DEPARTMENT OF PUBLIC HEALTH

5-YEAR FINANCIAL OUTLOOK

October 4, 2016

Overview

1. Overview
2. Historical Context
3. Current Budget/Financials
4. Baseline 5-Year Projection
5. Key areas of focus for 5-Year Planning
   - Value-Based Payments
   - Managed Care/Contracted Business
   - 1115 Waiver
   - UCSF Responsibilities
   - EHR Preparedness
   - Capital and Facilities
6. Alternative 5-Year Scenarios
7. Discussion

Overview

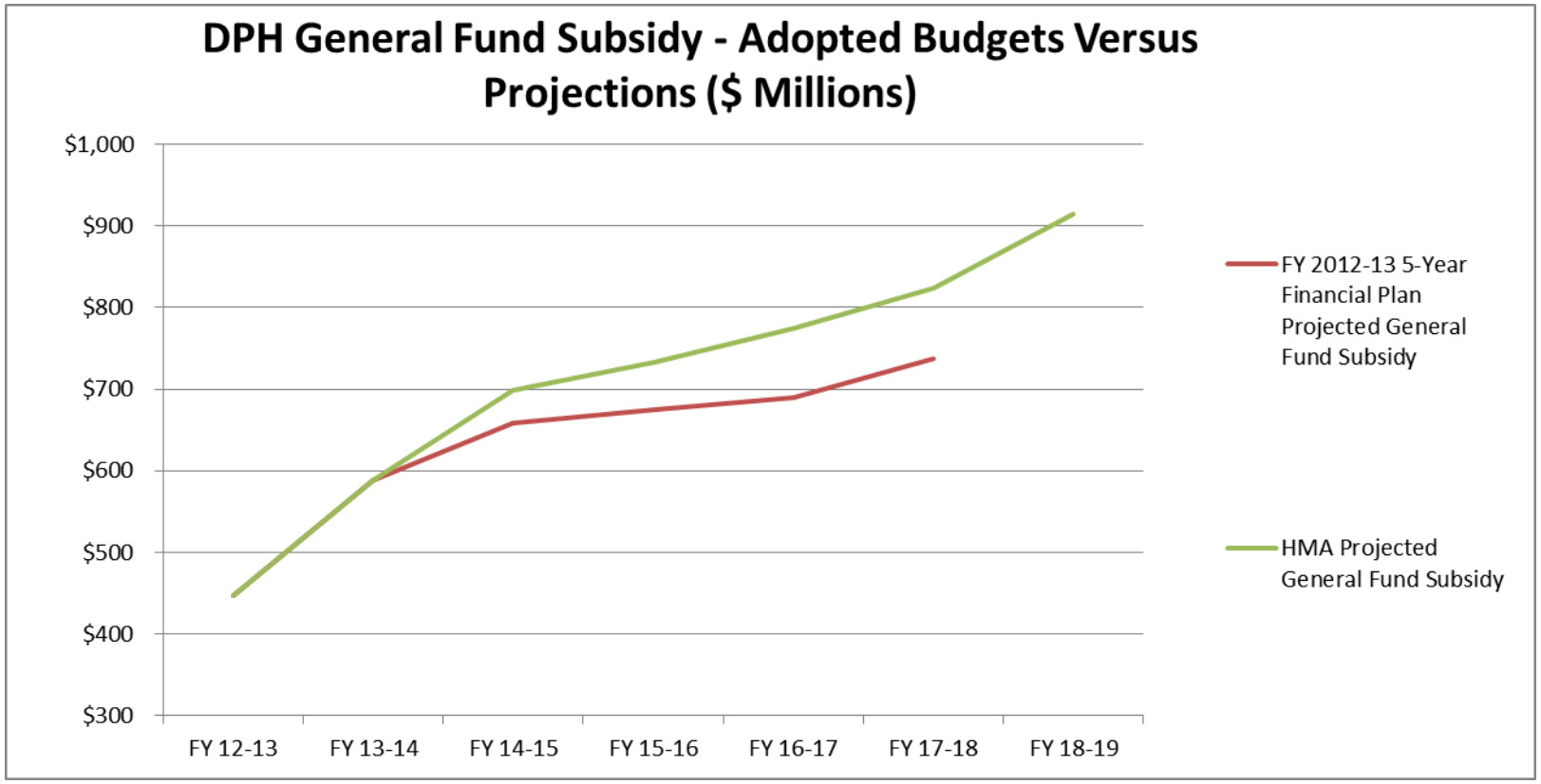
Key questions for 5-Year Financial Planning

- How can we serve our patients while keeping the amount of General Fund Subsidy required at a reasonable level the City can afford?
- What do we know (and not know) about what the financial environment will look like for DPH in 5 years? 10 years?
- Given changes in State and Federal policy/regulatory environment, how do our operations and payer mix need to change to ensure we fulfill our mission?
- With managed care enrollment growth plateauing 3 years after ACA, what steps do we need to take to maintain and grow revenue from these lines of business?
- What changes should we expect in SF over the coming decade – economic, demographic, etc. – and how do they affect financial planning and decision making?
- How do we prepare for the next economic downturn, and ensure services are insulated from impacts of economic cycles?

2. Historical Context

Revisiting Pre-ACA Previous 5-Year Projections

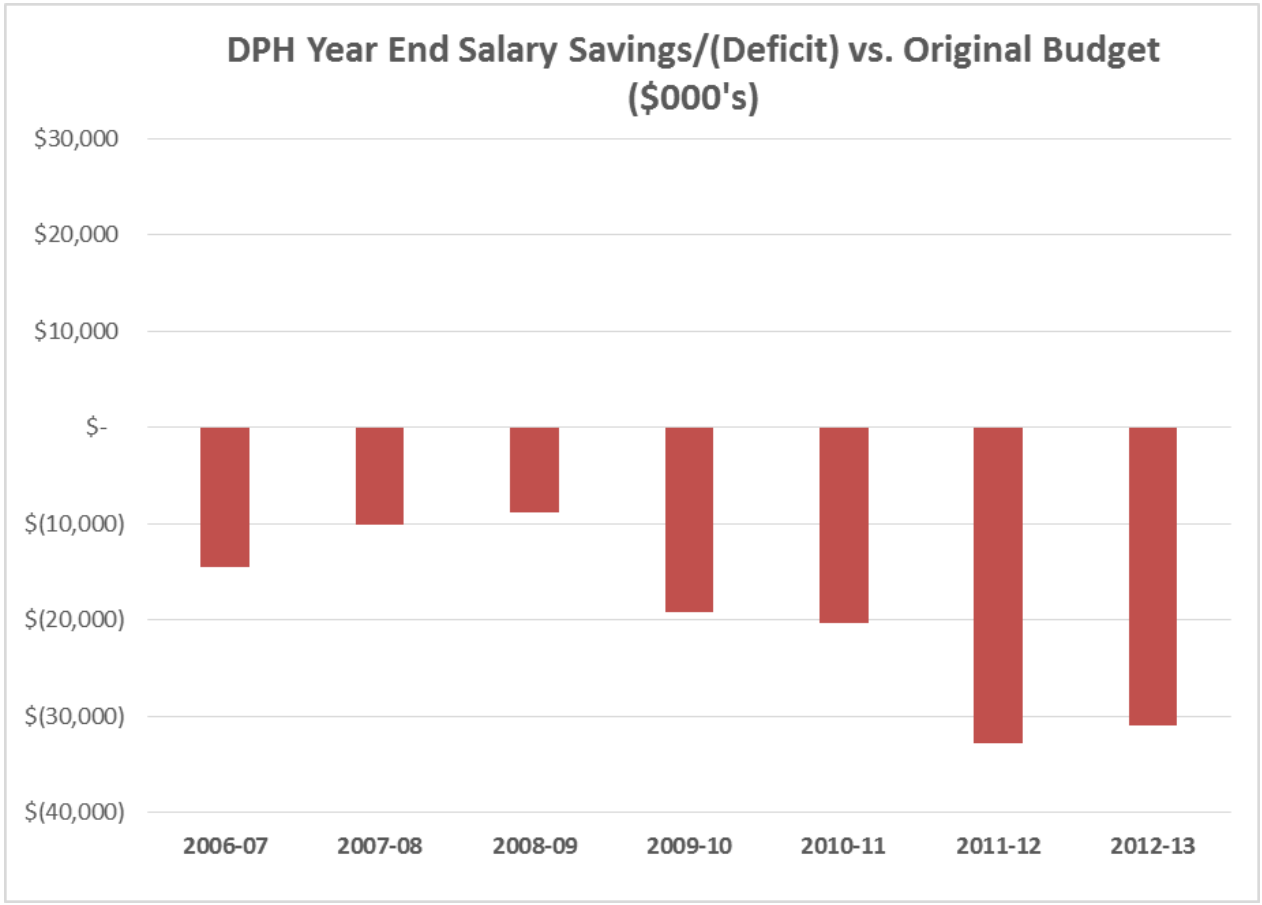
Prior to ACA, the gap between DPH revenues and expenditures was projected to grow rapidly absent corrective actions



2. Historical Context

Historical Pattern of Deficits

DPH consistently overspent its salary budgets during the 2000s and early 2010s.

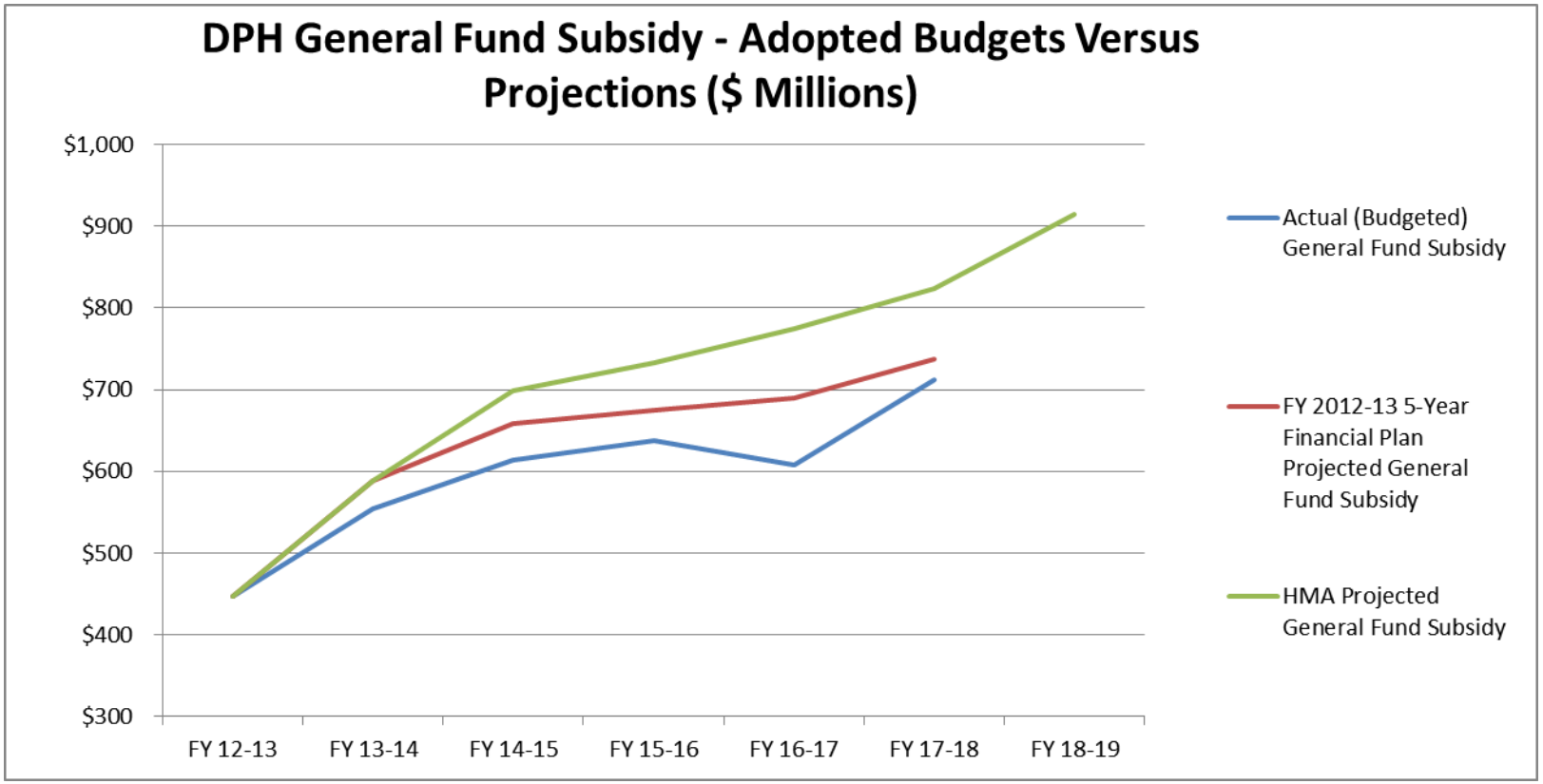


2. Historical Context

Revisiting Pre-ACA 5-Year Projections

Prior to ACA, the gap between DPH revenues and expenditures was projected to grow rapidly absent corrective actions.

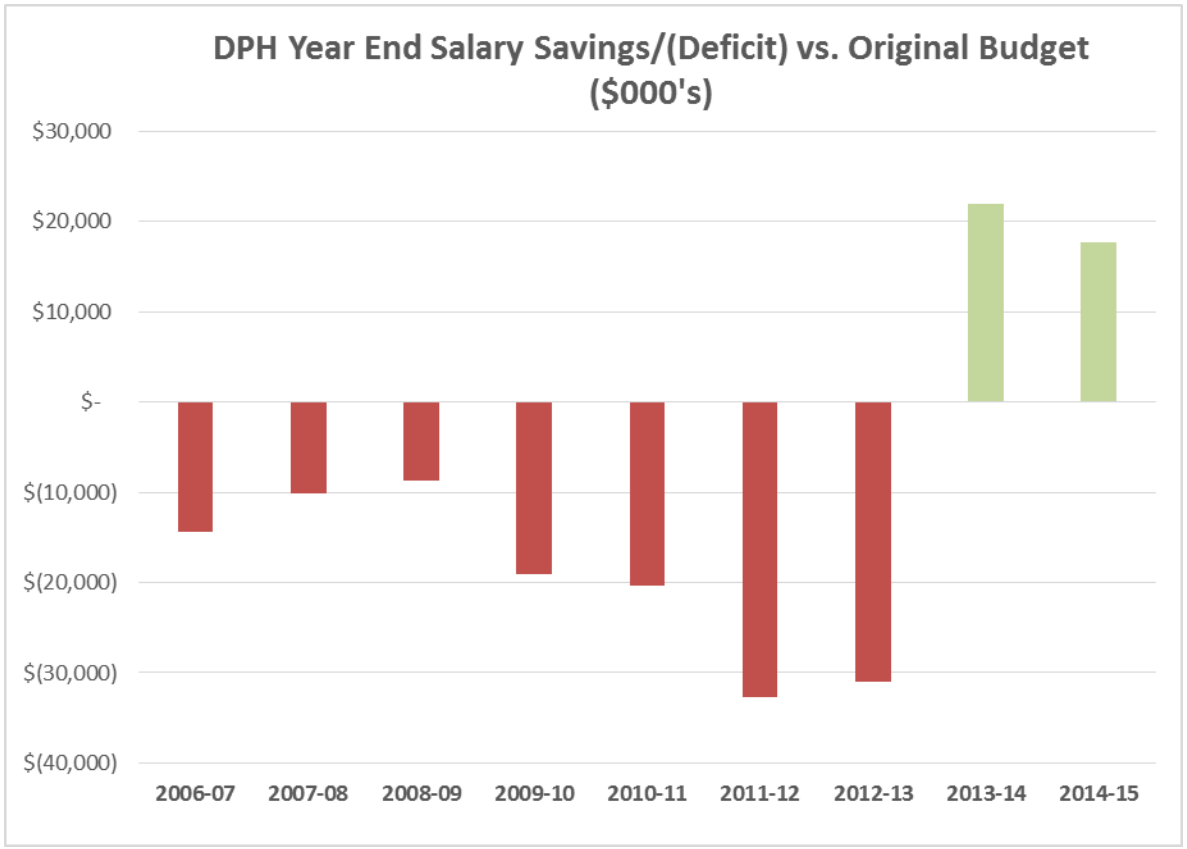
=> General Fund support has grown, but slower than projected.



2. Historical Context

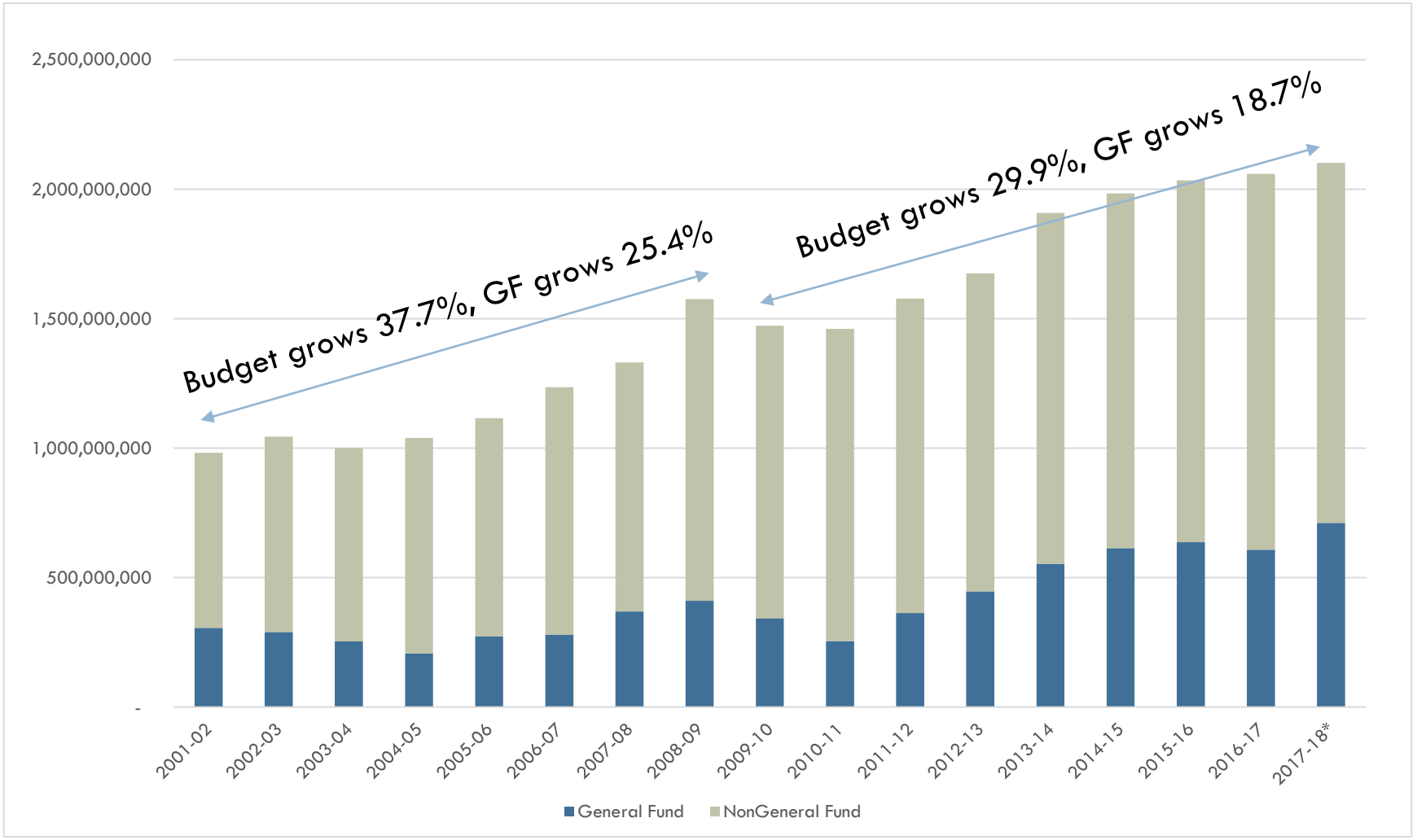
Historical Pattern of Deficits

DPH consistently overspent its salary budgets during the 2000s and early 2010s.
=> The Department is currently on track to finish its third consecutive year of managing personnel spending within budget.



2. Historical Context

DPH Budget Grows By $0.64 Billion Between 2010-11 and 2017-18



2. Historical Context

Revenue and Expenditure By Type

DPH Revenues By Type 2009 to 2018

	2008-09	2009-10	2010-11**	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18*
Medi-Cal	250,102,956	318,359,436	409,295,278	431,353,783	577,111,822	613,310,317	586,882,729	625,951,987	624,779,979	606,029,235
State Realignment	166,425,000	145,003,600	136,218,800	137,867,500	138,106,000	142,651,000	136,080,000	136,260,000	155,800,000	146,610,000
Medicare	78,562,054	83,841,146	89,168,086	96,992,857	101,505,093	100,219,835	96,451,005	108,834,218	106,786,393	106,786,393
Patient Revenues	235,430,586	263,191,945	230,029,835	297,938,787	171,374,959	186,097,551	277,706,863	257,494,224	236,264,342	250,531,713
Fees/Recovery/Fund Balance/Misc	89,113,033	86,916,026	69,529,464	65,738,097	65,133,149	89,175,688	74,034,795	96,140,714	148,649,044	104,696,531
State and Other Grants	62,950,470	71,574,648	162,797,007	43,736,295	41,997,054	74,104,565	128,905,252	137,237,506	132,766,468	136,709,735
Special Revenue/Project Funds	282,633,221	160,755,639	108,793,858	140,402,016	131,335,675	149,313,965	70,051,703	35,123,836	46,240,880	38,961,153
Total DPH	1,165,217,320	1,129,642,440	1,205,832,328	1,214,029,335	1,228,771,833	1,354,872,921	1,370,112,347	1,397,042,485	1,451,287,106	1,390,324,760
General Fund	410,705,175	343,741,633	255,025,751	363,248,532	446,564,180	553,738,906	614,148,840	636,954,904	607,589,333	711,635,334
Year over Year % Change in GF		-16.3%	-25.8%	42.4%	22.9%	24.0%	10.9%	3.7%	-4.6%	17.1%
General Fund as a % of Budget	26.1%	23.3%	17.5%	23.0%	26.7%	29.0%	31.0%	31.3%	29.5%	33.9%

ZSFG Medi-Cal revenue reflected is net revenues which excludes SB855 IGT payment of which is reflected in Medi-Cal revenues under the Public Health Division.

*2017-18 as proposed in FY 16-18

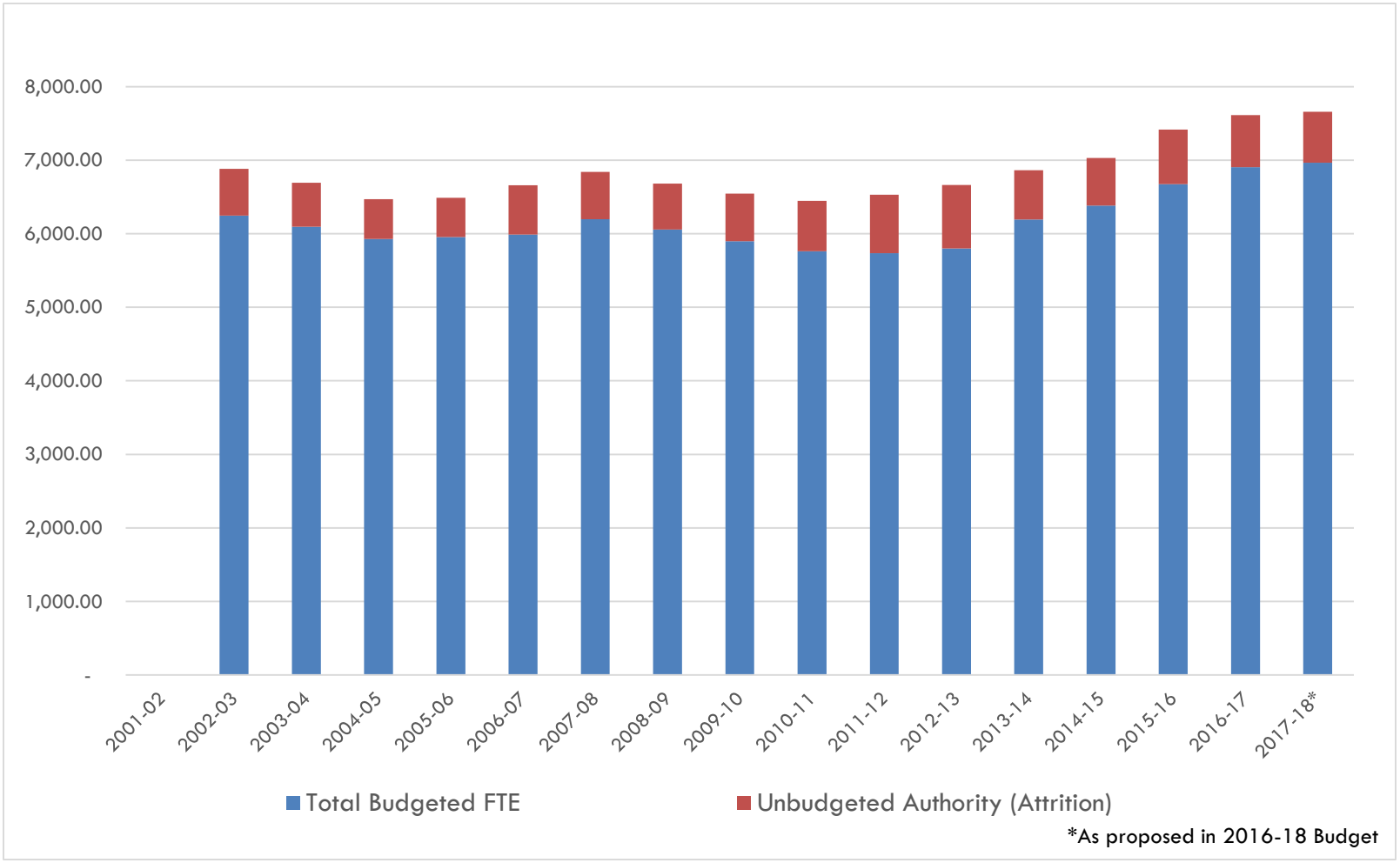
** In FY 2010-11, DPH budgeted $88 M in one time hospital fee revenues, temporarily reducing general fund support.

DPH Expenditures By Type 2009-2018

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18*
Salaries & Fringe Benefits	713,263,227	720,748,948	726,117,606	755,640,499	809,887,764	896,159,745	951,930,496	999,582,272	1,061,287,295	1,090,569,059
Non-Personnel Services	480,871,858	514,667,574	560,242,713	632,459,378	650,721,536	744,570,391	723,263,751	767,935,428	717,147,532	741,956,428
Materials & Supplies	105,766,900	87,240,722	88,212,529	93,261,662	102,142,507	107,779,826	112,740,854	114,295,071	118,196,948	121,810,552
Equipment	22,433,659	1,287,068	2,153,329	2,548,493	3,679,735	51,960,279	67,419,173	28,404,150	40,553,634	22,352,378
Facilities Maint & Capital	182,840,570	75,723,327	16,738,226	18,751,920	29,153,670	24,311,789	31,690,412	22,986,936	18,945,804	23,379,964
Services of Other Depts	70,746,281	73,716,434	67,393,676	74,615,915	79,750,801	83,829,797	97,216,501	100,793,532	102,745,226	101,891,713
Total	1,575,922,495	1,473,384,073	1,460,858,079	1,577,277,867	1,675,336,013	1,908,611,827	1,984,261,187	2,033,997,389	2,058,876,439	2,101,960,094
Percent Growth From Prior Year		-6.5%	-0.9%	8.0%	6.2%	13.9%	4.0%	2.5%	1.2%	2.1%
Average Annual Growth:	3.4%									

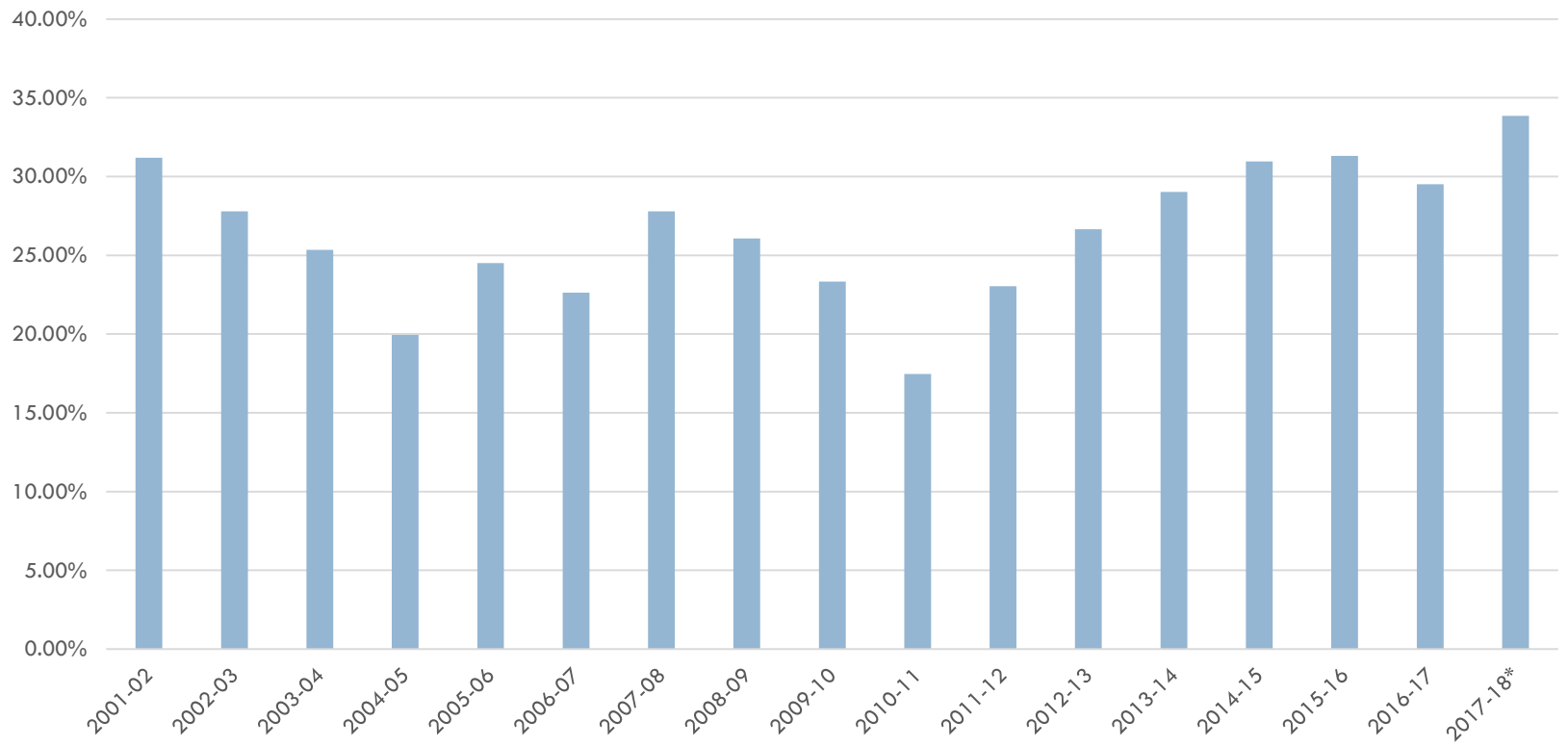
2. Historical Context

DPH Position Authority, 2002-03 to 2017-18*



2. Historical Context

General Fund as a Percentage of DPH's Budget



Note: FY 10-11 DPH budgeted $88 M in one-time Hospital Fee Revenue, reducing GF support temporarily.

3. Overview of Current Budget and Financials

Expenditures by Division and Type

Division	Salaries & Fringe Benefits	Non-Personnel Services	Materials & Supplies	Equipment	Facilities Maint & Capital Including Debt Service	Transfers to and Services of Other Depts	Total
Zuckerberg San Francisco General	491,939,013	206,209,846	75,638,203	7,081,875	4,191,261	52,114,438	**837,174,636**
Health at Home	7,280,206	304,294	106,776	-	-	76,416	**7,767,692**
Jail Health	27,037,794	2,856,992	3,159,202	-	-	612,063	**33,666,051**
Laguna Honda Hospital	192,573,295	2,042,829	19,929,287	28,732,359	14,190,283	17,360,667	**274,828,720**
Mental Health	84,912,353	206,828,223	7,260,832	-	134,505	3,694,908	**302,830,821**
Primary Care	75,900,631	4,934,252	2,788,730	2,906,000	364,928	4,010,132	**90,904,673**
Public Health	171,394,587	236,330,604	8,987,318	1,833,400	64,827	24,612,559	**443,223,295**
Substance Abuse	10,249,416	57,640,492	326,600	-	-	264,043	**68,480,551**
Total	1,061,287,295	717,147,532	118,196,948	40,553,634	18,945,804	102,745,226	**2,058,876,439**
%	51.5%	34.8%	5.7%	2.0%	0.9%	5.0%	100.00%

Source: Annual Appropriation Ordinance (AAO)

Revenues by Division and Type

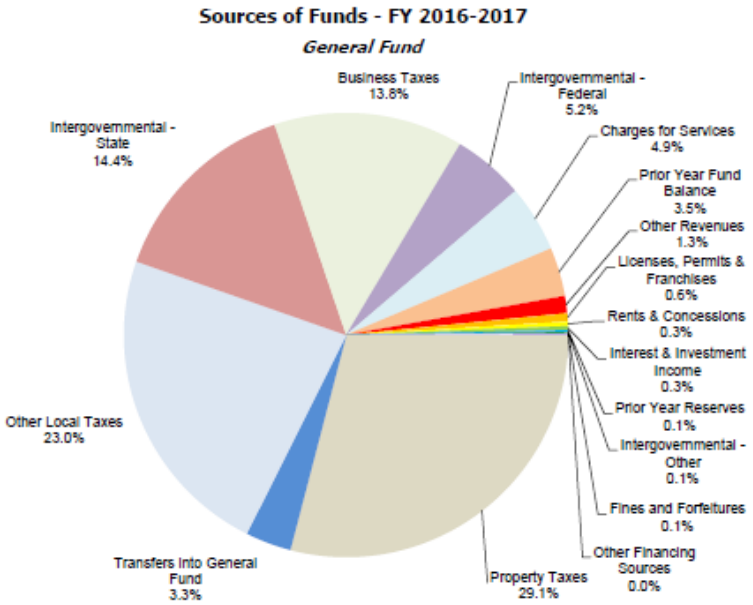
Revenues	Medi-Cal	State Realignment	Medicare	Patient Revenues	Transfers and Recoveries From Other Departments	Fees	State and Other Grants	Special Revenue/ Project Funds	Total Revenues Not Including General Fund	City General Fund Subsidy	Percent General Fund
Zuckerberg San Francisco General	253,243,563	57,250,000	91,779,521	220,445,311	34,182,896	9,195,141	2,387,066	-	**668,483,498**	168,691,138	20.2%
Health at Home	114,372	-	1,497,447	388,450	-	271,003	-	-	**2,271,272**	5,496,420	70.8%
Jail Health	-	-	-	-	-	678,975	-	-	**678,975**	32,987,076	98.0%
Laguna Honda Hospital	154,548,864	-	8,000,783	350,391	23,583,695	843,740	14,301,649	-	**201,629,122**	73,199,598	26.6%
Mental Health	77,622,369	65,840,000	1,648,139	617,600	19,101,282	5,456,516	28,394,396	42,967,730	**241,648,032**	61,182,789	20.2%
Primary Care	8,813,070	-	3,859,503	8,203,260	2,584,735	1,813,393	1,646,784	-	**26,920,745**	63,983,928	70.4%
Public Health	117,885,768	32,710,000	1,000	6,259,330	13,754,691	33,465,954	67,404,771	3,156,050	**274,637,564**	168,585,731	38.0%
Substance Abuse	12,551,973	-	-	-	3,365,141	351,882	18,631,802	117,100	**35,017,898**	33,462,653	48.9%
Total	624,779,979	155,800,000	106,786,393	236,264,342	96,572,440	52,076,604	132,766,468	46,240,880	**1,451,287,106**	607,589,333	29.5%
	30%	7.6%	5.2%	11.5%	4.7%	2.5%	6.4%	2.2%	70.5%	29.5%	100.00%

1. SFGH Medi-Cal revenue reflected is net revenues which excludes SB855 IGT payment of $88,746,561 which is reflected in Medi-Cal revenues under the Public Health Division.

3. Overview of Current Budget and Financials

"The General Fund" vs. General Fund Support

- "The General Fund" is governmental accounting fund that includes a wide range of revenues and types of expenses
- Within the General Fund is a pool of local tax revenues that may be allocated for any lawful governmental use by the Mayor and Board of Supervisors through the annual budget process.
- "General Fund Support" is an allocation of these discretionary tax dollars received in the General Fund support a Department's operations.
- General Fund Support may be allocated to departmental operations within the General Fund itself or in certain other funds.
- Some of DPH's operations are within the General Fund, some are in other funds (ZSFG, LHH, Grant Funds, etc). Both hospital funds receive a transfer of General Fund Support to close the gap between revenues and expenses, even though they are in separate funds.
- Financial management is focused on the level of General Fund support required across DPH.



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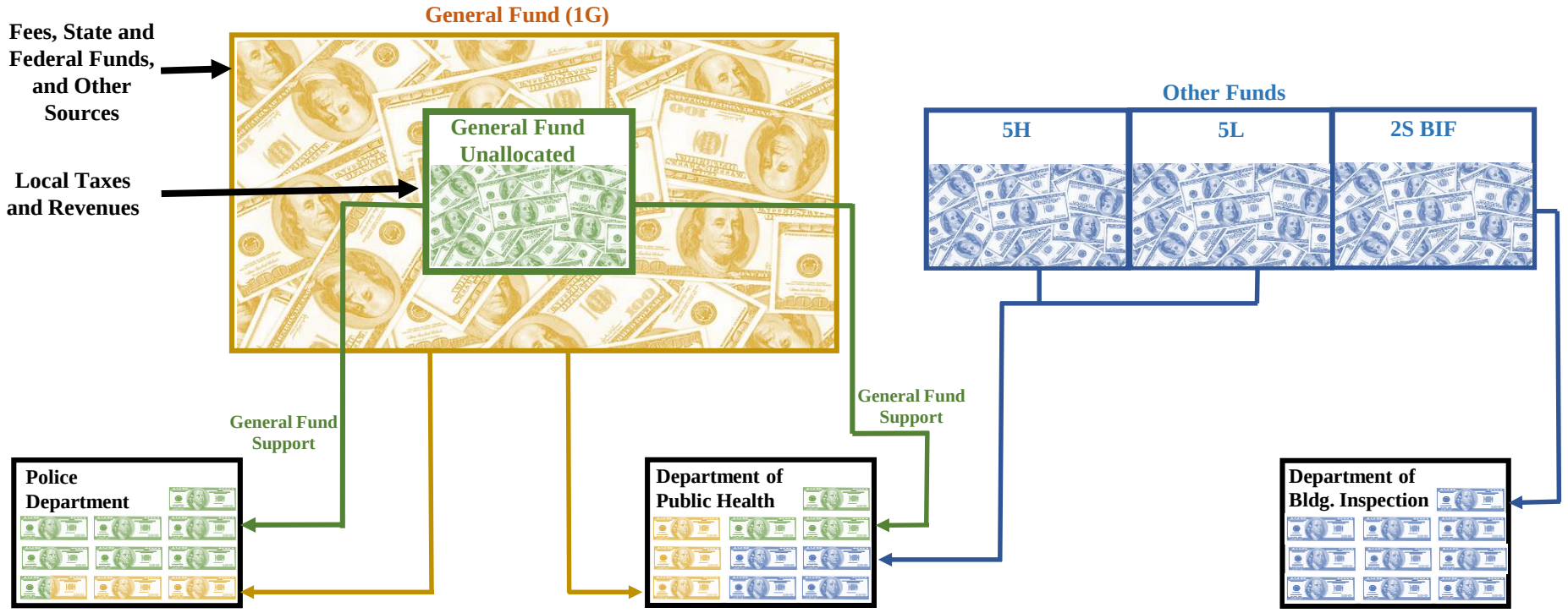

- Example 1: DPH's behavioral health programs are within the General Fund, and receive General Fund Support to close the gap between revenues and expenses
- Example 2: DPH's Restaurant Inspection program is within the General Fund, but it recovers its costs through fees, and therefore does not receive budgeted General Fund Support.
- Example 3: Zuckerberg San Francisco General Hospital has its own accounting fund (5H), outside of the General Fund. However, the Mayor and Board of Supervisors each year allocate General Fund Support to subsidize ZSFG's operations
- Example 4: Some Departments such as the Port, Airport, or Department of Building Inspection (Enterprise Funds) are wholly outside of the General Fund do not receive any General Fund Support

5. Key Areas of Focus for 5-Year Planning

What will the financial environment look like in 5 Years?

- Continued transition toward value-based payments
- Payments and outcome measurements coordinated across boundaries of historical "silos" – e.g., Whole Person Care pilot
- Continued movement away from fee-for-service and toward managed care model
- Continued competition for ACA expansion population, but less movement of population across providers
- Continued reduction of historical State/Fed formula-based payments for uninsured (e.g., DSH, Realignment) – must be replaced with earned revenue
- End of 1115 Waiver
- Adoption of Enterprise EHR Complete
- Major capital and facilities transition underway (movement of OP services to Building 5, relocate staff from 101 Grove, re-use of old LHH wards)

Baseline 5-Year Projection

5A. Transition to Value-Based Payments

Health Reform

Fee for service
Payments based on VOLUME (number, minutes) of visits or procedures without regard for QUALITY or COST.

Value-based payments
Payments or penalties tied to outcomes (quality, experience, cost), rewards providers for effectiveness and efficiency of care.

5A. Transition to Value-Based Payments

Perspective

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

N Engl J Med 2015; 372:897-899 | March 5, 2015 | DOI: 10.1056/NEJMp1500445

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ng Articles (137) Metrics

"Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018." NEJM 1/26/15

Act (ACA) has expanded health care coverage and made it affordable
have the opportunity to shape the way care is delivered and improve
e, while helping to reduce the growth of health care costs. Many efforts
n these fronts, leveraging the ACA's new tools. The Department of Health and Human Services (HHS) now intends to focus its energies on augmenting reform in three important and interdependent ways: using incentives to motivate higher-value care, by increasingly tying payment to value through alternative payment models; changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and harnessing the power of information to improve care for patients.

As we work to build a health care system that delivers better care, that is smarter about how dollars are spent, and that makes people healthier, we are identifying metrics for managing and tracking our progress. A majority of Medicare fee-for-service payments already have a link to quality or value. Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and

5A. Transition to Value-Based Payments

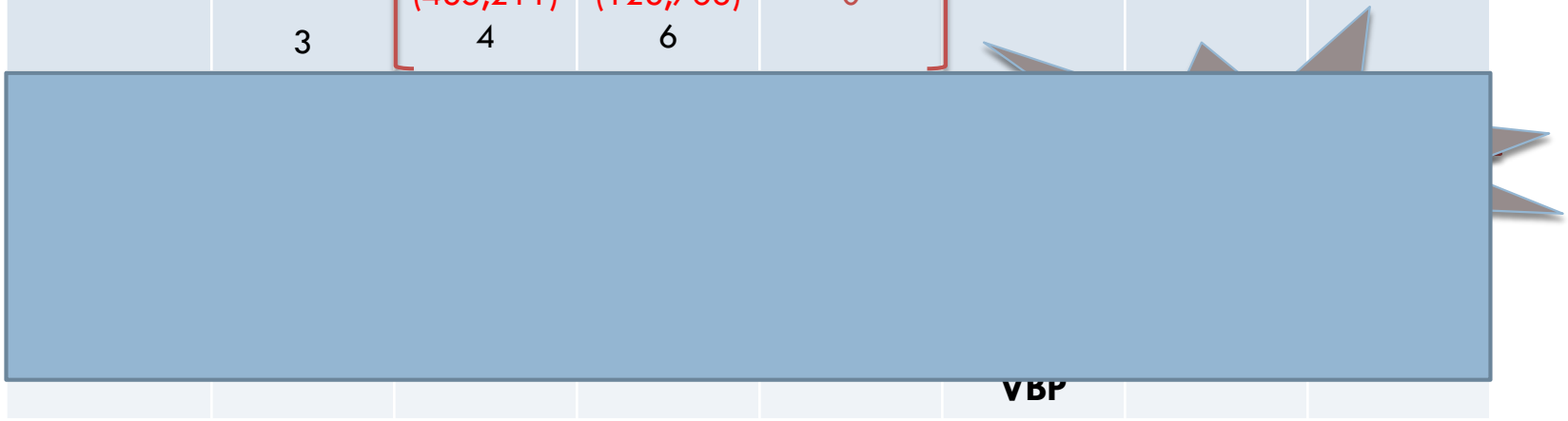
CMS Initiatives

Program Penalty #measures	2013	2014	2015	2016	2017	2018	2019	2020
	VBP							
	1% 20	1.25% 24	1.5% 26	1.75% 26	2% 26			
	Readmits							
	1% 3	2% 3	3% 5	3% 6				
		HAC						
		1% 3	1% 4	1% 6				

5A. Transition to Value-Based Payments

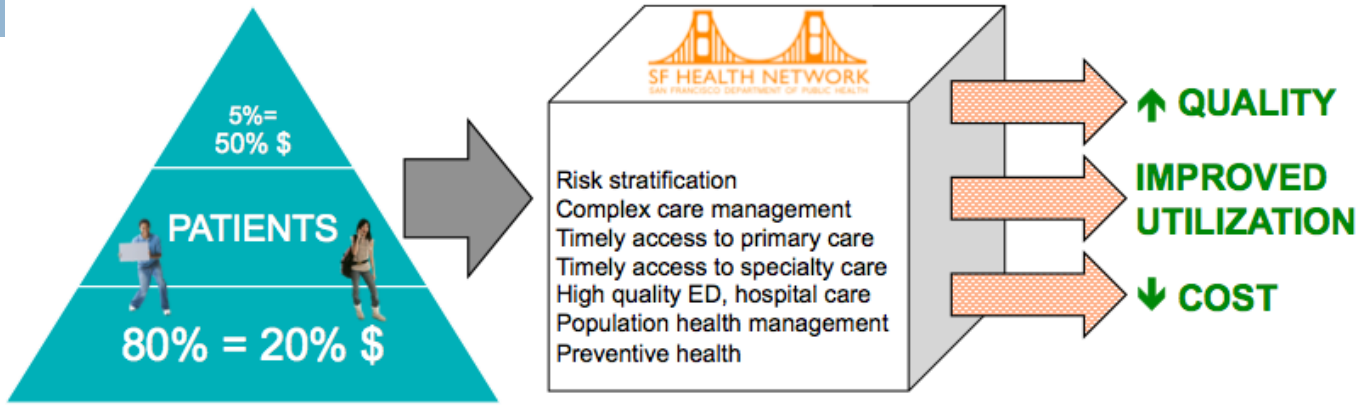
CMS Initiatives

Program Penalty #measures	2013	2014	2015	2016	2017	2018	2019	2020
VBP	20	24	(68,675) 26	(65,306) 26	(66,952) 26			
Readmits	3	3	(62,176) 5	(86,398) 6	(136,952)	Total FY 15-17 ($1.05m)		
		HAC 3	(435,211) 4	(123,768) 6	0			



5A. Transition to Value-Based Payments

Readiness Analysis



1. DATA ACCURACY AND COMPLETENESS
- Multiplicity of EHRs
- Lack of standardization in documentation and coding
- Incomplete quality data
- Lack of cost data

2. POPULATION MANAGEMENT
- Inability to risk stratify
- Inability to perform subgroup analyses
- Lack of investment in registry functions
- Minimal central population management
- Minimal patient-facing engagement

3. CARE MODELS
- Multiple programs targeting high users with little coordination or standardization
- Not driven by population data analysis or projected need, but by funding and champions
- Care models not linked to outcomes or cost

unprepared for new era of value based payments

4. CULTURE
- Variable culture of data-driven improvement
- No historical culture of fiscal stewardship
- Nascent culture of patient experience

5. PROVIDER ALIGNMENT
- Affiliation agreement and CPG payments not tied to quality or outcomes
- SFDPH provider compensation not tied to quality or outcome measures
- SFCCC clinics do not share financial risk in care of jointly capitated patients

6. INSTITUTIONAL ALIGNMENT
- Financial and operational alignment across SFHN primary care, ZSFG, and LHH/HAH weak given historical independence and existing budgetary silos.

7. MANAGEMENT OF RISK
- Lack requisite actuarial, underwriting, and financial experience to manage risk
- Unclear if population large enough to account for outliers and effectively cross-subsidize

5A. Transition to Value-Based Payments

Take Homes

- CMS clearly moving towards value based payments
- For SFHN, Medicare value based payment less important than Medi-Cal
- PRIME is opportunity/challenge to identify our gaps and judiciously invest
- Similar infrastructure and capabilities required regardless of payor: ability to **measure and manage risk, utilization, cost, and quality, including patient experience**.
- New mindsets and capabilities are required to perform in this new framework.
  - culture of data-driven improvement, fiscal stewardship, and customer service
  - clinical and financial alignment among SFHN Divisions, physicians and key partners such as SFCCC
  - robust data analytic and risk stratification capabilities
  - population management and care models clearly linked to improving quality and reducing cost

5B. Managed Care and Contracts

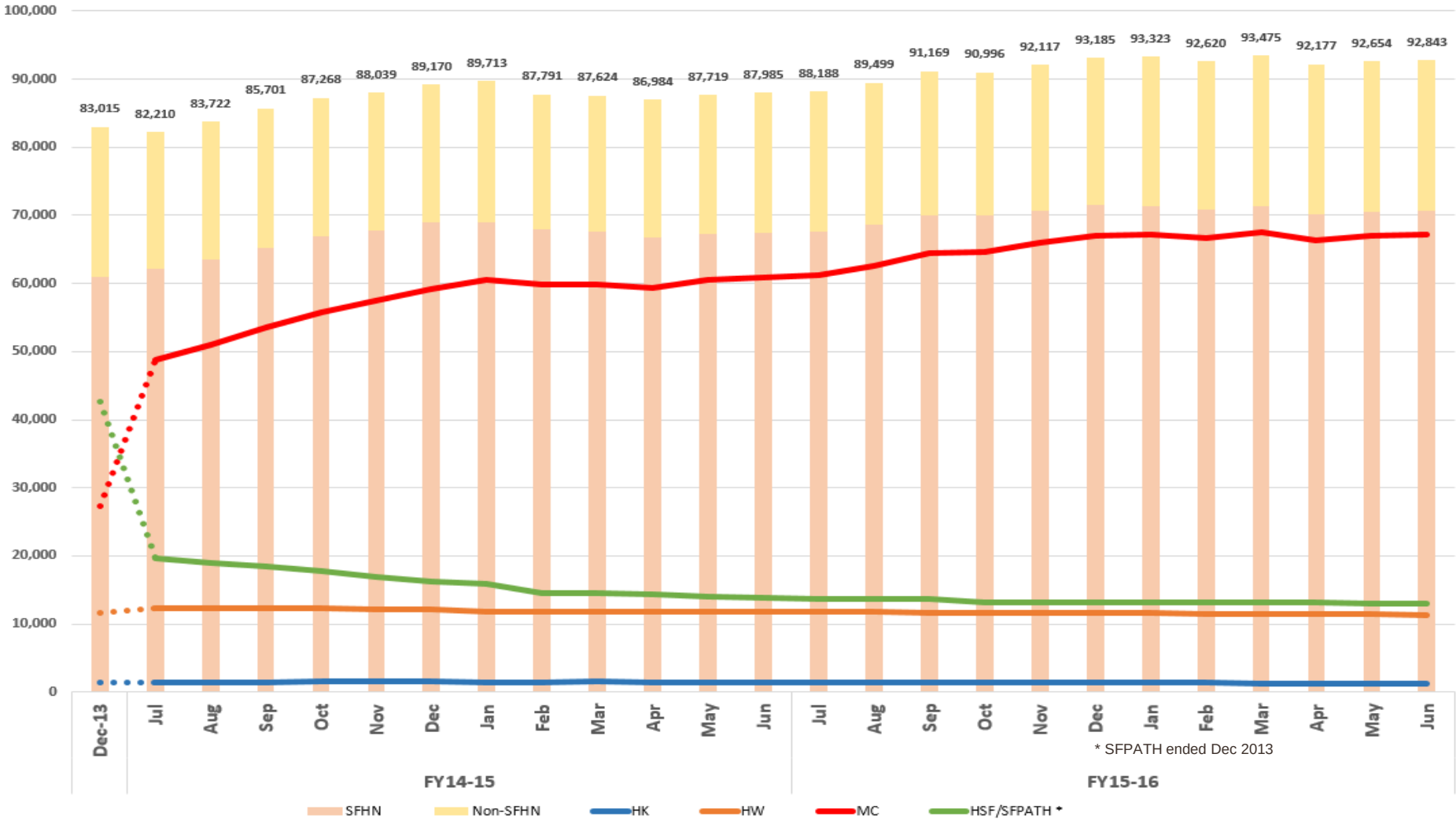
Agenda

1. Managed Care Medical Services Enrollment
   - San Francisco Health Plan
   - Anthem Blue Cross
2. Total Enrollment
   - Managed Care + Other Programs
3. Capitation Revenue
   - Hospital and primary care
3. Contracting Efforts

5B. Managed Care and Contracts

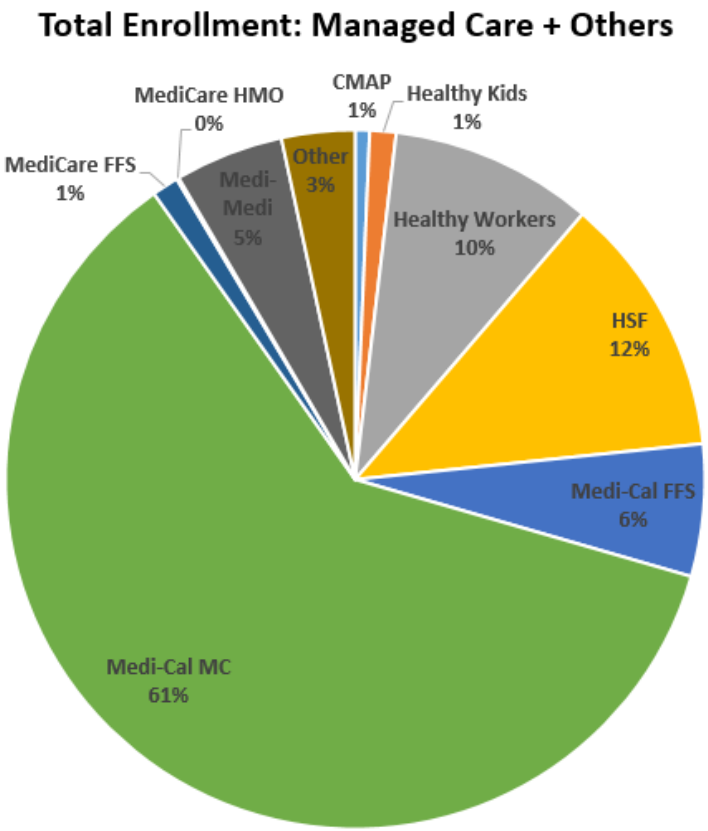
Medical Services Enrollment, FY 14-15 and 15-16

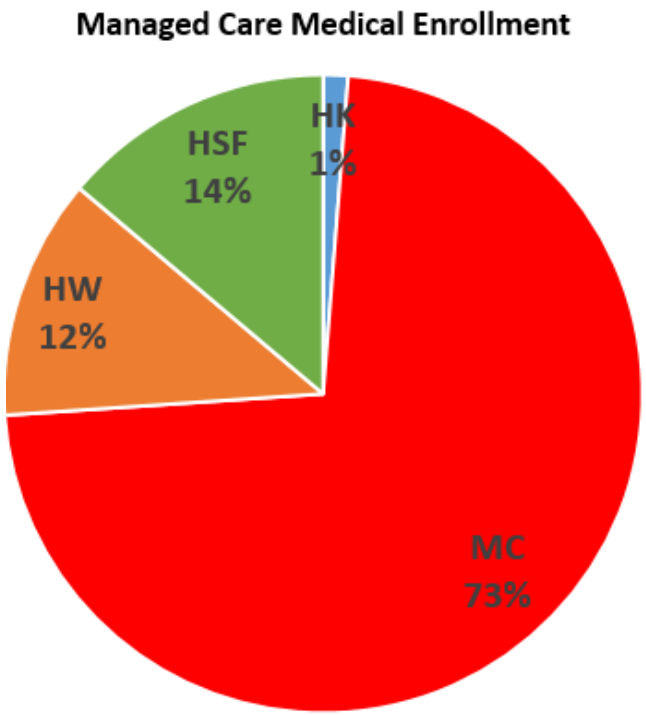
Hospital Services Only or Hospital + Primary Care

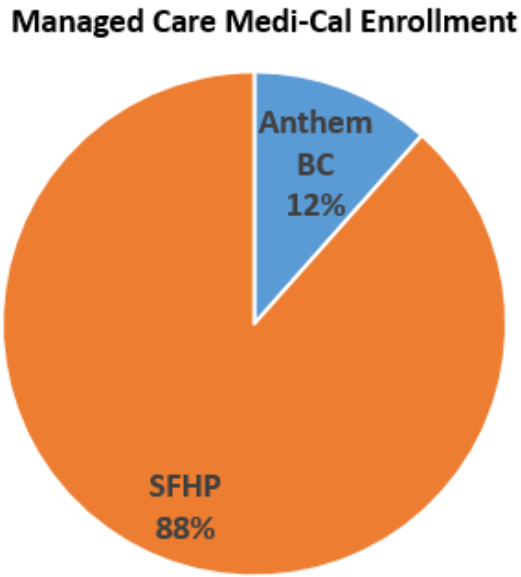


5B. Managed Care and Contracts

SFHN Total Enrollment as of June, 2016

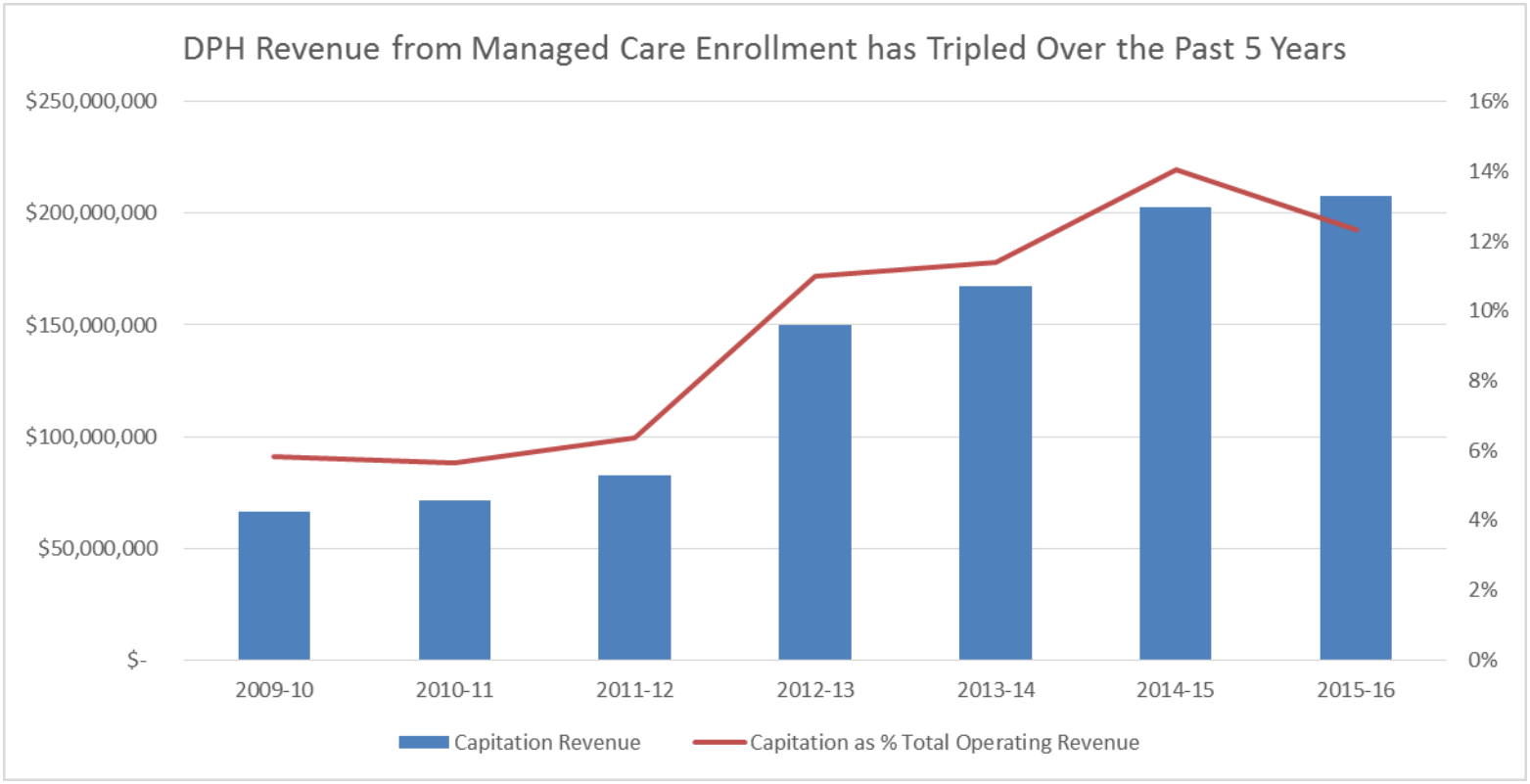






5B. Managed Care and Contracts

Capitation Revenue – PC and Hospital Only



5B. Managed Care and Contracts

Contracting Efforts Since January, 2015

Contracting Party	Type of Efforts	Target Population	Effective Date
SF Health Plan - NEMS	New contract	Medi-Cal, Healthy Kids enrolled with SFHP NMS medical group	Jan. 1, 2015
Beacon	New contract	Medi-Cal enrolled with SFHP CHN for NSMH services	Jan. 1, 2015
SF Health Plan	New contract	Third party administrative service agreement	Jul. 1, 2016
Anthem	Renewal contract	Medi-Cal	Oct. 15, 2016
Blue Shield	New contract	CCSF employees enrolled thru Hill Physicians	Early 2017 (est.)
United Health Care	New contract	CCSF employees enrolled in the City's PPO plan	Mid 2017 (est.)
SF Health Plan	Amendment	Mitigating SFHN's financial risk for OON services for MC, HW, HK	Tbd.

5C. 1115 Waiver

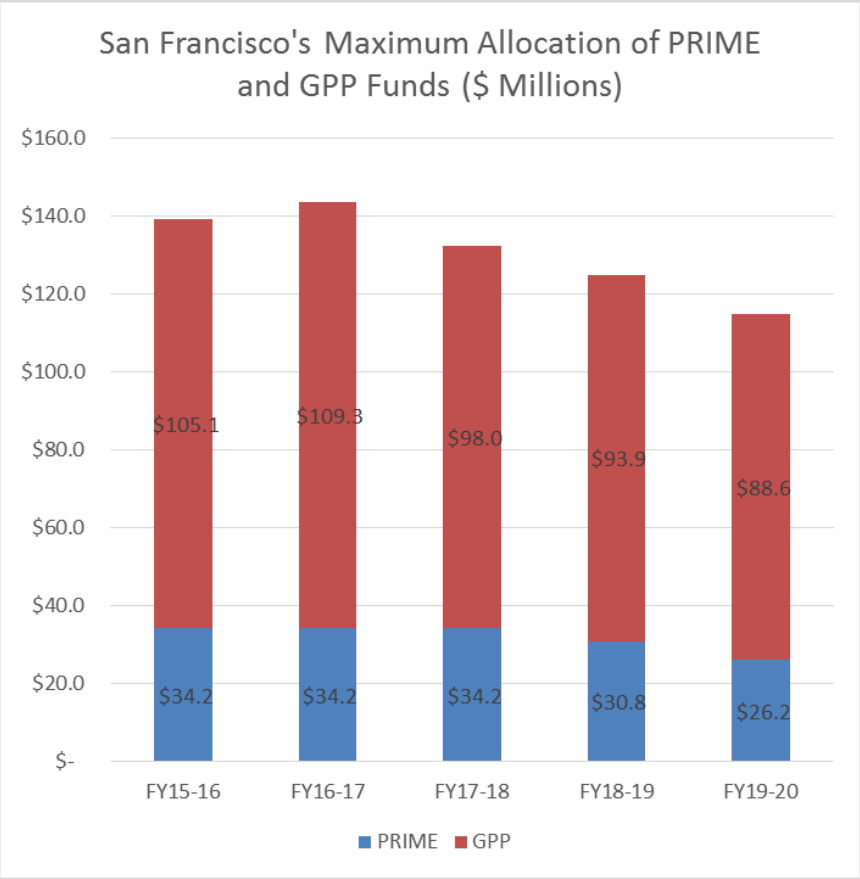
Key Financial Components:

- PRIME – Successor to DSRIP
- Global Payment Program (GPP) – Successor to DSH/Safety Net Care Pool
- Whole Person Care – New Program
- Drug Medi-Cal Organized Delivery System

5C. 1115 Waiver

Prime and GPP

- PRIME
  - Payments earned through achievement of specified metrics
- GPP
  - Payments based on services provided to uninsured patients/clients
  - Over 5 years shifts payment weight away from inpatient and toward preventative/ambulatory
- Both programs require improvements in data collection to maximize payments
- Baseline budget assumes ~77% of max payments earned for FY 16-17 and 17-18
- Program design indicates direction of federal payment policies post-Waiver



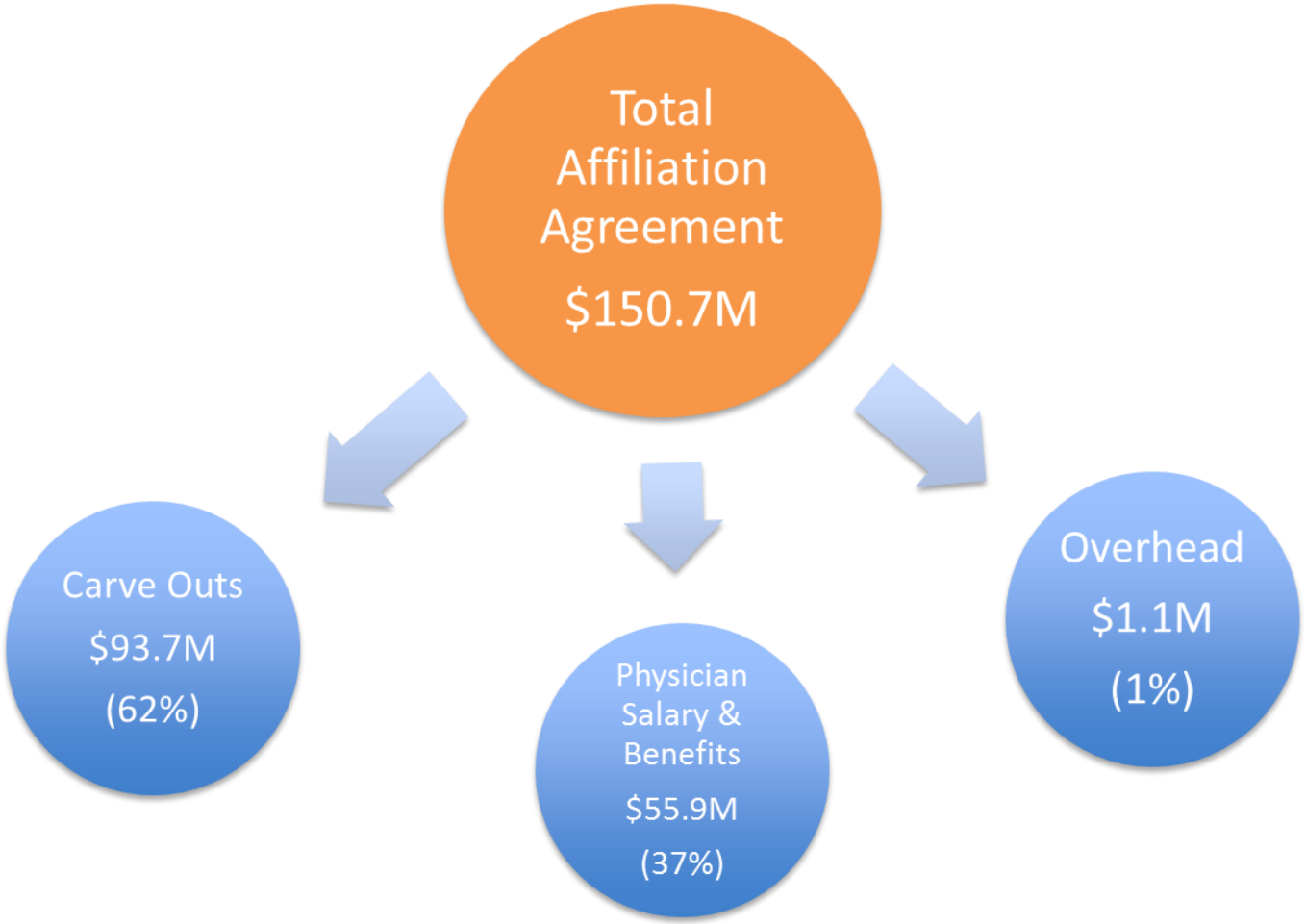
5C. 1115 Waiver

Drug Medi-Cal ODS and Whole Person Care

- Drug Medi-Cal Organized Delivery System
  - Allows reimbursement for Substance Use Disorder for Medi-Cal eligible clients
  - Baseline budget assumes revenues of ~$6 million in FY 16-17 and $10 million in FY 17-18
  - Challenges for implementation:
    - Dependent on Medi-Cal certification by providers
    - Requires enhanced documentation and compliance to bill successfully
    - Staffing mix and program design must change in some areas to draw funds
- Whole Person Care
  - Application-based program; SF submitted application that is currently under review by DHCS
  - Provides funds to improve outcomes for target populations through partnership/collaboration of multiple agencies (e.g., multiple City departments, health plans, CBOs)
  - Payments based on metrics and milestones (with some administrative cost recovery)
  - Upcoming Health Commission discussion of application status

5D. UCSF Budget

Average Spending on Permanent Affiliation Agreement FY15 and FY16



5D. UCSF Budget

Goal of Project

- Develop sustainable budget process for UCSF provider support at ZSFG ($56M) that addresses the following:
  - Links budget process to provider productivity
  - Introduces incentive structure to create alignment with ZSFG True North
  - Keeps AA at FY16 level through FY21 in order to support funding of UCSF ApeX

Note: Physician salaries and benefits are approximately 37% of the total Affiliation Agreement

5D. UCSF Budget

Timeline

- FY16: UCSF Dean's Office at ZSFG and the UCSF Clinical Practice Group (CPG) conducted detailed department analysis of spending
- Fall 2016: UCSF, ZSFG, and DPH leadership to develop funding model
- Spring 2017: Finalize FY18 budget
- Fall 2017: Evaluate effectiveness and accuracy of model to address any changes for FY19 model
- Spring 2018: Finalize FY19 budget

Note: This will be an ongoing process in partnership with UCSF, ZSFG, and DPH leadership

5E. EHR Preparedness

- $105.3 million budgeted in project to date
- Review of industry experience indicates:
  - Initial drop in revenues due to productivity loss following implementation
  - Eventual uptick of ~3% due to improved documentation, acceleration of cash collection
    - SFHN upside is lower than many systems due to payer mix
- Additional financial benefits:
  - Improved data collection to document outcomes and coordinate across system of care – critical for earning value-based payments
  - Needed for ability to contract with advanced payers
  - Imposes discipline for documentation, standard work

5E. EHR Preparedness

- Challenges:
  - Managing cost of implementation and ongoing support
  - Successful revenue cycle implementation requires deep coordination between finance and operations
  - Discipline to adopt “as-is” required to maximize cost savings from retired systems, limit add-ons, customization
  - Planning and preparation for process changes to mitigate length and depth of productivity drop at go-live

5F. Capital and Facilities

- Key Goals:
  - Proposition A (2016) – Re-use of Building 5 and Primary Care clinic improvements
  - Exit 101 Grove by 2020 (Seismic deficiencies)
  - Long-term space planning to alleviate crowding, anticipated loss of existing office space, mitigate seismic risk
- Initiatives:
  - Oversight structure in place for 2016 Bond
  - Studies underway to evaluate options for re-use of ZSFG campus brick buildings, old wings at LHH
  - Capital Plan update and DPH planning retreat winter, 2016
- Challenges/Risks:
  - Scope "wish list" vs. available funds
  - Limit operational cost expansion in new facilities
  - DPH will require 2022 G.O. Bond to complete ZSFG campus renovations, consolidation of operations into seismically updated facilities

Overview

Key questions for 5-Year Financial Planning

- How can we serve our patients while keeping the amount of General Fund Subsidy required at a reasonable level the City can afford?
- What do we know (and not know) about what the financial environment will look like for DPH in 5 years? 10 years?
- Given changes in State and Federal policy/regulatory environment, how do our operations and payer mix need to change to ensure we fulfill our mission?
- With managed care enrollment growth plateauing 3 years after ACA, what steps do we need to take to maintain and grow revenue from these lines of business?
- What changes should we expect in SF over the coming decade – economic, demographic, etc. – and how do they affect financial planning and decision making?
- How do we prepare for the next economic downturn, and ensure services are insulated from impacts of economic cycles?

6. Key Areas of Focus for 5-Year Planning
5-Year Plan Scenarios

Planning Scenarios

6. Key Areas of Focus for 5-Year Planning

Proposed areas of focus:

- Target: Limit Growth in GF Support to Projected Growth in City Tax Revenue
- Manage cost growth
  - EHR – manage implementation and operating budgets
  - New initiatives funded through re-purposing of existing dollars
  - UCSF Physician Costs – use productivity, incentives to guide budgeting
  - Development of cost-management information systems and reporting (cost-accounting system, cost-center level budget vs. actual reporting
  - Refine and formalize staffing models to match projected volumes (e.g., primary care panels, nurse staffing models
  - Budget education plan and implementation – ensure DPH staff have an understanding of how their day-to-day work affects financial outcomes

6. Key Areas of Focus for 5-Year Planning

Proposed areas of focus:

- Manage cost growth (Contd)
  - Manage growth in cost of purchased goods and services by leveraging purchasing power, strategic contracting
  - Careful planning for interdepartmental efforts
    - EMS
    - Dept of Homelessness and Supportive Housing
  - Capital Projects
    - Financial Oversight and Controls on Capital Projects
    - Manage operating cost impacts associated with Capital Projects

6. Key Areas of Focus for 5-Year Planning

Proposed areas of focus:

- Lean
  - EHR
  - Value-Based Payments: Waiver and Post-Waiver Preparedness
  - Contracts
  - PHD QI Efforts
- Revenue maximization
  - Careful coordination of EHR revenue cycle program between finance and clinical operations
  - Improve Billing in Public Health Clinics
  - Prepare for ongoing changes in PHD grant allocations

6. Key Areas of Focus for 5-Year Planning

Proposed areas of focus:

- Revenue maximization (Continued)
  - Payer Contracting strategy
    - Improving efficiency and revenue from existing contracts
    - Emphasize "foot-in-the-door" contracts with City HSS plans while building capability for larger engagements
    - Design contracts to maintain trauma/emergency revenues at ZSFG
    - Continue business case development for "Centers of Excellence" within SFHN – Births, Transgender services, etc.
    - Align outreach and communication strategy with contracting efforts

6. Key Areas of Focus for 5-Year Planning

Proposed areas of focus:

- Planning for long-term patient population – demographics, economic changes in SF
- Capitated member retention
  - Improve data on reasons for enrollment/disenrollment
  - Targeted efforts to reduce "bad" OOMG costs
  - Patient communications efforts – make sure patients and new enrollees receive information about SFHN and our services