# SFHP Care Plus D-SNP Model of Care (MOC) Training 2026

Not intended for consumer use. For informational purposes only.

# Welcome to SFHP Care Plus!

We're excited to introduce you to SFHP Care Plus! In this training, you'll explore how this program supports our members and how you play a key role in delivering care.

Not intended for consumer use. For informational purposes only.

# Learning Objectives

In this course, you will learn about:

# What is SFHP Care Plus?

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

SFHP 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.

Not intended for consumer use. For informational purposes only.

# Learn about the unique characteristics of SFHP's Care Plus membership

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

# Our Diverse Population Includes People with:

Multiple Chronic Conditions

Mental Illness

Dementia & Developmental Disabilities

Physical Disabilities

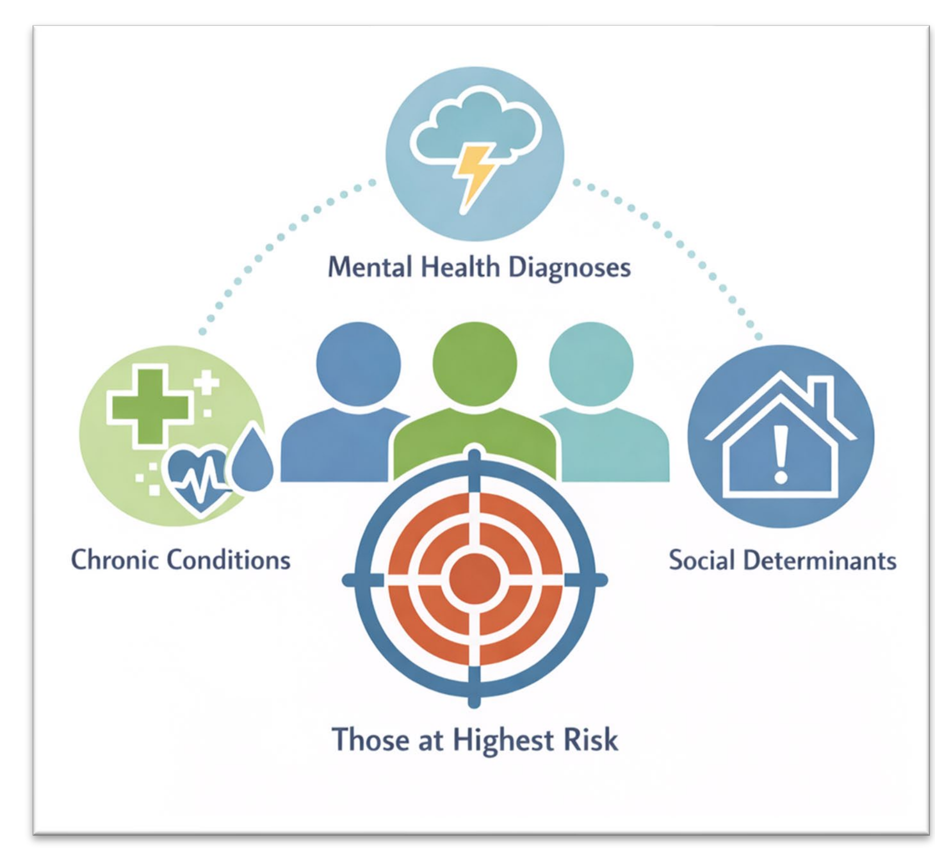
# SFHP identified the most vulnerable populations to focus on:

- Adults Experiencing Homelessness
- Adults at Risk for Avoidable Hospital or ED Utilization
- Adults with Serious Mental Health or Substance Use Disorder Needs
- Adults Transitioning from Incarceration
- Members Eligible for Long Term Care & at Risk of Institutionalization
- Nursing Home Residents Transitioning to the Community
- Pregnant, Postpartum & Subject to Racial & 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.  It 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

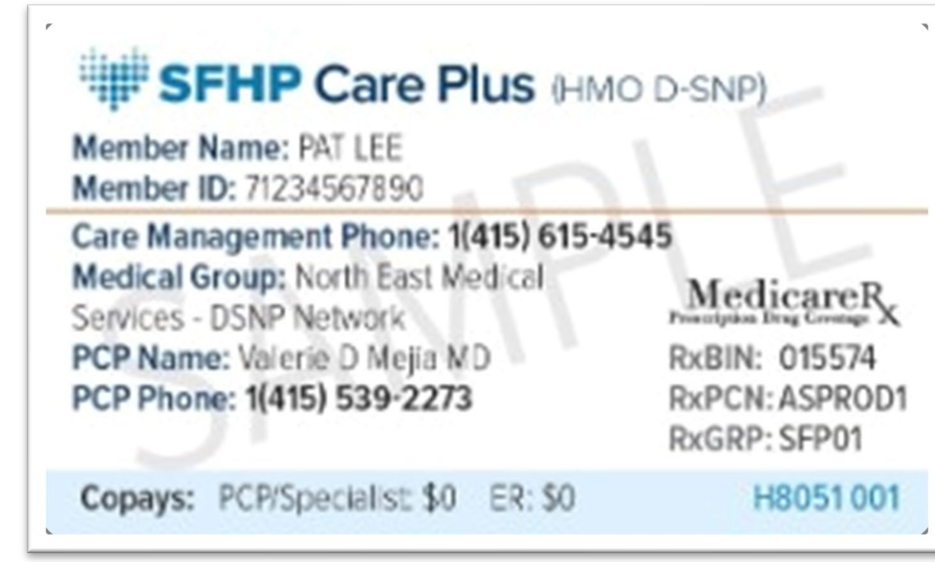
# Some of the benefits of identifying and targeting the most vulnerable populations include:

# Member Benefits, Rights and Responsibilities

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.

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



# Integrating Medicare and Medi-Cal Benefits

Member Claim – Provider submits claim for services

Medicare Benefits – Medicare pays first (contracted rate minus 20%)

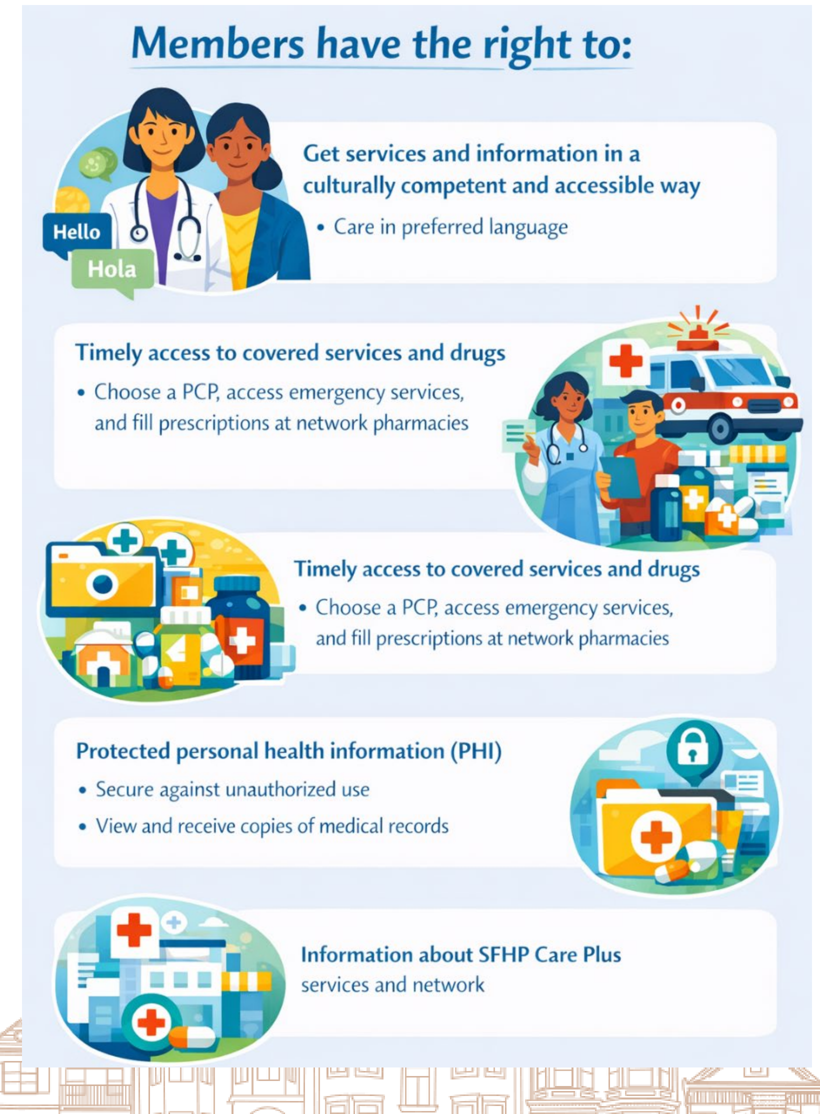
+

Medi-Cal Benefits – Medi-Cal will cover any additional provider payment up to the Medi-Cal rate

= $0

No member cost share

# Member Rights & Responsibilities



# Member Rights & Responsibilities Continued

# Care Coordination

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.

In this section, you'll learn about:

- Health Risk Assessments (HRAs)
- Individualized Care Plans (ICPs)
- Interdisciplinary Care Teams (ICTs)
- Face-to-Face Encounters
- Care Transitions
- Connecting Members

# Health Risk Assessment (HRA)

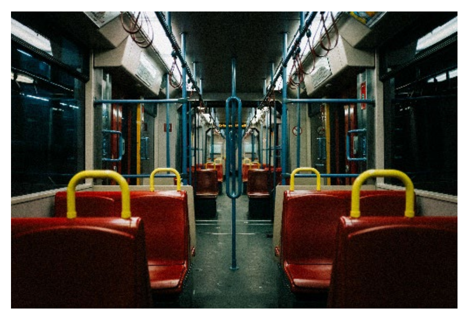
**An HRA** is a personalized survey used to evaluate the health status, needs, and risks of individuals who qualify for both Medicare and Medicaid. These patients often have complex medical, behavioral, and social needs, and the HRA is a foundational tool for developing their Individualized Care Plan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

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

# 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 the HRA 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.

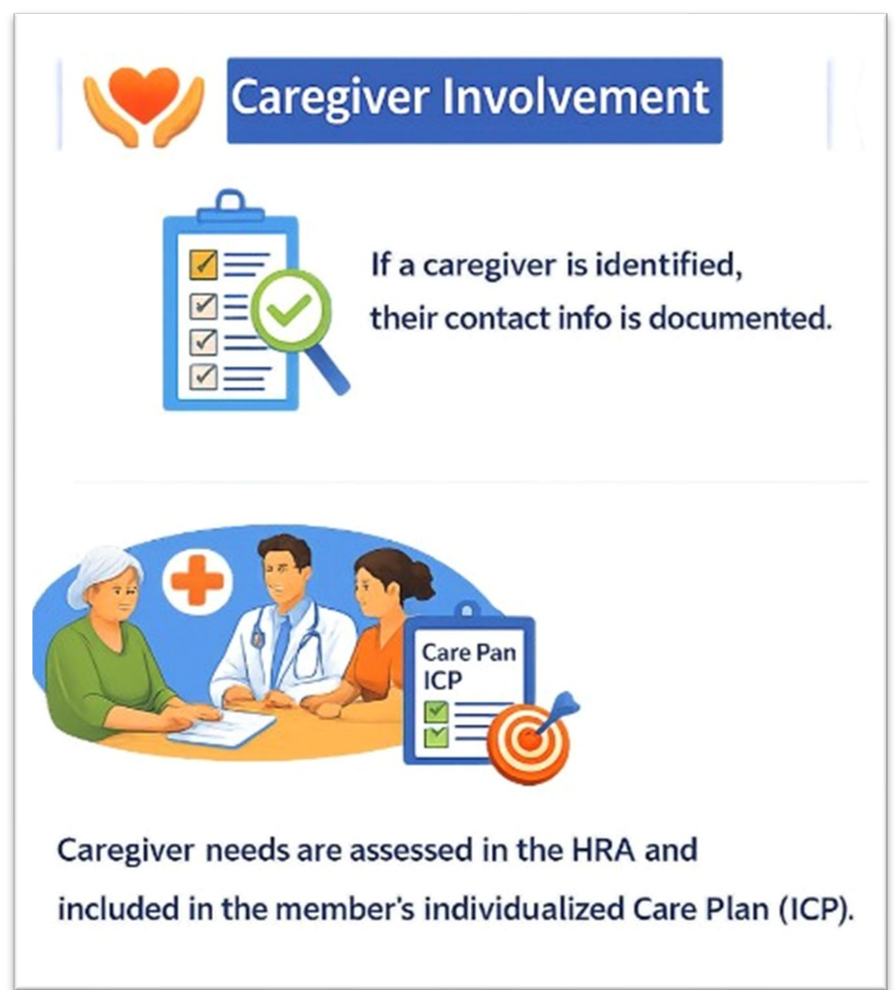
It also checks if the member uses services like in-home care, dental care, or support for Alzheimer's or palliative care.

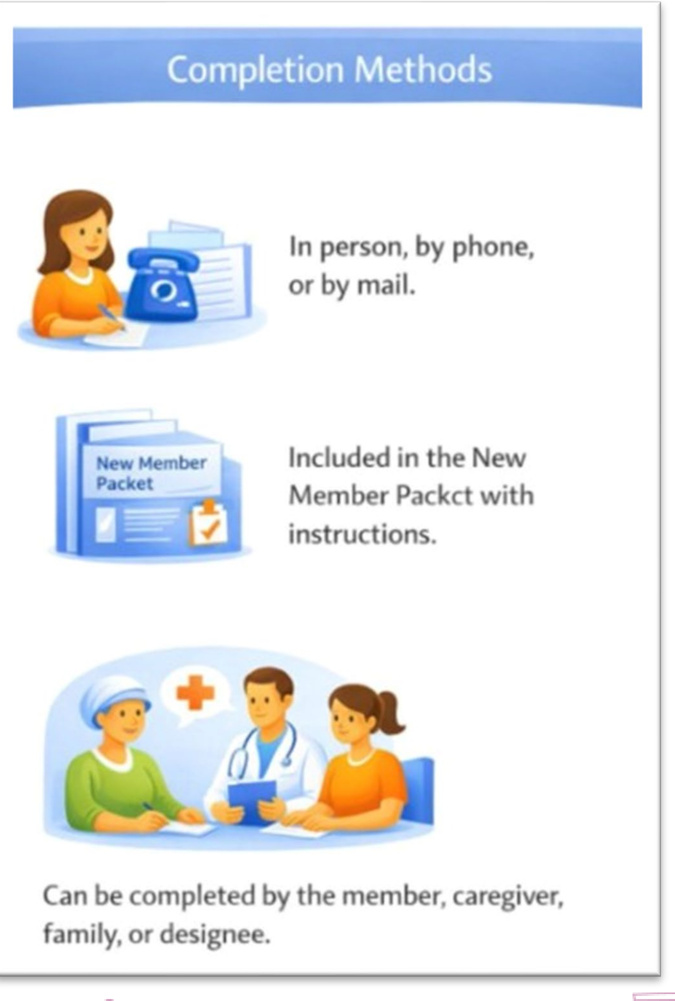
# Timing

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.

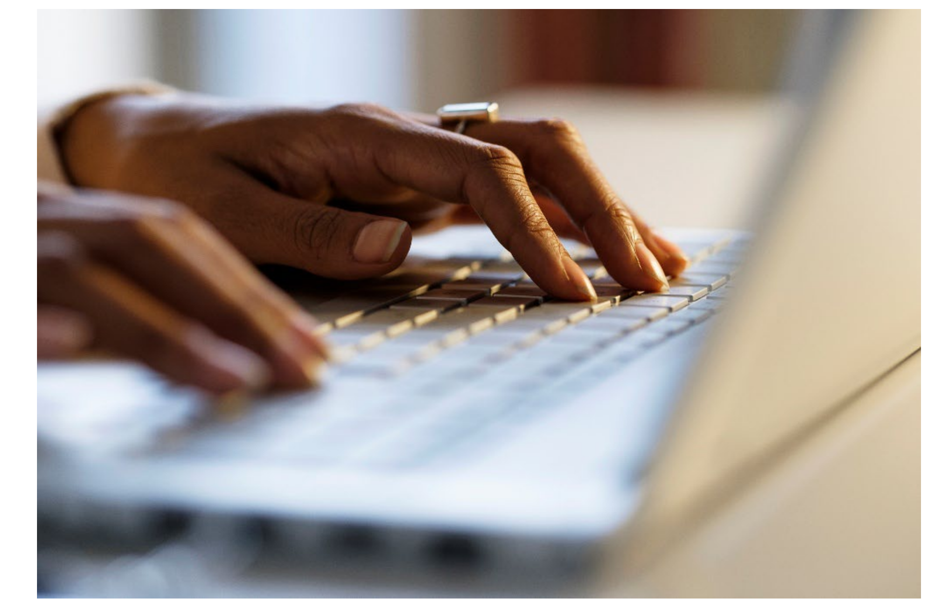
# Additional Aspects of the HRA Process



# Individualized Care Plan (ICP)

An 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 and who is involved?

**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)

**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 and how is it used?

**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

**The ICP :**

- Helps the member get the right care and services
- Is shared with the member, caregiver, and doctors
- Is updated at least once a year or when health changes
- Is adjusted if goals aren't being met

# Interdisciplinary Care Team (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:

# ICT Responsibilities include:

# Role of the Primary Care Provider (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 coordinate with the member's ICT and help the member get needed services.

# How the ICT Communicates

**Communication Occurs Via:**

Phone | Secure Email | Mail | In Person | I.T Meetunge

**ICP Updates Shared In Member's Preferred Language & Format**

Hello | Hola

**All Meetings & Communications Documented in Member Record**

Efficient

Attempt

Attempt

Attempt

Attempt

If Members decline participation Care Managers attempr
re engagement twice a Year and document decisions in ICT meetings

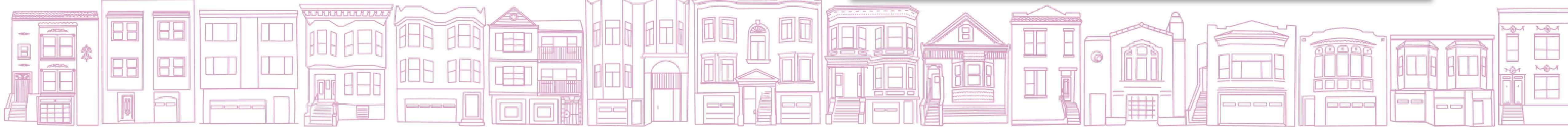
# Face-to-Face Encounters

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 will receive additional outreach.

## Purpose, goals, and benefits of Face-to-Face visits:

## Face-to-Face Encounters include:



# Addressing Identified Concerns:

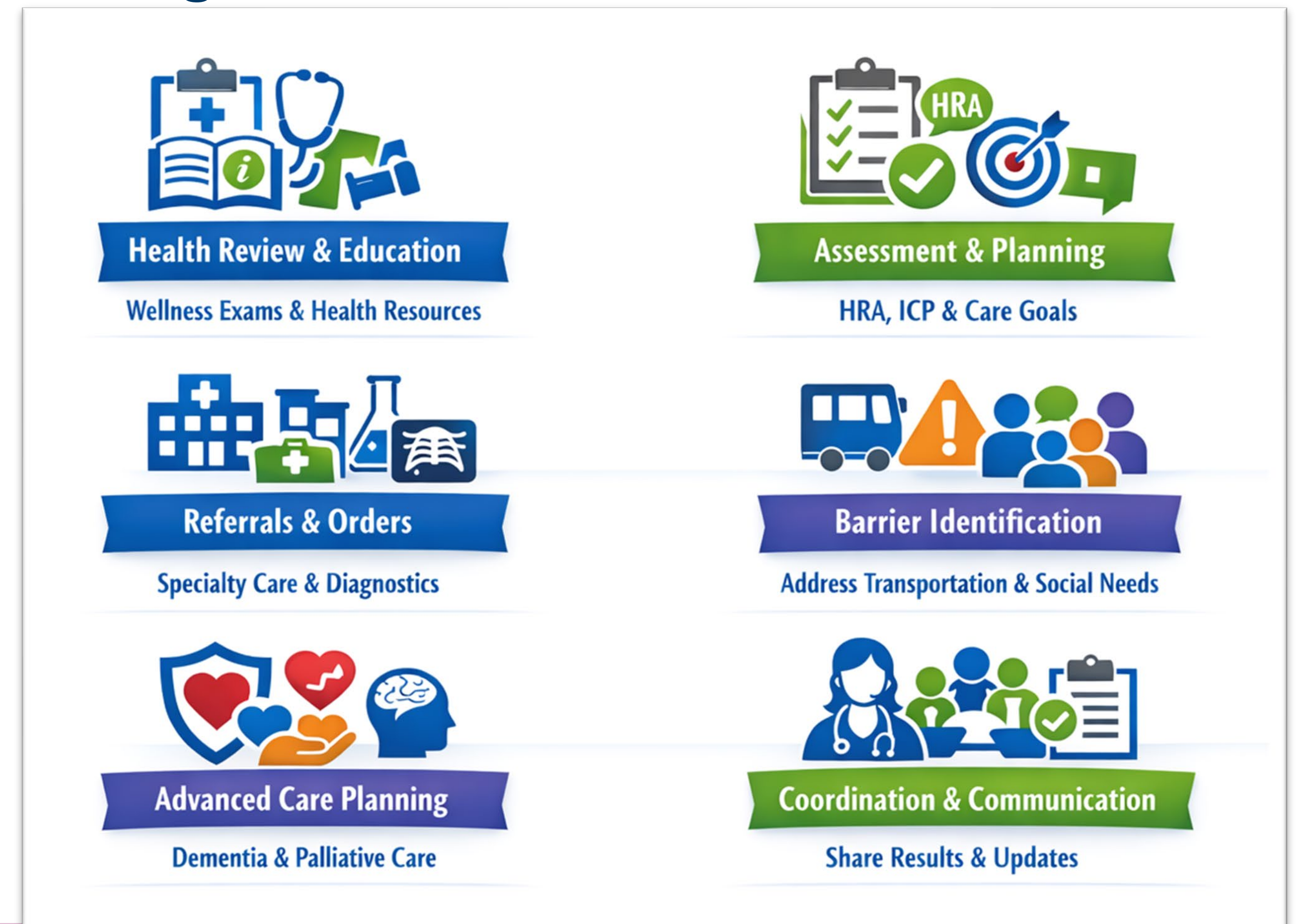
If a Care Manager or Coordinator finds a health concern during a visit, they document it in the member's ICP and notify the appropriate provider unless the care team can handle it directly.

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.

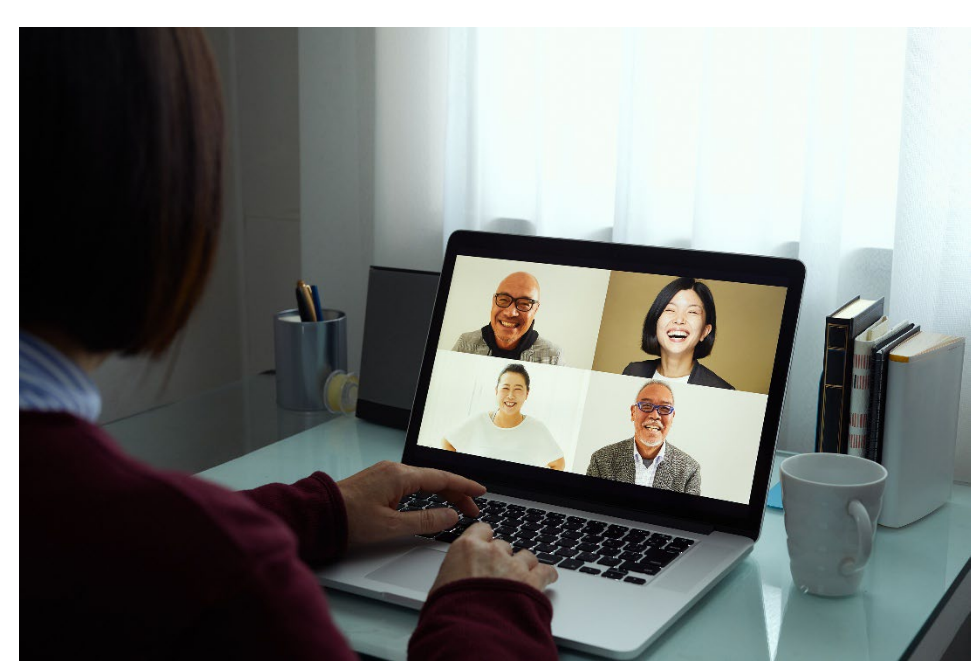
# If a member refuses or can't be reached:

- 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.

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



# Cultural Awareness and Member Preferences



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 D-SNP 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.

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:

# Care Transitions Communication

**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.

**Designated Point of Contact:**

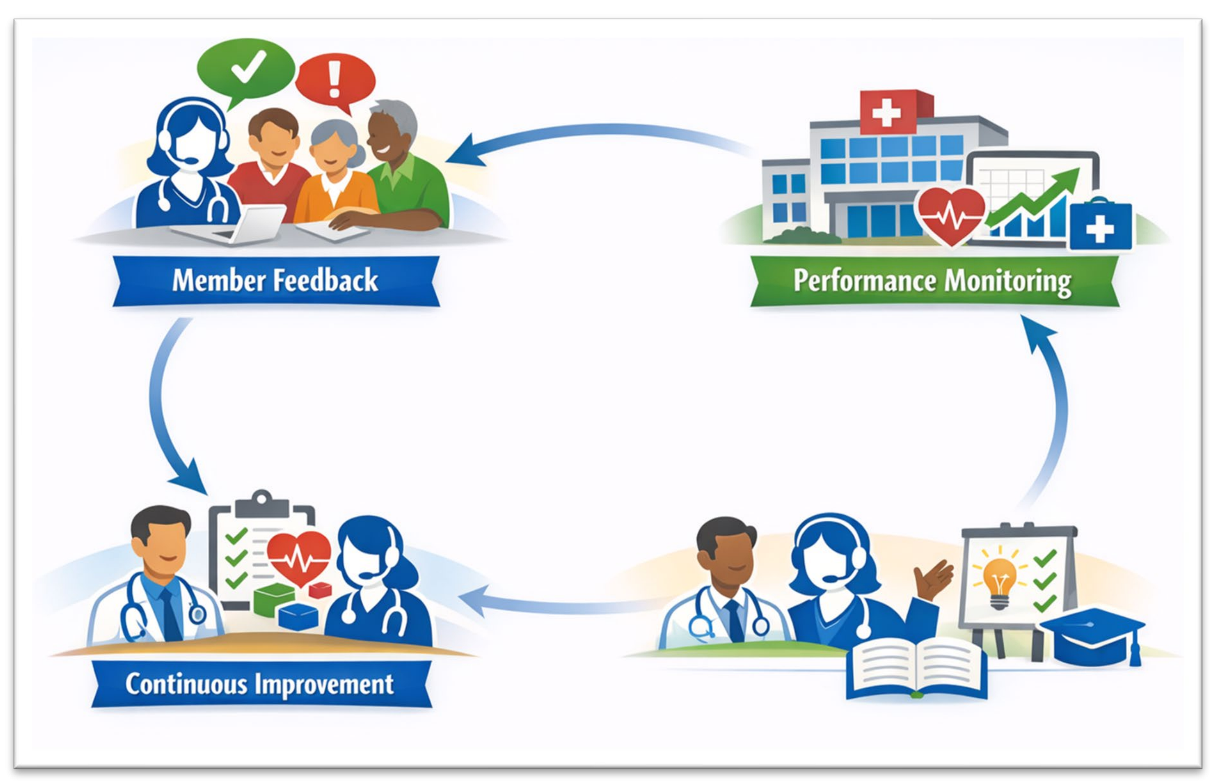
Members are introduced to their TOC RN, who serves as their main contact during the transition.

If unreachable, the member is connected to their Care Manager/Coordinator.

# 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.

# Making It Better Over Time




SFHP listens to feedback from members and families to identify and fix problems.

SFHP monitors key indicators like hospital readmissions to measure how well the system works.

To keep improving care transitions, doctors 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:

# SFHP Care Plus D-SNP Provider Network

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

In this section, you'll learn about:

- The Provider Network with Specialized Expertise
- Clinical Practice Guidelines (CPGs) & Care Transition Protocols (CTPs)
- Care Plus Programmatic Support Services

# Network Composition & Proven Expertise

**SFHP Care Plus includes a wide range of licensed practitioners:**

- PCPs (Family Practice, Geriatrics, Internal Medicine)
- Nurse Practitioners (NPs) & Physician Assistants (PAs)
- Specialists (e.g., Cardiology, Dermatology)
- Behavioral health providers
- Chiropractors
- Therapists (PT/OT/ST)
- Home health
- Palliative care
- Hospitals
- Skilled nursing facilities

**Providers must:**

- Meet rigorous credentialing and recredentialing NCQA standards.
- Be approved by SFHP's Physician Advisory Committee (PAC).
- Undergo continuous monitoring of licenses and sanction databases.
- Participate 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 next slides.**

# Behavioral Health Specialists

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 the SFHP Behavioral Health line Monday–Friday 8:00am–8:00pm PST at 1(855) 371-8117.

# Palliative Care Team

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.

# Dementia Care Specialists

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.

# Long-Term Services and Supports (LTSS Providers)

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.

# Specialized Palliative and Dementia Care Training

SFHP 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 and Dementia Care Training

**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:

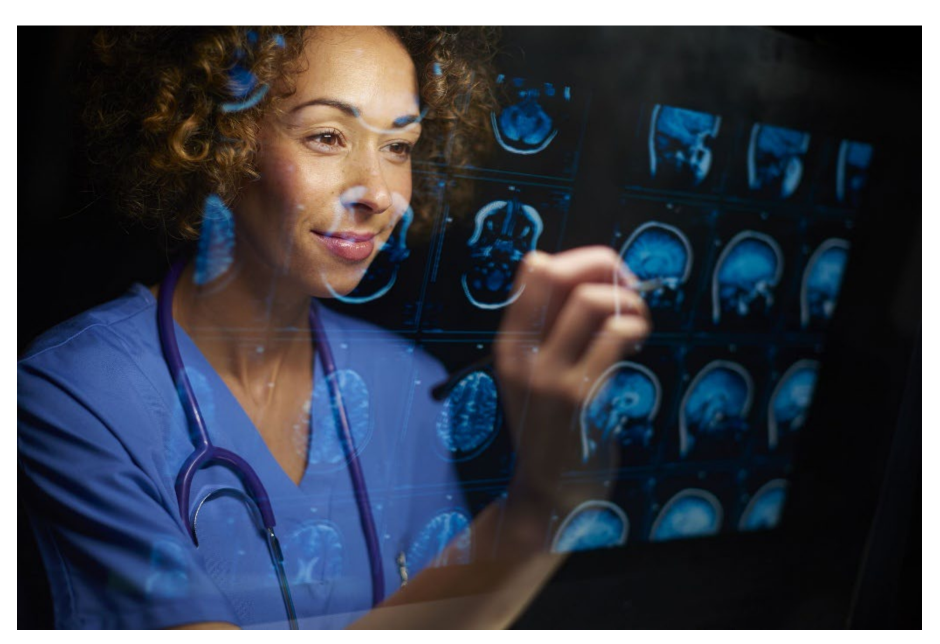
- General eligibility criteria for palliative care
- Disease-specific eligibility criteria for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), advanced cancer, and liver disease

**Dementia Care Training** is available for SFHP D-SNP RN Care Managers.

This 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

# Dementia Care Training & the Alzheimer’s Organization



Dementia Care 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.

### 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.

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

| CPG Identification | Provider Access | Training & Education | Monitoring & Oversight |
|---|---|---|---|
| • Collaborative process involving clinical committees (e.g., QIHEC) with multidisciplinary input.<br><br>• 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.<br><br>• Practical guidance provided to ensure clinical integration. | • Manual Medical Record Review: In-depth adherence assessments.<br><br>• Surveys & Feedback: Inform additional training and refinements.<br><br>• QIHEC Oversight: Reviews performance data, conducts audits, monitors HEDIS metrics. |


| CPG Identification | Provider Access | Training & Education | Monitoring & Oversight |
|---|---|---|---|
| • Collaborative process involving clinical committees (e.g., QIHEC) with multidisciplinary input.<br><br>• 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.<br><br>• Practical guidance provided to ensure clinical integration. | • Manual Medical Record Review: In-depth adherence assessments.<br><br>• Surveys & Feedback: Inform additional training and refinements.<br><br>• QIHEC Oversight: Reviews performance data, conducts audits, monitors HEDIS metrics. |

## 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 |

# Making Sure Guidelines Are Followed

# 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

# Training, Support, Teamwork, & Communication

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

# 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.

# Care Transition Protocols (CTPs) Continued

## Working Together

## Reviewing and Improving the Process

# Care Plus Programmatic Support Services

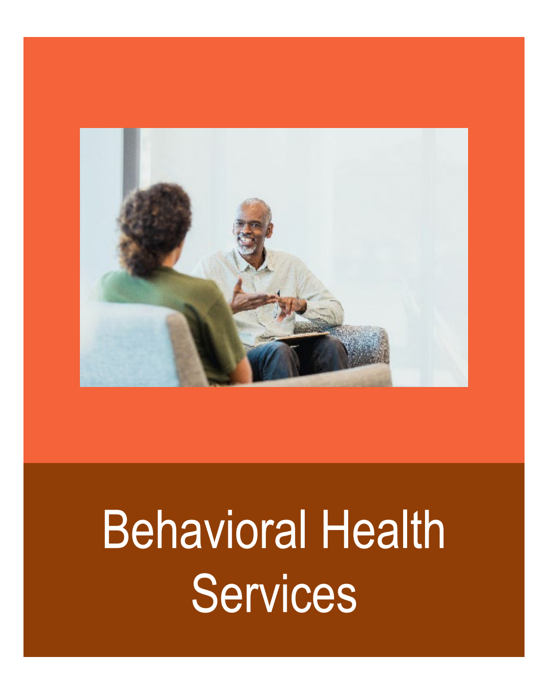
Our Care Management team works with internal teams, providers, and community partners to support members' clinical and non-clinical needs through a whole-person approach.

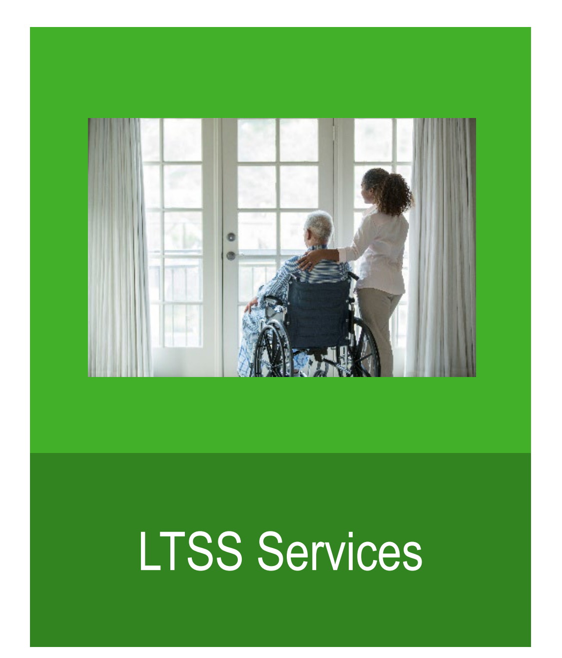
Members with higher needs may receive tailored services in addition to standard D-SNP benefits.

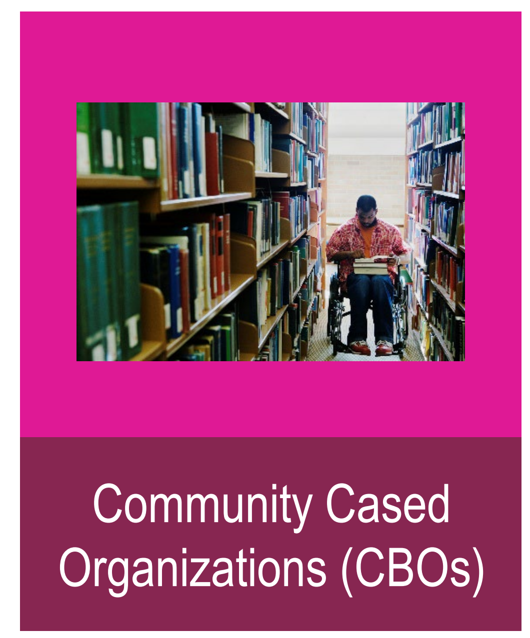
Each member's individual circumstances determine the level of support provided. The HRA includes questions that help identify the Medi-Cal services a member receives or may qualify for.

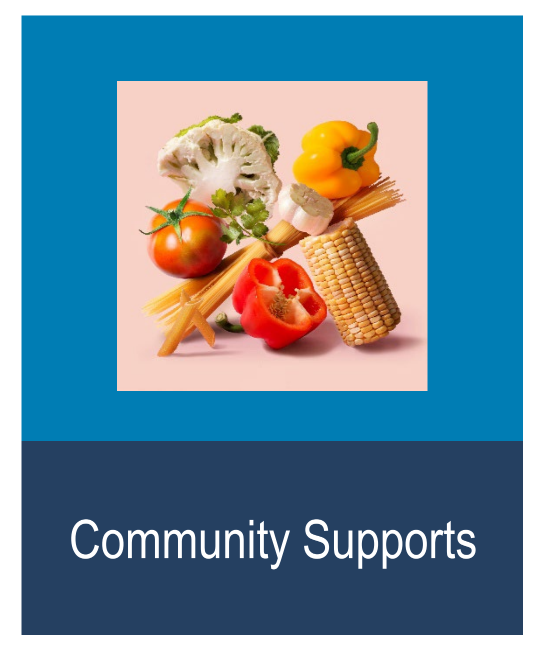
**SFHP's Care Management Team can help connect members to the services described in the following slides and Care Plus Customer Service can assist with questions.**

# Tailored Programs for SFHP Care Plus Members



# 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.

# 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.

# 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

## General Eligibility Criteria

**Frequent unplanned acute care use**

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

**Advanced illness with documented decline**

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

**Prognosis within one year**

The member's death within a year would not be unexpected based on clinical status

**Therapy status and reversibility**

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

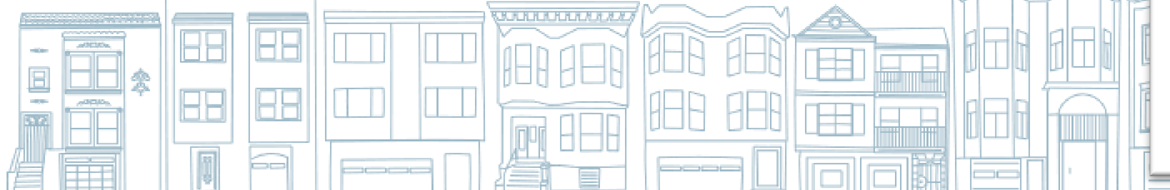
## Member and Support Person Agreements

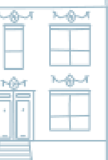
**Prefer outpatient or in-home management as appropriate**

Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department

**Advance care planning participation**

Participate in Advance Care Planning discussions (patient and, if applicable, family or designated support person)





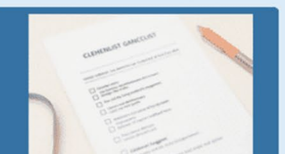
# Members in palliative care will receive the following programmatic services:

# Alzheimer's and Dementia Care Services

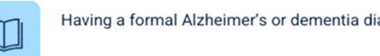
The SFHP Care Plus HRA includes questions to identify dementia needs.

## Alzheimer's & Dementia Care Services

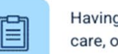
SFHP's care management team will determine whether members meet the criteria for additional Alzheimer's & Dementia Care Services when planning care and safety interventions.



### 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)

# Dementia Care Services & Specialists

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.

# 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 Quality Improvement (QI) Process
- QI Data Collection
- Measuring Patient Experience of Care

# Key Components of the 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

## 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

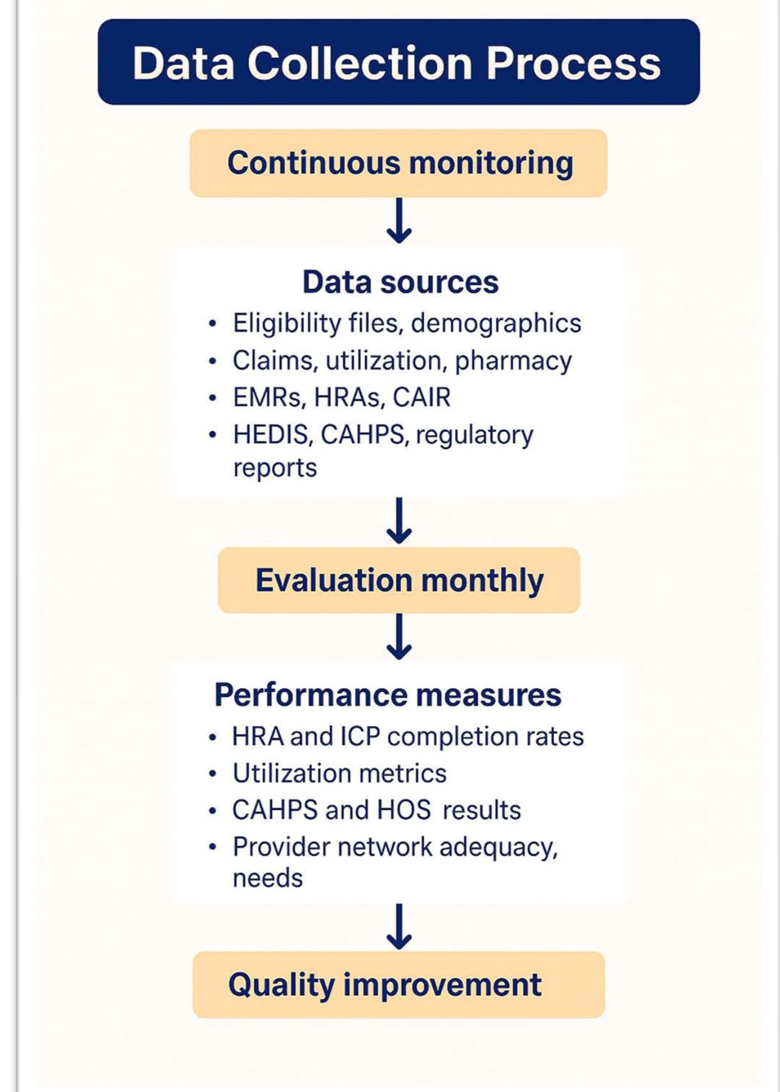
# QI and Health Equity Transformation Program (QIHETP)

## Key Functions of QIHETP

- **Improve care quality and health equity** for all SFHP members, especially vulnerable populations
- **Monitor and evaluate services** regularly through **scorecards** and annual reviews
- **Ensure access to safe, effective, and culturally competent care** including medical and behavioral health
- **Address health disparities** and social determinants of health
- **Coordinate care across settings** ensuring continuity and provider-patient relationships
- **Communicate standards and requirements** from regulatory bodies to providers and staff

# QI Data Collection

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



# 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.

# Setting and Evaluating Goals Continued

**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.**

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.

# 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.

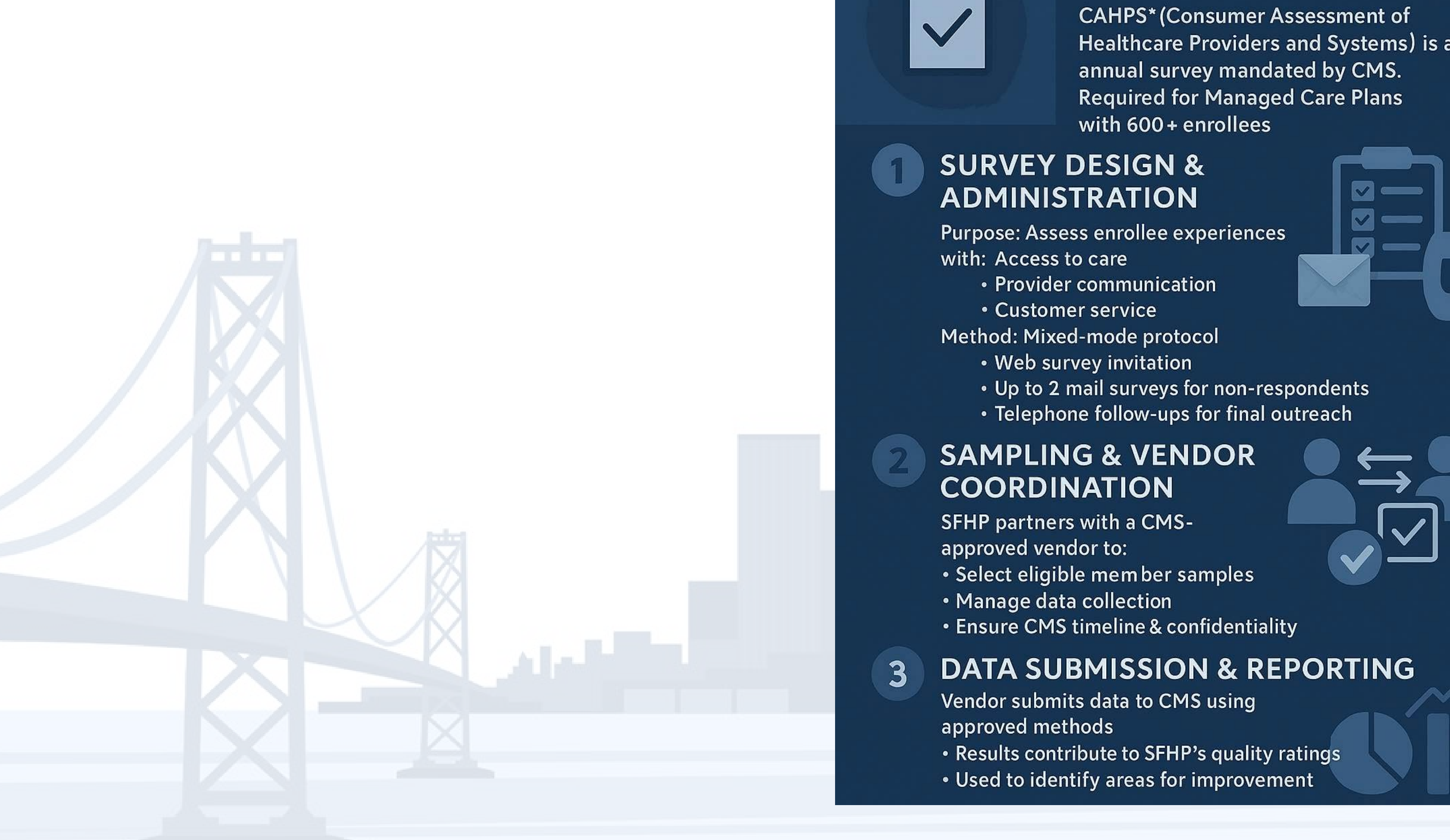
Understanding patient experience allows health plans to identify areas where care delivery can be improved to enhance outcomes, build trust, and ensure member-centered care.

# 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).**

# CAHPS Survey



# HOS Survey

## HOS SURVEY PROCESS

### WHAT IS HOS?

Medicare Health Outcomes Survey (HOS) is an annual CMS requirement.
Applies to Medicare Advantage, 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 mallings
- Telephone follow-up for non-respondents

### 2 SAMPLING & CONFIDENTIALITY

CMS provides eligible sample to approved HOS vendors
Vendors follow strict confidentiality protocols during data and processing

### 3 DATA COLLECTION & USE

Collect baseline and follow-up data over 2 years
Data supports evaluation and quality improvement, contribute to Star Rating

# 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**

# Questions?

If you have questions, please contact your Provider Relations representative. If you're unsure who your PR rep is, you can email provider.relations@sfhp.org.

SFHP
sfhp.org
Follow Us!
Stay Updated with SFHP.