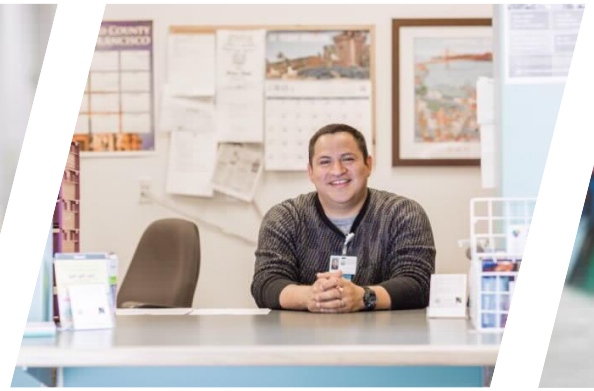
# SFHN Primary Care Update

## Health Commission | March 19, 2024

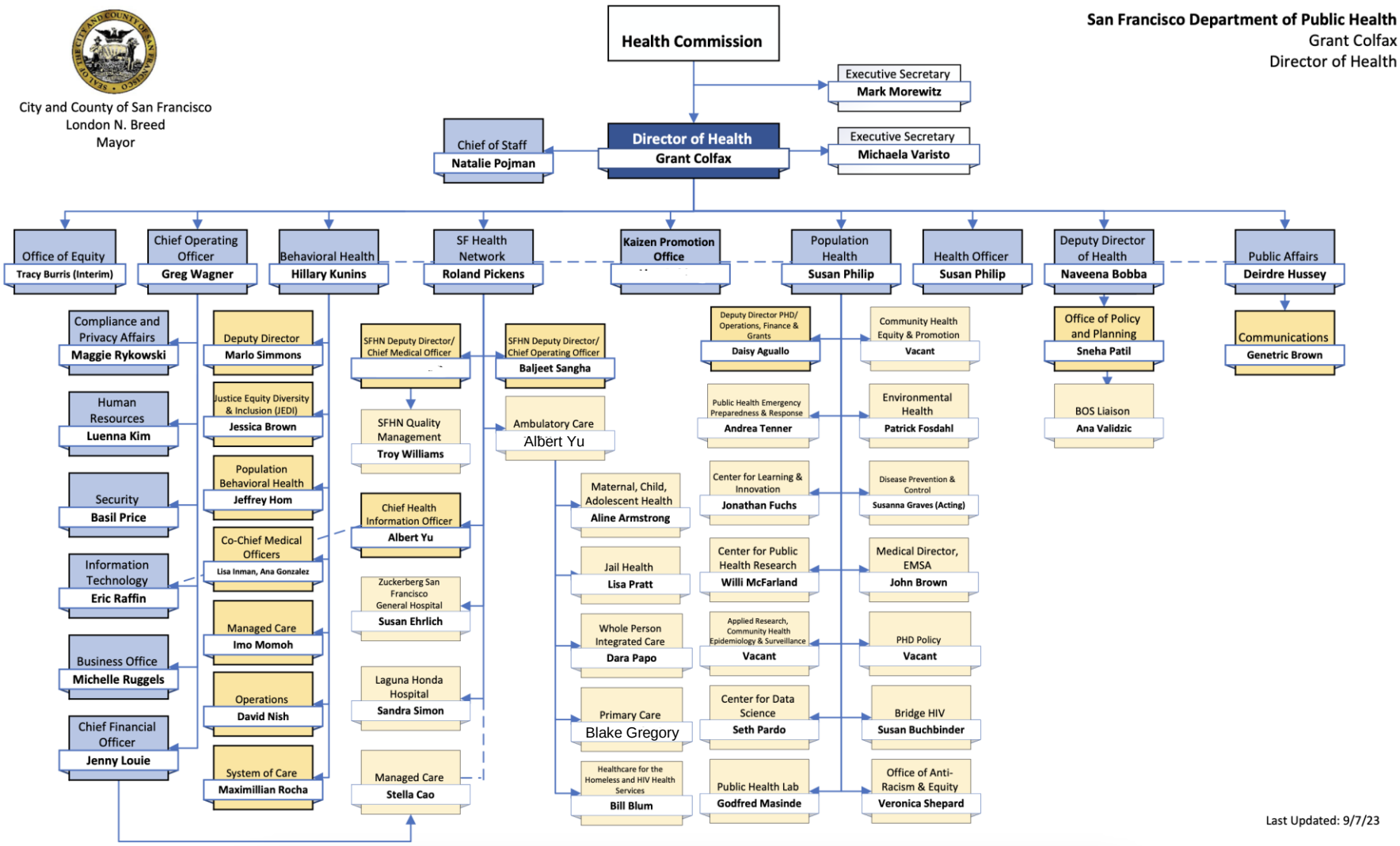
Blake Gregory, MD, Director of Primary Care

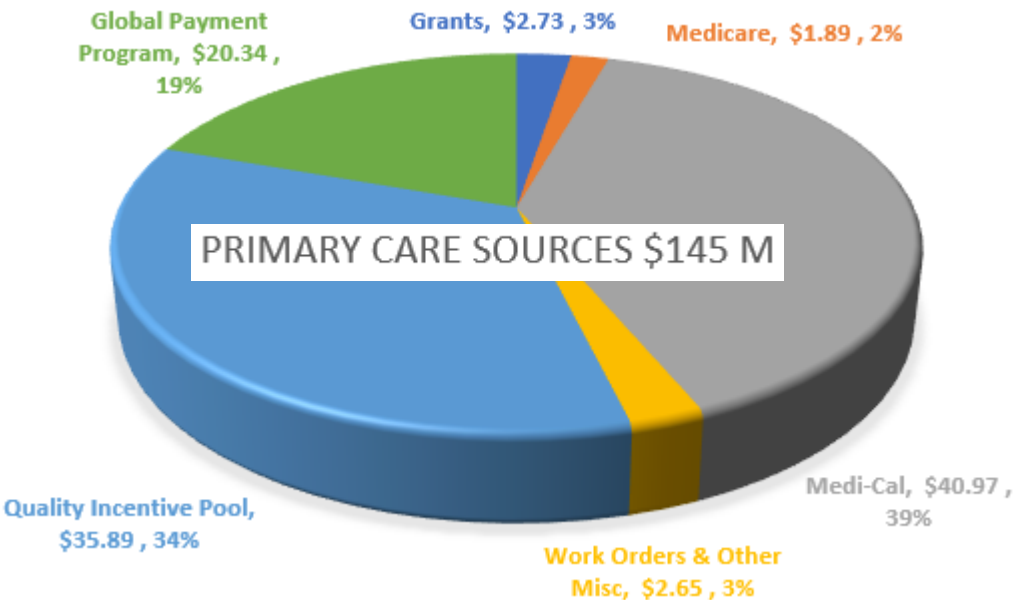

San Francisco Health Network

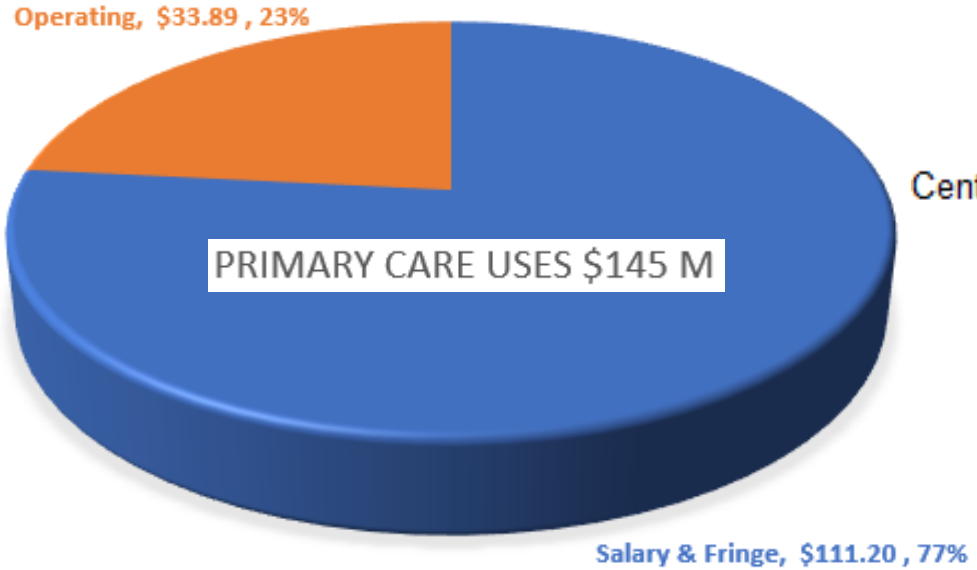
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

# DPH Organizational Chart



# Primary Care Budget




## FY 25 budget and current staffing level

| | STAFFING | | |
|---|---|---|---|
| | **Filled** | **Vacant** | **Total** |
| Primary Care | 449 | 119 | 568 |
| Nurse Advice Line | 11 | 3 | 14 |
| Centralized Call Center | 18 | 17 | 35 |
| Total | **478** | **139** | **617** |

# Clinic Distribution and Focus

primary care for adults and families

primary care for youth

primary care for adults

SPECIAL FOCUS CLINICS

***Geriatric:*** Curry

***Homeless or marginally housed:*** Tom Waddell Urban Health

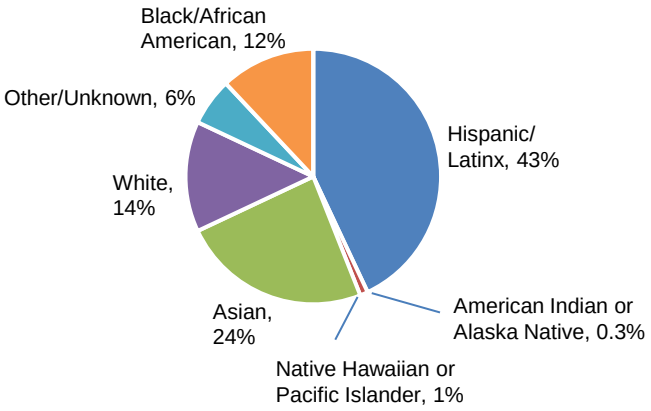
***HIV positive or at risk:*** PHP

***Children and youth:*** CHPY, CHC

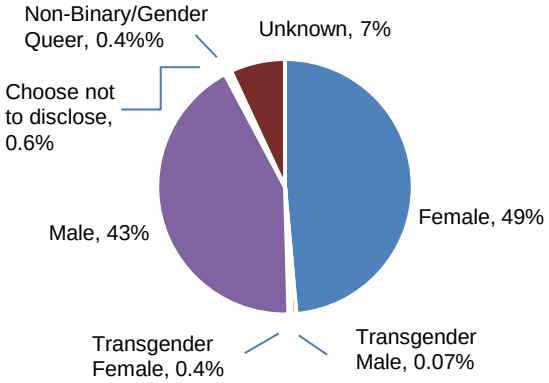
# Our Patients

Empanelment (current data):
- 55,852 active patients (seen in past 18 months)
- 39,192 enrolled and not seen in past 18 months

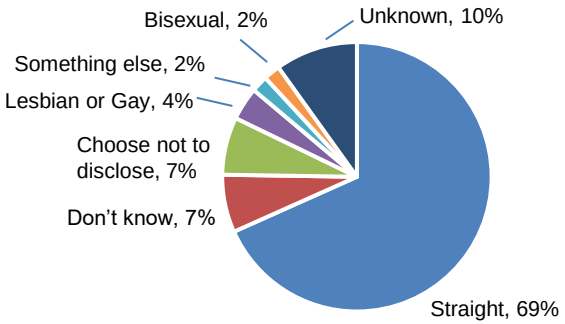
**Race**



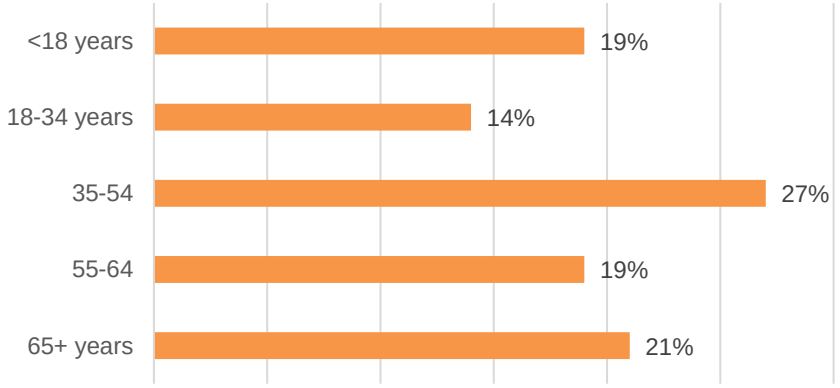

**Gender Identity**



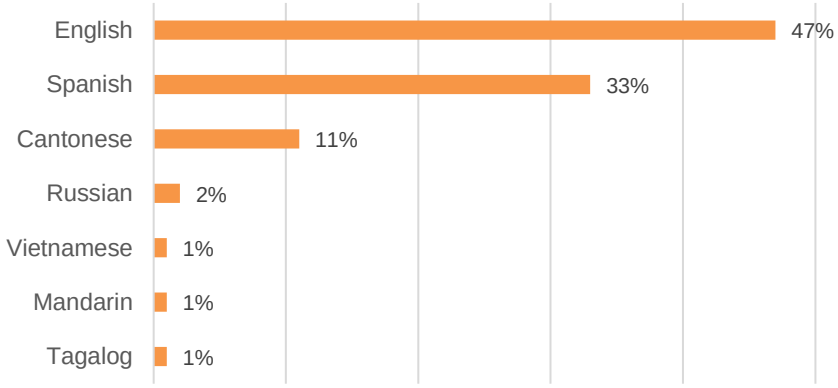

**Sexual Orientation**




Patients by Age Group




Preferred Language (top 7)



# A Vision for SFHN Primary Care

# SFHN Primary Care Vision

1st Choice for Health Care and Well Being

Improve the Health of the Patients We Serve

Optimize Access, Operations, and Cost-Effectiveness

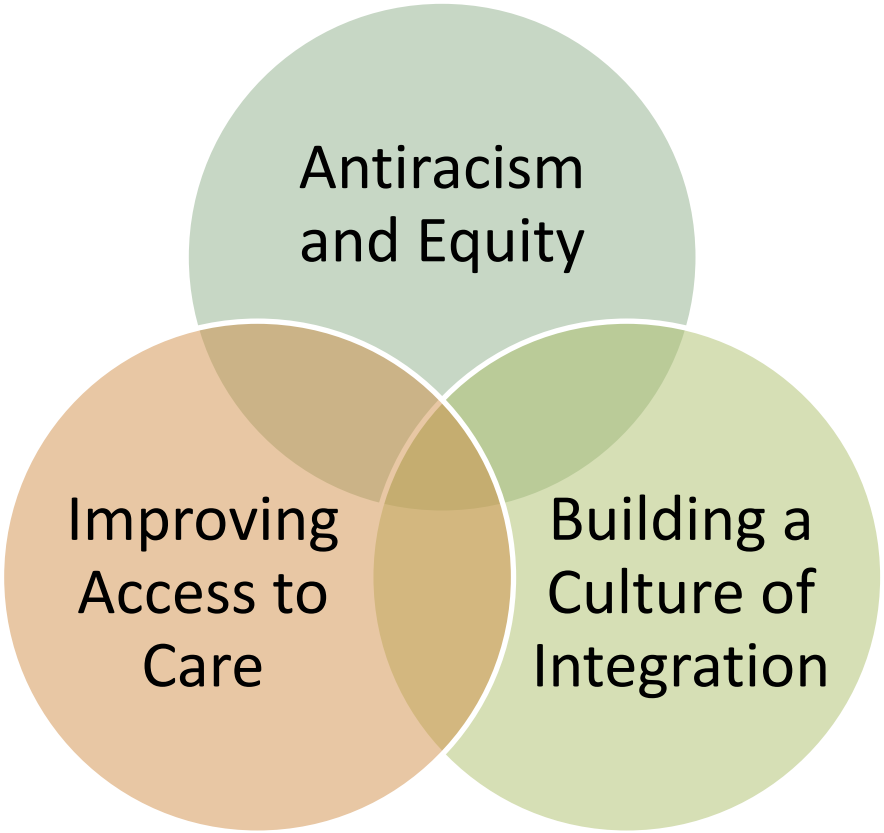
Ensure Excellent Patient Experience

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

# Primary Care Vision





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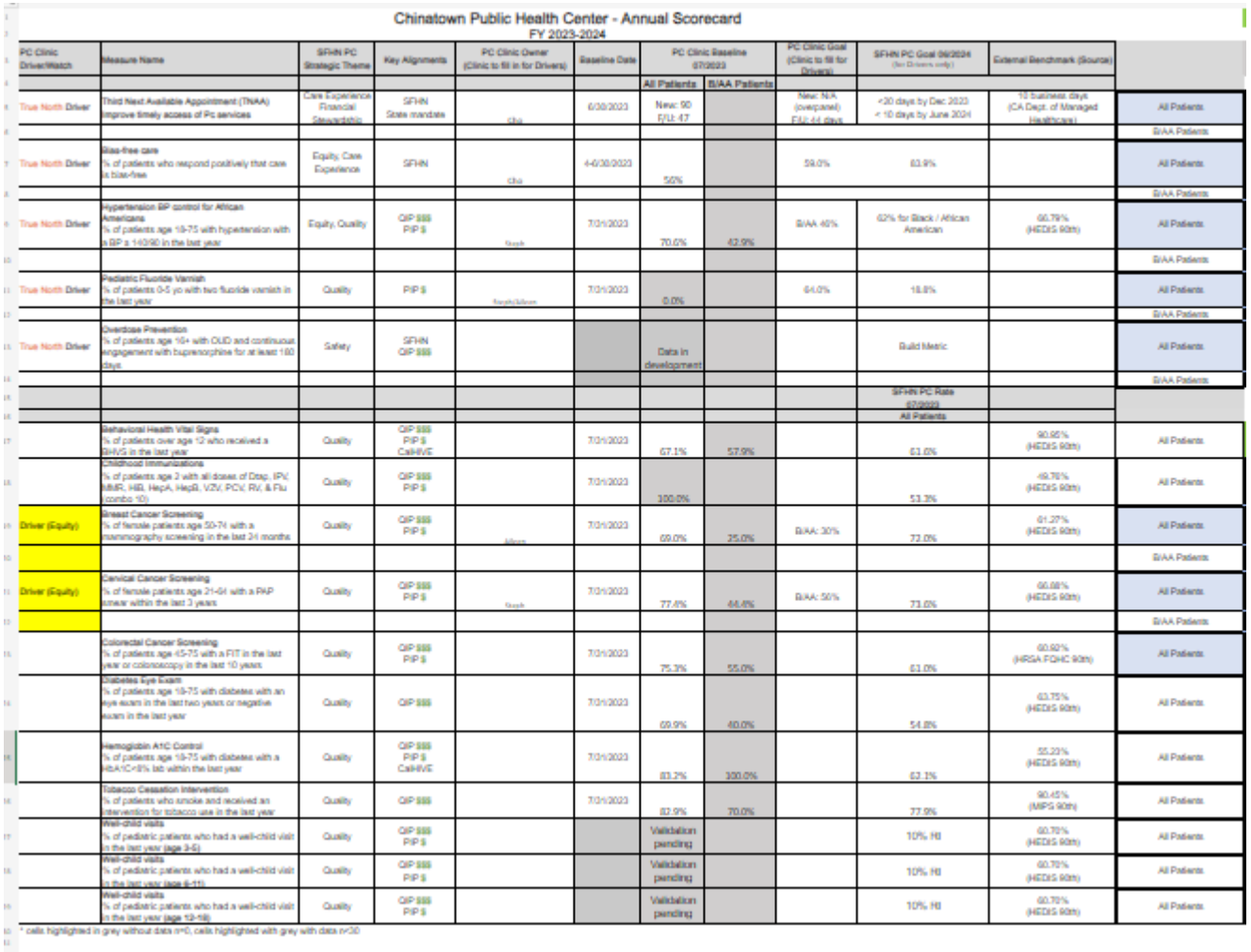
# Antiracism and Equity

# Annual PC Clinic Scorecards

**Consolidated List**

**Bi-Directional Transparency and Accountability**

**Priority Setting and Focus on Equity**



Chinatown Public Health Center - Annual Scorecard
FY 2023-2024

| PC Clinic Driver/Watch | Measure Name | SFHN PC Strategic Theme | Key Alignments | PC Clinic Owner (Clinic to fill in for Drivers) | Baseline Date | PC Clinic Baseline 07/2023 | | PC Clinic Goal (Clinic to fill for Drivers) | SFHN PC Goal 06/2024 (for Drivers only) | External Benchmark (Source) | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | All Patients | B/AA Patients | | | | |
| True North Driver | Third Next Available Appointment (TNAA)<br>Improve timely access of Pc services | Care Experience<br>Financial Stewardship | SFHN<br>State mandate | Chu | 6/30/2023 | New: 90<br>F/U: 47 | | New: N/A (overpanel)<br>F/U: 44 days | <20 days by Dec 2023<br><10 days by June 2024 | 10 business days (CA Dept. of Managed Healthcare) | All Patients |
| | | | | | | | | | | | B/AA Patients |
| True North Driver | Bias-free care<br>% of patients who respond positively that care is bias-free | Equity, Care Experience | SFHN | Chu | 4-6/30/2023 | 56% | | 59.0% | 63.9% | | All Patients |
| | | | | | | | | | | | B/AA Patients |
| True North Driver | Hypertension BP control for African Americans<br>% of patients age 18-75 with hypertension with a BP ≤ 140/90 in the last year | Equity, Quality | QIP $$$<br>PIP $ | Nash | 7/31/2023 | 70.6% | 42.9% | B/AA 46% | 62% for Black / African American | 66.79%<br>(HEDIS 90th) | All Patients |
| | | | | | | | | | | | B/AA Patients |
| True North Driver | Pediatric Fluoride Varnish<br>% of patients 0-5 yo with two fluoride varnish in the last year | Quality | PIP $ | Kayla/Juliana | 7/31/2023 | 0.0% | | 64.0% | 18.8% | | All Patients |
| | | | | | | | | | | | B/AA Patients |
| True North Driver | Overdose Prevention<br>% of patients age 16+ with OUD and continuous engagement with buprenorphine for at least 180 days | Safety | SFHN<br>QIP $$$ | | | Data in development | | | Build Metric | | All Patients |
| | | | | | | | | | | | B/AA Patients |
| | | | | | | | | | SFHN PC Rate 07/2023<br>All Patients | | |
| | Behavioral Health Vital Signs<br>% of patients over age 12 who received a BHVS in the last year | Quality | QIP $$$<br>PIP $<br>CalHIVE | | 7/31/2023 | 67.1% | 57.9% | | 63.0% | 90.95%<br>(HEDIS 90th) | All Patients |
| | Childhood Immunizations<br>% of patients age 2 with all doses of Dtap, IPV, MMR, HiB, HepA, HepB, VZV, PCV, RV, & Flu (combo 10) | Quality | QIP $$$<br>PIP $ | | 7/31/2023 | 100.0% | | | 53.3% | 49.76%<br>(HEDIS 90th) | All Patients |
| Driver (Equity) | Breast Cancer Screening<br>% of female patients age 50-74 with a mammography screening in the last 24 months | Quality | QIP $$$<br>PIP $ | Juliana | 7/31/2023 | 69.0% | 25.0% | B/AA: 30% | 72.0% | 61.27%<br>(HEDIS 90th) | All Patients |
| | | | | | | | | | | | B/AA Patients |
| Driver (Equity) | Cervical Cancer Screening<br>% of female patients age 21-64 with a PAP smear within the last 3 years | Quality | QIP $$$<br>PIP $ | Nash | 7/31/2023 | 77.4% | 64.4% | B/AA: 56% | 73.0% | 66.68%<br>(HEDIS 90th) | All Patients |
| | | | | | | | | | | | B/AA Patients |
| | Colorectal Cancer Screening<br>% of patients age 45-75 with a FIT in the last year or colonoscopy in the last 10 years | Quality | QIP $$$<br>PIP $ | | 7/31/2023 | 75.3% | 55.0% | | 61.0% | 60.92%<br>(HRSA FQHC 90th) | All Patients |
| | Diabetes Eye Exam<br>% of patients age 18-75 with diabetes with an eye exam in the last two years or negative exam in the last year | Quality | QIP $$$ | | 7/31/2023 | 69.9% | 40.0% | | 54.8% | 63.75%<br>(HEDIS 90th) | All Patients |
| | Hemoglobin A1C Control<br>% of patients age 18-75 with diabetes with a HbA1C<9% lab within the last year | Quality | QIP $$$<br>PIP $<br>CalHIVE | | 7/31/2023 | 83.2% | 100.0% | | 62.1% | 55.23%<br>(HEDIS 90th) | All Patients |
| | Tobacco Cessation Intervention<br>% of patients who smoke and received an intervention for tobacco use in the last year | Quality | QIP $$$ | | 7/31/2023 | 82.9% | 70.0% | | 77.9% | 90.45%<br>(MIPS 90th) | All Patients |
| | Well-child visits<br>% of pediatric patients who had a well-child visit in the last year (age 3-6) | Quality | QIP $$$<br>PIP $ | | | Validation pending | | | 10% HI | 60.75%<br>(HEDIS 90th) | All Patients |
| | Well-child visits<br>% of pediatric patients who had a well-child visit in the last year (age 8-11) | Quality | QIP $$$<br>PIP $ | | | Validation pending | | | 10% HI | 60.75%<br>(HEDIS 90th) | All Patients |
| | Well-child visits<br>% of pediatric patients who had a well-child visit in the last year (age 12-18) | Quality | QIP $$$<br>PIP $ | | | Validation pending | | | 10% HI | 60.75%<br>(HEDIS 90th) | All Patients |

* cells highlighted in grey without data n=0; cells highlighted with grey with data n<30

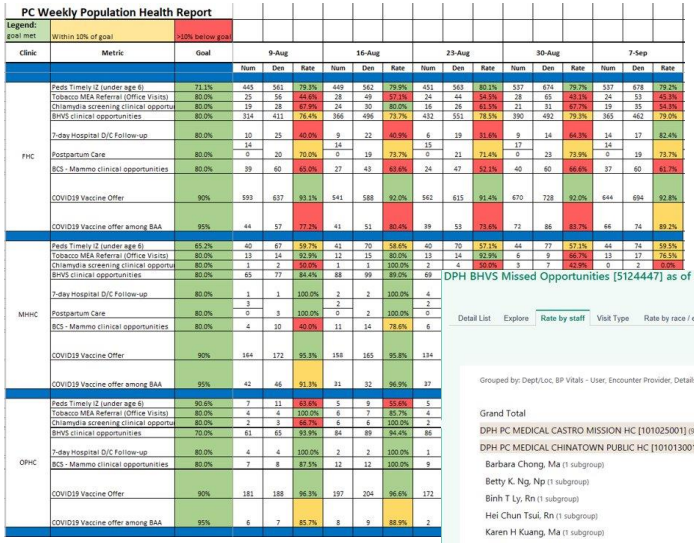
# Tools/Data Visualization

**Weekly Data**
- Sent to all managers and providers
- Shows what # of patients with a visit left the clinic with their care gap addressed

**Missed Opportunity Reports**
- Can be used to see how individuals performed on measures for patients with a visit in the last week

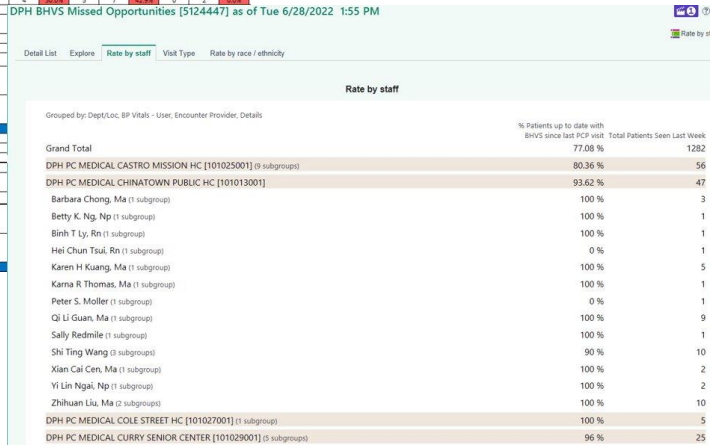
**Patient outreach reports**
- List of patients overdue for care gaps or meeting specific criteria

**Dashboards**
- View clinic rates by month and can compare to network average


PC Weekly Population Health Report

Legend: goal met | Within 10% of goal | >10% below goal

| Clinic | Metric | Goal | 9-Aug Num | 9-Aug Den | 9-Aug Rate | 16-Aug Num | 16-Aug Den | 16-Aug Rate | 23-Aug Num | 23-Aug Den | 23-Aug Rate | 30-Aug Num | 30-Aug Den | 30-Aug Rate | 7-Sep Num | 7-Sep Den | 7-Sep Rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FHC | Peds Timely IZ (under age 6) | 71.1% | 445 | 561 | 79.3% | 449 | 562 | 79.9% | 451 | 563 | 80.1% | 537 | 674 | 79.7% | 537 | 678 | 79.2% |
| | Tobacco MEA Referral (Office Visits) | 80.0% | 25 | 56 | 44.6% | 28 | 49 | 57.1% | 24 | 44 | 54.5% | 28 | 65 | 43.1% | 24 | 53 | 45.3% |
| | Chlamydia screening clinical opportu | 80.0% | 19 | 28 | 67.9% | 24 | 30 | 80.0% | 16 | 26 | 61.5% | 21 | 31 | 67.7% | 19 | 35 | 54.3% |
| | BHVS clinical opportunities | 80.0% | 314 | 411 | 76.4% | 366 | 496 | 73.7% | 432 | 551 | 78.5% | 390 | 492 | 79.3% | 365 | 462 | 79.0% |
| | 7-day Hospital D/C Follow-up | 80.0% | 10 | 25 | 40.0% | 9 | 22 | 40.9% | 6 | 19 | 31.6% | 9 | 14 | 64.3% | 14 | 17 | 82.4% |
| | Postpartum Care | 80.0% | 14 0 | 20 | 70.0% | 14 0 | 19 | 73.7% | 15 0 | 21 | 71.4% | 17 0 | 23 | 73.9% | 14 0 | 19 | 73.7% |
| | BCS - Mammo clinical opportunities | 80.0% | 39 | 60 | 65.0% | 27 | 43 | 63.6% | 24 | 47 | 52.1% | 40 | 60 | 66.6% | 37 | 60 | 61.7% |
| | COVID19 Vaccine Offer | 90% | 593 | 637 | 93.1% | 541 | 588 | 92.0% | 562 | 615 | 91.4% | 670 | 728 | 92.0% | 644 | 694 | 92.8% |
| | COVID19 Vaccine offer among BAA | 95% | 44 | 57 | 77.2% | 41 | 51 | 80.4% | 39 | 53 | 73.6% | 72 | 86 | 83.7% | 66 | 74 | 89.2% |
| MHHC | Peds Timely IZ (under age 6) | 65.2% | 40 | 67 | 59.7% | 41 | 70 | 58.6% | 40 | 70 | 57.1% | 44 | 77 | 57.1% | 44 | 74 | 59.5% |
| | Tobacco MEA Referral (Office Visits) | 80.0% | 13 | 14 | 92.9% | 12 | 15 | 80.0% | 13 | 14 | 92.9% | 6 | 9 | 66.7% | 13 | 17 | 76.5% |
| | Chlamydia screening clinical opportu | 80.0% | 1 | 2 | 50.0% | 1 | 1 | 100.0% | 2 | 4 | 50.0% | 3 | 7 | 42.9% | 0 | 2 | 0.0% |
| | BHVS clinical opportunities | 80.0% | 65 | 77 | 84.4% | 88 | 99 | 89.0% | 69 | | | | | | | | |
| | 7-day Hospital D/C Follow-up | 80.0% | 1 3 | 1 | 100.0% | 2 2 | 2 | 100.0% | 4 2 | | | | | | | | |
| | Postpartum Care | 80.0% | 0 | 3 | 100.0% | 0 | 2 | 100.0% | 0 | | | | | | | | |
| | BCS - Mammo clinical opportunities | 80.0% | 4 | 10 | 40.0% | 11 | 14 | 78.6% | 6 | | | | | | | | |
| | COVID19 Vaccine Offer | 90% | 164 | 172 | 95.3% | 158 | 165 | 95.8% | 134 | | | | | | | | |
| | COVID19 Vaccine offer among BAA | 95% | 42 | 46 | 91.3% | 31 | 32 | 96.9% | 37 | | | | | | | | |
| OPHC | Peds Timely IZ (under age 6) | 90.6% | 7 | 11 | 63.6% | 5 | 9 | 55.6% | 5 | | | | | | | | |
| | Tobacco MEA Referral (Office Visits) | 80.0% | 4 | 4 | 100.0% | 6 | 7 | 85.7% | 4 | | | | | | | | |
| | Chlamydia screening clinical opportu | 80.0% | 2 | 3 | 66.7% | 6 | 6 | 100.0% | 2 | | | | | | | | |
| | BHVS clinical opportunities | 70.0% | 61 | 65 | 93.9% | 84 | 89 | 94.4% | 86 | | | | | | | | |
| | 7-day Hospital D/C Follow-up | 80.0% | 4 | 4 | 100.0% | 2 | 2 | 100.0% | 1 | | | | | | | | |
| | BCS - Mammo clinical opportunities | 80.0% | 7 | 8 | 87.5% | 12 | 12 | 100.0% | 9 | | | | | | | | |
| | COVID19 Vaccine Offer | 90% | 181 | 188 | 96.3% | 197 | 204 | 96.6% | 172 | | | | | | | | |
| | COVID19 Vaccine offer among BAA | 95% | 6 | 7 | 85.7% | 8 | 9 | 88.9% | 2 | | | | | | | | |

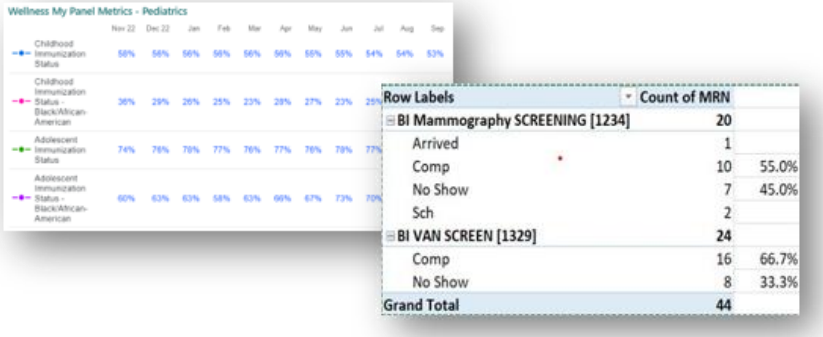



Wellness My Panel Metrics

| | Mar 23 | Apr 23 | May 23 | Jun 23 | Jul 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan | Feb | MTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Colorectal Cancer Screening | 58% | 58% | 59% | 60% | 62% | 63% | 62% | 62% | 62% | 61% | 61% | 61% | 61% |
| Colorectal Cancer Screening - Black/African-American | 46% | 47% | 47% | 48% | 51% | 51% | 51% | 50% | 50% | 50% | 50% | 50% | 50% |
| Cervical Cancer Screening | 72% | 72% | 73% | 73% | 74% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% |
| Opioid Safety | 37% | 38% | 36% | 37% | 38% | 38% | 40% | 38% | 34% | 33% | 30% | 32% | 33% |
| Tobacco Cessation Intervention - 12 Months | 74% | 74% | 75% | 76% | 78% | 81% | 81% | 82% | 82% | 82% | 82% | 82% | 82% |
| Behavioral Health Vital Signs (BHVS) | 58% | 58% | 59% | 60% | 62% | 65% | 66% | 67% | 67% | 67% | 67% | 67% | 67% |
| Screening, Brief Intervention, and Referral to Treatment (SBIRT) | 25% | 26% | 26% | 26% | 26% | 27% | 26% | 26% | 26% | 27% | 26% | 26% | 26% |
| Influenza Immunization | 56% | 57% | 56% | 57% | 58% | 0% | 0% | 17% | 31% | 40% | 48% | 53% | 54% |
| Breast Cancer Screening | 71% | 71% | 72% | 71% | 72% | 74% | 74% | 75% | 75% | 76% | 77% | 66% | 66% |
| Breast Cancer Screening - Black/African-American | 59% | 59% | 61% | 61% | 63% | 65% | 65% | 67% | 67% | 67% | 68% | 58% | 58% |
| Chlamydia Screening | 56% | 55% | 56% | 55% | 58% | 60% | 59% | 60% | 61% | 61% | 61% | 61% | 61% |

# Efforts to Reduce Disparities

**Data** – increased visibility of equity rates on our dashboard and using data to identify root causes of our access issues



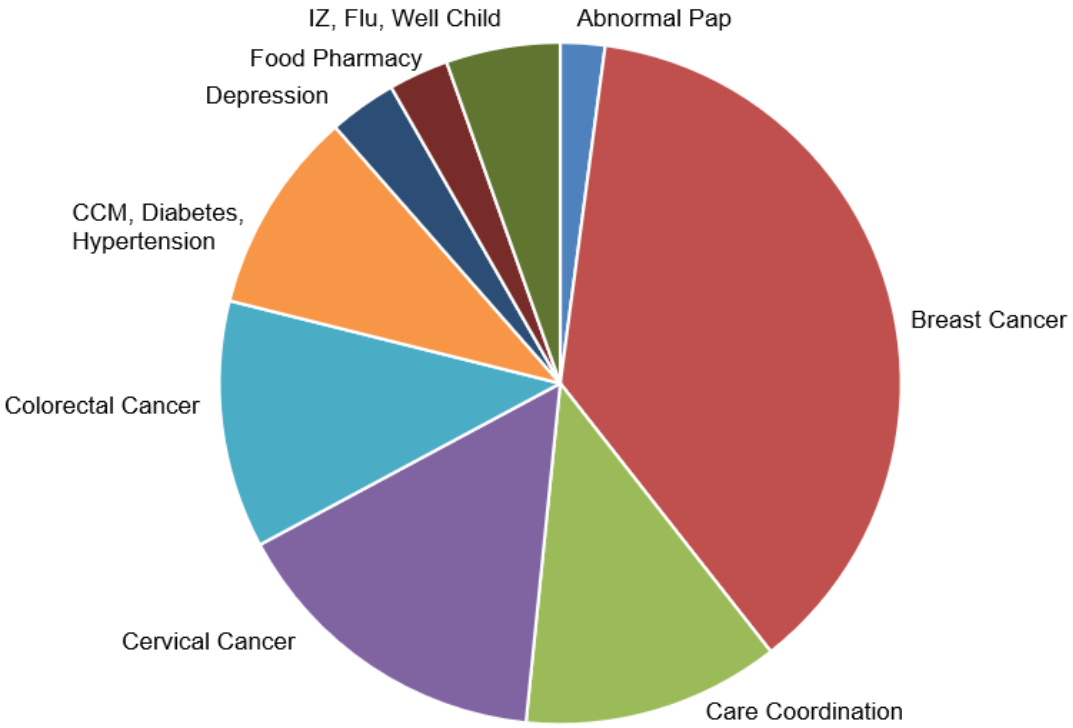

| Row Labels | Count of MRN | |
|---|---|---|
| BI Mammography SCREENING [1234] | 20 | |
| Arrived | 1 | |
| Comp | 10 | 55.0% |
| No Show | 7 | 45.0% |
| Sch | 2 | |
| BI VAN SCREEN [1329] | 24 | |
| Comp | 16 | 66.7% |
| No Show | 8 | 33.3% |
| Grand Total | 44 | |

**Addressing Social Determinants of Health (SDOH)** – tackling food insecurity through grocery vouchers and food pharmacy; increasing accessibility through transportation advocacy and counseling


**Antiracist A3 template** – focusing on societal, community and systems context and assessing counter measures based on upstream, midstream, & downstream impact

# Outreach

Health Outreach Workers proactively outreaching to patients to update their health maintenance (i.e., depression, hypertension, breast cancer, etc) and connect them with clinic services



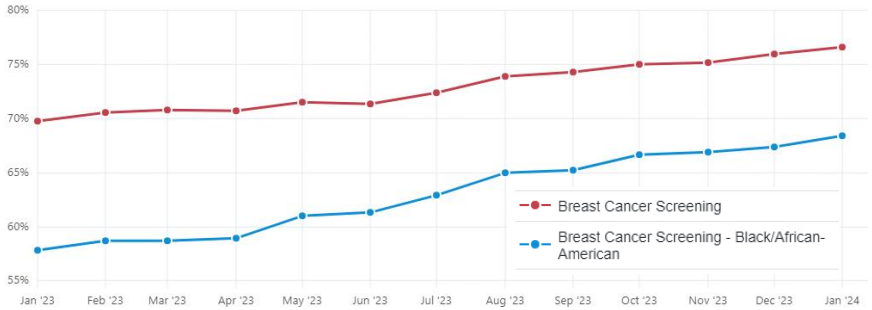

**In the last year…**

**967,000**
total encounters charted

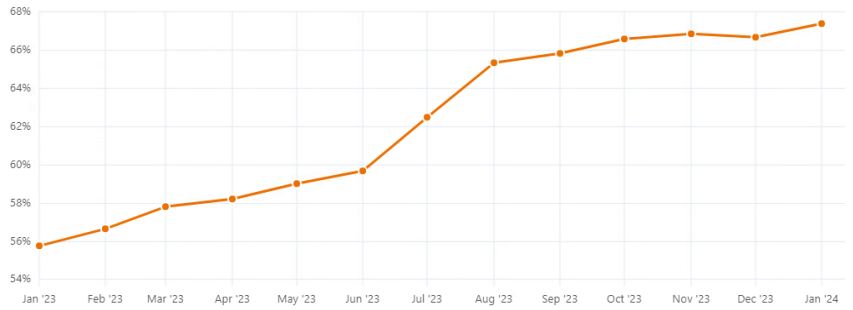
**248,500**
arrived or completed visits

**56,400**
patients seen in Primary Care

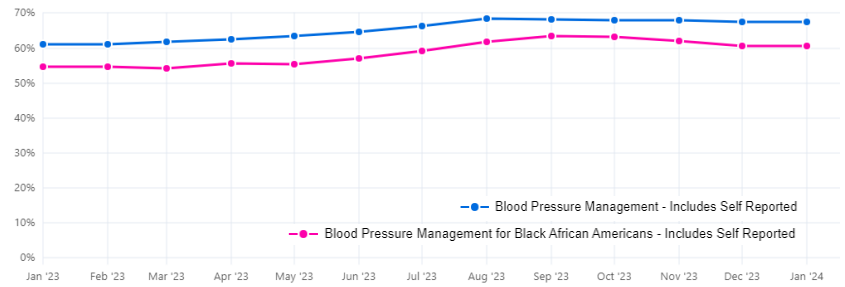
# Metric Highlights



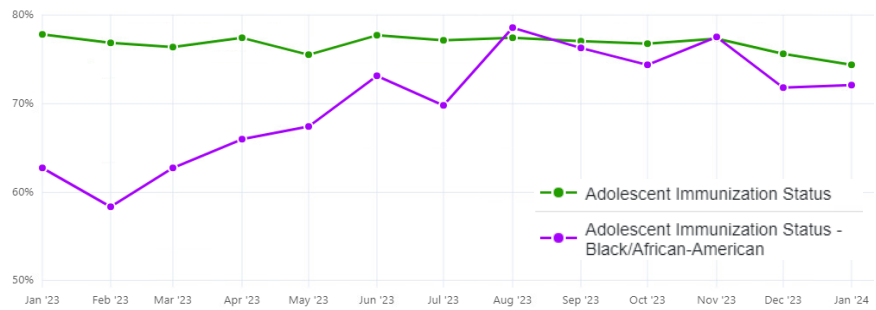

Breast Cancer Screening: 7% improvement for overall population and 10% improvement for B/AA population




Behavioral Health Vital Signs (BHVS): 10% improvement for overall population




Hypertension: 7% improvement for overall population and 5% improvement for B/AA population




Adolescent Immunization: reduced disparity gap by 13%

# MediCal Quality Incentive Pool (QIP) Program 2023

SFHN met 8 out of the 9 required measures for QIP

| Categories | Domain | Metric Title | Metric ID | Type | Target | 01/01/2023 - 12/31/2023 |
|---|---|---|---|---|---|---|
| Primary Care | Primary Care Access and Preventive Care | Child and Adolescent Well Care Visits | Q-WCV | Priority | 48.20% | 50.49% |
| | | Childhood Immunization Status | Q-CIS10 | Priority | 49.76% | 46.21% |
| | | Chlamydia Screening in Women | Q-CHL | Priority | 67.84% | 75.11% |
| | | Developmental Screening-1to3years-All | Q-DEV-YR13 | Priority | 44.37% | 75.21% |
| | | Immunizations for Adolescents | Q-IMA | Priority | 48.42% | 57.01% |
| | | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Q-CMS2 | Priority | 64.01% | 67.59% |
| | | Well-Child Visits in the First 15 Months of Life Rate 1 | Q-W30-15 | Priority | 67.56% | 72.37% |
| | | Well-Child Visits in the First 30 Months of Life Rate 2 | Q-W30-30 | Priority | 69.75% | 72.35% |
| Specialty | Maternal and Perinatal health | Postpartum Care | Q-PPC-PST | Priority | 84.18% | 84.97% |
| | | Timeliness of Prenatal Care | Q-PPC-PRE | Priority | 87.27% | 88.52% |

# MediCal Quality Incentive Pool (QIP) Program 2023

SFHN met ALL equity metrics for QIP

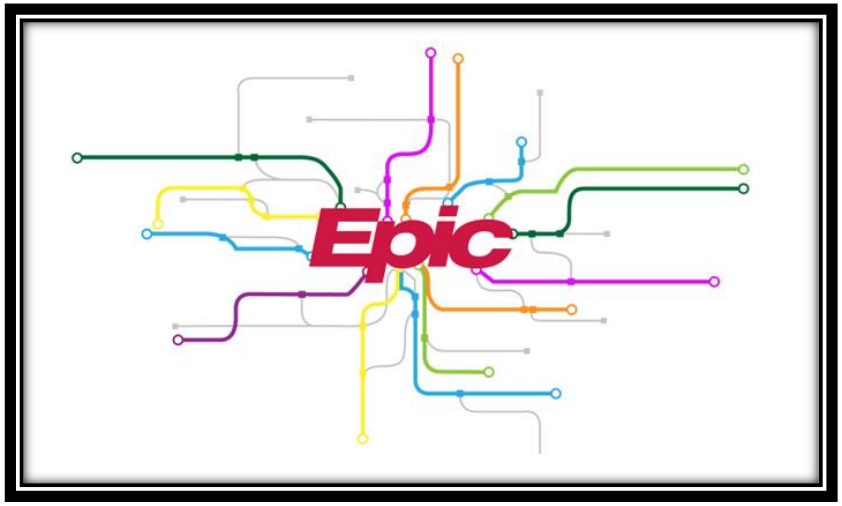
| Categories | Domain | Metric Title | Metric ID | Type | Effective Month | 202306 | 202307 | 202308 | 202309 | 202310 | 202311 | 202312 | 202401 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Target | 022 - 023 | 07/01/2022 - 06/30/2023 | 08/01/2022 - 07/31/2023 | 09/01/2022 - 08/31/2023 | 10/01/2022 - 09/30/2023 | 11/01/2022 - 10/31/2023 | 12/01/2022 - 11/30/2023 | 01/01/2023 - 12/31/2023 |
| Primary Care | Care of Acute and Chronic Conditions - Cardiovascular | Controlling High Blood Pressure | Q-CBP | Elective | 61.31% | .90% | 63.48% | 62.90% | 64.82% | 65.52% | 65.33% | 65.26% | 64.99% |
| | Care of Acute and Chronic Conditions - Diabetes | Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) ** | Q-HBD | Elective | 30.90% | .46% | 29.70% | 29.71% | 29.62% | 29.23% | 28.84% | 28.26% | 28.04% |
| | | Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) Improving Health Equity Black/African American ** | Q-HBD-IHE-BAA | Elective | 33.57% | .06% | 32.47% | 32.15% | 31.72% | 31.35% | 30.71% | 30.94% | 30.40% |
| | | Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) Improving Health Equity Hispanic ** | Q-HBD-IHE-H | Elective | 34.29% | .06% | 34.04% | 34.10% | 34.42% | 33.77% | 33.39% | 32.77% | 33.22% |
| | Improving Health Equity | Breast Cancer Screening Improving Health Equity Black/African American | Q-BCS-IHE-BAA | Elective | 50.45% | .69% | 53.69% | 54.98% | 56.05% | 55.49% | 57.38% | 56.91% | 56.83% |
| | | Controlling High Blood Pressure Improving Health Equity Black/African American | Q-CBP-IHE-BAA | Elective | 54.82% | .89% | 54.20% | 54.13% | 56.20% | 58.82% | 57.03% | 57.34% | 56.97% |
| | Primary Care Access and Preventive Care | Breast Cancer Screening | Q-BCS | Elective | 56.60% | .35% | 58.49% | 58.61% | 59.38% | 59.12% | 59.33% | 59.38% | 59.85% |

# Improving Access to Care

# Improving Access to Care


- Scheduling template pilot at Potrero Hill Health Center.

- Goals:
  - Test new approaches to scheduling patients
  - Reduce no-show rate
  - Improve timely access for patients




- Access Optimization Working Group

- Goals:
  - Partner with Epic to implement access tools
  - Use data to drive decisions
  - Involve front-line staff in design process

# Building a Culture of Integration

# What does integration mean?

- ***Thinking of ourselves as one team, one system***
- **Seamless integration of medical and behavioral health services**
- **Coordination across disciplines and locations**
- **Standardize workflows**
- **Increased engagement of central leadership with front-line staff**
- **Patient and staff drive improvement work**

San Francisco Health Network

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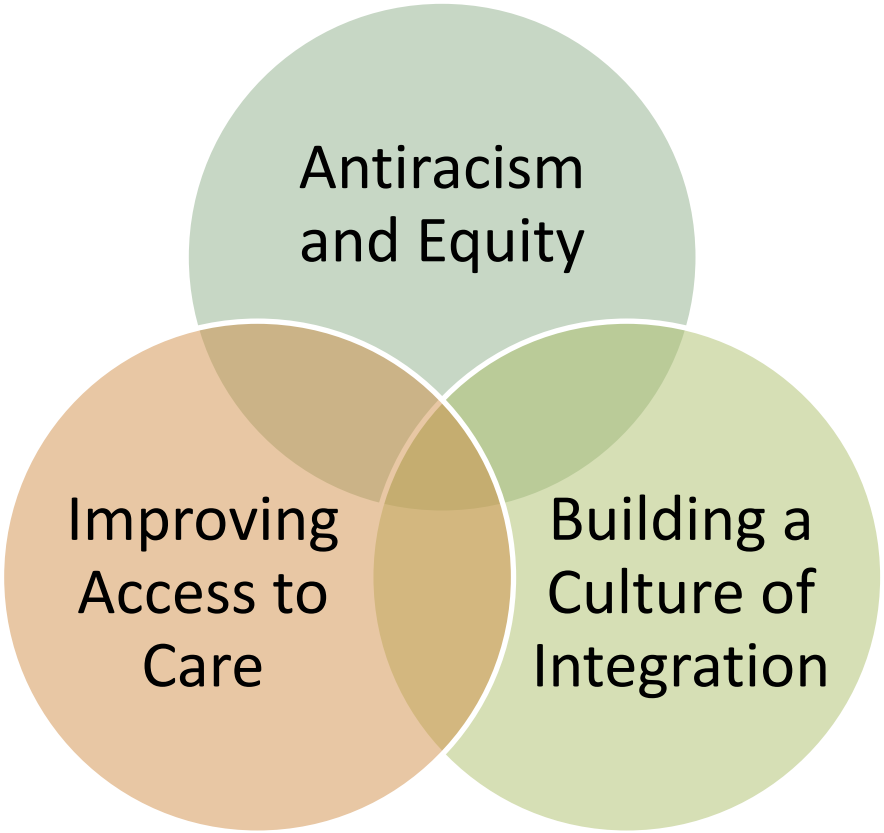
# Primary Care Vision



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# Thank you!