Sonder Health A Medicare Advantage Company	
Department: Health Services Department	**Number:** HS-003
Title: Health Services Staffing and Training Overview	
Original Effective Date: 1/1/2021	**Latest Revision Date:** 8/28/2024

PURPOSE:

To provide a general overview of the staffing composition, qualifications and training protocols utilized by the Sonder Health Plans ("Sonder", "SHP") Health Services Department ("HSD") to ensure operational effectiveness, high standards of care, compliance with applicable regulatory standards and adoption of best practices by the Case Management, Disease Management, Quality, and Utilization Management staff.

DEFINITIONS:

- **Centers for Medicare & Medicaid Services (CMS)** - the U.S. federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program. CMS also works with the health care community to improve quality, equity, and outcomes in the health care system.

POLICY STATEMENT:

The Health Services Department functions, which includes Case Management, Disease Management, Quality, and Utilization Management, will be performed by individuals meeting the licensure and qualifications summarized below and as otherwise described in SHP's job descriptions and documents, such as the SNP Model of Care.

PROCEDURES:

SHP's Health Services Department is comprised of the following core staff members whose minimum licensure requirements, job responsibilities, and general training protocols are outlined below. These details are further elaborated in their respective job descriptions and other SHP documents, such as the SNP Model of Care.

1. STAFF ROLES, QUALIFICATIONS, AND GENERAL RESPONSIBILITIES

A. The Chief Medical Officer ("CMO") has a current and unrestricted license to practice medicine in the State of Georgia and holds either a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) degree. The CMO is board certified in internal medicine, family medicine, or other clinical discipline and has a minimum of 10 years of clinical experience, including direct patient care, with at least 5-7 years in a leadership role within a Medicare Managed Care Plan, Managed Care Organization (MCO), or a health insurance company. The CMO holds an executive leadership position and is responsible for overseeing clinical operations and ensuring regulatory compliance in the performance of duties (including those of direct reports). The Chief Medical Officer, with assistance from the VP of Health Services and/or Director of Health Services, provides strategic clinical leadership and oversight of the HSD to ensure the delivery of high-quality, cost-effective healthcare services to SHP's members. He/she leads the Health Services Committee.

B. **The Medical Director** has a current and unrestricted license to practice medicine in the State of Georgia and holds either a Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.)

degree. The Medical Director is responsible for ensuring the clinical accuracy of all organization determinations and reconsiderations involving medical necessity and works with and through SHP's Health Services Committee and HSD to guide the development and implementation of clinical policies, oversight of utilization management and quality improvement initiatives, and compliance with applicable regulatory requirements. As required by CMS, the Medical Director ensures policies and processes provide guidance on assessing and elevating issues of clinical concern and determining when the Medical Director's involvement is necessary.

C. **The VP of Health Services ("VP")** has a degree and experience in managing health services operations, including case and disease management, utilization management, and quality improvement. Reporting to the Chief Medical Officer, he/she has strategic oversight of all clinical operations and health services functions within SHP. This role ensures the delivery of high-quality, member-centric care while maintaining compliance with CMS guidelines, other relevant regulations, and contractual requirements. As a member of the executive team, he/she provides vision and leadership to the HSD, has operational accountability for HSD initiatives, and coordinates with appropriate personnel to achieve program goals and objectives.

D. **The Director of Health Services** ("Director") is a licensed Registered Nurse (RN) in the State of Georgia with experience in utilization management, case management, disease management and/or managed care. The Director of Health Services is responsible for leading, managing, staffing, and the daily oversight of the clinical functions of the HSD to include Utilization Management and Population Health (comprised of Care Management and Disease Management). This includes, but is not limited to, working with the Health Services team to ensure timely and appropriate care coordination; monitoring clinical performance; and managing staff development. He/she collaborates closely with the Chief Medical Officer, Medical Director(s), VP of Health Services, and other SHP teams to drive continuous improvement in care management processes and member satisfaction. This role involves developing and implementing strategies that promote efficient use of resources, improve clinical outcomes, and ensure compliance with quality initiatives and applicable regulatory standards.

E. **The Utilization Review Nurse** has an active and unrestricted RN license in the State of Georgia, and at least two years' experience with utilization management, case management, and/or clinical experience in a hospital, acute care, or managed care environment. The individual has a strong understanding of CMS and clinical guidelines and can make decisions based on established evidence-based and regulatory criteria for organization determinations, prior authorizations, concurrent reviews, and other applicable utilization management requests. They are responsible for reviewing and evaluating the medical necessity, appropriateness, and efficiency of healthcare services provided to SHP's members. The Utilization Review Nurse collaborates with physicians, healthcare providers, and members to facilitate timely authorization of services, prevent unnecessary costs, and promote optimal health outcomes.

F. **The Case Manager** has an active and unrestricted RN license in the State of Georgia and preferably is a Certified Case Manager (CCM). The individual has prior experience in case or disease management, managing acute chronic conditions, discharge planning, and working in a managed care environment. The role involves assessing members' health needs, developing, and adjusting individualized care plans, and collaborating with members, their families, and healthcare providers to manage chronic conditions, facilitate transitions of care, optimize health outcomes, and reduce hospital readmissions. The Case Manager also monitors members' progress and provides education and support to promote self-management.

G. **The Social Worker** is licensed in Social Work in the State of Georgia and is in good standing with the applicable state licensing board. He/she plays a critical role in addressing the psychosocial needs of members. They are responsible for assessing, coordinating, and providing resources and support services to enhance the overall health and well-being of SHP's members. They collaborate with case managers, physicians, SHP staff, community resources, and other healthcare professionals to develop comprehensive care plans that address both medical and social determinants of health. The Social Worker ensures that SHP members have access to community resources, counseling, and other support services to facilitate continuity of care and improve health outcomes.

H. **The Quality Director and/or Manager** is responsible for overseeing and managing all aspects of quality improvement initiatives to ensure that SHP meets or exceeds regulatory and accreditation standards. This role involves developing, implementing, and evaluation of quality improvement programs and activities, including the SNP Program, HEDIS (Healthcare Effectiveness Data and Information Set) reporting, STAR ratings, and other CMS quality measures. The Quality Manager and/or Director will collaborate with various departments, such as clinical, operations, and compliance to ensure that quality improvement activities align with organizational goals and regulatory requirements.

I. **Support Staff** have credentials as needed for roles identified by the VP of Health Services and/or the Director of the Health Services Department. Functions for support staff include the gathering of pertinent clinical documentation required to process authorization requests and/or the provision of the clerical support to department staff, including, but not limited to, data entry, preparing census reports, and case management/utilization management reports and activities.

2. TRAINING PROTOCOLS

A. **Initial:** New Health Services Department staff must complete all company mandated onboarding as well as company and department specific orientation requirements. In addition, the Health Services Department requires new staff to review and/or train on the following documents. Training may be instructor-led or self-paced depending on the SHP process in effect at the time of hire. Training records are maintained to provide evidence of completion.
   i. SHP's Health Services Department Policies, Procedures and Workflows
   ii. The current Physician/Provider Manual
   iii. SHP's Evidence of Coverage (EOC) and Summary of Benefits for each plan
   iv. The Member Rights/Responsibilities Document
   v. SHP's SNP Model of Care Training *(Must be completed within 30 days of hire)*

B. **Ongoing:** All staff within the Health Services Department must participate in ongoing training programs to maintain competency and ensure compliance with regulatory requirements and SHP's internal policies. Training will be conducted annually and/or as needed based on regulatory updates, organizational changes, or department requirements. Training records will be maintained to provide evidence of completion. Completion of SHP's SNP Model of Care Training is required annually.

C. **Inter Rater Reliability (IRR) Assessment –** Utilization Management Nurses will be evaluated at least annually using an IRR Assessment. The IRR assessment is a tool used to monitor and evaluate the consistent application of standardized clinical criteria and the accuracy of decision making of medical necessity determinations requests by Utilization Management (UM) nurses.

- **ATTACHMENT(S):**
- **STATUTORY REFERENCE(S):**
    - § 422.562(a)(4)) – Medical Director Responsibilities
    - CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance, Section 10.4.2, Role of the Medical Director
- **CONTRACT REFERENCE(S):** N/A
- **ELEMENT REFERENCE(S):** N/A
- **RELATED POLICY(S):**
    - SNP Models of Care