ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on May 25, 2021
May 2021 MEC Meetings

Community Primary Care (CPC) Service Report – Joseph Pace, MD, Service Chief

Details of the reports are as follows:

I. Scope of the Clinical Service
   A. Vision - CPC's vision incorporates the True North Values by providing high quality health care that enables San Franciscans to live vibrant and healthy lives, along with building a strong foundation of a healthy, engaged, and sustained Primary Care workforce.
   B. Structure of the Department
      1. CPC involves two areas: Primary Care and Whole Person Integrated Care. These 2 areas fall under Ambulatory Care per DPH's organizational structure. CPC services patients both at ZSFG campus and the community.
      2. The CMO, Dr. Joseph Pace, oversees credentialing of medical providers at the community-based clinics and Whole Person Integrated Care. His DPH colleagues in management team and other discipline leads (e.g., Director of Nursing and Director of Behavioral Health) supervise both community-based and Primary Care staff at ZSFG.
   C. Clinical Services/Programs
      1. There are 10 clinics/programs across SF which provide full spectrum primary care for children, adolescents, pregnant women, and adults.
      2. At multiple clinics, special population focus is provided to the following:
         a. Adolescents/Transitional Age Youth (CHPY)
         b. Elders (Curry)
         c. Gender Health (CHMC, TWUHC)
         d. People Experiencing Homelessness/Unstable Housing (TWUHC)
         e. People Living with HIV (CHMC, MHHC, SEHC, TWUHC)
      3. Behavioral Health and Substance Use Services include the following:
         a. Behavioral Health teams – Services are administered by Behavioral Health clinicians, comprising mostly of social workers. Other staff members include MSTs and behavioral assistants, with the latter helping in various tasks that include Smoking Cessation counseling and support of providers with resource and benefits access.
         b. Primary Care Psychiatry – Most sites have 4 hours/week consultative model. TWUHC has the highest number of psychiatrists with 3 clinicians on-site throughout the week.
         c. Behavioral Health Homes – Primary Care is brought into Behavioral Health with partnership of 4 PC clinics and stand-alone Behavioral Health/Mental Health clinics. PC services are directly rendered on-site to patients at the Mental Health clinics. The partnerships are the following: (1) CHMC/MMH, (2) CPHC/CTNB, (3) OPHC/SMH, and (4) SOMMH/TWUHC.
         d. Office-Based Opioid Treatment – Several clinics provide service which involves not only buprenorphine treatment through x-waiver but also methadone maintenance treatment (Potrero Hill Health Center and TWUHC received waiver from the state for a number of years) for stable patients and those discharged from the methadone maintenance program.
      4. Ancillary Services – These include areas of Complex Care Management, Dental (clinic and school-based), Integrative (Acupuncture), Nutrition Counseling, Pharmacy, Podiatry, and Tattoo Removal.
      5. Centralized Call Center – The center hosts the New Patient Access Unit, Nurse Advice Line (M-F, 7 am–7 pm), and Telephone Appointment Providers (for past several years/pre-COVID).
      6. Whole Person Integrated Care (WPIC) – The service has 4 programs which are Medical Respite and Sobering Center, Shelter Health, Street Medicine, and Tom Waddell Urgent Care.

II. Providers and Patients
   A. Credentialed Providers – There are 154 credentialed providers, most of which are physicians (66) and NPs/PAs (43). There are also 11 Obstetrician/Gynecologists who are operating at the New Generation Health Center, a DPH clinic (formerly a UCSF clinic). A neurologist serves patients with dementia and the elderly.
   B. Patients –
      1. SFHN PC Managed Care Enrollment (Healthy Workers, Healthy San Francisco, Medi-Cal) - From Aug 2018 to February 2020, there was a steady decline in the enrollment. March 2020 was the inflection point caused by the pandemic with the following occurrences:
         a. Many became unemployed and subsequently became Medi-Cal eligible.

b. Both Medi-Cal and Healthy San Francisco waived requirement for yearly re-enrollment. To date, the number of patients continues to increase.

2. Patient Profile – There are about 63K active patients and close to 30K patients enrolled and not yet active. From April 2020-April 2021, there were 280K encounters. Majority of patients are Black, Indigenous, and People of Color. Also, most are adults. There are about 48% male patients and 52% patients, with <0.5% non-binary patients. The top 10 diagnoses include hypertension, hyperlipidemia, chronic pain, among others.
3. Primary Care Visits –
   a. With EPIC's launch in August 2019, the number of patients declined that month which is not uncommon with new electronic health record system that entails learning new workflows.
   b. Subsequently, the volume of patient visits was stabilizing back at the normal level until the pandemic resulted to decreased number of total visits.
   c. The pandemic also led to utilization of telehealth visits with April 2020 posting lowest number of in-clinic visits and highest number of telehealth visits.
   d. The number of patients continues to rise with volume better than pre-EPIC figures. For the last couple of months, in-clinic visits substantially increased. The COVID restrictions continue to limit the number of in-clinic visits particularly for space-challenged clinics.

III. COVID-19 Response

A. Focus on Equity – For both COVID testing and COVID vaccinations, there are several strategies: (1) prioritize Black and Latinx communities, (2) locate vaccine in hard-hit communities, (3) create low-barrier access, and (4) allocate scarce resources to SFHN.

B. Services – Novel services arose due to the pandemic. The PC staff (hospital and community) was called to support Covid Command Center (C3) in its development and staffing (i.e., guiding policies, leadership positions, etc.). The services include the following:
   1. Testing – Alternate Test Sites (CMHC/MMH, MHHC, PHHC, SEHC, ZSFG), Mobile Testing, and Result Disclosure
   2. Field Care Clinic (SEHC)
   3. Vaccination – Hubs (MHHC, PHHC, SEHC, ZSFG) and Mobile Vaccination for hard to reach/homebound
   4. Outreach calls to patients with high-risk conditions
   5. Isolation/Quarantine (I/Q) sites – implementation and clinical support
   6. Shelter In Place (SIP) sites – implementation and clinical support
   7. C3 Deployments

C. Centralized Call Center – The Center expanded to 24/7 services with additional on-call CPC physicians for support to the innumerable calls and types of calls since February 2020. The calls relate to the following:
   1. Approval for COVID testing
   2. After-hours risk assessment for daycare, housing programs, schools, etc.
   3. Anyone tested or vaccinated at sites
   4. Support for I/Q nursing staff: referrals, review for discharge, medical advice, initiation of low barrier substance use treatment (managed alcohol; buprenorphine for OUD)
   5. General Public
   6. "Other duties as assigned"

D. COVID Deployments – A huge proportion of total FTE was deployed to COVID-specific tasks. Those left serving at the clinic have taken full responsibly to care for patients (in-person or telehealth).

E. COVID Testing –From February 2020–April 2021, 60% of testing across network was done at CPC sites. The 10.6% positivity rate across all SFHN sites (CPC and hospital) was much higher than the .6% average citywide positivity. The fact that 10.6% positive COVID patients received primary care at SFHN underscores that CPC served and continues to serve communities that are most impacted by the pandemic.

F. COVID-19 Vaccine Outreach – The multipronged approached included text messaging (126K texts), robo-call (25K calls), outreach phone call (9.5K calls), and vaccine webinars. All these were done with prioritization for those hardest hit or most at risk by race, ethnicity, and zip code. The yield was quite low, but much was learned in reaching out to people and tailoring outreach efforts to their needs.

G. Data Informs Strategy – With the efforts of Population Health Team, a series of data slides was prepared and shared with clinics and management team on a daily basis to quickly pivot strategy and optimize its effectivity.

H. Vaccine Equity – In comparison to many areas in US, the SFHN vaccine access matched the burden of infections. Most SFHN vaccine access sites were concentrated at areas with highest COVID-19 cases per 10K residents.

IV. Primary Care True North and Driver Metrics – The complex needs of CPC patients were exacerbated by the pandemic due to decreased in-patient care or patients' high-risk conditions. The metrics are being utilized to refocus

on how to bring patients back to care and to close care gaps. Also, the murders of Black/African Americans have focused attention on racial bias in the city and healthcare system. In response, the following have been developed:

A. Anti-Racism and Equity Action Plan – This entailed a multi-month process in developing A3 by front-line staff, clinic managers, and PC leaders. The primary areas of focus are both patient experience/outcomes and staff experience/development opportunities. This plan has been presented to all clinic management teams, leading to establishment of a standing Anti-Racism and Equity Committee.
B. Racial Health Disparities – A comparison of PC Health metrics (done in January 2021) for all patients versus Black/African American patients was performed.
    1. Lower percentages for the Black/African American patients indicate failure in serving them in various areas such as adolescent and childhood immunizations, breast and colorectal cancer screenings, among others.
    2. Use of data (clinic scorecard for each clinic) on comparing service for the two groups (during pre-EPIC, pre-COVID, and current period) has highlighted particular PC Health Metrics needing improvement for better service of Black/African Americans. Also, lean tools have been utilized to improve processes.
C. Staff Experiences – Per DPH Pulse Surveys in 2019 and 2020 for CPC staff (ZSFG and community), the Black/African American staff members experienced a significantly different and lower satisfaction in the workplace with regard to respectful treatment of staff by both managers and co-workers.

V. Key Projects and Contributions
    A. DPH, SFHN, ZSFG Committees – The participation in various committees by CPC leaders and staff was noted.
    B. Teaching Activities – Many UCSF students and trainees are taught in various disciplines at multiple sites. Also, several CPC physicians attend at ZSFG.
    C. Selected Publications – Publications specific to COVID responses and Integrative Pain Management Program (access to acupuncture, massage, peer support for those in chronic pain) were highlighted.

VI. Financial Report (FY 19-20) – Significant amount of funding was provided by the General Fund Subsidy. However, there was a General Fund offset of around $50M through additional PC revenue/income from Global Payment Program and PRIME/QIP.

VII. Summary
    A. Strengths – These include the following: (1) mission-driven staff, (2) strong collaboration between UCSF and SFHN PC, (3) supportive city for sustained funding, (4) excellent performance on key population health metrics, (5) strong patient-care team relationships, and (6) enhanced continuity of care and care coordination with Enterprise Medical Record.
    B. Challenges – These include the impacts of COVID-19 such as staff burnout, care gaps, stalling of EPIC optimization, inadequate infrastructure to support video visits, and inequity of telecommuting.
    C. Goals – These include the following: (1) filling leadership positions (i.e., new Director of Primary Care Anti-Racism, Equity, Inclusion, and Diversity; multiple medical director positions) and behavioral health staff positions, (2) continuing partnership with staff and UCSF on improving experiences of Black/African American patients and staff with the Anti-Racism and Equity Action Plan, (3) closing care gaps, and (4) resuming in-person meetings with staff and management teams.

VIII. Facility Updates/Remodels – Three clinics (i.e., MHHC, SEHC, CMHC) are being remodeled. Later this year, WPIC will create a new Services Hub between 6th and 7th that will make 50 Ivy Street obsolete.