

San Francisco Health Plan
Dual Eligible Special Needs Plan (D-SNP)
Model of Care
Contract #H8051

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Introduction

San Francisco Health Authority dba San Francisco Health Plan (SFHP), a Medicaid (Medi-Cal) Managed Care Organization (MCO), is a unique public-private partnership established in 1994 by the San Francisco Health Authority as a public agency distinct from the County and City governments. SFHP was licensed by the California Department of Health Care Services (DHCS) in 1996 to serve the healthcare needs of the City and County of San Francisco, California. SFHP provides a person-centered community care delivery model for universal access, particularly for the medically needy and underserved populations.

SFHP is directed by a nineteen-member Governing Board. The Board includes physicians, other healthcare providers, health plan members, health and government officials, and labor representatives. It is responsible for SFHP's overall strategic direction and meets openly for public participation.

SFHP offers a fully integrated healthcare system that will provide D-SNP members access to medical and non-medical services by working through a provider safety net responsible for delivering and organizing care. In collaboration with our Care Coordination and Care Management teams, this comprehensive, integrated care network will help connect our members with services and supports in their local communities (e.g., primary and specialty care, behavioral health care, meals, home modifications, etc.)

SFHP serves over 177,646 Medi-Cal members, including 32,750 full-benefit dual eligibles.¹

MOC 1: Description of the SNP Population (General Population)

Element A: Description of Overall SNP Population

Factor 1: Determine, Verify, and Track Eligibility

SFHP will follow an established process to determine, verify, and track the eligibility of all D-SNP enrollment applications as identified by the Centers for Medicare & Medicaid Service (CMS) requirements contained in Chapter 2 of the Medicare Managed Care Manual (MMCM) and the California State Medicaid (Medi-Cal) requirements. A dedicated D-SNP Member Eligibility Management team (MEM), experienced in Medicare and Medi-Cal eligibility, follows a three-step process before enrolling members into our D-SNP plan. This process includes:

1. Completion of the Medicare Advantage Enrollment Request Form. This is often done with the help of the dedicated Medicare sales team, through an insurance agent/broker, or by the member and submitted to SFHP in person, through our member portal at SFHP.org, or via the U.S. Mail. Once received, the Enrollment Request Form is entered into our Customer Relationship Management (CRM) system.
 - a. The member must have Medicare Parts A and B before completing the enrollment request form to join SFHP. The form is available on the CMS website at CMS.org. Once completed, the member submits it to their local Social Security Office.
2. Confirmation of Eligibility. Before enrolling the member into our D-SNP plan, the application moves from the CRM into the Enrollment Administration Manager (EAM), where elements of the application are validated to ensure all enrollment factors are met. The member's eligibility in the CMS Online Eligibility System (MARx) and the Medi-Cal

¹ SFHP Enrollment/Eligibility Data, Sept 2024

Automated Eligibility Verification System (AEVS) is also validated. A Batch Eligibility Query (BEQ) file is generated to transmit the member's enrollment application to CMS. SFHP must submit the enrollment request form to CMS within seven calendar days of receipt of the completed enrollment request. SFHP can submit these files individually or through a batch submission process.

3. Processing Applications. Processing enrollment and eligibility data involve two primary external data sources: the CMS Daily Transaction Reply Report (DTRR) and the California Department of Healthcare Services (DHCS) 834 State Eligibility File. The DTRR contains confirmed enrollments, disenrollments, cancellations, and updates reported by CMS. These files are processed, reconciled, and uploaded daily into the EAM. The 834 State File is received and reconciled daily as well. A notice acknowledging and confirming enrollment acceptance or denial must be provided to the member by SFHP within ten calendar days of receiving the DTRR from CMS.

SFHP tracks ongoing eligibility using a daily and monthly file from DHCS that reflects the Medi-Cal status of each D-SNP member. If SFHP is notified that a member enrolled in our D-SNP plan no longer qualifies for Medi-Cal, SFHP provides a three-month deeming period for that member to obtain confirmation of their continued Medi-Cal eligibility. During this period, members continue receiving their health plan benefits but may be responsible for paying the Medicare cost-sharing portion, such as copayments, coinsurance, deductibles, and premiums. The deeming period begins on the first of the month following the month in which SFHP *received the information* that the member no longer qualifies for Medi-Cal and ends on the last day of the third month after receiving that information. The MEM team sends a letter to those members identified as no longer qualifying for Medi-Cal and/or at risk of losing their Medi-Cal eligibility. The letter will review the Medi-Cal eligibility requirements and how to get the appropriate documentation submitted to DHCS. This written notification from SFHP to the member will be sent within ten days of learning of the change in the member's eligibility status. The MEM team will share the deemed member data with the Care Manager, as the Care Management team will also work with the member to re-establish Medi-Cal eligibility. The member is notified of the implications of not regaining Medi-Cal eligibility, including potential fiscal responsibility for Medicare Part B premiums and cost-sharing. Additionally, SFHP works closely with our Medicare sales team, our agents/brokers, and the providers in SFHP's safety network to help those members identified as at risk of losing eligibility to take the steps necessary to remain eligible for benefits.

Members who CMS accepts to enroll in SFHP are identified from the DTRR file sent to us from CMS and moved into our EAM. The EAM will consume the member data and move it to QNXT. QNXT is our claims operating system and core system for member eligibility and enrollment. It allows for real-time tracking of information in the member record. If CMS does not accept the member, the MEM team will identify the issue and work with the sales agent/broker and member to correct the problem. Once corrected, the member can resubmit their application for consideration.

Factor 2: Describe the Health Status and Health Disparities of the Target Population

SFHP currently serves Medicaid members throughout San Francisco County. Our existing knowledge of the overall demographic profile of the county provides a foundation for understanding and tailoring our Model of Care (MOC) to the members we will be serving. The following sections provide a description of the characteristics of the Medicare and dual eligible population residing in California and San Francisco County².

Almost a quarter (22.4% or 1.4 million) of Californian Medicare beneficiaries are dually eligible for Medicare and Medi-Cal. Thirty-two percent (32.0%) of San Francisco Medicare beneficiaries are dually eligible. Dually eligible beneficiaries are eligible

² ATI Advisory analysis of MBSF administrative data licensed from CMS, based on enrollment records for March 2021.

for both Medicare and Medicaid due to their age, disability, or low income. This is a diverse population that includes people with multiple chronic conditions, physical disabilities, mental illness, and cognitive impairment such as dementia and developmental disabilities.³

Health Status

The dually eligible population has greater healthcare needs, increased service use, and more complex Care Coordination requirements than the overall population. Multiple chronic conditions are more prevalent in San Francisco County dual-eligible members than non-dual eligible members (81% compared to 57%).⁴ Dual-eligible members with behavioral health disorders and/or multiple co-morbidities are at greater risk of serious complications and have an increased need for coordination of care.

These same members experience high rates of chronic illness, with many having long-term care needs and social risk factors. Forty-seven percent (47%) of dually eligible individuals have at least one mental health diagnosis, and 63% have three or more chronic conditions. Fourteen percent (14%) of dually eligible individuals report having “poor” health status, compared to 4% of other Medicare beneficiaries.⁵

The top ten medical and behavioral health conditions impacting the dual population in San Francisco County, as reported by the National T-MSIS 2022 Data, are:

Table 1: Top Medical and Behavioral Health Conditions – National Data

Disease	Count	% of Duals
Hypertension	25,559	68%
Hyperlipidemia	24,071	64%
Cataract	17,777	47%
Rheumatoid Osteoarthritis	14,474	38%
Diabetes	14,152	38%
Anemia	11,421	30%
Depression	10,231	27%
Chronic Kidney Disease	8,036	21%
Glaucoma	7,173	19%
Osteoporosis	6,713	18%

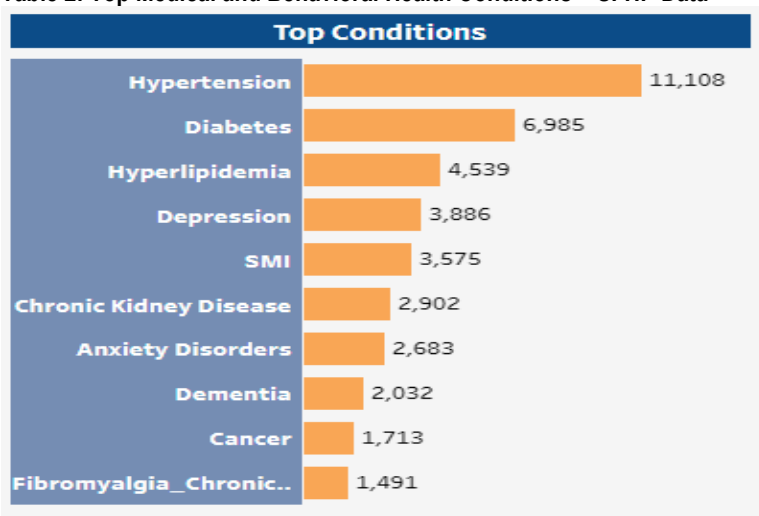
³ MACPAC

⁴ National T-MSIS 2022 Data

⁵ KFF report: <https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles>

The top medical and behavioral health conditions are similar within the SFHP dually eligible members compared to those represented nationally. Hypertension, hyperlipidemia, diabetes, depression, and chronic kidney disease are the top conditions impacting this population.

Table 2: Top Medical and Behavioral Health Conditions – SFHP Data



To better understand how these conditions affect dually eligible members of SFHP, the Care Management team, in collaboration with the Population Health team, may consider creating and implementing enhanced medical management programs specifically designed for these key areas, as needed.

As noted previously, dually eligible members have increased utilization of acute/non-acute inpatient visits and emergency room (ER) visits. This is represented in current SFHP utilization data for dual and non-dual eligible members. The data indicates that acute inpatient admissions were 1.9 times higher for dual-eligible members. Inpatient admissions, acute and non-acute, were 1.9 times higher for dual-eligible members than non-dual-eligible ones, and ER visits were 2.6 times higher.

Table 3: SFHP Utilization Metrics

Utilization Metric	Dual-Eligible Members	Non Dual-Eligible Members
Acute Inpatient Admissions/1000 members	190	103
Inpatient (both acute and non-acute) Admissions/1000 members	201	106
Emergency Room Visits per 1000 members	676	256

Health Disparities

Individuals dually eligible for Medicare and Medicaid often have multiple chronic medical and behavioral health conditions and long-term care needs. This population also has higher rates of social needs compared to non-dually eligible individuals. Unmet social needs can make it difficult for individuals to access care and follow care recommendations which result in avoidable

hospitalizations and emergency department visits.⁶ In San Francisco County, California, 2,223 hospital stays per 100,000 people enrolled in Medicare might have been prevented by outpatient treatment. This is greater than 2,153 hospital stays per 100,000 in California statewide.

In San Francisco County, lack of transportation, compounded with other factors such as language barriers and functional and cognitive limitations, impacts health care access and utilization for low-income and dual eligible populations. ER utilization and avoidable hospitalization for many identified health indicators is potentially preventable through appropriate access to and management in the primary care setting. Effective care navigation, coordination, access, and addressing barriers to care for dual eligible members is a key foundational element of SFHP's D-SNP Model of Care (MOC).

Access to safe and reliable transportation for our population is associated with essential activities such as access to health care (physician visits and pharmacies), grocery shopping services and social connection. Overall, 29% of San Francisco households are without a vehicle. Reliance on other means of transportation, including public transportation, to access essential services and health care can be a limitation for the D-SNP population, which may be unable to accommodate the pre-scheduled transit availability, routes, cost, and time required to travel.

Social support and isolation are key factors impacting our D-SNP population⁷. Individuals living alone may lack social support and assistance when needed and are at higher risk of social isolation, poor health outcomes, institutionalization, and loss of independence. On average, 29.7% of adults aged 65 and older live alone in San Francisco County. The California and national rates are lower (22% and 27%). San Francisco County residents 65 years and older, 19% reported difficulty living independently compared to the lower state and national rates of 16% and 13%, respectively. In San Francisco County, 38% of county residents report feeling socially isolated, which is higher than the statewide rate of 35%. Of adults in San Francisco county, 27% reported low social-emotional support, higher than state and national rates (25% and 21%).

Cognitive difficulties include serious difficulty concentrating, remembering, or making decisions due to physical, mental, or emotional conditions. They impact daily activities, including self-care and health management. The percentage of people with cognitive difficulties in San Francisco County overall is 4.9%. That rate rises to 6.9% for those ages 65 to 74 in San Francisco County and to 16.2% for those 75 years or older. Comparatively, the percentage of California residents with cognitive difficulties statewide is 4.32%.

In terms of environmental factors, San Francisco County ranks seventh out of all California counties for health outcomes and third for health factors, according to the 2024 County Health Rankings. San Francisco County has been consistent in this area for the last few years.⁸ This is primarily driven by physical environmental indicators such as air pollution, housing issues, and transportation.

Factor 3: Identify Population Demographics

SFHP currently serves Medi-Cal members throughout San Francisco County. Knowledge of the county's overall demographic profile provides a foundation for understanding and tailoring our MOC to the county's D-SNP population we will serve. There are notable differences in living conditions and environmental and social factors based on where our members live within the county. This helps inform the identification and coordination of community-based services at the local community level.

⁶ Center for Health Care Strategies

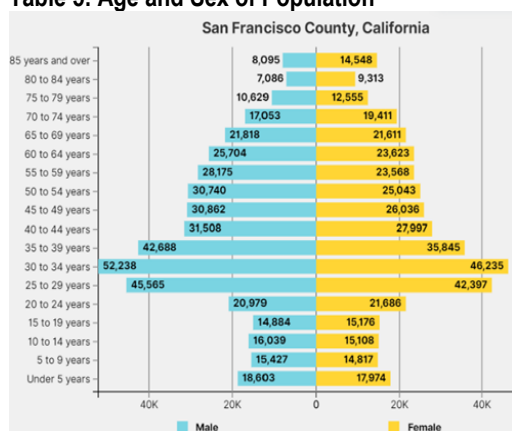
⁷ Metopio

⁸ Countyhealthrankings.org

The 2022 American Community Survey (ACS) 1-Year Estimate Data for San Francisco County listed a total population of 808,437, down 0.3% from 2021. The data yielded several key demographic data points that have enhanced the understanding of our potential D-SNP membership.

We begin by looking at the sex and average age of the residents living in San Francisco County. Males make up 51% of the population (438,093) compared to 412,943 females (49%), though the numbers skew more female as the population ages. For an overall view of the San Francisco County population, please refer to Table 5, a wider population pyramid on the top means the overall population is older. Looking at adults 65 years and over, there are 77,438 or 54% women compared to 64,681 or 46% men. The median age of the county's population is 40.7, compared to 38.2 for the State of California. Eighty-seven percent (87%) of the population are U.S. Citizens. Leveraging this data, care management programs developed will target the health and social needs of our population.

Table 5: Age and Sex of Population



In San Francisco County, 43.9% speak a language other than English in the home, which closely matches the state rate of 45%. We will create programming considering our D-SNP members' health and social needs, including a diverse outreach staff and culturally appropriate educational information in multiple languages.

Both the State of California and San Francisco County are ethnically diverse. While three-quarters of the population are either White or Asian, as shown below, the remaining 25% represent a mix of ethnicities, with 10% identifying as biracial.

Table 6: Racial Breakdown of San Francisco County Population

Racial Breakdown	Population	% of Total Population
White (One Race Alone)	361,382	41%
Asian (One Race Alone)	296,505	34%
Biracial	86,233	10%
Other Race (One Race Alone)	73,169	8%
Black or African-American (One Race Alone)	46,725	5%
American Indian and Alaska Native (One Race Alone)	6,475	1%
Native Hawaiian and Other Pacific Islander (One Race Alone)	3,476	0%

Total Population – San Francisco County	873,965	100%
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In San Francisco County, individuals 25 years of age and older education levels include the following:

Table 7: Education Levels of San Francisco Population

Education Level	% of Total Population
Graduate or Professional Degree	25%
Bachelor’s Degree	34.7%
Associate’s Degree	5.1%
Some College	11.8%
High School or Equivalent	11.9%
Less than High School	11.5%

Limited health literacy and English proficiency may be potential barriers to understanding care needs, accessing care, and improving health outcomes. Almost four in ten San Francisco County residents 65 years and older speak an Asian or Pacific Island language, and 58% of this population reported limited English proficiency.⁹ Limited health literacy and English proficiency are barriers to successful navigation between Medicare, Medi-Cal, and the medical/behavioral/social care systems. To enhance readability of member educational materials, materials and correspondence are provided at 6th-grade or lower reading levels and in languages other than English for those members reporting limited English proficiency to improve health literacy.

Forty-six percent of older adults 65 years of age and older in San Francisco County don’t have enough income to meet their basic needs. Compared to 33% of older adults 65 years of age and older statewide don’t have enough income to meet their basic needs.¹⁰ The higher cost of living in California, particularly in the San Francisco Bay Area, is evident when we look at the median gross rent in the county in 2023 of \$2,356 per month compared to a median gross rent of \$1,992 per month for the state. The homeownership rate in the county is only 37.1%, due to the inflated cost of homeownership, as opposed to the 55.9% homeownership rate for the state. About 74% of the homes owned in San Francisco County are valued at more than \$1,000,000.

Homelessness in the state continues to be a persistent problem. The Department of Homelessness and Supportive Housing (HSH), City of San Francisco, conducts a Point-in-Time (PIT) survey every two years. The PIT Survey collects information on people in emergency shelters and transitional housing (the sheltered count). The Survey also collects information about people sleeping on the streets, in cars, in abandoned properties, or in places not meant for human habitation (the unsheltered count). The 2024 PIT Survey preliminary results for San Francisco County are as follows:

- 8,323 total homeless individuals. This is a 7% increase since the last PIT count in 2022 (7,778 homeless individuals).

⁹ Metopio

¹⁰ Justice in Aging, Snapshot of Older Adults in San Francisco County

- Of the total count:
 - 3,969 individuals were in shelters, an 18% increase since 2022.
 - 4,354 individuals were unsheltered, a 1% decrease from 2022.
 - 2,910 of these individuals lived on the street or in tents.
 - 1,444 individuals lived in vehicles, a 37% increase since 2022.
- The largest proportion of people experiencing homelessness in San Francisco are White at 37%, followed by Latino or Hispanic at 34% and Black at 25%.

The ability to meet our members where they are, wherever that may be, will be critical to the successful engagement and attainment of better health outcomes for our D-SNP members.

Factor 4: Define the Unique Characteristics of the SNP Population Served

The D-SNP population is a subset of the Medicare population and experiences different challenges. The D-SNP population is a more vulnerable subgroup of Medicare and Medi-Cal members, with higher prevalence rates of physical and mental health conditions, multiple chronic conditions and comorbidities, inpatient and emergency room utilization, and more complex health care and psycho-social needs.

Medicare-Medicaid enrollees include people ages 65 and over with significantly higher rates of age-related conditions (approximately 86%) that impact self-care and independence with activities of daily living. They include people with lifelong intellectual and developmental disabilities who have always faced employment challenges and people under the age of 65 with robust work histories who left the labor force on account of significant physical or mental impairments.

The share of individuals dually eligible for Medicare and Medicaid benefits with selected chronic conditions differed between those under age 65 versus those ages 65 and older. Conditions such as cognitive impairment, Alzheimer's disease or related dementia was much more common among the older dual-eligible beneficiaries (20% vs. 4%). More dual-eligible beneficiaries under age 65 had an intellectual disability (11% vs. 2%). Physical health condition rates such as diabetes, heart failure, hypertension, and ischemic heart disease were higher in those 65 and older than those under age 65. Behavioral health conditions—*anxiety disorders, bipolar disorder, depression, and schizophrenia and other psychotic disorders*—were consistently more common among the dual-eligible population under age 65 than those ages 65 and older.¹¹

Overall, dually eligible enrollees have lower incomes, are more racially and ethnically diverse and are more likely to be in poorer health with greater needs than Medicare beneficiaries without Medicaid coverage.

These characteristics - lower incomes, higher psychosocial needs, living in neighborhoods with poorer living conditions, and unstable housing or homelessness are detrimental to our members' overall health.

Element B: Subpopulation – Most Vulnerable Enrollees

Factor 1: Define and Identify the Most Vulnerable Enrollees

The most vulnerable subset that SFHP expects to serve through our D-SNP includes a diverse, high-need population.

¹¹ MACPAC Databook Beneficiaries Dually Eligible for Medicare and Medicaid

SFHP has experience managing care for our current plan members who have coverage through both Medicare and Medi-Cal. We understand the challenge of quickly identifying newly enrolled members who may have immediate clinical and psychosocial needs. Promptly linking new members with needed Care Management and other resources can reduce exacerbations of chronic conditions and avoid potential costs related to unnecessary emergency department visits or hospital stays. Information obtained during early outreach can also address any immediate housing or food needs that a member may have.

High-Risk Vulnerable Members

Our most vulnerable population will be defined as those members who will most often have multiple comorbid conditions, including cardiovascular disease (68% of duals have hypertension), diabetes (38% of duals), chronic pain/musculoskeletal disease (38% of duals have Rheumatoid Osteoarthritis; 18% have Osteoporosis), chronic kidney disease (21% of duals), and co-occurring behavioral health diagnosis(es). In addition, 27% of duals experience depression.¹² Hyperlipidemia, a comorbidity associated with hypertension and diabetes, is prevalent in 64% of duals and, if not controlled, may lead to increased morbidity and mortality. Additionally, SFHP has identified the following populations of focus, as identified by DHCS, which may be considered vulnerable and potentially high-risk. These populations include:

- Adults Experiencing Homelessness
- High utilizer adults with frequent hospital admissions, short-term Skilled Nursing Facility (SNF) stays, or Emergency Department (ED) visits
- Adults with Serious Mental Illness (SMI) and Substance Use Disorder (SUD)
- Adults transitioning from Incarceration
- Members eligible for Long Term Care (LTC) and at risk of institutionalization
- Nursing Home residents transitioning to the community
- Adults who are Pregnant or Postpartum and subject to Racial and Ethnic Disparities
- Adults with documented Dementia needs

Identification of Most Vulnerable Members

The cornerstone of our Care Management program comes from our ability to risk stratify our population accurately. Population risk stratification has many benefits that align with the goals of our Care Management program, including promoting whole-person care, improving health equity and outcomes, and reducing the overall cost of care. Some of the benefits obtained from risk stratifying our population include:

- a better understanding of the needs of the population
- the ability to target and tailor care to make better use of the limited resources available
- the ability to proactively manage a population
- the ability to respond to member needs more promptly

The process of risk stratification is based on the gathering of data that reflects key demographic and clinical-psycho-social elements. We store thousands of pieces of information and data from various sources, enabling us to analyze better, manage, connect, and share data to drive whole-person care. These data sources may include but are not limited to:

- Admission, discharge, and transfer data (ADT)

¹² National T-MSIS 2022 Data

- Utilization reporting, including high-cost claimant (HCC) and authorization reports
 - Number of Inpatient admissions
 - Number of ER visits
- Claims and hospital discharge data
- Pharmacy data
 - Number of Medications
- Data obtained from Health Risk Assessments or other member-specific assessments
- Data supplied by purchasers or providers
- Data from CMS
- Data from the California Department of Health
- Public data sources including:
 - Geocoded member addresses, which can be mapped to the Healthy Places Index, a California-only vulnerability index.

In addition, SFHP will incorporate the California DHCS Populations of Focus criteria to add to the data used to risk stratify our population. The Populations of Focus and their respective criteria, as per the DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide – Contract year 2026, are as follows:

- **Adults Experiencing Homelessness** - defined as meeting one or more of the following conditions:
 - Lacking a fixed, regular, and adequate nighttime residence
 - Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground
 - Living in a supervised publicly or privately operated shelter designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing)
 - Exiting an institution into homelessness (regardless of length of stay in the institution)
 - Will imminently lose housing in the next 30 days
 - Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence **and**
 - Have at least one complex physical, behavioral, or developmental need, with an inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services
- **Adults At Risk for Avoidable Hospital or ED Utilization** – defined as meeting one or more of the following conditions:
 - Five or more emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved adherence
 - Three or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence
- **Adults with Serious Mental Health and/or SUD Needs** – defined as:
 - Meet the eligibility criteria for participation in or obtaining services through:
 - a. SMHS delivered by Mental Health Plans (MHPs)

- b. The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program **and**
 - Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms **and**
 - Meet one or more of the following criteria:
 - a. Are at high risk for institutionalization, overdose, and/or suicide
 - b. Use crisis services, EDs, urgent care, or inpatient stays as the primary source of care
 - c. Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months
 - d. Are pregnant or postpartum (12 months from delivery)
- **Adults Transitioning from Incarceration** – defined as:
 - Transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) **OR** transitioned from a correctional facility within the past 12 months **and**
 - Have at least one of the following conditions:
 - a. Mental illness
 - b. SUD
 - c. Chronic Condition/Significant Non-Chronic Clinical Condition
 - d. Intellectual or Developmental Disability (I/DD)
 - e. Traumatic Brain Injury (TBI)
 - f. HIV/AIDS
 - g. Pregnant or Postpartum.
- **Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization** – defined as:
 - Living in the community who meets the SNF Level of Care (LOC) criteria OR who requires lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury **and**
 - Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring) **and**
 - Can reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high acuity needs or conditions that are not suitable for home-based care due to safety or other concerns)
- **Adult Nursing Facility Residents Transitioning to the Community** – defined as:
 - Interested in moving out of the institution **and**
 - Likely candidates to do so successfully **and**
 - Can reside continuously in the community
- **Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities** – defined as:
 - Are pregnant **OR** are postpartum (through 12 month period) **and**
 - Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality
- **Adults with Documented Dementia Needs** – defined by:

- Have a formal Alzheimer's or dementia diagnosis **or**
- Have documented dementia care needs, including but not limited to:
 - a. Wandering
 - b. Home safety concerns
 - c. Poor self-care
 - d. Behavioral issues
 - e. Issues with medication adherence
 - f. Poor compliance with management
 - g. Inability to manage ADLs/IADLs

One additional Medi-Cal Population of Focus includes:

- **Adults eligible for Community Based Palliative Care** - who meet the following criteria:

General Eligibility Criteria:

- The member is likely to, or has started to, use the hospital or emergency department to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures
- The member has an advanced illness, as defined in section **I.B below**, with appropriate documentation of continued decline in health status and is not eligible for or declines hospice enrollment
- The member's death within a year would not be unexpected based on clinical status
- The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation
- The member and, if applicable, the family/member-designated support person, agree to:
 - a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department **and**
 - b. Participate in Advance Care Planning discussions.

Disease-Specific Eligibility Criteria:

- Congestive Heart Failure (CHF): Must meet (a) and (b)
 - a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher **and**
 - b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities
- Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
 - a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute **or**
 - b. The member has a 24-hour oxygen requirement of over or equal to three liters per minute.
- Advanced Cancer: Must meet (a) and (b)
 - a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia **and**
 - b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failed two lines of standard-of-care therapy (chemotherapy or radiation therapy)
- Liver Disease: Must meet (a) and (b) combined or (c) alone
 - a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, **and**

- b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices
or
- c. The member has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score greater than 19.

Risk Stratification Process

Our Business Analytics team utilizes the data to model and stratify members into one of three broader risk categories. We may include the member's Risk Adjustment Factor and Hierarchical Condition Codes (RAF/HCC), as assigned by CMS, which measure the complexity of individual members. With this information, all D-SNP members are assigned a preliminary risk score identifying them as low, medium/rising, or higher/complex risk requiring additional Care Management and Care Coordination.

However, this is a preliminary risk assignment. After reviewing this information, the Care Manager makes the final determination, reviewing the HRA data and completing comprehensive medical, psychosocial, cognitive, functional, mental health, and social determinants of health (SDoH) assessments. The results of this review are shared with the member, provider(s), and others designated as part of the member's ICT as appropriate.

The stratification process is dynamic over time, allowing members to move between stratification levels to meet their changing needs across the continuum of care. Stratification levels may be revised upon a member's change of condition, upon review of additional data obtained through the utilization review or claims review process, and from data obtained during the initial and annual HRA assessments. Furthermore, the definition of most vulnerable members may be adjusted based on further experience and analysis of our D-SNP population in 2026.

This population health approach maximizes efficiency and improves outcomes. Higher-intensity resources are reserved for members at the highest risk level. A care model based on this approach can flexibly match needs with the most appropriate resources to meet those needs.

Factor 2: Identify Demographic Characteristics of the Most Vulnerable Members

The demographic characteristics of the most vulnerable members have an impact on the health outcomes of the most vulnerable population. The impact of those characteristics on health outcomes is summarized below:

Table 7: Characteristics and Impact on Health Outcomes

Characteristics	Description	Health Outcomes Impact
Age	An estimated 86% of San Francisco County dual members are 65 and older. ¹³ The rate of San Francisco County adults aged 65-74 with a disability is 23%. For adults aged 75+, the rate is 50%. ¹⁴ The prevalence of comorbid conditions and age-related conditions such as declining vision and hearing, impaired cognition, changes in kidney and liver function, and loss of mobility is higher for San Francisco	As people age, their risk of developing chronic health conditions like heart disease, diabetes, osteoporosis, dementia, and certain cancers significantly increases, making older adults more susceptible to experiencing multiple health issues simultaneously, impacting their overall quality of life and health outcomes; this is due to natural physiological changes in the body like decreased

¹³ National T-MSIS 2022 Data

¹⁴ Metopio

Characteristics	Description	Health Outcomes Impact
	County dual members than non-duals and significantly higher for vulnerable duals of older age.	immune function, muscle mass loss, and reduced organ efficiency as they age. ¹⁵
Gender	<p>Approximately 54% of dual members will be female. Gender-specific screenings, preventive care, and gender differences in condition prevalence rates inform the care and impact health outcomes for the most vulnerable population. In addition, clinical symptoms are often experienced differently by men than by women, such as heart attack symptoms. The following measures reflect San Francisco County:</p> <ul style="list-style-type: none"> • Breast cancer incidence in women is 5.3% for CA duals and 5.5% for SF duals. • Prostate cancer incidence rate of 4,507/100,000 men is lower than the statewide rate of 4,873/100,000. • The colorectal cancer incidence rate is 2,115/100,000 for men and 1,712/100,000 for women. • The prevalence of high blood pressure for men is 64% compared with 72% for women. ¹⁶ 	Gender significantly impacts health outcomes, with women generally experiencing higher rates of chronic diseases and mental health issues while men tend to have shorter life expectancies due to higher rates of risky behaviors like alcohol and tobacco use, contributing to disparities in disease prevalence, access to healthcare, and mortality rates across various health conditions; these differences are influenced by a combination of biological sex, social gender norms, and access to healthcare services.
Ethnicity	San Francisco County has a relatively high Asian population. Asians represent 47% of San Francisco County's dual population. Asians in San Francisco County show higher rates of hypertension and hyperlipidemia. The higher rates of diabetes and obesity among Hispanics, for example, compound the lower rates of access, preventive care, outcomes, and health disparities. ¹⁷	Ethnicity can significantly impact health outcomes, with research consistently showing that individuals from minority ethnic groups often experience poorer health compared to the dominant population, including higher rates of chronic diseases, infant mortality, and premature death, due to factors like systemic racism, socioeconomic disparities, and limited access to quality healthcare. ¹⁸
Language barriers	San Francisco County has a higher percentage of Asian and Pacific Island language-speaking, foreign-born, and non-English-speaking residents than the national rate. 33.7% of San Francisco County residents are foreign-born compared to the national rate of 14%. 11% of San Francisco County residents have limited English proficiency compared to the national rate of 4.2%. ¹⁹	Language barriers impact access to care and treatment plan adherence, often leading to poorer health for individuals who cannot effectively communicate with health care providers due to limited English proficiency. These limitations can result in misdiagnosis, delayed treatment, lower adherence to treatment plans, longer hospital stays, and increased risk of medical errors.
Health Literacy	Almost four in ten San Francisco County residents 65 years and older speak an Asian or Pacific Island language, and	Low health literacy is associated with more hospitalizations, greater use of emergency care,

¹⁵ World Health Organization

¹⁶ National T-MSIS 2022 Data

¹⁷ National M-TSIS Data 2022

¹⁸ National Institutes of Health

¹⁹ Metopio

Characteristics	Description	Health Outcomes Impact
	58% of this population reported limited English proficiency. ²⁰ Limited health literacy and English proficiency are barriers to successful navigation between Medicare, Medi-Cal, and the medical/behavioral/social care systems.	decreased use of preventive services, poorer ability to interpret labels and health messages, poorer health status, higher mortality, and higher health care costs. ²¹
Socioeconomic Status, including Poverty and Homelessness	Approximately 10.4% of San Francisco residents live in poverty, this is higher than other Bay Area counties. San Francisco has had the highest poverty rate in the region since the 1970s. ²²	Low socioeconomic status (SES) is strongly linked to poorer health outcomes, including increased risk of chronic diseases, higher mortality rates, lower life expectancy, and decreased access to healthcare, primarily due to limited ability to afford medical care, healthy food, and stable housing, leading to higher stress levels and poorer health behaviors. ²³
Chronic Conditions	Most dual-eligible members have multiple chronic conditions and comorbidities compounded by increasing age and frailty. 18% of San Francisco County duals have 2-3 chronic conditions. 21% have 4-5 conditions, and 42% have 6+ conditions. ²⁴	Chronic conditions can have a significant impact on health outcomes, including increased risk of death and disability, and decreased quality of life. Chronic conditions can also lead to increased healthcare costs and decreased productivity. ²⁵

Factor 3: Establish a Correlation between Demographic Characteristics and Clinical Requirements

SFHP’s focus for the most vulnerable D-SNP population will be identifying barriers to care, coordinating their complex medical, functional, cognitive, psychosocial, mental health care, and LTSS needs, managing transitions of care, and reviewing, revising, and managing the member’s ICP. This includes provider treatment recommendations and education on conditions to manage better and prevent avoidable utilization. Our team will help our highest-risk members navigate the healthcare system, better manage their chronic conditions as appropriate, engage in the necessary routine, follow-up, and preventive care with their PCP and specialists, and gain access to the essential resources and supportive services that are required to address these complex needs of our most vulnerable members.

In MOC 1.B. Factor 2, it was noted that the most vulnerable population typically has chronic conditions that are associated with high morbidity and mortality if not well managed. The data shows that this population also has multiple co-morbidities, a prevalence of behavioral health conditions, multiple functional health needs, and social determinants of health factors. Complex conditions in this population emphasize the need for unique clinical interventions supported by intensive Care Coordination to make covered benefits and community services available to support our members’ needs.

SFHP will work with our members to create an individualized care plan to address the complex needs of this vulnerable population. Our most vulnerable members may require specially tailored services in addition to their supplemental benefits and services available to all D-SNP members. These services will be fully leveraged, as needed, to meet their individualized

²⁰ Metopio

²¹ National Institutes of Health

²² SF.gov

²³ U.S. Centers for Disease Control and Prevention

²⁴ National T-MSIS 2022 Data

²⁵ U.S. Centers for Disease Control and Prevention

needs and will be documented within their ICP. The individual needs of the member will drive the level and type of support or services they may receive. The ICP may include the interventions outlined below.

Table 8: Services for the Most Vulnerable Population

Service	Description	Assistance to Most Vulnerable
Remote Patient Monitoring	In-home devices for members to monitor their blood pressure, blood sugar levels, and weight.	Understanding remote monitoring can be challenging to apply healthy living in everyday life, remote patient monitoring meets members where they are and expands healthcare outside of the conventional setting, increasing access to care and services.
Telehealth and Virtual Services	Teladoc® provides care from a provider for simple, non-emergency problems via a telephone or computer.	Telemedicine enables patients who might otherwise struggle to reach a healthcare provider due to distance, transportation issues, or lack of access to specialized care to receive consultations from their homes or community centers.
Medically Tailored Meals / Nutritional Education	Meals or groceries specifically designed for members with certain chronic conditions for 12-26 weeks. This includes four nutrition counseling sessions with a registered dietician nutritionist.	Specially designed meals delivered to individuals with severe, complex, or chronic illnesses, tailored to meet their specific dietary needs as prescribed by a healthcare professional. Helps increase access to healthy food and meets the member where they are.
Pharmacy Services	Medication Therapy Management (MTM), medication reconciliation, medication delivery, and bubble packaging.	Comprehensive medication reviews to identify potential drug interactions, dosage adjustments, and adherence issues are especially important for patients with complex medication regimens. Offering services like delivery options, extended hours, and language interpretation to overcome barriers to accessing pharmacy care. Providing clear and accessible information about medications, including proper use, side effects, and potential interactions, often tailored to individual needs and literacy levels.
Community Palliative Care	This includes Advanced Care Planning, Palliative Care Assessments and Consultation, Care Planning, a Dedicated Palliative Care Team, Care Coordination, Pain and Symptom Management, and Mental Health and Social Health Services.	<p>This program of services may be offered in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based palliative care program, including a telephonic palliative care advice line.</p> <p>May contract with hospitals, LTC facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers based on local provider qualifications and the needs of our population.</p>
Health Education Classes	Comprehensive health educational opportunities for members managing chronic conditions and trying to maintain their health and independence as they age. Online registration may be required, and a PCP referral is usually not required.	<p>Classes are offered in the community setting and include:</p> <ul style="list-style-type: none"> • Chronic disease self-management • Classes offered by local Senior Centers • Exercise and fall prevention programs • Nutrition and healthy eating workshops <p>Members visit SFHP.org to participate in SFHP health education classes. All classes are free, though they may have eligibility requirements.</p>

Service	Description	Assistance to Most Vulnerable
Health Education Videos	SFHP offers a comprehensive library of health education videos accessible on the website.	<p>These videos serve as a valuable resource for members seeking visual guidance on various health topics and behavior change strategies, including:</p> <ul style="list-style-type: none"> • Behavioral Health • Blood Pressure Management • Breast Cancer Awareness • Diabetes Care • Flu Shot Information • Heart Health • Mental Health • Men's Health • Nutrition • Specialty Mental Health Services • Smoking Cessation • Stress Reduction <p>These videos provide an excellent supplement to in-person classes, allowing members to access health education content at their convenience.</p>
Health Education Library	SFHP's Health Education Library is a comprehensive resource designed to empower members/caregivers with knowledge to manage and maintain their health better.	<p>These resources are available online and for download in all threshold languages and include the following subjects:</p> <ul style="list-style-type: none"> • Managing Chronic Conditions (Asthma, Diabetes, Chronic Pain) • Preventive Care (vaccinations, blood pressure management) • Women's Health • Mental Health and Stress Reduction • Nutrition and Physical Activity • LGBTQIA+ Care • Age-Specific Health Visits • Sexual Health and STI Prevention <p>Members are encouraged to share these handouts with their healthcare team, family members, and other important individuals. The library is regularly updated, ensuring access to the most current health information.</p>
Pharmacy Health Library	SFHP also provides a valuable online Pharmacy Health Library. This resource enhances members' understanding of their medications, contributing to their safety and overall health.	<p>The library offers easy-to-read handouts on various medication-related topics, including:</p> <ul style="list-style-type: none"> • Risks of Taking Both Opioids and Benzodiazepines • Managing Asthma Medications • Heart Failure: Medication Treatment • Diabetes: Medication Treatment <p>The library also provides links to patient information from reputable organizations such as the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). This ensures members have access to reliable, up-to-date information</p>

Service	Description	Assistance to Most Vulnerable
		about their medications. SFHP demonstrates our commitment to supporting members in understanding and managing their medications effectively by offering the Pharmacy Health Library.
Member Newsletter	SFHP produces a quarterly newsletter called "Your Health Matters," which is mailed to all SFHP members.	This informative publication serves as a valuable resource for members, offering a wide range of content, including updates on healthcare services, guidance on maximizing member benefits, and practical tips for maintaining a healthy lifestyle. Members can access current and past "Your Health Matters" issues through the SFHP website's newsletter archive. This feature allows members to revisit important information or catch up on any issues they may have missed. The newsletter archive is an excellent tool for members who want to stay informed about their health plan and various wellness topics.
Member Health Blog	SFHP maintains an active health education and benefits blog at SFHP.org. This valuable resource is updated three times a month with new content covering various topics relevant to members' health and well-being.	Blog posts address recent healthcare guidance, provide information on SFHP benefits, offer health education, and share practical tips for effective health management. The blog is designed to be user-friendly, allowing members to read the content in their preferred language and ensuring that important health information is accessible to all SFHP members regardless of their primary language.

Services tailored to the demographic characteristics of the vulnerable population may also include:

- Gender-specific communications
- Community health worker/peer support outreach, especially to disengaged vulnerable members
- Intensive coordination of services with local community centers, shelters, and public health departments on things like vaccinations and COVID-19 testing

We have established partnerships with various organizations, resources, and programs to support the holistic needs of our most vulnerable members, particularly focusing on the newly identified CICM population. As our plan is new, we are actively working to expand our collaborations with additional organizations to enhance support for all our members.

Table 9: SFHP Community Partners and Resources

Resource	Organization(s)	Focus or Support
Caregiver Resources	Area Agency on Aging (AAA), Senior Centers, Community Centers, Senior Housing, and LTC Services	San Francisco County community resources offer provider information, support groups, care planning, legal and financial support, respite care, counseling, and professional training. These services are generally free or very low cost.
Adult Day Health Centers	A network of adult day centers throughout the county	Centers are designed to provide support through social and health-related services. These community-based programs offer medical, therapeutic, rehabilitative, respite, and recreational programs and supervision for dependent adults.

Resource	Organization(s)	Focus or Support
Disease-Specific Organizations	American Diabetes Association, American Heart Association, American Cancer Society San Francisco County, California Health Care Foundation Community Based Palliative Care, and American Foundation for Suicide Prevention	Local chapters offer valuable community resources to vulnerable populations, especially those with complex needs and/or multiple conditions. Organizations that offer these resources include the
Community-Based Services	Charitable organizations, places of worship, community mental health centers, and senior centers,	Unique community programs and organizations in San Francisco County that generally provide free or low-cost services.
Telehealth	Teladoc	Members can access telehealth by phone or video, providing convenient and timely access to care. This is a supplemental benefit to our members through our contracted partner.
Healthy Aging and Exercise	Senior and Community Centers throughout San Francisco County	Members can access exercise classes and health and fitness programs through the many senior centers and community centers in San Francisco County. These programs are tailored to senior populations and emphasize balance, functional mobility, and fall prevention.
Food banks and Home Delivery of Food	Meals on Wheels, Food Share, and the AAA	Nutrition can be a concern for our members due to their income levels. To help address these needs, we assist members in utilizing local food banks and agencies
Transportation	Non-Medical Transportation Provider	Many of our members have limited access to transportation. We offer transportation as a supplemental benefit through a contracted partner to ensure members have reliable transportation to their PCP and specialist appointments when needed.
Dental and Vision Services	A mobile dental van brings dental services to members within their communities. D-SNP members have access to all Denti-Cal covered services	We offer access to our dental and/or vision vendors for exams, preventive dental services, or, in some contracts, restorative dental services or vision hardware coverage as part of our supplemental benefits.
Physicians and Practitioners	Our network of contracted providers includes PCPs, specialists, nursing, behavioral health, therapists, pain management, wound care facilities, pharmacies, and home health agencies	Provides the range of services required of our vulnerable population.
Social Service Organizations	Food banks and homeless shelters	Community-based social service organizations provide valuable services for our D-SNP members who have difficulties paying for housing, food, and other necessities.

A concern with our aging, vulnerable population is the risk of polypharmacy and potential medication interaction. Coordination with a pharmacist for Medication Therapy Management (MTM) and/or medication reconciliation will be encouraged, especially if there are concerns about taking multiple medications, tolerance issues, or interactions between drugs. Coordination between medical and behavioral health providers and connecting members to behavioral health resources is essential.

Many of our most vulnerable members may have functional limitations that can be supported through Long-Term Services and Supports (LTSS), such as caregiver services, community support, obtaining durable medical equipment or home

modifications as appropriate, and coordination of transportation benefits. Care Coordination would also facilitate communication between LTSS service providers to ensure that the services provided enhance the overall care experience for the member and are not duplicative.

Social determinants of health significantly impact our members' physical and behavioral health needs. If left unaddressed, they can hinder the success of the interventions employed and the attainment of our members' goals. SFHP will help our most vulnerable population by addressing issues such as food insecurity, housing instability, and social isolation. This will involve identifying, assisting with access, and coordinating available benefits, services, and resources from local providers and community-based organizations.

Factor 4: Establish Relationships with Community Partners

SFHP is a local, community-based health plan serving primarily low-income and senior populations in San Francisco County. We have an exceptional knowledge of and relationships with local community resources, an extensive provider network, and well-established relationships with community partners and providers. We are involved in multi-stakeholder community projects, including collaboratively conducting the San Francisco Community Health Assessment (SF CHA) every three years with the San Francisco Department of Public Health and the other San Francisco Managed Care Plans. This assessment develops a Community Health Improvement Plan that identifies the community's strengths, opportunities, goals, and outcomes for the next three years. The community health improvement process focuses on "gaining an understanding of why health outcomes exist in San Francisco and helps gear efforts towards addressing root causes and developing better interventions, policies, and infrastructure."²⁶

As the county health plan, SFHP Care Managers and social workers know our county's community resources as they currently work with them to support the needs of our Medi-Cal membership. They will connect our vulnerable D-SNP members to the services and programs that will best meet their unique needs, such as assistance for home modifications (e.g., ramps and grab-bars, mold remediation, and home repairs), financial assistance, connecting with support groups, housing support, spiritual care, palliative care, dementia care, meal delivery, and in-home supportive services.

SFHP Strategies to Collaborate with and Engage Community Based Organizations (CBO)

We are committed to partnering with organizations and providers that possess a deep understanding of the San Francisco community and can address the specific needs of our population, including vulnerable groups such as the CICM population. This includes food banks, homeless shelters, senior centers, and mental health support groups. SFHP will integrate community-based organization (CBO) services into care plans by collaborating with care managers to ensure seamless access to resources such as transportation assistance, meal delivery, and social support programs. Additionally, we will work with our network of CBOs and providers to conduct outreach campaigns that educate dual-eligible individuals about the services available to them and how to access these resources.

As programs and services can change, our staff maintains relationships with agencies such as San Francisco Human Services Agency, Institute on Aging, and San Francisco Behavioral Health in San Francisco County to keep current on all available resources and establish relationships with new organizations as new needs are identified. In addition to relationships with community agencies and service organizations, relationships with local chapters of national organizations such as the

Alzheimer's Association, the American Diabetes Association, the California Hospice and Palliative Care Association and the American Heart Association are beneficial to managing our D-SNP population.

Through our partnerships with CBOs and providers we can help our members overcome barriers to care by providing transportation, translation services, and addressing social needs that impact health outcomes. CBOs can help us provide culturally competent support and build trust within the community. We will work to facilitate communication between healthcare providers and community organizations to create a holistic plan of care for our members.

SFHP collaborates closely with providers and shares:

- Actionable, aggregated population health data and reports to improve care for the vulnerable population.
- Aggregated gaps in care, pharmacy, and utilization reports.
- Clinical Practice Guidelines
- Member-level reports to facilitate communication and coordination of care and services for vulnerable members.

In collaboration with our internal teams, extensive provider network, established community partners, our Care Management team takes a whole-person approach to care, addressing our members' clinical and non-clinical needs. Our process for engaging members and connecting them to providers, community partners, and resources includes:

- Outreach and engagement with all our members
- Screening and completion of comprehensive assessments that lead to the development of individualized care plans with S.M.A.R.T goals
- Enhanced Care Coordination with our primary care, specialists, and community partners
- Promotion of a healthy lifestyle and self-management techniques for chronic conditions
- Provision of transitional care across and between all care settings
- Support for our members and their families/caregivers
- Coordination of community and social support services, including LTSS, housing, and community support

For a further detailed description, please refer to MOC 2 where we describe our process for Individualized Care Plan (ICP) development and the detailed personnel responsible for ICP development.

As a local health plan serving low-income and senior populations across San Francisco County, SFHP has developed exceptional relationships with our community partners to provide the resources and services needed most by SFHP's most vulnerable members and their caregivers. As we launch our D-SNP plan, we will continue to identify and partner with those organizations and community partners that will meet the needs of our expanding population.

MOC 2: Care Coordination

Element A: SNP Staff Structure

Factor 1: Define Administrative Staff Roles and Responsibilities

San Francisco Health Plan (SFHP) has diverse departments staffed by dedicated, highly qualified, and extensively trained personnel. These teams are committed to providing seamless administrative support to D-SNP staff and members.

The Chief Operating Officer (COO) oversees the daily administrative and operational functions of SFHP, ensuring the efficient delivery of healthcare services. This includes Performance Management, Financial Oversight, Workforce Management, Member Engagement and Services, Technology and Innovation, and Crisis Management. The COO reports directly to the Chief Executive Officer (CEO).

The Chief Compliance and Regulatory Affairs Officer ensures that SFHP adheres to all applicable laws, regulations, and internal policies. This role oversees the compliance program, policy development, and incident management. The Chief Compliance and Regulatory Affairs Officer conducts risk assessments, establishes monitoring and auditing protocols, and serves as the primary point of contact for regulatory agencies.

Following is a list of the administrative departments and a description of their functions.

Table 1: SFHP Administrative Departments

SFHP Administrative Department	Function
Claims: Employed	<ul style="list-style-type: none"> Receive, adjudicate, and pay claims Research and resolve complex inquiries and issues related to claims Assist providers in identifying and resolving claim issues Handle provider disputes Correct/adjust claims due to system errors and rate changes Handle misdirected paper claims Recoup overpayments Audit claims to ensure accuracy <p>All Claims staff report through the Director of Claims, who reports to the COO.</p>
Member Data: Employed	<ul style="list-style-type: none"> Reconcile member data on a daily/monthly basis between our core system and the data/file sent by the California DHCS, In-Home Supportive Services (IHSS), etc. Ensure the accuracy of enrollments and disenrollments in the member's record Collect and update member demographic information Validate PCP assignment during enrollment and apply manual assignment/reassignment as needed Conduct research and verification for other health coverage (OHC) and Third-Party Liability (TPL) Report the OHC and TPL cases to DHCS within the mandated timeline Ensure the data /file exchange between CMS and SFHP is sent and received timely and sequentially Reconcile data between CMS and DHCS during the deeming period <p>All Member Data staff report through the Senior Manager, Member Services, who reports to the COO.</p>
Customer Service:	<ul style="list-style-type: none"> Inbound member & provider contacts Non-medical transportation (NMT) Health Information Form/Member Evaluation Tool (HIF/ MET)

SFHP Administrative Department	Function
Employed	<ul style="list-style-type: none"> • Health Risk Assessment (HRA) • Grievance & Appeal (G&A) • PCP changes, ID Card request • Medi-Cal renewal enrollment appointment scheduling • Claims-related email inquiries (provider/ facility) • Claims inbound calls <p>All Customer Service staff report through the Senior Manager, Member Services, who reports to the COO.</p>
Grievances and Appeals: Employed	<ul style="list-style-type: none"> • Grievance and appeals • Provider escalations, tracking & trending of reported issues • Corrective action plan (CAP) development and implementation • Monitor access to services • Compliance reporting and delegation oversight for mental health grievances & appeals <p>All Grievance and Appeals staff report through the Senior Manager, Member Services, who reports to the COO.</p>
Marketing and Communications: Employed	<ul style="list-style-type: none"> • Mandated and strategic marketing and communications to members across all lines of business and all channels, print and digital • Administrators of SFHP.org, sfcityoption.org, healthysanfrancisco.org, the member and provider portals, and the intranet/SharePoint sites • Mailings • Written communication <p>All Marketing and Communications staff report to the Director of Marketing and Communications, who reports to the COO.</p>
Compliance and Oversight: Employed	<ul style="list-style-type: none"> • Maintains compliance program activities, including compliance training, privacy monitoring, internal audits, and internal monitoring • Delegation oversight, including auditing and report monitoring • Oversight for the chair of the Provider Network Oversight Committee • Lead external audit preparation, document gathering, and auditor support • Program integrity, including internal and external monitoring, fraud, waste, and abuse identification, investigation, and remediation • Third Party Liability and subrogation and reporting <p>All Compliance and Oversight staff report to the Director of Compliance and Oversight, who in turn reports to the Chief Compliance and Regulatory Affairs Officer.</p>
Regulatory Affairs: Employed	<ul style="list-style-type: none"> • Primary liaison for regulatory authorities, such as DMHC, DHCS, and CMS • Manages and submits responses, filings, and periodic reports to regulatory authorities • Works with IT Security to investigate and report privacy and security incidents • Reviews and provides consultation on contracts, non-disclosure agreements, and business associate agreements • Manages all CAP activity related to audit findings • Informs SFHP on regulatory guidance found in DHCS or DMHC All-Plan Letters (APLs) and HPMS Memos from CMS • Responsible for intake and response to State Fair Hearings (DHCS), Independent Medical Review (DMHC), and Consumer Complaints (DMHC)

SFHP Administrative Department	Function
	<ul style="list-style-type: none"> Manages SFHP's Policy and Procedures, including agenda items brought to Policy and Compliance Committee meetings <p>All Regulatory Affairs staff report to the Director of Regulatory Affairs, who in turn reports to the Chief Compliance and Regulatory Affairs Officer.</p>
Provider Network Operations: Employed	Provider Relations and Provider Data: <ul style="list-style-type: none"> Ensure the available network meets the needs of the population Engage providers to expand the network or add new benefits Maintain updated directory Inform and train providers on the D-SNP program to ensure their effective participation Assist providers with questions and problem-resolution Contracting: <ul style="list-style-type: none"> Engage providers on terms for their participation in each coverage program Engage vendors on terms for their services to the health plan Credentialing: <ul style="list-style-type: none"> Ensure that participating providers and organizations are qualified to perform the duties for which the health plan contracts them Monitor all providers for disciplinary action or any changes in their qualifications that would affect participation Facility Site Review: <ul style="list-style-type: none"> Evaluate preventive care, clinical site standards, and medical record standards at network sites for primary care, high-volume specialty, and others Train providers in preventive care standards and medical records documentation standards <p>All Provider Network Operations staff report to the Director of Provider Network Operations, who reports to the COO.</p>
Information Technology Services: Employed	<ul style="list-style-type: none"> Responsible for technology solutions that SFHP uses to conduct business, including all hardware, software, and peripheral equipment, programming, and data and information processing and storage <p>All ITS staff report through the Information Officer, who reports to the COO.</p>

Factor 2: Identify Clinical Staff Roles and Responsibilities

The Health Services department at SFHP is led by the Chief Medical Officer (CMO). The CMO is responsible for ensuring the availability, quality, and delivery of healthcare services to all SFHP members. The CMO provides oversight of the plan's Clinical Operations, Care Management (CM), Utilization Management (UM), and Pharmacy Benefits Management (PBM). Additionally, with guidance from the CMO, the Chief Health Equity Officer (CHEO) drives the implementation of the strategies and operational goals to ensure alignment of quality and health equity efforts. The CHEO oversees the plan's Quality Improvement (QI), Behavioral Health (BH), and Population Health Management (PHM). Finally, the CMO is responsible for developing and implementing medical policies and collaborating with the executive team to achieve organizational objectives and operational excellence.

The clinical Care Management team consists of licensed and unlicensed individuals from diverse backgrounds and experience who support our D-SNP population. This includes Registered Nurses (RN), Licensed Vocational Nurses (LVN), Licensed Clinical Social Workers (LCSW), Marriage and Family Therapists (LMFT), and Community Health Workers (CHW) who utilize their clinical judgment within their scope of practice to screen, assess, develop interventions and evaluate the outcomes of care planning. Non-clinical staff support our members and clinical staff with the clinical administrative functions. SFHP's Human Resources department has oversight of the licensing and verification of licensure for our licensed staff. Staff leadership provides competency verification as appropriate for each licensed role. SFHP contracts with a PBM to manage the administrative functions of the pharmacy benefit. Our pharmacy department monitors and oversees the PBM and other administrative and clinical program functions that support our Care Management team.

SFHP contracts with a BH vendor to manage the D-SNP BH benefit. The plan also contracts with LTSS and primary, specialty, and ancillary providers to support our members' physical, behavioral, psychosocial, cognitive, and functional needs in alignment with our MOC. Most of these entities employ licensed clinical staff (RN, LVN, Social Worker, Physician, Nurse Practitioners, Physician Assistants, Physical/Occupational/Speech Therapy) to provide face-to-face visits for members who may come into the office setting or be unable to leave their homes and need complex care in the home setting. SFHP considers these contracted entities an extension of our Care Management team. They contribute to the care planning process and often participate in the ICT. These entities are trained in our MOC and must adhere to our MOC standards.

Following is a list of the Clinical Health Team and their Roles and Responsibilities.

Table 2: SFHP Clinical Departments

Department	Clinical Position/Licensure and/or Credentials	Role Responsibilities	Oversight provided by:
Health Services	Sr. Medical Director Unrestricted Licensed Doctor of Medicine (M.D.) in the state of California	<ul style="list-style-type: none"> Provides leadership in developing and implementing UM, clinical appeals, and quality improvement strategies Supports medical directors in UM, clinical appeals, potential quality issues, and other clinical decision-making 	The Senior Medical Director reports to the CMO.
	Medical Director Unrestricted Licensed Doctor of Medicine (M.D.)/Doctor of Osteopathic Medicine (D.O.) in the state of California	<ul style="list-style-type: none"> Provides clinical guidance on medical necessity decisions to support UM and pharmacy staff Responsible for contacting attending and ED physicians to discuss member's care when appropriate Shares responsibility for UM and pharmacy decisions, making medical necessity determinations on authorization requests based on established criteria Investigate and resolve potential quality incidents and clinical grievances Provides clinical support to the Care Management team 	The Medical Director reports to the Senior Medical Director.
Care Management	Director, Care Management Licensed Marriage & Family Therapist (LMFT)/Licensed Clinical Social Worker (LCSW)/Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> Oversees Care Management operations and provides strategic leadership to ensure delivery of high-quality member Care Coordination and adherence to clinical protocols and regulatory standards Develop and implement Care Management programs, management protocols, and departmental strategy in consultation with senior leadership 	All Care Management staff report to the Director, Care Management, who reports to the CMO.

Department	Clinical Position/Licensure and/or Credentials	Role Responsibilities	Oversight provided by:
		<ul style="list-style-type: none"> Responsible for measurement, analysis, coordination, and implementation of initiatives aimed to improve the overall health outcomes of our D-SNP members 	
	Manager, Care Management Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> Responsible for the day-to-day operations of the Care Management department, including the direction, planning, implementation, and continuous improvement of all Care Management activities Function as the escalation point for clinical and operational issues from staff, members, and providers Responsible for the development and/or updates to policy and procedures, workflows, and department documents 	
	Supervisor, Care Management Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> Responsible for the clinical and administrative oversight of their multidisciplinary care team, who are providing Care Management for high/moderate/low-risk members 	
	Nurse, Care Manager Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> Responsible for conducting comprehensive assessments, developing individualized care plans, and ensuring continuity of care across healthcare settings Operates within an interdisciplinary team, collaborating closely to meet the diverse needs of high-risk members and optimizing health outcomes Educates members on self-management techniques to better manage their chronic conditions 	
	Nurse, Care Manager Licensed Registered Nurse (RN) in the state of California	In addition to the position functions of a Care Manager listed above, there will be Care Managers with experience and specialized training in the following: <p><u>Dementia Care Specialist(s)</u> must know the following:</p> <ul style="list-style-type: none"> Alzheimer's Disease and related Dementias Symptoms and Progression Managing behaviors and communication problems Caregiver stress Management of community resources for members and caregivers Dementia Care Specialists will be included in the development of the ICP and be part of the ICT <p><u>Palliative Care Specialist(s)</u> must know the following:</p> <ul style="list-style-type: none"> Eligibility criteria for Palliative Care Disease-specific Eligibility Criteria for Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Advanced Cancer and Liver Disease Advanced Care Planning 	

Department	Clinical Position/Licensure and/or Credentials	Role Responsibilities	Oversight provided by:
		<ul style="list-style-type: none"> • Palliative Care Assessment and Consultation • Plan of Care • Care Coordination • Pain and symptom Management • Mental Health and Medical Social Services needed <p>This role may lead the Palliative Care Team, which works together to meet the member's physical, medical, psychosocial, emotional, and spiritual needs.</p>	
	Transitions of Care Nurse Licensed Registered Nurse in the state of California	<ul style="list-style-type: none"> • Coordinates seamless transitions for members who are moving between different levels of care and care settings, including transitions to a home setting • Plays an integral role in ensuring continuity of care, preventing readmissions, and enhancing member outcomes 	
	Care Coordinator no license required	<ul style="list-style-type: none"> • Supports members, families, and caregivers with Care Coordination, including but not limited to: <ul style="list-style-type: none"> ○ Screening activities and general wellness education ○ Contributing to and updating the member care plan ○ Facilitating communication across the ICT ○ Referral follow-up and other administrative tasks • Provides ongoing education to the member about self-management techniques to remain an optimum state of health 	
	Health Risk Assessment (HRA) Coordinator no license required	<ul style="list-style-type: none"> • Supports the completion of HRAs both telephonically and face-to-face with identified members in the setting of the member's choice • May help members access services, including: <ul style="list-style-type: none"> ○ Scheduling appointments ○ Obtaining a medical home ○ Post-discharge follow-up • Accompanying members to provider visits and appointments with community resource agencies • Assisting with completing applications for programs for which they may be eligible. 	
	Interdisciplinary Care Team (ICT) Coordinator no license required	<ul style="list-style-type: none"> • Provides clerical support to the Care Management team by scheduling ICT meetings annually and as needed based on member need • Additional responsibilities include: <ul style="list-style-type: none"> ○ Telephonic outreach and engagement of members to complete their initial and annual health risk surveys ○ Data entry from completed HRAs into the member record, the Care Management documentation platform 	

Department	Clinical Position/Licensure and/or Credentials	Role Responsibilities	Oversight provided by:
		<ul style="list-style-type: none"> ○ Scheduling home visits for Care Management staff who need to meet with members in their homes or communities ○ Provide the primary intake and triage services for telephonic inquiries and referrals for the D-SNP Care Management team 	
Clinical Operations	Director, Clinical Operations Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> ● Oversees Utilization Management (UM), including concurrent review (CCR), prior authorization (PA), post-acute, long-term care (LTC), and complex discharge planning ● Provides strategic guidance to ensure members receive the proper care at the right time and place ● Ensures the UM department adheres to all regulatory and accrediting body requirements ● Provides direction to clinical operations leadership to ensure adequate staffing and training ● Collaborates cross-functionally to ensure the successful servicing of members and providers 	All Clinical Operations staff report to the Director, Clinical Operations, who reports to the CMO.
	Nurse Manager Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> ● Oversees the daily operations of the prior authorization, CCR, and LTC teams ● Ensures UM nurses are meeting turn-around times (TATs) ● Ensures adequate staffing and training to support the authorization volume ● Manages clinical and operational issues and escalates to the director or medical director as appropriate ● Build relationships with providers to manage any UM concerns 	
	Nurse Supervisor Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> ● Supervise CCR or post-acute nurse staff ● Builds and maintains relationships with SNF, hospital, and other post-acute providers 	
	UM Nurse Licensed Registered Nurse (RN) or Licensed Vocational Nurse (LVN) in the state of California	<ul style="list-style-type: none"> ● Responsible for reviewing prior authorization requests for medical necessity and benefit ● Work collaboratively with medical directors on authorization requests ● Coordinate care/provide discharge planning assistance for members when needed ● Post-acute nurses assist members and facilities in transferring members to the right level of care 	
	Authorization Coordinator no license required	<ul style="list-style-type: none"> ● Review all intake authorization requests that come in by phone, fax, email, or portals ● Creates authorizations and attaches appropriate documentation ● Provides administrative support to nurses 	
Pharmacy	Director, Pharmacy	<ul style="list-style-type: none"> ● Coordinates and monitors all aspects of the pharmacy program for members, ensuring the pharmacy 	All Pharmacy staff report through the Director, Pharmacy

Department	Clinical Position/Licensure and/or Credentials	Role Responsibilities	Oversight provided by:
	Licensed Doctor of Pharmacy (PharmD) in the state of California	department's overall compliance, operational and financial performance, and customer experience	who reports to the CMO.
	Clinical Pharmacist Licensed Doctor of Pharmacy (PharmD) in the state of California	<ul style="list-style-type: none"> Provides both direct medication-related counseling to selected/targeted members and medication-related consultative expertise to other health services clinical staff Produce Drug Utilization Review (DUR) analyses as required and respond to pharmacy-related population health priorities Supports the quality improvement program via measure development, tracking, and data analysis Provide oversight of Medi-Cal pharmacy utilization, including state-level advocacy and provider support 	
	Program Manager, Pharmacy Certified Pharmacy Technician (CPhT) in the state of California	<ul style="list-style-type: none"> Ensures that pharmacy staff have current and clear policy direction for clinical and procedural decision-making through Policies and Procedures (P&Ps) and desktop processes reconciled with state and regulatory requirements and NCQA guidelines Coordinates pharmacy preparation and participation in all audits Provide program oversight and planning to ensure regulatory and accreditation compliance for pharmacy services and all delegated vendor-delivered services Accountable for oversight and monitoring of functions delegated to the PBM, the pharmacy network, and other vendors/delegates 	
	Pharmacy Analyst Certified Pharmacy Technician (CPhT) in the state of California	<ul style="list-style-type: none"> Accountable for accurate and timely analysis of pharmacy claims transactions utilizing the pharmacy claims processing system and other PBM reporting tools Use research and analysis to identify claim anomalies and offer solutions Manage special projects within the pharmacy department Participate as the pharmacy representative on cross-departmental projects 	
Behavioral Health	Behavioral Health Manager Licensed Professional Clinical Counselor (LPCC) in the state of California	<ul style="list-style-type: none"> Manages the administrative aspects of all delegated and carved-out behavioral health and substance use disorder programs for SFHP Responsible for managing the MBHO contract and overall relationship Ensures delegated entity provides and /or arranges for member counseling as needed 	The Behavioral Health Manager reports to CHEO who reports to the CMO.
Quality	Nurse Supervisor, Quality Review Licensed Registered Nurse (RN) in the state of California	<ul style="list-style-type: none"> Responsible for overseeing the clinical (non-administrative) functions of grievances and appeals, including ensuring that grievances and appeals are adequately categorized and processed appropriately (i.e., expedited vs. standard) and thoroughly investigated, ensuring that any risk of 	All Quality Review staff report through the Nurse Supervisor, Quality Review, who

Department	Clinical Position/Licensure and/or Credentials	Role Responsibilities	Oversight provided by:
		imminent harm to members is identified and acted upon promptly	reports to the Senior Medical Director.
	Quality Review Nurse Licensed Registered Nurse (RN) or Licensed Vocational Nurse (LVN) in the state of California	<ul style="list-style-type: none"> Ensures each case is reviewed for potential quality issues and investigated accordingly Responsible for processing clinical aspects of grievances and appeals according to regulatory requirements Review each case to assign category and subcategory, identify potential quality of care issues, and ensure medical director review Conduct member assessments and education by phone as needed Screen each case for PQIs 	
	Quality Review Navigation Specialist no license required	<ul style="list-style-type: none"> Provides support to the quality review team in following up to ensure members receive the care or services they requested Includes interacting with providers, vendors, and members to ensure timely access to providers and receipt of appropriate DME Assists with projects related to improving member satisfaction and reducing grievances 	

As SFHP looks to the future to enhance our Care Management team, we may consider other care team roles as necessary to best meet the needs of our members.

As aligned with DCHS, there are eight distinct California Integrated Care Management (CICM) populations amongst the most vulnerable members who are prioritized for enrollment in our Care Management programs. These populations include:

- Adults Experiencing Homelessness
- High utilizer adults with frequent hospital admissions, short-term Skilled Nursing Facility (SNF) stays, or Emergency Department (ED) visits
- Adults with Serious Mental Illness (SMI) and Substance Use Disorder (SUD)
- Adults transitioning from Incarceration
- Members eligible for Long Term Care (LTC) and at risk of institutionalization
- Nursing Home residents transitioning to the community
- Adults who are Pregnant or Postpartum and subject to Racial and Ethnic Disparities
- Adults with documented Dementia needs

Members within these CICM populations will require evaluation, assessment, and enrollment in the most appropriate Care Management programs to improve their health outcomes. Without the support of Care Management, they risk increased utilization of costlier, more fragmented services and institutionalization.

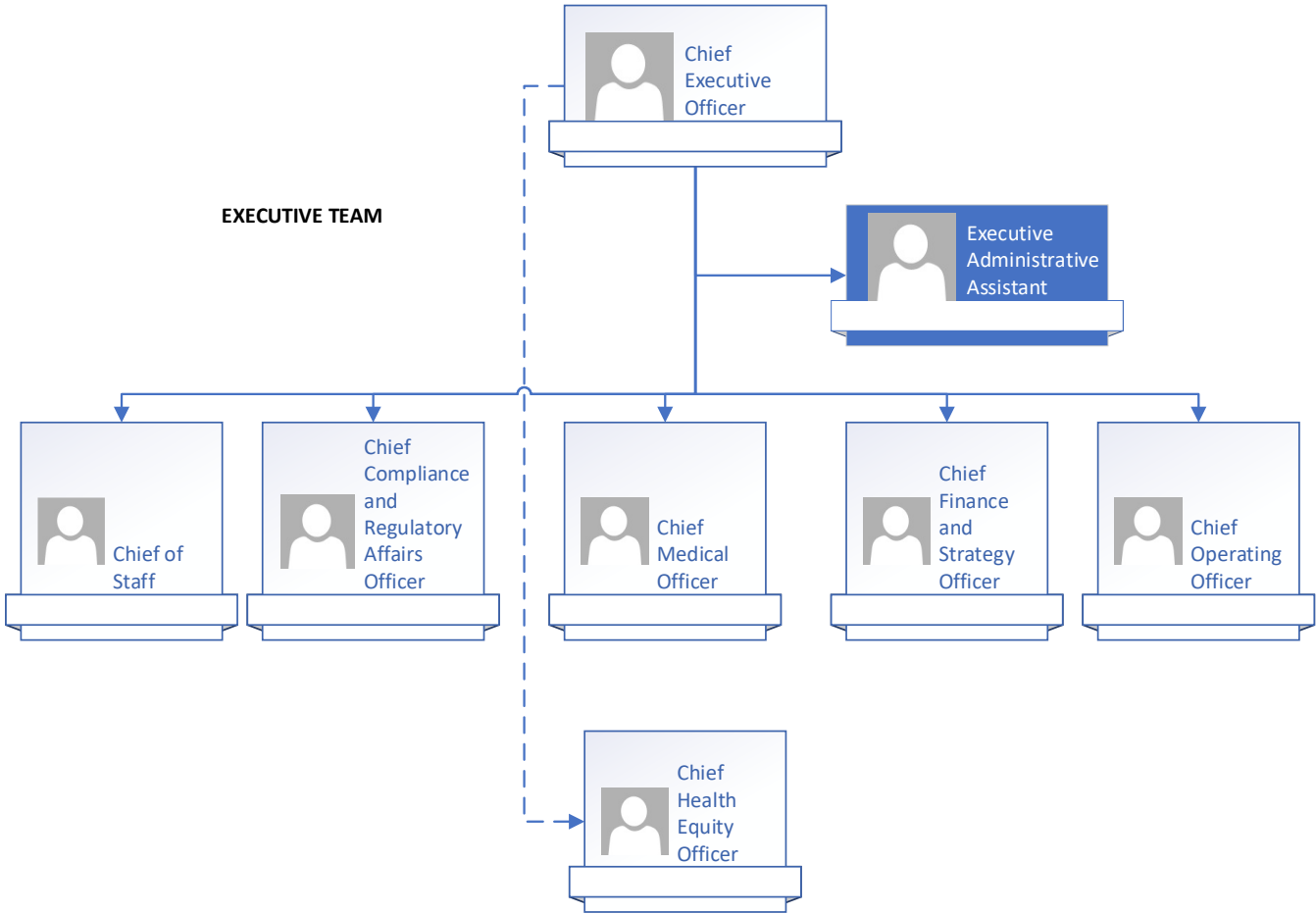
Members within the CICM populations will be provided opportunities for intensive interactions and in-person visits in settings that are most appropriate for them, such as where they live, seek care, or prefer to access services, and in a culturally relevant and timely manner, as aligned with their preferences.

In collaboration with our internal teams and extensive provider network, our Care Management team takes a whole-person approach to care, addressing our members' clinical and non-clinical needs. Together, we ensure the following:

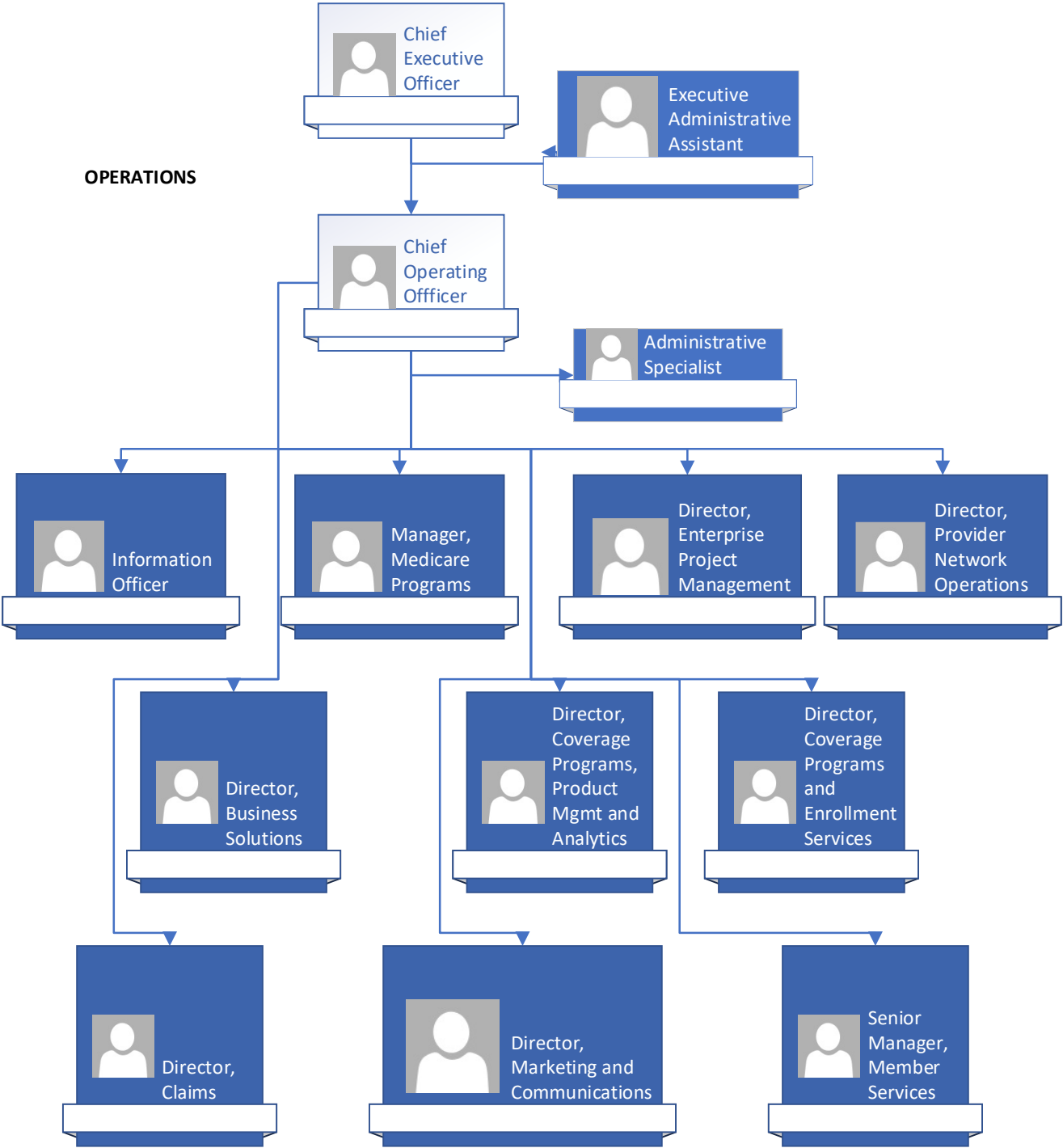
- Outreach and engagement with all our members
- Screening and completion of comprehensive assessments that lead to the development of individualized care plans with S.M.A.R.T goals
- Enhanced Care Coordination with our primary care, specialists, and community partners
- Promotion of a healthy lifestyle and self-management techniques for chronic conditions
- Provision of transitional care across and between all care settings
- Support for our members and their families/caregivers
- Coordination of community and social support services, including LTSS, housing, and community support

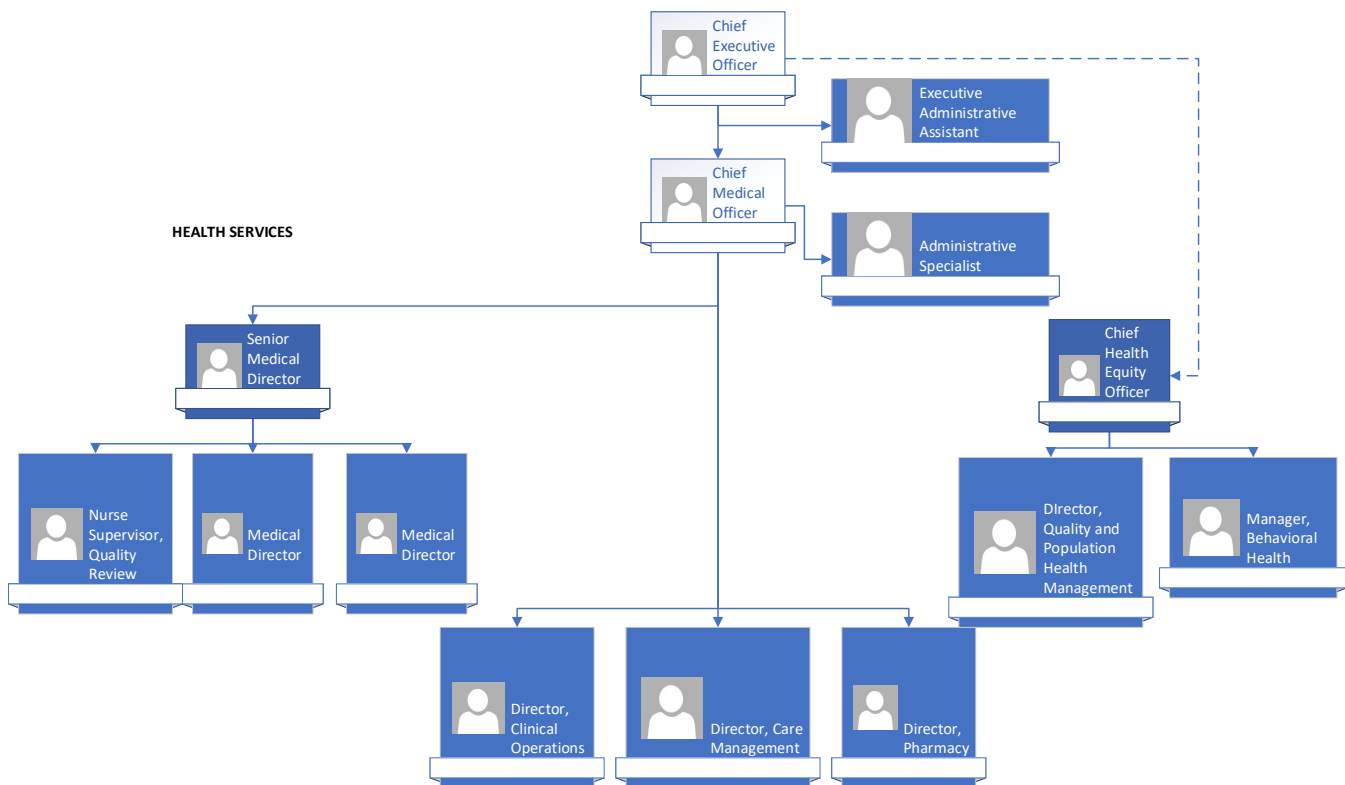
Factor 3: Provide Organizational Chart

Below are organizational charts for SFHP, including the reporting structure for the executive team, operations, and healthcare services through which all positions ultimately report. When a change to staff title/position or level of accountability is requested to accommodate operational changes in the D-SNP, an updated job description and organizational chart will be completed to reflect the change.



OPERATIONS





Factor 4: Specify Contingency Plans

SFHP has established policies and processes to prepare for and respond to potential interruptions or disasters that may impact the organization. These documented processes are reviewed annually and outline SFHP’s steps to assess, activate, and communicate disaster recovery, business continuity, and data backup and restoration plans to ensure core business applications and critical business functions continue within determined Recovery Time Objectives (RTOs). SFHP aims to continue critical functions and services to its members, providers, and staff members with the minimum disruption possible while concurrently meeting any applicable contractual and regulatory requirements. Some examples of these critical functions include members’ access to care, vital resources, and essential updates during any operational disruptions that SFHP may encounter.

Designated SFHP employees receive regular training and reminders on disaster recovery & business continuity plans, including routine testing using real-world scenarios. SFHP is a hybrid work organization and has a network infrastructure that allows staff to conduct work in alternate locations in the event of a regional disruption, declared emergency, or natural disaster. SFHP’s Information Technology Services team annually performs a failover disaster recovery test to a secondary data center to ensure resources and information are available to continue critical functions. Functional testing is performed, and SFHP utilizes database mirroring to prevent data loss. Additionally, SFHP contracts with third-party business continuity and disaster recovery vendors that provide alternate physical locations where SFHP staff can work when needed. The business continuity vendor helps prepare SFHP for potential business disruptions by facilitating tabletop exercises to test plans in various scenarios.

Care Managers/Coordinators will work with providers and contact members who may be affected by a disaster, particularly vulnerable populations dependent on technology or in-home care providers for their well-being. In addition, to ensure members' needs are met during a disaster, SFHP will maintain contractual relationships with a vendor to assist with essential staffing.

Factor 5: Describe MOC Staff Training

SFHP utilizes a multidisciplinary approach in developing and annually reviewing the MOC training materials. This ensures that the training remains relevant, addresses content applicable to the D-SNP population, and meets all regulatory requirements. D-SNP MOC training is administered to all SFHP-employed and contracted staff upon hire and annually after that. The following topics are included in the MOC training.

Section 1: Description of the D-SNP Population, including the Most Vulnerable Population

This section will include the demographics (age, gender and ethnicity), incidences and prevalence of major diseases and chronic conditions and other medical, behavioral, cognitive, and psychosocial needs identified in the population assessment and vulnerable population characteristics.

Section 2: Care Coordination Process

This section will include details of the care team's responsibilities, specific considerations related to our members' characteristics identified in the population, and specific responsibilities related to the Care Management process.

- Roles & Responsibilities of the Care Team, both Administrative and Clinical.
- Health Risk Assessment Tool (HRAT), including how initial and annual HRA assessments are completed, how the data from the HRAT is used to develop the ICP and how it is disseminated among the ICT members.
- Individualized Care Plan (ICP) including the essential components of the ICP, how the ICP is developed, where it is maintained and how it is updated and shared with the ICT.
- Face-to-Face Encounter (F2F), detailing the F2F encounter essentials, the personnel qualified to hold a F2F encounter, how SFHP verifies F2F encounters, the clinical functions and assessments that can be completed, how any identified health concerns are addressed and the Care Coordination activities that occur during the F2F encounter.
- Interdisciplinary Care Team (ICT), describing the ICT members often a part of the ICT meetings, the roles and responsibilities of those participating in the ICT, how Care Management outcomes for the member are evaluated and the communication plan for sharing information among the ICT. All ICT members will be trained on our MOC, especially concerning LTSS and community-based services.
- Care Transition Protocols including how the Care Management team facilitates all care transitions, the care transition personnel involved, how ICP elements are transferred between entities with the member and the importance of self-management activities.
- Cultural Competency is training designed to improve staff's understanding and sensitivity towards diverse cultures.
- LTSS include medical and personal care services for people who struggle with self-care due to aging, illness, or disability. Questions in the HRAT will identify these services and whether the member is receiving them or eligible for these services.
- Dementia care training includes specific information about how the care team manages our members with Dementia, including:
 - Understanding Alzheimer's disease and related dementias
 - Symptoms and progression

- Understanding and managing behaviors and communication problems
- Caregiver stress and its management
- Community resources for members and caregivers

This training will include the importance of the Alzheimer’s Organization and the training and resources that the agency offers. The Dementia Specialists on the care team will be included in developing member care plans for this population of members and discussions with the ICT as the ICP is created and updated.

- Palliative Care training will include specific information on how the care team manages our members needing or receiving Palliative Care. This training will consist of:
 - General eligibility criteria for palliative care
 - Disease-specific eligibility criteria for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), advanced cancer, and liver disease
 - Members in palliative care will receive the following programmatic services:
 - Advanced care planning
 - Palliative care assessment and consultation
 - Plan of care specific to the care needs of these members
 - Palliative care team
 - Care Coordination
 - Pain and symptom management
 - Mental health and medical social services

Our Palliative Care Specialists will lead the member’s ICT to provide information, ongoing education, and guidance to the ICT in the care planning and delivery. The Palliative Care Treating team will be included as part of the ICT to ensure appropriate ICP development in alignment with the member’s preferences and current treatment plan.

- Behavioral health services encompass a broad range of services, including helping members understand their thought processes, emotional responses, and stress reactions, addressing addictions and changing habits, and facilitating further diagnosis and treatment for mental health and substance use disorders.
- Integration of Medicare & Medi-Cal Benefits through SFHP. This provides a seamless experience for the member, enabling both program benefits to be coordinated and maximized to obtain the best health outcomes for the member. Several questions related to Medi-Cal benefits are included in the HRAT to understand what the member is receiving and could potentially be eligible to receive.
- Community Supports (CS): This section provides an overview of Medi-Cal Community Supports program benefits and how to refer D-SNP members to those providers.
- Member rights & responsibilities, including what members can expect from their health plan and SFHP network providers and what the SFHP and our network of providers expect of them.

Section 3: Provider Network

This section discusses the specialized network of providers and the expertise it brings to caring for SFHP members. It also includes the role of the PCP and other providers in the member’s ICT and ICP development.

Section 4: MOC Quality Measurement and Performance Improvement

This section will review the overall Quality Improvement (QI) process, including how QI data is collected, the process of setting and evaluating QI goals, and the survey process for D-SNP plans.

The first MOC training for new Care Management staff is conducted after the new hire orientation. Depending on the presented content, it is provided using different modalities, including in-person, virtual, and/or self-study formats. Training is offered using multiple strategies to cater to the needs of adult learners. These strategies include the ability to revisit slides, repeat content,

and provide audio cues as well as written transcription. The Care Management trainer coordinates the training schedules for the Care Management staff and ensures completion of the training within the first 90 days of employment. A competency test is included at the end of each training. Upon completion, staff must pass the test with an 80% or higher score.

Training materials are provided to all staff (employees, contracted and non-contracted) through Litmos, our learning management platform. They are stored in the Learning Center within Litmos and are also available to providers through the SFHP provider portal.

Please refer to Appendix A for a sample of the MOC Training Program.

Factor 6: Maintain Training Records

SFHP provides MOC training during new hire orientation and annually after that. All employed and contracted staff must complete the training through Litmos within 90 days of their hire date. The Litmos software tracks the course test grades for all employed and contracted staff and electronic attestations that they completed the training. The software generates a report to identify staff who have not completed the training for appropriate follow-up from their supervisors. All network providers are required to take the MOC training and complete a statement attesting to that as well. Training for providers is detailed further in MOC 3 Provider Network.

Factor 7: Actions Taken for Incomplete or Deficient Training

SFHP recognizes that there may be challenges associated with employed and contracted staff completing the MOC training. Examples may include a leave of absence or staff illness. In this instance, staff have 30 days to complete the training upon returning to work. Other challenges may consist of competing tasks, limited time to take the training, or system challenges. The staff member is responsible for communicating these challenges to their supervisor, who can assist with removing barriers. Supervisors can track any staff who have not completed the training within the given timeframe in the Litmos system. Failure to complete training in a timely manner may result in progressive corrective actions, beginning with a supervisory discussion and developing an action plan with deliverables and due dates established, up to and including possible termination.

As part of the MOC Training, all employed and contracted Care Management staff will receive education regarding Dementia and Palliative Care. This is included with the general training topics outlined earlier. Newly hired Care Management staff are also required to complete this part of the training.

Element B: Health Risk Assessment Tool (HRAT)

The Health Risk Assessment Tool (HRAT) is vital for gathering annual baseline and comparative information on new members. SFHP has structured policies and procedures for the HRA process, and the SFHP employed and contracted staff are monitored for adherence to our policies and procedures

Factor 1: Conduct Initial and Annual HRA Assessments

SFHP has an established policy and procedure regarding the HRA process. It details how the HRA is distributed and available to the member, the staff available to assist the member, and how outreach is conducted, including who does the outreach, the timing and frequency, and the modalities employed to complete the HRA. The HRA will attempt to screen every D-SNP member upon initial enrollment and annually after that, as well as when there is a change in the member's status or if a care transition should occur. The HRA assesses the member's medical, functional, cognitive, psychosocial, and behavioral health needs. It also includes questions about current Medi-Cal services that the member may be accessing, actual and potential

LTSS needs, and any Alzheimer's and palliative care support needs that the member may have. There are questions specifically addressing the use of or potential need for Medi-Cal and LTSS services that the member may have. Specific attention was paid to the three domains (housing stability, food security, and access to transportation) that the State requires health plans to address. The member is asked explicitly about the following:

- Transportation help
- County Alcohol or Drug Outpatient Services
- County Mental Health Services
- Food Assistance Programs (Meals on Wheels, CalFresh, Food Banks)
- Help paying Utility bills
- In-home Supportive services
- Regional Centers for assistance
- Housing Services – specifically if the member is at immediate risk for homelessness
- Dental Services

Based on the answers to the questions above, the Care Manager/Coordinator will pursue further questioning for additional information and clarity. Any questions identifying potential issues or problems will be included in the member's ICP for further discussion among the ICT and problem-solving opportunities.

Additionally, the HRA screens the CICM Populations identified in MOC 2, Element A, Factor 2 for any additional care and service needs they may have. If a member identifies a caregiver involved with their care, an assessment of caregiver support is integrated into the HRAT and the member assessment process. The caregiver's name, phone number, and relevant contact information are documented and included in the development of the member's ICP. Services to support the caregiver are included in the ICP as appropriate.

Each question on the HRA generates information that can identify the services and support the member is receiving, and the additional Care Management services the member needs or could benefit from. The member, the member's caregiver, family, or any other designee can complete the HRA in collaboration with or on behalf of the member.

The HRA includes questions to obtain the following information:

- Demographic characteristics (i.e., race or ethnicity)
- Self-perceived health status (assessment of general health)
- Personal health history (i.e., past and current medical conditions, medical utilization)
- Lifestyle (i.e., tobacco and alcohol use)
- Social determinants of health (i.e., transportation needs, financial, food insecurity, housing)
- Special needs assessment (i.e., language preference)
- Mental health history or concerns
- Medi-Cal services currently being utilized
- Actual or potential LTSS needs
- Dementia needs
- Palliative care needs
- Caregiver involvement and support

HRAs may be completed in person, by phone, or by mail. A letter within the New Member Packet is sent with the HRA to explain the purpose of the self-reported assessment and how the information obtained from the HRA will be used. If no HRA was completed from this opportunity, outreach to members to complete the HRA is initiated by a member of our Care Coordination staff. Within the first ninety (90) calendar days of the effective enrollment date, Care Coordination staff will attempt a combination of three (3) telephonic attempts or texts at different times of the day and days of the week and one (1) mailing requesting that the member contact SFHP. The purpose of the call, text, and letter is to follow up on the HRA status and to assist the member with completing the HRA telephonically or in person. A subsequent mailing may be necessary if a member requests to fill out the HRA and return it by mail. If the staff fails to engage the member, they will attempt to contact the member's PCP to confirm the correct contact information.

For continuously enrolled members, annual HRA reassessments are completed within three hundred and sixty-five (365) calendar days of the previously completed HRA or by the enrollment anniversary. Care Management staff will complete three (3) attempts via telephone, at different times of the day and other days of the week, and one (1) letter before the three hundred sixty-fifth (365th) calendar day from the previously completed HRA or anniversary of enrollment.

If a member experiences a change in health status and is hospitalized before completing their HRA, they will be offered assistance to finish it over the phone or in person while in the hospital. Additionally, members will receive outreach follow-up phone calls throughout the year as part of our Care Management Policy and Procedures to update their HRA and care plan as needed. All communication with members, their PCP, and ICT, including mailings, texts, and phone calls, is documented in the member record located within our Care Management documentation system.

Factor 2: Use of HRAT Information to Develop the ICP

There is an in-house process for collecting, disseminating, and acting upon the HRA responses received. Upon receipt of completed HRAs, the members' responses to the questions are entered into their Care Management records. Completing the HRA assists Care Management leaders in risk stratification and assigning the members to the most appropriate Care Management staff. It, along with additional assessments appropriate for the member, will inform the creation of the ICP in collaboration with the member and their ICT.

The Care Manager/Coordinator will go over the issues and concerns listed in the ICP with the member or caregiver, and together, they will prioritize what the member wants to focus on. In our experience, members may choose to focus on more immediate needs, such as SDoH, before addressing physical or behavioral issues. Because the ICP is member-centered, the care team supports the member's choice to the extent possible. If a critical health issue is identified, the Care Management team will also work with the member to prioritize this issue. Issues identified through the HRA are listed in the ICP and addressed according to the member's preferred timeline. The ICP will be updated based on the member's responses to the HRA and any changes in their health status, such as transitioning to a different level of care, onset of new conditions, or changes in existing conditions.

Factor 3: Dissemination of HRA Information to the ICT

Potential ICT members are identified and discussed during the early discussions that the Care Manager/Coordinator has with the member/caregiver. At a minimum, the ICT is comprised of the member/caregiver, the member's PCP, and SFHP's Care Manager/Coordinator. It can include additional members based on the needs and preferences of the member. ICT members include specialists, LTSS providers, Alzheimer's and palliative care specialists, other community agency representatives, and the members' friends and families. All ICT members offer unique perspectives and insight into the member's care journey. They are all trained on the MOC before their inclusion in the ICT.

Information from the members' HRA and ICP is shared with the ICT during ICT meetings and through ad hoc discussions, as necessary. Members in palliative care have an ICT led by our Palliative Care Specialist. This ICT also includes the member's palliative care treatment team to ensure alignment of the ICP with the treatment plan established. Members with dementia have ICTs that our Dementia Specialists lead. Members with complex diagnoses must have an ICT consisting of providers and specialists whose expertise can contribute to developing the ICP. This exchange of information with a member's ICT is to help coordinate care from multiple perspectives and from people who know the member best. Such discussions are documented in the member record and updated in the ICP. The member's primary Care Manager/Coordinator is responsible for confidentially conveying all updates to the appropriate ICT members via phone, mail, secure email, fax, or text. If the member chooses not to complete the HRA or ICP, their access to covered services will not be affected. However, the member will remain assigned to a Care Coordinator who will periodically attempt to engage with the member and reassess if the member is interested in further Care Management services.

If the HRA is not completed with the member/caregiver, either by the member declining to participate or being unable to be reached, the member's medical and pharmacy claims, utilization data, and any other available information or data points are used to guide the development of their ICP. Members receive a copy of their ICP and the contact information of their assigned Care Manager/Coordinator, along with the Care Management department at SFHP. The member's assigned PCP also receives a copy of the ICP. The PCP gets information about their role in the ICT and how to contact the member's Care Manager/Coordinator to discuss the ICP.

Factor 4: Explain the HRAT Methodology and Communication Plan

One of the uses of HRA data is to help determine the member's potential risk level. The risk level drives the member's assignment to the appropriate Care Management program and staff member. Post-HRA completion, a clinical Care Management staff member reviews the HRA data to validate that the suggested level of risk (high, moderate, or low) from the HRA appears appropriate. In addition to the HRA data, members are stratified based on several other data points, including but not limited to claims data, the number of chronic conditions, pharmacy data, frailty indicators, and SDoH risk scores. Our internal data systems compile all of this data and run it through an algorithm that categorizes members into appropriate risk tiers. This data is refreshed daily to account for member status and utilization changes.

SFHP Care Managers/Coordinators review the HRA results to assess the member's overall health and wellness needs, including their self-management abilities. In conjunction with the HRA responses, Care Managers review all available health plan data to ensure the member is assigned to the most appropriate Care Management risk level that will address their medical, cognitive, social, mental, and functional health needs as appropriate. Subsequently, program-specific assessments are conducted to determine if any specific barriers, such as cognitive, social determinants, or caregiver deficits, would impair the member's ability to access health care. Program-specific ICP interventions are developed to address the member's health care risks.

Element C: Face-to-Face Encounter

Factor 1: Detail Face-to-Face Encounter Essentials

All members must have at least one (1) face-to-face encounter with their care team within the first 12 months of enrollment and at least annually after that. These encounters can be with the member's healthcare provider, with a member of their ICT, or with a Care Management team member. These visits can be delivered through telephonic and in-person interactions in settings most appropriate for the member, such as where the member lives, seeks care, or prefers to access services, and in a culturally relevant and timely manner, aligned with the members' preferences. Care Management staff are equipped to

utilize any audio/visual or translation assistance available during their interactions with members. Should a member request a virtual/telehealth visit with their provider's office, the provider is expected to accommodate that request if it is safe and feasible. Care Management staff offer opportunities to meet with members in person during their initial enrollment to the health plan, during their annual reassessment, and if indicated by the member's ICP. Our team recognizes the value of face-to-face interaction and strongly encourages it with our members. At a minimum, the intended outcome of a face-to-face encounter is to increase member engagement and promote coordination of services between members, their providers, and individuals of their ICT.

The objective and expected outcomes of a face-to-face encounter include:

- Engagement in primary and specialty care
 - Increase access to preventive care
 - Increase access to chronic condition care
- Building a trusting relationship with a Care Management staff member
- Connect in multi-sensory ways to:
 - Enhance the member experience, particularly for members with one or more impairments
 - Maximize the assessment process using all available senses of the Care Coordination staff

If the member declines the face-to-face visit or cannot be reached to schedule the visit, documentation is placed in the member's record. Staff must follow the process of three (3) telephonic/text attempts on different days and at different times of the day, along with a letter mailed to the member. Reporting is available, informing Care Management leadership of which members need a face-to-face encounter. Supervisors follow up with the appropriate Care Manager or Care Coordinator to schedule the visit.

Factor 2: Describe Qualified Personnel

The SFHP care team consists of clinical and non-clinical staff from various departments throughout the Health Services division. It includes registered nurses (RN), licensed clinical social workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Care Coordinators, health educators, community health workers (CHW), and pharmacists, all of whom may conduct the annual face-to-face encounter with the member. The SFHP care team also consults with SFHP Medical Directors as needed.

Specifically, the qualified personnel to conduct the annual face-to-face visit include:

- A member of the care management staff, working with the member as part of the team
- Participants of the member's ICT, including providers and specialists treating the member.
- A contracted health plan care provider treating the member

The SFHP staff coordinates opportunities for in-person encounters according to members' needs and preferences. If preferred by the member and with their consent, these staff may see a member face-to-face or use real-time and visual technology. Care Management staff adhere to SFHP's telehealth and privacy policies, including telehealth platforms meeting confidentiality and privacy protection requirements. In addition, contracted providers must conform to SFHP's telehealth and privacy policies.

SFHP understands that some members may be challenging to reach to complete their annual face-to-face visit, such as those experiencing homelessness. SFHP is committed to partnering with community-based organizations that may be able to connect hard-to-reach members to SFHP and our Care Management program. Members with mobility limitations or BH

conditions that prevent them from engaging with in-person care or visits may receive, with member consent, in-home services/visits or other qualifying telehealth services. The Care Management team may assist in arranging transportation or interpreter services for providers to ensure members have a successful provider visit.

Individuals transitioning from incarceration often face homelessness, making it vital for them to receive support in rebuilding trust and re-engaging with the healthcare system and their Dual Special Needs Plan (D-SNP). To meet the annual face-to-face requirement for this population, the Care Management team will collaborate with providers who serve justice-involved individuals, including our behavioral health (BH) providers and community partners that specialize in assisting those experiencing homelessness. Many of these members may lack a stable home upon their release, highlighting the importance of working with providers who understand their unique challenges.

Members transitioning from an inpatient setting to a skilled nursing facility (SNF) or a long-term care (LTC) facility will receive support from their Care Management team. This team may conduct an in-person or face-to-face visit with the member to ensure a smooth transition and to address all transitional care needs. Additionally, the Care Management team, in collaboration with the Utilization Management (UM) team, will monitor members in SNF and LTC settings for opportunities to facilitate their return to the community with the necessary long-term services and supports (LTSS).

Factor 3: Verify Qualifying Encounters

One of the goals of our Care Management program is to ensure that all D-SNP members access primary care and specialty care, if needed, at least annually to address preventative care measures and health maintenance opportunities. Reporting is available to identify all members' face-to-face encounter statuses each week. This report will capture claims and encounters data for face-to-face and qualifying telehealth visits. SFHP will also collect encounter data from other ICT participants, such as LTSS providers, and face-to-face visits with the Care Management team. The monthly report will flag members nearing the 12-month mark who have not had a face-to-face visit. Those members will receive intensified outreach through multiple avenues, including a face-to-face visit whenever possible.

Factor 4: Specify Clinical Functions and Assessments

Face-to-face encounters with providers may include but are not limited to any encounter or visit between the member and a provider either in person or via telehealth to discuss the member's health condition, health care goals, including behavioral health interventions and goals, SDoH needs, answer healthcare questions, or receive an annual physical/wellness assessment. Face-to-face encounters with SFHP Care Management staff may occur for completion of the HRA and other additional assessments relevant to members' current condition and needs, development or updates to the ICP, participation and attendance at the members' scheduled ICT meeting, or to assist members experiencing a transition of care.

The ability to meet with members where they live allows Care Management staff to see firsthand the home environment and conditions in which the member may live. Knowing this can often help the Care Manager, Care Coordinator, member/caregiver, and ICT set or reset more realistic care plan goals.

Factor 5: Address Identified Health Concerns

SFHP contracts with primary and specialty care providers to assess, examine, diagnose, and treat our members according to their licensure and scope of practice. They educate the member/caregiver on care recommendations and potential issues that may arise from a treatment option or if the member chooses not to engage in a recommended treatment option.

The Care Management staff gathers information about the treatment plan and provider recommendations. They reinforce and clarify, identify additional materials and resources, and locate/facilitate referrals to services and community-based organizations that can help members successfully achieve their healthcare goals.

If the Care Manager/Coordinator identifies a health concern during a visit, including a face-to-face visit, it is documented in the ICP and communicated to the appropriate provider for additional direction unless the Care Manager/Coordinator and the ICT can provide the proper intervention and follow-up. Health concerns can encompass many physical, emotional, and social support issues. Care Managers/Coordinators follow SFHP policies and procedures to communicate, escalate, and address problems in alignment with their licensure, scope of practice, or training.

Factor 6: Conduct Care Coordination Activities

Care Coordination activities encompass various potential actions and services provided or coordinated by the Care Management or ICT team, often in collaboration with a medical or BH provider.

For members stratified as low-risk, Care Coordinators seek to keep them healthy and engaged in their healthcare system and community without unnecessary healthcare services. They discuss the importance of annual wellness exams and routine physicals with their PCP and assist in closing gaps in care. If they have a medical or behavioral health condition, it is often well managed. Health education resources are identified and provided as needed. Care coordination activities at this level may be primarily conducted through the PCP and can include, but are not limited to, submitting referrals for specialty care, ordering laboratory work or radiology, and communicating results between and among service providers. Care coordinators ensure that results are communicated to the member and members of the ICT and noted in the ICP as well.

Members at a moderate risk level often have a chronic condition(s) that may or may not be well-controlled. That, combined with a set of risk factors, like smoking, obesity, hypertension, or diabetes, can result in the member being at an increased risk for worsening of the condition(s) or hospitalization. Disease management programs in collaboration with monitoring technology can allow the member, the Care Manager/Coordinator, and the provider to monitor and work with the member to improve their self-management skills. Care Managers/Coordinators work closely with providers regarding additional referrals or social and supportive services that might be needed. Examples of care coordination activities could include referrals for standing lab work, medical equipment or supplies, and referrals to appropriate disease management programs or outpatient classes. The Care Manager/Coordinator ensures that referrals are made, and/or orders sent to the appropriate service provider or entity and that there is f/u by the member. Identifying barriers to member follow-through and removing those barriers are key activities of the Care Manager/Coordinator.

Members stratified as high-risk need a more structured Care Management program with frequent support in managing medical, social, and behavioral issues. They receive Care Management from a licensed RN or social worker, which is enhanced by the coordination within the provider's office. High-risk members may experience lower health literacy, experience additional cognitive and functional limitations, and engagement with the healthcare system may be intermittent at best. Advanced care planning is done with the member/caregiver, the ICT, and the providers. Consideration for dementia supportive services or a palliative care program may be necessary, requiring support from the ICT and providers to gain the member's acceptance. Additional examples of care coordination activities at this risk level could include but is not limited to, following up on referral status, scheduling appointments or transportation, facilitating communication between multiple entities, and referring to LTSS or other community-based resources as needed.

Care Coordination activities before, during, and after any care management interaction, including the face-to-face visits, are based on a number of factors including, but not limited to, the member's risk level, as detailed above, the urgency of the care

coordination needs, and if there are pending referrals. The Care Manager/Coordinator works with the member, their caregiver if involved, and their PCP to coordinate all the needed medical, behavioral, and social services identified to meet the needs of the member. The PCP plays a pivotal role in coordinating primary and preventative care with care provided by specialists and community-based providers.

In looking at the CICM populations identified earlier, coordinating care for the homeless may represent a significant challenge. Our Care Managers/Coordinators will work with local street reach organizations for example, who specifically treat the homeless. For members frequenting the Emergency Department or Inpatient Setting, the Care Manager/Coordinator will work to establish open lines of communication so that needs can be identified and interventions put into place quickly. Care Managers/Coordinators will access the BH services team to assist in managing members with mental health and substance use disorders to ensure proper placement and support are in place for recovery. BH services may also assist in contributing to the management and coordination of services for those members transitioning from incarceration. Finally, the Care Manager/Coordinator will work with prenatal and postpartum service programs in place to further support pregnant women during and after delivery as needed.

Many of these populations will require the face-to-face visit to build rapport, establish trust, and ensure that needed services are identified and provided in a culturally appropriate way and in accordance with member choice.

Element D: Individualized Care Plan (ICP)

Factor 1: Describe Essential Components of the ICP

The ICP is developed utilizing data from several data sources, including but not limited to:

- Completed HRAs
- Additional assessments relevant to member's current condition and needs
- Medical and pharmacy claims
- Lab and diagnostic results
- CPT codes
- Medical records
- Utilization data, including inpatient stays, emergency department visits, and PCP visits
- Number of chronic conditions

The Risk Stratification and Segmentation (RSS) Report transforms this data into a Risk Tier Report, categorizing members as high, moderate, and low risk. This assists leadership in assigning members to the appropriate level of Care Management programming.

The ICP also incorporates member/caregiver input, including member self-management goals and objectives, member healthcare preferences, the role of the member's caregiver, if applicable, relevant preventative care screenings, services specifically tailored to meet the member's individualized needs, and identification of ICP goals. As goals are established, they are reviewed to determine whether they are met within the established time frame(s). If, during the review of the ICP, it is determined that ICP goal(s) are not being met or need to be realigned, the Care Manager/Coordinator will update the ICP. The Care Manager/Coordinator will continue to work with the member and the ICT to determine the appropriate actions to take and provide the update(s) to the ICP.

An example of ICP content created specifically for the member is a member with diabetes, who may be having trouble managing blood sugar levels because of non-compliance with a recommended diet plan. Changes in food consumption can be particularly challenging. The Care Manager/Coordinator, in collaboration with the member/ICT, might incorporate individual 1:1 educational/counseling sessions with a dietician, a food delivery service to take the guesswork out of what the member can eat, and/or a support group for members going through similar challenges with diabetes. The preference(s) of the member would be included in the ICP.

Member ICPs are shared with the member/caregiver and ICT during the ICT meetings to gain additional insight into the member's care needs and to capture the member's needs and preferences. Updates to the ICPs are provided to the member/caregiver and PCP via mail/phone/email as appropriate.

After all goals are identified, the Care Manager/Coordinator works with the engaged members/caregivers to prioritize their care plan goals. Every member (whether engaged or not) will have a care plan. A care plan featuring a member outreach goal will be created for members who cannot be reached or refuse to participate in the Care Management process.

Care Management department policies and procedures ensure members receive the appropriate level of Care Coordination necessary to meet their needs and circumstances. ICP goals are based on the SMART--Measurable Goal Model:

- Specific – What is to be learned/accomplished by the member
- Measurable – A quantifiable goal with specific results that can be captured, reported, and documented in the ICP
- Attainable – The goal is potentially achievable by the member
- Relevant – The goal is linked to health or social status needs
- Time-Bound – The deadline to motivate and evaluate is specific regarding hours/ days/ weeks/ months or calendar year

The SMART goal methodology helps the team facilitate a plan outlining the member's self-management goals, prioritized goals, and responsibilities that align with the individual's interests and healthcare preferences. The ICP is designed to support the development of individual unique needs based on the HRA and additional assessments, medical, behavioral, or pharmacy claims that identify the member's primary diagnosis, the existence of comorbid conditions, the risk of progression, or the risk of developing new conditions. The ICP is designed to provide a plan for members to gain access to social, medical, and behavioral services. Accessing these services can optimize their health outcomes and address access issues arising from barriers they may be experiencing. The ICP will be reviewed frequently with the member/caregiver to understand whether their current healthcare goals are still relevant and appropriate.

The ICP is documented and maintained in the member's record. Our Care Management documentation platform has built-in modules or assessments, care plan goal identification and prioritization, and interventions. Communication with members/caregivers, the ICT, progress toward goal achievement, and member outcomes are all captured in this documentation platform.

Factors 2 & 3: Describe the ICP Development Process & Detail Personnel Responsible for ICP Development

Before contacting and engaging with members, the Care Manager/Coordinator reviews all available data collected from HRA responses and other sources. Additional screening and assessment are conducted with members/caregivers as appropriate. As part of the care management assessment process and development of the ICP, Medi-Cal services that are carved out of the D-SNP benefit may be identified. The HRA specifically asks a series of questions to determine the Medi-Cal Services that the member is receiving or may be eligible for. If the member is receiving community mental health services for depression,

for example, the Care Manager/Coordinator will work with the mental health service providers to ensure that all services that were being provided are captured within the ICP and that services continue should the member wish to continue receiving those services. If there is any disruption in the services, and the provider stops working with the member, the Care Manager/Coordinator will ensure appropriate referrals are made, and services re-established. In some instances, the Care Manager/Coordinator may need to do a three-way call to ensure that a connection between the member and service provider occurs. Other examples may include:

- Community-based organizations such as those serving members with disabilities (Independent Living Centers) and those serving members with dementia (Alzheimer's Organization)
- Community mental health and substance use disorder services
 - The Care Manager/Coordinator will ensure all appropriate providers are included in the ICT and that their input is included in the ICP.
- Housing and homeless Services
 - These members may need to be engaged in care management via face-to-face, in-person visits. SFHP will utilize the relationships with our community-based organizations to assist in engaging and managing the care of this population.
- Medi-Cal Community Supports Services
- LTSS Programs
 - Both Community Supports and LTSS programs are often essential programs that enable members to remain living independently in their homes. In addition to ensuring these services are continued, if appropriate, providers from these programs will be included in the member's ICT with their input included in the development of the ICP.
- Transportation Services
 - The Care Manager/Coordinator will assist the member in setting up transportation to appointments as needed.
- Dental Services
 - These services are important in the management of the overall health of our members. The care management team will ensure that the members have both access and transportation if needed.

Additionally, a member's dementia or palliative care needs may be identified. These needs will be addressed in collaboration with the ICT and incorporated into the ICP. Members receiving palliative care are often clinically complex with an incurable medical condition. The ICP will include goals related to symptom relief, easing stress, and improving overall quality of life. The ICT for a member in palliative care may include the SFHP palliative care specialist (RN with advanced training and experience), the member and/or family/caregiver and some of the treating providers, including the palliative care physician and nurse, social worker, nutritionist, financial consultant, and/or spiritual advisor. The ICP is shared in person, via secured email, standard mail, telephonically, and through the member/provider portals. The care plan is created based on all information gathered, discussed, and prioritized with members/caregivers during routine interactions and ICT meetings. If the member/caregiver is not available or declined to participate, a care plan is still created during the initial ICT meeting, which includes outreach activities and goals based on the data presented.

The member's assigned Care Manager/Coordinator will regularly monitor and update the member's progress toward achieving their goals and adjust the prioritization and timing based on their needs, preferences, and abilities. At least once a year, the ICP will be updated with input from the member or caregiver. If there is a significant change in the member's condition or a care transition occurs, the ICP will be updated to address these changes and any additional needs the member may have. If the Care Manager/Coordinator assesses that the member's goals are not progressing or need to be realigned, they will discuss

with the member or caregiver to understand the circumstances, including any barriers and the need to reprioritize the goals. If necessary, the Care Manager/Coordinator will coordinate an additional meeting to discuss changes to the ICP. All updates will be documented in the member record, and the new ICP will be shared among the member/caregiver and the care team.

Members' needs are identified through their responses to the HRA, the RSS Tier Report, and other available data. Based on this information, members are assigned to the appropriate level of Care Management. The Care Manager/Coordinator will update their ICP as necessary. If a member does not meet their goals while actively engaged in the program, the Care Manager/Coordinator will continue to work with them to progress towards meeting or realigning their goals as needed.

SFHP's Care Management staff includes RNs, LCSW/LMFTs, Care Coordinators, and HRA coordinators. The Learning and Development Team provides training on the HRA, ICP, and ICT process via Litmos, an internal learning management platform that assigns and tracks progress. Attendance reports may be generated to ensure completion and compliance.

When SFHP hires Care Coordination staff, we prioritize bilingual proficiency in our threshold languages to better assist our diverse membership. The HRA coordinators are responsible for conducting necessary outreach and helping the member to complete the HRA. Once members are reached and complete the HRA, a Care Manager/Coordinator is assigned to work with the member/caregiver to develop ICP goals for accessing and establishing care with providers, preventative screenings, health education, accessing SFHP benefits, and available community resources. Care Manager/Coordinators also document members' abilities and preferences to further develop their ICP according to their health and wellness needs.

The Care Manager/Coordinators are responsible for reviewing the HRA and working with the members/caregivers to develop and prioritize the ICP and individualized goals using the SMART methodology, with input from the PCP and other providers. This involvement promotes an interdisciplinary and member-centered approach to addressing members' needs and preferences. The member/caregiver plays a significant role in creating their ICP. The ICP is communicated with the member/caregiver and PCP via mail/email/telephone as appropriate.

Factor 4: Specify ICP Documentation and Maintenance

All ICP efforts by the Care Management staff are documented in the member record. This electronic system houses all ICP elements, including assessments, goals, interventions, barriers, and outcomes. All ICP goals are associated with recommended interventions that the Care Manager/Coordinators can easily select when the goal is added to the ICP. The electronic ICP allows the Care Manager/Coordinators to document their discussions, actions, and plans with the creation date of the entry. The Care Management documentation platform can also capture the member's consent to the ICP as developed. The Care Manager/Coordinators can set target completion dates for goals and interventions to help keep track of the progression of the goals. Once saved, the ICP is immediately available and accessible by internal SFHP staff. The ICT discussion and outcomes are also documented in the member record. The ICP is a printed document that can be shared via mail/email/fax with members/caregivers, PCP, and other providers. Any pertinent documents related to Care Coordination for individual members are uploaded and stored in the member's record. Developing the ICP, including how often the ICP is modified, is based on changes in members' healthcare needs.

Factor 5: Describe ICP Updates and Modifications

SFHP receives daily information on members, whether it be notification of an inpatient admission, an emergency room visit, or a request for prior authorization for new diagnostic testing. The plan also receives claims daily from providers, which can contain new information about members. This information is available to the Care Manager/Coordinators through our documentation platform and incorporated into the member's ICP as appropriate. ICT members, including the PCP and

member/caregiver, are encouraged to update the ICP with any new information that is discovered. This is usually done through the Care Manager/Coordinator, the primary point of contact for the member at SFHP. The Care Manager/Coordinator will document all member updates within the member record, including the ICP. The information in the ICP is shared with appropriate health plan personnel directly involved in the member's care. Providers, including ICT members of our palliative care members, can access the ICP via the provider portal available on the SFHP website or mail, secure email, fax, or telephone. When the updated information needs to be relayed to the provider more immediately, the Care Manager/Coordinator may contact the Provider directly.

Element E: Interdisciplinary Care Team (ICT)

Factor 1: Detail ICT Membership

As part of the initial and ongoing MOC training, our Care Management team understands that every member must have an ICT, whether or not they are successfully engaged with their Care Manager/Coordinator. The members' needs and preferences help determine the ICT's composition. It may include representatives identified through member responses to the HRA and other assessments or by the Care Manager/Coordinator, PCP, member, or caregiver. Specialists, home health providers, community resource partners, dietitians, health educators, behavioral health professionals, pharmacy, members of the utilization management team, provider services representatives, medical director, LTSS provider, or any other participant, including but not limited to trained dementia care and palliative care specialists, are added according to the member's clinical and health status and preference.

- SFHP verifies clinical, medical, and behavioral health team members' expertise and licensure status through the credentialing process. Participants in the ICT are also required to complete the MOC training program. Additionally, there is a training program for the SFHP D-SNP RN Care Manager who would want to become a Dementia Care Specialist. The training program consists of several hours of theory and requires the completion of an exam before certification can be obtained. Dementia care training includes specific information about how the care team manages our members with dementia, including:
 - Understanding Alzheimer's Disease and Related Dementias (ADRD)
 - Symptoms and progression of dementia
 - Understanding and managing behaviors and communication problems of members with dementia
 - Caregiver stress and its management, including the support services offered by the Alzheimer's Organization
 - Community resources for members and their caregivers

This training will include the importance of the Alzheimer's Organization and the training and resources that the agency offers. The dementia care specialist will lead the care team and provide the expert assistance in developing member care plans for this population. Additionally, they will lead discussions with the ICT as the ICP is created and updated.

SFHP supports the ongoing training of dementia and palliative Care Manager specialists who lead the ICT teams for their respective members. These Care Management specialists educate the general Care Management team about the unique needs of these two populations and how to manage them efficiently and effectively.

At a minimum, the ICT comprises the member/caregiver, the member's PCP, and the Care Manager/Coordinator. ICT members are selected to participate for their expertise in areas that would benefit the members and enhance their healthcare outcomes. Each ICT meets as the care plan is established, whenever changes in the member's status occur, and at least annually. The Care Manager/Coordinator may invite additional participating members who align with the member's needs and whomever the member may want to include.

The ICT is the forum for communicating the designation of specific ICP interventions to the most appropriate party. ICT communication of the progress and completion of interventions to progress the ICP may be done in person, by phone, mail, or secure email.

Factor 2: Describe ICT Roles and Facilitation of Enrollee Participation

The member is at the center of the ICT, and the Care Manager/Coordinator and PCP play integral roles.

- The **PCP** ensures members receive comprehensive, coordinated, holistic, and member-centric care. The PCP's expert knowledge in health maintenance, health promotion, comprehensive assessments, and complex medical condition management put them in the hub of our ICT model. Other ICT individuals will assist the member and PCP with their specialty or license to ensure identified needs are appropriately addressed and delivered according to the member's ICP.
- The **Care Manager/Coordinator** acts as the primary point of contact for all ICT members involved in the member's care and follows up on services based on input from the other ICT members. The Care Manager/Coordinator is responsible for completing the HRA with the member/caregiver to help initiate the development and updates of the ICP. ICT participants are aligned with the member's identified clinical and social needs.
- For members with dementia, a **dementia care specialist** will be included to ensure all care needs for the member are identified and resourced appropriately, including using community-based organizations as needed. All providers and services aim to help the member improve their health outcomes.
- **Member/caregiver** input is pertinent in developing goals to meet their needs, prioritizing objectives, and addressing potential issues or barriers.

For the CICM populations identified previously, specialty and other providers may need to be included in the ICT to address any unique needs of these populations. For example:

- **Adults Experiencing Homelessness** may need to have street-reach providers, a homeless coalition member, a CHW or peer support specialist, or a community mental health worker on the member's ICT.
- **High-utilizer adults with frequent hospital admissions, short-term Skilled Nursing Facility (SNF) stays, or Emergency Department (ED) visits** may need an IP discharge planner, an ED Care Manager/Social Worker, an SNF liaison, an LTS Coordinator, a CHW, peer support specialist, or community mental health worker to be part of the ICT and help address their needs. A BH clinician may be needed for members with unmet BH needs.
- **Adults with Serious Mental Illness (SMI) and Substance Use Disorder (SUD)** will likely benefit from a BH clinician, a community mental health worker, a peer support specialist, and/or a drug treatment provider/counselor on their ICT.
- **Adults transitioning from Incarceration** might need a prison/jail representative, which could include their medical/psychological worker if they had one while incarcerated, a community mental health worker, or their Medi-Cal case worker as part of their ICT.
- **Members eligible for Long Term Care (LTC) and at risk of institutionalization** may need the services of an LTS or LTC liaison, and/or their Medi-Cal case worker as part of their ICT.
- **Nursing Home residents** transitioning to the community will need the input of their LTC liaison and/or LTS-liaison as part of their ICT.
- **Adults who are Pregnant or Postpartum and subject to Racial and Ethnic Disparities** would need the input of their OB provider, their maternal-child health program representatives (as appropriate), and a BH clinician or provider, especially if the member was experiencing post-partum depression as part of their ICT.

- **Adults with documented Dementia needs** will need a dementia specialist, potentially a neurologist, a geriatrician if the patient is aging, a BH clinician/provider, and potentially in-home care provider staff, depending on the member's needs.

As the HRA and other assessments are completed, the data obtained becomes part of the pool of data points that feed the risk stratification process. Newly acquired data can and often does impact the member's care management risk level. The Care Manager/Coordinator monitors their members for changes in status and risk level. If a change is noted through the reporting process, the Care Manager/Coordinator will reach out to the member, complete any appropriate assessments or surveys, discuss concerns with the appropriate provider(s), update the ICP, and share it with the ICT.

The enrollee's Health Risk Assessment Tool (HRAT), referenced in MODEL OF CARE Element 2B, and the Individualized Care Plan (ICP), outlined in MODEL OF CARE Element 2D, are pivotal in determining the composition of the Interdisciplinary Care Team (ICT). The HRAT helps to identify the specific needs, risks, and challenges faced by the enrollee, while the ICP formalizes these findings into a tailored care strategy. Together, they enable the ICT to assemble the right mix of professionals required to address the unique circumstances of each member.

In cases where the standard team composition may not suffice, these assessments signal when additional team members are necessary to effectively meet the enrollee's needs. This is especially relevant for California-specific sub-populations identified in Element 1B, as their unique context may require specialized expertise and resources. The Care Manager's judgment also plays a crucial role, as they can often uncover or detect changes in the member's healthcare status long before the data will, ensuring that the ICT can adapt and respond proactively.

The Care Manager/Coordinator facilitates communication with the member's ICT and assists members in obtaining necessary care and services. They are responsible for ensuring the member's ICP is current and addresses the needs based on the information from the member's HRA and other available health plan data. Interactions and discussions with the member/caregiver will address any needed changes and update the ICP to align with the member's current status.

The Care Management team, which also includes the ICT Coordinator, serves as the communication hub of the ICT to ensure that the ICT members are updated and current with any significant health or social changes or care transitions. The ICT Coordinator is responsible for scheduling and facilitating ICT meetings and documenting details of the discussions and recommendations.

Factor 3: Evaluate Member Outcomes

The individuals participating in a member's ICT work collaboratively to develop and update the member's ICP based on their clinical expertise. Recommendations are documented, reflected in the member's ICP, and communicated to members/caregivers and providers. By evaluating ICP elements, the ICT will collectively determine how the member/caregiver understands the recommendations and how the member acts upon them. The ICT reviews the ICP during scheduled and ad hoc ICT meetings to ensure that the interventions are helping members meet identified needs to improve overall health. The ICT reviews the progress and completion of the member's care plan goals and clinical data about health outcomes. Any barriers to achieving the care plan goals are discussed, and adjustments are made to the ICP by the interdisciplinary team as necessary.

Factor 4: Describe the Communication Plan

The CM Care Manager/Coordinator is the primary contact for the ICT and provides their contact information to all ICT members. They establish ICT communication and follow-up timeframes according to members' needs, abilities, and

preferences. ICT communication can be done through the phone, secure email, in-person, and mail. Members and caregivers are encouraged to participate in the ICT meeting to actively contribute to how the member is or isn't meeting their healthcare goals. ICT meetings can be regularly scheduled sessions (annually at the minimum) and periodically based on need or as requested by a member/caregiver, the PCP, or an ICT member to discuss and collaborate with pertinent ICT individuals on how to best proceed with the plan of care.

ICPs are updated after ICT meetings to reflect the changes or updates, if applicable, and communicated, at a minimum, to the member in the member's preferred language and by any audio or visual accommodation available, PCP, and other ICT participants present at the meeting if authorized by the member. The Care Manager/Coordinator regularly explains to the members/caregivers the purpose of the HRA, ICP, and ICT and encourages their participation to meet their goals and establish a self-management plan. The ICT Coordinator will be responsible for scheduling ICT meetings and inviting members/caregivers, PCP, and other relevant providers to the ICT meetings via email/phone/mail. ICT communications and ICP meeting minutes are documented in the member record. Members/caregivers who are unable to be reached or are reached and opt out of completing an HRA, developing an ICP, and identifying individuals of their ICT will be provided the contact information of their Care Manager/Coordinator, who will attempt to reengage with the member biannually and on an as-needed basis. Their decision to not participate will be discussed at the member's ICT meeting. The Care Manager/Coordinator is also responsible for sending out ICP meeting minutes to members/caregivers and all parties who participated in the meeting. Internal staff can access documentation in the member record.

Element F: Care Transition Protocols

Factor 1: Facilitate Continuity of Care

SFHP recognizes the importance of coordinating care transitions for all D-SNP members. Care transition policies, procedures, and protocols are in place to maintain continuity of care, reduce fragmentation, and facilitate communication across systems of care, relevant ICT participants, and the member and/or caregiver. To achieve the most effective health outcomes, our care management team ensures that members receive care from the appropriate systems of care and providers with the expertise necessary to support members throughout the care transition process (before, during, and after).

Our ADT (Admission, Discharge, and Transfer) data alerts the Care Management Transition of Care (TOC) team of members being admitted, discharged, or experiencing a transition in care. This could include transitioning to the member's home, active home health care, acute care facilities, nursing facilities (skilled and custodial), and/or rehabilitation facilities. Transitions can be planned and unplanned, covering both contracted and non-contracted network providers. Additionally, the UM concurrent review nurse, who works collaboratively with the hospital or SNF Care Management staff, alerts the CM TOC team of the acute inpatient admission or impending care transition.

The TOC process includes the actual logistical arrangements of moving a member, providing education to the member and/or caregiver, coordinating and exchanging information between healthcare professionals, facilitating authorizations for services, and creating a provider network with appropriate specialists who can address the complex needs of the D-SNP population. It involves securely receiving and sending health care information across settings during the transfer. Providing continuity of care and creating an environment where the member and provider partner in ongoing health management can result in the member receiving higher quality, more cost-effective care. The TOC RN initiates outreach to the member and/or caregiver and inpatient facility Care Management team to collaborate and identify the current plan of care, any potential barriers to discharge, and the planned discharge location. The TOC RN collaborates with the inpatient facility Care Manager to ensure that the following occur:

- Notification of the care transition to all key stakeholders
- Communication of relevant information to the receiving setting or entity as per 45 CFR §§164.502(a)(ii), and 164.506(c)(1), (2).
- Providing the member and/or caregiver with a central point of contact – the TOC RN and/or the Care Manager/Coordinator
- Assessing for change in member needs post-transition
- Collaborating with the system of care, PCP, specialty care, and other ICT participants to develop a safe discharge plan.
- Facilitating relevant discharge information to the PCP from the system of care or SFHP
- Educating the member and/or caregiver on expectations, warning signs and who to contact for questions
- Arranging appointments and services, including necessary durable medical equipment, home health services, and transportation
- Assessing for Home and Community Based and LTSS needs. These services may need to be resumed or initiated, depending on circumstances of member
- Medication reconciliation
- Follow-up with the member for at least 30 days post-transition

The TOC RN will continue working with the member and caregiver throughout the transition of care until all identified needs and goals are met or handed off to the member's primary Care Manager. Updated and new information gathered during the member's engagement in the care transition process will prompt the assigned TOC RN to update the member's ICP. The updated ICP will be transmitted telephonically or via secure email or facsimile to the receiving facility.

Factor 2: Identify Care Transition Personnel

The care transition process includes staff from multiple departments and facilities who work together to ensure member access to high-quality, cost-effective care. This may include UM nurses, Care Managers/Coordinators, PCPs, specialists, LTSS providers, dietitians, and pharmacists. The care transition process begins with notification of a transition of care via the ADT data, if available, or via an alert from the UM team to the Care Management TOC team. This notification alerts the TOC team of the member's admission to the acute or skilled facility at the time of the admission to promote real-time discharge planning. The assigned TOC RN, responsible for the seamless transition of the member during the entire TOC process, gathers all relevant information related to the care transition to create the discharge plan and modifies the member's ICP accordingly.

The transition of care can occur between the member's home and acute facility, subacute, skilled nursing facility, acute rehabilitation, or long-term care facility. In each transition, the TOC RN, often in collaboration with the Care Manager/Coordinator, the PCP or treating provider, and the facility staff, ensures that the TOC assessment is completed, the needs of the member are identified, follow-up services are ordered, and appropriate referrals are made. Post hospitalization, members often need to utilize home-based supportive services, including in-home health care, personal care, assistance with ADLs, medical equipment and/or home modifications, and transportation assistance. The TOC RN will ensure referrals are made, services are ordered and initiated or resumed upon discharge, and that all follow-up care is obtained. The TOC RN follows the member for the first thirty days post-discharge, at which point the member's care will transition back to the Care Manager/Coordinator for care continuity.

During engagement, the TOC RN will assist with making follow-up appointments, including a post-ambulatory visit, and obtaining necessary medical records, orders, or referrals from providers as outlined in the discharge documentation. TOC RNs may also refer to pharmacists for assistance with new follow-up medications and medication reconciliation. The assigned

TOC RN will provide Care Coordination services till the member is connected to all needed services and supports at the least restrictive level of care to promote a positive health outcome. The TOC RN then provides a warm handoff to the assigned Care Manager/Coordinator after the transition of care process.

Factor 3: Transfer ICP Elements and Describe the Transition Process

An essential element in the transition of care process is sharing relevant information with all pertinent parties. If the member transfers from an inpatient acute facility to an SNF or LTC facility, the Care Manager/Coordinator will ensure that the essential hospital record is transferred with the member, including the history and physical, labs and x-rays, medications, follow-up care, and the discharge summary. The member's updated ICP will also be shared with the receiving facility, the member, caregiver, PCP, and any post-discharge providers, as necessary. A TOC assessment allows the TOC RN to understand better the member's situation, including the member's understanding of and adherence to their discharge instructions, medication follow-up, and follow-up with the PCP and specialty care as appropriate. The assessment may also include referrals for home health care, LTSS, or HCBS. The TOC RN provides education and support for the member/caregiver and schedules follow-up contacts for the first 30 days post-discharge. Assessment of the member's post-discharge needs and barriers are shared with the PCP, including clinical background of the reason for their hospitalization. Subsequent notifications to PCPs and specialists, as appropriate, include an updated ICP.

The TOC RN, in collaboration with the facility team, will utilize available Health Information Exchange (HIE) and data sharing platforms, secure email, fax, hard copies, or virtual meetings as needed to share information related to the ICP with appropriate parties, including the members' care team and post-discharge providers.

Factor 4: Describe Access to Member Personal Health Information

The TOC RN can educate members and caregivers on accessing their health information from previous healthcare settings where they received care and from their providers. This includes assisting and educating the member on requesting member records by phone, fax, or secure email. The Care Management team can also help members access their health information via the SFHP member portal, if available. Any sharing of personal health information follows HIPAA privacy and information security requirements.

Factor 5: Describe the Approach to Self-Management Activities

The TOC RN will aim to keep the member informed of their health status and their self-management plan, including necessary follow-up care, medication regimen, and signs and symptoms of concern to notify their PCP. This effort is reiterated and reinforced throughout the member's engagement during the care transition process. All communication attempts, successful or unsuccessful, will be documented within the member record. The ICP that is developed and updated may be shared with the member/caregiver and the ICT as requested via mail, secure email, or telephone.

The TOC RN will review discharge instructions with the member/caregiver using "teach back" methods to promote successful understanding. This includes reviewing the member's conditions, whether they have improved or worsened, and medication reconciliation. The TOC RN will also assist the member/caregiver in obtaining a copy of the discharge instructions or after-visit summaries.

Factor 6: Describe the Notification Process for the Designated Point of Contact

Members will be made aware of the name and contact information of their assigned TOC RN when the TOC RN makes initial contact with the member/caregiver to begin discussing the discharge planning process. It is emphasized to the

member/caregiver that the TOC RN will remain their main point of contact for their transitional care needs throughout the entire care transition process, which is often the first 30 days post-discharge. The TOC RN will provide the member and caregiver with the SFHP customer service number, a nurse advice line number, instructions on how to reach their PCP, and any other necessary post-discharge providers. When the TOC RN cannot reach the member/ caregiver, despite following the SFHP's inability to reach process, the TOC RN will complete a warm handoff to the member's assigned Care Manager/Coordinator. The member can always refer to their initial Care Management outreach letter to access their assigned Care Manager/Coordinator information. Customer service can also assist in identifying and connecting the member/caregiver to the Care Manager/Coordinator. Should the assigned Care Manager/Coordinator change, the member will be sent a new letter, including the new Care Manager/Coordinator's information and phone number. A warm hand-off between the outgoing Care Manager/Coordinator, the new Care Manager/Coordinator, and the member will be attempted telephonically.

MOC 3: Provider Network

MOC 3. Element A: Specialized Expertise

Factor 1: Describe Specialized Network

The SFHP provider network is meticulously crafted to meet our target population's unique and specialized health care needs, as identified in MOC 1. Our network includes diverse healthcare providers and facilities, each with specialized expertise to ensure comprehensive, high-quality care for our members. Below, we provide a detailed description of the specialized expertise available within our provider network.

Specialized Network Description

Our provider network is a robust and dynamic system designed to deliver exceptional care through a wide array of primary and specialty care providers and state-of-the-art facilities. This network is structured to ensure that all members have seamless access to the necessary medical expertise and services tailored to their specific health needs. Examples of PCPs, specialists, and facilities include, but are not limited to, those listed in the tables below.

Table 1: Primary Care Providers

Family Practice	Family practice providers offer holistic care for individuals and families, addressing health needs across all ages and stages of life. Their comprehensive approach ensures continuity of care and fosters long-term patient-provider relationships.
Geriatrics	Specialists in geriatrics focus on the unique health challenges elderly patients face. They are skilled in managing multiple chronic conditions, geriatric syndromes, and providing compassionate end-of-life care.
Internal Medicine	Our internal medicine physicians are adept at managing a broad spectrum of adult health conditions, from common illnesses to complex diseases. They play a crucial role in preventive care, chronic disease management, and health education.
Nurse Practitioners	Advanced practice registered nurses delivering primary and specialty care services. Their expertise in health promotion, disease prevention, and management of acute and chronic conditions is invaluable to our network.
Physician Assistants / Physician Associates	These licensed professionals extend the reach of our healthcare services by providing a wide range of medical care under the supervision of physicians. They are integral to our team-based approach to patient care.

Table 2: Specialty Care Providers

Allergy and Immunology	Our specialists in allergy and immunology are experts in diagnosing and treating allergic reactions, asthma, and immune system disorders. They provide personalized care plans to improve patient's quality of life.
Cardiology	Cardiologists in our network are dedicated to preventing, diagnosing, and treating heart and vascular diseases. They utilize advanced diagnostic tools and innovative treatments to manage cardiovascular health.
Cardiothoracic Surgery	These surgeons perform complex surgeries on the heart, lungs, and other thoracic organs, addressing conditions such as coronary artery disease and lung cancer.
Chiropractors	These providers focus on diagnosing and treating neuromuscular disorders, emphasizing manual adjustment and manipulation of the spine to improve function and alleviate pain.
Clinical Psychology	Clinical psychologists provide psychological assessment and therapy, helping patients manage mental health conditions and improve their emotional well-being.
Clinical Social Work	Clinical social workers offer support and resources for social and emotional health, assisting patients with coping strategies and connecting them to community resources.
Dermatology	Dermatologists in our network address a wide range of skin, hair, and nail conditions. They offer both medical and cosmetic treatments to enhance patients' dermatological health.
Endocrinology	Endocrinologists specialize in hormone-related diseases, including diabetes, thyroid disorders, and metabolic conditions. Their expertise is critical for managing complex endocrine disorders.
ENT / Otolaryngology	Specialists in ear, nose, and throat disorders provide comprehensive care for conditions affecting these areas, including hearing loss, sinusitis, and voice disorders.

Gastroenterology	Gastroenterologists focus on the digestive system, diagnosing and treating conditions such as irritable bowel syndrome, Crohn's disease, and liver disorders.
General Surgery	Our general surgeons perform a wide range of surgical procedures, from routine operations to complex surgeries, ensuring high standards of surgical care.
Gynecology / Ob/Gyn	Specialists in women's reproductive health provide care ranging from routine gynecological exams to complex obstetric and gynecological surgeries.
Infectious Disease	Infectious disease specialists are experts in diagnosing and treating infections caused by bacteria, viruses, fungi, and parasites. They play a vital role in managing outbreaks and preventing the spread of infectious diseases.
Nephrology	Nephrologists in our network specialize in kidney care, treating conditions such as chronic kidney disease, hypertension, and electrolyte imbalances.
Neurology	Neurologists focus on disorders of the nervous system, including stroke, epilepsy, and neurodegenerative diseases. Their expertise is essential for managing complex neurological conditions.
Neurosurgery	Neurosurgeons perform intricate surgeries on the brain and spinal cord, addressing conditions such as tumors, aneurysms, and spinal disorders.
Oncology (Medical / Surgical / Radiological)	Our oncology team provides comprehensive cancer care, including chemotherapy, surgery, and radiation therapy. They work collaboratively to develop personalized treatment plans for each patient.
Ophthalmology	Ophthalmologists specialize in eye and vision care, offering treatments for conditions such as cataracts, glaucoma, and macular degeneration.
Orthopedic Surgery	Orthopedic surgeons focus on the musculoskeletal system, treating conditions such as fractures, joint disorders, and sports injuries.
Physiatry / Rehabilitative Medicine	Specialists in physical medicine and rehabilitation help patients recover from injuries and improve their physical function through tailored rehabilitation programs.
Plastic Surgery	Plastic surgeons perform reconstructive and cosmetic procedures to enhance patients' appearance and function, addressing issues such as congenital anomalies, trauma, and aesthetic concerns.
Podiatry	Podiatrists specialize in foot and ankle care, treating conditions such as bunions, heel pain, and diabetic foot complications.
Psychiatry	Psychiatrists provide mental health care, diagnosing and treating psychiatric disorders such as depression, anxiety, and schizophrenia. They offer both medication management and psychotherapy.
Pulmonology	Pulmonologists specialize in lung and respiratory system care, treating conditions such as asthma, chronic obstructive pulmonary disease (COPD), and pulmonary fibrosis.
Rheumatology	Rheumatologists focus on rheumatic diseases, including arthritis, lupus, and other autoimmune conditions. They provide comprehensive care to manage pain and improve joint function.
Urology	Urologists treat disorders of the urinary tract and male reproductive system, offering treatments for conditions such as kidney stones, urinary incontinence, and prostate cancer.
Vascular Surgery	Vascular surgeons specialize in the treatment of blood vessel disorders, including aneurysms, varicose veins, and peripheral artery disease.

Table 3: Facilities and Agencies

Acute Inpatient Hospitals	Our network includes hospitals with Intensive Care Units (ICUs) and Outpatient Surgery centers, providing critical and surgical care.
Cardiac Catheterization Services	Facilities equipped for diagnostic and interventional cardiac procedures, ensuring comprehensive heart care.
Cardiac Surgery Programs	Specialized programs for heart surgery, offering advanced surgical treatments for cardiovascular conditions.
Community-based Palliative Care	Our network includes community-based palliative care providers who specialize in delivering compassionate care for individuals with serious illnesses. These providers focus on relieving symptoms, managing pain, and improving the quality of life for patients and their families. They work closely with other healthcare professionals to ensure a holistic approach to patient care, addressing physical, emotional, and spiritual needs.

Home Health & Hospice	Services providing in-home medical care and compassionate end-of-life support, ensuring comfort and dignity for patients.
Infusion & Chemotherapy	Centers providing intravenous treatments and cancer care, ensuring effective and timely treatment.
Inpatient Psychiatry	Facilities offering intensive mental health care, providing a safe and therapeutic environment for patients.
Occupational Therapy	Services helping patients regain daily living and work skills, promoting independence and quality of life.
Physical Therapy	Facilities offering rehabilitation services to improve physical function and mobility.
Skilled Nursing Facilities	Including subacute care for patients requiring intensive rehabilitation and long-term care.
Speech Therapy	Providers addressing speech, language, and swallowing disorders, enhancing communication and swallowing function.

Our provider network is strategically developed to cater to the specific needs of SFHP’s target population. By employing predictive risk assessments and utilization monitoring, we ensure that our network encompasses a wide range of specialties and maintains an adequate number of providers. This approach guarantees that all members receive the necessary care. Additionally, we have established robust coordination of care standards among network participants to efficiently manage complex and comorbid conditions.

Factor 2: Include Evidence of Provider Expertise

SFHP is dedicated to ensuring that all members receive high-quality, specialized health care through a meticulously designed provider network. Our network is composed of providers and facilities that have undergone rigorous credentialing and recredentialing processes to verify their qualifications, licensure, and competency. By implementing thorough verification procedures and continuous monitoring, SFHP guarantees that each member is supported by an Interdisciplinary Care Team (ICT) with demonstrated expertise and training in areas relevant to the target population. This commitment to excellence ensures that all health care needs are met with the highest standards of care, tailored to the unique requirements of our members.

Credentialing, recredentialing, screening, and California Medicaid (“Medi-Cal”) enrollment standards used by SFHP are based on federal and state requirements and comply with SFHP’s contract with the Department of Health Care Services (DHCS) and license from the Department of Managed Health Care (DMHC). SFHP adopts current National Committee for Quality Assurance (NCQA) credentialing standards.

SFHP requires every practitioner contracted to provide care to SFHP members to be credentialed according to the appropriate standards before delivering care to SFHP members. SFHP assures that all information obtained during credentialing, recredentialing, and screening activities remains confidential, except as required by law.

Documents gathered by or for any applicant for consideration as an SFHP Provider by the Physician Advisory Committee (PAC) cannot be more than 120 calendar days old at the time of the committee’s dated decision. Practitioners agree to report any change in the status of the information contained in the credentialing files within 10 calendar days of the change in status.

Initial Credentialing and Recredentialing

Credentialing Application: Upon receipt of the application, the credentialing staff verifies that the application is signed and dated. Applications that are missing a signature and date are returned to the practitioner. All applications must have a wet or faxed, digital, electronic, scanned, or photocopied signature. The application should be typed or legibly printed in black or blue ink. SFHP will conduct primary source verification of the practitioner’s credentials.

Rescreening, Recredentialing, and Re-enrolling: Fewer than thirty-six months from the last credentialing approval, SFHP will send a copy or reproduction of the Initial Application or Last Recredentialing Application for the practitioner’s

review, verification, or correction of the information and attestation of its accuracy. SFHP will conduct primary source verification of the practitioner's credentials.

- **Periodic Review:** SFHP Credentialing Staff will pull and review reports of any grievances or Potential Quality Issues (PQIs) filed against practitioners undergoing re-credentialing and produce copies of the documents, with PHI redacted, as well as any relevant documentation for consideration by PAC. Should any additional information or monitoring be requested, such as medical record reviews, the Credentialing Staff will gather the information and provide it at the next PAC meeting.
- **Performance Evaluation:** SFHP Credentialing Staff will provide any relevant Facility Record Review Scores and Medical Record Review (MRR) Scores to the PAC as part of the re-credentialing process. Facility Site Reviews (FSRs) and MRRs are performed at all sites for primary care, high-volume specialty care, adult day health care, and obstetric/gynecological care.
- **Updated Verification:** During the recredentialing process, and prior to the approval of recredentialing, SFHP will re-verify the provider's applicable licenses, board certifications, and any other applicable credentials.

The following documents must be submitted along with the application:

Table 4: Practitioner Documentation Requirements

Practitioner Type	Required Documents
Medical Practitioners: <ul style="list-style-type: none"> • Allopathic medical doctors (MD) • Osteopathic medical doctors (DO) • Chiropractors • Podiatrists • Oral surgeons 	<ul style="list-style-type: none"> • Credentialing Application signed and dated • Credentialing Questionnaire signed and dated • Addendum A: Practitioner Rights signed and dated • Addendum B: Professional Liability Action Explained, if applicable, signed and dated • Addendum C: DHCS Provider Agreement signed and dated, or proof of Medi-Cal FFS enrollment • Addendum D: DHCS Supplemental Questions signed and dated, or proof of Medi-Cal FFS enrollment • State Medical/Professional License(s) • DEA/CDS/NPF Certificate (if applicable) • Face Sheet of Professional Liability Policy or certification • Curriculum Vitae or Resume (For initial applications only) • Highest Level Diploma or Transcripts (For initial applications only, if applicable) • Educational Commission for Foreign Medical Graduates (ECFMG) - if applicable • Board Certification (MDs and DOs if applicable) • Specialty Board Certification (if applicable) • Documentation of Hospital Privileges or explanation of use of hospitalist • Signed and dated New Provider Training Attestation (For initial applications only) • Completed Language Capacity Self- Assessment, if speak a language other than English (For initial applications only)

Practitioner Type	Required Documents
Non-Physician Medical Practitioners: <ul style="list-style-type: none"> ● Nurse Practitioners (NP) ● Physicians Assistants (PA) ● Nurse Midwives ● Dentists providing care under medical benefits 	<ul style="list-style-type: none"> ● Credentialing Application signed and dated ● Credentialing Questionnaire signed and dated ● Addendum A: Practitioner Rights signed and date ● Addendum B: Professional Liability Action Explained, if applicable, signed and dated ● Addendum C: DHCS Provider Agreement signed and dated or proof of Medi-Cal FFS enrollment ● Addendum D: DHCS Supplemental Questions signed and dated or proof of Medi-Cal FFS enrollment ● State Medical/Professional License(s) ● DEA/CDS/NPF Certificate (if applicable) ● Face Sheet of Professional Liability Policy or certification ● Curriculum Vitae or Resume (For initial applications only) ● Highest Level Diploma or Transcripts (For initial applications only, if applicable) ● Signed and dated New Provider Training Attestation (For initial applications only) ● Completed Language Capacity Self- Assessment, if speak a language other than English (For initial applications only)
Allied Health: <ul style="list-style-type: none"> ● Acupuncturist ● Physical Therapists ● Occupational Therapists ● Speech and Language Therapists ● Audiologists ● Hearing Aid Dispenser ● Ocularist ● Electrologist ● Registered Dietitian 	<ul style="list-style-type: none"> ● Credentialing Application signed and dated ● Credentialing Questionnaire signed and dated ● Addendum A: Practitioner Rights signed and dated ● Addendum B: Professional Liability Action Explained, if applicable, signed and dated ● Addendum C: DHCS Provider Agreement signed and dated or proof of Medi-Cal FFS enrollment ● Addendum D: DHCS Supplemental Questions signed and dated or proof of Medi-Cal FFS enrollment ● State Medical/Professional License(s) ● Face Sheet of Professional Liability Policy or certification ● Curriculum Vitae or Resume (For initial applications only) ● Highest Level Diploma or Transcripts (For initial applications only, if applicable) ● Signed and dated New Provider Training Attestation (For initial applications only). ● Completed Language Capacity Self- Assessment, if speak a language other than English (For initial applications only)
Telemedicine Consultants: <ul style="list-style-type: none"> ● Allopathic medical doctors (MD) ● Osteopathic medical doctors (DO) 	<ul style="list-style-type: none"> ● Credentialing process delegated to and managed by telemedicine vendor
Behavioral Health Practitioners: <ul style="list-style-type: none"> ● Psychiatrists and other physicians (MD, DO) ● Addiction medicine specialists 	<ul style="list-style-type: none"> ● Credentialing process delegated to and managed by behavioral health plan

Practitioner Type	Required Documents
<ul style="list-style-type: none"> • Doctoral or master's-level psychologists who are state certified or licensed • Master's-level clinical social workers who are state certified or licensed • Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed • Autism services practitioner • Other behavioral healthcare specialists, who are licensed, certified or registered by the state to practice independently such as LMFTs and LMHCs 	
Hospital	<ul style="list-style-type: none"> • State of California License(s) (current within 12 months) • The Joint Commission Accreditation Letter or other accrediting body (if applicable) • Face Sheet of General Liability Policy or certification (current within 12 months, coverage of \$100,000 per incident and \$300,000 annual aggregate) • W9 • Evidence of Site Visit conducted by CMS, California Department of Public Health, or accrediting body - (current within 36 months or according to standards set by organization performing the site visit) • DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment • DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment
Family Planning Clinic, Ambulatory Surgical Center, Freestanding Birthing Center	<ul style="list-style-type: none"> • Completed, signed and dated Credentialing Application • Signed and dated Attestation Questions • Signed and dated Information Release/Acknowledgements • Signed and dated Provider Rights 5. State of California License(s) (current within 12 months), if applicable • Evidence of Site Visit conducted by CMS, HRSA, California Department of Public Health, or accrediting body - (current within 36 months or according to standards set by organization performing the site visit) • Evidence of accreditation (if applicable) • Face Sheet of General Liability Policy or certification (current within 12 months, coverage of \$100,000 per incident and \$300,000 annual aggregate) • W9 • Provider Roster • DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment • DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment

Practitioner Type	Required Documents
Community-Based Adult Services (CBAS); Dialysis Center	<ul style="list-style-type: none"> ● Completed, signed, and dated Credentialing Application ● Signed and dated Attestation Questions ● Signed and dated Information Release/Acknowledgements ● Signed and dated Provider Rights ● State of California License (current within 12 months) ● Business License (current within 12 months) ● Face Sheet of General Liability Policy or certification (current within 12 months, coverage of \$100,000 per incident and \$300,000 annual aggregate) ● W9 ● Evidence of Site Visit conducted by CMS, California Department of Public Health, or accrediting body - (current within 36 months, or according to standards set by organization performing the site visit) ● DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● Accreditation Approval Letter (if applicable)
Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)	<ul style="list-style-type: none"> ● Completed, signed and dated Credentialing Application ● Signed and dated Attestation Questions ● Signed and dated Information Release/Acknowledgments ● Signed and dated Provider Rights ● If necessary, a separate page with any Professional Liability Action explained, signed and dated ● Fingerprinting receipt from Live Scan (if applicable) ● State of California License (current within 12 months). ● Business License (current within 12 months) ● Face Sheet of General Liability Policy or certification (current within 12 months, coverage of \$100,000 per incident and \$300,000 annual aggregate) ● W9 ● DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● Evidence of Medi-Cal FFS enrollment or a site visit conducted by SFHP staff ● Accreditation Approval Letter (if applicable)
Diabetes Prevention Program Providers (DPPs)	<ul style="list-style-type: none"> ● Completed, signed and dated Credentialing Application ● Signed and dated Attestation Questions ● Signed and dated Information Release/Acknowledgments ● Signed and dated Provider Rights ● If necessary, a separate page with any professional liability action explained, signed and dated ● Business License (current within 12 months) ● Pending, preliminary, or full recognition as a Diabetes Prevention Program through the Centers for Disease Control and Prevention (For DPPs) ● A list of all administrative locations in SFHP's service area (For DPPs) ● A roster of all peer coaches with their full names, NPI numbers, birth dates, and social security numbers (For DPPs) ● Face Sheet of General Liability Policy or certification (current within 12 months, coverage of

Practitioner Type	Required Documents
	<p>\$100,000 per incident and \$300,000 annual aggregate)</p> <ul style="list-style-type: none"> ● W9 ● DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● Fingerprinting receipt from Live Scan (if applicable) ● Accreditation Approval Letter (if applicable)
Hospice Home Health Home Infusion Skilled Nursing Facility	<ul style="list-style-type: none"> ● Completed, signed and dated Credentialing Application ● Signed and dated Credentialing Questionnaire ● State of California License (current within 12 months) ● Business License (current within 12 months) ● Federal Drug Administration (FDA) Certification (if Home Infusion) ● Face Sheet of General Liability Policy or certification (current within 12 months, coverage of \$100,000 per incident and \$300,000 annual aggregate) ● W9 ● Evidence of Site Visit conducted by CMS, California Department of Public Health, or accrediting body - (current within 36 months or according to standards set by organization performing the site visit) ● DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● Accreditation Approval Letter (if applicable)
Imaging Services Portable X-ray Supplier	<ul style="list-style-type: none"> ● Completed, signed and dated Credentialing Application ● Completed, signed and dated Attestation Questions ● Signed and dated Information Release/Acknowledgment ● Signed and dated Provider Rights ● If necessary, a separate page with any professional liability action explained, signed and dated ● Business License (current within 12 months) ● Accreditation Approval Letter (if applicable) ● Federal Drug Administration (FDA) Certification (if applicable) ● Face Sheet of General Liability Policy or certification (current within 12 months, coverage of \$100,000 per incident and \$300,000 annual aggregate) ● W9 ● DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● Evidence of Site Visit conducted by CMS, California Department of Public Health, or accrediting body - (current within 36 months or according to standards set by organization performing the site visit), if applicable

Practitioner Type	Required Documents
Skilled Nursing Facility (SNF)	<ul style="list-style-type: none"> ● Completed, signed and dated Credentialing Application ● Completed, signed, and dated Attestation Questions ● Signed and dated Information Release/Acknowledgements ● Signed and dated Provider Rights ● If necessary, a separate page with any professional liability action explained, signed and dated ● State of California License (current within 12 months) ● Business License (current within 12 months) ● CLIA Accreditation Approval Letter (current within 24 months) ● College of American Pathologists Accreditation (current within 36 months) ● Face Sheet of General Liability Policy or certification (current within 12 months, coverage of \$100,000 per incident and \$300,000 annual aggregate) ● W9 ● DHCS 6207 completed, signed, and dated or proof of Medi-Cal FFS enrollment ● DHCS 6208 completed, signed, and dated or proof of Medi-Cal FFS enrollment

Verification Process: SFHP conducts timely verification of credentialing information to ensure that practitioners have the legal authority and relevant training and expertise to provide quality care. Practitioners' credentials are screened through the Verification Process described in the table below.

Table 5: Verification Process

Document	Verification	Time Limit
Credentialing Application	<ul style="list-style-type: none"> Confirm that all required data elements are filled out. Confirm that the application is signed and dated. Confirm that Addendum A: Practitioner's Rights is signed and dated. Confirm that Addendum B: Professional Liability Action Explained is signed and dated (if applicable). Confirm that Addendum C: DHCS Provider Agreement is signed and dated. Confirm that Addendum D: DHCS Supplemental Questions is signed and dated. Re-verification during recredentialing is required. 	Verification must be completed within 120 calendar days from date of the signed application.
Attestation Questions	<ul style="list-style-type: none"> SFHP confirms that the attestation questions and Addendum: Supplemental Questions are signed and dated. At initial credentialing, practitioners attest to all of the statements since their initial licensure. At recredentialing, practitioners attest to all statements since the last credentialing cycle. When any of the questions are answered "yes": <ul style="list-style-type: none"> Practitioners must submit a written explanation of the answer. The CMO will review the credentialing file, may request additional information or conduct further investigation, and will submit recommendations for next steps to the PAC. The PAC makes the final decision in the credentialing process. Re-verification during recredentialing is required. 	<p>Verification must be completed within 120 calendar days from date of the signed application.</p> <p>If the signed attestation exceeds the time limit before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete but is not required to complete another application. SFHP will send a copy of the completed application with the new attestation form when it requests the practitioner to update the attestation.</p>
Clinical License	<ul style="list-style-type: none"> Confirm that the practitioner holds a valid, current clinical California license. Re-verification during recredentialing is required. 	<p>Verification must be completed within 120 calendar days from date of the signed application.</p> <p>License must be active at the time of the decision.</p>
DEA (as applicable)	<ul style="list-style-type: none"> Confirm that the practitioner holds a valid, current DEA certificate. <ul style="list-style-type: none"> If a practitioner has a pending DEA certificate application, SFHP must obtain documented evidence that another practitioner with a valid DEA certificate will write all prescriptions until the applicant has a valid DEA certificate. Re-verification during recredentialing is required. 	Prior to the credentialing decision. DEA must be in effect at the time of the decision.
Applicable continuing education requirements	<ul style="list-style-type: none"> Confirm that the practitioner holds a valid, current clinical 	Verification must be completed within 120 calendar days from date of the

Document	Verification	Time Limit
	California license. <ul style="list-style-type: none"> Practitioners must meet continuing education requirements to maintain a valid license, so license confirmation is acceptable evidence. 	signed application.
Board Certification (if provided)	<ul style="list-style-type: none"> Board certification is not required; however, SFHP verifies current certification status of practitioners who state that they are board certified. SFHP documents the expiration date of the Board certification. If a practitioner has a “Lifetime” certification status and there is no expiration date for certification, SFHP verifies that Board certification is current. 	Verification must be completed within 120 calendar days from date of the signed application.
Work History	<ul style="list-style-type: none"> SFHP verifies practitioners’ work history through the practitioner’s application, resume, or CV. If the practitioner has fewer than five (5) years of work history. If there is a gap in employment exceeds six (6) months, the practitioner must clarify the gap verbally or in writing. SFHP will document a verbal clarification in the practitioner’s credentialing file by noting the name of the individual who provided the clarification, organization, title, email, phone number, and date the clarification was made. • If the gap in employment exceeds one (1) year, the practitioner clarifies the gap in writing. PAC may request that practitioner be subject to proctoring; practitioner must submit written, and signed, confirmation that proctoring has occurred. PAC may request employment verification from primary sources if employment gap is longer than one (1) year. 	Verification must be completed within 120 calendar days from date of the signed application.
Malpractice History	<ul style="list-style-type: none"> SFHP obtains written confirmation of the past five (5) years of history of malpractice settlements from the malpractice carrier, or by querying the National Practitioner Data Bank (NPDB). 	Verification must be completed within 120 calendar days from date of the signed application.
History of any suspension or curtailment of hospital and clinic privileges History of liability claims against the provider	<ul style="list-style-type: none"> Querying the National Practitioner Data Bank (NPDB). 	Verification must be completed within 120 calendar days from date of the signed application.
Liability Insurance	<ul style="list-style-type: none"> SFHP obtains proof of current and adequate liability insurance with minimum coverage: <ul style="list-style-type: none"> \$100,000 per incident \$300,000 annual aggregate. 	Liability must be in effect at the time of the decision.

Credentialing Decisions: All organizations and practitioners participating in the SFHP network must be approved by the SFHP PAC. When issues are found during the credentialing process, the PAC reviews the file and makes the determination to approve or reject the application. The PAC may not approve practitioners or organizations suspended or terminated by a State or Federal agency or the Medical Board of California.

If a serious quality deficiency is identified and the PAC elects to impose any disciplinary actions, including reduction, suspension, or termination of a provider’s privileges, the provider will be reported to the appropriate oversight entities.

Notification of Credentialing Decision: SFHP notifies, in writing, applicants of initial credentialing and recredentialing decisions, both approval and denial, within 30 days from the date the decision was made. Practitioners who are denied have the right to appeal the decision, and the process is described in CR-03: Notification to Authorities of Practitioner Disciplinary Actions.

Monitoring of Sanctions and Exclusions: SFHP continuously monitors practitioners and organizational providers between credentialing cycles and takes appropriate action when it identifies issues of non-compliance with SFHP credentialing requirements. Appropriate action includes but is not limited to: removal from SFHP's network; review by SFHP's Credentialing Committee; or referral to PQI processes.

Practitioner License: Data team staff pulls license termination data from the health plan's core provider data in QNXT:

- Data staff checks the State of CA Department of Consumer Affairs or appropriate licensure website to obtain a copy of the most recent license report. If the website does not provide an updated license report, the data staff will check a second time prior to termination date.
- If a practitioner fails to renew their license, SFHP will immediately terminate the provider.

Organizational Provider Licenses and Organizational Provider Accreditation (if applicable): Credentialing staff reviews data in credentialing data system:

- License and Accreditation (if applicable) must be reviewed, at minimum, every 36 months. When license or accreditation reviews are within 30 days of the 36-month review timeframe, credentialing staff checks the appropriate website to obtain a copy of the most recent report.
- If the website does not provide an updated license or accreditation report, the credentialing staff will contact the organizational provider. Credentialing staff will request a copy of the license or accreditation (or evidence that the license or accreditation has been renewed – e.g. payment receipt) from the practitioner. Credentialing staff will monitor the state or accreditation website for updates, and once it is updated, Credentialing staff will print a copy and save it in the practitioner's credentialing file.
- If organizational provider fails to provide evidence of renewal, SFHP will terminate the provider.

Organizational Provider Site Visits (if applicable): Credentialing staff reviews data in credentialing data system:

- Site visits must be reviewed, at minimum, every 36 months and must be current according to the licensing or accrediting body conducting the site visits. When site visits are within 30 days of the 36-month review timeframe, credentialing staff checks the appropriate website to obtain a copy of the most recent report.
- If the website does not include a current site visit report, the credentialing staff will contact the organizational provider. Credentialing staff will request a copy of the updated site visit report (or evidence that the site visit has been completed) from the organizational provider. Credentialing staff will monitor the site visit website for updates, and once it is updated, credentialing staff will print a copy and save it in the provider's credentialing file.
- Site visits can be performed by SFHP staff in some circumstances. See CR-11: Practitioner and Organization Provider Office Site Visits.
- If the organizational provider fails to provide evidence of updated site visit, SFHP will terminate the provider.

Interdisciplinary Team Demonstrated Experience

SFHP ensures that each member is provided with an ICT that includes providers with demonstrated experience and training in areas applicable to treating individuals in our target population. This includes applicable training, expertise in specialty areas, and applicable licensure.

The ICT is composed of dedicated providers who have undergone specialized training designed to meet the unique needs of members of each of the target populations and holds active licenses and relevant board certifications, ensuring they are fully qualified to deliver the specialized care required.

What sets this team apart is the careful selection of providers based on their proven expertise and experience. They are chosen for their ability to manage the specific health conditions that are common within the population they serve. This commitment to exceptional care and targeted skills allows the ICT to effectively address the member's health challenges.

Evidence of ICT Requirements

The ICT is composed of highly trained professionals who have completed specialized training in the MOC tailored for the specific needs of their member's target population. Each team member takes pride in their expertise, knowing they have the skills necessary to provide quality care.

To maintain high standards, SFHP ensures that all providers hold active licenses and, where applicable, possess board certifications. This verification process involves liaising with the relevant licensing bodies and certification boards, guaranteeing that every provider is fully qualified.

Moreover, the ICT emphasizes the importance of ongoing competency. The team continuously monitors the performance of its providers through regular evaluations, peer reviews, and requirements for further education. This commitment to continuous improvement helps providers enhance their skills and ensures that they remain informed about the latest advancements in their respective fields, ultimately benefiting the patients they serve.

Factor 3: Update Provider Information

To maintain the integrity and accuracy of our provider network directory, SFHP employs a systematic approach that ensures our information is current and reliable. This process includes regular updates and a thorough verification procedure for all providers within our network.

Provider information is primarily obtained from our Credentialing Department and delegated credentialing departments. This data is entered into our unified system of record, QNXT, which serves as the central repository for all contracted provider information. QNXT generates reports for state agencies, creates provider directories, and supports our online provider search tool.

Our online Provider Search Tool, available on our website, is updated regularly to ensure that the public has access to accurate provider information. This tool includes details about PCPs and specialists and guidance on how to view information about other contracted providers. It also informs members about the necessity for authorizations or referrals, the availability of interpreter services, and access to reproductive health services.

Frequency of Updates

- **Online Provider Search Tool:** Updated weekly to reflect any new additions or changes to provider information. This ensures that the most current data is always available to the public.
- **Printed Provider Directories:** Updated quarterly to ensure that all printed materials distributed to members and stakeholders contain accurate information.
- **Data Extracts:** Provider data is extracted from QNXT on a weekly basis to support the online directories and on a quarterly basis for printed directories. Monthly extracts are also performed to support the Symphony provider directory utility.

Responsible Parties

- **Credentialing Team:** Handles primary source verification for any changes that require credentialing validation. They ensure that all credentialing information is accurate before it is updated in the system.
- **Provider Network Operations Staff:** Responsible for requesting data additions and changes into the QNXT system via TeamDynamix service requests. They ensure that new provider data is updated within three business days of completing the credentialing process, changes in the status of participation are updated within a week, and that changes to other existing data are entered as soon as possible.

Provider Manual and Notifications

Providers receive the SFHP Provider Manual, which outlines the process for notifying us of any changes in their network data. This manual is updated and redistributed as needed. Additionally, provider groups are required to submit updated provider rosters at least quarterly. These rosters are validated against primary sources to ensure accuracy.

New Additions and Changes

New providers are added to our network following a thorough credentialing process. Provider groups inform us of new additions through quarterly submissions, and any changes to existing provider information are processed promptly. Changes that require primary source verification are managed by our Credentialing Team to ensure compliance and accuracy.

We have a system in place for addressing potential inaccuracies reported by members, providers, or the public. Reports of inaccuracies are investigated and resolved within 30 business days, ensuring that our provider directory remains accurate and reliable.

By following these processes, we maintain an up-to-date and accurate provider network directory, ensuring that our members have access to reliable information about their healthcare providers.

Factor 4: Facilitate Collaboration with the ICT

SFHP's MOC outlines comprehensive processes and strategies to ensure that providers within the network collaborate effectively with ICT members to deliver specialized services to members promptly and efficiently. This collaboration addresses each member's unique health care needs and ensures seamless coordination across different providers and settings.

Providers in the SFHP network are integral members of the ICT and actively participate in the care planning and management process. Regular meetings are scheduled with the provider network team to discuss and refine collaboration strategies, ensuring all team members are aligned regarding each member's care.

Effective communication is a cornerstone of this collaboration. Providers communicate member care needs to the ICT through various channels, including telephone, secured email, and a dedicated online portal. This portal is a central hub where providers can access and update care plans, share reports, and communicate with other ICT members.

Providers are not only informed about the care plans but are also actively involved in their development. They are invited to ICT meetings where the care of their members is discussed, allowing them to provide direct input and ensure that the care plans are up-to-date and reflect the member's current health status and needs. This involvement ensures that providers have up-to-date care plans for their members and can contribute their specialized knowledge to the care planning process.

Our data warehouse, claims platform, and portal ensure that all reports and documentation regarding services rendered are shared with the ICT in a timely manner. This includes detailed records of medical treatments, diagnostic tests, and any other relevant health care services provided to the member. These reports are uploaded to the online portal, where all members of the ICT can access them. This centralized system facilitates the seamless integration of information into the ICP, ensuring all team members have access to the most current and comprehensive data.

The ICT is responsible for incorporating all relevant information into the ICP, which serves as the central document guiding the member's care. This includes medical information and social, psychological, and functional assessments critical for holistic care planning. Providers contribute to the ICP by sharing their specialized knowledge and insights, ensuring the care plan is tailored to the member's needs. Information is also incorporated into the ICP whenever there is a change in the member's condition, an updated health risk assessment, or other information affecting the member. Additionally, input from the member, caregivers, and others involved in the member's care is integrated to ensure a comprehensive and personalized care plan.

To ensure that providers have the necessary information to deliver high-quality care, we make ICPs readily available to all relevant providers. This is achieved through the online portal, where providers can access and review the care plans at any time. This accessibility ensures that providers are well-informed about the member's care plan and can make informed decisions about their treatment.

SFHP emphasizes continuous improvement in communication and collaboration practices. Regular feedback is sought from providers and ICT members to identify areas for improvement and implement best practices. This iterative process ensures that we remain responsive to the evolving needs of members and the healthcare environment.

By fostering robust collaboration and communication within the ICT, SFHP ensures that specialized services are delivered effectively and efficiently, ultimately enhancing the quality of care for all members. This comprehensive approach addresses members' immediate health needs and supports their long-term well-being through coordinated, personalized care.

MOC 3 Element B: Use of Clinical Practice Guidelines (CPGs) and Care Transition Protocols (CTPs)

Factor 1: Monitor Use of Guidelines and Protocols

Through the structured use of CPGs and CTPs, SFHP demonstrates our commitment to providing high-quality, evidence-based care to our members. The processes for identifying, disseminating, and monitoring these guidelines ensure that providers have the tools and support to deliver the right care at the right time. By focusing on population-level decision-making and continuous improvement, SFHP enhances the health outcomes of our target population and upholds our mission of delivering exceptional care.

Identification and Dissemination of CPGs

Identifying CPGs is a collaborative effort involving clinical review and input from various committees within SFHP. These committees, composed of healthcare professionals with diverse expertise, review and select CPGs based on their relevance, evidence base, and alignment with nationally recognized standards. The selected CPGs are sourced from reputable organizations such as the American Heart Association, the American Diabetes Association (ADA), and other evidence-based entities.

Once identified, the CPGs are accessible to all network providers through multiple channels. The guidelines are posted on SFHP's website and included in the provider manual, ensuring easy access for all providers. Additionally, providers can discuss these guidelines with the CMO if they have any questions or need further clarification. SFHP also conducts regular training sessions and workshops to ensure that providers are familiar with the guidelines and understand how to apply them in clinical practice.

Monitoring Provider Utilization and Adherence

To ensure that network providers adhere to the established CPGs and CTPs, SFHP employs a comprehensive monitoring process that focuses on population-level oversight. Given the plan's new and small size, the following mechanisms are used:

- **Manual Medical Record Review:** SFHP conducts manual reviews of medical records to ensure that providers are following the guidelines. This method provides a detailed and qualitative assessment of adherence.
- **Surveys and Feedback:** SFHP conducts regular surveys and feedback sessions with providers to assess their understanding and application of CPGs. This feedback is used to make necessary adjustments and provide additional training if needed.
- **Quality Oversight:** The Quality Improvement and Health Equity Committee (QIHEC) oversees the adherence to CPGs and CTPs. This committee reviews provider performance data, conducts audits, and identifies areas for improvement.
- **HEDIS Measures:** The QIHEC uses Healthcare Effectiveness Data and Information Set (HEDIS) measures to evaluate provider performance. These measures provide standardized metrics for assessing the quality of care and adherence to CPGs.

Demonstrating the Use of CPGs and CTPs

SFHP demonstrates the use of CPGs and CTPs through various initiatives and documentation. Additionally, SFHP conducts performance evaluations to ensure that CPGs and CTPs are applied consistently and effectively across the population.

The following table provides examples of CPGs sourced from nationally recognized, evidence-based organizations that we will utilize based on our population identified in MOC 1:

Table 6: Clinical Practice Guidelines

Condition	Clinical Practice Guideline	Online Source
Hypertension Management	Guidelines for the diagnosis and management of hypertension, including lifestyle modifications and pharmacotherapy.	2023 ESH Hypertension Guideline Update: Bringing Us Closer Together Across the Pond - American College of Cardiology (acc.org)
Hyperlipidemia	Guidelines for the management of high blood cholesterol, including risk assessment and pharmacotherapy.	2018 Guideline on the Management of Blood Cholesterol - Professional Heart Daily American Heart Association
Cataract	Guidelines for the management of cataracts, including surgical techniques and postoperative care.	Cataract in the Adult Eye Preferred Practice Pattern® - Ophthalmology (aojournal.org)
Rheumatoid Osteoarthritis	Guidelines for the management of osteoarthritis, including pharmacologic and nonpharmacologic treatments.	Osteoarthritis Management: Updated Guidelines from the American College of Rheumatology and Arthritis Foundation AAFP
Diabetes Management	Comprehensive guidelines for the management of type 2 diabetes, including blood glucose monitoring, medication, and lifestyle changes.	Standards of Care in Diabetes American Diabetes Association
Anemia	Guidelines for the management of iron deficiency anemia, including diagnosis and treatment options.	Iron Deficiency Anemia: Guidelines from the American Gastroenterological Association AAFP
Depression	Guidelines for the treatment of depression across different age groups, including therapy and medication.	Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (apa.org)
Chronic Kidney Disease	Guidelines for the evaluation and management of chronic kidney disease, including risk assessment and treatment strategies.	CKD Evaluation and Management – KDIGO
Osteoporosis Management	Strategies for the prevention and treatment of osteoporosis, including calcium and vitamin D supplementation, and pharmacotherapy.	Osteoporosis Treatment: Updated Guidelines From ACOG AAFP

Oversight of CPG use is a critical component of SFHP's quality assurance framework. The QIHEC and designated clinical leaders are responsible for monitoring and enforcing adherence to CPGs. This oversight involves regular audits, feedback sessions with providers, and ongoing education regarding the importance of evidence-based practice.

SFHP is committed to continuous improvement in the application of CPGs and CTPs. To enhance their effectiveness, regular feedback from providers and other stakeholders is actively sought. This feedback is collected through surveys, performance reviews, and direct communication channels. The QIHEC reviews this input and recommends necessary adjustments to the guidelines and protocols. This iterative process ensures that CPGs and CTPs remain current, relevant, and effective in addressing the health needs of the population.

To support the effective implementation of these guidelines, SFHP provides ongoing training and education for network providers. Regular training sessions and workshops ensure that providers stay informed about the latest guidelines and understand their practical application. These educational initiatives cover a variety of topics, including the rationale behind the guidelines, their application in clinical settings, and updates on new evidence or changes to existing protocols.

Effective communication and collaboration are essential for the successful implementation of CPGs and CTPs. SFHP facilitates communication between providers and the ICT through various channels, including telephone, secured email, and an online portal. This connectivity ensures that all care team members are informed and can work together to provide

coordinated, evidence-based care. Providers are encouraged to participate in ICT meetings, contributing their expertise to developing and refining care plans.

SFHP's approach to using CPGs and CTPs emphasizes population-level decision-making. By focusing on the overall health outcomes of the target population, SFHP ensures that care is delivered consistently and effectively to all members. This population-level focus enables SFHP to identify trends, address common health issues, and implement strategies that benefit the entire member population.

Factor 2: Specify Challenges and Exceptions to Guidelines

SFHP recognizes that while CPGs and nationally recognized protocols are essential for ensuring high-quality, evidence-based care, they may not always be appropriate for all members, particularly those with complex health care needs. Certain vulnerable populations may present unique challenges that necessitate modifications to standard guidelines. SFHP has established a comprehensive process to identify and address these challenges, ensuring that care remains individualized and appropriate for each member.

One of the primary challenges in applying CPGs to vulnerable SNP members is the presence of multiple comorbidities. Members with complex health conditions often have overlapping and interacting medical issues that make strict adherence to standard guidelines impractical or even harmful. For instance, a guideline for managing diabetes may not fully account for the needs of a member who also has advanced heart disease and chronic kidney disease. In such cases, SFHP's clinical team must carefully balance the recommendations of various guidelines to develop a cohesive and safe care plan.

Another significant challenge is the variability in how different members respond to treatments recommended by CPGs. Individual differences in genetics, lifestyle, and SDoH can influence the effectiveness and appropriateness of standard protocols. SFHP addresses this by incorporating personalized medicine approaches and regularly reviewing and adjusting treatment plans based on the member's response to therapy.

SFHP also encounters challenges related to our members' social and environmental contexts. Many vulnerable members face barriers such as limited access to healthcare resources, financial constraints, and lack of social support, which can impede their ability to adhere to standard treatment protocols. SFHP mitigates these challenges by leveraging telehealth services, coordinating with local healthcare providers, and providing additional support through Care Managers/Coordinators and social workers.

To systematically identify and address these challenges, SFHP has implemented a robust process that includes several key components. First, SFHP conducts comprehensive assessments of each member's health status, medical history, and SDoH. These assessments are performed by members of the ICT and are used to identify potential conflicts between standard guidelines and the member's unique needs.

Second, SFHP employs a collaborative approach to care planning. The ICT, which includes PCPs, specialists, nurses, social workers, and other relevant healthcare professionals, meets regularly to discuss and review each member's care plan. During these meetings, the team identifies challenges in applying standard guidelines and develops tailored care plans that address the member's specific circumstances. This collaborative process ensures that all aspects of the member's health are considered and that care plans are both evidence-based and individualized.

Third, SFHP utilizes a feedback loop to monitor and adjust care plans continuously. Members and their caregivers are encouraged to provide feedback on their care experiences and any difficulties they encounter following treatment protocols. This feedback is reviewed by the ICT and used to make necessary adjustments to the care plan. Additionally, SFHP tracks clinical outcomes and quality metrics to identify trends and areas for improvement in the application of CPGs.

Finally, SFHP provides ongoing education and support to our providers to ensure they are equipped to handle the complexities of caring for vulnerable members. This includes training on the principles of personalized medicine, the importance of considering SDoH, and strategies for modifying standard guidelines to meet the needs of complex patients. Providers are also encouraged to consult with the CMO and other clinical leaders when faced with particularly challenging cases.

Factor 3: Detail the Decision Process to Modify Guidelines

Modifying Clinical Practice Guidelines for Clinically Complex Members

SFHP is dedicated to ensuring that clinically complex members receive care tailored to their unique health needs. This often requires modifications to standard CPGs and nationally recognized protocols. The process for making these modifications is comprehensive and involves several key steps to ensure that changes are evidence-based, effectively communicated, and properly implemented. SFHP's process for modifying CPGs and nationally recognized protocols for clinically complex members is designed to ensure that all members receive care tailored to their unique needs. By involving a dedicated committee, ensuring thorough documentation and communication, maintaining continuous monitoring and feedback, and providing ongoing education and support, SFHP upholds our commitment to delivering high-quality, individualized care. This comprehensive approach enhances the quality of care and supports better health outcomes for SFHP's most vulnerable populations.

Decision-Making Process

The decision to modify CPGs or nationally recognized protocols for clinically complex members is made by the member's PCP and specialists as supervised by the PAC. This committee comprises experienced healthcare professionals, including PCPs, specialists, nurses, pharmacists, and representatives from the QIHEC. The PAC meets regularly to review cases where standard guidelines may not be appropriate and to make decisions regarding necessary modifications.

When a clinically complex member is identified with questions regarding care, the PAC thoroughly reviews the member's medical history, current health status, and any relevant SDoH. This review helps the committee understand the specific challenges and needs of the member. Based on this comprehensive assessment, the PAC evaluates the applicability of the current guidelines and determines whether modifications are necessary. This evaluation includes considering alternative treatments, adjusting dosages, or incorporating additional monitoring protocols. The PAC relies on the latest clinical evidence and expert consensus to inform their decisions, ensuring that any modifications are both safe and effective.

Incorporation into the ICP

Once a decision to modify a guideline is made, the changes are incorporated into the member's ICP. In collaboration with the ICT, the Care Manager/Coordinator updates the ICP to reflect the modified guidelines. This update includes detailed documentation of the rationale for the changes, the specific modifications made, and any additional actions required to implement the new plan.

Communication with the ICT

Effective communication is essential for the successful implementation of modified guidelines. The Care Manager/Coordinator is responsible for communicating the changes to all members of the ICT. This communication occurs through multiple channels, including secure email, telephone calls, and updates to the online portal where the ICP is stored. During ICT meetings, the Care Manager/Coordinator presents the modified guidelines and explains the rationale behind the changes. This presentation allows all team members to understand the new plan and ask any questions they may have. It also ensures that everyone involved in the member's care is aware of the modifications and can act accordingly.

Implementation and Action by the ICT

Once the modified guidelines are communicated, the ICT is responsible for implementing the changes and providing care according to the updated ICP. Each member of the ICT plays a specific role in this process, ensuring that all aspects of the member's health are addressed. For example, PCPs may adjust medications, specialists may order additional tests or treatments, and nurses may provide enhanced monitoring and support. The Care Manager/Coordinator continues to oversee the implementation of the modified guidelines, ensuring that all actions are carried out as planned. Regular follow-up meetings are scheduled to monitor the member's progress and make any further adjustments as needed. This ongoing oversight helps to ensure that the modified guidelines are effective and that the member's health outcomes are optimized.

Continuous Monitoring and Feedback

SFHP strongly emphasizes continuous monitoring and feedback to ensure that the modifications to CPGs and protocols are effective and appropriate for clinically complex members. This ongoing process involves regular assessments and adjustments based on the member's response to the modified care plan. The Care Manager/Coordinator maintains regular contact with the member and their caregivers through scheduled follow-up visits, phone calls, and secure messaging to monitor progress and address any concerns. This information is then shared with the ICT during regular meetings, where the team reviews the member's progress and evaluates the effectiveness of the modified guidelines. If the member's condition changes or the current plan does not yield the desired outcomes, the ICT collaborates to make further adjustments. This iterative process ensures the care plan remains dynamic and responsive to the member's evolving needs.

Documentation and Reporting

Accurate documentation and reporting are critical components of SFHP's process for modifying CPGs and protocols. All modifications, rationale, and expected outcomes are documented in the member's ICP. This documentation provides a clear record of the decision-making process and serves as a reference for all members of the ICT. The PAC reviews these records regularly to ensure compliance with regulatory requirements and to identify any patterns or trends that may indicate the need for broader changes to the guidelines. This oversight helps maintain high standards of care and ensures that all modifications are evidence-based and justified.

Provider Education and Support

To support providers in implementing modified guidelines, SFHP offers ongoing education and training. These educational initiatives include workshops, webinars, and one-on-one coaching sessions that focus on the principles of personalized medicine, the importance of considering SDoH, and strategies for modifying standard guidelines to meet the needs of complex patients. Providers are also encouraged to consult with the CMO and other clinical leaders when faced with challenging cases. This support network ensures that providers can access expert advice and make informed decisions about modifying care plans.

Factor 4: **Oversee Care Transition Protocols**

Care transitions, whether within the network or outside of it, present significant challenges for maintaining continuity of care. SFHP has established comprehensive care transition protocols to ensure members receive seamless and coordinated care during these critical periods. These protocols are designed to facilitate effective communication, timely information exchange, and coordinated actions among all providers involved in a member's care. SFHP also provides robust oversight to ensure network providers adhere to these protocols.

SFHP's care transition protocols are developed based on best practices and nationally recognized standards. These protocols outline specific steps and responsibilities for providers to follow when a member transitions from one care setting to another, such as from a hospital to a rehabilitation facility or from a specialist back to primary care. The protocols emphasize the importance of timely and accurate information exchange, clear communication, and coordinated care planning.

Communication and Information Exchange

Effective communication and information exchange are critical components of the care transition process. SFHP ensures that all relevant information about the member's health status, treatment plan, and care needs is communicated promptly to the receiving provider. This includes detailed discharge summaries, medication lists, and any follow-up care instructions. SFHP utilizes secure communication channels, such as encrypted emails and a dedicated online portal, to facilitate the timely exchange of information.

The Care Manager/Coordinator plays a central role in this process by liaising between the sending and receiving providers. The Care Manager/Coordinator ensures that all necessary information is transferred and that both providers are aware of the member's care plan and any specific needs. This proactive approach helps prevent gaps in care and reduces the risk of adverse events during transitions.

Coordinated care planning is essential for ensuring that members receive continuous and appropriate care during transitions. SFHP's care transition protocols require a comprehensive care plan to be developed and shared with all providers involved in the member's care. This care plan includes detailed information about the member's medical history, current treatments, and any special considerations that need to be addressed. The ICT is responsible for developing and updating the care plan. The ICT includes PCPs, specialists, nurses, social workers, and other relevant healthcare professionals. The team meets regularly to review the member's progress and make any necessary adjustments to the care plan.

Oversight and Monitoring

SFHP collects feedback from members and caregivers about their experiences during care transitions. This feedback is used to identify any challenges or gaps in the process and to make necessary improvements. SFHP also tracks key performance indicators, such as readmission rates and follow-up appointment adherence, to assess the effectiveness of the care transition protocols.

Continuous Improvement

SFHP is committed to continuous improvement in the care transition process. Regular training and education are provided to network providers to ensure they are familiar with the care transition protocols and understand their importance. SFHP also encourages providers to share best practices and lessons learned from their experiences with care transitions. The QIHEC reviews the results of audits, feedback, and performance metrics to identify trends and areas for improvement. Based on this

analysis, the committee makes recommendations for updates to the care transition protocols and implements changes as needed. This iterative process ensures that the protocols remain effective and responsive to the needs of members.

Provider Education and Support

To ensure that network providers are well-equipped to follow care transition protocols, SFHP offers ongoing education and support. Training sessions and workshops are conducted regularly to familiarize providers with the protocols and emphasize their importance in maintaining continuity of care. These educational initiatives cover a range of topics, including effective communication strategies, the role of the Care Manager/Coordinator, and best practices for information exchange during transitions.

Providers are also encouraged to participate in case discussions and debriefings after care transitions. These sessions provide an opportunity to review what went well and identify any areas for improvement. By fostering a continuous learning and collaboration culture, SFHP helps providers stay informed and engaged in the care transition process.

MOC 3 Element C: MOC Training for the Provider Network

Factor 1: Implement MOC provider training

SFHP ensures that all in-network and out-of-network providers who routinely see members are comprehensively trained on the MOC. This multifaceted training process involves various methods and materials to accommodate different learning preferences and schedules. Providers receive detailed instructional documents, slide presentations, and guides covering essential topics such as MOC requirements, clinical guidelines, and best practices for treating the SNP population. Training is conducted through in-person meetings, web-based modules accessible via the SFHP website, audio/video conferencing, and printed materials. All training materials are available on the SFHP website for easy access and reference. Initial training is provided to all new providers upon joining the network, with ongoing sessions conducted annually and at the time of recertification to ensure providers remain up to date with the latest MOC requirements and clinical practices. The content of these training sessions includes detailed information on the MOC, clinical guidelines, Care Coordination, patient engagement strategies, and initial screening and comprehensive assessment for dementia.

Examples of the provider MOC training slides:

Model of Care (MOC)

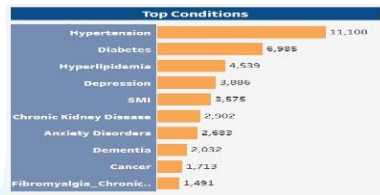
The MOC is divided into four areas:



MOC 1: Target Population

SAN FRANCISCO HEALTH PLAN 
Here for you

Top Medical and Behavioral Health Conditions:



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Description of the SNP Population



California Integrated Care Management (CICM) refers to the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. This includes:

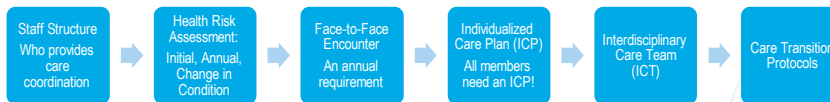
- Adults Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or Emergency Department Utilization
- Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- Adults Transitioning from Incarceration
- Adults Living in the Community and At Risk for Long-Term Care (LTC)
- Institutionalization
- Adult Nursing Facility Residents Transitioning to the Community
- Adults who are Pregnant or Postpartum and Subject to Racial and Ethnic Disparities
- Adults with Documented Dementia Needs

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MOC 2: Care Coordination



This section describes care coordination for all D-SNP members:



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MOC 3: Provider Network



This section describes how the Provider Network will meet the needs of D-SNP members (General and Most Vulnerable)

Specialized Expertise:

- Describes the specialized clinical expertise available within the provider network to meet the needs of the SNP population.

Clinical Practice Guidelines and Care Transition Protocols:

- Ensures that providers follow evidence-based guidelines and protocols for care transitions.

Provider Training:

- Details the training provided to network providers on the MOC, including documentation and actions for incomplete training.

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MOC-4 Quality Measurement & Performance Improvement



This section provides details on how SFHP will provide the highest quality D-SNP program

- Describes the MOC Quality Performance Improvement Plan
- Lists measurable goals & health outcomes for the MOC
- Measure patient experience of care (Member Satisfaction)
- How SFHP will provide ongoing performance improvement evaluation of the MOC
- How SFHP will disseminate D-SNP quality performance information related to the MOC

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Factor 2: Document and Maintain Evidence of Training

SFHP meticulously documents and maintains records of all training activities to ensure compliance and accountability. This includes keeping dated attendee lists, electronic records confirming the completion of online training modules, and a centralized database that tracks training activities, including dates, participants, and completion status. Providers also sign attestations confirming their participation and understanding of the training content and the training and/or provider team track the training that is not completed for actions outlined in Factor 4.

Training records for in and out-of-network providers trained by SFHP are maintained in each contracted provider's credentialing file, and in the learning management platform (Litmos). Attestation of each kind of training is tied to the provider's profile in the training platform.

Factor 3: Describe Challenges to Training Completion

SFHP recognizes several challenges associated with the completion of MOC training for network providers. Providers managing and coordinating training for a large number of providers can be logistically challenging. Providers' busy schedules and varying availability can make finding suitable times for training sessions difficult. Providers in SFHP's dense, urban county are usually participating with multiple plans, and separately accountable to the training expectations of all plans simultaneously.

To address these challenges, offering MOC training online can be a highly effective solution. By providing access to training materials and sessions that can be accessed at any time, we can accommodate the diverse schedules and varying availability of network providers. This online format allows providers to participate without the need for travel, making engaging with the training easier. Furthermore, recorded sessions can be made available, enabling providers to revisit the material at their convenience, ensuring a more comprehensive understanding of the content. This flexible approach not only enhances accessibility but also helps streamline the training process for a larger number of participants.

Factor 4: Actions Taken for Incomplete or Deficient Training

To address incomplete or deficient training, SFHP employs best practices such as flexible training schedules, multiple training formats, and personalized reminders to ensure compliance. For providers who do not complete the required training, SFHP takes specific actions beyond simple notifications. These actions include direct contact with non-compliant providers to discuss the importance of training and address any barriers to completion, involving higher-level management or clinical leaders to emphasize the necessity of training, scheduled and unscheduled in-person visits and large-scale group trainings to catch any deficient providers, and fringe benefits to training sessions like meals and raffles. Finally, SFHP may make continued participation in the network contingent upon the completion of required training.

MOC 4: Quality Measurement and Performance Improvement

Element A: MOC Quality Performance Improvement Plan

Factor 1: Detail Quality Improvement (QI) Process

SFHP is committed to continuous quality improvement for both the health plan and our health care delivery system. The purpose of the SFHP QI and Health Equity Transformation Program (QIHETP) is to establish comprehensive methods for systematically monitoring, evaluating, and improving the quality of the care and services provided to SFHP members and take appropriate actions to improve upon health equity. The QIHETP is designed to ensure that members have access to quality medical and behavioral health care services that are safe, effective, accessible, equitable, and meet the unique needs of the D-SNP population as identified in MOC 1. This includes the vulnerable members as defined by the state for California Integrated Care Management (CICM) including:

- Adults Experiencing Homelessness
- High utilizer adults with frequent hospital admissions, short-term Skilled Nursing Facility (SNF) stays, or Emergency Department (ED) visits
- Adults with Serious Mental Illness (SMI) and Substance Use Disorder (SUD)
- Adults transitioning from Incarceration
- Members eligible for Long Term Care (LTC) and at risk of institutionalization
- Nursing Home residents transitioning to the community
- Adults who are Pregnant or Postpartum and subject to Racial and Ethnic Disparities
- Adults with documented Dementia needs

Delivery of these services must be in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. SFHP contracts with medical and behavioral health care providers, including medical groups, clinics, independent physicians and their associated hospitals, ancillary providers, behavioral health clinicians, and pharmacies, to provide care. SFHP maintains responsibility for communicating regulatory and contractual requirements as well as policies and procedures to participating network providers.

Under the leadership of SFHP's Governing Board, the QIHETP is developed and implemented through the Quality Improvement and Health Equity Committee (QIHEC). The QIHEC structure, under the leadership of the SFHP CMO and the SFHP CHEO, ensures ongoing and systematic collaboration between SFHP and our key stakeholders: members, provider groups, and practitioners. The QIHETP is also part of a broader SFHP improvement strategy that includes a Population Health Management Program. The Population Health Management Program oversees the development of SFHP's strategic targets for addressing the needs of SFHP members across the continuum and manages the effective execution of that strategy. Strategic targets from Population Health Management process are incorporated into the QIHETP. A shared leadership team ensures accountability and collaboration between both programs.

The QIHETP's objectives and outcomes are detailed in the QIHET Work Plan. Each program objective is monitored at least quarterly, evaluated at least once per year and is shared with QIHEC quarterly in the form of a QIHET scorecard. Measures and targets are selected based on volume, opportunities for improvement, risk, organizational priorities, evidence of disparities, and alignment with the DHCS Comprehensive Strategy.

The scope and goals of the QIHET Program are comprehensive and encompass major aspects of care and services in the SFHP delivery system, as well as the clinical and non-clinical issues that affect its membership. These include:

- Improving members' health status, including reducing health disparities and addressing, where possible, the social determinants of health that adversely impact our members
- Ensuring continuity and coordination of Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships
- Ensuring access to primary and specialty care and services, including parity between medical and behavioral health care services
- Ensuring availability and regular engagement with PCP
- Ensuring member knowledge of rights and responsibilities
- Providing culturally and linguistically appropriate services
- Ensuring that health care practitioners are appropriately credentialed and re-credentialed
- Ensuring timely communication of DMHC and DHCS standards and requirements to participating medical groups and organizational providers
- Ensuring timely communication of CMS standards and requirements to participating medical groups and organizational providers as well as internal staff
- Ensuring effective and appropriate utilization management of health care services, including medical, pharmaceutical, and behavioral health care services
- Providing health education resources
- Ensuring clinical quality and safety in all health care settings including quality of behavioral health care focusing on prevention, recovery, resiliency, and rehabilitation
- Ensuring excellent member care experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination
- Ensuring that responsibilities delegated to medical groups meet plan standards
- Evaluating the overall effectiveness of the QIHETP through an annual comprehensive program evaluation
- Evaluating the overall effectiveness of the MOC through an annual comprehensive program evaluation
- Using the annual evaluation to update the QIHET Program and MOC to develop an annual QIHET Work Plan

Factor 2: Describe QI Data Collection

SFHP applies continuous quality improvement to all aspects of health care service delivery for D-SNP beneficiaries through ongoing monitoring, analysis, evaluation, and systematic enhancements. Various data sources are collected and used for monitoring and evaluating performance and outcome measures. The plan evaluates dashboards and reports at least monthly for program effectiveness and to identify improvement activities.

Data sources include, but are not limited to:

- Eligibility files including demographics
- Claims and encounter data
- Utilization data
- Case management notes, care plans
- Pharmacy data
- Supplemental data
- Laboratory data
- Population Needs Assessments
- Results of risk adjustments and stratification
- Health Risk Assessment (HRA)
- California Immunization Registry (CAIR)
- Electronic Medical Records
- Healthcare Effectiveness Data and Information Set (HEDIS) and CMS Star Rating (Part C & D) performance
- Consumer Assessment of Healthcare Providers & Systems (CAHPS)
- Health Outcomes Survey (HOS)
- Regulatory reporting

Data is continuously collected, analyzed and evaluated for use in monitoring performance and outcome measures. Quality performance and outcome measures includes the following, but is not limited to:

- The number and percent of initial HRAs completed for D-SNP members
- The number and percent of annual HRAs completed for D-SNP members
- The number and percent of initial ICPs completed by SFHP
- The number and percent of updated ICPs generated during the measurement year
- Claims data and specific utilization metrics including readmission rates, ED visits, etc.
- HEDIS measures data
- CAHPS and HOS survey findings
- Grievance and appeals data, including CTMs
- Medical record review audits for standard of care documentation
- Provider network adequacy, including accessibility and availability of appropriate clinical care and of a network of providers
- Cultural & linguistic needs
- Compliance with CPGs and evidence-based medicine

Factor 3: Detail QI Staff and Oversight

The QIHETP details the structure, goals, and objectives of QI initiatives. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives, which are approved by the Governing Board and QIHEC and periodically evaluated and updated.

Improvements in processes, quality of care, and service are throughout all levels of the organization.

SFHP Executive team consists of the Chief Executive Officer, Chief Financial and Strategy Officer, Chief Medical Officer, Chief Operating Officer, Chief Health Equity Officer, Chief of Staff, and Chief Compliance & Regulatory Affairs Officer.

- All Executive team members are actively involved in the Governing Board and Committees for quality improvement and the Health Equity Program at different levels based on their related aspects.
- Staff and physicians provide vital information necessary to support continuous improvement in work processes.
- Individuals and department stakeholders initiate improvement projects within their area of authority, which support the strategic goals of the organization.
- Specific performance improvement projects may be initiated by the state or federal government.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority) and items deemed to be high risk, high volume, or problem-prone processes.
- Project coordination occurs through the various leadership structures: Governing Board, Management, QIHEC and UM Committees, etc., based upon the scope of work and impact of the effort.
- These improvement efforts are often cross functional and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the identified groups.

Staffing Structure

Chief Medical Officer (CMO) – The CMO is responsible for leading the QIHEC, Physician Advisory/Peer Review/Credentialing Committee, Pharmacy and Therapeutics Committee, various functions spanning state programs, Population Health, Care Management, Utilization Management, clinical appeals, and all quality improvement and health equity studies and activities. The CMO provides guidance and oversight for developing policies, programs, and projects that support all activities identified in the QIHETP.

Chief Health Equity Officer (CHEO) - The CHEO provides leadership, strategy, and program development across the organization ensuring that health equity is addressed throughout the organization, including the QIHETP. The CHEO, in collaboration with the CMO, is responsible for reporting to the Governing Board at least quarterly on the QIHETP. The CHEO, in collaboration with the CMO, is also responsible for communicating information and updates regarding the QIHETP to SFHP leadership and staff via staff meetings, executive team meetings, and other internal meetings. The CHEO serves as a voting member of the QIHEC.

Senior Medical Director – The Senior Medical Director holds an active, unrestricted medical license in accordance with California state laws and provides clinical leadership to ensure high-quality care delivery, regulatory compliance, and member satisfaction. This role oversees medical necessity determinations, supervises grievance and appeals processes, and addresses potential quality issues. Additionally, the Senior Medical Director provides strategic support to the Quality Improvement, Utilization Management, and Care Management teams by driving evidence-based policies, enhancing Care Coordination, and improving performance on key metrics such as HEDIS and Star Rating while fostering collaboration across clinical and operational teams.

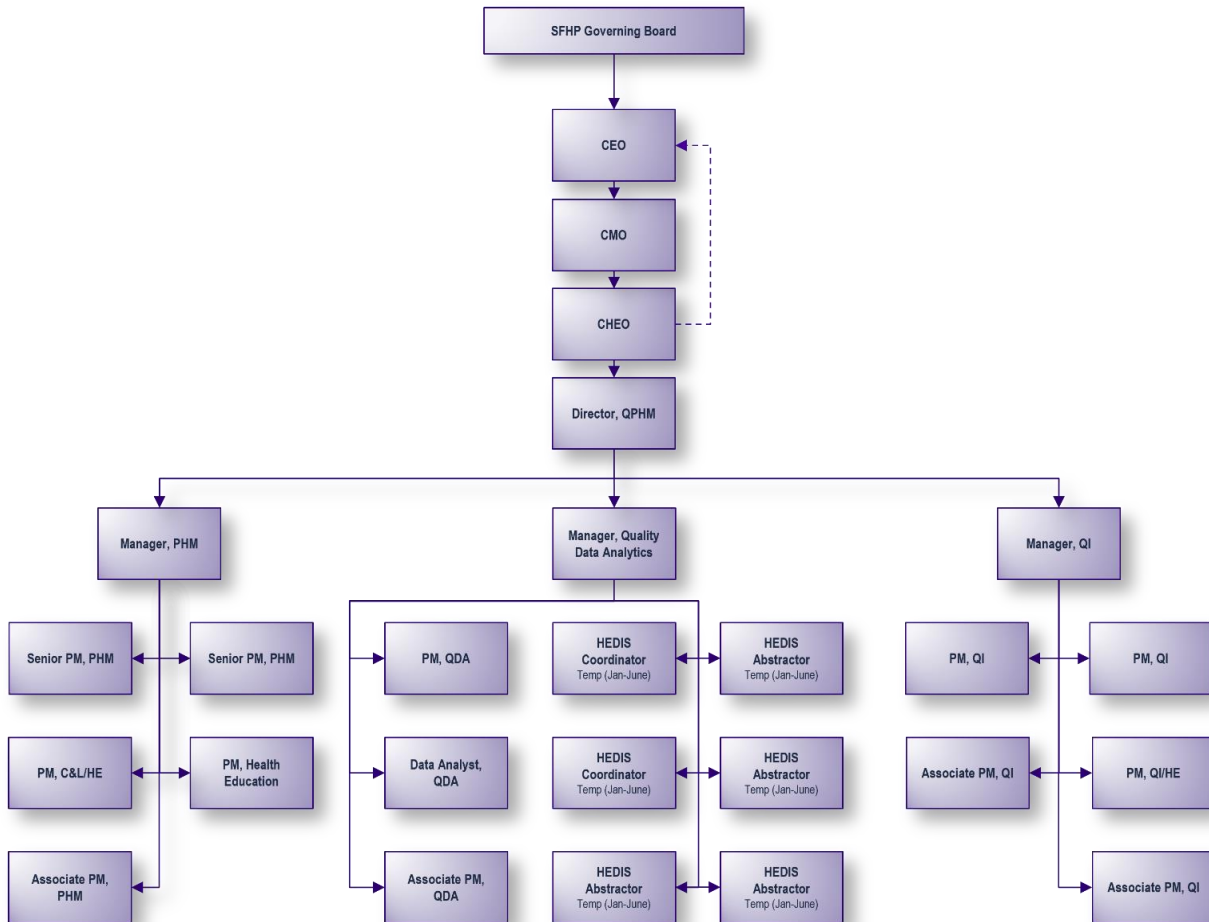
Director, Quality and Population Health Management (PHM) – The Quality/PHM Director ensures the completion of the QIHETP and directs the execution of QIHET activities identified in the QIHET Work Plan. They oversee teams focused on fostering quality for our members: PHM, quality improvement, and quality data analytics.

The Quality and Population Health Management (QPHM) department within Health Services is primarily responsible for implementing the QIHETP and its associated Work Plan. The department is structured to ensure interdisciplinary collaboration in promoting quality and health equity in the care and services provided to SFHP's members.

QPHM staff are tasked with monitoring quality indicators and overseeing the implementation and evaluation of the Plan's quality improvement and health equity initiatives. They also develop and adhere to policies and procedures that align with SFHP standards, legislative, and regulatory requirements, contractual obligations, the MOC and NCQA quality standards.

Additionally, QPHM staff manage QIHET-related studies and reports, including conducting statistical analyses and interpreting data. Based on activities outlined in the QIHET Work Plan, QPHM provides summary data, analyses, and actionable recommendations to the QIHEC.

Quality Staff Organizational Chart



Governing Board

The Governing Board is responsible to review, act upon and approve the overall QIHETP, Quality Improvement and Health Equity Work Plan, and Annual Evaluation. The Governing Board routinely receives reports from the QIHEC describing actions taken, progress in meeting quality objectives and improvements made. The Board makes recommendations regarding additional interventions and actions to be taken when objectives are not met.

The Director of QPHM is responsible for the coordination and distribution of all quality improvement related data and information. The QIHEC reviews, analyzes, makes recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The CEO, CMO or CHEO communicates the QIHEC activities to the Board. The Board reviews the QIHEC activities, and any concerns of the Board are communicated back to the source for clarification or resolution.

The Quality Improvement and Health Equity Committee (QIHEC)

The SFHP QIHEC is comprised of network clinicians (physicians, behavioral health, and pharmacists) and three members of the Member Advisory Committee, one of whom is from the special needs/disabled population. The QIHEC is co-chaired by SFHP's CMO and CHEO. The QIHEC is a standing committee of the San Francisco Health Authority Governing Board that meets at least four times a year. It is the main forum for member and provider oversight, ensuring the quality of the healthcare delivery system. The committee is responsible for reviewing and approving the annual QIHETP and QIHETP Evaluation, and for providing oversight of the plan's quality improvement and health equity activities. SFHP brings new quality improvement programs to the QIHEC to ensure the committee members provide input into program planning, design, and implementation. SFHP maintains an annual calendar to ensure that key SFHP QIHETP activities are brought to the QIHEC for ongoing review, analysis, and evaluation. This includes annual review of the results of performance measures, utilization data, consumer satisfaction surveys, delegation oversight and the findings and activities of the Member Advisory Committee, the Physician Advisory/Peer Review/Credentialing Committee, the Pharmacy & Therapeutics Committee, and the Utilization Management Committee. The QIHEC institutes actions to address performance deficiencies including policy recommendations and ensures appropriate follow-up of identified performance deficiencies. SFHP maintains minutes of each QIHEC meeting, submits them to the Governing Board for review and approval, and submits these to DHCS on a quarterly basis. The QIHEC meetings are open to the public and agendas and minutes are published on SFHP's website.

The Pharmacy and Therapeutics (P&T) Committee

The P&T Committee convenes at least quarterly to review, evaluate, and approve the SFHP formulary revisions based on safety, comparable efficacy, and cost and to adopt pharmaceutical management procedures including prior authorization criteria, quantity limits, and step therapy protocol for covered outpatient prescription medications. The P&T Committee is responsible for pharmaceutical and therapeutic treatment guidelines and an annual approval of the pharmacy clinical policies and procedures for formulary, prior authorization, monitoring of utilization rates, timeliness of reviews, and drug utilization review (DUR) processes. The P&T Committee governs retrospective DUR processes and related policies for Medi-Cal and the D-SNP for the purpose of oversight of adherence and disease and medication management, including targeted quality measures. The P&T Committee is comprised of network physicians, including a psychiatrist, and pharmacists along with the SFHP Pharmacy Director and is chaired by SFHP's CMO or designee. The committee meets quarterly and on an ad hoc basis, and meetings are open to the public. The P&T Committee reports to the QIHEC.

The Physician Advisory/Peer Review/Credentialing Committee

The Physician Advisory/Peer Review/Credentialing Committee (PAC) provides comments and recommendations to SFHP on standards of care and peer review. The PAC Committee is chaired by SFHP's Senior Medical Director and consists of providers in SFHP's network. The PAC Committee serves to review and provide recommendations regarding substantive quality of care concerns, particularly those related to credentialed provider performance.

The Sanctions Monitoring Report is reviewed monthly to identify providers under investigation or with actions against them. Providers with confirmed Potential Quality Issues of sufficient severity or Facility Site Review findings are referred to the PAC Committee for review. The PAC Committee also evaluates credentials and approves practitioners for participation in the SFHP network as needed. Meeting every two months, the PAC Committee operates as a subcommittee of QIHEC.

The Member Advisory Committee (MAC)

The MAC serves as the Public Policy Committee of SFHP as defined and required by the Knox-Keene Act. The MAC advises the plan on issues of concern to SFHP's service beneficiaries. The committee is made up of SFHP members and health care advocates. In this forum, members can voice concerns and give advice about what health services are offered and how services are delivered to members. It consists of at least 10 to no more than 30 members and is led by an SFHP member. The Committee meets four times per year and reports to the Governing Board.

The Practice Improvement Program (PIP) Advisory Committee

The PIP Advisory Committee provides guidance to SFHP on pay-for-performance program development, implementation, and evaluation. Committee members review prior and current year PIP network performance, identify, and predict barriers to success for participants, and problem-solve solutions. Membership is made up of representatives from all PIP-participating organizations. Meetings are held at least twice a year. The PIP Advisory Committee reports to the CMO.

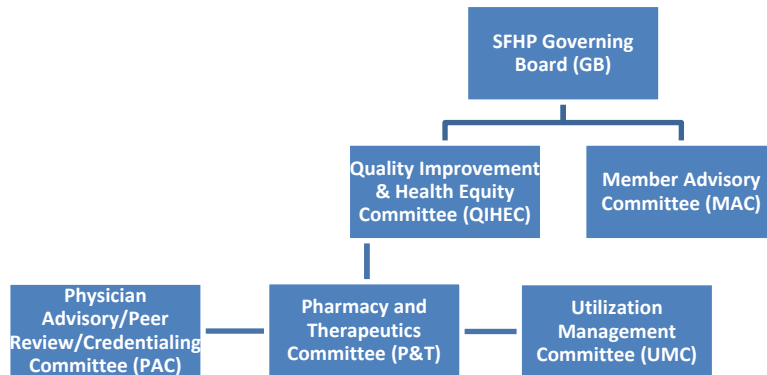
The Utilization Management Committee (UMC)

The UMC is responsible for overseeing both D-SNP Care Management and Utilization Management. It ensures the effective and compliant implementation of SFHP's Utilization Management Program, aligning with SFHP's policy requirements, CMS regulation, the Medi-Cal contract, NCQA accreditation standards, and DHCS/DMHC statutory and regulatory mandates. The UMC's discussions may lead to:

- enhancements in Care Management processes and supports;
- updates in medical policy and criteria;
- adjustments to prior authorization requirements; and/or
- enhancements to UM processes.

As a subcommittee of QIHEC, the UMC meets at least six times annually and provides QIHEC with meeting minutes, quarterly trend analyses, and annual summary reports.

Quality Committees Reporting to Governing Board



Factor 4: Determine Whether Goals Met/Not Met

SFHP works to align, develop, coordinate, strengthen, and expand efforts to improve quality of care and health equity for D-SNP members. D-SNP specific goals and health outcome objectives are integrated into plan overall performance through the QIHEP and work plan, PHM Strategy, Committees and Advisory Councils. The D-SNP work plan, evaluation and reports tie to goals and outcomes are submitted to the QIHEC for review. The work plan, evaluation and reports include one or more of the following: goals, benchmarks, timeframe, qualitative and quantitative analysis, root cause analysis and plan for when goals are not met. Significant findings of quality improvement activities are incorporated into process or systems improvement, practitioner educational programs, the re-credentialing process, and the re-contracting process. All quality improvement activities are documented, and the results of actions taken are recorded to demonstrate the program's overall impact on improving health care and the delivery system.

Improving access, affordability, and health outcomes for the D-SNP population requires a comprehensive and data-driven approach. The table below outlines specific measurable goals and health outcomes objectives that will be integrated into the overall performance plan.

Topic/ Applicable Party for H8051	Measurement/ Methodology/ Data Source	Measurement Objective	Benchmark Goal	Benchmark Source	Frequency of Measurement/ Time Frame to Meet Goal
Goal: Improve and maintain beneficiaries' access to essential services (medical, mental health, and social services)					
Member Access	PCP Assignment: PCP Assignment for all members enrolled PCP serves as a gatekeeper for members, and therefore, each member must have a PCP assignment upon initial enrollment and throughout enrollment. Provider Relations collects and verifies through membership reports.	Improve Access	100%/ 100%	Internal	Monthly membership report
Member Access	Network Availability/ Adequacy Analysis: GeoAccess mapping to match membership demographics/ needs. The provider network department gathers information using our analytics tool.	Improve Access	80%/ 95%	CMS Thresholds	Bi-Monthly GeoAccess report/ Annual evaluation
Goal: Improve and maintain Affordable Care					
Member Readmission Rates	30-day Post Discharge outreach: Care Team Contacts SNP Members discharged from an inpatient setting within 30 days of discharge. SNP Business Analyst reports on this measure.	Improve Coordination of Care	65%/85 %	Internal	Quarterly/Annual

Measurable goals and health outcome objectives are continuously analyzed to assess whether they are being achieved. If a goal is not met, it is reported to the (QIHEC) to facilitate documentation and collaboration on progress toward reaching the goals and any necessary interventions. These goals are documented and reviewed until they are successfully achieved. If a goal is not met or if no improvement is observed, the process is repeated.

Additionally, the findings and efforts related to these goals are incorporated into the overall quality program to ensure a comprehensive approach to improving health outcomes and maintaining high standards of care. This integration facilitates ongoing learning and enhances the effectiveness of the quality improvement initiatives.

Improve and Maintain Member Access to Essential Services

- PCP Assignment
 - The enrollment process is designed to assign a Primary Care Provider (PCP) to each new Special Needs Plan (SNP) member. Existing SNP members have the option to maintain, update, or change their PCP selection through the established PCP assignment process. Each member will be assigned to a PCP, and members are encouraged to stay engaged with their PCP to effectively address their healthcare needs.
 - ***This is a new contract; measurable goals and outcomes will be reported in the next MOC submission.***
 - ***If the goal is not achieved, remeasurement is performed monthly.***
- Network Adequacy
 - The Centers for Medicare & Medicaid Services (CMS) establishes objectives and benchmarks to ensure that members receive adequate and appropriate coverage for Medicare services. CMS specifies the time and distance requirements, which are contingent upon the patterns of care and the Medicare enrollment in each county and specialty.
 - Our Provider Network Management department conducts a comprehensive assessment of network adequacy. Geo-access reports are compiled into a comprehensive document and distributed to the Network teams for their review. Meetings are then scheduled with network stakeholders to address any gaps in network adequacy and develop actionable plans for resolution.
 - ***This is a new contract; measurable goals and outcomes will be reported in the next MOC submission.***
 - ***If the goal is not achieved, network adequacy is remeasured ongoing and, at minimum, bi-weekly.***

Improve and Maintain Affordable Care

- Inpatient Readmission Rate
 - The Post-Hospital outreach helps members transition from the hospital or skilled nursing facility (SNF) to home. It identifies and addresses barriers to care, such as understanding their health conditions, obtaining discharge medications, scheduling follow-up appointments with their primary care provider (PCP), and arranging transportation. During interdisciplinary team (ICT) meetings, cases are reviewed to identify members at risk of readmission or developing new health issues. These individuals receive tailored education and support to help manage their conditions effectively. Additionally, readmissions within 30 days of discharge from the initial hospitalization are closely monitored.
 - ***This is a new contract; measurable goals and outcomes will be reported in the next MOC submission.***
 - ***If the goal is not achieved, remeasurement of the IP readmission rates is measured monthly and annually.***

Element B: Measurable Goals and Health Outcomes for the MOC

Factors 1 & 2: Identify Goals & Health Outcome Measures

Improving access, affordability, and health outcomes for the D-SNP population requires a comprehensive and data-driven approach. This document outlines specific measurable goals and health care needs that are central to the SFHP MOC elements, with a focus on enhancing member engagement, ensuring Care Coordination, and achieving optimal health outcomes. The identified measures align with CMS and D-SNP standards and serve as a framework to track performance, prioritize interventions, and foster accountability at the plan level.

The following goals and metrics have been carefully selected to address key health outcomes and chronic Care Management challenges faced by the D-SNP population, as discussed in MOC 1. These measures encompass core activities such as HRA completion, ICP development, and ICT coordination, as well as chronic condition management such as controlling blood pressure. By setting clear benchmarks and measuring progress against them, SFHP aims to drive continuous improvement and meet the unique needs of our members.

Table 1: Goals and Health Outcomes Measures

Topic	Measure	Measure Description	Objective	Goal	Benchmark Source	Frequency of Measurement	Goal Met / Not Met
Health Outcomes	HRA completion for new D-SNP beneficiaries	Percentage of new D-SNP members who has completed an HRA	To ensure comprehensive and timely identification of member health risks and needs through the completion of an initial Health Risk Assessment (HRA), enabling personalized care planning and proactive interventions.	100%	D-SNP Core 2.1 Standard	Quarterly	TBD
Health Outcomes	HRA re-assessment	Percentage of current D-SNP members who received an annual HRA re-assessment and/or completed an HRA re-assessment	To evaluate and update member health status through periodic re-assessments of the Health Risk Assessment (HRA), ensuring continuity of care and adjustments to care plans based on current needs.	100%	D-SNP Part C Standard	Quarterly	TBD
Health Outcomes	ICP Completion	Percentage of current D-SNP members who have a completed ICP	To develop and document an Individualized Care Plan (ICP) tailored to the member's health goals, preferences, and clinical needs, ensuring a coordinated and member-centric approach to care delivery.	100%	D-SNP Core 3.2 Standard	Quarterly	TBD
Health Outcomes	ICT Completion	Percentage of D-SNP members	To establish and document an effective Interdisciplinary Care Team (ICT) that	100%	D-SNP Standard	Quarterly	TBD

Topic	Measure	Measure Description	Objective	Goal	Benchmark Source	Frequency of Measurement	Goal Met / Not Met
		who have an ICT meeting	collaborates to address the member's holistic needs, ensuring integration of services and alignment with the member's care plan.				
Chronic Care	Controlling Blood Pressure	Percentage of members 18 - 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140-90mm Hg)	To improve cardiovascular health by achieving and maintaining optimal blood pressure levels for members through evidence-based interventions, education, and consistent	85%	CMS 5 Star Rating	Monthly	TBD

Through the implementation of comprehensive strategies, we aim to ensure that every Member receives personalized, efficient, and cost-effective healthcare services. The following key initiatives outline how we will achieve these goals:

Improving Access and Affordability of Healthcare Needs

Efforts are being made to enhance processes and minimize challenges related to care. These initiatives may involve broadening remote services, increasing provider availability, and providing financial support options. The overall aim is to improve accessibility and affordability in healthcare for members.

Coordination of Care and Appropriate Delivery of Services through Alignment of the HRA, ICP, and ICT

Enhancing the coordination of care and service delivery relies on the seamless integration of the Health Risk Assessment (HRA), Individualized Care Plan (ICP), and Interdisciplinary Care Team (ICT). This integration allows for a more personalized and effective management of each Member's care. The HRA plays a crucial role by identifying the specific health risks and needs of every Member, which are subsequently addressed in the ICP. The ICT, which includes a diverse group of healthcare professionals, works together to ensure that the care plan is implemented effectively and adjusted as necessary. This cohesive strategy promotes comprehensive care management, fosters better communication among providers, and guarantees that Members receive appropriate care in a timely manner. Moreover, the emphasis on preventive health services ensures that Members have access to essential screenings, vaccinations, and other preventive measures that aid in maintaining their health and reducing the risk of chronic conditions.

Enhancing Care Transitions

The primary goal is to enhance the transitions of care across all healthcare environments and among different providers. This requires the establishment of strong communication protocols and strategic care coordination to guarantee that SNP Members enjoy seamless moves between various levels of service. Effective discharge planning, careful follow-up care, and collaboration between primary care physicians and specialists are crucial for minimizing readmissions and ensuring ongoing continuity of care.

Ensuring Appropriate Utilization of Services

Utilizing data-driven strategies allows for effective monitoring and management of healthcare services, specifically for individuals with chronic conditions. By regularly analyzing service usage trends and proactively overseeing chronic conditions, we can avoid unnecessary hospital admissions and enhance disease management. This approach not only improves patient health outcomes but also helps in lowering overall healthcare expenses.

Promoting Preventive Health Measures

Highlighting the significance of preventive health measures, we focus on educating members and encouraging regular health screenings. By accessing preventive care services like screenings and vaccinations, SNP members can identify potential health issues early, manage risks effectively, and enhance their overall well-being. This forward-thinking approach not only fosters improved health outcomes but also contributes to lower long-term healthcare expenses.

Factor 3: Track and Assess Goals

The plan gathers data from multiple sources, including HEDIS, CAHPS, surveys, HRAs, ICPs, ICTs, audits, utilization reports, and other channels, to create a comprehensive set of metrics for monitoring performance.

Table 2: Data Sources and Collection Frequency

Data Type	Collection Frequency & Analysis
HEDIS (claims, encounter, lab, etc.)	Monthly
CAHPS, HOS, Other Surveys	Annually
HRA	Quarterly

Outcomes are evaluated against both internal and external benchmarks, such as NCQA, CMS, Medicare Advantage and D-SNP specific member data. Each program objective has associated metrics that are tailored to the needs of the D- D-SNP population. These metrics are re-evaluated annually, and measurable goals are set based on baseline performance and comparative reference values within defined timeframes. Performance results are analyzed year over year and against available measure-specific benchmarks to ensure continuous improvement.

Factor 4: Determine if Goals Are Met

The plan has established goals and benchmarks aligned with internal goals, regulatory requirements, and the CMS 5 Star Rating system. At the end of each measurement period, data from HEDIS, survey, HRAs, ICT, and ICP activities are thoroughly analyzed to determine whether each goal has been achieved.

As described in MOC 4 Element A Factor 4, D-SNP specific measures are included in the annual QIHETP Work Plan and Evaluation. These measures are assessed annually to verify whether they meet the established goals, ensuring alignment with the broader quality improvement objectives

Factor 5: Take Actions When Goals Not Met

If analysis reveals that certain measures fall short of established goals, the plan conducts a barrier assessment to identify factors preventing success. Improvement activities are then designed and implemented to bridge the gap. These activities may include:

- Member engagement efforts: Targeted outreach campaigns to improve participation and adherence.
- Provider support initiatives: Education, guidance, and communication to enhance provider awareness and compliance.
- Process improvement strategies: Application of PDSA (Plan-Do-Study-Act) cycles and other quality improvement methods.

Specific interventions may include newsletters from the organization, educational materials distributed to providers, and targeted messaging at high-traffic points of service. These efforts aim to boost screenings, annual wellness visits, and overall member satisfaction.

Additionally, the plan analyzes data to uncover potential health disparities within the D-SNP population. Tailored interventions are then deployed to address inequities and promote health equity, ensuring all members have access to the care and resources they need to achieve optimal outcomes.

Element C: Measuring Patient Experience of Care

Factor 1: Describe the Survey Tool

Patient experience of care is a critical component of quality measurement because it captures how effectively health plans and providers meet the needs, preferences, and expectations of members. Understanding patient experience allows health plans to identify areas where care delivery can be improved to enhance outcomes, build trust, and ensure member-centered care.

SFHP will utilize standardized survey tools that are commonly used for all Medicare Advantage and Special Needs Plans. The main surveys will include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Medicare Health Outcomes Survey (HOS). These surveys are well-regarded for their reliability and validity in assessing member experiences. In addition to CAHPS and HOS, SFHP may implement supplemental surveys tailored to focus on specific aspects of the Special Needs Plan (SNP) program. These supplemental surveys will help gather more targeted feedback, allowing for a deeper understanding of member needs and preferences.

Medicare Advantage and Prescription Drug Plan (MA-PDP) CAHPS® Survey

The MA-PDP CAHPS® survey is a standardized tool for assessing Medicare enrollees' experiences with their health plan and the services they receive. It provides vital insights for:

- Monitoring health plan performance.
- Helping consumers evaluate health plans based on quality.
- Identifying strengths and areas for improvement to enhance care delivery.

The survey measures key aspects of the patient experience, such as:

- Ease of accessing needed care and seeing specialists.
- Timeliness of appointments and care delivery.
- Doctor-patient communication.
- Coordination of healthcare services.
- Support and information provided by the health plan.
- Ease of obtaining prescriptions.
- Ratings of the health plan, drug plan, and overall healthcare quality.

These insights help guide quality improvement initiatives, ensuring the plan delivers high-quality, accessible, and patient-focused care.

Medicare Health Outcomes Survey (HOS)

The HOS is designed to evaluate how well Managed Care Plans help beneficiaries maintain or improve their physical and mental health over time. By measuring outcomes at two points—baseline and follow-up two years later—the HOS tracks improvements in:

- Physical health
- Mental health
- Risk factors like falling and bladder control

The HOS also includes the Veterans RAND 12-Item Health Survey (VR-12) and collects data for selected HEDIS Effectiveness of Care measures. Additional topics covered include activities of daily living (ADL), pain, depression, sleep quality, and chronic conditions.

Patient Experience vs. Customer Satisfaction

It is important to distinguish patient experience surveys from customer satisfaction surveys. Patient experience surveys focus on whether or how often patients encountered critical aspects of high-quality care, such as:

- Effective communication with doctors
- Clear understanding of medication instructions
- Coordination of care

Unlike satisfaction surveys, which may emphasize amenities, patient experience surveys highlight key processes and interactions that directly impact health outcomes. This focus ensures that quality improvement efforts target meaningful aspects of care delivery that drive better health and member satisfaction.

By measuring and prioritizing patient experience, SFHP can align their efforts to deliver care that is not only clinically effective but also responsive to the needs and preferences of D-SNP members.

Factor 2: Specify Rationale for Survey Tool Selection

The MA-PDP CAHPS® and HOS surveys were chosen for their rigorous methodologies and effectiveness in evaluating the experiences and health outcomes of Medicare Advantage members. Designed with scientific principles, these surveys use standardized questions that allow for reliable comparisons across various healthcare settings. They involve extensive stakeholder engagement, ensuring the measures are relevant and reflective of user experiences.

The MA-PDP CAHPS® survey follows scientific principles in survey design and development and is designed to reliably assess the experiences of a large sample of health plan members. The survey uses standardized questions and data collection protocols to ensure that information can be compared across healthcare settings. All CAHPS surveys are developed with broad stakeholder input, including a public solicitation of measures, a technical expert panel, and a comments period through the Federal Register. Additionally, many CAHPS measures are statistically adjusted to correct for differences in the mix of patients across providers and the use of different survey modes.

The HOS allows objective and meaningful comparisons among MA contracts. The public and research communities use results to assess plan performance, monitor the health of the Medicare population and vulnerable subgroups, and evaluate treatment outcomes. Health plans use HOS results to identify areas for quality improvement, and Medicare administrators and policymakers rely on these measures to monitor MA plans.

Factor 3: Describe the Process for Collecting Enrollee Feedback

CAHPS Survey Process

The MA-PDP Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is an annual requirement from CMS for Managed Care Plans with at least 600 enrollees. The process involves several critical steps, as outlined in the *Quality Assurance Protocols & Technical Specifications V15.0*.

1. Survey Design and Administration:

- CMS specifies that the survey must assess enrollee experiences with their health plan and providers, including topics such as access to care, communication, and customer service.
- To ensure a robust data collection process, the survey is conducted using a mixed-mode protocol. This involves an initial web survey invitation to enrollees, followed by up to two mail surveys for non-respondents, and finally, telephone follow-ups for those who still do not respond.

2. Sampling and Vendor Coordination:

- SFHP contracts with a CMS approved CAHPS survey vendor who manages:
 - the selection of a sample of eligible members
 - the data collection process
 - ensuring adherence to CMS-approved timelines and confidentiality protocols

3. Data Submission and Reporting:

- The vendor collects and reports the survey data to CMS, following the prescribed methods to ensure accuracy and compliance.
- The results are part of SFHP's quality ratings and are used to identify areas for improvement.

The most current *Quality Assurance Protocols & Technical Specifications* further standardize the process to maintain consistency, ensure high-quality data, and enhance comparability across plans.

HOS Survey Process

The Medicare Health Outcomes Survey (HOS) is an annual requirement for Medicare Advantage plans with at least 500 enrollees. The guidelines are detailed in the *Medicare Health Outcomes Survey Quality Assurance Guidelines and Technical Specifications (QAG)*. Key elements include:

1. Survey Objective and Methodology:

- The HOS assesses physical and mental health outcomes over time, focusing on health-related quality of life.
- The process uses a mixed-mode protocol similar to CAHPS, with two mailings and telephone follow-ups for non-respondents.

2. Sampling and Confidentiality:

- CMS determines the eligible sample and provides it to approved HOS vendors.
- Vendors must adhere to strict confidentiality protocols to protect member privacy during data collection and processing.

3. Data Collection and Use:

- Vendors collect baseline and follow-up data to evaluate changes in enrollees' health status over a two-year period.
- The data informs plan performance in key areas, supports quality improvement efforts, and contributes to star ratings.

The CAHPS survey gathers crucial information about enrollees' experiences regarding access to care, communication, and customer service. Together with the HOS, which assesses physical and mental health outcomes over time, these surveys provide a comprehensive view of the enrollees' overall health-related quality of life.

The collected data is analyzed to evaluate SFHP's performance and informs star ratings, reflecting the organization's commitment to providing quality care. More importantly, the findings identify specific areas for improvement, allowing for targeted quality improvement initiatives. These efforts, whether focused on enhancing communication or improving access to services, are driven by feedback from enrollees. Furthermore, the results of these surveys are integrated into the overall MOC performance improvement plan, ensuring that insights are used to enhance organizational practices effectively.

Factor 4: Analyze Enrollee Feedback and Address Identified Issues

Following the completion of each survey period, the approved survey vendor will provide analyzed results to SFHP. *The MA-PDP CAHPS® Survey* analyzed results will include the survey's sample size and response rate, scoring of question ratings and composites, and ranking or comparison of SFHP to NCQA and CMS National Multi-Plan Benchmarks. *The HOS* analyzed results will include a baseline report and a performance measurement report based on the 2-year follow-up survey, which provides comprehensive summaries of the health status of sampled members.

The analyzed results serve as a tool to inform the development, implementation, and success of quality improvement initiatives. The analyzed results will first be reviewed by SFHP's Quality Improvement (QI) Team, where results will be curated to highlight performance changes and opportunities for improvement. The full results along with the analysis will then be presented to various stakeholder groups, including: SFHP Executives, Directors, and Managers; the Quality Oversight Team (QOT); the QIHEC, inclusive of select SFHP providers and members; The MAC as well as to network provider groups via SFHP's Joint Administrative Committee Meetings (JOC).

The QOT and QIHEC will make recommendations for quality improvement to the SFHP QI Team, who will develop strategies, activities, and targets to address the identified areas for improvement. These will be reviewed and approved by the QOT. The QI Team will lead the operationalizing and implementation of recommended strategies and activities, then monitor and report on improvement progress via quarterly updates to the QOT and an annual update to the QIHEC.

Element D: Ongoing Performance Improvement Evaluation of the MOC

Factor 1: Support Ongoing Improvement

SFHP staff collect, review, and analyze both quantitative and qualitative data quarterly, providing comprehensive insights into performance and areas for improvement. This information is reported to the QOT, the QIHEC, and the Governing Board to guide decision-making and ensure accountability.

Quantitative Data

Quantitative data includes metrics that provide measurable insights into plan performance:

- **HEDIS Data:** Used to assess plan performance against clinical quality benchmarks.
- **Monthly Trends:** Evaluate plan progress toward stated benchmarks and goals.
- **Intervention Outcome Results:** Monitor the effectiveness of implemented interventions, identifying gaps and areas for improvement.

This data is analyzed to determine whether specific benchmarks have been met and to inform potential adjustments to interventions. Plan department stakeholders are functional area leads and the staff responsible for specific interventions. This group reviews their assigned measurements at least quarterly and implement any necessary improvement activities. Results are reported to the Senior Management Team to maintain transparency and promote actionable steps.

Qualitative Data

Qualitative data provides context and insights into the member experience, the effectiveness of interventions, and operational challenges. This includes:

- **Member Feedback:** Surveys, focus groups, and anecdotal reports from the MAC or other customer service line. These are used to assess satisfaction and identify barriers to care.
- **Intervention Evaluation:** Reviews of how and why interventions succeed or face challenges, including stakeholder input.

- **Process Observations:** Identifying systemic issues that may impact health outcomes or plan operations.

Data Utilization

The results of this comprehensive data analysis inform quality improvement activities, projects, and the development of specialized services and benefits. Specifically:

- **Annual Evaluations:** Members' health outcomes are compared year-over-year and against benchmarks or goals to assess overall performance.
- **Goal Achievement:** Measurable goals are reviewed and designated as “met” or “unmet,” driving accountability.
- **Recommendations:** Findings from data analysis guide adjustments to interventions, new project proposals, and enhancements to the SFHP MOC.

These quarterly and annual evaluations ensure the plan not only meets regulatory requirements but also continuously improves member health outcomes and operational effectiveness.

Factor 2: Evaluation of Results

To ensure the timely implementation of improvements, action plans, and continuous monitoring of performance indicators, the plan has developed a D-SNP Dashboard. This dashboard serves as a centralized tool to track, assess, and evaluate interventions aimed at enhancing performance measures. It integrates both quantitative and qualitative data for a holistic evaluation:

- **Quantitative Data:** Includes HEDIS metrics, benchmarks, and monthly trends that measure plan performance against established goals.
- **Qualitative Data:** Incorporates insights from member feedback, provider collaboration, and operational observations to contextualize quantitative findings.

Performance metrics and the dashboard are reviewed monthly by the QOT, and the functional area leads to enable real-time identification of barriers, progress updates on interventions, and rapid response to emerging trends.

In addition to these monthly reviews, the SFHP conducts an annual evaluation of performance and outcome measures through the following frameworks:

- The Annual QIHETP Evaluation: Focuses on assessing progress toward quality improvement and health equity goals.
- The Population Health Management Strategy: Identifies member needs and assesses the effectiveness of interventions designed to address them.
- The QIHETP Work Plan: Provides a roadmap for implementing actionable changes based on lessons learned.

This comprehensive evaluation process ensures continuous alignment with regulatory requirements and the evolving needs of the D-SNP population.

Factor 3: Assess Ability to Improve

The plan employs a systematic approach to assess and enhance its ability to improve performance measures. Key activities include:

- **Data Analysis:** Ongoing analysis of quantitative and qualitative data to identify trends, gaps, and opportunities for improvement.

- **Root Cause Analysis:** Investigation of underlying issues that may hinder performance or limit the effectiveness of interventions.
- **Best Practice Integration:** Gathering insights and best practices from providers, members, and industry peers to enhance care delivery and operational efficiency.

These activities inform the annual D-SNP MOC Evaluation, ensuring that the plan continuously incorporates lessons learned into our operations.

The functional area leads and plan leadership review performance data, progress on interventions, and outcomes. This continuous oversight ensures that:

- Interventions remain aligned with performance goals and member needs.
- Adjustments are made proactively to address barriers and optimize results.

This iterative process demonstrates the plan's commitment to evidence-based improvement and stakeholder collaboration.

Factor 4: Document and Communicate Lessons Learned

The plan conducts an annual D-SNP MOC evaluation to document progress toward established goals and identify opportunities for improvement. This evaluation includes:

- **Successes and Challenges:** An analysis of what worked, what did not, and why.
- **Actionable Insights:** Recommendations for refining the D-SNP program based on data and stakeholder feedback.

Findings are disseminated through a structured communication process:

1. Internal Stakeholders:

- The evaluation is shared with the functional area leads, executive leadership, and QIHEC.
- Presentations are prepared to facilitate discussions and drive consensus on next steps.

2. Leadership and Governance:

- An electronic PowerPoint presentation summarizing the evaluation is presented to the Governing Board.
- Details of the evaluation are documented in meeting minutes for transparency.

3. External Stakeholders and Public:

- The annual evaluation, along with the QIHETP Program Description, Evaluation, and Work Plan, is posted on the SFHP website.
- Announcements are sent via newsletters to providers and members, ensuring broad accessibility.

By ensuring the dissemination of findings to all relevant parties, the plan fosters a culture of transparency, accountability, and continuous improvement.

Element E: Dissemination of D-SNP Quality Performance Related to the MOC

Factor 1: Process for Communicating Results of Performance Evaluation

The plan outlines a detailed and systematic approach for communicating the results of our D-SNP MOC performance evaluation. This process highlights how we consistently share quality performance outcomes with a diverse range of stakeholders who play a critical role in our operations and the well-being of our members. Our stakeholders include:

- SNP Leadership: Senior executives responsible for strategic decisions and overall program direction.
- SNP Management Groups: Teams overseeing daily operations and ensuring that quality standards are met.
- SNP Board of Directors: Governing body that provides oversight and guidance on performance and accountability.
- SNP Personnel and Staff: Employees who directly engage with enrollees, delivering services and support.
- SNP Provider Networks: Healthcare providers who collaborate with us to offer medical care and services to enrollees.
- SNP Enrollees and Caregivers: Individuals receiving care and their support systems, who need clear information about performance outcomes and services available to them.
- The General Public: Community members interested in learning about the quality and effectiveness of our programs.
- Regulatory Agencies: Government bodies that monitor compliance and performance standards within the program. E.g., DHCS, DMHC, CMS

This structured reporting mechanism ensures that all relevant parties receive timely, accurate, and consistent information regarding our performance evaluation results. By fostering open communication, we aim to enhance accountability, transparency, and collaboration among all stakeholders involved in our program.

Factor 2: Detail Schedule for Routine Communications

SFHP Quality staff conduct an annual written evaluation of the QIHETP and D-SNP MOC and make information about the QIHETP and D-SNP MOC available to various stakeholders through various methods, outlined in the table below. The evaluation is written by the Director, Quality & Population Health Management or designee and is posted on the SFHP's website. Applicable D-SNP, Quality Improvement, and Health Equity related committees contribute to the annual evaluation, which is ultimately reviewed and approved by the Governing Board. SFHP reports our quality improvement performance results and other pertinent information to Governing Board members who seek to improve access to quality healthcare, maintain and preserve a healthcare safety net for San Francisco.

Table 3: Schedule for Routine Communications

Stakeholders	How Information is Shared	When Information is Shared	SFHP Staff Responsible
D-SNP leadership & management groups	Annual D-SNP MOC shared in meeting packets, reviewed in meetings and documented in minutes	Annually	<ul style="list-style-type: none"> • Director, Quality and Population Health Management
D-SNP board of directors	Annual D-SNP MOC shared in meeting packets, reviewed in meetings and documented in minutes	Annually	<ul style="list-style-type: none"> • Chief Health Equity Officer • Chief Medical Officer
D-SNP personnel and staff	Annual D-SNP MOC posted to SFHP Intranet and announced via internal messaging to all staff	Annually	<ul style="list-style-type: none"> • Chief Health Equity Officer • Chief Medical Officer
D-SNP provider networks	Annual D-SNP MOC posted to SFHP Website and announced via Provider Newsletter	Annually	<ul style="list-style-type: none"> • Director, Provider Network Operations • Director, Quality and Population Health Management
	Ongoing data sharing and collaboration via Quality Collaboratives	Quarterly/ Ad hoc	<ul style="list-style-type: none"> • Director, Quality and Population Health Management

Stakeholders	How Information is Shared	When Information is Shared	SFHP Staff Responsible
	JOCs	Quarterly/ Ad hoc	<ul style="list-style-type: none"> • Director, Provider Network Operations, • Director, Quality and Population Health Management
D-SNP enrollees and caregivers	Annual D-SNP MOC posted to SFHP Website and announced via Member Newsletter	Annually	<ul style="list-style-type: none"> • Chief Health Equity Officer • Chief Medical Officer
General public	Annual D-SNP MOC posted to SFHP Website and included in QIHEC meeting agenda, which is posted according to Brown Act regulations for general public	Annually	<ul style="list-style-type: none"> • Chief Health Equity Officer • Chief Medical Officer
Regulatory agencies	Annual D-SNP MOC posted to SFHP Website and announced via messaging to regulatory bodies	Annually	<ul style="list-style-type: none"> • Chief Compliance Officer

Factor 3: Ad Hoc Communications Process

In addition to routine communications, SFHP uses ad hoc communications to address urgent needs or emerging priorities. These communications may include:

- **Emergency Provider Updates:** Sent via newsletters or direct outreach when critical performance issues or regulatory changes arise.
- **Rapid Response Meetings:** Convened with relevant stakeholders to address immediate barriers or implement new interventions.
- **Supplementary Data Sharing:** Provided to providers or committees when additional insights are needed to inform decisions.

These flexible communication channels allow the Plan to adapt quickly to changing circumstances, ensuring continuous alignment with goals.

Factor 4: Identify Staff Responsible for Communication of Performance Results

The responsibility for communicating performance results is distributed among a multidisciplinary team, including staff from the following functional area:

- Enrollment and Eligibility
- Utilization Management
- Care Management
- Behavioral Health
- Quality and Population Health Management
- Provider Network Operations
- Customer Service
- Long-Term Services and Supports

The CMO and CHEO oversee all communications, ensuring consistency, accuracy, and alignment with organizational goals. These leaders collaborate with departmental staff to ensure timely updates and transparent reporting to internal and external stakeholders.

To address communication issues or issues uncovered with the communication processes, the quality staff will initiate a systematic approach with oversight from the CHEO and CMO. They will start by gathering feedback from staff to identify gaps and evaluate their impact on stakeholder understanding and engagement.

Based on this assessment, the quality staff will develop and implement improved communication strategies that align with the organization's goals. After the rollout, they will collect stakeholder feedback to assess effectiveness and make necessary adjustments. Finally, the CHEO and CMO will review the results and communicate them to internal and external stakeholders to reaffirm the organization's commitment to better communication and stronger relationships.

SFHP is committed to monitoring, evaluating, and improving our D-SNP MOC. Through structured oversight, routine and ad hoc communications, and a focus on continuous learning, the plan ensures our strategies effectively address member needs while meeting regulatory expectations.

Appendix A

Staff Training



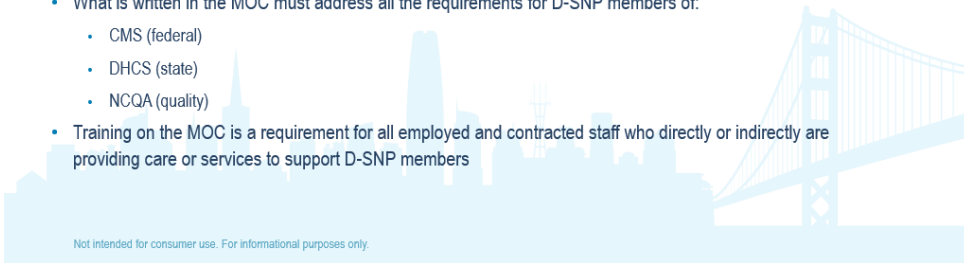
Example slides



Model of Care (MOC)



- The MOC is an important document that explains how SFHP will care for the D-SNP population
- The MOC is a regulatory requirement & must be approved by the state of CA and CMS before implementing a D-SNP line of business
- What is written in the MOC must address all the requirements for D-SNP members of:
 - CMS (federal)
 - DHCS (state)
 - NCQA (quality)
- Training on the MOC is a requirement for all employed and contracted staff who directly or indirectly are providing care or services to support D-SNP members



Model of Care (MOC)



The MOC is divided into four key Elements

- MOC 1: Description of the SNP Population
- MOC 2: Care Coordination
- MOC 3: Provider Network
- MOC 4: Quality Measurement and Performance Improvement

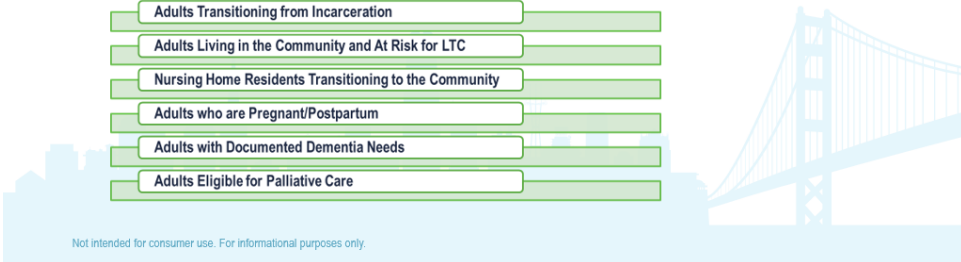


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MOC 1: Population of Focus for SFHP



- Adults Experiencing Homelessness
- Adults At Risk for Avoidable Hospital or ED Utilization
- Adults with Serious Mental Health and/or SUD Needs
- Adults Transitioning from Incarceration
- Adults Living in the Community and At Risk for LTC
- Nursing Home Residents Transitioning to the Community
- Adults who are Pregnant/Postpartum
- Adults with Documented Dementia Needs
- Adults Eligible for Palliative Care

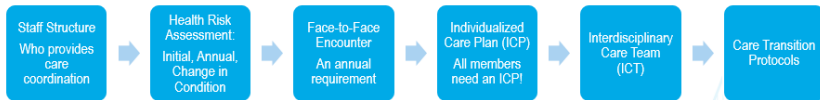


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MOC 2: Care Coordination



This section describes care coordination for all D-SNP members:



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MOC 3: Provider Network



This section describes how the Provider Network will meet the needs of D-SNP members (General and Most Vulnerable)

Specialized Expertise:

- Describes the specialized clinical expertise available within the provider network to meet the needs of the SNP population.

Clinical Practice Guidelines and Care Transition Protocols:

- Ensures that providers follow evidence-based guidelines and protocols for care transitions.

Provider Training:

- Details the training provided to network providers on the MOC, including documentation and actions for incomplete training.

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MOC-4 Quality Measurement & Performance Improvement



This section provides details on how SFHP will provide the highest quality D-SNP program

- Describes the MOC Quality Performance Improvement Plan
- Lists measurable goals & health outcomes for the MOC
- Measure patient experience of care (Member Satisfaction)
- How SFHP will provide ongoing performance improvement evaluation of the MOC
- How SFHP will disseminate D-SNP quality performance information related to the MOC



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