Health Care Services Master Plan

2019

San Francisco
Department of Public Health

San Francisco Planning

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1.0 EXECUTIVE SUMMARY & KEY FINDINGS

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1. BACKGROUND & PURPOSE

THE 2019 HEALTH CARE SERVICES MASTER PLAN (HCSMP OR THE PLAN) IS A LONG-RANGE POLICY DOCUMENT INTENDED TO IMPROVE COMMUNITY HEALTH BY IDENTIFYING WAYS TO IMPROVE HEALTH CARE ACCESS, PARTICULARLY FOR VULNERABLE POPULATIONS. THE PURPOSE OF THE PLAN IS TO IDENTIFY THE CITY'S CURRENT AND PROJECTED NEEDS FOR HEALTH CARE SERVICES; ADDITIONALLY, THE PLAN RECOMMENDS HOW TO REACH AND MAINTAIN AN APPROPRIATE GEOGRAPHIC DISTRIBUTION OF AND EQUITABLE ACCESS TO CARE.

The principle goals of the 2019 HCSMP are to:

1) Provide the most current and available data describing the type, capacity, utilization, and distribution of health care services,
2) Highlight health inequities and critical health care issues,
3) Conduct an assessment of trends in medical facility development and needs,
4) Assess HCSMP Consistency Determination Guidelines for potential revision, and
5) Develop recommendations that support the HCSMP goals of improving access to health care, particularly for vulnerable populations.

The Plan is used by the San Francisco Department of Public Health (SFDPH), city agencies, other health care stakeholders, and elected officials to support decision-making processes (especially regarding land-use decisions for medical use projects), and to understand health needs, priorities, and

challenges in the local health care landscape. Moreover, the HCSMP may be used to guide health care policy decisions and evaluate proposals for new and existing medical facilities.

The Plan is made up of two distinct parts: (1) the assessments, and (2) the Consistency Determination Guidelines. The assessments are the bulk of the Plan and report on demographics, health behaviors, health outcomes, socioeconomic factors impacting the health of San Francisco residents, current capacity of health services provided throughout the city, how land is occupied and used throughout San Francisco, and finally, a look at policies that shape the health system. The findings of the HCSMP are then used to create the Consistency Determination Guidelines. The Guidelines are used to evaluate proposals for new hospital facilities and expansions to existing medical facilities in San Francisco and help determine whether a proposal aligns with the goals of the HCSMP.

2. IMPLEMENTATION OF THE PLAN – CONSISTENCY DETERMINATION GUIDELINES

THE HCSMP REQUIRES THAT CERTAIN NEW MEDICAL USE DEVELOPMENT PROJECTS IN SAN FRANCISCO APPLY FOR A CONSISTENCY DETERMINATION FROM THE HEALTH DEPARTMENT AND PLANNING DEPARTMENT, IN ORDER TO DETERMINE IF PROPOSED MEDICAL USES SUPPORT HCSMP GOALS.

Projects demonstrate consistency with the HCSMP by providing services to vulnerable populations, providing specific types of services, providing services in certain neighborhoods with disparities, and/or developing a project that is consistent with healthy and active design guidelines

Prior to the 2019 HCSMP update, projects that required Consistency Determination included Hospitals/Medical Centers or Health Service/Medical Service Uses are subject to the HCSMP if they met the following size thresholds:

- A change of use to a Medical Use that occupies 10,000 GSF or greater, or
- An expansion of an existing Medical Use by 5,000 GSF or greater

As a part of the supporting legislation to the 2019 HCSMP, Consistency Determination will now be a requirement only of Hospitals and hospital-affiliated facilities as a part of their Institutional Master Plans (IMP).

3. PLAN DEVELOPMENT & OUTREACH

THE 2019 HCSMP RELIES ON BOTH QUANTITATIVE AND QUALITATIVE DATA METHODS, INCLUDING A COMPREHENSIVE REVIEW OF SECONDARY DATA SOURCES AND TARGETED OUTREACH TO A CROSS-SECTION OF THE CITY'S HEALTH CARE STAKEHOLDERS.

The Plan document is comprised of four assessments, which are quantitatively focused:

1) **Community Health Assessment:** highlights major health trends in morbidity and mortality and identifies social determinants of health.
2) **Land Use Assessment:** analyzes the current supply of medical uses, demand and need for new medical space, and potential land use impacts of new medical facilities.
3) **Capacity and Gap Assessment:** describes utilization and resource availability of the

health care system and evaluates geographic, cultural, and linguistic access.

4) **Health Systems Trends Assessment:** reviews current changes in the local, state, and national health care environment impacting service delivery.

In addition to the quantitatively focused assessments, the HCSMP update is guided by qualitative data from health service stakeholders. Planning Code Section 342 mandates that SFDPH and the Planning Department develop a HCSMP public outreach and plan adoption process that includes a minimum number of components. Compared to the outreach conducted in support of the 2013 HCSMP, the revision process was deliberately more targeted, as the 2019 Plan was intended to build off the 2013 Plan. Outreach for the 2019 update included:

- Stakeholder interviews with subject matter experts and health provider organizations
- Briefings and workshops with key stakeholders and advocacy organizations

The resulting HCMSP is a data and community driven document that sets forth a series of recommendations and related guidelines intended to improve health access and the distribution of health services in the City of San Francisco. The Plan's focus is on improving access to care, particularly for San Francisco's vulnerable populations, including low-income areas and geographic areas with high rates of health disparities.

4. DEMOGRAPHIC SNAPSHOT

DEMOGRAPHIC DATA REFERS TO SOCIAL AND ECONOMIC INDICATORS, SUCH AS POPULATION, RACE, ETHNICITY, INCOME, EDUCATIONAL ATTAINMENT, AND EMPLOYMENT.

The following demographic data is sourced from the 2013-2017 American Community Survey 5-year estimates[1] and projection estimates are sourced from the California Department of Finance.[2]

San Francisco's total population is estimated to be 864,263 people (2017). By 2040, San Francisco's population is expected to total one million and by 2060, nearly 1.2 million. The neighborhoods with the greatest population density include the Tenderloin, Nob Hill, and Chinatown. The San Francisco Planning Department has predicted that most population and household growth in San Francisco is expected in the Bayview Hunters Point, Treasure Island, and Park Merced neighborhoods.

The median age for the city of San Francisco is 38.3 years old, which is slightly older compared to the median age of the State of California (36.1 years). The neighborhoods with the highest percent of youth under age 18 include Seacliff, Presidio, and Bayview Hunters Point. The neighborhoods with the highest percent of older adults (age 65+) include Lincoln Park (which contains the VA hospital), Japantown, and Chinatown. The City's greatest population growth will be among the population age 65+. Conversely, projections estimate a decrease in the proportion of prime working-age residents in San Francisco.

People of color represent approximately 59% of the total population of San Francisco. Asians represent the largest minority group (33.9%). The largest proportion of people of color live in the southeast part of the city in the Bayview Hunters Point, Visitation Valley, Portola, McLaren Park, Excelsior, Outer Mission, and Oceanview/Merced/Ingleside neighborhoods.

[1] United States Census Bureau. 2013-2017 American Community Survey 5-Year Estimates. Retrieved from: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S0101&prodType=table

[2] California Department of Finance. Demographic Projections. Retrieved from: http://www.dof.ca.gov/Forecasting/Demographics/Projections/

Demographic projections indicate that the number of multi-ethnic residents is expected to rise, and the African American, Asian, and Latinx populations are expected to decline between 2018 and 2060.

Nearly a quarter of San Franciscans, age five and older, have limited ability to speak English. The neighborhood with the highest percent of residents with limited English proficiency is Chinatown (71%). Limited English proficiency is also highest among senior residents.

Approximately 10% of San Franciscans are estimated to have a disability, the most common are mobility disabilities, which can be especially challenging in a city setting. African Americans are twice as likely to have a disability compared to other race or ethnicity groups.

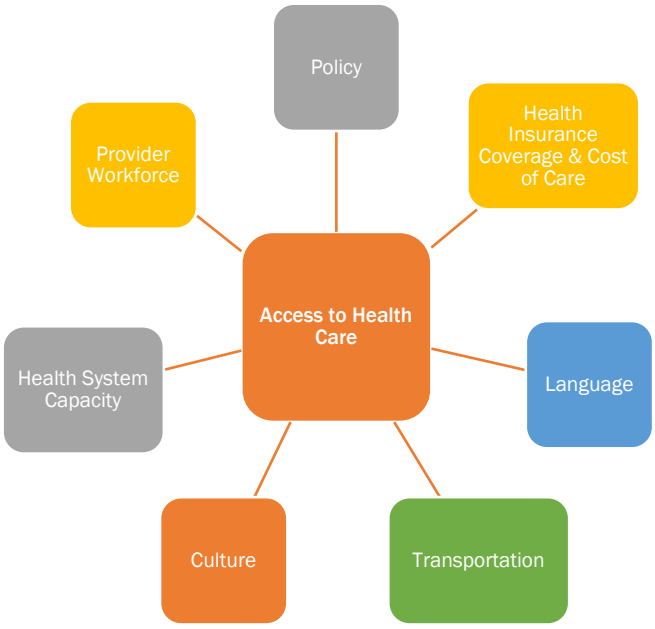
Nearly a quarter of San Francisco residents live below 200% of the federal poverty level (FPL).[3] Neighborhoods with the highest proportion of residents living below 200% FPL are Chinatown, Tenderloin, Lakeshore, McLaren Park, and Treasure Island.

The percent of residents without health insurance in San Francisco is approximately 3.4%, which is lower than the rate of uninsured residents for the state of California and the United States. Neighborhoods with the highest rates of uninsured include Treasure Island, Tenderloin, Mission, Portola, Excelsior, and Oceanside/Merced/Ingleside.

5. A FRAMEWORK FOR UNDERSTANDING HEALTH CARE ACCESS

THE HCSMP DESCRIBES HEALTH CARE RESOURCES IN SAN FRANCISCO AND ATTEMPTS TO DESCRIBE KEY FACTORS IMPACTING HEALTH CARE ACCESS FOR FUTURE PLANNING.

A geography's or population's ability to access health care is measured through a variety of indicators, including insurance rates, birth outcomes, immunization rates, disease screening rates, primary care visits, and preventable hospitalizations or emergency room visits. However, the ability to access health care can be impacted by several socioeconomic factors, which can profoundly affect physical, social, and mental health outcomes. The figure to the right displays some of the factors that impact one's ability to access appropriate health care.



The four assessments of the HCSMP investigate these factors along with other health outcome metrics and demographic trends to describe which populations in San Francisco have health

[3] In 2017, the Federal Poverty Level (FPL) for an individual was $12,060 annual income and $24,600 annual income for a family of four.

care access challenges and why they may have these challenges.

The result of the four assessments is a set of key findings that represent important health care access considerations and planning goals. These key findings are used to develop the Consistency Determination Guidelines. The Consistency Determination Guidelines are then used as a framework to evalute how new hospital and hospital-affiliated medical use developments are supporting the health care goals of San Francisco. Hospitals and hospital-affiliated medical use developments are required to meet at least one consistency determination guideline to be determined Consistent with the HCSMP. As a part of the supporting legislation package for the 2019 HCSMP, the Consistency Determination process will no longer apply to community clinics or other non-hospital affiliated health facilities.

6. KEY FINDINGS & CONSISTENCY DETERMINATION GUIDELINES

THE FOLLOWING SECTION SUMMARIZES KEY FINDINGS FROM THE 2019 HCSMP ASSESSMENTS AND THE CORRESPONDING CONSISTENCY DETERMINATION GUIDELINES. THE KEY FINDINGS AND RELATED GUIDELINES ARE DIVIDED INTO THE FOLLOWING FOCUS AREAS:

1) *VULNERABLE POPULATIONS*
2) *BEHAVIORAL HEALTH*
3) *POST-ACUTE & LONG-TERM CARE*
4) *TECHNOLOGY & TRANSPORTATION*
5) *MEDICAL FACILITY DEVELOPMENT*

Vulnerable Populations

San Francisco has many health care services and resources, including numerous medical facilities and a high provider to patient ratio. However, gaps exist for vulnerable populations in accessing primary care, dental care, and culturally and linguistically appropriate care.

San Francisco residents have high insurance and coverage rates due to implementation of the Affordable Care Act (ACA) and maintenance of Healthy San Francisco, a health care access program designed to make health care services available and affordable to uninsured San Francisco residents regardless of immigration status. City agencies, non-profit hospitals, and health care providers must foster shared responsibility to maintain progress made under the ACA, despite ongoing federal threats.

For San Francisco's most vulnerable populations, health care delivery is shifting toward providing whole person care which includes care coordination, the integration of physical and mental health, and collaboration between medical and social service providers.

Recommendations – **(1) Increase access to appropriate care for San Francisco's vulnerable populations, and (2) Support collaboration between San Francisco's existing health and social service network providers and the community to maximize service- and cost-effectiveness.**

Key Findings & Guidelines

San Francisco exceeds national benchmarks for the number of primary care physicians per population and is the highest in the state. San Francisco has one physician per 630 residents, California has one physician per 1,280 residents, and the United States has one physician per 1,040 residents.

California licensed primary care clinics in San Francisco serve a majority low-income individuals and families. Of San Francisco's 43 California state licensed primary care clinics, 68% of patients are below 200% FPL. The San Francisco Health Network (SFHN) operates 14 primary care sites that serve approximately 63,000 patients, a majority of whom are insured through Medi-Cal.[4]

State licensed primary care facilities in San Francisco are saturated in the northeast quadrant of the city making access to primary care difficult for residents living outside of the northeast quadrant. Low-income residents and seniors are most likely to be dependent on public transportation. The neighborhoods with the lowest transit access to health care facilities include Lakeshore, Treasure Island, Seacliff, Lincoln Park, Visitation Valley, and Sunset/Parkside. Neighborhoods such as Bayview Hunters Point, Portola, Excelsior, Sunnyside, Richmond and the Sunset lack access to larger facilities such as hospitals, and smaller facilities as well, such as urgent care clinics.

Preventable hospitalizations and emergency room (ER) visits are a primary indicator of inadequate access to health care. There are higher rates of preventable hospitalizations and emergency room visits among Black/African Americans compared to other race or ethnic groups in San Francisco. The zip codes with the highest rates of preventable ER visits include zip codes in Treasure Island, Tenderloin, South of Market, and Bayview Hunters Point.

There are 10 Federally Qualified Health Center (FQHC) dental sites and 17 private providers who accept Denti-Cal[5] in the City of San Francisco, making access to dental services challenging for Medi-Cal patients.

Patients are more inclined to seek medical care when there is an ethnic or linguistic match. In San Francisco, there are a higher percentage of White physicians compared to the population overall. Linguistically, there is a shortage of physicians who speak Chinese and Tagalog relative to the resident population.

Since the implementation of the ACA there has been a 61% decrease in San Francisco's uninsured rate. Approximately 3.6% or between 30,000 and 35,000 San Francisco residents are uninsured.

There is a select population of vulnerable Medi-Cal beneficiaries who are high utilizers of multiple health care systems but continue to have poor outcomes. Additional services like supportive housing are needed in order to provide adequate, effective, continued, and coordinated behavioral health care for homeless individuals with behavioral health conditions.

[4] Medi-Cal is California's Medicaid program, which provides insurance for low-income residents

[5] Medi-Cal's dental program

CONSISTENCY DETERMINATION GUIDELINES TO IMPROVE HEALTH CARE ACCESS FOR VULNERABLE POPULATIONS

1.1 Increase the availability and accessibility of primary care in: (1) low-income areas, (2) areas with documented high rates of health disparities and/or, (3) areas with limited existing health care resources.

1.2 Increase the availability and accessibility of culturally competent primary care among vulnerable subpopulations including but not limited to: (1) Medi-Cal beneficiaries, (2) uninsured residents, (3) limited English speakers, and (4) populations with documented high rates of health disparities.

1.3 Increase the availability and accessibility of prenatal care within neighborhoods with: (1) documented high rates of health disparities, and (2) for subpopulations with documented high rates of related health disparities including but not limited to Black/African American residents.

1.4 Increase the availability and accessibility of dental care in/among: (1) low-income areas, and (2) areas with documented high rates of health disparities among vulnerable populations.

1.5 Employ and train culturally competent providers serving low-income and uninsured populations, which may include but is not limited to supporting projects that can demonstrate through metrics that they have served and/or plan to serve a significant proportion of existing/new Medi-Cal and/or uninsured patients, particularly in underserved neighborhoods.

1.6 Deliver and facilitate access to specialty care for underserved populations (e.g., through transportation assistance, mobile services, and/or other innovative mechanisms).

1.7 Provide innovative education and outreach efforts that: (1) target youth and other hard-to-reach populations, such as homeless people and those with behavioral health problems that inhibit them from seeking medical care and other health services, as well as invisible populations that are often overlooked due to their legal status, and (2) help low-income, publicly insured, and/or uninsured persons identify health care facilities where they may access care.

1.8 Promote support services for patients likely to have difficulty accessing or understanding health services (e.g., escorting patients to medical appointments, using case managers to help patients navigate the health care system, for e.g. dual diagnosed or homeless persons).

1.9 Offer non-traditional facility hours to accommodate patients who work during traditional business hours.

1.10 Participate in Healthy San Francisco.

1.11 Support collaborations between medical service providers and existing community-based organizations with expertise in serving San Francisco's diverse populations.

1.12 Engage in partnerships between medical service providers and entities not specifically focused on health or social services (e.g., schools, private businesses, faith community, etc.) to leverage expertise and resources and expand access to health services and promote wellness.

Behavioral Health

Increased community services are needed for individuals with behavioral health conditions.

Recommendation – **Increase access to behavioral health services for vulnerable populations.**

Key Findings & Guidelines

In San Francisco approximately 19.2% of adults are estimated to have a mental illness, which is just slightly higher compared to nearby counties such as Alameda (18.9%), Contra Costa (18.2%), and San Mateo (15.8%)

Approximately 30% of San Francisco adults reported needing help for mental health problem and/or use of alcohol or drugs (approximately 250,000 residents).

San Francisco has several facilities for residents needing higher levels of behavioral health care, but additional capacity is needed to improve patient flow to long-term treatment.

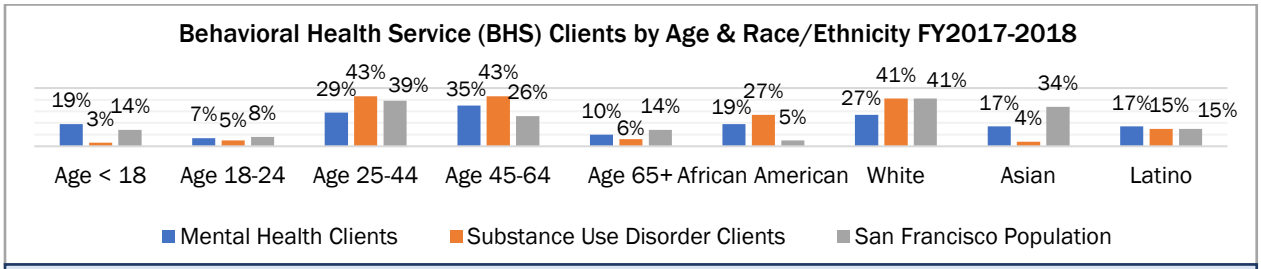
Expansion of existing community-based behavioral health services is needed to meet increasing demand.

San Francisco, like California and the United States, is facing workforce shortages of behavioral health professionals who have the skills to work with children, older adults, and diverse linguistic and cultural populations.

Additional services like supportive housing are needed in order to provide adequate, effective, continued, and coordinated health care for homeless individuals with behavioral health conditions.

The San Francisco Behavioral Health Plan, through SFDPH, serves diverse populations, yet disparities exist for Black/African American residents, homeless residents, and youth. Black/African Americans account for 19% of mental health clients and 27% of substance use disorder clients but only comprise 5% of San Francisco's population.

It's estimated that approximately 4,000 homeless individuals in San Francisco are living with mental illness and a substance use disorder.



CONSISTENCY DETERMINATION GUIDELINES TO IMPROVE ACCESS TO BEHAVIORAL HEALTH

2.1 Increase the availability of behavioral health and trauma-related services– including school-based services – in neighborhoods with documented high rates of violence.

2.2 Expand the availability and accessibility of residential treatment beds for mental health and substance use, especially for people experiencing homelessness.

2.3 Support expansion of safe indoor spaces that provide low-threshold, harm reduction (ex. naloxone), and basic services, including drop-in centers, shelters and navigation centers.

2.4 Support behavioral health workforce development and recruitment through efforts like scholarship programs, loan forgiveness, and other financial incentives.

2.5 Improve care coordination through case management and navigation services, especially for high utilizers of the health care system.

Post-Acute & Long-Term Care

San Francisco's growing senior population, coupled with the decline in skilled nursing facilities (SNF) and residential care facilities for the elderly (RCFE), will increase demand for post-acute and long-term care options.

Recommendation – **Increase access to and capacity of long-term care options for San Francisco's growing senior population and for persons with disabilities to support their ability to live independently in the community.**

Key Findings & Guidelines

San Francisco's freestanding SNFs operate at near capacity and the occupancy rate for Medi-Cal facilities is much higher compared to non Medi-Cal facilities. The availability of long-term beds for Medi-Cal patients may be limited.

The closure of many hospital based SNFs has reduced bed supply and the current bed supply may not meet future demand.

With the closure of St. Luke's campus, all subacute beds in the City will revert to short term SNF beds once no longer used by the patient receiving subacute care.

Across all SNF types in San Francisco, there are approximately 19 beds per 1,000 adults over age 65 (Medi-Cal beds: 14 beds per 1,000 adults over age 65). If the bed supply remains constant over the next 15 years, San Francisco's bed rate would decrease from 19 to 11 SNF beds per 1,000 adults over age 65.

There is a trend toward converting long-term SNF beds to short-term rehabilitation as the funding shifts from Medi-Cal to the more financially lucrative Medicare.

Low reimbursement rates and high operating costs due to the high cost of living in San Francisco has led to a shortage in the supply of RCFE beds.

San Francisco will require enough community-based care options for its growing senior population.

CONSISTENCY DETERMINATION GUIDELINES TO IMPROVE ACCESS TO POST-ACUTE & LONG-TERM CARE

3.1 Increase availability and accessibility of post-acute and long-term care facilities, specifically: (1) Skilled Nursing Facilities (SNFs), (2) Subacute SNF, and/or (3) Board and Care Homes/Residential Care Facilities for the Elderly (RCFEs).

3.2 Increase availability and accessibility of home and community-based services for residents with short and long-term care needs.

3.3 Provide affordable and supportive housing options for seniors and persons with disabilities, enabling them to live independently in the community.

3.4 Support workforce development through job trainings and/or wage stipend programs especially for home-based services.

Technology & Transportation

Technology and transportation are key facilitators for patients in accessing health care, particularly amongst patients who are low-income or underserved.

Recommendations: **(1) Utilize health information technology systems that increase access to high-quality health care and improve care coordination, and (2) Ensure that San Francisco residents – particularly those without regular care access – have available a range of appropriate transportation options (e.g., public transportation, shuttle services, bike lanes, etc.) That enable them to reach their health care destinations safely, affordably, and in a timely manner.**

Key Findings & Guidelines

A significant portion of low-income San Francisco residents use digital technologies, such as phones and computers. These technologies could be leveraged to communicate health care resources to low-income populations.

Residents living in the southern neighborhoods likely experience longer travel times because of less frequent and less diverse transit options and fewer neighborhood-located health care services.

The lowest income patients, who also report the most mobility limitations, were more likely to report relying on Muni to reach health care services and were more likely to cite public transportation as a barrier.

CONSISTENCY DETERMINATION GUIDELINES TO IMPROVE ACCESS THROUGH TECHNOLOGY & TRANSPORTATION

4.1 Support technology-based solutions that expand access to health services for San Francisco's vulnerable populations, such as telehealth and mobile device utilization (e.g., video medical interpretation, mobile applications, remote health monitoring, etc.).

4.2 Integrate support service information into electronic health records in order to have a more complete picture of a patient's health and improve care coordination.

5.1 As part of transit demand management efforts for patients, develop safe health care transit options beyond the public transportation system to increase health care access for those without regular car access.

5.2 Provide transportation options from low-income areas and areas with documented high rates of health disparities – particularly those with transportation access barriers – to health care facilities.

5.3 Increase awareness of transportation options to health care facilities during facility hours. This may include but not be limited to providing relevant transit information in provider offices or assisting with enrollment in programs like Paratransit.

Medical Facility Development

While larger facilities will continue to be updated and modernized, future health care service growth is expected in smaller outpatient facilities of all provider types, distributed throughout San Francisco neighborhoods.

Recommendation – **Ensure that the facility contributes positively to neighborhood character and promotes health and safety throughout the design of its site and buildings.**

Key Findings & Guidelines

Recent updates to land use throughout San Francisco include: (1) the removal of conditional use requirements for residential care facilities and (2) an increase in restrictions on medical service/health service uses in neighborhood commercial areas.

Due to increased emphasis on preventive health, the rising cost of doing business, and other factors, health care providers are shifting more of their services to outpatient settings, even for traditionally inpatient procedures. Growth in medical facilities will be in smaller facilities providing community-based care.

Displacement and gentrification are complex issues, and there is no consensus on what factors are responsible. Medical uses in commercial corridors generate foot traffic, which benefits neighboring businesses. Neighborhood concerns remain that health care facilities are deadening the streetscapes with drawn shades or that they may be able to pay higher rents than other types of neighborhood retail.

Up to four million square feet of new medical space may be needed in the coming twenty years given population and employment

projections. The many caveats to this projected growth are described in Chapter 5.2.

CONSISTENCY DETERMINATION GUIDELINES TO IMPROVE MEDICAL FACILITY DESIGN & DEVELOPMENT

6.1 Encourage site and building design that supports health and safety, through amenities such as restorative open spaces, environmental sustainability features, indoor air quality measures, Crime Prevention Through Environmental Design (CPTED) design strategies, and other health promoting interior design

6.2 Design hospital-affiliated medical facilities so that more "active uses" line the street, particularly when located in neighborhood commercial corridors or other predominantly retail and residential neighborhoods. Non-active uses should ideally be sited at the building interior and/or on the second floor and above.

7. CONCLUSION

The five principle goals of the Health Care Services Master Plan have been met in the following ways:

1. The 2019 Plan provides the most current and available data describing the type, capacity, utilization, and distribution of health care services. The Plan utilizes the most up to date publicly available data from sources like the United States Census Bureau, the California Office of Statewide Health Planning and Development, and the California Health Interview Survey.
2. The Plan highlights the health inequities and critical health care issues. Since the 2013 Plan, two distinct public health issues have come to the forefront. (1) Behavioral health challenges are increasing, especially within San Francisco's homeless population. (2) A loss of long-term care (skilled nursing facilities (SNFs), subacute, and board and care homes) is creating a gap in needed care.
3. The Plan assessment of trends in medical facility development and needs shows that medical jobs are growing, and that the city has added 2.1 million square feet of hospital space since 2013 (Chapter 5.2). World class research and patient care facilities expanded, notably in Mission Bay. Delivery of health care continues to change rapidly, and since 2013, the city has seen the emergence of urgent care facilities in neighborhoods as providers look to improve patient access and decrease costs. As described in the Needs Assessment (Chapter 4), geographic proximity is not the only barrier facing at-risk populations needing to access to health care. In some cases, such as the Bayview, lack of geographic access correlates with insufficient health care, but for at-risk populations in the Mission, Chinatown, or Tenderloin, which are close to health care facilities, the barriers to access may be cultural, linguistic, or other.
4. The 2019 Plan includes several changes to the HCSMP Consistency Determination Guidelines, which will simplify the review process for applicants and City agencies.
5. The 2019 HCSMP includes broad recommendations for health care services throughout San Francisco, by way of the streamlined Consistency Determination Guidelines. Additionally, the 2019 HCSMP includes amendments to current planning code that would make Institutional Master Plans (IMPs) subject to Consistency Determination, this would ensure that hospital long-range plans fit with the health care goals of San Francisco.
6. Several changes to the Planning Code are being proposed in tandem with the 2019 HCSMP. These changes would simplify the approvals process for certain health services, which would reduce the time and cost associated with opening new facilities.

2.0 INTRODUCTION

CONTENTS

1. BACKGROUND & POLICY CONTEXT

THE 2019 HEALTH CARE SERVICES MASTER PLAN IS A LONG-RANGE POLICY DOCUMENT INTENDED TO PROVIDE THE HEALTH COMMISSION, THE PLANNING COMMISSION AND BOARD OF SUPERVISORS WITH INFORMATION AND RECOMMENDATIONS TO GUIDE THE CITY'S LAND USE AND POLICY GOALS RELATED TO DISTRIBUTION AND ACCESS TO HEALTH CARE SERVICES.

The purpose of the Health Care Services Master Plan (HCSMP) is to identify current and projected needs for health care services in San Francisco. The HCSMP also recommends how to achieve and maintain an appropriate geographic distribution and equitable access to care. The HCSMP is used by the Health Commission, Planning Commission, and the Board of Supervisors to guide health care policy and land use decisions and evaluate proposals for new medical facilities.

Under Planning Code Section 341 (adopted under Ordinance No. 300-10), the San Francisco Department of Public Health (SFDPH) and the San Francisco Planning Department are required to create the HCSMP. The first version of the HCSMP ("2013 HCSMP") was adopted and came into effect on December 26, 2013 after an extensive public process, which was guided by a 41-member taskforce comprised of a variety of stakeholders from the health care services field. The 2013 HCSMP document and background materials are available on the Planning Department and SFDPH websites.

In the summer of 2016, DPH and the Planning Department began the 2019 HCSMP update process. The 2019 HCSMP includes multiple assessment and policy components, described in Table 2.0-1.1

Table 2.0 - 1.1. 2019 Health Care Services Master Plan (HCSMP) – Assessment and Policy Components

HCSMP Assessments	The HCSMP includes four data-driven assessments: 1) Community Health Assessment: highlights major health trends in morbidity/mortality and identifies social determinants of health.[6] 2) Land Use Assessment: analyzes the current supply of medical uses, demand and need for new medical space, and potential land use impacts of new medical facilities. 3) Capacity & Gaps Assessment: describes utilization and resource availability of the health care system and evaluates geographic, cultural, and linguistic access.

[6] This assessment is drawn from the San Francisco Community Health Needs Assessment, which is developed every three years by the San Francisco Health Improvement Partnership (SFHIP).

	4) Health System Trends Assessment: reviews current changes in the local, state, and national health care environment impacting service delivery.
HCSMP Consistency Determination Guidelines	The HCSMP Consistency Determination Guidelines are intended to advise policymakers and health care providers on strategies to improve community health and access to care in San Francisco. They are used to evaluate whether new medical facilities[7] are, on balance, consistent with the goals and recommendations of the HCSMP
Supporting Legislation & Policy Recommendations	As part of the 2019 HCSMP process, the City develops recommendations that help advance the goals of the 2019 HCSMP. The list of policy recommendations is subject to change, and Plan adoption is not contingent on their development or passage.

The HCSMP is structured to align with multiple ongoing city-wide health-focused processes and initiatives, allowing the Plan to leverage the work of these processes. For example, due to the HCSMP Community Health Assessment component's alignment with the San Francisco Community Health Needs Assessment (CHNA), the assessment can draw heavily on this work. The CHNA is conducted every three years by SFDPH and the San Francisco Health Improvement Partnership and takes a comprehensive look at the health of San Franciscans through an extensive data review process of a broad range of variables affecting health outcomes, health disparities and inequities. The findings from the CHNA are, therefore, able to inform and support the *Community Health Assessment*, which highlights major health trends in morbidity/mortality and identifies social determinants of health. The Plan, in addition to drawing on the information produced by other city-wide planning efforts, also helps to inform ongoing processes as well. For example, components of the Plan meet several standards for achieving Public Health Accreditation, which SFDPH successfully achieved in 2017 and has already begun the process of reaccreditation for 2021. In particular, the Plan satisfies standards around assessing the capacity of health care services and access. Finally, the Plan is used by SFDPH, city agencies, other health care stakeholders, and elected officials to support the decision-making process (especially with regards to land-use decisions for medical use projects), and to understand health needs, priorities, and changes in the local health care landscape.

The principal goals of the 2019 HCSMP update are to:

1) Provide the most current and available data describing health care services capacity, utilization, and distribution.
2) Highlight health inequity and critical health care issues that have emerged since the 2013 HCSMP.
3) Conduct an updated assessment of trends in medical facility development.
4) Assess the Consistency Determination Guidelines for potential revision.
5) Develop recommendations to implement the HCSMP goals of improving access to health care, particularly for vulnerable populations.

Although some new topics and priorities have emerged in recent years, many of the original findings from the first plan still hold today. Given that, the 2019 HCSMP process focused on refining the HCSMP document and Consistency Determination process, researching new trends in medical facility development, and developing supporting legislation in order to implement the City's public health goals more effectively.

[7] Currently, the requirement is applicable to Hospital/Medical Centers (Planning Code Sections §102, §890.44), Health Service/Medical Service (§102, §890.114), and Residential Care Facilities (§102, §890.50) uses that are adding 5,000+ gross square feet of new/expanded space or adding 10,000+ gross square feet of a change of use to medical. However, City agencies are proposing modifications to this process as part of the 2019 HCSMP supporting legislation.

Policy Context & Jurisdiction

The structure and implementation of the HCSMP was created with consideration of San Francisco's existing policy context. A health care provider may work with a range of local, state, and federal government agencies when developing a new facility or expanding an existing facility. The section below describes the roles that key agencies and legislators may play in reviewing and shaping the development of health care facilities; this list is not comprehensive.

San Francisco Department of Public Health (SFDPH)

The mission of SFDPH is to protect and promote the health of all San Franciscans. To fulfill its mission, the Department has two primary roles, carried out by two major divisions. The Population Health Division (PHD) protects the health of the population through consumer safety, health promotion, and the monitoring of threats. The San Francisco Health Network (SFHN), which is the City's complete system of care, provides direct health services to thousands of insured and uninsured residents of San Francisco, including those most socially, economically and medically vulnerable. The SFHN's health care services include primary care, dental care, emergency and trauma treatment, medical and surgical specialties, diagnostic testing, skilled nursing and rehabilitation, behavioral health services and jail health services. Despite SFDPH's role of providing health care services and promoting protection of public health, the department has limited decision-making authority related to city-wide health facility planning.

San Francisco Planning Department

The Planning Department is responsible for regulating, and planning for, growth and development in the City of San Francisco. As described more fully in the *Land Use Assessment* chapter, the Planning Department works with legislators and City agencies to amend the San Francisco Planning Code and to update the City's General Plan, both of which are used to review new development projects, including medical facilities. Certain facilities are exempt from portions of Planning Department review due to their ownership (e.g. by state or federal agencies) or location (e.g. within an area governed by a Redevelopment Plan). Further, the Department's review is limited to issues of land use (e.g. types/intensity of use and urban design), and other aspects of medical development projects may be reviewed by different agencies at the City, state, or federal level.

Elected Officials

City agencies are held accountable by the Mayor and Board of Supervisors, who ultimately approve and/or amend policy proposals, and have approval authority over departments' budgets and use of resources. They directly approve and review certain types of land use entitlements (e.g. Development Agreements), and they are the final approval authority for the HCSMP.

State and Federal Agencies

The complex jurisdictional structure overseeing health care facilities by public agencies creates limitations on what authority City agencies and the HCSMP have in decision making processes that determine facilities' development and operations. Oversight of California's health care facilities devices is distributed between two state agencies (Health and Human Services Agency and Department of Consumer Affairs), seven state departments, and 18 largely autonomous boards and commissions. For some regulated health facility types, different state departments share responsibility for basic licensure and certification. One of the primary agencies responsible for overseeing health facilities across the state is the California Department of Public Health (CDPH). CDPH is responsible for the licensure, regulation,

inspection, and certification of 40 different types of health care facilities in the state. California Office of Statewide Health Planning & Development (OSHPD) also plays major role in facility oversight and is responsible for monitoring the construction, renovation, and seismic safety of hospitals and skilled nursing facilities. Other than participation in Medicare and Medi-Cal, the federal government plays no major role in regulating licensure of health care facilities, deferring to the state to perform this function.

Because state and federal agencies are primarily responsible for licensing and ensuring adherence to standards of medical care, the HCSMP is structured less as a regulatory tool, and more as a mechanism to identify and incentivize facilities to meet the City's identified health needs. The HCSMP focuses on land use policies, such as zoning and design review, which the City has authority to help shape the location and intensity of medical uses.

Related Initiatives

Various city agencies and partners are working to coordinate their services and develop short- and long-term health policies with the aim of addressing health care service needs related to those identified in the 2019 HCSMP. The HCSMP provides a long-range, comprehensive policy framework that is complementary and supportive of these other efforts.

Table 2.0-1.2 describes some of these related policy initiatives and collaborative efforts focused on long-term and strategic planning; this list is not inclusive of the breadth and diversity of health policy work happening in San Francisco.

Table 2.0 - 1.2. Policy Initiatives and Collaborative Efforts Related to Health Care Services In San Francisco

Policy Area	Initiative	Key Agencies/Partners
Population Health Improvement	**San Francisco Health Improvement Partnership (SFHIP)**	Cross-sector initiative with the following organizations represented on the steering committee: • SFDPH • Asian and Pacific American Family Support Services (Asian and Pacific Islander Health Parity Coalition) • SF Interfaith Council • St. Mary's Medical Center (Dignity Health) • Chinese Hospital • Saint Francis Memorial Hospital (Dignity Health) • Rafiki Coalition (African American Community Health Equity Council) • California Pacific Medical Center (CPMC) • Kaiser Permanente San Francisco • San Francisco Unified School District (SFUSD) • San Francisco Community Clinic Consortium (SFCCC) • University of California, San Francisco (UCSF) • Metta Fund • Instituto Familiar de la Raza (Chicano/Latino/Indigena Health Equity Coalition) • Human Services Network (HSN)
Skilled Nursing Facilities (SNFs) & Long-Term Care	**Post-Acute Care Collaborative**	• SFDPH • San Francisco Hospital Council
	Long-Term Care Coordinating Council (LTCCC)	• Department of Aging & Adult Services (DAAS) • SFDPH • Department of Human Services Agency (HSA) • Mayor's Office on Disability • Mayor's Office on Housing & Community Development (MOHCD) • San Francisco Department of Homelessness & Supportive Housing (HSH) • San Francisco Municipal Transit Authority (MTA)

Behavioral Health	**Mental Health Reform**	• SFDPH
Health Needs Assessments & Data	**Community Health Needs Assessment (CHNA)**	• San Francisco Health Improvement Partnership (SFHIP) • SFDPH
	San Francisco Indicator Project	• SFDPH
	Black/African American Health Report (Black African American Health Initiative)	• SFDPH
Land Use Policies & Long-Range Planning	**Institutional Master Plans**	• San Francisco Planning Department • SFDPH
	San Francisco Planning Code & General Plan	• San Francisco Planning Department
	Transportation Demand Management Program	• San Francisco Planning Department • San Francisco Municipal Transit Authority (MTA) • San Francisco Department of the Environment
	Urban Design Guidelines	• San Francisco Planning Department
Economic Development & Business Support	**Nonprofit Sustainability Initiative**	• San Francisco Office of Economic & Workforce Development (OEWD) • Mayor's Office of Housing & Community Development (MOHCD)
	Invest in Neighborhoods	• San Francisco Office of Economic & Workforce Development (OEWD) • San Francisco Planning Department

3.0 PLAN DEVELOPMENT & OUTREACH

CONTENTS

1. PLAN DEVELOPMENT & METHODOLOGY

THE HEALTH CARE SERVICES MASTER PLAN (HCMSP OR THE PLAN) IS A COMMUNITY- AND DATA-DRIVEN DOCUMENT THAT SETS FORTH A SERIES OF RECOMMENDATIONS AND RELATED GUIDELINES INTENDED TO IMPROVE HEALTH AND HEALTH SERVICES IN THE CITY OF SAN FRANCISCO. THE FOCUS OF THE 2019 HCSMP IS ON IMPROVING ACCESS TO CARE, PARTICULARLY FOR SAN FRANCISCO'S VULNERABLE POPULATIONS, INCLUDING LOW-INCOME AREAS AND GEOGRAPHIC AREAS WITH HIGH RATES OF HEALTH DISPARITIES.

The San Francisco Department of Public Health (SFDPH) and San Francisco Planning Department relied on both primary and secondary data to complete the HCSMP components mandated by the ordinance. This includes a comprehensive review of secondary data sources and targeted outreach (primary data collection) to a cross section of the city's health care stakeholders.

The HCSMP document is comprised of four assessments, which are compiled using secondary data sources:

1) **Community Health Assessment:** highlights major health trends in morbidity and mortality and identifies social determinants of health.
2) **Land Use Assessment:** analyzes the current supply of medical uses, demand and need for new medical space, and potential land use impacts of new medical facilities.
3) **Capacity and Gap Assessment:** describes utilization and resource availability of the health care system and evaluates geographic, cultural, and linguistic access.
4) **Health Systems Trends Assessment:** reviews current changes in the local, state, and national health care environment impacting service delivery.

In addition to the assessments, the HCSMP update is guided by primary data from key health service stakeholders. Planning Code Section 342 mandates that SFDPH and the Planning Department develop a HCSMP public outreach and plan adoption process that includes a minimum number of components. Compared to the outreach conducted in support

of the 2013 HCSMP, the update process was deliberately more targeted, as the 2019 Plan was intended to build off the 2013 Plan. Outreach for the 2019 update included:

- Stakeholder interviews with subject matter experts and health provider organizations,
- Briefings with key stakeholders and advocacy organizations,
- A public workshop,
- An implementation brainstorming workshop with stakeholders involved in the HCSMP update process.

A complete description of the methodology used to engage the larger community is discussed in the outreach section of this chapter.

Secondary Data Sources

Secondary data sources and resources include, but are not limited to the United States Census Bureau, the American Community Survey (ACS), the California Department of Public Health (CDPH), the California Department of Finance (DOF), the California Office of Statewide Health Planning and Development (OSHPD), the California Department of Education (CDE), SFDPH, the California Health Interview Survey (CHIS), the CDC's Behavioral Risk Factor Surveillance System (BRFSS), Health Resources and Services Administration (HRSA), Healthy People 2020 (HP 2020), Plan Bay Area 2040, etc. All data from secondary data sources were carefully analyzed and reviewed by staff professionals.

Data Limitations

Due to the timeliness of when many public data sources collect, analyze, and publish their data, some of the data points may be out of date. In some cases, hospital utilization data does not reflect very recent changes in the hospital landscape of San Francisco. The most recent hospital utilization data publicly available is for hospitals reporting in 2017. For 2017 data points, notes have been provided that mention the more recent changes (2017-2019), however, the utilization data for any new developments was not yet available at the time of writing the 2019 HCSMP update.

Data compiled by OSHPD to examine health care utilization throughout San Francisco describes individuals who access health care service based on patient discharge data or patient registration data. Therefore, the data does not capture those who did not access health services or who access health services at a health agency whose data is not collected or reported to OSHPD.

2. OUTREACH

PLANNING CODE SECTION 342 MANDATES THAT SFDPH AND THE PLANNING DEPARTMENT DEVELOP A HCSMP PUBLIC OUTREACH AND PLAN ADOPTION PROCESS THAT INCLUDES A MINIMUM NUMBER OF COMPONENTS. THE PUBLIC OUTREACH FOR THE 2019 HCSMP MET AND EXCEEDED THESE REQUIREMENTS. AS NOTED, COMPARED TO THE OUTREACH CONDUCTED IN SUPPORT OF THE 2013 HCSMP, THE 2019 PROCESS WAS DELIBERATELY MORE TARGETED AS THE 2019 PLAN WAS INTENDED TO BUILD OFF OF THE 2013 PLAN.

Table 3.0 - 2.1 2019 HCSMP Outreach Activities

HCSMP Ordinance Requirement	2019 HCSMP Outreach (Completed/In Progress)
Three public hearings: • At least two publicly noticed informational hearings • A joint public hearing of the Health Commission and Planning Commission,	Four public hearings: • Informational hearing at the Health Commission – **February 4, 2020** • Informational hearing at Planning Commission – **December 12, 2019** • Initiation hearing at Planning Commission – **March 12, 2020**

at which they may recommend approval or disapproval of the Plan	• Joint adoption hearing at Health Commission/Planning Commission - **March 12, 2020**
A public comment period of no fewer than 30 days, upon completion of the draft Plan	**January 10, 2020 – February 20, 2020**
A decision at the Board of Supervisors, who may choose to approve or disapprove the Plan	Hearing at the full Board of Supervisors and committees - Land Use & Transportation Committee
	Additional outreach completed: • Stakeholder interviews **(Spring 2017)** • Workshop for health care sector stakeholders **(December 2017)** • Focus group with Bayview Residents **(March 2018)** • Urban Design Policy Meeting **(March 2018)** • Meetings and briefings with advocacy organizations and stakeholders **(Fall 2017 – Spring 2019)** • An implementation brainstorming workshop for health care sector stakeholders **(November 2019)**

Stakeholder Interviews – Spring 2017

In Spring of 2017, SFDPH and the Planning Department held a series of one-hour stakeholder interviews in order to obtain information on San Francisco's current and future health care needs, discuss trends in medical facility development, and obtain feedback on the HCSMP Consistency Determination process and the land use development process more broadly. *Appendix B* lists the organizations that participated in the interviews.

In total, staff conducted interviews with 33 representatives from 25 organizations in three key groups: (1) health care service providers; (2) health advocacy and research organizations; and (3) health facility planning/design and neighborhood planning groups. Staff sought to capture a diversity of opinions and roles – for instance, including representatives from both large and small health care providers, as well as providers of both primary and specialty care services.

Some key themes that emerged from the interviews include:

Health Care Facility Development Process:

- The biggest challenge health care providers expressed was uncertainty regarding development timelines, requirements, and the likelihood of approval.
- Health care providers tended to feel that land use controls are overly restrictive and/or confusing when it comes to size limits and permitted locations.
- Community outreach was shared as being essential toward facilitating the planning process and shaping the final development project.
- For smaller organizations, there were requests for guidance and assistance throughout the permitting and approval process to make the development process much less discouraging.

HCSMP Process (as of June 2019, only five projects have completed the HCSMP Consistency Determination application process):

- According to one organization that completed the Consistency Determination application process, the experience was initially frustrating given the other various development requirements. The organization stated that that the process of working with SFDPH to complete the review went smoothly, and that staff were helpful and professional. In the end, the organization stated the process was

valuable, as the data and text generated were helpful for their fundraising and communications efforts.
- Stakeholders questioned the utility of the Consistency Determination application process, given that so few projects have been subject to the requirement and that it only applies to new developments, and not existing providers.

Care for Vulnerable Populations:

- New facilities are not targeted towards underserved populations, rather tending to those who are socioeconomically advantaged.
- Telemedicine has the potential to address health care disparities in low-income and vulnerable patient populations.
- It is difficult to open facilities that cater to low-income and vulnerable populations because of low Medi-Cal reimbursement rates.
- The integration of multiple services, with a focus on holistic approaches to care, will benefit low-income and vulnerable patient populations.
- Facilities should engage with the community to ensure that they are supporting and benefiting the neighborhood in which they reside.

Health Care Sector Needs & Trends:

- Facilities throughout the US are moving towards outpatient/ambulatory model of care.
- Increased insurance coverage has led to greater demand for primary care in the City.
- There is a lack of post-acute, and specifically, skilled nursing beds in the City.
- There is a lack of acute psychiatric hospital beds available throughout the City.
- Most of the growth in medical facilities nationwide will continue to be driven by smaller facilities providing community-based care.
- Due to the increasing costs of doing business in the City, health care providers are looking to other business models and technologies.
- There are projected physician shortages nationwide, and San Francisco and local teaching institutions can do more to encourage providers to work in the City with vulnerable populations.

Workshop for Health Care Sector Stakeholders – Winter 2017

In December 2017, SFDPH and Planning Department staff held a workshop as a part of the 2019 HCSMP update. The objectives of the workshop were to (1) inform stakeholders from the 2013 HCSMP task force about the updated HCSMP and any key changes, (2) share findings from the updated HCSMP assessments, and (3) solicit feedback on supporting legislation and policy recommendations regarding land use.

The core audience invited to participate in the workshop included:

- 2013 HCSMP task force members
- Health care providers – management staff, facilities planners, and government relations
- Health care policy advocacy organizations and researchers
- Stakeholders interviewed as a part of the 2019 HCSMP update process

Organizations that participated in the December 2017 workshop are listed in *Appendix B*. Key themes that emerged during the workshop are like those that emerged during the stakeholder interviews. The following subsection notes the topics themes of discussion from the December 2017 workshop.

Health Care Needs and Trends:

- Many health services throughout the city do not have accessible parking, patients want the ability to have their car for health appointments.
- There is a growth in outpatient facilities throughout neighborhood commercial districts, there is a desire to encourage the growth of these facilities so that access improves, and people stay out of hospitals, but also to keep active uses of medical uses.
- San Francisco has an aging population; the City must support and address long-term care gaps.
- There is an increased need for dental providers who accept pediatric patients.
- The City needs to call attention to the gaps in services, especially the poor geographic distribution of health care services.
- There is an identified lack of primary care providers in the pipeline as many primary care providers will be at retirement age in the next decade.
- Health facility responsibility should be de-siloed, and the knowledge base of all city departments should be increased around the benefit of health care services.
- One suggestion was to create guidelines for ideal healthcare access in neighborhoods, transportation has a key role in improving access throughout San Francisco neighborhoods.
- There is a need to increase collaboration between organizations and commissions to address root causes and social determinants of health.

Development Process & Incentives / Supporting Legislation

- Incentives to encourage health care facility growth – this would include for-profit facilities if they meet a certain payer mix for low-income patients.
- Land use incentives that follow the developer throughout the process, for example – expedited permitting at multiple City agencies.
- One of the most significant hurdles for a developer is finding affordable space, especially for non-profits, having support in site selection would be helpful.
- Health care and medical use experts are needed at various City agencies who facilitate the development process.
- Some specific incentives mentioned as a great tool for encouraging medical uses: land use incentives, financial and cost of capital incentives, and tax break incentives for meeting certain benchmarks.
- Many medical use developers feel pressure to locate on second floor. There is a need to support growth in all capacities and locations.

Urban Design Policy Meeting – Spring 2018

In March of 2018, City Planning and DPH staff met with a group of developers to discuss urban design policies and their impact on health care and medical use development. A main concern highlighted during this meeting was the conflict between visibility requirements specified by city design guidelines and patient privacy priorities for medical use developments.

Meetings & Briefings – Spring 2019

During the spring of 2019, DPH and City Planning staff organized a series of briefings with community organizations who had provided feedback between 2017 and 2018. The objectives of this series of briefings were to review key findings, provide a timeline update, and continue policy conversations with health provider stakeholder groups. A list of organizations who participated in a spring 2019 briefing is available in *Appendix B*.

Public Comment Period – January – February 2020

Pursuant to Planning Code Section 342, HCSMP draft must be posted for public comment for a minimum of 30 days.

The draft 2019 HCSMP was posted from January 10, 2020 through February 20, 2020 on the Health Care Services Master Plan's main web page: https://sfplanning.org/project/health-care-services-master-plan-update-2019. Comments on the draft HCSMP were also received via oral comment and email submissions, as listed below:

- Planning Commission Informational Hearing – December 12, 2019 (oral comments)
- Health Commission Informational Hearing – February 4, 2020 (oral comments)
- HCSMP.DPH@sfdph.org – January 10, 2020 through February 20, 2020 (written/email comments)

Comments were received from the following groups and individuals:

- Members of the Planning Commission – oral comments
- Members of the Health Commission – oral comments
- Tom Radulovitch – oral comment at Planning Commission hearing
- Teresa Palmer – oral comment at Planning commission hearing
- Francisco Da Costa – oral comment at Planning Commission hearing
- San Francisco Community Clinic Consortium (SFCCC) – written/email comments
- North East Medical Services (NEMS) - written/email comments

Comments were addressed by SFDPH and Planning staff and will be presented as a part of the joint Planning Commission and Health Commission hearing on March 12, 2020.

Key revisions to the draft HCSMP include:

- Edits to the proposed Consistency Determination Guidelines,
- Improved description of community health centers and their role in serving San Francisco's vulnerable populations,
- A package of supporting legislation that reduces barriers to the development of priority health services and reduces limits on residential care facilities, and
- Updated information regarding emerging trends and new policies impacting health care access and delivery for vulnerable populations.

4.0 AREAS OF IDENTIFIED NEED

CONTENTS

OVERVIEW

THE FOLLOWING SECTION HIGHLIGHTS AREAS OF SAN FRANCISCO WHERE NEW MEDICAL DEVELOPMENT COULD BE PRIORITIZED TO ADDRESS HEALTH DISPARITIES, SERVE FUTURE GROWTH, AND IMPROVE EQUITABLE ACCESS TO HEALTH CARE.

These maps are intended to inform policymakers, health care providers, and the broader community about areas of the city which may have higher health needs. They can also be used for medical facility projects that are required to submit a Consistency Determination application, in order to illustrate how the proposed facility could help meet a demonstrated health need.

It is important to note that these maps are not all-inclusive, and that readers should also refer to the various assessments sections in order to access additional data on health services and needs.

Each of the maps include Zuckerberg San Francisco General Hospital, SFDPH primary care clinics, and San Francisco Community Clinic Consortium (SFCCC) network clinics. SFCCC is a partnership of nonprofit health centers in San Francisco, which have long been the source of primary care, behavioral health and dental care for low-income, uninsured, and medically underserved populations. SFCCC represents 11 member clinics, operating 27 sites and providing care to over 112,000 patients in San Francisco's most vulnerable neighborhoods.

1.DEMOGRAPHICS

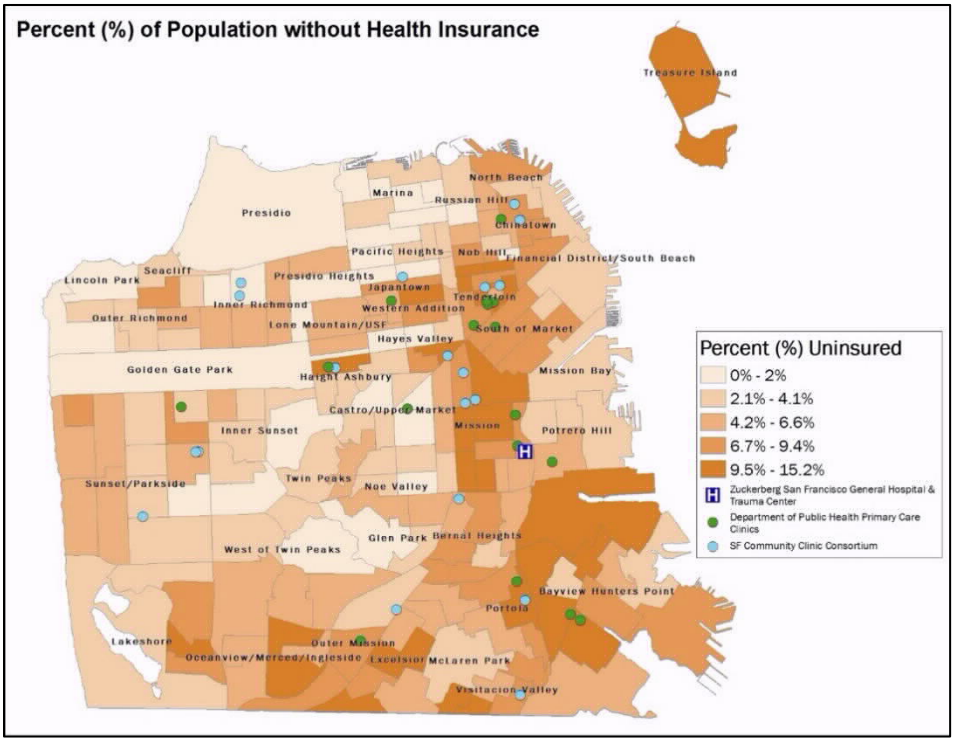
AS STATED IN THE 2019 SAN FRANCISCO COMMUNITY HEALTH NEEDS ASSESSMENT, TRACKING DEMOGRAPHIC INFORMATION IS CRITICAL FOR PLANNING FUTURE NEEDS OF A POPULATION. THE FOLLOWING SECTION INCLUDES MAPS OF DEMOGRAPHIC DATA, I.E. STATISTICAL INFORMATION ABOUT A POPULATION.

Insurance Status

Health insurance is a type of insurance coverage that covers the cost of an insured individual's medical and surgical expenses. There are two types of health insurance, public and private. Public Health insurance is insurance that is subsidized by government funds. Private health insurance is paid for by the individuals being covered. Private health coverage is most commonly offered through employer-based health insurance and can also be purchased by individuals on an insurance marketplace.

Health insurance coverage is a key aspect of health care access. The ability to access health care has effects on one's physical, social, and mental health. Having proper access to health care can prevent disease or disability, detect and treat illnesses, maintain quality of life, delay death, and extend life expectancy. Rates of health insurance coverage are important indicators of a community's ability to access health services and a community's overall health. The neighborhoods with the highest percent of individuals uninsured include Treasure Island, Bayview Hunters Point, Excelsior, Mission, Tenderloin, Haight Ashbury, Western Addition, and Japantown.

Figure 4.0 – 1.1. Percent of Population without Health Insurance, 2013-2017 [8]



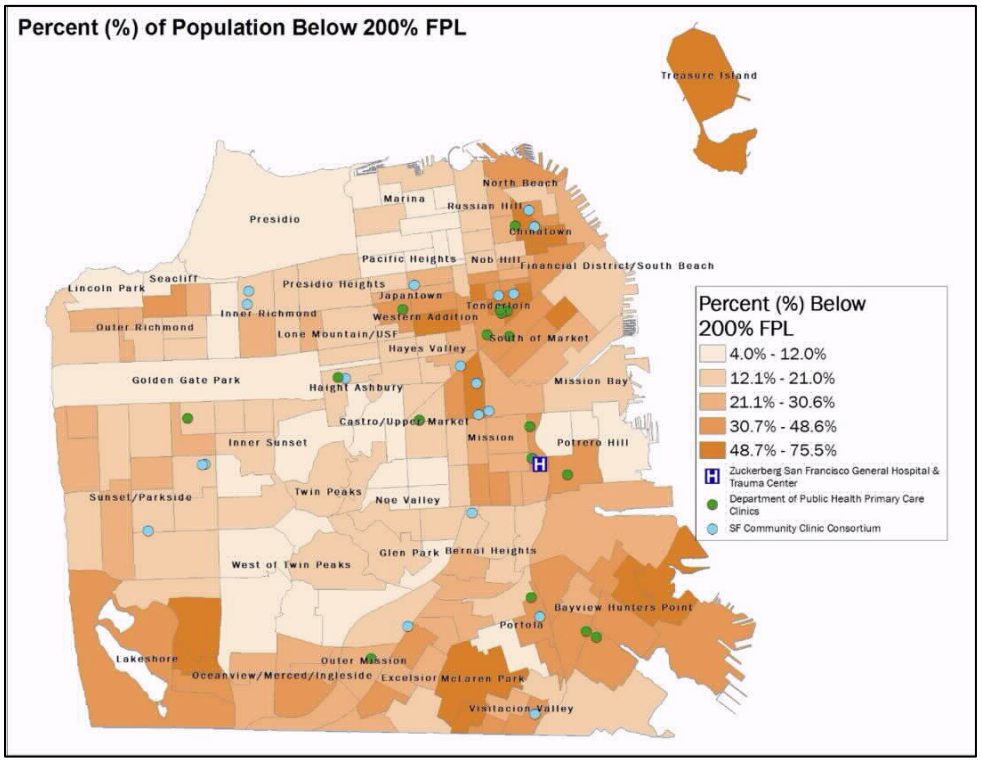
[8] U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Poverty

Economic status is a key factor in predicting an individual's health. Income increases access to resources that positively impact health, most specifically health care. The impact of income on health begins early in life as studies have shown a relationship between income and birth weight, child development, the risk of chronic disease later in life, and total life expectancy.[9] In 2017, the Federal Poverty Level (FPL) for an individual was $12,060 annual income and $24,600 annual income for a family of four.

Figure 4.0 – 1.2 shows the percent of individuals living below 200% of the FPL, or otherwise stated as, the percent of individuals with an annual income less than $24,120. From the map we can see that census tracts in the Bayview Hunters Point, McLaren Park, Lakeshore, Tenderloin, Chinatown, and Treasure Island neighborhoods have the highest rates of individuals living in poverty. See the *Community Health Assessment* chapter for more information about how poverty impacts the health of San Francisco's population.

Figure 4.0 – 1.2. Percent of Population Living Below 200% Federal Poverty Level (FPL)[10], 2013-2017[11]



[9] Paula Braveman, Susan Egerter, and Colleen Barclay. Exploring the social determinants of health: Income, wealth and health. Technical report, Robert Wood Johnson Foundation, 2011.

[10] The Federal Poverty Level (FPL) in 2017 for an individual was $12,060 annual income.

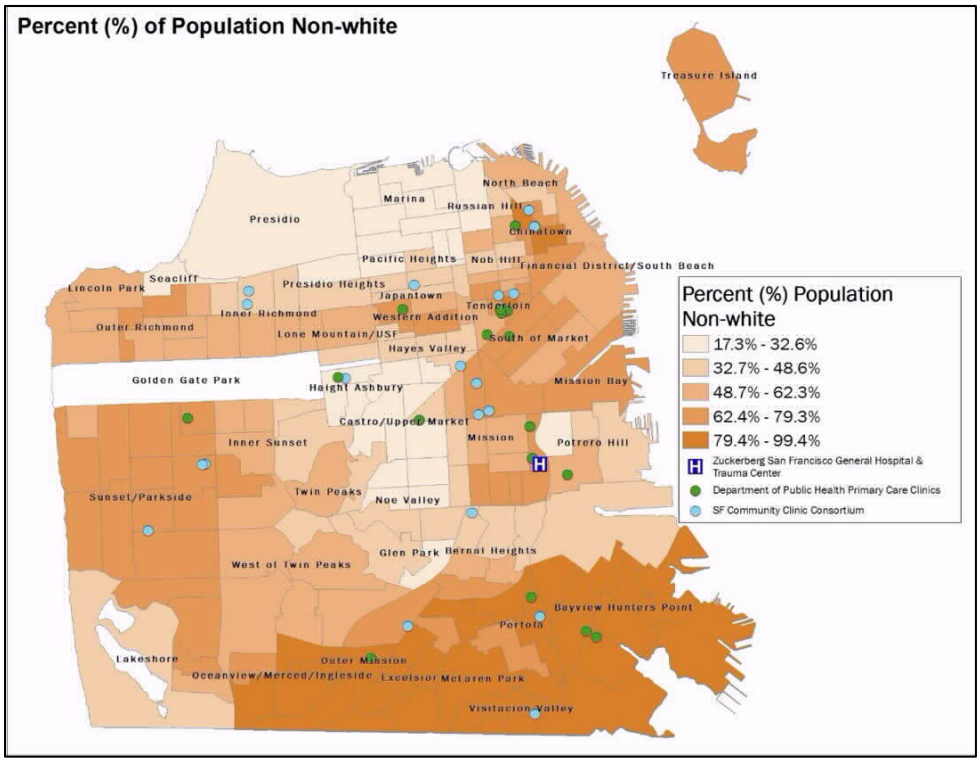
[11] U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Persons of Color

San Francisco is a majority minority city, meaning that people of color account for approximately 58% of the total population. Figure 4.0 – 1.3 displays the geographic distribution of the non-White population throughout the City.

The largest proportion of people of color live in the southeast part of the city in the Bayview Hunters point, Visitation Valley, Portola, McLaren Park, Excelsior, Outer Mission, and Oceanview/Merced/Ingleside neighborhoods. Demographic projections indicate that while the multi-ethnic population is expected to rise, the African American, Asian, and Latinx resident populations are expected to decline between 2018 and 2060. Conversely, the white population is expected to increase by 9.5%. This trend is the opposite of what is expected statewide, where there is a projected decrease in the proportion of residents who are white and significant growth in the Latinx population.[1, 12]

Figure 4.0 – 1.3. Percent of Population Non-White, 2013-2017 [13]



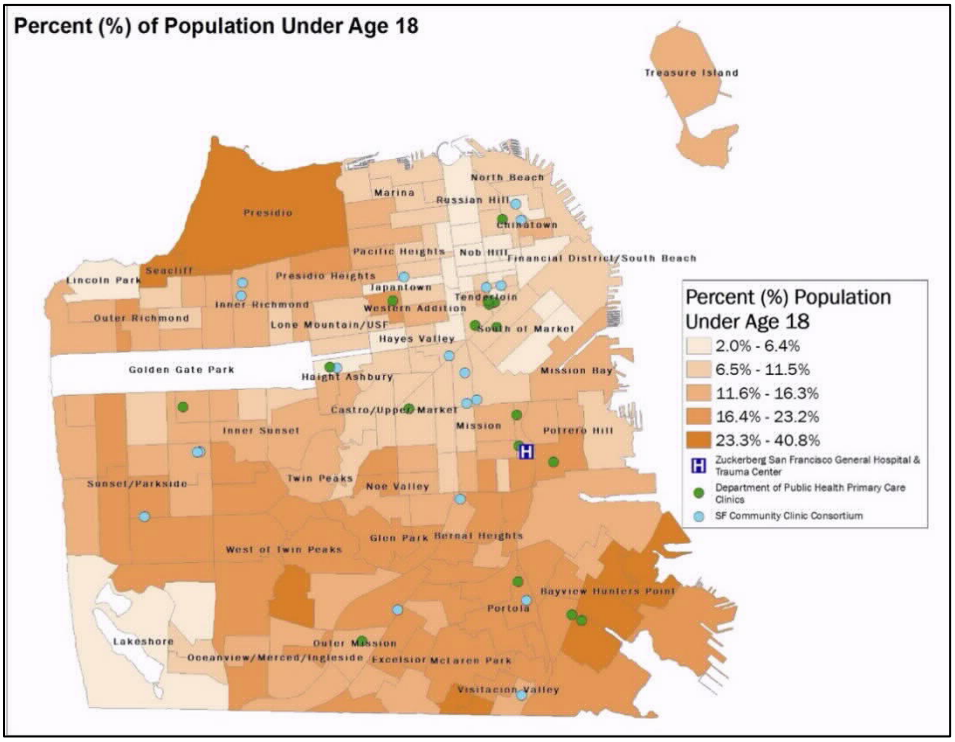
[12] California Department of Finance. Demographic Projections. Retrieved from: http://www.dof.ca.gov/Forecasting/Demographics/Projections/

[13] Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Children & Youths

The population under 18 years makes up approximately 13.5% of the total population. A city with a young population may have increased demands for resources like childcare services, schools and after-school education programs. Figure 4.0 – 1.4 shows the geographical distribution of the population under 18 years of age throughout San Francisco.

Figure 4.0 – 1.4. Percent of Population Under 18 Years, 2013-2017 [14]

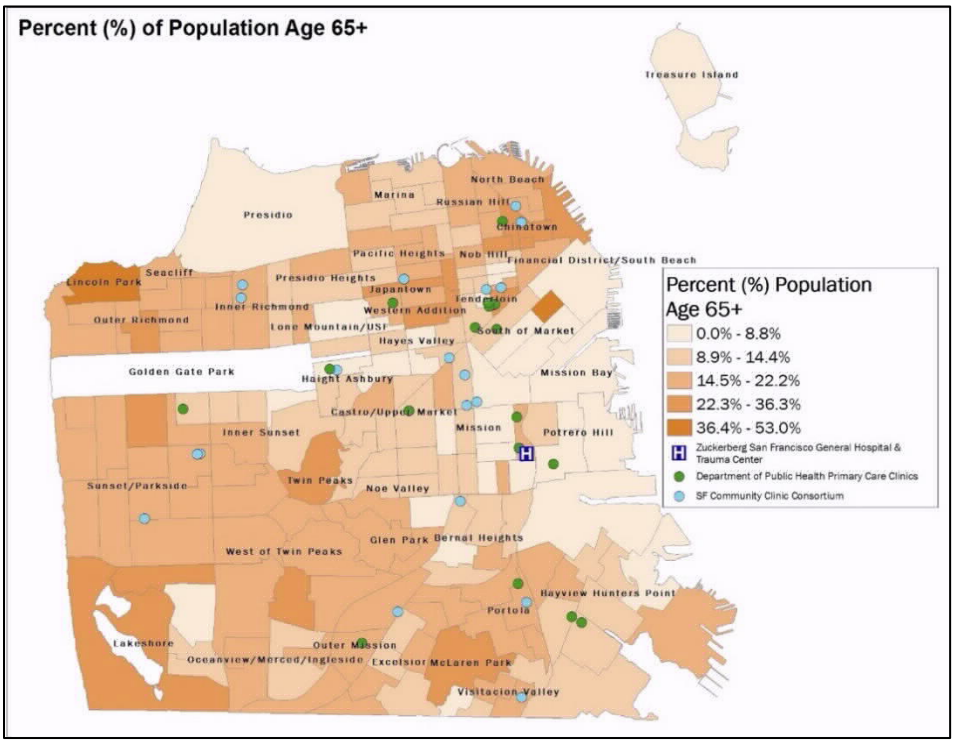


[14] Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Seniors

As populations age, the need for health care services increases. Older adult populations have higher utilization of health care services compared to younger populations. California is expected to see a 128% increase in the population age 65 and older, and in San Francisco specifically, the older adult age-group is expected to have the greatest rate of growth compared to other age groups. Figure 4.0 – 1.5 shows the geographic distribution of the older adult population in San Francisco.

Figure 4.0 – 1.5. Percent of Population Age 65+, 2013-2017 [15]



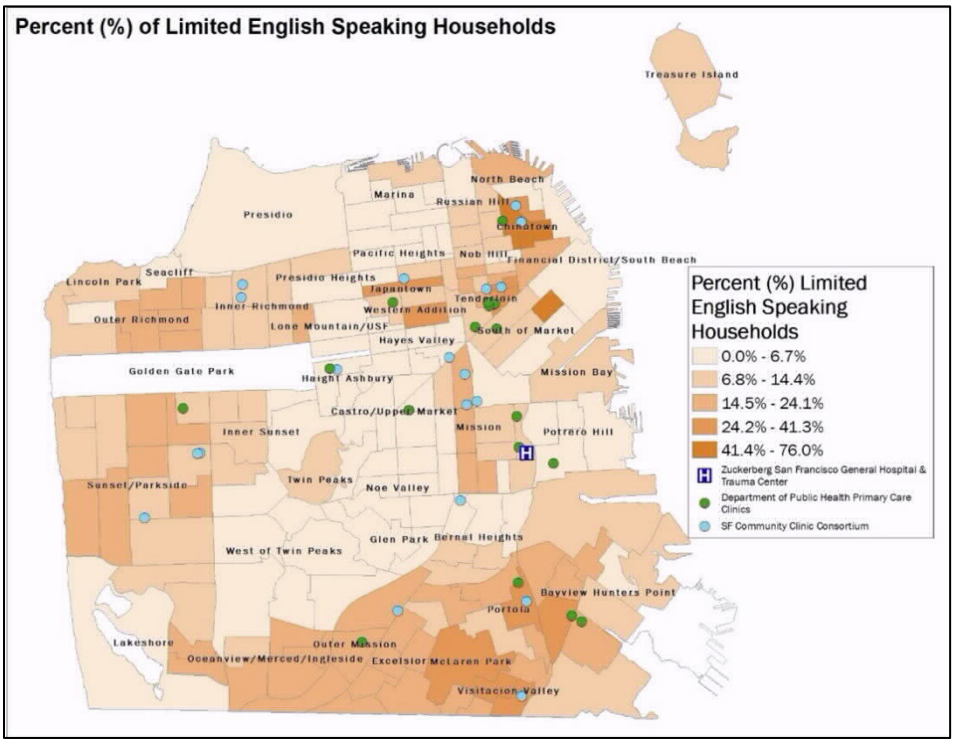
[15] Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Limited English Proficiency (Linguistically Isolated Households)

About 24% of San Franciscans, age five years and older, have limited ability to speak English.

Among San Francisco residents that have limited English proficiency, Chinese (Mandarin, Cantonese, and others) and Spanish are the most common non-English languages spoken. Chinatown is the neighborhood with the highest proportion of residents with limited English proficiency.

Figure 4.0 – 1.6. Percent of Limited English-Speaking Households, 2013-2017 [16]

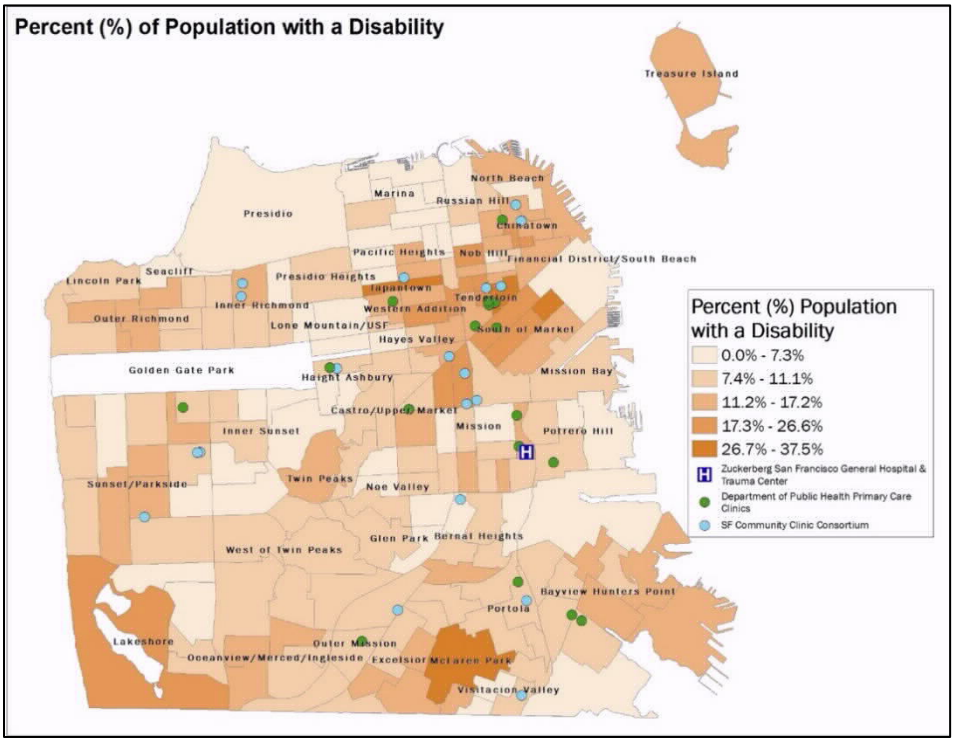


[16] Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Disability

Approximately 10% of San Franciscans report having a disability, and almost half of people with a disability are under age 65. The most common type of disability reported by San Francisco residents are mobility disabilities, which can be even more challenging in a city setting. Disability rates in San Francisco also vary by ethnicity, with African Americans being twice as likely to have a disability compared to other groups. As stated by the San Francisco Human Services Agency Department of Aging and Adult Services (DAAS), investing in the disabled community is important for the future of the City.[17] Figure 4.0 – 1.7 shows the geographical distribution of the percent of the population who have a disability.

Figure 4.0 – 1.7. Percent of Population with a Disability, 2013-2017[18]



[17] San Francisco Human Services Agency Department of Aging and Adult Services (DAAS). Disability in San Francisco, 2018. Retrieved from: https://www.sfhsa.org/file/7416/download?token=AkjlCEOc

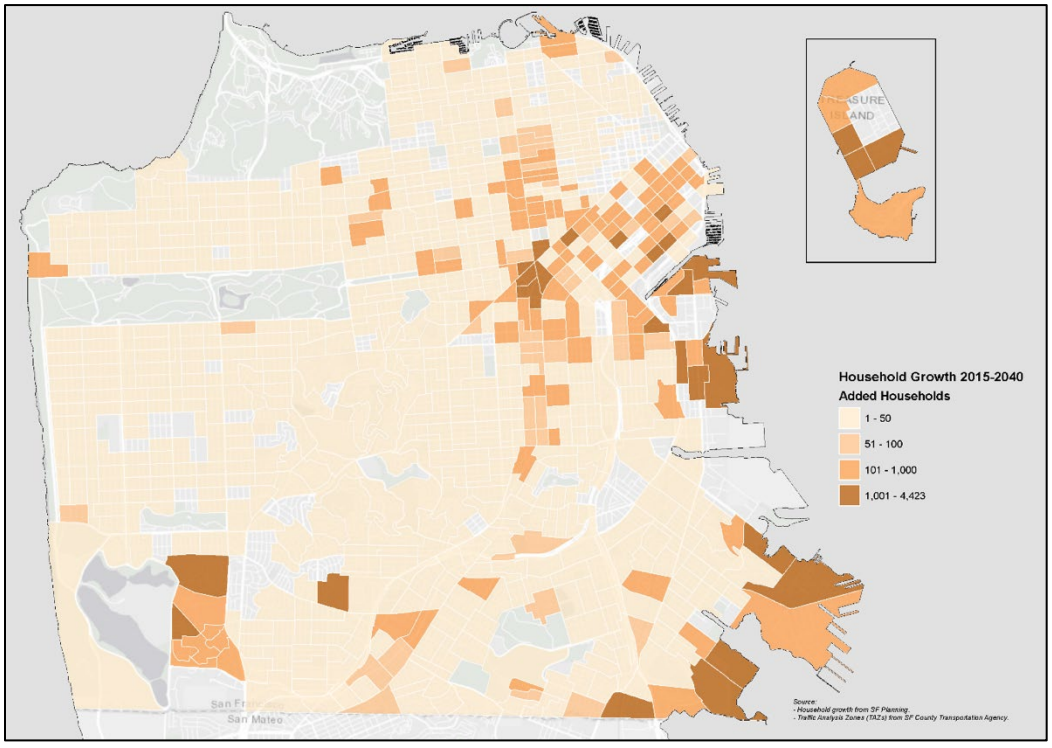
[18] Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

2.PROJECTED POPULATION GROWTH

THE PROJECTED POPULATION GROWTH MAP SHOWS AREAS OF SAN FRANCISCO THAT ARE EXPECTED TO ADD ADDITIONAL HOUSEHOLDS BY 2040. THE METROPOLITAN TRANSPORTATION COMMISSION (MTC) AND ASSOCIATION OF BAY AREA GOVERNMENTS (ABAG) PERIODICALLY DEVELOP PROJECTIONS OF REGIONAL JOB AND POPULATION GROWTH AS PART OF THE PLAN BAY AREA PROCESS. THESE REGIONAL ESTIMATES ARE THEN ALLOCATED TO CITIES AND COUNTIES.

In San Francisco, the Planning Department further allocates future population and job projections to areas of the city where that growth can be expected to occur through its Land Use Allocation (LUA) process. The LUA looks at existing unused zoning capacity, major residential and commercial projects in the pipeline, and expected future growth (for instance, due to rezoning or large development projects) to predict where future residents and jobs will locate. Major population growth is expected in the Bayview, Treasure Island and Parkmerced developments, which are relatively distant from existing healthcare facilities.

Figure 4.0 – 2.1. San Francisco Household Growth from 2015-2040 by Traffic Analysis Zones (TAZ)[19]



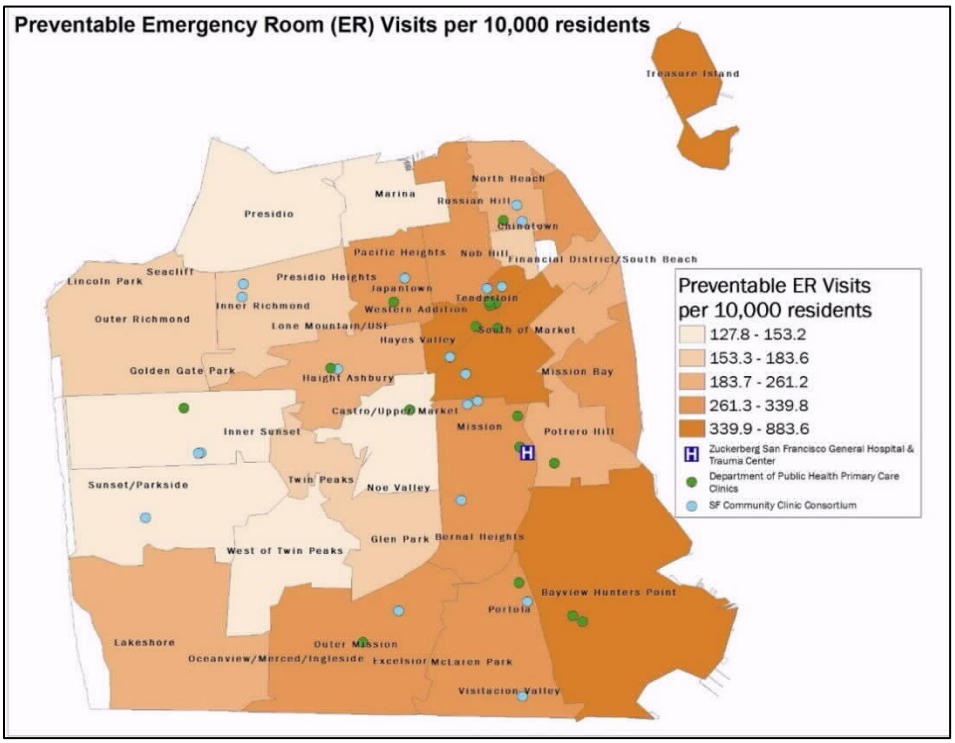
[19] Source: Household growth data from San Francisco Planning; Traffic Analysis Zones (TAZs) from San Francisco County Transportation Agency

3.PREVENTABLE ER VISITS

HIGH RATES OF PREVENTABLE EMERGENCY ROOM VISITS AND HOSPITALIZATIONS ARE CONSIDERED INDICATORS OF INADEQUATE ACCESS TO PRIMARY CARE. THE CALIFORNIA OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHPD) TRACKS STATEWIDE DATA ON PREVENTABLE EMERGENCY ROOM VISITS.

The map included here shows the number of preventable ER visits per 10,000 residents, broken down by zip code. Preventable hospitalizations and emergency room visit rates are higher in the Bayview, Tenderloin and South of Market areas, which correlates with the higher rates of poverty, homelessness, and lower rates of insurance coverage in these neighborhoods.

Figure 4.0 – 3.1. Age-Adjusted Preventable Emergency Room Visit Rate per 10,000 Residents by Zip Code, all ages, 2012-2016[20]



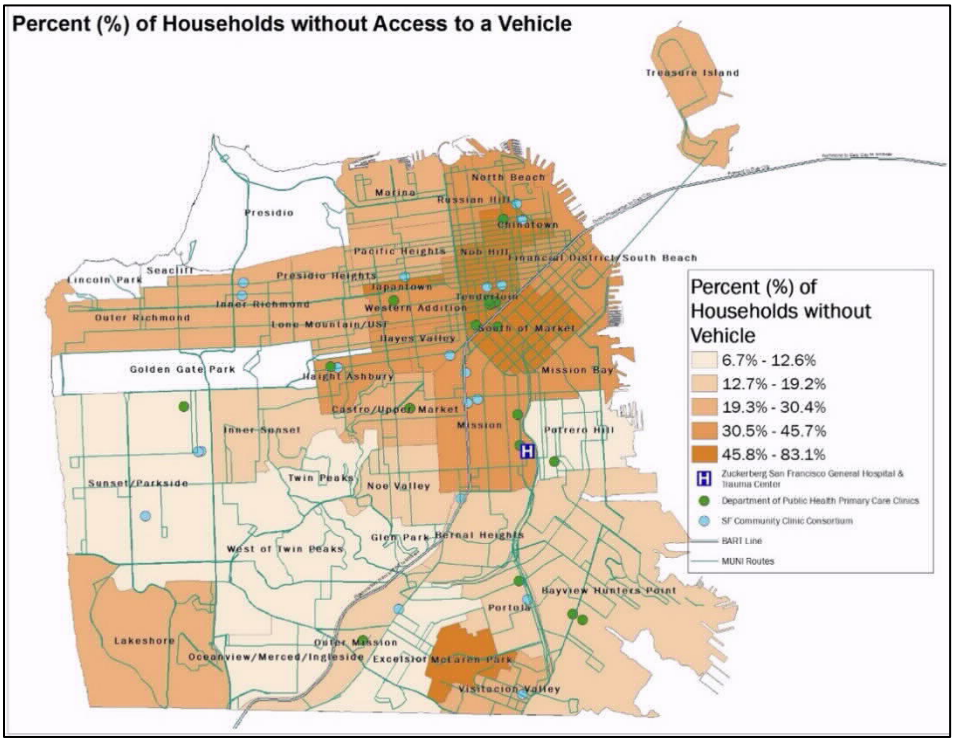
[20] Source: California Office of Statewide Health Planning and Development, 2012-2016

4.TRANSIT TRAVEL TIME TO HOSPITALS

PEOPLE WHO MUST TRAVEL LONGER AND/OR GREATER DISTANCES TO HEALTH CARE SERVICES ARE LESS LIKELY TO USE OUTPATIENT AND PREVENTIVE HEALTH SERVICES AND ARE MORE LIKELY TO VISIT THE EMERGENCY ROOM. THIS SUGGESTS THAT PATIENTS ARE LESS RELIANT ON COSTLY EMERGENCY CARE WHEN PRIMARY CARE IS READILY AVAILABLE.

In San Francisco, where 50% of low-income households do not have access to a car, transit access to health care is especially important. The map below displays vehicle accessibility by neighborhood. The Lakeshore, McLaren Park and Treasure Island neighborhoods have a high proportion of their residents without access to a vehicle, making these residents even more isolated from health care services. State licensing standards for Medi-Cal funded programs set the target that patients should be no more than 30 minutes of travel time from primary health care services.

Figure 4.0 – 4.1. Percent of Households without a Vehicle, 2012-2016[21]



[21] Source: American Community Survey, 2012-2016

5.0 HEALTH CARE SERVICES MASTER PLAN ASSESSMENTS

CONTENTS

5.1 COMMUNITY HEALTH ASSESSMENT

CONTENTS

OVERVIEW

THE COMMUNITY HEALTH ASSESSMENT COMPONENT OF THE HCSMP HIGHLIGHTS MAJOR HEALTH TRENDS IN MORBIDITY/MORTALITY AND IDENTIFIES SOCIAL DETERMINANTS OF HEALTH IN SAN FRANCISCO. THIS COMMUNITY HEALTH ASSESSMENT RELIES IN LARGE PART ON THE 2019 SAN FRANCISCO COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA).[22]

The CHNA, which is conducted every three years by the San Francisco Health Improvement Partnership (SFHIP)[23], is a community-driven assessment of health outcomes and disparities in San Francisco, and the key economic and social determinants of poor health. It reviews local risk and protective factors for health and provides disease and death rates for conditions across neighborhoods, race, age, and income. The creation of the CHNA involves four steps: (1) community health status assessment, (2) review of prior assessments, (3) community engagement, and (4) health need identification. This effort was led by SFHIP in partnership with SFDPH. The CHNA is critical toward informing DPH's work and is also used by health care service providers and community-based organizations as part of their programs and reporting activities.

The 2019 CHNA data show that, overall, San Francisco fares well in key health areas compared to other counties in the state and the nation; however, the data also clearly demonstrate that the City and County of San Francisco, with its diverse population and contrasting neighborhood communities, has key opportunities to reduce health disparities and inequities. The following highlights some indicators of health that have improved in San Francisco in recent years:

- **Insurance:** More San Franciscan's have health insurance.
- **HIV:** The estimated rate of new HIV infection in San Francisco has continued to decrease.
- **Life Expectancy:** Life expectancy has increased for all San Franciscans with the largest gains seen by Black/African Americans.
- **Cancer:** Mortality rates due to lung, colon, and breast cancers and influenza and pneumonia continue to decline.
- **Tobacco:** The availability of tobacco products has decreased and at 11%, rates of smoking are lower than the HP2020 goal of 12%.
- **Preventable Deaths:** 2017 had the lowest number of traffic-related fatalities since record keeping began in 1915.

The following sections highlight key findings from the CHNA. The full report is available on the SFDPH website.

[22] San Francisco Health Improvement Partnership. San Francisco Community Health Needs Assessment 2019. Retrieved from: http://www.sfhip.org/
[23] The San Francisco Health Improvement Partnership (SFHIP) is a cross-sector collaboration designed to improve the health and wellness of all San Franciscans.

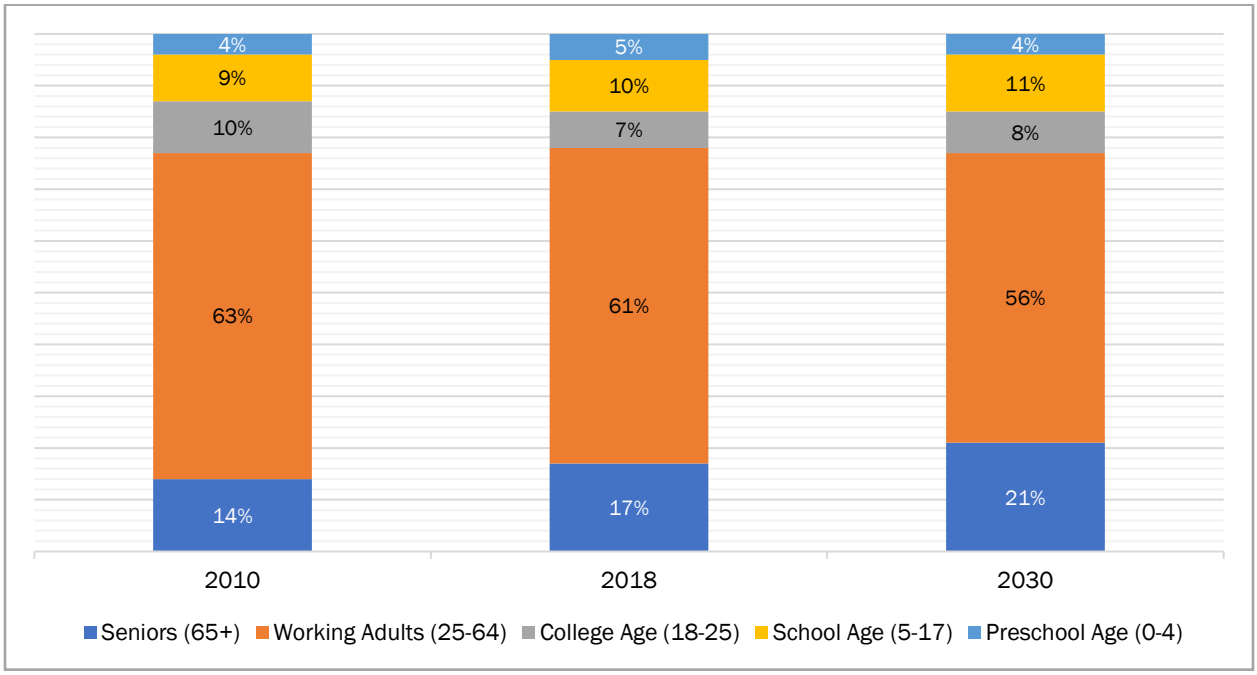
1. DEMOGRAPHICS

BETWEEN 2011 AND 2018, THE POPULATION OF SAN FRANCISCO GREW BY ALMOST 8% TO 888,817, OUTPACING GROWTH IN CALIFORNIA (6%). ACCORDING TO THE STATE OF CALIFORNIA DEPARTMENT OF FINANCE, BY 2030, SAN FRANCISCO'S POPULATION IS EXPECTED TO TOTAL NEARLY 980,000 AND BY 2060 IS ESTIMATED TO BE NEARLY 1.2 MILLION.[24]

As of 2017, the median age of residents in San Francisco is slightly older than that of the state of California (38.3 years old to 36.2 years old).[25] Looking ahead, the greatest population growth in San Francisco is expected to be among the 65-plus age group, which is estimated to increase from 17% of the total population in 2018, to 21% in 2030, and is projected to reach 29% in 2060. Within the older adult population, the largest increase is anticipated to be the population aged 75 and up.

Figure 5.1 - 1.1 compares the age composition of the city in 2010 compared to projections for 2030.

Figure 5.1 - 1.1 San Francisco Population by Age 2010, 2018 and 2030



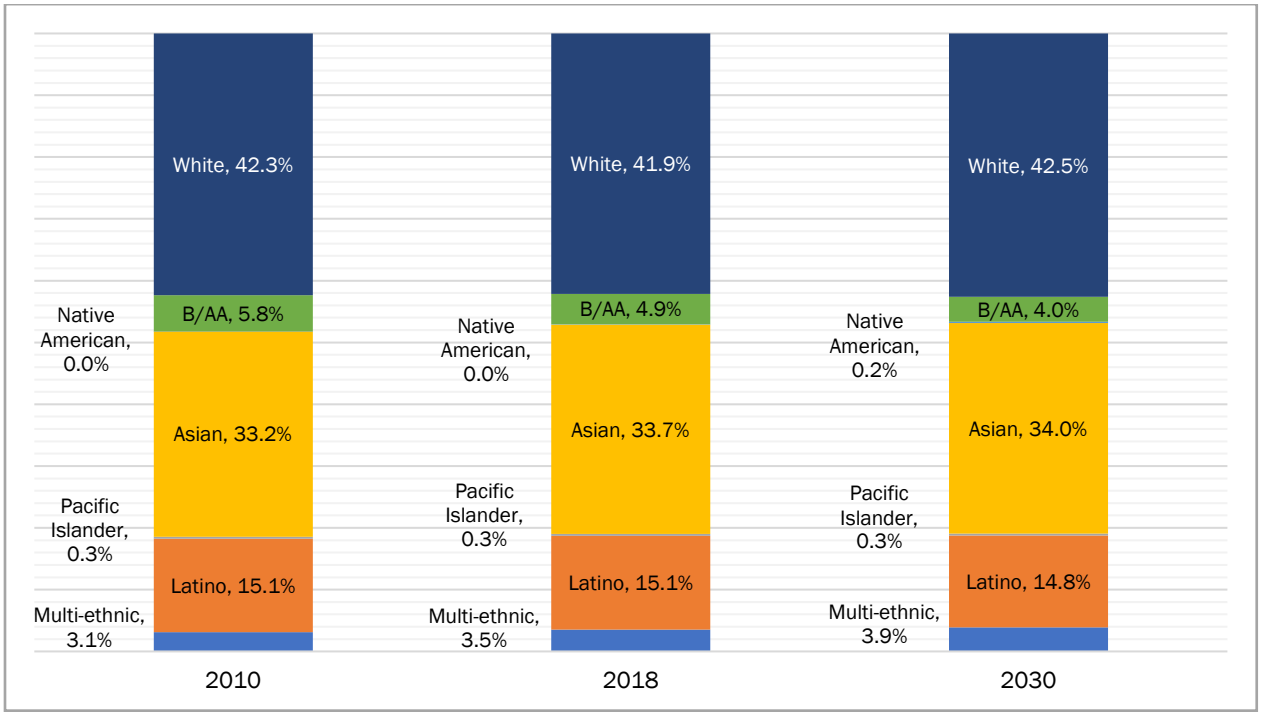
Source: State of California Department of Finance, 2018

[24] State of California Department of Finance. Report p-2: County Population Projections (2010-2060) by Age. Sacramento, California, 2018.
[25] US Census Bureau. American Community Survey. https://www. census.gov/programs-surveys/acs/, 2012-16.

Similarly, the race and ethnic composition of San Francisco has shifted over the recent decade. San Francisco is a majority minority city in that people of color account for 58% of the City's total population. Asians represent the largest minority population (33.7%), followed by Latinos (15.1%). The Black/African American community has experienced the greatest recent change in population. Between the years 2010 and 2018, the Black/African American population shrank by 15.5%, now comprising 4.9% of the city's total population. Demographic trend analyses estimate that by 2060, Black/African Americans will make up approximately 3% of the San Francisco population.[26]

Figure 5.1 - 1.2 shows how the City's racial/ethnic composition is projected to change; looking back to 2010 and looking forward to 2030. The City will continue to see a greater proportion of people of color, though not all subgroups are projected to increase. Although the proportion of whites is projected to decrease, the actual number of whites in San Francisco is projected to continue increasing, due to relative population growth.

Figure 5.1 - 1.2. San Francisco Population by Race/Ethnicity 2010, 2018 and 2030



Source: State of California Department of Finance, 2018

[26] State of California Department of Finance. Report p-2: County Population Projections (2010-2060) by Race/Ethnicity. Sacramento, California, 2018.

2. FOUNDATIONAL ISSUES

Racial Health Inequities

IN SAN FRANCISCO AND ACROSS THE UNITED STATES, COMPARED TO WHITES, MEMBERS OF RACIAL AND ETHNIC MINORITY POPULATIONS ARE LESS LIKELY TO RECEIVE PREVENTIVE HEALTH SCREENINGS AND OFTEN LOWER-QUALITY HEALTH CARE. IN TURN, RACIAL AND ETHNIC MINORITY POPULATIONS HAVE WORSE HEALTH OUTCOMES FOR MANY HEALTH CONDITIONS. RESEARCH AND BEST PRACTICES HAVE SHOWN THAT IT IS THE DUTY OF HEALTH CARE PROFESSIONALS TO ACKNOWLEDGE THE IMPACT THAT RACISM HAS IN HEALTH CARE AND TAKE STEPS TO ADDRESS IT.[27]

Interpersonal and structural racism are two types of racialized social interaction that impact health disparities in San Francisco. Briefly described, interpersonal racism is more commonly described as everyday racism or bias. Interpersonal racism represents the impacts of daily experiences and stressors for populations of people of color. Structural or institutional represents the historical and current system in which racism is developed, maintained and protected, which in turn impacts the accessibility of marginalized populations through society.

In San Francisco there continues to be several socioeconomic and health issues disproportionately impacting minority populations. For example, socioeconomic and health outcome indicators for Black/African American populations in San Francisco show disparities across the life course. Black/African American pregnant women are more likely to experience food insecurity compared to white pregnant women. Nearly 46% of Black/African American children live in poverty, and Black/African American youth make up over 57% of bookings in San Francisco juvenile hall despite making up only 6% of the total youth population. White households typically earn four times the median income compared to Black/African American households, and Black/African Americans in San Francisco have a shorter life expectancy by nine years compared to whites.

Recognizing and understanding racial and ethnic health disparities and inequities is a critical step in identifying the vulnerable populations in a community, and furthermore, a key component of effective public health planning.

It should be noted that while a few disparity data points were referenced in this section, racial and ethnic disparities regarding health outcomes and health care accessibility are addressed throughout this chapter and the other HCSMP assessments.

Income Inequality & Poverty

INCOME AND POVERTY HAVE CYCLICAL IMPACTS ON AN INDIVIDUAL'S HEALTH. RESEARCH SHOWS THAT INCOME IS ASSOCIATED WITH POOR HEALTH THROUGH CLINICAL, BEHAVIORAL, SOCIAL AND ENVIRONMENTAL MECHANISMS, AND THAT OFTEN TIMES POOR HEALTH FURTHER CONTRIBUTES TO REDUCED INCOME. INCOME-RELATED HEALTH DISPARITIES APPEAR TO BE GROWING OVER TIME.[28]

San Francisco has high levels of income inequality, with the wealthiest 5% of households in SF earning 16 times more than the poorest

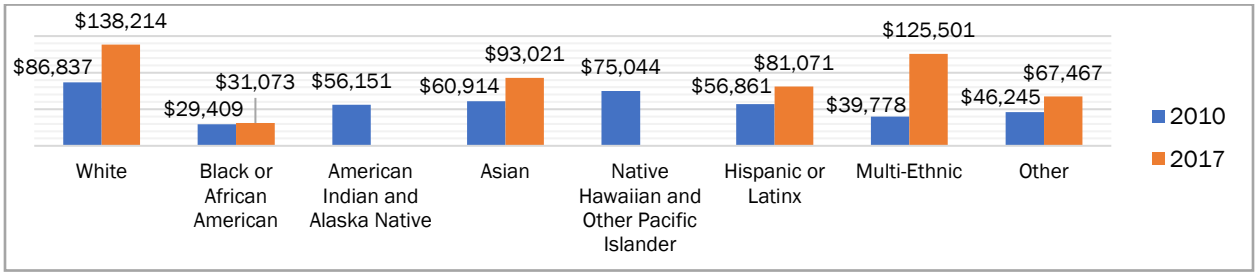
[27] Hostetter, M., Klein, S., In Focus: Reducing Racial Disparities in Health Care by Confronting Racism. The Commonwealth Fund. September 27, 2018. Retrieved from: https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting

[28] Khullar, D., Chokshi, D. Health, Income, & Poverty: Where We are and What Could Help. Health Affairs. October 4, 2018. Retrieved from: https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/

20% of households.[29] In San Francisco in 2017, 10% of residents lived below 100% of the federal poverty level (FPL) and more than one in five residents lived below 200% of FPL. For a family of four, 200% FPL is $50,200.[30] For a family of four in San Francisco, an income of greater than $120,000 is necessary to meet all their needs.[31] Low income groups have greater risk for a wide range of health issues culminating to shorter life expectancy. People who live in communities with larger income disparity have a higher likelihood of premature death (death before age 75) compared to people who live in communities with less income disparity.[32] The neighborhoods with the highest proportion of residents living below 200% FPL are Chinatown, Tenderloin, Lakeshore, McLaren Park, and Treasure Island – which all have more than 50% low-income residents.

Economic disparities are not just visible across San Francisco neighborhoods, but are also visible across race and ethnic groups as illustrated in Figure 5.1 - 2.1. On average, people of color in San Francisco have lower household incomes than Whites. Between 2010 and 2017, Whites earned more than four times the amount earned by Black/African Americans.[33,34] In 2017, the unemployment rate in San Francisco was 4.5% - the lowest it has been in the past 10 years. However, Black/African American and Pacific Islander residents have the lowest employment rates (83% and 84%, respectively), while all other race/ethnic groups have employment rates over 90%. One factor that may be contributing to this disparity is that Black/African Americans in San Francisco are one-third as likely as Whites to have a bachelor's degree or higher and five times more likely to have less than a high school education.[35]

Figure 5.1 - 2.1. San Francisco Median Household Income by Race/Ethnicity, 2010 vs. 2017



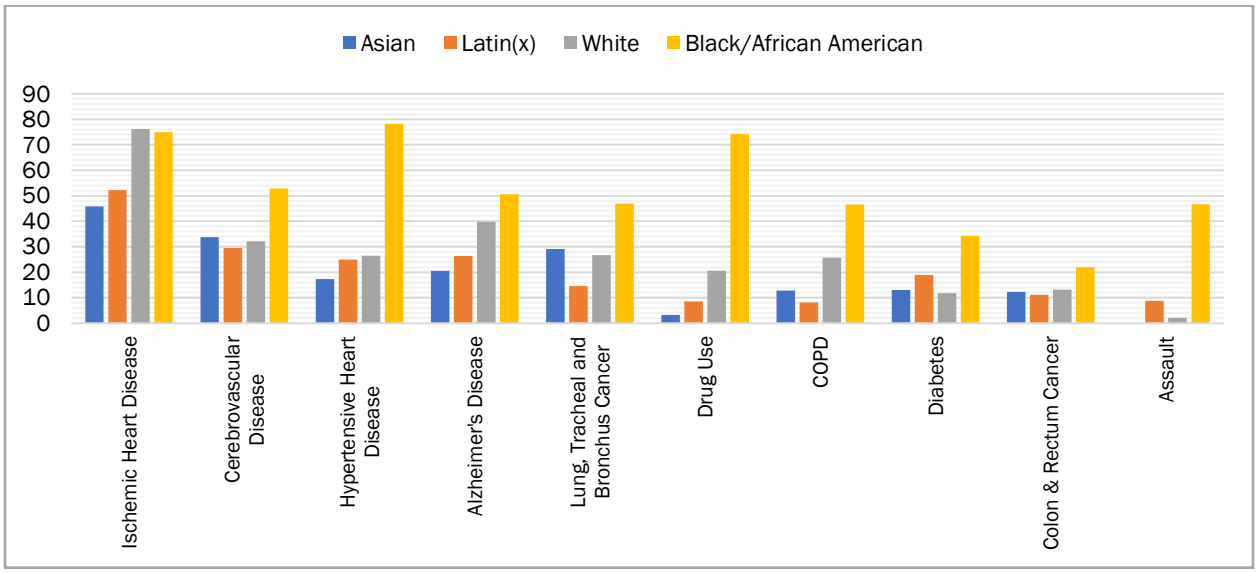
Source: American Community Survey, 2010 & 2017.
Note: For some race/ethnicity groups, data was not available in 2017 due to small population sample size.

[29] Alan Berube. City and metropolitan income inequality data reveal ups and downs through 2016. https://www.brookings.edu/research/city-and-metropolitan-income-inequality-data-reveal-ups-and-downs-through-2016/, February 2018.
[30] HealthCare.gov. Federal poverty level (fpl). https://www.healthcare.gov/glossary/federal-poverty-level-fpl/, Accessed 12/3/18.
[31] Insight Center for Community Economic Development. The self-sufficiency standard for California. http://www.selfsufficiencystandard.org/california, 2018.
[32] Paula Braveman, Susan Egerter, and Colleen Barclay. Exploring the social determinants of health: Income, wealth and health. Technical report, Robert Wood Johnson Foundation, 2011.
[33] US Census Bureau. American Community Survey. https://www.census.gov/programs-surveys/acs/, 2010.
[34] US Census Bureau. American Community Survey. https://www.census.gov/programs-surveys/acs/, 2017.
[35] US Census Bureau. American Community Survey. https://www.census.gov/programs-surveys/acs/, 2012-16.

3. MORTALITY & LIFE EXPECTANCY

APPROXIMATELY 60% OF DEATHS IN SAN FRANCISCO ARE CAUSED BY CHRONIC DISEASES. FOR THE 2015-2017 TIME PERIOD, CARDIOVASCULAR DISEASES REPRESENTED FOUR OF THE TOP 20 LEADING CAUSES OF DEATH IN SAN FRANCISCO; THESE INCLUDE: ISCHEMIC HEART DISEASE, INFLAMMATORY HEART DISEASE, HYPERTENSIVE DISEASE, AND CEREBROVASCULAR DISEASE. THESE FOUR CARDIOVASCULAR DISEASES, ALONE, ACCOUNTED FOR NEARLY 25% OF ALL DEATHS IN SAN FRANCISCO.

Figure 5.1 - 3.1. Top 10 Leading Causes of Death in San Francisco by Race/Ethnicity, 2015-2017 (age-adjusted rates per 100,000 pop)



Source: California Department of Public Health, 2015-2017

Six of the 20 leading causes of death in San Francisco were cancers, which account for 15% of all deaths in San Francisco. These cancers include: Lung, Tracheal and Bronchial, Colon, Pancreatic, Liver, Breast, Lymphoma and Prostate. While a significant proportion of the leading causes of death are chronic diseases, other diseases such as substance use – drug use and alcohol dependence, suicide, and influenza and pneumonia are leading causes of death. As depicted in Figure 5.1-3.1, Black/African Americans in San Francisco are disproportionately affected by nearly all the top ten leading causes of death.[36,37]

The average life expectancy for a typical San Franciscan is just over 83 years, which is a few years older than the average US life expectancy of 78 years. Life expectancy does, however, vary by race/ethnicity in San Francisco. On average, Asians can expect to live the longest (87 years). According to the most recent data (2015-2017), Black/African Americans and Pacific Islanders have an average life expectancy of only 72 to 76 years, nearly 11-15 years less when compared to the race/ethnic group with the longest life expectancy in San Francisco. Black/African American men are more likely to die younger than persons of other race/ethnicities. Women have a longer life expectancy than men across all race/ethnicities.[38]

[36] San Francisco Health Improvement Partnership. Community Health Needs Assessment. Retrieved from: http://www.sfhip.org/mortality.html.

[37] California Department of Public Health. Death Statistical Master File.

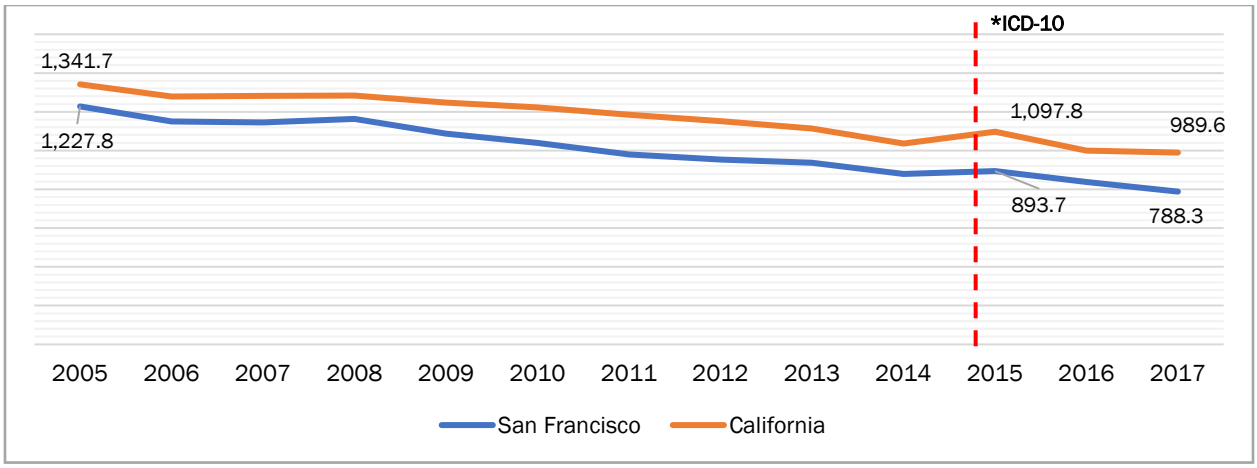
[38] California Department of Public Health. Death Statistical Master File

4. PREVENTABLE VISITS

PREVENTABLE HOSPITAL VISITS ARE THOSE WHICH COULD BE PREVENTED THROUGH ACCESS TO HIGH QUALITY OUTPATIENT CARE, THUS HIGH RATES OF PREVENTABLE EMERGENCY ROOM VISITS AND HOSPITALIZATIONS CAN BE CONSIDERED INDICATORS OF INADEQUATE ACCESS TO PRIMARY CARE.[39] *REGULAR ACCESS TO QUALITY HEALTH CARE SERVICES HELPS PATIENTS PREVENT DISEASE, AND DETECT AND TREAT ILLNESSES EARLY ON, RESULTING IN INCREASED LIFE EXPECTANCY AND HIGHER QUALITY OF LIFE. IN CALIFORNIA, APPROXIMATELY 3.5 BILLION IS SPENT ON PREVENTABLE HOSPITALIZATIONS.*[40]

According to the most recently available data, San Francisco's overall rate of preventable hospitalizations has decreased over time, however, preventable hospitalizations for certain conditions have increased (including diabetes, hypertension, COPD, and perforated appendix).[41] Specifically, preventable hospitalizations for hypertension and diabetes have increased 45% and 50%, respectively, between 2011 and 2016. This indicates that these diseases are not being well managed at the population level. In 2017, rates of preventable hospitalizations were 788.3 hospitalizations per 100,000 residents in San Francisco, which is lower than the statewide rate of 989.6 hospitalizations per 100,000 residents. As indicated in Figure 5.1 - 4.1, San Francisco has consistently had lower rates of preventable hospitalizations compared to the state of California over time.

Figure 5.1 - 4.1. Preventable Hospitalizations per 100,000: Prevention Quality Overall Composite, 2005-2017

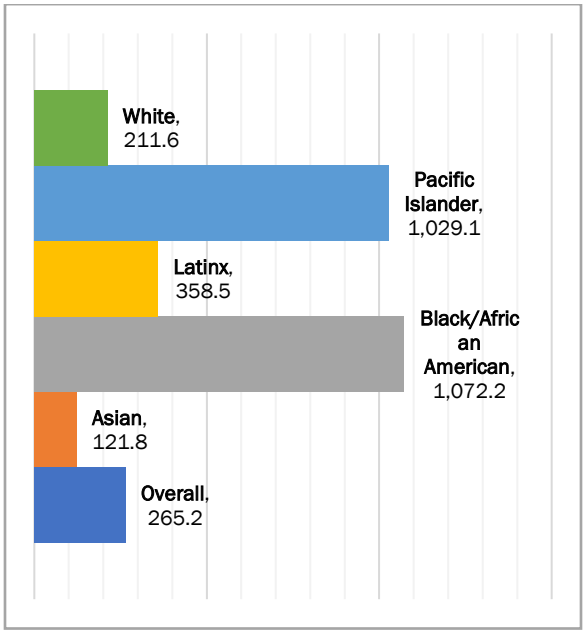


Source: Office of Statewide Health Planning and Development, Preventable Hospitalizations County Dataset, 2005-2017
Note: In 2015, hospitals switched from ICD-9 to ICD-10 as the system of codes used to classify all diagnoses, symptoms and procedures during a patient's visit. Comparisons between ICD-9 and ICD-10 rates should not be made

[39] Healthy People 2020, "Access to Health Services." http://www. healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
[40] Office of Statewide Health Planning and Development. Statewide and County Trends in Access to Quality of Outpatient Care. 2010.
[41] Office of Statewide Health Planning and Development, Preventable Hospitalizations County Dataset, 2005-2017

As noted in Figure 5.1-4.2, the overall rate of preventable emergency room visits in San Francisco for 2012-2016 was 256.2 visits per 10,000 residents. However, there are disparities for race/ethnic groups. Black or African Americans have the highest rate of preventable emergency room visits, followed by Pacific Islanders (1,072.2 visits per 10,000 residents and 1,029.1 visits per 10,000 residents, respectively).[42]

Figure 5.1 - 4.2. Preventable Emergency Room Visit Rates per 10,000 Residents, 2012-2016, by Race/Ethnicity



Source: California Office of Statewide Health Planning and Development, 2012-2016

The rate of preventable emergency room visits in San Francisco is disparate depending on resident zip code. The zip codes with the highest preventable emergency room rates are 94130 (Treasure Island), 94102 (Tenderloin), 94103 (SoMa), and 94124 (Bayview) for both adults and youth. This largely indicates that these communities, specifically, have poor or inadequate access to primary care.

[42] California Office of Statewide Health Planning and Development, 2012-2016

5. HEALTH NEEDS

THE COMMUNITY HEALTH NEEDS ASSESSMENT IDENTIFIES FIVE HEALTH DETERMINANTS, INCLUDING BOTH PHYSICAL AND MENTAL HEALTH, WHICH ARE STRONG PREDICTORS OF DISEASE AND DEATH IN SAN FRANCISCO. THESE HEALTH NEEDS LISTED BELOW ARE SUMMARIZED IN THE FOLLOWING SECTION. ADDRESSING THESE NEEDS ARE CRITICAL TOWARD ENSURING EQUITABLE HEALTH AMONG ALL SAN FRANCISCO RESIDENTS.

- *ACCESS TO COORDINATED, CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE AND SERVICES*
- *FOOD SECURITY, HEALTHY EATING, AND ACTIVE LIVING*
- *HOUSING SECURITY AND AN END TO HOMELESSNESS*
- *SAFETY FROM VIOLENCE AND TRAUMA*
- *SOCIAL, EMOTIONAL, AND BEHAVIORAL HEALTH*

Access to Coordinated, Culturally and Linguistically Appropriate Care and Services

While insurance coverage and enrollment in access programs are primary indicators of access to health care, access to services is influenced by a variety of factors such as: location, affordability, hours of operation, and cultural and linguistic appropriateness of health care services. Adequate access to health care can prevent disease and disability, detect and treat illness, and extend life expectancy. The following section briefly describes access to health care in San Francisco by examining rates of insurance coverage, measures of routine visits and preventative care, and finally by looking at key factors that influence a person's ability to access services: transportation and language.

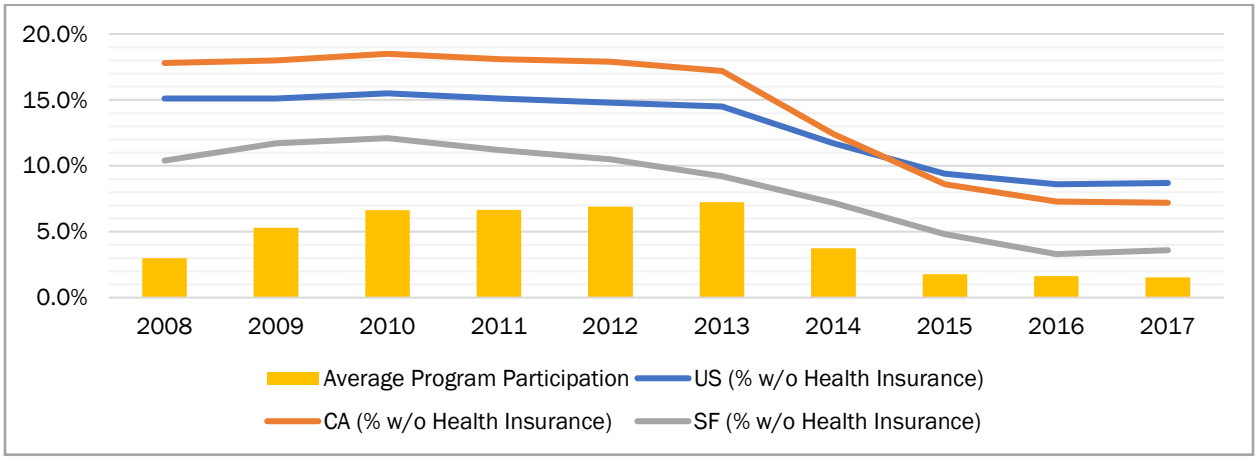
Health Insurance Coverage

From 2015 to 2017, San Francisco saw a reduction of approximately 10,000 uninsured residents as the City continued to see gains in access to health care. Of the estimated 31,500 uninsured residents, close to half access health care through the programs Healthy San Francisco and Healthy Kids. Approximately 2% of the San Francisco resident population does not have access to care.[43]

As indicated in Figure 5.1 - 5.1, San Francisco has continued to have low rates of uninsured compared to the state of California and the United States over the past 10 years. Between 2013 and 2016 there was a sharp decline in the number of uninsured and the number of individuals enrolled in San Francisco's health access programs, which is most likely because of the implementation of the Affordable Care Act (ACA).

[43] Calculated using American Community Survey 2017 estimates and Healthy San Francisco enrollment data.

Figure 5.1 - 5.1. Percentage of Residents without Health Insurance and Percent Participating in San Francisco Health Access Programs (Healthy San Francisco, Healthy Kids), 2008-2017.



On the measure of health insurance coverage, access to health care in San Francisco is better compared to many other places across the nation, but despite this success, significant disparities exist by race, age and income. Young adults between 18-34 and Latinx and Black/African American residents are the least likely to be covered by insurance. Examining insurance rates by neighborhood, Treasure Island, Tenderloin, Mission, Portola, Excelsior, and Outer Mission have the highest percent of residents without health insurance.[44]

Routine Visits & Preventative Care

Despite growth in the percent of the population insured, many San Franciscans are not accessing timely health care. Approximately 8% of San Franciscans do not have a usual place to go for medical care, nearly a quarter (24%) of adult San Franciscans have not had a routine check-up in the past year, and 51% have not had a flu shot in the past year. People ages 25-44 had the highest rates of delaying medical care. [45]

Culturally & Linguistically Appropriate Care

Access to coordinated and appropriate care is influenced by a variety of factors, but two factors were identified in the 2019 CHNA as a community need. These two factors are language and transportation. Compared to the resident population, there is a shortage in the percent of physicians and health care providers who speak Chinese and Tagalog. Similarly, Asian, Black/African American and Latinx physicians are underrepresented relative to the racial and ethnic makeup of San Francisco's population.[46] Research has shown that cultural and language barriers often inhibit positive patient experiences in multicultural urban settings, like in San Francisco. Patients who see providers who speak the same language and have similar cultures report greater trust with their provider, and greater activation and interest in their personal health goals.[47] Patients are more likely to seek medical care when there is an ethnic or linguistic match. Information and data further describing culturally and linguistically appropriate care in

[44] United States Census Bureau. American Community Survey, 2013-2017.
[45] UCLA Center for Health Policy Research. California Health Interview Survey, 2016-2017

[46] Medical Board of California, 2013 Physician Survey and American Community Survey, 2011-2015
[47] Berkowitz RL, Phillip N, Berry L, Yen IH. Patient Experiences in a Linguistically Diverse Safety Net Primary Care Setting: Qualitative Study. J Participat Med 2018;10(1):e4

San Francisco is available in the *Health Care Capacity and Gaps Assessment* chapter.

Transportation

Transportation is another key factor influencing one's ability to access health care services in San Francisco. Approximately 30% of San Francisco households and 50% of low-income San Francisco households do not have access to a personal vehicle and must rely on public transportation, walking, biking, ride sharing, or other forms of transportation to get to their destinations.[48] As health care services are generally concentrated in the northeastern quadrant of the city, the neighborhoods with the lowest health care transit access are Lakeshore, Treasure Island, Seacliff, Lincoln Park, Visitacion Valley, and Sunset/Parkside. In addition to having low transit access, the Lakeshore, McLaren Park, and Treasure Island neighborhoods have a high proportion of residents without access to a vehicle, which makes these residents more isolated from health care services. Transportation challenges and opportunities for improvement are discussed further in the *Land Use Assessment* chapter.

Food Security, Healthy Eating, and Active Living

A diet lacking proper nutrition and physical activity contributes to many of the causes of premature death in San Francisco, including heart failure, stroke, hypertension, diabetes, prostate cancer, colon cancer, Alzheimer's, breast cancer, and lung cancer. A healthy diet and physically active lifestyle are essential for growth, development, mental and physical function, immunity, stamina, strength, and long-term health.[49]

Access to Healthy Food

The U.S. Department of Agriculture (USDA) defines food insecurity as the lack of consistent access to enough food for an active, healthy life. Food insecurity refers to a lack of available financial resources for food at the household level.[50] In San Francisco, food insecurity is most prevalent amongst vulnerable populations, including pregnant women, children, older adults, and low-income or socioeconomically disadvantaged individuals and families. Approximately one in four low-income San Francisco residents report food insecurity, nearly half of the students in San Francisco Unified School District qualify for free or reduced-priced meals, and over 80% of single resident occupancy (SRO) hotel tenants are food insecure with high nutritional risk.[51,52]

Within San Francisco's population of pregnant women, some racial and ethnic minority groups experience food insecurity at higher rates compared to white pregnant women. Food insecurity during pregnancy is highest amongst Hispanic pregnant women (27%) and Black/African American pregnant women (20%).[53]

Food insecurity and limited accessibility to healthy food and public facilities are all barriers to healthy eating. In addition to the food insecurity issues cited above, the income gap for access to healthy food is widening in San Francisco. The number of fast food and full-service restaurants increased, while the number

[48] United States Census Bureau. American Community Survey, 2013-2017.
[49] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System. 2013
[50] US Department of Agriculture. Definitions of Food Security. 2019. Retrieved from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx
[51] Food Security Task Force. FY 2018-19 & FY 2019-20 Funding Request. Retrieved from: https://www.sfdph.org/dph/files/mtgsGrps/FoodSecTaskFrc/docs/FSTF-Budget-Request-FY-18-19.pdf
[52] SFDPH Child Care Health Program. 2016-2017 Change in Fruit and Vegetable Intake. Retrieved from: https://www.sfdph.org/dph/files/MCHdocs/Epi/Data-Table-Early-Childhood-Change-in-Fruit-and-Vegetable-Intake-2016-2017.pdf
[53] WIC Program. Eat SF WIC Participant Survey, 2017.

of food establishments that accept SNAP (food stamps) has decreased.[54]

Access to healthy food varies across the city of San Francisco. The USDA has designated Oceanview, Merced, Ingleside, Bayview Hunters Point, Visitacion Valley, and Treasure Island as neighborhoods with low food access.[55]

Healthy Eating

Many San Franciscans are not meeting national dietary recommendations. Only approximately 29.3% of children 37.5% of teens are eating five or more servings of fruits/vegetables each day. While nearly 44% of San Franciscans report eating fast food at least once in the past week.[56]

Similarly, at least one in ten San Franciscans do not drink the recommended amount of water each day, and approximately 8.9% are drinking soda seven or more times per week.[57]

Active Living

San Francisco has a rich network of parks and recreation facilities to support physical activity. 95% of San Franciscans live within a half mile of a recreation facility run by the San Francisco Recreation and Park Department. There are a few neighborhoods where recreation facilities are scarce or access is more limited, these include: Treasure Island, Mission Bay, and Financial District/South Beach.

Despite the network of parks throughout the City, many San Franciscans are not meeting physical activity recommendations. Roughly 45% of adults do not walk the recommended 150 minutes per week for transportation or leisure, almost half (47%) of children in child care are not physically active for the recommended 90 minutes per school day, 34% of middle schoolers and more than 60% of high schoolers do not get the recommended 60 minutes of physical activity per day.[58,59,60]

Housing Security and an End to Homelessness

Between 2011 and 2015, the Bay Area added approximately 500,000 new jobs but only 65,000 new homes; the Bay Area is experiencing a housing shortage. It is estimated that nearly 24,000 San Francisco residents live in substandard living conditions, and according to the latest count, there are nearly 8,000 homeless individuals living in San Francisco shelters and streets. Adequate housing is a key social determinant of health, as housing that is stable, of quality, safe, and affordable all directly contributes to personal and community health.

Housing

A key measure of housing security in a community is housing production. Housing production has recently declined in the Bay Area, especially for moderate to low income housing. San Francisco has reached nearly 80% of the 2023 production target for above moderate-income housing. Meanwhile, San Francisco has built only 35% of the 2023 production target for low and very low-income housing.[61] The housing supply has a direct impact on whether people who work in San Francisco are also able to live in the City. Between 1990 and 2014-2015, there has been a decline in the number of low-income workers who also live in San Francisco.

As market rate rent prices increase, housing in San Francisco becomes less affordable. The median percent of income paid to rent in San Francisco was 30% in 2017, and 17% of renters spend 50% or more of their income on rent. Neighborhoods with high levels of rent burden (households spending 30-50% of income in rent)

[54] San Francisco Department of Public Health. San Francisco Indicator Project.
[55] USDA Economic Research Service
[56] California Health Interview Survey. 2013-2018.
[57] California Health Interview Survey. 2013-2016
[58] California Health Interview Survey, 2017
[59] SFDPH Childcare Health Program
[60] YRBS Youth Risk Behavioral Surveillance System, 2015 and 2017. Retrieved From: https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=CA
[61] 2017 San Francisco Housing Inventory. San Francisco Planning Department.

include: Chinatown, Tenderloin, Outer Mission, Oceanview/Merced/Ingleside, Excelsior, Visitacion Valley, Bayview Hunters Point and Lakeshore. A higher percent of Asian and Latinx households pay more than 50% of their income to rent compared to white households, and over 50% of households living below 200% of the Federal Poverty Level (FPL) pay 50% or more of their income to rent. Rent burden greatly impacts the amount of disposable income for necessary items like food and health care expenses.[62]

The high-pressure housing market in the Bay Area mixed with insufficient supply of permanently affordable housing, may force residents into crowded living situations. Overcrowding is defined as having more than one person per room in the dwelling. Families and individuals that are evicted from their homes or unable to afford their homes may choose to "double-up" or have more than one adult in addition to the head of the household or two related or unrelated families residing together. Overcrowding is highest in Chinatown with only 71% of households living in uncrowded conditions.[63] Overcrowding has both direct and indirect health impacts as it can increase risk for respiratory infections and other illnesses, while also contributing to poor child development and increased environmental stressors.[64, 65 66]

Homelessness

In 2019, the Homeless Point-in-Time Count and Survey reported 8,011 people experiencing homelessness in San Francisco. This is a 17% increase since the 2017 Point-in-Time Count. In San Francisco, approximately 2,831 of the 8,011 are sheltered. A vast majority (85%) were in emergency shelter, while only 15% (432 persons) were in transitional housing programs. About 8% of the total Point-in-Time Count were persons with families. Approximately 35% of the homeless population are Black/African American despite making up only 5% of the general San Francisco population. Supervisorial districts six (Tenderloin, SoMa, Treasure Island, Mission Bay) and ten (Bayview Hunters Point, Visitacion Valley, Potrero Hill) have the largest homeless populations (3,659 and 1,863, respectively). In 2019 the primary cause of homelessness for more than a quarter of homeless individuals was lost job (26%), followed by alcohol or drug use (18%) and eviction (13%).[67] Between 2011 and 2016, there had been a steady increase in the number of evictions in San Francisco. However, in 2017 there was a 27% decrease in evictions, likely caused by the implementation of eviction and tenant protection measures.[68]

Safety from Violence and Trauma

Violence can be traced to a number of individual and community risk factors, including but not limited to: poverty, poor housing, illiteracy, alcohol and drug use, mental illness, community deterioration, discrimination and oppression, and trauma associated with experiencing or witnessing violence.[69] Violence in a community can cause stress and trauma to residents that impacts their day to day lives. Children and young adults are especially vulnerable to violence because of their stage of development. Witnessing and/or experiencing violence at a

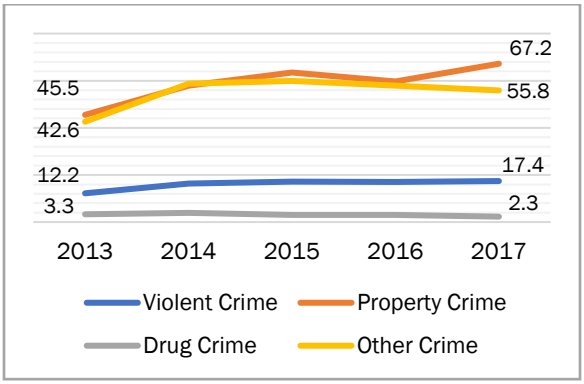
[62] United States Census Bureau. American Community Survey 1-year estimates, 2017.
[63] United States Census Bureau. American Community Survey. 2013-2017
[64] US Department of Housing and Urban Development, "American Housing Survey Reveals Rise in Doubled-Up Households During Recession." [Online]. Available: https://www.huduser.gov/portal/pdredge/pdr_edge_research_012714.html. [Accessed: 04-Sep-2018].
[65] W. Cox, "Overcrowded California," New Geography, 17-Nov-2016. [Online]. Available: http://www.newgeography.com/content/005452-overcrowded-california. [Accessed: 05-Sep-2018].
[66] R. Baggott, T. J. Brown, R. Hunt, and K. L. Jones, "The impact of overcrowding on health and education: a review of the evidence and literature," 2004.
[67] Applied Survey Research (ASR). 2019 San Francisco Point-in-Time Count & Survey. Retrieved from: http://hsh.sfgov.org/wp-content/uploads/FINAL-PIT-Report-2019-San-Francisco.pdf
[68] DataSF. Total Eviction Notices by Year. SF Housing Data Hub, 2018
[69] San Francisco Heath Improvement Partnership. 2019 Community Health Needs Assessment. Safety from Violence and Trauma. Retrieved from: http://www.sfhip.org/safety-from-violence-and-trauma.html

young age has been shown to cause long-term behavioral, physical, and emotional development issues. Experiences in family and community violence is often related to long-term intergenerational cycles of continued abuse and violence.[70,71] Community violence decreases the safety of a neighborhood and negatively impacts resident social cohesion and engagement in the outdoor and community spaces.

Crime & Safety

Since 2013, violent crime, property crime, and drug crime have increased in San Francisco. In 2017, violent crime rates were highest in the SoMa, Tenderloin, Financial District/South Beach, and Mission neighborhoods. Since 2013 property crime rates have seen the largest increase. Property crime is concentrated in the SoMa, Financial District/South Beach, and Japantown neighborhoods. Drug crime is mostly concentrated in the city center, or Tenderloin and SoMa neighborhoods.[72]

Figure 5.1 - 5.2. Crime Rates per 1,000 residents, 2013-2017



Source: San Francisco Health Improvement Partnership (SFHIP) 2019 CHNA; San Francisco Police Department via DataSF
Note: **Violent crime** includes 1) forcible sexual offenses, 2) robbery, and 3) assault. Homicide data is excluded, because it is not publicly available. **Property crimes** included 4) burglary, 5) larceny/theft, 6) vehicle theft, and 7) arson. **Drug crimes** include incidents coded as 8) drug/narcotic. All other crimes fall in the "**other**" category. Because crime incidents may include multiple crime categories, incidents were coded with the most severe crime category listed (1-8 listed previously).

The connection between crime rates and everyday experience of residents can be measured through perceived safety. San Francisco measures resident perception of safety at night and during the day. Since 2001, there has not been a significant change in the percent of residents that feel safe walking alone in their neighborhood during the day or at night. Overall, in 2017 approximately 66.3% of San Franciscans felt safe during the day, and 51.1% felt safe at night. Perceptions of safety during the day and night is lowest in zip codes 94102 (Tenderloin), 94103 (SoMa), 94124 (Bayview Hunters Point) and 94134 (Visitacion Valley) neighborhoods. Latinx and Black/African American residents had the lowest perception of safety during the day and at night compared to all other race/ethnicities.[73]

Violence & Trauma

Violence in San Francisco disproportionately impacts Black/African American men. Violence is the fifth leading cause of death among Black/African American men in San Francisco. From 2012-2016 the rate of emergency room (ER) visits for assault for Black/African American males was 267 ER visits per 10,000 population, while the overall rate was 58 ER visits per 10,000 population.[74] The zip codes with the highest rates of residents admitted to the ER for assault are 94102 (Tenderloin), 94103 (SoMa), and 94124 (Bayview Hunters Point).

As mentioned above, witnessing or experiencing violence at a young age impacts development and behaviors over the lifecycle. While cases of child abuse in San Francisco have decreased since 2009, Black/African American children continue to be disproportionately impacted by

[70] Theall, K. P., Shirtcliff, E. A., Dismukes, A. R., Wallace, M., & Drury, S. S. (2017). Association Between Neighborhood Violence and Biological Stress in Children. JAMA pediatrics, 171(1), 53–60. doi:10.1001/jamapediatrics.2016.2321
[71] Pingley, Terra. (2017). The Impact of Witnessing Domestic Violence on Children: A Systematic Review. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/776
[72] San Francisco Police Department via DataSF. Retrieved from: http://www.sfhip.org/crime-and-safety.html
[73] San Francisco Police Department via DataSF. Retrieved from: http://www.sfhip.org/crime-and-safety.html
[74] California Office of Statewide Planning and Development, 2012-2016

maltreatment. In 2017, the number of substantiated cases of child maltreatment was 4.0 cases per 1,000 children in San Francisco. For Black/African American children, the rate was 28.0 cases per 1,000 children.[75] It is estimated that child abuse costs the city of San Francisco $226.5 million a year on health care, criminal justice, child welfare, and other related costs.

Incarceration

From a young age, the justice system in San Francisco disproportionately impacts Black/African American residents. According to the 2019 CHNA, Black/African American students in SFUSD schools are the most likely to be suspended or expelled. Approximately 86% of Juvenile Hall bookings are among Black/African American youth despite making up 6% of the youth population. And as adults, Black/African American individuals are disproportionately detained, searched, and arrested by San Francisco police. Incarceration harms the mental and physical health of the incarcerated and the non-incarcerated. Mass incarceration compromises community health and contributes to racial health inequities.[76,77]

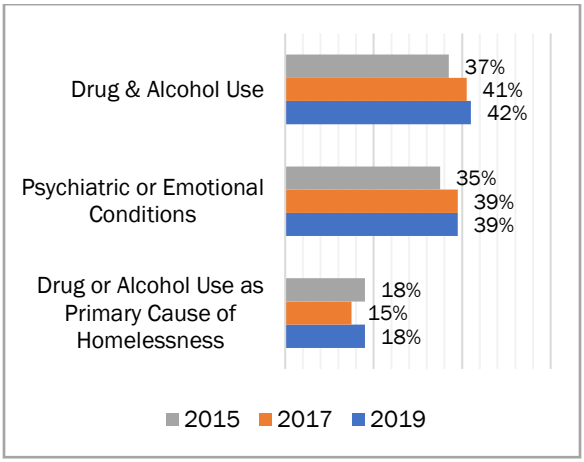
Social, Emotional, and Behavioral Health

Behavioral Health in San Francisco

Behavioral health is a term used to describe disorders related to mental health and/or substance use.

One of the challenges in estimating the prevalence of behavioral health issues in San Francisco is that many survey instruments do not count San Francisco's homeless population. As many population based estimates are based on U.S. Census data, they do not account for San Francisco's homeless population of approximately 8,011 adults, families, and unaccompanied youth.[78, 79] According to the 2019 Point-in-Time-Count, homeless individuals in San Francisco have high rates of drug and alcohol misuse, psychiatric or emotional conditions, and substance use as the primary cause of their homelessness.

Figure 5.1 – 5.6. Point-in-Time-Count Homeless Study Findings, San Francisco, 2019

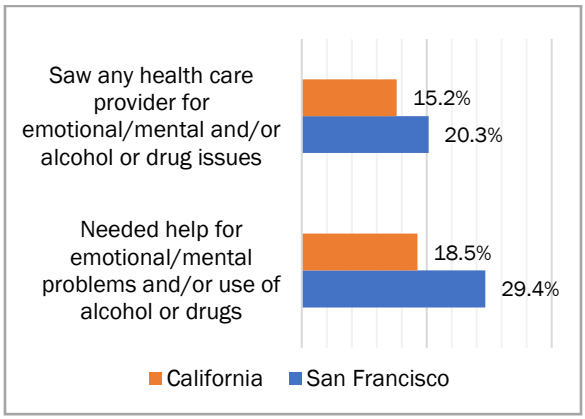


Source: 2019 San Francisco Homeless Point-In-Time-Count

Self-reported data from the 2017 California Health Interview Survey (CHIS) indicates that more than one-quarter (29%) of San Francisco adults reported needing help for emotional/mental health issues and/or the use of alcohol or drugs, and 20% of San Francisco adults reported seeing any healthcare provider for emotional/mental and or/alcohol or drug issues (Figure 5.1 – 5.6).[80]

[75] University of California at Berkeley, California Child Welfare Indicators Project, 2017
[76] San Francisco Health Improvement Partnership. 2019 CHNA. Retrieved from: http://www.sfhip.org/safety-from-violence-and-trauma.html
[77] Christopher Wildeman and Emily A Wang. Mass incarceration, public health, and widening inequality in the USA. Lancet (London, England), 389:1464–1474, April 2017.
[78] Substance Abuse and Mental Health Services Administration (2012). 2010-2012 National Surveys on Drug Use and Health: Guide to Substate Tables and Summary of Small Area Estimation Methodology. Retrieved from http://www.samhsa.gov/data/sites/default/files/substate2k12-Methodology/NSDUHsubstateMethodology2012.pdf
[79] Applied Survey Research. (2019). San Francisco Homeless Point-in-time Count & Survey, Comprehensive Report. Retrieved from http://hsh.sfgov.org/wp-content/uploads/FINAL-PIT-Report-2019-San-Francisco.pdf
[80] UCLA Center for Health Policy Research. Ask CHIS 2017. Needed Help for Emotional/Metal problems and/or use of alcohol or drugs (San Francisco). Available at askchis.ucla.edu.

Figure 5.1 – 5.6. Adults Reporting Needing Help for Mental Health Issues and/or use of Alcohol or Drugs in the Last 12 Months, 2017



Source: CHIS, 2017

Given these figures, it is estimated that approximately 250,000 San Franciscans may experience symptoms of a behavioral health condition.

Utilization of community and hospital based behavioral health services is discussed at greater length in the *Capacity and Gaps Assessment* chapter.

Mental Health & Mental Disorders

According to the World Health Organization, mental disorders are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behavior and relationship with others. They include: depression, bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities and developmental disorders including autism.[81] According to the 2019 CHNA, people at high risk for mental illness include: people with low education attainment, low-income, and/or low social status, and those who experience discrimination on the basis of race, gender, social class, or other characteristics.[82]

Depression is the most common mental illness in the United States. In San Francisco, depression is common amongst youth. In an assessment of feelings of hopelessness or prolonged sadness, approximately 26% of San Francisco Unified School District (SFUSD) high school students reported feeling that way. These feelings are higher for lesbian, gay, bisexual, transgender, and queer (LGBTQ) students. In California, about two-thirds of adults with mental illness and two-thirds of adolescents with major depressive episodes did not get treatment, pointing to a greater need for awareness and access to behavioral health services.[83] Other groups at high risk for depression include pregnant women, women with less than a high school education, and women with Medi-Cal insurance.[84]

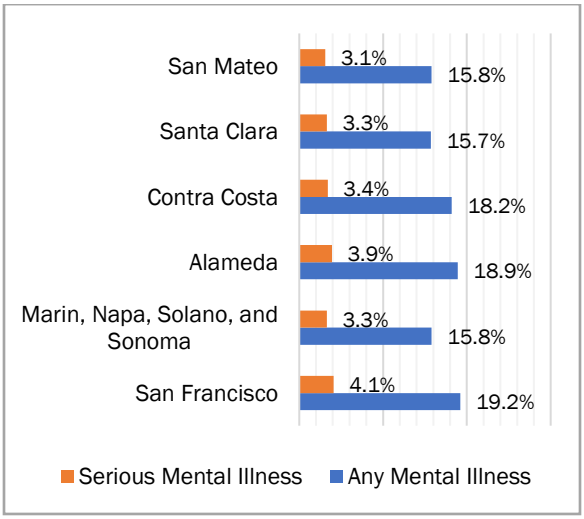
Data indicates that certain race/ethnicity groups – white, Latino, and Black/African American – are at higher risk for mental health issues. From 2014-2016, Black/African American and Whites had the highest rates of hospitalization for depression compared to other racial/ethnic groups across the city (23.8 and 15.1 hospitalizations per 10,000, respectively)[85]. Additionally, populations with lower socioeconomic status demonstrate higher rates of psychological distress. From 2012-2016, those living below 200% of the Federal Poverty Level (FPL) were almost three times as likely to experience distress as those living above 200% of the FPL.[86]

Mental health indicators in San Francisco largely parallel the general pattern of risk, incidence,

[81] World Health Organization. (2018). Mental Disorders Key Facts. Retrieved from: who.int/news-room/fact-sheets/detail/mental-disorders
[82] San Francisco Health Improvement Partnership. 2019 CHNA. Retrieved from: sfhip.org/social-emotional-and-behavioral-health.html
[83] Substance Abuse and Mental Health Services Administration, *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration. (2015). Retrieved October 27, 2015 from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf
[84] San Francisco Health Improvement Partnership. 2019 CHNA. Retrieved from: sfhip.org/social-emotional-and-behavioral-health.html
[85] OSHPD, 2014-2016
[86] CHIS, 2011-2016

and prevalence in California. The prevalence of both serious mental illness and any mental illness in San Francisco is similar to most Bay Area counties and the state overall. It is estimated that the prevalence of any mental illness in California is 17.4% while the prevalence of serious mental illness is 3.6% statewide.

Figure 5.1 - 5.3. Estimates of Prevalence of Serious Mental Illness and Any Mental Illness, 2014-2016



Source: SAMHSA, 2014-2016 NSDUH Substate Estimates of Substance Use and Mental Disorders

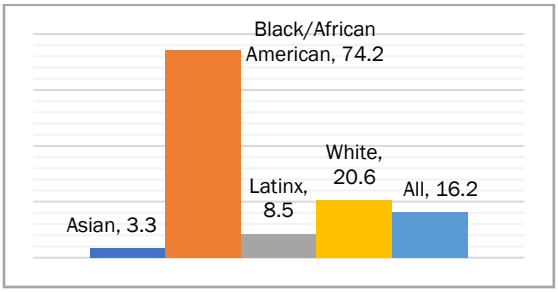
Substance Use

The impacts of drug and alcohol use are cumulative and contribute to many social, physical, mental, and public health problems. Some of the individual and community issues related to drug and alcohol use include poor academic performance, developmental delays, unintended pregnancy, HIV and other STD/STIs, Hepatitis C, motor vehicle crashes, violence, child abuse, violent crimes, chronic diseases, and mental or behavioral health disorders. Some of the risk factors that enable alcohol and/or drug use include poor social environment, substance use within individual network, mental illness, poverty, and engagement with the justice system.[87]

Substance use in San Francisco is common. It's estimated that approximately 40% of adults engage in binge drinking, which is defined as having five or more alcoholic drinks for men and four or more for women on one occasion.[88] Binge drinking has also been reported by approximately 8.4% of SFUSD high school students. Additionally, through school surveys, it's estimated that 27% of SFUSD high school students and 6% of middle school students smoked marijuana, and 12% of SFUSD high school students and 3% of middle school students have used prescription drugs.[89]

Rates of emergency room visits for substance use disproportionately impacts Black/African American San Franciscans. Between 2012 and 2016, Black/African Americans had higher rates of emergency room visits for alcohol, cannabis, cocaine, methamphetamine, and opioids compared to all other race/ethnicity groups. Similar trends are seen with mortality rates due to drug use, as presented in the figure below.

Figure 5.1 - 5.4. Age-adjusted Mortality Rates due to Drug Use Disorders per 100,000 population by Race/Ethnicity in San Francisco, 2015-2017.



Source: San Francisco Health Improvement Partnership, 2019; California Department of Public Health (CDPH)

[87] San Francisco Health Improvement Partnership (SFHIP). 2019 CHNA. Retrieved from: http://www.sfhip.org/social-emotional-and-behavioral-health.html

[88] Centers for Disease Control and Prevention. (2018). Alcohol and Public Health: Fact Sheets – alcohol and your health. Retrieved from: https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm

[89] Centers for Disease Control and Prevention (CDC). Youth risk behavior surveillance system. https://www.cdc.gov/healthyyouth/data/yrbs/index.htm.

5.2 LAND USE ASSESSMENT

CONTENTS

OVERVIEW

SAN FRANCISCO HAS A DIVERSE NETWORK OF MEDICAL FACILITIES AND PROVIDERS, INCLUDING EXTENSIVE VITAL SAFETY NET SERVICES. HOWEVER, DISPARITIES IN ACCESS TO QUALITY CARE PERSIST, CONTRIBUTING TO INEQUITABLE HEALTH OUTCOMES. DEMOGRAPHIC TRENDS, AN EVOLVING POLICY CONTEXT, AND CHANGES IN THE WAY HEALTH CARE IS PROVIDED ARE SHIFTING THE LANDSCAPE FOR HEALTH CARE FACILITIES IN SAN FRANCISCO.

The Land Use Assessment (LUA) is required by Planning Code Section 342 to consider: (1) the supply, need, and demand for space for medical uses in the different neighborhoods of the City; (2) the potential effects and land use burdens of locating such services in particular neighborhoods; and (3) the potential for displacement of other neighborhood-serving uses that may occur as a result of the placement of medical uses. To give these considerations context, the LUA includes six sections.

1) Existing Supply of Medical Uses
2) Planning Context
3) Trends in Medical Use Development
4) Demand and Need for Medical Uses
5) Transportation Planning and Access to Health Care
6) Potential for Land Use Burdens and Displacement of Neighborhood Services

1.EXISTING SUPPLY OF MEDICAL USES

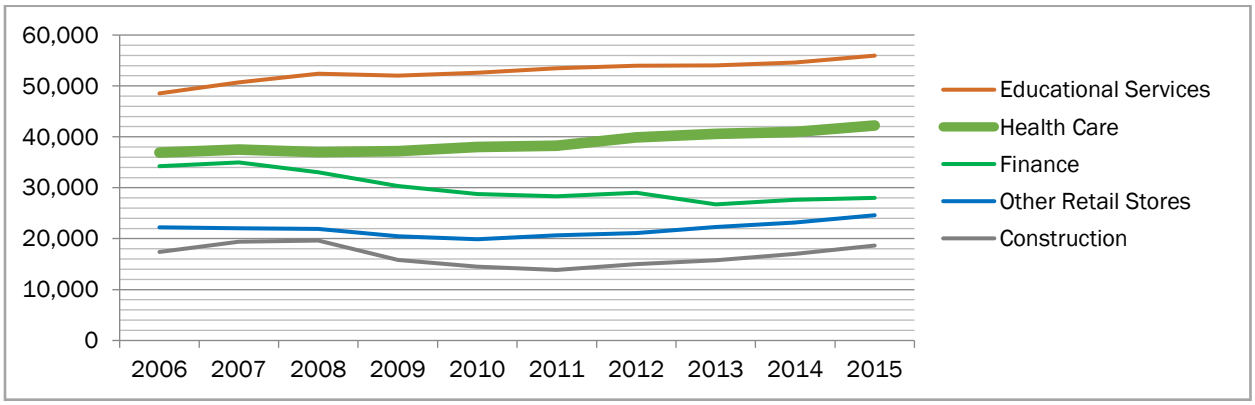
HEALTH CARE IS A SIGNIFICANT DRIVER OF SAN FRANCISCO'S ECONOMY. THE CITY IS A REGIONAL HUB FOR MEDICAL SERVICES, RESEARCH, AND ADMINISTRATION. THE CITY HAS DIVERSE TYPES OF MEDICAL FACILITIES AND ONE OF THE HIGHEST RATES OF PROVIDERS PER CAPITA IN THE STATE.

Total Medical Establishments and Employees

Health care jobs make up 6.6% of all employment in the city. At the end of 2015[90], there were 44,300 jobs in health care related industries in San Francisco. Health care related employment has grown steadily over the past decade and, unlike most other industries, did not see major declines during the Great Recession (see Table 5.2-1.1 below for more details).

Traditionally, the distribution of medical facilities has followed a "hub and spoke" model, with hospitals and large medical services clustered near Downtown and on major corridors, and private practitioner offices, long-term care, and other medical services distributed throughout the city's neighborhoods. This is beginning to change, as the larger medical campuses implement long-standing plans to upgrade and reconfigure their facilities, and as trends and preferences stimulate growth in smaller outpatient medical facilities.

Figure 5.2 - 1.1 Employment in select industry groups in San Francisco (2006-2015)



Medical establishments, for the purposes of this analysis, include all public, private, and nonprofit hospitals, clinics, and other facilities. Hospitals, generally concentrated in north-central San Francisco, are by far the largest medical facilities, employing almost 20,000 people. Clinics, doctors' and dentists' offices, and long-term care facilities make up the bulk of the remainder (roughly 17,000 jobs) and are located along the city's many neighborhood-commercial and major transit corridors.

Generally, all segments of the health care industry in San Francisco saw growth in number of establishments and jobs from 2010 to 2018. One notable exception is long-term care and

[90] 2015 is the most recent year for which employment data is available.

skilled nursing facilities, which saw a decrease in establishments, but fairly large increase in employment (perhaps reflecting an increase in the number of in-home care practitioners). While the industry saw steady growth over the period, medical jobs grew at a slower rate (15%) than the citywide economy, which added jobs at an unprecedented rate (24%). This may be partially attributed to the fact that medical employment did not drop significantly during the Great Recession, and thus did not need to add as many jobs to recover to pre-recession levels. The difference in employment trends in the health care industry over the past decade suggests medical employment is less susceptible to economic fluctuations, and may be more influenced by population growth, demographic changes, and national and state health care policy.

From 2010 to 2018, San Francisco added more than 12,300 jobs in medical fields. The largest growth was at hospitals, which added more than 10,000 new jobs and can be largely attributed to new hospitals in Mission Bay. Long term care was the only area that saw a loss during this time with closure of 37 facilities and the loss of 534 jobs (Table 5.2-1.1).

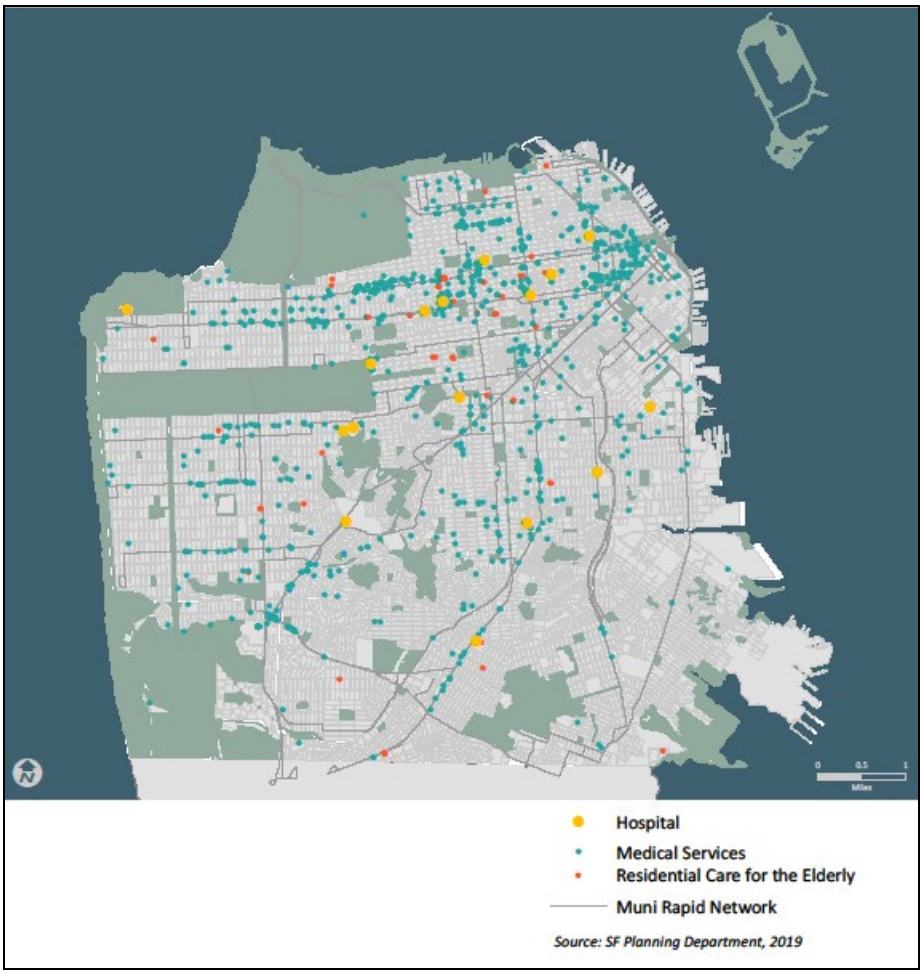
Table 5.2 – 1.1 Medical Establishments and Employees, 2010-2018(i)

Facility Type	NAICS Code(s)(i)	NAICS Title	Establishments (2010)	Employees (2010)	Establishments (2018)	Employees (2018)
Hospitals	622	Hospitals	15(ii)	18,243	15(ii)	28,531
Physician Offices	6211	Offices of Physicians	766	5,233	881	5,970
Dentist Offices	6212	Offices of Dentists	619	3,027	630	3,339
Outpatient Care (Including mental health practitioners)	6213	Offices of Outpatient Care	324	1,348	481	2,241
Long-Term Care	623	Nursing and Residential Care Facilities	197	5,728	160	5,194
Other Medical-Supporting Uses	6215, 6219	Ambulance Services; Medical and Diagnostic Laboratories; Blood and Organ Banks	42	760	59	1,424
TOTAL			1,963	34,339	2,226	46,699

Note: (i) The *North American Industry Classification System* (NAICS) is the current classification system that groups business establishments according to similarity of production processes. NAICS is a six-digit coding system. Under NAICS, the first two digits of the code are designated as sector to represent general categories of economic activities. '62' is the two-digit code representing Health Care and Social Assistance. (ii). This figure includes multiple facilities located within a single hospital campus (for instance, specialty care facilities)

Hospitals are clustered in central San Francisco and notably absent from the low-density neighborhoods in the Sunset, Richmond, Excelsior, and Bayview. Other health facilities cluster downtown and close to hospitals, but also spread out into all neighborhoods (Figure 5.2-1.2).

Figure 5.2 – 1.2. All Health Facilities

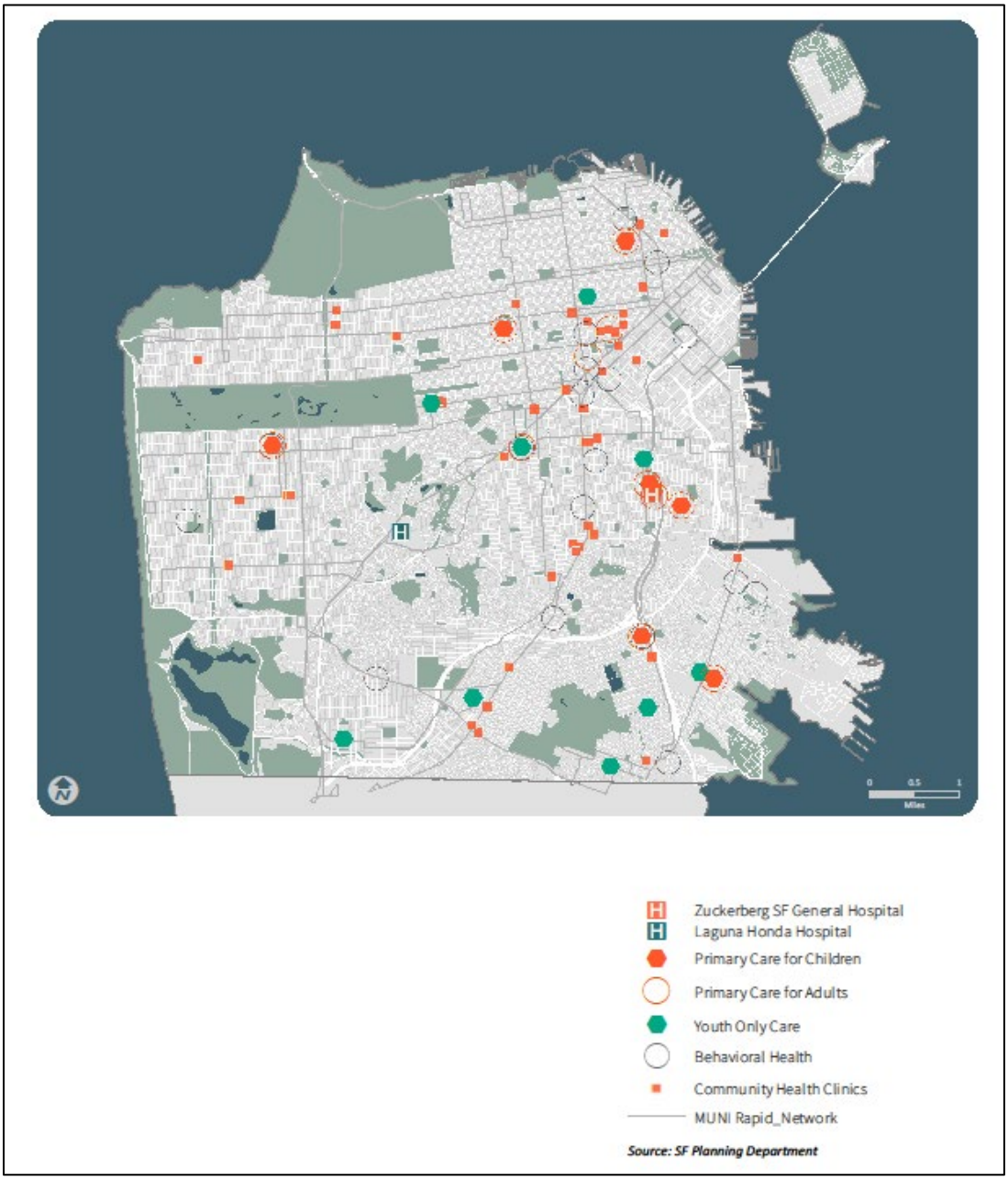


Facilities for publicly insured or uninsured

For populations who are uninsured or who have public insurance (such as Healthy San Francisco or Medi-Cal), there are two general categories of facilities where they can receive care. These facilities (Figure 5.2-1.3) are operated by public agencies or nonprofit entities.

- **The San Francisco Health Network**: 45 facilities owned and operated by the City and County of San Francisco, including Zuckerberg SF General Hospital and several primary care and behavioral health clinics.
- **Community Health Clinics:** A network of 49 nonprofit-owned and operated community clinics that provide a broad range of services but do not offer inpatient care.

Figure 5.2 – 1.3. Facilities for Publicly Insured or Uninsured



2.PLANNING CONTEXT

SAN FRANCISCO'S MEDICAL SERVICES ARE DELIVERED BY A VARIED AND EVER-CHANGING SET OF INSTITUTIONS, RANGING FROM PRIVATE PRACTICES AND SMALL CLINICS TO PUBLIC AND PRIVATE LARGE HOSPITALS AND TEACHING UNIVERSITIES.

The Health Care Services Master Plan provides a framework for the development of health care facilities citywide. **The HCSMP does not modify zoning controls.** This section provides an overview of existing land use policies related to medical uses.

Overview of Land Use regulations

The San Francisco General Plan and San Francisco Planning Code are policy documents that shape the city's physical growth and development. Both are relatively silent when it comes to policies and goals related to health care. The General Plan includes policy objectives for health care within the Industry and Commerce Element. The Planning Code regulates the intensity and operation of various land uses parcel by parcel but cannot ensure that hospitals and health facilities are built. Rather than regulating the actual building of the facilities, the Planning Code simply regulates where facilities cannot be built. Planning Code regulations were developed primarily to meet two valid, but sometimes competing needs: the desire to limit the clustering of certain land uses and the desire to protect neighborhood character, particularly in neighborhood commercial and residential districts.

The San Francisco Planning Code regulates what types of medical services can operate throughout the city. The degree of review and the types of permits required vary. A small project, such as an optometrist's office selling eye glass frames relocating to an existing retail space, might require very limited review and can be approved over the counter. A hospital, on the other hand, must go through a much more rigorous planning and review process. These large-scale medical projects take many months to approve and require a Conditional Use Authorization in addition to other approvals.

It is important to note that projects owned and operated by the State (UCSF) or the Federal government (San Francisco Veterans Affairs Medical Center) are exempt from Planning Code requirements, as their jurisdiction supersedes local land use regulations.

Land Use Categories & Definitions

The Planning Code separates medical uses into broad land use types (referred to as "land use categories"), such as residential, office, retail, and institutional. Health care uses and their corresponding land use categories are summarized in Table 5.2-2.1. The first part of the table describes the medical uses specifically designated in the HCSMP Ordinance as subject to the Consistency Determination requirement. The subsequent section describes other medical and supporting uses that are relevant to this Plan, but that are exempted from the HCSMP process.

These land use definitions do not distinguish between types of providers (e.g., nonprofit or private). They may not align with the way medical service providers themselves categorize these uses. This may lead to some confusion when interpreting which Planning Code requirements apply to a specific project. For instance, a physician's office might fall under either the "Hospital or Medical Center" (considered an institutional use) or "Medical Service" (considered a retail or office use) use category, depending on whether it's at a hospital, a smaller clinic, or private office.

In cases where it is unclear which land use category a proposed health care facility falls under; the Zoning Administrator has the authority to make a final determination.

Table 5.2 – 2.1. Medical Land Use Definitions in the San Francisco Planning Code

Facility Type	Land Use Definitions	General Land Use Category & Description	Examples
MEDICAL USES SUBJECT TO HCSMP			
Hospitals	Article 1 & 7: "Hospital" (§102) Articles 8: "Hospital or Medical Center" (§890.44)	*"Institutional" use.* A hospital, medical center, or other medical institution that provides facilities for inpatient or outpatient medical care and may also include medical offices, clinics, laboratories, and employee or student dormitories and other housing associated with the institution.	Hospital Medical Campus
Outpatient Care / Ambulatory Health Service	Article 1 & 7: "Service, Health" (§102) Articles 7 & 8: "Service, Medical" (§890.114)	*"Retail Sales & Service" or "Office" use.* A clinic, medical office, or other medical facility providing outpatient care by licensed medical and allied health service professional, and not part of a hospital or medical center.	Community clinic Urgent care center Physician Offices Dentist Offices Optometrists Psychiatrists Chiropractors Kidney dialysis
Residential Care Facilities / Nursing Facilities	Article 1 & 7: "Residential Care Facility" (§102) Article 8: "Other Institution" (§890.50)	*"Institutional" use.* Facilities providing a variety of services to meet both medical and non-medical needs of patients with chronic illness, disability, or other condition. Such facilities shall include, but not necessarily be limited to, a board and care home, family care home, long-term nursery, orphanage, rest home or home for the treatment of addictive, contagious or other diseases, or psychological disorders.	Skilled Nursing Facility Hospice Facility Residential behavioral health (psychiatric and/or substance abuse) facilities
OTHER MEDICAL & SUPPORTING FACILITIES NOT SUBJECT TO HCSMP			
Other Health Care Supporting Facilities	Varies by use	*Varies.* Other uses that provide patient care and/or other supporting uses, not affiliated with a hospital or medical center.	Ambulance services Pharmacies Medical and diagnostic laboratories

Land Use Districts & Controls

The Zoning Map establishes dozens of zoning districts across the City (77 unique zoning districts, in addition to dozens of special use districts). Similar to the land use definitions, these districts are grouped into general categories based on common characteristics and purpose, as follows:

- Residential & Downtown Residential
- Neighborhood Commercial
- Mixed Use
- Commercial
- Industrial & Production, Distribution, and Repair (PDR)
- Public & former Redevelopment Agency

For each zoning district, the Code specifies allowable land uses, stating whether a land use is:

- **Principally Permitted**, e.g. permitted in the zoning district, subject to administrative review by the Planning Department
- **Conditionally Permitted**, e.g. the Planning Commission must determine the use to be necessary and desirable

- **Not Permitted**, e.g. not permitted in this district

Land use categories and districts provide some basic clues as to where specific uses are permitted. For example, residential zoning districts generally permit residential land uses and may prohibit nonresidential uses; industrial / PDR districts typically allow industrial land uses and exclude office and residential.

The maps in Figures 5.2 - 2.1, 2.2, and 2.3 illustrate where the three main categories of health care services (hospitals, outpatient facilities, and residential care facilities) are permitted in San Francisco. Each map reflects a different policy approach. For instance, hospitals and medical centers (Figure 5.2-2.1) are principally permitted in a few locations. They are conditionally permitted in most of the city, except for some Neighborhood Commercial, Industrial, and Mixed-Use districts, where they are not permitted. The intent is to provide flexibility combined with a rigorous standard of review. Hospitals could potentially operate in many places, including in residential districts that prohibit most other commercial uses; however, the project must justify that it is necessary and desirable at a conditional use authorization hearing at the Planning Commission. This approach acknowledges that hospitals are an essential service throughout the City, but also that they have specific land use needs and impacts related to their scale and operations.

In contrast, medical service / health service uses (which include a broad range of outpatient services) are not permitted in most residential districts. However, they are generally permitted as of right in most Neighborhood Commercial and Mixed-Use districts, but many districts cap the size at 2,500 or 5,000 square feet) and only allow these uses on some floors of a building but not others. These smaller medical uses are generally seen as compatible with other neighborhood-serving uses, but each district has different regulations for these uses.

The zoning for residential care facilities is the most permissive (Figure 5.2-2.3), allowing the use in most of the city. Legislation effective in January 2019 (Board File 180915/303-18) removed the conditional use requirements for residential care facilities for seven or more people. These facilities are now Principally Permitted in most residential districts and Neighborhood Commercial districts regardless of numbers of people served.

Standards of Operation and Other Requirements

In addition to regulating the permitted locations for land uses across the city, the Planning Code requires a range of other standards. The main requirements that a medical facility would need to comply with include, but are not limited to:

- Height, bulk, and size restrictions
- Permitted hours of operation
- Design guidelines & streetscape design requirements
- Transportation Demand Management (TDM) strategies to limit impacts on traffic congestion
- Impact fee requirements
- For hospital projects, requirements for neighborhood notification before and during the application process (Health and Medical Services are not required to do notification per Planning Code Section 311)

In addition, depending on the project scope, medical facilities may be subject to requirements at several other agencies during the permitting process, including the Department of Public Health, Department of Building Inspections (DBI), San Francisco Public Utilities Commission (SFPUC), San Francisco Public Works, and San Francisco Municipal Transit Agency (SFMTA), in addition to State and Federal regulators.

Per Section 304.5 of the Planning Code, hospitals and other large medical institutions are required to complete an Institutional Master Plan (IMP). Although there is some overlap in

terms of the goals and purpose of the HCSMP and IMP, there is currently no relationship between the two policies. The 2019 HCSMP includes a policy recommendation on how the two policies can be better aligned.

Figure 5.2-2.1. Zoning Controls – Hospitals

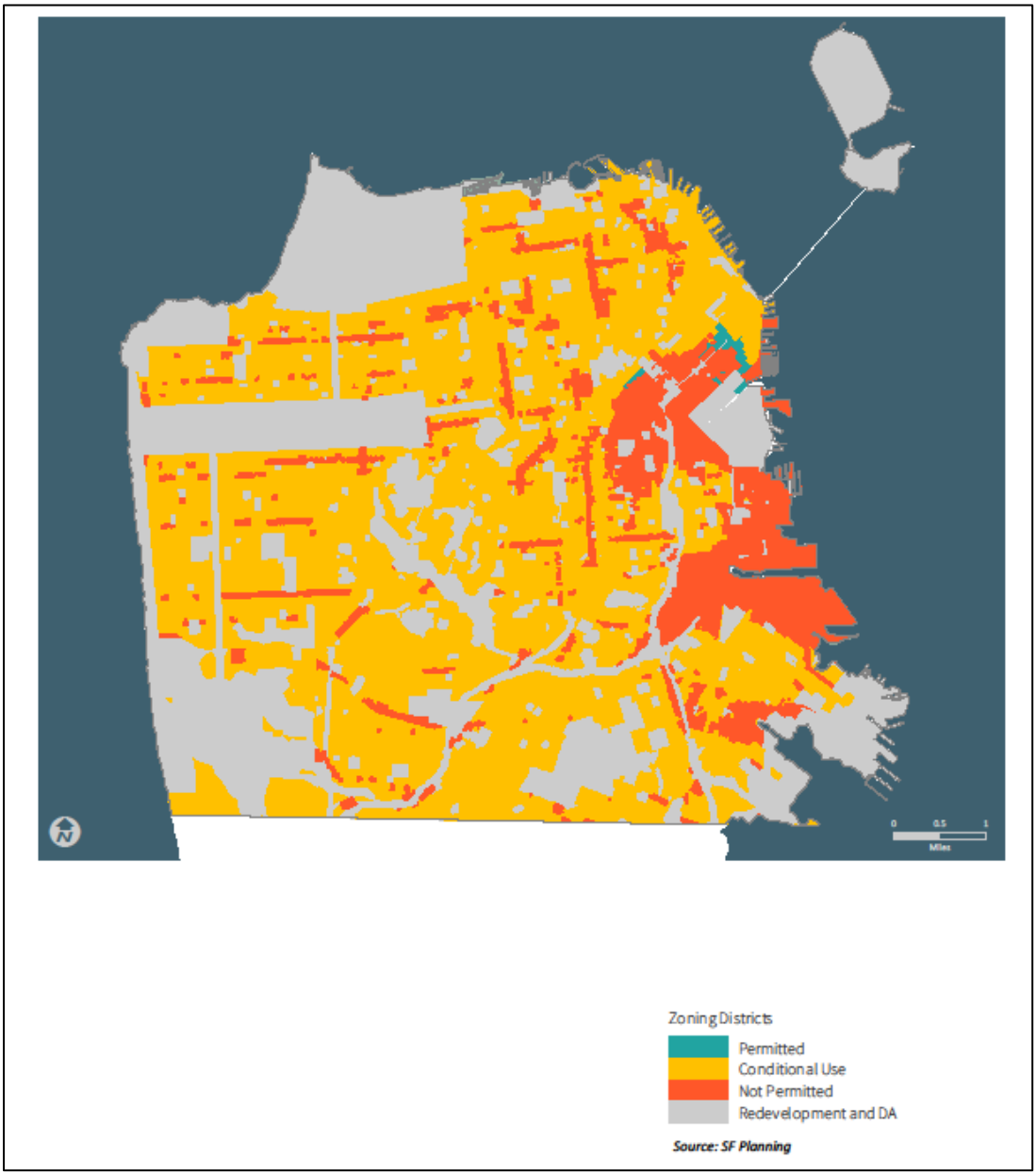


Figure 5.2-2.2. Zoning Controls – Outpatient Facilities

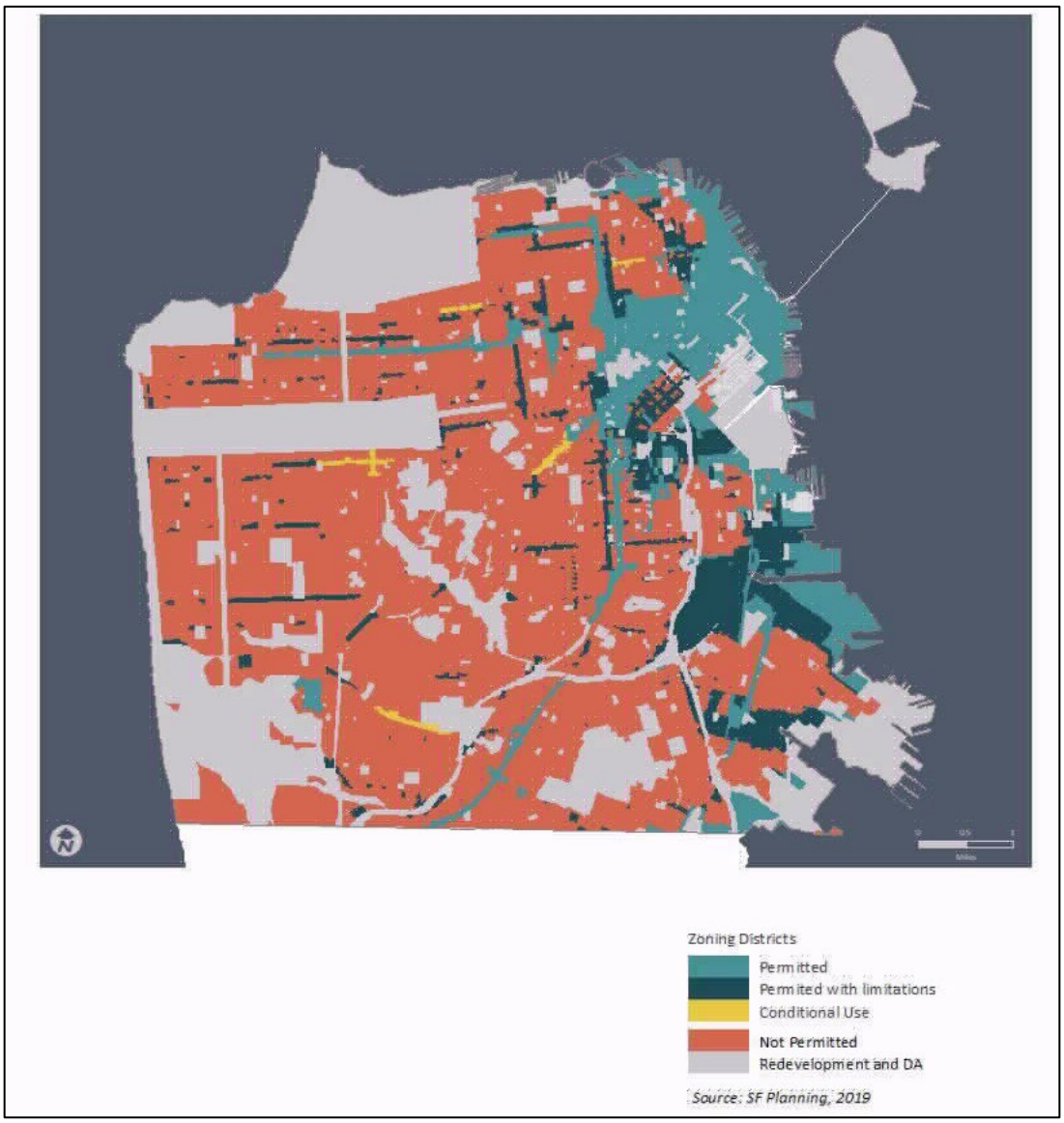
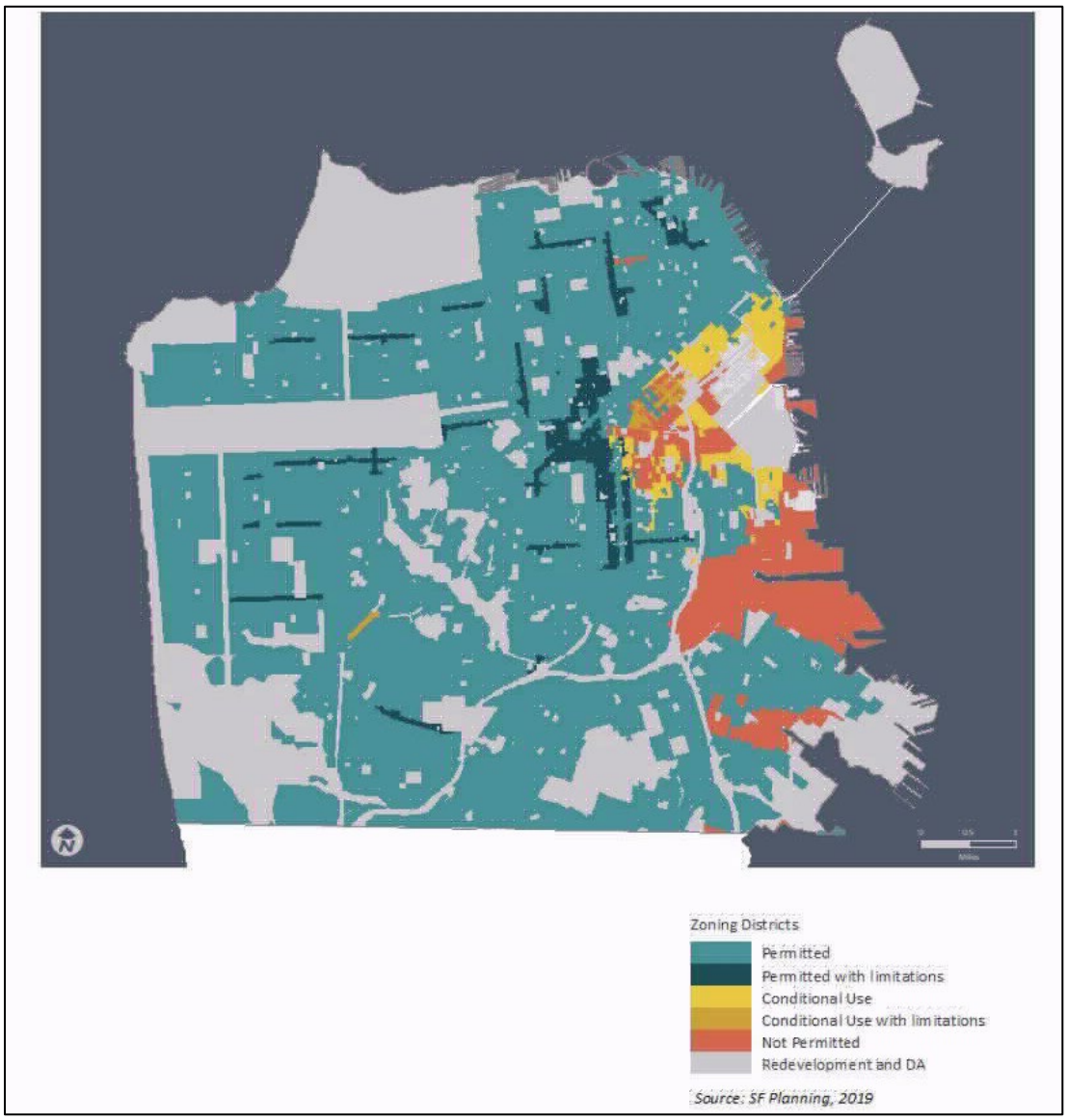


Figure 5.2-2.3: Zoning Controls – Residential Care Facilities



Institutional Master Plan (IMP) Requirement
How does it relate to the HCSMP?

The Planning Code requires larger medical and post-secondary institutions to submit, and update periodically, an Institutional Master Plan (IMP) that provides information on their current and future development plans. The IMP is ***institution-based***; in other words, each plan covers all San Francisco facilities owned by a single operator (e.g. CPMC has an IMP on file describing their five hospitals and network of clinics). In contrast, the HCSMP is ***project-based***, requiring that any project meeting the size threshold comply with the Consistency Determination process, regardless of whether or not the operator is subject to the IMP. In summary, the IMP must contain:

- A description of the institution, including the services it provides and population served, employment characteristics, and history of growth in San Francisco
- The current physical presence of the institution in San Francisco, including all owned and leased properties
- The future development plans of the institution for a period of no fewer than ten years, including
- Anticipated impact on surrounding neighborhoods, including impacts on housing and commercial properties, traffic and parking, and urban design
- Design alternatives and mitigations that could alleviate these impacts

Although the HCSMP establishes a broad vision and direction for health care facilities, currently there is no formal relationship between the HCSMP and the IMP. The supporting legislation that accompanies this Plan recommends that the City create greater alignment between these two processes, by requiring that future IMPs use the HCSMP Recommendation & Guidelines as a basis for data collection and describing their current and future services.

3.TRENDS IN MEDICAL USE DEVELOPMENT

SINCE 2013, SAN FRANCISCO HAS ADDED 2.1 MILLION SQUARE FEET OF HOSPITALS, WITH 236 BEDS, AND 348,907 SQUARE FEET OF MAJOR OUTPATIENT HEALTH SERVICES. AN ADDITIONAL 775,580 SQUARE FEET OF MEDICAL USES ARE IN THE PIPELINE. THIS SECTION DESCRIBES RECENT TRENDS IN MEDICAL USE DEVELOPMENT, INCLUDING MAJOR MEDICAL USE PROJECTS AND SMALL OUTPATIENT FACILITIES.

Recently Completed Major Medical Use Projects

California Senate Bill 1953, passed in 1996, has been a major driver of hospital building projects, requiring health systems to either retrofit existing buildings or construct new facilities to meet seismic safety requirements by 2020. Since 2013, five major hospital projects have been completed in San Francisco (Table 5.2-3.1).

In recent years, seven outpatient facilities were completed by a mix of providers (facilities affiliated with hospital systems, community clinics, and private offices). Notably, Kaiser opened a 245,500 square foot outpatient facility in Mission Bay, extending the provider's reach into additional San Francisco neighborhoods (Table 5.2-3.2).

Table 5.2-3.1. Recently Completed Major Hospital Projects 2013-2019

Facility Type + Name	Address	Year Completed	Description	Number of beds (#)	Net Addition of Medical Space (SF)
Zuckerberg SF General Hospital	1001 Potrero Avenue	2015	New Construction and Renovation/Addition: New 419,070 ft² acute care hospital building, and renovation of Building 5 (129,706 ft²).	283	419,070
Chinese Hospital	845 Jackson Street	2016	New Construction and Renovation/Addition: New 7-story hospital and medical office building.	88	68,010
UCSF Mission Bay Campus	Various Locations in Mission Bay	2015	New Construction: Construction of a new 289-bed medical campus with specialty hospitals for children, women and cancer patients.	289	878,000
CMPC Van Ness Campus	1101 Van Ness Avenue	2019	New Construction: Demolition of hotel and office buildings and construction of a 15 story, 265-foot tall hospital.	274	740,000
CPMC Mission Bernal Campus	1580 Valencia Street	2018	New Construction and Addition/Renovation: Demolition of the existing St. Luke's hospital building and construction of a 215,000 square foot, 120-bed acute health care facility.	120	215,000
CMPC St Luke's	1580 Valencia Street	2019	Demolition of seismically unsound 1957 building	-228	-197,983
CPMC Pacific Campus	2333 Buchanan Street	2019	Closure: All inpatient services at the Pacific Campus, including the Emergency Department, were moved to the Van Ness Campus. Specialty outpatient services remain.	-291	unknown
CPMC California Campus	3700 California Street	2019	Closure: Pediatric emergency room care and all inpatient services were moved to the Van Ness Campus. Specialty outpatient services remain.	-299	unknown
TOTAL				236	2,122,097

Table 5.2-3.2. Recently Completed Major Outpatient Health Service Projects 2013-2019

Facility Type + Name	Address	Year Completed	Description	Net Addition of Medical Space (SF)
Fresenius Kidney Care	626 Potrero Avenue	2014	Renovation/Change of Use	32,700
Sutter Health Care Center	55 2nd Street	2015	Renovation/Change of use	unknown
Professional Medical Building	2320 Sutter Street	2015	Addition to Existing Building	11,132
Kaiser Mission Bay Medical Offices	1600 Owens Street	2016	New Construction	245,500
HealthRight360	1563 Mission Street	2017	Addition/Renovation.	50,000
TOTAL				339,332

Major Medical Use Projects Currently in the Development Pipeline

As of early 2019, the development pipeline of health care facilities includes two major new facilities near the UCSF Mission Bay campus, which will provide specialty care for neurosciences, psychiatry, and for children, teen, and families. Combined with the outpatient and residential care facilities in the pipeline, the total pipeline projections are an additional 775,580 square feet of medical space (Tables 5.2-3.3, 3.4, and 3.5).

Table 5.2- 3.3. Major Hospital Projects in the Development Pipeline (as of spring 2019)[91]

Facility Type + Name	Address	Year Filed[92]	Description	Number of beds	Net new Medical Space (SF)
UCSF – Joan and Sanford I. Weill Neurosciences Building[93]	Mission Bay Block 23A	2017	New Construction. Facility will house outpatient clinical research / clinical care space, and laboratory research programs in psychiatry and neurosciences. Occupancy anticipated in spring 2020.	0	274,000
UCSF – Child, Teen, and Family Center & Department of Psychiatry[94]	2130 Third Street	2017	New Construction. Facility will house outpatient mental health and related pediatric, neurology and pre-term birth obstetric clinics, education, research, office space, and a small retail space. Scheduled to open in 2021.	0	170,000
TOTAL				0	444,000

Table 5.2- 3.4 Major Outpatient Health Services Projects in the Development Pipeline (as of spring 2019)

Facility Type + Name	Address	Year Filed	Description	Number of beds	Net new Medical Space (SF)
Southeast Health Center	2401 Keith Street	2016	Addition/Renovation: Two-story addition adjacent to the existing SFDPH Southeast Health Center.	n/a	11,064
Planned Parenthood	1522 Bush Street	2017	Addition/Renovation: Convert 13,410 sf of automotive services space to a clinic. Opening in 2020.	n/a	13,410
Kaiser Mental Health and Wellness Clinic	939 Ellis Street	2018	Addition/Renovation: Convert 42,122 square feet of office space for a Mental Health & Wellness Clinic (MHWC).	n/a	42,122
TOTAL				n/a	66,596

[91] This list includes UCSF projects that are not officially in the Planning Department Pipeline, but that were approved by the Board of Regents of the University of California (which supersedes local land use authority).
[92] "Year filed" refers to the date that the project sponsor submitted a development application (e.g. a building permit, conditional use authorization, environmental evaluation, or other similar application).
[93] University of California San Francisco. "UC Regents Approve Building Plans for 3 Projects in Mission Bay, Dogpatch." May 19, 2017. Accessible at: https://www.ucsf.edu/news/2017/05/407096/uc-regents-approve-building-plans-3-projects-mission-bay-dogpatch#
[94] Ibid.

Table 5.2- 3.5 Major Residential Care Projects in the Development Pipeline (as of spring 2019)

Facility Type + Name	Address	Year Filed	Description	Number of beds	Net new Medical Space (SF)
Jewish Home of San Francisco	302 Silver St	2011	New Construction and Addition/Renovation Construction of two new buildings housing up to 210 Residential Care Facility Beds. Opening in 2019.	210	264,984
TOTAL				210	264,984

Health care models are fluctuating significantly, and many of the trends identified in the ***Health Systems Trends Assessment*** (insurance and payment structures, technology, etc.) could significantly impact the types and amount of medical facilities needed in the future. In addition, UCSF and the San Francisco VA Medical Center are major medical systems not under the jurisdiction of the City.

Important trends to note:

- **Significant growth in new medical space may continue to be in smaller facilities providing community-based care.** Although larger hospitals and medical systems will continue to expand and modernize their facilities, the bulk of the anticipated development activity is expected to occur in smaller facilities, of all different types. Due to increased emphasis on preventive health, the rising cost of doing business, and other factors, health care organizations are increasingly looking to shift more of their services to outpatient settings, even for traditional inpatient procedures (such as certain surgical procedures).
- **Due to the increasing costs of doing business in the city, health care providers are looking to other business models and technologies.** Organizations believe that there is a need to rethink health care delivery models and technologies (such as telemedicine) to meet future needs, contain health care costs, and provide better service. These trends will impact the number, size, and types of medical facilities needed.
- **Geographic and socioeconomic health disparities will continue.** Access is measured by geographic proximity and the ability to access care even if it is not proximate (e.g. reliable transit, income, disability status, and other socioeconomic factors that can make it difficult to access timely and quality care). By both measures, the deepening inequalities among San Francisco's population (e.g. by income, race, geography) will continue to contribute to inequitable access to health care services. For example, it may be a challenge to meet the needs of a growing aging population in outlying residential neighborhoods that currently do not have easy access to medical facilities. However, many of these issues cannot be solved by land use decisions.
- **Behavioral health services and skilled nursing facilities are priority health care needs**, although the solutions and the resources needed are not yet fully unidentified. For example, even though the City and health organizations acknowledge an urgent need for skilled nursing facilities, the economics of these projects are such that it is unlikely there will be enough new services to meet the need without significant public and private investment, which may not be feasible. These challenges are driving

conversations about creative ways to meet the health needs (such as in-home or "day care" models).

URGENT CARE FACILITIES

As of fall 2019, 14 urgent care facilities operate in San Francisco. They range in size from 2,000 to 5,000 square feet.

These facilities tend to operate in Neighborhood Commercial areas and in the downtown area (Figure 5.1-3.1). They are generally well distributed across San Francisco, with a notable absence of urgent care services in Bayview Hunters Point. As indicated in the Health *Systems Trends Assessment*, numerous reasons are driving this trend, including providers' desire to reduce operating costs and consumer preferences for convenient and accessible health care services.

Figure 5.2-3.1 Urgent Care Facilities (as of fall 2019)

4.NEED AND DEMAND FOR MEDICAL USES

PER THE HCSMP ORDINANCE, "THE HEALTH CARE SERVICE S MASTER PLAN SHALL ASSESS THE SUPPLY, NEED AND DEMAND FOR MEDICAL USES IN THE DIFFERENT NEIGHBORHOODS OF THE CITY." THIS SECTION FOCUSES ON THE NEEDS OF VULNERABLE POPULATIONS BY NEIGHBORHOOD, BUILDING ON THE FINDINGS OF CHAPTER 4.0, AREAS OF HIGH NEED, AND OTHER ASSESSMENTS, WHICH HIGHLIGHT SPECIFIC HEALTH CARE SERVICE GAPS. IN ADDITION, COMPUTATIONS BASED ON PROJECTED GROWTH IN POPULATION AND EMPLOYMENT PROVIDE AN APPROXIMATION OF HOW MUCH SPACE IN NEW OR EXPANDED MEDICAL FACILITIES MAY BE NEEDED BY 2040.

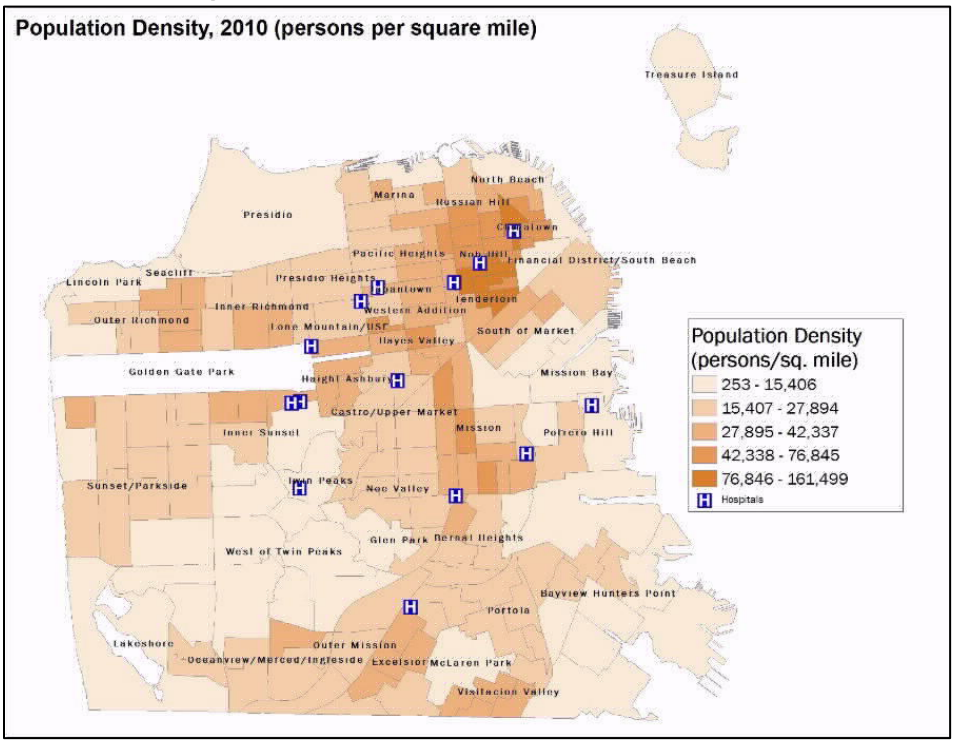
Neighborhood Need

Chapter 4.0 details neighborhood clusters of need and demand for medical uses. Summarized below, the need by neighborhood can be qualified through two lenses: (1) geographic distribution of services and (2) concentration of higher-risk populations.

Geographic Distribution of Services

As described in the Existing Supply section at the start of this chapter, hospital facilities are geographically concentrated in the City's northeast quadrant, mirroring population density (Figure 5.2-4.1), and medical services are available throughout the city with a notable exception of Bayview Hunters Point and Treasure Island (Figure 5.2-1.2) San Francisco has experienced a recent growth in outpatient care (Figure 5.2-3.1), although clinics tend to cluster where population density is higher.

Figure 5.2-4.1. San Francisco Hospitals with Population Density



Neighborhoods with At Risk Populations

As described in Chapter 4.0, eight metrics identify at risk populations: insurance status, poverty, persons of color, children and youth, seniors, limited English proficiency, disabilities, and preventable ER visits. There are more seniors living in western and southwestern southern San Francisco compared to other neighborhoods; while those living in poverty and those without insurance live in eastern and southern San Francisco: Chinatown, Tenderloin, SoMa, Mission, Western Addition, OMI/Excelsior, Visitation Valley and Bayview Hunters Point, also in pockets of the Sunset and Richmond, northern waterfront, and Treasure Island/Yerba Buena Island. The most intense concentration of residents with disabilities is in the Tenderloin and SoMa.

Oral health disparities exist among San Francisco's youth population. Chinatown, Tenderloin, Excelsior and Bayview have some of the highest rates of dental caries among kindergarteners. Despite a high number of dentists, publicly insured and uninsured residents struggle to access oral health services, primarily due to a lack of insurance coverage.

San Francisco Behavioral Health Services serve diverse populations, yet disparities exist for Black/African American residents, homeless residents, LGBTQA, and youth. Expansion of existing community-based behavioral health services and improving access to existing services is needed to meet increasing demand.

Given the complexities of the issues and the solutions, there is no single definitive answer to what health care is needed, where it should be located, or how to improve access. It is clear however, that some neighborhoods have health disparities and lack access to health care.

- The **Bayview Hunters Point** neighborhood has high concentrations of people living in poverty, without health insurance, youth and children, and people of color. The DPH-run Southeast Health Center—one of the only health facilities in the neighborhood—will be renovated in 2020. There are no urgent care clinics to serve the more than 85% of the population who have insurance. Although just south of UCSF Mission Bay, access to health care is an issue for many residents. These barriers contribute to higher rates of preventable ER visits for Bayview residents.
- The **Tenderloin and adjacent SoMa** have high rates of poverty many uninsured residents, people of color, and residents living with disabilities. Although centrally located and close to many health care services, the behavioral health services bundled with other supportive services that are most needed by Tenderloin residents are difficult to access. San Francisco's public safety-net hospital, ZSFG, treats the highest percentage of residents from neighborhoods with elevated rates of health disparities, including the Tenderloin. The density of land uses in this area, and competition for limited land supply, may be a challenge to adding health care services.
- The **Mission** neighborhood has a large population of uninsured residents living in poverty. Mission residents are 34% foreign born and 45% speak a language other than English at home (13% of households are in linguistic isolation[95]). The neighborhood has access to ZSFG and the CMPC Mission Bernal campus, and is not far from the UCSF Mission Bay Campus. There are clinics, physicians, and urgent care facilities in the neighborhood. Yet there are opportunities to increase insurance rates and improve access to culturally and linguistically appropriate health services. Like the Tenderloin, land

[95] Linguistic isolation is a term used by the US Census Bureau for households who speak limited English.

values and commercial rents are high in the Mission, which can make it difficult to add health care that serves low-income populations.

- Like the Mission, **Chinatown** has a large monolingual immigrant population that needs access to culturally and linguistically appropriate health services. Chinatown residents are 71% foreign born and 81% speak a language other than English at home (63% of households are in linguistic isolation). Chinatown's population includes seniors, uninsured, and those living in poverty and/or with disabilities. Centrally located, the neighborhood has physical access to hospitals and other health services, but language, cultural, and other barriers may be keeping residents from getting the care they need.
- The **Western Addition** includes higher rates of residents who are people of color, lack insurance, live in poverty, are seniors, have disabilities, and have limited proficiency in English. Like other central neighborhoods, although health services are geographically close, barriers to access persist.
- **Western, low-density neighborhoods, including the Richmond and Sunset**, have higher percentages of people of color and children and youth. There also have a growing population of seniors who may need improved access to care that supports their specific needs. Land use regulations in these neighborhoods are not a barrier to adding medical uses along commercial corridors. The challenges to adding medical services are primarily economic from the provider perspective: limited access to transit, high vacancy rates that don't foster commercial activity, and occasional neighborhood opposition to uses that generate automotive traffic. An alternative to bringing the services to the aging population is to improve transportation options for residents to access existing health care options.
- The southern neighborhoods of **OMI, Excelsior, and Visitation Valley** include higher populations of people of color, those with limited English proficiency, those without health insurance, children and youth, and those living in poverty. In the OMI, 54% of the population is Asian, 46% of the population is foreign-born, and 65% of residents own their homes. These neighborhoods have a dearth of health facilities nearby and may face additional access barriers.
- **Treasure Island** anticipates adding 8,000 housing units (25% below market rate) in the coming decades, as well as three hotels, restaurants, retail, and entertainment. Development plans do not currently include health care services. As an island, this new community will need local access to medical care. Current residents lack insurance and live in poverty. They are predominantly people of color.
- The **Northern waterfront**, bound by the Bay, Columbus Avenue and Chestnut Street, includes residents who lack insurance, live in poverty are people of color, are seniors, and those with disabilities.

Projected Growth

Regional projections of population and job growth were used to estimate what share of growth may be dedicated to medical uses. This provides only a rudimentary idea of space needs and should be considered in the context of existing resources, who needs health care and the barriers to access care.

The limitations and caveats to these projections are that (1) health care delivery is rapidly changing in response to technology and State and Federal health policy, (2) demographic shifts in coming years may influence the demand for health care, and (3) as a renowned

center for health care, San Francisco draws patients from far beyond city limits. Developing projections of real estate demand for medical facilities may provide a general indication of future need, but how that demand is implemented throughout the City will be driven by policy and market forces.

Two methodologies were used to calculate potential future demand for space for medical uses. One methodology is based on projected employment growth and medical uses' share of the economy; the other is based on projected population growth. These two methodologies may illustrate the range of potential square footage of new medical space that may be needed by 2040 to maintain current levels of medical services. These same methodologies were used in the 2013 HCSMP. **San Francisco has the zoned capacity for this potential growth.**

Method one estimates the amount of medical space necessary to accommodate projected growth in medical jobs. It starts with the Plan Bay Area job and sector projections developed by the Association of Bay Area Governments (ABAG) by 2040. That growth is multiplied by an estimate of how much space each employee requires (approximately 350 square feet).[96] After subtracting medical space in the current development pipeline, this method estimates a potential need for 4.3 million square feet of new medical space by 2040.

Method two estimates the amount of medical space potentially needed to serve the city's residential population growth. Using Plan Bay Area's estimate of an additional 252,737 residents in San Francisco by 2040 (based on 2020 actuals), and assuming that demand for medical space may grow at the same rate as the population in order to ensure a similar level of service, this method estimates a potential need for 4.78 million square feet of new medical space.

There are caveats and limitations to these calculations. It is not clear that maintaining the current ratio or using these methodologies is an accurate prediction of future needs.

- In 2019, San Francisco has 18.8 million square feet of medical uses.[97] There may be surplus capacity within existing facilities to accommodate some future growth
- Medical service delivery trends— like telemedicine and the availability of outpatient and preventive care—may impact how much space is required for medical care.
- San Francisco has a high physician per capita ratio of 630 compared to 1,280 statewide. San Francisco's physician per capita rate is also 33% higher than other Bay Area counties. The City also has a high ratio of beds per capita—3.6 for every 1,000 residents—which is much higher than California's ratio of 1.9. This is indicative of San Francisco's status as a regional and even national center for innovative medical care and research.
- These projections do not adjust for those coming into San Francisco for care or San Francisco residents using care outside of the city.
- The composition of the health care workforce may change, resulting in shortages in certain skillsets such as nursing.
- The demographic mix of San Francisco may change, and different populations use health care services in different ways. For example, an increase in the population of seniors may create more demand for long-term care.

[96] The estimate of space per medical employee (350 square feet) is consistent with the Planning Department's Land Use Allocation model, which is an input to the *Plan Bay Area*, updated every four years by the Association of Bay Area Governments (ABAG).

[97] From the MED category of the Planning Department's Land Use Database.

- The 2014 UCSF Long Range Development Plan (LRDP) plans for an additional 2.39 million square feet by 2035. Although this includes housing and other university amenities, it will increase the amount of medical uses in the city.

Table 5.2-4.1 Projected Potential Demand for Medical Space BY-2040

Method 1: Employment Growth	
2040 net new medical jobs [98]	14,519
Estimated employment density (square foot per job) [99]	350
2040 projected net new medical space (square feet)	5,081,650
Less: square footage of medical space in pipeline	-775,580
Projected net new medical space (square feet)	**4,306,070**
Method 2: Population Growth	
2019 medical supply (square feet per capita) [100]	22
2040 additional population growth [101]	252,737
2040 projected net new medical space (square feet)	5,560,214
Less: square footage of medical space in pipeline	-775,580
Projected net new medical space (square feet)	**4,784,634**

5.TRANSPORTATION PLANNING AND ACCESS TO HEALTH CARE

THIS SECTION EXAMINES TRANSPORTATION BARRIERS TO HEALTH CARE ACCESS AND EFFORTS TO HELP IMPROVE ACCESS TO ESSENTIAL DESTINATIONS AND MEDICAL SERVICES.

People who must travel longer and/or greater distances to health care services are less likely to use outpatient and preventive health services and are more likely to visit the emergency room, suggesting that patients are less reliant on costly emergency care if primary care is readily available.[102, 103] Residing longer distances from health care is also associated with poorer health

[98] Source: 2017 Land Use Allocation, SF Planning Department
[99] Source: 2017 Land Use Allocation, SF Planning Department
[100] Source: Total 2018 square feet (18,802,735) from the MED category of the Planning Department's Land Use Database and the population estimate of 864,263 from the 2013-2017 American Community Survey 5-year estimates
[101] Population growth figures from ABAG projections for Plan Bay Area 2040
[102] Hadley J, Cunningham C. (2004). Availability of Safety Net Providers and Access to Care of Uninsured Persons." Health Serv Res.; 39(5): 1527–1546. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361082/?tool=pubmed
[103] Ludwick A, Fu R, Warden C, Lowe R. (2009). "Distances to Emergency Department and to Primary Care Provider's Office Affect Emergency Department Use in Children." Academy of Emergency Medicine, Vol. 16, no. 5. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00395.x/pdf

outcomes, including lower rates of mammography screening, higher rates of asthma-related death, and lower cancer survival rates.[104, 105]

"I have scoliosis, and it takes me one to one-and-a-half hours to get to my [medical] appointments on public transit, and my mom has to miss work. There should be more services in the Southeast." - Visitacion Valley Youth

Efficient, reliable, and affordable transportation options play a key role in making health care and other basic human services accessible to all. According to Medi-Cal Managed Care standards (applicable to San Francisco's Medi-Cal programs), primary health care services should be no more than 30 minutes of travel time or 10 miles of travel distance from each member's place of residence.[106, 107] While San Francisco offers a rich array of health and wellness services within a relatively small geographic area—nearly all residents have a public health facility (a hospital or clinic) within 1.5 miles, and all residents have one within five miles—accessing health care services in a timely manner remains a challenge for some residents. This is particularly true for residents without access to a car and who are more likely to rely on public transit. About one-third of San Francisco adults do not have access to a private vehicle, with low-income and older adults the least likely to own a vehicle (90% of high-income households have access to a vehicle, compared to 50% of low-income households)[108, 109]

Figure 5.2-5.1 displays the percent of households without access to a personal vehicle alongside the major transit routes in San Francisco (MUNI & BART) and the locations of hospitals and primary care clinics. As illustrated by the map, the northeast quadrant of San Francisco has the greatest concentration of primary care clinics, hospitals, and transit lines, which also has neighborhoods where there are households without access to a personal vehicle. Where transportation to health services is of concern are in the southeast and western neighborhoods of San Francisco. Neighborhoods including Lakeshore, Maclaren Park, and Treasure Island all have limited to no primary care clinics in the neighborhood in addition to few transit routes. Geographic proximity and/or public transit availability to a health care facility is but one measure of health care access and does not consider other systemic barriers to care (e.g. the capacity of providers to take additional patients, the types of insurance accepted, or a provider's linguistic or cultural competence, among other factors).

104 Hyndman JC, Holman CD, Dawes VP. (2000). Effect of distance and social disadvantage on the response to invitations to attend mammography screening. J Med Screen; 7(3): 141-5. http://jms.rsmjournals.com/content/7/3/141.full.pdf.

105 Jordan H, Roderick P, Martin D, Barnett S. (2004). Distance and rurality and the need for care: access to health services in South West England." International Journal of Health Geographics, 3:2 Retrieved from http://www.ij-healthgeographics.com/content/3/1/21

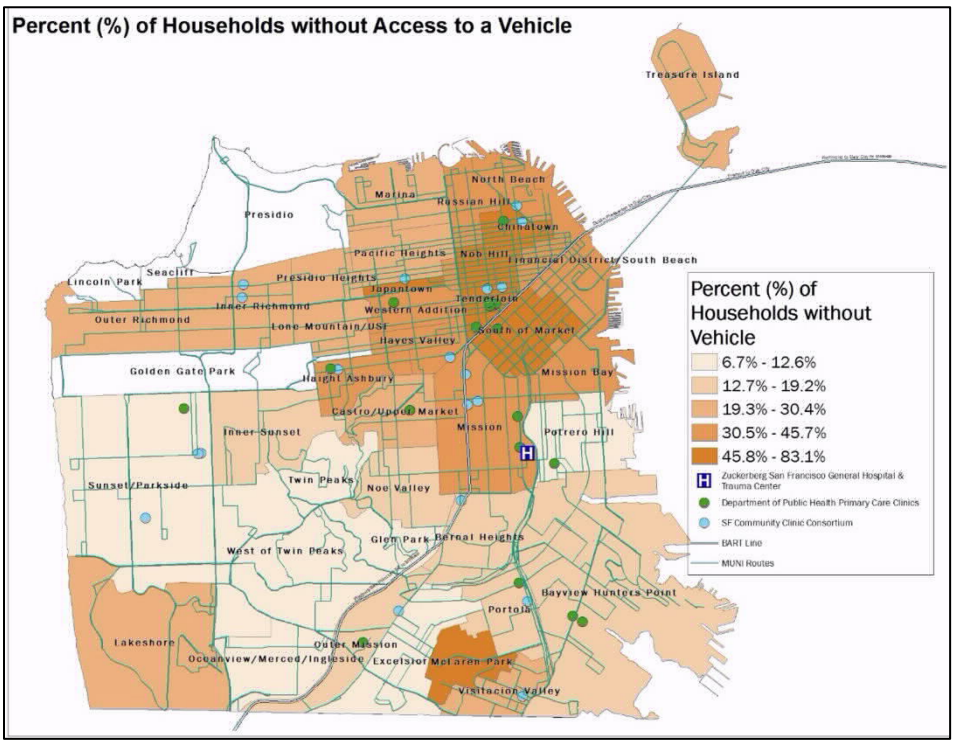
106 California Code of Regulations, Title 22, Section 53885, "Travel Distance Standards." Retrieved from http://weblinks.westlaw.com/result/default.aspx?cite=22CAADCS53885&db=1000937&findtype=L&fn=%5Ftop&pbc=DA010192&rlt=CLID%5FFQRLT28804265110123&rp=%2FSearch%2Fdefault%2Ewl&rs=WEBL12%2E01&service=Find&spa=CCR%2D1000&sr=TC&vr=2%2E0.

107 Please note that eligible beneficiaries may elect to seek care beyond the specified time/distance standard if desired.

108 United States Census Bureau, 2015 American Community Survey. Retrieved from https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml#

109 UCLA Center for Health Policy Research. Ask CHIS 2015. Has a Car for Regular Use. (San Francisco). Available at askchis.ucla.edu.

Figure 5.2-5.1 Percent of households without access to a personal vehicle alongside major MUNI & BART transit routes and the locations of hospitals and primary care clinics



In an analysis completed by the Department of Public Health in 2014[110], neighborhoods in San Francisco were given an average health facility transit score. Transit service areas were defined by (1) a total trip time to a health facility is less than 30 minutes, (2) no walking portions of the trip are over a quarter of a mile, and (3) there is not more than one transfer between transit lines. Using this relative score, the neighborhoods with the lowest relative health care transportation access includes: Lakeshore, Treasure Island, Seacliff, Lincoln Park, Visitacion Valley, and Sunset/Parkside.

In 2014, Potrero Hill Health Center (PHHC), a safety net clinic serving primarily low-income vulnerable populations, with the assistance of University of California San Francisco (UCSF) medical students, surveyed patients to assess the extent that transportation barriers impact patients' access to the clinic and health outcomes. Barriers include geographic (the clinic is located on the top of a hill) factors, transportation factors (such as limited bus service to the clinic), and the time and distance patients must travel to visit the clinic. The following lists key findings of the survey:

- Over 30% of PHHC patients cannot comfortably walk more than one block up a steep hill

[110] Source: San Francisco Department of Public Health, 2014. Methodology: the Google Transit API was used to calculate average transit trip times. Trip start time was defined as 8:00am on April 27th, 2014 from the centroid of each census block group to each health facility. Trip data was then summarized at a census block level for analysis. One point was given for clinics that had a total trip time less than 30 minutes, one or less transit transfers, and all walking legs of the trip were a quarter mile or less. 0.9 of a point was given if the trip consisted entirely of walking but the distance walked was greater than a quarter mile. 0.75 of a point was given if for clinics that had a total trip time less than 30 minutes, one or less transit transfers, but any walking leg was greater than a quarter mile. If a clinic trip didn't meet any of the above it was scored 0. Each clinic trip was then summed at a census block group level and normalized to a scale of 0-100. Averages scores were calculated for neighborhoods.

- 85% of patients have at least one symptom impacting their ability to walk (back pain, shortness of breath, pain in legs or feet, dizziness, balance problems, chest pain, pregnancy, etc.)
- 26% of patients reported using at least one assistive device (cane, walker, wheelchair, white cane, crutches, braces)
- 57% of survey respondents typically relied on Muni to get to the clinic
- 58% of survey respondents reported spending more than 30 minutes of travel time the clinic

25%[111] Estimated percentage of residents in the Excelsior neighborhood who spend 60 minutes or more traveling to see a health care provider -

Compared to patients at higher income levels, the lowest income patients who reported the most mobility limitations were more likely to cite public transportation as a barrier to receiving care, causing them to miss appointments, delay care, arrive late to an appointment, or go without health services.[112] Similarly, according to a 2012 survey by the Chinese Progressive Association, roughly one in every four (25%) Excelsior residents, reported spending 60 minutes or more traveling to see a health care provider.[113] Community members at workshops led by the San Francisco Health Improvement Partnership—co-hosted with the African American Art Cultural Center and Asian Americans Advancing Justice of the Asian Law Caucus—voiced similar concerns, citing transportation issues and travel time as barriers to care.[114]

Transportation Planning + Future Development

Plan Bay Area projects that San Francisco will grow to 1.1 million residents by 2040. By that year, it is projected that the city will add 260,000 jobs, and household and employment growth will lead to increased demands on infrastructure and services. Based on planned development through 2040, the Planning Department expects the bulk of that growth to happen on the eastern side of the city. Major housing-focused plans include Treasure Island (8,000 units), Hunters Point-Candlestick Point (12,000 units), Parkmerced (5,700 units), and Central SoMa (8,800 units). Other large residential projects are expected at Mission Rock, Pier 70, and the former Potrero Power Plant site. In addition, policies such as the Accessory Dwelling Units (ADU) program and HOME-SF aim to add housing in established mixed-use neighborhoods close to existing infrastructure and services.

In order to meet the demands of new growth and improve the performance of the transportation system overall, the City is engaged in multiple long-term transportation planning efforts. San Francisco is currently developing ConnectSF[115], a multi-agency collaboration to build an effective, equitable and sustainable transportation system for the city's future. The first phase of work defined a 50-year vision for San Francisco's future that represents the collective goals and aspirations of the city. The next two phases of work will include: (1) technical studies that involve the development, evaluation, and prioritization of project concepts for the city's transit, streets, and freeway networks, and (2) transportation policies and funding priorities incorporated into the San

[111] Chinese Progressive Association. (2012). Creating Healthy Communities: Making Healthcare Services Accessible in San Francisco. Draft Report, March 2012.
[112] San Francisco Department of Public Health. (2015) Potrero Hill Health Center (PHHC) Transportation Access: Implications for Health. Draft Report Under Review
[113] Chinese Progressive Association. (2012). Creating Healthy Communities: Making Healthcare Services Accessible in San Francisco. Draft Report, March 2012.
[114] San Francisco Health Improvement Partnership. (2016). San Francisco Community Health Needs Assessment 2016. Appendices
[115] ConnectSF. https://connectsf.org/about/about-connectsf/

Francisco Transportation Plan and the Transportation Element of the city's general plan.

As of early 2019, several major transportation projects are underway in San Francisco, including the Central Subway and Van Ness Bus Rapid Transit (BRT), scheduled for completion in early 2020 and 2021, respectively. The Central Subway will bring underground light-rail service from Chinatown through SoMa to the existing Muni T line. The Central Subway will improve public transportation access to both the Chinese Hospital and the UCSF Mission Bay campus, as well as to burgeoning residential neighborhoods like Mission Bay and Dogpatch, providing faster connections to regional transit: BART at Market Street and Caltrain at the 4th and King station. The Van Ness BRT will construct a dedicated busway along Van Ness Avenue from Greenwich Street to Mission Street, providing a faster, more reliable trip along one of the city's busiest transit corridors, passing immediately adjacent to the new CPMC Van Ness campus.

Longer-term transportation projects include the Geary Street BRT, which will serve four major hospitals: CMPC Van Ness, two Kaiser Permanente campuses, and the VA Hospital. Another notable project in the planning phase is the extension of Caltrain (and future High-Speed Rail) from its current terminus at 4th and King Street to the downtown Salesforce Transit Terminal.

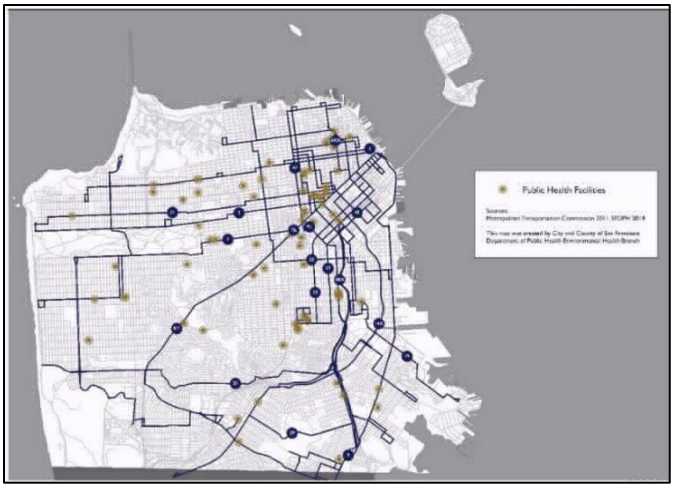
SFMTA Muni Service Equity Strategy

In March 2018, the San Francisco Municipal Transportation Agency (SFMTA) published its Muni Service Equity Strategy Report covering fiscal years 2018-19 and 2019-20, the first of which was adopted in 2016. Advised by an Equity Working Group comprised of local community-based organizations, the report uses a neighborhood-based approach to improve Muni transit routes most critical to low-income households and people of color.

The Muni Service Equity Strategy is focused on eight "equity neighborhoods"—Chinatown, Western Addition, Tenderloin/South of Market, Mission, Excelsior/Outer Mission, Visitacion Valley, Oceanview/Ingleside, and Bayview. The 2016 strategy heavily focused on routes used by seniors and people with disabilities, and the 2018 strategy expanded that focus by engaging riders through community-based organizations. After a community outreach process, the adopted 2018 Equity Strategy was adopted and informs a two-year capital and implementation operating budget.

The report evaluates the performance of Muni lines providing transit to these areas. As indicated in Figure 5.2-5.2, roughly 80% of San Francisco's public health facilities (hospitals and clinics) are within 500 feet of these transit routes.

Figure 5.2-5.2 Public Health Facilities and Transit Lines from the Muni Service Equity Strategy



SFMTA has multiple initiatives aimed at improving transit reliability and performance, including Muni Forward and various streetscape plans. The SF Paratransit program, which provides public transportation service to people with disabilities, is one explicit effort to address transportation barriers to health care. In 2018, the program provided 775,000 trips to 13,000 riders; however, users have reported concerns with the reliability of services, resulting in delayed access to medical services and missed appointments.[116, 117] One such example of public health and transportation collaboration is in the pilot completed with the Potrero Hill Health Center (PHHC), a safety-net clinic in San Francisco. SFDPH and PHHC staff conducted an assessment to better understand geographic and transportation barriers faced by the clinic patients. SFDPH then worked with SFMTA to implement methods of addressing the issues identified, which included increased coordination to ensure patients have access to paratransit services. This particular pilot project has been featured as a case study by the CDC for having potential to improve health in five years through transit and public health collaborations.[118] City agencies will continue to explore opportunities for improving transit access to care (for example, through the FTA Rides to Wellness program, shuttles, or other best practices).

Vision Zero

Eighty-five percent of San Francisco's public health facilities are located on unsafe streets, as identified in the City's High Injury Network created by Vision Zero SF, a collaborative City and community initiative to eliminate traffic fatalities by 2024. The high injury network comprises just 13% of San Francisco's streets but accounts for over 75% of severe and fatal traffic injuries, with pedestrians making up over half of traffic deaths.[119] Half of these streets are located in Communities of Concern as defined by the Metropolitan Transportation Commission—low-income communities, communities of color, and communities with many seniors and people who rely on walking and transit as their primary means of transportation.

Pedestrian safety and comfort are especially critical around hospitals and community clinics, where there may be higher numbers of people

[116] San Francisco Municipal Transportation Agency, Fiscal Year 2017-2018 Annual Report. Retrieved from: https://www.sfmta.com/reports/2018-annual-report-year-movement

[117] DAAS Needs Assessment Focus Groups 2016

[118] Transit Equity: Addressing Barriers to Health Care Access for Vulnerable Populations. Retrieved from https://www.sfdph.org/dph/EH/PHES/PHES/TransportationandHealth.asp

[119] Vision Zero SF. What You Need To Know. Retrieved from http://visionzerosf.org/wp-content/uploads/2015/04/VZSF_What-You-Need-To-Know.pdf

with mobility challenges and/or transit-dependent patients. Specifically, more thoughtful planning and design around facilities—including siting bus stops nearby, managing parking and loading issues, posting and/or reducing speed limits, and other traffic calming and design features—can ensure that patients arrive quickly and safely to their medical appointments. More broadly, the 2019 Vision Zero Action Strategy establishes a range of actions the City is implementing to improve traffic safety along the High Injury Network and citywide, such as streetscape improvements, education, and stronger enforcement.

6.POTENTIAL FOR LAND USES BURDENS AND DISPLACEMENT OF NEIGHBORHOOD SERVICES

WHILE MEDICAL FACILITIES ARE AN ESSENTIAL SERVICE AND A KEY DRIVER OF THE LOCAL ECONOMY, THEIR SPECIFIC LOCATIONS AND OPERATIONS MAY HAVE BOTH POSITIVE AND NEGATIVE IMPACTS ON SURROUNDING NEIGHBORHOODS. THIS SECTION, REQUIRED IN THE HCSMP ORDINANCE, DESCRIBES SOME OF THE POTENTIAL LAND USE IMPACTS AND DISPLACEMENT IMPACTS ASSOCIATED WITH MEDICAL LAND USES.

Health care is a basic need for all San Francisco residents and workers, and critical to thriving, healthy communities. However, this Plan acknowledges that individual medical facilities can have unintended negative impacts in addition to the valuable services they provide. In many cases, the benefits these projects bring outweigh their potential drawbacks. Further, the project review process itself can help identify, lessen, or altogether mitigate negative impacts.

This section describes of some of the potential negative land use and displacement impacts of medical facilities based on data analysis and feedback from stakeholder interviews. It provides a general overview; given the considerable diversity of medical facility types, the specific impacts of an individual project can vary significantly depending on the size, design, and operations, and existing neighborhood context.

Land Use Impacts

Every type of land use comes with potential positive and negative impacts. The original purpose of the first zoning regulations adopted in the early 20th century was to limit the impact of land use nuisances (such as pollution and excess noise) by creating zoning districts that encouraged compatible uses to locate near each other. These concepts have evolved into complex modern zoning and environmental review policies, which consider a wide range of potential impacts as a condition of approval. The fundamental purpose of land use policies is to balance these potential burdens and benefits.

Some potential medical land use burdens are highlighted below. This is not a comprehensive list of land use and environmental impacts. It is a description of some of the more common themes, based on past development projects and key stakeholder interviews.

Transportation

Some medical uses, such as hospitals, are viewed as higher trip generators than other commercial uses (such as office or retail) for a variety of reasons. Patients may have physical limitations and making a trip in a vehicle is the only feasible option for them. Meanwhile, staff, patients, and visitors may rely on driving to get to and from the facility, particularly at late night hours when other options are unavailable.

Transportation impacts from medical facilities vary significantly depending on the facility size,

design, and existing context. Regulations are in place to ensure that the impacts of a new large hospital or any other medical facility on increased traffic congestion, transit crowding and delay, parking supplies, and on pedestrian and bicycle safety, particularly when facilities are built in already busy, built-out areas are understood and mitigated. Ensuring that new facilities are accessible by multiple transportation options and incorporating Transportation Demand Management (TDM) strategies can greatly mitigate these impacts. The City's TDM Program requires new projects to include features that will lessen its transportation impacts by promoting sustainable modes of travel, tailored to a project's specific land use, amount of parking, and location in the City.

It's important to note that these impacts may be very different for smaller facilities. This is particularly true of outpatient and ambulatory care facilities, particularly if they are in convenient, transit-accessible locations in neighborhood commercial districts or near where people live and work.

Transparency

Aesthetic impacts refer to whether a project has a major, degrading impact on the visual character of the surrounding neighborhood, including scenic vistas, natural features, or other visual landmarks. The Planning Code regulates aesthetics of medical uses in many ways. For example, ground floor active uses, such as clinics or doctors' offices, must meet transparency guidelines. Another example is the design review process to ensure that "Formula Retail" uses (e.g., retail businesses with 11+ locations) do not have deleterious effects on surrounding properties. This more intense level of review for formula retail was codified in response to concerns about chain retailers that have opened facilities in San Francisco with standardized design features that are unresponsive to and unsuitable for the neighborhood context (such as blank facades or poorly placed and outsized signage). Larger buildings, such as hospitals, are also subject to a more rigorous design review process. Design review ensures that the building size and placement of signage is limited, the ground floor remains open and transparent, and the overall design and scale fits with the character of the existing neighborhood.[120]

Economic & Displacement Impacts

The deepening housing affordability crisis has heightened anxieties about gentrification and the potential for displacement of longstanding residents and businesses. Displacement and gentrification are complex issues, and there is no consensus on what factors are responsible. The limited research on commercial gentrification presents varied findings (much of the academic literature focuses on residential displacement).[121] It is beyond the scope of this Plan to conduct the detailed economic analysis necessary to determine if health care uses either contribute to and/or are impacted by displacement in San Francisco. However, this section provides a general discussion of the potential economic impacts that medical facilities might have on surrounding communities, using data and feedback from stakeholder interviews. As noted, this is meant to be a generalized list of considerations, and the impacts of individual facilities will vary.

When the HCSMP Ordinance and 2013 Plan were adopted, displacement concerns focused on the impacts of larger facilities such as hospitals (triggered in part by CPMC's hospital

[120] San Francisco Planning Department. July 2014. *Commission Guide for Formula Retail. Determining Locational Appropriateness and Performance-Based Design Guidelines.* http://sf-planning.org/sites/default/files/FileCenter/Documents/9343-FormulaRetail_Commission_Guide.pdf

[121] Zuk M, Bierbaum A, Chapple K, Gorska K, Loukaitou-Sideris A, Ong P, and Thomas T (2015). *Gentrification, Displacement, and the Role of Public Investment: A Literature Review.* Accessed at: http://www.urbandisplacement.org/research

expansion plans, which were being negotiated under a Development Agreement at the time). While concern about displacement pressures of large facilities persist, stakeholder interviews indicated that there may be new displacement concerns focused on smaller outpatient facilities in neighborhood commercial corridors. However, economic studies conducted by the City indicate that neighborhood outpatient facilities generate foot traffic and may help bolster local retail.[122]

There are no singularly accepted definitions of displacement and gentrification. For purposes of this discussion, two broad definitions[123] are used to characterize these trends.

- **Direct physical displacement:** The medical facility directly replaces an older building where other lower-paying uses are located.
- **Indirect economic displacement:** The medical facility increases rent, making it more difficult for surrounding businesses to remain viable.

Data on commercial vacancies is limited and data on commercial rents is not tracked, so it is impossible to know whether a specific change of use to a medical facility directly displaced a lower paying use or if the site sat vacant for some time before the medical facility opened.

Feedback from stakeholder interviews with developers, commercial brokers, and neighborhood/merchant associations suggest that there is likely a low risk of direct displacement. Neighborhood commercial corridors are experiencing an increase in vacant storefronts due to the changing retail landscape (a nationwide trend), so these facilities may be filling existing vacancies rather than displacing prior uses. In addition, since some medical facilities require a larger footprint (2,000-8,000 square feet) than typical retail storefronts (500-2,000 square feet), they may be filling the larger commercial spaces that are typically harder to rent and more likely to sit vacant.

A 2018 study[124] by the Office of Economic and Workforce Development looking at the state of the retail sector in San Francisco found that health and personal care is one of the few categories of retail growth. To some extent, vacancies left by traditional retailers may be filled by other uses. While demand appears to be slowing generally, brokers reported that most of the interest in ground floor space in the NCDs is coming from restaurants, nightlife and entertainment, and service providers (such as fitness centers and medical services) and that this trend has intensified. This could mitigate some of the effects on vacancy rates of any local retraction in the retail industry. The study found medical services to be a driver of retail demand in commercial corridors because of the daily foot traffic generated. For example, Upper Fillmore benefits from its proximity to California Pacific Medical Center, which generates daytime customers (workers and patients).

The study found that services, including medical services, contribute to the healthy mix of a commercial corridor. Dining, entertainment, and services are essential to creating a diverse and interesting district. These uses are becoming more prevalent relative to traditional retail as e-commerce continues to grow. Certain services, such as medical care, cannot easily be replaced by online retail options.

The question of whether new medical facilities result in indirect economic displacement is more

[122] State of the Retail Sector: Challenges and Opportunities for San Francisco's Neighborhood Commercial Districts. February 2018. https://oewd.org/sites/default/files/Invest%20In%20Neighborhoods/State%20of%20the%20Retail%20Sector%20-%20Final%20Report.pdf

[123] The definitions are taken from the "Community Services Economic and Nexus Study: Level of Service Standards and Best Practices Report" (2014) prepared for the City and County of San Francisco by Economic & Planning Systems, Inc.

[124] [124] Strategic Economics. *State of the Retail Sector: Challenges and Opportunities for San Francisco's Neighborhood Commercial Districts – Executive Summary.* (conducted for the San Francisco Office of Economic & Workforce Development) Available at: https://sfgov.legistar.com/View.ashx?M=F&ID=5782348&GUID=BB47CD23-E434-4007-A8BD-EEE094D5DC7F

complex. Research and interviews suggest that broader economic trends may be primarily responsible for the current loss of small businesses. In addition to shrinking demand for brick-and-mortar retail, commercial rents are increasing citywide concurrently with the increase in residential demand. As additional residents and higher income households move into San Francisco, there is increased demand for commercial space to serve these residents, leading to higher rents—from 2014 to 2017, asking retail rents increased by nearly 30%.[125] These impacts are exacerbated when leases for longstanding businesses come up for renewal after 10-20 years or more, leading to "sticker shock" and waves of closures as landlords attempt to bring rents up to market rates. Paradoxically, as storefront vacancies increase, rents increase, perhaps reflecting unrealistic revenue expectations on the part of landlords.

Notable Considerations

Health care facilities are not often the primary cause of these economic trends, but some health care facilities may play a role in hastening increasing rents. The following considerations are noteworthy and were confirmed through the HCSMP outreach process.

- **Health care may be viewed as a stable tenant with the capacity to pay higher rents.** Some medical facilities can pay higher rents than existing uses, or even higher than current market values. Medical facilities may be seen by landlords as more stable and lower risk than many retail uses. Collectively, this could drive real estate pressure and rents upward. However, this can vary significantly by facility, for example, nonprofit clinics serving patients with no insurance or public insurance may be less likely to be able to afford high rents.
- **Health care has flexible space needs & low cost of tenant improvements.** On a per square foot basis, construction costs for outpatient facilities are considerably lower than for hospital construction, which must adhere to rigorous licensing standards. Similarly, tenant improvement costs might be less for outpatient medical uses than for a restaurant or other more intensive commercial use that requires more costly plumbing and ventilation systems (which typically must be built into the building at the time of construction and cannot be added later). Outpatient facilities thus tend to have greater flexibility than other uses and can choose from a greater selection of possible commercial spaces.
- **The permitting process for health care is simpler.** Depending on the zoning district, the existing use, and the specific scope of work, converting an existing commercial space to an outpatient medical facility can be a relatively straightforward permitting process at the Planning Department, sometimes approvable over the counter. Whereas, for example, a restaurant could require extensive neighborhood notification adding months to the review process.
- **Health care may be a more attractive tenant.** For the above reasons, medical uses—particularly small outpatient medical centers—may be seen by landlords and brokers as desirable tenants. However, although these uses can pay high rents, a landlord may still prefer to rent to a restaurant, grocer, or other more general retail use, especially in mixed-use residential buildings where landlords want a variety of retail that caters to residents.
- **Health may have both a "deadening" impact on surrounding businesses and**

[125] Loopnet: San Francisco, California Market Trends. Accessed 4/4/2017 at: http://www.loopnet.com/San-Francisco_California_Market-Trends

generate retail demand. The privacy considerations of health facilities can sometimes be at odds with City and neighborhood goals to maintain open and "active" storefronts. This can be problematic when facilities locate in prime locations in a neighborhood (e.g. at a prominent intersection, directly adjacent to major transit, or at a site with a long store frontage). Some medical facilities appear to actively seek out these spaces, particularly the newer and expanding operators who are competing for market share and place a higher premium on visibility. While this can increase access to care, it may have a "deadening" impact on surrounding businesses and discourage foot traffic to the area, particularly if the facility design is opaque or walled off from the street. On the other hand, a well-designed facility can be a welcome addition to commercial corridors. In either case, health care generates foot traffic. As noted in the 2018 OEWD study, medical facilities can generate retail demand by attracting people to commercial areas, and that diversification of uses is a potential strategy to address rising retail vacancy rates.

- **Economic "cluster" impacts.** Business clusters are geographic concentrations of firms in related sectors, and are often seen as an economic boon, generating more business activity and innovation than firms operating in isolation. Business clusters are more likely to form around large facilities (for instance, medical offices and laboratories might cluster near a hospital campus), but smaller medical use clusters are also forming in neighborhood commercial districts (such as a grouping of pharmacies, medical offices, and clinics). This growing diversity of accessible medical services in neighborhoods may be a positive trend for residents. However, an overconcentration of medical services and other similar types of uses (such as personal services) may detract from the vibrancy of retail corridors.

In summary, the growing trend of smaller medical facilities is unlikely to result in widespread direct physical displacement, and that the increase of business closures and storefront vacancies may have more to do with larger economic forces that are unrelated to health care. However, there may be potential indirect economic displacement impacts that are dependent on the specific project and neighborhood where a facility is located.

5.3 CAPACITY & GAP ASSESSMENT

CONTENTS

OVERVIEW

SAN FRANCISCO'S NETWORK OF HEALTH CARE SERVICE PROVIDERS OFFERS A RICH VARIETY OF HEALTH AND WELLNESS SERVICES, STRIVING TO MEET THE CITY'S DIVERSE NEEDS FOR PRIMARY CARE, EMERGENCY, LONG-TERM CARE, AND OTHER HEALTH NEEDS FACING SAN FRANCISCO'S GROWING AND DIVERSE POPULATION. DESPITE SAN FRANCISCO'S RELATIVELY SMALL SIZE AND "SERVICE RICH" ENVIRONMENT, MANY OF SAN FRANCISCO'S MORE VULNERABLE RESIDENTS STILL STRUGGLE TO ACCESS THE HEALTH CARE SERVICES NECESSARY TO THRIVE.

As a requirement in Ordinance 300-10, the Health Care Service Master Plan (HCSMP) must include both a capacity assessment and a gap assessment, the purposes of which are defined in the next box.

Capacity Assessment – quantifies the current and projected capacities of existing Medical Uses in San Francisco (public and private facilities and for and non-profit organizations); describes, analyzes, and projects resources available for emergency services, including trauma services; acute hospital services, including beds and services that require specialized facility accommodations; ambulatory care services including primary care; specialty physician services; hospital-based and free-standing urgent care services; rehabilitation, long-term care and home health services; and behavioral health services including psychiatric emergency services; and quantifies "surge capacity" needs in the event of a disaster.

Gap Assessment – identifies medical service gaps across the City and medically underserved areas for particular services with reference to geography, transportation/communication options, and unique barriers to accessing care, including but not limited to the absence of cultural competence, language, race, immigration status, gender identity, substance abuse, and public assistance.

The 2019 HCSMP Capacity and Gap Assessment explores the current capacity of San Francisco's health care facilities and projects future needs based on population projections, with a focus on underserved populations. This assessment also addresses access, or "connectivity" gaps in San Francisco's health care system that were voiced by members of the public and the 2013 HCSMP Task Force. This chapter also examines potential geographic barriers or disparities, and gaps in meeting residents' health literacy and cultural/linguistic needs. While health insurance coverage also affects an individual's ability to connect to health care services, coverage issues are not presented in this section (see the *Health System Trends Assessment* chapter for more information about insurance coverage). Detail about the data sources used for this section is available in the *Plan Development & Outreach Chapter*.

The Capacity and Gap Assessment chapter includes the following sections:

1. Hospital Services
2. Emergency Medical Services
3. Primary Care
4. Dental Care
5. Behavioral Health Services
6. Post-Acute and Long-Term Care
7. Culturally and Linguistically Competent Care
8. Medical Surge and Disaster Planning

Highlights from each of these sections are have been summarized:

HOSPITAL SERVICES

- *Hospital facilities are geographically concentrated in the City's northeast quadrant, mirroring population density.*
- *San Francisco's supply of general acute care hospital beds for the population exceeds that of state and may be sufficient to meet the increasing demands of a growing population.*
- *Total hospital discharges from San Francisco hospitals have increased while City resident discharges have decreased.*
- *Hospital use patterns vary by neighborhood. San Francisco's public safety-net hospital, Zuckerberg San Francisco General Hospital & Trauma Center (ZSFG), treats the highest percentage of residents from neighborhoods with elevated rates of health disparities, including Tenderloin, Mission, and Bayview.*

EMERGENCY MEDICAL SERVICES

- *San Francisco hospitals have increased emergency care capacity, but demand for services may outpace supply.*
- *San Francisco ambulance diversion rates have increased, indicating potential need to improve hospital efficiencies beyond increasing Emergency Medical Services (EMS) bed numbers.*

PRIMARY CARE

- *San Francisco exceeds national benchmarks for primary care physicians per population and is highest in the state.*
- *There are a limited number of physicians who care for Medi-Cal patients, posing barriers to health care access.*
- *Similar to the geographic distribution of hospitals, primary care clinics are geographically concentrated in the northeaster quadrant of San Francisco.*
- *San Francisco has experienced growth in the number of small outpatient clinics.*

DENTAL CARE

- *Despite a high number of dentists, publicly insured and uninsured residents struggle with access to oral health services*
- *Low-income residents and homeless residents can access free dental services through Denti-Cal and the San Francisco Health Network (SFHN), but disparities in access and oral health outcomes remain.*
- *Oral health disparities exist among San Francisco's youth population – Chinatown, Tenderloin, Excelsior and Bayview have some of the highest rates of dental caries among kindergarteners.*

BEHAVIORAL HEALTH SERVICES

- *San Francisco has a similar prevalence of mental illness compared with most Bay Area counties and the state.*
- *San Francisco Behavioral Health Services serve diverse populations, yet disparities may exist for black/African American residents, homeless residents, and youth.*
- *San Francisco has several facilities for residents needing higher levels of behavioral care, but additional capacity is needed to improve patient flow into lower levels of care and/or treatment.*
- *Expansion of existing community-based behavioral health services is needed to meet increasing demand.*
- *San Francisco is facing a behavioral health workforce shortage.*

POST-ACUTE AND LONG-TERM CARE

- *Population projections through 2040 show the most significant amount of growth within the older adult population (adults age 65 and older).*
- *San Francisco has approximately 15 Skilled Nursing Facility (SNF) beds per 1,000 adults over age 65. If the number of SNF beds remains constant, and accounting for growth in the population of older adults, the ratio will decrease by 40% to nine SNF beds for every 1,000 adults over 65 by 2040.*

- *San Francisco has recently experienced a significant reduction in the number of small assisted living facilities – commonly called "board and care" homes. These facilities provide 24-hour non-medical care and supervision to adults with disabilities, elderly populations, formerly homeless, and individuals with mental health disorders.*

CULTURALLY AND LINGUISTICALLY COMPETENT CARE

- *Limited health literacy and Limited English Proficiency act as barriers to health care access and is associated with poor health outcomes, particularly among San Francisco's vulnerable populations.*
- *Innovative strategies promise to increase linguistic competence of health providers. Outreach and education are needed to make residents more aware of interpretation services available at San Francisco hospitals.*
- *The diversity of San Francisco's health workforce does not reflect the city's demographics. A well-trained and diverse workforce is central to increasing cultural and linguistic competence.*
- *Many of San Francisco's community clinics offer linguistically competent and culturally sensitive care.*

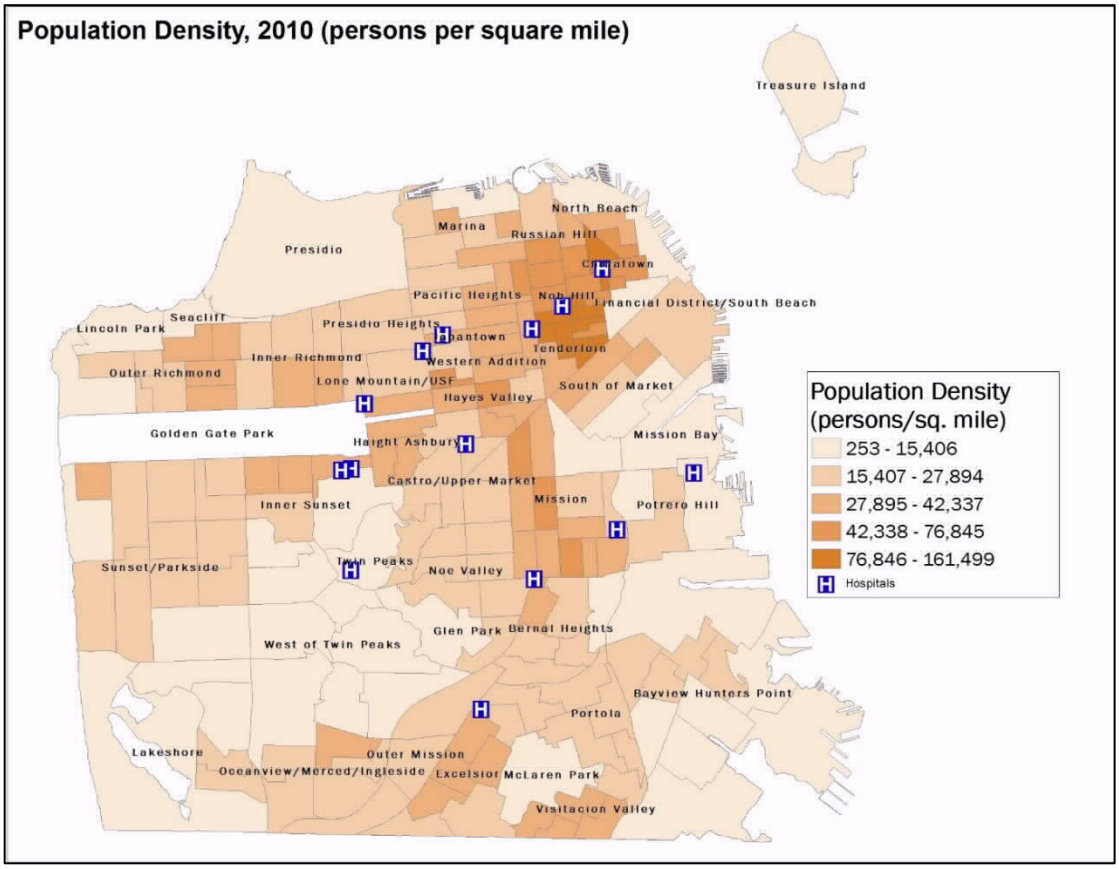
MEDICAL SURGE AND DISASTER PLANNING

- *San Francisco general acute hospitals aim to be able to increase their average daily number of staffed beds by at least 15% in a surge event under current patient care standards.*
- *SFDPH's Climate and Health Program works to address the public health consequences of climate change by projecting how climate change will impact San Francisco.*

1. HOSPITAL SERVICES

SAN FRANCISCO'S EXISTING HOSPITAL FACILITIES ARE CONCENTRATED IN THE CITY'S NORTHEAST QUADRANT, WHICH INCLUDES THE CITY'S MOST DENSELY POPULATED NEIGHBORHOODS (Figure 5.3 - 1.1). SAN FRANCISCO'S HOSPITALS PROVIDE LICENSED INPATIENT, OUTPATIENT, AND EMERGENCY TREATMENT FOR A RANGE OF MEDICAL CONDITIONS.

Figure 5.3 - 1.1 San Francisco Hospitals with Population Density



Source: United States Census Bureau, 2010
Note: San Francisco Hospitals as of April 2019

General acute care hospitals[126]:

- Chinese Hospital
- California Pacific Medical Center (CPMC; Davies, Mission Bernal, and Van Ness Campuses)
- Kaiser Permanente San Francisco Medical Center
- Zuckerberg San Francisco General Hospital & Trauma Center (ZSFG)
- Saint Francis Memorial Hospital
- St. Mary's Medical Center
- University of California, San Francisco (UCSF; Mission Bay, Mount Zion, and Parnassus Campuses)

Other hospitals:

- Jewish Home (long-term care facility, short-term and rehabilitation care, and acute geriatric psychiatric)
- Laguna Honda Hospital (a long-term care facility)
- Kentfield Hospital San Francisco (long-term acute care)
- Langley Porter Psychiatric Hospital

Kaiser Permanente, Dignity Health, and Sutter Health are the three largest hospital systems in California, accounting for one-fourth of hospital beds statewide. In San Francisco, the three largest hospitals systems are UCSF, Dignity

[126] According to the California Health and Safety Code – HSC Division 2. Licensing Provisions. Chapter 2. Health Facilities. Article 1(a) – "general acute care hospital" means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

Health (St. Mary's Medical Center and Saint Francis Memorial Hospital), and Sutter Health (California Pacific Medical Center; CPMC), accounting for 88% of the hospital beds in the City.

Several San Francisco hospitals are in the process of renovating and/or constructing new facilities, both to meet their own organizational objectives as well as to comply with seismic upgrade mandates under California Senate Bill (SB) 1953[127]. Hospitals failing to meet specified seismic safety standards must be rebuilt by 2020 or 2030 depending on their Structural Performance Category (SPC) rating.[128] Five major hospital projects have been completed since 2013:

1) UCSF opened a new medical center in the Mission Bay neighborhood in February 2015. This medical center includes UCSF Benioff Children's Hospital San Francisco, UCSF Betty Irene Moore Women's Hospital, UCSF Bakar Cancer Hospital, and an outpatient service medical building.
2) ZSFG Hospital completed its new acute care and trauma facility in November 2015, providing 58 emergency stations (31 more beds than the previous hospital), six trauma rooms, 13 operating rooms, 284 acute care beds, and four pediatric emergency exam rooms.
3) Chinese Hospital completed its new, enlarged hospital facility, expanding its capacity from 54 to 88 beds and adding other critical services. It is the last independent, community-based institution of its kind in San Francisco.
4) CPMC completed the St. Luke's Hospital rebuild and in August of 2018 reopened as the CPMC Mission Bernal Campus.
5) In March of 2019 CPMC opened the Van Ness campus, a 274-bed acute-care hospital, and transitioned all acute care services from the California and Pacific campuses to the new Van Ness campus.

In 2017, general acute care beds comprised roughly 66% of the 4,704 licensed hospital beds in San Francisco, exceeding the statewide bed rate (3.5 vs. 1.9 licensed general acute care hospital beds per 1,000).[129] Although the absolute number of beds has increased since 2013 with the addition of 289 new general acute care beds at UCSF Mission Bay, San Francisco's bed rate has not changed since 2013 due to population growth and a reduction of licensed beds in some hospitals.

Given San Francisco's relatively high bed rate, San Francisco's supply of acute care hospital beds may be sufficient to meet the acute care needs of San Francisco residents. Table 5.3-1.1 shows the breakdown by types of licensed hospital beds in San Francisco in 2017. While 2017 is the most recent year for which hospital data is available, the absolute number of beds may not reflect recent construction and bed transfers that have taken place since 2017. See the note below the table for further context and explanation.

[127] Signed into law on September 21, 1994, SB 1953 establishes a seismic safety building standards program under OSHPD's jurisdiction for California hospitals built after March 7, 1973. Hospitals must be retrofitted, reconstructed, or closed in order to meet requirements.

[128] All general acute care hospital buildings are assigned a structural performance category (SPC) rating from 1 to 5. California law mandates that all SPC-1 buildings be removed from providing general acute care services by 2020 and all SPC-2 buildings be removed from providing general acute care services by 2030. Retrieved from: https://oshpd.ca.gov/construction-finance/seismic-compliance-and-safety/

[129] Office of Statewide Health Planning & Development (2017). Hospital Utilization Data. State of California. Retrieved from https://data.chhs.ca.gov/dataset/hospital-annual-utilization-report

Table 5.3 - 1.1 Number of Hospital Beds by Type in San Francisco, 2017

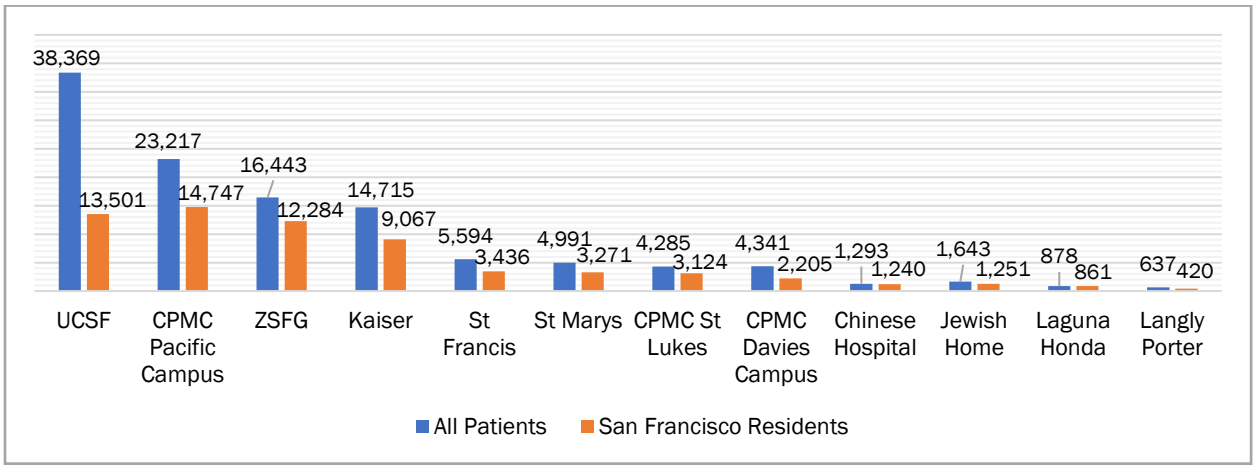
Hospital	Type of Bed			
	General Acute	Acute Psychiatric	Skilled Nursing	Total
California Pacific Medical Center (CPMC)				
California Campus[i]	299	0	0	299
Davies Campus	185	0	38	223
Pacific Campus[i]	291	18	0	309
St. Luke's Campus[ii]	149	0	79	228
Chinese Hospital	65	0	0	65[iv]
Jewish Home	0	13	378	391
Kaiser Foundation Hospital	239	0	0	239
Laguna Honda Hospital & Rehabilitation Center	11	0	769	780
Saint Francis Memorial Hospital	253	35	0	288
St. Mary's Medical Center	332	35	32[iii]	399
University of California, San Francisco (UCSF)				
Langley Porter	0	67	0	67
Mission Bay	289	0	0	289
Mt. Zion	140	0	0	140
Parnassus	590	0	0	590
Zuckerberg San Francisco General Hospital	284	83	30	397
Total	3,127	251	1,326	4,704

Source: OSPHD Hospital Utilization Data, 2017
Note: (i) As of March 2, 2019, all acute-care services provided at CPMC California and Pacific campuses were transferred to the newly opened CPMC Van Ness Campus. CPMC Van Ness is a 274 acute-care bed hospital. (ii) In 2018 CPMC completed the St. Luke's campus rebuild and reopened as the Mission Bernal campus, during the rebuild, some Skilled Nursing beds were transferred to CPMC Davies Campus. (iii) As of 2017, St. Mary's no longer supported skilled nursing care. (iv) Chinese hospital increased its bed capacity to 88 with recent renovations.

Locally, and across the state and nation, the number of skilled nursing and acute psychiatric beds have declined as hospitals focus more on general acute care services.[130] In 2017, approximately 34% of San Francisco hospital beds were designated for skilled nursing and acute psychiatric services, compared to less than 16% statewide. Yet, because of a decline in these beds and a growing population with these service needs, the current supply may not be enough to meet current and projected demand. Hospital-based skilled nursing and psychiatric beds are discussed in greater detail in the respective, post-acute and long-term care services and behavioral health services sections of this chapter.

[130] California HealthCare Foundation. (2015). California Hospitals: An Evolving Environment. Retrieved from https://www.chcf.org/publication/2015-edition-california-hospitals-evolving-environment/

Figure 5.3 - 1.2 General Acute Medical Service Discharge by San Francisco Hospitals (2017)



Source: OSHPD Patient Origin & Market Share Report, 2017
Note: UCSF includes Mission Bay, Mt. Zion, and Parnassus campuses; values represent all inpatient discharges (patients classified as inpatient or inpatient from ED transfers).

Figure 5.3-1.2 lists San Francisco's licensed acute care hospitals in order of greatest acute care utilization to least. Discharge volume reflects hospital utilization by both San Francisco residents (comprising 56% of total patients) and out-of-county patients (43% of total patients).[131] Among the 43% of out-of-county patients, 22% are from neighboring counties: 7% from San Mateo County, 5% from Alameda County, 4% from Marin County, 3.5% from Contra Costa County, and 3% from Sonoma County. In 2017, nearly a third of all patients hospitalized in San Francisco were discharged by UCSF Medical Center (33%), followed by CPMC – Pacific (20%), ZSFG (14%), and Kaiser (13%). The total number of discharges from all San Francisco hospitals has increased substantially (21%) in recent years from 96,260 in 2010 to 116,406 in 2017. [132]

The number of discharges for San Francisco residents alone has decreased by 12% in the top 10 hospitals (from 74,256 in 2008 to 64,126 in 2017). Among residents, approximately a third (31%) of those hospitalized were discharged from California Pacific Medical Center (all campuses), followed by UCSF Medical Center (21%), ZSFG (19%), and Kaiser Foundation Hospital (14%).

Hospital selection by residents varies greatly by neighborhood. For instance, 39% of hospitalized Bayview residents were discharged from ZSFG compared to approximately 17% of residents citywide, and 13% of hospitalized Chinatown residents were discharged from Chinese Hospital compared to less than 2% of residents citywide (Table 5.3-1.2). Focus groups conducted as a part of the 2019 HCSMP assessment process identified proximity to hospitals, types of services needed and offered at each facility, cultural/linguistic barriers, economic and/or policy-related reasons, and/or personal preference as potential causes of the variation. These factors notwithstanding, as San Francisco's public safety-net hospital, ZGSF treats the highest percentage of residents from neighborhoods with socioeconomic challenges and elevated rates of health disparities; including neighborhoods such as the Tenderloin, South of Market, Mission, and Bayview.

[131] Includes data from California Pacific Medical Center - Pacific Campus, Chinese Hospital, Kaiser - Geary, Laguna Honda, Langley Porter, San Francisco General Hospital, St. Francis Memorial Center, St. Mary's Medical Center, St. Luke's Hospital, and UCSF Medical Center.

[132] Office of Statewide Health Planning & Development. (2017). Patient Origin/Market Share. State of California. Retrieved https://data.chhs.ca.gov/dataset/patient-origin-market-share-pivot-profile-inpatient-emergency-department-and-ambulatory-surgery

Table 5.3 - 1.2 Hospital Use by Residents of Select San Francisco Neighborhoods, 2017

Hospital	Percent All Hospitalized San Francisco Residents	Percent All Hospitalized Tenderloin[i] Residents	Percent All Hospitalized Mission/ Bernal/ SoMa[ii] Residents	Percent All Hospitalized Chinatown[iii] Residents	Percent All Hospitalized Bayview[iv] Residents
	(Rates that exceed the SF average are highlighted below)				
CPMC – Pacific Campus	20.3%	**22.7%**	11.1%	**31.6%**	10.7%
Zuckerberg San Francisco General Hospital	16.9%	**18.5%**	**31.9%**	9.1%	**38.5%**
UCSF Medical Center	18.6%	14.5%	15.3%	11.9%	14.7%
Kaiser Foundation Hospital – Geary SF	12.5%	9.2%	10.8%	7.4%	10.6%
CPMC –St. Luke's Hospital	4.3%	2.4%	**9.7%**	--	**8.6%**
St. Francis Memorial Hospital	4.7%	**16.5%**	4.5%	**11.6%**	2.1%
St. Mary's Medical Center, San Francisco	4.5%	3.9%	1.9%	3.6%	1.9%
CPMC – Davies	3.0%	2.7%	**3.4%**	2.3%	1.9%
Chinese Hospital	1.7%	1.7%	--	**12.9%**	--
Seton Medical Center	1.3%	--	--	--	--
Kaiser Foundation Hospital – South San Francisco	1.7%	--	--	--	**2.0%**

Source: OSHPD Patient Origin & Market Share Report, 2017
Note: These neighborhoods correspond to communities in which HCSMP 2013 Task Force meetings were held, based on an analysis of risk indicators from Health Matters in San Francisco. (i) Tenderloin (94102, 94109). (ii) Mission/Bernal/SoMa (94110, 94103). (iii) Chinatown (94108, 94133, 94111). (iv) Bayview (94124). Rates of less than 1% of residents are omitted.

2. EMERGENCY MEDICAL SERVICES

THE FOLLOWING SECTION DESCRIBES SAN FRANCISCO'S EMERGENCY MEDICAL SERVICE (EMS) CAPACITY. EMERGENCY MEDICAL SERVICES PROVIDE OUT-OF-HOSPITAL ACUTE MEDICAL CARE, TRANSPORT TO DEFINITIVE CARE, AND TREATMENT IN HOSPITAL EMERGENCY DEPARTMENTS. EMS TREATMENT STATIONS ARE, AS DEFINED BY OSHPD, A SPECIFIC PLACE WITHIN THE EMERGENCY DEPARTMENT (ED) THAT IS ADEQUATE TO TREAT ONE PATIENT AT A TIME – HOLDING OR OBSERVATION BEDS ARE NOT INCLUDED.

As of the most recent data available, in 2017 San Francisco had 227 Emergency Medical Service (EMS) treatment stations (refer to Table 5.3-2.1 for count by hospital location). The number of EMS treatment stations remained stable at 164 between 2011 and 2014 and increasing by 38% to 227 in 2017 mostly due to new stations constructed at University of California San Francisco (UCSF) Mission Bay and Zuckerberg San Francisco General (ZSFG). [133]

[133] Office of Statement Health Planning and Development. Emergency Medical Service Pivot Profile. "2013-2017 Emergency Department Services Trends." Retrieved from https://data.chhs.ca.gov/dataset/emergency-department-services-trends

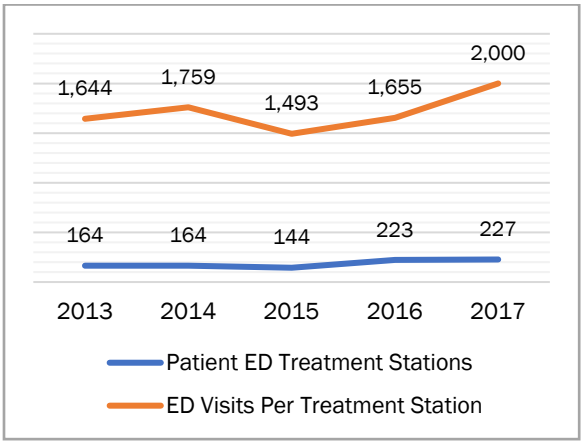
Table 5.3 - 2.1 San Francisco ED Stations, 2017

Hospital	# of ED Stations
Chinese Hospital	7
CPMC California(i)	6
CPMC Davies	11
CPMC Pacific(i)	19
CPMC St. Luke's	12
Kaiser Foundation Hospital	24
Saint Francis	20
St. Mary's	17
UCSF Medical Center	33
UCSF Mission Bay	19
ZSFG	59
TOTAL	**227**

Source: OSHPD Emergency Medical Service Pivot Profile, 2017
Note: (i) In March 2019, all emergency services at CPMC California and CPMC Pacific were transferred to the newly opened CPMC Van Ness location.

While the number of stations has remained relatively stagnant, the number of ED visits per treatment station has increased in recent years.[134]

Figure 5.3 - 2.1 San Francisco Emergency Department Treatment Stations & Visits Per Station, 2013 - 2017



Source: OSHPD Emergency Department (ED) Utilization Trends 2013-2017

Over the same time period, San Francisco experienced a growth in the total number of ED visits by almost 20%, from 220,075 in 2013 to 263,451 in 2017. Alongside the growth in the number of treatment stations and the number of total ED encounters, the estimate of the number of ED patients who register and leave without being seen (LWBS) has remained stable over time. In 2017 approximately, 2.5% of total ED encounters were patients who left without being seen, which is just slightly higher than the state average of 2.1% of all ED encounters. Recent studies have suggested that patients who register but leave without being seen (LWOBS) are more often seriously ill, at risk of poorer health outcomes, and tend to be high utilizers of the emergency health care system. These studies suggest that higher rates of LWBS are reflected higher rates may be associated poor access to primary care, rather than EMS crowding issues.[135, 136]

The degree to which San Francisco's EMS capacity is sufficient to meet patient demand is unclear. Crowded EMS conditions, for example, may be the result of patient flow issues rather than a need for more EMS treatment stations. According to the U.S. Government Accountability Office:

ONE KEY FACTOR CONTRIBUTING TO CROWDING AT MANY HOSPITALS INVOLVES THE INABILITY TO MOVE PATIENTS OUT OF EMERGENCY DEPARTMENTS AND INTO INPATIENT BEDS WHEN THESE PATIENTS MUST BE ADMITTED TO THE HOSPITAL RATHER THAN RELEASED AFTER TREATMENT. WITH NO INPATIENT BEDS AVAILABLE FOR THEM, THESE PATIENTS THEN HAVE TO BOARD IN THE EMERGENCY DEPARTMENT, REDUCING THE EMERGENCY DEPARTMENT'S ABILITY TO SEE ADDITIONAL PATIENTS.[137]

[134] Office of Statewide Health Planning & Development. (2017). Emergency Department Outpatient and Inpatient Data Pivot Profile. Retrieved from https://data.chhs.ca.gov/dataset/hospital-emergency-department-characteristics-by-facility-pivot-profile

[135] Zubieta, L., Fernandez-Peña, J., & Gomes, H. (2017). Characteristics of patients who leave without being seen: comparing with those who do not leave. Medical Research Archives, 5(4). Retrieved from https://journals.ke-i.org/index.php/mra/article/view/1124

[136] Li BS, David R., et. al. (2019). Patients who Leave the Emergency Department Without Being Seen and Their Follow-Up Behavior: A Retrospective Descriptive Analysis. Retrieved from: https://www.sciencedirect.com/science/article/abs/pii/S0736467919302586

[137] United States General Accounting Office. (2003). Hospital Emergency Departments: Crowded Conditions Vary Among Hospitals and Communities. Report to Ranking Minority

Similarly, a lack of sufficient space in lower-acuity and post-acute settings to discharge patients to may also contribute to overcrowding in emergency rooms. Most of the growth in the number of ED visits in San Francisco is from patients who were not admitted for inpatient stays. This suggests an increased number of visits by lower-acuity patients who may not need ED care.[138] In 2017, 84.3% of visits to EDs in San Francisco did not result in an admission, compared to 86.8% statewide (refer to Table 5.3 - 2.2).

Table 5.3 - 2.2 San Francisco Emergency Department Visits and Admissions, 2017

	ED Visits(i)	ED Admits	Total ED
SF	263,451 (84%)	48,510 (16%)	311,961 (100%)
CA	12,996,560 (87%)	1,932,405 (13%)	14,928,965 (100%)

Source: OSHPD Emergency Department (ED) Utilization Trends 2013-2017
Note: (i) number does not include ED admits

When hospital EDs have high occupancy rates, they may go on "diversion" or a temporary status that informs local EMS that their hospital beds are full, and they cannot take new patients.

What do Diversion Rates mean?

Diversion rates are considered one metric for assessing a facility's capacity to accommodate and serve new patients; however, high diversion rates do not necessarily signify that more health care facilities are needed to meet patient demand. Diversion can also signal:

- Patient flow issues
- Emergency department overcrowding
- Internal management issues
- Multiple ambulances arriving simultaneously at the same facility
- Patient choice (i.e., patient preference for one hospital over another)
- Seasonal (e.g. flu) or other outbreaks

SFDPH's EMS division maintains the city's Ambulance-Transport Destination Policy, which:

- Establishes a network of approved ambulance-transport destinations;
- Sets parameters for when patients should be transported to general and specialty care hospitals and approved alternate destinations; and
- Allows patients to be transported to the most appropriate destination from the field.

This policy ensures more appropriate use of San Francisco's health care facilities in a manner tailored to the needs of each patient. Ambulances may only transport patients to approved receiving hospitals or specialty care facilities, or to pre-approved alternate destinations, if appropriate. In addition, patients in need of specialty treatment (e.g. obstetric care) may bypass the receiving hospital's emergency department and instead be taken to that hospital's appropriate specialty care department. If, through pre-established criteria,

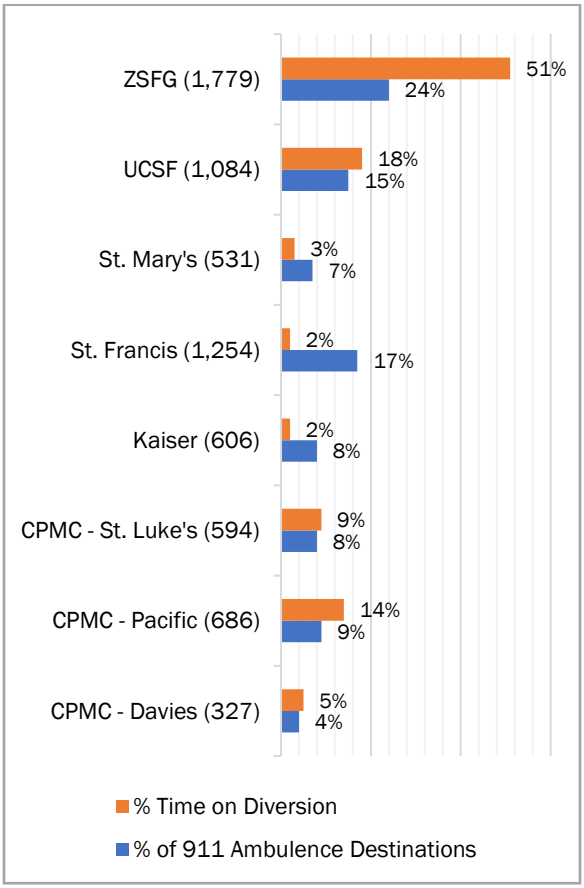
Member, Committee on Finance, US Senate. Retrieved from http://www.gao.gov/new.items/d03460.pdf.

[138] Hospital Council of Northern and Central California. (2016). Protecting San Francisco Emergency Services: Diagnosing and Addressing the Challenges of San Francisco's EDs

it is determined that a receiving hospital is unable to accommodate more patients, an ambulance is diverted to an alternate destination. Some patients meeting specific criteria are not subject to diversion; for instance, ZSFG may not divert incarcerated patients or patients in police custody.[139] It is important to note that diversions impact only those patients who arrive via ambulance. Nearly 70% of all ED patients walk in or arrive by private transport and cannot be turned away, by law.[140]

The percentage of time spent on facility diversion status relative to ambulance transport volume may indicate facility efficiency and patient flow.[141] Overall, the average monthly time hospitals spend on diversion has increased since 2011. Figure 5.3-2.2 depicts the average monthly diversion status and ambulance volume for San Francisco's eight full receiving hospitals during 2018.

Figure 5.3 - 2.2 San Francisco Hospitals by Percent Time on Diversion and Percent of 911 Ambulance Destinations, 2018



Source: San Francisco Department of Emergency Management, Division of Emergency Services, 2018
Note: Parenthetical numbers listed below each hospital label reflect the total number of ambulance transports at the specified facility from January 2018 to January 2019

Figure 5.3-2.2, ZSFG is the number one destination for ambulance calls (24% of all 911 calls) and spends the most amount of time on diversion relative to other San Francisco hospitals (51%, on average). This is due to it being the only Level 1 Trauma Center for the residents of San Francisco and northern San Mateo County. In addition, ZSFG is the only

[139] This exclusion applies to patients requiring specialty triage care, patients in imminent or full respiratory or cardiac arrest or a post-arrest resuscitation, or patients originating from a hospital-based clinic.

[140] Hsia R, Asch S, Weiss R, Zingmond D, Liang L, Han W, McCreath H, Sun B. (2012.) California Hospitals Serving Large Minority Populations Were More Likely Than Others to Employ Ambulance Diversion. Health Affairs 31, No. 8 Retrieved from http://content.healthaffairs.org/content/31/8/1767.full.pdf+html

[141] Ambulance transport volume was extracted from the 911 Computer Aided Dispatch System. These counts do not represent unique patients (i.e., units may transport more than one patient on occasion) and do not include non 911 emergency calls dispatched through call centers for private ALS ambulance providers that resulted in transport to a receiving facility. The denominator used (5,551) for the percentage of transports includes the 418 transports not shown for partial receiving hospitals; out-of-county ED transports; SF Sobering Center; CPMC-California Campus; and entries of "missing" for hospital names. As a specialty care receiving center, the CPMC-California Campus ED does not use diversion.

acute hospital in San Francisco that provides 24-hour psychiatric emergency services (PES).

If one hospital goes on diversion, others may be soon to follow, for a variety of reasons (such as seasonal disease outbreaks, spikes at hours when non-emergency care is unavailable, etc.). Generally, the high rate of diversion is driven by the increasing rate of ED visits overall, challenges in finding in-patient and post-acute discharge options for patients, and Medi-Cal beneficiaries using the ED to address non-acute needs. In addition, patients placed under emergency psychiatric care ("5150" patients)[142] may be placed in stations at smaller EDs for up to 24-72 hours. The number of these psychiatric emergency visits at ZSFG has increased by 8% from 6,570 in FY16-17 to 7,118 in FY17-18.[143]

EMS staff monitor diversion data to meet diversion policy goals and ensure that patients receive timely, quality care. Diversion data monitoring is of importance to San Francisco, given the diversity of its population. Research suggests that hospitals serving greater numbers of minority patients employ diversion at higher rates, which is linked to poorer health outcomes.[144]

In addition to increasing ED capacity, it is important to pursue other strategies to relieve pressure on EDs, such as providing alternative care settings for residents and utilizing mobile integrated telemedicine. The 2016 Emergency Department Study[145] made several recommendations to address supply and demand challenges in San Francisco EDs:

1) Continue to support/promote lower-acuity settings that serve substance abuse-related as well as psychiatric needs (i.e. Sobering Center, Dore Clinic).
2) Empower the Local Emergency Management Agency to triage and transport patients in a way that optimizes care continuity and capacity.
3) Direct the Post-Acute Care Collaborative to focus on programs that will speed the discharge and transition of patients ready for post-acute care.
4) Support case management of high-utilizers, increased availability of alternatives to ED, and consumer education.
5) Create a cross-functional task force with representation from the City, behavioral health and public health leaders, as well as ED physicians and operators.

3. PRIMARY CARE

PRIMARY CARE INCLUDES HEALTH PROMOTION, DISEASE PREVENTION, HEALTH MAINTENANCE, COUNSELING, PATIENT EDUCATION, DIAGNOSIS AND TREATMENT OF ACUTE AND CHRONIC ILLNESSES, AND IS DELIVERED IN A VARIETY OF SETTINGS FROM OFFICES, TO CLINICS, TO HOME CARE.[146] TIMELY ACCESS TO PRIMARY CARE CAN SUPPORT OVERALL WELLNESS AND ASSIST IN THE DETECTION AND MANAGEMENT OF CHRONIC DISEASES, RESULTING IN LOWER OVERALL HEALTH CARE COSTS.

[142] Section 5150 is a section of the California Welfare and Institutions Code which authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes them a danger to themselves, a danger to others, or gravely disabled.

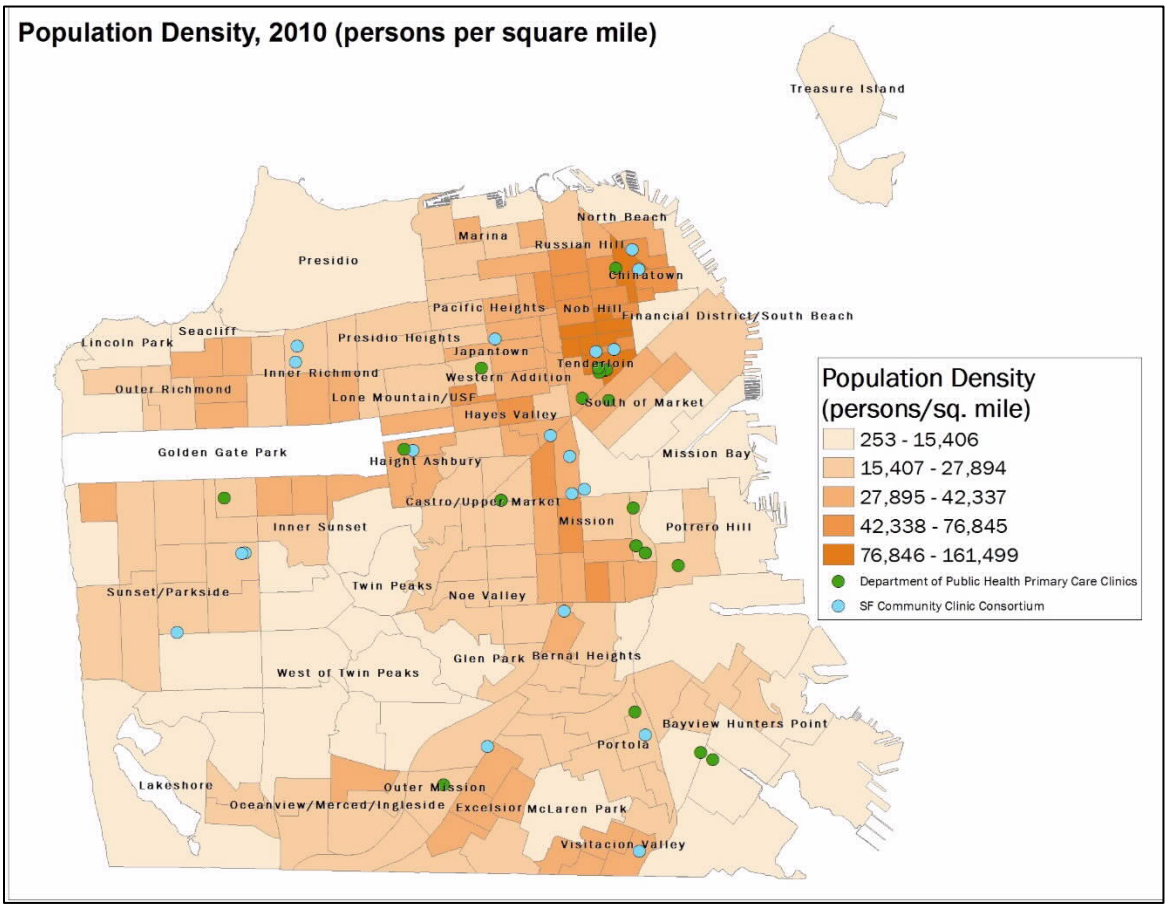
[143] Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center. Annual Report FY17-18.

[144] Shen, Y. C., & Hsia, R. Y. (2016). Do patients hospitalized in high-minority hospitals experience more diversion and poorer outcomes? A retrospective multivariate analysis of Medicare patients in California. BMJ open, 6(3), e010263. doi:10.1136/bmjopen-2015-010263

[145] Hospital Council of Northern and Central California. (2016). Protecting San Francisco Emergency Services: Diagnosing and Addressing Challenges of San Francisco's EDs

[146] American Academy of Family Physicians. (2019). Primary Care. Retrieved from: https://www.aafp.org/about/policies/all/primary-care.html

Figure 5.3 - 3.1 San Francisco Primary Care Clinics by Location



Source: United States Census Bureau, 2010; OSHPD Primary Care Clinic Utilization, 2017
Note: Green markers represent DPH primary care clinics, blue markers represent the San Francisco Community Clinic Consortium's non-profit primary care clinics.

This section describes the availability of primary care physicians and primary care clinics – community and free clinics typically owned by public agencies or nonprofit organizations, that offer a range of primary care services to uninsured and underinsured populations.

In addition to primary care clinics, as just defined, San Francisco residents and nonresidents utilize primary care services at independent physician offices and facilities run by Health Maintenance Organizations (HMOs), such as Kaiser Permanente. The number of these facilities has increased in recent years, a trend described further in the *Land Use Assessment* chapter.

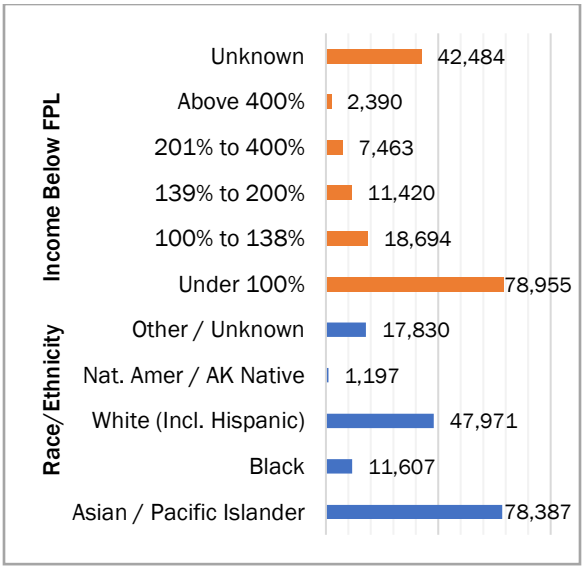
Important to note is that availability is not a guarantee of accessibility, as primary care providers may not accept all types of health coverage, or patients may have specific cultural and linguistic needs that cannot be met at all facilities. These accessibility barriers are discussed throughout the entirety of the *Capacity and Gaps Assessment* chapter.

Primary care clinics continue to be an important resource for community residents, offering a full range of primary care services to the uninsured and underinsured in the community. Figure 5.3-3.1 illustrates the geographic distribution of San Francisco's primary care health clinics (SFDPH & SFCCC clinics) compared to population density. As with hospitals, primary care clinics are predominantly located in San Francisco's

northeast and southeast quadrants, mirroring population density.

In 2017, San Francisco's 43 California Department of Public Health (CDPH)-licensed primary care clinics, 20 of which are Federally Qualified Health Centers (FQHCs) served more than 161,406 patients.[147] Of these patients, 49% of patients are Asian and 30% are White (including Hispanic).[147] In addition, 68% are below 200% FPL[148]. Throughout the state of California, between 2011 and 2015 the number of primary care clinics increased by 23%, and the number of patients served by clinics has increased by 20%, likely a result of Medi-Cal expansion.[149] Refer to Figure 5.3 - 3.2 for a demographic breakdown of the population served by CDPH-licensed primary care clinics.

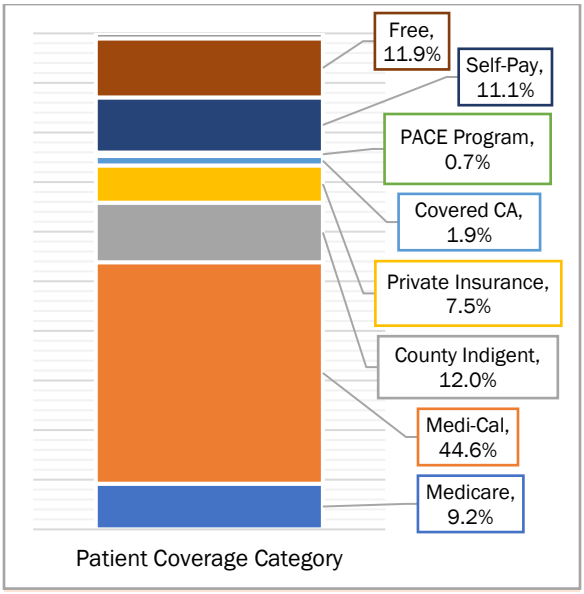
Figure 5.3 - 3.2 Population Served in San Francisco Primary Care Clinics Reporting to OSHPD, 2017



Source: OSHPD Primary Care Clinic Utilization, 2017

Figure 5.3 – 3.3 displays detailed information of the populations served and the coverage types accepted by San Francisco's primary care clinics.

Figure 5.3 - 3.3 Patient Coverage at San Francisco Primary Care Clinics Reporting to OSHPD, 2017



Source: OSHPD Primary Care Clinic Utilization, 2017

San Francisco Health Network (SFHN)

SFDPH's San Francisco Health Network (SFHN) is San Francisco's only complete system of care and provides a wide array of services across its continuum of care. SFHN's direct service providers consist of Zuckerberg San Francisco General (ZSFG), which includes the Behavioral Health Center (BHC); Laguna Honda Hospital (LHH); Health at Home (HAH); Jail Health Services; and Primary Care (PC). Primary care clinics as a part of SFHN are under different licensure[150], and these clinics serve low-income, uninsured, and underserved patients.

The following table lists the SFHN primary care service sites:

[147] Office of Statewide Health Planning & Development. (2017). Primary Care Clinic Utilization Data. State of California. Retrieved from https://data.chhs.ca.gov/dataset/primary-care-clinic-annual-utilization-data

[148] The Federal Poverty Level (FPL) in 2017 for an individual was $12,060 annual income.

[149] Office of Statewide Health Planning & Development. (2017). 2011-2015 Primary Care Clinic Annual Utilization Report Profile with Trends. Retrieved from https://www.oshpd.ca.gov/HID/PCC-Utilization-Trends.html

[150] FQHCs and other types of non-profit community clinics are required to be licensed as primary care clinics through CDPH's Licensing and Certification Division. Publicly owned FQHCs that are not included on a public hospital license are not required to be licensed as primary clinics.

Primary Care Center	Address
3rd Street Youth Center and Clinic	1728 Bancroft Avenue
Balboa Teen Health Center	1000 Cayuga Avenue
Castro-Mission Health Center	3850 17th Street
Children's Health Center	1001 Potrero Avenue
Chinatown Public Health Center	1490 Mason Street
Cole Street Clinic	555 Cole Street
Curry Senior Center	333 Turk Street
Dimensions Clinic	3850 17th Street
Family Health Center	995 Potrero Avenue
Larkin Street Youth Services	134 Golden Gate Avenue
Maxine Hall Health center	1301 Pierce Street
Medical Respite and Sobering Center	1171 Mission Street
New Generation Health Center	2500 18th Street
Ocean Park Health Center	1351 24th Avenue
Positive Health Program	995 Potrero Avenue
Protrero Hill Health Center	1050 Wisconsin Street
Richard Free People's Clinic	1001 Potrero Avenue
Silver Avenue Family Health Center	1525 Silver Avenue
Southeast Health Center	2401 Keith Street
Tom Waddell Urban Health Center	230 Golden Gate Avenue
Tom Waddell Urgent Care	50 Ivy Street

In FY 2017-18, SFHN primary care saw more than 63,000 patients, the majority of whom are insured by Medi-Cal.

San Francisco Community Clinic Consortium (SFCCC)

The SFCCC is a partnership of individual nonprofit health centers in San Francisco, which have long been the source of primary care, behavioral health and dental care for low-income, uninsured, and medically underserved populations. SFCCC represents 11 member clinics, operating 27 sites and providing care to over 112,000 patients in San Francisco's most vulnerable neighborhoods. Services are available in up to 20 languages, and no one is turned away due to their inability to pay. Services are offered on a sliding scale and may be free depending upon an individual's circumstances and programs offered.

The SFCCC's vision is a future in which all persons have access to quality health care in culturally-, linguistically-, and population-sensitive, community-based settings.

The following table lists the SFCCC partnership clinics:

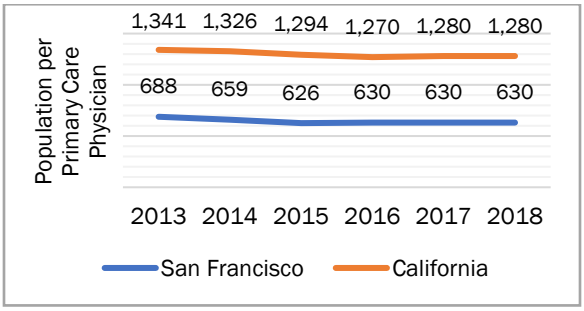
Member Clinic	Site(s)
BAART Community HealthCare	1111 Market Street 433 Turk Street
Curry Senior Center	333 Turk Street
HealthRIGHT 360	1563 Mission Street (Office) 1735 Mission Street (Women's Community Clinic) 330 Ellis Street (Tenderloin Health Services) 1735 Mission St (Lyon-Martin Health Services) 558 Clayton St (Haight Ashbury Free Clinic)
Mission Neighborhood Health Center	240 Shotwell Street (Office) 4434 Mission Street (Excelsior Clinic) 165 Capp Street (Resource Center)
Native American Health Center	160 Capp Street
North East Medical Services	1520 Stockton Street (Office) 728 Pacific Avenue (Pacific Clinic) 2574 San Bruno Avenue (Portola Clinic) 82 Leland Avenue (Visitacion Valley Clinic) 518 Ellis Street (Ellis Clinic) 1400 Noriega Street (Sunset Clinic) 1450 Noriega Street (Noriega Clinic) 2308 Taraval Street (Sunset Taravel Clinic) 1033 Clement Street (Richmond Clinic)
Planned Parenthood Northern California	1650 Valencia Street
San Francisco Community Health Center	730 Polk Street (Office) 726 Polk Street (Tenderloin Clinic) 1800 Market Street (Castro Clinic)
San Francisco Free Clinic	4900 California Street
South of Market Health Center	229 7th Street
St. Anthony's Medical Clinic	150 Golden Gate Avenue

Both San Francisco and California have seen an increase in the number of primary care physicians, bolstered by the Affordable Care Act (ACA), which improved coverage of primary care services and expanded coverage to previously uninsured and underinsured populations. In San Francisco, there is one primary care physician for every 630 residents—exceeding every other county in California and the national average (statewide and national ratios are 1:1,280 of 1:1040, respectively).[151, 152]

SAN FRANCISCO HAS NEARLY TWICE THE RATE OF PRIMARY CARE PROVIDERS PER POPULATION THAN CALIFORNIA – FAR EXCEEDING NATIONAL BENCHMARKS.

There are a couple of important things to note; first, San Francisco is an academic center for training medical professionals, and as a result, many physicians may not practice full time; second, due to the geographic nature of the Bay Area, many individuals residing outside of San Francisco in neighboring counties may see a physician in San Francisco rather than in their resident county. Trend data shows that at the local, state, and federal levels, ratios of population to physician have decreased since 2013 despite population growth, thus indicating an increased availability of physicians locally and nationally.

Figure 5.3 - 3.4 Ratio of Population to Primary Care Physicians, 2013-2018



Source: Health Resources and Services Administration Area Resource File (ARF), 2010-2012, via 2013-2018 County Health Rankings[153]

Similarly, the number of non-physician primary care providers (e.g. nurse practitioners, physician assistants, and clinical nurse specialists) has increased in San Francisco and California, a trend which is expected to continue and discussed further in the *Health System Trends Assessment*. San Francisco has one of the highest rates of non-physician primary care providers to resident population in California (1 provider for 1,227 residents in 2017, compared to 1: 1,915 statewide).[154, 155]

Although there is a higher ratio of primary care practitioners in San Francisco compared to California and nationally, not all physicians accept publicly insured or uninsured patients. Members of Medi-Cal (California's Medicaid program, providing insurance for low-income residents) struggle to access primary care services, which may have been exacerbated by the Medi-Cal enrollment increases under the ACA. California physicians are less likely to have

[151] County Health Rankings & Roadmaps. 2017. Primary Care Physicians. Retrieved from http://www.countyhealthrankings.org/app/california/2017/measure/factors/4/data

[152] The definition of primary care physicians used non-federal Doctors of Medicine (MDs) and Doctors of Osteopathic Medicine (DOs) under age 75 who are not hospital residents and whose major professional activity is classified as patient care and whose self-designated practice is identified as general practice, general family medicine, general internal medicine, or general pediatrics."

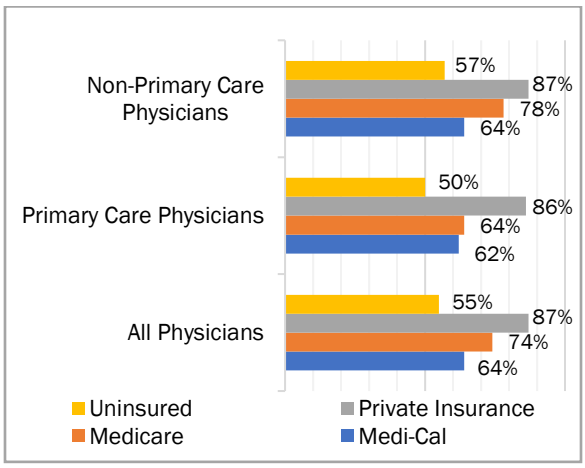
[153] The 2013 HCSMP used the 2012 County Health Rankings for the ratio of population to primary care physicians. The County Health Rankings recently detected an error in their estimates of primary care physicians: the number of general practice physician was double counted. The HRSA data source used to calculate San Francisco's population to primary care physician ratio updated the definition of primary care physicians to reflect the ACA requirements on work force growth such that the data reported in the 2013 HCSMP cannot be directly compared to the data provided in this report.

[154] County Health Rankings & Roadmaps. (n.d.). Non- Primary Care Physicians. Retrieved from http://www.countyhealthrankings.org/app/california/2018/measure/factors/131/data

[155] County Health Rankings & Roadmap.s (n.d.). Non- Primary Care Physicians. Retrieved from http://www.countyhealthrankings.org/app/california/2018/measure/factors/131/data

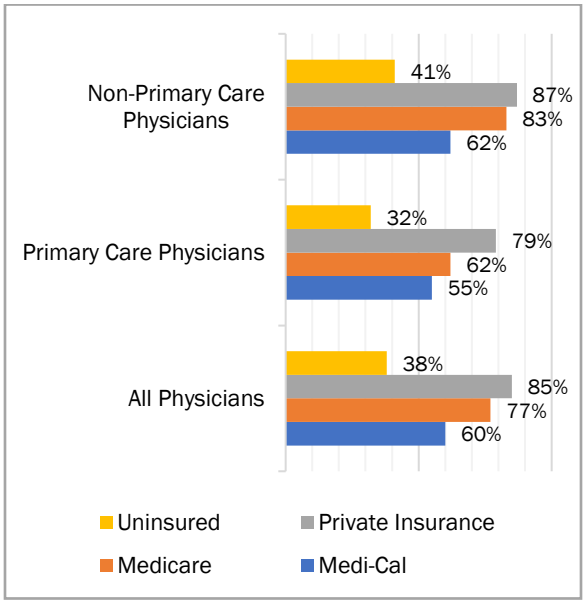
uninsured or Medi-Cal patients than patients with Medicare or private insurance (Figure 5.3-3.5). Only two-thirds of physicians currently see Medi-Cal patients in their practice (64%); in comparison, 74% currently see Medicare patients and 87% see privately insured patients.[156]

Figure 5.3 - 3.5 CA Physicians with Any Patient by Payer, 2015



Source: California Health Care Foundation, 2015

Figure 5.3 - 3.6 CA Physicians Accepting New Patients by Payer, 2015



Source: California Health Care Foundation, 2015

Additionally, Medi-Cal beneficiaries were more than twice as likely to report challenges finding a provider that is accepting of their insurance compared to those with employer-based coverage.[156] As described further in the *Health Systems Trends Assessment* chapter, California has the 47th lowest Medicaid reimbursement rates in the nation, presenting a significant barrier to provider participation.

In addition to the challenge of finding a provider accepting of Medi-Cal, other barriers commonly faced by populations enrolled in public insurance programs or who are uninsured include: cost of health care, location of health care provider, current health status, language, and trust with medical professionals. These populations often have the greatest risk for preventable diseases and multiple chronic conditions, which are further exacerbated by social determinants of health such as poverty, low educational status, and unhealthy living environments. Other barriers include greater "time burden" – time spent traveling to, waiting for, and receiving ambulatory medical care – which is 25 to 28% longer for racial and ethnic minorities and unemployed individuals.[157] A significant portion of low income consumers use digital technologies (such as phones and computers), providing an opportunity for the health care industry to leverage these digital resources.

Further, residents in some neighborhoods struggle to access primary care if it is not located nearby – particularly residents who are more likely to be transit-dependent, including low-income residents and seniors. Health Professional Shortage Areas (HPSA) are federal designations that indicate provider shortages in primary care, dental health, or mental health, based on geography, and population demographics. HPSA scores are not an all-inclusive metric to understand the gaps and

[156] California Health Care Almanac (2018). California Physicians: Who They Are, How They Practice. Retrieved from https://www.chcf.org/resource-center/california-health-care-almanac/

[157] Ray, K.N., Chair, A.V., Engberg, J., Bertolet, M., & Mehrotra, A. (2015). Disparities in Time Spent Seeking Medical Care in the United States. JAMA. 175, 12

shortages in primary care for those who have access barriers such as language, income, insurance, and the like.

As of January 2019, California has 647 areas designated as having a primary care shortage, impacting over 7.5 million residents.[158] Furthermore, 446 are designated as dental care shortage areas, and 498 are designated as mental health shortage areas; an increase since 2017. These areas are most often located in remote rural towns and urban inner cities.[159, 160, 161] In San Francisco, the Bayview/Candlestick/Hunters Point/Portola region is a HPSA designated Medicaid Eligible Population with a score of 11.68, which represents the estimated number of full-time equivalent (FTE) primary care practitioners needed to achieve the population to practitioner target ratio.

In San Francisco there are eight health care organizations designated as serving primary care, dental, and mental health shortage areas:

1) **Asian and Pacific Islander Wellness Center, Inc.** – Federally Qualified Health Center
2) **Mission Area Health Associates** – Federally Qualified Health Center
3) **North East Medical Services** – Federally Qualified Health Center
4) **San Francisco Community Clinic Consortium** – Federally Qualified Health Center
5) **San Francisco Medical Center Outpatient Improvement Programs** – Federally Qualified Health Center
6) **HealthRIGHT 360** – Federally Qualified Health Center Look-alike
7) **Friendship House Association of American Indians** – Indian Health Service, Tribal Health, and Urban Indian Health Organizations
8) **Native American Health Center – San Francisco NAHC** – Indian Health Service, Tribal Health, and Urban Indian Health Organizations

4. DENTAL CARE

SIMILAR TO PHYSICIAN AND NON-PHYSICIAN PRIMARY CARE PROVIDERS, SAN FRANCISCO HAS A HIGH AVAILABILITY OF DENTISTS: 1,291 DENTISTS PRACTICE IN THE CITY, OR ONE DENTIST FOR EVERY 670 RESIDENTS COMPARED TO 1 DENTIST FOR EVERY 1,210 RESIDENTS STATEWIDE.[162]

In the 2016-2017 time period nearly 72% of San Francisco residents self-reported utilizing dental care services in the last year, which exceeds the national goal of 49% in the healthy people 2020 framework[163], established by the us department of health and human services (refer to Table 5.3-4.1).

[158] The Henry J. Kaiser Family Foundation (2016). Primary Care Health Professional Shortage Areas (HPSAs). State Health Facts. Retrieved from https://www.kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22california%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[159] The Henry J. Kaiser Family Foundation (2017). Dental Care Health Professional Shortage Areas. Retrieved from https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22california%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[160] The Henry J. Kaiser Family Foundation (2017). Mental Health Care Health Professional Shortage Areas. Retrieved from https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22california%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[161] UCLA Health (2017). Primary Care Health Professional Shortage Areas. Retrieved from https://www.uclahealth.org/family-medicine/hpsa

[162] County Health Rankings & Roadmaps. (n.d.). Dentists. Retrieved from http://www.countyhealthrankings.org/app/california/2018/measure/factors/88/data?sort=sc-3

[163] https://www.healthypeople.gov/2020/leading-health-indicators/Leading-Health-Indicators-Development-and-Framework

Table 5.3 - 4.1 San Francisco Residents Dental Visits, 2016-2017

Time Since Last Dental Visit: Adults	San Francisco	California	HP 2020 National Target Percent
6 months ago, or less	60.2%	56.1%	49.0%
More than 6 months up to 1 year ago	12.0%	15.5%	
More than 1 year ago up to 2 years ago	11.3%	10.0%	N/A
More than 2 years up to 5 years ago	9.1%(i)	8.7%	N/A
More than 5 years ago	4.8%(i)	7.3%	
Never been to dentist	2.7%(i)	2.4%	

Note: (i) Statistically unstable
Source: 2016-2017 California Health Interview Survey

Despite these relatively high utilization rates, the San Francisco Health Network, HCSMP stakeholder interviews, and health literature describe a number of challenges in providing dental care in San Francisco, including:

- Limited access to dental care for uninsured and underinsured residents, including Denti-Cal[164] patients (who most dentists will not serve due to low Medi-Cal reimbursement rates).
- Limited access to dental care for seniors, which is not provided under Medicare, except for certain medical conditions. Supporting this, almost two-thirds of Medicare beneficiaries nationwide do not have dental coverage, and as a result of not having coverage, 49% of Medicare beneficiaries have not visited the dentist in the past year. Black Medicare recipients are most likely to have not seen a dentist in the past year (71%).[165]
- A need for greater integration of dental care with primary care. The Institute of Medicine and others have proposed integrating oral health into primary care as a primary strategy to expand access to recommended treatments, reduce disparities, and promote better health overall[166]
- A need for increased dental services in the Bayview Hunters Point and Visitacion Valley neighborhoods due to the limited number of providers in these areas.
- Limited access to pediatric specialty dental services.

SAN FRANCISCO EXCEEDS CALIFORNIA AND THE NATION ON MEASURES OF DENTAL PROVIDER AVAILABILITY; HOWEVER, SAN FRANCISCO'S PUBLICLY INSURED AND UNINSURED RESIDENTS OFTEN STRUGGLE WITH DENTAL CARE ACCESS DUE TO COST.

Uninsured and underinsured residents continue to face challenges accessing dental care, including the 12,706 enrollees of Healthy San Francisco (HSF) as of January 2019.[167] HSF only provides emergency dental care, which means many individuals are left without a reliable source of preventive dental care.

For residents on Medi-Cal, additional care is available through California's Denti-Cal program, serving more than 207,834 San Francisco residents and more than 13 million residents statewide.[168] However, funding for the program

[164] Denti-Cal is Medi-Cal's dental program.
[165] Freed, M., Neuman, T., Jacobson, G. *Drilling Down on Dental Coverage and Costs for Medicare Beneficiaries.* Kaiser Family Foundation. March, 2019. Retrieved from: https://www.kff.org/medicare/issue-brief/drilling-down-on-dental-coverage-and-costs-for-medicare-beneficiaries/?utm_campaign=KFF-2019-March-Medicare-Dental-Coverage-Care&utm_source=hs_email&utm_medium=email&utm_content=70737320&_hsenc=p2ANqtz-9f5GS8ar_syyKb0ijvpOKvSvVT5GJTryvJFav4IFkDkEIND05bKdAc7Z5yicmCTMF3zbv1modyYMWJDX84ZI5UKXi2xg&_hsmi=70737320
[166] Institute of Medicine, *Advancing Oral Health in America* (Washington, D.C.: National Academies Press, April 2011); and Institute of Medicine, *Improving Access to Oral Health Care for Vulnerable and Underserved Populations* (Washington, D.C.: National Academies Press, July 2011)
[167] Healthy San Francisco (HSF) is the City/County's program that provides health services to uninsured residents
[168] California Department of Health Care Services. Medi-Cal Dental Performance Measures – High Level. January – December 2018. Retrieved from: https://www.dhcs.ca.gov/services/Pages/DentalReports.aspx

was tenuous given shortfalls in the State budget. In July 2009, the State eliminated most Denti-Cal services for adults age 21 and up, leaving three million adults without coverage for cleanings, gum treatment, exams, root canal procedures, dentures and fillings. These benefits were fully restored for adults as of 2018 (Senate Bill 97).

Even for residents with Denti-Cal, accessing services may remain a challenge due to difficulty finding providers. Low reimbursement rates for providers, in part, contribute to this issue. In 2017, approximately 23% of San Francisco's Denti-Cal enrollees (children and adults) had an annual dental visit compared to 42% statewide. Highest utilization of Med-Cal dental services is with children ages 6-9 (61.7% of enrollees), and lowest utilization of Medi-Cal dental services is for adults between age 21 and 34 (11.4% of enrollees).[169]

There are currently 10 Federally Qualified Health Centers (FQHC) and 17 private providers in San Francisco who accept Denti-Cal patients.[170] The Department of Public Health's San Francisco Health Network has five dental clinic sites, which provided a total of 12,596 patient visits in FY 2017-2018, 53% of which were for children. This represents a 25% increase from FY 2015-2016

Table 5.3 - 4.2. San Francisco Health Network Dental Providers

Clinic Name	Service Population
Chinatown Public Health Center	Children, Adults, Pregnant Women
Potrero Hill Health Center	Children, Adults, Pregnant Women
Silver Avenue Family Health Center	Ages 0-20 years, Pregnant Women
Southeast Health Center	Children, Adults, Pregnant Women
Tom Waddell Urgent Health Clinic	Homeless Adults, Ryan White (HIV+) Adults

Additionally, on-site dental services are offered at several SFCCC member clinics, including: Native American Health Center, North East Medical Services (NEMS), Mission Neighborhood Health Center, South of Market Health Center and St. Anthony's Medical Clinic. Dental services are offered on-site at these clinics through a collaborative formed by SFDPH. These clinics also accept Denti-Cal patients.

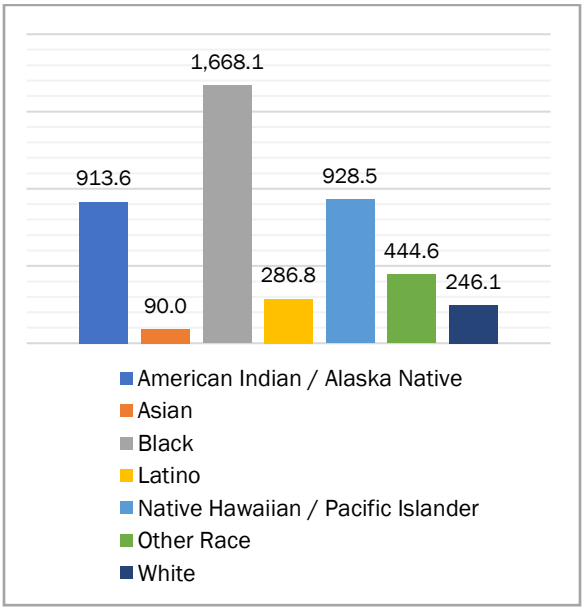
San Francisco's homeless population is especially at risk of poor dental health. In 2016, SFDPH received an Oral Health Services Expansion grant from the US Health Resources and Services Administration, allowing the City to provide a full scope of dental services at no cost to homeless patient regardless of network, insurance or immigration status. Tom Waddell Urgent Health Clinic is the main site for these services and saw 797 homeless patients in FY 16-17 (an increase of 47% from the prior year).

As mentioned throughout the HCSMP assessments, emergency utilization is an indicator of poor access to health care. The California Office of Statewide Health Planning and Development (OSPHD) collects data about each emergency department visit from all hospitals in California. OSHPD analyzed these data sets to identify cases of non-traumatic dental conditions that are seen in the emergency room, indicating number of visits in the emergency room for dental conditions that could have been prevented with proper access to oral health or prevented through routine dental visits. From the chart in Figure 5.3-4.1 we see that the African American population has a disproportionately higher rate of non-traumatic dental visits.

[169] Department of Health Care Services. (2017). Multi Year Medi-Cal Dental Measures Data by County and Age Calendar Year 2013 to 2017. Retrieved from https://data.chhs.ca.gov/dataset/test-dhcs-multi-year-dental-measures-data-by-county-calendar-year-2013-to-2015

[170] San Francisco Department of Public Health. (n.d). Dental Services Report

Figure 5.3 - 4.1. Rate of Non-Traumatic Dental Visits to Emergency Room in San Francisco per 10,000 Population, by Race/Ethnicity, 2012-2016[171]



Source: California Office of Statewide Health Planning and Development, 2012-2016

Over the past decade, San Francisco has seen a steady improvement in children's oral health. From 2012-2017, the percent of kindergarteners with untreated caries (cavities or other tooth decay) declined from 26% to 17%, which is just better than the national average of 17.5%.[172, 173] During that same period, caries experience (e.g. whether a child has ever had cavities), declined from 44% to 35%.[174] Despite improvements in cavity rates in both white and children or color, disparities persist, with children of color 2-3 times more likely to have untreated decay as white children. Some schools and neighborhoods are especially impacted by poor oral health - Chinatown, Tenderloin, Excelsior and Bayview have some of the highest rates of dental caries among kindergarteners[175]. Within the San Francisco Unified School District, the rate of untreated caries among kindergarten children is eight times higher in low-income schools (schools with high rates percent of National School Lunch Program (NSLP) eligibility) than higher income schools (40% vs. 5%). While the prevalence of caries is decreasing in higher income schools, the trend has shown an increase in the prevalence of dental caries in lower income schools.[174]

In 2014, the San Francisco Children's Oral Health Collaborative began implementing San Francisco's Oral Health Strategic Plan 2014-2020[176] with the mission of ensuring all San Francisco children are caries-free. The plan includes the following recommendations to improve children's oral health status:

1) **Access:** Increase access to oral health care services for San Francisco children and pregnant women.
2) **Integration:** Integrate oral health with overall health.
3) **Promotion:** Increase awareness and practice of optimal children's oral health behaviors among diverse communities.
4) **Evaluation:** Develop and establish an ongoing oral health population-based surveillance system.
5) **Coordination:** Provide coordination and oversight for the implementation of the strategic plan.

One such initiative working in this arena is the SF Dental Transformation Initiative. The San Francisco Dental Transformation Initiative Local

[171] California Office of Statewide Health Planning and Development, 2012-2016
[172] San Francisco Health Improvement Partnership. (2018). San Francisco Children's Oral Health Strategic Plan 2014-2020. Received from: https://www.sfdph.org/dph/files/dentalSvcsdocs/SanFranciscoChildrensOralHealthStrategicPlan2014-2020.pdf
[173] Centers for Disease Control and Prevention. (2015). National Health and Nutrition Examination Survey. Retrieved from https://www.cdc.gov/nchs/data/hus/hus15.pdf#060
[174] San Francisco Health Improvement Partnership. (2018). San Francisco Children's Oral Health Strategic Plan 2014-2020. Received from: https://www.sfdph.org/dph/files/dentalSvcsdocs/SanFranciscoChildrensOralHealthStrategicPlan2014-2020.pdf
[175] San Francisco Health Improvement Partnership. "San Francisco Community Health Needs Assessment 2019: Children's Oral Health." Received from: http://www.sfhip.org/childrens-oral-health.html
[176] San Francisco's Oral Health Strategic Plan. 2014-2020. Retrieved from: https://www.sfdph.org/dph/files/dentalSvcsdocs/SanFranciscoChildrensOralHealthStrategicPlan2014-2020.pdf

Dental Pilot Project (SF DTI LDPP) aims to improve the dental health of Medi-Cal beneficiaries 0-5 years old in San Francisco. San Francisco Department of Public Health is the lead entity of this collaborative project. SF DTI LDPP is funded by the California Department of Health Care Services. Over 4 years, the project will receive $5.8 million in funding to increase the use of preventive services by 0-5-year-old Medi-Cal beneficiaries and to decrease early childhood caries experience in kindergarteners in San Francisco.[177]

5. BEHAVIORAL HEALTH SERVICES

THIS SECTION DESCRIBES THE CAPACITY, UTILIZATION, AND LOCATION OF BEHAVIORAL HEALTH SERVICES IN SAN FRANCISCO. FOR INFORMATION REGARDING BEHAVIORAL HEALTH OUTCOMES, SEE THE COMMUNITY HEALTH ASSESSMENT CHAPTER.

Hospital-based Behavioral Health Services

Although most people with diagnosed mental health issues never require hospitalization, and many with the most serious conditions can be successfully treated in the community, inpatient psychiatric treatment remains an essential component of a complete mental health care continuum. The literature does not yield a clear standard regarding the recommended number of psychiatric hospital beds per population; however, San Francisco appears to perform well on this measure compared to the state. According to 2017 OSHPD data, there were 251 licensed acute psychiatric hospital beds in six hospitals across San Francisco, for a rate of 3.2 licensed acute psychiatric hospital beds per 10,000 population (compared to 2.2 per 10,000 statewide; Table 5.3 - 5.1).[178] However, when examining the actual occupancy rate of these psychiatric hospital beds – a measure of how many beds are staffed and operational, not of patient demand – the number of beds actually available for patients fell to 118, which is much closer to the state's rate of occupied beds (1.4 vs. 1.6 occupied beds per 10,000 population). Occupancy rates have remained generally stable over the last decade. San Francisco's lower occupancy rates may reflect of the high level of service provided in non-acute settings (e.g. crisis stabilization units and residential treatment programs) compared to other counties.

Table 5.3 - 5.1. Licensed & Occupied Acute Psychiatric Beds, 2017

Facility	Licensed Beds	Licensed Bed Occupancy Rate
Zuckerberg San Francisco General Hospital	83	57%
UCSF Langley Porter Psychiatric Hospital	67	27%
St. Mary's Medical Center	35	25%
St. Francis Memorial Hospital	35	59%
California Pacific Medical Center – Pacific Campus	18	76%
Jewish Home	13	80%
San Francisco Total	**251**	**47%**
California	**6,761**	**74%**

Source: OSHPD 2017 Hospital Annual Utilization
Note: Zuckerberg San Francisco General Hospital also operates 55 long-term mental health treatment beds, licensed by the California Department of Health Care Services. The San Francisco Veteran's Administration Fort Miley has 12 acute psychiatric beds

In addition to acute psychiatric services, a range of behavioral health services are offered through the hospital systems (Dignity, Sutter/CPMC, UCSF, and Kaiser) located in San Francisco. A brief description of these services is detailed in Table 5.3-5.2.

[177] SF Dental Transformation Initiative. Retrieved from: https://sfdti.weebly.com/

[178] Office of Statewide Health Planning & Development. (2016). Hospital Utilization Data. State of California. Retrieved from https://www.oshpd.ca.gov/HID/Hospital-Utilization.html

Table 5.3 - 5.2 Hospital-based Behavioral Health Services (Non-San Francisco Health Network (DPH))

University of California, San Francisco (UCSF) – Langley Porter Psychiatric Hospital & Clinics (LPPHC)
Adult Services
• Adult Acute Psychiatric Inpatient • Partial Hospitalization & Intensive Outpatient • Adult Outpatient
Child & Adolescent Services
• Cognitive Behavioral Therapy (CBT) for Depression and Anxiety • Dialectical Behavioral Therapy (DPT) for Adolescents & Young Adults • Depression Center • Eating Disorder Program • General Evaluation & Short-Term Treatment Clinic • Hyperactivity & Learning Problems Clinic • Medication Management Clinic • Obsessive Compulsive Disorder (OCD) & Trichotillomania (Tics) Clinic • Path Program (formerly early psychosis program) • STAR Center for Autism Spectrum Disorder (ASD) and other Neurodevelopmental Disorder (NSDs) • Young Adult & Family Center (YAFC)
Dignity Saint Francis Memorial Hospital
Adult Services
• Inpatient Mental Health Services
Dignity St. Mary's Medical Center
Adolescent Services
• McAuley Adolescent Inpatient Unit • McAuley Counseling Enriched Education Program
California Pacific Medical Center (CPMC) – Pacific Campus
Behavioral Health Outpatient Services
• Evaluation & Diagnostic Services • Counseling & Therapy Services • Child & Adolescent Behavioral Health
Interventional Psychiatry
• Electroconvulsive Therapy (ECT) • Vagal Nerve Stimulation (VNS) • Transcranial Magnetic Stimulation (TMS) • Ketamine Infusion Therapy (KIT)
Kaiser Permanente San Francisco
Addiction Medicine & Recovery Services (formerly Chemical Dependency Recovery Program)
• Full range of detoxification services • Psychological and medical evaluation services • Group and individual therapy • Education & skill building

In the Spring of 2019, as a part of the community input process, a series of interviews was conducted with staff and providers from UCSF, CPMC, Dignity Saint Francis and St. Mary's Hospitals. Interviews focused on the current state of behavioral health service offerings within each hospital and health system as well as identification of gaps in services.

A common concern brought up by hospital staff was the challenge to place their patients into more appropriate levels of treatment post-hospitalization. Hospital staff spoke to the community need for residential treatment beds and highlighted the community impact of not having options for placement. Staff recognized that in many cases, once individuals discharge from the hospital or ED, they return to the street because of long wait times for entry into treatment. As reported by social workers, during that time it is difficult to keep track of their patients. For many of these individuals who are waiting in shelter and not in treatment, their mental health or substance use condition is often exacerbated, and they end up back in the ED. Providers also cited that, in addition to the need for more treatment beds, more mobile services should be available. Hospitals recognize that the patient population they most often see for mental health, substance use, or dual diagnosis are homeless individuals with limited access to, or knowledge of behavioral health services; thus, effectively planned services are ones that meet the community where they are located.

Noted that institutional plans for behavioral health service expansion was not discussed as a part of these interviews but is discussed further in the *Land Use Assessment* chapter.

Behavioral Health Services[179]

Low-income, uninsured or underinsured San Franciscans can access a range of specialty behavioral health services through the San Francisco Behavioral Health Plan, which is operated through Behavioral Health Services (BHS) of the San Francisco Department of Public Health (SFDPH). BHS provides client-centered,

[179] While residents can access an array and behavioral health services (private and public) from various health care organizations/entities, data on access to services could only be obtained for the Community Behavioral Health Services (CBHS) of the San Francisco Department of Public Health (SFDPH). Therefore, the focus of this section is on these services.

culturally competent, evidence-based mental health and substance abuse treatment services to individuals on a full spectrum from prevention to crisis, acute and long-term care. The system of care includes DPH, multiple hospitals, and community-based organizations, and encompasses more than 300 different programs.[180] The basic categories of behavioral health services are described in Table 5.3 - 5.3, in order of increasing acuity. Services are based in principles of recovery and wellness, with a goal of supporting individuals' ability to live in the least acute environment. Consistent with this philosophy, the highest levels of care represent the smallest proportion of patients and the most robust services offered.

Table 5.3 - 5.3 Behavioral Health Level of Care (listed from top/lowest acuity to bottom/highest acuity)

Level of Care	Definition
Prevention and Early Treatment	Community education on behavioral health needs and how to access services. Services may also include emotional support, early engagement for those seeking counseling services and/or peer support and referring individuals into treatment through crisis services or law enforcement, if necessary.
Outpatient Treatment	Services targeted to work with individuals who can access services in an outpatient clinic setting, including case management, integrated behavioral health and primary care clinics, patient vocational training, peer support, and medication-assisted treatment.
Residential Treatment	Services provided in a residential care setting, ranging from short-term services (e.g. medical detox, acute diversion units) to longer-term residential programs serving individuals with substance use disorder and mental health disorder needs.
Crisis Programs	Services designed to work with individuals who are experiencing a behavioral health crisis, such as mobile crisis programs that can conduct field assessments, crisis stabilization units, and behavioral health urgent care facilities.
Hospitalization and Involuntary Treatment	Services designed to treat individuals in need of acute behavioral health care. Psychiatric Emergency Services conduct assessments to determine if an individual requires an inpatient hospitalization under Welfare and Institutions Code 5150. Hospital beds are located citywide, with most involuntary hospitalizations occurring at Zuckerberg San Francisco General Hospital. *Not all individuals at this level of care are held involuntarily (5150)*
Locked Facility/ Conservatorship	This level of care includes placements for individuals who are placed on a Lanterman-Petris-Short (LPS) Conservatorship and are unable to live safely in lower levels of care.

During FY 2017-18, BHS provided services to 21,775 mental health clients and 6,596 substance use disorder clients.[181] While national data from SAMSHA indicates that prevalence of serious mental illness is generally consistent across race/ethnicity, the BHS data in San Francisco shows disparities for some racial groups regarding who is accessing services. Most notably, Black/African Americans only comprise 5% of San Francisco's population, but represent 19% of mental health and 27% of substance use disorder clients served.[182] Other socioeconomic factors may also be correlated with an individual's need to access care, such as poverty status, exposure to environmental stressors, and complex trauma. (Note that this data reflects utilization rates of BHS services and utilization rates by residents for behavioral health services outside of BHS may differ).

With respect to age, the majority of both mental health and substance use disorder clients were

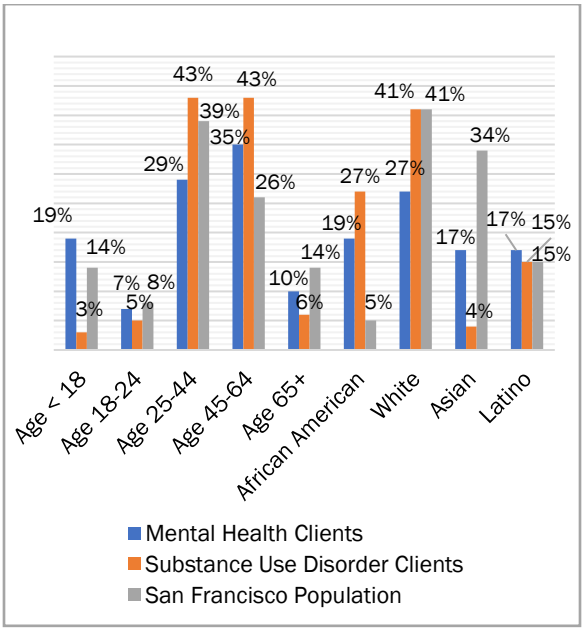
[180] Tipping Point Community, UCSF, DPH. Behavioral Health and Homelessness in San Francisco. 2019. Retrieved from: http://chi.tippingpoint.org/wp-content/uploads/2019/09/JSI_SF-BH-and-Homelessness_2019.pdf

[181] San Francisco Department of Public Health. (2019). Annual Report 2017-2018. Retrieved from https://www.sfdph.org/dph/files/reports/PolicyProcOfc/SFDPH-AnnualReport-2017-2018.pdf

[182] San Francisco Department of Public Health. (2019). Annual Report 2017-2018. Retrieved from https://www.sfdph.org/dph/files/reports/PolicyProcOfc/SFDPH-AnnualReport-2017-2018.pdf

between the ages of 25 and 64, and a significant proportion of mental health clients were under the age of 18, implying a need for more behavioral health programs for children and youth. In general, males were more likely to utilize behavioral health services, comprising 56% of mental health clients and 68% of substance use disorder clients.

Figure 5.3 - 5.1 BHS Clients by Age & Race/Ethnicity, FY2017-2018



Source: SFDPH Annual Report, FY 2017-2018 Annual Report and US Census Bureau, 2012-2016 5-Year American Community Survey
Note: Native Americans comprise approximately 1% of the population served and less than 1% of San Franciscans, and multi—race/multi-ethnic individuals also comprise approximately 1% of the population served and make up about 3% of Sa Franciscans. Race/ethnicity data is unknown for 0-14% of patients served.

Poor mental health and substance abuse are correlated with increased risk of homelessness. As mentioned earlier, according to the 2019 Point-in-Time-Count, there were 8,011 homeless persons in San Francisco, with 1,145 of those being unaccompanied youth under 25. In FY 2017-2018, 24% of BHS mental health clients were homeless and an additional 12% did not have identified housing. Of the estimated 4,000 homeless San Franciscan's with mental health and substance use disorders, approximately 41% frequently use urgent and emergent psychiatric services.[183] It can be especially difficult to maintain healthcare access and continuity of care for homeless residents.

In instances when homeless individuals are hospitalized during episodes of acute mental health crisis, hospitals will coordinate with the SF Homeless Outreach Team to help homeless patients find shelter after an emergency, inpatient, or outpatient stay. However, additional long-term supportive housing is needed in order to adequately provide continued and coordinated behavioral health care for homeless individuals with mental health conditions. The Whole Person Care Pilot, a Medi-Cal waiver program led by SFDPH, is a citywide effort to coordinate care for homeless individuals through a comprehensive, human-centered approach.

SF Behavioral Health Bed Capacity

SFDPH's Community Behavioral Health Services ability to provide mental health and substance use service to residents in need in part depends on the bed capacity of each program. In 2019, SFDPH was allocated funding for 15 additional behavioral health respite and 72 additional substance use recovery beds. SFDPH provides a range of behavioral health services, briefly described below from highest acuity to lowest:

1) **Crisis Stabilization** – continuum of services that are provided to individuals experiencing a psychiatric emergency
2) **Acute Psychiatric** – high intensity, acute psychiatric services 24 hours a day for those experiencing psychiatric distress or symptoms and/or at risk of harm to themselves or others

[183] Heal our City. News Release. Retrieved from: http://sfmayor.org/article/mayor-london-breed-tipping-point-and-ucsf-announce-partnership-expand-and-strengthen-mental

3) **Withdrawal Management & Respite** – acute and post-acute medical care for individuals who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in the hospital
4) **Locked Residential Treatment** – 24-hour locked facilities providing intensive diagnostic evaluation and treatment services for severely impaired individuals suffering from psychiatric illness
5) **Open Residential Treatment** – live-in health care facility providing therapy for substance abuse, mental illness, or other behavioral problems
6) **Residential Care Facilities** – group living for seniors and/or people with disabilities who need help with meal preparation, medication monitoring, and personal care, but who do not need daily acute medical care
7) **Transitional & Supportive Housing** – provides people with significant barriers to housing stability with a place to live and intensive social services while they work toward self-sufficiency and housing stability.

Table 5.3 - 5.4 SFDPH Behavioral Health Adult Programs, 2019 (listed from highest acuity to lowest)

Crisis Stabilization	**Psychiatric Emergency Services (PES)** – *[maximum 23 hours]* Psychiatric Emergency Services (PES) provides crisis stabilization, complete medical and psychiatric assessment and evaluation services, and initial treatment, if appropriate.
	Acute Diversion Unit (ADU) – *[maximum 14 days]* Licensed 24-hour certified mental health rehabilitation treatment environment.
	Psychiatric Urgent Care – *[maximum 23 hours]* Services at Dore Urgent Care are designed to work with individuals who are experiencing a behavioral health crisis, crisis stabilization units, and behavioral health urgent care facilities.
Acute Psychiatric Services	**Acute Inpatient Psychiatric Services** – *[average 5-10 days]* Acute psychiatric services provide high-intensity, acute psychiatric services 24 hours a day for individuals in acute psychiatric distress and experiencing acute psychiatric symptoms and/or at risk of harm to self or others.
Withdrawal Management & Respite	**Medical Respite** – *[average 39 days for hospital referral; 60 days for shelter referral]* Acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized.
	Sobering Center – *[average 7 hours]* Provides a safe, short-term sobering and care coordination for intoxicated adults.
	Withdrawal Management – *[maximum 22 days]* Provides a medically supportive (24-hour nursing care) residential program for detoxification of substances (e.g. alcohol and other drugs).
	Social Detox – *[maximum 20 days]* Shelter-like environment for homeless or marginally housed adults to live temporarily to recuperate from substance intoxication, abuse, or dependence.
	Behavioral Health Respite Navigation Center – *[average 14 days]* Hummingbird Place Peer Respite provides behavioral health support and engagement to adults and older adults in a behavioral health respite program with a navigation center threshold.
Locked Residential Treatment	**Locked Sub-Acute Treatment** – *[average 9 months]* Facilities for individuals who are placed on a Lanterman-Petris-Short (LPS) Conservatorship due to grave disability or are on a forensic court ordered hold.
	Psychiatric Skilled Nursing Facility – *[no limit]* A psychiatric skilled nursing facility (SNF) is a licensed health facility, or a distinct part of a hospital, providing 24-hour inpatient care and includes physician, skilled nursing, dietary, and pharmaceutical services, and an activity program.

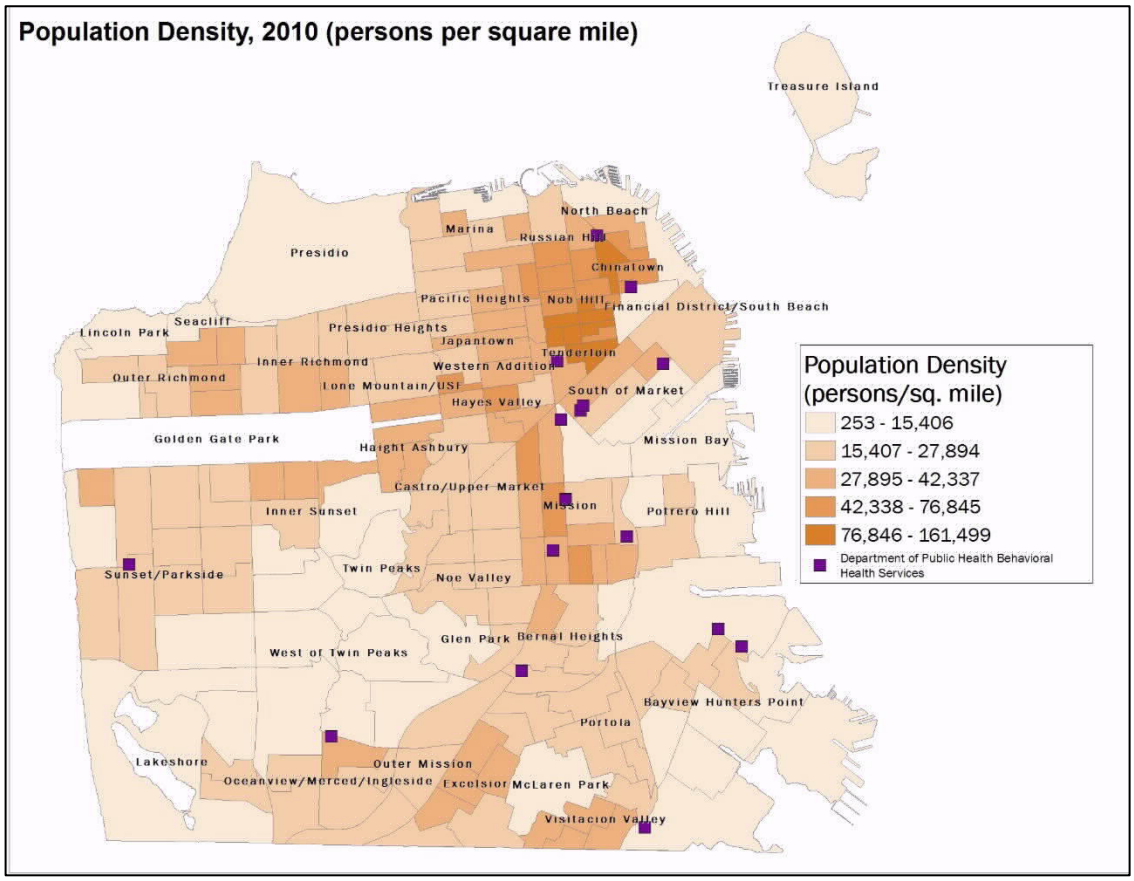
Open Residential Treatment	**Co-Occurring Diagnoses** – *[90-100 days]* Residential group living program provides treatment to individuals with both mental health and substance use disorder issues.
	Substance Use Disorder – *[90-100 days]* Residential group living program provides treatment to limit or abstain from inappropriate use of alcohol and other drugs, life skills and social skills, positive coping strategies, etc.
	Mental Health – *[90 – 365 days]* Residential group living program provides treatment for managing life with mental illness.
Residential Care Facilities	**Residential Care Facilities for the Elderly (RCFE)** – *[no limit]* RCFE's generally offer group living for seniors (either medical or psychiatric) who need help with meal preparation, medication monitoring, and personal care, but do not need daily acute medical care.
	Residential Care Facilities – *[no limit]* RCF's offer group living for people with disabilities (either medical or psychiatric) who need help with meal preparation, medication monitoring, and personal care, but do not need daily acute medical care.
Transitional & Supportive Housing	**Residential Step-Down** – *[maximum 12 months]* These services provide short term care, mental health services and support in a residential environment.
	Cooperative Living – *[no limit]* Apartments that are leased or owned by an agency and rented by four to five residents who share the responsibility for rent and utilities.
	Support Hotel – *[no limit]* While the hotel itself is not a clinical treatment environment, the level of practical support exceeds that available in a standard hotel or shelter placement.
	Stabilization Rooms – *[7-day increment]* Stabilization rooms are single room occupancy units that are dispersed in other supportive housing locations or within unsupported SROs.
	Shelter – *[maximum 90 days]* Managed by the Department of Homelessness and Supportive Housing (DHSH).

Source: SFDPH

BHS Facility Locations

California, as well as the United States more broadly, has experienced a long-term transition from hospital to community-based mental health care, which has been reinforced by managed care systems and reforms under the ACA. As discussed above, San Francisco's BHS providers employ principles of recovery and wellness, and provide client-centered and integrated care to meet complex trauma needs. Approximately half of BHS facilities are operated by private community-based organizations distributed throughout San Francisco neighborhoods. Figure 5.3-5.5 illustrates where these facilities are located, in relation to population density.

Figure 5.3 - 5.2 San Francisco Behavioral Health Service Provider Locations & Population Density



Source: United State Census Bureau, 2010

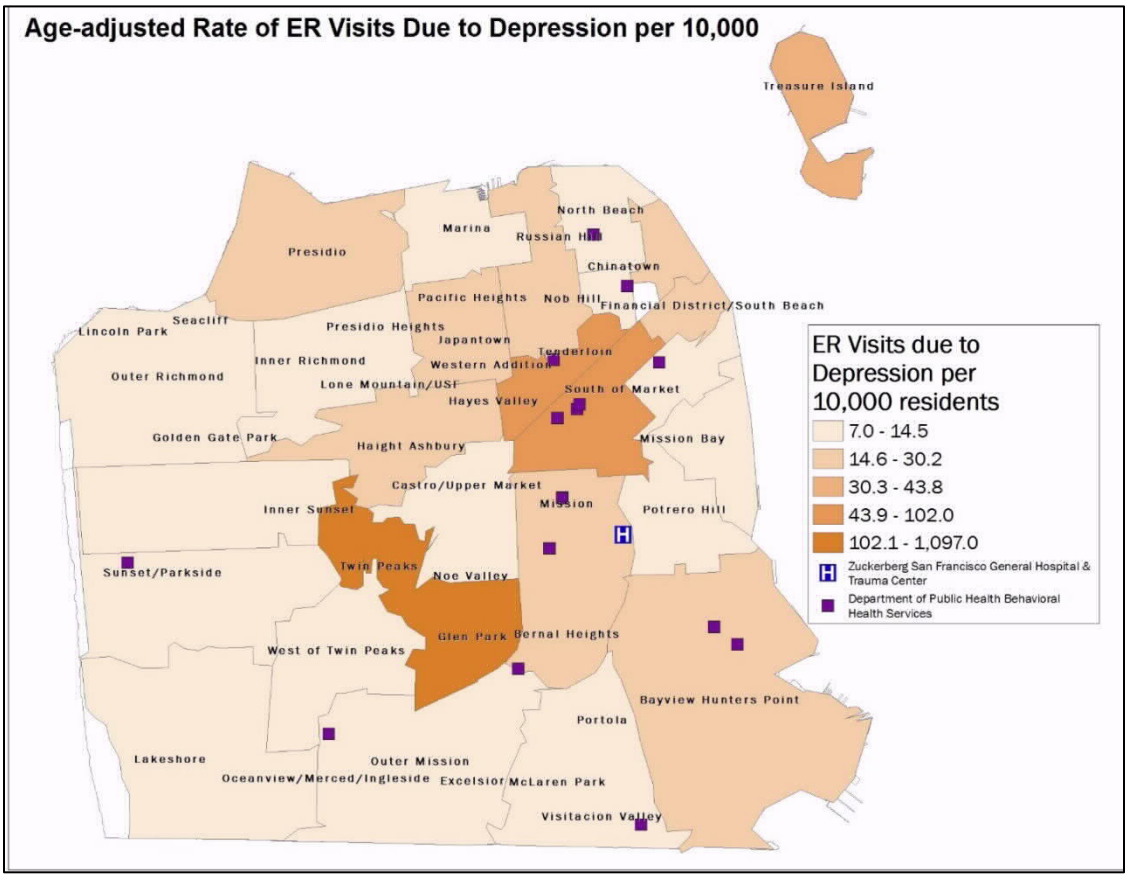
DPH Community Behavioral Health Services

African American Alternatives -- 2712 Mission Street
Behavioral Health Access Services -- 1380 Howard Street
Central City Older Adults Clinic -- 1563 Mission Street
Chinatown Child Development Center -- 720 Sacramento Street
Chinatown North Beach Mental Health Services --729 Filbert St, SF CA 94133
Community Justice Center/Violence Intervention Program – 555 Polk Street
Comprehensive Crisis – 3801 3rd Street
Family Mosaic -- 1309 Evans Street
Filipino-American Counseling Team – 1001 Potrero Avenue
Foster Care Mental Health and Crisis Services – 3801 3rd Street
Fully Integrated Recovery Services -- 1001 Potrero Avenue
Integrated Service Center – 170 9th Street
LEGACY – 1305 Evans Street
Mission ACT / Mission Mental Health Services -- 2712 Mission Street
Mission Family Center -- 759 S Van Ness Avenue
OMI Family Center -- 1701 Ocean Avenue
SE Mission Geriatrics -- 3905 Mission Street
South of Market Mental Health -- 760 Harrison Street
South Van Ness Behavioral Health Services -- 755 South Van Ness Avenue
Southeast Child/Family Therapy Center -- 100 Blanken Avenue
Sunset Mental Health -- 1990 41st Avenue
Transitional Aged Youth Services -- 755 South Van Ness Avenue

Emergency Utilization

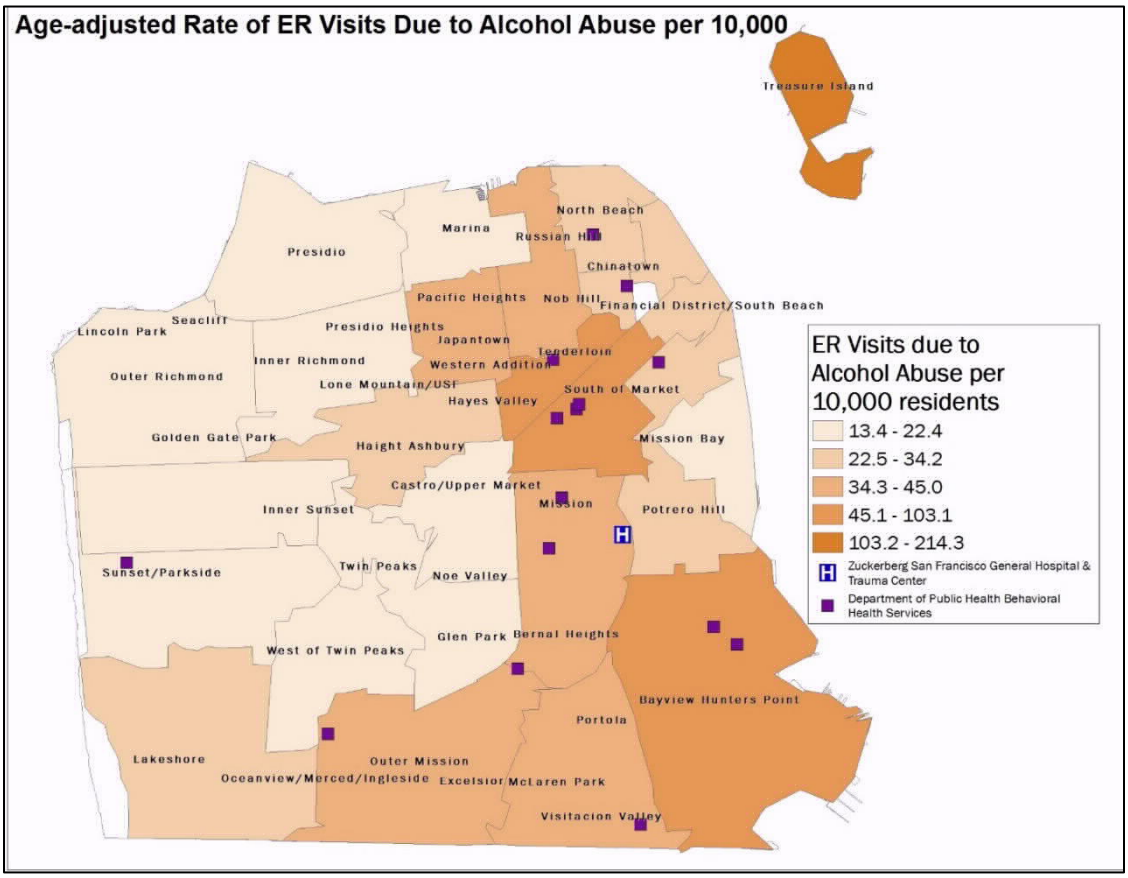
Figure 5.3-5.3 through 5.3-5.5 display utilization of emergency services for a variety of behavioral health indicators: depression, alcohol abuse, and drug use. Similar to other forms of health services, there is a higher concentration of services in the city's northeast quadrant to meet the needs of areas with the highest population density. However, there are fewer services in the southeast sector in neighborhoods like Bayview/Hunters Point and Excelsior/Outer Mission, which have high rates of ER visits for alcohol abuse and drug use.

Figure 5.3 - 5.3 Age-adjusted Rate of ER Visits Due to Depression per 10,000 by Zip Code (2012-2016)



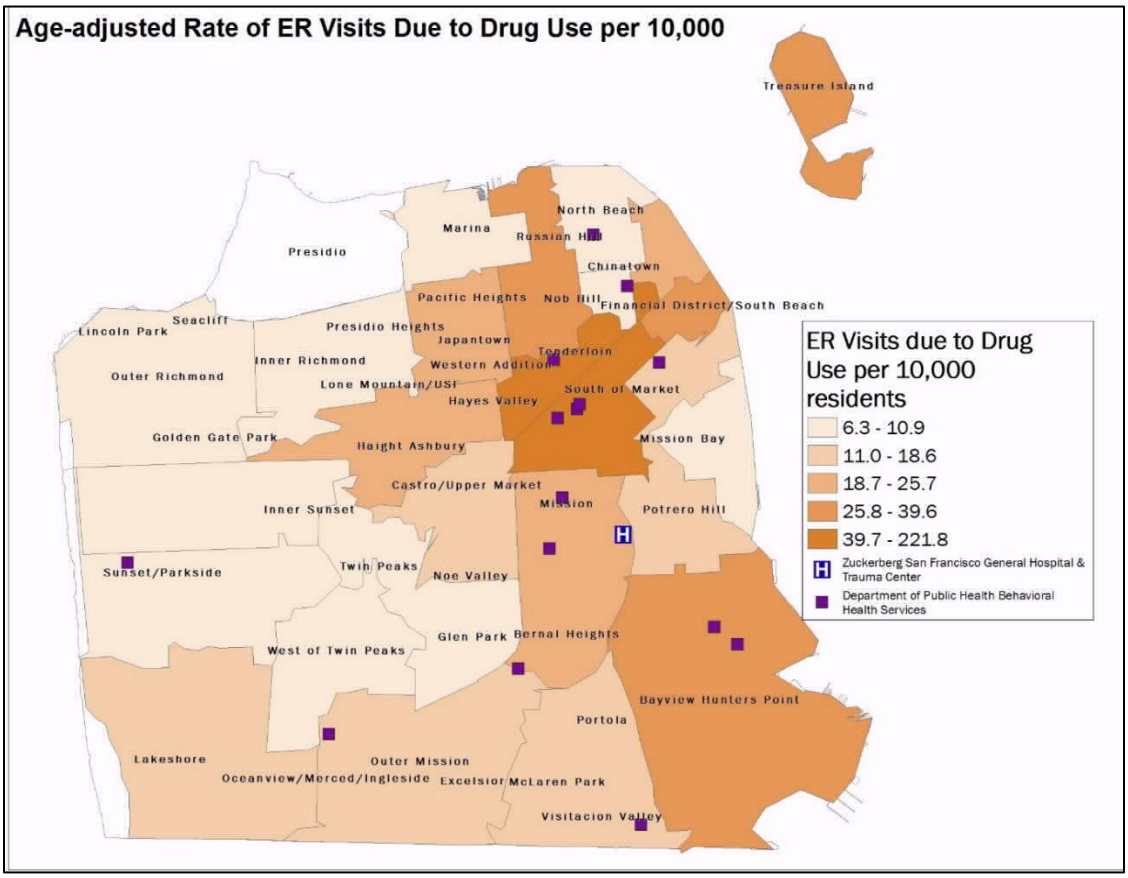
Source: California Office of Statewide Health Planning & Development, 2012-2016

Figure 5.3 - 5.4 Age-adjusted Rate of ER Visits Due to Alcohol Abuse per 10,000 by Zip Code (2012-2016)



Source: California Office of Statewide Health Planning & Development, 2012-2016

Figure 5.3 - 5.5 Age-adjusted Rae of ER Visits Due to Drug Use per 10,000 by Zip Code (2012-2016)



Source: California Office of Statewide Health Planning & Development, 2012-2016

Figure 5.3 - 5.3 through Figure 5.3 - 5.5 display the age-adjusted ER visit rate by zip code for a variety of behavioral health indicators: depression, alcohol abuse, and drug use. Similar to other forms of health services, there is a higher concentration of services in the city's northeast quadrant to meet the needs of areas with the highest population density. However, there are fewer services in the southeast sector in neighborhoods like Bayview Hunters Point, Excelsior and Outer Mission, which have high rates of ER visits for alcohol abuse and drug use. Figure 5.3 - 5.3 displays the age-adjusted rate of emergency room (ER) visits due to depression. Zip codes in the Twin Peaks, Glen Park, Tenderloin, and SoMa neighborhoods have the highest rates of ER visits due to depression. Figure 5.3 - 5.4 displays the age-adjusted rate of ER visits due to alcohol abuse. Zip codes in the Treasure Island, Bayview Hunters Point, SoMa, and Tenderloin neighborhoods have the highest rates of ER visits due to alcohol abuse. Finally, Figure 5.3 - 5.5 displays the age-adjusted rate of ER visits due to drug use. Zip codes in the SoMa, Tenderloin, Bayview Hunters Point, and Treasure Island neighborhoods have the highest rates of ER visits due to alcohol abuse.

Many of the neighborhoods with higher rates of emergency visits for behavioral health issues have behavioral health care services located in the neighborhood. This suggests that an individual's ability to access needed behavioral health services may be impacted by factors other than location.

Meeting the Need

A 2015 national survey conducted by the National Alliance on Mental Illness (with the majority of respondents living in California) reported that the need for behavioral health

services is largely unmet.[184] Meeting the City's increasing demands for behavioral health services may require expansion of existing services and facilities. For example, there is a lack of options for behavioral health services after-hours (5pm-10pm). Survey Respondents reported barriers to obtaining quality care including challenges finding providers in health insurance plan networks. However, San Francisco has fared better in behavioral health access compared other counties because of the Healthy San Francisco program. San Francisco employs teams to outreach to individuals who may benefit from services offered in the system of care and works to engage individuals in these services. Further, there is a walk-in Behavioral Health Access Center, as well as a 24/7 phone line, for individuals interested in learning more about the array of services.

Greater collaboration between the behavioral health and primary care services may relieve some strain from the behavioral health safety net providers. Beginning in 2014 and continuing through 2020, the San Francisco Health Network implemented the Primary Care Behavioral Health (PCBH) model by placing behavioral health practitioners at five primary care clinics, and primary care staff at three mental health clinics. Behavioral health clinicians at these sites deliver services such as: evidence-based therapeutic interventions, consultation with primary care team members, facilitation through population-based care "pathways", and self- and chronic-care management. [185] It should be noted that PCBH serves low acuity behavioral health needs, while BHS (discussed earlier in the chapter) serves severe mental illness. Similarly, many SFCCC member clinics provide a broad array of behavioral health and/or substance use disorder treatment in a primary care setting.

In September of 2019, San Francisco Mayor London Breed and SFDPH announced a mental health reform initiative which includes a plan to help the approximately 4,000 homeless San Franciscans who have mental health and substance use disorders. One of the initial steps in this initiative are to provide enhanced care coordination, create a multi-agency program to streamline housing and health care for 230 of San Francisco's most vulnerable homeless individuals, and increase access to behavioral health services by expanding the hours of the City's Behavioral Health Access Center.[186]

In November of 2019, the San Francisco Board of Supervisors passed Mental Health SF. Mental Health SF is a program designed to provide access to mental health services, substance use treatment, and psychiatric medications to adult residents of San Francisco with mental illness and/or substance use disorders who are homeless, uninsured, or enrolled in Medi-Cal or Healthy San Francisco. The ordinance also establishes an Office of Private Health Insurance Accountability, to advocate on behalf of privately insured individuals not receiving timely and appropriate mental health care under their private insurance. It should be noted that Mental Health SF will not become operative in San Francisco until adequate funds have been identified. The intent of Mental Health SF is to expand on the services provided by SFDPH in order to increase access and improve care coordination for residents with behavioral health needs.

Jail Behavioral Health Services

The City and County of San Francisco Jail Health Services (JHS) provides a comprehensive and integrated system of medical, psychiatric and substance abuse care to prisoners in the San Francisco County Jail system. This includes

[184] National Alliance on Mental Illness. (2015). A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care. Retrieved from http://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf.

[185] San Francisco Department of Public Health. San Francisco Mental Health Services Act, 2017-2020 Integrated Plan.

[186] Office of the Mayor of San Francisco London Breed. Press Release Mayor London Breed, Tipping Point & UCSF Announce Partnership to Expand & Strengthen Mental Health Support. September 12, 2019

evaluation, evidence-based individual and group therapy, medication management, assessment and referrals to community treatment, substance abuse assessment and treatment, reentry services and crisis intervention. Innovative programs offered through Jail Behavioral Health Services include medication assisted treatment (MAT) of Methadone and Buprenorphine for substance use treatment.

Harm Reduction Services in San Francisco

San Francisco's continuum of substance use disorder services is based on the principles of harm reduction. Harm reduction is a public health philosophy that promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors that impact individuals and their community. Harm reduction methods are free of judgment and directly involve clients in setting their own health goals. Currently, San Francisco provides an array of harm reduction services, including syringe access to people who inject drugs (PWID) to promote HIV prevention, on demand medication assisted treatment (MAT) strategies (methadone and buprenorphine) for opioid addiction, and making Naloxone readily available to members of the public to reduce opioid overdoses. These programs also link individuals to medical care and treatment services. The City is also exploring new harm reduction strategies like safe injection services.[187] Safe injection sites are provided professionally supervised facilities where drug users can consume drugs in safer conditions and aim to promote safer drug injection practices, enhance health-related behaviors among people who inject drugs, and connect them with external health and social services.[188] Discussed more in the *Health Systems Trends Assessment*, in June 2019 AB362 was passed in the California State Assembly to allow San Francisco to launch a supervised safe injection pilot program through 2026. The Bill will go before the State Senate in January of 2020.[189]

Mental Health Provider Workforce

Mental health providers include licensed psychiatrists, psychologists, clinical social workers, counselors, psychiatric nurse specialists, and marriage and family therapists. California is facing a substantial shortage of qualified and diverse behavioral health professionals. By 2028, the state would have only about half psychiatrists and 28% fewer psychologists, social workers, and counselors than would be needed in the State based on current service utilization and unmet need. [190] Among California adults with any mental illness who sought treatment, approximately 17% did not receive mental health treatment. The most common barriers cited were lack of health insurance, inability to pay for treatment due to provider coverage, and a lack of treatment providers. Similarly, for individuals with serious mental illness, access to appropriate treatment has become increasing difficult to find.[191]

San Francisco has the highest ratio of mental health providers to residents among California counties; in 2015, there was one mental health provider for every 120 San Francisco residents,

[187] In 2017, the San Francisco Health Commission passed a resolution supporting the San Francisco Safe Injection Task Forces 17 recommendations, including the implementation of safe injection services in San Francisco.
[188] San Francisco Department of Public Health. "Harm Reduction Services in San Francisco." Issue Brief. San Francisco, CA: San Francisco Department of Public Health, June 2017. https://www.sfdph.org/dph/files/SIStaskforce/IssueBrief-06202017.pdf.
[189] Controlled Substances: Overdose Prevention Programs. AB362. California 2019-2020 Regular Session. Retrieved from: https://legiscan.com/CA/text/AB362/2019
[190] "Mental Health Worker Shortage Takes Center Stage." *California Health Care Foundation* (blog). Accessed March 5, 2019. https://www.chcf.org/blog/mental-health-worker-shortage-center-stage/.
[191] California HealthCare Foundation. (2018). California Health Care Almanac. Mental Health in California: For Too many, Care Not There. Retrieved from https://www.chcf.org/publication/mental-health-in-california-for-too-many-care-not-there/

compared to a statewide ratio of 1:330.[192, 193] However, the City lacks a sufficient number of psychiatrists serving low-income patients due to low reimbursement rates, resulting in long wait times to get a behavioral health appointment. One study found that only 46% of California psychiatrists accept Medi-Cal.[53] Additionally, due to the high cost of living in San Francisco and disproportionately low pay as a health care provider, it is often difficult to retain all types of behavioral health providers. One such intervention to address the shortage in mental health providers is a collaboration between UCSF, UC Davis and UCLA that offers a training program for psychiatric-mental health nurse practitioners (PHMNPs). PMHNPs are specialized mental health professionals authorized to prescribe psychotropic medications, treat severe mental illness and substance abuse disorders, and offer psychiatric care. It's estimated that this program will train 300 new mental health providers throughout the state by 2025.[194]

Finally, the demographics of the mental health provider workforce does not reflect the needs of San Francisco's diverse population. African Americans and Latinos are underrepresented among psychiatrists and psychologists. Additionally, 45% of psychiatrists and 37% of psychologists are over the age of 60, meaning that a large proportion of California's behavioral health workforce will be reaching retirement age within the next decade. San Francisco faces workforce shortages of behavioral health professionals who have the necessary skills to work with children, older adults, and linguistically and culturally diverse populations.

6. POST-ACUTE & LONG-TERM CARE

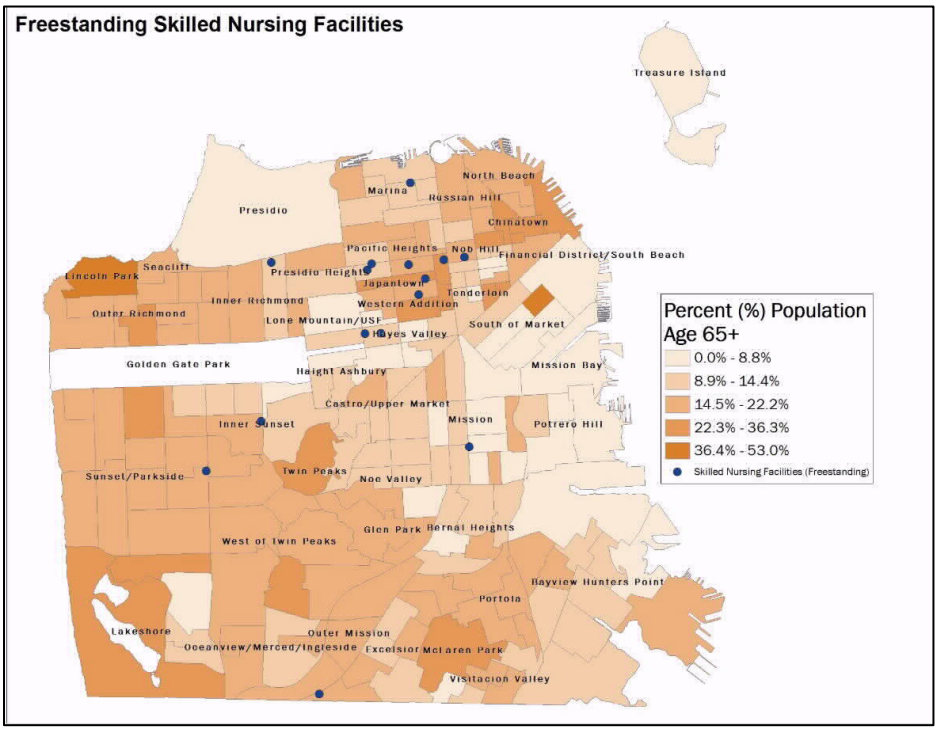
LONG-TERM AND POST-ACUTE CARE SERVICES ARE INCREASINGLY NEEDED AS THE POPULATION OF OLDER ADULTS IN SAN FRANCISCO INCREASES. THESE SERVICES ARE NECESSARY TO ENSURE THAT SENIORS AND ADULTS WITH DISABILITIES ARE ABLE TO REMAIN IN THE COMMUNITY INDEPENDENTLY AFTER AN INJURY OR SERIOUS ILLNESS.

[192] County Health Rankings & Roadmaps. (n.d.). Mental Health Providers. Retrieved from http://www.countyhealthrankings.org/app/california/2018/measure/factors/62/data?sort=sc-3%5C

[193] In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure.

[194] Training Nurse Practitioners to Fill the Gap in Mental Health Care. (2020). Retrieved from: https://www.ucsf.edu/news/2020/01/416596/training-nurse-practitioners-fill-gap-mental-health-care

Figure 5.3 - 6.1. Freestanding Skilled Nursing Facilities & Population Age 65+



Source: United States Census Bureau, American Community Survey 5-Year Estimates, 2013-2017

Skilled Nursing Facilities (SNFs)

Facility-based post-acute and long-term care is typically provided in a skilled nursing facility, or SNF. The California Department of Public Health licenses SNFs as either: 1) a distinct part (DP) of a hospital (DP/SNF); or, 2) a freestanding facility, which are more common nationally. Figure 5.3 - 6.1 displays the locations of the 15 freestanding SNFs in San Francisco. Medi-Cal contracts with some facilities to provide "subacute care" or, specialized care for adults with higher needs, such as ventilator care. Subacute care can be provided by either a freestanding SNF or DP/SNF.

As of October 2019, and across all SNF facility types, San Francisco has approximately 15 SNF beds per 1,000 adults age 65 and older (short and long-term beds[195]). Rough estimations, based on available data, indicate that the available bed rate for long-term Medi-Cal beds is much lower, at 12 beds per 1,000 adults 65 and older. Alternatively, if the bed supply remains constant over the next 20 years, San Francisco's bed rate would decrease from 15 to 9 SNF beds per 1,000 adults 65 and older. For comparison, the entire State of California has approximately 22 SNF beds for every 1,000 adults age 65 and older (short and long-term beds). Several efforts have been made to address this particular issue in San Francisco, including the Hospital Council of Norther California's Post-Acute Care Collaborative and the Long-Term Care Coordinating Council (LTCCC). San Francisco is not alone in facing these shortfalls, as the number of DP/SNFs has declined nationally.[196]

Hospital-Based SNF Beds

As of 2017, Laguna Honda Hospital and Rehabilitation Center (LHH) and Jewish Home are the largest providers of institutional skilled nursing care in San Francisco, with a total of

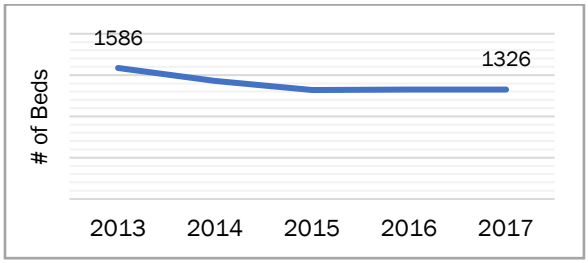
[195] Medicare is often the payment source for short-term skilled nursing beds, while Medi-Cal covers long-term beds.

[196] Financial Fact Sheets. 2016. (Accessed January 27, 2016, at http://www.aha.org/research/policy/finfactsheets.shtml.)

1,147 (769 and 378, respectively) DP/SNF beds.

The total number of SNF beds in San Francisco as of 2017 was 1,326, however, this number has since decreased with the closures of skilled nursing care at St. Mary's Medical Center and CPMC St. Luke's.

Figure 5.3 - 6.2 San Francisco Hospital DP/SNF Beds, 2013-2017



Source: OSHPD Hospital Utilization Report, 2017
Note: Due to closures in SNF beds at CPMC St. Luke's and St. Mary's Medical Center, the estimated number of hospital DP/SNF beds in 2019 is 1,232 beds.

SNFs may provide short-term or long-term care, or a combination thereof. Facilities oriented toward short-term stays tend to focus on rehabilitation following an illness or injury and may have constant resident turnover. On the other hand, residents of long-term care facilities may consider those locations as their permanent home. San Francisco acute care DP/SNFs primarily provide short-term rehabilitative care, while Laguna Honda Hospital and the Jewish Home have a greater number of beds oriented towards long-term patient stays. Table 5.3 - 6.1 provides an estimate of the number of short and long-term beds in each DP/SNF.

Table 5.3 - 6.1 Estimate of Hospital-Based Short and Long-Term SNF Beds, 2017

Facility	Short-term Bed SNF Estimate	Long-term Bed SNF Estimate	Total Number of SNF Beds
Acute Care Hospitals			
ZSFG	30	0	30
CPMC Davies	38	0	38
CPMC St. Luke's(i)	39	40 (subacute)	79
St. Mary's Medical Center(ii)	32	0	32
Skilled Nursing Facilities[197]			
Laguna Honda	100	669	769
Jewish Home	80	298	378
TOTAL	**319**	**967 (1,007 incl. subacute)**	**1,326**

Source: OSHPD Hospital Utilization Report, 2017
Note: (i) CPMC St. Luke's campus closed in June 2018, and at the time of closure there were 17 subacute care beds filled, all of which were transferred to CPMC Davies campus. These 17 subacute beds will revert back to short-term SNF beds once no longer used by the patient receiving subacute care. (ii) As of 2017, St. Mary's Medical Center no longer supported skilled nursing care.

As of June 2019, and accounting for the closures of skilled nursing facilities at CPMC St. Luke's (-79 SNF beds) and St. Mary's Medical Center (-32 SNF beds), the total number of SNF beds in San Francisco is 1,232 (248 short-term and 984 long-term, of which 17 are subacute).

SINCE 2001, SAN FRANCISCO HAS EXPERIENCED A 47% DECREASE IN THE NUMBER OF HOSPITAL-BASED SHORT AND LONG-TERM HOSPITAL-BASED SNF BEDS.

Freestanding SNF Beds

Freestanding SNFs provide the majority of institutional short- and long-term care in the United States. As of 2017, San Francisco's 15 freestanding SNFs provide 1,133 skilled nursing beds (refer to Table 5.3 - 6.2 for a list of facilities and bed capacity). The majority of freestanding SNFs have high occupancy rates, indicating that they generally operate at full capacity. In 2017, Kindred Healthcare was the largest freestanding SNF provider in San Francisco, with four facilities and approximately 45% (508) of the total freestanding SNF beds. Kindred Healthcare has since transferred ownership and management of their skilled nursing facilities, as described in the note of the next table.

Table 5.3 - 6.2 Certified Freestanding Skilled Nursing Facilities (SNF), 2017

Freestanding SNF Facility	2017 Licensed SNF Beds
Medi-Cal Certified Facilities	
Pacific Heights Transitional Care Center(i)	120
The Avenues Transitional Care Center(i)	140
Tunnell Skilled Nursing & Rehabilitation Center(i)	180
Lawton Skilled Nursing & Rehabilitation Center(i)	68
St. Anne's Home	46
Hayes Convalescent Hospital	34
Providence (SF Nursing Center)	53
San Francisco Health Care	168
Central Gardens	92
Sub-Total	***901***
Medicare or Private Pay (Does Not Accept Medi-Cal) Facilities	
Laurel Heights Community Care	32
San Francisco Towers	55
Sequoias SF Convalescent Hospital	50
Sheffield Convalescent Hospital	34
California Convalescent Hospital- SF	29
Heritage on the Marina	32
Sub-Total	***232***
TOTAL	1,133

Source: OSHPD Long-Term Care Annual Utilization Data, 2017
Note: (i) As of 2019 all Kindred Healthcare San Francisco SNF facilities have transitioned to new ownership. Pacific Heights Transitional Care Center and The Avenues Transitional Care Center are now affiliate organizations of Aspen Skilled Healthcare. Tunnell Skilled Nursing & Rehabilitation and Lawton Skilled Nursing & Rehabilitation are now affiliate organizations of Generations Healthcare.

In 2017, San Francisco had nine Medi-Cal certified freestanding SNFs, which accounted for 901 licensed SNF beds (80% of total licensed freestanding SNF beds). Annual census data reported by San Francisco freestanding SNFs to OSHPD in 2017 reveal that most SNF residents (57%) were covered by Medi-Cal— however, this rate may fluctuate widely, given the transitional nature of many facilities. Additionally, the

[197] Laguna Honda Hospital and Jewish Home are licensed as hospitals instead of as long-term care facilities.

occupancy rate for Medi-Cal certified facilities was 88% compared to 73% for non Medi-Cal SNFs. These data indicate that the availability of longer-term beds for Medi-Cal patients is limited.

In total, freestanding SNF facilities made 2,683 discharges in 2017, but had an annual point-in-time census of 865 patients, indicating a high volume of short-term patient discharges (Refer to Table 5.3 - 6.3).[198]

Table 5.3 - 6.3 San Francisco Freestanding Skilled Nursing Facilities, 2017

	Medi-Cal Certified SNFs	Medicare or Private Pay SNFs	Total (15 facilities)
Licensed Beds	901	232	1,133
Licensed Bed Days	328,865	80,272	409,137
Patient Days	239,889	54,835	294,724
Admissions	2,224	375	2,601
Discharges	2,290	391	2,683
Patient Census, 2017	720	145	865

Source: OSHPD Long-Term Care Annual Utilization Data, 2017

The trend of high-volume short-term patient discharges is more pronounced at SNFs that are not Medi-Cal certified. Locally and nationally, SNFs beds are being converted from long-term care to short-term rehabilitation, shifting their funding from Medi-Cal to the more lucrative Medicare. This trend is further discussed in the *Health System Trends Assessment* chapter. Skilled nursing facilities are under financial pressure to complete the course of rehabilitation and discharge patients within prescribed time frames. They may emphasize rehabilitative activities at the expense of custodial care, or they may hurry discharge without the needed supports in place for the patient to transition home safely. The San Francisco Ombudsman Program, which investigates complaints of seniors in care, frequently responds to complaints about poor care in rehabilitation facilities (feeding assistance, unanswered call bells, etc.), as well as claims related to discharge planning (a process to help address patient needs for a smoother transition from one level of care to another).

Assisted Living Facilities (ALFs)

As stated in the San Francisco Long Term Coordinating Council's Assisted Living Workgroup Report, assisted living facilities (ALFs) are a vital resource for many seniors and people with disabilities who are no longer able to live independently and safety in San Francisco.[199] The two types of ALFs discussed in this section are Residential Care Facilities for the Elderly (RCFEs) and Adult Residential Care Facilities (ARFs). RCFEs support seniors age 60 and older, and ARFs serve adults between ages 18 and 59. While ALFs come in a variety of sizes, smaller facilities are commonly called "board and care" homes. In San Francisco, board and care facilities provide formerly homeless, elderly, and mentally ill people with 24-hour a day care in a home-like environment, and many individuals occupy board and care facilities for years.

Unlike SNFs, assisted living care is long-term care that is predominately a private-pay service and the cost is often prohibitively expensive, especially for seniors and adults with disabilities.

Residential Care Facilities for the Elderly (RCFEs)

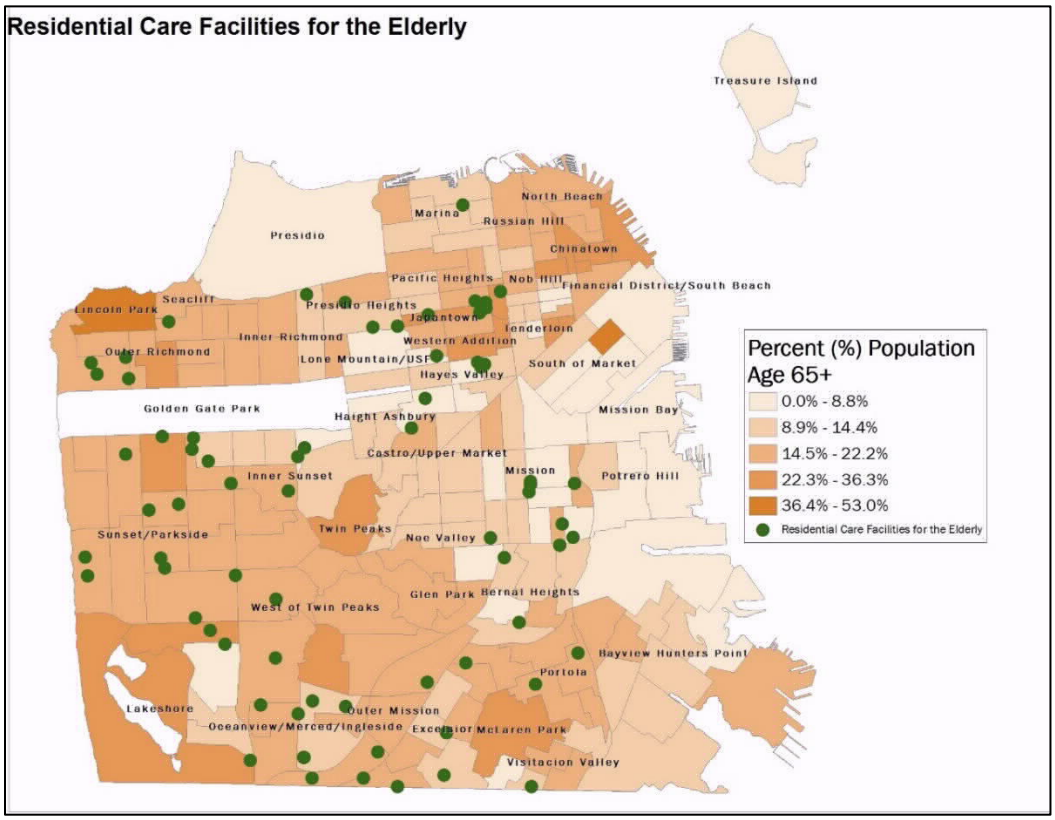
Residential Care Facilities for the Elderly (RCFEs) are community-based care – rather than institutional – for seniors and persons with disabilities. Similar to SNFs, the number of RCFE beds is also scarce, despite increasing demand. According to the California Department of Social Services (CDSS), as of November 2018, there

[198] Office of Statewide Health Planning & Development. (2017). Long-Term Care Annual Utilization Data. Retrieved from https://oshpd.ca.gov/data-and-reports/healthcare-utilization/long-term-care-utilization/

[199] San Francisco Long Term Coordinating Council. Assisted Living Workgroup Report. January 2019. Retrieved from: https://www.sfhsa.org/file/8256/download?token=RgD1puZf

are 64 RCFE facilities and approximately 3,071 RCFE beds.[200] RCFEs serve those who do not require constant skilled nursing or medical support, but who benefit from on-site personal care. Figure 5.3 - 6.3 displays the location of licensed RCFEs throughout San Francisco.

Figure 5.3 - 6.3 Residential Care Facilities for the Elderly & Percent Age 65+



Source: United States Census Bureau, American Community Survey, 2013-2017; California Department of Social Services, 2018

Approximately 984 (32%) of RCFE beds are in Continuing Care Retirement Communities, which indicates that a portion of these beds are independent living apartments for those who do not yet require supportive services and are relatively inaccessible to the general public due to cost. The following table excludes RCFE beds located in Continuing Care Retirement Communities and shows the number of RCFE beds and count of RCFE facilities by size.

Table 5.3 - 6.4. RCFE Facility and Bed Count, 2018

Facility Size	Facilities	Beds
1 to 6 beds	20	118
7 to 15 beds	19	233
16 to 49 beds	9	301
50 to 99 beds	5	337
100 + beds	7	1,098
Total	**60**	**2,087**

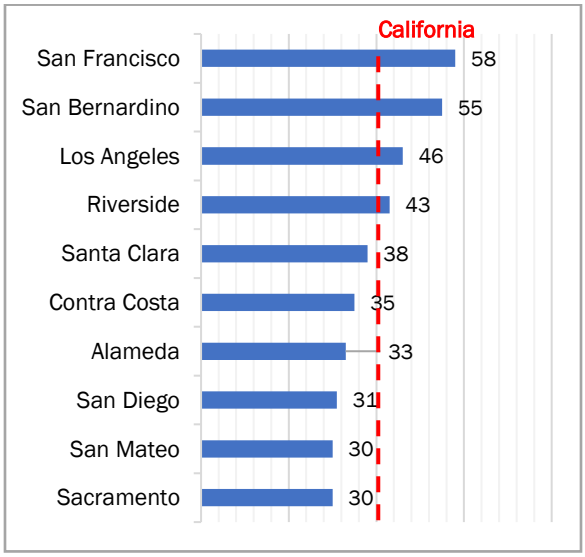
Source: California Department of Social Services (CDSS). Community Care Licensing, 2018

Similar to the shortage of SNF beds, the city faces a short supply of RCFE beds, with particular decline across smaller facilities. This is of concern as smaller RCFEs have generally been more affordable and accessible for low-income older adults. Since 2012, San Francisco

[200] California Department of Social Services (CDSS). Community Care Licensing – Residential Elder Care Facility Locations. November 2018.

has seen a loss of 20 RCFE facilities and 65 RCFE beds. The shortage of RCFE beds is particularly visible when compared to other large California counties. As shown below in Figure 5.3 - 6.4, there are 58 seniors age 60 and older for every RCFE bed in San Francisco, compared to a statewide rate of 39 seniors. These trends are driven by low reimbursement rates for long-term care and exacerbated by the high operating costs (due to higher costs of living and land prices in the City).

Figure 5.3 - 6.4 Ratio of Seniors (60+) per Residential Care Facility for the Elderly Beds in 10 Select Large Counties



Source: California Department of Social Services. Residential Care Facility Update 2019; American Community Survey 2013-2017.

Adult Residential Facilities (ARFs)

As mentioned above, Adult Residential Facilities (ARFs) serve adults between ages 18 and 59. Also commonly known as "board and care" homes, they are facilities that provide 24-hour a day nonmedical care and supervision According to the California Department of Social Services (CDSS), as of November 2018, there are 43 ARF facilities and approximately 484 ARF beds.[201]

Table 5.3 - 6.5. ARF Facility and Bed Count, 2018

Facility Size	Facilities	Beds
1 to 6 beds	28	164
7 to 15 beds	7	80
16 to 49 beds	7	185
50 to 99 beds	1	55
Total	**43**	**484**

Source: California Department of Social Services (CDSS). Community Care Licensing, 2018

Since 2012, the city has seen 33% reduction in the number of ARF facilities, and a 20% reduction in the number of ARF beds. The majority of this decline has been in smaller facilities, which similar to RCFEs, have traditionally been more accessible to lower-income residents including those supported with City subsidies.

According to the San Francisco Long Term Coordinating Council's Assisted Living Workgroup Report, ARFs are much more likely to be small facilities or board and care homes.[202] The City has witnessed a rapid loss of small ARF facilities which is likely driven by high operating costs and property value (due to higher costs of living and land prices in the City).

Palliative & Hospice Care

Palliative care is specialized medical care that provides patients with relief from pain, symptoms, and stress that can occur with serious chronic illness, including illness at the end of life. In recent years, the prevalence of hospital-based and community-based specialist palliative care programs has increased dramatically, as payers, providers, and consumers have come to appreciate the benefits of such services. Still, palliative care is not available to many Californians due to a general shortage in supply and uneven distribution of services across the state. California law requires Medi-Cal health plans to provide palliative care services under California Senate Bill 1004.

[201] California Department of Social Services (CDSS). Community Care Licensing – Residential Elder Care Facility Locations. November 2018.

[202] San Francisco Long Term Coordinating Council. Assisted Living Workgroup Report. January 2019. Retrieved from: https://www.sfhsa.org/file/8256/download?token=RgD1puZf

77% OF PATIENTS WHO DIED IN SAN FRANCISCO NEEDED PALLIATIVE CARE IN THE LAST YEAR OF LIFE

San Francisco is ahead of many counties in the state regarding inpatient palliative care capacity. A 2017 report found that 77% of patients in San Francisco needed palliative care in the last year of life, or 4,269 of the 5,580 deaths; this is an increase since the data was first collected in 2015. Twelve inpatient programs have the capacity to meet 103% San Francisco's estimated palliative care need, compared to California overall, which only has the capacity to meet 52% of the estimated need. San Francisco also has 16 community-based palliative programs that have the capacity to provide care to 2,434 patients, which would meet only 57% the city's estimated overall need. [203]

Similarly, hospice care provides quality care for people facing a life-limiting illness or injury and provides a team-oriented approach to providing medical care, pain management, emotional and spiritual support. Hospice care is most often provided in a patient's home, but can also be provided in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. In San Francisco, five hospice facilities report to OSHPD and served 2,608 patients in 2017 (refer to Table 5.3 - 6.6). The majority of patients (80%) are covered by Medicare and 75% of patients received care in a home setting. It is important to note that patients may receive hospice care in other facilities that report to OSHPD under different licensure. For example, Laguna Honda Hospital also provides on-site hospice services to patients.

Table 5.3 - 6.6 San Francisco Hospices Reporting to OSHPD, 2017

Hospice Facility	Patients Served	Visits by Staff(i)	Patients Discharged
Kaiser Foundation Hospital Hospice - San Francisco	568	14,648	528
Sutter Visiting Nurse Association and Hospice	643	21,624	597
American Carequest Hospice	60	1,196	47
Hospice by The Bay	1,227	45,705	1,040
Crossroads Home Health Care & Hospice	110	5,599	94
Total	2,608	88,772	2,306

Source: 2017 OSHPD Home Health Agencies and Hospice Facility Annual Utilization Data
Note: Other Hospice Services are available through Hospice and Palliative Care of Jewish Family Community Center, Zen Hospice, Laguna Honda Hospital, Self-Help Home Care & Hospice, And Crossroads Hospice. (i) The word staff here represents nurses, social workers, physicians, and home health workers.

7. CULTURALLY & LINGUISTICALLY COMPETENT CARE

CULTURALLY AND LINGUISTICALLY COMPETENT CARE IS NECESSARY TO PROVIDE SERVICES THAT RESPOND TO PATIENTS' LEVEL OF HEALTH LITERACY, PREFERRED LANGUAGES, CULTURAL HEALTH BELIEFS, AND OTHER COMMUNICATION NEEDS. THIS TYPE OF CARE IS PARTICULARLY IMPORTANT IN SAN FRANCISCO GIVEN THE DIVERSITY OF ITS POPULATION. [204]

This section presents information on the delivery of culturally and linguistically responsive care in San Francisco by examining: 1) rates and disparities of health literacy and language proficiency; 2) capacity and innovations in language interpretation services; and, 3) racial, ethnic, and linguistic diversity of San Francisco's physician workforce. It should be noted this section focuses on a few of the factors that influence access to culturally and linguistically

[203] California Healthcare Foundation. (2018). Palliative Care in California: Narrowing the Gap. Retrieved from https://www.chcf.org/publication/palliative-care-california-narrowing-gap/

[204] US Department of Health and Human Services, Office of Minority Health Retrieved from https://www.thinkculturalhealth.hhs.gov/clas

competent care; however, there are many other factors that can influence access to health services, such as age, education, religion, physical or mental disability, and income.

Health Literacy

Health literacy is defined as a patient's capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Low levels of health literacy are linked to:

- Limited ability to interpret and act on medication labels, thereby increasing the incidence of medication errors;
- Difficulty understanding and following health care instructions;
- Reduced likelihood of seeking preventive care;
- Increased hospitalization and use of emergency services;
- Poorer health outcomes; and
- Higher mortality rates.[205]

Research also suggests that certain populations are more likely to experience low health literacy, subjecting them to poorer health outcomes and health inequities.[206] For example:

- **Older adults:** One study found that two-thirds of US adults age 60 or older have inadequate or marginal health literacy skills, and 60% of patients at one public hospital were unable to read and understand basic health materials (e.g. prescription labels).
- **People of color:** Research shows that Black, Hispanic, American Indian/Alaska Native, and multiracial adults have lower average health literacy than White and Asian/Pacific Islander adults, and that Hispanic adults have the lowest average health literacy than adults in any of the other racial/ethnic groups.[207]
- **Immigrants:** Immigrants may face multiple challenges to health literacy, including linguistic barriers and lack of familiarity with US health care systems. This is of particular concern given San Francisco's substantial immigrant population—as of 2017, 35% of San Francisco's residents were foreign-born (compared to 27% statewide).[208]
- **Low-income persons:** Adults living below the poverty level have lower average health literacy than adults with higher incomes.[209]

Levels of educational attainment do not necessarily correlate with health literacy. A person with advanced degrees, for example, may have difficulty understanding complicated health insurance enrollment forms and navigating the health care system. Health literacy is influenced by a convergence of factors, including educational attainment, cultural and social factors, and access to health education and services.[210]

A study focused on San Francisco's Black/African American community, called the Rapid Estimate of Adult Health Literacy in

[205] Koh H, Berwick D, Clancy C, Baur C, Brach C, Harris L, and Zerhusen E. (2012). New Federal Policy Initiatives to Boost Health Literacy Can Help the Nation Move Beyond the Cycle of Costly 'Crisis Care.' Health Affairs no. 2. Retrieved from http://content.healthaffairs.org/content/early/2012/01/18/hlthaff.2011.1169.full.pdf+html.

[206] National Network of Libraries of Medicine. Health Literacy. Retrieved from http://nnlm.gov/outreach/consumer/hlthlit.html

[207] Kutner M, Greenberg E, Jin Y, Paulsen C, White S. (2006.) The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy. Retrieved from http://nces.ed.gov/pubs2006/2006483.pdf.

[208] United States Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S0501&prodType=table

[209] Kutner M, Greenberg E, Jin Y, Paulsen C, White S. (2006). The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy. Retrieved from http://nces.ed.gov/pubs2006/2006483.pdf.

[210] Institute of Medicine. (2004). "Health Literacy: A Prescription to End Confusion." Report Brief. Retrieved from http://www.iom.edu/~/media/Files/Report%20Files/2004/Health-Literacy-A-Prescription-to-End-Confusion/healthliteracyfinal.pdf.

Medicine (REALM) Survey[211, 212], found that an estimated 39% of Black/African American adults in San Francisco had a health literacy level equivalent to the 8th grade or below.

According to the survey, persons with health literacy skills:

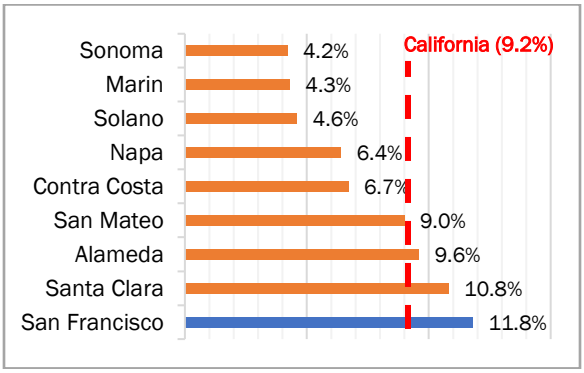
- At the 7th or 8th grade level (23% of Blacks/African Americans in San Francisco) will struggle with most patient education materials;
- Between the 4th and 6th grade levels (10% of Blacks/African Americans in San Francisco) will need to receive materials tailored to a limited-literacy audience and may struggle with prescription labels;
- At the 3rd grade level or below (6% of Blacks/African Americans in San Francisco) may not be able to read even limited-literacy materials, will need repeated oral instructions, and may need additional help (e.g. illustrations, audio recordings, etc.) to act on health information appropriately.

The implementation Affordable Care Act (ACA) spurred opportunities for service providers to integrate health literacy throughout their systems of care. The law promotes the use of strategies such as advanced medical homes, accountable care organizations (ACOs), health information technology expansion, improved training requirements, streamlining of insurance enrollment procedures, and requiring insurers to provide easy to understand information on health coverage.[213, 214] Such efforts align well with the US Department of Health and Human Services' National Action Plan to Improve Health Literacy, which sets forth seven unified health literacy goals and strategies for the country.

Limited English Proficiency

Approximately 21% of San Francisco's residents ages 5 and up are of Limited English Proficiency (LEP), defined by the US Census as speaking English "less than very well" (compared to 18% statewide).[215] Further, 12% percent of San Francisco households are linguistically isolated (in which all members ages 14 and up have at least some difficulty with English)—the highest proportion among Bay Area counties (Figure 5.3 - 7.1). San Francisco's high degree of linguistic diversity poses a challenge for providing linguistically competent health services.

Figure 5.3 - 7.1 Percentage of Linguistically Isolated Households in Bay Area Counties, 2017



Source: US Census Bureau, 2013-2017 5-Year American Community Survey

[211] Physical Health Committee of the San Francisco African American Community Health Equity Council (AACHEC). (2012). Community Diagnosis Report of the Physical Health Committee of the African American Community Health Equity Council: A Project of the Black Coalition on AIDS/Rafiki Wellness. Retrieved from https://www.sfdph.org/dph/files/hc/HCCommPublHlth/Agendas/2012/dec%2018/BCA_Rafiki_Presentation_121212.pdf

[212] The Physical Health Committee of the AACHEC surveyed community members to establish their levels of health literacy between April and November 2011. AACHEC conducted this descriptive study at two health clinics located in predominantly African American neighborhoods in San Francisco as well as at community organizations, civic groups, and community events. Survey conductors administered the REALM to a total of 158 African American respondents living in San Francisco. Please note that REALM was not administered to a random sample, meaning that results may not be representative of San Francisco's African American population.

[213] Koh H, Berwick D, Clancy C, Baur C, Brach C, Harris L, and Zerhusen E. (2012). New Federal Policy Initiatives to Boost Health Literacy Can Help the Nation Move Beyond the Cycle of Costly 'Crisis Care.' Health Affairs no. 2. Retrieved from http://content.healthaffairs.org/content/early/2012/01/18/hlthaff.2011.1169.full.pdf+html.

[214] Schillinger D, Keller D. The Other Side of the Coin: Attributes of a Health Literate Health Care Organization. University of California, San Francisco. In How Can Health Care Organizations Become More Literate: Workshop Summary. Roundtable on Health Literacy, Board on Population Health and Public Health Practice, Institute of Medicine. Washington (DC): National Academies Press.

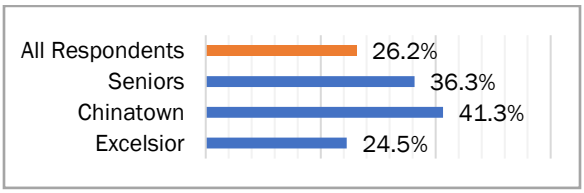
[215] United States Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_DP02&prodType=table

Individuals with LEP status are more likely to report dissatisfaction with health services, increased incidence of misdiagnosis, longer hospital stays, and poorer health outcomes.[216,217] According to the Institute of Medicine:

LANGUAGE BARRIERS MAY AFFECT THE DELIVERY OF ADEQUATE CARE THROUGH POOR EXCHANGE OF INFORMATION, LOSS OF IMPORTANT CULTURAL INFORMATION, MISUNDERSTANDING OF PHYSICIAN INSTRUCTION, POOR SHARED DECISION-MAKING OR ETHICAL COMPROMISES (E.G. DIFFICULTY OBTAINING INFORMED CONSENT). LINGUISTIC DIFFICULTIES MAY ALSO RESULT IN DECREASED ADHERENCE TO MEDICATION REGIMES, POOR APPOINTMENT ATTENDANCE, AND DECREASED SATISFACTION WITH SERVICES.[218]

Given these challenges, it is not surprising that residents in neighborhoods with large foreign-born populations (such as Chinatown and Excelsior) cite provider familiarity with language and culture as one of the top three criteria they consider when selecting a health care facility (Figure 5.3 - 7.2).[219]

Figure 5.3 - 7.2 Respondents Citing Provider "Familiarity with Language and Culture" Among Top Three Reasons for Selecting a Provider, 2011



LEP status can also present barriers to receiving health insurance and services. LEP individuals were underrepresented in the first open enrollment period (October 2013 – April 2014) for Covered California—the state's health insurance marketplace created to implement the ACA. Although LEP persons comprised 40% of eligible enrollees, they comprised only 10% of applicants.[220] According to research from the UCLA Center for Health Policy Research, the UC Berkeley Labor Center, and the California Pan-Ethnic Health Network, it is projected that more than 110,000 LEP Californians will remain uninsured—comprising more than half of those without insurance—unless targeted outreach efforts are implemented.[221] Similarly, a Covered California analysis of 2019 insurance enrollment shows substantial impact on some populations where English is not the preferred spoken language due to the federal removal of the individual mandate. Specifically, enrollment among Mandarin speakers dropped 28%, Spanish speakers dropped 29%, and Korean speakers dropped by 46%; by comparison, English speaker enrollment dropped 22% in California.[222]

[216] Hasnain-Wynia R, Yonek J, Cohen A, Restuccia J. (2009). Improving Care for Individuals with Limited English Proficiency: Facilitators and Barriers to Providing Language Services in California Public Hospitals. Funded by the California Endowment.

[217] Jacobs E, Sanchez-Leos G, Rathouz P, Fu P. (2011). Shared Networks of Interpreter Services, At Relatively Low Cost, Can Help Providers Serve Patients with Limited English Skills. Health Affairs. 30, No. 10. Retrieved from http://content.healthaffairs.org/content/30/10/1930.full?ijkey=IMIBLJYyuNUbw&keytype=ref&siteid=healthaff

[218] Institute of Medicine. (2002). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academy Press.

[219] Chinese Progressive Association. (2012). Creating Healthy Communities: Making Healthcare Services Accessible in San Francisco."

[220] The Greenlining Institute. (2014) Covered California's First Year: Strong Enrollment Numbers Mask Serious Gaps. Retrieved from http://greenlining.org/wp-content/uploads/2014/06/iHealth-Report-spreads.pdf

[221] UCLA Center for Health Policy Research and UC Berkeley Labor Center. (2015) Which Californians will Lack Health Insurance under the Affordable Care Act? Retrieved from http://laborcenter.berkeley.edu/pdf/2015/remaining_uninsured_2015.pdf

[222] Covered California 2019 Open Enrollment Early Observations and analysis. (2019) Retrieved from: https://hbex.coveredca.com/data-

All San Francisco hospitals provide some level of language interpretation services in multiple languages, ranging from on-site staff interpreters to telephone and video medical interpretation. However, public comments from the 2013 HCSMP suggest that some populations still struggle to access interpretation services, pointing to a need to expand services and provide outreach and education on available interpretation services. Innovative strategies have been developed to improve the health care for LEP populations. Some California examples include:

- **Remote Interpreters via Phone and Video Medical Conferencing**: The Health Care Interpreter Network (HCIN) is a cooperative of California public, community, district, and University of California hospitals, their affiliated clinics, and community clinics sharing trained health care interpreters through an automated video/voice call center.[223] Through the HCIN, more than 60 interpreters are available to provide member hospitals with interpretation services in multiple languages, including American Sign Language.
- **Recorded Hospital Discharge Instructions in Patients' Native Language**: Children's Hospital Central California provides non-English speaking patients with a recording of their discharge instructions in their native language; the hospital also provides this service to English-speaking patients with limited literacy skills. For up to two weeks post-discharge, patients and their families may access these instructions as needed via a password-protected telephone mailbox.
- **Physician Incentives and Targeted Recruitment for Language-Concordant Physicians**: Kaiser Permanente Southern California's Language Concordance Program improves patients' access to primary care and specialty physicians who have been certified as speaking their preferred language. The program provides fluency certification in 21 languages, incentives, and educational benefits to physicians who speak or wish to become fluent in another language, and actively recruits bilingual providers.

Increasing Linguistic Competence at Zuckerberg SF General Hospital

Zuckerberg San Francisco General (ZSFG) and all community-oriented primary care (COPC) clinics offer interpretation services in 50 different languages to LEP patients and the deaf/hearing impaired. ZSFG's Interpreter Services Department provides various interpretation services 24 hours, seven days per week, including in-person interpreting (25 different languages), telephone-based interpreting, and videoconferencing interpreting (with an average wait time of <1 minute).

San Francisco's non-profit community clinics are long-standing national models for culturally and linguistically competent care. For example, NEMS offers linguistically competent and culturally sensitive health care services in many languages and dialects, including Cantonese, Mandarin, Toishan, Vietnamese, Burmese, Korean, Spanish, and Hindi. NEMS also actively recruits a medical workforce that is fluent in a language other than English. Mission Neighborhood has special support groups for monolingual Spanish pregnant patients and for Latinx HIV positive patients. The following lists SFCCC member clinics and the language services at these clinics:

- **Curry Senior Center:** Arabic, English, Hindustani, Japanese, Laotian, Punjabi
- **HealthRIGHT 360:** Chinese, English, Portuguese, Spanish, and sign language (by prior arrangement)

research/library/CoveredCA_2019_Open_Enrollment_Early_Analysis.pdf

[223] California HealthCare Foundation. (2013). Health Care Interpreter Network. Retrieved from http://www.chcf.org/projects/2009/health-care-interpreter-network.

- **Mission Neighborhood Health Center**: Chinese, English, Korean, Portuguese, Spanish, Vietnamese
- **Native American Health Center**: Chinese, English, Portuguese, Spanish
- **North East Medical Services**: Chinese, English, Korean, Spanish, Vietnamese
- **Planned Parenthood of Northern California**: English; Spanish; Interpretation by telephone available for other languages
- **SF Community Health Center**: Chinese, English, Spanish, Tagalog
- **SF Free Clinic**: Chinese, English, Spanish
- **South of Market Health Center**: Chinese, English, Spanish, Tagalog
- **St. Anthony Medical Clinic**: Chinese, English, Laotian, Punjabi, Russian, Spanish, Vietnamese

LGBTQ Health

San Francisco has a large lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities, with an estimated 12% of San Franciscans identifying as LGBTQ in 2019.[224] Innovative, population-specific health resources and research centers have been developed to serve these communities, such as the University of California San Francisco Center of Excellence for Transgender Health (CoE), which aims to increase access to comprehensive, effective, and affirming health care services for transgender and gender-variant communities by developing and implementing programs in response to community-identified needs.[225] More broadly, UCSF's Lesbian, Gay, Bisexual, and Transgender Resource Center has developed a comprehensive set of strategies to offer more equitable, culturally competent care to LGBTQ individuals at the medical center. These included altering registration forms, visitation policies, electronic systems, and verbal communication protocols to make them more inclusive and welcoming, as well as providing training for faculty and staff to help implement these changes in their daily workflow. This innovative program helped the medical center achieve top scores on the Healthcare Equality Index, and resulted in enhanced provider knowledge, skills, and confidence in addressing LGBTQ issues.

SFDPH Transgender Health Services enhances access and quality of healthcare for transgender San Franciscans. In addition to the existing range of health services provided to transgender residents (such as primary care, behavioral health, hormone therapy, and specialty and inpatient care), the program provides transgender surgery to eligible adult residents enrolled in Medi-Cal, Healthy San Francisco, Healthy Workers, or Healthy Families.

The San Francisco Community Health Center and Lyon-Martin Health Services have specific outreach to LGBTQ community, including specialized screenings for gender nonconforming patients.

In 2016, the San Francisco Board of Supervisors passed an Ordinance[226] – effective in 2017 – that required City departments and contractors that provide health care and social services to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve. By collecting this data, City departments like DPH will be able to identify health disparities among sexual orientation and gender minority populations, and strategically plan to address and eliminate those disparities.

Culturally Competent Care

San Francisco's diverse population represents a rich mix of races and ethnicities, ages, income

[224] City and County of San Francisco, Office of the Controller. (2019). 2019 City Survey Report. Retrieved from: https://sfgov.org/citysurvey/

[225] Center of Excellence for Transgender Health, University of California, San Francisco. Retrieved from http://transhealth.ucsf.edu/

[226] City and County of San Francisco Board of Supervisors. Ordinance – Administrative Code – Collection of Sexual Orientation and Gender Identity Data. (2016). Retrieved from: https://sfgov.legistar.com/LegislationDetail.aspx?ID=2689136&GUID=78F7C8C6-0285-4FC1-BC83-42C546DA6B79&Options=ID|Text|&Search=Sexual+orientation

levels, sexual orientations and gender identities, abilities, and other possible identities. Many individuals fall into more than one cultural group.

Cultural competence is an essential requirement for health care providers to provide effective services to San Francisco's diverse populations. Cultural competence is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors.[227] When providers, organizations, and systems are not working together to provide culturally competent care, patients are at higher risk of having negative health consequences, receiving poor quality care, or being dissatisfied with their care. African Americans and other minority groups report less partnership with physicians, less participation in medical decisions, and lower levels of satisfaction with care.[228] While there has been a limited number of studies on whether culturally competent care improves patient health outcomes, research does suggest that cultural competency training can improve the knowledge, attitudes, and skills of health care providers, increasing patient satisfaction with health care services.[229, 230]

To ensure that all San Franciscans can access the health care they need, it is essential that the health care workforce is able to provide services that aligns with their patients' experiences and perspectives. Providers must recruit a diverse workforce, train staff in cultural competence, and ensure they approach their patients with humility and sensitivity. San Francisco-based health needs assessments have cited this as a continuing need.[231, 232]

The HRSA, National Centers of Excellence, and other entities are working to compile best practices on the appropriate delivery of health care services to specific populations. In particular, the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS), is comprised of 15 Standards that provide individuals and organizations with a blueprint for culturally and linguistically appropriate services, aiming to advance health equity, improve quality, and help eliminate health care disparities.[233]

[227] Agency for Healthcare Research and Quality. Improving Cultural Competence to Reduce Health Disparities for Priority Populations. (2014). Retrieved from: https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol

[228] Cooper, L. A., Roter, D. L. 2003. Patient-provider communication: The effect of race and ethnicity on process and outcomes of healthcare. In B. D. Smedley, A. Y. Stith & A. R. Nelson (Eds.) Unequal treatment: Confronting racial and ethnic disparities in health care (pp. 552-593). Washington, DC: The National Academies Press.

[229] Beach M, Price E, Gary T, Robinson K, Gozu A, Palacio A, Smarth C, Jenckes M, Feuerstein C, Bass E, Powe N, Cooper L. (2005). Cultural Competency: A Systematic Review of Health Care Provider Educational Intervention. Med Care. 43(4): 356-373.

[230] Lie D, Lee-Rey E, Gomez A, Bereknyei S, Braddock C. (2010). Does Cultural Competency Training of Health Professionals Improve Patient Outcomes? A Systematic Review and Proposed Algorithm for Future Research. Journal of General Internal Medicine. 26(3): 317-325.

[231] Perez Rendon A. (2011). The Health and Mental Health of Maya Children and Youth in San Francisco. Instituto Familiar de la Raza, Indígena Health and Wellness Collaborative.

[232] Flynn S, Weber K. (2011). Mental Health Needs for At-Risk Youth in the Bayview-Hunters Point Community. Masters of Nonprofit Administration Requirement, University of San Francisco.

[233] US Department of Health and Human Services, Office of Minority Health. Think Culture Health. (2019). Retrieved from: https://thinkculturalhealth.hhs.gov/clas/standards

Culturally Competent Care
The Enhanced CLAS Principal Standard

Culturally competent care is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. The first CLAS standard states:

> *"Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."*

If the other 14 Standards are adopted, implemented, and maintained, then the Principal Standard will be achieved.

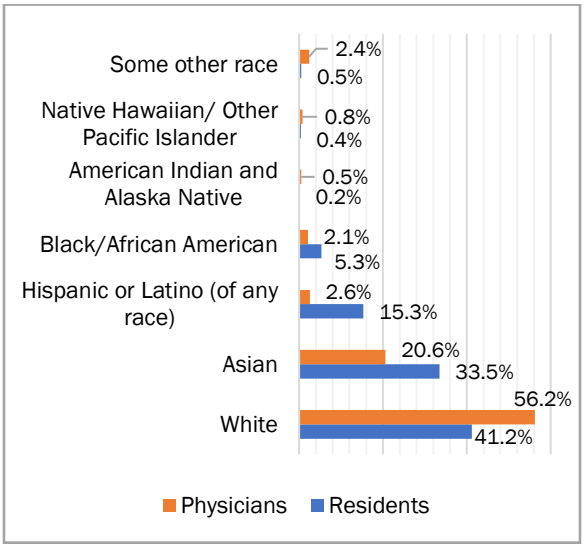
The SFDPH Office of Equity, Social Justice and Multicultural Education (formerly Cultural Competence), strives to promote and embed the Federal CLAS Standards into the policies, procedures, and makeup of health programs across SFDPH. This office supports the efforts of public and nonprofit programs in addressing cultural competence in order to improve health care service delivery.

Workforce Diversity

The National Prevention Strategy cites increasing diversity within the prevention workforce as one factor necessary to eliminate health disparities and ensure culturally competent care. [234] Increasing diversity within the health care workforce may also offer the added benefit of increasing the supply of culturally competent services in traditionally underserved areas. Research has found that people of color physicians in California are more likely than white physicians to practice in Medically Underserved Areas, Health Professional Shortage Areas, and communities with higher proportions of people of color and/or low-income residents. [235]

Among California physicians, Latinos, African Americans, and other ethnic groups are underrepresented relative to the state's population. [236] Similarly, as shown in Figure 5.3 - 7.3, the racial/ethnic background of San Francisco's physicians is not representative of the city's diversity. The 2013 California Medical Board Survey found that less than 30% of San Francisco physicians come from racial/ethnic minority groups, even though they make up 55% of city residents. [237, 238] In particular, Asian, Hispanic or Latino (of any race), and Black/African American physicians are significantly underrepresented.

Figure 5.3 - 7.3 San Francisco Physician Race/Ethnicity Compared to Residential Population, 2013/2015



Source: Medical Board of California, 2013 Physician Survey and 2015 5-year American Community Survey

[234] National Prevention Council. (2011). National Prevention Strategy: America's Plan for Better Health and Wellness. Retrieved from http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf

[235] Grumbach K, Odom K, Moreno G, Chen E, Vercammen-Grandjean C, Mertz E. (2008). Physician Diversity in California: New Findings from the California Medical Board Survey. Center for California Health Workforce Studies. University of California, San Francisco

[236] California Health Care Foundation. California Physician Supply and Distribution: Headed for a Drought? (2018). Retrieved from: https://www.chcf.org/wp-content/uploads/2018/06/CAPhysicianSupply2018.pdf

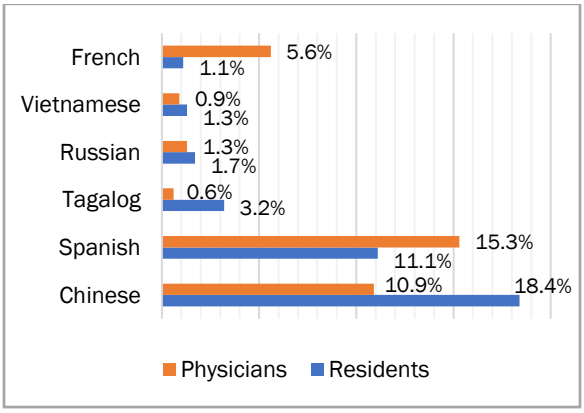
[237] Medical Board of California. (2013). Physician Survey. Retrieved from http://www.mbc.ca.gov/survey/

[238] Please note that a total of 726 physicians practicing in San Francisco declined to state or did not report their race/ethnicity in the 2013 California Medical Board Survey.

Notes: The percentages for residents represent the proportion of the total population that identifies with the corresponding race/ethnicity category. On the US Census, people were able to mark more than one race category. Additionally, Hispanic origin is an ethnicity that is calculated separately from race. The percentages, therefore, do not add up to 100%. The physician data reflects those with a renewed and current license in 2013 and excludes those in an inactive, retired, or disabled license status. The percentages for physicians do not add up to 100% because not all physicians reported their race/ethnicity and physicians may have reported more than one race/ethnicity.

Similarly, San Francisco physicians' foreign language fluency does not reflect the city's linguistic diversity. Among San Francisco residents, the most frequent languages spoken at home other than English include Chinese, Spanish, Tagalog, Russian, Vietnamese, and French. As shown in Figure 5.3 - 7.4, physicians who have the linguistic fluency to serve San Francisco's Chinese, Tagalog, Russian, and Vietnamese speaking communities are underrepresented, while the proportion of physicians who reported speaking Spanish or French appear to be well-represented. It should be noted that many other languages are spoken by physicians practicing in San Francisco, such as German, Hindi, Italian, Korean, Portuguese, and Hebrew.

Figure 5.3 - 7.4. San Francisco Physician Foreign Language Fluency Compared to Language Spoken at Home by Residents, 2013/2015



Source: Medical Board of California, 2013 Physician Survey and 2015 5-year American Community Survey

8. MEDICAL SURGE & DISASTER PLANNING

MEDICAL SURGE IS "THE ABILITY TO PROVIDE ADEQUATE MEDICAL EVALUATION AND CARE DURING EVENTS THAT EXCEED THE LIMITS OF THE NORMAL MEDICAL INFRASTRUCTURE OF AN AFFECTED COMMUNITY" (E.G. A NATURAL DISASTER OR PANDEMIC OUTBREAK).[239] SURGE CAPACITY IS HIGHLY SITUATIONAL AS CRITICAL SURGE ASSETS DEPEND ON RESOURCE AVAILABILITY AND DEMAND FOR HEALTH CARE SERVICES AT A GIVEN TIME, AS WELL AS THE PROCESSES AND SYSTEMS THAT INFLUENCE ASSET QUANTITY.

[239] United States Department of Health and Human Services. (2007). Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies. Second Edition. Retrieved from https://www.phe.gov/Preparedness/planning/mscc/handbook/Documents/mscc080626.pdf.

A major disaster resulting in a surge of casualties needing medical care impacts the entire continuum of health care services. The most current initiatives to address medical surge gauges the capacity in general acute care hospitals. Specifically, initiatives have focused on identifying adequate numbers of hospital beds, personnel, pharmaceuticals, supplies, and equipment.

There is no standard definition or quantification of surge capacity for health care facilities at the present time. However, San Francisco acute care hospitals aim to be able to increase their average daily number of staffed beds by at least 15% in a surge event under current patient care standards. Staffed beds are defined as physically available beds that are staffed and equipped with the necessary medical supplies to care for a patient, and are distinguished from licensed beds, which are the maximum number of beds for which a hospital holds a license to operate.[240] Table 5.3-8.1 below presents an estimation of the number of surge beds that should be available in San Francisco during a surge event. Note that the approximations are calculated based on hospital data published by California OSHPD and may not accurately reflect actual hospital medical surge capacities.

Table 5.3 - 8.1 San Francisco Hospitals Medical Surge Capacity, 2017 Estimates

Hospital	Licensed Beds	Average Daily Staff Beds	Estimated Surge Beds	Total Estimated Surge Capacity(i)
Chinese Hospital	65	19	3	22
California Pacific Medical Center (includes California, Pacific & Davies Campus)	831	403	60	463
California Pacific Medical Center – St. Luke's Campus	228	95	14	109
Kaiser Hospital – San Francisco	239	161	24	185
Zuckerberg San Francisco General Medical Center	397	286	43	329
Saint Francis Memorial Hospital	288	99	15	114
St. Mary's Medical Center – San Francisco	399	79	12	91
UCSF Medical Centers (includes Parnassus, Mission Bay, & Mount Zion)	782	782	131	913
TOTAL	**3,229**	**1,924**	**302**	**2,226**

Source: OSHPD 2017 Hospital Financial Report
Note: (i) Surge Beds= (average daily staffed beds + 15% of average daily staffed beds). Data for San Francisco VA Hospital is not available

Public Health Disaster Planning

The following section discusses San Francisco's disaster planning efforts and the role of local agencies in preparing for emergencies, including the public health consequences of climate change.

Public Health Emergency Preparedness & Response (PHEPR)

SFDPH's Public Health Emergency Preparedness & Response (PHEPR) Branch (part of the Population Health Division) works with local agencies, the health care sector, and community partners to coordinate public health emergency preparedness, response, and recovery efforts.

[240] US Department of Health and Human Services. Assistant Secretary for Preparedness and Response. Hospital Preparedness Program (HPP) Measure Manual: Implementation Guidance for the BP3 HPP Program Measurement Activities. July 1, 2014 – June 30, 2015. Retrieved from: http://www.phe.gov/Preparedness/planning/sharper/Documents/bp3-hpp-implementation-guide.pdf

PHEPR emergency planning and training tasks include:

1) Establishing a comprehensive all-hazard Emergency Operations Plan that is flexible and scalable to respond to a given emergency.
2) Developing a communications plan to allow for redundant systems in a disaster.
3) Capability-building and developing partnerships across all sectors of the health care system to ensure health care services are maintained during a disaster. Partners include home health, hospice, community clinics, urgent care centers, dialysis providers and blood banks.
4) Developing a logistics and resource management system to track medical and public health assets during an emergency.
5) Working with behavioral health organizations to ensure access to services during and after disasters, especially for vulnerable populations.
6) Providing training for first aid providers to deal with psychological trauma.
7) Developing and disseminating community health information related to disaster planning.

Future goals include increased training and exercises to improve response capacity, and the creation of a continuous quality improvement program for preparedness and response, in coordination with the San Francisco Department of Emergency Management (discussed below).

Department of Emergency Management (DEM)

The San Francisco Department of Emergency Management (DEM) leads the City's planning, preparedness, communication, response, and recovery for daily emergencies, large-scale citywide events, and major disasters. DEM is the vital link in emergency communication between the public and first responders, providing key coordination and leadership to City Departments, stakeholders, residents, and visitors. DEM's emergency management work is divided into three core divisions:

1) **Division of Emergency Communications (DEC)** oversees the City's 9-1-1 call and dispatch center.
2) **Division of Emergency Services (DES)** conducts the City's emergency planning, training, and preparation efforts; and manages emergency response and recovery operations conducted with San Francisco's Emergency Operations Center.
3) **Urban Area Security Initiative (UASI)** manages federal homeland security grant funds to analyze regional risks, identify capability gaps, and build a secure, prepared, and resilient region.

DEM also maintains several city-wide emergency plans to ensure that the City is ready to respond to a variety of threats and hazards. SFDPH will work closely with DEM's emergency managers and planners on the federal Emergency Support Function #8 Public Health Annex, which directs response to incidents that have either a public health or medical impact.[241]

In addition, DEM regularly assembles a variety of advisory groups and strategic partnerships, such as the Disaster Preparedness Coordinators (DPC) situated within City agencies. SFDPH's DPC helps with city-wide emergency planning and regularly meets with all the City Department's DPCs to share information on major events and training opportunities.

[241] Emergency Support Function (ESF) #8 – Public Health and Medical Services provides the mechanism for Federal assistance to supplement local, state, tribal, territorial, and insular area resources in response to a disaster, emergency, or incident that may lead to a public health, medical, behavioral, or human service emergency, including those that have international implications.

Emergency Medical Services (EMS) Agency

The Emergency Medical Services (EMS) Agency works with DEM to coordinate the medical 911 system, for both day-to-day medical emergency responses and for multi-casualty incidents. Unlike the police and fire operations of the 911 system, the medical emergency system is composed of multiple agencies and organizations: San Francisco Fire Department–EMS; private ambulance companies; 911 dispatch; and hospitals in San Francisco and Northern San Mateo. On July 1, 2017, the EMS Agency transitioned from DEM to SFDPH, with the goal of better integrating the EMS programs into the Population Health Division's programs.

Additionally, the EMS Agency will continue efforts focused on improving ambulance availability and response intervals as well as reducing hospital diversion of ambulances. The EMS Agency will continue to partner closely with DEM for the planning and management of large, planned special events such as the annual Fleet Week festivities and unplanned incidents such as mass power outages affecting local hospitals or mass transportation incidents.

Climate & Health Program

SFDPH's Climate and Health Program works to address the public health consequences of climate change by projecting how climate change will impact San Francisco, connecting those climate impacts to health outcomes, identifying communities most vulnerable to those health outcomes, and designing interventions to protect those communities.

In San Francisco, climate change is expected to cause more variable weather including extreme heat days and heat waves, intense storms and heavy precipitation events, sea level rise and flooding, droughts, and air pollution. These extreme weather events have significant and cascading effects on the environment, economy, and public health. Extreme heat increases hospital admissions for kidney, cardiovascular, and respiratory disorders. Flood inundation will increase exposure to molds and change the distribution of disease vectors. Worsened air quality will exacerbate respiratory illnesses and trigger asthma symptoms. Droughts may change growing patterns for allergen-producing plants. Power outages associated with extreme weather events will reduce access to city resources. Additional indirect impacts of climate change include income loss from increased food costs or property damage, and mental health impacts including anxiety and depression.

Although all San Franciscans will be impacted by climate change, not all San Franciscans will suffer these impacts evenly. The inequitable distribution of climate-related health impacts is referred to as the climate gap. Factors that can influence the climate gap are often rooted in current and historic systemic inequality and include socioeconomics and demographics, environmental factors, exposure to hazards, infrastructure factors, access to neighborhood goods and services, transportation, and pre-existing health conditions.

In spring of 2017, the program released its Climate and Health Adaptation Framework. Many San Francisco health facilities are in neighborhoods with populations at a higher risk for the health impacts of extreme heat or flooding and extreme storms. These facilities may benefit from developing adaptive infrastructure to increase resilience to climate impacts. This adaptive infrastructure includes expanding solar capacity, enhancing stormwater management, improving heating and cooling systems, or installing blue or green roofs. Additionally, as vulnerable populations rely on these facilities for care in extreme weather events, staff should be trained on how best to diagnose climate-related health outcomes and pro-actively discuss climate risks with patients. For additional information about the Climate and Health Program, please see: https://sfclimatehealth.org/

5.4 HEALTH SYSTEM TRENDS

CONTENTS

OVERVIEW

THE HEALTH SYSTEM TRENDS ASSESSMENT IS INTENDED TO ANALYZE TRENDS IN HEALTH CARE SERVICES IN THE CITY (BUT ALSO HIGHLIGHTS RELEVANT STATE AND FEDERAL POLICY TRENDS), INCLUDING GOVERNMENTAL POLICY, CLINICAL AND COMMUNICATIONS TECHNOLOGY, REIMBURSEMENT AND FUNDING, ORGANIZATION AND DELIVERY OF SERVICES, AND WORKFORCE.

The Health System Trends Assessment includes the following sections:

1) San Francisco & Health Reform
2) Health Care Coverage and Access
3) Health Care Delivery
4) Health Care Workforce
5) Health Care Spending
6) Health Information Technology

The following highlights the 2019 HCSMP key findings from the *Health System Trends Assessment*. Since the 2013 HCSMP:

- Thousands of San Franciscans gained health coverage and access to health care services under the Affordable Care Act (ACA).
- Health care delivery continues shifting to outpatient care, integration, and collaboration.
- San Francisco's health care provider supply remains robust in the face of a national provider shortage, an aging population, and increased demand for services.

- Health care spending continues to climb.
- Technological advances, adoption of electronic health records, and health care analytics spur health information technology growth, but interoperability, cybersecurity, and privacy remain challenges.

1.HEALTH REFORM & SAN FRANCISCO'S COMMITMENT

SAN FRANCISCO REMAINS COMMITTED TO THE GOALS AND VALUES OF THE AFFORDABLE CARE ACT (ACA) DESPITE AN UNCERTAIN FUTURE.

On March 23, 2010, President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act (ACA), and H.R. 4872, the Health Care and Education Reconciliation Act of 2010. ACA provisions – collectively referred to here as "health reform" – went into full effect on January 1, 2014, bringing historic changes to the US health care system. Health reform required most US citizens and legal residents to have health insurance and assists individuals in meeting that requirement through health insurance reforms and new health coverage options. This section describes the impact of these reforms on access to health insurance, coverage, and health care services in San Francisco and beyond.

The key reforms brought about by the ACA include:

Individual Mandate Required Most US Citizens and Legal Residents to Have Health Coverage: Beginning January 1, 2014, most US citizens and legal residents were required to have baseline health insurance or pay a tax penalty, and the reforms discussed below were engineered to assist individuals in complying with this mandate. However, sweeping federal tax legislation signed in December 2017 repealed the penalty associated with the requirement, effective January 1, 2019. In June 2019, California passed SB78 which created the Individual Mandate to require Californian's to purchase health insurance and imposed a fine for those who fail to do so.

Medicaid Expansion Extends Coverage to Millions More Low-Income People: One of the most significant milestones in health reform was the expansion of eligibility for full-scope Medicaid coverage to all eligible individuals under age 65 with incomes up to 138% of federal poverty level (FPL). This expansion particularly benefits childless and/or low-income adults who otherwise would not qualify for their state's Medicaid program without a waiver.

Health Insurance Exchanges: Health Insurance Exchanges are state-based online marketplaces where individuals and small businesses can purchase health insurance. Exchanges also assist individuals in learning if they are eligible to either enroll in Medicaid or receive federal subsidies to purchase coverage. By law, each state must implement an exchange, and they can be operated by either: the state alone; the federal government; or jointly by the state and federal government. On September 30, 2010, California became the first state to pass legislation creating a marketplace, called Covered California. Citizens, legal immigrants, and employers with fewer than 100 employees may purchase plans through this exchange, known as Qualified Health Plans (QHP), which are required to meet a minimum set of standards. These plans offer four levels of coverage with various premiums, out-of-pocket costs, and benefits, and include catastrophic coverage. Credits are provided on a sliding scale to help defray costs for individuals and families with incomes between 138-400% of FPL.

Private Insurance Reforms Provide Greater Consumer Protections and Essential Health Benefits: The ACA established federal requirements on private health insurance that affect coverage for groups, individuals, and employer-sponsored health plans. Generally, these reforms expanded access to coverage and set minimum requirements for health plan premiums, cost sharing, benefit packages, and consumer protections. While they do not universally apply to all types of plans and markets, the ACA requires uniformity for all health plans offered inside and outside the health insurance exchanges.

Employer Responsibility Requires Medium and Large Businesses to Offer Coverage to Employees: The Employer Shared Responsibility Provision under section 4980H of the Internal Revenue Code penalizes employers who do not offer coverage, or who provide coverage that exceeds cost and value standards. In California, the rule applies to employers with 100 or more full-time employees. [242, 243]

Health reform has been consistently met with aggressive opposition, and Republican congressional leaders have attempted to repeal the Affordable Care Act (ACA) in its entirety over 60 times since 2010. Since the 2016 presidential election, the health care environment continues to face significant uncertainty as a result of federal intent to "repeal and replace" the ACA, threatening to topple the US health care system's substantial progress and reforms discussed in this chapter. Federal actions taken since 2016, such as the cancelling of Cost-Sharing Reduction (CSR) payments to insurer, and repealing the individual mandate penalty, risk destabilizing the insurance market, driving the cost of coverage and health care upward while influencing significant numbers of individuals to lose or forgo insurance.

Regardless of the volatile environment around health reform, San Francisco remains steadfast in its commitment to protect and promote the health of all its residents, particularly its most vulnerable populations. The spirit and ideals that led the City to pioneer legislation and innovative health care programs well before the ACA was signed into law (such as Healthy San Francisco, Health Care Security Ordinance, Health Care Accountability Ordinance, and Charity Care) will endure beyond the present political climate.

2.HEALTH CARE COVERAGE & ACCESS

THOUSANDS OF SAN FRANCISCANS GAINED HEALTH COVERAGE AND ACCESS TO HEALTH CARE SERVICES UNDER THE AFFORDABLE CARE ACT (ACA).

The following section discusses selected legislative updates since the ACA went into full implementation on January 1, 2014 that have enabled millions of Americans to gain new coverage and access needed health care services. The layers of reforms at the national, state, and local levels have also broadened financial protections and support for health care consumers

[242] Internal Revenue Service (2016). Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act. Retrieved from https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act

[243] Employers with more than 50 employees that have at least one employee who accesses a premium tax credit for insurance will be required to pay a fee. However, as allowed by the law, California defines a small business as one with 100 or fewer employees for insurance purposes. As defined by the statute, a full-time employee is an individual employed on average at least 30 hours of service per week. An employer that meets the threshold is an applicable large employer and will be assessed a $2,000 fee per full-time employee if they do not offer coverage. Those that do offer coverage will pay the lesser of the following: $3,000 for each employee receiving the premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment.

and provided options for San Francisco's most vulnerable populations.

San Francisco

Between 2013 and 2019, San Francisco's uninsured population has fallen by over two-thirds. However, thousands of San Franciscans remain uninsured.

Even before the ACA, San Francisco has been a leader in providing access to comprehensive health care. This foundation has enabled San Francisco to successfully implement ACA reforms and leverage federal resources to increase health care coverage, bolster existing health services, add system capacity, and refine cost-effective operations.

Between 2013 and 2019, the number of uninsured San Franciscans has plunged from an estimated 117,000 to an estimated range of 30,000 to 35,000, or roughly 3.5% of the City's population.[244] A significant contributing factor in this reduction has been the expansion of Medi-Cal (the state's Medicaid program) to adults with incomes up to 138% of the FPL. From 2013 to 2019, the number of San Franciscans enrolled in Medi-Cal as a result of expansion rose by 64,000 (44%), from approximately 146,000 to 207,000 people.[245] Over a third (71,000) of the total number are non-elderly adults, and nearly 6,500 are undocumented with limited-scope coverage, including the nearly 3,000 children that gained full-scope coverage since May 2016.[246,247,248]

As of May 2019, 33,650 San Franciscans were obtaining coverage through Covered California, the state health insurance marketplace created for residents to purchase health plans and access financial assistance if they qualify. Nearly all (99.2%) were under 65 years old and four out of five enrollees received financial assistance (79%). One San Francisco ZIP code (94112 – which includes the Outer Mission, Ingleside, and Excelsior neighborhoods) had the eighth highest number of new Covered California enrollees in the state, with 4,050 residents purchasing health coverage. [249]

With so many San Francisco residents now eligible for Medi-Cal or Covered California, enrollment in the Healthy SF program (a program operated by SFDPH providing health care services for the uninsured) fell from a high of 51,000 in 2013 to 13,668 by March 2019.[250] Most of the remaining people enrolled in HSF are ineligible for ACA-sponsored coverage or are unable to afford to purchase it.

Overall, more San Franciscans report they can access health care services. Between the time periods 2007-2009 and 2015-2016, the share of adult San Franciscans that reported delaying or had difficulty obtaining care dropped from 16.3%to 11.6%. The number of adults reporting they have a usual source of health care has remained relatively consistent over time, at around 85%.[251] Altogether, these trends suggest that San Francisco has demonstrated successful implementation of ACA reforms and residents are experiencing tangible benefits.

[244] United States Census Bureau. (2018). Selected Characteristics of Health Insurance Coverage in the United States 2018 American Community Survey 1-Year Estimates.

[245] Note that new enrollees of Medi-Cal may have previously obtained insurance privately, and, therefore, the overall insurance rate in San Francisco would not have changed with this transition in their coverage.

[246] California Department of Health Services (2019). County Certified Eligibles as of May 2019. Medi-Cal Certified Eligibles: Recent Trends. Research and Analytic Studies Division. Retrieved from: https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx

[247] Covered California (2017). Medi-Cal Overview. Retrieved from http://www.coveredca.com/medi-cal/

[248] California Department of Health Services (2019). County Certified Eligibles as of May 2019. Medi-Cal Certified Eligibles: Recent Trends. Research and Analytic Studies Division. Retrieved from https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-Eligibles.aspx

[249] Covered California (2019). May 2019 Active Member Profiles. Retrieved from http://hbex.coveredca.com/data-research/.

[250] Healthy San Francisco Enrollment Dashboard. (2019).

[251] San Francisco Health Improvement Partnership (2019). Health / Access to Health Services. All Data. Retrieved from: http://www.sfhip.org/health-care-access-and-quality.html

Despite these gains, SFDPH estimates that approximately 30,000 to 35,000 San Franciscans remain uninsured, and 88% of them are non-elderly adults (18-64 years).[252] This population is most likely to identify as white (33%), Asian (30%), or Hispanic or Latinx (30%), and males make up nearly two out of three uninsured people.[253] Individuals remain uninsured for a variety of reasons, including not enrolling in Medicaid despite eligibility, immigration status, affordability, and religious objections, amongst others.

Local Legislative Reforms

The following highlights local health care service-related legislation that was passed between 2013 and 2019.

Health Care Security Ordinance Updates

San Francisco's Health Care Security Ordinance (HCSO) was created to assist San Franciscans with obtaining accessible and affordable health care services. The law requires medium- and large-size employers to satisfy the City's Employer Spending Requirement (ESR) by making required health care expenditures on behalf of their employees. The vast majority of employers in San Francisco comply with the HCSO by providing health insurance to their employees, while others employers comply by contributing to the SF City Option, which provides their employees either with medical reimbursement accounts (see *SF Covered MRA*) to pay for health care expenses or with discounted enrollment in Healthy San Francisco. In June 2014, the San Francisco Board of Supervisors amended the HCSO to gradually eliminate employers' use of revocable expenditures (funds paid to a third party administrator that can revert back to the employer if they are unused), in essence requiring that employers invest a minimum amount of funds on their employees' health care.

SF Covered Medical Reimbursement Account (MRA)

SF Covered MRA was developed at the request of the San Francisco Board of Supervisors and the Department of Public Health in response to low- and middle-income residents' challenges affording health insurance in San Francisco. Citing a study by the UC Berkeley Labor Center that found the City's cost of living to be 59% higher than the national average, SF Covered MRA provides financial support to eligible City Option employees by providing a complementary premium assistance through a Medical Reimbursement Account (MRA). The premium assistance caps maximum out-of-pocket health care cost to about 5% of household income and is available to employees with incomes at or below 500% of the Federal Poverty Level (in 2017, $60,000 for an individual and $123,000 for a family of four). This change enables another 3,000 San Franciscans to afford health coverage on Covered California.[254]

California

California leads the way among states in successful health reform implementation, experiencing the largest decrease in uninsured population and increased access to care. However, many Californians continue facing challenges in gaining health coverage.

California is a model of successful implementation of ACA reforms, benefitting from bipartisan support and stakeholder cooperation. California was the first state in the US to create a health insurance exchange, Covered California, and immediately embraced expansion of its Medicaid program (Medi-Cal).

[252] United States Census Bureau. (2019). Selected Characteristics of Health Insurance Coverage in the United States 2018 American Community Survey 1-Year Estimates.

[253] United States Census Bureau. (2019). Selected Characteristics of Health Insurance Coverage in the United States 2018 American Community Survey 1-Year Estimates.

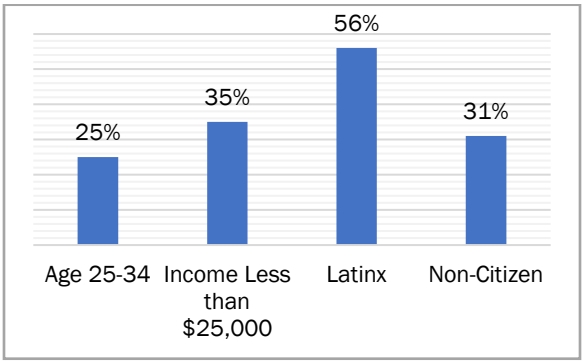
[254] Health Management Associates (2015). Addressing Affordability of Health Insurance in San Francisco. San Francisco Department of Public Health.

California enacted innovative strategies to redesign the health care delivery system within its safety net and continues to redesign delivery systems with the goal of providing efficient, high-quality care to the state's residents. California's efforts demonstrate the profound results of leveraging federal reforms to achieve significant gains in health care access for millions of residents.

Due to health reform, California experienced the largest decline in the uninsured rate of any state — a drop from 16% in 2013 to a low of 7.2% in 2017. This represents over 3 million new Californians who now have health insurance coverage.[255] Further, Medi-Cal enrollment from 2014 to 2018 rose by nearly 40% to cover an additional 4.2 million people, bringing the total to over 13 million—about a third of the state's population. This growth accounts for 27% of the growth in Medicaid nationally (compared to the state's 12% share of the U.S. population). For the sake of comparison, New York, the state with the next largest increase, increased enrollment by less than 750,000 people.[256]

However, despite these coverage gains, an estimated 3 million Californians remain uninsured, with certain groups, including 25-34-year-olds, Hispanic/Latinx, and underemployed or unemployed remaining uninsured at disproportionately high rates (refer to Figure 5.4-2.1 for more details). Nearly three-fifths of these residents are undocumented and ineligible for both expanded Medicaid coverage and financial assistance available under the ACA, the overwhelming majority of whom are Latino and male.[257]

Figure 5.4 - 2.0.1. Selected Characteristics of California's Uninsured Population, 2018



Source: California Health Care Foundation, 2018

According to estimates from the UC Berkeley Center on Labor Research and Education and the UCLA Center for Health Policy Research, there are a few reasons why California residents remain uninsured. An estimated 18% are eligible to purchase coverage on Covered California, though they don't qualify for federal ACA subsidies to bring down the cost of their premiums. Cost is the biggest barrier cited by this group to obtaining coverage. Another 13% are eligible to purchase coverage on Covered California and qualify for federal ACA subsidies, but this group also cites cost and California's high cost of living as the main barriers to becoming insured.[258]

In addition, while millions of new Californians gained health coverage through Medicaid expansion, today there are fewer California physicians accepting Medi-Cal patients compared to 2013 due to the state's low rates of Medi-Cal reimbursement (at 81% of the national average and ranking 47th overall).[259]

[255] Fronstin, P., Employee Benefit Research Institute (2018). 2018 Edition – California's Uninsured. California Health Care Foundation. Retrieved from: https://www.chcf.org/publication/2018-edition-californias-uninsured-progress-universal-coverage/

[256] Blue Sky Consulting Group. (2019). 2019 Edition – Medi-Cal Facts and Figures. California Health Care Foundation. Retrieved from: https://www.chcf.org/publication/2019-medi-cal-facts-figures-crucial-coverage/

[257] California's Uninsured: Progress Toward Universal Coverage. (2018). California Health Care Foundation. Retrieved from: https://www.chcf.org/publication/2018-edition-californias-uninsured-progress-universal-coverage/

[258] How Many in Your Area are Uninsured – and Why? (2018). California Health Care Foundation. Retrieved from: https://www.chcf.org/publication/how-many-area-uninsured-why/

[259] Coffman, J. (2016). Physician Participation in Medi-Cal: Is Supply Meeting Demand?. California Medicaid Research Institute. Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PD

These enduringly low payment rates discourage provider participation, resulting in limited healthcare access for low-income communities. A 2016 survey data shows that roughly one-half of California and San Francisco office-based physicians accept new Medi-Cal patients, well below the national average of 69%.[260] As a result of this low participation, two-fifths of California physicians provide care to four-fifths of all Medi-Cal patients.[261]

Reasons CA Physicians Limit Medi-Cal Participation

- Amount of Medi-Cal payment (78%)
- Administrative hassles (72%)
- Delays in Medi-Cal payment (72%)

Source: California Health Care Foundation (2016)

Participation by safety net providers are required for health plans operating in Covered California. Safety net providers are defined in the new law as those eligible to participate in the 340B drug discount program. Under Covered California, health plans must contract with 15% of 340B entities (or designated essential community providers). For Plan Year 2018, San Francisco has 22 sites designated as essential community providers.[262]

State Legislative Reforms

The following highlights state health care service-related legislation that was passed between 2013 and 2019.

Reinstate the Individual Mandate

In 2019 and effective in 2020, the California legislature reinstated the individual mandate that was part of the Affordable Care Act (ACA) but revoked in 2017. Like the ACA's mandate, individuals opting not to carry insurance coverage will incur a financial penalty under the state-level mandate. The penalty could be up to nearly $2,100 per family, which is based on 2.5 percent of household income or a minimum of $695 per adult, whichever is greater.

Increase in Covered California Insurance Premium Supports

In connection with the reinstatement of the individual mandate, California passed a second affordability measure, increased state subsidies. These subsidies provide premium supports for individuals with incomes between 400 and 600 percent of the federal poverty level (FPL) as well as reduce out-of-pocket premiums for those with incomes under 138 percent of the FPL over the next three years. Covered California projects that 922,000 people will be eligible to benefit from the new state subsides.[263]

Full-Scope Medi-Cal Extended to Undocumented Children

On May 2016, Senate Bill (SB) 75 – known as Health4All Kids – authorized children under 19 years of age whose families have incomes at or below 266% of the FPL to become eligible for full-scope Medi-Cal coverage regardless of their immigration status. Additionally, undocumented Californians with Deferred Action for Childhood Arrivals (DACA) status and qualifying income can receive full-scope Medi-Cal coverage.[264]

F/PDF%20P/PDF%20PhysicianParticipationMediCal2016Slides.pdf

[260] Centers for Disease Control and Prevention (2016). Health Expenditures. National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/fastats/health-expenditures.htm

[261] Kirzinger, A., DiJulio, B., Sugarman, E., Wu, B., & Brodie, M (2016). A Final Look: California's Previously Uninsured after the ACA's Third Open Enrollment Period. The Henry J Kaiser Family Foundation. Retrieved from http://kff.org/health-reform/report/a-final-look-californias-previously-uninsured-after-the-acas-third-open-enrollment-period/

[262] Data.Healthcare.gov (2017). Final PY 2018 ECP List. Retrieved from https://data.healthcare.gov/dataset/FINAL-PY-2018-ECP-LIST/ecf3-gujb

[263] News Release. Covered California. (2019). Retrieved from: https://www.coveredca.com/newsroom/news-releases/2019/07/09/californias-initiatives-will-lead-to-hundreds-of-thousands-gaining-health-care-coverage-with-lower-premiums-and-new-financial-help/

[264] California Department of Health Services (2017). SB 75 Transitions and New Enrollees by County. Medi-Cal Eligibility Division. Retrieved from http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/SB75/SB75_Enrollees_County_020217.pdf

Medi-Cal Broadens Mental and Behavioral Health Coverage

In 2014, Medi-Cal broadened coverage for mental health and substance use disorder services for beneficiaries. Previously, Medi-Cal mental health services were typically provided through county-based mental health plans, with eligibility restricted to patients with serious mental health needs and impairments. Those with mild-to-moderate needs were forced to seek limited outpatient treatment through their primary care provider or a fee-for-service (FFS) network. The 2014 reforms created a new set of mental health benefits for members with mild-to-moderate mental health needs, while maintaining the benefits for those classified as severe or specialty.

Medi-Cal's managed care plans are now required to contract with network providers to deliver mental health services, and the majority do so through a managed behavioral health organization (MBHO). MBHOs oversee development of the provider network, contract negotiations, claims administration and reimbursement. Beacon Health Strategies manages the San Francisco Health Plan's behavioral and mental health services for its members, while Anthem Blue Cross administers their services in-house.[265]

Medi-Cal Healthier California for All

Introduced in late 2019, Medi-Cal Healthier California for All is a multi-year initiative by the California Department of Health Care Services (DHCS) to improve the quality of life and health outcomes by implementing broad delivery system, program, and payment reforms across Medi-Cal. The major components of the initiative will build on successful pilots from the previous federal waivers, including but not limited programs such as Whole Person Care Pilots, Health Homes, and the Coordinated Care Initiative). At the time of this update to the HCSMP, the details of Medi-Cal Healthier California for All were still in development.[266]

California Looking to Expand Coverage despite ACA Uncertainty

Since 2017, the US has faced continuous federal threats to ACA consumer protections and the loosening of regulations that potentially destabilize the individual insurance market. Nevertheless, California continues moving towards universal coverage by exploring potential legislation that would further strengthen the marketplace and expand access and affordability options for individuals and families.

United States

U.S. uninsured rates have decreased across all demographics, especially in Medicaid expansion states. Despite coverage gains, challenges persist for many Americans.

From 2010 through 2016, the US had experienced historic gains in health insurance coverage, with the uninsured rate falling from 15.7% in 2010 before the ACA was signed into law to 8.6% in the first quarter of 2016, representing 15 million additional Americans receiving health care.[267] The uninsured rate fell among virtually every demographic category, including populations that are historically less likely to be insured, such as non-elderly adults,

[265] San Francisco Health Plan (2017). Medi-Cal Mental Health Benefits. Retrieved from http://www.sfhp.org/providers/provider-resources/mental-health-resources/

[266] DHCS. California Advancing and Innovating Medi-Cal. 2020. Retrieved from: https://www.dhcs.ca.gov/calaim

[267] Covered California (2016). California's Proposal to Waive Affordable Care Act Requirements to Expand Access to Undocumented Individuals. Retrieved from http://hbex.coveredca.com/stakeholders/Covered%20California%201332%20Waiver/Covered%20California%201332%20Application_FinalDraft%20%208-5-16.pdf

Latinos, and part-time workers.[268, 269] The uninsured rate also plummeted for adults under age 26, as the ACA allowed them to retain coverage through parents' health insurance. About half of the people who gained health insurance (7 million people) benefited from the expansion of Medicaid benefits for low-income residents in 31 states and the District of Colombia. Adults in these expansion areas were more likely to find a usual source of health care and reported lower health care costs compared to adults in other states. [270] The uninsured rate in 2015 was 7.2% in states that had expanded Medicaid and 12.3% in non-expansion states.[271] If the uninsured rate had fallen in non-expansion states at the same rate as in expansion states, an additional 3.7 million uninsured Americans would have gained coverage since 2013.[272]

Despite a record number of children with health coverage, 5 million children remain uninsured.[273] About half live in just seven states, generally in the South and West. Hispanic and American Indian and Alaskan Native children are at least twice as likely to remain uninsured compared to White children, and two-thirds (65%) of the remaining uninsured children are eligible for Medicaid or the Children's Health Insurance Program (CHIP). In 2018, funding for CHIP was extended an additional 10 years through FY 2027 as part of broader legislation to fund the federal government.[274, 275, 276]

Unfortunately, since 2017 there have been nationwide decreases in the number of insured. In 2018, the number of people in the United States without health insurance rose up to 27.5 million, an increase from 7.9% uninsured to 8.5% uninsured. The decrease in the number of insured is mainly due to decreases in enrollment from Medicaid, which could be from a variety of factors including the repeal of the individual mandate, work requirements, and public charge.[277]

Other Federal Legislative Reforms

The following highlights federal health care service-related legislation that was passed between 2013 and 2019.

[268] Zuckerman, S., Williams, A., & Stockley, K. (2009). Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare. California Health Care Foundation. Retrieved from http://www.chcf.org/publications/2009/04/medical-physician-and-dentist-fees-a-comparison-to-other-medicaid-programs-and-medicare

[269] Broaddus, M. & Park, E. (2016). Census Data Show Large Health Coverage Gains Continued in 2015: Health Reform Coverage Expansions Are Key Driver. Center on Budget and Policy Priorities. Retrieved from http://www.cbpp.org/research/health/census-data-show-large-health-coverage-gains-continued-in-2015

[270] Gunja, M.Z., Collins, S.R., Doty, M.M., & Beutel, S. (2017). nsurance Coverage, Access to Care, and Medical Debt Since the ACA: A Look at California, Florida, New York, and Texas. The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/publications/issue-briefs/2017/mar/coverage-access-medical-debt-aca-california-florida-new-york-texas

[271] Broaddus, M. & Park, E. (2016). Census Data Show Large Health Coverage Gains Continued in 2015: Health Reform Coverage Expansions Are Key Driver. Center on Budget and Policy Priorities. Retrieved from http://www.cbpp.org/research/health/census-data-show-large-health-coverage-gains-continued-in-2015

272 Broaddus, M. & Park, E. (2016). Census Data Show Large Health Coverage Gains Continued in 2015: Health Reform Coverage Expansions Are Key Driver. Center on Budget and Policy Priorities. Retrieved from http://www.cbpp.org/research/health/census-data-show-large-health-coverage-gains-continued-in-2015

[273] Cornachione, Rudowitz, & Artiga (2016). Children's Health Coverage: The Role of Medicaid and CHIP and Issues for the Future. The Henry J. Kaiser Family Foundation. Retrieved from: https://www.kff.org/health-reform/issue-brief/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future/

274 California Association of Public Hospitals & Health Systems, & Safety Net Insititute (2016). Issue Brief: The Global Payment Program. Improving Care for the Uninsured in California's Public Health Care Systems. Retrieved from http://caph.org/wp-content/uploads/2016/09/caph-sni-issue-brief-gpp.pdf

[275] 115th Congress (2018). H.R.195 - Making further continuing appropriations for the fiscal year ending September 30, 2018, and for other purposes. Retrieved from https://www.congress.gov/bill/115th-congress/house-bill/195

[276] 115th Congress (2018). H.R.1892 — Bipartisan Budget Act of 2018. Retrieved from https://www.congress.gov/amendment/115th-congress/senate-amendment/1930/text.

[277] United States Census Bureau. 2008 to 2018 American Community Survey, 1-year estimates.

"Individual Mandate" Penalty Repealed

The ACA included an individual shared responsibility payment provision that required most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance that meets specific standards. It imposed a financial penalty for those that were uninsured without a specified exemption. The "individual mandate" was created to stabilize the private non-group insurance market by influencing healthier individuals to purchase health insurance and, therefore, spread the cost of insuring consumers with pre-existing conditions and greater health care needs. Without this provision, insurers may choose to increase premiums in response to the higher-risk pool and potentially result in fewer people to purchase coverage; or they may leave the market entirely, leaving consumers with fewer coverage options.

In December 2017, the Republican-controlled federal government broad tax legislation that included a provision to remove the penalty for not having insurance, beginning in 2019. Although it is difficult to predict how the numerous health system parties will respond, The Congressional Budget Office (CBO) estimates that 13 million fewer people in the U.S. will have health insurance in 2027 without the mandate and premiums will rise by 10% in most years of the decade.[278]

Medicaid Work Requirements

In January 2018, the federal government reversed a policy on instituting work requirements for Medicaid eligibility. Work requirements have been previously rejected because they undermine access to health care. The specifics of work requirements vary by state, but most require enrollees to work approximately 20 hours per week or 80 hours per month in order to receive Medicaid benefits. California was the first state to ban Medicaid work requirements. As of August of 2019, nine states have imposed work requirements, and work requirements in three states have been blocked by the courts.[279]

Public Charge

In determining inadmissibility, "public charge" is defined as an individual who is likely to become "primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense. In August 2019, the federal government set grounds that enrollment in government health programs would be used to determine public charge. In October of 2019, US District Court judges from New York, California, Washington, Illinois, and Maryland have ordered that this rule cannot be implemented.[280]

Mental Health Parity Laws Require Health Plans to Cover Mental and Behavioral Health Services

The Mental Health Parity and Addiction Equity Act (MHPAEA), passed in 2008, was designed to improve coverage for mental health and substance abuse issues. For example, most health insurance plans can no longer charge higher copays or separate deductibles for mental health care. Starting in 2014, Medicaid, individual, and small group health plans created after March 23, 2010 are required to comply with federal parity requirements. Moreover, health plans offered through the Health Benefit Exchange must include coverage for mental and substance use disorders as an Essential Health Benefit.

More information on San Francisco's capacity to meet increased demand for mental and

[278] "Repealing the Individual Health Insurance Mandate: An Updated Estimate." Washington (DC): Congressional Budget Office, November 8, 2017. https://www.cbo.gov/publication/53300.

[279] Medicaid Work Requirements. (2019) American Academy of Family Physicians.

[280] Public Charge. October 2019. United States Citizenship and Immigration Services. Retrieved from: https://www.uscis.gov/greencard/public-charge

behavioral health services is included in the *Capacity and Gap Assessment*.

Federal Travel Bans & Immigration Policies

In January 2017, the Trump administration signed its first executive order temporarily barring the entry of nationals from seven countries to the United States. Some physicians, employed and practicing in the United States, were caught up in the executive order. Particularly in California, it's estimated that thousands of physicians could be affected by immigration bans. Of California's physician workforce, approximately 5% are non-US-citizens and another 31% are naturalized US citizens. Similarly, in 2010 approximately 16% of the total health care workforce in the United States were foreign born. Finally, immigrant health care workers disproportionately serve in medically underserved communities.

Immigration bans may have adverse impacts on international medical students applying to practice in the United States. These policies may negatively impact access issues related to the projected physician supply shortfall.

3.HEALTH CARE DELIVERY

A FEW KEY TRENDS HAVE SHAPED HEALTH CARE DELIVERY FROM 2013 TO 2019. HEALTH CARE DELIVERY CONTINUES SHIFTING TO OUTPATIENT CARE, INTEGRATION, AND COLLABORATION; AMBULATORY FACILITIES ARE PROLIFERATING ACROSS THE LOCAL AND NATIONAL HEALTH CARE LANDSCAPE; AND HOSPITALS SYSTEMS ARE DEVELOPING INTEGRATED NETWORKS.

Health care delivery in the United States is rapidly shifting from acute care in hospitals to care in ambulatory settings, driven by increased access to preventive care and population health services, as well as improving technologies and medical advances that allow patients to receive lower-cost treatment and procedures outside of hospitals. Hospital revenue from outpatient services grew from approximately 30% to 47% in 2016.[281]

Health reform has accelerated this trend through increased funding for preventive care as well as structural shifts in payment and reimbursement systems and replacing the predominant fee-for-service (FFS) policies with value-based payments requiring that hospitals demonstrate value and efficiency. FFS, in which health care providers are paid for each service performed, incentivize hospitals and providers to perform a greater volume of tests and services than are medically necessary.

Given this context, stand-alone outpatient care facilities are on the rise as hospital systems bring more ambulatory surgical centers, medical laboratories, imaging facilities, and other outpatient facilities into their network. Compared to the traditional FFS payment model, Medicare and commercial payers are now requiring that hospitals must demonstrate value and efficiency. The low-cost structure of stand-alone facilities is economically advantageous for achieving this aim. Because these facilities focus exclusively on a small number of procedures, they can typically reduce costs compared to hospitals, which have more complex and larger scale demands for oversight, space, resources, and other overhead costs. Additional advantages of these facilities for hospital systems include:

- Increasing the number of locations that patients can receive services enables

[281] Abrams, K., Balan-Cohen, A., Durbha, P., Growth in Outpatient Care – the Role of Quality and Value Incentives. 2018. Deloitte Insights. Retrieved from: https://www2.deloitte.com/us/en/insights/industry/health-care/outpatient-hospital-services-medicare-incentives-value-quality.html?id=us:2el:3dp:mdrnhlth:awa:lshc:090118

them to better compete based on access and convenience;
- Adding low-cost facilities supports their goal in managing costs for care for a growing number of patients whom incur a diverse range of financial risks; and
- Lower cost structures enable systems to better compete for privately insured patients in an economic environment where (a) many households are still recovering from the Great Recession, (b) more patients have high-deductible health plans, and (c) people are incentivized to minimize out-of-pocket costs; and
- Reduced waiting times leads to increased patient satisfaction.

Health reform has also spurred both providers and insurers towards collaborative health care models that offer integrated access to services, similar to Kaiser Permanente's HMO system.[282] Compared to mergers and acquisitions, these collaborative models generally allow each entity to remain autonomous, avoid increased regulatory scrutiny, and incur lower costs and risks. In the Bay Area, Sutter Health/CPMC is developing its own network spanning the region, while UCSF and John Muir Health formed a strategic partnership to develop a wider presence throughout the Bay Area – Canopy Health – which has expanded to partner with ten hospitals and four prominent medical groups (Hill Physicians, Muir Medical Group IPA, Meritage Medical Network, and Santa Clara County IPA). UCSF and John Muir Health also created Bay Health Development, a joint venture to focus on IT integration and explore development opportunities, including new hospitals, clinics, and outpatient centers.[283] Stanford Health care is also acquiring physician practices, including a pediatric hospital in the East Bay.

These strategies aim to manage care efficiently and provide comprehensive services to attract more patients. Yet, there is growing concern that provider consolidation may ultimately lead to less competition and drive prices upwards, as other national markets have experienced.[284, 285]

Recent studies have shown that in areas with high levels of hospital market concentration, annual premiums were approximately 5% higher than areas with low hospital market concentration.[286] Another study explored the effect of market consolidation across California, specifically, between 2010 and 2016. The study found that between 2010 and 2016, the number of physicians in hospital-owned practices or networks increased from 25% to 40%. In areas with high consolidation and high hospital-owned physician practices, premiums rose by 12%. Hospital outpatient visit costs were also higher.[287]

In a related trend, many US cities have seen the rise of private medical clinics and health care startups over the last decade. In San Francisco, these clinics include OneMedical and Go Health Urgent Care. These facilities commonly raise venture capital and offer a concierge model of health care delivery that emphasizes modern aesthetics and cutting-edge technologies. The clinics tout consumer benefits such as greater

[282] Tu, H., Finocchio, L., Doubleday, A., & Liao, K. (2016). San Francisco Bay Area: Major Players Drive Regional Network Development. California Health Care Foundation. California Health Care Almanac. Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20A/PDF%20AlmanacRegMktBriefSanFran16.pdf

[283] About Canopy Health (2019). Retrieved from: https://www.canopyhealth.com/en/about.html

[284] Evans, M. (2015). Hospitals face closures as 'a new day in healthcare' dawns. Modern Healthcare. Retrieved from http://www.modernhealthcare.com/article/20150221/MAGAZINE/302219988

[285] NCCI Insights. (2018). The Impact of Hospital Consolidation on Medical Costs. Retrieved from: https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx

[286] Boozary, A., Feyman, Y., Reinhardt, U., Jha, A., The Association Between Hospital Concentration and Insurance Premiums in ACA Marketplaces. (2019). Health Affairs. Retrieved from: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05491

[287] Scheffler, R., Arnold, D., Whaley, C., Consolidation in California's Health System Leads to Higher Prices and Premiums. (2018). The Commonwealth Fund. Retrieved from: https://www.commonwealthfund.org/publications/journal-article/2018/sep/consolidation-california-health-system-higher-prices

access to appointments, enhanced communication with providers, the ability to spend more time with patients, and point-of-care technology. More information on the growing number of these outpatient facilities in San Francisco is included in the *Land Use Assessment*.

4.HEALTH CARE WORKFORCE

THIS SECTION DISCUSSES THE LOCAL, STATE, AND NATIONAL HEALTH CARE SYSTEMS' ABILITY TO MEET THE INCREASED DEMAND FOR HEALTH CARE SERVICES AS A RESULT OF PROJECTED PHYSICIAN SHORTAGES, THE GROWING OLDER ADULT POPULATION, AND INCREASED NUMBER OF PEOPLE WITH INSURANCE AS A RESULT OF HEALTH REFORM.

More information on San Francisco's capacity to meet increased demand for primary care, behavioral health care and long-term care services is included in the *Capacity and Gap Assessment*.

San Francisco

San Francisco's primary care provider supply exceeds the national benchmark – however, the high cost of living exacerbates recruitment challenges for some facilities, particularly community clinics. Similarly, San Francisco specialist supply exceeds national standards; however, the uninsured and Medi-Cal populations experience challenges accessing specialty care.

The 2017 County Health Rankings indicate that San Francisco exceeds the national primary care benchmark relative to the size of its population. The ratio of primary care physicians (PCPs) to residents of 1:630 is virtually unchanged from 2013 (despite population growth), and outperforms both the state and national ratios of 1:1,280 and 1:1,040, respectively.[288] The city ratio is also well below the Council on Graduate Medical Education's recommended supply of PCP to resident of 1:1,250 -1,666.[289, 290, 291] The City's provider supply will need to evolve to respond to demographic shifts in the future, including population growth and the increase of seniors (as described in the *Community Health Assessment*).

Similarly, the ratio of non-physician primary care providers (e.g. nurse practitioners, physician assistants, and clinical nurse specialists) has increased in San Francisco, a trend that is expected to increase and is detailed later in this chapter. San Francisco already has one of the highest ratios of non-physician primary care providers to resident population, compared to California statewide.[292]

Despite a high concentration of PCPs relative to the state and nation, some facilities, particularly community clinics, have faced difficulties recruiting and retaining doctors due to San Francisco's high cost of living. Even though some facilities have increased provider salaries to attract new hires and retain existing staff,

[288] County Health Rankings & Roadmaps (2017). Primary Care Physicians. Retrieved from http://www.countyhealthrankings.org/app/california/2017/measure/factors/4/data

[289] Association of American Medical Colleges (2016). New Research Confirms Looming Physician Shortage. Retrieved from https://www.aamc.org/newsroom/newsreleases/458074/2016_workforce_projections_04052016.html

[290] Centers for Disease Control and Prevention (2016). Primary Care Provider Access. Community Health Status Indicators. Retrieved from https://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/CA/San%20Francisco/25

[291] Paxton, P. (2014). California Physicians: Surplus or Scarcity? California Health Care Foundation. California Health Care Almanac. Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaliforniaPhysiciansSurplusSupply2014.pdf

[292] County Health Rankings & Roadmaps (2017). Non-physician Primary Care Providers. Retrieved from http://www.countyhealthrankings.org/app/california/2017/measure/factors/4/data

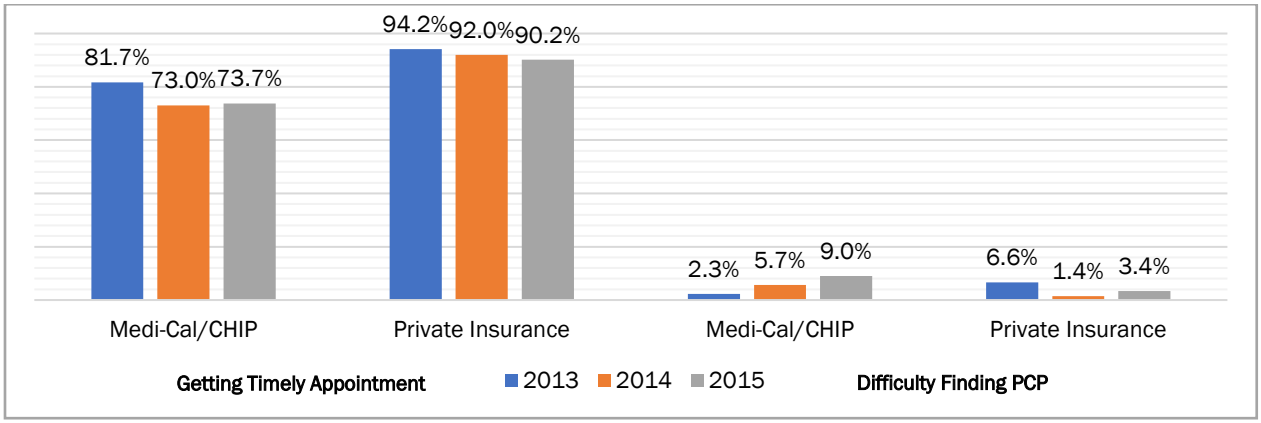
many report difficulties competing against the large hospital systems and their affiliated groups on both compensation packages and working conditions.

California

Since 2013, California's health care system of providers has shown strain under the increase in demand due to Health Reform. While all doctors were more likely to accept patients with health insurance over uninsured patients, they more often accepted other types of insurance over Medi-Cal.

In a study conducted between 2013 and 2015, patients reported greater difficulty in getting timely medical care and in finding primary care providers accepting new patients. The network of Medi-Cal and CHIP providers—already lean before health reform— is facing even greater strain as a result of the significant number of new Medi-Cal enrollees. Members of these health plans report significantly more difficulty getting an appointment or finding a primary care provider compared to those with employer-sponsored coverage (Figure 5.4-4.1). [293]

Figure 5.4 - 4.1 Californian's Ease in Getting an Appointment or Finding a PCP by Insurance Type, 2013-2015



Source: California Health Care Foundation, 2015

Even though the San Francisco Bay Area exceeds national standards for the number of specialists per population, access to specialty care is a challenge in California, particularly for the expanded Medi-Cal population and those who remain uninsured. Research suggests that California's uninsured and Medi-Cal populations continue to face specialty care access challenges because:

- Not enough specialists will accept referrals from safety net providers, leading to longer wait times and, potentially, poorer health outcomes for the referred; and
- Existing referral systems are inefficient, resulting in long wait times, the exchange of incomplete information, and poor patient-provider interactions.

For example, despite an increase in coverage, California's adult safety net population is consistently less likely to find a specialty care provider that accepts their insurance compared to the individuals with employer-sponsored coverage. Between 2013 and 2015, the share of individuals with public insurance that reported difficulty finding a specialist that accepts their insurance increased from 20.1% to 23.1%, compared to those with employer-sponsored coverage, whose rate stayed at 8.6%.

Additionally, specialists are nearly four times more likely to refuse a new patient with public insurance than employer-sponsored coverage.[294]

The ongoing patient-provider relationship is key to the Medical Home model, which allows each patient's designated primary care provider to take a more comprehensive, holistic approach to patient care. Through California's previous 1115 Medicaid Waiver all Medi-Cal eligible seniors and persons with disabilities must be connected to a Medical Home to ensure better care coordination. The same was true for members of the former Low-Income Health Program (LIHP) prior to being transitioned to managed care in 2014. Most people who gained health coverage under Health Reform were able to continue to see their same primary care provider.

United States

Health care experts predict that the US will face a significant shortage of physicians nationally and at the state level. The Association of America Medical Colleges (AAMC) projects that the US will face a total physician shortfall of up to nearly 122,000 physicians by 2032. These figures account for both physician supply and demand (e.g. due to population growth or other factors). For some provider types—such as primary care physicians—the absolute number of physicians is projected to grow but is insufficient to keep up with projected demand. For others, such as surgeons, the actual supply of physicians is shrinking. Some key reasons driving these trends include:

- **Retirement:** For all specialty categories, retirement is projected to exert the greatest pressure on physician supply, as more than one-third of physicians will be 65 years or older within the next decade. Currently, physicians ages 65 to 75 account for over one-fifth of the active workforce, and those between ages 55 and 64 make up one-fourth of the active workforce. In California, nearly one-third (32.6%) of physicians are over 60 years old, the fifth highest rate among states.
- **Population growth and the rapidly expanding Medicare population:** National demand for physicians is projected to increase by 14% by 2025 due to changing demographics, or about 111,000 physicians nationally. Over this period, the US population is projected to grow by over 8% to 346 million. The population of older adults will see the greatest share of this growth, with the population aged 65 and over expected to grow by 41%, compared to 5% for the population under age 18. These shifts foreshadow the growing demand for health care services that disproportionately serve seniors.[295]

Since the 1960s, Medicare has paid for the majority of the cost that teaching hospitals spend on training medical residents. Between 2002 and 2016, medical school enrollment has increased by nearly 30% across the US and is expected to maintain that rate through 2019.[296] Yet, despite the rising numbers of medical school graduates, the Balanced Budget Act of 1997 capped the number of residency slots the federal government would fund. Consequently, there has not been a corresponding increase in federal support for the number of residency positions for graduates to complete their training. According to the Accreditation Council for Graduate Medical Education, residency

[294] California Health Care Foundation (2016). ACA 411: Explore the Data. Retrieved from http://www.chcf.org/aca-411/explore-the-data#chart%2Caccesstocare%2Cbarrierstocare%2Cspec_accept%2CPies%20(InsuranceType)%2C2015%2Cindividual

[295] Association of American Medical Colleges (2019). The Complexities of Physician Supply and Demand. Retrieved from: https://www.aamc.org/media/26541/download

[296] Association of American Medical Colleges (2016). Medical School Enrollment to Approach 30 Percent Increase by 2019. Retrieved from https://www.aamc.org/newsroom/newsreleases/431036/20150430.html

programs are growing at a rate of about 1% each year. Although teaching hospitals incur $17.4 billion annually in direct training costs, Medicare covers only about 20%, or $3.5 billion, and the rest is paid for by the hospitals where residents train.[297] Though hospitals could increase the number of residents they train, they would have to fund the entire cost of those positions. As a result, each year roughly 5% of graduates are not matched to a residency.[298]

Nurse Practitioners and Physician Assistants Fill Primary Care Gaps

Nurse Practitioners (NPs) and Physician Assistants (PAs) have been cited as two types of health care providers that may be able to fill the projected shortfalls in primary care providers. By 2030, California is projected to have 78,000 to 103,000 primary care clinicians, with NPs and PAs composing nearly half of the total.[299] Non-physician clinicians and physician assistants are well-positioned to address the physician shortage in primary care because of their professional, extensive training. NPs and PAs also have a more documented interest in primary care, as 78% of NPs specialize in primary care while only 33% of physicians specialize in primary care. Finally, both the NP and PA profession are expected to see increases (47% and 38%, respectively.)[300]

However, there are policy related obstacles related to scope of practice. California is one of 28 states that restricts NPs by requiring that they practice with physician oversight. Removing these restrictions would help address California's workforce shortages.[301]

Federally Qualified Health Centers are Meeting Increased Demand for Health Care Services

The term Community Health Center (CHC) includes Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, Migrant Health Centers, Rural and Frontier Health Centers, and Free Clinics. CHCs are an essential segment of the safety-net. In many California counties, they provide a significant proportion of comprehensive primary care services to those who are publicly subsidized or uninsured.

Medicaid expansion removed significant financial barriers for people who were previously uninsured, resulting in a sizable increase in demand for health care services. Because most new Medi-Cal enrollees are entering managed care arrangements, health plans focus on placing enrollees in "medical homes" to provide primary care and care coordination. With capacity strained across the health system – and the limited number of participating Medi-Cal providers due to reimbursement rates – Federally Qualified Health Centers (FQHC) have increased their role as medical homes for Medi-Cal enrollees and the remaining uninsured.

From 2018-2019, California had 1,334 licensed community health centers (FQHC, rural health centers, community clinics and free sites, and FQHC look alike sites). California's health centers served approximately 6.9 million patients in 2018-2019. As an indication of the

[297] Association of American Medical Colleges (2016). Graduate Medical Education: Training Tomorrow's Physician Workforce. Retrieved from https://www.aamc.org/download/458040/data/graduatemedicaleducationtrainingtomorrowsphysicianworkforce2016.pdf

[298] Results and Data: 2017 Main Residency Match. Washington, DC: National Resident Matching Program (NRMP), April 2017. http://www.nrmp.org/main-residency-match-data/.

[299] Maier, S. California Demand for Primary Care Providers to Exceed Supply by 2030. Retrieved from: https://www.ucsf.edu/news/2017/08/408046/california-demand-primary-care-providers-exceed-supply-2030

[300] UnitedHealth Group. Addressing the Nation's Primary Care Shortage: Advanced Practice Clinicians and Innovative Care Delivery Models. (2018). Retrieved from: https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2018/UHG-Primary-Care-Report-2018.pdf

[301] California Future Health Workforce Commission. (2019). Executive Summary: Meeting the Demand for Health. Retrieved from: https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf

impact of Health Reform and Medicaid expansion, 47% of health center patients were enrolled in Medi-Cal, and the program accounted for just over 11% of revenue in 2013. In 2016, those proportions jumped to 50% and have remained consistent. San Francisco's 44 service sites provided nearly 700,000 medical, dental and mental health visits to nearly 160,000 low-income residents in 2018.[302]

5.HEALTH CARE SPENDING

US HEALTH CARE SPENDING CONTINUES CLIMBING DURING IMPLEMENTATION OF HEALTH REFORM. PREMIUMS ARE LOWER IN STATES THAT EXPANDED MEDICAID. CONSUMERS ARE PAYING MORE FOR EMPLOYER-SPONSORED COVERAGE. ALTHOUGH CALIFORNIA'S HEALTH CARE COSTS ARE INCREASING, PER CAPITA EXPENDITURES IS ONE OF THE LOWEST IN THE NATION.

This section describes the local, state, and national health care finance landscape and the primary drivers of increasing costs for all participants in the health care industry.

National Trends in Health Care Spending

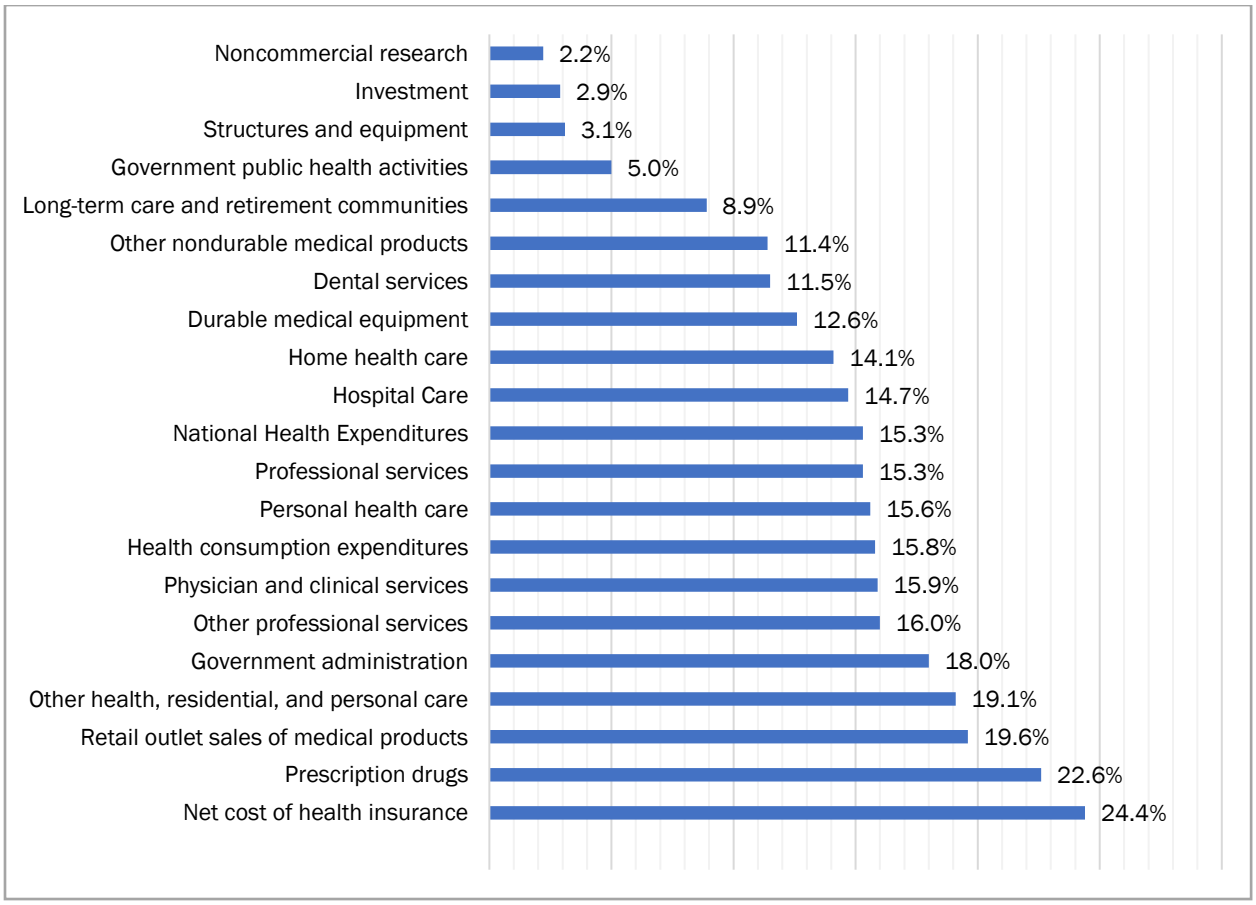
At the end of 2013, health care spending was growing at approximately 3.7% annually. During the implementation of the ACA in 2014, health care spending grew relatively fast at around 4.4% to 5.0%. This was largely fueled by increased utilization in services because millions more people gained coverage. In 2017, health care spending began to slow (increase by 3.9%). Health care spending projections indicate that this trend will likely continue. US health spending reached $3.5 trillion in 2017, or $10,739 per capita, and accounted for 17.9% of gross domestic product (GDP). The slowdown in 2017 health spending can be attributed to slower growth in spending for hospital care, physician services, and prescription drugs.

Figure 5.4-5.1 illustrates the types of health expenditures that have increased the most in recent years and shows that health insurance and prescription drugs costs have seen the largest rate of growth between 2013 and 2016. Hospital care continues to be the largest spending category and has been for the last 20 years.[303]

[302] California Primary Care Association. CHC Data and Reports. (2018). Retrieved from: https://www.cpca.org/CPCA/CPCA/About/CHC_Data.aspx

[303] California Health Care Foundation (2016). US Health Care Spending. California Health Care Almanac Quick Reference Guide. Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HealthCareCostsQRGDec16.pdf

Figure 5.4 - 5.1 Health Care Expenditures Growth, 2013-2016

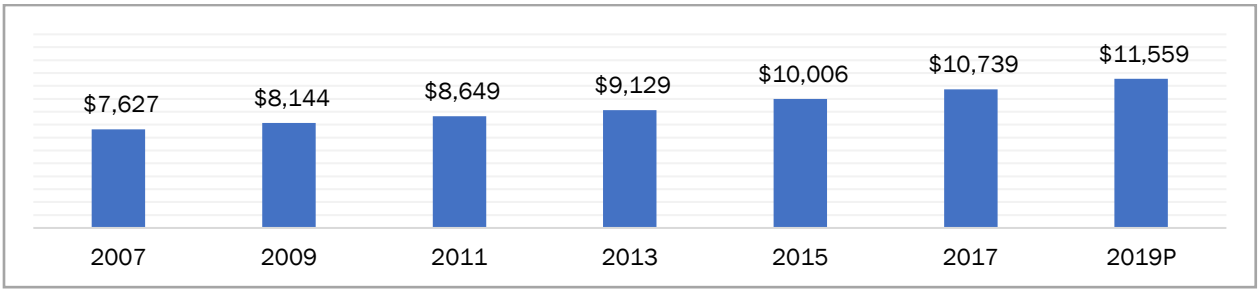


Source: California Health Care Foundation, 2016

Health Care Spending Per Capita

Health care spending has increased faster than inflation, growing at more than double the rate of the Consumer Price Index (CPI) and median household income. In inflation-adjusted dollars, on a per capita basis, health spending has increased by almost 6-fold from $1,797 In 1970 to $10,739 in 2017. [304] Figure 5.4.-5.2 shows how per capita health spending has changed in the last ten years and projected into 2019.

Figure 5.4 - 5.2 Health Care Spending Per Capita



Source: Kaiser Family Foundation, 2019

Prior to 2017, health care spending has been growing at fairly modest rates leading to greater out of pocket costs for consumers. This growth in out-of-pocket costs came at a time when workers' wages had been largely stagnant, and employees are being exposed to ever-higher health care costs. In addition, low economic growth coupled with rising health care costs had prompted many employers to pass their benefit plan costs onto employees, through increased deductibles and other cost-sharing provisions. For example, over the years, employer-sponsored health plans with high deductibles have become more common among smaller employers.

The average annual premiums for employer-sponsored health insurance in 2019 are $7,188 for single coverage and $20,576 for family coverage. The average single premium increased 4% and the average family premium increased 5% over the past year. Workers' wages increased 3.4% and inflation increased 2%. Over the last five years, the average premium for a family has increased 22%, and 54% over the last ten years. In terms of employer contributions, since 2014 the average dollar amounts contributed has risen by 25%. [305]

While health care costs are also increasing in California, the state spends less per capita on health care compared to the United States average (refer to Figure 5.4-5.3). According Centers for Medicare and Medicaid Service's (CMS) National Health Expenditure data for 2014, California ranked 15th in Medicaid personal health care spending per enrollee in part because of the state's low Medi-Cal reimbursement rate, which reduces spending, but can make it more difficult to access health care. Data from 2014 shows that overall per capita Medicaid spending was approximately 21% less than the US average, which equates to nearly $1,500 less spent per enrollee. [306] California's reliance on managed care for its Medi-Cal population may also help explain the state's continued low spending rate. Under managed care, California contracts with health

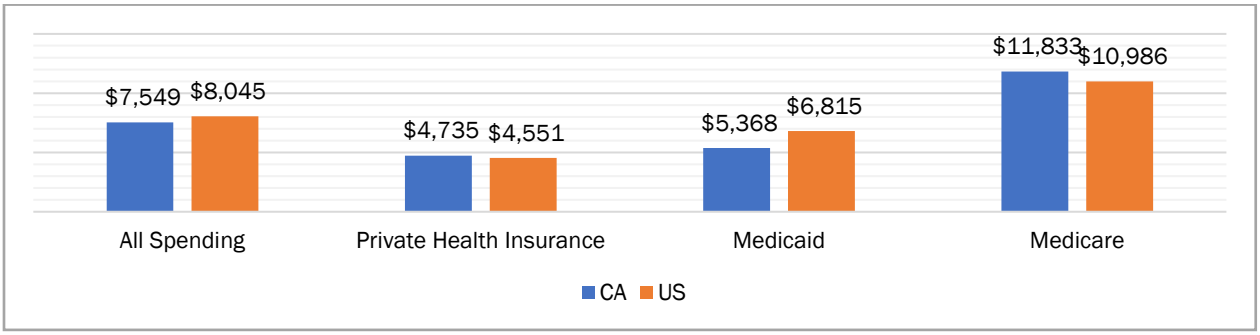
[304] Kamal, R., Sawyer, B., McDermott, D. How much is health spending expected to grow? Kaiser Family Foundation. (2019). Retrieved from: https://www.healthsystemtracker.org/chart-collection/much-health-spending-expected-grow/#item-start

[305] Kaiser Family Foundation. (2019). 2019 Employer Health Benefits Survey. Retrieved from: https://www.kff.org/report-section/ehbs-2019-summary-of-findings/

[306] Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Data, Health Expenditures by State of Residence, 1991-2014. Retrieved from: https://www.chcf.org/publication/california-health-care-spending/

plans to deliver Medi-Cal benefits to enrollees in exchange for a monthly payment for each enrollee. Thus, health plans are accountable for and at financial risk for providing the services in the contract.[307]

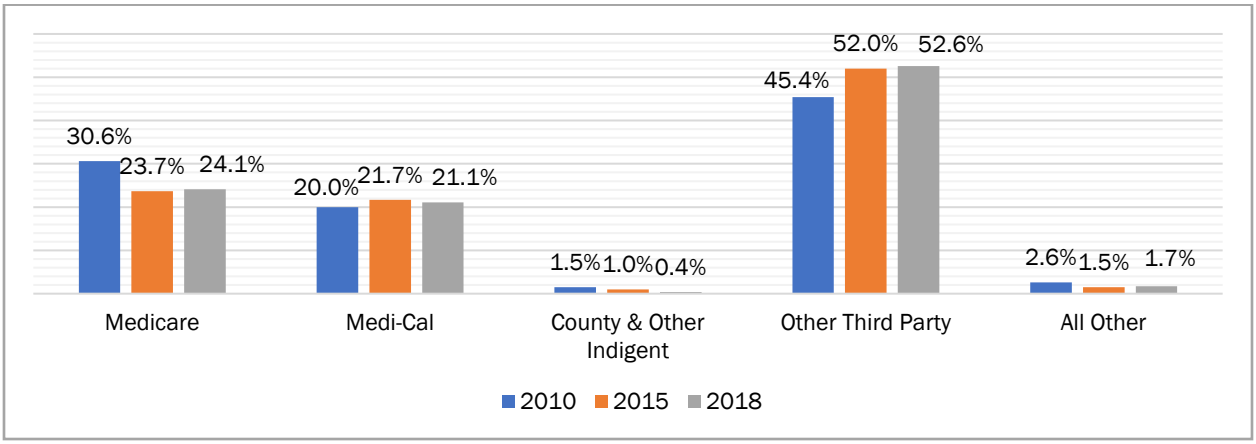
Figure 5.4 - 5.3 Per Capita Spending on Health Care, US and CA, 2014



Source: Centers for Medicare and Medicaid Services, 201

Health care financing has shifted as a result of ACA implementation. Figure 5.4-5.4 illustrates gross and net revenue by payer source for all San Francisco hospitals reporting to the Office of Statewide Health Planning and Development (OSHPD) in 2010, 2015 (post-ACA), and 2018. As indicated below, "Other Third Party" payers – representing both traditional and managed care health plans – contributed the greatest share of gross and net revenue to reporting San Francisco hospitals, and have grown as a share of SF hospital revenues (increasing by 7.2%). Net revenue from Medicare payments fell commensurately by 6.5% while payments for indigent (or underinsured patient) payer sources also dropped modestly.[308, 309, 310]

Figure 5.4 - 5.4 Net Revenue by Payer Source, San Francisco Hospitals 2010, 2015, 2019



In contrast, net revenues from Medi-Cal reimbursement increased by 1.1% as more residents became eligible due to Medicaid expansion, coupled with the transition of Medi-

[307] California Department of Health Care Services (2018). Medi-Cal Managed Care. Retrieved from http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.
[308] Office of Statewide Health Planning & Development (2013). Hospital Annual Financial Disclosure Data. State of California. Retrieved from https://www.oshpd.ca.gov/HID/Find-Hospital-Data.html
[309] Office of Statewide Health Planning & Development (2015). Hospital Annual Financial Disclosure Data. State of California. Retrieved from https://www.oshpd.ca.gov/HID/Find-Hospital-Data.html
[310] Office of Statewide Health Planning & Development (2018). Hospital Annual Financial Disclosure Data. State of California. Retrieved from https://www.oshpd.ca.gov/HID/Find-Hospital-Data.html

Cal's Seniors and Persons with Disabilities population into managed care. There has been dramatic growth in enrollment in the San Francisco Health Plan (SFHP), the City's Medi-Cal plan, increasing from 36,000 enrollees in 2010 to over 150,000 in 2016. This increased SFHP's market share of San Francisco Medi-Cal patients by an additional 12 percentage points to 87% in 2016. SFHP continues to receive high marks as a well-managed, financially strong and stable health plan providing high-quality care. California's Medi-Cal Managed Care Performance Dashboard places SFHP among California's highest-performing Medi-Cal plans.[311]

The amount of charity care (uncompensated care provided by non-profit hospitals to low-income individuals) provided by San Francisco hospitals has also changed dramatically due to increased availability of health coverage under the ACA. In San Francisco, there are two categories of charity care: Healthy San Francisco (HSF) charity care, which is provided as part of hospitals' participation in the program; and traditional charity care, which is provided to under- or uninsured patients who are not enrolled in HSF, and in many cases are ineligible for Medi-Cal. In 2010, eight hospitals served over 104,000 unduplicated patients and spent approximately $178 million in charity care. By 2015, the number of patients decreased 42% to 60,500, and total expenditures dropped by more than half (53%) to $84 million, and since then has remained consistent (refer to Figure 5.4 - 5.5).[312] This trend is mirrored across the state, with uncompensated care costs between 2013 and 2016 plummeting by 54%, from $3.1B to $1.4B.[313] Similarly, uncompensated care across the U.S. fell 9.3%, or $4.6 billion, from 2013 to 2014. States that expanded Medicaid have seen a 47% reduction in uncompensated care costs, while states that did not have seen an 11% decrease in uncompensated care costs.[314, 315]

However, an estimated 30,000 - 35,000 San Franciscans remain uninsured due to ineligibility or inaccessibility of health insurance. Many of these individuals will continue to rely on Healthy SF or charity care services. In addition, the uncertain future of the ACA also stresses the importance of maintaining charity care programs.

[311] California Department of Health Services (2019). Quarterly Release Notes. Medi-Cal Managed Care Performance Dashboard Glossary. Retrieved from http://www.dhcs.ca.gov/services/Documents/MMCD/ManagedCareDec2016.pdf

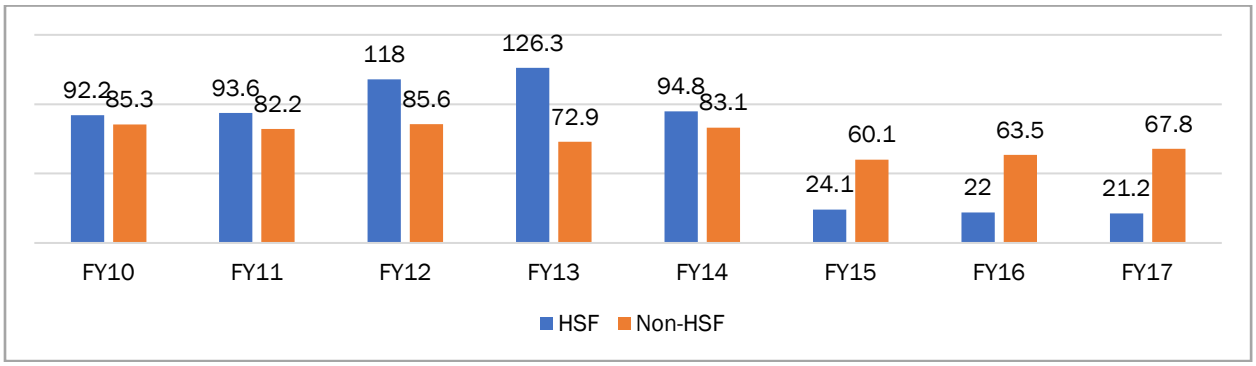
[312] San Francisco Department of Public Health (2019). San Francisco Hospitals Charity Care Report 2017. Retrieved from https://www.sfdph.org/dph/hc/HCFinance/agendas/2019/May%207/DRAFT%202017%20Charity%20Care%20Report_05.01.2019.pdf

[313] Hartman, L. Uncompensated Hospital Care Costs in California Continued to Decline in 2016. (2018). California Health Care Foundation. Retrieved from: https://www.chcf.org/blog/uncompensated-hospital-care-costs-in-california-continued-to-decline-in-2016/

[314] Dickinson, V. (2017). Federal funds still needed despite drop in uncompensated care. Modern Healthcare. Retrieved from http://www.modernhealthcare.com/article/20170411/NEWS/170419981?utm_source=modernhealthcare&utm_medium=email&utm_content=20170411-NEWS-170419981&utm_campaign=am

[315] Schubel, J., Broaddus, M., Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect. (2018). Center on Budget & Policy Priorities. Retrieved from: https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage

Figure 5.4 -5.1. Total Charity Care Expenditures, San Francisco Hospitals Reporting to OSHPD **(in millions of dollars)**



Source: California Office of Statewide Health Planning & Development, 2010 - 2017

Drivers of Increasing Costs

Even though Californians spend less per capita on health care relative to the country, the amount of total consumer expenditures that San Franciscans spent on medical services rose from 2016 to 2017, from 4.4% to 5.4%.[316] This increase may be driven by numerous factors, including the increasing cost of living and doing business (which drives medical costs upwards) and health care and policy trends. San Francisco's health care system is also adapting to ACA-accelerated payment reforms as evidenced in its shifting overall payer mix. This section explains some of the main factors that may be driving up the cost of health care.

Demographic Trends

Consistent with demographic trends, health care expenditures have been rising as the population continues to age. In 2012, the US population aged 65 years and over made up 14% of the population but accounted for 33% of personal health care spending. In contrast, children made up 25% of the population and accounted for only 12% of personal health care spending. Working-age adults (19 to 44) spent $4,458 per person in 2012 on personal health care, 26% more than children, but half as much as older working adults (age 45-64). Those aged 85 years and overspent $32,411 per person.[317]

Market Adjustments During Initial ACA Implementation

Premium costs are now much easier to compare across insurers due to the ACA's rules on uniform insurance rating and transparency. While in the long-term this may help stabilize costs, from 2013-present it has led to some fluctuations while the market adjusts to the new rules. For instance, some insurers initially underpriced premiums in order to compete with other providers, and then had to raise premiums in later years.

The ACA also implemented temporary federal programs designed to ease the transition for private insurance carriers and stabilize premiums for consumers. These reinsurance and risk corridor programs ended in 2016, and it is estimated that some premiums increased by up to 7% in 2017 as a result.[318]

In October 2017, the federal government immediately ceased cost-sharing reduction (CSR) payments to insurers offering plans on

[316] San Francisco Health Improvement Plan (2017). Consumer Expenditure Data. http://www.sfhip.org/index.php?module=indicators&controller=index&action=dashboard&alias=consumerexpenditure

[317] California Health Care Foundation (2019). Health Care Costs 101: Spending Keeps Growing. California Health Care Almanac. Retrieved from https://www.chcf.org/wp-content/uploads/2019/05/HealthCareCostsAlmanac2019.pdf

[318] Cox, C., Semanskee, A., Claxton, G., & Levitt, L. (2016). Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors. The Henry J Kaiser Family Foundation. Retrieved from http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/

state exchanges. [319] Nevertheless, the ACA still requires insurers to offer reduced cost-sharing through enhanced silver-level plans to low-income consumers with incomes up to 250% of the poverty level. In response, many health insurance exchanges (including Covered CA) announced alternative rates that included a premium surcharge for silver plans. [320]

Prescription Drug Costs

The cost of prescription drugs spiked between 2014 and 2015, but that spike has since leveled off through 2017. Per capita, prescription drug spending in the United States was $1,025 in 2017. Prescription drug spending growth is most attributed to the growth in introduction of new drugs and the relative price increase of existing drugs. Prices for generic drugs has decreased by 37% since 2014, while prices for branded and new drugs have increased by over 60%. Among adults who take prescriptions, nearly a quarter report having a difficult time affording their medication. [321]

Prescription drug pricing has become a cornerstone health care issue, especially as it relates to the price paid in the United States vs. other countries. For example, a prescription used to treat certain types of cancer is $470 in the UK, $1,752 in Switzerland, and $3,930 in the United States, on average. [322]

For many of these reasons, there have been a focus on prescription drug pricing in policies at the State level. In 2017, the California Senate passed SB17 to increase prescription drug price transparency. It does this by (1) requiring advance notification to public and private purchasers before a significant prescription drug wholesale acquisition cost increase occurs, and making public certain information associated with the increase, and (2) requiring the provision of information about the impact to health care plans and insurers of cost increases. [323]

California Governor Newsom also released an executive order in August 2019 that would transition responsibility of Medi-Cal drug price negotiation from individual managed care insurance plans to the state. It's estimated to save the state $393 million by 2023. [324] This transition may also impact the amount of money that community clinics and safety-net hospitals receive through a federal drug discount program (340B). The revenue from 340B allows clinics and safety-net hospitals to provide otherwise uncompensated care. Newsom's FY20-21 budget includes the creation of a supplemental payment pool to provide payments to non-hospital clinics for 340B pharmacy services.

Regional and Provider Network Consolidation

The increase in hospital and medical group consolidations over the past decade has resulted in the formation of larger multi-hospital systems throughout the US. Research indicates that increased consolidation and concentration of the healthcare market can lead to higher prices for hospital and physician services and insurance premiums. [325] When a region is

[319] Department of Health and Human Services (2017). Payments to Issuers for Cost-Sharing Reductions (CSRs). Retrieved from https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf

[320] Kamal, R., Semanskee, A., Long, M., Claxton, G. and Levitt, L. (2017). How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums." *The Henry J. Kaiser Family Foundation* (blog). Retrieved from https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/.

[321] Kamal, R., Cox, C., McDermott, D. What are the recent and forecasted trends in prescription drug spending?. (2019) The Henry J.Kaiser Family Foundation. Retrieved from: https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-start

[322] Kamal, R., Cox, C., McDermott, D. What are the recent and forecasted trends in prescription drug spending? (2019) The Henry J.Kaiser Family Foundation. Retrieved from: https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-start

[323] California Office of Statewide Health Planning & Development. (n.d.) Cost Transparency: Prescription Drugs. Retrieved from: https://oshpd.ca.gov/data-and-reports/cost-transparency/rx/

[324] Ho, C. (2019). Will Gavin Newsom's plan lower prescription drug costs in California?. San Francisco Chronicle. Retrieved from: https://www.sfchronicle.com/business/article/Will-Gavin-Newsom-s-plan-lower-prescription-14404947.php#

[325] The Herfindahl-Hirschman Index (HHI) is used to measure insurer, hospital, and physician market concentration. HHI is used in the U.S. Department of Justice and Federal Trade Commission (DOJ/FTC)'s Horizontal Merger Guidelines (U.S.

dominated by a few large integrated hospital systems and medical groups, health insurers have much less negotiating leverage to secure lower contracted rates for health services.[326] Between 2004 and 2013, hospital prices in California grew by 76% across all hospitals and services.[327] In fact, prices at hospitals that are members of the largest, multi-hospital systems grew far faster (113%) than prices paid to all other California hospitals (70%).[328]

Healthcare has historically been more expensive in Northern California, and its regional market is recognized to be considerably more concentrated than in the south. For example, in Northern California, the adjusted price of medical procedures is often 20-30% higher, and insurance premiums are 35% higher. Average premium costs for plans on Covered California are 30% higher in the San Francisco region compared to the Los Angeles region ($453 versus $346).

In San Francisco, the median price for the following services is markedly higher than other areas in the state:

- Double the price for a cardiomyopathy compared to Los Angeles;
- 68% higher for a breast cancer exam compared to the Central Coast; and
- 56% higher to treat a common cold compared to Orange County.[329]

Broader network plans, such as PPOs, tend to have higher provider reimbursement rates, but research suggests that patients and providers may have a worse experience than people in narrower network plans. That has led some health plans to eliminate PPO plans, resulting in premium increases for the remaining broad network plans in the market.

Local Cost of Living

San Francisco is one of the most expensive cities in the world, and the cost of living is a significant factor that puts upward pressure on salaries for health care professionals, insurance premiums, space, and other costs to deliver care. An analysis by the UC Berkeley Labor Center indicates the cost of living in San Francisco is estimated to be 59% higher than

Department of Justice and the Federal Trade Commission 2010).

[326] Covered California (2016). Covered California for Small Business Announces Rate Change and Expanded Coverage Choices for 2017. Covered California Daily News. Retrieved from http://news.coveredca.com/2016/09/covered-california-for-small-business.html

[327] Scheffler, R. (2018). Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums. Retrieved from http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf

[328] Melkin, GA & Fonkych, K. (2016). Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-hospital Systems. The Journal of Health Care Organization, Provision, and Financing, 53.

[329] Scheffler, R. (2018). Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums. Retrieved from http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf

the national average.[330] Over the past decade, San Francisco has observed one of highest increases in housing costs, significantly contributing to its high cost of living.

6.HEALTH INFORMATION TECHNOLOGY

TECHNOLOGICAL ADVANCES, ADOPTION OF ELECTRONIC HEALTH RECORDS, AND HEALTH CARE ANALYTICS SPUR HEALTH INFORMATION TECHNOLOGY (HIT) GROWTH, BUT INTEROPERABILITY, CYBERSECURITY, AND PRIVACY REMAIN CHALLENGES.

The following section discusses selected trends related to the advancement and integration of health information technology (HIT) in health care delivery, including the benefits and challenges of increasing their usage in the health care system.

Although US health care spending exceeds that of other developed nations—nearly 40% higher than the next highest country—the US places 42nd in the world for life expectancy compared to all countries and 28th among industrialized countries. [331,332] Ongoing, significant investments in health information technology are needed to improve health outcomes while containing health care costs.

Telehealth & Telemedicine

Telehealth and telemedicine use telecommunication and information technologies (e.g. phone, email, video conferencing) to provide care to patients remotely. Examples of these services include, but are not limited to:

- Patient/provider email communication;
- Video conferencing, for instance to improve access to medical specialists or to provide language interpretation for non-English speaking patients;
- "Store-and-forward" communication, such as sending an image to an outside provider for consultation; and
- Remote health monitoring, such as when a diabetic patient submits blood glucose test results in real time.

From 2004 to 2013, the number of telehealth and telemedicine visits increased by more than 25%.[333] And from 2016 to 2017, telehealth jumped 53%.[334] Virtual visits accounted for more than half (52%) of Kaiser Permanente's total visits in 2015.[335] Utilization is higher for the Medicare population and in states with parity laws (e.g. states requiring the same reimbursement rates as for in-person visits).[336] While the most popular delivery platforms are telephone, email, and text, the use of video is gaining traction. Most common issues that people used telehealth for included: bruises,

[330] Health Management Associates (2015). Addressing Affordability of Health Insurance in San Francisco. San Francisco Department of Public Health.
[331] OECD (2015). Health at a Glance 2015: OECD Indicators. OECD Publishing. Retrieved from http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2015_health_glance-2015-e
[332] Central Intelligence Agency (2016). Country Comparison: Life Expectancy at Birth. The World Factbook. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html
[333] Mehrotra, A., Jena, A.B., Busch, A.B., Souza, J., Uscher-Pines, L., & Landon, B.E. (2016). Utilization of Telemedicine Among Rural Medicare Beneficiaries. JAMA. 315, 18
[334] Kacik, A., (2019). Telehealth use Surged in 2017. Modern Healthcare. Retrieved from: https://www.modernhealthcare.com/care-delivery/telehealth-use-surged-2017
[335] Wicklund, E. (2016). Kaiser CEO: Telehealth Outpaced In-Person Visits Last Year. Retrieved from http://mhealthintelligence.com/news/kaiser-ceo-telehealth-outpaced-in-person-visits-last-year
[336] Siegel, J., Kush, J. & Philip, S. (2016). Telemedicine and the long-tail problem in healthcare. Milliman. Retrieved from http://us.milliman.com/insight/2016/Telemedicine-and-the-long-tail-problem-in-healthcare/

open wounds, respiratory infections, digestive problems, and mental health.[337]

Telemedicine and telehealth solutions using these technologies must be designed and employed in ways that match the complex needs of the vulnerable patients they are intended to reach. While promising, telehealth alone may not be sufficient to reach underserved communities for the following reasons:

Limited access to ancillary diagnostic services and in-person follow-up: Employing telehealth in underserved communities generates new demand for health care services such as procedures or tests that must be done in-person. Telehealth requires integration into a health care system that has the capacity to meet the additional patient needs that telehealth generates.

Potential cost increases to the system: Similarly, telehealth may also boost some types of health care spending, despite lower costs (an average telehealth visit costs $79, compared with $146 for an office visit). For example, research indicates that 88% of telehealth visits result in new or higher utilization of services.[338, 339]

Access to digital technology: Many of the most vulnerable patients such as the elderly, economically disadvantaged, or homeless lack an internet connection and videoconferencing equipment.[340]

Varied generational appeal: Surveys indicate that telemedicine appears to be more attractive to Millennials than Baby Boomers, and that people 55 years and older prefer higher quality patient-physician relationships over ease of access.[341]

Electronic Health Records (EHR)

The federal Health Information Technology and Clinical Health Act (HITECH; part of the American Recovery and Reinvestment Act of 2009 stimulus bill) created incentives for health care providers to adopt health information technologies, including Electronic Health Records (EHR). EHR refers to the computerized history of individual patient health information recorded at each provider encounter in any delivery setting, and includes information such as patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, and laboratory and radiology reports. From 2008 to 2017, the proportion of office-based physicians that have adopted an EHR system more than doubled, from 42% to 87%.[342]

Under the law, health care providers must implement an EHR, exchange information electronically with other health care organizations, and meet specified benchmarks that allow them to qualify for incentives. Since 2011, over 20,000 Medi-Cal professionals have received over $500 million in incentive payments to purchase and implement an EHR system.[343] Through May 2016, the Office of the National Coordinator for Health Information

[337] Kacik, A., (2019). Telehealth use Surged in 2017. Modern Healthcare. Retrieved from: https://www.modernhealthcare.com/care-delivery/telehealth-use-surged-2017

[338] Ashwood, J.S., Mehrotra, A., Cowling, D., & Uscher-Pines, L. (2017). Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending. Health Affairs. 36, 3, 485-491

[339] Ibarra, A.B. (2017). Are Virtual Doctor Visits Really Cost-Effective? Not So Much, Study Says. California Healthline. Retrieved from http://californiahealthline.org/news/are-virtual-doctor-visits-really-cost-effective-not-so-much-study-says/

[340] Koury, T. (2015). Perspectives on the Acute Care Continuum. CEP America. Retrieved from http://www.cepamerica.com/news-resources/perspectives-on-the-acute-care-continuum/2015-february/the-possibilities-and-pitfalls-of-telemedicine

[341] Cohen, J.K. (2016). The growth of telehealth: 20 things to know. Becker's Health IT & CIO review. Retrieved from http://www.beckershospitalreview.com/healthcare-information-technology/

[342] Table: Percentage of office-based physicians using any electronic health record (EHR)/electronic medical record (EMR) system and physicians that have a certified EHR/EMR system, by U.S. state: National Electronic Health Records Survey, 2017

[343] California Medical Association (2016). Reminder: 2016 is last year to start Medi-Cal EHR Incentive Program. Retrieved from https://www.cmanet.org/news/detail?article=reminder-2016-is-last-year-to-start-medi-cal

Technology (ONC) reported that over 96% of acute care hospitals eligible for the Medicare and Medicaid EHR Incentive Program have completed the requirements to obtain a "certified EHR".[344] These efforts have been bolstered by health reform's mandate to reduce overall health care costs and shift to value-based population health management and preventive care. These changes require analytics tools and technologies to effectively enable the health care system to collect, aggregate, analyze, and employ tremendous amounts of patient data – what is commonly known as "Big Data".[345] Robust health IT infrastructure will allow health providers to identify subpopulations, stratify risks, scale and redesign services based on changing variables, coordinate care, and measure population-level outcomes.

The health care industry will need to overcome a number of barriers before EHRs can achieve their full potential, including the lack of universal industry standards. EHRs, devices, and other systems often utilize proprietary protocols to communicate with their respective servers, resulting in an array of technologies that are unable to share information. Other challenges include antiquated EHR designs that predate the use of analytics, heightened privacy concerns, and institutional silos.

The mass digitization of health records has triggered a dire need for enhanced cybersecurity to protect sensitive patient information. Between 2009 and 2019 there were 2,546 health care data breaches. Those breaches have resulted in the theft/exposure of 189,945,874 healthcare records which equates to approximately 59% of the United States Population. 2018 was the worst year in terms of the number of data breaches that took place, but 2015 was the worst year in terms of the number of patient records accessed. Prior to 2015, many breaches were caused by loss/theft of health care records. With better policies and procedures, in addition to the use of encryption, many of these breaches are preventable. Recent health care data experts report that hacking and IT incidents are now the main causes of incidents, with unauthorized access becoming more commonplace.[346]

[344] Henry, J., Pylypchuk, Y., Searcy, T., & Patel, V. (2016). Adoption of Electronic Health Record Systems among U.S. Non-Federal Acute Care Hospitals: 2008-2015. The Office of the National Coordinator for Health information Technology. ONC Data Brief 35

[345] Whittington, J.W., Nolan, K., & Torres, T. (2015). Pursuing the Triple Aim: The First 7 Years. The Millbank Quarterly. 93, 2, 263-300

[346] HIPAA Journal. (2018). Healthcare Data Breach Statistics. Retrieved from: https://www.hipaajournal.com/healthcare-data-breach-statistics/

6.0 RECOMMENDATIONS & CONSISTENCY DETERMINATION GUIDELINES

CONTENTS

OVERVIEW

THE FOLLOWING CHAPTER PRESENTS THE 2019 HEALTH CARE SERVICES MASTER PLAN (HCSMP) RECOMMENDATIONS AND ASSOCIATED UPDATED CONSISTENCY DETERMINATION GUIDELINES. THE RECOMMENDATIONS ARE THE RESULT OF KEY FINDINGS FROM THE HCSMP ASSESSMENTS AND OUTREACH. AS MENTIONED IN EARLIER CHAPTERS, MANY OF THE KEY FINDINGS FROM THE 2013 HCSMP HAVE HELD TRUE THROUGH THE UPDATE PROCESS. AS SUCH, THE 2019 HCSMP RECOMMENDATIONS REPRESENT A CONSOLIDATED AND UPDATED VERSION OF THE ORIGINAL 2013 HCSMP RECOMMENDATIONS.

From the recommendations, staff from SFDPH and Planning developed the 2019 HCSMP Consistency Determination Guidelines. The guidelines are an evaluation tool used to review new Medical Use development projects in the City of San Francisco as part of the Consistency Determination application process. The 2013 HCSMP included 51 guidelines, which have been revised and consolidated. The result of this process is a list of 28 guidelines that will be used to evaluate new Medical Use development projects.

Prior to the 2019 HCSMP update, projects that required Consistency Determination included

Hospitals/Medical Centers or Health Service/Medical Service Uses are subject to the HCSMP if they met the following size thresholds:

- A change of use to a Medical Use that occupies 10,000 GSF or greater, or
- An expansion of an existing Medical Use by 5,000 GSF or greater

As a part of the supporting legislation to the 2019 HCSMP, Consistency Determination will now be a requirement **only** of Hospitals and hospital-affiliated facilities as a part of their Institutional Master Plans (IMP).

Facilities Required to go through Consistency Determination

Hospitals – Section 102, San Francisco Planning Code – An Institutional Healthcare Use that includes a hospital, medical center, or other medical institution that provides facilities for inpatient or outpatient medical care and may also include medical offices, clinics, laboratories, and employee or student dormitories and other housing, operated by and affiliated with the institution, which institution has met the applicable provisions of Section 304.5 of this Code concerning Institutional Master Plans.

1. RECOMMENDATIONS

THE 2019 HCSMP RECOMMENDATIONS SERVE AS THE FRAMEWORK TO DEVELOP THE UPDATED CONSISTENCY DETERMINATION GUIDELINES.

The recommendations are as follows:

1) Increase access to appropriate care for San Francisco's vulnerable populations,
2) Increase access to behavioral health services for vulnerable patients,
3) Increase access to and capacity of long-term care options for San Francisco's growing senior population and for persons with disabilities to support their ability to live independently in the community,
4) Utilize health information technology systems that increase access to high-quality health care and improve care coordination,
5) Ensure that San Francisco residents – particularly those without regular care access – have available a range of appropriate transportation options (e.g., public transportation, shuttle services, bike lanes, etc.) that enable them to reach their health care destinations safely, affordably, and in a timely manner, and
6) Ensure that facility design and development promote health and safety through the design of its site and buildings and that, when located in neighborhood commercial areas, facilities lining the street are active.

2. GUIDELINES

THE TABLE BELOW PRESENTS THE PROPOSED 2019 HCSMP CONSISTENCY DETERMINATION GUIDELINES. THE FOLLOWING GUIDELINES WILL BE USED TO REVIEW NEW MEDICAL USE DEVELOPMENT PROJECTS AS A PART OF THE CONSISTENCY DETERMINATION PROCESS.

Recommendation 1. Increase access to appropriate care for San Francisco's vulnerable populations.

1.1	Increase the availability and accessibility of primary care in: • low-income areas (i.e., areas where the percentage of low-income residents – defined as individuals living below 200% of the Census Poverty Threshold[i] – is greater than the San Francisco average), • areas with documented high rates of health disparities (e.g., areas in which residents face the highest rates of morbidity or premature mortality) and/or • areas with limited existing health care resources
1.2	Increase the availability and accessibility of culturally competent primary care among vulnerable subpopulations including but not limited to: • Medi-Cal beneficiaries, • uninsured residents, • limited English speakers, and • populations with documented high rates of health disparities.
1.3	Increase the availability and accessibility of prenatal care within neighborhoods with: • documented high rates of related health disparities. • for subpopulations with documented high rates of related health disparities including but not limited to Black/African American residents

1.4	Increase the availability and accessibility of dental care in/among:
	• low-income areas (i.e., areas where the percentage of low-income residents – defined as individuals living below 200% of the Census Poverty Threshold[i] – is greater than the San Francisco average) and
	• areas with documented high rates of health disparities (e.g., areas in which residents face the highest rates of morbidity or premature mortality) among vulnerable subpopulations including but not limited to:
	  ○ Medi-Cal beneficiaries,
	  ○ uninsured residents,
	  ○ limited English speakers, and
	  ○ populations with documented high rates of health disparities.

1.5	Employ and train culturally competent providers serving low-income and uninsured populations, which may include but is not limited to supporting projects that can demonstrate through metrics that they have served and/or plan to serve a significant proportion of existing/new Medi-Cal and/or uninsured patients, particularly in underserved neighborhoods.
1.6	Deliver and facilitate access to specialty care for underserved populations (e.g., through transportation assistance, mobile services, and/or other innovative mechanisms).
1.7	Provide innovative education and outreach efforts that: • Target youth and other hard-to-reach populations, such as homeless people and those with behavioral health problems that inhibit them from seeking medical care and other health services, as well as invisible populations that are often overlooked due to their legal status. • Help low-income, publicly insured, and/or uninsured persons identify health care facilities where they may access care.
1.8	Promote support services for patients likely to have difficulty accessing or understanding health care services (e.g., escorting patients to medical appointments, using case managers to help patients navigate the health care system, for e.g. multiply diagnosed or homeless persons).
1.9	Offer non-traditional facility hours to accommodate patients who work during traditional business hours.
1.10	Participate in Healthy SF
1.11	Support collaborations between medical service providers and existing community-based organizations with expertise in serving San Francisco's diverse populations.
1.12	Engage in partnerships between medical service providers and entities not specifically focused on health or social services (e.g., schools, private business, faith community, etc.) to leverage expertise and resources and expand access to health services and promote wellness.

Recommendation 2. Increase access to behavioral health services for vulnerable patients

2.1	Increase the availability of behavioral health and trauma-related services– including school-based services – in neighborhoods with documented high rates of violence (i.e., neighborhoods exceeding citywide violence rates per San Francisco Police Department data).
2.2	Expand the availability and accessibility of residential treatment beds for mental health and substance use, especially for people experiencing homelessness.
2.3	Support expansion of safe indoor spaces that provide low-threshold, harm reduction (ex. naloxone), and basic services, including drop-in centers, shelters and navigation centers.
2.4	Support behavioral health workforce development and recruitment through efforts like scholarship programs, loan forgiveness, and other financial incentives.
2.5	Improve care coordination through case management and navigation services, especially for high utilizers of the health care system.

Recommendation 3. Increase access to and capacity of long-term care options for San Francisco's growing senior population and for persons with disabilities to support their ability to live independently in the community

3.1	Increase availability and accessibility of post-acute and long-term care facilities, specifically: • Skilled Nursing Facilities (SNFs) • Subacute SNF • Board and Care Homes/Residential Care Facilities for the Elderly (RCFEs)
3.2	Increase availability and accessibility of home and community-based services for residents with short and long-term care needs, for example: • Adult Day Care Programs with memory care services (programs that serve adults with dementia and Alzheimer's)
3.3	Provide affordable and supportive housing options for seniors and persons with disabilities, enabling them to live independently in the community.
3.4	Support workforce development through job trainings and/or wage stipend programs especially for home-based services.

Recommendation 4. Utilize health information technology systems that increase access to high-quality health care and improve care coordination

4.1	Support technology-based solutions that expand access to health services for San Francisco's vulnerable populations, such as telehealth and mobile device utilization (e.g., video medical interpretation, mobile applications, remote health monitoring, etc.).
4.2	Integrate support service information into electronic health records in order to have a more complete picture of a patient's health and improve care coordination.

Recommendation 5. Ensure that San Francisco residents – particularly those without regular care access – have available a range of appropriate transportation options (e.g., public transportation, shuttle services, bike lanes, etc.) That enable them to reach their health care destinations safely, affordably, and in a timely manner

5.1	As part of transit demand management efforts for patients, develop safe health care transit options beyond the public transportation system (e.g., bike storage, health care facility shuttle service, etc.) to increase health care access for those without regular car access
5.2	Provide transportation options (e.g., taxi vouchers, shuttles, other innovative transportation options, etc.) from low-income areas and areas with documented high rates of health disparities – particularly those with transportation access barriers – to health care facilities.
5.3	Increase awareness of transportation options to health care facilities during facility hours. This may include but not be limited to providing relevant transit information in provider offices or assisting with enrollment in programs like Paratransit.

Recommendation 6. Ensure that facility design and development promote health and safety through the design of its site and buildings and that, when located in neighborhood commercial areas, facilities lining the street are active.

6.1	Encourage site and building design that supports health and safety, through amenities such as restorative open spaces, environmental sustainability features, indoor air quality measures, and other health-promoting interior design (such as open stairwells).
6.2	Design medical facilities so that more "active uses" line the street (e.g. lobbies and waiting areas), particularly when located in predominantly retail and residential neighborhoods. Non-active uses (such as patient care areas, offices, other medical support functions) should ideally be sited at the building interior and/or on the second floor and above. Encourage the addition of ground floor uses that can also serve the broader public, such as retail and food service.

Appendix A. ABBREVIATIONS

ACA	Affordable Care Act
API	Asian and Pacific Islander
BRT	Bus Rapid Transit
CBHS	Community Behavioral Health Services, San Francisco Department of Public Health
CBO	Congressional Budget Office
CHIP	Children's Health Insurance Program
CHIS	California Health Interview Survey
CHNA	Community Health Needs Assessment
CLAS	National Standards for Culturally and Linguistically Appropriate Services
CMS	Center for Medicare & Medicaid Services
CoE	Center of Excellence for Transgender Health
COPD	Chronic Obstructive Pulmonary Disease
CPI	Consumer Price Index
CPMC	California Pacific Medical Center
CPTED	Crime Prevention Through Environmental Design
CSR	Cost-sharing Reduction
DACA	Deferred Action for Childhood Arrivals
DBI	Department of Building Inspections
DEC	Division of Emergency Communications
DEM	Department of Emergency Management
DES	Division of Emergency Services
DP/SNF	A Distinct Part/Skilled Nursing Facility
DPC	Disaster Preparedness Coordinators
DPW	San Francisco Department of Public Works
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Service
ESR	Employer Spending Requirement
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
HCIN	Health Care Interpreter Network
HCSO	Health care Security Ordinance
HIT	Health Information Technology
HITECH	Health Information Technology and Clinical Health Act
HMO	Health Maintenance Organizations
HPSA	Health Professional Shortage Areas

HRSA	Health Resources and Services Administration, US Department of Health and Human Services
HSF	Healthy San Francisco
IMP	Institutional Master Plan
LEP	Limited English Proficiency
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LHH	Laguna Honda Hospital and Rehabilitation Center, San Francisco Department of Public Health
LIHP	Low-Income Health Program
MACRA	Medicare Access and CHIP Reauthorization Act
MBHO	Managed Behavioral Health Organization
MHPAEA	Mental Health Parity and Addiction Equity Act
MRA	Medical Reimbursement Account
NAICS	North American Industry Classification System
NAMI	National Alliance on Mental Illness
NEMS	North East Medical Services
NP	Nurse Practitioner
NSLP	National School Lunch Program
OEWD	Mayor's Office of Economic and Workforce Development
OSHPD	Office of Statewide Health Planning and Development
PA	Physician Assistant
PCP	Primary Care Physician
PDR	Production, Distribution, and Repair
PHEPR	Public Health Emergency Preparedness and Response, San Francisco Department of Public Health
PRSPR	Promoting Recovery and Services for the Prevention of Recidivism
PUC	San Francisco Public Utilities Commission
QHP	Qualified Health Plan
RCFE	Residential Care for the Elderly
REALM	Rapid Estimate of Adult Health Literacy in Medicine
SAMHSA	Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services
SFDPH	San Francisco Department of Public Health
SFHIP	San Francisco Health Improvement Partnership
SFHN	San Francisco Health Network
SFHP	San Francisco Health Plan
SFMTA	San Francisco Municipal Transit Agency
SNF	Skilled Nursing Facility
SSI	Supplemental Social Security
TDM	Transportation Demand Management
UASI	Urban Area Security Initiative
UCSF	University of California, San Francisco Medical Center
WIC	Women Infants and Children
ZSFG	Zuckerberg San Francisco General Hospital & Trauma Center

Appendix B. OUTREACH

KEY INFORMANT INTERVIEWS

Key Informant Participating Organizations

Health Care Providers		
Kaiser Permanente	CPMC / Sutter Foundation	HealthRight 360
North East Medical Services (NEMS)	Jewish Home	Planned Parenthood
OneMedical		
Health Advocacy/Research Organizations		
San Francisco Hospital Council	UCSF Center for Healthcare Value	California Primary Care Association
San Francisco Dental Society	San Francisco Community Clinic Consortium	Bay Area Council: Transforming Healthcare Initiative
Ensign Consulting (independent healthcare consultant)	None (independent healthcare consultant)	
Health Facility Planning/Design & Neighborhood Stakeholders		
American Institute of Architects (AIA): Architecture for Health Initiative	HOK Architects	Prado Group (real estate management firm)
Colliers (real estate management firm)	Tenderloin Neighborhood Development Corporation (TNDC)	Castro Street Merchants Association
Liberty Hill Neighborhood Association	Noe Valley Community Benefit District	

WORKSHOP FOR HEALTH CARE SECTOR STAKEHOLDERS

Attending Organizations

- Asian and Pacific Islander Health Parity Coalition (APIHPC)
- California Pacific Medical Center (CPMC)
- Chinese Hospital
- City Planning (CPC)
- HealthRight 360
- Hospital Council of Northern California
- Long-term Care Coordinating Council (LTCCC)
- Mission Neighborhood Health Center (MNHC)

- North East Medical Services (NEMS)
- Saint Francis Memorial Hospital (SFMH)
- San Francisco Department of Public Health (SFDPH)
- San Francisco Health Plan (SFHP)
- University of San Francisco (UCSF)

IMPLEMENTATION WORKSHOP

Attending Organizations

- Asian Pacific Islander Health Parity Coalition (APIHPC)
- Bernal Heights Neighborhood Center
- Black/African American Health Initiative (BAAHI)
- California Pacific Medical Center (CPMC)
- Diversified Search
- GLIDE Foundation
- Kaiser Permanente
- Mission Neighborhood Health Center
- NAMI SF
- Northern California Hospital Council
- Saint Francisco Memorial Hospital
- San Franciscans for Health care, Housing, Jobs and Justice (H2J2)
- San Francisco Community Clinic Consortium
- San Francisco Health Plan
- San Francisco Marin Medical Society
- San Francisco Long Term Care Coordinating Council (LTCCC)
- St. Mary's Medical Center
- UC Hastings
- University of California San Francisco (UCSF)

BRIEFINGS

Participating Organizations

Organization	Date of Briefing
San Franciscan's for Health Care, Housing, Jobs and Justice	April 2019
Hospital Council of Northern California	May 2019
San Francisco Community Clinic Consortium	May 2019
San Francisco Long Term Care Coordinating Council	November 2019 & January 2020
San Francisco Health Improvement Partnership	January 2020

Appendix C. Consistency Determination Process & Guidelines

PROCESS

The Health Care Services Master Plan (HCSMP) requires that certain new medical use development projects in San Francisco apply for a Consistency Determination from the Health Commission and Planning Commission, verifying that the proposed medical use supports the HCSMP Recommendations & Guidelines.

The Planning Department, in conjunction with SFDPH, must determine whether certain Medical Use projects, as defined by the Planning Code, align with the Health Care Services Master Plan (HCSMP) by making a "Consistency Determination."

Consistency Determination

Prior to the 2019 HCSMP update, projects that required Consistency Determination included Hospitals/Medical Centers or Health Service/Medical Service Uses are subject to the HCSMP if they met the following size thresholds:

- A change of use to a Medical Use that occupies 10,000 GSF or greater, or
- An expansion of an existing Medical Use by 5,000 GSF or greater

As a part of the supporting legislation to the 2019 HCSMP, Consistency Determination will now be a requirement **only** of Hospitals and hospital-affiliated facilities as a part of their Institutional Master Plans (IMP).

Facilities Required to go through Consistency Determination

Hospitals – Section 102, San Francisco Planning Code – An Institutional Healthcare Use that includes a hospital, medical center, or other medical institution that provides facilities for inpatient or outpatient medical care and may also include medical offices, clinics, laboratories, and employee or student dormitories and other housing, operated by and affiliated with the institution, which institution has met the applicable provisions of Section 304.5 of this Code concerning Institutional Master Plans.

Consistency Determination Review Process

NEITHER THE PLANNING COMMISSION NOR THE PLANNING DEPARTMENT MAY ACT ON ANY RELATED ENTITLEMENT UNTIL A CONSISTENCY DETERMINATION FOR THE PROPOSED MEDICAL USE IS MADE.

The process is explained below:

- Applicants must complete and submit a HCSMP Consistency Determination Application as part of any applicable entitlement or building permit application.
- The Planning Department will conduct an initial review of the Consistency Determination Application to ensure that the project scope triggers the need for a Consistency Determination per San Francisco Ordinance No. 300-10. If Planning confirms that the project is subject to a Consistency Determination, Planning will then forward the Consistency Determination Application to DPH for their review.
- DPH staff will review the Application and accompanying justification to determine whether the project is consistent with HCSMP Recommendations and Guidelines. Based on its review, DPH staff will present the recommendation to the Health Commission (either as an informational item, or as an item for discussion). DPH will then recommend that the project be assigned one of three possible HCSMP Consistency Determination outcomes: Consistent, Consistent and Recommended for Incentives, or Inconsistent.
- DPH staff will forward their final recommendation regarding a project's Consistency with the HCSMP back to the Planning Department.
- Planning will post the final determination on its WEBSITE for a 15-day public comment period.

Consistency Determination Outcomes

Consistent Applications: Applications found to be Consistent with the HCSMP will be issued a Consistency Determination by the Planning Department, which will be posted on the Planning Department's website for 15 days. If the Planning Department receives no "substantive arguments", as determined by the Planning Director, the Consistency Determination will become final. If, however, the Planning Department receives substantive written objections, the application will be processed as an inconsistent application.

Consistent and Recommended for Incentives: Applications that DPH staff recommends as "Consistent and Recommended for Incentives" will be forwarded to the Health Commission for review at a public hearing. If the Health Commission concurs with the DPH staff recommendation, the application will undergo a similar review process as described for Consistent Applications, above. However, in addition, these applications will be reviewed on a case-by-case basis by Planning and DPH to determine appropriate project incentives, based on the project's health care benefits to the City's vulnerable populations. Projects that are seeking incentives should also consult the Department's Planning Director Bulletin No.2.

Inconsistent Applications: Applications that DPH staff recommends as "inconsistent" will be forwarded to the Health Commission for review at a public hearing. If the Health Commission disagrees with DPH staff and finds the application to be consistent with the HCSMP, it will issue findings to this effect. If the Health Commission agrees with DPH staff and finds the application to be inconsistent, it will make recommendations to achieve consistency. The Health Commission must submit its findings or recommendations to the Planning Commission within 30 days of receipt of the application.

The Planning Commission must hold a public hearing within 30 days of receiving the findings from the Health Commission (or at the same time as it considers other entitlements associated with the application) and make a determination as to whether or not to issue a Consistency Determination. The Planning Department may not approve any permit or entitlements for a Medical Use project that does not have a Consistency Determination unless the Planning Commission identifies countervailing public policy considerations that justify such approval.

Appeals

Any person may file an appeal within 30 days of the issuance or denial of a Consistency Determination. If the Board of Supervisors has appeal authority to review the associated entitlement(s), the appeal should be made to the Board of Supervisors. In all other cases, the appeal should be filed with the San Francisco Board of Appeals. The Board of Supervisors and the Board of Appeals have the authority to reverse the Planning Department's or Planning Commission's determination.

2. GUIDELINES

The following guidelines represent important health care access and planning goals that are applicable to medical use development projects in San Francisco. These guidelines have been updated to reflect the findings of the 2019 Health Care Services Master Plan.

In demonstrating consistency with the HCSMP, does the Medical Use Development Project do the following?

Recommendation 1. Increase access to appropriate care for San Francisco's vulnerable populations.

1.1	Increase the availability and accessibility of primary care in: • low-income areas (i.e., areas where the percentage of low-income residents – defined as individuals living below 200% of the Census Poverty Threshold[i] – is greater than the San Francisco average), • areas with documented high rates of health disparities (e.g., areas in which residents face the highest rates of morbidity or premature mortality) and/or • areas with limited existing health care resources
1.2	Increase the availability and accessibility of culturally competent primary care among vulnerable subpopulations including but not limited to: • Medi-Cal beneficiaries, • uninsured residents, • limited English speakers, and • populations with documented high rates of health disparities.
1.3	Increase the availability and accessibility of prenatal care within neighborhoods with: • documented high rates of related health disparities. • for subpopulations with documented high rates of related health disparities including but not limited to Black/African American residents

1.4	Increase the availability and accessibility of dental care in/among:
	• low-income areas (i.e., areas where the percentage of low-income residents – defined as individuals living below 200% of the Census Poverty Threshold[i] – is greater than the San Francisco average) and
	• areas with documented high rates of health disparities (e.g., areas in which residents face the highest rates of morbidity or premature mortality) among vulnerable subpopulations including but not limited to:
	  ○ Medi-Cal beneficiaries,
	  ○ uninsured residents,
	  ○ limited English speakers, and

	○ populations with documented high rates of health disparities.
1.5	Employ and train culturally competent providers serving low-income and uninsured populations, which may include but is not limited to supporting projects that can demonstrate through metrics that they have served and/or plan to serve a significant proportion of existing/new Medi-Cal and/or uninsured patients, particularly in underserved neighborhoods.
1.6	Deliver and facilitate access to specialty care for underserved populations (e.g., through transportation assistance, mobile services, and/or other innovative mechanisms).
1.7	Provide innovative education and outreach efforts that: • Target youth and other hard-to-reach populations, such as homeless people and those with behavioral health problems that inhibit them from seeking medical care and other health services, as well as invisible populations that are often overlooked due to their legal status. • Help low-income, publicly insured, and/or uninsured persons identify health care facilities where they may access care.
1.8	Promote support services for patients likely to have difficulty accessing or understanding health care services (e.g., escorting patients to medical appointments, using case managers to help patients navigate the health care system, for e.g. multiply diagnosed or homeless persons).
1.9	Offer non-traditional facility hours to accommodate patients who work during traditional business hours.
1.10	Participate in Healthy SF
1.11	Support collaborations between medical service providers and existing community-based organizations with expertise in serving San Francisco's diverse populations.
1.12	Engage in partnerships between medical service providers and entities not specifically focused on health or social services (e.g., schools, private business, faith community, etc.) to leverage expertise and resources and expand access to health services and promote wellness.

Recommendation 2. Increase access to behavioral health services for vulnerable patients

2.1	Increase the availability of behavioral health and trauma-related services– including school-based services – in neighborhoods with documented high rates of violence (i.e., neighborhoods exceeding citywide violence rates per San Francisco Police Department data).
2.2	Expand the availability and accessibility of residential treatment beds for mental health and substance use, especially for people experiencing homelessness.
2.3	Support expansion of safe indoor spaces that provide low-threshold, harm reduction (ex. naloxone), and basic services, including drop-in centers, shelters and navigation centers.
2.4	Support behavioral health workforce development and recruitment through efforts like scholarship programs, loan forgiveness, and other financial incentives.
2.5	Improve care coordination through case management and navigation services, especially for high utilizers of the health care system.

Recommendation 3. Increase access to and capacity of long-term care options for San Francisco's growing senior population and for persons with disabilities to support their ability to live independently in the community

3.1	Increase availability and accessibility of post-acute and long-term care facilities, specifically: • Skilled Nursing Facilities (SNFs) • Subacute SNF • Board and Care Homes/Residential Care Facilities for the Elderly (RCFEs)
3.2	Increase availability and accessibility of home and community-based services for residents with short and long-term care needs, for example: • Adult Day Care Programs with memory care services (programs that serve adults with dementia and Alzheimer's)
3.3	Provide affordable and supportive housing options for seniors and persons with disabilities, enabling them to live independently in the community.
3.4	Support workforce development through job trainings and/or wage stipend programs especially for home-based services.

Recommendation 4. Utilize health information technology systems that increase access to high-quality health care and improve care coordination

4.1	Support technology-based solutions that expand access to health services for San Francisco's vulnerable populations, such as telehealth and mobile device utilization (e.g., video medical interpretation, mobile applications, remote health monitoring, etc.).
4.2	Integrate support service information into electronic health records in order to have a more complete picture of a patient's health and improve care coordination.

Recommendation 5. Ensure that San Francisco residents – particularly those without regular care access – have available a range of appropriate transportation options (e.g., public transportation, shuttle services, bike lanes, etc.) That enable them to reach their health care destinations safely, affordably, and in a timely manner

5.1	As part of transit demand management efforts for patients, develop safe health care transit options beyond the public transportation system (e.g., bike storage, health care facility shuttle service, etc.) to increase health care access for those without regular car access
5.2	Provide transportation options (e.g., taxi vouchers, shuttles, other innovative transportation options, etc.) from low-income areas and areas with documented high rates of health disparities – particularly those with transportation access barriers – to health care facilities.
5.3	Increase awareness of transportation options to health care facilities during facility hours. This may include but not be limited to providing relevant transit information in provider offices or assisting with enrollment in programs like Paratransit.

Recommendation 6. Ensure that facility design and development promote health and safety through the design of its site and buildings and that, when located in neighborhood commercial areas, facilities lining the street are active.

6.1	Encourage site and building design that supports health and safety, through amenities such as restorative open spaces, environmental sustainability features, indoor air quality measures, and other health-promoting interior design (such as open stairwells).
6.2	Design medical facilities so that more "active uses" line the street (e.g. lobbies and waiting areas), particularly when located in predominantly retail and residential neighborhoods. Non-active uses (such as patient care areas, offices, other medical support functions) should ideally be sited at the building interior and/or on the second floor and above. Encourage the addition of ground floor uses that can also serve the broader public, such as retail and food service.

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