The Integrated Delivery System of the San Francisco Department of Public Health

6 Month Update on the Development of the SF Health Network
(last update 3/4/14)

Presented to the San Francisco Health Commission, October 7, 2014
SF Health Network (SFHN):
The Integrated Delivery System of San Francisco

- SFHN Highlights & Accomplishments
- Review Origins & Genesis of SFHN
- Way Forward - “Roadmap to Success”
- Impact of Healthcare Reform on DPH
- Questions/Comments/Suggestions?
SFHN Highlights & Accomplishments

- **Business Intelligence Unit**
  - Developed Business Intelligence Unit Infrastructure to provide data support and intelligence to help drive operational excellence and efficiency across the network

- **Ambulatory Care Structure**
  - Formalized new SFHN Ambulatory Care organization to better align and coordinate care across the network
  - Appointed Primary Care Director to solidify the role of the medical home as the primary point of entry into the network and hub for care coordination

- **Managed Care**
  - Established new Managed Care Office
  - Appointed SFHN Managed Care Director to give singular and dedicated focus to our Managed Care and Health Plan relationships
  - Initiated tracking of Network patient enrollment, capacity, and access
Origins & Genesis of SFHN

IDS Planning - 2011-2012
- 6 Multidisciplinary Groups
- 45 Recommendations
- 4 Broad Categories
  - Enhanced Operations (Clinical & Non-Clinical)
  - Aligned Organizational Structure
  - Match Strategic Plans to Policy Positions
  - Promote System Development & Change Management

Health Reform Readiness Assessment – 2013
- 6 Focus Areas
  - DPH Organizational Structure, Finance, Human Resources, Ambulatory Care, Care Coordination, Policy & Planning
  - 70 Recommendations & Tasks
IDS Planning & Health Reform Readiness Assessment Informed Roadmap to Success
SFHN Executive Leadership Prioritization

Ref #58 & Ref #33
Track HSF and SFPATH retention; Appoint SFHN Managed Care Director

Ref #57 Operationalize new Managed Care Office

Ref #36 Determine SFHN clinical, organizational, and financial priorities

Ref #45
Appoint Primary Care Director

Ref #44 Establish SFHN Ambulatory Care organization

Ref #17 Implement Financial Structure to support integrated SFHN

Ref #29 Participate in Statewide waiver discussions

Ref #51 Fill all vacant Primary Care Provider Positions

Ref #55 Identify, budget and implement IT needs

Ref #8 Implement system-wide financial management tool

Ref #69 Create joint utilization management structure (SFGH, LHH, BHC, community placement)

Ref #46 Accountability for Specialty Care with UCSF

= Completed & Ongoing Enhancements
= In Process
Purpose: Guide the San Francisco Health Network (SFHN) in developing actionable metrics that can measure, understand, and improve performance by providing a service consisting of data, information, education, and insight.
Way Forward – Roadmap to Success (Strategic Focus)

1. Achieve a Primary Care Panel Size = 1,350
2. Achieve Primary Care Support Staff to Provider Ratio = 4.5 FTE
3. Improve Patient Placement at the appropriate setting and level of care in Acute and Skilled Nursing Facility Operations by 5%
4. Meet or exceed budgeted performance in revenues and expenses
5. Improve Workforce Experience/Satisfaction Scores by 5%
6. Improve Civil Service Hiring, From Form 3 submission to start work date = 90 days or less
7. Improve Patient Experience/Satisfaction Scores by 5%
8. 50% of Staff should know the “Way Forward Plan”: Increasing the Value of Services Provided to our Patients, Workforce and SF Residents
9. Achieve a 75% mammogram screening rate for eligible primary care clients
10. Increase the number of clients seen in a Behavioral Health Center who have established care with a Primary Care Provider by 25%
Impact of Health Reform on DPH Tied to Way Forward Performance Measures of Success

**Timely Access**
- Right to care within a reasonable time
  - Primary & Specialty Care Capacity & Monitoring
  - Hospital Integration
  - Transitions

**Capitation**
- One rate of payment per member per month
  - Managed Care Office

**Provider of Choice**
- More providers interested in the same patients
  - Marketing & Branding
  - Business Intelligence Unit
### SFHN Way Forward Performance Measures

**Reporting Period:** Quarter 4 2014

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Freq</th>
<th>Baseline</th>
<th>Target</th>
<th>Prior Period Average</th>
<th>Current Period Average</th>
<th>Period % Change</th>
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</thead>
<tbody>
<tr>
<td>#10 Increase by 25% the number of clients seen in a Behavioral Health Center who have an identified Primary Care Provider in Avatar HER</td>
<td>Q</td>
<td>50.2%</td>
<td>62.3%</td>
<td>55.1%</td>
<td>69.6%</td>
<td>26.3%</td>
</tr>
</tbody>
</table>

- **At Target/Goal**
- ***/** Denotes direction of favorable outcome
- ***/** Denotes direction of unfavorable outcome

City and County of San Francisco
San Francisco Health Network
## SFHN Primary Care (Access and Capacity)

### Goals:
- No waiting lists for new patients
- Timely access (TNAA) of < 10 days
- Same day access for urgent issues
- Prompt telephone access
- Provider panel @ 1,350 pts/FTE

### New Patient Access Status

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<tr>
<th></th>
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<tbody>
<tr>
<td>CMHC</td>
<td>2</td>
<td>7</td>
<td>59</td>
<td>9/10/2014</td>
<td>14</td>
<td></td>
<td>57%</td>
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<tr>
<td>CPHC</td>
<td>0</td>
<td>20</td>
<td>69</td>
<td>9/9/2014</td>
<td>6</td>
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<td>100%</td>
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<tr>
<td>FHC</td>
<td>15</td>
<td>38</td>
<td>45</td>
<td>9/23/2014</td>
<td>4</td>
<td></td>
<td>75%</td>
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<tr>
<td>GMC</td>
<td>0</td>
<td>281</td>
<td>114</td>
<td>9/25/2013</td>
<td>10</td>
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<td>80%</td>
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<tr>
<td>MHHC</td>
<td>0</td>
<td>140</td>
<td>180</td>
<td>9/16/2014</td>
<td>10</td>
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<td>90%</td>
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<tr>
<td>OPHC</td>
<td>0</td>
<td>32</td>
<td>149</td>
<td>9/19/2014</td>
<td>16</td>
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<td>81%</td>
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<tr>
<td>PHHC</td>
<td>0</td>
<td>120</td>
<td>108</td>
<td>9/12/2014</td>
<td>6</td>
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<td>50%</td>
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<tr>
<td>SAHC</td>
<td>1</td>
<td>43</td>
<td>51</td>
<td>9/30/2014</td>
<td>4</td>
<td></td>
<td>100%</td>
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<tr>
<td>SEHC</td>
<td>34</td>
<td>1</td>
<td>126</td>
<td>none</td>
<td>6</td>
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<td>67%</td>
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<tr>
<td>TWUHC</td>
<td>8</td>
<td>0</td>
<td>26</td>
<td>none</td>
<td>3</td>
<td></td>
<td>67%</td>
</tr>
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</table>
SFHN Primary Care (Access and Capacity)

Goals:
- No waiting lists for new patients
- Timely access (TNAA) of < 10 days
- Same day access for urgent issues
- Prompt telephone access
- Provider panel @ 1,350 pts/FTE

Improvement Initiatives:
- Access and capacity dashboard
- RN Orientation Clinics for new patients
- Telephone provider appointment
- Centralized Call Center
- Customer service training
- Standard provider templates
- Active panel clean-up for disenrollees
- Right size staffing ratio

Total Panel per Clinical FTE (July 2014 avg 1,322)
SFHN Specialty Care (Access and Capacity)

Wait times
- National problem
- DMHC <15 d
- Realistic goal <30d
- Current state

Barriers
- Data reliability
- eClinicalWorks
- Lack of space
- Lack of practice management support

SFHN Specialty Care
(Access and Capacity)
LHH and SFGH Integration (Operational Efficiency)

- Joint Hospital Operations Improvement Council
  - LHH and SFGH Executive Committees
  - Quarterly meetings

- Integration Efforts to Support Operational Efficiency
  - Switchboards/Telephone Operators: Completed
  - Food & Nutrition Services: Ongoing
  - Rehabilitation Services: Ongoing
  - Pharmacy: Ongoing
  - Social Services & Utilization Management: Ongoing
Transitions Division
(Enhanced Patient Flow)

- Housing
- SF Behavioral Health Center Residential Care Facilities
- Placement
- Care Coordination
- SF HOT

- Business Office
  - Shared with Behavioral Health
- Data Analyst
  - Shared with Managed Care
- Deputy Director Administrative
- Transitions Director
- Administrative Support
- Deputy Director Clinical
- Medical Consultation
- Care Coordination

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
Accomplishments (May-August, 2014)
- Implemented the Office of Managed Care
- Standardized managed care membership reporting
- Finalized a Medi-Cal contract with North East Medical Services (NEMS)

Upcoming
- Operationalize the new NEMS/SFHN contract in November
- Implement Healthy San Francisco proposed policy changes
- Continue to explore Covered CA contracts
Managed Care Total Enrollment
(Retained Pre-ACA with Slight Gain)

January 2014

78,861 Network Services
(56,802 DPH + 22,059 Non-DPH Primary Care)

August 2014

83,723 Network Services
(63,505 DPH + 20,218 Non-DPH Primary Care)

HK = Healthy Kids
HW = Healthy Workers
MC = Medi-Cal
HSF = Healthy San Francisco
And the tagline is.....

Your bridge to wellness
Unknowns Ahead

- 2015-2020 1115 Medicaid Waiver outcome
- Changes in future Medi-Cal policies and rates
- Evolution of Covered California Market
- Patient Retention & Growth
- AB 85/Health Realignment
- Other local market dynamics, competition

Road to Success

- Maintain our focus on achieving Way Forward Measure of Success & IDS Tasks
- Become a more nimble organization in order to better anticipate and respond to a dynamic environment
SUMMARY OF IDS WORKGROUP PROPOSED RECOMMENDATIONS

The following document provides a high-level summary of the proposed recommendations from the following IDS groups:

- Case Management
- Clinical Leadership
- Disease Prevention and Health Promotion
- Innovations in Healthcare
- Integration Steering Committee
- Quality and Utilization Management

There are a total of 45 recommendations.

For each IDS group, the recommendations are listed in the following categories:

- Operational (clinical and non-clinical)
- Organizational Structure
- Policy/Strategic
- System Development/Change Management

The placement of a recommendation into a specific category can be adjusted based on further input and reflection from either the IDS Planning Group or the IDS Workgroup. The current categorization is not final.

For each IDS workgroup, below the proposed recommendations is a summary of the workgroup’s identified budgetary and/or information technology and informatics needs that would be required to implement the proposed recommendations.

The IDS goals have been identified for each category of proposed recommendations.
### SUMMARY OF IDS WORKGROUP PROPOSED RECOMMENDATIONS

#### CASE MANAGEMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendations</th>
<th>IDS Goal(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Operational (clinical and non-clinical)</strong></td>
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</tr>
<tr>
<td>1.</td>
<td>Adopt an algorithm to determine which DPH patients/clients should be referred for case management (&quot;CM&quot;) based on an electronic filter of all DPH patient and an in-person functional acuity index, if appropriate</td>
<td>Provide medical homes responsible for coordinating preventive, primary and specialty care</td>
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<tr>
<td>2.</td>
<td>Provide a range of services in a patient's &quot;care home&quot; where the care home could be one of the following: (1) primary care clinic, (2) behavioral health clinic or (3) street for homeless or marginally housed. Services will range from care coordination to intensive CM, based on the severity of disease(s), service utilization and functionality.</td>
<td>Ensure service excellence</td>
</tr>
<tr>
<td>3.</td>
<td>CM outcomes should be monitored on four levels: (1) overall Department system, (2) the intersection of individuals and health care, (3) the intersection of health care and society, and 4) the intersection of society and individuals. In all cases, the outcomes must be both meaningful and measurable.</td>
<td>Reduce misuse, overuse and underuse of services</td>
</tr>
<tr>
<td>4.</td>
<td>Use one common patient flow process and structure to ensure that clients receive CM services at the appropriate level and clinical location.</td>
<td>Enhance information technology to improve quality of care and decision making</td>
</tr>
<tr>
<td>5.</td>
<td>All CM clients must receive an individualized coordinated care plan (and reassessment) and the information in the care plan is entered into the CM information technology system for ease of retrieval and analysis.</td>
<td>Manage resources responsibly for the max. benefit of clients</td>
</tr>
<tr>
<td>6.</td>
<td>Work with the quality management and utilization management system by supporting the same provisions: (1) centralized utilization review process for care coordination, (2) referral tracking system, (3) use of a unique client identification number for all clients accessing any Department services and (4) standard quality measures.</td>
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## SUMMARY OF IDS WORKGROUP PROPOSED RECOMMENDATIONS

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<tr>
<td>Policy/Strategic</td>
<td>12. Each client will be assigned only one primary case manager for Department funded services (staff or contract).</td>
<td>Manage resources responsibly for the max. benefit of clients</td>
</tr>
<tr>
<td>Organization Structure</td>
<td>13. Department designate one individual to help oversee the delivery of case management services across divisions and contracted providers. The designated Department case management director would work with case management leadership in CBHS, COPC, Jail Health Services, LHH and SFGH to ensure consistency in delivery of services across the DPH network, including contracted providers. Case management leadership in the divisions might have a dotted line relationship to this designated Department case management director.</td>
<td>Manage resources responsibly for the max. benefit of clients</td>
</tr>
</tbody>
</table>

**Identified Budgetary Needs:**
- Additional staff may be need to perform the functional acuity index
- Staff and contractor development and training (one time training for current and future staff)
- Ongoing Health Care Analyst (this may be an existing staff reassigned duties noted above or new staff)
- One-Time information technology position for referral tracking system
- Potential need for additional case managers may be needed to ensure that all care homes have on-site case management capability
- Budget for Department case management director position (ongoing)
- Consultant for case management training

**Identified Information Technology and Informatics Needs**
- One centralized case management information technology system that can be used for: (1) patient treatment and (2) reporting.
# SUMMARY OF IDS WORKGROUP PROPOSED RECOMMENDATIONS

## CLINICAL LEADERSHIP

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<tr>
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<tbody>
<tr>
<td>Operational (clinical and non-clinical)</td>
<td>14. Establish a Clinical Leadership Group charged with promoting service excellence and integrating and aligning clinical practice across departments</td>
<td>Ensure service excellence</td>
</tr>
<tr>
<td></td>
<td>15. Create a Chief Clinical Operations Officer position charged with facilitating cross-department and discipline decisions about clinical priorities and patient care</td>
<td>Manage resources responsibly for the max. benefit of clients</td>
</tr>
<tr>
<td>Organizational Structure</td>
<td>16. Make improving patient transitions a priority and promote the spread of the Quality Roadmap for Improving Patient Transitions as a template for placing patients at the appropriate level of care in an efficient manner.</td>
<td>Reduce misuse, overuse and underuse of services</td>
</tr>
<tr>
<td>Policy/Strategic</td>
<td>17. Foster a culture of collaboration, teamwork, cross-systems problem-solving, and whole-systems thinking.</td>
<td>Ensure service excellence</td>
</tr>
<tr>
<td>System Development/Change Management</td>
<td>18. Incorporate the following change management principles into future integration training efforts: (1) create a vision, (2) build commitment to the vision, (3) design an effective and inclusive change process, (4) use data and information, (5) model the vision and (6) communicate the vision.</td>
<td>Ensure service excellence</td>
</tr>
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### Identified Budgetary Needs:
- In-kind support from different departments (ongoing)
- Budget for Chief Clinical Operations Officer position (ongoing)
- Identify support/facilitation staff to assist with ongoing Clinical Leadership Workgroup meetings (ongoing)
- Training consultant hours for educating leadership on change management principles (one-time)

### Identified Information Technology and Informatics Needs
- IT system that captures patients’ discharge planning activities, pending issues to resolve, and listing responsibility for completion of discharge plan actions
- IT system that integrates shared data systems (for example, can compare costs across settings/transition points, quality metrics, waitlists, lengths of stay, volume indicators, level of care availabilities, high users)
<table>
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</thead>
<tbody>
<tr>
<td>Operational (clinical and non-clinical)</td>
<td>19. Adopt a Process Implementation Plan that will ensure that the goals are achieved</td>
<td>See below</td>
</tr>
<tr>
<td>System Development</td>
<td>20. Every person working in the IDS should understand and appreciate the broader context of public health and the social and environmental determinants of health and illness, and the role of the integrated delivery system within the larger context of health promotion and disease prevention and overall mission of the SF Department of Public Health.</td>
<td>Provide medical homes responsible for coordinating preventive, primary and specialty care</td>
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<tr>
<td></td>
<td>21. The IDS should align its health promotion and disease prevention activities with an overall SF DPH strategic plan for health promotion and disease prevention in San Francisco, to ensure synergies of effort and messaging. The divisions in the DPH with a traditional public health and population health focus should consider how to most effectively engage clinical sites in the IDS as part of coordinated public health campaigns in San Francisco (e.g., shared messaging and educational resources on reducing consumption of sweetened beverages).</td>
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<tr>
<td></td>
<td>22. The IDS should coordinate and facilitate linkages between IDS primary care clinic sites and community based resources for health promotion and disease prevention, through such methods as a county-wide online referral system for community resources, co-location of medical and social services, and other strategies.</td>
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<td>23. All sites within the IDS should view themselves as a resource for community health improvement and community wellness, and consider how their human and capital resources may be leveraged to promote healthier communities.</td>
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<td>24. The IDS should optimize delivery of clinical preventive services for the populations it serves, including systematically measuring IDS performance in delivery of clinical preventive services and holding practices accountable for achieving targeted quality standards for preventive services.</td>
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**Identified Budgetary Needs:**
Importance of having a staff person and consultants dedicated to gathering information, coordinating, and implementing the work of the steering committee.

**Identified Information Technology and Informatics Needs - None Identified**
# SUMMARY OF IDS WORKGROUP PROPOSED RECOMMENDATIONS

## INNOVATIONS IN HEALTHCARE

<table>
<thead>
<tr>
<th>Category</th>
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</table>
| Operational (clinical and non-clinical) | 25. Establish an internal Innovations in Healthcare Advisory Group in order to: (1) gain recognition and build support (possibly through providing technical assistance), (2) foster cross-sector collaboration, and/or (3) prioritize spread by disseminating ideas (e.g., through peer review or selective presentations). 26. Implement the following five innovation priority areas and a test project in each area:  
   A. Improve the patient and staff experience in order to become a provider and employer of choice  
   B. Coordinate care and share accountability across the continuum of services in order to advance health outcomes  
   C. Increase access to primary care to meet standard wait times for primary care appointments  
   D. Integrate and provide relevant patient information in a meaningful and timely fashion to improve clinical decision-making, understand populations, and better design systems of care  
   E. Create a transparent, engaged organizational culture aligned around a common mission and vision for DPH | Ensure service excellence  
Increase the number of insured patients served  
Provide medical homes responsible for coordinating preventive, primary and specialty care |

**Identified Budgetary Needs:**

For fiscal year 2013, $30,000 in innovation training/conference, awards to support projects, and coordination, support, and management of clearinghouse. Additional items (e.g., technical assistance for innovators, training to support culture transformation) are to be determined. All expenses are ongoing for future fiscal years. Revenue potential includes savings that result from efficiencies created by the spread of innovative projects.

**Identified Information Technology and Informatics Needs – None Identified**
<table>
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<tr>
<th>Category</th>
<th>Recommendations</th>
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<tr>
<td><strong>Operational</strong> (clinical and non-clinical)</td>
<td>27. Give managers budgetary oversight and accountability as part of their job responsibilities and that this new responsibility should be incorporated into each manager’s annual work plan and performance appraisal as a “budget performance plan.” Senior managers with program responsibility receive monthly budget reports indicating expenditures to date. 28. Participate in existing consortiums that offer data in clinical, operational, financial, and supply chain areas such as the University Health Consortium and Global Healthcare Exchange. 29. Work with the City and County of San Francisco departments that authorize hiring to develop a process that expedites requisition approvals for the Department (e.g., options available to the Department include, but are not limited to developing a requisition pool, prioritization plan, etc.) 30. Make strategic decisions on what administrative or service programs to locate or relocate into a facility based on the following: (1) identified list of Department program needs that provides description of service, why relocation is desired, client population to be served, potential community response (both movement of program from a current site and to a new site), space/square footage needs, specific facility or amenity requirements, (2) programmatic benefit to clients/patients and (3) revenue potential, if any. 31. When contemplating contracting out a service, the Department ask the following and answer the question based on both quantitative and qualitative data: (1) why is the service needed, population to be served and goal to be accomplished, (2) should the Department provide service directly or contract with a provider (including the cost of contracting out versus providing directly) and (3) if contracting out, then does the RFP program description and service need tie to Department goals and not community provider goals.</td>
<td>Manage resources responsibly for the max. benefit of clients Enhance information technology to improve quality of care and decision making</td>
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</table>
| Policy/Strategic | 32. Serve newly insured patients by continue to serve the Department’s existing uninsured population as it transitions into either Medi-Cal or the California Health Benefits Exchange in January 2014  
33. Between now and 2014, focus on access, elimination of barriers to entry, patient experience, ensure primary care medical home (solidify patient-provider relationship), care coordination to ensure that the DPH is a provider of choice.  
34. Undertake the following analyses in order determine appropriate course of action regarding serving additional uninsured patients who currently do not use the Department as a primary care provider but who will become insured in 2014: (1) fiscal analysis or estimated cost, revenues and patient population, (2) demand and capacity analysis and (3) clarify role of DPH as a provider of care to SFCCC patients and patients of other community based stand-alone clinics unaffiliated with a hospital.  
35. Ensure that prioritization of services be based on:  
  A. A goal to improve health outcomes and health access rather than deliver a particular health services  
  B. Services that are most beneficial and offer the greatest value  
  C. Evidence, clinical effectiveness and the ability to maintain high quality care.  
  D. A public process that allows for input  
36. Consider grouping provision of clinical services and treatments into the following categories for prioritization purposes:  
  - Emergency care for life-threatening diseases  
  - Treatment which prevents catastrophic or very serious long-term consequences  
  - Treatment which prevents less serious long-term consequences (e.g., hypertension)  
  - Treatment with some beneficial effects (e.g., common cold)  
  - Treatment with no documented effects  
37. Consider new services after a thorough strategic business plan has been developed, vetted and approved, if appropriate. This would be consistent with current Department practice.  
38. Engage in a rigorous process to quantify the cost of clinical services being provided (this may or may require a formal actuarial analysis). It is difficult to prioritize (based on clinical benefit) without information on the cost of a service. | Increase the number of insured patients served  
Provide medical homes responsible for coordinating preventive, primary and specialty care  
Ensure service excellence  
Manage resources responsibly for the max. benefit of clients |
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<td>Organizational Structure</td>
<td>39. Organization structure be reviewed and modified, if necessary, based on the following principles:</td>
<td>Manage resources responsibly for the max. benefit of clients</td>
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<td></td>
<td>• Develop an organizational structure which is consistent with the Department’s mission and is responsive to health reform, not divisional interests.</td>
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<td>• If an administrative, clinical and/or service function is interdependent across all divisions, then it should be considered for centralized administrative oversight.</td>
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<td>• The extent to which an administrative, clinical and/or service function requires a Department-wide approach (for consistency), then it should be more centralized.</td>
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<td>• Minimize duplication when possible for efficiency.</td>
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<td>• Simplify reporting relationships to the extent possible.</td>
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<td>• Push responsibility down to service delivery—where clients receive care.</td>
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<td>40. Explore the feasibility of creating a centralized oversight structure for health care services which would include health care services provided within Community Programs, Laguna Honda Hospital, San Francisco General Hospital and Jail Health Services. It is anticipated that leadership (administrative and clinical) would have dotted line relationship to this designated divisional leadership.</td>
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**Identified Budgetary Needs** – None Identified

**Identified Information Technology and Informatics Needs** – None Identified
### QUALITY AND UTILIZATION MANAGEMENT

<table>
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<tr>
<th>Category</th>
<th>Recommendations                                                                控</th>
<th>IDS Goal(s)</th>
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</table>
| Operational (clinical and non-clinical) | 41. Establish a system of care coordinators for all high risk or high utilizer patients/clients.  
42. Establish a set of common quality measures within a “triple aim” framework: Clinical Quality, Cost Efficiency, and Patient-Centered Care. Potential measures include:  
   - 30 Day Hospital Readmissions: e.g., targeted diagnoses, Psychiatry  
   - Access to routine appointments within specified timeframe  
   - Patient/Client Satisfaction  
43. Develop a Quality Improvement & Leadership Academy for the Department of Public Health. | Reduce misuse, overuse and underuse of services  
Ensure service excellence  
Enhance information technology to improve quality of care and decision making |
| Policy/Strategic                 | 44. Based on cost, placement priority is given to Lower Level of Care patients at SFGH, and LHH patients who are appropriate for community placement. | Reduce misuse, overuse and underuse of services |
| Organizational Structure         | 45. Create centralized Utilization Management oversight committee for DPH, with representation from all service delivery programs within DPH. | Reduce misuse, overuse and underuse of services  
Manage resources responsibly for the max. benefit of clients |

**Identified Budgetary Needs:**
- Program planner/ data analyst (ongoing)
- Less than $10,000 for training consultant related to Quality Improvement & Leadership Academy (one-time)

**Identified Information Technology and Informatics Needs**
- A unique common patient identifier is needed to support the overall goal of improving coordination of services, appropriate patient placement and efficiency of services.
- A common Utilization Management software program is needed to support the overall goal of improving coordination of services, appropriate patient placement and efficiency of services.
### Integration Steering Committee Task Monitoring Grid

**DPH Priorities:** Integrated Delivery System ■ Public Health Accreditation ■ Operational and Financial Efficiency

<table>
<thead>
<tr>
<th>Ref #</th>
<th>Area</th>
<th>Org Structure</th>
<th>Accountability</th>
<th>Target Completion</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>SFHN Ambulatory Care</td>
<td>Establish new SFHN Ambulatory care organization, leadership, accountabilities and processes</td>
<td>Albert Yu, Roland Pickens</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
<tr>
<td>42</td>
<td>SFHN Ambulatory Care</td>
<td>Identify and appoint Primary care director</td>
<td>Albert Yu</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
<tr>
<td>43</td>
<td>SFHN Ambulatory Care</td>
<td>Work out mechanisms for accountability for specialty care with UCSF</td>
<td>Albert Yu</td>
<td>12/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>44</td>
<td>SFHN Ambulatory Care</td>
<td>Implement primary care panel size targets through revised templates</td>
<td>Albert Yu, Lisa Johnson</td>
<td>11/30/13</td>
<td>Complete</td>
</tr>
<tr>
<td>45</td>
<td>SFHN Ambulatory Care</td>
<td>Implement call center</td>
<td>Albert Yu, Lisa Golden</td>
<td>12/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>46</td>
<td>SFHN Ambulatory Care</td>
<td>Implement nurse orientation clinics</td>
<td>Albert Yu, Judy Sansone</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
<tr>
<td>47</td>
<td>SFHN Ambulatory Care</td>
<td>Implement chronic disease visits staffed by RN/PharmD</td>
<td>Albert Yu, Judy Sansone</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
<tr>
<td>48</td>
<td>SFHN Ambulatory Care</td>
<td>Hire to fill all vacant primary care provider positions</td>
<td>Albert Yu, Roland Pickens, Marcellina Ogbu</td>
<td>12/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>49</td>
<td>SFHN Ambulatory Care</td>
<td>Establish four health homes for integrated primary care and behavioral health care</td>
<td>Albert Yu, Jo Robinson, Primary Care leader to be named</td>
<td>Ongoing</td>
<td>In progress</td>
</tr>
<tr>
<td>50</td>
<td>SFHN Ambulatory Care</td>
<td>Identify targets for increased specialty care capacity and implement plan</td>
<td>Albert Yu, Alice Chen</td>
<td>10/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>51</td>
<td>SFHN Ambulatory Care</td>
<td>Address physical plant improvements</td>
<td>Albert Yu, Bill Blum, Cathy Jung</td>
<td>Ongoing</td>
<td>In progress</td>
</tr>
<tr>
<td>52</td>
<td>SFHN Ambulatory Care</td>
<td>Identify, budget and implement information technology needs</td>
<td>Albert Yu, Bill Kim, Marcellina Ogbu, Roland Pickens</td>
<td>11/30/14</td>
<td>In progress</td>
</tr>
<tr>
<td>53</td>
<td>SFHN Ambulatory Care</td>
<td>Implement ambulatory performance improvement process, leadership and teams</td>
<td>Albert Yu</td>
<td>12/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>54</td>
<td>SFHN Care Coordination</td>
<td>Operationalize new SFHN Transitions division</td>
<td>Kelly Hiramoto, Barbara Garcia</td>
<td>10/28/13</td>
<td>In progress</td>
</tr>
<tr>
<td>Ref #</td>
<td>Area</td>
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</tr>
<tr>
<td>55</td>
<td>SFHN Care Coordination</td>
<td>Finalize and implement risk stratification and assessment tool</td>
<td>Kelly Hiramoto</td>
<td>10/31/13</td>
<td>In progress</td>
</tr>
<tr>
<td>56</td>
<td>SFHN Care Coordination</td>
<td>Identify format for care management database</td>
<td>Kelly Hiramoto</td>
<td>10/31/13</td>
<td>In progress</td>
</tr>
<tr>
<td>57</td>
<td>SFHN Care Coordination</td>
<td>Determine staffing needs and process to complete</td>
<td>Kelly Hiramoto</td>
<td>10/31/13</td>
<td>In progress</td>
</tr>
<tr>
<td>58</td>
<td>SFHN Care Coordination</td>
<td>Initiate QI with process, leadership, and teams identified</td>
<td>Kelly Hiramoto</td>
<td>12/31/13</td>
<td>In progress</td>
</tr>
<tr>
<td>59</td>
<td>SFHN Care Coordination</td>
<td>Reduce community placement LOS: set targets, create dashboard, identify process to success</td>
<td>Overlap with Institutional/Post Institutional Group-Mivic Hirose as lead</td>
<td>12/31/13</td>
<td>In progress</td>
</tr>
<tr>
<td>60</td>
<td>SFHN Care Coordination</td>
<td>Prioritize areas of and establish processes to assure coordination with SFHN ambulatory, hospitals (including UM programs) and managed care</td>
<td>Kelly Hiramoto, Albert Yu, Stella Cao, Jo Robinson, Sue Currin and Mivic Hirose</td>
<td>12/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>61</td>
<td>SFHN Director</td>
<td>Identify and appoint SFHN Managed Care Director</td>
<td>Roland Pickens</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
<tr>
<td>62</td>
<td>SFHN Director</td>
<td>Establish SFHN Executive Leadership processes and accountabilities</td>
<td>Roland Pickens</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
<tr>
<td>63</td>
<td>SFHN Director</td>
<td>Determine Network representation on restructured ISC</td>
<td>Roland Pickens</td>
<td>11/30/13</td>
<td>Complete</td>
</tr>
<tr>
<td>64</td>
<td>SFHN Director</td>
<td>Determine clinical, organizational and financial priorities for SFHN and establish workplan and accountabilities</td>
<td>Roland Pickens</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
<tr>
<td>65</td>
<td>SFHN Institutional/Post-Institutional</td>
<td>Reduce denied/administrative days to targets set for SFGH and LHH</td>
<td>Sue Currin, Mivic Hirose, Kelly Hiramoto, Maria X. Martinez, Baljeet Sangha</td>
<td>Ongoing LHH denied/LLOC days report (as part of SFHN report) - create by March/April 2014</td>
<td>SFHN Metrics Report Monitoring on-going &amp; in-process</td>
</tr>
</tbody>
</table>
### Integration Steering Committee Task Monitoring Grid

**DPH Priorities:** Integrated Delivery System ■ Public Health Accreditation ■ Operational and Financial Efficiency

<table>
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<tbody>
<tr>
<td>66</td>
<td>SFHN Institutional/Post-Institutional</td>
<td>Reduce <strong>ALOS to targets</strong> at SFGH and LHH</td>
<td>Sue Currin, Mivic Hirose, Kelly Hiramoto, Baljeet Sangha</td>
<td>Ongoing</td>
<td>In progress</td>
</tr>
<tr>
<td>67</td>
<td>SFHN Institutional/Post-Institutional</td>
<td><strong>Reduce out of network referrals</strong> from LHH and other DPH facilities</td>
<td>Mivic Hirose, Diana Guevara, Stella Cao</td>
<td>Ongoing</td>
<td>In progress</td>
</tr>
<tr>
<td>68</td>
<td>SFHN Institutional/Post-Institutional</td>
<td>Create <strong>joint utilization management structure</strong> and operations for SFGH, LHH, BHC and community placement</td>
<td>Kelly Hiramoto, Sue Currin, Mivic Hirose</td>
<td>11/30/14</td>
<td>In progress</td>
</tr>
<tr>
<td>69</td>
<td>SFHN Institutional/Post-Institutional</td>
<td>Improve <strong>patient flow in psychiatry</strong> and reconfigure beds as appropriate</td>
<td>Sue Currin, Jo Robinson, Kelly Hiramoto</td>
<td>Ongoing</td>
<td>In progress</td>
</tr>
<tr>
<td>70</td>
<td>SFHN Institutional/Post-Institutional</td>
<td>Operationalize <strong>dashboard of inpatient flow metrics</strong> including SFGH, LHH, BHC, and community placement</td>
<td>Sue Currin, Kelly Hiramoto, Mivic Hirose, Baljeet Sangha</td>
<td>12/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>71</td>
<td>SFHN Institutional/Post-Institutional</td>
<td>Set priorities and start implementation of <strong>targeted departments between SFGH and LHH</strong> (including social work)</td>
<td>Sue Currin and Mivic Hirose, Marcellina Ogbu &amp; Kelly Hiramoto</td>
<td>12/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>72</td>
<td>SFHN Managed Care</td>
<td>Operationalize <strong>new managed care office, processes and accountabilities</strong></td>
<td>Diana Guevara, Stella Cao, Roland Pickens</td>
<td>10/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>73</td>
<td>SFHN Managed Care</td>
<td>Establish process and start to <strong>track retention of HSF and SFPATH</strong> lives within SFHN</td>
<td>Diana Guevara, Kim Oka &amp; Stella Cao</td>
<td>10/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>74</td>
<td>SFHN Managed Care</td>
<td>Establish clear accountabilities between SFHealth Network and the SF Health Plan</td>
<td>Barbara Garcia, Roland Pickens, Stella Cao</td>
<td>10/31/14</td>
<td>Complete</td>
</tr>
<tr>
<td>75</td>
<td>SFHN Managed Care</td>
<td>Track and set <strong>SFHN plan to reduce OON expenses</strong></td>
<td>Stella Cao</td>
<td>10/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>76</td>
<td>SFHN Managed Care</td>
<td>Finalize <strong>contracts with Consortium</strong> and other clinics for primary care</td>
<td>Diana Guevara, Kim Oka &amp; Stella Cao</td>
<td>10/31/14</td>
<td>In progress</td>
</tr>
</tbody>
</table>
## Integration Steering Committee Task Monitoring Grid

**DPH Priorities:** Integrated Delivery System ■ Public Health Accreditation ■ Operational and Financial Efficiency

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>SFHN Managed Care</td>
<td>Finalize contracts with NEMS for primary and specialty care services</td>
<td>Diana Guevara, Kim Oka &amp; Stella Cao</td>
<td>10/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>78</td>
<td>SFHN Managed Care</td>
<td>Finalize contract with CCHP</td>
<td>Diana Guevara, Kim Oka &amp; Stella Cao</td>
<td>10/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>79</td>
<td>SFHN Managed Care</td>
<td>Operationalize dashboard of metrics to track managed care performance</td>
<td>Diana Guevara, Stella Cao &amp; Baljeet Sangha</td>
<td>8/31/14</td>
<td>In progress</td>
</tr>
<tr>
<td>80</td>
<td>SFNH Director</td>
<td>Identify and appoint SFHN Ambulatory Director</td>
<td>Roland Pickens</td>
<td>12/31/13</td>
<td>Complete</td>
</tr>
</tbody>
</table>
Vision and Goals of the Ambulatory Care System

- Provide and manage the care for a defined number of people, both those currently getting their care in the SFDPH system and new enrollees in the integrated delivery system;
- Organize the elements of the delivery system into one network which will work together to assure that gaps are filled, duplication is eliminated, quality is enhanced, and the health of the population is improved;
- Build an integrated operational infrastructure (including the necessary elements of participating in a managed care environment) that supports the delivery of care in a way that maximizes efficiency, consistency and quality;
- Assure that all patients are cared for at the right place, the right level and the right time; and
- Collaborate with other providers, partners and health plans to assure the long-term sustainability of the delivery system as the core of the safety net in San Francisco.

Objective 1.1 – By 2/14/14, achieve panel size targets for all PCMH teams.

Milestones
- 11/1/13 – Implement monthly enrollment targets for each health center (adjusted quarterly and when providers on-boards or leave) and a process to hit this number
- 12/1/13 – Achieve “functional empanelment” of shadow panels (zero wait list, response to requests)
- 1/1/14 – Greater than 90% of providers are above 95% target panel size of site-adjusted method
- 1/1/14 – Transition to new prospective weighting method with 1350 patient-equivalents per FTE
- 3/1/14 – Based on call center start, improved staffing ratios and alternative visits, adjust patient-equivalents down by 1% per month for four months

Key Actions
- Hire vacant positions identified as high priority (see Obj. 5)
- Meet with SFHP to define process for monthly enrollment and for making shadow panels functionally active
- Develop a prospective weighting system using i2i (with CDI) to actively monitor panel sizes
- Develop a methodology and process with SFHP for creating a functional empanelment environment for patients on “shadow panels”
Objective 1.1 – By 2/14/14, achieve **panel size targets** for all PCMH teams.

Dependencies
- Achieve a functional state of shadow panels being active by patient experience:
  - Achieve a zero waiting list state for shadow panels (see Obj. 1.4)
  - Achieve access standards (see Obj 1.3) for shadow panel patients
- Staffing ratios defined and met (see Obj. 6)
- Float pools (see Obj 6)
- Adequate space created (See Obj. 5)

Objective 1.2
By 3/15/14, achieve **phone access and quality standards for all primary/specialty sites via Call Center**.

Measures/Standards
- call abandonment rate - <5%
- staff per 1000 patients - TBD
- CG-CAHPS phone access (always got through during office hours) - (70% increase) to 64%

Objective 1.4.1 – By December 1, 2013, implement **nurse orientation clinics**.

Milestones
10/1/13 – OC scheduling template standardized; begin scheduling patients
10/31/13 – Full cohort of as needed hires and permanent COPC staff trained to conduct OC
10/31/13 – OC routinely scheduled at all COPC8 sites

Objective 1.4.2 – By April 1, 2014, implement **chronic disease visits** (including 7 day post-hospital transition care visits) conducted by RNs and PharmDs

Measures/Standards
- Percent post-hospital patients with PCP follow-up appointment within 7 days
- Reduce hospital readmission rates - 30 day readmissions: 10% reduction from baseline
Objective 1.4.2 – By April 1, 2014, implement chronic disease visits (including 7 day post-hospital transition care visits) conducted by RNs and PharmDs

Milestones
10/1/13 – Primary care clinical RN role and position description finalized
11/15/13 – Phase 1 chronic disease/transition care training completed
1/1/14 – Chronic disease visits implemented in 1 SFGH and 3 COPC clinics
6/30/14 – Chronic disease visits are implemented throughout SFDPH primary care

Objective 1.5 - By 2/1/14, Total Clinical FTEs of PCPs (MD and NP) are increased by 15.0%

Measures/Standards
• FTE by number of empaneled patients
Milestones
• By 10/1/13, develop incentive structure to increase clinical FTEs for MDs
• By 3/1/14, increase clinical FTEs from 90 to 100
Key Actions
• Implement an incentive structure for MDs that increase their clinical FTEs
• Hire into vacant PCP positions
• Contracts with locums for rapid hiring

Dependencies
• Work with union re: job configuration
• Funding for primary care incentive
• PCP uptake of the primary care incentive
• Associated PCMH staff (RN, MA, Clerk) to support staffing ratios

*Based on enrollment and surge.

Objective 2.1 – By 7/14/14, the structure for establishing 4 Health Homes that meet Departmental/CMS/State standards will be in place

Measures/Standards (These are CMS measures; need targets/consideration of other proposed measures)
• Adult body mass index assessment
• Ambulatory care sensitive condition admission
• Care transition record transmitted to healthcare professional
• Follow-up after hospitalization for mental illness
• Reduce all causes of readmission
• Screening for clinical depression and follow-up plan
• Initiation and engagement of alcohol and other drug dependence treatment
• Controlling high blood pressure

Objective 3.1 – By 12-31-13, to have established sufficient capacity to meet expectations for access to major subspecialty services and assure staff and space efficiencies.

Measures/Standards
• Response to eReferal request (3 business days)
• TTNA new specialty appointment (≤45 calendar days)
• Specialist productivity (# visits/FTE, TBD)
• Proportion of patients who are new to clinic (TBD)
• Clinic cycle times
• Patient satisfaction (CG-CAHPS)
• #FTE specialists for population of 90,000

Objective 3.1 – By 12-31-13, to have established sufficient capacity to meet expectations for access to major subspecialty services and assure staff and space efficiencies.

Milestones
• By 10/1/14, meet with clinic chiefs and nurse managers to identify units requiring additional space or staff to meet standards
• By 10/1/13, identify key ambulatory procedures to target for wait time reduction and work with UR committee to delineate resources needed to reduce wait times to target (TBD)
• By 10/1/13, specialty chiefs and SFDPH agree on operational standards (productivity, new patients, etc)
• By 11/30/15, prepare business plan for expansion of staff, space or other resources to accomplish goals
• By 12/31, develop and implement discharge criteria in an additional 2-4 high priority specialty areas
• By 12/31, rehabilitate W02 physical plant for patient privacy
• By 3/1/14, identify specialty capacity at SFDPH
• By 6/30/14, develop system to anticipate and backfill absences
• By 6/30/14, 60% of specialties will have a TTNA of ≤45 calendar days; 20% of 45-60 days; and
• 20% >60 days
• By 6/30/14, implement system to bill for IPP patients
• By 7/31, begin collecting CG-CAHPS data for all specialty clinics
Objective 4 – By 12/31/2013, an overarching **ambulatory organizational structure** exists with leadership positions filled and accountable for achieving Goals 1, 2, 3.

**Milestones**
- By September 15, 2013, finalize Ambulatory Org Chart
- By September 30, 2013, a position posting and job description for the Director of SFDPH Ambulatory Care and the Directors of Primary Care and Specialty Care will be finalized.
- By November 30, 2013, a Director of SFDPH Ambulatory Care will be hired.
- By December 31, 2013, Directors of Specialty Care and Primary Care will be hired, and Jail Health and Maternal, Child, Adolescent Health will be incorporated into the new IAC service under the director of the Ambulatory Care Director, implementation of Health Home model will be underway.
- The Ambulatory Care Director will be responsible for recommending New charters for the Ambulatory Care Committee, Primary Care Coordinating Committee and Primary Care Quality Improvement Committee to relevant bodies for approval and representation on the committees confirmed. The reporting relationships within the IAC organizational chart will be finalized.

Objective 5 – By 4/1/2014, **capital investments** in the following areas have been made to support the achievement of Goals 1, 2, 3.

**Objective 5.1 – Physical Plant**

**Measures/Standards**
- Aesthetic Conforming Standard (for signage, paint status, furniture, lighting, configuration)
- Square feet/clinical FTE
- Exam rooms per clinical FTE defined as 1350 patient equivalents (2 rooms per FTE and non-provider space requirements)
- Call center stations per 10,000 patients (2.5)
Objective 5.1 – Physical Plant

Milestones

• By 9/30/13, Facility management executive sponsor of the Ambulatory Beautification Initiative (ABI) is identified
• By 10/30/13, Define a standard set of signature, furniture, and etcetera (an aesthetic conforming standard)
• By 11/30/13, Begin renovation and remodeling work to conform to aesthetic and increase space through renovation
• By 12/01/13, Complete an initial draft and scope of work for increasing space across the system that conforms with model of care
• By 02/01/14, if Obj 1.2 results in internal call center Complete build out 30 unit call center

Objective 5.2 – Information Technology and Equipment

Milestones

• 10/15/2013 Detailed Financial Transaction (DFT) interface between eCW and Invision
• 11/1/2013 Ambulatory care network telecommunication strategy completed
• 12/01/2013 (if call center internal) Call center management software purchased
• 10/15/13 IS personnel and resource requirements to address gaps in hardware, desktop, helpdesk, infrastructure and ergonomics support are identified
• 1/30/2014 Ambulatory care – IS organizational plan in place
• 2/1/2014 A signed OCA approved contract between DPH and i2i Systems

Objective 5.2 – Information Technology and Equipment

Key Actions

• Coordinated engagement from IS, ambulatory care, facility management, occupational health, and especially PCMH leadership
• Successful execution of the DFT interface
• IT department reorganization that results in a business unit liaison to ambulatory care and more immediately to primary care
• Reorganization of current IT network, desktop and helpdesk support groups
• System-level planning involving facility management, occupational health and HC leadership to define and procure required hardware and ergonomic equipment
• Endorsement of an accountable ambulatory care – IS infrastructure
• Clear communications to PCMH staff about the IT reorganization structure

Objective 5.3 – Data-Driven Performance Improvement Structure

Measures/Standards

• One overarching DPH ambulatory service line performance improvement governance structure
• An accountable structure for CPI with executive sponsors/process owners w/ roles/responsibilities clearly defined.
• Performance measures for PCMH, BH, specialty services must include clinical, financial and patient experience and provider satisfaction measures.
• Regular management reports that are relevant, timely and actionable related to above.

Objective 5.3 – Data-Driven Performance Improvement Structure

Milestones

• By 9/30/13, complete inventory of existing organizational structures and resources within DPH Ambulatory and develop one overarching PI structure.
• By 9/30/13, Leverage the ambulatory care-IS stakeholder group to begin plans for implementing short-term PCMH business intelligence/data analytics strategy focus on behavioral health/specialty care.
Objective 5.3 – Data-Driven Performance Improvement Structure

- By 10/31/13, develop initial draft of amb care, data-driven performance improvement structure and performance measures
- By 11/30/13, engage w/ current QI leaders/committee chairs to solicit input on plan
- By 11/30/13, engage w/ IT, QI, HR, and Admin leadership to develop a reporting plan and structure to push actionable reports to users
- By 12/30/13, develop training plan re: use of reports
- By 12/30/13, beta-test initial core set of dashboard reports
- By 2/28/14, finalize core set of amb care PI dashboards w/ defined reporting periods

Objective 6 – By 3/31/14, a human resources management infrastructure is in place to support the achievement of Goals 1, 2, 3.

**Milestones**

- By 9/30/13, Ambulatory Care-HR stakeholder group is convened
- By 12/13/13, all “high priority” amb care open positions are filled
- By 12/30/13, job descriptions, performance evaluation tools, training plan are completed; short-term training strategies are executed
- By 2/28/14, long-term training strategies, accountable structure, performance standards and timeline to onboard all new hires and provide refresher training to current employees are developed and initiated

**Measures/Standards**

- 80% of unexpected absences or open positions are filled by float pool within 5 days
- Staffing ratios by function are >80% expected at all sites
- Staff competencies are assessed

**Next Steps**

- Adoption of Ambulatory Care org chart
- Make decision on how to prioritize access to specialty
- Integrate Ambulatory Care Action team report with those of other Action teams’ reports
- Hire Ambulatory Care Director
- The Ambulatory Care Director and Leadership will develop structure and mechanism for implementing recommendations

**Acknowledgement**

- Marcelina Ogbu
- Roland Pickens
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- Lisa Golden
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- Hali Hammer
- Albert Yu
- Susan Philip
- Tracey Packer
- Diane Havir
- Brad Hare
- Sue Carlisle
- Cathryn Thurow
- Kathryn Homer
- Bill Blum
- Anna Robert
- Judith Sansone
- Gloria Wilder
- Hung-Ming Chu
- Irene Sung
- Leslie Daubin
- Margaret D’Laura
- Amy Petenain
- Michelle Shurf
- Jennifer Tuda
- Fidez Bitum
- Laura Bustos
- Greg Custer
- Michelle Ruggels
- Lisa Catanzaro
1. Facilitate completion of key HMA financial deliverables:
   - SFGH Operating Budget
   - Financial Model with Scenario Analysis
   - Managed Care Forecast
   - Financial Management Tracking and Reporting Tools

2. Produce Financial Management Tracking and Reporting Tools
   - Implement for the current fiscal year
   - Provide a roadmap for improvement over time

3. Recommend integrated financial management structure that reflects and supports the SF Health Network model.

Goals

4. Establish a hiring and staffing strategy and work plan in line with Action Team recommendations, including a roadmap of next budgetary priorities.

5. Develop recommendations related to upcoming MOU process reflective of the changes inherent in the establishment of SF Health Network.

Goals

Recommendations and Deliverables

2. Financial Model, SFGH Operating Budget, and Managed Care forecast
   - Financial model and SFGH operating budget data will be compared with City’s 5-Year Financial Plan projections and used for base budget development in fall of 2013.
   - Managed care model to be updated monthly with actual enrollment data for comparison to financial projections
   - Quarterly reporting to Health Commission, Mayor’s Budget Office, Controller’s Office on performance compared to scenarios

   Status
   - Financial Model and SFGH operating budget target to be complete by October
   - Data updates and performance monitoring ongoing

Recommendations and Deliverables

3. Integrated Financial Management Structure
   - Align DPH financial organization to reflect an integrated department

   Status
   - Ongoing – target late fall for proposal
4. Hiring and Staffing Strategy
- Identify priority positions to hire over next 6 months
- Identify process, policy and administrative changes to HR processes
- Propose revisions to MOUs to encourage flexibility, efficient staffing levels, and align incentives with key DPH strategic goals

Status (Ron – these are just ideas – pls fill in/replace):
- Internal hiring LEAN process – Complete x/x/13
- Continuous posting for MDOs
- Priority focus on 2008, 2009, 2010 classes
- Weekly meetings with SFGH, LHH on requisition status

Recommendations and Deliverables

5. Other/Continuing Work
- Ongoing work to prepare for case-rate model for mental health
- Timeline and work plan to prepare for case rate by December 2013
- Advocate for administrative changes to accelerate LHH supplemental payments and maximize FQHC reimbursement (with State/Federal Work Group)
- Clarify and simplify capitation split and financial relationship with UCSF

Recommendations and Deliverables

Work Group Members
James Alexander
Doug Elwell
Valerie Inouye
Ray Jenkowski
Jenny Louie
Chie To Ma
Dob Mathias
Anne Okubo
Michelle Ruggels
Peg Stevenson
Greg Wagner
Ron Weigelt
Organizational Structures

- Develop organizational and leadership structures to improve patient flow between SFGH, LHH, community care sites and other SFDPH units, including skilled nursing facilities and behavioral health units.

Charge

- Identify organizational structures that enhance care delivery and communication related to patient flow among SFDPH hospitals and with ambulatory and community sites.
- Define operational and administrative strategies that will increase the efficiency and value of integrated delivery system activities in SFDPH hospitals.

Organizational and Leadership Structures to Improve Patient Flow

- Identify, prioritize and evaluate opportunities to improve integrated organizational functions and systems.
- Determines and prioritizes performance goals and targets.
- Ensures integration of approved performance and safety improvement recommendations into SFGH and LHH management accountabilities.

See Attachment 1
Organizational Structures
- Develop organizational and leadership structures to improve patient flow between SFGH, LHH, community care sites and other SFDPH units, including skilled nursing facilities and behavioral health units.
- Identify units at LHH and SFGH to be targeted for integration in order to improve efficiency of patient care and resource utilization.

High Priority LHH and SFGH Departments Targeted for Integration
- Cafeteria
- Food Services Management
- Clinical Nutrition
- Electrocardiogram
- Electroencephalogram
- Chronic Dialysis
- Interpreter Services
- Clinical Laboratories
- Pharmacy
- Radiology
- Rehabilitation Therapies
- Respiratory Therapy
- Telecommunication
- Biomedical
- Utilization Management

See Attachment 2

Organizational Structures
- Develop organizational and leadership structures to improve patient flow between SFGH, LHH, community care sites and other SFDPH units, including skilled nursing facilities and behavioral health units.
- Identify units at LHH and SFGH to be targeted for integration in order to improve efficiency of patient care and resource utilization.
- Create a utilization management structure, including initiation of discharge planning on admission, which supports the efficient care of San Francisco Health managed care and other inpatients.

Utilization Management Structure/Model

See Attachment 3

Operational and Administrative Strategies
- Develop recommendations on changes in policies in SFDPH institutions to more effectively manage resources.

Hospital/Post Hospital Principles for Care
- Appropriate Level of Care
- Combined effort by all DPH
  - Care Coordination
  - Foster Wellness and Independence
  - Reduce reliance on subsidized care
Recommendations on changes in policies/practices in SFDPH
- DPH clients/patients will receive absolute priority for DPH placements and services.
- Best available placement.
- Increase Utilization Management (e.g., daily, monthly) to improve patient flow.
- Increase community placement capacity by improving flow and turnover rates.
- Decrease out of network cost.

Operational and Administrative Strategies
- Develop recommendations on changes in policies in SFDPH institutions to more effectively manage resources.
- Establish targets for reductions in referral of SFDPH patients to non-SFDPH locations to decrease overall cost by 4 million dollars over 2 years.

Strategies for Achieving Reduction Targets: SFGH, LHH and Community Placement
- Conduct daily review on all acute patient cases.
- Conduct monthly utilization review on each LHH resident and Community Placement client.
- Establish Utilization Management in the Emergency Department 24 hours/7 days a week.
- Establish Utilization Management in Psychiatric Emergency Department 24 hours/7 days a week.
- Implement electronic review of InterQual criteria.
- Identify Utilization Management physician champions and provide training on acute criteria.

Recommendations on changes in policies/practices in SFDPH
- Admission to SFGH are limited to patients meeting acute level of care InterQual criteria.
- Admission and continued stay at LHH is predicated on ongoing rehabilitation and restorative care.
- LHH is not intended as an option for permanent housing (except for end of life care).
- Goal of Community Placement is to prepare clients/patients for return to independent living.
- Define discharge goals and date upon admission at each level of care.

Reduction Targets for Lower Level of Care and Out of Network Referrals
- SFGH will reduce LLOC Days by 60% of FY 11-12 Level and increase acute admissions by 640/year
- 10 LLOC per day for Medical/Surgical; reduction of 49% from current average of 20.5 days
- 18 LLOC per day for Psychiatry; reduction of 51% from current average of 35.0 days
- LHH will reduce average length of stay by 12.4%, from 629 days to 551, and increase DPH referrals by an additional 140/year
- Community Placement will reduce length of stay by 50% to increase capacity for SFGH and LHH referrals

Strategies for Achieving Reduction Targets: SFGH, LHH and Community Placement
- Expand SFGH policy for management of non-acute hospitalized patients to acute Psychiatry.
- Streamline processing of public guardianship patients.
- Monitor patient flow clinical guidelines.
- Complete reconfiguration of Behavioral Health Center.
- Evaluate current psychiatric bed configuration; make recommendations to Joint Hospital Executive Staff Council and the Integrated Steering Committee.
- Use dashboard metrics to drive additional strategies and to set targets for additional improvements.

See Attachment 4
Operational and Administrative Strategies

- Develop recommendations on changes in policies in SFDPH institutions to more effectively manage resources.
- Establish targets for reductions in referral of SFDPH patients to non-SFDPH locations to decrease overall cost by 4 million dollars over 2 years.
- Develop dashboard of metrics on inpatient flow, access and post-institutional follow-up for SFDPH inpatients.

Inpatient Flow Metrics

- SFCH
  - Daily LLOC days
  - Barriers to Discharge
  - Discharge Destinations
  - 30 Day Related Readmissions

- LHH
  - ALOS – Bed Turnover Rate
  - Barriers to Discharge
  - Discharge Disposition
  - Readmissions
  - Community Placement
    - Number of clients
    - Length of stay
    - Cost of placements
    - Percent of total admits from SFCH
    - Percent of total admits from LHH

Timeline

<table>
<thead>
<tr>
<th>Action Team Priorities</th>
<th>Deliverables</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce OON cost</td>
<td>Set OON targets; Set LLOC targets; Meet targets</td>
<td>August 2013; August 2013; 18 months after BHC reconfiguration</td>
</tr>
<tr>
<td>Create Leadership Structures for Patient Flow Oversight</td>
<td>Establish Joint Hospital Executive Council</td>
<td>November 2013</td>
</tr>
<tr>
<td>Integrate Services</td>
<td>Identify areas; Charge workgroups</td>
<td>Completed November 2013</td>
</tr>
<tr>
<td>UM Structure and Process</td>
<td>Implement Electronic InterQual; Establish Reporting Structure; Hire UM Physician Leader</td>
<td>1st Quarter 2014; November 2013; 1st Quarter 2014</td>
</tr>
<tr>
<td>Improve patient flow</td>
<td>Map current and future flow; Approval of policies; Approval of clinical guidelines</td>
<td>Completed November 2013; November 2013</td>
</tr>
<tr>
<td>Develop monitoring metrics</td>
<td>Dashboard reports for Leadership</td>
<td>November 2013</td>
</tr>
</tbody>
</table>

Thank you for all your hard work

Lisa Catanzaro  Sue Currin (lead)
Regina Gommes  Joe Goldenson
Kelly Hiramoto  Kathy Grabbill
Judith Klein  Mivlic Hirose
Chia Yu Ma  Maurice Lemon (lead)
Debra Mathias  Michael McShane
Anson Moore  Todd May
Colleen Riley  Frank Palt
Michelle Schurig  Ana Sampara
Shannon Thyne  Irene Sung
Michael Wylie

See Attachment 6
Goals

I. Managed Care Principles
II. Managed Care Operations Model;
III. Enrollment Forecasts and Projected Market Changes;
IV. Understand the provider and contracting players within the county;
V. Internal vs. External Capabilities;
VI. Develop Market Penetration Strategies.

Eventual Managed Care Functions to be Added

1. Medical Director
   - Oversees Medical Management functions
   - Engages with providers and provider appeals
2. Medical Management
   - Oversees UM, CM, QM
3. Finance
   - Product line financial health
   - Analytics

What We Need to Know When Contracting...

1. Demographic Characteristics (for those transitioning):
   - FPL
   - Citizenship status
   - Preferred Language
   - Assigned Medical Home
2. Medical Home & Specialty Capacity;
3. Niche Services (i.e. LHH, Mental Health, AIDS, etc.);
4. Types of Risk;
5. Risk Profiling;
6. Our Cost;
7. Reimbursement Method and Rates;
8. Administrative Components;
   - Credentialing, Enrollment, Claims, UM, CM, QI
9. How we’ll measure success.

Health Reform Impact on HSF/SFPATH

<table>
<thead>
<tr>
<th>Enrolled</th>
<th>Adult Care</th>
<th>Eligible for Insurance</th>
<th>Underinsured (Total)</th>
<th>Eligible HSF/SFPATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSF/SFPATH</td>
<td>60,325</td>
<td>19,289</td>
<td>41,036</td>
<td>10,791</td>
</tr>
<tr>
<td>Eligible HSF/SFPATH</td>
<td>59,142</td>
<td>14,376</td>
<td>44,620</td>
<td>9,655</td>
</tr>
<tr>
<td>Underinsured</td>
<td>10,389</td>
<td>3,913</td>
<td>7,476</td>
<td>1,414</td>
</tr>
<tr>
<td>Underinsured HSF/SFPATH</td>
<td>29.1%</td>
<td>18.5%</td>
<td>40.4%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>

Policy changes need to maintain uptake

- 21.1%
- 32.2%
- 40.3%
Predicted Enrollment by Population

FY 13-14 to FY 18-19 Forecast

1,099 Credentialed Providers

DPH Can’t do this alone...

- Current Medical Home Capacity:
  - 10 out of 17 (60%) DPH Medical Homes are “closed” to new patient assignments;
  - 12 of 22 (55%) Consortium Clinics and Provider Groups are “closed” to new patient assignments.

Current Specialty Capacity

Types of Risk
2-Plan County (83K Medi-Cal Lives)

- 15,000 lives total
- Cap 2K with BTP
- Moving towards capitation

Biggest Competitors

1. Medi-Cal
   - NEMS (collaborating)
   - CCHCA (collaborating)
   - BTP
   - HIL

2. Commercial
   - Kaiser
   - HIL
   - BTP
   - CCHCA (Collaborating)
   - Private physicians

SFHP Strategic Partnership

I. DPH pays 4% admin fee for:
   - Medi-Cal and LIHP claims processing
     - Doesn’t pay OON claims for LIHP
   - Medi-Cal UM services
     - Limited to OON only. Ok...DPH should continue to enhance eReferral capabilities
   - CM
     - Careful not to duplicate with DPH CM
   - Enrollment
   - Member Services

DPH Will Need to Sub-contract risk for Primary Care

I. Leverage SFHP as contracting entity
   - PCP Agreements need to be established with:
     1. BAART
     2. Mission
     3. Glide
     4. Haight Ashbury
     5. Lyon-Martin
     6. Native American
     7. St. Anthony
     8. South of Market
     9. NEMS (desires full risk arrangement)

Niche Specialty Agreements

I. Managed Care Organization Contracts:
   - CCHP (for Medi-Cal and Commercial—rate TBD)
     - Infectious Disease
     - Endocrine
     - Ability to perform UM services
   - NEMS (for Medi-Cal—140% of MC)
     - Neurosurgery
     - Plastic
     - Urology
     - Ortho (160% of Medi-Cal)
     - ENT (peds and adult)
     - Pain Management
     - LHH (rate TBD)
   - Others

Targeted Covered CA Participating Plans
LOI with CCHP Effective 9/12/13

I. Out of 13,000 HEBX eligible, estimate ~4,400 will sign up with CCHP (2K speak Chinese and 2K due to 50 premium at 150%
FPL).

II. Global capitation arrangement;

III. Projected total average PMPM = $437.67
   - Less Exchange related fees of $88.74 PMPM
   - Less Administrative costs of $78.28 PMPM
   - Less Rx drug costs of $41 PMPM
   - Less peds dental and Vision of $13.50 PMPM
   - Plus estimated reinsurance of $4.50
   - Plus estimated member co-pays of $17.50

IV. Will leverage CCHP’s OON hospital costs (average 31% of billed charges).

V. Network loading beginning September 15th for October 1st open enrollment.

Update on Other Covered CA Plans

1. Health Net – In discussion with lead contracting person for Covered CA

2. Anthem Blue Cross – Contacted their Regional VP of Contracting

3. Blue Shield – Identifying lead contracting person for Covered CA

Risk Profiling

I. In collaboration with Care Coordination Work Group, leverage established profiling systems to stratify population:
   - Chronic Disease Pricing System (CDPS) – developed by UC San Diego
   - CalOptima’s Risk Stratification Algorithm

II. As of 6/30/13, 15% of HSF population has no visit history in the last 2 years
   I. 10% of which are assigned to DPH Medical Homes
   II. 4.5% were assigned to a SFCCC Medical Home

Covered CA-Eligible Top 20 OPt Diagnoses

<table>
<thead>
<tr>
<th>Top 20 Diagnoses for Covered CA Eligible Patients</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</td>
<td>1336</td>
<td>22%</td>
</tr>
<tr>
<td>2. CHRONIC OBSTRUCTIVE HYPERTENSION</td>
<td>1235</td>
<td>20%</td>
</tr>
<tr>
<td>3. CHRONIC KIDNEY DISEASE</td>
<td>1187</td>
<td>19%</td>
</tr>
<tr>
<td>4. CHRONIC ALCOHOLIC LIVER</td>
<td>1132</td>
<td>18%</td>
</tr>
<tr>
<td>5. CHRONIC RENAL FAILURE</td>
<td>1092</td>
<td>17%</td>
</tr>
<tr>
<td>6. CHRONIC RENAL Failure</td>
<td>1091</td>
<td>17%</td>
</tr>
<tr>
<td>7. CHRONIC RENAL FAILURE</td>
<td>1085</td>
<td>17%</td>
</tr>
<tr>
<td>8. CHRONIC RENAL FAILURE</td>
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<td>9. CHRONIC RENAL FAILURE</td>
<td>1080</td>
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<td>17%</td>
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<td>11. CHRONIC RENAL FAILURE</td>
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<td>12. CHRONIC RENAL FAILURE</td>
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<td>19. CHRONIC RENAL FAILURE</td>
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</tr>
<tr>
<td>20. CHRONIC RENAL FAILURE</td>
<td>1069</td>
<td>17%</td>
</tr>
</tbody>
</table>

Estimated PMPM Cost

- Actuarial Firm Optumas performed actuarially sound capitation rate ranges for the SF LIHP using Coverage Initiative claims data (2007-2010)

<table>
<thead>
<tr>
<th>Rate Range PMPM</th>
<th>Group</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCE (Medicaid Coverage Expansion)</td>
<td>$408.54</td>
<td>$457.42</td>
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</tr>
<tr>
<td>HCCO (Health Care Coverage Initiative – AKA Covered CA)</td>
<td>$316.51</td>
<td>$354.56</td>
<td></td>
</tr>
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</table>
Cross Check FY 2011-12: Covered CA-Eligible PMPM Cost

<table>
<thead>
<tr>
<th>Component</th>
<th>PMPM Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPH</td>
<td>$343.17</td>
</tr>
<tr>
<td>CPG</td>
<td>$54.39</td>
</tr>
<tr>
<td>Total</td>
<td>$397.56</td>
</tr>
</tbody>
</table>

*FY 11-12 HSF actual claims data.

Assessing Managed Care Performance

I. Hospital (By Line of Business)
   - Days per 1,000
   - Denied days
   - Length of stay
   - ALOS
   - Out-of-network days
   - Outpatient surgeries
   - ER visits (in-network & out-of-network)
   - Discharges for Ambulatory Care Sensitive Conditions per 2,000

II. Patient Satisfaction
   - CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey

I. Professional (By Line of Business)
   - Readmission rates
   - In-Network vs. out-of-network
   - Visits per 1,000 (primary and specialty)
   - Average # of visits/member/year
   - Diagnostic utilization per visit
   - Average cost per visit
   - Procedures per 1,000 visits per year
   - Preventive Care visits
   - Prescription/visit or per member
   - % generic and formulary compliance
   - Referral rate per 100/100 visits or per 1,000 members/yr (and by PDP)
   - HEDIS Measures
   - Wait times
   - Open vs. Closed Medical Home panels

Overall Managed Care Goals
1. Retention of HSF and SFPATH lives
   - Minimize loss on Covered CA (we already know we won’t make a profit on this line of business—
     not in the beginning)
   - Likely to be much cross-over between Covered CA and Medi-Cal due to income changes;
   - Make our cost + 4% on all Medi-Cal enrollees;
2. Leverage referral platform for UM services
   - Save plan and provider administrative burden;
   - DPH to negotiate more of the UM data;
3. Enhance Care Management services and connect system-wide;
4. Manage out-of-network costs by collaborating with IDS components and working closely with plan UM;
   - Subcontract to private ITC partners where financially feasible to assist with lower level SNF capacity;
5. Continuously manage our $17,000, and to the extent politically possible, maintain employer mandate and member share of cost;
   - Raise share of cost for Covered CA-eligible members to encourage enrollment into HBE
   - Aggressively recruit Medi-Cal eligible enrollees;
6. Healthy Worker/City Worker Program
   - Negotiate better rates to compensate high ODR expenses;
7. Transparency and clarity around risk arrangements with CPG.

Accomplishments Thus Far
1. Letter of intent signed with Chinese Community Health Plan to commit the retention of 5,000 Covered CA lives;
2. Laid the groundwork to UCSF/CPG and DPH/SFG to refine and simplify risk sharing under capitated contracts;
3. Identified niche specialty service needs from Chinese Community Health Plan and NEMS;
4. Strategized plan with SFHP to contractually sub-capitate with consortium clinic partners;
5. Recommended short-term IT strategies to establish system wide deployment of CM and continuity of care data records;
6. Supplied risk stratification criteria and best practice guidelines for analytics and CM activities;
7. Educated and interviewed all SFCCC leadership to discuss ACA impact on county, and understand concerns and recommendations to improved access to quality care.

To be Accomplished by end of 2013
1. Recruit Managed Care and HSF Director Positions;
2. Disseminate MCE and HCCI transition letter to members;
3. Operationalize contract with CCHP;
   - Join Delta Dental network for peds dental benefit;
   - Join Navitus PBM network for pharmacy carveout;
4. Assist in selecting CM vendor;
5. Secure contracts with consortium clinics;
6. Secure full risk and specialty contracts with NEMS;
7. Address issues identified from SFCCC meetings;
8. Collaborate with HSA on outreach and enrollment;
STATE AND FEDERAL POLICY ACTION TEAM RECOMMENDATIONS

Presented to Integration Steering Committee
08/21/13

Original Charge

• Begin a dialogue with state and federal officials that supports the innovations in SFDPH financially and consistent with health care reform.

Original Priorities

1. Work with the state on a change to the Distinct Part Unit licensure rules to allow SFDPH to combine LHH and SFGH licenses without losing reimbursement if that proves beneficial.
2. Explore new ways to fund behavioral health consistent with integration and managed care principles, particularly pursuing a Regional Behavioral Health Authority.
3. Review opportunities for California to adopt a Health Home model under section 2703 of the ACA that benefits the citizens of SF.
4. Create the bullet points and rationale for change to assist the state and federal government to remove barriers and incentivize SFDPH to continue to evolve.

Revised Priorities

1. Provide State with language for a State Plan Amendment (SPA) for Health Homes favorable to the SF situation (may need to pay State for the investment of their time to pursue)
2. Pursue supplemental Medicaid payments for clinic services
3. Pursue options for expanding Covered California assistor training
4. Target issues related to the enrollment of the jail inmate population into SF PATH and Healthy San Francisco
5. Assure the timeliness of supplemental payment calculations

RECOMMENDATIONS
1. Health Homes

**Priority and Status**
- High Priority
- Active

**Goal**
- Develop SPA language to access federal Health Home funds or partner with others to include health home model in the next CA 1115 waiver.

**Strategy**
- Explore the potential of state funds for grants that go to the legislature for the next session through 9/13, or early next session. Or engage in waiver conversations with public hospital partners.

**Key Partners**
- California Association of Public Hospitals
- Los Angeles County Department of Health Services

**Major Activities**
- Maximize HICH funding
- Track ACA/Health Home Model with lobbyist
- Participate in waiver conversations

**Timeline**
- September 2013 for legislative solution
- December 2013 for waiver discussions

2. Supplemental Payments for Clinic Services

**Priority and Status**
- High Priority
- Active

**Goal**
- Increased FQHC reimbursement

**Strategy**
- Encourage DHCS to develop a SPA to allow for an increased reimbursement rate OR determine whether Directive language can be added to the realignment waiver bill.

**Key Partners**
- Other counties with FQHCs

**Major Activities**
- Run ballpark fiscal estimates
- Review L.A. SPA to determine if applicable to SF
- If not, develop SPA language

**Timeline**
- September 2013 for legislative solution

3. Covered California Assistor Training

**Priority and Status**
- High Priority
- Completed

**Goal**
- Increase training opportunities, as needed

**Strategy**
- Ascertain schedule w/ Health Benefits Exchange contact.
- If needed, advocate for expanded offerings

**Key Partners**
- Health access advocates
- Other counties

**Major Activities**
- Outreach determined that in addition to in-person trainings, online trainings would be available

**Timeline**
- Priority completed June 2013
- Trainings to be launched September/October 2013

4. Enrollment of Jail Inmate Population

**Priority and Status**
- High Priority
- Active

**Goal**
- Ensure jail population has coverage and access to care prior to being released from jail

**Strategy**
- Explore magnitude and process of enrolling inmates in LIHP (waiver from the state to transition general assistance recipients to the LIHP program required); Explore internal policy or operational issues

**Key Partners**
- Jail Health
- Human Services Agency

**Major Activities**
- Determine policy and operational barriers (e.g., staffing, issues preventing enrollment prior to release)
- Collect data (e.g., recidivism and length of stay, inventory of general assistance recipients)
- Explore potential to either develop substance abuse programs and have those enrollees in jail psychiatric services be transferred to enroll in HSF
- Develop operational opportunities to jail health; focus on state-wide policy opportunities

**Timeline**
- October 15, 2013 for pilot

5. Timeliness of Supplemental Payment Calculations

**Priority**
- Medium Priority
- Active

**Goal**
- Reduce LHH supplemental payment lag time

**Strategy**
- State Administrative process change

**Key Partners**
- None

**Major Activities**
- Determine fiscal impact of reduced lag time
- Contact and work with State to decrease supplemental payment lag time

**Timeline**
- Spring 2014

Low Priority Issues

- Medi-Cal Mental Health Case Rate Reimbursement
  - Fact Finding
  - Understand the case rate model as compared to capitation
  - Direction/Strategy
  - Faculty and operationally model the case rate vs. capitation models; develop a strategy for DPH
  - Policy Changes
    - Advocate, as necessary, for developed strategy

- HRSA FQHC Review
  - Track issue in other counties
  - Alameda
  - San Mateo
  - No action needed until prompted
Issues on Hold

- **LHH/SFGH Licensure Issue**
  - **Goal**: Combine LHH/SFGH licensure
  - Operational and environmental assessment needed
  - Legislation & possible regulatory change required

- **Jail Health Pharmacy Billing**
  - **Goal**: Merge Jail Health Pharm Billing with SFGH
  - Determine feasibility of Jail Health pharm billing with SFGH as hospital based clinic or FQHC

- **SF Behavioral Health System Integration (RHBA)**
  - **Goal**: Explore new ways to fund behavioral health consistent with integration and managed care principles, particularly pursuing a RHBA
  - No action required until further information from Case Rate research

- **DPH FQHC Status**
  - **Goal**: TBD, dependent on HRSA FQHC review tracking
  - Pre-work to determine if FQHC status of DPH clinics necessary/possible - hold until appropriate time

- **FamilyPACT**
  - **Goals**: Determine if privacy clause is an issue for billing under managed care
  - Due to low fiscal impact, hold until specific policy issue arises
SFDPH-HMA
CARE COORDINATION ACTION TEAM
RECOMMENDATIONS

August 7, 2013
Presented By: Kelly Hiramoto, LCSW, Director of Placement
Mission

♦ Develop a centralized Care Coordination model that will improve the value and efficiency of care management services and support the managed care system.

♦ Align case management structure with care coordination services in PCMH and Health Homes.

♦ Improve accountability for outcomes of care management services delivered.
Priority 1

Create a leadership and organizational structure for Care Coordination services within SFDPH
Care Coordination

A Care Coordinator, based in the person’s Medical or Health Home, provides professional oversight that helps ensure that our consumers’ needs and preferences for medical and behavioral health services and information sharing across people, disciplines, systems of care, and sites are met over time.

The goals of Care Coordination are to facilitate beneficial, efficient, safe and high quality patient experiences, prevent avoidable costs, and improve the health, functional status, wellness and social outcomes for our consumers.

This person may also function as the Care Manager.
A Care Manager implicitly improves Care Coordination by providing direct care management services targeted to people with a diverse combination of health, functional and social challenges.

This person may also function as the Care Coordinator
A Service Coordinator provides consumers who have stable medical conditions with navigation assistance, access to services, and/or referrals to resources.
Care Model: Children System

- Care Coordination and Care Management in the Children’s System of Care and within Maternal, Child and Adolescent Health should continue to use mandated models of care during the first two years of Affordable Care Act implementation unless the State or Federal Government issue system changes that impact patient flow.
<table>
<thead>
<tr>
<th>Caseloads</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT/FSP/Specialty ICM</td>
<td>5-10</td>
</tr>
<tr>
<td>Intensive CM</td>
<td>15-25</td>
</tr>
<tr>
<td>Non-Intensive CM</td>
<td>40-50</td>
</tr>
<tr>
<td>Care Coordinator</td>
<td>200</td>
</tr>
<tr>
<td>Behaviorists</td>
<td>900-1800 Panel</td>
</tr>
<tr>
<td>Behavioral Health Provider</td>
<td>60-100</td>
</tr>
<tr>
<td>Psychiatrist/Prescribers</td>
<td>100-300</td>
</tr>
<tr>
<td>COPC/SFGH</td>
<td>use existing algorithm</td>
</tr>
</tbody>
</table>
Priority 2

Define the necessary Care Coordination resources, data needs and administrative support for a San Francisco Health population of 60,000 – 80,000 clients
80,000 served
4,000 (5%) receive higher support
200 (5%) HUMS = 13 ACT/FSP/Specialty ICM
950 (25% of remainder) = 19 CM
2,850 (remainder) = 15 Service Coordinators

76,000 will receive episodic Service Coordination,
Short Term Care Coordination or
will manage independently
Data Systems

Anticipated Data System Transitions

Short-Term (0 – 3 years)

*CCMS, SF GetCare, LCR, eCW, Avatar*

Mid-Term (3.1 – 7 years)

*MobileMD, SF GetCare, eCW, LCR, Avatar*

Long Term (7.1 – 10 years)

*Single EHR System*
Data Collection

Standardized data sets will be established

- Community Care Plan
- Continuity of Care Document requirements

Standardized Utilization Management indicators across the System of Care

- 30 day Readmissions
- No Show Rates
- Timely Access Success Rates
- Out of Network use
- Excess use of Urgent/Emergent services
- Incarceration rates
Gaps

- Care Coordination will require knowledge of biopsychosocial care
- Teamwork in Team-Based Care model will be new
  => *Health Workers should cross train to MEA skills*
- IT training: comfort, ease of use
- Documentation including collaborative charting
- Quick transitions between levels of care
- Forensic pathways
- Population Health knowledge across systems
- Billing agility
- QI integrated and accountable across systems
Funding Streams

Need to coordinate with SFDPH-HMA Finance and Managed Care groups

Identified Payer sources in the mix:

- Short Doyle
- FQHC
- Drug Medi-Cal
- MAA/TCM
- Health Home funding (if approved)
- General Funds will still be needed in the short-term to bridge
Create the operational plans for managing Care Coordination services with Primary Care management located in Patient-Centered Medical Homes (PCMH), Behavioral Health Homes (BHH), Jail-based care or Homeless/Transient Care
Getting Ready

• Training on new role expectations
• Improve Health knowledge for Behavioral Health Care Managers
• Improve general resource knowledge across all Systems of Care
• Identify and train staff to provide Care Management for consumers with Substance Abuse and/or Medical issues with no co-occurring Mental Health issues
## Service Components

**SFDPH-HMA CARE COORDINATION ACTION TEAM**  
**JOB RESPONSIBILITY COMPARISON**  
**July 30, 2013**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Care Coordinator</th>
<th>Care Manager</th>
<th>Service Coordinator</th>
<th>Utilization Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorize and Manage the Delivery of Service</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Assessment</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Develop Community Care Plan</td>
<td>X</td>
<td>*participates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify Participants in Care and Specify Roles</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Ensure Information Exchange across care system is accurate and efficient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Implement Community Care Plan Interventions</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Face to Face meetings with client in office to work on Community Care Plan issues</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Face to Face meetings with client at home visits to work on Community Care Plan issues</td>
<td></td>
<td>X</td>
<td></td>
<td>*with Care Manager</td>
</tr>
<tr>
<td>Assist with forms or other applications for services</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Transport/Escort client to appointments</td>
<td>X</td>
<td>X</td>
<td>Escort only</td>
<td></td>
</tr>
<tr>
<td>Recovery and Wellness Education</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor Care Needs are being met</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Identify Coordination Problems that Impact Outcomes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Modify Community Care Plan</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Document care events as they happen</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Review progress notes and other care documentation</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Call Case Conference when problems arise</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Track Services and Cost</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Evaluate frequency, duration and cost of services accessed</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*can be the same person*
## Staffing Qualifications

<table>
<thead>
<tr>
<th>Care Coordinator</th>
<th>Care Manager</th>
<th>Service Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2912</td>
<td>2912</td>
<td>2586</td>
</tr>
<tr>
<td>2920</td>
<td>2920</td>
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<td>2922</td>
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<td>2320</td>
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<td></td>
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<td>2574</td>
<td>2574</td>
<td></td>
</tr>
<tr>
<td>2830</td>
<td>2830</td>
<td></td>
</tr>
</tbody>
</table>
Priority 4

Define the guidelines needed for appropriate risk adjusting for San Francisco Health populations, assigning them to care coordination, tracking and assessing quality of care.
Risk Stratification

Algorithm Options Considered:

- CalOptima
- Memorial Care
- Humboldt 4 Quadrant

- UC San Diego Chronic Illness and Disability Payment System

- Will append the selected tool with Behavioral Health, Functional and Social functioning criteria
  
  (HUMS method of top 1% and top 5% with Elixhauser)
Assessment & Assignment

- LOCUS/CALOCUS (possibly with Elixhauser modifiers) *
  * under consideration
- RUG scores (Laguna Honda)
- InterQual (SFGH)

Score ranges will be associated for assignment to appropriate level of support

- Care Coordination with Care Management
- Care Coordination
- Care Management
- Service Coordination
- Independent navigation
Utilization Management

- Utilization Management Oversight Committee should be established to track Dashboard Metrics
- Data Analyst should be assigned to track data metrics and assemble reports related to Utilization, Outcome Measures and Quality
Quality Improvement Process

- Will be consulting with Lisa Golden, Regina Gomez, Deborah Sherwood, Iman Nazeeri-Simmons
- There should be a responsible party for Quality Improvement in each Clinic/Site
- The centralized referral tracking system and designated staff will monitor the individual and system-level outcomes related to Care Coordination and Care Management.
Next Steps

• Finalize Risk Stratification and Assessment tools
• Identify format and database to support the Community Care Plan
• Get cost reimbursement options from Finance and Managed Care Action Teams
• Obtain current staffing numbers for Care Managers and Care Coordinators to determine if additional staffing requests need to be submitted
• Determine if a Health Care Analyst is available to assist with data management
• Submit recommendations on Care Models and staffing requirements for the Community Programs RFP
• Coordinate with Institutional/Post Institutional Action Team on Utilization Management standards and metrics
• Partner with SFHP on their plans for Care Coordination
• Establish Quality Improvement process
Roll the Credits!
## Appreciation

Many thanks to everyone who contributed to our Action Team!
(in alphabetical order)

<table>
<thead>
<tr>
<th>Edwin Batongbacal</th>
<th>Kellee Hom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dan Castillo</td>
<td>Sharon Kwong</td>
</tr>
<tr>
<td>Lisa Catanzaro</td>
<td>Tina Lee</td>
</tr>
<tr>
<td>Carol Chapman</td>
<td>Maurice Lemon</td>
</tr>
<tr>
<td>Hung-Ming Chu</td>
<td>Maria X. Martinez</td>
</tr>
<tr>
<td>Terry Conway</td>
<td>Tanya Mera</td>
</tr>
<tr>
<td>Elizabeth Davis</td>
<td>Winona Mindolovich</td>
</tr>
<tr>
<td>Rosaly Ferrer</td>
<td>Jo Robinson</td>
</tr>
<tr>
<td>Janet Gillen</td>
<td>Ana Sampera</td>
</tr>
<tr>
<td>Regina Gomez</td>
<td>Judith Sansone</td>
</tr>
<tr>
<td>Diana Guevara</td>
<td>Michelle Schurig</td>
</tr>
</tbody>
</table>
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  Maria X. Martinez
  Tanya Mera
  Winona Mindolovich
Jo Robinson
  Ana Sampera
Judith Sansone
  Michelle Schurig
Climb mountain from here

THE END
Overview of the SFHN

Business Intelligence Unit

Main Topics

- Background
- BIU Purpose
- BIU Processes
- BIU Structure & Responsibilities
- CSA Role
- High Level Calendar
- BIU Metric Development Process Update

Background

- How did we get here?
  - June – Sept 2013: DPH-HMA Action Teams
  - Oct 2013: SFHN Born
  - Nov 2013: HMA delivered list of 65+ operational and financial metrics
  - Today:

  - HMA recommended the implementation of a select set of metrics to track the operational and financial progress of the SFHN toward Network goals and objectives
  - SFHN began preliminary development of metrics and the governance structure to operationalize these metrics via the Business Intelligence Unit or BIU
  - Today we will discuss this structure

BIU Purpose

- Purpose:
  - Guide the San Francisco Health Network (SFHN) in developing actionable metrics that can measure, understand, and improve performance by providing a service consisting of data, information, education, and insight

- Tactics:
  - Establish a formal BIU via an operations and finance focused mindset, skillset, and toolset
  - Construct a cost and quality effective BIU infrastructure for the SFHN
  - Build tools and teach skills to measure progress
  - Identify and prioritize strategic processes and improvements

- Goal:
  - For SFHN stakeholders to be connected with credible, relevant, actionable, and readily-available information when needed to drive enhanced operational and financial performance collaboratively across the SFHN.

BIU High Level Process

- Monitoring process: The BIU will also ensure metrics, dashboards, and reports continue to be relevant, actionable, and utilized through a follow-up or monitoring process

BIU Structure

- OPERATIONAL: Roland Pickens
- DATA / I/S: Bill Kim
- FINANCIAL: Greg Wagner

  Categories
  - Client Flow
  - Client Satisfaction
  - Staff Satisfaction

  Categories
  - All

  Categories
  - Financial Stewardship
  - Managed Care
City Service Auditor’s (CSA) Role

- The BIU is not fully staffed; therefore, CSA’s role is to:
  - Assist in the development of metrics and reports
  - Support the BIU and related governance efforts

Examples include:
- Static inpatient flow dashboard
- Interactive outpatient quality measures dashboard

BIU Metric Development Process

<table>
<thead>
<tr>
<th>Metric Category</th>
<th>Completed</th>
<th>In Progress</th>
<th>Not Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Managed Care</td>
<td>0</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Access, Capacity, Flow</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staff Satisfaction &amp; HR</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Clinical</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>21</td>
<td>0</td>
</tr>
</tbody>
</table>

Percent of Total: 5% 95% 0%

Feedback, Questions, Discussion

BIU Leads Contact Information

Baljeet Sangha
Baljeet.sangha@sfdph.org
415-206-3821

Jenny Louie
Jenny.louie@sfdph.org
415-554-2605

Tina Lee
tina.lee@sfdph.org
415-206-4167
High Level BIU Structure & Process

Purpose: To distinguish information flow, data requests, and report dissemination between BIU and PI/QRC/QDC

Discussion: What is the interaction between PI and BIU? What is PI/QRC/QDC’s role(s) in the below diagram?
Methodology (how did we determine this list of metrics?)

(1) Division Prioritization: All divisions were asked to prioritize metrics based on the following general criteria: (1) relevance to your division, and (2) which measures will assist the division in tracking the "pulse" around fiscal and operational efficiency

(2) Level of Effort Estimation: A subjective level of effort was assigned to each metric based on whether or not a report already exists, whether or not the data source is known, and the difficulty of data collection.

(3) BIU Lead Categorization: BIU leads categorized all metrics into three buckets. Metrics will be developed in order of group A, B, C, P (proposed), and C (complete).

NEXT STEPS: DPH BIU, DPH I/S, and Controller's Office analysts will be contacting your staff to determine definitions, inclusion/exclusion criteria, etc. for Priority Group A.

Priority Group A: August 2014

<table>
<thead>
<tr>
<th>Category</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Primary Care Revenue vs. Budget</td>
</tr>
<tr>
<td></td>
<td>Primary Care Cost vs. Budget</td>
</tr>
<tr>
<td></td>
<td>PATCH costs</td>
</tr>
<tr>
<td></td>
<td>Staff Vacancy</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Cost PMPM</td>
</tr>
<tr>
<td></td>
<td>Revenue PMPM</td>
</tr>
<tr>
<td></td>
<td>Inpatient Days Per 1000</td>
</tr>
<tr>
<td></td>
<td>Cost per visit</td>
</tr>
<tr>
<td></td>
<td>Visits per hour (aka Patients Per Hour)</td>
</tr>
<tr>
<td></td>
<td>OON costs</td>
</tr>
<tr>
<td></td>
<td>ED Visits OON</td>
</tr>
<tr>
<td></td>
<td>ED Visits in network</td>
</tr>
<tr>
<td></td>
<td>Membership</td>
</tr>
<tr>
<td></td>
<td>SFHN Client Attrition</td>
</tr>
<tr>
<td></td>
<td>Average Number of Visits Per Member</td>
</tr>
<tr>
<td></td>
<td>ASC Visits (ambulatory sensitive condition)</td>
</tr>
<tr>
<td>Access, Capacity, Flow</td>
<td>3rd to Next F/U Appt</td>
</tr>
<tr>
<td></td>
<td>PC - 3rd Next Visit to a Provider New Visit</td>
</tr>
<tr>
<td></td>
<td>% Post-Hospital Empaneled Patients Seen in PC within 7 Days</td>
</tr>
<tr>
<td></td>
<td>Panel Size per Provider</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>% 9 or 10 out of 10; CG-CAHPS and HCAHPS</td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td>Number of Requisitions (Turnover)</td>
</tr>
<tr>
<td></td>
<td>Staff Satisfaction to measure employee, staff views</td>
</tr>
</tbody>
</table>

Priority Group B: TBD Date

<table>
<thead>
<tr>
<th>Category</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Clinical Care Hours vs. % Budgeted Hours PC, SC, MH</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Visits or Admits</td>
</tr>
<tr>
<td></td>
<td>PC - Visits per 1000</td>
</tr>
<tr>
<td>Access, Capacity, Flow</td>
<td>Actual Panel Size vs. Expected Panel Size</td>
</tr>
<tr>
<td></td>
<td>Wait List by Clinic</td>
</tr>
</tbody>
</table>

Priority Group C: TBD Date

<table>
<thead>
<tr>
<th>Category</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>Case rate cost of care</td>
</tr>
<tr>
<td></td>
<td>FTE/ Adj Occupied Bed</td>
</tr>
<tr>
<td>Access, Capacity, Flow</td>
<td>Placement at HUH/DAAS</td>
</tr>
</tbody>
</table>
## SFHN Performance Metrics Prioritization

### Complete X

<table>
<thead>
<tr>
<th>Access, Capacity, Flow</th>
<th>ADC</th>
<th>ALOS</th>
<th>Bed Holds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30-Day All Cause Readmits</td>
<td>Functional Vacancy</td>
<td>Non-Acute Days or Patients</td>
</tr>
<tr>
<td></td>
<td>Barriers to discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Proposed Metrics

<table>
<thead>
<tr>
<th>Finance</th>
<th>Percentage of clients with health coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Treatment Plans Past Due</td>
</tr>
<tr>
<td></td>
<td>P103 Cost</td>
</tr>
<tr>
<td></td>
<td>Pharmacy Costs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Katie A Penetration Rate (CYF only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Asian Penetration Rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access, Capacity, Flow</th>
<th>Post-discharge clients enrolled into care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post-discharge clients with appts in primary care</td>
</tr>
<tr>
<td></td>
<td>Wait list for primary care appts in jail health (similar to TNAA FU) – # of patients not seen within 2 weeks of referral</td>
</tr>
<tr>
<td></td>
<td>Initial visit to mental health – # of patients not seen within 48 hours</td>
</tr>
<tr>
<td></td>
<td>Youth in care for &gt;18 mos (addresses outflow)</td>
</tr>
<tr>
<td></td>
<td>Engagement in OP Substance Abuse Tx (3 or more services in first 30 days)</td>
</tr>
</tbody>
</table>

| Patient Satisfaction | Overall average item score on MHSIP or YSS = 4.0 or higher out of 5.0 |
SFHN Performance Metrics Prioritization

Methodology (how did we determine this list of metrics?)

(1) Division Prioritization: All divisions were asked to prioritize metrics based on the following general criteria: (1) relevance to your division, and (2) which measures will assist the division in tracking the "pulse" around fiscal and operational efficiency"

(2) Level of Effort Estimation (not applicable here): A subjective level of effort was assigned to each metric based on whether or not a report already exists, whether or not the data source is known, and the difficulty of data collection.

(3) BIU Lead Categorization (not applicable here): BIU leads categorized all metrics into three buckets. Metrics will be developed in order of group A, B, C, P (parking lot), and C (complete).

NEXT STEPS: Meet with the PI group to determine how these align with their metrics.

Additional Proposed Metrics

Clinical

Falls with Injuries rate+
Hospital Acquired Pressure Ulcers+
Surgical Site Infection rate+
Sepsis bundle compliance rate+
Central Line Bloodstream Infections+
VTE Prophylaxis+
Mammography screenings*
Diabetes LDL-control*
Diabetes, hospitalization for short-term complications +*
Uncontrolled Diabetes hospitalization +*
Hospitalization for Chronic Obstructive Pulmonary Disease+*
Hospitalization for Congestive Heart Failure+*
Influenza Immunization*
Child Weight Screening- Calculated BMI*
Pediatric BMI above 85th percentile*
Tobacco Cessation received or referred*
Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure*
30-day congestive heart failure readmission rate+*
(Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure
Pediatrics Asthma Care -controller medication prescribed*
Emergency Department Left Without Being Seen
Exclusive Breastfeeding at Discharge+
C-Section Rate+A65
### Field Definitions

**Status**

<table>
<thead>
<tr>
<th>Priority</th>
<th>BIU recommended prioritization based on division input. Once final, this will be taken to executive sponsors for approval.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status (C-IP-NS)</td>
<td>Metric development status - complete (C) - in progress (IP) - not started (NS)</td>
</tr>
<tr>
<td>Collected? (Y-N)</td>
<td>Based on HMA assessment, whether or not the metric can be found in another</td>
</tr>
<tr>
<td>Level of Effort (L-M-H)</td>
<td>Subjective assessment of level of effort needed based on matrix below</td>
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</table>

**Level of Effort Report exists Known source Low effort Score**

<table>
<thead>
<tr>
<th>Level of effort</th>
<th>Report exists</th>
<th>Known source</th>
<th>Low effort</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Low</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Medium</td>
<td>No</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>1-2 Yes</td>
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<tr>
<td>High</td>
<td>No</td>
<td>No</td>
<td>No</td>
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**Summary of Considerations/ Issues**

A shorthand of issues, considerations, and feasibility questions that have arisen. Separate, longer documentation exists for most in progress metrics in word or other format.

**Intent**

<table>
<thead>
<tr>
<th>Connection to objective</th>
<th>Still needs to be refined, but intended to be the criteria that ties the metric to the overall objective of SFHN category.</th>
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**Metrics**

<table>
<thead>
<tr>
<th>Measurable signs of progress that reflect objectives</th>
<th>Metric name</th>
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<tbody>
<tr>
<td>Metric description</td>
<td>Metric name</td>
</tr>
<tr>
<td>Proposed Granularity</td>
<td>Ideally, how metric information can be “sliced-and-diced”</td>
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**Data Sources**

<table>
<thead>
<tr>
<th>Contact</th>
<th>Contact person(s) if known</th>
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</thead>
<tbody>
<tr>
<td>Data Location</td>
<td>Data source(s) if known</td>
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</tbody>
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**Data Analysis**

| Collection method, caveats | This still must be determined based on discussions, particularly with I/S |

**Communication Plan**

<table>
<thead>
<tr>
<th>Audience</th>
<th>Intended audience for all metrics is SFHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>The division that will be held responsible for explaining variations, trends, etc. to</td>
</tr>
</tbody>
</table>

### Metric Summary

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Current</th>
<th>Proposed</th>
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</thead>
<tbody>
<tr>
<td>Finance</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Managed Care</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Access, Capacity, Flow</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Clinical</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>36</td>
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### Status Summary

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<th>Metrics</th>
<th>Completed</th>
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<th>Not Started</th>
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<tbody>
<tr>
<td>Finance</td>
<td>0</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Managed Care</td>
<td>1</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Access, Capacity, Flow</td>
<td>7</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Staff Satisfaction</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clinical</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>9</td>
<td>21</td>
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</tbody>
</table>

Percent of Total: 21% 24% 55%
### Financial Metrics Tracking Sheet

**SFHN Objective:** To design, acquire, and implement new systemwide financial structure to support integrated SFHN. Control costs.

**BIU Owner:** Jenny Louie/Tina Lee

**BIU Analyst(s) / User License:** Anastassia, Chris, Jasmeen/Karen

**I/S Staff / Developer License:** None

**CSA Analyst / TBD License:** If needed, TBD

**Target Tracking Sheet Completion Date:** TBD

<table>
<thead>
<tr>
<th>Status</th>
<th>Priority</th>
<th>Status (C-IP-NS)</th>
<th>Collected? (Y-N)</th>
<th>Level of Effort (L-M-H)</th>
<th>Summary of Considerations/ Issues</th>
<th>Intent</th>
<th>Metrics</th>
<th>Description</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Data Analysis</th>
<th>Audience</th>
<th>Accountability</th>
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<tr>
<td>A</td>
<td>A</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>• Data lag; Data filters</td>
<td>Improve revenue strategy development and generation</td>
<td>Primary Care Revenue vs. Budget</td>
<td>Total primary care revenue and total primary care budget.</td>
<td>• by cost center • by index code • by clinic • by provider • by payor source</td>
<td>Diana Guevara/Jenny Louie/Tina Lee</td>
<td>PFS Finance/EIS SFHP</td>
<td>TBD</td>
<td>SFHN AMB</td>
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<tr>
<td>A</td>
<td>B</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>• Data lag; Data filters</td>
<td>Improve cost control</td>
<td>Primary Care Cost vs. Budget</td>
<td>Total primary care cost and total primary care budget.</td>
<td>• by cost center • by index code • by clinic • by provider</td>
<td>Jenny Louie/James Alexander</td>
<td>EIS/FAMIS</td>
<td>TBD</td>
<td>SFHN AMB</td>
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<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>• Define “vacancy”</td>
<td>Improve hiring/retention rate</td>
<td>Staff Vacancy</td>
<td>Measures turnover rate</td>
<td>• by division • by location (clinic, specialty/department, ancillary service) • by position</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>SFHN HR</td>
</tr>
<tr>
<td>B</td>
<td>C</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>• Data lag; Data filters</td>
<td>Improve staff efficiency to control costs</td>
<td>Clinical Care Hours vs. % Budgeted Hours; PC, SC, MH</td>
<td>Variance between total hours scheduled vs. total hours open</td>
<td>• by clinic • by provider</td>
<td>TBD</td>
<td>Patient Appt Unit; eCW</td>
<td>TBD</td>
<td>SFHN AMB</td>
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<tr>
<td>C</td>
<td>C</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>• Develop methodology via consultant</td>
<td>Adapt and improve cost control</td>
<td>Case rate cost of care</td>
<td>Mental health cost of care per State</td>
<td>• by cost center • by index code • by clinic • by provider • by dx code category</td>
<td>TBD</td>
<td>BH</td>
<td>TBD</td>
<td>SFHN AMB; CBHS</td>
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<tr>
<td>C</td>
<td>C</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>• UHC benchmark</td>
<td>Improve staff efficiency to control costs</td>
<td>FTE/ Adj Occupied Bed</td>
<td>Number of FTEs per Adj Occupied Bed. Measures hospital productivity</td>
<td>• by location (specialty/department, ancillary service)</td>
<td>Tina Lee</td>
<td>SFGH I/S</td>
<td>TBD</td>
<td>SFGH</td>
</tr>
</tbody>
</table>

**Contact:**
- Diana Guevara
- Jenny Louie
- Tina Lee

**Audience:**
- SFHN
- AMB
- SFHN
- AMB
- SFHN
- HR
- SFHN
- AMB
- SFHN
- AMB
- SFHN
- SFGH

**Accountability:**
- SFHN
- AMB
- SFHN
- AMB
- SFHN
- SFGH
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<th>Status</th>
<th>Priority</th>
<th>Level of Effort</th>
<th>Collected?</th>
<th>Status</th>
<th>Intent</th>
<th>Metrics Description</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Data Analysis</th>
<th>Communication Plan</th>
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<td>L-M-H</td>
<td>Y-N</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary of Considerations/ Issues</th>
<th>Metrics</th>
<th>Data Location</th>
<th>Data Collection method, caveats</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection to objective</td>
<td>Measurable signs of progress that reflect objectives</td>
<td>Contact</td>
<td></td>
<td>Account-ability</td>
</tr>
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<td></td>
<td></td>
<td>Data Sources</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Collected?</td>
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</table>

### Parking Lot - Metrics to be vetted and categorized at future date via TBD criteria/request process

<table>
<thead>
<tr>
<th>P</th>
<th>Percentage of clients with health coverage</th>
<th>AMB; CBHS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Possibly include in Managed Care dashboard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Possibly move to clinical metrics under PI</td>
<td></td>
</tr>
<tr>
<td>% Treatment Plans Past Due</td>
<td>AMB; CBHS</td>
<td></td>
</tr>
<tr>
<td>P103 Cost</td>
<td>AMB; Jail</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Costs</td>
<td>AMB; Jail</td>
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</tr>
</tbody>
</table>

### Proposed Next Steps

**Goal:** To develop a first draft of Priority A metrics by August 2014 for BIU lead and Executive Sponsor approval.

1. **Resource Assignment**
   - **BIU leads** to assign BIU analyst (user license), I/S staff person (developer license), CON analyst (user or developer license as needed, provide support to BIU and I/S as needed).

2. **Business Requirements Collection**
   - **BIU analyst** (and/or CON analyst) to facilitate the identification of data sources / key players and raise consideration/decisions to BIU leads (escalate as advised).

3. **Technical Requirements Collection**
   - **BIU analyst** (and/or CON analyst) to engage I/S staff person as needed to gather information I/S needs to develop data infrastructure (see I/S sample spreadsheet).

4. **Data Infrastructure / Dashboard Template Development.**
   - **I/S staff person** to connect identified data sources, build data infrastructure, and build dashboard templates, as needed, via developer license.

5. **Tile Development and Final BIU Lead Approval**
   - **BIU analyst** (and/or CON analyst) to develop charts and graphs via the user license interface.
## SFHN Objective
To operationalize new managed care office, processes, accountabilities, and performances. Maximize revenue.

### Managed Care Metrics Tracking Sheet

<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
<th>Status (C-IP-NS)</th>
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<th>Level of Effort (L-M-H)</th>
<th>Summary of Considerations/ Issues</th>
<th>Intent</th>
<th>Metrics</th>
<th>Description</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Data Analysis</th>
<th>Communication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A</td>
<td>Green</td>
<td>Green</td>
<td>Green</td>
<td>• Top priority for Diana G/OMC, along with prim care capacity measures • Data filters: new members by line of business and by medical home</td>
<td>Increase revenue via enrollment</td>
<td>Membership</td>
<td>Network membership/enrollment</td>
<td>• by clinic / medical home • by provider • by payor source /line of business</td>
<td>Jackie Haslam</td>
<td>SFGH IS (OneEapp Reptng)</td>
<td>TBD SFHN MC</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>Green</td>
<td>Green</td>
<td>Orange</td>
<td>• Top priority for Diana G/OMC, along with prim care capacity measures • Not currently collected for the entire population (just HSF, SFHP, Anthem) • The State must provide remaining data (FFS) • Measures the retention of members</td>
<td>Improve service to retain members and maximize revenue</td>
<td>SFHN Client Attrition Rate</td>
<td>Number of current enrollees plus new enrollees (enrollment) minus enrollees leaving (disenrollment).</td>
<td>• by clinic / medical home • by provider • by payor source /line of business</td>
<td>Jackie Haslam</td>
<td>SFHP, OneEapp Reptng, State</td>
<td>TBD SFHN MC</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>Green</td>
<td>Green</td>
<td>Orange</td>
<td>• Top priority for Diana G/OMC, a prim care capacity measure • Define visits</td>
<td>Improve utilization to max revenue</td>
<td>Average Number of Visits Per Member</td>
<td>Number of PC visits per SFHN member. Measures utilization</td>
<td>• by clinic / medical home • by provider • by payor source /line of business</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD SFHN MC, AMB</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>Orange</td>
<td>Orange</td>
<td>Orange</td>
<td>• Define unit versus mgmt cost • Additional cost analysis needed</td>
<td>Improve cost control</td>
<td>Cost PMPM</td>
<td>Total cost per patient. Measures overall cost of care.</td>
<td>• by clinic / medical home • by provider • by payor source /line of business</td>
<td>TBD</td>
<td>SFHP/ PFS / EIS</td>
<td>TBD SFHN MC</td>
</tr>
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<td>Orange</td>
<td>Orange</td>
<td>Orange</td>
<td>• Data filters • Additional analysis needed</td>
<td>Increase revenue</td>
<td>Revenue PMPM</td>
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<td>• by clinic / medical home • by provider • by payor source /line of business</td>
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<td>Red</td>
<td>Improve utilization to max revenue</td>
<td>Inpatient Days Per 1000</td>
<td>Inpatient days per 1000. Measures hospital use.</td>
<td>• by department • by provider • by payor source /line of business</td>
<td>Tina Lee</td>
<td>SFGH I/S</td>
<td>TBD SFHG</td>
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<tr>
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<td>Level of Effort</td>
<td>Summary of Considerations/ Issues</td>
<td>Intent</td>
<td>Metrics</td>
<td>Description</td>
<td>Proposed Granularity</td>
<td>Data Sources</td>
<td>Data Analysis</td>
<td>Communication Plan</td>
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</tr>
<tr>
<td>A</td>
<td>A</td>
<td>C</td>
<td>Y</td>
<td>H-M-H</td>
<td>Data lag: Data filters&lt;br&gt;- Define cost: HMA rec. &quot;direct&quot;&lt;br&gt;- Define visit: HMA rec. &quot;billed&quot; (MD/NP)&lt;br&gt;- COPC budget / finance data by index code &amp; clinic?</td>
<td>Improve op efficiency to control costs</td>
<td>Cost per visit</td>
<td>Average cost of a visit. Measures cost of care. For primary care, mental health, specialty care.</td>
<td>by type of visit&lt;br&gt;- by clinic / medical home&lt;br&gt;- by specialty&lt;br&gt;- by provider&lt;br&gt;- by payor source /line of business</td>
<td>TBD</td>
<td>TBD</td>
<td>Invision and FAMIS</td>
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<tr>
<td>A</td>
<td>A</td>
<td>C</td>
<td>Y</td>
<td>H-M-H</td>
<td>Data lag: Data filters (PC, MH, H@H)&lt;br&gt;- Define &quot;patients&quot; - billed only&lt;br&gt;- Define in/exclusion of subcontractors</td>
<td>Improve op efficiency to control costs</td>
<td>Visits per hour (aka Patients Per Hour)</td>
<td>Total number of patients per hour. Measures provider productivity</td>
<td>by type of visit&lt;br&gt;- by clinic / medical home&lt;br&gt;- by provider&lt;br&gt;- by payor source /line of business</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>C</td>
<td>Y</td>
<td>H-M-H</td>
<td>Data lag; Data filters&lt;br&gt;- Working with SFHP on ensuring regular reports sent&lt;br&gt;- Additional cost analysis needed</td>
<td>Improve cost control</td>
<td>OON costs</td>
<td>Total non-network costs</td>
<td>by facility/division&lt;br&gt;- by encounter type (ED, primary care, outpatient, inpatient, etc.)&lt;br&gt;- by clinic / medical home&lt;br&gt;- by specialty&lt;br&gt;- by services (incl. ancillary here)&lt;br&gt;- by provider&lt;br&gt;- by payor source /line of business&lt;br&gt;- by time/day&lt;br&gt;- by reason?</td>
<td>TBD</td>
<td>SFHP</td>
<td>TBD</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>C</td>
<td>Y</td>
<td>H-M-H</td>
<td>Data lag&lt;br&gt;- Data filters&lt;br&gt;- Resolve SFHP data sharing issue</td>
<td>Improve cost control</td>
<td>ED Visits OON</td>
<td>Average (or total) number of ED visits OON. Measures emergency use systemwide.</td>
<td>by clinic / medical home&lt;br&gt;- by services (ancillary, dx?)&lt;br&gt;- by provider&lt;br&gt;- by payor source /line of business&lt;br&gt;- by time/day&lt;br&gt;- by reason?</td>
<td>TBD</td>
<td>SFHP</td>
<td>SFGH I/S</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
<td>C</td>
<td>Y</td>
<td>H-M-H</td>
<td>Data lag&lt;br&gt;- Data filters</td>
<td>Improve cost control</td>
<td>ED Visits in network</td>
<td>Average (or total) number of ED visits in-network. Measures emergency use systemwide</td>
<td>by clinic / medical home&lt;br&gt;- by services (ancillary, dx?)&lt;br&gt;- by provider&lt;br&gt;- by payor source /line of business</td>
<td>TBD</td>
<td>TBD</td>
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<tr>
<td>Status</td>
<td>Priority</td>
<td>Intent</td>
<td>Metrics</td>
<td>Description</td>
<td>Proposed Granularity</td>
<td>Data Sources</td>
<td>Data Analysis</td>
<td>Communication Plan</td>
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<tr>
<td></td>
<td>A</td>
<td>Improve service to control costs</td>
<td>ASC Visits (ambulatory sensitive condition)</td>
<td>Number of inappropriate ED use (ASC) to SFGH in reporting period.</td>
<td>by clinic / medical home • by provider (PCP) • by payor source /line of business • by time/day • by reason / dx?</td>
<td>Tina Lee SFGH I/S MC CFO</td>
<td>TBD SFHN</td>
<td>MC SFGH</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>B (long)</td>
<td>Improve utilization to max revenue</td>
<td>Visits or Admits</td>
<td>TBD</td>
<td>by facility/division • by encounter type (ED, primary care, outpatient, inpatient, etc.) • by clinic / medical home • by specialty • by services (incl. ancillary here) • by provider • by payor source /line of business</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD SFHN AMB SFGH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>Improve utilization to max revenue</td>
<td>PC - Visits per 1000</td>
<td>Visits per 1000 enrolled members. Measures utilization of primary care.</td>
<td>by clinic / medical home • by provider (PCP) • by payor source /line of business</td>
<td>Jonathan Albright SFHP / COPC HMA Panel Size Calculator</td>
<td>TBD SFHN</td>
<td>AMB</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Parking Lot - Metrics to be vetted and categorized at future date via TBD criteria/request process

| Katie A Penetration Rate (CYF only) | AMB; CBHS |
| Asian Penetration Rate | AMB; CBHS |

Proposed Next Steps
Goal: To develop a first draft of Priority A metrics by August 2014 for BIU lead and Executive Sponsor approval.

1. **Resource Assignment**
   - BIU leads to assign BIU analyst (user license), I/S staff person (developer license), CON analyst (user or developer license as needed, provide support to BIU and I/S as needed).

2. **Business Requirements Collection**
   - BIU analyst (and/or CON analyst) to facilitate the identification of data sources / key players and raise consideration/issues/decisions to BIU leads (escalate as advised).

3. **Technical Requirements Collection**
   - BIU analyst (and/or CON analyst) to engage I/S staff person as needed to gather information I/S needs to develop data infrastructure (see I/S sample spreadsheet).

4. **Data Infrastructure / Dashboard Template Development**
   - I/S staff person to connect identified data sources, build data infrastructure, and build dashboard templates, as needed, via developer license.

5. **Tile Development and Final BIU Lead Approval**
   - BIU analyst (and/or CON analyst) to develop charts and graphs via the user license interface.
<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
<th>Collected?</th>
<th>Level of Effort</th>
<th>Summary of Considerations/ Issues</th>
<th>Intent</th>
<th>Metrics</th>
<th>Description</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Data Analysis</th>
<th>Communication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C-I-P-N(S)</td>
<td>Y-N</td>
<td>L-M-H</td>
<td>Connection to objective</td>
<td>Measurable signs of progress that reflect objectives</td>
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</tbody>
</table>
### SFHN Objective:
To establish new SFHN ambulatory care organization, leadership, accountabilities, processes, in order to identify targets for increased primary care capacity. To prioritize areas and establish QI processes to assure coordination with SFHN ambulatory, hospitals, and managed care. Improve Quality through Efficient Service Delivery.

### Client Access, Capacity, and Flow Metrics Tracking Sheet

<table>
<thead>
<tr>
<th>Status Priority</th>
<th>Status</th>
<th>Data Sources</th>
<th>Communication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
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<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
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<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>AMB / HMA Panel Size Calculator</td>
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<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
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</tbody>
</table>

**Access, Capacity, Flow**

<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
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<th>Communication Plan</th>
</tr>
</thead>
<tbody>
<tr>
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<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
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<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
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<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>AMB / HMA Panel Size Calculator</td>
</tr>
<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
</tr>
</tbody>
</table>

**Client Access, Capacity, and Flow Metrics Tracking Sheet**

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<th>Status</th>
<th>Priority</th>
<th>Data Sources</th>
<th>Communication Plan</th>
</tr>
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<tbody>
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<td>A</td>
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<td>TBD</td>
<td>SFHN / AMB</td>
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<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
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<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>AMB / HMA Panel Size Calculator</td>
</tr>
<tr>
<td>A</td>
<td>E</td>
<td>TBD</td>
<td>SFHN / AMB</td>
</tr>
<tr>
<td>Status</td>
<td>Priority</td>
<td>Status</td>
<td>Collected?</td>
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<td>B</td>
<td>B</td>
<td>[C-I]</td>
<td>[P-NS]</td>
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<tr>
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<td>C</td>
<td>[3]</td>
<td>[L-M-H]</td>
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<td>[5]</td>
<td>[L-M-H]</td>
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</tr>
</tbody>
</table>
### Parking Lot - Metrics to be vetted and categorized at future date via TBD criteria/request process

<table>
<thead>
<tr>
<th>Status</th>
<th>Priority</th>
<th>Level of Effort</th>
<th>Summary of Considerations/Issues</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Contact</th>
<th>Data Location</th>
<th>Collection method, caveats</th>
<th>Audience</th>
<th>Accountability</th>
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</thead>
<tbody>
<tr>
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<th>Priority</th>
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<th>Summary of Considerations/Issues</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Contact</th>
<th>Data Location</th>
<th>Collection method, caveats</th>
<th>Audience</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C-IP-NS</td>
<td>Y-N</td>
<td>L-M-H</td>
<td>To develop a first draft of Priority A metrics by August 2014 for BIU lead and Executive Sponsor approval.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

### Proposed Next Steps

**Goal: To develop a first draft of Priority A metrics by August 2014 for BIU lead and Executive Sponsor approval.**

<table>
<thead>
<tr>
<th>Proposed Next Steps</th>
<th>(1) Resource Assignment</th>
<th>(2) Business Requirements Collection</th>
<th>(3) Technical Requirements Collection</th>
<th>(4) Data Infrastructure / Dashboard Template Development.</th>
<th>(5) Tile Development and Final BIU Lead Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• BIU leads to assign BIU analyst (user license), I/S staff person (developer license), CON analyst (user or developer license as needed, provide support to BIU and I/S as needed).</td>
<td>• BIU analyst (and/or CON analyst) to facilitate the identification of data sources / key players and raise consideration/issues/decisions to BIU leads (escalate as advised).</td>
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<td>• I/S staff person to connect identified data sources, build data infrastructure, and build dashboard templates, as needed, via developer license.</td>
<td>• BIU analyst (and/or CON analyst) to develop charts and graphs via the user license interface.</td>
</tr>
<tr>
<td>Status</td>
<td>Priority</td>
<td>Status (C-IP-NS)</td>
<td>Collected? (Y-N)</td>
<td>Level of Effort (L-M-H)</td>
<td>Summary of Considerations/Issues</td>
</tr>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Connection to objective</td>
</tr>
</tbody>
</table>

Contact | Data Location | Collection method, caveats | Audience | Accountability |
## Patient Satisfaction Metrics Tracking Sheet

**SFHN Objective:** To improve patient experience scores. Attract and Retain Members.

<table>
<thead>
<tr>
<th>BIU Owner</th>
<th>BIU Analyst(s) / User License</th>
<th>I/S Staff / Developer License</th>
<th>CSA Analyst / TBD License</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baljeet Sangha</td>
<td>Kim Nguyen</td>
<td>Shameem</td>
<td>If needed, TBD</td>
</tr>
</tbody>
</table>

**# Metrics:** 1  
**Frequency:** Monthly  
**Target Tracking Sheet Completion Date:** TBD

### Status

<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
<th>Collected?</th>
<th>Level of Effort</th>
<th>Summary of Considerations/Issues</th>
<th>Intent</th>
<th>Metrics</th>
<th>Description</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Data Analysis</th>
<th>Communication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
<td>(L-M-H)</td>
<td></td>
<td>Connection to objective</td>
<td>Measurable signs of progress that reflect objectives</td>
<td>% 9 or 10 out of 10; CG-CAHPS and HCAHPS</td>
<td>Percentage of clients rating overall SFHN ambulatory or inpatient care at a “9” or “10” on a scale of 10. Measures satisfaction with care.</td>
<td>TBD</td>
<td>CAHPS - AMB</td>
<td>SFHN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AMB CAHPS Visit Survey Rating</td>
<td>by facility/division</td>
<td>by clinic / medical home</td>
<td>by speciality</td>
<td>by provider</td>
<td>TBD</td>
<td>CAHPS - AMB</td>
<td>SFHN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SFGH CAHPS Service Rating</td>
<td>by source</td>
<td>by specialty</td>
<td>by provider</td>
<td>SFH</td>
<td>CAHPS - AMB</td>
<td>SFHN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>LHH CAHPS Service Rating</td>
<td>by specialty</td>
<td>by provider</td>
<td>SFH</td>
<td>AMB</td>
<td>CAHPS - AMB</td>
<td>SFHN</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Data already exists</td>
<td>SFH</td>
<td>CDM</td>
<td>SFH</td>
<td>AMB</td>
<td>CAHPS - AMB</td>
<td>SFHN</td>
<td></td>
</tr>
</tbody>
</table>

### Parking Lot - Metrics to be vetted and categorized at future date via TBD criteria/request process

**Overall average item score on MHSIP or YSS = 4.0 or higher out of 5.0**  
**Audience:** SFHN  
**Accountability:** AMB, CBHS

### Proposed Next Steps

**Goal:** To develop a first draft of Priority A metrics by August 2014 for BIU lead and Executive Sponsor approval.

1. **Resource Assignment**
   - BIU leads to assign BIU analyst (user license), I/S staff person (developer license), CON analyst (user or developer license as needed, provide support to BIU and I/S as needed).
2. **Business Requirements Collection**
   - BIU analyst (and/or CON analyst) to facilitate the identification of data sources / key players and raise consideration/issues/decisions to BIU leads (escalate as advised).
3. **Technical Requirements Collection**
   - BIU analyst (and/or CON analyst) to engage I/S staff person as needed to gather information I/S needs to develop data infrastructure (see I/S sample spreadsheet).
4. **Data Infrastructure / Dashboard Template Development**
   - I/S staff person to connect identified data sources, build data infrastructure, and build dashboard templates, as needed, via developer license.
5. **Tile Development and Final BIU Lead Approval**
   - BIU analyst (and/or CON analyst) to develop charts and graphs via the user license interface.
### Staff Satisfaction Metrics Tracking Sheet

**SFHN Objective:** To improve workforce experience scores. To improve civil service hiring and recruitment and retention.

- **BIU Owner:** Baljeet Sangha
- **BIU Analyst(s) / User License:** Chris Dunne & Kim Nguyen
- **I/S Staff / Developer License:** None
- **CSA Analyst / TBD License:** If needed, TBD

<table>
<thead>
<tr>
<th>Priority</th>
<th>Status</th>
<th>Status (C-IIP-NS)</th>
<th>Collected? (Y-N)</th>
<th>Level of Effort (L-M-H)</th>
<th>Summary of Considerations/ Issues</th>
<th>Intent</th>
<th>Metrics</th>
<th>Description</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Data Analysis</th>
<th>Communication Plan</th>
</tr>
</thead>
</table>
| A (long) | +      | +                | +               | +                      | • Data filters  
• Data clean up related to "Finance - Staff Vacancy" required | Connection to objective | Measurable signs of progress that reflect objectives | Contact | Data Location | Collection method, caveats | Audience | Accountability |
| A (long) | +      | +                | +               | +                      | • Currently being developed and will be implemented by NRC in fall 2014 | Reduce turnover rate | Number of Requisitions (Turnover) | TBD | TBD | TBD | SFHN HR |

**Parking Lot - Metrics to be vetted and categorized at future date via TBD criteria/request process**

### Proposed Next Steps

**Goal:** To develop a first draft of Priority A metrics by August 2014 for BIU lead and Executive Sponsor approval.

1. **Resource Assignment**
   - **BIU leads** to assign BIU analyst (user license), I/S staff person (developer license), CON analyst (user or developer license as needed, provide support to BIU and I/S as needed).

2. **Business Requirements Collection**
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   - **I/S staff person** to connect identified data sources, build data infrastructure, and build dashboard templates, as needed, via developer license.

5. **Tile Development and Final BIU Lead Approval**
   - **BIU analyst** (and/or CON analyst) to develop charts and graphs via the user license interface.
# Metrics:

<table>
<thead>
<tr>
<th>Priority</th>
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<th>Level of Effort</th>
<th>Summary of Considerations/ Issues</th>
<th>Metrics Description</th>
<th>Proposed Granularity</th>
<th>Data Sources</th>
<th>Data Analysis Plan</th>
<th>Communication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Connection to objective</td>
<td>Measurable signs of progress that reflect objectives</td>
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</tbody>
</table>

**Parking Lot - Metrics to be vetted and categorized at future date via TBD criteria/request process**

- Falls with Injuries rate+
- Hospital Acquired Pressure Ulcers+
- Surgical Site Infection rate+
- Sepsis bundle compliance rate+
- Central Line Bloodstream Infections+
- VTE Prophylaxis+
- Mammography screenings*
- Diabetes LDL-control*
- Diabetes, hospitalization for short-term complications *
- Uncontrolled Diabetes hospitalization **
- Hospitalization for Chronic Obstructive Pulmonary Disease*
- Hospitalization for Congestive Heart Failure*
- Influenza Immunization*
- Child Weight Screening - Calculated BMI*
- Pediatric BMI above 85th percentile*
- Tobacco Cessation received or referred*
- Diabetes Mellitus: Hemoglobin A1c Control (<8%) measure*
- 30-day congestive heart failure readmission rate*
- (Hypertension (HTN): Blood Pressure Control (<140/90 mmHg) measure*
- Pediatrics Asthma Care -controller medication prescribed*
- Emergency Department Left Without Being Seen
- Exclusive Breastfeeding at Discharge+
- C-Section Rate+A65

**Proposed Next Steps:** Present these to PI Steering Committee to add to their bucket of metrics.

**SFHN Objective:** PI to define
**Objective**

**BIU/CON Analyst:** To develop the 23 Priority A metrics, both business and technical requirements, for the SFHN and to provide I/S staff with all necessary information needed to build the data infrastructure by August 31, 2014.

**I/S Staff:** To develop the data infrastructure for the 23 Priority A metrics and to timely raise questions, concerns, needs, issues to the BIU/CON analyst for resolution.

**High Level Process**

*Note: This project only covers Phase I: Metric Development below. The Phase II: Dashboard Development is provided for context.*

### PHASE I: METRIC DEVELOPMENT

**Collect Metrics Requirements**

- **BIU/CON analyst** to facilitate the identification of data sources / key players and raise consideration/ issues/decisions to BIU leads (escalate as advised).
- **BIU/CON analyst** to engage I/S staff person as needed to gather information I/S needs to develop data infrastructure *(see I/S sample spreadsheet).*

**Build Data Infrastructure**

- **I/S staff person** to connect identified data sources and build data infrastructure.

### PHASE II: DASHBOARD DEVELOPMENT

**Dashboard Template Development**

- **I/S staff person** (or identified BIU/CON analyst) to build dashboard templates via developer license.

**Tile Development**

- **BIU/CON analyst** to develop charts and graphs via the user license interface.

### Roles & Responsibilities

**BIU/CON Analysts**

- **Collect Business Requirements.** Facilitate the identification of data sources / key players and raise considerations, issues, decisions to BIU performance metric leads or supervisors, as needed. Work with subject matter experts to determine appropriate inclusion/exclusion criteria among other criteria.

- **Collect Technical Requirements.** Gather information I/S needs to develop data infrastructure *(see I/S sample spreadsheet).* If I/S staff needs additional information, BIU/CON analyst to find this information timely.

- **Document Requirements, Caveats, and Definitions.** Document all requirements, caveats, and definitions in spreadsheet provided by performance metric leads.
I/S Staff

- **Build Data Infrastructure.** Build data infrastructure and queries per business and technical requirements gathered by BIU/CON analysts.
- **Utilize BIU/CON Analyst Service.** I/S staff to utilize the BIU/CON analysts to gather necessary information to ensure I/S resources and staff time are utilized for data infrastructure and query building.

### Metric Development Assignments

<table>
<thead>
<tr>
<th>Metric</th>
<th>BIU/CON Analyst</th>
<th>I/S Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Revenue vs. Budget</td>
<td>Anastassia</td>
<td>Shameem</td>
</tr>
<tr>
<td>Primary Care Cost vs. Budget</td>
<td>Anastassia</td>
<td>Shameem</td>
</tr>
<tr>
<td>PATCH costs</td>
<td>Matt &amp; Anastassia</td>
<td>Shameem</td>
</tr>
<tr>
<td>Staff Vacancy</td>
<td>Chris</td>
<td>Andy Chow</td>
</tr>
<tr>
<td>3rd to Next F/U Appt</td>
<td>Karen</td>
<td>Shameem</td>
</tr>
<tr>
<td>PC - 3rd Next Visit to a Provider New Visit</td>
<td>Karen</td>
<td>Shameem</td>
</tr>
<tr>
<td>% Post-Hosp Empaneled Pts Seen in PC w/in 7 Days</td>
<td>Matt</td>
<td>Shameem</td>
</tr>
<tr>
<td>Panel Size per Provider</td>
<td>Matt</td>
<td>Shameem</td>
</tr>
<tr>
<td>% 9 or 10 out of 10; CG-CAHPS and HCAHPS</td>
<td>Kim</td>
<td>Shameem</td>
</tr>
<tr>
<td>Number of Requisitions (Turnover)</td>
<td>Chris</td>
<td>Andy Chow</td>
</tr>
<tr>
<td>Staff Satisfaction to measure employee, staff views</td>
<td>Kim</td>
<td>Shameem</td>
</tr>
<tr>
<td>Cost PMPM</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>Revenue PMPM</td>
<td>Matt</td>
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</tr>
<tr>
<td>Inpatient Days Per 1000</td>
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<td>Jackie</td>
</tr>
<tr>
<td>Cost per visit</td>
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<td>Jackie</td>
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<tr>
<td>Visits per hour (aka Patients Per Hour)</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>OON costs</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>ED Visits OON</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>ED Visits in network</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>Average Number of Visits Per Member</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>ASC Visits (ambulatory sensitive condition)</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>Membership</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
<tr>
<td>SFHN Client Attrition</td>
<td>Matt</td>
<td>Jackie</td>
</tr>
</tbody>
</table>

### Weekly Process

1. **Requirements Gathering.** Work with your designated BIU/CON analyst or I/S staff person to determine the business and technical requirements needed.

2. **Escalation.** Escalate issues and barriers to your supervisors and/or performance metrics leads (listed below) to ensure metric development moves forward.

3. **Updates.** Provide Matt an update via email by Thursdays at 5pm. If no response by Thursday, Matt will contact you on Friday morning. Please include:
   - Decisions made this reporting period
   - Accomplished this reporting period
   - Tasks behind schedule
   - Work completed but not planned
   - Objectives for the next reporting period
   - Any other issues

### Questions

Performance metric leads listed below:

- Matt Podolin, Controller’s Office, (415) 554-5311, [matthew.podolin@sfgov.org](mailto:matthew.podolin@sfgov.org)
- Kim Nguyen, DPH SFHN Operations, (415) 554-2657, [kimvan.nguyen@sfdph.org](mailto:kimvan.nguyen@sfdph.org)
**Way Forward Dashboard Purpose:**
To track the newly formed Network’s progress toward the integrated delivery system’s intent, goals, and objectives.

**Background:**
Way Forward Performance Metrics were approved in February 2014 by SFHN Executive leadership. Divisions were charged to develop tracking mechanism for each metric under their administration. Business Intelligence Unit (BIU) was charged to facilitate data collection methodology and confirm availability of data for dashboard reporting.

**BIU Process in Producing Dashboard**

<table>
<thead>
<tr>
<th>Month</th>
<th>Met with individual divisions and determined:</th>
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</thead>
<tbody>
<tr>
<td>February - June</td>
<td>1. Collection methodology</td>
</tr>
<tr>
<td></td>
<td>2. Frequency in data reporting</td>
</tr>
<tr>
<td></td>
<td>3. Report contact who is responsible for sending data to BIU analyst</td>
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<tr>
<td></td>
<td>4. Determine data source for the measure</td>
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<tr>
<td></td>
<td>5. Baseline and target determination (i.e. time frame/period)</td>
</tr>
<tr>
<td>March - June</td>
<td>Drafted dashboard with baseline data</td>
</tr>
<tr>
<td>April - June</td>
<td>Reviewed dashboard draft with key stakeholders for feedback</td>
</tr>
<tr>
<td>July</td>
<td>Share dashboard with SFHN Exec Leaders for feedback and ensure readiness to present at Health Commission.</td>
</tr>
</tbody>
</table>

**Questions, Feedback, or Edits:**
Baljeet Sangha at baljeet.sangha@sfdph.org or Kim Nguyen at kimvan.nguyen@sfdph.org
City and County of San Francisco  
San Francisco Health Network  
SFHN Way Forward Performance Measures  
Reporting Period: Quarter 4 2014

<table>
<thead>
<tr>
<th>At Target/Goal</th>
<th>Denotes direction of favorable outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denotes direction of unfavorable outcome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Freq</th>
<th>Baseline</th>
<th>Target</th>
<th>Prior Period Average</th>
<th>Current Period Average</th>
<th>Period % Change</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Achieve Primary Care Weighted Panel Size = 1,350</td>
<td>Q</td>
<td>1,011</td>
<td>1,350</td>
<td>1,123</td>
<td>1,285</td>
<td>14.4%</td>
<td>↑</td>
</tr>
</tbody>
</table>

- Special populations clinics are currently excluded from the standard panel size targets and support staff ratio due to significant variation in staffing and care models. These include: Curry Senior Center, Tom Waddell Urban Health, Positive Health Program, Children’s Health Center, Community Healthy Programs for Youth (CHPY) and Special Programs for Youth (SPY)
- “Weighted” refers to a complicated system of using medical diagnoses and demographic factors to assign complexity to patients and predict utilization and risk. A more medically complicated panel of patients (for a given provider or clinic) counts as more than a less complicated panel of patients.

| #2 Achieve Primary Care support staff ratio per unweighted active patient panel = 4.5 FTE | Q | 4.10 | 4.50 | 4.29 | 4.48 | 4.4% | ↑ |

- Special populations clinics are currently excluded from the standard panel size targets and support staff ratio due to significant variation in staffing and care models. These include: Curry Senior Center, Tom Waddell Urban Health, Positive Health Program, Children’s Health Center, Community Healthy Programs for Youth (CHPY) and Special Programs for Youth (SPY)

| #3 Improve by 5% over baseline, Patient Placement at the appropriate setting and level of care in Acute and Skilled Nursing Facility | |
|----------------------------------------|-----------------|--------|--------|-----------------|-----------------|-----------------|-------|
| Institutional Operations               | Q                | 22     | 23     | 26               | 27              | 5.1%            | ↑     |

- Total Average Appropriate Discharges (Community)
- Targeted to improve appropriate discharges by 5% over baseline

<table>
<thead>
<tr>
<th>Laguna Honda Hospital</th>
<th>Q</th>
<th>22</th>
<th>23</th>
<th>26</th>
<th>27</th>
<th>5.1%</th>
<th>↑</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco Hospital</td>
<td>Q</td>
<td>661</td>
<td>628</td>
<td>576</td>
<td>482</td>
<td>-16.3%</td>
<td>↓</td>
</tr>
</tbody>
</table>

- Total Average Non-Acute LOS day (number of admn days, denied days, and non-acute days)
- Targeted to improve LOS days by 5% under baseline

| Care Transitions/Patient Placement | Q | 410 | 390 | 447 | 459 | 3% | ↑ |

- Flow Beds: Beds occupied ≤ 3 yrs
- Targeted to reduce Average Length of Stay (ALOS) by 5% under baseline to increase capacity for SFH and LHH referrals

| #4 Meet or exceed budgeted performance in revenues and expenses | Q | $1,718,617.20 | ≥ $34,213,009.00 | - | - | - |

- Favorable figure projects a general fund surplus. Unfavorable figure projects a general fund deficit.
- This surplus is largely driven by net favorable variances in state and federal reimbursements and savings compared to budget in salary and fringe benefits
- Target is to ensure at least zero general fund deficit as indicator of meeting budgeted performance
- These figures are based on projected revenue collected and billed, and expenses incurred for San Francisco General Hospital, Laguna Honda Hospital, Primary Care, Health at Home, Jail Health, Public Health, Mental Health, Substance Abuse
## Performance Measures

### #5 Improve by 5% over baseline Workforce Experience/Satisfaction Scores

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Freq</th>
<th>Baseline</th>
<th>Target</th>
<th>Prior Period Average</th>
<th>Current Period Average</th>
<th>Period % Change</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>#5 Improve by 5% over baseline Workforce</td>
<td>A</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

- Collection is progress due to efforts to launch DPH-wide survey administration. High level objectives include:
  1. SFHN to identify and approve vendor, (2) Survey tool demo, (3) Survey Preparations, (4) Survey Administration & Data Management, (5) Executive Results Presentation; and (6) Reporting, Action Planning & Taking Action.
  2. See Appendix A, Table 1: Establishing Baseline for Workforce Experience for Process Measures.

### #6 Improve Civil Service Hiring, From Form 3 submission to start work date = 90 days or less

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Freq</th>
<th>Baseline</th>
<th>Target</th>
<th>Prior Period Average</th>
<th>Current Period Average</th>
<th>Period % Change</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>#6 Improve Civil Service Hiring, From Form 3 submission to start work date = 90 days or less</td>
<td>Q</td>
<td>-</td>
<td>≥ 90</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

- Collection is progress due to efforts to modify HRM system. High level objectives include:
  1. Network-wide Planning Group assembled to meet and define scope for system requirements, (2) Discuss modifications to HRMS & e-Merge with Chief Information Office (CIO), (3) Begin HRMS & e-Merge modifications to prepare for data gathering/collection, (4) Testing of modified HRMS, (5) Introduce and provide staff training to new data entry requirements, (6) Begin pilot of new system & test / modify system, as needed. Team to utilize PDSA quality improvement model (Plan, Do, See, Act). (7) Initiate initial test of report query; and (8) Report data for January - March 2015.
  2. See Appendix A, Table 2: Establishing Baseline for Improving Civil Service Hiring Process Outcomes.

### #7 Improve by 5% over baseline Patient Experience/Satisfaction Scores

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Freq</th>
<th>Baseline</th>
<th>Target</th>
<th>Prior Period Average</th>
<th>Current Period Average</th>
<th>Period % Change</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health (Mental Health)</td>
<td>A</td>
<td>January-March 2014</td>
<td>April 2014</td>
<td>I like the services that I received here.</td>
<td>4.56</td>
<td>4.78</td>
<td>-</td>
</tr>
<tr>
<td>Behavioral Health (Substance Abuse)</td>
<td>A</td>
<td>January-March 2014</td>
<td>April 2014</td>
<td>I like the services that I received here.</td>
<td>4.47</td>
<td>4.69</td>
<td>-</td>
</tr>
<tr>
<td>Health at Home</td>
<td>Q</td>
<td>January-March 2014</td>
<td>April - June 2014</td>
<td>We want to know your rating of your care from this agency's home health providers.</td>
<td>80.40%</td>
<td>84.42%</td>
<td>85.20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Would you recommend this agency to your family or friends if they needed home health care?</td>
<td>82.20%</td>
<td>86.31%</td>
<td>80.00%</td>
</tr>
</tbody>
</table>

- Division who met 5% goal will revise target to NRC Picker 75th percentile in July 2015. NRC Picker is DPH’s 3rd party vendor who disseminates and analyzes survey results.
# Establish a Unified Understanding of Staff Role in the Success of the Network by documenting 50% of surveyed Staffs’ ability to reference our “Way Forward Plan”: Increasing the Value of Services Provided to our constituents; Patients, Workforce and SF Residents & Consumers

- Begin Halogen/Health Stream course and survey following 2014 SFHN Launch Event to reinforce messages to staff and continue to spread SFHN information.
- Halogen/Health Stream data will serve as metric baseline
### Performance Measures

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Freq</th>
<th>Baseline</th>
<th>Target</th>
<th>Prior Period Average</th>
<th>Current Period Average</th>
<th>Period % Change</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>#9 Achieve a 75% mammogram screening rate for eligible primary care clients</td>
<td>Q</td>
<td>73.49%</td>
<td>75.00%</td>
<td>73.98%</td>
<td>74.40%</td>
<td>0.6%</td>
<td>🔺</td>
</tr>
<tr>
<td>#10 Increase by 25% the number of clients seen in a Behavioral Health Center who have an identified Primary Care Provider in Avatar HER</td>
<td>Q</td>
<td>50.2%</td>
<td>62.3%</td>
<td>55.1%</td>
<td>69.6%</td>
<td>26.3%</td>
<td>🔺</td>
</tr>
</tbody>
</table>

### Notes:
- The SFHN Dashboard is issued on a quarterly basis.
- Metrics that are reported on a quarterly basis will include new data from the prior three months. Metrics that are reported on a semi annual basis, will include data from the prior six months. Metrics that are reported on an annual basis, will include data from the prior twelve months.
- Date range connected to baseline of each performance metric varies. Quarterly (Q), SA (Semi-Annually), and Annually (A) denotes frequency of reporting.
- The Prior Period Average is the average of monthly values. Date range is indicated above the value.
- The Current Period Average is the average of monthly values for the most recent period. Date range is indicated above the value.
- The Period Percent change reflects the change since the previous period (e.g., October-December 2013 compared to July-September 2013).
- Trend lines are made up of data provided by divisions. The scale of the trend lines display potential fluctuations.
- For additional detail on measure definitions and department information, please contact SFHN Business Intelligence Unit.
### Table 1. Way Forward Metric 5: Establishing Baseline for Workforce Experience

<table>
<thead>
<tr>
<th>High-Level Timeline</th>
<th>MAY</th>
<th>JUNE</th>
<th>JULY</th>
<th>AUG</th>
<th>SEPT</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APRIL</th>
<th>MAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SFHN to identify and approve vendor</td>
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<td></td>
<td></td>
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<tr>
<td>2. Survey tool demo</td>
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<td>3. Survey Preparations</td>
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<tr>
<td>4. Survey Administration &amp; Data Management</td>
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<tr>
<td>5. Executive Results Presentation &amp; Reporting</td>
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<tr>
<td>6. Action Planning &amp; Taking Action</td>
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</tbody>
</table>

**Process Objectives**
1. By July 2014, a vendor survey tool will be identified and procured.
2. By December 2014, the Workforce Training and Develop Committee will partner with NRC to administer a network-wide staff experience survey.
3. By January 2015, workforce experience dashboard reports will be disseminated and shared with Network and entity leadership.
4. By January 2015, the Workforce Training and Develop Committee will identify the three network-level workforce improvement practices.
5. By February 2015, each entity will share dashboard reports with staff.
6. By May 2015, each entity will identify and implement one workforce improvement practice.

### Table 2. Way Forward Metric 6: Establishing Baseline for Improving Civil Service Hiring

<table>
<thead>
<tr>
<th>High-Level Timeline</th>
<th>MAY</th>
<th>JUNE</th>
<th>JULY</th>
<th>AUG</th>
<th>SEPT</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APRIL</th>
<th>MAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Network-wide Planning Group assembled to meet and define scope for system requirements</td>
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<tr>
<td>2. Discuss modifications to HRIMS &amp; e-Merge with Chief Information Office (CIO)</td>
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<tr>
<td>3. Begin HRIMS &amp; e-Merge modifications to prepare for data gathering/collection</td>
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<tr>
<td>4. Testing of modified HRIMS</td>
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<tr>
<td>5. Introduce and provide staff training to new data entry requirements</td>
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<tr>
<td>6. Begin pilot of new system &amp; test / modify system, as needed. Team to utilize PDSA quality improvement model (Plan, Do, See, Act).</td>
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<tr>
<td>7. Initiate initial test of report query</td>
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</table>

**Process Objectives**
1. By May 2014, network-wide Planning Group will be assembled to meet and define scope for system requirements
2. By June 2014, Planning Group to discuss modifications to HRIMS & e-Merge with Chief Information Office (CIO)
3. By July 2014, begin HRIMS & e-Merge modifications to prepare for data gathering/collection
4. By August 2014, testing of modified HRIMS
5. By Sept 2014, introduce and provide staff training to new data entry requirements.
6. From October - December 2014, begin pilot of new system & test / modify system, as needed. Team to utilize PDSA quality improvement model (Plan, Do, See, Act).
7. By January 2015, initiate initial test of report query
<p>| Metric # | Way Forward Metric | Intent | Way Forward Metric Technical Definition | Accountable Team/Organization | Distribution Frequency | Data Contact/Data Owner | Data Source | Baseline Determination &amp; Time Period (Determined by Division Leaders) | Target |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Achieve Primary Care Weighted Panel Size = 1,350 | 1. Increase weighted panel size to measure primary care access | • The active patient panel is all primary care patients who have that clinic listed as their medical home and who have been seen for a medical visit at least once within the past 2 years. • “Weighted” refers to a complicated system of using medical diagnoses and demographic factors to assign complexity to patients and predict utilization and risk. A more medically complicated panel of patients (for a given provider or clinic) counts as more than a less complicated panel of patients. • Special populations clinics are currently excluded from the standard panel size targets and support staff ratio due to significant variation in staffing and care models. These include: Currie Senior Center, Tom Waddell Urban Health, Positive Health Program, Children’s Health Center, Community Healthy Programs for Youth (CHPY) and Special Programs for Youth (SPY) | 1A. Primary Care: Hall Hammer | Quarterly | Jonathan Albright | CTE | January – March 2014 to be unreported as accurate data collection began in April 2014. April 2014 will serve as baseline | Per Way Forward, achieve primary care weighted panel size of 1,350 |
| 2 | Achieve Primary Care support staff ratio per unweighted active patient panel = 4.5 FTE | 2. Improve support staff ratio for active patient panel | • Special populations clinics are currently excluded from the standard panel size targets and support staff ratio due to significant variation in staffing and care models. These include: Currie Senior Center, Tom Waddell Urban Health, Positive Health Program, Children’s Health Center, Community Healthy Programs for Youth (CHPY) and Special Programs for Youth (SPY) • Data to be shared by clinics. | 2A. Primary Care: Hall Hammer | Quarterly | Jonathan Albright | Multiple sources: Attnion rates, weighted panel, etc. | January – March 2014 to be unreported as accurate data collection began in April 2014. April 2014 will serve as baseline | Per Way Forward, achieve patient panel =4.5 FTE |
| 3 | Improve by 5% over baseline, Patient Placement at the appropriate setting and level of care in Acute and Skilled Nursing Facility Institutional Operations | 3. Improve patient placement by decreasing lower level of care days. | SFGH to retrieve data from Controller’s Office for Total Average Non-Acute LLOC dates. Lower Level of Care is defined as total number of admin days, denied days, and total non-acute days. Note that the goals for Med/Surg and Psych were a result of the DPH-HMA institutional/Post-Institutional action team and differ from the goals displayed | 3A. SFGH: Sue Currin | Quarterly | Controller’s Office - Inpatient Dashboard | Invasion via RTZ | Total Average Non-Acute LLOC days (admin &amp; denied days) for July - Sept 2013 | Improve by 5% over baseline • Additionally, to add HMA target for med-surg (304 days) and psych (548 days). |
| 4 | Meet or exceed budgeted performance in revenues and expenses | 4. Improve patient placement by increasing appropriate discharges by unit. | Average length of stay for clients in the reporting month by flow [3]. Three years or less included here. | 3B. SFGH: Sue Currin | Quarterly | Controller’s Office - Inpatient Dashboard | Avatar via RTZ | Total Average Length of Stay for months July 2013 - September 2013 | Improve by 5% under baseline |
| 5 | Improve by 5% over baseline, Workforce Experience/Satisfaction Scores | 5. Meet or exceed budgeted performance in revenues and expenses | Discharges by unit are defined as number of discharges made to the community. If a patient was discharged to the community, defined as the appropriate level of care, then they will not be routed back into the SFHN system. LHH Online Patient Flow Data can be retrieved here: <a href="http://ln-slghweb01.in.slhph.net/LHH/PatientDataFlow/showdr.asp">http://ln-slghweb01.in.slhph.net/LHH/PatientDataFlow/showdr.asp</a> | 3C. LHH: Mivic Hirose | Quarterly | Mivic Hirose – Delegates to Trever | Avatar via RTZ | Total Average Appropriate Discharges (Community) for July - Sept 2013 | Improve by 5% over baseline |
| 6 | Improve workforce experience for the network | 6. Improve workforce experience for the network | Workforce experience survey questions and data are available in NRC Picker. NRC Picker is DPH’s 3rd party vendor who disseminates and analyzes survey results. Workforce experience surveys measure staff satisfaction through a series of questions that superimpose with patient satisfaction scores/survey questions. | 4A. DPH Finance: Greg Wagner, Jenny Louie | Revenue &amp; Expenses Report by Division: Quarterly | Jenny Louie | EIS, Invasion | FY 2011-2012 4th Quarter Year End Total DPH Surplus/(Deficit) | Target is to ensure at least zero general fund deficit as indicator of meeting budgeted performance |
| 7 | Improve by 5% over baseline, Workforce Experience/Satisfaction Scores | 7. Improve workforce experience for the network | Workforce experience survey questions and data are available in NRC Picker. NRC Picker is DPH’s 3rd party vendor who disseminates and analyzes survey results. Workforce experience surveys measure staff satisfaction through a series of questions that superimpose with patient satisfaction scores/survey questions. | 5A. DPH HR: Ron Weigelt, Primary Care: Tani Rucker | Outcome Data: Annually First report Fall Process Measures: Semi-Annually First report July | Ron Weigelt | NRC Picker | First Report to be shared January 2015, which will serve as baseline | Target calculated from 5% over baseline Workforce Experience/Satisfaction Scores |</p>
<table>
<thead>
<tr>
<th>Metric #</th>
<th>Way Forward Metric</th>
<th>Intent</th>
<th>Way Forward Metric Technical Definition</th>
<th>Accountable Team/Organization</th>
<th>Distribution Frequency</th>
<th>Data Contact/Date Owner</th>
<th>Data Source</th>
<th>Baseline Determination &amp; Time Period (Determined by Division Leaders)</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Improve Civil Service Hiring, From Form 3 submission to start work date = 90 days or less</td>
<td>Intent to improve civil service hiring</td>
<td>Defined as completion of HR hiring steps 1-16, which entail: Step 1: Department Hiring Manager submits Form 3 to DPH HR. Step 2: DPH-HR and Local Finance/Budget Office approves Form 3 Step 3: DPH-HR submits Request to Fill (RTF) for approval Step 4: DHR approves position Step 5: DPH Budget Director's Office submits position to Mayor's Office Step 6: Mayor's Office approves position Step 7: Hiring Manager / Department submits Job flyer request Step 8: Merit Division posts recruitment or exam announcement Step 9: Merit Division administers exam Step 10: Merit Division adopts Eligibility List Step 11: DPH-HR requests Referral from DHR Step 12: DHR issues the Referral Step 13: Manager receives notification and reviews applications Step 14: Hiring Manager / Department submits Request to Hire (RTH) Step 15: Employee completes new hire processing Step 16: New employee start date / Orientation date</td>
<td>Quarterly</td>
<td>Ron Weigelt Analyst: Chris Dunne</td>
<td>HRIM and e-Merge</td>
<td>January - March 2015 First report will not be shared until April 2015</td>
<td>Per Way Forward metric, target is 90 days or less</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Improve by 5% over baseline Patient Experience/Satisfaction Scores of achieve NRC Picker 75th percentile</td>
<td>Intent to improve patient satisfaction for the network</td>
<td>• Patient experience survey questions and data are available in NRC Picker. NRC Picker is DPH's 3rd party vendor who disseminates and analyzes survey results. • Patient experience survey measures patient satisfaction through a series of questions that superimpose with workforce satisfaction scores/survey questions. • Composites derived from the following agreed-upon categories: &quot;Rate Care&quot; and &quot;Would Recommend&quot;. Each division will report one (1) question for each category for reporting. • Primary Care Clinics include Maxine Hall Health Center, Ocean Park Health Center, Castro-Mission Health Center, Southeast Health Center, Silver Avenue Family Health Center, Potrero Hill Health Center, Chinatown Public Health Center, Tom Waddell Health Center, General Medical Clinic at SFGH, Family Health Center at SFGH, Pediatrics, Primary Care 6M Clinic at SFGH</td>
<td>Quarterly</td>
<td>Kathryn Horner (SFGH - CG CAHPS Specialty)</td>
<td>Patient Satisfaction Surveys NRC Picker</td>
<td>July - December 2013 Baseline</td>
<td>Improve by 5% over baseline</td>
<td></td>
</tr>
<tr>
<td>7A</td>
<td>SFGH Specialty - CG CAHPS: Kathryn Horner</td>
<td>Quarterly</td>
<td>Kathryn Horner (SFGH - CG CAHPS Specialty)</td>
<td>Patient Satisfaction Surveys NRC Picker</td>
<td>July - December 2013 Baseline</td>
<td>Improve by 5% over baseline</td>
<td></td>
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</tr>
<tr>
<td>7B</td>
<td>SFGH - HCAHPS: Sue Schwartz</td>
<td>Quarterly</td>
<td>Sue Schwartz (SFGH - HCAHPS)</td>
<td>Patient Satisfaction Surveys NRC Picker</td>
<td>July - December 2013 Baseline</td>
<td>Improve by 5% over baseline</td>
<td></td>
<td></td>
<td></td>
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<td>7C</td>
<td>Primary Care - CG CAHPS: Amy Peterson/Trever Pearson</td>
<td>Quarterly</td>
<td>Amy Peterson/Trever Pearson (primary care - CG CAHPS Primary Care)</td>
<td>Patient Satisfaction Surveys NRC Picker</td>
<td>July - December 2013 Baseline</td>
<td>Improve by 5% over baseline</td>
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<tr>
<td>7D</td>
<td>Health at Home: Idy Chan</td>
<td>Quarterly</td>
<td>Idy Chan (Health at Home)</td>
<td>Patient Satisfaction Surveys</td>
<td>July - December 2013 Baseline</td>
<td>Improve by 5% over baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7E</td>
<td>Behavioral Health: Deborah Sherwood</td>
<td>Annually</td>
<td>Deborah Sherwood (Mental Health)</td>
<td>Collection through state mandated manual survey</td>
<td>FY 2012-2013 Average Data</td>
<td>Average Score on a 5 point scale</td>
<td>Improve by 5% over baseline</td>
<td></td>
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<tr>
<td>7F</td>
<td>LHH: Regina Gomez</td>
<td>Quarterly reporting for Discharge Resident Surveys Annual Reporting for Peer Group/Resident Satisfaction Data. This data is in house Semi-annual</td>
<td>Regina Gomez -- Dominic</td>
<td>• For annual reporting, LHH use Resident Satisfaction • For quarterly reporting, LHH to compile data from discharge surveys that is conducted by the Patient Satisfaction Surveys given to patients after their care</td>
<td>MyTurnerView National Database for April 2013</td>
<td>Improve by 5% over baseline</td>
<td></td>
<td></td>
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<tr>
<td>7G</td>
<td>Jail Health: Joe Goldenstein/Frank Pratt</td>
<td>Semi-annual</td>
<td>Carrie Gustafson</td>
<td>• For annual reporting, LHH use Resident Satisfaction • For quarterly reporting, LHH to compile data from discharge surveys that is conducted by the Patient Satisfaction Surveys given to patients after their care</td>
<td>Q3 and Q4 2014 to be unreported due to semi-annual reporting. April 2014 data will serve as baseline.</td>
<td>Improve by 5% over baseline</td>
<td></td>
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<tr>
<td>8</td>
<td>Establish a Unified Understanding of Staff Role in the Success of the Network by documenting 50% of surveyed Staffs' ability to reference our &quot;Way Forward Plan&quot;, Increasing the Value of Services Provided to our constituents; Patients, Workforce and SF Residents &amp; Consumers</td>
<td>Intent to achieve staff understanding of Way Forward goals</td>
<td>Staff survey will include SFHN talking points in halogen powerpoint slides. Slides require a pre-test, as well as multiple choice questions at the conclusion of the learning module, as a method of ensuring that employees understand Way Forward Plan. Halogen is DPH's learning module – used for various educational mandates, such as orientation or new learning expectations. Percentage of accurate answers will be determined by: accurate answers/Total number of staff surveyed</td>
<td>Quarterly</td>
<td>Rachael Kagan</td>
<td>50% of surveyed Staff to answer questions correctly</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Metric #</td>
<td>Way Forward Metric</td>
<td>Intent</td>
<td>Way Forward Metric Technical Definition</td>
<td>Accountable Team/Organization</td>
<td>Distribution Frequency</td>
<td>Data Contact/Data Owner</td>
<td>Data Source</td>
<td>Baseline Determination &amp; Time Period (Determined by Division Leaders)</td>
<td>Target</td>
</tr>
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<tr>
<td>9</td>
<td>Achieve a 75% mammogram screening rate for eligible primary care clients</td>
<td>Intent is to increase access to mammogram screening for eligible primary care clients. Methodology is to measure screening rate for eligible primary care clients. For the breast cancer screening metric, they are aligning this metric with current DSRIP reporting. They are currently in demonstration year 9, so moving forward, they will report out with the DSRIP measure.</td>
<td>9A. Primary Care: Lisa Golden</td>
<td>Quarterly</td>
<td>Lisa Golden</td>
<td>DSRIP data</td>
<td>Baseline from DSRIP demonstration in year 7, which indicated Primary Care’s first time reporting on this measure</td>
<td>Per Way Forward, achieve 75%</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Increase by 25% the number of clients seen in a Behavioral Health Center who have an identified Primary Care Provider in Avatar HER</td>
<td>Intent is to ensure Behavioral Health Center clients have a primary care provider identified in their AVATAR Electronic Health Record.</td>
<td>10A. CBHS: Deborah Sherwood, Jo Robinson</td>
<td>Quarterly</td>
<td>Deborah Sherwood, Jo Robinson</td>
<td>Avatar - PCP is noted in the patient’s chart</td>
<td>8/21/13 data</td>
<td>Per Way Forward, increase by 25% the number of clients</td>
<td></td>
</tr>
</tbody>
</table>

Footnote:
9 Achieve a 75% mammogram screening rate for eligible primary care clients. Intent is to increase access to mammogram screening for eligible primary care clients. Methodology is to measure screening rate for eligible primary care clients. For the breast cancer screening metric, they are aligning this metric with current DSRIP reporting. They are currently in demonstration year 9, so moving forward, they will report out with the DSRIP measure.
## Performance Measure

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>#1 Achieve Primary Care Weighted Panel Size = 1,350</td>
<td>Q 1,011</td>
<td>1,350.00</td>
<td>1,011</td>
<td>-</td>
<td>1,123</td>
<td>1,285.00</td>
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<td>#2 Achieve Primary Care support staff ratio per unweighted active patient panel = 4.5 FTE</td>
<td>Q 4.10</td>
<td>4.50</td>
<td>4.10</td>
<td>-</td>
<td>4.29</td>
<td>4.48</td>
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<td>#3 Improve by 5% over baseline, Patient Placement at the appropriate setting and level of care in Acute and Skilled Nursing Facility Institutional Operations</td>
<td>Q 0.00</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Laguna Honda Hospital</td>
<td>Q 22</td>
<td>23</td>
<td>22</td>
<td>26</td>
<td>27</td>
<td>26.67</td>
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<tr>
<td>San Francisco General Hospital</td>
<td>Q 661</td>
<td>628</td>
<td>661</td>
<td>576</td>
<td>482</td>
<td>529.17</td>
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<tr>
<td>Care Transitions/Patient Placement</td>
<td>Q 410</td>
<td>390</td>
<td>410</td>
<td>447</td>
<td>459</td>
<td>453</td>
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<td>#4 Meet or exceed budgeted performance in revenues and expenses</td>
<td>Q $ 1,718,617.20</td>
<td>0</td>
<td>$ 1,718,617.20</td>
<td>$ 34,213,009.00</td>
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<td>Revenues</td>
<td>Q $ 1,674,997,955.24</td>
<td>-</td>
<td>$ 1,674,997,955.24</td>
<td>$ 1,995,237,560.00</td>
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<td>San Francisco General Hospital</td>
<td>Q $ 865,272,000.00</td>
<td>-</td>
<td>$ 865,272,000.00</td>
<td>$ 1,100,262,000.00</td>
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<td>Laguna Honda Hospital</td>
<td>Q $ 226,058,245.00</td>
<td>-</td>
<td>$ 226,058,245.00</td>
<td>$ 242,424,255.00</td>
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<td>Primary Care</td>
<td>Q $ 69,096,000.00</td>
<td>-</td>
<td>$ 69,096,000.00</td>
<td>$ 81,541,000.00</td>
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<td>Health at Home</td>
<td>Q $ 6,431,000.00</td>
<td>-</td>
<td>$ 6,431,000.00</td>
<td>$ 6,887,000.00</td>
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<td>Jail Health</td>
<td>Q $ 29,611,000.00</td>
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<td>$ 29,611,000.00</td>
<td>$ 31,794,000.00</td>
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<td>Public Health</td>
<td>Q $ 129,721,453.62</td>
<td>-</td>
<td>$ 129,721,453.62</td>
<td>$ 168,141,808.00</td>
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<tr>
<td>Mental Health</td>
<td>Q $ 280,207,662.78</td>
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<td>$ 280,207,662.78</td>
<td>$ 287,106,852.00</td>
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<td>287,106,852.00</td>
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<td>Substance Abuse</td>
<td>Q $ 68,600,593.84</td>
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<td>$ 68,600,593.84</td>
<td>$ 77,080,645.00</td>
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<td>77,080,645.00</td>
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<tr>
<td>Expenses</td>
<td>Q $ 1,673,279,338.04</td>
<td>-</td>
<td>$ 1,673,279,338.04</td>
<td>$ 1,961,024,551.00</td>
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<td>San Francisco General Hospital</td>
<td>Q $ 864,997,000.00</td>
<td>-</td>
<td>$ 864,997,000.00</td>
<td>$ 1,081,004,000.00</td>
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<tr>
<td>Laguna Honda Hospital</td>
<td>Q $ 222,061,189.00</td>
<td>-</td>
<td>$ 222,061,189.00</td>
<td>$ 216,573,246.00</td>
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<td>216,573,246.00</td>
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<tr>
<td>Primary Care</td>
<td>Q $ 69,779,000.00</td>
<td>-</td>
<td>$ 69,779,000.00</td>
<td>$ 81,621,000.00</td>
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<tr>
<td>Health at Home</td>
<td>Q $ 7,209,000.00</td>
<td>-</td>
<td>$ 7,209,000.00</td>
<td>$ 7,209,000.00</td>
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<tr>
<td>Jail Health</td>
<td>Q $ 30,703,000.00</td>
<td>-</td>
<td>$ 30,703,000.00</td>
<td>$ 32,788,000.00</td>
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<td>32,788,000.00</td>
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<tr>
<td>Public Health</td>
<td>Q $ 126,167,248.26</td>
<td>-</td>
<td>$ 126,167,248.26</td>
<td>$ 170,441,808.00</td>
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<tr>
<td>Mental Health</td>
<td>Q $ 284,581,908.68</td>
<td>-</td>
<td>$ 284,581,908.68</td>
<td>$ 294,006,852.00</td>
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<tr>
<td>Substance Abuse</td>
<td>Q $ 67,780,992.10</td>
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<td>$ 67,780,992.10</td>
<td>$ 77,380,645.00</td>
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<td>77,380,645.00</td>
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<tr>
<td>#5 Improve by 5% over baseline Workforce Experience/Satisfaction Scores</td>
<td>A -</td>
<td>-</td>
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<td>#6 Improve Civil Service Hiring, From Form 3 submission to start work date = 90 days or less</td>
<td>A -</td>
<td>90</td>
<td>-</td>
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<td>#7 Improve by 5% over baseline Patient Experience/Satisfaction Scores</td>
<td>A 4.56</td>
<td>4.78</td>
<td>4.56</td>
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<td>Behavioral Health (Mental Health) n=3,150</td>
<td>n=3,150</td>
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<tr>
<td>I like the services that I received here.</td>
<td>A 4.49</td>
<td>4.71</td>
<td>4.49</td>
<td>#N/A</td>
<td>4.41</td>
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<td>Behavioral Health (Substance Abuse) n=3,150</td>
<td>n=3,150</td>
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</table>

Rating scale: 0= strongly disagree and 5 = strongly agree

Behavioral Health (Substance Abuse) 0.00 - - #DIV/0!
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>I like the services that I received.</td>
<td></td>
<td>4.47</td>
<td>4.69</td>
<td></td>
<td>4.47</td>
<td>#N/A</td>
<td>4.49</td>
<td></td>
<td>#N/A</td>
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<tr>
<td>I would recommend this agency to a friend or family member.</td>
<td></td>
<td>4.47</td>
<td>4.69</td>
<td></td>
<td>4.47</td>
<td>#N/A</td>
<td>4.47</td>
<td></td>
<td>#N/A</td>
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<tr>
<td>Rating scale: 0= strongly disagree and 5 = strongly agree</td>
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<tr>
<td>Health at Home</td>
<td></td>
<td>0.00</td>
<td>-</td>
<td></td>
<td>0.00</td>
<td>-</td>
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</tr>
<tr>
<td>We want to know your rating of your care from this agency's home health providers.</td>
<td></td>
<td>80.4%</td>
<td>84.4%</td>
<td></td>
<td>80.4%</td>
<td>85.2%</td>
<td>80.0%</td>
<td>0.83</td>
<td></td>
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<tr>
<td>Would you recommend this agency to your family or friends if they needed home health care?</td>
<td></td>
<td>82.2%</td>
<td>86.3%</td>
<td></td>
<td>82.2%</td>
<td>80.0%</td>
<td>79.6%</td>
<td>0.80</td>
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<tr>
<td>Rating Scale: 0 = worst home health care possible and 10 = best home health care possible</td>
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<td>Jail Health</td>
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<tr>
<td>How would you rate the care you received from JHS?</td>
<td></td>
<td>86.0%</td>
<td>90.3%</td>
<td></td>
<td>86.0%</td>
<td>-</td>
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<tr>
<td>Laguna Honda Hospital</td>
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<td>0.00</td>
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<tr>
<td>Overall satisfaction</td>
<td></td>
<td>84.00%</td>
<td>88%</td>
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<td>84.00%</td>
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<tr>
<td>Recommendation to others</td>
<td></td>
<td>81.00%</td>
<td>85%</td>
<td></td>
<td>81.00%</td>
<td>-</td>
<td>-</td>
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<td>#DIV/0!</td>
</tr>
<tr>
<td>Rate Provider</td>
<td></td>
<td>59.40%</td>
<td>62.37%</td>
<td></td>
<td>59.40%</td>
<td>62.5%</td>
<td>59.0%</td>
<td>0.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would recommend provider's office to family and friends</td>
<td></td>
<td>68.70%</td>
<td>72.14%</td>
<td></td>
<td>68.70%</td>
<td>72.9%</td>
<td>68.5%</td>
<td>0.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate scale: 0=worst and 10=best</td>
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<td>0.00</td>
<td>-</td>
<td></td>
<td>0.00</td>
<td>-</td>
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<tr>
<td>Primary Care (CG-CAHPS)</td>
<td></td>
<td>0.00</td>
<td>-</td>
<td></td>
<td>0.00</td>
<td>-</td>
<td>-</td>
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<td>San Francisco General Hospital Specialties (Adult Primary Care)</td>
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<td>0.00</td>
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<tr>
<td>Overall Rating of Provider 9 or 10</td>
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<td>59.40%</td>
<td>62.37%</td>
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<td>59.40%</td>
<td>62.5%</td>
<td>59.0%</td>
<td>0.61</td>
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<tr>
<td>Would Definitely Recommend Provider Office</td>
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<td>68.70%</td>
<td>72.14%</td>
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<td>68.70%</td>
<td>72.9%</td>
<td>68.5%</td>
<td>0.71</td>
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<tr>
<td>San Francisco General Hospital Specialties (Adult Specialty CAHPS - GI, Diabetes, GYN, Ortho, Urology)</td>
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<tr>
<td>Overall Rating of Provider 9 or 10</td>
<td></td>
<td>62.00%</td>
<td>65.1%</td>
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<td>62.00%</td>
<td>58.4%</td>
<td>65.8%</td>
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<tr>
<td>Would Definitely Recommend Provider Office</td>
<td></td>
<td>60.90%</td>
<td>63.9%</td>
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<td>60.90%</td>
<td>62.8%</td>
<td>60.8%</td>
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<td>Overall Rating of Provider 9 or 10</td>
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<td>56.40%</td>
<td>59.22%</td>
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<td>56.40%</td>
<td>-</td>
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</tr>
<tr>
<td>Would Definitely Recommend Provider Office</td>
<td>Q</td>
<td>66.30%</td>
<td>69.62%</td>
<td>66.30%</td>
<td>n=262</td>
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<tr>
<td>San Francisco General Hospital (HCAHPS)</td>
<td>Q</td>
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<td>n=512</td>
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<td>Overall Rating of Hospital 9 or 10</td>
<td>Q</td>
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<td>62.7%</td>
<td>59.70%</td>
<td>n=509</td>
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<tr>
<td>Would Definitely Recommend Hospital</td>
<td>Q</td>
<td>66.30%</td>
<td>69.62%</td>
<td>66.30%</td>
<td>n=262</td>
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<tr>
<td># Establish a Unified Understanding of Staff Role in the Success of the Network by</td>
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<tr>
<td>documenting 50% of surveyed Staffs’ ability to reference our “Way Forward Plan”:</td>
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<tr>
<td>increasing the value of services provided to our constituents; Patients, Workforce</td>
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<tr>
<td>and SF Residents &amp; Consumers</td>
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<tr>
<td>#9 Achieve a 75% mammogram screening rate for eligible primary care clients</td>
<td>Q</td>
<td>73.5%</td>
<td>75.00%</td>
<td>73.5%</td>
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<td>n=10,432</td>
<td>n=10,622</td>
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<td>#10 Increase by 25% the number of clients seen in a Behavioral Health Center who</td>
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<td>50.2%</td>
<td>62.25%</td>
<td>50.2%</td>
<td>n=39,808</td>
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<td>0.55</td>
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<tr>
<td>have an identified Primary Care Provider in Avatar HER</td>
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Notes:
- The SFHN Dashboard is issued on a quarterly basis.
- Metrics that are reported on a quarterly basis will include new data from the prior three months. Metrics that are reported on a semi annual basis, will include data from the prior six months. Metrics that are reported on an annual basis, will include data from the prior twelve months.
- Date range connected to baseline of each performance metric varies. Quarterly (Q), SA (Semi-Annually), and Annually (A) denotes frequency of reporting.
- The Prior Period Average is the average of monthly values. Date range is indicated above the value.
- The Current Period Average is the average of monthly values for the most recent period. Date range is indicated above the value.
- The Period Percent change reflects the change since the previous period (e.g., October-December 2013 compared to July-September 2013).
- Trend lines are made up of data provided by divisions. The scale of the trend lines display potential fluctuations.
- For additional detail on measure definitions and department information, please contact SFHN Business Intelligence Unit.
Adult Medical Health Center
FY14-15 SFGH Labor Actual vs Budget

Actual

Budget

PPE

Labor ($)
Employees In Danger of Exceeding the 25% OT Cap Max (520 Hours) PPE 06/30/14

Board of Supervisors has amended the Overtime Ordinance and reduced the maximum permissible overtime limit in a FY of 30% for a full-time employee (624 hours) to 25% (520 hours). This change takes effect in the current fiscal year.

City's DHR may grant limited exemptions in the event of a critical staffing shortage. If an exemption is needed, SFGH Administration must communicate to Michael Brown before any employee is scheduled for OT that would exceed the cap of 520 OT hours.

City's payroll system currently codes the additional hours worked by part-time employees as OT, even though the employee earns straight-time on all hours up to 80 regular hours in a pay period. Pending implementation of the City's new payroll system, we Executive Staff members are responsible to ensure employees in their span of control do not exceed the Cap.

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<tr>
<th>DEPARTMENTS/NAME</th>
<th>STANDARD HR</th>
<th>CLASS</th>
<th>YTD OT HRS</th>
<th>YTD COMP TIME</th>
<th>OT AND COMP ACCRUED TO DATE</th>
<th>YTD REG HRS</th>
<th>YTD OT &amp; COMP HRS/YTD REG HRS</th>
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<td>300</td>
<td>108</td>
<td>408</td>
<td>1314</td>
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<td>225</td>
<td>784</td>
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</table>

***Please refer to Part-Time Employee Tab to see "True" OT hours paid at time and one-half.
FY1415 MATERIALS & SUPPLIES (040) EIS MONTHLY REPORT

Organization: San Francisco General Hospital
Cost Center Name: 7086 4M ADULT SURGICAL
Cost Center Index Code: HGH1HSC40121
Materials and Supplies Budget: $340,354.85

Performance Indicators
Annual Projection: $220,963.34
Remaining Budget YTD FAV/(UNFAV): $303,527.62

Variance (Budget vs. Annual Projection) FAV vs. [UNFAV]: $119,391.51
Variance % (Budget vs. Annual Projection) FAV vs. [UNFAV]: 35%

M&S Expenses by Month
Cost Center Name: 7086 4M ADULT SURGICAL

<table>
<thead>
<tr>
<th>Subobjects</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>YTD Total</th>
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<td>768.98</td>
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<td>36,827.22</td>
</tr>
</tbody>
</table>

M&S Expenses by Subobjects

For questions, please contact Kim Nguyen at kmnvan.nguyen@sfdph.org or Chris Dunne at chris.dunne@sfdph.org
## FY1415 MATERIALS & SUPPLIES (040) EIS MONTHLY REPORT

**Organization:** San Francisco General Hospital  
**Cost Center Name:** 7086 4M ADULT SURGICAL  
**Cost Center Index Code:** HGH1H5C40121  
**Materials and Supplies Budget:** $340,354.85

### M&S Expenses by Vendors

#### Debits = Increased Expenditure Amount  
(Credits) = Decreased Expenditure Amount  
Note: No vendor indicates journal entries or CPD issues.

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<th>February</th>
<th>March</th>
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<th>May</th>
<th>June</th>
<th>YTD Total</th>
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<td>WILSON OPHTHALMIC CORP</td>
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<td>10.00</td>
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<tr>
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<td>945.13</td>
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<td>1,523.24</td>
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<td><strong>YTD Total</strong></td>
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<td><strong>13,708.91</strong></td>
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<td></td>
<td><strong>36,827.22</strong></td>
<td></td>
</tr>
</tbody>
</table>

For questions, please contact Kim Nguyen at kimvan.nguyen@sfdph.org or Chris Dunne at chris.dunne@sfdph.org
FY1415 MATERIALS & SUPPLIES (040) EIS MONTHLY REPORT

Organization: San Francisco General Hospital
Cost Center Name: 7520 PATHOLOGY
Cost Center Index Code: HGH1HCX40031
Materials and Supplies Budget: $167,357.79

Performance Indicators
Annual Projection: $81,520.55 Remaining Budget YTD FA/(UNFAV) $153,771.03

Variance (Budget vs. Annual Projection) FA/(UNFAV) $85,837.24 Variance % (Budget vs. Annual Projection) FA/(UNFAV) 51%

M&S Expenses by Month
Debits = Increased Expenditure Amount
Credits = Decreased Expenditure Amount
Note: if expenditures did not incur, month name will not appear in chart

Cost Center Name: 7520 PATHOLOGY

<table>
<thead>
<tr>
<th>Subobjects</th>
<th>Months</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>YTD Total</th>
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<tbody>
<tr>
<td>04299 OTHER BUILD MAINT SUPPLIES</td>
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<td>33.13</td>
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<tr>
<td>04431 LABORATORY SUPPLIES</td>
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<td>4,052.06</td>
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<td>7,247.69</td>
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<td>04441 MEDICAL SUPPLIES</td>
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<td>1,668.23</td>
<td>2,475.50</td>
<td></td>
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<td>4,143.73</td>
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<tr>
<td>04499 OTHER HOSP. CLIN/CS SUPPLS</td>
<td></td>
<td>784.74</td>
<td>1,033.21</td>
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<td>964.55</td>
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<td>1,195.30</td>
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<td>YTD Total</td>
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<td></td>
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<td>13,586.76</td>
</tr>
</tbody>
</table>

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## FY1415 MATERIALS & SUPPLIES (040) EIS MONTHLY REPORT

**Organization:** San Francisco General Hospital  
**Cost Center Name:** 7520 PATHOLOGY  
**Cost Center Index Code:** HGH1HCX40031  
**Materials and Supplies Budget:** $167,357.79

### M&S Expenses by Vendors

Debits = Increased Expenditure Amount  
Credits = Decreased Expenditure Amount  
Note: No vendor indicates journal entries or CPD issues.

<table>
<thead>
<tr>
<th>Cost Center Name</th>
<th>7520 PATHOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Expenditures</strong></td>
<td><strong>Months</strong></td>
</tr>
<tr>
<td>CARDINALHEALTH MEDICAL PRODUCTS &amp; SVCS</td>
<td>$16,863.86</td>
</tr>
<tr>
<td>P K SAFETY SUPPLY</td>
<td>784.74</td>
</tr>
<tr>
<td>SANTORA SALES</td>
<td>16.58</td>
</tr>
<tr>
<td>Open PO</td>
<td>162.09</td>
</tr>
<tr>
<td><strong>YTD Total</strong></td>
<td><strong>5,827.27</strong></td>
</tr>
</tbody>
</table>

For questions, please contact Kim Nguyen at kimvan.nguyen@sfdph.org or Chris Dunne at chris.dunne@sfdph.org
Purpose

To build, provide direction for, and maintain a Supply Chain Council (SCC) that will develop best practices, align processes, measure performance, and implement solutions to enable the San Francisco Department of Public Health (SFDPH) to leverage its purchasing power and drive long term improvements in the divisional supply chains.

Background

Public Health manages the hospitals & clinics of the City and County of San Francisco, monitors, and regulates emergency medical services, and oversees a number of primary care, behavioral health, disease prevention, and jail health clinics. Public Health’s decentralized and siloed purchasing system has resulted in inconsistent practices and inefficiencies. The Controller’s Office made nine recommendations to improve DPH purchasing, which will serve as the starting point for the SCC’s strategic planning for department wide changes.

[Refer to The Department’s Siloed and Decentralized Purchasing Structure Results in Inefficiencies, for Office of the Controller, City Services Audit details]

Objectives

Key objectives include achieving efficiencies, establishing best practices, improving end user value, realizing financial success, negotiating optimal contracts, properly aligning technology, standardizing supplies, and monitoring deliverables, and complying with applicable service guidelines.
• **Achieving Efficiencies.** Establish supply chains that balance efficiency with effectiveness to optimize overall performance.

• **Complying with applicable service guidelines, rules, and regulations.** Ensure service requirement compliance with different City departments’ requirements, such as Office of the Controller, Office of Contracts Administration, Treasurer/Tax Collector, Contract Monitoring Division and Risk Management

• **Driving End User Value.** Ensuring highly consistent delivery, including just-in-time where appropriate.

• **Establishing best practices with industry specific issues.** Ensure operational competitiveness with industry standards by recognizing disruptions, overcoming them, and redesigning processes to reduce future risk

• **Monitoring deliverables.** Provide summaries of technical information and ensure results achieved during performance of a contract.

• **Negotiating optimal contracts with vendors.** Identify and address potential risks and liabilities, and insist on cost effectiveness and performance optimization. Purchasing and procurement teams to negotiate significant potential savings and communicate contract terms to the other divisions

• **Properly aligning the technology in supply chain procurement.** Review the processes that need improvement, and select the technology that best satisfies those process needs (i.e. PMM).

• **Realizing Financial Success.** Focus on cost efficiency—streamline stock levels to reduce inventory carrying cost, automate fulfillment operations to minimize labor expense, and consolidate orders to cut freight spending.

• **Standardizing Supplies and other products.** Review supplies and products and determine overlap in order to negotiate ever better rates with suppliers whilst maintaining or increasing quality and service.

**Scope of Work**

SCC’s strategic planning for department-wide changes for all things related to procurement, including commodities and services, include, but are not limited to:

1. Medical equipment
2. Medical & Laboratory supplies
3. Point of service testing supplies
4. IT equipment
5. Medications
6. Furniture
7. Uniforms
Composition and Roles

The council is intended for members who can influence policy and workflow changes and serve as representatives of the Purchasing and Accounts Payable teams from across the DPH divisions for all things related to procurement, including commodities and services. Participating divisions include:

1. Behavioral Health
2. DPH Information Technology
3. Jail Health
4. Laguna Honda
5. Maternal, Child, Adolescent Health
6. Population Health
7. Primary Care
8. San Francisco General Hospital
9. DPH Contracts Ad Hoc
10. Office of Contract Administration Ad Hoc

[For more information, refer to Appendix A, Chart 1, SFDPH Supply Chain Council Membership]

A broad range of skills and knowledge gives council members a thorough grasp of procurement issues, and the basis for developing, communicating, and implementing the solutions to resolve them.

SFDPH Supply Chain Council Chairperson is responsible for:

- Ensuring the SFDPH Supply Chain Council Charter is followed
- Facilitating and communicating the high level operations of the team and the team's deliverables
- Providing support and assistance to individual team members
- Providing consistent status reports to the DPH CFO and San Francisco Health Network Director

Council Meeting Commitment

- Council will meet quarterly
- Meeting dates are TBD, based on availability of members
- Meeting locations will rotate throughout DPH

Council Member Commitment

- All Council members are required to attend each quarterly meeting, or send a designee to represent their division
• All Council members are required to communicate and update their respective divisions and clinical experts on the activities and progress of the DPH SCC

• All Council member are to work, collaborate, and coordinate across DPH divisions, and with their own divisions, to positively promote change that meets the aims of the DPH SCC
Appendix A

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

SFDPH Supply Chain Council Membership

Greg Wagner, DPH CFO
Roland Pickens, Director SFHN

SFDPH Supply Chain Council
Rajdeep Sangha, SFHN
Kimvan Nguyen, SFHN

Information Technology
Purchasing
Nonie Cardona
Nancy Wong

SFHN, Primary Care, Adult Health
Purchasing
Reid Kennedy
Daisy Aquello

Accounts Payable
Wilfredo Lim
Russel Nakai
Sharon Cheng

Laguna Honda

Accounts Payable
Teresa Tan

Behavioral Health
Purchasing
Michelle Ruggels
Tyron Navarro
Gloria Wilder

Maternal, Child, Adolescent Health
Purchasing
Josh Nositer

Population Health
Purchasing
Christine Studer
Lorna Garica

Accounts Payable
Mynha Boengaling
**Supply Chain Council (SCC) Task Tracker**

**Purpose:** To document SCC progress and action items

Documented and maintained by Co Chair, Kim Nguyen. Questions/comments, email Kim at kimvan.nguyen@sfdph.org

<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>Task Description</th>
<th>Status</th>
<th>Accountable Division/Team Member</th>
<th>Additional Comments</th>
<th>Start Date</th>
<th>Due Date</th>
<th>End Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Office Supplies</td>
<td>Set up BPOs for Office Max for the following divisions: Population Health, Substance Abuse, Behavioral Health, Transitions, and MCAH.</td>
<td>In progress</td>
<td>Dept. Of Public Health: Myrna Boongaling</td>
<td>Intent is to transition and roll out Office Max portal and BPO to all departments.</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td>9/12/2014</td>
<td>Unable to increase or modify existing BPHC14000086 because the vendor’s business tax expired 6/30/14 per FAMIS screen print below. In the meantime, Myrna will request Lorna, Tyrone and Josh to submit their requests so we can modify the BPO once the vendor is compliant.</td>
</tr>
<tr>
<td>2</td>
<td>Office Supplies</td>
<td>Identify super user in each division with whom to coordinate the Office Max onboarding</td>
<td>In progress</td>
<td>Dept. Of Public Health: Myrna Boongaling</td>
<td>Intent is to transition and roll out Office Max portal and BPO to all departments.</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td>9/12/2014</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Office Supplies</td>
<td>Send Office Max &quot;user set up form&quot; to Baljeet/Kim</td>
<td>Completed</td>
<td>San Francisco General Hospital: Daisy Aguallo</td>
<td>Intent is to transition and roll out Office Max portal and BPO to all departments.</td>
<td>8/29/2014</td>
<td>9/5/2014</td>
<td>9/5/2014</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Office Supplies</td>
<td>Coordinate site visit orientations with Scott Hrudicka</td>
<td>In progress</td>
<td>SF Health Network: Baljeet Sangha/Kim Nguyen</td>
<td>Intent is to transition and roll out Office Max portal and BPO to all departments.</td>
<td>8/29/2014</td>
<td>9/19/2014</td>
<td>9/19/2014</td>
<td>Conference call with Scott Hrudicka concluded. Scott and Baljeet will determine next steps</td>
</tr>
<tr>
<td>5</td>
<td>Office Supplies</td>
<td>Invoice Scraping</td>
<td>Completed</td>
<td>SF Health Network: Kim Nguyen</td>
<td>Intent is to review all materials and supplies expenditures, to ensure merge with PMM</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Policy and Procedure</td>
<td>Confirm the SFGH purchasing policy and procedure details around the process for internal bidding amongst GPO approved vendors</td>
<td>Completed</td>
<td>San Francisco General Hospital: Daisy Aguallo / Chris Dunne</td>
<td>Intent is to spread GPO bidding to all departments</td>
<td>8/29/2014</td>
<td>9/5/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Policy and Procedure</td>
<td>Send IT or LHH purchasing policies and procedures to Baljeet/Kim by 9/12 in order to consolidate SFGH and 1380 policies and maintain one consistent set of DPH Purchasing Guidelines</td>
<td>In progress</td>
<td>Laguna Honda Hospital: Russel Nakai DPH IT: Nancy Wong</td>
<td>Intent is to develop DPH-wide supply chain policies and procedures. Currently, the policies and procedures shares 1380 and SFGH's content -- need to integrate LHH and IT.</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td>9/12/2014</td>
<td>Kim received files and will work to consolidate</td>
</tr>
<tr>
<td>8</td>
<td>Novation</td>
<td>All divisions to identify the users to attend Novation training</td>
<td>Completed</td>
<td>All Divisions</td>
<td>Intent is spread Novation contract to all DPH</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td>9/12/2014</td>
<td>See Tab 2, Novation Trainees.</td>
</tr>
<tr>
<td>9</td>
<td>Novation</td>
<td>Coordinate with Marla Modesit (UHC Rep) setting up the different divisions in Novation and scheduling an orientation so end</td>
<td>In progress</td>
<td>SF Health Network: Baljeet Sangha/Kim Nguyen</td>
<td>Intent is spread Novation contract to all DPH</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Committee</td>
<td>Follow up with Hali Hammer for including the Primary Care Ops Manager</td>
<td>Completed</td>
<td>SF Health Network: Baljeet Sangha/Kim Nguyen</td>
<td>Intent is to ensure Primary Care Ops Manager represented at SCC meetings</td>
<td>8/29/2014</td>
<td>9/5/2014</td>
<td>9/5/2014</td>
<td>Circle back prior to the Spring meeting to touch base again re: hiring of Primary Care Ops Manager</td>
</tr>
<tr>
<td>11</td>
<td>Committee</td>
<td>Follow up and ensure OCA representative on ad hoc basis</td>
<td>Completed</td>
<td>SF Health Network: Baljeet Sangha/Kim Nguyen</td>
<td>Intent is to ensure OCA representative at SCC meetings</td>
<td>8/29/2014</td>
<td>9/5/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Committee</td>
<td>Scheduled and confirm next quarterly SCC meeting</td>
<td>Completed</td>
<td>SF Health Network: Kim Nguyen</td>
<td>Intent is to ensure SCC upholds quarterly meeting standards</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td>9/12/2014</td>
<td></td>
</tr>
</tbody>
</table>
### Supply Chain Council (SCC) Task Tracker

**Purpose:** To document SCC progress and action items  
Documented and maintained by Co Chair, Kim Nguyen. Questions/comments, email Kim at kimvan.nguyen@sfdph.org

<table>
<thead>
<tr>
<th>No.</th>
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<th>Due Date</th>
<th>End Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>IS Infrastructure</td>
<td>CBO's from BHS cannot access CHN/intranet. Confirm with IS access abilities</td>
<td>In progress</td>
<td>SF Health Network: Baljeet Sangha/Kim Nguyen</td>
<td>Intent is to ensure all divisions can access intranet page to retrieve PMM login</td>
<td>8/29/2014</td>
<td>9/12/2014</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In October 2013, Department of Public Health (DPH) reorganized its healthcare delivery system into the San Francisco Health Network (SFHN), the city’s only complete system of care, as a step toward achieving the goal of a fully integrated delivery system. Building on a two-year planning effort, DPH engaged Healthcare Management Associates (HMA) to assist in integrating its service delivery system. Among many recommendations was the proposal to create the SFHN Ambulatory Care Division that will work in a coordinated manner with other divisions of the Network – San Francisco General Hospital (SFGH) and Trauma Center, Laguna Honda Hospital and Rehabilitation Center (LHH), Office of Managed Care, and Transitions – to integrate all ambulatory services and advance the Network’s strategic goals:

- Achieve quality patient care and efficient service delivery through improved access, capacity, coordination and client flow
- Manage service and resource utilization and contracts
- Set performance accountability
- Strive for financial sustainability

Created in December 2013, when its first director was hired, the SFHN Ambulatory Care Division now includes four sections: Behavioral Health Services, Jail Health Services, Maternal Child and Adolescent Health, and Primary Care. The mission of the Network is to improve the value of services to patients, staff and San Franciscans. To achieve this mission, Ambulatory Care adheres to the following vision in guiding its daily work:

- Any door is the right door to receive seamless, coordinated, quality and appropriate care.
- Every staff behind any door is accountable to SFHN’s entire patient and client populations.
- Every staff behind any door is resourced and empowered to excel, innovate, teach and celebrate.

To remain a competitive provider in the new healthcare environment, the Network and Ambulatory Care will need to provide health care access to more people, improve quality, and rein in costs. As such, Ambulatory Care is pursuing strategic priorities that align with the Triple Aim goals of enhancing the patient care experience, improving the health of populations, and reducing the per capita cost of health care. Its staff and leadership will uphold six core aspirational values in their daily work:

- Address patients’ and clients’ health care concerns in the manner and timeframe they expect
- Embrace service standards that honor each patient and client in every interaction
- Commit to health excellence and equity for the populations we served
- Respect, recognize, and give staff the opportunity, training and coaching to succeed and grow
- Strive to maximize revenue, optimize efficiency, and eliminate waste
- Facilitates seamless, safe, reliable, and cost-effective transitions of care
## SFHN Ambulatory Care Priorities

<table>
<thead>
<tr>
<th>Triple AIM Strategic Alignment</th>
<th>Improve Patient Care Experience</th>
<th>Improve The Health of Populations</th>
<th>Reduce Per Capita Cost of Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Capacity</td>
<td>Embraces service standards that honor each patient and client in every interaction</td>
<td>• Understands how their work adds value to the patient/client they are serving</td>
<td>• Feels respected, recognized and given the opportunity, training and coaching to succeed and grow</td>
</tr>
<tr>
<td>Patient and Client Experience</td>
<td>Commits to health excellence and equity for the populations served</td>
<td>• Understands the key drivers that impact health equity and outcomes through continuous quality improvement activities</td>
<td>• Contributes actively to the norm that SFHN staff are the greatest assets in the organization</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>Staff Experience</td>
<td>Finance and Managed Care</td>
<td>Efficiency and Effectiveness</td>
</tr>
<tr>
<td>Staff Experience</td>
<td></td>
<td>• Delivers the right care at the right time, in the right amount, and in the most cost-effective way possible</td>
<td>• Assists the patient/client to navigate between clinical programs to optimize efficiency, effectiveness and flow</td>
</tr>
<tr>
<td>Core Values Every staff ...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People and Workforce Create a work culture where every staff ...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>System Processes Create policies, procedures, governance &amp; accountability where ...</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enabling Technology Tools Create a work environment where timely and relevant ...</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SFHN Ambulatory Care 2014 Accomplishments

Since December 2013, Ambulatory Care has worked actively and collaboratively within and across SFHN Divisions to organize a governance structure, consolidate a team of talented and dedicated leaders and staff, build a shared vision and alignment with Network priorities, and redesign and integrate its clinical programs. Moreover, Ambulatory Care has been disciplined, deliberate and inclusive in convening stakeholders and organizing efforts to complete the recommendations that are attributable to Ambulatory Care within the DPH Health Reform Readiness report.

1. Establish a new SFHN Ambulatory Care organization, leadership, accountabilities and processes

The SFHN Ambulatory Care organization chart, accountability structure, and leadership team are now established. The leadership team includes the four section Directors and three new cabinet positions, all occupied by reassigned leaders – Chief Program Integration Officer, Chief Quality Officer, and Chief Workforce Development Officer. In order to achieve improvements where SFHN health services are the preferred option for patients and clients and where DPH is an attractive work place that can recruit and retain talented staff, Ambulatory Care leadership will focus keenly on workforce development, continuous performance improvement, and strategic integration of programs to enhance efficiency and effectiveness.
The first of the four Ambulatory Care sections is the Network’s Behavioral Health Services (BHS), also known as Community Behavioral Health Services. It is the largest provider of publicly-funded behavioral health services in San Francisco. The mission of SFHN Behavioral Health Services is to maximize clients' recovery and wellness for healthy and meaningful lives in their communities. BHS adheres to the following core principles:

- Welcoming: Any door is the right door.
- People can and do overcome the barriers and obstacles that confront them.
- Co-occurring issues/dual diagnosis is the “expectation,” not the exception.
- All programs will be “dual diagnosis capable” and work in collaboration to meet the multiple needs of clients.
- Both substance abuse and mental health disorders will be addressed with appropriate services; integrated services will be the standard of practice.
- Recognition that all clients are not the same; each client will be provided with appropriate approaches to care.
- Best practices will be employed.
- The strengths and potentials of all clients will be recognized. Caregivers will seek to install hope and practice positive engagement.
- All of our clients will have a health home.

Behavioral health treatments include a broad continuum of mental health and substance use services from prevention and early intervention to treatment and after care.
Behavioral health services are provided through a network of programs throughout the City and County organized around two systems of care: a) Child, Youth and Family (CYF) System of Care comprised of 14 Civil Service programs and 40 contract agencies and b) Adult and Older Adult (AOA) System of Care comprised of 15 Adult Civil Service programs and 47 contract agencies. As the system names suggest, the CYF System of Care serves primarily children, youth and young adults, birth to age 18, while the AOA System of Care serves adults and older adults, aged 19 and older. Some CYF services, such as substance use prevention and treatment services, focus on transition age youth and young adults, aged 19-24.

In FY 2013-2014, the CYF System of Care provided behavioral health treatment to 5,433 children, youth and their families. Substance use treatment was provided to 906 children, youth and young adults up to ages 24. An additional 4,527 children and youth up to ages 18 received mental health treatment. The AOA Systems of Care reached 27,769 adults and older adults. Of these 6,547 adults and older adults received substance use treatment services, while 21,222 received mental health treatment services.
The second of the four Ambulatory Care sections is the City and County of San Francisco’s **Jail Health Services (JHS)**. It provides 24/7 comprehensive and integrated system of medical, psychiatric and substance use care to prisoner/patients in the San Francisco County Jail system. JHS has a relatively small and flat organizational structure.

The provision of health services to jail inmates presents unique challenges to JHS staff. They meet this challenge by delivering quality care to a diverse population that often does not utilize existing health services, particularly preventive and early intervention care, when in the community. JHS’ reentry program develops links between patients and existing community-based health and human services, enabling individuals to engage in the appropriate systems after release from jail. This results in the improved health and well-being for the individuals, their families and the community. During FY 13-14, JHS staff performed a total of 40,944 medical triages and screenings for incarcerated patients.
Populations Served
The average daily population (census) in FY 13-14 of the Jail System was approximately 1,312 prisoners, with an average length of stay of 4 months. Over three-quarters of prisoners have substance use problems. Close to 30% are homeless, and about one in seven have significant mental health problems. Ninety percent of the jail population is male and slightly more than half are African-American.

Clinical Programs
Jail Health Services provides an array of medical, behavioral health and substance use services, which include: outpatient medical services; multidisciplinary behavioral health services including crisis intervention; screening and initial evaluation; post-release placement and referral services; residential consultation with the Sheriff’s Department; group therapy; stabilization treatment; coordination with SFGH for hospitalization of patients with acute mental illness; reentry services; case management; HIV and integrated services; dental and podiatry services; a full range of outpatient women’s health services in collaboration with the UCSF/SFGH Department of Obstetrics and Gynecology; pharmacy services; coordination with SFGH for medical and surgical specialty services as well as emergency room and acute hospitalization transfers; and a continuous quality improvement program focusing on improving systems, operational procedures and patient care protocols.

Facilities
The City and County of San Francisco maintains four County Jails. Three of these jails are in San Francisco (County Jail #’s 1, 2, and 4). The fourth facility is situated in San Bruno, just south of San Francisco (County Jail # 5). All the jails, except for County Jail # 1, which is the intake and release facility, provide prisoner housing. JHS provides medical and mental health services at all of the facilities. The San Francisco Sheriff’s Department (SFSD) maintains a locked security unit at San Francisco General Hospital to provide inpatient services to patients whose medical/mental health problems require a higher level of care than is available in an outpatient setting.
The third of the four Ambulatory Care sections is the San Francisco Department of Public Health’s Maternal, Child and Adolescent Health (MCAH) section. It focuses on the most vulnerable children and families, filling what would otherwise be a serious public health gap. MCAH assesses the needs of newborns, children and mothers, identifies and addresses urgent MCAH issues, and mobilizes partners to take on such MCAH challenges as children and youth with special health care needs (CYSHCN). The work of MCAH is critical to protecting and promoting the health of San Francisco women and children. MCAH aims to reduce health disparities and improve health outcomes by strengthening the public health systems and services that address the root causes of poor health. Because of its dual structural relationship to SFDPH’s Population Health Division and the SFHN Ambulatory Care Division, MCAH’s organizational and leadership structure is more complex.

**Essential MCAH Services in the Department of Public Health and SF Health Network**

- Improve access to health care services – link vulnerable and yet-to-be-reached populations to enrollment and needed personal health services, prioritizing low income and CYSHCN and promoting utilization of clinical preventive services, e.g., family planning, lactation support, tobacco cessation.
• Investigate health problems affecting women, children, and youth.
• Inform and educate the public about maternal, youth, and child health issues.
• Engage community partners such as health care providers, families, child and youth advocates, the general public, and others to identify and solve maternal and child health problems.
• Promote and implement evidence-based practices, such as WIC provision of Participant Centered Education, Motivational Interviewing, Breastfeeding Peer Counseling, and the Baby Behavior parent education program.
• Assess and monitor MCAH health status to identify and address health problems.
• Maintain the public health work force to effectively address maternal and child health needs.
• Leverage clinical and community experience, shared resources, and collaborations to develop upstream public health policies and systems that improve health and living conditions.
• Enforce public health laws that protect the health and safety of women, children, and youth and that ensure public accountability for their well-being.
• Ensure quality improvement by partnering with other agencies to monitor health status, service effectiveness, accessibility, and quality to identify and solve community health problems.

MCAH Programs and Core Functions

1. Improving Access to High Quality Health Care
   Child Health Disability Prevention (CHDP)
   Comprehensive Perinatal Services Program (CPSP)
   Family Planning
   Fetal-Infant Mortality Review
   Health Care for Children in Foster Care Program
   Office of Childhood Hearing
   Pre-conception /Young Women’s Health

2. Promoting MCAH
   Black Infant Health Program
   Prevention of Sudden Infant Death Syndrome
   Child Care Health Project
   HOPE SF – Hunter’s View Pilot
   MCAH Field and Vulnerable Population Public Health Nursing
   Nurse Family Partnership
   Child Welfare Services: Substance Abuse/ HIV
   Child Welfare Services: Zero to Five

3. Preventing Chronic Diseases in MCAH Population
   Epidemiology
   Nutrition Services
      Feeling Good Project
      Women, Infant & Children Supplemental Nutrition Program (WIC)

4. Ensuring Comprehensive Health Care for Children and Youth with Special Health Care Needs
   California Children’s Services
   Medical Therapy Unit
2. Identify and appoint a Primary Care director

The last of the four Ambulatory Care sections is the recently reorganized SFHN Primary Care section. In March 2014, Ambulatory Care leadership recruited and hired the SFHN Director of Primary Care. Since the new Director was hired in March, she has defined new roles for the previous COPC (community-oriented primary care) directors and developed a leadership and oversight structure accountable for all SFGH-based clinics, community-based Primary Care health centers, and related programs. The team is almost fully in place, and a new organizational chart and accountability structure have been developed.

With the reorganization of Ambulatory Care at the end of 2013, leadership reconfigured Primary Care by integrating the SFGH-based and community-based health centers. SFHN Primary Care introduced the vision of creating a model of sustainable patient- and family-centered care and introduced the associated strategic priorities to all SFHN Primary Care staff. The 2014 SFHN Primary
Care strategic priorities are to:

1. Ensure prompt access to care for all our patients
2. Improve the health of the people we serve
3. Guarantee an optimal experience for each patient and family who comes to us for care
4. Create an operational infrastructure which supports excellent patient care and a healthy work environment
5. Build a workforce which is valued, does their best work every day, and upholds our mission in every interaction
6. Ensure sustainability through
   - Maximizing revenue,
   - Growing our patient population, and
   - Reducing waste

As the foundation and entry point for patients and clients into the Network, Primary Care will integrate and transform all of its 15 health centers – four at SFGH and eleven community-based (formerly referred to as Community Oriented Primary Care), into high-functioning patient-centered medical homes. The network of PC health centers serves almost 70,000 unduplicated patients, the great majority of whom are economically disadvantaged, psychosocially and medically complex individuals, and their socioeconomic and cultural diversity reflects the rich diversity of San Francisco. As part of Primary Care’s ‘whole person’ approach to care, the medical home includes a range of services provided by other health care professionals, in addition to primary care providers (physicians and nurse practitioners): clinical pharmacists, nutritionists, optometrists, podiatrists, dentists, psychologists, social workers, and psychiatrists. In all its clinical services, SFHN Primary Care emphasizes the following core principles: a) enhanced access, b) whole-person orientation, c) seamless coordination of care, d) superior safety and quality, e) robust team-based service models, f) responsible management of resources and finance, and g) development of an engaged and sustained Primary Care workforce.

Since the establishment of the integrated SFHN Primary Care division in March 2014, its focus has been on the first strategic priority, which is access. Access improvement initiatives described below have led to dramatic reductions in wait times for new patients, access to same day appointments in the medical home for established patients, and enhanced access to care and appointments over the phone. Moreover, historical silos between primary care, behavioral health services, transition programs, SFGH, LHH, and even between hospital and community-based primary care clinics are scrutinized to identify high-value opportunities for strategic integration and system accountability.

3. Implement primary care panel size targets through revised templates

As part of the Health Reform Readiness report, HMA recommended a target primary care panel size of 1,350 patients per clinical FTE (full-time equivalent), tracked monthly using a panel calculator that HMA had developed working in collaboration with Network leadership in early 2014. This target has been adopted as an SFHN Way Forward performance measure. Over the past year, Primary Care leadership has rigorously engaged clinic leadership, clinicians, and staff to ensure they understand this performance expectation as part of each clinic’s roles and responsibilities. To achieve our access and capacity priorities, Primary Care is implementing the following tactics: 1) simplify provider schedule templates, 2) standardize scheduling protocols and decision rules, 3) create telephone models for both nurse advice and nurse practitioner management of common problems,
4) align the Nurse Advice Line, the New Patient Appointment Unit and in the near future, the Centralized Call Center, 5) expand Nurse Orientation clinics for new patients, and 6) optimize provider productivity.

In order for us to ensure prompt access through maximizing capacity at each clinic, Primary Care has begun tracking many measures of access and productivity for the non-special populations health centers. Clinics serving “special” populations include Positive Health Program, Tom Waddell Urban Health (including Respite and Sobering), Community Health Programs for Youth, the SPY clinic at Youth Guidance Center, Curry Senior Center, and the SFGH Children’s Health Center. These clinics are expected to conform to the standard of immediate access to care for the populations they serve, but vary in terms of panel sizes, care model, and support staffing and so are not included in these overall tracking reports. As the graph below shows, the non-special populations clinics are making steady progress toward the goal of 1350 patients per clinical FTE.

A number of community-based clinics have already standardized their provider clinic templates. Primary Care leadership is working with the remaining clinics to adopt this best practice, a tactical solution that aims to enhance the efficiency of appointment scheduling by standardizing appointment duration, types and rules and that can facilitate the eventual transition of this responsibility to the SFHN Centralized Call Center.

According to a recent SFHN Office of Managed Care assessment, total enrollment into SFHN Primary Care has grown only modestly since the beginning of the year due largely to disenrollment offsetting
the monthly gains of new enrollees. Moreover, three operational challenges continue to negatively impact access despite there being additional primary care capacity:

- Hiring delays in support staff despite active engagement of Ambulatory and Primary Care leadership and DPH Human Resources;
- The continuing implementation of the Network’s electronic medical record throughout ambulatory care clinics, which predictably lead to a significant, but temporary, loss in clinic capacity;¹
- The lack of physical space at the higher in-demand clinics, especially SFGH General Medicine Clinic and Family Health Center.

4. **Implement a centralized call center**

Health care reform has created a more competitive health care market, and DPH must provide excellent customer service to maintain and grow its market share of primary care members. Timely telephone response is crucial to ensuring customer access, satisfaction, and loyalty. SFHN Primary Care patients have historically rated telephone access among the lowest across measures of customer satisfaction. Furthermore, health care reform has created new resource constraints, and DPH must improve financial and operational efficiencies to adapt successfully.

By absorbing the time-consuming tasks of answering phone calls for general inquiries and patient appointment scheduling, a Centralized Call Center (CCC) will help minimize no show rates by maximizing clinic efficiencies and continuity of care within the medical home, while enhancing the patient experience and benefitting from a multi-lingual CCC customer agent staff. Clinic staff will be free to focus on the provision of direct patient care services. A Call Center is also more cost efficient than having each site staffed with the necessary clerical support required for these functions.

Network and Ambulatory Care leadership are working closely with the Office of the Controller to operationalize this Health Reform Readiness recommendation. To date, a project charter, governance structure, and implementation team have been organized. Due to facility renovation, personnel hiring, and telecommunication technology dependencies, the CCC is projected to go-live in the spring of 2015 with the goals to:

- Provide excellent customer service as shown by increasing CG-CAPHS patient satisfaction scores by 25% from baseline
- Ensure access to care by improving call abandonment rate to industry gold standard of <5%
- Improve efficiency of operations by ensuring the CCC costs DPH less than staffing individual sites with adequate call takers

¹ In our experience with eClinicalWorks implementation, it takes typically 6 – 12 months for clinics to return to pre-launch capacity and productivity.
5. Implement nurse orientation clinics

Nurse Orientation Clinics (OC) have been used across SFHN primary care sites in various forms for many years, primarily focused on providing a prompt and patient-centered entry point of care in the new medical home. For the past few years, Chinatown Public Health Center (CPHC) has refined an OC model that is used primarily to manage new patient demand and expand PCP capacity. CPHC established workflows, standing orders, and scheduling templates to accommodate all new patients requesting service. Two years ago, CPHC began working closely with the New Patient Appointment Unit (NPAU) to respond in real-time to new patient requests by creating OC visits on demand.

As part of the Health Reform Readiness assessment, HMA interviewed key OC leaders within primary care and concluded that the OC model should be spread throughout SFHN Primary Care clinics. Metrics for OC expansion were delineated. Since the beginning of the year, all non-specialty populations, community-based primary care clinics have implemented a standardized OC model, achieving the following outcomes: 1) standardized OC workflows and standing orders have been developed, 2) all clinic RNs have been fully trained to practice within this model throughout Primary Care, 3) electronic medical record order sets and progress note templates have been created, and 4) standard scheduling templates and visit type coding rules have been defined.

Successes of Nurse Orientation Clinics:
New patient waiting list reduction. While there are many factors contributing to the reduction of the waiting list (including hiring additional providers), the OCs have played a large role. The number of new patients waiting for appointments improved from 654 on July 1, 2013 to 22 on September 18, 2014.
a) **Primary care integration and standardization.** The collaboration across Primary Care to standardize the process for bringing new patients into SFHN is unprecedented and sets the stage for ongoing standard work that we expect will significantly improve both staff and patient experience.

San Francisco Health Network Primary Care Weekly New Patient and Urgent Appt Access Report

<table>
<thead>
<tr>
<th>Date</th>
<th>New patient status</th>
<th>New patient waiting list</th>
<th>New patient appts available through end of October</th>
<th># of new patient appts made in August</th>
<th>Third Next Available new patient appt</th>
<th># of new patient appts available in September 2014</th>
<th># of NAL urgent appts needed, week before</th>
<th>% PCMH or Telephone Provider Appts, week before</th>
</tr>
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<tbody>
<tr>
<td>CMHC</td>
<td>0</td>
<td>22</td>
<td>59</td>
<td>9/19/2014</td>
<td>22</td>
<td>29</td>
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<tr>
<td>CPHC</td>
<td>0</td>
<td>16</td>
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<td>10/16/2014</td>
<td>0</td>
<td>12</td>
<td>92%</td>
<td></td>
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<tr>
<td>FHC</td>
<td>5</td>
<td>19</td>
<td>45</td>
<td>10/21/2014</td>
<td>1</td>
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<td>30%</td>
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<tr>
<td>GMC</td>
<td>0</td>
<td>129</td>
<td>113</td>
<td>10/15/2014</td>
<td>0</td>
<td>16</td>
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<td></td>
</tr>
<tr>
<td>MHHC</td>
<td>0</td>
<td>147</td>
<td>173</td>
<td>10/2/2014</td>
<td>1</td>
<td>7</td>
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<td></td>
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<tr>
<td>OPHC</td>
<td>0</td>
<td>84</td>
<td>142</td>
<td>9/23/2014</td>
<td>13</td>
<td>26</td>
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<tr>
<td>PHHC</td>
<td>0</td>
<td>159</td>
<td>105</td>
<td>9/22/2014</td>
<td>33</td>
<td>7</td>
<td>57%</td>
<td></td>
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<tr>
<td>SAHC</td>
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<td>8</td>
<td>49</td>
<td>10/28/2014</td>
<td>0</td>
<td>7</td>
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<tr>
<td>SEHC</td>
<td>2</td>
<td>0</td>
<td>123</td>
<td>none</td>
<td>0</td>
<td>20</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>TWUHC</td>
<td>15</td>
<td>0</td>
<td>26</td>
<td>none</td>
<td>0</td>
<td>3</td>
<td>67%</td>
<td></td>
</tr>
</tbody>
</table>

Note: While appointment access is limited at Tom Waddell Urban Health Clinic because they are now currently in eCW preparation, their medical home patients are always accommodated for drop-in/same day care.
6. Implement chronic disease visits staffed by registered nurses and pharmacists

Over the past year, Primary and Ambulatory Care leadership have invested time and resources to lay the groundwork for a quality improvement infrastructure that can fully engage all clinical staff, especially registered nurses and pharmacists, in the institutional priority of enhanced access to care. We developed and implemented two professional development programs for front line clinic staff and nurse leaders—Nursing Leadership Academy (NLA) and Quality Improvement 101 (QI 101).

In consultation with a national expert on registered nurse (RN) workforce development, the SFHN Primary Care Director of Nursing implemented a yearlong leadership and QI program for Primary Care nurses. The program focused on engaging RNs to understand and be prepared for ACA, lead QI projects, expand their clinical roles, and network across clinics in order to spread best practices.

The program included a half-day session every three months and four webinars. Topics included: a) vision and strategy, b) stakeholder engagement, c) change management, d) team management, e) data management, f) sustainability and spread, g) PDSAs, h) SMART goals and goal setting, and i) role clarification and accountability. RNs applied these skills by working on a Primary Care Improvement Project (PCIP). They developed SMART goals, conducted PDSAs, and presented posters summarizing their projects. This gave them opportunities to practice new skills and competencies while improving outcomes at their clinics.

Overall, 75 RNs from 13 clinics participated. RN teams completed 14 PCIPs that tackled improvements in patient access, clinical outcomes, medication refill processes, standing orders, and patient experience and education. Several projects that focused on enhancing non-provider visits are being considered for system-wide adoption. Nurse OCs for new patients, standing orders to support brief visits for simple acute complaints (i.e. dysuria, common cold), and protocols for emergency contraception are being spread throughout Primary Care.

The NLA facilitated the process of integrating Primary Care by creating opportunities for networking, forming peer-to-peer relationships, and sharing best practices. The NLA also increased visibility of the value of standard work for RN staff and leadership. An example of where this generated momentum for standardization is RN-led OCs where standardized workflows, orders and training were developed and implemented for all RNs in primary care. Plans are underway to standardize other workflows and templates that support RN-led visits. Another important outcome of this work is the development of Primary Care-wide Standardized Protocols for RNs, which reflect expansion of roles to include such activities as medication refills.

Pre/post-training assessments have demonstrated increases in RNs’ confidence and self-efficacy for all categories: their own ability to effect change and generate improvement ideas, team work, use of QI methods and data in improving patient care, and organizational savvy.
The trainings had a clear impact on participant self-efficacy in four categories:

<table>
<thead>
<tr>
<th>Impact Category</th>
<th>% of responses that are &quot;agree&quot; or &quot;strongly agree&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Training</td>
</tr>
<tr>
<td>Self-Efficacy - setting goals and leading improvement work</td>
<td>57%</td>
</tr>
<tr>
<td>Team Work - collaborative, shared purpose, healthy conflict, respect</td>
<td>42%</td>
</tr>
<tr>
<td>Quality Improvement - use of QI approach &amp; tools, use of data</td>
<td>44%</td>
</tr>
<tr>
<td>Organizational Savvy - understanding organization culture and managing up</td>
<td>55%</td>
</tr>
</tbody>
</table>

Statements with the most increase in participant-assessed confidence & self-efficacy included:

<table>
<thead>
<tr>
<th>Statement</th>
<th>% of responses that are &quot;agree&quot; or &quot;strongly agree&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving my professional goals is well within my reach</td>
<td>Pre-Training</td>
</tr>
<tr>
<td>Team members take time to examine evidence and test results before designing and implementing changes</td>
<td>60%</td>
</tr>
<tr>
<td>Studying, measuring, and improving care are essential parts of team members' daily work</td>
<td>Pre-Training</td>
</tr>
<tr>
<td>Team members often use QI tools and technology (i.e., PDSA cycles)</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>24%</td>
</tr>
</tbody>
</table>
Row 1: (left) Staff RNs present their Primary Care Improvement Projects at culmination of Nursing Leadership Academy. (middle) Participants practice conveying ideas and projection at Quality Improvement 101 “Train the Trainers” session. (right) Staff RNs participate in discussion on leadership skills and sustainability of QI efforts.

Row 2: (left ) Primary care clinic staff are engaged in tennis ball activity to learn about iterative PDSA cycles and measurement - "Tennis ball game helps me understand how the PDSA works in a fun way."(middle) Primary care clinic staff compiled Quality Improvement Tree with branches for the “Triple Aim” and improvement ideas on leaves. (right) Nurse leaders conducted role play during training to develop coaching skills.

Row 3: (left) Castro Mission Health Center receives Quality Award at second annual SFDPH Primary Care Quality Improvement Retreat in recognition of their ability to accelerate, innovate and lead QI. (right) Staff RNs collaborate at Nursing Leadership Academy to brainstorm Aim statements and SMART goals for their improvement projects.

To help sustain and spread the work of the NAL and Quality Improvement 101 initiatives to develop robust team-based care models, SFHN Primary Care was recently awarded a Blue Shield of California Foundation – Expanding Access Through Team Care Project grant. Over the next year with funding and technical assistance support, SFHN diabetic patients will be referred to RN and clinical pharmacist (PharmD) visits to coordinate individualized care plans. This project is focused on diabetes management to help build an infrastructure that will later support broader dissemination of RN/PharmD led visits for other chronic conditions.

7. Hire to fill vacant primary care provider positions

Over the past year, SFHN Primary Care leadership has invested significant time and resources in an effort to grow and sustain our primary care provider pool. This is essential in order to ensure that SFHN has sufficient capacity and access to new ACA enrollees. Our work thus far has included:

- Working with DPH Human Resources to improve hiring work flows
- Engaging with respective unions for physicians, nurse practitioners and physician assistants
- Contracting with a locum physician recruitment firm
- Hosting several medical residents recruitment events
- More actively recruiting interested physician and nurse practitioner candidates
- Instituting a Joy in Practice series aimed at new providers with a goal of retention through enhance provider well-being
Another critical factor to achieving high-functioning, primary care medical homes is robust team-based care, which depends heavily on well-trained clinical staff to work collaboratively with PCPs. We recognize that working in a true team-based care model is an essential component in sustaining our primary care workforce. The HMA Health Reform Readiness report recommended a staffing ratio of 4.5 FTE (full-time equivalent) to each primary care provider FTE, which SFHN has adopted as a Way Forward measure. In addition to aggressive efforts to recruit and hire PCPs, SFHN Primary Care leadership has invested equally in the recruitment and retention of support staff across multiple job classes (clerks, eligibility workers, health workers, medical evaluation assistants, registered nurses, nutritionists, pharmacists, medical social workers, health care analysts, behavioral health staff, and public service aides).

**FY13-14: SFHN Primary Care recruitment and hiring summary**

<table>
<thead>
<tr>
<th>Personnel Role</th>
<th>Number Hired</th>
<th>FTE Hired</th>
<th>Remaining FTE Vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>13</td>
<td>7.33</td>
<td>13.16</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>9</td>
<td>3.49</td>
<td>2.63</td>
</tr>
<tr>
<td>Support Staff</td>
<td>&gt;100</td>
<td>62.28</td>
<td>57.58</td>
</tr>
</tbody>
</table>

Lastly, SFHN Primary Care hired a handful of locum physicians over the past year to help with provider coverage at various clinics throughout the Network due to a very limited physician supply pool given the competitive, local and national health care environment. As we fill our PCP vacancies, we expect to phase out our reliance on contracted locum tenens physicians.

**8. Establish four health homes for integrated primary care and behavioral health care**

A behavioral health home (BHH) is a behavioral health clinic which provides whole-person (medical and behavioral) care for all individuals in that clinic. BHHs are the “next generation” of mental health and substance use disorder delivery organizations that address the whole health needs of target population. This is a significant culture change in the behavioral health care community and has prompted us to develop a partnership between SFHN Primary Care and Behavioral Health Services, expand role development, and reorganize behavioral health staff into teams where medical issues are regularly discussed and coordinated with Primary Care. This effort has meant addressing head-on many long-standing institutional barriers that have caused separation between the two services to create whole person care linkage models throughout the Network’s primary care medical homes (PCMH) and BHHs.
SFHN Behavioral Health Services and Primary Care have actively collaborated over the past year to forge four partnerships where primary care services are offered to behavioral health home clients at the familiar clinic where they are receiving behavioral health services and where they have developed trusting relationships with behavioral health providers: South of Market Mental Health Services (SOMMHS) with Tom Waddell Urban Health Clinic (TWUHC); Mission Mental Health Clinic (MMH) with Castro Mission Health Center (CMHC); Chinatown North Beach Mental Health (CTNB) with Chinatown Public Health Clinic (CPHC); and Sunset Mental Health Services (SMH) with Ocean Park Health Center (OPHC).

A Medical Director of Behavioral Health Homes, who is double-boarded in psychiatry and family medicine, was appointed in January 2014 to oversee the establishment of the four integrated clinics, develop the care model, and implement practice standards. This position reports directly to the SFHN Behavioral Health Services Chief Medical Officer with an indirect matrix report to the SFHN Director of Primary Care. Beyond forging the four partnerships, this team is creating a shared governance structure involving both Primary Care and Behavioral Health clinic leadership, defining the appropriate scope of services, addressing operational and logistic requirements, developing training plans for behavioral health staff to embrace expanded roles in medical services, engaging behavioral health providers to identify appropriate clients to receive such integrated services, incorporating primary care quality metrics, and formalizing an evaluation plan that assesses its effectiveness and impact.
In addition to providing whole person care for all clients, these four sites will each have a co-located primary care clinic to provide direct medical care services for the clients that are not able to connect to a traditional primary care clinic, usually due to serious mental illness. At this time two sites, South of Market and Mission Mental Health, are providing primary care on-site. South of Market has five clinics a week staffed by two Nurse Practitioners from their partner primary care clinic. Mission Mental Health provides one clinic weekly staffed by a combined primary care and psychiatry trained physician, who also is the psychiatrist on the Intensive Case Management team. Health Workers have been hired at both sites to provide medical assistant duties and serve as a care coordination liaison to the behavioral health staff. Mission Mental Health is in the final stages of a collaborative hiring process with Castro Mission Health Center to hire a shared Nurse Practitioner. The third site, Chinatown North Beach is in final planning stages with a target start date of January 2015. It has an NP from its partner clinic ready and has already hired a Health Worker. The fourth site, Sunset Mental Health, is set to begin services April 2015 and is in the final stages of both Health Worker and Nurse Practitioner hiring in collaboration with Ocean Park HC.

In 2011, South of Market Mental Health Services (SOMMHS) was awarded a Primary and Behavioral Health Care Integration (PBHCI) grant from Substance Abuse and Mental Health Services Administration (SAMHSA), a federal initiative meant to stimulate integrated care innovation. The four year grant funded the initial implementation of what is now the network’s flagship Behavioral Health Home. SOMMHS was chosen with the goal of targeting low-income, homeless and at-risk behavioral health clients, who are high utilizers of public crisis services, a population they are historically known for treating. The project has been particularly successful in addressing several areas that are critical in providing primary care for the seriously mentally ill (SMI). Specifically, they created a smoking cessation program, which has benefitted numerous clients as well as educating behavioral health staff to increase their confidence in treatment. They have generated many creative interventions to elicit referrals and engage the clients, some of whom are not always motivated for care. Perhaps most importantly, they have increased the number of their high-risk clients, who are receiving basic primary care screening and monitoring. This effort has helped the Network better understand the complicated process of establishing behavioral health homes, and despite working with a challenging cohort, has managed to provide full-service care while creating a template for the rest of the behavioral health homes to follow. Below is the June 2014 monthly dashboard from the SOMMHS tracking multiple outcome measures to assess the effectiveness and efficiency of its primary care services.
South of Market Mental Health Primary Care Clinic
Process Dashboard, June 30, 2014

333
total clients enrolled
(_met grant criteria & enrolled, 8/2012-present)

77
discharged

256
total active clients (currently enrolled in grant)

Completed vs. Cancelled Clinics

<table>
<thead>
<tr>
<th>2014 Q1</th>
<th>2014 Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>122</td>
<td>87</td>
</tr>
<tr>
<td>42.64%</td>
<td>60.87%</td>
</tr>
</tbody>
</table>

Productivity:

- Q3: 6.8 clients/clinics
- Q4: 5 clients/clinics

New Primary Care Patients
Oct 2013-June 2014

Engagement rate & Referral count
Oct 2013-June 2014

<table>
<thead>
<tr>
<th>FY 13/14</th>
<th>O1</th>
<th>O2</th>
<th>O3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals/month</td>
<td>18</td>
<td>24</td>
<td>18</td>
</tr>
<tr>
<td>Engaged/month</td>
<td>12</td>
<td>20</td>
<td>21</td>
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</table>

Engagement rate (%) clients referred who completed

- FY 13/14: 61%
- O1: 50%
- O2: 72%
- O3: 75%

Days to first appointment, new clients

- FY 13/14: 26 days
- O1: 23 days
- O2: 20 days

Grant Goals for Primary Care Patients

1. Regular appointments (every 6 months)
   - PBHCI Clients seen in Primary Care, last 7 months

2. Reassessment Surveys Completed
   - FY 13/14 Q1: 20
   - FY 13/14 Q2: 33
   - FY 13/14 Q3: 52
   - # Surveys Complete
   - FY 13/14: 20
   - FY 13/14 Q1: 33
   - FY 13/14 Q2: 52
   - Goal: 100%
   - % Complete, SF PBHCI: 52%
   - % Complete, National PBHCI: 62%

3. Fasting Labs (annual & vitals (every 6 months))
   - FY 13/14 Q1: 63%
   - FY 13/14 Q2: 74%
   - FY 13/14 Q3: 78%
   - Vitals recorded, goal = 100%
   - Blood pressure, goal = 80% (87%, 89%)
   - BMI, goal = 80% (65%, 89%)
   - Labs recorded, goal = 90%
   - HgbA1c, goal = 80% (78%, 80%)
   - Fasting insulin, goal = 90% (78%, 80%)

Prepared by Alice Gill 11/2010 | alice.gill@sfph.org | 415-255-6663

22
9. **Address physical plant improvements and identify, budget, and implement information technology needs**

To assure accountability, Ambulatory Care leadership has engaged and forged partnerships with leaders from DPH Human Resources, Facilities, Occupational Health, Information Technology (IT), and Business and Finance to create a responsive oversight structure that can help address underlying infrastructural issues that were highlighted in the Health Reform Readiness report. We have appointed four active workgroups: Business Intelligence and Performance Improvement, IT Infrastructure, Facilities and Occupational Health, and Workforce Development. Each workgroup is co-chaired by an Ambulatory Care leader and a lead from one of the four operational units, meets monthly and reports to the Ambulatory Care executive leadership group every four months. In September 2014, Ambulatory Care leadership convened a retreat, where all four workgroups came together to develop workgroup charters, membership, communication channels, and expected deliverables for the upcoming year to help Ambulatory Care achieve stated priorities.
Ambulatory Care Operational Infrastructure Committee

**Committee Charge (Purpose)**
- Develop an accountability structure to ensure deliverables and priorities set forth by each of four operational infrastructure workgroups are on time and on budget
- Provide project management oversight in each of the four operational infrastructure workgroups
- Develop processes to complete rapid root cause analysis and troubleshooting for solutions
- Identify local champions and essential resources to spread best practices and solutions
- Track risks that may hinder the completion of project plans and escalate or engage appropriate stakeholders to find alternative solutions
- Develop communication strategies that can engage relevant staff at the appropriate time

**Membership:**
**Standing Members: (attends every month)**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>Jo Robinson, Irene Sung, Gloria Wilder, Edwin Batongbacal, Ken Epstein, Deborah Sherwood,</td>
</tr>
<tr>
<td>Jail Health Services</td>
<td>Joe Goldenson, Frank Patt</td>
</tr>
<tr>
<td>MCAH</td>
<td>Mary Hansell, Josh Nossiter</td>
</tr>
<tr>
<td>Primary Care</td>
<td>Hali Hammer, Bill Blum</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>Albert Yu, Toni Rucker, Lisa Golden, Leslie Dubbin, Michelle Ruggels, Trever Pearson, Wesley Chow</td>
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**Operational Infrastructure Workgroup Members:**

**Workforce Development**

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<tr>
<td>Ambulatory Care</td>
<td>Toni Rucker, Elaine Lee <em>(co-chairs)</em></td>
</tr>
<tr>
<td></td>
<td>Amy Petersen, Norman Aleman, Greg Cutcher, Frank Patt, Hali Hammer, PC Director of Operations, Judith Sansone, Ken Epstein, Michele Sampogna, Marlo Simmons, Catherine James,</td>
</tr>
<tr>
<td>DPH and other SFHN Divisions</td>
<td>Elaine Lee, Leslie Holpit, Gillian Otway, Kathryn Horner, Jonathan Fuchs</td>
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**Business Intelligence & Performance Improvement**

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<td>Ambulatory Care</td>
<td>Lisa Golden, Deborah Sherwood <em>(co-chairs)</em></td>
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<tr>
<td></td>
<td>Ellen Chen, Alice Gleghorn, Kellee Hom, Joshua Nossiter, Michael Marcin, Ryan Shackelford, Hamilton Holt, Winnie Tse, Amy, Petersen, Jonathan Albright, Rani Marx, Linda Burgest, Hali Hammer, PC Director of Operations, Anne Hirozawa, Monica Rose</td>
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<tr>
<td>DPH and other SFHN Divisions</td>
<td>Baljeet Sangha, Kimvan Nguyen, Tina Lee, Shameem Mohamed, Pablo Munoz, Diana Guevara, Stella Cao, Ann Okubo, Chona Peralta, Maria Barteaux, Kathryn Horner, Jenny Louie, Dirk Schwarzhoff</td>
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**Facilities and Occupational Safety and Health**

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<td>Ambulatory Care</td>
<td>Tyrone Navarro, Vicki Wells, Diana Kenyon <em>(co-chairs)</em></td>
</tr>
<tr>
<td></td>
<td>Marise Rodriguez, Frank Patt, Josh Nossiter, Hali Hammer, PC Director of Operations, John Grimes, Max Rocha</td>
</tr>
<tr>
<td>DPH and other SFHN Divisions</td>
<td>Karen Heckman, John Lee, Shawn Holle, Lann Wilder, Max Bunuan, Security Program Manager, somefrom IT networks unit</td>
</tr>
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</table>
10. Implement ambulatory performance improvement process, leadership and teams

The Ambulatory Care Chief Quality Officer has been appointed with the charge to:

- Work with each Ambulatory Care section’s performance improvement lead and structure to ensure SFHN priorities and section-specific regulatory mandates are optimally aligned;
- Ensure that AC staff and quality improvement leaders have the skills, resources, and mindset to practice daily continuous improvement;
- Introduce and implement improvement methodologies such as Lean Management Systems as standard operating practice.

To support this work, the Ambulatory Care Performance Improvement Committee (ACPI) will serve as the primary liaison between Ambulatory Care and all its sections to SFHN and DPH-wide performance accountability structures including, but not limited to, DPH Business Intelligence Unit, SFGH Kaizen Promotion Office, DPH Data Center and IT reporting team, and DPH budget and business office.

Over the coming year, Ambulatory Care leadership and the ACPI committee will work with each section to develop a balanced scorecard with performance measures on clinical outcomes, operational efficiency, patient experience, and finance and resource utilization. These dashboards will roll up to SFHN Way Forward measures and strategic priorities, as well as drill down to each section, unit, or program.

Conclusion

Since the formation of the SFHN Ambulatory Care Division in late 2013, its leadership has prioritized building an accountable governance structure with performance targets; recruiting a talented team of senior executives; maintaining discipline to ask often how and where we should integrate clinical programs in order to add value to patients and clients; and most importantly, addressing access, capacity and timely new patient enrollment in a concerted manner, competing to be the health care system of choice to San Franciscans. It is equally important to note that while Ambulatory Care has prioritized access, capacity and financial sustainability over the past year, Ambulatory Care continues to excel in its clinical quality performance when compared with external benchmarks, as illustrated in the chart below. Moreover, it is actively planning to create an Ambulatory Care Population Health Center to better serve all SFHN enrollees to improve their overall health status, optimize their utilization of appropriate services, and enhance their experience with the SFHN delivery system.
Breast Cancer Screening is a Big Aims/Way Forward measure, with somewhat different denominator so these don’t match.

Data from i2i registry 8.31.2014 (excluded CHPY and Positive Health Program)

** Breast Cancer Screening is a Big Aims/Way Forward measure, with somewhat different denominator so these don’t match.**
NEEDS ASSESSMENT OF SFGH MEDICAL & SURGICAL SUBSPECIALTY CLINICS

Prepared by:
THE SFGH AMBULATORY INTEGRATION TEAM

Authors:
Lukejohn Day, Kathryn Horner, Marika Russell, George Su, and Alice Chen
ACKNOWLEDGEMENTS

We thank the following for their efforts and time to help create this document:

Donald Abrams, Erin Amerson, Maribel Amodo, Brian Bast, Igor Berman, Sarah Blaschko, Sean Braden, Benjamin Breyer, Rosaly Ferrer, Kathleen Flanagan, Juliann Fusaro, Nora Goldschlager, Mary Gray, Scott Hansen, Claude Hemphill, John Imboden, Rebecca Jackson, Sam James, Cheryl Jay, Bennie Jeng, Mary Ellen Kelly, Sarah Kim, Peggy Knudson, Jim Larson, Brad Lewis, Judith Luce, Jacquelyn Maher, Geoff Manley, Toby Maurer, Ted Miclau, Lisa Murphy, Andrew Murr, Payam Nahid, Dana Nelson, Jan Ong, Jennifer Park, David Pearce, Diane Putney, Laura Salcido, Neel Singhal, and Brenda Stengele

Data provided by Harriet Ashley, Tom Holton, and Juliana Oronos
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Purpose and Overview</td>
<td>2</td>
</tr>
<tr>
<td>II. Summary of Results</td>
<td>4</td>
</tr>
<tr>
<td>III. Data Collection and Analysis</td>
<td>5</td>
</tr>
<tr>
<td>IV. Key Themes From Interviews</td>
<td>7</td>
</tr>
<tr>
<td>V. Proposed Next Steps in Addressing Subspecialty Needs</td>
<td>13</td>
</tr>
<tr>
<td>Engage in Data-Driven Planning</td>
<td>14</td>
</tr>
<tr>
<td>Maximize Operational Efficiencies</td>
<td>19</td>
</tr>
<tr>
<td>Commit to Service Excellence</td>
<td>26</td>
</tr>
<tr>
<td>Prepare for Healthcare Reform</td>
<td>33</td>
</tr>
<tr>
<td>VI. Conclusion</td>
<td>40</td>
</tr>
<tr>
<td>VII. Appendices</td>
<td>41</td>
</tr>
</tbody>
</table>

Needs Assessment of SFGH Medical and Surgical Subspecialty Clinics, 2013
I. PURPOSE AND OVERVIEW

Purpose

The purpose of the needs assessment for the San Francisco General Hospital (SFGH) medical and surgical subspecialty clinics is to identify opportunities for enhancing clinical quality, operational efficiency, and patient experience.

Overview

San Francisco General Hospital serves as the primary source of specialty care for the City’s 60,000 uninsured, as well as for many of its Medicaid and Medicare patients. Many of our subspecialists are internationally and nationally recognized for their patient care, teaching, and research. The physicians, nurses, and staff in each subspecialty clinic demonstrate a commitment to and passion for providing care to the underserved that is readily apparent.

In the context of healthcare reform, the San Francisco Department of Public Health (DPH) and SFGH are facing a rapidly changing healthcare environment, with new payment models, an increased emphasis on measurement and accountability, and a strong focus on patient experience. In order to meet these challenges, the DPH and SFGH are committed to developing an integrated delivery system for the San Francisco safety net. Given the important role specialty care plays in our healthcare delivery system, the goal of the needs assessment was to identify challenges that need to be addressed for
specialty care to operate as part of a highly functioning integrated delivery system. Over the course of four months, the SFGH Ambulatory Integration Team gathered baseline data and conducted in-person meetings with each of the 26 subspecialty clinics’ medical directors and nurse managers. We identified priorities based on issues mentioned consistently across clinics, issues raised by a subset of clinics, and campus-wide initiatives that will require support for successful implementation.

Based on our analysis, we developed an action plan for the next 18 months with four overarching themes:

**SFGH Medical and Surgical Subspecialty Clinics Needs Assessment: Four Plan of Action Themes**

1) Engage in data-driven planning
2) Maximize operational efficiencies
3) Commit to Service Excellence
4) Prepare for healthcare reform

The analysis and interpretation of the data collected was performed by the SFGH Ambulatory Leadership Team: Lukejohn Day, Kathryn Horner, Marika Russell, George Su, and Alice Chen.
II. SUMMARY OF RESULTS

SFGH subspecialty clinics consistently reported two top priorities: 1) delivery of high quality care to patients and 2) offering an outstanding educational experience to trainees.

The perceived culture among the clinics was described as “diverse, dedicated, and fun” but at the same time, was noted to be “chaotic, complicated, frustrating, and overwhelming.” The latter description stems from operational inefficiencies, poor access and impaired patient flow. All clinics were keenly aware of the challenges they faced in terms of staffing, facilities, and patient flow, but there was significant heterogeneity in how these challenges were addressed.

Medical subspecialty clinics included in this needs assessment were Cardiology, Dermatology, Diabetes, Endocrinology, Gastroenterology, Hematology, Hepatology, Nephrology, Obstetrics & Gynecology, Oncology, Pulmonary, and Rheumatology. Surgical subspecialties included General Surgery, Neurosurgery, Ophthalmology, Oral Surgery, Orthopedic Surgery, Otolaryngology, Plastic Surgery, Urology, and Neurology (grouped with the surgical specialties due to its location in 4M clinic). Of note, primary care clinics (Children’s Health Center, General Medicine Clinic (GMC), Family Health Center (FHC), and the Positive Health Program) and the Urgent Care Center were not included in this needs assessment, as their roles in the health system are qualitatively different. Also, pediatric subspecialty clinics were not included because their operations and medical oversight are intimately linked with the pediatric primary care clinic.
III. DATA COLLECTION AND ANALYSIS

Data collection for the medical and surgical subspecialty needs assessment occurred in three phases that spanned four months (July-October 2012):

**Phase 1: Baseline Operational Data**

In this phase, we collected information on the current operations of each subspecialty clinic by distributing a survey to the nurse manager, division (for medical subspecialties) or service chief, and clinic chief. Questions focused on leadership; clinic staffing; facilities, including location, clinic layout, number of clinic rooms, and equipment used; number and structure of clinics; and operational and clinical metrics tracked.

**Phase 2: Clinic Leadership Interviews**

This phase involved an hour-long interview with each subspecialty clinic leadership team (nurse manager, charge nurse, division or service chief, and clinic director). Each interview was conducted by two members from the ambulatory integration team. These interviews focused on the clinic leadership team’s priorities and perceived challenges for the clinic, staff culture, patient satisfaction, workforce, workflow, teamwork, care coordination, and CareLinkSF (eClinicalWorks™) preparedness. As a follow-up to these interviews, we visited each clinic and interviewed key staff members and observed patient flow and clinic workflows.
**Phase 3: Patient Experience**

The final phase of the needs assessment involved interviews assessing patient experience in the subspecialty clinics. We met with the Family Health Center (FHC) Patient Advisory Boards (one in English, the other in Spanish) to learn about patient experiences with SFGH subspecialty clinics. Discussion questions focused on expectations for subspecialty clinic visits, experiences with clerical and registration staff, interactions with providers, and clarity of communication regarding care plans. We also attended the CARE program held at the Wellness Center and asked for volunteers to share their experiences with us. We spoke with five CARE patients via telephone about their experiences in SFGH subspecialty clinics; each phone call lasted approximately 10-15 minutes.
IV. KEY THEMES FROM INTERVIEWS

Concerns Raised Consistently Across Clinics

1. LACK OF SPACE

Inadequacy of space was a common theme for both medical and surgical clinics. Most felt their capacity was limited by the NUMBER OF EXAM ROOMS that were consistently available. In many instances, there were multiple clinics operating at the same time in the same location with shared rooms and staffing.

2. IT INFRASTRUCTURE

Patient flow and efficiency within clinics is limited by INADEQUATE IT INFRASTRUCTURE such as a lack of functional computers, printers, phones, Polycom® devices, and Videoconferencing Medical Interpreting (VMI) machines. Additionally, many clinics need access to UCSF Medical Center’s electronic medical record for coordination of care but have limited to no access.

3. HUMAN RESOURCES

A majority of clinics expressed a desire for INCREASED COLLABORATION WITH SFGH HUMAN RESOURCES. They requested additional guidance and assistance from the SFGH Human Resources department in prioritizing, posting, advertising, interviewing and hiring for vacant positions. This is most pronounced for clerical and nursing positions.
In addition to having difficulty with hiring nurses and clerks, a number of clinics expressed concerns about insufficient attending staffing within their respective clinical areas. Many services highlighted their reliance on volunteer faculty to help fill the gaps created by the lack of physicians. Some felt that insufficient attending staffing may contribute to increased wait times. Additionally, they felt this issue negatively impacts physician morale and limits flexibility in scheduling and coverage.

4. **Interpreter Services**

For the surgical clinics in particular, access to interpreter services was cited as a major barrier to patient flow. The lack of Polycom™ devices and long wait times for interpreters is felt to significantly slow patient care. The skill level and accuracy of interpreters was questioned by some. Also, patients mentioned other problems, including clinic staff making assumptions about their preferred language.

5. **Care Coordination**

There is no consistent mechanism for care coordination. The four priorities that were identified in this area included: 1) continuity of subspecialty care for clinic patients (given that many clinics only occur once or twice a week and that clinics need to respond to patient needs between clinics as well as after hours), 2) pharmacy management/authorization, 3) tracking/follow-up of referrals for diagnostic studies, procedures and clinical consultations, and 4) communication and coordination with primary care/referring providers.

6. **No-show Rate**

There is a high and unpredictable patient no-show rate that creates significant inefficiencies and uncertainty in terms of clinic staffing and patient scheduling. Many clinics “schedule to the no-show rate”, i.e. they overschedule patients with the expectation that a certain number of patients will not show. While this is true on average, this creates a “feast or famine” experience. Interestingly, amongst the medical subspecialty clinics, the perceived no-show rate was estimated at 45% while the measured no-show rate ranged from 13% to 43% (average 29%).
7. **Scheduling Templates**

Scheduling templates are poorly designed. Clinics do not schedule patients realistically. For example, in most clinics, all patients are scheduled for the same amount of time even though the length of visit can vary significantly between new and follow-up encounters (as little as 5 minutes for a follow-up and up to an hour for a new patient). Furthermore, in some clinics, patients are batched at the beginning of the clinic with appointment slots only available during the first 1.5 hours of clinic. Many patients we spoke with mentioned having long wait times to see a provider (1-2 hours) on the day of their appointment.

**Issues Observed by a Subset of Clinics**

8. **Poor Physical Layout and Appearance**

Poor layout and overall appearance of facilities in some clinical areas create physical barriers for patient access to clinics and a difficult working environment for staff. This theme was most prominent amongst the medical subspecialties housed in Ward 92. As stated by some staff members, the clinic facilities are “outdated and grossly inadequate…the infrastructure is so poor as to be demoralizing to patients, physicians, and nursing staff alike,” and “we are overlooked and overbooked.” Operational inefficiencies include stairwells being inaccessible, inadequate equipment (e.g. lights) in exam rooms, unkempt and small exam rooms, damaged facilities (e.g. inability to close windows), and an insufficient number of computers, printers, and phones for the staff and providers.

9. **Staff Performance Variability**

In the surgical clinics, and some medical clinics, there is significant variability in staff performance, which is perceived to result from a lack of standard work and employee turnover. This leads to inconsistent or inadequate preparation for patient visits. For example, charts are not prepared, necessary equipment is not available, or patients are not properly prepared for an examination; this lack of preparedness results in inefficient provider visits and longer wait times for patients. While many clinic leaders praised their staffs for maintaining clinic flow, there was also a sense that their staff were “stretched in too many different directions.”
Campus-wide Initiatives Impacting All Clinics

10. **Service Excellence**

Clinics have no mechanism to measure patient satisfaction other than using patient complaints (written or verbal). While many clinics voiced that they “would like patients to choose their clinic” or to be “the number one clinic,” they speculate that patients would rate clinics poorly in terms of patient wait times and flow. The patients we spoke with were generally satisfied with their care, but did highlight some difficulties. First, the registration process varied at each clinic and could be confusing during a patient’s first visit. Second, the friendliness of staff varied, with accounts of both positive and negative experiences. Third, care and communication by providers was generally positive, although a number of instances of poor communication and a lack of shared decision-making were voiced by our patients. Fourth, patients reported being misinformed about services available at SFGH. Our team believes this stems from lack of readily available information about our services across campus as well as inadequate orientation for new trainees or hires about our system. In one case, a patient regularly came to SFGH for injections, incurring time and travel expenses. Only after she took initiative to ask whether she could self-administer the injections was she shown how to do so.

11. **CareLinkSF (eClinical-Works™) Implementation**

Most clinic leadership teams were aware of eClinicalWorks™ and expressed high expectations that it would improve care coordination. However, they also voiced many concerns. Specifically, clinic leaders expressed apprehension that electronic medical record implementation would impede clinic flow, reduce provider interaction with patients, increase wait times (due to reduced capacity), cause provider and staff burnout (particularly if capacity is not sufficiently reduced), and would increase fragmentation of care due to lack of interoperability with the UCSF Medical Center. Many raised concerns about whether or not dictation would be available. Clinics appeared uninformed about the implementation process in terms of implementation date, identifying a clinical champion, and pre-implementation preparation.

12. **Planning for Ambulatory Center**

Few of the subspecialty clinics, aside from procedural or inpatient-based
services, will be relocated to the new hospital. Clinics felt strongly that they would like to be included in planning for any new ambulatory center. Additionally, common themes emerged about the need for “subspecialty homes” (i.e. dedicated space, staff, equipment focused on each subspecialty in one central location that can deliver coordinated and comprehensive care), co-location with other services and a physical infrastructure that meets the needs of individual clinics and their patients.

13. **Timely Access Standards**

The California Department of Managed Care has issued regulations stipulating that all managed care patients receive specialty appointments within 15 business days of a request for an appointment. While eReferral has significantly improved wait times, allowed for transparent triage, and enhanced documentation for the referral process, there is uncertainty as to whether eReferral meets the timely access regulations. Clinics that provide robust co-management support and timely triage for urgent cases using eReferral may be able to justify longer wait times for routine clinic appointments.

14. **Incentive Payments**

SFGH now has several new incentive payment programs where full payment is contingent on meeting defined milestones or metrics. Besides the Centers for Medicare and Medicaid Services Incentive Plan (CMSIP), which encompasses a possible $270 million in payment over five years, San Francisco Health Plan has implemented a performance incentive program (PIP) for subspecialty clinics through the Clinical Practice Group (CPG), and the Department of Public Health has initiated its own performance incentive plan through the affiliation agreement. Most subspecialty clinics were unaware that these new incentive programs are currently in effect.

Specific quality improvement (QI) projects that will be part of the SFHP incentive payment program include:

- **DEVELOPING CLINICAL REGISTRY AND POPULATION MANAGEMENT SYSTEMS FOR AT LEAST ONE SUBSPECIALTY CLINIC**

- **IMPLEMENTING DASHBOARDS FOR SUBSPECIALTY CLINICS INCLUDING CLINICAL AND OPERATIONAL METRICS**

- **IMPLEMENTING SERVICE EXCELLENCE TRAININGS FOR PHYSICIANS**

- **IMPLEMENTING PATIENT SHADOWING IN SUBSPECIALTY CLINICS**
15. **Attending Supervision and Documentation**

There is significant variation in the level of supervision provided to trainees (medical students, residents, and fellows) during subspecialty clinics. For example, in some subspecialty clinics, an attending physician will see and examine every patient when a trainee is involved, whereas in other clinics an attending physician will discuss patients with trainees without any direct face-to-face time with the patient.

Attending documentation also varies from clinic to clinic. Such inconsistency is not only confusing for patients but also has financial implications. CMS requires direct attending involvement and documentation for all Medicare patients, and the California Medicaid program has similar requirements for unlicensed physicians. SFGH is currently unable to bill for up to 40% of visits in some clinics due to lack of attending supervision and documentation. Equally important, variable attending oversight impacts both quality of education and patient satisfaction. Moreover, in the vast majority of cases, clinic leadership and providers across clinics were not aware of these documentation regulations and possible financial impacts and
V. PROPOSED NEXT STEPS IN ADDRESSING SUBSPECIALTY NEEDS

Given the wide variation and differing levels of complexity noted in both our needs assessment and gap analysis of subspecialty clinics, we identified four core areas that need to be addressed in order to successfully move forward. Within each of these themes we tackle specific issues raised during our assessment and then propose action items to begin addressing them.

SFGH MEDICAL AND SURGICAL SUBSPECIALTY CLINICS NEEDS ASSESSMENT: FOUR PLAN OF ACTION THEMES

1) Engage in data-driven planning
2) Maximize operational efficiencies
3) Commit to service excellence
4) Prepare for healthcare reform
ENGAGE IN DATA-DRIVEN PLANNING

Most subspecialty clinics are operating with a dearth of timely, relevant, actionable data on both clinical and operational fronts. Our goal is to strengthen our system’s use of data for both planning and assessment. Our plan is to develop metrics that can inform operational and quality improvement, as well as support data-driven decision making.

Data for Operational and Clinical Improvement

Over the coming year, we plan to develop data dashboards with basic operational metrics such as the number of patients seen per clinic, patient show rates, clinic cancellations, telephone access, and appointment wait times. Working with clinic leadership, we will also develop clinical metrics that can be used to drive quality improvement.

Goals 2013
Data for Operational and Clinical Improvement:

- By June 2013 develop the operational metrics for subspecialty clinic data dashboards
- By December 2013 engage the subspecialty clinic leadership in defining relevant clinical metrics

Utilize data dashboards to systematically collect data and use this for operational and quality improvement
Data for Planning

Over three-quarters of our clinic leadership cited space constraints as a key factor limiting their ability to see more patients and increase access to subspecialty care. While the hope is that space constraints will be alleviated when the new hospital opens, in the meantime there is a pressing need to plan space more judiciously.

We recognize that it is challenging and difficult to quantify space allocation and utilization across clinics due to important operational differences, including the types and complexity of encounters, length of time required for an encounter, attending and trainee staffing, and variation in room utilization (even within a given subspecialty clinic).

Our goal was to document the current variation in staffing ratios, provider capacity, and space availability across SFGH subspecialty clinics (Appendix A). However, we need data to guide investments in clinic staffing and space.
GOALS 2013
DATA FOR PLANNING

- By May 2013 identify benchmarks used for monitoring space utilization and provider capacity in healthcare settings especially within public hospitals
- By July 2013 systematically collect data on available resources used in subspecialty clinics (rooms available, providers, staff)
- By October 2013 develop benchmarks for optimal space utilization at SFGH
- By January 2014 develop benchmarks for provider capacity at SFGH
Future Planning and Organizational Design of Clinic Space

The opening of the new hospital has created a great deal of excitement amongst SFGH staff and patients. Services that will move into the new hospital have been clearly defined and space allocation is well documented. Conversely, the process for space allocation for those services that will remain in the older SFGH facility remains unclear.

**GOALS 2013**
**FUTURE ALLOCATION AND ORGANIZATIONAL DESIGN OF CLINIC SPACE**

- By September 2013 convene an SFGH Ambulatory Center Advisory Committee in partnership with the SFGH Facilities and Rebuild leadership
MAXIMIZE OPERATIONAL EFFICIENCIES

Our subspecialty clinics have a number of opportunities for operational improvements. In addition to developing operational dashboards to inform improvement efforts, we plan to identify and spread “best practice” solutions across our institution.

No-show Rates

No-show rates vary significantly, and range from a low of 12.6% to a high of 42.9% (Figure 1). The mean no-show rate for both medical and surgical subspecialty clinics is 28.5%.

Several subspecialty clinics have implemented strategies aimed at addressing high no-show rates. These have included calling patients in advance, reducing wait times (which have been shown to decrease no-show rates) by reserving clinic slots for urgent cases, or developing non-clinic-visit models for patient education. While some clinics have noted a slight increase in patient attendance with these efforts, the impact on patient show rates has generally been small.

Our team has developed a root-cause analysis (Figure 2), which we will bring to the No-Show Taskforce for feedback. Through this Taskforce, we will identify key factors to address. Of note, we have identified several promising practices involving scheduling, templates, and patient phone access that deserve further evaluation, and if appropriate, dissemination.
Figure 1
Maximize Operational Efficiencies: Clinic No-Show Rates

1  Fiscal year July 2011-June 2012. Data obtained from Invision using clinic resource codes
2  Optometry included in Ophthalmology
3  Podiatry included in Orthopedic Surgery
4  Cardiothoracic Surgery included in General Surgery
High No-show Rates

- Appointments scheduled without input from patients about availability
- Reminder phone calls done inconsistently and not according to best practices
- Appointment letters returned because of inadequate or out-of-date demographics
- Culture of arriving early in order to be seen on a first-come, first-served basis
- Phone access for patients to reschedule appointments is inconsistent
Scheduling Templates

There are a large number of scheduling templates used by both medical and surgical subspecialty clinics, with little standardization. Presently, each subspecialty is assigned one or more CLINIC CODES, creates its own RESOURCE CODES for individual providers or groups of providers, and develops TEMPLATES comprised of individual appointment slots that are assigned a time, duration and ACTIVITY TYPE (e.g. follow-up, new).

Higher numbers of activity types and templates increases the risk of scheduling errors and results in more difficulty managing clinic scheduling. As an example, there is wide variation in time allocated for follow-up visits (range of 5-30 minutes) and new patient visits (range of 15-60 minutes). In addition, there is significant variability in the use of provider-specific resource codes, which results in patients seeing a different specialist each time they present to clinic, undermining continuity of care for both patients and providers.
Presently, there is a lack of standard work in how our clinics schedule patients. Our team will work with the leadership of each clinic to document its current activity types, templates and resource codes. We plan to streamline, condense, and standardize templates and activity types, as well as explore increasing the use of provider-specific resource codes to improve continuity of care for patients in subspecialty clinics. Critically, these improvements should occur prior to eClinical-works™ implementation in each clinic.

Ideally, our clinics would be scheduled as shown in Figure 3.

<table>
<thead>
<tr>
<th>GOALS 2013</th>
<th>SCHEDULING TEMPLATES</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ By June 2013 map out scheduling templates, clinic codes, resource codes, and activity types, for each subspecialty clinic in preparation for eClinicalworks™ implementation</td>
<td></td>
</tr>
<tr>
<td>■ By August 2013 develop guidelines for optimal use of scheduling templates, clinic codes, and resource codes</td>
<td></td>
</tr>
</tbody>
</table>
**ACTIVITY CODES**

Identify activity types (e.g. RF, AO, FU) with longer/shorter visit lengths

Schedule each activity type for the expected (and realistic) length of time

Minimize the number of activity types to streamline

**TEMPLATES**

Templates should describe how many, when, and what types of visits that one provider will see during a clinic session

Creates uniform expectations for productivity across providers

Empowers clinic leadership to control workflow

**RESOURCE CODES**

One per provider

If a clinic session adds a provider, a clinic clerk should add a resource code for that provider, along with the provider’s template
Interpreter Services

Approximately one third of our patients are limited English speaking, requiring interpreter services in over 35 different languages. Access to interpreter services can be difficult and inconsistent. The types of interpreter services used vary greatly and include in-person interpreters, bilingual staff, videoconference medical interpretation (VMI), Polycom® devices, and traditional speakerphones. While utilization of a trained in-person interpreter is often ideal, given the tremendous demand, technology and remote interpreting are necessary to leverage our existing pool of resources.

**Goals 2013**
**Interpreter Services**

- By June 2013 share via the ambulatory website standards for identifying patient language preference and guidance for use of interpreter service modalities
Lack of interpreter access

- Lack of guidelines about which interpreter services are best for patients meeting certain criteria
- Providers, and especially new trainees, unsure how to effectively use an interpreter
- No standards for when to assess a patient’s preferred language
- Equipment malfunction
- Equipment not always set up in room for provider
COMMIT TO SERVICE EXCELLENCE

Service Excellence describes the ability of a healthcare organization and its staff to consistently meet and manage patient expectations in a responsive, professional and respectful manner. A commitment to Service Excellence is critical for any high functioning healthcare delivery system. This commitment encompasses not only a focus on patient satisfaction, but also on staff experience.

Patient Experience

Improving patient experience is a key institutional priority: we need to transform SFGH from a “provider of last resort” to a “provider of choice.” In order to do this effectively, we need data to identify improvement targets, engage staff and providers, and track progress. Currently there is no systematic way to assess patient experience in the subspecialty clinic arena. Some clinics use patient grievances as a proxy, while others track telephone abandonment rate (the percentage of inbound phone calls made to a call center or service desk that are abandoned by the customer before speaking to an agent) as one narrow measure of patient experience (Table 1 and Appendix C).

Our longer term goal is to use the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) across all subspecialty clinics. This year we were able to identify funding for a smaller group of five clinics which were chosen to represent a range of medical and surgical subspecialties.
To augment the surveys, we are pursuing a number of alternative options, including implementing a patient shadowing initiative as part of the SFHP CPG physician incentive payment program, and piloting a “poker chip” patient satisfaction project where patients are asked to deposit a poker chip in a box indicating whether they would recommend the clinic to their family and friends. The goal behind this last project is to collect patient experience data in a tangible, immediate fashion that increases staff engagement.

**GOALS 2013**

**PATIENT EXPERIENCE**

- By May 2013 implement CG-CAHPS in at least 5 specialty clinics
- By June 2013 support at least three clinics in completing a patient shadowing experience
<table>
<thead>
<tr>
<th>Clinic</th>
<th>Total number of incoming calls</th>
<th>Abandoned call rate (%) (total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5M</td>
<td>5,274</td>
<td>20% (1,041)</td>
</tr>
<tr>
<td>1M³</td>
<td>1,843</td>
<td>3% (54)</td>
</tr>
<tr>
<td>3M⁴</td>
<td>3,753</td>
<td>4% (139)</td>
</tr>
<tr>
<td>Ward 92⁵</td>
<td>1,954</td>
<td>8% (161)</td>
</tr>
<tr>
<td>1N⁶</td>
<td>1,533</td>
<td>2% (26)</td>
</tr>
<tr>
<td>3D⁶</td>
<td>1,511</td>
<td>3% (50)</td>
</tr>
<tr>
<td>4M⁶</td>
<td>3,340</td>
<td>4% (122)</td>
</tr>
</tbody>
</table>

1 Phone call data not yet available for 6G
2 Recorded for the month of January 2013
3 Cardiology, Diabetes, Pulmonary, and GMC
4 General Surgery, Breast Clinic, Plastic Surgery, Urology, Orthopedic Surgery, and Vascular Surgery
5 Dermatology, Rheumatology, Nephrology, Pain Clinic, Diabetes, Endocrine, Urgent Cardiology, and Lipid Clinic
6 1N, 3D, and 4M data collection began 11/22/2012
**Staff Experience**

Results from recent staff satisfaction surveys highlight significant variation across parameters surveyed (Appendices D and E):

- **Most clinics score highly on teamwork, but the range was 44% to 96%**

- **Responses to the question “I know exactly what is expected of me at work” ranged from 50% to 84%**

- **Responses to the question, “I always have the opportunity to do what I do best every day” ranged from 25% to 74%**

- **Agreement with the statement, “We have enough staff to handle the workload” ranged from 0% to 71%**

- **Agreement with the statement, “We work in crisis mode trying to do too much, too quickly” ranged from 14% to 86%**

Lack of adequate staffing is clearly a factor in staff experience in some clinics. Additionally, the role of the clinic director in many clinics was not well defined. Among the medical (including women’s health and dermatology) subspecialties, the majority (83.3%) had an identified clinic director, yet there was significant variation in the amount of support provided for the role (range 2.5% - 15% effort). However, few had a defined job description. Even fewer of the surgical subspecialties had a defined role or percent effort for clinic leadership.
While the nurse managers play a pivotal role in clinic operations, strong medical leadership is critical for provider engagement and accountability. Our findings are in contrast to other institutions that have clinic directors for each subspecialty with salary support and clearly defined job roles which, in many cases, are tied to specific metrics and benchmarks for their specific subspecialty.

**Goals 2013**

**Staff Experience**

- By December 2013 develop expectations for the role and responsibilities of specialty clinic directors
**Care Coordination**

Given that most of our subspecialty clinics are held at most a few times a week, continuity of care for patients can be a challenge. Patients who have clinical or logistical issues that arise between clinics or after hours need a defined point of contact for their questions and concerns. For the medical subspecialty clinics in particular, many of these issues stem from prescriptions that require prior authorization. In addition, our subspecialty clinics serve as our system’s main interface with the UCSF Medical Center for specialized studies (e.g. nuclear medicine) and subspecialty expertise that is not available at SFGH, and therefore require a system for coordinating and tracking referrals for diagnostic studies, procedures and clinical consultations. Finally, in the context of trainee-staffed clinics, further standardization of communication and coordination with referring primary care providers is needed.

**GOALS 2013 CARE COORDINATION**

- By September 2013 identify best practices across clinics for coordination of care and develop recommended practices
Facilities

Over the course of our interviews it became apparent that the condition of SFGH facilities contributes to poor staff morale and patient satisfaction. There are two distinct categories of concerns: 1) responsiveness of facilities to fix acute problems that impact staff work environment and patient experience (e.g. leaking roof) and 2) structural problems such as inadequate space/number of rooms and poor physical plant as a result of aging buildings (e.g. exam rooms are not fully enclosed).

**Goals 2013 Facilities**

- By April 2013 meet with the leadership of key clinical areas, facilities, and material management to conduct a detailed facilities gap and needs assessment
U.S. healthcare is rapidly changing in pursuit of the triple aim: improving patient experience and health outcomes, and decreasing the cost of care.

PREPARE FOR HEALTHCARE REFORM

Healthcare in the United States is facing precipitous changes. As part of this shifting landscape, SFGH is implementing a new ambulatory electronic medical record, focusing on increasing timely access to subspecialty care, investing in data and quality improvement infrastructure, and exploring strategies to maximize revenue. All of these endeavors have a common goal of the triple aim: improving patient experience and outcomes at the lowest cost possible. Additionally, our goal is to continue to serve as a national leader in medical care, quality, research, and innovation among safety-net hospitals.

CareLinkSF (eClinicalWorks™) Implementation

While all subspecialties were aware of eClinicalWorks™ implementation, many had concerns regarding its implementation within their respective clinics. None of the clinics knew (September 2012, when these needs assessment interviews were conducted) their scheduled eClinicalWorks™ implementation and “Go-Live” dates and only 15% (4/26) had an identified clinical champion. Critical to the success of an electronic health record is a smooth and transparent implementation process with early buy-in from clinic leadership.

Beginning in January 2013, the eClinicalWorks™ implementation team in conjunction with the medical directors of the medical/surgical subspecialty clinics will conduct a series of meetings with the leadership of each medical and surgical subspecialty clinic. The purpose of these meetings will be to introduce the eClinicalWorks™ implementation
Develop a timeline for and engage in eClinicalWorks™ planning

**Integrated Delivery System**

According to our patients, there are times when providers provide patients with inaccurate or confusing systems information. Many of our providers – both faculty and trainees – are not aware of the full scope of services at SFGH, other DPH providers, and our non-DPH delivery system partners in the San Francisco safety net. In addition, institutional policy changes (e.g. change in designated pharmacy by insurance) may not be
widely known, resulting in unanticipated barriers to patient care.

We propose to develop and compile practical information about the safety net delivery system, such as information about our primary care referral network, diagnostic and pharmacy services, and managed care guidelines. Our team has developed an Ambulatory Services internet site as a mechanism for providing centralized, updated information about our system’s ambulatory services:

www.sfghambulatoryservices.com

**GOALS 2013 \nINTEGRATED DELIVERY SYSTEM**

- By May 2013 develop resources for the ambulatory intranet to orient trainees, staff and faculty to the DPH health care delivery system

**Physician Incentive Payment Programs**

Starting in 2013, both DPH and the SFHP will implement physician incentive payment plans, where full funding is contingent on meeting specific metrics, some of which involve the subspecialty clinics. Fortunately, the metrics are largely aligned with the operational and clinical needs of our services. Our team will take a proactive role in working with the specialty clinics to meet the incentive plan requirements.
By May 2013 present and disseminate information on incentive payment plans with an emphasis on timing, metrics to be used, and associated implications for subspecialty clinics.

By June 2013 support at least three clinics in completing a patient shadowing experience.

By October 2013 implement Service Excellence trainings for 90 physicians.

By December 2013 implement dashboards for specialty clinics that include operational and specialty-specific clinical metrics.

By December 2013 develop clinical registry and population management systems for at least one specialty clinic.
Ensuring that our patients receive timely access to subspecialty care is a priority for SFGH in terms of maintaining patient satisfaction and complying with regulatory requirements. There is great variability in wait times for patients who are referred to our subspecialty clinics (Appendix A). The majority of our clinics (69.6%) do not meet specialty care timely access guidelines established by the California Department of Managed Care. In order to improve patient satisfaction and avoid possible financial penalties, we will work with specialty clinic leadership to meet these requirements (Table 2).
<table>
<thead>
<tr>
<th>Clinical Service</th>
<th>State Department of Managed Care (Medi-Cal, Healthy Families, Healthy Kids, Healthy Workers, Private HMO)</th>
<th>1115 Waiver for Low Income Health Program (SF PATH) Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care - No Authorization</td>
<td>48 hours</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent Care - Prior Authorization</td>
<td>96 hours</td>
<td>96 hours</td>
</tr>
<tr>
<td>Primary Care (Non-Urgent)</td>
<td>10 business days</td>
<td>20 business days*</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>15 business days</td>
<td>30 business days</td>
</tr>
<tr>
<td>Mental Health</td>
<td>10 business days</td>
<td>No access standard</td>
</tr>
<tr>
<td>Ancillary</td>
<td>15 business days</td>
<td>No access standard</td>
</tr>
<tr>
<td>Nurse Advice</td>
<td>Provision of 24/7 telephone triage or screening services</td>
<td>Services made available 24/7 when medically necessary</td>
</tr>
</tbody>
</table>

* 30 business days (through 6/30/2012); then 20 business days (from 7/1/2012 through 12/31/2013)
Trainee Supervision

Trainees have been integral to both providing outstanding care to our patients and fulfilling our mission of educating future clinicians. However, the supervision provided to them across departments is disparate and inconsistent at SFGH, which can diminish trainee educational experience as well as jeopardize our financial standing. Our goal is to ensure that trainees are provided the necessary supervision to facilitate their learning, ensure high quality patient care, and comply with regulatory mandates set forth by payers.

Goals 2013
Trainee Supervision

- By September 2013 meet with clinic leadership to review trainee supervision requirements (identify current practices across all clinics for medical student, resident, and fellow supervision)
- By September 2013 educate clinic leadership about the financial implications of current practices
- By January 2014 set uniform standards for medical student supervision across all clinics
- By January 2014 set uniform standard for use of “Dr. Statistical” (billing mechanism used when trainee supervision is not satisfied)
- By December 2014 incorporate “Dr. Statistical” into all subspecialty dashboards
VI. Conclusion

The San Francisco Department of Public Health and SFGH are facing a time of unprecedented change in healthcare. Multiple challenges are forthcoming, including new electronic medical record (EMR) Meaningful Use requirements, shifting payment models that are tied to quality metrics, and increased regulatory mandates. At the same time, we have an extraordinary opportunity to build a robust infrastructure focused on data-driven improvement, staff and patient experience, and operational efficiencies that fosters a culture of excellence and strengthens our commitment to serve the underserved. Our hope is that this needs assessment and our proposed action plans will lay the groundwork for a highly functioning integrated delivery system that can fulfill our mission of providing quality healthcare with compassion and respect for all.
# VII. APPENDICES

## APPENDIX A: CLINIC OPERATIONAL DATA

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Annual visits</th>
<th>No-shows (%)</th>
<th>Wait time (days)</th>
<th>Clinic sessions/week</th>
<th>Rooms available/clinic</th>
<th>Total provider sessions/week</th>
<th>Nurses/clinic</th>
<th>NPIs/clinic</th>
<th>MEAs/clinic</th>
<th>Clerks/clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Surgery</td>
<td>1,522</td>
<td>12.7</td>
<td>39</td>
<td>1</td>
<td>7</td>
<td>4.5</td>
<td>2</td>
<td>1.5</td>
<td>3</td>
<td></td>
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<tr>
<td>Cardiology</td>
<td>3,980</td>
<td>30.6</td>
<td>20</td>
<td>5</td>
<td>2-8</td>
<td>13</td>
<td>1</td>
<td>1-2</td>
<td>1</td>
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<tr>
<td>Dermatology</td>
<td>9,944</td>
<td>24.6</td>
<td>76</td>
<td>5</td>
<td>1-13</td>
<td>8.5</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>2,958</td>
<td>42.9</td>
<td>21</td>
<td>2</td>
<td>4-8</td>
<td>10</td>
<td>1</td>
<td>3</td>
<td>1.5</td>
<td></td>
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<tr>
<td>Endocrinology</td>
<td>2,438</td>
<td>26.5</td>
<td>17</td>
<td>3</td>
<td>1-8</td>
<td>7.75</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Gastroenterology</td>
<td>7,035</td>
<td>34.7</td>
<td>153</td>
<td>3</td>
<td>1-6</td>
<td>9</td>
<td>2-6</td>
<td>1</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td>4,198</td>
<td>26.1</td>
<td>77</td>
<td>4</td>
<td>7</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Gynecology</td>
<td>13,165</td>
<td>38.1</td>
<td>27</td>
<td>9</td>
<td>23</td>
<td>38</td>
<td>0.5-1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Hematology</td>
<td>1,948</td>
<td>16.3</td>
<td>115</td>
<td>2</td>
<td>3-4</td>
<td>5.5</td>
<td>1-2</td>
<td>1</td>
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<tr>
<td>Hepatology</td>
<td>2,041</td>
<td>21</td>
<td>162</td>
<td>7</td>
<td>1-6</td>
<td>8</td>
<td>1-6</td>
<td>1</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td>Lipid clinic</td>
<td>405</td>
<td>27.9</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Neurology</td>
<td>3,455</td>
<td>37.3</td>
<td>159</td>
<td>3</td>
<td>2-8</td>
<td>9-10</td>
<td>1</td>
<td>3</td>
<td>3</td>
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<td>Neurosurgery</td>
<td>1,376</td>
<td>35.4</td>
<td>39</td>
<td>1.5</td>
<td>2-7</td>
<td>5.25</td>
<td>1</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Obstetrics</td>
<td>10,984</td>
<td>27.6</td>
<td>7</td>
<td>5</td>
<td>23</td>
<td>19</td>
<td>1</td>
<td>1.5</td>
<td>1</td>
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<tr>
<td>Oncology</td>
<td>3,477</td>
<td>12.6</td>
<td>22</td>
<td>2</td>
<td>6-7</td>
<td>9.5</td>
<td>1-2</td>
<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>Ophthalmology</td>
<td>18,640</td>
<td>31.3</td>
<td>101/91</td>
<td>10</td>
<td>9</td>
<td>41.5</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td></td>
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<tr>
<td>Oral surgery</td>
<td>3,870</td>
<td>42.7</td>
<td>-</td>
<td>2</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
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<tr>
<td>Orthopedic Surgery</td>
<td>16,053</td>
<td>27.2</td>
<td>48</td>
<td>9</td>
<td>8-10</td>
<td>47</td>
<td>1</td>
<td>1.5</td>
<td>3</td>
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<td>Otolaryngology</td>
<td>5,037</td>
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<td>33</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>1</td>
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<td>3</td>
<td></td>
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<tr>
<td>Pain clinic</td>
<td>220</td>
<td>38.6</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>4,203</td>
<td>27.9</td>
<td>110</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
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<tr>
<td>Pulmonary</td>
<td>1,496</td>
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<td>19</td>
<td>1</td>
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<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>Renal</td>
<td>2,545</td>
<td>25.9</td>
<td>112</td>
<td>3</td>
<td>2-12</td>
<td>8</td>
<td>1-3</td>
<td>0.5-2</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>3,413</td>
<td>25.3</td>
<td>75</td>
<td>2</td>
<td>4.5-13</td>
<td>8</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>4,081</td>
<td>37.3</td>
<td>67</td>
<td>3</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>591</td>
<td>31.8</td>
<td>34</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX A: CLINIC OPERATIONAL DATA

NOTES

1 Fiscal year July 2011-June 2012. Data obtained from Invision using clinic resource codes
2 Data obtained from the appointment status report using clinic resource codes within Invision (http://in-sfghweb01/Invision/NoShowReporting)
3 Show rates are from November 1, 2011 to October 21, 2012
4 Self-reported data by clinic leadership; data is reported in ranges given that the number of rooms (or providers) can vary for a particular subspecialty clinic during the week
5 Includes both attendings and nurse practitioners/physician assistants; sum of the total number of providers per clinic session in one week
6 Cardiothoracic Surgery included in General Surgery
7 Optometry included in Ophthalmology
8 Podiatry included in Orthopedic Surgery
APPENDIX B: NUMBER OF ANNUAL VISITS

1 Fiscal year July 2011-June 2012. Data obtained from Invision using clinic resource codes
2 Optometry included in Ophthalmology
3 Podiatry included in Orthopedic Surgery
4 Cardiothoracic Surgery included in General Surgery
APPENDIX C: PATIENT PHONE CALL DATA BY CLINIC LOCATIONS (SEPTEMBER 2012 - JANUARY 2013)

1 Phone call data not yet available for 6G
2 General Surgery, Breast Clinic, Plastic Surgery, Urology, Orthopedic Surgery, and Vascular Surgery
3 Cardiology, Diabetes, Pulmonary, and GMC
4 Dermatology, Rheumatology, Nephrology, Pain Clinic, Diabetes, Endocrine, Urgent Cardiology, and Lipid Clinic
5 1N, 3D, and 4M data collection began 11/22/2012
## APPENDIX D: RESULTS FROM AHRQ HOSPITAL SURVEY ON PATIENT SAFETY (JULY/AUGUST 2012)

### STAFFING

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Staffing</th>
<th>&quot;We have enough staff to handle the workload&quot;</th>
<th>&quot;Staff in this unit work longer hours than is best for patient care&quot;</th>
<th>&quot;We work in crisis mode trying to do too much, too quickly&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1M¹: Adult Medical (n=20)</td>
<td>25%</td>
<td>25%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>3D² (n=14)</td>
<td>71%</td>
<td>54%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Ward 92: Specialty³ (n=7)</td>
<td>0%</td>
<td>43%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>3M and 4M: Surgical⁴ (n=7)</td>
<td>43%</td>
<td>71%</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>5M and 6G⁵ (n=31)</td>
<td>16%</td>
<td>39%</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Ward 86⁶ (n=18)</td>
<td>28%</td>
<td>50%</td>
<td>28%</td>
<td></td>
</tr>
</tbody>
</table>

### TEAMWORK

<table>
<thead>
<tr>
<th>Ward/Unit</th>
<th>Teamwork</th>
<th>&quot;People support one another in this unit&quot;</th>
<th>&quot;We work together as a team to get the work done&quot;</th>
<th>&quot;People treat each other with respect&quot;</th>
<th>Total Teamwork Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1M¹: Adult Medical (n=20)</td>
<td>95%</td>
<td>90%</td>
<td>90%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>3D² (n=14)</td>
<td>88%</td>
<td>93%</td>
<td>88%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>Ward 92: Specialty³ (n=7)</td>
<td>100%</td>
<td>86%</td>
<td>86%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>3M and 4M: Surgical⁴ (n=7)</td>
<td>86%</td>
<td>100%</td>
<td>86%</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>5M and 6G⁵ (n=31)</td>
<td>39%</td>
<td>55%</td>
<td>42%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Ward 86⁶ (n=18)</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>96%</td>
<td></td>
</tr>
</tbody>
</table>

---

1 Cardiology, Diabetes, Pulmonary, GMC (General Medicine Clinic)
2 Gastroenterology/Hepatology
3 Dermatology, Rheumatology, Nephrology, Pain Clinic, Endocrine, Diabetes, Urgent Cardiology Clinic, Lipid Clinic
4 3M (General Surgery, Breast Clinic, Plastic Surgery, Urology, Orthopedic Surgery, Vascular Surgery) and 4M (Ophthalmology/Optometry, Otolaryngology, Neurology, Neurosurgery)
5 5M (Women's Health Center) and 6G (Women's Option Center)
6 HIV/AIDS/Positive Health, Hematology, Oncology
### APPENDIX E: RESULTS FROM STAFF EXPERIENCE SURVEY (JULY/AUGUST 2012)

<table>
<thead>
<tr>
<th>Department</th>
<th>Q1: I know exactly what is expected of me at work (%)</th>
<th>Q2: I always have the opportunity to do what I do best every day (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1M&lt;sup&gt;1&lt;/sup&gt; Adult Medical (n=108)</td>
<td>62%</td>
<td>39%</td>
</tr>
<tr>
<td>3D&lt;sup&gt;2&lt;/sup&gt; (n=20)</td>
<td>64%</td>
<td>64%</td>
</tr>
<tr>
<td>Ward 92: Specialty clinics&lt;sup&gt;3&lt;/sup&gt; (n=4)</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>3M&lt;sup&gt;4&lt;/sup&gt;: Surgical Clinic (n=20)</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>4M&lt;sup&gt;4&lt;/sup&gt;: Surgical (n=21)</td>
<td>81%</td>
<td>48%</td>
</tr>
<tr>
<td>6G: Women’s Option Center (n=19)</td>
<td>84%</td>
<td>74%</td>
</tr>
<tr>
<td>5M&lt;sup&gt;5&lt;/sup&gt; (n=27)</td>
<td>52%</td>
<td>26%</td>
</tr>
<tr>
<td>Ward 86&lt;sup&gt;6&lt;/sup&gt; (n=36)</td>
<td>53%</td>
<td>33%</td>
</tr>
<tr>
<td>SFGH Total (n=2745)</td>
<td>61%</td>
<td>37%</td>
</tr>
</tbody>
</table>

---

1. Cardiology, Diabetes, Pulmonary, GMC (General Medicine Clinic)
2. Gastroenterology/Hepatology
3. Dermatology, Rheumatology, Nephrology, Pain Clinic, Endocrine, Diabetes, Urgent Cardiology Clinic, Lipid Clinic
4. 3M (General Surgery, Breast Clinic, Plastic Surgery, Urology, Orthopedic Surgery, Vascular Surgery) and 4M (Ophthalmology/Optometry, Otolaryngology, Neurology, Neurosurgery)
5. 5M (Women’s Health Center) and 6G (Women’s Option Center)
6. HIV/AIDS/Positive Health, Hematology, Oncology
Outpatient Quality Measures Dashboard:

**VOLUME**

<table>
<thead>
<tr>
<th>Total Visits</th>
<th>Appointments: % No Shows</th>
<th>Total unbilled charges with missing Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Graph" /></td>
<td><img src="image2.png" alt="Graph" /></td>
<td><img src="image3.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

**ACCESS**

<table>
<thead>
<tr>
<th>Third Next Available Routine Appointment for New Patients (in days)</th>
<th>Telephone Access: % abandoned calls</th>
<th>Appointment Cancellations</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image4.png" alt="Graph" /></td>
<td><img src="image5.png" alt="Graph" /></td>
<td><img src="image6.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

**FINANCIAL**

- **Total unbilled charges with missing Dx**: $439

**CLINICAL METRICS** - coming soon!

**PATIENT EXPERIENCE** - Note: Only survey data current through report date will appear below.
Outpatient Quality Measures Dashboard:

**Cardiology**

**Clinic:** All

**Start Date**

**End Date**

---

**VOLUME**

- **Total Visits**

- **Appointments: % No Shows**

- **Total unbilled charges with missing Dx**

---

**ACCESS**

- **Third Next Available Routine Appointment for New Patients (in days)**

- **Telephone Access: % abandoned calls**

- **Appointment Cancellations**

---

**FINANCIAL**

---

**CLINICAL METRICS** - coming soon!

---

**PATIENT EXPERIENCE** - Note: Only survey data current through report date will appear below.
Outpatient Quality Measures Dashboard:

**VOLUME**

- **Total Visits**
  - July 2013: 888
  - September 2013: 922
  - January 2014: 749
  - April 2014: 790
  - June 2014: 648

- **Appointments: % No Shows**
  - July 2013: 31%
  - October 2013: 33%
  - January 2014: 33%
  - April 2014: 34%
  - June 2014: 30%

- **Total unbilled charges with missing Dx**
  - August 2013: $716
  - October 2013: $0
  - December 2013: $0
  - February 2014: $0
  - April 2014: $0
  - June 2014: $1,203

**ACCESS**

- **Third Next Available Routine Appointment for New Patients (in days)**
  - July 2013: 30
  - September 2013: 38
  - November 2013: 44
  - January 2014: 37
  - March 2014: 37
  - May 2014: 38

- **Telephone Access: % abandoned calls**
  - July 2013: 9%
  - October 2013: 6%
  - January 2014: 10%
  - April 2014: 5%
  - June 2014: 9%

- **Appointment Cancellations**
  - July 2013: 90
  - September 2013: 12
  - November 2013: 32
  - January 2014: 54
  - March 2014: 88
  - May 2014: 57

**CLINICAL METRICS** - coming soon!

**PATIENT EXPERIENCE** - Note: Only survey data current through report date will appear below.
Outpatient Quality Measures Dashboard:

VOLUME

Total Visits

- eReferral
- Diabetes

Appointments: % No Shows

100%

40%

35%

42%

41%

44%

46%

33%

July-13  Oct-13  Jan-14  Apr-14  Jul-14

Financial

Total unbilled charges with missing Dx

July-13  Oct-13  Dec-13  Feb-14  Apr-14  Jun-14

$0

$0

$0

$0

$0

$0

ACCESS

Third Next Available Routine Appointment for New Patients (in days)

July-13  Sep-13  Nov-13  Jan-14  Mar-14  May-14  Jul-14

Diabetes

Goal= 30

Timely eReferral Response Rate (within 3 business days)

Timely eReferral  DSRIP goal above 80%

July-13  Sep-13  Nov-13  Jan-14  Mar-14  May-14  Jul-14

CLINICAL METRICS - coming soon!

PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.

<table>
<thead>
<tr>
<th>CG-CAHPS questions</th>
<th>June-14</th>
<th>May-14</th>
<th>April-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Clerks/receptions always treated patient w/ respect</td>
<td>6</td>
<td>83%</td>
<td>7</td>
</tr>
<tr>
<td>Patient always knew who to call for help after apt</td>
<td>6</td>
<td>83%</td>
<td>7</td>
</tr>
<tr>
<td>Provider always knew medical history</td>
<td>6</td>
<td>100%</td>
<td>7</td>
</tr>
<tr>
<td>Provider always showed respect for what pt said</td>
<td>6</td>
<td>100%</td>
<td>7</td>
</tr>
<tr>
<td>Pt always got answer calling during office hours</td>
<td>4</td>
<td>25%</td>
<td>7</td>
</tr>
<tr>
<td>Pt always saw provider w/in 15 min of apt time</td>
<td>6</td>
<td>67%</td>
<td>7</td>
</tr>
<tr>
<td>Rate provider office (% 9 or 10 out of 10)</td>
<td>6</td>
<td>67%</td>
<td>7</td>
</tr>
</tbody>
</table>
Outpatient Quality Measures Dashboard:

**VOLUME**

**Total Visits**

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>171</td>
<td>197</td>
<td>210</td>
<td>163</td>
<td>195</td>
<td>211</td>
<td>210</td>
<td>113</td>
<td>186</td>
<td>198</td>
<td>186</td>
<td>201</td>
</tr>
<tr>
<td>e-Referral</td>
<td>69</td>
<td>59</td>
<td>63</td>
<td>68</td>
<td>68</td>
<td>57</td>
<td>75</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>63</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>102</td>
<td>138</td>
<td>143</td>
<td>95</td>
<td>138</td>
<td>128</td>
<td>137</td>
<td>53</td>
<td>128</td>
<td>118</td>
<td>123</td>
<td>138</td>
</tr>
</tbody>
</table>

**Appointments: % No Shows**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% No Shows</td>
<td>27%</td>
<td>21%</td>
<td>21%</td>
<td>22%</td>
<td>28%</td>
<td>29%</td>
<td>29%</td>
<td>30%</td>
<td>28%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FINANCIAL**

**Total unbilled charges with missing Dx**

- Jul-13: 13
- Sep-13: 13
- Nov-13: 14
- Jan-14: 28
- Mar-14: 23
- May-14: 20
- Jul-14: 4

**ACCESS**

**Third Next Available Routine Appointment for New Patients (in days)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Days</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Goal=30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CLINICAL METRICS - coming soon!**

**PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.**
### Outpatient Quality Measures Dashboard:

**Gastroenterology**

**Clinic:** All

**Start Date:** Jul-13  
**End Date:** Jul-14

**VOLUME**

**Total Visits**

- **July 2013:** 203  
- **October 2013:** 245  
- **January 2014:** 267  
- **April 2014:** 256  
- **July 2014:** 208

**Appointments: % No Shows**

- **July 2013:** 33%  
- **October 2013:** 33%  
- **January 2014:** 33%  
- **April 2014:** 36%  
- **July 2014:** 32%

**Total unbilled charges with missing Dx**

- **July 2013:** $28,238  
- **October 2013:** $1,902

**ACCESS**

**Third Next Available Routine Appointment for New Patients (in days)**

- **July 2013:** 58  
- **September 2013:** 51  
- **November 2013:** 62  
- **January 2014:** 58

**Telephone Access: % abandoned calls**

- **July 2013:** 2%  
- **October 2013:** 3%  
- **January 2014:** 21%  
- **April 2014:** 12%

**Appointment Cancellations**

- **September 2013:** 3  
- **November 2013:** 2  
- **January 2014:** 2  
- **March 2014:** 6

**FINANCIAL**

### CLINICAL METRICS - coming soon!

**PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.**

<table>
<thead>
<tr>
<th>CG-CAHPS questions</th>
<th>Jun-14</th>
<th>Apr-14</th>
<th>May-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clerks/receptions always treated patient w/ respect</td>
<td>8</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Patient always knew who to call for help after appt</td>
<td>8</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>Provider always knew medical history</td>
<td>8</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Provider always showed respect for what pt said</td>
<td>8</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Pt always got answer calling during office hours</td>
<td>7</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Pt always saw provider w/in 15 min of appt time</td>
<td>8</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Rate provider office (% 9 or 10 out of 10)</td>
<td>8</td>
<td>28</td>
<td>28</td>
</tr>
</tbody>
</table>
Outpatient Quality Measures Dashboard: Lipid Clinic

**VOLUME**

- **Total Visits**
  - Jul-13: 29
  - Aug-13: 28
  - Sep-13: 21
  - Oct-13: 19
  - Nov-13: 17
  - Dec-13: 16
  - Jan-14: 13
  - Feb-14: 18
  - Mar-14: 18
  - Apr-14: 21
  - May-14: 19
  - Jun-14: 20

- **Appointments: % No Shows**
  - Jul-13: 43%
  - Aug-13: 24%
  - Sep-13: 26%
  - Oct-13: 39%
  - Nov-13: 27%
  - Dec-13: 39%
  - Jan-14: 33%
  - Feb-14: 32%
  - Mar-14: 43%
  - Apr-14: 31%
  - May-14: 18%

- **Total unbilled charges with missing Dx**
  - Jul-13: $0
  - Aug-13: $0
  - Sep-13: $0
  - Oct-13: $0
  - Nov-13: $0
  - Dec-13: $0
  - Jan-14: $0
  - Feb-14: $0
  - Mar-14: $0
  - Apr-14: $0
  - May-14: $0

**ACCESS**

- **Third Next Available Routine Appointment for New Patients (in days)**
  - Jul-13: 28
  - Aug-13: 30
  - Sep-13: 30
  - Oct-13: 30
  - Nov-13: 30
  - Dec-13: 30
  - Jan-14: 22
  - Feb-14: 22
  - Mar-14: 22
  - Apr-14: 21
  - May-14: 21
  - Jun-14: 18

- **Timely eReferral Response Rate**
  - Jul-13: 9%
  - Aug-13: 5%
  - Sep-13: 9%
  - Oct-13: 6%
  - Nov-13: 10%
  - Dec-13: 7%
  - Jan-14: 6%
  - Feb-14: 9%
  - Mar-14: 6%
  - Apr-14: 4%
  - May-14: 7%

**FINANCIAL**

- **Appointments: % No Shows**
  - Jul-13: 43%
  - Aug-13: 24%
  - Sep-13: 26%
  - Oct-13: 39%
  - Nov-13: 27%
  - Dec-13: 39%
  - Jan-14: 33%
  - Feb-14: 32%
  - Mar-14: 43%
  - Apr-14: 31%
  - May-14: 18%

- **Appointments: % No Shows**
  - Jul-13: 43%
  - Aug-13: 24%
  - Sep-13: 26%
  - Oct-13: 39%
  - Nov-13: 27%
  - Dec-13: 39%
  - Jan-14: 33%
  - Feb-14: 32%
  - Mar-14: 43%
  - Apr-14: 31%
  - May-14: 18%

- **Total unbilled charges with missing Dx**
  - Jul-13: $0
  - Aug-13: $0
  - Sep-13: $0
  - Oct-13: $0
  - Nov-13: $0
  - Dec-13: $0
  - Jan-14: $0
  - Feb-14: $0
  - Mar-14: $0
  - Apr-14: $0
  - May-14: $0

**ACCESS**

- **Timely eReferral Response Rate**
  - Jul-13: 9%
  - Aug-13: 5%
  - Sep-13: 9%
  - Oct-13: 6%
  - Nov-13: 10%
  - Dec-13: 7%
  - Jan-14: 6%
  - Feb-14: 9%
  - Mar-14: 6%
  - Apr-14: 4%
  - May-14: 7%

**CLINICAL METRICS**

- **Third Next Available Routine Appointment for New Patients (in days)**
  - Jul-13: 28
  - Aug-13: 30
  - Sep-13: 30
  - Oct-13: 30
  - Nov-13: 30
  - Dec-13: 30
  - Jan-14: 22
  - Feb-14: 22
  - Mar-14: 22
  - Apr-14: 21
  - May-14: 18

**PATIENT EXPERIENCE**

- **Note: Only survey data current through report date will appear below.**
Outpatient Quality Measures Dashboard:

**VOLUME**

- **Total Visits**
  - Jul-13: 252
  - Aug-13: 268
  - Sep-13: 262
  - Oct-13: 246
  - Nov-13: 178
  - Dec-13: 172
  - Jan-14: 210
  - Feb-14: 48
  - Mar-14: 51
  - Apr-14: 45
  - May-14: 37
  - Jun-14: 67

- **Appointments: % No Shows**
  - Jul-13: 26%
  - Aug-13: 23%
  - Sep-13: 24%
  - Oct-13: 23%
  - Nov-13: 27%
  - Dec-13: 26%
  - Jan-14: 29%
  - Feb-14: 24%
  - Mar-14: 24%
  - Apr-14: 24%
  - May-14: 31%

- **Total unbilled charges with missing Dx**
  - Jul-13: $80
  - Aug-13: $102
  - Sep-13: $45
  - Oct-13: $53
  - Nov-13: $80
  - Dec-13: $98
  - Jan-14: $94
  - Feb-14: $84
  - Mar-14: $101
  - Apr-14: $30
  - May-14: $30

**ACCESS**

- **Third Next Available Routine Appointment for New Patients (in days)**
  - Jul-13: 45
  - Aug-13: 53
  - Sep-13: 57
  - Oct-13: 80
  - Nov-13: 98
  - Dec-13: 94
  - Jan-14: 84
  - Feb-14: 101
  - Mar-14: 102
  - Apr-14: 30

- **Telephone Access: % abandoned calls**
  - Jul-13: 9%
  - Aug-13: 9%
  - Sep-13: 9%
  - Oct-13: 9%
  - Nov-13: 5%
  - Dec-13: 6%
  - Jan-14: 4%
  - Feb-14: 6%
  - Mar-14: 21%
  - Apr-14: 7%

**FINANCIAL**

- **Total Visits**
  - Jul-13: 252
  - Aug-13: 268
  - Sep-13: 262
  - Oct-13: 246
  - Nov-13: 178
  - Dec-13: 172
  - Jan-14: 210
  - Feb-14: 48
  - Mar-14: 51
  - Apr-14: 45
  - May-14: 37

**CLINICAL METRICS**

- **Timely eReferral Response Rate**
  - Jul-13: 74%
  - Aug-13: 95%
  - Sep-13: 100%
  - Oct-13: 100%
  - Nov-13: 100%
  - Dec-13: 100%
  - Jan-14: 100%
  - Feb-14: 100%
  - Mar-14: 100%
  - Apr-14: 100%
  - May-14: 100%

**PATIENT EXPERIENCE**

- **Note: Only survey data current through report date will appear below.**
Outpatient Quality Measures Dashboard: Neurology

**VOLUME**

- **Total Visits**

- **Appointments: % No Shows**

- **Total unbilled charges with missing Dx**
  - Jul-13: $0, Aug-13: $0, Sep-13: $0, Oct-13: $0, Nov-13: $0, Dec-13: $0, Jan-14: $0, Feb-14: $0, Mar-14: $0, Apr-14: $0, May-14: $0

**ACCESS**

- **Third Next Available Routine Appointment for New Patients (in days)**

- **Telephone Access: % abandoned calls**

**FINANCIAL**

- **Appointment Cancellations**

- **Timely eReferral Response Rate**

- **CLINICAL METRICS**
  - coming soon!

- **PATIENT EXPERIENCE**
  - Note: Only survey data current through report date will appear below.
### Outpatient Quality Measures Dashboard:

#### Neurosurgery

**VOLUME**

<table>
<thead>
<tr>
<th>Total Visits</th>
<th>Appointments: % No Shows</th>
<th>Total unbilled charges with missing Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Graph" /></td>
<td><img src="image2.png" alt="Graph" /></td>
<td><img src="image3.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

**ACCESS**

<table>
<thead>
<tr>
<th>Third Next Available Routine Appointment for New Patients (in days)</th>
<th>Telephone Access: % abandoned calls</th>
<th>Appointment Cancellations</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image4.png" alt="Graph" /></td>
<td><img src="image5.png" alt="Graph" /></td>
<td><img src="image6.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

**FINANCIAL**

<table>
<thead>
<tr>
<th>Timely eReferral Response Rate (within 3 business days)</th>
<th>CLINICAL METRICS - coming soon!</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image7.png" alt="Graph" /></td>
<td>Note: Only survey data current through report date will appear below.</td>
</tr>
</tbody>
</table>

**PATIENT EXPERIENCE** - Note: Only survey data current through report date will appear below.
Outpatient Quality Measures Dashboard: Oncology

**VOLUME**

Total Visits

- July 2013: 350
- October 2013: 274
- January 2014: 305
- April 2014: 323
- May 2014: 342
- July 2014: 356

**FINANCIAL**

Total unbilled charges with missing Dx

- August 2013: $992
- October 2013: $0
- December 2013: $0
- February 2014: $0
- April 2014: $0
- June 2014: $0

**ACCESS**

Third Next Available Routine Appointment for New Patients (in days)

- July 2013: 35
- September 2013: 30
- November 2013: 30
- January 2014: 30
- March 2014: 30
- May 2014: 30
- July 2014: 29

Telephone Access: % abandoned calls

- July 2013: 2%
- October 2013: 3%
- January 2014: 3%
- April 2014: 1%
- July 2014: 2%

Appointment Cancellations

- Cancellations initiated by clerk: 3
- Cancellations initiated by physician: 1

**CLINICAL METRICS**

Timely eReferral Response Rate

- (within 3 business days)

- July 2013: 100%
- September 2013: 99%
- November 2013: 99%
- January 2014: 99%
- March 2014: 100%
- May 2014: 100%
- July 2014: 100%

**PATIENT EXPERIENCE**

- Note: Only survey data current through report date will appear below.
**Outpatient Quality Measures Dashboard: Ophthalmology**

### VOLUME

**Total Visits**

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>1,010</td>
<td>972</td>
<td>1,135</td>
<td>1,028</td>
<td>1,094</td>
<td>1,023</td>
</tr>
</tbody>
</table>

**Appointments: % No Shows**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>28%</td>
<td>27%</td>
<td>28%</td>
<td>29%</td>
<td>27%</td>
<td>28%</td>
</tr>
</tbody>
</table>

**Total unbilled charges with missing Dx**

<table>
<thead>
<tr>
<th>Month</th>
<th>August 2013</th>
<th>October 2013</th>
<th>December 2013</th>
<th>February 2014</th>
<th>April 2014</th>
<th>June 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>$1,360</td>
<td>$325</td>
<td>$180</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### ACCESS

**Third Next Available Routine Appointment for New Patients (in days)**

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>59</td>
<td>30</td>
</tr>
</tbody>
</table>

**Telephone Access: % abandoned calls**

<table>
<thead>
<tr>
<th>Month</th>
<th>July 2013</th>
<th>September 2013</th>
<th>November 2013</th>
<th>January 2014</th>
<th>March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Appointment Cancellations**

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancellations:</td>
<td>127</td>
<td>121</td>
<td>146</td>
<td>193</td>
<td>223</td>
<td>107</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>8</td>
<td>77</td>
<td>18</td>
</tr>
</tbody>
</table>

### CLINICAL METRICS - coming soon!

### PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.
**Outpatient Quality Measures Dashboard:**

**VOLUME**

- Total Visits
- Appointments: % No Shows
- Total unbilled charges with missing Dx

**ACCESS**

- Third Next Available Routine Appointment for New Patients (in days)
- Telephone Access: % abandoned calls
- Appointment Cancellations

**FINANCIAL**

- Financial Volume Access
- Clinic: All

**CLINICAL METRICS**

- Timely eReferral Response Rate
  (within 3 business days)

**PATIENT EXPERIENCE**

- Note: Only survey data current through report date will appear below.
**Outpatient Quality Measures Dashboard:**

### VOLUME

#### Total Visits

- **Oral Surgery**
  - Jul-13: 547
  - Aug-13: 452
  - Sep-13: 496
  - Oct-13: 468
  - Nov-13: 396
  - Dec-13: 386
  - Jan-14: 477
  - Feb-14: 428
  - Mar-14: 412
  - Apr-14: 333
  - May-14: 413
  - Jun-14: 435

- **Oral and Maxillofacial Surgery**
  - Jul-13: 547
  - Aug-13: 452
  - Sep-13: 496
  - Oct-13: 468
  - Nov-13: 396
  - Dec-13: 386
  - Jan-14: 477
  - Feb-14: 428
  - Mar-14: 412
  - Apr-14: 333
  - May-14: 413
  - Jun-14: 435

### FINANCIAL

#### Appointments: % No Shows

- Jul-13: 39%
- Aug-13: 43%
- Sep-13: 40%
- Oct-13: 34%
- Nov-13: 34%
- Dec-13: 34%
- Jan-14: 39%
- Feb-14: 45%
- Mar-14: 46%
- Apr-14: 44%
- May-14: 39%
- Jun-14: 39%

#### Total unbilled charges with missing Dx

- Jul-13: $229
- Aug-13: $386
- Sep-13: $386
- Oct-13: $386
- Nov-13: $386
- Dec-13: $386
- Jan-14: $386
- Feb-14: $386
- Mar-14: $386
- Apr-14: $386
- May-14: $386
- Jun-14: $781

### ACCESS

#### Third Next Available Routine Appointment for New Patients (in days)

- Jul-13: 39
- Aug-13: 38
- Sep-13: 39
- Oct-13: 38
- Nov-13: 39
- Dec-13: 38
- Jan-14: 39
- Feb-14: 38
- Mar-14: 39
- Apr-14: 38
- May-14: 39

#### Telephone Access: % abandoned calls

- Jul-13: 2%
- Aug-13: 2%
- Sep-13: 2%
- Oct-13: 2%
- Nov-13: 2%
- Dec-13: 2%
- Jan-14: 2%
- Feb-14: 2%
- Mar-14: 2%
- Apr-14: 2%
- May-14: 2%

#### Appointment Cancellations

- Jul-13: 39
- Aug-13: 35
- Sep-13: 35
- Oct-13: 39
- Nov-13: 35
- Dec-13: 22
- Jan-14: 5
- Feb-14: 8
- Mar-14: 9
- Apr-14: 1
- May-14: 18

### CLINICAL METRICS - coming soon!

### PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.
Outpatient Quality Measures Dashboard: Otolaryngology

### VOLUME

**Total Visits**

- July 2013: 506
- September 2013: 439
- November 2013: 386
- January 2014: 394
- March 2014: 412
- May 2014: 386
- July 2014: 384

**Appointments: % No Shows**

- July 2013: 25%
- October 2013: 30%
- January 2014: 29%
- April 2014: 33%
- May 2014: 32%
- January 2014: 31%
- July 2014: 37%

**Total unbilled charges with missing Dx**

- August 2013: $518
- October 2013: $0
- December 2013: $0
- February 2014: $0
- April 2014: $0
- June 2014: $0

### ACCESS

**Third Next Available Routine Appointment for New Patients (in days)**

- July 2013: 55 days
- September 2013: 30 days
- November 2013: 30 days
- January 2014: 30 days
- March 2014: 30 days
- May 2014: 30 days
- July 2014: 65 days

**Telephone Access: % abandoned calls**

- July 2013: 8%
- October 2013: 7%
- January 2014: 7%
- April 2014: 10%
- May 2014: 11%

### CLINICAL METRICS - coming soon!

**Timely eReferral Response Rate** (within 3 business days)

- July 2013: 100%
- September 2013: 100%
- November 2013: 100%
- January 2014: 100%
- March 2014: 100%
- May 2014: 100%
- July 2014: 80%

**Appointment Cancellations**

- July 2013: 13
- September 2013: 17
- November 2013: 9
- January 2014: 6
- March 2014: 17
- May 2014: 14

- Cancellations: initiated by clerk, initiated by physician

### PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.
Outpatient Quality Measures Dashboard:

**VOLUME**

Total Visits

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</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>16</td>
<td>17</td>
<td>15</td>
<td>15</td>
<td>17</td>
<td>19</td>
<td>21</td>
<td>121</td>
<td>150</td>
<td>150</td>
<td>115</td>
<td>30</td>
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<tbody>
<tr>
<td>Pain</td>
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**FINANCIAL**

Total unbilled charges with missing Dx

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<tbody>
<tr>
<td>Pain</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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**ACCESS**

Third Next Available Routine Appointment for New Patients (in days)

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</thead>
<tbody>
<tr>
<td>Pain</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
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</thead>
<tbody>
<tr>
<td>Pain</td>
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</table>

**CLINICAL METRICS** - coming soon!

Timely eReferral Response Rate

(within 3 business days)

**PATIENT EXPERIENCE** - Note: Only survey data current through report date will appear below.
Outpatient Quality Measures Dashboard:

**VOLUME**

<table>
<thead>
<tr>
<th>Total Visits</th>
<th>Jul-13</th>
<th>Oct-13</th>
<th>Jan-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jul-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Op</td>
<td>431</td>
<td>301</td>
<td>385</td>
<td>349</td>
<td>411</td>
<td>337</td>
</tr>
<tr>
<td>eReferral</td>
<td>330</td>
<td>262</td>
<td>239</td>
<td>291</td>
<td>282</td>
<td>332</td>
</tr>
</tbody>
</table>

**Appointments: % No Shows**

<table>
<thead>
<tr>
<th>Jul-13</th>
<th>Oct-13</th>
<th>Jan-14</th>
<th>Apr-14</th>
<th>Jul-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>16%</td>
<td>19%</td>
<td>23%</td>
<td>19%</td>
<td>18%</td>
</tr>
</tbody>
</table>

**Total unbilled charges with missing Dx**

- Jul-13: 22
- Sep-13: 11
- Nov-13: 10
- Jan-14: 14
- Mar-14: 6
- May-14: 8
- Jul-14: 30

**FINANCIAL**

- Total visits: $1,238

**ACCESS**

- Third Next Available Routine Appointment for New Patients (in days)
  - Jul-13: 30
  - Aug-13: 30
  - Sep-13: 11
  - Oct-13: 8
  - Nov-13: 10
  - Dec-13: 19
  - Jan-14: 30
  - Feb-14: 30
  - Mar-14: 30
  - Apr-14: 30
  - May-14: 30
  - Jun-14: 30

**CLINICAL METRICS** - coming soon!

**PATIENT EXPERIENCE** - Note: Only survey data current through report date will appear below.
**Outpatient Quality Measures Dashboard:**

**VOLUME**

- **Total Visits**
  - September-13: 69, October-13: 68
  - November-13: 70, December-13: 59
  - January-14: 79, February-14: 84
  - March-14: 89, April-14: 85
  - May-14: 90, June-14: 85
  - July-14: 90

- **Appointments: % No Shows**
  - July-13: 44%, August-13: 42%
  - September-13: 42%, October-13: 43%
  - November-13: 41%, December-13: 41%
  - January-14: 40%, February-14: 39%
  - March-14: 38%, April-14: 37%
  - May-14: 38%, June-14: 35%
  - July-14: 41%

**FINANCIAL**

- **Total unbilled charges with missing Dx**
  - August-13: $0, September-13: $1,224
  - October-13: $0, November-13: $0
  - December-13: $0, January-14: $0
  - February-14: $0, March-14: $0
  - April-14: $0, May-14: $0
  - June-14: $2,692

**ACCESS**

- **Third Next Available Routine Appointment for New Patients (in days)**
  - July-13: 39, August-13: 33
  - September-13: 43, October-13: 27
  - January-14: 39, February-14: 29
  - March-14: 38, April-14: 30
  - May-14: 30, June-14: 30
  - July-14: 30

- **Telephone Access: % abandoned calls**
  - July-13: 4%, August-13: 3%
  - September-13: 4%, October-13: 3%
  - November-13: 3%, December-13: 4%
  - January-14: 18%, February-14: 18%
  - March-14: 15%, April-14: 12%
  - May-14: 12%, June-14: 12%

**ACCESS**

- **Timely eReferral Response Rate (within 3 business days)**
  - July-13: 91%, August-13: 94%
  - September-13: 99%, October-13: 99%
  - November-13: 99%, December-13: 99%
  - January-14: 99%, February-14: 99%
  - March-14: 100%, April-14: 100%
  - May-14: 100%, June-14: 99%
  - July-14: 87%

**CLINICAL METRICS - coming soon!**

**PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.**
**VOLUME**

- **Total Visits**
  - July 13: 311
  - Oct 13: 324
  - Jan 14: 314
  - Apr 14: 314
  - Jul 14: 301

- **Appointments: % No Shows**
  - July 13: 37%
  - Oct 13: 36%
  - Jan 14: 37%
  - Apr 14: 40%
  - Jul 14: 41%

- **Telephone Access: % abandoned calls**
  - July 13: 7%
  - Oct 13: 21%
  - Jan 14: 25%
  - Apr 14: 22%
  - Jul 14: 21%

**ACCESS**

- **Third Next Available Routine Appointment for New Patients (in days)**
  - July 13: 73
  - Sep 13: 36
  - Nov 13: 61
  - Jan 14: 56
  - Apr 14: 77

- **Appointment Cancellations**
  - July 13: 31
  - Sep 13: 32
  - Nov 13: 35
  - Jan 14: 17
  - Mar 14: 29
  - May 14: 25

**CLINICAL METRICS** - coming soon!

**FINANCIAL**

- **Total unbilled charges with missing Dx**
  - August 13: $387

**PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.**

<table>
<thead>
<tr>
<th>CG-CAHPS questions</th>
<th>Jun-14</th>
<th>May-14</th>
<th>Apr-14</th>
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</thead>
<tbody>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Clerks/receptions always treated patient w/ respect</td>
<td>11</td>
<td>82%</td>
<td>24</td>
</tr>
<tr>
<td>Patient always knew who to call for help after appt</td>
<td>11</td>
<td>100%</td>
<td>24</td>
</tr>
<tr>
<td>Provider always knew medical history</td>
<td>11</td>
<td>73%</td>
<td>24</td>
</tr>
<tr>
<td>Provider always showed respect for what pt said</td>
<td>11</td>
<td>82%</td>
<td>24</td>
</tr>
<tr>
<td>Pt always got answer calling during office hours</td>
<td>9</td>
<td>22%</td>
<td>21</td>
</tr>
<tr>
<td>Pt always saw provider w/in 15 min of appt time</td>
<td>11</td>
<td>45%</td>
<td>22</td>
</tr>
<tr>
<td>Rate provider office (% 9 or 10 out of 10)</td>
<td>11</td>
<td>36%</td>
<td>24</td>
</tr>
</tbody>
</table>
**Outpatient Quality Measures Dashboard:**

### VOLUME

**Total Visits**
- Jul-13: 90
- Oct-13: 113
- Nov-13: 111
- Jan-14: 100
- Apr-14: 98
- Jul-14: 108

**Appointments: % No Shows**
- Jul-13: 33%
- Oct-13: 36%
- Jan-14: 46%
- Apr-14: 35%
- Jul-14: 38%

**Total unbilled charges with missing Dx**
- Jul-13: 58
- Oct-13: 57
- Nov-13: 85
- Jan-14: 86
- Mar-14: 120
- Apr-14: 106
- May-14: 58
- Jul-14: 57

### ACCESS

**Third Next Available Routine Appointment for New Patients (in days)**
- Jul-13: 85
- Sep-13: 86
- Nov-13: 111
- Jan-14: 103
- Mar-14: 106
- May-14: 58
- Jul-14: 57

**Telephone Access: % abandoned calls**
- Jul-13: 7%
- Oct-13: 21%
- Jan-14: 25%
- Apr-14: 22%
- Jul-14: 20%

**Appointment Cancellations**
- Jul-13: 33%
- Sep-13: 18%
- Nov-13: 25%
- Jan-14: 19%
- Mar-14: 11%
- May-14: 13%

### FINANCIAL

**Total visits**
- Jul-13: $629

### CLINICAL METRICS - coming soon!

### PATIENT EXPERIENCE - Note: Only survey data current through report date will appear below.
SFHN Integration Activities
SFGH and LHH

September 2014
Integration Objectives

• Identify as network
  • San Francisco Health Network
  • Keeping our patients in our network – continuity of care and appropriate level of care

• Improve Efficiency
  • Use of Staff Time – shared staff resources
  • Use of Equipment
  • Standardize process/procedures when appropriate

• Reduce Cost Duplication

• Improve Staff Satisfaction
  • Cross-orientation – shared knowledge
  • Opportunities
  • Increase experiences

• Improve patient/customer experience
  • Improve access to services
  • Improve convenience
Active Integration Initiatives

1. Switchboard/Telephone Operators
2. Rehabilitation Services
3. Pharmacy Services
Switchboard/Telephone Operators

• Develop work schedule; LHH to be covered 24/7 – Completed
• Develop unified scope of service
  ○ Integrated scope of service – Completed
  ○ Complete cross-orientation of staff and training on all three shifts - Completed
  ○ Access to SFGH and LHH Directory/INVISION - Completed
  ○ IT Profile and user rights issue – Completed
• Prepare physical setting
  ○ Workstations – Ward 11, added 1 additional workstation – Completed
  ○ PC Console installation and wiring - Completed
• LHH Staff relocated to SFGH as of July 5, 2014
Next Steps

- Convening ongoing check ins
- Plan to improve processes and systems from feedback
- Future integration initiatives
Rehabilitation Services

• Develop common mission and vision - Completed
  – Review and improve organization of departments
• Develop unified scope of service – In progress
  – Inventory job descriptions and staff expertise
• Centralize outpatient rehabilitation services
  – Implement e-referral – In progress
  – Plan for LHH Outpatient Rehab to access and provide services for SFHN patients - being explored
  – Pursue shared appointment system - being explored
  – Pursue shared/standardized IT patient record system - being explored
Rehabilitation Services

• Standardize eligibility procedures within sites - in discussion with Eligibility

• Develop action plan to improve staff satisfaction – In progress
  – At LHH, staff satisfaction survey completed May 2014
  – At SFGH, data from 2013 available
Integration of SFHN Pharmacy Services

- Ambulatory Care
  - Primary Care
  - Behavioral Health
  - Jail Health
- Laguna Honda Hospital
- San Francisco General Hospital
Pharmacy Services
“Current State” of Integration

• Formulary
  • Financial Stewardship
  • Alignment for un-insured patients
  • Behavioral Health continuity
  • Diabetes Testing
  • Staff Safety (enoxaparin syringes)

• Regulatory Preparedness
  • CDPH
  • Board Of Pharmacy
  • USP 797 Sterile Compounding
  • USP 800 Hazardous Drugs

• Disaster Planning and Preparedness
Pharmacy Services
“Current State” of Integration

• Clinical Alignment- consistent Standardized Procedures
• Clinical Initiatives
  • Anticoagulation
  • Behavioral health
  • Big AIMS- cholesterol
  • Buprenorphine
  • Naloxone Rescue
  • Pharmacy operations
  • Transitions of Care
Pharmacy Services
“Current State” of Integration

• Finance- Pharmaceutical inflation/budgeting
• Consistent policies and procedures for drug manufacturer representatives
• Bridge to Health Care Reform
• Medicare Part D
What We’re Working On

• Universal Medication Schedule
• IT integration-enterprise wide solutions
• Transitional Care
• Collaboration on Anticoagulation/ Pain Management/Teaching Opportunities
• Impact of SB493- Expanding Roles of Advanced Practice Pharmacists
• ASHP guidelines for Pharmacy Technicians
• Managed Care Contracts
Looking Ahead

• Establish productivity metrics, benchmarks, clinical outcomes

• Healthcare Reform
  • Pharmacy Navigation
  • Transitional Care
Summary

Integration efforts are continuing and will continue to expand

Thank you!

Comments
CURRENT PLAN for SF BEHAVIORAL HEALTH CENTER (SF BHC)
September, 2014

CURRENT PLAN:
THIRD FLOOR: 24 beds MHRC
SECOND FLOOR: 59 beds for Residential Care Facility for the Elderly (RCFE)
FIRST FLOOR: 41 beds currently licensed ARF (Adult Residential Facility)
               14 bed ARF expansion
               Psychiatric Respite
               - 6-10 maximum overnight stay capacity
               - 25 maximum daytime participants (dependent on number of staff onsite)

COMPLETED
Dec, 2013   RCFE Application and Payment submitted to Community Care Licensing (CCL)
Jan, 2014   Proof of proposed RCFE Administrator Fingerprints submitted to CCL
Aug, 2014   RCFE Administrator Certificate awarded
Sep, 2014   RCFE License issued by CCL

OSHPD decommissions 2nd Floor at BHC as Skilled Nursing Facility and CCSF DBI assumes oversight

PENDING
DHCS approval to remove 2nd floor beds from their jurisdiction
Determine appropriate number of MHRC beds at BHC to meet service needs
OSHPD decommissions MHRC at BHC if appropriate

POTENTIAL REVENUE
ARF beds     approx $1,000 per month per resident with SSI
RCFE beds    approx $1,000 per month per resident with SSI
Appropriate use of PES   amount TBD; redirecting inappropriate high users of PES to Psych Respite allows
                        for appropriate Crises to be served
Decreased Lower Level of Care days at SFGH  additional acute care days due to increased access to lower levels of care

<table>
<thead>
<tr>
<th>FLOOR</th>
<th>MHRC - 24 beds (LOCKED)</th>
<th>TBD - 23 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Residential Care Facility for Elderly [60 y.o.+] (59 beds) (OPEN - with Delayed Exit)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Adult Residential Facility [18-50 y.o.] - 41 beds (OPEN)</td>
<td>ARF Expansion - 14 beds (OPEN)</td>
</tr>
</tbody>
</table>
There is a gap service area for people who are not yet accepting of the need to manage their mental health symptoms/issues in a more productive and healthy manner and people who would benefit from a supervised setting to monitor medication changes after an inpatient stay. SFHN Transitions in collaboration with CBHS and MHSA will oversee development and launch of a hybrid Peer + Clinical Staff Model Psychiatric Respite that can provide a safe place for these identified individuals to rest and re-group before returning home. At Respite, they can have 1:1 Peer support, access to Recovery and Wellness conversation, activities and programs in a home-like environment. The programs will not be mandatory. Average length of stay is anticipated to be 3-5 days with a maximum stay of 14 days. Medications will be kept in a centralized area for safekeeping. CNAs will be able to provide reminders, education and support to maintain medication compliance.

- We are trying to do a soft opening for Psychiatric Respite Oct 20:
  - Maximum 4 overnight guests and 15 participants for day use
- Peers to staff the program are selected and Tracey Helton is supervising the program development
- CNAs formerly with the BHC SNF will be returning as clinical staff
- Identifying Participants for the Pilot
  - We are initially targeting people who are appropriate to ADU but decline to do the programming. We will ask Stephanie Twu, Progress Foundation Evaluator, to refer people from PES in addition to people she assesses on the unit.
  - We will identify PES High Users who rarely meet eligibility for admit and could use the Respite model appropriately
  - We may consider people recommended by Intensive Care Managers

CURRENT STATUS

MHSA has generously agreed to allocate some one time only funds to help furnish and decorate the space.
- The Peers will be responsible for decorating and furnishing the space within the allocated MHSA funds.
- CNAs need to meet with the Peers to develop rapport. This will be scheduled in early October.
- The Peers and the CNAs are responsible for making first draft of programming. This will take place through September and early October.
- We will try and honor the request from the Peers to arrange for Peers and CNAs to tour Second Story Respite in Santa Cruz if possible.

PARTICIPATING STAFF

Marlo Simmons, MHSA Director
- MHSA will be providing a Facilitator to lead the Peers in the program development
- MHSA will be providing funds for furnishings

Tracey Helton, CBHS Consumer Employment Manager
- Lead on Program Development and Peer Supervision

Jennie Hua, CBHS Director of Vocational Rehab Services
- Collaborating on the Program Design

Sharon McCole-Wicher, Director of SF Behavioral Health Center, and Kelly Hiramoto, Director of Transitions, are the Program Directors
TO: Members of the San Francisco Health Commission
FROM: Stella Cao, Director of Managed Care, San Francisco Health Network
DATE: September 16, 2014
RE: SFHN Managed Care Updates

The Office of Managed Care (OMC) provided a managed care update report to the Finance and Planning Committee on September 2, 2014 (see attached). Since then, OMC has received updated managed care membership data, which has been incorporated in the PowerPoint slides to be presented to the full Health Commission by the SFHN leadership on October 7, 2014. This data is also summarized below.

**January 2014**

*78,861* Hospital Services

(56,802 DPH + 22,059 Non-DPH Primary Care)

**August 2014**

*83,723* Hospital Services

(63,505 DPH + 20,218 Non-DPH Primary Care)
SFHN's overall managed care enrollment for hospital services has increased 6% (or added 4,862 members) since January 2014. While enrollment continues to grow, the distribution of the overall managed care enrollment remained steady for the Healthy Workers and Healthy Kids programs at 15% and 2%, respectively. As a result of the implementation of the Affordable Care Act in January 2014, a portion of the Healthy San Francisco participants have transitioned to other programs such as Medi-Cal, and Healthy San Francisco membership now comprises 23% of the total SFHN enrollment for hospital services in August 2014, down from 35% in January 2014. Medi-Cal enrollment has increased to 61% of the overall managed care enrollment in August 2014, up from 49% in January 2014.
MANAGED CARE UPDATE

FY 2013-14
TABLE OF CONTENTS

1. DPH Enrollment ................................................................. 1
2. Low Income Health Program Transition .................................. 3
3. Access & Capacity ............................................................... 5
4. Managed Care Contracts ....................................................... 6
5. Contact Information ............................................................ 8
Appendix .................................................................................... 9
1. DPH Enrollment

**NETWORK SERVICES: 82,593 & PRIMARY CARE SERVICES: 61,202**

As of June 2014, the San Francisco Department of Public Health (DPH) through the San Francisco Health Network (SFHN) was responsible for providing network services to 82,593 managed care enrollees. Of these enrollees, DPH clinics were responsible for the primary care services for 61,202 (74%) enrollees and non-DPH clinics were responsible for 21,391 (26%) enrollees.

Medi-Cal (MC) accounted for 46,595 (56%) of the total network services enrollees. The following public programs accounted for the remaining enrollees: Healthy Workers (HW) 12,242 (15%); Healthy Kids (HK), 1,388 (2%); and Healthy San Francisco (HSF), 22,368 (27%)\(^1\).

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\(^1\)HSF enrollment in this report represents only partial enrollment of the program. It includes only participants who are assigned to DPH and non-DPH clinics as their medical home and to San Francisco General Hospital and Laguna Honda Hospital for hospital and ancillary services. Participants enrolled with Brown & Toland Physicians, Chinese Community Health Care Association, Kaiser Permanente, North East Medical Services and Sister Mary Philippa are not included as these participants seek network services outside of DPH.
The overall enrollment numbers for network services increased 1.8% in the last 12 months, from 81,084 in June 2013 to 82,593 in June 2014. The increase in enrollment as a result of the Affordable Care Act (ACA) implementation effective January 1, 2014 has not been significant primarily due to application approval delay. However, changes at the program level were more predominant, including:

- MC expansion in January 2014 with the passing of AB85, a state mandate requiring all managed care health plans to assign 75% of the new Medi-Cal expansion (MCE) members who do not choose a primary care provider (PCP) to the public health system;
- The transition of San Francisco Provides Access to Health Care (SF PATH), San Francisco’s Low Income Health Program (LIHP), participants to MC in January 2014 (see section 2 of this report);
- The transition of HF members to MC in October 2013; and
- The transition of some HSF participants to MC, resulting a 30% decrease of membership over the last 12 months.

As illustrated in Chart 1 below, enrollment of individual programs fluctuated, but the trending pattern remained relatively steady, with DPH’s primary care enrollment trending upward slightly by 3%, from 59,338 in June 2013 to 61,202 in June 2014, and with non-DPH’s primary care enrollment down about 1.7% from 21,746 in June 2013 to 21,391 in June 2014. Additional enrollment details are included in the Appendix.
2. Low Income Health Program Transition

**PROGRAM BACKGROUND AND ELIGIBILITY**
In response to California’s “Bridge to Reform” Demonstration 1115 Medicaid Waiver, a new statewide health care program called the Low Income Health Program (LIHP) was created. LIHP, called San Francisco Provides Access to Health Care (SF PATH) in San Francisco, was administered by the Department of Public Health (DPH) and was designed to move low-income uninsured individuals into a coordinated system of care to improve access to care, enhance quality of care, reduce episodic care and improve health status.

**PROGRAM TERMINATION AND TRANSITION TO MEDI-CAL EXPANSION**
The SF PATH program successfully ended on December 31, 2013. This program finished with 15,046 participants, of which 14,290 were preliminarily determined eligible for Medi-Cal expansion (MCE) and 756 were not eligible for Medi-Cal (MC) but were eligible for subsidized health insurance through Covered California. As of May 31, 2014, all SF PATH participants were dispositioned by the Department of Health Care Services (DHCS) and 13,680 individuals were transitioned to MC with coverage effective January 1, 2014. 430 were not transitioned because of various reasons such as already having active Medi-Cal, exceeding the age limit by January 1, 2014 and so forth.

The SF PATH transition accounts for the majority of current MCE patients assigned to the San Francisco Health Network’s (SFHN) primary care clinics. In January 2014, it was confirmed that in San Francisco, 11,780 LIHP participants had transitioned to a Medi-Cal managed care plan based on eligibility data sent by both San Francisco Health Plan (SFHP) and Anthem Blue Cross (Anthem), the two Medi-Cal managed care plans in San Francisco. DHCS was able to confirm 13,380 SF PATH participants successfully transitioned to Medi-Cal by February 18, 2014.

SFHN continues to track the LIHP transitioned enrollments since ACA implementation in order to ensure all eligible participants successfully transitioned and to monitor retention of these members within SFHN. Individuals who were enrolled in Medi-Cal through LIHP were given an aid code of L1, which will remain until these participants have a full Medi-Cal determination by the Human Services Agency (HSA). However, LIHP participants who transitioned to Medi-Cal have 90 days to select a plan and primary care provider through
Health Care Options, a branch of DHCS that assists members with enrollment into Medi-Cal, will be in the Medi-Cal fee for service (FFS) program until they make a selection or are defaulted to a plan and provider. As LIHP participants undergo full Medi-Cal eligibility determinations, they will transition from LIHP eligibility to other Medi-Cal eligibility, leading to a decrease in L1 participants over time (Table 1).

Table 1. LIHP Transitioned Medi-Cal Enrollees with Active L1 Aid Code by Health Plan

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>May 2014</th>
<th>June 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee For Service (FFS)</td>
<td>614</td>
<td>467</td>
</tr>
<tr>
<td>Anthem Blue Cross</td>
<td>1,042</td>
<td>1,046</td>
</tr>
<tr>
<td>SFHP</td>
<td>11,025</td>
<td>10,602</td>
</tr>
<tr>
<td>Non SF Plan</td>
<td>421</td>
<td>315</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13,102</strong></td>
<td><strong>12,430</strong></td>
</tr>
</tbody>
</table>
3. Access & Capacity

Department of Public Health (DPH) clinics are responsible for 61,202 managed care members’ primary care services. The San Francisco Health Network (SFHN), formed in October 2013, has been working to improve access and capacity with the divisions of primary care, subspecialty and other network services by:

- Developing metrics and reports to understand, monitor and communicate to stakeholders access and capacity in each DPH clinic;
- Monitoring and evaluating enrollment, disenrollment and out-of-network costs; and
- Taking measures to improve patient appointment scheduling.

SFHN is working with the Controller’s Office in the City to develop key performance indicators (KPIs) to monitor and help communicate to internal and external stakeholders access and capacity in each DPH clinic and for specialty care within SFHN. These KPIs include 3rd to next follow-up appointment, 3rd to next new appointment, panel size per provider, active panel (seen in last two years) and visit per hour.

SFHN has also developed a Managed Care Enrollment Dashboard and out-of-network (OON) cost analysis to provide clinics feedback on enrollment progress, disenrollment and OON costs for primary care services in each clinic and for overall network services. A workgroup has also been formed to monitor and address some of the issues identified. For instance, one area being addressed is to ensure that health plan-initiated disenrolled members are also removed from DPH’s system successfully as active patients so that the clinic capacity can be further maximized.

In addition to monitoring and evaluating, access, capacity, enrollment, disenrollment and OON costs, SFHN has taken the first step towards developing a full call center by implementing a centralized patient appointment scheduling system for clinics before the end of the year to secure appropriate managed care eligibility clearance and authorization for services.
4. Managed Care Contracts

San Francisco Health Network (SFHN) is looking for all aspects of contracting opportunities to expand its membership and recapture those switching to different programs due to Affordable Care Act (ACA) implementation. SFHN amended its contract with Anthem Blue Cross (Anthem) in 2014 to include Laguna Honda Hospital and has successfully entered into an agreement with North East Medical Services (NEMS) as of September 1, 2014 for the Medi-Cal (MC) population through San Francisco Health Plan. It is also in discussion with a couple of private payors to explore opportunities to participate in Covered California.

ANTHEM BLUE CROSS CONTRACT AMENDMENT

SFHN has a contract with Anthem for Medi-Cal managed care. Enrollment has grown 54%, from 3,299 members in July 2013 to 5,075 members in June 2014. This is primarily due to more people becoming eligible for MC as a result of ACA implementation in January 2014. Highlights during the year include:

- **Addition of Laguna Honda Hospital to the contract effective July 1, 2014**
  ACA mandated that Medi-Cal managed care provide short term inpatient rehabilitation services as an essential benefit. This contract enables SFHN to provide these services to these patients.

- **Addition of SFGH and Laguna Honda Hospital pharmacies to the Anthem pharmacy network**
  Anthem made modifications to their pharmacy network on May 1, 2014, resulting in fewer in-network pharmacies within San Francisco. SFHN responded to this reduction by requesting that the SFGH pharmacy be added to the pharmacy network for better patient access. It also identified a list of local pharmacies that are near its clinics and recommended they be added to the pharmacy network. As of June 2014, Anthem confirmed that SFGH pharmacy and Bay Drug Pharmacy have been added to the network.

NEMS/SFHN PARTNERSHIP

After several months of negotiation, SFHN has successfully entered into an agreement with NEMS on the newly enrolled MC population through San Francisco Health Plan (SFHP).
This agreement requires NEMS to provide primary care services and SFHN to provide the hospital and ancillary services to assigned members starting on January 1, 2015. Enrollment of these members can start as early as November 2014. The estimated membership for the first year is between 500 and 3,000 members. For the specialty care of this population, NEMS is working with the UCSF Clinical Practice Group (CPG) at SFGH to develop an agreement and referral process. An implementation team and workgroups are being formed among NEMS, CPG, SFHN and SFHP to ensure our readiness to provide care to these enrollees.

**COVERED CALIFORNIA PARTNERSHIP**

SFHN is exploring opportunities to participate in Covered California to recapture patients who are required to transition from existing programs such as Healthy San Francisco to Medi-Cal through Covered California and to expand its membership in the commercial business.
5. Contact Information

Stella Cao, MS, MPA
Director of Managed Care
Office of Managed Care
San Francisco Health Network
San Francisco Department of Public Health

101 Grove Street, Room 308
San Francisco, California 94102
(415) 554-2862
stella.cao@sfdph.org
## Enrollment Details: DPH Clinics and Non-DPH Clinics That Access SFGH Services by Program

<table>
<thead>
<tr>
<th>DPH CLINICS (Primary Care + Hospital)</th>
<th>Benchmark</th>
<th>Month.1</th>
<th>Month.2</th>
<th>Month.3</th>
<th>Month.4</th>
<th>Month.5</th>
<th>Month.6</th>
<th>Month.7</th>
<th>Month.8</th>
<th>Month.9</th>
<th>Month.10</th>
<th>Month.11</th>
<th>Month.12</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC</td>
<td>18,121</td>
<td>18,137</td>
<td>18,244</td>
<td>18,307</td>
<td>18,339</td>
<td>18,643</td>
<td>18,788</td>
<td>29,949</td>
<td>30,706</td>
<td>32,198</td>
<td>33,877</td>
<td>34,887</td>
<td>36,419</td>
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<tr>
<td>HW</td>
<td>11,577</td>
<td>11,547</td>
<td>11,643</td>
<td>11,667</td>
<td>11,625</td>
<td>11,797</td>
<td>11,709</td>
<td>11,751</td>
<td>11,966</td>
<td>12,087</td>
<td>12,163</td>
<td>12,223</td>
<td>12,242</td>
</tr>
<tr>
<td>HK</td>
<td>776</td>
<td>771</td>
<td>767</td>
<td>755</td>
<td>752</td>
<td>754</td>
<td>750</td>
<td>741</td>
<td>730</td>
<td>732</td>
<td>736</td>
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<tr>
<td>HF</td>
<td>8</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<tr>
<td>HSF</td>
<td>18,997</td>
<td>19,040</td>
<td>18,790</td>
<td>18,331</td>
<td>14,950</td>
<td>14,835</td>
<td>14,638</td>
<td>14,361</td>
<td>13,952</td>
<td>13,619</td>
<td>13,083</td>
<td>12,347</td>
<td>11,782</td>
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<tr>
<td>SFPATH</td>
<td>9,859</td>
<td>10,139</td>
<td>10,400</td>
<td>13,555</td>
<td>14,034</td>
<td>14,529</td>
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<tr>
<td>DPH CLINICS TOTAL</td>
<td>59,338</td>
<td>59,673</td>
<td>59,826</td>
<td>62,617</td>
<td>59,700</td>
<td>60,559</td>
<td>60,931</td>
<td>56,802</td>
<td>57,354</td>
<td>58,836</td>
<td>59,871</td>
<td>60,222</td>
<td>61,202</td>
</tr>
</tbody>
</table>

| NON-DPH CLINICS (Hospital Only)     |          |         |         |         |         |         |         |         |         |         |           |           |          |
|                                      | MC       | 8,508   | 8,535   | 8,497   | 8,449   | 8,397   | 8,462   | 8,457   | 8,515   | 8,643   | 8,311     | 9,150     | 9,587    | 10,176   |
|                                      | HK       | 574     | 578     | 572     | 579     | 595     | 600     | 590     | 601     | 592     | 597       | 610       | 629      |          |
|                                      | HF       | 2       | 2       | 2       | 2       | 0       | 0       | 0       | 0       | 0       | 0         | 0         | 0        |          |
|                                      | HSF      | 12,662  | 12,586  | 12,631  | 12,675  | 12,862  | 13,021  | 13,027  | 12,956  | 12,495  | 12,146    | 11,609    | 11,041   | 10,586   |
| NON-DPH CLINICS TOTAL                | 21,746   | 21,701  | 21,700  | 21,703  | 21,854  | 22,083  | 22,084  | 22,061  | 21,739  | 21,649  | 21,356    | 21,238    | 21,301   |

| TOTAL DPH CLINICS + NON-DPH CLINICS  |          |         |         |         |         |         |         |         |         |         |           |           |          |
|                                      | MC       | 26,029  | 26,702  | 26,741  | 26,756  | 26,736  | 27,105  | 27,245  | 38,464  | 39,349  | 41,109    | 43,027    | 44,474   | 46,595   |
|                                      | HW       | 11,577  | 11,547  | 11,643  | 11,667  | 11,625  | 11,797  | 11,709  | 11,751  | 11,966  | 12,087    | 12,163    | 12,223   | 12,242   |
|                                      | HK       | 1,350   | 1,349   | 1,339   | 1,324   | 1,347   | 1,354   | 1,350   | 1,331   | 1,331   | 1,324     | 1,345     | 1,375    | 1,388    |
|                                      | HF       | 10      | 11      | 2       | 2       | 0       | 1       | 0       | 0       | 0       | 0         | 0         | 0        | 0        |
|                                      | SFPATH   | 9,859   | 10,139  | 10,400  | 13,558  | 14,044  | 14,529  | 15,046  | 0       | 0       | 0         | 0         | 0        | 0        |
| GRAND TOTAL                          | 81,084   | 81,374  | 81,526  | 84,320  | 81,554  | 82,642  | 83,015  | 78,863  | 79,093  | 80,285  | 81,227    | 81,460    | 82,593   |

**Notes:** HSF enrollment in this report represents only partial enrollment of the program. It includes only participants who are assigned to DPH and non-DPH clinics as their medical home and to San Francisco General Hospital and Laguna Honda Hospital for hospital and ancillary services. Participants enrolled with Brown & Toland Physicians, Chinese Community Health Care Association, Kaiser Permanente, North East Medical Services and Sister Mary Philippa are not included in here as these participants seek network services outside of DPH.
LAUNCH PARTY

WED, JULY 30TH AT 12PM
GERALD SIMON THEATER

WED, JULY 30 AT 8PM
KANALEY COMMUNITY CENTER
Launch

1,235 People Attended the Network Launch throughout the DPH!

- San Francisco General Hospital - 300
- Laguna Honda Hospital - 200
- DPH Central Administration - 60
- Mission Health Center - 30
- Ocean Park Health Center - 29
- California Child Services Medical Therapy Unit - 18
- Sunset Mental Health Services - 18
- 1300 Howard St - 16
- San Francisco City Clinic - 25
- Christsove Public Health Center - 25
- Christsove Child Development Center - 20
- Christsove North Beach Behavioral Health - 27
- Silver Avenue Family Health Center - 40
- Southeast Health Center - 40
- Southeast Mission Geriatric, Southeast Child Family Therapy Center - 10
- Tori Woodard Urban Health - 40
- Carrey Senior Center - 30
- Mission Mental Health - 20
- Castro Mission Health Center - 15
- Mission Family Center - 23
- 25 Van Ness and 20 Van Ness - 16
- Oceanview/Merced/Ingleside Family Center - 20
- Legacy and Family Mosaic Project - 18
- Comprehensive Child Crisis Services - 20
- South of Market Mental Health - 40

Successes

- 25 sites ran Launch successfully
- 19 sites ran the video successfully
- Night time events at SFGH and LHH
- CBO meeting on 7/31 – 100 contractors

South of Market Mental Health

Comprehensive Child Crisis Services

LEGACY
Feedback

Had a good discussion- the power point was really helpful.

Way Forward!

The staff felt that the information presented was understandable and had few questions regarding the launch.

Thank you for the event. It was a great opportunity for staff to gather and learn about the SHN. Approximately 18 of us attended the launch, followed by a rare non-holiday potluck lunch together.

We had a very successful launch!

We had 20 attendees and plenty of lively discussion.

The video was played and applauded before the selfie was taken. And then... cake! :)

Thanks again for all your support with the launch event. The cake, clips, banner & video/slides were great!

Everything went off without a hitch!

Big, big, BIG Thank you to...

- Dalia Rosendo and Bill Kim’s IT group
- Marcelinda Ogbu and Rachael Kagan
- Barbara Garcia and Roland Pickens
- Linda Acosta and Arla Escontrias
- Mivic Hirose (aka Cake Queen)
- Baljeet Sangha, Chris Dunne, Kimvan Nguyen, Denise Lopez and Manjot Multani
- Joshua Nosasier, Jacquie McNight, Gloria Wilder – The Launch Committee
- Ed Shields
- Ben Briones
- Site Liaisons
- Ace, SFGH and LHH Couriers
- Fidez Bituin and all Admin Assistants
- Marketing and Branding group
- Porters and facilities
- EVERYONE WHO HELPED MAKE THE LAUNCH POSSIBLE!!!
Hospitals and Primary Care Clinics

San Francisco General
1001 Potrero Ave

Laguna Honda
375 Laguna Honda Blvd

Chinatown Public Health Center
1490 Mason Street

Tom Waddell Urban Health
230 Golden Gate Ave

Curry Senior Center
333 Turk

Ocean Park Health Center
1351 24th Ave
Hospitals and Primary Care Clinics (Continued)

Southeast Health Center
2401 Keith

Behavioral Health Clinics

South of Market Health Center
760 Harrison Street

Castro Mission Health Center
3850 17th Street

Chinatown Child Development Center
720 Sacramento Street

Chinatown/North Beach
729 Filbert

Children's System of Care/L.E.G.A.C.Y
1305 Evans Ave
Behavioral Health Clinics (Continued)

Behavioral Health Access Center and Health Services Administration
1380 Howard

Comprehensive Child Crisis Services
3801 3rd Street

OMI Family Center
1701 Ocean Ave

Sunset Mental Health
1990 41st Ave
Population Health

HIV/AIDS Office
25 Van Ness

City Clinic
356 7th Street

Maternal, Child, Adolescent Health

Child Services
1595 Quintara Street
Welcome to the San Francisco Health Network
This is an exciting time in the Department of Public Health. The Affordable Care Act has prompted us to create an integrated, managed care delivery system. This system, the SF Health Network, is comprised of San Francisco General Hospital and Trauma Center, Laguna Honda Hospital and Rehabilitation Center, Primary Care, Behavioral Health, Maternal, Child and Adolescent Health and Jail Health.
What makes us special?

We are the only comprehensive care delivery system in San Francisco. We deliver everything from primary care to rehab, from behavioral health to long-term care, from pre-natal to pediatric, from specialty to trauma care.
Together we:

serve more than 106,000* hospital patients each year

deliver more than 1,000 babies

have more than 592,000 outpatient visits

care for more than 31,000 mental health patients

treat 3,300 trauma incidents

operate 15 community clinics

and help countless people get to their highest levels of functioning
What is a brand?

A brand is the sum impression or reputation derived from a consumer’s experience of a company’s products, services, communications and people.
Why Have a Style Guide?

A Style Guide helps to shape an organization’s brand. A well-adhered to brand gives targeted audiences—in our case, health care consumers and others—a clear sense of who we are.
Please follow the style guide when you are producing materials intended to represent the San Francisco Health Network to the public, including materials that will be distributed or posted only in-house. Examples of such items are forms, brochures, fliers, maps, hospital uniforms, PowerPoint presentations, conference posters, caps, mugs, or pins.
I. Logos

The City Seal

The city seal may be appropriate for some official documents and the San Francisco Health Network for others. Generally, the seal is reserved for use on our most official communications. It may also be used on other communications to formally designate that the document is an official City and County of San Francisco communication. Please do not combine the San Francisco Health Network logo with the city seal. For letterhead or business cards, for example, choose one or the other; do not use the two together.

Elements of the Logo

Department of Public Health. A critical requirement of the logo is the designation “Department of Public Health.” All materials should indicate that the San Francisco Health Network is a part of the San Francisco Department of Public Health.

The look and feel, or sense of purpose, that one gets from the network’s collateral materials play an integral part in establishing it as a health care leader.

Adherence to the guide helps to advance San Francisco Health Network’s quality of care by ensuring communication of a consistent impression through the hundreds of communications the network generates every year.
San Francisco Health Network collateral materials use a specific color palette. The consistent use of the colors helps to unify presentation.

The colors in the main palette are Pantone 021 U, Pantone 320 U and Pantone 533 U. They can be created using process color, RGB or HEX, according to the specifications to the left.
The use of additional secondary colors provides consistency, but allows for a more robust and exciting palette.

The secondary colors were chosen because they are complimentary or tertiary colors on the color wheel, which are harmonious to the eye.
<table>
<thead>
<tr>
<th>Main Color Palette</th>
<th>Secondary Colors</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Color Swatch" /></td>
<td><img src="image2" alt="Color Swatch" /></td>
</tr>
<tr>
<td>PANTONE: PMS 021 U CMYK: 0, 72, 86, 0 RGB: 255, 108, 47 HEX: FF6C2F</td>
<td>PANTONE: PMS 655 U CMYK: 0, 100, 65, 52 RGB: 78, 93, 127 HEX: 4E5D7F</td>
</tr>
<tr>
<td><img src="image3" alt="Color Swatch" /></td>
<td><img src="image4" alt="Color Swatch" /></td>
</tr>
<tr>
<td>PANTONE: PMS 320 U CMYK: 95, 15, 36, 0 RGB: 0, 157, 165 HEX: 009DA5</td>
<td>PANTONE: PMS 655 U CMYK: 100, 65, 0, 52 RGB: 219, 213, 205 HEX: DBD5CD</td>
</tr>
<tr>
<td><img src="image5" alt="Color Swatch" /></td>
<td><img src="image6" alt="Color Swatch" /></td>
</tr>
<tr>
<td><img src="image7" alt="Color Swatch" /></td>
<td><img src="image8" alt="Color Swatch" /></td>
</tr>
<tr>
<td>PANTONE: PMS Warm Gray 1 CMYK: 2, 3, 7, 8 RGB: 219, 213, 205 HEX: DBD5CD</td>
<td>PANTONE: PMS Warm Gray 3 CMYK: 8, 9, 11, 20 RGB: 190, 182, 175 HEX: BEB6AF</td>
</tr>
<tr>
<td><img src="image9" alt="Color Swatch" /></td>
<td><img src="image10" alt="Color Swatch" /></td>
</tr>
</tbody>
</table>
The preferred fonts for use in materials are Arial and Arial Narrow. Using other fonts dilute the effectiveness of the image and the message.

Font sizes 11, 12 and 14 are preferred both for body text and section headings in documents. Try to keep it simple. Bold, italics, all caps, small caps should not be used all at once.
Writing Style

Please refer to the AP (Associated Press) Style Guide. Consult this guide for rules on punctuation, capitalization, word choice and easy to misspell words.

Some helpful hints:

- Commas and periods always go inside quotes.
- Avoid unnecessary capitalization of important words (capitalize proper names, not technical terms or titles).
- Avoid passive sentence structure and verbs.
The Logo

The SF Health Network logo was designed to unify all of our network providers. Please do not alter the logo. Also do not combine it or use it with any other logo.

Consider the size, clearance, and layout in relation to overall context, such as the other information and graphic elements that will appear on the page.
The Wordmark

The SF Health Network wordmark can be used instead of the logo in some cases (where the logo does not fit, design wise). Do not lock it up or use it with any other logo.

Again, consider the size, clearspace and layout in relation to overall context, such as the other information and graphic elements that will appear on the page.
Other Variations of the Logo

The MySFHealth logo is for use on the SFHN patient portal. It appears with the bridge on unbranded pages and as a wordmark on SFHN branded pages.
The City Seal

The City Seal is reserved for use on our most official communications (Mayor’s Office, Board of Supervisors, Health Commission, Joint Conference Committee, and other government agencies).

Again, please do not combine it with any other logo. Consider the size, clearspace and layout in relation to overall context, such as the other information and graphic elements that will appear on the page.
You may also use this logo to emphasize the affiliation with the City.
Checklist for using the logo:

1. Am I using the correct logo?

2. Is the logo displayed in a clear and undistorted manner?

3. Is there breathing room around the logo?
Combining the Logos

If the logos must be used together, please allow adequate space between them. Generally the city seal should be placed in the upper left corner of the document and the SFHealth Network in the right corner. Other arrangements are allowable with permission from the Communications Department.
If co-branding with another organization, please allow adequate space between the two logos. Generally the bridge should be placed in the upper left corner of the document and the other organization’s logo in the right corner. The other organization’s logo should never be larger than the bridge logo. Other arrangements are allowable with permission from the Communications Department.
Need help with inserting the Logos?

see next page
Inserting the logo:

In Microsoft Word or PowerPoint:

Click on “insert” tab, and choose “picture” from drop down (looks like this)

Choose your logo:
  If you are inserting into a colored background, choose a png file, which will support transparency and will eliminate a white box around your logo.

  Otherwise, a jpeg should work fine.
Templates
front:

NAME HERE
TITLE HERE

SF HEALTH NETWORK
LAGUNA HONDA
375 LAGUNA HONDA BLVD
SAN FRANCISCO, CA 94116

TEL 415-123-4567
FAX 415-789-0000
PAGER 415-000-0000
FIRST.LAST@SFDPH.ORG

back:

a member of the

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
The letterhead with the city seal is reserved for use in our most official communications.
The SF Health Network is the city’s only complete system of care. Our top goal is to improve the value of services provided to our patients, staff and San Franciscans.

Instructions on next page
For OWA users:
Instructions for how to incorporate an image into your email signature.

Type your contact info (and confidentiality text below) into a word document and save as “web page” which will save as html

Open the html file, copy the text and go to Office 365
click on Options (under gear icon – looks like this
then settings (in left column)
in the email signature box, control-V to paste the html text in.

Now go to:

your link here

right-click on png and choose “copy image”

now go back to your 365 email signature window and control-V to paste your logo in.

Now click save!

CONFIDENTIALITY NOTICE: This e-mail is intended for the recipient only. If you receive this e-mail in error, notify the sender and destroy the e-mail immediately. Disclosure of the PHI contained herein may subject the discloser to civil or criminal penalties under state and federal privacy laws.

For Full Outlook users:
Instructions for how to incorporate an image into your email signature.
Click on New E-mail
Then click on Signatures and choose Signatures.. under dropdown menu
Click New
Type a name for this signature
Insert your graphic by clicking the icon that looks like this
Type your contact information and confidentiality text (below)
Choose your default signature in upper right corner
Click save!

CONFIDENTIALITY NOTICE: This e-mail is intended for the recipient only. If you receive this e-mail in error, notify the sender and destroy the e-mail immediately. Disclosure of the PHI contained herein may subject the discloser to civil or criminal penalties under state and federal privacy laws.

You can call Linda Acosta at 415-554-2928 with questions or comments.
Fax cover

Report covers

Newsletters

Flyers

To be developed
http://brand.universityofcalifornia.edu/guidelines/editorial.html

AP Style Guide

For questions or help with this Style Guide, please contact Linda Acosta at linda.acosta@sfdph.org or at 415-554-2928
Please contact Linda Acosta at linda.acosta@sfdph.org or at 415-554-2928
SF Health Network
The Integrated Delivery System of the
San Francisco Department of Public Health

Presentation for DPH staff
July 2014

Presentation Overview

SF Health Network(SFHN):
- Origins of SFHN
- What is SFHN?
- How does SFHN Fit into the DPH Structure?
- Why is DPH changing its Organizational Structure?
- What does SFHN mean for patients?
- What has been the focus of SFHN so far?
- SFHN Branding and Marketing
- How You Can Help Move SFHN Forward

The Birth of
A Health Network

IDS Planning

Health Reform Readiness Assessment by HMA

What is SFHN?

- COMPLETE
- VALUE
- COMMUNITY

Top 3 Points

- The SF Health Network is the City’s only complete system of care.
- The Network’s top goal is to improve the value of services provided to our patients (clients, consumers), staff and all San Franciscans.
- We are San Francisco: Services in every neighborhood, we listen to community input and we have a diverse staff committed to community health.

Overview

- An integrated delivery system of SFDPH’s direct health care services
- All components to build a seamless continuum of care
- SF Health Network will:
  - Deliver managed care
  - Improve quality and health
  - Build an infrastructure to maximize quality and efficiency
  - Patient care at the right place, the right level, the right time
  - Collaborate with providers, partners and health plans
Together we:
- serve more than 110,000 hospital patients annually
- deliver more than 1,000 babies
- have more than 592,000 outpatient visits
- care for more than 33,000 mental health patients
- treat 3,300 trauma incidents
- operate 15 community clinics
- operate 28 behavioral health services clinics
- and help countless people get to their highest levels of functioning

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>Number of Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>296,641</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>257,143</td>
</tr>
<tr>
<td>Dental Care</td>
<td>11,786</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>28,167</td>
</tr>
<tr>
<td>Emergency Encounters</td>
<td>77,628</td>
</tr>
<tr>
<td>Medical Encounters</td>
<td>70,783</td>
</tr>
<tr>
<td>Encounters Requiring Trauma Center</td>
<td>3,188</td>
</tr>
<tr>
<td>Diagnostic and Ancillary</td>
<td>140,840</td>
</tr>
<tr>
<td>Acute Inpatient</td>
<td>96,858</td>
</tr>
<tr>
<td>Days at SFGH</td>
<td>95,636</td>
</tr>
<tr>
<td>Days at Laguna Honda</td>
<td>1,222</td>
</tr>
<tr>
<td>Home Health Care Visits</td>
<td>19,098</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td>312,850</td>
</tr>
<tr>
<td>Actual Days at SFGH</td>
<td>7,326</td>
</tr>
<tr>
<td>Actual Days at BHC</td>
<td>28,272</td>
</tr>
<tr>
<td>Actual Days at Laguna Honda</td>
<td>277,216</td>
</tr>
</tbody>
</table>

*This is current available data from FY12-13 DPH Annual Report

Payor Source

- **SFGH**
  - Medi-Cal: 31%
  - Medi-Cal Managed Care: 12%
  - Uninsured: 34%
  - Private Pay: 2%
  - Medicare: 16%
  - Other: 4%

- **COPC**
  - Medi-Cal: 11%
  - Medi-Cal Managed Care: 31%
  - Uninsured: 29%
  - Private Pay: 1%
  - Other: 9%
  - Medicare: 12%

- **CCHR**
  - Medi-Cal: 11%
  - Medi-Cal Managed Care: 13%
  - Uninsured: 5%
  - Private Pay: 0%
  - Other: 4%
  - Medicare: 28%

- **Laguna Honda**
  - Medi-Cal: 98%
  - Medi-Cal Managed Care: 1%
  - Uninsured: <1%
  - Private Pay: <1%
  - Medicare: 1%

*This is current available data from FY12-13 DPH Annual Report
Why are we changing?

- Health Care Reform
- Affordable Care Act
- Obamacare

Why Are We Changing? Impact of Health Reform on DPH

- Better Health
- Better Care
- Lower Costs

Our patients deserve this.

- Timely Access
  - Right to care within a reasonable time
- Capitation
  - One rate of payment per member per month
- Competition
  - More providers interested in the same patients

What We’ve Done so Far:

- Establish Care Coordination
- Implement system-wide financial management tool
- Identify, budget and implement IT needs
- Establish SFHN Ambulatory care organization
- Implement financial structure to support integrated SFHN
- Create primary care calculator to help reduce wait time
- Develop SFHN brand ambassadors and internal champions
- Develop SFHN branded materials
- Begin Marketing and Branding Process
- Implement Nurse Orientation Course
- Implement Primary Care Disease Management VALUE Initiative
- Develop SFHN staff communications and internal champions
- Develop SFHN brand ambassadors and internal champions
- Develop SFHN branded materials
- Begin Marketing and Branding Process
- Implement Nurse Orientation Course
- Implement Primary Care Disease Management VALUE Initiative

Branding & Marketing
And the tagline is…..

Your bridge to wellness

Questions?

- COMPLETE
- VALUE
- COMMUNITY
Welcome to the SF Health Network!

Laguna Honda, together with SF General, the Primary Care Clinics and Behavioral Health:

• We are the city's only complete system of care
• Our goal is to improve the Value of services provided
• We are a diverse staff committed to community health

Pass it on- and thank you for all the wonderful work you do every day!
TALKING POINTS

TOP 3 POINTS:

1. **Complete.** The San Francisco Health Network is the City’s only complete system of care.

2. **Value.** The Network’s top goal is to improve the value of services provided to our patients (clients, consumers), staff and all San Franciscans.

3. **Community.** We are San Francisco: We provide services in every neighborhood, we listen to community input and we have a diverse staff committed to community health.

OVERARCHING MESSAGES:

- The San Francisco Health Network is the City’s only complete system of care.

Our services run the gamut from pre-natal and pediatric, primary and specialty care, hospital and long-term care, rehabilitation, substance abuse treatment and mental health services. We also include trauma care, which no other health care delivery system in San Francisco provides.

Every member of our staff has a role to play in making the Network successful. From doing a great job to being an ambassador for the Network, each of us contributes to this new endeavor.

- The Network’s top goal is to improve the value of services provided to our patients, staff and all San Franciscans.

As the City and County’s health care delivery system, we serve not only our patients, but also our staff and the entire community. We are obligated to be good fiscal stewards of public resources. We operate services that are open to all San Franciscans, such as trauma care. We are part of the Department of Public Health, which performs a wide range of functions to protect and promote the health of the entire city. These include disease control and surveillance, environmental health and the Healthy San Francisco program.

- We are San Francisco: We provide services in every neighborhood, we listen to community input and we have a diverse staff committed to community health.

The Network is made up of primary care clinics and mental health services throughout the community. Our history of working together with communities to take on their most pressing health concerns is reflected in the wide variety of programs that meet the needs of our patients and families. We have extensive expertise in working with diverse groups, developing creative solutions and looking at health with a capital “H” – understanding that many factors define our wellbeing. We are innovative, inclusive, mission driven and dedicated to our patients, families and the entire community.

- Our tagline: “Your Bridge to Wellness” reflects the spirit and value of our network. It was created by a contest with more than 400 participants city-wide.