

Saint Francis Memorial Hospital

**Community Benefit Report 2014
Community Benefit Implementation Plan 2015**

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

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At Saint Francis Memorial Hospital we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 108 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report its community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at each of its facilities, including those in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, Saint Francis Memorial Hospital provided \$31,505,802 in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was \$54,178,153.

Saint Francis Memorial Hospital, an affiliate member Dignity Health, Board of Trustees Directors reviewed and approved the annual Community Benefit Report and Implementation Plan at their October 2, 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 415-353-6000.



Jim Houser
President/CEO



Dr. David Malone
Chairperson, Board of Directors

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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 478 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 17-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.

2013 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 2013 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 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 the San Francisco's 2013 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, including San Francisco Health Improvement Partnership (SFHIP) and the newly formed Tenderloin Health Improvement Partnership (Tenderloin HIP).

The FY14-16 priorities to improve the health of the community are:

- Ensure Safe and Healthy Living Environments
- Increase Healthy Eating and Physical Activity
- Increase Access to Quality Health Care and Services

Highlights from the plan

Tenderloin Health Improvement Plan is a cross-sector collective impact partnership committed to improving community health, safety and well-being in San Francisco's Tenderloin neighborhood. Working collaboratively and in alignment, Tenderloin HIP seeks to address both the social determinants impacting the overall health of the people who live and work in the Tenderloin and the underlying health disparities that perpetuate the status quo. The partnership brings together not-for-profit organizations conducting social service work across a broad spectrum of constituencies, corporate funding allies committed to improving the lives of all who live and work in the neighborhood, and civic leaders and government institutions seeking collective solutions to the seemingly intractable community health challenges in the Tenderloin.

Healthy San Francisco, Enrollment in MediCal Expansion and Covered California San Francisco's innovative program serves the uninsured in San Francisco since 2008. Over the last year, concerted efforts across the city resulted in significant numbers of persons migrating from Healthy San Francisco to primarily MediCal. The Community Benefits staff

partnered with community based agencies and promoted ongoing enrollment into Medical as well as open enrollment into Covered California last fall.

In fiscal year 2014, Saint Francis Memorial Hospital provided \$31,505,802 in financial assistance, community benefit, and unreimbursed patient care. Charity care services which includes services to those enrolled in San Francisco's Health San Francisco program, accounted for \$8,720,154 of these benefits. Including the unreimbursed cost of caring for patients covered by Medicare, the total community benefit expense was \$54,178,153.

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"> ◆ 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 ◆ 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 ◆ Take leadership role in working with Community partners to support the implementation of key initiatives resulting from the hospital's Community Needs Assessments ◆ Improve access to primary care services for under/uninsured and culturally diverse populations in the community through physician recruitment and other hospital sponsored efforts.

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. On November 15, 2013, the CAC agreed to reconstitute the membership to guide the work of the new Tenderloin Health Improvement Partnership initiative; the newly reconstituted committee met in April 2014.

The Chair of the CAC is an Executive Member of the Board of Trustees. Robert Harvey, MD, is the current Chair. Two members of the Board of Trustees serve on the CAC as well two members from the Saint Francis Foundation Board. Additionally, Jim Houser, President/CEO, David Malone, MD, Board of Trustees Chair, and Kevin Causey, Saint Francis Foundation President, serve as ex-officios of the CAC. The CAC is accountable to the 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:

1. Review and approval of the Community Health Needs Assessment.

2. Oversee the development and provides strategic direction of the Community Benefit Report and Plan (Community Action Plan) to advance the Mission and Vision of Tenderloin HIP:
 - a. Community Benefit Plan – The Community Benefit Report and Plan is written by staff members with the input of the CAC. The report provides a thorough summary of all the hospital’s community benefit activities, including Tenderloin Health Improvement initiative, for the previous fiscal year and outlines goals and objectives for the coming fiscal year (i.e. the Common Agenda).
 - b. Function as the governance body for the Tenderloin Health Improvement Partnership (see TLHIP governance documents.)
3. 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.
4. 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.
5. Program Design - The CAC reviews and provides feedback on program and services recommendations developed by the Community Benefit Staff.
6. Program Targeting - Program activities are guided by the use of the Community Needs Index, population specific data from our SFHIP website www.sfhip.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.
7. 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.
8. 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

True community health improvement cannot be achieved without collaboration and shared ownership of strategies and goals with others. Beyond the level of programs and services offered, SFMH is committed to connecting with the community - working with public health and other government agencies, the nonprofit health and social service sectors, civic leaders and constituents - to bring about long-term change in health care quality and delivery.

Advocacy

SFMH staff advocate for local and state health policy. SFMH staff engages with elected and appointed officials at the local, state and federal level as well as a diversity of healthcare thought leaders from the public and private sector in support of SFMH and Tenderloin HIP strategic objectives.

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.

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.

Palliative Care Task Force

SFMH staff participants in the Palliative Care Task Force which focuses on ensuring that San Franciscans have access to palliative care now and in the future, and that the delivery of this care is a collaborative effort between all stakeholders, the San Francisco Department of Public Health (SFDPH) and San Francisco Department of Aging and Adult Services (DAAS) are co-sponsoring the San Francisco Palliative Care Task Force. The San Francisco Palliative Care Task Force brings together a diverse group of representatives from leading health care and community organizations, advocacy and professional associations, as well as consumers and caregivers, to summarize and evaluate the current state of palliative care in San Francisco and make recommendations for the future.

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.

San Francisco Transitional Care Program

The San Francisco Transitional Care Program (SFTCP) is a city-wide, four-to-six week, hospital-to-home program which emphasizes the empowerment of the client or family to manage their health conditions. The program incorporates a "coaching model" which utilizes skill transfer, role modeling and role playing in order to build upon one's confidence and ability to manage one's own care in the home. By providing tools and support that promotes more sustainable self-care skills far-reaching beyond the four to six week intervention, it is a model of client engagement, empowerment and patient-centered focus.

SFTCP is working in collaboration with the Department of Aging and Adult Services which has a 2 year contract starting October 2012 with CMS with demonstration goals to reduce readmissions by 22%. It may extend to a subsequent 3rd year if readmission reduction goals are achieved.

SFTCP has a network of 8 hospitals and 9 community-based organizations to improve transitions of care across settings, improve quality and safety, reduce avoidable hospital readmissions, and generate a savings to the Medicare program.

COMMUNITY BUILDING

San Francisco Health Improvement Partnership (SFHIP)

SFMH staff are active in the SFHIP leadership and steering committees. SFHIP is motivated by a common vision, values, and community-identified health priorities and as such SFHIP will drive community health improvement efforts in San Francisco. The road map for SFHIP is San Francisco's Community Health Improvement Plan (CHIP), the development process for which engaged close to 700 community residents and local public health system partners. The CHIP identifies San Francisco's health priorities (at left) as well as goals, objectives, measures, and strategies for each priority. Building on this foundation, SFHIP will "move the needle" on community health in the next three to five years, and future iterations of the CHIP will drive SFHIP going forward. The SFMH CB plan is designed to align with SFHIP priorities.

Tenderloin Health Improvement Partnership (Tenderloin HIP)

In 2013, SFMH partnered with the Saint Francis Foundation (SFF) to form the Tenderloin Health Improvement Partnership (Tenderloin HIP), a multi-sector collective impact partnership committed to improving community health, safety and well-being in San Francisco's Tenderloin neighborhood. Working collaboratively and in alignment with SFHIP, Tenderloin HIP seeks to address both the social determinants impacting the overall health of the people who live and work in the Tenderloin and the underlying health disparities and inequities that perpetuate the status quo.

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.

San Francisco Hep B Free

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

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 41.7% White, 33.8% Hispanic 15.4%, Asian, 5.3% African American, 0.2% American Indian/Alaska Native, 0.3% other. 3.3% two or more races. The population is highly educated with 85% high school graduates. There is an estimated 15% persons without health insurance in San Francisco, 12.7% persons covered by MediCal, 7.3% unemployed, and 59% persons renting their residences. The cost of living in San Francisco is one of the highest in the nation.³

The Tenderloin (94102)

The Tenderloin neighborhood is the primary focus of the SFMH community benefit plan. It is a very densely populated and destitute neighborhood in San Francisco. Approximately 32,657 residents live in the 94102 zip code.¹ According to the Bay Area and Women's and Children's Center, there is an estimate of 3,500 children that in the Tenderloin.⁴ 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 is a very diverse community: 45.5% is White, 13.4% are African American, 1% is American Indian/Alaska Native, 25.0% are Asian, and 0.4% is Native Hawaiian or Other Pacific Islander, 4.5% are some other race and 10.3% are two or more races.¹ The Tenderloin population by ethnicity and single race include 6,708 (20.5%) Hispanic/Latino and 25,949 (79.5%) Not Hispanic/Latino.¹
- 45% of residents speak a language other than English at home, including Spanish, Asian and Pacific Islander Language, Indo-European Language and other Language.¹
- The average median income of households is only \$25,600, with 14.32% of families living below the federal poverty level.
- It is home to a spectrum of non-profit organizations that provide health, housing, arts, youth, senior and other social services that provide the resources and networks that individuals need to build new lives.

The Tenderloin has been federally designated as a Medically Underserved Area/Population zone, given that 4 Federally Qualified Health Centers (FQHC) are located in the 94102, 94103 and 94133 zip codes. They are: Glide Health Services, Curry Senior Center, 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. The Tenderloin population and economic challenges are 'areas of need' metrics as defined by the Community Needs Index (CNI).

The Tenderloin neighborhood is identified as 'areas of need' using the Community Needs Index (CNI). Refer to Appendix C for CNI map.

¹ www.sfhip.org

² <http://www.countyhealthrankings.org/>

³ www.dignityhealth.org/cni

⁴ <http://www.sfgate.com/opinion/article/Growing-up-in-the-Tenderloin-3-500-kids-must-2620698.php>

COMMUNITY BENEFIT PLANNING PROCESS

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, to 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 need." 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.

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.

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.

Developing the Hospital's Implementation Plan (Community Benefit Report & Implementation Plan)

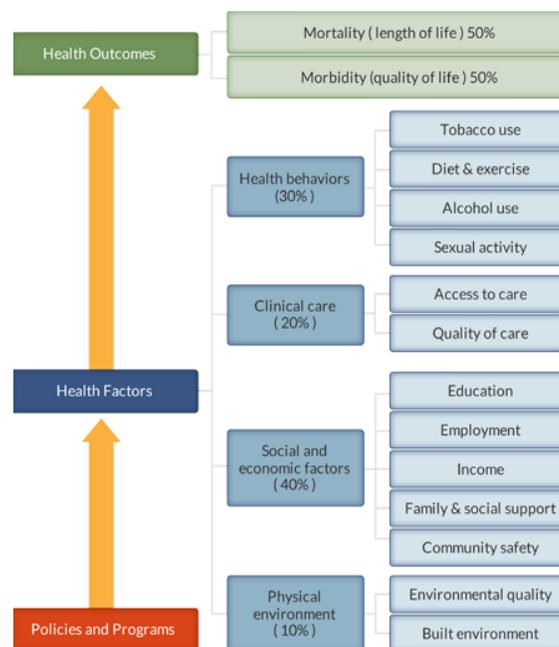
In June 2013, the Board of Trustees and hospital leadership reviewed and approved the priorities of the SFMH Community Benefit Plan which was driven by the 2012 CHNA and SFHIP. This plan encompasses a 3 year period and recognizes that many of the upstream contributing factors to health outcomes require 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.)

Charity Care

The hospital's primary expression of community benefit is through direct care provided to residents of the Tenderloin in the Emergency Department and those admitted to the hospital. The community health needs assessment describes the health disparities of the residents of the Tenderloin. The hospital and the foundation decided that it would explore a different approach to address the health of the residents of the Tenderloin. This yielded the inception of the Tenderloin Health Improvement Partnership (Tenderloin HIP). Exploration through reviewing the literature and having discussions with stakeholders led to the understanding that social determinants are impacting health. Thus, the long-term outcome of Tenderloin HIP is to reduce preventable emergency department visits and ambulatory care sensitive conditions.

The County Health Rankings model below shows schematically how health factors affect health outcomes. The Rankings measure four types of health factors including physical environment, social and economic factors, clinical care, and health behaviors. (A fifth set of factors that influence health – genetics and biology – is not included in the Rankings model.) The Rankings model holds that social and economic factors – also called social determinants of health – account for 40 percent of the impact on health outcomes. A clear implication of this framework is that vulnerable populations and communities often experience health disparities, at the foundation of which are often health inequities.



County Health Rankings model ©2012 UWPHI

Source: County Health Rankings model 2012

The Formation of the Tenderloin HIP

In the fall of 2013, the community benefit work began to focus primarily on Tenderloin HIP, a multi-sector collective impact partnership formed by the SFMH and Saint Francis Foundation, committed to improving community health, safety and well-being in San Francisco's Tenderloin neighborhood. Working collaboratively and in alignment, Tenderloin HIP seeks to address both the social determinants impacting the overall health of the people who live and work in the Tenderloin and the underlying health disparities and inequities that perpetuate the status quo.

Driven by a population-based approach rooted in the vision, values of alignment and health equity and priorities of the San Francisco Health Improvement Partnership (SFHIP), the implementation of the SFMH Community Benefit Plan aims to support and enhance the community building capacity of organizations who have partnered through Tenderloin HIP to develop key initiatives and block action plans to improve the health of residents in the Tenderloin. The plan is also aligned with the goals identified in Community Vital Signs, San Francisco's health assessment and improvement effort conducted in 2012 and based on key public health findings on social determinants of health and collective impact.

Collective Impact Model

The CAC is using the Collective Impact model as a framework to guide the implementation of Tenderloin HIP initiatives. Compared to other collaborative efforts, Collective Impact is the commitment of a group of stakeholders from different sectors coordinating their efforts and working together around a clearly defined goal to create lasting solutions to social problems on a large-scale. There are five conditions of Collective Impact that, together, lead to meaningful results:

1. **Common Agenda:** All participants **share a vision for change** that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.
2. **Shared Measurement:** All participating organizations **agree on the ways success will be measured and reported**, with a short list of common indicators identified and used for learning and improvement.
3. **Mutually Reinforcing Activities:** A diverse set of stakeholders, typically across sectors, coordinate a set of differentiated activities through a **mutually reinforcing plan of action**.
4. **Continuous Communication:** All players engage in **frequent and structured open communication** to build trust, assure mutual objectives, and create common motivation.
5. **Backbone Support:** An **independent, funded staff dedicated to the initiative** provides ongoing support by guiding the initiative's vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing resources.

Priorities

Building on SFHIP, input from a series of stakeholder sessions helped to further refine Tenderloin HIP priorities as follows:

- Safety and Healthy Movement/Physical Activity
- Healthy Eating
- Health Care Access

Goals

The goals of the Implementation Plan include: 1) Safety, 2) Community Connectedness, 3) Opportunities to Make Healthy Choices, 4) Youth/Family Support/Multi-Generations, and 5) Community Services for Unmet Needs. The consensus on Goals 1 and 2 were high and lend themselves to a place-based strategy. Goal 3, which trailed behind, reinforces the place-based strategy, while also making inroads into the other two priorities. Most mentioned opportunities were food/nutrition/cooking access; exercise/physical activity; health education/fairs/screenings; escorts and navigation; and language and cultural supports. Goals 4 and 5 rely on mid-term alignment and policy strategies, and can be incorporated as opportunities arise. The top gaps in community services for unmet needs that emerged were mental health services, substance abuse services, dental care, pediatric care, prenatal care, cultural/linguistic support, and urgent care.

Theory of Change

The hypothesis of Tenderloin HIP is that place-based initiatives focusing on grassroots action and scalable pilot projects built on common needs identified by Block Teams, and provide avenues for resident design, implementation, decisions, learning, connections, and employment will facilitate coordinated, positive street activation and improve safety and promote healthy movement.

Strategies

The Implementation Plan's strategy seeks to weave the benefits of:

- Collective Impact and Alignment

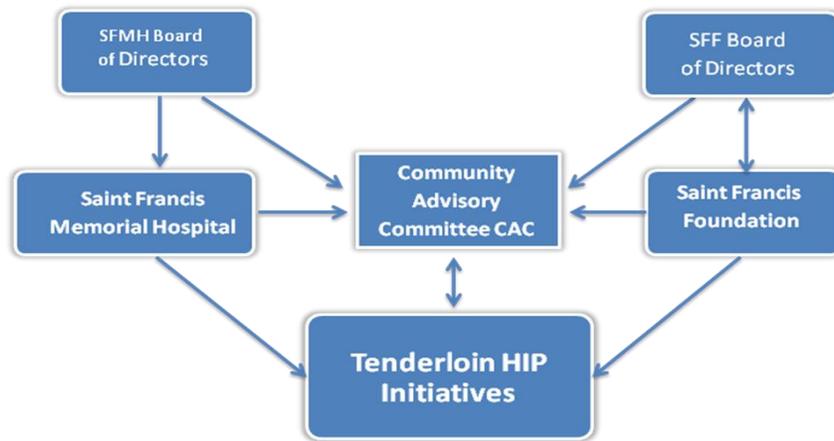
- Place-Based Initiatives built on evidenced-based, best and promising practices
- Investments
- Backbone Infrastructure and Resources
- Shared Learning

Collective Impact and Alignment: Public/Private Partners to Community/Residents

One of the conditions of collective impact is backbone support. SFMH and SFF have dedicated staff and resources to implement a systemic approach to facilitate the alignment and support of contributions, policies and connections between public and private partners, community and residents. Examples of alignment activities include the following:

- Engage and align relevant multi-sector partners, working groups, resources, activities, and policies.
- Address the systemic underpinnings needed to improve health and well-being of Tenderloin residents.
- Strengthen the Tenderloin voice and impact on policy and resource decisions.

As part of building the Collective Impact infrastructure, the Community Advisory Committee was reconstituted to align and guide the work of Tenderloin HIP a key component of the hospital’s FY15 Community Benefit Plan:



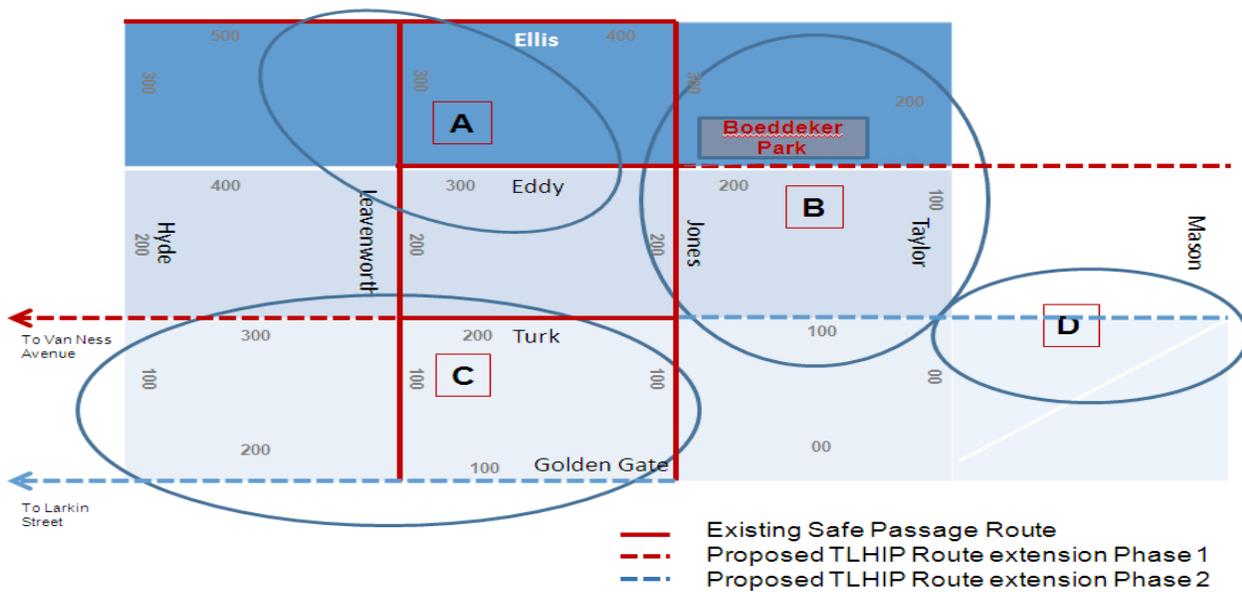
Place-Based Initiatives built on evidenced-based, best and promising practices

A Tenderloin HIP stakeholder team comprised of law enforcement, housing, city real estate development data, Office of Economic and Workforce Development, healthy corner store, health care and San Francisco Department of Public Health’s Environmental Health recommended three specific block areas within a ten block zone to anchor the development of place-based projects based on hard data, mapping, and participant expertise. The criteria below included:

- Blocks with properties that will not gentrify
- Proximity of blocks to each other
- Supports and builds on key assets
- Safe Passage resident corridors
- Healthy anchor organizations for residents
- Density of families and seniors

Members of Tenderloin HIP self-identified to join block teams to build on local strengths and leadership, develop a plan to identify pilot projects and identify common needs in the neighborhood to increase community capacity. Blocks A, B, and C activities build on existing and/or new block activities to positively activate the streets through mutually reinforcing activities. Block D is continuing its independent *Take Back the Block* activities, while staying in communication about future alignment opportunities.

Tenderloin HIP Action Zones:



Investments

SFMH and SFF staff strategizes to mobilize and align resources (public and private) in support of organizations implementing key initiatives, in addition to providing technical support. Project selection criteria were developed by the Tenderloin HIP staff and vetted by the CAC to provide a framework to discern opportunities with the potential for short-term quick wins and for mid- and long-term catalytic approaches to address complex challenges.

Backbone Infrastructure and Resources

One of the conditions of the Collective Impact approach is backbone support, an independent, funded staff dedicated to the initiative provides ongoing support by guiding the initiative's vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing resources. SFMH and SFF staff and resources are dedicated to the Tenderloin HIP project to provide effective backbone support. Overtime, Tenderloin HIP can expect these activities to lead to changes among partners, funders, and community members which, in turn, lead to more effective systems and improved community outcomes.

Shared Learning

To facilitate shared measurement, coordinate activities, and engage in continuous communication, the Tenderloin HIP orchestrates opportunities for shared learning which include the following:

- Stakeholder Sessions: Learning sessions designed and facilitated to analyze outcomes, refine metrics, and sharpen the focus of Tenderloin HIP activities and ensure sustainability through rapidly institutionalizing successful efforts.
- Complex Issue Exploration Working Groups: Mental Health, Crime and Drugs, Housing and Gentrification, Substance Abuse and Recovery, Business and Economy, and Resident Workforce and Leadership Development.
- Evaluation: Investing and coordinating in infrastructure and resources to measure the success of the initiative at large and effectiveness of place-based initiatives occurring at the block level.

Initiative/Project Selection Criteria

Multiple approaches are needed to systemically and sustainably improve health. The initiative mix creates mutually reinforcing activities that help achieve top goals and build a platform for more complex systemic interventions. Key initiatives emerged from common needs identified by Block Team Plans. Block Team Plans reflected input from over 100 stakeholder organizations and from Tenderloin resident focus groups. Project selection has been driven by stakeholders, data, research, best and promising practices, and collective impact principles. The following lenses inform how the Community Advisory Committee considers programs, and will continue to be refined to strengthen results as the initiative matures overtime.

Criteria

- Project is specific, relates to purpose and supports Tenderloin HIP vision.
- New collaborations, different ways to collaborate for greater/efficient outcomes.
- Goals and Objectives are “SMART”: Specific – target a specific area for improvement. Measurable – quantify or at least suggest an indicator of progress. Assignable – specify who will do it. Realistic – state what results can realistically be achieved, given available resources. Time-related – specify when the result(s) can be achieved.
- Evaluation plan/strategy is clearly stated and relevant.
- Measurable results with available or easily accessible metrics.
- Sustainable solution.
- Scalable, Tenderloin-wide impact.
- Builds on best and promising practices.
- Addresses SFHIP Core Values: Equity for underserved; Aligns resources/actions; Community connections.
- Addresses Tenderloin HIP Priorities: Safe Environment & Healthy Movement; Health Care Access; Healthy Eating.
- Addresses Tenderloin HIP Top Goals: Safety; Community Connectedness; Opportunities to Make Healthy Choices.
- Multiple, mutually reinforcing activities.
- Community/resident-driven selection, design, implementation, employment, learning, decisions.
- Participation and support of residents, volunteers, property owners and/or merchants.
- Invests in youth and families/multigenerational approach.
- Fills top service gaps (dental, mental health, substance abuse, urgent care, prenatal, pediatrics).
- Budget is complete, realistic, accurate and appropriate.

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, and Rally Visitation Services. Data used to validate this selection includes data from the SFHIP.org website.

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 were implemented in FY2014.

FY14-16 PLAN INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major priorities, goals, strategies, and expected outcomes for key community-based programs operated or substantially supported by SFMH in 2015. The FY 14-16 Community Benefit priorities were updated to align FY14-16 CHNA Community Vital Signs 2.0 with FY15-16 Tenderloin HIP priorities. 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

FY11-13 Community Vital Signs	FY14-16 Community Vital Signs 2.0	FY15-16 Tenderloin HIP
Increase Access to Quality Medical Care	Increase Access to High Quality Health Care and Services	Safety and Healthy Movement
Reduce Chronic Disease through Physical Activity and Healthy Eating	Increase Healthy Eating and Physical Activity	Healthy Eating
Stop the Spread of Infectious Diseases	Ensure Safe and Healthy Living Environments	Health Care Access
Improve Behavioral Health		
Have a Safe and Healthy Place to Live		
Promote Healthy Aging		

FY 14 Community Benefit Plan Programs and Activities

Establishment of the Tenderloin Health Improvement Partnership

In a parallel process to its partnership with the San Francisco Health Improvement Partnership (SFHIP), SFMH collaborated with the Saint Francis Foundation (SFF) initiated the Tenderloin Health Improvement Partnership (Tenderloin HIP), a multi-sector collective impact partnership committed to improving the safety, health and well-being of residents in San Francisco’s Tenderloin neighborhood. From January-April 2014, Tenderloin HIP convened over 100 organizations to participate in stakeholder sessions to identify needs, assets and activities. The stakeholders used existing data from the Community Health Improvement Plan (CHIP) for San Francisco, Community Vital Signs 2.0 and others to help inform the development of goals and strategies. In the spirit of alignment, Tenderloin HIP adopted and re-prioritized the priorities of SFHIP as follows:

- Safety and Healthy Movement/Physical Activity
- Healthy Eating
- Health Care Access

Reconstitution of the Community Advisory Committee Membership

In November 2013, the Community Advisory Committee agreed to reconstitute the membership of the Community Advisory Committee as a means of harnessing the combined strengths of the content experts and community to guide the work of the new Tenderloin HIP initiative. The reconstituted committee convened its inaugural meeting April 2014. The membership includes multi-disciplinary representation which reflects the diversity of Tenderloin HIP and the Tenderloin community. The Committee approved the inclusion of Tenderloin HIP as a key component of the hospital’s FY15 Community Benefit Plan, which focuses on addressing upstream social determinants of health through community building activities.

Increase Access to Quality Health Care and Services (formerly 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. Healthy San Francisco HSF allowed participants that were eligible for Medi-cal and Covered California to remain in HSF due to the enrollment problems with Covered California in 2013. It is estimated that 47% of current HSF participants are estimated to qualify for expanded Medi-Cal or health insurance through Covered California².

- The following program Eligibility Changes that need to be approved by the San Francisco Health Commission (September 2, 2014 meeting).
 - Remove the 65 age limit for eligibility
 - Decrease income eligibility limit from 500% FPL to 400% FPL
 - Extend the current HSF Transition Period to allow those eligible for Covered California to continue their HSF participation through December 31, 2015.³
- On July 25, 2014 Mayor Ed Lee announced he was reconstituting the UHC to be chaired by Barbara Garcia, Director of Department of Public Health. Dignity Health will have representation on the UHC via representation from Wade Rose and Abbie Yant.

Glide Health Services is a medical home to over 3000 patients, many whom are enrolled in Healthy San Francisco and are eligible for the expansion under MediCal. 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, a founding partner of the **SF Transitional Care Program**, continues to participate in the governance and operations of the program. This program is no longer considered a community benefit program because it is now funded by the Centers for Medicare and Medicaid as a benefit for Medicare fee for service beneficiaries.

Outreach to the Uninsured

The Community Benefits staff worked with Patient Financial Services staff to ensure that in language information was available to persons accessing care and services at SFMH regarding affordable health insurance options through Medi-Cal or Covered California.

Increase Healthy Eating and Physical Activity (formerly Reduce Chronic Disease through Physical Activity and Healthy Eating)

FY 2014 marked the fifth year that Chronic Disease Management was identified as a priority focus area. SFMH sustained its partnership with Self Help for the Elderly, Curry Senior Services and North East Medical Services (NEMS) and supported the network of providers in the Tenderloin that offer the Chronic Disease Self Management Program developed by Stanford University.

In order to address Healthy Eating and Physical Activity, a Community Grant was awarded to the Bay Area Women's and Children's Center for Tenderloin Youth Sports Initiative with Tenderloin Community School; the Boys and Girls Club Tenderloin Clubhouse for Power Play a healthy lifestyles initiative that delivers physical activity, healthy meals and cooking classes; and Episcopal Community Services for the provision of microwave and mini-fridges, cooking classes and health fairs to 124 residents at the Crosby Hotel, a single room occupancy building in the Tenderloin.

Ensure Safe and Healthy Living Environments (formerly 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.

² July 18, 2014 Report to Healthy San Francisco Advisory Committee by Kathleen Abanilla

³ July 18, 2014 Healthy San Francisco and City Options Policy Change from Kim Oka

FY 14-16 Community Benefit Plan Programs and Activities

Note: Programs to be continued in 2015 are noted by an asterisk (*)

Tenderloin Health Improvement Partnership (Tenderloin HIP)*

Tenderloin HIP short- and mid-term initiatives focused on improving safety and healthy movement are underway or poised for launch fall 2014. Resident engagement is essential to success and is being built into design, implementation, participation, learning, and employment opportunities. The hypothesis is that success of these initiatives will build the groundwork for broader, targeted, and systemic solutions alike to meet the five core principles of the Community Benefit Plan described above.

Tenderloin HIP Goals	Tenderloin HIP Strategies
<ul style="list-style-type: none"> • Community Connectedness • Opportunities to Make Healthy Choices • Youth/Family Support/Multi-Generations • Community Services for Unmet Needs 	<ul style="list-style-type: none"> • Collective Impact and Alignment • Place-Based Initiatives built on evidenced-based, best and promising practices. • Investments • Backbone Infrastructure and Resources • Shared Learning

Overview of Tenderloin HIP Activities and Outcomes

Activity	Short-Term Outcomes	Intermediate Outcomes
Guide vision and strategy	Partners share a common understanding of the need and desired result	Partners' individual work is increasingly aligned with the initiative's common agenda
Support aligned activities	Partners increasingly communicate and coordinate their activities toward common goals	Partners collaboratively develop new approaches to advance the initiative
Establish shared measurement practices	Partners understand the value of sharing data	Partners increasingly use data to adapt and refine their strategies
Build public will	Guide vision and strategy	More community members feel empowered to take action on the issue(s)
Advance policy	Partners increasingly communicate and coordinate their activities toward common goals	Policy changes increasingly occur in line with initiative goals
Mobilize funding	Funding is secured to support initiative activities	Philanthropic and public funds are increasingly aligned with initiative goals

Collective Impact and Alignment: Public/Private Partners to Community/Residents

Building the Collective Impact Backbone

Phase 1 Planning: From November 2013-June 2014, SFMH in partnership with SFF achieved the following:

- Create backbone organization
- Collect and map data
- Convene stakeholders/identify partners
- Build a common agenda
- Draft a collective plan
- Select success indicators
- Design governance structure
- Develop funding process
- Fundraise/align revenue streams

Phase 2 Implementation: Expected to launch Fall 2014 and include the following objectives:

- Implement 3 Healthy Block Pilot Projects
- Align/convene working groups
- Gather data

- Learn from results
- Refine strategies & plan based on outcomes
- Address policies

Office of Economic and Workforce Development: Central Market/Tenderloin Partnership Economic Strategy

In parallel to Tenderloin HIP, the Mayor’s Office of Economic and Workforce Development (OEWD) has been working on revising their Central Market/Tenderloin Partnership Economic Strategy. Tenderloin HIP meets regularly with OEWD to learn and integrate the Tenderloin HIP with the city’s urban development plan.

Funding

With the new governance structure in place to guide the work of Tenderloin HIP, staff and the CAC have worked to align the grants solicitation and allocation processes of SFMH and SFF. In addition, SFMH and SFF work collaboratively to identify and align assets and resources and influence the distribution of private and government funds.

Place-Based Initiatives built on evidenced-based, best and promising practices:

Boeddeker Park and Clubhouse: Boeddeker Park and Clubhouse is a newly renovated property located in the heart of block area B and is scheduled to reopen in the fall of 2014. The Park will offer diverse programming for the Tenderloin community seven days a week using a new public/private partnership model that includes the Boys and Girls Club of San Francisco as the Master Tenant of the Park, YMCA and Safe Passage as Anchor Organizations, and Recreation and Parks Department. The Park will be a community hub for the Tenderloin to stimulate community connectedness and impact ability of residents of all ages to make healthy choices.

The Boys and Girls Club of San Francisco is facing entirely additive work to the existing operations of their organization serving as the Master Tenancy of Boeddeker Park. Operating expenses include Site Director and Program Manager (both FTE), Teen Staff, and various other staff member (PTE) to offer specialized programs for youth after-school and in the summer and the supplies required to run these programs.

- Tenderloin HIP staff have been attending and coordinating meetings to understand and develop solutions to address safety and security needs of the park and provide technical assistance and align/secure funding from both public and private sectors to support start-up costs and/or offset security costs.

Safe Passage: Tenderloin Safe Passage is a direct response to safety concerns raised in 2008, by neighborhood parents, following an incident where a six year old child was lost in the Tenderloin neighborhood. These parents requested a heightened sense of community-based responsibility for children’s safety. It is the first comprehensive, community driven effort to address neighborhood-wide street safety in the Tenderloin.

Tenderloin Safe Passage uses a three-pronged community-based approach to improve safety in a high crime neighborhood. Improving public safety through a) personal safety trainings for all members of the community, b) a sidewalk mural installation visually designating the safe route, and c) volunteers posted as Corner Captains to be a safety presence, activating a coordinated system of response.

The current Tenderloin Safe Passage model focuses on youth safety, but it ultimately benefits all community members, including adults and seniors, in keeping themselves safe. In fact, there has been much interest and promised engagement from senior serving agencies in the neighborhood through Tenderloin HIP. Tenderloin Safe Passage will respond to the safety needs of other target populations, such as seniors, through engagement, involvement, and route/shift expansion.

- Tenderloin HIP staff have been working with Safe Passage staff to provide technical assistance to expand the program scope to include multi-generations and stipend residents, in addition to providing technical assistance to secure funding from both public and private sectors to support start-up costs.

Boeddeker Park and Safe Passage were endorsed by the CAC as foundational to the success of the place-based strategy in which initiatives and activities can be layered upon.

Block Plan Projects:

Tenderloin HIP staff builds capacity within Tenderloin HIP block zones through community convening that fosters neighbor- to-neighbor relationships, understands activities and opportunities that can be programmed to create positive street activation and resident engagement block-by-block.

- Tenderloin HIP staff are working with block teams to provide technical assistance to develop these place-based block plans to include initiatives that build on Boeddeker Park and Safe Passage.

Green Mobile Health Education Program: FGTT's Green Mobile Health Education Program addresses health needs by teaching skills and knowledge to prevent obesity, diabetes, and other health problems in communities where health is most negatively impacted. The kitchen's mobility allows outreach to areas hardest hit and difficult to reach. The project will provide a kick-off Theater Event at 12 different SROs in the Tenderloin neighborhood (initially in block A), followed by 8 weekly health, cooking, and green lifestyle classes and twice weekly physical development classes for 8 weeks (including Tai Chi or White Crane Chinese Martial Arts) at each hotel for a total of 92 health classes and 92 physical development sessions.

Merchant Engagement and Business Attraction/Retention: The North of Market Neighborhood Improvement Corporation/Tenderloin Economic Development Project (TEDP) will continue and expand its successful TenTechConnect and Business Attraction/Retention programs in key block groups identified through the Tenderloin HIP. This approach assures that outcomes will be concentrated in the blocks identified by Tenderloin HIP as being in the greatest need of assistance and with the greatest potential to produce positive change in the neighborhood. Over the coming year, TEDP will engage with merchants in these targeted blocks so their business operations become more profitable and sustainable. TEDP will also work to attract new businesses in the targeted zones that will provide needed services and employment opportunities for Tenderloin residents. By engaging with business owners, TEDP's efforts will promote and create a positive business climate, improve the health and safety of the Tenderloin community, and create conditions necessary for business success and self sufficiency. TEDP will be able to successfully implement these programs through its ability to overcome significant language and cultural barriers that tend to isolate and constrain the success of Tenderloin business owners. TEDP is able to engage the large population of Vietnamese business owners in their native language and has the resources to translate materials and services into Chinese and Spanish.

Backbone Infrastructure and Resources:

SFMH and SFF will continue to dedicate staff to build capacity, efficiency and effectiveness of Tenderloin activities and resources, gather and disseminate relevant data and information to Tenderloin HIP stakeholders and develop common measures and learning to strengthen Tenderloin activities, partnerships, and outcomes. Staff will also invest time in exploring the Community Platform and developing the evaluation plan.

Shared Learning:

To facilitate shared measurement, coordinate activities, and engage in continuous communication, the backbone orchestrates opportunities for shared learning which include the following:

- Stakeholder Sessions (Twice a year): Design and convene at least 2 facilitated learning sessions to analyze outcomes, refine metrics, and sharpen the focus of Tenderloin HIP activities and ensure sustainability through rapidly institutionalizing successful efforts.
- Complex Issue Exploration Working Groups: Design and convene at least 6 working groups focused on Mental Health, Crime and Drugs, Housing and Gentrification, Substance Abuse and Recovery, Business and Economy, and Resident Workforce and Leadership Development.
- Evaluation: Invest and coordinate infrastructure and resources to measure the success of the initiative at large and activities happening at the block level.

Other Ongoing Community Benefit Programs:

Safety and Healthy Movement (Formerly Have a Safe and Healthy Place to Live and Ensure Safe and Healthy Living Environments)

- Burn Education*

Healthy Eating (Formerly Increase Physical Activity and Healthy Eating to Reduce Chronic Disease and Increase Healthy Eating and Physical Activity)

- 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** *

Health Care Access (Formerly Increase Access to Quality Medical Care and Increase Access to High Quality Health Care and Services)

- **Healthy San Francisco***
- **Glide Health Clinic***

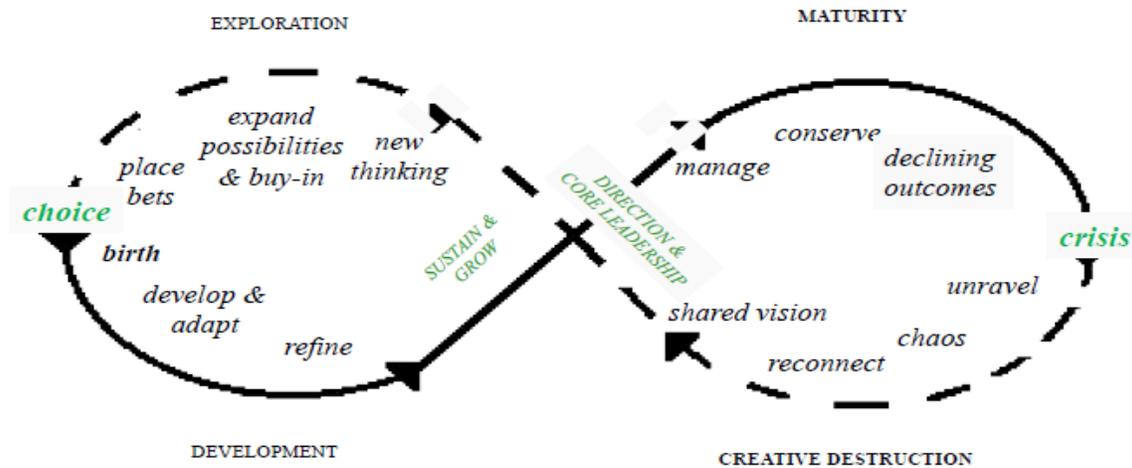
- Delancey Street Foundation*
- Enrollment Assistance for Government Programs and Charity Care*
- SF Transitional Care Program (Discontinue FY15)
- Support to the MD Charity Care Programs*
- Radiation Oncology Medical Residency Rotation*
- **ED Transitional Care Program***
- **Rally Family Visitation 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 (e.g. Alcoholic Anonymous, Bipolar Support and SMART Groups)*

EVALUATION

Tenderloin HIP Collective Impact Initiative

According to the Tamarack Institute, there are four phases of collaborative work: Exploration, Development, Maturity and Creative Destruction. Currently, Tenderloin HIP is in the exploration and development phases which speaks to the dynamic nature of group formation and the need to explore a number of complex issues underlying the health disparities and inequities of Tenderloin residents.

FOUR PHASES OF COLLABORATIVE WORK



Source: Tamarack Institute

Per recommendation of the CAC, Tenderloin HIP will invest resources to continue exploring participatory and utilization-based evaluation approaches in order to measure and refine the mutually reinforcing activities of Tenderloin HIP and the effectiveness of the collective as a whole. It is anticipated that the evaluation plan will involve a mixed-methods approach incorporating both traditional and developmental evaluation techniques.

Other Ongoing Community Benefit Programs: 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

Tenderloin Health Improvement Partnership (Tenderloin HIP)	
Hospital CB Priority Areas - 2014	<ul style="list-style-type: none"> X Increase Access to High Quality Health Care and Services X Increase Healthy Eating and Physical Activity X Ensure Safe and Healthy Living Environments
Program Emphasis	<ul style="list-style-type: none"> <input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	The Tenderloin neighborhood health indicators show disproportionate negative health outcomes in all major health indicators.
Program Description	<p>SFMH partnered with the Saint Francis Foundation (SFF) to initiate the Tenderloin Health Improvement Partnership (Tenderloin HIP), a multi-sector collective impact partnership committed to improving community health, safety and well-being in San Francisco's Tenderloin neighborhood. Working collaboratively and in alignment, Tenderloin HIP seeks to address both the social determinants impacting the overall health of the people who live and work in the Tenderloin and the underlying health disparities and inequities that perpetuate the status quo.</p> <p>Tenderloin HIP work that began in the fall of 2013 has helped to further shape and refine the focus and scope SFMH's Community Benefit Plan implementation. Driven by a population-based approach rooted in the vision, values of alignment and health equity and priorities of the San Francisco Health Improvement Partnership (SFHIP), the FY15 SFMH Community Benefit Implementation Plan aims to support and enhance the community building capacity of organizations who have partnered through Tenderloin HIP to develop key initiatives and block action plans to improve the health of residents in the Tenderloin. The plan is also aligned with the goals identified in Community Vital Signs, San Francisco's health assessment and improvement effort conducted in 2012 and based on key public health findings on social determinants of health and collective impact.</p> <p>Short- and mid-term initiatives are underway or poised for launch in Fall 2014 through Tenderloin HIP. Resident engagement is essential to success and is being built into design, implementation, participation, learning, and employment opportunities. The hypothesis is that success of these initiatives will build the groundwork for broader, targeted, and systemic solutions alike to meet the Community Benefit Plan priorities and goals.</p>
FY 2014	
Goal FY 2014	Develop and launch collective impact project to improve the safety, health and well-being of Tenderloin residents.
2014 Objective Measure/Indicator of Success	<p>Phase 1 Planning: November 2013-June 2014</p> <ul style="list-style-type: none"> • Create backbone organization • Collect and map data • Convene stakeholders/identify partners • Build a common agenda • Draft a collective plan • Select success indicators • Design governance structure • Develop funding process • Fundraise/align revenue streams
Baseline	Evaluation scorecard under development
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Collective Impact and Alignment • Place-Based Initiatives built on evidenced-based, best and promising practices • Investments • Backbone Infrastructure and Resources • Shared Learning • Evaluation
Result FY 2014	<p>Phase 1 Planning Objectives: Completed November 2013-June 2014</p> <ul style="list-style-type: none"> • Created backbone organization: Dedicated staff and governance structure in place. • Collected and mapped data: Partnered with SFDPH Environmental Health and Tenderloin Economic Development Project to create electronic and paper-based maps. • Convened stakeholders/identify partners: Convened 3 stakeholder sessions, 1 Formal Block Planning Workshop + 1:1 Technical Assistance, 1 Health Care Working Group, 1 Mental Health Working Group, and community meetings. • Built a common agenda • Drafted a collective plan • Began to select success indicators • Designed governance structure • Developed funding process

Tenderloin Health Improvement Partnership (Tenderloin HIP)	
	<ul style="list-style-type: none"> • Fundraised/aligned revenue streams
Hospital's Contribution / Program Expense	<ul style="list-style-type: none"> • Direct costs absorbed by SFMH Community Benefit Operations • In kind contributions and direct donation by the SFF
FY 2015	
Hospital CB Priority Areas - 2014	<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
Goal 2015	Support Tenderloin HIP partners providing place-based and community-wide initiatives focused on ensuring safety and healthy movement in the Tenderloin.
2015 Objective Measure/Indicator of Success	Phase 2 Implementation: Expected to launch Fall 2014 and include the following objectives: <ul style="list-style-type: none"> • Implement 3 Healthy Block Pilot Projects • Align/convene working groups • Gather data • Learn from results • Refine strategies & plan based on outcomes • Address policies
Baseline	<ul style="list-style-type: none"> • Evaluation plan under development
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Collective Impact and Alignment • Place-Based Initiatives built on evidenced-based, best and promising practices • Investments • Backbone Infrastructure and Resources • Shared Learning • Evaluation
Community Benefit Category	Broader-Community Building Activities

Chronic Disease Management Program (CDSMP)	
Hospital CB Priority Areas - 2014	<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
Program Emphasis	<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
Link to Community Needs Assessment	The Community Needs Assessments data indicates significant hospitalization rates for chronic disease levels in the zip codes adjacent to SFMH.
Program Description	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.
FY 2014	
Goal FY 2014	Support coalition of agencies providing CDSMP in the Tenderloin and Chinatown.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Each of the 4 participating agencies to hold 2 class sessions • 80% number of participants completing the program
Baseline	<ul style="list-style-type: none"> • 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 39 classes were completed, including 18 classes onsite. • 259 of 337 participants graduated (77%). • Hospitalization rates: 0% • Participants recruited, program scheduled to begin October 2013.
Intervention Strategy for Achieving Goal	Market program to physicians' offices, volunteers and community members.
Result FY 2014	<ul style="list-style-type: none"> • 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 42 classes were completed, including 6 classes onsite. • 66 of 81 participants graduated (81%). • Hospitalization rates: 3% • Participants recruited, program scheduled to begin October 2014.
Hospital's Contribution / Program Expense	<ul style="list-style-type: none"> • \$ 15,000 expenses donated by SFMH
FY 2015	
Hospital CB Priority Areas - 2015	<input checked="" type="checkbox"/> Safety and Healthy Movement <input checked="" type="checkbox"/> Healthy Eating <input type="checkbox"/> Health Care Access
Goal 2015	Support coalition of agencies providing CDSMP in the Tenderloin and Chinatown.

Chronic Disease Management Program (CDSMP)	
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Each of the 4 participating agencies to hold 2 class sessions 80% number of participants completing the program
Baseline	<ul style="list-style-type: none"> 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 42 classes were completed, including 6 classes onsite. 66 of 81 participants graduated (81%). Hospitalization rates: 3% Participants recruited, program scheduled to begin October 2014.
Intervention Strategy for Achieving Goal	Market program to physicians' offices, volunteers and community members.
Community Benefit Category	Broader-Community Health Improvement Services

Glide Health Clinic	
Hospital CB Priority Areas - 2014	<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
Program Emphasis	<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
Link to Community Needs Assessment	The residents of the Tenderloin have significant health challenges as measured by the CNI hospitalization rates for all ACSC.
Program Description	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.

FY 2014	
Goal FY 2014	<ul style="list-style-type: none"> Provide inpatient services to Healthy San Francisco participants that identify Glide Health Services as their medical home. Sustain fiscal support of outpatient diagnostic services for Glide patients. Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Provide inpatient services to Healthy San Francisco participants that identify Glide Health Services as their medical home. Sustain fiscal support of outpatient diagnostic services for Glide patients. Sustain conversion to drug discount program (340b). Sustain implementation of Health Information Exchange. Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.
Baseline	<ul style="list-style-type: none"> FY13: SFMH Glide HSF IP 56; Out Pt 2,865 FY13: GHS UDC- 2,098, GHS Encounters 1,547 Received support from CCSF for Glide/HSF (\$575,000)
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Quarterly progress meeting re: diabetes collaborative. Quarterly utilization meetings and report re: HSF utilization. Facilitate contractual and operations processes for 340b project.
Result FY 2014	<ul style="list-style-type: none"> Continued to provide outpatient diagnostic services and outpatient pharmaceuticals to Glide patients. Saint Francis partnered with Glide Health Services to provide inpatient hospitalization services to Healthy San Francisco participants that utilize Glide as their medical home. Facilitated conversion to drug discount program (340b). Completed implementation of Health Information Exchange. FY14: SFMH Glide HSF IP 39; Out Pt 2,097. FY14: GHS UDC- 2136 (1457 HSF); GHS Encounters 10,268. Received support from CCSF for Glide/HSF (\$449,375)
Hospital's Contribution / Program Expense	<ul style="list-style-type: none"> Pharmacy, Supplies, In-Patient & Out-Patient Services (<i>In-PT Out-PT and ED services included in Charity Care contribution</i>) \$2,155,301* offset by \$449,375 grant = \$1,705,926; *Direct clinical services are accounted for within the traditional care dollar.

FY 2015	
Hospital CB Priority Areas - 2014	<input type="checkbox"/> Safety and Healthy Movement <input type="checkbox"/> Healthy Eating <input checked="" type="checkbox"/> Health Care Access
Goal 2015	<ul style="list-style-type: none"> Provide inpatient services to Healthy San Francisco participants that identify Glide Health Services as their medical home. Sustain fiscal support of outpatient diagnostic services for Glide patients. Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.
2015 Objective	<ul style="list-style-type: none"> Provide inpatient services to Healthy San Francisco participants that identify Glide Health

Measure/Indicator of Success	<p>Services as their medical home.</p> <ul style="list-style-type: none"> • Sustain fiscal support of outpatient diagnostic services for Glide patients. • Sustain conversion to drug discount program (340b). • Sustain implementation of Health Information Exchange. • Continue to monitor reduction in hospitalizations of patients enrolled in Glide diabetes collaborative.
Baseline	<ul style="list-style-type: none"> • Continued to provide outpatient diagnostic services and outpatient pharmaceuticals to Glide patients. • Saint Francis partnered with Glide Health Services to provide inpatient hospitalization services to Healthy San Francisco participants that utilize Glide as their medical home. • Facilitated conversion to drug discount program (340b). • Completed implementation of Health Information Exchange. • FY14: SFMH Glide HSF IP 39; Out Pt 2,097. • FY14: GHS UDC- 2136 (1457 HSF); GHS Encounters 10,268. • Received support from CCSF for Glide/HSF (\$449,375)
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Quarterly progress meeting re: diabetes collaborative. • Quarterly utilization meetings and report re: HSF utilization. • Facilitate contractual and operations processes for 340b project.
Community Benefit Category	Poor-Community Health Improvement Services

Healthy San Francisco	
Hospital CB Priority Areas - 2014	<ul style="list-style-type: none"> X 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
Program Emphasis	<ul style="list-style-type: none"> X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	<p>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.</p>
Program Description	<p>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 31,965 participants enrolled in 36 medical homes. Saint Francis actively supports Healthy San Francisco through its partnership with Glide Health Services. The numbers of person enrolled in Healthy San Francisco is declining as eligible individuals enroll in MediCal.</p>
FY 2014	
Goal FY 2014	Provide seamless continuum of care for Healthy San Francisco patients with Glide assigned as their medical home.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Provide inpatient services to Healthy San Francisco participants that identify Glide Health Services as their medical home. • Sustain fiscal support of outpatient diagnostic services for Glide patients. • Aim to provide electronic notification to medical home through Mobile MD. • Collaborate with community partners to enroll eligible HSF persons in the MediCal expansion • Collaborate with SFHP and DPH to develop a system of care for Glide patients that builds on existing provider relationships.
Baseline	<ul style="list-style-type: none"> • FY13: SFMH Glide HSF IP 56; Glide OP HSF 2,865. • FY 13: Other IP HSF 125, IP SMMC HSF 1, Other OP HSF 2,128,, OP HSF – CCHA 15, OP HSF RWP 1 . • FY13 GHS-HSF UDC 2,098.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Participate in Glide Health Services Committee monthly meetings. • Monitor uptake of Glide HSF patient into managed MediCal • Facilitate contractual and operations processes for 340b project. • Facilitate interagency discussions with Glide, SFHP and DPH.
Result FY 2014	<ul style="list-style-type: none"> • Continued to provide outpatient diagnostic services and outpatient pharmaceuticals to Glide patients. • Saint Francis partnered with Glide Health Services to provide inpatient hospitalization services to Healthy San Francisco participants' that utilize Glide as their medical home. • FY14: SFMH Glide HSF IP 39; Out Pt 2,097. • FY 14: Other IP HSF 67, IP SMMC HSF 1, IP Short Doyle HSF 63, IP HSF CCCHA 2, Other OP HSF 1,456 , OP HSF CCHA 23, OP Short Doyle HSF 3. • FY14 GHS-HSF UDC 1,457 • Received support from CCSF for Glide/HSF (\$449,375)
Hospital's Contribution / Program Expense	\$ 4,377,442 (Accounted for as a Means-Tested Program)

FY 2015	
Hospital CB Priority Areas - 2015	<input type="checkbox"/> Safety and Healthy Movement <input type="checkbox"/> Healthy Eating <input checked="" type="checkbox"/> Health Care Access
Goal 2015	Provide seamless continuum of care for Healthy San Francisco patients with Glide assigned as their medical home.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Provide inpatient services to Healthy San Francisco participants that identify Glide Health Services as their medical home. • Sustain fiscal support of outpatient diagnostic services for Glide patients. • Aim to provide electronic notification to medical home through Mobile MD. • Collaborate with community partners to enroll eligible HSF persons in the MediCal expansion • Collaborate with SFHP and DPH to develop a system of care for Glide patients that builds on existing provider relationships.
Baseline	<ul style="list-style-type: none"> • Continued to provide outpatient diagnostic services and outpatient pharmaceuticals to Glide patients. • Saint Francis partnered with Glide Health Services to provide inpatient hospitalization services to Healthy San Francisco participants' that utilize Glide as there medical home. • FY14: SFMH Glide HSF IP 39; Out Pt 2,097. • FY 14: Other IP HSF 67, IP SMMC HSF 1, IP Short Doyle HSF 63, IP HSF CCCHA 2, Other OP HSF 1,456 , OP HSF CCHA 23, OP Short Doyle HSF 3. • FY14 GHS-HSF UDC 1,457 • Received support from CCSF for Glide/HSF (\$449,375)
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Participate in Glide Health Services Committee monthly meetings. • Monitor uptake of Glide HSF patient into managed MediCal • Facilitate contractual and operations processes for 340b project. • Facilitate interagency discussions with Glide, SFHP and DPH.
Community Benefit Category	Poor-Community Health Improvement Services

ED Transitions Program	
Hospital CB Priority Areas – 2014	<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
Program Emphasis	<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 <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	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.
Program Description	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.
FY 2014	
Goal FY 2014	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.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Continue to refine measures of success for the ED Transitions Program (i.e. financial and utilization analysis) • 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.
Baseline	<ul style="list-style-type: none"> • Time period: 9 months: ~1200 encounters (GHS & 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"> • 15% (33) were not readmitted within 6 months of their meeting • 46% (99) were readmitted within one month • 12% (26) were readmitted within one to two months • 8% (18) were readmitted within two to three months • 5% (11) were readmitted within three to four months • 7% (16) were readmitted within four to five months

ED Transitions Program	
	<ul style="list-style-type: none"> • 6% (13) were readmitted five months or later after their meeting
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Shift focus to primarily Glide and managed care MediCal patients • Ensure that at least 30% of navigated patients keep their post-discharge follow-up appointment with a primary care provider at their medical home. • Continue to track utilization data to demonstrate impact of program on emergency department return rate and decreased readmission rate. • Continue to improve communications between ED and medical homes
Result FY 2014	<p>Time period: 7 months – 317 encounters (GHS), attendance rate: 75%</p> <p>Of the 177 encounters in which patients who were referred to Glide attended their primary care appointment: 116 did not return to the ED at all (65.5%); 30 returned in less than 30 days (16.9%), with 20 returning multiple times, and 31 returned in greater than 30 days (17.5%), with 16 returning multiple times.</p> <p>Of the 61 encounters in which patients did not attend their primary care appointment: 37 did not return to the ED at all (60.7%), 12 returned in less than 30 days (19.7%), with 6 multiple times, and 12 returned in greater than 30 days (19.7%), with 6 returning multiple times.</p>
Hospital's Contribution / Program Expense	\$50,000 from Dignity Health Community Grants Program
FY 2015	
Hospital CB Priority Areas - 2015	<input type="checkbox"/> Safety and Healthy Movement <input type="checkbox"/> Healthy Eating <input checked="" type="checkbox"/> Health Care Access
Goal 2015	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.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • Resume transitions program with new management of Glide Health Clinic • Continue to refine measures of success for the ED Transitions Program (i.e. financial and utilization analysis) • 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.
Baseline	Time period: 7 months – 317 encounters (GHS), attendance rate: 75%
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Shift focus to primarily Glide and managed care MediCal patients • Ensure that at least 30% of navigated patients keep their post-discharge follow-up appointment with a primary care provider at their medical home. • Continue to track utilization data to demonstrate impact of program on emergency department return rate and decreased readmission rate. • Continue to improve communications between ED and medical homes
Community Benefit Category	Poor-Community Health Improvement Services

Rally Family Visitation Services	
Hospital CB Priority Areas - 2014	<input checked="" type="checkbox"/> Increase Access to High Quality Health Care and Services <input type="checkbox"/> Increase Healthy Eating and Physical Activity <input checked="" type="checkbox"/> Ensure Safe and Healthy Living Environments
Program Emphasis	<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
Link to Community Needs Assessment	80% or more of the families in conflict referred to Rally Family Visitation program have a history of domestic violence or child abuse.
Program Description	<ul style="list-style-type: none"> • Rally Family Visitation Program provides a safe and secure structured environment in which children can visit with their court-ordered non-custodial parent when there is a high level of conflict, including domestic violence, between divorced/separated parents. • The goal of the program is to ensure the safety of children and adult victims. • The program serves predominantly low-income families.
FY 2014	
Goal FY 2014	<ul style="list-style-type: none"> • Continue to work with government and community partners to achieve goals and objectives and ensure long term sustainability of program. • Research other sources of funding to provide further sustainability for the program. • Fully implement services in San Mateo and Marin County. • Develop funding sources for a case management program.
2014 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • San Mateo County is in a new facility. • Additional funding sources have been identified.

Rally Family Visitation Services	
	<ul style="list-style-type: none"> Funding is secured for additional years to ensure long term sustainability.
Baseline	<ul style="list-style-type: none"> FY 2013: 2628 of monitored exchanges, 1754 supervised and facilitated visits. In addition, provided 489 intake/orientation services to 1141 children and adults.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Continue to work with government and community partners to achieve goals and objectives and ensure long term sustainability of program.
Result FY 2014	<ul style="list-style-type: none"> FY2014: 2005 of monitored exchanges, 3572 supervised and facilitated visits. In addition, provided 324 intake/orientation services to 843 children and adults. Obtained another federal grant and increased funding from the court for San Francisco. The Saint Francis Foundation hired consultants to work on private foundation grants. San Mateo program is in a new facility.
Hospital's Contribution / Program Expense	<ul style="list-style-type: none"> Expenses: \$566,379, Revenue: \$430,183, Benefit: \$136,196
FY 2015	
Hospital CB Priority Areas - 2015	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Safety and Healthy Movement <input type="checkbox"/> Healthy Eating <input type="checkbox"/> Health Care Access
Goal 2015	<ul style="list-style-type: none"> Fully implement Therapeutic services. Increase funding stream for San Mateo and Marin programs Hire additional full time staff.
2015 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> Provide information to court to make therapeutic referrals. Write grants for all programs. Assess staffing needs.
Baseline	<ul style="list-style-type: none"> FY2014: 2005 of monitored exchanges, 3572 supervised and facilitated visits. In addition, provided 324 intake/orientation services to 843 children and adults.
Intervention Strategy for Achieving Goal	Continue to work with government and community partners to achieve goals and objectives and ensure long term sustainability of program.
Community Benefit Category	Poor-Subsidized Health Services

**227 Saint Francis Memorial Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2013 through 6/30/2014**

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Expenses	Organization Revenues
<u>Benefits for Living In Poverty</u>						
Financial Assistance	2,249	4,342,712	0	4,342,712	2.0	2.1
Medicaid	9,031	40,729,896	19,879,236	20,850,660	9.6	10.3
Means-Tested Programs	1,920	4,377,442	0	4,377,442	2.0	2.2
Community Services						
Community Benefit Operations	0	160,180	0	160,180	0.1	0.1
Community Health Improvement Services	2,306	727,786	0	727,786	0.3	0.4
Financial and In-Kind Contributions	1,015	263,235	4,343	258,892	0.1	0.1
Subsidized Health Services	1,262	950,876	430,183	520,693	0.2	0.3
Totals for Community Services	4,583	2,102,077	434,526	1,667,551	0.8	0.8
	17,783					
Totals for Living In Poverty		51,552,127	20,313,762	31,238,365	14.4	15.5
<u>Benefits for Broader Community</u>						
Community Services						
Community Building Activities	1	14,500	0	14,500	0.0	0.0
Community Health Improvement Services	448	76,424	225	76,199	0.0	0.0
Financial and In-Kind Contributions	2,973	88,435	16,844	71,591	0.0	0.0
Health Professions Education	549	341,566	236,419	105,147	0.0	0.1
Totals for Community Services	3,971	520,925	253,488	267,437	0.1	0.1
	3,971					
Totals for Broader Community		520,925	253,488	267,437	0.1	0.1
Totals - Community Benefit	21,754	52,073,052	20,567,250	31,505,802	14.5	15.6
Medicare	22,875	67,513,461	44,841,110	22,672,351	10.4	11.2
Totals with Medicare	44,629	119,586,513	65,408,360	54,178,153	24.9	26.8
Totals Including Medicare	44,629	119,586,513	65,408,360	54,178,153	24.9	26.8

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 development of the SF CHA, CHIP which in turn informed the CHNA that serves as the basis for this community benefit plan.
- SFMH participates in SFHIP Steering Committee meetings, which is part of San Francisco's strategy to continue the engagement of experts and community advocates, thereby enhancing health improvement process of San Francisco.
- SFMH leads in partnership with SFF the Tenderloin Health Improvement Partnership aligned with the SFHIP.
- SFMH participates annually in the public presentation of our Charity Care and Community Benefit Reports to the San Francisco Health Commission
- 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 sfhip.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

To view the SFMH Community Benefit Report, visit:

http://www.dignityhealth.org/Who_We_Are/Community_Health/STGSS044509

**Appendix A –
Saint Francis Memorial Hospital 2015-2016 Community Advisory Committee Members**

	First	Last	Title	Organization
1	Michael	Anderer-McClelland	VP Mission & Advancement	DeMarillac Academy
2	Darryl	Burton	Healthcare Policy & Economic Analyst	Office of the Regional Administrator Centers for Medicare and Medicaid Services
3	Michaela	Cassidy	CEO & President	Aspen Affiliates*
4	Jason	Cherniss	Captain	Tenderloin Police Station
5	Don	Falk	Executive Director	Tenderloin Neighborhood Development Corporation
6	Paula	Fleisher	Navigator	UCSF - Community Engagement and Health Policy (CEHP) program and San Francisco Health Improvement Partnerships (SF HIP)
7	Carmela	Gold	President of the Board of Trustees	North of Market Improvement Corporation (NOMNIC/TEDP)
8	Robert	Harvey, MD	Chair	Saint Francis Memorial Hospital*
9	Richard	Heasley	Executive Director	Conard House
10	Victoria	Joseph	Vice President, Northern California	Citi Community Development
11	David	Knego	Executive Director	Curry Senior Center
12	Duncan	Ley	Partner	Tonic Nightlife Group**
13	Kathy	Looper	Executive Director	Reality House, Inc./ Cadillac Hotel
14	Fraser	McAlpine	Office Managing Shareholder	Jackson Lewis LLP**
15	Susie	McKinnon	Associate Director	Tenderloin North of Market Community Benefit District
16	Sonia	Melara	Executive Director	Rally Family Visitation Services, Police Commissioner
17	Angie	Pratt	Director of Community Engagement	NCPHS SF Senior Center
18	John	Rampulla, MD	Physician	Saint Francis Memorial Hospital
19	Katy	Richey	Corporate Sustainability	PG&E
20	Rita	Shimmin	Co-Executive Director	Glide
21	Barry	Stenger	Executive Director	St. Anthony Foundation
22	Pedro	Torres	Director of Youth and Family Services	TL/SOMA Youth Collaborative & National Council on Alcoholism
23	Joseph	Tsang	Senior Property Manager	Mercy Housing (Marlton Manor & Padre Apartments)
24	Meg	Wall	Lead - Land Use Planning and Health, Environmental Health Protection, Equity, and Sustainability, Population Health Division	San Francisco Department of Public Health – Environmental Health Branch
25	Midge	Wilson	Executive Director	Bay Area Women's and Children's Center
26	Pat	Zamora	Area Director, Citywide Arts Program, Treasure Island Clubhouse, Tenderloin Clubhouse	Boys and Girls Club
27	TBD			Tech or Workforce Development
28	TBD			Business Community Rep
29	TBD			Community Member
30	TBD			Community Member

*SFMH Board of Trustees, **SFF Board Member

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.

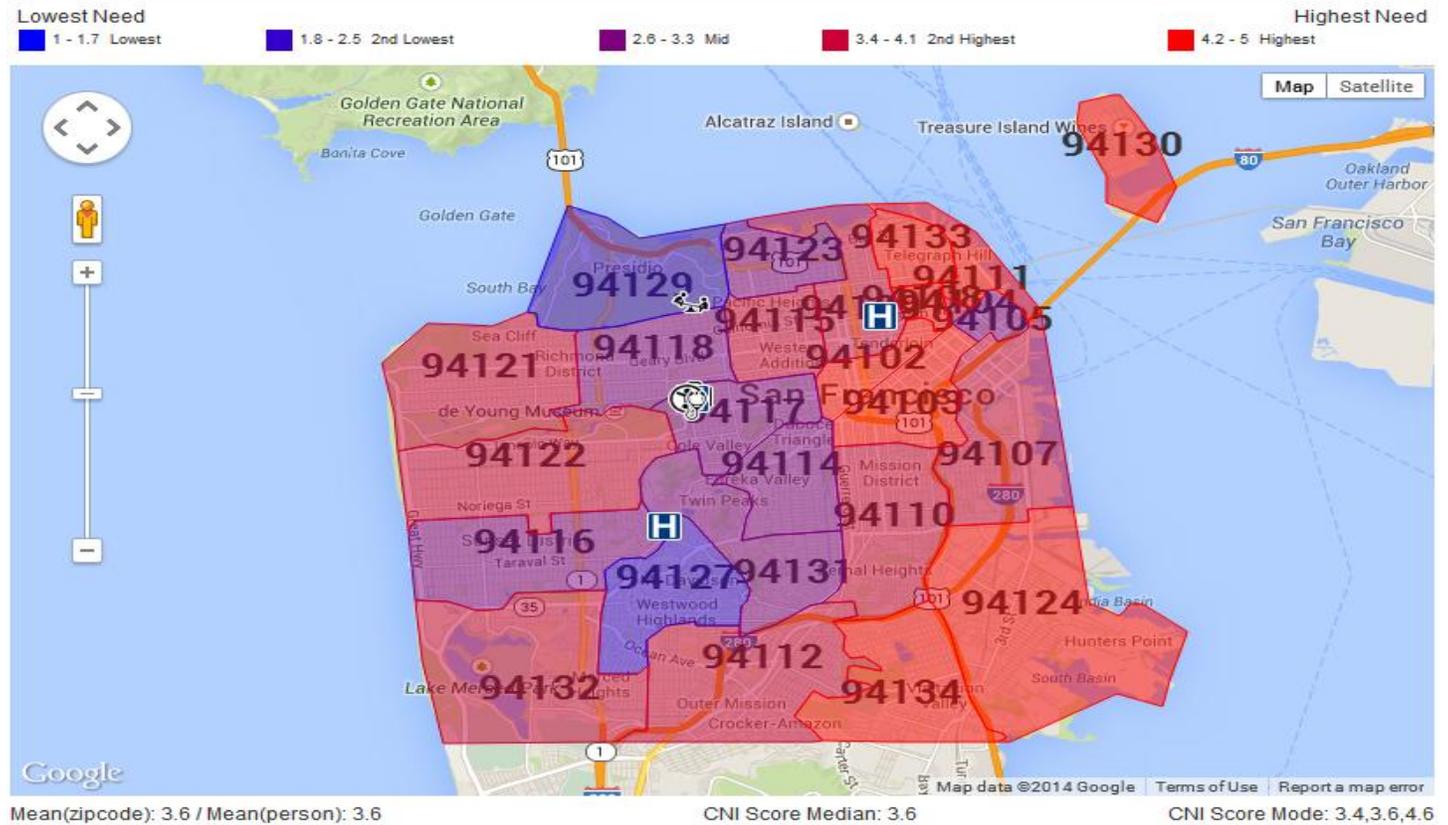
Relationship to Collection Policies:

- 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.

Appendix C– Community Needs Index



Zip Code	CNI Score	Population	City	County	State
94102	4.6	32657	San Francisco	San Francisco	California
94103	4.6	29568	San Francisco	San Francisco	California
94104	4	325	San Francisco	San Francisco	California
94105	2.8	7822	San Francisco	San Francisco	California
94107	3.4	29437	San Francisco	San Francisco	California
94108	4.8	13392	San Francisco	San Francisco	California
94109	4	56586	San Francisco	San Francisco	California
94110	3.6	72181	San Francisco	San Francisco	California
94111	4.2	4392	San Francisco	San Francisco	California
94112	3.8	81984	San Francisco	San Francisco	California
94114	2.8	31926	San Francisco	San Francisco	California
94115	3.6	33975	San Francisco	San Francisco	California
94116	3.2	44269	San Francisco	San Francisco	California
94117	2.6	40088	San Francisco	San Francisco	California
94118	3.2	39504	San Francisco	San Francisco	California
94121	3.4	42647	San Francisco	San Francisco	California
94122	3.4	58175	San Francisco	San Francisco	California
94123	2.6	25190	San Francisco	San Francisco	California
94124	4.6	35764	San Francisco	San Francisco	California
94127	2.2	19260	San Francisco	San Francisco	California
94129	2.4	3717	San Francisco	San Francisco	California
94130	4.4	3120	San Francisco	San Francisco	California
94131	3	27976	San Francisco	San Francisco	California
94132	3.6	29515	San Francisco	San Francisco	California
94133	5	27436	San Francisco	San Francisco	California
94134	4.4	43182	San Francisco	San Francisco	California

Source: <http://cni.chw-interactive.org/>

Appendix D – Demographics Snapshot

City and County of San Francisco 2014	
Population	825,580
Diversity - %	
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%
<i>Diversity total</i>	<i>100.0%</i>
Average Income	\$108,281
Uninsured	15.60%
No HS Diploma%	14.3%
Renters %	59%
Medicaid Patients	12.7%
Unemployment	7.3%

Source: Community Needs Index (CNI) Tool

