Sutter Health
CALIFORNIA PACIFIC MEDICAL CENTER

2022 – 2024 Implementation Strategy Plan
Responding to the 2022 Community Health Needs Assessment

P.O. Box 7999, San Francisco, CA 94120-7999
Facility License Number 220000197 (Van Ness and Davies Campuses)
www.sutterhealth.org

Table of Contents

Introduction

The Implementation Strategy Plan describes how California Pacific Medical Center (CPMC), a Sutter Health affiliate, plans to address significant health needs identified in the 2022 Community Health Needs Assessment (CHNA). The document describes how the hospital plans to address identified needs in calendar (tax) years 2022 through 2024.

The 2022 CHNA and the 2022-2024 Implementation Strategy Plan were undertaken by the hospital to understand and address community health needs, and in accordance with state law and the Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

The Implementation Strategy Plan addresses the significant 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 Plan 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 healthcare to the community, regardless of ability to pay.

CPMC welcomes comments from the public on the 2022 Community Health Needs Assessment and 2022-2024 Implementation Strategy Plan. Written comments can be submitted:

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

Executive Summary

CPMC is affiliated with Sutter Health, a not-for-profit parent of not-for-profit and for-profit companies that together form an integrated healthcare system located in Northern California. The system is committed to health equity, community partnerships and innovative, high-quality patient care. Our over 65,000 employees and associated clinicians serve more than 3 million patients through our hospitals, clinics and home health services.

Learn more about how we're transforming healthcare at sutterhealth.org and vitals.sutterhealth.org.

Sutter Health's total investment in community benefit in 2021 was $872 million. This amount includes traditional charity care and unreimbursed costs of providing care to Medi-Cal patients. This amount also includes investments in community health programs to address prioritized health needs as identified by regional community health needs assessments.

As part of Sutter Health's commitment to fulfill its not-for-profit mission and help serve some of the most vulnerable in its communities, the Sutter Health network has implemented charity care policies to help provide access to medically necessary care for all patients, regardless of their ability to pay. In 2021, Sutter Health invested $91 million in charity care. Sutter's charity care policies for hospital services include, but are not limited to, the following:

1. Uninsured patients are eligible for full charity care for medically necessary hospital services if their family income is at or below 400% of the Federal Poverty Level ("FPL").
2. Insured patients are eligible for High Medical Cost Charity Care for medically necessary hospital services if their family income is at or below 400% of the FPL and they incurred or paid medical

expenses amounting to more than 10% of their family income over the last 12 months. (Sutter Health's Financial Assistance Policy determines the calculation of a patient's family income.)

Overall, since the implementation of the Affordable Care Act, greater numbers of previously uninsured people now have more access to healthcare coverage through the Medi-Cal and Medicare programs. The payments for patients who are covered by Medi-Cal and Medicare do not cover the full costs of providing care. In 2021, Sutter Health invested $557 million more than the state paid to care for Medi-Cal patients.

Through community benefit investments, Sutter helped local communities access primary, mental health and addiction care, and basic needs such as housing, jobs and food. See more about how Sutter Health reinvests into the community by visiting sutterpartners.org.

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

Through the 2022 Community Health Needs Assessment process the following significant community health needs were identified:

- Access to care
- Behavioral health
- Economic opportunity

The 2022 Community Healthy Needs Assessment conducted by CPMC is publicly available at www.sutterhealth.org.

2022 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 improve community health and wellness in San Francisco through collective impact. SFHIP is comprised of mission-driven anchor institutions, health equity coalitions, the San Francisco Department of Public Health (SFDPH), funders, and educational, faith-based, healthcare, and other service provider networks and institutions. This year's CHNA process was facilitated by Harder+Company Community Research, an independent California-based evaluation company with expertise in community participation.

The needs assessment for this report was conducted from mid-2021 through mid-2022. Meetings were facilitated by Harder+Company, and the final CHNA document that was collectively developed by SFHIP was prepared by Harder+Company.

The CHNA process involved the following parts:

- Primary Qualitative Data Collection: To identify community strengths, health needs, and suggested solutions, five focus groups were conducted. Three were with the San Francisco Equity Coalitions (the African American Health Equity Coalition, Asian & Pacific Islander Health Parity Coalition, and Chicano/Latino/Indígena Health Equity Coalition), one was with funder agencies (including Blue Shield of California Foundation, California HealthCare Foundation, Hirsch Philanthropy Partners, Metta Fund, Northern California Grantmakers, The California Wellness Foundation, and Zellerbach Family Foundation), and the final focus group was with San Francisco health insurers (including Anthem, Blue Shield, Canopy Health, Kaiser Permanente, and San Francisco Health Plan). Information was also included from the 15 key informant interviews conducted as part of the Kaiser CHNA with San Francisco service providers, nonprofit groups, and government agencies.

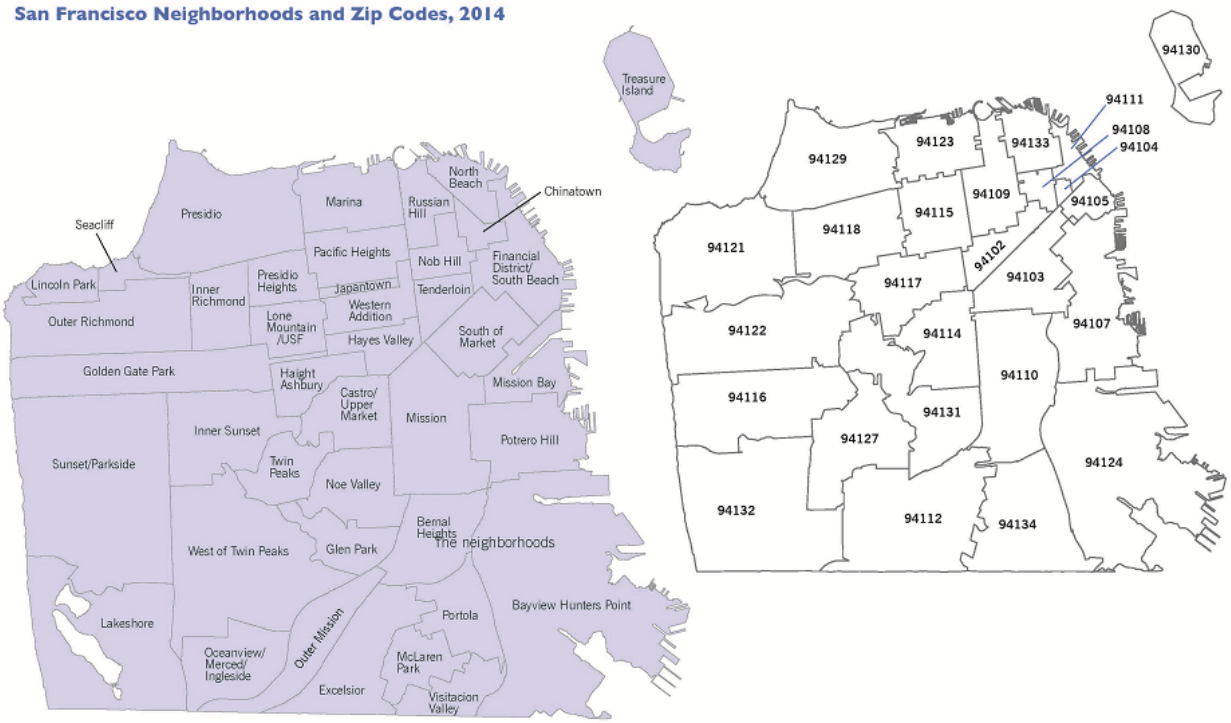
- Secondary Quantitative Data Collection: Quantitative data came from publicly available reports and data portals, including national sources such as the American Community Survey, Race Counts, and the California Health Interview Survey (CHIS), as well as local sources such as Data SF and City Health Dashboard. The Kaiser Permanente data platform also provided local data compiled from approximately 100 publicly available indicators. For all metrics, we used the most recently available public data that included as many race/ethnicity groups as possible.

- To identify the most significant health needs in San Francisco, SFHIP's CHNA subcommittee collectively reviewed the data and findings over the course of several meetings. Each health need for which the committee had data was considered and discussed. SFHIP then reviewed the comprehensive findings. They engaged in a robust discussion about the data, including the connection of each potential need to the San Francisco CHNA goal to elevate the impact of systemic racism. Finally, participants voted on the health needs. Subsequent discussions clarified the names and definitions of the needs.

The full 2022 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 City and County has 815,201 residents living within its 46.9 square miles of land area. It is the 13th most populous city in the country. San Francisco is the second most densely populated city in the country (after New York City), with 18,633 people per square mile. By total area, San Francisco is geographically the smallest county in California, which contributes to the high cost of living, property costs, and the corollary impact on housing disparities.

In the past three decades, about 275,000 Black Californians have left expensive coastal cities to move inland or to other states. During the same timeframe, the Black populations of some of California's historically Black neighborhoods in cities across California have plunged: Compton by 45%, San Francisco by 43%, and Oakland by 40%.

Race/Ethnicity by percentage of population	
American Indian and Alaska Native alone	1%
Asian alone	34%
Black or African American alone	5%
Native Hawaiian and Other Pacific Islander alone	0.4%
White alone	41%
Some Other Race alone	8%
Two or More Races	10%
Hispanic or Latino (of any race)	16%

San Franciscans have a median age of 38.3 years. 13% are under 18 years and a similar proportion (16%) are age 65 and over. San Francisco is the most childless major city in the U.S.

Age Group as a percentage of population	
Under 5 years	5%
5 to 9 years	4%
10 to 14 years	3%
15 to 19 years	4%
20 to 24 years	5%
25 to 34 years	23%
35 to 44 years	16%
45 to 54 years	13%
55 to 59 years	6%
60 to 64 years	6%
65 to 74 years	9%
75 to 84 years	4%
85 years and over	3%

Overall life expectancy is high in San Francisco, with the typical resident living to 83 years. This is higher than the life expectancy in the U.S. of 77.3 years and in California of 80.9 years. However, the average length of life varies widely by race/ethnicity.

Life Expectancy in Years	
Asian	87.8
Latino	85.4
White	83.3
Native American	78.0
Black	73.1

Almost half of San Franciscans (43%) speak a language other than English at home.

Language Spoken at Home	
English only	57%
Asian and Pacific Islander language	25%
Spanish	11%
Iino-European language	6%
Other language	1%

More than half (59%) of San Franciscans age 25 and over have at least a college degree. However, rates of higher education expose large disparities by race/ethnicity.

Bachelor's Degree or Higher by race/ethnicity	
American Indian or Alaska Native alone	20%
Asian alone	48%
Black alone	30%
Hispanic or Latino origin	36%
Native Hawaiian and Other Pacific Islander alone	31%
White alone	74%
Some Other Race alone	26%
Two or More Races	64%

COVID cases disproportionately impacted Latinx people, while deaths from COVID were higher in the Asian, Black, and Latinx communities.

San Francisco COVID Cases and Deaths by Race/Ethnicity			
Race/Ethnicity	**COVID Cases**	**COVID Deaths**	**% of Population**
Asian	18%	37%	34%
Black	8%	8%	5%
Latinx	36%	20%	15%
Other race/ethnicity	7%	2%	5%
Unknown	6%	29%	--
White	25%	4%	41%

Significant Health Needs Identified in the 2022 CHNA

The following significant health needs were identified in the 2022 CHNA:

1. Access to care
   Access to care refers to the right to welcoming, accessible, affordable, culturally grounded, and linguistically responsive acute and preventative healthcare. Welcoming care is delivered in local neighborhoods, by healthcare professionals who are from the communities they are serving, are grounded in anti-racism and interpersonal bias, have knowledge of the community's historic relationship with the healthcare system, and are equitably compensated for their work. There is a special focus on care that is welcoming to communities who have been – and continue to be, as exemplified by COVID rates and response – marginalized and harmed by care, including Black, Indigenous, and People of Color (BIPOC) communities, and gender and sexual orientation diverse communities. Addressing access to care also includes tackling barriers such as language, transportation, insurance, cost, childcare, and long wait times.

2. Behavioral health
   Behavioral health as a community health need refers to access, availability, and affordability of mental health and substance use disorder professionals and services. Additionally, it refers to substance access, use, and availability of support for substance misuse. The behavioral health need references the lack of community assets to support mental health such as cultural traditions, language, community events, and trusted spaces (e.g., faith-based institutions, schools, etc.) and how they are not recognized as supportive and accessible behavioral and mental health services.

3. Economic opportunity
   Economic opportunity refers to the financial and socioeconomic conditions that allow for an individual and community to effectively afford the tangible and intangible materials and resources necessary to thrive, including affordable housing. These materials and resources intertwine with various social determinants of health located in a community, taking into account the systemic conditions that perpetuate unequal access to positive economic outcomes among historically and/or systematically under-resourced populations such as undocumented, BIPOC, and gender and sexual orientation diverse communities.

   In addition to affordable housing, economic opportunity includes (but is not limited to) exposure to environmental and climate-related factors and/or hazards, and the ability to obtain nutrient-dense, culturally relevant food. Affordable housing closely intertwines with economic opportunity, and refers to housing that effectively enables occupants to experience a reasonable level of safety and shelter, with consideration around the housing's cost, quality, and availability. It also refers to how issues with maintaining safe and affordable housing relate to spikes in rent, living in households with many people and extended families, and making decisions among essentials to maintain rent.

2022 – 2024 Implementation Strategy Plan

The implementation strategy plan describes how CPMC plans to address significant health needs identified in the 2022 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 significant health needs identified in the 2022 CHNA.

Prioritized Significant Health Needs the Hospital Will Address

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

1. Access to care
2. Behavioral health
3. Economic opportunity

Access to Care

Name of program/activity/initiative	Mission Bernal Clinics (including CPMC's Mission Bernal Women's Clinic and Mission Neighborhood Health Center's Mission Bernal Clinic)
Description	CPMC's Mission Bernal Women's Clinic provides a full range of obstetric and gynecological care. Clinicians and staff are bilingual in English and Spanish, ensuring culturally and linguistically competent care. This program also includes CPMC's grant support for adult and pediatric services provided by Mission Neighborhood Health Center (MNHC) at MNHC's Mission Bernal Clinic. In April 2021, CPMC transferred the assets of its Mission Bernal Adult Clinic, Mission Bernal Pediatric Clinic, and Mission Bernal Pediatric After Hours Clinic to MNHC. CPMC provides cash contributions to MNHC to partially fund organizational and operational costs in order to ensure the successful expansion of adult and pediatric services at what is now MNHC's Mission Bernal Clinic. Without these clinics, many of these patients would have to use services at Zuckerberg San Francisco General and its public clinics, facilities that are operating at full capacity. The clinics' services also counter limited access that may be caused by primary care providers being less likely to serve Medi-Cal beneficiaries due to low government reimbursement rates.
Goals	Expand the city's safety net and bridge gaps in accessibility 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 healthcare services for uninsured and underinsured patients residing in communities south of Market Street in San Francisco, such as the Mission, Bayview Hunters Point, Downtown/Civic Center, Visitacion Valley and Excelsior – some of

	the neighborhoods identified as having the highest disparities related to important socioeconomic determinants of health.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographic data) Number of encounters

Name of program/activity/initiative	HealthFirst
Description	HealthFirst is a center for prevention and education located at CPMC's Mission Bernal Campus, and serves patients in chronic disease management by integrating community health workers (CHWs) into the multidisciplinary healthcare 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	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 healthcare services for uninsured and underinsured patients residing in communities south of Market Street in San Francisco – some of the neighborhoods identified as having the highest disparities related to important socio-economic determinants of health. Improve patients' self-management skills.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographic data) Number of encounters Number of health screenings (spirometry tests, eye exams, foot exams, albumin/creatinine ratio tests)

Name of program/activity/initiative	African American & Sister to Sister Breast Health Program
Description	CPMC's African American & Sister to Sister Breast Health Program offers 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.
Goals	Increase early breast cancer detection by providing access to no-cost mammography screening for uninsured women who live in San Francisco. Reduce barriers to quality care.
Anticipated Outcomes	Increase early mammography screenings for women in need. Women who face particular challenges in completing treatment will receive assistance with care navigation services.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of screenings/mammograms Number of persons who received follow-up clinical care

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 offers psychological and case management services to families. 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. 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 healthcare 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.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of encounters Number of persons who received services from a primary care provider Number of persons connected to mental health services

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.
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 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 grant funding to support Operation Access's operating costs.
Goals	Increase healthcare 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
Metrics Used to Evaluate the program/activity/initiative	Number of persons served Number of operating room procedures provided Number of GI procedures provided Number of minor and radiology procedures provided Number of specialist evaluations, physical therapy Number of CPMC medical volunteers Client compliance rate Median wait time from referral to specialty visit Patient satisfaction rate

Name of program/activity/initiative	Advanced Illness Management (AIM) Program
Description	Sutter Health'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. CPMC supports the program, providing funding towards the care of the people who enroll in the program in the San Francisco service area. 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.
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in the program's San Francisco service area Number of persons transitioned to home/self-care from hospital Number of persons transitioned to home healthcare service

Name of program/activity/initiative	Healthcare Coverage Enrollment Assistance
Description	Program staff assist eligible CPMC patients and their families to enroll in assistance programs such as Medi-Cal, Healthy Families, and county programs.
Goals	Make healthcare services more readily available to previously uninsured populations and reduce the financial burden of medical bills.
Anticipated Outcomes	Increased access to more timely, high-quality preventive care, primary care, and specialty care services.
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in assistance programs

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. Services include medical and nursing care, psycho-social counseling, spiritual counseling, religious services, massage therapy, medication monitoring and assistance, personal care assistance, laundry services, recreational activities and entertainment.
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.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served (including demographic data)

Name of program/activity/initiative	Grants and Sponsorships Addressing Access t**o** 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 healthcare 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 healthcare services for uninsured and underinsured patients by supporting community-based organizations that develop/expand clinical services, outreach programs, and health education efforts to ensure that the needs of underserved populations are met.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics used to evaluate efforts to address access to care. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. Number of persons served Number of classes/workshops offered Number of health screenings and other services provided

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 clinics and San Francisco Health Plan (SFHP), a licensed community health plan that provides affordable healthcare coverage to over 145,000 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, providing them with inpatient services, hospital-based specialty and ancillary services, and emergency care. CPMC also provides access to quality services at its Mission Bernal Campus for patients who select Hill Physicians or Brown & Toland as their medical group through San Francisco Health Plan. Additionally, CPMC provides lab services free of charge for NEMS patients in order to further improve access and support NEMS and their patients.
Goals	Improve access to quality services for publicly insured people in San Francisco.
Anticipated Outcomes	More Medi-Cal patients residing in San Francisco will receive timely, high-quality healthcare services.
Metrics Used to Evaluate the program/activity/initiative	Number of persons enrolled in the program Bed days per 1,000, if available ER visits per 1,000, if available

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 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 fourth-to-eighth-grade students in

	San Francisco's Tenderloin District, where many children suffer from 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 and language pathologists, educational therapists, and clinical psychologists provide more intensive services as needed at the school; occupational therapy is done at KCDC locations.
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.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served at San Francisco clinic locations and through outreach at De Marillac Academy Number of encounters

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 to patients in need of behavioral health services at community-based organizations and public institutions. These organizations provide treatment for substance use disorder and other mental health problems, 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.
Metrics Used to Evaluate the program/activity/initiative	Number of persons served through the residents' time spent at each of the community/public organizations

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 healthcare 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.
Metrics Used to Evaluate the program/activity/initiative	Number of psychiatry residents and psychology interns and fellows trained

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	• 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.
Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics used to evaluate efforts to address behavioral health. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. Number of persons served Number of encounters Number of persons who received mental health services Number of persons who received substance use services

Economic Opportunity

Name of program/activity/initiative	Grants and Sponsorships Addressing Economic Opportunity
Description	Grants and sponsorships are decided annually based on community need. Selected executed grants and sponsorships will be reported at year-end.
Goals	Residents have access to safe, affordable, and stable housing, living-wage jobs, nutritious food, educational opportunities, and other resources that provide the conditions necessary for health and well-being.
Anticipated Outcomes	• People experiencing homelessness or housing instability have access to comprehensive support services and resources. • People experiencing homelessness are placed in interim or permanent/stable housing. • People retain housing, preventing entry or re-entry into homelessness. • Unemployed or underemployed people obtain employment.

Metrics Used to Evaluate the program/activity/initiative	The following are examples of metrics used to evaluate efforts to address economic opportunity. Metrics are selected by partners in alignment with their organization/program objectives and reported at year-end. Number of persons served Number who received case management services Number placed in interim housing (including emergency shelter) Number placed in permanent/stable housing Number who retained permanent/stable housing through program assistance Number of meals provided Number referred for comprehensive support services such as housing/food/financial assistance, childcare, employment supports Number of class, workshop, or support group sessions provided Number trained through skills-based workforce development and job training programs Number who obtained employment

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 health needs identified in the 2022 Community Health Needs Assessment. As a member of SFHIP, CPMC will continue to work in collaboration with other local hospitals and health plans to identify gaps in service and to determine when 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 Community Health Needs Assessment and Implementation Strategy Plan were approved by the Sutter Bay Hospitals Board of Directors on October 19, 2022.