San Francisco Health Plan℠

Provider Quality Performance Program

2025 Program Guide

Primary Care

Guide Published: 01/16/2025

Primary Contact:
PIP_Contact@sfhp.org

San Francisco Health Plan℠

Acknowledgements

We are grateful to the PQP Advisory Committee and Staff at the participating organizations for their insights contributing toward the publication of this guide. Thank you for your inspiring commitment to improving health care for San Francisco residents.

San Francisco Health Plan

Table of Contents

San Francisco Health Plan

Section I: 2025 Provider Quality Performance Program (PQP) Overview

Primary Objectives	• Aligned with the Quadruple Aim: 1. Improving patient experience 2. Improving population health 3. Reducing the per capita cost of health care 4. Improving staff satisfaction • Financial incentives to reward improvement efforts in the provider network
Eligibility Requirements	• Contracted clinic or medical group with SFHP • Assigned primary care medical home for 300+ SFHP members and/or HSF participants
Funding Sources	As approved by SFHP's Governing Board: • 20% of Medi-Cal capitation payments
How Surplus Funds are Managed	• Participants' unearned funds roll over from one quarter to the next for the duration of the year • At the end of the year, unused funds are reserved for training and technical assistance to improve performance in PQP-related measures
Measure Development Criteria	Measures that are appropriate for inclusion in PQP are measures that align with external health care measurement entities (e.g. HEDIS, PRIME, NCQA accreditation), SFHP organizational priorities, and/or PQP network priorities. Measures are not designed to incentivize providers to deny services to members. In order to make informed measure decisions, SFHP can request information from participants during the development phase, such as current performance, population (n) size, goal, measure source/rationale. **All measures** should: • Affect a high volume of patients and/or a high-risk process. • Address an area that needs improvement. To that end, SFHP is committed to rewarding relative improvement as well as absolute performance. • Support SFHP priorities, including mandates from the Department of Health Care Services (DHCS), National Committee for Quality Assurance (NCQA), and the California Department of Managed Health Care (DMHC). • Have a proven methodology for measurement and data reporting prior to the start of the program year. • Primary Care program only: Present improvement opportunities for multiple networks. **Clinical Quality measures** should be: • Quantitative • Nationally recognized with an external comparator/benchmark

	• Able to follow Priority Five scoring methodology

Section II: PQP History

In 2010, San Francisco Health Plan's governing board approved the funding structure for the Provider Quality Performance Program (PQP), which launched in January 2011 with 26 participating provider organizations (clinics and medical groups). The long-term objective of PQP is to reward performance-based outcome measures, and has aimed to achieve this through the following stages:

- In the first two years of PIP in 2011-2012, participants were incentivized to build data and reporting capacities.
- In 2013, PIP introduced thresholds for clinical measures and began rewarding based on performance for the first time.
- In 2014, the Healthy San Francisco-funded initiative Strength in Numbers was fully integrated into PIP to streamline reporting requirements.
- In 2015, SFHP reduced the measure set to those most important and lowest performing measures.
- In 2016, Specialty Care access measures were added for medical groups because access remains the area for most opportunity with San Francisco's Medi-Cal population.
- In 2017, new measures were added to the Clinical Quality domain to increase alignment with external entities
- In 2018, new measures were added to the Systems Improvement domain to support appropriate utilization of primary care visits and expansion of the palliative care Medi-Cal benefit.
- In 2019, the patient experience domain was assessed with the goal of strengthening the measure set to improve alignment with SFHP and participant improvement priorities, strengthen patient experience metrics (i.e. methodology and targets), and simplify reporting.
- In 2020, SFHP condensed the measure set to address concerns during the COVID-19 pandemic. SFHP also introduced Quality Improvement Projects (QIPs).
- In 2023, SFHP retired Quality Improvement Projects. The program was also aligned with the calendar year. To accomplish this, SFHP implemented a 6-month program to bridge the remainder of 2023 (July-December).
- In 2024, new CQ scoring methodology was implemented to align with DHCS expectations. Added PIP Reserves to Q4 available funds to earn for all participants.
- In 2025, name change of the program from Practice Improvement Program to Provider Quality Performance Program. In 2025, a new CQ and HP-CAHPS scoring methodology was implemented to align with DHCS expectations. Two (2) CQ measures were added to the program.

Section III: Summary of Key Changes for PQP 2025

- Scoring methodology updates: please refer to the PQP Scoring Methodology and Measure Specifications sections for more information.
- Updated measure set, please refer to the measure specification section for more information.

San Francisco Health Plan

Section IV: PQP Reporting Rules and Timeline

Reporting requirements and lookback periods vary based on the individual measure (see Section VII for detailed measure specifications).

Lookback period: To determine the lookback period for each measure, please refer to the individual measure specification. For all measures, the final day of data to be included is the date listed under "Quarter End Date" above. The first day varies by measure based on lookback period.

Late Submissions Acceptance Policy and Procedure

Late submissions will be accepted up to two weeks after each quarter's deadline if an extension is asked for two weeks in advance of the original due dates. Any extensions requested past the 2 weeks prior to the original due date will be reviewed by SFHP QI leadership. When an extension has been granted, points and payment will not be affected. When an extension has not been granted, the late submission will not be accepted, and the participant will forfeit the associated points.

Mid-Year Measure Change Policy

Mid-year measure changes are discouraged; however, there are cases that merit a measure change mid-year. The following cases are used to evaluate a measure change request:

- When a measure no longer represents both participant and SFHP priorities.
- When a measure is dictated by external agencies and the agency removes their support for the measure.
- When the relevancy/validity of the measure is undermined due to substantive interim changes in medical evidence and/or widely accepted clinical practice guidelines including, but not limited to, USPTF guideline changes.

Section V: PQP Scoring Methodology and Payment Details

Incentive payments will be based on the percent of points achieved of the total points that a participant is eligible for in each quarter. Should a participant be exempt from a given measure (as described in the measures specifications), the total possible points allocated to that measure will not be included in the denominator when calculating the percent of total points received. Participants will receive a percent of the available incentive allocation based on the following algorithm:

- 90-100% of points = 100% of payment
- 80-89% of points = 90% of payment
- 70-79% of points = 80% of payment
- 60-69% of points = 70% of payment
- 50-59% of points = 60% of payment
- 40-49% of points= 50% of payment
- 30-39% of points= 40% of payment
- 20-29% of points = 30% of payment
- Less than 20% of points = no payment

The point allocation for each individual measure is determined based on the degree of alignment with overall program priorities and prioritization of the measure nationally. See individual measure specifications for details.

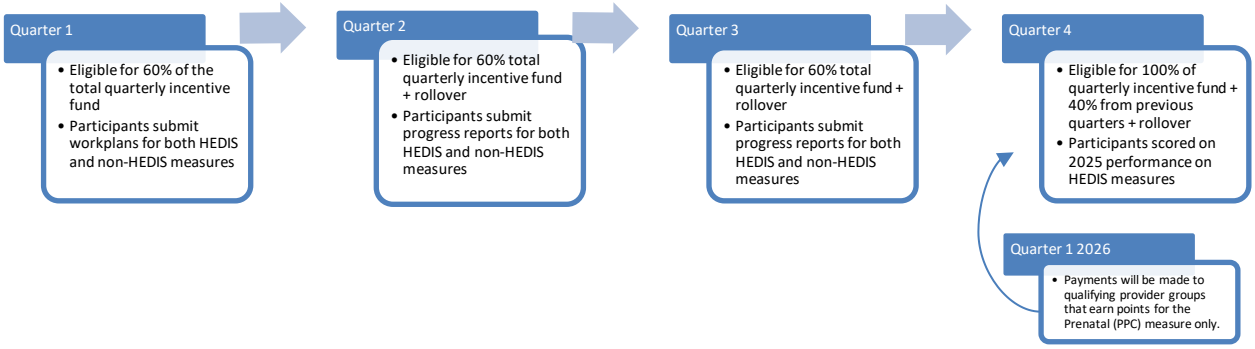
Measures are designed to be reasonably challenging. While SFHP wants to distribute the maximum funds possible, the primary goal is to drive improvement in patient care. Pairing high quality standards and a financial incentive is just one approach in achieving this goal. As has been the case each year, any funds not earned in one quarter will be rolled over into the next quarter. Funds not earned by the end of the program year are reserved for training and technical assistance to improve performance in PQP-related measures.

Payments will be disbursed quarterly via electronic funds transfer, within two weeks of the scorecard being sent.

Timely submission of claim/encounter data is important for improving performance on quality measures, advocating for adequate rates from the state, and ensuring fair payments to providers. Participants will only be eligible for PQP incentive payments during quarters in which at least one encounter file is received each month in the correct HIPAA 837 file format. Failure to submit at least one data submission each month will result in disqualification from PQP payments for all domains for the relevant quarter. Those funds will NOT be rolled over into the next quarter. All measures that are scored with claims/encounter data require data to be in the correct HIPAA 837 file format. SFHP provides a data clearinghouse (OfficeAlly) for submitters who do not have this ability; please contact the PQP Team for more information on this option.

Incentive Allocation

Some annual incentive funds will be allocated to HEDIS (CQ) measures in Q4. In other words, Q4 will account for **40% of Q1-Q3s' withhold amounts**. To calculate this, SFHP will automatically withhold 40% of the total available funds in Q1-Q3 to carry over to Q4. In Q4, SFHP will calculate 40% of the three quarters. Participants will automatically receive the difference in the calculated 40% and what was available for Q1-Q3 if all materials were received in those quarters. Available funds in Q4 will comprise of 100% of Q4's incentive fund and the 40% withhold amount from Q1-Q3. Funds will continue to rollover until Q4.



Participants who qualified for the PPC measure, please see measure specifications to review payment timeline.

Measure Exemptions

Each measure has certain requirements for exemptions, see the specifications for details. Exemptions are determined once for the program year upon enrollment and communicated to participants via the

annual measure grid. Thus, if a participant is determined to be exempt from a measure at the beginning of the year, they remain exempt from the measure for the remainder of the year. For those participants who are exempt from a measure, SFHP may have other resources for which to collaborate on improvement efforts. If interested, please contact the PQP team.

Section VI: Clinical Quality Domain

Clinical Quality Scoring

Q1-Q3, all CQ measures will be worth 1 point each for workplan and progress report submissions. Points assigned to CQ measures will be fixed for Q4:

Measure	Total Points
Follow-Up After Hospitalization for Mental Illness (FUM)	3
Follow-Up After Hospitalization for Alcohol / Other Drug Abuse (FUA)	3
Well Child Visits in the First 15 Months of Life (W30-6)	3
Timeliness of Prenatal Care (PPC)	3
Asthma Medication Ratio (AMR)	2
Developmental Screenings (DEV)	2
Colorectal Cancer Screening (COL-E)	1
Depression Screening for Adolescents and Adults (DSF-E)	1
Depression Screening Follow-Up for Adolescents and Adults (DSF-E)	1

Bonus Points will be awarded in Q4 2025 by achieving:

- 2025's 90th percentile or above for any of the CQ measures **except** DEV.
- 20% RI from 2024 scores for Hispanic identifying W30-6+ members. Participant must have qualified for W30-6+

A tiered scoring methodology will be implemented for CQ measures in Q4 2025:

a. Tier A: Participants who score at the 50th percentile or above in MY 2024 will be able to earn points for each measure assigned by scoring within a range of percentiles per MY 2025 benchmarks released Fall of 2025.
b. Tier B: Participants who score below the 50th percentile in MY 2024 will be able to earn points for each measure assigned through absolute improvement OR reaching the 50th percentile for MY 2025.

Tier A Points Earned	What needs to be achieved to earn points?
Full points	75th percentile or above for MY 2025
Partial points (80%)	66.67th percentile for MY 2025
Lower partial points (40%)	50th percentile for MY 2025
No points	Score below the 50th percentile for MY 2025

Tier B Points Earned	What needs to be achieved to earn points?
Full points	8% absolute improvement from MY 2024 OR 50th percentile for MY 2025
Partial points (80%)	5% absolute improvement from MY 2024
Lower partial points (40%)	3% absolute improvement from MY 2024
No points	Don't achieve 3% absolute improvement from MY 2024.

Clinical Quality Thresholds

SFHP will use the most up to date NCQA thresholds to score participants at the end of the calendar year. Thresholds are released by NCQA in the fall of 2025. This section will be updated, and the guide rereleased once SFHP has access to the 2025 thresholds. *The thresholds provided below are for 2024 and should only be used for reference.*

Measure	2024 33rd Percentile	2024 50th Percentile	2024 66.67th Percentile	2024 75th Percentile	2024 90th Percentile
CQ01 Asthma Medication Ratio	-	66.24%	70.56%	72.22%	76.65%
CQ02 Developmental Screening in the First 3 Years of Life	-	35.70%			
CQ03 Follow-Up After Hospitalization for Alcohol/Other Drug Abuse	-	36.18%	39.35%	41.86%	49.40%
CQ04 Follow-Up After Hospitalization for Mental Illness	-	53.82%	59.65%	63.06%	73.12%
CQ05 Timeliness Access to Prenatal Care	-	84.55%	86.89%	88.58%	91.85%
CQ06 Well Child Visits in the First 15 Months of Life	-	60.38%	63.29%	64.99%	69.67%
CQ07 Colorectal Cancer Screening	-	38.07%	41.59%	43.71%	49.35%
CQ08 Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	-	1.03%	2.67%	4.52%	16.22%
CQ09 Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on Positive Screen	-	70.91%	77.07%	78.82%	87.39%
PE 1 Improving Member Rating of Personal Doctor	67.32%	69.26%	71.05%	72.35%	74.42%

Section VIII: Primary Care Measure Specifications

The rest of this document consists of the individual specifications for each of the 2025 measures across all domains: clinical quality, patient experience, and systems improvement.

Bonus point measure specifications were incorporated for eligible participants. This is to aid the development of workplans to receive 1 bonus point per eligible measure.

CQ 01: Asthma Medication Ratio

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the rate of patients with persistent asthma who had a ratio of controller medication units to total asthma medication of 0.50 or greater.

Asthma Medication Ratio =

Numerator: Number of patients in the denominator population who have a ratio of 0.5 or greater of controller asthma medication units to total asthma medications in the measurement year.

Denominator: Total number of patients between the ages 5-64 with persistent asthma as defined as one or more of the following in the past two years:

- At least one ED visit with a primary diagnosis of asthma
- At least one inpatient encounter with a primary diagnosis of asthma
- At least four outpatient visits, observation visits, telephone visits, or e-visits or virtual check ins with a diagnosis of asthma **and** at least two asthma medication dispensing events for any controller or reliever medication
- At least four asthma medication dispensing events for any controller or reliever medication

Continuous Enrollment: The measurement year and the year prior to the measurement year.

Measure Rationale

Asthma can be managed through the regular administration of asthma controller medications, which can control chronic symptoms and can prevent future exacerbation and progressive decline in lung function (or for children, reduced lung growth). The use of reliever or short acting medications will help ease acute symptoms but do not provide long-term asthma control and if used more than recommended, can cause long-term side effects. Asthma control strategies can reduce ED visits by as much as 68% and hospitalizations by as much as 85%, resulting in cost savings to inpatient care (CDC, 2015).

Measure Source

Inclusion of this measure is supported by alignment with external healthcare measurement entities, including DHCS MCAS, NCQA accreditation, and EAS.

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- One controller medication unit is defined as an amount of medication lasting 30 days or less; one medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication.
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.
- Persistent asthma is defined as meeting at least one of the four denominator criteria.

CQ 02: Developmental Screening in the First 3 Years of Life

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the rate of patients 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 is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.

$$\textbf{Developmental Screening} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator who were screened for risk of developmental, behavioral, and social delays using a standardized tool during the measurement year.}}{\textbf{Denominator:}\ \text{Total number of patients who turned 1,2, or 3 years of age during the measurement year.}}$$

Continuous Enrollment: Children who maintain continuous enrollment for the 12 months leading up to their first, second, or third birthday.

Measure Rationale

According to Ages & Stages, 1 in 7 children are affected by developmental delays, learning disorders, and behavioral and social-emotional problems. Only a fraction of these children (20% to 30%) are identified as needing help before school begins. Intervention before kindergarten has huge benefits because it sets children up for future success. Studies have shown that children who receive early treatment for developmental delays are more likely to graduate from high school, hold jobs, live independently, and avoid teen pregnancy, delinquency, and violent crime.

Measure Source

Inclusion of this measure and PQP benchmark determination is supported by alignment with external healthcare measurement entities, including DHCS MCAS.

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Standardized Tool – tools that have been normed and validated and must meet the following criteria:
  - Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
  - Established Reliability: Reliability scores of approximately 0.70 or above.
  - Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
  - Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.

CQ03: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the rate of patients ages 13 years and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD.

$$\textbf{Follow-Up for AOD} = \frac{\textbf{Numerator:}\ \text{Number of patients in denominator who received a follow-up visit with a diagnosis of AOD or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days).}}{\textbf{Denominator:}\ \text{Total number of patients 13 years of age and older with an emergency department (ED) visit with a principal diagnosis of SUD } \textbf{or}\ \text{any diagnosis of drug overdose between January 1st and December 1st of the measurement year.}}$$

Continuous Enrollment: From the date of the ED visit up to 30 days afterward (31 total days).

Measure Rationale

For people with AOD, multiple trips to the ED may mean they lack access to care or have issues with continuity of care. Timely follow-up care for people with AOD seen in the ED can reduce substance use, future ED use, hospital admissions and length of stay. A study by the Substance Abuse and Mental Health Services Administration found that more than 21 million people ages 12 and older in the U.S. needed substance use treatment but that only 4.2 million people received it.

Measure Source

Inclusion of this measure is supported by alignment with external healthcare measurement entities, including HEDIS measure FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.

CQ 04: Follow-Up After Emergency Department Visit for Mental Illness

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the rate of patients ages 6 years and older who receive a follow-up visit within 30-days of an emergency department (ED) visit with a diagnosis of mental illness or intentional self-harm.

$$\textbf{Follow-Up for Mental Illness} = \frac{\textbf{Numerator:}\ \text{Number of patients in denominator who received a follow-up visit with a diagnosis of a mental health disorder within 30 days after the ED visit (31 total days).}}{\textbf{Denominator:}\ \text{Total number of patients 6 years of age and older with an emergency department visit with a principal diagnosis of mental illness } \textbf{or} \text{ intentional self-harm in any position on the claim between January 1st and December 1st of the measurement year.}}$$

Continuous Enrollment: From the date of the ED visit up to 30 days afterward (31 total days).

Measure Rationale

Mental illness can affect people of all ages. In the United States, 18% of adults and 13%–20% of children under 18 years of age experience mental illness. Research suggests that follow-up care for people with mental illness is linked to fewer repeat ED visits, improved physical and mental function and increased compliance with follow-up instructions.

Measure Source

Inclusion of this measure is supported by alignment with external healthcare measurement entities, including HEDIS measure FUM: Follow-Up After Emergency Department Visit for Mental Illness.

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.

CQ 05: Timely Access to Prenatal Care

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the rate of patients who received a prenatal care visit in the first trimester of their pregnancy or within 42 days of enrollment into Medi-Cal, whichever is later.

$$\textbf{Timely Access to Prenatal Care} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who received a prenatal visit in the first trimester of their pregnancy or within 42 days of enrollment into Medi-Cal, whichever is later.}}{\textbf{Denominator:}\ \text{Number of patients who had a live birth on or between October 8}^{th}\ \text{of the prior measurement year to October 7}^{th}\ \text{of the current measurement year.}}$$

Continuous Enrollment: 43 days prior to delivery through 60 days after delivery.

Measure Rationale

Prenatal care visits inform patients about the important steps they can take to ensure a safe pregnancy and protect their infant. As such, timely access to prenatal care can reduce complications from pregnancy and the associated health care costs.

Measure Source

Inclusion of this measure and PQP determination is supported by alignment with external healthcare measurement entities, including NCQA accreditation, EAS, and PRIME.

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.

Scoring and Payment Update

To ensure all participants are scored fairly, and enough time has passed to capture as many encounters as possible for the measure, PPC will not be scored until May 2026. Funds will be released on the Q1 2026 payment. PPC is a hybrid measure, and rates are not finalized until May of the following calendar year. Your baseline and 2025 data will be used for the score calculation.

CQ 06: Well Child Visits in the First 15 Months of Life

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the rate of patients 15 months of age who had six or more Well Child Visits with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

$$\textbf{Well Child Visits} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who had at least six well-child visits before the child's 15-month birthday.}}{\textbf{Denominator:}\ \text{Number of active patients who turned 15 months old during the measurement year}}$$

Continuous Enrollment: 31-days to 15 months of age with no more than one gap in enrollment up to 45 days.

Measure Rationale

Well-child visits are important during the early months of a child's life to assess growth and development and identify and address any problems early. In addition, well-child visits can help to establish a strong relationship between parent(s) and pediatrician. The American Academy of Pediatrics (AAP) recommends six well-child visits on or before a child's 15-month birthday (AHRQ, National Quality Measures Clearinghouse, 2014).

Measure Source

Inclusion of this measure and PQP benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA accreditation, HEDIS measure W15: Well-Child Visits in the First 15 months of Life, MCAS, and NQF(#1392).

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.
- Well Child Visits should include evidence of monitoring physical, behavioral, and emotional development as well as checking immunization records at every visit and administering vaccines that are due.

CQ 07: Colorectal Cancer Screening (COL-E)

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Postpartum Screening and Follow-Up	=	**Numerator:** Total number of patients in the denominator who received one or more of the following cancer screenings during the measurement year: • Fecal occult blood test during the measurement year. • Flexible sigmoidoscopy during or the 4 years prior to measurement year. • Colonoscopy during or the 9 years prior to the measurement year. • CT colonography during or the 4 years prior to the measurement year. • Stool DNA with FIT test during or the 2 years prior to the measurement year. **Denominator**: Total number of patients ages 46-75 during the measurement year.

Continuous Enrollment: The prior measurement year and the current measurement year.

Measure Rationale

Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after five years. However, more than a third of adults 50–75 do not get recommended screenings (American Cancer Society, 2017). Colorectal cancer screening of asymptomatic adults in that age group can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.

Measure Source

Inclusion of this measure and PQP benchmark determination is supported by alignment with external healthcare measurement entities, including HEDIS measure COL-E Colorectal Cancer Screening.

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.

CQ 08: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) – Depression Screening

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Depression Screening and Follow-Up	=	**Numerator:** Total number of eligible patients with a depression screening during the measurement year. **Denominator**: Total number of patients 12 years old and older during the measurement year.

Measure Rationale

Screening for depression is an important first step in increasing behavioral health utilization, which is low for SFHP members. In addition, depression has a large effect on health care costs and on productivity. It is estimated that monthly depression-related worker productivity losses had human capital costs of nearly $2 billion while adults with depression or depressive symptoms have significantly higher health care costs, even after adjusting for chronic medical conditions (Katon et al., 2003). Inclusion of this measure supports early detection with potential for cost savings from treatments associated to health complications from depression.

Measure Source

Inclusion of this measure and PQP benchmark determination is supported by alignment with external healthcare measurement entities, including HEDIS measure DSF: Depression Screening and Follow-Up for Adolescents and Adults.

Definitions & Exclusions

- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Participants with < 15 SFHP members in the eligible population are exempt from this measure.

CQ 09: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) – Follow-Up on Positive Screen

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Depression Screening and Follow-Up	=	**Numerator:** Total number of patients with a positive depression screening and documented follow-up within 30-days during the measurement year. **Denominator**: Total number of patients 12 years old and older during the measurement year with a positive depression screening.

Measure Rationale

Screening for depression is an important first step in increasing behavioral health utilization, which is low for SFHP members. In addition, depression has a large effect on health care costs and on productivity. It is estimated that monthly depression-related worker productivity losses had human capital costs of nearly $2 billion while adults with depression or depressive symptoms have significantly higher health care costs, even after adjusting for chronic medical conditions (Katon et al., 2003). Inclusion of this measure supports early detection with potential for cost savings from treatments associated to health complications from depression.

Measure Source

Inclusion of this measure and PQP benchmark determination is supported by alignment with external healthcare measurement entities, including HEDIS measure DSF: Depression Screening and Follow-Up for Adolescents and Adults.

Definitions & Exclusions

- Follow-up for a positive screening must include one of the following on or up to 30 days after the first positive screen:
    - An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
    - A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
    - A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
    - A dispensed antidepressant medication. OR
    - Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.
- Please refer to the PQP webpage for numerator compliance and exclusion codes: https://www.sfhp.org/providers/improving-quality/hedis-measure-guides/
- Participants with < 15 SFHP members in the eligible population are exempt from this measure

DQ 1: Provider Roster Updates

2025 Practice Improvement Program Measure Specification

IPA & ACADEMIC MEDICAL CENTER ONLY

Measure Description

Participants will receive points for reviewing SFHP provider data on a quarterly basis and providing new information when applicable. The process will be as follows:

1. *Within the first week after the quarter has ended:* SFHP will email SFHP-generated provider roster to designated PQP contact. Roster will include data regarding providers who were known to be active during the three months of the quarter.
2. *During the month after the quarter has ended:* the designated PQP contact will review the SFHP-generated provider roster. The roster will contain information for each provider known to be active at any point during the three months of the quarter. Contractors, courtesy staff, fellows, and residents are excluded. The following elements are *required* (unless stated otherwise) to be included about each provider:

    a) First and last name (legal with preferred in parenthesis)
    b) Medical degree
    c) Type of Practitioner (PCP or Specialist)
    d) Primary Specialty
    e) Secondary Specialties (*if applicable*)
    f) Language(s) spoken other than English *(if applicable)*[1]
    g) License number
    h) NPI
    i) Email address*
    j) For NPs, PAs, CNMs only: Name of MD/DO Supervisor* (*if applicable)*
    k) Site Name
    l) Language(s) spoken at site other than English (*if applicable*)
    m) Hours & Days Site is Open
    n) Date listed with SFHP
    o) Date terminated/left the organization* (*if applicable*)
    p) Open to new members (Y/N)^ (For PCPs only)
    q) Open to auto-assignment (Y/N)*^ (For PCPs only)

    **This information is for SFHP internal use only.*
    ^Not applicable to the SFHN.

[1] SFHP providers are not required to speak English, however the vast majority do. Therefore in an effort to save time when reporting for this measure we will not require you to specify if providers speak English.

- *By the Quarter's Due Date:*
  - When changes need to be made:
    - Return the SFHP-produced roster with changes noted in the first column
  - When no changes need to be made:
    - Indicate no changes in the first column
- Complete a Provider Roster Attestation verifying that all information has been reviewed and (if applicable) updates provided. Attestation and supporting information template (if applicable) should be uploaded via Wufoo.

Measure Rationale

Timely submission of updated provider rosters ensures that SFHP maintains key compliance objectives and accurate member assignments. SFHP does not routinely receive timely and accurate provider data from all clinics and medical groups. This has resulted in very poor scores on state audits; for example, a 2015 Department of Health Care Services audit found 88% of randomly selected SFHP provider data to have errors. Moreover, CA Senate Bill 137 requires all Knox-Keene-licensed health plans in California to collect much more robust provider data, effective 7/1/2016. The revised process for this measure will support SB137.

Measure Source

Inclusion of this measure is supported by alignment with external healthcare measurement entities, including the Department of Health Care Services (DHCS) Quality Measures for Encounter Data (QMED).

Exclusions

- The following providers should be excluded from the roster: contractors, courtesy staff, fellows, and residents.

Data Source/Resources

- Questions related to your provider roster can also be submitted to provider.relations@sfhp.org, or by calling (415) 547-7818 x7084.

Deliverables and Scoring

Deliverable	Due Dates	Scoring
• **If there are *no changes* that need to be made to the current quarter's provider roster, please indicate so in the comments section of the roster.** • **If *changes do need to be made* to the current quarter's provider roster, please submit the supporting information.**	• Quarter 1 (April 30, 2025) • Quarter 3 (October 31, 2025)	2.0 points

PE 1: Improving Member Rating of Personal Doctor

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description
Participants will receive points for reporting a quality improvement plan on how they will improve the below measure and hitting improvement goals in Quarter 3.

Question from HP-CAHPS Survey: On a scale of 0-10, with 0 being the worst personal doctor and 10 being the best personal doctor, what number would you use to rate your personal doctor?

NCQA considers scores 9/10 or 10/10 to this question as compliant.

Measure Rationale
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an AHRQ program that began in 1995. Its purpose is to boost our scientific understanding of patient experience with healthcare as part of a larger effort to advance the delivery of safe, patient-centered care. Patient experience encompasses the range of interactions that patients have with the healthcare system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities. The survey is sent to SFHP members on an annual basis.

Measure Source
Inclusion of this measure is supported by alignment with external healthcare measurement entities, including NCQA accreditation.

Resources
See PQP website for resources.

Deliverables and Due Dates

Deliverable	Due Date	Quarterly Scoring
Submit quality improvement workplan	Quarter 1 (April 30, 2025)	1.0 points
Submit update on progress on quality improvement workplan	Quarter 2 (July 31, 2025)	1.0 point
HP-CAHPS scores released to participants.	Quarter 3 (October 31, 2025)	3.0 points

Tier A (at or above 33rd 2024)	Tier B (below the 33rd 2024)	Points
2025 75th percentile or above	10% RI from 2024 score	3
2025 67th percentile	7% RI from 2024 score	2
2025 33rd percentile	5% RI from 2024 score	1
Less than 2025 33rd percentile	Less than 5% RI from 2024 score	0

PE 2: Health Equity

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for reporting a quality improvement plan on how they will improve ONE (1) of the below health disparities. These disparities have been identified by SFHP through extensive analysis.

1. Telehealth utilization for African American and/or Spanish speaking patients
2. Well-child visits for Hispanic and/or African American patients (W30-6+)
3. Access to prenatal care for African American, Latina/o, and/or Native American patients (PPC – Prenatal)
4. Access to postpartum care for African American, Native American, and/or Asian/Pacific Islander patients (PPC – Postpartum)

Measure Rationale

Health disparities result in about $93 billion in excess medical care costs and $42 billion in lost productivity each year, according to a 2018 analysis from the W.K. Kellogg Foundation. On top of being costly, disparities hinder the nation's overall health, as groups who historically have had access to fewer resources have higher rates of illness and death from a variety of preventable conditions.

Measure Source

Inclusion of this measure is supported by alignment with external healthcare measurement entities, including NCQA accreditation.

Deliverables and Scoring

Deliverable	Due Date	Quarterly Scoring
Submit quality improvement workplan	Quarter 1 (April 30, 2025)	1.0 points
Submit update on progress on quality improvement workplan	Quarter 2 (July 31, 2025) Quarter 3 (October 31, 2025)	1.0 point

PE 3: Improving Access to Tests and Treatment

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description
Participants will receive points for reporting a quality improvement plan on how they will improve the below measure.

Question from HP-CAHPS Survey: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

NCQA considers scores "Usually" or "Always" to this question as compliant.

Measure Rationale
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an AHRQ program that began in 1995. Its purpose is to boost our scientific understanding of patient experience with healthcare as part of a larger effort to advance the delivery of safe, patient-centered care. Patient experience encompasses the range of interactions that patients have with the healthcare system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities. The survey is sent to SFHP members on an annual basis.

Measure Source
Inclusion of this measure is supported by alignment with external healthcare measurement entities, including NCQA accreditation.

Resources
See PQP website for resources.

Deliverables and Due Dates

Deliverable	Due Date	Quarterly Scoring
Submit quality improvement workplan	Quarter 1 (April 30, 2025)	1.0 points
Submit update on progress on quality improvement workplan	Quarter 2 (July 31, 2025) Quarter 3 (October 31, 2025)	1.0 point

PE 4: Improving Getting Care Quickly Part 1

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description
Participants will receive points for reporting a quality improvement plan on how they will improve the below measure.

Question from HP-CAHPS Survey: In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

NCQA considers scores "Usually" or "Always" to this question as compliant.

Measure Rationale
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an AHRQ program that began in 1995. Its purpose is to boost our scientific understanding of patient experience with healthcare as part of a larger effort to advance the delivery of safe, patient-centered care. Patient experience encompasses the range of interactions that patients have with the healthcare system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities. The survey is sent to SFHP members on an annual basis.

Measure Source
Inclusion of this measure is supported by alignment with external healthcare measurement entities, including NCQA accreditation.

Resources
See PQP website for resources.

Deliverables and Due Dates

Deliverable	Due Date	Quarterly Scoring
Submit quality improvement workplan	Quarter 1 (April 30, 2025)	1.0 points
Submit update on progress on quality improvement workplan	Quarter 2 (July 31, 2025) Quarter 3 (October 31, 2025)	1.0 point

PE 5: Improving Getting Care Quickly Part 2

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description
Participants will receive points for reporting a quality improvement plan on how they will improve the below measure.

Survey Question from HP-CAHPS: In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?

NCQA considers scores "Usually" or "Always" to this question as compliant.

Measure Rationale
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an AHRQ program that began in 1995. Its purpose is to boost our scientific understanding of patient experience with healthcare as part of a larger effort to advance the delivery of safe, patient-centered care. Patient experience encompasses the range of interactions that patients have with the healthcare system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities. The survey is sent to SFHP members on an annual basis.

Measure Source
Inclusion of this measure is supported by alignment with external healthcare measurement entities, including NCQA accreditation.

Resources
See PQP website for resources.

Deliverables and Due Dates

Deliverable	Due Date	Quarterly Scoring
Submit quality improvement workplan	Quarter 1 (April 30, 2025)	1.0 points
Submit update on progress on quality improvement workplan	Quarter 2 (July 31, 2025) Quarter 3 (October 31, 2025)	1.0 point

SI 1: Initial Health Appointment Completion

2025 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for reporting a quality improvement plan on how they will improve the below measure.

IHA Rate = **Numerator**: Number of SFHP members in the denominator population with at least one IHA or exemption claim or encounter / **Denominator:** Total number of newly enrolled (120 consecutive days) SFHP Medi-Cal members assigned to your organization.

Measure Rationale

Completing a timely Initial Health Appointment (IHA) provides an opportunity for members to establish a relationship with their primary care physician (PCP). In addition, the appointment allows members to obtain necessary health care and preventive services, which can lead to positive health outcomes and improvement in their overall health status.

All newly enrolled SFHP members must receive an IHA within 120 days of enrollment, as required by DHCS. The IHA includes, but is not limited to:

- A comprehensive health history (medical, social, family)
- Physical exam, including a systems review
- Immunizations
- Medical testing and treatment
- Health screening for common diseases
- Referrals for follow-up care

Note: IHA visit and exemption notes must be maintained in the patient's chart and will be audited annually.

Measure Source

Inclusion of this measure and PQP benchmark determination was informed by SFHP in conjunction with the PQP advisory committee.

Deliverables and Due Dates

Deliverable	Due Date	Quarterly Scoring
Submit quality improvement workplan	Quarter 1 (April 30, 2025)	1.0 point
Submit update on progress on quality improvement workplan	Quarter 2 (July 31, 2025) Quarter 3 (October 31, 2025)	1.0 point