SAN FRANCISCO COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) 2026–2028

This report was compiled by Population Health Division, San Francisco Department of Public Health.

San Francisco
Department of Public Health

San Francisco
Community Health Improvement Plan (CHIP)
2026-2028

Table of Contents

San Francisco

Community Health Improvement Plan (CHIP) 2026–2028

OVERVIEW

The Community Health Improvement Plan (CHIP) team created this report to explain our goals for improving health in San Francisco. The plan includes one overall result statement, two main health priorities, three measures that show how community is doing, and five population strategies that guide our work.

INTRODUCTION

The **San Francisco Community Health Improvement Plan (CHIP) 2025–2028** is a shared roadmap for improving health and equity across our city. The CHIP was developed using the Community Health Assessment (CHA) as a foundation. The CHIP was created with help from community members, public health staff, local organizations, and other partners. Together, we chose key health issues affecting San Franciscans. We selected indicators from the CHA data to measure progress. We also identified strategies that promote equitable access to care and resources in different communities.

The CHIP has two parts.

The first part explains our population-level priorities. Partners across many sectors agreed to focus on **Mental Health** and **Chronic Disease**. These areas were chosen based on several factors. These included community input, CHA data, and the experiences of people most affected by health inequities. We will track progress using three indicators:

- The percentage of adults who experienced serious psychological distress in the past year
- Age-adjusted hospitalization rates for diabetes
- Age-adjusted hospitalization rates heart failure

To improve these outcomes, we selected five strategies. These strategies address factors that affect health, strengthen service coordination,

support culturally responsive services, and expand prevention in trusted community settings.

The second part includes program plans submitted by partner organizations. These plans show how current and future programs support the strategies and help improve health outcomes for people living in San Francisco.

POPULATION

All San Franciscans

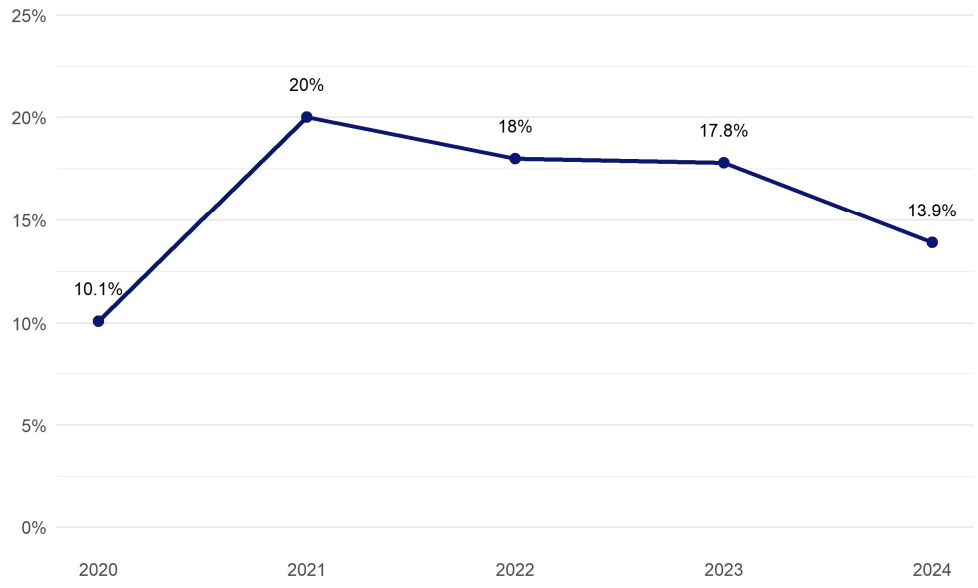
POPULATION RESULT STATEMENT

San Franciscans are healthy and thriving when systems work collaboratively to eliminate disparities, address root causes like poverty and racism, and ensure that all people—especially those most impacted—are supported holistically with culturally and linguistically responsive resources, relationships, dignity, and opportunities to live well and belong.

POPULATION INDICATORS

Population Indicator 1-Mental Health: Psychological Distress (Adults)

Measure name: Proportion of San Francisco adults who experienced serious psychological distress in the past year (CHIS/Kessler-6 derived)

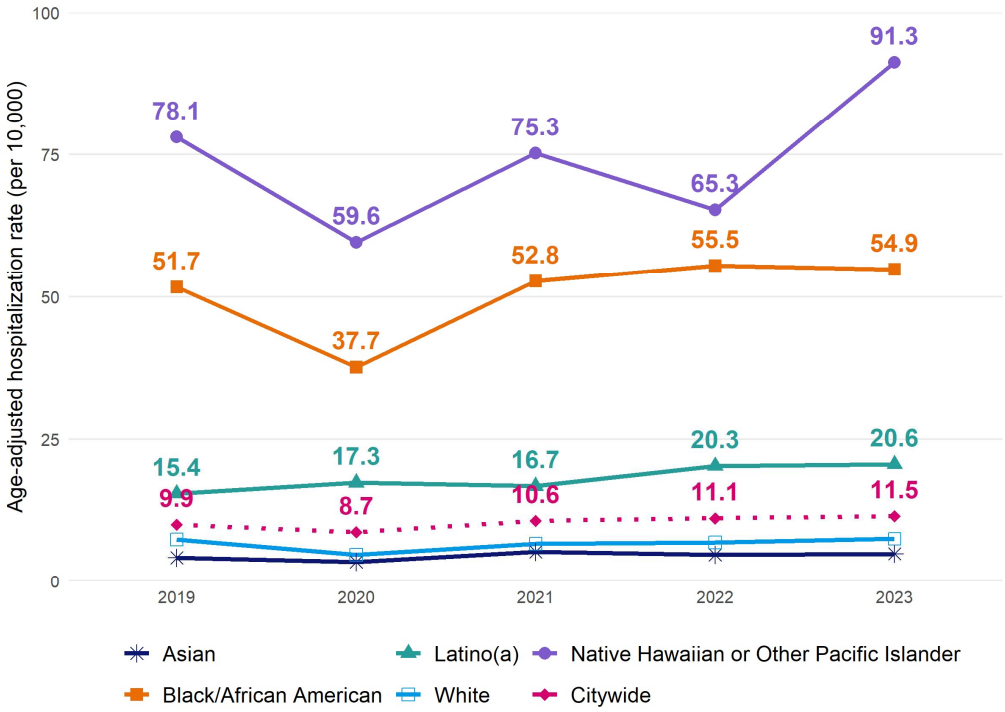


Data source: UCLA *California Health Interview Survey (CHIS)*, AskCHIS Neighborhood Edition (SF county). Years available: 2020–2024.
What it shows: This measure shows the percentage of adults in San Francisco who experienced serious psychological distress in the past year. The data comes from the California Health Interview Survey (CHIS). The trend increased from

2020 to 2021, then steadily declined through 2024. Because the data is based on self-report, some people may under- or over-report their experiences.

Population Indicator 2 — Chronic Disease: Diabetes Hospitalizations

Measure name: Age-adjusted hospitalization rate per 10,000 San Franciscans due to diabetes (ICD10 primary diagnosis aligned with AHRQ PQI93)

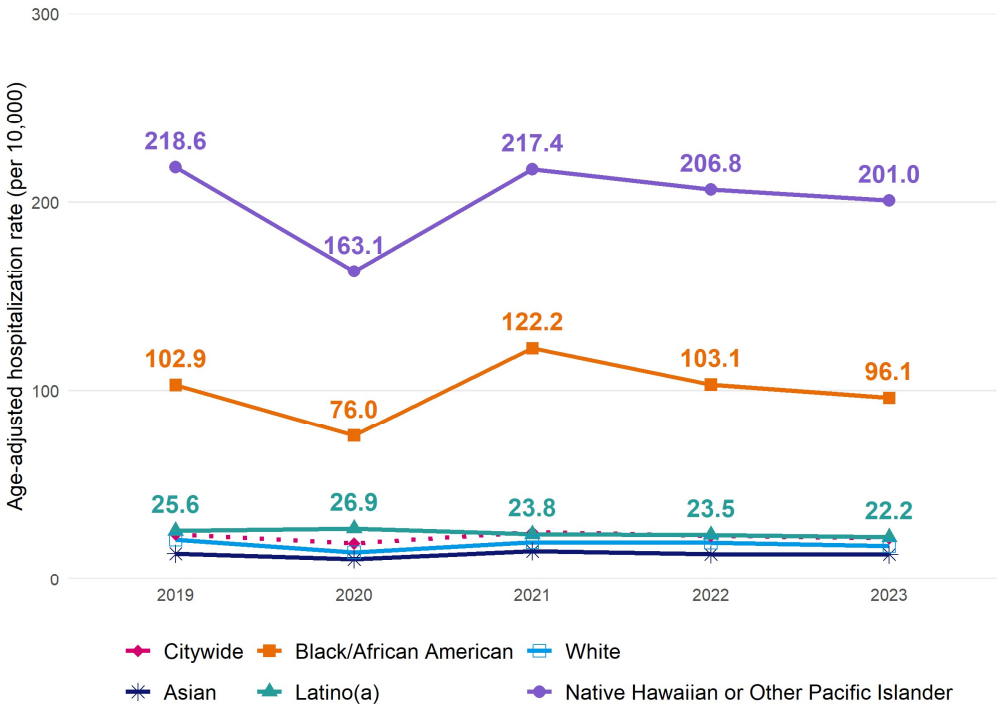


Data source: California Department of Health Care Access and Information (HCAI) Patient Discharge Data (via CDPH Data Use Agreement); U.S. Census Bureau Population Estimates Program (PEP) for denominators; 2019–2023.

What it shows: This measure tracks how many people are hospitalized for diabetes per 10,000 residents. Data is age-adjusted so groups can be compared fairly. Rates increased slightly from 9.9 in 2019 to 11.5 in 2023. Some groups face much higher hospitalization rates, including Black/African American residents and Native Hawaiian and Other Pacific Islander residents.

Population Indicator 3 — Chronic Disease: Heart Failure Hospitalizations

Measure name: Age-adjusted hospitalization rate per 10,000 San Franciscans due to heart failure (ICD10 primary diagnosis aligned with AHRQ 2025 CCSR). Years 2019–2023.



Data source: HCAI Patient Discharge Data (via CDPH DUA) with U.S. Census PEP denominators.

What it shows: This measure tracks hospitalizations for heart failure per 10,000 residents and is also age-adjusted. Citywide rates decreased from 23.8 in 2019 to 21.6 in 2023. Similar to diabetes, Black/African American and Native Hawaiian and Other Pacific Islander residents experience much higher rates than the citywide average.

STORY BEHIND THE CURVE

CHIP partners came together to look at the main reasons behind the two priority areas: Mental Health and Chronic Disease. Some of what they learned matches the findings from the 2024 CHA, but much of the insight comes from partners who work directly in communities with fewer resources. The summary below reflects what they shared.

MENTAL HEALTH

The CHIP workgroup noted that mental health needs remain high in the community. These needs are closely linked to challenges such as housing instability, food insecurity, and poverty. Many people struggle to get mental health care due to unclear pathways between different services, language barriers, and systems that are hard to navigate. Stigma also plays a major role, and some individuals avoid care because they fear being judged or child welfare involvement.

System-level issues, including limited culturally responsive care, structural racism, and lack of representation in decision-making, make access even harder. Workforce burnout, low pay, and limited support create additional strain. All of this makes it difficult to meet community needs. Broader issues like economic stress and isolation (which worsened during COVID) also impact mental health. Gaps in technology and long-term low investment in access continue to limit the system's ability to respond effectively.

CHRONIC DISEASE

The CHIP workgroup noted how chronic diseases like diabetes, heart disease, and high blood pressure are closely connected. For example, diabetes increases the risk of heart disease and can lead to worse health for mothers and their children. Further, these conditions do not affect all groups equally; Black/African American and Native Hawaiian and Other Pacific Islander communities experience higher hospitalization rates.

Social factors make chronic disease harder to manage. Many people cannot get routine care because they must focus on basic needs like food and housing. Insurance and transportation problems, along with stigma, fear, and mistrust, make it even harder to get care. Poverty, racism, housing and food insecurity, economic instability, and isolation during the pandemic also make staying healthy more difficult.

Fragmented health systems face challenges in preventing chronic disease. Workforce shortages and burnout limit the ability to provide

preventive, culturally responsive, and coordinated care. Poor information sharing and gaps in care coordination slow down access to needed services. This causes many people to rely on emergency care as their main way to enter the healthcare system.

Cultural and social factors also affect chronic disease for better or worse. Distrust of government and medical institutions can delay care. Limited access to healthy foods can also raise risk. At the same time, some communities have strong supports such as cultural districts, community organizations, and trusted institutions. These supports help improve food access, increase health education, and provide culturally responsive care.

PARTNERS

There were many partners involved in the CHIP process and more can join in the future. Current partners included:

- **San Francisco Department of Public Health** (Behavioral Health Services, Maternal Child Adolescent Health, Primary Care Behavioral Health, Population Health Division, Office of Health Equity, San Francisco Health Network [CalAIM])
- **Asian Pacific Islander Health Parity Coalition**
- **Black / African American Health Equity Coalition** (Rafiki Coalition for Health and Wellness)
- **Chicano Latino Indigena (CLI) Health Equity Coalition**
- **Community Based Organizations** (Tenderloin Housing Clinic (THC), Brothers Against Drug Deaths (BADD), Richmond Area Multi-Services, Inc. (RAMS), Community Youth Center of San Francisco (CYC), Instituto Familiar de la Raza, SF AIDS Foundation, CARECENSF, APAFSS, American Indian Cultural District, Bay Area American Indian Two-Spirit (BAAITS), Code Tenderloin, Northeast Medical Services (NEMS), On Lok, Senior Disability Action)
- **Medi-Cal Managed Care Plans** (San Francisco Health Plan, Anthem Blue Cross Blue Shield, Kaiser Permanente)
- **Healthcare organizations** (hospitals and clinics including UCSF, Native American Health Center, and San Francisco Community Clinic Consortium (SFCCC), San Francisco Health Network, Chinese Hospital)
- **San Francisco Health Improvement Partnership (SFHIP)**

POPULATION STRATEGIES

The strategies in this plan are based on data, community experiences, and the community strengths and assets identified in the CHA. They focus on early prevention, culturally rooted resources, and community voice to support long-term health improvements.

MENTAL HEALTH STRATEGIES

Provide coping tools and education that are culturally tailored and available in multiple languages

Strengthen systems coordination across systems so people can move more easily between different types of care

Foster a culturally responsive workforce and support workforce retention through practice-based coaching, paid supervision, and clear career pathways

CHRONIC DISEASE STRATEGIES

Address social determinants of health – like food access, healthy and safe spaces, and social support - through community engagement

Expand access to preventive care through community engagement by offering screenings, education, brief interventions, and referrals

CHIP PROGRAM PLANS

Along with the priority areas and strategies, CHIP partners were asked to share program plans that connect to the five population strategies. The list below shows the programs grouped by strategy, and the following pages give more details about each plan.

MENTAL HEALTH - PROGRAM LIST BY STRATEGY

Provide coping tools and education

- Progresa (San Francisco AIDS Foundation – Latine Health Program)
- Maternal, Postpartum and Community Health Program (Rafiki Coalition for Health and Wellness)
- Salud Y Bienestar Indigena Indigena Health and Wellness (Instituto Familiar de la Raza, Inc.)
- Brothers Against Drug Deaths (BADD) – Community-Based Overdose Prevention & Recovery Advocacy Program
- Asian Pacific Island Youth and Family Community Support Services TAY (Community Youth Center)

Strengthen systems coordination

- Follow-up After Involuntary Hold 5150 (SFDPH Behavioral Health Services)
- Recovery Services Department (Tenderloin Housing Clinic (THC))

Foster cultural humility in the workforce and support retention

- Asian Pacific Islander Health Parity Coalition (APIHPC)

CHRONIC DISEASE - PROGRAM LIST BY STRATEGY

Address social determinants of health through community engagement

- NEMS Nourish (Northeast Medical Services)
- Medically Tailored Meals (San Francisco Health Plan)
- ModivCare: Anthem Transportation Benefit (Anthem)
- Your Health Your Care (Kaiser Permanente)
- Implementing Closed Loop Referrals through FindHelp to Address Social Determinants of Health (SFDPH Enhanced Care Management)
- SF Soda Distributor Tax Advisory Committee (CLI Health Equity Coalition)
- Tobacco Free Project (TFP) Cessation Program (SFDPH Community Health Equity and Promotion)
- Black / African American Community Health Wellness Initiative (BAACHWI) (SFDPH Community Health Equity and Promotion)
- SFDPH Advancing Cardiovascular Health through a Community Health Improvement Plan (SFDPH Office of Health Equity)

Expand access to preventive care through community engagement

- Medi-Cal Redetermination / Re-enrollment Project (San Francisco Community Clinic Consortium)
- UCSF Health Bedside ECM Enrollment
- Hypertension Control for SFHN (SFDPH Primary Care)
- SF Pregnancy Family Village (Anthem)

Community Health Improvement Plan (CHIP)

Program Plan Summaries

MENTAL HEALTH (1 of 2)

STRATEGY: Provide coping tools and education

Program Name	**Progresa**
Program Organization	San Francisco AIDS Foundation / The Gubbio Project / SFDPH Street Medicine
Population Served	Unhoused Latine immigrants and Indigenous people from Latin America who are open to regulating their methamphetamine use
Program Description	This is an evidence-based, culturally congruent biweekly contingency management program that uses incentives to reinforce positive behavior change in individuals who want to regulate or stop their methamphetamine use while providing support and connection to medical services during the period of 12 weeks.
Program Result Statement	- Participants will report a decrease or abstinence from methamphetamine use. - Number of connections to primary care, substance use treatment, sexual health, housing and other support services.
Program Performance Measure	% of program graduates who demonstrate increased capacity to manage their methamphetamine use and make informed decisions that support their health and well-being **Goal**: at least 80%

Program Name	**Maternal, Postpartum & Community Health Program (MPCHP)**
Program Organization	Black / African American Healthy Equity Coalition Rafiki Coalition for Health and Wellness
Population Served	Black/African Americans in Bayview Hunters Point — specifically pregnant people, postpartum mothers/birthing parents, fathers/co-parents, caregivers, and families with children from birth through age 3
Program Description	MPCHP is a culturally responsive, low-barrier behavioral health continuum offering perinatal/maternal mental wellness support, individual and group therapy, mental health screening, and warm linkage to care — all delivered by a Black-led, culturally sensitive workforce. The underlying strategy is to build skills, knowledge, and confidence to manage stress and isolation associated with pregnancy and early parenthood.
Program Result Statement	Black/African American pregnant and postpartum mothers, infants, children 0–3, and families in San Francisco are emotionally well, socially connected, and confident accessing trusted, culturally responsive mental health care, coping tools, and education — while addressing the root causes of mental health and birth-equity disparities.
Program Performance Measure	% of participants reporting improved coping skills, reduced stress/isolation, and/or stronger connection to social supports **Goal**: By Dec 31, 2027 — at least 75% of surveyed participants will report ≥1 positive change

MENTAL HEALTH (2 of 2)

STRATEGY: Provide coping tools and education

Program Name	**Salud y Bienestar Indigena – Indigena Health & Wellness (IHW)**
Program Organization	Chicano-Latino-Indigena (CLI) Health Parity Coalition, Latino Parity Equity Coalition (LPEC) Instituto Familiar de la Raza, Inc (IFR)
Population Served	Chicana, Latinx, Indigena
Program Description	Salud y Bienestar Indígena (IHW) is a program of IFR that addresses the growing needs of the Indigenous community. IHW fosters emotional/spiritual healing and wellness, using language, culture, and tradition as vital drivers of health. IHW activities offer early intervention for trauma, depression, addiction, and mental health concerns.
Program Result Statement	To increase access to mental health services for Indigena community and strengthen mental health specialists' understanding of culture in their practice of trauma-informed therapy and other traditional healing practices.
Program Performance Measure	% of individuals participating in peer-support groups or receiving Care Management services who are directly referred to a one-on-one Mental Health Specialist or Therapist **Goal**: at least 10%

Program Name	**Brothers Against Drug Deaths (BADD) – Community-Based Overdose Prevention & Recovery Advocacy Program**
Program Organization	Brothers Against Drug Deaths (BADD)
Population Served	Individuals and families impacted by substance use, overdose, and mental health challenges in San Francisco, with a focused commitment to Black, African American, and underserved communities.
Program Description	Substance use and overdose are closely tied to mental health, trauma, and systemic inequities, and BADD addresses these challenges through a culturally responsive, community led approach grounded in lived experience to engage individuals who may not connect with traditional systems. The program provides peer led education on overdose prevention, recovery pathways, and mental wellness; offers practical coping strategies rooted in resilience and community support; engages credible messengers whose lived experiences reflect those of the populations served; and builds trust in communities with longstanding mistrust of institutions.
Program Result Statement	BADD works to reduce overdose deaths, expand access to recovery pathways, and restore hope so that individuals most affected by substance use and systemic inequities can ultimately thrive in purposeful, healthy, and connected lives.
Program Performance Measure	% of people who utilize the treatment and recovery services and stay in recovery

MENTAL HEALTH (1 of 1)

STRATEGY: Strengthen systems coordination

Program Name	**Follow-up After Involuntary Hold (5150)**
Program Organization	SFDPH Behavioral Health Services (BHS)
Population Served	San Francisco residents with Medi-Cal, Healthy San Francisco or who are underinsured and who experience a behavioral health crisis resulting in an involuntary hold (5150)
Program Description	A renewed multi-departmental effort to improve care for people after an involuntary hold (5150). This effort, led by Zuckerberg San Francisco General Hospital (ZSFG) and BHS, has included a creation of a cross-city department advisory group, creation and implementation of standard procedures for connecting people to follow-up care and shared metrics.
Program Result Statement	Timely and appropriate follow-up after an involuntary hold (5150).
Program Performance Measure	% of follow-up after an involuntary hold (5150) within 30 days

Program Name	**THC Recovery Services Department**
Program Organization	Tenderloin Housing Clinic (THC)
Population Served	All justice involved clients
Program Description	Since 2015, the Department of Recovery Services has provided clean, sober transitional housing that supports justice involved adults in building stability and moving toward permanent housing. Through three core programs, the department offers case management, housing navigation, income planning, and assistance with housing transitions, while ensuring eligibility under San Francisco's Fair Chance Ordinance.
Program Result Statement	Reduce recidivism by connecting clients to recovery and reentry resources with clients building a recovery network, completing probation, obtaining employment or stable income and eventually transitioning to stable or permanent housing
Program Performance Measure	% recidivism of clients

MENTAL HEALTH (1 of 1)

STRATEGY: Foster cultural humility in the workforce and support retention

Program Name	**Training Culturally Responsive Counselors**
Program Organization	Asian Pacific Islander Health Parity Coalition
Population Served	San Francisco Asian and Pacific Islander communities
Program Description	Build, support and retain a culturally responsive workforce
Program Result Statement	To develop a cadre of culturally responsive Asian and/or Pacific Islander counselors
Program Performance Measure	**Goal**: Train 10 mental health counselors-in-training identified as Asian and/or Pacific Islanders serving the Asian Pacific Islander communities

CHRONIC DISEASE (1 of 5)

STRATEGY: Address social determinants of health through community engagement

Program Name	**NEMS Nourish (NN)**
Program Organization	North East Medical Services (NEMS)
Population Served	NEMS patients with • Chronic condition(s) that can be managed through supportive foods • Medi-Cal coverage
Program Description	The NEMS Nourish (NN) program takes a food is medicine approach combined with health education, health coaching, and medical visits to provide a culturally sensitive, clinically-integrated intervention for long-term behavior changes in health for patients with chronic conditions.
Program Result Statement	Every elderly and low-income NEMS patient with a chronic condition has the knowledge, resources, and community to support their health and wellness.
Program Performance Measure	% of patients with HbA1c less than 7%

Program Name	**Medically Tailored Meals (MTM)**
Program Organization	San Francisco Health Plan
Population Served	MediCal members with serious medical conditions or high risk health needs, such as: Diabetes, Heart Disease, Renal Disease, Cancer, HIV/AIDS, Pregnancy Complications, Diet-Responsive Conditions, Food Insecurity, Housing instability, Recent Hospitalization
Program Description	Provides home delivered, nutritionally complete meals that are designed by registered dietitians. Meals support disease management, improve nutritional status, and reduce preventable health care utilization. Services include nutrition assessment, individualized meal planning, meal preparation, and reliable delivery to a person's residence.
Program Result Statement	Members with diagnosed diabetes are under control for 12 months post MTM enrollment.
Program Performance Measure	**Goal**: 75% (3 of 4) MTM-enrolled members with diagnosed diabetes are under control 12 months post MTM enrollment

CHRONIC DISEASE (2 of 5)

STRATEGY: Address social determinants of health through community engagement

Program Name	**ModivCare: Anthem Transportation Benefit**
Program Organization	Anthem
Population Served	Medi-Cal members in San Francisco covered by Anthem
Program Description	When people can consistently access primary care and preventive services, they're more likely to manage chronic conditions, avoid preventable ER visits, and maintain ability to work or attend school—affecting economic stability and overall well-being. Access also connects people to supports like behavioral health, substance use treatment, and referrals to community resources (food assistance, housing help), which can improve upstream SDOH needs. Medi-Cal members are entitled to free transportation to health-related appointments and meetings.
Program Result Statement	Anthem Medi-Cal members in San Francisco will know how and when to access Anthem's no cost transportation benefit including (non-emergency medical transportation (NEMT) and non-medical transportation (NMT).
Program Performance Measure	% of eligible members using the transportation benefit **Goal**: 2%

Program Name	**Your Health Your Care**
Program Organization	Kaiser Permanente
Population Served	San Francisco Medi-Cal members and community members who may qualify for Enhanced Care Management, with a focus on current and former foster youth up to age 26 and pregnant or recently postpartum individuals within the birth equity populations of focus. While statewide, the campaign includes San Francisco-serving audiences and partners as part of local CHIP-aligned outreach and amplification.
Program Description	This program focuses on Medi-Cal members and community members who may qualify for Enhanced Care Management. While *Your Health Your Care* is a statewide campaign, San Francisco is a key local market for outreach and partner amplification. The campaign uses influencers, trusted messengers, and CBOs to increase ECM awareness and help eligible individuals, families, providers, and community partners understand how to connect with Medi-Cal managed care plans for support.
Program Result Statement	Foster youth and birth equity populations have increased awareness and understanding of Enhanced Care Management.
Program Performance Measure	• Campaign engagement, views, and audience reach • % increase in ECM referral/enrollment rates • % increase in community-based ECM referrals

CHRONIC DISEASE (3 of 5)

STRATEGY: Address social determinants of health through community engagement

Program Name	**Implementing Closed Loop Referrals through FindHelp to Address Social Determinants of Health (SDoH)**
Program Organization	SFDPH San Francisco Health Network
Population Served	Clients who: Have managed Medi-Cal insurance; Are experiencing complex medical, behavioral, and/or social conditions; Are enrolled in DPH Community Supports or Enhanced Care Management; Primarily reside in the Tenderloin, Bayview/Hunter's Point, SOMA, or Mission District (Note: List is not fully inclusive and additional clients will be served.)
Program Description	FindHelp is a technology platform that connects clients with social needs to free or low-cost community-based services through Closed Loop Referrals, improving care coordination and reducing social barriers that affect health outcomes. DPH ECM and Community Supports Providers refer clients with (+) SDOH needs to SDOH program, are notified of status of services provided, and clients get the help they need.
Program Result Statement	Clients get the help they need to close SDoH gaps and improve health outcomes
Program Performance Measure	% of clients referred to a CBO on Findhelp and got help (Baseline: 6%)

Program Name	**SF Soda Distributor Tax Advisory Committee**
Program Organization	Chicano / Latino / Indigena (CLI) Health Equity Coalition
Population Served	SF populations that are inequitably burdened by chronic disease
Program Description	Soda Taxes reduce consumption and provide revenue for investment in chronic disease prevention. The SDDTAC recommends to the Mayor's office investments that are data, literature and community informed for reduction of consumption and for comprehensive strategies that address the multiple factors that contribute to chronic disease inequity.
Program Result Statement	San Francisco improves health, eliminates health disparities, and achieves equity through effective services and changes to the environment, systems, and policies.
Program Performance Measure	Conduct evaluation of the SDDTAC and its influence on investments

CHRONIC DISEASE (4 of 5)

STRATEGY: Address social determinants of health through community engagement

Program Name	**Tobacco Free Project (TFP) Cessation Program**
Program Organization	SFDPH Community Health Equity and Promotion Branch
Population Served	TFP focuses on communities most impacted by tobacco related disparities, including Black/African American, Latine, Asian and Pacific Islander, low income, LGBTQ+, and youth. These communities are at higher risk for chronic health conditions, including cardiovascular disease and other tobacco-related illnesses.
Program Description	TFP aims to reduce health inequities and improve long-term health outcomes through 7 week Stop Smoking classes at Southeast Health Center and SFGH's Richard Fine People's Clinic. The program also funds and trains community partners to offer culturally tailored classes in Spanish and Samoan. Graduates can join a weekly support group that offers ongoing guidance, peer support, accountability, and connections to community resources. By expanding access to evidence-based services and promoting tobacco free environments, TFP helps lower smoking rates and reduce tobacco related disparities, contributing to better long term cardiovascular, respiratory, and overall health.
Program Result Statement	All San Francisco residents — especially communities disproportionately targeted by the tobacco industry — will quit tobacco.
Program Performance Measure	% of participants who reduced or quit tobacco at the end of the cessation classes series (Baseline: 31%)

Program Name	**Black / African American Community Health Wellness Initiative (BAACHWI)**
Program Organization	SFDPH Community Health Equity and Promotion Branch
Population Served	Focus is on Black/African American population, but BAACHWI provides services to all SF residents who engage with the participating CBOs.
Program Description	The purpose of BAACHWI is to create healthier and thriving Black/African American communities in San Francisco. It currently funds three orgs to provide free and inclusive holistic and culturally responsive services and activities to all community members. It integrates physical, behavioral, and mental health interventions.
Program Result Statement	Eliminate health disparities in cardiovascular disease & other nutrition-sensitive conditions for Black/African Americans.
Program Performance Measure	% of participants who maintain/improve blood pressure

CHRONIC DISEASE (5 of 5)

STRATEGY: Address social determinants of health through community engagement

Program Name	**SFDPH Advancing Cardiovascular Health through Improved Coordination and Collaboration**
Program Organization	SFDPH Office of Health Equity
Population Served	San Francisco residents disproportionately impacted by cardiovascular disease (CVD), with highest burden among Black/African American (B/AA), American Indian/Alaska Native, and Native Hawaiian/Pacific Islander communities.
Program Description	A cross-department plan to unify and strengthen CVD equity work by aligning clinical, community, equity, and data strategies. CVD remains the leading cause of death in San Francisco, with longstanding inequities affecting B/AA communities most significantly. Current CVD work is strong but fragmented across divisions, leading to inconsistent workflows and data systems. OHE will provide support for existing CVD efforts in Primary Care and Population Health Division to break down silos and strengthen community engagement and co-design with patients and CBOs.
Program Result Statement	Reduce cardiovascular disease disparities through a unified, equity-centered system that coordinates partners, standardizes metrics, and strengthens both clinical and upstream prevention pathways.
Program Performance Measure	% of patients with controlled blood pressure (<130/80)

CHRONIC DISEASE (1 of 2)

STRATEGY: Expand access to preventive care through community engagement

Program Name	**SFCCC Medi-Cal Redetermination / Re-enrollment Project**
Program Organization	San Francisco Community Clinic Consortium (SFCCC)
Population Served	SFCCC member clinics serve over 100,000 SF residents, almost all of whom are low income, most of whom are from minority and/or immigrant communities, and who are over-represented with conditions such as homelessness and HIV / AIDS. Most were previously covered by public insurance.
Program Description	SFCCC has initiated a planning process internally, with our member clinics, and with the SFHP to re-enroll those eligible members who have not yet re-enrolled in Medi-Cal. SFCCC has worked with the SFHP to identify those who are within 60 days of their dis-enrollment date and those within 90 days after (when they can still re-enroll).
Program Result Statement	All eligible members will re-enroll in Medi-Cal to maintain continuity of care.
Program Performance Measure	# of Medi-Cal members who are NOT re-enrolled in Medi-Cal

Program Name	**UCSF Health Bedside ECM Enrollment**
Program Organization	University of California, San Francisco (UCSF)
Population Served	Medi-Cal patients who have been admitted to UCSF Stanyan and Hyde
Program Description	A pilot study showed that bedside Enhanced Care Management (ECM) enrollment at UCSF Stanyan and Hyde hospital improved patient connection to case managers and increased follow-up appointment adherence. This program addresses the risk of readmission among high-acuity patients with complex care plans by linking them to a community partner who can support them after discharge. Its goal is to boost ECM engagement through in-person bedside enrollment, strengthening care transitions and improving connection to primary care for long-term health management.
Program Result Statement	All Medi-Cal patients seen at UCSF Stanyan and Hyde have support needed to manage their long-term health.
Program Performance Measure	Increase screening and enrollment of individuals in Medi-Cal to ECM **Goal**: By March 1, 2027, the program will enroll 120 SFHP patients into ECM services

CHRONIC DISEASE (2 of 2)

STRATEGY: Expand access to preventive care through community engagement

Program Name	**Hypertension Control for San Francisco Health Network (SFHN)**
Program Organization	SFDPH Primary Care
Population Served	San Francisco Health Network patients with Medi-Cal who receive full scope primary care at 1 of 14 neighborhood primary care clinics.
Program Description	It is novel for SFDPH Primary Care (PC) Behavioral Health Clinics to support stress management for patients with uncontrolled hypertension. However, research suggests it is a highly effective adjunct to treatment and early improvement efforts within our clinics have demonstrated the same. Furthermore, PC patient interviews report loneliness and grief as key drivers. Primary Care Behavioral Analysts will continue to increase medically tailored meal referrals, as well as other community resources, to these patients as well.
Program Result Statement	Patients with uncontrolled hypertension will receive high-quality behavioral health clinical support for necessary behavior change and high-quality Behavioral Analyst support for linkage to social determinants of health community resources.
Program Performance Measure	% of Black / African American patients with blood pressure <130/80

Program Name	**San Francisco's Pregnancy Family Village (SFPFV) program**
Program Organization	Anthem
Population Served	Black / African American pregnant and postpartum residents of San Francisco and their children
Program Description	The SFPFV activity aligns with the CHIP goal of expanding access to preventive care by engaging communities in trusted settings through education, brief interventions, and referrals. It also supports the CHIP's social determinants of health strategy by strengthening food access, social support, trusted community spaces, and connections to family supporting resources. The model fosters culturally affirming environments where Black pregnant and postpartum residents can build relationships with community organizations, public agencies, healthcare partners, and housing and family-support services. This activity does not provide MediCal–covered services; instead, it strengthens upstream community infrastructure, community voice, cross sector coordination, trust-building, and resource awareness.
Program Result Statement	Improve Black pregnant and postpartum residents' and families' access to culturally responsive health, wellness, and social determinant resources while increasing community trust, belonging, resource connections, and partner coordination
Program Performance Measure	# of individuals reached through the Village community wellness events (pregnant/postpartum, parents of children aged 1-5, support person of a pregnant/postpartum person i.e. partners, family members)

APPENDICES

Appendix A – Population Indicator Technical Notes

- Age adjustment: Hospitalization rates are age-adjusted per 10,000 to allow fair comparison across groups with different age structures. The method applies age specific rates to a standard population (e.g., U.S. 2000) to produce comparable rates.
- Hospital discharge data: Measures count patient discharges (a person may have multiple admissions). Diabetes case definition aligns with AHRQ PQI93; heart failure aligns with AHRQ 2025 CCSR.
- Survey based mental health measure: CHIS estimates the proportion of adults with serious psychological distress using Kessler6 derived scoring; self-report limitations apply (recall, social desirability, nonresponse).

Appendix B - Process Narrative (PHAB Measure 5.3.1)

PHAB Standard 5.3.1: *The health department conducts a collaborative process to develop a community health improvement plan as a result of the community health assessment (CHA).*

How this CHIP meets the standard:

1. Collaborative, inclusive development
   The health department convened multisession stakeholder meetings and orientation(s) engaging SFDPH divisions (Behavioral Health Services, Primary Care Behavioral Health, Epidemiology/Data), community-based organizations, managed care plans, training institutions, and community members—emphasizing diverse participation and inclusion of communities most impacted by poor outcomes. The CHIP's population indicators and equity framing were informed by the 2024 CHA and the *CHIP Population Indicators* report prepared by the Center for Data Science (CDS).
2. Shared vision (Result Statement)
   Stakeholders co-created a single overarching Result Statement centering equity, dignity, language access, and root causes (poverty, racism)—which guides indicators and strategies throughout this plan.
3. Priority issues and indicators
   The group selected Mental Health and Chronic Disease as priorities and confirmed three population indicators: psychological distress (CHIS), and hospitalizations due to heart failure and diabetes (HCAI/CDPH with PEP denominators). These have documented definitions, sources, years, trends, and limitations inside the plan.
4. Evidence informed strategies and rationale
   A broad menu of options was considered for each priority; the final five population level strategies were chosen for feasibility, equity alignment, and potential to "turn the curve," directly addressing the root causes described in the Story Behind the Curve.
5. Action orientation and accountability
   The plan specifies partners with roles across health, community, education, and city agencies; strategies emphasize culturally responsive practice, warm handoffs, and community-based prevention—reinforcing accountability for population impact.
6. Data practices and transparency
   Indicator cards include clear measure definitions, sources, years, and limitations, and highlight equity disparities (e.g., markedly higher hospitalization rates for NHOPI and Black/African American residents) to guide action. Age-adjustment methods and CHIS caveats are documented for accuracy.
7. Community engagement and codesign
   The CHIP commits to community codesign, multilingual materials, culturally congruent care, and use of trusted spaces (barbershops, cultural districts, schools) to reduce stigma, improve navigation, and expand preventive access—meeting PHAB expectations for meaningful engagement.