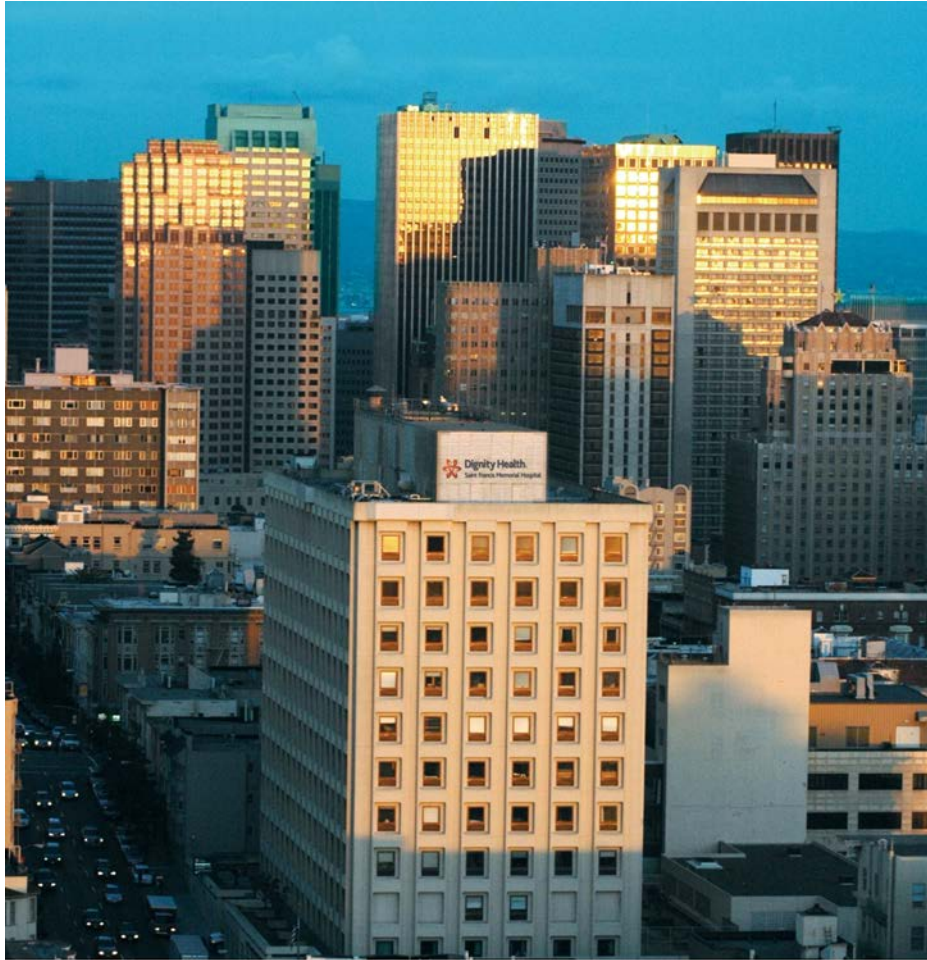


Saint Francis Memorial Hospital

Community Benefit 2020 Report and 2021 Plan

Adopted October 2020



Saint Francis Memorial Hospital

A message from

Jeffrey Fee, president and CEO of Saint Francis Memorial Hospital, and Man Kit Leung, MD Chair of Saint Francis Memorial Hospital Board of Trustees.

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 2020 Report and 2021 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 voluntary 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 2020 (FY20), Saint Francis Memorial Hospital provided \$62,728,009 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred \$28,708,065 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Board of Trustees reviewed, approved and adopted the Community Benefit 2020 Report and 2021 Plan at its October 1, 2020 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 the Community Health Department at (415) 353-6000.







Jeffrey Fee
President/CEO


Man-Kit Leung, MD
Chair, Board of Trustees

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At-a-Glance Summary

<p>Community Served</p> 	<p>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.</p>		
<p>Economic Value of Community Benefit</p> 	<p>\$62,728,009 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits</p> <p>\$28,708,065 in unreimbursed costs of caring for patients covered by Medicare</p>		
<p>Significant Community Health Needs Being Addressed</p> 	<p>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:</p> <table border="1"> <tbody> <tr> <td> <ul style="list-style-type: none"> • Access to Coordinated, Culturally and Linguistically Appropriate Care and Services • Food Security, Healthy Eating and Active Living </td><td> <ul style="list-style-type: none"> • Housing Security and an End to Homelessness • Safety from Violence and Trauma • Social, Emotional and Behavioral Health </td></tr> </tbody> </table>	<ul style="list-style-type: none"> • Access to Coordinated, Culturally and Linguistically Appropriate Care and Services • Food Security, Healthy Eating and Active Living 	<ul style="list-style-type: none"> • Housing Security and an End to Homelessness • Safety from Violence and Trauma • Social, Emotional and Behavioral Health
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<p>FY20 Programs and Services</p> 	<p>The hospital delivered several programs and services to help address identified significant community health needs. These included:</p> <ul style="list-style-type: none"> • 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. • HealthRIGHT360 Patient Navigator Program: The hospital partners with HealthRIGHT360 to provide patient navigator services. The Patient Navigator works closely in coordination with hospital case management, financial counseling departments and community-based clinics to case find and assist patients transitioning out of the Emergency Department into appropriate medical homes, including primary and/or specialty care 		

	<p>appointments.</p> <ul style="list-style-type: none"> • 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.
<p>FY21 Planned Programs and Services</p> 	<p>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.</p>

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.

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 delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital 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.

A plain language summary of the policy is at the end of this report. The financial assistance policy and plain language summary 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	Tenderloin (94102)
Total Population	893,803	37,290
Race		
White - Non-Hispanic	39.5%	38.2%
Black/African American - Non-Hispanic	4.7%	10.8%
Hispanic or Latino	15.6%	20.6%
Asian/Pacific Islander	36.1%	26.4%
All Others	4.2%	4.1%
Total Hispanic & Race	100.0%	100.0%
Median Income (2018)*	\$103,876	\$38,562
% Below Poverty	5.4%	9.3%
Unemployment	4.1%	4.1%
No High School Diploma	11.9%	15.7%
Medicaid	7.6%	14.5%
Uninsured	2.8%	5.2%

Source: Claritas Pop-Facts® 2020; SG2 Market Demographic Module

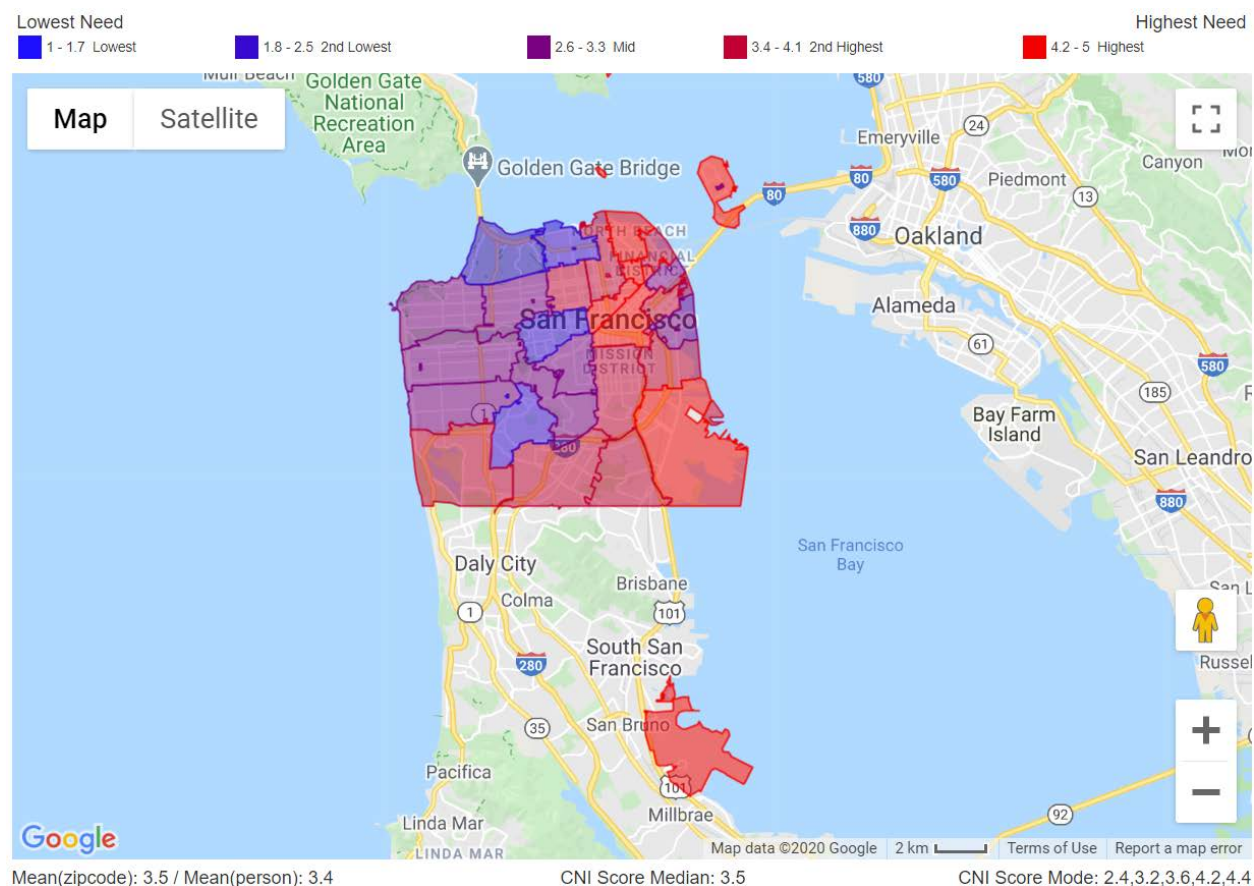
* Source: © 2018 IBM Watson Health

The SFMH Community Benefit Plan focuses on the health needs of 94102 (Tenderloin), one of San Francisco's lowest income neighborhoods. With a population of 28,233, about 58% of families live below 200% of the FPL (ACS American Community Survey 2012-2016). Housing is an important concern in the Tenderloin. Nearly half of the City's 2019 homeless population lives in and around the Tenderloin: 3,659 homeless individuals of the 9,700 citywide (San Francisco Homeless Count Survey Comprehensive Report, 2015 - 2019).

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.



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 health implementation strategy 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 identified the following significant community health needs:

- 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.

The CHNA also 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.

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 through Tenderloin Health Improvement Partnership initiatives. Lists and descriptions of those planned actions are included in this report.

2020 Report and 2021 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 FY20 and planned activities for FY21, 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

SFMH 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/) <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

As coronavirus spread across San Francisco, all the health needs of those living in the Tenderloin were exacerbated. Two months into COVID, the Tenderloin saw a 300% increase in homeless encampments as shelters and navigation centers closed to new referrals to ensure current residents were socially distanced. The increased tent encampments and open air drug dealing discouraged residents from leaving their homes, making it more difficult for residents to get groceries and other necessities. Playgrounds in the neighborhood were closed to preserve social distancing, limiting another option for residents to get out of their home. Finally, the 2019 San Francisco Community Health Needs Assessment points out that income plays an outsized factor in health outcomes, and this continues to play out in the corona virus pandemic. The Tenderloin has a median income that is more than half that of San Francisco, and is also has the second highest case rate per 10,000 residents in San Francisco.

Work has been done to alleviate some of these issues: the City leased hotel rooms to put homeless residents in so they could have shelter and be socially distant, food distribution programs increased their scope and new street patters were put into place by SFMTA to provide outdoor space for residents and families to congregate. Yet Tenderloin residents continue to experience health outcomes that are worse than their fellow San Franciscans.

In FY 2020, the hospital responded to the increased community needs by zeroing in on its core mission to provide compassionate acute health care so that our neighbors would have access to the care they need. Hospital staff worked tirelessly increase capacity and to prepare our staff to diagnose, contain and treat patients with COVID. In the early days when information about the pandemic was ever changing Dignity Health set up free virtual care visits so that patients could meet with primary care doctors to diagnosed symptoms and get up to date information, while reducing potential transmission of the coronavirus.

The hospital then opened the first COVID ward in San Francisco in partnership with the University of California – San Francisco medical center and Zuckerberg General Hospital. The ward brought 40 beds acute care and eight intensive care beds online in April when beds were in high demand. This represents a significant increase to the City’s hospital capacity and created flexibility as the City housed COVID patients from cruise ships, San Quentin State Prison and other hard hit counties in California.


In FY 2021 the Hospital plans to continue its work create capacity to meet the acute care needs of COVID pandemic, and also leverage its community grants to help meet the needs of the community. The Hospital has recommended that three applications be moved forward that aid in the creation of a low-barrier primary care clinic in the Tenderloin, supports a rapid rehousing program for survivors of sex trafficking, and creates a small business grant program to help Tenderloin small businesses keep their doors open. All these programs are done with anchor organization deeply rooted in the communities they serve.

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 FY20	Planned FY21
Patient Financial Assistance	<ul style="list-style-type: none"> 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. 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Healthy San Francisco (HSF)	<ul style="list-style-type: none"> 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. 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Tenderloin Health Services	<ul style="list-style-type: none"> With HealthRIGHT360's decision to close THS in October 2019, SFMH continues its referral process and partnership with HealthRIGHT360. Due to the coronavirus pandemic, HealthRIGHT360 paused its implementation of the Mobile Medical Clinic. SFMH now plans to collaborate with GLIDE Foundation to design and launch a Health Access Point (HAP) at the former site of HealthRIGHT 360's Tenderloin Health Services Clinic. 	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
HealthRIGHT360 Patient Navigator	<ul style="list-style-type: none"> Because of various barriers to primary care, the Emergency Department is the primary source of care for many Medi-Cal and uninsured patients. SFMH partners with HealthRIGHT360 to provide patient navigator services. The Patient Navigator works closely in coordination with hospital case management, financial counseling departments and community-based clinics to identify and assist patients transitioning out of the hospital setting into 	<input checked="" type="checkbox"/>	<input type="checkbox"/>

	appropriate medical homes, including primary and/or specialty care appointments and services.		
Delancey Street Foundation	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> SFMH nurses and physicians provide burn education to nurses and health professionals. 	☒	☐
Burn Support Group	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Serves as a resource of volunteers with 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. Meetings are free of charge and open to newly-diagnosed patients, patients currently undergoing treatment, prostate cancer survivors, their spouses/partners, family members and friends, and health care professionals interested in sharing information and learning more about prostate cancer. 	☒	☒
Easy Breathers	<ul style="list-style-type: none"> A support group for individuals with COPD, asthma, 	☒	☒

Program	<p>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.</p> <ul style="list-style-type: none"> Led by trained facilitators and guest speakers, individuals learn skills that will help them manage their pulmonary conditions and improve their quality of life. 		
Meeting Rooms	<ul style="list-style-type: none"> Meeting space is at a premium in San Francisco. Community-based organizations (CBO) are often unable to find affordable venues to hold meetings. SFMH offers 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 place, 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 FY20	Planned FY21
Strengthening Tenderloin Parks Network (TLHIP)	<ul style="list-style-type: none"> With fewer than 10-acres of open space and stressful conditions on the sidewalks, access to open space and parks in the Tenderloin is one of the biggest barriers to active living for many Tenderloin residents. Through a community grant awarded to the Tenderloin Community Benefit District, SFMH partners with the Tenderloin Community Benefit (TLCBD) to lead the implementation of the community's vision for a coordinated network of active, vibrant, safe and clean park spaces with a dedicated full-time Tenderloin Park Coordinator: 1) 	☒	☒

	where people will be able to connect to each other and to the natural world, and 2) that will support a more active lifestyle for Tenderloin residents. The Parks Network includes: Boeddeker Park, Turk Hyde Mini Park, Sergeant Macaulay Park, TL National Forest and the Tenderloin Wellness Trail.		
La Cocina Municipal Marketplace at 101 Hyde Street (TLHIP)	<ul style="list-style-type: none"> 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. 	☒	☒
HealthRIGHT360 Green Mobile Medical Test Kitchen (TLHIP)	<ul style="list-style-type: none"> Through a community grant awarded to HealthRIGHT360, SFMH partners with HealthRIGHT360 and Green Mobile Health Education Kitchen to design, build, and install a <i>Green Mobile Test Kitchen</i> using safe induction stove-top and energy-efficient technology at the medical clinic. The goals of the project include improved client engagement, quality of life, chronic disease management and substance use. HealthRIGHT360 also partners with the Food Bank of San Francisco/Marin to acquire fresh produce weekly for hands-on cooking demonstrations on healthy, sustainable and safe cooking among their homeless or transitional housed clinic population. 	☒	☒

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 Parks Network: Tenderloin Community Benefit District, Boys & Girls Clubs of San Francisco – Tenderloin Clubhouse, La Voz Latina, Lower Polk Community Benefit District, and Luggage Store. Additional partners include: Rec and Park, Demonstration Gardens, YMCA, Kroc Center, Faithful Fools, SFPD – Tenderloin Police Station, and CCSRO Collaborative.

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

HealthRIGHT360 Green Mobile Medical Test Kitchen: HealthRIGHT360, From the Garden to the Table/Green Mobile Health Education Kitchen, Food Bank of San Francisco/Marin.



Health Need: Housing Security and an End to Homelessness

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
Economic Opportunity (TLHIP)	<ul style="list-style-type: none">Through a community grant awarded to Downtown Streets Team (DST), SFMH partners with DST and Code Tenderloin to engage individuals currently or formerly experiencing homelessness using a peer-to-peer outreach model that provides individuals with work experience opportunities that lead to job placement, career pathways, and stable housing.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supportive Housing Tenant Engagement (TLHIP)	<ul style="list-style-type: none">Through a community grant awarded to Delivering Innovation in Supportive Housing (DISH), SFMH partners with DISH to launch a community wellness pilot in collaboration with EngAGE, Department of Homelessness and Supportive Housing, DISH Community Advisory Board members of each site, and community-based programs offered through the Healing Well and Shih Yu-Lang Central YMCA to increase tenant engagement and wellness, and decrease isolation in DISH operated supportive housing sites. The residents of these housing sites are predominantly formerly homeless male adults, represent communities of color and experience chronic health issues, mental health and substance use.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Conditions of Homelessness (TLHIP)	<ul style="list-style-type: none">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.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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:

Economic Opportunity: Downtown Streets Team, CODE Tenderloin, OEWD, CPMC, Zendesk.

Supportive Housing Tenant Engagement: Delivering Innovation in Supportive Housing (DISH) EngAGE, Healing Well, Shih Yu-Lang Central YMCA, and San Francisco Department of Homelessness and Supportive Housing.

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 FY20	Planned FY21
Rally Family Visitation Services	<ul style="list-style-type: none">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.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Tenderloin Neighborhood Safety (TLHIP)	<ul style="list-style-type: none">Through partnerships with neighborhood-based organizations, SFMH strengthens community capacity to create safer conditions and experiences throughout the Tenderloin neighborhood.The Golden Gate Safety Group organizes positive daily activities and monthly 4-Corner Friday events to activate the sidewalks of the Tenderloin. Building on the success of advocating and supporting positive use of community spaces like Big Boy Market which is now 826 Valencia on the corner of Golden Gate and Leavenworth, the Golden Gate Safety Group continues to meet regularly to coordinate positive activation events throughout the entire community.The coordinated work of the Golden Gate Safety Group has created a culture of safety and is a model for emerging block safety groups that are now supported by the Tenderloin Community Benefit District (TLCBD) to create a coordinated network of safety groups and neighborhood improvement projects.TLCBD also leads <i>Tenderloin Thrives</i>, an initiative that stemmed from conversations at the CAC, that is collaborating with community-based organizations and city agencies to change the deep-rooted systems and policies that allow community harms directly	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

	from, and within, the drug trade to persist in the Tenderloin.		
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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: Local 2 Union, Golden Gate Safety Group, Tenderloin Community Benefit District, Network of Tenderloin Block Safety Groups, Office of Supervisor Matt Haney, District Attorney's Office, Courts, San Francisco Police Department, San Francisco Office of Economic and Workforce Development, San Francisco Municipal Transportation Agency, Faithful+Gould, UC Hastings.



Health Need: Social, Emotional and Behavioral Health

Strategy or Program Name	Summary Description	Active FY20	Planned FY21
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.	☒	☒
Neighborhood Harm-Reduction (TLHIP)	<ul style="list-style-type: none"> Over the past four years, through TLHIP, SFMH and partners have been successful in building relationships and consensus amongst multi-sector stakeholders, and spear-heading advocacy, education and outreach efforts around access to overdose prevention services/clinic as an evidence-based pathway to treatment and recovery for people who use drugs and to mitigating community harms 	☒	☒

	<p>associated with public injecting and improper needle disposal. These efforts included playing an instrumental role in Mayor Breed’s Supervised Injection Services Taskforce and hosting a demonstration overdose prevention site at GLIDE in the Tenderloin. SFMH continues to address neighborhood harm-reduction through its CAC and TLHIP workgroups, focusing on improving access to Medication Assisted Treatment (MAT)/Substance Use Disorders (SUD) services and treatment for people with opioid use disorders (OUD). This includes collectively identifying neighborhood level and system-wide barriers to access MAT/SUD treatment and services, lowering incidents of overdose and strengthening treatment pathways that integrate wrap-around services such as navigation, mental health, housing, transportation and peer support.</p> <ul style="list-style-type: none"> • SFMH also participates in the Law Enforcement Assisted Diversion (LEAD) San Francisco’s Policy Committee. Based on the model developed in Seattle, LEAD SF is an innovative pre-booking diversion program that refers 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 and includes a multi-agency approach co-chaired by the San Francisco Chief of Police, District Attorney, and Director of Health. 		
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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.

Neighborhood harm-reduction: GLIDE, Safer Inside Community, Homeless Outreach Team (HOT), Harm Reduction partners – city agencies, community-based clinics, San Francisco Aids Foundation, Drug Policy Alliance, San Francisco Department of Public Health, and Mayors Office.

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 FY20, the hospital awarded the grants below totaling \$118,358. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Tenderloin Community Benefit District	Tenderloin Park Network: Inviting Space	\$68,358
Downtown Streets, Inc.	Downtown Streets Team and Code Tenderloin Community Fellowship Pilot	\$25,000
Delivering Innovation in Supportive Housing (DISH)	DISH Community Wellness Pilot	\$25,000

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	<p>X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services</p> <p><input type="checkbox"/> Food Security, Healthy Eating and Active Living</p> <p><input type="checkbox"/> Housing Security and an End to Homelessness</p> <p><input type="checkbox"/> Safety from Violence and Trauma</p> <p><input type="checkbox"/> Social, Emotional and Behavioral Health</p>
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 2020 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)	<ul style="list-style-type: none"> To be developed.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> To be developed.
Collaboration	Saint Francis Memorial Hospital, GLIDE Foundation, UCSF Community Engagement & Health Policy Program, Transitions Clinic Network (TCN), The Healing Well
Performance / Impact	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Community Grant
FY 2021 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)	<p>By Fall 2021:</p> <ul style="list-style-type: none"> 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.

	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<p>X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services</p> <p><input type="checkbox"/> Food Security, Healthy Eating and Active Living</p> <p><input type="checkbox"/> Housing Security and an End to Homelessness</p> <p><input type="checkbox"/> Safety from Violence and Trauma</p> <p><input type="checkbox"/> Social, Emotional and Behavioral Health</p>
Program Description	<p>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.</p>
Community Benefit Category	Means-Tested Programs
FY 2020 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)	<ul style="list-style-type: none"> Number of HSF participants served by SFMH – inpatient (3) and

with Indicator(s)	outpatient (132) <ul style="list-style-type: none"> • 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: \$218,477 (Total Expense \$218,477 – Offsetting Revenue \$0.00)

FY 2021 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)	<ul style="list-style-type: none"> • Number of HSF participants served by SFMH – inpatient and outpatient • Sustained implementation of Health Information Exchange.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • Track and monitor utilization and expenses.
Planned Collaboration	Continued collaboration with HealthRIGHT360, San Francisco Health Plan and San Francisco Department of Public Health.



HealthRIGHT360 / Patient Navigator Program

Significant Health Needs Addressed	X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services <ul style="list-style-type: none"> <input type="checkbox"/> Food Security, Healthy Eating and Active Living <input type="checkbox"/> Housing Security and an End to Homelessness <input type="checkbox"/> Safety from Violence and Trauma <input type="checkbox"/> Social, Emotional and Behavioral Health
Program Description	Because of various barriers to primary care, the Emergency Department is the primary source of care for many Medi-Cal and uninsured. The hospital partners with HealthRIGHT360 to provide patient navigator services. The Patient Navigator works closely in coordination with hospital case management, financial counseling departments and community-based clinics to case find and assist patients transitioning out of the hospital setting into appropriate medical homes, including primary and/or specialty care appointments. This iteration of the program builds on previous navigator programs which began in FY2010 as partnership with the San Francisco Health Plan and Department of Public Health.
Community Benefit Category	A3-Health Care Support Services

FY 2020 Report

Program Goal / Anticipated Impact	Increase the ability of patients to access primary care follow-up appointments and retain those appointments with the help of Navigator to address emergency room visits for preventable ambulatory care sensitive conditions.
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> Projected: 12 month; average 110 encounters/month.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> Continued focus on managed care Medi-Cal patients. Tracked show rates for select clinics. Continued to improve communications between ED and medical homes.
Collaboration	HealthRIGHT 360 THS and Saint Francis Memorial Hospital.
Performance / Impact	Of the 87 encounters in FY20Q1, 62 appointments were made or 71%. Show rates across Tenderloin Health Services, Tom Waddell Health Clinic, Curry and St. Anthony's was 78% (18 total show count / 23 total appointments made).
Hospital's Contribution / Program Expense	\$3,788.96 for services. Office space.

FY 2021 Plan

Program Goal / Anticipated Impact	In reviewing the program with Care Coordination, the decision was made to align these resources toward the Medically Assistant Treatment and Substance Use Navigator to better serve the patients of Saint Francis Memorial Hospital.
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Medication Assisted Treatment and Substance Use Navigator (formerly Alcohol & Other Drugs Counselor)

Significant Health Needs Addressed	<ul style="list-style-type: none"> X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services <input type="checkbox"/> Food Security, Healthy Eating and Active Living <input type="checkbox"/> Housing Security and an End to Homelessness <input type="checkbox"/> 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.
Community Benefit Category	A3-Health Care Support Services
FY 2020 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)	<p>By August 2020:</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.

	<ul style="list-style-type: none"> 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	<p><u>November 2019 – June 2020</u></p> <p>Total # patients seen by SUN: 306 Total # patients identified by care team member as having OUD and offered MOUD/MAT, if appropriate: 148 Total # patients accepted referral or linkage to ongoing MOUD/MAT treatment: 52 # patients successfully contacted by the SUN within 10 days of discharge from any care setting: 50 # patients who attended at least one follow-up visit for MOUD/MAT after discharge from any care setting: 68</p> <p>Total # patients prescribed buprenorphine at time of discharge: 8 Total # patients administered buprenorphine during an ED Visit and prescribed buprenorphine upon discharge: 18, 8 Total # patients who were administered buprenorphine during an inpatient admission and prescribed buprenorphine upon discharge: 9, 4</p> <p>Cumulative # hospital-based clinicians with DEA X waivers and their specialty: 27 Cumulative # DEA X Waiver training sessions provided on site (live training sessions only) and number of clinicians who attended during the past month: 7</p>
Hospital's Contribution / Program Expense	Net Benefit: \$5,017
FY2021 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) with Indicator(s)	<p>Improved coordination between AOD Counselors, Patient Navigator, Social Workers, and X-Waivered Physicians to expand access to MAT and improved care coordination.</p> <ul style="list-style-type: none"> 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

	<ul style="list-style-type: none"> • # 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	<ul style="list-style-type: none"> • 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	<p>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</p>

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
- ☐ Housing Security and an End to Homelessness
- ☒ 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.

Community Benefit Category

C5-Women's and Children's Services

FY 2020 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
- FY20: 3000 hours of Exchanges, 2000 hours of supervised, facilitated and therapeutic visits. Provide 500 intakes to approximately 250 families.

Hospital's Contribution / Program Expense

Net Benefit: \$469,118 (Total Expenses: \$867,546 – Offsetting Revenue: \$398,428)

FY 2021 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> 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	<p>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.</p> <p>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.</p> <p>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,</p>

	<p>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:</p> <ul style="list-style-type: none"> • Neighborhood Safety/ Tenderloin Thrives • Strengthening the Parks Network • Neighborhood Harm-Reduction • Economic Opportunity • Conditions of Homelessness
Community Benefit Category	G1- Assigned Staff
FY 2020 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 FY20, began to discuss conditions of homelessness and continued to focus on Neighborhood Safety, Park Activation and Access to ensure all Tenderloin parks are safe and active for residents and that residents feel safe accessing parks.
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • <i>Park Use and Safety:</i> All TL parks are safe and active for residents and all TL residents feel safe accessing parks (Increase total number of TL park visitors; increase #/percent who feel safe in a park; Increase frequency of park use; increase the #/percent who feel welcome in parks).
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • 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 neighborhood level, TLHIP has collaborated with DPH and others on maintaining Central Market Tenderloin Data Portal which includes neighborhood indicators www.cmtldata.org. • 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.

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	<ul style="list-style-type: none"> • 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. • For progress on neighborhood indicators, visit www.cmtldata.org. • 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.
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 2021 Plan	
Program Goal / Anticipated Impact	<p>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:</p> <ul style="list-style-type: none"> • Neighborhood Safety/ Tenderloin Thrives • Strengthening the Parks Network

	<ul style="list-style-type: none"> • Neighborhood Harm-Reduction • Economic Opportunity • Conditions of Homelessness
Measurable Objective(s) with Indicator(s)	<ul style="list-style-type: none"> • Develop collaborative strategies between community-based organizations, city agencies and businesses.
Intervention Actions for Achieving Goal	<ul style="list-style-type: none"> • 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 park use/safety, neighborhood safety, neighborhood harm-reduction, economic opportunity, La Cocina, HealthRIGHT360 and the Green Mobile Health Education Kitchen, Tenderloin Community Benefit District, Downtown Streets, Inc., DISH
Planned 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, St. Anthony's, 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.

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.

ED Behavioral Health Taskforce

Under the auspices of the San Francisco section of the Hospital Council of Northern and Central California, SFMH staff participates in the Taskforce whose goal is to diagnose and address the challenges of San Francisco's Emergency Departments. Taskforce objectives includes identifying the type, quantity, location and funding of additional and behavioral and mental health capacity needed to relieve the strain on the Emergency Departments.

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

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.

San Francisco Housing Accelerator Fund

In 2015 Dignity Health approved a 7-year \$5,000,000 loan for start-up capital to an innovative new public-private partnership that provides the City and County of San Francisco with powerful new tools for producing additional affordable housing. Affordable housing is scarce in San Francisco, a city with the largest income gap and most severe affordability crisis in the nation.

Bay Area Video Coalition (BVC)

BVC 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 BVC for \$144,167 in June of 2020 for 2-years, enabling BVC 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 Municipal 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.

HealthRIGHT 360 (HR360)

In 2015 Dignity Health approved a 5-year \$3,000,000 participation loan with Nonprofit Finance Fund to help HR360 construct its new headquarters and intake center where low-income patients primarily with addictive-related disorders and/or HIV-positive can receive primary care and other services. This loan matured in December 2019.

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.

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.

Tenderloin Neighborhood Development Corporation

The Tenderloin Neighborhood Development Corporation (TNDC) is a nonprofit affordable housing developer founded over 37 years ago in the City of San Francisco (City). As the City's largest affordable housing developer, TNDC owns 41 buildings in eight neighborhoods and has total assets of almost \$900 million. In September, 2019 Dignity Health approved a \$5,000,000, 7-Year loan to TNDC for design and construction of 88 units of affordable housing plus commercial space and on-site social work services for low-income and homeless individuals.

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.

Economic Value of Community Benefit

Saint Francis Memorial Hospital Complete Summary - Classified Including Non Community Benefit (Medicare)

For period from 7/1/2019 through 6/30/2020

	Persons Served	Net Benefit	% of Org. Expenses
<u>Benefits for Living in Poverty</u>			
Financial Assistance	5,676	14,664,497	6.12
Medicaid	13,286	46,242,350	19.3
Means-Tested Programs	161	218,477	0.09
<u>Community Services</u>			
A - Community Health Improvement Services	8,829	594,854	0.25
C - Subsidized Health Services	116	294,186	0.12
E - Cash and In-Kind Contributions	1,321	106,537	0.04
G - Community Benefit Operations	0	85,477	0.04
Totals for Community Services	10,266	1,081,054	0.45
Totals for Living in Poverty	29,389	62,206,378	26.0
<u>Benefits for Broader Community</u>			
<u>Community Services</u>			
A - Community Health Improvement Services	81	163,029	0.07
B - Health Professions Education	591	267,216	0.11
E - Cash and In-Kind Contributions	4,192	79,236	0.03
F - Community Building Activities	5	12,150	0.01
Totals for Community Services	4,869	521,631	0.22
Totals for Broader Community	4,869	521,631	0.22
 Totals - Community Benefit	 34,258	 62,728,009	 26.2
 Medicare	 18,095	 28,708,065	 11.9
 Totals with Medicare	 52,353	 91,436,074	 38.2

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.

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Financial Assistance Policy Summary

Summary Of Financial Assistance Programs

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 250% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 250-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
- If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

Dominican Hospital 1555 Soquel Dr, Santa Cruz, CA 95065 | **Financial Counseling** 831-462-7831
Patient Financial Services 831-457-7001 | www.dignityhealth.org/dominican/paymenthelp

Sequoia Hospital 170 Alameda de las Pulgas, Redwood City, CA 94062 | **Financial Counseling** 650-367-5551
Patient Financial Services 888-488-7667 | www.dignityhealth.org/sequoia/paymenthelp

Saint Francis Memorial Hospital 900 Hyde St, San Francisco, CA 94109 | **Financial Counseling** 415-353-6136
Patient Financial Services 888-488-7667 | www.dignityhealth.org/saintfrancis/paymenthelp

St. Mary's Medical Center 450 Stanyan St, San Francisco, CA 94117 | **Financial Counseling** 415-750-5817
Patient Financial Services 888-488-7667 | www.dignityhealth.org/stmarys/paymenthelp