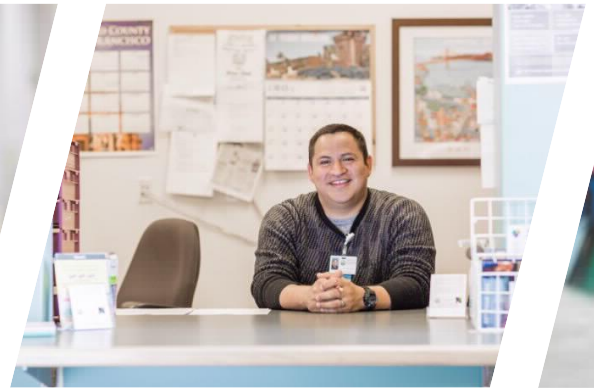
SFHN Primary Care Update

Health Commission | January 17, 2022

Anna Robert, RN, MSN, DrPH, Director of Primary Care

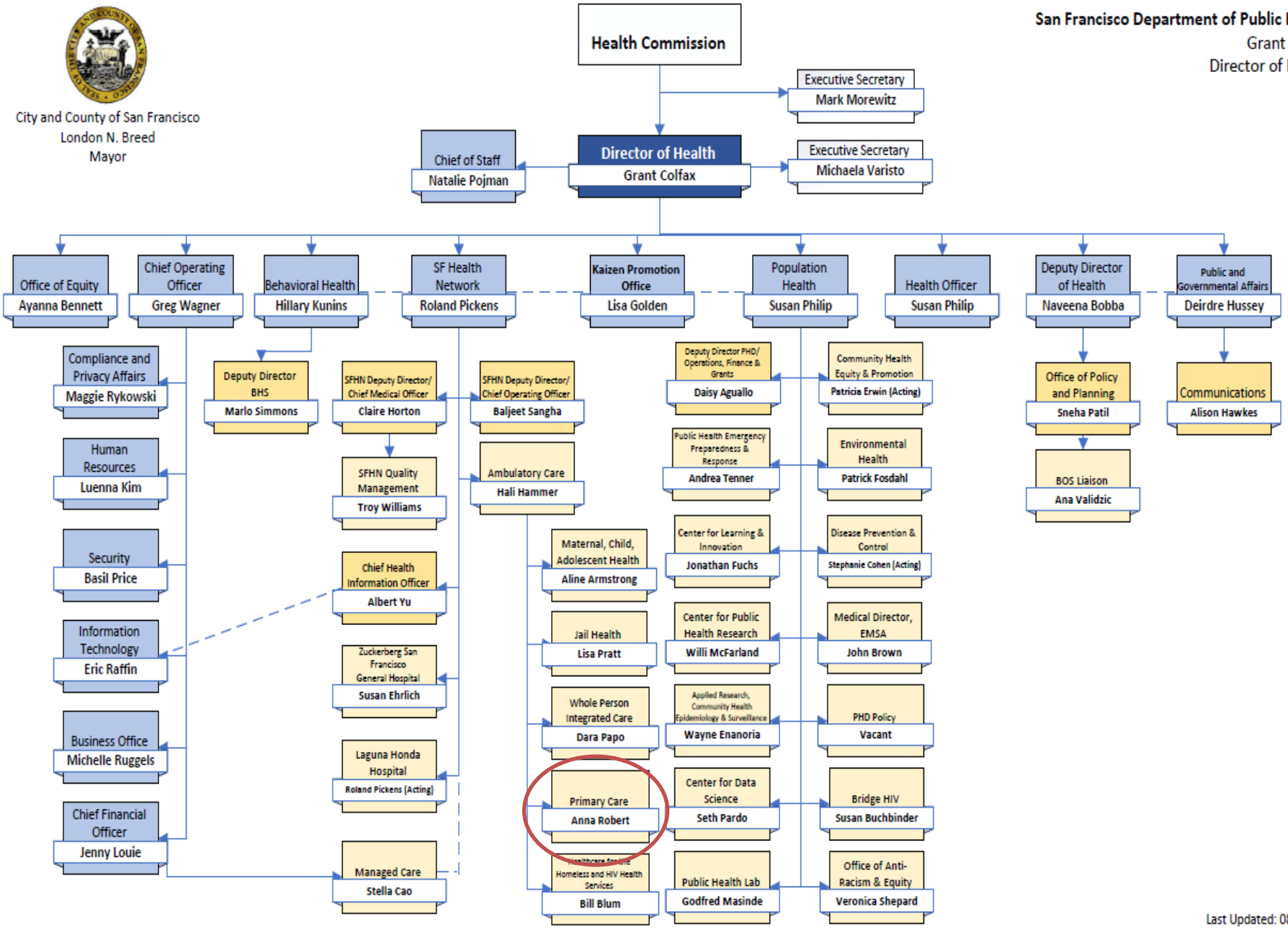




San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

City and County of San Francisco
London N. Breed
Mayor

San Francisco Department of Public Health
Grant Colfax
Director of Health



Last Updated: 08/17/2022

San Francisco Health Network
Primary Care

- 14 Primary Care Clinics across San Francisco
  - 4 resident teaching clinics at Zuckerberg San Francisco General
  - 9 community-based clinics
  - 1 adolescent focused primary care program with multiple, small single provider sites
- 59,000 Active Primary Care Patients
- Changed EMR to EPIC in 2019

San Francisco Health Network

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San Francisco Health Network provides care at more than 20 different locations in San Francisco.
We welcome you and we make sure you get high-quality care regardless of insurance or immigration status.

Balboa Park
Balboa Teen Health Center - youth only

Bayview
Southeast Health Center Clinic
3rd Street Youth Center and Clinic - youth only

Castro
Castro-Mission Health Center
Dimensions Clinic - youth only

Chinatown
Chinatown Public Health Center

Civic Center
Tom Waddell Urban Health Center
Curry Senior Center
Larkin Street Youth Services - youth only

Forest Hill
Laguna Honda Hospital and Rehabilitation Center

Haight Ashbury
Cole Street Clinic - youth only

Mission
Zuckerberg San Francisco General Hospital
Family Health Center at ZSFG
Positive Health Program at ZSFG
Richard H. Fine People's Clinic at ZSFG
Children's Health Center at ZSFG
CARECEN 2nd Chance Tattoo Removal Clinic

Ocean View
Hip Hop to Health Clinic - youth only

Portola
Silver Avenue Family Health Center

Potrero Hill
Potrero Hill Health Center

Sunset
Ocean Park Health Center

Visitacion Valley
Hawkins Youth Clinic
Burton High School Based Health Center - youth only

Western Addition
Maxine Hall Health Center

San Francisco
Health Network

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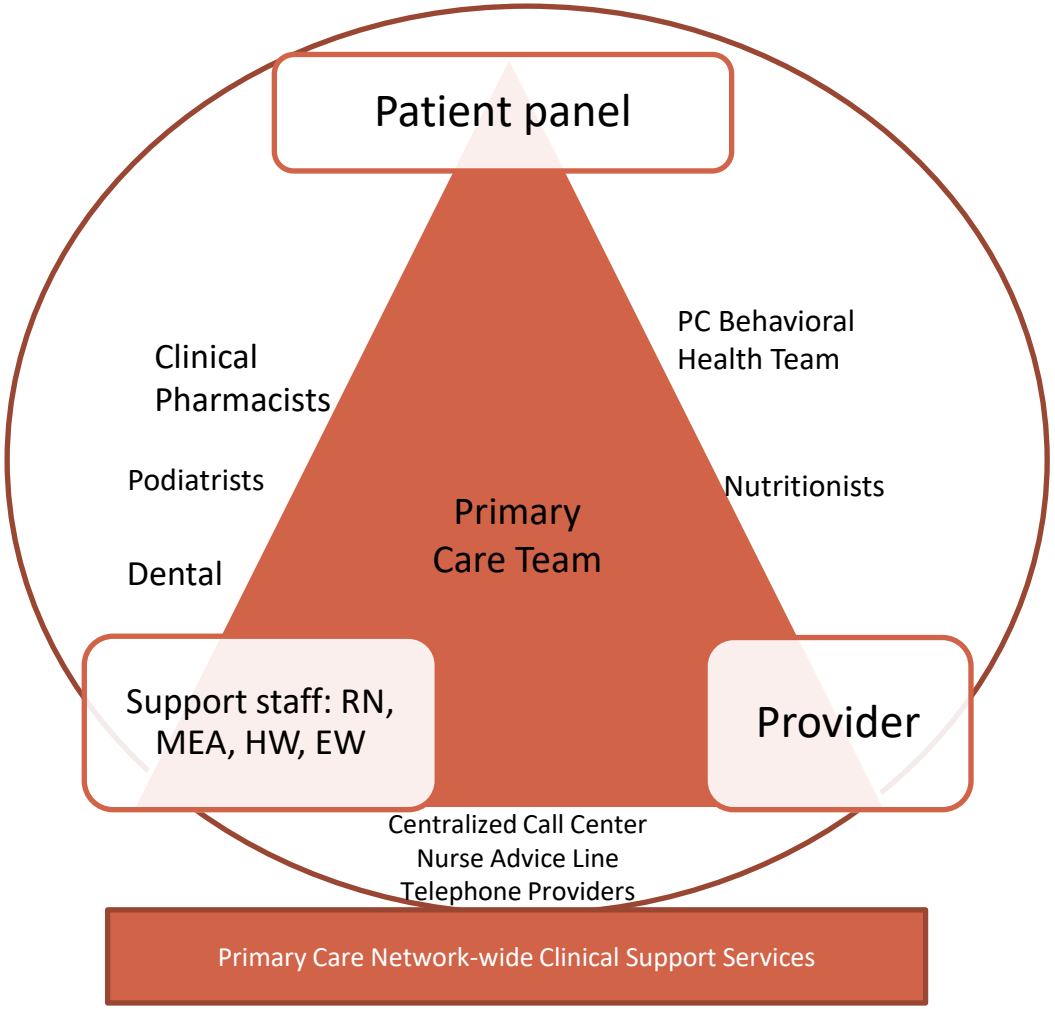
Multidisciplinary Team-based Model of Care



Scope of Services

- Primary Care
  - 14 clinics/programs across San Francisco
  - Full spectrum primary care (children, adolescents, pregnant women, adults)
  - 24 hour call – seven days/week

- Special population focus
  - Adolescents/Transitional Age Youth (CHPY, CHC)
  - Elders (Curry)
  - Gender health (CMHC, TWUHC, Ward 86)
  - People Experiencing Homelessness/unstable housing (TWUHC, CMHC)
  - People Living With HIV (CMHC, MHHC, SEHC, TWUHC, Ward 86, FHC)

Scope of Services

- Behavioral Health and Substance Use Services
  - Primary Care Behavioral Health teams
  - Primary Care Psychiatry
  - Behavioral Health Homes
    - CMHC => MMH, CPHC => CTNB, OPHC => SMH, TWUHC => SOMMH
  - Office Based Opioid Treatment

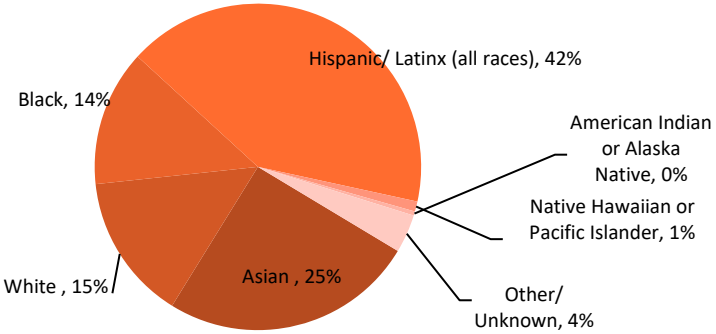
- Ancillary Services
  - Dental- clinic and school-based
  - Integrative medicine - acupuncture
  - Nutrition
  - Pharmacy
  - Podiatry

Scope of Services

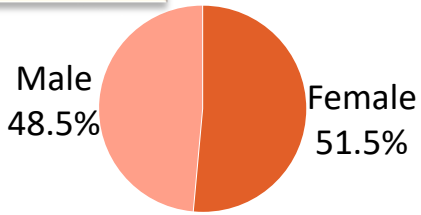
- Centralized Call Center
  - New Patient Access Unit
  - Nurse Advice Line
  - Telephone Appointment Providers
- CalAIM/Enhanced Care Management
  - Complex Care Management Team
- Population Health Team
  - Analysts and outreach staff
- Care Experience Team
  - Centralized, specialized support for staff development
  - Centralized, specialized support for patient experience enhancement and community advisory boards

Who are our patients?

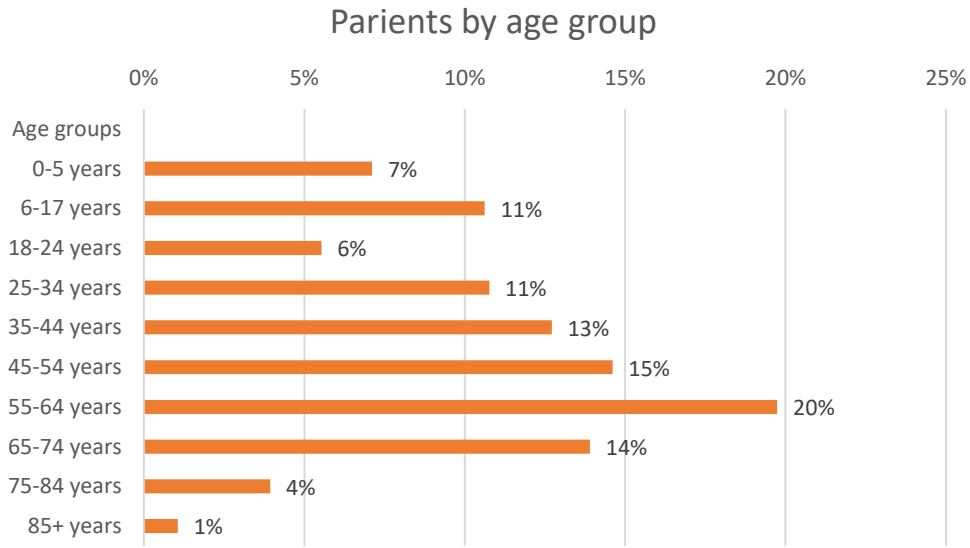
Empanelment (current data):
•59,287 active pts
•38,701 enrolled and not yet active

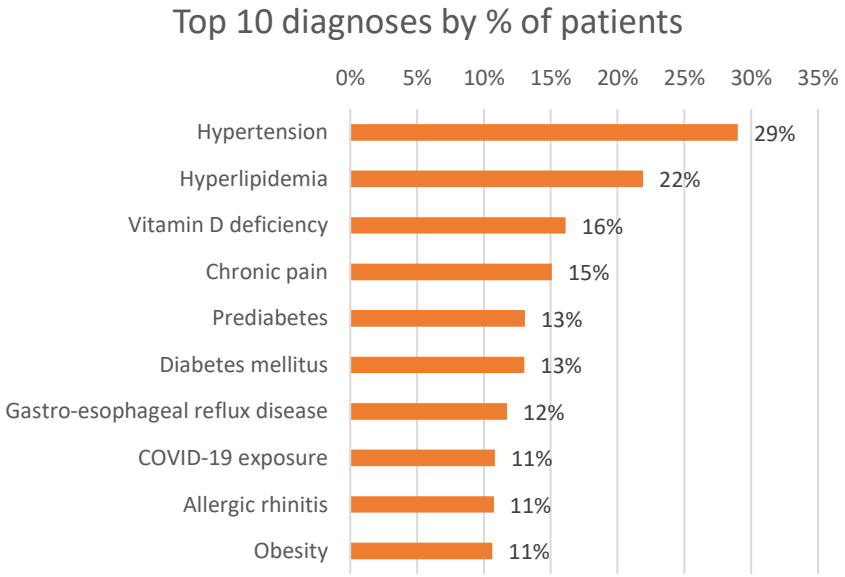


July 2021 - June 2022
•271,000 total encounters

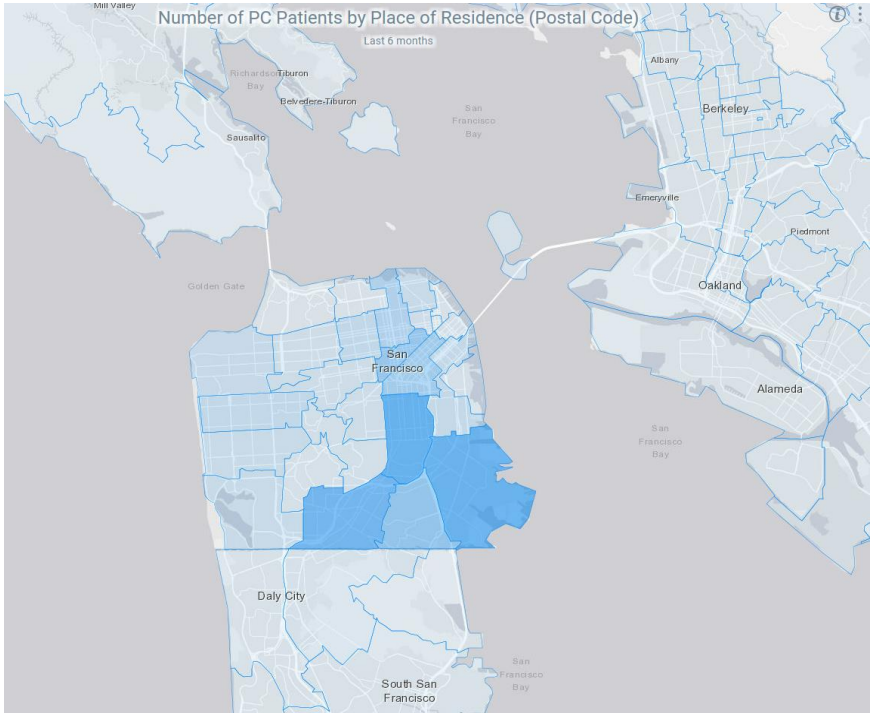


Gender identity: Non-binary <0.5%, Transgender ~0.5%





SFHN Primary Care provides healthcare to 99,000 San Franciscans – 12% of San Franciscans



Our Vision

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

TRUE NORTH VALUES

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

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

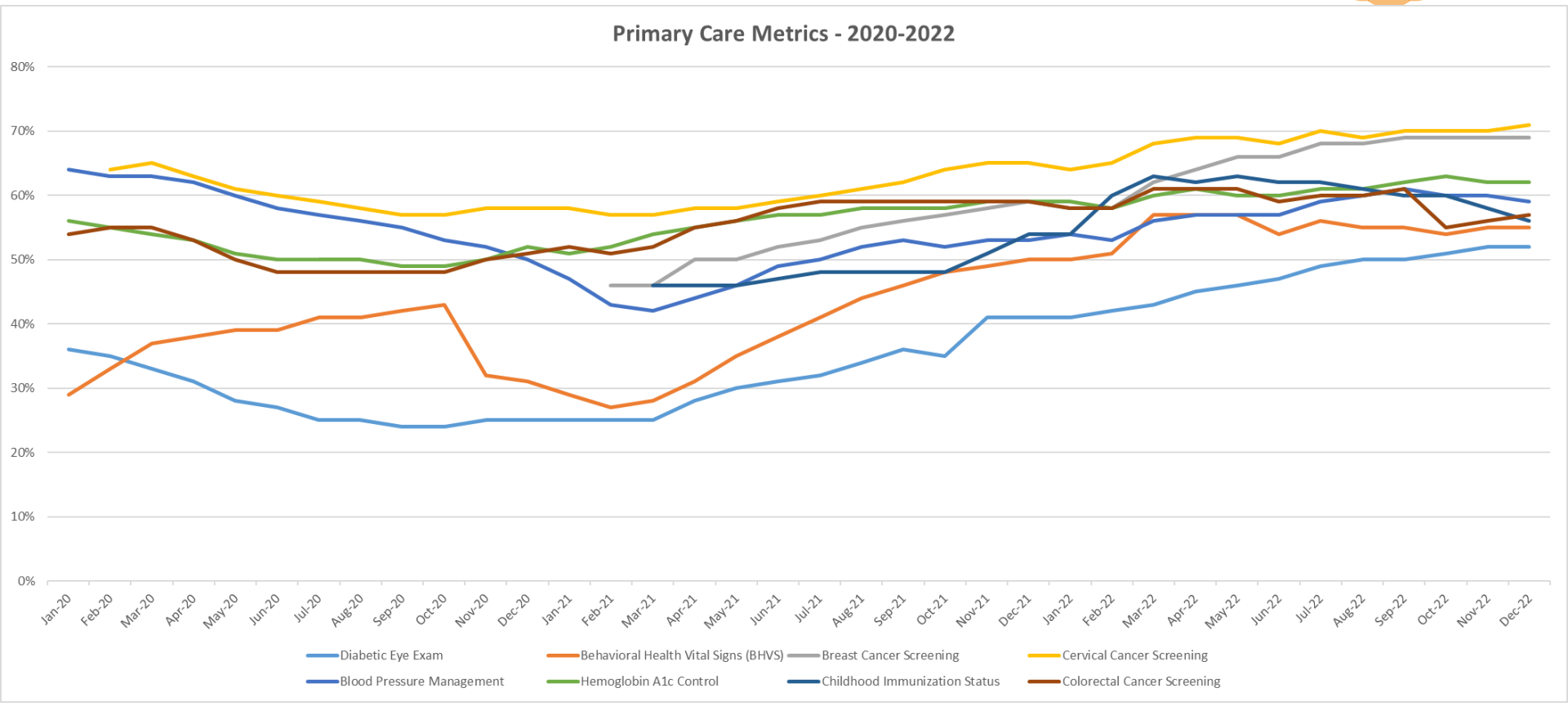
We Provide High Quality Health Care that Enables San Franciscans to Live Vibrant, Healthy Lives

SFHN Primary Care - Annual Scorecard

FY 2022-2023

SFHN PC Driver / Watch	Measure Name	SFHN PC Strategic Theme	Key Alignments	Baseline Date (Source)	SFHN PC Baseline 06/2022		SFHN PC 12/2022 Status		SFHN PC Goal 06/2023 (for Drivers only)	External Benchmark (Source)
					All Patients	B/AA Patients	All Patients	B/AA Patients		
True North Driver	**Third Next Available Appointment (TNAA) Improve timely access of Pc services**	Care Experience Financial Stewardship	SFHN State mandate	6/30/2022	New: 31 days FU: 16 days	Do not have stratified by race.	As of 1/12/23: New: 2/13 clinics at goal. Return: 10/13 clinics at goal		<20 days by Dec 2022 < 10 days by June 2023	10 business days (CA Dept. of Managed Healthcare)
True North Driver	Bias-free care % of patients who respond positively that care is bias-free	Equity, Care Experience	SFHN	6/30/2022	75.40%		75.9%		83.9%	n/a
True North Driver	**Hypertension BP control for African Americans** % of patients age 18-75 with hypertension with a BP ≤ 140/90 in the last year	Equity, Quality	QIP $$$ PIP $	6/30/2022	59.5%	53.5%	61.0%	54.0%	63% overall 59% for B/AA	66.79% (HEDIS 90th)
True North Driver	**Pediatric Fluoride Varnish** % of patients 0-5 yo with FV in last 6 months	Quality	PC	6/30/2022	25.1%	18.6%	31.0%		40.6%	n/a
True North Driver	**Overdose Prevention** % of patients age 16+ with OUD and continuous engagement with buprenorphine for at least 180 days	Safety	SFHN	6/30/2022	Working to get the metric built				10% RI	n/a
	Adolescent Immunizations % of patients age 13 with all doses of Tdap, MCV, & HPV	Quality	QIP $$$ PIP $	6/30/2022	72.54%	45.45%	76.0%	63.0%	No goals for Driver Metrics. Green cells indicate improvement. Red cells indicate backslide.	50.61% (HEDIS 90th)
	Behavioral Health Vital Signs % of patients over age 12 who received a BHVS in the last year	Quality	QIP $$$ PIP $	6/30/2022	52.3%	48.5%	55.0%			89.88% (HEDIS 90th)
	Childhood Immunizations % of patients age 2 with all doses of Dtap, IPV, MMR, HiB, HepA, HepB, VZV, PCV, RV, & Flu (combo 10)	Quality	QIP $$$ PIP $	6/30/2022	62.54%	41.93%	56.0%	29.0%		53.66% (HEDIS 90th)
	Breast Cancer Screening % of female patients age 50-74 with a mammography screening in the last 24 months	Quality	QIP $$$ PIP $	6/30/2022	66.19%	53.50%	69.0%	57.0%		63.77% (HEDIS 90th)
	Cervical Cancer Screening % of female patients age 21-64 with a PAP smear within the last 3 years **or HPV test in the last 5 years**	Quality	QIP $$$ PIP $	6/30/2022	67.77%	59.67%	71.0%			67.99% (HEDIS 90th)
	Chlamydia Screening % of patients age 16-24 with a chlamydia screening in the last year	Quality	QIP $$$ PIP $	6/30/2022	51.19%	63.1%	53.0%			66.15% (HEDIS 90th)
	Colorectal Cancer Screening % of patients age 51-75 with a FIT in the last year or colonoscopy in the last 10 years	Quality	QIP $$$ PIP $	6/30/2022	58.0%	46.0%	57.0%	46.0%		60.66% (PIP 75th)
	Diabetes Eye Exam % of patients age 18-75 with diabetes with an eye exam in the last two years or negative exam in the last year	Quality	QIP $$$	6/30/2022	47.8%	41.9%	52.0%			63.02% (HEDIS 90TH)
	Hemoglobin A1C Control % of patients age 18-75 with diabetes with a HbA1C<8% lab within the last year	Quality	QIP $$$ PIP $	6/30/2022	60.5%	61.2%	62.0%			55.23% (HEDIS 90TH)
	Opioid Safety % of patients with chronic pain on opioids with a controlled substance agreement, urine tox screen, & CURES report reviewed in the last year	Quality	PIP $	6/30/2022	33.9%	37.2%	35.0%			≥ 60% (PIP)
	Tobacco Cessation Intervention % of patients who smoke and received an intervention for tobacco use in the last two years	Quality	QIP $$$ PHASE $	6/30/2022	80.8%	83.0%	83.0%			91.99% (MIPS)

Primary Care: maintaining preventive care and population health before, during and “after” COVID-19



How are we able to make these improvements?:

Teamwork, PDSA's, pilot projects, and dedicated, mission-driven, frontline staff who have shown great resilience over the last several years.

Central weekly updated data, outreach and celebrations:

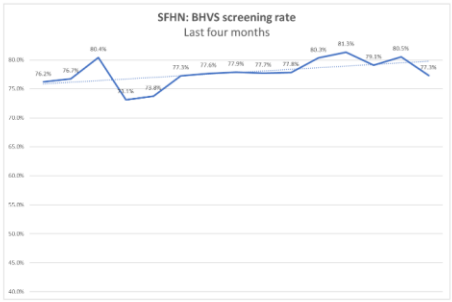
Updates

- **Outreach updates! The central outreach team is working on the following outreach projects:**
  - **COVID-19 results disclosure** calls
  - Calling patients with **unchecked or uncontrolled hypertension** for MHHC, SEFHC, & RFPC
  - Calling patients overdue for **Pap smear** at TWUHC, CMHC, PHHC, MHHC & SAFHC
  - Calling parents with children age 5-17 **overdue for school vaccines** and scheduling them at 3rd Street Clinic & Cole
  - **FIT kit text reminders** for any patient that received a FIT kit in clinic 2-3 weeks ago that hasn't been resulted
  - NHC AmeriCorps members calling Latino/a/x patients with **diabetes overdue for A1c**

- **School age vaccines**
  - SFUSD is working to ensure all of their enrollees are up-to-date on vaccines and will be coordinating with the network to support children who are overdue for mandatory vaccines.
  - We are conducting outreach to overdue patients and scheduling them into Cole & 3rd Street Clinic and
  - A report is available to see due patients at your clinic. You will need to add in your clinic to the "care team" and save as: DPH HP Patients Missing School Immunizations / Vaccines [2596966]

Stat of the week

Behavioral Health Vital Signs dropped a bit last week after being above goal. Please make sure overdue patients are screened at least 80% of the time!

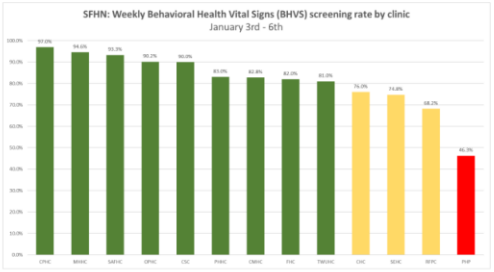


Shout-outs!

Top performers!

- Tobacco referrals for patients who smoke:
  - Ana Reyes (CMHC) - 5/6 - 83%
  - Lisbeth Lule (MHHC) - 4/4 - 100%
  - Jennifer Davalos (SAFHC) - 4/4 -100%
  - Christine Wu (FHC) - 5/6 - 83%
  - Elizabeth Lynch (PHP) - 4/4 - 100%
  - Susan Tomaini (RFPC) - 9/10 - 90%

- Behavioral Health Vital Signs:
  - Jonathan Villalobos (CMHC) - 18/20 - 90%
  - Lynette Buttram (CMHC) - 16/16 - 100%
  - Shuru Wu (CPHC) - 14/14 - 100%
  - Claudia Briones (CSC) - 20/20 - 100%
  - Yingzi Chen (OPHC) - 19/19 - 100%
  - Maria Franco (PHHC) - 15/16 - 94%
  - Shixin Situ (SAFHC) - 30/30 - 100%
  - Shara Garcia (SEFHC) - 14/15 - 94%
  - Cristal Sanchez (TWUHC) - 22/24 - 92%
  - Alexis Blueford (FHC) - 20/21 - 95%
  - Josefina Velis (FHC) - 35/36 - 97%
  - Karen Duong (FHC) - 30/33 - 91%
  - Shayna Samoa (FHC) - 22/23 - 96%



QIP Update: 3 Depression Metrics

For the first time *ever* SFHN reached goal on all 3 Depression metrics!

- ✓ **Depression Follow-Up**: PHQ-9 rescreen 4-8 months after qualifying depression score
  - Goal = 36%
- ✓ **Depression Response**: 50% decrease in PHQ-9 score at repeat screening
  - Goal = 9.6%
- ✓ **Depression Remission**: New PHQ-9 score of < 5 at repeat screening
  - Goal = 4.1%

Reaching these goals required a big end-of-year push across teams. Between 9/1 - 12/7/2022 we rescreened 150 patients through the following methods:

- 41% through MEA standard work at clinic encounters
- 36% through BHC outreach to patients due for rescreen
- 23% through Pop Health Outreach calling (started 10/27)

San Francisco Health Network

Big thanks to our BHCs & PCBH leaders, our clinical teams especially MEAs, and our Health Outreach worker Joycelynn Green!

QUALITY IMPROVEMENT

2022 Highlights – Chronic Care

Diabetes Chronic Care Pilot at Maxine Hall Health Center

March (Baseline)
0 of 24 (0%) with A1c <9%

→

October
9 of 23 (39%) with A1c <9%

- Focus on Black/African American & Latino/a/x patients
- 24 patients enrolled with EatSF food vouchers
- 75% attended at least one nutrition visit
- 83% attended lab visit
- 41% met with pharmacist
- 20 patients started at SAFHC

Outreach Campaigns helped meet QIP equity benchmarks for:

- Diabetes A1c control for Latino/a/x patients
- Hypertension control for Black/African American patients

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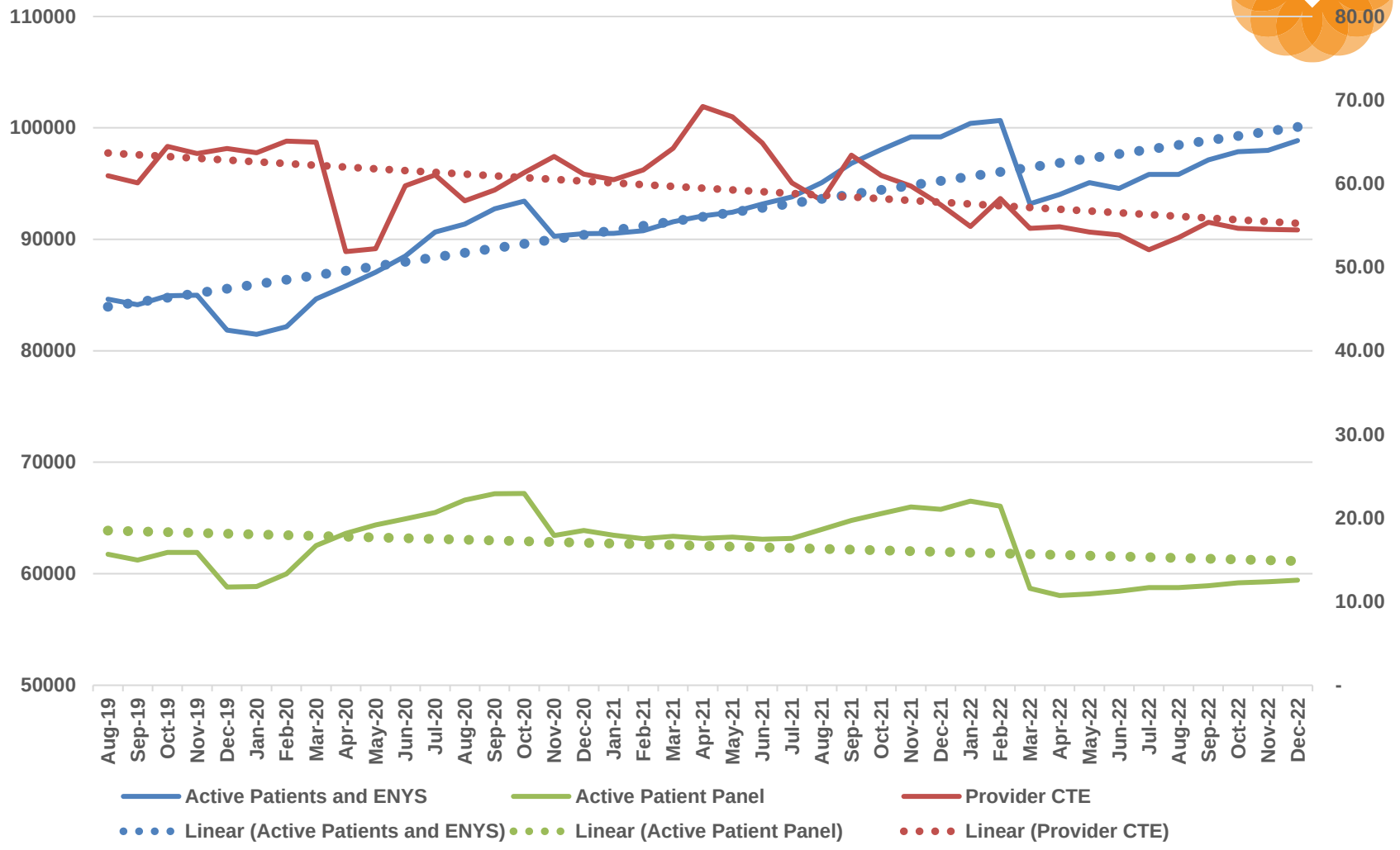
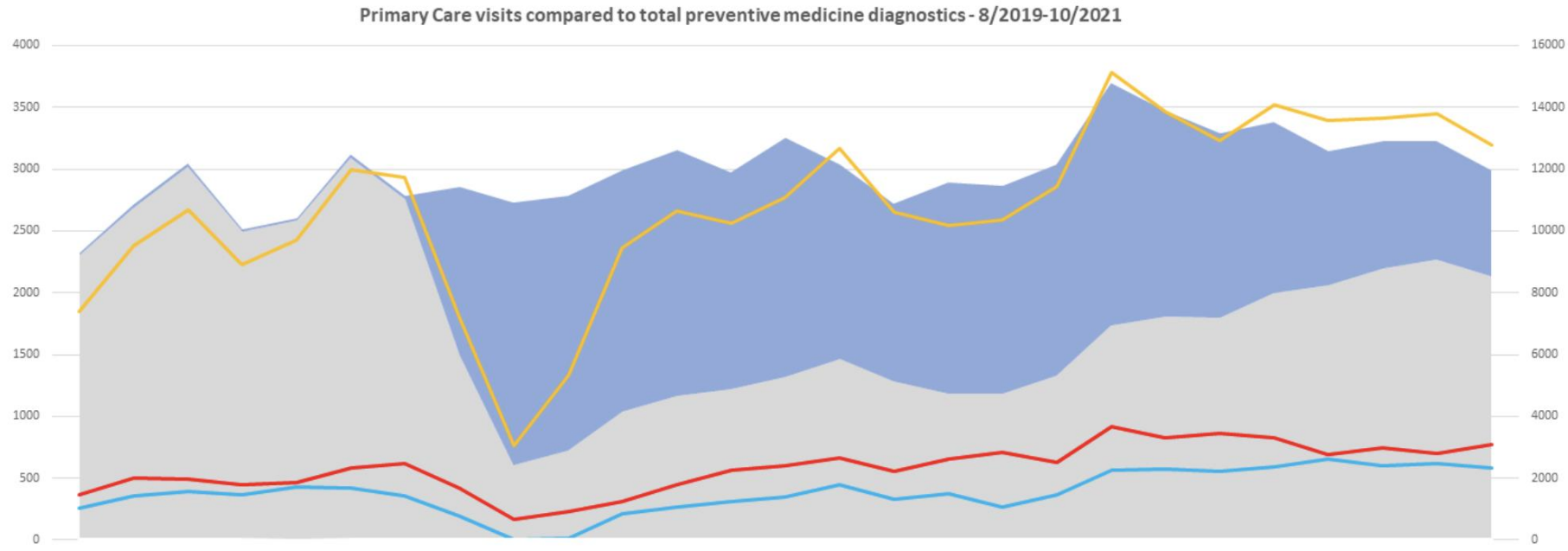
Patient Panels and Provider Clinical FTE, August 2019 – December 2022



Primary Care: impact of COVID-19 on volume and population health



	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21
Telehealth visits	63	123	122	70	62	91	124	5430	8519	8242	7808	7944	7017	7730	6303	5755	6836	6734	6825	7861	6649	5940	5544	4326	4126	3855	3441
In-person visits	9225	10730	12062	9992	10355	12374	11020	5977	2406	2878	4159	4658	4889	5285	5846	5117	4732	4722	5320	6928	7234	7212	7974	8247	8770	9064	8533
A1c	1849	2383	2668	2227	2424	2998	2930	1800	762	1330	2363	2663	2563	2774	3168	2656	2546	2586	2858	3783	3469	3231	3522	3395	3412	3450	3191
Mammo	257	357	396	363	428	421	360	190	8	12	212	265	313	352	447	330	378	269	367	563	570	552	594	657	597	619	583
FIT	370	498	492	446	462	584	618	422	165	227	309	450	569	597	666	557	659	713	625	916	825	862	828	693	745	699	775
TV ratio	0.7%	1.1%	1.0%	0.7%	0.6%	0.7%	1.1%	47.6%	78.0%	74.1%	65.2%	63.0%	58.9%	59.4%	51.9%	52.9%	59.1%	58.8%	56.2%	53.2%	47.9%	45.2%	41.0%	34.4%	32.0%	29.8%	28.7%

In-person visits Telehealth visits A1c Mammo FIT TV ratio

Looking Ahead

Filling several frontline staff and leadership positions including new, multiple **medical director** positions, pharmacy tech, and behavioral health positions

Sustaining focus on the goals our **Anti-Racism and Equity Action Plan** to improve the experience and outcomes of our **Black/African American patients and staff**

Resetting **standard work** across sites and roles to **close care gaps** and ensuring **timely telephone and appointment access**.

Continuing **regular meetings** across PC and with clinic management teams using **data to drive improvement** with a focus on continued **recovery and resilience** of PC team members.