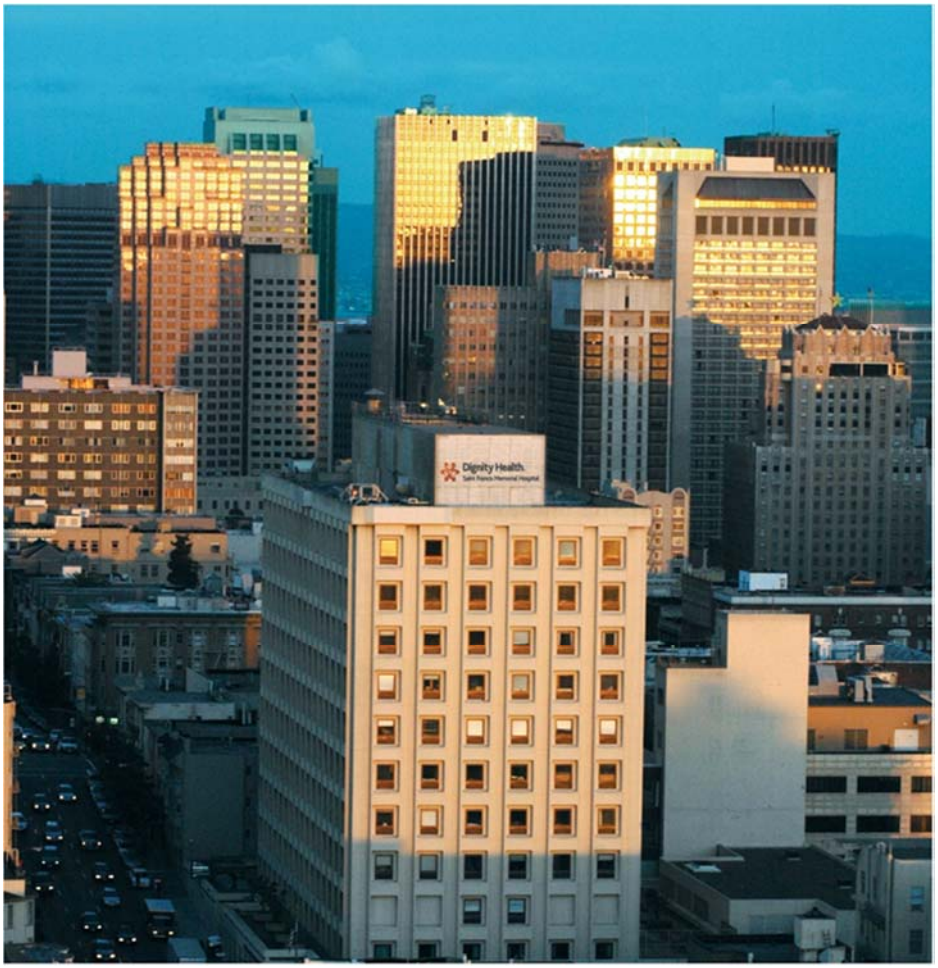
Saint Francis Memorial Hospital

2019 Community Health Implementation Strategy

Adopted October 2019



Dignity Health.
Saint Francis Memorial Hospital

Table of Contents

At-a-Glance Summary

Community Served

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

Significant Community Health Needs Being Addressed

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

- 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

Strategies and Programs to Address Needs

The hospital intends to take several actions and to dedicate resources to these needs, including:

- **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 appointments.
- **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.
Anticipated Impact 	Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; help create conditions that support good health; and increase community alignment to address local challenges.
Planned Collaboration 	Resources potentially available to address the significant health needs are vast in San Francisco. The organized health care delivery systems include the Department of Public Health, University of California, Sutter Health, Kaiser Permanente, Dignity Health Saint Francis Memorial Hospital and St. Mary's Medical Center and the San Francisco Community Clinic Consortium. In addition there are numerous health and social service non-profit agencies, many of which are supported by local government funds. Faith-based organizations, private and public school systems and health equity councils also contribute resources to address these identified needs. All of these organizations are represented on the San Francisco Health Improvement Partnership (SFHIP) steering committee, in which SFMH participates. In the Tenderloin, TLHIP has and will continue to engage community-based partners that represent a spectrum of agencies providing services vital to the Tenderloin community.

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 5 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 288 beds, with a staff of over 1,000 employees and an average of 175 active physicians. About 59% of the patients are residents of San Francisco. Among the hospital's inpatient population, there are 55% Caucasian, 17% Asian, 13% African Americans, and 10% Hispanics. 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

We are committed and dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Financial Assistance for Medically Necessary Care

SFMH 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. The financial assistance policy and a plain language summary and other materials are on the hospital's website.

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	**94102 Tenderloin**
Total Population	884,998	36,539
Race		
White - Non-Hispanic	40.1%	38.4%
Black/African American - Non-Hispanic	4.8%	11.0%
Hispanic or Latino	15.4%	20.2%
Asian/Pacific Islander	35.5%	26.2%
All Others	4.2%	4.1%
Total Hispanic & Race	100.0%	99.9%
Median Income	$103,876	$38,562
Unemployment	3.9%	3.4%
No High School Diploma	12.5%	17.1%
Medicaid *	19.6%	44.3%
Uninsured	6.5%	16.7%

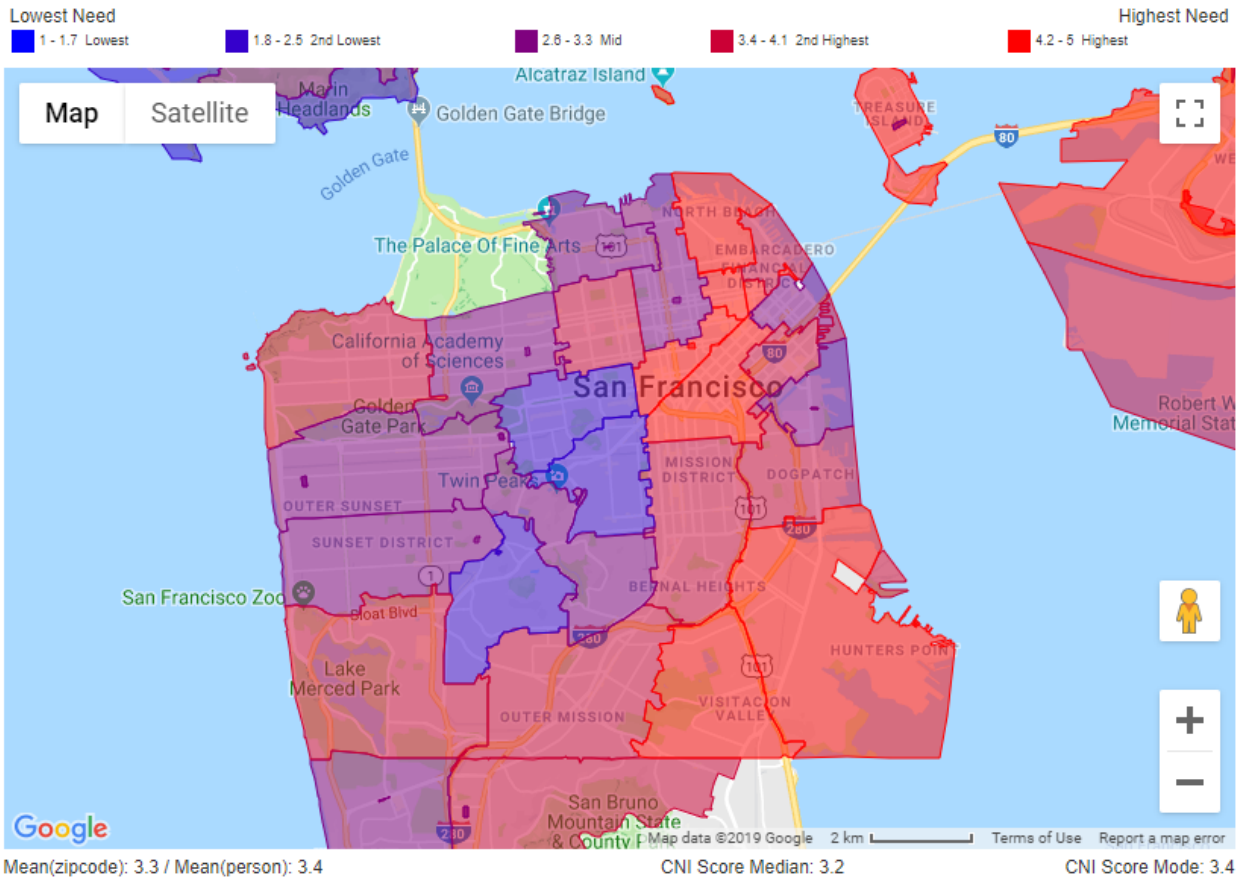
* Does not include individuals dually-eligible for Medicaid and Medicare.
Source: © 2018 IBM Watson Health

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.



Mean(zipcode): 3.3 / Mean(person): 3.4 CNI Score Median: 3.2 CNI Score Mode: 3.4

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 and collaborating with 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 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 remaining 31,500 uninsured residents, 15,373 have health care access through Healthy San Francisco or Healthy Kids. Approximately 2% of San Francisco residents remain without insurance. 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 nine 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 the Tenderloin Health Improvement Partnership initiative. Lists and descriptions of those planned actions are included in this report.

2019 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years. It summarizes planned activities with statements on anticipated impacts and planned collaboration. Program Digests provide additional detail on select programs.

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 Implementation Strategy

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 through

dialogue with community to improve the health, safety and well-being of Tenderloin residents. Whereas in the first 5-years TLHIP was about creating the context for collaboration, the next phase focuses on supporting bridges between action-oriented workgroups to address social determinants of health (SDoH) and health equity underlying the community health needs. TLHIP is rooted in the vision, values of alignment and health equity and priorities of the San Francisco Health Improvement Partnership (SFHIP) and the Dignity Health Community Health Strategy Blueprint 2019 - 2023.

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

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

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

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: Seek to address the needs of communities with disproportionate unmet health-related needs.
- Emphasize Prevention including Activities that Address the Social Determinants of Health: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- Build Community Capacity: Target charitable resources to mobilize and build the capacity of existing community assets.
- Demonstrate Collaboration: Work together with community stakeholders on community health needs assessments, health improvement program planning and delivery to address significant health needs.
- Contribute to a Seamless Continuum of Care: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.

Strategy by Health Need

The tables below present strategies and program activities the hospital intends to deliver to help address significant health needs identified in the CHNA report.

They are organized by health need and include statements of the strategies' anticipated impact and any planned 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
Patient Financial Assistance	• SFMH provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services.
Healthy San Francisco (HSF)	• Means tested charity care program that links uninsured participants with medical home - a clinic that provides primary care, social services, case management and preventative care. The vast majority of HSF enrollees are not Medi-Cal recipients.
HealthRIGHT360 Patient Navigator	• 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 appropriate medical homes, including primary and/or specialty care appointments and services.
Delancey Street Foundation	• SFMH partners with the Delancey Street Foundation to provide Delancey's residential substance abuse rehabilitation and vocational training participants with health services at the Saint Francis Memorial Hospital Health Center.
Physician Support for Charity Care Programs	• Physicians are reimbursed for coverage to indigent patients in the Emergency Department and for patients in the Hospitalist program.
Health Professions Education: Clinical Pastoral Education Program (CPE)	• One-year program that provides CPE students with a collaborative, interfaith and clinical learning environment to develop their skills in pastoral reflection, pastoral formation, pastoral competence and pastoral specialization.

Health Professions Education: Nurse Preceptor	• In partnership with local colleges and universities, SFMH's Nursing Preceptor Program is designed to provide student nurses with the tools, skills, and experience of the Registered Nurse (RN). This includes one-on-one time with an RN where the students develops assessment, clinical reasoning, leadership, and delegation skills.
Health Professions Education: Dietetic Intern	• In partnership with the San Francisco State University, SFMH's Food and Nutrition Department serves as a preceptor for Dietetic intern students. This internship provides the knowledge and practice requirements necessary to be eligible to take the Registered Dietitian (R.D.) examination.
Health Professions Education: Burn Education	• SFMH nurses and physicians provide burn education to nurses and health professionals.
Burn Support Group	• Working in collaboration with the Alisa Ann Ruch Burn Foundation, SFMH provides monthly support groups for burn survivors free of charge.
Us Too Prostate Cancer Support Group	• 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 Program	• A support group for individuals with COPD, asthma, lung cancer, and other chronic lung diseases, and their caregivers featuring and discussing educational presentations on various topics, including medications, environmental triggers, nutrition, home exercise, and supplemental oxygen. • 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	• 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)

Anticipated 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.
Planned 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
Strengthening Tenderloin Parks Network (TLHIP)	• 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)	• 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)	• Through a community grant awarded to HealthRIGHT360, SFMH partners with HealthRIGHT360 and Green Mobile Health Education Kitchen to design, build, and install a *Green Mobile Test Kitchen* 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.

Anticipated 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.

Planned 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
Economic Opportunity (TLHIP)	• 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.
Supportive Housing Tenant Engagement (TLHIP)	• 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.
Conditions of Homelessness (TLHIP)	• Through the Community Advisory Committee and TLHIP workgroups/subcommittees, address the conditions of homelessness, including quality of life on the sidewalks and streets in the Tenderloin.

Anticipated 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.

Planned 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
Rally Family Visitation Services	• Launched by the San Francisco Unified Family Court in 1991, Rally was adopted by Saint Francis Memorial Hospital in 1997. Rally is the only program of its kind in the San Francisco Bay Area providing services to families dealing with diverse situations, including allegations and/or history of domestic violence, child abuse (sexual, physical, emotional, etc.), substance abuse, mental health issues, parenting concerns, and cases referred for lack of contact between the non-custodial parents and their child/children in Marin, San Francisco, and San Mateo counties. These visitation services are designed for children who may be at risk of emotional or physical harm following their parents' separation or divorce and is staffed by highly trained and licensed mental health professionals and volunteers who supervise visits and exchanges between children and parents.
Tenderloin Neighborhood Safety (TLHIP)	• 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 too 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 *Tenderloin Thrives*, 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 from, and within, the drug trade to persist in the Tenderloin.

Anticipated 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.

Planned 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 Fools, UC Hastings.

Health Need: Social, Emotional and Behavioral Health

Strategy or Program Name	Summary Description
Medication Assisted Treatment and 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. SFMH's primary outpatient partners in this work are San Francisco's Office-Based Buprenorphine Induction Clinic (OBIC) and HealthRight360. Currently, following the administration of buprenorphine, methadone, or suboxone on-site, ED physicians refer patients to OBIC for further treatment. SFMH's Patient Navigator assists in care coordination and navigation to community based resources, including HealthRIGHT360. SFMH is currently on-boarding an Alcohol and Other Drug (AOD) Counselor to assist in the identification of patients with SUD needs and provide care coordination.
Neighborhood Harm-Reduction (TLHIP)	• 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 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. • 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.

Anticipated 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.

Planned 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.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. 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.

 **Healthy San Francisco**	
Significant Health Needs Addressed	X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services ❑ Food Security, Healthy Eating and Active Living ❑ Housing Security and an End to Homelessness ❑ Safety from Violence and Trauma ❑ Social, Emotional and Behavioral Health
Program Description	Healthy San Francisco (HSF) is a program that provides a system of health care services to the uninsured. Healthy San Francisco links participants with a Medical Home, a clinic that provides primary care, social services, case management and preventative care. Healthy San Francisco has approximately 13,615 participants enrolled in 35 medical homes and participating hospitals (according to HSF FY16-17 annual report). The number of persons enrolled in Healthy San Francisco has declined as eligible individuals enroll in Medi-Cal. SFMH has supported HSF clients through its partnership with HealthRIGHT360's Tenderloin Health Services (THS) clinic. With HealthRIGHT360's decision to close THS in October 2019, SFMH continues its partnership with HealthRIGHT360 as it consolidates services that were offered at the THS location with other clinic sites in San Francisco (including HealthRIGHT360's Integrated Care Center at 1563 Mission and Lyon Martin at 1735 Mission which are HSF medical homes) and continues to have a presence in the Tenderloin medical community with the launch of its Mobile Medical Clinic.
Community Benefit Category	Means-Tested Programs
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Provide inpatient services and outpatient diagnostics services to Healthy San Francisco participants that identify HealthRIGHT360 as their medical home.
Measurable Objective(s) with Indicator(s)	• Number of HealthRIGHT360 HSF participants served by SFMH – inpatient and outpatient. • Sustained implementation of Health Information Exchange.

Intervention Actions for Achieving Goal	• Track and monitor utilization and expenses. Support the launch and operations of HealthRIGHT360's Mobile Medical Clinic through referrals from the hospital and partner engagement.
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 ❑ 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	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

Planned Actions for 2019 - 2021

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 help address emergency room visits for preventable ambulatory care sensitive conditions.
Measurable Objective(s) with Indicator(s)	Projected: 12 month; average 100 encounters/month. Of these encounters, secure at least 75% appointments and have at least 65% show rate at each clinic.
Intervention Actions for Achieving Goal	• Continued focus on managed care Medi-Cal patients. • Continue to track show rates for selected community-based clinics and explore how to measure repeat visits to Emergency Department. • Continue to improve communications between ED and medical homes.

Planned Collaboration	• Continued collaboration with HealthRIGHT360 and its medical and behavioral health services, community-based clinics: Tom Waddell Health Clinic, Curry Senior Center, and St. Anthony.

Medication Assisted Treatment and Alcohol & Other Drugs Counselor

Significant Health Needs Addressed	X Access to Coordinated, Culturally and Linguistically Appropriate Care and Services ❑ Food Security, Healthy Eating and Active Living ❑ Housing Security and an End to Homelessness ❑ Safety from Violence and Trauma X Social, Emotional and Behavioral Health
Program Description	SFMH services a high-utilizing, vulnerable population suffering from the worst health outcomes in San Francisco. Many 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 began a pilot program for Medication for Opioid Use Disorder (MOUD) and Medication Assisted Treatment (MAT) in the Emergency Department, modeled after the Highline Hospital Program. SFMH's primary outpatient partners in this work are San Francisco's Office-Based Buprenorphine Induction Clinic (OBIC) and HealthRight360. Following the administration of buprenorphine, methadone, or suboxone on-site, ED physicians refer patients to OBIC for further treatment. SFMH's Patient Navigator assists in care coordination and navigation to community based resources, including HealthRIGHT360. 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, 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.
Community Benefit Category	A3-Health Care Support Services

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Current barriers to treatment services include a shortage of available in-patient beds, inadequate care coordination between community services, and a lack of community and provider education to destigmatize screening and treatment of SUD. Developing provider and staff targeted training and protocols, and X-Waivering key physicians in the ED and other units, will dramatically increase SFMH's ability to provide improved support and maintenance to patients needing MAT while connecting them to different treatment pathways and critical services.
Measurable Objective(s) with Indicator(s)	By August 2020: • Improved coordination between AOD Counselors, Patient Navigator, Social Workers, and X-Waivered Physicians to expand access to MAT and improved care coordination • Increase 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	• Amend the hospital's electronic medical record (EMR) system to enable assessment, identification, flagging, and referral/care coordination for SUD/MAT patients hospital-wide • Integrate MAT/SUD trainings into nurse and provider continued education programs with hospital-wide "kick-off" training event to raise awareness, with videography for future use • Provide targeted trainings starting with specific staff in the ED and scale to Burn Unit, In-Patient, ICU, and Behavioral Health Care Units • Develop and issue protocols to integrate more targeted SUD/MAT identifiers into the current SBIRT screenings and ensure unilateral implementation • Enable 24 hour on-site prescribing and out-patient care via X-waivering for 2-3 providers • Ensure effective coordination between AOD Counselors, Patient Navigator, Social Workers, and X-Waivered Physicians to expand access to MAT and improved care coordination • 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 • Improve data collection, reporting, map patient treatment pathways and discharge planning • Share best practices across Dignity Health hospital network via SUD/MAT Summit to share lessons learned.
Planned Collaboration	HealthRIGHT360 residential treatment facilities, outpatient treatment programs, mental health services and variety of wrap-around services,

	Baker Place/Joe Healy – medical detox of opioid and alcohol detoxification/stabilization, San Francisco Fire Department's EMS 6 Transportation Unit and Sobering Center, San Francisco's Office-Based Buprenorphine Induction Clinic (OBIC) – MAT for suboxone and buprenorphine patients with co-occurring behavioral health needs and dual diagnoses patients, methadone clinic – treatment of addiction and pain management protocols, GLIDE – outreach, needle exchange, education related to risk of Hepatitis and HIV exposure, San Francisco Department of Public Health, Public Health Institute's California Bridge Program, CCI Center for Care Innovations - Addiction Treatment Starts Here: Community Partnerships.

Rally Family Visitation Services

Significant Health Needs Addressed	❑ Access to Coordinated, Culturally and Linguistically Appropriate Care and Services ❑ Food Security, Healthy Eating and Active Living ❑ Housing Security and an End to Homelessness X 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

Planned Actions for 2019 - 2021

Program Goal / Anticipated Impact	Provide supervised visitation to families in need of supervised visitation to families in three Bay Area Counties.
Measurable Objective(s) with Indicator(s)	• Provide a secure and safe environment for visits • Ensure children have access to both parents in a healthy environment • Ensure safety for victims of domestic violence while at Rally • FY19: 3000 hours of Exchanges, 2000 hours of supervised, facilitated and therapeutic visits. Provide 500 intakes to approximately 250 families.
Intervention Actions for Achieving Goal	Continue to work closely with the court 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, substance abuse and other related services.

Tenderloin Health Improvement Partnership

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

Community Benefit Category	G1- Assigned Staff
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Seek to address community inequities by fostering multi-sector alignment, building common agenda, investing in and supporting mutually reinforcing activities, building measurement and evaluation capacity, and providing backbone support. In addition to continued support of 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 homelessness: better tent/encampment policies, sanitation and coordination of services, including improved relationship with the San Francisco Police Department and the Healthy Streets Operations Center (HSOC). Continue to support the following workgroups: • Neighborhood Safety/ Tenderloin Thrives • Strengthening the Parks Network • Neighborhood Harm-Reduction • Economic Opportunity
Measurable Objective(s) with Indicator(s)	• Develop collaborative strategies between community-based organizations, city agencies and businesses.
Intervention Actions for Achieving Goal	• Continue to use collective impact model to serve as the guide for deep collaboration in neighborhood issues. • SFMH and Saint Francis Foundation will continue to collaborate on 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.
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, 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 Department of Homelessness and Supportive Housing, San Francisco Municipal Transportation Agency, UC Hastings, St. Anthony's.

Board of Trustees Community Advisory Committee

First Name	Last Name	Organization
Andrew	Desruisseau, MD	HealthRIGHT360
Aashish	Karkhanis	NOMNIC/TEDP
David	Knego	Curry Senior Center
Del	Seymour	Code Tenderloin
Joanne	Sun, MD**	Saint Francis Memorial Hospital
Karl	Robillard	Twitter
Kathy	Curran	The Healing WELL
Kenneth	Kim	GLIDE
Liz	Orlin	TNDC
Michael	Schrader	Saint Francis Memorial Hospital
Michael	Vuong	Boys & Girls Clubs of San Francisco
Michaela	Cassidy*	Aspen Affiliates
Paula	Fleisher	UCSF
Robert	Harvey, MD*	Saint Francis Memorial Hospital
Sam	Dennison	Faithful Fools, Tenderloin Resident
Shally	Iyer	Metta Fund
Sonia	Melara	Rally Family Visitation Services
Simon	Bertrang	Tenderloin Community Benefit District
David	Klein, MD***	Saint Francis Memorial Hospital
Mark	Ryle***	Saint Francis Foundation
Andrea (Andi)	Nelson***	SF Planning
Carl	Fabbri***	SF Police Department: Tenderloin Police Station
Hali	Hammer, MD***	SF Department of Public Health
Honey	Mahogany***	Office of Supervisor Matt Haney
Meg	Wall***	SF Department of Public Health
Mark	Cota***	SF Police Department: Healthy Streets Operations Center

**SFMH Board of Trustees, ** SFF Board Member, ***Ex-Officios*
SF Office of Economic Workforce Development Ex-Officio TBD