Sutter Health
CALIFORNIA PACIFIC MEDICAL CENTER

2016 – 2018 Implementation Strategy
Responding to the 2016 Community Health Needs Assessment

P.O. Box 7999, San Francisco, CA 94120-7999
Facility License Number 220000197 (Pacific, Davies, California campuses)
www.sutterhealth.org

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Introduction

The implementation strategy describes how California Pacific Medical Center (CPMC), a Sutter Health affiliate, plans to address significant health needs identified in the 2016 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2016 through 2018.

The 2016 CHNA and the 2016–2018 implementation strategy were undertaken by the hospital to understand and address community health needs, and in accordance with the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The implementation strategy addresses the community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

CPMC welcomes comments from the public on the 2016 Community Health Needs Assessment and 2016–2018 implementation strategy. Written comments can be submitted:

- By emailing the Sutter Health System Office Community Benefit department at SHCB@sutterhealth.org;
- Through the mail using CPMC's address at P.O. Box 7999, San Francisco, CA 94120-7999, Attention: Community Benefit Department; and
- In-person at each hospital campus's Information Desk.

About Sutter Health

CPMC is affiliated with Sutter Health, a not-for-profit network of hospitals, physicians, employees and volunteers who care for more than 100 Northern California towns and cities. Together, we're creating a more integrated, seamless and affordable approach to caring for patients.

The hospital's mission is to enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in health care services.

Over the past five years, Sutter Health has committed nearly $4 billion to care for patients who couldn't afford to pay, and to support programs that improve community health. Our 2015 commitment of $957 million includes unreimbursed costs of providing care to Medi-Cal patients, traditional charity care and investments in health education and public benefit programs. For example:

- In 2015, Sutter Health invested $712 million more than the state paid to care for Medi-Cal patients. Medi-Cal accounted for 20 percent of Sutter Health's gross patient service revenues in 2015. Sutter Health hospitals proudly serve more Medi-Cal patients in our Northern California service area than any other health care provider.
- As the number of insured people grows, hospitals across the U.S. continue to experience a decline in the provision of charity care. In 2015, Sutter Health's investment in charity care was $52 million.
- Throughout our health care system, we partner with and support community health centers to ensure that those in need have access to primary and specialty care. We also support children's health centers, food banks, youth education, job training programs and services that provide counseling to domestic violence victims.

Every three years, Sutter Health hospitals participate in a comprehensive and collaborative Community Health Needs Assessment, which identifies local health care priorities and guides our community benefit strategies. The assessments help ensure that we invest our community benefit dollars in a way that targets and addresses real community needs.

For more facts and information about CPMC, visit www.sutterhealth.org.

2016 Community Health Needs Assessment Summary

CPMC participates in a collective needs assessment process as a member of the San Francisco Health Improvement Partnership (SFHIP), a collaborative body whose mission is to embrace collective impact and to improve community health and wellness in San Francisco. Membership in SFHIP includes San Francisco Department of Public Health (SFDPH), San Francisco Mayor's Office, the city's nonprofit hospitals, and other health care-related nonprofit stakeholders.

SFHIP completes a CHNA once every three years, which provides data enabling identification of priority issues affecting health and is the foundation for various citywide health planning processes, as well as each San Francisco nonprofit hospital's Community Health Needs Assessment and Implementation Strategy.

The needs assessment for this report was conducted from February to December 2015. Meetings were facilitated by SFDPH, and the final CHNA document that was collectively developed by SFHIP was prepared by SFDPH.

The CHNA process involved four steps:

1. **Community health status assessment**, in which 177 health determinant and outcome variables were analyzed, ranked and selected, recognizing the essential role that social determinants of health play in the health of San Franciscans;
2. **Assessment of prior assessments**, in which a variety of health needs assessments already completed by various San Francisco organizations was reviewed to ensure that this existing knowledge was integrated into the CHNA;
3. **Community engagement**, in which we co-hosted meetings with community organizations representing target populations identified through the assessment of prior assessments – or we joined their existing meetings. Target populations were selected based on four factors:
   - the population has known health disparities;
   - little information describing the health of the population was available;
   - the population was not included in a recent health assessment; and
   - the population was reachable through an existing community group.

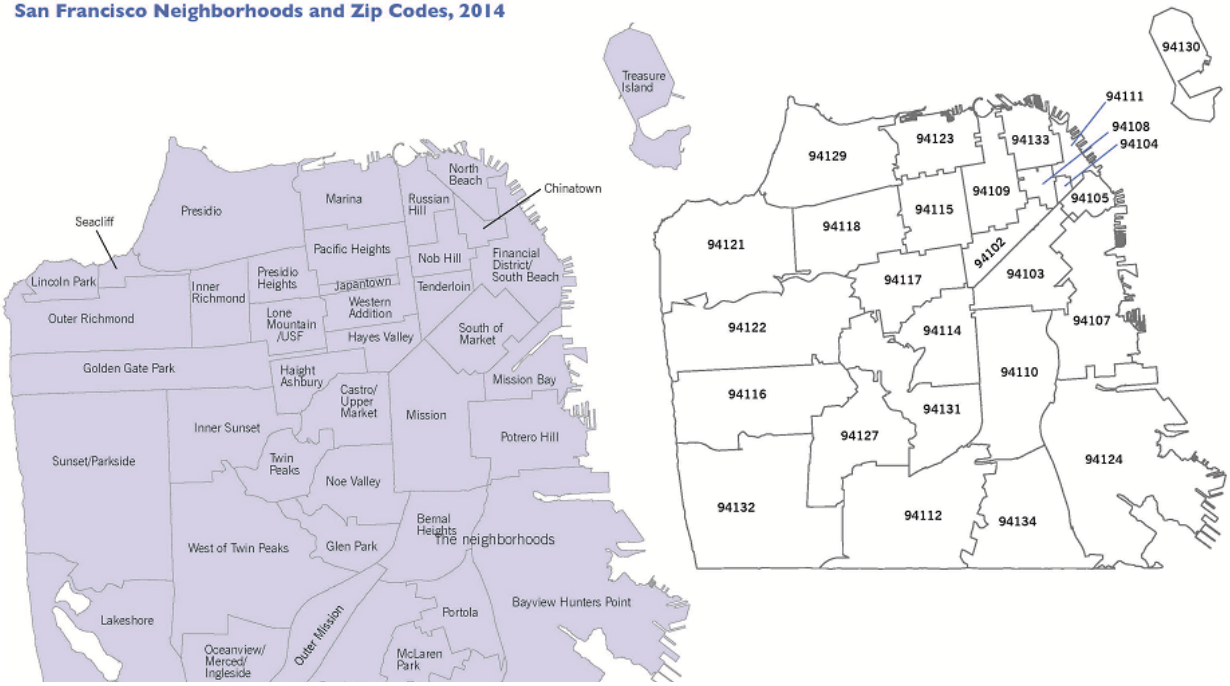
   Contributing community partners included: Asian Americans Advancing Justice (Asian Law Caucus), African American Art and Culture Complex, Asociación Mayab, CARECEN, Filipino American Development Foundation, Instituto Familiar de la Raza, Larkin Street Youth Services, SF LGBT Community Center, Native American Health Center, On Lok 30th Street Senior Center, Swords to Plowshares, and Transitions Clinic.
4. **Health needs identification and prioritization**, in which SFHIP members reviewed and screened all findings according to pre-established criteria in a multi-step process.

The full 2016 Community Health Needs Assessment conducted by CPMC is available at www.sutterhealth.org.

Definition of the Community Served by the Hospital

CPMC serves all populations residing in the City and County of San Francisco.

San Francisco Neighborhoods and Zip Codes, 2014



Ethnic composition by percentage of population, San Francisco, 2010 vs. 2030

Ethnicity	2010	2030 Projected
White	42.1%	39.3%
Black/African American	5.8%	4.5%
Asian	33.3%	33.4%
Pacific Islander	0.4%	0.4%
Latino	15.1%	18.0%
Native American	0.2%	0.2%
Multi-ethnic	3.1%	4.1%

Population by age group as a percentage of the total population projections, San Francisco, 2010–2030

Groups by age	2010	2020	2030
Seniors (65+)	13.7%	17.1%	19.9%
Working age (25-64)	63.4%	61.6%	57.7%
College age (18-24)	9.6%	5.8%	6.7%
School age (5-17)	9.0%	10.4%	11.4%
Preschool age (0-4)	4.4%	5.1%	4.3%

The CHNA reviewed health data on all San Francisco populations. Some important findings include:

- Total population (2015 est.): 845,602
- While over 97,000 San Franciscans gained health insurance in 2014 under the Affordable Care Act, an estimated 7.3 percent of residents (60,877) still do not have health insurance.
- 13 percent do not have a usual place to go for medical care.
- 41 percent of adults have not had a routine check-up in the past year.
- 42 percent have not had a flu shot in the past year.
- 40 percent of women ages 18–44 have not received counseling or information about birth control from a doctor or medical provider in the past year.
- 22 percent of women with public safety-net insurance do not receive timely prenatal care.

- 35 percent of adults have not seen a dentist in the past year.
- Less than 5 percent of Whites are unemployed, while almost 18 percent of Black/African Americans are unemployed.
- Almost 1 in 3 San Franciscans (211,000 people) live below 200 percent of the federal poverty level.
- 2 percent of White children and 48 percent of Black/African American children live in poverty.
- 16 percent of Whites and 63 percent of Black/African Americans did not graduate from high school.

For further details regarding San Francisco's population, please refer to the full CHNA.

Significant Health Needs Identified in the 2016 CHNA

The following significant health needs were identified in the 2016 CHNA:

1. Psychosocial health
   Mental health is an important part of community health. In San Francisco the number of hospitalizations among adults due to major depression exceeds that of asthma or hypertension. Presence of mental illness can adversely impact the ability to perform across various facets of life such as work, home, and social settings. It also impacts the families, caregivers and communities of those affected.

2. Healthy eating
   Poor nutrition contributes to six of the top 10 causes of death in San Francisco – heart failure, stroke, hypertension, colon cancer, Alzheimer's, and other dementias – as well as to the eleventh top cause of death, diabetes.

3. Safety and violence prevention
   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. One out of five residents reports not walking because of fear of violence or crime.

4. Access to coordinated, culturally and linguistically appropriate services across the continuum
   In 2014, 97,000 residents gained health insurance. However, more than 10 percent do not have a usual place they go to receive care. Access to services is influenced by location, affordability, hours of operation, and cultural and linguistic appropriateness of health care services.

5. Housing stability/homelessness
   Sub-standard housing quality, overcrowding, housing instability, and homelessness impact health by decreasing opportunity for self-care (sound sleep, home-cooked food, warmth, hygiene) and increasing risk exposure. Between 2000 and 2012, fair market rents increased by 22 percent, and all-cause evictions are at a 10-year high.

6. Substance abuse
   Substance abuse, including drugs, alcohol and tobacco, contributes to seven of the top 10 causes of death in the city – lung cancer, COPD, heart failure, stroke, hypertensive heart disease, Alzheimer's and organic dementias, and poisonings.

7. Physical activity
   A lack of physical activity contributes to five of the top 10 causes of death in San Francisco – lung cancer, heart failure, hypertension, colon cancer, and dementias – and to the eleventh top cause of death, diabetes. 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.

In addition to these significant health needs, the CHNA also identified two foundational issues that shape the context from which health needs emerge, affecting health at every level:

1. Economic barriers to health
   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 such as air pollution and poor-quality housing conditions.

2. Racial health inequities
   Health inequities are avoidable differences in health outcomes between population groups. Health inequities result from unevenly distributed systematic social, economic, and environmental obstacles that impact risk, prevention, and treatment of health problems.

Health needs identification and prioritization was a multi-step process. SFHIP members reviewed the comprehensive set of data generated from the first three steps (see page 4) and screened findings according to pre-established criteria in order to come to consensus on a satisfactory list of health needs. To further prioritize, consolidate, and refine the initial list, SFHIP Steering Committee members engaged in a scoring exercise in which each member scored each need according to severity, disparity in the community, importance to the community, and feasibility of intervention/impact. This process and further discussion resulted in the three "priority health needs" that will be addressed in this Implementation Strategy (see below). Please refer to the CHNA for more information regarding the criteria and processes used to identify and prioritize health needs.

2016 – 2018 Implementation Strategy

The implementation strategy describes how CPMC plans to address the priority health needs identified in the 2016 Community Health Needs Assessment and is aligned with the hospital's charitable mission. The strategy describes:

- Actions the hospital intends to take, including programs and resources it plans to commit;
- Anticipated impacts of these actions and a plan to evaluate impact; and
- Any planned collaboration between the hospital and other organizations in the community to address the priority health needs identified in the 2016 CHNA.

The Implementation Strategy serves as a foundation for further alignment and connection of other CPMC initiatives that may not be described herein, but which together advance CPMC's commitment to improving the health of the communities it serves. Each year, CPMC programs are evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Depending on these variables, programs may change to continue CPMC's focus on the health needs listed below.

The priority health needs identified through the CHNA, all of which the hospital will address, are:

1. Access to care
2. Healthy eating and physical activity
3. Behavioral health

Priority Health Need #1: Access to Care

Name of program/activity/initiative	St. Luke's Health Care Center (SLHCC) & HealthFirst
Description	CPMC's SLHCC provides a full range of obstetric and gynecological care at its Women's Center; well-baby care, well-child care, and care for ill or injured children at its Pediatric Clinic; and primary, acute and chronic care at its Adult Internal Medicine Clinic for teenagers and adults. SLHCC's clinicians and staff are bilingual in English and Spanish, ensuring culturally and linguistically competent care. Without SLHCC, many of these patients would have to use services at San Francisco General Hospital and its public clinics, facilities that are overwhelmed and operating at full capacity. HealthFirst, an affiliated center for health education and disease prevention, serves patients in chronic disease management by integrating community health workers (CHWs) into the multidisciplinary health care team. CHWs are culturally and linguistically competent as they are recruited from the same community as the patients that HealthFirst serves. CHWs provide health education, assist patients to improve their self-management skills, and encourage them to receive timely and comprehensive care.
Goals	Expand the city's safety net by making services more readily available to publicly insured and uninsured populations, and making those services culturally and linguistically appropriate.
Anticipated Outcomes	Increase culturally and linguistically appropriate health care services for uninsured and underinsured patients residing in communities south of Market Street in San Francisco.
Plan to Evaluate	CPMC will evaluate SLHCC's and HealthFirst's impact by annually tracking metrics via electronic health records.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available) Number of encounters

Name of program/activity/initiative	Kalmanovitz Child Development Center (KCDC)
Description	CPMC's Kalmanovitz Child Development Center provides diagnosis, evaluation, treatment and counseling for children and adolescents with learning disabilities and developmental or behavioral problems caused by prematurity, autism spectrum disorder, epilepsy, Down syndrome, attention deficit disorder, or cerebral palsy. Its comprehensive assessments and ongoing therapy programs include the following disciplines: Developmental/Behavioral Pediatrics; Psychology and Psychiatry; Speech/Language and Auditory Processing; Occupational Therapy; Behavior Management Consultations; Early Intervention/Parent-Infant Program; Social Skills Groups; Feeding Assessment and Therapy; Assessment and Therapy for the Neonatal Intensive Care Unit and Assessment for the Follow-Up Clinic; Educational Assessment, Therapy and Treatment. These services provided at reduced or no cost to families are particularly important since children from low-income families have a 50 percent higher risk of developmental disabilities; early identification and treatment can change the course of these children's lives. Besides operating its own clinics, KCDC also extends its services to a large number of at-risk children and brings services to them in their community by partnering with local schools and other community organizations, such as De Marillac Academy and Sacred Heart Cathedral Preparatory. De Marillac Academy is a tuition-free independent Catholic school serving low-income

	4th-to-8th-grade students in San Francisco's Tenderloin District, where the majority of students suffer from some form of post-traumatic stress disorder, impacting their ability to learn. In a unique program that goes beyond the daily classroom setting, clinical and family support services are provided by KCDC to help children process those experiences and overcome the emotional challenges that often accompany them. Speech therapists, language therapists, educational therapists and psychological counselors from KCDC provide more intensive services as needed at the school.
Goals	Help children and youth in San Francisco to thrive and live up to their full potential by providing early multidisciplinary assessment and treatment for children with one or more conditions that affect their growth and development, regardless of the patient's ability to pay.
Anticipated Outcomes	Increase services for children with one or more conditions that affect their growth and development.
Plan to Evaluate	CPMC will evaluate KCDC's impact by annually tracking metrics via electronic health records for clinical services and time logs for staff outreach activities.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters Number of staff outreach hours

Name of program/activity/initiative	Joint Venture Health
Description	Joint Venture Health (JVH) is a partnership between UC Berkeley School of Public Health, North East Medical Services (NEMS), and CPMC. CPMC's contribution supports the creation of a cost-effective, comprehensive developmental and behavioral health screening, treatment and referral program for the 10,000 children and their families who have NEMS as their medical home. UC Berkeley School of Public Health's long-term vision for this program is to partner with community health centers, health systems, and health professional training programs to create high-performing primary care systems for kids and families from low-income communities. The first three-year pilot initiative at NEMS began services at the Stockton clinic in August 2014 and expanded to the San Bruno Avenue clinic in July 2015. It seeks to build primary care teams to systematically detect, treat and support kids with developmental and behavioral health needs at the community clinics where they already receive their medical care. Early identification and intervention is key to changing the course of developmental conditions and helping to minimize the life-impact of these conditions on children and the costs to society.
Goals	Improve early detection of developmental disabilities by integrating developmental and behavioral health services for low-income children into the community clinics where they receive medical services.
Anticipated Outcomes	Increase screenings to detect developmental disabilities and onsite treatment for children with moderate conditions, and coordinate services across care environments for children with high-risk conditions.
Plan to Evaluate	CPMC will evaluate JVH's impact by annually tracking metrics via reporting from UC Berkeley School of Public Health's Center for Innovation and Research.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters/screenings Number of classes/workshops provided

Name of program/activity/initiative	South of Market Bayview Child Health Center (BCHC)
Description	BCHC offers routine preventative and urgent pediatric care in one of San Francisco's most medically underserved neighborhoods, and addresses prevalent community health issues such as weight control and asthma management. BCHC focuses on keeping infants, children and adolescents healthy, and on closely managing their care when they are ill. The center is particularly attuned to the impact of community violence and childhood trauma on children's mental and physical health. The clinic also offers psychological and case management services to families through a partnership with the Center for Youth Wellness. Dental services are provided through South of Market Health Center at their main facility. The clinic was started as a collaboration between CPMC, Sutter Pacific Medical Foundation, and CPMC Foundation. In 2014, clinic ownership was transferred to South of Market Health Center (SMHC), and we were jointly awarded a grant to transition BCHC to become a Federally Qualified Health Center. CPMC continues to be the hospital and specialty partner for BCHC and continues to help fund operational costs as well as construction costs connected to the clinic's modernization plan. CPMC and SMHC will work together to ensure that kids in the Bayview have access to high-quality care while ensuring the clinic's long-term sustainability.
Goals	Improve access to high-quality health care close to home for uninsured and underinsured children residing in the Bayview Hunters Point district of San Francisco, regardless of ability to pay.
Anticipated Outcomes	Increase pediatric care, psychological, and case management services to children and families of Bayview Hunters Point.
Plan to Evaluate	CPMC will evaluate BCHC's impact by annually tracking metrics via reporting from South of Market Health Center.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters Number of persons connected to a PCP Number of persons connected to mental health services Number of persons connected to case management services

Name of program/activity/initiative	African American Breast Health Program (AABH), Sister to Sister Breast Health Program, and St. Luke's Breast Health Partnerships
Description	CPMC's AABH and Sister to Sister programs offer women mammography screening and all the subsequent breast health diagnostic testing and treatment they may need at no cost. Early detection allows for better treatment outcomes and longevity of life. Partnership organizations such as HealthRIGHT 360, San Francisco Free Clinic, and Clinic by the Bay refer uninsured, underinsured, disadvantaged and at-risk women for mammography services. CPMC's Breast Center at the St. Luke's Campus promotes breast health in underserved communities by partnering with neighborhood clinics and community agencies, including Southeast Health Center, Mission Neighborhood Health Center, and Latina Breast Cancer Agency.
Goals	Increase early breast cancer detection by providing access to no-cost mammography screening for uninsured women who live in San Francisco.
Anticipated Outcomes	Increase early mammography screenings for women in need.
Plan to Evaluate	CPMC will evaluate the breast health programs' impact by annually tracking metrics via patient logs maintained by CPMC staff and year-end reporting from Latina Breast Cancer Agency.

Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of screenings/mammograms Number of first-time mammograms Number of persons who received follow-up clinical care

Name of program/activity/initiative	Coming Home Hospice
Description	CPMC's Coming Home Hospice provides 24-hour care for terminally ill clients and their families in a caring, homelike setting. CPMC ensures that high-quality residential hospice care is accessible to terminally ill patients regardless of their ability to pay, by covering the difference between the full cost of providing these services and patient revenue.
Goals	Increase access to quality hospice care and support for those for whom home is no longer an option, regardless of ability to pay.
Anticipated Outcomes	Increase quality hospice care services and support.
Plan to Evaluate	CPMC will evaluate Coming Home Hospice's impact by annually tracking metrics via patient logs maintained by hospice staff.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available)

Name of program/activity/initiative	Medi-Cal Managed Care Partnerships
Description	A key part of CPMC's Medi-Cal program is the Medi-Cal Managed Care partnership with North East Medical Services (NEMS) community clinic and San Francisco Health Plan (SFHP), a licensed community health plan that provides affordable health care coverage to over 130,000 low- and moderate-income San Francisco residents. Working together with NEMS, CPMC serves as the hospital partner for these Medi-Cal beneficiaries who select NEMS as their medical group through San Francisco Health Plan. CPMC also provides access to quality services at the St. Luke's Campus for patients who select Hill Physicians or Brown & Toland as their medical group through San Francisco Health Plan.
Goals	Make quality services more readily available to publicly insured populations.
Anticipated Outcomes	Increase health care services for Medi-Cal patients residing in San Francisco.
Plan to Evaluate	CPMC will evaluate the impact of these partnerships by annually tracking metrics via reporting from San Francisco Health Plan and NEMS.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Utilization

Name of program/activity/initiative	San Francisco General Hospital (SFGH) Diagnostic Services
Description	In this partnership with SFGH, CPMC provides diagnostic services free of charge to patients referred by SFGH, and pays physicians for associated professional fees.
Goals	Improve timely access to key diagnostic services for uninsured and underinsured patients.
Anticipated Outcomes	Increase these diagnostic services for uninsured and underinsured patients; decrease wait times for SFGH patients to receive these diagnostic services.
Plan to Evaluate	CPMC will evaluate impact by annually tracking metrics via electronic health records, and wait time metrics from SFGH.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available) Number of diagnostic tests provided Average wait times

Name of program/activity/initiative	North East Medical Services (NEMS) Lab Services
Description	In this partnership with NEMS, CPMC provides lab services free of charge to NEMS patients.
Goals	Improve access to these lab services for uninsured and underinsured patients.
Anticipated Outcomes	Increase these lab services for uninsured and underinsured patients.
Plan to Evaluate	CPMC will evaluate impact by annually tracking metrics via electronic health records.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available)

Name of program/activity/initiative	Lions Eye Foundation
Description	Lions Eye Foundation and CPMC partner together to provide highly specialized eye care procedures free of charge to people without insurance or financial resources.
Goals	Provide access to highly specialized eye care for people without insurance or financial resources.
Anticipated Outcomes	Increase eye care procedures/services for uninsured, low-income patients residing in San Francisco.
Plan to Evaluate	CPMC will evaluate Lions Eye Foundation's impact by annually tracking metrics via electronic health records and patient logs maintained by physicians and clinic staff.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters Number of general surgical procedures Number of laser surgeries Number of intravitreous injections for macular degeneration and eye complications due to diabetes Number of diagnostic tests (OCTs, B-scans, angiograms, etc.)

Name of program/activity/initiative	Operation Access
Description	CPMC partners with Operation Access and the San Francisco Endoscopy Center to provide access to diagnostic screenings, specialty procedures, and surgical care at no cost for uninsured Bay Area patients who have limited financial resources. CPMC physicians volunteer their time to provide these free surgical services, while the hospital donates the use of its operating rooms. CPMC also provides a grant to support Operation Access's operating costs.
Goals	Increase health care equity for uninsured and underserved patients facing barriers to getting the outpatient surgical and specialty care that they need, by: • Providing the resources and promoting the medical volunteerism needed for the donation of these services; • Increasing culturally competent case management; • Providing medical interpreters to facilitate donated care.
Anticipated Outcomes	Increase number of timely surgical procedures and diagnostic services provided to uninsured and underserved patients.
Plan to Evaluate	CPMC will evaluate the impact of its collaboration with Operation Access by annually tracking metrics via electronic health records and Operation Access reporting.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of services provided (surgeries, procedures, etc.) Number of CPMC medical volunteers Number of persons served with culturally competent case management Number of persons served with interpretive services

Name of program/activity/initiative	Advanced Illness Management (AIM) Program
Description	CPMC's Advanced Illness Management (AIM) program provides customized support for patients with advanced chronic illnesses in order to manage their health/illness symptoms, manage their medications, coordinate their care, plan for the future, and live the kind of life they want. Once the AIM team understands the patient's health issues, lifestyle, and personal preferences, they work with the patient to tailor a care plan, ease the transition from hospital to home, and provide continuing over-the-phone support and in-person visits in the home or at the doctor's office as needed. If the patient returns to the hospital, AIM staff continues to support the patient there. The AIM team also provides support for the patient's family and helps them understand anything about the patient's condition that the patient wants them to know.
Goals	Help chronically ill patients better manage their health/illness through skilled, respectful coaching and care tailored to their needs.
Anticipated Outcomes	Increase coaching services and support for patients who need help in self-managing advanced chronic illness.
Plan to Evaluate	CPMC will evaluate the AIM program's impact by annually tracking metrics via reporting from the Sutter Health corporate office.
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in the program (including demographics if available) Number of persons transitioned to home from hospital Number of persons assisted with self-managing their medications

Name of program/activity/initiative	Grants and Sponsorships Addressing Access to Care
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	Expand the city's safety net by making health care services more readily available to publicly insured and uninsured populations, and making those services culturally and linguistically appropriate.
Anticipated Outcomes	Increase affordable, accessible, culturally and linguistically appropriate health care services for uninsured and underinsured patients by supporting community-based organizations that develop/expand clinical services, outreach programs, and health education workshops to ensure that the needs of underserved populations are met.
Plan to Evaluate	CPMC will evaluate the impact of grants by annually tracking metrics via reporting from grantee organizations.
Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Number of persons served (including demographics if available/applicable) Number of classes/workshops offered Number of screenings provided

Priority Health Need #2: Healthy Eating and Physical Activity

Name of program/activity/initiative	HealthFirst
Description	HealthFirst is a center for health education and disease prevention affiliated with CPMC's St. Luke's Health Care Center. It concentrates on best practices in chronic disease management and particularly on integrating community health workers (CHWs) into the multidisciplinary health care team. CHWs provide health education, assist patients to improve their self-management skills, and encourage them to receive timely and comprehensive care. CHWs teach community workshops in healthy eating to parents of children at risk for obesity in the South of Market, Mission, and Bayview Hunters Point districts. They also teach classes on nutrition designed to manage chronic adult diabetes.
Goals	Manage chronic illness with cost-effective, quality care by providing prevention, outreach, and education services in a primary care setting that is culturally and linguistically appropriate for uninsured and underinsured patients residing in communities south of Market Street in San Francisco.
Anticipated Outcomes	Increase culturally and linguistically appropriate services to assist patients with self-management skills.
Plan to Evaluate	CPMC will evaluate the impact of HealthFirst by annually tracking metrics via electronic health records and other reporting from HealthFirst.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available) Number of encounters Percentage of patients under control for hemoglobin HbA1c (diabetic), blood pressure, asthma, LDL cholesterol

Name of program/activity/initiative	Grant to Community Health Resource Center (CHRC)
Description	CHRC collaborates with over 20 different health care centers in San Francisco, providing supportive services to thousands of clients through the many free or low-cost programs, screenings and counseling services that are available to anyone in the community. Programs include dietitians, social work counseling, nutrition guidance, community health screenings, educational lectures including monthly wellness events, health information and local resources, employee and group wellness presentations, and support groups. Services are offered free, at a reduced cost, or on a sliding scale. In CHRC's Nutrition Counseling program, the team of highly qualified registered dietitians is available by appointment for nutrition counseling and diet review, with the goal of establishing a diet balanced for all life stages. Nutritionists are cross-trained to meet the nutritional needs and provide guidance for a variety of conditions, concerns and goals. Dietitians are also trained to address weight management concerns specific to age through a number of healthy, supportive treatment options. Dieticians also bring their knowledge to the community by presenting to a variety of community groups.
Goals	Increase knowledge and awareness regarding healthy eating and help patients to effectively meet their goals as they relate to nutrition and diet.
Anticipated Outcomes	Increase high-quality, professional supportive services, tools and information for healthy eating among San Francisco residents.
Plan to Evaluate	CPMC will evaluate the impact of this grant by annually tracking metrics via reporting from Community Health Resource Center.
Metrics Used to Evaluate the program/activity/initiative	Number of appointments with a registered dietitian Number of health screenings related to diet/exercise (BMI, glucose, etc.) Number of health education presentations/classes related to nutrition/ exercise, with number of attendees

Name of program/activity/initiative	Grants and Sponsorships Addressing Healthy Eating and Physical Activity
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	Facilitate behavioral changes of adults and children in homes, schools, worksites, and communities that will lead to the consumption of healthier foods and increased physical activity. Identify and respond to risk factors such as obesity and inactivity that have been linked to cardiovascular disease, stroke, diabetes, gallbladder disease, osteoarthritis, and certain cancers. Establish a culture of health consciousness among adults and children.
Anticipated Outcomes	Examples: • Increase knowledge and awareness regarding healthy eating and physical activity among adults and children through culturally relevant tools and information. • Increase children's and adults' access to healthy and nutritious foods. • Increase children's and adults' participation in various forms of exercise through exercise and fitness programs. • Increase referral and case management for children who are at risk of poor nutrition, obesity, and obesity-related diseases.
Plan to Evaluate	CPMC will evaluate the impact of grants by annually tracking metrics via reporting from grantee organizations.

Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Number of persons served (including demographics if available/applicable) Number of classes/workshops offered Number of screenings provided

Priority Health Need #3: Behavioral Health

Name of program/activity/initiative	Kalmanovitz Child Development Center (KCDC)
Description	CPMC's Kalmanovitz Child Development Center provides diagnosis, evaluation, treatment and counseling for children and adolescents with learning disabilities and developmental or behavioral problems caused by prematurity, autism spectrum disorder, epilepsy, Down syndrome, attention deficit disorder, or cerebral palsy. Its comprehensive assessments and ongoing therapy programs include the following disciplines: Developmental/Behavioral Pediatrics; Psychology and Psychiatry; Speech/Language and Auditory Processing; Occupational Therapy; Behavior Management Consultations; Early Intervention/Parent-Infant Program; Social Skills Groups; Feeding Assessment and Therapy; Assessment and Therapy for the Neonatal Intensive Care Unit and Assessment for the Follow-Up Clinic; Educational Assessment, Therapy and Treatment. These services provided at reduced or no cost to families are particularly important since children from low-income families have a 50 percent higher risk of developmental disabilities; early identification and treatment can change the course of these children's lives. Besides operating its own clinics, KCDC also extends its services to a large number of at-risk children and brings services to them in their community by partnering with local schools and other community organizations, such as De Marillac Academy and Sacred Heart Cathedral Preparatory. De Marillac Academy is a tuition-free independent Catholic school serving low-income 4th-to-8th-grade students in San Francisco's Tenderloin District, where the majority of students suffer from some form of post-traumatic stress disorder, impacting their ability to learn. In a unique program that goes beyond the daily classroom setting, clinical and family support services are provided by KCDC to help children process those experiences and overcome the emotional challenges that often accompany them. Speech therapists, language therapists, educational therapists and psychological counselors from KCDC provide more intensive services as needed at the school.
Goals	Help children and youth in San Francisco to thrive and live up to their full potential by providing early multidisciplinary assessment and treatment for children with one or more conditions that affect their growth and development, regardless of the patient's ability to pay.
Anticipated Outcomes	Increase services for children with one or more conditions that affect their growth and development.
Plan to Evaluate	CPMC will evaluate KCDC's impact by annually tracking metrics via electronic health records for clinical services and time logs for staff outreach activities.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters Number of staff outreach hours

Name of program/activity/initiative	Joint Venture Health
Description	Joint Venture Health (JVH) is a partnership between UC Berkeley School of Public Health, North East Medical Services (NEMS), and CPMC. CPMC's contribution supports the creation of a cost-effective, comprehensive developmental and behavioral health screening, treatment and referral program for the 10,000 children and their families who have NEMS as their medical home. UC Berkeley School of Public Health's long-term vision for this program is to partner with community health centers, health systems, and health professional training programs to create high-performing primary care systems for kids and families from low-income communities. The first three-year pilot initiative at NEMS began services at the Stockton clinic in August 2014 and expanded to the San Bruno Avenue clinic in July 2015. It seeks to build primary care teams to systematically detect, treat and support kids with developmental and behavioral health needs at the community clinics where they already receive their medical care. Early identification and intervention is key to changing the course of developmental conditions and helping to minimize the life-impact of these conditions on children and the costs to society.
Goals	Improve early detection of developmental disabilities by integrating developmental and behavioral health services for low-income children into the community clinics where they receive medical services.
Anticipated Outcomes	Increase screenings to detect developmental disabilities and onsite treatment for children with moderate conditions, and coordinate services across care environments for children with high-risk conditions.
Plan to Evaluate	CPMC will evaluate JVH's impact by annually tracking metrics via reporting from UC Berkeley School of Public Health's Center for Innovation and Research.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters/screenings Number of classes/workshops provided

Name of program/activity/initiative	Project Homeless Connect (PHC)
Description	CPMC annually sponsors a Project Homeless Connect event where CPMC staff and other volunteers help to provide medical and social services to homeless people in San Francisco, including mental health services, substance abuse connections, shelter and housing information, employment assistance, primary medical care, eye exams, wheelchair repair, dental treatment, and even acupuncture and massage. Besides donating hours of staff volunteer time to the event, CPMC also contributes a cash sponsorship to help cover event costs.
Goals	Improve the mental and physical health and well-being of homeless people by making it easier for them to access difficult-to-obtain services at a one-stop shop event.
Anticipated Outcomes	Increase mental health, substance abuse, medical and social services to San Francisco's homeless population.
Plan to Evaluate	CPMC will evaluate the impact of its collaboration with Project Homeless Connect by annually tracking metrics via reporting from PHC.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available) Number of encounters in the many categories of PHC services

Name of program/activity/initiative	Grant to Center for Youth Wellness (CYW)
Description	The Center for Youth Wellness is an integrated center for children, offering pediatric care that addresses the root causes of poor outcomes for children and youth in high-risk communities. Care is based on emerging data on how exposure to poverty, domestic and community violence and other early life stressors affects the developing brains and bodies of children. CPMC's funding makes it possible for patients and families referred by Bayview Child Health Center to receive mental health services at CYW.
Goals	Reduce health disparities and help children to heal and thrive by addressing the health effects of traumatic Adverse Childhood Experiences.
Anticipated Outcomes	Increase psychiatry, psychology, and case management services to children and families in the Bayview Hunters Point district of San Francisco.
Plan to Evaluate	CPMC will evaluate the impact of this grant by annually tracking metrics via reporting from CYW.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available) Number of encounters Number of persons connected to mental health services Number of persons connected to social services

Name of program/activity/initiative	Grant to San Francisco Child Abuse Prevention Center (SFCAPC)
Description	San Francisco Child Abuse Prevention Center and its Child Advocacy Center endeavor to prevent child abuse and reduce its devastating impact by providing supportive services to children and families; education for children, caregivers and service providers; and through advocacy for systems improvement and coordination.
Goals	Ensure that every child is protected and our community is free from abuse; prevent child abuse and reduce its devastating impact through supportive services, education, and policy advocacy.
Anticipated Outcomes	• Increase services for victims of child abuse; • Increase community education/public awareness of child abuse and its prevention; and • Improve facilities and infrastructure to continue to provide high-quality and effective services.
Plan to Evaluate	CPMC will evaluate the impact of this grant by annually tracking metrics via reporting from SFCAPC.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographics if available) Number of encounters Number of persons connected to mental health services Number of persons connected to social services

Name of program/activity/initiative	Grant to Community Health Resource Center
Description	CHRC collaborates with over 20 different health care centers in San Francisco, providing supportive services to thousands of clients through the many free or low-cost programs, screenings and counseling services that are available to anyone in the community. Programs include dietitians, social work counseling, nutrition guidance, community health screenings, educational lectures including monthly wellness events, health information and local resources, employee and group wellness presentations, and support groups. Services are offered free, at a reduced cost, or on a sliding scale. CHRC's Behavioral/Mental Health Services by a licensed team of professionals offer support to individuals, groups and families looking for emotional or practical guidance and support for a wide range of needs. Fees for services are on a sliding scale. Counseling sessions may include: Individualized Needs Assessment to help clarify and prioritize the patient's most urgent concerns in order to develop goals and identify possible solutions; Short-term Emotional Support where counselors help align resources and make recommendations; Resource and Referral where a social worker can help connect the patient with other resources and agencies such as insurance, housing, reduced billing options for utilities, transportation, as well as a wide range of specific community support; Psychotherapy based on individual needs; and Follow-up Support. Examples of support groups/programs include the Cancer Buddy Program that connects recently diagnosed cancer patients with trained volunteer cancer survivors; the Stroke Survivor Support Group designed to aid the recovery of stroke survivors at any stage by providing a safe and supportive atmosphere where individuals are able to share their experiences; and the Liver Cancer Support Group, where those living with liver cancer, family members, loved ones, and caregivers are provided with emotional and social support, education, and shared experience in an open, accepting environment. Educational classes offered by the CHRC social workers include topics such as advanced health care directives, bereavement, care for givers, and dementia.
Goals	Improve the mental health and well-being of San Francisco residents.
Anticipated Outcomes	Increase behavioral/mental health services and connectivity to needed social services for San Francisco residents.
Plan to Evaluate	CPMC will evaluate the impact of this grant by annually tracking metrics via reporting from Community Health Resource Center.
Metrics Used to Evaluate the program/activity/initiative	Number of appointments for behavioral health/social work services Number of support group attendees Number of health education presentations/classes related to behavioral health, with number of attendees

Name of program/activity/initiative	Psychiatry Residents Serving at Community-Based Organizations
Description	As part of CPMC's health professions education program, CPMC psychiatry residents provide services one day per week to patients in need of behavioral health services at community-based organizations and public institutions, including HealthRIGHT 360, Jewish Home, and San Quentin Prison. These organizations provide treatment for substance use disorder and other mental health problems, geriatric psychiatric services, and/or social support and re-entry services for incarcerated/formerly incarcerated clients to help them to attain self-sufficiency and continued recovery.
Goals	Improve the mental health and well-being of at-risk populations by making high-quality services more readily available.
Anticipated Outcomes	Increase mental health and substance abuse services for at-risk populations.
Plan to Evaluate	CPMC will evaluate the impact of this program by annually tracking the number of CPMC residents who provided these services.
Metrics Used to Evaluate the program/activity/initiative	Number of residents providing services one day per week at community/ public organizations

Name of program/activity/initiative	Grants and Sponsorships Addressing Behavioral Health
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year end.
Goals	Promote mental health and the healthy development of children and families in both the broader community and at-risk communities; prevent child abuse and domestic violence.
Anticipated Outcomes	Examples: • Increase re-entry social support services that empower formerly incarcerated residents to attain economic self-sufficiency, continued recovery, and creation of a stable living environment by building skills, accessing resources, and modeling professional behavior. • Increase substance use disorder treatment services that are gender-responsive and welcoming to people of any gender identity. • Increase support to families in need of resources, such as employment training, parent education classes, housing, child care, and shelters. • Increase intensive assessment, counseling, and referral services to help families and individuals avert homelessness. • Increase mental health services to homeless and at-risk youth. • Increase linguistically and culturally appropriate support groups and counseling. • Increase early childhood education for at-risk families. • Increase integrated treatment services for clients with co-occurring substance use disorder and mental health problems. • Increase integration of behavioral health services into existing primary care settings for at-risk San Francisco residents.
Plan to Evaluate	CPMC will evaluate the impact of grants by annually tracking metrics via reporting from grantee organizations.
Metrics Used to Evaluate the program/activity/initiative	Possible metrics include: Number of persons served (including demographics if available/applicable) Number of encounters Number of persons connected to mental health services or social services

Name of program/activity/initiative	Psychiatry Residency & Psychology Intern Training Program
Description	As a multi-campus teaching hospital, CPMC offers educational experience to physicians through its residency training programs, which include Psychiatry. Psychology interns and fellows also receive training while working in locations such as Kalmanovitz Child Development Center, Adult In-Patient, and Women's Health Initiative. CPMC usually trains 16 psychiatric residents, 10 psychology interns, and 2 psychology fellows annually.
Goals	The next generation of mental/behavioral health care professionals will receive world-class training/educational experience.
Anticipated Outcomes	Increase number of well-trained psychiatrists and psychologists and the availability of these services in the future.
Plan to Evaluate	CPMC will evaluate the impact of this program by annually tracking metrics via reporting from CPMC's Graduate Medical Education Department.
Metrics Used to Evaluate the program/activity/initiative	Number of psychiatry residents and psychology interns and fellows trained

Foundational Issues and the Social Determinants of Health

Name of program/activity/initiative	Investments in Housing, Transportation and Workforce Development
Description	Besides identifying the three priority health needs, the Community Health Needs Assessment also identifies two Foundational Issues: economic barriers to health, and racial health inequities. These broader factors point to the social determinants of health that are shaped by the distribution of money, power and resources, and that influence the context from which health needs emerge, affect health at every level, and must be addressed to improve health. These social, economic and physical environmental conditions are now recognized as important drivers of health. As part of its Development Agreement with the City and County of San Francisco that made possible the building of CPMC's new hospitals at Van Ness/Geary and at the St. Luke's Campus, CPMC annually contributes funds to the San Francisco Foundation and various local government agencies in support of affordable housing, increased access to health care, workforce training, and transit and pedestrian safety improvements. These upstream investments help to address the root causes of health disparities and ensure healthy and safe living environments with good housing and jobs.
Goals	Create social, economic, and physical environments that shape the conditions of daily life in a way that promotes good health for all.
Anticipated Outcomes	Increase opportunities for San Franciscans to access the resources that lead to good health by investing in affordable housing, transit, safe neighborhoods and the built environment, health care innovation, and job training.
Plan to Evaluate	CPMC will report the investments made each year in compliance with its Development Agreement with the City and County of San Francisco.
Metrics Used to Evaluate the program/activity/initiative	CPMC will report the investments made each year in compliance with its Development Agreement with the City and County of San Francisco.

Needs CPMC Plans Not to Address

Although no hospital can address all aspects of the health needs present in its community, CPMC plans to address all three of the priority health needs identified in the 2016 Community Health Needs Assessment. As a member of the San Francisco Health Improvement Partnership (SFHIP), CPMC will continue to work in collaboration with other local hospitals and health plans to identify gaps in service and to determine where efforts should be collectively redirected in order to most effectively improve the health of San Francisco residents. For more information about SFHIP, please visit www.sfhip.org.

CPMC is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits.

Approval by Governing Board

The implementation strategy was approved by the Sutter Health Bay Area Board on November 16, 2016.