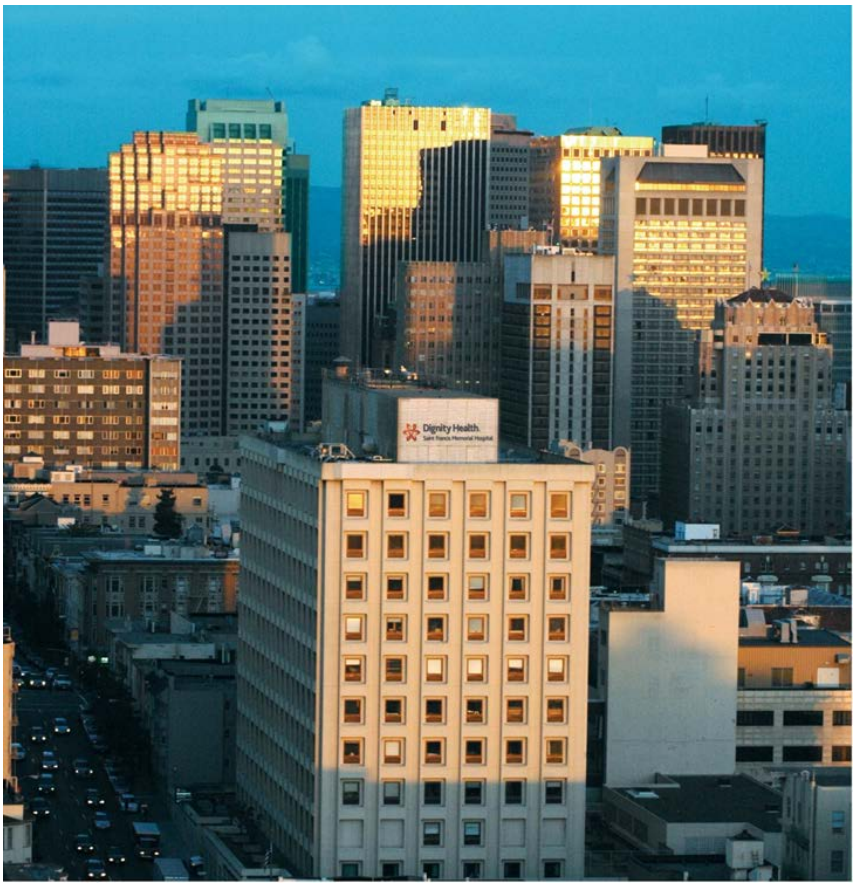
Saint Francis Memorial Hospital

Community Benefit 2021 Report and 2022 Plan

Adopted October 2021



Dignity Health.
Saint Francis Memorial Hospital

A message from

Daryn Kumar, president and CEO of Saint Francis Memorial Hospital, and Kimberly MacPherson, Chair of the Dignity Health Saint Francis Memorial Hospital Board of Trustees.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the 2019 Community Health Needs Assessments (CHNA) that we conduct with community input, including from the local public health department. The Assessment called out two foundation issues, poverty and racial health disparities, which help create and intensify the five identified health needs below.

- 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

Our initiatives to address these health needs and 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 2021 Report and 2022 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. 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 2021 (FY21), Saint Francis Memorial Hospital provided $52,755,373 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $29,727,835 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its October 7th, 2021 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 to out to the Community Health Department at (415) 353-6000.

Daryn Kumar
President/CEO

Kimberly MacPherson
Chair, Board of Trustees

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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

$52,755,373 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$29,727,835 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 hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

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

FY21 Programs and Services

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

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- **Healthy San Francisco (HSF):** A means-tested charity care program that links uninsured participants with a medical home which is a clinic that provides primary care, social services, case management and preventative care. The vast majority of HSF enrollees are not Medi-Cal recipients. Saint

Francis actively supports Healthy San Francisco through its partnership with HealthRIGHT360.

- **COVID Education and Vaccination:** Saint Francis Memorial Hospital supported numerous vaccination and education initiatives including the Moscone Vaccination effort, Tenderloin Vaccination effort, Ingleside Vaccination effort. We also recruited medical professionals of color for UCSF's COVID Education initiative to provide information on the COVID vaccines in January 2021 to communities.
- **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.
- **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.

FY22 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.

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 294 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 46% Caucasian, 14.2% Asian, 16.8% African Americans, 9.7% Hispanics, and 13.2% 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

Saint Francis Memorial Hospital is dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospital's web site.

Description of the Community Served

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 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.

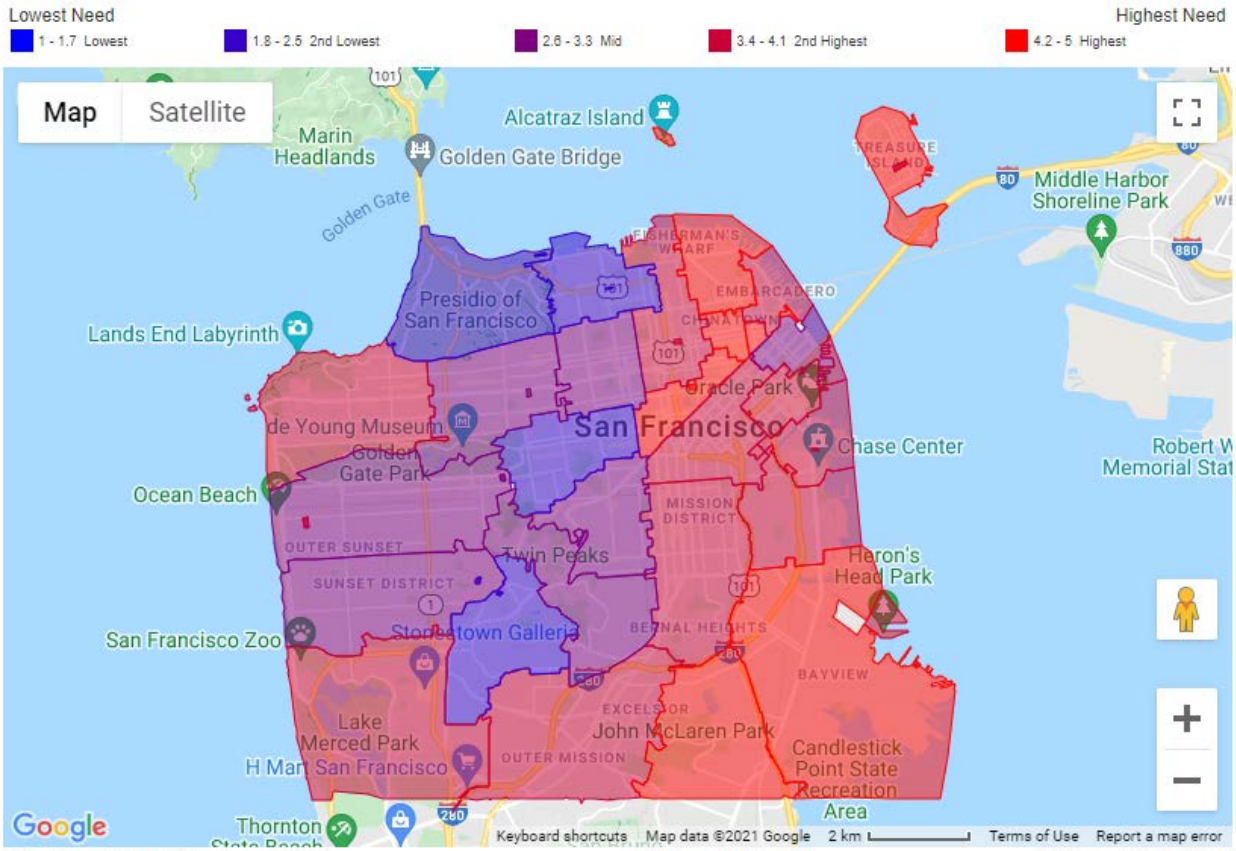
	San Francisco
Total Population	888,069
Race	
White - Non-Hispanic	39.30%
Black/African American - Non-Hispanic	4.70%
Hispanic or Latino	15.60%
Asian/Pacific Islander	36.00%
All Others	4.30%
% Below Poverty	5.10%
Unemployment	3.80%
No High School Diploma	10.90%
Medicaid (household)	7.40%
Uninsured (household)	2.70%

Source: Claritas Pop-Facts® 2021; *SG2 Market Demographic Module*

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.



Mean(zipcode): 3.4 / Mean(person): 3.4 CNI Score Median: 3.4 CNI Score Mode: 3.4,4.2

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 plan and programs were identified in the most recent CHNA report, which was adopted in June, 2019.

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/saintfrancis/about-us/community-benefits or upon request at the hospital's Community Health office.

Significant Health Needs

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

1) **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.

2) **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.

3) **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.

4) **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.

5) **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.

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.

2021 Report and 2022 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 FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

Saint Francis Memorial 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.

The hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging the hospital's Community Advisory Committee and other stakeholders in the development of the annual community benefit plan and triennial Implementation Strategy.

Recognizing that many of the upstream contributing factors to health outcomes require long term effort and commitment, in 2013 SFMH and the Saint Francis Foundation expanded its role and resources launching the Tenderloin Health Improvement Partnership (TLHIP), a multi-sector collective impact

initiative. Today, SFMH continues to co-lead and support neighborhood local capacity building to improve the health, safety and well-being of Tenderloin residents. Whereas 2014 – 2019 TLHIP was about creating the context for collaboration, the next phase focuses on supporting bridges between action-oriented workgroups to address social determinants of health (SDoH) and health equity underlying the community health needs. TLHIP is rooted in the vision, values of alignment and health equity and priorities of the San Francisco Health Improvement Partnership (SFHIP) and the Dignity Health Community Health Strategy Blueprint 2019 - 2023.

The hospital's Community Advisory Committee is comprised of neighborhood leaders, residents, city agencies, funding partners, and hospital staff. Guided by the CAC, TLHIP helps enhance and support community building capacity through an aligned focus on community needs, identifying neighborhood priorities, making strategic investments, and convening stakeholders around complex issues to advance community-based efforts that address the social, economic and environmental conditions influencing health and health equity of vulnerable populations. After reviewing and discussing the 2019 Community Health Needs Assessment report and neighborhood data available through the Central Market/Tenderloin Data Portal http://www.cmtldata.org/, the CAC affirmed the applicability of the findings to the Tenderloin in May 2019. From August to September 2019, the CAC reviewed the hospital's existing community benefit programs and initiatives against the CHNA and TLHIP initiatives, in addition to identifying opportunities for collaboration in the Tenderloin for the next 3 years, including Neighborhood Safety, Strengthening the Parks Network, Neighborhood Harm-Reduction, and Economic Opportunity.

The implementation strategy seeks to weave the benefits of collective impact and alignment, place-based initiatives based on evidenced-based, best and promising practices, investments, and backbone infrastructure and resources. Programs and initiatives to address identified needs were selected and informed by:

- community priorities of safety, community connectedness and opportunities for healthy choices (identified through a series of community stakeholder meetings in 2014)
- existing program with evidence of success/impact
- research into effective interventions
- ability to measure impact
- goal to address an immediate need
- goal to address prevention or social determinants

Additionally, as a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention including Activities that Address the Social Determinants of Health
- Build Community Capacity
- Demonstrate Collaboration
- Contribute to a Seamless Continuum of Care

Impact of the Coronavirus Pandemic

In FY21, Saint Francis continued to support its work to serve the community and underserved populations amid multiple COVID surges that strained staff and resources. In addition to living its mission to provide high-quality, compassionate care, the hospital undertook an extensive vaccination effort, created meaningful connections with city departments and non-profit partners, and recruited medical professionals to provide vaccination education for communities of color in the Bay Area and across the country.

The major undertaking this fiscal year was the establishment and staffing of the COVID mass vaccination site at Moscone and community sites in the Tenderloin. Saint Francis and Dignity Health joined with Kaiser, SFDPH, and the COVID Command Center to staff the Mass Vaccination site at Moscone. Dignity Health staff recruited, staffed and managed the effort in partnership with Kaiser and COVID Command. The site vaccinated over 330,000 individuals and was a universally lauded clinic for its ease of use. At its peak the site ran seven days a week from 7:00 am – 8:00 pm.

Dignity Health also provided support for the Tenderloin community vaccination. As it became apparent that vaccines were in the pipeline, Saint Francis conducted a flu vaccine pilot with GLIDE in October and November of 2020. This served as a dry run for future community COVID vaccine clinics with DPH, GLIDE and Saint Francis. After establishing the mass vaccination clinics, Saint Francis was re-connected by DPH to GLIDE, SF Community Health Clinic and UCSF to support the SFCHC/GLIDE Vaccine clinics. The clinics lead to over 1,800 shots in the arm from April – June, after the many individuals had already received their vaccine from the mass vaccination efforts. The Tenderloin neighborhood has a vaccination rate of 83%, in part because of the diligent work from at the SFCHC/GLIDE Vaccine clinics.

Saint Francis also recruited black, Latino and Asian medical professionals for UCSF's Vaccine Education Program in January 2021. The effort brought vaccine education to community groups around the country to make space questions without a pressuring attitude in safe spaces hosted by community leaders.

As has been documented extensively, the COVID pandemic has exacerbated many social determinants of health including housing, food security, mental health, and overall access to care. As outlined throughout this report the hospital has worked to increase access to care via clearer connections to services, increased food delivery services during the depths of the pandemic in January, and deepening connections with the city partners to connect patients to available housing resources and better coordinate care for patients with severe mental health issues.

In a year with health care was stretch to the limit, Saint Francis and Dignity Health took major steps to combat COVID, and create a more inclusive and equitable health care system.

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 FY21	Planned FY22
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.	☒	☒
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.	☒	☒
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.	☒	☒
COVID Vaccination Effort	• Saint Francis provided staff and material for the Moscone, Tenderloin and Ingleside vaccination clinics.	☒	☐
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.	☒	☒
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 HealthRIGHT360, San Francisco Department of Public Health, Healthy San Francisco, community-based clinics and organizations.

Health Need: Food Security, Healthy Eating and Active Living

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Tenderloin Food Security Work	• Through a community grant Saint Francis supported meals to at-risk populations identified by the Tenderloin Food Security Taskforce. This provided needed meals for at-risk populations, while also serving as a financial bridge for small businesses.	☒	☐
La Cocina Municipal Marketplace at 101 Hyde Street (TLHIP)	• Through a community grant awarded to La Cocina, SFMH partners with La Cocina to create the Municipal Marketplace at 101 Hyde Street which will be the country's first women-led food hall, offering below-market-rate rent to women, immigrant and people of color-owned businesses and providing healthy and affordable food options to Tenderloin residents.	☒	☐

Impact: The hospital's initiatives to address access to healthy eating and physical activity are anticipated to result in improved access to healthy eating and physical activity options Tenderloin residents and improved rates of healthy behaviors and health literacy.

Collaboration:
Tenderloin Food Security Work: Tenderloin Community Benefit District, Tenderloin Food Security Taskforce

La Cocina Municipal Marketplace at 101 Hyde Street: La Cocina, City of San Francisco Mayor's Office of Housing and Community Development.

Health Need: Housing Security and an End to Homelessness

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
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.	☒	☒

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

Conditions of Homelessness: San Francisco Police Department, Healthy Streets Operations Center, San Francisco Department of Homelessness and Supportive Housing, San Francisco Department of Public Health, St. Anthony's, GLIDE, Faithful Fools, Tenderloin Community Benefit District.

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.	☒	☒

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 FY21	Planned FY22
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 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.

In FY21, the hospital awarded the grants below totaling $112,818. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
GLIDE Foundation	GLIDE Health Access Point (HAP)	$71,818
San Francisco SafeHouse	San Francisco SafeHouse Rapid Rehousing Program	$20,000
Tenderloin Community Benefit District (TLCBD)	Tenderloin Small Business Resiliency Project	$21,000

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Tenderloin Health Services (THS) / GLIDE Health Access Point (HAP)	
Significant Health Needs Addressed	X 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	SFMH continues its referral process and partnership with HealthRIGHT360. After HealthRIGHT360's decision to close THS in October 2019, HealthRIGHT360 launched a Mobile Medical Clinic pilot that provided medical services to homeless residents of the Tenderloin that do not otherwise seek care. This pilot ended due to the pandemic and shelter at home orders. Because of this transition, SFMH is reviewing 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.
Community Benefit Category	A2-Community-Based Clinical Services A3-Health Care Support Services
FY 2021 Report	
Program Goal / Anticipated Impact	The GLIDE Health Access Point (HAP) will provide integrated testing, basic health services, and health navigation to members of the Tenderloin community that are not being reached by currently available health care options with a focus on the Black/African American and people who use drugs, including injecting drugs. The first year will comprise planning and development among the four partner organizations.
Measurable Objective(s) with Indicator(s)	• Leadership and staff from GLIDE, Community Engagement & Health Policy Program, Transitions Clinic Network (TCN), The Healing Well gain knowledge of practices to best address the needs of the target populations. • Service blueprint, design of physical space, protocols, budget, and implementation plan are developed for implementation in years two and three that embody strategies to reach the target populations effectively and improve health outcomes.

Intervention Actions for Achieving Goal	• Convene Partners: Work group meetings to delineate partner roles and responsibilities and develop overall plan and timeline, service blue print, protocols and implementation plan. • Identify staff for Training - Alabama Pilgrimage: Ten leaders from the partner organizations participate together in a three-day "retreat" (possibly virtual) focused on history of racial inequities and health disparities to gain a deeper understanding of the origins, current state, and strategies to address health disparities.
Collaboration	Saint Francis Memorial Hospital, GLIDE Foundation, UCSF Community Engagement & Health Policy Program, Transitions Clinic Network (TCN), The Healing Well
Performance / Impact	• Service blueprint, design of physical space, protocols, budget, and implementation plan are developed for implementation in years two and three that embody strategies to reach the target populations effectively and improve health outcomes.
Hospital's Contribution / Program Expense	• Community Grant
FY 2022 Plan	
Program Goal / Anticipated Impact	GLIDE Health Access Point (HAP) will provide integrated testing, basic health services, and health navigation to members of the Tenderloin community that are not being reached by currently available health care options with a focus on the Black/African American and people who use drugs, including injecting drugs. The first year will comprise planning and development among the four partner organizations.
Measurable Objective(s) with Indicator(s)	By Fall 2021: • Leadership and staff from GLIDE, Community Engagement & Health Policy Program, Transitions Clinic Network (TCN), The Healing Well gain knowledge of practices to best address the needs of the target populations. • Service blueprint, design of physical space, protocols, budget, and implementation plan are developed for implementation in years two and three that embody strategies to reach the target populations effectively and improve health outcomes.
Intervention Actions for Achieving Goal	• Convene Partners: Work group meetings to delineate partner roles and responsibilities and develop overall plan and timeline, service blue print, protocols and implementation plan. • Identify staff for Training - Alabama Pilgrimage: Ten leaders from the partner organizations participate together in a three-day "retreat" (possibly virtual) focused on history of racial inequities and health disparities to gain a deeper understanding of the origins, current state, and strategies to address health disparities.

Planned Collaboration	Saint Francis Memorial Hospital, GLIDE Foundation, UCSF Community Engagement & Health Policy Program, Transitions Clinic Network (TCN), The Healing Well

Healthy San Francisco

Significant Health Needs Addressed	X 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	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 135 HSF patients.
Hospital's Contribution / Program Expense	Net Benefit: $420,800 (Total Expense $420,800 – Offsetting Revenue $0.00)

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 HealthRIGHT360, San Francisco Health Plan and San Francisco Department of Public Health.

Homeless Health Initiative: Emergency Department Social Worker

Significant Health Needs Addressed	X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services ❑ Food Security, Healthy Eating and Active Living X Housing Security and an End to Homelessness ❑ Safety from Violence and Trauma ❑ Social, Emotional and Behavioral Health
Program Description	In recognition that limited social work staffing in the emergency department brings challenges in addressing the needs of our patients experiencing homelessness, the HHI project funded a project to fund social work staff to connect with homeless patients during their stay and after admission to better connect patients to services, while also standardizing SDoH screening. The program will develop and strengthen collaborative efforts with local community partners including the homeless continuum of care, homeless service providers, government agencies, and others to identify opportunities to improve coordination of care and access to community resources for populations experiencing homelessness as they discharge from our hospitals.
Community Benefit Category	A3-Health Care Support Services

FY 2021 Report

Program Goal / Anticipated Impact	Improve coordination of care and access to community resources for populations experiencing homelessness as they discharge from our hospitals.
Measurable Objective(s) with Indicator(s)	• 904 encounters from February 2021 to June 2021.

Intervention Actions for Achieving Goal	• Directed meetings with social workers in the Emergency Department • Standardized questionnaire for • Post-discharge follow up • Continued to improve communications between ED and medical homes.
Collaboration	Dignity Health: Homeless Health Initiative, Saint Francis Memorial Hospital: Case Management, San Francisco Department of Homelessness and Supportive Housing, San Francisco Department of Public Health
Performance / Impact	To be decided
Hospital's Contribution / Program Expense	Staff time to manage and train grant funded positions
FY 2022 Plan	
Program Goal / Anticipated Impact	Improve coordination of care and access to community resources for populations experiencing homelessness as they discharge from our hospitals.
Measurable Objective(s) with Indicator(s)	Encounters with homeless patients
Intervention Actions for Achieving Goal	• Directed meetings with social workers in the Emergency Department • Standardized questionnaire for • Post-discharge follow up Continued to improve communications between ED and medical homes.
Planned Collaboration	Dignity Health: Homeless Health Initiative, Saint Francis Memorial Hospital: Case Management, San Francisco Department of Homelessness and Supportive Housing, San Francisco Department of Public Health

Medication Assisted Treatment and Substance Use Navigator (formerly Alcohol & Other Drugs Counselor)

Significant Health Needs Addressed	X 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 X 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.
Community Benefit Category	A3-Health Care Support Services
FY 2021 Report	
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.
Measurable Objective(s) with Indicator(s)	By August 2021: • 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.
Intervention Actions for Achieving Goal	• Hire AOD counselor September 2019 (also referred to Substance Use Navigator or SUN) with addiction counseling certificate. Identified Emergency Department Physician Champion to facilitate X-waiver training among ED physicians. • Engage patients in the Emergency Department, Inpatient Units, Intensive Care Unit and Burn Unit to discuss various MAT treatment options. • Establish relationships with social workers, ED staff, Hospitalist Team and Intensivist Physicians, providing education on addiction management, SUN's role and triggers for referral to SUN, including opioid use disorder, alcohol use disorder and other substance use disorders.

	• Increase awareness of SUN and MAT options which has led to inclusion of SUN and MAT services into the treatment/care plan early in the patient's stay. Coordinate direct referrals to residential treatment for patients identified as ready to do so when it is not possible to utilize inpatient providers to provide MAT. • Form connections with MAT providers in the community, including HealthRIGHT 360 as a resource center for detox and rehab treatment for direct patient intake and referral. • Develop strong tracking process for patient follow-up.
Collaboration	HealthRIGHT 360 residential treatment facilities, outpatient treatment programs, mental health services and variety of wrap-around services, Baker Place/Joe Healy – medical detox of opioid and alcohol detoxification/stabilization. San Francisco's Office-Based Buprenorphine Induction Clinic (OBIC)
Performance / Impact	Update: total from fiscal year 7/2020 – 6/2021 (FY20 numbers) Total # patients seen by SUN: 650 (306) Total # patients identified by care team member as having OUD and offered MOUD/MAT, if appropriate: 250 (148) Total # patients accepted referral or linkage to ongoing MOUD/MAT treatment: 99 (52) # Patients successfully contacted by the SUN within 10 days of discharge from any care setting: 102 (50) # Patients who attended at least one follow-up visit for MOUD/MAT after discharge from any care setting:112 (68) Total # patients prescribed buprenorphine at time of discharge: 46 (8) Total # patients administered buprenorphine during an ED Visit and prescribed buprenorphine upon discharge: 30, 19 (18, 8) Total # patients who were administered buprenorphine during an inpatient admission and prescribed buprenorphine upon discharge: 21, 14 (9,4) Cumulative # hospital-based clinicians with DEA X waivers and their specialty: 28 (27) Cumulative # DEA X Wavier training sessions provided on site (live training sessions only) and number of clinicians who attended during the past month: 1 (7)
Hospital's Contribution / Program Expense	Staffed position
FY2022 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.
Measurable Objective(s)	Improved coordination between AOD Counselors, Patient Navigator,

with Indicator(s)	Social Workers, and X-Waivered Physicians to expand access to MAT and improved care coordination. Total # patients seen by SUN Total # patients identified by care team member as having OUD and offered MOUD/MAT, if appropriate Total # patients accepted referral or linkage to ongoing MOUD/MAT treatment # patients successfully contacted by the SUN within 10 days of discharge from any care setting # patients who attended at least one follow-up visit for MOUD/MAT after discharge from any care setting Total # patients prescribed buprenorphine at time of discharge Total # patients administered buprenorphine during an ED Visit and prescribed buprenorphine upon discharge Total # patients who were administered buprenorphine during an inpatient admission and prescribed buprenorphine upon discharge Cumulative # hospital-based clinicians with DEA X waivers and their specialty Cumulative # DEA X Wavier training sessions provided on site (live training sessions only) and number of clinicians who attended during the past month
Intervention Actions for Achieving Goal	Sustain funding for AOD counselor (also referred to Substance Use Navigator or SUN). Continue to engage patients in the Emergency Department, Inpatient Units, Intensive Care Unit and Burn Unit to discuss various MAT treatment options. Continue to strengthen relationships with social workers, ED staff, Hospitalist Team and Intensivist Physicians, providing education on addiction management, SUN's role and triggers for referral to SUN, including opioid use disorder, alcohol use disorder and other substance use disorders. Coordinate direct referrals to residential treatment for patients identified as ready to do so when it is not possible to utilize inpatient providers to provide MAT. Expand connections with MAT providers in the community. Improve tracking process for patient follow-up. Improve data collection, reporting, map patient treatment pathways and discharge planning Share best practices across Dignity Health hospital network via SUD/MAT Summit to share lessons learned.
Planned Collaboration	HealthRIGHT360 residential treatment facilities, outpatient treatment programs, mental health services and variety of wrap-around services, Baker Place/Joe Healy – medical detox of opioid and alcohol detoxification/stabilization, San Francisco Fire Department's EMS 6 Transportation Unit and Sobering Center, San Francisco's Office-Based

	Buprenorphine Induction Clinic (OBIC) – MAT for suboxone and buprenorphine patients with co-occurring behavioral health needs and dual diagnoses patients, methadone clinic – treatment of addiction and pain management protocols, GLIDE – outreach, needle exchange, education related to risk of Hepatitis and HIV exposure, San Francisco Department of Public Health, Public Health Institute's California Bridge Program, CCI Center for Care Innovations - Addiction Treatment Starts Here: Community Partnerships.

Rally Family Visitation Services

Significant Health Needs Addressed	❑ Access to Coordinated, Culturally and Linguistically Appropriate Care and Services ❑ Food Security, Healthy Eating and Active Living X Safety from Violence and Trauma ❑ Housing Security and an End to Homelessness X 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.
Community Benefit Category	C5-Women's and Children's Services
FY 2021 Report	
Program Goal / Anticipated Impact	Provide supervised visitation to families in need of supervised visitation in three Bay Area Counties.
Measurable Objective(s) with Indicator(s)	• 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.
Intervention Actions for Achieving Goal	• Continued to work closely with the family courts in three counties and program funders to achieve goals and objectives.
Collaboration	Rally Family Visitation Services collaborates with service providers that provide services to the population served. Service providers include domestic violence, children, substance abuse and other related services.
Performance / Impact	• 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. • FY21: 62 (3,000) hours of Exchanges, 1,934 (2000) hours of supervised, facilitated and therapeutic visits. Provide 129 (500) intakes to approximately 70 (250) families. In FY21 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 FY21.
Hospital's Contribution / Program Expense	Net Benefit: $300,641 (Total Expenses: $446,652 – Offsetting Revenue: $146,011)
FY 2022 Plan	
Program Goal / Anticipated Impact	Provide supervised visitation to families in need of supervised visitation in three Bay Area Counties.
Measurable Objective(s) with Indicator(s)	• Provide a secure and safe environment for visits • Ensure children have access to both parents in a healthy environment • Ensure safety for victims of domestic violence • Hours of exchanges, supervised, and facilitated as well as therapeutic sessions. Number of intakes to families served.
Intervention Actions for Achieving Goal	• Continue to work closely with the court in three counties and program funders to achieve goals and objectives.
Planned Collaboration	Rally Family Visitation Services collaborates with service providers that provide services to the population served. Service providers include domestic violence, children, substance abuse and other related services.

Tenderloin Health Improvement Partnership

Significant Health Needs Addressed	X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services X Food Security, Healthy Eating and Active Living X Housing Security and an End to Homelessness X Safety from Violence and Trauma X 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
Community Benefit Category	G1- Assigned Staff
FY 2021 Report	
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 FY21, continued information gathering around Shelter-in-Place hotel plan and coordinated alignment of focus with the committee to move forward on two of the five priority issue areas.
Measurable Objective(s) with Indicator(s)	• Created alignment between partners on the issue areas to move forward: Neighborhood Safety/Violence Prevention and Health Access/Equity.
Intervention Actions for Achieving Goal	• Continued to use collective impact model to serve as the guide for deep collaboration in neighborhood issues. • Served as the backbone for TLHIP and workgroups and grant programs, including existing groups focused on park use/safety, neighborhood safety, neighborhood harm-reduction, economic opportunity

	• Convened regular Community Advisory Committee Meetings to oversee TLHIP activities and discuss and identify solutions to challenging neighborhood issues in areas of homelessness, drug-dealing, mental health, behavioral health and recovery services, community policing and neighborhood safety. • Tracked progress at a population, systems, and program level. • At a strategy/project level, backbone staff has helped build measurement capacity by teaching Improvement Science approaches, providing various capacity support for evaluation learning so that partner organizations can establish whether or not actives are showing improvement. • At a neighborhood level, TLHIP has collaborated with DPH and HSH to bring information about
Collaboration	HealthRIGHT360, Tenderloin Health Services, NOMNIC/TEDP, Curry Senior Center, Code Tenderloin, GLIDE, TNDC, Boys & Girls Clubs of San Francisco, Aspen Affiliates, UCSF, Faithful Fools/Tenderloin Resident, Metta Fund, Rally Family Visitation Services, Tenderloin Community Benefit District, SF Planning, SF Police Department: Tenderloin Police Station, SF Department of Public Health, Office of Supervisor Matt Haney, SF Department of Public Health, SF Police Department: Healthy Streets Operations Center, Healing Well, La Cocina, Green Mobile Health Education Kitchen, Local 2 Union, Golden Gate Safety Group, District Attorney's Office, Courts, San Francisco Police Department, San Francisco Municipal Transportation Agency, UC Hastings.
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 grants to address Food Security, Safety from Violence and Trauma, Access to Health Care and Services, and Social, Emotional and Behavioral Health. • Participated in policy development/advocacy efforts, elevating community voice at local and national levels. • Park Use and Safety: In accordance with San Francisco's Health Orders issued Spring 2020, Playgrounds, adult fitness areas, picnics areas, and basketball/pickleball courts closed. With support from Dignity Health Community Grants Program, the Tenderloin Community Benefit District hired a Director of Inviting Space to lead and coordinate the transformation and connectivity of Tenderloin Parks and open spaces, including Play Streets and other temporary closures. • 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 2022 Plan	
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 addition to continuing supporting existing groups focused on park use/safety, neighborhood safety, neighborhood harm-reduction, economic opportunity, healthy eating/active living, the planned focus for 2019 – 2021 is to address the conditions of homelessness, including quality of life on the sidewalks and streets in the Tenderloin. Continue to support the following workgroups: • Neighborhood Safety/ Violence Prevention • Health Access and Equity
Measurable Objective(s) with Indicator(s)	• Develop collaborative strategies between community-based organizations, city agencies and businesses.
Intervention Actions for Achieving Goal	• Continue to use collective impact model to serve as the guide for deep collaboration in neighborhood issues. • Explore and evaluate governance structure/community-based anchor partner to co-lead TLHIP, including how to best address social determinates through funding, convening and capacity building. • Serve as the backbone for TLHIP through a co-leadership approach in order to support a broad network model that includes steering committee through the hospital's CAC as well as tactical working groups that blend CAC, TLHIP stakeholders and broad community input. • Support TLHIP workgroups/subcommittees and grant programs, including existing groups focused on safety and violence prevention and health access/equity.
Planned Collaboration	HealthRIGHT360, Curry Senior Center, Code Tenderloin, GLIDE, TNDC, Boys & Girls Clubs of San Francisco, Aspen Affiliates, UCSF, Faithful Fools/Tenderloin Resident, Metta Fund, Rally Family Visitation Services, Tenderloin Community Benefit District, SF Planning, SF Police Department: Tenderloin Police Station, SF Department of Public Health, Office of Supervisor Matt Haney, SF Department of Public Health, SF Police Department: Healthy Streets Operations Center, Healing Well, La Cocina, Green Mobile Health Education Kitchen, Local 2 Union, Golden Gate Safety Group, District Attorney's Office, Courts, San Francisco Police Department

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.

COVID Vaccination Efforts
At a cost of $1.5 million per month, Saint Francis and St. Mary's supported multiple vaccination efforts in San Francisco including Moscone Mass Vaccination Clinic, Tenderloin Vaccination Clinic and the Ingleside Vaccination site.

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.

Law Enforcement Assisted Diversion San Francisco (LEAD SF)
On April 20th, 2017, San Francisco received notification of a 26-month grant award from the Board of State and Community Corrections to implement the Law Enforcement Assisted Diversion program in San Francisco (LEAD SF) which is a multi-agency collaborative project overseen by a Policy Committee composed of partner agency representatives and co-chaired by: Chief of Police, District Attorney, and

Director of Health; TLHIP is represented on the LEAD Policy Committee. Based on the model developed in Seattle, LEAD SF is an innovative pre-booking diversion program that will refer repeat, low-level drug offenders, at the earliest contact with law enforcement, to community-based health and social services as an alternative to jail and prosecution. San Francisco's program focuses on the Tenderloin and Mission District.

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.

Post-Acute Care Collaborative
Identifies solutions to improve the availability and accessibility of post-acute care services for vulnerable populations and MediCal beneficiaries in San Francisco; and, to make responsive post-acute care policy, research, and operational recommendations to the Health Commission and Hospital Council.

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.

Community Investment Programs: Active Loans

Bay Area Video Coalition (BAVC) BAVC has been a partner with Dignity Health for over 21 years. This nonprofit organization has inspired social change by empowering media makers to develop and share diverse stories through art, education, and technology. The organization directs its services to under-represented and at risk youth, dislocated workers, and others looking to work in the tech industry, as well as nonprofit organizations that need digital media support. CommonSpirit Health approved the extension of a line of credit with BAVC for $117,000 in June of 2020 for 2-years,enabling BAVC to manage cash flow while it waits for reimbursement from city contracts.

La Cocina In 2018, Dignity Health approved a 7-year, $1,000,000 loan to La Cocina to help finance the construction and equipment costs for the Tenderloin Municpal Marketplace in San Francisco. La Cocina is a California 501(c)(3) nonprofit formed in 2007 to cultivate low-income food entrepreneurs as they formalize and grow their businesses by providing affordable kitchen space, industry-specific technical assistance, and access to market and capital opportunities.

Larkin Street Youth Services (Larkin Street) Larkin Street is San Francisco’s largest nonprofit provider dedicated to the unique needs of homeless youth. The agency serves more than 3,000 youth per year, ages 12-24, through a broad array of programs that move homeless youth from crisis to stability. Dignity Health’s 7-year $1,600,000 loan approved in 2015 was used to purchase a six-bedroom facility to shelter homeless HIV-positive youth.

Mercy Housing (Mercy Family Plaza) Dignity Health's original loan of $1,219,955 is enabling Mercy Housing to finance 36 units of affordable housing for low income families at 333 Baker Street, San Francisco, known as Mercy Family Plaza. This loan matures in 2022.

Mission Neighborhood Centers (MNC) In January, 2020 CommonSpirit Health approved a 7-year $4,000,000 loan to MNC, enabling this nonprofit community development organization to acquire a 30,000-square-foot facility at 2929 19th Street in San Francisco. The facility will be part of a consortium and provide necessary vocational medical assistant training classes, culinary and hospital programs, and program services for youth and child development. It will also preserve a "land-banking" opportunity for a future affordable senior housing development.

San Francisco Housing Accelerator Fund In June 2021 CommonSpirit approved a 15-year $7,000,000 loan to SFHAF for accelerating the production and preservation of affordable housing in SF's most economically disadvantaged communities. In 2021, SFHAF supported the production and preservation of approximately 1,300 affordable homes in SF. This loan replaces SFHAF's original $5,000,000 loan with Dignity Health.

San Francisco Housing Development Corp Dignity Health's original loan of $447,500 is being used to acquire and refurbish properties for low-income families and individuals in the Bayview-Hunters Point area of San Francisco. This loan matures in 2021.

RSF Social Finance (RSF) In 2017 Dignity Health approved a 5-year $500,000 loan to RSF for purposes of financing loans to progressive or innovative enterprises engaged in high-impact projects involving the repurposing of waste into valuable products, creating sustainable materials, and employing traditionally underserved populations.

The Kelsey In September 2020, CommonSpirit approved a 3-year, $1,000,000 loan to The Kelsey with loan proceeds used for predevelopment costs relating to the development of 115 units of affordable housing for San Francisco. Founded in 2017, The Kelsey is a nonprofit California-based organization dedicated to accelerating inclusive, accessible, affordable communities for people with disabilities.

Economic Value of Community Benefit

227 Saint Francis Memorial Hospital					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2020 through 6/30/2021					
	Persons	**Expense**	**Revenue**	**Net Benefit**	**% of Expense**
Benefits for Poor					
Financial Assistance	**4,552**	**5,930,425**	**0**	**5,930,425**	**2.4%**
Medicaid	**12,299**	**96,237,465**	**52,646,173**	**43,591,292**	**17.7%**
Means-Tested Programs	**61**	**422,278**	**1,478**	**420,800**	**0.2%**
Community Services					
A - Community Health Improvement Services	18,188	1,558,391	555,536	1,002,855	0.4%
C - Subsidized Health Services	50	355,275	0	355,275	0.1%
E - Cash and In-Kind Contributions	701	176,612	157,702	18,910	0.0%
Totals for Community Services	2	159,715	0	159,715	0.1%
Totals for Community Services	**18,941**	**2,249,993**	**713,238**	**1,536,755**	**0.6%**
Totals for Poor	**35,853**	**104,840,161**	**53,360,889**	**51,479,272**	**20.9%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	49	153,912	0	153,912	0.1%
B - Health Professions Education	368	1,330,436	227,253	1,103,183	0.4%
F - Community Building Activities	10	19,256	250	19,006	0.0%
Totals for Community Services	**427**	**1,503,604**	**227,503**	**1,276,101**	**0.5%**
Totals for Broader Community	**427**	**1,503,604**	**227,503**	**1,276,101**	**0.5%**
Totals - Community Benefit	**36,280**	**106,343,765**	**53,588,392**	**52,755,373**	**21.4%**
Medicare	**14,987**	**70,714,931**	**40,987,096**	**29,727,835**	**12.1%**
Totals with Medicare	**51,267**	**177,058,696**	**94,575,488**	**82,483,208**	**33.5%**

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

BOARD OF TRUSTEES

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Michael Schrader, M.D.	**Trustee**
Todd Strumwasser, M.D.	**President, Common Spirit Health Northern California Division**
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Michael Taylor, M.D.	**Trustee**
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Benjie Loanzon	**System SVP/Finance & Corporate Controller**
Victor Prieto, M.D.	**Chief of Staff**

Officer

Charles Thevnin	**Treasurer/Chief Financial Officer**

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