



Health at Home

Joint Conference Committee Annual Report to

March 8, 2016





HAH Overview

Mission

To provide high quality, culturally competent home health services to residents of SF, resulting in reducing reliance on institutionalization and supporting independent living in the community

Regulatory Bodies

- Medicare Conditions of Participation for Home Health Agencies
- California Title XXII, CA Health and Safety Code







Program Highlights

- Served 1,286 clients and 19,781 home visits
- Increase in revenue of \$652,291 which was 25% above the budgeted revenue projection
- Achieved Medicare payer mix increase to 41% from 36%
- Received overall rating of Commendable/Exceeds Standards for the annual HIV CARE contract program compliance monitoring site
- Initiated staff satisfaction committee which presented findings and recommendations in spring 2015
- Replaced all laptops with built-in Wi-Fi which resolved significant communication issues
- Onsite IT support available on Monday, Wednesday and Thursday for total of 9 hours per week



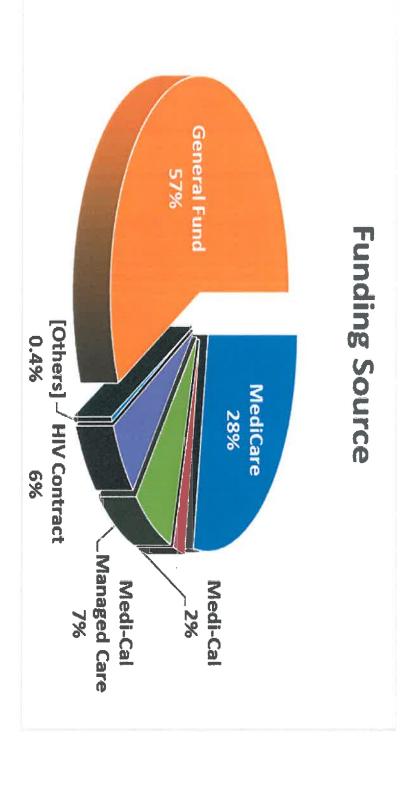


	57%	General Fund reliance %
	\$4,063,876	General Fund (GF)
5	\$3,089,103	Revenue
D A	\$7,152,979	TOTAL EXPENSES
٦	\$504,196	Operating Expenses
	\$6,648,783	Labor expenses
	FY1415	

\$2,200	\$3,089,103	19781	1404	TOTAL
	\$0	756	34	HSF/Sliding Scale/Mcal Pending
\$981	\$29,429	416	30	Others
\$989	\$513,133	7650	519	Medi-Cal Managed Care
\$1,546	\$148,431	1601	96	Medi-Cal
\$2,196	\$423,819	1204	193	HIV Contract
\$3,711	\$1,974,291	8154	532	Medicare
REVENUE /CLIENT	TOTAL REVENU	# OF VISITS	# OF CLIENTS	PATIENT SERVICE REVENUE











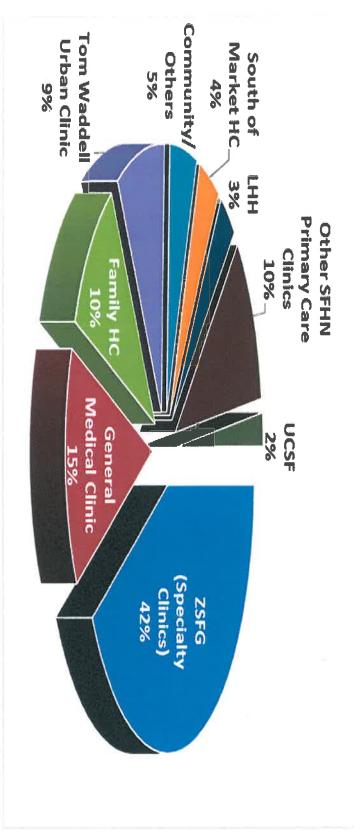
Key Program Statistics

1415 27.61 19783 1286 109



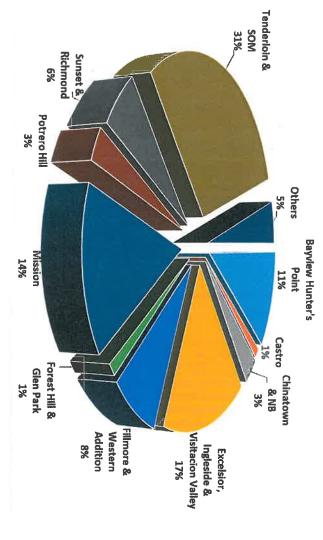


Clients by Primary Care Homes

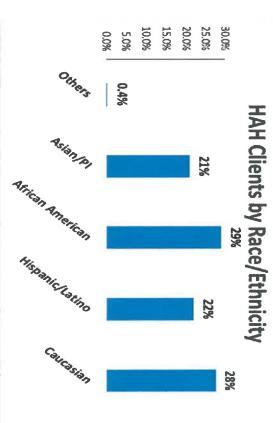




Clients Served by Neighborhood



Client Demographics







Access to Care

- Designated Home Health Provider for Healthy SF, Sliding Scale/MIA and Medi-Cal pending clients
- Preferred home health provider for Medi-Cal and Medi-Cal Managed Care clients with the San Francisco Health Network
- HIV Contract & Medication Treatment Adherence Program





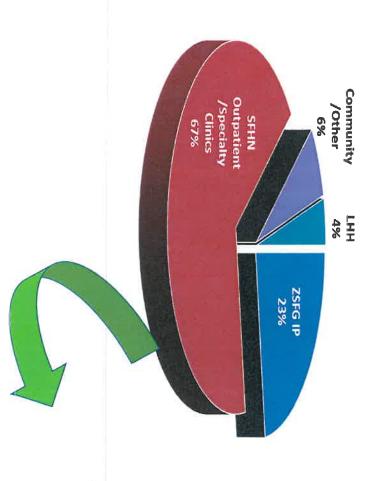
Field Staff Language Capacity Chinese 19% 19% Tagalog_ 6% (n=36) English 56%



Clients by Referral Source

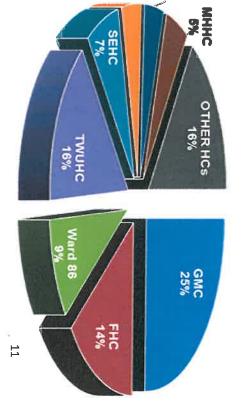
Referral Source

(n=1,655)



Referrals from SFHN Outpatient Clinics

(n=1109)



PHHC 4%C Eng &





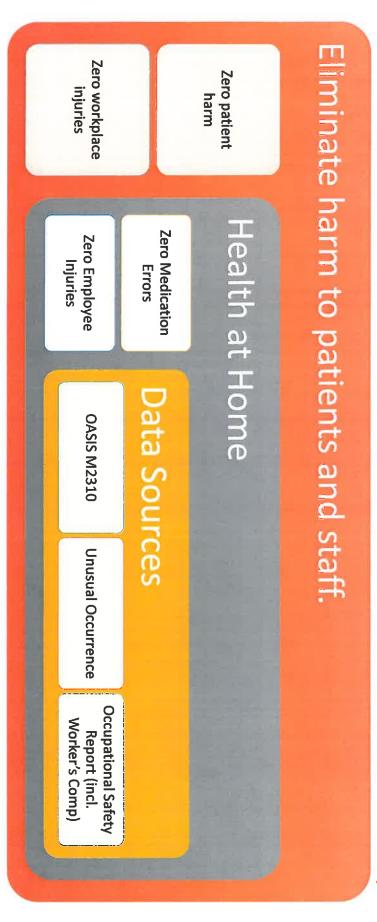
Goals vs. Targets

measurable metrics, when appropriate, to seek continuous improvement. Goals: Laguna Honda and Health at Home set goals at zero and or 100% for all

based on data benchmarks from the prior fiscal year. are specific, measurable, action-oriented, realistic and timely for current fiscal year Targets: Laguna Honda and Health at Home also establish performance targets that



SFHN True North Metric #1: Safety





SFHN True North Metric #2: Financial Stewardship





SFHN True North Metric #3: Care Experience





SFHN True North Metric #4: Quality





SFHN True North Metric #5: Workforce



*True North Metrics subject to change





SFHN True North Metric #6: Equity

Eliminate disparities.

BAAHI

(Black African American Health Initiative)

REAL

(Race, Ethnicity and Language)

SOGI

(Sexual Orientation, Gender Identity)

Health at Home

Reduction in disparities in workforce race, ethnicity and/or language

Good or excellent limited English proficient (LEP) client satisfaction

Data Sources

HRS Data

Satisfaction Survey

^{*}True North Metrics subject to change





Metrics Review and 2016 Calendar Plan - HAH

SFHN TRUE NORTH METRICS	RTH METRICS	HEALTH AT HOME TRUE NORTH METRICS	Jan	Mar	May	直	Sep	Nov
SAFETY Eliminate harm to patients and	1) Zero patient harm	a) Zero medication errors.	TBD	TBD	×	×	×	×
staff.	2) Zero workplace injuries	b) Zero employee injuries.	TBD	TBD	×	×	×	×
FINANCIAL STEWARDSHIP	1) Meets budget	a) Zero budget variance.	TBD	TBD	×	×	×	×
health care services.	2) Productivity	b) Increase productive time	TBD	TBD	×	×	×	×
CARE EXPERIENCE	1) Likelihood to recommend	a) Good or excellent likelihood to recommend.	TBD	TBD	TBD	×	×	×
Provide the best healthcare experience.	2) Timely access	 b) Timely initiation of care (within 48 hours of MD order or per specific instructions) 	TBD	TBD	TBD	×	×	×
QUALITY	1) Appropriate utilization	a) Appropriate length of stay (LOS)	TBD	TBD	×	×	×	×
we serve	2) Preventative care	b) Zero re-hospitalization in 1st 30 days of home care	TBD	TBD	×	×	×	×
WORKFORCE	1) Staff engagement	a) Good or excellent job satisfaction rating	TBD	TBD	TBD	TBD	×	×
and respects our people.	2) HR Measures TBD	b) Pending per HRS	TBD	TBD	TBD	TBD	×	×
EQUITY	1) BAAHI Initiative	 a) Reduction in disparities in workforce race, ethnicity and/or language. 	TBD	TBD	TBD	180	×	×
Eliminate disparities.	2) REAL/SOGI Data	 b) Good or excellent limited English proficient (LEP) client satisfaction 	TBD	TBD	TBD	TBD	×	×





Challenges and Opportunities

- Current electronic home health documentation software is suboptimal. We look forward to the transition to the network enterprise-wide electronic health records.
- Identified a HAH RN who will be trained and certified as a Wound Care Specialist
- Relocation to C3 will allow for efficient use of space and work stations that are more ergonomically suited to staff which will improve staff satisfaction and work flow





Challenges and Opportunities

- Integration of LHH & HAH Finance, Information Technology, Health Information System and Rehabilitation departments
- supplies via a new drop/ship program through Medline Increase efficiency and cost effectiveness in obtaining medical





Annual Holiday Gift Bag Project

Assembled and Distributed 80 Holiday Gift Bags to HAH Clients

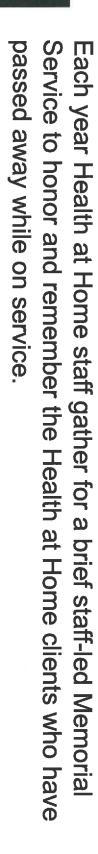






Above and Beyond

Annual Memorial Service





- Allows staff to gather support for the challenging work that was provided
- their clients' lives and their efforts towards promoting comfort and Recognizes the impact that the Health at Home providers have made in dignity.







Questions/Comments