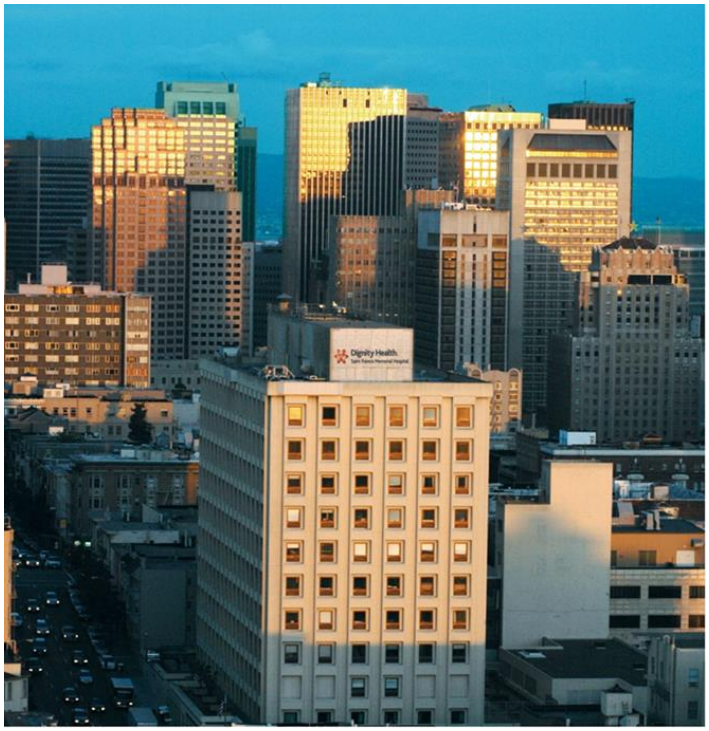
Saint Francis Memorial Hospital

Community Benefit 2022 Report and 2023 Plan

Adopted October 2022



Dignity Health.
Saint Francis Memorial Hospital

A message from

Daryn Kumar, President, and Kimberly Mac Pherson, Chair of the Dignity Health Saint Francis Memorial Hospital Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Saint Francis Memorial Hospital shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2022 Report and 2023 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntarily produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2022 (FY22), Saint Francis Memorial Hospital provided $ 46,781,464 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also served 11,659 Medicare patients leading to $21,012,720 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its October 6th, 2022 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching out to Saint Francis Memorial Hospital Community Health Office, 900 Hyde St., San Francisco CA 94109 or by e-mail to Alexander.Mitra@DignityHealth.org.

Daryn Kumar
President

Kimberly MacPherson
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served

Located in northern California, San Francisco is a seven by seven square mile coastal, metropolitan city and county that includes Treasure Island and Yerba Buena Island, just northeast of the mainland. The only consolidated city and county in the state, San Francisco is densely populated and boasts culturally diverse neighborhoods in which residents speak more than 12 different languages.
Saint Francis Memorial Hospital is the only downtown hospital in San Francisco and is located in the Nob Hill neighborhood, north of the Tenderloin - one of San Francisco's lowest income neighborhoods. Over half of the City's homeless population lives in the Tenderloin and South of Market neighborhoods. The primary geographical focus area of the hospital's Community Benefit Plan is the Tenderloin.

Economic Value of Community Benefit

$46,781,464 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits.

$21,052,720 in unreimbursed costs of caring for patients covered by Medicare

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the 2019 Community Health Needs Assessment (CHNA). The needs the hospital plans to address in the coming year are guided by the hospital's 2022 Community Health Needs Assessment. Needs addressed by strategies and programs were:

Foundational Issues:
- Racial health inequities
- Poverty

Health Needs:
- Access to coordinated, culturally and linguistically appropriate care and services

Health Needs (Continued):
- Food security, healthy eating and active living
- Housing security and an end to homelessness
- Safety from violence and trauma
- Social, emotional, and behavioral health

FY22 Programs and Services

The hospital delivered several programs and services to help address identified significant community health needs. These included:

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- **Medication Assisted Treatment and Alcohol & Other Drugs Counselor**: As a result of a 2018 pilot, SFMH's leadership, physicians and support staff saw that the need for increased substance use disorder (SUD) and

medication assisted treatment (MAT) services far exceeds the current capacity to provide treatment options to patients. In 2019, SFMH received grants to expand this work, including increased capacity for Medical Director and Addiction Specialist to oversee the program, provide specialized communication training to destigmatize SUD and provide support to prescribing physicians and care-teams for complex patient cases, as well as hire an Alcohol and Other Drugs (AOD) Counselor. Saint Francis has continued the

- **Homeless Health Initiative: ED Navigation**
  With support from the Dignity Health's Homeless Health Initiative, Saint Francis piloted placing social workers in the Emergency Department to solely focus on homeless patients with a goal to screen for SDoH factors and build trust to enable successful referrals to appropriate care.
- **Care for Patients under 5150 Holds:**
  Saint Francis and St. Mary's host monthly meetings to better coordinate care for patients held on 5150 holds with San Francisco Police Department, San Francisco Fire Department and San Francisco Department of Public Health. From these meetings Saint Francis has
- **Rally Family Visitation Services:** Through the Rally Family Visitation Services program, the hospital 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 high conflict, including domestic violence, between divorced/separated parents. The program serves predominantly low-income families.
- **Tenderloin Health Improvement Partnership (TLHIP):** Co-led by the Saint Francis Memorial Hospital, TLHIP is a multi-sector, collective impact initiative that provides a framework to address health equity and improve neighborhood health outcomes in the Tenderloin.

FY23 Planned Programs and Services

The hospital plans to continue prior year programs and activities to address significant community health needs. As the coronavirus pandemic continues, the hospital will work with its partners to continue to address the evolving health needs.

- **Medication Assisted Treatment and Alcohol & Other Drugs Counselor**: As a result of a 2018 pilot, SFMH's leadership, physicians and support staff saw that the need for increased substance use disorder (SUD) and medication assisted treatment (MAT) services far exceeds the current capacity to provide treatment options to patients. In 2019, SFMH received grants to expand this work, including increased capacity for Medical Director and Addiction Specialist to oversee the program, provide specialized communication training to destigmatize SUD and provide support to prescribing physicians and care-teams for complex patient cases, as well as hire an Alcohol and Other Drugs (AOD) Counselor. Saint Francis has continued the
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- **Tenderloin Health Improvement Partnership (TLHIP):** Co-led by the Saint Francis Memorial Hospital, TLHIP is a multi-sector, collective impact initiative that provides a framework to address health equity and improve neighborhood health outcomes in the Tenderloin.
- **San Francisco Health Improvement Partnership:** Through this partnership between hospitals, health departments, and non-profits we hope drive community health improvement efforts in San Francisco through information sharing and advocacy.

This document is publicly available online at https://www.dignityhealth.org/bayarea/locations/saintfrancis/about-us/community-benefits

Written comments on this report can be submitted to the hospital's Community Health Office, 900 Hyde Street, San Francisco, CA 94109 or emailed to Alexander.Mitra@DignityHealth.org.

Our Hospital and the Community Served

About Saint Francis Memorial Hospital

Saint Francis Memorial Hospital is a member of Dignity Health, which is a part of CommonSpirit Health. Saint Francis Memorial Hospital (SFMH) has been meeting the health needs of San Francisco for over 100 years. Founded in 1905 by a group of five physicians, SFMH continues to carry out its mission: "dedicate our resources to: delivering compassionate, high-quality, affordable health services for our sisters and brothers who are poor and disenfranchised; and partnering with others in the community to improve the quality of life." Today, SFMH remains a thriving center of healing and innovation in medicine as well as a spiritual anchor to its community.

SFMH is located on Nob Hill, and maintains 293 beds, with a staff of over 1,000 employees and 200 active physicians. About 59% of the patients are residents of San Francisco. Among the hospital's inpatient population, there are 43% Caucasian, 20% Asian, 14% African Americans, 9% Hispanics, 3% Multiracial, 1% Native American and 10% Other. The hospital also has a number of specialized programs that 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 operating suites in the surgery department. SFMH also offers inpatient psychiatric services, acute rehabilitation, and hyperbaric services. The Saint Francis Orthopedic and Sports Institute offers a full spectrum of orthopedic services.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

Saint Francis Memorial Hospital serves the City and County of San Francisco. San Francisco, at roughly 47 square miles, is the most densely populated large city in California. Between 2011 and 2018, San Francisco grew by almost eight percent to 888,817 persons outpacing population growth in California (6 percent).

The population is aging and the ethnic shifts continue with an increase in the Asian and Pacific Islander population, increase in multiethnic populations and a decrease in the Black/African American population.

San Francisco has a relatively small proportion of households with children (19 percent) compared to the state overall (34 percent).

Despite areas of affluence, there remain significant pockets of poverty (as evidenced in the Community Needs Index which follows) particularly in the African American and Hispanic/Latino communities.

A summary description of the community is below. Additional details can be found in the CHNA report online here:

According to the 2019 San Francisco Health Improvement Partnership (SFHIP) Community Health Needs Assessment, San Francisco is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. At roughly 47 square miles, San Francisco is the most densely populated large city in California. Between 2011 and 2018, San Francisco grew by almost eight percent to 888,817 persons outpacing population growth in California (6 percent). By 2030, San Francisco's population is expected to total more than 980,000. The population is aging and the ethnic shifts continue with an increase in the Asian and Pacific Islander population, increase in multiethnic population and a decrease in the Black/African American population. Although San Francisco has a relatively small proportion of households with children (19 percent) compared to the state overall (34 percent), the number of school-aged children is projected to rise. As of 2017, San Francisco is home to 67,740 families with children, 26 percent of which are headed by single parents. There are many neighborhoods within San Francisco. Health status varies by neighborhood, economic status, ethnicity, age and other factors.

SFMH serves the San Francisco's zip codes with the richest and poorest residents, including 94102 (Tenderloin), 94103 (SoMa), 94104 (Downtown), 94108 (Chinatown), and 94133 (North Beach). A summary description of the community is below. Additional details can be found in the CHNA report online.

Total Population	831,456
Race	
Asian/Pacific Islander	34.6%
Black/African American - Non-Hispanic	5.6%
Hispanic or Latino	16.1%
White Non-Hispanic	38.1%
All Others	5.6%
% Below Poverty	5.1%
Unemployment	3.7%
No High School Diploma	11.4%
Medicaid	18.5%
Uninsured	4.0%

Source: Claritas Pop-Facts® 2022; SG2 Market Demographic Module

SG2 Analytics Platform Reports:

Demographics Market Snapshot

Population Age 16+ by Employment Status

Families by Poverty Status, Marital Status and Children Age

Insurance Coverage Estimates (map data export)

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit report and programs were identified in the most recent CHNA report, which was adopted in June, 2019. The health issues identified in the 2022 CHNA form the basis of the community benefit plan.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/bayarea/locations/stmarys/about-us/community-benefit or upon request at the hospital's Community Health office.

Significant Health Needs

The 2019 CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

The most recent Community Health Needs Assessment identifies two overarching foundational issues that contribute significantly to local health needs:

1) **Racial health inequities:** Health inequities are avoidable differences in health outcomes between population groups. Health inequities result from both the actions of individuals (health behaviors, biased treatment by health professionals), and from the structural and institutional behaviors that confer health opportunities or burdens based on status.
2) **Poverty:** Enough income generally confers access to resources that promote health—like good schools, health care, healthy food, safe neighborhoods, and time for self-care—and the ability to avoid health hazards—like air pollution and poor quality housing conditions.

These foundational issues play a significant role in creating and intensifying the health needs identified in the community health needs assessment:

Significant Health Need	Description	Intend to Address?
Access to coordinated, culturally and linguistically appropriate care and services	San Francisco continued to see gains in access to health care with 10,000 fewer residents uninsured in 2017 than in 2015. Of the estimated 31,500 uninsured residents, 15,373 have health care access through Healthy San Francisco or Healthy Kids. Approximately 2% of residents remain without access. Having insurance or an access program is only the first step; however, as true access to services is influenced by location, affordability, hours of operation, and cultural and linguistic appropriateness of health care services.	●
Food security, healthy eating and active living	Inadequate nutrition and a lack of physical activity contribute to 9 of the leading 15 causes of premature death in San Francisco —heart failure, stroke, hypertension, diabetes, prostate cancer, colon cancer, Alzheimer's, breast cancer, and lung cancer. Studies have shown that just 2.5 hours of moderate intensity physical activity each week is associated with a gain of approximately three years of life.	●
Housing security and an end to homelessness	Housing is a key social determinant of health. Housing stability, quality, safety, and affordability all have very direct and significant impacts on individual and community health. Much of California, and especially the Bay Area, is currently experiencing an acute shortage in housing, leading to unaffordable housing costs, overcrowding, homelessness and other associated negative health impacts.	●
Safety from violence and trauma	Violence not only leads to serious mental, physical and emotional injuries and, potentially, death for the victim, but also negatively impacts the family and friends of the victim and their community. Persons of color are more likely to be victims of violence, to live in neighborhoods not perceived to be safe and to receive inequitable treatment through the criminal justice system.	●
Social, emotional, and behavioral health	Mental health is an important part of community health. In San Francisco the number of hospitalizations among adults due to major depression exceed that of asthma or hypertension. Presence of mental illness can adversely impact the ability to perform across various facets of life—work, home, social settings. It also impacts the families, caregivers, and communities of those affected. Substance abuse including drugs, alcohol and tobacco, contributes to 14 of the top causes of premature death in the City—lung cancer, Chronic Obstructive Pulmonary Disease, HIV, drug overdose, assault, suicide, breast cancer, heart failure, stroke, hypertensive heart disease, colon cancer, liver cancer, prostate cancer, and Alzheimer's.	●

The 2022 CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

These foundational issues play a significant role in creating and intensifying the health needs identified in the community health needs assessment:

Significant Health Need	Description	Intend to Address?
Access to Welcoming Healthcare	Access to Welcoming Healthcare refers to the right to accessible and affordable, culturally grounded, relevant, and competent acute and preventative healthcare. Welcoming care is delivered in local neighborhoods, by healthcare professionals who are from the communities they are serving, are grounded in anti-racism and interpersonal bias, have knowledge of the community's historic relationship with (and harm done by) the healthcare system, and are equitably compensated for their work.	●
Behavioral Health & Substance Use	Behavioral Health and Substance Use refers to access, stigma, availability, and affordability of behavioral and mental health professionals and services. Substance use refers to substance access, use, and availability of support for substance misuse. Behavioral Health also refers to the freedom from external and environmental trauma. Community violence decreases the real and perceived safety of a neighborhood disrupting social networks by inhibiting social interactions, causing chronic stress among residents who are worried about their safety, and acting as a disincentive to engage in social interactions.	●
Economic Opportunity	Economic opportunity refers to the financial and socioeconomic conditions which allow for an individual and community to effectively afford the tangible and intangible materials and resources necessary to thrive. Additionally, economic opportunity includes (but is not limited to) exposure to environmental/climate-related factors and/or hazards, freedom from violence and trauma, and the ability to obtain nutrient-dense, culturally relevant food items, and affordable housing.	●

Significant Needs the Hospital Does Not Intend to Address

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2022 Report and 2023 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY22 and planned activities for FY23, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

The hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included Care Coordination, Emergency Department, Nursing, Graduate Medical Education, Surgery, Business Development, Mission, and Palliative Care. Department leaders were asked about their staff and patient needs, connection to community resources, and department goals. Staff shared that valuable insights such as need to break down silos in the organization, support patients with services pre- and post- hospitalization, access city services and increase safety for staff in the Emergency Department.

Community input or contributions to this implementation strategy included the Tenderloin Health Improvement Partnership, sitting as the Hospital's Community Advisory Committee, and San Francisco Health Improvement Partnership. Through the Tenderloin Health Improvement Partnership, attendees provided valuable input on the needs of the community for case management and other community supports, housing, substance use treatment and an environment free of danger.

The programs and initiatives described here were selected on the basis of existing programs with evidence of success and impact, research into effective interventions, access to appropriate resources and addressing immediate goals of the hospital.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Advance Community Health Alignment and Integration

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Expand Clinical - Community Partnerships and Linkages

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Build Capacity for More Equitable Communities

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Inspire, Innovate and Scale High Impact Initiatives

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Access to coordinated, culturally and linguistically appropriate care and services

Strategy or Program Name	Summary Description	Active FY22	Planned FY23
Patient Financial Assistance	• SFMH provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.	☒	☒
Tenderloin Health Services	• With HealthRIGHT360's decision to close THS in October 2019, SFMH has worked with GLIDE to support re-envisioning the Tenderloin Health Services project to enhance health access to the Tenderloin Neighborhood. This year the hospital has entered into a street-based medicine pilot for homeless individuals with the San Francisco Community Health Clinic.	☒	☒
Serious Illness Project for Chinese Seniors	• With Self-Help for the Elderly and All-American Medical Group, Saint Francis and St. Mary's are collaborating to create a holistic wrap around model to support the health of Chinese seniors with support from a Stupski grant. Along with post discharge support, the program includes palliative care/Advanced Care Plans, and AI directed primary care outreach using AAMG's insurer database.	☒	☒
Homeless Health Initiative: ED Navigator	• With support from the Dignity Health's Homeless Health Initiative, Saint Francis piloted placing social workers in the Emergency Department to solely focus on homeless patients with a goal to screen for SDoH factors and build trust to enable successful referrals to appropriate care.	☒	☐
Delancey Street Foundation	• SFMH partners with the Delancey Street Foundation to provide Delancey's residential substance abuse rehabilitation and vocational training participants with health services at the Saint Francis Memorial Hospital Health Center.	☒	☒
Physician Support for Charity Care Programs	• Physicians are reimbursed for coverage to indigent patients in the Emergency Department and for patients in the Hospitalist program.	☒	☒
Health Professions Education: Clinical Pastoral Education Program (CPE)	• One-year program that provides CPE students with a collaborative, interfaith and clinical learning environment to develop their skills in pastoral reflection, pastoral formation, pastoral competence and pastoral specialization.	☒	☒

Health Professions Education: Nurse Preceptor	• In partnership with local colleges and universities, SFMH's Nursing Preceptor Program is designed to provide student nurses with the tools, skills, and experience of the Registered Nurse (RN). This includes one-on-one time with an RN where the students develops assessment, clinical reasoning, leadership, and delegation skills.	☒	☒
Health Professions Education: Dietetic Intern	• In partnership with the San Francisco State University, SFMH's Food and Nutrition Department serves as a preceptor for Dietetic intern students. This internship provides the knowledge and practice requirements necessary to be eligible to take the Registered Dietitian (R.D.) examination.	☒	☒
Healthy San Francisco (HSF)	• Means tested charity care program that links uninsured participants with medical home - a clinic that provides primary care, social services, case management and preventative care. The vast majority of HSF enrollees are not Medi-Cal recipients.	☒	☒
Health Professions Education: Burn Education	• SFMH nurses and physicians provide burn education to nurses and health professionals.	☒	☐
Burn Support Group	• Working in collaboration with the Alisa Ann Ruch Burn Foundation, SFMH provides monthly support groups for burn survivors free of charge.	☐	☒
Us Too Prostate Cancer Support Group	• Due to COVID restrictions, the hospital suspended all community meeting groups. When the pandemic recedes, the hospital looks forward to again providing peer-to-peer support and educational materials to help men and their families/caregivers make informed decisions about prostate cancer detection, treatment options and related side effects.	☐	☒
Easy Breathers Program	• Due to COVID restrictions, the hospital suspended all community meeting groups. When the pandemic recedes, the hospital looks forward to again providing a support group for individuals with COPD, asthma, lung cancer, and other chronic lung diseases, and their caregivers featuring and discussing educational presentations on various topics, including medications, environmental triggers, nutrition, home exercise, and supplemental oxygen.	☐	☒
Meeting Rooms	• Due to COVID restrictions, the hospital suspended all community meeting groups. When the pandemic recedes, the hospital looks forward to again offering free and low cost meeting space to CBO's. (e.g. Overeaters Anonymous, Alcoholic Anonymous, Depression and Bipolar Support Alliance, SMART	☐	☒

	Recovery, NAMI, Little Brothers Friends of the Elderly)		

Impact: The hospital's initiatives to address access to coordinated, culturally and linguistically appropriate care and services are anticipated to result in: improved access to appropriate health care services, providers, social services and support, particularly for the uninsured and underinsured, vulnerable and/or marginalized populations. Accessible health care can prevent disease and disability, detect and treat illnesses, maintain quality of life, and extend life expectancy. From a population health perspective, regular access to quality health care and primary care services also reduces the number of unnecessary emergency room visits and hospitalizations and can save public and private dollars. While the availability and access to health care and social services in San Francisco may be better than many other places, significant disparities exist by race, age, and income.

Collaboration: The hospital partners with San Francisco Community Health Clinic, San Francisco Department of Public Health, Healthy San Francisco, Self-Help for the Elderly, All-American Medical Group, community-based clinics and organizations.

Health Need: Housing Security and an End to Homelessness

Strategy or Program Name	Summary Description	Active FY22	Planned FY23
Homeless Health Initiative: ED Social Work	• With support from the Dignity Health's Homeless Health Initiative, Saint Francis piloted placing social workers in the Emergency Department to solely focus on homeless patients with a goal to screen for SDoH factors and build trust to enable successful referrals to appropriate care	☒	☐
Conditions of Homelessness (TLHIP)	• Through the Community Advisory Committee and TLHIP workgroups/subcommittees, address the conditions of homelessness, including quality of life on the sidewalks and streets in the Tenderloin.	☒	☐
Homeless Health Initiative: Flexible Housing Subsidy Pool	• With support from the Dignity Health's Homeless Health Initiative, Saint Francis piloted a referral process to permanently house homeless patients with a change in medical condition that were not being prioritized by the current City algorithm.	☒	☐
Cal-AIM	• Cal-AIM is a re-imagining of the Medi-Cal system to create investments into upstream determinants of health. Saint Francis and St. Mary's are looking to ensure staff know how to refer patients to program perks like case management, medically tailored meals and housing navigation.	☒	☒

Tiny Homes Pilot with DignityMoves	• St. Mary's and Saint Francis, along with the Homeless Health Initiative from CommonSpirit Health, supported the building of 70 tiny homes on a safe sleeping site with wrap around services to support clients.	☒	☐

Impact: The hospital's initiatives to address housing security and homelessness are anticipated to result in: improved pathways to employment and opportunities for healthy choices and wraparound services among currently or formerly homeless individuals.

Collaboration:

Homeless Health Initiative: San Francisco Department of Homelessness and Supportive Housing, Brilliant Corners, Citywide Case Management, Felton Case Management

San Francisco Police Department, San Francisco Department of Homelessness and Supportive Housing, San Francisco Department of Public Health, GLIDE, Tenderloin Community Benefit District, DignityMoves, San Francisco Health Plan.

Health Need: Safety from Violence and Trauma

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Rally Family Visitation Services	• Launched by the San Francisco Unified Family Court in 1991, Rally was adopted by Saint Francis Memorial Hospital in 1997. Rally is the only program of its kind in the San Francisco Bay Area providing services to families dealing with diverse situations, including allegations and/or history of domestic violence, child abuse (sexual, physical, emotional, etc.), substance abuse, mental health issues, parenting concerns, and cases referred for lack of contact between the non-custodial parents and their child/children in Marin, San Francisco, and San Mateo counties. These visitation services are designed for children who may be at risk of emotional or physical harm following their parents' separation or divorce and is staffed by highly trained and licensed mental health professionals and volunteers who supervise visits and exchanges between children and parents.	☒	☒
Tenderloin Neighborhood Safety (TLHIP)	• As conditions on the street worsened, TLHIP focused its efforts on safety and violence prevention with a goal. With the leadership of GLIDE, the Committee is looking to envision and design a coordinating body	☐	☒

	for violence prevention efforts, as recommended by the City's Drug Dealing Taskforce.		
Convening on Care for 5150 Patients	• With the support of Saint Francis Emergency Department leadership, the hospital began convening meetings with SFPD: CIT, SFDPH: Comprehensive Crisis Services around coordinating care for patients under 5150 holds. The meetings have grown to encompass SFFD: SCRT and SFDPH: AOT, and have been helpful in creating clearer connections between the various partners worked	☒	☒

Impact: The hospital's initiatives to address safety and violence from trauma are anticipated to result in safer and secure environments to reduce rates of injury, death and emotional trauma among clients served by Rally Family Visitation Services and Tenderloin residents.

Collaboration:
Rally Family Visitation Services: San Francisco Unified Family Court, service providers working in domestic violence, mental health, and substance use.

Tenderloin Neighborhood Safety (TLHIP): GLIDE, Tenderloin Community Benefit District, Code Tenderloin

Health Need: Social, Emotional and Behavioral Health

Strategy or Program Name	Summary Description	Active FY22	Planned FY23
Medication Assisted Treatment and Substance Use Navigator (formerly Alcohol & Other Drugs Counselor	• In 2018, SFMH began a pilot program for Medication for Opioid Use Disorder (MOUD) and Medication Assisted Treatment (MAT) in the Emergency Department, modeled after the Highland Hospital Program in Oakland, CA. As a result of this pilot, SFMH's leadership, physicians and support staff saw that the need for increased SUD and Medication Assisted Treatment (MAT) services far exceeds the current capacity to provide treatment options to patients. In 2019, SFMH received grants to expand this work and increase SFMH's ability to identify and provide onsite medication assisted treatment (buprenorphine, methadone, suboxone) and community-based support to patients with alcohol/substance use disorders. An Alcohol and Other Drug (AOD) Counselor (Substance Use Navigator) assists in the identification of patients with SUD needs and provides care coordination/navigation to community-based resources.	☒	☒
Convening Group on the Care for Patients under 5150 holds	• With the support of Saint Francis Emergency Department leadership, the hospital began convening meetings with SFPD: CIT, SFDPH: Comprehensive Crisis Services around coordinating care for patients under 5150 holds. The meetings have grown to encompass SFFD: SCRT and SFDPH: AOT, and have been helpful in creating clearer connections between the various partners worked	☒	☒

Impact: Challenges to address social, emotional and behavioral health include 1) Common understanding of the scope and scale of the existing system and resource availability and deployment; 2) Time and resources for X-Waiver training and training of hospital and community organizational staff. Training hospital providers and staff (i.e., destigmatizing and effectively screening, treating and referring); 3) Coordination, capacity-building and bandwidth for creating thoughtful and well-established pathways to treatment and support services; and 4) A lack of sustainable resources for organizations and departments seeking to address OUD in an effective way. A further ongoing challenge is bringing diverse, often siloed, agencies and community members together around such a complex issue and finding a common language and shared goals through consensus. The hospital's initiatives to address social, emotional, and behavioral health are anticipated to result in a better understanding of the existing MAT/SUD service continuum, including education, outreach, and

referral. The initiatives also strengthen prevention and early intervention services, address risk and protective factors and enhance access to and community capacity for treating acute illness.

Collaboration:
Medication Assisted Treatment and Alcohol & Other Drugs Counselor: HealthRIGHT360, San Francisco's Office-Based Buprenorphine Induction Clinic (OBIC), San Francisco Department of Public Health, Public Health Institute's California Bridge Program, CCI Center for Care Innovations - Addiction Treatment Starts Here: Community Partnerships.

Convening Group on the Care for Patients under 5150 holds: San Francisco Police Department: Crisis Intervention Team, San Francisco Department of Public Health: Comprehensive Crisis Services, San Francisco Department of Public Health: Assisted Outpatient Treatment, San Francisco Fire Department: Street Crisis Response Team, San Francisco Fire Department: EMS-6

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY22, the hospital awarded the grant below totaling $114,014.

Grant Recipient	Project Name	Amount
Glide Foundation	Street Level Coordination Project	$114,014

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Tenderloin Health Services	
Significant Health Needs Addressed	• Access to Coordinated, Culturally and Linguistically Appropriate Care and Services
Program Description	Tenderloin Health Services is a program where Saint Francis seeks to align, coordinate and support health services within the Tenderloin. In FY22 the
Population Served	Homeless patients in the Tenderloin
Program Goal / Anticipated Impact	Coordinate regular, documented communications between SFCHC team and SFMH team to assess our progress, make Improvements in real time, discuss and triage patients as needed. Develop a coordinated tracking system that is shared between SFMH and SFCHC. Street-based team will document and track all street-based efforts and chart all patient notes, referrals, and lab results through our electronic health record system. This will enable us to monitor patient health progress and outcomes, as well as track overall project progress.
FY 2022 Report	
Activities Summary	SFMH supported a proposal from the GLIDE Foundation to pilot a Health Access Point (HAP) located on the sixth floor of GLIDE which formerly housed the HealthRIGHT360 Tenderloin Health Services Clinic. The review found that hosting health services would not be feasible. In FY22 the Saint Francis Foundation and Saint Francis Memorial Hospital engaged with the San Francisco Community Health Clinic to begin the Street-Based Medicine Outreach program to provide primary care and labs work to homeless individuals in the Tenderloin. The program increased the days that the outreach team is out in the field and also provided a connection to the Saint Francis Memorial Hospital by enabling staff to refer patients that reside in the TL for follow up by the outreach team.
Performance / Impact	Healthier communities by ensuring homeless patients receive primary care services closer to home.

Hospital's Contribution / Program Expense	Community Grant allocation for GLIDE Health Access Point. Staff time to create linkages for street based outreach and centering work in the emergency department setting.
FY 2023 Plan	
Program Goal / Anticipated Impact	Coordinate regular, documented communications between SFCHC team and SFMH team to assess our progress, make Improvements in real time, discuss and triage patients as needed. Develop a coordinated tracking system that is shared between SFMH and SFCHC. Street-based team will document and track all street-based efforts and chart all patient notes, referrals, and lab results through our electronic health record system. This will enable us to monitor patient health progress and outcomes, as well as track overall project progress.
Planned Activities	Continue to iterate and connect patients to outpatient services in the community in conjunction with SFCHC and their street-based teams.

Healthy San Francisco

Significant Health Needs Addressed	
Program Description	Healthy San Francisco (HSF) is a program that provides 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 approximately 13,615 participants enrolled in 35 medical homes and participating hospitals (according to HSF FY16-17 annual report). The number of persons enrolled in Healthy San Francisco has declined as eligible individuals enroll in Medi-Cal. SFMH has supported HSF clients through its partnership with HealthRIGHT360's Tenderloin Health Services (THS) clinic. Since HealthRIGHT360's decision to close THS clinic in October 2019, SFMH continues its referral process and partnership with HealthRIGHT360.
Community Benefit Category	Means-Tested Programs
FY 2021 Report	
Program Goal / Anticipated Impact	Provide financial support for the pharmaceuticals for the projected 400 Healthy San Francisco patients enrolled at the THS clinic. Sustain fiscal support of outpatient diagnostic services for THS patients.

Measurable Objective(s) with Indicator(s)	• Number of HSF participants served by SFMH: 61 • Sustained implementation of Health Information Exchange.
Intervention Actions for Achieving Goal	Secured HSF funding for pharmaceutical support from DPH/SFHP/THS.
Collaboration	Continued collaboration with SF Department of Public Health, HealthRIGHT360 and San Francisco Health Plan.
Performance / Impact	Provided hospital services for 79 HSF patients.
Hospital's Contribution / Program Expense	Net Benefit: $179,408 (Total Expense $179,428 – Offsetting Revenue $20)
FY 2022 Plan	
Program Goal / Anticipated Impact	Provide inpatient services and outpatient diagnostics services to Healthy San Francisco participants that identify HealthRIGHT360 as their medical home.
Measurable Objective(s) with Indicator(s)	• Number of HSF participants served by SFMH – inpatient and outpatient • Sustained implementation of Health Information Exchange.
Intervention Actions for Achieving Goal	• Track and monitor utilization and expenses.
Planned Collaboration	Continued collaboration with San Francisco Health Plan and San Francisco Department of Public Health.

Medication Assisted Treatment and Substance Use Navigator (formerly Alcohol & Other Drugs Counselor)	
Significant Health Needs Addressed	• Access to Coordinated, Culturally and Linguistically Appropriate Care and Services • Social, Emotional and Behavioral Health
Program Description	Many SFMH patients live 200% below the poverty line, struggle with homelessness, substance use disorder (SUD), chronic mental health conditions, and other health outcomes associated with poverty. In 2018, SFMH initiated a pilot program for Medication for Opioid Use Disorder (MOUD) and Medication Assisted Treatment (MAT) in the Emergency Department and determined that the need for increased Substance Use Disorder (SUD) and Medication Assisted Treatment (MAT) services exceeded the hospital's capacity to provide treatment options. In 2019, SFMH received grants to expand this work, including increased capacity for Medical Director and Addiction Specialist to oversee the program, provide specialized communication training to destigmatize SUD and provide support to prescribing physicians and care-teams for complex patient cases. SFMH's primary outpatient partners in this work are San Francisco's Office-Based Buprenorphine Induction Clinic (OBIC) and HealthRIGHT 360. Saint Francis hosted a Transitions Coordinator in partnership with GLIDE and HealthRIGHT360. In October 2019 the hospital hired the Transitions Coordinator to be the full time Substance Use Navigator and Transitions Coordinator in recognition of the impact of the coordinator's work on patient care.
Population Served	The primary beneficiaries of the program are the patients and community members getting referrals and connections to services.
Program Goal / Anticipated Impact	Increase SFMH's ability to identify and provide onsite medication assisted treatment (buprenorphine, methadone, suboxone) and community-based support to patients with alcohol/substance use disorders. • Improved coordination between AOD Counselors, Patient Navigator, Social Workers, and X-Waivered Physicians to expand access to MAT and improved care coordination. • Increased number of Emergency Department patients started or continued on MOUD per week from 2018 baseline of 5-7 to 10-15. • Increase number of In-patient Medicine patients started or continued on MOUD per week from 2018 baseline of 3 to 7-10. Increase number of In-patient surgery patients started or continued on MOUD per week from 2018 baseline of 0 to 3-5.
FY 2022 Report	

Activities Summary	The substance use navigator at Saint Francis met with referred patients of the hospital to connect them to treatment and harm reduction services. They also supported the Stimulant Use Prevention in Communities of Color initiative.
Performance / Impact	Update: total from fiscal year 7/2021 – 6/2022 Total # patients seen by SUN: 715 Total # naloxone units distributed: 304 Total number of patients referred for housing support services: 121
Hospital's Contribution / Program Expense	Staffed position
FY 2023 Plan	
Program Goal / Anticipated Impact	Increase SFMH's ability to identify and provide onsite medication assisted treatment (buprenorphine, methadone, suboxone) and community-based support to patients with alcohol/substance use disorders.
Planned Activities	In FY23 staff plan to hire a new substance use navigator and create meaningful connections between the substance use navigator at St. Mary's to better align efforts and share best practices.

Rally Family Visitation Services	
Significant Health Needs Addressed	• Safety from Violence and Trauma • Social, Emotional and Behavioral Health
Program Description	Through the Rally Family Visitation Services program, SFMH 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 high conflict, including domestic violence, between divorced/separated parents. The program serves predominantly low-income families.
Population Served	Children and their court-ordered non-custodial parent
Program Goal / Anticipated Impact	Provide supervised visitation to families in need of supervised visitation in three Bay Area Counties.
FY 2022 Report	
Activities Summary	• Provided a secure and safe environment for visits • Ensured children have access to both parents in a healthy environment Ensured safety for victims of domestic violence Hours of exchanges, supervised, and facilitated as well as therapeutic sessions. Number of intakes to families served.
Performance / Impact	Rally is the only program of its kind in the Bay Area. Without these services, parents who cannot afford private providers would not be able to see their children. • Provided a secure and safe environment for visits • Ensured children have access to both parents in a healthy environment • Ensured safety for victims of domestic violence while at Rally • Secured new locations for services due to hospital visitor limitations. In FY22 there was a substantial drop in service due to pandemic conditions. In-person visits were prevented for an extended period of time and all exchange services were cancelled. Staff provided virtual visits to clients, and established new venues to start providing in-person visits at the end of FY22.
Hospital's Contribution / Program Expense	Hospital contributed $96,885 in staff time, use of space and supplies.
FY 2023 Plan	
Program Goal / Anticipated Impact	Provide supervised visitation to families in need of supervised visitation in three Bay Area Counties.
Planned Activities	Continue to provide services to families.

Tenderloin Health Improvement Partnership

Significant Health Needs Addressed	• Access to Coordinated, Culturally and Linguistically Appropriate Care and Services • Food Security, Healthy Eating and Active Living • Housing Security and an End to Homelessness • Safety from Violence and Trauma • Social, Emotional and Behavioral Health
Program Description	Co-led by the Saint Francis Memorial Hospital since 2013, the Tenderloin Health Improvement Partnership (TLHIP) is a multi-sector, collective impact initiative that provides a framework to address health equity and improve neighborhood health outcomes in the Tenderloin. SFMH was recognized as a national leader in the field of Community Health by the American Hospital Association (AHA) through the 2018 Foster G. McGaw Prize. This distinguished award honors TLHIP's innovative upstream interventions and impact on social determinants in the Tenderloin community. TLHIP is a vehicle to engage multisector partners and help foster coordination between government, business, and nonprofit sectors, work with community, and co-create solutions to deliver a deeper impact. Today, TLHIP continues to be a strong forum with broad stakeholder participation and interest in finding the "middle" or path forward on developing collaborative approaches and solutions that improve outcomes. TLHIP is often cited as the reason that agencies are working collaboratively on addressing issues outside of their walls. The long history of serving the community enables SFMH and the Saint Francis Foundation to serve as a neutral ground for difficult and nuanced topics and helps to facilitate activities including collaborative agenda-setting, convening and continuous communication, local capacity building, supporting data collection, supporting advocacy and policy change, and leveraging funding to support local efforts. The key initiatives that continue to bring community together searching for solutions and partnership include: • Neighborhood Safety/ Tenderloin Thrives • Strengthening the Parks Network • Neighborhood Harm-Reduction • Economic Opportunity • Conditions of Homelessness
Population Served	The primary beneficiaries of this program are the residents and visitors of the Tenderloin neighborhood.
Program Goal / Anticipated Impact	Seek to address community inequities by fostering multi-sector alignment, building common agenda, investing in and supporting

	mutually reinforcing activities, building measurement and evaluation capacity, and providing backbone support. In FY22, the collaborative seeded ideas to
FY 2022 Report	
Activities Summary	• Hosted a retreat to understand the appetite for getting clarity as to organizations' appetite to participate and work in a new TLHIP model, designed to address current Tenderloin public health needs distinct from the CAC • Created a Request for Qualification Process to find a backbone organization to host the collaborative • Completed the Community Health Needs Assessment though SFHIP and used input from retreat to highlight health needs around safety from violence and trauma and substance use • Brought multiple city stakeholders to the table to discuss current projects around homelessness, safety, and physical and mental health • Germinated a community grant around safety from violence and trauma headed by GLIDE to design a violence prevention coordinating body
Performance / Impact	• Fostered alignment across social determinants of health among community-based organizations and city agencies, including neighborhood safety and park activation and community capacity to strengthen overdose prevention services. • Awarded community grant to design the only unanimous recommendation from San Francisco's Open Air Drug Dealing Taskforce: the Violence Prevention Coordinating Body • Participated in policy development/advocacy efforts, elevating community voice at local levels. • Supported small businesses and food security needs in partnership with the Tenderloin Community Benefit District and the Tenderloin Food Security Taskforce.
Hospital's Contribution / Program Expense	Staff time dedicated to the TLHIP program is included as part of the total Community Benefit Operations net benefit reported in the Economic Value of Community Benefit section of the report.
FY 2023 Plan	
Program Goal / Anticipated Impact	In FY23 we plan to continue to find a community backbone to support the Tenderloin Health Improvement Partnership convening that seek to address community inequities by fostering multi-sector alignment, building common agenda, investing in and supporting mutually reinforcing activities, building measurement and evaluation capacity, and providing backbone support.
Planned Activities	Connect with interested parties applying through the Request for Qualification Process and circle back with the Committee on next steps.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

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 TLHIP strategic objectives.

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.

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.

Human Trafficking
In the fall of 2014, Dignity Health launched the Human Trafficking Response (HTR) Program to ensure that trafficked persons are identified in the health care setting and that they are appropriately assisted with victim-centered, trauma-informed care and services. SFMH staff leads a local, facility taskforce to implement the HTR Program which provides staff education and response procedures.

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 SFMH community health plan and strategy is designed to align with SFHIP priorities.

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.

Economic Value of Community Benefit

Saint Francis Memorial Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2021 through 6/30/2022

	Persons Served	Net Benefit	% of Org. Expenses
Benefits for Living in Poverty			
Financial Assistance	**5,245**	**6,702,942**	**2.9**
Medicaid	**13,164**	**37,931,033**	**16.2**
Means-Tested Programs	**20**	**179,408**	**0.1**
Community Services			
A - Community Health Improvement Services	22,009	177,390	0.1
C - Subsidized Health Services	120	271,700	0.1
E - Cash and In-Kind Contributions	874	149,432	0.0
G - Community Benefit Operations	2	126,518	0.1
Totals for Community Services	**23,003**	**725,040**	**0.3**
Totals for Living in Poverty	**35,853**	**45,538,423**	**19.5**
Benefits for Broader Community			
Community Services			
A - Community Health Improvement Services	0	220,740	0.1
B - Health Professions Education	247	934,573	0.4
E - Cash and In-Kind Contributions	1,174	75,089	0.0
F - Community Building Activities	41	12,639	0
Totals for Community Services	**1,462**	**1,243,041**	**0.5**
Totals for Broader Community	**1,462**	**1,243,041**	**0.5**
Totals - Community Benefit	**42,953**	**46,781,464**	**20.0**
Medicare	**14,987**	**21,052,720**	**9.0**
Totals with Medicare	**51,267**	**67,834,184**	**29.0**

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board and Committee Rosters

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