SFHP Care Plus D-SNP Model of Care (MOC) Training

SFHP Care Plus™

Welcome to SFHP Care Plus — our enhanced care coordination program designed to support members with complex needs.

Learning Objectives

Upon completion of this course, you will be able to:

- Identify the key components and goals of SFHP Care Plus.
- List and describe the core services offered through SFHP Care Plus, including care coordination and member support.

We're excited to introduce you to SFHP Care Plus! In the next 15–20 minutes, you'll explore how this program supports our members and how you play a key role in delivering care.
Click the "*Start Course*" button to begin.

SFHP Care Plus

Lesson 1 of 1

SFHP Care Plus

What is SFHP Care Plus?

We at SFHP believe every person deserves access to affordable quality health care.

Care Plus supports San Franciscans who are dual eligible in Medicare and Medi-Cal.

Our D-SNP program addresses the complex healthcare needs of vulnerable populations by offering specialized benefits, care coordination, and tailored provider networks to improve health outcomes.

The term D-SNP is short for Dual Special Needs Plans. This will be the target audience for our SFHP Care Plus.

CONTINUE

DESCRIPTION OF SNP POPULATION	CARE COORDINATION	SFHP CARE PLUS PROVIDER NETWORK	QUALITY MEASUREMENT & PERFORMANCE IMPROVEMENT

Overview of the D-SNP population served by SFHP Care Plus.

DESCRIPTION OF SNP POPULATION	CARE COORDINATION	SFHP CARE PLUS PROVIDER NETWORK	QUALITY MEASUREMENT & PERFORMANCE IMPROVEMENT

Key stakeholders and processes involved in coordinating care.

DESCRIPTION OF SNP POPULATION	CARE COORDINATION	SFHP CARE PLUS PROVIDER NETWORK	QUALITY MEASUREMENT & PERFORMANCE IMPROVEMENT

Overview of providers, hospitals, and vendors in the network.

How SFHP measures success and drives continuous improvement.

Complete the content above before moving on.

Learn about the unique characteristics of SFHP Care Plus

Understanding who we serve is the first step in delivering effective care. The SFHP Care Plus Program is designed to meet the needs of this unique population.

Our diverse population includes people with:

Multiple Chronic Conditions

Mental Illness

Cognitive Impairment such as Dementia and Developmental Disabilities

Physical Disabilities

With these unique characteristics in mind, SFHP identified the most vulnerable populations to focus on.

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

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

San Francisco's Most Vulnerable Members

Within the SFHP Care Plus D-SNP population, we will identify members with the most complex needs—those at highest risk due to multiple chronic conditions, mental health diagnoses, or social determinants of health. These members will be part of the **California Integrated Care Management (CICM) population.**

What is CICM?

California Integrated Care Management, or **CICM**, is a special program that helps people who have serious health problems get better care.

CICM focuses on:

- People who go to the hospital a lot
- People who are homeless or don't have stable housing
- People with mental health or drug problems
- Pregnant moms who need extra support
- People getting out of jail or prison
- Older adults who might need help living on their own

Imagine someone who is sick a lot, maybe has trouble getting to the doctor, or needs help with things like food, housing, or mental health. CICM is like a team of helpers—doctors, nurses, social workers—who work together to make sure that person gets everything they need to stay healthy

Some of the benefits of identifying and targeting the most vulnerable populations 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.

Why this Matters

Our Care Plus members receive enhanced services to meet their complex needs.

Let's take a moment to review your understanding.

True or False?

SFHP's Care Plus population is composed of individuals who are dual eligible for both Medicare and Medi-Cal.

- ○ True
- ○ False

SUBMIT

What does CICM stand for?

- ○ California Integrated Care Management
- ○ Coordination of Information for Case Management

SUBMIT

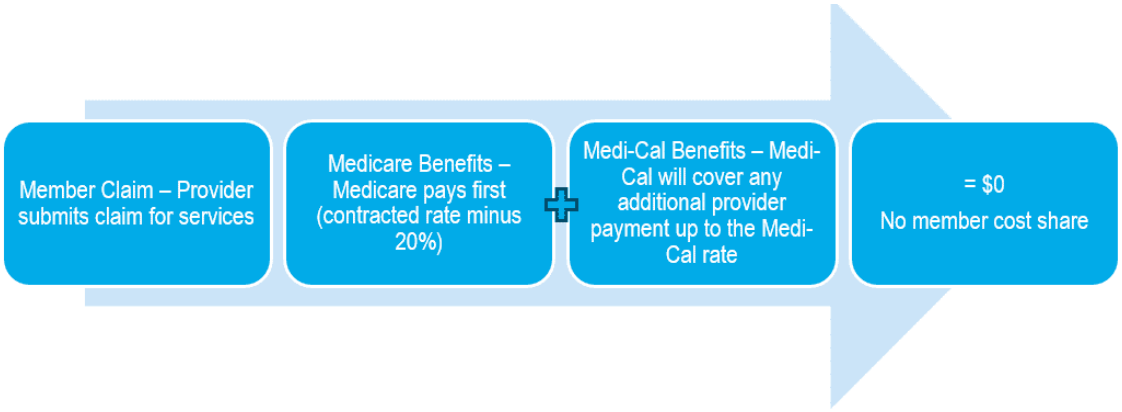
CONTINUE

Member Benefits, Rights and Responsibilities

Integrating Medicare and Medi-Cal Benefits

SFHP Care Plus provides a seamless experience for the member, enabling both Medicare and Medi-Cal benefits to be coordinated and maximized to obtain the best health outcomes for the member.

The Health Risk Assessment Tool (HRAT) includes several questions related to Medi-Cal benefits to help identify the services a member is currently receiving and assess potential eligibility for additional benefits.



Member Rights & Responsibilities

SFHP Care Plus members have specific rights and responsibilities. Members are informed of their rights and responsibilities through member education materials, and these rights and responsibilities include:

- The right to get services and information in a way that meets the members' needs. This includes received care in a culturally competent and accessible manner and providing member care and materials in their preferred language.
- The right to timely access to covered services and drugs. Members have the right to choose a PCP from the Care Plus network, receive timely services from providers, access emergency services without a prior approval, and get their prescriptions filled at any network pharmacy.
- The right to have their personal health information (PHI) protected. PHI is protected as required by state and federal laws.
    - PHI must be secured against unauthorized use.
    - Members do have the right to look at their medical records and receive a copy.
- The right to receive information about SFHP Care Plus, the provider network, and covered services.
- The right to not be billed directly by network providers. Members cannot be balance billed.
- The right to leave SFHP Care Plus.
- The right to make decisions about their health care
    - The right to know their treatment options and risks and make decisions.
    - The right to say no and get a second opinion.

    - The right to create an advance directive and file a complaint if it is not followed.

- The right to make complaints and ask SFHP Care Plus to reconsider decisions. Members should contact SFHP Care Plus at 1(833) 530-7327 (TTY: 711)
- The right to express concerns about unfair treatment and get more information about their rights.
- The right to be involved with SFHP Care Plus.
- The responsibility to: Work with and help their Providers and Case Managers, Read the Member Handbook, Pay any premiums and for services and drugs that are not covered, Keep their contact information up to date

  Please consult the SFHP Care Plus Member Guidebook for detailed responsibilities and rights for these members.

SFHP Care Plus (HMO D-SNP)

Member Name: PAT LEE
Member ID: 71234567890

Care Management Phone: **1(415) 615-4545**
Medical Group: North East Medical Services - DSNP Network
PCP Name: Valerie D Mejia MD
PCP Phone: **1(415) 539-2273**

MedicareRx Prescription Drug Coverage

RxBIN: 015574
RxPCN: ASPROD1
RxGRP: SFP01

Copays: PCP/Specialist: $0 ER: $0

H8051 001

In case of emergency, call **911**

Customer Service: **1(833) 530-7327** (toll-free) or **711** (TTY)
Dental Care: **1(888) 704-9838**
Vision Care: **1(855) 492-9028**
Behavioral Health: **1(855) 371-8117**
Pharmacy Help Desk: **1(877) 391-9293**
Website: **sfhp.org/care-plus**

Send claims to: SFHP Care Plus, Attn: Claims
PO Box 194247, San Francisco, CA 94119
Claim Inquiry: **1(415) 547-7818 ext. 7115**
Provider Services: **1(415) 547-7818 ext. 7084**

Care Coordination

Care Coordination Key Components

Care coordination is the heart of the SFHP Care Plus Model of Care. Our model ensures that every member receives personalized, proactive, and integrated support. This section describes the key components necessary to provide this care coordination for all SFHP Care Plus members.

Step 2

Health Risk Assessment (HRA):

An HRA is a personalized survey used to evaluate the health status, needs, and risks of individuals who qualify for both Medicare and Medicaid. These patients often have complex medical, behavioral, and social needs, and the HRA is a foundational tool for developing their Individualized Care Plan (ICP).

All SFHP Care Plus members must complete an initial HRA within the first 90 days of their enrollment with SFHP and annually. This annual assessment must be conducted within **1 year** of their last HRA**.**

Step 3

Individualized Care Plan (ICP)

An Individualized Care Plan (ICP) is a living document that captures the member's preferences, abilities, and input from caregivers and support persons. It also includes recommendations from the care team and care conference participants.

The ICP outlines problems, goals, and tailored interventions to address the member's health needs, self-management objectives, and caregiver roles.

Step 4

Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) reviews member health outcomes and updates the Individualized Care Plan (ICP) as needed.

The Care Manager develops and maintains the ICP, ensuring it reflects changes in condition, goals, and interventions.

Primary Care Providers review the ICP through secure channels, and all ICT participants contribute based on their expertise.

Follow-up timing should align with documented goals and interventions.

Step 5

Face-to-Face Encounter

All members must have, at minimum, an annual face-to-face encounter with a member of their Interdisciplinary Care Team (ICT). This can be with a plan provider treating the member or a care management team member.

Step 6

Care Transition Protocols

SFHP has an established Care Transition Protocols for SFHP Care Plus members.

This is a process for managing transitions before, during, and after care events

Step 7

Interdisciplinary Care Conference (ICC)

An Interdisciplinary Care Conference (ICC) is a meeting where care team members, the member, and their support persons collaborate to review care needs and make recommendations.

ICCs can be formal or informal, and all discussions must be documented in the medical management system or ICP. Participation is encouraged whenever a formal ICC is needed, and recommendations are shared during follow-up calls or in writing if requested

Summary

Care Coordination is essential to delivering our SFHP Care Plus mission. The foundational knowledge and emphasis on supporting our members with a health care community creates trust with our members and population.

Health Risk Assessments (HRAs)

Purpose of the HRA

The Health Risk Assessment (HRA) is a tool used to evaluate the health and social needs of D-SNP members. It supports care planning and coordination by identifying medical, behavioral, functional, and

social service needs.

What It Covers

The HRA asks about the member's health conditions, medications, mental health, ability to do daily tasks, and needs like housing, food, and transportation. It also checks if the member uses services like in-home care, dental care, or support for Alzheimer's or palliative care.

Timing

The Health Risk Assessment (HRA) is completed when a member first enrolls, every year, and whenever their health changes or they move to a new care setting.

SFHP starts outreach within 90 days of enrollment, making three phone or text attempts at different times and days, sending one letter, and contacting the member's primary care provider if the member cannot be reached.

Additional Aspects of the HRA Process

Specific Services Screened

- Transportation assistance
- County mental health and substance use services
- Food programs (e.g., CalFresh, Meals on Wheels)
- Utility bill support
- In-home supportive services
- Regional center services
- Dental and housing services

Caregiver Involvement

- If a caregiver is identified, their contact info is documented.

- Caregiver needs are assessed in the HRA and included in the member's Individualized Care Plan (ICP).

Completion Methods

- In person, by phone, or by mail
- Included in the New Member Packet with instructions
- Can be completed by the member, caregiver, family, or designee

Individualized Care Plan (ICP)

What Is an ICP?

An Individualized Care Plan (ICP) is a personal health plan made for each member to help them stay healthy and get the care they need. It's created by a Care Manager or Coordinator who works with the member, their family or caregiver, and their care providers.

How Is the ICP Created?

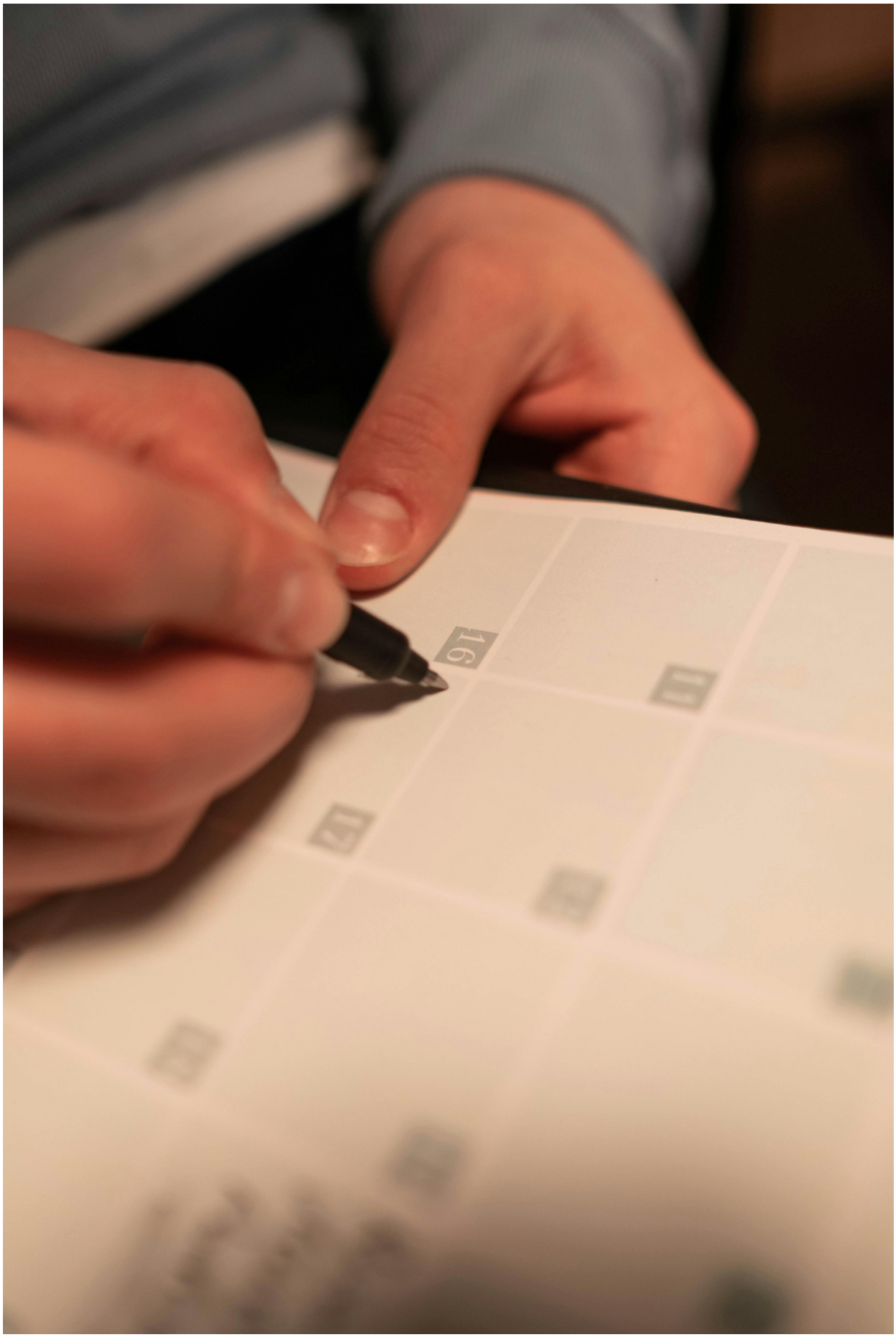
The Care Manager uses:

- Answers from the member's **Health Risk Assessment (HRA)**
- Medical records and test results
- Information about doctor visits and medications
- Member's own goals and preferences.

What's in the ICP?

The components of the ICP are Problems, Goals, and Interventions, which include:

- Health goals
- Services the member needs (like help with food, housing, or transportation)
- Support for caregivers if needed
- Updates when the member's health changes



Who Helps Create the ICP?

- The member and their caregiver
- The Care Manager/Coordinator
- Doctors, nurses, social workers, and other specialists
- Community organizations (like those for mental health or housing)

How Is the ICP Used?

- It helps the member get the right care and services
- It's shared with the member, caregiver, and doctors

- It’s updated at least once a year or when health changes
- If goals aren’t being met, the plan is adjusted

Where is the ICP maintained and how is it shared?

The Care Manager/Coordinator documents all interactions in the ICP which is housed in Jiva, SFHP's Care Management and UM software. Each entry in Jiva is dated and timestamped.

The ICP is shared with all ICT members through the member portal, provider portal, by email, standard mail or facsimile.

Interdisciplinary Care Team (ICT)

What Is an ICT?

An Interdisciplinary Care Team (ICT) is a group of people with demonstrated expertise and training who work together to help a member stay healthy.

The team usually includes:

- The member and their caregiver
- A Primary Care Provider (PCP)
- A Care Manager or Coordinator
- Other experts like mental health professionals, LTSS providers, Palliative Care Specialists, dietitians, housing support staff, or dementia care specialists—**based on what the member needs**
- All members of the team are trained on SFHP's Care Plus MOC, especially concerning LTSS and community-based services

ICT Responsibilities

- Help create and update the member's Individualized Care Plan (ICP)
- Ensure the member gets the right services and support
- Meet regularly (at least once a year) or when the member's health status changes
- Document all formal Interdisciplinary Care Conferences (ICCs) and informal ICT discussions in the medical management system or within the Member's ICP
- Evaluate if interventions are helping members meet their health goals.
- Identify barriers and adjust the ICP as needed

Role of the PCP

The Primary Care Provider is responsible for reviewing the Member's ICP, which is shared by SFHP.

PCPs should work with members and caregivers to support the ICP.

Role of the Care Manager/Coordinator

The Care Manager or Coordinator develops the ICP and keeps it up to date based on health assessments and other data or, at minimum, annually. Any changes discussed with the member or caregiver are documented and reflected in the ICP to match the member's current needs.

The Care Manager/Coordinator is responsible for communicating the ICP changes to the member and/or caregiver, their primary care provider and the members of the ICT.

They communicate and coordit with the member’s ICT and help the member get needed services.

How the ICT Communicates

- The Care Manager/Coordinator is the main contact for ICT members and sets communication timelines based on member needs.
- Communication occurs via phone, secure email, mail, or in-person.
- Through formal and informal ICT meetings
- Updates to the ICP are shared with the member in their preferred language and format.
- Meeting minutes and communications are documented in the member's record.
- If members decline participation, Care Managers attempt re-engagement biannually and note decisions in ICT meetings.

Face-to-Face Encounters

Every member must have at **least one face-to-face visit** with their care team in the first year and then once every year after that.

SFHP staff monitor weekly reports tracking face-to-face and telehealth encounters, including data from providers and ICT participants. Members nearing the 12-month mark without a visit receive additional outreach.

These visits can be:

- With the member's doctor, an ICT member, or a Care Management staff member.
- In person or by phone/video, in a place that works best for the member (home, clinic, or preferred location).

Face to Face Encounters include:

- In-person or telehealth visits with providers to review health conditions, goals, behavioral health needs, and complete annual assessments.
- Meetings with Care Management staff for HRAs, care plan updates, ICT participation, or during care transitions.

Purpose, goals, and benefits of these visits:

- Help members get preventive and specialty care.
- Build trust and engagement
- Improve the experience, especially for members with disabilities.

- Allows staff to assess home environments for realistic care planning.
- Supports coordination of medical, behavioral, and social services

Addressing Identified Concerns

If a Care Manager or Coordinator finds a health concern during a visit, they document it in the member's ICP and notify the appropriate provider unless the care team can handle it directly.

Health concerns may include physical, emotional, or social issues. Care Managers follow SFHP policies to communicate, escalate, and address problems within their training and scope of practice.

Care coordination activities are part of the face to face visit and can include the following:

- **Health Review and Education**: Discuss annual wellness exams, routine physicals, and provide health education resources.
- **Assessment and Planning**: Complete an HRA, update the ICP, and review care goals.
- **Referrals and Orders**: Submit referrals for specialty care, labs, radiology, medical equipment, or disease management programs.
- **Barrier Identification**: Identify and address obstacles to care follow-through, such as transportation or social needs.
- **Advanced Care Planning**: For high-risk members, discuss dementia support, palliative care, and long-term services.
- **Coordination and Communication**: Share results and updates with providers and the ICT, ensuring all actions are documented.

If a member refuses or can't be reached:

- Staff must try **three times** by phone/text on different days and times, and send a letter.
- This is documented, and supervisors follow up to schedule the visit.

Visits should respect each member's culture and preferences, with translation and video tools available when needed. If a member requests a virtual visit and it is safe and feasible, the provider should accommodate that request.

Care Management staff also offer in-person visits during enrollment, annual check-ins, or whenever indicated by the member's care plan.

Care Transitions

SFHP has a process to help DSNP members move safely between different care settings (like hospitals, rehab centers, or home care). The goal is to ensure smooth transitions, avoid gaps in care, and improve health outcomes.

Monitoring Transitions:

SFHP uses Admission, Discharge, and Transfer (ADT) alerts and hospital notifications to track when members move between care settings.

The Care Management Transition of Care (TOC) team receives and responds to these alerts.

The Transition of Care (TOC) Team:

- The team includes UM nurses, Care Managers/Coordinators, PCPs, specialists, LTSS providers, dieticians, and pharmacists

- The TOC RN coordinates care before, during, and after transitions and works with Care Managers, PCPs, specialists, and facility staff to ensure all needs are met.
- They communicate with providers, arrange services, educate members/caregivers, and update the member's ICP.
- They follow up with members for 30 days after discharge or until all identified needs and goals are met or handed off to the member's primary Care Manager/Coordinator
- Services like home health, medical equipment, and transportation are arranged as needed.

Information Sharing

- Updated ICPs and discharge summaries are securely shared with all relevant parties.
- Health Information Exchange (HIE) tools, email, fax, and virtual meetings are used.

Member Access to Health Information and Self-Management

- Members are taught how to access their medical records and health information securely
- Members are educated on their health conditions, medications, and warning signs.
- "Teach-back" methods are used to confirm understanding.

Designated Point of Contact:

- Members are introduced to their TOC RN, who serves as their main contact during the transition.
- If unreachable, the member is connected to their Care Manager/Coordinator.

Making It Better Over Time

SFHP listens to feedback from members and families to identify and fix problems. We monitor key indicators like hospital readmissions to measure how well the system works. To keep improving care transitions, doctors and and other care professionals receive regular training and share ideas for best practices.

The Care Plus Care Management Team helps connect members to the following services:

- Dementia Care
- Palliative Care
- Culturally Competent Care
- Long-Term Services and Supports (LTSS)
- Behavioral Health Services
- CICM and Community Supports

Care Coordination in Action

Imagine a member with diabetes is struggling to manage their blood sugar due to difficulty following a recommended diet. To support the member, the Care Manager or Coordinator—working with the member and the Interdisciplinary Care Team (ICT)—may include personalized interventions in the member's Individualized Care Plan (ICP). These could include:

- **1:1 sessions with a dietician** for education and counseling
- **Food delivery services** to simplify meal choices
- **Support groups** for peer encouragement and shared experiences

The member's preferences are central to the plan and are documented in the ICP to ensure the care is tailored and effective.

Let's take a moment to review your understanding.

Match the care coordination topic with its definition.

The ICP is	a tool to to evaluate the health and social needs of D-SNP members
The HRA is	a personal health plan made for each member to help them stay healthy and get the care they need.
The ICT is	a group of people who work together to help a member stay healthy.

SUBMIT

CONTINUE

A Provider Network with Specialized Expertise

The SFHP Care Plus provider network is designed to meet the specialized needs of its members.

Network Composition

Includes a wide range of licensed practitioners: PCPs (Family Practice, Geriatrics, Internal Medicine), Nurse Practitioners, PAs, specialists (e.g., Cardiology, Dermatology), behavioral health providers, chiropractors, therapists (PT/OT/ST), home health, palliative care, hospitals, and skilled nursing facilities.

Proven Expertise

- Providers undergo rigorous credentialing and recredentialing per NCQA standards.
- Approval by SFHP's Physician Advisory Committee.
- Continuous monitoring of licenses and sanction databases.
- Participation in Interdisciplinary Care Teams (ICTs) with verified expertise

Expert Teams, Specialists and Services

SFHP 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.

These providers, often staffed by licensed clinicians, deliver in-office and in-home care for complex cases. They are considered extensions of the Care Management team, contribute to care planning, participate in the ICT, and are trained to follow MOC standards.

Learn more about these teams, specialists and services in the slides below:

BEHAVIORAL HEALTH SPECIALISTS	PALLIATIVE CARE TEAM	DEMENTIA CARE SPECIALISTS	LONG-TERM SERVICES AND SUPPORTS (LTSS PROVIDERS)

SFHP Care Pare Plus has partnered with Carelon Behavioral Health Services to offer a network of behavioral health specialists trained to meet the mild to moderate needs of these vulnerable populations.

SFHP doesn't provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through county behavioral health agencies.

If you have questions about behavioral health services, authorization for services, screening for level of impairment to determine appropriate services, referral procedures, or problem resolution process, call your SFHP Behavioral Health line Monday–Friday 8:00am–8:00pm PST at 1(855) 371-8117.

BEHAVIORAL HEALTH SPECIALISTS | PALLIATIVE CARE TEAM | DEMENTIA CARE SPECIALISTS | LONG-TERM SERVICES AND SUPPORTS (LTSS PROVIDERS)

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.

Palliative Care Specialists at SFHP receive extra training to help guide the ICT in care planning and delivery. The Palliative Care team is included in the ICT to ensure the ICP reflects the member's preferences and treatment plan.

BEHAVIORAL HEALTH SPECIALISTS	PALLIATIVE CARE TEAM	DEMENTIA CARE SPECIALISTS	LONG-TERM SERVICES AND SUPPORTS (LTSS PROVIDERS)

SFHP offers a training program for RN Care Managers who want to become Dementia Care Specialists.

The program includes several hours of theory, an exam for certification, and covers topics such as Alzheimer's and related dementias, symptoms and progression, managing behaviors and communication, caregiver stress, and available community resources.

Specialists lead the care team and provide expert guidance in creating care plans for members with dementia

Many vulnerable members have functional limitations that can be supported through Long-Term Services and Supports (LTSS).

LTSS include medical and personal care services for people who struggle with self-care due to aging, illness, or disability. Services may involve caregiver support, community resources, medical equipment, home modifications, and transportation.

Questions in the HRA will identify these services and whether the member is receiving them or eligible for these services.

Care Coordination ensures these services work together to improve the member's experience and avoid duplication.

SFHP also provides specialized training for 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.

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

Dementia care training is available for SFHP D-SNP RN Care Managers and it 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.

Clinical Practice Guidelines (CPGs) & Care Transition Protocols (CTPs)

SFHP Care Plus uses medical guidelines called CPGs and CTPs to make sure patients get the best care possible.

CPG Identification	Provider Access	Training & Education	Monitoring & Oversight
• Collaborative process involving clinical committees (e.g., QIHEC) with multidisciplinary input. • Selected based on evidence, relevance, and alignment with national standards (e.g., AHA, ADA).	• CPGs are posted on SFHP website, included in the provider manual, and available for discussion with the CMO.	• Regular provider workshops and trainings on guideline rationale, application, and updates. • Practical guidance provided to ensure clinical integration.	• Manual Medical Record Review: In-depth adherence assessments. • Surveys & Feedback: Inform additional training and refinements. • QIHEC Oversight: Reviews performance data, conducts audits, monitors HEDIS metrics.

Provider Feedback Loop	Communication & Collaboration	Care Transitions	Ongoing Support
• Continuous input collected via surveys, reviews, and communication. • QIHEC uses feedback to improve guidelines and protocols.	• Multiple channels: phone, secure email, online portal. • Providers are active participants in ICT meetings and care planning.	• Formal protocols ensure smooth transitions and continuity of care. • Post-transition case reviews and debriefings promote quality improvement.	• SFHP offers technical resources and education at www.sfhp.org. • Providers encouraged to engage in care reviews and continuous improvement initiatives.

Identifying and Sharing CPGs

- SFHP works with doctors and experts and internal committees to choose guidelines from trusted sources like the American Heart Association.
- These guidelines are shared with all healthcare providers through the website, manuals, and training sessions.

The table below includes example of CPGs sourced from nationally recognized, evidence-based organizations that will be used to support the needs of SFHP Care Plus's membership.

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 (aaojournal.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

Details of these CPGs are available in the SFHP Care Plus MOC, viewable online.

Making Sure Guidelines Are Followed

- SFHP checks medical records and asks providers for feedback to see if they're using the guidelines correctly.
- A committee, the QI and Health Equity Committee (QIHEC), reviews how well providers are doing and uses national standards to measure quality

Adjusting Care for Complex Patients

- Some patients have many health problems or special needs.
- SFHP changes the guidelines for these patients by:
    - Reviewing their health and social situations.
    - Creating personalized care plans with a team of doctors, nurses, and social workers.
    - Getting feedback from patients and updating plans as needed.

Teamwork and Communication

- SFHP uses secure emails, phone calls, and online tools to help care teams work together.
- Everyone involved in a patient's care stays informed and helps carry out the plan

Training and Support

- SFHP trains doctors on how to use and adjust guidelines.
- Doctors can ask experts for help with tough cases.

Care Transition Protocols (CTPs)

Helping Members Move Between Different Types of Care

When members move from one place of care to another—like from a hospital to a rehab center—it can be hard to keep everything organized. SFHP Care Plus has established rules called Care Transition Protocols (CTPs) to make sure members get smooth and safe care during these changes.

Working Together

- **Clear Communication**: Doctors and other experts share important health information quickly and securely, like medication lists and discharge notes.
- **Care Managers Help**: A Care Manager makes sure all the right information gets to the new care team and that everyone knows the patient's needs.
- **Team Planning**: The ICT works together to create and update an ICP for each patient.

Checking and Improving the Process

- SFHP Care Plus staff listens to feedback from members and families to find problems and fix them.
- They track things like how often patients return to the hospital to see if the system is working.
- SFHP Care Plus helps trains doctors and other experts regularly and encourages them to share ideas to make care transitions better.

SFHP

For more information on our Clinical Practice Guidelines and Care Transition Protocols, visit

SFHP.COM

Care Plus Programmatic Support Services

In collaboration with our internal teams, extensive provider network, and established community partners, our Care Management team takes a whole-person approach to care, addressing our members' clinical and non-clinical needs.

Our most vulnerable members may benefit from specially tailored services in addition to their supplemental benefits and services available to all D-SNP members.

The individual needs of the member will drive the level and type of support or services they may receive. The HRA specifically asks a series of questions to determine the Medi-Cal Services that the member is receiving or may be eligible for.

SFHP's Care Management Team can help connect members to the services described in the following slides and sections below or Care Plus Customer Service can assist with questions.

Step 2

Behavioral Health Services

Members may access BH clinicians, community mental health workers, a peer support specialist, and/or a drug treatment providers/counselors who can be a valuable members of the on their ICT.

SFHP will connect Care Plus members with specialty mental health or substance use disorder services and these services are available to members through county behavioral health agencies.

For questions about behavioral health services, authorization for services, screening for level of impairment to determine appropriate services, referral procedures, or the problem resolution process, call SFHP Behavioral Health line Monday–Friday 8:00am–8:00pm PST at 1(855) 371-8117.

Step 3

LTSS Services

SFHP Care Plus members may have functional limitations that can be supported through Long-Term Services and Supports (LTSS). LTSS programs are often essential programs that enable members to remain living independently in their homes.

Questions in the HRAT will identify these services and whether the member is receiving them or eligible for these services.

Examples of these services include caregiver services, community support, access to durable medical equipment or home modification, and coordination of transportation benefits.

Another type of LTSS, the In-Home Supportive Services (IHSS) program, may be an options for Care Plus members. These services are provided through SF County Human Services Agency IHSS and can be contacted by call (415) 355-6700 or call Care Plus Customer Service.

Step 4

Community Based Organizations (CBOs)

SFHP will integrate community-based organization (CBO) services into care plans by collaborating with Care Managers to ensure seamless access to resources.

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.

Community Supports

Community Supports programs are essential services that enable members to remain living independently in their homes.

Some examples of the Community Supports offered by SFHP include Medically Tailored meals, Medical Respite, and Housing Transition Navigation Services.

SFHP Care Plus members can get connected to the Community Supports offered by SFHP by working with their Care Manager or contacting Care Plus customer service and determining eligibility.

Palliative Care Services

Members in palliative care will receive the following programmatic services:

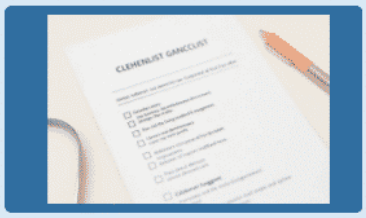
- Advanced care planning
- Palliative care assessment and consultation
- Plan of care specific to the care needs of these members
- Palliative care team

- Care Coordination
- Pain and symptom management
- Mental health and medical social services

Alzheimer's and Dementia Care Services

Alzheimer’s & Dementia Care Services

SFHP's care management team will determine whether members meet the criteria for additional Alzheimer's & Dementia Care Services when planning care and safety interventions.



1 Members with Documented Dementia Needs are defined by:

- Having a formal Alzheimer’s or dementia diagnosis documented by a qualified provider.
- Having documented dementia care needs, with symptoms or behaviors that affect safety, care, or daily functioning. (See symptoms checklist in Section 2.)

2 Symptoms & Indicators

- Wandering or elopement risk
- Home safety concerns (falls, hazards, fire risk)
- Poor self-care (personal hygiene, grooming, nutrition)
- Behavioral issues (agitation, aggression, sundowning)
- Issues with medication adherence (missed or incorrect doses)
- Poor compliance with care or management plans
- Inability to manage ADLs/IADLs (dressing, bathing, shopping, banking)

The Care Plus HRA includes questions to identify dementia needs.

If these needs are identified, the member will have an ICT lead by SFHP's Dementia Specialists. The dementia care specialist will be included to ensure all care needs for the member are identified and resourced appropriately, including using community-based organizations, such as the Alzheimer's Organization, as needed.

As dementia symptoms progress, members may access additional providers to support their care including a neurologist, a geriatrician if the patient is aging, a BH clinician/provider, and potentially in-home care provider staff. Access to additional care and services depends on the member's needs.

All providers and services aim to help the member improve their health outcomes.

Culturally Competent Care

The Department of HealthCare Services requires network providers to complete training on diversity, equity, and inclusion. Most providers will have already completed this training through their medical group, or completed the training SFHP developed.

If you have not completed a cultural competency training, reach out to your medical group or SFHP for instructions on how to complete it.

Let's take a moment to review your understanding.

Who ultimately decides whether a provider's qualifications are acceptable to participate in SFHP Care Plus' network?

- ○ The CMO of San Francisco Health Plan
- ○ The Physicians' Advisory Committee
- ○ Medicare
- ○ The Member & Community Committee

SUBMIT

Which of the following specialized services do members have access to? (more than one can be selected)

- ☐ LTSS Services
- ☐ Dementia and Alzheimer's Care
- ☐ Community Supports
- ☐ Palliative Care

SUBMIT

CONTINUE

Quality Measurement & Performance Improvement

SFHP Care Plus is committed to continuous quality improvement for both the health plan and our health care delivery system.

In the sections below, you'll learn more about the key components of the SFHP Care Plus QI Program.

Quality Improvement Process

Learn how the Quality Department collaborates with other teams to drive performance.

QI Data Collection

Discover how SFHP drives continuous quality improvement for D-SNP members through proactive monitoring, data-driven analysis, and strategic enhancements

Setting and Evaluating Goals

Understand how we define and track success. Set using data-driven benchmarks and member outcomes.

Measuring Patient Experience of Care

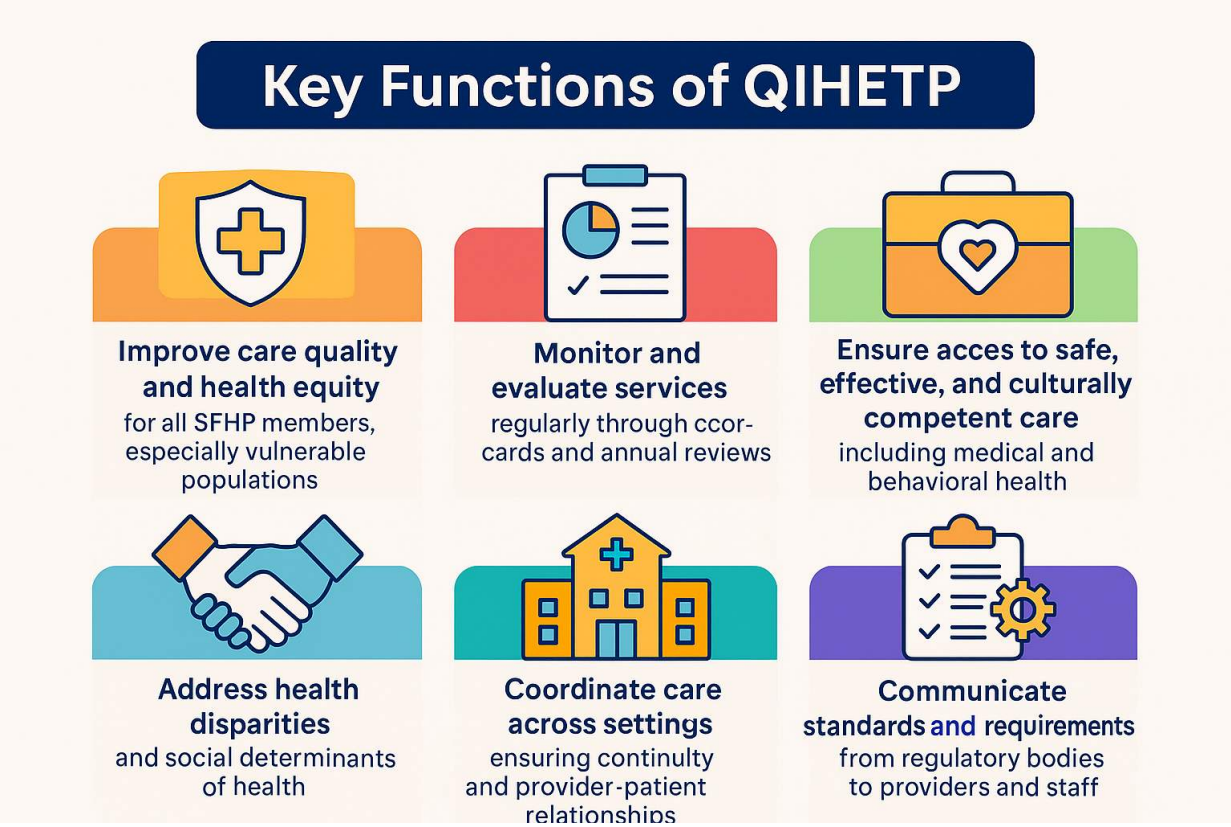
Explore how member feedback shapes our services. Measured through surveys, feedback loops, and service reviews.

Quality Improvement (QI) Process

SFHP is committed to continuous quality improvement for both the health plan and our health care delivery system.

Key components of the QI Process:

- Collaboration through the QI and Health Equity Committee (QIHEC) under SFHP leadership.
- Integration with SFHP's Population Health Management Program to align strategic goals.
- Focus on vulnerable groups such as those experiencing homelessness, SMI/SUD, incarceration transitions, LTC needs, and racial/ethnic disparities.
- Regular monitoring via a QIHET scorecard, quarterly reviews, and annual evaluations.
- Goals include improving health outcomes, care coordination, access, cultural competence, provider credentialing, communication of standards, utilization management, and member experience



QI Data Collection

SFHP applies continuous quality improvement for D-SNP members through ongoing monitoring, analysis, and systematic enhancements.

Data Collection Process

Continuous monitoring

↓

Data sources

- Eligibility files, demographics
- Claims, utilization, pharmacy
- EMRs, HRAs, CAIR
- HEDIS, CAHPS, regulatory reports

↓

Evaluation monthly

↓

Performance measures

- HRA and ICP completion rates
- Utilization metrics
- CAHPS and HOS results
- Provider network adequacy, needs

↓

Quality improvement

Setting and Evaluating 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.

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 DSNP 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.

Measurable goals and health outcomes are continuously monitored and reviewed until successfully achieved.

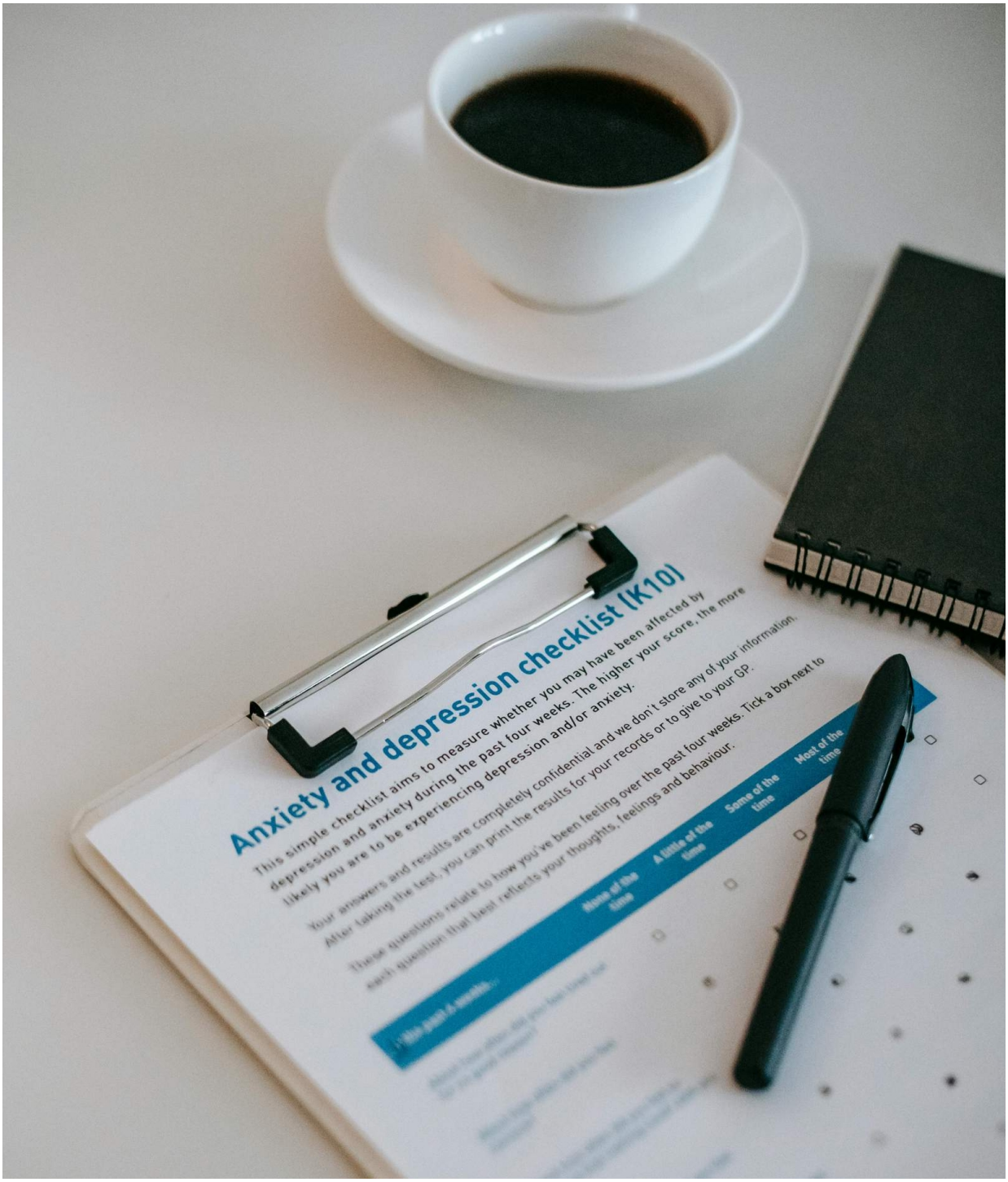
Unmet goals are reported to QIHEC to support documentation, collaboration, and intervention planning. If no improvement is observed, the evaluation cycle is repeated.

All findings are integrated into the broader quality program to promote ongoing learning and enhance the effectiveness of improvement initiatives.

Improving access, affordability, and health outcomes for the D-SNP population requires a comprehensive and data-driven approach.

The SFHP Quality Team will be in touch to collaborate on these processes.

Measuring Patient Experience of Care



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.

Survey Tools

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).**

Survey Process for Assessing DSNP Plans

CAHPS SURVEY PROCESS

WHAT IS CAHPS?

CAHPS* (Consumer Assessment of Healthcare Providers and Systems) is an annual survey mandated by CMS. Required for Managed Care Plans with 600+ enrollees

1 SURVEY DESIGN & ADMINISTRATION

Purpose: Assess enrollee experiences with: Access to care

- Provider communication
- Customer service

Method: Mixed-mode protocol

- Web survey invitation
- Up to 2 mail surveys for non-respondents
- Telephone follow-ups for final outreach

2 SAMPLING & VENDOR COORDINATION

SFHP partners with a CMS-approved vendor to:

- Select eligible member samples
- Manage data collection
- Ensure CMS timeline & confidentiality

3 DATA SUBMISSION & REPORTING

Vendor submits data to CMS using approved methods

- Results contribute to SFHP's quality ratings
- Used to identify areas for improvement

HOS SURVEY PROCESS

WHAT IS HOS?

Medicare Health Outcomes Survey (HOS) is an annual CMS requirement.
Applies to Medicare Advantage plans with 500+ enrollees

1 SURVEY OBJECTIVE & METHODOLOGY

Purpose: Assess physical and mental health outcomes over time

Focus on health-related quality of life

Method: Mixed-mode protocol

- Two mailings
- Telephone follow-up for non-respondents

2 SAMPLING & CONFIDENTIALITY

CMS provides eligible sample to approved HOS vendors

Vendors follow strict confidentiality protocols during data collection and processing

3 DATA COLLECTION & USE

Collect baseline and follow-up data over 2 years

Data supports evaluation in quality improvement, contribute to Star Rating

Let's take a moment to review your understanding.

What survey tools are used by SFHP Care Plus to measure Patient Experience? (More than one answer may be correct)

- [ ] CAHPS Survey (Consumer Assessment of Healthcare Providers & Systems)
- [ ] HEDIS Survey (Healthcare Effectiveness Data and Information Set)
- [ ] HOS Survey (Health Outcomes Survey)
- [ ] NHCS Survey (National Hospital Care Survey)

SUBMIT

Congratulations!

Congratulations! You've completed the SFHP Care Plus 2026 MOC and Care Coordination Training. Your commitment to delivering excellent, quality care makes a real difference in the lives of our members. Thank you we will see you again next year!

Please share your feedback on the training experience by following the link to a brief 5 question survey: https://forms.cloud.microsoft/r/riGCkeFM3t?origin=lprLink

Complete Course

Click the **Complete Course** button to exit the course and mark your completion of this training.

COMPLETE COURSE

CONTINUE