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San Francisco Health Plan

2022 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 A, representing the current year improvement activities and measure targets. The QI Work Plan is evaluated twice a year as well as consolidated annually. The QI Evaluation provides a detailed review of progress towards the measures and goals set forth in the QI Work Plan. In this evaluation, the results are presented for seven activity domains:

- Quality of Service & Access to Care
- Keeping Members Healthy
- Patient Safety or Outcomes Across Settings
- Managing Members with Emerging Risk
- Managing Multiple Chronic Illnesses
- Utilization of Services
- Quality Oversight

1.1 Executive Summary

Oversight
Under the leadership of SFHP's Governing Board, the Quality Improvement Committee (QIC) oversees the development and implementation of the QI Program and annual QI Work Plan. The QIC and the QI Program 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 Interim 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 Interim Chief Medical Officer (CMO) and Vice President of Health Services Programs, provided key leadership for the QI program. SFHP's Chief Executive Officer (CEO) participates in the QI program by championing SFHP's NCQA accreditation journey as well as an organization-wide effort to improve member care and quality of service, namely by establishing organizational strategic priorities and ensuring resources to support key initiatives. In addition, the CEO ensures that Governing Board members received regular reports and involvement on components of the QI program.

The Interim CMO provides ongoing support for all quality improvement studies and activities and was responsible for leading the Quality Improvement Committee; Physician Advisory/Peer Review/Credentialing Committee; Pharmacy and Therapeutics Committee; and Grievance Program Leadership. The Interim CMO leads key clinical improvement efforts, particularly prioritizing and recommending interventions for clinical quality performance measures as represented in the QI Work Plan.

Beyond SFHP senior leadership, SFHP achieved stakeholder participation in the QI program through provider and member involvement in several key committees. Stakeholders participate in the Quality Improvement Committee and the Practice Improvement Program (PIP) Advisory Committee that advises on the pay-for-performance program (PIP). Overall, leadership and practitioner participation in the QI program in 2022 was sufficient to support the execution of the QI Plan. In 2023, SFHP seeks to engage more provider network leadership to collaborate on quality activities and align QI priorities.

The staff accountable for implementing the annual QI Work Plan work cross-functionally to oversee and carry out quality improvement activities at SFHP. Staff monitor quality indicators and programs and implement and evaluate SFHP's QI work plan. In 2022, SFHP experienced challenges in staffing shortages which impacted the completion of quality activities and the data monitoring for several measures. This shortage also impacted the overall monitoring of the quality workplan as a whole. While the existing committees outlined int the QI Program Description met regularly as scheduled, had sufficient attendance, and completed action items, SFHP identified that the oversight of quality was not sufficient in tracking the completion of quality activities and data monitoring, as several areas had challenges with staffing and associated resources. In 2023, SFHP seeks to improve staff collaboration via committees and workgroups to maintain and improve quality measures and activities. For a detailed summary of all staff supporting the QI Program, please refer to the Quality Improvement Program Description.

1.2 Highlights from the 2022 QI Program Measures

SFHP had positive outcomes during the 2022 QI Program period. Of the 21 measures included in the 2022 QI Evaluation, six met the target. SFHP utilizes lessons learned from 2022 QI Evaluation to inform the 2023 QI Program and Work Plan and to drive continuous improvement in operations and outcomes.

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

Quality of Service and Access to Care:

SFHP met one of three measure targets in this domain.

Notable improvement:

- Cultural & Linguistic Services: Provider Data – Collected data from contracted providers on non-English spoken languages in order to meet the needs of SFHP members who seek language concordance with their provider. Out of 6,397 SFHP contracted providers, 1,529, or 23.9%, reported speaking a language other than English.

Recommendation for continued improvement:

- HP-CAHPS – SFHP will prioritize improvement in HP-CAHPS through cross-functional workgroups, member and provider intervention, and supplemental surveys to identify key improvement areas.

Keeping Members Healthy:

SFHP did not meet either of the two measure targets in this domain.

Notable activity:

- SFHP continued partnership with the community-based organization Rafiki Coalition to offer member navigation services for Black/African American members due for a breast cancer screening. While this measure launched before 2022, staff launched navigation services for members in 2022 and provided navigation for 77 members.

Recommendation for continued improvement:

- Building off of the success of breast cancer screening navigation, expand collaboration with community-based organizations and providers and clinics that are engaged with members.

Patient Safety or Outcomes Across Settings:

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

Notable improvement:

- Exceeded target of 7.0% for reducing the percent of members prescribed both opioids and benzodiazepine with a final result of 4.5%.

Recommendation for continued improvement:

- Expand members eligible for Medication Therapy Management beyond Care Management to members not engaged in care management who have complex medication needs. And shift focus of the MTM program from members who have completed an MTM assessment to those who have completed an assessment and received a prescription fill and a provider visit after the MTM intervention. This shift in evaluation will provide more clarity on the success of the intervention.

Managing Members with Emerging Risk:

SFHP met three out of six measure targets in this domain.

Notable improvement:

- Members who participated in the Diabetes Prevention Program showed success in losing weight and being satisfied with the program upon completion.

Recommendation for continued improvement:

- Members with diabetes and prediabetes engaged in SFHP's collaboration with Project Open Hand to receive medically tailored meals or groceries demonstrated satisfaction and found the program helpful. SFHP will expand the eligible population for this program beyond members

with diabetes or pre-diabetes to include members with chronic kidney disease, end stage renal disease, long Covid, acute hospital discharge requiring nutritional support, and members with other complex chronic conditions needing nutritional support.

Managing Multiple Chronic Illnesses:

SFHP met none of the three measure targets in this domain.

Notable activity:

- SFHP Care Management staff received extensive training in the past year to aid in their care coordination skills, including training in Chronic Kidney Disease, cholesterol, transgender and gender affirming care, medication coverage for Medicare beneficiaries, COVID-19 vaccination and treatment, conservatorship, Enhanced Care Management Provider Core Tenets, palliative and hospice care, supporting clients during end of life, intensive case management, domestic violence 101, Cognitive Behavioral Therapy, safety precaution and client de-escalation.

Recommendation for continued improvement:

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

Utilization of Services:

SFHP met neither of the two measure targets in this domain.

Recommendation for continued improvement:

- Collaborate with SFHP non-specialty mental health benefit partner Beacon Health Options on member and provider outreach and education.

2. Quality of Service & Access to Care

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

2.1 Routine Appointment Availability in Specialty Care

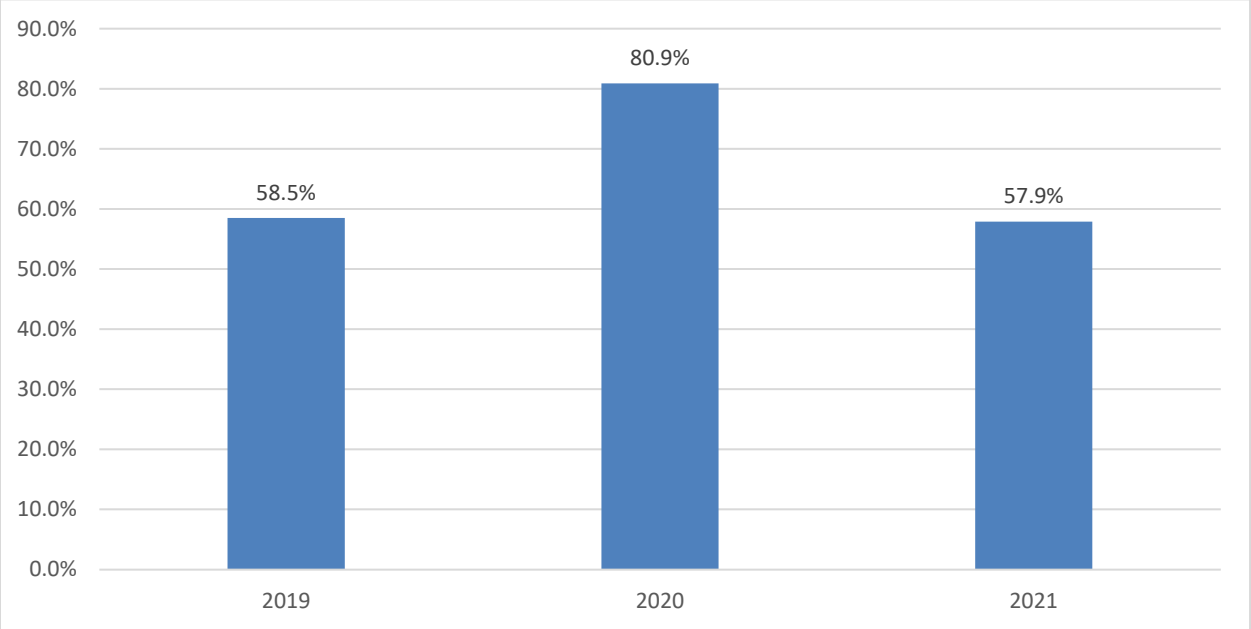
Measure: Routine Appointment Availability in Specialty Care					
Numerator	755	**Baseline**	80.9%	**Final Performance**	57.9%
Denominator	1,304	**Target**	82.9%	**Evaluation Year**	2022

The Routine Appointment Availability in Specialty Care measure is in the Quality of Service & Access to Care domain. Increasing timely appointment availability improves access to care for members. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care and chronic disease management in order to better manage their health. Increasing appointment availability may also support other QI program measures such as HEDIS and CAHPS, as members with timely specialty care visits are more likely to receive recommended care and members with a physician visit tend to score SFHP higher in CAHPS.

Routine Appointment Availability in Specialty Care is the total number of providers with appointments offered within 15 business days out of the total number providers surveyed in the Provider Appointment Availability Survey, set by the Department of Managed Health Care. SFHP set a target of 82.9% based on 2.0% absolute improvement from baseline.

Data is based on returned surveys of the Provider Appointment Availability Survey created by DMHC. Performance decreased by 23.0% from the previous measurement year, thus not meeting the target. The following chart demonstrates the three year trend in routine specialty appointment availability. The table below that shows the appointment availability broken down by specialty type.

Specialty Appointment Availability 2019 – 2021



Specialty Appointment Availability Survey Denominator & Results by Provider Type

	2020 Denominator	2020 Routine Appointment Availability	2021 Denominator	2021 Routine Appointment Availability
Cardiology	120	86.7%	111	73.0%
Dermatology	50	60.0%	67	25.4%
Endocrinology	45	77.8%	68	57.4%
Gastroenterology	53	92.4%	78	62.8%
General Surgery	51	76.4%	82	68.3%
Gynecology & Obstetrics	162	71.6%	175	70.3%
Hematology	25	96.0%	39	38.5%
HIV/Infectious Diseases	21	90.4%	17	29.4%
Nephrology	56	75.0%	33	69.7%
Neurology	70	74.2%	92	51.1%

	2020 Denominator	2020 Routine Appointment Availability	2021 Denominator	2021 Routine Appointment Availability
Oncology	77	88.3%	47	66.0%
Ophthalmology	72	81.9%	114	50.9%
Orthopedics	72	88.9%	94	57.4%
Otolaryngology	31	93.5%	35	45.7%
Physical Medicine & Rehabilitation	8	100.0%	14	50.0%
Pulmonology	18	83.3%	24	41.7%
Total	**931**	**80.9%**	**1,304**	**57.9%**

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

Barriers include:

- Supply of providers – some provider groups' supply of appointments with providers is fixed due to resident and attending schedules or the number of part time providers working in a specific system or clinic.
- Variation in use of emerging appointment reminders, self-scheduling technology, and alternative visits – provider groups demonstrate uneven uptake or implementation of technologies such as telemedicine, electronic appointment reminders, and member self-scheduling. Provider groups also show uneven uptake of alternative visits such as nurse visits or group visits. Electronic tools are less optimized for low literacy or non-English speaking member and may require customizations or additional investments to fully leverage.
- Team based care – some clinics and health systems effectively utilize care team members to ensure good access while other settings may not be able to employ or as effectively utilize other licensed providers (e.g. health educator, pharmacist, behavioral health clinician).
- Electronic consult for specialty care – with the right technology in place, many consults can be managed without the need for a face-to-face visit. Different specialty care arrangements and coordination efforts as well as very recent changes in reimbursement options impact access to and timeliness of specialty care.
- Private behavioral health practitioners – SFHP's behavioral health network include both public and private providers. While private providers are contracted, they may not have availability to accept new clients. Depending on their caseload they may close their practice or limit the number of new clients they accept based on their ability to provide timely initial and ongoing appointments.
- High-impact and high-volume providers – oncology, obstetrics & gynecology. Overall compliance rates for all SFHP's high volume obstetrics & gynecology providers decreased for routine appoints from 71.6% in 2020 to 70.3% in 2021. SFHP's high impact oncology providers decreased in appointment availability more significantly from 88.3% in 2020 to 66.0% in 2021. A potential barrier for oncology appointment availability is in the low response rate from 2020 to 2021.

- Social determinants of health – transportation, housing and employment related barriers can impact members' ability to make and keep appointments. Missed appointments that go unused can contribute poorer access.

To improve performance, SFHP completed the activities listed below.

- 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 and under 50% survey response rate.
- 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.

SFHP did not complete the planned activity: train network providers on proving successful telehealth visits. The main barrier to completing this activity was due to SFHP staff capacity; SFHP did not have the necessary resources to conduct this activity.

For the next evaluation period SFHP will retain this measure. The target for this revised measure will be set at 59.9% or 2.0% absolute improvement over 2021 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.

2.2 Cultural & Linguistic Services – Provider Data

Measure: Cultural & Linguistic Services: Provider Data					
Numerator Non-English Language	1,529	**Baseline**	N/A	**Final Performance Non-English Language**	23.9%
Numerator Race or Ethnicity	158			**Final Performance Race or Ethnicity**	2.5%
Denominator	6,397	**Target**	10.0%	**Evaluation Year**	2022

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

Data is based on provider information collected during the credentialling process. SFHP exceeded the 10.0% target for provider non-English languages with a final rate of 23.9%. SFHP did not meet the10.0% target for collecting provider race/ethnicity data with a final rate of 2.5%. The barrier to meeting the race/ethnicity data target is due to this information not being routinely collected through the credentialling process. SFHP collected 158 providers' race/ethnicity information via the providers' voluntary reporting.

SFHP completed the activities listed below:

- Collected information about providers' race/ethnicity identity and languages in which a provider is fluent when communicating about medical care via the credentialing process.
- Explored ways to collect practitioner race/ethnicity and practitioner language data.
- Published individual practitioner languages in the provider directory.
- Provided practitioner race/ethnicity on request and/or explored publishing practitioner race/ethnicity in the provider directory. Provider race/ethnicity not yet viewable to members in the provider directory but is being planned as an activity for the 2023 update to this measure.

To address the racial, ethnic, and linguistic needs and preferences of our members, SFHP will revise this measure and create two separate measures – one related to recording the race/ethnicity of individual practitioners with a target of 5.0% and one related to the languages spoken by providers with a target of 25.0%.

Activities for collecting language data 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.
- Publish individual practitioner languages in the provider directory.
- Publish language services available through the practice in the provider directory.

Activities for collecting race/ethnicity data include:

- Explore ways to collect practitioner race/ethnicity data.
- Provide practitioner race/ethnicity on request and/or explore publishing practitioner race/ethnicity in the provider directory.

2.3 HP-CAHPS – Rating of Health Plan

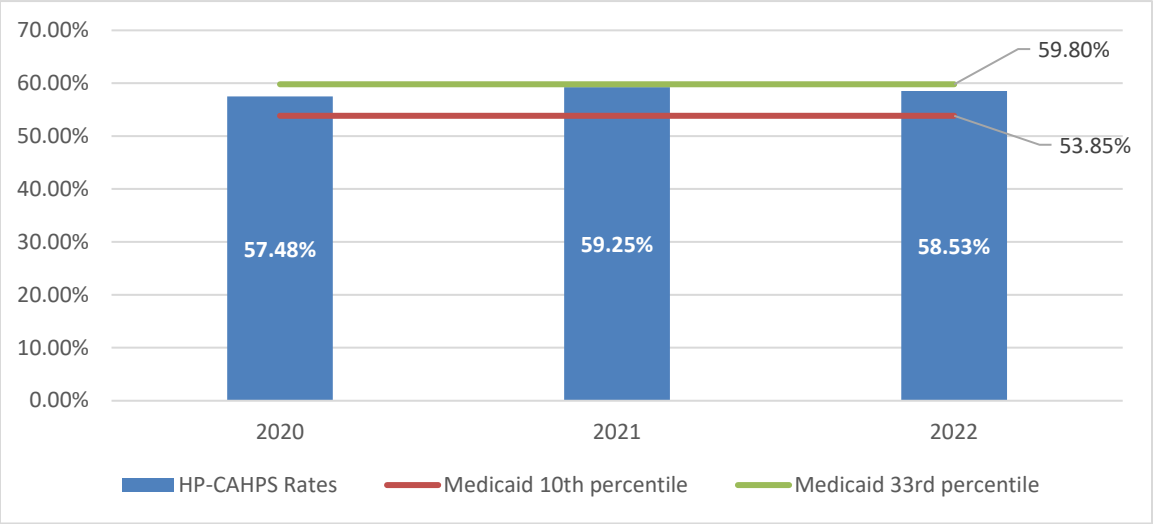
Measure: HP-CAHPS – Rating of Health Plan					
Numerator	151	**Baseline**	59.30%	**Final Performance**	58.53%
Denominator	258	**Target**	61.30%	**Evaluation Year**	2022

Rating of Health Plan 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.

HP-CAHPS – Rating of Health Plan is the total number of members included in the HP-CAHPS sample who respond to the question, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?" The performance for this measure reflects members responding with a nine or 10 rating. SFHP set a target of 61.3% based on 2.0% absolute improvement from baseline. Performance decreased by 0.77% from the

previous measurement year, thus not meeting the target. The following chart demonstrates the three year trend in HP-CAHPS – Rating of Health Plan with comparison Medicaid percentile benchmarks.

HP-CAHPS Rating of Health Plan 2020 – 2022



Three out of the four planned activities to support this measure were completed, including:

- Implemented and communicated member experience YouTube videos.
- Identified access-related issues via the Access Compliance Committee and developed plans to address found issues.
- Conducted a mini-CAHPS survey at a time period off-cycle from the annual HP-CAHPS survey.

SFHP did not complete the planned activity: promote SFHP's telehealth services to increase access to care. The use of telehealth modalities across SFHP's network have increased since the onset of the COVID-19 pandemic. However, in 2022, SFHP did not have the resources to devote additional promotions of SFHP's telehealth service Teladoc.

The main barriers to improve HP-CAHPS – Rating of Health Plan were low response rate compared to previous years, the COVID-19 pandemic, and organizational capacity. Before the COVID-19 pandemic, SFHP received a high response rate to the HP-CAHPS survey, with a rate of 31.8% response in 2019, the last survey fielded before the COVID-19 pandemic. A higher response rate coincided with a greater proportion of members of various demographics that more closely matched SFHP's membership including younger members who tend to rate the health plan higher. In recent years SFHP's HP-CAHPS response rate has declined, to the rate of 21.1% in 2022. In addition to impacting response rate, the COVID-19 pandemic impacted members' experience and perception of care. Throughout 2021 and through early 2022 when this survey was fielded, restrictions and limitations on accessing health care put in place due to prioritizing COVID-19 were lifting, resulting in members attempting to re-engage in care. As a result of this re-engagement, members experienced lower access to care, in particular access to specialty care. Finally, SFHP experienced organizational changes and staff shortages throughout 2021 and 2022 which limited the amount of organizational effort devoted to HP-CAHPS improvement.

Addressing these barriers of response rate, effects of the COVID-19 pandemic, and organizational capacity will be crucial in order to have an impact in future years of HP-CAHPS improvement.

For 2022, SFHP will retire this measure and create three new measures to focus on improvement in the HP-CAHPS composite Getting Needed Care and the questions Rating of Personal Doctor and Rating of Specialist. Activities to improve these measures will include:

- Increase response rate to survey overall, but particularly for Black members and Spanish speaking members through member mailer.
- Promote translation services and a process for Spanish-speaking members to connect with physicians and clinical leaders that speak Spanish.
- Implement member focus groups and a supplemental member experience survey to identify specific actions to drive improvement.
- Promote SFHP's telehealth services to increase access to care.
- Develop marketing, education and communication approaches to increase members understanding of what additional care options are available.
- Identify provider network member experience champions and launch a CAHPS provider workgroup to develop shared goals, outline strategies and shared lessons learned on ways to improve SFHP member experience.

3. Keeping Members Healthy

These are measures that improve clinical outcomes involving preventative care.

3.1 COVID-19 Vaccination

Measure: COVID-19 Vaccination					
Numerator	140,089	**Baseline**	N/A	**Final Performance**	77.9%
Denominator	179,892	**Target**	83.0%	**Evaluation Year**	2022

The COVID-19 Vaccination measure is in the Keeping Members Healthy domain. This rate is calculated based on the total number of SFHP Medi-Cal and Healthy Worker members eligible for COVID-19 vaccination and have had at least one dose of the vaccine. COVID-19 vaccination is important because it aids in lessening the health outcomes of members impacted COVID-19 pandemic. This effort also aligned with city and state efforts and goals in vaccination. SFHP chose the target of no greater than 10% less than percentage of SF residents who have received first dose. As of November 2022, 813,631 out of 847,747 eligible SF residents received one dose, or 93.0%. Therefore, SFHP's target is 83.0%. SFHP did not meet the target, with a final result of 77.9%, 5.1% percentage points below target.

The following activities were completed:

- Incentivized members 12 years and up to receive vaccination through the COVID-19 Vaccine Incentive.
- Conducted letter outreach and live phone outreach to unvaccinated members 12 years and up to provide vaccine information and coordination of vaccination appointments and transportation to vaccination appointments.

- Provided grants to provider groups and community-based organizations for outreach to underserved populations.
- Coordinated with the SF Department of Public Health and community organizations via weekly meetings.
- Letter outreach to members age five to 11 to communicate need for members to be vaccinated.
- Outreached to SFHP providers via provider newsletters and SFHP website updates.

The main barrier to meet the target were in challenges reaching members who may not engage with SFHP via mail materials or web outreach, which were the primary channels SFHP utilize to reach members.

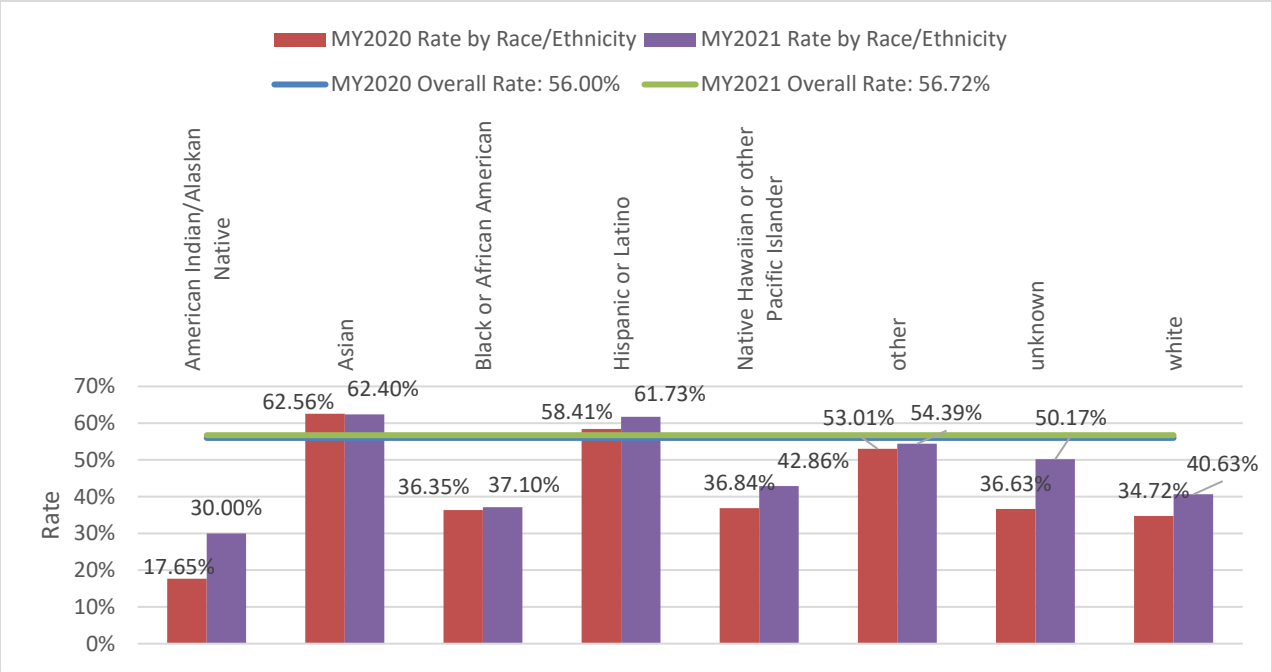
SFHP will retire this measure as there is no expressed prioritization for this measure and SFHP will focus on other priorities related to Keeping Members Healthy.

3.2 Breast Cancer Screening

Measure: Breast Cancer Screening					
Numerator	536	**Baseline**	36.0%	**Final Performance**	42.0%
Denominator	1,276	**Target**	50.0%	**Evaluation Year**	2022

Breast Cancer Screening (BCS) is in the Keeping Members Healthy domain. The goal of the BCS measure is to improve the breast cancer screening rate for African American SFHP members. Breast Cancer Screening is the percentage of African American members with a female gender marker who are ages 52 – 74 during the measurement year who had a mammogram to screen for breast cancer. The mammogram breast cancer screening visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the member. BCS is a preventative HEDIS measure and is important as is aids in reducing negative health outcomes for members whose cancer screening identifies positive results. The chart below shows SFHP's overall BCS rates for measurement years (MY) 2020 and 2021, SFHP's BCS rates broken down by race and ethnicity, and the denominators, or eligible members, in each race/ethnicity category. Overall SFHP reached 56.00% in breast cancer screening in MY 2020 and 56.72% in MY 2021. SFHP chose the target of 50.0% for Black or African American members to receive BCS to demonstrate incremental improvement toward SFHP's overall BCS rate.

HEDIS Breast Cancer Screening by Race & Ethnicity MY 2020 – 2021



	American Indian/Alaskan Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian or other Pacific Islander	other	unknown	white
Denominator MY 2020	17	4,460	619	630	19	1,462	101	530
Denominator MY 2021	20	5,401	814	938	28	2,311	299	694

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.

The gaps represented in the BCS HEDIS indicator impact a large number of members; SFHP prioritized screening Black or African American members for BCS, as Black members represent the largest population experiencing disparities in MY 2020 and MY2021 and according to the CDC, Black women have a higher rate of death from breast cancer than white women. This measure is also aligned with SFHP's DHCS Health Equity Performance Improvement Project (DHCS-PIP)

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

- Provided health education materials to Black/African American SFHP members.
- Incentivize providers through inclusion of breast cancer screening improvement indicator in SFHP's pay-for-performance program.
- Provided member navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening. Since the beginning of navigation services in early 2022, the Rafiki Coalition outreached to 147 eligible members, coordination mammograms for 32 eligible members and coordinated PCP care for 45 members.

The final rate is 42.0% of Black or African American members in the eligible population completed a mammogram to screen for breast cancer during the measurement year. This result is 8.0% below the target of 50.0%. The primary barrier to reaching the target in 2022 is due to the member navigation services starting in 2022. SFHP and the Rafiki Coalition intended to initiate community outreach and

navigation earlier but delayed the start due to the COVID-19 pandemic and due to not having adequate staffing resources at the community organization to provide member navigation.

SFHP will continue this measure in the 2023 QI workplan as the DHCS-PIP project and corresponding collaboration with the Rafiki Coalition to administer member navigation is planned to continue until June 2023.

Planned activities:

- Provide Health Education materials to Black/African American SFHP members.
- Provide member navigation services through Rafiki Coalition for Black/African American members due for a breast cancer screening.
- Incentivize providers through inclusion of breast cancer screening improvement indicator in SFHP's pay-for-performance program.

4. Patient Safety or Outcomes Across Settings

These are measures that improve clinical outcomes related to safety. Patient safety prevents adverse health outcomes, such as death or poor quality of life.

4.1 Opioid Safety – Buprenorphine Prescription

Measure: Opioid Safety – Buprenorphine Prescription					
Numerator	847	**Baseline**	22.0%	**Final Performance**	28.6%
Denominator	2,961	**Target**	30.0%	**Evaluation Year**	2022

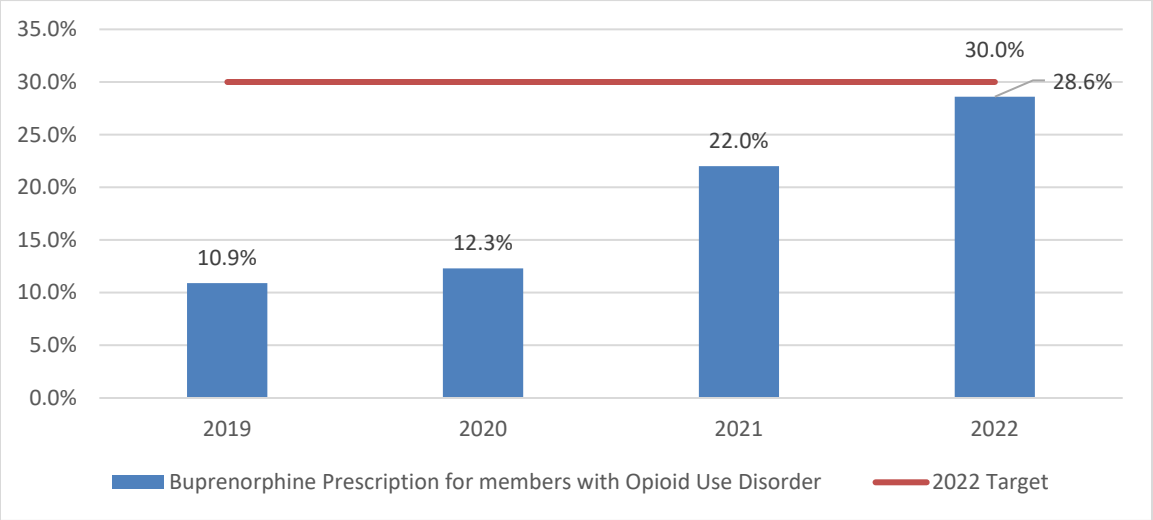
The Opioid Safety – Buprenorphine Prescription measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members with Opioid Use Disorder (OUD) with at least one buprenorphine prescription in the last year, out of the total number of SFHP members with OUD. SFHP works to reduce the risk of overdose and address the psychological and physical impact of Opioid Use Disorder. Promoting the use of Buprenorphine in this population helps reduce the risk of overdose and death.

OUD is a pattern of opioid use which includes behaviors such as: craving, withdrawal, tolerance, continued use despite medical or social consequences, using opioids in hazardous situations, and taking opioids at higher doses or for a longer period than intended. Members are considered for the denominator of this measure if they have ever had a diagnosis of OUD or an encounter for an opioid overdose. This broad definition has been implemented to ensure that all members who might be candidates for buprenorphine therapy are considered. The target of 30.0% was chosen based on incremental improvement from 2021 performance.

Medication-Assisted Treatment (MAT) is the treatment of substance use disorder with medications in combination with counseling. MAT options to treat OUD include buprenorphine, methadone, and naltrexone. These medications can be taken for a short time or continued indefinitely. The goal of treatment is to reduce the risk of overdose, eliminate the use of illicit opioids, and to provide the

member with strategies to address their mental and physical health needs. The following chart demonstrates the four year trend in SFHP's buprenorphine prescriptions.

Rate of Buprenorphine Prescriptions 2019 – 2022



The following activities were completed:

- Monitor buprenorphine adherence using the repository.
- Communicate to the provider community on adherence and measure performance during the Pharmacy & Therapeutics Committee.

The following activities were not completed:

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

The activities were that were not completed were postponed due to competing priorities within SFHP and staffing resources including not having SFHP's qualified health educator to aid in creating materials. Pharmacy staff's priorities shifted during this period included creating and disseminating information on monkey pox and on COVID-19 vaccinations.

The final result is 28.6%, which did not meet SFHP's target of 30.0% by 1.4%. SFHP will continue this measure in 2023 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 remain at 30.0% and activities to support this measure include:

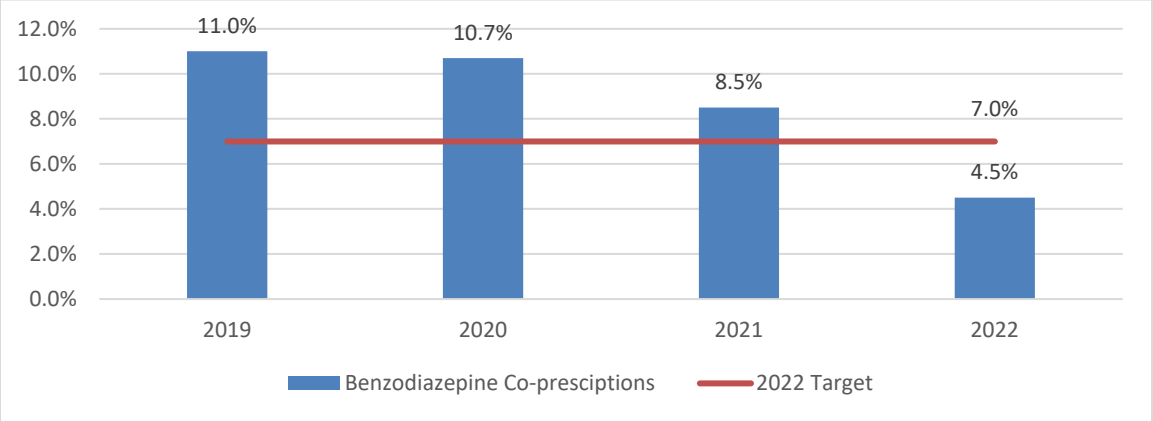
- Collaboration with methadone clinic providers in order to better support the use of Medication Assisted Therapy.
- Monitor buprenorphine adherence using the repository.
- Outreach to providers and members with buprenorphine single fills.
- Disseminate educational material to members on Medication Assisted Therapy options.

4.2 Opioid Safety – Benzodiazepine Co-prescribing

Measure: Opioid Safety – Benzodiazepine Co-prescribing					
Numerator	140	**Baseline**	8.5%	**Final Performance**	4.5%
Denominator	3,112	**Target**	7.0%	**Evaluation Year**	2022

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 7.0% 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 1.5% absolute improvement from SFHP's baseline rate. The following chart demonstrates the four year trend in benzodiazepine co-prescriptions.

Rate of Benzodiazepine Co-prescriptions 2019 – 2022



The following activity was completed:

- Outreached to mental health and substance use specialist providers.

The following activity was not completed:

- Distribute provider information how to taper members off benzodiazepines and alternate treatments for anxiety and insomnia.

The activity that was not completed was postponed due to competing priorities within SFHP and staffing resources including not having SFHP's qualified health educator to aid in creating materials. Pharmacy staff's priorities shifted during this period included creating and disseminating information on monkey pox and on COVID-19 vaccinations.

SFHP exceeded the target of reducing benzodiazepine co-prescribing by 2.5% with a final performance of 4.5%. SFHP will retire this measure due to exceeding the target and focus work on the other opioid related measures of buprenorphine prescriptions and high-dose opioids.

4.3 Opioid Safety – High Dose Opioids

Measure: Opioid Safety – High Dose Opioids					
Numerator	144	**Baseline**	8.0%	**Final Performance**	4.7%
Denominator	3,052	**Target**	6.0%	**Evaluation Year**	2022

The Opioid Safety – High Dose Opioids measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members with an opioid prescription prescribed between 120-500 morphine milligram equivalents for at least one quarter in the last year who do not have a buprenorphine prescription in that quarter, out of the total number of SFHP members prescribed opioids. This measure allows SFHP to evaluate members at high risk for negative outcomes related to central nervous system depression such as overdose, coma, and death. SFHP chose a target of 6.0% or lower in order to reduce the percentage of members who have been high dose opioids. This target was chosen as a 2.0% absolute improvement from SFHP's baseline rate of 8.0%.

The following activity was not completed:

- Work with mental health and substance use specialist providers to create and distribute provider information on buprenorphine prescribing.

The activity that was not completed was postponed due to competing priorities within SFHP and staffing resources including not having SFHP's qualified health educator to aid in creating materials. Pharmacy staff's priorities shifted during this period included creating and disseminating information on monkey pox and on COVID-19 vaccinations.

The final result is 4.7%, which exceeded SFHP's reduction target of 6.0% by 1.3%. SFHP will continue this measure in 2023 to continue monitoring and improving the percentage of members on high dose opioids without a buprenorphine prescription and the target will be reduced to 4.0%. Activities will include:

- Collaboration with mental health and substance use specialist providers to create and distribute provider information on buprenorphine prescribing
- Partner with Medi-Cal Rx to facilitate member reduction of opioid prescriptions.

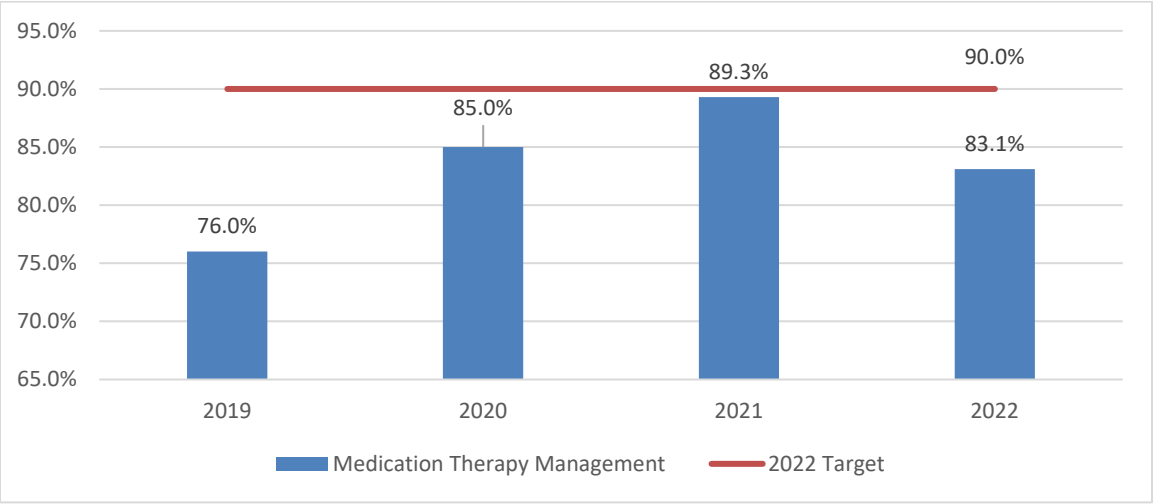
4.4 Medication Therapy Management

Measure: Medication Therapy Management					
Numerator	62	**Baseline**	89.3%	**Final Performance**	77.5%
Denominator	80	**Target**	90.0%	**Evaluation Year**	2022

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 2022 MTM rate is calculated by the number of initial medication reconciliation completed by a pharmacist out of the number of members engaged in SFHP's Care Management and Care Transitions programs with a pharmacist recommendation for medication reconciliation. The MTM target of 90.0% is based on results using the 2021 MTM measure's final performance of 89.3%. The following chart demonstrates the four year trend in MTM.

Rate of Medication Therapy Management 2019 – 2022



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

- Trained two pharmacy technicians and once pharmacist to help pharmacists with the increasing case load of members in Enhanced Care Management program who would benefit from having medications optimized.
- Updated Pharmacist and Pharmacy Technician workflows on all program types for efficiencies.
- Piloted program of assessing members medications with the Medi-Cal Rx Contract Drug List and created workflow to provide clinical recommendations if medications were not covered for the Care Management team to inform the client and/or provider.
- Expanded member eligibility to Medi-Cal-Medicare clients to align with Enhanced Care Management program.
- Trained 20 Care Coordinators and three Care Management Nurses on the updated pharmacy workflow and tasking the pharmacist with an MTM assessment.
- Implemented improvements to SFHP's case management software to make medication reconciliation assessments reportable.
- Improved medication adherence by providing fanny packs and medi-sets to members engaged in Care Management programs.

The final result of 77.5% did not meet the target of 90.0%. The significant barrier to reaching the target was SFHP's pharmacy benefit transitioning to Medi-Cal Rx on January 1, 2022. This limited SFHP's autonomy in coordination of medications for members. SFHP's pharmacy staff could not perform the functions of medication synchronization, early refill overrides, covering over-the-counter products, and authorizing non-formulary medications based on medical necessity. Without control of the pharmacy

benefit, SFHP leveraged third party access to Medi-Cal Rx to complete these tasks, which meant each intervention required increased time and effort. In many cases, members and providers cannot leverage SFHP and must connect with Medi-Cal Rx directly.

SFHP recommends revising this measure to focus on members who have received MTM and who have received at least one filled prescription within 90 days and a visit with their provider within 30 days of receiving medication therapy management service. The target will be set to 70.0% and activities to support this measure will include:

- Monitor the pharmacist resource requirements needed to support the population of members engaged in Care Management.
- Assess for additional efficiencies in workflow and member assessment configurations.
- Continue reviewing members in the initial assessment process which recommends a Medication Therapy Management assessment and establish the denominator population for this measure.
- Expand Medication Therapy Management to include members not engaged in Care Management. These members may include those with multiple providers, with ten or more prescriptions, and/or members utilizing multiple pharmacies.

4.5 Pharmacy Transition

Measure: Pharmacy Transition					
Numerator	5,835	**Baseline**	N/A	**Final Performance**	100.0%
Denominator	5,835	**Target**	80.0%	**Evaluation Year**	2021

The Pharmacy Transition measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of medication-related medium and high-risk SFHP members as identified by the high-risk member dataset who received targeted member outreach to inform them of the transition of their pharmacy benefit from SFHP to Medi-Cal Rx. This measure was important to ensure the effective and safe continuity of medications member received through this transition. This target was chosen as an 80.0% as no baseline was established.

The following activities were completed:

- SFHP Sent pre-transition outreach letter to all medium- and high-risk members offering plan support. All 5,835 members identified in the final analysis were sent the SFHP-specific high-risk member outreach letter.
- Conducted analysis of Medi-Cal Rx utilization to measure accessibility post-transition for medium and high-risk members. Of the 5,835 original members, 5,637 unique members remained Medi-Cal eligible through June 2022 and 5,362 – 95.1% – of those successfully obtained paid claims through Medi-Cal Rx.
- Provided member-specific support to staff working with high-risk members engaged in Care Management.
- Provided education and resources to internal member-facing staff to support continuity of care related to pharmacy transition.

The following activities were not completed:

- Provided high-risk member profiles to delegated medical groups to facilitate provider-member communication. Member lists were not needed or requested by the medical group staff due to DHCS adjustments to the Medi-Cal Rx benefit, including suspension of multiple prior authorization requirements and extension of transition logic.

SFHP exceeded the target of outreach to medium and high-risk members by 20% with a final performance of 100%. SFHP will retire this measure due to exceeding the target and focus work on the other pharmacy related quality activities.

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 – 5.3 Diabetes Prevention Program

Measures: Diabetes Prevention Program – Do 150 Mins of Physical Activity Per Week					
Numerator	6	**Baseline**	N/A	**Final Performance**	27.2%
Denominator	22	**Target**	95.0%	**Evaluation Year**	2021
Measures: Diabetes Prevention Program – Weight Loss					
Numerator	7	**Baseline**	18.8%	**Final Performance**	31.8%
Denominator	22	**Target**	25.0%	**Evaluation Year**	2021
Measures: Diabetes Prevention Program – Satisfaction					
Numerator	1,463	**Baseline**	N/A	**Final Performance**	91.7%
Denominator	3,956	**Target**	90.0%	**Evaluation Year**	2021

The Diabetes Prevention Program (DPP) measures are in the Managing Members with Emerging Risk domain and include indicators of weight loss, member satisfaction, and members doing 150 minutes of physical activity per week. The DPP is an evidence-based lifestyle change program intended to prevent or delay the onset of type 2 diabetes for members with prediabetes, those who have been identified as at risk for developing it. The YMCA of San Francisco offers a CDC-recognized DPP and has an established relationship with providers and the public; therefore, SFHP contracted with the YMCA to offer the DPP to members. The YMCA offers 25 classes led by lifestyle coaches over the course of 12 months.

This benefit was offered over the calendar year of 2021; outcome data of the DPP became available in early 2022. This rate is calculated based on the total number of SFHP members who completed the DPP and have achieved at least a 5% weight loss, were completely satisfied or mostly satisfied with the DPP, and completed 150 minutes of activity during the course of the program.

All activities to support this measure were completed, including:

- Offered virtual and in-person classes.
- Provided DPP enrollees with home exercise equipment, such as jump ropes or stretch bands.
- Developed targeted training for providers to improve program referrals.

SFHP exceeded the weight loss target by 6.8% with a final result of 31.8% of members achieving at least 5% weight loss. SFHP met the satisfaction target of 90.0% with a final result of 91.7% of members being satisfied or highly satisfied. SFHP did not meet the 95.0% target of DPP participants achieving 150 minutes of exercise. The primary barrier to reaching this target was due to challenges in implementing the DPP benefit during the COVID-19 pandemic in which participants had lower access to exercise resources.

SFHP will not include measures related to DPP in the 2023 QI work plan. SFHP will continue to work to provide the DPP to members in the future and will consider adding measures in the QI work plan in order to evaluate the effectiveness of the program.

5.4 Hepatitis C Treatment

Measure: Hepatitis C Treatment			
Baseline	37.0%	**Final Performance**	Not Available
Target	40.0%	**Evaluation Year**	2022

The Hepatitis C Treatment measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of SFHP members with any past history of Hepatitis C diagnosis who have completed the Hepatitis C treatment regimen. The measure benefits members because treatment can prevent the spread of Hepatitis C disease and lowers the risk of liver disease. The target of 40.0% was selected based on incremental improvement from 2021 final performance.

The planned activities were not completed:

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

The activities were that were not completed were postponed due to competing priorities within SFHP and staffing resources. Pharmacy staff's priorities shifted during this period included creating and disseminating information on monkey pox and on COVID-19 vaccinations. This shifting in priorities also resulted in SFHP not being able to measure the rate of Hepatitis C treatment completion in 2022.

SFHP will continue this measure in 2023. The target will remain 40.0% and 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 Management programs.

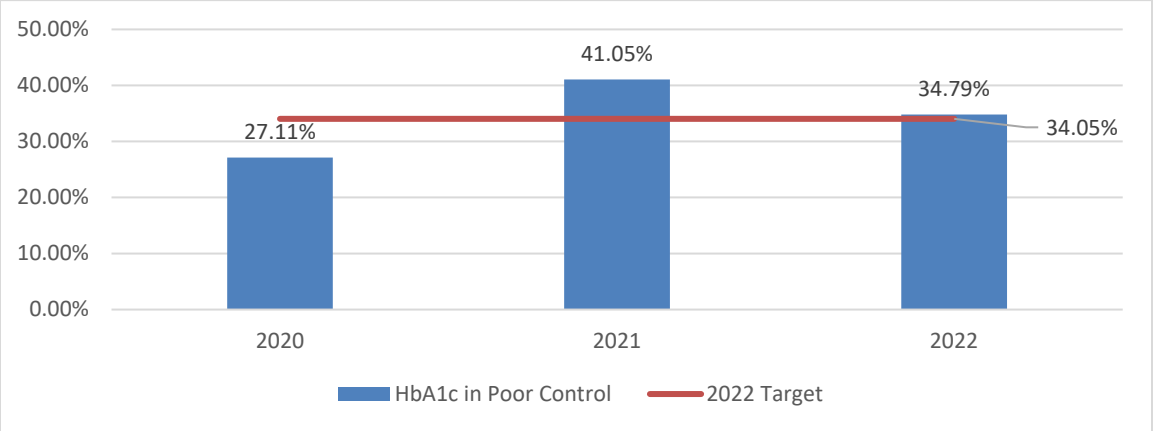
- Work with local community group EndHepC to receive feedback from SFHP clinicians providing Hepatitis C care and treatment.

5.5 Diabetes Care – HbA1c in Poor Control

Measure: Diabetes Care – HbA1c in Poor Control					
Numerator	143	**Baseline**	41.05%	**Final Performance**	34.79%
Denominator	411	**Target**	34.05%	**Evaluation Year**	2022

The Diabetes Care – HbA1c in Poor Control measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of SFHP members with who are age 18 – 75 who have their most recent HbA1c level greater than 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Members with diabetes who have 9.0% or greater can indicate chronically blood glucose and can result in negative health outcomes such as vascular damage. SFHP chose the target of 34.05% based on national HEDIS benchmarks. Reducing SFHP's rate of HbA1c in poor control to 34.05% would place SFHP in the 90th percentile of plans for this measure. The following chart demonstrates the three year trend in the rate of members with HbA1c in poor control.

Rate of Diabetes Care – HbA1c in Poor Control 2020 – 2022



The following activities were completed:

- Conducted Drug Utilization Review with members with diabetes prescribed multiple diabetes medications.
- Enrolled 75 members with diabetes into the Medically Tailored Meals program to provide medically tailored meals and medically tailored groceries administered by Project Open Hand.
- Incentivized providers through inclusion of controlling diabetes improvement indicator in SFHP's pay-for-performance program.

The following activity was not completed:

- Promote screening for members diabetes through member incentives.

SFHP delayed providing incentives for members with chronic conditions until 2023 due to staffing changes and shortages. SFHP did not reach the target, falling short by 0.74%. A barrier to reaching the target included not incentivizing members with diabetes to visit their provider for screening.

SFHP will continue this measure in 2023 with a new target of 30.90% based on achieving the national HEDIS benchmark of 90th percentile. Activities to support this measure will include:

- Promote screening and care visits for members with diabetes through a member incentive gift card.
- Enroll members with diabetes into the Medically Tailored Meals program administered by Project Open Hand.
- Conduct Drug Utilization Review with members with diabetes prescribed multiple diabetes medications.
- Incentivize providers through inclusion of controlling diabetes improvement indicator in SFHP's pay-for-performance program.

5.6 Project Open Hand Member Satisfaction

Measure: Project Open Hand Member Satisfaction					
Numerator	44	**Baseline**	N/A	**Final Performance**	95.7%
Denominator	46	**Target**	85.0%	**Evaluation Year**	2022

The Project Open Hand (POH) Member Satisfaction measure is in the Managing Members with Emerging Risk domain. SFHP partners with POH to provide medically tailored meals and medically tailored groceries to members with chronic conditions, including members with diabetes and pre-diabetes. Those who are eligible and enrolled into the program will receive 12-26 weeks of medically tailored meals or medically tailored groceries in addition to four medical nutrition therapy sessions with a registered dietician. Members who complete their 12-26 week program have the option to continue in the program.

The rate for this measure is determined by the number of members with diabetes and pre-diabetes enrolled in the POH program who complete the Project Open Hand client survey and rate the program helpful. Members who receive healthy food through medically tailored meals and groceries can aid in the management of diabetes. This is the first year SFHP has collaborated on this program benefit and does not have baseline satisfaction data. SFHP chose a target of 85.0% to achieve high satisfaction and helpfulness with the program.

The following activities were completed:

- The POH program enrolled 75 total participants who received medically tailored meals or groceries depending on their preference and received medical nutrition therapy sessions with a dietician.
- SFHP received 46 satisfaction surveys for members who completed their 12-26 week program.

SFHP exceeded the target by 10.7% with a final performance of 95.7%. SFHP will continue this measure and collaboration with Project Open Hand to provide medically tailored meals and groceries and

nutrition counseling. SFHP will expand the eligible population to receive this benefit beyond members with diabetes and pre-diabetes to include members with chronic kidney disease, end stage renal disease, long Covid, acute hospital discharge requiring nutritional support, and members with other complex chronic conditions needing nutritional support. Activities to support this measure will include:

- Partner with Project Open Hand, a community organization which will deliver medically tailored meals and/or groceries to SFHP members with chronic conditions and evaluate members' food needs through appointments with dieticians.

6. Managing Multiple Chronic Illnesses

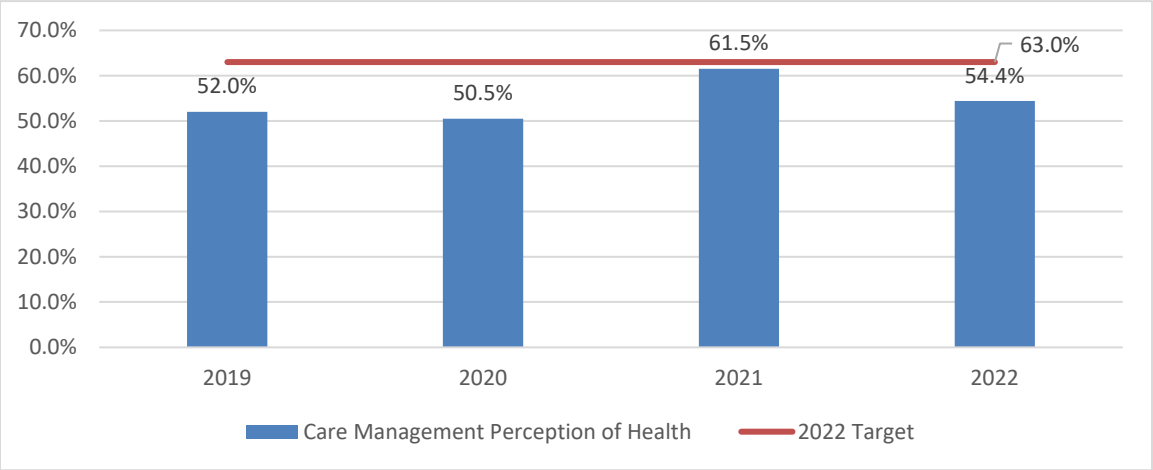
These are measures that improve care and facilitate coordination of care across multiple providers and facilities. They may also be defined as serving a specific population with complex medical needs.

6.1 Care Management Client Perception of Health

Measure: Care Management Client Perception of Health					
Numerator	43	**Baseline**	61.5%	**Final Performance**	54.4%
Denominator	79	**Target**	63.0%	**Evaluation Year**	2022

The Care Management Client Perception of Health measure is in the Managing Multiple Chronic Illnesses domain. This measure reflects activities to improve adult Care Management (CM) clients' perception of their health. A member's stronger relationship with their PCP and a greater understanding of their conditions can positively impact the member's perception of their health since they have more resources to manage their conditions. This outcome is based on changes in their self-reported health status between initial and closing assessments. Clients self-report via a question on the SF-12; a health questionnaire used to capture self-reported health status for clients with chronic conditions. The target for this measure was 63.0%. The target was selected based on incremental improvement from 2021. This target represents SFHP's commitment to ensuring that Care Management programs are member-centered, support self-management of health conditions, and promote members feeling in control of their health. The following chart demonstrates the four year trend in the rate of members with Care Management Client Perception of Health.

Care Management Perception of Health 2019 – 2022



The following activities were completed:

- The Associate Medical Director met bi-weekly with the Care Management Nurses and joined the Care Management Nurses and Clinical Supervisors meetings to provide individual feedback on health coaching and education efforts as needed.
- SFHP's Pharmacy team provided the Care Management team with training on: Chronic Kidney Disease, cholesterol, transgender and gender affirming care, medication coverage for Medicare beneficiaries, COVID-19 vaccination and treatment.
- Reviewed client 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.
- Utilized of Milliman Care Guidelines condition specific assessments and health education materials by CM Nurses.

SFHP did not meet the target of 63.0%, falling short by 8.6% with a final result of 54.4%. The main barrier to reaching the target was due to the COVID-19 pandemic, which limited CM staff's activities for most of the measurement period. CM staff provided solely telephonic case management services with no in-person outreach or coordination with CM clients.

SFHP will continue this measure in 2023 with a target of 60.0%. Activities to support this measure will include:

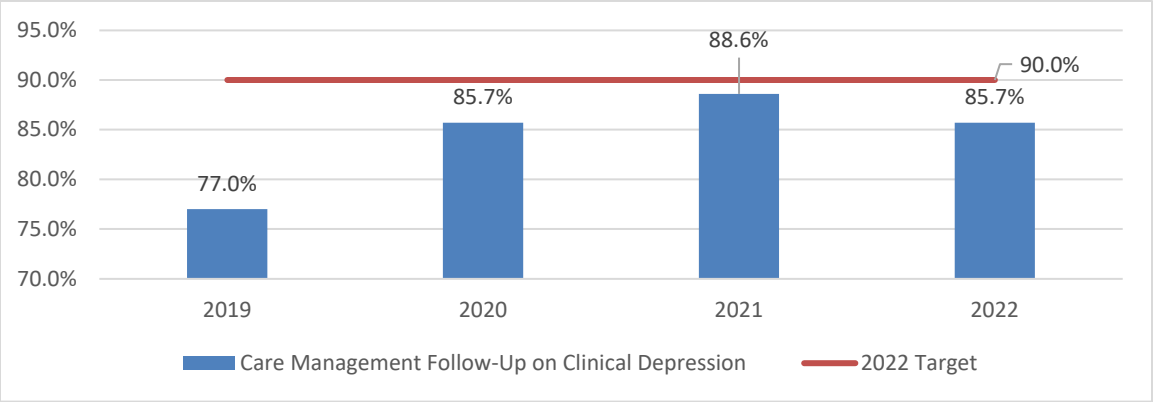
- Clinical Supervisors and Medical Director coaching the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- Develop a two year training syllabus for CM staff, to include trainings on subjects the team have identified gaps in and areas management feel would benefit the team in their ongoing work with members.
- Utilization of Milliman Care Guidelines condition specific assessments and health education materials by CM Nurses.

6.2 Care Management Follow-Up on Clinical Depression

Measure: Care Management Follow-Up on Clinical Depression					
Numerator	24	**Baseline**	88.6%	**Final Performance**	85.7%
Denominator	28	**Target**	90.0%	**Evaluation Year**	2022

The Care Management Follow-Up on Clinical Depression measure is in the Managing Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of adult clients in SFHP's Care Management (CM) programs who screen positive for depression symptoms and are connected to services for care. This measure represents SFHP's commitment to ensuring that Care Management programs are member-centered, and address follow up care for members with behavioral health needs. The target for this measure was 90.0% based on incremental improvement from the previous measurement year. The following chart demonstrates the four year trend in the rate of members with Care Management Follow-Up on Clinical Depression.

Care Management Follow-Up on Clinical Depression 2019 – 2022



The following activities were completed:

- Trained 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. Trainings included: conservatorship, Enhanced Care Management Provider Core Tenets, palliative and hospice care, supporting clients during end of life, intensive case management, domestic violence 101, Cognitive Behavioral Therapy, safety precaution and client de-escalation.
- Clinical Supervisors reviewed monthly reports and a CM dashboard with staff and coached staff to ensure members were screened and received appropriate follow up.
- Completed bi-monthly staff self-audits which enabled Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.
- Clinical Supervisors conducted quarterly audits to ensure best practices and regulatory requirements are met.

SFHP did not meet the target of 90.0%, falling short by 4.3% with a final result of 85.7%. The main barrier to reaching the target was due to the COVID-19 pandemic, which limited CM staff's activities for most of the measurement period. CM staff provided solely telephonic case management services with no in-person outreach or coordination with CM clients.

SFHP will continue this measure in 2023 and retain the target of 90.0%. Activities to support this measure will include:

- Train staff in mental health, particularly on severe mental illness (SMI) and community resources, 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 CM dashboard monthly 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 quarterly staff self-audits which will enable Coordinators to identify and remedy any gaps in the member's care plan including completing the PHQ-9 screening when indicated.

- Clinical Supervisors to conduct quarterly audits ever four months to ensure best practices and regulatory requirements are met.

6.3 Care Management Client Satisfaction

Measure: Care Management Client Satisfaction					
Numerator	34	**Baseline**	97.0%	**Final Performance**	70.8%
Denominator	48	**Target**	90.0%	**Evaluation Year**	2022

The Care Management Client Satisfaction measure is in the Managing Multiple Chronic Illnesses domain. This measure reflects activities to increase the percentage of clients enrolled in SFHP's Care Management (CM) programs who respond “Yes” to Question 2: ‘Has the Care Management program helped you reach your health goals?’ and who respond “Always” or “Often" to Question 6: ‘After receiving information from the Care Management staff, I feel confident I can take the actions needed to maintain or improve my health.’ The client satisfaction survey is conducted twice a year and is used to assess client experience with CM services and staff. This measure represents SFHP’s commitment to ensuring that Care Management programs are member centered. The target for this measure was 90% and was chosen based on incremental improvement from the previous measurement year.

The following activities were completed:

- Trained staff in order to address needs. Trainings included: Chronic Kidney Disease, cholesterol, transgender and gender affirming care, medication coverage for Medicare beneficiaries, COVID-19 vaccination and treatment, conservatorship, Enhanced Care Management Provider Core Tenets, palliative and hospice care, supporting clients during end of life, intensive case management, domestic violence 101, Cognitive Behavioral Therapy, safety precaution and client de-escalation.
- CM Supervisors tracked completion of six month reassessments of member satisfaction.
- Updated SFHP’s health education library.

SFHP did not meet the target of 90.0%, falling short by 19.2% with a final result of 70.8%. The main barrier to reaching the target was due to the COVID-19 pandemic, which limited CM staff’s activities for most of the measurement period. CM staff provided solely telephonic case management services with no in-person outreach or coordination with CM clients. Additionally, SFHP received a lower than normal number of responses, as typically this survey is conducted in person twice. Due to the COVID-19 pandemic, surveys were only able to be mailed resulting in a low response rate.

SFHP will continue this measure in 2023 and retain the target of 90.0%. Activities to support this measure will include:

- 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 pertained to their health maintenance.
- Improve communication of care plan goal progress between Care Management staff and members.

- CM staff completes a six-month reassessment and review of care plan including goals with member.

7. Utilization of Services

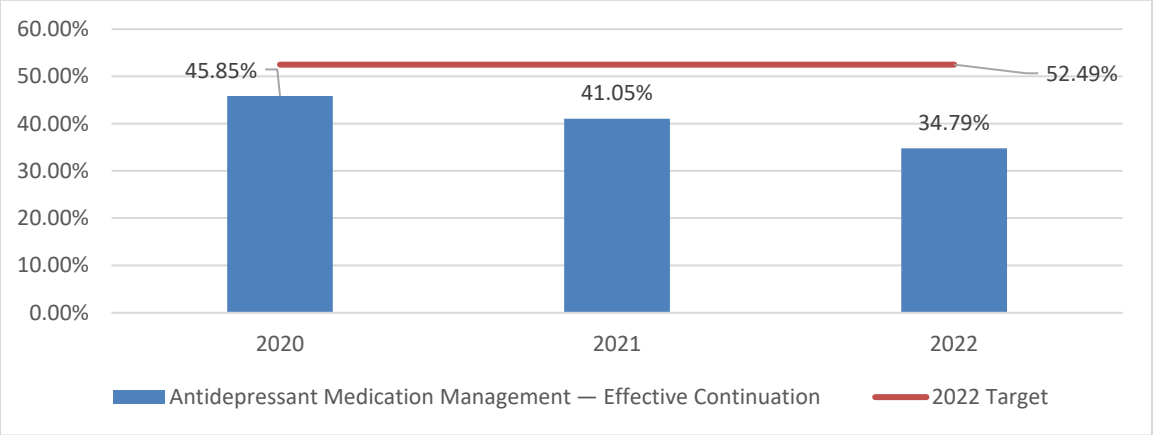
These are measures that address appropriate utilization, i.e., decrease over-utilization or increase under-utilization.

7.1 Antidepressant Medication Management — Effective Continuation

Measure: Antidepressant Medication Management — Effective Continuation					
Numerator	605	**Baseline**	48.86%	**Final Performance**	51.98%
Denominator	1,164	**Target**	52.49%	**Evaluation Year**	2022

The Antidepressant Medication Management (AMM) — Effective Continuation is in the Utilization of Services domain. This rate is based on the total number of SFHP members with who are age 18 and older with a diagnosis of major depression treatment who were treated with antidepressant medication and who remained on an antidepressant medication treatment for at least 180 days. Increasing AMM reflects improved management for members with behavioral health conditions. SFHP chose the target of 52.49% based on national HEDIS benchmarks. Increasing SFHP's AMM rate would place SFHP in the 90th percentile of plans for this measure. The following chart demonstrates the three year trend in AMM.

Rate of Antidepressant Medication Management — Effective Continuation 2020 – 2022



The planned activities were not completed:

- Members enrolled in a Care Management program will be engaged to assist members adhering to medication. Care Management staff will be given access to AMM dashboards to identify members falling in this denominator.
- Conduct annual training on HEDIS related measures to Provider Advisory Council. Disseminate HEDIS Toolkit which includes billing recommendation, best practices, and resources available to providers for their members that meet the HEDIS definitions.
- Share PCP Toolkit with Health Plans to post on their website and promote to their providers. Educate physical health providers on assessment and treatment of depression.

SFHP did not meet the target of 52.49%, falling short by 17.70% with a final result of 34.79%. The activities were that were not completed were postponed due to competing priorities within SFHP and staffing resources. This shifting in priorities and challenges in staffing resources also represented a barrier in SFHP reaching the target.

SFHP will continue this measure in 2023 with a target of 56.24% in order to achieve HEDIS 90th percentile. Activities to support this measure will include:

- Collaborate with Beacon Health Options on member and provider outreach and education.
- Create member-level health education materials about antidepressant adherence.
- Conduct member level outreach for members not achieving adherence goals.

7.2 Inpatient Admissions

Measure: Inpatient Admissions					
Numerator	13,987	**Baseline**	96.2	**Final Performance**	90.2
Denominator	1,862,376	**Target**	82.9	**Evaluation Year**	2022

The Inpatient Admissions measure is in the Utilization of Services domain. This rate is based on the sum of acute inpatient admissions out of the annualized sum of member months. Decreasing Inpatient Admissions reflects improvement of an over-utilized service. SFHP chose the target of 90.2 based on national HEDIS benchmarks.

One planned activity was completed:

- Reviewed diagnostic related groups that are driving utilization in Utilization Management Committee

One planned activity was not completed:

- Recommend care management programs to look address driver population.

SFHP did not meet the target of 82.9, falling short by 7.9 with a final result of 90.2. SFHP experienced competing priorities and challenges with staffing resources. This shifting in priorities and challenges in staffing resources represented a barrier in completing the planned activity and reaching the target. SFHP will retire this measure to focus on other priorities involving over and under-utilization and continue to monitor the rate of inpatient admissions in the Utilization Management Committee.

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	Interim CMO	• Five meetings held in 2022	12/30/2022
B	Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	Interim CMO	• Quarterly and ad hoc P&T Committee meetings	12/30/2022
C	Physician Advisory/Peer Review/Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	Interim CMO	• Five meetings held in 2022	12/30/2022
D	Utilization Management Committee	Ensure oversight of SFHP Utilization Management program	Director, Clinical Operations	• Ten meetings held in 2022	12/30/2022
E	Annual Evaluation of the QI Program	Review Quality Improvement plan and determine efficacy of implemented plan based on outcomes	Interim CMO	• Evaluated each measure in the QI work plan • QIC reviewed QI evaluation • Governing Board reviewed QI Evaluation	3/1/2022
F	QI Plan Approval for Calendar Year	Review and approve proposed Quality Improvement work plan	Interim CMO	• QIC reviewed QI work plan • Governing Board reviewed QI Work Plan	3/1/2022
G	Delegation Oversight for QI	Ensure oversight of QI for all delegated entities	Interim CMO	• Followed delegation oversight procedures • QIC review of Delegated Oversight Audits for QI • All groups delegated for QI passed audit	12/30/2022
H	DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects (PIPs)	Interim CMO	• Attended DHCS-led PIP calls • Adhered to process delineated by DHCS	12/30/2022

Reviewed and Approved by:

Interim Chief Medical Officer: *Eddy Ang, MD, MPH* **Date:** 12/2/2022

Quality Improvement Committee Review Date: 12/8/2022

Board of Directors Review Date: 1/4/2023