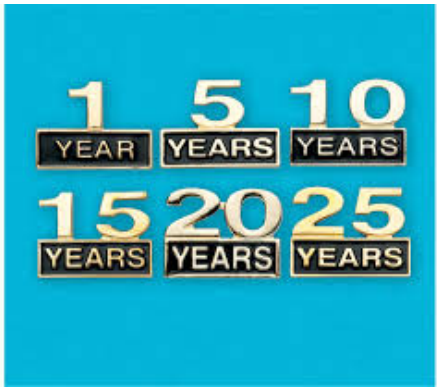
PRIMARY – SPECIALTY CARE 2014 RETREAT

improving the primary-specialty care interface in the San Francisco safety net: past, present and future

Introductions

- Please sit next to someone you don't know or don't see on a regular basis
- 30 seconds to introduce yourself
  - Name and title/organization
  - How long you've worked in/with the SF safety net
  - What your most commonly used nickname is, if you have one



Agenda

- Background: why focus on specialty care?
- Establishing the foundation: eReferral
- Catalyzing collaboration: PC-SC workgroups
- Developing systems: ambulatory integration
- Future directions
- Q & A, Discussion

Why focus on specialty care?

- Specialty visits comprise than 50% of all ambulatory visits
- For patients <65, 1/3 patients referred to specialist/year
- For patients ≥ 65 average of 2 referrals per person per year
- On average, for every 100 Medicare patients a PCP takes care of, s/he has to interact with 99 other physicians in 53 different practices
- Lack of timely specialty care can result in adverse outcomes, unnecessary ED visits and hospitalizations, and potentially higher health care costs

Specialty Care Access in Safety Net

SPECI

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Have Adec

In five diverse
pharmaceutica

by Suzanne Fel

ABSTRACT: The s
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Access To Sp
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Health Cent

Lack of access to specialty
CHCs than previously thou

by Nakela L. Cook, LeRoi S.
Edward Guadagnoli, and Br

ABSTRACT: Although community
the medically underserved and pc
to poorer outcomes among underi
cialty health services for patients
tors of all federally qualified CHCs
uninsured patients had greater di
cluding referrals and diagnostic te
vate insurance. [*Health Affairs* 26,

The New York Times

U.S.

WORLD | U.S. | N.Y. / REGION | BUSINESS | TECHNOLOGY | SCIENCE | HEALTH | SPORTS | OPINION

Medicaid Growth Could Aggravate Doctor Shortage

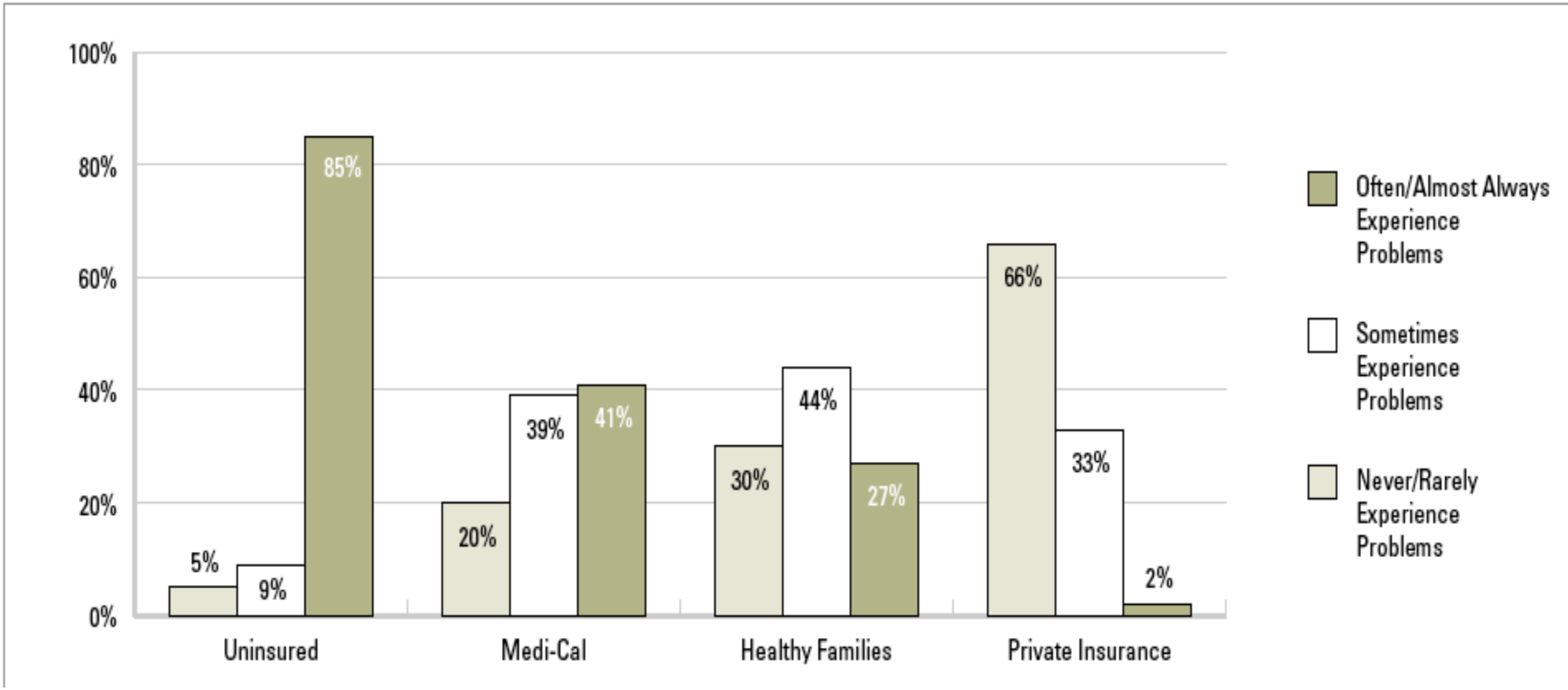
Emily Berl for The New York Times

Dr. Ted Mazer, an ear, nose and throat specialist in San Diego who treats people on Medicaid, with Oresta Johnson.

By ABBY GOODNOUGH
Published: November 28, 2013

Specialty Care Access in Safety Net

Figure 1. Percent of Medical Directors Reporting Patients Experiencing Problems Obtaining Specialty Care



Felt-Lisk S, McHugh M. "Examining Access to Specialty Care for California's Uninsured." California Health Care Foundation Issue Brief, May 2004.

102,000 enrollees
51% receive specialty care through SFHN

SAN FRANCISCO HEALTH PLAN
Here for you

SFCCC
Community Clinic Consortium

11 independent primary care clinics
105,000 primary care patients

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

123,500 patients/clients*
28% L, 23% As, 23% W, 17% B

14 primary care health centers
70,000 primary care patients

comprehensive ambulatory specialty and diagnostic services
332,000 visits in 2012-2013

UCSF
University of California San Francisco

*FY 12-13 includes COPC, SFGH, LHH, CBHS

patient photos courtesy of Rachel Gepner

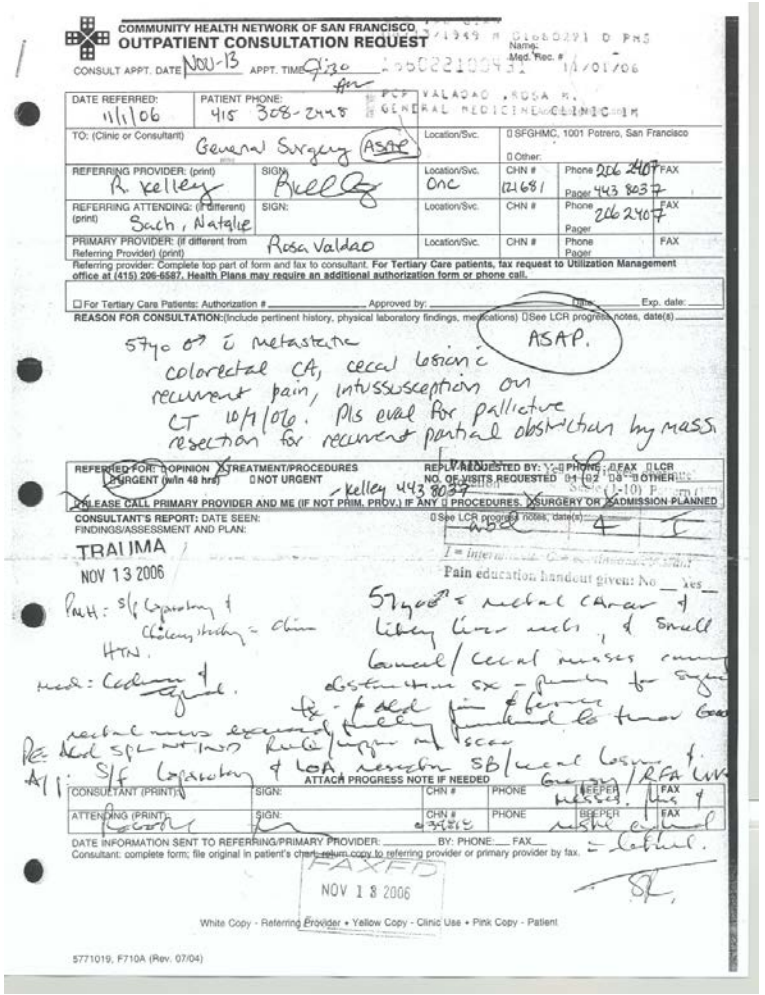
Year	Specialty Care Initiatives	SFDPH Primary Care	SFCCC	SFHP	Health Reform
2005	eConsult in GI	CCLC – 1st Diabetes Collaborative	Healthcare for the Homeless Ryan White Part C		
2006		Auto-assignment to PC clinic	CPCA AQICC	**Funded eReferral spread**	
2007	eReferral spread	Empanelment to PCC + PCP			HSF
		i2iTracks initiated, KP PHASE Grant I SF Safety Net Quarterly Team Meetings			
2008	**KP Specialty Planning Grant**			SLIM Network	
2009	**KP Specialty Care Initiative Grant I**	KP PHASE Grant II	EHR Implementation KP PHASE Grant II	Strength in Numbers	HITECH
2010		All adult clinics using i2i Tracks	Electronic HCH & HIV Audit	PIP; Patient Experience Collaborative	ACA
2011	**KP Specialty Care Initiative Grant II**	KP Grant DataWall KP PHASE GRANT III	Empanelment PCMH	SPD transition	Medicaid Waiver
		San Francisco Quality Culture Series Tides Health Home Grant			
2012	Telehealth initiatives	" Year of the Team" CMMI Proposal Submitted		CareSupport Program	
2013	**CHCF eReferral Grant**	"Year of the Nurse" Nursing Leadership Academy	**BSCF SNI Grant**	**Specialty Performance Improvement Program**	Covered California
2014	Integrated Healthcare Delivery System for SF's Safety Net				

eREFERRAL

leveraging technology to connect clinicians

State of PC-SC interface circa 2005

- Paper, telephone, and fax based referral system
- Clerical process of first referred, first scheduled
- Significant inefficiencies
  - referral to wrong clinic
  - unnecessary referrals
  - premature referrals
  - inability to discern referral question
  - lack of equitable triage
- Wait times up to 11 mo



COMMUNITY HEALTH NETWORK OF SAN FRANCISCO
OUTPATIENT CONSULTATION REQUEST

CONSULT APPT. DATE Nov-13 APPT. TIME 9:30 for

DATE REFERRED: 11/1/06 PATIENT PHONE: 415 308-2448

TO: (Clinic or Consultant) General Surgery ASAP

REFERRING PROVIDER: (print) R. Kelley SIGN: Onc

REFERRING ATTENDING: (print) Sach, Natalie SIGN:

PRIMARY PROVIDER: (if different from Referring Provider) (print) Rosa Valdao

REASON FOR CONSULTATION: ASAP.

57yo ♂ ↑ metastatic colorectal CA, cecal lesion c recurrent pain, intussusception on CT 10/1/06. Pls eval for palliative resection for recurrent partial obstruction by mass.

REFERRED FOR: ☒OPINION ☒TREATMENT/PROCEDURES ☒URGENT (w/in 48 hrs) ☐NOT URGENT

REPLY REQUESTED BY: ☐PHONE ☐FAX ☐LCR

NO. OF VISITS REQUESTED 01 02 03 ☐OTHER

Kelley 443 8037

☒PLEASE CALL PRIMARY PROVIDER AND ME (IF NOT PRIM. PROV.) IF ANY ☐PROCEDURES, ☒SURGERY OR ☐ADMISSION PLANNED

CONSULTANT'S REPORT: DATE SEEN:

FINDINGS/ASSESSMENT AND PLAN:

TRAUMA

NOV 13 2006

Pain education handout given: No Yes

PMH: s/p Laparotomy & Cholecystectomy - clean

HTN.

Med: Codeine & Tylenol.

57yo ♂ + metal cancer + Liver mets & small bowel/cecal masses causing obstruction sx - plan for surgery

Re: Abd spiral CT w/ PO Rule/Augment scan

A/P: S/P Laparotomy & LOA, resection SB/cecal lesion, ? Gastrectomy/RFA Liver mets

ATTACH PROGRESS NOTE IF NEEDED

CONSULTANT (PRINT) SIGN: CHN # PHONE BEEPER FAX

ATTENDING (PRINT) SIGN: CHN # PHONE BEEPER FAX

DATE INFORMATION SENT TO REFERRING/PRIMARY PROVIDER: BY: PHONE: FAX

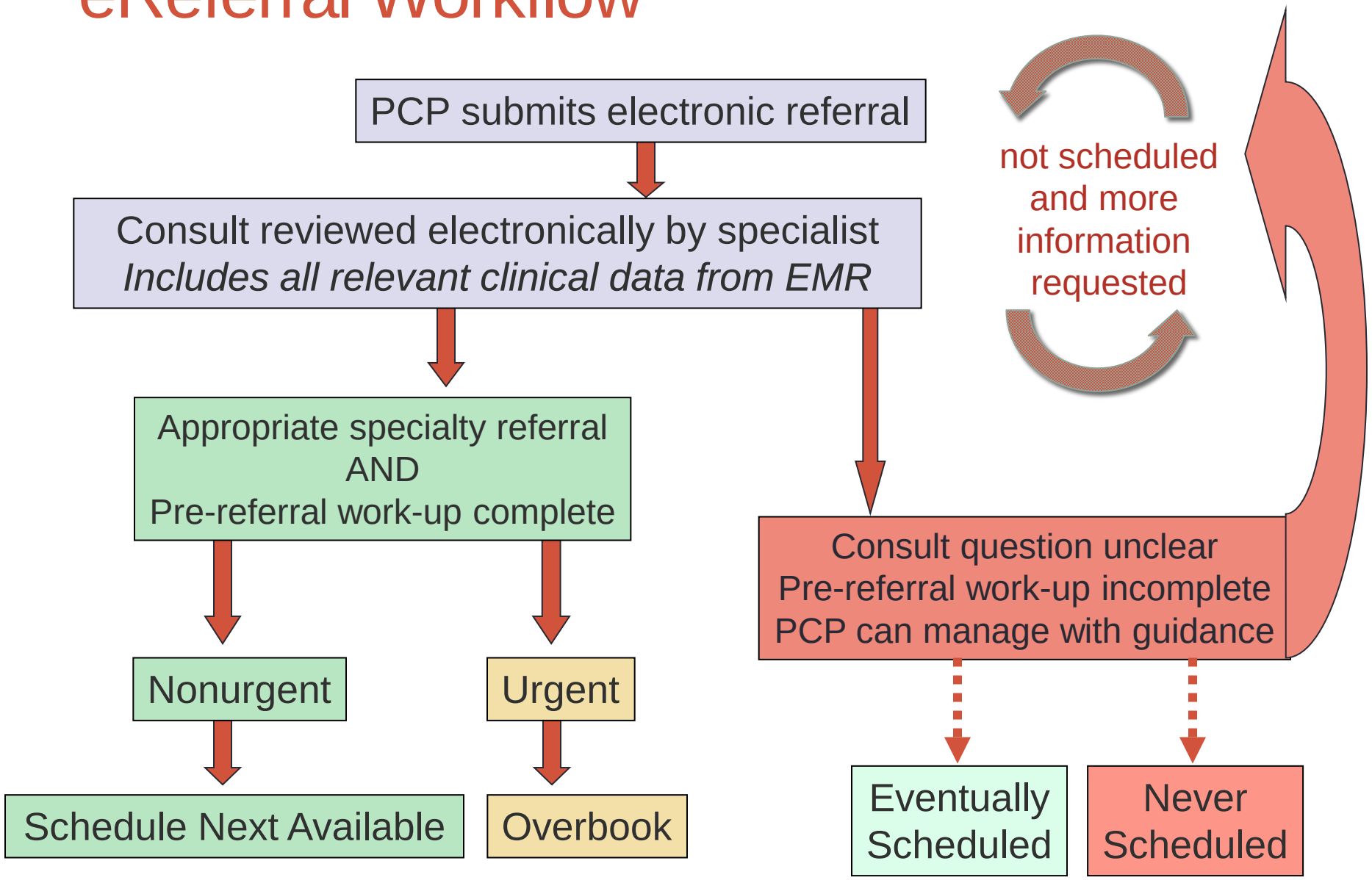
Consultant: complete form; file original in patient's chart; return copy to referring provider or primary provider by fax.

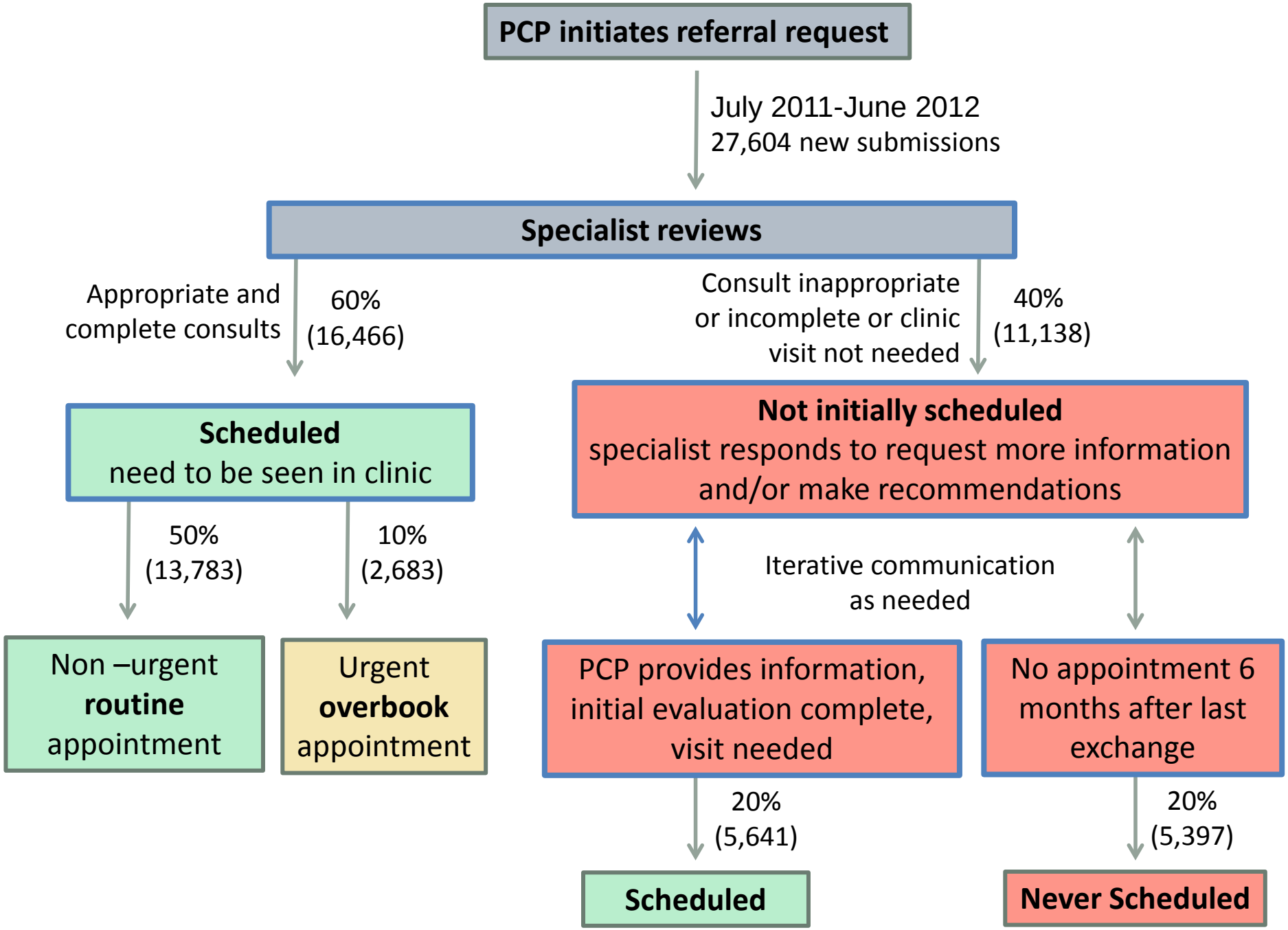
FAXED NOV 13 2006

White Copy - Referring Provider • Yellow Copy - Clinic Use • Pink Copy - Patient

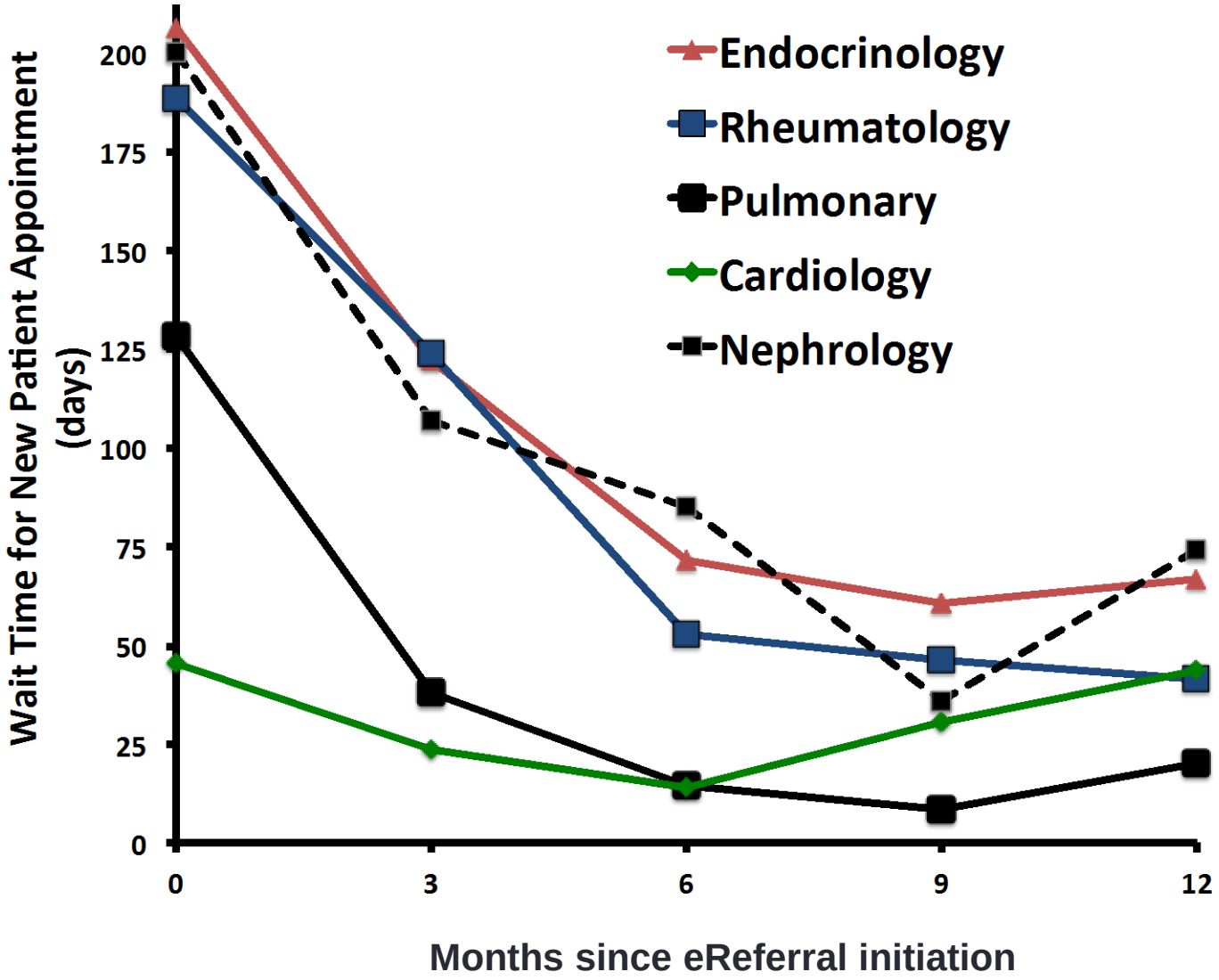
5771019, F710A (Rev. 07/04)

eReferral Workflow




PCP initiates referral request
July 2011-June 2012
27,604 new submissions
Specialist reviews
Appropriate and complete consults
60% (16,466)
Consult inappropriate or incomplete or clinic visit not needed
40% (11,138)
Scheduled
need to be seen in clinic
Not initially scheduled
specialist responds to request more information and/or make recommendations
50% (13,783)
10% (2,683)
Iterative communication as needed
Non –urgent routine appointment
Urgent overbook appointment
PCP provides information, initial evaluation complete, visit needed
No appointment 6 months after last exchange
20% (5,641)
20% (5,397)
Scheduled
Never Scheduled

eReferral impact on wait times



Switch to SFGH Pediatrics Portal | Switch to Laguna Honda Portal

SFGH Adult Portal

Welcome to the eReferral site, which has been developed to handle appointment requests from Community Health Network (CHN) and CHN-affiliated providers for outpatient specialty consultations. Routine consultation requests for the below clinics will no longer be accepted by hardcopy, facsimile, or phone. Please follow the steps outlined below in submitting your referral request.

Begin by selecting an eReferral type for:PRECIVALE, GOLDIE

Medical Specialty Clinics

- TB Clinic New!!
- Allergy Adult Clinic
- Cardiology Clinic
- Chest Specialty Service
- Diabetes Services
- Endocrinology Clinic
- Gastroenterology Clinic
- Geriatrics Clinic
- Hematology Clinic
- Liver Clinic
- Neurology Clinic
- Oncology Service
- Renal Clinic
- Rheumatology Clinic

Womens Health Specialty Clinics

- 5M Breast Evaluation and Referral Clinic
- Gynecology Clinics
- Obstetric Clinics

Other Programs

- Anticoagulation FHC (No Review)
- 1M Anticoagulation Clinic (No Review)
- Financial Fitness Clinic (No Review)
- Comprehensive Pharmacy Care
- Wellness Center (No Review)
- Transgender Health Services
- Health At Home
- Psychosocial Medicine
- Respite Program
- Stop Smoking Program (No Review)

Surgical Specialty Clinics

- Anesthesia PreOp Clinic (No Review)
- Cardiothoracic Surgery Service
- 3M Breast Surgery Clinic
- Otolaryngology-Head and Neck Surgery Clinic (ENT)
- General Surgery Clinic
- Neurosurgery Clinic
- Concussion eScheduling (No Review)
- Ophthalmology/Optometry eScheduling (No Review)
- Orthopaedic Surgery Clinic
- Plastic Surgery Clinic
- Podiatry Clinic
- Urology Clinic
- Vascular Surgery
- Vasectomy Service at FHC (No Review)
- Interventional Radiology (No Review)

Diagnostic Services

- Audiology eScheduling (No Review)
- Echocardiography Clinic (No Review)
- EEG Service (No Review)
- Ambulatory ECG Monitoring (No Review)
- Treadmill Exercise Testing (ETT) (No Review)
- Thoracentesis Service (No Review)
- Sleep Study
- Radiology CT Service
- Radiology Fluoroscopy
- Radiology Mammo Screening Service (No Review)
- Radiology Breast Diagnostic Service New!!
- Radiology MRI Service
- Radiology Ultrasound Service

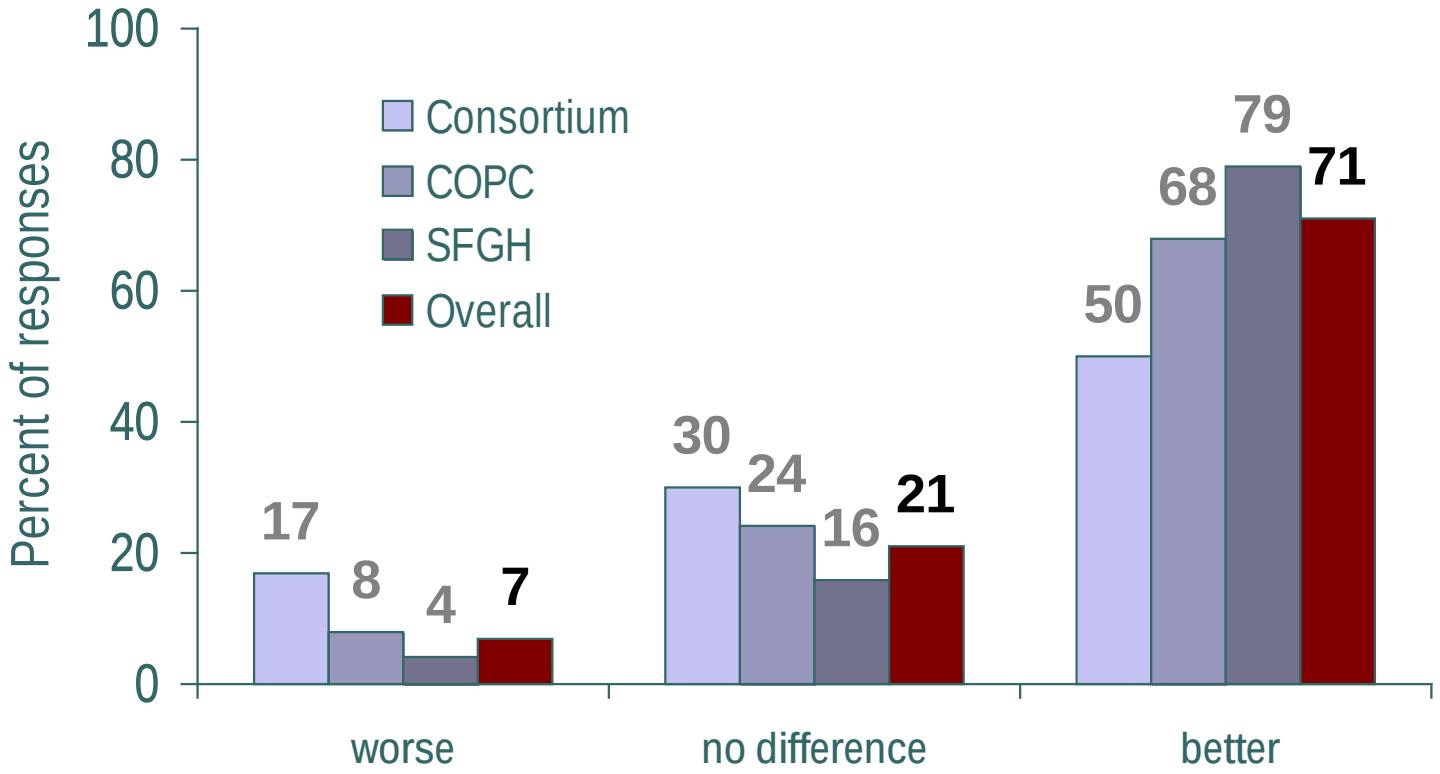
Rehabilitation Services

- Occupational Therapy New!!
- Physical Therapy New!!
- Speech Language Pathology New!!

Primary care satisfaction with eReferral

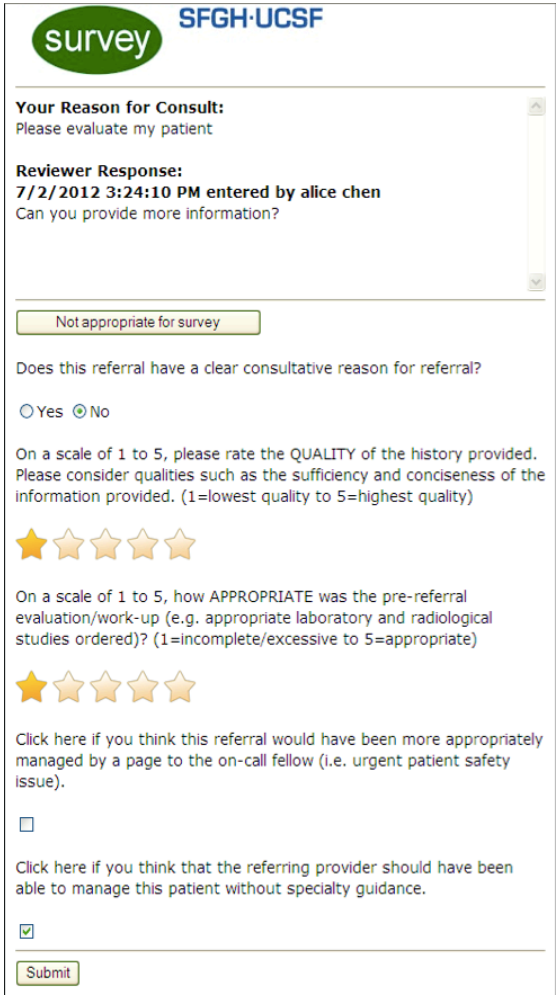
Overall, how has eReferral changed clinical care for your patients?

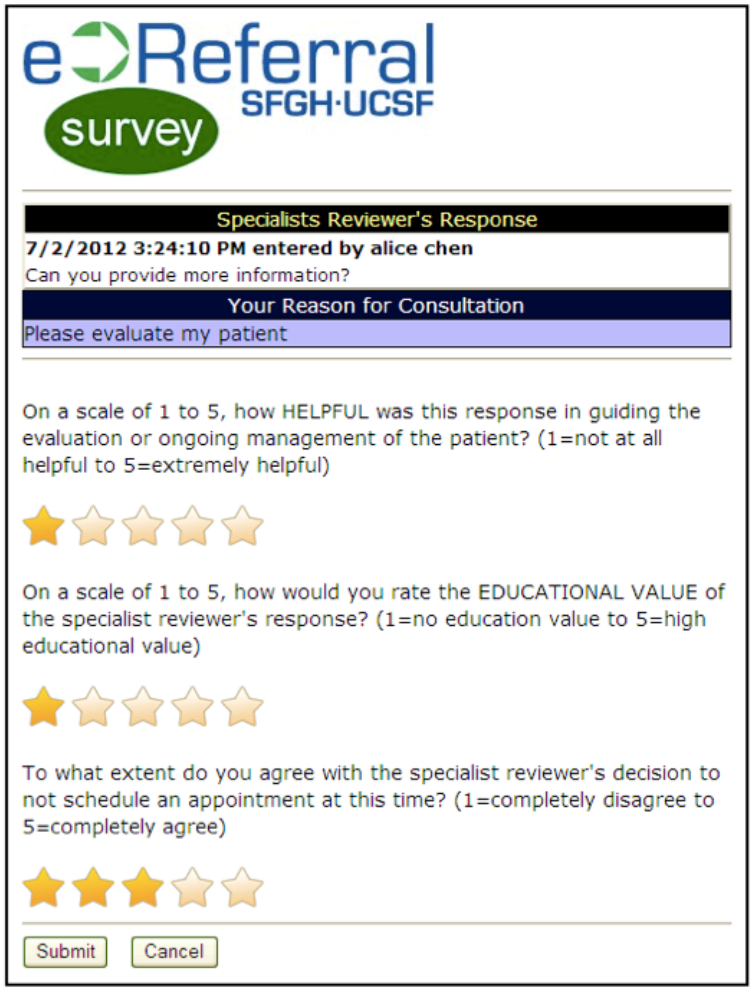
81% response rate (298 of 368)



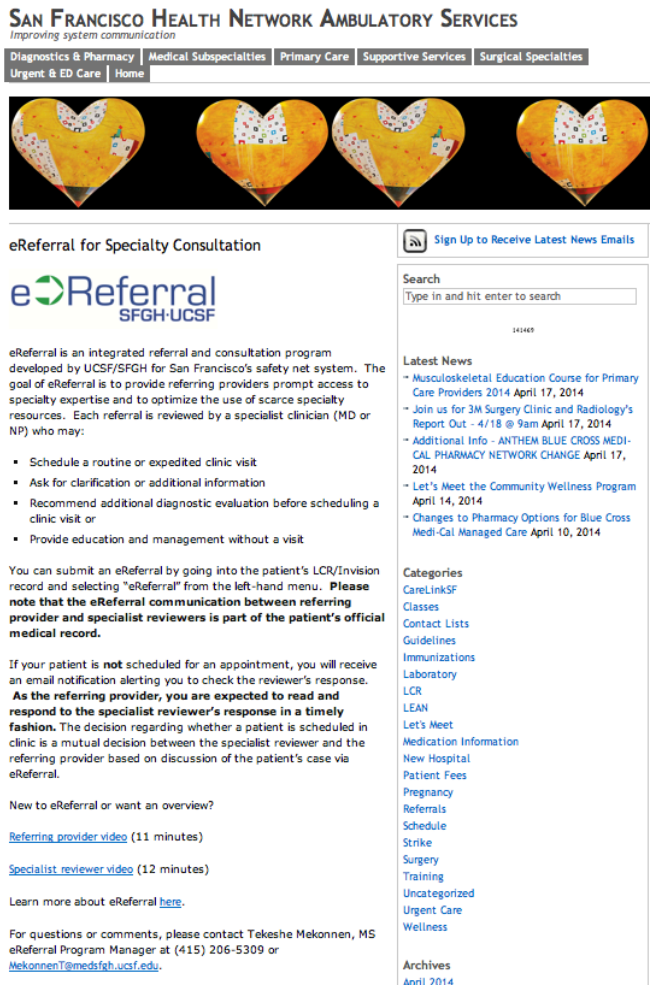
Kim Y, Chen AH, Keith E, Yee HF, Kushel MB. "Not perfect, but better: primary care providers' experiences with electronic referrals in a safety net health system." *Journal of General Internal Medicine* 2009; 24(5):614-619.

Bidirectional feedback for improvement





Systems support



SAN FRANCISCO HEALTH NETWORK AMBULATORY SERVICES

Improving system communication

Diagnostics & Pharmacy | Medical Subspecialties | Primary Care | Supportive Services | Surgical Specialties | Urgent & ED Care | Home

eReferral for Specialty Consultation

eReferral SFGH·UCSF

eReferral is an integrated referral and consultation program developed by UCSF/SFGH for San Francisco's safety net system. The goal of eReferral is to provide referring providers prompt access to specialty expertise and to optimize the use of scarce specialty resources. Each referral is reviewed by a specialist clinician (MD or NP) who may:

- Schedule a routine or expedited clinic visit
- Ask for clarification or additional information
- Recommend additional diagnostic evaluation before scheduling a clinic visit or
- Provide education and management without a visit

You can submit an eReferral by going into the patient's LCR/Invision record and selecting "eReferral" from the left-hand menu. **Please note that the eReferral communication between referring provider and specialist reviewers is part of the patient's official medical record.**

If your patient is **not** scheduled for an appointment, you will receive an email notification alerting you to check the reviewer's response. **As the referring provider, you are expected to read and respond to the specialist reviewer's response in a timely fashion.** The decision regarding whether a patient is scheduled in clinic is a mutual decision between the specialist reviewer and the referring provider based on discussion of the patient's case via eReferral.

New to eReferral or want an overview?

Referring provider video (11 minutes)

Specialist reviewer video (12 minutes)

Learn more about eReferral here.

For questions or comments, please contact Tekeshe Mekonnen, MS eReferral Program Manager at (415) 206-5309 or MekonnenT@medsfgh.ucsf.edu.

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Search

Type in and hit enter to search

Latest News

- Musculoskeletal Education Course for Primary Care Providers 2014 April 17, 2014
- Join us for 3M Surgery Clinic and Radiology's Report Out - 4/18 @ 9am April 17, 2014
- Additional Info - ANTHEM BLUE CROSS MEDI-CAL PHARMACY NETWORK CHANGE April 17, 2014
- Let's Meet the Community Wellness Program April 14, 2014
- Changes to Pharmacy Options for Blue Cross Medi-Cal Managed Care April 10, 2014

Categories

CareLinkSF
Classes
Contact Lists
Guidelines
Immunizations
Laboratory
LCR
LEAN
Let's Meet
Medication Information
New Hospital
Patient Fees
Pregnancy
Referrals
Schedule
Strike
Surgery
Training
Uncategorized
Urgent Care
Wellness

Archives

April 2014

PRIMARY-SPECIALTY CARE WORKGROUPS

engaging PCPs and specialists in joint problem solving

KP Specialty Care Initiative 2008-2012
BSCF Safety Net Integration 2013

- Goal: to improve primary-specialty interface through collaborative problem solving
- Workgroups

  Endocrinology
  Gastroenterology
  Nephrology
  Obstetrics/gynecology
  Orthopaedic Surgery
  Pulmonary
  Urology

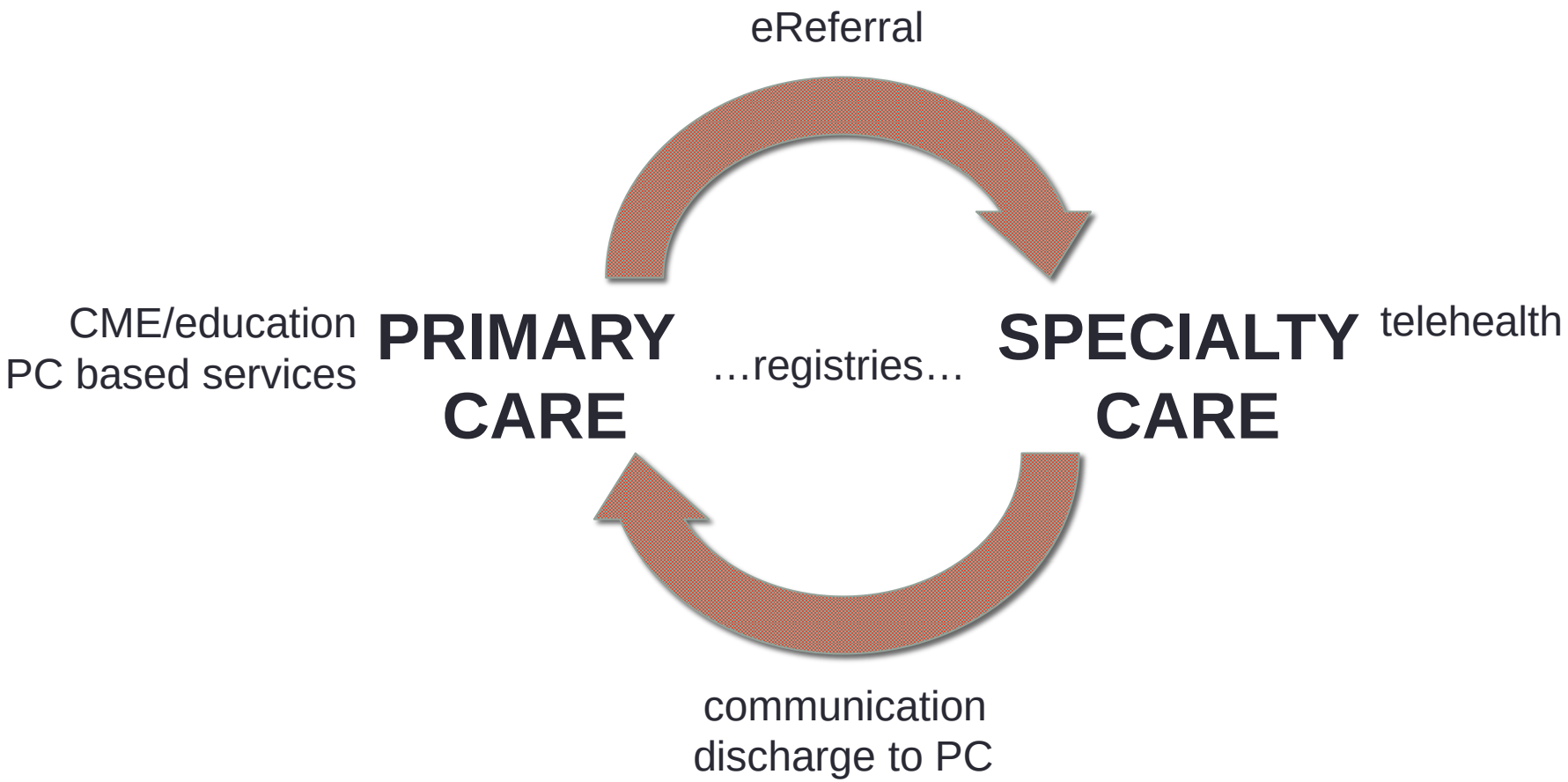
- Representation

  COPC primary care
  SFGH primary care
  SFCCC primary care
  Specialty services

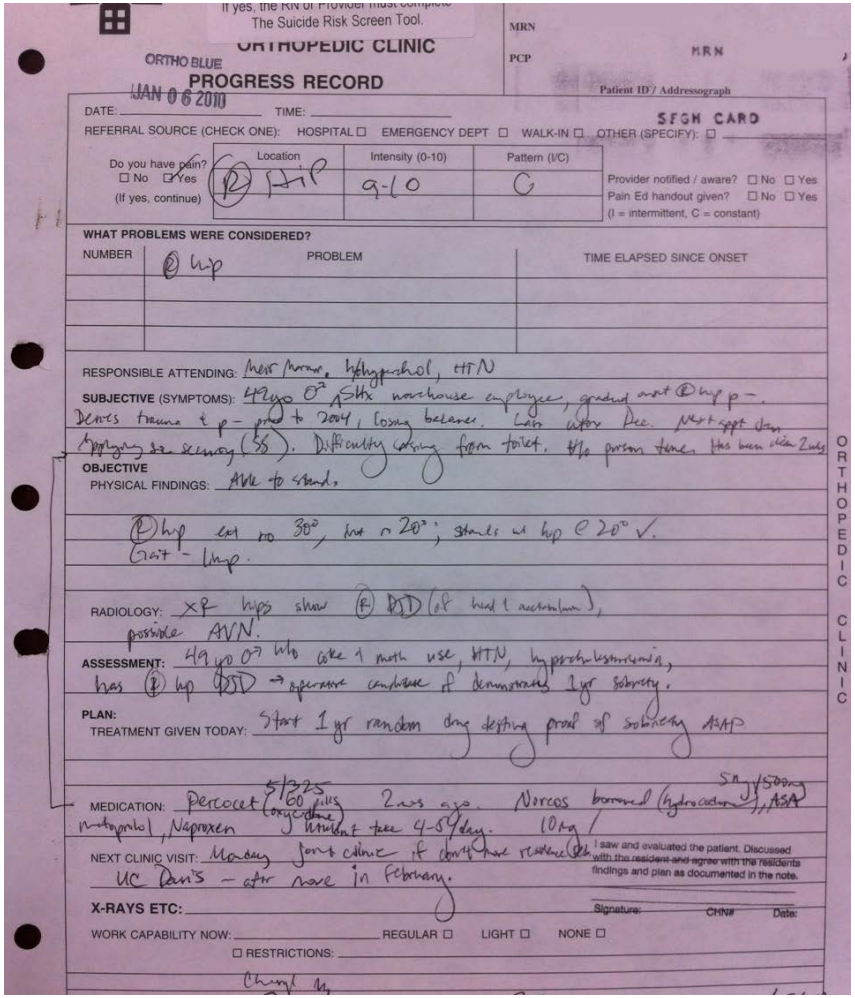
Objectives

improved communication
improved access
improved co-management

Managing supply-demand mismatch



Closing the loop: specialty notes



If yes, the RN or Provider must complete The Suicide Risk Screen Tool.

ORTHOPEDIC CLINIC

ORTHO BLUE

PROGRESS RECORD

JAN 06 2010

MRN

PCP

Patient ID / Addressograph

SFGH CARD

DATE: TIME:

REFERRAL SOURCE (CHECK ONE): HOSPITAL ☐ EMERGENCY DEPT ☐ WALK-IN ☐ OTHER (SPECIFY): ☐

Do you have pain? ☐ No ☒ Yes (If yes, continue)

Location	Intensity (0-10)	Pattern (I/C)
(R) hip	9-10	C

Provider notified / aware? ☐ No ☐ Yes

Pain Ed handout given? ☐ No ☐ Yes

(I = intermittent, C = constant)

WHAT PROBLEMS WERE CONSIDERED?

NUMBER	PROBLEM	TIME ELAPSED SINCE ONSET
	(R) hip	

RESPONSIBLE ATTENDING: heart murmur, hyperlipidemia, HTN

SUBJECTIVE (SYMPTOMS): 49yo ♂ Sthx warehouse employee, gradual onset (R) hip p -. Denies trauma to p - prob to 2004, coming because. Can't work Dec. Must support dau. Applying for security (SS). Difficulty rising from toilet. Hip pain tenderness has been slow 2mos

OBJECTIVE

PHYSICAL FINDINGS: Able to stand.

(R) hip ext no 30°, int ~20°; stands w hip @ 20° V.

Gait - limp.

RADIOLOGY: XR hips show (R) DJD (of head & acetabulum), possible AVN.

ASSESSMENT: 49 yo ♂ hx coke & meth use, HTN, hyperlipidemia, has (R) hip DJD → aggressive candidate if demonstrates 1yr sobriety.

PLAN:

TREATMENT GIVEN TODAY: Start 1yr random drug testing proof of sobriety ASAP

MEDICATION: Percocet 5/325 60 pills Oxycodone 2 mos ago. Norcos borrowed (hydrocodone) 5mg/500mg, ASA metoprolol, Naproxen Ibuprofen tabs 4-5/day. 10mg

NEXT CLINIC VISIT: Monday joint clinic if [illegible] resident UC Davis - after move in February.

I saw and evaluated the patient. Discussed with the resident and agree with the resident's findings and plan as documented in the note.

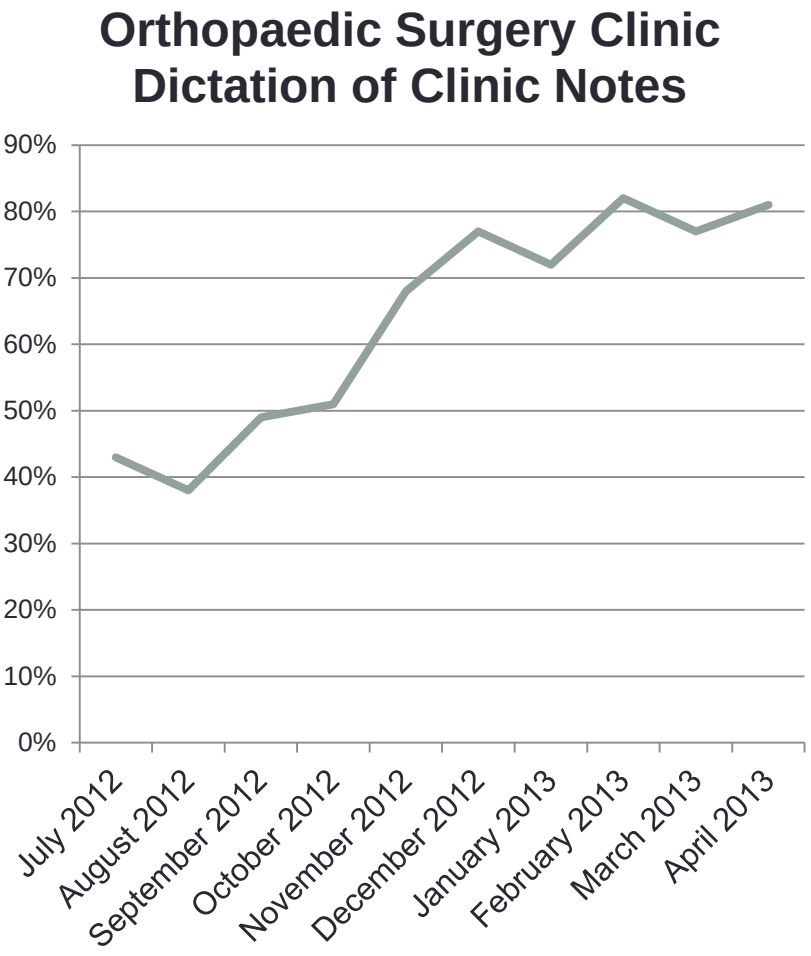
X-RAYS ETC:

Signature: CHN# Date:

WORK CAPABILITY NOW: REGULAR ☐ LIGHT ☐ NONE ☐

☐ RESTRICTIONS:

ORTHOPEDIC CLINIC



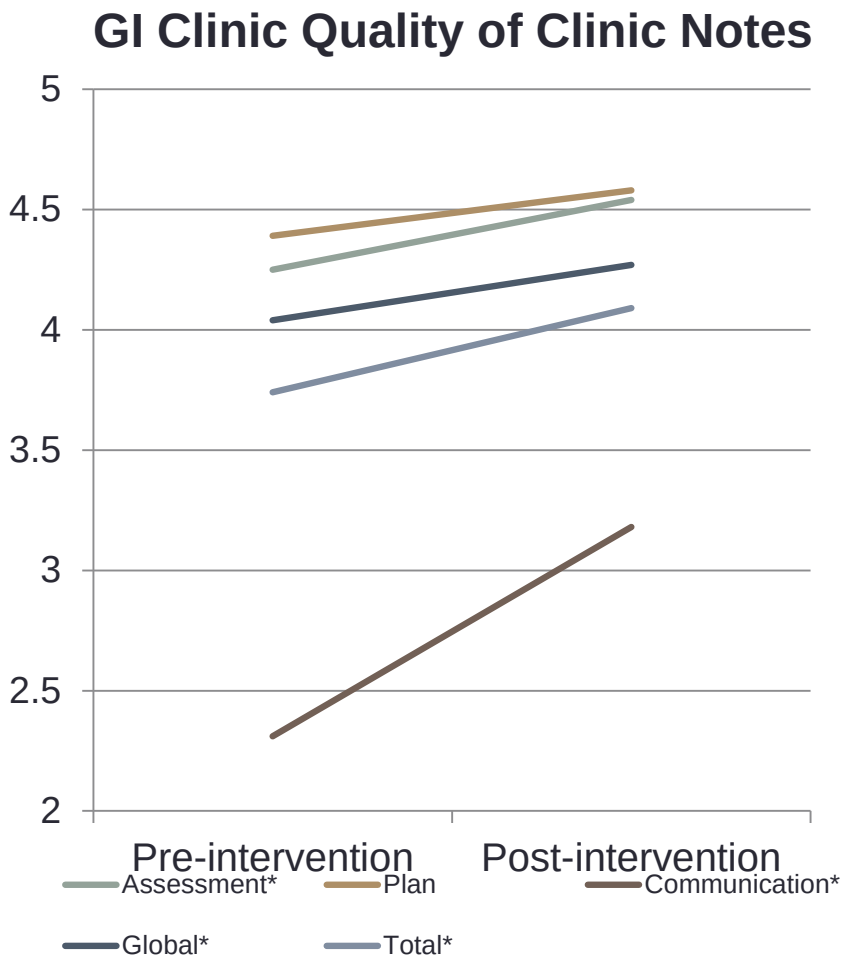
Closing the loop: specialty notes

Assessment Domain
- Reason for consultation clearly specified
- A&P focuses on reason for consultation
- Differential diagnosis provided

Plan Domain
- Rationale for diagnostic plan
- Rationale for therapeutic plan

Communication Domain
- Responsibility for labs/studies
- Responsibility for medications
- Urgency of planned procedures
- Follow-up clearly specified
- Anticipatory guidance given
- Bulleted recommendation format

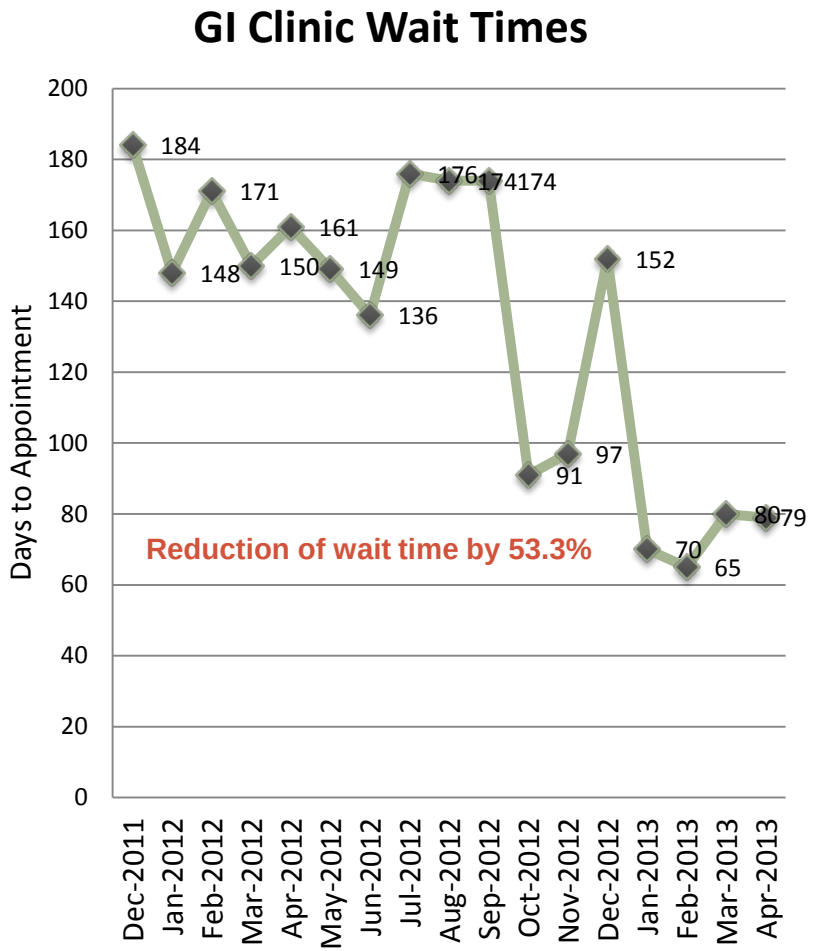
Global Quality
- "This note clearly conveys information I would want as the referring provider"
- "This is a high-quality consultation note"
- "This note was easy to read"



Sewell JL, Day LW, Tuot DS, Alvarez R, Yu A, Chen AH. A brief, low-cost intervention improves the quality of ambulatory gastroenterology consultation notes. Am J Med. 2013 Aug; 126(8):732-8.

Discharging patients to primary care

- Delphi process
- Historically post-procedure patients scheduled for follow up – 1200-1500 slots annually
- Develop and implement “discharge criteria” for post-endoscopy patients who could safely be discharged to PC



Tuot DS, Sewell JL, Day L, Leeds K, Chen AH. Increasing access to specialty care: patient discharges from gastroenterology clinic. AJMC 2014; *in press*.

Discharging patients to primary care

Nephrology eCW "transfer of care" template

Current Medications
Taking Benazepril HCl 10 MG Tablet 1 tablet Once a day
Taking BuPROPion HCl 100 MG Tablet 1 tablet two times a day (1 tab in the morning, 1 tab in mid-afternoon)
Taking Ferrous Fumarate 325 (106 Fe) MG Tablet Take 1 tablet once a day, Notes: not taking
Taking Gabapentin 300 MG Capsule 1 capsule Three times a day, Notes: doesn't think she is taking
Taking Hydrocortisone 1 % Cream Use twice daily to vulva X 1 week, then once daily X 1 week, then as needed

Reason for Appointment
1. FUR.041213/1YR FU PER DT

Assessments & Plan
1. Chronic kidney disease, Stage II (mild) - 585.2 (Primary)
2. Proteinuria - 791.0

****
Proteinuria: most likely represents early FSGS secondary to obesity. Ddx also includes IgA nephropathy (though less likely as she does not have any evidence of hematuria).

Preventive Medicine
-- Renal Transfer of Care --
Given patient's stability, she will be transferred back to primary care. We will not reschedule another renal clinic appointment at this time. If any questions/concerns arise, please don't hesitate to contact me (Delphine Tuot) by email or the renal clinic at 206.4777. I am happy to see her back in clinic if we can contribute to her care.
Below are some recommendations:
* Proteinuria: please try to minimize albuminuria to < 300mg/g if possible. You can titrate up the Benazepril as high as 40mg BID to achieve this effect, being mindful of her normal/low BP. At her next visit, I recommend increasing Benazepril to 20mg daily and then checking her K/Cr two weeks later. I tolerate an increase in creatinine of 15% and K as high as 5.5. Please check urine alb/cr ratio a few months later to see effect. If ratio is still > 300mg/g, please titrate Benazepril up by 10mg daily.
* Metabolic bone disease: Please check serum calcium, phosphorous, Vit D, and parathyroid hormone (PTH) yearly; if 25-OH Vit D is < 30, please replete with Ergocalciferol 50,000 units weekly x8 and then continue cholecalciferol 1,000-2,000 units daily.

Follow Up
prn

LAB: MICROALBUMIN CREATININE RATIO, URINE

ALBUMIN, URINARY QUANT.	170.6	H	(<11) - mg/L
URINARY ALB/CREA RATIO	438.6	H	(<30) - mg/g
CREATININE,URINE	38.9		- mg/dL

Notes : This lab was reviewed by Delphine Tuot on 04/15/2014 at 09:55 AM PDT

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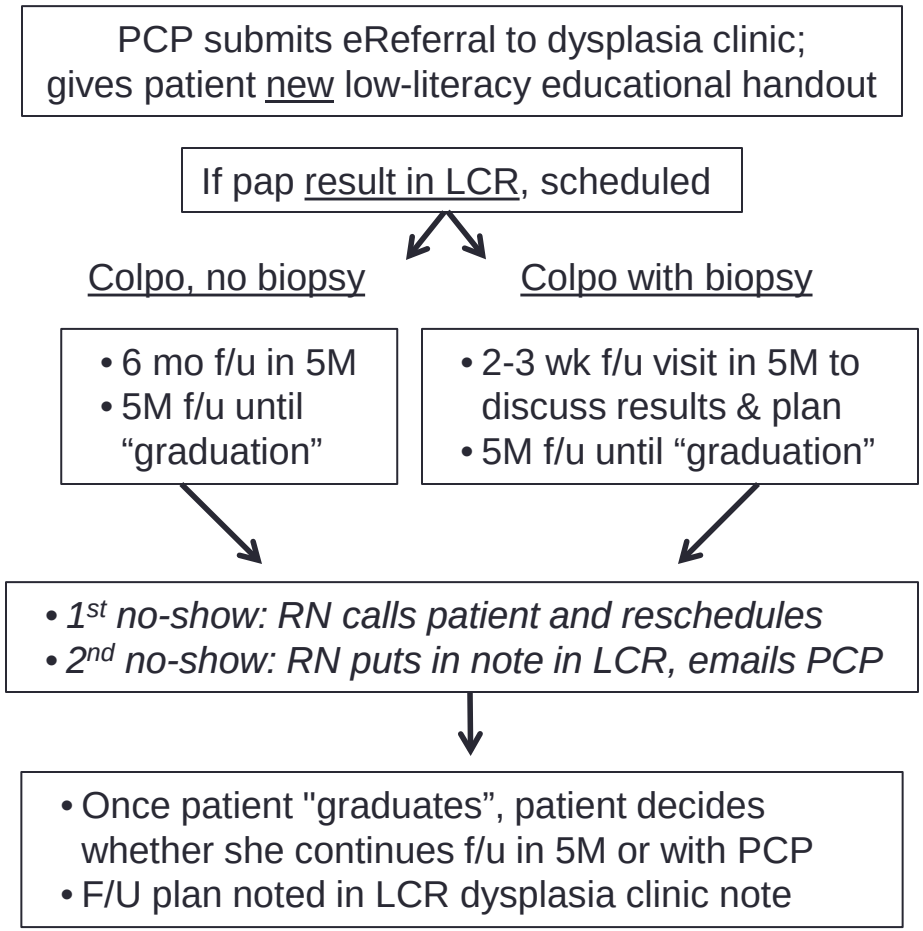
Follow Up
prn

Care coordination for high risk patients

UROLOGY REGISTRY

- Prostate cancer active surveillance
- i2i tracks software
- Patients identified by CPT
- Metrics
  - PSA screening q 6 months
  - Prostate biopsy yearly
- Urology panel manager identified
- N= 100 patients

GYNECOLOGY – PC HANDOFF



Enhancing PC capacity with education

Making It Work: Lifestyle Strategies and Clinical Tools for Diabetes, Obesity and Atherosclerosis
Friday, May 6th, 2011

8:00a – 8:30a	Registration/Breakfast
8:30a – 8:50a	Welcome/Introductory Remarks *Elizabeth Murphy, MD, DPhil*
8:50 – 9:20	The Power of Therapeutic Lifestyle Change *Thomas Bersot, MD*
9:20 – 10:10	Practical Nutrition in the 15-minute Office Visit *Mikelle McCoin, MPH, RD*
10:10 – 10:30	New Diabetes Tools and Resources *Elizabeth Murphy, MD, DPhil*
10:30 – 10:45	BREAK
10:45 – 11:45	Concurrent sessions: a) Aggressive Glycemic Control: Who needs it and who doesn't? *Elizabeth Murphy, MD, DPhil* b) Supporting Your Patients: Moving from oral agents to insulin. (Hands-on Learning) *Amalia Fyles, CNS, CDE, Elissa Hallen, RN, CDE, Charlotte Kuo, NP, and Audrey Tang, FNP.*
11:45 – 12:45	LUNCH HOUR
12:45 – 1:30	Breakout sessions a) Motivational Interviewing. *Susan Scheidt, Psy.D.* b) Thinking Outside the Box: Beyond the traditional 1:1 patient visit. *David Lown, MD* c) Improving Panel Management: Using your data. *Lisa Johnson, MD, and Lisa Golden, MD* d) Development of the DM RN Care Manager Role. *Amalia Fyles, CNS, CDE, and Elissa Hallen, RN, CDE.*
1:30 – 2:00	Clinic groups meet: formulating action plans.
2:00 – 2:45	Making the Most of SMBG. *Lawrence Fisher, Ph.D.*
2:45 – 3:00	Psychological Insulin Resistance: Addressing barriers. *Amalia Fyles, CNS, CDE.*
3:00 – 3:50	Hormone Replacement Therapy…Insulin, is it for everybody? *Kim Higgins, RN, CDE.*
3:50 – 4:10	Applying the Insulin Algorithm. *Suneil Koliwad, MD*
4:10 – 4:20	Closing *Elizabeth Murphy, MD, DPhil*

Orthopaedic Trauma Institute
UCSF + SAN FRANCISCO GENERAL HOSPITAL

Presented by the Orthopaedic Trauma Institute
and supported by the San Francisco Health Plan

Musculoskeletal Education Course for Primary Care Providers 2014

Intended for Primary Care Providers, this course reviews the evaluation and management of common orthopedic problems in the ambulatory setting, highlights the recent advances in musculoskeletal care, and facilitates improved referrals to the orthopaedic surgery service.

SESSIONS:

New Topic! February 27, 2014, Diagnosis and Treatment of Common Shoulder Conditions
New Date and Topic! March 25, 2014, Diagnosis and Treatment of Common Foot and Ankle Conditions
New Date and Topic! April 22, 2014, Orthotics and Prosthetics
New Date and Topic! May 20, 2014, Diagnosis and Treatment of Common Hand & Wrist Conditions
New Date and Topic! June 24, 2014, Management of OA of the Hip and Knee
New Date! July 22, 2014, Knee Injuries: Diagnosis and Management
New Topic! August 26, 2014, Muskuloskeletal Radiology 101
New Date and Topic! September 23, 2014, Knee & Shoulder Injections Lab
New Date! October 21, 2014, Treatment of Common Fractures in the Ambulatory Setting
New Topic! November 20, 2014, Management of Osteporosis and Fragility fractures

REGISTRATION:

Please email Erin Simon at simone@orthosurg.ucsf.edu to register for the course(s).
Each course has a maximum of 60 participants.
The cost is complimentary and includes light refreshments and snacks.

LOCATION/TIME:

All sessions will be held, 6-8pm, at OTI.
Orthopaedic Trauma Institute (OTI) at SFGH
2550 23rd Street, Building 9,
2nd Floor Conference Room,
San Francisco, CA

ACCREDITATION:

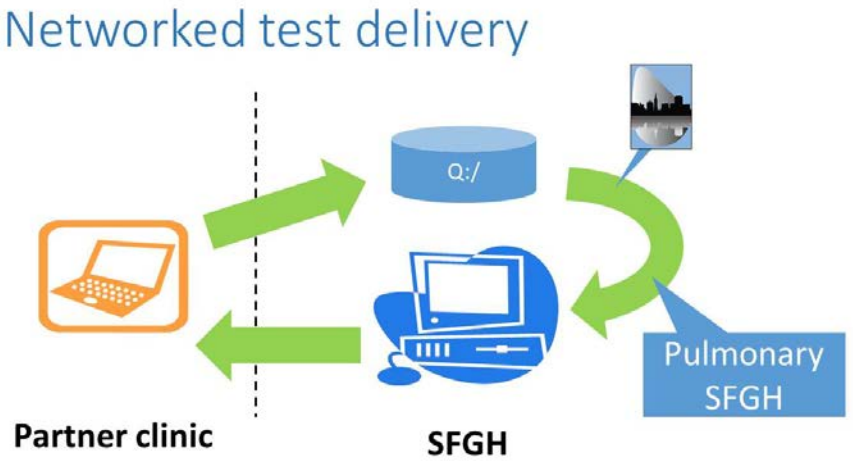
American Academy of Family Physicians has approved the course for CME credit and Dr. Anne Rosenthal will make a few announcements about this during opening remarks.

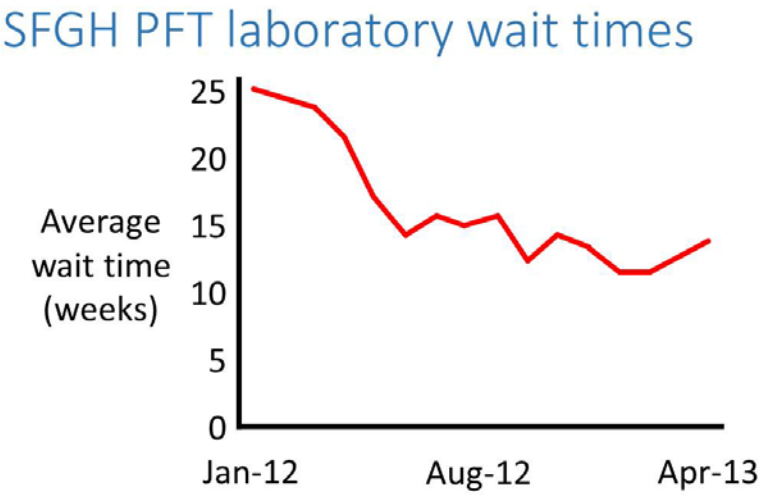
FOR MORE INFORMATION:

Please log onto - http://orthosurg.ucsf.edu/oti
or email Erin Simon at SimonE@orthosurg.ucsf.edu

Hospital to community: spirometry

- Off-load PFT lab
- Store-and-forward file delivery
- Quality assurance provided by SFGH staff: poor results returned and reviewed with coach; real time support provided via videoconference
- Interpretations and results posting to EMR
- >1,300 reviewed, >800 posted since October 2011





KP Specialty Care Initiative Team

STEERING COMMITTEE

Organization	Name	Role
SFGH	Alice Chen, MD, MPH	Project Lead, SFGH Chief Integration Officer, eReferral Director
SFCCC	David Lown, MD, MA	Chief Medical Officer
COPC	Lisa Johnson, MD	Medical Director
SFGH	Delphine Tuot, MD, MAS	Evaluation Lead
SFGH	Justin Sewell, MD, MPH	Gastroenterology Clinic
SFGH	Elizabeth Murphy, MD, DPhil	Chief, Endocrinology
SFGH CIAQ	Kiren Leeds	Project Coordinator

ENDOCRINOLOGY WORK GROUP

Role	Name	Clinic
Specialty Lead	Elizabeth Murphy, MD, DPhil	Endocrinology
Specialty Co-Lead	Jennifer Park-Sigal, MD	Endocrinology
SFCCC	Kenneth Tai, MD	North East Medical Services
COPC	Lisa Johnson, MD	Medical Director
SFGH Campus Clinics	Hali Hammer, MD	SFGH Family Health Center
Evaluation Lead	Delphine Tuot, MD, MAS	Nephrology

PULMONARY WORK GROUP

Role	Name	Clinic
Specialty Lead	George Su, MD	Pulmonary
SFCCC	Peter Berman, MD, MPH	South of Market Health Center
COPC	Lisa Johnson, MD	Medical Director
SFGH Campus Clinics	Katie Murphy, MD	SFGH Family Health Center
Evaluation Lead	Hilary Seligman, MD, MAS	Nephrology

GI WORK GROUP

Role	Name	Clinic
Specialty Lead	Justin Sewell, MD, MPH	Gastroenterology
Specialty Co-Lead	Lukejohn Day, MD	Gastroenterology
SFCCC	Ricardo Alvarez, MD	Mission Neighborhood Health Center
COPC	Albert Yu, MD, MPH, MBA	Chinatown Public Health Center
SFGH Campus Clinics	Alice Chen, MD, MPH	SFGH General Medicine Clinic
Evaluation Lead	Delphine Tuot, MD, MAS	Nephrology

ORTHOPAEDIC SURGERY WORK GROUP

Role	Name	Clinic
Specialty Lead	Theodore Miclau, MD	Chief, Orthopaedic Surgery
Specialty Co-Lead	Harry Jergesen, MD	Orthopaedic Surgery
Specialty Co-Lead	Saam Morshed, MD	Orthopaedic Surgery
Specialist	Brenda Stengele, NP	Orthopaedic Surgery
SFCCC	David Lown, MD, MA	Chief Medical Officer & St. Anthony Medical Clinic
COPC	Trudy Singzon, MD, MPH	Maxine Hall Health Center
SFGH Campus Clinics	Margot Kushel, MD	SFGH General Medicine Clinic
SFGH	Dana Nelson, RN	Nurse Manager, Orthopaedic Surgery, 4M, EKG
SFGH	Juliann Fusaro, RN, MSN, CNL	Orthopaedic Surgery
SFGH	Terry Dentoni, RN, MSN, CNL	Chief Nursing Officer
Evaluation Lead	Delphine Tuot, MD, MAS	Nephrology

SFGH: San Francisco General Hospital
COPC: SF Department of Public Health Community Oriented Primary Care
SFCCC: San Francisco Community Clinic Consortium

BSCF Safety Net Integration Team

STEERING COMMITTEE

Organization	Name	Role
SFGH	Benjamin Breyer, MD	Urology Lead
SFGH	Alice Chen, MD, MPH	Project Co-Lead, SFGH Chief Integration Officer
SFGH	Rebecca Jackson, MD	Obstetrics and Gynecology Lead
COPC	Lisa Johnson, MD	Medical Director
SFCCC	David Lown, MD, MA	Project Lead, SFCCC Chief Medical Officer
SFGH	Delphine Tuot, MD, MAS	Evaluation Lead , Nephrology Co-Lead
SFGH CIAQ	Kiren Leeds	Project Coordinator

NEPHROLOGY WORK GROUP

Role	Name	Clinic
Specialty Lead	Sam James, MD	Nephrology
Specialty Co-Lead and Evaluation Lead	Delphine Tuot, MD, MAS	Nephrology
SFCCC	Laurence Peiperl, MD and Nicole Una, NP	Glide Clinic
COPC	Elsa Tsutaoka, MD	Southeast Health Center
SFGH Campus Clinics	Elizabeth Davis, MD	General Medicine Clinic

UROLOGY WORK GROUP

Role	Name	Clinic
Specialty Lead	Benjamin Breyer, MD	Urology
SFCCC	Jerry Jew, MD	North East Medical Services
COPC	Heralio Serrano, MD	Castro-Mission Health Center
SFGH Campus Clinics	Jacqueline Tulsky, MD	Positive Health Program
Evaluation Lead	Delphine Tuot, MD, MAS	Nephrology

OB/GYN WORK GROUP

Role	Name	Clinic
Specialty Lead	Rebecca Jackson, MD	Chief, Obstetrics and Gynecology
SFCCC	Rosalia Mendoza, MD	Mission Neighborhood Health Center
COPC	Sandy Wu, NP	Silver Avenue Health Center
SFGH Campus Clinics	Isabel Lee, MD	Family Health Center
Evaluation Lead	Delphine Tuot, MD, MAS	Nephrology

Ambulatory Integration Team
Luke Day
Kathryn Horner
Marika Russell

SFGH: San Francisco General Hospital
COPC: SF Department of Public Health Community Oriented Primary Care
SFCCC: San Francisco Community Clinic Consortium

SPECIALTY OPERATIONS

developing systems to support specialty clinic improvements

Needs assessment

- Assessment of current state, strengths, and challenges
- Included 26 medical and surgical clinics
- Analysis included
  - Baseline operational data
  - Clinic leadership interviews
  - Patient perspectives

NEEDS ASSESSMENT OF SFGH MEDICAL & SURGICAL SUBSPECIALTY CLINICS

Prepared by:

THE SFGH AMBULATORY INTEGRATION TEAM

Authors:

Lukejohn Day, Kathryn Horner, Marika Russell, George Su, and Alice Chen

March 2013

Needs assessment findings

STRENGTHS

- Locally, nationally and internationally recognized for patient care, research and teaching
- Working on innovative and cutting edge ways in which to deliver healthcare
- Strong commitment to caring for the underserved of San Francisco
- Dedicated to educating future healthcare providers

CHALLENGES

- Space
- IT infrastructure
- Human resources/staffing
- Interpreter services
- Scheduling templates
- High and unpredictable no-show rate
- Care coordination

Action plans

DATA-DRIVEN IMPROVEMENT

- Need for timely, relevant, actionable data
- **Data dashboards**
  - Operational
  - Patient experience
  - Clinical
  - Financial

OPERATIONAL EFFICIENCIES

- Standardizing scheduling templates
- Standardizing telephone trees
- Improving access to interpreter services
- Decreasing no show rates

Action plans

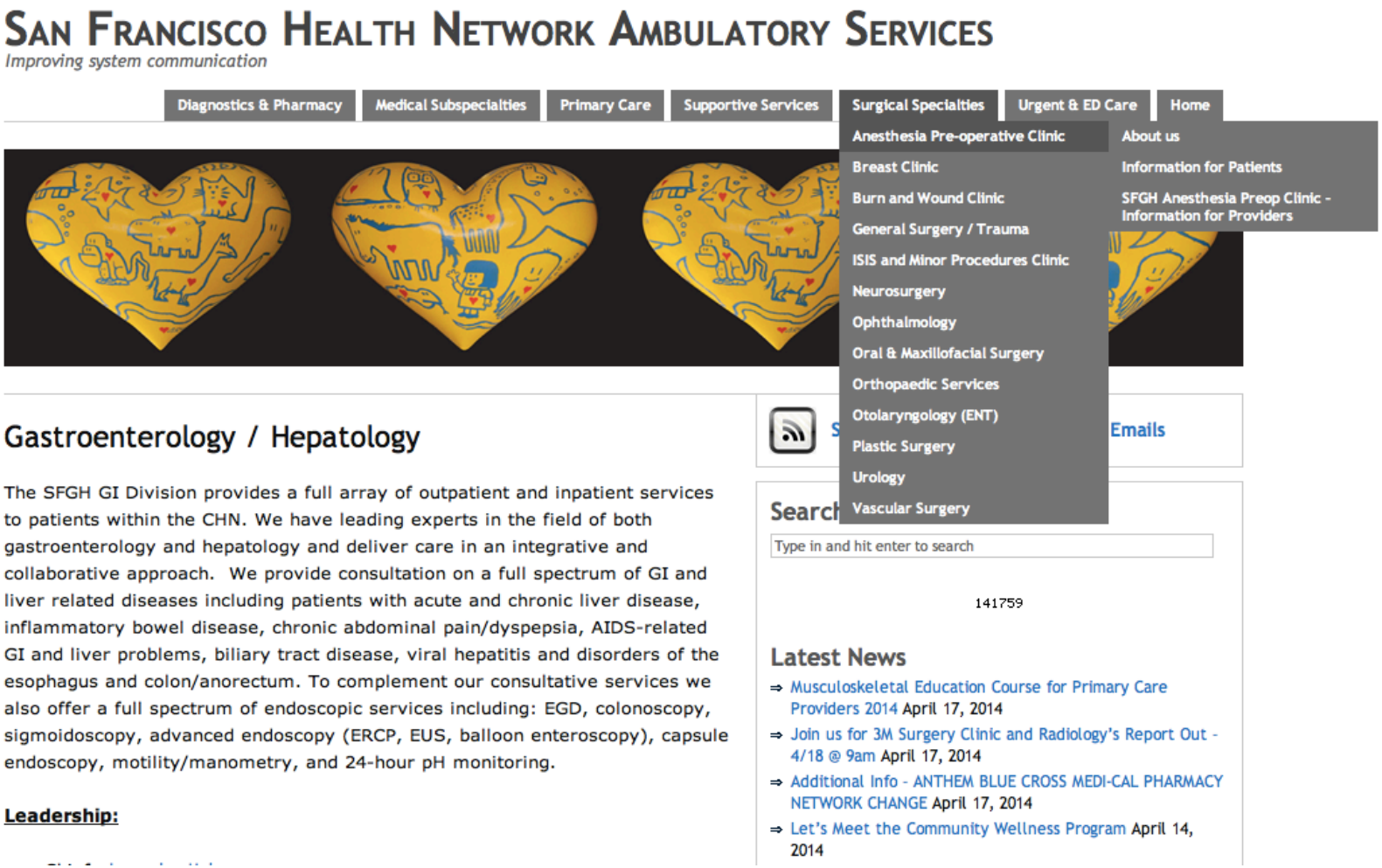
SERVICE EXCELLENCE

- Move from reactive patient grievances to systematic assessment of patient experience
- **CG-CAHPS**
- Poker chip project
- Patient shadowing

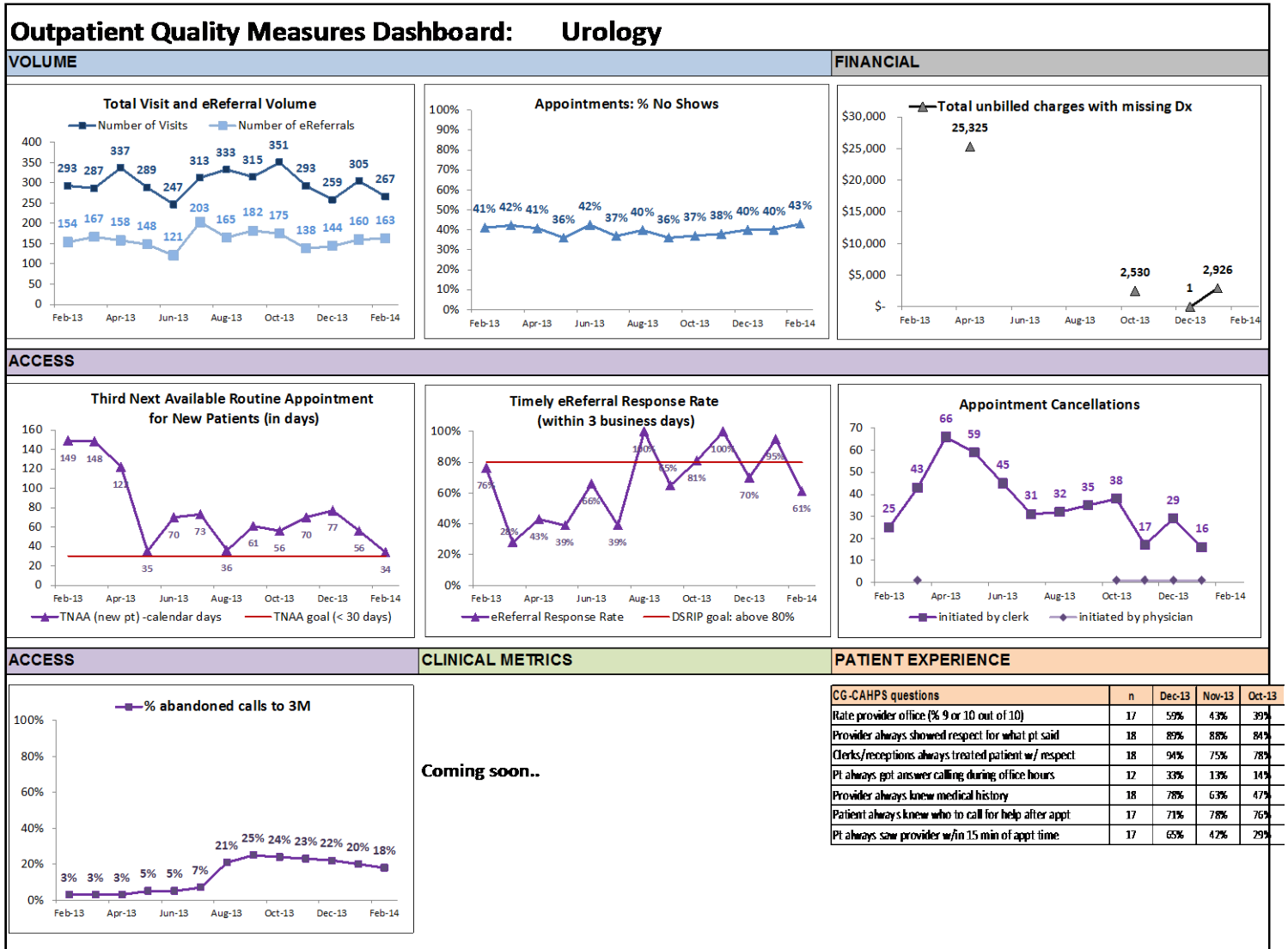
HEALTH REFORM

- **Focus on timely access**
- Implementation of “pay for performance” programs
- **Promote development of integrated delivery system**
  - Increased transparency about clinical services (internet)
  - Improved communication across clinical services (eCW implementation)

Ambulatory internet

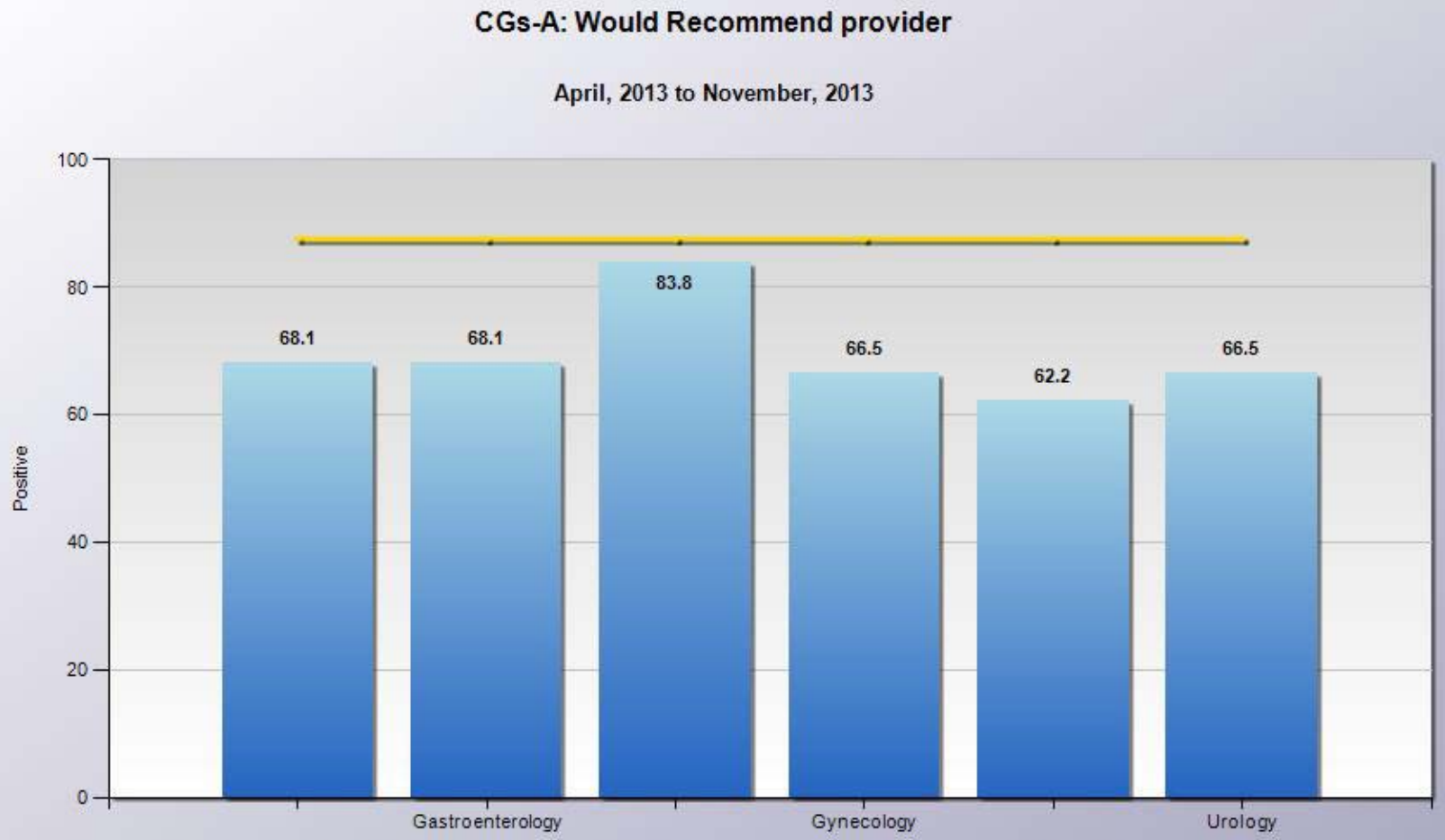


Specialty dashboards



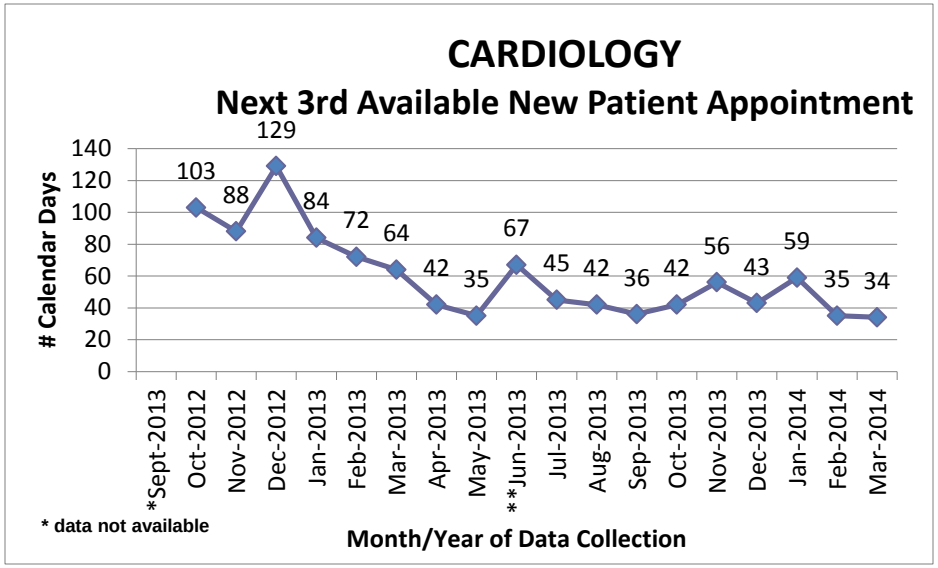
CG-CAHPS questions	n	Dec-13	Nov-13	Oct-13
Rate provider office (% 9 or 10 out of 10)	17	59%	43%	39%
Provider always showed respect for what pt said	18	89%	88%	84%
Clerks/receptions always treated patient w/ respect	18	94%	75%	78%
Pt always got answer calling during office hours	12	33%	13%	14%
Provider always knew medical history	18	78%	63%	47%
Patient always knew who to call for help after appt	17	71%	78%	76%
Pt always saw provider w/in 15 min of appt time	17	65%	42%	29%

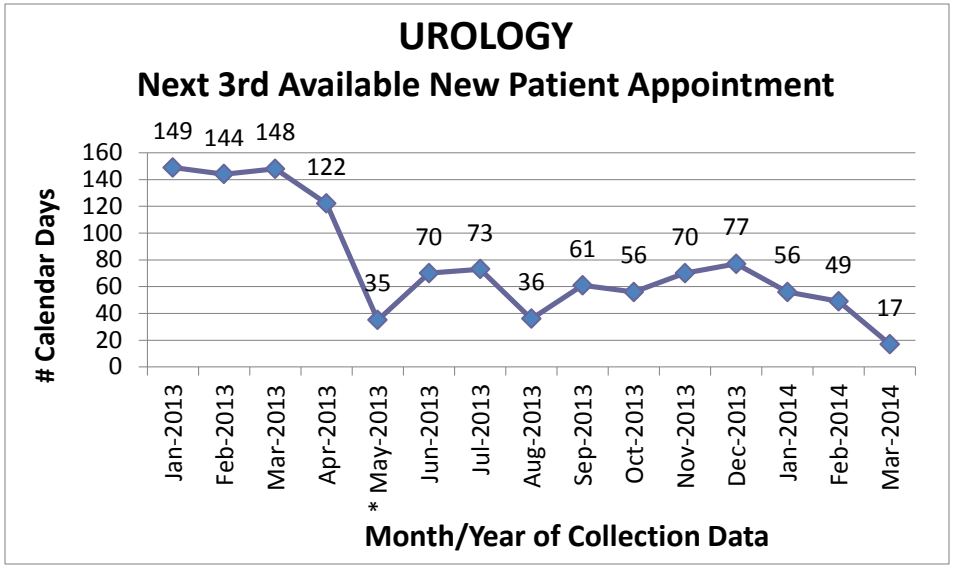
CG-CAHPS

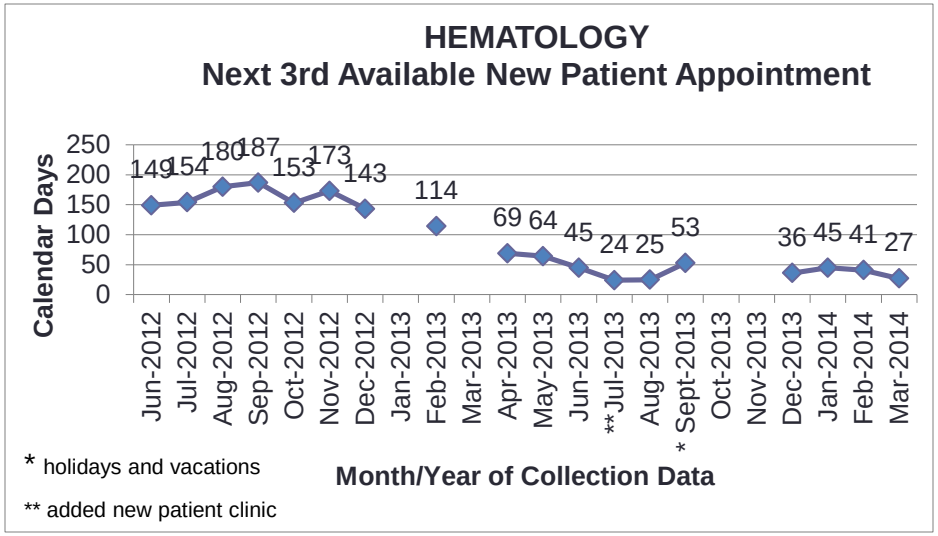


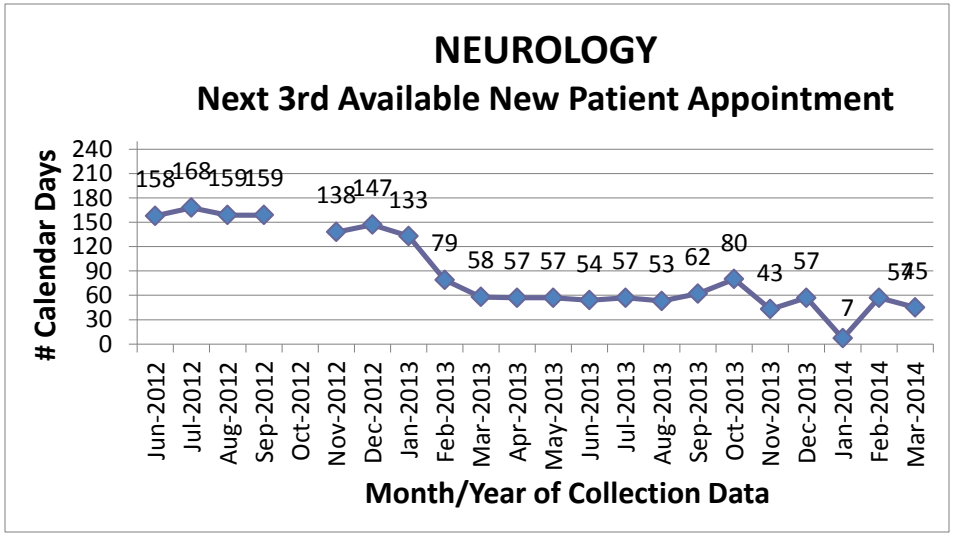
Response rates: 28% 32% 36% 24% 24% 30%

Timely access successes









Timely access ongoing challenges

Consistently >60 days

- Dermatology*
- Nephrology
- Ophthalmology*
- Orthopedics
- (Pain)
- (Plastics)

Consistently >120 days

- Audiology
- Echocardiography
- Exercise treadmill
- Pulmonary function tests

**telehealth planned*

Performance improvement program

Attachment 1: Overview of PIP Measures, Due Dates and Points

CPG Matrix of Measures				
Domain	**Measure**	**Max Pts**	**Reporting**	**Annual Due Date**

eCW implementation

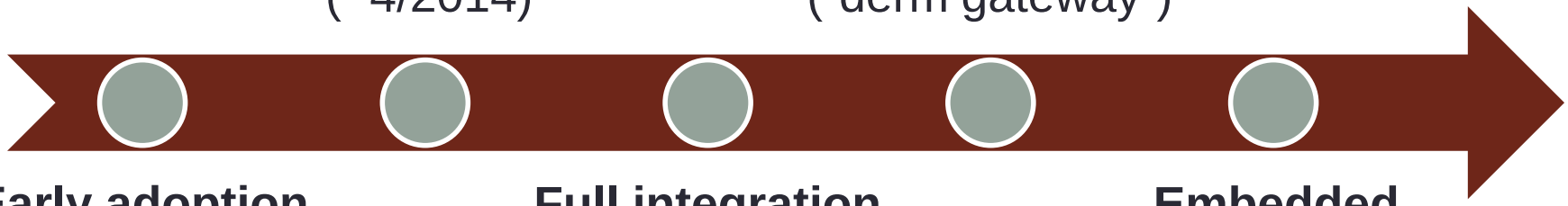
“LIVE” WITH eCW

- Cardiology
- Diabetes
- Dermatology
- Endocrinology
- Gastroenterology
- Hepatology
- Lipid
- Nephrology
- Pain
- Pulmonary
- Rheumatology

TO BE LAUNCHED

- General surgery
- Hematology
- Neurology
- Neurosurgery
- Oncology
- Ophthalmology
- Oral surgery
- Orthopedics
- Otolaryngology
- Urology
- Women’s health

Telehealth initiatives



Early adoption
Derm (11/2013)
Walk-in retinopathy screening
(10/2012)

“ICIS”
Completion of Imaging clinical information system
(~4/2014)

Full integration
Active directory
“Openlink” integration with EMRs
(~4/2014)

Full rollout (Derm)
Start ~7/2014
Goal: All COPC and hospital based clinics
(“derm gateway”)

Embedded retinal cameras
6 cameras distributed in “nodal” centers
(~10/2014)

Teledermatology

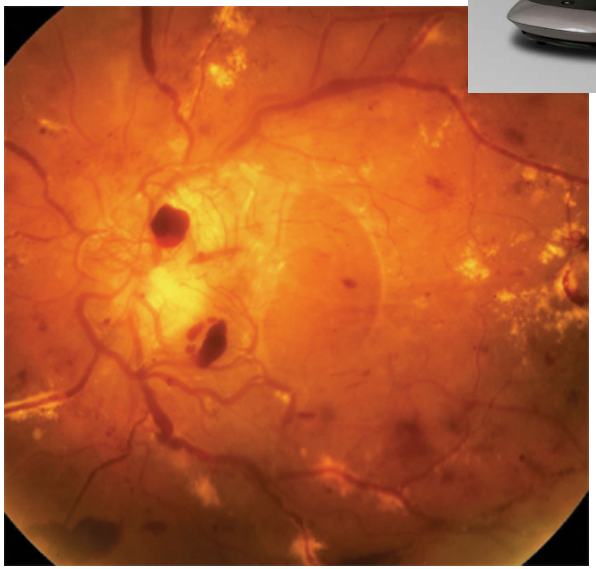
- Dermatology wait times 71-101 days
- Up to 70-80% of referred cases can be managed with photos
- OPHC and CPHC early adopter clinics (11/2013)
- Currently establishing resource and support requirements for full SFHN rollout

Medweb®
Distributed RIS/PACS and Telemedicine

Teleretinopathy

optos®

OIS

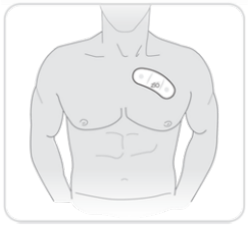


- Optometry wait 65-85 days
- Diabetic retinopathy is the leading cause of blindness among working-age adults
- Early detection and treatment can reduce vision loss by 90%
- Walk-in service debut 10/2012; over 160 studies performed to date
- 6 Optos cameras will be embedded in PC for point-of-service imaging

Specialty diagnostics: Zio Patch

SFGH eReferral

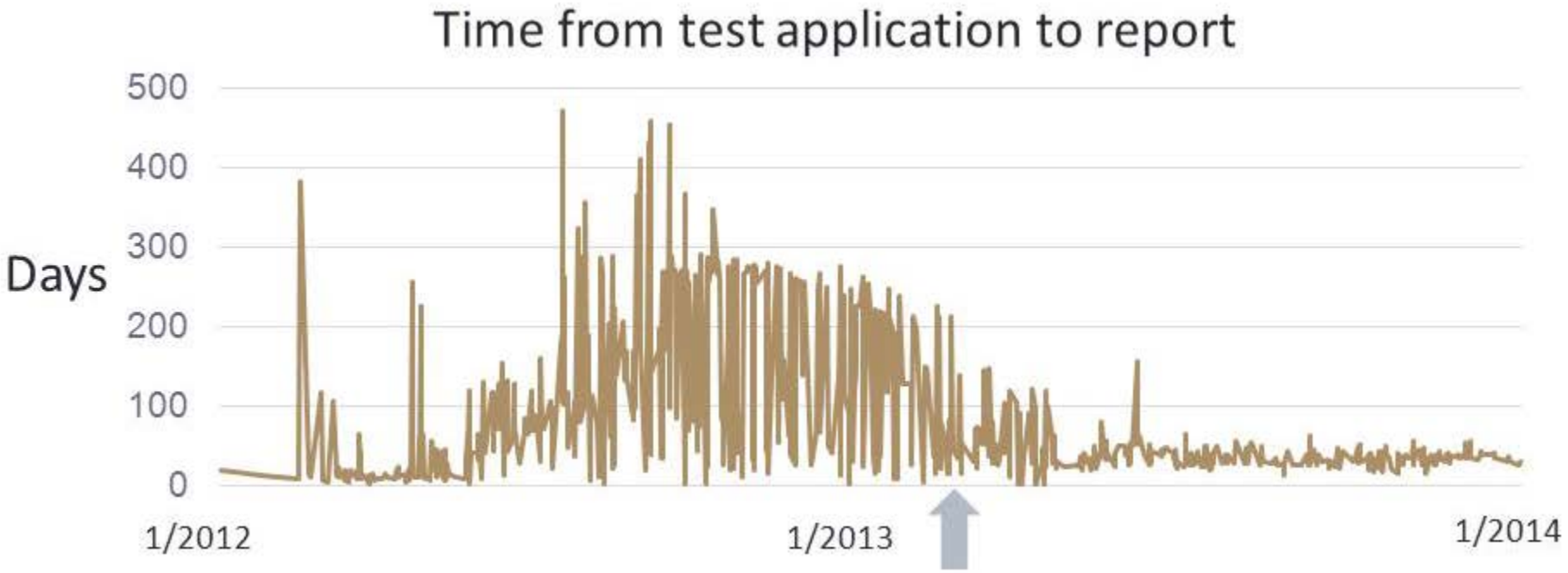
↑ comfort
↑ ease of use



↑ diagnostic yield vs. Holter (14 days of data vs. 1-2 day)

Mail to iRhythm (outsourced data processing)
In-house
~ 5 months

Report to SFGH Cardiology



LOOKING FORWARD

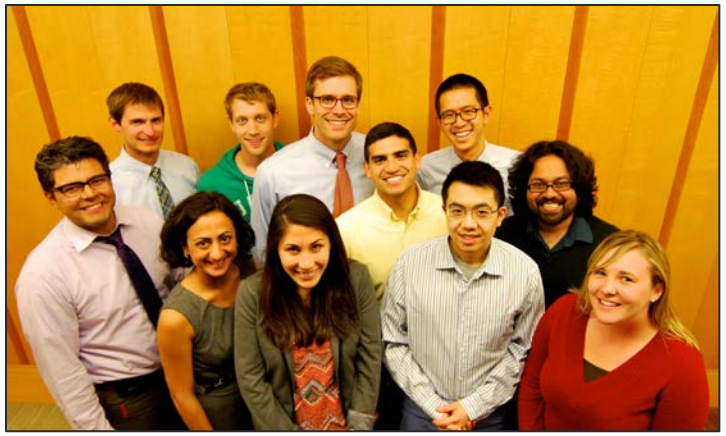
priority areas in the era of the San Francisco Health Network

SF CARES

Strategy for Coordinating Access & Resources for Excellence in Specialties

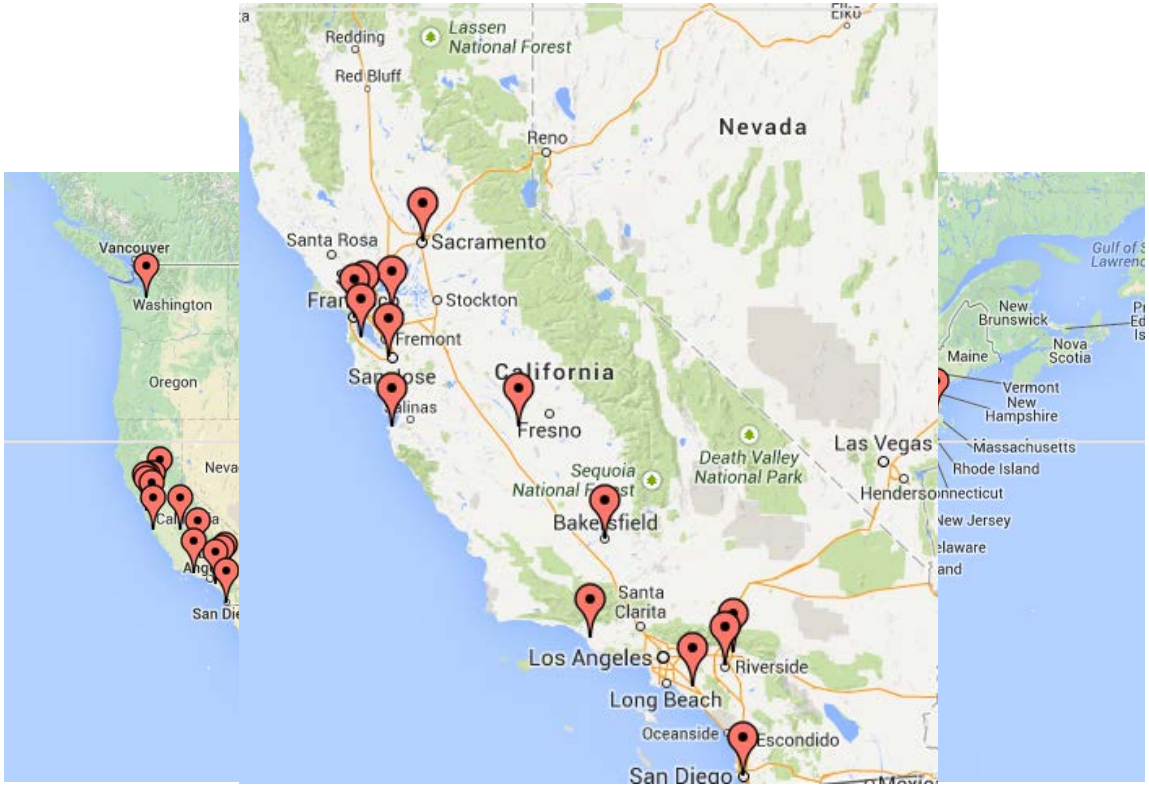
Optimizing Ambulatory Specialty Care in the Safety Net

PATHWAYS TO DISCOVERY HEALTH & SOCIETY

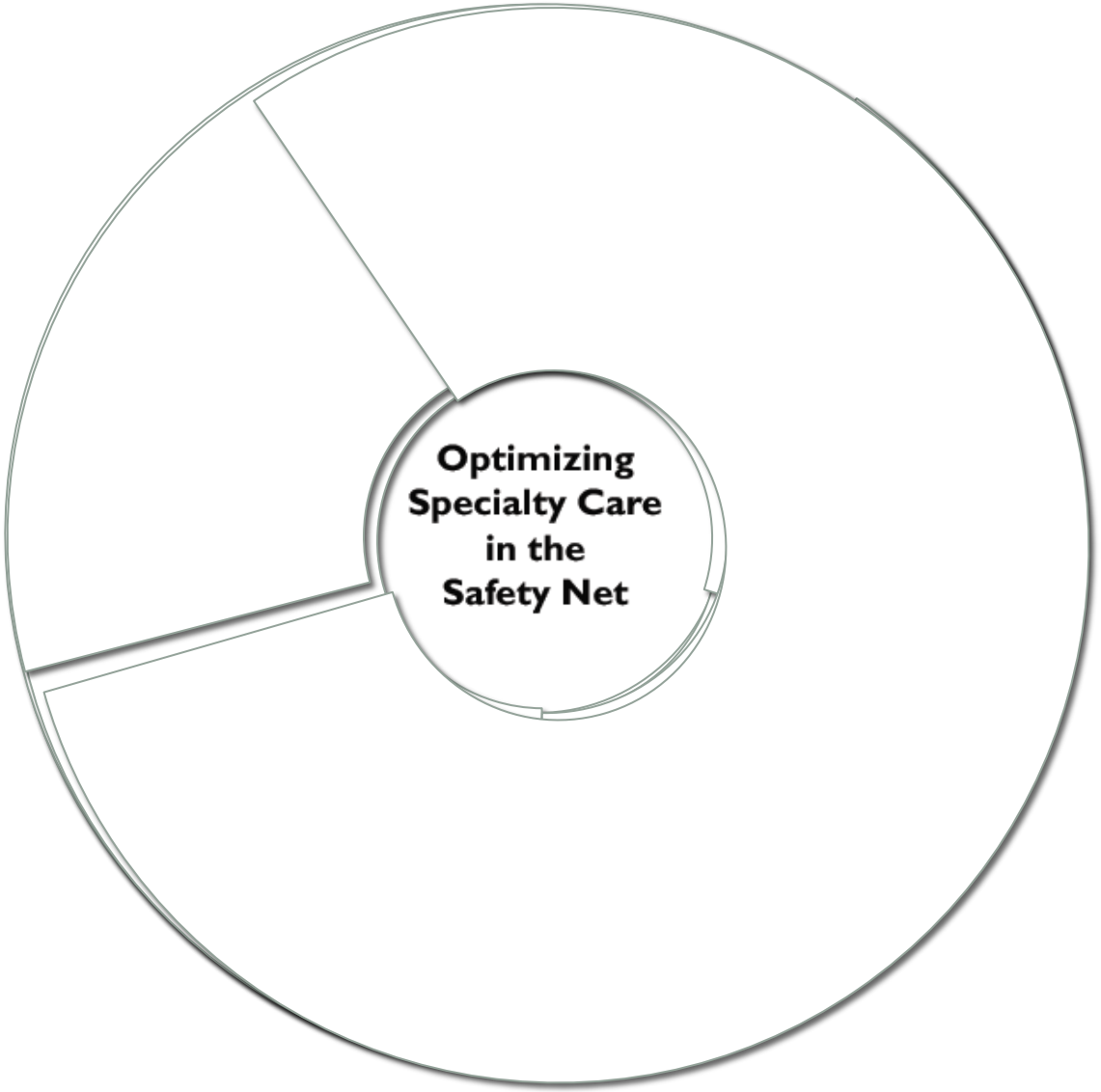


Methods

- 31 hospitals, 18 respondents
- Semi-structured phone interviews
- Quantitative survey
- Themes extracted from interview transcripts



A Comprehensive Approach to Optimizing Specialty Care



Taking stock 2013

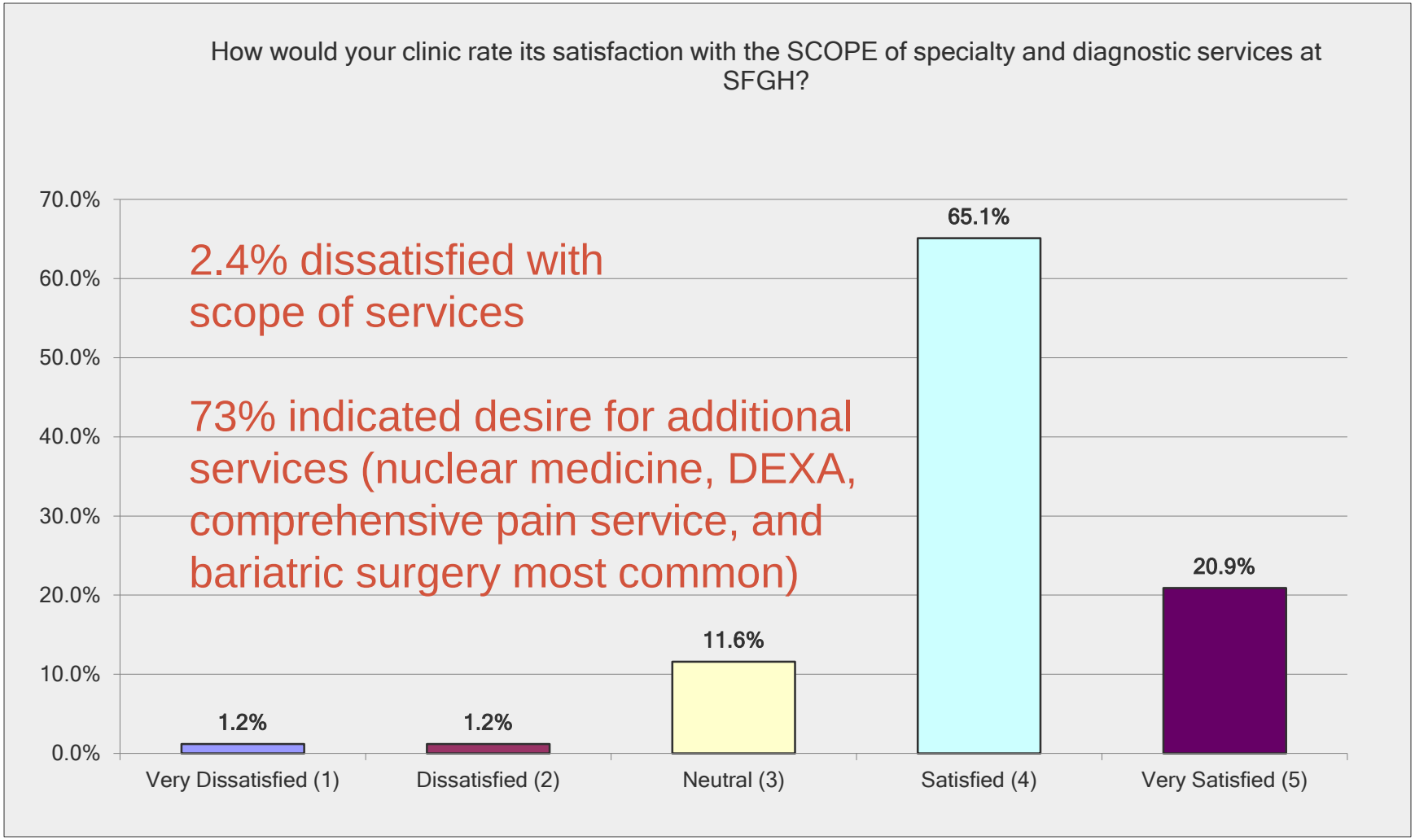
REFERRING PROVIDERS

- 87 respondents
- 20 clinics represented
- Scope
- Access/wait times
- Communication

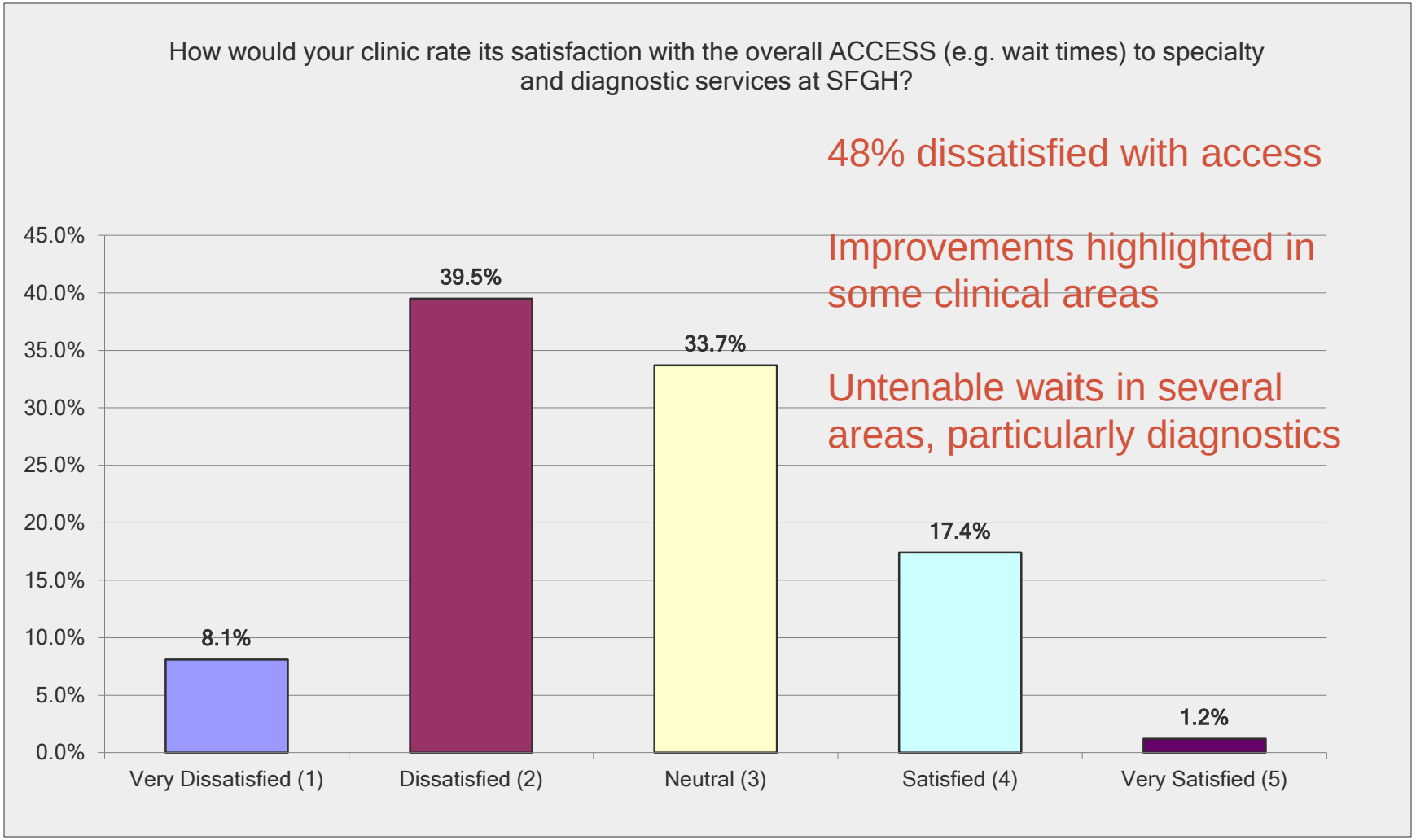
SPECIALIST PROVIDERS

- 42 respondents, MD and RN
- 28 clinics represented
- Barriers to serving insured patients

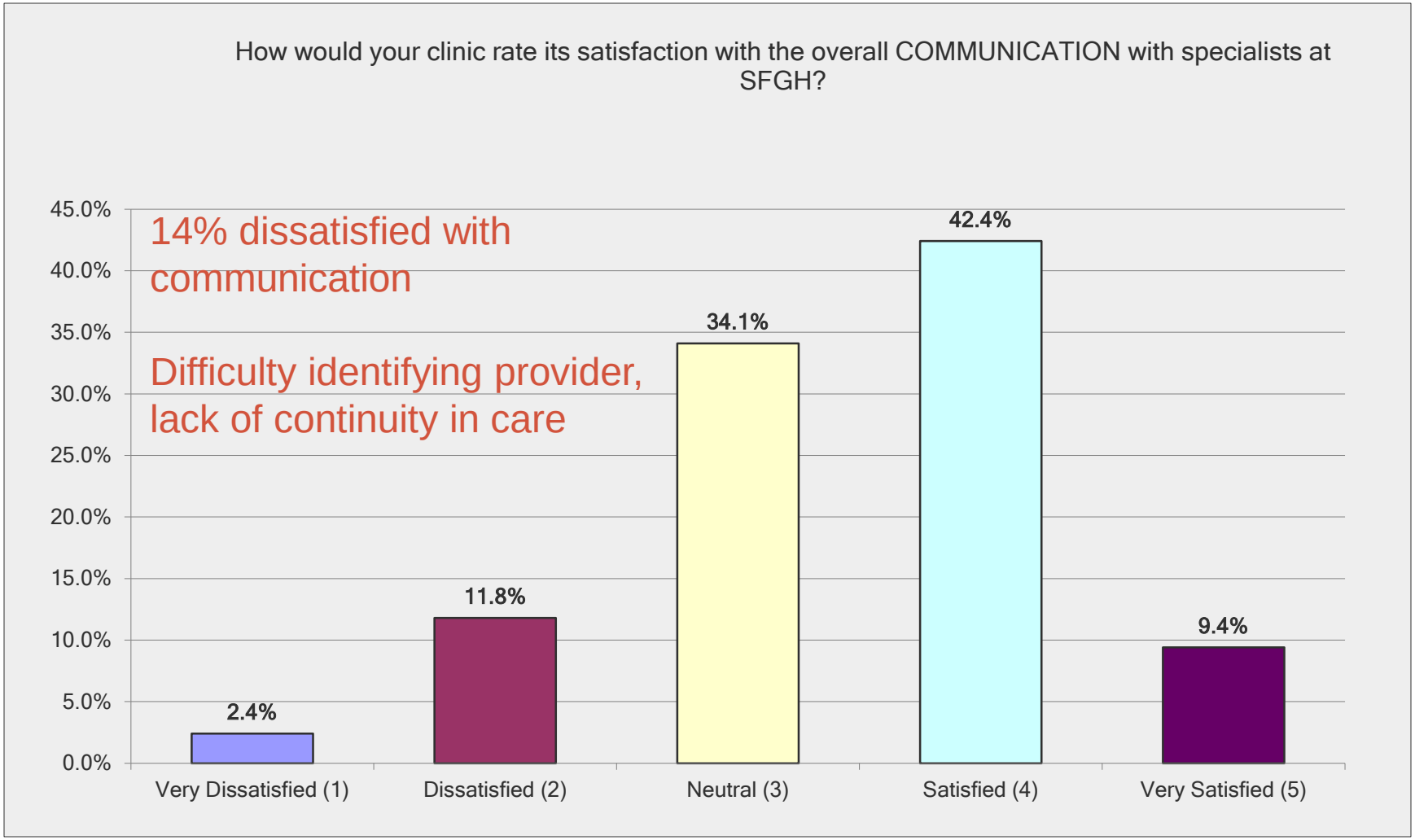
Referring provider survey



Referring provider survey



Referring provider survey



Specialist survey

Barriers to providing care to privately insured

- Insufficient space
- Insufficient attending/provider staffing
- Insufficient support staff
- Poor physical plant
- Long wait times
- OR limited capacity/long wait times
- Lack of billing infrastructure
- Service excellence/attitudes towards patients
- Negative perceptions of county hospital

Key priorities

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

- eCW implementation, optimization, and MU attestation
- Spread of CG-CAHPS, provider scheduling and telephone access
- Focus on no shows
- Ongoing access work with targeted clinics
- Establishing medical director for every clinic
- Access to diagnostics
- More, better data to drive improvement and proactive planning
- eReferral replacement
- Rational co-location of services in building 5

Team

Alice Chen, Chief Integration Officer

Luke Day, Medical Director Medical Subspecialties

Kathryn Horner, Administrative Director for Ambulatory Care

Kiren Leeds, CIAQ Manager

Tekeshe Mekonnen, eReferral Program Manager

Lisa Murphy, eReferral Specialty Lead

Marika Russell, Medical Director Surgical Subspecialties

Justin Sewell, CIAQ/eReferral faculty

George Su, Medical Director Telehealth

Delphine Tuot, CIAQ/eReferral faculty, lead evaluator

THANK YOU!

Blue Shield of California Foundation

California HealthCare Foundation

Kaiser Permanente Community Benefit

San Francisco Health Plan

SFGH Foundation