Title: Right Care, Right Place, Right Time

Owner: Kelly Hiramoto & Dennis McIntyre
Team: Sung, Pratt, Hammer, Hirose, Marks, Pickens, Ehrlich

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I. Background

The San Francisco Health Network (SFHN) has a shared responsibility among its providers and component institutions for the health care of patients seen, regardless of where in the delivery system they are seen. However, numerous factors preclude SFHN from providing optimal care within such a context, including---but not limited to---the following:

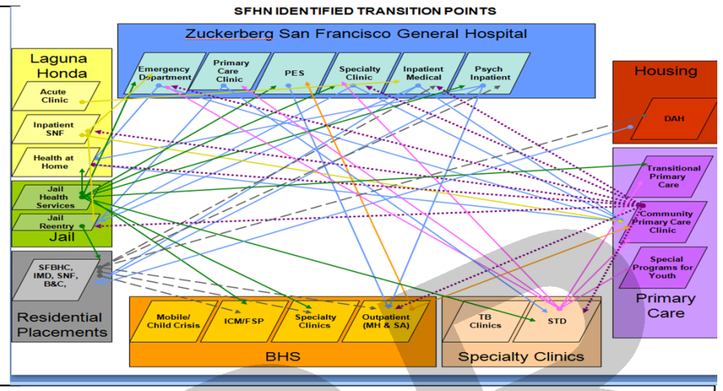
1) the network employs numerous information systems that lack integration and interoperability across all venues of care, thus interfering with the ability to conduct high-quality and effective clinical, quality and utilization management;
2) the number of aging homeless individuals in San Francisco is growing;
3) SFHN patients have inordinately large social, behavioral and medical illness burdens which often can only be partially addressed because of system inadequacies;
4) there is an increasing supply/demand gap for behavioral health, substance abuse and housing services;
5) Inappropriate use of emergency departments and inpatient beds as care venues for conditions that can be treated at a lower level of resource consumption.

All these factors impact staff ability to consistently deliver quality care and for patients/clients to consistently have a positive care experience.
SFHN has an unprecedented opportunity through public policy and funding initiatives to create the type of health care delivery system that we want to offer to patients, i.e., delivering the *right care*, in the *right place*, at the *right time*, by the *right provider* and in the *right clinical setting*. Health care continues to shift towards an environment that rewards clinical and service performance, and allows consumers to make informed choices related to their care provider. Previously, most delivery systems---especially "safety net" systems---were insulated from these pressures, but now---through changes in federal funding for safety net care (e.g. PRIME)---we have three to five years to create a system that will demonstrate it can be both competitive and sustainable.

II. Current Conditions

Sections within SFHN define service populations differently and there is disagreement about who takes responsibility for coordinating care when individuals present service challenges across different access points.

System, service and communication gaps contribute to interrupted flow. This often results in people being held in clinically inappropriate settings, diverted Out of Medical Group (OOMG) or left out of care loops entirely. The financial and quality of care impacts are notable.

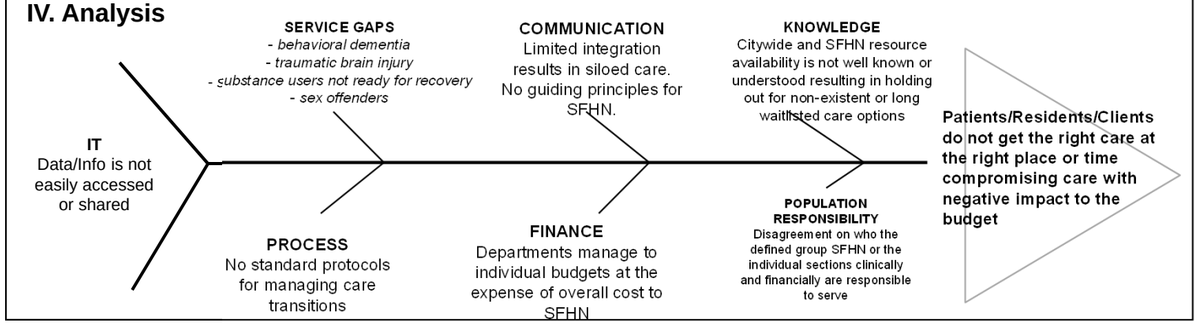


Problem Statement: Our patients, clients, and residents are not consistently receiving high-quality care, in the right place, and in a timely manner. This compromises patient health, patient and staff experience, and increases cost.

III. Goals & Targets

- Reduce the out of medical group cost (OOMG) 15% from baseline by 12/31/17
- All SFHN clients/patients will be connected to primary care
- Composite: Increase timely access to any level of care (as defined by each entity)
  - Behavioral health: 40% of BHS clients will have/know who their MH provider is
  - Jail health: All discharges from Jail will have a primary care appointment
  - Primary Care: X% of patients who have a Primary Care home will have been seen at least once
  - SFHN Transitions: Reduce fiscal impact of top 5% of HUMS by 2% from current baseline
  - ZSFGH: will be on Emergency Room/Psychiatric Emergency Services diversion less than 25% of the time

IV. Analysis



V. Proposed Countermeasures

1. Agree on who SFHN serves and what service sections/providers are accountable for ensuring seamless care.
2. SFHN-wide implementation of a best available and not necessarily most ideal patient flow protocol.
3. Re-allocate, re-deploy, re-purpose resources to address limited capacity areas.
4. Create work standards and INTER-Departmental Policy & Procedures. Compile in an SFHN Standard Operating Procedures Manual.

EXAMPLES:

a. Direct admissions to the ZSFGH Emergency Department and Urgent Care Clinic for patients assessed in an SFHN Primary Care clinic and deemed to require emergency care
b. Linkage to primary care for medically complex in higher care settings such as Jail, Acute Inpatient, Locked Sub Acute Treatment, Laguna Honda Hospital, prior to release/discharge
c. Linkage from Primary Care to higher care services and settings (Residential Care facilities, Intensive Case Management)

4. Create SFHN level governance structure to ensure compliance
5. Create a new centralized outreach function to engage facilitate getting Enrolled Not Yet Seen patients into care.
6. Devise a external marketing strategy targeting specific groups of Enrolled Not Yet Seen patients and inviting them into care.

VI. Plan

1. Create a short term workgroup charged with:
   a) Compile the SFHN Standard Operating Procedure Manual
   b) Develop proposals for resource reallocations/redeployment/repurposing for SFHN Leadership to approve
   c) Brainstorm on culture change and collaborate with the Workforce Development A3 group

VII. Follow-Up

1. Assign a Project Manager to keep the Workgroup on a timeline that is aligned with implementation deadlines that will come from SFHN Leadership
2. Create metrics to track whether identified Goals & Targets are met and if not, why not
3. Financial impact may result in short term budget overage for some departments.
4. Re-convene RCRPRT A3 Team in 180 days to review progress