SAN FRANCISCO HEALTH PLAN
Here for you

Quality Improvement Committee Minutes

Date: June 29, 2023
Meeting Place: Microsoft Teams Meeting
+1 323-475-1528,,519741547#

Meeting Time: 8:00AM – 10:00AM

QIC Members Present:

In person: Jackie Lam, Medical Director/ QI Director at North East Medical Services (NEMS); Ana Valdez, Chief Health Officer at HealthRight360; Alecia Martin, Director of Quality at San Francisco Behavioral Health Services (BHS); Idell Wilson, community member; David Ofman, Chief Medical Officer at San Francisco Consortium of Community Clinics (SFCCC)

Virtual: Irene Conway, community member; Ed Evans, community member; Amy Lu, Chief Quality Officer, UCSF

Not present: Lukejohn Day, MD; Jaime Ruiz, MD; Kathleen Chung, MD

SFHP Staff Present:

In person: Stephanie MacAller, Associate Program Manager, Quality Improvement; Yves Gibbons, Supervisor, Quality Improvement; Kaitlin Hawkins, Pharmacy Operations Manager; David Ries, Director of Behavioral Health and Housing; Hilary Gillette-Walch, Director of Population Health; Eddy Ang, Chief Medical Officer

Virtual: Eileen Kim, Clinical Pharmacist; Lena Liu, Program Manager, Grievances and Appeals; Jose Mendez, Manager, Health Services Product Management

Topic		Follow-up [if Quality Issue identified, Include Corrective Action]	Resolution, or Closed Date [for Quality Issue, add plan for Tracking after Resolution]
Call to Order	• Meeting called to order at 8:20 AM with a quorum. Jackie Lam, Medical Director/ QI Director at North East Medical Services (NEMS) Ana Valdez, Chief Health Officer at HealthRight360 Alecia Martin, Director of Quality at San Francisco Behavioral Health Services (BHS) Idell Wilson, community member		

	David Ofman, Chief Medical Officer at San Francisco Consortium of Community Clinics (SFCCC) *Eddy: Can I get the voting members to allow your participation of the remote members for the meeting today?* • Welcome new members Alecia Martin, Director of Quality at San Francisco Behavioral Health Services (BHS) David Ofman, Chief Medical Officer at San Francisco Consortium of Community Clinics (SFCCC) Blake Gregory, Primary Care Director of Population Health and Quality at San Francisco Health Network Amy Lu, Chief Quality Officer at UCSF • Welcome SFHP attendees • Scheduling future QIC meetings for Wednesday or Thursday. What's better for committee? JL- either BG– Thursday AV– either AM– Thursday best, Wednesday ok IW– either DO – Wednesdays, except 4th Wednesday (4th Thursday better) AL – Thursday (can make Wednesday work if better for the rest of the members) IC– either	• Stephanie will send out future schedule	Approved
Consent Calendar	March 2023 QIC Minutes • We went over usual reports that include grievance report, appeals report, PQIs, access report, and UMC policy changes. • No actions pending from the last meeting Q1 2023 Grievance Report • Some strands that we continue to monitor, but nothing that deviates from previous trends • Turnaround time is still at 98—99% compliance rate • Drivers for grievances (graph on p. 10 of consent calendar) o PCP service, specialist grievance, and SFHP top 3 o Nothing unique about 3 main drivers		Approved. • March 2023 QIC Minutes • Q1 2023 Grievance Report • Q1 2023 Appeals Report • Q1 2023 PQI Report • Q4 2022 ER Access Report

	Q1 2023 Appeals Report • Numbers pretty steady year after year—not a lot of deviations Q1 2023 PQI Report • PQI has jumped from previous years b/c we've been better educating our team to ID them and refer to quality review team • PQI turnaround time outside of 60 days is 7 cases ○ This is actually a much shorter timeframe than many other plans ○ Other plans are 180 days ○ SFHP changed policy and have adopted 180 day compliance rate Q4 2022 ER Access Report • ER visit volume by facility and visits ○ ZSFGH & UCSF top ○ Chest, abdominal, and acute respiratory infections top 3 reasons *AV: where do ODs from fentanyl, etc. show up? Are they not making it to ER? Or is it coming under something like syncope and collapse?* *KH: It's not all diagnoses, just top categories. Could be under "all other diagnoses" and just lower percentage. Possible that they could come into ER with diagnosis associated with one of these top categories and they had overdose, but unlikely. Probably right that they're not showing up in ER* *EA: can we add line item for SUD or overdose?* *KH: will have to go back to data, but can add that.* *EA: next time will get more granular and share numbers* UM Committee Minutes and supporting documentation January 2023/ April 2023 • Usual reporting and policy changes: ○ Major organ transplant and gender affirming services Health Services Policies & Procedures (P&P) Updates Summary • Standardized benefits and we monitor changes to Medicaid managed care benefits that come down through APS and then have usually 30 to 60 days to revamp, so there's a lot of policy changes included at the end. QI Scorecard *EA: any questions or comments? (no). Hearing none, motion to approve?* *JL: motion to approve* *BG: second* *Approved*	• Add more granular data to show SUD/overdose data	• UM Committee Minutes and supporting documentation ○ January 2023 ○ April 2023 • Health Services Policies & Procedures (P&P) Updates Summary • QI Scorecard

	HEDIS Priority Quality Measure Overview Just wrapped up HEDIS performance for 2022. From 18 measures held to MPL (minimum performance level), we didn't meet MPL for just 2: FUM • Headed in right direction • Went from below 5th percentile in 2021 to 33rd percentile in 2022 W30 • For last two years SFHP has been at 10th percentile • In order for measure to be counted, you have to be using specific codes • We believe work is happening, and when discussing w/providers they agree • We'll work on *IC: well child visits may be due to coding, but in the past years we've had member incentives like $25 Walgreens gift card that stalled during pandemic. Have they revived the program?* *EA: Thank you for the question. It's been there and we're making it easier to receive incentive by using claims data instead of needing a card to be signed off.* *HGW: Because of KP ransomware attack they haven't been mailed out for last couple of months but we hope to resume in the next few weeks* *EA: Thanks. As Hilary mentioned, one of our vendors for mailing is currently under ransomware attack. Good news is that our member data has not been compromised, and we're not using them for any mailings right now. We're doing all mailings (ex. Late notice of action letters, denial or notification letters, etc.) manually here in office with internal staff. Takeaway here is that member data is safe.* *IC: I still have a follow up question. So I understand that payments are mailed automatically rather than a card, but are parents aware of the incentives? In past ,they had a card and brought it in intentionally, but is it all in the background? Or they may not be aware that this is a program?* *HGW: Yes, all eligible members are receiving mailings indicating that they are eligible for this incentive ahead of time, prompting them to see their primary care services. Once we have compliance, gift cards go out.* *JL: ok so the gift cards are going to go back to the families. I assume it's based on correct coding. In my experiences there are cases where parents are expecting something might come back and they don't get the stuff they've requested, so that might mean that there is some miscoding going on.*		

	HGW: the parent can call customer service if they believe we've missed them and we can look into. We are looking for the HEDIS compliant codes *JL: so in cases of miscoding, are you contacting rendering provider to try and make the coding changes?* *HGW: no, we're not tracking that down if we see that were visits. We are sending out coding guides as a resource.* *EA: I think this may be a gap. If the codes aren't being captured by us, then we don't know that the parent has met those visits. One ask is that if you hear from any of your providers or patients that they have met the 6 visits, then have them call our customer service. We can work with provider to ask for some proof and that could be an opportunity for the provider to recode or adjust the code to reflect that those were actually well child visits.* *HGW: Yes, you're always able to submit another corrected claim.* *EA: feel free to send me or e-mail Hilary. Stephanie can follow up with measure owners contact.* *KH: Are the times between visits also a factor?* *HGW: Yes, there's a minimum spacing of two weeks.* *KH: so if they went for one visit a week later? That doesn't count?* *HGW: yes, spacing can be a factor; you might lose credit for one.* *EA: so it has to a minimum of 14 days apart between visits for both to count.* *HGW: yes, it will count the first visit.* • Wrap up performance from MY 2022. Where does that leave us? How do we compare to other health plans in CA or other Medicaid plans in CA? • Top 2 performing plans are Kaiser (Kaiser North and Kaiser South) • If we exclude Kaiser and look at local Medicaid plans, two tied for #1: Cal Optima in Orange County (southern California) and San Luis Obispo. • #2 Contra Costa and SFHP o #1 quality score was 82.67% o #2 our quality score was 82%, only .06% difference. • This performance is a reflection of providers' hard work. Please take this news back and share our gratitude and appreciation to your organization. *Ed: One thing that may be affecting quality of life for our disabled recipients has to do with in home support care. There's a new system that they have for the providers that will be implemented on July 1. Many of the providers I've been speaking with don't know anything about the reporting thing and some of them are talking about leaving their recipients as a result of this?*	• Stephanie to follow up with measure owners contact info	

	EA: I need to take this question back and investigate the IHSS benefit and we will follow up with you separately by email.	• Eddy to follow up with Ed re: IHSS benefit	
	QIC Vision and Purpose • Reset and renewed energy around quality in heath plans, QIC and our own quality efforts. • New team and new workgroups digging into details of priority measures • QIC has been compliance-related committee primarily responsible for reviewing and approving annual QI program and QI evaluation, providing monitoring and oversight of workplan. • We're wanting to hear more feedback, more brainstorming and input from you on what we're doing and to align what you're doing with what we're doing. • We will continue to share data with you but want to hear from you what you're seeing and hearing and how we can continue to support your work.		
	HEDIS At Risk Measures (danger of not meeting MPL) AMR • One of ER top visits, so this is a really important clinical lens • Want suggestions about ways we can partner with members of community and provider partners • As of last year we're at 10th percentile, but goal is to move from that to MPL • How do we support providers in terms of individually working with members? It's complicated and there can be multiple factors. • New GINA guidelines recommend using controller medications as both controller and rescue medication (esp. For adults) • We've been collaborating w/providers and developing educational materials for providers & patients • Reviewing this class for our pharmacy and therapeutics committee to see which drugs we cover and we have seen an increase in maintenance inhalers. • Looking at high numbers of prescriptions ○ Complicated for children who may need extra inhalers (school, home, etc.) ○ Pharmacies are potential source of issue because of auto refills, so we're working with them to work on that.		

	• Working on adding generic inhalers to approved controller list to help with that number • *DO: could be a role here for doing some provider education in terms of offering a presentation. Quarterly DHP provider meeting where most of primary care providers show up, so that could be an opportunity.* • *AV: something on demand would be helpful, and something with CE.* • *Ed: has there been any reports of people with asthma not being able to get their medication in a timely manner?* ○ *KH: we have reporting that looks at adherence and we see how often they're filling their inhalers. When we look at data from Medi-Cal Rx, we have seen utilization of controllers has gone up, so that make me hopeful that their access is better. But I haven't heard anything directly about the experience at pharmacies that it's causing problems with access.* • *Blake: Thanks for printing out qualifying controller meds. Disappointed that LAMAs aren't on here.* ○ *KH: we can ask auditors about this* ○ *Blake: where we struggle is pharmacies getting a 90 day supple and we can't catch up with that. With one or two dispensers a year, we're underwater.* ○ *KH: hopefully generics will help improve the numbers* ○ *Blake: there are some coding issues where people have COPD but they're not noted as such* ○ *EA: so we'll take that info to auditors and share feedback. This is a good example of how we can partner w/ providers because we have direct access to auditors. Two takeaways:* ▪ *continue this discussion with consortium and come up with on demand/ CME type seminars (follow up with Ana to get thoughts on that as well)* ▪ *Share thoughts on LAMA with the auditors*	• SFHP to come up with on demand/ CME type seminars • SFHP to share thoughts on LAMA with the auditors	
	FUM/FUA • Next two measures behavioral heath measures • Last year in summer DHCS released Comprehensive Quality Strategy (CQS) ○ Lots of ambitious goals state would like to achieve by 2025 ○ Three categories ▪ Behavioral health		

	▪ Maternal health ▪ Child health o This is why a lot of priority measures you're seeing today can fall into one of these buckets • Follow up after emergency department visit • Touch on challenges of health care system o Real need for care coordination ▪ Serious mental illness--> BHS ▪ Mild to moderate illness-->HCP • Huge improvement in measures because of data efforts. But there are still struggles: o State won't share SUD information with us o Avatar (BHS) isn't available to us o DPH uses Epic for information o Trying to integrate sharing of information among systems o We're getting out info on ED visits to provider partners so they can do follow ups o New under CalAIM is enhanced care management (ECM) focused just on care management for certain populations, including those with serious mental illness. o Providing ED visit to PCP on weekly basis o Working directly w/hospitals ▪ Substance use navigators (community health workers in hospitals) ▪ Bringing awareness to EDs to work on discharge planning o Carelon (formerly Beacon) is SFHP's network of mental health clinicians ▪ Ability to peer-to-peer consults w/psychiatrist ▪ Ability to offer telehealth services that patients can receive in person in the clinics (brings more services to clinics who may not have staffing otherwise) *AV: disjointed system w/DPH, clinics, and BHS paid in different ways. We've modeled having AUD counselors in clinics who are peers, people who have been through this, and it's successful, but they are not billable providers. It's an added cost for clinics and we have to figure out how to cover this.* *Navigation is going to be key and by peers. Our intake is on the first floor and they get seen on the 2nd floor and we lose them between the 1st and 2nd floor. Having*		

	navigators for short distances, providing transportation, essentially hand holding will get them from one place to another. Working with EDs on a way to get direct referrals. How to bridge these two systems. Telehealth is hard • *Not everyone has the resources (phone, etc.)* • *High utilization (struggling w/addiction or mental illness) may not be able to receive telehealth services* • *It's good for those who have travel issues, of course* • *We had a horrible case where someone who left to get meds didn't' come back the next day b/c they overdosed in our ICU. We have to bridge their meds and put them right into van and take them in b/c otherwise this is exactly what happens.* *Education for providers: most of the patients we see we can't tell if it's a mental illness or substance use issue. Are they psychotic because they're using a lot of meth? Or are they using meth to try and treat their psychosis? I have been trying to hire an addiction psychiatrist for 5 years now. They're hard to come by or they're so costly we can't afford them. There's a lot of potential in city because people are doing the work and so committed, but how do we overcome those barriers?* *DR: hospitals say same thing regarding navigation, not sure how to get them from ED to follow up.* *KH: Is there an opportunity with the plan for us to do a project around that to get folks in on site where it's going to make a difference in terms of care coordination and follow up appointments?* *DR: Community health workers feels like a great opportunity, but they have too much admin.* *DO: So to be counted, the person needs to physically show up with appt. Not just have the appointment made, correct? The visit to the ED is likely to be more mundane than what a specialty mental health provider can help with. For example, it's not needing to change meds today, it's that they started drinking and stopped taking medicine. There's a crisis in their life and everything is falling apart. I suspect that the navigation piece is key. Getting support to the person to get to the appointment. Most primary clinics have workflows to make appointments after ED visits and admissions. If provider doesn't have a slot, they get them to someone else in 7—10 days. I don't think it's an issue making the appt. I think it's getting the person physically to the appointment.* *EA: Yes—that's a good call out and I agree. Every transition we lose so many opportunities. We need to think about how to tackle this from system point of view…from a patient or member journey perspective. How can we connect services*		

	between primary care and county and Carelon. I think FUM and FUA will remain on HEDIS set for next 5-10 years, so this will probably take multiyear effort. Need to continue discussion. We're working on data exchange process, but from clinical perspective, we need to develop pathway or come up with some resources to make sure that if a member wants to get treated, there will be no issues or friction around transportation, wait time, access to system. This is the type of feedback we want to hear from our providers, what are the real pain points. Also, for FUM, the visit can be with any type of provider—not necessarily psychiatrist or mental health providers.		
	DEV • Relatively new measure • Benchmark is 35.6% and we came in just below at 35.1% • One issue is data collection o Are they coding for developmental screening w/o modifier • Starting a member incentive later this summer • Working with Dept. Of Early Childhood on promoting the Sparkler application o Phone app w/developmental screening tool for families o Providers share specific code so they can see results *Blake: We've shared with you that this is a problem...we were at the 90th percentile for this metric; our rates are 70%.* *HGW: we were talking to a group and they were doing it, but not coding it* *DO : the group was ours. There was some resistance from providers. Usual stuff, too busy, can't be bothered. Fix can't be at provider level. If you rely on providers to do something that's not required for next step they won't do it. Can we add an automatic reminder in the first three years if you haven't already used code. Did you provide developmental screening and you have to say yes or no to go onto the next step.* *HGW: I've heard from some groups that they have a dot phrase, so when they start to chart the developmental screenings or they bring it up it automatically adds the code, so making an EHR change.* *Blake: I think we enter all of our ASQ and so I think if there's some way when those fields are complete it automatically is pulled forward as a CPT. Not sure what's possible with auditor because we record all of this for QIP to DHCS. It all validated; is there a possibility to accept the local mapping as we work on an EHR fix?* *HGW: Jose and I are setting up a standardized template for data submissions so we can collect data that isn't coming through.*	• SFHP to share standard data sharing template with provider partners	

	TFL-CH • Another new measure • Covers children 1—20 years of age and it's looking for two fluoride applications o Not in alignment with US Preventive Services Task Force recommendation for American Academy of Pediatrics o Asking to change to HEDIS measure (from tooth eruption to 5 years of age) o SFHP working with local health plans association to push back on age range with DHCS o We have to comply with clinical guidelines based on evidence, not just DHCS range because they say so • Looking to clinics to regularly apply fluoride varnish	• SFHP will update QIC on developments in measure definition	
	W30 • Down at 10th percentile • CA overall is lowest 25th percentile in nation. • Primary barrier is infant billing under mother's ID for first 2 months • Working w/providers to secure infant well visits that are happening to close data gaps • Working on Infant Wellness Map o Small map that unfolds (size of credit card) o Place for them to write in the dates of visits o Includes milestones for developmental screening and infant immunizations *Blake: is there a plan for addressing the ID issues?* *HGW: Yes, it's to get your EHR data. Once we have that ID we can pull those with missing visits. Because it's an all or nothing, if they have 5 out of 6, they're not compliant.* *EA: if you have any data in whatever format that you think should be included in the accounting for the HEDIS performance please let us know. Please reach out to the measure owners so we can gather your feedback and work with auditors. At least for these 6 measures, we want to make sure we have a good handle on the data that's available on your end or what rates you see and to close that gap with auditors.*		
	Data Gaps and SFHP Provider Guide		

	• Purpose is to give guidance on what information or logic is being used for the measurements, including specific codes or practitioner requirements. If you have any feedback, please reach out to me. *EA: we as a plan cannot dictate what diagnosis or ICD 10 or CPT codes that you and your providers. We're not here to dictate how to provide care, just a cheat sheet. We were going to go over anonymized data but we will follow up with that info in an email. We will also follow up in an email in about a month about closing some of the loops on the action items from today.*		
	Meeting adjourned at 10:00am	• Stephanie will follow up with anonymous data and other info requested/discussed in meeting	

QI Committee Chair's Signature & Date: 

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