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San Francisco Health Plan 2025 Quality Improvement & Health Equity Transformation Program Evaluation

1. Introduction

The goal of the San Francisco Health Plan (SFHP) Quality Improvement and Health Equity Transformation Program (QIHETP) is to ensure high quality, equitable care and services for its members by proactively seeking opportunities to improve the performance of its internal operations and health care delivery system.

SFHP's QIHETP is detailed in the SFHP 2025 QIHETP Description. The QIHETP Description contains an annual Work Plan, outlined in Appendix A, representing the previous year's improvement activities and measure targets. The Work Plan is reviewed three times a year as well as consolidated annually. The QIHETP Evaluation provides a detailed review of progress towards the measures and goals set forth in the QIHETP Work Plan. In this evaluation, the results are presented for six activity domains:

- Access to Primary and Specialty Care
- Care Coordination and Continuity of Care
- Clinical Quality - Behavioral Health
- Clinical Quality – Medical Care
- Engagement with Primary Care
- Member Experience

1.1 Executive Summary

1.1.1 Oversight

Under the leadership of SFHP's Governing Board, the Quality Improvement and Health Equity Committee (QIHEC) oversees the development and implementation of the QIHETP and annual QIHETP Work Plan. The QIHEC and the QIHETP are supported by multiple committees including Utilization Management, Physician Advisory/Peer Review/Credentialing, Pharmacy and Therapeutics. The QIHETP is also supported by multiple other committees including Access Compliance, Grievance Program Leadership, Grievance Review, Policy and Compliance, Provider Quality Performance Program and Provider Network Oversight. SFHP's Quality Committees, under the leadership of the Chief Medical Officer (CMO) and Chief Health Equity Officer (CHEO), ensure ongoing and systematic involvement of SFHP's staff, members, medical groups, practitioners, and other key stakeholders where appropriate.

1.1.2 Participation in the QIHETP: Leadership, Practitioners, and Staff

Senior leadership, including the CMO and CHEO, provided key leadership for the QIHETP. SFHP's Chief Executive Officer (CEO) participates in the QIHETP by championing SFHP's NCQA accreditation journey as well as an organization-wide effort to improve member care and quality of service, namely by establishing organizational strategic priorities and ensuring resources to support key initiatives. In addition, the CEO ensures that Governing Board members receive regular reports and involvement on components of the QIHETP.

The CMO provides ongoing support for all quality improvement studies and activities and was responsible for leading the Quality Improvement and Health Equity Committee; Physician Advisory/Peer Review/Credentialing Committee; Pharmacy and Therapeutics Committee; and Grievance Program Leadership. The CMO leads key clinical improvement efforts, particularly

prioritizing and recommending interventions for clinical quality performance measures as represented in the QIHETP Work Plan.

Beyond SFHP senior leadership, SFHP achieved stakeholder participation in the QIHETP through provider and member involvement in key committees. Stakeholders participate in the QIHEC and the Provider Quality Performance (PQP) Advisory Committee that advises on the pay-for-performance program. SFHP QI staff also meet with QI representatives from the provider network in quarterly quality collaborative meetings. Overall, leadership and practitioner participation in the QIHETP in 2025 was robust and supported the execution of the QIHETP. In 2026, SFHP seeks to engage provider network leadership in quality committees and collaboratives to work together on quality activities and align QI and health equity priorities.

The QI staff is accountable for implementing the annual QIHETP Work Plan work, cross-functionally, to oversee and carry out quality improvement activities at SFHP. Staff monitor quality indicators, programs, and implement and evaluate SFHP's QIHETP work plan. In 2024, the CMO identified the need to establish a quality framework to accomplish an increasing set of quality measures that SFHP will be held accountable to, including Stars measures that will be part of SFHP's quality systems with the advent of SFHP becoming a Dual Special Needs plan in 2026. In 2025, SFHP sought to improve quality oversight and improvement through the development and implementation of this quality framework. Additionally in 2025, effective actions were taken to improve care where deficiencies were identified in the from the 2024 QIHET Program Evaluation and all planned follow-up activities were completed. In 2026, SFHP will foster staff collaboration via committees, provider & clinic engagement, and workgroups to maintain and improve quality measures and activities. For a detailed summary of all staff supporting the QIHETP, please refer to the 2026 Quality Improvement & Health Equity Transformation Program Description.

1.1.3 Highlights from the 2025 QI Program Measures

SFHP had positive outcomes during the 2025 QIHETP period. Of the 27 measures included in the 2025 QIHETP Evaluation, eleven, 41%, met the target. SFHP utilizes lessons learned from the 2025 QIHETP Evaluation to inform the 2026 QIHETP Work Plan and to drive continuous improvement in operations and outcomes.

In summary, SFHP identified the following areas from the QIHETP Work Plan as either demonstrating effectiveness or as opportunities for improvement.

1.1.3.1 Access to Primary and Specialty Care

Measure Title	Target Met
Routine Appointment Availability in Specialty Care	Yes
Timeliness of Prenatal Care	Yes

SFHP met both measure targets in this domain.

Notable improvements:

- Routine Appointment Availability in Specialty Care increased by 3.22%, exceeding the target with a final rate of 60.42% of specialty providers offering routine appointments within 15 business days.
- Timeliness of Prenatal Care increased by 5.02%, exceeding the target with a final rate of 88.82% of pregnant members receiving their prenatal care in the first trimester.

Recommendation for continued improvement:

- In addition to focusing on improvement of Timeliness of Prenatal Care for all SFHP pregnant members, SFHP identified the need to expand work in this measure to focus on improvement for Black/African-American members and will collaborate with SFHP's Enrollment Team to enhance perinatal health education information shared during monthly SF Pregnancy Family Village community outreach events which focus on Black/African American perinatal members.

1.1.3.2 Care Coordination and Continuity of Care

Measure Title		Target Met
Plan All-Cause Readmissions		Yes
Follow-Up After High-Intensity Care for Substance Use	7 Day	No
Follow-Up After Emergency Department Visit for Substance Use	30 Day	Yes
	7 Day	Yes
Follow-Up After Emergency Department Visit for Mental Illness	30 Day	Yes
	7 Day	Yes
Follow-Up After Hospitalization for Mental Illness	7 Day	Yes

SFHP met six out of seven measure targets in this domain.

Notable improvements:

- Two measures in this domain are key quality and organizational priorities that have both exceeded their targets: Follow Up After Emergency Department for Substance Use – 30 Day and Follow Up After Emergency Department for Mental Illness – 30 Day. SFHP is held accountable to attaining the 50th percentile for each measure and has reached that benchmark as of October 2025. Key activities that led to this include inclusion in SFHP's pay-for-performance program, incorporation of supplemental health records data from the provider network, and improvements to provider access to hospital discharge data.
- The four 7-Day indicators in this domain were included in the 2025 workplan to prioritize SFHP meeting NCQA Continuity and Coordination of Care Standard (Standard QI, Element 3): Follow Up After High-Intensity Care for Substance Use (FUI-7), Follow Up After Emergency Department for Substance Use (FUA-7), Follow Up After Emergency Department for Mental Illness (FUM-7), and Follow Up After Hospitalization for Mental Illness (FUH-7). While FUI-7 did not meet its target, each of the others exceeded their targets and met the 33rd or 66th percentile.

Recommendation for continued improvement:

- SFHP will expand its focus in Plan All-Cause Readmission through a 10-month Zuckerberg San Francisco General Hospital Enhanced Care Management Discharge Pilot (Sept 2025 – Jun 2026), with the objective to reduce all cause readmissions by 15% for members enrolled in the pilot compared to those members who were eligible but chose not to enroll in the pilot. This initiative to community health outcomes has also been included in SFHP's annual organizational goals, representing 10% of the weight of all goals.

1.1.3.3 Clinical Quality – Behavioral Health

Measure Title	Target Met
Depression Screening Follow-Up for Adults & Adolescents	No
Engagement of Substance Use Disorder Treatment	No

SFHP did not meet either of the two measure targets in this domain.

Notable improvement:

- While Engagement of Substance Use Disorder measure did not reach its target, it is on track to move from below the 10th percentile in 2024 performance to attaining the 10th percentile in 2025. This measure represents members engaging in substance use treatment and aligns with SFHP's commitment to ensuring that members receive follow-up care for behavioral and substance use needs.

Recommendation for improvement:

- In addition to focusing on improvement of Depression Screening Follow-Up for all SFHP members, SFHP identified the need to expand work in this measure to focus on improvement for Asian SFHP members and will collaborate with at least one provider or community partner serving the Asian-identified community to provide health education on depression screenings; focus on the importance of identifying depressive symptoms by completing screenings in order to schedule follow-up behavioral health services.

1.1.3.4 Clinical Quality – Medical Care

Measure Title	Target Met
Asthma Medication Ratio	No
Hepatitis C Treatment	No
Controlling Blood Pressure	No

SFHP did not meet any of the three measure targets in this domain.

Notable improvement:

- While SFHP did not meet target for 2025, the data as of October 2025 (73.56%) is performing at a higher rate than the same time in 2024 (66.70%) and is on track to at least maintain the same percentile achieved as in 2024.

Recommendation for continued improvement:

- In 2026, SFHP will shift focus to targeting improvement in health equity populations for the entirety of the Clinical Quality – Medical Care Domain, including Controlling Blood Pressure for Black/African American members and Glycemic Status Assessment for Patients with Diabetes for Latinx members.

1.1.3.5 Engagement with Primary Care

Measure Title		Target Met
Colorectal Cancer Screening		No
Breast Cancer Screening		No
Well-Child Visits in the First 15 Months of Life	0-15 months	No
	0-15 months; Latinx	No

Measure Title		Target Met
Topical Fluoride Application for Children		No
Initial Health Appointment		Yes
Developmental Screening for Children		Yes
Child and Adolescent Well-Care Visits	Black/African American	No
	Native-American, Alaska Native, Hawaiian Native & Other Pacific Islander	No

SFHP met two of nine measure targets in this domain.

Notable improvements:

- The Initial Health Appointment measure increased from baseline by 2.92%, exceeding its target with a final result of 24.82%. This result demonstrates the efforts made in 2025 to improve the performance, as performance from 2022 – 2024 plateaued between 21.00% and 21.90%. Interventions that impacted increased performance included sending monthly gap-in-care reports and rates to providers, expanding provider education, and issuing Medical Record Review Correction Action Plans to ensure providers' compliance with IHAs.
- SFHP is held accountable to meeting minimum performance of the median rate set by the Centers for Medicare and Medicaid for two measures: Developmental Screening for Children and Topical Fluoride Application for Children. While Developmental met target and Topical Fluoride did not, both measures increased from 2024 baseline, largely due to member incentives which promoted to members to receive these services. Primary care providers were also incentivized to improve Developmental Screening, which is attributed to why the measure met its target.

Recommendations for continued improvement:

- In 2025, SFHP initiated multiple health equity initiatives with performance targets for the measures Well-Child Visits in the First 15 Months of Life and Child & Adolescent Well-Care Visits, which included interventions such as live telephone outreach to schedule appointments and member incentives. While SFHP did not reach these health equity performance targets by October 2025 proactive data, SFHP will continue health equity initiatives for these measures in 2026 and expand to include health equity initiatives and performance targets for several more measures in this domain: Well-Child Visits in the First 15-30 Months of Life, Colorectal Cancer Screening, and Breast Cancer Screening.

1.1.3.6 Member Experience

Measure Title		Target Met
Health Plan CAHPS	Getting Needed Care - Adult	Yes
	Getting Needed Care - Child	No
	Getting Care Quickly - Adult	No
	Getting Care Quickly - Child	No

SFHP met one of four measure targets in this domain.

Notable improvement:

- Health Plan Consumer Assessment of Healthcare Providers and Systems (HP-CAHPS) Getting Needed Care access composite for the adult population increased by 7.17%,

exceeding the target with a final rate of 76.38%. This rate also met the NCQA 10th percentile based on NCQA MY 2024 benchmarks; this attainment marks the first time SFHP has attained a percentile at or above the 10th percentile for the Getting Needed Care adult score since SFHP began annual measurement of CAHPS in 2015. SFHP attributes this achievement to the multiple initiatives SFHP has implemented in the last few years, including communication campaigns to inform members on getting access to care and incentivizing primary care and specialty care providers to improve performance in access to care and member perception of access.

Recommendation for continued improvement:

- All remaining HP-CAHPS measures, Getting Needed Care for child members and Getting Care Quickly access composite for both adult and child members, did not reach their target and each fell below the 10th percentile based on NCQA MY 2024 benchmarks. Improvement to member perception of access to care is a key quality priority and has also been included in SFHP's annual organizational goals, representing 10% of the weight of all goals. In 2026 SFHP will implement organizational initiatives to improve the member care experience including holding primary care and specialty care providers to performance outcomes in HP-CAHPS and providing consultation and ongoing technical assistance with individual primary care clinics for improving appointment wait times and interventions to outreach members not engaged in primary care services.

2. Evaluation

2.1 Access to Primary and Specialty Care

The Access to Primary and Specialty Care domain incorporates all aspects of the services provided to members including customer service, language access, appointment access, and wait times.

2.1.1 Routine Appointment Availability in Specialty Care

2.1.1.1 Overview & Performance

Measure: Routine Appointment Availability in Specialty Care (PAAS)					
Numerator	429	Baseline	57.20%	Final Performance	60.42%
Denominator	710	Target	59.00%	Evaluation Year	2025

The measure is in the Access to Primary and Specialty Care domain. Increasing timely appointment availability improves access to care for members. This measure reflects activities designed to increase the percentage of specialty care appointments offered within 15 business days surveyed in the Provider Appointment Availability Survey set by the Department of Managed Health Care. This measure demonstrates SFHP's continued emphasis on connecting members to preventive care and chronic disease management to better manage their health. Increasing appointment availability may also support other QIHET program measures such as HEDIS and CAHPS, as members with timely specialty care visits are more likely to receive recommended care and members with a physician visit tend to score SFHP higher in CAHPS. SFHP set a target of 59.00% based on 1.80% absolute improvement from baseline.

2.1.1.2 Activities

The following activities were completed to support measure improvement in 2025:

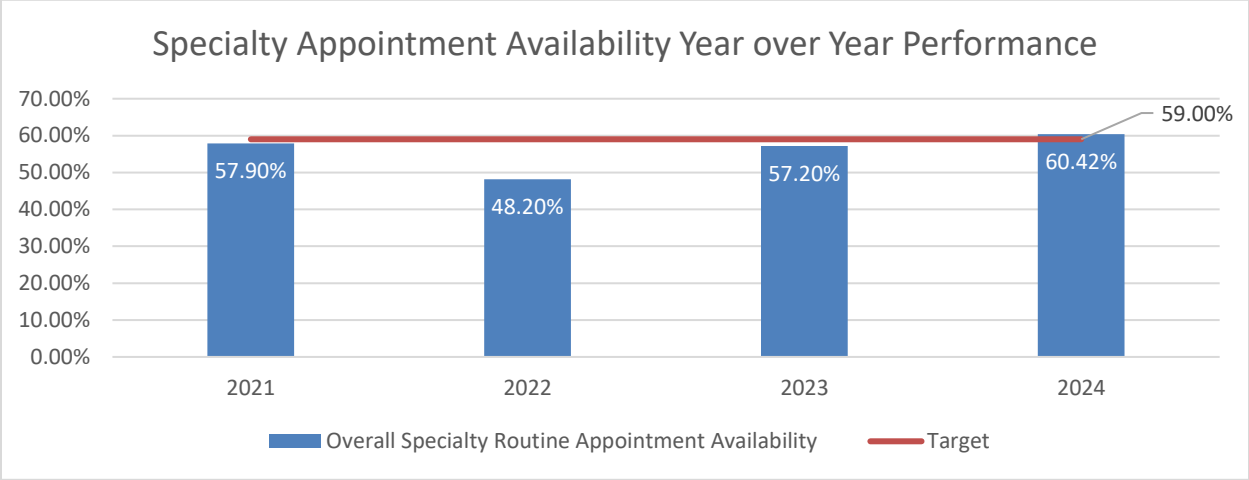
- Requested Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
    - 13 provider groups and clinics were issued corrective action plans.
- Provided technical assistance with Corrective Action Plans.
    - SFHP led technical assistance meetings with Hill Physicians Medical Group and San Francisco Behavioral Health Services to facilitate their access improvement plans.
- Provided funding to Zuckerberg San Francisco General Specialty Care providers to implement appointment access interventions. Through this grant, Zuckerberg San Francisco General conducted the following improvements:
    - Specialty clinic staff were re-trained on core eligibility knowledge elements, scheduling functions in electronic health record software, and how to sign-up patients for the new multi-lingual texting platform that allows patients to request rescheduling of specialty care appointments.
    - Specialty care leadership team and patient access leadership team engaged front line stakeholders to review the standard work for common patient access workflows and revised specialty care scheduling templates to optimize use of visit slots.

    - Specialty care staff conducted a Kaizen that consisted of direct observations, data analysis, and implementation of PDSAs to optimize clinic workflows, including front office registration, communication between front office and back-office staff, and patient clinics.
    - Arranged additional telehealth clinics and in-person evening and Saturday clinics the most highly impacted specialties. Grant funds were used to pay SFDPH staff and UCSF clinicians for this over time work.
- Incentivized Zuckerberg San Francisco General providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.

2.1.1.3 Analysis

2.1.1.3.1 Quantitative

The final result of 60.42% exceeded the target of 59.00% by 1.42%.



2.1.1.3.2 Qualitative

While SFHP achieved the target, several barriers to improving specialty appointment availability were:

- Provider groups report a recruiting problem for all specialties largely because of the cost of living in the San Francisco Bay Area.
- Supply of providers – some provider groups' supply of appointments with providers is fixed due to resident and attending schedules or the number of part time providers working in a specific system or clinic.
- Variation in use of emerging appointment reminders, self-scheduling technology, and alternative visits – provider groups demonstrate uneven uptake or implementation of technologies such as telemedicine, electronic appointment reminders, and member self-scheduling. Provider groups also show uneven uptake of alternative visits such as nurse visits or group visits. Electronic tools are less optimized for low literacy or non-English speaking member and may require customizations or additional investments to fully leverage.
- Team based care – some clinics and health systems effectively utilize care team members to ensure good access while other settings may not be able to employ or as effectively utilize other licensed providers (e.g. health educator, pharmacist, behavioral health clinician).

- Electronic consult for specialty care – with the right technology in place, many consults can be managed without the need for a face-to-face visit. Different specialty care arrangements and coordination efforts as well as very recent changes in reimbursement options impact access to and timeliness of specialty care.
- Social determinants of health – transportation, housing and employment related barriers can impact members' ability to make and keep appointments. Missed appointments that go unused can contribute to poorer access.

To address these barriers, SFHP will:

- Review how CAPs are issued. Rather than focusing on the results at a provider level, focusing on availability at the site level paints a better picture on access. Quality Improvement, Compliance and Regulatory Affairs, and the Provider Network Management departments will conduct the review and propose the changes to the Access Compliance Committee at the Q4 2025 meeting.

2.1.1.4 Recommendations

SFHP will continue this measure in 2026 with a target of 63.00% to demonstrate incremental improvement. Activities to support improvement will include:

- Continue to request Corrective Action Plans of provider groups performing below 80% compliance rate and below 50% response rate.
- Provide technical assistance with Corrective Action Plans.
- Continue to incentivize Zuckerberg San Francisco General providers through inclusion of a third next available monitoring measure in SFHP's specialty pay-for-performance program.

2.1.2 Timeliness of Prenatal Care

2.1.2.1 Overview & Performance

Measure: Timeliness of Prenatal Care (PPC-Pre)					
Numerator	1,080	Baseline	83.80%	Final Performance	88.82%
Denominator	1,216	Target	86.89%	Evaluation Year	2025

The Timeliness of Prenatal Care (PPC-Pre) measure is in the Access to Primary & Specialty Care domain. This measure reflects activities designed to increase the percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization. SFHP chose the target of 86.89% based on meeting the 66th percentile based on NCQA MY 2023 benchmarks.

2.1.2.2 Activities

The following activities were completed to support measure improvement in 2025:

- Promoted and encouraged pregnant members to engage in services through a member incentive for both prenatal and postpartum visit.
    - As of November 2025, a total of 661 gift cards were distributed to members for prenatal visits. The top three medical groups that members who received a prenatal

visit gift card were assigned to San Francisco Health Network (312), North East Medical Services (130), and Community Clinic Network (123).

- Incentivize providers through inclusion of a prenatal measure and a health equity prenatal measure in SFHP's primary and specialty care pay-for-performance programs.
    - Some of the primary care providers participating in the provider incentive program were eligible for the PPC-Pre measure incentive, including three out of seven provider groups and two out of eight independent clinics.
    - While PPC-Pre was offered as a choice for health equity measure among other choices, no participant chose this option.
- Distributed prenatal education booklets to providers, SFHP Service Center, and community partners to share with members.
    - A total of 552 perinatal education booklets were distributed to seven centers including Provider Clinics, SFHP Service Center, SFHP Care Management, an ECM Provider, two Family Resource Centers and a Doula network. The top three languages requested were English, Spanish and Chinese.

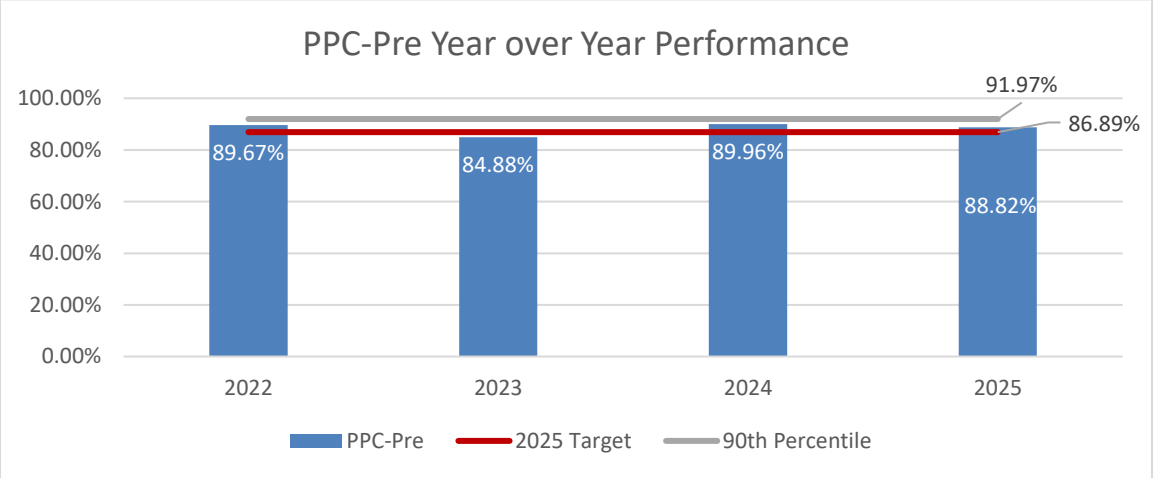
The following activities were not completed:

- Survey providers to understand best practices and identify areas for quality improvement at member or clinic level.
    - An optional survey was sent to five providers; SFHP received no responses.

2.1.2.3 Analysis

2.1.2.3.1 Quantitative

The result of 88.82% exceeded the target of 86.89% by 1.93% and is estimated to achieve the 66th percentile based on NCQA MY 2024 benchmarks – 88.56%.



2.1.2.3.2 Qualitative

The measure exceeded the target of 86.89%. A number of activities contributed to the success of this measure including activities at the member level including member incentives and SFHP's provider pay-for-performance program.

2.1.2.4 Recommendations

SFHP will continue PPC-Pre with both overall and Health Equity populations in the 2026 QIHE Workplan with new targets of:

- Overall population: 91.97% to meet the 90th percentile based on NCQA MY 2024 benchmarks
- Black/African American population: 86.37% to meet the 50th percentile based on NCQA MY 2024 benchmarks.

Activities to support improvement will include:

- Continue to promote and encourage pregnant members to engage in services through a member incentive for both prenatal and postpartum visit.
- Continue to incentivize Providers through inclusion of a prenatal measure and a health equity prenatal measure in SFHP's primary and specialty care pay-for-performance programs.
- Collaborate with Enrollment Team to enhance perinatal health education information shared during monthly SF Pregnancy Family Village community outreach event which focuses on Black/African American perinatal members.

2.2 Care Coordination and Continuity of Care

The domain of Care Coordination and Continuity of Care involves activities related to Long Term Care Quality, Care Transitions, Care Management, Enhanced Care Management, monitoring of over and underutilization, and otherwise improved coordination across multiple providers and facilities and focuses on members with more complex medical and psychosocial needs.

2.2.1 Plan All-Cause Readmissions

2.2.1.1 Overview & Performance

Measure: Plan All-Cause Readmissions (PCR)					
Numerator	9.99%	Baseline	1.1465	Final Performance	1.0714
Denominator	9.32%	Target	1.1783	Evaluation Year	2025

The Plan All-Cause Readmission (PCR) measure is part of the Care Coordination and Continuity of Care Domain. The goal of this measure is to decrease the ratio of the observed rate of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days compared to the predicted probability of an acute readmission. SFHP chose the target of 1.1783 to meet the 10th percentile before the 2024 rates were finalized; the baseline was initially set at 1.3507 which placed SFHP below the 5th percentile based on NCQA MY 2023 benchmarks. The final rate of 1.1465 met the benchmark of the 33rd percentile.

2.2.1.2 Activities

The following activities were completed to support measure improvement in 2025:

- Shared daily Admission, Discharge, and Transfer (ADT) data with nine delegated medical groups and nine community clinics via secure SFTP file transfer. This resulted in outreach, scheduling and follow-up with an ambulatory provider within seven calendar days of discharge for 4727 out of 10,567 (44.7%) SFHP members (January 2024 to July 2025).
- Provided Transitional Care Services via SFHP Care Management staff to 1,126 high risk

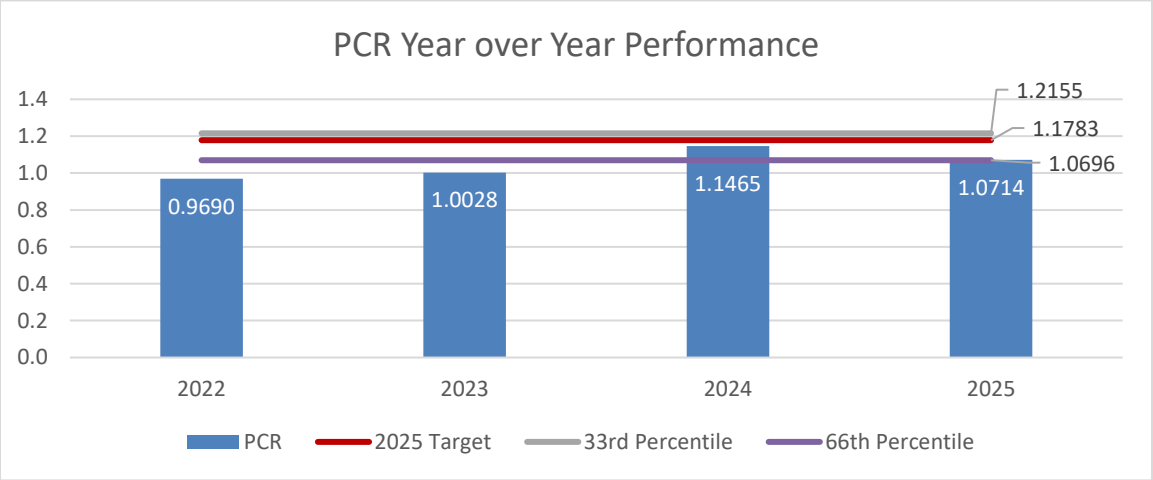
members connected to the SFHP Direct network (January 2025 to July 2025).

- Conducted 10 audits of contracted providers; identified and addressed a key barrier by ensuring providers had access to and understood how to export ADT feeds.
- Attended seven Joint Operations Meetings with provider partners to share updates and best practices and receive feedback from delegated medical groups.
- Created a facility insert, approved by DHCS, outlining the definition of Transitional Care Services and promoting the dedicated Transitional Care Services intake line; partnered with network hospitals and Skilled Nursing Facilities to integrate this insert into the discharge documentation or after visit summaries for SFHP Medi-Cal members.
- Launched a 10-month Zuckerberg San Francisco General Hospital Enhanced Care Management Discharge Pilot (Sept 2025 – Jun 2026), with the objective to reduce all cause readmissions by 15% for members enrolled in the pilot compared to those members who were eligible but chose not to enroll in the pilot.

2.2.1.3 Analysis

2.2.1.3.1 Quantitative

For Plan All-Cause Readmission, a lower rate is better. The final result of 1.0714 exceeded meet the target of 1.1783 by 0.1069 and will likely attain the 33rd percentile based on NCQA MY 2024 benchmarks – by being below 1.2155.



2.2.1.3.2 Qualitative

Measured over a seven-month period, SFHP Direct Network Transitional Care Services member participants had a 42.7% reduction in readmission rates within 30 days of discharge compared to members who did not participate in Transitional Care Services.

Although SFHP met its target, a key barrier identified was found with one Provider Group, San Francisco Health Network, which offers Transitional Care Services only to members enrolled in their Enhanced Care Management program; this excludes a majority of SFHP members who fall into the PCR numerator and limits their access to Transitional Care Services to reduce readmission rates. Additionally, SFHP's delegated medical groups and partner clinics showed consistent challenges with accessing the daily Admission, Discharge, and Transfer (ADT) reports being sent by SFHP. This limited providers' ability to identify and engage SFHP members in need of transition support.

To address these barriers, SFHP worked internally to address ITS limitations and improve access to ADT feeds for additional users. SFHP also implemented a 10-month pilot with Zuckerberg San Francisco General Hospital, the largest provider in San Francisco Health Network to increase enrollment to Enhanced Care Management and eligibility for TCS. This pilot launched in September 2025 and will continue through June 2026.

2.2.1.4 Recommendations

SFHP will continue this measure in 2026 with a new target of 1.0696 to meet the 66th percentile; activities to support this measure will include:

- Ensure Provider access to daily ADT census reports used to identify new admissions, discharges, and transfers, and support care coordination for SFHP members.
- Participate in quarterly Joint Operations Meetings with delegated medical groups and contracted partners to share feedback and best practice and escalate issues across the network.
- Collaborate with contracted provider, Zuckerberg San Francisco General in conjunction with the 10-month pilot, to increase SFHP members' participation in Enhanced Care Management (ECM) and track readmission rates for ECM members participating in Transitional Care Services provided by ZSFG.

2.2.2 Follow-Up After High-Intensity Care for Substance Use Disorder

2.2.2.1 Overview & Performance

Measure: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI-7)					
Numerator	53	Baseline	21.68%	Final Performance	22.75%
Denominator	233	Target	23.08%	Evaluation Year	2025

The Follow-Up After High-Intensity Care for Substance Use Disorder 7-Day (FUI-7) measure is in the Care Coordination and Continuity of Care domain. This measure reflects activities intended to increase the percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder within seven days. This measure represents SFHP's commitment to ensuring that members receive follow up care for members with behavioral health needs and aligns with NCQA standards in improving performance on continuity and coordination of care measures. SFHP chose the target for FUI-7 based on meeting the 25th percentile based on NCQA MY 2023 benchmarks.

2.2.2.2 Activities

The following activities were completed to support measure improvement in 2025:

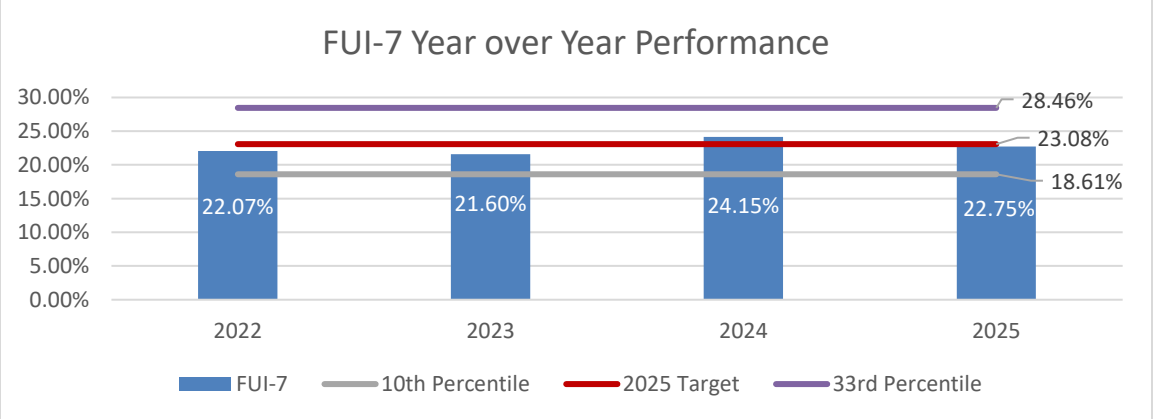
- Shared with 12 network providers data of hospital admissions of members eligible for Follow-Up After High-Intensity Care for Substance Use Disorder to facilitate follow-up outreach and scheduling of PCP appointments.
    - January to June 2025: SFHP informed SFHP's network groups and individual clinics of members needing care coordination via weekly files of members being Admitted, Discharged, and Transferred (ADT) from hospitals and emergency departments.

    - July to December 2025:
        - Increase in frequency: SFHP increased communication to daily (weekday) to the primary care network groups and individual clinics advising them of a pending discharge and need to coordinate care.
        - Making the data actionable via HEDIS denominators: These daily files contain member and discharge information as well as which care coordination HEDIS measure is applicable to the member, including FUI-7; i.e. which care coordination denominator the member falls into. The daily files also contain members' frequency of ED use and Enhanced Care Management eligibility and enrollments status.
        - These new data reports aim to improve providers' ability to know who to target for timely follow-up.
- Partnered with PCP sites to get them access to a live ADT feed of the daily SFHP data.
    - January to July 2025: contracted Enhanced Care Management have direct access to a portal to access live members being admitted, discharged, and transferred (ADT) from hospitals and emergency departments; however, this portal does not have the feature to identify the applicable HEDIS measure for each member.
    - August & September 2025: SFHP piloted expanding the Enhanced Care Management ADT portal to include HEDIS measure identification through partnership with a local community clinic - St. Anthony's Medical Clinic. This pilot gave the local community clinic information on which members who were hospitalized needed care aligned with FUI-7.
    - October 2025: SFHP spread the improvement of Enhanced Care Management ADT portals to include HEDIS measure identification to North East Medical Services.
- Provided SFHP's network groups and individual clinics with provider education resources. In May 2025, SFHP created the Provider Measure Guide for Follow-Up After High-Intensity Care for Substance Use Disorder and made it available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.

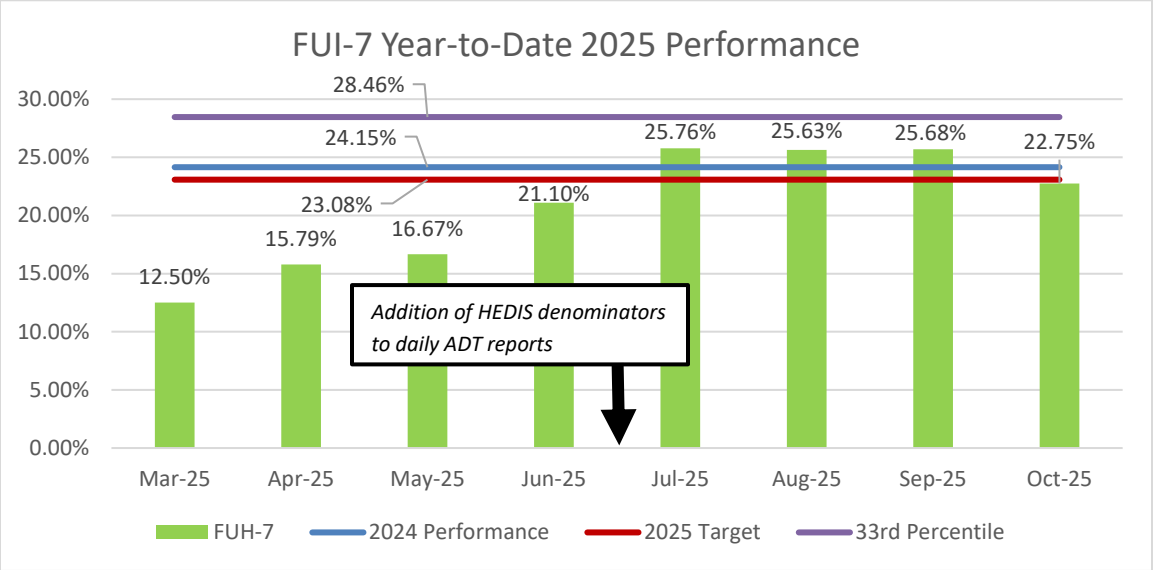
2.2.2.3 Analysis

2.2.2.3.1 Quantitative

The final result of FUI-7 is 22.75%, which did not meet the target by 0.33% and is estimated to achieve the 10th percentile based on NCQA MY 2024 benchmarks – 18.61%. While SFHP did not meet target for 2025, the measure data is expected to improve by end of the year.



The chart below demonstrates FUI-7 performance throughout 2025 up to the most recent data available, starting in March 2025 when SFHP began to measure monthly performance. The chart is annotated with an arrow showing when the ADT data was improved to include applicable HEDIS denominators



2.2.2.3.2 Qualitative

Providers face barriers offering care coordination follow-up care to members after hospitalization for substance use, including member contact information, transportation to get to appointments, and obtaining timely appointments. Another barrier that providers raised to SFHP staff in 2025 was in not knowing which members in the daily Admission Discharge & Transfer report were in the denominator to FUI-7 versus other care coordination measures. In response to this barrier, SFHP staff initiated the activities to improve reporting of daily data. This change is reflected in the increase in rate in July immediately after the change in reporting was introduced.

2.2.2.4 Recommendations

SFHP will continue this measure in 2026 with a new target of 28.46% to attain the 33rd percentile; activities to support this measure will include:

- Share with network providers data of hospital admissions of members eligible for Follow-Up After Hospitalization for Mental Illness to facilitate follow-up outreach and scheduling of a PCP appointments.
- Partner with network providers to get them access to live hospital admissions data.

2.2.3 Follow up After Emergency Department for Substance Use

2.2.3.1 Overview & Performance

Measure: Follow up After Emergency Department for Substance Use – 30 Day (FUA-30)					
Numerator	704	Baseline	30.32%	Final Performance	42.56%
Denominator	1,654	Target	36.18%	Evaluation Year	2025
Measure: Follow up After Emergency Department for Substance Use – 7 Day (FUA-7)					
Numerator	462	Baseline	18.13%	Final Performance	27.93%
Denominator	1,654	Target	24.00%	Evaluation Year	2025

The Follow up After Emergency Department for Substance Use (FUA) measure is in the Care Coordination and Continuity of Care domain. This measure calculates the percentage of SFHP members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence, who had a follow up visit for substance use disorder within seven (FUA-7) or 30 (FUA-30) days after ED visit, out of the total number of SFHP members who had an ED visit with a principal diagnosis of substance use disorder.

This measure represents SFHP's commitment to ensuring that members receive follow up care for members with substance use issues and SFHP is held accountable to improvement in FUA-30 by DHCS; SFHP is at risk of incurring fines and non-monetary penalties if the 50th percentile is not reached. SFHP chose the target for FUA-30 & FUA-7 based on meeting the 50th percentile based on NCQA MY 2023 benchmarks.

2.2.3.2 Activities

The following activities were completed to support measure improvement in 2025:

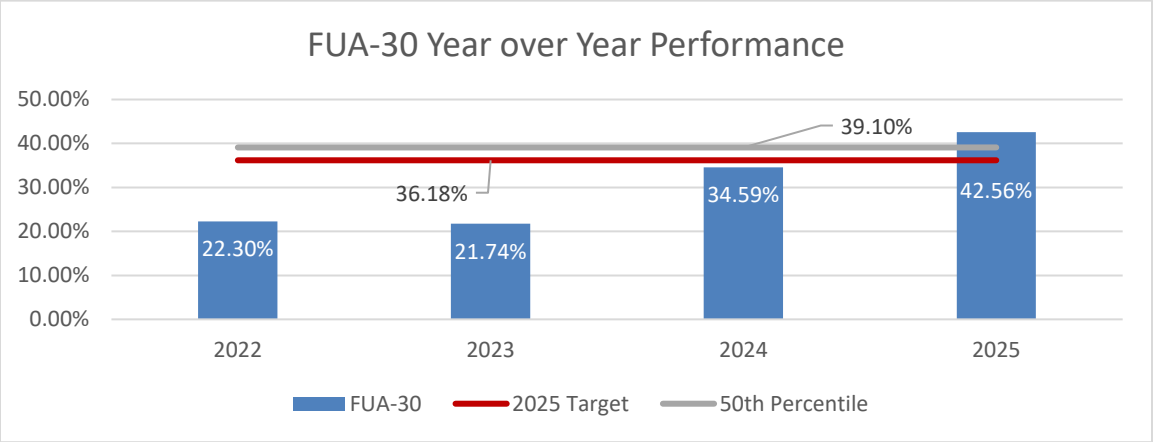
- Emergency Department Navigators assisted members with connections to providers. SFHP worked with three emergency departments by providing grant funding to support care coordination work. The emergency departments trained their care management staff in arranging follow-up care for SFHP members visiting the ED.
- Shared with network providers data of hospital and ED admissions of members eligible for FUA to facilitate follow-up outreach and scheduling of PCP appointments.
    - In July 2025, SFHP increased sharing of these reports with providers from weekly to daily on weekdays to the primary care network groups and individual clinics advising them of a pending discharge and need to coordinate care.
    - These daily files contain member and discharge information as well as which care coordination HEDIS measure is applicable to the member, including FUA.
- SFHP received supplemental health records data from the provider network which included follow-up visit data from county-affiliated providers.
- Incentivized providers through inclusion of a FUA-30 measure in SFHP's primary care pay-for-performance program. Most of the primary care providers participating in the provider incentive program were eligible for the FUA-30 measure incentive, including five out of seven provider groups and six out of eight independent clinics.

- Provided SFHP's network groups and individual clinics with provider education resources. In May 2025, SFHP created the Provider Measure Guide for Follow up After Emergency Department for Substance Use and made it available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.

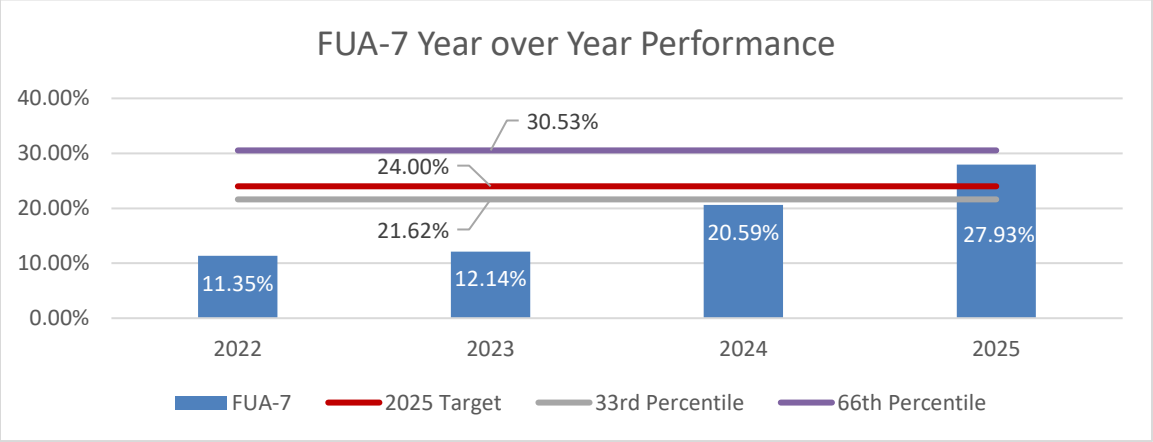
2.2.3.3 Analysis

2.2.3.3.1 Quantitative

The result for FUA-30 of 42.56% exceeded the target of 36.18%. The measure has steadily improved since 2023 and is estimated to achieve the 50th percentile based on NCQA MY 2024 benchmarks – 39.10%.



The result for FUA-7 of 27.93% met the target of 24.00% by 3.93%. The measure has steadily improved since 2023 and will likely maintain the 33rd percentile based on NCQA MY 2024 benchmarks – 39.10%.



2.2.3.3.2 Qualitative

While SFHP achieved both FUA-7 and FUA-30 targets, several barriers were identified while implementing improvement initiatives:

- Contact information: primary care provider report difficulty in reaching some members; for example, working phone numbers is a challenge that has been cited by provider and plan staff.

- Lack of previous engagement: providers also state difficulty in reaching members who have never been previously engaged in care with them.

To address these barriers, SFHP will continue to develop strategies to update member contact information and engage members with their assigned primary care providers.

2.2.3.4 Recommendations

SFHP will retire FUA-7 in 2026 but will continue to monitor this measure. SFHP will continue FUA-30 in the 2026 QIHE Workplan with a new target of 43.24% to meet the 66th percentile based on NCQA MY 2024 benchmarks; activities to support this measure will include:

- Continue to share with network providers ED visit data of members eligible for Follow-Up After ED Visit for Substance Use to facilitate follow-up outreach and scheduling of a PCP appointments.
- Continue to incentivize providers through inclusion of a Follow-Up After ED Visit for Substance Use 30-day measure in SFHP's primary care pay-for-performance program.
- Improve member contact information in order for providers to outreach members for follow-up care. Offer technical assistance to providers to update member contact info in shared electronic health records.
- Provide individual consultation/ongoing technical assistance to primary care providers to address questions.

2.2.4 Follow up After Emergency Department for Mental Illness

2.2.4.1 Overview & Performance

Measure: Follow up After Emergency Department for Mental Illness – 30 Day (FUM-30)					
Numerator	1,110	Baseline	47.75%	Final Performance	60.76%
Denominator	1,827	Target	53.82%	Evaluation Year	2025
Measure: Follow up After Emergency Department for Mental Illness – 7 Day (FUM-7)					
Numerator	871	Baseline	29.88%	Final Performance	47.67%
Denominator	1,827	Target	38.62%	Evaluation Year	2025

The Follow up After Emergency Department for Mental Health (FUM) measure is in the Care Coordination and Continuity of Care domain. This measure calculates the percentage of SFHP members age six and older who received a follow-up visit for mental illness within seven (FUM-7) and 30 (FUM-30) days of an emergency department visit with a diagnosis of mental illness or intentional self-harm out of the total number of SFHP members who had an ED visit with a diagnosis of mental illness or intentional self-harm.

This measure represents SFHP's commitment to ensuring that members receive follow up care for members with mental health issues and SFHP is held accountable to improvement in FUM-30 by DHCS; SFHP is at risk of incurring fines and non-monetary penalties if the 50th percentile is not reached. SFHP chose the targets for both FUM-30 & FUM-7 based on meeting the 50th percentile based on NCQA MY 2023 benchmarks.

2.2.4.2 Activities

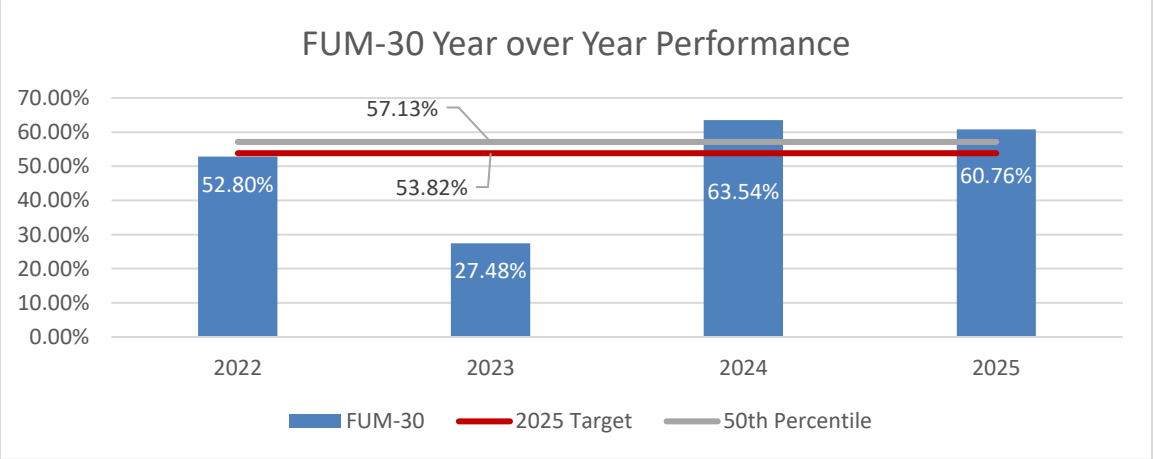
The following activities were completed to support measure improvement in 2025:

- Emergency Department Navigators assisted members with connections to providers. SFHP worked with three emergency departments by providing grant funding to support care coordination work. The emergency departments trained their care management staff in arranging follow-up care for SFHP members visiting the ED.
- Shared with network providers data of hospital and ED admissions of members eligible for FUM to facilitate follow-up outreach and scheduling of PCP appointments.
    - In July 2025, SFHP increased sharing of these reports with providers from weekly to daily on weekdays to the primary care network groups and individual clinics advising them of a pending discharge and need to coordinate care.
    - These daily files contain member and discharge information as well as which care coordination HEDIS measure is applicable to the member, including FUM.
- SFHP received supplemental health records data from the provider network which included follow-up visit data from county-affiliated providers.
- Incentivized providers through inclusion of a FUM-30 measure in SFHP's primary care pay-for-performance program. Most of the primary care providers participating in the provider incentive program were eligible for the FUM-30 measure incentive, including five out of seven provider groups and six out of eight independent clinics.
- Provided SFHP's network groups and individual clinics with provider education resources. In May 2025, SFHP created the Provider Measure Guide for Follow-up after Emergency Department for Mental Illness and made it available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.

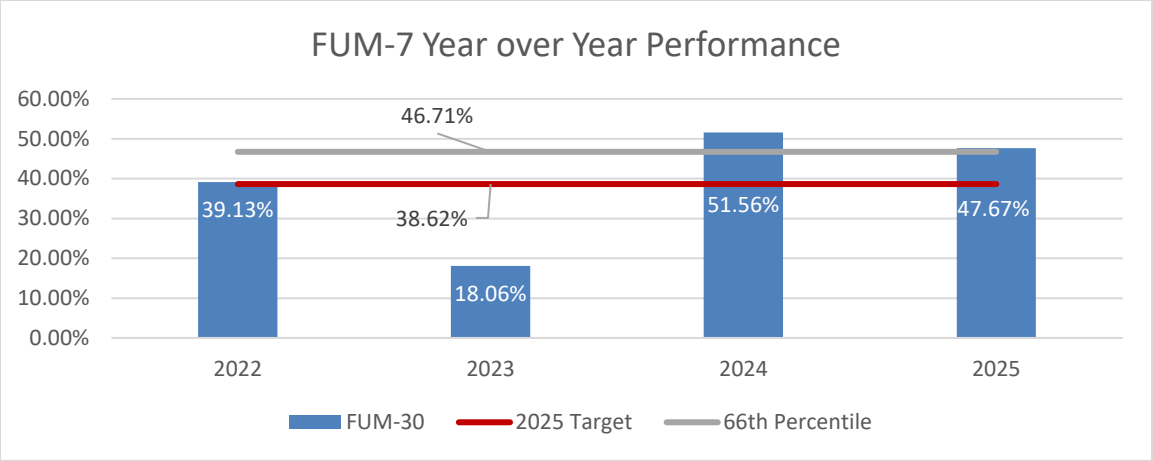
2.2.4.3 Analysis

2.2.4.3.1 Quantitative

The result for FUM-30 of 60.76% met the target of 53.82% by 6.94%. The measure has steadily improved since a dip in performance in 2023 and will likely attain the 50th percentile based on NCQA MY 2024 benchmarks – 57.13%.



The result for FUM-7 of 47.67% met the target of 38.62% by 9.05%. The measure has steadily improved since a dip in performance in 2023 and will likely maintain the 66th percentile based on NCQA MY 2024 benchmarks – 46.71%.



2.2.4.3.2 Qualitative

While SFHP achieved both FUM-7 and FUM-30 targets, several barriers were identified which implementing improvement initiatives:

- Contact information: primary care provider report difficulty in reaching some members; for example, working phone numbers is a challenge that has been cited by provider and plan staff.
- Lack of previous engagement: providers also state difficulty in reaching members who have never been previously engaged in care with them.

To address these barriers, SFHP will continue to develop strategies to update member contact information and engage members with their assigned primary care providers.

2.2.4.4 Recommendations

SFHP will retire FUM-7 in 2026 but will continue to monitor this measure. SFHP will continue FUM-30 in the 2026 QIHE Workplan with a new target of 62.41% to meet the 66th percentile based on NCQA MY 2024 benchmarks; activities to support this measure will include:

- Continue to share with network providers ED visit data of members eligible for Follow-Up After ED Visit for Mental Illness to facilitate follow-up outreach and scheduling of a PCP appointments.
- Continue to incentivize providers through inclusion of a Follow-Up After ED Visit for Mental Illness 30-day measure in SFHP's primary care pay-for-performance program.
- Improve member contact information in order for providers to outreach members for follow-up care. Offer technical assistance to providers to update member contact info in shared electronic health records.
- Provide individual consultation/ongoing technical assistance to primary care providers to address questions.

2.2.5 Follow-Up After Hospitalization for Mental Illness

2.2.5.1 Overview & Performance

Measure: Follow-Up After Hospitalization for Mental Illness (FUH-7)					
Numerator	46	Baseline	11.11%	Final Performance	46.46%
Denominator	99	Target	18.10%	Evaluation Year	2025

The Follow-Up After Hospitalization for Mental Illness 7-Day (FUH-7) measure is in the Care Coordination and Continuity of Care domain. This measure reflects activities intended to increase the percentage of discharges for members six years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service within seven days. This measure represents SFHP's commitment to ensuring that members receive follow up care for members with behavioral health needs and aligns with NCQA standards in improving performance on continuity and coordination of Care Measures. SFHP chose the target for FUH-7 based on meeting the 5th percentile based on NCQA MY 2023 benchmarks.

2.2.5.2 Activities

The following activities were completed to support measure improvement in 2025:

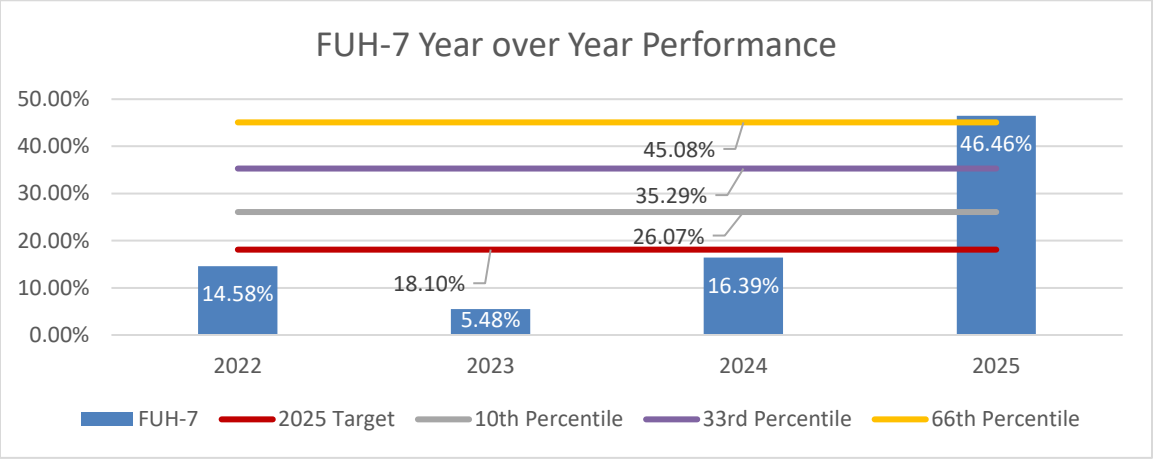
- Shared with 12 network providers data of hospital admissions of members eligible for Follow-Up After Hospitalization for Mental Illness to facilitate follow-up outreach and scheduling of PCP appointments.
    - January to June 2025: SFHP informed SFHP's network groups and individual clinics of members needing care coordination via weekly files of members being Admitted, Discharged, and Transferred (ADT) from hospitals and emergency departments.
    - July to December 2025:
        - Increase in frequency: SFHP increased communication to daily (weekday) to the primary care network groups and individual clinics advising them of a pending discharge and need to coordinate care.
        - Making the data actionable via HEDIS denominators: These daily files contain member and discharge information as well as which care coordination HEDIS measure is applicable to the member, including FUH-7; i.e. which care coordination denominator the member falls into. The daily files also contain members' frequency of ED use and Enhanced Care Management eligibility and enrollments status.
        - These new data reports aim to improve providers' ability to know who to target for timely follow-up.
- Partnered with PCP sites to get them access to a live ADT feed of the daily SFHP data.
    - January to July 2025: Contracted Enhanced Care Management have direct access to a portal to access live members being admitted, discharged, and transferred (ADT) from hospitals and emergency departments; however, this portal does not have the feature to identify the applicable HEDIS measure for each member.
    - August & September 2025: SFHP piloted expanding the Enhanced Care Management ADT portal to include HEDIS measure identification through

partnership with a local community clinic - St. Anthony's Medical Clinic. This pilot gave the local community clinic information on which members who were hospitalized needed care aligned with FUH-7.
    - October 2025: SFHP spread the improvement of Enhanced Care Management ADT portals to include HEDIS measure identification to North East Medical Services.
- Provided SFHP's network groups and individual clinics with provider education resources. In May 2025, SFHP created the Provider Measure Guide for Follow-Up After Hospitalization for Mental Illness and made it available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.

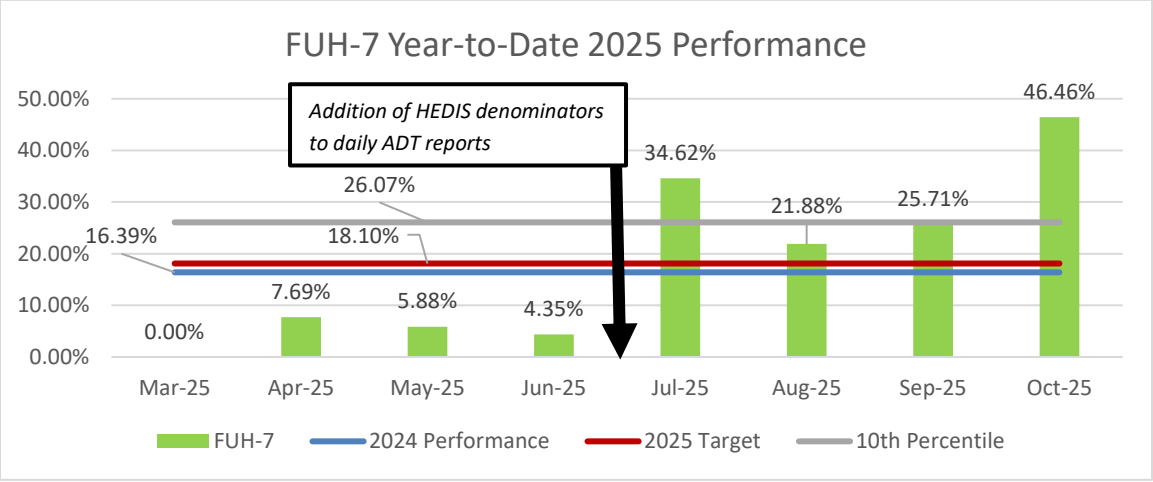
2.2.5.3 Analysis

2.2.5.3.1 Quantitative

The final result of FUH-7 is 46.46%, exceeding the target by 28.36% and is estimated to achieve the 66th percentile based on NCQA MY 2024 benchmarks – 45.08%. The measure has steadily improved since a dip in performance 2023, as shown by the following chart.



The chart below demonstrates FUH-7 performance throughout 2025 up to the most recent data available, starting in March 2025 when SFHP began to measure monthly performance. The chart is annotated with an arrow showing when the ADT data was improved to include applicable HEDIS denominators.



2.2.5.3.2 Qualitative

In addition to the positive impact from the implemented activities, FUH-7 measure increased greatly in performance from 2024 to 2025 due to a change in specification; previously measure only allowed follow-up care to be counted if it was submitted as the primary diagnosis. The change allows for that diagnosis in any field, not just primary diagnosis.

While this measure did attain its target, providers do face barriers offering care coordination follow-up care to members after hospitalization for mental illness, including member contact information, transportation to get to appointments, and obtaining timely appointments. Another barrier that providers raised to SFHP staff in 2025 was in not knowing which members in the daily ADT report were in the denominator to FUH-7 versus other care coordination measures. In response to this barrier, SFHP staff initiated the activities to improve reporting of daily data. This change is reflected in the spike in rate in July immediately after the change in reporting was introduced.

2.2.5.4 Recommendations

SFHP will retire FUH-7 in 2026 but will continue to monitor this measure.

2.3 Clinical Quality - Behavioral Health

The domain of Clinical Quality – Behavioral Health involves activities related to clinical outcomes of behavioral health chronic condition care management.

2.3.1 Depression Screening Follow-Up for Adults & Adolescents

2.3.1.1 Overview & Performance

Measure: Depression Screening Follow-Up for Adults & Adolescents (DSF-E-FU)					
Numerator	1,672	Baseline	63.90%	Final Performance	67.34%
Denominator	2,483	Target	70.91%	Evaluation Year	2025

The Depression Screening – Follow-Up for Adolescents and Adults (DSF-E-FU) measure is in the Clinical Quality - Behavioral Health domain. This measure reflects activities intended to increase the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days. This measure represents SFHP's commitment to ensuring that members receive follow up care for members with behavioral health needs and aligns with DHCS bold goals and comprehensive quality strategy. SFHP chose the target for DSF-E-FU based on meeting the 50th percentile based on NCQA MY 2023 benchmarks.

2.3.1.2 Activities

The following activities were completed to support measure improvement in 2025:

- Incentivized providers through inclusion of the DSF-E measure (both screening and follow-up) in SFHP's primary care pay-for-performance program. All of the primary care providers participating in the provider incentive program were eligible for the DSF-E measure incentive, including seven provider groups and eight independent clinics.

- Produced monthly gap in care reports to providers for members eligible for depression screening and follow-up. These gap in care reports served as a guide for primary care providers to know what members assigned to them who needed depression screening and follow-up.
- Provided SFHP's network groups and individual clinics with provider education resources. In May 2025, SFHP created the Provider Measure Guide for Depression Screening and Follow-Up and made it available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.

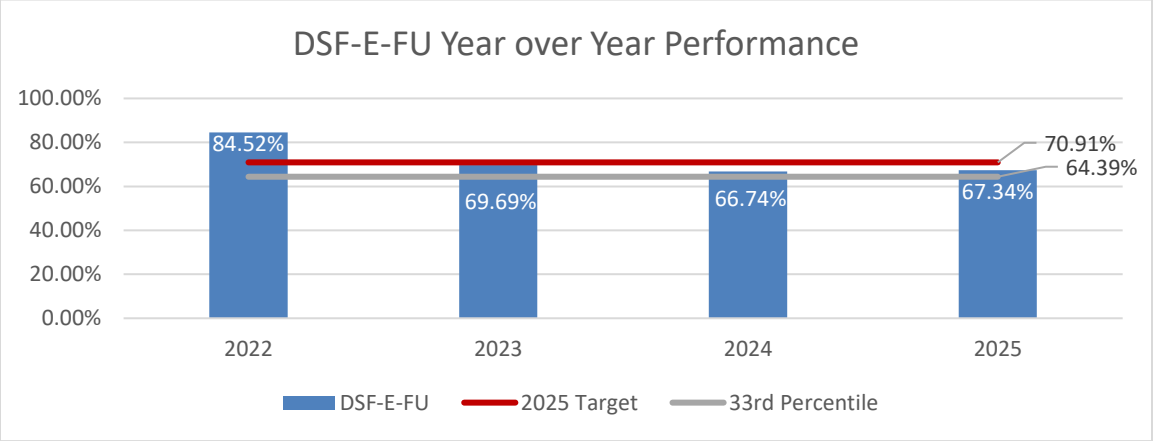
The following activity was not completed:

- Deliver member and provider education materials on the benefits and importance of dyadic care services.
    - While SFHP did not promote dyadic care services, SFHP promoted accessing mental health services in the member newsletter Your Health Matters. Member education on dyadic care and depression screening and treatment had not been prioritized by SFHP staff in 2025.

2.3.1.3 Analysis

2.3.1.3.1 Quantitative

The result of 67.34% did not to meet the target of 70.91% and is expected to achieve the 33rd percentile based on NCQA MY 2024 benchmarks – 64.39%. While SFHP did not meet target for 2025, the measure data is expected to improve by end of the year.



2.3.1.3.2 Qualitative

The main barrier to reaching the target was visibility in the process of coordinating follow-up depression screening for members who had an initial positive screening. SFHP providers aren't able to contact SFHP's behavioral health network Carelon directly; they can only send a referral or have member call Carelon directly to set up their own care. This process relies on members independently navigating and coordinating their own care, which may not result in receiving a follow-up appointment within 30 days and providers do not have insight if they are going to Carelon. This process makes it difficult for providers to know who needs assistance in receiving follow-up care.

To address these barriers, SFHP will continue to strategize with providers for addressing the follow-up appointment and availability. SFHP will work with Carelon to see how their contracted behavioral health providers can support the measure. Additionally, follow-up from depression screening need not be conducted by a Carelon or behavioral health clinician; the follow-up can be completed by primary care providers. SFHP will work with the primary care network to ensure follow-up is being done through primary care services.

2.3.1.4 Recommendations

SFHP will continue DSF-E-FU with both overall and Health Equity populations in the 2026 QIHE Workplan with new targets of:

- Overall population: 71.18% to meet the 50th percentile based on NCQA MY 2024 benchmarks
- Asian population: 64.39% to meet the 33rd percentile based on NCQA MY 2024 benchmarks.

Activities to support this measure will include:

- Continue to incentivize providers through the inclusion of the DSF-E measure (screening and follow-up) in SFHP's primary care pay-for-performance program.
- Continue to receive DSF-E data from SFHP's Behavioral Health network Carelon.
- Collaborate with at least one provider or community partner serving the Asian-identified community to provide health education on depression screenings; focus on the importance of identifying depressive symptoms by completing screenings in order to schedule follow-up behavioral health services.

2.3.2 Engagement of Substance Use Disorder Treatment

2.3.2.1 Overview & Performance

Measure: Engagement of Substance Use Disorder Treatment (IET-EN)					
Numerator	269	Baseline	7.08%	Final Performance	7.92%
Denominator	3,396	Target	8.62%	Evaluation Year	2025

The Engagement of Substance Use Disorder (IET-EN) measure is in the Clinical Quality - Behavioral Health domain. This measure reflects activities intended to increase the percentage of new substance use disorder episodes that have evidence of treatment engagement within 34 days of initiation. This measure represents SFHP's commitment to ensuring that members receive follow up care for members with behavioral health needs and aligns with NCQA standards in improving performance on continuity and coordination of Care Measures. SFHP chose the target for IET-EN based on meeting the 25th percentile based on NCQA MY 2023 benchmarks.

2.3.2.2 Activities

The following activities were completed to support measure improvement in 2025:

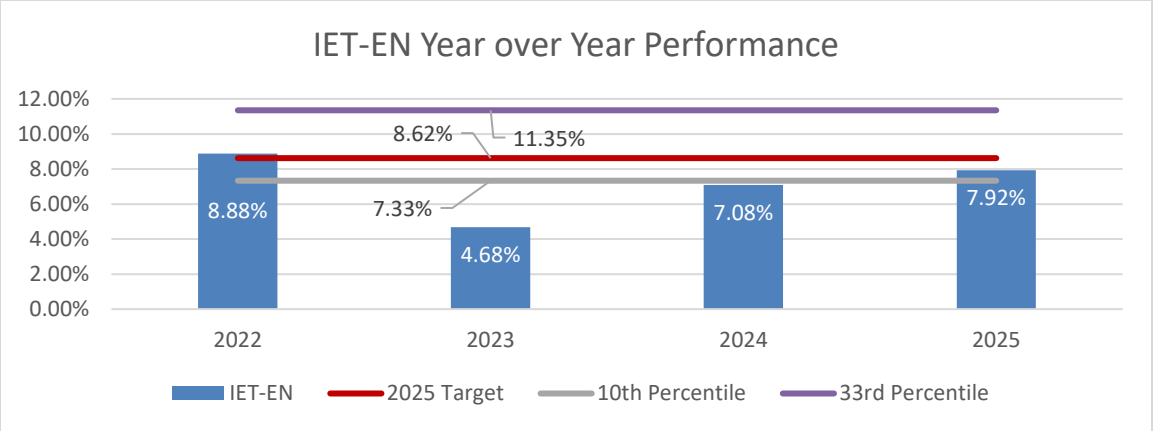
- Shared with 12 network providers data of hospital admissions of members eligible for Engagement of Substance Use Disorder to facilitate follow-up outreach and scheduling

of PCP appointments.
    - January to June 2025: SFHP informed SFHP's network groups and individual clinics of members needing care coordination via weekly files of members being admitted, discharged, and transferred (ADT) from hospitals and emergency departments.
    - July to December 2025:
        - Increase in frequency: SFHP increased communication to daily (weekday) to the primary care network groups and individual clinics advising them of a pending discharge and need to coordinate care.
        - Making the data actionable via HEDIS denominators: These daily files contain member and discharge information as well as which care coordination HEDIS measure is applicable to the member, including IET-EN; i.e. which care coordination denominator the member falls into. The daily files also contain members' frequency of ED use and Enhanced Care Management eligibility and enrollments status.
        - These new data reports aimed to improve providers' ability to know who to target for timely follow-up.
- Partnered with PCP sites to get them access to a live ADT feed of the daily SFHP data.
    - January to July 2025: contracted Enhanced Care Management have direct access to a portal to access live members being admitted, discharged, and transferred (ADT) from hospitals and emergency departments; however, this portal does not have the feature to identify the applicable HEDIS measure for each member.
    - August & September 2025: SFHP piloted expanding the Enhanced Care Management ADT portal to include HEDIS measure identification through partnership with a local community clinic - St. Anthony's Medical Clinic. This pilot gave the local community clinic information on which members who were hospitalized needed care aligned with IET-EN.
    - October 2025: SFHP spread the improvement of Enhanced Care Management ADT portals to include HEDIS measure identification to North East Medical Services.
- Provided SFHP's network groups and individual clinics with provider education resources. In May 2025, SFHP created the Provider Measure Guide for Engagement of Substance Use Disorder and made it available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.

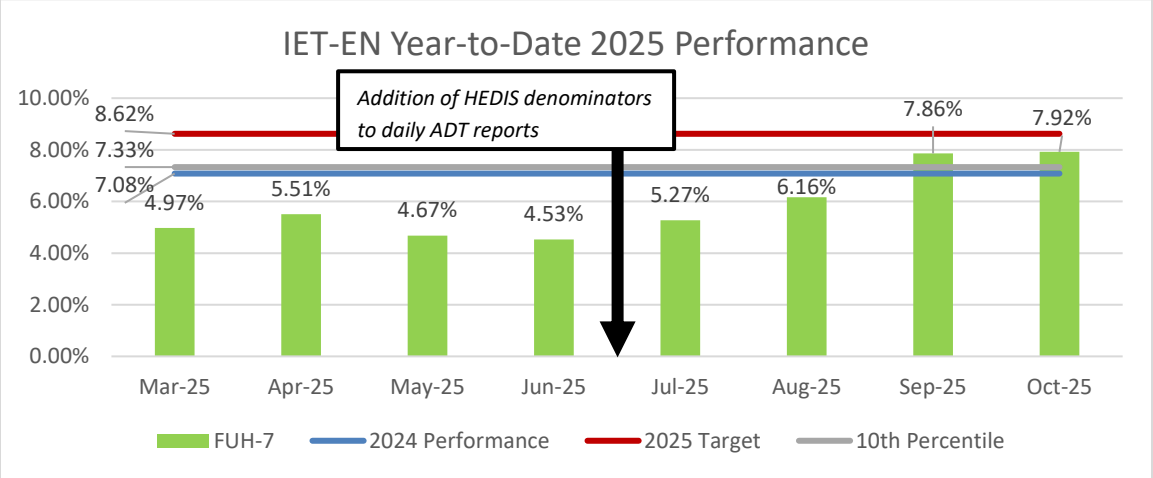
2.3.2.3 Analysis

2.3.2.3.1 Quantitative

The final result of 7.92% did not meet the target of 8.62% and is estimated to achieve the 10th percentile based on NCQA MY 2024 benchmarks – 7.33%. The measure has improved after a dip in performance in 2023, as shown by the following chart.



The chart below demonstrates IET-EN performance throughout 2025 up to the most recent data available, starting in March 2025 when SFHP began to measure monthly performance. The chart is annotated with an arrow showing when the ADT data was improved to include applicable HEDIS denominators.



The Engagement of Substance Use Disorder measure is a combination of three indicators: Alcohol, Opioid, and Other Drug. The Other Drug indicator contributes to lower overall performance of Engagement of Substance Use Disorder, as it is lower performing and has a significantly larger denominator than either Alcohol or Other Drug. The following table shows each IET indicator's denominator and performance as of October 2025 and their NCQA percentile met.

		Denominator	2025 YTD Performance	NCQA Percentile Met
IET-EN Indicator	Alcohol	977	7.16%	10th
	Opioid	690	16.81%	10th
	Other Drug	1,729	4.80%	5th
	IET-EN Total	3,396	7.92%	10th

2.3.2.3.2 Qualitative

Providers face barriers offering care coordination follow-up care to members after substance use episodes, including member contact information, transportation to get to appointments, and obtaining timely appointments. Another barrier that providers raised to SFHP staff in 2025 was in not knowing which members in the daily Admission Discharge & Transfer report were in the denominator to IET-EN versus other care coordination measures. In response to this barrier,

SFHP staff initiated the activities to improve reporting of daily data. This change is reflected in the increase in rate in July immediately after the change in reporting was introduced.

2.3.2.4 Recommendations

SFHP will continue this measure in 2026 with a new target of 11.35% to meet the 33rd percentile; activities to support this measure will include:

- Share with network providers data of hospital admissions of members eligible for Engagement of Substance Use Disorder to facilitate follow-up outreach and scheduling of a PCP appointments.
- Partner with network providers to get them access to a live hospital admissions data.

2.4 Clinical Quality – Medical Care

The domain of Clinical Quality – Medical Care involves activities related to clinical outcomes related to chronic condition care management, patient safety, and pharmacy services including drug utilization review.

2.4.1 Asthma Medication Ratio

2.4.1.1 Overview & Performance

Measure: Asthma Medication Ratio (AMR)					
Numerator	473	Baseline	75.41%	Final Performance	73.56%
Denominator	643	Target	76.65%	Evaluation Year	2025

The Asthma Medication Ratio measure is in the Clinical Quality – Medical Care domain. This measure reflects activities designed to increase the percentage of SFHP members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 out of the total number of SFHP members who were identified as having persistent asthma. This measure represents SFHP's commitment to ensuring that members with chronic conditions receive the care they need; SFHP is also at risk of incurring fines and non-monetary penalties if the 50th percentile (63.66%) is not reached. SFHP chose the target for AMR of 76.65% based on meeting the 90th percentile based on NCQA MY 2023 benchmarks.

2.4.1.2 Activities

The following activities were completed to support measure improvement in 2025:

- Created educational materials for providers around the Global Initiative for Asthma guidelines and updated the SFHP website to include provider education materials for asthma to reflect Global Initiative for Asthma 2025 guidelines.
- Incentivized providers groups through inclusion of the measure in SFHP's primary care pay-for-performance program. Some of the primary care providers participating in the provider incentive program were eligible for the AMR measure incentive, including four out of seven provider groups and one out of eight independent clinics.
- Sent monthly gap in care reports to providers to identify members with persistent asthma and support with care coordination.

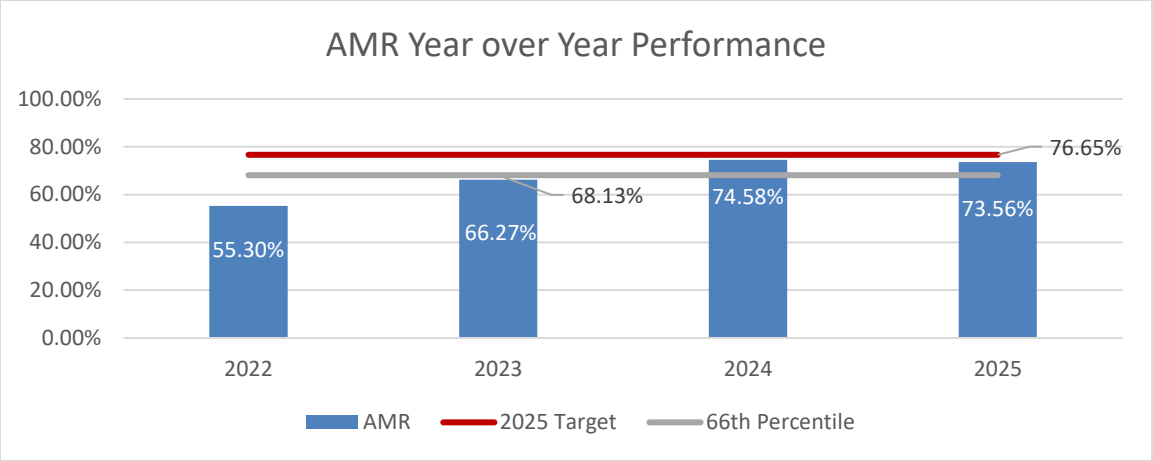
The following activities were not completed:

- Launch a new member incentive to support members needing intervention to address their Asthma medications.
    - SFHP planned to launch the new incentive in the fall of 2025. However, in August 2025 NCQA announced retirement of the AMR measure in 2026. As a result, this activity was discontinued.

2.4.1.3 Analysis

2.4.1.3.1 Quantitative

The result of 73.56% did not to meet the target of 76.65% and is expected to achieve the 66th percentile based on NCQA MY 2024 benchmarks – 68.13%. While SFHP did not meet target for 2025, the data as of October 2025 (73.56%) is performing at a higher rate than the same time in 2024 (66.70%). The measure data is expected to improve by end of the year.



2.4.1.3.2 Qualitative

The main barriers to reaching the target were:

- Staffing limitations in SFHP's Pharmacy Operations team.
- The discontinuation of the AMR member incentive as a result of NCQA retiring AMR as a measure for 2026.

2.4.1.4 Recommendations

SFHP will discontinue the AMR measure in the 2026 workplan as a result of NCQA retiring the measure.

2.4.2 Hepatitis C Treatment

2.4.2.1 Overview & Performance

Measure: Hepatitis C Treatment (HEP-C)					
Numerator	1,350	Baseline	30.76%	Final Performance	30.44%
Denominator	4,435	Target	40.00%	Evaluation Year	2025

The Hepatitis C Treatment measure is in the Clinical Quality – Medical Care domain. This measure reflects activities designed to increase the percentage of the total number of SFHP members with any past history of Hepatitis C diagnosis who have completed the Hepatitis C treatment regimen within the last 36 months. of the total number of SFHP members who were identified as having persistent asthma. This measure represents SFHP's commitment to ensuring that members with chronic conditions receive the care they need; treatment can prevent the spread of Hepatitis C disease and lowers the risk of liver disease. The target of 40.00% was selected based on incremental improvement from 2024 final performance.

2.4.2.2 Activities

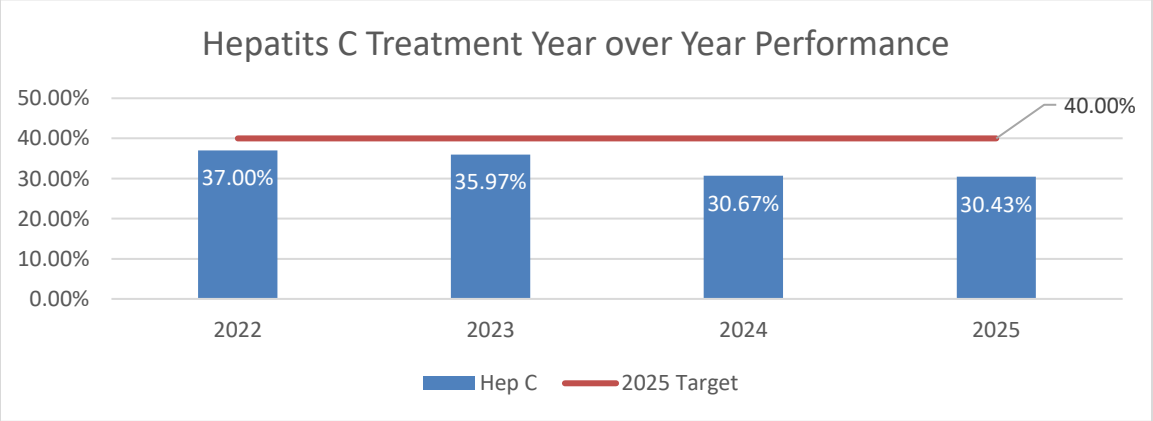
The following activities were completed to support measure improvement in 2025:

- Collaborated with End Hep C group on provider education and to promote Hepatitis C testing in the community.
    - Established contact with the strategic director of End Hep C and had a 1:1 meeting to discuss strategies for reaching out to providers.
    - Attended End Hep C workgroup meeting with other providers in the community to discuss hepatitis C treatment.
- Provided analysis and trends on members who have not completed Hepatitis C treatment to providers.
    - Established contact with 3 clinics identified via analysis to have the highest number of untreated members.
    - Provided a list of 41 untreated members to one of the clinics as follow-up.
- Created an outreach letter template for providers with members with a diagnosis of Hepatitis C who have not yet received treatment.
    - Formed an outreach letter template to accompany the analysis and list of untreated Hepatitis C members to be sent to the providers in identified clinics.

2.4.2.3 Analysis

2.4.2.3.1 Quantitative

SFHP did not meet the target of 40.00%, missing it by 9.57%, with a final result of 30.43%.



2.4.2.3.2 Qualitative

The main barrier to reaching the target was staffing limitations in SFHP's Pharmacy Operations. The departure of the subject matter expert responsible for developing and leading this work created a barrier to achieving the goal. Their institutional knowledge and lack of documented

processes left a gap that required redistribution of responsibilities and adjustment of the timeline.

As a result, the remaining staff who assumed role of Hepatitis C Measure Champion faced additional barriers including:

- Lack of contact with the End Hep C SF workgroup and local clinics of interest.
- Difficultly using existing Hepatitis C reports to execute the 2025 workplan.
- Social determinants of health such as having stable housing, working phones for providers to connect to members, and ability to complete the long course of treatment may have had an impact on the measure reaching the target.

To address these barriers, SFHP Pharmacy staff has:

- Re-established contact with the End Hep C SF workgroup and identified local clinics of interest for provider outreach.
- Collaborated with the SFHP business analytics department to modify internal Hepatis C reporting.

2.4.2.4 Recommendations

SFHP will discontinue the Hepatitis C treatment measure in the 2026 workplan and focus improvement on other chronic condition measures.

2.4.3 Controlling Blood Pressure

2.4.3.1 Overview & Performance

Measure: Controlling Blood Pressure					
Numerator	2,524	Baseline	71.75%	Final Performance	28.85%
Denominator	8,748	Target	72.75%	Evaluation Year	2025

The Controlling High Blood Pressure (CBP) measure is in the Clinical Quality – Medical Care domain. This measure reflects activities designed to increase the percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. This measure represents SFHP's commitment to ensuring that members with chronic conditions receive the care they need. SFHP also chose this measure to prepare for launching a new Medicare product, with CBP being a key priority measure. SFHP chose the target of 72.75% based on meeting the 90th percentile based on NCQA MY 2023 benchmarks.

2.4.3.2 Activities

The following activities were completed to support measure improvement:

- Created and shared provider education materials for visit coding, member care and communication. SFHP made these available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.
- Provided gap in care reports and CBP Action Plans to providers to facilitate outreach for members with high blood pressure.
    - Due to staffing resource constraints, SFHP limited the dissemination of CBP gap

in care reports to one provider group, North East Medical Services, and one community clinic, Mission Neighborhood Health Center, to support their work in the Equity and Practice Transformation program, a state program for Federally Qualified Health Centers to support reduction of care disparities.

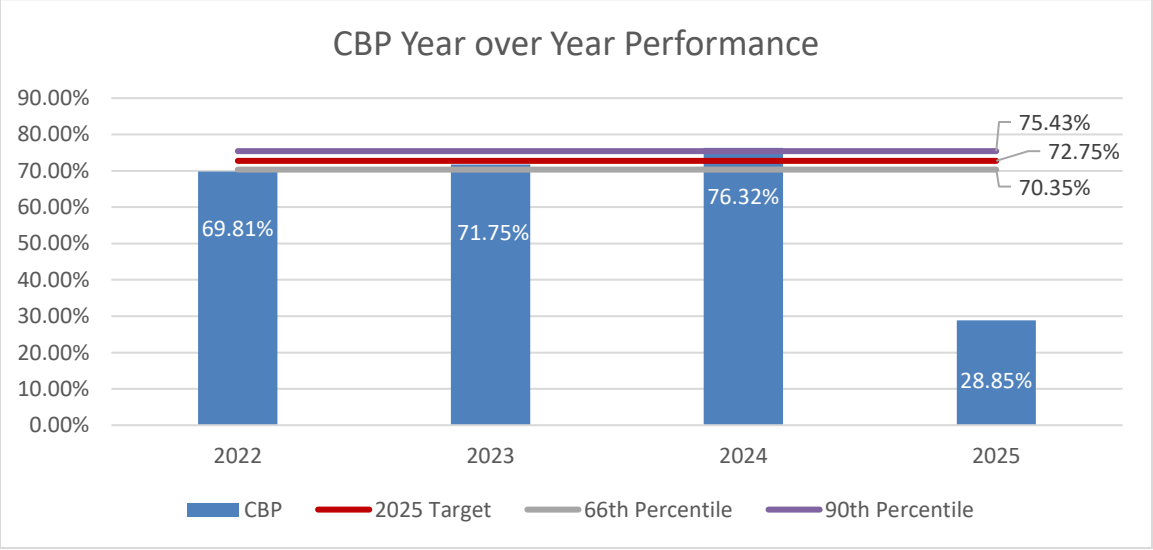
The following activities were not completed:

- Implement alerts in SFHP's care management system to facilitate appointment coordination and warm transfers.
    - Due to technology resource constraints among SFHP staff, this activity was not prioritized to be complete in 2025. However, the infrastructure was created to implement this, to launch in early 2026.
- Promote and encourage members to engage in services through a member incentive to obtain an annual care/wellness visit and care to control their high blood pressure.
    - Due to financial resource constraints at SFHP this activity was not prioritized to be complete in 2025.

2.4.3.3 Analysis

2.4.3.3.1 Quantitative

This HEDIS measure is a hybrid measure, which means that SFHP won't have final rates until medical record review is finalized in May 2026. For this reason, SFHP will be evaluating the measure based on year to date performance, which includes the entire eligible population rather than the sample required for hybrid rate reporting (sample of whole population). As of October 2025, the final result of 28.85% did not meet the target. However, in comparison to the same proactive rate in October 2024, SFHP performed is performing 3.70% higher than the rate then at 25.15%. While SFHP did not reach the target, SFHP expects that the supplemental medical record review process ending in May 2026 to obtain hybrid rates for this measure will result in achieving the target. The measure has shown steady improvement since 2022.



2.4.3.4 Recommendations

SFHP will continue this measure in 2026 with a target of 66.88% to improve the CBP rate for Black/African-American members to reach the 50th percentile. Activities to support this measure will include:

- Partner with Roots Community Health Center to provide clinical services related to hypertension control in identified barbershops or salons.
- Track CBP compliance rates for Black/African American members engaged in SFHP's Enhanced Care Management (ECM) and Complex Care Management (CCM) Programs.

2.5 Engagement with Primary Care

The domain of Engagement with Primary Care involves activities related to the delivery of preventative care services and Initial Health Assessments.

2.5.1 Colorectal Cancer Screening

2.5.1.1 Overview & Performance

Measure: Colorectal Cancer Screening					
Numerator	13,299	Baseline	48.22%	Final Performance	44.83%
Denominator	29,667	Target	49.36%	Evaluation Year	2025

The Colorectal Cancer Screening measure is in the Engagement with Primary Care domain. This measure reflects activities designed to increase the percentage of members 45–75 years of age who had appropriate screening for colorectal cancer. This measure represents SFHP's commitment to preventing preventative screenings and ensuring routine engagement with primary care providers. SFHP also chose this measure to prepare for launching a new Medicare product, with COL-E being a key priority measure. SFHP chose the target of 49.36% based on 2.00% absolute improvement from the initial baseline set in January 2025 of 47.36% as COL-E did not have benchmarks until late 2025.

2.5.1.2 Activities

The following activities were completed to support measure improvement:

- Created and shared provider education materials for visit coding, member care and communication. SFHP made these available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.
- Produced monthly gap in care reports to providers for members eligible for colorectal cancer screening. These gap in care reports served as a guide for primary care providers to know what members assigned to them who needed colorectal cancer screening.
- Provided technical assistance to providers to facilitate outreach for members eligible for colorectal cancer screening.
    - In October 2025 SFHP outreached to five primary care clinics with high gap rates for COL-E in an effort to close gaps by the end of year. Each clinic was given tools to assist with their improvement efforts, including:
        - COL-E member gap list
        - Action item worksheet to conduct outreach and close gaps
        - COL-E data tracking template to track their progress
- Incentivized providers through inclusion of a colorectal cancer screening measure in SFHP's primary care pay-for performance program. All of the primary care providers participating in the provider incentive program were eligible for the COL-E measure

incentive, including seven provider groups and eight independent clinics.
- Promoted and engage members eligible for colorectal cancer screening through a member incentive.
    - As of November 2025, a total of 323 gift cards were distributed to members for developmental screenings. The top three medical groups where members received a developmental screening gift card were assigned to San Francisco Health Network (182), Community Clinic Network (30), and North East Medical Services (25).

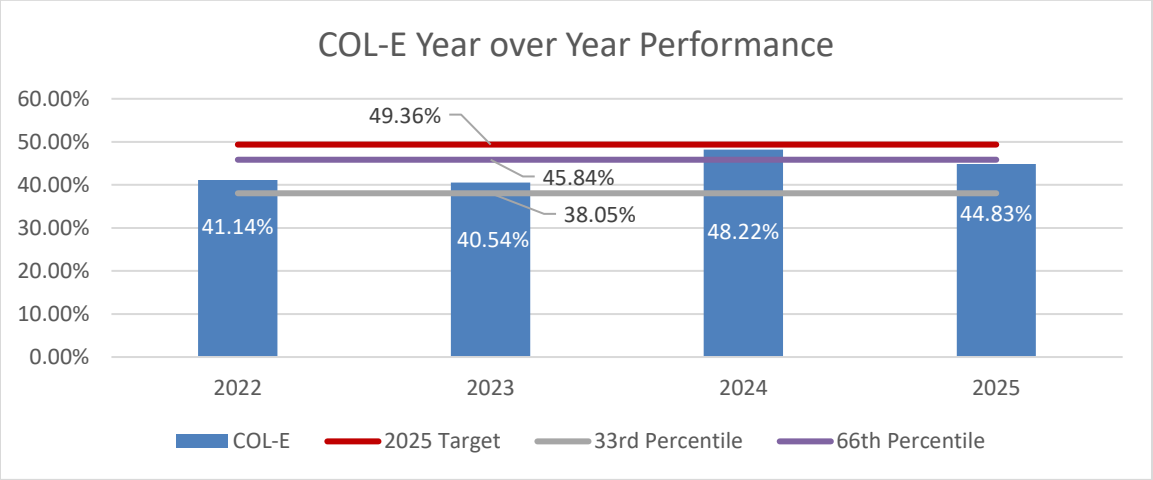
The following activities were not completed:

- Implement alerts in SFHP's care management system to facilitate appointment coordination and warm transfers.
    - Due to technology resource constraints among SFHP staff, this activity was not prioritized to be complete in 2025. However, the infrastructure was created to implement this, to launch in early 2025.

2.5.1.3 Analysis

2.5.1.3.1 Quantitative

The final result of 44.83 % fell short of the target of 49.36% by 4.53% and will likely attain the 33rd percentile based on NCQA MY 2024 benchmarks – 38.05%. While SFHP did not meet target for 2025, the measure data is expected to improve by end of the year.



2.5.1.3.2 Qualitative

Barriers to reaching the target included:

- While SFHP conducted multiple activities throughout the year, lack of resources and time SFHP staff had to devote to this measure resulted in not implementing care management alerts and not initiating technical assistance until late 2025.
- Social determinants of health of members such as having stable housing, working phone, and ability to take time off from work, childcare, or other obligations may have had an impact on members being able to receive preventative care services like colorectal cancer screening.

2.5.1.4 Recommendations

SFHP will continue this measure in 2026 with a specific target to improve rate of Black/African-American members to 41.11% to reach the 33rd percentile. Activities to support this measure will include:

- Continue to incentivize providers through inclusion of a colorectal cancer screening measure in SFHP's primary care pay-for performance program.
- Continue to provide gap in care reports to providers to facilitate outreach for members eligible for colorectal cancer.
- Continue to promote and encourage Black/African American members aged 45 to 75 years to engage in services through a member incentive to obtain colorectal cancer screening.
- Track COL-E compliance rates for Black/African American members engaged in SFHP's Enhanced Care Management and Complex Care Management Programs.

2.5.2 Breast Cancer Screening

2.5.2.1 Overview & Performance

Measure: Breast Cancer Screening					
Numerator	8,933	Baseline	60.65%	Final Performance	58.82%
Denominator	15,186	Target	63.48%	Evaluation Year	2025

The Breast Cancer Screening measure is in the Engagement with Primary Care domain. This measure reflects activities designed to increase the percentage of members 40–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer. This measure represents SFHP's commitment to preventing preventative screenings and ensuring routine engagement with primary care providers. SFHP also chose this measure to prepare for launching a new Medicare product, with BSC-E being a key priority measure. SFHP chose the target of 63.48% based on meeting the 90th percentile based on NCQA MY 2023 benchmarks.

2.5.2.2 Activities

The following activities were completed to support measure improvement:

- Created and shared provider education materials for visit coding, member care and communication. SFHP made these available to SFHP's provider network on the SFHP Provider Portal, found on the Provider Resources page of the portal.
- Provided technical assistance and gap in care reports to providers to facilitate outreach for members eligible for breast cancer screening.
    - In October 2025 SFHP outreached to five primary care clinics with high gap rates for BCS-E in an effort to close gaps by the end of year. Each clinic was given tools to assist with their improvement efforts, including:
        - BCS-E member gap list
        - Action item worksheet to conduct outreach and close gaps
        - BCS-E flow chart for the outreach and screening procedures
        - BCS-E data tracking template to track their progress

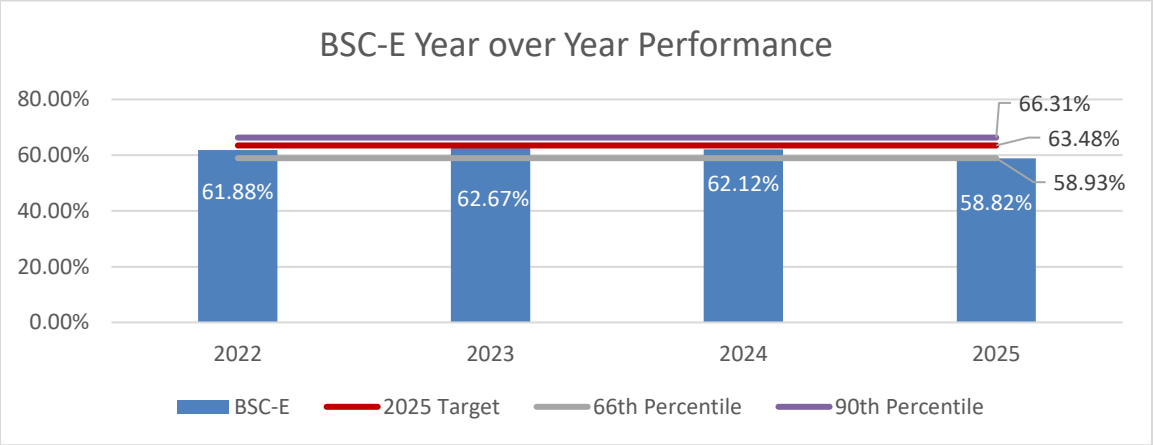
The following activities were not completed:

- Implement alerts in SFHP's care management system to facilitate appointment coordination and warm transfers.
    - Due to technology resource constraints among SFHP staff, this activity was not prioritized to be complete in 2025. However, the infrastructure was created to implement this, to launch in early 2026.
- Promote and encourage members to engage in services through a member incentive to obtain an annual care/wellness visit and receive a breast cancer screening.
    - Due to financial resource constraints at SFHP this activity was not prioritized to be complete in 2025.

2.5.2.3 Analysis

2.5.2.3.1 Quantitative

The result of 58.82% did not to meet the target of 63.48% and will likely attain the 66th percentile based on NCQA MY 2024 benchmarks – 58.93%. While SFHP did not meet target for 2025, the measure data is expected to improve by end of the year.



2.5.2.3.2 Qualitative

Barriers to reaching the target included:

- Lack of resources and time SFHP staff had to devote to this measure, resulting in not prioritizing and therefore not conducting activities targeted at improving this measure.
- Social determinants of health of members such as having stable housing, working phone, and ability to take time off from work, childcare, or other obligations may have had an impact on members being able to receive preventative care services like breast cancer screening.

2.5.2.4 Recommendations

SFHP will continue this measure in 2026 with a target of 58.22% to improve rate of Black/African-American members to reach the 33rd percentile. Activities to support this measure will include:

- Provide gap in care reports to providers for members eligible for breast cancer screening with priority on Black/African American.
- Promote and encourage Black/African American members to engage in services through a member incentive to obtain breast cancer screening.
- Track BSC-E compliance rates for Black/African American members engaged in SFHP's

Enhanced Care Management (ECM) and Complex Care Management (CCM) Programs.

2.5.3 Well Child Visits in the First 15 Months of Life

2.5.3.1 Overview & Performance

Measure: Well Child Visits in the First 15 Months of Life (W30-6)					
Numerator	316	Baseline	65.68%	Final Performance	58.96%
Denominator	536	Target	69.67%	Evaluation Year	2025
Measure: Well Child Visits in the First 15 Months of Life, Latinx (W30-6 HE)					
Numerator	144	Baseline	61.87%	Final Performance	60.00%
Denominator	240	Target	63.29%	Evaluation Year	2025

The Well Child Visits in the First 15 Months of Life (W30-6) measure is in the Engagement with Primary Care domain. The goal of this measure is to increase the percentage of members who turned 15 months old during the measurement period and received six or more well-child visits. This measure aligns with DHCS bold goals and comprehensive quality strategy to address racial disparities and SFHP is held accountable to improvement in W30-6 by DHCS; SFHP is at risk of incurring fines and non-monetary penalties if the 50th percentile (63.38%) is not reached for the entire W30-6 population. SFHP chose the target of 69.67% based on NCQA MY 2023 benchmarks for W30-6 entire population reaching the 90th percentile. Additionally, SFHP also chose a health equity focus population of Latinx members as this population had the largest disparity in rate with the largest population in W30-6; SFHP chose the target of 63.29% for this health equity component to reach the 66th percentile.

2.5.3.2 Activities

The following activities were completed to support overall W30-6 measure improvement in 2025:

- Promoted and encouraged members age zero to 15 months to engage in services; as of October 2025, 64 members have received a gift card for completing their well-child visits.
    - As of November 2025, a total of 86 gift cards were distributed to members for well-child screenings. The top three medical groups where members received a developmental screening gift card were assigned to North East Medical Services (52), San Francisco Health Network (15), and Community Clinic Network (9).
- Expanded the member incentive Plan-Do-Study-Act project at Zuckerberg San Francisco General Children's and Family Health Centers to test providing member gift cards in-person and at more visits.
    - Over the course of the project 146 gift cards were distributed to members during their two-month visit or their nine-month visit resulting in a reduction of rate of appointment-no-shows from 11.7% in April 2025 to 6.5% in August 2025.
- Outreached to members via a vendor, Carenet, to contact pediatric populations to coordinate appointments for measures prioritized by SFHP including W30-6.
    - The vendor successfully contacted 308 members resulting in 22 members with appointments scheduled and confirmation from 151 members that they would arrange their own appointment.

- Incentivized providers through inclusion of a well-child visit in the first 15 months of life measure in SFHP's primary care pay-for performance program. Some of the primary care providers participating in the provider incentive program were eligible for the W30-6 measure incentive, including three out of seven provider groups and one out of eight independent clinics.
- Produced monthly gap in care reports to providers for members eligible well-child visits. These gap in care reports served as a guide for primary care providers to know what members assigned to them who needed well-child visits.
- Established supplemental data feeds to better align SFHP data with provider data. These supplemental data feeds allow for providers to submit electronic health records and other supplemental data to demonstrate that well-child visits occurred even in the absence of claim or encounter data.

SFHP also implemented the following activities to support W30-6 measure improvement in 2025 for the Latinx member population:

- Collaborated with one community-based organization to co-develop member education materials and deliver workshops designed for Latinx caregivers/guardians, including outreach to pregnant and birthing members. These workshops were aligned with DHCS Performance Improvement Project requirements.
    - SFHP partnered with community-based organization, CARECEN (Central American Resource Center) to host four online workshops for 27 pregnant or birthing members.
- Incentivized providers through inclusion of a well-child health equity measure in SFHP's primary care pay-for-performance program; three providers participating in this measure conducted well-child quality improvement activities for the measure for members who are Latinx:
    - University of California, San Francisco – offered well-child visits in community settings in areas – zip codes with highest proportion of Black and Latinx members in their Primary Care population. These visits were designed to meet members in their community and offer a range of other services as well as incentives to encourage screening.
    - Mission Neighborhood Health Center – texted Black and Latinx members due for well-child visits to promote the SFHP well-child incentive gift card.
    - North East Medical Services – conducted phone outreach to Latinx members to coordinate scheduling of well-child visits.
- Collaborated with primary care clinic serving majority of Latinx members ages 0-15 months to facilitate reminder phone calls and distribute gift cards to members attending W30 appointments.
    - SFHP partnered with Zuckerberg San Francisco General Children's Health Center which has a significant Latinx pediatric population. This intervention reached 124 members (total number of gift cards distributed). This led to an increase in Well Child Visits for SFHP members compared to members in other health plans. SFHP members had a lower no-show rate from Oct 2024 – Dec 2024 (average rate: 11.75%) compared to all other CHC patients (average rate: 16.75%) over the same time.
- Developed a visual tool to map organizations and entities that serve or support Latinx members and identify partnership opportunities.
    - SFHP completed the mapping which included resources from government, education and childcare systems, health systems, social services, and parent, family, and community services. SFHP identified the need for SFHP to serve to

connect members and services to each other, and prioritized partnering with Family Resource Centers and Child Care Centers.

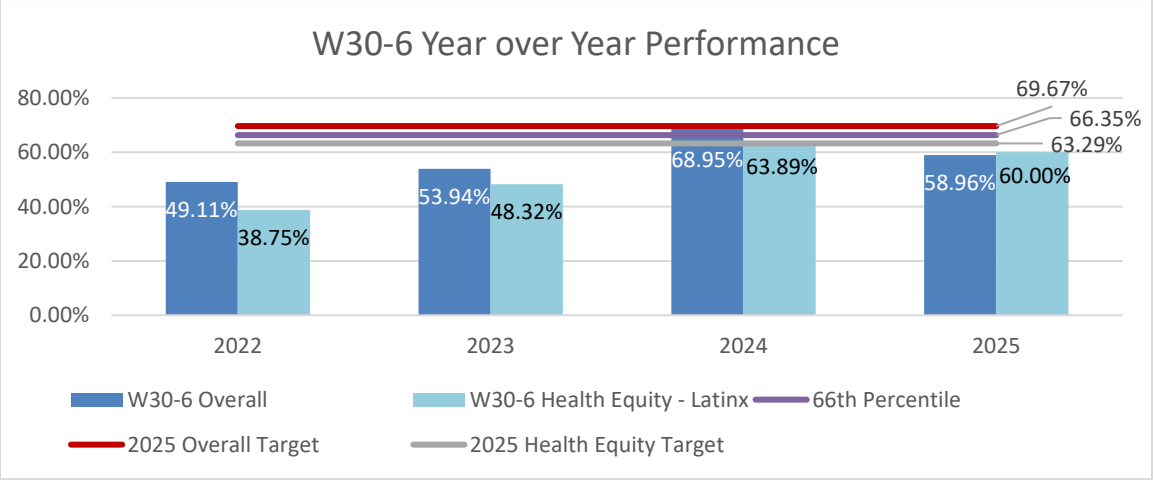
- Interviewed community stakeholders to understand barriers to care and identify areas for quality improvement at member or organizational level.
    - In collaboration from Zuckerberg San Francisco General Children's Health Center, SFHP completed a total of 19 surveys with member caregivers and pediatric providers.
    - As a result of the interviews, SFHP identified the top challenges: transportation issues, appointment scheduling, finding time to get off work, coordinating with the clinic, and language access.
    - The interviews also brought to light change ideas for future interventions, including a better accessible transportation benefit, support from care managers to avoid no shows, offering mobile clinic, and SFHP providing a language line for interpretation when interpretation is challenging to access.

2.5.3.3 Analysis

2.5.3.3.1 Quantitative

- Overall population: The final result for the overall W30-6 population of 58.96% fell short of the target of 69.67% by 10.71% and is at risk of not meeting the 50th percentile based on NCQA MY 2024 benchmarks – 63.38%.
- Latinx population: For the health equity component of measure focusing on well-child visits for Latinx members, the final result for the Latinx W30-6 population of 60.00% fell short of the target of 63.29% by 3.29%.

While SFHP did not meet targets for 2025, the measure data is expected to improve by end of the year.



2.5.3.3.2 Qualitative

SFHP conducted a barrier analysis via a fishbone diagram to identify barriers to completing the well-child visits in the first 15 months of life based on six domains: process, environment, resources, policy, people, and provider. SFHP determined that the main barrier to reaching the target was the process of scheduling appointments and the lack of availability of appointments. Additional barriers included patients lacking the ability to schedule appointments in their preferred language, distrust in the medical system, transportation issues, and a complex medical system to navigate.

To address these barriers, SFHP partnered with a community-based organization, CARECEN (Central American Resource Center), to inform members of SFHP benefits such as transportation. SFHP also piloted a gift card program with the Zuckerberg San Francisco General Children's Health Center and Family Health Center to educate members about the well-child visit schedule and address social determinants of health factors affecting members' ability to attend well child visits. SFHP will continue to partner with the Zuckerberg San Francisco General Children's Health Center and Family Health Center to address appointment availability and scheduling issues.

2.5.3.4 Recommendations

SFHP will continue W30-6 with both overall and Health Equity populations in the 2026 QIHE Workplan with new targets of:

- Overall population: 66.35% to meet the 66th percentile based on NCQA MY 2024 benchmarks.
- Latinx population: 63.38% to meet the 50th percentile based on NCQA MY 2024 benchmarks.

Activities to support measure improvement will include:

- Continue to incentivize providers through inclusion of W30-6 in SFHP's pay-for-performance program.
- Continue to promote and encourage members aged zero to 15 months to engage in services through a member incentive to obtain well-child visits.
- Continue to provide gap in care reports to providers for members' eligible for well child visits.
- Participate in Phase 2 of Child Health Equity Collaboration with the Zuckerberg San Francisco General Children's Health Center and Family Health Center to address appointment availability and scheduling issues.

2.5.4 Topical Fluoride Application for Children

2.5.4.1 Overview & Performance

Measure: Topical Fluoride Application for Children (TFL-CH)					
Numerator	5,032	Baseline	11.99%	Final Performance	14.78%
Denominator	34,038	Target	19.00%	Evaluation Year	2025

The Topical Fluoride for Children (TFL-CH) measure is in the Engagement with Primary Care domain. The goal of this measure is to increase the percentage of members 1-20 years of age who receive at least two topical fluoride varnish applications in the measurement year. This measure aligns with DHCS bold goals and comprehensive quality strategy and SFHP is held accountable to improvement in TFL-CH by DHCS; SFHP is at risk of incurring fines and non-monetary penalties if the Centers for Medicare & Medicaid Services (CMS) median is not reached. SFHP chose the target of 19.00% based on meeting the CMS median.

2.5.4.2 Activities

The following activities were completed to support measure improvement:

- Promoted and encouraged members age 12 to 47 months to engage in services through

a member incentive to obtain an initial fluoride varnish treatment. SFHP offered this initial fluoride incentive throughout 2025; however, two fluoride varnish treatments are required to be compliant with the measure. As result, in summer 2025 SFHP launched a second varnish treatment incentive.
    - Initial fluoride treatment: As of November 2025, a total of 1,139 gift cards were distributed to members for fluoride varnish for both initial and second treatments. The top three medical groups where members received a fluoride varnish gift card were assigned to San Francisco Health Network (587), North East Medical Services (264) and Community Clinic Network (156).
- Outreached to members via a vendor, Carenet, to contact pediatric populations to coordinate appointments for measures prioritized by SFHP including TFL-CH.
    - The vendor successfully contacted 1,398 members resulting in 158 members with appointments scheduled and confirmation from 574 members that they would arrange their own appointment.
- Coordinated with SF Department of Public Health and local oral health coalitions to promote awareness of the importance of topical fluoride application in the primary care setting for all children from tooth eruption to five years of age and for older children and teens at risk of caries.
    - SFHP provided six years of aggregate data on TFL-CH compliance to Cavity Free SF as well as the health promotion materials for SFHP's fluoride member incentive.

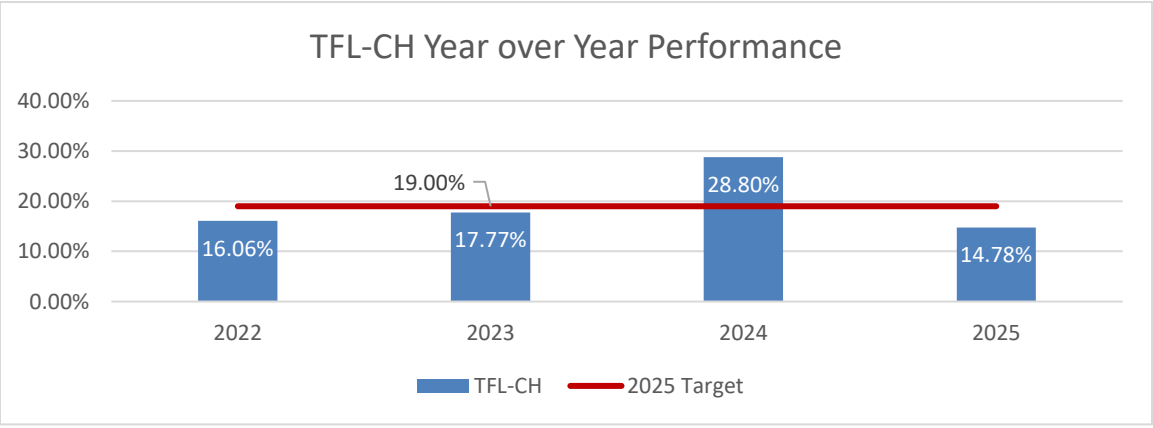
The following activity was not completed:

- Provide gap in care reports to providers for members eligible for topical fluoride treatment.
    - Due to resource constraints at SFHP this activity was not prioritized to be complete in 2025.
- Surveyed providers to understand best practices and identify areas for quality improvement at member or clinic level.
    - An optional survey was sent to five providers; SFHP received no responses.

2.5.4.3 Analysis

2.5.4.3.1 Quantitative

The result of 14.78% did not meet the target of 19.00% by 4.22%. While SFHP did not meet target for 2025, the measure data is expected to improve by end of the year.



2.5.4.3.2 Qualitative

The main barriers to reaching the target were:

- Eligible population: current guidelines set by the United States Preventive Services Taskforce recommend fluoride varnish for children ages one to five, which is the focus of SFHP's primary care providers. DHCS requires the eligible population to be from one to 20. This misalignment of ages in recommendation, provider practice, and DHCS measurement & requirement proves difficult to improve the measure, particularly for members aged six to 20.
- Setting of care: service may be provided by dentists and/or PCPs and there may be a lack of coordination between settings to ensure members are receiving service. Gap-in-care outreach by Carenet highlighted that most SFHP providers do not offer topical fluoride as a stand-alone service. Some providers only offer fluoride varnishes at well child visits while other providers refer members to visit their dentist.
- The closing of the California Department of Public Health meant the discontinuation of Topical Fluoride Application training. As a result, no referral to training resources led to fewer providers able to apply fluoride varnish.

2.5.4.4 Recommendations

SFHP will continue this measure in 2026 with a same target of 19.00% to achieve the CMS median; activities to support this measure will include:

- Continue to promote and engage members aged 12 to 47 months through a member incentive to obtain the first and second fluoride varnish treatments.
- Coordinate with SF Department of Public Health and local oral health coalitions to promote awareness of the importance of topical fluoride application in the primary care setting for all children from tooth eruption to five years of age and for older children and teens at risk of caries.

2.5.5 Initial Health Appointment

2.5.5.1 Overview & Performance

Measure: Initial Health Appointment (IHA)					
Numerator	4,285	Baseline	20.68%	Final Performance	24.82%
Denominator	17,261	Target	22.75%	Evaluation Year	2025

The Initial Health Appointment (IHA) measure is in the Engagement with Primary Care domain. IHA is the percentage of new members enrolled in the prior 120 days who had a comprehensive PCP visit. This measure represents SFHP's commitment to ensuring that members receive primary care services and engagement in the care they need upon enrollment with the plan. SFHP chose the target of 22.75% to achieve 10% relative improvement from the baseline of 20.68%.

2.5.5.2 Activities

The following activities were completed to support measure improvement in 2025:

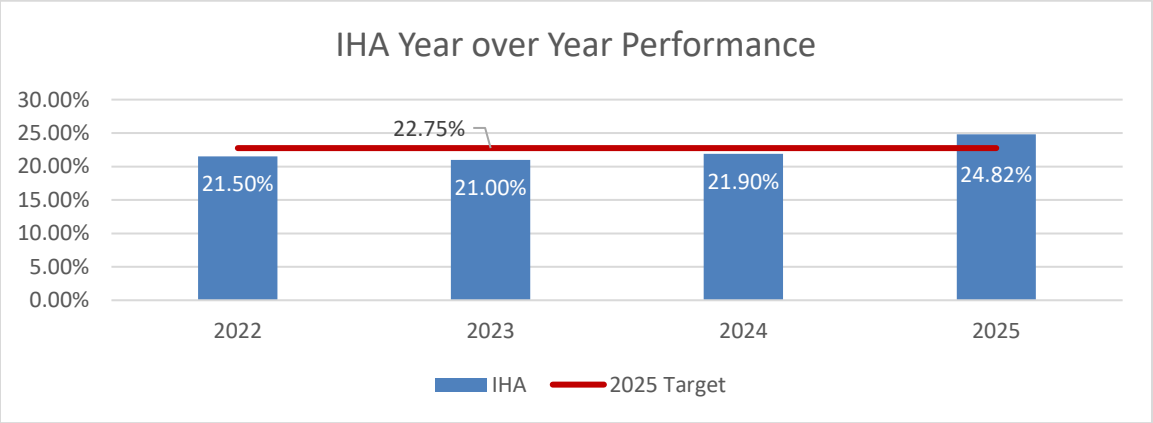
- Offered monthly gift card raffle to incentivize new members to complete the IHA; 10 gift cards were raffled per month for members who completed their IHA.

- Mailed an average of 2,000 outreach letters monthly to individual members with no record of IHA after 60 days of enrollment to educate on the importance of the appointment, how to schedule it, and how to contact SFHP with questions.
- Incentivized providers to improve IHA completion through inclusion of the measure in SFHP's primary care pay-for-performance program. All of the primary care providers participating in the provider incentive program were eligible for the IHA measure incentive, including seven provider groups and eight independent clinics.
- Educated providers via:
    - Disseminated a Frequently-Asked-Questions document to improve IHA coding.
    - Released one Provider Newsletter Article with an IHA Tip Sheet and IHA/Health Risk Assessment Summary Chart.
    - Updated the Provider Portal User Guide to include instructions on how to generate a member roster for outstanding IHAs using the SFHP provider portal.
- Sent monthly gap-in-care reports to providers to support them with member outreach and scheduling of outstanding IHAs.
- Issued 12 Medical Record Review Corrective Action Plans to ensure continued compliance and improvement of contracted Providers.
- Developed and automated new audit tools for use with Delegated Medical Groups, including review of IHA policies and member medical records; completed 3 audits using new tools.

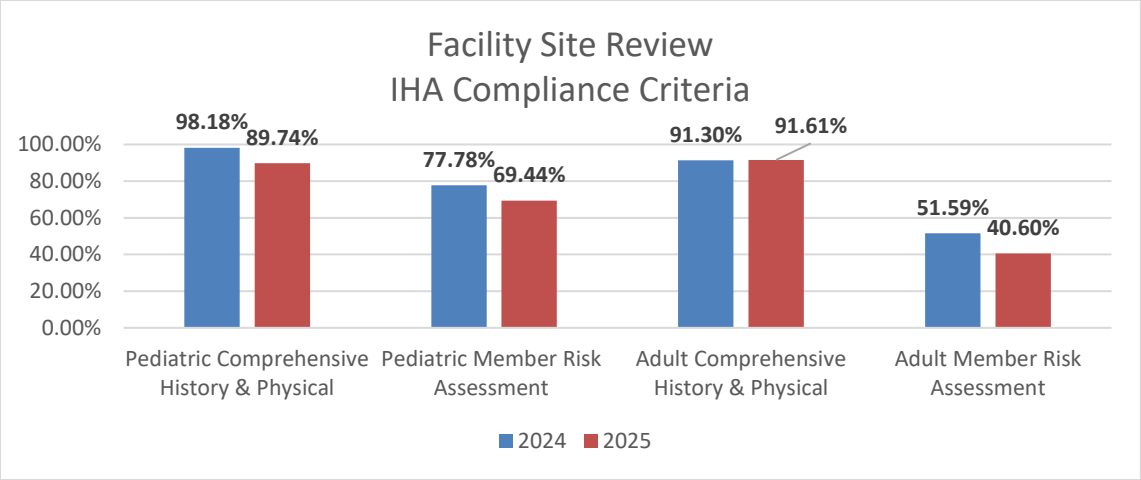
2.5.5.3 Analysis

2.5.5.3.1 Quantitative

The final result as of November 2025 of 24.82% surpassed the target of 22.75% by 2.07%. The measure has improved significantly since similar performance in years 2022-2024.



One significant way SFHP conducts oversight of IHA compliance is through Facility Site Reviews. These Facility Site Review assess Providers' IHA compliance through two separate criteria during Medical Record Review: 1) the comprehensive history and physical, and 2) the member risk assessment. The chart below shows Medical Record Reviews conducted in 2024 and 2025 on a sample of the SFHP PCP Network and illustrates the overall compliance with these individual components of the IHA. The charts shows lower compliance with IHA criteria from 2024 to 2025. This is likely due to the introduction of new IHA standards that went into effect. As a result, SFHP will incorporate additional oversight and provider education into the IHA activities in 2026.



2.5.5.4 Recommendations

SFHP will continue this measure in 2026 with a new target of 27.30% to represent 10% relative improvement from the 2025 rate as of October 2025; activities to support this measure will include:

- Improve delegation oversight and IHA audit protocol, and revise desktop procedures.
- Monitor compliance through Medical Record Review and address identified gaps through DHCS Corrective Action Plan process.
- Develop an IHA Preventive Practice Guide and provide ongoing technical assistance for providers/clinics to improve compliance with IHA standards.
- Update and enhance SFHP's internal IHA rate report to include additional billing codes.
- Continue outreach via mail to members with no record of an Initial Health Appointment within 60 days of enrollment to promote appointment scheduling.
- Continue to offer a raffle to incentivize new members to complete their Initial Health Appointment.
- Continue to provide gap in care reports to providers for members' eligible for well child visits.

2.5.6 Developmental Screening for Children

2.5.6.1 Overview & Performance

Measure: Developmental Screening for Children (DEV)					
Numerator	1,922	Baseline	61.87%	Final Performance	64.58%
Denominator	2,976	Target	63.84%	Evaluation Year	2025

The Developmental Screening (DEV) measure is in the Engagement with Primary Care domain. The goal of this measure is to increase the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This measure aligns with DHCS bold goals and comprehensive quality strategy and SFHP is held accountable to improvement in DEV by DHCS; SFHP is at risk of incurring fines and non-monetary penalties if the CMS median (37.40%) is not reached. SFHP chose the target of 63.84% based on 2.00% absolute

improvement from when the baseline was initially set at 61.84%; final performance in 2024 was 61.87%.

2.5.6.2 Activities

The following activities were completed to support measure improvement in 2025:

- Promoted and engage members eligible for developmental screening through a member incentive.
    - As of November 2025, a total of 939 gift cards were distributed to members for developmental screenings. The top three medical groups where members received a developmental screening gift card were assigned to San Francisco Health Network (297), North East Medical Services (291) and Community Clinic Network (154).
- Incentivized providers through inclusion of developmental screening measure in SFHP's primary care pay-for-performance program. Most of the primary care providers participating in the provider incentive program were eligible for the DEV measure incentive, including six out of seven provider groups and two out of eight independent clinics.
- Provided monthly gap in care reports to providers for members eligible for developmental screening in SFHP's primary care pay-for-performance program.
- Collaborated with SF Department of Early Childhood to promote medical groups the use of the Sparkler app, which is an app that can be used by organizations and families to track required developmental screenings including DEV.
    - The Sparkler app was promoted by staff from San Francisco Department of Early Childhood during a Children and Maternal Health Quality Collaborative Meeting. The meeting had representatives from five Provider groups.

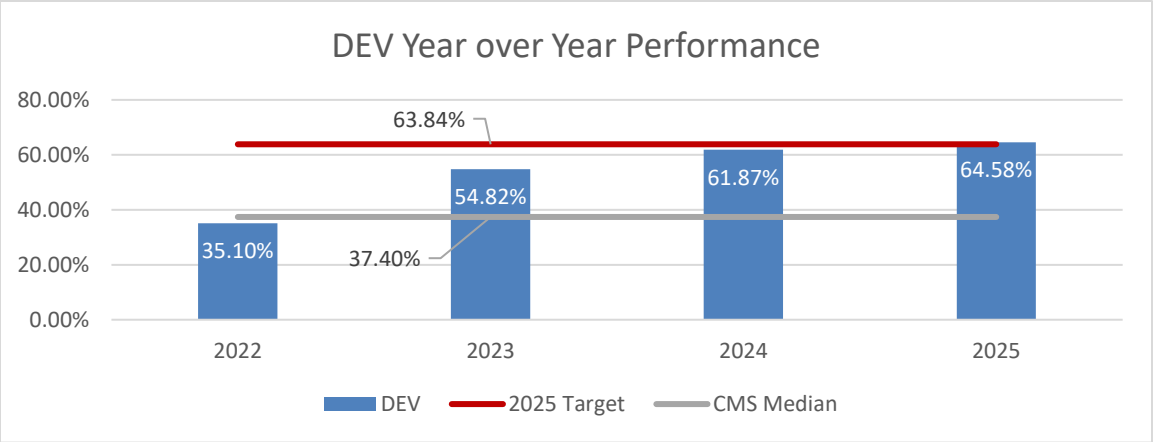
The following activity was not completed:

- Survey providers to understand best practices and identify areas for quality improvement at member or clinic level.
    - An optional survey was sent to five providers; SFHP received no responses.

2.5.6.3 Analysis

2.5.6.3.1 Quantitative

The final result of DEV is 64.58%, exceeding the target by 0.74% and will maintain performance above the CMS median – 37.40%. The measure has improved performance since 2022.



2.5.6.4 Recommendations

SFHP will continue this measure in 2026 with a new target of 67.58% to achieve 3.00% absolute improvement from 2025; activities to support this measure will include:

- Continue to promote and engage members eligible for developmental screening through a member incentive.
- Continue to incentivize Providers through inclusion of developmental screening measure in SFHP's primary care pay-for performance program.
- Continue to provide gap in care reports to providers for members eligible for developmental screening.

2.5.7 Child and Adolescent Well-Care Visits – Black/African American, Native Hawaiian/Other Pacific Islander, Native American/Alaska Native

2.5.7.1 Overview & Performance

Measure: Child and Adolescent Well-Care Visits – Black / African American					
Numerator	845	Baseline	43.82%	Final Performance	39.07%
Denominator	2,163	Target	48.15%	Evaluation Year	2025
Measure: Child and Adolescent Well-Care Visits – Native American and OPI					
Numerator	83	Baseline	35.02%	Final Performance	35.93%
Denominator	231	Target	41.83%	Evaluation Year	2025

The Child and Adolescent Well-Care Visits (WCV) measure is in the Engagement with Primary Care domain. The goal of this measure is to increase the percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner. This measure aligns with DHCS bold goals and comprehensive quality strategy to address racial disparities and SFHP is incentivized to improvement in WCV for two populations: Black/African American performance and the combined performance of Native American/Alaska Native, Native Hawaiian and Other Pacific Islanders. Based on NCQA MY 2023 benchmarks, SFHP chose the target of 48.15% for the Black/African American WCV population reaching the 33rd percentile and chose the target of 41.83% for the Native Hawaiian/Other Pacific Islander and Native American/Alaska Native WCV population reaching the 10th percentile.

2.5.7.2 Activities

The following activities were completed to support measure improvement in 2025:

- Promoted and encouraged Black/African American, Native Hawaiian/Other Pacific Islander and Native American/Alaska Native members age 3-21 years to engage in services through a member incentive to obtain a comprehensive WCV.
    - As of November 2025, a total of 756 gift cards were distributed to members for well-child screenings. The top three medical groups where members received a developmental screening gift card were assigned to University of California, San Franciso (316), North East Medical Services (204), and San Francisco Health Network (185).
- Outreached to members via a vendor, Carenet, to contact pediatric populations to

coordinate appointments for measures prioritized by SFHP including WCV for the priority health equity populations of Black/African American, Native Hawaiian/Other Pacific Islander and Native American /Alaska Native.
    - Carenet outreach project started in July 2025. They outreached to 1986 non-compliant WCV members from the populations of focus who had English and Spanish as the member's preferred spoken languages.
    - Carenet successfully scheduled, confirmed that member had already scheduled an appointment/attended an appointment or placed a member on a waitlist for an appointment for 14.65% of the member list (n=291).
    - Of the successful calls, 92% (n=269) identified as Black/African American and 8% (n=22) identified as Native Hawaiian/Other Pacific Islander.
    - The top three medical groups where Carenet scheduled an appointment for were assigned to UCSF (n=35), SFHN (n=21) and NEMS (n=17).
    - The top three medical groups where members reported that they had already scheduled an appointment with their clinic or recently attended an appointment were assigned to UCSF (n= 61), NEMS (n=51), SFHN (n=26).
    - The medical group with the highest number of members on the waitlist to schedule an appointment is SFHN (n=30).
- Interviewed community stakeholders and providers to understand barriers to care and identify areas for quality improvement at member or organizational level.
    - In collaboration from Zuckerberg San Francisco General Children's Health Center, SFHP completed a total of 19 surveys with member caregivers and pediatric providers
    - As a result of the interviews, SFHP identified the top challenges: transportation issues, appointment scheduling, finding time to get off work, coordinating with the clinic, and language access.
    - The interviews also brought to light change ideas for future interventions, including a better accessible transportation benefit, support from care managers to avoid no shows, offering mobile clinic, and SFHP providing a language line for interpretation when interpretation is challenging to access.

The following planned activity was not completed:

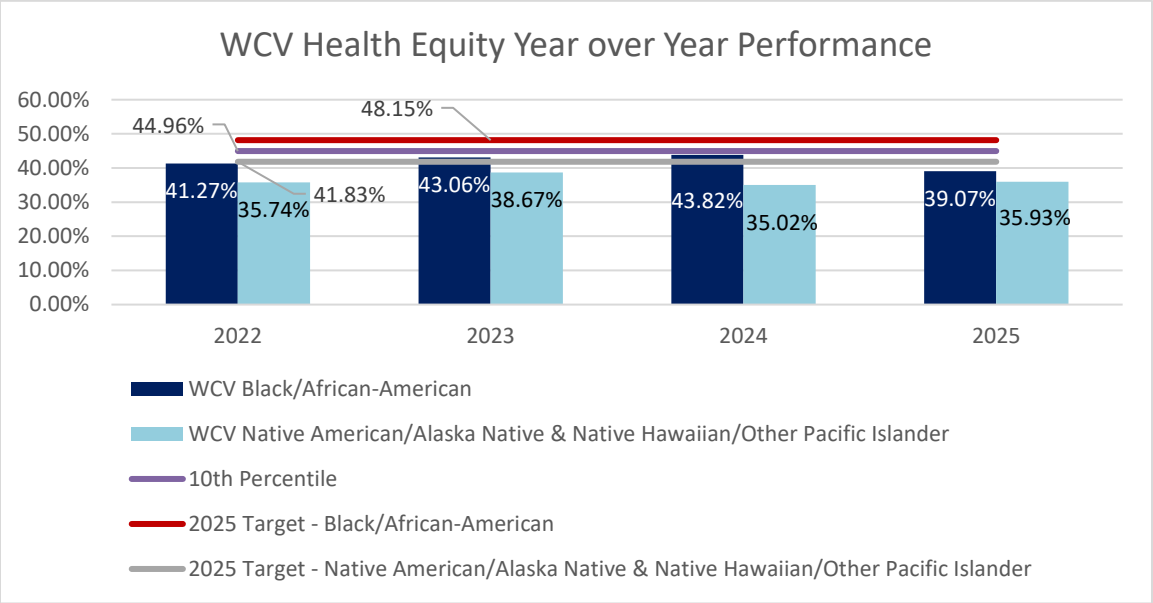
- Collaborate with one PCP clinic and one community-based organization serving a high proportion of members who are Black/African American, Native Hawaiian/Pacific Islander, Native Alaskan/Native American to implement one PDSA test of change for improvement to address identified barriers to care.
    - Due to limited resources, SFHP decided to pursue working with the vendor Carenet (gap in care outreach) in order to make an impact at a wider scale than one clinic.

2.5.7.3 Analysis

2.5.7.3.1 Quantitative

- Black/African-American population: The final result for the Black/African-American WCV population of 39.07% fell short of the target of 48.15% by 9.08% and is at risk of not meeting the 10th percentile based on NCQA MY 2024 benchmarks – 44.96 %.
- Native American/Alaska Native, Native Hawaiian & Other Pacific Islanders population: The final result for the Native American/Alaska Native, Native Hawaiian & Other Pacific Islanders WCV population of 35.93% fell short of the target of 41.83% by 5.90%.

While SFHP did not meet targets for 2025, the measure data is expected to improve by end of the year.



2.5.7.3.2 Qualitative

SFHP conducted a barrier analysis via a fishbone diagram to identify barriers to completing the well-child visits in the first 15 months of life based on six domains: process, environment, resources, policy, people, and provider. The main barrier to reaching the target was due to numerous unsuccessful call attempts by SFHP's outreach vendor Carenet to members who had disconnected or invalid phone numbers (30%, n=591) or members not answering the phone (31%, n=617). Additional barriers included long wait times to schedule appointments with clinics, members being placed on waitlists due to lack of providers/open schedules, distrust in the medical system and lack of culturally congruent care. Furthermore, the Member Incentive intervention was delayed and only started in September 2025.

To address these barriers, SFHP will work with SFHP's Customer Service and Business Systems Analytics teams to identify opportunities to obtain accurate contact numbers for children and youth to support with future telephonic outreach attempts. SFHP will also explore opportunities to participate in community outreach and/or partnerships with community-based organizations to increase awareness of the importance and benefits of annual well care visits and promote SFHP Care Management services to support with addressing other social determinants of health factors.

2.5.7.4 Recommendations

SFHP will continue WCV with both Health Equity populations in the 2026 QIHE Workplan with new targets of:

- Black/African-American population: 44.96% to meet the 10th percentile based on NCQA MY 2024 benchmarks
- Native American/Alaska Native, Native Hawaiian & Other Pacific Islanders population: 44.96% to meet the 10th percentile based on NCQA MY 2024 benchmarks

Activities to support measure improvement include:

- Continue to promote and encourage Native American, Native Hawaiian/Other Pacific

Islander and Black/African-American members age 3-21 years to engage in services through a member incentive to obtain a comprehensive well-child visit (WCV)
- Collaborate with Customer Service and Business Systems Analytics to identify opportunities to obtain accurate contact numbers for our children and youth members.
- Provide an information session to ECM Providers on Medi-Cal for Kids and Teens and the importance of Well-Care Visits.
- Work with ITS and Care Management team to track WCV compliance rates for children and youth engaged in ECM.
- Collaborate with at least one provider or community partner to provide health education on the importance of annual well-care visits for populations of focus (Native American, Native Hawaiian/Pacific Islander, and Black/African-American).

2.6 Member Experience

The domain of Member Experience involves activities related to member materials, improvement of care experience as measured by Health Plan CAHPS, trends in Grievances & Appeals, awareness of Cultural and Linguistic Services, as well as engagement in Health Education and Community Supports.

2.6.1 Health Plan CAHPS (Consumer Assessment of Healthcare Providers & Systems)

2.6.1.1 Overview & Performance

Measure: Getting Needed Care – Adult (CAHPS-A)					
Numerator	157	Baseline	69.21%	Final Performance	76.38%
Denominator	206	Target	75.52%	Evaluation Year	2025
Measure: Getting Needed Care – Child (CAHPS-CH)					
Numerator	132	Baseline	82.38%	Final Performance	71.12%
Denominator	186	Target	85.70%	Evaluation Year	2025
Measure: Getting Care Quickly – Adult (CAHPS-A)					
Numerator	141	Baseline	72.44%	Final Performance	72.47%
Denominator	195	Target	73.26%	Evaluation Year	2025
Measure: Getting Care Quickly – Child (CAHPS-CH)					
Numerator	152	Baseline	78.14%	Final Performance	77.91%
Denominator	195	Target	84.62%	Evaluation Year	2025

Getting Needed Care and Getting Care Quickly assess members' experience of healthcare access and timeliness to appointments via the annual Health Plan CAHPS survey.

Getting Needed Care is a composite of two questions: “In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?” *and* “In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?” Scores for this measure are determined by the total number of members responding *Usually or Always* to each question and then aggregated for the composite (or final measure) score. SFHP set a target of 75.52% for the Adult population and 85.70% for the Child population in an effort to increase its Health Plan percentile ranking to 10th and 66th, respectively, based on NCQA MY 2023 benchmarks.

Getting Care Quickly is a composite of two questions: “In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?” *and* “In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?” Scores for this measure are determined by the total number of members responding *Usually or Always* to each question and then aggregated for the composite (or final measure) score. SFHP set a target of 73.26% for the Adult population and 84.62% for the Child population in an effort to increase its Health Plan percentile ranking to 10th and 33rd, respectively, based on NCQA MY 2023 benchmarks.

2.6.1.2 Activities

The following activities were completed to support measure improvement in 2025:

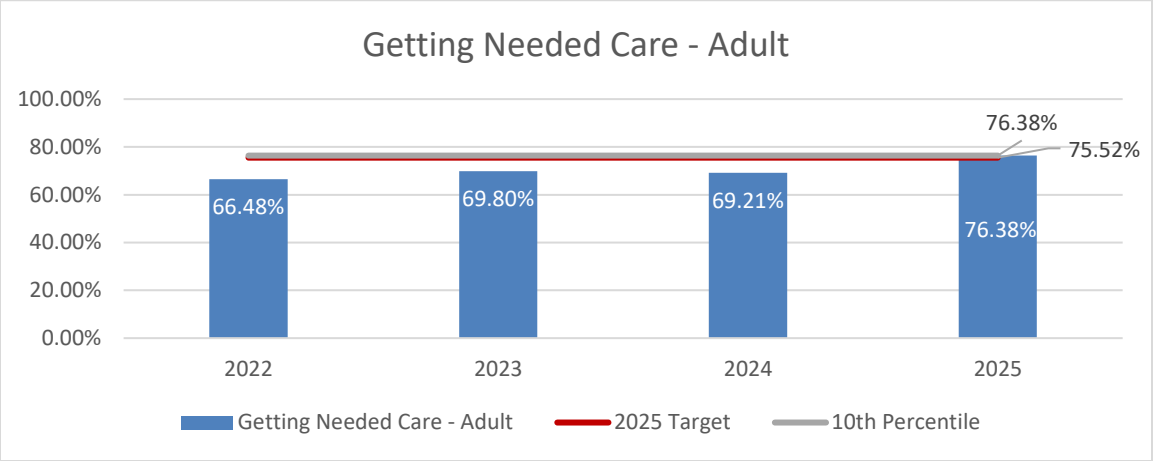
- Improved workflows and system efficiencies for Durable Medical Equipment across vendors, referring providers, and SFHP.
    - Developed a Vendor Scorecard to improve overall evaluation and expectation setting of DME vendors; completed 6 vendor site visits to discuss barriers and opportunities using the Scorecard
    - Identified a key gap in the DME network for gender affirming services; developed processes to improve prior authorization submission for vendors covering DME for gender affirming surgeries
- Delivered a nine-month digital education and awareness campaign for members focused on ways to access specialty care and vision services as well as how to complete the HP-CAHPS survey if randomly selected to participate.
- Designed and delivered member experience survey for dual-eligible beneficiaries and established baseline performance in preparation for 2026 D-SNP product launch.
    - Developed a configuration roadmap for member record management software, Jiva, with use cases to assess members’ risk for low care experience
- Completed a network analysis to understand trends and barriers to accessing specialty care and developed a member education insert to accompany all Referral Authorization Notices providing education on next steps in the specialty referral process.
- Incentivized eight provider groups and eight independent clinics through inclusion of HP-CAHPS Care Experience measures in SFHP’s primary care pay-for-performance programs. 20% (two out of eight) of providers achieved 33rd percentile for Rating of a PCP.
- Provided funding to Zuckerberg San Francisco General Specialty Care providers to implement appointment access interventions. Through this grant, Zuckerberg San Francisco General conducted the following improvements:
    - Specialty clinic staff were re-trained on core eligibility knowledge elements, scheduling functions in electronic health record software, and how to sign-up patients for the new multi-lingual texting platform that allows patients to request rescheduling of specialty care appointments.
    - Specialty care leadership team and patient access leadership team engaged front line stakeholders to review the standard work for common patient access

workflows and revised specialty care scheduling templates to optimize use of visit slots.
- Specialty care staff conducted a Kaizen that consisted of direct observations, data analysis, and implementation of PDSAs to optimize clinic workflows, including front office registration, communication between front office and back-office staff, and patient clinics.
- Arranged additional telehealth clinics and in-person evening and Saturday clinics the most highly impacted specialties. Grant funds were used to pay SFDPH staff and UCSF clinicians for this over time work.

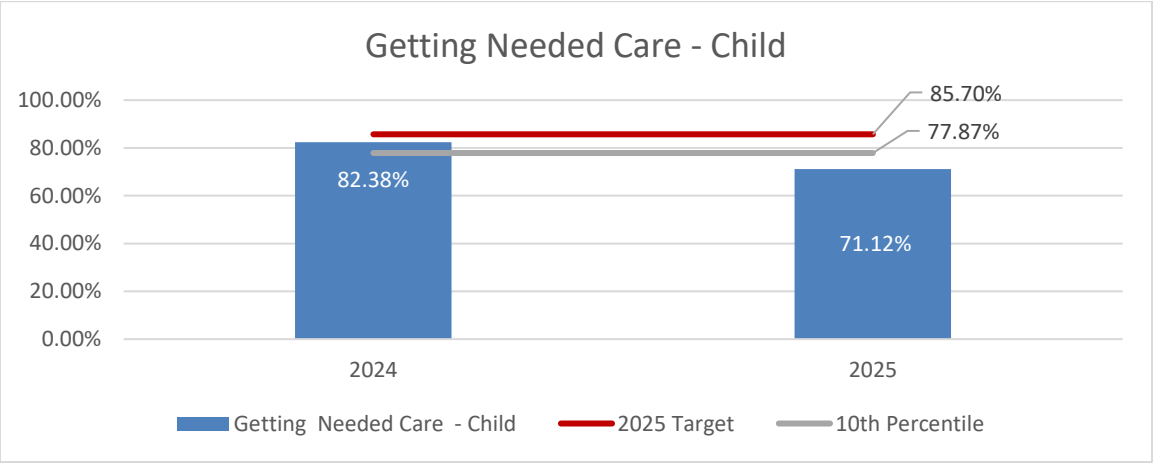
2.6.1.3 Analysis

2.6.1.3.1 Quantitative

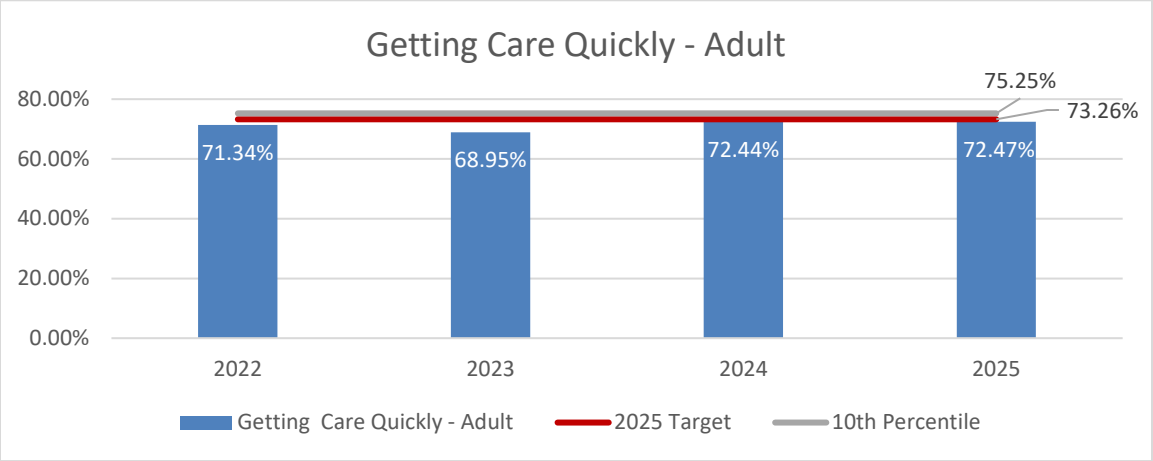
For the Getting Needed Care – Adult Measure, the final result of 76.38% exceeded the target of 75.52% and achieved the 10th percentile based on NCQA MY 2024 benchmarks. The following chart shows the four-year trend in this measure's scores with comparison to the 2025 target.



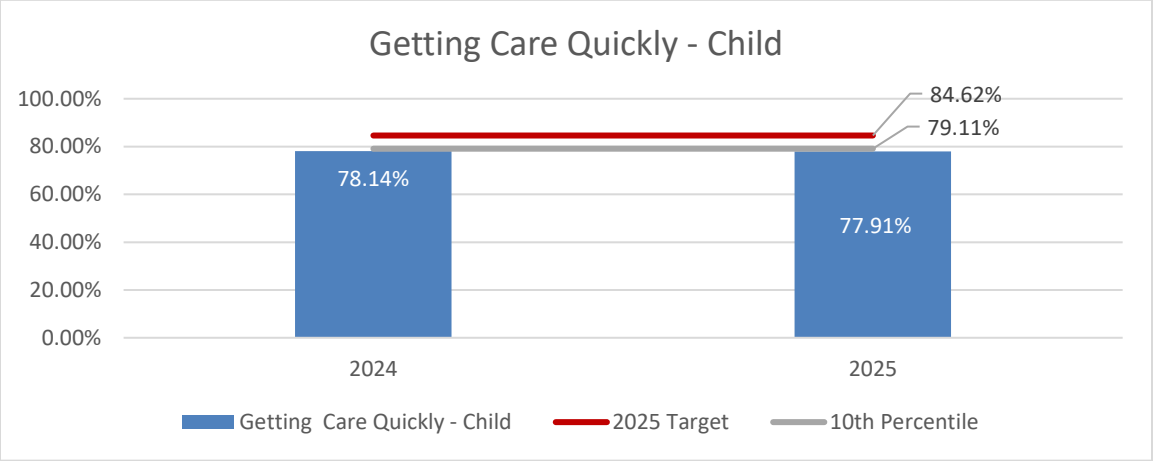
The Getting Needed Care – Child Measure did not achieve the target. Performance decreased by 11.26% from 82.38% to 71.12% and did not achieve the 10th percentile based on NCQA MY 2024 benchmarks. The following chart shows the measure's score in 2024 and 2025 with comparison to the 2025 target.



The Getting Care Quickly – Adult measure, did not achieve the target of 73.26%. Performance increased by 0.03% overall from 2024 for a final score of 72.47%. The measure did not achieve the 10th percentile based on NCQA MY 2024 benchmarks. The following chart shows a four-year trend in this measure's performance with comparison to the 2025 target.



The Getting Care Quickly – Child measure did not achieve the target of 84.62%. Performance decreased by 0.23% and did not achieve the 10th percentile based on NCQA MY 2024 benchmarks. The following chart shows the measure's score in 2024 and 2025 compared to the 2025 target.



2.6.1.3.2 Qualitative

Barriers to HP-CAHPS improvement include:

- The primary barrier encountered for Getting Needed Care improvement was lack of systems integration and ensuring reliable data. Each entity uses different systems to track and report patient encounters and approvals which made it difficult to determine last patient interaction and whether previous problems identified had been solved. This barrier points to a continued need for improved care coordination for patients between settings and the opportunity to enhance systems for better tracking.
- SFHP attributes the lack of performance for Getting Care Quickly to the reality that only one of at least 10 contracted providers in the network were able to implement the targeted interventions, so many members may have still experienced challenges with

timely access during the measure period. Not all SFHP members receive the CAHPS survey and provide feedback on their care experience – SFHP estimates that those individuals who were positively impacted by the access initiatives did not receive a copy or respond to the CAHPS survey.

2.6.1.4 Recommendations

SFHP will continue improvement efforts for the HP-CAHPS Access Measures in 2026. Targets will be:

- Getting Needed Care: the target for Child Getting Needed Care is 82.32% which reflects reaching the 33rd percentile; the target for Adult Getting Needed Care is 79.43% which reflects reaching the 25th percentile.
- Getting Care Quickly: each population target reflects reaching the 10th percentile; 79.11% for Child Getting Care Quickly, 75.25% for Adult Getting Care Quickly.

Activities to support these measures will include:

- Deliver a multi-month digital communications campaign centered on Members' Getting Needed Care, inclusive of blog and social media posts about the importance of engagement with a Primary Care Provider, how to navigate the specialty referral process, and how to complete the HP-CAHPS survey if randomly selected to participate.
- Incentivize providers through inclusion of HP-CAHPS Access Measures in SFHP's primary and specialty care pay-for-performance programs.
- Provide consultation/ongoing technical assistance with individual primary care clinics for improving appointment wait times and interventions to outreach members not engaged in primary care services.

3. Quality Oversight Activities

These are quality oversight activities monitored and completed this year.

	Oversight	Summary	Responsible Staff	Activities	Due Date
A	Quality Improvement & Health Equity Committee	Ensure Quality Improvement & Health Equity Committee (QIHEC) oversight of QIHE activities outlined in the QIHET Workplan	CMO CHEO	• Four meetings held in 2025	12/31/2025
B	Pharmacy and Therapeutics Committee	Ensure oversight and management of the SFHP formulary and DUR initiatives	CMO	• Quarterly and ad hoc P&T Committee meetings	12/31/2025
C	Physician Advisory/Peer Review/Credentialing Committee	Ensure oversight of credentialing and peer review by the Provider Advisory Committee	CMO	• Five meetings held in 2025	12/31/2025
D	Utilization Management Committee	Ensure oversight of SFHP Utilization Management program	Director, Clinical Operations	• Eight meetings held in 2025	12/31/2025
E	Annual Evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP)	Review QIHETP and determine efficacy of implemented plan based on outcomes	CMO CHEO	• Evaluated each measure in the QIHETP work plan • QIHEC reviewed QI evaluation • Governing Board reviewed QIHTP Evaluation	12/11/2025
F	QIHETP Plan Approval for Calendar Year	Review and approve proposed Quality Improvement & Health Equity Transformation work plan	CMO CHEO	• QIHEC reviewed QIHETP work plan • Governing Board reviewed QIHET Work Plan	12/11/2025

	Oversight	Summary	Responsible Staff	Activities	Due Date
H	DHCS Performance Improvement Projects	Ensure oversight and follow through on required DHCS Performance Improvement Projects	CMO	• Attended DHCS-led Performance Improvement Project calls • Adhered to process delineated by DHCS	12/31/2025

Reviewed and Approved by:

Chief Medical Officer: *Steve O'Brien, MD* Date: 11/30/2025

Chief Health Equity Officer: *Edwin Poon, PhD* Date: 11/21/2025

Quality Improvement & Health Equity Committee Review Date: 12/11/2025

Board of Directors Review Date: 1/21/2026