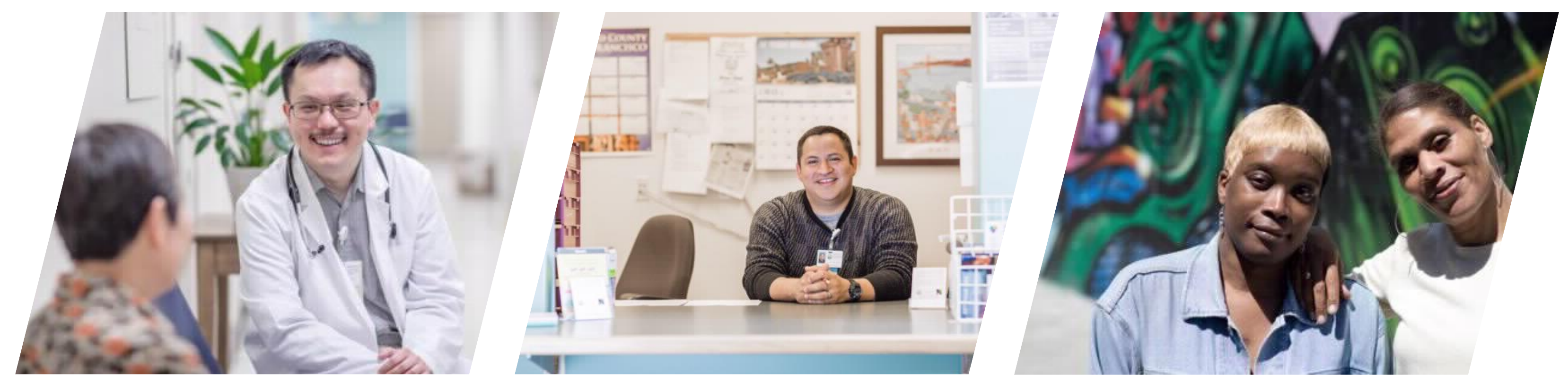
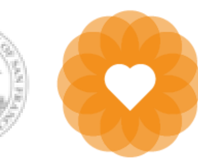
SFHN Primary Care Update

Health Commission | September 15, 2020

Anna Robert, RN, MSN, DrPH

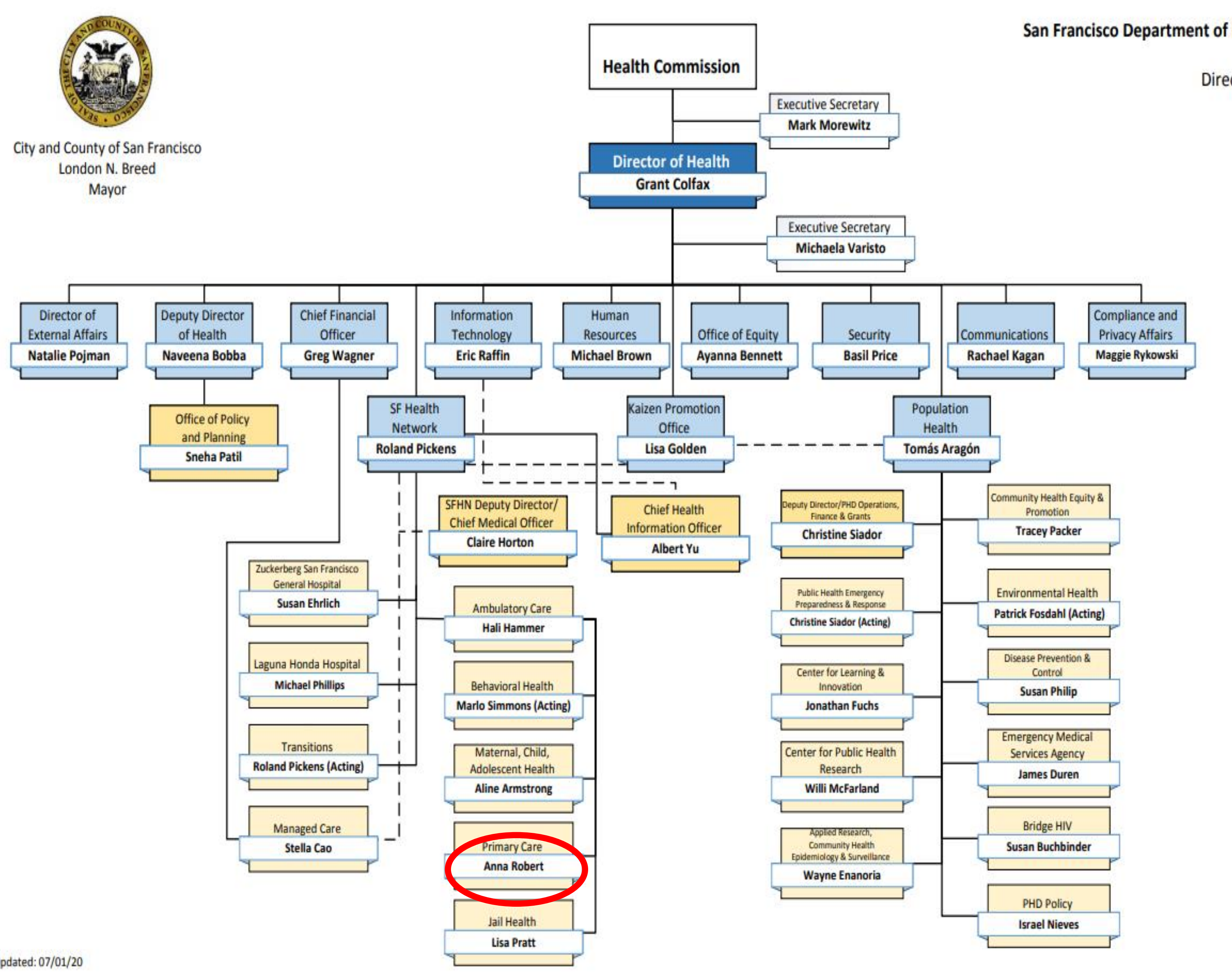
Director of Primary Care





San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH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Last Updated: 07/01/20

SFHN Primary Care Vision

1st
Choice
for Health Care
and Well Being

Improve the Health of the Patients We Serve

Optimize Access, Operations, and Cost-Effectiveness

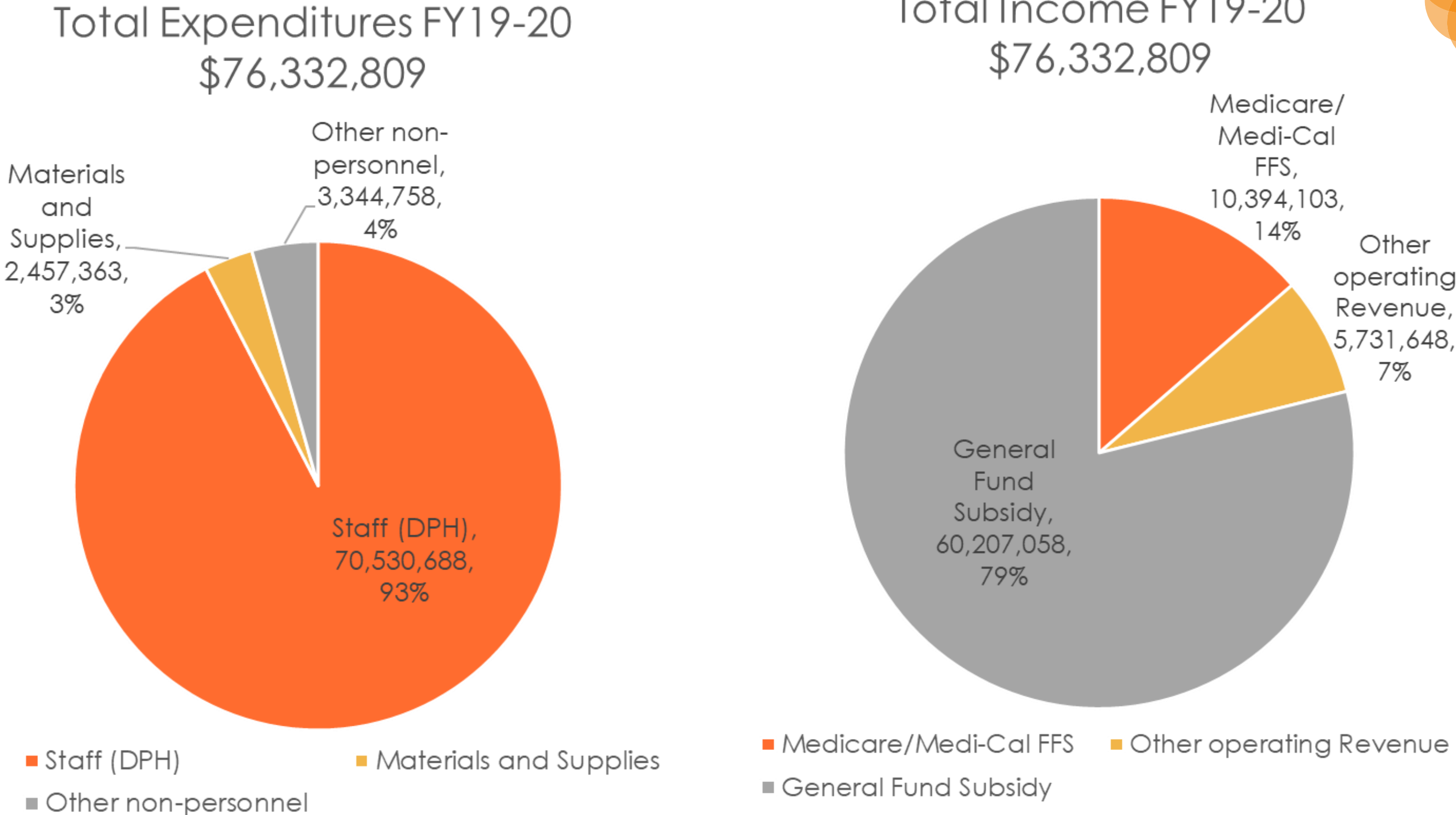
Ensure Excellent Patient Experience

Safety	Quality	Care Experience	People Development	Financial Stewardship	Equity

Build a Strong Foundation of a Healthy, Engaged, and Sustained Primary Care Workforce

We Provide High Quality Health Care that Enables San Franciscans to Live Vibrant, Healthy Lives

PC Financial Summary: FY19-20



Additional PC Revenue/Income FY19-20:

- Global Payment Program - $27 million
- PRIME/QIP - $26 million
- Health Homes - $115K

Clinic Distribution and Focus

primary care for adults and families

primary care for youth

primary care for adults

SPECIAL FOCUS CLINICS

Geriatric: Curry

Homeless or marginally housed: Tom Waddell Urban Health

HIV positive or at risk: PHP

Children and youth: CHPY, CHC

Chinatown Public Health Center (CPHC)

Maxine Hall Health Center (MHHC)

CHPY Larkin Street Clinic

Tom Waddell Urban Health Clinic

Curry Senior Center

CHPY Cole Street Clinic

CHPY New Generation HC

ZSFG Campus Clinics

RFPC

CHC

FHC

PHP

Ocean Park Health Center (OPHC)

Castro Mission Health Center (CMHC)

Special Programs for Youth (SPY)

Potrero Hill Health Center (PHHC)

Silver Avenue Family Health Center (SAFHC)

Southeast Health Center (SEHC)

CHPY Balboa Teen Health Center

CHPY 3rd Street Youth Clinic

Facility Updates/Remodels

- Maxine Hall Health Center
  - Temporary location at 1181 Golden Gate
  - Construction started – July 2019
  - Goal for completion – December 2020
- Southeast Health Center
  - Construction started – May 2020
  - Goal for completion – September 2022
- Castro Mission Health Center
  - Temporary location at ZSFG Building 80
  - Goal to start construction – January 2021
  - Goal for completion - February 2022

Maxine Hall Health Center (rendering)

Castro Mission (rendering)

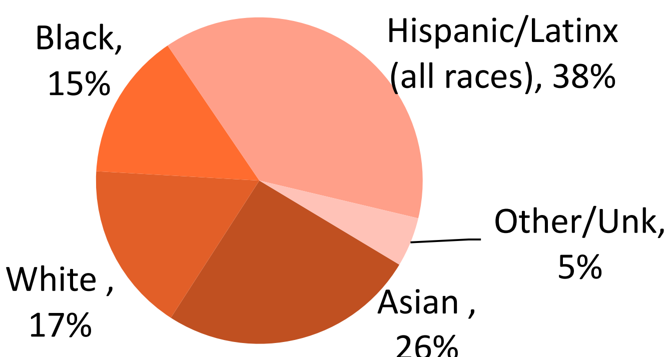
Southeast Health Center (existing)

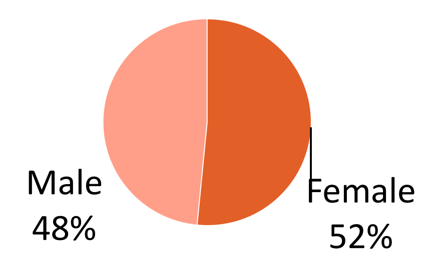
New Southeast Health Center (rendering)

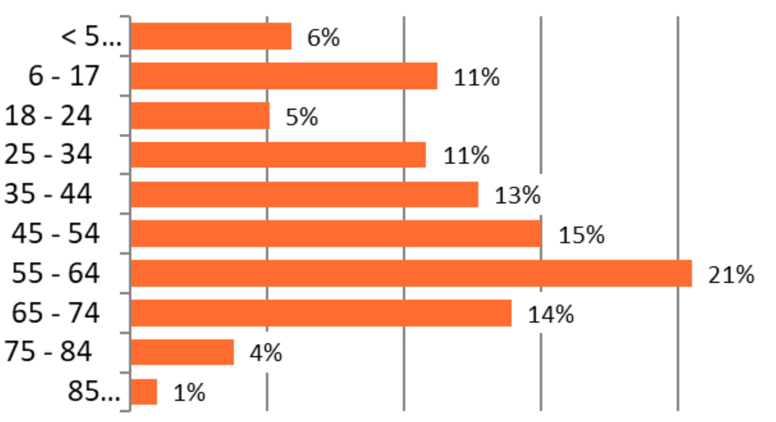
Who are our patients?

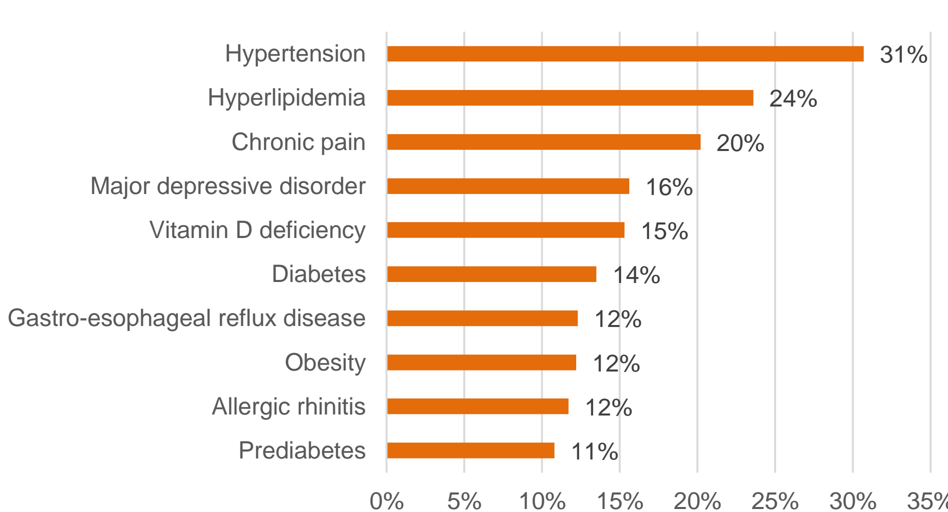
Empanelment (current data):
- 66,368 active pts
- 25,152 enrolled and not yet active

8/3/2019-8/2/2020
- 230,807 total encounters

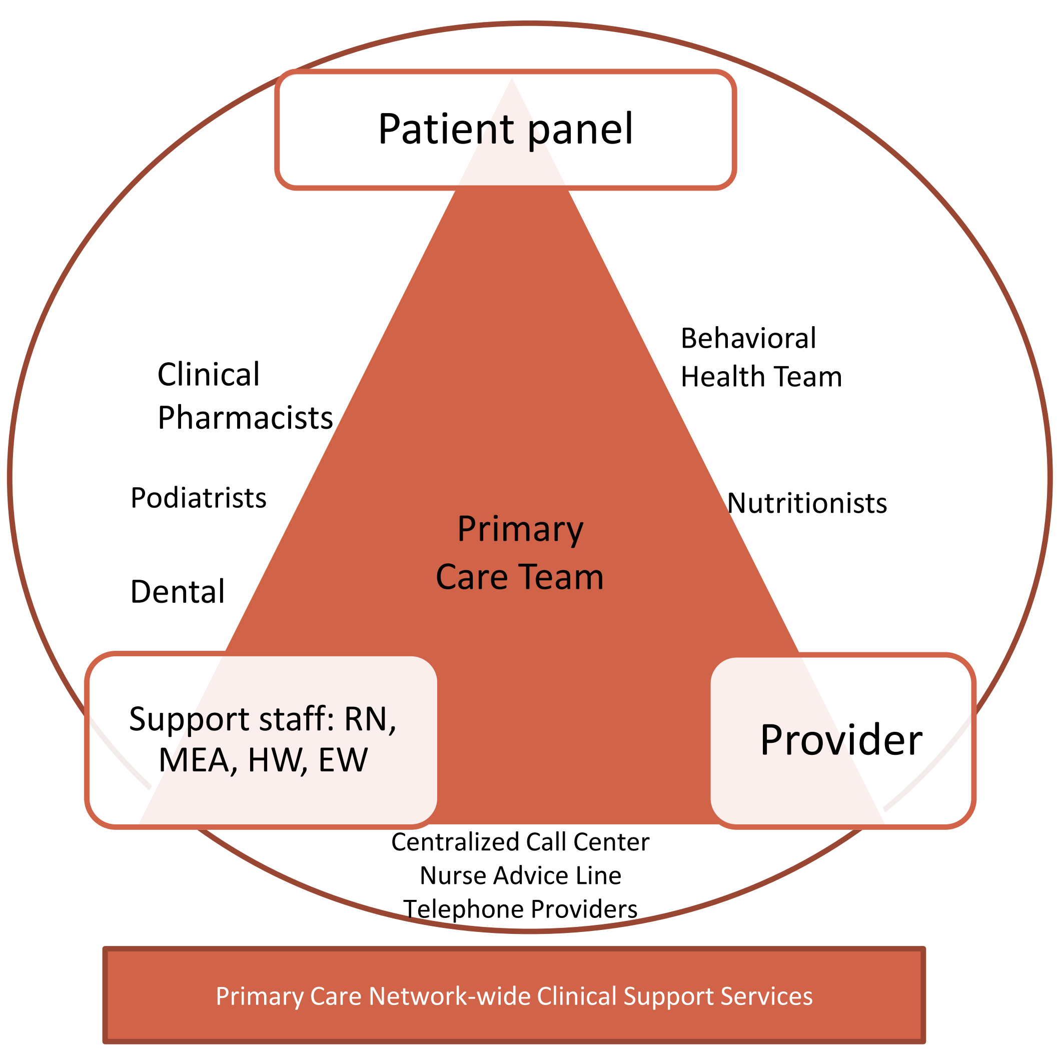








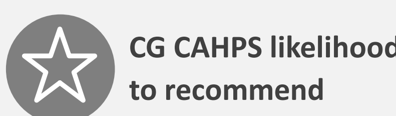
Multidisciplinary Team-based Model of Care



Primary Care
True North & Driver Metrics

STRATEGIC THEME	**Quality**	**Safety**	**Equity**
Primary Care True North Metrics **2016-2018**	Improve population health through **preventive care** and **chronic condition management**, with focus on: preventive oral health care, blood pressure management, and helping smokers quit	 Improve timely coordination of care to prevent high risk events, prioritizing reducing hospital readmissions	 Reduce health disparities in blood pressure control Implement standard work to reduce bias in hiring and increase diversity
Primary Care Driver Metrics (PCDM) **2017-18**	**Hypertension control** **Behavioral Health Vital Signs**	**7 day post-discharge follow up**	**Hypertension control for African Americans**

Primary Care
True North & Driver Metrics

STRATEGIC THEME	Care Experience	People Development	Financial Stewardship
Primary Care True North Metrics **2016-2018**	Increase the number of patients with a positive response to CG-CAHPS "would you recommend" question Improve access to care	Improve workforce engagement, as measured by the Gallup staff engagement score	Increase annual revenue through billing for all revenue-generating encounters
Primary Care Driver Metrics (PCDM)	**Routine appointment access**  **CG CAHPS likelihood to recommend**	**Performance appraisals completed and submitted**	**Notes locked on time and with a diagnosis**

METRIC:

Behavioral Health Vital Signs

WHY WE MEASURE THIS:

Behavioral Health is Integral to Overall Health. Untreated behavioral health conditions complicate chronic health conditions and lead to preventable deaths and disabilities nationwide. So far, BHVS has found 17% of patients without existing depression have a positive PHQ-2. BHVS is an opportunity to identify and address depression, substance misuse, and interpersonal violence in our patient populations. Patients may be more willing to see a primary care behavioral health provider than another mental health provider or may not have access to a mental health provider.

Goal:

SFHN Goal

By June 30, 2019, increase rate of 12+ screened with BHVS from **8.8%** (June 2018) to **36.2%** (30% RI).

PCC Goal

Increase by 30% RI from BHVS baseline

Pre-EPIC and Pre-COVID

June 2019

(data through May 2019)

1087 **Additional patients screened with BHVS in the last month**

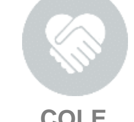
39.9% **Compared to 37.1% April 2019**

0 **Patients need BHVS screening to reach goal**

9/13 Met RI goal of 30% screened with BHVS from baseline to this month

CHC

CMHC


COLE

CPHC

CSC

FHC

LARKIN

MHHC

OPHC

PHHC

PHP

RFPC

SAFHC

SEHC

TWUHC

Met 30% RI BHVS goal

Implemented BHVS

Not Yet Implemented

Lee came into clinic and was given a BHVS form. He answered yes to both PHQ2 questions and substance use. Lee was referred to behavioral health the same day where identifying depressed mood and substance misuse also led to a conversation about his past interpersonal trauma and how it was affecting his adherence to treatment for HIV. Afterwards he thanked the team and stated his relief in having a plan to move towards feeling more hopeful about his future.

EQUITY

METRIC:

Hypertension Control

WHY WE MEASURE THIS:
1 in 4 SFHN PC patients have hypertension. Research shows that a blood pressure reduction of 12 mmHg for 11 patients prevents 1 death over 10 years. Of the 9,600 B/AA patients within the SFHN, approximately 39% have hypertension. While BP control rates for B/AA patients improved from 62% to 64% over the last fiscal year of 2017-2018, the disparity gap between B/AA and the total population only decreased 1% from 8% to 7%.

May, 2019
(data through April, 2019)

GOAL:

SFHN Goal
By June 2019, increase BP control for B/AA patients with hypertension from **61.4%** *(June 2018)* to **65.3%** (10% RI).

PCC Goal
Increase BP control by **15% RI** or 71% threshold for B/A⁄ patients with hypertensio⁄

Pre-EPIC and Pre-COVID

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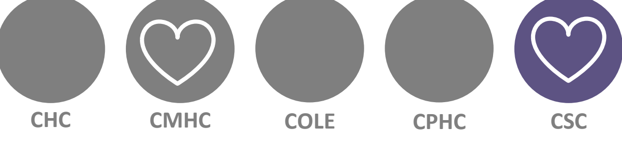
…n Network

2 **Additional net B/AA patients with controlled blood pressure this month**

64.1% **Compared to 64.0% in March, 2019**

45 **B/AA patients needed to control BP to reach goal**

5/11 **Met relative improvement goal of 15% this month**



Did not meet RI goal

SEHC has having a difficult time reaching Mrs. Lee to schedule her for an appointment with the pharmacist at HTN clinic. After three outreach attempts, SEHC sent Mrs. Lee a letter encouraging her to call and schedule. Mrs. Lee called the clinic and was so appreciative and grateful that SEHC sent a letter; she said, “It showed me that you all really care about my blood pressure.” She scheduled an appointment, came in, and had her blood pressure in control!

METRIC:

7 Day Post-Hospitalization Follow-up

WHY WE MEASURE THIS:

Leaving the hospital is one of the most vulnerable times for patients because they are sick and often have new medications. Connecting them to a care team reduces the chance of them going back to the hospital. This is also a pay for performance measure with money tied to how well we are doing.

TARGET:

By end of June 2019, have **69%** of our discharged patients connected with a care team within 7 days post hospitalization compared to baseline of **64%** (4/2018 - 6/2018).

Our target is **15%** relative improve

Pre-EPIC and Pre-COVID

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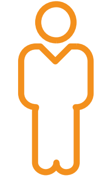
Health Network

May 2019

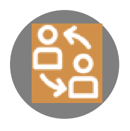
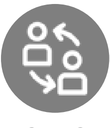
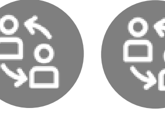
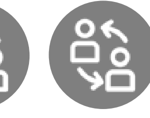
(Data for April 2019)

Clinic or phone visit w/in 7 days

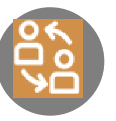


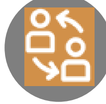
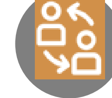
AT GOOOOOOOOOOOOOOAL!

6/14 **Met relative improvement goal of 15% this month**

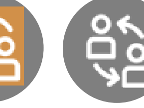
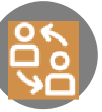





CHC CMHC CPHC CSC FHC



LARKIN MHHC OPHC PHHC PHP

RFPC SAFHC SEHC TWUHC

Lee, homeless patient of RFPC (resident), admitted for pyelonephritis and COPD exacerbation. Staying at medical respite after discharge, inpatient team and respite team communicated dc follow up visit plan to her which she attended with NP Sobel-Twain. Had O2 DME and DM medication needs, both were sorted at this visit.

QUALITY

METRIC:

Adolescent Immunizations

WHY WE MEASURE THIS:

Adolescents should receive 1 dose of Tdap, 1 dose of MCV4 and 2 doses of HPV9 vaccine. Immunizing adolescents with these vaccines before their 13th birthday offers greater immunity to protect individual health and safe guards our public health. Vaccination rates for HPV are lower than other adolescent immunization rates, presenting a critical opportunity to safely prevent multiple forms of cancer. The HPV vaccine works best when it is given to young adolescents, as early as 9 years old— only requiring 2 doses (instead of 3) to provide long term protection.

GOAL:

SFHN Goal
By June 2019, increase rate of patients age 13 with appropriate adolescent immunizations received and documented from approx. **63.4%** (June 2018) **to** approx. **67.0%** (10% RI).

PCC Goal
Increase rate of appropriate ac' immunizatic and doc **15% F** ge 13

Pre-EPIC and Pre-COVID

...n Francisco Health Network

June 2019
(Data as of May 31, 2019)

6

Additional net adolescents patient age 13, who received all appropriate adolescent immunizations

66.1%

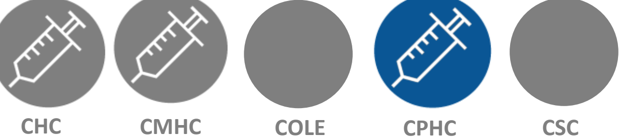
Compared to approx. 65.0% in March, 2019

4

Patients needed to receive immunization(s) to reach goal

6/9

Met relative improvement goal of 15% from baseline to this month

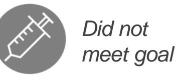


CHC CMHC COLE CPHC CSC

FHC LARKIN MHHC OPHC PHHC

PHP RFPC SAFHC SEHC TWUHC

Met 15% RI goal



Did not meet goal

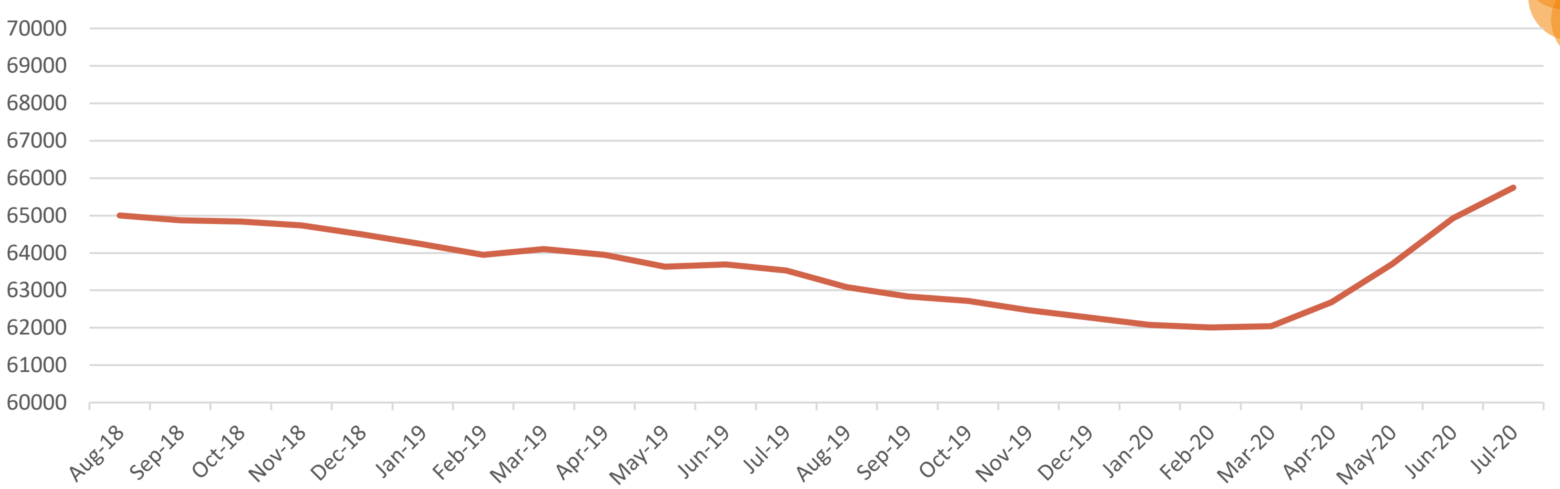
Lee is 10 and was due for adolescent immunizations. Through an outreach call this month, an MEA was able to reach Lee's father and schedule both him and his brother in for well-child checks on the same day. Both brothers received the vaccines they needed and the family left happy!

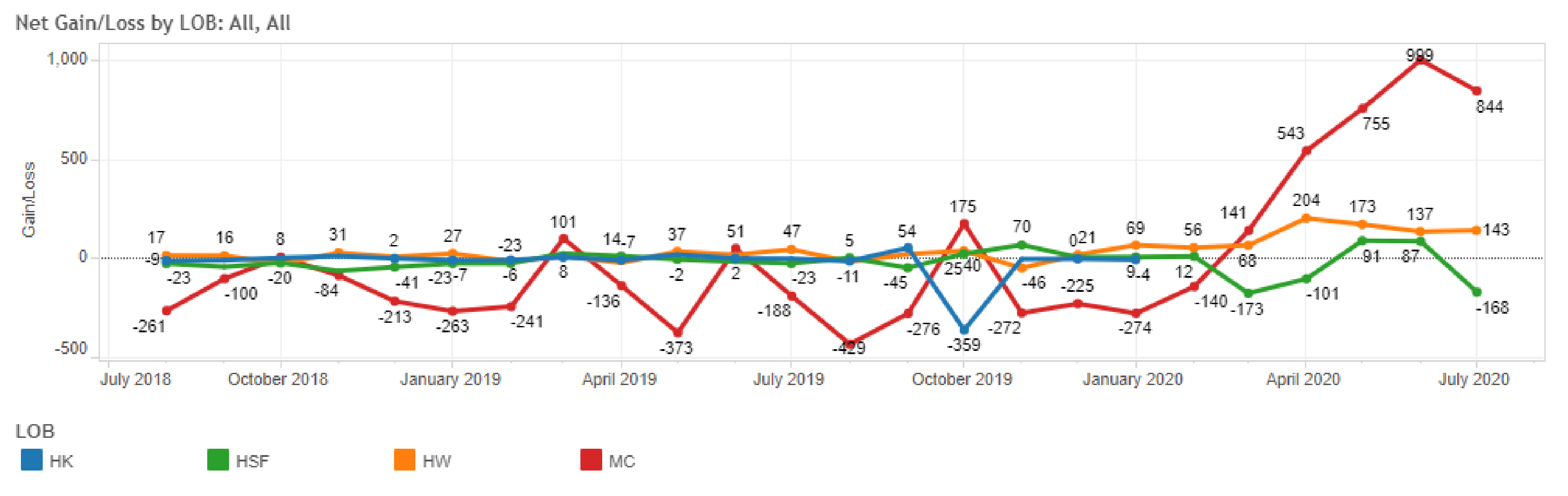
Impact of COVID-19 on Primary Care

Impact on Staffing

- Total budgeted FTE: ~500 (approx. 70 vacant)
- Employees out on any “leave” (including self-certification due to COVID-19): ~80
- Currently deployed to COVID-19 activation: ~90
- Ever deployed: ~200

SFHN Primary Care Managed Care Enrollment:
Healthy Workers, Healthy San Francisco, Medi-Cal





Primary Care Visits

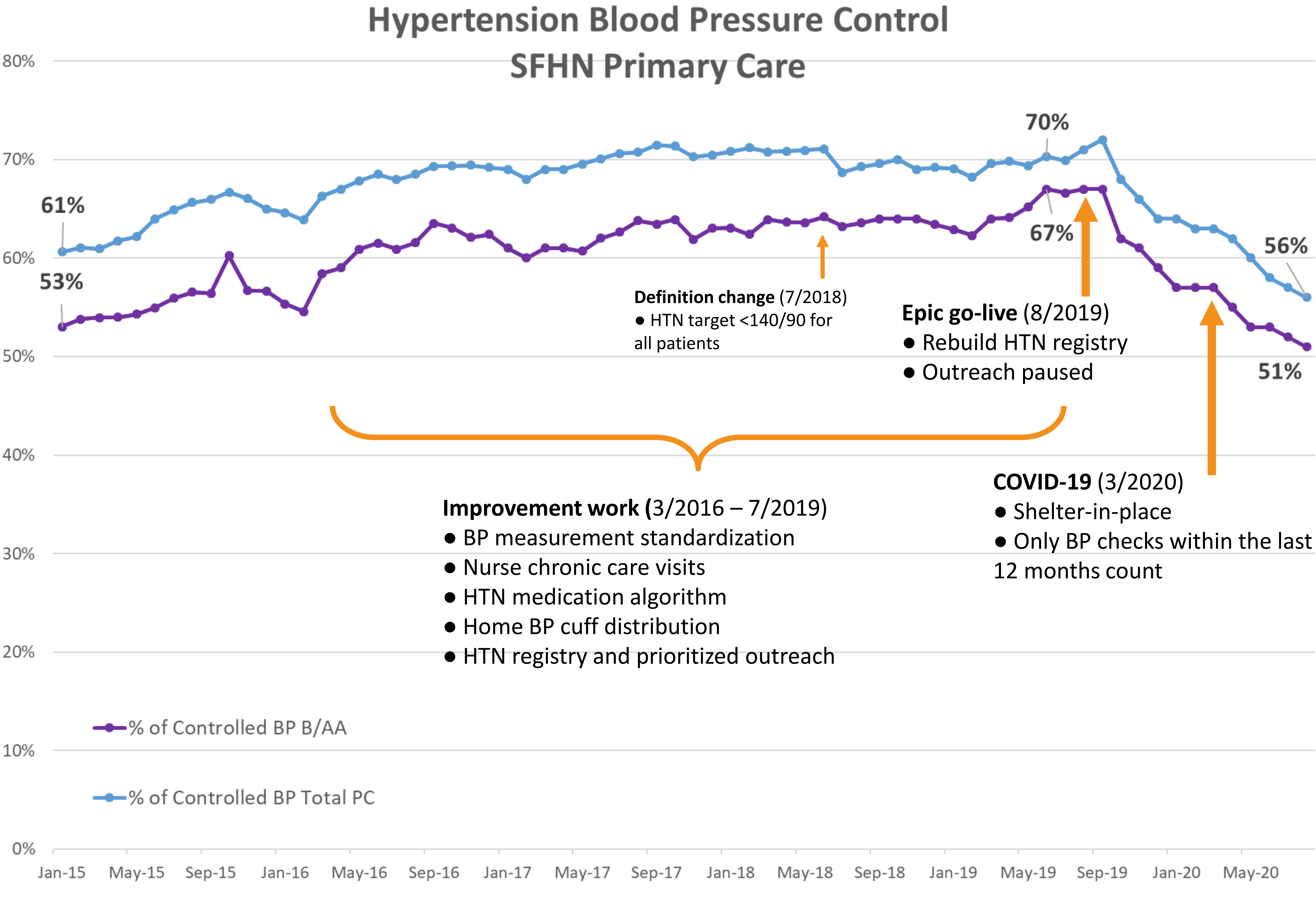
Primary Care visits (all types): August 2019 - August 2020

30000
25000
20000
15000
10000
5000
0

August-19
September-19
October-19
November-19
December-19
January-20
February-20
March-20
April-20
May-20
June-20
July-20
August-20

In-clinic
Telehealth

- Departments:
  - Medical
  - Dental
  - Behavioral Health
  - Urgent Care
  - Alternative Testing Sites
  - Nutrition
  - Podiatry



Hypertension Blood Pressure Control
SFHN Primary Care
80%
70%
60%
50%
40%
30%
20%
10%
0%
61%
53%
70%
67%
56%
51%
Definition change (7/2018)
● HTN target <140/90 for all patients
Epic go-live (8/2019)
● Rebuild HTN registry
● Outreach paused
Improvement work (3/2016 – 7/2019)
● BP measurement standardization
● Nurse chronic care visits
● HTN medication algorithm
● Home BP cuff distribution
● HTN registry and prioritized outreach
COVID-19 (3/2020)
● Shelter-in-place
● Only BP checks within the last 12 months count
% of Controlled BP B/AA
% of Controlled BP Total PC
Jan-15
May-15
Sep-15
Jan-16
May-16
Sep-16
Jan-17
May-17
Sep-17
Jan-18
May-18
Sep-18
Jan-19
May-19
Sep-19
Jan-20
May-20

Healthcare Maintenance:
Behavioral Health Vital Signs

% of patients screened for BHVS by month, FY 18-19 compared to FY 19-20

Healthcare Maintenance: Continued

Number of patients due for healthcare maintenance - July 19 vs August 20

	2019	2020
Overdue pap smear	5654	7843
Overdue colorectal cancer screening	10002	14616
Overdue controlled substance agreement	517	961
Uncontrolled BP or no BP check	5224	8023
Poor DM control or no A1c test	3539	4426

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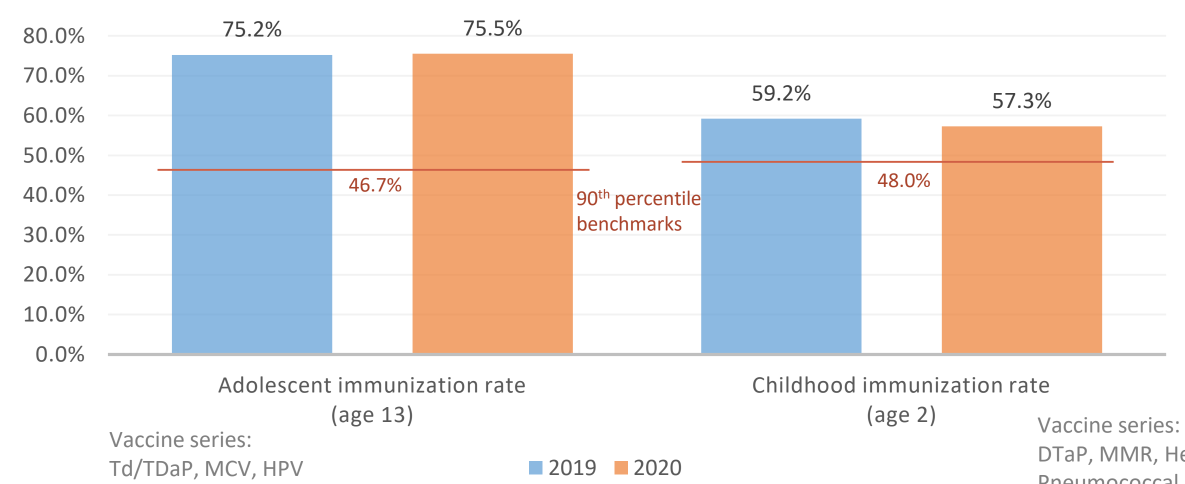


Vaccine series:
DTaP, MMR, Hep A, Hep B, VZV, IPV, HiB, Pneumococcal, Rotavirus, Influenza

COVID-19 Prevention Measures and Population Health Initiatives

- Identified our high risk patients
  - Diabetes: 4,771
  - Congestive Heart Failure: 2,058
  - HIV: 3,148
  - COPD: 2,929
  - Asthma: 6,437
  - Total: 13,248
- Conducted outreach – educated about COVID prevention, offered medication refills, food resources, and a telehealth or in-person with PCP

- 10,854 patients contacted through visits or outreach calls
- 4959 of these patients had in-person visits after shelter-in-place
- 6614 of these patients had telehealth visit after shelter-in-place
- Ongoing focused outreach for patients due for immunizations between 0 and 6 years of age and our Black/African American patients with Hypertension and Diabetes
- Piloting new workflows to get patients in at curb-side immunization appointments to minimize risk for COVID-19 exposure
- Monitoring and reporting all missed opportunities for Behavioral Health Vital Signs

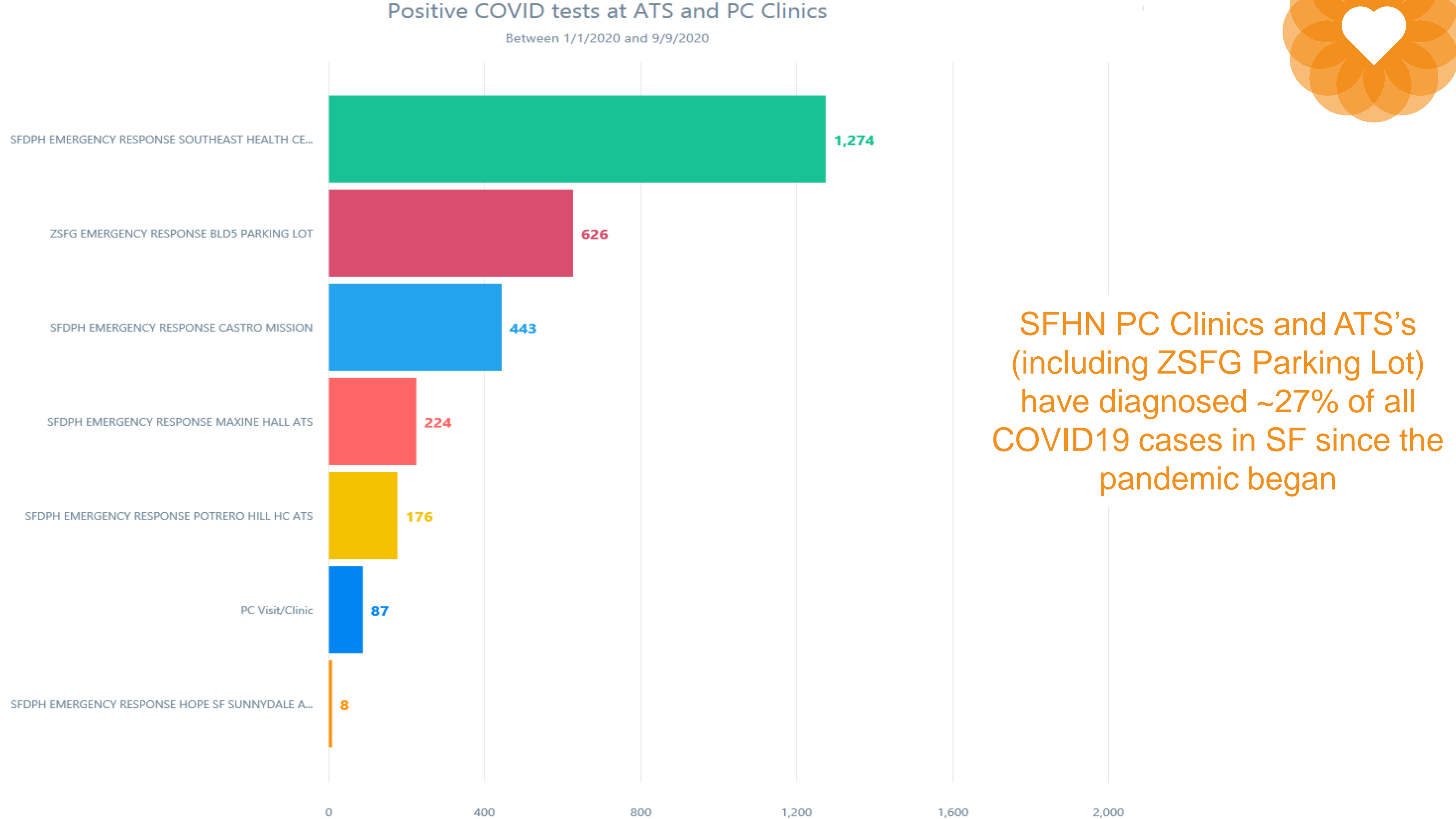
PC COVID-19 Support

- Staffing/managing alternate COVID-19 testing locations
  - Potrero Hill Health Center
  - Maxine Hall Health Center
  - Southeast Health Center
  - 17th Street (Castro Mission Original Site)
  - Chinatown Public Health Center (TBD)
  - HopeSF Sunnydale
  - Hopesf Potrero (TBD)

- Staffing/managing Field Care Clinic at Southeast Health Center
  - Open to anyone in the community
  - 7am-7pm, 7 days a week

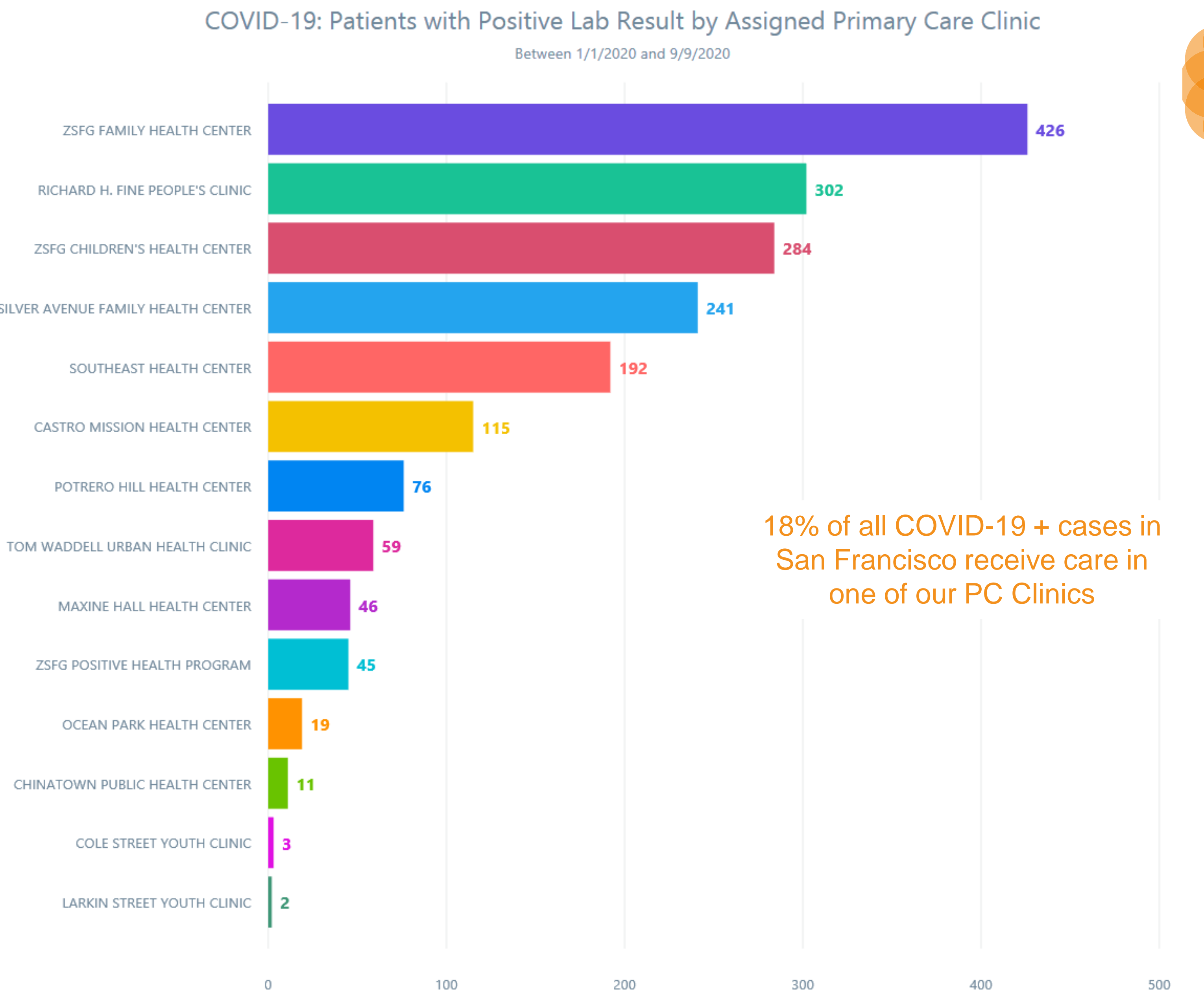
- Isolation and Quarantine Hotels
- Shelter in Place Hotels
- Contract Tracing/Contact Investigation
- Outbreak Management Group
- Support for ZSFG and Laguna Honda
- General COVID Command Center Support

PC COVID-19 Alternate Testing Sites and PC Clinics



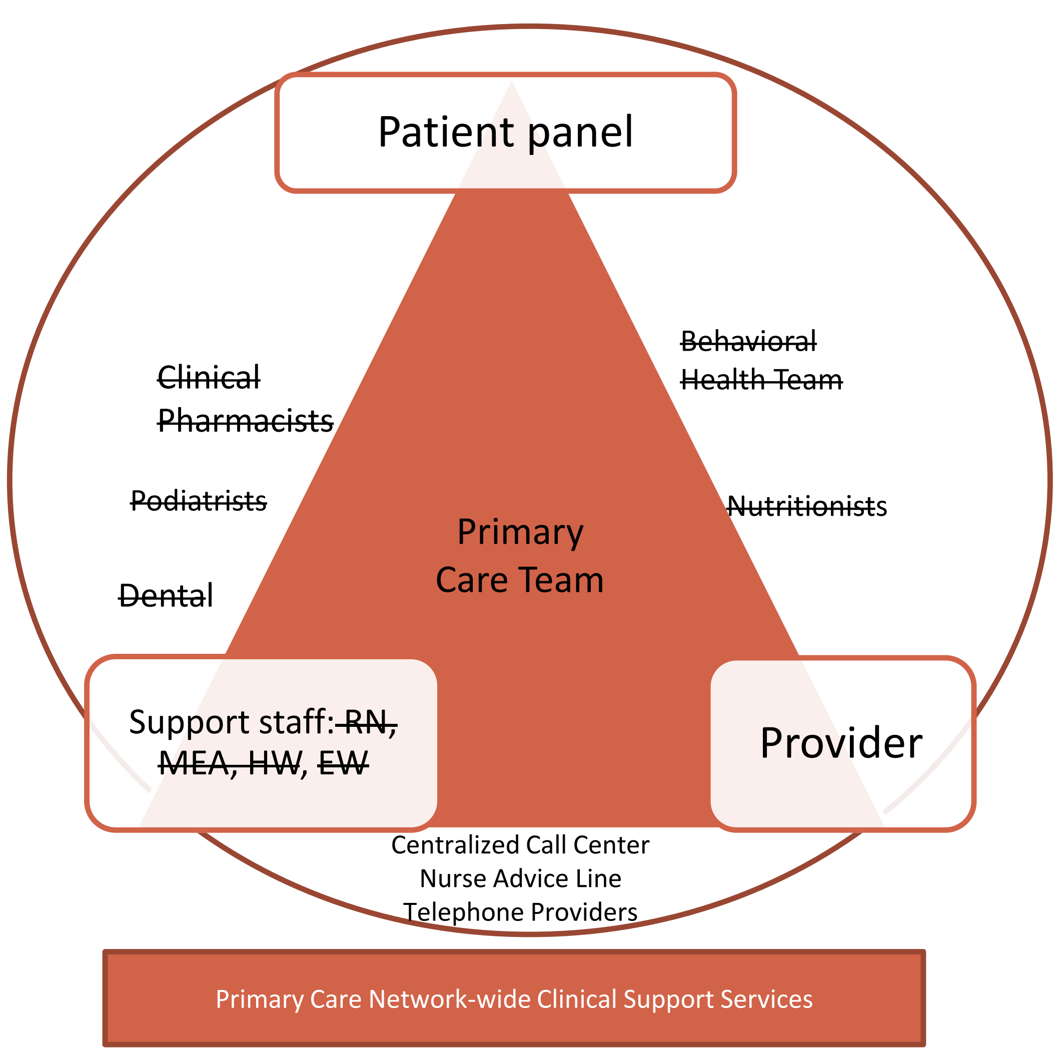
Primary Care "Alternate" testing site = Essential COVID-19 service for the city

- Only testing locations that tests kids
- Drop-ins (no online scheduling required)
- Testing positivity rate is 14%, compared to 2.5% for all of SF
- PC providers/RNs call and telephone manage all of the COVID-19 + patients tested from our sites – including those with private health coverage



18% of all COVID-19 + cases in San Francisco receive care in one of our PC Clinics

Multidisciplinary Team-based Model of Care



Programmatic Reductions for Community Health Programs for Youth

- Assisted Care/After Care
  - In Tenderloin neighborhood
  - Serves HIV Positive Youth
  - Hours maintained
- Dimensions Clinic
  - At Castro Mission Health Center
  - Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Queer Youth
  - Hours reduced
- New Generation Health Center
  - Co-located at Homeless Prenatal on 18th and Potrero
  - Reproductive health clinic for all youth
  - Completely closed for several months – now has a reduced schedule
- 3rd Street Youth Center and Clinic
  - In Bayview neighborhood
  - Serves all youth
  - Closed with Shelter in Place, just re-opened one afternoon a week – hope to increase
- Special Programs for Youth
  - Juvenile Hall
  - Provider available as needed

Programmatic Closures for Community Health Programs for Youth

- Cole Street Youth Clinic
  - Haight Ashbury neighborhood
  - Youth, ages 12-24, including homeless and runaway youth
  - Referral/connection to Tom Waddell, New Generation, or other PC Clinic
- Larkin Street Youth Clinic
  - Tenderloin neighborhood
  - Youth, ages 12-24, including homeless and runaway
  - Referral/connection to Tom Waddell, New Generation, or other PC Clinic
- School Based Health Centers:
  - Balboa Teen Health Center
    - Excelsior/Mission Terrace neighborhood
    - Serves all youth 12-25
  - Burton Teen Clinic
    - Portola neighborhood
    - Serves Burton HS student only
  - Willie Brown Middle School Wellness Center
    - Silver Terrace/Bayview neighborhood
    - Serves Willie Brown Middle School students, referrals from Thurgood Marshall High School

Priorities for Upcoming Year

- Anti-racism and Equity Action Plan
- Addressing impact of COVID-19 on patient care
  - Patient Access to Appointments
  - Overall patient panel sizes and accepting new patients
  - Delayed preventive health care (ie BH screening, immunizations, cancer screening)
- Re-imagining Primary Care
  - Care model
  - Staffing
  - Productivity
  - Budget considerations
- Restoring/building leadership teams and staffing post EPIC and post COVID-19
- Optimizing revenue