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
Additional PC Revenue/Income FY19-20:
- Global Payment Program - $27 million
- PRIME/QIP - $26 million
- Health Homes - $115K
Clinic Distribution and Focus

SPECIAL FOCUS CLINICS

**Geriatriic:** Curry

**Homeless or marginally housed:** Tom Waddell Urban Health

**HIV positive or at risk:** PHP

**Children and youth:** CHPY, CHC
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
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

Top 10 diagnosis by % of patients

- Hypertension: 31%
- Hyperlipidemia: 24%
- Chronic pain: 20%
- Major depressive disorder: 16%
- Vitamin D deficiency: 15%
- Diabetes: 14%
- Gastro-esophageal reflux disease: 12%
- Obesity: 12%
- Allergic rhinitis: 12%
- Prediabetes: 11%

Age Groups

- < 5: 6%
- 6 - 17: 11%
- 18 - 24: 5%
- 25 - 34: 11%
- 35 - 44: 13%
- 45 - 54: 15%
- 55 - 64: 21%
- 65 - 74: 14%
- 75 - 84: 4%
- 85+: 1%
Multidisciplinary Team-based Model of Care

- Primary Care Team
  - Clinical Pharmacists
  - Podiatrists
  - Dental
  - Support staff: RN, MEA, HW, EW
- Behavioral Health Team
- Nutritionists
- Centralized Call Center
  - Nurse Advice Line
  - Telephone Providers

Primary Care Network-wide Clinical Support Services

Primary Care Leadership Team
## Primary Care
### True North & Driver Metrics

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Quality</th>
<th>Safety</th>
<th>Equity</th>
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<tbody>
<tr>
<td>Primary Care True North Metrics</td>
<td>Improve population health through <strong>preventive care</strong> and <strong>chronic condition management</strong>, with focus on: preventive oral health care, blood pressure management, and helping smokers quit</td>
<td>Improve timely coordination of care to prevent high risk events, prioritizing reducing hospital readmissions</td>
<td>Reduce health disparities in blood pressure control</td>
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<td>Implement standard work to reduce bias in hiring and increase diversity</td>
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### Hypertension control

**Primary Care Driver Metrics (PCDM)** 2017-18

- Behavioral Health Vital Signs
- 7 day post-discharge follow-up
- Hypertension control for African Americans
## Primary Care
### True North & Driver Metrics

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<th>Care Experience</th>
<th>People Development</th>
<th>Financial Stewardship</th>
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| 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**

**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 (data through May 2019)

**June 2019**

<table>
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<tr>
<th>Additional patients screened with BHVS in the last month</th>
<th>Met RI goal of 30% screened with BHVS from baseline to this month</th>
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<td><strong>1087</strong></td>
<td><strong>9/13</strong></td>
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**39.9%** Compared to 37.1% April 2019

0 Patients need BHVS screening to reach goal

**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.

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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.
METRIC:
Hypertension Control

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/AA patients with hypertension.

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)

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

Compared to 64.0% in March, 2019
64.1%

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

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

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!
SAFETY

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 improvement.

May 2019
(Data for April 2019)

Clinic or phone visit w/in 7 days

70.2% (n=389)

AT GOOOOOOOOOOOOOOOOOOAL!

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

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.
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 safeguards 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 adolescent immunizations received and documented from approx. 63.4% (June 2018) to approx. 67.0% (10% RI).

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

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

- Departments:
  - Medical
  - Dental
  - Behavioral Health
  - Urgent Care
  - Alternative Testing Sites
  - Nutrition
  - Podiatry
Hypertension Blood Pressure Control
SFHN Primary Care

Definition change (7/2018)
- HTN target <140/90 for all patients

Epic go-live (8/2019)
- Rebuild HTN registry
- Outreach paused

COVID-19 (3/2020)
- Shelter-in-place
- Only BP checks within the last 12 months count

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
Healthcare Maintenance: Behavioral Health Vital Signs

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

Screening for:
- Depression
- Substance misuse
- Alcohol misuse
- Interpersonal violence

COVID-19

Epic go-live

% of PHQ-9 with a high score (>10)
July 2019 vs August 2020

FY 19-20
FY-18-19
Healthcare Maintenance: Continued

**Immunizations - July 19 vs August 20**

- **Adolescent immunization rate (age 13):**
  - 2019: 75.2%
  - 2020: 75.5%
  - 90th percentile benchmarks: 46.7%

- **Childhood immunization rate (age 2):**
  - 2019: 59.2%
  - 2020: 57.3%
  - 90th percentile benchmarks: 48.0%

Vaccine series:
- Td/TDaP, MCV, HPV
- 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
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

SFHN PC Clinics and ATS’s (including ZSFG Parking Lot) have diagnosed ~27% of all COVID19 cases in SF since the pandemic began
18% of all COVID-19 + cases in San Francisco receive care in one of our PC Clinics
Multidisciplinary Team-based Model of Care

Patient panel

Primary Care Team

Clinical Pharmacists
Pediatrists
Dental

Support staff: RN, MEA, HW, EW

Behavioral Health Team
Nutritionists

Provider

Centralized Call Center
Nurse Advice Line
Telephone Providers

Primary Care Network-wide Clinical Support Services

Primary Care Leadership Team
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 youth
  - 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