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.
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.
SFHN Primary Care
Total encounters and medical encounters

![Graph showing total encounters and medical encounters over time]

Number of Visits

- All Visits
- Medical Visits

- 6/30/2014:
  - All Visits: 286,650
  - Medical Visits: 182,446

- 6/30/2015:
  - All Visits: 277,424
  - Medical Visits: 169,854

- 6/30/2016:
  - All Visits: 293,923
  - Medical Visits: 172,311
Vision for SFHN Primary Care

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

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

We provide high quality health care that enables all San Franciscans to live vibrant, healthy lives
## SFHN Primary Care
### True North & Driver Metrics

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Quality</th>
<th>Safety</th>
<th>Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care True North Metrics 2016-2018</td>
<td>Improve population health through <strong>preventive care</strong> and <strong>chronic condition management</strong>, with focus on: <strong>preventive oral health care</strong>, <strong>blood pressure management</strong>, and helping smokers quit</td>
<td>Improve timely coordination of care to <strong>prevent high risk events</strong>, prioritizing reducing hospital readmissions</td>
<td>Reduce <strong>health disparities</strong> 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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### Primary Care Driver Metrics (PCDM) 2016
- Hypertension control
- Fluoride Varnish
- Smoking Cessation
- 7 Day Post-Discharge Follow Up
- Hypertension control for African Americans
SFHN Primary Care
True North & Driver Metrics

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Care Experience</th>
<th>Develop People</th>
<th>Financial Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care True North Metrics</strong>&lt;br&gt;2016-2018</td>
<td>Increase the number of patients with a positive response to CG-CAHPS <em>would you recommend</em> question</td>
<td>Improve workforce engagement, as measured by the Gallup staff engagement score</td>
<td>Increase annual revenue through billing for all revenue-generating encounters</td>
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<td></td>
<td>Improve access to care</td>
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**Primary Care Driver Metrics (PCDM)**<br>2016
- Routine appointment access
- CG CAHPS likelihood to recommend
- Gallup staff engagement composite (annual data)
- Lock all notes to enable timely, accurate billing
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

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!”
SFHN Primary Care
Hypertension equity timeline

**Jan 2015**
- Frame Equity as QI
  - Begin monthly data review

**July 2015**
- Engage key stakeholders for workgroup
- Clarify problem

**Dec 2015**
- Identify key interventions

**Jan 2016**
- Create collective work plan

**July 2016**
- Design materials/support outreach pilots

**Sep 2016**
- Present & finalize materials

**Dec 2016**
- Explore and identify engagement modalities
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
- High blood pressure
- High cholesterol
- Diabetes (family history of diabetes)
- 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 (ZSFH)
(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:

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 45% 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.
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**

**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:**

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

  - August was 40 days.

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

  - CMHC
  - CSC
  - CPHC
  - MHHC
  - OPHC
  - PHHC
  - SAFHC
  - SEHC
  - TWUHC
  - FHC
  - RFPC
  - PHP

  - < 20 days
  - < 14 days

**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.

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.
<table>
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<td>CMHC</td>
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Developing a centralized call center
2015-2017


Richard Fine People’s Clinic
Ocean Park Health Center
Castro Mission Health Center

Projected timeline for 2017

Jan, 2017
18 Call Center Agents

Children’s → Silver Dental → FHC → Maxine Hall → Potrero Hill → Curry → Tom Waddell..... expanded hours

March, 2017
25 Call Center Agents

June, 2017
28 Call Center Agents
Call Center expansion: 22 additional workstations
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
• 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**