



**SAN FRANCISCO
HEALTH PLAN™**

Here for you

San Francisco Health Plan:

Our Journey to Improve Quality and the Health of Our Population

1/29/2015



Introduction

San Francisco Health Plan (SFHP) won the California Department of Health Care Service's Gold Award for Quality six years in a row, from 2008 through 2013. We are often asked "How do you do it?" by colleagues who want to hear how we score so well on quality measures. This white paper is a response to that question. Our hope is that by sharing information about our activities and our plans for continued improvement, we will participate in a community of learning that can drive improvements in healthcare across our country.

In this white paper, we will describe our three-part strategy to improve healthcare quality:

1. **Supporting primary care practice transformation**
2. **Directly engaging our health plan members and providers through incentives**
3. **Aggressively capturing data on an ongoing basis**

We will also describe our growing partnership with the San Francisco safety net providers to create a data-driven culture of quality improvement. Finally, we will share our plans for the future.

One more note about SFHP's quality journey: SFHP benefits from the great ideas and successes of other health plans and improvement beacons, such as CareOregon, Partnership Health Plan of California, Redwood Community Health Coalition, and LA Care. We are grateful to these and other peers for their generous sharing of strategies and information.

Sincerely yours,

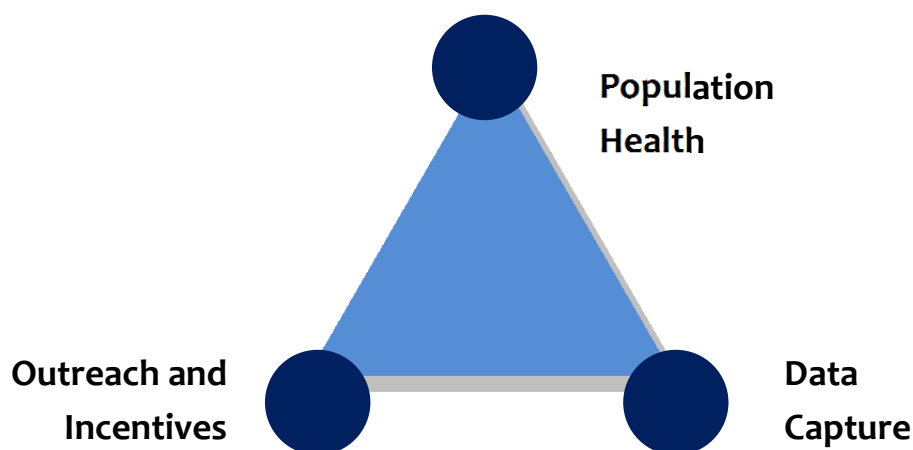
Kelly Pfeifer, MD, Chief Medical Officer, and John Grgurina, Jr., CEO,
San Francisco Health Plan

SFHP Strategies for improving performance

San Francisco Health Plan uses a combination of activities to support our provider network and ensure reliable, evidence-based primary care for SFHP members:

- **Supporting primary care practice transformation, particularly focused on population health**
- **Encouraging members to get recommended care through direct outreach and incentive programs,**
- **Pursuing clinical data aggressively**

Our work in these three domains continues to evolve, as detailed in the “Future Plans” section below.



1. Supporting practice transformation in the safety net

Compared to traditional episode-based primary care, being accountable for the health of a population of patients requires a re-design of how providers deliver care, to ensure the right care happens at the right time, consistently. SFHP has invested substantial resources in supporting primary care transformation, specifically focusing on population management, team-based care, barrier-free access, and skilled clinical leadership. This section describes some of our efforts to support high-performing primary care through providing technical assistance, incentives, training, and project funding.

Strength in Numbers

In March 2009, San Francisco Health Plan launched a new program called Strength in Numbers, with funding from San Francisco’s universal access program, Healthy San Francisco, and start-up funds from the California HealthCare Foundation. The program supported panel management and the use of clinic registries through standardized measures, incentives, and technical assistance. Strength in Numbers started with four diabetes care measures reported quarterly by San Francisco safety net clinics. Through the end of 2010, clinics achieved significant improvements in these four diabetes measures (A1C testing and control, LDL testing and control), along with developing a shared culture of data-driven improvement across the safety net.

Strength in Numbers quickly broadened its focus from diabetes to other chronic conditions, as well as access improvement, patient experience, and meaningful use. Clinics earned modest incentive payments through improvements on measures over their own baseline. By 2010, the program included 24 clinics, representing 95% of Healthy San Francisco participants and 72% of SFHP insured adult members.

To support the integration of registries and data-driven clinical work into the daily work of clinics, Strength in Numbers offered resources to build panel management skills for front-line and nursing staff. Training and technical assistance focused on registry use, panel management skills, and self-management “health coaching” trainings from Dr. Tom Bodenheimer and the staff at the Center for Primary Care Excellence at the University of California – San Francisco.

Although data quality issues prevented analysis across the network, a focused, rigorous analysis of participating public health clinics (n=10), showed statistically significant results in three out of the four diabetes measures: HbA1c Testing, HbA1c Poor Control, and LDL Testing over the past year. Unfortunately, those measures have plateaued since that point, largely due to access challenges in the network. Therefore subsequent work has focused most intensively on access, with training and technical assistance on decreasing appointment delays, no-show rates, and cycle time, while improving continuity and efficiency.

Strength in Numbers ultimately was folded into our SFHP incentive bonus initiative, the Practice Improvement Program, as of January 2014.

One of the core lessons of Strength in Numbers was that salaried clinic medical directors were tremendously motivated by relatively small amounts of money – often as little as \$15,000 per clinic per year. Medical directors typically had no discretionary funds, and the ability to receive incentive payments for focused QI work meant Strength in Numbers was surprisingly impactful. Funds were used to pay for food for QI team meetings, health education supplies, educational video equipment, temporary staff for special outreach efforts, etc. Medical directors have attributed the following impacts to the Strength in Numbers program:

- Agreement across many safety net systems on a common set of quality measures, with unblinded data-sharing and healthy peer pressure
- Recognition that access measures (“third next available” appointment, show rate) are also important quality metrics, and can be shared outside of internal operations
- United focus on panel management skills, enhancing the roles of medical assistants and nurses
- Leadership attention and focus on the impact of delays on quality of care

Practice Improvement Program (PIP)

A common complaint of capitated and fee-for-service providers is “who will pay me to do this improvement work?” Improving care takes staff and resources, and so SFHP developed the Practice Improvement Program to have a mechanism to pay for value, and to drive improvements in our network. The program launched in January, 2011, and provides incentive payments to clinics and medical groups based on four domains:

- Clinical Quality (traditional HEDIS, or Healthcare Effectiveness Data and Information Set, measures)

- Patient Experience (including access improvement)
- Systems Improvement (focused on improved coordination between care providers)
- Data Quality (including timeliness, comprehensiveness, and accuracy)

Rather than specifically focusing only on HEDIS measures, as is the practice of many pay-for-performance programs, PIP also focuses on changing practices to not only improve care for this year, but to improve care for future years. Please see the following for some examples of measures in each domain.

Clinical Quality:

- In the first year, sites were rewarded for identifying a low-performing HEDIS measure, developing a test of change, measuring the impact, and then spreading, if successful.
- Most measures are HEDIS measures, and sites are rewarded for relative improvement over baseline, or achievement of the 90th percentile. Allowing full points for meeting thresholds of relative improvement prevents favoritism for sites with healthier populations.

Patient Experience:

- SFHP incentivized sites to participate in a SFHP-administered CG-CAHPS survey (sites could also do their own) and then to develop an improvement plan based on data
- Sites received bonuses for participating in a SFHP-administered staff satisfaction survey, and then developing a focused improvement project. This measure was based on research showing an association between staff satisfaction and patient satisfaction.
- Sites reported on third-next-available appointment, show rate, and continuity rate, and were incentivized for relative improvement over baseline, or achievement of thresholds.

Systems Improvement:

- Sites were incentivized to develop quality reports at the provider level, and share them with providers to support data-driven improvements.
- Sites were incentivized to develop protocols that supported pain management best practices, including implementing pain management agreements, checking urine drug screens, and setting up peer review.
- Sites were incentivized to follow up with patients within seven days of hospital discharge, in attempt to decrease all-cause readmissions.

Data Quality

- Sites were rewarded for meeting encounter timeliness and accuracy standards.
- Sites were incentivized to have more comprehensive coding by measuring the percent of encounters that had two or more diagnosis codes for patients over 45 years old.

To ensure the PIP measures are impactful, SFHP invests a significant sum of money in PIP, approximately \$14 million in 2014. Sites are eligible to receive up to 18.5% of their professional capitation rate in incentive bonuses. Any unearned funds are put back into the PIP program in the form of more technical assistance and training aimed at helping sites improve their PIP scores.

PIP BLOCK FUNDING PROGRAM

To further support improvement activity, SFHP developed the PIP Block Funding Program in 2013. \$8 million of an operational surplus was put into the program, and sites were encouraged to submit project ideas related to improving access, over-utilization, or data quality. The program functions as a grant, with 80% of the funds distributed on approval of the project, 10% distributed based on meeting project milestones, and 10% distributed based on performance in outcome measures.

HEALTHIER LIVING PROGRAM

Kate Lorig's chronic disease [self-management programs](#) are internationally known for improving healthcare outcomes and lowering costs through peer-led self-management classes. SFHP partnered with On Lok and Tenderloin Neighborhood Development Corporation's Kelly Cullen Community to spread these classes into supportive housing communities (focused on the recently homeless population) and community clinics. Several SFHP staff have also been trained to lead the courses, with the aim of spreading the courses throughout San Francisco, so members with diabetes and other chronic conditions have the skills to better manage their health.

Patient Experience Pilots

Although SFHP has prided itself on high HEDIS scores and gold medals for quality, we have not fared well in measurement of patient experience: our patient satisfaction scores are among the lowest in California. Based on analysis of problem areas in our scores on the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey, and on input from SFHP’s Performance Improvement Advisory Group, we decided to focus on two key areas of patient experience: **access to care** and **communication between patients and provider care teams**. In January, 2010, SFHP launched two small-scale learning collaboratives, based on the Institute for Healthcare Improvement’s (IHI) Breakthrough Series model. These two pilot programs were collaboratively funded by SFHP, Healthy San Francisco, the California HealthCare Foundation, and the University of California-San Francisco Center for the Health Professions.

The access collaborative, “**Optimizing the Primary Care Experience (OPCE)**,” aimed to improve both access to appointments and office efficiency during appointments. Four clinics participated. Our expert faculty for the program was Dr. Mark Murray, with SFHP staff providing quality improvement coaching support to the improvement teams throughout the program. The program had the following goals:

- Reduce waiting times both **for** and **at** appointment services.
- Optimize health outcomes by improving clinical care, including continuity of care, defined as providers seeing their own panel of patients.

In summary, “See your own – don’t make them wait.” In two day-long OPCE Learning Sessions, clinics learned skills and techniques to work down visit backlogs, decrease delays, and improve efficiencies:

- **How to accurately measure supply**, demand and activity, plan for predictable variation and define a manageable panel size per full-time provider equivalent.
- **How to increase visit capacity** (“supply”) through optimizing provider schedules, teaming up part-time providers, simplifying scheduling templates, creating effective staff teams, and teaching access-maximizing scheduling practices to front-office staff.

A note on survey bias due to ethnicity and language:

In 2009 and 2010, SFHP conducted extensive research and data analysis on the issue of language and cultural bias in the CAHPS surveys of patient experience.

Literature supports that scoring varies by population: all other things being equal, Asian members (and in particular, Chinese-speaking members) tend to rate satisfaction scores lower across the board.

Within our own scores, SFHP found performance correlated with a large percentage of Cantonese-speaking patients, roughly 40% of our network.

SFHP was able to successfully advocate to state agencies (MRMIB for Healthy Families, Department of Health Care Services for Medi-Cal) to provide language explaining bias in public reporting, and to case-mix adjust results based on race/ethnicity.

SFHP launched additional CAHPS surveys, and analysis showed that case-mix adjustment helped certain scores, but access remained an issue across the board.

- **How to decrease or moderate demand** through extending visit intervals, “max-packing” visits, and decreasing no-show rates.
- **How to create efficient work-flows** to decrease wait times during the visit.

The second collaborative, “**Patient-Centered Communication (PCC)**,” focused on improving the effectiveness of provider- patient and staff-patient communication. Five clinics participated. Expert faculty from the Institute for Healthcare Communication and SFHP staff provided quality improvement coaching support. The program had the following primary goals:

- **Optimize** health outcomes by improving communication and shared decision-making.
- **Improve** provider, staff and patient satisfaction.

PCC trainings featured key communications techniques for providers and staff: agenda setting, staff huddles, warm greetings for patients, and teamwork techniques.

SFHP believes that a core component of our success in these collaboratives was the intensive, customized clinic coaching provided by two IHI-trained Improvement Advisors on the SFHP staff, and monthly teleconferences to cover specific content and allow sharing of successes and challenges among the clinics.

Both collaboratives showed initial positive results. All four sites working on access improvement (OPCE) cut their average wait time for a routine appointment by over half in the first six months of the collaborative. One site went from 42 days to 20 days; another site went from 10 days to less than one day. For PCC (communication), results from the patient experience surveys demonstrated that four out of the five clinics improved over baseline in more than 50% of the survey measures.

Unfortunately, these gains were not sustained. Access scores worsened again, due to many factors: increasing patient demand, inadequate provider and front-line staffing at many clinics, and electronic health record implementation.

SFHP came to realize that the collaborative model alone, where teams left the clinic, learned, and then came back to try to implement their findings, was not sufficient to create sustained changes in San Francisco clinics. Once the improvement teams returned on-site, they found it difficult to bring the rest of the clinic along with the improvement efforts.

Based on this experience, SFHP decided to change strategies:

1. **Invest in training clinic leadership teams** with skills in quality improvement, people management, project management, and overall leadership. We launched the San Francisco Quality Culture Series, described below.
2. **Bring consultants on-site to the clinic**, instead of hosting improvement efforts off-site. SFHP has brought in Coleman Associates to conduct Rapid Dramatic Performance Improvement initiatives at 16 clinics, as of June 2014.
3. **Take on spread and sustainability directly**, and help clinics get beyond “projectitis” (lurching from project to project, with no sustained gains), to operational improvements integrated into clinic daily operations.

SFHP is committed to continuing to improve the triple aim: improving quality, experience and affordability. Primary care access impacts all three, so we continue to prioritize access over all of our interventions. We hope to improve the care overall for our members, and as secondary benefits, improve our HEDIS scores, our CAHPS scores (Consumer Assessment of Healthcare Providers and Systems) and make an impact on the sustainability of the San Francisco safety net.

Patient Experience Initiatives

In recognition that improving patient experience required focus and creativity, SFHP developed a full-time position titled Project Manager, Care Experience. This position was created in 2012 and examples of initiatives are listed below:

- **Design on a Dime:** An interior designer visits clinics and develops low-cost plans to improve the physical environment of the practice site. This initiative is low-cost (approximately \$2,000 per site) and very popular with clinics.
- **Customer Service Training:** SFHP offers customer service training for both in-person and telephone-based patient interactions. The training provides tactical methods and protocols for providing high-quality, patient-centered service. After the training sessions, clinics implement sustainability strategies and measured their improvement progress over time.
- **Building a Better Workplace:** Care team satisfaction and patient satisfaction are strongly linked. This program provides clinics and medical groups with tools and skills for improving their staff's experience. The Center for Excellence in Primary Care implemented a brief survey to measure staff experience, and ExperiaHealth provided personalized coaching, webinars, and in-person learning events.
- **Rapid Dramatic Performance Improvement, through Coleman Associates:** In this intensive program, 3 to 5 consultants work side-by-side with clinic staff for one week, redesigning clinic processes to improve teamwork, patient access, and visit efficiency. This week is followed by two months of coaching, monitoring and reporting of performance measures.
- **Provider-Patient Communication Trainings:** SFHP has offered trainings to give providers the tools to set boundaries, express empathy, and share resources even during their most challenging interactions with patients.

SF Quality Culture Series – Improving Clinic Leadership and Change Capacity

SFHP supports the concept of the “patient-centered medical home,” and believes that reaching peak performance in quality will require real transformation in how care is delivered in the safety net. Practices that have successfully transformed themselves to achieve high performance in the triple aim (population health, patient experience, and cost containment) have three key elements in common:

- **The will to change** (the classic business-critical burning platform, or at least recognition that the current system is not working)
- **High-performing leadership teams**, who communicate the vision and lead the transformation

- Core skills in **quality improvement** (creating small tests of change, measuring, spreading), **people management** (accountability, delegation, creating high-performing staff teams) and **operations** (creating lasting functional and efficient systems – not leaping from project to project)

During the patient experience collaboratives, it became clear that many well-meaning clinic leaders lacked some of the basic skills to launch, complete, and sustain successful improvement. This became apparent when the coaches observed disorganized meetings, missed deadlines, and chaotic project management. Many medical directors, nurse managers, and staff supervisors never had formal leadership or management training. As a result, many operated in the crisis of the moment, and struggled with sustaining improvements over time.

Redwood Community Health Coalition, a consortium of clinics in four Northern California counties, began the Quality Culture Series in 2006, building on similar leadership development training at Intermountain Health Care in Utah that began in 1992. Redwood Community Health Coalition saw improvements in the areas of chronic care, access, EHR, and patient experience. San Francisco's Quality Culture Series is adapted from this program.

With funding from the Gordon and Betty Moore Foundation, SFHP and Healthy San Francisco, and in collaboration with the SF Department of Public Health and the SF Community Clinic Consortium, SFHP launched the SF Quality Culture Series in January 2011. Eight day-long sessions provided the core curriculum, covering QI basics, management basics (how to run an effective meeting, how to coach performance, how to manage the dynamics of change), and project management. Instruction was done in an interactive adult-learning style, ensuring time for clinic teams to make action plans, to support them in taking the skills back to their clinic staff, in a “train the trainer” model. Expert faculty from the UCSF Center for Health Professions and other Bay Area leaders provided the instruction, and each clinic received support from a seasoned improvement coach. Each clinic was charged with developing and completing a QI project related to access improvement, patient experience, or electronic health record implementation. Almost all clinics reported measurable improvements in their clinic's capacity for quality improvement and team effectiveness (based on pre- and post-assessment scores), and saw improvement on at least one project measure.

SFQCS now continues as 2 to 4 full-day sessions each year, with coaching provided by SFHP and the 10 Building Blocks program (see below), with near-universal participation of SF safety net clinics.

SFQCS is described as a transformative experience for clinic leadership teams. Attendance continues to be strong, with active engagement and high program ratings across the board.

10 Building Blocks Coaching Program

The success of the SF Quality Culture Series highlighted the effectiveness of coaching. As Atul Gawande says in a 2011 [New Yorker article](#), we would never expect super-bowl wins without coaches; wouldn't the same logic apply to healthcare providers, who are expected to deliver near-perfect care consistently across time?

SFQCS used executive-level coaches – although very effective, it was also very expensive. SFHP decided to test the concept of practice coaching in a more affordable model, hiring people skilled in project management and operations to provide coaching to safety net and academic clinics, using Tom Bodenheimer's 10 Building Blocks of High-Performing Primary Care (see [article](#) for details).

Funded by the Metta Foundation, this collaboration between SFHP and the UCSF Center for Excellence in Primary Care launched in 2013 and will continue for three years.

Preliminary results show that clinics are benefiting from the program, and demonstrating improvements on infrastructure and process measures. As of one year into the program, there have not been changes in outcome measures; this will be tracked and reported at the end of the grant.

Clinics report the coaching is helpful in terms of building momentum and accountability for change. Predictably, higher performing clinics and leaders tend to take more advantage of the resources. It became clear in the first year of the program that coaches with operational experience in clinics were better received by the clinics, and seemed to have an easier time having “difficult conversations” related to giving challenging feedback, pushing for accountability, or encouraging progress against defined measures.

Other Training and Technical assistance

SFHP has provided several training programs for safety net leaders and providers that have been highly rated, and help build a collaborative relationship between the plan and the provider network. Trainings are developed in response to provider requests, and were launched in 2009 with the SLIM conference (“Sharing/Learning/Improving/Measuring”) which focused on panel management, registry use, chronic pain management, and access improvement. Training topics since 2009 have included health coaching, chronic pain management, childhood obesity prevention, “difficult conversations,” and improving patient-doctor communication in the era of electronic health records, motivational interviewing, and customer service, among others.

Care Oregon site visit

CareOregon has become nationally known as a leader in health plan innovation. In 2010, SFHP led a delegation of 26 safety net executives and physician leaders to learn from their Primary Care Renewal experience, which paired coaching and technical assistance to support safety net clinics in developing patient-centered, high-performing primary care. A smaller group returned in 2013 to learn about innovative care management, and their approach to the opioid overdose epidemic. The visit heavily influenced the development of SFHP’s CareSupport department (see below, named after CareOregon CareSupport), our 10 Building Blocks Coaching Program, and the SFHP Pain Management Program.

CareSupport

When seniors and persons with disability joined Medi-Cal managed care, SFHP realized that a segment of this population heavily utilize the emergency department and hospital, but continue to suffer poor outcomes. Health plan-based nurse case management proved ineffective in reaching and engaging these members. To better address their needs, SFHP developed the CareSupport program, based on what we learned from CareOregon and a community-based care management program in New York, led by Dr. Maria Raven (<http://nyshealthfoundation.org/uploads/general/raven-slides-cost-containment-conference-november-2009.pdf>)

The model involves teams of 5 community care coordinators, supervised by a licensed clinical social worker, spending most of their time outside the health plan, meeting with members and helping facilitate social services and coordinate medical care. Training for this role is intensive, and community coordinators receive training in motivational interviewing, trauma-based care, health coaching, suicide prevention, and other relevant topics.

Early data is promising for showing decreases in emergency department and hospital use, however as of June 2014, it is too soon to know if these trends are statistically significant.

These coordinators are very creative in thinking about how to engage trust, and build commitment for change. They frequently have to go to single-room-occupancy hotels three or four times before a member will answer the door, and they build trust through cups of coffee, kindness, and persistence. Below are a few stories showing how the approach is different from traditional health plan case management:

1. Trying to figure out how to motivate someone to attempt sobriety, a coordinator asked, “tell me about a day when you were happy and sober.” The man said “I was fishing.” So the coordinator got a couple fishing rods, took him to the pier, and they spent some time fishing and talking about the first steps of sobriety.
2. A client had been in and out of the hospital repeatedly, receiving weeks of IV treatment for infections, leaving AMA, and then returning to the hospital. An amputation had been indicated, but refused on numerous occasions. A coordinator developed a relationship with the client over three months, talked through the pros and cons of the procedure, and worked tirelessly with the client to put together a post-discharge care plan that worked for the client. She had the amputation and dramatically improved her quality of life. No more hospitalizations, and she was able to find long-term safe placement.
3. A client was discharged from the hospital and was very discouraged. Told the coordinator “I have been 8 years sober, but why bother. Today is my anniversary of my sobriety and no one cares.” The coordinator went out, bought a fancy cupcake, came back, and said “let’s celebrate together. I care.” And the client was sober another day.

The goals of the program are to help meet the member’s self-identified immediate needs, and to facilitate the member attaining preventive and chronic disease care, with less dependence on the emergency department. SFHP will be studying the impact on clinical outcomes (such as HEDIS measures), as well as utilization.

2. Improving clinical care through member outreach and incentives

SFHP credits part of our high quality scores to our direct outreach to our members. Among the most long-standing and effective interventions are the member incentive programs, where SFHP members receive gift cards for completing recommended care services such as annual well child visits or recommended tests for diabetes. Other interventions include live and automated phone call reminders for overdue care, and our ongoing work to provide health education materials and support for providers to teach patients how to manage their health and receive recommended care.

In 2013, SFHP piloted incentivizing pharmacists to encourage patients to refill asthma controller medication and to receive lab tests for members on anti-hypertensives (due to SFHP’s poor performance on these measures). Results showed 33% of asthma patients and 80% of members on anti-hypertensives received the needed intervention after counseling. SFHP will be testing the impact of involving pharmacies as part of the care team in a new Medication Therapy Management Program in 2014.

Member Incentives

Our member incentive programs began with incentives for well-adolescent visits (2002) and well-child visits (2003). Like other community health plans, we continue to redesign our incentives to accommodate new measures and address measures we want to improve. The table below shows the HEDIS measures and activities of our six current incentive programs

SFHP HEDIS Measure Incentives			
HEDIS Measure	Eligible Members, Required Services	SFHP Incentive Program	2013 Member Response Rate
Prenatal Care	Expectant mothers. Must attend a prenatal medical visit during first trimester, or within 42 days of SFHP enrollment.	General women’s health mailer to all female members includes description of incentive. Members may call for incentive card. SFHP also does live outreach calls to women who are pregnant. If provider signs, member receives \$25 gift card.	62% of eligible members submitted a card that qualified them for the incentive gift card.
Postpartum Care	New mothers. Must attend a postpartum medical visit within 3 to 8 weeks of delivery.	General women’s health mailer to all female members includes description of incentive. Members may call for incentive card. SFHP also does live outreach calls to women using list of recent births. \$25 gift card.	53% of eligible members submitted a card that qualified them for the incentive gift card.
Childhood Immunizations	Children up to their second birthday. Must receive all doses for 10 immunizations: DTaP, Flu, HepA, HepB, HiB, MMR, Polio, Pneumococcal, Rotavirus, Varicella	Incentive-specific mailer to all eligible member-parents includes card for provider to sign for complete immunizations. Live and automated reminder calls to member-parents reminding them to make/keep appointments and reminder of incentive. \$50 gift card.	14% of all eligible members returned fully completed cards that qualified for the incentive gift card.
Well-child Visits	Children between ages of 3 to 6. Must attend a well-child medical visit within the calendar year.	Mailer to all eligible member-parents each year at child’s birthday. Automated phone call reminders go out just prior to mailing. \$25 gift card.	32% of eligible members returned fully completed cards that qualified for the incentive gift card.
Comprehensive Diabetes Care	Members with diabetes, ages 18 to 75. Must receive six screening tests in the year: hemoglobin A1c, blood pressure, cholesterol (LDL-C), neuropathy, eye exam, diabetic foot exam.	Mailer to all eligible members includes card for provider to sign attesting to the completion of the six required screening tests. \$25 gift card.	12% of all eligible members returned an incentive card. Of these, 54% qualified for the incentive gift card.

Additional HEDIS Measures Outreach

To support and supplement the HEDIS incentives programs detailed above, SFHP engages in targeted interventions for many more HEDIS measures. Some of these activities are described below.

Comprehensive Diabetes Care: In addition to the Diabetes Care incentive program, we reach out to members directly who are overdue for interventions, with call centers conducting the calls after hours with detailed scripts.

Automated Outreach Calls: SFHP reaches out to members to remind them of needed care and of incentive programs through automated calls throughout the year.

Population Outreach Lists: Along with the automated calls, lists of SFHP members who have not received care are provided to clinics and providers, to encourage them to call their patients directly. Providers are asked to provide feedback on how they use these lists, to allow us to tailor these lists by site or by provider in the future.

Leveraging an Optometry Vendor Relationship to Improve Chronic Care

In 2010, our optometry vendor offered to do direct outreach to members who are overdue for an eye exam. The vendor has also worked with optometry offices to institute diabetic screening, to capture undiagnosed diabetics and refer them to primary care.

Member Health Education and Cultural and Linguistic Services

SFHP develops health education materials tailored to our members, in English, Spanish, Chinese, Vietnamese, and Russian, among other languages, often in response to provider requests. We also mail these educational materials directly to members, and we also distribute materials to provider practices. Examples include translating existing pertussis (whooping cough) education materials for parents of infants and young children into Vietnamese, and printing full-color child oral health screening and treatment guidelines posters in four languages for posting in pediatric primary care sites. Health education fact sheets on a variety of health topics are available on the Health and Wellness section of our website, in addition to information on preparing for a clinic visit, clinic-based health education classes, and other health education programs in San Francisco. SFHP also offers a free opt-in health text messaging program for our members living with diabetes or asthma. The SFHP member newsletter is distributed quarterly, with topics identified by our Member Advisory Committee, our health educator, and our provider network Quality Improvement Committee.

3. Improving HEDIS performance through aggressive data capture

Performance cannot be evaluated without accurate information. Optimum scores cannot be achieved without exploiting all data sources, and encounter data from our capitated network is often incomplete. Aggressive data capture is SFHP's third strategy for achieving high HEDIS scores. Some of these are year-round pursuits, while some occur during the HEDIS audit season.

Monthly Metrics Review of HEDIS Data

The manager of clinical quality closely tracks HEDIS administrative rates each month, so the team can act quickly if the rates are trending lower than previous years. Where there is a difference of

3% or more, the team investigates this discrepancy through detailed analysis of provider submissions, to identify if it is a data problem or a care delivery problem. This analysis informs our action plan, so we can target the solution to the appropriate problem, either focused on a particular medical group, or a SFHP department.

We also analyze trended claims and encounter volume monthly, by provider group, to identify any specific data issues well in advance of HEDIS season. When problems are identified, our Information Technology Services Department contacts data submitters to facilitate improved data quality and timeliness.

This regular analysis is important, as it is one way to act on data issues within the HEDIS measurement year. We can uncover any problems with data submissions or care delivery and act quickly to correct them. We don't have to play wait-and-see until the annual HEDIS audit to know where to improve.

Intensive Data Capture Efforts During HEDIS Season

Every year, SFHP adds new strategies to ensure that we get credit for all clinical care that is done, as data quality issues lead to incomplete administrative data. Examples of strategies include:

- Deeming new databases as administrative sources, such as the California Immunization Registry and the local chronic disease registry (i2i), and the SF Department of Public Health Electronic Health Record
- Taking advantage of every data source, such as disease registries and lab feeds.
- Paperless pursuit, using secure iPhones to capture chart records. This intervention greatly improved the efficiency of the data collection efforts.

SFHP believes the only way to ensure rigorous pursuit is to have the team in-house. We hire clinical and administrative staff to work full-time at SFHP during HEDIS pursuit season, and the team leader deliberately cultivates a culture of cohesion, passion, inventiveness, creativity, and resourcefulness. Their mission-driven enthusiasm is infectious, and they build strong relationships with staff in the provider practices (with kind words, appreciation, and cupcakes), which translates into improved cooperation with chart pulls. They also cultivate an attitude of “we will go to the end of the earth to find a positive hit,” and there was almost a sports-like team spirit to every successful find. Staff called Indonesia and China looking for confirmation of completed immunizations. We also have been experimenting with the ideal team composition, such as training medical assistants to perform chart reviews that had formally been done by nurses. The SFHP chief medical officer consistently stays available for chart over-reads, questions and encouragement, demonstrating leadership commitment to the importance of the project, and calling recalcitrant providers when they don't respond to staff record requests.

Quality is a top organizational priority: staff communications and bonuses

SFHP attributes its success to the fact that there is consistent CEO and executive support for making quality a top priority at SFHP. Review of our mission and organizational goals is emphasized at all staff meetings. The importance of HEDIS scores as a measure of quality is a consistently repeated to all SFHP staff.

For many years, all SFHP staff received a modest incentive bonuses based on HEDIS results. In 2009, this program was phased out and replaced with a broader staff incentive program that emphasizes results on metrics for a broader set of goals. In the current program, SFHP staff receive an annual bonus based on success in three areas:

- **Organizational goals and metrics**, reviewed and approved annually by our Governing Board.
- **Department goals and metrics**, reviewed and approved by the Executive Team.
- **Individual goals** (3-5 different goals for every staff member, created by the staff member and their manager, revised annually)

SFHP believes the reinforcement of mission with goals, metrics, and staff bonuses based on performance, contributes to our high quality scores.

Summary

At San Francisco Health Plan, we take pride in the many ways we partner with our provider network to continue to improve quality and access to care. We follow the Model for Improvement; since it is not always clear what is the best way to achieve a goal, we frequently pilot interventions, measure the outcomes, and then revise our approach. We have benefitted greatly from learning from other health plans and providers, so we hope this paper is helpful in demonstrating what we have learned, and what we are continuing to learn. Please let us know if you would like any more detailed information on any of the programs we described.

For More Information	
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