COMMUNITY PRIMARY CARE

THE HERE AND NOW AND WHERE WE’RE HEADED

Report to Health Commission Community & Public Health Committee
February 2013

Lisa Johnson, MD
Medical Director, Community Oriented Primary Care
Community Oriented Primary Care Principles
(from CPC Rules and Regulations)

• Public health services that focus on the health of the community
  • a commitment to working with the community as a partner
  • a multi-disciplinary model of care

• Access to care is not adversely affected by race, sex, religion, national origin, age, handicap, sexual orientation, diagnosis, or source of payment.

• Medical Staff and Affiliated Professional members maintain high quality performance of their professional duties.
New models: Patient Centered Medical Home

8 CHANGE CONCEPTS
Safety Net Patient Centered Medical Home Initiative
www.safetynetmedicalhome.org
1. Empanelment
2. Continuous, Team-based Healing Relationships
3. Patient Centered Interactions
4. Engaged Leadership
5. QI Strategy
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence Based Care

10 BUILDING BLOCKS (T. Bodenheimer, M.D.)
Patient Centered Medical Home
http://www.chcf.org/publications/2012/04/building-blocks-primary-care
✓ 1. Mission and Goals
✓ 2. Data-driven Improvement
✓ 3. Empanelment
4. Team-based Care
✓ 5. Population-based Care
✓ 6. Continuity of Care
7. Prompt Access to Care
8. Template of the Future
9. Coordination of Care
10. Conscious and Trained Leadership

NCQA Recognition standards for Patient Centered Medical Home
www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
COPC Active Panel
• 40,739 Active Pts

FY 2011-2012
• 40,739 Active Pts
• 36,377 Undup Pts
• 115,376 Med Visits
• 197,056 Total Visits

Payor

Top 10 Diagnoses

- Hypertension 24%
- Diabetes 14%
- Cholesterol 12%
- CHN Capitated 29%
- Healthy SF 18%
- Sliding Scale 8%
- Medicare 16%
- Medi-Cal Managed Care 4%
- LIHP/SF PATH 16%
- CHN Capitated 29%

New Programs, New Leadership COPC-wide

• Jennifer Elton, RN - Nurse Manager, Complex Care Management
• Anna Robert, RN, MSN, DrPH - Nurse Manager, Nurse Advice Line & New Patient Appointment Unit
• Albert Yu, MD, MBA, MPH - Chief Medical Information Officer, COPC
• Lisa Golden, MD - Medical Director, Quality Improvement, Community Programs
### COPC Primary Care Providers (PCPs) FTEs (Number of bodies)

<table>
<thead>
<tr>
<th>Role</th>
<th>FTEs</th>
<th>BODIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff MDs</td>
<td>43.8</td>
<td>(61)</td>
</tr>
<tr>
<td>NP/PA</td>
<td>20</td>
<td>(32)</td>
</tr>
</tbody>
</table>

### Aging PCP base (Age 60 and over)

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>14 of 43</td>
</tr>
<tr>
<td>NP/PA</td>
<td>7 of 20</td>
</tr>
<tr>
<td>Total</td>
<td>21 of 63</td>
</tr>
</tbody>
</table>

### New Clinician Team Members since 2010

<table>
<thead>
<tr>
<th>PCBH Clinicians</th>
<th>9 COPC Clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC Behaviorists</td>
<td>13</td>
</tr>
<tr>
<td>Behaviorist Assistants</td>
<td>11</td>
</tr>
<tr>
<td>PCBH vacant positions</td>
<td>3</td>
</tr>
</tbody>
</table>

### COPC7 Support Staff FTE per 1.0 PCP FTE

<table>
<thead>
<tr>
<th>Role</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>0.65</td>
<td>0.9</td>
</tr>
<tr>
<td>Clinical</td>
<td>1.72</td>
<td>2.0</td>
</tr>
<tr>
<td>Clerical</td>
<td>1.77</td>
<td>1.6</td>
</tr>
</tbody>
</table>
2012: YEAR OF THE TEAM

- Quarterly Meetings:
  - Providers
  - Management Teams
- Monthly/Bi-Weekly Meetings:
  - Medical Directors
  - Nurse Managers
  - Principal Clerks
- Quality Culture Series
- QI & Leadership Academy
- Center for Excellence in Primary Care
- Coleman - Rapid DPI
PCMH-A Results – Average Score

Patients see own provider or care team

Roles defined and tasks distributed across team according to skills, abilities and credentials

Team trained & cross trained to ensure patient needs met

2013 Trainings & Staff Development

- Nursing Leadership Academy
- Quality Improvement 101
- Service Excellence
- QI & Leadership Academy
PANEL MANAGEMENT

**Prepared**  **Proactive**  **Effective**

IDENTIFY PATIENTS WITH CARE GAPS

outreach and in-reach

ENGAGE PATIENTS
## SFDPH Primary Care - Quality Council Goals

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Documentation</td>
<td>56%</td>
<td>85%</td>
<td>91%</td>
<td>90% or 50% IOB</td>
<td>Retired</td>
<td>Meaningful Use: 50%</td>
</tr>
<tr>
<td>DM Blood Pressure Control</td>
<td></td>
<td></td>
<td>67%</td>
<td>New for 2013</td>
<td>New: 70% or 10% IOB</td>
<td>N/A</td>
</tr>
<tr>
<td>Smoking Status Assessed</td>
<td>51%</td>
<td>73%</td>
<td>79%</td>
<td>80% or 50% IOB</td>
<td>80%</td>
<td>Meaningful Use: 50%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>44%</td>
<td>47%</td>
<td>57%</td>
<td>60% or 10% IOB</td>
<td>70% or 10% IOB</td>
<td>HEDIS 2011 HMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Commercial: 62%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medicare: 60%</td>
</tr>
<tr>
<td>DM HgA1c Control &lt;8</td>
<td>62%</td>
<td>74%</td>
<td>72%</td>
<td>70%</td>
<td>Retired</td>
<td>HEDIS 2011 HMO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Commercial: 68%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medicaid: 58%</td>
</tr>
<tr>
<td>Pt Experience: Phone Access</td>
<td></td>
<td></td>
<td>34%</td>
<td>New for 2013</td>
<td>New: 41%</td>
<td>CA Average: 56%</td>
</tr>
</tbody>
</table>

**IOB = Relative Improvement Over Baseline**

<table>
<thead>
<tr>
<th>Measure</th>
<th>HEDIS 2011 HMO Medicaid</th>
<th>HEDIS 2011 HMO Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>66%</td>
<td>71%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>72%</td>
<td>77%</td>
</tr>
<tr>
<td>DM HgA1c</td>
<td>83%</td>
<td>90%</td>
</tr>
<tr>
<td>DM LDL Testing</td>
<td>74%</td>
<td>85%</td>
</tr>
</tbody>
</table>
March 2012 CRC Awareness Month Outreach

- Joint effort: SFDPH-PC, with ACS, Center for Excellence in Primary Care, SF Health Plan
- 10 SFDPH clinics: registry, mass mail out, training, and phone bank
- In time training on registry use and scripts for talking to patients about CRC screening
- 4900 postcards mailed - 4 languages
- 35 clinic staff members at the phone bank
- Screening rate for the 10 participating clinics have increased from 49% to 57% age points from 02/2012 to 10/2012.

Slide Courtesy of Lisa Golden, M.D.
Road to Reform – Access

October 2012, Source: Primary Care Report Registry > 02_Patient_Panels\Shadow Panels\2012-10> 02_Patient_Panels\Panel Stats
CG-CAPHS Patient Experience Survey Results

When they finally get to us, they like us:
- “This is great clinic, but the wait time to speak to a nurse is way too long.”
- “Everything is good but the waiting time is too long”

<table>
<thead>
<tr>
<th>Positive Rating (CA avg)</th>
<th>Positive Rating (SFDPH PC)</th>
<th>n Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider seen within 15 min of appt time in past year</td>
<td>29%</td>
<td>16%</td>
</tr>
<tr>
<td>Got urgent care appt when needed in past year</td>
<td>57%</td>
<td>32%</td>
</tr>
<tr>
<td>Got routine care appt when needed in past year</td>
<td>60%</td>
<td>33%</td>
</tr>
<tr>
<td>Got answer calling during office hrs in past year</td>
<td>56%</td>
<td>35%</td>
</tr>
<tr>
<td>Provider knew medical history</td>
<td>79%</td>
<td>77%</td>
</tr>
<tr>
<td>Provider explained things understandably</td>
<td>88%</td>
<td>81%</td>
</tr>
<tr>
<td>Provider listened carefully</td>
<td>90%</td>
<td>84%</td>
</tr>
<tr>
<td>Provider showed respect for what patient said</td>
<td>92%</td>
<td>87%</td>
</tr>
</tbody>
</table>

Plans to Improve Access

- Staff the Team (PCPs, RNs, MEA’s/HW’s)
- Working with HR
- PCP Recruitment
- Enhanced RN role
- System-wide Standing Orders
- Nurse Advice Line (NAL) improvements
- Develop Operational Metrics Dashboard
- Coleman Rapid Dramatic Performance Improvement
Challenges

• **Primary Provider Shortage:** Recruitment difficult
• **Civil Service and Union Environment:** challenges for recruiting, rewarding, promoting
• **Physical Plant:** Need more attractive design, design to facilitate team care workflow
• **Patient Experience & Service Excellence:**
  • **Access:** we need:
    • Appropriate, consistent staffing ratios to meet demands and retain existing patients
    • Spread of QI methods for improving access across system
    • Further development of / support for team based care to increase capacity
• **Training and Coaching infrastructure for Patient Centered Medical Home**
  • Effective clinical care teams require training infrastructure for these new skills.
• **Operations Infrastructure**
  • No Center Director/ Center Manager in COPC clinics
  • Small central COPC administration team
• **Supply / Demand mismatch for medical services:** need decisions about scope of SFDPH Delivery System going into 2014, with planning matched to those decisions
2013: Initiatives

- **Year of the Nurse - Enhanced Role of the RN in Primary Care clinics**
  - Dynamic and leadership-focused training program
  - Complex Care Management Program
- **Continue to Get Better at Team-based Care**
  - Co-location of team members, Role and responsibility definition
  - Training: MEA/HW skills in panel mgmt, QI tools for improving team care
  - Expand the team – BH-PC integration, Pharmacists and dieticians in clinic, NAL and NPAU as part of the team
- **Access**
  - eCW implementation complete in 2014
  - Operations Metrics Dashboard project
- **Coaching**
  - Coleman DPI for more clinics??
  - Coaching Program through the SFHP / Metta Grant – 10 Building Blocks
- **Prop C Funding for consultation on transition to PCMH in DPH**