

**Saint Francis Memorial Hospital**

**Community Benefit Report 2013  
Community Benefit Implementation Plan 2014**

A message from Tom Hennessy, President/CEO and Dr. David Malone, Chair, Board of Trustees

When we talk about health care today, the words *budget*, *cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care*. At Saint Francis Memorial Hospital we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

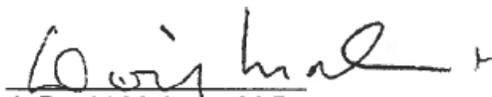
The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At Saint Francis Memorial Hospital we share a commitment to optimize the health of our community. In fiscal year 2013 Saint Francis Memorial Hospital provided \$43,447,236 in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the Saint Francis Memorial Hospital Community Board has reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 3, 2013 meeting.



Thomas Hennessy  
President/CEO



J. David Malone, M.D.  
Chair, Board of Trustees

# TABLE OF CONTENTS

<b>Executive Summary</b>	(Page 4)
<b>Mission Statement</b> Dignity Health Mission Statement	(Page 6)
<b>Organizational Commitment</b> Organizational Commitment Non-Quantifiable Benefit	(Page 6) (Page 7)
<b>Community</b> Definition of Community Description of the Community Community Demographics	(Page 8) (Page 8) (Page 8) (Page 8)
<b>Community Benefit Planning Process</b> Community Needs and Assets Assessment Process Developing the Hospital's Implementation Plan (Community Benefit Report and Plan) Planning for the Uninsured/Underinsured Patient Populations	(Page 9) (Page 9) (Page 11) (Page 12)
<b>Implementation Plan FY14-16</b>	
<b>Report and Update including Measurable Objectives and Timeframes</b> Summary of Key Programs and Initiatives – FY 2014-16 Description of Key Programs and Initiatives (Program Digests)	(Page 13) (Page 14) (Page 16)
<b>Community Benefit and Economic Value</b> Report – Classified Summary of Un-sponsored Community Benefit Expense Telling the Story	(Page 21) (Page 22)
<b>Appendices</b> A. Community Advisory Committee Members B. Patient Financial Assistance Policy C. Community Needs Index (CNI) D. Demographics Snapshot E. Selected Health Care Facilities in San Francisco (map)	(Page 24) (Page 25) (Page 27) (Page 29) (Page 30)

# EXECUTIVE SUMMARY

A member of Dignity Health, Saint Francis Memorial Hospital (SFMH) is located on Nob Hill, and maintains 239 licensed beds, with a staff of over 900 employees and 447 active physicians. The majority, 65 %, of SFMH patients are San Francisco residents, while another 9% live in the greater Bay Area. Among the hospital's inpatient population, 58% are Caucasian, and 16% Asian. African Americans comprise 11% of patients, and Hispanics 8%. SFMH has three offsite 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 nine new operating suites in 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 inpatient psychiatric services, acute rehabilitation, and hyperbaric services.

SFMH has a 15-year partnership with Glide Health Services and provides outpatient and pharmaceutical services for their patients.. 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. SFMH has a history of partnering with the Department of Public Health and other community based agencies to support services that meet the needs of our shared patient population. As all healthcare organizations experience and prepare for changes under the Affordable Care Act (ACA), these partnerships remain essential as together we define the systems of care for the populations who access care at SFMH and those that reside in the communities served by the hospital.

## ***2010 Health Priorities and FY 2013 Accomplishments:***

The 2010 San Francisco community health needs assessment (CHNA), Community Vital Signs, identified the following priority areas which SFMH adopted for FY13: Increase Access to Quality Medical Care, Reduce Chronic Disease through Physical Activity and Healthy Eating, Improve Behavioral Health, Have a Safe and Healthy Place to Live, Promote Healthy Aging and Stop the Spread of Infectious Diseases.

### **Increase Access to Quality Medical Care**

Healthy San Francisco is a means tested charity care program that is organized to provide a system of health care services to the uninsured. Healthy San Francisco links participants with a Medical Home, which is a clinic that provides primary care, social services, case management and preventative care.

Glide Health Services is a medical home to over 3000 patients, most of who are now enrolled in Healthy San Francisco. SFMH supports Glide's 340B drug purchasing program by reimbursing Glide Health Services for the costs of the drugs and drug dispensing. This remarkable program has reduced the costs of pharmaceuticals significantly. SFMH continues to provide outpatient diagnostic services for Glide Health Services patients.

In addition, the SFMH Emergency Department Transitions Program is staffed by a Glide Transitions Coordinator who is out stationed at the SFMH Emergency Department to assist patients in securing and keeping their primary care appointments at community clinics.

SFMH also partners with the SF Transitional Care Program, and supports the Northern California Presbyterian Homes & Services (NCPHS), the agency that provides the network coordination, and transition care staff under City contract. The program provides temporary case management, home care assistance, escorts and in-home personal needs for medically at-risk patients for a safe transition from care facilities to home.

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

FY 2013 marked the fourth year that Chronic Disease Management was identified as a priority focus area. SFMH 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 additional community based agencies, including North East Medical Services (NEMS) and trained instructors for the Diabetes Self Management Program.

In order to address Healthy Eating, a Community Grant was awarded to the Healthy Corner Store Coalition whose target population is Tenderloin neighborhood residents including youth, seniors, disabled, families, formerly homeless, and immigrants who can benefit from having increased access to healthy and affordable food. The Coalition's efforts empower residents to advocate for food justice, engage storeowners around increasing access to healthy corner stores, and create a community-wide shift in how healthy and affordable food is accessed in the Tenderloin. Using the South East Food Access (SEFA) Food Guardian Project, and Mandala Market in Oakland, as their models, the Coalition aims to conduct targeted resident-based research through surveys, assessing corner stores in FY2013. Next, the Coalition will work to support and guided the redesign of one to two corner stores, and training and paying Tenderloin residents to become Food Guardians who actively engage with the community and corner store owners to increase access to healthy and affordable food. The SEFA website is: [www.southeastfoodaccess.org](http://www.southeastfoodaccess.org).

### **Improve Behavioral Health**

Rally Family Services serves children and their parents in San Francisco, Marin and San Mateo counties to provide 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 Chinese American Coalition for Compassionate Care (CACCC) for consultative services to SFMH in order to improve Palliative Care Services for Chinese patients. SFMH provides also office space to Little Brothers Friends of Elderly, an organization that serviced 550 non-duplicated elders in FY2013.

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

SFMH continues to be an active partner in the Hepatitis B Coalition, participating in coalition activities including sponsoring the annual gala.

### ***2012 Community Health Needs Assessment (CHNA) and FY14-16 Health Priorities:***

Building on the success of the 2010 CHNA, San Francisco relied on the Mobilizing for Action through Planning and Partnerships (MAPP) framework to guide the city's 2012 CHNA. The result was a community-driven process that engaged more than 500 community residents, the local health department and nonprofit hospitals and academic partners and embraced the following values:

- To facilitate alignment of San Francisco's priorities, resources, and actions to improve health and well-being.
- To ensure that health equity is addressed throughout program planning and service delivery.
- To promote community connections that support health and well-being.

In June 2013, the SFMH's Community Advisory Committee (CAC) evaluated current programs and the ability, and opportunities to meet the needs of the community. The CAC affirmed that the health priorities and indicators identified through San Francisco's 2012 CHNA are reflective of the community served by the hospital and align with and complement other health improvement efforts at the local, state and national levels. The FY14-16 priorities to improve the health of the community are:

1. Ensure Safe and Healthy Living Environments
2. Increase Healthy Eating and Physical Exercise
3. Increase Access to High Quality Health Care and Services

The SFMH Community Benefit Plan was written to reflect the CHNA and prioritization process and 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 FY2013, SFMH contributed \$43,447,236 in Community Benefit Dollars, including \$4,338,209 in Charity Care services. The social accountability report accounts for all of the costs of financial assistance, including charity care, Medical and Medicare shortfalls and community benefit programs.

## MISSION STATEMENT

The mission of SFMH, as a member of Dignity Health, 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

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

### Excerpt from the Dignity Health San Francisco Service Area Strategic Plan FY2012-2014:

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>

The Community Advisory Committee (CAC) was established in 1997 by the SFMH 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. Robert Harvey, MD, is the current Chair. Four members of the Board of Trustees serve on the CAC as well as representatives from the Saint Francis Foundation. 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.

The CAC roles and responsibilities are defined by its charter as:

- Review and approval of the Community Health Needs Assessment

- Budget Decisions - Annual Community Benefit Budget, developed by staff is reviewed by Senior Leadership and approved by the SFMH 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 SFMH 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 Benefit Plan's goals on a regular basis.

## **NON-QUANTIFIABLE BENEFITS**

### **Advocacy**

SFMH staff advocate for local and state health policy. As such, SFMH staff were appointed to the SF Health Care Services Master Plan Task Force and participated in a number of community meetings gathering input for the SF Health Care Services Master Plan. In addition, SFMH staff met with the Mayor, Director of Public Health, members of the Board of Supervisors, State and Federal representatives regarding matters of importance to SFMH.

### **CHNA Planning Process – San Francisco Health Improvement Partnership (SFHIP)**

SFMH staff actively engaged in the leadership of the Community Health Needs Assessment process, chairing the Building a Healthier San Francisco Coalition, participating on the planning team, hosting meetings and leading the public launch event on June 4, 2013. The CHNA process resulted in the formation of San Francisco Health Improvement Partnership (SFHIP) which is using the collective impact model to oversee the implementation of the changes required to meet the goals and measure set forth. SFMH staff are leading this effort and sit on the SFHIP Steering Committee.

### **Charity Care**

SFMH 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 periodically throughout the year to discuss the annual citywide 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.

### **Long Term Care Coordinating Council (LTCCC)**

SFMH staff participates in the LTCCC whose purpose is to guide the development of an integrated network of home, community-based, and institutional long term care services for older adults and adults with disabilities.

- The LTCCC is an advisory body to the Mayor's Office. The LTCCC oversees all implementation activities and system improvements identified in the Living with Dignity Strategic Plan.
- The LTCCC evaluates all issues related to long term care (LTC) and supportive services, including how different service delivery systems interact. It makes recommendations about how to improve service coordination and system interaction.
- The LTCCC is now part of The SCAN Foundation's Community of Constituents initiative, building a statewide movement to transform the system of care so that all Californians can age with dignity, choice and independence.

The SCAN Foundation's Community of Constituents website is: <http://www.thescanfoundation.org/community-of-constituents>.

### **Mental Health Crisis Systems of Care Workgroup**

SFMH staff participates in this workgroup charged with improving the linkages within the network of services aimed at serving the severely mentally ill in crisis situation. SFMH emergency department and inpatient Behavioral Health Department are part of this network.

### **High Users of Multiple Systems (HUMS)**

SFMH staff participates in this workgroup of providers caring for the patients with high rates of utilization of Emergency Medical Services (ambulances), hospital emergency departments, sobering services and a variety of case management services. The aim of the program is to reduce recidivism through case conferencing and intensive service delivery on a case by case basis.

## **COMMUNITY BUILDING**

### **Immaculate Conception Academy**

SFMH has partnered with Immaculate Conception Academy (ICA) in a work-study program in which students are placed in entry-level, clerical positions exposing them to hospital-based work at SFMH. 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.

## **COMMUNITY**

SFMH is the only hospital located in downtown San Francisco. Patients' accessing the hospital's services encompasses both the city's richest to poorest residents. The 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 825,538 and a daytime population over 1.2 million. The city embraces a diverse ethnic culture 48.4% White, 33.7% Asian, 5.6% African American, 0.4% Native Hawaiian/Pacific Islander, 0.50% American Indian/Alaska Native, 6.7% other. 4.8% two or more races.<sup>1</sup> The population is highly educated with 86% high school graduates.<sup>1</sup> There is an estimated 128,000 persons without health insurance in San Francisco. The cost of living in San Francisco is one of the highest in the nation.

### **The Tenderloin (94102)**

The Tenderloin is one of San Francisco's most densely populated and neediest neighborhoods. Approximately 32,140 residents live in the 94102 zip code.<sup>1</sup> 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.<sup>1</sup> 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 households is only \$24,604, with 13.3% of families living below the federal poverty level. The Tenderloin is a very diverse community: 46.2% is White, 12.9% are African American, 0.9% is American Indian, 25.5% are Asian, and 0.4% are Native Hawaiian or Other Pacific Islander, 9.6% are some other race and 4.5% are two or more races.<sup>1</sup> According to Midge Wilson, Executive Director of the Bay Area Women's and Children's Center, there are 3,500 children living in the Tenderloin.<sup>2</sup> 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.

The Tenderloin 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. For a map of local assets, please see Healthcare Services Master Plan (HCSMP) map of healthcare facilities in Appendix E.

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<sup>1</sup> [www.sfhip.org](http://www.sfhip.org)

<sup>2</sup> <http://www.sfgate.com/opinion/article/Growing-up-in-the-Tenderloin-3-500-kids-must-2620698.php>

### **South of Market Area (94103, 94104)**

South of Market Area (SOMA) is the fastest growing neighborhood in San Francisco with a population of 29,205 residents.<sup>1</sup> 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 continues to be issues for residents. 11.7% of SOMA families live below the federal poverty line. SOMA is a very diverse neighborhood: 48.2% of residents are White, 10.4% are African American, 1.6% are American Indian, 26.0% are Asian, 0.60% are Native Hawaiian/Pacific Islander, 8.1% are some other race, and 5.4% are two or more races.<sup>1</sup> 43% of SOMA residents speak a language other than English at home.<sup>1</sup> 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.

### **Chinatown (94108)**

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 13,182 residents living in this small area.<sup>1</sup> Since the neighborhood's birth in the 1800's it has been home to many immigrants. Today, 23.8% of its families live below the poverty line.<sup>1</sup> The median household income in Chinatown is \$28,719. A majority of residents (57%) living in this neighborhood are Asian. Only 2.2% of residents living in Chinatown are African American, 0.2% are Native Hawaiian/Pacific Islander, and 6.7% are Hispanic or Latino. 63% of residents speak a language other than English at home.<sup>1</sup>

These communities described above are identified as areas of needs using the Community Needs Index (CNI). Refer to Appendix C for CNI map.

## **COMMUNITY BENEFIT PLANNING PROCESS**

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

#### ***FY 2010-2013 Community Needs Assessment Process***

In January 2012, SFMH became aware of a number of other community-based needs assessments that were in progress throughout the city. In order to reduce duplication of effort, leverage resources and to respect community members' time, the hospital aligned its community health needs assessment process with the San Francisco Department of Public Health's (SFDPH) community health assessment (CHA) and improvement processes. The alignment brought together representatives from San Francisco neighborhoods, health care institutions, government agencies, community groups and service providers.

Specifically, hospital and academic partners joined SFDPH to form the CHA/CHIP Leadership Council, which supported the CHA and guided the development and implementation of San Francisco's Community Health Improvement Plan (CHIP). The Leadership Council is committed to transparency and community and partner engagement throughout the community health improvement process.

Community residents from each of San Francisco's 21 neighborhood areas came together for a day-long event to discuss their views of health and their hopes for San Francisco's health future. This resulted in elements of a community-guided health vision for the City and County of San Francisco.

SFDPH convened a 42-member Task Force to support San Francisco's CHA and a parallel effort, the Health Care Services Master Plan (HCSMP). Task Force members represented a range of community stakeholders such as hospitals/clinics, K-12 education, small business, urban planning, consumer groups, nonprofits representing different ethnic minority groups, and more. To ensure community participation in the HCSMP and CHA processes, the Task Force met a total of 10 times between July 2011 and May 2012 – four of those in different San Francisco neighborhoods – and engaged more than 100 community residents in dialogue to better determine how to improve the health of all San Franciscans with a particular focus on the City and County's most vulnerable populations. To encourage community dialogue, Task Force neighborhood meetings took place in the evening, and SFDPH provided interpretation services in Spanish and Cantonese.

SFDPH engaged 224 community residents in focus groups and interviewed 40 community stakeholders to learn more about San Franciscans' definitions of health and wellness as well as perceptions of San Francisco's strengths versus areas for health improvement. Focus groups targeted San Francisco subpopulations (seniors and persons with disabilities, transgendered people, monolingual Spanish speakers, and teens) and specific neighborhoods (Bayview-Hunters Point, Chinatown, Excelsior, Mission, Sunset/Richmond, and Tenderloin). Focus group participants greatly informed San Francisco's health vision as well as the Community Themes and Strengths Assessment.

A 10-member data advisory committee comprised of local public health system partners, residents, and SFDPH staff oversaw the collection of data indicators for the Community Health Status Assessment (CHSA). This body also ensured the integrity of the CHSA's methodology and qualitative data.

A number of consulting firms were also involved throughout the health assessment process, including 1) Heart Beets for community engagement; 2) Circle Point for ongoing communication with stakeholders; 3) Harder and Company for data collection and analysis; 4) Nancy Shemick, MPA, for meeting facilitation and report writing.

### **Community Needs Index**

SFMH 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/language, 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 higher 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 Dignity Health CNI findings are in alignment with the other health indicator data found on the SFHIP.org website.

### ***Establishing Community Health Improvement Plan (CHIP) Priorities***

On August 3, 2012, SFDPH and its nonprofit hospital and academic partners convened nearly 30 stakeholders for a half-day session to identify community-driven, data-based health priorities for action in San Francisco. Participants included representatives from SFDPH, San Francisco's nonprofit hospitals and other members of the Community Benefit Partnership, the University of California San Francisco, and the San Francisco Human Services Agency. Following a brief presentation of San Francisco's Community Health Assessment efforts and resulting data and cross-cutting themes, session participants selected San Francisco's 3 health priorities as follows:

1. Participants reviewed a set of five standard criteria developed and vetted by San Francisco's CHA/CHIP Leadership Council. Inspired by the "Hanlon Method," San Francisco priority-selection criteria include:
  - Magnitude/Size of the Public Health Issue
  - Other Factors Related to Importance of the Public Health Issue
  - Effectiveness of Interventions
  - Feasibility and Sustainability of Intervention Implementation
  - Equity (Please note that San Francisco elected to highlight equity as a priority-selection criterion to uphold the city/county's fundamental value of reducing disparities in health access and outcomes for San Francisco's diverse communities.
2. Each participant individually ranked the seven identified cross-cutting data themes against health priority-selection criteria with "1" indicating highest rank and "7" indicating lowest rank.
3. Facilitators totaled individual scores for each data theme and criterion to identify San Francisco's top 3 health priorities for action. These priorities include:
  - Ensure safe and healthy living environments
  - Increase physical activity and healthy eating
  - Increase access to quality health care and services
4. Session participants reviewed the identified priorities and agreed that all selected priority issues were reasonable and appropriate for San Francisco.

## ***B. San Francisco CHIP: Goals, Objectives, Indicators, Targets Strategies and Community Assets/Resources Aligned with each priority***

The Citywide CHIP process included detailed goals, objectives, indicators, and targets for San Francisco's health priorities as well as strategies and community assets/resources aligned with each priority. Please note that CHIP process selected

the best available indicators to measure community health improvement along its chosen health priorities; however, there is acknowledgement that all indicators present limitations, meaning that more specific and appropriate indicators may become available in the future. In addition, please note that there are a select number of strategies in the current CHIP. This list in no way represents the full spectrum of efforts and partners working to improve population health in San Francisco; rather, listed strategies serve as an abbreviated representation of health improvement work happening in San Francisco among community residents, community-based organizations, as well as the private and public sectors.

San Francisco elected to set targets for each health improvement objective for both 2020 – in alignment with Healthy People 2020 – and 2016. In general, San Francisco determined the 2020 targets by adopting the Healthy People 2020 methodology of setting a 10 percent improvement over the most recent citywide baseline measurement for the respective indicator. This translates to an intermediate target of five percent improvement for 2016.

Focused on health equity, San Francisco deliberated its target setting methodology, considering whether to base targets on citywide averages versus targets that reflect the best-performing sub-populations (e.g., racial/ethnic group, neighborhood, or age group depending on the measure). San Francisco ultimately set targets based on the citywide average – intentionally not setting distinct targets by subpopulation – to show levels of acceptable improvement while also conveying the conviction that all San Francisco residents are entitled to the same high standard of health and wellness.

Utilizing the City and County's Community Health Assessment, SFMH's Community Advisory Committee reviewed and discussed the hospital's existing community benefit activities and assets in regard to each priority, and identified opportunities for collaboration in order to enhance impact and avoid unnecessary duplication of services.

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

At the March 2013 SFMH CAC retreat, the CAC conducted an asset and opportunity mapping activity to identify existing institutional and community partner resources and categorized them under each of the three health priorities from the City and County of San Francisco's Community Health Needs Assessment. In the center of this process was a visual representation created from the Community Health Improvement Process of what community stakeholders view as the future of the Tenderloin.

In May 2013, the CAC evaluated current programs and the ability, and opportunities to meet the needs of the community. The CAC confirmed that health priorities and indicators identified through the City and County's Community Health Assessment are reflective of the Tenderloin community served by the hospital and align with and complement other health improvement efforts at the local, state and national levels. SFMH current priorities align with the goals identified in Community Vital Signs, San Francisco's health assessment and improvement effort conducted in 2010.

In June 2013, the Board of Trustees and hospital leadership reviewed and approved the priorities of the SFMH Community Benefit Plan. This plan will encompass a 3 year period and recognize that many of the upstream contributing factors to health outcomes require a long term effort and commitment. In addition, the plan was approved using the following guiding principles:

- The strategies are to build upon assets and resources and are evidenced-based or best practice strategies, wherever possible.
- Work with our partners to align our efforts to enhance impact and to avoid unnecessary duplication of services.
- These strategies will take into account the Dignity Health goals and metrics and the SFMH Strategic plan.
- Primary focus on geographical area of the Tenderloin. (From the assessment, access to food and ability to increase physical activity are limited in the Tenderloin neighborhood, as reflected by prevention quality indicators, ED utilization and hospitalization rates for these residents, which are high for almost every indicator.)

Many of the services or programs directly address the needs of vulnerable populations in our community with Disproportionate Unmet Health Needs (DUHN). 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, Emergency Department, Glide Health Services, Hep B Free, ED Transitions Coordinator Program, Rally Visitation Services. Data used to validate this selection includes data from the SFHIP.org website.

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

SFMH abides by the Dignity Health 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, SFMH provides outpatient diagnostic services and pharmaceuticals to Glide Health Clinic patients, many of whom are now enrolled in Healthy San Francisco.

In November 2003, the San Francisco Board of Supervisors voted in the "Charity Care Ordinance." This ordinance requires SFMH (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 throughout the year 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.

Efforts to educate and assist residents, patients and their families to the options available under the Affordable Care Act are planned for FY2014.

# FY14-16 PLAN INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major priorities, goals, strategies, expected outcomes for key community-based programs operated or substantially supported by SFMH in 2013. The FY 14-16 Community Benefit priorities are updated according to the new CHNA. Programs to be continued in 2014 are noted by \*. Programs 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 problems.
- 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.

## *Shifting SFMH Community Benefit Plan Priorities*

<b>FY11-13 Community Vital Signs</b>	<b>FY14-16 Community Vital Signs 2.0</b>
Increase Access to Quality Medical Care	Increase Access to High Quality Health Care and Services
Reduce Chronic Disease through Physical Activity and Healthy Eating	Increase Healthy Eating and Physical Activity
Stop the Spread of Infectious Diseases	Ensure Safe and Healthy Living Environments
Improve Behavioral Health	
Have a Safe and Healthy Place to Live	
Promote Healthy Aging	

### ***2010 Health Priorities and FY 2013 Accomplishments:***

The 2010 San Francisco Community Health Needs Assessment (CHNA), Community Vital Signs , identified the following priority areas which SFMH adopted for FY13: Increase Access to Quality Medical Care, Reduce Chronic Disease through Physical Activity and Healthy Eating, Improve Behavioral Health, Have a Safe and Healthy Place to Live, Promote Healthy Aging and Stop the Spread of Infectious Diseases.

#### **Increase Access to Quality Medical Care**

Healthy San Francisco is a means tested charity care program that is organized to provide a system of health care services to the uninsured. Healthy San Francisco links participants with a Medical Home, which is a clinic that provides primary care, social services, case management and preventative care.

Glide Health Services is a medical home to over 3000 patients, most of who are now enrolled in Healthy San Francisco. SFMH supports Glide’s 340B drug purchasing program by reimbursing Glide Health Services for the costs of the drugs and drug dispensing. This remarkable program has reduced the costs of pharmaceuticals significantly. SFMH continues to provide outpatient diagnostic services for Glide Health Services patients.

In addition, the SFMH Emergency Department Transitions Program is staffed by a Glide Transitions Coordinator who is out stationed at the SFMH Emergency Department to assist patients in securing and keeping their primary care appointments at community clinics.

An outgrowth of the Homecoming Services program that began at Saint Francis Memorial Hospital in 2003 is the San Francisco Transitional Care Program. This program received CMS funding this year and is now administered by the Department of Adult and Aging Services. The SFTCP is projected to reduce avoidable hospital readmissions among 5,063 isolated and vulnerable Medicare beneficiaries age 65 and over by approximately 22%. Through transitional care interventions including coordinated communication between hospital discharge teams and community-based Transition Specialists. The model includes: 1) Use of a Personal Health Record 2) Client understanding of Self-Care and Medication Management 3) Confirmation and coordination of Primary Care Physician visit, and 4) Utilization and coordination of

Community Based Services. SFMH continues to partner with Northern California Presbyterian Homes who is the primary services provider for the SFTCP.

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

FY 2013 marked the fourth year that Chronic Disease Management was identified as a priority focus area. SFMH 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 additional community based agencies, including North East Medical Services (NEMS) and trained instructors for the Diabetes Self Management Program.

In order to address Healthy Eating, a Community Grant was awarded to the Healthy Corner Store Coalition whose target population is Tenderloin neighborhood residents including youth, seniors, disabled, families, formerly homeless, and immigrants who can benefit from having increased access to healthy and affordable food. The Coalition's efforts empower residents to advocate for food justice, engage storeowners around increasing access to healthy corner stores, and create a community-wide shift in how healthy and affordable food is accessed in the Tenderloin. Using the South East Food Access (SEFA) Food Guardian Project, and Mandala Market in Oakland, as their models, the Coalition aims to conduct targeted resident-based research through surveys, assessing corner stores in FY2013. Next, the Coalition will work to support and guided the redesign of one to two corner stores, and training and paying Tenderloin residents to become Food Guardians who actively engage with the community and corner store owners to increase access to healthy and affordable food. The SEFA website is: [www.southeastfoodaccess.org](http://www.southeastfoodaccess.org).

### **Improve Behavioral Health**

Rally Family Services serves children and their parents in San Francisco, Marin and San Mateo counties to provide 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 Chinese American Coalition for Compassionate Care (CACCC) for consultative services to SFMH in order to improve Palliative Care Services for Chinese patients. SFMH provides also office space to Little Brothers Friends of Elderly, an organization that serviced 550 non-duplicated elders in FY2013.

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

SFMH continues to be an active partner in the Hepatitis B Coalition, participating in coalition activities including sponsoring the annual gala.

## ***FY 14-16 Community Benefit Plan Programs and Activities***

*(See details in program digest for underlined programs.)*

### **Increase Access to Quality Medical Care**

- **Healthy San Francisco\***
- **Glide Health Clinic\***
- Delancy Street Foundation
- Enrollment Assistance for Government Programs and Charity Care\*
- **SF Transitional Care Program\***
- Support to the MD Charity Care Programs\*
- Radiation Oncology Medical Residency Rotation\*
- **ED Transitional Care Program\***
- **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\*
- Clinical Pastoral Education Program\*
- Meeting Rooms for Alcoholic Anonymous, Bipolar Support and SMART Groups\*
- 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\*

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

- Food Runners program to distribute leftover food to those in need \*
- Little Brothers Friend of the Elderly Program Support \*
- Low cost meals for seniors in the hospital cafeteria \*
- **Chronic Disease Self Management Program** \*

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

- Burn Education\*

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 Dignity Health 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 (CDSMP)</b>	
<b>Hospital CB Priority Areas - 2010</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 hospitalization 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, Curry Senior Center and Northeast Medical Services. 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 2013</b>	
<b>Goal FY 2013</b>	Support coalition of agencies providing CDSMP in the Tenderloin and Chinatown.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Each of the 4 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 a total of 7 classes were completed, including 1 onsite.</li> <li>80% of 106 participants. 85 total completed the class.</li> <li>Hospitalization rates: 0%</li> <li>Trained hospital staff as Diabetes facilitator.</li> <li>Participants recruited, program began September 2012.</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	Market program to physicians' offices, volunteers and community members.
<b>Result FY 2013</b>	<ul style="list-style-type: none"> <li>In partnership with Curry Senior Center and Self Help for the Elderly, North East Medical Services and Department of Adult and Aging Services a total of 20 classes were completed, including 4 classes onsite</li> <li>77% of 337 participants. 259 total completed the class</li> <li>Hospitalization rates: 0%</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	<ul style="list-style-type: none"> <li>\$25,000 from Dignity Health Community Grants Program In Kind expenses donated by SFMH</li> </ul>
<b>FY 2014</b>	
<b>Hospital CB Priority Areas - 2012</b>	<input type="checkbox"/> Increase Access to High Quality Health Care and Services <input checked="" type="checkbox"/> Increase Healthy Eating and Physical Activity <input type="checkbox"/> Ensure Safe and Healthy Living Environments
<b>Goal 2014</b>	Support coalition of agencies providing CDSMP in the Tenderloin and Chinatown.
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Each of the 4 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, North East Medical Services and Department of Adult and Aging Services a total of 20 classes were completed, including 4 classes onsite</li> <li>77% of 337 participants. 259 total completed the class</li> <li>Hospitalization rates: 0%</li> <li>Participants recruited, program scheduled to begin October 2013.</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 - 2010</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 and provides primary care, mental health, HIV/AIDS and recovery services to adults.
<b>FY 2013</b>	
<b>Goal FY 2013</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>2013 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>• FY12: SFMH Glide HSF IP 45; Out Pt 2,504</li> <li>• FY12: GHS UDC- 2,954 GHS Encounters 16,349</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>Result FY 2013</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>• FY13: SFMH Glide HSF IP 56; Out Pt 2,865.</li> <li>• FY13: GHS UDC- 2,098, GHS Encounters 1,547</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>• \$2,254,609* offset by \$575,000 grant = \$1,679,609; *Direct clinical services are accounted for within the traditional care dollar.</li> </ul>
<b>FY 2014</b>	
<b>Hospital CB Priority Areas - 2012</b>	<input checked="" type="checkbox"/> Increase Access to High Quality Health Care and Services <input type="checkbox"/> Increase Healthy Eating and Physical Activity <input type="checkbox"/> Ensure Safe and Healthy Living Environments
<b>Goal 2014</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>2014 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>• FY13: SFMH Glide HSF IP 56; Out Pt 2,865</li> <li>• FY13: GHS UDC- 2,098, GHS Encounters 1,547</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
<b>Healthy San Francisco</b>	
<b>Hospital CB Priority Areas - 2010</b>	<input checked="" type="checkbox"/> Increase Access to Quality Medical Care <input 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>	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 2013</b>	
<b>Goal FY 2013</b>	Provide seamless continuum of care for Healthy San Francisco patients with Glide assigned as their medical home.
<b>2013 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>• FY12: SFMH Glide HSF IP 45; Glide OP HSF2,504; Other IP HSF 380, Other OP HSF 1,957, OP HSF – SMMC 6, OP HSF – CCHA 22</li> <li>• FY12 GHS-HSF UDC 1713</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 2013</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>• FY13: SFMH Glide HSF IP 56; Glide OP HSF 2,865;</li> <li>• FY 13: Other IP HSF 125, IP SMMC HSF 1, Other OP HSF 2,128, , OP HSF – CCHA 15, OP HSF – RWP 1</li> <li>• FY13 GHS-HSF UDC 2,098</li> <li>• Received support from CCSF for Glide/HSF (\$575,000)</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$ 5,731,758(Accounted for as a Means-Tested Program)
<b>FY 2014</b>	
<b>Hospital CB Priority Areas - 2012</b>	<input checked="" type="checkbox"/> Increase Access to High Quality Health Care and Services <input type="checkbox"/> Increase Healthy Eating and Physical Activity <input type="checkbox"/> Ensure Safe and Healthy Living Environments
<b>Goal 2014</b>	Provide seamless continuum of care for Healthy San Francisco patients with Glide assigned as their medical home.
<b>2014 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>• Aim to provide electronic notification to medical home through Mobile MD.</li> <li>• Collaborate with community partners to enroll eligible HSF persons in the MediCAL expansion</li> <li>• Collaborate with SFHP and DPH to develop a system of care for Glide patients that builds on existing provider relationships.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• FY13: SFMH Glide HSF IP 56; Glide OP HSF 2,865;</li> <li>• FY 13: Other IP HSF 125, IP SMMC HSF 1, Other OP HSF 2,128, , OP HSF – CCHA 15, OP HSF – RWP 1</li> <li>• FY13 GHS-HSF UDC 2,098</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Participate in Glide Health Services Committee monthly meetings.</li> <li>• Monitor uptake of Glide HSF patient into managed MediCAL</li> <li>• Facilitate contractual and operations processes for 340b project.</li> <li>• Facilitate interagency discussions with Glide, SFHP and DPH.</li> </ul>
<b>Community Benefit Category</b>	Poor-Community Health Improvement Services

<b>ED Transitions Program</b>	
<b>Hospital CB Priority Areas – 2010</b>	<input checked="" type="checkbox"/> Increase Access to Quality Medical Care <input 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 type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity

	X Collaborative Governance
<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>	In FY13, Glide Health Services was granted funds to employ the Transition Coordinator. The program 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 programs.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	Increase the ability of patients to access primary care follow-up appointments and retain those appointments with the help of Transitions Coordinator, thereby decreasing the over-use of the emergency room for primary care sensitive conditions.
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Track outcome of all Transitions Coordinator 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>	<ul style="list-style-type: none"> <li>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.</li> <li>Hired new Transitions Coordinator in Feb 2012</li> <li>Transitions Coordinator had 373 patient contacts, average of 9 patients per day.</li> <li>88% were seen in the ED; 12% were seen as inpatients</li> <li>50% medical home appointment scheduled; 40% attended</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>Create quarterly reports outlining outcome of all Transitions Coordinator 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 2013</b>	<ul style="list-style-type: none"> <li>Time period: 9 months: ~1200 encounters (GHS &amp; SFMH), attendance rate: 50% Of the 216 patients, seen by the Transitions Coordinator, who had an Emergency Department or Inpatient Admission in the 6 months prior to or after their individual meeting with the Transitions Coordinator: <ul style="list-style-type: none"> <li>15% (33) were not readmitted within 6 months of their meeting</li> <li>46% (99) were readmitted within one month</li> <li>12% (26) were readmitted within one to two months</li> <li>8% (18) were readmitted within two to three months</li> <li>5% (11) were readmitted within three to four months</li> <li>7% (16) were readmitted within four to five months</li> <li>6% (13) were readmitted five months or later after their meeting</li> </ul> </li> </ul>
<b>Hospital's Contribution / Program Expense</b>	\$50,000 from Dignity Health Community Grants Program
<b>FY 2014</b>	
<b>Hospital CB Priority Areas - 2012</b>	<ul style="list-style-type: none"> <li>X Increase Access to High Quality Health Care and Services</li> <li><input type="checkbox"/> Increase Healthy Eating and Physical Activity</li> <li><input type="checkbox"/> Ensure Safe and Healthy Living Environments</li> </ul>
<b>Goal 2014</b>	Increase the ability of patients to access primary care follow-up appointments and retain those appointments with the help of Transitions Coordinator, thereby decreasing the over-use of the emergency room for primary care sensitive conditions.
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>Continue to refine measures of success for the ED Transitions 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 ED Transitions services.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>Time period: 9 months: ~1200 encounters (GHS &amp; SFMH), attendance rate: 50%</li> <li>Of the 216 patients, seen by the Transitions Coordinator, who had an Emergency Department</li> </ul>

	<p>or Inpatient Admission in the 6 months prior to or after their individual meeting with the Transitions Coordinator:</p> <ul style="list-style-type: none"> <li>• 15% (33) were not readmitted within 6 months of their meeting</li> <li>• 46% (99) were readmitted within one month</li> <li>• 12% (26) were readmitted within one to two months</li> <li>• 8% (18) were readmitted within two to three months</li> <li>• 5% (11) were readmitted within three to four months</li> <li>• 7% (16) were readmitted within four to five months</li> <li>• 6% (13) were readmitted five months <b>or later after their meeting</b></li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Shift focus to primarily Glide and managed care MediCal patients</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>• 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>San Francisco Transitional Care Program</b>	
<b>Hospital CB Priority Areas - 2010</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>	The SFTCP programs is targeting the 5,063 Medicare fee for service admissions that are eligible for services.
<b>Program Description</b>	A hospital-to-home transitional care service for older adults and people with disabilities.
<b>FY 2013</b>	
<b>Goal FY 2013</b>	<ul style="list-style-type: none"> <li>• Participate in SFTCP Governance and Operations Committee to add in program enhancement and functionality</li> <li>• Increase number of referrals and acceptance of eligible Medicare beneficiaries in program.</li> <li>• Participate in Operations/Steering Committee</li> </ul>
<b>2013 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• SFMH Target: 90% of eligible persons referred accept the service</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• FY2010: 74 people referred to Homecoming Services</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• Develop methods for identifying eligible Medicare population</li> <li>• Partner with SFTCP.</li> </ul>
<b>Result FY 2013</b>	Launched the CMS funded San Francisco Transitional Care Program (formerly known as Homecoming Services), a community wide transitional care program administered by the Department of Adult and Aging Services. The SFTCP is projected to reduce avoidable hospital readmissions among 5,063 isolated and vulnerable Medicare beneficiaries age 65 and over by approximately 22%. Through transitional care interventions including coordinated communication between hospital discharge teams and community-based Transition Specialists. The model includes: 1) Use of a Personal Health Record 2) Client understanding of Self-Care and Medication Management 3) Confirmation and coordination of Primary Care Physician visit, and 4) Utilization and coordination of Community Based Services.
<b>Hospital's Contribution / Program Expense</b>	\$25,000 from Dignity Health Community Grants Program
<b>FY 2014</b>	
<b>Hospital CB Priority Areas - 2012</b>	<ul style="list-style-type: none"> <li>X Increase Access to High Quality Health Care and Services</li> <li><input type="checkbox"/> Increase Healthy Eating and Physical Activity</li> <li><input type="checkbox"/> Ensure Safe and Healthy Living Environments</li> </ul>
<b>Goal 2014</b>	<ul style="list-style-type: none"> <li>• Participate in SFTCP Governance and Operations Committee to add in program enhancement and functionality</li> <li>• Increase number of referrals and acceptance of eligible Medicare beneficiaries in program.</li> </ul>
<b>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• Participate in SFTCP Governance and Operations Committee to add in program enhancement and functionality</li> <li>• Increase number of referrals and acceptance of eligible Medicare beneficiaries in program.</li> </ul>
<b>Baseline</b>	<ul style="list-style-type: none"> <li>• Actual: SFMH 94 referrals</li> </ul>
<b>Intervention Strategy for Achieving Goal</b>	<ul style="list-style-type: none"> <li>• SFMH Target: 90% of eligible persons referred accept the service</li> <li>• Develop methods for identifying eligible Medicare population</li> <li>• Partner with SFTCP Transition Care Coordinators to increase program acceptance and services.</li> </ul>
<b>Community Benefit Category</b>	Poor-Community Health Improvement Services

<b>Rally Family Visitation Services</b>	
<b>Hospital CB Priority Areas - 2010</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 2013</b>	
<b>Goal FY 2013</b>	Provide full services at all centers to serve the Tenderloin and SOMA, Mission, OMI and Bayview neighborhoods. Open Marin county site.
<b>2013 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>• FY 2012:1300 of monitored exchanges, 1500 supervised and facilitated visits. In addition, provided 286 intake/orientation services to198 children and 296 adults.</li> <li>• 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.</li> <li>• The increase in supervised and facilitated visits and the numbers of children and adults served is directly a result of the opening of the Marin County site.</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 2013</b>	<ul style="list-style-type: none"> <li>• Implemented federal grant by establishing satellite centers in two San Francisco neighborhoods, Marin County is operational and opened a new center in San Mateo County.</li> <li>• Began case management services and therapeutic visits.</li> <li>• FY 2013:2628 of monitored exchanges, 1754 supervised and facilitated visits. In addition, provided 489 intake/orientation services to1141 children and adults.</li> <li>• Marin County is operational</li> </ul>
<b>Hospital's Contribution / Program Expense</b>	<ul style="list-style-type: none"> <li>• Expenses: \$510,452, Revenue: \$114,576, Benefit: \$395,876</li> </ul>
<b>FY 2014</b>	
<b>Hospital CB Priority Areas - 2012</b>	<input checked="" type="checkbox"/> Increase Access to High Quality Health Care and Services <input type="checkbox"/> Increase Healthy Eating and Physical Activity <input type="checkbox"/> Ensure Safe and Healthy Living Environments
<b>Goal 2014</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>2014 Objective Measure/Indicator of Success</b>	<ul style="list-style-type: none"> <li>• San Mateo County is in a new facility</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>	<ul style="list-style-type: none"> <li>• FY 2013:2628 of monitored exchanges, 1754 supervised and facilitated visits. In addition, provided 489 intake/orientation services to1141 children and adults.</li> </ul>
<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

227 Saint Francis Memorial Hospital  
 Complete Summary - Classified Including Non Community Benefit  
 For period from 7/1/2012 through 6/30/2013

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<b><u>Benefits for Living In Poverty</u></b>						
Financial Assistance	1,860	4,338,209	0	4,338,209	2.0	2.0
Medicaid	8,129	40,327,808	24,815,037	15,512,771	7.2	7.3
Means-Tested Programs	3,302	5,731,758	0	5,731,758	2.7	2.7
<b>Community Services</b>						
Community Benefit Operations	1	132,177	0	132,177	0.1	0.1
Community Health Improvement Services	3,124	832,812	0	832,812	0.4	0.4
Financial and In-Kind Contributions	4,875	415,227	0	415,227	0.2	0.2
Subsidized Health Services	3,435	824,761	114,576	710,185	0.3	0.3
<b>Totals for Community Services</b>	<b>11,435</b>	<b>2,204,977</b>	<b>114,576</b>	<b>2,090,401</b>	<b>1.0</b>	<b>1.0</b>
	<b>24,726</b>					
<b>Totals for Living In Poverty</b>		<b>52,602,752</b>	<b>24,929,613</b>	<b>27,673,139</b>	<b>12.8</b>	<b>13.0</b>
<b><u>Benefits for Broader Community</u></b>						
<b>Community Services</b>						
Community Building Activities	30	14,704	0	14,704	0.0	0.0
Community Health Improvement Services	452	14,232	400	13,832	0.0	0.0
Financial and In-Kind Contributions	5,126	87,117	23,351	63,766	0.0	0.0
Health Professions Education	688	375,483	274,781	100,702	0.0	0.0
<b>Totals for Community Services</b>	<b>6,296</b>	<b>491,536</b>	<b>298,532</b>	<b>193,004</b>	<b>0.1</b>	<b>0.1</b>
	<b>6,296</b>					
<b>Totals for Broader Community</b>		<b>491,536</b>	<b>298,532</b>	<b>193,004</b>	<b>0.1</b>	<b>0.1</b>
<b>Totals - Community Benefit</b>	<b>31,022</b>	<b>53,094,288</b>	<b>25,228,145</b>	<b>27,866,143</b>	<b>12.9</b>	<b>13.1</b>
<b>Medicare</b>	<b>23,649</b>	<b>65,456,442</b>	<b>49,875,349</b>	<b>15,581,093</b>	<b>7.2</b>	<b>7.3</b>
<b>Totals with Medicare</b>	<b>54,671</b>	<b>118,550,730</b>	<b>75,103,494</b>	<b>43,447,236</b>	<b>20.1</b>	<b>20.4</b>
<b>Totals Including Medicare and Bad Debt</b>	<b>54,671</b>	<b>118,550,730</b>	<b>75,103,494</b>	<b>43,447,236</b>	<b>20.1</b>	<b>20.4</b>

# COMMUNITY BENEFIT AND ECONOMIC VALUE

SFMH 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

SFMH is committed to soliciting feedback and information from the community around it to help develop goals for its plan. SFMH 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:

- SFMH 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.
- SFMH used the data from the Health Matters in San Francisco website as a basis for their assessment this cycle.
- SFMH 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.
- SFMH participates annually in the public presentation of our Charity Care and Community Benefit Reports to the San Francisco Health Commission
- SFMH 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.
- SFMH Grants Program derives its direction from the community benefit plan.
- The Corporate Office of Dignity Health 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.
- SFMH 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 San Francisco Health Improvement Partnership initiatives and Community Health Needs Assessment [sfhip.org](http://sfhip.org)

To view the SFMH Community Benefit Report, visit:

[http://www.dignityhealth.org/Who\\_We\\_Are/Community\\_Health/STGSS044509](http://www.dignityhealth.org/Who_We_Are/Community_Health/STGSS044509)

**Appendix A –  
Saint Francis Memorial Hospital 2013-2014 Community Advisory Committee Members**

<b>Robert Harvey, MD, Chair</b> Board Member Internal Medicine	<b>Cynthia Kilroy</b> Optum Insight Board of Trustees
<b>Gary Aguilar, M.D.</b> Ophthalmologist	<b>Jennifer Kiss</b> Saint Francis Foundation
<b>Mel Blaustein, MD</b> Psychiatry	<b>Ann Lazarus*</b> Interim-President <b>Saint Francis Foundation</b>
<b>Darryl Burton</b> Resident San Francisco	<b>Bridgett Lanza*</b> Saint Francis Foundation
<b>Susan Campbell*</b> <i>Chair – Board of Trustees</i>	<b>Duncan Ley</b> Saint Francis Foundation Board
<b>Michaela Cassidy</b> Board Member Aspen Affiliates Inc.	<b>David Malone, MD</b> <i>Chair – Board of Trustees</i>
<b>Kevin Causey</b> President Saint Francis Foundation	<b>Fraser McAlpine</b> Hunton & Williams Saint Francis Foundation Board
<b>David Fernandez</b> Transformation Project Director Mercy Housing	<b>Sonia Melara</b> Executive Director Rally Family Visitation Services SF Health Commissioner
<b>Dr. Patricia Galamba</b> Former Chief of Staff/Board Member Family Practice	<b>Charles Range</b> Executive Director South of Market Health Center
<b>Geoffrey C. Grier*</b> San Francisco Recovery Theater	<b>Joanne Sun, MD</b> Medical Director, Emergency Department Saint Francis Memorial Hospital
<b>Tom Hennessy</b> President and CEO Saint Francis Memorial Hospital	<b>Ana Valdes, MD*</b> Medical Director St. Anthony's Free Medical Clinic
<b>Karen Hill, RN, MSN, NP</b> Glide Health Services	<b>JoBeth Walt</b> Manager, Community Services Saint Francis Memorial Hospital
<b>Dina Hilliard*</b> Executive Director North of Market Community Benefit District	<b>Jennifer Lacson – Staff</b> Community Services Coordinator Saint Francis Memorial Hospital
<b>Deborah Jones</b> Director, Case Management Saint Francis Memorial Hospital	<b>Abbie Yant – Staff</b> Vice President Mission, Advocacy and Community Health Saint Francis Memorial Hospital
<b>David Knego</b> Executive Director Curry Senior Center	

\* Member inactive starting FY2014

## Appendix B –

### **DIGNITY HEALTH** SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY (June 2012)

#### Policy Overview:

Dignity Health is committed to providing payment 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, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment 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 Payment Assistance:

- Eligibility for payment 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 payment 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 Dignity Health 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 payment assistance and a determination of financial need occur prior to rendering of services. The need for payment 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 payment assistance becomes known.
- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

#### Patient Payment 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 termination 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 Dignity Health 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 Dignity Health 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 Dignity Health facility.

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

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

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health 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 Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment 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:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.
- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health 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, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.



■	94110	4	78,562	San Francisco	San Francisco	California
■	94111	3.6	3,568	San Francisco	San Francisco	California
■	94112	3.8	78,572	San Francisco	San Francisco	California
■	94114	2.6	30,083	San Francisco	San Francisco	California
■	94115	3.6	34,797	San Francisco	San Francisco	California
■	94116	3	43,812	San Francisco	San Francisco	California
■	94117	3	38,464	San Francisco	San Francisco	California
■	94118	3.4	38,499	San Francisco	San Francisco	California
■	94121	3.4	43,380	San Francisco	San Francisco	California
■	94122	3.2	58,326	San Francisco	San Francisco	California
■	94123	2.4	24,979	San Francisco	San Francisco	California
■	94124	4.8	34,517	San Francisco	San Francisco	California
■	94127	1.8	19,189	San Francisco	San Francisco	California
■	94129	2.8	2,538	San Francisco	San Francisco	California
■	94130	3.2	1,882	San Francisco	San Francisco	California
■	94131	2.6	28,300	San Francisco	San Francisco	California
■	94132	3.4	27,886	San Francisco	San Francisco	California
■	94133	4.8	28,399	San Francisco	San Francisco	California
■	94134	4.2	42,489	San Francisco	San Francisco	California

**CNI MEDIAN SCORE: 3.5**

**Appendix D – Demographics Snapshot**

<b>City and County of San Francisco 2013</b>	
<b>Population</b>	825,580
<b>Diversity - %</b>	
Caucasian	41.7%
Hispanic	15.4%
Asian/Pacific Islander	33.8%
African American	5.3%
American Indian/Alaska Native	0.2%
2+ races	3.3%
Others	0.3%
<b><i>Diversity total</i></b>	<b><i>100.0%</i></b>
<b>Average Income</b>	\$108,281
<b>Uninsured</b>	15.60%
<b>No HS Diploma%</b>	14.3%
<b>Renters %</b>	59%
<b>Medicaid Patients</b>	12.7%
<b>Unemployment</b>	7.3%

Source: Truven Health Analytics

