Performance Evaluation Report

San Francisco Health Plan

July 1, 2009–June 30, 2010

Medi-Cal Managed Care Division
California Department of
Health Care Services

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1. Introduction

Purpose of Report

The Department of Health Care Services (DHCS) administers the Medi-Cal Managed Care (MCMC) Program to approximately 4 million beneficiaries (as of June 2010)[1] in the State of California through a combination of contracted full-scope and specialty managed care plans. The DHCS is responsible for assessing the quality of care delivered to members through its contracted plans, making improvements to care and services, and ensuring that contracted plans comply with federal and State standards.

Federal law requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services plans provide. The EQRO's performance evaluation centers on federal and State-specified criteria that fall into the domains of quality, access, and timeliness. The EQRO assigns compliance review standards, performance measures, and quality improvement projects (QIPs) to the domains of care. The report must contain an assessment of the strengths and weaknesses of the plans, provide recommendations for improvement, and assess the degree to which the plans addressed any previous recommendations.

The DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report. Due to the large number of contracted plans and evaluative text, HSAG produced an aggregate technical report and plan-specific reports as follows:

- The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of plans' performance through organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care.
- Plan-specific evaluation reports include findings for each plan regarding its organizational assessment and structure, performance measures, QIPs, and optional activities, such as member satisfaction survey results, as they relate to the quality, access, and timeliness domains of care. Plan-specific reports are issued in tandem with the technical report.

[1] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

This report is specific to the MCMC Program's contracted plan, San Francisco Health Plan ("SFHP" or "the plan"), which delivers care in San Francisco County, for the review period of July 1, 2009, through June 30, 2010. Actions taken by the plan subsequent to June 30, 2010, regarding findings identified in this report will be included in the next annual plan-specific evaluation report.

Plan Overview

SFHP is a full-scope managed care plan in San Francisco County that serves members as a local initiative (LI) under the Two-Plan Model. SFHP has been Knox-Keene licensed since 1996. Knox-Keene licensure is granted by the Department of Managed Health Care (DMHC) to plans that meet minimum required standards according to the Knox-Keene Health Care Service Plan Act of 1975. The act includes a set of laws that regulate managed care organizations (MCOs).

In a Two-Plan Model county, the DHCS contracts with two managed care plans in each county to provide medical services to members. Most counties offer an LI plan and a nongovernmental, commercial health plan.

Members of the MCMC Program in both counties may enroll in either the LI plan operated by SFHP or in the alternative commercial plan. SFHP became operational with the MCMC Program in January 1997, and as of June 30, 2010, SFHP had 38,147 MCMC members.[2]

[2] *Medi-Cal Managed Care Enrollment Report—June 2010*. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

Conducting the Review

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards.

The DHCS conducts this review activity through an extensive monitoring process that assesses plans' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers the DHCS's medical performance and member rights review activities. These reviews occur independently of one another, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed results from the DHCS's compliance monitoring reviews to draw conclusions about SFHP's performance in providing quality, accessible, and timely health care and services to its MCMC members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Medical Performance Review

Medical performance reviews are often a collaborative effort by various State entities. The DHCS's Audits and Investigations Division (A&I) and the Medical Monitoring Unit (MMU) of the Medi-Cal Managed Care Division often work in conjunction with the Department of Managed Health Care (DMHC) to conduct joint audits of MCMC plans. In some instances, however, medical performance audits are conducted solely by the DHCS or DMHC. These medical audits assess plans' compliance with contract requirements and State and federal regulations. A medical performance audit is conducted for each MCMC plan approximately once every three years.

HSAG reviewed the most current medical performance review reports available as of June 30, 2010, to assess plans' compliance with State-specified standards. A&I and DMHC conducted a medical performance review of SFHP from March 23, 2009, through April 1, 2009 covering the review period of February 1, 2008, through January 31, 2009.[3]

The 2009 review identified strengths as well as deficiencies across all categories, including the Hyde contract requirements. Hyde contract covers abortion services funded only with State funds, as these services do not qualify for federal funding. Most review findings were resolved based on corrective actions taken by the plan.

Utilization Management

Under the utilization management area, the plan was fully compliant with its utilization management program, and delegation of utilization management. SFHP also met review requirements for ensuring that qualified health care professionals supervise review decisions and a physician reviews all denials. Medical review findings related to utilization management are listed below.

- The plan's prior authorization Notice of Action (NOA) letters did not contain the DMHC contact information in the proper format. The plan amended the letters and the issue was considered resolved.
- The plan had not implemented a system to track prior authorization referrals through completion, which was a repeat finding. Within its corrective action plan (CAP), SFHP developed a report to identify all referrals requiring authorization and matched them to claims submitted for referral visits. The plan would flag remaining referrals as outstanding or open and notify the requesting provider to follow up with the member. Within the medical review close-out letter, the MMU indicated that the plan submitted a summary report showing that during the period of July 1, 2009, through December 31, 2009, standing referrals were tracked and providers were notified when a claim had not been submitted for an outstanding referral. The MMU indicated that the issue was still unresolved because the plan did not submit supportive documentation to verify that referrals were tracked as required (the summary report did not allow the MMU to confirm that the corrective action fully resolved the issue).
- A review of 10 appeals found that in one instance, the physician who completed the appeal was the same physician who made the initial denial. The plan was instructed to ensure that first-level appeals are reviewed by a physician other than the one that made the initial denial decision. The plan revised the policy to require a different physician to review appeals. Within the medical close-out letter, however, the MMU indicated that the finding was not corrected. As part of the follow-up to the CAP, the plan submitted a summary report which indicated that 11 of 16 denials were reviewed by a second reviewer; however, the remaining five appeals were reviewed and processed by the medical director who made the initial decision. The plan considered itself

[3] *California Department of Health Care Services Medical Review – Northern Section, Audits and Investigations, SFHP*, September 30, 2009.

still compliant with the DMHC/DHCS approved policy for processing appeals. The MMU indicated that it was unable to verify how the 16 appeals were processed because the plan did not submit its appeal log. In addition, the plan's process for handling appeals was not compliant with requirements for adjudicating appeals fairly and thoroughly. Appeals must be processed by a physician other than the one who made the initial decision.

Continuity of Care

Under the continuity of care area, SFHP was fully compliant with requirements for coordination of care within and outside of the network, systems to identify children who may be eligible for the Early Start program, and procedures to identify members with developmental disabilities.

SFHP was cited for not reporting Initial Health Assessment (IHA) completion information to the Quality Committee. In addition, the plan had internal discrepancies with IHA completion counts between information collected on its facility site reviews and other internal IHA completion reports. Finally, the plan's policy and procedure did not specify the 60-day requirement for completion of the IHA and Initial Health Education Behavioral Assessment (IHEBA) for members under 18 months of age. The plan modified its policy and procedure and reported IHA information to the Quality Committee as part of its corrective action. Within the close-out letter, the MMU indicated that the issue was fully resolved.

Access and Availability

Under the access and availability area, SFHP was fully compliant with requirements related to provider network adequacy, access to emergency medical care, and telephone access procedures. SFHP also quickly resolved an issue with an outdated policy describing how the plan monitors the time and distance standard for PCPs, hospitals, and ancillary care facilities. Medical review findings related to access and availability are listed below.

- The plan produced a summary report of wait time studies for its contracted medical groups; however, the plan's largest medical group did not have any wait time studies conducted. In addition, the plan noted within its Quality Improvement Program Evaluation an upward trend of access-related grievances. Many of the access grievances involved the plan's largest medical group. SFHP created an internal access work group to focus on four key areas impacting access (primary care assessments, front office customer service training assessment, comparative provider-level data, and provider specific satisfaction data). The MMU indicated the finding was fully corrected in the medical performance review close-out letter.
- The plan did not send NOA letters to members regarding denials of emergency room claims or family planning services. The plan indicated that it believed that sending out denial letters to Medi-Cal members might cause confusion since the plan cannot bill the member. The plan amended the policy and submitted summary documentation of an internal audit indicating full compliance with sending out NOA letters for denied emergency room claims. An internal audit

of the requirement for sending NOA letters for family planning service denials noted a programming error that caused the plan not to be fully compliant. Within the close-out letter, the MMU stated that the issue was not corrected because the plan did not submit any supportive documentation to substantiate the internal audit findings, and the programming error required resolution.

- SFHP was cited for insufficient monitoring of after-hours access to prescription drugs, a repeat finding. The medical performance review findings indicated that the plan's process for monitoring access through member grievances was considered a passive system; and, in addition, the plan's number of after-hours pharmacy providers had been significantly reduced. Within its CAP, the plan indicated that the Utilization Management Department would produce and review a semi-annual report to monitor and trend after-hours pharmacy services; however, the plan did not include a policy and procedure for monitoring and oversight of after-hours pharmacy needs. The close-out letter indicated that a policy and procedure was developed but was pending DHCS's approval. In addition, the MMU indicated that the issue remained unresolved because SFHP did not submit documentation to support the implementation process that was described.

Member Rights

Under the area of member rights, SFHP was fully compliant with requirements for online access to the grievance process and cultural and linguistic services. Under the Confidentiality Rights standard, the plan had developed new policies related to the reporting of breaches of personal health information, which had not been submitted to the DHCS for approval. The plan submitted the policies, which were approved by the DHCS, and the issue was considered fully resolved.

The plan's member handbook was also missing information related to informing members of their right to request an independent medical review. The plan revised the appropriate section of the member handbook and MMU considered the finding fully resolved.

SFHP had several findings related to grievances. The plan was cited for an inadequate medical oversight mechanism in the grievance process. Verification studies also indicated that the medical director did not review all clinical grievances. The Quality Improvement Committee's board meeting minutes indicated that a review of grievance data was not always included as a discussion item. The plan's member handbook did not contain DHMC-required statutory language, and the plan's grievance letter templates did not display the DHMC contact information. The plan revised its policies and procedures and grievance review process to address the review findings. The plan also revised the member handbook and grievance letter templates to contain the required information. As of the close-out letter, the plan still had issues with ensuring full compliance with review of clinical grievances, and the MMU considered the finding as not corrected.

Quality Management

Under the area of quality management, SFHP was fully compliant with requirements for its quality improvement system, provider qualifications, credentialing and recredentialing, provider disciplinary actions, and delegation of quality improvement activities.

Under delegated credentialing, the review noted that there was no evidence that the plan performed oversight and monitoring of the pharmacy benefit manager's (PBM's) credentialing process. The plan implemented a new policy and procedure, which was approved by the DHCS, and the MMU considered the finding fully resolved.

The medical performance review also noted issues related to documentation of the QI Committee meeting activities and review of meeting minutes by the governing board. Within the close-out letter, the MMU noted that all findings were fully resolved.

Administrative and Organizational Capacity

Under the area of administrative and organizational capacity, a verification study found that the medical director had not reviewed all grievances related to medical quality of care issues, as required. The plan revised its policy and procedure and performed an internal review to determine compliance with the new process. Initially, the internal review noted some deficiencies and the plan subsequently implemented additional corrective actions. SFHP performed a second internal audit of nine grievances and noted 100 percent compliance. The MMU close-out letter, however, indicated that, because the plan did not submit documentation to support the internal audit findings, the issue was not resolved and remained an uncorrected finding.

MCMC plans are required to ensure that all providers receive training regarding the Medi-Cal Managed Care Program within ten working days after a provider is newly effective with the plan. SFHP sent all new prospective providers the required training information with their credentialing application. The plan instructed the providers to submit a form attesting that the provider reviewed the training materials. Once the provider was approved for active status, the plan considered the required training completed. A verification study noted that the signed attestation forms acknowledging receipt of training materials ranged from 14 days to over nine months prior to becoming active with the plan. This process did not meet the DHCS contract of ensuring training was performed within 10 days after active status was granted, which was a repeat finding for the plan.

SFHP revised its policy and implemented mechanisms to ensure that all providers, including those credentialed by delegated medical groups, received training within 10 days of their active status. The plan performed oversight audits of its seven medical groups to ensure compliance with the new process. The plan found that two groups were 100 percent compliant, two received CAPs, and one had no new providers. The two remaining groups, however, trained front office staff and nursing personnel, arguing that their providers did not interact directly with members regarding

health plan procedures. SFHP allowed these groups to proceed with their established process. Within the close-out letter, the MMU noted the finding remained uncorrected because the plan did not submit supportive documentation to verify its oversight audit results. Furthermore, the MMU documented that the two groups were in violation of contractual requirements, which clearly stated that the training must be delivered to providers.

Also under the area of administrative and organizational capacity, the medical performance review cited SFHP's procedures for fraud and abuse reporting. A review of the plan's compliance program noted that the program implementation did not reflect the level of proactive interventions for fraud and abuse compared to the written program description. The review noted that the plan's Pharmacy Department had not yet determined the criteria for working with the PBM on internal utilization reports that may assist in detecting fraud and abuse. Within its CAP, SFHP revised the compliance program and created a new position to conduct internal audits to target potential fraud and abuse. While the MMU noted the plan's efforts on resolving this issue, the revised compliance program was not yet approved by the plan's governing board or the DMHC, and the MMU could not verify the implementation and monitoring procedures of the revised program.

SFHP was fully compliant with its processes for ensuring that medical decisions are not unduly influenced by financial or administrative conflicts of interest.

State Supported Services

The State Supported Services contract, also referred to as the Hyde contract, covers abortion services. The medical performance review noted that the plan's Evidence of Coverage and Disclosure Form and the Medical Group Operations Manual (i.e., the provider manual) had conflicting and incorrect language regarding access to abortions and sterilization services. Within the close-out letter, the MMU indicated that the plan had corrected the language in both documents; and the issue was fully resolved.

Medi-Cal Managed Care Member Rights and Program Integrity Review

The Medi-Cal Managed Care Program's Member Rights/Program Integrity Unit (MRPIU) is responsible for monitoring plan compliance with contract requirements and State and federal regulations pertaining to member rights and program integrity. To accomplish this, MRPIU reviews and approves plans' written policies and procedures for member rights (such as member grievances, prior-authorization request notifications, marketing and enrollment programs, and cultural and linguistic services) and for program integrity (fraud and abuse prevention and detection). These member rights reviews are conducted before a plan becomes operational in the MCMC Program, when changes are made to policies and procedures, during contract renewal, and if the plan's service area is expanded.

As part of the monitoring process, MRPIU conducts an on-site member rights review of each plan approximately every two years and follow-up visits when necessary to address unresolved compliance issues and provide technical assistance. For this report, HSAG reviewed the most current MRPIU plan monitoring reports available as of June 30, 2010.

MRPIU conducted an on-site review of SFHP in March 2010 covering the review period of January 1, 2009, through December 31, 2009. The plan was fully compliant with requirements related to marketing, program integrity, and detecting and reporting potential cases of fraud and abuse.

The MRPIU noted two findings and two issues that were considered to be technical assistance issues. Both of the review findings related to cultural and linguistic services. The MRPIU visited ten provider offices and noted that the staff in two offices indicated that they did not discourage the use of family, friends, or minors as interpreters. Contract requirements indicate that plans must not suggest that limited-English-speaking members provide their own interpreters. Furthermore, the use of family, friends, or minors may compromise the accuracy of the medical information that is exchanged. Secondly, the plan was cited because staff members in two of the ten provider offices indicated that they did not document the request for, or refusal of, language interpreter services, another contract requirement.

The MRPIU noted two areas that required technical assistance but were not cited as formal review findings. The first related to member grievances. A review of 50 member grievance files found one written notice of action letter that was written in the member's preferred language; therefore, the MRPIU reviewer could not verify that the language met contract requirements (the letter should contain a clear and concise explanation of the plan's decision). The second technical assistance issue related to prior authorization. One of 46 prior authorization files contained a notice of action letter with an incorrect date. In both cases, the MRPIU provided SFHP with technical assistance to ensure full compliance.

Strengths

While SFHP had multiple findings, especially from the medical performance review, the plan made a concerted effort to address and resolve all deficiencies. The plan was able to resolve several findings as of the date the close-out letter was produced.

Opportunities for Improvement

SFHP demonstrated multiple opportunities for improvement. The plan should ensure all open review issues are fully resolved, particularly the areas in which current procedures put SFHP at risk for continued violation of a contract requirement. These include appeal procedures, monitoring access to after-hours pharmaceutical services, and provider training protocols. The plan should routinely monitor the status of all corrective actions to ensure they were effective in resolving review findings. For future reviews, SFHP should proactively provide detailed documentation to support all internal monitoring and audit activities to further demonstrate full compliance.

Conducting the Review

The DHCS selects a set of performance measures to evaluate the quality of care delivered by contracted plans to Medi-Cal managed care members on an annual basis. These DHCS-selected measures are referred to as the External Accountability Set (EAS). The DHCS requires that plans collect and report EAS rates, which provide a standardized method for objectively evaluating plans' delivery of services.

HSAG conducts validation of these performance measures as required by the DHCS to evaluate the accuracy of plans' reported results. Validation determines the extent to which plans followed specifications established by the MCMC Program for its EAS-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about SFHP's performance in providing quality, accessible, and timely care and services to its MCMC members. The selected EAS measures fell under all three domains of care—quality, access, and timeliness.

Performance Measure Validation

The DHCS's 2010 EAS consisted of Healthcare Effectiveness Data and Information Set (HEDIS®) measures; therefore, HSAG performed a HEDIS Compliance Audit™ of SFHP in 2010 to determine whether the plan followed the appropriate specifications to produce valid rates.[4] Based on the results of the compliance audit, HSAG found all measures to be reportable and did not identify any areas of concern.

[4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Results

In addition to validating the plan's HEDIS rates, HSAG also assessed the results. The following table displays a HEDIS performance measure name key with abbreviations contained in Table 3.2.

Table 3.1—HEDIS® 2010 Performance Measures Name Key

Abbreviation	Full Name of HEDIS® 2010 Performance Measure
AAB	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
AWC	*Adolescent Well-Care Visits*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
CDC–BP	*Comprehensive Diabetes Care (CDC)—Blood Pressure Control (140/90 mm Hg)*
CDC–E	*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
CDC–H8 (<8.0%)	*Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (< 8.0 Percent)*
CDC–H9 (>9.0%)	*Comprehensive Diabetes Care—HbA1c Poor Control (> 9.0 Percent)*
CDC–HT	*Comprehensive Diabetes Care—HbA1c Testing*
CDC–LC (<100)	*Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
CDC–LS	*Comprehensive Diabetes Care—LDL-C Screening*
CDC–N	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
CIS–3	*Childhood Immunization Status—Combination 3*
LBP	*Use of Imaging Studies for Low Back Pain*
PPC–Pre	*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
PPC–Pst	*Prenatal and Postpartum Care—Postpartum Care*
URI	*Appropriate Treatment for Children With Upper Respiratory Infection*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC–BMI	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—BMI Assessment: Total*
WCC–N	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Nutrition Counseling: Total*
WCC–PA	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents—Physical Activity Counseling: Total*

Table 3.2 presents a summary of SFHP's HEDIS 2010 performance measure results (based on calendar year [CY] 2009 data) compared with HEDIS 2009 performance measure results (based on CY 2008 data). In addition, the table shows the plan's HEDIS 2010 performance compared with the MCMC-established minimum performance levels (MPLs) and high performance levels (HPLs).

For all but one measure, the MCMC Program based its MPLs and HPLs on the National Committee for Quality Assurance's (NCQA's) national Medicaid 25th percentile and 90th percentile, respectively. For the CDC–H9 (>9.0 percent) measure, a low rate indicates better performance and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile and the HPL is based on the national Medicaid 10th percentile.

Table 3.2—2009–2010 Performance Measure Results for San Francisco Health Plan—San Francisco County

Performance Measure[1]	Domain of Care[2]	2009 HEDIS Rates[3]	2010 HEDIS Rates[4]	Performance Level for 2010	Performance Comparison[5]	MMCD's Minimum Performance Level[6]	MMCD's High Performance Level (Goal)[7]
AAB	Q	32.2%	46.6%	★★★	↑	20.2%	33.4%
AWC	Q,A,T	52.4%	60.6%	★★★	↑	37.9%	59.4%
BCS	Q,A	55.7%	60.3%	★★	↑	45.0%	63.0%
CCS	Q,A	80.6%	79.7%	★★★	↔	60.9%	79.5%
CDC–BP	Q	‡	74.1%	Not Comparable	Not Comparable	NA	NA
CDC–E	Q,A	73.1%	67.8%	★★	↓	44.4%	70.8%
CDC–H8 (<8.0%)	Q	‡	58.0%	Not Comparable	Not Comparable	NA	NA
CDC–H9 (>9.0%)	Q	25.9%	21.8%	★★★	↔	50.6%	29.2%
CDC–HT	Q,A	89.5%	89.7%	★★★	↔	76.5%	89.3%
CDC–LC (<100)	Q	47.4%	46.0%	★★★	↔	27.2%	44.7%
CDC–LS	Q,A	80.8%	82.8%	★★★	↔	71.5%	82.5%
CDC–N	Q,A	87.1%	85.9%	★★★	↔	73.4%	85.4%
CIS–3	Q,A,T	90.3%	87.0%	★★★	↔	62.4%	80.6%
LBP	Q	‡	85.1%	Not Comparable	Not Comparable	NA	NA
PPC–Pre	Q,A,T	92.3%	88.8%	★★	↔	78.5%	92.2%
PPC–Pst	Q,A,T	69.5%	66.4%	★★	↔	57.9%	72.7%
URI	Q	95.3%	97.2%	★★★	↑	81.1%	94.5%
W34	Q,A,T	82.4%	86.6%	★★★	↔	64.0%	80.3%
WCC–BMI	Q	‡	72.7%	Not Comparable	Not Comparable	NA	NA
WCC–N	Q	‡	74.5%	Not Comparable	Not Comparable	NA	NA
WCC–PA	Q	‡	55.8%	Not Comparable	Not Comparable	NA	NA

[1] DHCS-selected HEDIS performance measures developed by National Committee for Quality Assurance (NCQA).

[2] HSAG's assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

[3] HEDIS 2009 rates reflect measurement year data from January 1, 2008, through December 31, 2008.

[4] HEDIS 2010 rates reflect measurement year data from January 1, 2009, through December 31, 2009.

[5] Performance comparisons are based on the *z* test of statistical significance with a *p* value of <0.05.

[6] The MPL is based on NCQA's national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, the MPL is based on the national Medicaid 75th percentile because a higher rate indicates poorer performance.

[7] The HPL is based on NCQA's national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, the HPL is based on the national Medicaid 10th percentile because a lower rate indicates better performance.

‡ The DHCS did not require plans to report this measure in 2009.

★ = Below average performance relative to the national Medicaid 25th percentile. Note: For the CDC–H9 (>9.0%) measure, below average performance is relative to the Medicaid 75th percentile.

★★ = Average performance relative to national Medicaid percentiles (between the 25th and 90th percentiles). Note: For the CDC–H9 (>9.0%) measure, average performance is relative to the national Medicaid 10th and 75th percentiles.

★★★ = Above average performance relative to the national Medicaid 90th percentile. Note: For the CDC–H9 (>9.0%) measure, above average performance is relative to the national Medicaid 10th percentile.

↑= Statistically significant increase.

↓ = Statistically significant decrease.

↔ = Nonstatistically significant change.

Not Comparable = Performance could not be compared due to either significant methodology changes between years or because the rate was not reported.

Performance Measure Result Findings

Overall, SFHP demonstrated exceptional performance, achieving the HPL for 11 performance measures, statistically significant improvement in four, and no measures falling below the MPL. The plan had one measure that experienced a statistically significant decline.

HEDIS Improvement Plans

Plans have a contractual requirement to perform at or above the established MPLs. The DHCS assesses each plan's rates against the MPLs and requires plans that have rates below these minimum levels to submit an improvement plan to the DHCS. For each area of deficiency, the plan must outline steps to improve care.

For plan measure rates that required a 2009 HEDIS improvement plan, HSAG compared the plan's 2009 improvement plan with the plan's 2010 HEDIS scores to assess whether the plan was successful in achieving the MPL or progressing toward the MPL. In addition, HSAG assessed the plan's need to continue existing improvement plans and/or to develop new improvement plans.

None of SFHP's 2009 performance measure rates required an improvement plan.

Strengths

SFHP's strengths in the area of performance measures were numerous. The plan exceled at providing high-quality care across such areas as preventive screening, avoiding inappropriate antibiotic use, management of diabetic patients, and well-care visits for children and adolescents. In addition, despite high performance in 2009, the plan was able to achieve continued statistically significant improvement in several measures.

Opportunities for Improvement

SFHP should evaluate the factors that led to a statistically significant decline in its performance on the *Comprehensive Diabetes Care—Eye Exams* measure.

Conducting the Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas.

HSAG reviews each QIP using the Centers for Medicare & Medicaid Services' (CMS') validating protocol to ensure that plans design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, the DHCS and interested parties can have confidence in reported improvements that result from a QIP.

The *Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010*, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed validated QIP data to draw conclusions about SFHP's performance in providing quality, accessible, and timely care and services to its MCMC members.

Quality Improvement Projects Conducted

SFHP had one clinical QIP and one QIP proposal in progress during the review period of July 1, 2009, through June 30, 2010. The first QIP targeted the reduction of avoidable emergency room (ER) visits among members 12 months of age and older as part of the DHCS statewide collaborative QIP. SFHP's second project, an internal QIP, aimed to improve the patient experience. Both QIPs fell under the quality and access domains of care.

The statewide collaborative QIP sought to reduce ER visits that could have been more appropriately managed by and/or referred to a primary care provider (PCP) in an office or clinic setting. Accessing care in the primary care setting encourages timely preventive care to avoid or minimize the development of chronic disease.

SFHP selected two Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] measures as strategies to improve the patient experience. The measures related to: (1) the communication between physician and patient, and (2) the patient's overall rating of care. Improving doctor-patient communication is associated with improved adherence to physician recommendations and improved self-management skills.

[5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Quality Improvement Project Validation Findings

The table below summarizes the validation results for both of SFHP's QIPs across the CMS protocol activities during the review period.

Table 4.1—Quality Improvement Project Validation Activity for San Francisco Health Plan—San Francisco County July 1, 2009, through June 30, 2010

Name of Project/Study	Type of Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Statewide Collaborative QIP				
Reducing Avoidable Emergency Room Visits	Annual Submission	26%	10%	*Not Met*
	Resubmission	86%	100%	*Met*
Internal QIPs				
Improving the Patient Experience	Proposal	73%	63%	*Partially Met*
	Resubmission	73%	63%	*Partially Met*

[1] **Type of Review**—Designates the QIP review as a new proposal, annual submission, or resubmission. A resubmission means the plan was required to resubmit the QIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Beginning July 1, 2009, HSAG provided plans with an overall validation status of *Met, Partially Met,* or *Not Met.* In the prior review period (July 1, 2008, through June 30, 2009), HSAG provided plans with an overall status of *Not Applicable* since HSAG's application of the CMS validation requirements was more rigorous than previously experienced by the plans. HSAG provided training and technical assistance to plans throughout the prior review period to prepare plans for the next validation cycle (which began July 1, 2010).

Validation results during the review period of July 1, 2009, through June 30, 2010, showed that SFHP's annual submission of its *Reducing Avoidable Emergency Room Visits* QIP received an overall validation status of *Not Met.* Additionally, SFHP received a *Partially Met* validation status for its *Improving the Patient Experience* QIP proposal submission. As of July 1, 2009, the DHCS required plans to resubmit their QIPs until they achieved an overall *Met* validation status. Based on the validation feedback, the plan resubmitted the two QIPs and upon subsequent validation, achieved an overall *Met* validation status for the *Reducing Avoidable Emergency Room Visits* QIP and a *Partially Met* validation status for its *Improving the Patient Experience* QIP proposal. The plan's second

resubmission of the proposal fell outside of this review period; therefore, HSAG will include the validation results in the next evaluation report.

Table 4.2 summarizes the validation results for both of SFHP's QIPs across the CMS protocol activities during the review period. The validation scores presented in Table 4.2 reflect the last submission validated before June 30, 2010.

Table 4.2––Quality Improvement Project Average Rates* for San Francisco Health Plan
(Number = 2 QIP Submissions, 2 QIP Topics)
July 1, 2009, through June 30, 2010

QIP Study Stages	Activity	*Met* Elements	*Partially Met* Elements	*Not Met* Elements
Design	I: Appropriate Study Topic	100%	0%	0%
	II: Clearly Defined, Answerable Study Question(s)	100%	0%	0%
	III: Clearly Defined Study Indicator(s)	69%	31%	0%
	IV: Correctly Identified Study Population	100%	0%	0%
Design Total †		**88%**	**13%**	**0%**
Implementation	V: Valid Sampling Techniques (if sampling is used)	Not Applicable	Not Applicable	Not Applicable
	VI: Accurate/Complete Data Collection	100%	0%	0%
	VII: Appropriate Improvement Strategies	100%	0%	0%
Implementation Total		**100%**	**0%**	**0%**
Outcomes	VIII: Sufficient Data Analysis and Interpretation	75%	25%	0%
	IX: Real Improvement Achieved	25%	0%	75%
	X: Sustained Improvement Achieved	‡	‡	‡
Outcomes Total		**58%**	**17%**	**25%**

*The activity average rate represents the average percentage of applicable elements with a *Met, Partially Met,* or *Not Met* finding across all the evaluation elements for a particular activity.
‡ The QIP did not progress to this activity during the review period and could not be assessed.
†The sum of an activity or stage may not equal 100 percent due to rounding.

For the *Improving the Patient Experience* QIP proposal, only Activities I through V were required and therefore completed. SFHP submitted Remeasurement 1 data for its *Reducing Avoidable Emergency Room Visits* QIP; therefore, HSAG validated Activities I through IX. SFHP demonstrated an accurate application of the Design and Implementation stages, scoring 100 percent on all evaluation elements except for five of the six applicable activities. Activity III was scored down for the plan's incomplete definition/description of the second study indicator for its *Improving the Patient Experience* QIP. For the Outcomes stage, SFHP was scored lower in Activity VIII for the plan's lack of documentation of the statistical testing and inaccurate presentation of the results for its *Reducing Avoidable Emergency Room Visits* QIP. Additionally, the *Reducing Avoidable Emergency Room Visits* QIP did not demonstrate statistically significant improvement; therefore, SFHP received a score of 25 percent for Activity IX.

Quality Improvement Project Outcomes

Table 4.3 summarizes the QIP study indicator results and displays whether statistically significant improvement was achieved after at least one remeasurement period and whether sustained improvement was achieved after two remeasurement periods. Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

Table 4.3––Quality Improvement Project Outcomes for San Francisco Health Plan—San Francisco Health Plan July 1, 2009, through June 30, 2010

QIP #1—Reducing Avoidable Emergency Room Visits				
QIP Study Indicator	**Baseline Period (1/1/07–12/31/07)**	**Remeasurement 1 (1/1/08–12/31/08)**	**Remeasurement 2 (1/1/09–12/31/09)**	**Sustained Improvement¥**
Percentage of ER visits that were avoidable	16.3%	17.0%	‡	‡

QIP #2—Improving the Patient Experience				
QIP Study Indicator	**Baseline Period (4/5/10–4/16/10)**	**Remeasure-ment 1 (4/5/11–4/16/11)**	**Remeasure-ment 2 (4/5/12–4/16/12)**	**Sustained Improvement¥**
1) Percentage of patients surveyed within the measurement period in five (5) pilot clinics who selected the top response choice ("Yes, definitely") from the communication items that comprise the communication composite on the Clinician-Group CAHPS Visit Survey	‡	‡	‡	‡
2) Percentage of patients surveyed within the measurement period in five (5) pilot clinics who selected a "9" or "10" on the survey item, "Overall Ratings of Care" on the Clinician-Group CAHPS Visit Survey	‡	‡	‡	‡

‡The QIP did not progress to this phase during the review period and could not be assessed.
¥ Sustained improvement is defined as improvement in performance over baseline, which is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect improvement when compared to the baseline results.

In the *Reducing Avoidable ER Visits* QIP, SFHP reported an increase in the percentage of avoidable ER visits; however, the increase was not statistically significant and could have been due to chance. An increase for this measure reflects a decline in performance. Since collaborative interventions were not initiated until early 2009, HSAG could not evaluate the effectiveness of those interventions.

For SFHP, the *Improving the Patient Experience* QIP had not progressed to the point of producing study indicator results.

Strengths

SFHP demonstrated an effective application of the QIP process for QIP topic selection, the development of study questions, and the definition of the study population. Additionally, SFHP implemented accurate data collection methods and appropriate improvement strategies.

Opportunities for Improvement

SFHP has an opportunity to improve its QIP documentation to increase compliance with the CMS protocol for conducting QIPs. HSAG recommends that the plan uses HSAG's QIP Completion Instructions, which will help the plan document all required elements within the CMS protocol activities. SFHP should incorporate the recommendations provided in the QIP Validation Tool when it resubmits QIPs to avoid the need for a second resubmission.

SFHP should include methods to evaluate the efficacy of any interventions implemented, thereby using data to support decisions regarding the revision or continuation of interventions.

Conducting the Review

In addition to conducting mandatory federal activities, the DHCS periodically assesses the perceptions and experiences of Medi-Cal Managed Care (MCMC) members as part of its process for evaluating the quality of health care services provided by plans to MCMC members. To evaluate member satisfaction with care and services, the DHCS contracted with HSAG to administer CAHPS health plan surveys.

The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DHCS requires that CAHPS Surveys be administered to both adult members and the parents or caretakers of child members at the county level unless otherwise specified. In 2010, HSAG administered standardized survey instruments, CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys, to members of all 20 MCMC full-scope regular plans, which resulted in 36 distinct county-level reporting units.

The Medi-Cal Managed Care Program Technical Report, July 1, 2009–June 30, 2010, provides an overview of the objectives and methodology for conducting the EQRO review.

Findings

HSAG organized, aggregated, and analyzed CAHPS data to draw conclusions about SFHP's performance in providing quality, accessible, and timely care and services to its MCMC members. HSAG evaluated data on the four CAHPS global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

CAHPS Composite Measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

National Comparisons

In order to assess the overall performance of the MCMC Program, HSAG calculated county-level results and compared them to the National Committee for Quality Assurance's (NCQA's) HEDIS® benchmarks and thresholds or NCQA's national Medicaid data, when applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating (i.e., *Poor*) and five being the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 5.1.

Table 5.1—Star Ratings Crosswalk

Stars	Adult Percentiles	Child Percentiles
★★★★★	≥ 90th percentile	≥ 80th percentile
★★★★	75th percentile–89th percentile	60th percentile–79th percentile
★★★	50th percentile–74th percentile	40th percentile–59th percentile
★★	25th percentile–49th percentile	20th percentile–39th percentile
★	< 25th percentile	< 20th percentile

Table 5.2—San Francisco Health Plan—San Francisco County Medi-Cal Managed Care County-Level Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Adult	★	★	★	★
Child	★★	★	★	★+

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Table 5.3— San Francisco Health Plan—San Francisco County Medi-Cal Managed Care County-Level Composite Measures

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
Adult	★	★	★	★+	★
Child	★	★	★	★+	★

+The health plan had fewer than 100 respondents for the measure; therefore, caution should be exercised when evaluating these results.

Strengths

SFHP has focused one of its QIPs on improving the patient experience, which will hopefully improve its future CAHPS results.

Opportunities for Improvement

SFHP's CAHPS results showed poor performance for all child and adult global rating categories and composite measures. HSAG conducted an analysis of key drivers of satisfaction that focused on the top three highest priorities based on the plan's CAHPS results. The purpose of the analysis was to help decision makers identify specific aspects of care that are most likely to benefit from quality improvement (QI) activities. Based on the key driver analysis, HSAG identified the following measures as SFHP's highest priorities: *Rating of All Health Care, Customer Service,* and *Getting Needed Care*. The plan should review the detailed recommendations for improving member satisfaction in these areas, which HSAG outlined in the *Medi-Cal Managed Care Program—2010 SFHP CAHPS Plan-Specific Report*. Areas for improvement spanned the quality, access, and timeliness domains of care.

Overall Findings Regarding Health Care Quality, Access, and Timeliness

Quality

The quality domain of care relates to a plan's ability to increase desired health outcomes for Medi-Cal managed care members through the provision of health care services and the plan's structural and operational characteristics.

The DHCS uses the results of performance measures and quality improvement projects (QIPs) to assess care delivered to members by a plan in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, the DHCS monitors aspects of a plan's operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. Finally, some member satisfaction measures relate to quality of care.

The plan showed average to above-average performance based on SFHP's 2010 performance measure rates (which reflect 2009 measurement data), QIP outcomes, member satisfaction survey results, and the results of the medical performance and member rights reviews as they related to measurement and improvement. The plan achieved statistically significant improvement on four measures and met or exceeded the HPL on eleven. The plan had one measure, *Comprehensive Diabetes Care—Eye Exams,* which experienced a statistically significant decline. All measures fell under the quality domain. At the time this performance evaluation was conducted, SFHP was considered the top performing MCMC plan with respect to performance measures.

Conversely, SFHP performed poorly in both adult and child satisfaction surveys in both the composite and global ratings for measures of quality, inferring that plan members did not perceive that they received high-quality care.

The plan had issues with ensuring that the medical director reviewed all potential quality of care grievances, based on the medical performance review.

QIP results showed that the plan experienced a decline in performance in its *Reducing Avoidable Emergency Room Visits* QIP. The plan had opportunities to improve its QIP documentation to ensure compliance with the CMS protocol for conducting valid and reliable QIPs.

Access

The access domain of care relates to a plan's standards, set forth by the State, to ensure the availability of and access to all covered services for Medi-Cal managed care members. The DHCS has contract requirements for plans to ensure access to and the availability of services to members. The DHCS uses monitoring processes, including audits, to assess a plan's compliance with access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and coverage of services.

Performance measures, QIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because members rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

The plan demonstrated average performance based on a review of 2010 performance measure rates that related to access, QIP outcomes, results of the medical performance and member rights reviews related to the availability and accessibility of care, and member satisfaction results. Of the 11 performance measures that relate to access, SFHP had seven that achieved the HPL and two that achieved a statistically significant improvement. One measure that falls under the access domain experienced a statistically significant decline, although the rate did not fall below the MPL.

Member satisfaction related to access was low across adult and child global and composite ratings.

For access-related compliance standards, the medical performance review noted an increase in member grievances related to access. In addition, the plan was cited for insufficient monitoring of its after-hours prescription drug services.

Finally, the plan reported a decline in the first remeasurement of its *Reducing Avoidable Emergency Room Visits* QIP.

Timeliness

The timeliness domain of care relates to a plan's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

The DHCS has contract requirements for plans to ensure timeliness of care and uses monitoring processes, including audits, to assess plans' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because

they relate to providing a health care service within a recommended period of time after a need is identified.

SFHP exhibited average performance in the timeliness domain of care based on 2010 performance measure rates for providing timely care, medical performance and member rights reviews related to timeliness, and member satisfaction results related to timeliness.

Performance measure rates showed that the plan met or exceeded the HPL for three of the five measures that fall under the timeliness domain.

Member satisfaction results showed that the plan demonstrated poor performance in the global and composite ratings related to timeliness for both adult and child populations. This suggested that members perceived that they did not always receive timely care.

SFHP had an unresolved deficiency related to ensuring all providers receive training on the Medi-Cal Managed Care Program within the required time frame.

Follow-Up on Prior Year Recommendations

The DHCS provided each plan an opportunity to outline actions taken to address recommendations made in the 2008–2009 plan-specific evaluation report. SFHP's self-reported responses are included in Appendix A.

Conclusions and Recommendations

Overall, SFHP achieved average to above-average performance during this review period in the quality domain, and average performance in the access and timeliness domains. Overall, the plan provided high-quality, accessible, timely health care services to its MCMC members.

At the time this performance evaluation was conducted, SFHP was the top-performing plan with respect to performance measures; however, member satisfaction results across all areas were particularly poor. The plan had numerous findings across all contract compliance areas, with several open deficiencies. The plan proposed a QIP targeting member satisfaction, demonstrating a concerted effort to improve performance in that area.

Based on the overall assessment of SFHP in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following:

- Ensure that all open medical performance review deficiencies are fully resolved and maintain clear evidence of the implementation of corrective actions.
- Carefully monitor member grievances related to access issues and implement targeted actions to resolve any potential access to care issues.

- Ensure that monitoring of after-hours access to prescription drug services is sufficient, and proactively address any potential access-related issues, given the reduction in after-hours pharmaceutical providers.
- Address QIP data elements that did not achieve a *Met* status in the QIP validation results. Ensure future QIP submissions include all necessary documentation required for a valid QIP.
- Explore factors that led to a decline in performance on the *Comprehensive Diabetes Care—Eye Exams* measure and implement targeted improvement efforts.
- Review the 2010 plan-specific CAHPS results report and develop strategies to address the *Rating of All Health Care, Customer Service,* and *Getting Needed Care* priority areas.

In the next annual review, HSAG will evaluate SFHP's progress with these recommendations along with its continued successes.

The table on the next page provides the prior year's EQR recommendations, plan actions that address the recommendations, and comments.

Table A.1—Follow-Up on the Prior Year's Recommendations Grid

EQR Recommendation	Plan Actions That Address the Recommendation
Explore factors that led to the decrease of the Breast Cancer Screening (BCS) rate to prevent further decline.	Decline was multifactorial: radiologist shortage at County hospital serving approximately half our members; providers receiving mixed messages from the State (e.g., EWC not covering mammograms for women ages 40–49, recent national controversy on the value of mammography. We evaluated HEDIS results by race and ethnicity to identify disparities and are working with our QI committee to identify appropriate interventions.
Improve QIP documentation by using HSAG's QIP Summary Form, which provides guidance to increase compliance with the CMS protocol for conducting QIPs.	Starting in 2010 we began using the HSAG QIP Forms and are following HSAG guidelines for reports submission.
Formally retire the Diabetes Care Management QIP, given the multiple remeasurement periods and sustained improvement.	Diabetes QIP has been formally retired.
Focus on a nonclinical, actionable area in need of improvement for the next QIP, given the plan's above-average performance measures rates in clinical areas.	Launched Patient Experience QIP. Tammy Fisher received state recognition for this work.
Increase network capacity for specialty providers to reduce member grievances and appointment wait times.	We have recently expanded our network to include two private provider groups, Hill Physicians and Brown and Toland Physicians. We are also working with SFGH to expand eReferral access.
Continue to monitor and address noncompliance in audit areas.	We provided our delegated entities with template denial letters; these letters include the reason for denial of service, and it is required that an MD signs the letter. Review of denial letters is a standard item of review in our oversight audits.
Continue to monitor compliance with the DHCS standards for access to care, structure and operations, and quality measurement and improvement.	Detailed requirements regarding wait time are specified in each delegated entity's Responsibilities and Reporting Requirements (R3) Grid. Monitoring is done though site audits; corrective action plans are put into place at the closing of each audit and as needed.