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San Francisco Health Plan

2021 Quality Improvement Program Evaluation

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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.

Care Coordination and Services:

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:

- Prioritizing 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

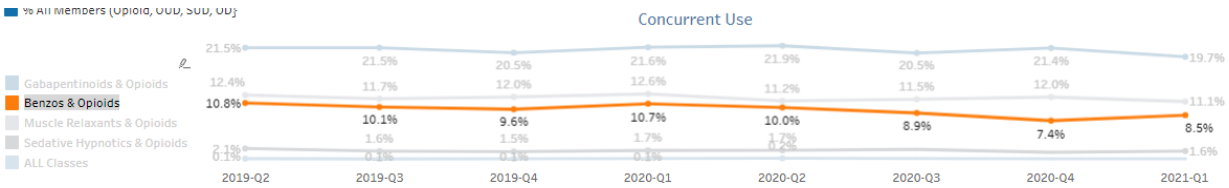
The Opioid Safety – Benzodiazepine Co-prescribing measure is in the Patient Safety or Outcomes Across Settings Domain. This measure calculates the percentage of SFHP members prescribed both opioids and benzodiazepine, out of the total number of SFHP members prescribed opioids. This measure allows SFHP 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 is 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**: 12/2/2021

Quality Improvement Committee Review Date: 12/9/2021

Board of Directors Review Date: 1/5/2022