SFHN Primary Care

Update for the Community and Public Health Subcommittee
of the San Francisco Health Commission
December 20, 2016

HALI HAMMER
DIRECTOR OF SFHN PRIMARY CARE

We provide high quality care that enables all San Franciscans to live vibrant, healthy lives.

PRIMARY CARE

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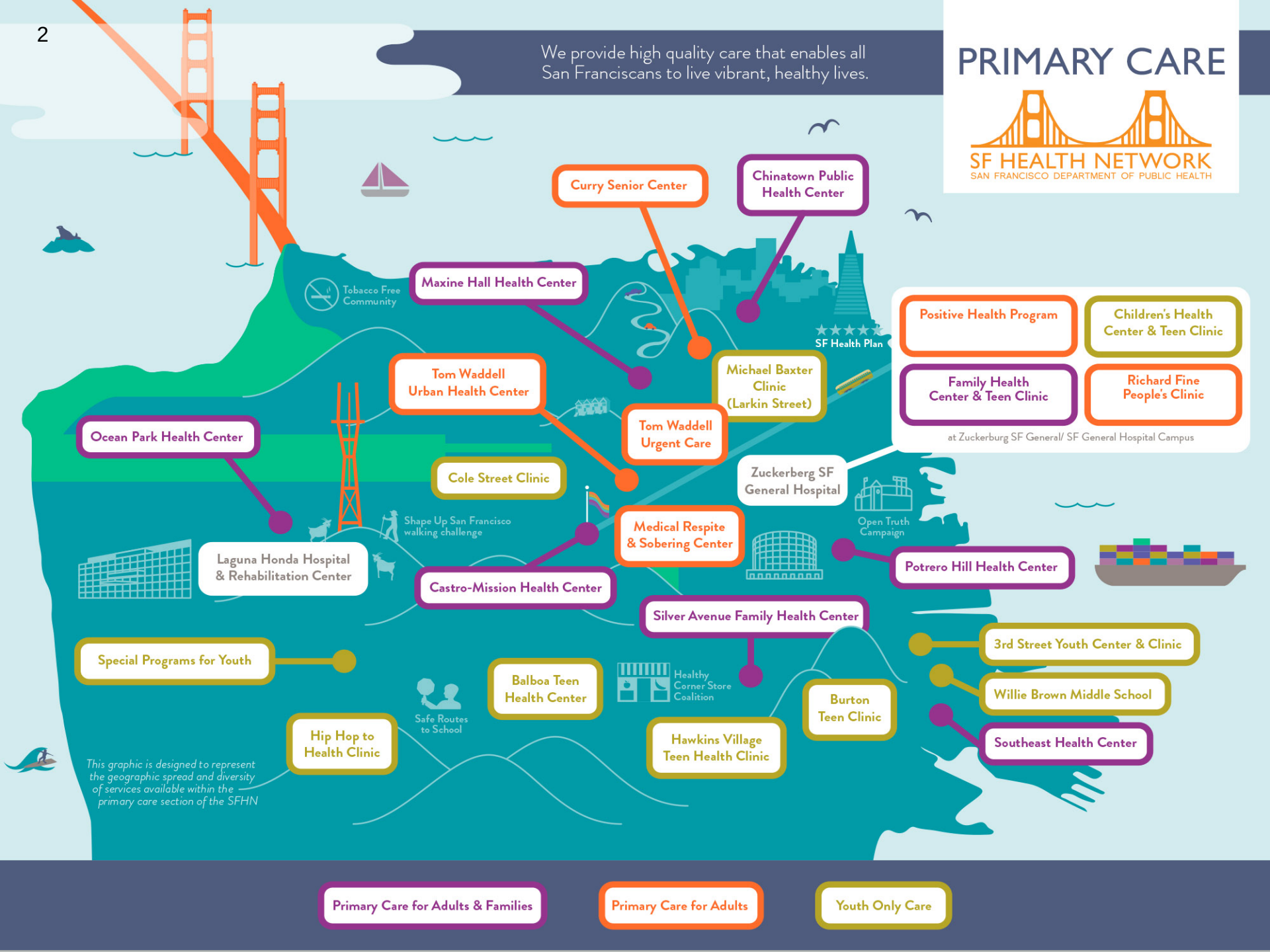

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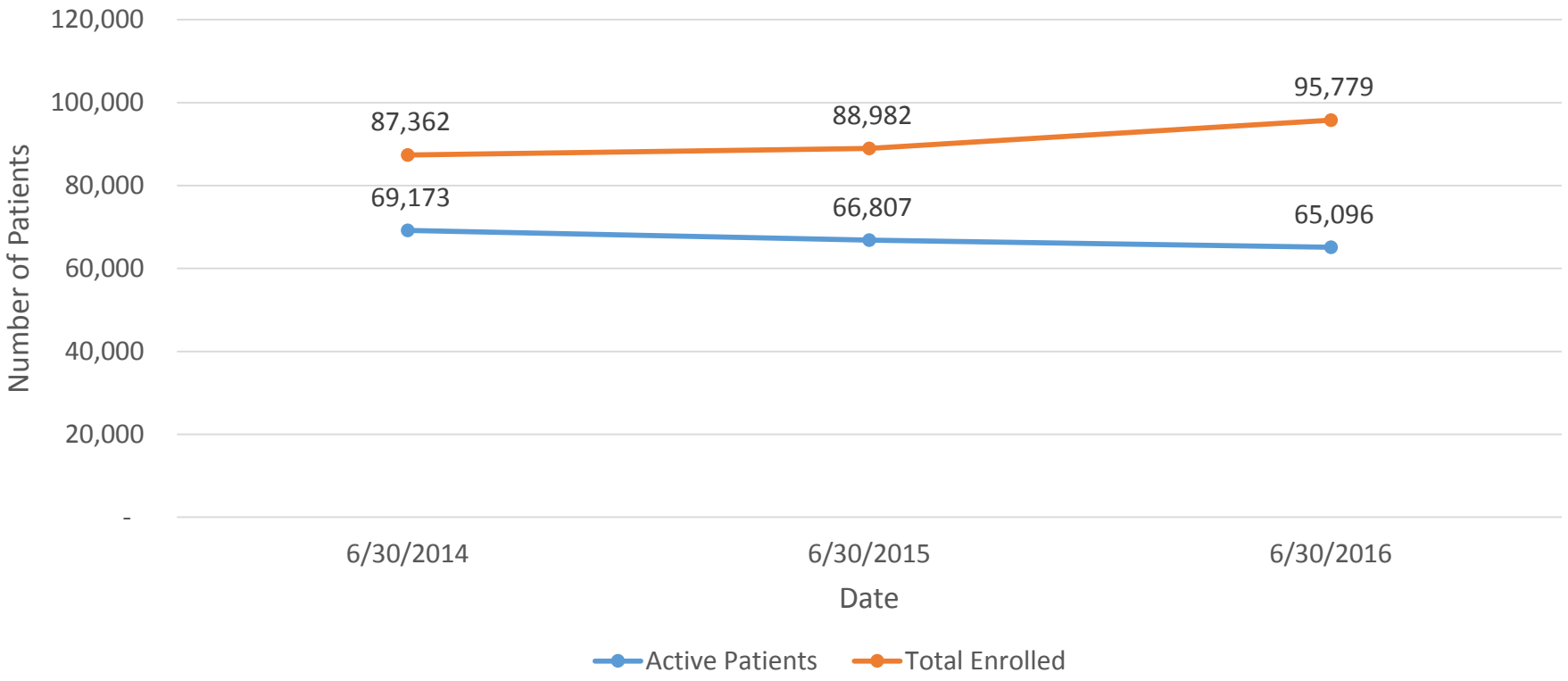
SFHN Primary Care

Active Panel Patients and Total Enrolled Patients by Fiscal Year



* Active patient defined as assigned to an SFHN medical home and been seen for a medical visit within the past 24 months.

** Total panel for 2016 includes Enrolled Not Yet Seen (ENYS) Anthem BC Medi-Cal enrollees (n=4,725); this information was not previously available for previous years. All years include HSF and SFHP programs.

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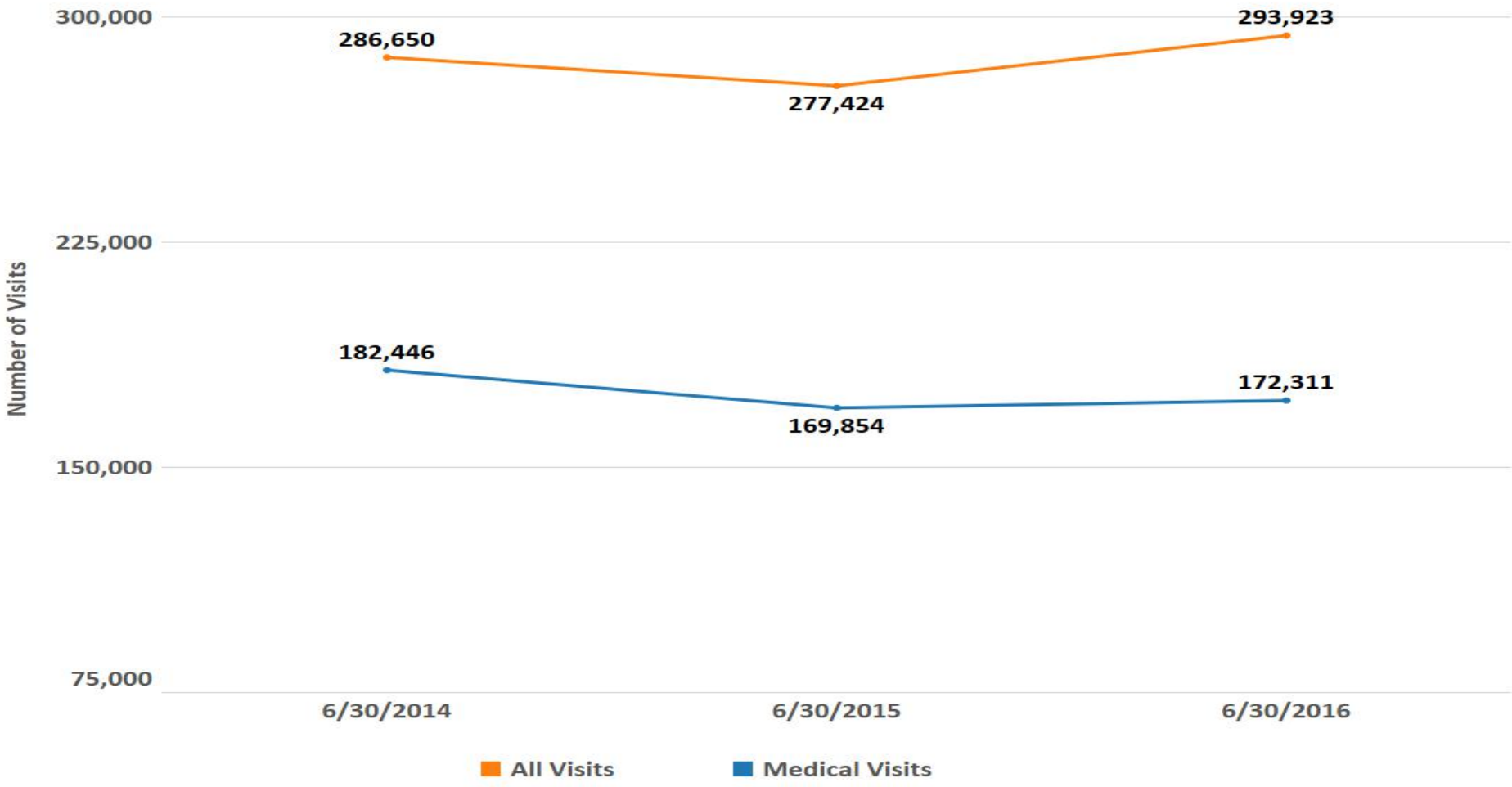
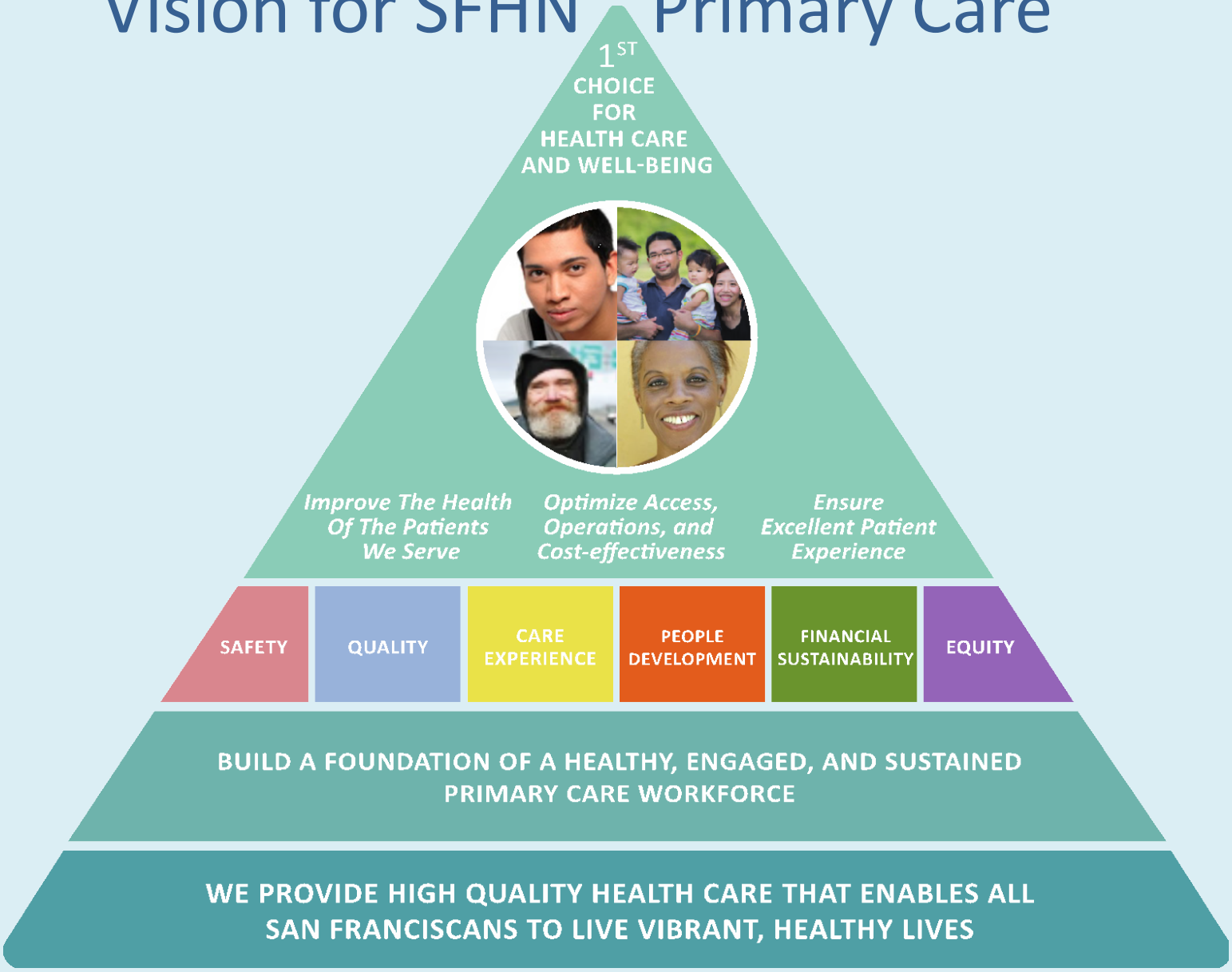
SFHN Primary Care

Total encounters and medical encounters



Vision for SFHN – Primary Care



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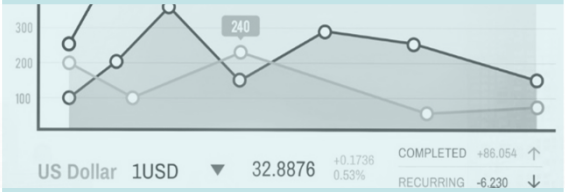
SFHN Primary Care
True North & Driver Metrics

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) **2016**	Hypertension control Fluoride Varnish Smoking Cessation	7 Day Post-Discharge Follow Up	Hypertension control for African Americans

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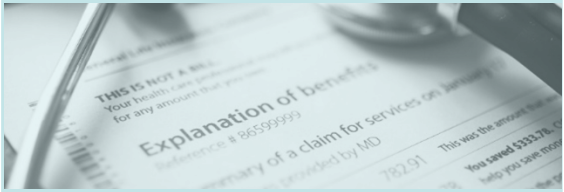
SFHN Primary Care
True North & Driver Metrics

Strategic Theme	Care Experience	Develop People	Financial Sustainability
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) **2016**	Routine appointment access CG CAHPS likelihood to recommend	Gallup staff engagement composite (annual data)	Lock all notes to enable timely, accurate billing

EQUITY

METRIC:

Hypertension control: reducing disparities

Why we measure this:

Of the 11,000 Black/African American patients in SFHN PC (15% of total), our equity interventions have focused on the health needs of the 4,000 BAA patients with hypertension. While BP control rates for these BAA patients improved from 53 to 57% over 2015, the disparity gap between BAA and the total population increased from 7% to 10%.

Target:

Our target is 20% relative improvement for all of SFHN PC and each individual clinic for the Black patient population. Given our baseline of 57% in December 2015, we aim to have 65% of our Black hypertensive patient population in SFHN PC at state of controlled blood pressure.

82 Additional African American patients with controlled blood pressure this month

64%
From 57% baseline

60
Patients needed to control to reach goal

4/12 Met relative improvement goal of 20% this month

CMHC CPHC CSC MHHC OPHC

PHHC SAFHC SEHC TWUHC FHC

RFPC PHP

Ms. Lee takes care of her father through the IHSS program. She and her father came back in to see RN Jessica, with his home BP log, medicine bottles and his new mediset. Ms. Lee smiles and thanks Jessica. "I showed him how high his blood pressure gets when he skips his medicines, and he finally started taking them on most days!"

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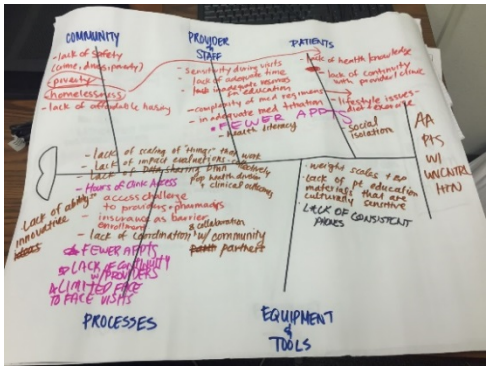
SFHN Primary Care Hypertension equity timeline

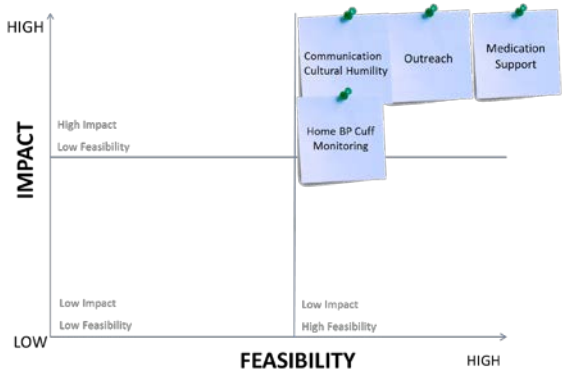
Jan 2015 – July 2015 – Dec 2015

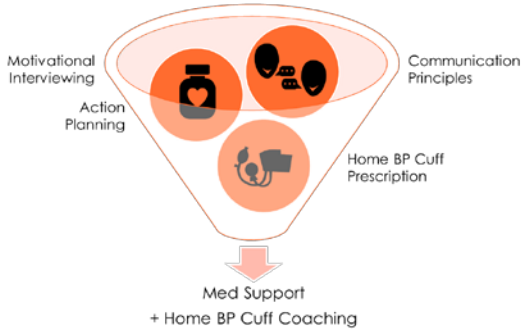
- Frame Equity as QI
- Begin monthly data review
- Engage key stakeholders for workgroup
- Clarify problem
- Identify key interventions

Jan 2016 – July 2016 – Sep 2016 – Dec 2016

- Create collective work plan
- Design materials/ support outreach pilots
- Present & finalize materials
- Explore and identify engagement modalities







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SFHN Primary Care
Hypertension equity patient education

ARE YOU AT RISK FOR HEART DISEASE?

The following things can put you at risk for heart disease.
Check all your risk factors and follow up with your doctor.

- ☐ Being overweight — ☐ Not sure
- ☐ High blood pressure — ☐ Not sure
- ☐ High cholesterol — ☐ Not sure
- ☐ Diabetes (family history of diabetes) — ☐ Not sure
- ☐ Lack of physical activity
- ☐ Cigarette smoking
- ☐ Age (older than 45 for men, over 55 for women)
- ☐ Family history (father or brother with heart disease before age 55 or mother or sister with heart disease before age 65)

PHYSICAL ACTIVITY AND HEALTHY LIFESTYLE RESOURCES

Community Wellness Center at Zuckerberg
San Francisco General Hospital (ZSFG)
☎ (415) 206-4995

American Heart Association
http://heart.org/healthyliving

FREE physical activities go to healthyheartsSF.com

Write the name and phone of your healthcare provider here:

POPULATION HEALTH DIVISION
COMMUNITY HEALTH EQUITY & PROMOTION

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Sources:
1) National Heart, Lung, and Blood Institute; National Institutes of Health; U.S. Department of Health and Human Services.
2)Mozaffarian D, Benjamin EJ, Go AS, et al. Heart Disease and Stroke Statistics—2015 update: A report from the American Heart Association. Circulation. 2015; 131(4):e29-322.
August 2016

STEPS TO PREVENT HEART DISEASE AT ALL AGES

Heart disease is a serious health problem. Family history and habits can make you more likely to develop heart disease. Although it is the number one killer of Americans, most people do not know that they are at risk for heart disease. Nearly 44% of African American men and 48% of African American women have some form of heart disease. This includes heart attack and stroke.

The good news is that you can take steps now to lower your risk of heart disease. Preventing or lowering high blood pressure, decreasing your blood sugar and cholesterol can decrease your chances of a heart attack and stroke. Heart healthy changes are good for your whole body!

Turn the page for ideas!

Know Your Risk!

Take the self-test on the back of this booklet to find out if you are at risk for heart disease.

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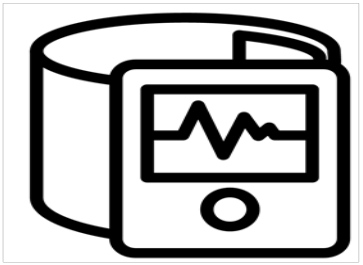
SFHN Primary Care 2016 hypertension outreach events and 2017 next steps

Silver Avenue Family Health Center

Southeast Health Center



Home BP Cuff Prescription + Coaching

Partner with RN Visits

Partner with Food Pharmacies

CARE EXPERIENCE

METRIC:

Time to Third Next Appointment

Why we measure this:
Patients expect to get routine, non urgent health care within a reasonable time. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability.

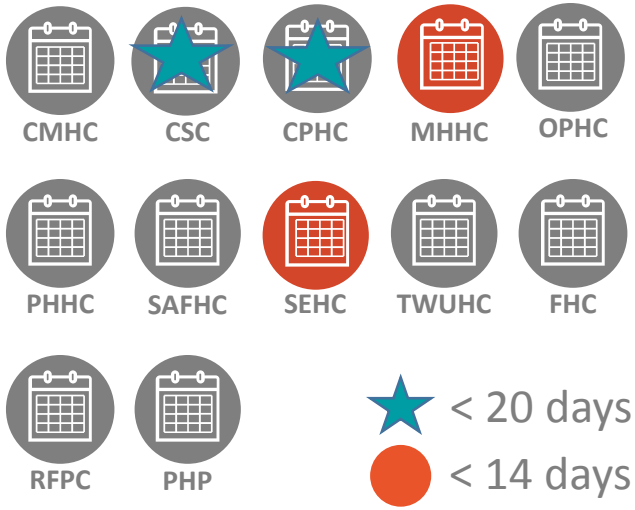
Target:
Either relative improvement goal of reducing current time by 7 days or reaching goal of 14 days

Weeks of 10/11, 10/18, 10/25:

31 Average of clinic median days until third next available RT appointment

August was 40 days.

2/12 With 14 days or less until next available appointment



Lee and his girlfriend just moved to San Francisco. They are in desperate need of family planning counseling, and Lee needs a PPD before he can start his new job. Lee called to make an appointment at their new medical home and was given one that same week. If it hadn't been so fast, he would have been at risk of both an unplanned pregnancy and not being able to start his new job.

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San Francisco Health Network Primary Care Weekly Patient Appointment Access Report

Date	12/1/2016							
	New Patient Access Status	New Patient Waiting List	# of New Patient Appts Made in Nov 2016	New Patient Appts Available through end of January 2017	Third Next Available New Patient Appt	Third Next Available RT Appt (clinic-wide median)	% PCMH or Telephone Provider Appt, Week Before	% ZSFG discharges with phone or office f/u within 7 days, October 2016
CMHC		0	79	108	9	26	73%	21%
CPHC		0	46	45	9	8	87%	71%
Curry		0	16	177	5	7	N/A	25%
FHC		0	105	93	15	60	55%	72%
RFPC		0	195	68	48	49	71%	50%
MHHC		0	49	150	6	3	67%	69%
OPHC		0	69	3	9	6	91%	71%
PHHC		4	50	15	5	15	N/A	63%
SAHC		0	64	32	8	33	100%	68%
SEHC		0	73	2	none	60	63%	53%
TWUHC		0	60	47	7	50	N/A	41%
CHC		0	40	64	14	31	79%	63%

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Developing a centralized call center 2015-2017

Southeast Health Center

Chinatown Public Health Center

Silver Avenue Health Center

5/6/15 — **9/1/15** — **11/2/15** — **3/1/16** — **6/24/16** — **10/17/16** — **11/9/16: OPHC; 12/5/16: CPHC**

Richard Fine People's Clinic

Ocean Park Health Center

Castro Mission Health Center

Projected timeline for 2017

Children's ➡ Silver Dental ➡FHC ➡Maxine Hall ➡Potrero Hill ➡ Curry ➡Tom Waddell….. expanded hours

Jan, 2017 ➡ **March, 2017** ➡ **June, 2017**

18 Call Center Agents — **25 Call Center Agents** — **28 Call Center Agents**

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Call Center expansion: 22 additional workstations

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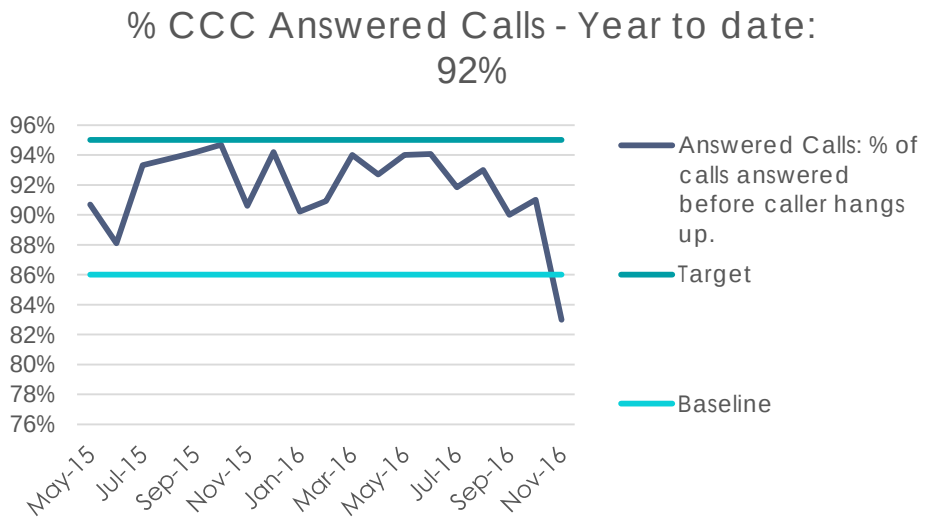
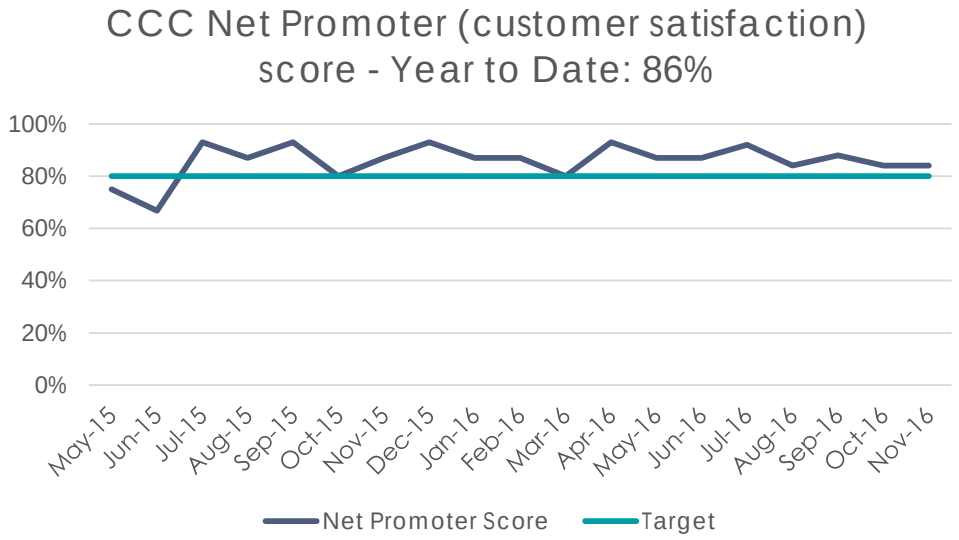
PC Centralized Call Center Goals for 2017

- Expansion of Centralized Call Center to all SFHN Primary Care clinics
- Expand population health outreach functions of the Call Center
- PRIME Projects
- Expansion of eReferral services (Primary Care Dental, Podiatry)
- MySFHealth
- Create sustainable staffing model to support expansion of hours to match patient demand

All while maintaining our target metrics for calls answered / response time and customer satisfaction





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SFHN Primary Care
major initiatives in 2017

- Expansion of **Centralized Call Center**
- Planning for ZSFGH **Building 5** ambulatory care center, SEHC expansion, and other large clinic remodels
- Statewide waiver programs **(PRIME, GPP, Dental Services Transformation Program)**
- Expand **Medical Respite and Sobering Center—**developing a new building in order to accommodate respite patients from shelters
- Build infrastructure to coordinate complex care management through the **Health Homes Program**
- Kick off **Lean Leadership Development** training throughout Primary Care in January 2017
- **Non-specialty mental health billing** and implementation of PCBH model to special populations clinics; strengthen PC-based children's behavioral health programs through work with BHS and Department of Psychiatry
- Expand **teaching opportunities** for UCSF students and residents in the CPC clinics
- Onboard a new **CPC Chief of Service**