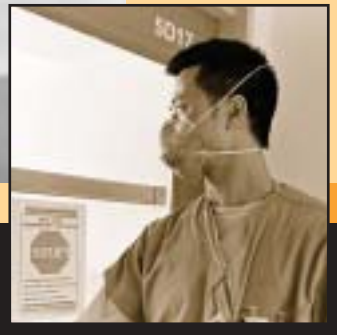
san francisco

general hospital medical center

annual report

2001-2002



Message from the Executive Administrator

Gene Marie O'Connell

As we enter our 130th year in the Mission, San Francisco General Hospital Medical Center has maintained its mission of delivering humanistic, cost-effective, and culturally competent care to the City and County of San Francisco. Our patient population, the majority of whom are ethnic minorities, over half are uninsured, and 9% are homeless, represents San Francisco's most vulnerable residents.

Fiscal Year 2001-2002 marked a year of strengthening our core services and providing greater integration of medical services with mental health, substance abuse, and other social services to better serve the complex needs of our patients. Through the tireless efforts of staff, we were successfully awarded accreditation for another three years from the Joint Commission on Accreditation of Health Care Organizations (JCAHO) in 2002. We enhanced services of our Level 1 Trauma Center through establishing a Traumatic Brain Injury Program and implementing the City and County's Trauma Care System Plan. We also improved our response to substance abuse and mental health issues through efforts such as creating a Medical-Behavioral Unit, extending programs for methadone treatment, and developing standardized assessment and treatment for alcohol withdrawal. Through a generous grant from the Avon Foundation, we furthered breast cancer research and began plans to build a comprehensive breast center here on our campus to increase access to mammography services for women in the City. Furthermore, we made improvements in patient flow, particularly for mental health patients in acute psychiatry and the Mental Health Rehabilitation Facility.

In this year, we also looked towards the future. As we and other acute care hospitals in California face the need to meet new seismic safety standards, SFGHMC underwent a Long Range Service Delivery planning process to help guide the future rebuild of the hospital not only to improve seismic safety, but also to identify options for reconfiguring services to better meet the future health care needs of San Francisco. In addition, we began a major effort to reduce adverse drug events by initiating work on a Computerized Provider Order Entry system that would enable the electronic entry of physician orders.

In the book "Catastrophes, Epidemics, and Neglected Diseases: San Francisco General Hospital and the Evolution of Public Care," Dr. William Blaisdell and Dr. Moses Grossman wrote, "San Francisco General rightly lays claim to being the most outstanding public hospital in the United States, one of which all of the citizens of San Francisco can be justly proud." Through the outstanding leadership of the San Francisco Health Commission and our Director of Health, Dr. Mitchell Katz, a strong partnership with the University of California, San Francisco, a dedicated Executive Team, and the strength and commitment of nearly 6,000 employees, I firmly believe that we are the best public hospital in the country.

It is with great honor and pride that I present this report as a celebration of the work of thousands of employees, and as a testimonial to an organization and an institution that strives to be the very best.

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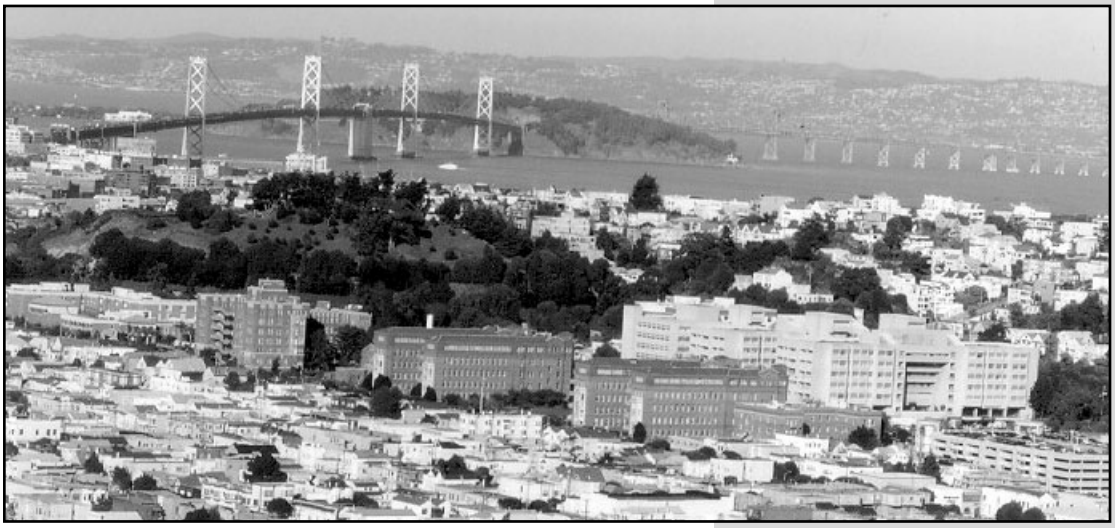
who we are

San Francisco General Hospital Medical Center (SFGHMC) is a licensed general acute care hospital within the Community Health Network, which is owned and operated by the City and County of San Francisco, Department of Public Health. SFGHMC provides a full complement of inpatient, outpatient, emergency, skilled nursing, diagnostic, mental health, and rehabilitation services for adults and children. It is the largest acute inpatient and rehabilitation hospital for psychiatric patients in the City. Additionally, it is the only acute hospital in San Francisco that provides twenty-four hour psychiatric emergency services and operates the only Level I Trauma Center for 1.5 million residents of San Francisco and northern San Mateo County.



Vision

To be the best public hospital in the country!

Mission

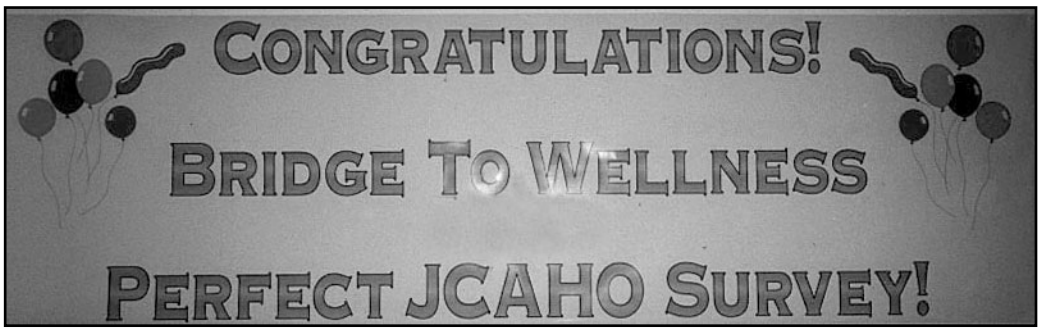
To deliver humanistic, cost-effective, and culturally competent health services to the residents of the City and County of San Francisco by:

- Providing access for all residents by eliminating financial, linguistic, physical, and operational barriers
- Providing quality services that treat illness, promoting and sustaining wellness, and preventing the spread of disease, injury and disability
- Participating in and supporting training and research
- The commitment to community education and involvement in healthcare needs

JCAHO Accreditation

Every three years, most hospitals undergo an intensive joint accreditation survey conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the California Department of Health Services (DHS) and the California Medical Association's Institute for Medical Quality (MSQ). JCAHO accreditation is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

From April 22-26, 2002, over 15 surveyors from DHS and IMQ evaluated SFGHMC's level of performance in relation to numerous functional areas such as patient rights, patient treatment, infection control, and medical staff credentialing.



The Long-term Care Survey of the Mental Health Rehabilitation Facility (MHRF) and the 4A/Skilled Nursing Facility received a score of 97 and received perfect scores in areas such as Resident Rights and Organizational Ethics, Care and Treatment of Residents, Improving Organization Performance, Leadership and Management of Environment of Care. On the Hospital Survey, SFGHMC received a score of 87 and received perfect and acceptable compliance scores in such areas as Patient Rights and Organizational Ethics, Patient and Family Education, Improving Organization Performance, Medical Staff, Leadership, Nursing, and Management of Human Resources. Finally the Bridge-to-Wellness Program was surveyed under the JCAHO Behavioral Health Manual and received a perfect score of 100.

In daily briefings, the consolidated survey team frequently mentioned the dedication of the entire SFGHMC health care team to its patients, clients and visitors, and congratulated them for their delivery of quality health care during often-times very challenging circumstances.

SF department of public health strategic plan

In August 1999, the San Francisco Health Commission directed the San Francisco Department of Public Health (SFDPH) to undertake a Strategic Planning Initiative. In 2000, SFDPH completed a planning process that resulted in a Strategic Plan, which was adopted by the Health Commission in January 2001. The Strategic Plan provides long-term organizational directions, strategic goals and strategic approaches for the Department to address the health needs and concerns of San Francisco.

In the second year of the Strategic Plan, San Francisco General Hospital Medical Center continues to embrace these strategic goals as a means to more efficiently and effectively meet the community's demand for services. This 2001-2002 annual report focuses on new and continuing programs that SFGHMC has established and supported to further the SFDPH Strategic Goals.

The Strategic Goals are:

Goal 1: San Franciscans have access to the health services they need, while the Department emphasizes services to its target populations.

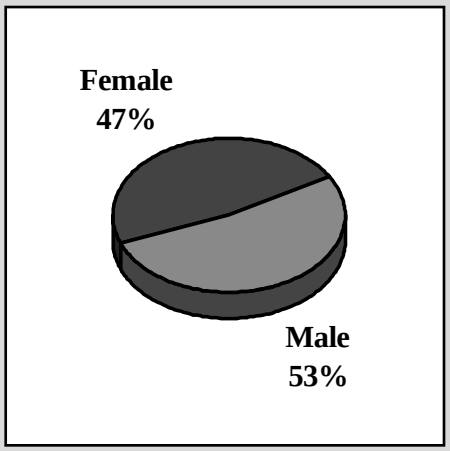
Goal 2: Disease and injury are prevented.

Goal 3: Services, programs and facilities are cost-efficient and resources are maximized.

Goal 4: Partnership with communities are created and sustained to assess, develop, implement and advocate for health funding, policies, programs and services.

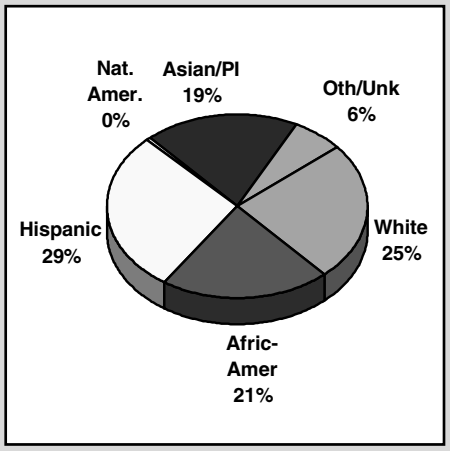
who we serve

In Fiscal Year 2001-2002, SFGHMC served 92,879 patients, of whom 53% were males and 47% were females. Nearly 66% were adults ages 25 to 64. SFGHMC places priority on providing health care services to San Francisco's most vulnerable populations, which include racial and ethnic minorities, persons from targeted low-income neighborhoods, children, frail elderly, the uninsured, and the homeless.



Racial and Ethnic Minorities:

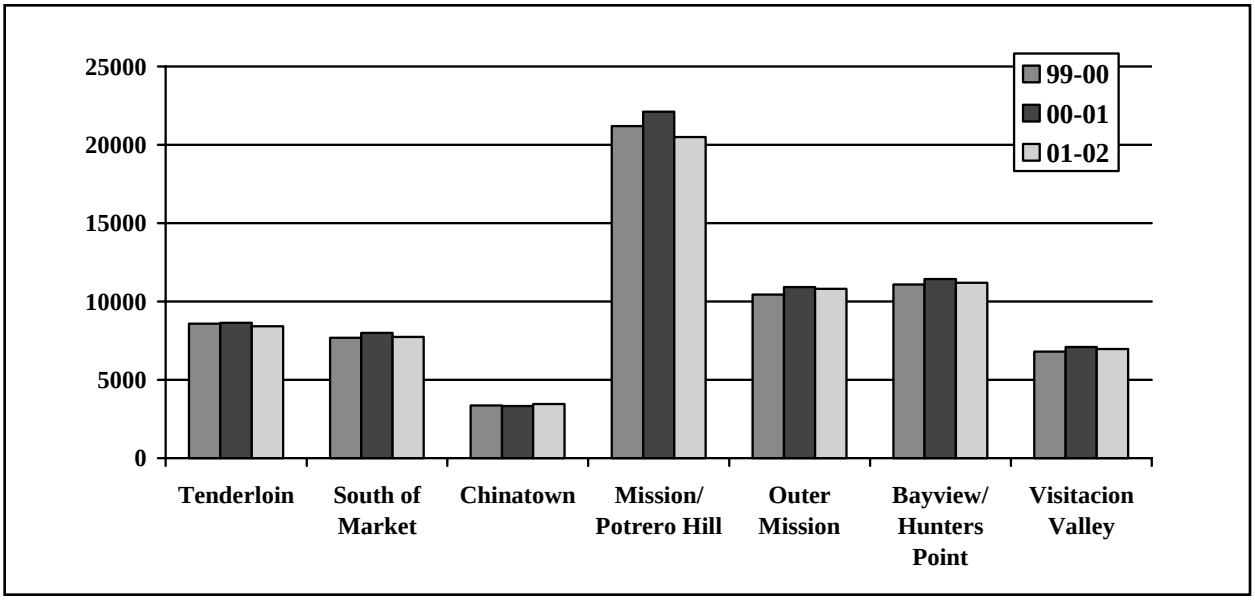
SFGHMC's patient population continues to have a high percentage of ethnic minorities (69%): 29% are Hispanic, 21% are African American, and 19% are Asian Pacific Islander. African Americans and Hispanics make up a greater proportion of the SFGHMC patient population than their respective proportion of the City's population.



Target Neighborhoods:

SFGHMC maintained its commitment to residents from Bayview/Hunters Point (94124), Chinatown (94108 and 94133), Mission /Potrero Hill (94110), Outer Mission (94112), South of Market (94103), Tenderloin (94102) and Visitation Valley (94134). Nearly 60% (n=53,814) of SFGHMC patients resided within these neighborhoods, the largest number being from the Mission/Potrero Hill area. SFGHMC patients represent 21% of all people living in the Tenderloin, 60% of South of Market residents, 5% of Chinatown residents, 25% of those living in the Mission or Potrero Hill, 12% of Outer Mission residents, 40% of residents of the Bayview/Hunters Point area, and 16% of Visitacion Valley residents.

Number of Patients by Neighborhood

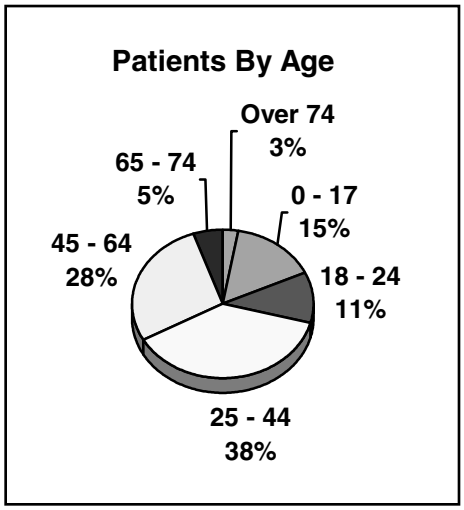


Children:

The number of children (under age 18) treated at SFGHMC comprised of 15% of the total patient population, the same as in Fiscal Year (FY) 2000-2001. Over 88% were ethnic minorities - 45% of children seen were Hispanic, 25% were African-American and 18% were Asian/Pacific Islander. Nearly 75% resided in one of the targeted neighborhoods (23% from Mission/Potrero Hill, 18% from Bayview/Hunters Point, and 13% from the Outer Mission). 40% of children seen were uninsured on at least one encounter during the fiscal year.

Frail Elderly:

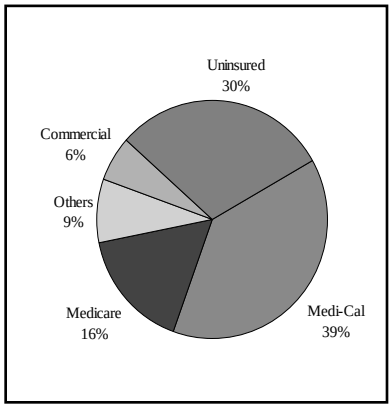
The proportion of frail elderly (over age 74) treated by SFGHMC increased by 2% from FY 2000-2001 to 3% of the patient population. Over 71% were ethnic minorities, of which 34% were Asian/Pacific Islander, 15% were African-American and 22% were Hispanic. Over 61% resided in one of the targeted neighborhoods, however, 5% were homeless during at least one of their encounters. 20% of the frail elderly were uninsured on at least one encounter during the fiscal year.



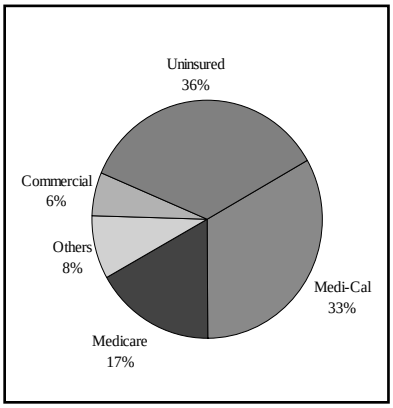
Uninsured:

57% of all SFGHMC patients were uninsured at some point during the year. 39% of acute inpatients, 52% of outpatients, and 64% of emergency department patients were uninsured. While the percentage of uninsured inpatients has remained unchanged for three consecutive years, non-sponsored acute days increased by 4% from last fiscal year to 30%. 36% of total outpatient clinic visits were uninsured, a decrease of 1% from last fiscal year. Uninsured Emergency Department (ED) visits decreased by 4% from last fiscal year, to 55% of total ED visits.

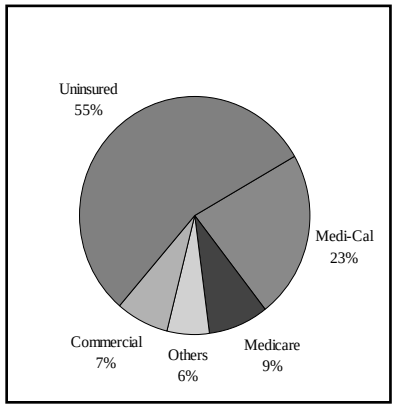
Inpatient Discharges: 17, 091



Outpatient Clinic Visits: 415,743



Non-admit Emergency Visits: 48,019



Homelessness:

9% or 8,547 of SFGHMC patients were homeless, defined as being on the streets at the time of his/her encounter, a 5% decrease from last fiscal year. They represent 22% of acute inpatient days, 6% of clinic visits, and 17% of emergency visits.

Strategy: Ensure that the Community Health Network Continues its Vital Role in the Delivery of Health Care.

Goal 1: San Franciscans have access to health services they need, while the Department emphasizes services to its target populations.

Level 1 Trauma Services

SFGHMC is the only Level 1 Trauma Center available for the over 1.5 million people living and working in San Francisco and northern San Mateo County. Approximately 2800 adult and pediatric patients per year are treated for injuries requiring the services of the Trauma Center.

In August 2001, the San Francisco Health Commission adopted a resolution accepting the City and County of San Francisco Trauma Care System Plan in compliance with California Title XXII trauma center designation regulations and American College of Surgeons trauma center verification standards. The plan was approved by the State of California Emergency Medical Services Authority in September 2001. SFGHMC is preparing for a site visit and local designation process for Level 1 Trauma Centers scheduled for 2003.

The Trauma Program implemented various enhancements in FY 01-02, including 1) hiring three trauma nurse practitioners to augment physician services and to assist in providing continuity of care, 2) hiring a Trauma Business Manager, 3) revising the trauma registry for enhanced data analysis and performance evaluation, 4) arranging with the University of California, San Francisco (UCSF) Department of Pediatrics for pediatric intensivist consultations, and 5) purchasing an ultrasound for use in the Emergency Department and portable ultrasound devices for the ICU.

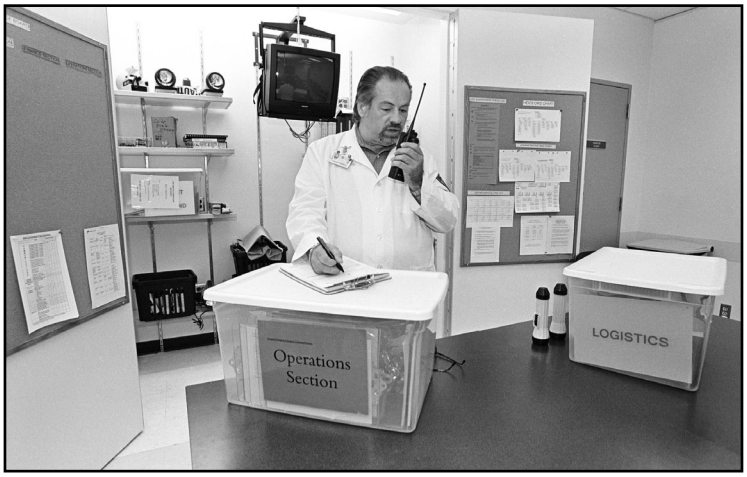
The Traumatic Brain Injury Program was initiated to optimize care for traumatic brain-injured patients. This program creates a continuum of care for these patients - from life saving efforts in the Emergency Department and Surgical Services, to the maximizing of day-to-day ability to function through rehabilitative care. Elements of the program would include around-the-clock attending neurosurgeon coverage to respond to all major resuscitations, continuity of care, and neuro-psychologist consults. These efforts should result in decreases in length of stay in critical care and advances in recovery of patients in acute units. So far, the program completed hiring of two nurse practitioners and a neuro-science clinical nurse specialist to provide continuity of care, and plans to add an additional neurosurgeon.

The Centers for Disease Control (CDC)-funded **Injury Center** at SFGHMC was reauthorized for a five-year grant. The Center brings together faculty from UCSF and beyond to collaborate in laboratory research, clinical trials, and injury prevention to improve outcomes for victims of trauma and to influence the field of injury control on a global basis. In October 2001, it released its fourth edition of "Profile of Injury in San Francisco," a collaboration with the Trauma Foundation. The top four causes of injury-related deaths in San Francisco listed were drug overdoses/poisonings (40%), motor vehicle/pedestrian crashes (14%), falls (11%), and firearms (10%).

Emergency and Disaster Response

SFGHMC, in collaboration with local and state experts in disaster planning, completed a hazard vulnerability analysis in February 2002. The analysis showed our greatest vulnerability areas as communication, Information Systems (IS) failure, and structural collapse and power failures. In response, new radios were purchased, a structural collapse drill was completed, and an IS Disaster Plan was developed

SFGHMC also continued to participate in annual Health and Medical Disaster Exercises coordinated by the California Emergency Medical Services Authority. In November of 2001, a functional exercise was held on the hospital campus to test its response to a chemical act of terrorism. Planning and participation for the exercise included representatives from the San Francisco Police Department (SFPD), including Special Operations, Special Weapons and Tactics, Bomb Squad, and Investigations; the San Francisco Fire Department (SFFD); SFFD Emergency Medical Services (EMS) and Hazardous Materials (Hazmat); Office of Emergency Services (OES); Auxiliary Communications Services; and the San Francisco Sheriff's Department. Hospital volunteers played the roles of victims of a chemical attack. A coordinated response between the hospital, police, fire and EMS worked to care for victims while protecting the hospital.



Pharmacy Services

Prior to the implementation of a Pharmacy Benefits Management (PBM) System in November 2000, the Outpatient Pharmacy at SFGHMC was the only access point for medically indigent adults (MIAs) to receive prescription benefit services. The large number of prescriptions processed daily (1,100 per weekday) and physical space limitations resulted in most patients having to wait 2 to 3 hours, sometimes as much as 6 hours, for prescriptions to be filled. Since its implementation, the PBM System proved to be effective in improving access and providing more timely prescription services to MIAs. A 12-month status report on the PBM system found that patients and providers highly favored and praised the PBM system. Ways of reducing cost are now being investigated.

Case Management

The Emergency Department Case Management Program (EDCM) is an intensive clinical case management program targeting patients who are high utilizers of the Emergency Department. EDCM has been effective in working with this largely homeless population, providing the critical linkages for medical care, housing, entitlements, and social services, as well as providing crisis intervention and individual and group counseling. The team is now comprised of social work case managers, a nurse practitioner, psychiatrist, and physician, allowing patients to receive integrated services. EDCM has been successful in reducing Emergency Department and inpatient visits, reducing hospital costs, while also improving quality of life for patients by arranging for stable housing, decreasing alcohol and substance use, arranging for additional financial entitlements, and improving linkages to primary care.

The program has been replicated by other hospitals in Seattle, WA, Denver, CO and Santa Clara County, CA. EDCM staff have been invited to present at the National Harm Reduction Conference in Seattle in December 2002 and plans to present to the Society for Social Work Leadership in Health Care in the Spring of 2003. The California Endowment and the California Healthcare Foundation has identified EDCM as one of 5 "Best Practices" in the country in their recent Health Services Initiative.

In addition, SFGHMC has established a **Medical High Utilizer Case Management Program** to focus on decreasing preventable admissions for patients frequently admitted or are at risk of frequent admissions to SFGHMC's inpatient units. The case management team would consist of physicians, psychiatrists, social work managers, and a public health nurse. As of June 2002, many of the staff have been hired, 24 patients have been screened and 10 enrolled.

Strategy: Improve integration of physical and behavioral health services for target, vulnerable, and at-risk populations who need multiple services

Integration of Medical, Mental Health, and Substance Abuse Services

A study of patients at SFGHMC, primary care clinics, and community mental health and substance abuse services found 55% of community mental health clients and 64% of community substance abuse services clients also used SFGHMC or primary care clinic services. In FY 2001-2002, SFGHMC created new programs and strengthened existing ones to create a stronger link between mental health, physical health, and substance abuse services.

Integrated Soft Tissue Infection Service (ISIS) Clinic

Prior to July 2000, the majority of patients with significant soft tissue infections (abscesses and cellulitis) were treated in the Emergency Department or admitted to the hospital. The ISIS clinic was created with the goal of providing appropriate, compassionate, efficient and cost effective care to patients with soft tissue infections. In addition to wound care, it provided integrated substance abuse referral and treatment services, on site counseling, and social services. After one year of operation, more than twice the original estimated numbers of clients were served (1,785). In this first year, annual hospital admissions with abscess or cellulitis as a primary diagnosis decreased 22%, and Emergency Department visits were reduced by 36%.

In FY 2001-2002, the clinic saw 2,383 patients and 4,112 visits. Hospital admissions with abscess or cellulitis as a primary diagnosis decreased 36% from FY 2000-2001, and Emergency Department visits for this patient population remained the same. Abscess or cellulitis dropped from being the number one most frequent inpatient diagnosis in FY 1999-2000 to the eighth most frequent diagnosis in FY 2000-2001 and to the tenth in FY 2001-2002.

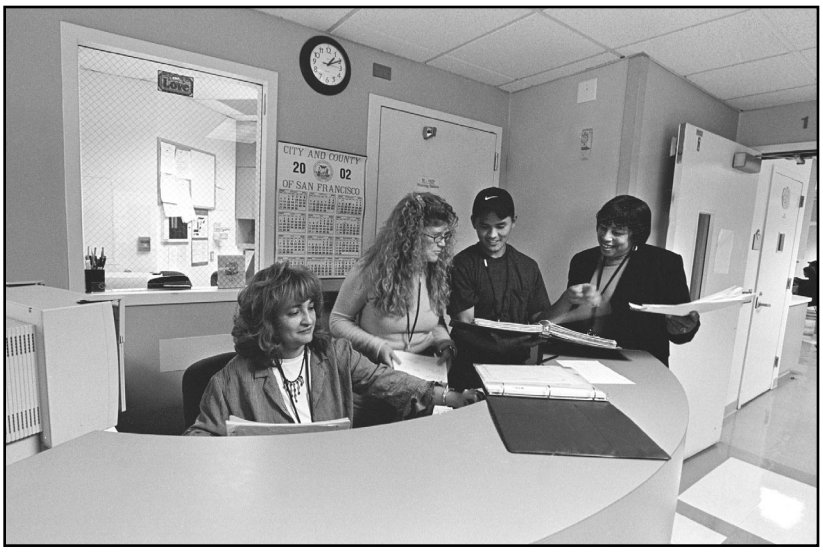
Medical-Behavioral Unit (MBU)

In January 2001, this unit was created to better facilitate integrated physical and behavioral health services for patients with complex needs. Common patient conditions seen in the MBU include alcohol withdrawal, behavior leading to 5150/5250 status, and neurologically impaired patients with traumatic brain injuries and dementia. An interdisciplinary team of practitioners includes substance abuse counselors, psychosocial consultation, a clinical nurse specialist, and medical and psychiatric social workers. The goals of the

MBU include improving patient safety by decreasing restraint usage and the rate of falls, decreasing the numbers of patients leaving without being discharged, as well as increasing staff competency around Safety Management and Response Techniques (SMART), psychotropic medications, and behavioral contracting.

Mental Health Rehabilitation Facility (MHRF)

The Mental Health Rehabilitation Facility is a 147 bed Distinct-Part Skilled Nursing Facility of SFGHMC whose mission is to provide long term care services to the sub-acute psychiatric population of San Francisco. The MHRF provides culturally competent diagnostic evaluation, treatment and biopsychosocial rehabilitation services to clients who have severe and persistent mental illness, whose symptoms may be refractory, or who may also experience problems with substance abuse. Primary care and health maintenance services are provided to psychiatric residents with urgent and chronic medical problems such as diabetes, hypertension, fractures, COPD or who have routine health care needs such as dental or eye care evaluations and treatment.



Treatment is based on a Biopsychosocial Rehabilitation Model designed to promote the development of skills that enable residents to achieve their highest level of psychiatric and physical functioning. It helps them gain and enhance their independent living skills as they prepare to transition to the next most appropriate level of care. Program components include skill development in socialization, symptom management, psychopharmacology, health maintenance, activities of daily living, substance abuse management and prevocational activities.

Service delivery is based on an interdisciplinary team, which includes the resident, his/her family and significant others, psychiatrists, nursing staff, social workers, activity staff, primary care staff and community based providers. The resident's personal goals and individualized needs serve as the basis for treatment planning.

Enhancements to the program in FY 2001-02 include:

1) Expanding its **Vocational Services** program from the General Store, in its 5th year of operation, to include a clothing project and development of a Health Resource Library for residents. Participants continue to graduate to work with the SFGHMC Volunteers Office, Community Vocational Enterprises and the Richmond Area Maxi Service Center.

2) Developing a model **Dual Diagnoses Program** that offers an integrated treatment approach to simultaneously address the problems created by mental illness and substance use. The program uses the newest techniques in treatment, including harm reduction and motivational interviewing.

3) The **Education Program** has established several community linkages through which residents attend ESL classes, obtain their GEDs or enroll at City College. A computer lab was established where residents learn computer skills and have access to the internet. An unexpected benefit has been that many residents have been able to re-establish contact with family members and friends through the Internet.

Substance Abuse Services

SFGHMC's Division of Substance Abuse and Addictive Medicine (DSAAM) within the Department of Psychiatry, in collaboration with Community Behavioral Health Services, provides addiction treatment to individuals who use, abuse or are dependent on drugs or alcohol. DSAAM operates under the principles of a collaborative model that integrates medical, psychiatric and addiction treatment.

The **Opiate Treatment Outpatient Program (OTOP)**, located in Ward 93, provides comprehensive substance use, psychiatric, and medical care to patients dependent on heroine. Due to changes in state legislation, OTOP was able to extend the length of stay from 21 days to 60 and 90-day programs, extending the period of methadone treatment available to SFGHMC patients. OTOP is working out final logistics and security issues for the launching of a new mobile methadone van. This van would expand access to methadone treatment for clients seen at two community sites: Walden House outpatient clinic on 15th and Mission, and the Institute for Community Health Outreach (ICHO) in the Bayview District. These sites are located in neighborhoods where heroine use is endemic and have established linkages with programs for substance using clients. OTOP also continues to play a pivotal role in the planning and development of the San Francisco "Office Based Opiate Addiction Treatment (OBOAT) Pilot Program," an innovative method of providing methadone treatment outside of the typical methadone clinic setting.

In July 2001, DSAAM, in collaboration with the St. Vincent DePaul Foundation, opened the Ozanam **Center Medically Assisted Detoxification Program**, a 16-bed unit to provide medical management of patients withdrawing from alcohol and other drugs. The Center is one of only three detoxification facilities that provide on site medical support 24 hours a day and seven days a week (the others being Baker Places 4th Avenue House, and Baker Places Fremont Place). During its first year of operation, over 300 patients were treated; most of who were referred from SFGHMC's Emergency Department, Psychiatric Emergency Services, and SFDPH community health centers. Upon opening the program, DSAAM also took on the responsibility of initially triaging clients being referred to any of three medically supported detoxification facilities. The intent of **centralizing triage** was to equalize access for all providers across the public health system seeking admission for their clients. Preliminary authorization to move forward with medical clearance is performed by a central contact person, and DSAAM reviews the case and makes a determination on the client's level of priority for the next available bed.

SFGHMC has also made progress in providing treatment for stimulant use. **The Stimulant Treatment Outpatient Program (STOP)** is an intensive outpatient program that provides counseling, treatment, and psychiatric services to clients who wish to abstain from the use of stimulants, such as cocaine, crack, or methamphetamines. Clients participate in group therapy five times a week and individual counseling once a week. Over the past year, STOP has experienced a greater demand for services, especially from clients with multiple diagnoses, lengthening their existing waiting list. In FY 01-02, STOP initiated three new client specialty groups – one focused on African American clients, another focused on Hispanic clients, and a third focused on spirituality. The program hired a senior resident in art therapy to provide this service to clients. Over 100 clients in FY 01-02 were treated through the program. **The Stonewall Project** is an outpatient harm reduction program that provides counseling and case management specifically to gay and bisexual men who use methamphetamines. In FY 01-02, Stonewall initiated an HIV prevention program funded by the Centers for Disease Control. The program established a web site called "**Tweaker.org**" created

by current and former methamphetamine users that provides tips on how to minimize the risk of HIV transmission and other harmful health effects from using methamphetamines. The program collaborated its outreach efforts with LYRIC and the Tenderloin AIDS Research Center.

Clinical Institute Withdrawal Assessment for Alcohol (CIWA)

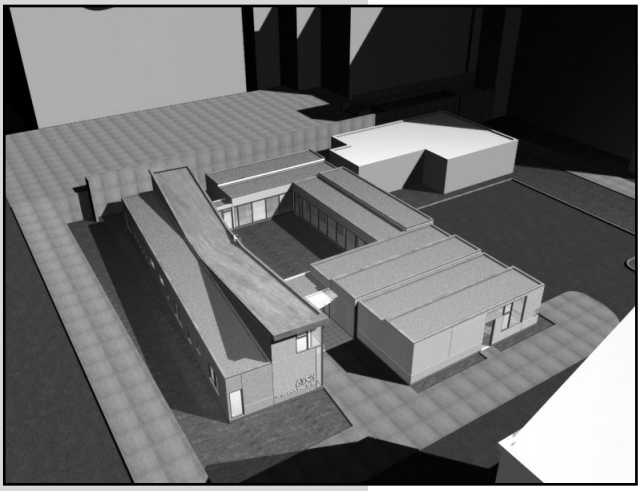
The development of acute alcohol withdrawal is a very frequent and challenging condition among patients hospitalized at SFGHMC. In late 1999, nurses and physicians recognized there was substantial variability among providers in the assessment and treatment of these patients. An ad hoc team of nurses, pharmacists, and physicians, including substance abuse specialists, convened to study the problem. They developed an education program to train nursing and physician staff in the use of a standardized alcohol withdrawal assessment tool (CIWA). Building on the foundation of consistent assessment of patients, the team developed and introduced innovative treatment guidelines and pre-printed orders that emphasized greater collaboration between nurses and physicians in the management of these patients. A more rational and standardized pharmacological approach was also developed. An educational campaign was launched in 2000, and the team continued to meet on a monthly basis to assess and build the program. After one year of implementation, an outcome analysis suggested improved outcomes for many patients, but unexpected and unintended problems for others. In 2002, the team identified the potential problems and revised the treatment guidelines. An updated educational effort is in progress and revised pre-printed orders are in place. The team also developed an intensive monitoring program to continue quality improvement interventions.

Goal 2: Disease and injury are prevented.

Strategy: Strengthen prevention activities of the Department.

Avon Foundation Comprehensive Breast Center

Breast cancer affects one of every eight women in the United States. It has been estimated that nearly 8,000 women between the ages of 40 and 79 would need mammography services in the City, primarily within the targeted neighborhoods of the Mission, Excelsior, and Bayview Hunters Point. SFGHMC's wait time for an appointment for a routine mammography has been as long as 100 days.



With a $12.2 million dollar gift from the Avon Foundation, SFGHMC, University of California at San Francisco's Comprehensive Cancer Center and Cancer Research Institute, and the SFGH Foundation collaborated in order to: 1) support clinical activities that would include SFGHMC's heterogenous breast cancer community of patients in breast cancer research underway at the UCSF Cancer Center; 2) provide equal access to the best breast care for medically undeserved women; and 3) develop new methods of educating patients about all aspects of breast care and treatment.

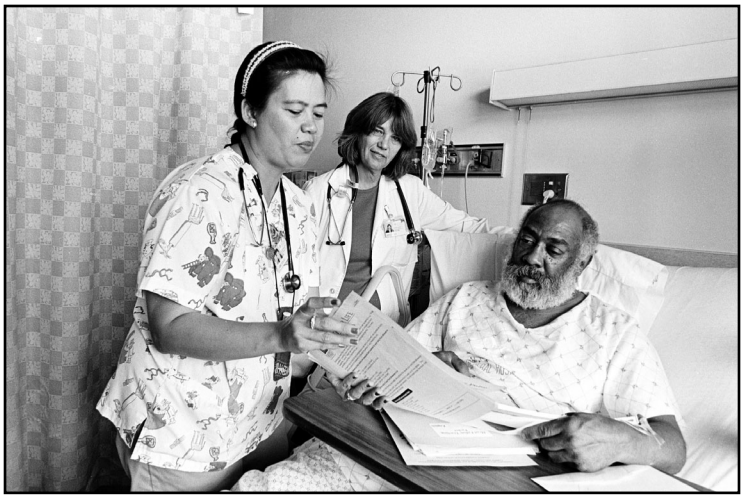
A significant portion of the funds would support new personnel, equipment and the construction of a 4,000 square foot facility at SFGHMC. This facility would allow for the provision of an additional 5,000 annual mammograms and for expansion into new service areas of stereotactic core biopsies and vacuum assisted large core ultrasound breast biopsies. State-of-the-art digital mammography machines have been purchased, giving San Francisco's most

vulnerable women access to world-class service. Construction of the modular building is scheduled to begin in January 2003 with a planned May 2003 opening.

Baby Friendly Initiative

The Perinatal Service developed a nursing education plan to meet the World Health Organization Baby Friendly Certification requirements. The goal of the certification is to increase the number of breast fed babies at the time of hospital discharge. A SFDPH kick off on January 11-12, 2002 focused on the social dimensions of breast-feeding and were taught by personnel from the Best Start Program. The core curriculum of the Baby Friendly program was completed in May 2002 and the Mother-Baby Dyad Care Model was implemented in June 2002. Currently, the mother and baby receive care in different locations (i.e., postpartum unit and nursery unit). Implementation of the new care model would result in one nurse caring for the mother and baby as a couplet in the postpartum area.

Inpatient Health Education



SFGHMC conducted its annual Patient Evaluation of Performance in California (PEP-C) survey to identify areas for quality improvement in inpatient services. The survey was mailed to patients after discharge and was available in English, Spanish, and Chinese. 151 patients responded to the survey, and identified inpatient health education as an area needing improvement. In February 2001, SFGHMC revised medical records forms to focus on patient/family learning preferences and health education. Staff were trained in techniques to assess educational needs, use of alternative teaching strategies, and methods for assessing a patient's understanding of the health information.

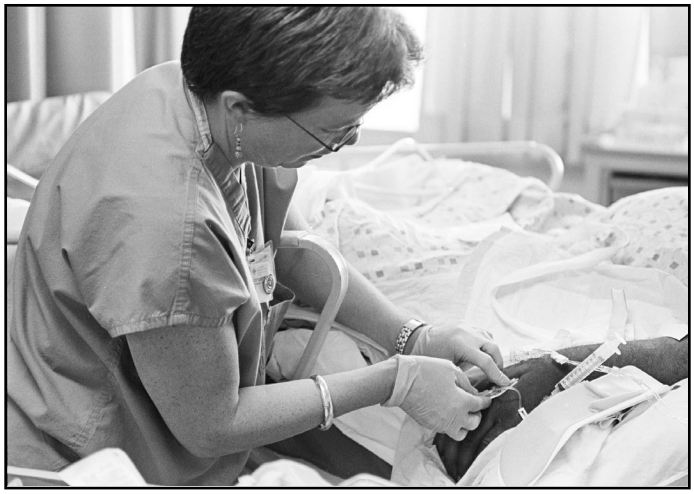
Patient Safety Programs

Patient Improvement and Safety Program (PIPS)

In the beginning of FY 2001-2002, the Quality Utilization Management Committee was reorganized into the Performance Improvement and Patient Safety Program (PIPS) to further focus on patient safety processes and programs. The objectives of the PIPS program are to:

- Promote a uniform monitoring and evaluation process for performance improvement and patient safety activities;
- Promote the involvement of care providers in defining quality, establishing standards, and developing mechanisms to monitor, evaluate, and improve the processes and patient outcomes;
- Promote a culture geared toward proactive risk assessment to reduce errors and reporting of medical errors and adverse events;
- Prioritize initiatives to enhance patient outcomes/safety based on analysis and assessment of the data, and in accordance with the organization's mission, vision, care and services provided, and the population served;

- Facilitate an interdisciplinary, collaborative approach to improving the quality of care, patient safety, and utilization of resources through the designation of continuous performance improvement and patient safety initiatives;
- Guide SFGHMC in meeting legal, professional, accreditation, and regulatory requirements; and
- Provide education and communication on performance improvement principles and tools.

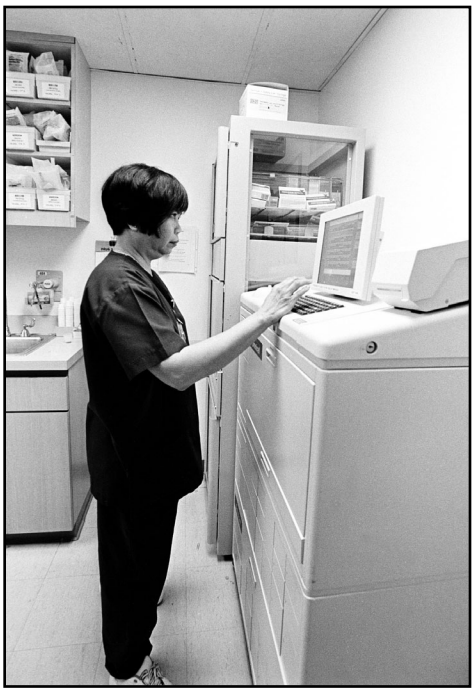


In October 2001, PIPS determined that the need to reduce adverse drug reactions and events was an important patient safety indicator to more proactively monitor and analyze. PIPS advocated for the purchase of a computerized provider order entry software as a means to further reduce adverse drug reactions.

In addition, a web-based system for reporting and monitoring of unusual occurrences was implemented in November 2001. With enhanced reporting capabilities, the web-based database increases the ability for Risk Management staff to monitor adverse events and identify patterns and trends.

Reducing Medication Errors

SFGHMC is using enhanced technology to decrease the chance of medication error by **upgrading automated dispensing machines (ADMs)**. Phase I of the upgrade was completed in March 2002 which improved reporting capability and control of medication dispensed through ADMs. The **emergency dispensing report** would be utilized by the Medication Use and Safety Subcommittee (MUSS) of the Pharmacy and Therapeutics Committee to monitor appropriateness of drug use and ensure that the right patient received the right dose and route of medication at the right time. This would augment review of systems and procedures already in place to decrease the chance of medication error occurrence. Improved **controlled substance use reports** allow for tighter inventory control and closer scrutiny of patient usage patterns. Units with traditionally high floor stock use now incorporate floor stock medication into their unit-based ADMs, enhancing control and supporting appropriate use of these drugs. When phase II of the upgrade was completed in June 2002, nurse managers were able to view and print reports of ADM activity, controlled substances use activity, and emergency drug use activity on their unit-based systems. This should increase timeliness of problem identification so that systems changes can occur to further improve safety and patient care.



SFGHMC also established a **Clinical Pharmacy Management Program** to minimize the inappropriate use of antibiotics and antimicrobials, thus decreasing cost and reducing hospital length of stays. The program initiated several prevention strengthening endeavors, including:

- Recruited and hired a Medication Use and Safety Officer position to improve patient safety and reduce medication errors.
- Established an adult asthma clinic at Southeast Health Center to improve patient adherence to prescribed asthma treatment and inhaled steroids, and adding a clinical pharmacist to the SFGHMC Adult Asthma Clinic team.
- Recruited and hired a clinical pharmacist specializing in infections to improve inpatient antibiotic use and decrease cost.
- Provided core team and leadership for establishment of a DPH-wide Pharmacy Bioterrorism Workgroup

Violence Prevention and Treatment Programs

Zero Tolerance for Violence in the Workplace

SFGHMC took several steps to ensure that the hospital provided a safe and secure environment of care for the community, employees, volunteers, patients, and visitors. SFGHMC developed a policy of zero tolerance for violence in the workplace, approved in August 2002.

SFGHMC employs an Institutional Police (IP) Department to provide total security to the Medical Center. In October 2001, the Department of Public Health entered into a memorandum of understanding with the San Francisco Sheriff's Department to pilot transferring oversight responsibilities for the Institutional Police to the Sheriff's Department. The transferring of oversight made positive improvements in leadership, training, morale, security management, and a reduction in crime statistics.

Also in 2001, an SFGHMC Management Response Team merged with one at the Departmental level to form a campus-wide Security Management and Response Team (SMaRT) to oversee security issues and conduct security assessments. Security improvements identified by the team and are in process include establishing a cardkey swipe badge system, upgrading panic alarm systems, and personal alarm systems for the MHRF. SFGHMC also established an Infant Security Task Force, which instituted a "Code Pink" response plan to alert staff immediately in cases of infant theft. The Well Baby and Intensive Care Nurseries are under a Secure Lock program, and SFHGMC is looking towards doing the same for Labor and Delivery.

Due to a rise in cases of patients assaulting staff in the acute psychiatric wards and the MHRF, SFGHMC implemented management and response training specific to working with psychiatric patients. Called SMART (Safety Management and Response) training, staff are provided a 4 hour training session every 2 years, which includes review of defensive and containment maneuvers and verbal de-escalation skills. IP are also given SMART training; a Memorandum of Understanding has been developed to clarify the roles of police and staff when intervening in violent situations. SFGHMC also refurbished inpatient units to provide a more homelike environment for patients as a means to reduce assaults, established specialized treatment plans for patients exhibiting violence, and provided a psychotherapist specializing in Post Traumatic Stress Disorder to provide assault counseling to staff.

Trauma Recover Center

In FY 2001-2002, SFGHMC launched a new Trauma Recovery Center (TRC). The Center serves as a 4-year demonstration project to increase access to mental health and clinical case management services for victims of interpersonal violence (e.g., domestic violence, sexual assaults, gunshot injuries, stabbings) using a multi-disciplinary team of nurse practitioners, social workers, psychologists and psychiatrists. The Center includes a research component to evaluate if the services are clinically and cost effective and is committed to the training of other health care providers in the identification and treatment of traumatized individuals. During its first year of operation, the Center provided clinical services to more than 600 victims of interpersonal violence.

Goal 3: Services, programs, and facilities are cost-efficient and resources are maximized.

Strategy: Continue to adapt a financial strategy that enhances revenue and reduces expenditures to ensure that the overall public health system operates cost-effectively.

Improvements in Patient Flow

A **Discharge Lounge** was established in December 2000 as a safe place for patients being discharged to wait for medications, transportation, and social services support instead of occupying an acute bed. This expedites bed availability for newly admitted patients. In FY 00-01, the Discharge Lounge served approximately 5% of all discharges. In FY 01-02, the Discharge Lounge was extended to include outpatients waiting for transportation and social services support.

SFGHMC also expanded the number of budgeted beds and admission hours at its skilled nursing unit, increasing the ability of Utilization Case Managers to discharge patients into a lower level of care. Budgeted beds for skilled nursing increased from 20 to 28 beds. Admission hours for the SNF were extended to 7 days a week, 24 hours a day. Average daily census increased from 23 last year to 27 this year, with an average of two bed holds. In FY 2001-2002, 328 patients were cared for, with an average length of stay of 24 days.

Utilization Review

The **Utilization Review Department** is responsible for performing admission and continued stay reviews, to ensure that patients receive timely, appropriate and medically necessary services in a cost effective manner. Deviations are reported to departments for corrective action plans. This year noted a 46% decrease in decertified days from last year. Less than 2% of SFGHMC non-Psychiatric acute bed days were decertified.

SFGHMC also established a **Bed Utilization Committee** to review patient flow data and develop strategies to decrease patient backups in acute care, emergency, and critical care. Strategies for more appropriate discharge included: instituting a daily review of patients admitted to various levels of care; closer communication with social services, utilization review, and direct care providers; implementing an Admission/Discharge Roving Nurse position during peak hours; instituting a Code Yellow and Red policy and procedure to focus resources during time when bed demand exceeds supply; and scheduling Medicine Service teaching at later times to facilitate earlier discharge orders.

Mental Health Patient Flow Pilot

SFGHMC established a formal collaboration with Community Mental Health Services (CMHS) to improve the placement of mental health patients at the appropriate level of care within psychiatric emergency services, acute psychiatry, the MHRF, and community treatment facilities. The collaboration resulted in identifying staff to conduct utilization review, conduct discharge meetings with social workers, and facilitate placement of mental health clients into long term care and community treatment facilities. Evidence of the success of this pilot was the increased flow of patients through the MHRF and acute care services. Comparing FY 2001-2002 to FY 2000-2001, the number of admissions and discharges increased by 13% for the MHRF and 8% for acute psychiatry. The average length of stay decreased by 13% for the MHRF and 9% for acute psychiatry.

Strategy: Make Overall Improvements in Financing and Operations

Efforts to Maximize Revenue

In Fiscal Year 2000-2001, SFGHMC was able to receive an increase in Medi-Cal rates from the State as determined by the California Medical Assistance Commission (CMAC). SFGHMC also conducted an independent review in December 2000 of the Health Information Services department and hospital coding activities to capture all areas of missed or potential billing opportunities. In FY 2001-2002, SFGHMC continued this work of capturing all patient charges and devising ways to effectively bill and collect. Accomplishments included:

- SFGHMC conducted an evaluation of its Nuclear Medicine Department in February 2002, enabling the Department to increase its productivity and revise its procedures for billing isotope charges to enable pass-through payments from Medicare and Medi-Cal.
- SFGHMC hired a new contractor to conduct eligibility outreach to enroll patients onto Medi-Cal and other insurance plans. The new contractor has surpassed the average monthly production of its predecessor firm.
- SFGHMC established a task force to review and reorganize the charge capture process in the clinics and ancillary departments to ensure that all encounters are billed, all charges are submitted by eligible providers, ICD-9 codes are in place for all tests to support billing, and medical supply charges are uniformly captured.
- A benchmarking study of pricing at other California hospitals resulted in increasing SFGHMC pricing by 27% overall.

Pharmaceutical Cost Containment

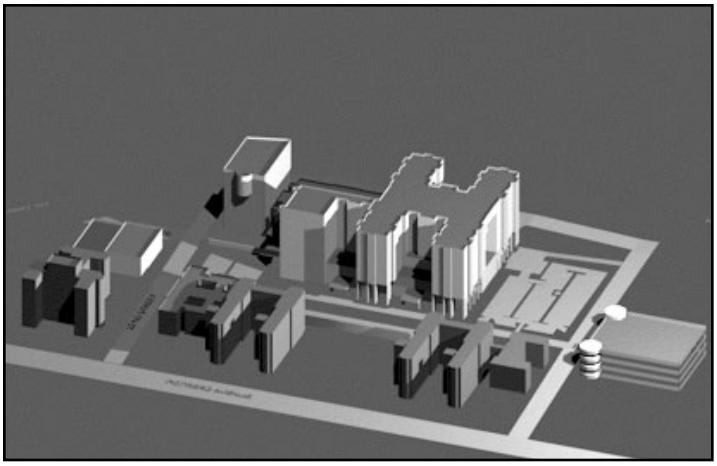
With pharmaceutical costs projected to increase by 18% next year, the Department of Pharmaceutical Services actively pursued initiatives to reduce or maintain current spending. The Department began optimizing its participation in **Manufacturer's Patient Assistance Programs (MPAPs)** in FY 2001-2002. These programs, administered by pharmaceutical companies, offer select drugs at no charge to indigent patients that meet eligibility criteria and fill out an application. With the aid of pharmacy technicians to fill out applications and getting patient consent at the time of admission to apply for MPAP's, the pharmacy began systematic pursuit of these free drug programs for CHN indigent patients. The return on investment could potentially save $500,000 or more in 2002, and has potential for increased annual cost savings in subsequent years. Also, legislation went into effect in January 2002 allowing Federally Qualified Health Centers (FQHC) and FQHC look-alikes to purchase drugs through the **Federal 340 B drug pricing program** in the absence of an on-site pharmacy. This new legislation permits clinics to contract with a single pharmacy to dispense drugs legally owned and purchased by the clinics at Federally discounted prices. The potential of such an arrangement to contain pharmaceutical costs is significant, and is preferable to either limiting the drug formulary or more

severely restricting access to prescription services. Considerable effort has gone toward implementation of this model for outpatient prescription services provided to indigent patients. Work has also continued on revising a demonstration project proposal to the Federal government using the current PBM model to participate in the 340 B program for outpatient prescription services. The demonstration project would not be necessary, however, if implementation of the model made possible by the new legislation occurs. Requests for proposals (RFP) from community pharmacies and third party administrator services necessary for implementation of the new model were published in November 2002.

Improving Infrastructure at SFGH

SFGHMC Rebuild

In 1996, California passed Senate Bill 1953, mandating that all California acute care hospitals meet new seismic safety standards by 2013 or face shutting down its services by 2008. In January 2001, the Health Commission approved a resolution to support the effort, and the Department of Public Health conducted a series of planning meetings to review its options. It became evident that rebuilding rather than retrofitting was required, and that rebuilding SFGHMC presented a unique opportunity for the Department to make system-wide as well as structural improvements in its delivery of care for patients in 2013 and beyond.



From February through July 2002, SFGH underwent a Long Range Service Delivery (LRSD) process with the assistance of the Lewin Group. Building on the first phase of the SFGHMC Rebuild planning that focused primarily on meeting SB 1953 mandates, the LRSD broadened the discussion within the context of the overall delivery system, incorporating the SFDPH strategic goals and priorities and predicted future health care needs for San Francisco. The plan, which was approved by the Health Commission on July 16, 2002, is being used to provide the programmatic guidance for the SFGHMC Institutional Master Plan (IMP). Major recommendations of the LRSD included:

- The SFDPH should continue discussions with UCSF to collocate SFGHMC and UCSFMC hospital capacity at Mission Bay. In the meantime, SFGHMC should move forward with planning for rebuilding SFGHMC at the current Potrero Avenue site.
- The SFDPH should expand community based ambulatory care services. The SFDPH should explore the feasibility of including its financing as part of the bond measure for the SFGHMC rebuild.
- The SFDPH should adopt the following program changes for the future of SFGHMC, and where

necessary, conduct financial and Institutional Master Planning analysis:

- Shifting capacity for 30,000 to 40,000 primary care visits from the SFGHMC campus to the CHN Community Primary Care Clinics. Organizing ambulatory care on the SFGHMC campus as a "SuperClinic"
- Expanding the SFGHMC Level I Trauma Service by serving additional areas of the Bay Area region and developing a medical air transport system
- In the rebuild of SFGHMC, increase the physical capacity of the SFGHMC Emergency Department to meet current visits to treatment station standards
- Develop programs and services to retain the elder patient population and insure that the rebuild of SFGHMC supports elder care
- Explore a partnership with UCSF that allows consolidation of inpatient pediatrics and obstetrics services

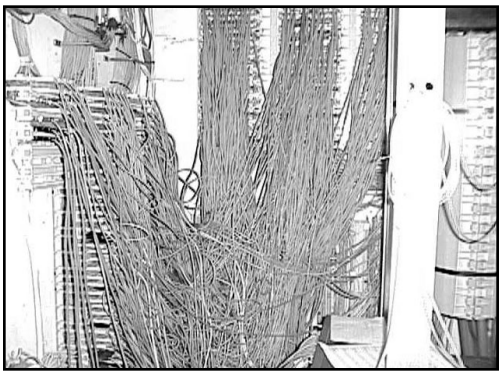
Information Systems

The Information Systems Department has increasingly played a role in improving access to patient care, providing more immediate access to patients' health information, supporting quality management and research activities, and improving the financial stability of the department.

In conjunction with SFGHMC's goal to reduce medication errors, a project to implement **Computerized Provider Order Entry (CPOE)** was started in March 2002. The objectives of the project are to improve patient safety by reducing the number of adverse drug events, increase the timeliness of care, promote better use of current medical knowledge, and improve coordination of care. This system would dramatically change the way providers, pharmacists and nurses do business. Extensive workflow analysis is underway, and the project is expected to go into a pilot unit in the summer of 2004.

Other accomplishments in IS include:

- A Citywide E-mail project was initiated in August 2001 to migrate to Lotus Notes.
- In January 2002, the network staff in conjunction with SBC Datacomm embarked upon a massive



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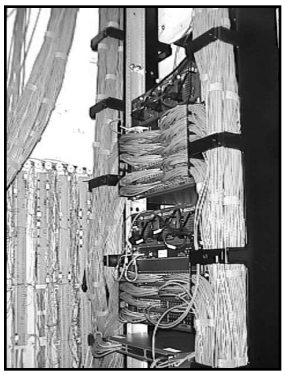


After

network upgrade. A state-of-the-art switch technology was acquired to: (1) Satisfy HIPAA requirements for network security and patient information privacy; (2) Improve network performance; and (3) Prepare for the bandwidth-intensive demands required to converge voice, data and images.

- A comprehensive **I/S Disaster Plan** was completed in February 2002. The I/S Steering Committee approved a list of "System Priorities in the Event of a Level 1 or 2 Emergency" that would be used to reinstate systems after an event has occurred. In addition, a "Unit-Based Disaster Plan" template was developed to assist departments in preparing for computer outages.
- **Re-engineering Patient Access**: In March 2002, a Sophisticated Matching Algorithm (SMA) was added to improve our ability to find the correct patient when they present for services. Patient insurance information and history will also be available enterprise-wide.
- Clinical system enhancements were made to the **Lifetime Clinical Record** to enable mammography tracking, chemotherapy tracking, and the availability of the Medicare Secondary Payor form.
- The introduction of a **Voice Recognition system** in the Radiology Department has dramatically changed the turnaround time for results availability to physicians. For the third quarter in 2001, 14% of results were available within 24 hours. For the fourth quarter, 2002, 71% were available within 24 hours, 40% of those being available within 4 hours.

Strategy: Improve Recruitment, Retention and Training of Staff

Staff Recruitment, Retention, and Training

Nursing

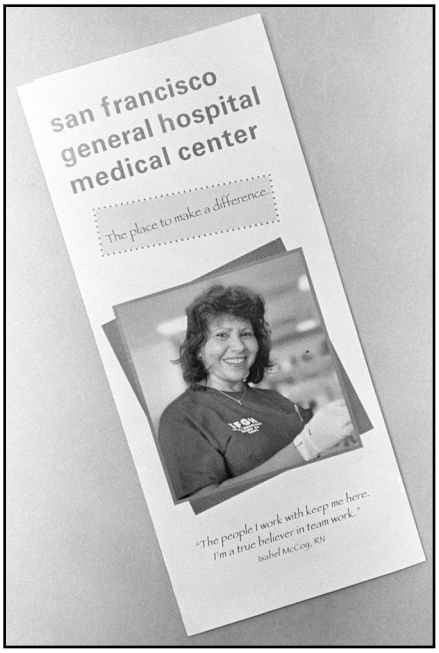
The State of California currently faces one of the worst nursing shortages in the nation – it is ranked 49th in the number of registered nurses per capita. The number of nursing FTE's at SFGHMC is 1,363 - the total number of nurses hired in FY 2001-2002 was 154 (57 per diem and 97 permanent hires).

To address this issue, the Nursing Retention and Recruitment Committee was convened in September 2001 to promote the retention and recruitment of nursing staff through activities and programs that: 1) enhanced organizational communication, 2) promoted professional development, 3) promoted job satisfaction, and 4) promoted participation in nursing organizational decision making.

In Fiscal Year 2001-2002, the Committee:

- Enhanced organizational communication by facilitating open staff meetings with the Chief Nursing Officer to share information affecting nursing practice as well as personnel issues.
- Promoted professional development by establishing professional contact with the LVN Refresher program at City College, and participated on their LVN Advisory Committee. Established a mentorship program for new graduate LVN's and RN's.

- Completed a campus wide Nursing Satisfaction Survey that got feedback from 364 nurses working in critical care, clinics, the Emergency Department, Acute Perinatal, Medical-Surgical units, MHRF, Perioperative Services, and Psychiatry. The survey was able to identify the satisfaction level of nurses within each service and general job title on a multitude of issues, such as salary, workload, and quality of care delivered.
- Participated in a Nurses Week Celebration in May 2002, which included a presentation by the President of the American Nurses Association, Mary Foley, and a reception sponsored by SFGHMC for nurses and students. The Executive Director of the California Board of Registered Nursing, Ruth Ann Terry, addressed the reception on the status of nursing in California.



As a result of the Committee's work, the turnover rate for RNs at SFGHMC was 7% for 2001, compared to the national average of 16.3%.

Training programs conducted this year included the Emergency Department, Critical Care, Critical Care Stepdown, Birth Center, Medical-Surgical Nursing, Acute Psychiatry, and Mental Health Rehabilitation Nursing.

Employee Performance and Competency

Employee competency at the Department of Public Health is tracked annually through reviewing performance appraisals. Competency is defined as the employee's ability to perform a particular job in a specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, and demonstration of skills and behaviors.

As of October 31, 2002, 98% of performance appraisals for City and County employees were completed. Analysis of these appraisals showed:

Patient Care (1,333 staff): 98.8% of staff exceeded or met the standards.
Clinical Support (303 staff): 99.5% of staff exceeded or met the standards.
Environmental Support (288 Staff): 99.7% of staff exceeded or met the standards.
Administrative Support (336 staff): 97.6% of staff exceeded or met the standards.
University of California (858 staff): 99.2% of staff exceeded or met the standards.

Medical Staff Services Department (MSSD)

The Medical Staff Services Department supports the activities of the organized Medical Staff at SFGHMC. Its responsibilities include performing the credentialing function for the appointment and reappointment process. In Fiscal Year 2001-2002, MSSD appointed 156 providers to SFGHMC's Medical and Affiliated Professional Staff and reappointed 543 providers.

Goal 4: Partnerships with communities are created and sustained to assess, develop, implement, and advocate for health funding, programs, and services.

Strategy: Develop Opportunities to Partner with Other Providers and the Community on Common Health Issues.

Alternatives to Inpatient Care

Health at Home (HAH) has been delivering home health services to residents throughout the city of San Francisco for the past seven years. Following its first year of adhering to new rules of a federally-mandated prospective payment system for home health agencies, HAH has been able to reorganize its operations and improve efficiency by increasing visits by 11% from the prior year, reaching a level of nearly 20,000 visits.

The diversity of clients served by the agency mirrors the population seen at SFGHMC. The primary neighborhoods in which 70% of HAH clients reside are the Tenderloin, Excelsior, Outer Mission, Visitacion Valley, Potrero Hill, Bay View Hunters Point, and the Mission districts of San Francisco. HAH has been able to meet the diverse language needs of its clients through a combination of utilizing 50% of its own staff who speak languages other than English and the use of interpreter services vendors for emergencies.

A distinct client group served by the agency is **HIV-infected individuals**. CARE funds received since 1998, along with City General Fund dollars allow HAH to care for growing numbers of HIV diagnosed clients. This group constitutes almost 25% of all clients receiving care from HAH. HAH partners with the members of the HIV Nursing Network, Positive Health Program (Ward 86), AIDS Health Project and other community agencies to provide coordinated care to clients. Most clients will have mental health or drug misuse problems that prevent effective management of their HIV disease. HAH will help support their primary care relationship and help them to access other community resources

In addition, **pediatric home care services** are provided through referrals from California Children's Services (CCS) for children (under the age of 21 years) with specific physical limitations and medical conditions. HAH is just beginning to expand its services to this target group in 2002, utilizing home care nurses, physical and occupational therapists and medical social workers

HAH also provides **Palliative Care and Continuing Care** services to clients who have reached their goals and have been discharged from the home health service, but still need to reach a level of stabilization in order to prevent re-institutionalization. A special team of providers, the Agency's palliative care team, is made up of individuals who provide compassionate, culturally sensitive, and language-specific care to the dying patient, who either cannot or does not want to choose hospice. This team consists of a physician consultant, nurse, social worker bereavement coordinator, and home health aide who support the client with services ranging from relief of pain and proper personal care to counseling of families before and after the patient's death.

In March 2002, the HAH Palliative Care Team of multidisciplinary and multi-cultural staff, received a SFDPH employee recognition award for their exceptional care to individuals at the end of life. Linkages are made by home care staff with palliative care services at Laguna Honda Hospital and with the Oncology Clinic on Ward 86 at SFGHMC. Nearly 3000 visits were provided to palliative care clients.

The **Bridge to Wellness Program (BTW)** is designed to provide alternatives to inpatient hospitalization, decrease length of stay and increase the level of functionality of patient with mental disorders. It is an outpatient adult psychiatric program that provides two different levels of care to patients with serious and persistent mental health conditions - a **Partial Hospitalization Program (PHP)** and an **Intensive Outpatient Program (IOP)**. PHP is designed to decrease the length of inpatient hospitalization, reduce acuity of symptoms and functional impairments, avert psychiatric hospitalization, and offer transitional treatment back into community life. IOP is designed to reduce or control the patient's symptoms to prevent relapse requiring a higher level of care. In FY 01-02, BTW had 172 admissions, 65 for PHP and 107 for IOP. 3% of patients were referred from acute inpatient psychiatry and 1% were from the Mental Health Rehabilitation Facility.

Of 93 patients that successfully transitioned out of BTW this year, 100% of its clients showed an increase in functioning level and decrease of symptoms. 100% were linked to community resources at discharge, and 83% of patients were linked to housing. In a patient satisfaction survey, 89% of all respondents indicated that they were 'satisfied' or 'highly satisfied' with the services provided. At least 85% of all patients complete these surveys.

1. Develop the Facility Master Plan for the Rebuild of SFGH

In 1996, California passed Senate Bill 1953, mandating that all California acute care hospitals meet new seismic safety standards by 2013 or face shutting down its services by 2008. In January 2001, the Health Commission approved a resolution to support the effort, and the Department of Public Health conducted a series of planning meetings to review its options. It became evident that rebuilding rather than retrofitting was required, and that rebuilding SFGH presented a unique opportunity for the Department to make system-wide as well as structural improvements in its delivery of care for patients in 2013 and beyond. From February through July 2002, SFGH underwent a Long Range Service Delivery (LRSD) process with the assistance of the Lewin Group, which reported to the Health Commission initial projections of service needs and introduced several potential scenarios for rebuilding, such as co-locating or sharing services with UCSF at Mission Bay, and consolidating with or shifting ambulatory care services to community clinics. Currently, SFGH has contracted with the architectural firm of SOM/Tsang and Kurt Solomon Associates to devise an institutional master plan, firming up the data generated from the LRSD to get a more accurate projection of need for acute care beds, exam rooms, and diagnostic and treatment services for years 2005, 2010, and 2015. The plan also involves narrowing down options for re-configuring services in order to develop a bond measure to subsidize the effort.

2. Complete Level 1 Trauma Designation Approval Process from the American College of Surgeons (ACS).

In August 2001, the San Francisco Health Commission adopted a resolution accepting the City and County of San Francisco Trauma Care System Plan in compliance with California Title XXII trauma center designation regulations and ACS verification standards. SFGH is the only Level 1 Trauma Center available for the over 1.5 million people living and working in San Francisco and northern San Mateo County. 2800 adult and pediatric patients a year are treated for injuries requiring the services of a Level 1 Trauma

Center. Last November, ACS conducted a consultative visit with a team of trauma surgeons, a neurosurgeon, and a trauma program coordinator, to prepare SFGH for re-verification and designation as a Level 1 Trauma Center. The team identified documentation of education, trauma certifications, multidisciplinary physician peer review, and continuity of patient care as areas for improvement, as well as the lack of aero-medical access as a key vulnerability in San Francisco's trauma system. SFGH is preparing for an ACS re-verification site visit and local designation process in 2003, as well as assessing the feasibility of aero-medical access (see below).

3. Complete the Helipad Feasibility Study and Plan for Medical Air Access.

San Francisco and its Level 1 Trauma Center are the only locations within the top 25 municipalities in the United States without aero-medical access for the people who live, work, and recreate in the city. The inability to air transport patients into and out of San Francisco and its Trauma Center compromises SFGHMC's ability to respond to critically injured patients whose needs are best served at a Level 1 Trauma Center. To better respond to all trauma patients within this region and maintain American College of Surgeons verification as a Level 1 Trauma Center, SFGH is conducting a needs assessment and feasibility study to determine the need for aero-medical access and if a helipad can be located at the SFGH campus. The architectural firm of Gerson/Overstreet has been retained on city contract with DPH to conduct the needs assessment, feasibility analysis, and community outreach for this important aero-medical access study. An SFGH team led by the Associate Administrator for Emergency and Trauma Services includes SFGH staff from Facility Planning and the Trauma Program, UCSF Dean's Office, the Emergency Medical Services Authority, and DPH Planning staff involved with the SFGH Rebuild Steering Committee. The project is divided into four main components:

1) Aeromedical Needs Assessment
2) Feasibility Analysis for the SFGH Campus
3) Noise and Safety Analysis for the SFGH Campus
4) Community Outreach

Work began on September 20, and will continue through January 31, 2003 culminating with a presentation before the full Health Commission in 2003.

4. Complete Program Development and Open the Avon Foundation Comprehensive Breast Center.

Breast cancer affects one out of eight women in the United States; women in low-income neighborhoods in San Francisco suffer an even higher rate. With an award of $12.2 million from the Avon Foundation, SFGH has partnered with the University of California at San Francisco's Comprehensive Cancer Center and Cancer Research Institute, and the SFGH Foundation to implement the Avon Breast Cancer Project in San Francisco, with the goal of bringing the best breast care to the

most vulnerable in the community. A significant portion of funds goes towards the construction of and equipment for the Avon Foundation Comprehensive Breast Center, a 4,000 square foot modular building being built on the SFGH campus. The Center will provide access to state-of-the-art digital mammography screening, expanded diagnostic services such as stereotactic core and ultrasound guided biopsies, multilingual patient education, and clinical research trials for the heterogeneous breast cancer community of patients in San Francisco. SFGH hopes to double its mammography screening capacity to 10,000 annually and contribute to advancements in breast cancer research for minority women. SFGH aims to open the Center in May 2003.

5. Maximize Revenue Through Improved Documentation and Charge Capture.

Due to rising unemployment and fall-off of capital gains and stock options, the State faces a $10 billion deficit in the next fiscal year. Given ongoing economic downturns and pending reductions in City General Funds, SFGH needs to take measures to identify new sources of revenue to minimize the reduction of services. Opportunities include identifying missing outpatient and late inpatient charges, training on appropriate ICD-9 coding on encounter forms and ancillary department interfaces, increasing accuracy of reporting referring or attending providers on billable claims, increasing enrollment of eligible patients into Medi-Cal, and adjusting patient charges so they are comparable to other hospitals in the Bay Area. Task forces are underway to improve ICD-9 coding and the reporting of referring and attending providers.

6. Implement Information Systems that Support Organizational Priorities and Implement Information System Projects.

SFGH is undertaking major information systems projects needed to simplify clinical and diagnostic functions and comply with various state and federal laws. With the passage of Senate Bill 1875 requiring hospitals to have a computerized system for entering physician orders in place by 2004, SFGH has begun implementation of a Computerized Provider Order Entry (CPOE) system that would enable clinicians to enter and retrieve orders electronically. Nursing orders and progress notes could be entered and retrieved at designated workstations, providing ready access to patient data for all providers and reducing adverse drug events and other potential errors caused by manual handwriting. SFGH is investigating purchase of wireless devices that would enable physicians as they perform rounds to input patient information on the spot. SFGH is also evaluating an Emergency Department Information System (EDIS) that would allow the department to become virtually 'paperless' and electronically track patients throughout their care, from their initial presentation to their discharge instructions. SFGH is also moving towards a filmless radiology department by purchasing a system that allows for electronic transfer of images, eliminating the problem of lost film or needing to reprint film, as well as address HIPAA compliance. In supporting these new systems and upgrading existing ones, the hospital must also invest in hardware upgrades, particularly for Critical Care units where hardware components have become obsolete and cannot support the most recent version of the existing software system.

7. Implement Changes to Place Mental Health Patients at the Appropriate Level of Care Within Psychiatric Emergency Services, Acute Psychiatry, MHRF, and Community Treatment Facilities.

SFGH is the only hospital that provides psychiatric emergency services in San Francisco, and has the largest acute inpatient and rehabilitation facilities for mental health patients in the City. Last year, SFGH began collaborating with Community Mental Health Services on a task force to devise ways of placing patients at the appropriate level of care when acute hospitalization is no longer necessary. The task force identified staff to conduct ongoing utilization review, coordinate discharge planning across facilities, and appropriately place patients in long-term care or community treatment facilities. The task force continues to look for ways to remove barriers to discharging patients to the appropriate facility, as well as addressing substance abuse issues, which seem to be a common factor among patients readmitted to the hospital from community treatment. SFGHMC's objectives include decreasing administrative and decertified days, examining and decreasing recidivism, and decreasing diversion of patients to private hospitals.

8. SFGH will Continue to Maintain Compliance with JCAHO and State Licensing Standards.

From its 2002 CALS/JCAHO survey, SFGH received five total Type 1 recommendations after its successful appeal of seven others, three of which were removed entirely. SFGH aims to have its leadership and staff maintain a constant state of JCAHO readiness, and incorporate standards and regulatory changes into hospital and medical staff policies and procedures as soon as possible. SFGH is currently working on removing all Type 1 Recommendations via written progress reports by December of this year. Future actions include conducting full and mini mock JCAHO surveys on a regular or annual basis before the April 2005 CALS/JCAHO survey, as well as incorporating JCAHO competency into performance appraisals and MEA goals. SFGHMC's survey preparation activities will be modified from previous experiences given JCAHO's launching of a new accreditation model in July 2005, which involves self-assessment of compliance and statement of corrections by the 18th month of the triennial cycle, and a survey on the 36th month where compliance is assessed by pulling medical charts and following the patient's receipt of care.

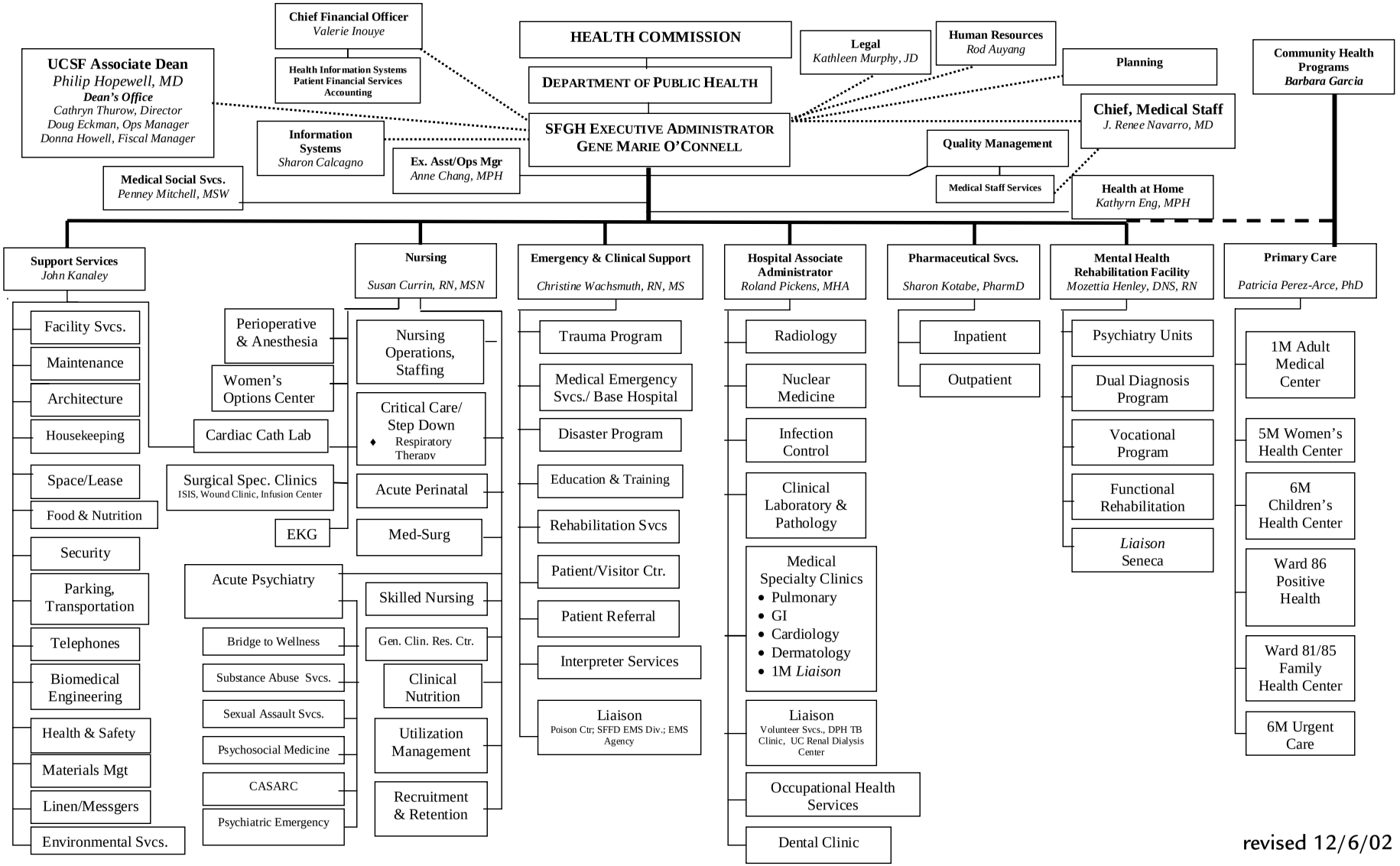
9. SFGH will Work Towards Decreasing Turnover of Staff and Vacancies.

It has been projected that there will be a 40% rate of retirement of City and County employees from 2000 to 2011. As of September 2002, the total rate of vacancies at SFGH was 12%. SFGH hopes to decrease turnover and vacancy rates by 5% through ways of improving staff morale and employee recognition, and exploring ways to expedite the hiring and requisition release process.

appendix

- **SFGHMC Organizational Chart**
- **SFGHMC Executive Team**
- **Utilization and Financial Charts**

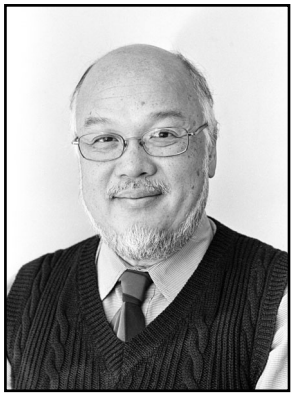
San Francisco General Hospital Medical Center



revised 12/6/02

San Francisco General Hospital Medical Center Executive Team

Gene O'Connell
Executive Administrator
SFGHMC

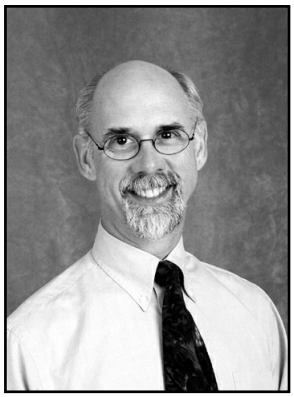


Rod Auyang
Director of Merit Services
Human Resources

Sharon Calcagno
Director of Info. Systems
SFGH

Anne Chang
Executive Assist/Ops Mgr
SFGH Administration

Susan Currin
Chief Nursing Officer
SFGH

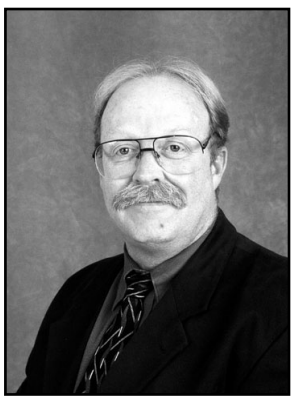


Doug Eckman
Operations Manager
UCSF Dean's Office

Kathy Eng
Director
Health at Home

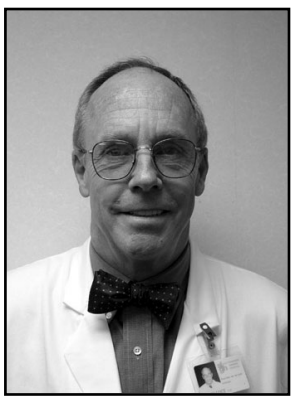
Mozettia Henley
Program Director
MHRF

Valerie Inouye
Chief Financial Officer
CHN

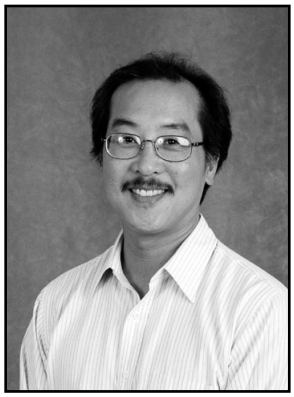


John Kanaley
Associate Administrator
Support Services, SFGH

Sharon Kotabe
Director
Pharmaceutical Services

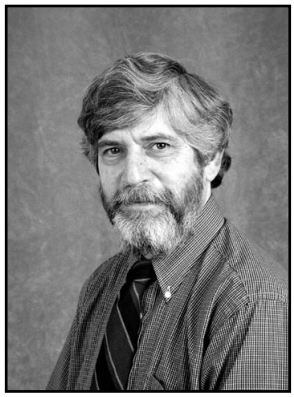


John Luce
Medical Director
Quality Management



Anson Moon
Sr. Health Prog. Planner
CHN Planning

Renee Navarro
Chief of Medical Staff
SFGHMC



David Ofman
Medical Director
Primary Care

Patricia Perez-Arce
Associate Administrator
Primary Care

Roland Pickens
Associate Administrator
Diag. & Med. Specialties

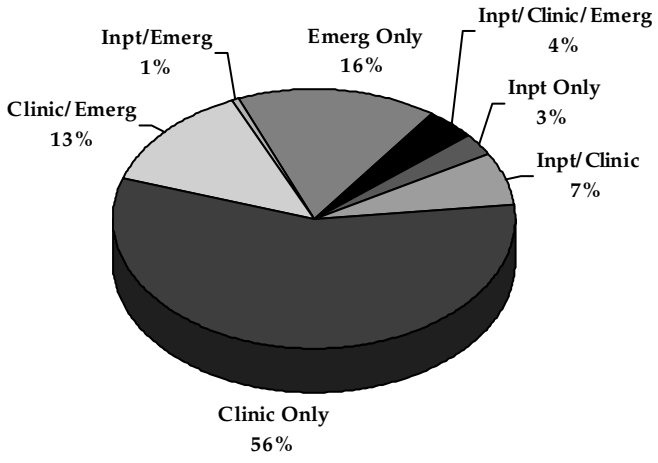
Cathryn Thurow
Director
UCSF Dean's Office

Hiroshi Tokubo
Associate Administrator
Quality Management

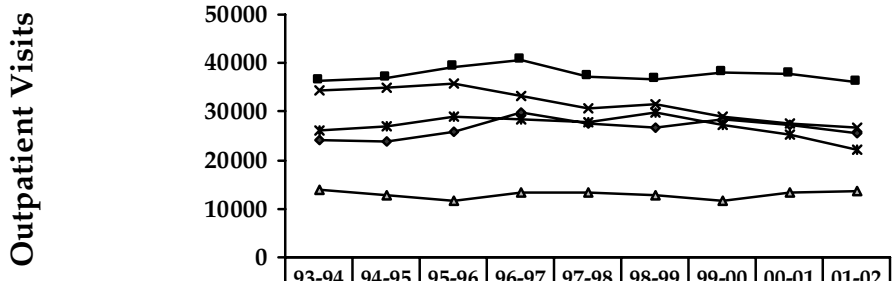
Chris Wachsmuth
Associate Administrator
ED & Clin. Support Svc.

Sharon McCole-Wicher
Director of Nursing
Psychiatry

Patients Utilization of Services
FY 01-02 Total Patients: 92,879



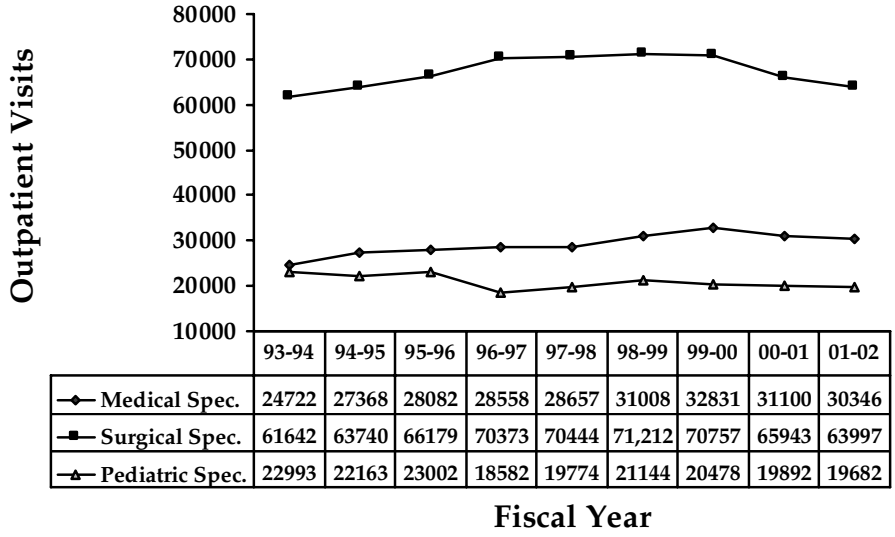
PRIMARY CARE SERVICES



	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02
Adult Medical	24194	23815	25803	29855	27566	26672	28347	27159	25706
Family Health	36453	36887	39099	40690	37167	36,699	38119	37648	35953
Children's Health	14062	12786	11734	13331	13287	12911	11537	13244	13547
Women's Health	34272	34885	35693	33327	30582	31410	28974	27571	26780
Positive Care	26120	26939	28860	28358	27773	29963	27210	25340	22050

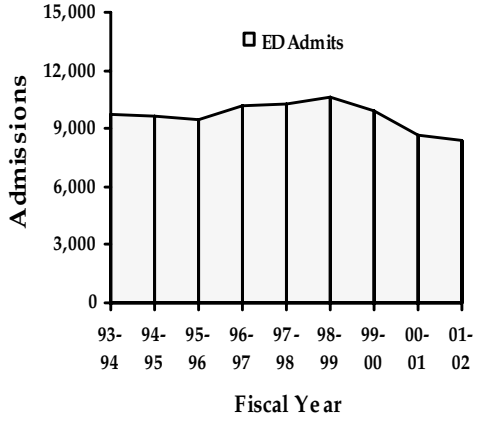
Fiscal Year

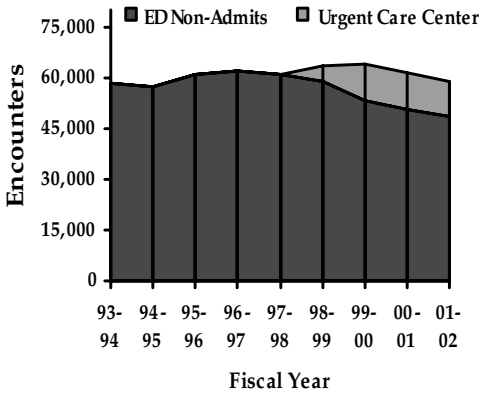
SPECIALTY SERVICES



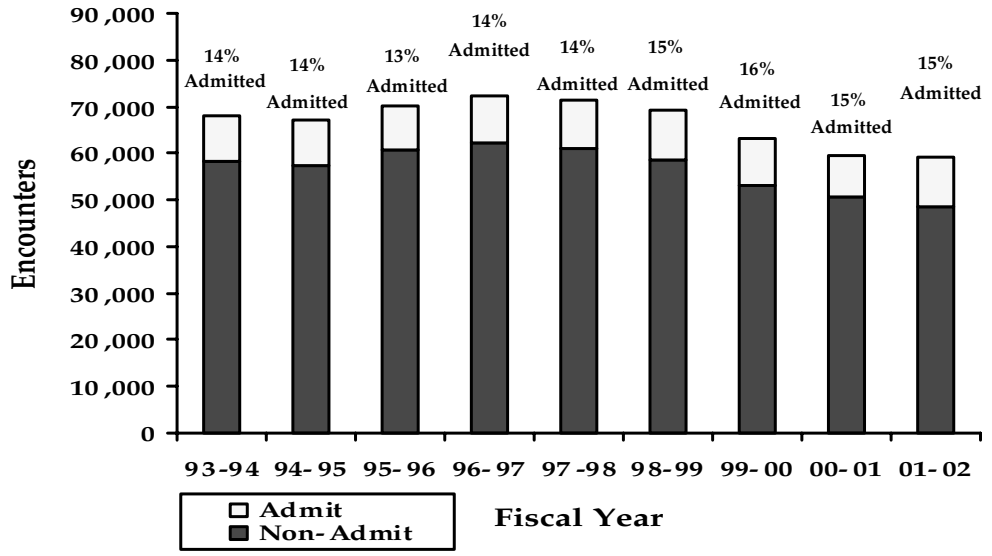
	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02
Medical Spec.	24722	27368	28082	28558	28657	31008	32831	31100	30346
Surgical Spec.	61642	63740	66179	70373	70444	71,212	70757	65943	63997
Pediatric Spec.	22993	22163	23002	18582	19774	21144	20478	19892	19682

EMERGENCY AND URGENT CARE SERVICES

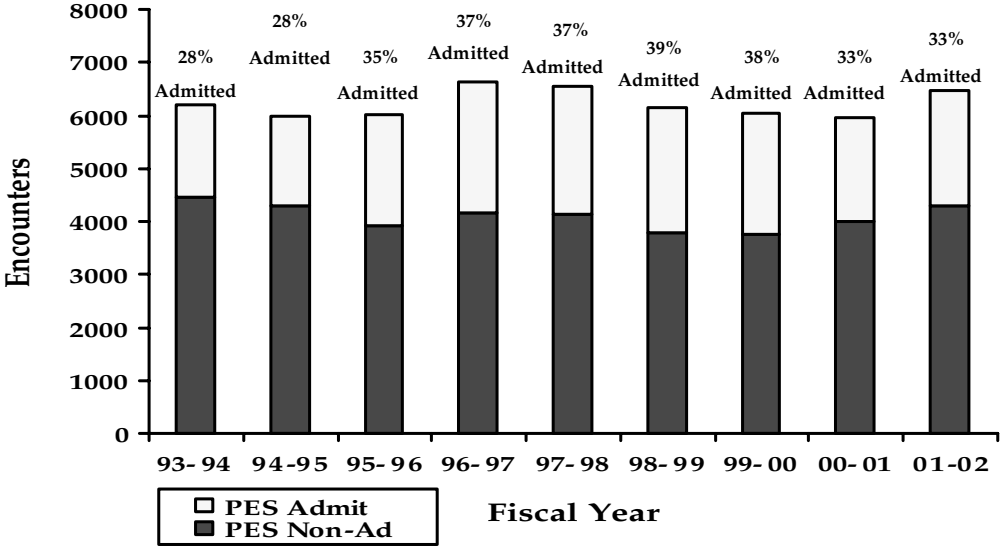




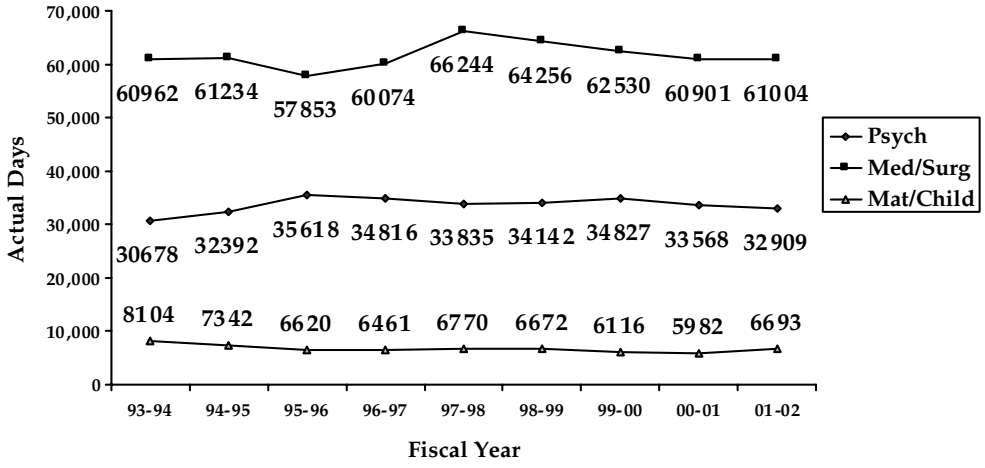
EMERGENCY DEPARTMENT



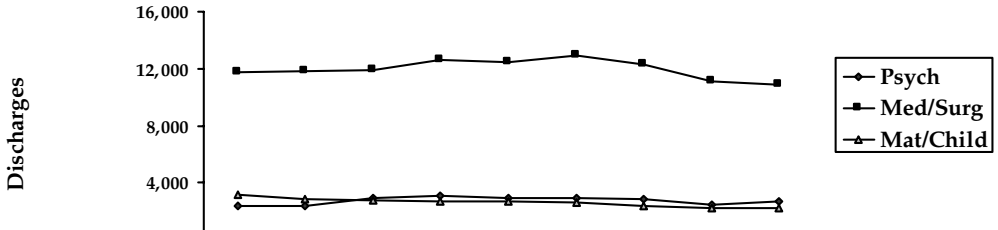
PSYCHIATRIC EMERGENCY



ACUTE CARE - ACTUAL DAYS



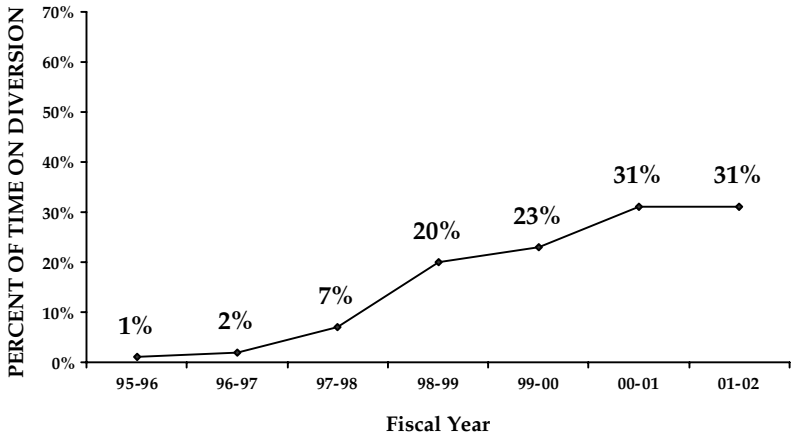
ACUTE CARE DISCHARGES



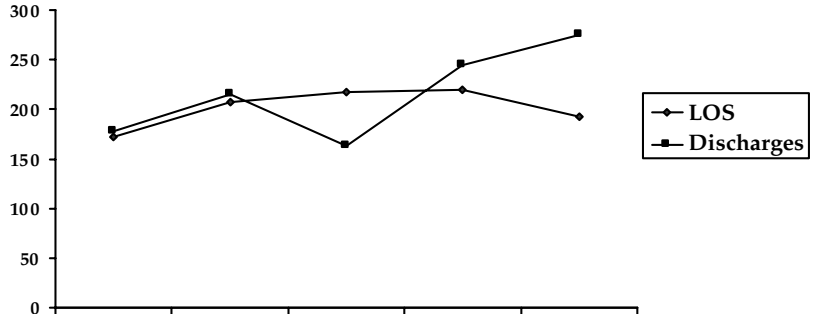
	93-94	94-95	95-96	96-97	98-99	99-00	00-01	01-02
Psych	2370	2397	2913	3062	2889	2824	2444	2658
Med/Surg	11770	11862	11905	12603	12908	12308	11093	10898
Mat/Child	3130	2852	2734	2686	2602	2358	2246	2237

Fiscal Year

PERCENT TIME ON DIVERSION



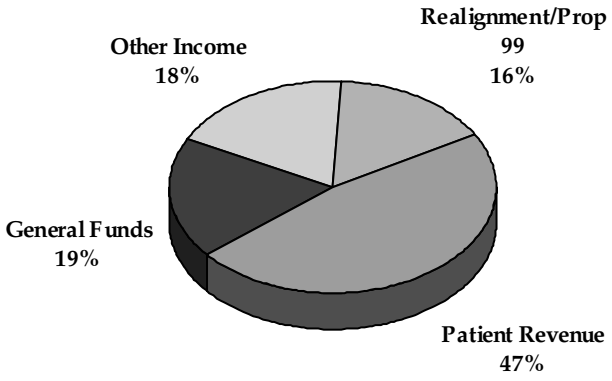
MHRF - DISCHARGES AND LOS



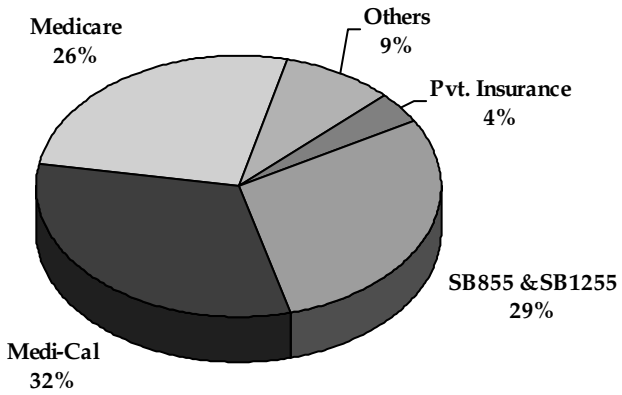
	97-98	98-99	99-00	00-01	01-02
LOS	172	207	217	220	192
Discharges	178	215	163	244	275

Fiscal Year

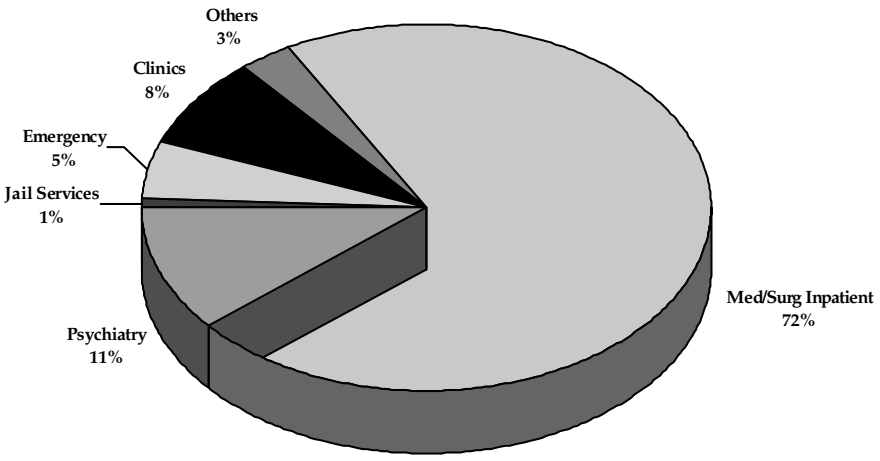
Source of Funds
Total: $402 Million



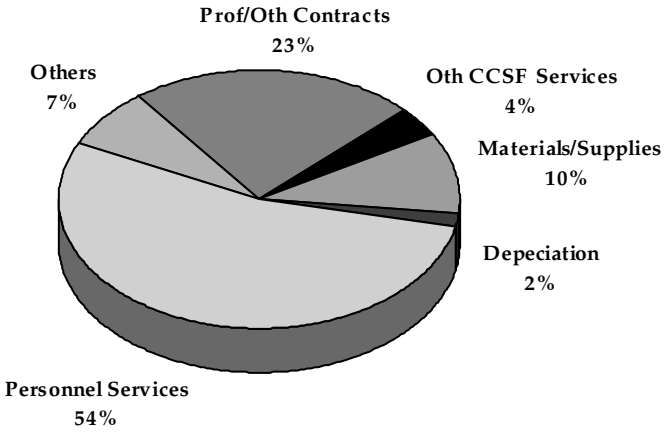
Source of Patient Revenue
Total: $190 Million



Uses of Funds by Program
Total: $402 Million



Uses of Funds
Total: $402 Million



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2001-2002 annual report