SAN FRANCISCO HEALTH PLAN

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San Francisco Health Plan

2023 Quality Improvement Program Evaluation

Table of Contents

Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement and Health Equity Transformation (QIHET) 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. Before 2024, SFHP's QIHET Program was titled the Quality Improvement (QI) Program.

SFHP's QI Program is detailed in the SFHP 2023 QI Program Description. The QI Program Description contains an annual Work Plan, outlined in Appendix A, representing the previous year improvement activities and measure targets. The Work Plan is reviewed 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 are 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 (CMO), 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 CMO, 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 receive 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 Program Leadership. The 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). SFHP QI staff also meet with QI representatives from the provider in monthly and bimonthly quality collaborative meetings. Overall, leadership and practitioner participation in the QI program in 2023 was sufficient to support the execution of the QI Plan. In 2024, SFHP seeks to engage provider network leadership in quality committees and collaboratives to work together on quality activities and align QI priorities. Starting in 2024, the QI Program will henceforth be called the Quality Improvement & Health Equity Transformation (QIHET) Program and the QIC will be called the Quality Improvement & Health Equity Committee (QIHEC).

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 2023, based on the challenges assessed as part of the 2022 QI Program, staff convened a Quality Strike Team to provide a comprehensive evaluation of the QI program and in what ways the program needs to expand and change to incorporate health equity and be more agile in responding to gaps and disparities in health outcomes and management of resources devoted to quality. An outcome of the Quality Strike Team was the formation of the Quality Oversight Team and Quality Implementation Teams which are comprised of cross-functional groups of leaders from across SFHP. While the existing committees outlined in 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 2024, 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 2024 Quality Improvement & Health Equity Transformation Program Description.

1.2 Highlights from the 2023 QI Program Measures

SFHP had positive outcomes during the 2023 QI Program period. Of the 28 measures included in the 2023 QI Evaluation, 12 met the target. SFHP utilizes lessons learned from 2023 QI Evaluation to inform the 2024 QIHET 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 three of six measure targets in this domain.

Notable improvement:

- Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Rating of Specialist increased by 4.38%, exceeding the target with a final rate of 64.38%.

Recommendation for continued improvement:

- HP-CAHPS – Getting Needed Care: while this measure exceeded its target, it continues to perform below the 10th percentile compared to other Medicaid plans. SFHP will implement three organizational initiatives to improve the member care experience which include interventions focused on access to primary and specialty care, telehealth, and members engaged in SFHP member-facing programs and services.

Keeping Members Healthy:

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

Notable improvement:

- Well Child Visits in the First 15—30 Months exceeded its target by 3.73% for a final result of 75.97%. SFHP reached the 75th percentile for this measure, moving up from performing below the 50th percentile in the previous year compared to other Medicaid plans.

Recommendation for continued improvement:

- Well Child Visits in the First 15 Months. SFHP did not meet its target and performs below the 50th percentile in this area. In 2024 SFHP will conduct a Maternal Child Health Gap Analysis, collaborate with the SF Department of Public Health and other health plans on coordinated improvement. Additionally, SFHP will incentivize providers through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting well-child quality improvement activities for the measure for members who are Hispanic or Latino or Black or African American.

Patient Safety or Outcomes Across Settings:

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

Notable improvement:

- Follow up After Emergency Department for Substance Use increased by 12.40% exceeding the target of 21.24% by 1.06%. This achievement resulted in SFHP reaching the 50th percentile compared to other Medicaid plans.

Recommendation for continued improvement:

- Follow up After Emergency Department for Mental Health did not reach its target, falling short by 1.71%. SFHP will incentivize providers through inclusion of a Follow-up After ED Visit for Mental Illness measure within 30 days in SFHP's primary care pay-for-performance program.

Managing Members with Emerging Risk:

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

Notable improvement:

- Postpartum Care for Black & Native American Members: SFHP exceeded the target, improving by 31.75% for a final result of 88.89%.

Recommendation for continued improvement:

- Asthma Medication Ratio: this measure did not meet its target and achieved 10th percentile compared to other Medicaid plans. SFHP will work to improve this measure by incentivizing providers through inclusion of an Asthma Medication Ratio measure in SFHP's primary care pay-for-performance program.

Managing Multiple Chronic Illnesses:

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

Notable improvement:

- SFHP exceeded its target for Care Management Client Perception of Health by 8.06% from a target of 60.00%.

Recommendation for continued improvement:

- The measure Care Management Follow-Up on Clinical Depression did not reach its goal. Care Management staff will work to initiate a weekly behavioral health office hour between SFHP Care Management, SFHP Behavioral Health, and Carelon clinical teams to staff cases and ensure timely connection to behavioral health services.

Utilization of Services:

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

Notable improvement:

- Antidepressant Medication Management — Effective Continuation achieved 90th percentile compared to other Medicaid plans across the country.

Recommendation for continued improvement:

- While Antipsychotic Medication Adherence met the 2023 target, the measure achieved 50th percentile compared to other Medicaid plans; SFHP will continue to prioritize this measure and collaborate with behavioral health providers to ensure continued adherence.

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

Overview & Performance

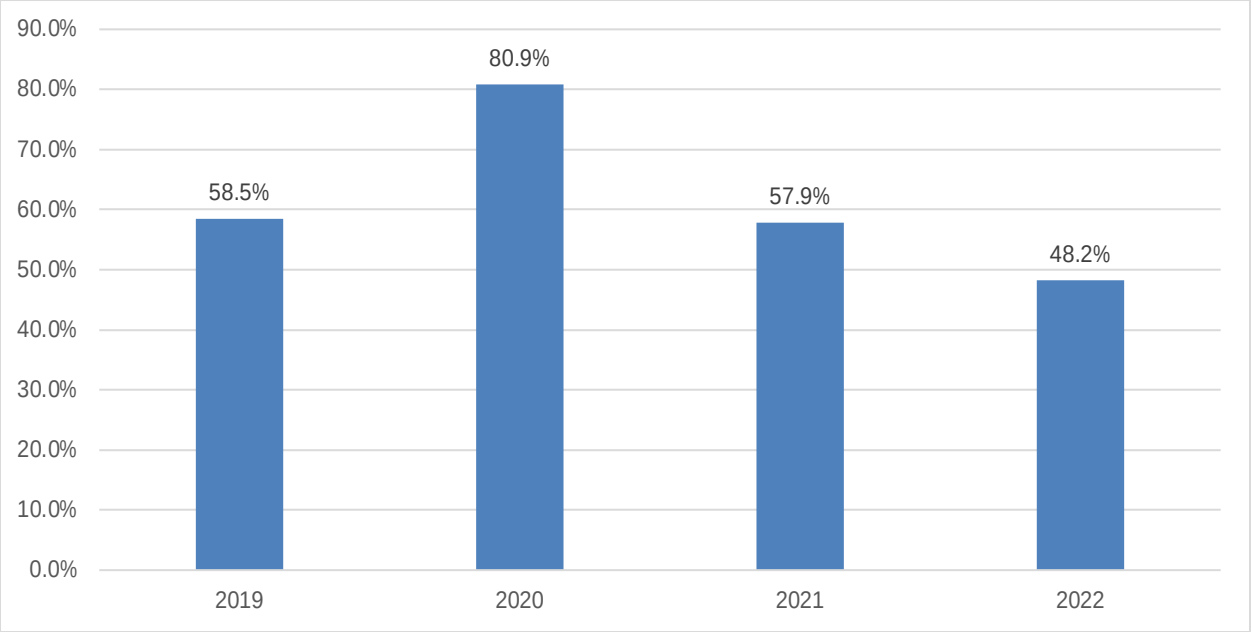
Measure: Routine Appointment Availability in Specialty Care					
Numerator	608	Baseline	57.9%	Final Performance	48.22%
Denominator	1261	Target	59.9%	Evaluation Year	2023

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 in 2022, set by the Department of Managed Health Care. SFHP set a target of 59.9% based on 2.0% absolute improvement from baseline.

Data is based on returned surveys of the Provider Appointment Availability Survey created by DMHC. The following chart demonstrates the four-year trend in routine specialty appointment availability. The table below that shows the appointment availability broken down by specialty type.

Specialty Appointment Availability 2019 – 2022



Specialty Appointment Availability Survey Denominator & Results by Provider Type

	2021 Denominator	2021 Routine Appointment Availability	2022 Denominator	2022 Routine Appointment Availability
Cardiology	111	73.0%	131	45.8%
Dermatology	67	25.4%	49	22.4%
Endocrinology	68	57.4%	63	30.0%
Gastroenterology	78	62.8%	82	28.0%

	2021 Denominator	2021 Routine Appointment Availability	2022 Denominator	2022 Routine Appointment Availability
General Surgery	82	68.3%	106	54.7%
Gynecology & Obstetrics	175	70.3%	183	55.7%
Hematology	39	38.5%	25	48.0%
HIV/Infectious Diseases	17	29.4%	14	64.3%
Nephrology	33	69.7%	53	47.1%
Neurology	92	51.1%	121	25.6%
Oncology	47	66.0%	111	72.1%
Ophthalmology	114	50.9%	121	62.0%
Orthopedics	94	57.4%	118	58.5%
Otolaryngology	35	45.7%	51	39.2%
Physical Medicine & Rehabilitation	14	50.0%	14	50.0%
Pulmonology	24	41.7%	19	47.4%
Total	**1,304**	**57.9%**	**1261**	**48.2%**

Activities

To improve performance, SFHP completed the activities listed below.

- Request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
- Provide technical assistance with Corrective Action Plans.

Analysis

Quantitative

Performance decreased by 9.7% from the previous measurement year, thus not meeting the target.

Qualitative

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.
- Overall compliance rates for all SFHP's high volume gynecology providers decreased for routine appointments from 70.3% in 2021 to 55.7% in 2022.
- 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.
- Barriers related to the planned activity of Corrective Action Plans:
    - In 2022, SFHP did not have sufficient staff resources follow-up on CAP closures and evidence. PAAS and CAP main responsibilities are now the responsibility of one staff member.
    - Larger medical groups like University of California San Francisco and San Francisco Health Network have their own methodology to assess appointment availability access and have grieved about the PAAS methodology. These medical groups submitted their own data to close findings where they found themselves to be compliant.

Recommendations

For the next evaluation period SFHP will retain this measure. The target for this revised measure will be set at 50.2%. 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.
- Provide funding to ZSFG Specialty Care providers to implement appointment access interventions.
- Incentivize ZSFG providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.

2.2 – 2.3 Cultural & Linguistic Services – Provider Data

Overview & Performance

Measure: Cultural & Linguistic Services: Provider Data					
Numerator Non-English Language	2,289	Non-English Language Baseline	23.9%	Final Performance Non-English Language	32.2%
Numerator Race or Ethnicity	113	Race or Ethnicity Baseline	2.5%	Final Performance Race or Ethnicity	1.6%
Denominator	7,100	Non-English Language Target	25.0%	Evaluation Year	2023
		Race or Ethnicity Target	5.0%		

The Cultural & Linguistic Services – Provider Data measure is in the Quality of Service & Access to Care domain. The goal of these measures is to ensure the organization's use provider data to determine the race/ethnicity of providers and languages spoken. SFHP chose the target of 25.0% for collecting provider non-English languages based on incremental improvement from 2022's 23.9% baseline and a target of 5.0% for provider race or ethnicity based on 2.5% absolute improvement from 2022.

Activities

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 and race/ethnicities in the provider directory that is viewable to members.

Analysis

Quantitative

Data is based on provider information collected during the credentialling process. SFHP exceeded the 25.0% target for provider non-English languages with a final rate of 32.2%. SFHP did not meet the 5.0% target for collecting provider race/ethnicity data with a final rate of 1.6%.

Qualitative

The barrier to meeting the race/ethnicity data target is due to this information not being routinely collected through the credentialling process. SFHP collected 113 providers' race/ethnicity information via the providers' voluntary reporting. The number of credentialed clinicians who provided their race/ethnicity declined most likely due to providers leaving SFHP's network.

Recommendations

Due to meeting its goal, SFHP will discontinue the goal of collecting more data on non-English languages spoken by providers. To address the racial, ethnic, and cultural needs and preferences of our members, SFHP will continue the measure to collect race/ethnicity of individual practitioners with a target of 8.0%.

Activities to support this measure will include:

- Engage provider groups in collecting data from their clinicians.
- Conduct communication campaign to network providers to encourage providers to volunteer race and ethnicity information.
- Explore offering a provider incentive for collecting race and ethnicity information
- Integrate race and ethnicity data collection with credentialing data.

2.4 – 2.6 HP-CAHPS

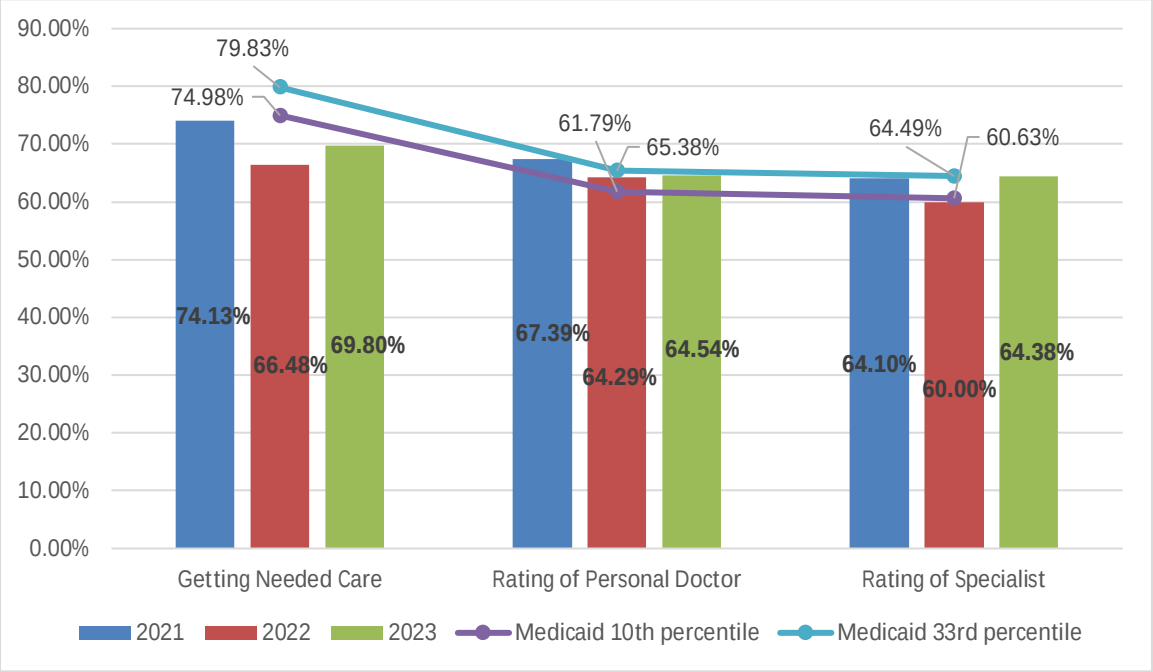
Overview & Performance

Measure: HP-CAHPS – Getting Needed Care					
Numerator	162	Baseline	66.48%	Final Performance	69.80%
Denominator	232	Target	68.48%	Evaluation Year	2023
Measure: HP-CAHPS – Rating of Personal Doctor					
Numerator	233	Baseline	64.29%	Final Performance	64.54%
Denominator	361	Target	66.86%	Evaluation Year	2023
Measure: HP-CAHPS – Rating of Specialist					
Numerator	94	Baseline	60.00%	Final Performance	64.38%
Denominator	146	Target	62.79%	Evaluation Year	2023

Getting Needed Care, Rating of Personal Doctor, and Rating of Specialists represent questions 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 – Getting Needed Care is the total number of members who responded to the Getting Needed Care composite responding with 'usually' or 'always' to the composite of two questions: "In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?" and "In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?". SFHP set a target of 68.48% based on 2.0% absolute improvement from baseline. HP-CAHPS – Rating of Personal Doctor is the total number of members who responded to the Rating of Personal Doctor question responding with '9' or '10' to the question: "Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?". HP-CAHPS – Rating of Specialist is the total number of members who responded to the Rating of Specialist question responding with '9' or '10' to the question: "We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?". The following chart demonstrates the three-year trend in HP-CAHPS scores with comparison Medicaid percentile benchmarks.

HP-CAHPS Rating of Health Plan 2021 – 2023



Activities

The following activities were completed:

- Launched an organizational cross-functional work group to plan and implement member and provider-facing improvement projects involving assessments of members' needs, identification of disparities in access to care and care experience, designing of member communication tools, and implementing interventions for the provider network.
- Identified provider network member experience champions and launched a CAHPS provider workgroup to develop shared goals, outline strategies and shared lessons learned on ways to improve SFHP member experience.

- SFHP's Marketing Team launched a digital ad campaign on website and social media channels educating and informing members on Access to Care, such as when and where to get care, who to contact, and average appointment wait times.
- Enhanced Care Management launched in 2022 as a new benefit for multiple member populations and provided mobile education events (online and in-person) to inform providers, members, and the community of the benefit, encouraged provider and self-referral; and collaborated with partners to streamline and simplify referral processes to track member-patient utilization and outcomes.
- The Grievance and Appeals department implemented a new weekly meeting with the Quality Review Nurses to discuss complex cases, work together to resolve grievances in a timely manner, discuss process improvement initiatives, and share best practices to solve system-related challenges around Access.
- Promoted response to the survey through member mailer for members with lower response rates: Black members and Spanish speaking members.

The following activities were not completed:

- 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.

Analysis

Quantitative

- Getting Needed Care: Performance increased by 3.32% from the previous measurement year, exceeding the target. However, despite achieving the target, SFHP's Getting Needed Care composite score continued to perform below the 10th percentile compared to other Medicaid plans.
- Rating of Personal Doctor: Performance increased by 0.25% from the previous measurement year, not meeting the target. SFHP's Rating of Personal Doctor score achieved the Medicaid 10th percentile, missing the 33rd percentile by 0.84%.
- Rating of Specialist: Performance increased by 4.38% from the previous measurement year, exceeding the target. SFHP's Rating of Specialist score achieved the Medicaid 10th percentile, missing the 33rd percentile by 0.11%.

Qualitative

The main barriers to meeting the Rating of Personal Doctor target for this measure were:

- Members experience difficulty accessing primary care, in particular for those who do not have a PCP.
- The quality of interpreter services for members whose primary language is not English is not consistent in primary care or other care settings.
- Inability to schedule an appointment within a reasonable amount of time is a consistent issue.

Recommendations

SFHP will continue these three measures in 2024 with the following targets:

- Getting Needed Care – 72.80%
- Rating of Personal – 67.38%
- Rating of Specialist – 67.54%

Activities to support this measure will include:

- Implement three organizational initiatives to improve the member care experience which include interventions focused on access to primary and specialty care, telehealth, and members engaged in SFHP member-facing programs and services.
- Implement a telehealth initiative that increases awareness and utilization, with a focus on African Americans and Spanish-speaking members
- Incentivize providers through inclusion of a Rating of Personal Doctor measure in SFHP's primary care pay-for-performance program.
- Reduce gaps in care utilization through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting telehealth quality improvement activities for the measure for members who are Hispanic or Latino or Black or African American.
- Provide funding to ZSFG Specialty Care providers to implement appointment access interventions.
- Incentivize ZSFG providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.
- Collaborate with network providers who work in care experience to align priorities & strategy, and work on shared initiatives.
- Create a specialty referral guide by medical group for members.

3. Keeping Members Healthy

These are measures that improve clinical outcomes involving preventative care.

3.1 Breast Cancer Screening

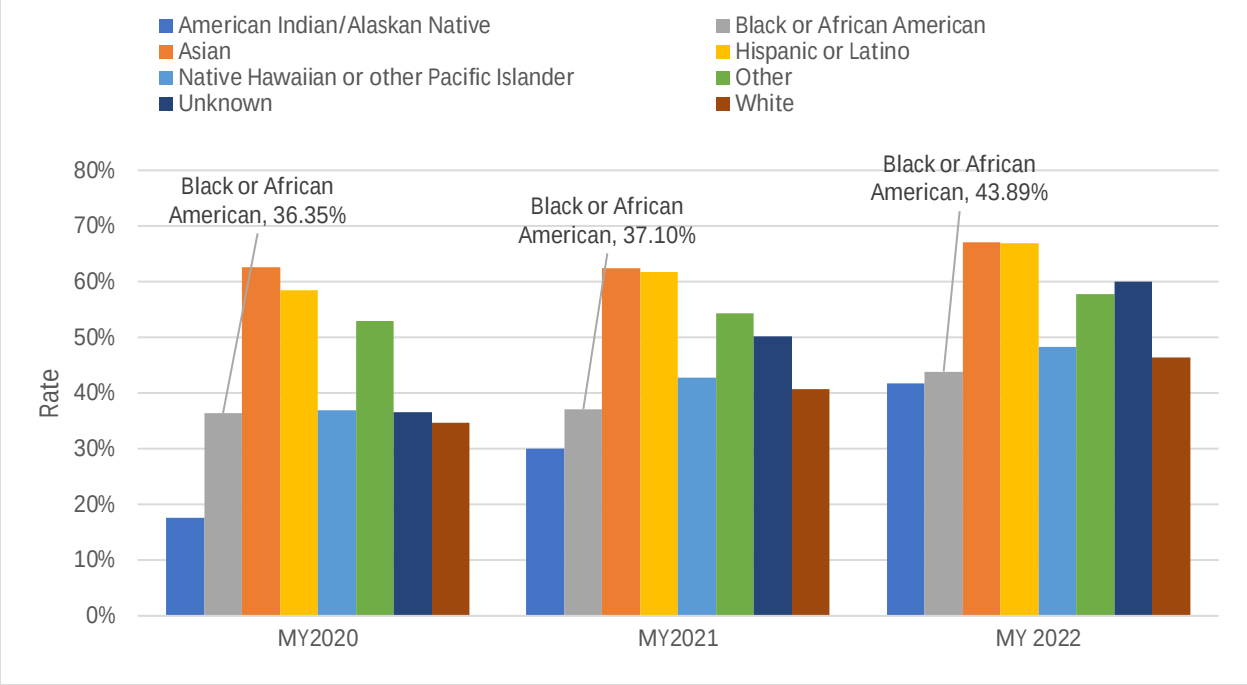
Overview & Performance

Measure: Breast Cancer Screening					
Numerator	370	Baseline	37.10%	Final Performance	43.89%
Denominator	843	Target	50.0%	Evaluation Year	2023

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 it 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 – 2023, SFHP's BCS rates broken down by race and ethnicity, and the denominators, or eligible members, in each race/ethnicity category. Overall, SFHP reached 55.99% in breast cancer screening in MY 2020, 56.72% in MY 2021, and 61.92% in MY 2022. SFHP chose the target of 50.0% for Black or African American members to receive BCS to demonstrate improvement toward SFHP's overall BCS rate toward the Medicaid 50th percentile benchmark of 50.95%.

HEDIS Breast Cancer Screening by Race & Ethnicity MY 2020 – 2023



Measurement Year	American Indian/ Alaskan Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian or Other Pacific Islander	Other Race	Unknown Race	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
Denominator MY 2022	25	5,692	843	1,191	28	886	2,222	743

Of women of race/ethnicities that are lower performing breast cancer screening rates, Black or African American and white women have the largest denominators 843 and 743, 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—MY 2022 and according to the CDC, Black women have a higher rate of death from breast cancer than white women.

Activities

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

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

Analysis

Quantitative

The final rate is 43.89% of Black or African American members in the eligible population completing a mammogram to screen for breast cancer during the measurement year. This result is 6.11% below the target of 50.0% but does show an improvement of 6.79% over baseline.

Qualitative

While the measure did not meet the target in 2023, since this project began in 2020 there was an overall 7.73% increase for Black or African American members receiving Breast Cancer Screening. This change reflects the positive impact that care navigation had on this screening provided by the Rafiki Coalition. The primary barrier to reaching the target in 2023 is due to social determinants of health that prevented the measure from reaching its multi-year goal of 50%. Social determinants of health such as having stable housing, working phone, and ability to take time off from work, childcare, or other obligations may have had an impact on members being able to receive preventative care services like Breast Cancer Screening.

Recommendations

SFHP will not continue this measure in 2024 as the Breast Cancer Screening navigation project with the Rafiki Coalition ended in 2023. In 2024, SFHP will continue to work on Health Equity related measures and activities that align with quality workplan measures that are lower performing such as postpartum care screening and well-child visits

3.2 Well Child Visits in the First 15 Months

Overview & Performance

Measure: Well Child Visits in the First 15 Months					
Numerator	469	Baseline	41.63%	Final Performance	49.11%
Denominator	955	Target	55.72%	Evaluation Year	2023

The Well Child Visits in the First 15 Months measure is in the Keeping Members Healthy domain. This measure calculates the percentage of SFHP members age zero to 15 months who receive six well-child visits out of the total number of SFHP members age zero to 15 months. This measure allows SFHP to improve child health and engagement with a primary care

practitioner. SFHP chose a target of 55.72%. This target was chosen based on the Medicaid 50th percentile benchmark and represents significant improvement from SFHP's baseline rate of 41.63% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Promoted well-child visits for members age zero to 15 months through a member incentive gift card.
- Partnered with local community-based organizations including the Office of Early Childhood to pilot a Well Child screening program to educate members and facilitate connection to care.
- Incentivized providers through inclusion of well-child screening improvement indicator in SFHP's pay-for-performance program.

Analysis

Quantitative

The final result of 49.11% did not meet the target of 55.72%, falling short by 6.61%. However, SFHP did improve over the baseline rate by 7.48%. This measure achieved the Medicaid 10th percentile.

Qualitative

The main barriers to meeting the target for this measure were:

- New education materials need a lot of time to produce.
- Parents don't know when to bring kids in for well checks.
- Clinics don't have adequate capacity for well child visits.

Recommendations

SFHP will continue this measure in 2024 with a target of 58.38% and activities to support this measure will include:

- CM team to contact members with three or four out of the required six visits to coordinate their remaining PCP visits.
- Complete Maternal Child Health gap analysis.
- Promote and encourage members aged zero to 15 months to engage in services through a member incentive to obtain well-child visits.
- Collaborate with SF Department of Public Health and other health plans on coordinated effort to improve measure.
- Incentivize providers through inclusion of a well-child visit in the first 15 months of life measure in SFHP's primary care pay-for-performance program.

3.3 Well Child Visits in the First 15—30 Months

Overview & Performance

Measure: Well Child Visits in the First 15—30 Months					
Numerator	1,296	Baseline	69.33%	Final Performance	75.97%
Denominator	1,706	Target	72.24%	Evaluation Year	2023

The Well Child Visits in the First 15—30 Months measure is in the Keeping Members Healthy domain. This measure calculates the percentage of SFHP members age 15 to 30 months who receive six well-child visits out of the total number of SFHP members age 15 to 30 months. This measure allows SFHP to improve child health and engagement with a primary care practitioner. SFHP chose a target of 72.24%. This target was chosen based on the Medicaid 75th percentile benchmark and represents incremental improvement from SFHP's baseline rate of 69.33% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Partnered with local community-based organizations including the Office of Early Childhood to pilot a Well Child screening program to educate members and facilitate connection to care.
- Incentivized providers through inclusion of well-child screening improvement indicator in SFHP's pay-for-performance program.

Analysis

Quantitative

The final result of 75.97% met the target of 72.24%, exceeding it by 3.73%.

Recommendations

SFHP will continue this measure in 2024 with a target of 77.78% and activities to support this measure will include:

- CM team to contact members with three or four out of the required six visits to coordinate their remaining PCP visits.
- Complete Maternal Child Health gap analysis.
- Promote and encourage members aged zero to 15 months to engage in services through a member incentive to obtain well-child visits.
- Collaborate with SF Department of Public Health and other health plans on coordinated effort to improve measure.
- Incentivize providers through inclusion of a well-child visit in the first 15 months of life measure in SFHP's primary care 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

Overview & Performance

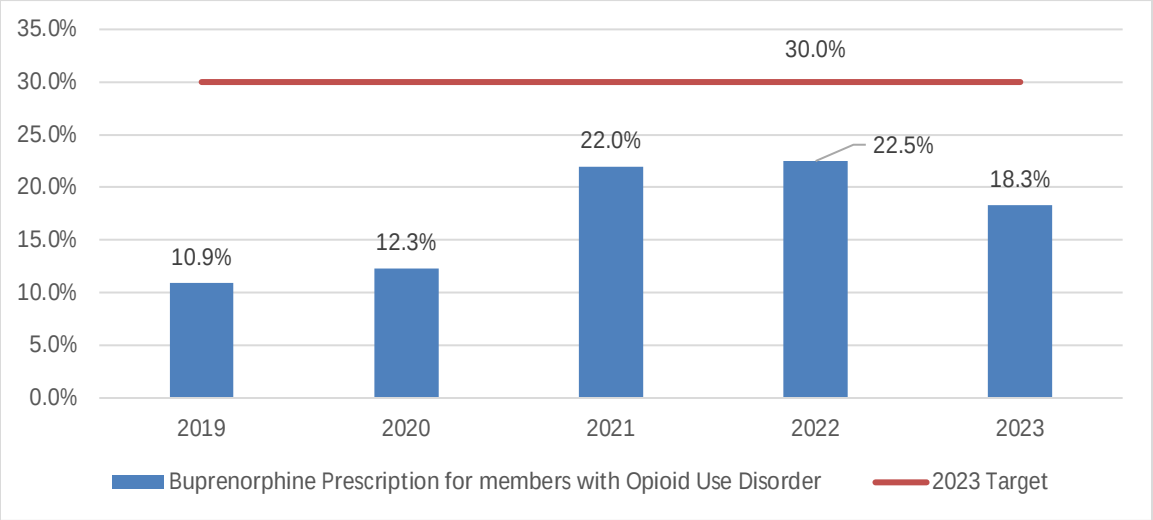
Measure: Opioid Safety – Buprenorphine Prescription					
Numerator	368	Baseline	22.5%	Final Performance	18.30%
Denominator	2,011	Target	30.0%	Evaluation Year	2023

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 absolute improvement from an erroneous baseline rate of 28.6%. During 2023 the baseline was re-calculated to be 22.6%.-

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 five-year trend in SFHP's buprenorphine prescriptions.

Rate of Buprenorphine Prescriptions 2019 – 2023



Activities

The following activities were completed:

- Monitored buprenorphine adherence using the repository.
- Disseminated educational material to members on Medication Assisted Therapy options.

The following activities were not completed:

- Collaboration with methadone clinic providers in order to better support the use of Medication Assisted Therapy.
- Outreach to providers and members with buprenorphine single fills.

The activities were that were not completed were postponed due to competing priorities within SFHP and staffing resources.

Analysis

Quantitative

The final result is 18.3%, which did not meet SFHP's target of 30.0% by 11.7%.

Qualitative

The main barriers to achieving the target for this measure were:

- Erroneous baseline data during measure planning.
- Staffing limitations in SFHP's Pharmacy Operations team.
- Social determinants of health such as having stable housing, working phone for providers to connect to members, and ability to engage in OUD treatment may have had an impact on the measure reaching the target.

Recommendations

SFHP will not continue this measure in 2024 because of Pharmacy staffing limitations. SFHP will continue to monitor opioid safety.

4.2 Opioid Safety – High Dose Opioids

Overview & Performance

Measure: Opioid Safety – High Dose Opioids					
Numerator	157	Baseline	5.2%	Final Performance	4.5%
Denominator	3,465	Target	4.0%	Evaluation Year	2023

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 originally chose the target of 4.0% or lower in order to reduce the percentage of members who have been prescribed high dose opioids. This target was chosen as a 0.8% absolute improvement from an erroneous baseline rate of 4.8%. The correct baseline for the period was 5.2%.

Activities

The following activities were completed:

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

Analysis

Quantitative

The final result is 4.5%, which did not meet SFHP's original target of 4.0% by 0.5%. However, since the new baseline was recalculated to be 5.2%, the measure was reduced by 1.7% which surpassed the original goal of a 0.8% reduction.

Qualitative

The main barriers to achieving the target for this measure were:

- Erroneous baseline data during measure planning
- Staffing limitations in SFHP's Pharmacy Operations team.
- Social determinants of health such as having stable housing, working phone for providers to connect to members, and ability to address pain management issues may have had an impact on the measure reaching the target.

Recommendations

SFHP will not continue this measure in 2024 because of Pharmacy staffing limitations. SFHP will continue to monitor opioid safety.

4.3 Medication Therapy Management

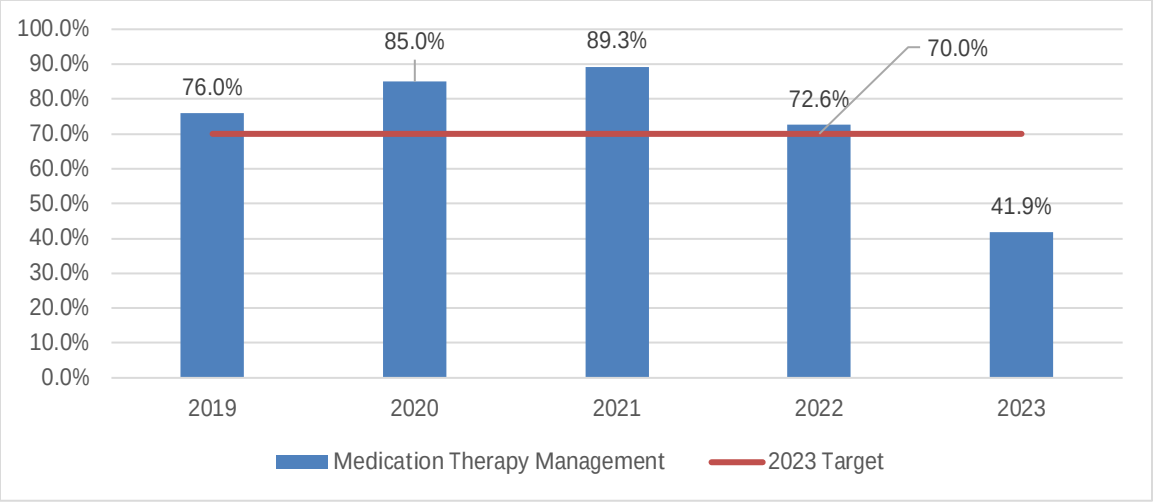
Overview & Performance

Measure: Medication Therapy Management					
Numerator	18	Baseline	72.6%	Final Performance	41.9%
Denominator	43	Target	70.0%	Evaluation Year	2023

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 2023 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 70.0% is based on results using the 2022 MTM measure's final performance of 72.6%. The following chart demonstrates the five-year trend in MTM.

Rate of Medication Therapy Management 2019 – 2023



Activities

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

- Monitored the pharmacist resource requirements needed to support the population of members engaged in Care Management.
- Assessed for additional efficiencies in workflow and member assessment configurations.
- Continued reviewing members in the initial assessment process which recommends a Medication Therapy Management assessment and establish the denominator population for this measure.

- Expanded 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.

Analysis

Quantitative

The final result of 41.9% did not meet the target of 70.0%.

Qualitative

Access to care barriers have remained prevalent since COVID-19 that includes longer than one month time to get a preventive service appointment that likely affected the rate of provider visits within 30 days during Cohort 1. An action plan was SFHP promoted telehealth as an option for members to increase primary care access.

An additional barrier to filling prescriptions happened when pharmacies temporarily closed due to vandalism or permanently closed. In January 2022, a major change also took place when the pharmacy benefit was carved out to Medi-Cal Rx. This transition caused processing delays and confusion for members who were filling prescriptions. An action plan included sending information to members, providers and pharmacies regarding Medi-Cal Rx transition and staff to help coordinate care for members who had trouble receiving medications at the pharmacy. The rate from Cohort 1 to Cohort 2 demonstrated a 6.7% change showing an effective trend with the interventions.

All members receiving MTM services during Cohort 1 and 2 are referred by the Care Management team. An action plan for Cohort 3 period was to expand the MTM services to include members who were not engaged in Care Management that would benefit from having a medication review by a pharmacist. In November 2022, Medication Adherence Program (MAP) started to complete MTM services for members who are noncompliant to HEDIS (Healthcare Effectiveness Data and Information Set) measures. For the first phase of MAP, the targeted HEDIS measure is Asthma Medication Ratio (AMR) of less than 0.5. A pharmacist often contacts the member directly regarding medication interventions that do not warrant a visit for the member to the provider (i.e., adherence issues, questions on how to use inhalers, etc.). Since Cohort 3 did not meet the benchmark goal – a reasonable quality improvement is to review the changes in program type and best ways to support members and medications.

Recommendations

SFHP will not continue this measure to focus on other QI and health equity priorities. SFHP will continue to provide Medication Therapy Management to members.

4.4 Follow up After Emergency Department for Substance Use

Overview & Performance

Measure: Follow up After Emergency Department for Substance Use					
Numerator	495	Baseline	9.90%	Final Performance	22.30%
Denominator	2,220	Target	21.24%	Evaluation Year	2023

The Follow up After Emergency Department for Substance Use measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD within 30 days after ED visit, out of the total number of SFHP members who had an ED visit with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence.

Timely follow-up care for individuals who were seen in an emergency department for a substance use disorder is associated with reduced hospital use and increased treatment adherence. Coordination of care for such individuals requires information-sharing between hospitals and primary care providers that may not occur under existing/standard workflows.

SFHP chose a target of 21.24%. This target was chosen based on the Medicaid 50th percentile benchmark and to demonstrate significant improvement from SFHP's baseline rate of 9.9% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Collaborated with SF County Behavioral Health Services and ZSFG's Addiction Care Team to coordinate follow-up care.
- Collaborated with Carelon on activities and interventions including service promotion, in-services for providers, member outreach, county engagement, and case management.
- Provided Prop 56 funding to segments of the provider network to integrate medical mental health, and substance use services.

Analysis

Quantitative

The final result of 22.30% exceeded the target of 21.24% by 1.06%. This represents an improvement over the baseline rate of 12.4%. The final rate achieved the Medicaid 50th percentile.

Recommendations

SFHP will continue this measure in 2024 with a target of 36.34% and activities to support this measure will include:

- ED member navigators provide motivational interviewing and referral to members' Enhanced Care Management provider or PCP for follow-up visit.
- Incentivize providers through inclusion of a Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence within 30 days measure in SFHP's primary care pay-for-performance program.

4.5 Follow up After Emergency Department for Mental Health

Overview & Performance

Measure: Follow up After Emergency Department for Mental Health					
Numerator	641	Baseline	12.18%	Final Performance	52.80%
Denominator	1,214	Target	54.51%	Evaluation Year	2023

The Follow up After Emergency Department for Mental Health measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of SFHP members (aged 6 and older) who received a follow-up visit for mental illness within 7 days of an emergency department visit with a diagnosis of mental illness or intentional self-harm out of the total number of SFHP members who had an ED visit with a diagnosis of mental illness or intentional self-harm out.

Timely follow-up care for individuals who were seen in an emergency department for a mental health is associated with reduced hospital use and increased treatment adherence. Coordination of care for such individuals requires information-sharing between hospitals and primary care providers that may not occur under existing/standard workflows.

SFHP chose a target of 54.51%. This target was chosen based on the Medicaid 50th percentile benchmark and to demonstrate significant improvement from SFHP's baseline rate of 12.18% to minimum performance level (MPL) as defined by DHCS MCAS.

Activities

The following activities were completed:

- Collaborated with Carelon on activities and interventions including service promotion, in-services for providers, member outreach, county engagement, and case management.
- Provided Prop 56 funding to segments of the provider network to integrate medical mental health, and substance use services.

Analysis

Quantitative

The final result of 52.8% did not meet the target of 54.51%, falling short by 1.71%. However, we did improve over the baseline rate by 40.62%.

Qualitative

The main barriers to meeting the target for this measure were:

- Behavioral health system care management system does not capture outpatient visits in claims/encounter format that can be counted towards HEDIS data.
- Member outreach is very difficult for this patient population due to unreliability of contact information and difficulty to reach by phone.

- Medi-Cal coverage dictates that services for serious mental illness and substance use treatment should occur via SF County Behavioral Health Services, which doesn't share encounter data, complicating coordination efforts for appropriate primary care follow-up.

Recommendations

SFHP will continue this measure in 2024 with a target of 54.87% and activities to support this measure will include:

- ED member navigators provide motivational interviewing and referral to members' Enhanced Care Management provider or PCP for follow-up visit.
- Incentivize providers through inclusion of a Follow-up After ED Visit for Mental Illness measure within 30 days in SFHP's primary care pay-for-performance program.

4.6 SFHN All Cause Readmission

Overview & Performance

Measure: SFHN All Cause Readmission					
Numerator	218	Baseline	16.50%	Final Performance	10.59%
Denominator	2,058	Target	13.50%	Evaluation Year	2023

The SFHN All Cause Readmission measure is in the Patient Safety or Outcomes Across Settings domain. This measure calculates the percentage of acute inpatient and observation stays for members 18 years of age and older in the SFHN network that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, out of the total number of acute inpatient and observation stays for members.

Members discharged from the hospital are at risk of readmission if they do not receive sufficient planning and coordination during discharge. Follow up care with a PCP can reduce the chance of readmission, but PCPs do not receive timely information about a member's discharge and the need to schedule a follow up appointment. In order to ensure that the member's needs are met and reduce the risk of hospital readmission, SFHP's Concurrent Review team supplements the hospital's discharge planning by aiming to identify members at high risk for readmission and to partner with the hospital care team to ensure linkage to their PCP and other community resources prior to discharge. The quality of coordination and discharge planning is essential in order to achieve positive health outcomes for members who have been hospitalized. This is particularly critical for members who have complex health needs and high utilizers of emergency and hospital services that should be managed preventatively.

SFHP chose a target of 13.5% or lower in order to reduce the percentage of members experiencing preventable readmissions. This target was chosen as a 3.0% absolute improvement from SFHP's baseline rate of 16.5%.

Activities

The following activities were completed:

- Incentivized providers through inclusion of follow-up after hospital discharge improvement indicator in SFHP's pay-for-performance program.

The following activities were not completed:

- SFHP nursing staff to conduct discharge planning including coordinating aspects of member care including coordination and communication of members' PCP follow-up appointment and following up with the member to review the discharge instructions and ensure a follow up appointment is made prior to discharge.

While CCR Nurses continue to do Discharge Planning (DCP) assessments, provide discharge summaries to in-network PCPs and aid hospital staff to facilitate safe discharges, they stopped doing pre/post-discharge calls to members in Nov. 2022 due to resource constraints, increased workload volume and competing regulatory initiatives. New transitions of care expectations were released in the LTC APL in January 2023 stating MCPs must provide "strengthened transitions care services" in which SFHP chose to target members at high risk for readmission discharging from skilled nursing facilities (SNFs). From this the Post-Acute Care Transitions (PACT) program was implemented in March 2023 which was a team of 2 CT Navigators who reviewed all SNF admissions, made connections to ECM or other community CM programs as applicable or sought to engage members themselves and follow them throughout their stay, ensuring they had a solid DCP.

Analysis

Quantitative

The final result of 10.59% exceeded the target reduction to 13.5% by 2.91%. This represents an improvement over the baseline rate of 5.91%.

Recommendations

SFHP will not continue this measure in 2024. Plan activities addressing the reduction of readmission are being launched in early 2024 by the Care Transitions team; SFHP will consider these activities in the planning of QI and health equity measures in future measures.

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 Asthma Medication Ratio

Overview & Performance

Measure: Asthma Medication Ratio					
Numerator	433	Baseline	55.47%	Final Performance	55.30%
Denominator	783	Target	59.94%	Evaluation Year	2023

The Asthma Medication Ratio measure is in the Managing Members with Emerging Risk domain. This measure calculates the percentage of SFHP members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total

asthma medications of 0.50 out of the total number of SFHP members who were identified as having persistent asthma. SFHP chose a target of 59.94%. This target was chosen based on the Medicaid 25th percentile benchmark and to represent incremental improvement from SFHP's baseline rate of 55.47%.

Activities

The planned activities were completed:

- Informed providers of the identified at-risk populations.
- Updated member education for members with asthma, integrating the newest guidelines.
- Hosted a training with SFHP Care Management staff focused on asthma treatment and place in therapy of rescue versus maintenance inhalers.
- Enrolled eligible and at-risk members Comprehensive Care Management (CCM) or Enhanced Care Management (ECM), or Medication Therapy Management (MTM).

Analysis

Quantitative

SFHP did not meet the target of 59.94%, missing it by 4.64% with a final result of 55.3% which remained in the 10th Medicaid percentile.

Qualitative

The main barriers to reaching the target were:

- Staffing limitations in SFHP's Pharmacy Operations team.
- Restrictions on recognized and approved generic inhalers.
- Auto-refill policies at pharmacy chains.

Recommendations

SFHP will continue this measure in 2024 with a target of 69.41%. Activities to support this measure will include:

- Collaborate with provider groups with most opportunity for improvement.
- Communicate updated asthma guidelines with providers and pharmacies.
- Incentivize providers through inclusion of an Asthma Medication Ratio measure in SFHP's primary care pay-for-performance program.
- Promote and encourage members with asthma to engage in services through a Chronic Condition incentive.

5.2 Hepatitis C Treatment

Overview & Performance

Measure: Hepatitis C Treatment					
Numerator	1,772	Baseline	37.00%	Final Performance	35.97%
Denominator	4,926	Target	40.00%	Evaluation Year	2023

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 2022 final performance.

Activities

The planned activities were completed:

- Used reporting to develop a profile (age, ethnicity, gender, location) for members not yet treated for Hepatitis C.
- Outreached to SFHP primary care providers and gather any information on treatment hesitancy or failure that they can provide for their patients.
- Continued to provide treatment support through SFHP's Care Management programs.
- Worked with local community group EndHepC to receive feedback from SFHP clinicians providing Hepatitis C care and treatment.

Analysis

Quantitative

SFHP did not meet the target of 40.00%, missing it by 4.03% with a final result of 35.97%.

Qualitative

Barriers to reaching the target included:

- Staffing limitations in SFHP's Pharmacy Operations team.
- Social determinants of health such as having stable housing, working phone for providers to connect to members, and ability to complete the long course of treatment may have had an impact on the measure reaching the target.

Recommendations

SFHP will continue this measure in 2024. The target will remain 40.0% and activities to support this measure will include:

- Collaborate with End Hep C group on provider education.
- Create outreach letter template for providers with members who need to complete Hepatitis C treatment to assist in coordination of care.
- Provide analysis and trends on members who have not completed Hepatitis C treatment to providers.

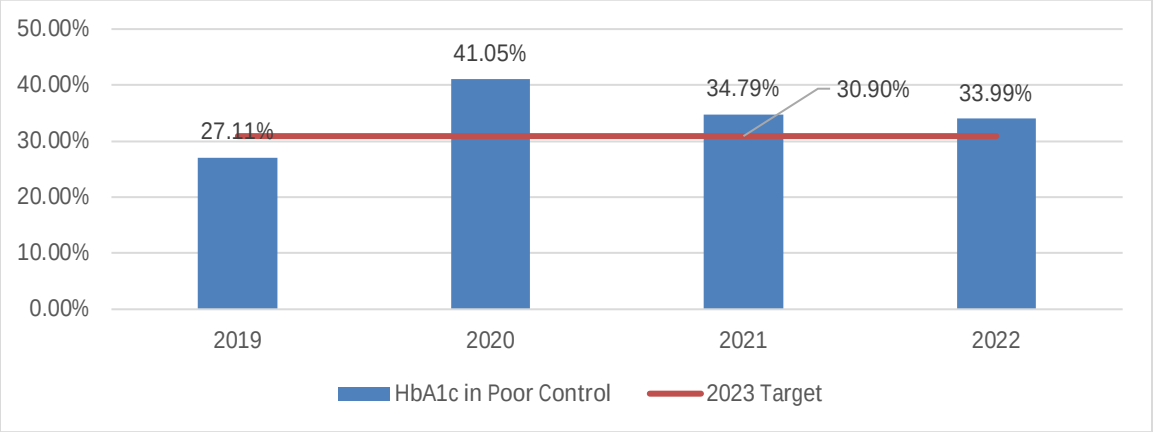
5.3 Diabetes Care – HbA1c in Poor Control

Overview & Performance

Measure: Diabetes Care – HbA1c in Poor Control					
Numerator	139	Baseline	34.79%	Final Performance	33.99%
Denominator	409	Target	30.9%	Evaluation Year	2023

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 30.9% based on achieving the 90th percentile among Medicaid plans. The following chart demonstrates the four-year trend in the rate of members with HbA1c in poor control.

Rate of Diabetes Care – HbA1c in Poor Control MY 2019 – 2022



Activities

The planned activities were completed:

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

SFHP began providing incentives for members with chronic conditions in 2023 but was interrupted by a ransomware attack on our vendor for distributing the incentive gift cards, resulting in most incentives being promoted in the latter half of 2023.

Analysis

Quantitative

SFHP did not meet the target of 30.9%, missing it by 3.09% with a final result of 33.99%. This result achieves the 75th percentile compared to Medicaid plans nationwide.

Qualitative

A barrier to reaching the target included not incentivizing members with diabetes to visit their provider for screening due to the vendor ransomware attack.

Recommendations

SFHP will not continue this measure in 2024 due to shifting focus to other QI and health equity priorities that are lower performing. SFHP will continue to promote screening to members with Diabetes through a chronic condition incentive in 2024.

5.4 Diabetes Care – Eye Exam

Overview & Performance

Measure: Diabetes Care – Eye Exam					
Numerator	248	Baseline	54.50%	Final Performance	60.64%
Denominator	409	Target	56.51%	Evaluation Year	2023

The Diabetes Care – Eye Exam measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of SFHP members who are age 18 – 75 with diabetes who have had a retinal eye exam, out of the total number of members with diabetes. SFHP chose the target of 56.51% based on national HEDIS benchmarks. Increasing eye exams for SFHP's members who have diabetes would place SFHP in the 75th percentile of plans for this measure.

Diabetic retinopathy is the leading cause of preventable vision loss and blindness in people ages 18 to 64 years old. Around 50% of people with diabetes do not get their eyes examined or are diagnosed too late for effective treatment. Annual eye exams play a crucial role in the early detection, intervention, and prevention of eye disease and vision loss caused by diabetes. Early detection, timely treatment, and appropriate follow-up care can reduce a person's risk for severe vision loss by 95%. However, a commonly cited referral barrier between PCPs and eye care providers (ECPs) is patients' difficulty or lack of incentive to schedule an eye care appointment**.**

SFHP members between the ages of 18 to 75 with diabetes should be getting a retinal eye exam annually. However, HEDIS rates show that there is an opportunity to improve follow-up care for members who are due for their eye exam. Referral barriers between a PCP and ECP can result in a member missing their annual vision checkup. Additionally, providers may miss opportunities to remind their patients with diabetes about the signs of eye problems and the importance of scheduling an eye care appointment.

Activities

The planned activities were completed:

- Promoted screening and care visits for members with diabetes through a member incentive gift card.
- Enrolled members with diabetes into the Medically Tailored Meals program administered by Project Open Hand.
- Conducted Drug Utilization Review with members with diabetes prescribed multiple diabetes medications.

Analysis

Quantitative

SFHP met the target of 54.5%, exceeding it by 4.13% with a final result of 60.64%. This result achieves the 75th percentile compared to other Medicaid plans.

Recommendations

SFHP will not continue this measure in 2024 due to shifting focus to other QI and health equity priorities that are lower performing. SFHP will continue to promote screening to members with Diabetes through a chronic condition incentive in 2024.

5.5 Project Open Hand Member Satisfaction

Overview & Performance

Measure: Project Open Hand Member Satisfaction					
Numerator	170	Baseline	95.7%	Final Performance	89.01%
Denominator	191	Target	96.00%	Evaluation Year	2023

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, 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. 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, 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 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. SFHP chose a target of 96% to demonstrate incremental improvement towards achieving high satisfaction and helpfulness with the program.

Activities

The following activities were completed:

- The POH program enrolled participants who received medically tailored meals or groceries depending on their preference and received medical nutrition therapy sessions with a dietician.
- SFHP received 191 satisfaction surveys for members who completed their 12–26-week program.

Analysis

Quantitative

SFHP did not meet the target of 96.00%, falling short by 6.99% with a final performance of 89.01%.

Qualitative

Recommendations

SFHP will not continue this measure in 2024. In 2023 Medically Tailored Meals became a Community Support funded by SFHP which will continue to provide meals and groceries to eligible members. In 2024 SFHP quality staff will work to create evaluation measures for Community Support services such as Medically Tailored Meals.

5.6 Prenatal Care for Black & Native American Members

Overview & Performance

Measure: Prenatal Care for Black & Native American Members					
Numerator	16	Baseline	92.86%	Final Performance	88.89%
Denominator	18	Target	95.86%	Evaluation Year	2023

The Prenatal Care for Black & Native American Members measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of birthing SFHP members who are Black or Native American who have received a prenatal care visit in the first trimester or within 42 days of enrollment with SFHP, out of the total number of birthing SFHP members who are Black or Native American. SFHP chose the target of 95.86% based on 3.00% absolute improvement from the previous measurement year .

Activities

The following planned activities were completed:

- Enrolled and credentialed 10 doulas that represent SFHP's diverse population
- Incentivized perinatal visits through a member incentive gift card.
- Promoted prenatal care visits through a reproductive health mail campaign.
- Developed provider incentive in SFHP's Pay for Performance (P4P) Program, PIP, to encourage increase in maternity care visits and share data.

The following activities were not completed:

- Conduct mail campaign to African American and Native American female identifying members ages 18-45 to encourage them to ask their PCP to submit a recommendation for a doula on their behalf.
- Operationalize Comprehensive Perinatal Services through development of a plan program charter.

The activities that were not completed were due to SFHP staffing issues and ransomware issues with SFHP's mailer vendor KP. Between April and June 2023, all member facing mailers was placed on hold. For doula services, members are no longer required to request a recommendation from their provider. SFHP has issued a standing order for the doula benefit.

Analysis

Quantitative

SFHP did not meet the target of 95.86%, falling short by 5.79% with a final result of 88.89%. This result aligns with achieving the 75th percentile compared to other Medicaid plans. As a whole population, SFHP also achieved the 75th percentile for timely prenatal care with a result of 89.67%.

Qualitative

The main barriers to reaching the target were:

- Lack of population health management staffing resources to conduct activities to support the improvement of this measure
- The mailing vendor ransomware attack which delayed incentive mailers and communication to members about the incentive and the doula benefit.

Recommendations

SFHP will not continue this measure in 2024 and instead focus on postpartum care. SFHP will continue to provide member incentives to receive prenatal care and will continue to include provider incentive to improve prenatal care in SFHP's Pay for Performance (P4P) Program.

5.7 Postpartum Care for Black & Native American Members

Overview & Performance

Measure: Postpartum Care for Black & Native American Members					
Numerator	16	Baseline	57.14%	Final Performance	88.89%
Denominator	18	Target	60.14%	Evaluation Year	2023

The Postpartum Care for Black & Native American Members measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of birthing SFHP members who are Black or Native American who have received a postpartum care visit between seven and 84 days after delivery, out of the total number of birthing SFHP members who are Black or Native American. SFHP chose the target of 60.14% based on 3.0% absolute improvement from the previous year's performance of 57.14%.

Activities

The following planned activities were completed:

- Enrolled and credentialed 10 doulas that represent SFHP's diverse population.
- Incentivized perinatal visits through a member incentive gift card.
- Promoted postpartum care visits through a reproductive health mail campaign.
- Operationalized Comprehensive Perinatal Services through development of a plan program charter.

The following activities were not completed:

- Develop provider incentive in SFHP's Pay for Performance (P4P) Program, PIP, to encourage increase in maternity care visits and share data.
- Conduct mail campaign to African American and Native American female identifying members ages 18-45 to encourage them to ask their PCP to submit a recommendation for a doula on their behalf.

The mail campaign activity that was not completed was due to SFHP staffing issues and ransomware issues with SFHP's mailer vendor KP. Between April and June 2023, all member facing mailers was placed on hold. For doula services, members are no longer required to request a recommendation from their provider. SFHP has issued a standing order for the doula benefit. SFHP did not include postpartum care in SFHP's Pay for Performance (P4P) Program, choosing to prioritize timely prenatal care as a P4P measure.

Analysis

Quantitative

SFHP met the target of 60.14%, exceeding it by 28.75% with a final result of 88.89%. This result aligns with achieving the 95th percentile compared to other Medicaid plans. As a whole population, SFHP also achieved the 05th percentile for timely prenatal care with a result of 92.39%.

Recommendations

SFHP will adjust this measure in 2024 to focus on the entire SFHP member population and will implement targeted equity interventions for Black or African American, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native members. The target will be 84.59% to align with the 90th percentile for the PPC-Postpartum Care HEDIS measure and activities to support this measure will include:

- Ensure a diverse and inclusive environment with a network of doulas and community health workers that can support all members engaging in perinatal care and connecting with plan benefits and services.
- Promote and encourage pregnant members to engage in services through a member incentive for both prenatal and postpartum visit.
- Incentivize providers through inclusion of a prenatal visit measure in SFHP's primary care pay-for-performance program.

Equity focused interventions for Black or African American, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native members will include:

- Build an outreach program using a diverse group of staff to reach out to at-risk persons who are less likely to engage in preventive care. Refer to community health workers and doulas for support and intervention.
- Incentivize providers through inclusion of a health equity measure in SFHP's primary care pay-for-performance program. Providers will complete the measure by conducting perinatal quality improvement activities for the measure for members who are Hispanic or Latino, Black or African American, Native American or Other Pacific Islander, and/or Asian/Pacific Islander patients.

5.8 Postpartum Depression Follow-Up for Black & Native American Members

Overview & Performance

Measure: Postpartum Depression Follow-Up for Black & Native American Members					
Numerator	2	Baseline	0%	Final Performance	40.00%
Denominator	5	Target	38.89%	Evaluation Year	2023

The Postpartum Depression Follow-Up for Black & Native American Members measure is in the Managing Members with Emerging Risk domain. This rate is based on the total number of birthing SFHP members who are Black or Native American who have screened positive for depression and have received follow-up care, out of the total number of birthing SFHP members who are Black or Native American who have screened positive for depression. SFHP chose the target of 38.89% based on MY2021 performance of 77.78% in this measure; 38.89% represented the halfway point between the baseline of zero and SFHP's overall performance.

Activities

The following planned activities were completed:

- Collaborated with Carelon to pilot a maternal mental health clinical program tailored to the specific needs of Black and Native American members SFHP members.
- Partnered with local community-based organizations to educate members and facilitate connection to care.
- Enrolled and credentialed 10 doulas that represent SFHP's diverse population

Analysis

Quantitative

SFHP met the target of 38.89%, exceeding it by 1.11% with a final result of 40.00%. However, this result reflects Black or African American members only; no Native American members were eligible to be included in this measure denominator. SFHP as a whole population performed at 62.50%.

Qualitative

Recommendations

SFHP will not continue this measure in 2024 due to shifting focus to other behavioral health QI and health equity priorities that are lower performing. However, SFHP will continue to monitor postpartum depression follow up.

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.

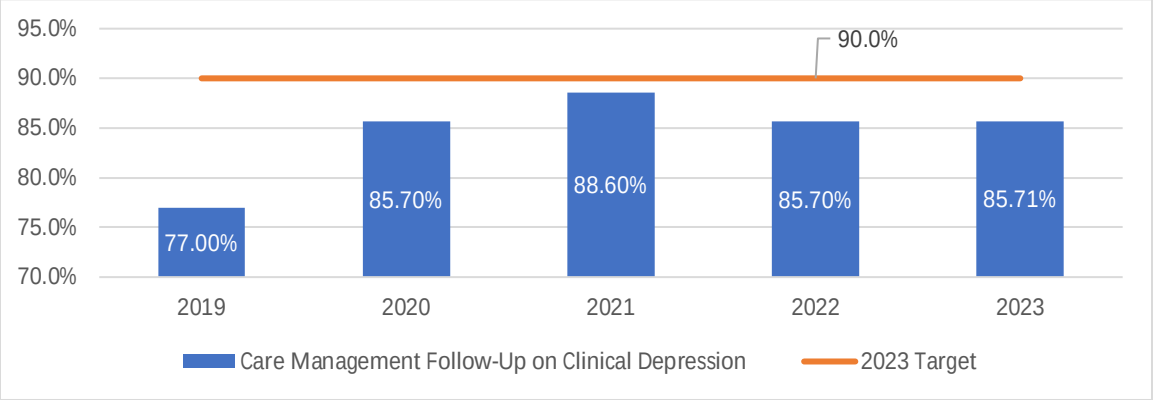
6.1 Care Management Follow-Up on Clinical Depression

Overview & Performance

Measure: Care Management Follow-Up on Clinical Depression					
Numerator	12	Baseline	85.71%	Final Performance	85.71%
Denominator	14	Target	90.00%	Evaluation Year	2023

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 five-year trend in the rate of members with Care Management Follow-Up on Clinical Depression.

Care Management Follow-Up on Clinical Depression 2019 – 2023



Activities

The following activities were completed:

- Offered 14 staff trainings in mental health, focused particularly on severe mental illness

(SMI) and community resources, to ensure that staff is equipped to identify signs and symptoms of clinical depression, address client safety including connection to behavioral health services.

  - Overdose Prevention and Community Health Initiatives
  - Post Pandemic Recovery_ Substance Use
  - Med Talk: Dementia Overview
  - Intensive Case Management
  - Heart Disease
  - Post Pandemic Substance Use Disorder
  - Stepping Stone Adult Day Health Care
  - Community Living Fund
  - Community and Home Injury Prevention Program for Seniors
  - Central American Resource Center SF and Overdose Prevention
  - Med Talk: Schizophrenia and the use of Antipsychotics
  - Secondary Trauma
  - Understanding and Preventing Compassion Fatigue
  - Person Centered Care Planning

- Clinical Supervisors reviewed CM dashboard monthly with staff and to coach staff to ensure members are screened and receive appropriate follow up.
- Coached and conducted role-playing activities to reduce the rate of members declining PHQ-9 screening. Clinical Supervisors and Trainer providing coaching and role playing as needed during weekly 1:1s and bi-weekly Clinical meetings.
- Quarterly staff self-audits completed in November 2022, February and August 2023 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 completed clinical audits in August and provided feedback to the team, including trends and gaps in training. Temporarily increased frequency of audits to every quarter. New CCM and TLC Supervision tracking tools developed in August.

Analysis

Quantitative

SFHP did not meet the target of 90.0%, falling short by 4.29% with a final result of 85.71%.

Qualitative

Barriers

Barriers in meeting this goal include:

- Since the COVID-19 pandemic, behavioral health providers have been highly impacted, resulting in longer wait times and limited in-person visits.
- The inconsistent presence of Carelon in the SFHP office and availability of staff to perform a warm hand off to Carelon's co-located case management team.
- Small sample size as since the COVID-19 pandemic there have been additional challenges connecting with members and more cases where members have gone Lost-to-Follow-Up.

Recommendations

SFHP will continue this measure in 2024 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, to ensure that staff is equipped to identify signs and symptoms of clinical depression and 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.
- Initiate a weekly behavioral health office hour between SFHP Care Management, SFHP Behavioral Health, and Carelon clinical teams to staff cases and ensure timely connection to behavioral health services.
- Collaborate to ensure effective coordination of care through the Managed Behavioral Health Care Committee which includes both SFHP and SF Behavioral Health Services.
- 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 audits every 4 months to ensure best practices and regulatory requirements are met.

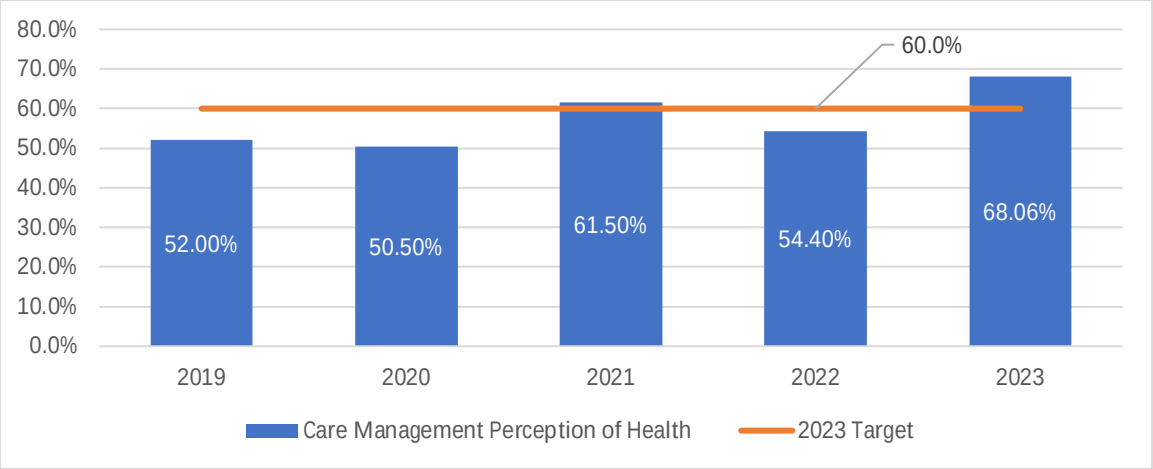
6.2 Care Management Client Perception of Health

Overview & Performance

Measure: Care Management Client Perception of Health					
Numerator	49	Baseline	54.40%	Final Performance	68.06%
Denominator	72	Target	60.00%	Evaluation Year	2023

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 60%. The target was selected based on incremental improvement from 2022. 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 five-year trend in the rate of members with Care Management Client Perception of Health.

Care Management Perception of Health 2019 – 2023



Activities

The following activities were completed:

- Clinical Supervisors and Medical Director provided coaching the CM Nurses and Community Coordinators to assess for client barriers and gaps in health education and connection to PCP.
- Developed 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.
- Utilized Milliman Care Guidelines condition specific assessments and health education materials by CM Nurses.

Analysis

Quantitative

SFHP met the target of 60%, exceeding it by 8.06% with a final result of 68.06%.

Recommendations

SFHP will not continue this measure in 2024 as the activities implemented in the previous year's improvement work have surpassed the target and the Care Management team will shift their focus to other measures of member-centered care.

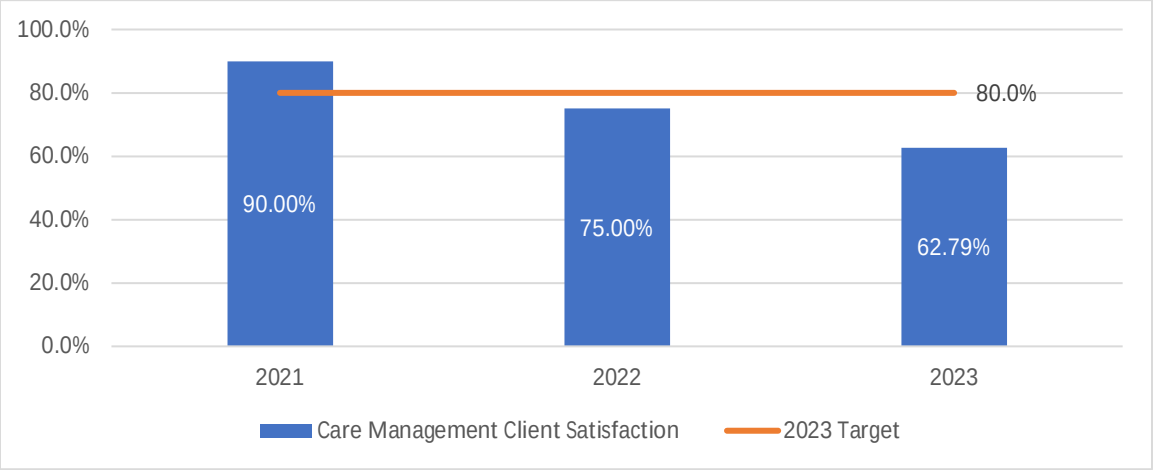
6.3 Care Management Client Satisfaction

Overview & Performance

Measure: Care Management Client Satisfaction					
Numerator	27	Baseline	75.00%	Final Performance	62.79%
Denominator	43	Target	80.00%	Evaluation Year	2023

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 80% and was chosen based on incremental improvement from the previous measurement year. The following chart demonstrates the three-year trend in the rate of members with Care Management Client Satisfaction.

Care Management Client Satisfaction 2021 – 2023



Activities

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, health 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.
- CM staff completed a 6-month reassessment and review of care plan including goals with member.

Analysis

Quantitative

SFHP did not meet the target of 80.0%, falling short by 17.21% with a final result of 62.79%.

Qualitative

Barriers to meeting this goal have mostly been caused by the COVID-19 pandemic, which has resulted in:

- The Care Management Team limiting services to telephonic case management for nearly two and a half years, and only resuming field work in June 2022 in a phased approach.
- Providers have been highly impacted, resulting in limited appointments and long wait times, especially for PCPs and specialists.
- Diminished resources provided by Community Based Organizations and other community partners, for example, most intensive case management programs have a year-long wait list currently. The main barrier to reaching the target was due to most intensive programs being highly impacted at this time with long wait lists.

Recommendations

SFHP will continue this measure in 2024 and reduce the target to 65.00% to better reflect improvement from 2023 performance. Activities to support this measure will include:

- Development of an individualized case management plan, including member's prioritized goals and preferences.
- Improve communication of care plan goal progress between Care Management staff and members.
- Provide more thorough life skills, health education and training to members pertaining to self management of their conditions and their health maintenance.
- CM staff completes a 6-month reassessment and review of care plan, including goals with member.
- Maintain a process to triage members into longer-term case management programs when requested by member or indicated by member's self-efficacy skills.
- Strengthen relationships with community based organizations and increase team knowledge of community resources.
- Include online resources in Case Management software system for easier access by CM Coordinators and Nurses.
- Initiate a Closed Loop Referrals project to seek a system for connecting members to needed resources.

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

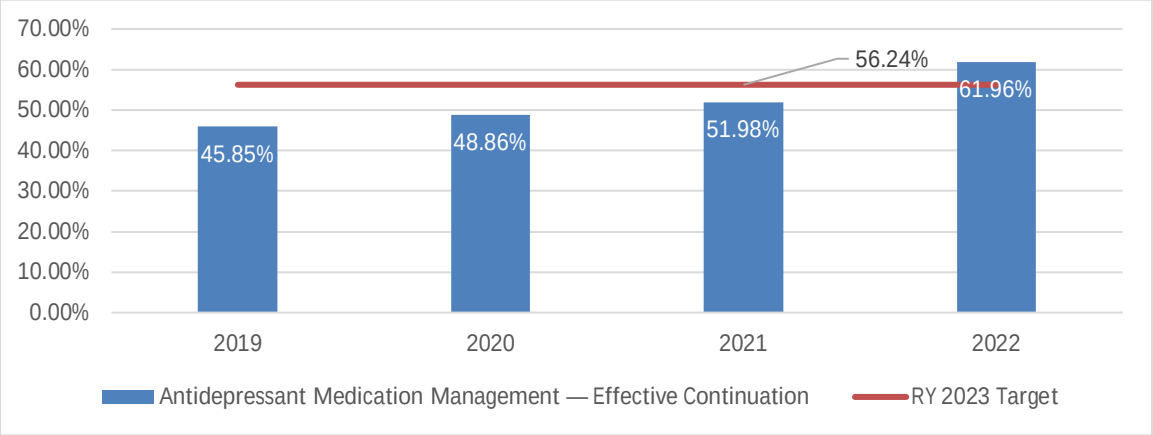
Overview & Performance

Measure: Antidepressant Medication Management — Effective Continuation					
Numerator	922	Baseline	51.98%	Final Performance	61.96%
Denominator	1,488	Target	56.24%	Evaluation Year	2023

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 56.24% 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 four-year trend in AMM.

Rate of Antidepressant Medication Management — Effective Continuation MY 2019 – 2022



Activities

The planned activities were completed:

- Collaborated with Carelon on member and provider outreach and education.
- Conducted member level outreach for members not achieving adherence goals.
- Created member-level health education materials about antidepressant adherence.
- SFHP refreshed and distributed articles around medication adherence for antidepressants in the October 2023 provider newsletter.

Analysis

Quantitative

SFHP met the target of 56.24%, exceeding it by 5.72% with a final result of 61.96%. This result achieved the 90th percentile among Medicaid plans.

Qualitative

An analysis was performed reviewing adherence rates for antidepressants, comparing members by affinity groups. Members who identified their preferred language as Spanish had among the lowest rate of adherence at 6 months (55.50%) as did those members who identified as Black (52.86%) or Hispanic (55.18%). These low adherence rates highlight a potential need for increased access to culturally competent care. SFHP has begun work with our behavioral health vendor to identify strategies for addressing these populations, and we hope to implement activities in the coming year.

Recommendations

SFHP will not continue this measure in 2024, due to lack of Pharmacy staff resources and prioritization of other QI and health equity activities.

7.2 Antipsychotic Medication Adherence

Overview & Performance

Measure: Antipsychotic Medication Adherence					
Numerator	337	Baseline	59.20%	Final Performance	62.64%
Denominator	538	Target	61.59%	Evaluation Year	2023

The Antipsychotic Medication Adherence (SAA) is in the Utilization of Services domain. This rate is based on members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. Increasing SAA reflects improved management for members with behavioral health conditions. SFHP chose the target of 61.59% based on national HEDIS benchmarks. Increasing SFHP's SAA rate would place SFHP in the 50th percentile of plans for this measure.

Activities

- Collaborated with Carelon on member and provider outreach and education.
- Outreached to SF Department of Public Health to discuss barriers to access for members with schizophrenia on antipsychotics.

Analysis

Quantitative

SFHP met the target of 61.59%, exceeding it by 1.05% with a final result of 62.64%. This result achieved the 50th percentile among Medicaid plans.

Recommendations

SFHP will continue this measure in 2024, with a target of 61.39% based on maintaining the Medicaid 50th percentile benchmark, since the MY 2023 Admin rate fell below the 2023 MPL.

Activities to support this measure will include:

- Communicate with SF Behavioral Health Services to discuss barriers to access for members with schizophrenia on antipsychotics.
- Include member education on medication adherence for chronic disease states in Your Health Matters

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	· Four meetings held in 2023	12/30/2023
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	12/30/2023
C	Physician Advisory/Peer Review/Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	· Five meetings held in 2023	12/30/2023
D	Utilization Management Committee	Ensure oversight of SFHP Utilization Management program	Director, Clinical Operations	· Ten meetings held in 2023	12/30/2023
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	3/1/2023
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	3/1/2023

	Oversight	Summary	Responsible Staff	Activities	Due Date
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	12/30/2023
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	12/30/2023

Reviewed and Approved by:

Chief Medical Officer: *Eddy Ang, MD, MPH* Date: 3/7/2024

Quality Improvement & Health Equity Committee Review Date: 3/7/2024

Board of Directors Review Date: 3/27/2024