SFHN Primary Care

Our Lean Journey

Presentation to the Community and Public Health Subcommittee of the San Francisco Health Commission

June 19, 2018





San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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

Safety | Quality | Care Experience | People Development | Financial Stewardship | Equity

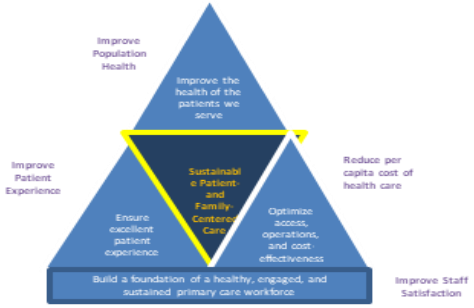
Build a Strong Foundation of a Healthy, Engaged, and Sustained Primary Care Workforce

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

Lean Journey in Primary Care

<u>2013-2014</u>
- Value stream at 1 health center & 3 improvement workshops (Kaizens)
- Lean certification series

<u>Summer 2014</u>
- Integration of PC in SFHN



2013 | 2014 | 2015 | 2016 | 2017 | 2018

<u>Fall 2015</u>
- Strategy Deployment Planning (Hoshin Kanri)
- Primary Care Driver Metrics / True North Metrics
- Site visit to ThedaCare

<u>2016</u>
- Rona Consulting Group assessment
- Strategic planning for Lean management
- Trained 25 PC leaders on A3 Thinking
- Hired manager/staff for Lean office
- 4 rapid improvement events

<u>2017-2019</u>
Lean Leadership Development series
- Lean leadership behaviors
- Daily management system
- 16 Primary Care clinic/program leadership teams in 4 cohorts

Primary Care A3-X Matrix

Quality: improve population health	Safety: coordinate care for safety and health	Equity: reduce health disparities	Care Experience: ensure patient- and family-centered care	Develop People	Financial Sustainability	SFHN Strategic Themes / Outcome Measures	Reduce TNAA to 14 days	Patients discharged from ZSFG receive care within 7 days	Expand CCC to all PC health centers	Improve blood pressure control among all patients and African American patients with hypertension	Increase screening for depression	Increase capture of SOGI and REAL data	Increase counseling for tobacco smoking cessation	90% of Health Center PACs will have met 10 times (months) during the year	DMS sites will have access to timely patient feedback	DMS site Practice Managers will demonstrate ICARE for Service Recovery competently in mystery shopper events	Notes locked on time and with a diagnosis	[keep in addition to more specific metric?] Reduce revenue cycle errors	[update/define] Increase A3 thinking capacity	90% of Primary Care executive leaders, managers and emerging experts are trained in DMS	80% of clinics will demonstrate visible use of DMS tools	80% of new PC employees will be provided onboarding guides for first 3 weeks and first 90 days on the job	95% of PC employees will receive an annual Performance Appraisal (PA)	80% of managers who identify a volunteer or student will have volunteer or student in place within 30 days of email being sent to central primary care coordinator	Facility improvement metrics (to be replaced): CMHC remodel MHHC remodel CPC clinic deferred maintenance projects SEHC rebuild & expansion Fiberoptics and electronic connectivity TW security report recommendations
2	1	2	1	2	1	**Access:** Ensure patients' health concerns are addressed using the modality and in the time frame they expect to ensure quality and safety	X	X	X																
1	1	1	2	2	2	**Health:** Improve population health processes and outcomes aligned with the needs of our population and incentive programs				X	X	X	X												
1	1	2	3	1	3	**Data:** Delivering timely, actionable reporting to drive improvement at SFHN (PC/PRIME)																			
2	2	2	1	1	1	**Patient Experience:** Increase the number of patients and families who recommend SFHN primary care by improving the customer service experience and partnering with patients and families on care experience improvement opportunities								X	X	X									
3	3	3	3	2	1	**Finance:** Improve financial stewardship to optimize revenue & reduce reliance on the General Fund											X	X							
1	2	2	1	1	2	**Leadership:** Develop PC directors and managers as Lean leaders by implementing Lean Management System													X	X	X				
2	2	2	1	1	1	**Workforce:** Create standard tools and systems for onboarding and developing primary care team members to improve engagement of PC																X	X	X	
2	2	2	1	1	2	**Facilities:** Use available resources to address ergonomic, internal, and external facilities deficiencies																			X

Primary Care Annual Tactics

Leading/Process Measures (3-12 month targets)

Primary Care
True North & Driver Metrics

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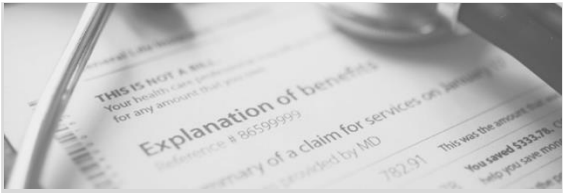
STRATEGIC THEME	Care Experience	People Development	Financial Stewardship
Primary Care True North Metrics **2016-2018**	 Increase the number of patients with a positive response to CG-CAHPS "would you recommend" question Improve access to care	 Improve workforce engagement, as measured by the Gallup staff engagement score	 Increase annual revenue through billing for all revenue-generating encounters
Primary Care Driver Metrics (PCDM) **2017-18**	**Routine appointment access** **CG CAHPS likelihood to recommend**	**Performance appraisals completed and submitted**	**Notes locked on time**

Primary Care
True North & Driver Metrics

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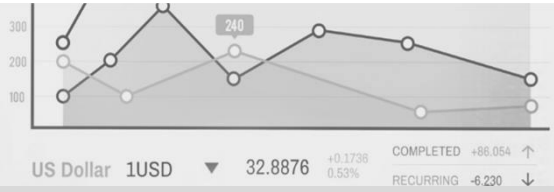
STRATEGIC THEME	Quality	Safety	Equity
Primary Care True North Metrics 2016-2018	 Improve population health through **preventive care** and **chronic condition management**, with focus on: preventive oral health care, blood pressure management, and helping smokers quit	 Improve timely coordination of 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** **Smoking Cessation**	**7 day post-discharge follow up**	**Hypertension control for Black and African American patients**

SAFETY

METRIC:

7 Day Post-Hospitalization Follow-up

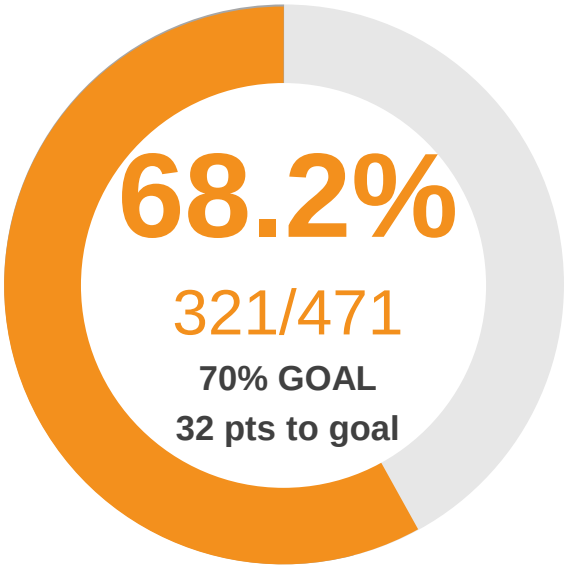
WHY WE MEASURE THIS:

Leaving the hospital is one of the most vulnerable times for patients because they are sick and often have new medications.

TARGET:

Ideally, all SFHN PC patients should have a phone or clinic visit within 7 days of hospital discharge. Our target is 15% relative improvement from Q4 of FY 2016-2017 (65%). We aim to have 70% of our discharged patients connected with a care team within 7 days post hospitalization.

April 2018:



57% (268)
Clinic visits w/in 7 days

31% (148)
Phone visits w/in 7 days

CLINICS MEETING GOAL:

SAFHC, CPHC, RFPC, SEHC, CSC

Mr. Lee is a patient of Mary M. at TWUH who was admitted for new diagnosis of diabetes and diabetes complications.
MEA Damika Kelly reviewed her discharge worklist and called patient. She discovered that he had trouble getting home insulin. She sent a TE to the pharmacist who helped resolve the medication issue. Potential readmission prevented!

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SAFETY

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	Clinic	Feb 2018	Target (15% RI from Q4 FY16-17
	CMHC	74%	87%
	CHC	59%	85%
	CPHC	74%	75%
★	CSC	62%	65%
	FHC	69%	75%
	Larkin	0%	15%
★	MHHC	76%	76%
	OPHC	73%	91%
	PHHC	60%	89%
	PHP	52%	55%
	RFPC	68%	71%
★	SAFHC	92%	79%
★	SEHC	60%	57%
	TWUH	52%	54%

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SAFETY

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ACTION ITEMS

- KEEP UP THE GREAT WORK! So close to this metric goal, nearly all clinics with improvement in last month
- Daily huddle discussions about how to handle the emails and LCR worklist
- Look at the tableau dashboard under “Primary Care” not “Primary Care Pilot”; we have a functional worklist! Reminder, target is 15% RI from Q4 FY 16-17.

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True North Focus: Safety

Timely follow up after hospital discharge

Tom Waddell Urban Health

Annual clinic presentation and
True North Deep Dive
September 22, 2017

Background

Nurse Note:

“Patient Mr. Lee missed his scheduled discharge appointment today. I called and spoke with the patient, asked if he could come in tomorrow. He said "no, I'm in a wheelchair and I can't get around."

I asked if he thought he could come to his appointment with Dr. Eveland and he said "I'll try." I asked him to bring all his medications and he said he wasn't taking any. He said St. Francis had given him a prescription, but "I'm a poor man, I can't afford it."

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Current Conditions

At baseline, 28% of patients received timely F/U after hospital DC

70% no-show rate for hospital DC F/U Appts (all hospitals)

2-4 homeless TWUH patients dc'd from ZSFG to street/shelter every week

Problem Statement: The majority of TWUH patients do not receive timely follow up after hospital discharge.

Target

By September, 2017, improve proportion of TWUH patients who have documented follow up within 7 days of hospital discharge from 28% to 50%.

Countermeasures

MEA Care Transitions Coordinator

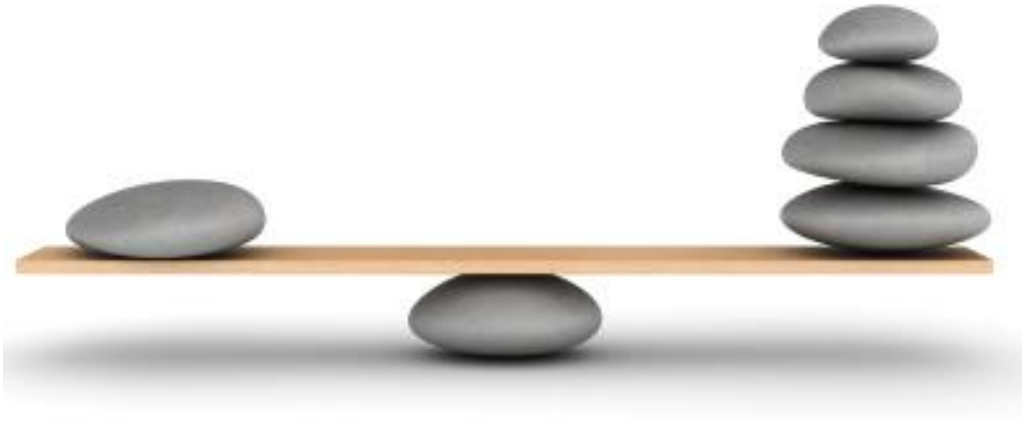
Outreach calls

Proactive scheduling

Expanding the circle of care

Behavioral Health Outreach

Hospital visits



7 Day Post-Discharge Follow Up

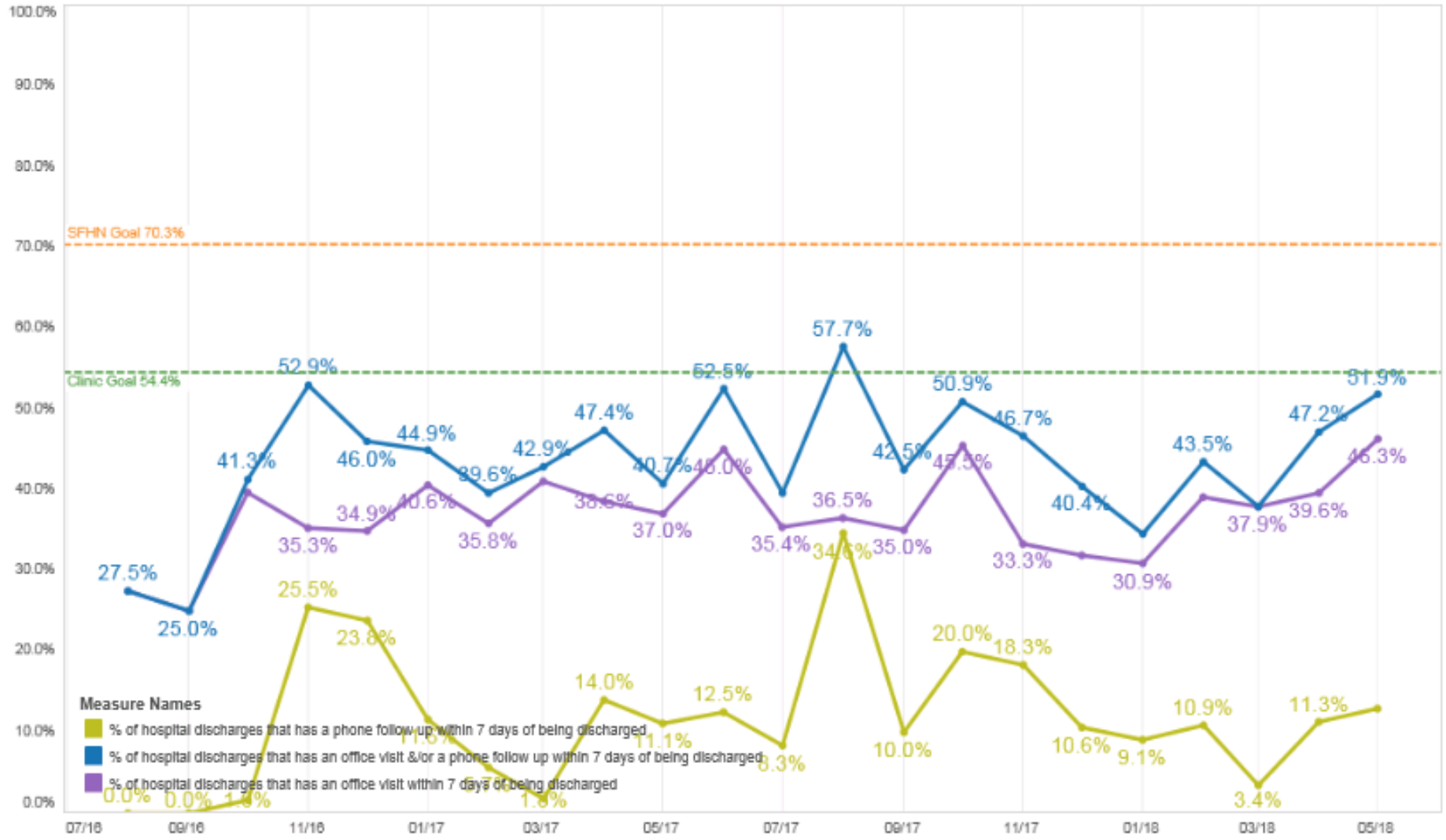
% of hospital discharges that has a/an
* office visit and/or phone follow up within 7 days of being discharged
* office visit within 7 days of being discharged
* phone follow up within 7 days of being discharged

Select PCC: TWUHC

Select Start Month: August, 2016

Select End Month: May, 2018

 # to goal May, 2018 1



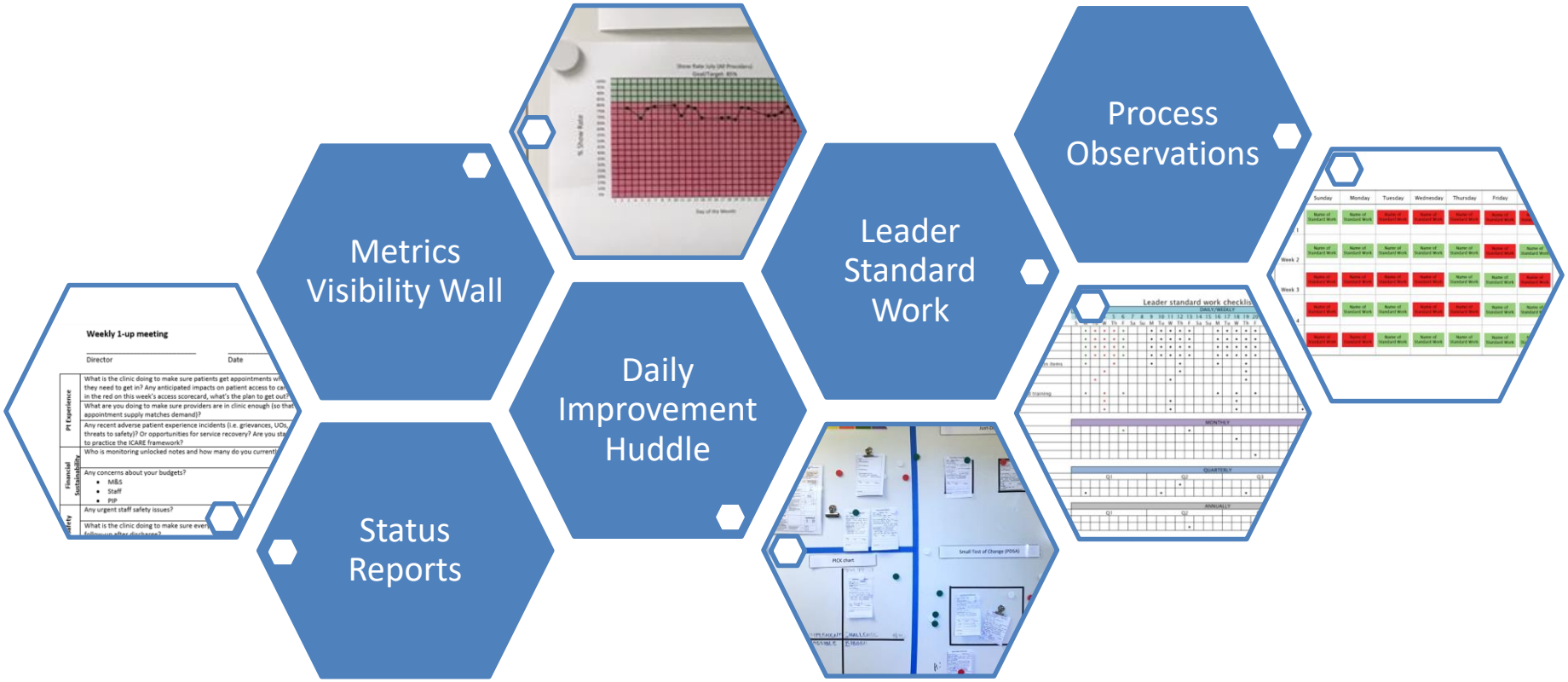
Lean Leadership Development in Primary Care

- Learn, adapt and implement a daily management system
- Learn and practice Lean Leadership Behaviors

	2017												2018			
Cohort 1: Curry, RFPC, SAFHC, TWUH PC		Feb						Aug								
Cohort 2: CHPY, MHHC, SEHC, Telecomm										Oct						Apr

	2018						2019		
Cohort 3: CMHC, CPHC, OPHC, PHHC		Aug						Feb	
Cohort 4: CHC, FHC, PHP, TWIMS				Oct			Jan	(with ZSFG)	

Lean Management System in Primary Care



Status Reports

rona consulting group

SF HEALTH NETWORK

Daily status report—template

Instructions:

- Leads/supervisors and their managers will use a daily status report to facilitate common understanding of the daily business for their unit/area/department.
- Use one sheet per day. Enter unit and date of report, and circle day of the week.
- Identify 15–20 questions with at least 1–2 in each category.
- Record brief notes as needed and complete the action plan to identify follow-up actions needed.

Unit: _____	**Date:** ___/___/___ **Day** (circle one): S M T W Th F S

True North themes	Daily measures	Notes
Quality	*How are we ensuring BP is taken properly?*	
	What clinical quality metrics are we focusing on today?	
Safety	*How many hospital discharges happened yesterday and need follow up?*	
Equity	*How did REAL data collection and data entry go yesterday?*	
Care Experience	*What barriers do we anticipate to access and flow today, what is plan to address them?*	
	How many available appointments do we have today and tomorrow, what is plan to fill?	
	What UOs, patient concerns or grievances occurred yesterday?	
Develop People	*Who are you coaching or developing today?*	
	Who do you want to recognize today?	
Financial Sustainability	*How many unlocked notes over 5 days do we currently have and what is plan to ensure these are completed?*	
Wrap Up	*What else should we be anticipating for today?*	

Action Plan

Item No.	Problem	Countermeasure	Responsibility	Date	Status

Status Reports

Weekly 1-up meeting

_____ _____

Director Date

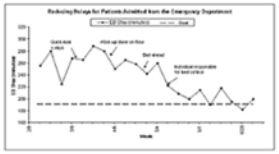
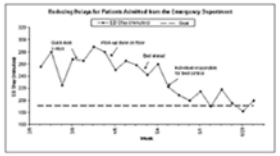
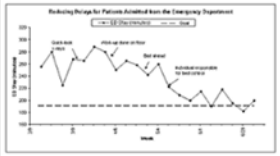
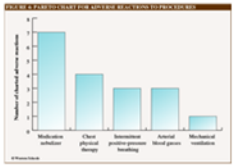
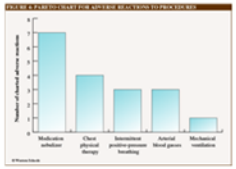
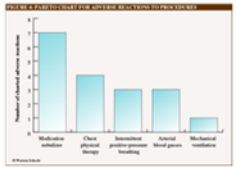
Pt Experience	What is the clinic doing to make sure patients get appointments when they need to get in? Any anticipated impacts on patient access to care? If in the red on this week's access scorecard, what's the plan to get out?	
	What are you doing to make sure providers are in clinic enough (so that appointment supply matches demand)?	
	Any recent adverse patient experience incidents (i.e. grievances, UOs, threats to safety)? Or opportunities for service recovery? Are you starting to practice the ICARE framework?	
Financial Sustainability	Who is monitoring unlocked notes and how many do you currently have?	
	Any concerns about your budgets? • M&S • Staff • PIP	
Safety	Any urgent staff safety issues?	
	What is the clinic doing to make sure every hospitalized patient has close follow-up after discharge?	
Pop Health	Which clinical quality metrics are you working on?	
	What BH integration work are you focused on? How many smokers are being referred for counselling?	
Equity	What specific health disparities work are you excited about?	
	Any specific equity concerns which you are addressing right now?	
Develop People	Which standard work or new tools are being implemented and how's it going? Examples: BH referrals, RNCC, flip visits, REAL, locking notes, LSW	
	How are you doing with your Leader Standard Work?	
	What observations did you do in clinic this week?	
	Who are you developing among your managers?	
	Who are you recognizing?	
	Who are you concerned about?	
	Any key hiring process which is stalled that I should know about?	
	What else should I know about or should I do to help you effectively manage your clinic?	

Getting to the frontline:
Daily Improvement Huddles

Started 05/2017 @ 4 sites

Getting to the Frontline: Metrics Visibility Wall

SFHN Metrics Visibility Wall

Strategic theme	Care Experience	Develop People	Equity	Financial Sustainability	Quality	Safety
Historical data (run charts)						
Daily data & tracking chart						
Top Contributors (pareto chart)						
Action plan (PDSA form)						

Started 07/2017 @ 4 sites

Future Directions:

- In process of surveying cohorts 1 and 2 to assess use of the DMS tools, value, and possible adjustments in model
- Cohorts 3 and 4 will launch in the fall, timed and tailored to Epic implementation
- Cohort 4 training will be aligned with ZSFG
- Use Daily Management System as basis for our Epic rollout
- True North 2018-19 in process, based on new Primary Care tactics:
    1. transforming our care team model
    2. value-based care
    3. developing managers and team members