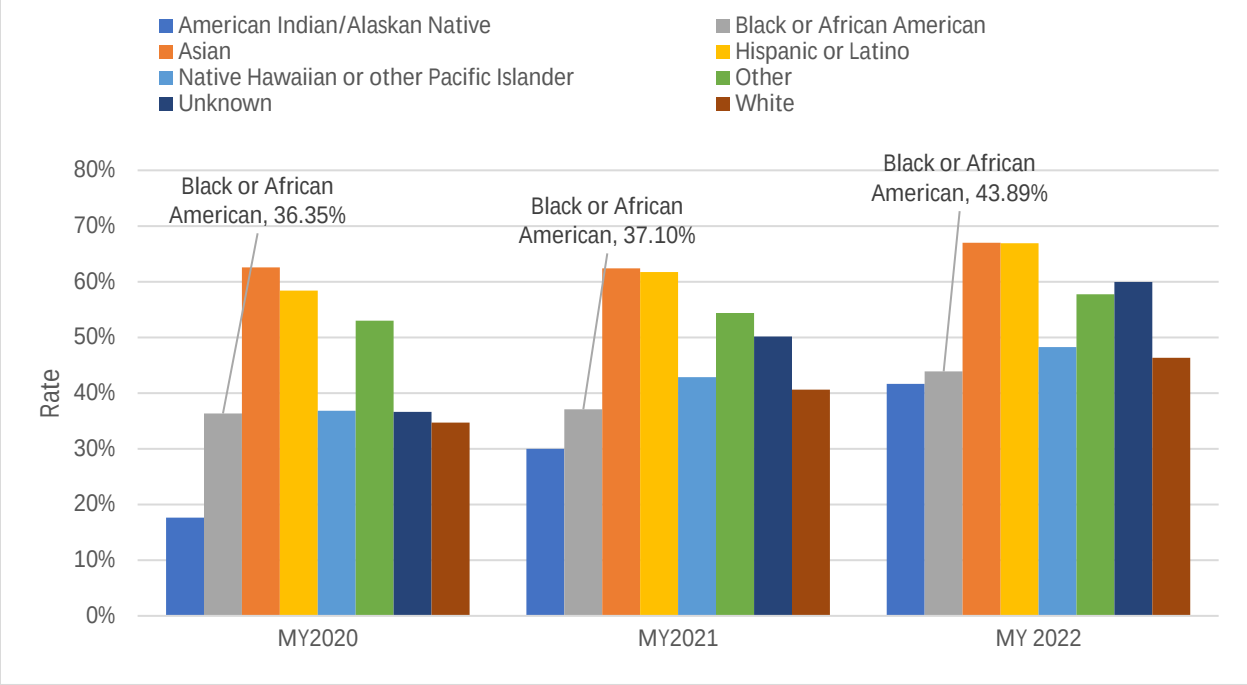
Overview & Performance

Measure: Breast Cancer Screening					
Numerator	370	Baseline	37.10%	Final Performance	43.89%
Denominator	843	Target	50.0%	Evaluation Year	2023

Breast Cancer Screening (BCS) is in the Keeping Members Healthy domain. The goal of the BCS measure is to improve the breast cancer screening rate for African American SFHP members. Breast Cancer Screening is the percentage of African American members with a female gender marker who are ages 52 – 74 during the measurement year who had a

mammogram to screen for breast cancer. The mammogram breast cancer screening visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the member. BCS is a preventative HEDIS measure and is important as it aids in reducing negative health outcomes for members whose cancer screening identifies positive results. The chart below shows SFHP's overall BCS rates for measurement years (MY) 2020 – 2023, SFHP's BCS rates broken down by race and ethnicity, and the denominators, or eligible members, in each race/ethnicity category. Overall, SFHP reached 55.99% in breast cancer screening in MY 2020, 56.72% in MY 2021, and 61.92% in MY 2022. SFHP chose the target of 50.0% for Black or African American members to receive BCS to demonstrate improvement toward SFHP's overall BCS rate toward the Medicaid 50th percentile benchmark of 50.95%.

HEDIS Breast Cancer Screening by Race & Ethnicity MY 2020 – 2023



Measurement Year	American Indian/ Alaskan Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian or Other Pacific Islander	Other Race	Unknown Race	White
Denominator MY 2020	17	4,460	619	630	19	1,462	101	530
Denominator MY 2021	20	5,401	814	938	28	2,311	299	694
Denominator MY 2022	25	5,692	843	1,191	28	886	2,222	743

Of women of race/ethnicities that are lower performing breast cancer screening rates, Black or African American and white women have the largest denominators 843 and 743, respectively.

The gaps represented in the BCS HEDIS indicator impact a large number of members; SFHP prioritized screening Black or African American members for BCS, as Black members represent

the largest population experiencing disparities in MY 2020—MY 2022 and according to the CDC, Black women have a higher rate of death from breast cancer than white women.

Activities

The following activities to support this measure were completed, including:

- Provided Health Education materials to Black/African American SFHP members.
- Provided member navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening.
- Incentivized providers through inclusion of breast cancer screening improvement indicator in SFHP's pay-for-performance program.

Analysis

Quantitative

The final rate is 43.89% of Black or African American members in the eligible population completing a mammogram to screen for breast cancer during the measurement year. This result is 6.11% below the target of 50.0% but does show an improvement of 6.79% over baseline.

Qualitative

While the measure did not meet the target in 2023, since this project began in 2020 there was an overall 7.73% increase for Black or African American members receiving Breast Cancer Screening. This change reflects the positive impact that care navigation had on this screening provided by the Rafiki Coalition. The primary barrier to reaching the target in 2023 is due to social determinants of health that prevented the measure from reaching its multi-year goal of 50%. Social determinants of health such as having stable housing, working phone, and ability to take time off from work, childcare, or other obligations may have had an impact on members being able to receive preventative care services like Breast Cancer Screening.

Recommendations

SFHP will not continue this measure in 2024 as the Breast Cancer Screening navigation project with the Rafiki Coalition ended in 2023. In 2024, SFHP will continue to work on Health Equity related measures and activities that align with quality workplan measures that are lower performing such as postpartum care screening and well-child visits

3.2 Well Child Visits in the First 15 Months

Overview & Performance

Measure: Well Child Visits in the First 15 Months					
Numerator	469	Baseline	41.63%	Final Performance	49.11%
Denominator	955	Target	55.72%	Evaluation Year	2023

The Well Child Visits in the First 15 Months measure is in the Keeping Members Healthy domain. This measure calculates the percentage of SFHP members age zero to 15 months who receive six well-child visits out of the total number of SFHP members age zero to 15 months. This measure allows SFHP to improve child health and engagement with a primary care

practitioner. SFHP chose a target of 55.72%. This target was chosen based on the Medicaid 50th percentile benchmark and represents significant improvement from SFHP's baseline rate of 41.63% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Promoted well-child visits for members age zero to 15 months through a member incentive gift card.
- Partnered with local community-based organizations including the Office of Early Childhood to pilot a Well Child screening program to educate members and facilitate connection to care.
- Incentivized providers through inclusion of well-child screening improvement indicator in SFHP's pay-for-performance program.

Analysis

Quantitative

The final result of 49.11% did not meet the target of 55.72%, falling short by 6.61%. However, SFHP did improve over the baseline rate by 7.48%. This measure achieved the Medicaid 10th percentile.

Qualitative

The main barriers to meeting the target for this measure were:

- New education materials need a lot of time to produce.
- Parents don't know when to bring kids in for well checks.
- Clinics don't have adequate capacity for well child visits.

Recommendations

SFHP will continue this measure in 2024 with a target of 58.38% and activities to support this measure will include:

- CM team to contact members with three or four out of the required six visits to coordinate their remaining PCP visits.
- Complete Maternal Child Health gap analysis.
- Promote and encourage members aged zero to 15 months to engage in services through a member incentive to obtain well-child visits.
- Collaborate with SF Department of Public Health and other health plans on coordinated effort to improve measure.
- Incentivize providers through inclusion of a well-child visit in the first 15 months of life measure in SFHP's primary care pay-for-performance program.

3.3 Well Child Visits in the First 15—30 Months

Overview & Performance

Measure: Well Child Visits in the First 15—30 Months					
Numerator	1,296	Baseline	69.33%	Final Performance	75.97%
Denominator	1,706	Target	72.24%	Evaluation Year	2023

The Well Child Visits in the First 15—30 Months measure is in the Keeping Members Healthy domain. This measure calculates the percentage of SFHP members age 15 to 30 months who receive six well-child visits out of the total number of SFHP members age 15 to 30 months. This measure allows SFHP to improve child health and engagement with a primary care practitioner. SFHP chose a target of 72.24%. This target was chosen based on the Medicaid 75th percentile benchmark and represents incremental improvement from SFHP's baseline rate of 69.33% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Partnered with local community-based organizations including the Office of Early Childhood to pilot a Well Child screening program to educate members and facilitate connection to care.
- Incentivized providers through inclusion of well-child screening improvement indicator in SFHP's pay-for-performance program.

Analysis

Quantitative

The final result of 75.97% met the target of 72.24%, exceeding it by 3.73%.

Recommendations

SFHP will continue this measure in 2024 with a target of 77.78% and activities to support this measure will include:

- CM team to contact members with three or four out of the required six visits to coordinate their remaining PCP visits.
- Complete Maternal Child Health gap analysis.
- Promote and encourage members aged zero to 15 months to engage in services through a member incentive to obtain well-child visits.
- Collaborate with SF Department of Public Health and other health plans on coordinated effort to improve measure.
- Incentivize providers through inclusion of a well-child visit in the first 15 months of life measure in SFHP's primary care pay-for-performance program.

4. Patient Safety or Outcomes Across Settings

These are measures that improve clinical outcomes related to safety. Patient safety prevents adverse health outcomes, such as death or poor quality of life.

4.1 Opioid Safety – Buprenorphine Prescription

Overview & Performance

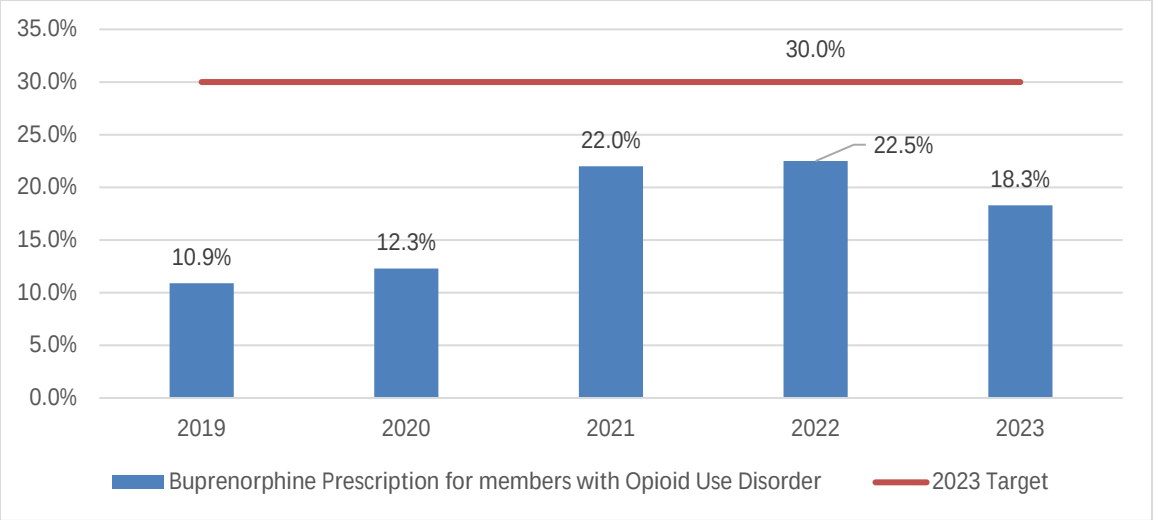
Measure: Opioid Safety – Buprenorphine Prescription					
Numerator	368	Baseline	22.5%	Final Performance	18.30%
Denominator	2,011	Target	30.0%	Evaluation Year	2023

The Opioid Safety – Buprenorphine Prescription measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members with Opioid Use Disorder (OUD) with at least one buprenorphine prescription in the last year, out of the total number of SFHP members with OUD. SFHP works to reduce the risk of overdose and address the psychological and physical impact of Opioid Use Disorder. Promoting the use of Buprenorphine in this population helps reduce the risk of overdose and death.

OUD is a pattern of opioid use which includes behaviors such as: craving, withdrawal, tolerance, continued use despite medical or social consequences, using opioids in hazardous situations, and taking opioids at higher doses or for a longer period than intended. Members are considered for the denominator of this measure if they have ever had a diagnosis of OUD or an encounter for an opioid overdose. This broad definition has been implemented to ensure that all members who might be candidates for buprenorphine therapy are considered. The target of 30.0% was chosen based on absolute improvement from an erroneous baseline rate of 28.6%. During 2023 the baseline was re-calculated to be 22.6%.-

Medication-Assisted Treatment (MAT) is the treatment of substance use disorder with medications in combination with counseling. MAT options to treat OUD include buprenorphine, methadone, and naltrexone. These medications can be taken for a short time or continued indefinitely. The goal of treatment is to reduce the risk of overdose, eliminate the use of illicit opioids, and to provide the member with strategies to address their mental and physical health needs. The following chart demonstrates the five-year trend in SFHP's buprenorphine prescriptions.

Rate of Buprenorphine Prescriptions 2019 – 2023



Activities

The following activities were completed:

- Monitored buprenorphine adherence using the repository.
- Disseminated educational material to members on Medication Assisted Therapy options.

The following activities were not completed:

- Collaboration with methadone clinic providers in order to better support the use of Medication Assisted Therapy.
- Outreach to providers and members with buprenorphine single fills.

The activities were that were not completed were postponed due to competing priorities within SFHP and staffing resources.

Analysis

Quantitative

The final result is 18.3%, which did not meet SFHP's target of 30.0% by 11.7%.

Qualitative

The main barriers to achieving the target for this measure were:

- Erroneous baseline data during measure planning.
- Staffing limitations in SFHP's Pharmacy Operations team.
- Social determinants of health such as having stable housing, working phone for providers to connect to members, and ability to engage in OUD treatment may have had an impact on the measure reaching the target.

Recommendations

SFHP will not continue this measure in 2024 because of Pharmacy staffing limitations. SFHP will continue to monitor opioid safety.

4.2 Opioid Safety – High Dose Opioids

Overview & Performance

Measure: Opioid Safety – High Dose Opioids					
Numerator	157	Baseline	5.2%	Final Performance	4.5%
Denominator	3,465	Target	4.0%	Evaluation Year	2023

The Opioid Safety – High Dose Opioids measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members with an opioid prescription prescribed between 120-500 morphine milligram equivalents for at least one quarter in the last year who do not have a buprenorphine prescription in that quarter, out of the total number of SFHP members prescribed opioids. This measure allows SFHP to evaluate members at high risk for negative outcomes related to central nervous system depression such as overdose, coma, and death. SFHP originally chose the target of 4.0% or lower in order to reduce the percentage of members who have been prescribed high dose opioids. This target was chosen as a 0.8% absolute improvement from an erroneous baseline rate of 4.8%. The correct baseline for the period was 5.2%.

Activities

The following activities were completed:

- Collaborated with mental health and substance use specialist providers to create and distribute provider information on buprenorphine prescribing.
- Partnered with Medi-Cal Rx to facilitate member reduction of opioid prescriptions.

Analysis

Quantitative

The final result is 4.5%, which did not meet SFHP's original target of 4.0% by 0.5%. However, since the new baseline was recalculated to be 5.2%, the measure was reduced by 1.7% which surpassed the original goal of a 0.8% reduction.

Qualitative

The main barriers to achieving the target for this measure were:

- Erroneous baseline data during measure planning
- Staffing limitations in SFHP's Pharmacy Operations team.
- Social determinants of health such as having stable housing, working phone for providers to connect to members, and ability to address pain management issues may have had an impact on the measure reaching the target.

Recommendations

SFHP will not continue this measure in 2024 because of Pharmacy staffing limitations. SFHP will continue to monitor opioid safety.

4.3 Medication Therapy Management

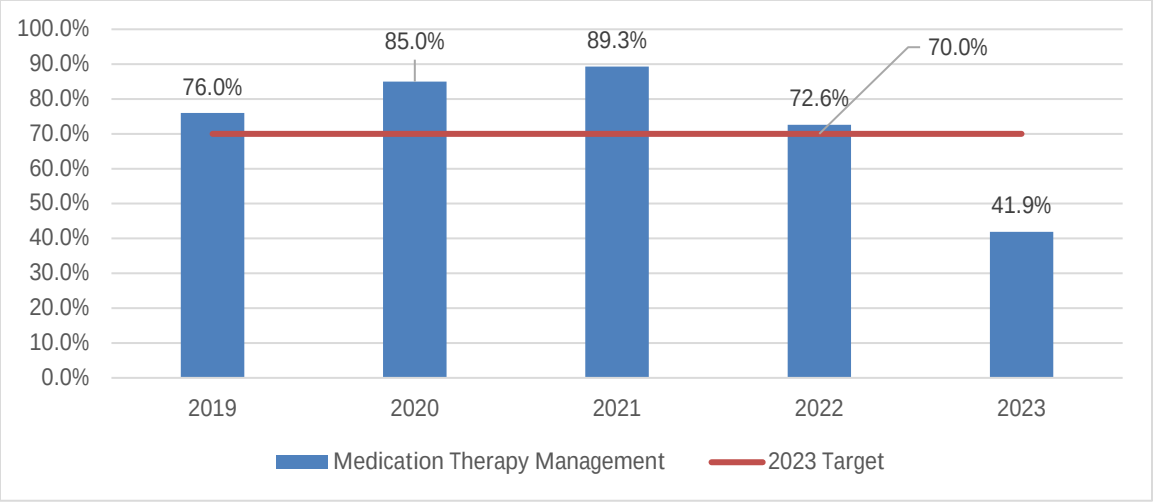
Overview & Performance

Measure: Medication Therapy Management					
Numerator	18	Baseline	72.6%	Final Performance	41.9%
Denominator	43	Target	70.0%	Evaluation Year	2023

The Medication Therapy Management (MTM) measure is in the Patient Safety or Outcomes Across Settings domain. MTM is a process of medication reconciliation, that consists of a clinical assessment by a pharmacist of all the medications a member is taking, identification of potential harmful medication issues, recommendations to optimize the medication regimen, and providing medication-related education and advice to the member and provider. This intervention improves medication safety among members with chronic diseases.

The 2023 MTM rate is calculated by the number of initial medication reconciliation completed by a pharmacist out of the number of members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation. The MTM target of 70.0% is based on results using the 2022 MTM measure's final performance of 72.6%. The following chart demonstrates the five-year trend in MTM.

Rate of Medication Therapy Management 2019 – 2023



Activities

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

- Monitored the pharmacist resource requirements needed to support the population of members engaged in Care Management.
- Assessed for additional efficiencies in workflow and member assessment configurations.
- Continued reviewing members in the initial assessment process which recommends a Medication Therapy Management assessment and establish the denominator population for this measure.

- Expanded Medication Therapy Management to include members not engaged in Care Management. These members may include those with multiple providers, with ten or more prescriptions, and/or members utilizing multiple pharmacies.

Analysis

Quantitative

The final result of 41.9% did not meet the target of 70.0%.

Qualitative

Access to care barriers have remained prevalent since COVID-19 that includes longer than one month time to get a preventive service appointment that likely affected the rate of provider visits within 30 days during Cohort 1. An action plan was SFHP promoted telehealth as an option for members to increase primary care access.

An additional barrier to filling prescriptions happened when pharmacies temporarily closed due to vandalism or permanently closed. In January 2022, a major change also took place when the pharmacy benefit was carved out to Medi-Cal Rx. This transition caused processing delays and confusion for members who were filling prescriptions. An action plan included sending information to members, providers and pharmacies regarding Medi-Cal Rx transition and staff to help coordinate care for members who had trouble receiving medications at the pharmacy. The rate from Cohort 1 to Cohort 2 demonstrated a 6.7% change showing an effective trend with the interventions.

All members receiving MTM services during Cohort 1 and 2 are referred by the Care Management team. An action plan for Cohort 3 period was to expand the MTM services to include members who were not engaged in Care Management that would benefit from having a medication review by a pharmacist. In November 2022, Medication Adherence Program (MAP) started to complete MTM services for members who are noncompliant to HEDIS (Healthcare Effectiveness Data and Information Set) measures. For the first phase of MAP, the targeted HEDIS measure is Asthma Medication Ratio (AMR) of less than 0.5. A pharmacist often contacts the member directly regarding medication interventions that do not warrant a visit for the member to the provider (i.e., adherence issues, questions on how to use inhalers, etc.). Since Cohort 3 did not meet the benchmark goal – a reasonable quality improvement is to review the changes in program type and best ways to support members and medications.

Recommendations

SFHP will not continue this measure to focus on other QI and health equity priorities. SFHP will continue to provide Medication Therapy Management to members.

4.4 Follow up After Emergency Department for Substance Use

Overview & Performance

Measure: Follow up After Emergency Department for Substance Use					
Numerator	495	Baseline	9.90%	Final Performance	22.30%
Denominator	2,220	Target	21.24%	Evaluation Year	2023

The Follow up After Emergency Department for Substance Use measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days after ED visit, out of the total number of SFHP members who had an ED visit with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence.

Timely follow-up care for individuals who were seen in an emergency department for a substance use disorder is associated with reduced hospital use and increased treatment adherence. Coordination of care for such individuals requires information-sharing between hospitals and primary care providers that may not occur under existing/standard workflows.

SFHP chose a target of 21.24%. This target was chosen based on the Medicaid 50th percentile benchmark and to demonstrate significant improvement from SFHP's baseline rate of 9.9% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Collaborated with SF County Behavioral Health Services and ZSFG's Addiction Care Team to coordinate follow-up care.
- Collaborated with Carelon on activities and interventions including service promotion, in-services for providers, member outreach, county engagement, and case management.
- Provided Prop 56 funding to segments of the provider network to integrate medical mental health, and substance use services.

Analysis

Quantitative

The final result of 22.30% exceeded the target of 21.24% by 1.06%. This represents an improvement over the baseline rate of 12.4%. The final rate achieved the Medicaid 50th percentile.

Recommendations

SFHP will continue this measure in 2024 with a target of 36.34% and activities to support this measure will include:

- ED member navigators provide motivational interviewing and referral to members' Enhanced Care Management provider or PCP for follow-up visit.
- Incentivize providers through inclusion of a Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence within 30 days measure in SFHP's primary care pay-for-performance program.

4.5 Follow up After Emergency Department for Mental Health

Overview & Performance

Measure: Follow up After Emergency Department for Mental Health					
Numerator	641	Baseline	12.18%	Final Performance	52.80%
Denominator	1,214	Target	54.51%	Evaluation Year	2023

The Follow up After Emergency Department for Mental Health measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members (aged 6 and older) who received a follow-up visit for mental illness within 7 days of an emergency department visit with a diagnosis of mental illness or intentional self-harm out of the total number of SFHP members who had an ED visit with a diagnosis of mental illness or intentional self-harm out.

Timely follow-up care for individuals who were seen in an emergency department for a mental health is associated with reduced hospital use and increased treatment adherence. Coordination of care for such individuals requires information-sharing between hospitals and primary care providers that may not occur under existing/standard workflows.

SFHP chose a target of 54.51%. This target was chosen based on the Medicaid 50th percentile benchmark and to demonstrate significant improvement from SFHP's baseline rate of 12.18% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Collaborated with Carelon on activities and interventions including service promotion, in-services for providers, member outreach, county engagement, and case management.
- Provided Prop 56 funding to segments of the provider network to integrate medical mental health, and substance use services.

Analysis

Quantitative

The final result of 52.8% did not meet the target of 54.51%, falling short by 1.71%. However, we did improve over the baseline rate by 40.62%.

Qualitative

The main barriers to meeting the target for this measure were:

- Behavioral health system care management system does not capture outpatient visits in claims/encounter format that can be counted towards HEDIS data.
- Member outreach is very difficult for this patient population due to unreliability of contact information and difficulty to reach by phone.

- Medi-Cal coverage dictates that services for serious mental illness and substance use treatment should occur via SF County Behavioral Health Services, which doesn't share encounter data, complicating coordination efforts for appropriate primary care follow-up.

Recommendations

SFHP will continue this measure in 2024 with a target of 54.87% and activities to support this measure will include:

- ED member navigators provide motivational interviewing and referral to members' Enhanced Care Management provider or PCP for follow-up visit.
- Incentivize providers through inclusion of a Follow-up After ED Visit for Mental Illness measure within 30 days in SFHP's primary care pay-for-performance program.

4.6 SFHN All Cause Readmission

Overview & Performance

Measure: SFHN All Cause Readmission					
Numerator	218	Baseline	16.50%	Final Performance	10.59%
Denominator	2,058	Target	13.50%	Evaluation Year	2023

The SFHN All Cause Readmission measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of acute inpatient and observation stays for members 18 years of age and older in the SFHN network that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, out of the total number of acute inpatient and observation stays for members.

Members discharged from the hospital are at risk of readmission if they do not receive sufficient planning and coordination during discharge. Follow up care with a PCP can reduce the chance of readmission, but PCPs do not receive timely information about a member's discharge and the need to schedule a follow up appointment. In order to ensure that the member's needs are met and reduce the risk of hospital readmission, SFHP's Concurrent Review team supplements the hospital's discharge planning by aiming to identify members at high risk for readmission and to partner with the hospital care team to ensure linkage to their PCP and other community resources prior to discharge. The quality of coordination and discharge planning is essential in order to achieve positive health outcomes for members who have been hospitalized. This is particularly critical for members who have complex health needs and high utilizers of emergency and hospital services that should be managed preventatively.

SFHP chose a target of 13.5% or lower in order to reduce the percentage of members experiencing preventable readmissions. This target was chosen as a 3.0% absolute improvement from SFHP's baseline rate of 16.5%.

Activities

The following activities were completed:

- Incentivized providers through inclusion of follow-up after hospital discharge improvement indicator in SFHP's pay-for-performance program.

The following activities were not completed:

- SFHP nursing staff to conduct discharge planning including coordinating aspects of member care including coordination and communication of members' PCP follow-up appointment and following up with the member to review the discharge instructions and ensure a follow up appointment is made prior to discharge.

While CCR Nurses continue to do Discharge Planning (DCP) assessments, provide discharge summaries to in-network PCPs and aid hospital staff to facilitate safe discharges, they stopped doing pre/post-discharge calls to members in Nov. 2022 due to resource constraints, increased workload volume and competing regulatory initiatives. New transitions of care expectations were released in the LTC APL in January 2023 stating MCPs must provide "strengthened transitions care services" in which SFHP chose to target members at high risk for readmission discharging from skilled nursing facilities (SNFs). From this the Post-Acute Care Transitions (PACT) program was implemented in March 2023 which was a team of 2 CT Navigators who reviewed all SNF admissions, made connections to ECM or other community CM programs as applicable or sought to engage members themselves and follow them throughout their stay, ensuring they had a solid DCP.

Analysis

Quantitative

The final result of 10.59% exceeded the target reduction to 13.5% by 2.91%. This represents an improvement over the baseline rate of 5.91%.

Recommendations

SFHP will not continue this measure in 2024. Plan activities addressing the reduction of readmission are being launched in early 2024 by the Care Transitions team; SFHP will consider these activities in the planning of QI and health equity measures in future measures.

5. Managing Members with Emerging Risk

These are measures that that improve clinical outcomes related to members with chronic conditions or emerging conditions.

5.1 Asthma Medication Ratio

Overview & Performance

Measure: Asthma Medication Ratio					
Numerator	433	Baseline	55.47%	Final Performance	55.30%
Denominator	783	Target	59.94%	Evaluation Year	2023

The Asthma Medication Ratio measure is in the Managing Members with Emerging Risk domain. This measure calculates the percentage of SFHP members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total

asthma medications of 0.50 out of the total number of SFHP members who were identified as having persistent asthma. SFHP chose a target of 59.94%. This target was chosen based on the Medicaid 25th percentile benchmark and to represent incremental improvement from SFHP's baseline rate of 55.47%.

Activities

The planned activities were completed:

- Informed providers of the identified at-risk populations.
- Updated member education for members with asthma, integrating the newest guidelines.
- Hosted a training with SFHP Care Management staff focused on asthma treatment and place in therapy of rescue versus maintenance inhalers.
- Enrolled eligible and at-risk members Comprehensive Care Management (CCM) or Enhanced Care Management (ECM), or Medication Therapy Management (MTM).

Analysis

Quantitative

SFHP did not meet the target of 59.94%, missing it by 4.64% with a final result of 55.3% which remained in the 10th Medicaid percentile.

Qualitative

The main barriers to reaching the target were:

- Staffing limitations in SFHP's Pharmacy Operations team.
- Restrictions on recognized and approved generic inhalers.
- Auto-refill policies at pharmacy chains.

Recommendations

SFHP will continue this measure in 2024 with a target of 69.41%. Activities to support this measure will include:

- Collaborate with provider groups with most opportunity for improvement.
- Communicate updated asthma guidelines with providers and pharmacies.
- Incentivize providers through inclusion of an Asthma Medication Ratio measure in SFHP's primary care pay-for-performance program.
- Promote and encourage members with asthma to engage in services through a Chronic Condition incentive.

5.2 Hepatitis C Treatment

Overview & Performance

Measure: Hepatitis C Treatment					
Numerator	1,772	Baseline	37.00%	Final Performance	35.97%
Denominator	4,926	Target	40.00%	Evaluation Year	2023

The Hepatitis C Treatment measure is in the Managing Members with Emerging Risk domain. This 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. The measure benefits members because treatment can prevent the spread of Hepatitis C disease and lowers the risk of liver disease. The target of 40.0% was selected based on incremental improvement from 2022 final performance.

Activities

The planned activities were completed:

- Used reporting to develop a profile (age, ethnicity, gender, location) for members not yet treated for Hepatitis C.
- Outreached to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.
- Continued to provide treatment support through SFHP's Care Management programs.
- Worked with local community group EndHepC to receive feedback from SFHP clinicians providing Hepatitis C care and treatment.

Analysis

Quantitative

SFHP did not meet the target of 40.00%, missing it by 4.03% with a final result of 35.97%.

Qualitative

Barriers to reaching the target included:

- Staffing limitations in SFHP's Pharmacy Operations team.
- Social determinants of health such as having stable housing, working phone for providers to connect to members, and ability to complete the long course of treatment may have had an impact on the measure reaching the target.

Recommendations

SFHP will continue this measure in 2024. The target will remain 40.0% and activities to support this measure will include:

- Collaborate with End Hep C group on provider education.
- Create outreach letter template for providers with members who need to complete Hepatitis C treatment to assist in coordination of care.
- Provide analysis and trends on members who have not completed Hepatitis C treatment to providers.

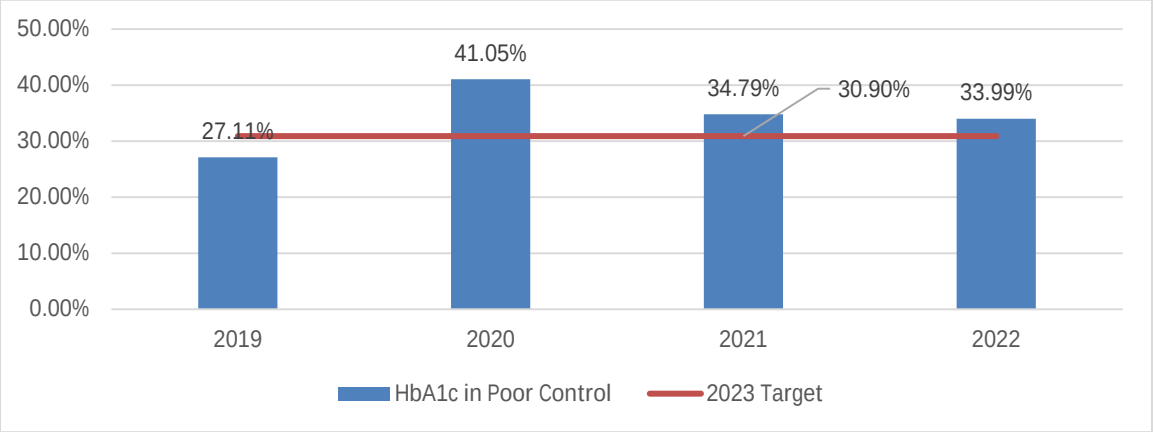
5.3 Diabetes Care – HbA1c in Poor Control

Overview & Performance

Measure: Diabetes Care – HbA1c in Poor Control					
Numerator	139	Baseline	34.79%	Final Performance	33.99%
Denominator	409	Target	30.9%	Evaluation Year	2023

The Diabetes Care – HbA1c in Poor Control measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of SFHP members with who are age 18 – 75 who have their most recent HbA1c level greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Members with diabetes who have 9.0% or greater can indicate chronically blood glucose and can result in negative health outcomes such as vascular damage. SFHP chose the target of 30.9% based on achieving the 90th percentile among Medicaid plans. The following chart demonstrates the four-year trend in the rate of members with HbA1c in poor control.

Rate of Diabetes Care – HbA1c in Poor Control MY 2019 – 2022



Activities

The planned activities were completed:

- Enrolled members with diabetes into the Medically Tailored Meals program administered by Project Open Hand.
- Conducted Drug Utilization Review with members with diabetes prescribed multiple diabetes medications.
- Incentivized providers through inclusion of controlling diabetes improvement indicator in SFHP's pay-for-performance program.

SFHP began providing incentives for members with chronic conditions in 2023 but was interrupted by a ransomware attack on our vendor for distributing the incentive gift cards, resulting in most incentives being promoted in the latter half of 2023.

Analysis

Quantitative

SFHP did not meet the target of 30.9%, missing it by 3.09% with a final result of 33.99%. This result achieves the 75th percentile compared to Medicaid plans nationwide.

Qualitative

A barrier to reaching the target included not incentivizing members with diabetes to visit their provider for screening due to the vendor ransomware attack.

Recommendations

SFHP will not continue this measure in 2024 due to shifting focus to other QI and health equity priorities that are lower performing. SFHP will continue to promote screening to members with Diabetes through a chronic condition incentive in 2024.

5.4 Diabetes Care – Eye Exam

Overview & Performance

Measure: Diabetes Care – Eye Exam					
Numerator	248	Baseline	54.50%	Final Performance	60.64%
Denominator	409	Target	56.51%	Evaluation Year	2023

The Diabetes Care – Eye Exam measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of SFHP members who are age 18 – 75 with diabetes who have had a retinal eye exam, out of the total number of members with diabetes. SFHP chose the target of 56.51% based on national HEDIS benchmarks. Increasing eye exams for SFHP's members who have diabetes would place SFHP in the 75th percentile of plans for this measure.

Diabetic retinopathy is the leading cause of preventable vision loss and blindness in people ages 18 to 64 years old. Around 50% of people with diabetes do not get their eyes examined or are diagnosed too late for effective treatment. Annual eye exams play a crucial role in the early detection, intervention, and prevention of eye disease and vision loss caused by diabetes. Early detection, timely treatment, and appropriate follow-up care can reduce a person's risk for severe vision loss by 95%. However, a commonly cited referral barrier between PCPs and eye care providers (ECPs) is patients' difficulty or lack of incentive to schedule an eye care appointment.

SFHP members between the ages of 18 to 75 with diabetes should be getting a retinal eye exam annually. However, HEDIS rates show that there is an opportunity to improve follow-up care for members who are due for their eye exam. Referral barriers between a PCP and ECP can result in a member missing their annual vision checkup. Additionally, providers may miss opportunities to remind their patients with diabetes about the signs of eye problems and the importance of scheduling an eye care appointment.

Activities

The planned activities were completed:

- Promoted screening and care visits for members with diabetes through a member incentive gift card.
- Enrolled members with diabetes into the Medically Tailored Meals program administered by Project Open Hand.
- Conducted Drug Utilization Review with members with diabetes prescribed multiple diabetes medications.

Analysis

Quantitative

SFHP met the target of 54.5%, exceeding it by 4.13% with a final result of 60.64%. This result achieves the 75th percentile compared to other Medicaid plans.

Recommendations

SFHP will not continue this measure in 2024 due to shifting focus to other QI and health equity priorities that are lower performing. SFHP will continue to promote screening to members with Diabetes through a chronic condition incentive in 2024.

5.5 Project Open Hand Member Satisfaction

Overview & Performance

Measure: Project Open Hand Member Satisfaction					
Numerator	170	Baseline	95.7%	Final Performance	89.01%
Denominator	191	Target	96.00%	Evaluation Year	2023

The Project Open Hand (POH) Member Satisfaction measure is in the Managing Members with Emerging Risk domain. SFHP partners with POH to provide medically tailored meals and medically tailored groceries to members with chronic conditions, including members with diabetes and pre-diabetes, chronic kidney disease, end stage renal disease, long Covid, acute hospital discharge requiring nutritional support, and members with other complex chronic conditions needing nutritional support. Those who are eligible and enrolled into the program will receive 12—26 weeks of medically tailored meals or medically tailored groceries in addition to four medical nutrition therapy sessions with a registered dietician. Members who complete their 12–26-week program have the option to continue in the program.

The rate for this measure is determined by the number of members with diabetes and pre-diabetes, chronic kidney disease, end stage renal disease, long Covid, acute hospital discharge requiring nutritional support, and members with other complex chronic conditions needing nutritional support enrolled in the POH program who complete the Project Open Hand client survey and rate the program helpful. Members who receive healthy food through medically tailored meals and groceries can aid in the management of diabetes. SFHP chose a target of 96% to demonstrate incremental improvement towards achieving high satisfaction and helpfulness with the program.

Activities

The following activities were completed:

- The POH program enrolled participants who received medically tailored meals or groceries depending on their preference and received medical nutrition therapy sessions with a dietician.
- SFHP received 191 satisfaction surveys for members who completed their 12–26-week program.

Analysis

Quantitative

SFHP did not meet the target of 96.00%, falling short by 6.99% with a final performance of 89.01%.

Qualitative

Recommendations

SFHP will not continue this measure in 2024. In 2023 Medically Tailored Meals became a Community Support funded by SFHP which will continue to provide meals and groceries to eligible members. In 2024 SFHP quality staff will work to create evaluation measures for Community Support services such as Medically Tailored Meals.

5.6 Prenatal Care for Black & Native American Members

Overview & Performance

Measure: Prenatal Care for Black & Native American Members					
Numerator	16	Baseline	92.86%	Final Performance	88.89%
Denominator	18	Target	95.86%	Evaluation Year	2023

The Prenatal Care for Black & Native American Members measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of birthing SFHP members who are Black or Native American who have received a prenatal care visit in the first trimester or within 42 days of enrollment with SFHP, out of the total number of birthing SFHP members who are Black or Native American. SFHP chose the target of 95.86% based on 3.00% absolute improvement from the previous measurement year .

Activities

The following planned activities were completed:

- Enrolled and credentialed 10 doulas that represent SFHP’s diverse population
- Incentivized perinatal visits through a member incentive gift card.
- Promoted prenatal care visits through a reproductive health mail campaign.
- Developed provider incentive in SFHP’s Pay for Performance (P4P) Program, PIP, to encourage increase in maternity care visits and share data.

The following activities were not completed:

- Conduct mail campaign to African American and Native American female identifying members ages 18-45 to encourage them to ask their PCP to submit a recommendation for a doula on their behalf.
- Operationalize Comprehensive Perinatal Services through development of a plan program charter.

The activities that were not completed were due to SFHP staffing issues and ransomware issues with SFHP's mailer vendor KP. Between April and June 2023, all member facing mailers was placed on hold. For doula services, members are no longer required to request a recommendation from their provider. SFHP has issued a standing order for the doula benefit.

Analysis

Quantitative

SFHP did not meet the target of 95.86%, falling short by 5.79% with a final result of 88.89%. This result aligns with achieving the 75th percentile compared to other Medicaid plans. As a whole population, SFHP also achieved the 75th percentile for timely prenatal care with a result of 89.67%.

Qualitative

The main barriers to reaching the target were:

- Lack of population health management staffing resources to conduct activities to support the improvement of this measure
- The mailing vendor ransomware attack which delayed incentive mailers and communication to members about the incentive and the doula benefit.

Recommendations

SFHP will not continue this measure in 2024 and instead focus on postpartum care. SFHP will continue to provide member incentives to receive prenatal care and will continue to include provider incentive to improve prenatal care in SFHP's Pay for Performance (P4P) Program.

5.7 Postpartum Care for Black & Native American Members

Overview & Performance

Measure: Postpartum Care for Black & Native American Members					
Numerator	16	Baseline	57.14%	Final Performance	88.89%
Denominator	18	Target	60.14%	Evaluation Year	2023

The Postpartum Care for Black & Native American Members measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of birthing SFHP members who are Black or Native American who have received a postpartum care visit between seven and 84 days after delivery, out of the total number of birthing SFHP members who are Black or Native American. SFHP chose the target of 60.14% based on 3.0% absolute improvement from the previous year's performance of 57.14%.

Activities

The following planned activities were completed:

- Enrolled and credentialed 10 doulas that represent SFHP's diverse population.
- Incentivized perinatal visits through a member incentive gift card.
- Promoted postpartum care visits through a reproductive health mail campaign.
- Operationalized Comprehensive Perinatal Services through development of a plan program charter.

The following activities were not completed:

- Develop provider incentive in SFHP's Pay for Performance (P4P) Program, PIP, to encourage increase in maternity care visits and share data.
- Conduct mail campaign to African American and Native American female identifying members ages 18-45 to encourage them to ask their PCP to submit a recommendation for a doula on their behalf.

The mail campaign activity that was not completed was due to SFHP staffing issues and ransomware issues with SFHP's mailer vendor KP. Between April and June 2023, all member facing mailers was placed on hold. For doula services, members are no longer required to request a recommendation from their provider. SFHP has issued a standing order for the doula benefit. SFHP did not include postpartum care in SFHP's Pay for Performance (P4P) Program, choosing to prioritize timely prenatal care as a P4P measure.

Analysis

Quantitative

SFHP met the target of 60.14%, exceeding it by 28.75% with a final result of 88.89%. This result aligns with achieving the 95th percentile compared to other Medicaid plans. As a whole population, SFHP also achieved the 05th percentile for timely prenatal care with a result of 92.39%.

Recommendations

SFHP will adjust this measure in 2024 to focus on the entire SFHP member population and will implement targeted equity interventions for Black or African American, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native members. The target will be 84.59% to align with the 90th percentile for the PPC-Postpartum Care HEDIS measure and activities to support this measure will include:

- Ensure a diverse and inclusive environment with a network of doulas and community health workers that can support all members engaging in perinatal care and connecting with plan benefits and services.
- Promote and encourage pregnant members to engage in services through a member incentive for both prenatal and postpartum visit.
- Incentivize providers through inclusion of a prenatal visit measure in SFHP's primary care pay-for-performance program.

Equity focused interventions for Black or African American, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native members will include:

- Build an outreach program using a diverse group of staff to reach out to at-risk persons who are less likely to engage in preventive care. Refer to community health workers and doulas for support and intervention.
- Incentivize providers through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting perinatal quality improvement activities for the measure for members who are Hispanic or Latino, Black or African American, Native American or Other Pacific Islander, and/or Asian/Pacific Islander patients.

5.8 Postpartum Depression Follow-Up for Black & Native American Members

Overview & Performance

Measure: Postpartum Depression Follow-Up for Black & Native American Members					
Numerator	2	Baseline	0%	Final Performance	40.00%
Denominator	5	Target	38.89%	Evaluation Year	2023

The Postpartum Depression Follow-Up for Black & Native American Members measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of birthing SFHP members who are Black or Native American who have screened positive for depression and have received follow-up care, out of the total number of birthing SFHP members who are Black or Native American who have screened positive for depression. SFHP chose the target of 38.89% based on MY2021 performance of 77.78% in this measure; 38.89% represented the halfway point between the baseline of zero and SFHP's overall performance.

Activities

The following planned activities were completed:

- Collaborated with Carelon to pilot a maternal mental health clinical program tailored to the specific needs of Black and Native American members SFHP members.
- Partnered with local community-based organizations to educate members and facilitate connection to care.
- Enrolled and credentialed 10 doulas that represent SFHP's diverse population

Analysis

Quantitative

SFHP met the target of 38.89%, exceeding it by 1.11% with a final result of 40.00%. However, this result reflects Black or African American members only; no Native American members were eligible to be included in this measure denominator. SFHP as a whole population performed at 62.50%.

Qualitative

Recommendations

SFHP will not continue this measure in 2024 due to shifting focus to other behavioral health QI and health equity priorities that are lower performing. However, SFHP will continue to monitor postpartum depression follow up.

6. Managing Multiple Chronic Illnesses

These are measures that improve care and facilitate coordination of care across multiple providers and facilities. They may also be defined as serving a specific population with complex medical needs.

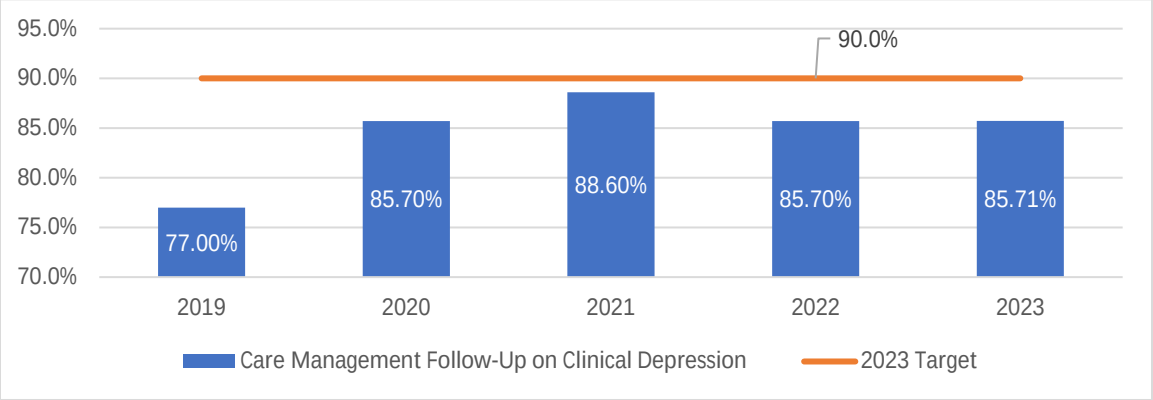
6.1 Care Management Follow-Up on Clinical Depression

Overview & Performance

Measure: Care Management Follow-Up on Clinical Depression					
Numerator	12	Baseline	85.71%	Final Performance	85.71%
Denominator	14	Target	90.00%	Evaluation Year	2023

The Care Management Follow-Up on Clinical Depression measure is in the Managing Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of adult clients in SFHP's Care Management (CM) programs who screen positive for depression symptoms and are connected to services for care. This measure 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 target for this measure was 90.0% based on incremental improvement from the previous measurement year. The following chart demonstrates the five-year trend in the rate of members with Care Management Follow-Up on Clinical Depression.

Care Management Follow-Up on Clinical Depression 2019 – 2023



Activities

The following activities were completed:

- Offered 14 staff trainings in mental health, focused particularly on severe mental illness

(SMI) and community resources, to ensure that staff is equipped to identify signs and symptoms of clinical depression, address client safety including connection to behavioral health services.

  - Overdose Prevention and Community Health Initiatives
  - Post Pandemic Recovery_ Substance Use
  - Med Talk: Dementia Overview
  - Intensive Case Management
  - Heart Disease
  - Post Pandemic Substance Use Disorder
  - Stepping Stone Adult Day Health Care
  - Community Living Fund
  - Community and Home Injury Prevention Program for Seniors
  - Central American Resource Center SF and Overdose Prevention
  - Med Talk: Schizophrenia and the use of Antipsychotics
  - Secondary Trauma
  - Understanding and Preventing Compassion Fatigue
  - Person Centered Care Planning

- Clinical Supervisors reviewed CM dashboard monthly with staff and to coach staff to ensure members are screened and receive appropriate follow up.
- Coached and conducted role-playing activities to reduce the rate of members declining PHQ-9 screening. Clinical Supervisors and Trainer providing coaching and role playing as needed during weekly 1:1s and bi-weekly Clinical meetings.
- Quarterly staff self-audits completed in November 2022, February and August 2023 which enabled Coordinators to identify and remedy any gaps in the member's care plan, including completing the PHQ-9 screening when indicated.
- Clinical Supervisors completed clinical audits in August and provided feedback to the team, including trends and gaps in training. Temporarily increased frequency of audits to every quarter. New CCM and TLC Supervision tracking tools developed in August.

Analysis

Quantitative

SFHP did not meet the target of 90.0%, falling short by 4.29% with a final result of 85.71%.

Qualitative

Barriers

Barriers in meeting this goal include:

- Since the COVID-19 pandemic, behavioral health providers have been highly impacted, resulting in longer wait times and limited in-person visits.
- The inconsistent presence of Carelon in the SFHP office and availability of staff to perform a warm hand off to Carelon's co-located case management team.
- Small sample size as since the COVID-19 pandemic there have been additional challenges connecting with members and more cases where members have gone Lost-to-Follow-Up.

Recommendations

SFHP will continue this measure in 2024 and retain the target of 90.0%. Activities to support

this measure will include:

- Train staff in mental health, particularly on severe mental illness (SMI) and community resources, to ensure that staff is equipped to identify signs and symptoms of clinical depression and address client safety, including connection to behavioral health services.
- Clinical Supervisors to review CM dashboard monthly with staff and to coach staff to ensure members are screened and receive appropriate follow up.
- Initiate a weekly behavioral health office hour between SFHP Care Management, SFHP Behavioral Health, and Carelon clinical teams to staff cases and ensure timely connection to behavioral health services.
- Collaborate to ensure effective coordination of care through the Managed Behavioral Health Care Committee which includes both SFHP and SF Behavioral Health Services.
- Complete quarterly staff self-audits which will enable Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.
- Clinical Supervisors to conduct audits every 4 months to ensure best practices and regulatory requirements are met.

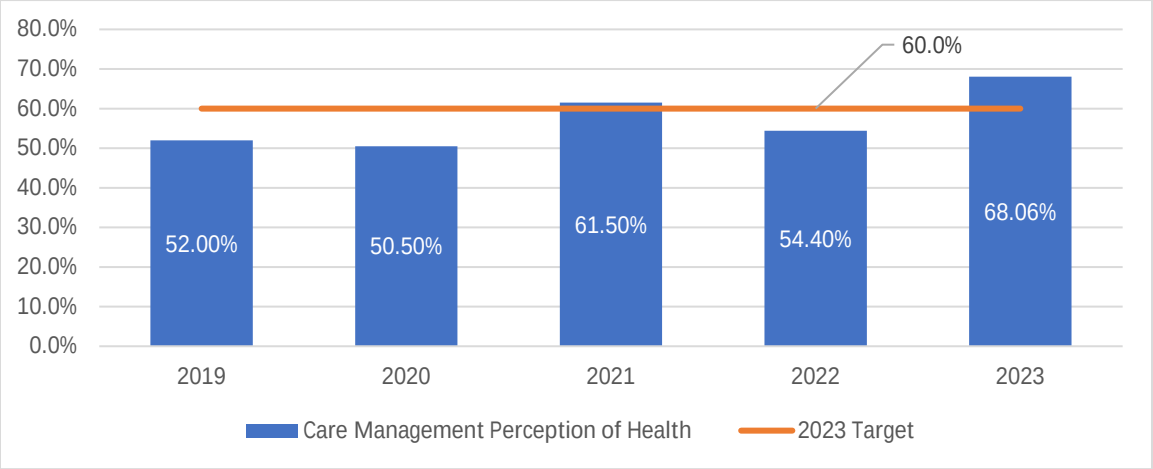
6.2 Care Management Client Perception of Health

Overview & Performance

Measure: Care Management Client Perception of Health					
Numerator	49	Baseline	54.40%	Final Performance	68.06%
Denominator	72	Target	60.00%	Evaluation Year	2023

The Care Management Client Perception of Health measure is in the Managing Multiple Chronic Illnesses domain. This measure reflects activities to improve adult Care Management (CM) clients' perception of their health. A member's stronger relationship with their PCP and a greater understanding of their conditions can positively impact the member's perception of their health since they have more resources to manage their conditions. 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 incremental improvement from 2022. 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 chart demonstrates the five-year trend in the rate of members with Care Management Client Perception of Health.

Care Management Perception of Health 2019 – 2023



Activities

The following activities were completed:

- Clinical Supervisors and Medical Director provided coaching the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- Developed a two-year training syllabus for CM staff, to include trainings on subjects the team have identified gaps in and areas management feel would benefit the team in their ongoing work with members.
- Utilized Milliman Care Guidelines condition specific assessments and health education materials by CM Nurses.

Analysis

Quantitative

SFHP met the target of 60%, exceeding it by 8.06% with a final result of 68.06%.

Recommendations

SFHP will not continue this measure in 2024 as the activities implemented in the previous year's improvement work have surpassed the target and the Care Management team will shift their focus to other measures of member-centered care.

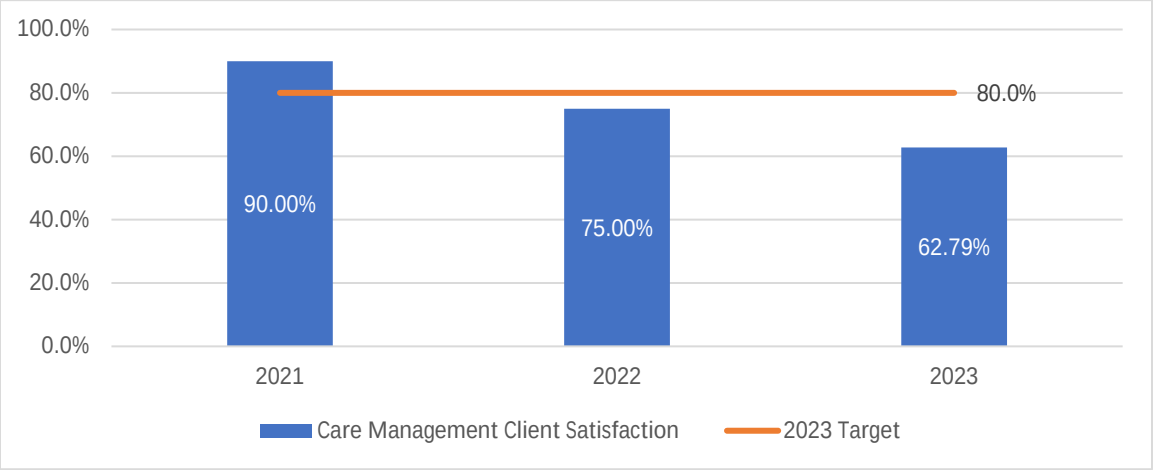
6.3 Care Management Client Satisfaction

Overview & Performance

Measure: Care Management Client Satisfaction					
Numerator	27	Baseline	75.00%	Final Performance	62.79%
Denominator	43	Target	80.00%	Evaluation Year	2023

The Care Management Client Satisfaction measure is in the Managing Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of clients enrolled in SFHP's Care Management (CM) programs who respond “Yes” to Question 2: ‘Has the Care Management program helped you reach your health goals?’ and who respond “Always” or “Often" to Question 6: ‘After receiving information from the Care Management staff, I feel confident I can take the actions needed to maintain or improve my health.’ The client satisfaction survey is conducted twice a year and is used to assess client experience with CM services and staff. This measure represents SFHP’s commitment to ensuring that Care Management programs are member centered. The target for this measure was 80% and was chosen based on incremental improvement from the previous measurement year. The following chart demonstrates the three-year trend in the rate of members with Care Management Client Satisfaction.

Care Management Client Satisfaction 2021 – 2023



Activities

The following activities were completed:

- Maintained a process to triage members into longer-term case management programs when requested by member or indicated by member’s self-efficacy skills.
- Provided more thorough life skills, health education and training to members as it pertained to their health maintenance.
- Improved communication of care plan goal progress between Care Management staff and members.
- CM staff completed a 6-month reassessment and review of care plan including goals with member.

Analysis

Quantitative

SFHP did not meet the target of 80.0%, falling short by 17.21% with a final result of 62.79%.

Qualitative

Barriers to meeting this goal have mostly been caused by the COVID-19 pandemic, which has resulted in:

- The Care Management Team limiting services to telephonic case management for nearly two and a half years, and only resuming field work in June 2022 in a phased approach.
- Providers have been highly impacted, resulting in limited appointments and long wait times, especially for PCPs and specialists.
- Diminished resources provided by Community Based Organizations and other community partners, for example, most intensive case management programs have a year-long wait list currently. The main barrier to reaching the target was due to most intensive programs being highly impacted at this time with long wait lists.

Recommendations

SFHP will continue this measure in 2024 and reduce the target to 65.00% to better reflect improvement from 2023 performance. Activities to support this measure will include:

- Development of an individualized case management plan, including member's prioritized goals and preferences.
- Improve communication of care plan goal progress between Care Management staff and members.
- Provide more thorough life skills, health education and training to members pertaining to self management of their conditions and their health maintenance.
- CM staff completes a 6-month reassessment and review of care plan, including goals with member.
- Maintain a process to triage members into longer-term case management programs when requested by member or indicated by member's self-efficacy skills.
- Strengthen relationships with community based organizations and increase team knowledge of community resources.
- Include online resources in Case Management software system for easier access by CM Coordinators and Nurses.
- Initiate a Closed Loop Referrals project to seek a system for connecting members to needed resources.

7. Utilization of Services

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

7.1 Antidepressant Medication Management — Effective Continuation

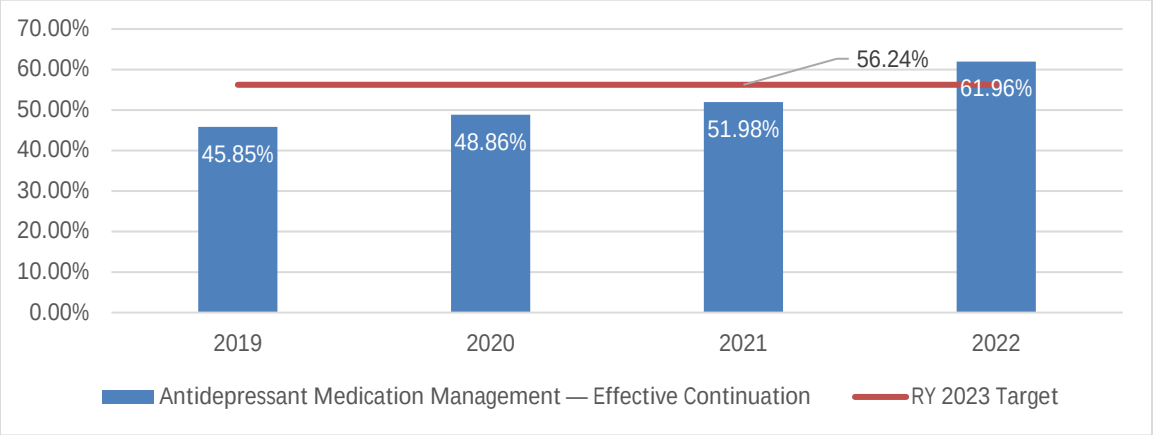
Overview & Performance

Measure: Antidepressant Medication Management — Effective Continuation					
Numerator	922	Baseline	51.98%	Final Performance	61.96%
Denominator	1,488	Target	56.24%	Evaluation Year	2023

The Antidepressant Medication Management (AMM) — Effective Continuation is in the Utilization of Services domain. This rate is based on the total number of SFHP members with who are age 18 and older with a diagnosis of major depression treatment who were treated with

antidepressant medication and who remained on an antidepressant medication treatment for at least 180 days. Increasing AMM reflects improved management for members with behavioral health conditions. SFHP chose the target of 56.24% based on national HEDIS benchmarks. Increasing SFHP's AMM rate would place SFHP in the 90th percentile of plans for this measure. The following chart demonstrates the four-year trend in AMM.

Rate of Antidepressant Medication Management — Effective Continuation MY 2019 – 2022



Activities

The planned activities were completed:

- Collaborated with Carelon on member and provider outreach and education.
- Conducted member level outreach for members not achieving adherence goals.
- Created member-level health education materials about antidepressant adherence.
- SFHP refreshed and distributed articles around medication adherence for antidepressants in the October 2023 provider newsletter.

Analysis

Quantitative

SFHP met the target of 56.24%, exceeding it by 5.72% with a final result of 61.96%. This result achieved the 90th percentile among Medicaid plans.

Qualitative

An analysis was performed reviewing adherence rates for antidepressants, comparing members by affinity groups. Members who identified their preferred language as Spanish had among the lowest rate of adherence at 6 months (55.50%) as did those members who identified as Black (52.86%) or Hispanic (55.18%). These low adherence rates highlight a potential need for increased access to culturally competent care. SFHP has begun work with our behavioral health vendor to identify strategies for addressing these populations, and we hope to implement activities in the coming year.

Recommendations

SFHP will not continue this measure in 2024, due to lack of Pharmacy staff resources and prioritization of other QI and health equity activities.

7.2 Antipsychotic Medication Adherence

Overview & Performance

Measure: Antipsychotic Medication Adherence					
Numerator	337	Baseline	59.20%	Final Performance	62.64%
Denominator	538	Target	61.59%	Evaluation Year	2023

The Antipsychotic Medication Adherence (SAA) is in the Utilization of Services domain. This rate is based on members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. Increasing SAA reflects improved management for members with behavioral health conditions. SFHP chose the target of 61.59% based on national HEDIS benchmarks. Increasing SFHP's SAA rate would place SFHP in the 50th percentile of plans for this measure.

Activities

- Collaborated with Carelon on member and provider outreach and education.
- Outreached to SF Department of Public Health to discuss barriers to access for members with schizophrenia on antipsychotics.

Analysis

Quantitative

SFHP met the target of 61.59%, exceeding it by 1.05% with a final result of 62.64%. This result achieved the 50th percentile among Medicaid plans.

Recommendations

SFHP will continue this measure in 2024, with a target of 61.39% based on maintaining the Medicaid 50th percentile benchmark, since the MY 2023 Admin rate fell below the 2023 MPL.

Activities to support this measure will include:

- Communicate with SF Behavioral Health Services to discuss barriers to access for members with schizophrenia on antipsychotics.
- Include member education on medication adherence for chronic disease states in Your Health Matters

8. Quality Oversight Activities

These are quality oversight activities monitored and completed this year.

	Oversight	Summary	Responsible Staff	Activities	Due Date
A	Quality Improvement Committee	Ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan	CMO	· Four meetings held in 2023	12/30/2023
B	Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	CMO	· Quarterly and ad hoc P&T Committee meetings	12/30/2023
C	Physician Advisory/Peer Review/Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	· Five meetings held in 2023	12/30/2023
D	Utilization Management Committee	Ensure oversight of SFHP Utilization Management program	Director, Clinical Operations	· Ten meetings held in 2023	12/30/2023
E	Annual Evaluation of the QI Program	Review Quality Improvement plan and determine efficacy of implemented plan based on outcomes	CMO	· Evaluated each measure in the QI work plan · QIC reviewed QI evaluation · Governing Board reviewed QI Evaluation	3/1/2023
F	QI Plan Approval for Calendar Year	Review and approve proposed Quality Improvement work plan	CMO	· QIC reviewed QI work plan · Governing Board reviewed QI Work Plan	3/1/2023

	Oversight	Summary	Responsible Staff	Activities	Due Date
G	Delegation Oversight for QI	Ensure oversight of QI for all delegated entities	CMO	· Followed delegation oversight procedures · QIC review of Delegated Oversight Audits for QI · All groups delegated for QI passed audit	12/30/2023
H	DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs)	CMO	· Attended DHCS-led PIP calls · Adhered to process delineated by DHCS	12/30/2023

Reviewed and Approved by:

Chief Medical Officer: *Eddy Ang, MD, MPH* **Date:**

Quality Improvement & Health Equity Committee Review Date:

Board of Directors Review Date:

SAN FRANCISCO HEALTH PLAN
50 Beale St. 12th floor
San Francisco, CA 94105
www.sfhp.org

San Francisco Health Plan

2024 Quality Improvement Health Equity Transformation Program Description & Work Plan

Contents

1. Introduction

San Francisco Health Plan (SFHP) is a community health plan that provides affordable health care coverage. As of January 2024, membership included 179,058 low and moderate-income individuals and families. Members have access to a range of medical benefits including preventive care, specialty care, hospitalization, prescription medications, behavioral health and family planning services. SFHP was designed by and for the residents it serves and takes great pride in its ability to serve a diverse population that includes children, young adults, and seniors and persons with disabilities (SPDs).

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

To ensure high quality care and service, SFHP embarked on a journey to be accredited with the National Center for Quality Assurance (NCQA) in 2015 for Medicaid. SFHP received interim accreditation status in 2016 and first survey accreditation in 2017. SFHP renewed its accreditation in 2023.

SFHP's products include Medi-Cal and Healthy Workers:

Medi-Cal

Medi-Cal is California's Medicaid program, which is a federal and state-funded public health insurance program for low-income individuals. As a managed care plan, SFHP manages the funding and delivery of health services for Medi-Cal members. As of January 2024, SFHP retained 85% (167,722 members) of the managed care market share in San Francisco County. [1]

Healthy Workers

Healthy Workers is a health insurance program offered to providers of In-Home Supportive Services and a small subset of temporary employees of the City and County of San Francisco. As of January 2024, 11,331 members are enrolled in this program.

2. Quality Improvement and Health Equity Transformation Program Purpose, Scope and Goals

SFHP is committed to continuous quality improvement for both the health plan and its health care delivery system. The purpose of the SFHP QI and Health Equity Transformation (QIHET) Program is to establish comprehensive methods for systematically monitoring, evaluating, and improving the quality of the care and services provided to San Francisco Health Plan members and take appropriate actions to improve upon Health Equity. The QIHET Program is designed to ensure that members have access to quality medical and behavioral health care services that

[1] Medi-Cal Managed Care Enrollment Report – September 2021, https://data.chhs.ca.gov/dataset/c6ccef54-e7a9-4ebd-b79a-850b72c4dd8c/resource/95358a7a-2c9d-41c6-a0e0-405a7e5c5f18/

are safe, effective, accessible, equitable, and meet their unique needs and expectations. Delivery of these services must be in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

SFHP contracts with medical and behavioral health care providers, including medical groups, clinics, independent physicians and their associated hospitals, ancillary providers, behavioral health clinicians, and pharmacies to provide care. SFHP maintains responsibility for communicating regulatory and contractual requirements as well as policies and procedures to participating network providers. SFHP retains full responsibility for its QIHET Program all quality and Health Equity functions and does not delegate quality improvement oversight. In certain instances, SFHP may delegate some or all QIHET functions to accredited provider organizations.

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

The QIHET Program's objectives and outcomes are detailed in the QIHET Work Plan (see Appendix A). Each program objective is monitored at least quarterly, evaluated at least once per year and is shared with QIHEC quarterly in the form of a QIHET scorecard. Measures and targets are selected based on volume, opportunities for improvement, risk, organizational priorities, evidence of disparities, and alignment with DHCS Comprehensive Strategy.

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

- Improving members' health status, including reducing health disparities and addressing, where possible, the social determinants of health that adversely impact our members
- Ensuring continuity and coordination of care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships
- Ensuring access of primary and specialty care and services, including parity between medical and behavioral health care services
- Ensuring availability and regular engagement with Primary Care Providers (PCP)
- Ensuring member knowledge of rights and responsibilities
- Providing culturally and linguistically appropriate services
- Ensuring that health care practitioners are appropriately credentialed and re-credentialed

- Ensuring timely communication of Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) standards and requirements to participating medical groups and organizational providers
- Ensuring effective and appropriate utilization management of health care services, including medical, pharmaceutical, and behavioral health care services
- Providing health education resources
- Ensuring clinical quality and safety in all health care settings including quality of behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation
- Ensuring excellent member care experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination
- Ensuring that responsibilities delegated to medical groups meet plan standards
- Evaluating the overall effectiveness of the QIHET Program through an annual comprehensive program evaluation
- Using the annual evaluation to update the QIHET Program and develop an annual QIHET Work Plan

3. QIHET Program Structure

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

Quality Committees

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

The Quality Improvement and Health Equity Committee

The SFHP QIHEC is comprised of network clinicians (physicians, behavioral health, and pharmacists) and three members of the Member Advisory Committee, one of whom is an SPD member. The QIHEC is co-chaired by SFHP's CMO and CHEO. The QIHEC is a standing committee of the San Francisco Health Authority Governing Board that meets at least four times a year. It is the main forum for member and provider oversight, ensuring the quality of the healthcare delivery system. The committee is responsible for reviewing and approving the annual QIHET Program and QIHET Program Evaluation, and for providing oversight of the Plan's quality improvement and health equity activities. SFHP brings new quality improvement programs to the QIHEC to ensure the committee members provide input into program planning, design, and implementation. SFHP maintains an annual calendar to ensure that key SFHP QIHET Program activities are brought to the QIHEC for ongoing review, analysis, and evaluation. This includes annual review of the results of performance measures, utilization data, consumer satisfaction surveys, delegation oversight and the findings and activities of the Member Advisory Committee, the Physician Advisory/Peer Review/Credentialing Committee, the Pharmacy & Therapeutics Committee, and the Utilization Management Committee. The QIHEC institutes actions to address performance deficiencies including policy recommendations and ensures appropriate follow-up of identified performance deficiencies. SFHP maintains minutes of each QIHEC meeting, submits them to the Governing Board for review and approval, and submits these to DHCS on a quarterly basis. The QIHEC meetings are open to the public and agendas and minutes are published on SFHP's website.

The Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee convenes at least quarterly to review, evaluate, and approve the SFHP Formulary revisions based on safety, comparable efficacy, and cost and to adopt pharmaceutical management procedures including prior authorization criteria, quantity limits, and step therapy protocol for covered outpatient prescription medications. The P&T Committee is responsible for pharmaceutical and therapeutic treatment guidelines and an annual approval of the pharmacy clinical policies and procedures for formulary, prior authorization, monitoring of utilization rates, timeliness of reviews, and drug utilization review (DUR) processes. The SFHP P&T Committee governs formulary, utilization management, and related policies/procedures for the Healthy Workers HMO line of business and Healthy San Francisco program. Formulary, utilization management, and related policies/procedures for Medi-Cal are governed by the Department of Health Care Services (DHCS) under Medi-Cal Rx as of January 1, 2022. The P&T Committee governs retrospective DUR processes and related policies for Medi-Cal for the purpose of oversight of adherence and disease and medication management, including targeted quality measures. The P&T Committee is comprised of network physicians, including a psychiatrist, and pharmacists along with the SFHP Pharmacy Director and is chaired by SFHP's CMO or designee. The committee meets quarterly and on an ad hoc basis, and meetings are open to the public. The P&T Committee reports to the QIHEC.

The Physician Advisory/Peer Review/Credentialing Committee

The Physician Advisory/Peer Review/Credentialing Committee (PAC) provides comments and recommendations to SFHP on standards of care and peer review. The PAC Committee is chaired by SFHP's Senior Medical Director and consists of providers in SFHP's network. The PAC Committee serves to review and provide recommendations regarding substantive quality of care concerns, in particular those related to credentialed provider performance. The Sanctions Monitoring Report is reviewed by SFHP monthly to ensure that any identified providers with investigations or actions are brought to the PAC Committee for review, including confirmed Potential Quality Issues of requisite severity and Facility Site Review finding. The PAC Committee also reviews credentials and approves practitioners for participation in the SFHP network as appropriate. The PAC Committee meets every two months and is a subcommittee of QIHEC.

The Member Advisory Committee

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

The Practice Improvement Program Advisory Committee

The Practice Improvement Program (PIP) Advisory Committee provides guidance to SFHP on pay-for-performance program development, implementation, and evaluation. Committee members review prior and current year PIP network performance, identify, and predict barriers

to success for participants, and problem-solve solutions. Membership is made up of representatives from all PIP-participating organizations. Meetings are held at least twice a year. The PIP Advisory Committee reports to the CMO.

Committees with Internal Membership Only

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

Quality Oversight Team

The Quality Oversight Team (QOT) serves as SFHP's steward for overall quality improvement. The group meets every other month to discuss strategy, priority setting and planning, and is responsible for executing priorities, providing updates on risk status, monitoring trends and collaborating across departments on high priority issues/projects. This team reviews monthly and quarterly data and analysis for quality improvement and health equity opportunities and workplan measures and makes recommendations before the QIHET scorecard is shared with QIHEC every quarter.

The goal of the QOT is to provide a formal process to assess priorities, develop strategy, and monitor and evaluate the quality, appropriateness, efficiency, and effectiveness of care. The QOT promotes the accountability of all employees for the quality of care and services provided to our members. The QOT supports SFHP's goal of ensuring members receive the right care at the right time in an equitable manner. The QOT is chaired by the Director of Quality Improvement, and consists of the following SFHP Staff:

Health Services Staff

- Chief Medical Officer
- Director, Quality Improvement (Chair)
- Officer, Health Services
- Officer, Programs Development
- Senior Medical Director
- Director, Clinical Operations
- Director, Care Management
- Senior. Manager, Health Services Product Management
- Manager, Health Services Product Management
- Senior Manager, Pharmacy Operations
- Manager, Behavioral Health
- Nurse Supervisor, Quality Review
- Associate Program Manager, Quality Improvement
- Supervisor, Quality Improvement

Operations Staff

- Senior Manager, Provider Network Operations
- Director, Marketing and Communications

Compliance Staff

- Supervisor, NCQA & Special Projects

ITS Staff

- Director, Business Analytics

The Policy & Compliance Committee

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

- Chief Officer, Compliance and Regulatory Affairs, Chairperson
- Director, Regulatory Affairs
- Director, Compliance and Oversight
- Director, Policy Development and Coverage Programs, or designee
- Controller, or designee
- Manager, Pharmacy Operations, or designee
- Director, Clinical Operations, or designee
- Director, Human Resources, or designee
- Director, Systems Development Infrastructure, or designee
- Director, Claims, or designee
- Senior Manager, Member Services, or designee
- Director, Marketing & Communications, or designee
- Senior Manager, Provider Network Operations, or designee
- Director, Care Management, or designee
- Officer, Health Services, or designee

The Provider Network Oversight Committee

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

- Director, Compliance and Oversight (Chair)
- Chief Officer, Compliance and Regulatory Affairs
- Senior Manager, Provider Network Operations
- Senior Manager, Member Services
- Director, Clinical Operations
- Manager, Behavioral Health
- Manager, Pharmacy Operations
- Director, Care Management
- Director, Quality Improvement
- Supervisor, NCQA and Special Projects

The Grievance Review Committee

The Grievance Review Committee (GRC) is an internal SFHP committee that reviews all grievances and serves as an escalation point for trends identified from member grievances. If a grievance trend is identified or there is a particularly concerning grievance, the committee will recommend a Corrective Action Plan (CAP) or a notification to the Medical Group. Member grievances are not delegated to Medical Groups, except Carelon Behavioral Health. The GRC also reviews individual member grievances through a collaborative process to ensure that all the components of the grievances have been resolved. The committee is led by the CMO with cross functional representation from Member Services, Provider Relations, Health Services, and Compliance and Regulatory Affairs departments. The committee meets three times a week. GRC members include:

- Chief Medical Officer or designee (Chair)
- Senior Medical Director
- Chief Officer, Compliance and Regulatory Affairs, or designee
- Director, Regulatory Affairs
- Senior Manager, Member Services
- Supervisor, Provider Relations
- Specialist, Provider Relations
- Quality Review Nurse
- Nurse Supervisor, Quality Review
- Supervisor, Grievances & Appeals
- Regulatory Affairs Legal Analyst
- Program Manager, Grievances & Appeals
- Associate Program Manager, Grievances & Appeals
- Specialists, Grievances & Appeals
- Supervisor, Customer Service
- Customer Service Lead or Specialist
- Pharmacy, Clinical Operations, Care Management, Health Education, and Cultural & Linguistics staff participate as needed.

The Grievance Program Leadership Team

The Grievance PLT is an internal SFHP committee that provides oversight and monitoring of all grievance program functions such as process improvement opportunities, audits, reporting, regulatory requirements, operations, and grievance trends. Grievance PLT also ensures follow through of Grievance Review Committee recommendations for grievance trends and reviews for system issues. The Grievance PLT is led by the Supervisor, Grievances & Appeals with cross

functional representation from Health Services, Member Services, and Compliance and Regulatory Affairs departments. Grievance PLT meets quarterly. PLT members include:

- Chief Medical Officer or designee (Chair)
- Senior Medical Director
- Chief Officer, Compliance and Regulatory Affairs
- Chief Officer, Operations
- Director, Regulatory Affairs
- Director, Compliance & Oversight
- Senior Manager, Member Services
- Senior Manager, Provider Network Operations
- Supervisor, Grievances & Appeals
- Nurse Supervisor, Quality Review
- Supervisor, Customer Service
- Quality Review Nurse
- Program Manager, Grievances & Appeals
- Associate Program Manager, Grievances & Appeals

The Access Compliance Committee

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

- Director, Quality Improvement (Chair)
- Director, Regulatory Affairs
- Director, Clinical Operations
- Senior Manager, Provider Network Operations
- Supervisor, Provider Relations
- Supervisor, Quality Improvement
- Specialist, Provider Relations
- Associate Program Manager, Access to Care

The Utilization Management Committee

The Utilization Management Committee (UMC) provides oversight to ensure effective and compliant implementation of SFHP's Utilization Management Program and to support compliance with SFHP's policy requirements, the Medi-Cal contract, NCQA accreditation requirements, and DHCS/DMHC statutory and regulatory requirements. Discussion outcomes may result in changes to medical policy and criteria, prior authorization requirements, and/or UM Process enhancements. The UMC is a subcommittee of the QIHEC. The UMC meets a minimum of 6 times annually and provides monthly minutes, quarterly trend reports, and annual reports to the QIHEC. The UMC membership, with voting rights on all motions, consists of:

- Chief Medical Officer
- Senior Medical Director
- Director, Clinical Operations

- Nurse Manager, Prior Authorizations
- Senior Manager, Concurrent Review
- Nurse Manager, Long-Term Care
- Program Manager, Clinical Operations
- Manager, Clinical Operations
- Senior Manager, Pharmacy Operations

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

- Director of Clinical Services – Carelon Behavioral Health (ad hoc)
- Valid State Clinical License required (RN, LCSW, LMFT, PhD, or PsyD)
- Medical Director (MD/Psychiatry) – College Health IPA (Carelon Behavioral Health) (ad hoc)

Quality Improvement Collaborations

SFHP partners with its provider groups which serve the majority of SFHP members to align priorities and identify opportunities on quality improvement and health equity activities and measures. SFHP meets monthly with each provider group: the San Francisco Health Network, North East Medical Services, UCSF, and the San Francisco Community Clinic Consortium. Agendas and topics for these Quality Collaborative meetings are planned based on quality and Health Equity priorities of SFHP and the provider groups and focus on sharing of performance data and discussion of improvement activities. Identified issues and action items are tracked and followed up on in subsequent meetings. QI and Health Equity staff and leadership from SFHP and the provider groups attend the meetings in addition to subject matter experts invited to meetings ad hoc. In addition to these monthly collaboratives, SFHP attends joint operating meetings with Carelon Behavioral Health as well as other San Francisco health care delivery stakeholders: University of California, San Francisco Health system, Anthem Blue Cross, the San Francisco Department of Public Health, and San Francisco Behavioral Health System.

SFHP collaborates with its providers in a combination of these fora to facilitate continuity and coordination of medical care across its delivery system, particularly when members move between practitioners and across settings. SFHP also collaborates with behavioral healthcare providers to collect and analyze data to facilitate coordination of care between medical and behavioral healthcare providers. The focus of these collaborative improvement activities is for SFHP to support providers when there are gaps in communication or data, as driven by data and analysis focusing on barriers for providers.

Quality Improvement Communications

Communication to members

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

Communication to providers

SFHP updates providers regularly regarding key QIHET activities, including:

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

Quality Improvement Staff

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

Health Services Staffing Structure

The Health Services Leadership that supports the QIHET program are:

Chief Medical Officer – responsible for leading the Quality Improvement Committee, Physician Advisory/Peer Review/Credentialing Committee, Pharmacy and Therapeutics Committee, various functions spanning state programs, population health, care management, utilization management, clinical appeals, and for all quality improvement and health equity studies and activities. The CMO provides guidance and oversight for development of policies, programs, and projects that support all activities identified in the QIHET Program. The CMO carries out these responsibilities with support from direct reports, including the Health Services Officer, the Programs Development Officer, and the Quality Improvement Director. The CMO has over 11 years of clinical experience. He has worked clinically in safety net care delivery organizations and administratively in Medicare and Medi-Cal managed care. The CMO graduated as Chief Resident from the Family Medicine residency program at Henry Ford Hospital, followed by a fellowship in Geriatric Medicine at Harvard Medical School. He earned his medical degree from Kaohsiung Medical University (Taiwan) and a Master of Public Health from Harvard University. He is board certified in Family Medicine and Geriatric Medicine.

Quality Improvement Staffing Structure

Director, Quality Improvement - reports to the CMO, ensures the completion of the QIHET Program, and directs the execution of QIHET activities identified in the QIHET Work Plan. The Director of Quality Improvement oversees teams focused on fostering quality for our members: Pharmacy Operations, Quality Improvement, and Health Services Product Management. The Quality Improvement Director has a Master's in Business Administration and has 15 years working in healthcare as a director responsible for quality improvement and compliance regulations within three managed care organizations, a Federally Qualified Health Center, and a Fortune 100 Health care company. Reporting to the Director of Quality Improvement are the following positions:

Senior Manager, Pharmacy Operations – reports to the Quality Improvement Director and oversees pharmacy operations and medication related clinical programs and activities. The Senior Manager of Pharmacy Operations has a Doctorate of Pharmacy with 16 years of healthcare experience including six years of clinical experience. The Senior Manager of Pharmacy Operations also achieved a Post Graduate Year One residency and holds a certification as a Board Certified Pharmacotherapy Specialist. Reporting to the Manager of Pharmacy Operations, the following positions support SFHP's QIHET efforts:

Supervisor, Clinical Pharmacy – responsible for oversight of pharmacy related QIHET measures and initiatives, Drug Utilization Review (DUR) program, and the Medication Therapy Management program. The Interim Supervisor of Clinical Pharmacy s has a doctorate of pharmacy with 16 years of healthcare experience including 11 years of clinical experience and six years of experience in quality improvement. The Interim Supervisor of Clinical Pharmacy also achieved a Post Graduate Year One residency and holds a license as an Advanced Practice Pharmacist. Reporting to the Clinical Pharmacy Supervisor are the following positions:

- **Clinical Pharmacist** – responsible for supporting the Medication Therapy Management program and supporting formulary, operations, and quality activities. The Clinical Pharmacist of Pharmacy Operations has a doctorate of pharmacy with 11 years of healthcare experience including six years of clinical experience and six years of experience in quality improvement. The Clinical Pharmacist of Pharmacy Operations also achieved a Post Graduate Year One residency, holds a license as an Advanced Practice Pharmacist, and a certification as a Board Certified Pharmacotherapy Specialist.

- **Clinical Pharmacist** – responsible for supporting the Drug Utilization Review (DUR) program including opioid review, managing activities related to pharmacy for HEDIS quality measures . The Clinical Pharmacist has a Doctorate of Pharmacy with six years of healthcare experience including five years of experience in quality improvement. The Clinical Pharmacist also completed a Post Graduate Year One residency.

- **Analyst, Pharmacy–** responsible for supporting pharmacist staff to execute their responsibilities. The Analyst of Pharmacy achieved a pharmacy technician

diploma and has 13 years of healthcare experience, including nine years of direct patient care. The Analyst of Pharmacy also is a licensed pharmacy technician.

- **Program Manager, Pharmacy Compliance –** responsible for supporting pharmacy operations including quality activities by ensuring compliance. The Program Manager of Pharmacy Compliance has 23 years of healthcare experience, including 11 years of direct patient care.

- **Senior Analyst, Pharmacy Business –** responsible for supporting pharmacy operations including quality activities via reporting development, training and maintenance. The Senior Analyst of Pharmacy Business has 26 years of healthcare experience, including five years of direct patient care. The Senior Analyst of Pharmacy Business also achieved certificates in California accounting I & II and New York data processing.

- **Analyst, Pharmacy Data** – responsible for supporting to pharmacist staff to execute their responsibilities. The Analyst of Pharmacy Data has 26 years of healthcare experience. The Analyst of Pharmacy Data is also a licensed pharmacy technician.

- **Program Manager, Pharmacy Vendor Oversight** – responsible for supporting to pharmacist staff to execute their responsibilities. The Analyst of Pharmacy achieved a Bachelors of Science in Healthcare Administration & Management and has 21 years of healthcare experience, including 16 years of direct patient care. The Analyst of Pharmacy also is a licensed pharmacy technician.

Senior Manager, Health Services Product Management – reports to the Quality Improvement Director and oversees internal applications supporting SFHP processes that impact member care. The Senior Manager of Health Services Product Management has a Master of Computer Science and Applications, with 17 years of experience in healthcare technology. Reporting to the Manager of Health Services Business Relationships, the following positions support SFHP's QIHET efforts:

- **Manager, Health Services Product Management –** responsible for overseeing SFHP's HEDIS process and systems and applications affecting multiple departments within Health Services, including Cotiviti (HEDIS software). The Manager of Health Services Product Management has an Associate Degree in Marketing and Management, with 22 years of managed care experience including seven years of experience in quality improvement. Reporting to the Manager of Health Services Product Management are the following positions:

    - **Associate Program Manager, Health Services Product Management –** responsible for the overall planning, execution, and implementation of small and medium scale programs including implementation of SFHP's HEDIS process. The Health Services Product Management Specialist has an Associate Science degree and seven years of healthcare experience.

- **Specialist, Health Services Product Management –** responsible for supporting various applications and programs within the Health Services Product Management Team including internal customer support and program reporting. The Health Services Product Management Specialist has a master's degree in public administration and 5 years of healthcare experience.

- **Senior Program Manager, Health Services Product Management –** responsible for overseeing systems and applications affecting multiple departments within Health Services including Essette (care management software). The Senior Program Manager of Health Services Product Management has Bachelors of Computer Information Systems and Political Science, with 18 years of healthcare experience.

- **Program Manager, Health Services Product Management –** responsible for overseeing systems and applications affecting multiple departments within Health Services. Examples include PIPBase (Pay-for-Performance database), MARA (member risk measurement), and PreManage ED (Hospital Information Exchange). The Associate Program Manager of Health Services Product Management has a Bachelors of Social Work and Social Science, with 14 years of care management experience.

- **Data Analyst, Health Services Product Management –** responsible for the analysis and reporting of data supporting quality initiatives and contributes to increasing the use of data in clinical decision making and improving data quality by identifying data gaps impacting Health Services quality initiatives including HEDIS and Care Management application. The Data Analyst of Health Services Product Management has a Bachelors of Science in Computer Engineering with one year of experience in healthcare.
- **Configuration Analyst, Health Services Product Management –** responsible for application configuration including project planning, execution, and implementation of changes to SFHP's Care Management system. The Configuration Analyst of Health Services Product Management has a Masters of Science in Health Informatics and a certification in Asure AZ 900 with 17 years of experience in healthcare.

Supervisor, Quality Improvement – reports to the Quality Improvement Director and oversees quality improvement programs focusing on care experience, access to care and incentive interventions for providers and members. The Quality Improvement Supervisor has 12 years of experience in a clinical setting and eight years of experience in quality improvement.

- **Program Manager, Care Experience –** responsible for measuring member experience performance, and develops and implements interventions to improve the care experience of SFHP members. The Care Experience Senior Program Manager has a Bachelor's of Science in exercise physiology, a Master's of science in organization development and has 13 years of experience in community health.

- **Program Manager, Quality Programs –** responsible for managing interventions to improve HEDIS and member experience through SFHP's pay-for-performance program and member incentive program. The Program Manager of Quality Programs has a

Master's of Science in Health Care Administration with 10 years of experience in healthcare.

- **Associate Program Manager, Access to Care –** responsible for operating quality improvement oversight and project manages SFHP's access monitoring requirements, measures CAHPS performance, develops and implements interventions to improve the care experience of SFHP members. The Access to Care Associate Program Manager has a Bachelor's of Arts in Psychology with seven years of experience in public health.

Associate Program Manager, Quality Improvement – reports to the Quality Improvement Director and is responsible for managing the QIHET program, oversight of the work plan, and facilitates QIHET collaborative activities with network providers. The Quality Improvement Associate Program Manager has a Master's of Arts, is a certified Project Management Professional, and has nine years of experience in healthcare and seven years of experience in community health advocacy.

Health Services Departments that contribute to the QIHET Program

Behavioral Health & Housing Department

SFHP's Behavioral Health & Housing Department implements quality improvement activities related to implementation of and oversight of behavioral health & housing supports including behavioral health therapy.

Care Management Department

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

Clinical Operations Department

SFHP's Clinical Operations Department conducts Utilization Management (UM) for both inpatient and outpatient requests. In addition, they oversee delegated UM activities within the provider network to comply with all regulatory UM requirements. Activities are comprised of the following functional areas: Concurrent Review, Post-Acute, Long Term Care, Prior Authorization, and UM Delegation Oversight.

Population Health Management Department

SFHP's Population Health Management Department is responsible for programs related to population Health Equity, Health Education, Cultural & Linguistic Services, and implementation of Basic Population Health Management with programs that include Community Health Workers, Early & Periodic Screening, Diagnostic, Screening, & Treatment, Wellness & Prevention Programs, Chronic Disease Programs, and programs focused on Maternal Health Outcomes.

State Programs Department

SFHP's State Programs Department implements the programs of Enhanced Care Management and Community Supports benefit to provide support to members with complex needs.

External Agencies that contributes to the QIHET program

Carelon Behavioral Health

Carelon is delegated to provide non-specialty mental health care to SFHP's Medi-Cal members. Carelon's Quality Director presents annually on their QI plan and participates in QIHEC meetings as needed. SFHP's CMO provides oversight and strategic guidance of the NSMH benefit to Carelon. Carelon's on-site clinical staff participates in Care Management rounds to ensure a smooth connection of our member to Carelon services. SFHP collaborates with Carelon's Clinical Management Director on QIHET initiatives as needed.

Teladoc

The Teladoc Program is a service which provides San Francisco Health Plan members with unlimited, toll-free access to telephonic or video consultations, available 24 hours per day, 365 days per year, provided by a state licensed physician. The Teladoc Program contributes to QIHET activities by aiming to reduce avoidable Emergency Room and Urgent Care utilization, increase utilization of the Non Specialty Mental Health benefit, and improve members care experience of access to care.

4. Quality Improvement Method and Data Sources

A. Identification of Important Aspects of Care

SFHP identifies priorities for improvement based on regulatory requirements, NCQA standards, data review, and provider and member-identified opportunities in the key domains of Clinical quality - medical care; Clinical quality - behavioral health; Access to primary and specialty care; Engagement with primary care; Care coordination and continuity of care; Member experience. Particular attention is paid to those areas that are high risk, high volume, high cost, or problem prone. The QIHET Program employs a systematic and data-driven method for identifying opportunities for improvement and evaluating the results of interventions.

Data Collection and Analysis to Identify Opportunities for Improvement

The organization regularly collects information related to medical and behavioral health care clinical quality, member access to and engagement with primary and specialty care, coordination and continuity of care, and member experience across the continuum of care. Information collected includes HEDIS measure rates, member survey data, member movement between practitioners, member movement across settings, opportunities for collaboration between medical care and behavioral healthcare, and feedback from providers on quality-related topics. SFHP staff perform quantitative and qualitative analysis of the data, including root cause analysis and identification of barriers to delivery of quality care to drive measurable improvements focused on improving member experience, supporting providers, and health outcomes. Once improvement opportunities are identified, they are discussed and approved in

the QIHEC. Approved opportunities are then included in the annual QI Workplan (Appendix A) as measures.

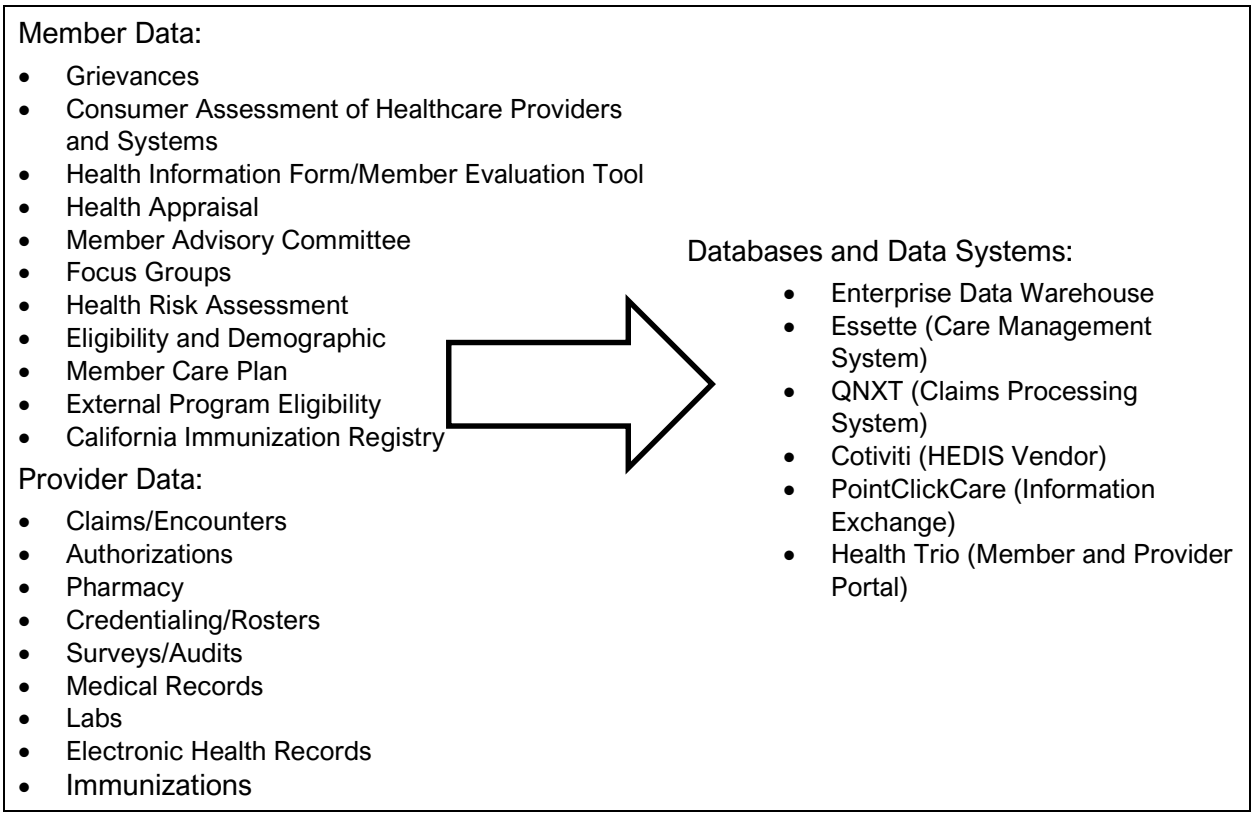
Acting on Opportunities

For each measure identified, SFHP "measure champions" lead cross-functional teams of staff who collaborate with providers and community organizations to plan and implement interventions based on best practices to resolve identified issues and barriers. The planning includes choosing a measure indicator by defining a numerator and denominator, baseline rate, target, and activities to be completed within a defined time period.

Measuring Effectiveness

The outcomes of these improvement activities are measured on a monthly and quarterly basis, and measure champions reassess planned activities based on a quarterly qualitative analysis of measure-related data. The quarterly measure performance is shared with and analyzed by the QIHEC in the form of a QI Scorecard. The Annual QI Program Evaluation (see details in section "5. QIHET Program, below) summarizes and analyzes the annual performance data and provides recommendations for the next measurement year.

Data Systems and Sources



B. Data Monitoring and Reporting

SFHP monitors and improves data quality via the following mechanisms:

- **Encounter Data Monitoring** – SFHP measures the quality of encounter data monthly for completeness, accuracy, reasonability, and timeliness using methodology published in

the DHCS Quality Measures for Encounter Data (QMED) document. SFHP works with its Trading Partners to ensure timely encounter submissions by reviewing error reports, reconciling and resubmitting rejected encounters.

- **Health Services Product Management (HSPM) Data Workgroup** – The HSPM Data Workgroup is a cross-functional internal SFHP workgroup drawn from ITS and Health Services (HS) to support facilitation and incorporation of external and internal data sources and to provide a forum to discuss business use cases for the various data sets, particularly external. The workgroup created a Desktop Procedure for the ingestion of new external data sources.
- **Monthly Proactive HEDIS Runs** – The HEDIS team monitors HEDIS data quality via monthly proactive runs. This includes a monthly QA and UAT process to identify and resolve any data quality issues. In addition, HEDIS rates are monitored monthly via the HEDIS Performance Monitoring Dashboard in Tableau which allows the HEDIS team to compare denominator and rate changes month over month. Additional data quality reporting within the HEDIS tool, Quality Reporter, allows the HEDIS Team to monitor the impact of all data sources on HEDIS numerators and exclusions.
- **Health Equity and Quality Measure Set** – The QI and HEDIS teams stratify HEDIS and CAHPS measures as by race, ethnicity, and age as required by the Department of Managed Health Care. This measure set is comprised of 12 HEDIS measures and one CAHPS measure: Colorectal Cancer Screening, Breast Cancer Screening, Hemoglobin A1c Control for Patients with Diabetes, Controlling High Blood Pressure. Asthma Medication Ratio, Depressions Screening and Follow-Up for Adolescents and Adults, Prenatal and Postpartum Care, Childhood Immunization Status, Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits, Plan All-Cause Readmissions, Immunizations for Adolescents, and Getting Needed Care

C. Policies and Procedures

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

5. Quality Improvement and Health Equity Transformation Program

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

QIHET Program Work Plan

Results of the annual evaluation (described in more detail, below), in combination with information and priorities determined by the Health Services leadership and staff in collaboration with providers and members, are reviewed and analyzed in order to develop an annual QIHET Program Work Plan (see Appendix A). This comprehensive set of measures and indicators is divided into six domains:

- Access to primary and specialty care

- Clinical quality - behavioral health
- Clinical quality - medical care
- Engagement with primary care
- Care coordination and continuity of care
- Member experience

The QIHET Program Work Plan also includes:

- A summary of Health Equity Activities including health equity activities planned for workplan measures and the implementation of DEI training.
- An overview of the Quality Oversight Activities

QIHET Program Annual Evaluation

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

- Brief description of the QI activity/intervention and how it aims to improve the domain in which it is included
- Measure target of the QI activity/intervention
- Measure definition
- Measure results, trended over at least three years when available
- Quantitative analysis comparing the results to the target, benchmarks, and any other comparable results
- Qualitative analysis including an examination of the underlying reason or cause of the result including listing of barriers and root causes
- Conclusion about the overall outcome and effectiveness of the measure
- Recommendation of interventions and actions to overcome barriers in the following year

6. QI Activities

A. Access to Primary and Specialty Care

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

Monitoring Member Access

SFHP monitors members' access to care, following regulations delineated by DMHC and DHCS as well as accreditation standards set by NCQA. DMHC monitoring requirements are met by the annual Timely Access Regulations submission in May. DHCS monitoring requirements are met via the annual contract oversight audit performed by DHCS. These access monitoring measures, among others, are reviewed quarterly by SFHP's Access Compliance Committee. Based on monitoring and survey results, the committee identifies issues and requests a response when performance thresholds are not met. Data are comprehensive, addressing core

areas such as member and provider experience with access, appointment availability, after hours care, wait times, as well as indicators of network adequacy to meet members' needs.

B. Clinical Quality - Medical Care

The domain of Clinical Quality – Medical Care involves activities related to clinical outcomes related to chronic condition care management, patient safety, and pharmacy services including drug utilization review.

Non-Behavioral Chronic Condition Management

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

- Asthma Medication Ratio
- Eye Exam for Patients with Diabetes
- Kidney Health Evaluation for Patients with Diabetes
- Hemoglobin A1c Control for Patients with Diabetes
- Medical Assistance with Smoking and Tobacco Use Cessation
- Pharmacotherapy Management of COPD Exacerbation

SFHP promotes chronic condition management guidelines to providers through the quarterly provider newsletter and by publishing guidelines on SFHP's public website. These guidelines include but are not limited to:

- American Diabetes Association: Clinical Practice Guidelines
- Institute for Clinical Systems Improvement Guidelines
- SFDPH Asthma Home Visiting Program and Resources
- JNC8 Guidelines for Hypertension

Pharmacy - Patient Safety

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

- **Medication Therapy Management (MTM) Program** – SFHP Clinical Pharmacists review medication needs for members identified by the Care Management program NCQA requirements. The goal is to optimize medication regimens by promoting safe and effective use of medications. Achieving this goal and completing interventions is a multidisciplinary effort between Pharmacy services, the Care Management and Transitions of Care team, Senior Medical Director, and primary care (including ECM) providers. Educational medication resources for targeted members will also increase adherence and knowledge of their drug regimen. The MTM program is currently expanding to target additional populations of focus under CalAIM, including long term care and others, as well as support improvement of targeted quality measures via the Medication Adherence Program. Medication Adherence Program is a pharmacy-only initiative targeting overutilization of "as needed" medications and underutilization of maintenance medications. Currently the Medication Adherence Program is on hold with plans to resume with additional staffing.

- **SFHP Pain Management Program** – SFHP conducts trainings for providers and clinic staff on multiple aspects of pain management, including safe opioid prescribing. SFHP works with external and internal experts to provide clinical and non-clinical pain management resources to the community. There is an internal report that monitors all members on opioids or with opioid use disorder on a quarterly basis. SFHP has an internal Pain and Opioid Workgroup and pain management is discussed at SFHP's Pharmacy & Therapeutics Committee. Currently the Pain and Opioid workgroup is held in tandem with the Quality Improvement and Drug Utilization Review meeting on a monthly basis.

Pharmacy Services Drug Utilization Review (DUR)

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

- **Retrospective DUR Program** consists of reporting and analysis for prescription claims data and other records to identify patterns of fraud, abuse, gross overuse, inappropriate or medically unnecessary care and other aspects of optimizing medication use. Drug utilization reports evaluate prescribing trends and potential over and under use and potential outlier cases. Utilization reports may include member adherence reports, controlled substance utilization reports, pharmacy outlier reports, etc.

- **Educational Program** consists of verbal and written communication outreach activities developed by the Medi-Cal DUR team and by SFHP to educate prescribers, pharmacists and members on common drug therapy problems with the aim of improving prescribing and dispensing practices.

Patient Safety: Potential Quality Issues (PQIs)

SFHP Clinical Operations, Care Management, and Pharmacy staff are trained to identify PQIs and refer them to the Quality Review Nurse. SFHP defines a Potential Quality Issue (PQI) as an identified adverse variation from expected clinical standard of care that may present potential or real harm to SFHP members and requires further investigation. SFHP ensures that PQIs are initially evaluated by the Quality Review Nurse for clinical review of elements meeting an acceptable standard of care and presents to the SFHP Medical Director to review investigation results and determine if a clinical quality issue is evident, which may result in corrective action plans and referral to Provider Advisory Committee (PAC) for peer review and next step recommendations.

C. Clinical Quality - Behavioral Health

The domain of Clinical Quality – Behavioral Health involves activities related to clinical outcomes related to behavioral health chronic condition care management.

Behavioral Chronic Condition Management

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

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Antidepressant Medication Management
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up After High-Intensity Care for Substance Use Disorder
- Follow-Up Care for Children Prescribed ADHD Medication
- Initiation and Engagement of Substance Use Disorder Treatment - Engagement
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Pharmacotherapy for Opioid Use Disorder
- Use of First-Line Psychosocial Care For Care for Children and Adolescents on Antipsychotics

SFHP promotes chronic condition management guidelines to providers through the quarterly provider newsletter and by publishing guidelines on SFHP's public website. These guidelines include but are not limited to:

- American Diabetes Association: Clinical Practice Guidelines
- Institute for Clinical Systems Improvement Guidelines
- SFDPH Asthma Home Visiting Program and Resources
- JNC8 Guidelines for Hypertension

D. Engagement with Primary Care

The domain of Engagement with Primary Care involves activities related to the delivery of preventative care services and Initial Health Assessments.

Preventive Care

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

- Adolescent Immunization Status
- Ambulatory Care
- Appropriate Testing for Pharyngitis
- Appropriate Treatment Upper Respiratory Infection
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- Breast Cancer Screening
- Cervical Cancer Screening

- Childhood Immunization Status
- Chlamydia Screening in Women
- Contraceptive Care: All Women Ages 15-44
- Contraceptive Care: Postpartum Women Ages 15-44
- Developmental Screening in The First Three Years of Life
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well-Care Visits
- Screening for Depression and Follow-Up Plan

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

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

To encourage members to receive high priority services, SFHP offers a $50 incentive to eligible members for completing well-child visits.

Financial Incentives to Primary Care Support Improvement

The Practice Improvement Program (PIP) is SFHP's pay-for-performance program. PIP incentive funds are sourced from approximately a 20% withholding of provider payments. Providers are eligible to earn 100% of these funds back if they meet program requirements. Supporting the goals of the triple aim, PIP has four domains: Clinical Quality, Patient Experience, Systems Improvement, and Data Quality. Participants have opportunities to gain incentive funds both from meeting benchmarks and from relative improvement. Unearned funds are reserved to support improvement of performance measures via technical assistance and provider-level grants.

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

E. Care Coordination and Continuity of Care

The domain of Care Coordination and Continuity of Care involves activities related to Long Term Care Quality, Care Transitions, Care Management, Enhanced Care Management, monitoring of over and underutilization, and otherwise improved coordination across multiple providers and facilities and focuses on members with more complex medical and psychosocial needs.

Long Term Care Quality Assurance Performance Improvement

San Francisco Health Plan (SFHP) is responsible for administering care and maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program. In accordance with regulatory requirements and guidance, QI maintains quality oversight and conducts annual monitoring of the care provided to SFHP Medi-Cal members at the following Medi-Cal contracted facilities: Skilled Nursing Facilities, Long Term Care, and Subacute Facilities. The QIHEC is responsible providing oversight of the Plan's QAPI activities.

Health Risk Assessment (HRA)

All new Seniors and Persons with Disabilities (SPDs) members complete Health Risk Assessments. Members are then reassessed annually. Members are stratified as either high or low risk based on their responses to the HRA questionnaire or the reassessment report data. Members who are high risk receive outreach both by phone and mail, while low risk members receive outreach by mail. HRA telephonic care management is provided for 30 days to members who receive services within the non-delegated medical groups (San Francisco Health Network, Community Clinic Network and UCSF Medical Group). In addition, the Long-Term Services and Supports (LTSS) standardized set of ten questions are embedded in the HRA assessment and utilized to assess members who might need LTSS. Members who answer "yes" to one of the LTSS questions are considered "high risk" and referred to Care Management for outreach. Members receiving care within delegated medical groups in the network receive follow-up from their assigned medical group.

Care Management Programs

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

Care Coordination with External Agencies

SFHP's Care Management and Utilization Management teams ensure coordination of care for members per Medi-Cal contractual requirements. These coordination activities include executed MOUs with key agencies such as California Children Services (CCS), Golden Gate Regional Services (GGRC), Department of Early Childhood and Community Behavioral Health Services (BHS) that outline coordination activities. These coordination activities are designed to ensure members are aware of non-plan benefits and programs available to them and confirm

coordination of care across agencies and services. Through collaboration with the Department of Homelessness and Supportive Housing, supportive housing providers, and various community partners, SFHP enhances the scope of care coordination to create a more unified and effective service system.

Children and Transitional Aged Youth

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

Transitional Care Services

As of January 1st 2024, SFHP expanded the scope of care transitions and launched the Transitional Care Services (TCS) program, an initiative under CalAIM. The goal of the TCS program is to provide care coordination to prevent gaps in services, care and support while members transition between one level of care or setting to another. Dedicated care management staff are responsible for providing transitional care services which include collaboration with the discharging facility, assistance with scheduling appointments and referrals to other programs, such as ECM if appropriate. The program lasts for 30 days post discharge or until the member is connected to all needed services and supports.

HIF/MET Services

Members receive the HIF MET assessment from SFHP as part of the new member Welcome Packet, SFHP Care Management staff reviews all assessments received by SFHP Business Intelligence, and applies the scoring system, "High-risk" members are referred to Care Management for care management services at SFHP and are outreached to participate in a 30 day Telephonic Care Management (TCM) program.

Enhanced Care Management

Enhanced Care Management (ECM) is a Medi-Cal benefit that was implemented in January 2022, and is a whole-person interdisciplinary approach to improve coordination, access to care, quality and outcomes for SFHP's highest risk group of members. ECM is available to individuals that qualify based on a defined Population of Focus (listed below) and includes the following seven services that are designed to address both the clinical and non-clinical needs: 1) outreach and engagement, 2) comprehensive assessment and care management plan, 3) enhanced coordination of care, 4) health promotion, 5) transitional care services, 6) member and family supports, and 7) coordination and referral to community and social support services. Together these services provide comprehensive care management that is high-touch, community based and focused on the individual needs of the member.

DHCS has identified 16 different Populations of Focus that are eligible for ECM including:

- Individuals experiencing homelessness
- Individuals with avoidable ED and hospital utilization

- Individuals diagnosed with Serious Mental Illness or Substance Use Disorder
- Individuals with intellectual and developmental disabilities
- Adult pregnant and postpartum individuals at risk for adverse perinatal outcomes
- Adults living in the community who are at risk for long-term institutionalization
- Nursing facility residents transitioning back to the community
- Children and youth with complex needs in the following categories:
    - Children and youth experiencing homelessness
    - Children and youth with avoidable ED and hospital utilization
    - Children and youth with SMI and SUD
    - Children and youth enrolled in CA children's services (CCS) or whole child model with additional needs beyond CCS condition
    - Children and youth involved in child welfare
    - Children and youth with intellectual and developmental disabilities
    - Child and youth who are pregnant and post-partum at risk for perinatal adverse outcomes
- Individuals transitioning from incarceration
- Pregnant and post-partum individuals at risk for perinatal adverse outcomes who are subject to racial and ethnic disparities

Over- and Under-Utilization of Services

SFHP monitors and evaluates outpatient, inpatient, emergency department, and ancillary services, through monthly reviews of service utilization data. The intent of the reviews is to identify patterns of under and overutilization of services and address any outlier patterns by creating actionable steps to promote evidence-based, medically appropriate service utilization.

Service utilization monitoring is reviewed through a UM trending report providing national and state benchmarks for:

- Ambulatory Care – Emergency Dept Visits
- Inpatient Utilization – Acute Care – Total Inpatient Average Length of Stay (ALOS)
- Inpatient Utilization – Acute Care – Total Inpatient Days/1000 MM
- Community Based Adult Services Utilization

Service utilization patterns are shared with internal leadership as well as external leadership in SFHP's provider network. Adverse patterns are discussed with SFHP's internal and external leadership for root-cause identification, and if needed, corrective action plans are developed.

F. Member Experience

The domain of Member Experience involves activities related to improvement of care experience as measured by Health Plan CAHPS, experience or satisfaction of specific programs, Grievances & Appeals, Cultural and Linguistic Services, Health Education, Community Supports and member materials.

Member Grievances and Appeals

SFHP ensures that member grievances and appeals are managed in accordance with Managed Care, Medi-Cal, and NCQA standards. SFHP manages and tracks complaints and grievances and provides a quarterly analysis, identifying trends and addressing patterns when evident, to

the QIHEC. To identify patterns and trends in grievances, grievance reports are generated to report rates by line of business, medical group, and grievance category. When a grievance pattern has been identified, SFHP works with clinics or medical groups to develop strategies for improvement or request corrective action as appropriate. SFHP's Utilization Management Committee (UMC) reviews all member appeals for issues and trends.

Cultural and Linguistically-Appropriate Services and Anti-Discrimination Procedures

SFHP's Cultural and Linguistic Services program is informed by regular assessment of the ethnic, racial, cultural and linguistic needs of its members via the DHCS Population Needs Assessment (PNA) and NCQA Population Assessment: Cultural, Ethnic, Racial and Linguistic Needs of SFHP Members and Practitioner Availability (NET 1 A). All SFHP member materials are available in Medi-Cal threshold languages. All SFHP health education materials are written at a sixth-grade reading level. Alternative formats for member materials, such as large text and braille, are available to members upon request.

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

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

Health Education

SFHP ensures that members have access to health education and self-management resources at the 6th grade literacy level and in all threshold languages mandated by DMHC and DHCS. These resources are available on the SFHP website, and through SFHP providers. Select materials are also mailed to members as part of SFHP's population health campaigns.

Health topics covered by these tools and fact sheets include smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, asthma and diabetes control, parenting, and perinatal care, among others. SFHP's member newsletter, "Your Health Matters," features emerging health education topics prioritized by SFHP's clinical leadership. In

addition, the SFHP website includes a sortable listing of free group wellness classes offered by SFHP's provider network on a variety of topics.

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

Community Supports

Community Supports are medically appropriate and cost-effective services that are intended to be alternatives to covered services. DHCS has identified 14 Community Supports that health plans can offer, which together seek to improve health outcomes and reduce unnecessary emergency room use, hospitalization/institutionalization. Since Community Supports launched in January 2022, SFHP gradually expanded its offerings to members and forged new partnerships with several community-based providers. Below is a list of the eight Community Supports currently available to eligible SFHP members, three additional CS services will be available in July 2024.

- Medical respite (January 2022): Short-term residential care for members who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment.
- Sobering centers (July 2022): Alternative destinations for individuals found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail.
- Medically tailored meals (July 2023): 12 weeks of medically supportive food (could be delivered meals or groceries) that are approved by a registered dietitian that reflect the appropriate dietary therapy for a member's health needs. Eligible individuals must have a qualifying chronic condition or complex health needs.
- Housing navigation (July 2023): Assists members with identifying and securing housing, which includes developing a housing plan, addressing barriers, and securing viable housing options.
- Housing deposits (January 2024): Provides up to $5,000 to assist with securing and funding one-time housing services necessary to establish a basic household (deposit, initial rent, utilities and some goods (e.g. heater, bed). Individuals must be in housing navigation.
- Housing tenancy and sustaining services (January 2024): Assistance with maintaining housing, including coordination with landlord, education on lease compliance, assistance with financial literacy, etc.
- Home modifications (January 2024): Up to $7,500 to support physical adaptations to a home that are necessary to ensure the health and safety of an individual, including grab bars, improvements to bathroom/shower, etc. They are intended to support greater independence and reduce the risk of hospitalization/LTC.
- Community Transitions (January 2024): Up to $7,500 to provide support to individuals in an LTC facility that want to transition back to the community. Services include identifying

housing options, coordinating with the landlord; and good related supports (e.g. home modifications, security deposits, first month of utilities, pest eradication, etc.).

G. Quality Oversight Activities

Member Rights and Responsibilities

SFHP works to ensure that members are aware of their rights and responsibilities. This includes the annual review, revision, and distribution of SFHP's statement of member rights and responsibilities to all members and providers for compliance with SFHP standards and legislative mandates. SFHP's member rights and responsibilities are available in the Medi-Cal Member Handbook, Medi-Cal Member Guidebook, Healthy Workers HMO Evidence of Coverage and Disclosure Form, and Healthy Workers HMO Member Guidebook. Members can also view their rights and responsibilities on SFHP's public-facing website. Providers are able to view the member rights and responsibilities in SFHP's Provider Manual. SFHP also implements specific policies that address the member rights to confidentiality and minor's rights. SFHP conducts a review of grievance and appeal policies and procedures to ensure compliance with SFHP standards, legislative mandates, DHCS contractual obligations, and NCQA standards, at least once every other year. In addition, SFHP analyzes member grievances and appeals that specifically concern member rights and responsibilities.

Provider Satisfaction

On an annual basis, SFHP conducts a Provider Satisfaction Survey to gather information about network-wide provider issues and concerns with SFHP's services. The survey targets primary care and specialty care providers, ancillary providers, and office staff. It measures their satisfaction with the following SFHP functions:

- Telehealth Services
- Utilization Management
- Care Management
- Network/Coordination of Care
- Timely Access to Health Care Services
- Pharmacy
- Health Plan Customer Service Staff
- Provider Relations
- Ancillary Provider Network
- Member Incentives

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

Provider Credentialing

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

Bi-annual review of credentialing policies and procedures for compliance with legislative and regulatory mandates, contractual obligations, and NCQA standards

Peer review of credentialing and re-credentialing recommendations, potential quality of care issues, and disciplinary actions through the Physician Advisory Committee (PAC)

Providing a mechanism for due process for practitioners who are subject to adverse actions

Reviewing licensing, accreditation, or vetting documentation of organizational providers, or reviewing for compliance with industry standards

Conducting ongoing provider monitoring through the Medical Board of California and other licensing organizations, List of Excluded Individuals/Entities (LEIE), DHCS' Suspend & Ineligible List (S&I), the System for Award Management (SAM), National Plan and Provider Enumeration System (NPPES), the Social Security Death Master File (SSADMF), and the Restricted Provider Database (RPD).

DHCS Performance Improvement Projects (PIP)

SFHP implements DHCS PIPs at any given time. PIP measures aim to understand key drivers of poor performance and conduct improvement activities based on the key drivers. One of SFHP's PIPs for 2023-2026 targets the large disparities in in infants receiving the six recommended well-child visits by 15-months of age seen among the SFHP member population by race/ethnicity. SFHP aims to improve the rate of Hispanic members who receive all six well-child visits within the HEDIS timeframe. The second PIP aims to improve the members visiting the emergency room for mental health or alcohol or other drugs to receive follow-up care within seven days.

Delegation Oversight

Standards and Process for Delegated Medical Groups

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

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

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

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

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

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

In addition to submission of a CAP, Delegates that have scores less than 95% in any critical element will be subject to quarterly audits of said element. The Delegate will remain under quarterly audit until the Delegate has obtained scores of 95% for two (2) consecutive audit periods.

Audit results are communicated to the Delegated Entity within 60 days from the completion of the audit. When a CAP is submitted by the Delegated Entity, the SFHP Provider Network Operations team will evaluate the response, collaborate with the Subject Matter Experts,and issue either an approval or a request for additional information.

Annually, the Provider Network Oversight Committee, the UM Committee, and the Quality Improvement Committee review a summary of delegated groups audit results, provide feedback or request additional information or corrections from the delegate as needed.

Delegated Functions

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

- All American Medical Group
- American Specialty Health
- Brown and Toland
- Carelon Behavioral Health
- Hill Physicians Medical Group
- Jade HealthCare Medical Group
- North East Medical Services
- San Francisco Health Network
- Teledoc
- University of California, San Francisco Medical Center (UCSF)
- VSP Vision Plan

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

- All American Medical Group
- American Specialty Health
- Brown and Toland
- Carelon Behavioral Health (ABA/BHT only)
- Hill Physicians Medical Group
- Jade HealthCare Medical Group
- North East Medical Services
- San Francisco Behavioral Health Services

Pharmacy Services –Magellan is delegated to manage pharmaceutical services on SFHP's behalf for the SFHP Healthy Worker HMOline of business.

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

- All American Medical Group
- Brown and Toland
- Hill Physicians Medical Group
- Jade HealthCare Medical Group

  North East Medical Services

Non-Specialty Mental Health –Carelon Behavioral Health provides non-specialty mental health services to all SFHP Medi-Cal members. San Francisco Behavioral Health Services (BHS) provides all non-specialty and specialty behavioral services to SFHP Healthy Worker HMO members.

Quality Management – Quality Management is not a delegated function. Review of each Delegate's Quality Workplan and Quality Measures specific to the delegate are conducted as part of the annual audit.

Member Appeals and Grievances – Carelon Behavioral Health is partially delegated for Grievances and Appeals. Carelon is responsible for processing all grievances and appeals. Carelon grievance and appeals are presented to the Grievance Review Committee (GRC) for review and approval.

Reviewed & Approved by:

Chief Medical Officer: *Eddy Ang, MD, MPH* **Date:**

Quality Improvement & Health Equity Committee Review Date:

Board of Directors Review Date:

Appendix A: Work Plan

Access to Primary and Specialty Care

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
Appointment Availability - Routine Specialty	Total number of specialists responding to PAAS with a routine appointment within 15 business days	Total number of specialists responding to PAAS with a routine appointment	50.0%	Supervisor, Quality Improvement	• Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate. • Provide technical assistance with Corrective Action Plans. • Provide funding to ZSFG Specialty Care providers to implement appointment access interventions. • Incentivize ZSFG providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.	6/30/2024
Provider Directory - Accuracy	Total number of provider data points confirmed accurate	Total number of data points surveyed in the reporting period	90.50%	Senior Manager, Provider Network Operations	• Incentivize providers through inclusion of a provider roster update measure in SFHP's primary care pay-for-performance program. • Segment scores to identify priority groups & conduct root cause analysis of provider data errors. • Outreach to those root cause partners and analyze data to target common sources of inaccuracy.	12/31/2024

Care Coordination and Continuity of Care

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
Care Management Follow Up on Clinical Depression	Total Complex Care Management clients 18 years or older who screened positive for clinical depression with PHQ-9 with a "Connect to Behavioral Health" care plan goal	Total Complex Care Management clients 18 years or older screened positive for clinical depression with PHQ-9	90.00%	Director, Care Management	• Train staff in mental health, particularly on severe mental illness (SMI) and community resources, to ensure that staff is equipped to identify signs and symptoms of clinical depression and address client safety, including connection to behavioral health services. • Clinical Supervisors to review CM dashboard monthly with staff and to coach staff to ensure members are screened and receive appropriate follow up. • Initiate a weekly behavioral health office hour between SFHP Care Management, SFHP Behavioral Health, and Carelon clinical teams to staff cases and ensure timely connection to behavioral health services.	6/30/2024
Complex Care Management Follow Up on	Total clients 18 years or older who screened positive	Total Care Management clients 18 years or	85.00%			

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
Clinical Depression	for clinical depression with PHQ-9 with a "Connect to Behavioral Health" care plan goal	older screened positive for clinical depression with PHQ-9			• Collaborate to ensure effective coordination of care through the Managed Behavioral Health Care Committee which includes both SFHP and SF Behavioral Health Services. • Complete quarterly staff self-audits which will enable Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated. • Clinical Supervisors to conduct audits every 4 months to ensure best practices and regulatory requirements are met.	
Depression Screening and Follow-Up for Adolescents and Adults: Follow-Up on Positive Screen	The percentage of members who received follow-up care within 30 days of a positive depression screen finding.	The percentage of members who were screened for clinical depression using a standardized instrument.	85.00%	Behavioral Health Manager	• Conduct member-outreach campaign encouraging treatment of symptoms of depression. • Disseminate depression screening health education to members. • Track Carelon Care Management staff completing PHQ-9 depression screening on all members who are referred to Carelon mental health services. • Target conversations with lower performing medical groups about increasing depression screening and follow up.	12/31/2024
Follow-up After ED visit for Mental Illness: 30-Day	Members (aged 6 and older) who received a follow-up visit for mental illness within 30 days of an emergency department visit with a diagnosis of mental illness or intentional self-harm	Emergency department visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm	54.87%	Health Services Officer	• ED member navigators provide motivational interviewing and referral to members' Enhanced Care Management provider or PCP for follow-up visit. • Incentivize providers through inclusion of a Follow-up After ED Visit for Mental Illness measure within 30 days in SFHP's primary care pay-for-performance program.	12/31/2024
Follow-up After ED visit for Mental Illness: 7-Day	Members (aged 6 and older) who received a follow-up visit for mental illness within 7 days of an emergency department visit	Emergency department visits for adults and children 6 years of age and older with a diagnosis of mental illness or	40.59%			

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
	with a diagnosis of mental illness or intentional self-harm	intentional self-harm				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day	Follow up visit by members 13 years of age and older for alcohol or other drug (AOD) within 30-days of an emergency department (ED) visit with a principal diagnosis of AOD abuse or dependence	Emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence	36.34%	Health Services Officer	• ED member navigators provide motivational interviewing and referral to members' Enhanced Care Management provider or PCP for follow-up visit. • Incentivize providers through inclusion of a Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence within 30 days measure in SFHP's primary care pay-for-performance program.	12/31/2024
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day	Follow up visit by members 13 years of age and older for alcohol or other drug (AOD) within 7-days of an emergency department (ED) visit with a principal diagnosis of AOD abuse or dependence	Emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence	24.51%			

Clinical Quality - Behavioral Health

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
Adherence to Antipsychotic Medication	Number of members on antipsychotic with 80% adherence (PDC)	Number of adults 18 years of age and older with schizophrenia or schizoaffective disorder with diagnosis: at least 2 outpatient visits or one acute inpatient visit	61.39%	Clinical Pharmacist	• Communicate with SF Behavioral Health Services to discuss barriers to access for members with schizophrenia on antipsychotics. • Include member education on medication adherence for chronic disease states in Your Health Matters	12/31/2024
Mental Health Utilization Rate	Number of unique Medi-Cal members with a mental health visit	Overall number of Medi-Cal members	4.50%	Health Services Officer	• Conduct member-outreach mental health awareness campaign. • Implement improved service-level agreement with Carelon to hold them accountable to care improvements. • Increase integration of clinics to include providers of behavioral therapy. • Implement dyadic care services to improve family well-being through care appointments that are scheduled in tandem to support parent and child health.	7/31/2024

Clinical Quality - Medical Care

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
Asthma Medication Ratio	Number of controller meds	Number of total asthma meds (controller and rescue) for 5-64 years of age and older with persistent asthma	69.41%	Clinical Pharmacist	• Collaborate with provider groups with most opportunity for improvement. • Communicate updated asthma guidelines with providers and pharmacies. • Incentivize providers through inclusion of an Asthma Medication Ratio measure in SFHP's primary care pay-for-performance program. • Promote and encourage members with asthma to engage in services through a Chronic Condition incentive.	12/31/2024
Hepatitis C Treatment	Number of members who	Number of members with any past history of Hep	40.00%	Clinical Pharmacist	• Collaborate with End Hep C group on provider education.	12/31/2024

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
	completed Hep C treatment regimen	C diagnosis in 36-month lookback for Medi-Cal and Healthy Workers			• Create outreach letter template for providers with members who need to complete Hepatitis C treatment to assist in coordination of care. • Provide analysis and trends on members who have not completed Hepatitis C treatment to providers.	

Engagement With Primary Care

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
Initial Health Appointment	Number of members who had a comprehensive PCP visit during first 120 days of Medi-Cal enrollment	Number of all new members enrolled in prior 120 days	35.00%	Manager, Population Health	• Initiate raffle to incentivize new members to complete their IHA • Incentivize providers through inclusion of an Initial Health Appointment measure in SFHP's primary care pay-for-performance program. • Coordinate with provider groups by providing new member lists on a monthly cadence, communicate their performance, and making coding requirements clear and accessible to providers. • Improve language in member materials, including website, to make more accessible.	12/31/2024
PCP Engagement	Medi-Cal members without a provider visit from the previous year who have a visit in the subsequent year	Medi-Cal members without a provider visit from the previous year	Increase of 2.0%	Director, Quality Improvement	• Incentivize providers through inclusion of a PCP visit measure in SFHP's primary care pay-for-performance program. • Promote and encourage members with asthma to engage in services through member incentives for: ○ well-child visits in the first 15 months of life ○ developmental screening in the first 36 months of life ○ members to receive colorectal cancer screening ○ members 12 to 47 months to receive fluoride treatment ○ members to receive initial health appointments ○ pregnant members to receive prenatal or postpartum visits ○ members with asthma, high blood pressure, or diabetes to receive a PCP visit	6/30/2024
Prenatal and Postpartum Care: Postpartum Care	Number of people with a live birth during the measurement period who had a postpartum check	Number of people with a live birth during the measurement period.	84.59%	Health Services Officer	• Ensure a diverse and inclusive environment with a network of doulas and community health workers that can support all members engaging in perinatal care and connecting with plan benefits and services. • Promote and encourage pregnant members to engage in services through a member incentive for both prenatal and postpartum visit.	12/31/2024

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
	between 7-84 days after delivery.				• Incentivize providers through inclusion of a prenatal visit measure in SFHP's primary care pay-for-performance program.	
Topical Fluoride for Children: Dental or Oral Health Services Total	Number of members one to 20 years of age who receive at least two topical fluoride varnish applications in the measurement year.	Number of members one to 20 years of age.	19.30%	Supervisor, Quality Improvement	• Coordinate with SF Department of Public Health and local oral health coalitions to promote awareness of the importance of topical fluoride application in the primary care setting for all children from tooth eruption to five years of age and for older children and teens (up to 20 years) at risk of caries. • Offer topical fluoride application training for those clinics requesting support. • Promote and encourage members aged 12 to 47 months to engage in services through a member incentive to obtain fluoride varnish treatment.	12/31/2024
Well-Child Visits in the First 30 Months of Life: 0-15 Months	Infants with six or more well visits by 15 months of age	All infants turning 15 months of age	58.38%	Manager, Population Health	• CM team to contact members with three or four out of the required six visits to coordinate their remaining PCP visits. • Complete Maternal Child Health gap analysis. • Promote and encourage members aged zero to 15 months to engage in services through a member incentive to obtain well-child visits. • Collaborate with SF Department of Public Health and other health plans on coordinated effort to improve measure. • Incentivize providers through inclusion of a well-child visit in the first 15 months of life measure in SFHP's primary care pay-for-performance program.	12/31/2024
Well-Child Visits in the First 30 Months of Life: 15-30 Months	Children with two or more well visits between 15 and 30 months of age	All children between 15 and 30 months of age	77.78%			

Member Experience

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
CAHPS: Getting Needed Care	Total number of members responding with 'usually' or 'always' to the Getting	Total number of members responding to the Getting Needed Care HP-CAHPS questions	72.80%	Supervisor, Quality Improvement	• Implement three organizational initiatives to improve the member care experience which include interventions focused on access to primary and specialty care, telehealth, and members engaged in SFHP member-facing programs and services.	6/30/2024

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
	Needed Care HP-CAHPS composite				• Implement a telehealth initiative that increases awareness and utilization, with a focus on African Americans and Spanish-speaking members • Incentivize providers through inclusion of a Rating of Personal Doctor measure in SFHP's primary care pay-for-performance program. • Reduce gaps in care utilization through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting telehealth quality improvement activities for the measure for members who are Hispanic or Latino or Black or African American. • Provide funding to ZSFG Specialty Care providers to implement appointment access interventions. • Incentivize ZSFG providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program. • Collaborate with network providers who work in care experience to align priorities & strategy, and work on shared initiatives. • Create a specialty referral guide by medical group for members.	
CAHPS: Rating of a Specialist	Total number of members rating 9 or 10 to the Rating of Specialist HP-CAHPS question	Total number of members responding to the Rating of Specialist HP-CAHPS question	67.38%			
CAHPS: Rating of PCP	Total number of members rating 9 or 10 to the Rating of Personal Doctor HP-CAHPS question	Total number of members responding to the Rating of Personal Doctor HP-CAHPS question	67.54%			
Care Management Client Satisfaction	Number of satisfaction survey respondents who respond "Yes" to Question 2: Has the Care Management program helped you reach your health goals? and who respond "Always" or "Often" to Question 6: After receiving information from the Care Management staff, I	Total Care Management clients who responded to the Care Management satisfaction survey	65.00%	Director, Care Management	• Development of an individualized case management plan, including member's prioritized goals and preferences. • Improve communication of care plan goal progress between Care Management staff and members. • Provide more thorough life skills, health education and training to members pertaining to self management of their conditions and their health maintenance. • CM staff completes a 6-month reassessment and review of care plan, including goals with member. • Maintain a process to triage members into longer-term case management programs when requested by member or indicated by member's self-efficacy skills. • Strengthen relationships with community based organizations and increase team knowledge of community resources.	6/30/2024

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
	feel confident I can take the actions needed to maintain or improve my health.				• Include online resources in Case Management software system for easier access by CM Coordinators and Nurses. • Initiate a Closed Loop Referrals project to seek a system for connecting members to needed resources.	
Complex Care Management Client Satisfaction	Number of satisfaction survey respondents who respond “Yes” to Question 2: Has the Care Management program helped you reach your health goals? and who respond “Always” or “Often" to Question 6: After receiving information from the Care Management staff, I feel confident I can take the actions needed to maintain or improve my health.	Total Complex Care Management clients who responded to self-reported health question of SF-12 on both the intake and closing assessments	100.00 %			
Provider Directory: Race & Ethnicity	Number of physicians with race/ethnicity data submitted	Number of physicians in SFHP Network	8.00%	Senior Manager, Provider Network Operations	• Engage provider groups in collecting data from their clinicians. • Conduct communication campaign to network providers to encourage providers to volunteer race and ethnicity information. • Explore offering a provider incentive for collecting race and ethnicity information	12/31/2024

Measure Name	Numerator	Denominator	Target	Responsible Staff	Activities	Date Activities to be Completed
					• Integrate race and ethnicity data collection with credentialing data.	

Health Equity Activities

Measure Title	Identified Ethnic/ Racial group(s) or Languages Experiencing Disparities	Staff Title	Planned Activities - Equity-focused interventions	End
Asthma Medication Ratio	Race/Ethnicity: • Black or African American • Native Hawaiian or Other Pacific Islander • American Indian or Alaskan Native Language • Vietnamese	Clinical Pharmacist	• Conduct root cause analysis of why certain groups experiencing disparities. • Ideate and explore equity-focused interventions for groups experiencing disparities.	12/31/2024
CAHPS: Getting Needed Care	Race/Ethnicity: • Asian Language: • Chinese	Supervisor, Quality Improvement	• Collaborate with SFHP's mental health provider Carelon and SFHP's provider group which serves the largest portion of Asian identifying and Chinese-speaking members North East Medical Services to increase referrals. • Improve provider credentialing issue with North East Medical Services and other provider groups to increase members' access to behavioral health providers. • Coordinate with Carelon to bring APA Family Support Services, a behavioral health provider serving the Chinese community, into Carelon's contracted network. • Provide network providers and staff training on racial equity.	6/30/2024
Depression Screening and Follow-Up for Adolescents and Adults: Follow-Up on Positive Screen	Race/Ethnicity: • Hispanic or Latino • Black or African American • Native Hawaiian or Other Pacific Islander • American Indian or Alaska Native Language • Spanish • Russian	Behavioral Health Manager	• Match primary care clinics which screen for depression with culturally congruent mental health providers for follow-up care.	12/31/2024

Measure Title	Identified Ethnic/ Racial group(s) or Languages Experiencing Disparities	Staff Title	Planned Activities - Equity-focused interventions	End
Prenatal and Postpartum Care: Postpartum Care	Race/Ethnicity: • Black or African American • Native Hawaiian or Other Pacific Islander • American Indian or Alaska Native	Health Services Officer	• Build an outreach program using a diverse group of staff to reach out to at-risk persons who are less likely to engage in preventive care. Refer to community health workers and doulas for support and intervention. • Incentivize providers through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting perinatal quality improvement activities for the measure for members who are Hispanic or Latino, Black or African American, Native American or Other Pacific Islander, and/or Asian/Pacific Islander patients.	12/31/2024
Well-Child Visits in the First 30 Months of Life: 0-15 Months	Race/Ethnicity: • Black or African American • Hispanic or Latino	Manager, Population Health	• Incentivize providers through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting well-child quality improvement activities for the measure for members who are Hispanic or Latino or Black or African American.	12/31/2024
Well-Child Visits in the First 30 Months of Life: 15-30 Months				

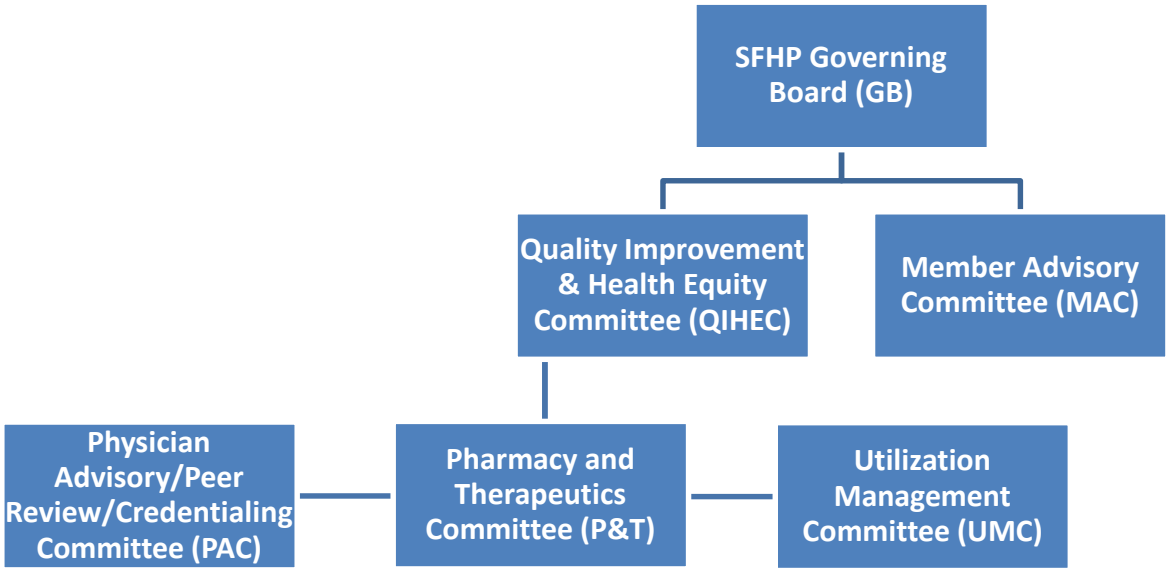
Quality Oversight Activities

Oversight	Summary	Resp. Staff	Activities	Due Date
Quality Improvement and Health Equity Committee	Ensure Quality Improvement and Health Equity Committee (QIHEC) oversight of QIHET activities outlined in the QIHET Program	CMO	• At least four meetings to be held in 2024	12/30/2024
Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	CMO	• Quarterly and ad hoc P&T Committee meetings	12/30/2024
Provider Advisory, Peer Review, and Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	• Six meetings to be held in 2024	12/30/2024
Annual Evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP)	Review QIHET Program and determine efficacy of implemented plan based on outcomes	Supervisor, Quality Improvement	• Evaluate each measure in the QIHET work plan • QIHEC review of QIHET evaluation • Governing Board review of QIHET Evaluation	3/27/2024
QIHET Plan Approval for Calendar Year	Review and approve proposed Quality Improvement Program work plan	CMO	• QIHEC review of QIHET Program Work Plan • Governing Board review of QIHET Program Work Plan	3/27/2024

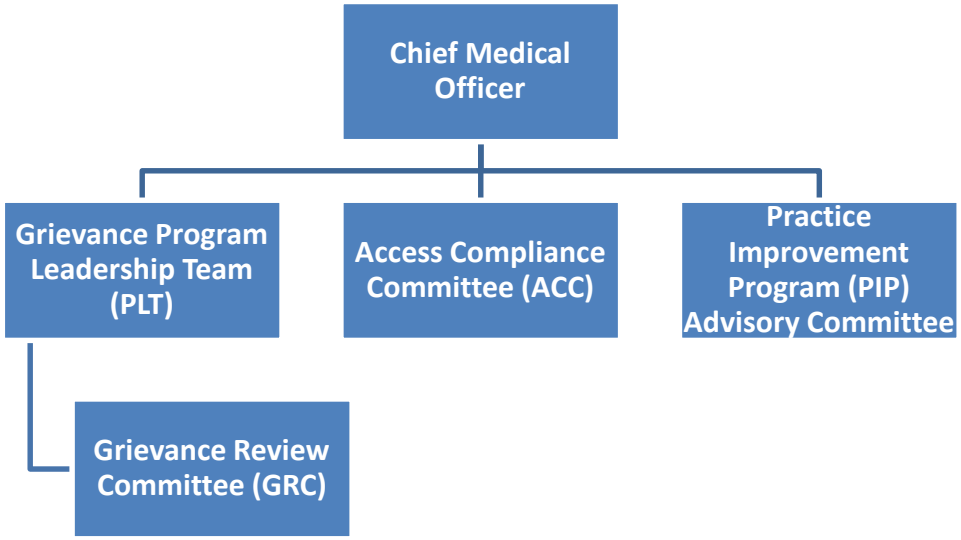
Oversight	Summary	Resp. Staff	Activities	Due Date
Delegation Oversight for QIHET	Ensure oversight of QIHET for all delegated entities	Supervisor, Quality Improvement	• Follow delegation oversight procedures • QIHEC review of Delegated Oversight Audits for QIHET	12/30/2024
DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs)	Manager, Population Health	• Attend DHCS-led PIP calls. • Adhere to process delineated by DHCS.	12/30/2024

Appendix B: Quality Committees and Staff Structure

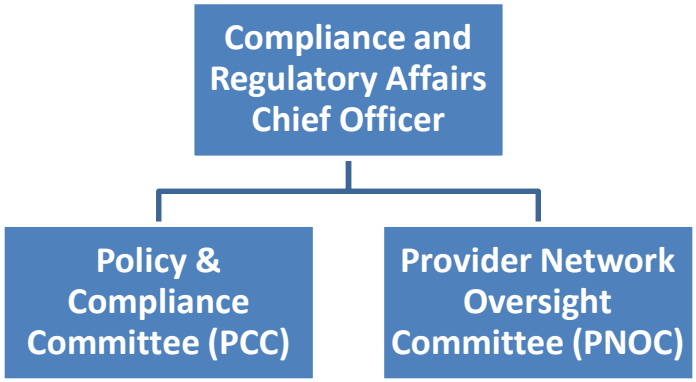
Quality Committees Reporting to Governing Board



Operational Quality Committees Reporting to Chief Medical Officer



Quality Committees Reporting to Chief Officer, Compliance and Regulatory Affairs



Quality Staff Reporting to the Chief Medical Officer