Population Needs Assessment

San Francisco Health Plan

2022

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1. Population Needs Assessment Overview

As outlined in All Plan Letter 19-011, the purpose of the Population Needs Assessment (PNA) is to determine priority gaps in care related to chronic conditions, preventative health, health education, access to care, and cultural and linguistic services, and to identify activities to be implemented by the health plan to address those gaps. The PNA utilizes data from claims and encounters, member demographics, provider languages, grievances, HEDIS, HP-CAHPS, and DHCS' managed care health plan (MCP) specific health disparities. The goal of the PNA is to improve health outcomes of members and is designed to ensure that SFHP identifies member health needs and disparities by evaluating health education, Culture & Linguistics (C & L) and quality improvement (QI) activities, and available resources to address identified disparities by implementing strategies and targeted interventions. This will ensure that SFHP 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 will be delivered 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. Section Three of the PNA outlines key findings and prioritizes the identified gaps in care for the following areas:

- Diabetes related care
- Breast cancer screening
- Well child visits
- Access to care

Section Four outlines strategies and actions to address the prioritized gaps in care. Section Five describes member and provider stakeholder engagement to solicit feedback and collaboration on implementing strategies and actions to address and improve access to care gaps.

2. Data Sources

SFHP leveraged a variety of data sources to carry out the 2022 PNA. SFHP reviewed its membership data to summarize key member demographics and analyzed its claims and encounters data to provide an overview of member disease prevalence. SFHP also used data from HEDIS results and benchmarks, HP-CAHPS, DHCS identified disparities, provider language data, and grievance data to inform key findings and determine priorities for the 2022 Action Plan. The following table provides an overview of each data source, a brief description of the data, and the year of data.

Data Source	Data Description	Year of Data
Claims and encounter data	Claims and encounters submitted by medical and behavioral provider networks which contain diagnosis and utilization codes.	2022
Member demographic data	Medi-Cal member eligibility files sent from DHCS including demographic data.	2022
Plan HEDIS data	Health Effectiveness Data and Information Set (HEDIS) indicators are key care markers for health plan oversight of population health. Measure rates are determined from claims and encounters, electronic health records, medical record review, and lab feeds, and are tied to member demographics.	MY2021/RY2022

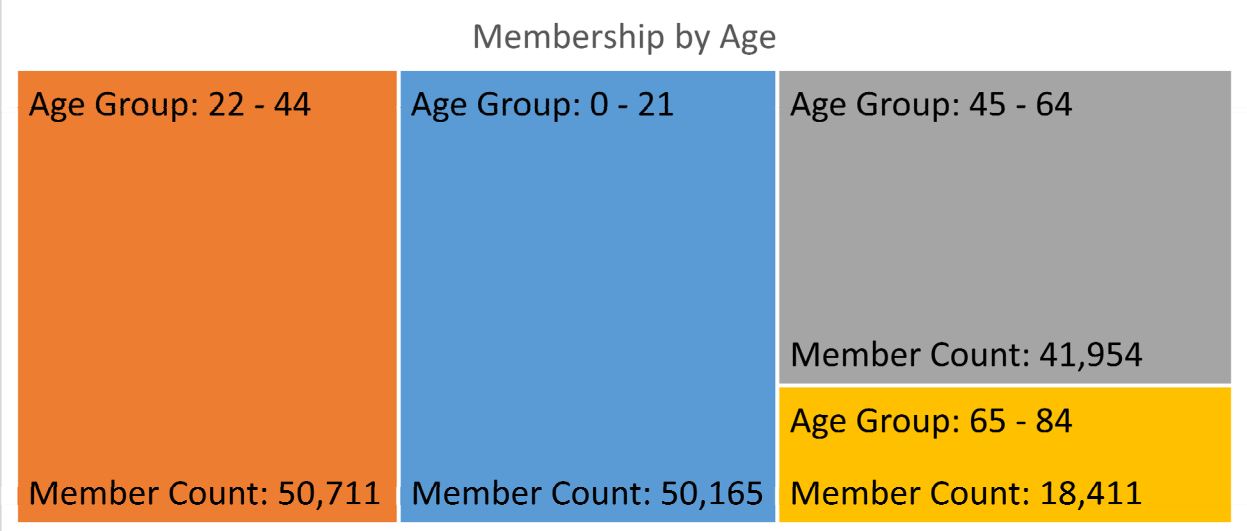
Data Source	Data Description	Year of Data
HEDIS national benchmarks	HEDIS national benchmarks compare plans within the same lines of business to provide percentiles and associated rate benchmarks.	2021
HP-CAHPS	Health Plan Consumer Assessment of Health Care Services (HP-CAHPS) is a member experience survey which reflects member perception of quality of service, access to care, perception of providers, and plan customer service.	2020, 2021, 2022
DHCS health disparities data	Data sent by DHCS on disparities specific to SFHP on Managed Care Accountability Sets (MCAS) HEDIS indicators.	MY 2020/RY 2021
Provider language data	Data on spoken languages from across contracted providers within SFHP's network.	2022
HECLS grievance data	Data on grievances from SFHP's grievance management systems that are categorized as involving Health Education, Cultural & Linguistic Services.	FY 2021-2022
APL 18-016	All Plan Letter (APL) 18-016 provides the structure of meeting health education requirements.	2018

3. Key Data Assessment Findings

3.1 Membership/Group Profile

SFHP's Medi-Cal membership reflects the diversity of San Francisco's adults, young adults, and children from a variety of cultural, racial, ethnic, and linguistic backgrounds. Analysis was conducted on this population by age, spoken language, racial/ethnic identifiers, and Medi-Cal Aid categories. SFHP receives member demographic data from the California Department of Health Care Services (DHCS), and therefore, categories, unless otherwise indicated, are defined by DHCS. The following sections describe the demographic characteristics of the SFHP Medi-Cal member population.

3.1.1 Age



Data source: Member demographic data	Year of data: 2022

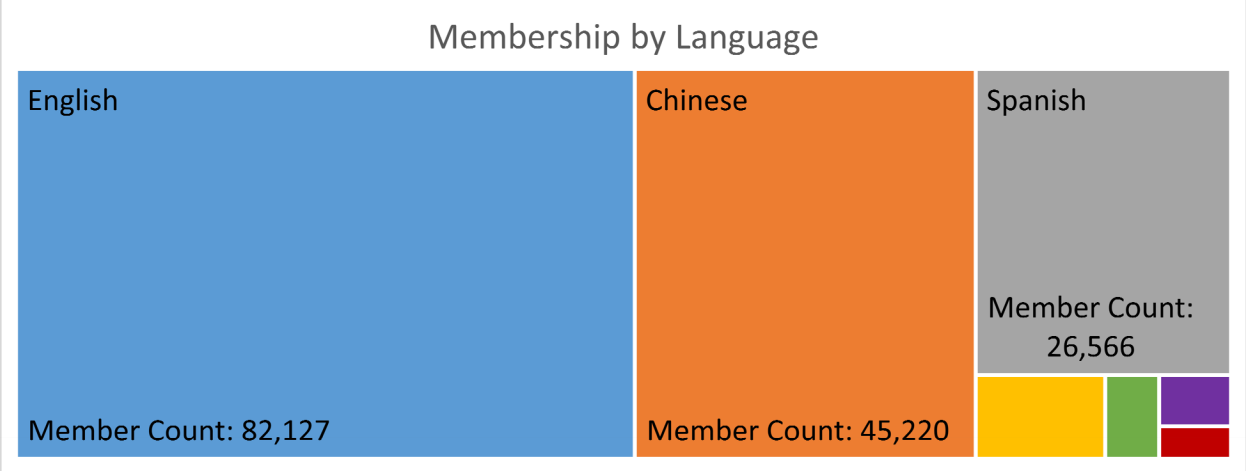
The Age Range figure above shows SFHP's overall membership by age categories for members with June 2022 Medi-Cal eligibility. As indicated above, member age category distribution between the 0-21, 22-24, 25-44, and 45-64 categories is similar with a notable decrease after age 65, which is typical for a Medicaid population. Most of the members aged 65+ are also enrolled in Medicare; for these members, the focus for SFHP is coordination of care. As SFHP's data analysis capabilities become more advanced with new tools, SFHP will continue to refine age categories, particularly for youth and adolescents.

In comparing this year's membership to the prior year below, we see a notable increase in all age ranges. The increase in all age ranges can be attributed to increases in Medi-Cal enrolment during the COVID-19 pandemic. The increase in seniors (65+) can be attributed to an aging Medi-Cal population. SFHP will be tracking the increase in our 65+ population who don't have Medicare as primary coverage to ensure they are receiving all eligible benefits.

Membership Change by Age Group from Prior Years

	Member Count			Percent Change in Member Count	
	June 2020	June 2021	June 2022	June 2020 to June 2021	June 2021 to June 2022
0 – 21	44,230	48,233	50,165	9.05%	4.01%
22 – 44	35,861	44,459	50,711	23.98%	14.06%
45 – 64	34,472	39,129	41,954	13.51%	7.22%
65 – 84	14,201	16,249	18,411	14.42%	13.31%
85+	746	893	994	19.71%	11.31%
Data source: Member demographic data				Year of data: 2022	

3.1.2 Language

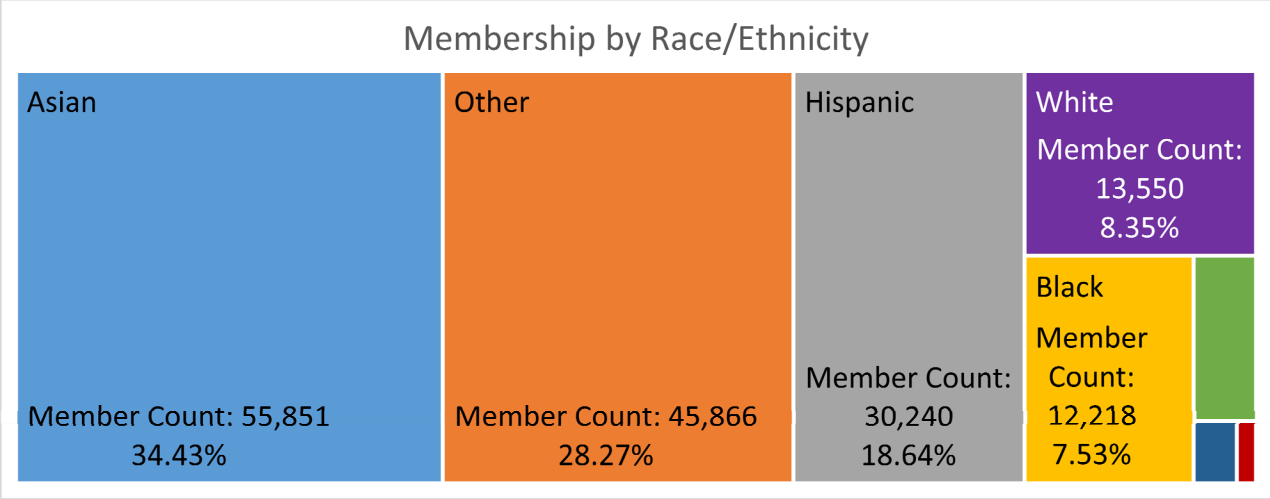


Vietnamese Member Count: 3,706	Other Languages Member Count: 1,259
Tagalog Member Count: 1,545	Russian Member Count: 800
Data source: Member demographic data	Year of data: 2022

The top three spoken languages among SFHP's Medi-Cal members are English (50.62%), Chinese (27.87%), and Spanish (16.38%). Analysis of member languages helps to ensure that health education materials, referrals, and resources are available in the most common languages. It is essential that SFHP's PNA Strategy takes into account member language in order to design programs and activities

that are linguistically appropriate because this is a social determinant of health that SFHP has the ability and responsibility to address in its work with members.

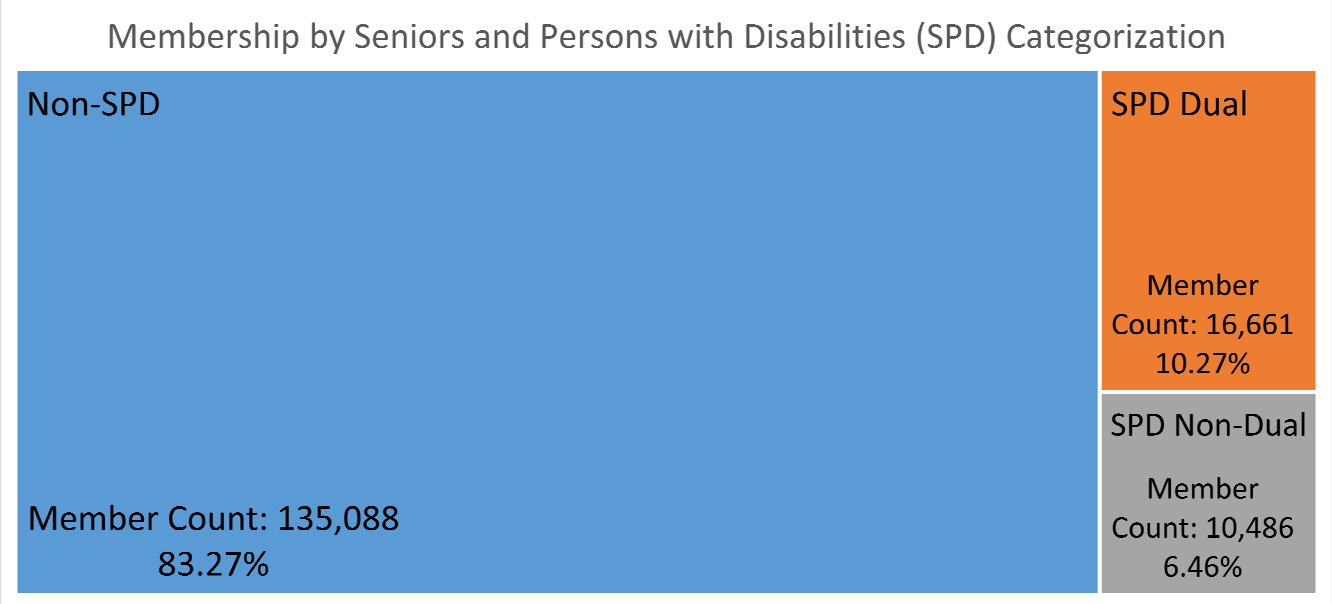
3.1.3 Race/Ethnicity



No race/ethnicity or unknown Member Count: 3,281 or 2.02%	
Hawaiian, Pacific Islander Member Count: 852 or 0.53%	
Alaskan, Native American Member Count: 377 or 0.23%	
Data source: Member demographic data	Year of data: 2022

The top three race/ethnicity groups among SFHP's Medi-Cal members according to 2022 member demographic data are Asian or Pacific Islander (34.43%), Other (28.27%) , and Hispanic (18.77%).

3.1.4 Members with disabilities



Data source: Member demographic data	Year of data: 2022

According to 2022 member demographic data, SFHP has a membership of 83.27% Non-SPD members, 10.27% SPD-Dual members, and 6.46% SPD-Non-Dual members.

3.2 Health Status and Disease Prevalence

3.2.1 Conditions by Overall Population

Condition	Rate in Overall Population
Asthma	2.86%
Chronic Kidney Disease (CKD)	2.92%
Chronic Obstructive Pulmonary Disease (COPD)	1.06%
Diabetes	8.19%
Heart Failure	0.78%
Hyperlipidemia	7.54%
Hypertension	10.81%
Obesity	3.20%
Data source: Claims and encounter data	Year of data: 2022

The table above represents the top eight diagnoses across the entire Medi-Cal population, according to 2022 claims and encounter data. The top three diagnoses identified are highlighted in red, yellow, and green representing the highest proportion of the age group (red), the second highest (yellow), and the third (green). The top diagnoses for SFHP's overall population identified are hypertension (10.81%), hyperlipidemia (7.54%), and diabetes (8.19%).

3.2.2 Condition by Age

Condition	Age 0 – 21	Age 22 – 44	Age 45 – 64	Age 65 – 84	Age 85+
Asthma	2.98%	1.67%	3.31%	4.81%	6.04%
CKD	0.23%	1.17%	5.26%	8.96%	14.69%
COPD	0.01%	0.11%	1.92%	4.32%	4.93%
Diabetes	0.27%	2.49%	15.60%	27.52%	23.54%
Heart Failure	-	0.27%	1.55%	2.16%	6.94%
Hyperlipidemia	1.26%	2.52%	14.05%	23.37%	10.76%
Hypertension	0.16%	2.41%	10.12%	39.50%	48.09%
Obesity	4.88%	2.33%	2.76%	2.47%	0.70%
Data source: Claims and encounter data, member demographic data					Year of data: 2022

The table above represents the top eight diagnoses across the entire Medi-Cal population, according to 2022 claims and encounter data, broken down by age group. The top three diagnoses identified for each age group are highlighted in red, yellow, and green representing the highest proportion of the age group (red), the second highest (yellow), and the third (green).

3.2.3 Condition by Language

Condition	Chinese	English	Others	Russian	Spanish	Unknown	Vietnamese
Asthma	2.03%	3.27%	2.97%	2.00%	3.13%	2.65%	2.21%
CKD	3.99%	2.47%	5.58%	3.75%	2.03%	3.97%	3.35%
COPD	1.30%	1.20%	1.11%	1.00%	0.22%	2.65%	0.73%
Diabetes	15.40%	4.83%	12.13%	8.38%	5.25%	14.02%	11.52%
Heart Failure	0.35%	1.06%	2.09%	1.63%	0.45%	1.06%	0.54%
Hyperlipidemia	18.31%	2.94%	6.66%	10.50%	2.10%	6.35%	17.57%.
Hypertension	18.05%	7.80%	17.60%	20.50%	5.27%	19.31%	19.97%
Obesity	3.07%	2.25%	2.15%	2.38%	6.47%	3.17%	3.75%
Data source: Claims and encounter data, member demographic data						Year of data: 2022	

The table above represents the top eight diagnosis across the entire Medi-Cal population, according to 2022 claims and encounter data, broken down by language spoken. The top three diagnoses identified for each age group are highlighted in red, yellow, and green representing the highest proportion of the age group (red), the second highest (yellow), and the third (green).

3.2.4 Condition by Race & Ethnicity

Condition	Alaskan, Native American	Asian	Black	Hawaiian, Pacific Islander	Hispanic	No race/ ethnicity, unknown	Other	White
Asthma	3.98%	2.13%	5.66%	3.99%	3.26%	2.96%	2.60%	3.26%
CKD	3.98%	3.64%	4.18%	4.81%	1.97%	3.51%	2.40%	2.34%
COPD	2.12%	1.12%	2.68%	1.17%	0.27%	1.58%	0.80%	1.76%
Diabetes	8.22%	12.87%	6.74%	8.92%	4.79%	12.10%	6.24%	3.42%
Heart Failure	1.06%	0.51%	2.38%	2.23%	0.46%	1.19%	0.70%	1.20%
Hyperlipidemia	3.71%	14.77%	1.82%	2.35%	1.97%	10.79%	5.18%	3.02%
Hypertension	12.73%	15.92%	13.60%	8.33%	4.92%	14.51%	8.63%	7.03%
Obesity	2.65%	2.84%	2.45%	5.75%	5.80%	2.71%	2.55%	1.79%
Data source: Claims and encounter data, member demographic data						Year of data: 2022		

The table above represents the top eight diagnoses across the entire Medi-Cal population, according to 2022 claims and encounter data, broken down race/ethnicity. The top three diagnoses identified for each age group are highlighted in red, yellow, and green representing the highest proportion of the age group (red), the second highest (yellow), and the third (green).

3.2.5 Condition by SPD Status

Condition	Non SPD	SPD Dual	SPD Non-Dual
Asthma	2.25%	5.36%	6.77%
CKD	1.68%	9.44%	8.54%
COPD	0.35%	4.58%	4.52%
Diabetes	5.18%	26.76%	17.53%
Heart Failure	0.36%	2.42%	3.48%
Hyperlipidemia	5.56%	21.56%	10.89%
Hypertension	6.12%	38.37%	27.50%
Obesity	3.22%	2.71%	3.79%
Data source: Claims and encounter data, member demographic data			Year of data: 2022

The table above represents the top eight diagnoses across the entire Medi-Cal population, according to 2022 claims and encounter data, broken down by SPD status. The top three diagnoses identified are highlighted in red, yellow, and green representing the highest proportion of the age group (red), the second highest (yellow), and the third (green).

3.2.6 Priority Conditions

Based on the tables presented in sections 3.2.2 through 3.2.5, the conditions listed in the table below are the top three conditions among populations segmented by age, language, race/ethnicity, and SPD status. While Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure are also represented as top conditions as outlined in 3.2.1, they are de-prioritized for further analysis. Population segmentation and analysis for the prioritized conditions outlined in the table below continues in section 3.4, which will include a review of HEDIS measures and populations experiencing disparities related to these prioritized conditions, along with a prioritized HEDIS preventative health measure not associated with one of the conditions listed below.

Condition	Associated HEDIS Measures with DHCS MCP Specific Health Disparities Data	Next Step for Analysis in PNA
Asthma	Asthma Medication Ratio (AMR)	See section 3.4 for measure breakdown.
Chronic Kidney Disease	No DHCS MCP Specific Health Disparities Data available; Kidney Health Evaluation for Patients with Diabetes (KED) is a new admin measure for MY2022.	SFHP will monitor performance for this measure in MY2022; no further analysis in SFHP's 2022 PNA.
Diabetes	• Comprehensive Diabetes Care—HbA1c Poor Control >9.0% (CDC – H9) • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• See section 3.4 for measure breakdown of CDC – H9. • No further analysis in SFHP's 2022 PNA for SSD ; at this time data exchange between county behavioral health services, which informs linkages between severe mental illness and SFHP's members, is under

Condition	Associated HEDIS Measures with DHCS MCP Specific Health Disparities Data	Next Step for Analysis in PNA
		development as part of the CalAIM *No Wrong Door* initiative. Therefore, limited information is available to support this measure.
Hyperlipidemia	No DHCS MCP Specific Health Disparities Data available.	No further analysis in 2022 PNA.
Hypertension	Controlling High Blood Pressure (CBP)	See section 3.4 for measure breakdown.
Obesity	• Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM – BC) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total (WCC – BMI)	• No further analysis in SFHP's 2022 PNA for APM – BC; at this time data exchange between county behavioral health services which informs linkages between severe mental illness and SFHP's members is under development as part of the CalAIM *No Wrong Door* initiative. Therefore, limited information is available to support this measure. • See section 3.4 for measure breakdown of WCC – BMI.
Data sources:	Claims and encounter data	Year of data: 2022
	Plan HEDIS data	Year of data: MY2021/RY2022

3.3 Access to Care

Access to care, tests, treatment, and appointments impact member experience through improving members' engagement to their healthcare. Access to care results in early detection of medical issues and ensures that all people can get treatment for their health conditions. SFHP annually conducts the Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS), a standardized survey measuring member experience with their health plan and covered health care services to quantify member experience with care, including access to care. SFHP underperforms on the Adult Medi-Cal HP-CAHPS compared to other Medicaid plans. Survey results provide SFHP and its provider network actionable member experience information.

Improving member access is a key organizational priority. SFHP's access-related HP-CAHPS composite scores outlined in the table below are the lowest performing among all SFHP HP-CAHPS ratings and composites.

Access Composite	2020	2021	2022*	2022 Medicaid Percentile*
Getting Needed Care	72.3%	74.1%	66.5%*	Below 10th*
Getting Care Quickly	72.2%	70.1%	71.3%*	Below 10th*
Data source: HP-CAHPS			Years of data: 2020, 2021, 2022	

*Final HP-CAHPS results from 2022 are preliminary and are set to be finalized in July 2022.

The two HP-CAHPS access composites are comprised of two questions each. Differences in responses can be segmented based on gender, age, Hispanic ethnicity, and race, and health status. Following are the results of 2021 HP-CAHPS access composite questions with segmentations of populations with statistically significantly different responses.

Getting Needed Care Composite – Ease of Getting Needed Care
"In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?"

Category	Demographic	Percent Answering Usually or Always
SFHP Overall Population	N/A	77.3%
Hispanic ethnicity	Hispanic	97.4%
	Not Hispanic	72.6%
Race	White	88.9%
	Other	72.1%
Data source: HP-CAHPS		Year of data: 2021

Getting Needed Care Composite – Ease of Seeing a Specialist
"In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?"

Category	Demographic	Percent Answering Usually or Always
SFHP Overall Population	N/A	77.3%
Data source: HP-CAHPS		Year of data: 2021

No population segmentation is listed, as there were no statistically significant differences between demographics identified in this question.

Getting Care Quickly Composite – Ease of Getting Urgent Care
"In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?"

Category	Demographic	Percent Answering Always
SFHP Overall Population	N/A	46.5%
Hispanic ethnicity	Hispanic	75.0%
	Not Hispanic	41.9%
Data source: HP-CAHPS		Year of data: 2021

Getting Care Quickly Composite – Ease of Getting a Check-Up or Routine Care
"In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?"

Category	Demographic	Percent Answering Usually or Always
SFHP Overall Population	N/A	64.9%
Hispanic ethnicity	Hispanic	83.8%
	Not Hispanic	58.9%
Data source: HP-CAHPS		Year of data: 2021

Analysis

In each of the HP-CAHPS access questions, except for ease of seeing specialist, SFHP saw significant differences in scores between Hispanic and non-Hispanic members, with the former scoring the health plan significantly higher. Based on this, Hispanic or Latino members seem to have a better perception of access as compared to other race ethnicities. The ease of getting needed care question, "In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?" demonstrates significant differences between white and non-white race ethnicities, with the former scoring the plan significantly lower. This difference in the ease of getting needed care question demonstrates a disparity in access to care for non-white members. Additionally, SFHP's HP-CAHPS vendor identified the ease of getting needed care question as the top key driver for SFHP to improve HP-CAHPS scores. As a result of the disparities in the ease of getting needed care question, which is a key driver for HP-CAHPS improvement, SFHP will prioritize improvement in the Getting Needed Care composite and has developed an action plan outlined in section four corresponding to this prioritized gap in access.

3.4 Health Disparities

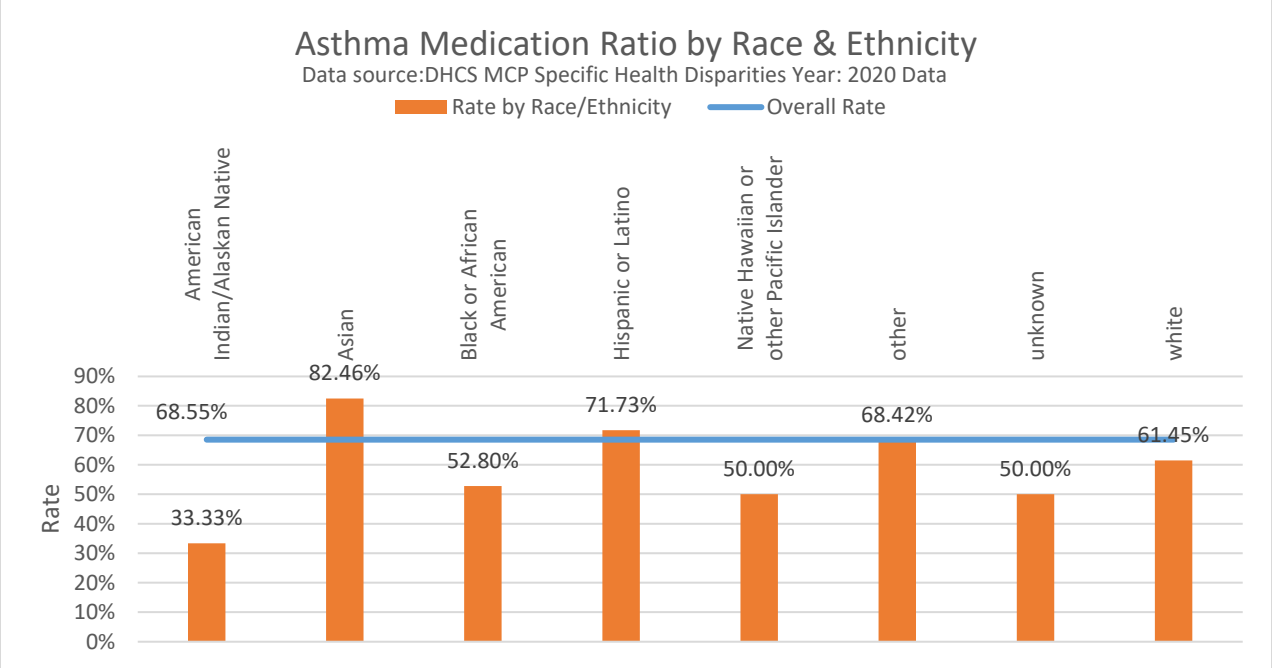
In addition to the priority chronic conditions and associated HEDIS indicators with MCP Specific Health Disparities data from 2020 identified in section 3.2.6, SFHP has identified the HEDIS indicators well child visits in the first 30 months of life (W30 – 6 & W30 – 2) as the two W30 indicators are the only two HEDIS measures with MCP Specific Health Disparities data from 2020 that did not meet minimum performance level in measurement year 2021 reporting year 2022 (MY 2021/RY 2022). The following table displays the overall HEDIS rates for the HEDIS measures prioritized from section 3.2.6, along with the two W30 measures.

HEDIS measure	**Rate - MY 2020/RY 2021**	**Rate - MY 2021/RY 2022**
AMR – Asthma Medication Ratio	68.55%	55.47%
BCS – Breast Cancer Screening	56.00%	56.72%
CBP – Controlling High Blood Pressure	63.99%	66.93%
CDC – Diabetes HbA1c Poor Control >9	41.05%	34.79%
W30-6 – Well-Child Visits in the First 30 Months of Life – zero to 15 Months	46.87%	41.63%
W30-2 – Well-Child Visits in the First 30 Months of Life – 15 to 30 Months	76.09%	69.33%
WCC-BMI – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total	72.02%	78.81%

Data sources:	DHCS health disparities data	Year of data: MY2020/RY2021
	Plan HEDIS data	Year of data: MY2021/RY2022

For these measures, SFHP has chosen to examine each measure as broken down by race/ethnicity, as demonstrated in the MCP Specific Health Disparities data from 2020. Race/ethnicity is used as an indicator to identify and highlight gaps in care among San Francisco's diverse population and communities. While race/ethnicity alone might not indicate the comprehensive nature of health disparities and outcomes, it does shed light on areas of opportunity for SFHP to enhance targeted intervention to improve health equity and culturally competent measures.

Asthma Medication Ratio



Denominator	3	171	125	191	6	190	10	83

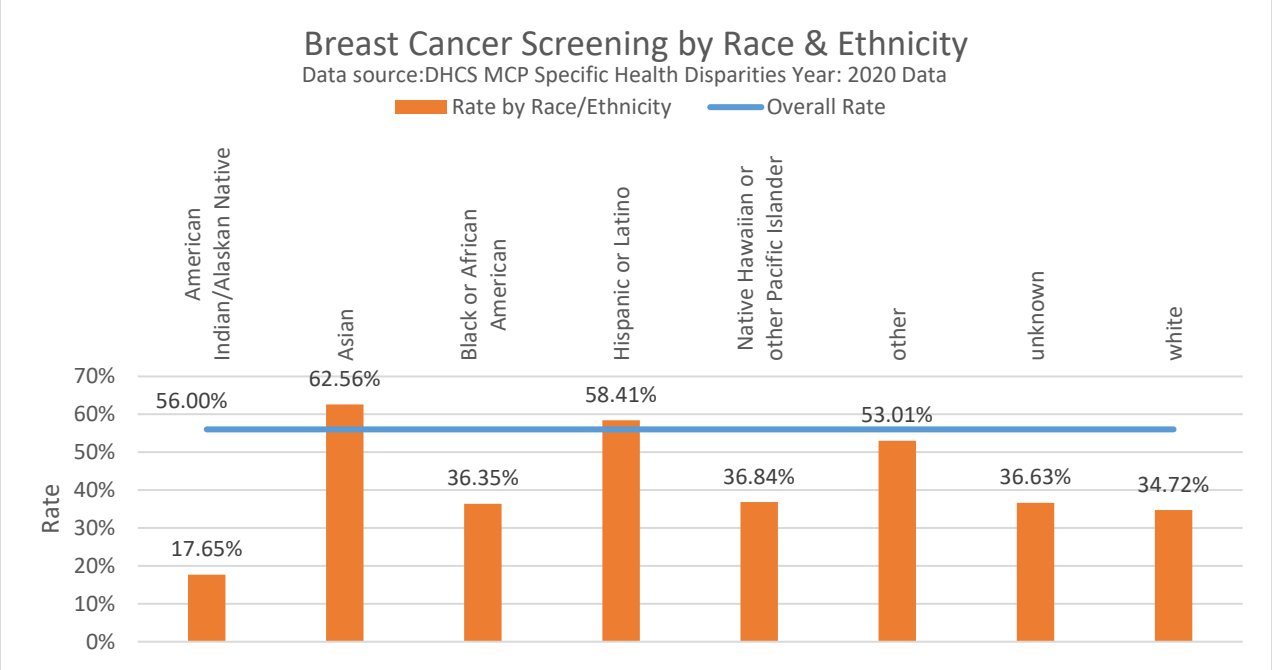
Data source: DHCS health disparities data	Year of data: MY 2020/RY 2021

The asthma medication ratio HEDIS indicator measures the percentage of members ages five to 64 with persistent asthma and a ratio of controller medications to total asthma medications of 0.50. Overall SFHP reached 68.55% in asthma medication ratio.

Findings:

- American Indian and Alaskan Native members (33.33%) had the lowest rate when compared to other race/ethnicity groups.
- In addition to the lowest rate group, Black or African American members, Native Hawaiian or other Pacific Islander members, and members of unknown race/ethnicity all have rates that are more than 10% below the overall plan rate.
- Of members of race/ethnicities that are 10% or more below the overall plan rate, Black or African American members have the largest denominator with 125 members.

Breast Cancer Screening



Denominator	17	4,460	619	630	19	1,462	101	530

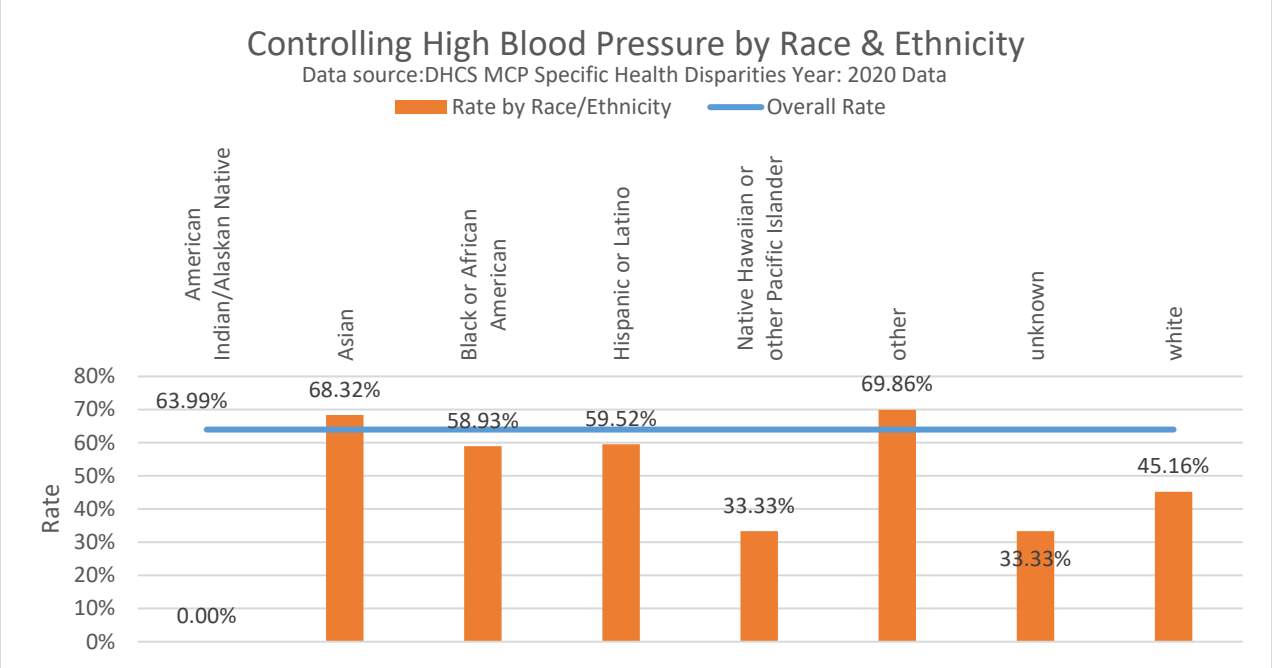
Data source: DHCS health disparities data	Year of data: MY 2020/RY 2021

The breast cancer screening HEDIS indicator measures the percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer. Overall SFHP reached 56.00% in breast cancer screening.

Findings:

- American Indian and Alaskan Native women (17.65%) had the lowest rate when compared to other race/ethnicity groups.
- Black or African American women, Native Hawaiian or other Pacific Islander women, women of unknown race/ethnicity, and white women all have rates nearly 20% or more below the overall plan rate.
- Of women of race/ethnicities that are lower performing breast cancer screening rates, Black or African American and white women have the largest denominators with 619 and 530, respectively.

Controlling High Blood Pressure



Denominator	1	202	56	42	3	73	3	31

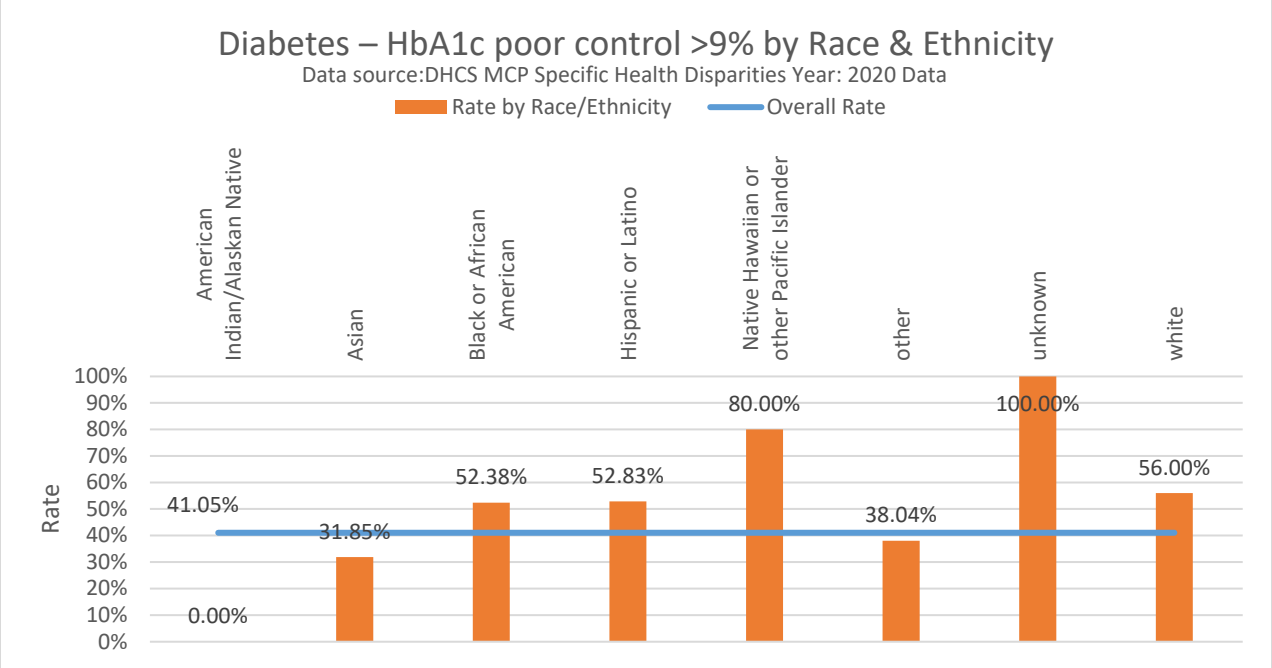
Data source: DHCS health disparities data	Year of data: MY 2020/RY 2021

The controlling high blood pressure HEDIS indicator measures the percentage of members ages 18 to 85 with hypertension and whose blood pressure was adequately controlled during the measurement year. Overall SFHP reached 63.99% in controlling high blood pressure.

Findings:

- American Indian and Alaskan Native members (0%) had the lowest rate when compared to other race/ethnicity groups.
- In addition to the American Indian and Alaskan Native members, Native Hawaiian or other Pacific Islander members, members of unknown race/ethnicity, and white members all have rates that are more than 15% below the overall plan rate.
- Of members of race/ethnicities that are 15% or more below the overall plan rate, white members have the largest denominator with 31.

Diabetes – HbA1c Poor Control >9%



Denominator	3	157	42	53	5	92	3	25

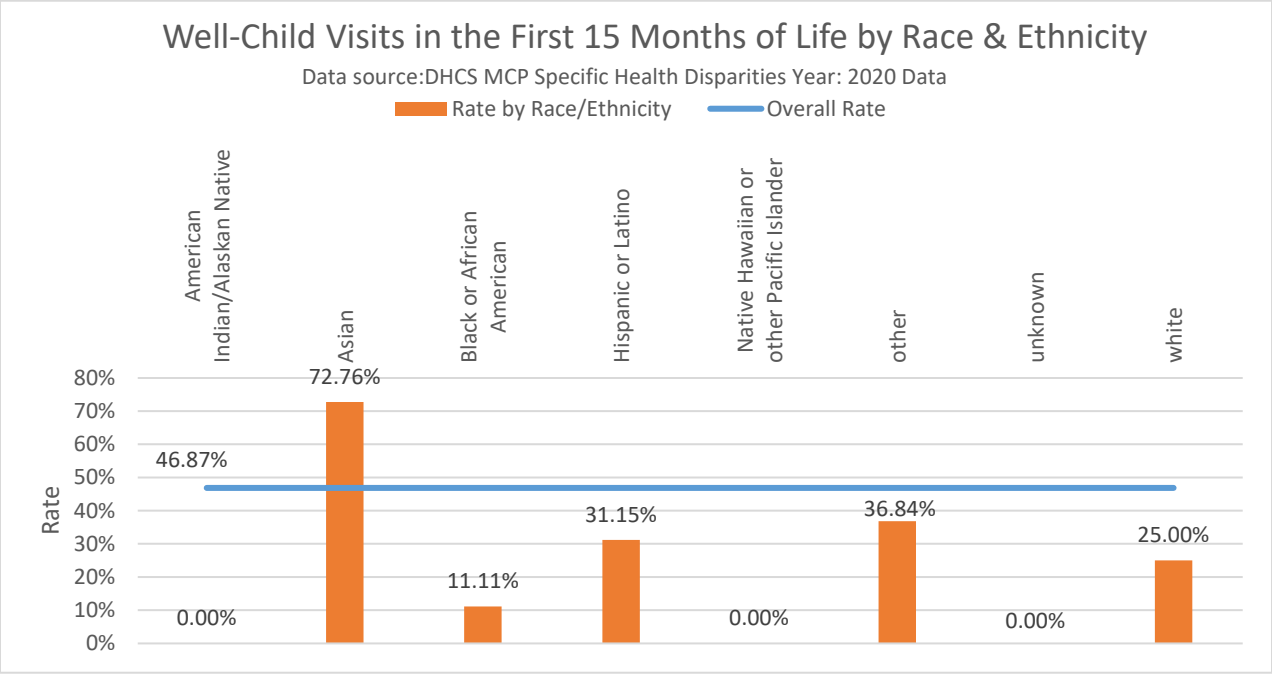
Data source: DHCS health disparities data	Year of data: MY 2020/RY 2021

The diabetes – HbA1c poor control >9% HEDIS indicator measures the percentage of members ages 18 to 75 with diabetes and whose most recent HbA1c level is greater than 9.0%, or is missing, or was not done during the measurement year. A lower rate indicates better performance for this indicator. Overall SFHP reached 41.05% in diabetes – HbA1c in poor control >9%.

Findings:

- Members of unknown race/ethnicity (0%) had the highest rate when compared to other race/ethnicity groups.
- In addition to the group of members of unknown race/ethnicity, Black or African American members, Hispanic or Latino members, Native Hawaiian or other Pacific Islander members, and white members all have rates that are more than 10% above the overall plan rate.
- Of members of race/ethnicities that are 10% or more above the overall plan rate, Black or African American and Hispanic or Latino members have the largest denominators with 42 and 53, respectively.

Well-Child Visits in the First 15 Months of Life (W30-6)



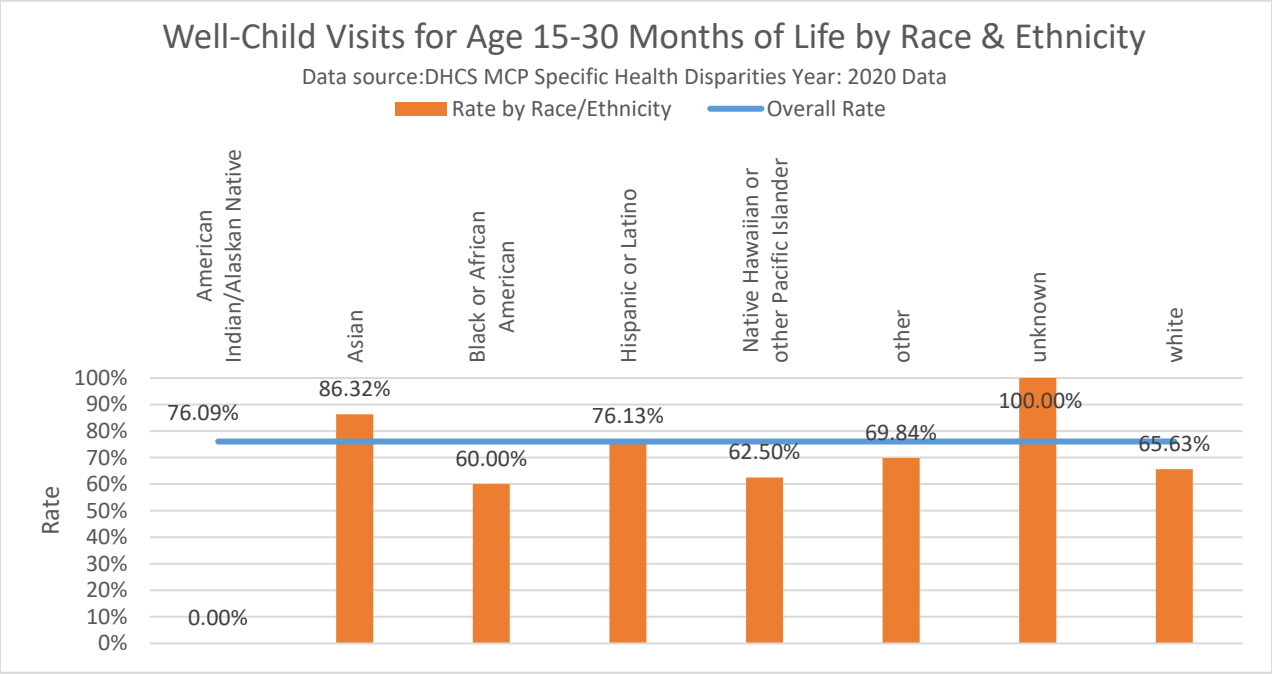
Data source: DHCS health disparities data	Year of data: MY 2020/RY 2021

The well-child visits in the first 15 months of life (W30-6) HEDIS indicator measures the percentage of members ages zero to 15 months who have had at least six well-child visits. Overall SFHP reached 46.87% for well-child visits in the first 15 months.

Findings:

- American Indian and Alaskan Native members (0%), Native Hawaiian or other Pacific Islander members (0%), and members of unknown race/ethnicity (0%) had the lowest rates when compared to other race/ethnicity groups. Each of these groups had a low denominator of one or two.
- In addition to the members of race/ethnicity groups with 0% rate, Black or African American members had the lowest rate with 11.11%.
- Of members of race/ethnicities that are 10% or more above the overall plan rate, Black or African American and Hispanic or Latino members have the largest denominators with 42 and 53, respectively.

Well-Child Visits for Age 15 – 30 Months of Life (W30-2)



Denominator	1	380	70	331	8	368	2	32

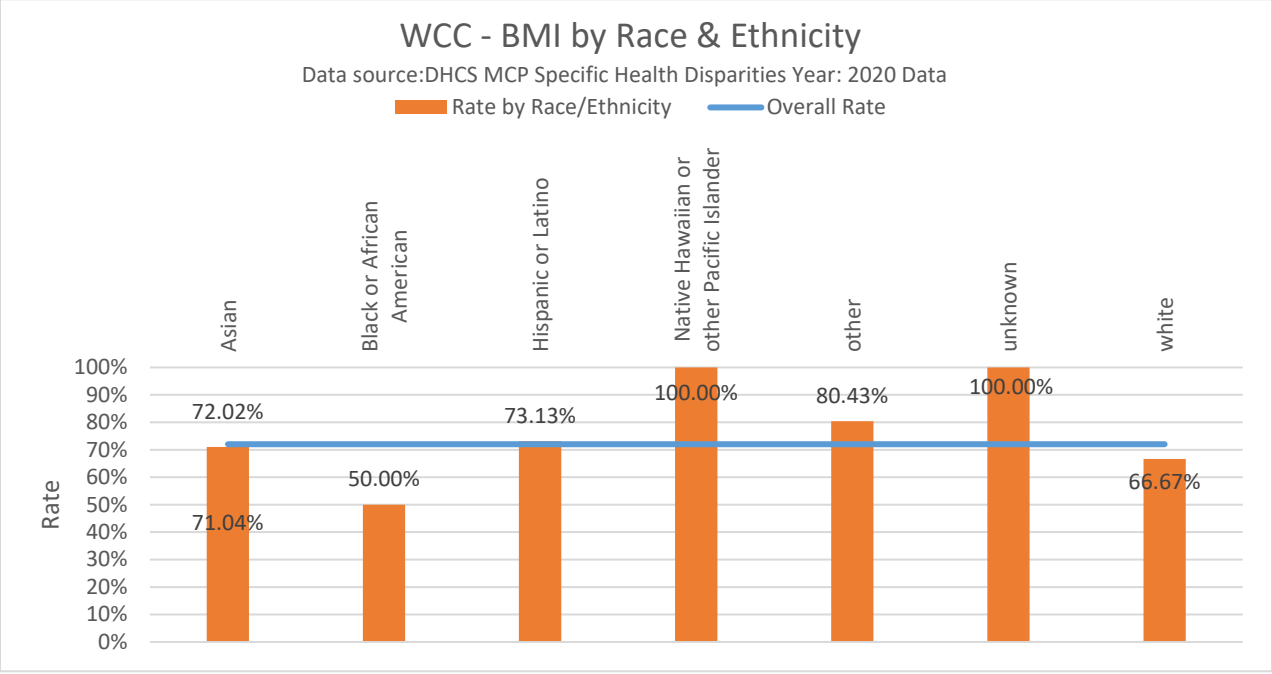
Data source: DHCS health disparities data	Year of data: MY 2020/RY 2021

The well-child visits for age 15 – 30 months of life (W30-2) HEDIS indicator measures the percentage of members ages 15 to 30 months who have had at least two well-child visits. Overall SFHP reached 76.09% for well-child visits for age 15 – 30 months.

Findings:

- American Indian and Alaskan Native members (0%) had the lowest rates when compared to other race/ethnicity groups.
- In addition to the American Indian and Alaskan Native members with 0% rate, Black or African American members, Native Hawaiian or other Pacific Islander members, and white members had rates greater than 10% below the overall plan rate.
- Of members of race/ethnicities that are 10% or more above the overall plan rate, Black or African American members have the largest denominator with 70 members.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents -BMI (WCC – BMI)



Data source: DHCS health disparities data	Year of data: MY 2020/RY 2021

The weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC – BMI) HEDIS indicator measures the percentage of members ages three to 17 who have had a visit with a PCP or OB/GYN and who had evidence of documentation of body mass index (BMI). Overall SFHP reached 72.02% for WCC – BMI.

Findings:

- Black or African American members (50.00%) had the lowest rates when compared to other race/ethnicity groups.

3.5 Health Education, Cultural & Linguistic, and QI Gap Analysis

SFHP reviewed and analyzed data pertaining to health education, cultural and linguistic services (HECLS) related member grievances and appeals, member and provider languages spoken, and data gaps related to quality improvement activities.

Health Education

The purpose of the review of provider and member language spoken was to identify any gaps in the health education needs of SFHP Medi-Cal members. SFHP's Health Education Program serves as an information resource center to members, providers, provider staff, SFHP staff and communities. SFHP promotes self-care and wellness among health plan members through a variety of strategies, including:

• Making resource information accessible and available upon request, e.g. provider newsletters, updating SFHP's website.

• Creating and improving educational materials.
• Developing program resources to assist contracted medical providers in providing and accessing health education services for members.

The Department of Health Care Services' All Plan Letter (APL) 18-016 serves as SFHP's guide for meeting the health education needs of our membership. The following table describes how SFHP meets health education requirements.

APL 18-016 Requirement	**Description of how SFHP meets the health education requirement**
Written Health Education Material	The SFHP Health Education Program produces written materials, including Health Education library content and quarterly e-newsletters covering different topics on preventative health, such as, mammograms, going to PCP appointments, and vaccines.
Written Member Information	The SFHP Health Education Program provides a list of free wellness classes around San Francisco for members to utilize and attend. Members also have access to the Member Handbook on our public-facing website or by contacting our customer service team, where SFHP provides the Member Handbook, provider directories, flyers, and other member materials electronically or via postal mail.
MCP Review and Approval Process	The SFHP Qualified Health Educator utilizes the readability and suitability checklist on all health education materials and maintains the signed/approved copy. During a portion of FY 21/22 Q3 and Q4 we submitted all health education materials to DHCS for approval by their Health Education department during our QHE vacancy. All readability and suitability checklists were saved. SFHP follows all the steps and requirements in accordance with APL 18-016 and renews the health education library materials at least once every five years.
Readability and Suitability Checklist	The SFHP Health Education Program is compliant in ensuring the written health education materials meet readability and suitability requirements. The Health Education Program also ensures materials are accessible to all members by ensuring the material is translated to the Medi-Cal threshold languages.
Assessing Reading Level of Materials	The SFHP Health Education Program is compliant in materials being at a sixth-grade reading level with the required font and grammar. The Qualified Health Educator uses a software program, HLA, to evaluate and review the required processes.
Field-Testing of Materials	The SFHP Health Education Program is compliant in field-testing written health education materials, working with interdisciplinary and member facing teams on the content. SFHP's health education related staff solicits feedback from other SFHP staff including case manager nurses, medical directors, the pharmacy team, and externally from Community Based Organizations, and SFHP's Member Advisory Committee and contracted providers patient care navigators.
Alternative Formats	SFHP's marketing team provides materials in alternative formats for visually impaired members, when requested.
Cultural Appropriateness	The SFHP Population Health team is compliant with ensuring the health education materials are culturally appropriate. SFHP also reviews images during field-testing to ensure they are inclusive and diverse.

APL 18-016 Requirement	Description of how SFHP meets the health education requirement
Font Size, Websites, and Newsletters	The SFHP Health Education Program ensures the font size in health education materials is at least 12-point font; this includes website content, newsletters, and print letters. SFHP's health education material creators use a checklist when designing materials.
DHCS Oversight	The SFHP Qualified Health Educator and Population Health team attend all DHCS Health Education Department calls, audits, and meetings. The Qualified Health Educator, or other SFHP health education support staff, submit all required documents to DHCS and records are kept to ensure that appropriate oversight from DHCS occurs.
Data source: APL 18-016	Year: 2018

As SFHP meets the requirements of APL 18-016, SFHP did not identify a gap in care related to health education. SFHP will continue to follow the policies and procedures of SFHP's Health Education Program to meet the requirements for providing health education resources to members.

Member Languages

The purpose of the review of provider and member language spoken was to identify any gaps in the language access needs of SFHP Medi-Cal members. All SFHP Medi-Cal members were included in the analysis, except for members who did not report a language, reported a language categorized as "other," and not specified.

English	49.00%	71,151	6,770	100.00%
Chinese	29.57%	42,941	261	3.86%
Spanish	15.99%	23,224	790	11.67%
Vietnamese	2.50%	3,629	39	0.58%
Russian	0.47%	677	45	0.66%
Total Medi-Cal Members with Known Languages	**97.53%**	**141,622**	**N/A**	**96.10%**
Other Languages	2.47%	3,587	Unknown	Unknown
Total Medi-Cal Members	**100.00%**	**145,209**	**N/A**	**NA**
Data source: member demographic data		Year of data: 2022		

Findings indicate that the majority of SFHP members speak English (49%). The same is true of SFHP providers, as 100% of all providers are English-speaking. SFHP and the provider groups provide access to interpreter services for all members who do not speak English and for those with limited English proficiency. As this interpreter service is available for all members, SFHP does not identify a gap in care related to language access. SFHP will continue to inform members and providers about access to interpreter services for members who are not assigned to or receiving services from a provider that speaks their language.

Cultural & Linguistic Competency

SFHP's providers come from diverse cultural backgrounds. To strengthen provider cultural competency further, SFHP requires that its provider groups administer ongoing cultural awareness trainings. This is monitored through annual oversight audits of its contracted medical groups. Entities that do not provide adequate evidence of related policies, training content, and implementation of cultural awareness trainings are issued a corrective action plan. In 2020, SFHP updated its provider credentialing process (which occurs every 3 years) to include provider completion of cultural awareness training. Currently all providers have completed cultural competency training which includes the key components of:

- Health disparities and how they impact care.
- Cross-cultural communication strategies.
- Working with interpreters and Limited English Proficiency (LEP) patients.
- Addressing patient health literacy needs.
- Addressing the needs of LGBT (lesbian, gay, bisexual, transgender) people.
- Working with Seniors and Persons with Disabilities (SPDs).

SFHP also reviewed and analyzed data pertaining to health education, cultural and linguistic services (HECLS) related member grievances and appeals in order to assess any gaps in cultural awareness. Upon review of HECLS related member grievances and appeals for Fiscal Year (FY) 2021/2022 SFHP found that:

- 808 total cases (Member Grievances, Appeals, Decline to File- Clinical (DTF-C), and Decline to File-Nonclinical (DTF-NC)) were received in FY 2021/2022.
- 6.31% (51) of the 808 overall clinical and non-clinical grievances, appeals and clinical and non-clinical decline to file cases involved Health Education or Cultural & Linguistic Services (HECLS).
- The most common subcategory of HECLS Clinical and non-clinical grievances, appeals and decline to file HECLS categorized cases was "Discrimination". 15 out of the 51 HECLS categorized cases alleged discrimination in FY21/22.
- 13 out of 51 HECLS categorized cases were filed by African American members (in comparison to white members who filed 6 out of the 51 cases). "Denial of Care" was the most common subcategory of HECLS categorized cases filed by African American members.
- 2 out of the 51 HECLS categorized cases were filed by Seniors. Both cases involved Chinese (Cantonese) speaking members. 1 out the 2 cases alleged discrimination.
- The most common language spoken by members involved in HECLS categorized cases was English (74.51%). The second most common language spoken by members involved in HECLS categorized cases was Spanish (13.73%).

Data source: HECLS grievance data	Year of data: FY 2021-2022

SFHP would identify gaps in cultural awareness through trends of HECLS grievances. A grievance trend is identified if SFHP receives three or more grievances filed by unique members, within a rolling three-month period, that have the same grievance subcategory and involve the same provider and/or clinic. However, if one grievance is egregious, SFHP may recommend further action outlined by the trending grievance process. The following tables provide further details on HECLS related grievances that qualify towards a grievance trend. In FY 2021-2022, there were no grievance trends identified by the trending grievance definition. Therefore, no gaps in cultural awareness were identified.

Table: Clinic Involved HECLS Grievances

Quarter	Clinic involved HECLS grievance?	HECLS Grievance Subcategory	Month Grievance Submitted	Does this grievance qualify as a trend?
Q1	Yes, Chinatown Public Health Center Castro Mission Health Center	Discrimination	September - 2021	No
	Yes, Chinatown Public Health Center Castro Mission Health Center	Discrimination	September - 2021	No
	Yes, Southeast Health Center	Discrimination	September - 2021	No
	Yes, Northeast Medical Services	Discrimination	September - 2021	No
	Yes, ZSFG ER	Lack of care	July - 2021	No
	Yes, St Anthony Medical Clinic	Slow reply	August - 2021	No
	Yes, SFN Clinic	Inappropriate care	August - 2021	No
Q2	Yes, UCSF Adolescent and Young Adult Clinic	Discrimination	October - 2021	No
	Yes, North East Medical Services	Disagreement with treatment	October - 2021	No
	Yes, St Anthony Medical Clinic	Denial of care	October - 2021	No
	Yes, St Anthony Medical Clinic	Denial of care	October - 2021	No
	Yes, Maxine Hall Health Center	Timely Access PCP	October - 2021	No
	Yes, ZSFG Vascular Clinic	Lack of care	October - 2021	No
	Yes, UCSF Otolaryngology Head and Neck Surgery	Slow reply	November - 2021	No
	Yes, NAHC	Discrimination	December - 2021	No
Q3	Yes, ZSFG	Disability Discrimination	February - 2022	No
	Yes, Potrero Hill Health Center and ZSFG	Discrimination	March - 2022	No
	Yes, Dimitra Skin Care	Discrimination	March - 2022	No
	Yes, Silver Avenue Family Health Center	Poor communication	January - 2022	No
	Yes, City Bay Urgent Care	Poor communication	February - 2022	No
Q4	Yes, Lyon-Martin Community Health Services	Denial of care	April - 2022	No
Data source: HECLS grievance data			Year of data: FY 2021-2022	

Table: Provider Involved HECLS Grievances

Quarter	Provider involved Grievance?	HECLS Grievance Subcategory	Month Grievance Submitted	Does this grievance qualify as a trend?
Q1	Yes, UCSF Staff	Lack of care	July - 2021	No
	Yes, SAMC Nurse	Denial of care	July - 2021	No
	Yes, SAMC Nurse	Lack of care	July - 2021	No
	Yes, Kaiser Pharmacist	Inappropriate care	August - 2021	No
Q2	Yes, BTP PCP	Discrimination	October-2021	No
	Yes, UCSF Pharmacist	Discrimination	November - 2021	No
	Yes, SFN PCP	Discrimination	November - 2021	No
	Yes, NEM Specialist	Disagreement with diagnosis	November - 2021	No
	Yes, Ambulance Company	Lack of care	November - 2021	No
Q3	Yes, SFN PCP	CLS-Other	January - 2022	No
	Yes, SFN PCP	Lack of care	January - 2022	No
	Yes, NEM PCP	Poor communication	February - 2022	No
	Yes, UCSF Specialist	Disagreement with treatment	March - 2022	No
Q4	Yes, SFN PCP	Lack of cultural sensitivity	April - 2022	No
	Yes, UCSF Nurse	Discrimination	April - 2022	No
	Yes, SFN PCP	Lack of cultural sensitivity	May - 2022	No
Data source: HECLS grievance data			Year of data: FY 2021-2022	

Table: Involved HECLS Grievances Other Administration, No Provider or Clinic Involvement

Quarter	HECLS Grievance Subcategory	Date Grievance Submitted	Does this grievance qualify as a trend?
Q1	Discrimination	September - 2021	No
	Discrimination	August - 2021	No
	Inappropriate billing	August - 2021	No
Q2	Administrative services	October - 2021	No
	Poor communication	October - 2021	No
Q3	Discrimination	January - 2022	No
Q4	Poor attitude	March - 2022	No
Data source: HECLS grievance data			Year of data: FY 2021-2022

Quality Improvement

Challenges in creating quality improvement measures and activities are represented by gaps in data, particularly for vulnerable populations. SFHP is actively working to close gaps in data by collaborating with external organizations to share data, as part of the ongoing CalAIM project being implemented across Medi-Cal managed care health plans. Examples of significant challenges or gaps in data are

outlined in the table below. SFHP will continue to collaborate with community-based organizations and other agencies to share data to better identify these populations, as well as, work to promote improved coding to identify individuals, such as, by requesting that providers use z-codes associated with homelessness.

Population		Current Data Source	Identified Gaps
LGTBQIA2S+ members		Member demographic data	Demographic information on gender and sexual identities is not included in member demographic data.
Members in long-term care		Claims and encounters	Long term care will soon be a managed care benefit as part of CalAIM implementation, so there is a benefit to better understanding care needs over the course of care. Members heretofore have been disenrolled from managed care upon transition to a long term care facility and may be re-enrolled after leaving long term care, leaving a gap in claims and encounter data.
Unhoused members		Claims and encounters	Homelessness has an associated z-code that can be used by providers, but it is not used as often as expected for SFHP's membership.
Data sources:	Claims and encounter data		Year of data: 2022
	Member demographic data		Year of data: 2022

3.6 Key Data Analysis & Prioritization

Throughout sections 3.3 through 3.5 SFHP identified gaps in care and other topics related to population health. The following table is a summary of the gaps identified in those sections (Description of Gap), a determination by SFHP on whether the gap is prioritized to be included in the PNA action plan (Prioritization Status), and a description of the reasoning for prioritization or non-prioritization (Explanation of Prioritization). Factors impacting determination of prioritization for the PNA action plan include HEDIS indicators not meeting DHCS minimum performance level, indicators with the largest populations or indicators with larger populations experiencing disparities, indicators with lower or the lowest percentiles, indicators that relate to top chronic conditions, and indicators that represent key drivers to improvement. The gaps that were prioritized are shaded in lighter grey and have associated action plans found in section 4.1.

PNA Category	Gap Area	Description of Gap	Prioritization Status	Explanation of Prioritization
Access	Getting Needed Care	HP-CAHPS composite score below 10th percentile compared to other Medicaid plans	Prioritized	The ease of getting needed care questions makes up half of this score and is identified as the top key driver question in HP-CAHPS
	Getting Care Quickly	HP-CAHPS composite score below 10th percentile compared to other Medicaid plans	Not Prioritized	SFHP will prioritize one access area to focus improvement on, which is the Getting Needed Care composite
Health Dispar-ities	AMR	The AMR HEDIS Indicator for MY 2021/RY 2022 falls within the 10th percentile of 2021 HEDIS	Not Prioritized	While the AMR HEDIS indicator is lower performing compared to other health plans, AMR is not held to DHCS minimum performance

PNA Category	Gap Area	Description of Gap	Prioritization Status	Explanation of Prioritization
		national benchmarks; in MY 2020/RY 2021 members who are American Indian and Alaskan Native, Black or African American, Native Hawaiian or other Pacific Islander, and members of unknown race/ethnicity all have rates over 10% below the overall plan rate		level, while every other HEDIS indicator in this table is; additionally, as compared to the other chronic condition HEDIS indicators within this table, AMR has the smallest population (878) in MY 2021/RY 2022 as compared to CBP (8,432) and CDC-H9 (6,644)
	BCS	In MY 2020/RY 2021, 1,286 members who are American Indian and Alaskan Native (17), Black or African American (619), Native Hawaiian or other Pacific Islander (19), white (530), and members of unknown race/ethnicity (101) all have rates 20% below or near 20% below the overall plan rate	Prioritized	The gaps represented in the BCS HEDIS indicator impact a large number of members; SFHP will prioritize screening Black or African American members for breast cancer, as Black members represent the largest population experiencing disparities in 2020/RY 2021 and according to the CDC, Black women have a higher rate of death from breast cancer than white women
	CBP	In MY 2020/RY 2021, 38 members who are American Indian and Alaskan Native (1), Native Hawaiian or other Pacific Islander (3), white (31), and members of unknown race/ethnicity (3) all have rates over 15% below the overall plan rate	Not Prioritized	The CBP HEDIS indicator for MY 2021/RY 2022 is higher performing, meeting the 75th percentile; while CDC-H9 is within the same percentile, the number of members within populations experiencing significant disparities (38) in MY2020/RY2021 is less than CDC-H9 and thus CDC-H9 is prioritized over CBP
	CDC–H9	In MY 2020/RY 2021, 128 members who are Black or African American (42), Hispanic or Latino (53), Native Hawaiian or other Pacific Islander (5), white (25), and members of unknown race/ethnicity	Prioritized	While the CDC–H9 HEDIS indicator for MY 2021/RY 2022 is higher performing, meeting the 75th percentile, CDC-H9 represents a gap in care for a top chronic condition within SFHP; and while CBP is within the same percentile, the number of members within populations experiencing

PNA Category	Gap Area	Description of Gap	Prioritization Status	Explanation of Prioritization
		(3) all have rates over 10% above the overall plan rate		significant disparities (128) in MY2020/RY2021 is greater than CBP and thus CDC-H9 is prioritized over CBP
	W30–6	HEDIS Indicator for MY 2021/RY 2022 falls within the 10th percentile of 2021 HEDIS national benchmarks	Prioritized	The W30 HEDIS indicators do not meet the DHCS minimum performance level of 50th percentile in MY 2021/RY 2022; The W30–6 indicator is prioritized as it is lower performing than W30–2
	W30–2	HEDIS Indicator for MY 2021/RY 2022 falls within the 33.33rd percentile of 2021 HEDIS national benchmarks	Not Prioritized	While both W30 HEDIS indicators do not meet the DHCS minimum performance level of 50th percentile in MY 2021/RY 2022, the W30–2 indicator is de-prioritized in favor of W30–6 as W30–6 is in a lower performing percentile than W30–2
	WCC–BMI	HEDIS Indicator for MY 2021/RY 2022 meets the 50th percentile of 2021 HEDIS national benchmarks	Not Prioritized	The WCC–BMI indicator meets the DHCS minimum performance level of 50th percentile
Quality Improve-ment	Data	Member demographic and claims and encounter data has gaps in identifying vulnerable populations	Not Prioritized	Activities related to closing these gaps in data are encompassed in SFHP's ongoing CalAIM implementation

Data sources:	HP-CAHPS	Year of data: 2022
	Plan HEDIS data	Year of data: MY2021/RY2022
	DHCS disparities data	Year of data: MY2021/RY2022
	HEDIS national benchmarks	Year of data: 2021
	Claims and encounter data	Year of data: 2022
	Member demographic data	Year of data: 2022

4. Action Plans

4.1 Action Plan Tables

Diabetes – HbA1c in Poor Control

Objective: Decrease the number of members who have diabetes in poor control from 34.79% to 34.06%. **Data Source:** MY2021/RY2022 HEDIS data
Strategies

1.) Promote screening and care visits for members with diabetes through a member incentive gift card.
2.) Enroll members with diabetes into the Medically Tailored Meals program administered by Project Open Hand.

Breast Cancer Screening – Health Disparity Action

Objective: Improve the Breast Cancer Screening rate for Black/African American SFHP members from 36.70% to 50.00%. **Data Source:** Claims and encounter data
Strategies
1.) Provide Health Education materials to Black/African American SFHP members.
2.) Partner with SF Women's Cancer Network to offer patient navigation services for Black/African American members due for a breast cancer screening.

Well-Child for Age Zero to 15 Months W30-6

Objective: Increase the number of members ages zero to 15 months who have six or more well-child visits from 41.63% to 54.92%. **Data Source:** MY2021/RY2022 HEDIS data
Strategies
1.) Promote well-child visits for members ages zero to 15 month through a member incentive gift card.
2.) Partner with local community-based organizations to educate members and facilitate connection to care.

Getting Needed Care

Objective: Increase the rate of the Getting Needed Care composite from 66.5% to 68.5%. **Data Source:** baseline – 2022 HP-CAHPS
Strategies
1.) Implement a supplemental member experience survey to drill down on key drivers to HP-CAHPS improvement.
2.) Promote SFHP's telehealth services to increase access to care.

4.2 Action Plan Review and Update Table

Objective 1.) Improve the Breast Cancer Screening rate for Black/African American SFHP members from 36.7% to 50.0%. **Start and end of objective:** July 1, 2021 to June 30,2022. **Data source:** 2021-2022 claims and encounter data	**Progress Measure:** The final result of 40.9% did not meet the target of 50.0%. **Data source:** 2022 claims and encounter data **Progress Toward Objective:** SFHP experienced barriers in this action plan. The main barrier was the ongoing COVID-19 pandemic, which impacted the timeline of the project across all stakeholders. SFHP will continue this action plan in the 2022 PNA.

Strategies	
Strategy 1.) Provide Health Education materials to Black/African American SFHP members. **Barrier:** Black/African American members do not have access to resources on navigating mammography services.	**Progress Discussion:** In May 2022 SFHP sent a letter to eligible members to inform them that they are part of an outreach program to help navigate mammography.
Strategy 2.) Partner with Ameri Corps to offer patient navigation services for Black/African American members due for a breast cancer screening. **Barrier:** Black/African American members do not have easily accessible mammography services.	**Progress Discussion:** SFHP identified the Rafiki Coalition as a community-based organization partner in offering patient navigation services as they were an organization located in a predominately Black neighborhood. Additionally, they are culturally competent in working with the focus population. Before the patient navigation project was implemented, the Rafiki Coalition lost funding as a result of the COVID-19 pandemic, and as a result could no longer provide patient navigation services. In order to provide this service, SFHP partnered with the San Francisco Women's Cancer Network to train a staff person working for them to provide the navigation services. In June 2022 this staff person was trained and started making outreach calls to members eligible for navigation on June 27, 2022.
Strategy 3.) Navigation data tracking **Barrier:** While navigation services are provided, barriers to care involving provider, transportation, communication, or other issues may result in low access to care and decreased outcome. Tracking the progress of navigation services will facilitate identifying barriers and improving navigation.	**Progress Discussion:** SFHP has created a tracking tool within SFHP's systems to trace each of the navigator's and members' points of contacts from the outreach to receiving the exam.

5. Stakeholder Engagement

Engagement with Members

SFHP's Member Advisory Committee (MAC), which services as the Community Advisory Committee, includes membership that is reflective of the Plan's Medi-Cal population in the San Francisco City and County service area. The MAC includes hard to reach populations and seniors and persons with

disabilities. The MAC engages members for feedback and advisement on a broad range of issues impacting the member experience to include access to care, service delivery, and benefits and service. Led by and comprised of up to 30 SFHP member and health care advocates, the MAC serves to inform SFHP on areas of opportunity to enhance services and the member experience. Key findings and actions from this PNA will be shared with MAC after approval by the Department of Health Care Services.

The SFHP MAC function is to provide information, advice, and recommendations on educational and operational issues with respect to SFHP programs, benefits, and services. Additionally, the MAC functions include, but are not limited to, providing input on the following:

- Culturally appropriate services and program design.
- Priorities for health education and outreach programs.
- Member satisfaction survey results.
- Findings on health education and cultural and linguistic PNA.
- Plan marketing materials and campaigns.
- Communication of needs for provider network development and assessment.
- Community resources and information.

Engagement with Providers

SFHP updates its contracted providers regularly regarding key PNA activities that may inform quality improvement projects and other opportunities to enhance member access to care. This includes, but is not limited to, the following:

- Disseminating the PNA to providers via SFHP's Quality Improvement Committee (QIC), which is comprised of network clinicians and three members of the Member Advisory Committee, and is the main forum for member and provider oversight, ensuring the quality of SFHP's healthcare delivery system.
- 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 preventative care and other clinical practice guidelines
- Distributing to provider groups the 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.
- Sharing data as part of the Practice Improvement Program, SFHP's pay-for-performance quality improvement program.