SAN FRANCISCO HEALTH PLAN
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Quality Improvement Committee Minutes

Date: October 14, 2021

Meeting Place: Microsoft Teams Meeting
+1 323-475-1528 : Conference ID: 982 103 462#

Meeting Time: 7:30AM - 9:00 AM

Members Present: Fiona Donald, MD *Chief Medical Officer, SFHP*; Jackie Lam, MD *Medical Director and QI Director Northeast Medical Services;* Kenneth Tai, MD *Chief Medical Officer, North East Medical Services*; Jaime Ruiz, MD *Chief Medical Officer, Mission Neighborhood Health Center;* Irene Conway *SFHP Member Advisory Committee Member*; Idell Wilson *SFHP Member Advisory Committee Member;* Ana Valdes, MD *Chief Healthcare Officer, Healthright360;* Lukejohn Day, MD *Chief Medical Officer, Zuckerberg San Francisco General Hospital*; Claire Horton, MD *Chief Medical Officer, San Francisco Health Network*

Staff Present: Lisa Ghotbi, PharmD *Director, Pharmacy;* Se Chung *Health Services Administrative Specialist*; Suu Htaung *Policy Analyst;* José A. Méndez *Senior Program Manager, Health Services Product Management (HSPM);* Kaitie Hawkins, PharmD BCPS *Pharmacist Supervisor, Clinical Programs;* Elizabeth Sekera, RN *Manager, Population Health;* Nicole Ylagan *Interim Supervisor of Appeals & Grievances*; Etecia Burrell *Population Health Program Manager*; Yves Gibbons *Sr. Program Manager, Quality & Access*; Sue Chan *Program Manager, Pharmacy Compliance*; Jim Glauber, MD *Health Plan Physician Advisor*

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 7:34 AM with a quorum. • Roll Call.		

Consent Calendar	All in favor to approve consent calendar. IHA Reinstatement update: State has requested that all Health Plans restart program and create a plan to catch up post pandemic. IHA requirement: All new enrollees as required to have an Initial Health Assessment within 120 days.		Approved. • Review of August 2021 Minutes • UM Committee Minutes - August and September 2021 • Q2 2021 Grievance Report • Q2 2021 Appeals Report • Q3 2021 PQI Report • Q2 PHM/QI Scorecard • P&T Committee Assignments • HE P&P Updates Summary - August – September 2021 • IHA Reinstatement
Quality Improvement	• ***Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) 2021*** Presented by Yves Gibbons -SFHP achievements: Rating of All Healthcare-ranking maintained, highest performing ranking. Improvement projects: increased registration & utilization of Teladoc, increased visits to primary/specialty care through telehealth, and created multi-language member experience videos. -Approximately 50 questions in survey; key focus area examples: rating of health plan, rating of personal doctor, coordination of care, etc. SFHP steady increase as of 2015. Getting Care quickly was the only area where there a slight decrease in performance. But also had slight increase in Getting Needed care. -Top Key Drivers: 3 priority questions for SFHP to address to improve overall member experience. 1. Ease of access to care, tests		

	or treatment (currently SFHP's score 77%; room for improvement 17% to reach best practice). Rating of doctor (current score 67%; 8% room for improvement to reach best practice) 3. Customer service provided needed information or help (current score 74%; 17% room for improvement to reach best practice). -Next Steps – CAHPS workgroup planning FY21/22 off cycle survey. Purpose to see if interventions are effective. Also providing feedback/guidance on member experience projects. SFHP has set an organization goal to meet NCQA's Health Equity accreditation standard. Also, there are plans to develop and implement a process to use this data in two member facing programs. *Dr. Fiona Donald: Any comments/challenges regarding access to care?* *Dr. Jamie Ruiz: Difficult recruitment from primary care, specialty and staff has created challenges for access to care. Especially in Behavioral Health.* *Dr. Fiona Donald: Beacon Health Options is SFHP's behavioral health provider. SFHP working with Beacon for solutions, looking expand telehealth.* • ***Disparities Leadership Program (DLP)*** Presented by Etecia Burrell, Elizabeth Sekera, RN, and Jim Glauber, MD -Project purpose: To support leaders in health care organizations to develop quality improvement programs/initiatives that specifically focus on disparities in the populations that they serve. -Project title: *Centering the Voices of Black & Transgender SFHP Members.* Focusing on these two populations because of ongoing trend of rates in access. Examples: Black members high utilization		

	of ER vs primary care. Transgender & Non-binary data is difficult to capture because this is a self- reported identity. Data shows: 31% lack access to regular care, 25% report insurance programs related to gender, and 23% avoid healthcare. -Milestone: Identifying TG/NB members – to develop quantitative data to analyze; traditionally qualitative data was collected since 2015. SFHP has developed an internal data model that can be added to HEDIS disparities and population assessment dashboards. Agreement with Quality Director's group of sister plans to have LHPC advocate on their behalf to DHCS to start to process of submitting the wavier to CMS to start collecting SO/GI data upon Medi-Cal enrollment. State has begun this process. -Milestone: Provider Directory Enhancement – create a filter function to include race, ethnicity, language, and LGBT identity. In early internal development and planning stage. -Milestone: Community Collaborations – partnerships to better understand community access, equity issues in vulnerable populations. SFHP developing more robust TG/NB Medical Necessity criteria; participating in State Doula access workgroup; discussing POC midwives to join network; collaborated with SF Women's Cancer Network & Rafiki Coalition for Breast Cancer Screening PDSAs. -Milestone: Social Vulnerability index – census tracked data to be incorporated into core data at member level. Will be able to apply scoring methodology for SDOH factors. -Milestone: Programs Incorporating DEI – include DEI lens to current projects. PIP has added health equity improvement project. DEI evaluation tool being used to evaluate and plan for health services programs. Diversified languages in Health Education materials.		

	• ***Potential Quality Issue (PQI)*** Presented by Nicole Ylagan and Fiona Donald, MD -Identified adverse variation from expected clinical standard of care requiring further investigation. Can be a confirmed quality issue with a provider or system. -Monitoring and oversight by quarterly report back to QIC; Inter-Rater Reliability (IRR) process; specific Policy & Procedure QI-18; trained staff to identify PQIs and make referrals. -SFHP PQI team: Quality Review Registered Nurse, CMO, Facility Site Review Nurse, Medical Director & Supervisor of Appeals & Grievances, Clinical Operations & Care Management clinical staff. -Examples of sources of PQI: external referrals, utilization management, provider preventable conditions, etc. -4 Steps in PQI process: 1. Referral (Description of quality concern) 2. Investigation (Nurse review, recommend to MD) 3. Findings (MD reviews; assigns severity rank) 4. Follow up or Recommendations (Notification, Correction Action Plan (CAP) and notification to Physician Advisory Committee (PAC)). • Will be reporting any PQIs to PAC for discussion and comments. • Meeting adjourned at 8:40 AM.		

QI Committee Chair's Signature & Date _____

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

Emergency Room Visit / Prescription Access Report
2nd Quarter 2021
San Francisco Health Plan Medi-Cal LOB

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

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

Findings:

Section 1 - ER Visits

In 2Q2021, 9,255 members had 14,027 ER visits, averaging 1.52 ER visits per member, which slightly lower from the previous quarter (1.63). This reflects an ER visit by approximately 7.5% of the SFHP Medi-Cal membership within the quarter, which increased from 5.3% previously. Visits by ER facility and the number of Member ER visits decreased compared to the previous quarter (12,233 and 7,505 respectively).

Table 1A: Visits by ER Facility

ER Facility	ER Visits
ZSFG – ACUTE CARE	5,576
UCSF MEDICAL CENTER	2,058
ST FRANCIS MEMORIAL	1,587
CPMC MISSION BERNAL CAMPUS-ACUTE CARE	1,268
CPMC VAN NESS CAMPUS-ACUTE CARE	792
CPMC PACIFIC CAMPUS-OUTPATIENT AND ER	748
ST MARYS MEDICAL CENTER	469
CHINESE HOSPITAL	339
CPMC DAVIES CAMPUS-ACUTE	312
KAISER HOSPITAL SF	264
Other ED Facilities	614
TOTAL	**14,027**

Table 1B: Member ER Visits

# ER Visits	Member
1	6,175
2	1,797
3	549
4	308
5	144
6	84
7	52
8	36
9	25
10	18
11+	67
TOTAL	**9,255**

Section 2 - Top Diagnoses

Of the 14,027 ER visits in 2Q2021, 6,149 visits (44%) resulted in a medication (from ER or pharmacy) within 72 hours of the ER Visit and 7,140 (56%) did not. Not all ER visits warranted medication treatment (i.e. chest pain, abdominal pain or altered mental status). Overall, the distribution of top ER visits by diagnoses category is shown in Table 2. COVID-19 related ER visits are no longer a top diagnosis because visits decreased by 76% in 2Q2021 due to the availability of COVID-19 vaccine.

Table 2: Percent ER Visits by Diagnoses (1Q2021)

Top Diagnoses Categories	ICD10	ER Visits	% of Visits
Chest pain	R07.xx	1,066	7.60%
Abdominal pain	R10.xx	739	5.27%
Headache	R51.9	209	1.49%
Shortness of breath	R06.02	190	1.35%
Dizziness and Giddiness	R42	140	1.00%
Head Injury Unspecified	S09.90	127	0.91%
Altered mental status	R41.82	121	0.86%
Encounter Screening Malignant Neoplasm of Colon	Z12.11	119	0.85%
Suicidal Ideations	R45.851	110	0.78%
Fever Unspecified	R50.9	108	0.77%
Urinary Tract Infection	N39	104	0.74%
Low Back Pain	M54.5	103	0.73%
Nausea with Vomiting	R11.2	94	0.67%
All Other Diagnoses		10,797	76.97%
TOTAL		**14,027**	**100.00%**

Section 3 - Key Diagnoses Category

Selected key diagnoses with a high likelihood for ER discharge prescription are reported in Table 3. In 2Q2021, greater than 85% 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
Asthma Exacerbation	J45.901, J45.909, J45.902	29	30	1	60	98%
COPD	J44, J44.1, J44.9	28	35	4	67	94%
UTI	N39.0	55	21	5	81	94%
Pneumonia	J18.9	11	9	3	23	87%

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 4,549 member visits to a pharmacy after an ER discharge, the top 16 most utilized pharmacies are reported in Table 4. One 24-hour pharmacy in San Francisco was top utilized. 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	541	9.50%
Walgreens 3711 (1189 Potrero Ave)	8AM – 10PM M-F,8AM – 9PM Sat-Sun	521	9.15%
Walgreens 5487 (5300 3rd St)	8AM – 9PM	326	5.72%
Walgreens 1327 (498 Castro St)	24 Hours	276	4.85%
Walgreens 4609 (1301 Market St)	8AM – 9PM	235	4.13%
Walgreens 4231 (2690 Mission St)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	190	3.34%
Chinese Hospital (845 Jackson St)	8AM – 7PM M-F, 9AM-5PM Sat-Sun	190	3.34%
Walgreens 3185 (825 Market St)	8AM – 9PM M-F, 9AM – 5PM Sat,10AM – 6PM Sun	179	3.14%
Daniels Pharmacy	9AM-6:30PM	161	2.83%
Walgreens 9886 (3400 Cesar Chavez)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	131	2.30%
Walgreens 7150 (965 Geneva Ave)	9AM – 9PM	128	2.25%
Walgreens 1626(2494 San Bruno Ave)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	125	2.19%
Scriptsite Pharmacy (870 Market St)	9:30AM-5:30PM M-F	114	2.00%
Walgreens 4558 (300 Gough St)	8AM – 9PM M-F, 9AM – 5PM Sat,10AM – 6PM Sun	95	1.67%
Walgreens 1120 (4645 Mission St)	9AM-9PM M-F, Sat 9AM-5PM, Sun 10AM-6PM	94	1.65%
NEMS- San Bruno	M-F 8:00 AM - 6:00 PM, Sat 8:00 AM - 12:00 PM, 1:00 PM - 5:00 PM Closed Sun	93	1.63%
All Other Pharmacy Locations		2,296	40.32%
TOTAL		**5,695**	**100.00%**

Summary:

No barrier to pharmacy access during after-hours was identified in this quarter. ER utilization was higher in 2Q2021 compared to 1Q2021 (14,027 visits versus 12,233) with each member utilizing the ER at 1.52 visits. About 44% of ER visits received a medication (from ER or pharmacy) within 72 hours of the ER visit, lower than last quarter (47%). Appropriate prescription fills were seen in all four key diagnoses category. Monitoring of member access to medication treatment after an ER visit will continue.

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

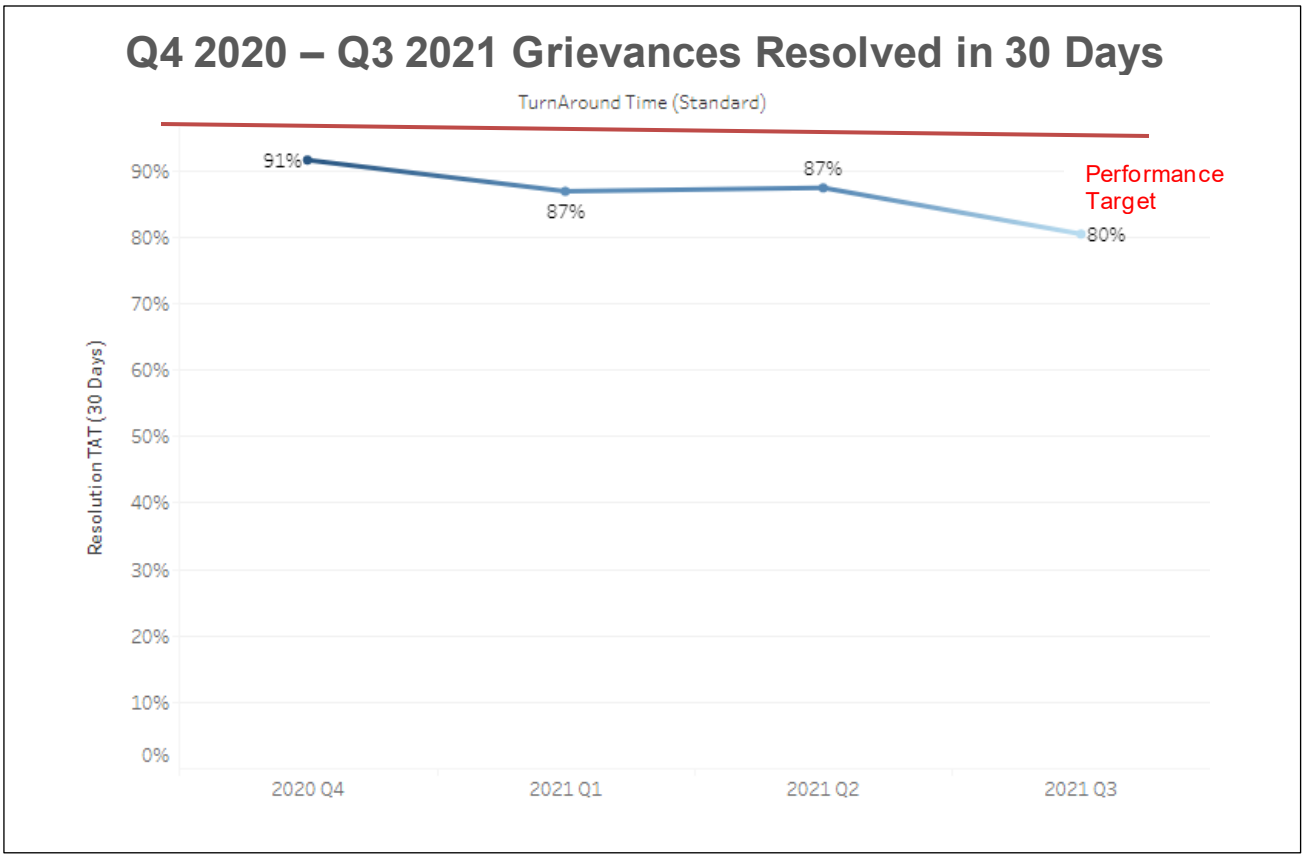
MEMO

Date: December 1, 2021

To	**Quality Improvement Committee**
From	**Nicole A. Ylagan** **Supervisor, Appeals & Grievances**
Regarding	**Q3 2021 Grievance Report**

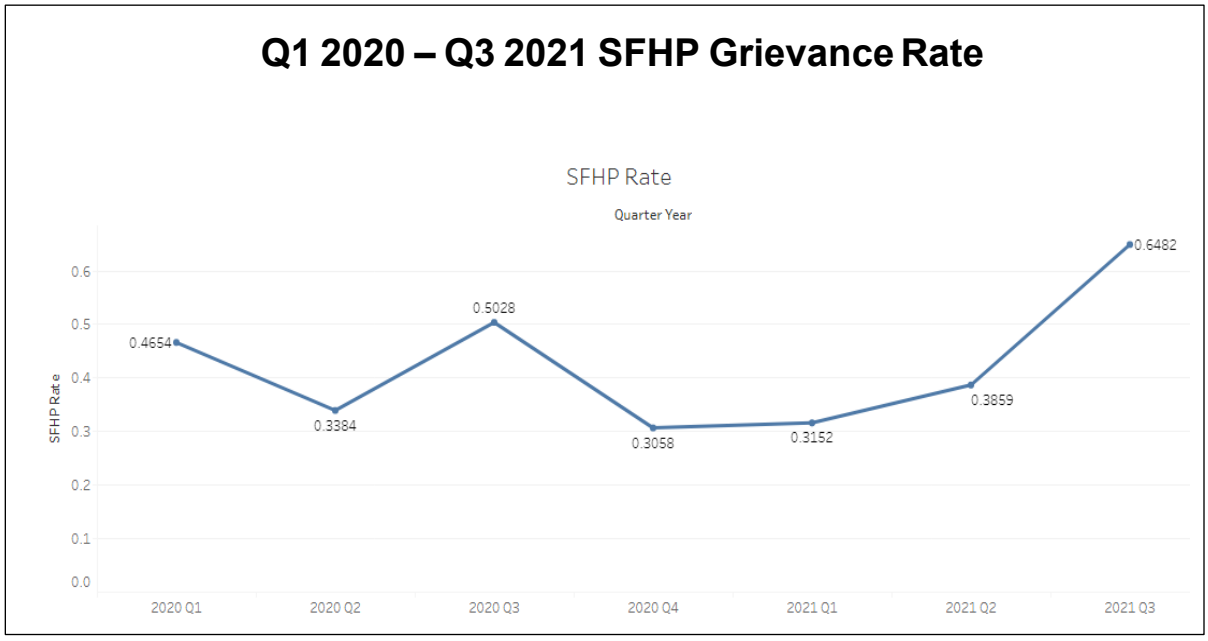
- SFHP received a total of 118 grievances in Q3 2021. Overall grievance volume increased by 20.4% from 98 total grievances in Q2 2021.
- In Q3 2021, 11 out of 118 grievances were not closed within the required timeframe of 30 calendar days, as mandated by the Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS).
- Ninety-nine percent of acknowledgement letters were 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 2021, the percentage of grievances resolved within 30 calendar days was 84%. SFHP was unable to close 11 cases within the 30-calendar day timeframe because SFHP did not receive timely grievance investigation responses from providers. SFHP closed these grievances after we received the responses from the providers. Four cases were not closed within the 30-calendar day timeframe because SFHP needed to obtain additional information in order to adequately address the member's concerns. SFHP closed these grievances after we obtained the information needed. Three cases were not closed due to delay of translation services. SFHP closed these grievances after the translation was completed. One case was not closed due to staff oversight. Additional training for staff was provided by the Supervisor of Appeals and Grievances.


Q4 2020 – Q3 2021 Grievances Resolved in 30 Days
TurnAround Time (Standard)
Resolution TAT (30 Days)
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
91%
87%
87%
80%
Performance Target
2020 Q4
2021 Q1
2021 Q2
2021 Q3

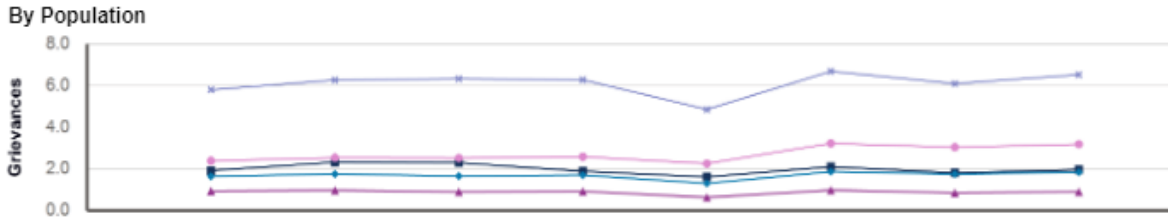
SFHP Grievance Rate

SFHP's grievance rate significantly decreased in Q1 2020 and Q2 2020 due to the COVID-19 pandemic. SFHP's grievance rate then increased in Q3 2020, decreased in Q4 2020 and Q1 2021, then increased again in Q2 2021. The grievance rate in Q3 2021 shows the increase of newly enrolled Medi-Cal members. SFHP can expect the grievance rate to increase with more newly enrolled Medi-Cal members.



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 two quarters behind.

DHCS Grievance Rates per 1,000 Member Months



	2019Q2	2019Q3	2019Q4	2020Q1	2020Q2	2020Q3	2020Q4	2021Q1
Dual	1.9	2.3	2.3	1.9	1.6	2.1	1.8	2.0
MO-ACA	2.4	2.5	2.5	2.6	2.3	3.2	3.0	3.2
MO-OTLIC	0.9	1.0	0.9	0.9	0.6	1.0	0.9	0.9
MO-SPD	5.8	6.3	6.3	6.3	4.9	6.7	6.1	6.5
MO-Other	1.7	1.8	1.7	1.7	1.3	1.9	1.8	1.8
Total	2.1	2.2	2.2	2.2	1.8	2.5	2.3	2.4

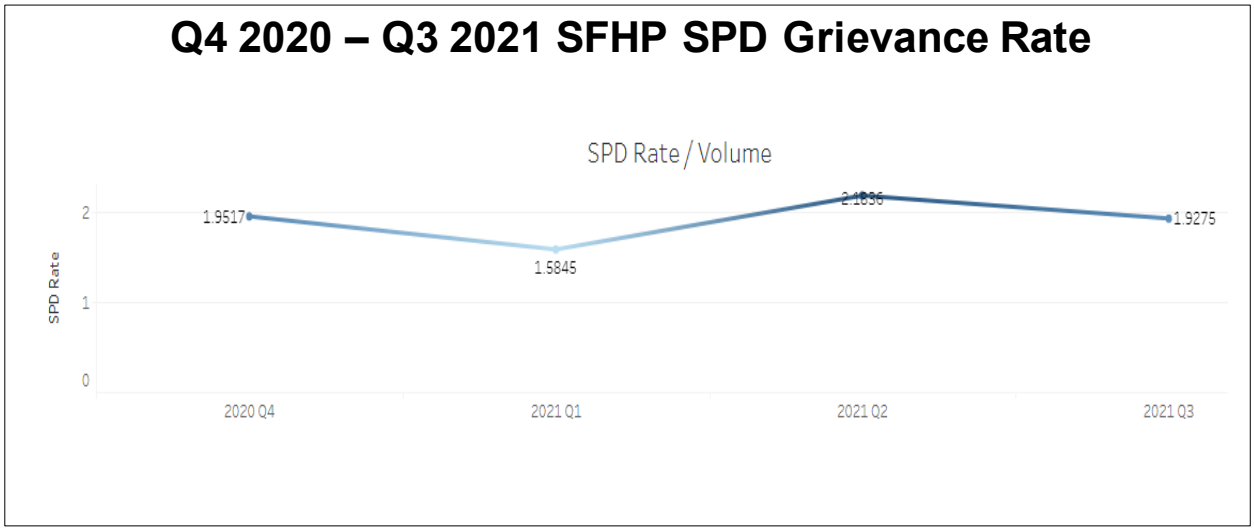
*MO-ACA: Medi-Cal Only Affordable Care Act
*MO-OTLIC: Medi-Cal Only Optional Targeted Low-Income Children
*MO-SPD: Medi-Cal Only Seniors and Persons with Disabilities

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

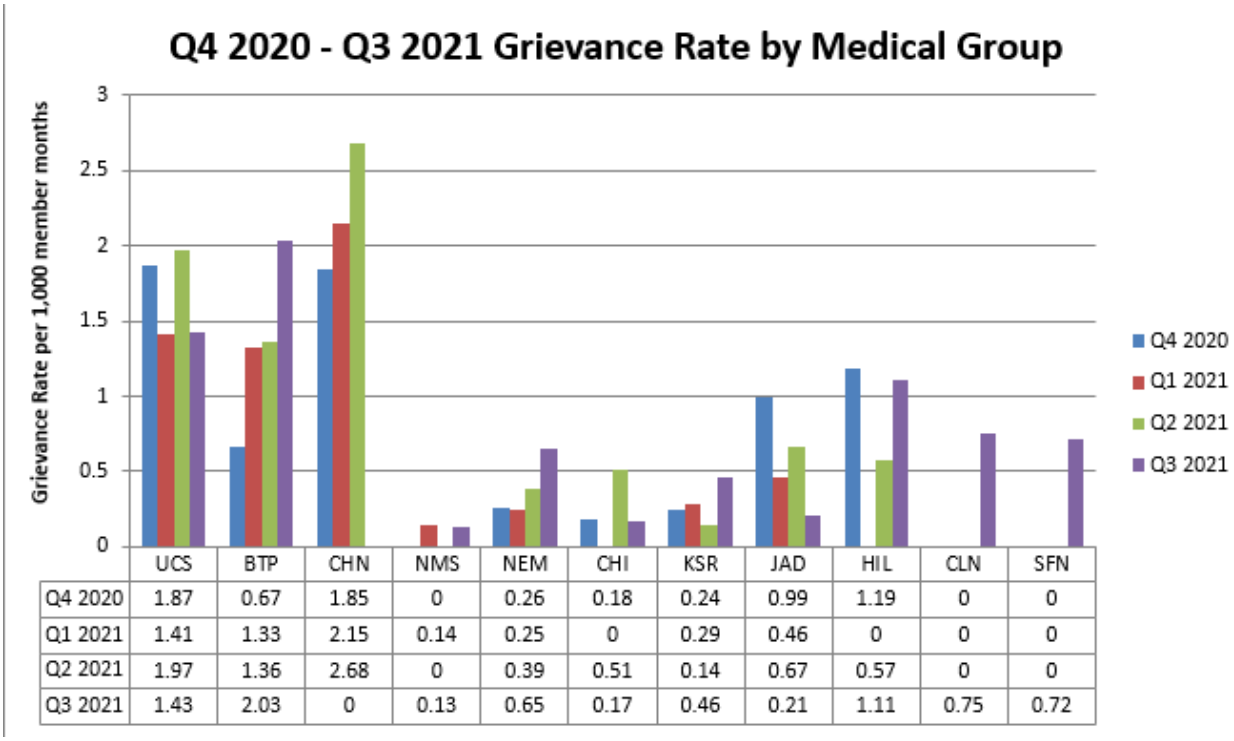
SFHP monitors grievances filed by members who are part of the SPD population.

- In Q3 2021, 47 grievances were filed by SPD members. The number of grievances filed by SPDs increased by 47% compared to Q2 2021 when a total of 32 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. This is similar for grievances filed by non-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.



Grievance Rate by Medical Group:



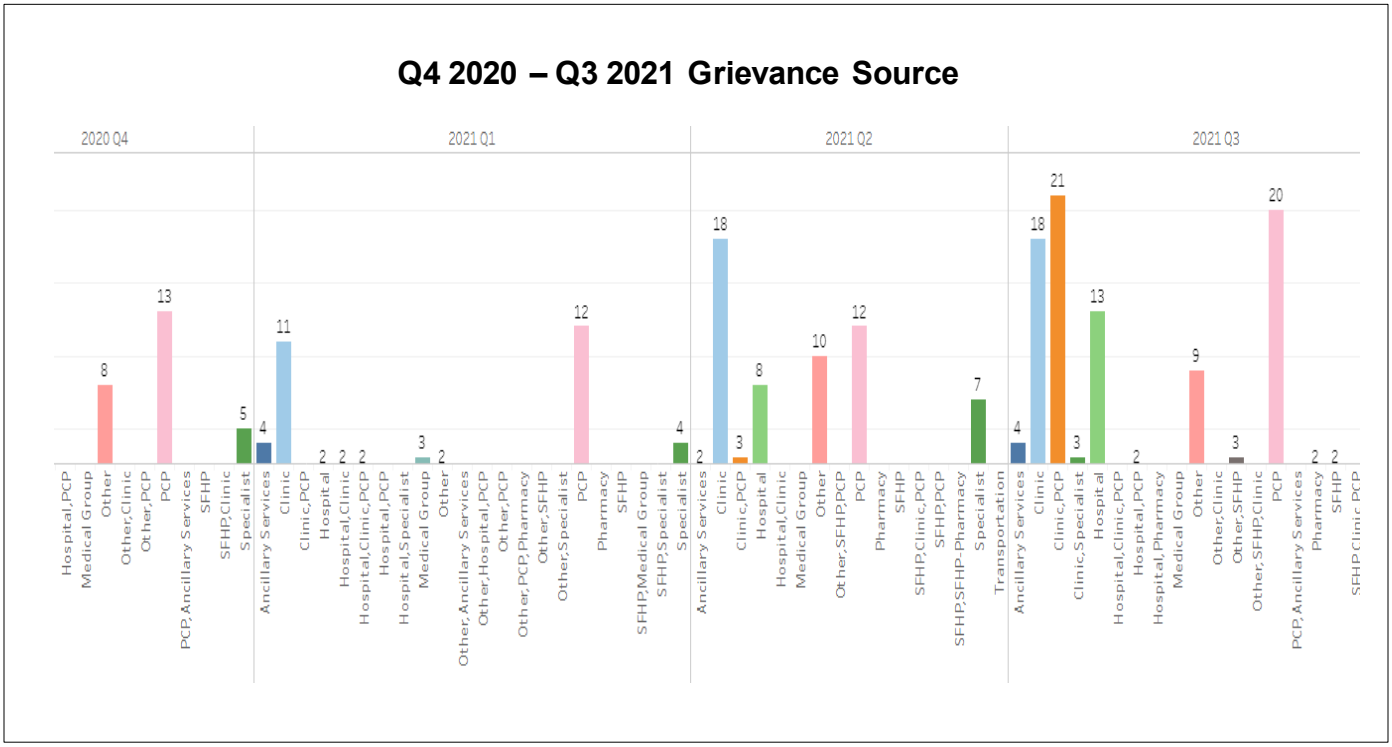
	UCS	BTP	CHN	NMS	NEM	CHI	KSR	JAD	HIL	CLN	SFN
Q4 2020	1.87	0.67	1.85	0	0.26	0.18	0.24	0.99	1.19	0	0
Q1 2021	1.41	1.33	2.15	0.14	0.25	0	0.29	0.46	0	0	0
Q2 2021	1.97	1.36	2.68	0	0.39	0.51	0.14	0.67	0.57	0	0
Q3 2021	1.43	2.03	0	0.13	0.65	0.17	0.46	0.21	1.11	0.75	0.72

*Includes clinical and non-clinical grievances only.
*Please note CHN split into two new medical groups called San Francisco Health Network (SFN) and Community Clinic Network (CLN) as of July 2021. The next QIC Report will reflect this change.

In Q3 2021, five of the medical group grievance rates increased whereas the remaining two decreased compared to Q2 2021.

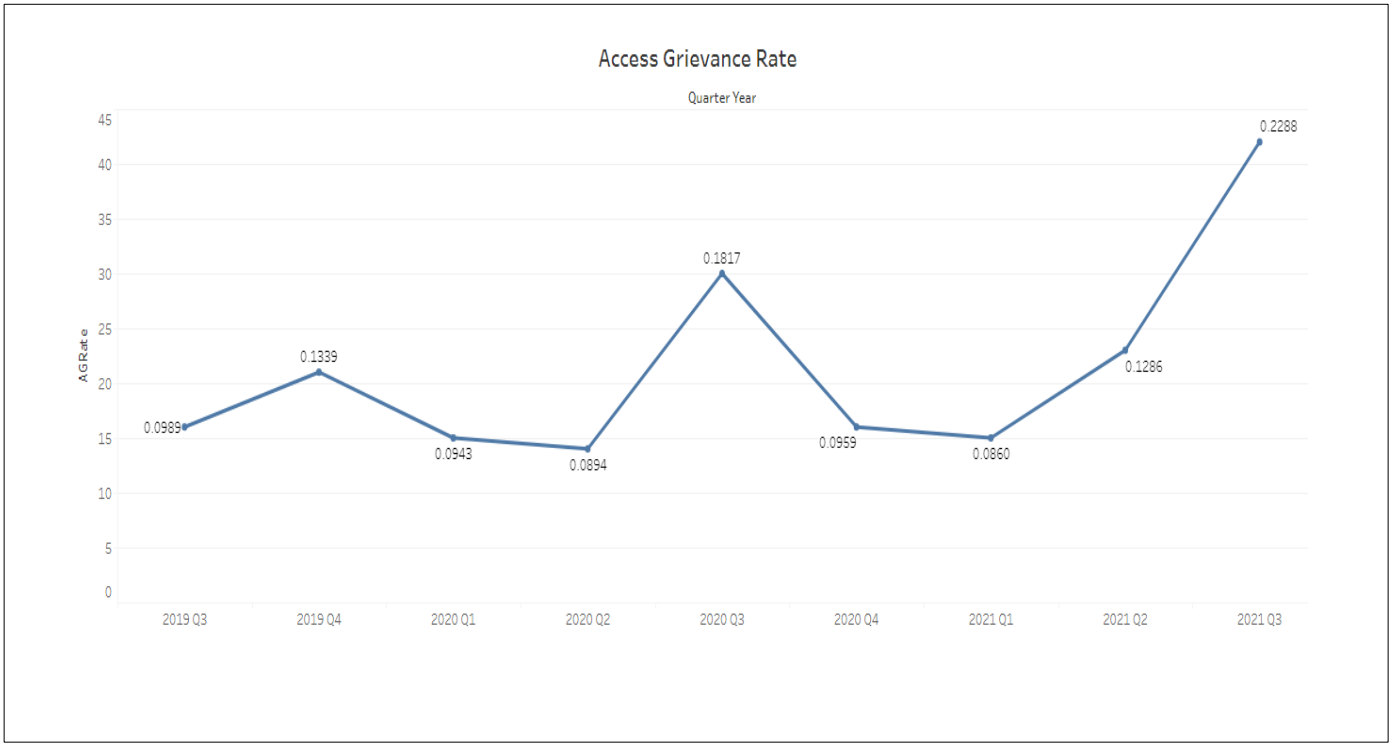
Source of the grievances:

The graph below shows who was involved in the grievance e.g. member's Primary Care Provider (PCP), clinic staff, or specialist. The source of most grievances received in Q2 2021 were those involving services provided by SFHP followed by the member's PCP and clinic.



Access to Care Grievances:

From Q2 2019 to Q4 2019, the access grievance rate increased and then decreased in Q1 2020 and Q2 2020. In Q3 2020, the rate increased significantly. It then decreased in Q4 2020 and Q1 2021 and increased from Q2 2021 – Q3 2021.



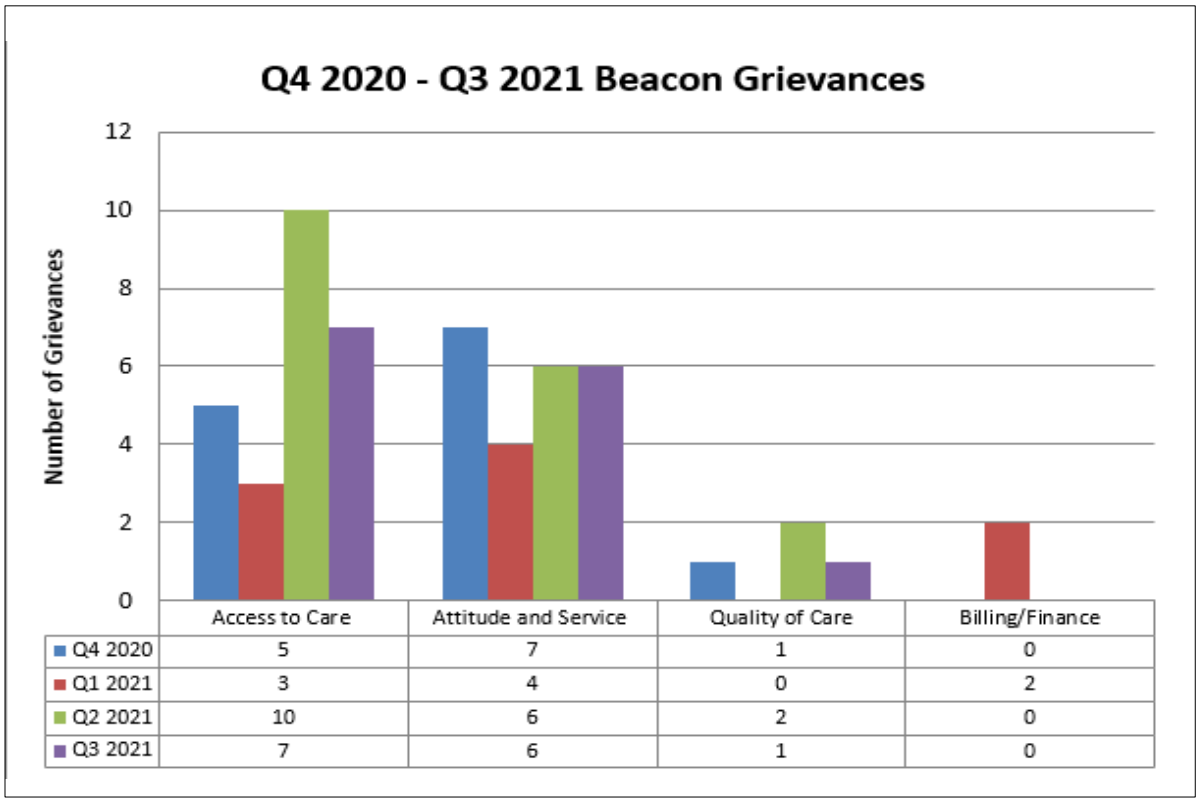
Access Grievances per 1,000 Member Months

Access Grievance Rate By Medical Group

	Quarter Year				
	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3
BTP	0.00	0.62	0.00		
CHI	0.00	0.00	0.00		
CHN	0.57	0.76	0.62	0.50	1.18
CLN					
HIL		0.56	0.00	0.00	0.59
JAD			0.26		0.25
KSR	0.00	0.10	0.09	0.19	0.00
NEM	0.06	0.09	0.05	0.03	0.13
NMS	0.00	0.19	0.00		0.30
SFN		0.00			0.04
UCS	0.40	0.08	0.24	0.41	0.32

Beacon:

Beacon Health Options is SFHP's non-specialty mental health provider. Beacon is partially delegated to process grievances. Most grievances received in Q3 2021 involved Access to Care followed by Attitude and Service. SFHP is currently working with Beacon to improve their services.



Kaiser:

Kaiser is fully delegated to investigate and resolve grievances. At the creation of this report the information for Q3 2021 had not been received. This information will be available in the QIC Q1 2022 report.

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

MEMO

Date: 24 November 2021

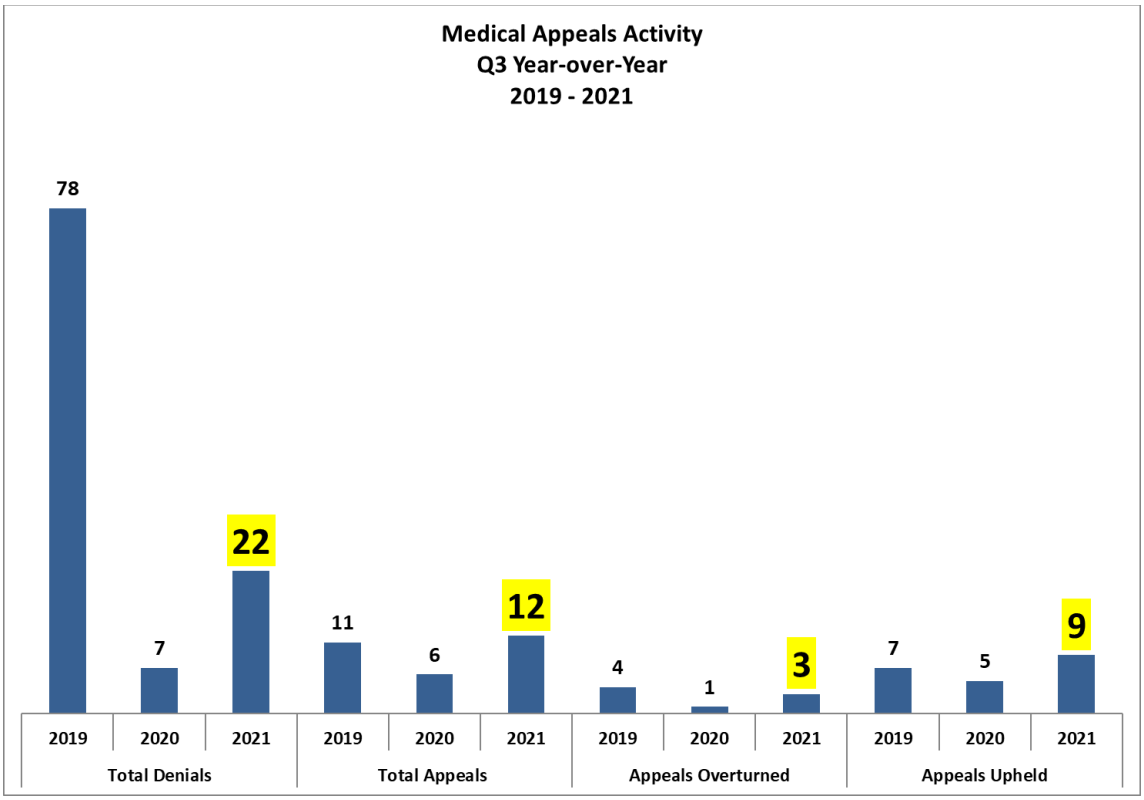
To	**Quality Improvement Committee**
From	**K. M. McDonald** **Program Manager, Clinical Operations** **On behalf of:** **Grace Cariño, MPH** **Program Manager, Appeals & Grievances**
Regarding	**Q3-2021 UM Medical and Pharmacy Appeals Activity**

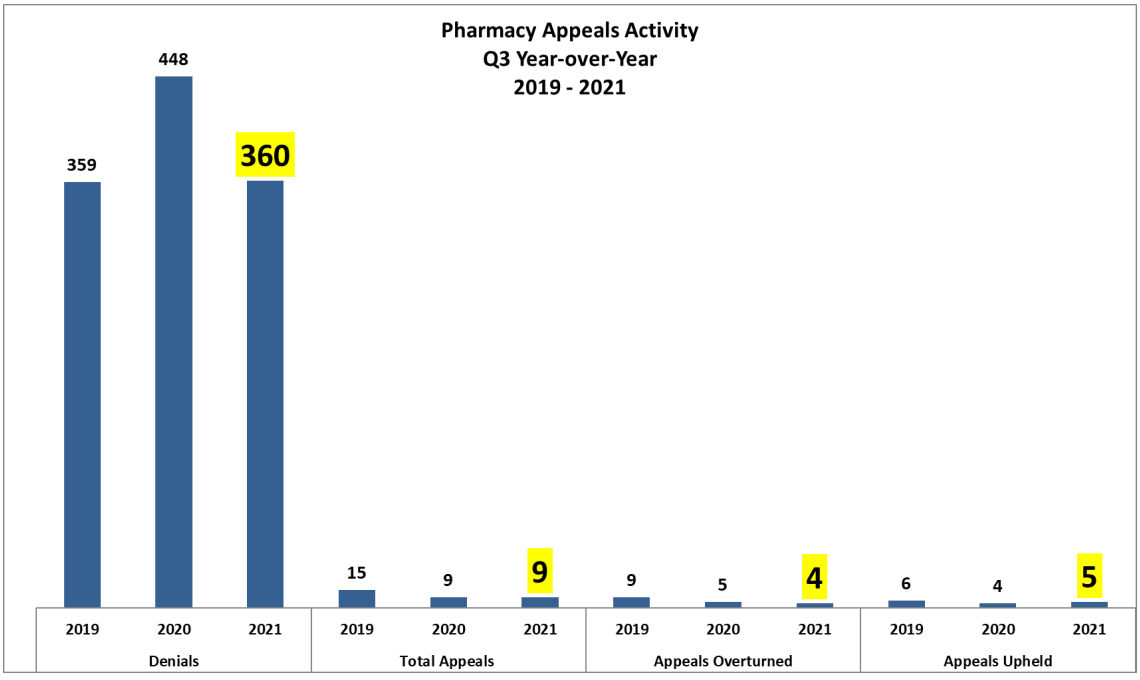
Q3-2021 Appeals Activity – Overview
During Q3-2021, there were a total of 21 appeals filed (medical – 12/pharmacy – 9)[i]. In Q3-2021, there were a total of 5,968 authorization[ii] requests (medical – 3,989/pharmacy –1,979) and a total of 382 denials (medical – 22/ pharmacy – 360).

On a per 1,000 total authorization basis:
- 3.5 total appeals per 1,000 total authorizations
- 2.0 medical appeals per 1,000 total authorizations
- 1.5 pharmacy appeals per 1,000 total authorizations

Comparing appeal activity in Q3-2021 to Q1-2021:
- 21 appeals in Q3-2021 vs. 22 appeals in Q2-2021
- 3.5 appeals/1000 in Q3-2021 vs. 3.7 appeals/1000 in Q2-2021

Of the 21 appeals in Q3-2021, 7 appeals were overturned (medical – 3/pharmacy – 4), which is a 33% overturn rate. This compares to a 27% overturn rate in Q2-2021 (6 overturned out of 22 appeals).


Medical Appeals Activity
Q3 Year-over-Year
2019 - 2021
78
7
22
11
6
12
4
1
3
7
5
9
2019
2020
2021
Total Denials
Total Appeals
Appeals Overturned
Appeals Upheld


Pharmacy Appeals Activity
Q3 Year-over-Year
2019 - 2021
359
448
360
15
9
9
9
5
4
6
4
5
2019
2020
2021
Denials
Total Appeals
Appeals Overturned
Appeals Upheld

Analysis

Q3-2020 – Q3-2021 Medical Denial Rates

Between Q3-2020 and Q3-2021, the medical denial rates ranged from 2.22% (Q4-2020) to 0.16% (Q3-2020):

	Medical Authorizations	Medical Denials	Medical Denial Rate
Q3-2020	4,319	7	0.16%
Q4-2020	4,373	97	2.22%
Q1 2021	3,762	12	0.32%
Q2 2021	3,801	13	0.34%
Q3-2021	3,989	22	0.55%

Q3-2020 – Q3-2021 Pharmacy Denial Rates

Between Q3-2020 and Q3-2021, the denial rates ranged from 27.70% (Q1-2021) to 18.19% (Q3-2021):

	Pharmacy Authorizations	Pharmacy Denials	Pharmacy Denial Rate
Q3-2020	1,678	448	26.70%
Q4-2020	1,689	431	25.52%
Q1-2021	1,798	498	27.70%
Q2-2021	2,151	543	25.24%
Q3-2021	1,979	360	18.19%

Q3-2020- Q3-2021 Collective Medical & Pharmacy Appeal Rates per 1000 Denials

Between Q3-2020 and Q3-2021, the collective medical and pharmacy appeal rates per 1000 denials ranged from 39.6 (Q2-2021) to 29.2 (Q4-2020):

	Medical + Pharmacy Denials	Medical + Pharmacy Appeals	Medical + Pharmacy Appeals / 1000 Denials
Q3-2020	455	15	33.0
Q4-2020	445	13	29.2
Q1-2021	510	20	39.2
Q2-2021	556	22	39.6
Q3-2021	382	21	55.0

Q3-2021 Collective Medical & Pharmacy Appeal Adjudication Turn-Around-Time

100% of the medical and pharmacy appeals were adjudicated within 30-days in Q3-2021:

	Q3-2021		
	Total (Med + Pharm)	**Medical**	**Pharmacy**
Number (#) of Appeals	21	12	9
Percentage (%) of Appeals Adjudicated within 30-days	100%	100%	100%
# of Appeals Upheld	14	9	5
# of Appeals Overturned	7	3	4

Q3-2021 Member and Provider Appeal Activity

Of 21 appeals filed in Q3-2021, 48% were member (10) initiated and 52% were provider (11) initiated.

Of all appeals filed in Q3-2021, 4 appeals were expedited.

		Q3-2021		
		Total (Med + Pharm)	Medical	Pharmacy
Member	# of Initiated Appeals	10	10	0
	% of Total Appeals	48%	100%	0%
Provider	# of Initiated Appeals	11	3	8
	% of Total Appeals	52%	27%	73%
Member	# of Expedited Appeals	0	0	0
	% of Initiated Appeals	0%	0%	0%
Provider	# of Expedited Appeals	4	0	4
	% of Initiated Appeals	100%	0%	100%

Q3-2021 Basis for Overturned Appeals

Of the overturned appeals in Q3-2021, one of the overturned decisions were based on the original clinical information submitted. % of the overturned decisions were based on additional clinical information submitted:

	Q3-2021		
	Total (Med + Pharm)	Medical	Pharmacy
# of Overturned Appeals	7	3	4
% of Total Appeals	33%	43%	57%
# of Appeals overturned due to additional clinical information offered	5	2	3
% of Appeals overturned due to additional clinical information offered	71%	28%	43%
# Appeals overturned due to decision based on the same submitted clinical information	2	2	0
% Appeals overturned due to decision based on the same submitted clinical information	28%	28%	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 7/1/2021 - 9/30/2021 as of 11/16/2021 2:59:36 PM.
ii Source for Medical data: Original_Q3-2021_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: email from Lisa Ghotbi (Mon 11/22/2021 11:12 AM).

Policies and Procedures (P&Ps) Updates

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:

Policy	Summary of New Policy and Updates
CARE-02: HIF and HRAs	**Policy Updates (DHCS APL 20-004 revised 9/10/21):** • Updated from SFHP evaluates SPD members from extended "90days" of enrollment to "SFHP evaluates SPD members within 44 days of enrollment"
CO-28: Transportation	**Policy Updates (MRX & MOT Carve-In DHCS Deliverable approved):** POLICY STATEMENT • Per DHCS request (MOT #2), added language to confirm that SFHP will provide transportation services to members and their living donors PROCEDURE • Updated provider type nomenclature for those that may certify need for NEMT. Physician Extender is defined in definition section • Per DHCS request (AIR SFHP MRX APL 20-XXX 20.A.), added language to confirm SFHP will continue to cover NEMT for pharmacy services after Medi-Cal RX implementation. • Referenced PSC form on website (removed from appendix) • Expanded and reformatted mandatory components of PSC form section • Clarified SFHP approves transportation authorizations in 1-year durations. Start date will be date provider indicates on PSC form • Clarified retro NEMT requests are only accepted if received within 30 days from DOS which is outlined in CO-22 • Added additional criteria bullet under NEMT Ambulance Service (in alignment with APL) APPENDIX • Deleted outdated PSC form.
CO-22: Authorization Request	**Policy Updates (Department Revision Request):** POLICY STATEMENT • Indicated the services lookup tool is available of sfhp.org PROCEDURE • Removed reference to 887Q report. Providers consult the Lookup tool available on sfhp.org • Updated Medi-Cal EOC to Member Handbook • Removed SFHP "arranges for". Contract requires us to cover OON services when unavailable in network, but not arrange for. • OON report is now done on a monthly basis (previously quarterly) • Clarified Essette (previously database) • Updated referenced P&P titles • Investigational/Experimental section: Removed "cancer". Clinicals

	trials are no longer limited to cancer diagnoses. • Urgent Concurrent section: Removed LTC/SNF/Acute Rehab references. These are not reviewed in an urgent time frame • Updated SFCBHS to SFBHS • Inpatient Determination of Medical Necessity section: Given we are not proactively repatriating members, removed documentation requirement about whether member is stable for transfer. • In Maternity Authorization section, removed historical authorization length of stay guidelines which were based on mode of delivery. No longer applicable given APRDRG. • Also, in Maternity Authorization section, clarified a separate authorization is only created when the neonate stays past mothers discharge. • Added "DME and medical supplies delaying hospital discharge" to retrospective review criteria • Remove benefits decisions from IRR. IRR's test for medical necessity decisions consistently (our internal audit looks at both) • Updated UM Denial Systems Control for NCQA UM12 standard and referenced newly developed DTP MONITORING • Added "dashboards" are reviewed at UMC • Condensed delegation oversight section and referenced DO-02 P&P RELATED DOCUMENTS • Added DTP UM Systems Control of UM Data • Updated P&P titles REFERENCES • Added DHCS APL 20-017 Requirements for Reporting Managed Care Program Data APPENDIX • Redid table for CHN Split – includes SFN, CLN, and UCS
CO-57: UM Clinical Criteria	**Policy Updates (NCQA Updates):** POLICY STATEMENT • Updated QIC's role in criteria review • As requested by DMHC, indicated which SF BHS policy addresses Healthy Workers mental health and SUD criteria – "BHS Services for Healthy Workers" PROCEDURE • Updated UMC and QIC's role in annual criteria review/approval in greater detail • As requested by DMHC, clarified that SFHP does not charge members or practitioners for criteria, when requested. • Removed statement regarding possible charges related to UM criteria requests when requested by public. Although this is allowable under 1363.5(b) (5), Clinical Op's does not charge nor has a mechanism to do so. MONITORING • As required by SB 855 (and DMHC), added specific details regarding IRR's related to gender affirmation medical services which are deemed a subset of mental health services which SFHP manages. Requirements include 90% passing threshold, immediate reeducation

	for those who do not reach 90%, and that all new hires who will conduct such reviews complete IRR successfully prior to unsupervised reviews. Because SFHP has homegrown criteria for these reviews, IRR assessments will also be developed internally • Clarified that for all other services (inpatient and outpatient), CO's utilizes MCG developed IRR testing • Added – All appeal requests (including those assigned to DMGs) are reviewed against SFHP's criteria hierarchy opposed to the DMGs hierarchy. This process is already in practice by SFHP's Appeals team. • Added UMC role and responsibility (in alignment with majority of CO P&Ps) • Added language confirming that upon request, the criteria will be provided at no cost for providers and members. RELATED DOCUMENTS • Referenced new P&P – CO-61 Gender Affirmation Services REFERENCES • Added DMHC APL 21-002 related to SB 855 requirements

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	Quality Improvement Committee
From	Fiona Donald, MD Chief Medical Officer, SFHP
Regarding	Summary of HE P&Ps Updates (October 2021)

12/09/21

Please review the following summary of updates of HE P&Ps from October 2021.
This is a FYI for the committee.

There are no significant changes to bring to the committee for review at this time.

If the committee has any questions/comments or would like a detailed review of a policy; the policy will be included for review at the next QIC meeting.

50 Beale St. 12th Floor
San Francisco, CA 94105
www.sfhp.org

San Francisco Health Plan

2021 Quality Improvement Program Evaluation

Table of Contents

1. Introduction

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

SFHP's QI Program is detailed in the SFHP QI Program Description. The QI Program Description contains an annual Work Plan, outlined in Appendix I, representing the current year improvement activities and measure targets. The QI Work Plan is evaluated on a quarterly basis and consolidated annually. The QI Evaluation provides a detailed review of progress towards the measures and goals set forth in the QI Work Plan. In this evaluation, the results are presented for 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 is supported by multiple committees including Utilization Management, Physician Advisory/Peer Review/Credentialing, Pharmacy and Therapeutics. The QI Program is also supported by multiple other committees including Access Compliance, Grievance Program Leadership, Grievance Review, Policy and Compliance, Practice Improvement Program and Provider Network Oversight. SFHP's Quality Committees, under the leadership of the Chief Medical Officer, ensure ongoing and systematic involvement of SFHP's staff, members, medical groups, practitioners, and other key stakeholders where appropriate.

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

The CMO provides ongoing support for all quality improvement studies and activities and was responsible for leading the Quality Improvement Committee; Physician Advisory/Peer Review/Credentialing Committee; Pharmacy and Therapeutics Committee; and Grievance Review

Committee. The CMO leads key clinical improvement efforts, particularly prioritizing and designing interventions for clinical quality performance measures as represented in the QI Work Plan.

Beyond SFHP senior leadership, SFHP achieved stakeholder participation in the QI program through provider and member involvement in several key committees. Stakeholders participate in the Quality Improvement Committee, the Practice Improvement Program (PIP) Advisory Committee that advises on the pay-for-performance program (PIP), and the annual Healthcare Effectiveness Data and Information Set (HEDIS) performance meetings during which health plan leadership meets with senior leadership in the network to review outcomes and solicit input on measures in the Keeping Members Healthy and Managing Members with Emerging Risk domains of the QI Program. Overall, leadership and practitioner participation in the QI program in 2021 was sufficient to support the execution of the QI Plan.

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

1.2 Highlights from the 2020 QI Program Measures

SFHP had positive outcomes during the 2021 QI Program period. Of the 22 measures included in the 2021 QI Evaluation, 11 met the target. SFHP will utilize lessons learned from 2021 to inform the 2022 QI Program and to drive continuous improvement in operations and outcomes.

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

Quality of Service and Access to Care:

SFHP met two of the measure targets in this domain.

Some notable activities include:

- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Interviewed three health plans high performing in Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) to collect best practices for member experience improvement. Best practices identified by the health plans that SFHP is not doing include conducting member experience surveys outside of HP-CAHPS survey fielding and implementing member interventions for specific populations or provider groups that have statistically significant scores.

Recommendations for continued improvement include:

- Conduct CAHPS surveying off-cycle from annual HP-CAHPS.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

Keeping Members Healthy:

SFHP did not meet any of the three measure targets in this domain. One additional measure was not completed.

Some notable activities include:

- Included chlamydia screening information in both member and provider communications. Sexual health mailers, in the form of pamphlets, were mailed out to members in the fall. In spring, Chlamydia screening information were included in provider newsletters and "Your Health Matters."
- Partnered with community-based organization to offer patient navigation services for Black/African American members due for a breast cancer screening.

A recommendation for continued improvement includes:

- Provide patient navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening.

Patient Safety or Outcomes Across Settings:

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

A notable improvement includes:

- Exceeded target of 15.0% for increasing the percent of members with Opioid Use Disorder with at least one buprenorphine prescription with a final result of 22.0 percent.

A recommendation for continued improvement includes:

- Work with mental health and substance use specialist providers to create and distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.

Managing Members with Emerging Risk:

SFHP did not meet the measure target in this domain. Three additional measure were not completed.

A notable activity includes:

- SFHP's Care Transitions and Care Management programs provided treatment support for members with Hep C.

A recommendation for continued improvement includes:

- Outreach to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.

Managing Multiple Chronic Illnesses:

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

Some notable improvements include:

- Attained high member satisfaction with care management services provided by SFHP.
- Met target of 89.0% for member clinical depression follow-up with a final result of 89.0 percent.

A recommendation for continued improvement includes:

- Provide more thorough life skills, health education and training to members as it pertains to their health maintenance.

Utilization of Services:

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

Some notable improvements include:

- Exceeded target of 25.0% for increasing the percent of visits delivered via tele-health modalities with a final result of 50.0 percent.
- Increased the percentage of members engaged in non-specialty mental health (NSMH) services receiving more than two NSMH visits from 39.8% to 44.6%, exceeding the target of 42.8 percent.

Recommendations for continued improvement include:

- Prioritize inpatient measures for monitoring over and under-utilization.

2. Quality of Service and Access to Care

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

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

Measure: Provider Appointment Availability Survey – Routine Appointment Availability in Specialty Care					
Numerator	753	**Baseline**	58.8%	**Final Performance**	80.9%
Denominator	931	**Target**	60.8%	**Evaluation Year**	2021

The Routine Appointment Availability in Specialty Care measure is in the Quality of Service and 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. 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, set by the Department of Managed Health Care. SFHP set a target of 60.8% based on 2.0% absolute improvement from baseline.

Provider Appointment Availability Survey Denominator & Results by Provider Type

	2020 Numerator	2020 Denominator	2020 Routine Appointment Availability
Cardiology	104	120	86.7%
Dermatology	30	50	60.0%
Endocrinology	35	45	77.8%
Gastroenterology	49	53	92.4%
General Surgery	39	51	76.4%
Gynecology	116	162	71.6%
Hematology	24	25	96.0%
HIV/Infectious Diseases	19	21	90.4%
Nephrology	42	56	75.0%
Neurology	52	70	74.2%
Oncology	68	77	88.3%
Ophthalmology	59	72	81.9%
Orthopedics	64	72	88.9%
Otolaryngology	29	31	93.5%
Physical Medicine & Rehabilitation	8	8	100.0%
Pulmonology	15	18	83.3%
Total	**753**	**931**	**80.9%**

Data is based on returned surveys of the Provider Appointment Availability Survey created by DMHC. Performance increased by 20.1% from the previous measurement year, exceeding the target.

To improve performance, SFHP completed the activities listed below.

- Included additional specialties in the 2020 survey.
- Communicated timeline, elements, and requirements of survey to network providers and provider network leadership.
- Issued requests for Corrective Action Plans of provider groups performing under 80% compliance with appointment access.
- Groups who received a request for a Corrective Action Plan from SFHP's access monitoring surveys implemented activities to improve access to care. SFHP provided technical assistance to providers for their access Corrective Action Plans.
- Provided incentives to support providers' telehealth visit delivery through Strategic Use of Reserves program.
- Published materials in the provider newsletter to promote telehealth.

For the next evaluation period SFHP recommends retaining this measure. The target for this revised measure will be set at 82.9% or 2.0% absolute improvement over 2020 performance. 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.
- Train network providers on providing successful telehealth visits.

2.2 Cultural & Linguistic Services (CLS)

Measure: Cultural & Linguistic Services (CLS)			
Final Performance	Not Available	**Evaluation Year**	2021

The Cultural & Linguistic Services (CLS) measure is in the Quality of Service and Access to Care domain. The goal of this measure is to ensure the organization's use provider data to determine the race/ethnic and languages spoken by 10.0% of individual practitioners in network. SFHP chose the target of 10.0% to help establish a baseline as this initiative has not been done before.

One out of the five planned activities to support this measure were completed, including:

- Explored ways to collect information about practitioner race/ethnicity and languages in which a practitioner is fluent when communicating about medical care. Possible sources identified through the exploration process: Practitioner survey, credentialing application, provider relations script, CVO, medical association, or medical specialty directories.

The following planned activities to support this measure were not completed:

- Collect information about language services available through the practice.
- Publish individual practitioner languages in the provider directory .
- Publish language services available through the practice in the provider directory.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

One barrier to reaching the target and completing all the planned activities to support this measure was the lack of organizational priority.

SFHP recommends continuing this measure to help establish a baseline and to address the racial, ethnic, and linguistic needs and preferences of our members. In order to establish a baseline for this measure SFHP will need to establish a cross-collaborative work group to support completing the planned activities and follow up on the next steps outlined during the exploration process mentioned above. The target for this measure will remain at 10.0%. Activities will include:

- Explore ways to collect information about languages in which a practitioner is fluent when communicating about medical care.
- Collect information about language services available through the practice.
- Explore ways to collect practitioner race/ethnicity data Sources of practitioner language and race/ethnicity information.
- Publish individual practitioner languages in the provider directory.
- Publish language services available through the practice in the provider directory.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

2.3 Health Plan Consumer Assessment of Healthcare Providers and Systems Rating of Specialist

Measure: Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Specialist					
Numerator	50	**Baseline**	57.5%	**Final Performance**	64.1%
Denominator	78	**Target**	59.5%	**Evaluation Year**	2021

Rating of Specialist is a question 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.

Five out of the six planned activities to support this measure were completed, including:

- Increased monitoring of network access and issued requests for Corrective Action Plans of provider groups performing under 80% compliance with appointment access.
- Identified access-related issues via the Access Compliance Committee and develop plans to address found issues.
- Promoted SFHP's telehealth services to increase access to care.
- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Interviewed three health plans high performing in HP-CAHPS to collect best practices for member experience improvement. Best practices identified by the health plans that SFHP is not doing include conducting member experience surveys outside of HP-CAHPS survey fielding and implementing member interventions for specific populations or provider groups that have statistically significant scores.

The following planned activity to support this measure was not completed:

- Conduct member focus groups.

The COVID-19 pandemic created barriers in 2021 that impacted the ability to conduct member focus groups. SFHP chose to not conduct member focus groups due to the difficulty in recruiting members to focus groups that would be conducted via tele-conference. SFHP staff prioritized member outreach around COVID-19 vaccination over member focus groups for this measurement period.

For 2022, SFHP recommends modifying this measure to focus on improvement in HP-CAHPS overall as measured by performance in Rating of Health Plan.. Activities to improve in Rating of Health Plan will include:

- Implement and communicate member experience YouTube videos.
- Identify access-related issues via the Access Compliance Committee and develop plans to address found issues.
- Conduct CAHPS surveying off-cycle from annual HP-CAHPS.
- Promote SFHP's telehealth services to increase access to care.

3. Keeping Members Healthy

These are measures that improve clinical outcomes involving preventative care.

3.1 Well-Child Visits in the First 15 Months of Life (W15)

Measure: Well Child Visits in the First 15 months of Life (W15)					
Numerator	305	**Baseline**	46.9%	**Final Performance**	45.2%
Denominator	673	**Target**	49.9%	**Evaluation Year**	2021

The Well-Child Visits in the First 15 Months of Life (W15) is in the Keeping Members Healthy Domain. The goal of the W15 measure is to improve the Well-Child Visits in the "First 15 months of Life" rate for SFHP members is in the Clinical Quality. W15 is a HEDIS measure specification which describes the percentage of members who turned 15 months old during the measurement year and who had a number of Well-Child visits with a PCP during their first 15 months of life. The Well-Child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. Preventive services may be rendered on visits other than Well-Child visits. Well-Child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure. Also not included in the measure are services rendered during an inpatient or ED visit.

The 2021 W15 rate is calculated based on the total number of members who turned 15 months old during the measurement year and who had the six or more well-child visits with a PCP during their first 15 months of life out of the total number of members who turned 15 months old during the measurement year. The W15 target is set based on results from the 2020 administrative rate of 46.9 percent.

The following activities to support this measure were completed, including:

- Restructured incentives report to filter for members who have not had a visit in past nine months to send incentive form three months before next birthday. Previous reporting mechanisms timing didn't incentivize visits; the new mechanism incentivizes visits that have not yet occurred and allow three months for members to receive incentive within the reporting year.
- Determined age groupings for target populations for Health Ed materials to be categorized by appropriate age milestones and will be sent on an annual basis.
- Health education materials added to incentive form to help inform parents/guardians of importance of visit.
- Explored ways to support provider network to promote telehealth visit options—provider newsletter, webpage updates, our Health Matters newsletter.

The final 2020 W15 rate is 45.2% of members in the eligible population during completed six Well-Child visits with their PCP during the measurement year. This result is 4.7% below the target of 49.9%. A barrier to meeting the 49.9% target is the COVID-19 pandemic effecting member's engagement with primary care and scheduling office visits. SFHP recommends retiring this measure to focus on other HEDIS measures identified for MY 2021 as priority.

3.2 Child and Adolescent Well-Care Visits

Measure: Child and Adolescent Well-Care Visits			
Final Performance	Not Available	**Evaluation Year**	2021

The Adolescent Well Care (AWC) measure is in the Keeping Members Healthy Domain. The goal of the AWC measure is to improve the Adolescent Well-Care Visits rate for SFHP members. AWC is a HEDIS measure specification which describes the percentage of enrolled members 12–21 years of age who had at least one comprehensive Well-Care visit with a PCP or an Obstetrician or Gynecology practitioner during the measurement year. Well-Care visits to Obstetrician and Gynecology providers are counted as PCPs since SFHP members can have an Obstetrician or Gynecology provider as their PCP. Visits to school-based clinics with practitioners with whom the organization would consider PCPs may be counted if documentation that a Well-Care exam occurred is available in the medical record or administrative system in the time frame specified by the measure.

This measure and its associated activities were not completed. The barrier to reaching the target and completing all the planned activities to support this measure was the lack of organizational priority. SFHP recommends retiring this measure to focus on other HEDIS measures identified for MY 2021 as priority.

3.3 Chlamydia Screening

Measure: Chlamydia Screening					
Numerator	1,247	**Baseline**	58.1%	**Final Performance**	60.2%
Denominator	2,073	**Target**	61.1%	**Evaluation Year**	2020

The Chlamydia Screening (CHL) measure is in the Keeping Members Healthy domain. This rate is calculated based on the total number of SFHP members, with a female gender marker 16–24 years of age, who are identified as sexually active and have had at least one test for chlamydia during the measurement year. Chlamydia Screening is important because chlamydia infections in patients can cause cervicitis and Pelvic Inflammatory Disease, which can result in Fallopian tube damage, scarring, and blockage. It can also result in long-term adverse outcomes of infertility, ectopic pregnancy, and chronic pelvic pain. Improvement in the chlamydia screening rate benefits members by enabling early detection and treatment of chlamydia infections and preventing complications from the infection. The target of 61.1% was set to achieve a 3% absolute improvement over baseline.

The following activities were completed:

- Continued to include Chlamydia Screening as a pay-for-performance measure in SFHP's Practice Improvement Program (PIP).
- Included STI topic in the Adult Wellness member incentives, which is sent out to members ages 18-24 who have not had a Chlamydia screening.
- Included chlamydia screening information in both member and provider communications. Sexual health mailers, in the form of pamphlets, were mailed out to members in the fall. In spring, Chlamydia screening information were included in provider newsletters and "Your Health Matters."

The following planned activities were not fully implemented and were barriers to achieving the target:

- Complete lab data analysis for other data sources to identify data and/or clinical quality issues potentially contributing to the screening rate and make recommendations for improvement. Due to time and resource constraints, lab data analysis was not able to be completed during the program year.

- Budget for and develop educational materials about Sexually Transmitted Infections (STIs) for teens. Instead of creating a separate budget for educational materials about STIs for teens, STI screening health education will be included in the annual Early and Periodic Screening, Diagnostic and Treatment (EPSDT) member letters for the 18-20 year-old age group.
- Explore expanding the Well Child member incentive population to the age of 21. The Health Outcome Improvement Leadership determined that it was not necessary to expand the age range of the Well Child member incentive population. Instead, STI is mentioned in the Adult Wellness incentive mailing.

The final result of 60.15% was a 2.05% percentage points increase from the baseline, but it was just 0.95% percentage points shy of the 61.1% target. SFHP recommends retiring this measure as there is no expressed prioritization for this measure. STI screening health education material will be included in the EPSDT member letters that are sent out annually. SFHP will retire this measure to focus on other HEDIS priorities. Data improvements made in the previous program year regarding the chlamydia lab data will continue to be applied and the HEDIS workgroup will continue to monitor this measure.

3.4 Breast Cancer Screening

Measure: Breast Cancer Screening					
Numerator	4,549	**Baseline**	65.1%	**Final Performance**	54.4%
Denominator	8,357	**Target**	68.9%	**Evaluation Year**	2020

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 SFHP members is in the Clinical Quality domain. BCS is the percentage of members with a female gender marker who are ages 50-74 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. Not included are services rendered during an inpatient or ED visit.

The 2021 BCS rate is calculated based on the total number of members with a female gender marker who were 50-74 years old months old during the measurement year and who had a mammogram to screen for breast cancer (numerator) divided by the total number of members with a female gender marker who were 50-74 years old months old during the measurement year (denominator). The BCS target is set based on the baseline administrative rate of 65.9 percent.

The following activities to support this measure were completed, including:

- Partnered with community-based organization to offer patient navigation services for Black/African American members due for a breast cancer screening.

The final 2021 BCS rate is 54.4% of members in the eligible population completed a mammogram to screen for breast cancer during the measurement year. This result is 14.5% below the target of 68.9%. SFHP recommends keeping this measure the same for the 2022 QI workplan, narrowing the population to members engaged with providers participating in SFHP's PIP program who are administering the BCS navigation project. Although the target was not reached SFHP made great progress in achieving the successful implementation of this measure and executing the planned activities. SFHP contracted with a community based organization, SF Women's Cancer Network for a placement of a patient navigator at the Rafiki Coalition whose mission is to eliminate health inequities in San Francisco's Black and

marginalized communities through education, advocacy, and by providing holistic health and wellness services in a culturally affirming environment. This navigator has been hired and training will be completed by the end of 2021. Moreover, navigation services will begin to be provided by January 2022. A barrier to completing the planned activity of developing health education materials for members was the organizations prioritizing the development of COVID-19 related health education materials. However, content creation of health education materials for Black members is currently being developed by Health Educator and other subject matter experts on BCS engagement for Black patients. In addition, SFHP is developing a structure for member feedback for health education materials. The Population Health team will continue their work with members to prioritize their health needs and the importance of mammograms to screen for breast cancer will be communicated to members who are a focus for this target population.

Recommended activities:

- Provide Health Education materials to Black/African American SFHP members.
- Provide patient navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening.

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

Measure: Opioid Safety – Buprenorphine Prescription					
Numerator	650	**Baseline**	12.3%	**Final Performance**	22.0%
Denominator	2,590	**Target**	15.0%	**Evaluation Year**	2021

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 15.0% was chosen based on results from last year's measure evaluation.

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 activity was completed:

- A review of frequency of buprenorphine fills, focusing on members with only one fill during 2020 was created in Q2.

There were two major barriers to reaching the target: the lack of access to methadone data and the ongoing impacts of the COVID-19 pandemic. Methadone taken to treat OUD is not provided to SFHP and the plan has no access to this data. As a result, SFHP has no insight into how many members with OUD are currently being treated with methadone. To address this barrier the internal SFHP Pain and Opioid Workgroup plan to reach out the providers at the methadone clinics in order to discuss any concerns they have for the population and how SFHP can assist in increasing access to MAT. Another barrier was the impact of the COVID-19 pandemic. COVID-19 also halted further outreach activities during this evaluation period.

The final result is 22.0%, exceeding the target of 15.0%. SFHP will keep this measure in 2022 to continue monitoring and improving the percentage of members with OUD with at least one buprenorphine prescription in the last year. We will also consider tracking buprenorphine adherence for the following year. Next year's target will be 30.0% and activities to support this measure include:

- Outreach to methadone clinic providers in order to better support the use of MAT.
- Monitor buprenorphine adherence using the repository.
- Disseminate educational material to members on MAT options.
- Consider targeted outreach to members with buprenorphine single fills or their providers.

4.2 Opioid Safety – Benzodiazepine Co-prescribing

Measure: Opioid Safety – Benzodiazepine Co-prescribing					
Numerator	246	**Baseline**	10.7%	**Final Performance**	8.5%
Denominator	2,898	**Target**	8.0%	**Evaluation Year**	2021

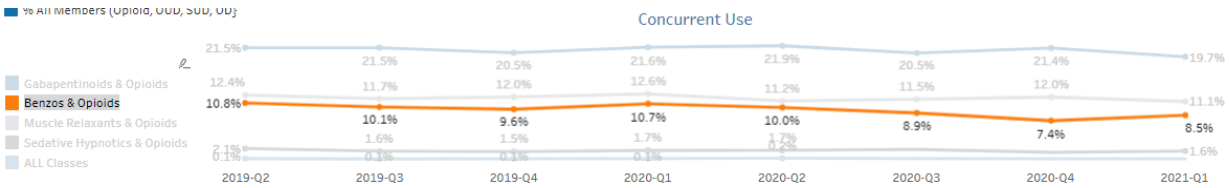
The Opioid Safety – Benzodiazepine Co-prescribing measure is in the Patient Safety or Outcomes Across Settings Domain. This measure calculates the percentage of SFHP members prescribed both opioids and benzodiazepine, out of the total number of SFHP members prescribed opioids. This measure allows SFHP to evaluate members at high risk for negative outcomes related to central nervous system depression such as overdose, coma, and death. SFHP chose a target of 8.0% or lower in order to reduce the percentage of members who have been prescribed both opioids and benzodiazepines to. This target was chosen as a 2.3% absolute improvement from SFHP's baseline rate.

The following activities were completed:

- SFHP staff began the process of creating provider information on how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia. This information will be completed and distributed to providers in 2022.
- Discussed expansion of the acupuncture benefit to include anxiety in the behavioral health committee meeting. If it is appropriate, this will be added to the activities for the first quarter of the next reporting period.

The main barrier to reaching the target was COVID-19, which caused a reorganization of priorities that impeded completion of planned activities. Additional barriers to reaching the target included self-paid prescriptions in the data not being available in the analysis. To address this barrier, providers are mandated to check the CURES database prior to all controlled drug prescriptions to ensure that providers are aware of members' current prescriptions and opioid safety risk. All controlled prescriptions, including self-paid, are recorded through the CURES database.

The current performance of 8.5% from the baseline of 10.7% indicates a slow reduction in benzodiazepine and opioid co-prescribing. As has been seen in previous quarters, the decline in opioid use has driven the decline in co-prescribing. From 2Q2019 to 1Q2021, the total number of members with opioid prescriptions fell from 3,469 to 2,898.



SFHP will retain this measure for 2022 and the target will be reduced to 7.0%. Activities will include:

- Work with mental health and substance use specialist providers to create and distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.

4.3 Medication Therapy Management (MTM)

Measure: Medication Therapy Management (MTM)					
Numerator	108	**Baseline**	85.0%	**Final Performance**	89.3%
Denominator	121	**Target**	87.0%	**Evaluation Year**	2020

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 2021 MTM rate is calculated by the number of initial medication reconciliation completed by a pharmacist (numerator) divided by number of members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation (denominator). The MTM target of 87.0% is based on results using the 2020 MTM measure's final performance of 85.0%. This target represents a significant increase from the 2020 target of 80%.

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

- Continued reviewing members in the initial assessment process which recommends an MTM assessment and establishes the denominator population for this measure.
- Designated pharmacist resources to support the population of members engaged in Care Management and Care Transitions team.

- Updated member management software workflow for both Pharmacist and Pharmacy Technician to improve efficiencies.
- Added question in Care Transitions Assessments to trigger a task for pharmacist to review medication history claims and if medication reconciliation is recommended.
- Developed member management software Pharmacist workflow for Care Transitions integration.
- Completed medication reconciliations for clients engaged in Care Transitions.

Added new member management software tasks to document pharmacist involvement: Pharmacist to review reconciled med list with Care Management Team and Pharmacist to contact provider.

- Developed new monthly pharmacy dashboard for MTM on number of interventions created and completed.
- Created new medical reconciliation tool in member management software for continued integration with Care Management and Care Transitions team.
- Presented new medical reconciliation tool to pharmacy, Care Management and Care Transitions team.
- Identified bug issues in the new med rec tool and resolved it with internal and external teams.

The final result of 89.3% exceeded the target of 87.0% and was an increase of 4.3 percentage points from baseline. SFHP recommends retaining this measure due to the benefits MTM adds to medication safety for members. The target will increase to 90% using this year's final performance as a baseline to ensure sustainability for this measure. Activities to support this measure will include:

- Monitor the pharmacist resource requirements needed to support the population of members engaged in Care Management and Care Transitions team.
- Assess for additional efficiencies in workflow and member assessment configurations.
- Continue reviewing members in the initial assessment process which recommends an MTM assessment and establishes the denominator population for this measure.

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 Hepatitis C Treatment

Measure: Hepatitis C Treatment					
Numerator	1,463	**Baseline**	37.3%	**Final Performance**	37.0%
Denominator	3,956	**Target**	40.0%	**Evaluation Year**	2021

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 year's final performance.

The following activities were completed:

- Care Transitions and Care Management programs provided treatment support for members with Hep C.
- SFHP Care Coordinators and Pharmacy staff have continued to recommend members with active Hep C be treated.
- SFHP staff met with San Francisco's End Hep C to discuss educational campaigns.
- SFHP Pharmacy staff collaborated with Business Analytics to create a new Hep C monitoring report that is more comprehensive.

Barriers for this measure include:

- COVID-19 proved to be the greatest barrier to carrying out activities and reaching the target. Educational activities were put on hold due to the COVID-19 public health emergency.
- SFHP's data is limited by ICD-10 codes that exist for diagnosis data, as there is no procedure code for Hepatitis C treatment and cure therefore, SFHP may be missing data for members who were previously treated and cured or who spontaneously cleared the virus and are cured.
- There is a stigma related to Hepatitis C that prevents members from wanting to seek screening and treatment.
- Members report not wanting a positive Hepatitis C screening to be in their medical record.
- Effective Hepatitis C Treatment requires eight – 12 weeks of medication adherence which can be a barrier for members without access to safe medication storage or are experiencing other barriers to completing treatment.
- The clinics and provider offices serving populations with a high prevalence of Hepatitis C infection have been aggressive to screen and treat infected members leaving the untreated members in clinics with a lower prevalence with less provider awareness and comfort.

The final result of 37.0% decreased 0.3 percentage points from baseline and did not reach the target of 40.0%. SFHP recommends retaining this measure to continue monitoring and improving the percentage of members who complete Hepatitis C treatment. For the next fiscal year, the target will remain 40.0% considering ongoing barriers to access from COVID-19. Activities to support this measure will include:

- Use reporting to develop a profile (age, ethnicity, gender, location) for members not yet treated for Hepatitis C.
- Outreach to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.
- Continue to provide treatment support through SFHP's Care Transitions and Care Management programs.

5.2 Diabetes Prevention Program

Measures: • Diabetes Prevention Program – Do 150 Mins of Physical Activity Per Week • Diabetes Prevention Program – Satisfaction • Diabetes Prevention Program - Weight Loss			
Final Performance	Not Available	**Evaluation Year**	2021

The Diabetes Prevention Program (DPP) measures are in the Managing Members with Emerging Risk Domain. The goal of the measures are to improve the efficacy of the DPP, including member satisfaction with the program, members losing weight as a result of the program, and members achieving at least 150

minutes of physical activity per week. This program was delayed in 2021 and outcome data will not be available until 2022. These measures will be included in the 2022 QI Evaluation.

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 Client Perception of Health

Measure: Care Management Client Perception of Health					
Numerator	48	**Baseline**	50.5%	**Final Performance**	61.5%
Denominator	78	**Target**	55.0%	**Evaluation Year**	2021

The Care Management Client Perception of Health measure is in the Managing Members with 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 55.0%. The target was selected based on evaluation data from the prior years of the Complex Care Management program. This target represents SFHP's commitment to ensuring that Care Management programs are member-centered, support self-management of health conditions, and promote members feeling in control of their health.

The following activities were completed:

- Clinical Supervisors and Medical Director provided coaching to the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- CM Nurses and Community Coordinators completed bi-monthly self-audits; this enabled them to identify and remedy any gaps in the member's care plan.
- Clinical Supervisors and Medical Director conducted quarterly audits to ensure best practices and regulatory requirements were met including members having chronic condition self-management goals as part of their care plans as indicated.
- Utilization of Milliman Care Guidelines (MCG) condition specific assessments and MCG health education materials by CM Nurses.
- Medical Director met weekly with the RNs and joined the RNs and Clinical Supervisors 1:1s to provide individual feedback on health coaching/education efforts as needed.
- Pharmacy team provided the CM team with educational trainings on effects of COVID-19 on Congestive Heart Failure and Chronic Obstructive Pulmonary Disease, Diabetes, Opioid Use Disorder, Use of Steroid Treatment in Autoimmune Conditions and a review of the Pharmacy Tool.

The final result for this measure was 61.5%. Forty-eight out of 78 CM clients completed the SF-12 health questionnaire during their initial and closing assessments and indicated an improvement in their self-reported health status. The target was met.

SFHP will keep this measure for 2022 and continue to focus on improving the health status of those who indicate "Poor" or "Fair" health and maintaining the health status of those who indicate "Good," "Very Good," or "Excellent" during their initial assessment. The target will be 63.0% as the baseline is 61.5%. Activities to support this measure will include:

- Clinical Supervisors and Medical Director coaching the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- CM Management have developed a 2-year training syllabus for the team, 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.
- Review of self-management goal report with CM Nurses to ensure that members have chronic condition self-management goals as part of their care plans as indicated.
- Utilization of Milliman Care Guidelines (MCG) condition specific assessments and MCG health education materials by CM Nurses.

6.2 Screening for Clinical Depression

Measure: Screening for Clinical Depression					
Numerator	54	**Baseline**	83.1%	**Final Performance**	85.7%
Denominator	63	**Target**	85.0%	**Evaluation Year**	2021

The Screening for Clinical Depression measure is in the Managing Members with Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of adult clients in SFHP's Care Management (CM) programs successfully screened for depression symptoms using the Patient Health Questionaire-9 (PHQ-9) when indicated by their responses to the Patient Health Questionaire-2 (PHQ-2). The PHQ-2 is a brief series of questions used to screen for possible depression and the PHQ-9 is an instrument used to screen, monitor, and measure the severity of depression. All adult clients enrolled in CM programs receive the PHQ-2 screening. The PHQ-9 is triggered based on the PHQ-2 score. The target for this measure was 85.0%. The target was selected based on results from past clinical measures.

The following activities were completed:

- Coaching Community Coordinators, including role-playing activities to reduce the rate of members declining PHQ-9 screening.
- Trained staff in mental health, particularly on severe mental illness (SMI), in order to ensure that staff was equipped to identify signs and symptoms of clinical depression and address client safety. Coordinators and RNs completed the following quarterly trainings: Psychosis 101/Depressive Disorder 101/The Sudden Shift from Face to Face Interviews to Telephone Interviews/Grief Literacy/Bipolar Disorders 101/Forecasting and Understanding the Behavioral Health Impacts of COVID-19/How to Reduce Risk for Patients with Substance Use Disorders during the Pandemic/ Health Equity Culturally Responsive Care in the context of COVID-19/Maximizing Resilience/Leveraging Strengths in a Challenging World/Co-Occurring Disorders/ Living with Chronic Pain/ ADLs/ Provider Tool Review/ CBAS overview.
- Clinical Supervisors reviewed monthly reports with staff and coached staff to ensure members were screened and received appropriate follow up.
- Monitored the rate of members declining the PHQ-9 screening via additional report tracking.
- Completed bi-monthly staff self-audits; this enabled Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.

- Clinical Supervisors conducted quarterly audits to ensure best practices and regulatory requirements were met.

The final result for this measure was 85.7%. Sixty-three Care Management clients screened positive using the PHQ-2, indicating additional follow-up was needed. Fifty-four of those clients had the longer, more in-depth PHQ-9 completed to identify the severity of their symptoms and inform follow up. The 85.0% screening target was met.

SFHP will retire this measure for 2021 because the Care Management Coordinators have continued to meet this goal with higher targets over the past few years. CM Management feel at this time it would be more beneficial to focus on following up on members who have screened positive for Clinical Depression.

6.3 Follow Up on Clinical Depression

Measure: Follow Up on Clinical Depression					
Numerator	39	**Baseline**	85.7%	**Final Performance**	88.6%
Denominator	44	**Target**	89.0%	**Evaluation Year**	2020

The Follow Up on Clinical Depression measure is in the Managing Members with 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. The target for this measure was 89.0%. The target was selected based on results from past clinical measures. This target represents SFHP's commitment to ensuring that Care Management programs are member-centered, and address follow up care for members with behavioral health needs.

The following activities were completed:

- Trained staff in mental health, particularly on severe mental illness (SMI), to ensure that staff was equipped to identify signs and symptoms of clinical depression and address client safety. Coordinators and RNs completed the following quarterly trainings: Psychosis 101/Depressive Disorder 101/The Sudden Shift from Face to Face Interviews to Telephone Interviews/Grief Literacy/Bipolar Disorders 101/Forecasting and Understanding the Behavioral Health Impacts of COVID-19/How to Reduce Risk for Patients with Substance Use Disorders during the Pandemic/ Health Equity Culturally Responsive Care in the context of COVID-19/Maximizing Resilience/Leveraging Strengths in a Challenging World/Co-Occurring Disorders/ Living with Chronic Pain/ ADLs/ Provider Tool Review/ CBAS overview.
- Reviewed monthly reports with staff and Clinical Supervisors coached staff to ensure members were screened and received appropriate follow up.
- Completed bi-monthly staff self-audits; this enabled Coordinators to identify and remedy any gaps in the member's care plan.
- Clinical Supervisors conducted quarterly audits to ensure best practices and regulatory requirements were met.

The final result for this measure was 88.6%, falling 0.4% of the 89.0% target. Forty-four Care Management clients had a positive score in the PHQ-9 completed to determine the severity of their depression. Thirty-nine of those CM Clients had a care plan goal completed, in progress, or had declined to connect to appropriate behavioral health services. Clients may decline services because they are

already connected to behavioral health services or they are not ready to discuss or prioritize their mental health; 15 clients declined the goal for these reasons. Staff is trained to re-assess every six months, at a minimum. Ultimately, 46.7% of clients who initially declined the "Connect to Behavioral Health" goal were re-engaged and connected to appropriate behavioral health services.

SFHP will keep this measure for 2022 to ensure sustained high rates of depression screening and follow up which continue to be a priority for Care Management programs. As of 2021, 6.7% of the overall SFHP Medi-Cal population had a depression diagnosis based on claims and encounters in the past 24 months, though there is reason to believe that depression is underdiagnosed due to stigma or failure to document diagnosis on claims or encounters, among other factors. Depression screening will continue to be a priority for the CM programs to connect clients to behavioral health services as clinically indicated and with the client's consent. The target will be increased to 90.0% to support continued improvement. Activities to support this measure will include:

- Train staff in mental health, particularly on severe mental illness (SMI) and community resources, in order to ensure that staff is equipped to identify signs and symptoms of clinical depression, address client safety including connection to behavioral health services.
- Clinical Supervisors to review monthly reports with staff and to coach staff to ensure members are screened and receive appropriate follow up.
- Coach and conduct role-playing activities to reduce the rate of members declining PHQ-9 screening.
- Complete bi-monthly 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 quarterly audits to ensure best practices and regulatory requirements are met.

6.4 Care Management Client Satisfaction with Care Management Services to achieve their health goals

Measure: Care Management Client Satisfaction with Staff					
Numerator	32	**Baseline**	100%	**Final Performance**	97.0%
Denominator	33	**Target**	90.0%	**Evaluation Year**	2021

The Care Management Client Satisfaction with Staff measure is in the Managing Members with 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. The target for this measure was 90% and was chosen based on results from previous versions of the survey. This target represents SFHP's commitment to ensuring that Care Management programs are member centered.

The following activities were completed:

- 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 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.

The final result for this measure was 97.0%. The target was met, however, the population measured was lower than usual. Typically, this survey is conducted in person twice a year during April and October. Due to the COVID-19 pandemic and San Francisco's shelter in place directive, surveys were only able to be mailed resulting in a low response rate. Staff continue to only provide telephonic case management at this time. This measure will be retired as the Care Management staff have continued to meet this goal over the past few years. CM Management feel at this time it would be more beneficial to focus on measures focused on future CalAIM initiatives.

- Maintain a process to triage members into longer-term case management programs when requested by member or indicated by member's self-efficacy skills.
- Provide more thorough life skills, health education and training to members as it pertains to their health maintenance.
- Improve communication of care plan goal progress between Care Management staff and members.
- CM staff completes a 6-month reassessment and review of care plan including goals with member

6.5 Health Homes CB-CME Case Conference Rate

Measure: Health Homes CB-CME Case Conference Rate					
Numerator	318	**Baseline**	44.0%	**Final Performance**	47.4%
Denominator	671	**Target**	51.0%	**Evaluation Year**	2021

The Health Homes CB-CME Case Conference Rate measure is in the Managing Members with Multiple Chronic Illnesses domain. This measure reflects the percent of unique Health Homes Program (HHP) enrolled members that had at least one case conference during their time in the program. The target for this measure was 51.0%. The target was selected based on baseline results to ensure continued improvement. Achieving the target would mean that more than half of the HHP members had at least one session where their care team collaborated in real time to discuss the best course of action for their care. This results in a more cohesive care team, who is more likely to collaborate in the future on behalf of the member, and ultimately produces better outcomes for patients in the program.

The following activities were completed:

- Provided CB-CMEs with education on importance of case conferences, the definition of case conference, and a reminder that this measure was being tracked.
- Trained new CM staff on HHP workflow.
- Review of quarterly metrics with team by Clinical Supervisors highlighting both strengths as well as areas for improvement.
- Completion of bi-monthly self-audits by staff to identify and remedy any gaps in the member's care plan including completing case conferences.
- Completion of quarterly audits by Clinical Supervisors to ensure best practices and regulatory requirements are met.

The final result for this measure was 47.4%. Three hundred and eighteen out of 671 HHP clients had at least one case conference completed. The target was not met. Barriers to meeting the target included some impacts from the COVID-19 pandemic on the program. There was some loss of staff due to reallocation of resources for SF COVID response. Clinics had to adjust and develop new workflows for COVID-19 response that deprioritized HHP activities.

SFHP will retire this measure as the Health Homes Program is being phased out in 2022. SFHP will transition into meeting the program requirements of the Department of Healthcare Services' CalAIM initiative beginning in January 2022. SFHP will consider adding ECM Case Conference Rates as a measure in the future once we have a full year of data available to establish a baseline and targets.

7. Utilization of Services

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

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

Measure: Percentage of Members Utilizing the Non-Specialty Mental Health Benefit with More Than Two NSMH Visits					
Numerator	925	**Baseline**	39.8%	**Final Performance**	44.6%
Denominator	2,075	**Target**	42.8%	**Evaluation Year**	2021

The Percentage of Members Utilizing the Non-Specialty Mental Health (NSMH) Benefit with More Than Two NSMH Visits is in the Utilization of Services domain. Increasing NSMH visits reflects improved access for members with behavioral health conditions who do not consistently seek or continue treatment once initiated. This measure reflects continued focus on enhancing member and provider awareness of the availability of the NSMH benefit and in sustaining engagement in care. The measure is the percentage of non-dually enrolled Medi-Cal members utilizing the NSMH benefit who had at least two or more visits with a behavioral health provider from April 1, 2020 to March 31, 2021.

Data is based on NSMH claims paid by Beacon Health Options. The baseline rate of 39.8% was based on a broad set of mental health therapy claim codes and SFHP set the target of 42.8% based on 3.0% absolute improvement from this initial baseline.

To improve performance, SFHP completed the following activities:

- Promoted in person and tele-behavioral health benefit to members through member communications including weekend and after-hours appointment access to members.
- Communicated to providers on how to refer to behavioral health services.

SFHP exceeded the target of 42.8% by 1.8% for a final performance of 44.6%. SFHP will retire this measure to focus on other behavioral health priorities.

7.2 Primary Care Utilization

Measure: Primary Care Utilization			
Baseline	Q3 2020 rate	**Final Performance**	315.1
Target	≥ Q2 2019 rate: 302.1	**Evaluation Year**	2021

The Primary Care Utilization measure is in the Utilization of Services domain. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care in order to better manage their health. Increasing the rate of members with a primary care visit may also support other QI program measures such as HEDIS and HP-CAHPS, as members with primary care visits are more likely to receive preventive care. Members with a primary care visit have higher satisfaction with their health care as reflected in HP-CAHPS. Primary Care Utilization is the number of outpatient visits from July 1, 2020 to June 30, 2021 out of 1000 member months.

Data is based on outpatient visit claims and encounters submitted by SFHP's provider groups. SFHP set a target of meeting or exceeding Q2 2019 rate of the same measure, reflecting pre-COVID-19 levels of utilization.

To improve performance, SFHP completed the following activities:

- Informed members of the importance of primary care visits through marketing to members.
- Included PCP visit rate improvement in SFHP's pay-for-performance program.
- Participated in a Disparities Leadership Program with the aim to increase primary care engagement among SFHP's Black members. As a result, SFHP provided health education materials to Black members.
- Conducted outreach to members high risk for COVID-19 to facilitate connection to care.
- Provided member financial incentive for adult wellness visit and expand age of target population for well child visit incentive.
- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Provided grants to SF Community Clinic Consortium for the purchase of Personal Protective Equipment for front line providers. This will make it safer for targeted providers to provide in-person care when indicated.

The following planned activities were not completed:

- Conduct Early and Periodic Screening, Diagnostic and Treatment calls mandated by DHCS
- Utilize Prop 56 Value Based Purchasing for several types of preventive and chronic care visits.

SFHP met the target. SFHP will retire this measure to focus on other priorities involving over and under-utilization.

7.3 Telehealth Utilization

Measure: Telehealth Utilization					
Numerator	264, 419	**Baseline**	Not Available	**Final Performance**	50.0%
Denominator	528,838	**Target**	25.0%	**Evaluation Year**	2021

The Telehealth Utilization measure is in the Utilization of Services domain. This measure demonstrates SFHP's focus on connecting members telehealth to aid members in managing their health during the COVID-19 pandemic. Telehealth Utilization is the outpatient visits by telehealth modalities from July 1, 2020 to June 30, 2021 out of all outpatient visits.

Data is based on outpatient visit claims and encounters submitted by SFHP's provider groups. SFHP set a target of meeting of 25.0%.

To improve performance, SFHP completed the following activities:

- Promoted tele-health services to members.
- Provided grants to provider network to invest in telehealth infrastructure.
- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Provided training to SFHP providers on how to conduct telehealth visits during the COVID-19 pandemic.

The following planned activities were not completed:

- Provide incentives for registration of tele-health services and for younger members to receive preventative health visits.

SFHP met the target. SFHP will retire this measure to focus on other priorities involving over and under-utilization.

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	• Five meetings held in 2021	12/30/2021
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	12/30/2021
C	Physician Advisory/Peer Review/Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	• Five meetings held in 2021	12/30/2021
D	Utilization Management Committee	Ensure oversight of SFHP Utilization Management program	Director, Clinical Operations	• Ten meetings held in 2020	12/30/2021
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	3/1/2021
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	3/1/2021
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	12/30/2021
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	12/30/2021

Reviewed and Approved by:

Chief Medical Officer: *Fiona Donald, MD* **Date**:

Quality Improvement Committee Review Date:

Board of Directors Review Date:

50 Beale St. 12th floor
San Francisco, CA 94105
www.sfhp.org

San Francisco Health Plan

2022 Quality Improvement 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 August 2021, membership included 162,516 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 (QI) Program. The Governing Board meetings are open for public participation.

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

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 August 2021, SFHP retained 88% (150,707 members) of the managed care market share in San Francisco County. [1]

- **Healthy Workers**
  Healthy Workers is a health insurance program offered to providers of In-Home Supportive Services or temporary exempt employees of the City and County of San Francisco. As of August 2021, 11,840 members are enrolled in this program.

2. QI Program Purpose, Scope and Goals

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

[1] Medi-Cal Managed Care Enrollment Report – September 2021, https://data.chhs.ca.gov/dataset/c6ccef54-e7a9-4ebd-b79a-850b72c4dd8c/resource/95358a7a-2c9d-41c6-a0e0-405a7e5c5f18/download/mcod-mc-mc-enrollment-report-september-2021.csv

SFHP contracts with medical and behavioral health care providers, including medical groups, clinics, independent physicians and their associated hospitals, ancillary providers, behavioral health clinicians, and pharmacies to provide care. SFHP maintains responsibility for communicating regulatory and contractual requirements as well as policies and procedures to participating network providers. SFHP retains full responsibility for its QI Program and does not delegate quality improvement oversight. In certain instances, SFHP may delegate some or all QI functions to accredited provider organizations.

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

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

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

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

3. QI Program Structure

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

A. Quality Committees

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

i. The Quality Improvement Committee

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

ii. The Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee 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 will be governed by the Department of Health Care Services (DHCS) upon implementation of Medi-Cal Rx (January 1, 2022). The retrospective DUR processes and related policies governed by the P&T Committee may include Medi-Cal for the purpose of oversight of adherence and disease and medication management. 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 QIC.

iii. The Physician Advisory/Peer Review/Credentialing Committee

The Physician Advisory/Peer Review/Credentialing Committee (PAC) provides comments and recommendations to SFHP on standards of care and peer review. The PAC Committee is chaired by SFHP's CMO and consists of providers in SFHP's network. The PAC Committee serves to review and provide recommendations regarding substantive quality of care concerns, in particular those related to 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 QIC.

iv. The Member Advisory Committee

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

v. The Practice Improvement Program Advisory Committee

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

B. Committees with Internal Membership Only

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

i. The Policy & Compliance Committee

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

- Chief Officer of Compliance and Regulatory Affairs Regulatory Affairs Counsel, Chairperson
- Regulatory Affairs Counsel, Chairperson
- Manager, Compliance and Oversight
- Director of Policy Development and Coverage, or delegate
- Director of Finance, or delegate
- Director of Pharmacy, or delegate
- Director of Clinical Operations, or delegate
- Director of Human Resources, or delegate
- Director of Systems Development Infrastructure, or a delegate
- Director of Claims, or delegate
- Senior Manager, Member Services

- Director of Marketing & Communications, or delegate
- Director of Provider Network Operations, or delegate
- Director of Care Management, or delegate
- Director of Health Services Program, or a delegate

ii. The Provider Network Oversight Committee

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

- Manager, Compliance and Oversight (Chair)
- Officer, Compliance and Regulatory Affairs
- Director, Provider NetworkDirector, Clinical Operations
- Manager, Access and Care Experience
- Director, Health Services
- Behavorial Health Manager
- Director of Pharmacy

iii. The Grievance Review Committee

The Grievance Review Committee (GRC) is an internal SFHP committee that reviews all grievances and serves as an escalation point for trends identified from member grievances. If a grievance trend is identified or there is a particularly concerning grievance, the committee will recommend a Corrective Action Plan (CAP) or a notification to the Medical Group. Member grievances are not delegated to Medical Groups, except Kaiser, Beacon, and Vision Service Plan (VSP). The GRC also reviews individual member grievances through a collaborative process to ensure that all the components of the grievances have been resolved. The committee is led by the CMO with cross functional representation from Member Services, Provider Relations, Health Outcomes Improvement, and Compliance and Regulatory Affairs departments. The committee meets twice weekly. GRC members include:

- Chief Medical Officer or designee (Chair)
- Health Plan Physician Advisor
- Chief Officer, Compliance and Regulatory Affairs
- Senior Manager, Member Services
- Account Manager, Provider Network Operations
- Quality Review Nurse
- Supervisor, Appeals and Grievances
- Counsel, Regulatory Affairs
- Senior Analyst, Regulatory Affairs
- Program Manager, Appeals and Grievances
- Grievance Staff
- Lead, Customer Service
- Pharmacy, Utilization Management, Care Management, Health Education, and Cultural & Linguistics staff participate as needed.

iv. The Grievance Program Leadership Team

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

- Chief Medical Officer or designee (Chair)
- Chief Officer, Compliance and Regulatory Affairs
- Chief Officer, Operations
- Senior Manager, Member Services
- Supervisor, Appeals and Grievances
- Quality Review Nurse
- Program Manager, Appeals and Grievances
- Manager, Provider Relations and/ or Account Manager, Provider Network Operations as needed.

v. The Access Compliance Committee

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

- Regulatory Affairs Counsel (Chair)
- Manager, Provider Relations
- Network Manager, Provider Relations
- Senior Analyst, Regulatory Affairs and Compliance
- Senior Program Manager, Quality and Access
- Specialist, Provider Relations

vi. The Utilization Management Committee

The Utilization Management Committee (UMC) provides oversight to ensure effective and compliant implementation of SFHP's Utilization Management Program and to support compliance with 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 QIC. The UMC meets 10 times annually and provides monthly minutes, quarterly trend reports, and annual reports to the QIC. The UMC membership, with voting rights on all motions, consists of:

- Chief Medical Officer, MD
- Associate Medical Director, MD
- Director, Clinical Operations, RN
- Senior Manager, Prior Authorization, RN

- UM Nurse Manager, Prior Authorizations, RN
- Manager, Concurrent Review and Care Transitions, RN
- Program Manager, Utilization Management, PhD
- Director of Pharmacy, Pharm.D
- Manager, Pharmacy, RPh

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

- Director of Clinical Services – Beacon Health Options (ad hoc)
- Valid State Clinical License required (RN, LCSW, LMFT, PhD, or PsyD)
- Medical Director (MD/Psychiatry) – College Health IPA (Beacon Health Options) (ad hoc)

C. Quality Improvement Communications

i. Communication to members

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

ii. Communication to providers

SFHP updates providers regularly regarding key QI activities, including:

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

D. Quality Improvement Staff

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

i. Health Services Staffing Structure

The Health Services Leadership that supports the QI program are:

Chief Medical Officer – responsible for leading the Quality Improvement Committee, Physician Advisory/Peer Review/Credentialing Committee, and the Pharmacy and Therapeutics Committee, and for all quality improvement studies and activities. The CMO provides guidance and oversight for development of policies, programs, and projects that support all activities identified in the QI Program. The CMO carries out these responsibilities with support from direct reports, including Medical Director, Associate Medical Director, and Directors of Health Outcomes Improvement, Pharmacy, Clinical Operations, and Care Management. In addition, the CMO partners with the Officer of Compliance and Regulatory Affairs. The CMO is a board-certified physician who holds a current license to practice medicine in California. The Senior Medical Director holds a Medical Doctorate and has 30 years of healthcare experience including 12 years of clinical practice experience and 18 years of clinical quality and managed care experience.

ii. Population Health & Special Programs Staffing Structure

Interim Director, Population Health & Quality – The Interim Director, Population Health & Quality reports to the Chief Medical Officer, ensures the completion of the QI Program (including work plan and evaluation), and directs the execution of QI activities identified in the QI Work Plan. The Interim Director, Population Health & Quality, oversees teams focused on fostering quality for SFHP's members. The Interim Director, Population Health & Qiality has a Master of Health Administration and has 19 years of experience in program development, process improvement, and quality implementation experience.

- **Senior Program Manager, Quality & Access –** reports to the Director, Population Health & Special Programs, and is 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 Quality & Access Senior Program Manager has 12 years of experience in a clinical setting and six years of experience in quality improvement.

- **Manager, Population Health –** reports to the Director, Population Health & Special Programs, and oversees activities related to the improvement and auditing of clinical HEDIS measures, health education & promotion programs, and pay-for-performance. The Population Health Manager is a Registered Nurse with an Associate Degree in Nursing Science. The Population Health Manager has 14 years of clinical experience and 11 years of quality improvement experience. Reporting to the Manager, Population Health, the following positions support SFHP's QI efforts:

    - **Program Manager, Population Health –** project manages interventions to improve HEDIS measures, including member incentives, medical record review, health disparities, and cultural linguistic services. The Population Health Program Manager has a Bachelor of Arts in Sociology and is a Certified Full Spectrum Doula and a Certified Family Planning Health Educator, with 11 years of experience in qualitative research, four years of experience in a clinical setting, and three years of experience in quality improvement.

    - **Program Manager, Population Health –** project manages interventions to improve HEDIS and member experience measures through SFHP's pay-for-performance program.

The Population Health Program Manager has a Master of Public Health, with four years of experience in quality improvement.

- **Program Manager, Population Health (Qualified Health Educator) –** designs and implements interventions to improve HEDIS rates, ensures that members have access to low-literacy health education materials/classes, and ensures that members have access to services in their preferred language. The Qualified Health Educator and Program Manager of Population Health has a Master of Public Health, with 16 years of experience in public health including 11 years of experience in health education.

- **Specialist –** provides support to the above staff to execute their responsibilities, developing marketing materials, pay-for-performance data management, and coordinating with providers to report pay-for-performance data. The Specialist in Population Health has a Bachelor of Science in Public Health, with one year of experience in clinical research, one year experience in health promotion, and two years experience in care coordination.

- **Supervisor, Special Programs** – reports to the Director, Population Health & Special Programs, and is responsible for the overall planning, execution, and implementation of projects and work products related to Special Projects within Health Services. The Program Manager Supervisor has10 years of experience in program management in a health care and administrative program setting. The Supervisor Program Manager has a Bachelor's of Science in Health Services.

  - **Program Manager, Social Determinants of Health –** reports to Supervisor of Special Programs and is responsible for navigating county and community SDoH agencies and interventions, analyzing SDoH policy trends as relevant to SFHP members and consults with internal staff on pathways connecting to communityagencies that address SDoH while tracking barriers to access. The SDoH Program Manager has a Bachelors of Science or Social Work , with four years of experience in program management, and two years of direct service.
  - **Program Manager, Children and Families –** reports to Supervisor of Special Programs and is responsible for implementing activities and measurement of programs involving children and family services. Children & Family program manager monitors DHCS & DHMC requirements, coordinates with county andcommunity services and develops and implements interventions to improve the care experience of SFHP members. The Children & Family Program Manager has a Bachelors of Science or Social Work , with four years of experience in program management, and two yearsof direct service with children and family.

iii. Health Services Departments that contribute to the QI Program

Clinical Operations Department
SFHP's Clinical Operations Department conducts Utilization Management (UM) for both inpatient and outpatient 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: Care Transitions, Concurrent Review, Prior Authorization, UM Delegation Oversight, UM Claims Edits, and Provider Dispute Resolutions.

Pharmacy Department
SFHP's Pharmacy Department leads initiatives to improve quality of care, including medication reconciliation and drug utilization reviews. The Pharmacy Department also includes the Health Services Product Management team, which oversees SFHP's HEDIS process and internal applications supporting SFHP processes that impact member care

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

iv. External Agency that contributes to the QI program

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

4. Quality Improvement Method and Data Sources

A. Identification of Important Aspects of Care

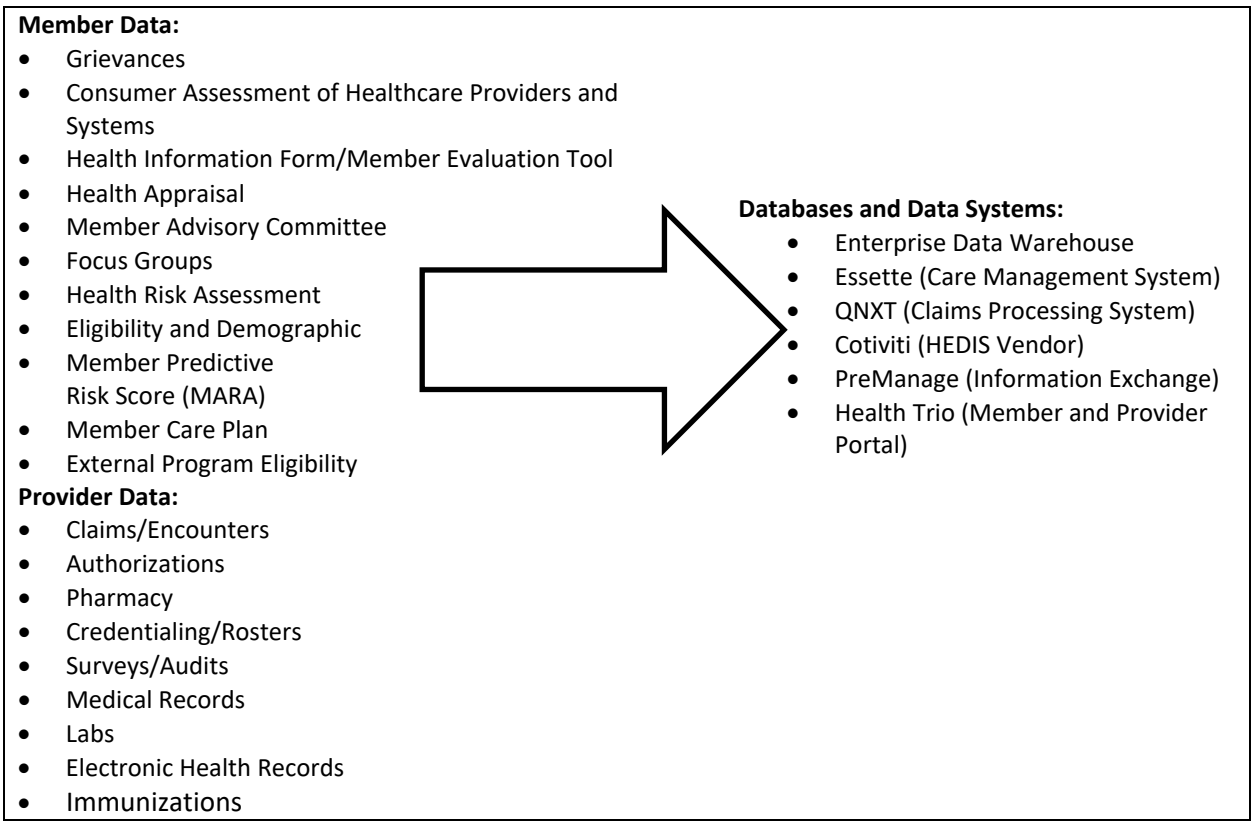
SFHP identifies priorities for improvement based on regulatory requirements, NCQA standards, data review, and provider- and member- identified opportunities in the key domains of Clinical Quality & Safety, Quality of Service & Access to Care, Utilization Management, and Care Coordination & Services.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

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

- Establish targets and/or benchmarks for key indicators within each domain
- Systematically collect data
- Analyze and interpret data at least annually
- Identify opportunities for improvement
- Identify barriers to improvement
- Prioritize opportunities

- Establish improvement objectives in support of priorities
- Design interventions based on best practices or previous interventions
- Implement and track progress of interventions
- Measure effectiveness of interventions based on progress toward standards or benchmarks

B. Data Systems and Sources



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

C. Policies and Procedures

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

5. QI Program

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

A. QI Work Plan

Results of the annual evaluation described above, in combination with information and priorities determined by the Health Services leadership and staff, are reviewed and analyzed in order to develop an annual QI Work Plan (see Appendix A). This comprehensive set of measures and indicators is divided into six domains:

1. Managing Members with Emerging Risk
2. Patient Safety or Outcomes Across Settings
3. Keeping Members Healthy
4. Quality of Service and Access to Care
5. Utilization of Services
6. Managing Multiple Chronic Illnesses

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

B. QI Program Evaluation

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

- Brief description of the QI activity/intervention and how it aims to improve the domain in which it is included
- Measure target of the QI activity/intervention

- Measure definition
- Measure results, trended over at least three years when available
- Barriers that affected the effectiveness of the activity/intervention
- Recommended interventions/actions to overcome barriers in the following year

6. QI Activities

A. Managing Members with Emerging Risk

The domain of Managing Members with Emerging Risk involves QI activities related to clinical outcomes related to chronic condition care management.

i. Chronic Condition Management

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

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Antidepressant Medication Management
- Asthma Medication Ratio
- Comprehensive Diabetes Care
- Concurrent Use of Opioids and Benzodiazepines
- Controlling High Blood Pressure
- 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 Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medications
- Medical Assistance with Smoking and Tobacco Use Cessation
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Pharmacotherapy Management of COPD Exacerbation
- Plan All Cause Readmissions
- Risk of Continued Opioid Use
- Statin Therapy for Patients with Cardiovascular Disease
- Statin Therapy for Patients with Diabetes
- Use of First-Line Psychosocial Care For Care for Children and Adolescents on Antipsychotics
- Use of Imaging Studies for Low Back Pain
- Use of Opioids at High Dosage
- Use of Opioids at High Dosage in Persons Without Cancer
- Use of Opioids from Multiple Providers

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

B. Patient Safety or Outcomes Across Settings

The domain of Patient Safety or Outcomes Across Settings involves QI activities related to clinical outcomes related to preventing adverse health outcomes.

i. 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 and Care Transitions program. 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 Care Transitions team, Senior Medical Director, and primary care providers. Educational medication resources for targeted members will also increase adherence and knowledge of their drug regimen.

SFHP Pain Management Program – SFHP conducts trainings for providers and clinic staff on multiple aspects of pain management, including safe opioid prescribing. SFHP works with external and internal experts to provide clinical and non-clinical pain management resources to the community. SFHP's pay-for-performance program (PIP) also supports best practices in opioid prescribing and pain management. SFHP has an internal Pain and Opioid Workgroup and pain management is discussed at SFHP's Pharmacy & Therapeutics Committee.

Potential Quality Issues (PQIs) – SFHP Clinical Operations, Care Management, and Pharmacy staff are trained to identify PQIs and refer them to the Quality Review Nurse. 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 Associate 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. Keeping Members Healthy

The domain of Keeping Members Healthy involves QI activities related to clinical outcomes related to disease prevention.

i. Preventive Care

SFHP monitors and reports on a subset of U.S. Preventive Services Task Force (USPSTF) clinical recommendations and preventive service guidelines as well as other preventive service HEDIS 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
- Screening for Depression and Follow-Up Plan
- 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

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 adult wellness visits.

ii. DHCS Performance Improvement Projects (PIP)

SFHP implements DHCS PIPs at any given time. PIP measures aim to understand key drivers of poor performance and conduct improvement activities based on the key drivers. One of SFHP's PIPs for 2019-2021 targets the large disparities in breast cancer screening rates seen among the SFHP member population by race/ethnicity. SFHP aims to improve the rate of African American members who receive a breast cancer screening within the HEDIS timeframe. The second PIP aims to improve the rate of well-child visits for infants up to the age of fifteen months. This is a new measure for SFHP so there is significant improvement opportunity for the entire SFHP member population. Due to COVID related delays, the two DHCS PIPs will continue through 2022.

iii. Health Education

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

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

SFHP's member portal prompts members to complete the Health Trio Health Appraisal tool to identify risk factors and health concerns. Based on the Health Appraisal results, members are provided with a risk

and wellness profile, along with prevention strategies. In addition, the Health Trio online platform provides members with access to dynamic and evidence-based self-management tools based on their individual areas of risk or interest. These include topics such as healthy weight, healthy eating, promotion of physical activity, managing stress, tobacco use cessation, avoiding at-risk drinking, and identifying symptoms of depression.

D. Quality of Service and Access to Care

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

i. Monitoring Member Access

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

ii. Financial Incentives to Support Improvement

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

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

iii. 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 QIC to identify and implement improvement activities. Applicable improvements are integrated into QI Program activities.

iv. 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 and accreditation 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).

v. 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 QIC. To identify patterns and trends in grievances, grievance reports are generated to report rates by line of business, medical group, and grievance category. When a grievance pattern has been identified, SFHP works with clinics or medical groups to develop strategies for improvement or request corrective action as appropriate. SFHP's Utilization Management Committee (UMC) reviews all member appeals for issues and trends.

vi. 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.

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

SFHP's Cultural and Linguistic Services program is informed by regular assessment of the cultural and linguistic needs of its members via the DHCS Population Needs Assessment (PNA) and NCQA Population Assessnent: 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.

Most SFHP members have the option to select a primary care provider that speaks their preferred language. The SFHP Provider Directory indicates languages spoken at clinic sites.

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.

E. Utilization of Services

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

i. Over and Under Utilization of Services

SFHP monitors 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
- Plan all Cause Readmission Rates

Service utilization patterns are shared with internal leadership, as well as, with 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.

ii. 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.

iii. Care Transitions

SFHP manages members assigned to the San Francisco Health Network, Community Clinic Network and UCSF Medical Group who are discharged from an out of medical group inpatient setting and assists in creating a discharge plan to ensure a medically safe and effective transition to an alternate level of care. The SFHP Concurrent Review and Care Transitions Nurses and Coordinators collaborate internally and with the acute care and SNF facilities to ensure that safe transitions are completed. These include medically necessary services and supportive services in the community for the member upon discharge. SFHP also conducts pre- and post- discharge calls or in-person visits with members and works to coordinate timely post-discharge follow-up appointments as part of the discharge planning process. These activities help to coordinate care with the goal of reducing avoidable readmissions or emergency department visits by ensuring the member's discharge needs are met and there is appropriate follow-up through the continuum of care.

F. Managing Multiple Chronic Illnesses

The Managing Multiple Chronic Illnesses domain encompasses QI activities that improve coordination across multiple providers and facilities and focuses on members with more complex medical and psychosocial needs.

i. Care Management Programs

SFHP's Care Management department administers case management programs aimed at improving care for members who may be high risk, high-utilizing, and/or experiencing challenges when trying to effectively engage the health care system. Care Management provides a wide range of services from basic telephonic care coordination to intensive, in-person case management. Effective March 2020, in

efforts to adhere to the Shelter in Place guidelines during the COVID-19 pandemic, all Care Management programs were adapted to providing telephonic case management only. 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. The Health Homes Program (HHP) will be ending on December 31st 2021 and effective January 1st 2022 we will be launching the Enhanced Care Management (ECM) program, an initiative under CalAIM. ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services nand comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered.

ii. Care Coordination with External Agencies

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

iii. Children and Transitional Aged Youth

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

iv. Health Risk Assessment (HRA)

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

G. Delegation Oversight

i. Standards and Process for Delegated Medical Groups

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

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

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

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

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

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

Audit results are communicated to the Delegated Entity within 60 days from the completion of the audit. When a CAP is submitted by the Delegated Entity, the SFHP Delegate Oversight team will evaluate the response and issue either an approval or a request for additional information.

Annually, the Provider Network Oversight Committee, the UM Committee, and the Quality Improvement Committee review a summary of delegated groups audit results, provide feedback or request additional information or corrections from the delegate as needed.

ii. Delegated Functions

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

- American Specialty Health
- Beacon Health Options
- Brown and Toland
- Chinese Community Health Care Association
- Hill Physicians Medical Group

- Jade HealthCare Medical Group
- Kaiser Foundation Health Plan
- North East Medical Services
- San Francisco Health Network
- University of California, San Francisco Medical Center (UCSF)
- Teladoc

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

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

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

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

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

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

Quality Management – Kaiser Foundation Health Plan and Beacon Health Options are delegated for QI.

Member Appeals and Grievances – Kaiser Foundation Health Plan and Beacon Health Options are delegated for Appeals and Grievances.

Reviewed & Approved by:

Chief Medical Officer: *Fiona Donald, MD* **Date:**

Quality Improvement Committee Review Date:

Board of Directors Review Date:

Appendix A: Work Plan

Managing Multiple Chronic Illnesses

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Care Management Follow Up On Clinical Depression	Total clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-9 with a "Connect to Behavioral Health" care plan goal	Total Care Management clients 18 years or older screened positive for clinical depression with Patient Health Questionnaire-9	90.0%	Senior Manager, Care Management	• Train staff in mental health, particularly on severe mental illness (SMI) and community resources, in order to ensure that staff is equipped to identify signs and symptoms of clinical depression, address client safety including connection to behavioral health services. • Clinical Supervisors to review monthly reports with staff and to coach staff to ensure members are screened and receive appropriate follow up. • Coach and conduct role-playing activities to reduce the rate of members declining PHQ-9 screening. • Clinical Supervisors to conduct quarterly audits to ensure best practices and regulatory requirements are met. • Complete bi-monthly 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.	6/30/2022
Care Management Client Perception Of Health	Total clients who responded to self-reported health question of SF-12 on both the intake and closing assessments and: - Increased at least one box in rating their health if "Poor" or "Fair" indicated - Maintained or increased at least one box in rating their health if "Good", "Very Good", or "Excellent" indicated	Total Care Management clients who responded to self-reported health question of SF-12 on both the intake and closing assessments	63.0%	Senior Manager, Care Management	• Clinical Supervisors and Medical Director coaching the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP. • CM Management have developed a 2-year training syllabus for the team, 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. • Utilization of Milliman Care Guidelines (MCG) condition specific assessments and MCG health education materials by CM Nurses. • Review of self-management goal report with CM Nurses to ensure that members have chronic condition self-management goals as part of their care plans as indicated.	6/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
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 Care Management clients who responded to the Care Management satisfaction survey	90.0%	Senior Manager, Care Management	• Maintain a process to triage members into longer-term case management programs when requested by member or indicated by member’s self-efficacy skills. • CM staff completes a 6 month reassessment and review of care plan including goals with member • Provide more thorough life skills, health education and training to members as it pertained to their health maintenance. • Improve communication of care plan goal progress between Care Management staff and members.	6/30/2022

Managing Members with Emerging Risk

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Percentage of Members completing Hepatitis C Treatment	Total number of members with any past history of Hepatitis C infection who have completed the Hepatitis C treatment regimen	Total number of members with any past history of Hepatitis C diagnosis	40.0%	Care Coordination Pharmacist	• Use reporting to develop a profile (age, ethnicity, gender, location) for members not yet treated for Hepatitis C. • Continue to provide treatment support through SFHP’s Care Transitions and Care Management programs. • Outreach to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.	6/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
HbA1c in Poor Control	Total members 18–75 years of age with diabetes who have their most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year	Total members 18–75 years of age with diabetes	34.05%	Care Coordination Pharmacist	• Promote screening for members diabetes through member incentives. • Conduct Drug Utilization Review with members with diabetes prescribed multiple diabetes medications. • Enroll members with diabetes into the Medically Tailored Meals program administered by Project Open Hand.	6/30/2022
Project Open Hand Member Satisfaction	Members with diabetes and pre-diabetes enrolled in the program who found the Project Open Hand program helpful	Members with diabetes and pre-diabetes enrolled in the program who complete the Project Open Hand client survey	85.0%	Social Determinants of Health Program Manager	• Partner with Project Open Hand, a community organization which will deliver medically tailored meals and/or groceries to SFHP members with chronic conditions and evaluate members' food needs through appointments with dieticians.	9/30/2022

Patient Safety or Outcomes Across Settings

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Medication Therapy Management (MTM)	Total number of SFHP members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation to be completed with initial medication reconciliation completed	Total number of SFHP members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation to be completed	90.0%	Care Coordination Pharmacist	• Monitor the pharmacist resource requirements needed to support the population of members engaged in Care Management and Care Transitions team. • Assess for additional efficiencies in workflow and member assessment configurations. • Continue reviewing members in the initial assessment process which recommends an MTM assessment and establishes the denominator population for this measure.	6/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Opioid Safety - Buprenorphine Prescription	Total number of SFHP members with Opioid Use Disorder with at least one buprenorphine prescription in the last year	Total number of SFHP members with Opioid Use Disorder	30.0%	Care Coordination Pharmacist	• Outreach to methadone clinic providers in order to better support the use of MAT. • Disseminate educational material to members on MAT options. • Monitor buprenorphine adherence using the repository. • Consider targeted outreach to members with buprenorphine single fills or their providers.	6/30/2022
Opioid Safety - Opioid and Benzodiazepine Co-prescribing	Total number of SFHP members with both an opioid and benzodiazepine prescription	Total number of SFHP members with an opioid prescription	7.0%	Care Coordination Pharmacist	• Work with mental health and substance use specialist providers to create and distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.	6/30/2022
High Dose Opioid Prescriptions	Total number 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	Total number of SFHP members with an opioid prescription	6.0%	Care Coordination Pharmacist	• Work with mental health and substance use specialist providers to create and distribute provider information on buprenorphine prescribing	6/30/2022
Pharmacy Transition	Total number of targeted members outreached	Total medium and high-risk members as identified by the high-risk member dataset	80.0%	Pharmacy Clinical Programs Supervisor	• Send pre-transition outreach letter to all medium- and high-risk members offering plan support. • Provide high-risk member profiles to delegated medical groups to facilitate provider-member communication. • Coordinate direct member outreach for high-risk members engaged in Care Management, Care Transitions, and Beacon services. • Provide education and resources to internal member-facing staff to support continuity of care related to pharmacy transition.	6/30/2022

Keeping Members Healthy

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Breast Cancer Screening	Total number of African American members who have had a mammogram	Total number of African American members 52-74 years of age	50.0%	Program Manager, Population Health	• Provide patient navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening. • Provide Health Education materials to Black/African American SFHP members.	6/30/2022
COVID-19 Vaccination	Members who have received first dose	Members eligible to receive first dose	No greater than 10% less than percentage of SF residents who have received first dose	Program Manager, Population Health	• Incentivize members 12 years and up to receive vaccination through the COVID Vaccine Incentive. • Conduct letter outreach and live phone outreach to unvaccinated members 12 years and up to provide vaccine information and coordination of vaccination appointments and transportation to vaccination appointments. • Provide grants to provider groups and community-based organizations for outreach to underserved populations. • Coordinate with the SF Department of Public Health and community organizations via weekly meetings. • Letter outreach to members 5 – 11 to communicate need for members to be vaccinated. • Provider outreach via provider newsletters and SFHP website update.	6/30/2022

Quality of Service and Access to Care

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Health Plan	Total respondents to SFHP's HP-CAHPS Rating of Health Plan question who rate the health plan 9 or 10	Total respondents to SFHP's HP-CAHPS Rating of Health Plan question	61.3%	Senior Program Manager, Access & Care Experience	• Implement and communicate member experience YouTube videos. • Identify access-related issues via the Access Compliance Committee and develop plans to address found issues. • Conduct CAHPS surveying off-cycle from annual HP-CAHPS • Promote SFHP's telehealth services to increase access to care.	9/30/2022

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Provider Appointment Availability Survey (PAAS) - Routine Appointment Availability In Specialty Care	Total non-behavioral health specialists surveyed in PAAS with eligible survey responses that indicate routine appointment availability compliant with Department of Managed Health Care standards	Total non-behavioral health specialists surveyed in PAAS with eligible survey responses	82.9%	Senior Program Manager, Access & Care Experience	• Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate. • Provide technical assistance with Corrective Action Plans. • Train network providers on proving successful telehealth visits	3/31/2022
Cultural and Linguistic Services (CLS) Provider Data	Total number of practitioners who have voluntarily provided SFHP with their race/ethnicity and language proficiency data	Total number of active credentialed practitioners in network	10.0%	Program Manager, Population Health	• Explore ways to collect information about languages in which individual practitioners are fluent when communicating about medical care. Possible sources may include: practitioner survey, credentialing application, provider relations script, Credentials Verification Organization. • Collect information about language services available through the practice. • Explore ways to collect practitioner race/ethnicity and practitioner language data. • Publish practitioner languages in the provider directory. • Publish language services available through the practice in the provider directory. • Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.	6/30/2020

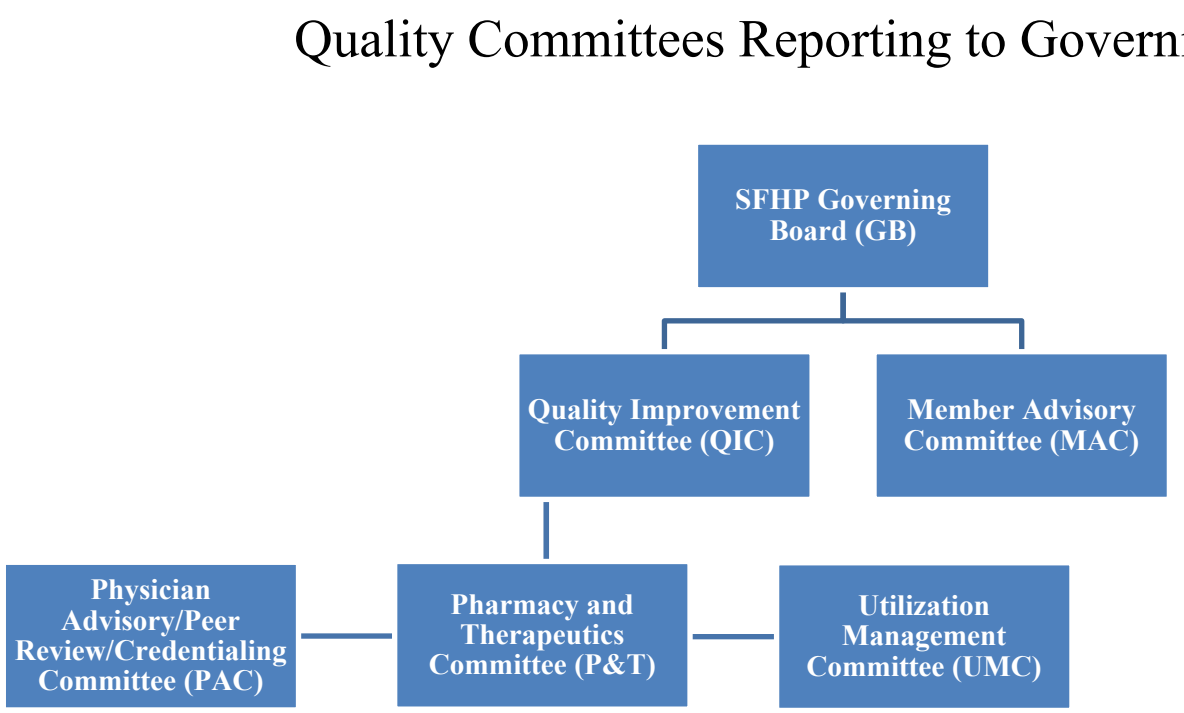
Utilization of Services

Measure Name	Numerator	Denominator	Target	Title	Activities	Date Activities to be Completed
Antidepressant Medication Management (AMM) — Effective Continuation Phase Treatment	Members 18 years of age 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	Members 18 years of age and older with a diagnosis of major depression treatment who were treated with antidepressant medication	52.49%	Interim Director, Population Health/Quality	• Members enrolled in a Care Management program will be engaged to assist members adhering to medication. Care Management staff will be given access to AMM dashboards to identify members falling in this denominator. • Conduct annual training on HEDIS related measures to Provider Advisory Council. Disseminate HEDIS Toolkit which includes billing recommendation, best practices, and resources available to providers for their members that meet the HEDIS definitions. • Share PCP Toolkit with Health Plans to post on their website and promote to their providers. Educate physical health providers on assessment and treatment of depression.	6/30/2022
Inpatient Admissions	Sum of acute inpatient admissions	Sum of member months (rate will be annualized)	82.8%	Director, Clinical Operations	• Review diagnostic related groups that are driving utilization in Utilization Management Committee • Recommend care management programs to look address driver population	6/30/2022

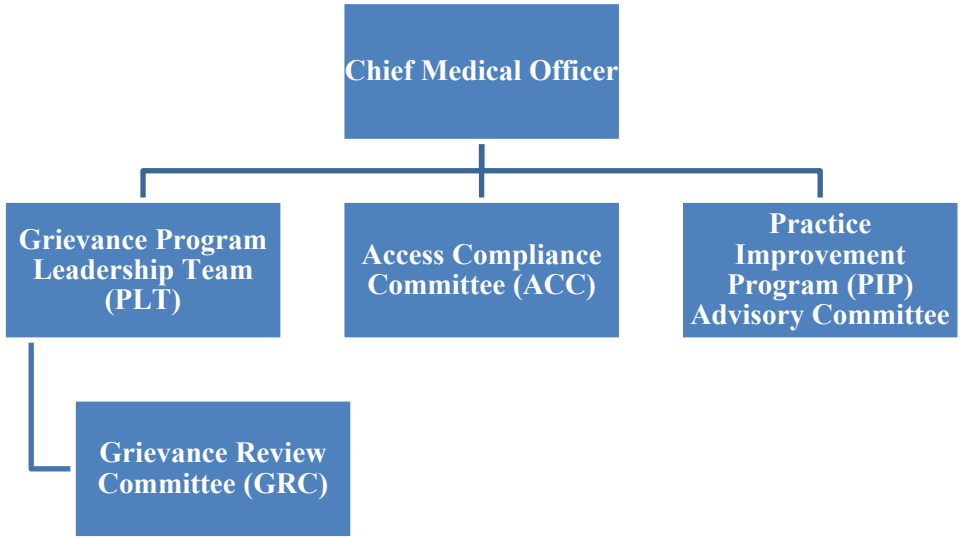
Quality Oversight Activities

Oversight	Summary	Resp. Staff	Activities	Due Date
Quality Improvement Committee	Ensure Quality Improvement Committee (QIC) oversight of QI activities outlined in the QI Plan	CMO	• Six meetings to be held in 2022	12/30/2022
Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	CMO	• Quarterly and ad hoc P&T Committee meetings	12/30/2022
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 2022	12/30/2022
Annual Evaluation of the QI Program	Review Quality Improvement plan and determine efficacy of implemented plan based on outcomes	Interim Director, Population Health & Quality	• Evaluate each measure in the QI work plan • QIC review of QI evaluation • Governing Board review of QI Evaluation	3/1/2022
QI Plan Approval for Calendar Year	Review and approve proposed Quality Improvement work plan	Interim Director, Population Health & Quality	• QIC review of QI work plan • Governing Board review of QI Work Plan	3/1/2022
Delegation Oversight for QI	Ensure oversight of QI for all delegated entities	Interim Director, Population Health & Quality	• Follow delegation oversight procedures • QIC review of Delegated Oversight Audits for QI	12/30/2022
DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs)	Interim Director, Population Health & Quality	• Attend DHCS-led PIP calls. • Adhere to process delineated by DHCS.	12/30/2022

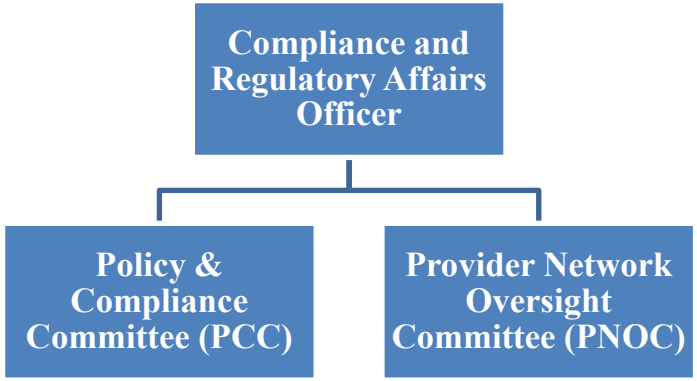
Appendix B: Quality Improvement Committee Structure



Operational Quality Committees Reporting to Chief Medical Officer



Quality Committees Reporting to Officer, Compliance and Regulatory Affairs



SFHP's Quality Improvement Program:
2021 Evaluation & 2022 Work Plan

Presentation to Quality Improvement Committee

Yves Gibbons, Senior Program Manager, Quality & Access

December 9, 2021

QIC's Role in QI Program

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

Measure Development & Evaluation Process

Dept of Managed Health Care

Dept of Health Care Services

National Committee for Quality Assurance

2021 Quality Improvement Program Evaluation

2021 Highlights & Recommendations
Quality of Service & Access to Care

Highlighted Successes

- Implemented a cross functional-work group to create a work plan to improve member engagement with the health plan. The work group created seven videos in five languages for members to learn how to access various types of care including primary and specialty care.
- Interviewed three health plans high performing in Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) to collect best practices for member experience improvement. Best practices identified by the health plans that SFHP is not doing include conducting member experience surveys outside of HP-CAHPS survey fielding and implementing member interventions for specific populations or provider groups that have statistically significant scores.

Recommendations

- Conduct CAHPS surveying off-cycle from annual HP-CAHPS.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

2021 Highlights & Recommendations
Keeping Members Healthy

Highlighted Successes

- Included chlamydia screening information in both member and provider communications. Sexual health mailers, in the form of pamphlets, were mailed out to members in the fall. In spring, Chlamydia screening information were included in provider newsletters and “Your Health Matters.”
- Partnered with community-based organization to offer patient navigation services for Black/African American members due for a breast cancer screening.

Recommendation

- Provide patient navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening.

2021 Highlights & Recommendations

Patient Safety or Outcomes Across Settings

Highlighted Success

- Exceeded target of 15.0% for increasing the percent of members with Opioid Use Disorder with at least one buprenorphine prescription with a final result of 22.0 percent.

Recommendation

- Work with mental health and substance use specialist providers to create and distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.

2021 Highlights & Recommendations
Managing Members with Emerging Risk

Highlighted Success

- SFHP's Care Transitions and Care Management programs provided treatment support for members with Hep C.

Recommendation

- Outreach to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.

2021 Highlights & Recommendations
Utilization of Services

Highlighted Successes

- Exceeded target of 25.0% for increasing the percent of visits delivered via tele-health modalities with a final result of 50.0 percent.
- Increased the percentage of members engaged in non-specialty mental health (NSMH) services receiving more than two NSMH visits from 39.8% to 44.6%, exceeding the target of 42.8 percent.

Recommendation

- Prioritize inpatient measures for monitoring over and under-utilization.

2021 Highlights & Recommendations

Managing Multiple Chronic Illnesses

Highlighted Successes

- Attained high member satisfaction with care management services provided by SFHP.
- Met target of 89.0% for member clinical depression follow-up with a final result of 89.0 percent.

Recommendation

- Provide more thorough life skills, health education and training to members as it pertains to their health maintenance.

2022 Quality Improvement Program Description & Work Plan

2022 Measures
Keeping Members Healthy

Measure Name	Denominator	Target
Breast Cancer Screening	Total number of women 50-74 years of age	50.0%
COVID – 19 Vaccination	Members eligible to receive first dose	No greater than 10% less than percentage of SF residents who have received first dose

2022 Measures
Patient Safety or Outcomes Across Settings

Measure Name	Denominator	Target
Medication Therapy Management (MTM)	Total number of SFHP members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation to be completed	90.0%
Opioid Safety - Buprenorphine Prescription	Total number of SFHP members with Opioid Use Disorder	30.0%
Opioid Safety - Opioid and Benzodiazepine Co-prescribing	Total number of SFHP members with an opioid prescription	7.0%
High Dose Opioid Prescriptions	Total number of SFHP members with an opioid prescription	6.0%
Pharmacy Transition	Total medium and high-risk members as identified by the high-risk member dataset	80.0%

2022 Measures
Managing Members with Emerging Risk

Measure Name	Denominator	Target
Percentage of Members who completed Hepatitis C Treatment	Total number of members with any past history of Hepatitis C diagnosis	40.0%
HbA1c in Poor Control	Total members 18–75 years of age with diabetes	34.05%
Project Open Hand Member Satisfaction	Members with diabetes and pre-diabetes enrolled in the program who complete the Project Open Hand client survey	85.0%

2022 Measures
Managing Multiple Chronic Illnesses

Measure Name	Denominator	Target
Care Management Client Perception Of Health	Total Care Management clients who responded to self-reported health question of SF-12 on both the intake and closing assessments	63.0%
Care Management Follow Up On Clinical Depression	Total Care Management clients 18 years or older screened positive for clinical depression with PHQ-9	90.0%
Care Management Client Satisfaction	Total Care Management clients who responded to the Care Management satisfaction survey	90.0%

2022 Measures
Quality of Service and Access to Care

Measure Name	Denominator	Target
Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Health Plan	Total respondents to SFHP's HP-CAHPS Rating of Health Plan question	61.3%
Provider Appointment Availability Survey (PAAS) - Routine Appointment Availability In Specialty Care	Total non-behavioral health specialists surveyed in PAAS with eligible survey responses	82.9%
Cultural and Linguistic Services (CLS) Provider Data	Total number of active credentialed practitioners in network	10.0%

2022 Measures
Utilization of Services

Measure Name	Denominator	Target
Inpatient Admissions	Sum of Member Months (annualized)	82.8%
Antidepressant Medication Management—Effective Continuation Phase Treatment	Members 18 years of age and older with a diagnosis of major depression treatment who were treated with antidepressant medication	52.49%

Quality Oversight Activities

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

QIC approval

- Approve the 2021 Evaluation
- Approve the 2022 QI Program Description and Work Plan

Next Steps

- SFHP will continue to integrate the QI and Population Health Management Programs
- Integration will better serve members by prioritizing measures and interventions based on Population Assessment