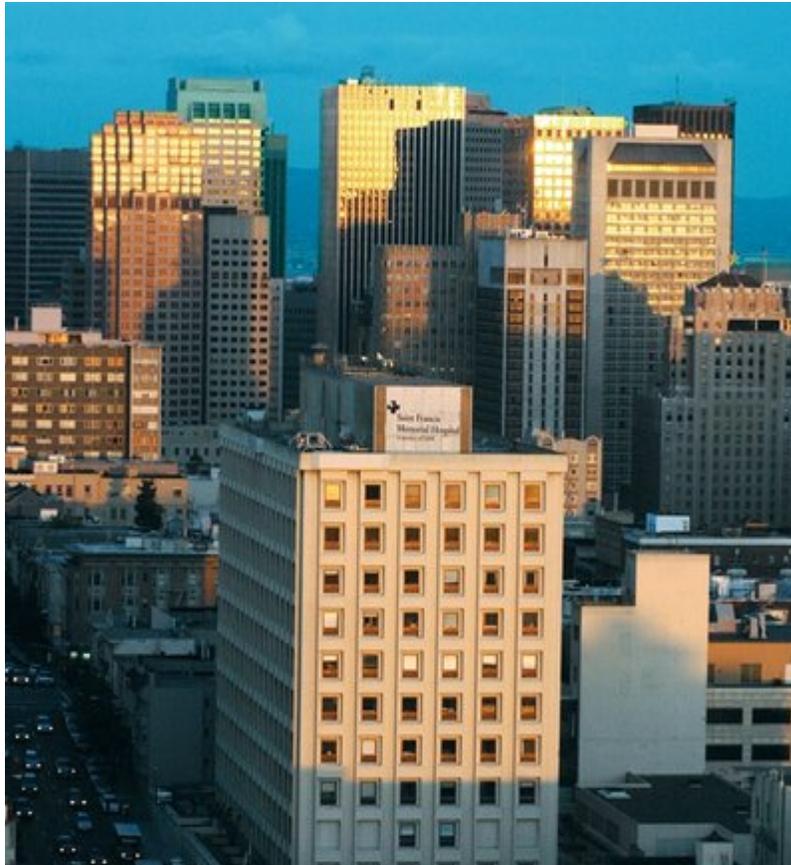




# Saint Francis Memorial Hospital

A member of CHW



## Saint Francis Memorial Hospital

## Community Benefit Report 2011 Community Benefit Plan 2012

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# EXECUTIVE SUMMARY

A member of Catholic Healthcare West, Saint Francis Memorial Hospital (SFMH) is located on Nob Hill, and maintains 239 staffed beds, with a staff of over 900 employees and 475 active physicians. The majority 71 % of SFMH patients are San Francisco residents, while another 9% live in the greater Bay Area. Among the hospital's inpatient population, 51% are Caucasian, and 22% Asian. African Americans comprise 15% of patients, and Hispanics 11%. SFMH has three outreach locations: AT&T Ballpark Health Center, Center for Sports Medicine in Walnut Creek, and Center for Sports Medicine in Corte Madera.

The hospital primarily serves San Francisco, however a number of specialized programs draw patients from all over Northern California and beyond. The Bothin Burn Center is the only verified burn center in San Francisco and one of only three centers in Northern California. SFMH has a state of the art emergency department and has opened new operating suites as part of the ongoing renovation of the surgery department. The Centers for Sports Medicine, the Spine Center and the Total Joint Center combine to offer a full spectrum of orthopedic services. SFMH also offers in/outpatient psychiatric services, acute rehabilitation, and comprehensive wound and hyperbaric services.

SFMH has a 13-year partnership with Glide Health Services and provides outpatient and pharmaceutical services for their patients. It is through its relationship with Glide Health Services that SFMH demonstrates its commitment to Healthy San Francisco – San Francisco's program to provide health services for the uninsured. SFMH also works closely with the other primary care clinics in the areas near the hospital: St. Anthony's Foundation Free Clinic, Curry Senior Center, South of Market Medical Clinic, and the Tom Waddell Clinic. Additionally, through its community benefit programs, SFMH partners with the Department of Public Health and other community based agencies to support services that meet the needs of our shared patient population; for example, the transitional care program – Homecoming Services, SF Senior Center, the Medical Respite Center, McMillan Sobering Center and the Dore Psychiatric Urgent Care Center.

In September 2010, the Building Healthier San Francisco Coalition completed the tri-annual Community Needs Assessment and launched Community Vital Signs on the Health Matters in SF website. These assessment findings were considered at the November 2010 meeting of the Community Advisory Committee and selected new priorities for the SFMH Community Benefit Plan that better align our plan with the Community Vital Sign goals. The SFMH Community Benefit Plan is in compliance with California state law and meets the new Federal IRS regulations. Community benefit programs are designed to improve [the](#) health of the communities, increase access to health care, are integral to community non-profit hospitals and are the basis of tax exemption.

During FY2011, Saint Francis Memorial Hospital contributed \$40,086,125 in Community Benefit Dollars, including \$8,511,792 in Charity Care services. The social accountability reporting system accounts for all of the costs of charity care and community benefit programs.

The Community Advisory Committee identified the following priority focus areas:

- Increase Access to Quality Medical Care
- Reduce Chronic Disease through Physical Activity and Healthy [E](#)ating
- Improve Behavioral Health
- Have a Safe and Healthy Place to Live
- Promote Healthy Aging
- Stop the Spread of Infectious Diseases

## ***Accomplishments in FY2011 in our priority areas include:***

### **Improve Access to Quality Medical Care**

Healthy San Francisco is a program to provide a system of health care services to the uninsured. Healthy San Francisco links participants with a Medical Home, a clinic that provides primary care, social services, case management and preventative care. Healthy San Francisco has upwards of 59,000 participants enrolled in 36 medical homes. Saint Francis actively supports Healthy San Francisco through its partnership with Glide Health Services.

Glide Health Services is a medical home to over 3000 patients, most of whom are now enrolled in Healthy San Francisco. Saint Francis continues to provide outpatient diagnostic and pharmaceuticals to all Glide patients.

The ED Navigator program in partnership with the SF Health Plan and the Department of Public Health aimed to assist patients in securing and keeping their primary care appointments at community clinics. While we were successful to some degree with this aim, we learned that helping patients stay connected with primary care is an ongoing issue. We will be adjusting the program in the next year to target patients already enrolled in medical homes.

### **Reduce Chronic Disease through Physical Activity and Healthy Eating**

FY 2011 marked the second year that Chronic Disease Management was identified as a priority focus area. Saint Francis sustained its partnership with Self Help for the Elderly and Curry Senior Services and supported the network of providers in the Tenderloin that offer the Chronic Disease Self Management Program developed by Stanford University. This year the program expanded to include additional community based agencies and trained instructors for the Diabetes Self Management Program.

### **Improve Behavioral Health**

Rally Family Visitation Program provides a safe and secure structured environment in which children can visit with their court-ordered non-custodial parent when there is a high level of conflict, including domestic violence, between divorced/separated parents. The program serves predominantly low-income families.

### **Promote Healthy Aging**

Community Grants were awarded to Self Help for the Elderly for Transition to Hospice Care Palliative Care Services and Self Help for the Elderly and Curry Senior Center for Chronic Disease Self Management Programs.

### **Stop the Spread of Infectious Diseases**

[Saint Francis Memorial Hospital continues to be an active partner in the Hepatitis B Coalition, participating in numerous coalition activities including sponsoring the annual gala.](#)

## MISSION STATEMENT

The mission of Saint Francis Memorial Hospital, as a member of Catholic Healthcare West, is to dedicate our resources to:

- delivering compassionate, high-quality, affordable health services
- serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- partnering with others in the community to improve the quality of life.

## ORGANIZATIONAL COMMITMENT

The Community Advisory Committee (CAC) was established in 1997 by the Saint Francis Memorial Hospital Board of Trustees. CAC exists to guide and participate in the planning and as appropriate, the development and implementation of projects and programs aimed at improving the health of the hospital's communities. The CAC represents diverse sectors of the community and interacts to raise issues and identify areas for community outreach opportunities. The CAC also serves as a catalyst for relationship building and partnering with community organizations, the business community, and the individuals who live in the community.

The Chair of the CAC is an Executive Member of the Board of Trustees. Guido Gores, MD, is the current Chair. Dr. Gores serves on the board of the Tenderloin Health Center and is very familiar with the hospital's underserved populations. Four members of the Board of Trustees serve on the CAC. Additionally, Thomas Hennessy, President/CEO and 3 members of the hospital management team serve on the CAC. The CAC is accountable to the full Board and reports their activities after each meeting and on an annual basis. See Appendix A for roster of Community Advisory Committee and Board of Trustees members.

During FY2011, the Board of Trustees updated the Strategic Plan for FY2012-FY2014. The strategic plan reaffirmed the hospital's commitment to Community Benefit. The vision statement reads: "The CHW San Francisco Service Area, anchored by St. Mary's Medical Center and Saint Francis Memorial Hospital, together with aligned physicians, is a premier provider of quality and accessible community-based care, with select specialties serving the Greater Bay Areas the provider of choice."

Strategic Dimension	Current Position (FY 2011)	Desired Position (FY 2014)	Key Strategies
Community Benefit	Recognition as leader in the community for collaboration and action to improve access to care for under/uninsured and other marginalized populations.	Recognition as leader in the community for collaboration and action to improve access to care for under/uninsured and other marginalized populations.	<ul style="list-style-type: none"> <li>◆ Continue to promote and improve the health status and quality of life of the community by partnering with others to serve the poor and disenfranchised</li> <li>◆ Continue to collaborate to promote community health education through partnership for chronic disease management classes, ambulatory care, and collaboration on "Building a Healthy San Francisco" Assessment Committee</li> <li>◆ Take leadership role in working with Community partners to support the implementation of key initiatives resulting from the hospital's Community Needs Assessments</li> <li>◆ Improve access to primary care services for under/uninsured and culturally diverse populations in the community through physician recruitment and other hospital sponsored efforts.</li> </ul>

Excerpt from [San Francisco Service Area](#) Strategic Plan FY2012-2014

The CAC roles and responsibilities are defined by its charter that was amended in FY2005 as part of Saint Francis' participation in the "Advancing the State of the Art in Community Benefit" pilot demonstration project with the Public Health Institute. The CAC's responsibilities include:

- Budget Decisions - Annual Community Benefit Budget, developed by staff is reviewed by Senior Leadership and approved by the Saint Francis Memorial Hospital Board of Trustees as part of the hospital budget. This budget is based upon approved Community Benefit Program activities and the commitment to Charity Care.
- Program Content - Selection of all new program content areas is informed by use of explicit priority setting criteria. Proposed content areas may originate with Community Benefit Staff, Senior Leadership, the Board of Trustees or the CAC.
- Program Design - The CAC reviews and provides input on draft program design developed by Community Benefit Staff. The CAC also reviews the final version and makes recommendations to the CEO.
- Program Targeting - Program activities are guided by the use of the Community Needs Index, population specific data from our Health Matters in San Francisco website <http://www.healthmattersinsf.org/>. Program activities are targeted and designed to ensure accessibility for communities and populations with disproportionate unmet health-related needs in the Saint Francis Memorial Hospital catchment area.
- Program Continuation or Termination - Community Benefit Staff makes recommendations to the CAC for program continuation or termination based upon progress toward identified measurable objectives, available resources, level/form of community ownership, and alignment with criteria for inclusion as a priority. After integration of CAC input, final recommendations are presented for approval to the Board and CEO.
- Program Monitoring - Program monitoring is the responsibility of the Community Benefit Staff. Progress toward measurable objectives is presented periodically to the CAC for input. The CAC participates in the development of the Community Benefit Plan on a yearly basis and monitors the implementation and achievement of the Community Benefits Plan's goals on a regular basis.

## **Non-Quantifiable Benefits**

### ***Advocacy***

#### Charity Care

Saint Francis continues to work hand in hand with the Department of Public Health on the issues of health reform and Charity Care. The Charity Care Workgroup, which includes representatives from the San Francisco Department of Public Health and all of the city's hospitals, meets monthly to discuss the annual Charity Care Report and examine issues related to Charity Care.

#### Healthy San Francisco

The goal of Healthy San Francisco is to make healthcare services accessible and affordable to uninsured San Francisco residents. The program is not designed as insurance but as an innovative reinvention of the City's healthcare safety net, enabling and encouraging residents to access primary and preventive care. The San Francisco Health Plan, in partnership with the San Francisco Department of Public Health, administers Healthy San Francisco.

#### Psychiatric Urgent Care

The Dore Urgent Care Center (DUCC) opened in August 2008. Saint Francis Memorial Hospital was a key member of the Psychiatric Emergency Services Workgroup that identified the urgent need for improvements to meet the needs of psychiatric emergencies. Staff from Saint Francis Memorial Hospital continue to participate in the oversight committee. The DUCC provides an alternative place for police to take patients placed on an involuntary hold by the police, helping to decrease the impact these patients are having in the city's Emergency Departments.

### ***Community Building***

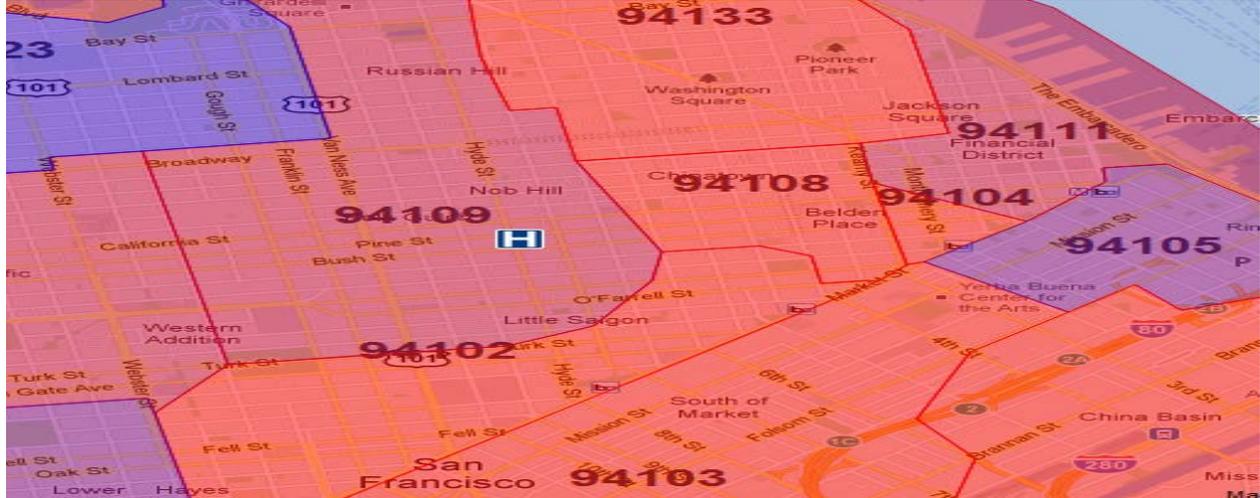
#### African American Health Disparity Project

African American Health Disparity Project is a Hospital Council sponsored program committed to improving the health status of African Americans and to eliminating institutional racism wherever it exists in the health care system of San Francisco. Saint Francis Memorial staff participate in planning meetings.

Immaculate Conception Academy

Immaculate Conception Academy (ICA) is an all-girls Catholic high school that offers college preparatory education in the Dominican Tradition. Membership in the Cristo Rey Network allows ICA to open its doors to capable students desiring faith-based high school education but without the means to afford it. Through ICA's work-study program at Saint Francis Memorial Hospital, students are placed in entry-level, clerical positions exposing them to hospital-based work.

**Community Needs Index**



Lowest Need ■ 1 - 1.7 Lowest ■ 1.8 - 2.5 2nd Lowest ■ 2.6 - 3.3 Mid ■ 3.4 - 4.1 2nd Highest ■ 4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County	State
<span style="color: red;">■</span> 94102	4.8	29328	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94103	4.6	26642	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94104	5	435	San Francisco	San Francisco	California
<span style="color: purple;">■</span> 94105	3	4993	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94107	4.2	22899	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94108	4.8	12769	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94109	4	55620	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94110	4	74575	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94111	3.6	3322	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94112	3.6	76079	San Francisco	San Francisco	California
<span style="color: purple;">■</span> 94114	2.6	29238	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94115	3.8	34195	San Francisco	San Francisco	California
<span style="color: purple;">■</span> 94116	3	42600	San Francisco	San Francisco	California
<span style="color: purple;">■</span> 94117	3	37043	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94118	3.4	37510	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94121	3.4	42002	San Francisco	San Francisco	California
<span style="color: purple;">■</span> 94122	3.2	56081	San Francisco	San Francisco	California
<span style="color: blue;">■</span> 94123	2.4	23255	San Francisco	San Francisco	California
<span style="color: red;">■</span> 94124	4.8	33516	San Francisco	San Francisco	California
<span style="color: blue;">■</span> 94127	1.8	18263	San Francisco	San Francisco	California
<span style="color: purple;">■</span> 94129	2.8	2667	San Francisco	San Francisco	California

94130	3.4	1733	San Francisco	San Francisco	California
94131	2.8	26688	San Francisco	San Francisco	California
94132	3.2	26745	San Francisco	San Francisco	California
94133	4.8	27333	San Francisco	San Francisco	California
94134	4.4	40354	San Francisco	San Francisco	California

## COMMUNITY

Saint Francis Memorial Hospital is the only hospital located in downtown San Francisco. Patients' accessing the hospital's services range from the city's richest to poorest residents. Our primary service area includes Downtown, Nob Hill, North Beach, the Waterfront and areas with disproportionate unmet health needs: the Tenderloin, Chinatown and South of Market Area (SOMA) communities. The City and County of San Francisco is a densely populated urban environment with a residential population of 805,235 and a daytime population over 1.2 million. The city embraces a diverse ethnic culture 48.5% Caucasian, 33.3% Asian, 6.1% African American, 15.1% Hispanic, 4.7% - two or more races, 0.4% Native Hawaiian/Pacific Islander, 0.5% American Indian/Alaska Native, 6.5% other. The population is highly educated with 85% high school graduates and 50% with a college degree. There are an estimated 73,000 persons without health insurance in San Francisco. The cost of living in San Francisco is one of the highest in the nation.

### The Tenderloin

The Tenderloin is one of San Francisco's most densely populated and neediest neighborhoods. Approximately 28,991 residents live in the 94102 zip code. The residents of the Tenderloin speak many languages, are of many races and income levels. The neighborhood is home to many immigrant families, 27.3% of which are linguistically isolated. 43% of residents speak a language other than English at home. The Tenderloin is one of the city's most impoverished neighborhoods. It is also home to many of the city's non-profits that provide the resources and networks that individuals need to build new lives. The average median income of residents is only \$22,351, with 24.5% of residents living below the federal poverty level. The Tenderloin is a very diverse community, 16.5% of residents are African American, 13.5% are Latino, 25% are Asian, and 0.4% are Native Hawaiian or Other Pacific Islander. The North of Market Community Benefit District was established in 2005 with the goal of providing consistent cleaning, beautification and safety services to the Tenderloin. These services are paid for by a tax on property owners. In 2009, the Tenderloin was deemed a National Historic District.

### Chinatown

Established in the 1850's this neighborhood is one of the oldest Chinatowns in Northern California. Chinatown's architecture, restaurants and shopping make it one of the city's most popular tourist destinations. Chinatown is one of the city's most densely populated neighborhoods with 13,716 residents living in this small area. Since the neighborhood's birth in the 1800's it has been home to many immigrants. Today, 16% of its residents live below the poverty line. The median income of residents living in Chinatown is \$31,542. A majority (58%) of residents living in this neighborhood are Asian or Pacific Islander. Only 1.3% of residents living in Chinatown are African American and 4.2% are Hispanic or Latino. 61% of residents speak a language other than English at home.

### South of Market Area

South of Market Area (SOMA) is the fastest growing neighborhood in San Francisco with a population of 23,016 residents. Dozens of high rise condos and retail outlets are currently under development. This neighborhood exhibits high poverty rates, particularly for adults and seniors. There is a high near poverty rate among Children and in SOMA, unemployment and labor force non-participation continue to be issues for residents. 22.5% of SOMA residents live below the federal poverty line. SOMA is a very diverse neighborhood: 11.8% of residents are African American, 24.9% are Asian or Pacific Islander and 25.1% are Hispanic or Latino. 49% of SOMA residents speak a language other than English at home. The Transbay Terminal Replacement Project, along with many new residential high rises, is transforming the city's skyline and these neighborhood demographics. However, the neighborhood is still home to a number of single room occupancy hotels and poor persons.

The community has been federally designated as a Medically Underserved Area/Population, given that 5 Federally Qualified Health Centers (FQHC) are located in the 94102, 94103 and 94133 zip codes. They are: Glide Health Services, Curry Senior Center, St. Anthony's Free Clinic, South of Market Health Center and North East Medical Services. Also in the community are non-FQHC clinics and Chinese Hospital.

## **COMMUNITY BENEFIT PLANNING PROCESS**

### ***A. Community Needs Assessment Process & Community Benefit Planning Process***

#### ***FY 2011 Community Needs Assessment Process***

Every three years the Building a Healthier San Francisco (BHSF) Coalition develops the California state-mandated Community Needs Assessment. BHSF participants include representatives from all of the city's private and public hospitals, the Department of Public Health, philanthropic foundations and community organizations. We have engaged Healthy Communities Institute who brings assessment data and much more through its web based tool Health Matters in San Francisco.

Saint Francis Memorial Hospital is an active member of BHSF and Community Benefit Partnership (CBP). The HealthMattersinSF.org (HMSF) continues to be the home of health data that serves as the foundation for the Community Needs Assessment. As a result of the 2010 Community Needs Assessment, the CBP created the Community Vital Signs—a dynamic portal to the community's priority health issues, and associated community resources. Community Vital Signs will also support the work of the Community Benefits Partnership by fostering infrastructure for community collaborations working to address these goals.

#### **Community Vital Signs**

The Partnership transitioned from 4 to 10 priority health goals for San Francisco, enhancing the 4 priority areas developed during the 2007 Community Needs Assessment. At a Community Stakeholder meeting on November 13, 2009, the Partnership hosted over 75 participants representing a cross-section of expertise in health and human services. These community stakeholders confirmed the relevance of the 10 health goals and planted the seeds for 10 affinity groups comprised of subject matter experts for each of the 10 health goals. The health goals were adopted by the San Francisco Health Commission on February 2, 2010, which now inform and guide the SFHM 2011 Community Benefit Report and the 2012 Community Benefit Plan.

The 10 priority health goals are:

1. Increase Access to Quality Medical Care
2. Increase Physical Activity and Healthy Eating to Reduce Chronic Disease
3. Stop the Spread of Infectious Diseases
4. Improve Behavioral Health
5. Prevent and Detect Cancer
6. Raise Healthy Kids
7. Have a Safe and Healthy Place to Live
8. Improve Health and Health Care Access for Persons with Disabilities
9. Promote Healthy Aging
10. Eliminate Health Disparities

On September 23, 2010, the San Francisco Community Benefit Partnership presented the dynamic 2010 Community Needs Assessment through the re-launch of Health Matters in San Francisco and introduction of Community Vital Signs and concept of Collaboration Centers. Community Vital Signs is the newest, most effective platform to provide current baseline for each indicator and their associated benchmarks, paving a clear and dynamic path forward in promoting the 10 priority health goals of San Francisco. It provides a central web-based location for: 1) Assessing health and health care needs; 2) Guiding health policy through collaboration; and 3) Evaluating impacts of health interventions.

## **Community Needs Index**

Saint Francis Memorial Hospital also makes full use of the Community Needs Index (CNI), which analyzes the community needs of a specific geographic region by measuring barriers to health care including income, education, cultural, insurance, and housing. A numerical value is assigned to those areas of highest to lowest needs. These CNI scores correlate with data showing these communities also have rates of hospitalization for ambulatory care sensitive conditions. Residents in the communities with scores of "5" are more than twice likely to need inpatient care for preventable conditions than communities with a score of "1". Of the six identified zip codes in our catchment area, five of them rate as "highest needy." These zip codes include 94102 (Tenderloin), 94103 (SOMA), 94104 (Downtown), 94108 (Chinatown), and 94133 (North Beach), which allow further focus or refinement of our Community Benefit intervention for maximum and strategic impact. The CHW CNI findings are in alignment with the other health indicator data found on the Health Matters in SF website.

## ***B. Assets Assessment***

Following the development of the Community Vital Signs, participants in these meetings aided in identifying current assets in the form of programs and projects related to the goal and indicators. Subsequently, during this process, over 350 potential data indicators were identified to measure progress of the health goals. The Partnership then narrowed down the indicators to the 34 most relevant indicators that have current available data and benchmarks with additional research by BHSF and input during the Stakeholder Workshop on June 4, 2010.

The Health Matters in SF website hosts a Collaboration Center for each health goal with the aim to continue and enhance the engagement of experts and community advocates, and health improvement process by participating in the Affinity Groups. BHSF is working with HCI to develop the web tools to enhance both individuals and organizations' ability to collaborate.

## ***C. Developing the Hospital's Implementation Plan (Community Benefit Report & Plan)***

At the November 2010 CAC meeting, the CAC conducted an exercise to identify existing institutional and community partner resources and categorizing them under each of the 10 health goals represented in Community Vital Signs.

The exercise consisted of 3 rounds. In round 1, the CAC listed an inventory of all the programs within the scope of Saint Francis Memorial Hospital Community Benefit program that is already being worked on to support each Community Vital Sign. In round 2, each member of the CAC voted for what they believed to be the top 3 goals to focus on by nominal group process voting. Finally in round 3, the results of the voting were announced and the Community Vital Sign indicator being used as a proxy to measure each goal was discussed in detail. As a result of the process, the CAC selected 6 of the 10 Community Vital Signs for the hospital's Community Benefit Plan focus.

Community Vital Signs which Saint Francis Memorial Hospital chose not to address this year were:

- Prevent and Detect Cancer: 2 votes
- Raise Healthy Kids: 1 vote
- Improve Health and Health Care Access for Persons with Disabilities: 0 Votes

These needs were not selected because they are beyond the scope of the services offered by Saint Francis Memorial Hospital and they are already being addressed by other organizations in the community.

Many of the services or programs directly address the needs of vulnerable populations in our community with Disproportionate Unmet Health Needs. Communities with DUHN are defined as having a high prevalence or severity for a particular health concern to be addressed by a program activity, or community residents who face multiple health problems and who have limited access to timely, high quality health care. Our Community Benefit plan's services that address DUHNs include: Charity Care, Community Health Fairs, Dore Urgent Clinic, Emergency Department, Glide Health Services, Hep B Free, Homecoming Services Program, Navigator Program, Rally Visitation Services, and Recuperation Programs. Data used to validate this selection includes data from the Health Matters in SF website.

At Saint Francis Memorial Hospital, some of our prominent Community Benefit programs serve to contain the growth of community health care costs. One example is the partnership with Glide Health Services, which enables timely access to health care and ensures the prevention of disease progression.

***D. Planning for the Uninsured/Underinsured Patient Population***

Saint Francis Memorial Hospital abides by the CHW Financial Assistance Policy (see appendix) that defines eligibility for Charity Care. Financial Counselors work directly with patients to assess whether they are eligible for government sponsored health programs. If the patient is eligible, the Financial Counselor will assist the patient with completing the application process. Patients that are making a good-faith effort to settle their bills may qualify for interest free, extended payment plans. This policy exceeds the California Hospital Association Voluntary Principles and Guidelines for Assisting Low-Income Uninsured Patients. Patient Financial Assistance notices, as required by local ordinance, are posted in four languages (Spanish, English, Russian and Chinese) in all registration areas.

Financial Counselors are trained to enroll eligible patients into Healthy San Francisco. Healthy San Francisco provides a medical home and primary physician to uninsured residents of San Francisco. Although this is not an insurance program, Healthy San Francisco reinvents the health care safety net enabling the uninsured to access primary and preventative care. Through our partnership with Glide Health Services, Saint Francis Memorial Hospital provides outpatient diagnostic services and pharmaceuticals to Glide patients, many of whom are now enrolled in Healthy San Francisco.

In November 2003, the San Francisco Board of Supervisors voted on “Charity Care Ordinance.” This ordinance requires Saint Francis Memorial Hospital (along with other San Francisco hospitals) to report to the Department of Public Health specific information related to the amount of Charity Care they provide and to notify patients of the hospitals Charity Care policies. Local hospitals meet monthly to prepare the annual Charity Care Report and to discuss projects and activities that are directed towards reducing the need for Charity Care in San Francisco.

# PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major initiatives and key community-based programs operated or substantially supported by Saint Francis Memorial Hospital in 2011. Programs to be continued in 2012 are noted by \*. Programs were developed in response to the current Community Health Needs Assessment and are guided by the following five core principles:

- Disproportionate Unmet Health-Related Needs: Programs that focus on vulnerable populations that lack access to health care because of financial, language/culture, legal or transportation barriers, and/or who possess physical or mental disabilities.
- Primary Prevention: Address the underlying causes of persistent health problem.
- Seamless Continuum of Care: Linkages between clinical services and community health improvement activities.
- Build Community Capacity: Enhance the effectiveness and viability of community based organizations, reduce duplication of effort, and provide the basis for shared advocacy and joint action to address the structural problems in a community.
- Collaborative Governance: Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

## Community Benefit Plan Priorities

FY 2010 - 2011	FY 2011- 2012 Community Vital Signs
Access to Care	Increase Access to Quality Medical Care
Chronic Disease Management	Reduce Chronic Disease through Physical Activity and Healthy Eating
Communicable Disease Prevention and Treatment	Stop the Spread of Infectious Diseases
Violence Prevention	Improve Behavioral Health
	Have a safe and Healthy Place to Live
	Promote Healthy Aging

**Community Benefit Plan Programs and Activities within the selected Community Vital Signs are summarized as follows:**

### Increase Access to Quality Medical Care

- Healthy San Francisco\*
- Glide Health Clinic\*
- Delancy Street Foundation
- Enrollment Assistance for Government Programs and Charity Care \*
- African American Health Disparities Project \*
- SF Senior Center Transitional Care Network for temporary case management, home care assistance, escorts and in-home personal needs for medically at-risk for a safe transition from care facilities to home\*
- Support to the Hospitalist, ED on call and MD Charity Care Programs\*
- Radiation Oncology Medical Residency Rotation\*
- Community Grant to San Francisco Health Plan for ED Navigator Program (this program will migrate to Glide Health Clinic in FY12 with Community Grant funding.)\*

### Increase Physical Activity and Healthy Eating to Reduce Chronic Disease

- Food Runners program to distribute leftover food to those in need \*
- Low cost meals for seniors in the hospital cafeteria \*
- Glide Wellness Center
- Chronic Disease Self Management Program \*

### Stop the Spread of Infectious Disease

- Hep B Free Coalition Support\*
- Flu Vaccines provided to Seniors \*

### **Improve Healthy Behavior**

- ***Rally Family Visitation Program*** \*
- Health Fair screenings and education \*
- Burn Support Group\*
- Us Too Prostate Cancer Support Group \*
- Pulmonary Rehab Program\*
- Better Breathers Program\*
- Smoking Cessation Consultation\*
- Smoke Free Environment
- Dore Urgent Care Center
- Sobering Center
- Clinical Pastoral Education Program\*
- Meeting Rooms for Alcoholic Anonymous, Bipolar Support and SMART Groups\*

### **Have a Safe and Healthy Place to Live**

- Burn Education\*

### **Promote Healthy Aging**

- Little Brothers Friend of the Elderly Program Support \*
- Community Grant to Self Help for the Elderly for Transition to Hospice Care Palliative Care Services
- Community Grant to Self Help for the Elderly and Curry Senior Center for Chronic Disease Self Management Programs\*
- Community Grant to Zen Hospice for Hospice Services for low income and uninsured patients.

These key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Advisory Committee, Executive Leadership, Board of Trustees and Catholic Healthcare West receive quarterly updates on program performance and news.

The following pages include Program Digests for a few key programs that address one or more of the Initiatives listed above:

# PROGRAM DIGEST

<b>Chronic Disease Management Program</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Increase Access to Quality Medical Care <input type="checkbox"/> Improve Behavioral Health <input checked="" type="checkbox"/> Promote Healthy Aging <input checked="" type="checkbox"/> Increase Physical Activity and Healthy Eating to Reduce Chronic Disease <input type="checkbox"/> Have a Safe and Healthy Place to Live
<b>Program Emphasis</b>	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	The Community Needs Assessments data indicates significant hospitalizations rates for chronic disease levels in the zip codes adjacent to SFMH.
<b>Program Description</b>	Support Chronic Disease Self Management Program (CDSMP) lay leadership class and subsequent public classes using a curriculum developed by Stanford University at Saint Francis Memorial Hospital, Self Help for the Elderly and Curry Senior Center. Develop a coalition of agencies providing CDSMP in the Tenderloin and Chinatown communities to assist leaders in recruitment and retention of participants and to share and reduce program costs as able.
<b>FY 2011</b>	
<b>Goal FY 2011</b>	Support coalition of agencies providing CDSMP in the Tenderloin.
<b>2011 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Each of the 3 participating agencies to hold 2 class sessions.</li> <li>80% number of participants completing the program.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>In partnership with Curry Senior Center and Self Help for the Elderly and Department of Adult and Aging Services completed train the trainer course (20 participants).</li> <li>Trained hospital staff as CDSMP facilitator. Participants recruited, program scheduled to begin In July 2009.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	Market program to physicians' offices, volunteers and community members.
<b>Result FY 2011</b>	<ul style="list-style-type: none"> <li>In partnership with Curry Senior Center and Self Help for the Elderly and Department of Adult and Aging Services completed train the trainer course (16 participants); a total of 13 classes were completed, including 2 classes onsite</li> <li>78% of 227 participants. 177 total completed the class.</li> <li>Hospitalization rates:</li> <li>Trained hospital staff as CDSMP facilitator.</li> <li>Participants recruited, program schedule to begin July 2010.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	<ul style="list-style-type: none"> <li>\$10,000 from CHW Community Grants Program In Kind expenses donated by SFMH</li> </ul>
<b>FY 2012</b>	
<b>Goal 2012</b>	Support coalition of agencies providing CDSMP in the Tenderloin.
<b>2012 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Each of the 3 participating agencies to hold 2 class sessions</li> <li>80% number of participants completing the program</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>In partnership with Curry Senior Center and Self Help for the Elderly and Department of Adult and Aging Services completed train the trainer course (20 participants).</li> <li>Trained hospital staff as CDSMP facilitator.</li> <li>Participants recruited, program scheduled to begin In July 2011.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	Market program to physicians' offices, volunteers and community members.
<b>Community Benefit Category</b>	Broader-Community Health Improvement Services

<b>Glide Health Clinic</b>	
<b>Hospital CB Priority Areas</b>	<input checked="" type="checkbox"/> Increase Access to Quality Medical Care <input checked="" type="checkbox"/> Improve Behavioral Health <input type="checkbox"/> Promote Healthy Aging <input type="checkbox"/> Increase Physical Activity and Healthy Eating to Reduce Chronic Disease <input type="checkbox"/> Have a Safe and Healthy Place to Live
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	The residents of the Tenderloin have significant health challenges as measured by the CNI hospitalization rates for all ACSC.
<b>Program Description</b>	The Glide Health Clinic is located at the Glide Methodist Church in the Tenderloin District of San Francisco. This clinic provides primary care, mental health, HIV/AIDS and recovery services to adults.

<b>FY 2011</b>	
<b>Goal FY 2011</b>	Provide seamless continuum of care for patients accessing SFMH and Glide Health Clinic. Sustain fiscal support of outpatient diagnostics and pharmaceuticals involving Healthy San Francisco as appropriate.
<b>2011 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Provide inpatient services to Healthy San Francisco participants' that identify Glide Health Services as their medical home.</li> <li>• Sustain fiscal support of outpatient diagnostic services for Glide patients.</li> <li>• Facilitate conversion to drug discount program (340b)</li> <li>• Complete implementation of Health Information Exchange.</li> <li>• Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• FY 2010: SFMH Glide HSF IP 13; Out Pt 1972; ED 354.</li> <li>• GHS UDC- 2,942 GHS total Encounters/Visits- 12,966</li> <li>• Received support from CCSF for Glide/HSF (\$500,000)</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Quarterly progress meeting re: diabetes collaborative.</li> <li>• Quarterly utilization meetings and report re: HSF utilization</li> <li>• Facilitate contractual and operations processes for 340b project.</li> </ul>
<b>Result FY 2011</b>	<ul style="list-style-type: none"> <li>• Continued to provide outpatient diagnostic services and outpatient pharmaceuticals to Glide patients.</li> <li>• Saint Francis partnered with Glide Health Services to provide inpatient hospitalization services to Healthy San Francisco participants' that utilize Glide as their medical home.</li> <li>• Facilitated conversion to drug discount program (340b)</li> <li>• Completed implementation of Health Information Exchange.</li> <li>• FY 2011: SFMH Glide HSF IP 24; Out Pt 2,369</li> <li>• GHS UDC- 1,556 GHS total Encounters/Visits- 8,101</li> <li>• Received support from CCSF for Glide/HSF (\$575,000)</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	<ul style="list-style-type: none"> <li>• Pharmacy, Supplies, In-Patient &amp; Out-Patient Services (<i>In-PT Out-PT and ED services included in Charity Care contribution</i>)</li> <li>• \$ 1,182,989* offset by \$575,000 grant = \$607,989</li> </ul>
<b>FY 2012</b>	
<b>Goal 2012</b>	<ul style="list-style-type: none"> <li>• Provide inpatient services to Healthy San Francisco participants' that identify Glide Health Services as their medical home.</li> <li>• Sustain fiscal support of outpatient diagnostic services for Glide patients.</li> <li>• Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.</li> </ul>
<b>2012 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Provide inpatient services to Healthy San Francisco participants' that identify Glide Health Services as their medical home.</li> <li>• Sustain fiscal support of outpatient diagnostic services for Glide patients.</li> <li>• Sustain conversion to drug discount program (340b)</li> <li>• Sustain implementation of Health Information Exchange.</li> <li>• Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• FY11: SFMH Glide HSF IP 24; Out Pt 2,369</li> <li>• GHS UDC- 1,556 GHS total Encounters/Visits- 8,101</li> <li>• Received support from CCSF for Glide/HSF (\$575,000)</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Quarterly progress meeting re: diabetes collaborative.</li> <li>• Quarterly utilization meetings and report re: HSF utilization</li> <li>• Facilitate contractual and operations processes for 340b project.</li> </ul>
<b>Community Benefit Category</b>	Poor-Community Health Improvement Services

\*Direct clinical services are accounted for within the traditional care dollar.

<b>Healthy San Francisco</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Increase Access to Quality Medical Care</li> <li><input type="checkbox"/> Improve Behavioral Health</li> <li><input type="checkbox"/> Promote Healthy Aging</li> <li><input type="checkbox"/> Increase Physical Activity and Healthy Eating to Reduce Chronic Disease</li> <li><input type="checkbox"/> Have a Safe and Healthy Place to Live</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li>X Primary Prevention</li> <li>X Seamless Continuum of Care</li> <li>X Build Community Capacity</li> <li>X Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	Healthy San Francisco (HSF) is an innovative health care program designed to expand access to health services and deliver appropriate care to uninsured adult residents. HSF is not insurance. HSF restructures the existing health care safety net system (both public and non-profit) into a coordinated, integrated system. It improves access to services and delivery of appropriate care. The Healthy San Francisco model is based on one of shared responsibilities.
<b>Program Description</b>	Healthy San Francisco is a program to provide a system of health care services to the uninsured.

	Healthy San Francisco links participants with a Medical Home, a clinic that provides primary care, social services, case management and preventative care. Healthy San Francisco has upwards of 59,000 participants enrolled in 36 medical homes. Saint Francis actively supports Healthy San Francisco through its partnership with Glide Health Services.
<b>FY 2011</b>	
<b>Goal FY 2011</b>	Provide seamless continuum of care for Healthy San Francisco patients with Glide assigned as their medical home.
<b>2011 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Provide inpatient services to Healthy San Francisco participants' that identify Glide Health Services as their medical home.</li> <li>• Sustain fiscal support of outpatient diagnostic services for Glide patients.</li> <li>• Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• FY 2010: SFMH Glide HSF IP 13; Out Pt 1972; ED 354.</li> <li>• GHS UDC- 2,942 GHS total Encounters/Visits- 12,966</li> <li>• Received support from CCSF for Glide/HSF (\$500,000)</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Quarterly progress meeting re: diabetes collaborative.</li> <li>• Quarterly utilization meetings and report re: HSF utilization</li> <li>• Facilitate contractual and operations processes for 340b project.</li> </ul>
<b>Result FY 2011</b>	<ul style="list-style-type: none"> <li>• Continued to provide outpatient diagnostic services and outpatient pharmaceuticals to Glide patients.</li> <li>• Saint Francis partnered with Glide Health Services to provide inpatient hospitalization services to Healthy San Francisco participants' that utilize Glide as their medical home.</li> <li>• FY11: SFMH Glide HSF IP 24; Glide OP HSF 2,369; Other IP HSF 153 , Other OP HSF 2,089 , OP HSF – SMMC 21 , OP HSF – CCHA 22</li> <li>• GHS UDC- 1,556 GHS total Encounters/Visits- 8,101</li> <li>• Received support from CCSF for Glide/HSF (\$575,000)</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$4,891,636 (Accounted for as a Means-Tested Program in CBISA)
<b>FY 2012</b>	
<b>Goal 2012</b>	Provide seamless continuum of care for Healthy San Francisco patients with Glide assigned as their medical home.
<b>2012 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Provide inpatient services to Healthy San Francisco participants' that identify Glide Health Services as their medical home.</li> <li>• Sustain fiscal support of outpatient diagnostic services for Glide patients.</li> <li>• Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.</li> <li>• Increase Healthy San Francisco Enrollment through Enrollment Assistance programs provided by Patient Financial Services.</li> <li>• Aim to provide electronic notification to medical home through Mobile MD</li> <li>• Connect with 3 additional clinics</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• FY11: SFMH Glide HSF IP 24; Glide OP HSF 2,369; Other IP HSF 153 , Other OP HSF 2,089 , OP HSF – SMMC 21 , OP HSF – CCHA 22</li> <li>• GHS UDC- 1,556 GHS total Encounters/Visits- 8,101</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Quarterly progress meeting re: diabetes collaborative.</li> <li>• Quarterly utilization meetings and report re: HSF utilization</li> <li>• Facilitate contractual and operations processes for 340b project.</li> </ul>
<b>Community Benefit Category</b>	Poor-Community Health Improvement Services

<b>Patient Navigator Program</b>	
<b>Hospital CB Priority Areas</b>	<ul style="list-style-type: none"> <li>X Increase Access to Quality Medical Care</li> <li><input type="checkbox"/> Improve Behavioral Health</li> <li><input type="checkbox"/> Promote Healthy Aging</li> <li><input type="checkbox"/> Increase Physical Activity and Healthy Eating to Reduce Chronic Disease</li> <li><input type="checkbox"/> Have a Safe and Healthy Place to Live</li> </ul>
<b>Program Emphasis</b>	<ul style="list-style-type: none"> <li>X Disproportionate Unmet Health-Related Needs</li> <li><input type="checkbox"/> Primary Prevention</li> <li>X Seamless Continuum of Care</li> <li><input type="checkbox"/> Build Community Capacity</li> <li>X Collaborative Governance</li> </ul>
<b>Link to Community Needs Assessment</b>	San Francisco, like the rest of the nation, suffers from a shortage of primary care providers, and few clinics are willing to take on new patients in a clinically relevant timeframe after an urgent ER visit requiring follow-up. Clinics would frequently prioritize existing patients over patients who were never seen, even if the patient had urgent needs and were reassigned to that site for primary care. Patients also do not always value primary care, seeing them more as a hassle. Wait times for a new patient in San Francisco clinics can be three months or longer; it can be difficult to get a new patient within two weeks. Because of these barriers to primary care, the Emergency Department is the primary source of care for many Medi-Cal and uninsured.
<b>Program Description</b>	Began in FY2010 as a partnership with the San Francisco Health Plan and the Department of Public

	Health, with the aim to assist patients in securing and keeping primary care appointments at community clinics in a clinically appropriate timeframe. The program built on a previous navigator program that was a joint effort between the South of Market Health Center and Saint Francis Memorial Hospital and was part of a culture shift in the SF Safety Net.
<b>FY 2011</b>	
<b>Goal FY 2011</b>	Increase the ability of patients to access primary care follow-up appointments and retain those appointments with the help of full-time navigator, thereby decreasing the over-use of the emergency room for primary care sensitive conditions.
<b>2011 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Track outcome of all patient navigator contacts and report quarterly</li> <li>Ensure that at least 30% of navigated patients keep their post-discharge follow-up appointment with a primary care provider at their medical home.</li> <li>Track utilization data to demonstrate impact of program on emergency department return rate and decreased readmission rate.</li> <li>Develop improved communications between ED and medical homes – Develop a system to ensure that medical homes are willing to schedule follow-up appointments, and that the ED is able to send relevant records needed by PCP.</li> </ul>
<b>Baseline</b>	The program launched in May 2011 with a full-time Navigator, who had previous experience working with low-income populations with a high prevalence of substance use.
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>Create quarterly reports outlining outcome of all patient navigator contacts, tracking number of patients receiving facilitated medical home appointments, and the outcome of those appointments (no show, cancelled, rescheduled, etc.)</li> <li>Develop a database to track demographic and utilization outcomes</li> <li>Fortify relationships with clinics to appropriately funnel unassigned and/or uninsured new patients to clinics where their needs will be best served. Clinics came to rely on navigator to obtain relevant medical records and agreed to make navigation patients a priority.</li> <li>Create a system to ensure that the navigator could reach a live person to schedule an appointment before the patient left the ED, and a template checklist to ensure the relevant clinical information (diagnosis, labs, diagnostic tests, abnormal findings, pending studies) is collected.</li> </ul>
<b>Result FY 2011</b>	<ul style="list-style-type: none"> <li>Navigator screened over 4,029 patients for navigation through chart review and referral</li> <li>Navigator completed 689 navigation encounters for unduplicated patients in the first year</li> <li>Navigator successfully coordinated follow-up care for more than 65% of those eligible for navigation that needed coordinated medical follow-up</li> <li>Navigator achieved 53% show rate and a 27% no-show rate over the course of the year</li> <li>Utilized Electronic Health Information Exchange (HIE) tool with one clinic that enabled the valuable provision of medical record documentation through a secured email system, which is now being rolled out to other clinics.</li> <li>Tracked outcome of all patient navigator contacts and report quarterly</li> <li>Ensured that at least 30% of navigated patients keep their post-discharge follow-up appointment with a primary care provider at their medical home.</li> <li>Tracked utilization data to demonstrate impact of program on emergency department return rate and decreased readmission rate.</li> <li>Developed improved communications between ED and medical homes – Develop a system to ensure that medical homes are willing to schedule follow-up appointments, and that the ED is able to send relevant records needed by PCP.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$41,000 from CHW Grants Program
<b>FY 2012</b>	
<b>Goal 2012</b>	Increase the ability of patients to access primary care follow-up appointments and retain those appointments with the help of full-time navigator, thereby decreasing the over-use of the emergency room for primary care sensitive conditions.
<b>2012 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Continue to refine measures of success for the navigation program (i.e. financial and utilization analysis)</li> <li>Continue to work collaboratively with San Francisco Health Plan to identify ways to continue improving communication between the ED and medical homes and to continue the navigation services through existing staff and improved systems, or through a position funded with another agency.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>FY 2011: Navigator screened over 4,029 patients for navigation through chart review and referral</li> <li>FY 2011: Navigator completed 689 navigation encounters for unduplicated patients in the first year</li> <li>FY 2011: Navigator successfully coordinated follow-up care for more than 65% of those eligible for navigation that needed coordinated medical follow-up</li> <li>FY 2011: Navigator achieved 53% show rate and a 27% no-show rate over the course of the year</li> <li>Utilized Electronic Health Information Exchange (HIE) tool with one clinic that enabled the valuable provision of medical record documentation through a secured email system, which is now being rolled out to other clinics.</li> </ul>
<b>Intervention Strategy for</b>	<ul style="list-style-type: none"> <li>Shift focus to primarily Glide and HSF patients</li> </ul>

<b>Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Ensure that at least 30% of navigated patients keep their post-discharge follow-up appointment with a primary care provider at their medical home.</li> <li>• Continue to track utilization data to demonstrate impact of program on emergency department return rate and decreased readmission rate.</li> <li>• Continue to improve communications between ED and medical homes</li> </ul>
<b>Community Benefit Category</b>	Poor-Community Health Improvement Services

<b>Rally Family Visitation Services</b>	
<b>Hospital CB Priority Areas</b>	<input type="checkbox"/> Increase Access to Quality Medical Care <input checked="" type="checkbox"/> Improve Behavioral Health <input type="checkbox"/> Promote Healthy Aging <input type="checkbox"/> Increase Physical Activity and Healthy Eating to Reduce Chronic Disease <input type="checkbox"/> Have a Safe and Healthy Place to Live
<b>Program Emphasis</b>	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
<b>Link to Community Needs Assessment</b>	80% or more of the families in conflict referred to Rally Family Visitation program have a history of domestic violence or child abuse.
<b>Program Description</b>	<ul style="list-style-type: none"> <li>• Rally Family Visitation Program provides a safe and secure structured environment in which children can visit with their court-ordered non-custodial parent when there is a high level of conflict, including domestic violence, between divorced/separated parents.</li> <li>• The goal of the program is to ensure the safety of children and adult victims.</li> <li>• The program serves predominantly low-income families.</li> </ul>
<b>FY 2011</b>	
<b>Goal FY 2011</b>	Establish full services at all centers to serve the Tenderloin and SOMA, Mission, OMI and Bayview neighborhoods.
<b>2011 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Committed satellite centers are in place and fully operational.</li> <li>• Funding is secured for additional years to ensure long term sustainability.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• Implemented federal grant by establishing satellite centers in two San Francisco neighborhoods.</li> <li>• Began case management services.</li> <li>• FY10: 1687 of monitored exchanges, 879 supervised and facilitated visits. In addition, provided intake/orientation services to 203 children and 300 adults.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Continue to work with government and community partners to achieve goals and objectives and ensure long term sustainability of program.</li> <li>• Research other sources of funding to provide further sustainability for the program.</li> </ul>
<b>Result FY 2011</b>	<ul style="list-style-type: none"> <li>• Implemented federal grant by establishing satellite centers in two San Francisco neighborhoods.</li> <li>• Began case management services.</li> <li>• FY 2011: 1303 of monitored exchanges, 772 supervised and facilitated visits. In addition, provided 276 intake/orientation services to 206 children and 276 adults.</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	<ul style="list-style-type: none"> <li>• Expenses: \$440,868, Revenue: \$288,373, Benefit: \$152,495</li> </ul>
<b>FY 2012</b>	
<b>Goal 2012</b>	<ul style="list-style-type: none"> <li>• Continue to work with government and community partners to achieve goals and objectives and ensure long term sustainability of program.</li> <li>• Research other sources of funding to provide further sustainability for the program.</li> <li>• Fully implement services in Marin County</li> <li>• Develop funding sources for a case management program</li> </ul>
<b>2012 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Marin County Center is fully operational.</li> <li>• Additional funding sources have been identified</li> <li>• Funding is secured for additional years to ensure long term sustainability.</li> </ul>
<b>Baseline</b>	Domestic Violence continues to be a major problem for families in San Francisco. Rally is the only program of its kind working directly with the family court. The present trend for Rally demonstrates that while there were fewer families served during FY11, they are receiving services for a longer period of time.
<b>Intervention Strategy for Achieving Goal</b>	Continue to work with government and community partners to achieve goals and objectives and ensure long term sustainability of program.
<b>Community Benefit Category</b>	Poor-Community Health Improvement Services

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 Complete Summary - Classified Including Non Community Benefit (Medicare)  
 For period from 7/1/2010 through 6/30/2011

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses Revenues	
<b><u>Benefits for Living in Poverty</u></b>						
Traditional Charity Care	3,497	3,620,156	0	3,620,156	1.8	1.7
Unpaid Cost of Medicaid	9,859	44,707,650	29,208,687	15,498,963	7.5	7.1
Means-Tested Programs	1,872	4,891,636	0	4,891,636	2.4	2.2
<b>Community Services</b>						
Cash and In-Kind Contributions	2,540	730,471	0	730,471	0.4	0.3
Community Benefit Operations	0	181,933	0	181,933	0.1	0.1
Community Health Improvement	1,813	1,795,631	43,193	1,752,438	0.8	0.8
Subsidized Health Services	35	283,265	0	283,265	0.1	0.1
<b>Totals for Community Services</b>	<b>4,388</b>	<b>2,991,300</b>	<b>43,193</b>	<b>2,948,107</b>	<b>1.4</b>	<b>1.4</b>
<b>Totals for Living in Poverty</b>	<b>19,616</b>	<b>56,210,742</b>	<b>29,251,880</b>	<b>26,958,862</b>	<b>13.0</b>	<b>12.4</b>
<b><u>Benefits for Broader</u></b>						
<b>Community Services</b>						
Cash and In-Kind Contributions	6,651	51,589	24,850	26,739	0.0	0.0
Community Building Activities	0	14,500	0	14,500	0.0	0.0
Community Health Improvement	257	5,054	0	5,054	0.0	0.0
Health Professions Education	806	413,821	237,818	176,003	0.1	0.1
Subsidized Health Services	33,754	196,883	0	196,883	0.1	0.1
<b>Totals for Community Services</b>	<b>41,468</b>	<b>681,847</b>	<b>262,668</b>	<b>419,179</b>	<b>0.2</b>	<b>0.2</b>
<b>Totals for Broader Community</b>	<b>41,468</b>	<b>681,847</b>	<b>262,668</b>	<b>419,179</b>	<b>0.2</b>	<b>0.2</b>
<b>Totals - Community Benefit</b>	<b>61,084</b>	<b>56,892,589</b>	<b>29,514,548</b>	<b>27,378,041</b>	<b>13.2</b>	<b>12.6</b>
<b>Unpaid Cost of Medicare</b>	<b>24,994</b>	<b>62,680,938</b>	<b>49,972,854</b>	<b>12,708,084</b>	<b>6.1</b>	<b>5.8</b>
<b>Totals with Medicare</b>	<b>86,078</b>	<b>119,573,527</b>	<b>79,487,402</b>	<b>40,086,125</b>	<b>19.4</b>	<b>18.4</b>
<b>Totals Including Medicare</b>	<b>86,078</b>	<b>119,573,527</b>	<b>79,487,402</b>	<b>40,086,125</b>	<b>19.4</b>	<b>18.4</b>

# COMMUNITY BENEFIT AND ECONOMIC VALUE

Saint Francis Memorial Hospital uses a cost-to-charge ratio to report charity care costs in our local jurisdiction reports for the City and County of San Francisco. The hospital uses a cost accounting methodology that allocates all indirect costs across all patients seen.

## Telling the Story

Saint Francis Memorial Hospital is committed to soliciting feedback and information from the community around it to help develop goals for its plan. Saint Francis Memorial Hospital collaborated with all private hospitals and the Department of Public Health to develop, evaluate, and publicize our Community Benefit and Charity Care activities in the following ways:

- Saint Francis Memorial Hospital participated in the Building a Healthier San Francisco Assessment Committee which is charged with accumulating data that informs and directs the selection of key areas of focus in each hospital benefit plan.
- Saint Francis Memorial Hospital used the data from the Health Matters in San Francisco website as a basis for their assessment this cycle.
- Saint Francis Memorial Hospital participates in Affinity Group meetings, which is part of the Health Matters in San Francisco's Collaboration Center strategy to continue the engagement of experts and community advocates, thereby enhancing health improvement process of San Francisco.
- Saint Francis Memorial Hospital participates annually in the public presentation of our Charity Care and Community Benefit Reports to the San Francisco Health Commission
- Saint Francis Memorial Hospital has also been a sponsor and steering committee participant for the African American Health Disparity Project and has provided comprehensive information about our hospital benefit plan through presentations to community groups and foundations.
- Saint Francis Memorial Hospital Grants Program derives its direction from the community benefit plan.
- The Corporate Office of CHW posts the Community Benefit Report online as does our own Hospital website.
- The Community Benefit plan is also submitted to the State of California OSHPD.
- Saint Francis Memorial Hospital will post the entire Community Benefit Plan on the HealthMattersinSF.org website, the official repository of the most recent shared County Health Assessment.

For more information about Health Matters in San Francisco initiatives and Health Needs Assessment: <http://www.healthmattersinsf.org/>

To view the Community Benefit Report from Saint Francis Memorial Hospital: [http://www.chwhealth.org/Who\\_We\\_Are/Community\\_Health/STGSS044509](http://www.chwhealth.org/Who_We_Are/Community_Health/STGSS044509)

**Appendix A – Saint Francis Memorial Hospital 2010-2011 Community Advisory Committee Members**

Guido Gores, MD  
**Chair - Community Advisory Committee**  
Internal Medicine, Saint Francis Memorial Hospital  
**SFMH Board of Trustees**

Leroy Looper  
Executive Director  
Reality House West Cadillac Hotel

Gary Aguilar, MD  
Ophthalmologist  
Saint Francis Memorial Hospital

John Rampulla, MD  
Medical Director, Emergency Department  
Saint Francis Memorial Hospital

Wade M. Aubry, MD  
Endocrinologist  
Saint Francis Memorial Hospital

Charlie Range  
Executive Director  
South of Market Health Center

Mel Blaustein, MD  
Psychiatry  
Saint Francis Memorial Hospital  
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Rally Family

Darryl Burton  
Director, Department of Administrative Services  
City & County of San Francisco

Julie Soo  
**SFMH - Board of Trustees**

Susan Campbell  
**Chair - SFMH Board of Trustees**

Ana Valdes, MD  
Medical Director  
St. Anthony's Free Medical Clinic

Bob Dureault  
President  
Saint Francis Foundation

Jennifer Lacson  
Coordinator, Community Services  
Saint Francis Memorial Hospital

Patricia Galamba, MD  
Family Medicine  
Saint Francis Memorial Hospital  
**SFMH Board of Trustees**

JoBeth Walt  
Manager, Community & Volunteer Services  
Saint Francis Memorial Hospital

Geoffrey C. Grier  
Chair - Treatment on Demand  
San Francisco Recovery Theater

Abbie Yant  
Vice President, Mission, Advocacy, and  
Community Health  
Saint Francis Memorial Hospital

Karen Hill, RN, MSN, NP  
Glide Health Services

Tom Hennessy  
President and CEO  
Saint Francis Memorial Hospital

David Knego  
Executive Director  
Curry Senior Center

## Appendix B

### CATHOLIC HEALTHCARE WEST SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY (June 2008)

#### Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

#### Eligibility for Patient Financial Assistance:

- Eligibility for financial assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.
- The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

#### Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
  - a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
  - b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
  - c. a reasonable effort by the CHW facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.
- It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. The need for financial assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.
- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

#### Patient Financial Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the determination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;

- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the CHW facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the CHW facility.

CHW's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as *income* for these purposes.

Communication of the Financial Assistance Program to Patients and the Public:

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient financial assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- CHW system management has developed policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CHW facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, CHW management and CHW facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.