SFHP CarePlus Model of Care (MOC) Training

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The Model of Care (MOC) Sections

MOC 1

Target Population

MOC 2

Care Coordination

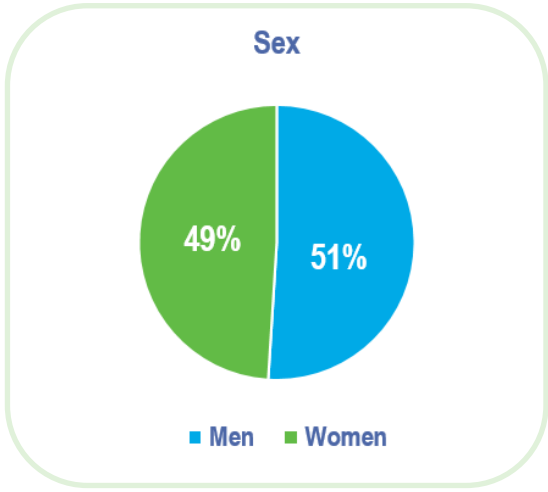
MOC 3

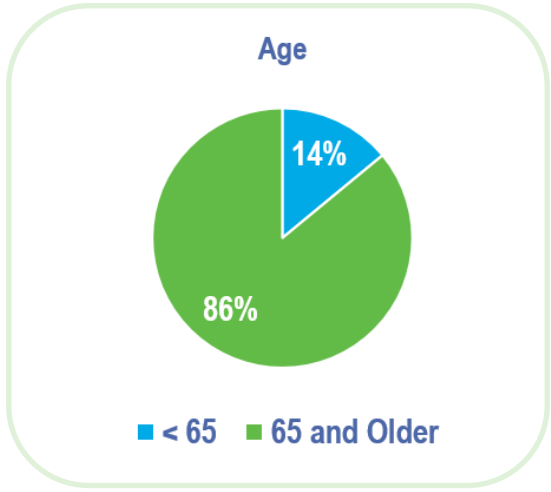
Provider Network

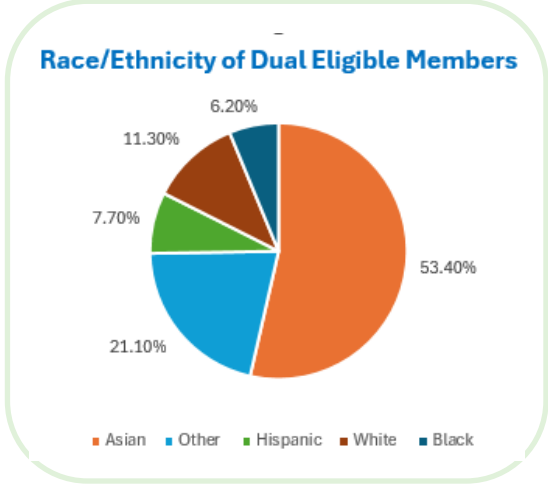
MOC 4

Quality Measurement

MOC 1: SFHP Care Plus General Population – Demographic Snapshot

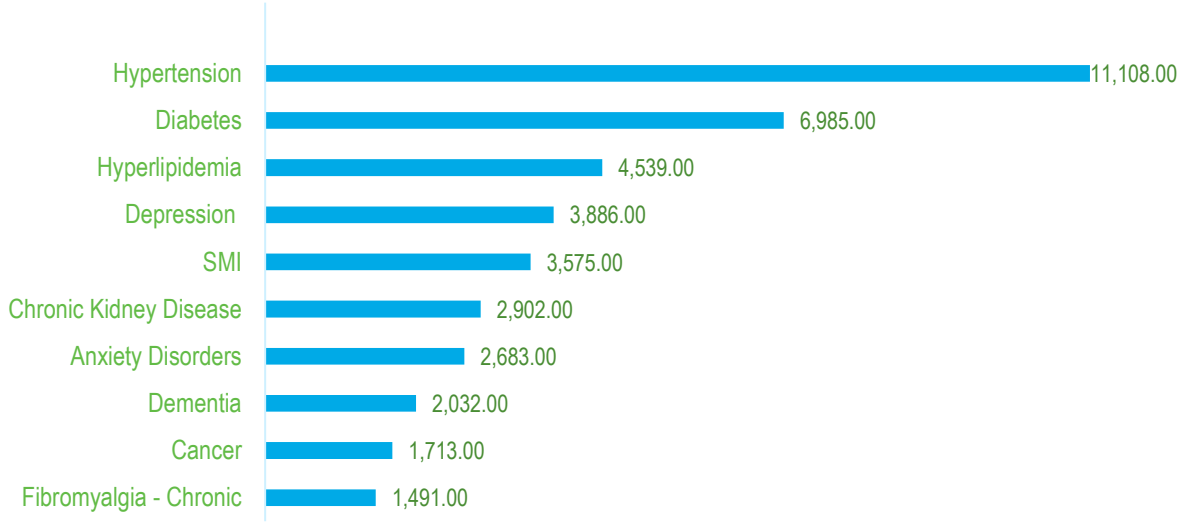






47%
have at least one mental health diagnosis

63%
have three or more chronic conditions



Source: SFHP Membership Tableau Dashboard, San Francisco Health Plan, May 2025

The Most Vulnerable Population:

California Integrated Care Management (CICM) Populations

- Some of the benefits obtained from risk stratifying enrollees to populations of focus 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

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

MOC 2: Care Coordination

- This section describes in detail how we are going to provide care coordination for ALL SFHP CarePlus members. This process includes:

Staff Structure
Who provides Care Coordination

Health Risk Assessment:
Initial, Annual, Change in Condition

Face-to-Face Encounter
An Annual Requirement

Individualized Care Plan (ICP)
All members need an ICP!

Interdisciplinary Care Team (ICT)

Care Transition Protocols

The Essentials

- **Staff Structure**:
  - SFHP described all departments and staff roles and responsibilities in coordinating care for our Care Plus members, ranging from Member Services, Claims and Pharmacy to Utilization Management and Care Management, among others.
- **Health Risk Assessment (HRA)**:
  - All SFHP Care Plus members must complete an initial HRA within the first 90 days of their enrollment with SFHP and annually (within 365 days of their last HRA).
  - When members have a change in condition *or* experience a care transition, an HRA and/or other assessment tool is used to determine whether their needs have changed, if needed.
  - If their needs have changed, the care plan must be updated.

The Essentials (continued)

- **Face-to-Face Encounter**: All members must have an annual (minimally) face-to-face encounter with a member of their ICT. This can be with a plan provider treating the member or a care management team member.
- **Individualized Care Plan (ICP)**: All SFHP CarePlus members must have an ICP, even if we cannot reach the member.
  - ICP needs to include the member's or caregiver's goals and preferences.
  - ICP needs to be shared with ICT participants (including member/caregiver).
  - ICP needs to be updated at least annually and with any change in the member's conditions.

The Essentials (Continued)

- **Interdisciplinary Care Team (ICT)**: ALL SFHP Care Plus members must have documented ICT participants who are involved in their care and services.
  - At a minimum, the ICT comprises the member/caregiver, the member's PCP and the Care Manager/Coordinator. Other disciplines may also be involved.
  - A dementia care specialist is included in an ICT for members who have documented dementia needs.
  - The Palliative care team is included as part of the ICT for members receiving palliative care.
  - The Care Manager/Coordinator has the lead role in forming the ICT, communicating with the ICT and scheduling the ICT meetings.
- **Care Transition Protocols**: SFHP provides TOC services for all SFHP Care Plus members, transitioning from one care setting to another, both planned and unplanned, across the care continuum.

Additional Training Topics

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

MOC 3 Provider Network

- Element A: Specialized Expertise
- Element B: Clinical Practice Guidelines (CPGs) & Care Transition Protocols (CTPs)
- Element C: Provider MOC training – What you're doing now!

MOC 3, Element A: Specialized Expertise

Factor	Description
1. Who is in the network?	The SFHP network is tailored to meet the specialized needs of our population (per MOC 1). It includes: • PCPs in Family Practice, Geriatrics, Internal Medicine, Nurse Practitioners, and PAs • Specialists (e.g., Cardiology, Dermatology, ENT, Allergy, Podiatry) • Behavioral Health (Psychologists, Social Workers) • Chiropractors, PT/OT/ST, Home Health, Palliative Care, Acute Hospitals, SNFs • All necessary licensed practitioners
2. How do we know we are specialized?	• Rigorous credentialing and recredentialing based on NCQA standards • Provider approval by SFHP's Physician Advisory Committee • Ongoing monitoring of licenses, qualifications, and exclusion/sanction databases • Providers participate in ICTs with verified expertise tailored to member needs
3. How do members know their providers?	• SFHP ensures provider directory accuracy through a systematic review process • Errors are validated and corrected promptly to maintain reliability
4. How do providers know about each other?	• Providers are active participants in Interdisciplinary Care Teams (ICTs) • Regular meetings foster collaboration and alignment on member care • Communication via phone, secure email, and a dedicated online portal • Providers access and update care plans and share input in real time through the portal • Care plans are co-developed, ensuring provider involvement and updated information

MOC 3, Element B:
Clinical Practice Guidelines (CPGs) & Care Transition Protocols (CTPs)

Category	Summary
CPG Identification	• 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).
Provider Access	• CPGs are posted on SFHP website, included in the provider manual, and available for discussion with the CMO.
Training & Education	• Regular provider workshops and trainings on guideline rationale, application, and updates. • Practical guidance provided to ensure clinical integration.
Monitoring & Oversight	• 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	• Continuous input collected via surveys, reviews, and communication. • QIHEC uses feedback to improve guidelines and protocols.
Communication & Collaboration	• Multiple channels: phone, secure email, online portal. • Providers are active participants in ICT meetings and care planning.
Care Transitions	• Formal protocols ensure smooth transitions and continuity of care. • Post-transition case reviews and debriefings promote quality improvement.
Ongoing Support	• SFHP offers technical resources and education at www.sfhp.org. • Providers encouraged to engage in care reviews and continuous improvement initiatives.

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- Practical guidance provided to ensure clinical integration.

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Provider Feedback Loop

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- QIHEC uses feedback to improve guidelines and protocols.

Communication & Collaboration

- Multiple channels: phone, secure email, online portal.
- Providers are active participants in ICT meetings and care planning.

Care Transitions

- Formal protocols ensure smooth transitions and continuity of care.
- Post-transition case reviews and debriefings promote quality improvement.

MOC 3, Element C: MOC Training

- Congratulations, you are here!
- All in-network and out-of-network providers who routinely see members need to be trained on the Model of Care every year.
- When you take the training, SFHP tracks completion to ensure that you and your colleagues on the ICT are equally familiar with the Model of Care, and each can be reminded when it is time to refresh.

MOC 4 Quality Measurement & Performance Improvement

MOC-4 describes:

- Quality performance improvement process including the quality department staff and how they relate to other departments
- How measurable goals are set
- Process for measuring patient experience
- Process for ongoing evaluation of MOC
- Communication of quality improvement plan and performance to stakeholders

MOC 4 Elements

Element A - MOC Quality Performance Improvement Plan	Outlines SFHP's quality improvement plan for SFHP Care Plus enrollees, including service delivery tailored to enrollee needs, use of data and performance measures, stakeholder involvement, and integration of measurable goals into overall performance.
Element B - Measurable Goals and Health Outcomes for the MOC	Defines measurable goals and outcomes for SFHP Care Plus enrollees, outlines methods to track and assess plan-level health impacts, and details procedures for evaluating progress and addressing unmet goals.
Element C - SNP Member Satisfaction	Explains the use of enrollee surveys for SFHP Care Plus, including rationale, administration, analysis, and integration of results into the MOC improvement plan to address identified issues.
Element D - Ongoing Performance Improvement Evaluation of the MOC	Describes how SFHP uses quality performance results to evaluate and improve the MOC, apply lessons learned, and share findings with key stakeholders.
Element E - Dissemination of SNP Qualify Performance related to the MOC	Outlines how and when SFHP shares performance results with stakeholders, including scheduled and ad hoc communications and responsible personnel.

Congratulations!

You have completed the SFHP MOC and Care Coordination Training.

Thank you for your dedication to provide Excellent, Quality Care to our SFHP CarePlus members!

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