SFHN Primary Care Update

Health Commission | September 17, 2019

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San Francisco
Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Vision for SFHN Primary Care

SFHN PC TRUE NORTH FY 18-19

TN MEASURE	BASELINE (June 2018)	GOAL	EOY (June 2019)	MET GOAL
7 Day Follow-Up	64%	69%	58.4%	
TNAA	23	14 (or -7)	21	
Courteous & Helpful Office Staff	66%	69%	65.2%	
BHVS	8.8%	36.2%	42.7%	★
Adolescent IZ	63.4%	67%	67.8%	★
Unlocked Notes	360	130	353	
HTN B/AA	61.4%	65.3%	67%	★
Coaching for Progress	59.4%	63.5%		

QUALITY

METRIC:

Behavioral Health Vital Signs

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.

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

July 2019

(data through June 2019)

1504 **Additional patients screened with BHVS in the last month**

42.7% **Compared to 39.9% May 2019**

0 **Patients need BHVS screening to reach goal**

9/13 Met RI goal of 30% screened with BHVS from baseline to this month

CHC, CMHC, COLE, CPHC, CSC

FHC, LARKIN, MHHC, OPHC, PHHC

PHP, RFPC, SAFHC, SEHC, TWUHC

Met 30% RI BHVS goal | Implemented BHVS | Not Yet Implemented

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.

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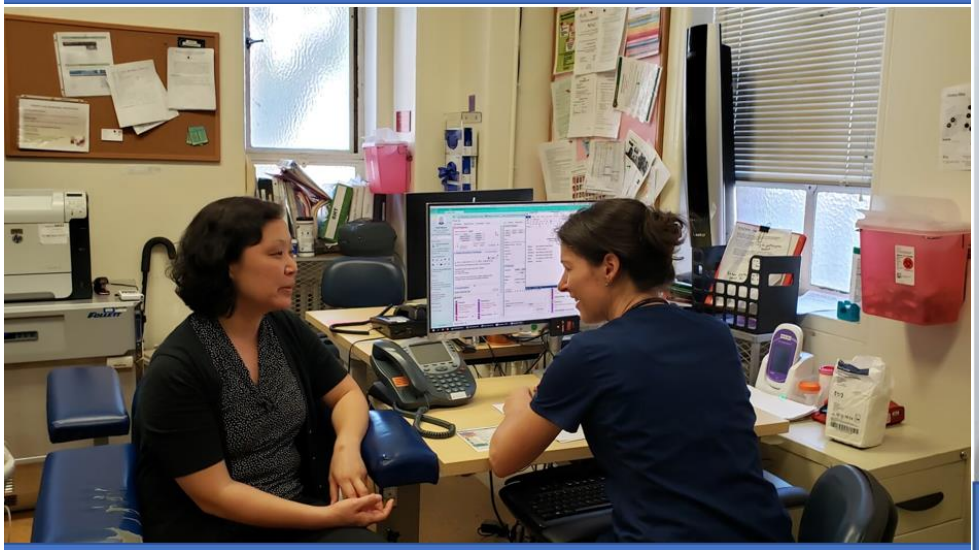
Front Desk staff welcome and register patients. For BHVS roll-out they also give patients the combined screener to fill out in the waiting room.

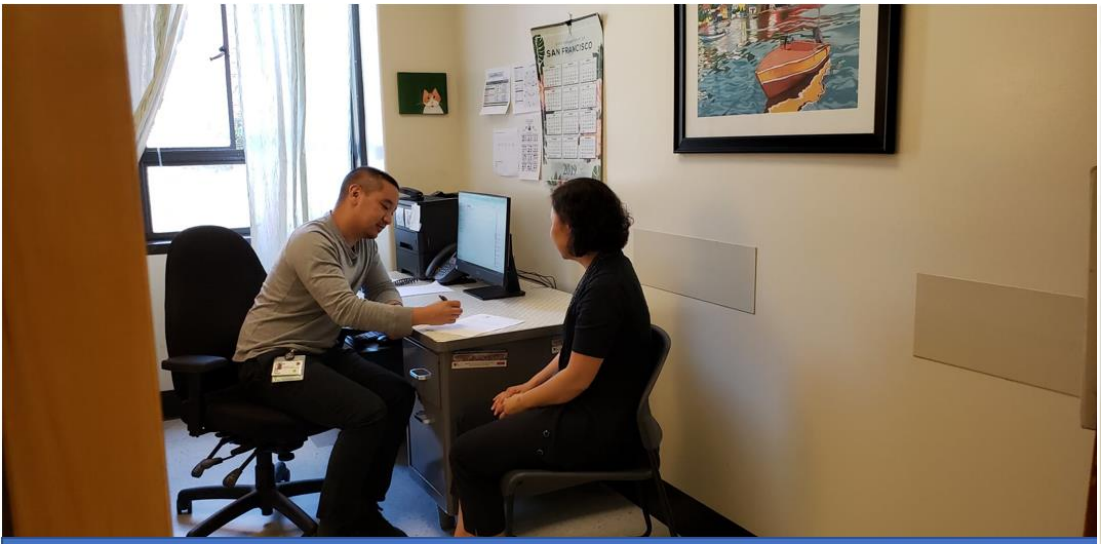


Medical Assistants (MEAs) collect and document BHVS forms in the EHR.

MEAs and PCP work together in teamlets. MEAs communicate positive results to PCP.

The patient and PCP talk about the screening results and how depression, substance use or trauma affect health. They share decision making on next steps like referrals or medicines.

PCPs also offer a warm handoff to Primary Care Behavioral Health for further assessment, brief interventions, or specialty referrals.



Collocated PCBH staff meet with patients in a therapeutic setting to build concrete coping skills to address behavioral health concerns.

Patients generally report high satisfaction and gratitude for access to behavioral health services as a part of their primary care.

EQUITY

METRIC:

Hypertension Control

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%.

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

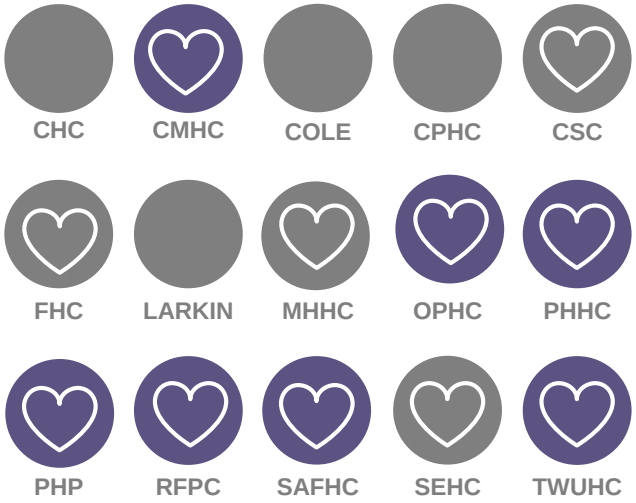
July, 2019
(data through June, 2019)

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

67.0% **Compared to 65.2% in May, 2019**

0 *GOAL MET
B/AA patients needed to control BP to reach goal

7/11 **Met relative improvement goal of 15% this month**



Met 15% RI goal Did not meet RI goal

Mrs. Lee is a frequent visitor to the SEHC Food Pharmacy. She was introduced to the Food Pharmacy as a resource to help her reduce her blood pressure which had been high. Now, after several visits, Mrs. Lee enjoys regular visits to the Food Pharmacy where she can socialize with other patients, share tips and recipes for healthy meals, and also get her blood pressure checked in between doctor visits.

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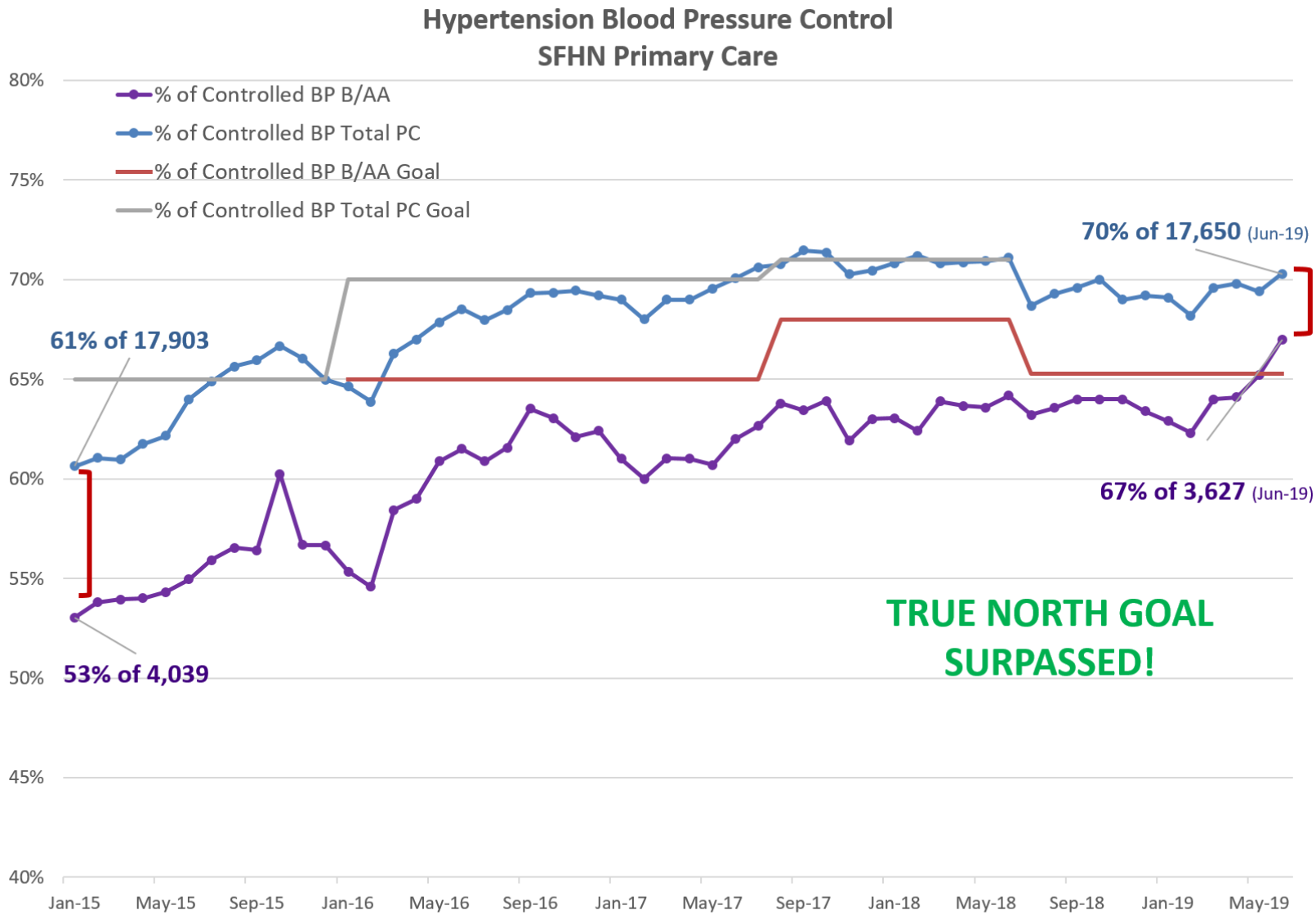
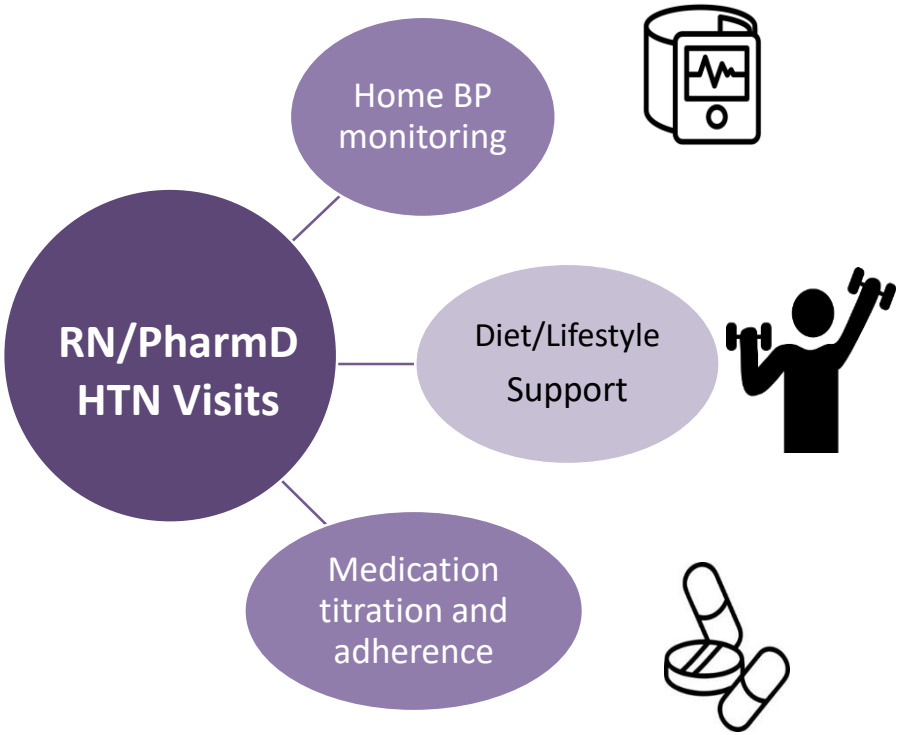
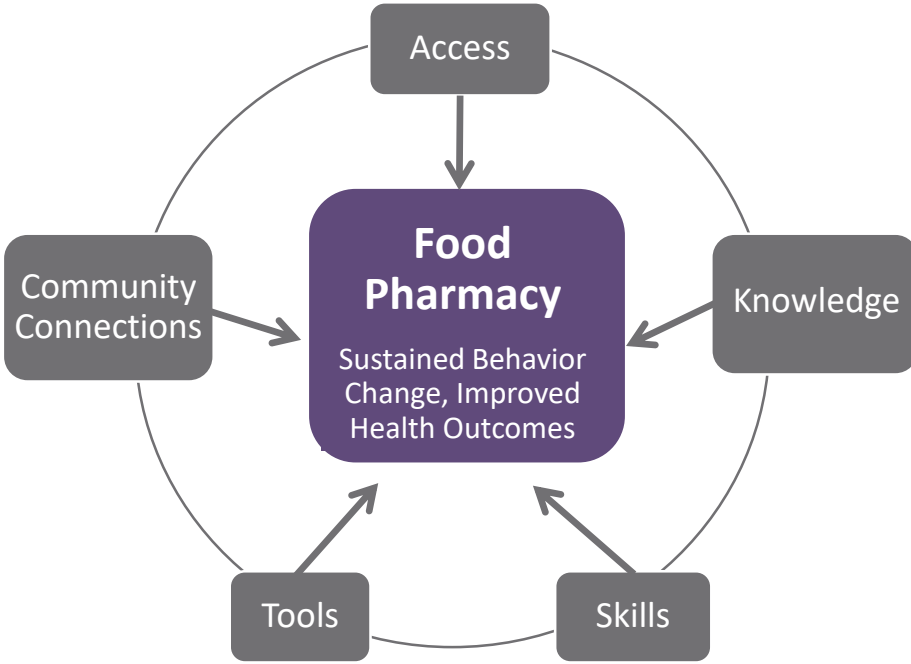

Hypertension Blood Pressure Control
SFHN Primary Care
% of Controlled BP B/AA
% of Controlled BP Total PC
% of Controlled BP B/AA Goal
% of Controlled BP Total PC Goal
80%
75%
70%
65%
60%
55%
50%
45%
40%
Jan-15
May-15
Sep-15
Jan-16
May-16
Sep-16
Jan-17
May-17
Sep-17
Jan-18
May-18
Sep-18
Jan-19
May-19
70% of 17,650 (Jun-19)
61% of 17,903
67% of 3,627 (Jun-19)
53% of 4,039
TRUE NORTH GOAL
SURPASSED!

Hypertension Equity Workgroup

RN and Pharmacist HTN Visits



Food Pharmacy



CARE EXPERIENCE

METRIC:

Routine Appointment Access

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:

By end of June 2019, we aim to reduce the median days to the third next available RT appt by **7 days** or down to **14 days** compared to our baseline of 23 days (5/29-6/26/18).

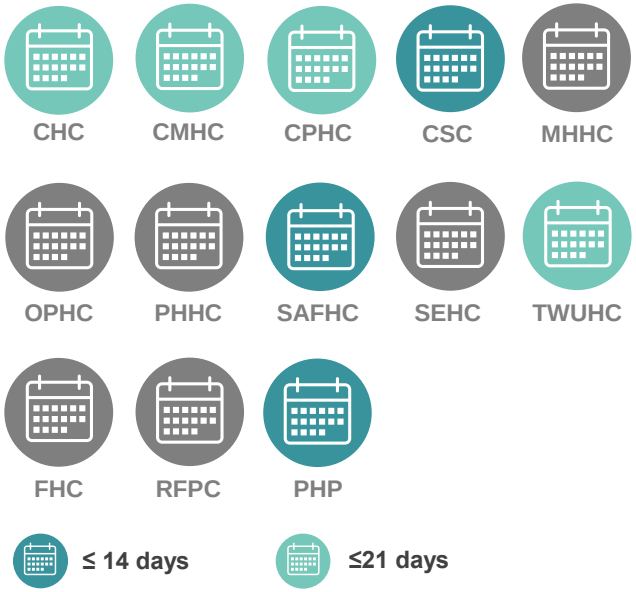
Our target is an absolute improvement of **7 days** or threshold of **14 days.**

July 2019

(5 weeks data for 6/27 – 7/25/19)

21 **Median of clinics' median days until third next available RT appointment**

7/13 **Clinics with less than or equal to 21 days or 14 days until third next available appointment**



Mr. Lee has had so much going on at work that he forgot to schedule a pre-kindergarten physical for his twin 5 year olds and a sports physical for his daughter who is hoping to swim on her school team. He called Chinatown Public Health Center, spoke to a Call Center Agent who spoke Mandarin, and was able to make appointment for both girls, as well as his dental check-up, all on the same day.

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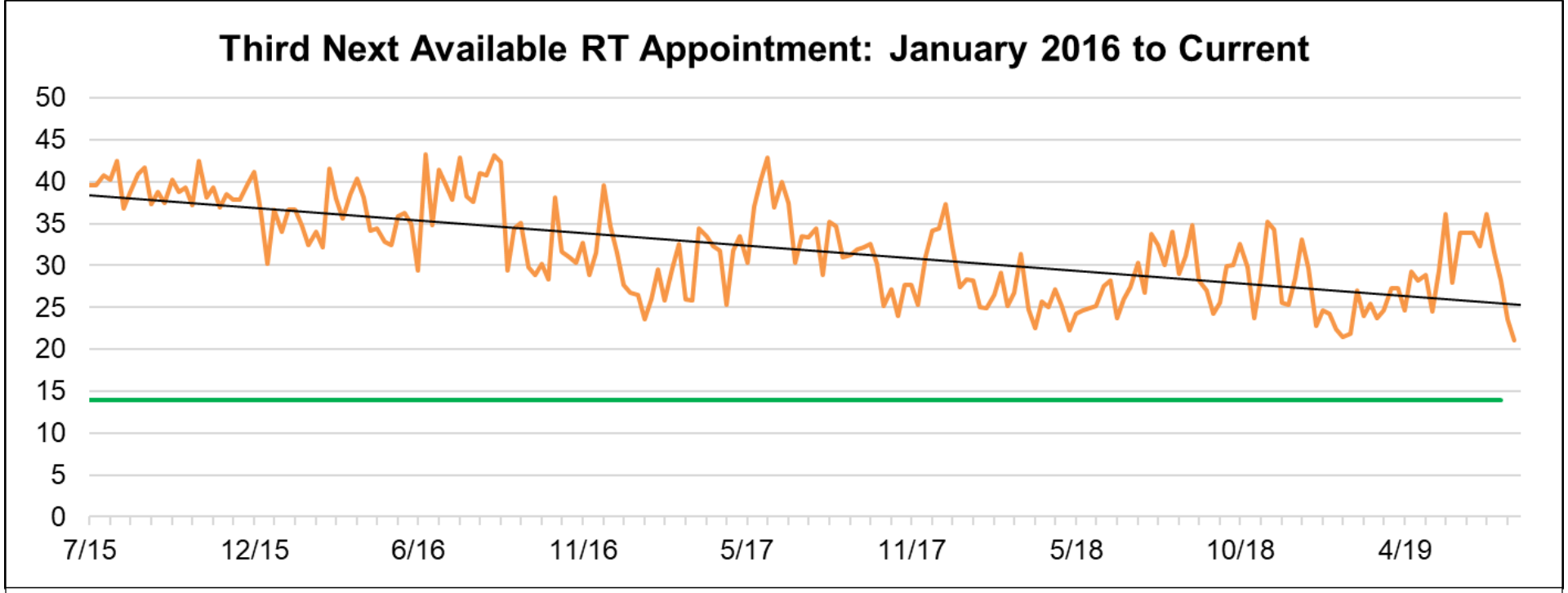
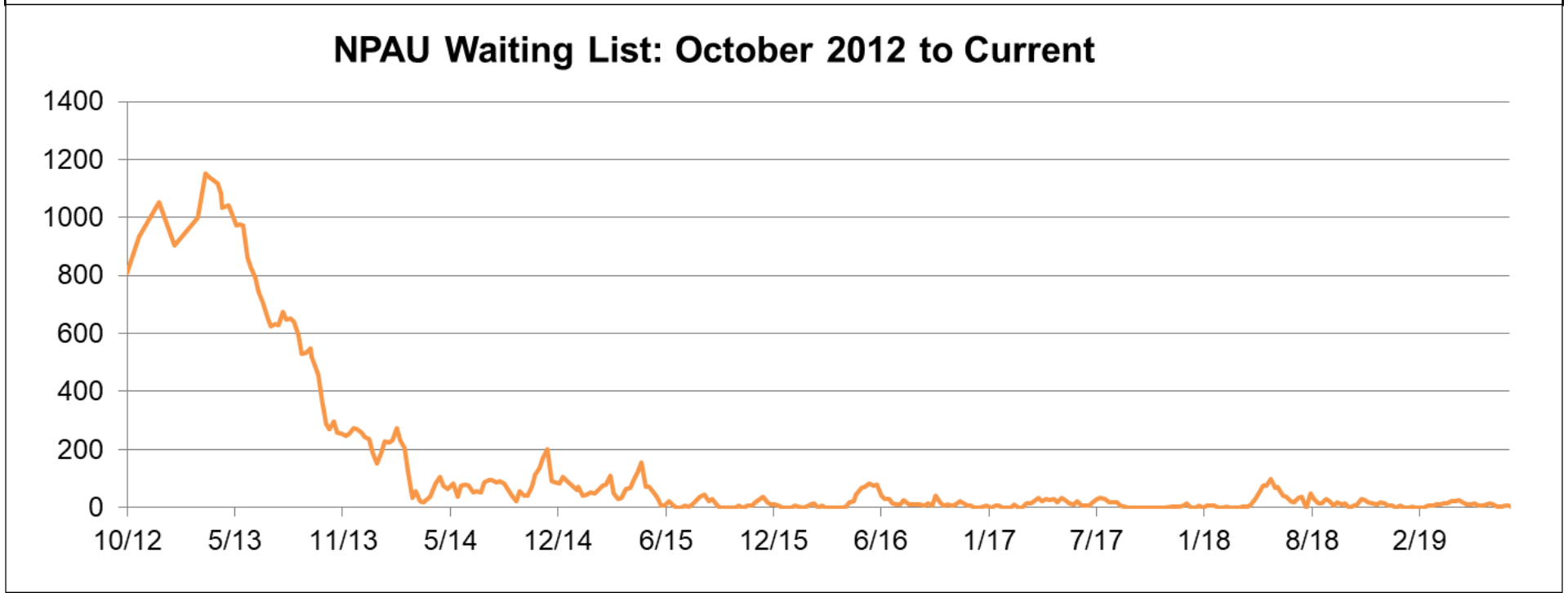

Third Next Available RT Appointment: January 2016 to Current
50
45
40
35
30
25
20
15
10
5
0
7/15
12/15
6/16
11/16
5/17
11/17
5/18
10/18
4/19


NPAU Waiting List: October 2012 to Current
1400
1200
1000
800
600
400
200
0
10/12
5/13
11/13
5/14
12/14
6/15
12/15
6/16
1/17
7/17
1/18
8/18
2/19

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.

July 2019

(Data for June 2019)

58.4% (n=316)

Clinic or phone visit w/in 7 days

4/14 **Met relative improvement goal of 15% this month**

CHC, CMHC, CPHC, CSC, FHC, LARKIN, MHHC, OPHC, PHHC, PHP, RFPC, SAFHC, SEHC, TWUHC

Lee, a PHP patient, is chronically homeless without a phone and was admitted for pneumonia. He was discharged to hummingbird respite, and was told by the inpatient team/social worker to attend the POPUP clinic same day of discharge. He made it to that clinic, medications were reviewed to ensure he got his full antibiotic course, he had access to ARVs, and his anti-depressive was up titrated at the POPUP clinic.

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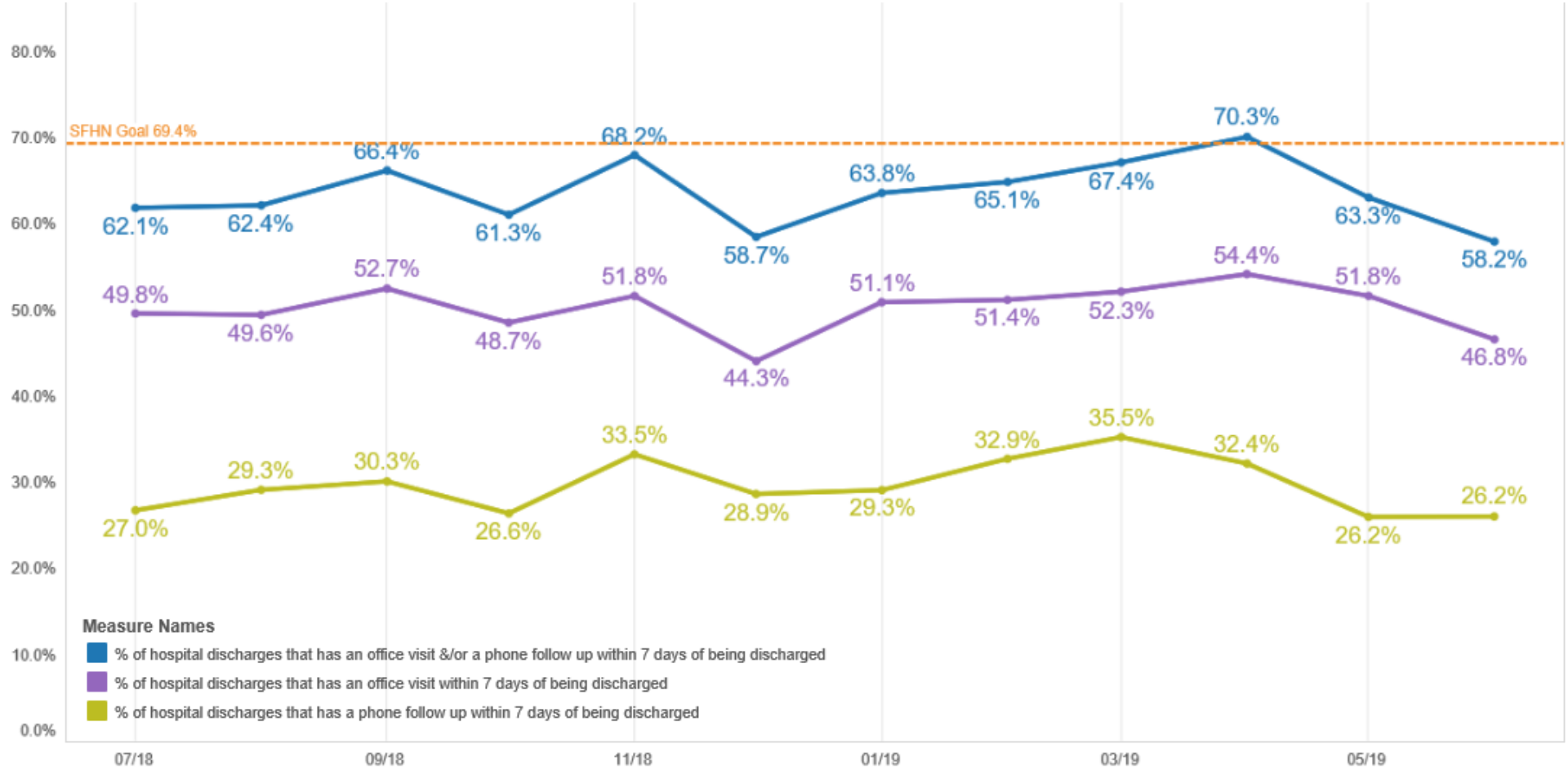
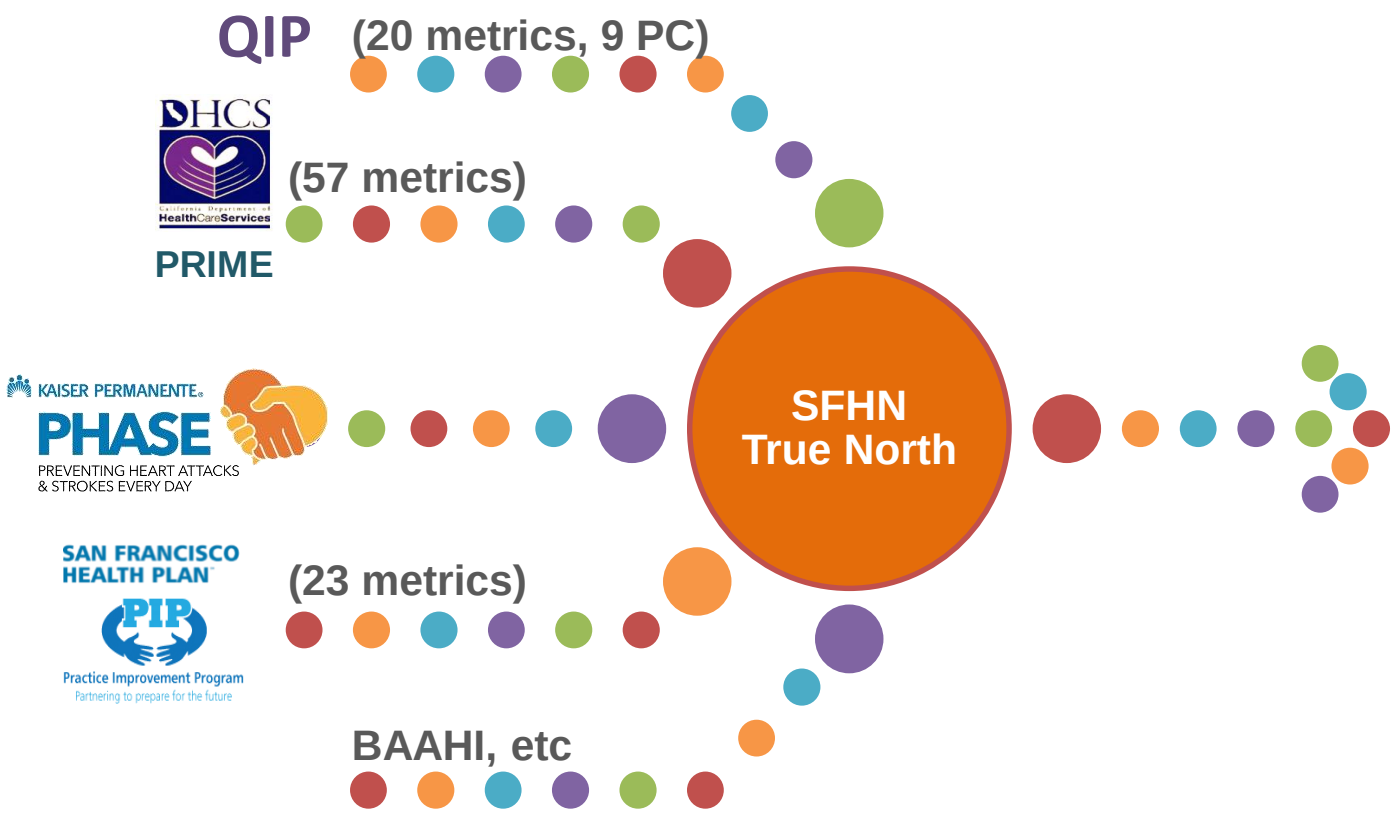
7 Day Post-Hospitalization Follow-Up



Aligning True North & P4P Programs: Integrated Annual Scorecard and P4P Program



Annual Clinic Scorecard (27 metrics)

SFHN PC Driver / Watch	Measure Name	SFHN PC Strategic Theme	Key Alignments	PCC Driver/Watch	PCC Owner	Baseline Date (Source)	PCC Baseline 06/2017
True North Driver	Third Next Available Appointment (TNAA)*	Care Experience	PIP $ PRIME mandate	Driver	ex	06/2017 (SFGS)	30 days
	Likelihood to recommend as a place for care (CG CAHPS) - 3 month rolling average	Care Experience	PIP $	Watch (except areas covered below)	ex	06/2016-06/2017 (NRC)	64.4%
	Unlocked notes	Financial Stewardship	PIP $	Watch	ex	06/2017	0
	7 day post-discharge follow up	Safety	PRIME $$$ PIP $	Watch	ex	06/2017	
	Hypertension BP control for All	Quality & Equity	PRIME $$$ PIP $ PHASE $ BAAHI	Driver	ex	06/2017 (Tableau)	68.2%
	Hypertension BP control for African Americans*			Driver	ex	06/2017 (Tableau)	54.2%
	Tobacco cessation: adult smoker intervention (age 18 years & up)	Quality	PRIME $$$ PIP $ PHASE $	Watch	ex	06/2017 (Tableau)	86.7%
	Tobacco cessation: adolescent smoker screening (age 12-17 years)			Watch	ex	10/2017 (Tableau)	94.6%
Driver	Depression screening (age 18 years & up)	Quality	PRIME $$$ PIP $	Driver	ex	06/2017 (Tableau) *	26.5%
	Adolescent immunizations: meningococcal, tetanus, HPV	Quality	PIP $	Driver	ex	06/2017 (Tableau)	40.5%
	Colorectal cancer screening	Quality	PRIME $$$ PIP $	Watch	ex	06/2017 (Tableau)	74.9%
	Opioid safety: pain agreement, urine tox screen, CURES report	Safety	PRIME $$$ PIP $	Driver	ex	10/2017 (Tableau) *	48.1%
Driver (central)	Customer Service Composite (CG CAHPS) - 3 month rolling average	Care Experience		Driver	ex	06/2016-06/2017 (NRC)	73.3%
	All cause 30-day readmissions for ZSFG (NQMC definition, care transitions)	Safety	PRIME $$$	Watch	NA	06/2017	

True North (7 metrics)

Integrated P4P Program for Clinics (17 metrics)

Annual PC Clinic Scorecards

Integrated Metrics & Priority Setting

Bi-Directional Transparency & Accountability

Communication & Engagement at Multiple Levels

Strategic Planning & QI Skill Building

SFHN PC Driver / Watch	Measure Name	SFHN PC Strategic Theme	Key Alignments	PCC Driver/Watch	PCC Owner	Baseline Date (Source)	PCC Baseline 06/2017
True North Driver	Third Next Available Appointment (TNAA)*	Care Experience	PIP $ state mandate	Driver	xx	06/2017 (SRSS)	30 days
	Likelihood to recommend as place for care (CG CAHPS) - 3 month rolling average	Care Experience	PIP $	Watch (except areas covered below)	xx	06/2016-06/2017 (NRC)	64.4%
	Unlocked notes	Financial Stewardship	PIP $	Watch	xx	06/2017	3
	7 day post-discharge follow up	Safety	PRIME $$$ PIP $	Watch	xx	06/2017	
	Hypertension BP control for All	Quality & Equity	PRIME $$$ PIP $ PHASE $ BAAHI	Driver	xx	06/2017 (Tableau)	68.3%
	Hypertension BP control for African Americans*			Driver	xx	06/2017 (Tableau)	54.2%
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Driver	Depression screening: (age 18 years & up)	Quality	PRIME $$$ PIP $	Driver	xx	06/2017 (Tableau) *	26.5%
	Adolescent immunizations: meningococcal, tetanus, HPV	Quality	PIP $	Driver	xx	06/2017 (Tableau)	40.5%
	Colorectal cancer screening	Quality	PRIME $$$ PIP $	Watch	xx	06/2017 (Tableau)	74.8%
	Opioid safety: pain agreement, urine tox screen, CURES report	Safety	PRIME PIP $	Driver	xx	10/2017 (Tableau) *	48.1%
Driver (central)	Customer Service Composite (CG CAHPS) - 3 month rolling average	Care Experience		Driver	xx	06/2016-06/2017 (NRC)	73.3%
	All cause 30-day readmissions for ZSFG [PRIME definition, care transitions]	Safety	PRIME $$$	Watch	N/A	06/2017	

PRIME $$$
PIP $
PHASE $

PRIME/QIP State Pay for Performance

PRIME Year 3 (2017-2018)

- Met all PC metrics
- ~$12 million incentive funds

PRIME Year 4 (2018-2019)

- Met all but 1 PC metric
- ~$25 million incentive funds (including QIP addition)

Looking Ahead: FY 2019-2020 with Epic

Sustainability during EHR implementation = Effort!

Rebuild and validate QI reports & actionable data tools

→

Establish new baseline & targets

Priority setting

→

Train on new tools & workflow modifications

→

QI

Measures to Sustain / Expand

Behavioral Health Vital Signs

Hypertension Control for Equity

Routine Appointment Access

Locked Notes -> Closed Encounters

Patient Experience - Courteous & Helpful

Staff Experience - Coaching for Progress

New Measures

Medication Reconciliation