Hyde Hospital

Community Benefit 2025 Report and 2026 Plan

Adopted January 2026

UCSF Health

Dignity Health
Saint Francis Memorial Hospital

A message from James Bennan, Interim Chief Operating Officer

This report details activities of Hyde Hospital from July 1, 2024 – June 31, 2025. Over that period both UCSF Health and Dignity Health owned Stanyan Hospital. In consultation with the California Department of Health Care Access and Information, the entity that oversees the Senate Bill 697 compliance, this report satisfies both UCSF Health Stanyan and Dignity Health's SB 697 commitment as it reports on the activities that were undertaken while the hospitals were owned by each entity.

The hospital's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Hyde Hospital shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2025 Report and 2026 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2025 (FY25), Hyde Hospital provided $74,989,754 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $42,338,613 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Board reviewed, approved and adopted the Community Benefit 2025 Report and 2026 Plan at its January 29, 2026 meeting. The Community Advisory Board reviewed the report at its December 19, 2025 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching out to Hyde Hospital Community Health Office, 900 Hyde St., San Francisco CA 94109 or by e-mail to Alexander.Mitra@ucsf.edu.

James Bennan
Chief Operating Officer
UCSF Health Hyde and Stanyan Hospitals

Table of Contents

At-a-Glance Summary

Community Served	The Hyde and Stanyan Hospitals serve the City and County of San Francisco. The City and County of San Francisco, with **827,526** people is the fourth-most populous city in California and the 17th-most populous city in the United States. Its 46.9 square miles is often rounded up to 49, to connect to 1849, the year that started the gold rush and the nickname for San Franciscans as the 49ers.
Economic Value of Community Benefit	$75,166,621 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $42,338,613 in unreimbursed costs of caring for patients covered by Medicare
Significant Community Health Needs Being Addressed	The hospital intends to take several actions and to dedicate resources to these needs, including: **Access to Care** Access to healthcare includes aging, patient and family-centered care, disability, oral health, and transportation. In San Francisco, access is shaped by affordability, provider availability, transportation, and cultural responsiveness, with disparities persisting in historically neglected communities. **Behavioral Health** Behavioral health includes mental health and substance use and is shaped by emotional, social, and environmental factors. Access to resources, socioeconomic status, housing conditions, and severe negative experiences all impact behavioral health. **Economic Opportunity** Economic security includes education, employment, food security, housing and homelessness, and income. It is essential for accessing basic resources like food, healthcare, education, transportation, and housing.
FY25 Programs and Services	The hospital intends to take several actions and to dedicate resources to these needs, including: **Access to Care** Work with care partners to support patient's access to Cal-AIM benefits Street-Based Medicine Outreach for homeless patients Serious Illness Program for Chinese Seniors Community Grants Program Patient Financial Assistance

	Behavioral Health Convening with SFPD, DPH, SFFD on Care for Patients Under 5150 Holds Cal-AIM Medication Assisted Treatment in the Emergency Room Substance Use Navigator San Francisco Health Improvement Partnership **Economic Opportunity** California Advancing and Innovating Medi-Cal Health Professions Education Graduate Medical Education Community Grants
FY25 Planned Program and Services 	The hospital plans to continue prior year programs and activities to address significant community health needs. As the coronavirus pandemic continues, the hospital will work with its partners to continue to address the evolving health needs.

This document is publicly available online at https://sfcommunityhospitals.ucsfhealth.org/saint-francis/about-us/community-benefits

Written comments on this report can be submitted to the hospital's Community Health Office at 900 Hyde Street, San Francisco, CA 94109 or emailed to Alexander.Mitra@ucsf.edu

Our Hospital and the Community Served

About Hyde Hospital

Hyde Hospital is currently a hospital within UCSF Health's Network Division. On August 1, 2024 the hospital was purchased by UCSF Health, which means that for the month of July the Hospital was part of CommonSpirit Health. The work described for FY25 was conducted under UCSF Health and CommonSpirit Health, while the FY26 plan was devised under UCSF Health.

Hyde Hospital (HH) has been meeting the health needs of San Francisco for over 100 years. Founded in 1905 by a group of five physicians, HH continues to carry out its mission: "dedicate our resources to: delivering compassionate, high-quality, affordable health services for our sisters and brothers who are poor and disenfranchised; and partnering with others in the community to improve the quality of life." Today, HH remains a thriving center of healing and innovation in medicine as well as a spiritual anchor to its community.

HH is located on Nob Hill, and maintains 293 beds, with a staff of over 1,000 employees and 200 active physicians. About 59% of the patients are residents of San Francisco. Among the hospital's inpatient population, there are 43% Caucasian, 20% Asian, 14% African Americans, 9% Hispanics, 3% Multiracial, 1% Native American and 10% Other. The hospital also has a number of specialized programs that draw patients from all over Northern California and beyond. The Bothin Burn Center is the only verified burn center in San Francisco and one of only three centers in Northern California. HH has a state-of-the-art emergency department and has nine operating suites in the surgery department. HH also offers inpatient psychiatric services, acute rehabilitation, and hyperbaric services. The Hyde Orthopedic and Sports Institute offers a full spectrum of orthopedic services.

Our Mission

The mission of UCSF Health is Caring, Healing, Teaching and Discovering.

The mission of CommonSpirit Health is to make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

The vision of UCSF Health is to be the best provider of health care services, the best place to work and the best environment for teaching and research.

The vision of CommonSpirit Health is a healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

UCSF Health treats all patients who require our services, without regard to race, color, religion, national origin, citizenship or other protected characteristics. We are committed to these responsibilities and vigorously enforce UC nondiscrimination and privacy policies. We do not release immigration related information to federal agencies or others without a warrant or subpoena or as otherwise required by law.

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

Hyde Hospital serves the City and County of San Francisco. San Francisco, at roughly 47 square miles, is the most densely populated large city in California. Between 2011 and 2018, San Francisco grew by almost eight percent to 888,817 persons outpacing population growth in California (6 percent).

The population is aging and the ethnic shifts continue with an increase in the Asian and Pacific Islander population, increase in multiethnic populations and a decrease in the Black/African American population.

San Francisco has a relatively small proportion of households with children (19 percent) compared to the state overall (34 percent).

Despite areas of affluence, there remain significant pockets of poverty (as evidenced in the Community Needs Index which follows) particularly in the African American and Hispanic/Latino communities.

HH serves the San Francisco's zip codes with the richest and poorest residents, including 94102 (Tenderloin), 94103 (SoMa), 94104 (Downtown), 94108 (Chinatown), and 94133 (North Beach). A summary description of the community is below. Additional details can be found in the CHNA report online.

Total Population	873,965
Race	
Asian/Pacific Islander	36.0%
Black/African American - Non-Hispanic	5.6%
Hispanic or Latino	15.2%
White Non-Hispanic	40.2%
All Others	3.0%
% Below Poverty	10.0%
Unemployment	2.2%*
No High School Diploma	11.4%
Medicaid	30%+
Uninsured	5.2%

Source: Census Bureau, 2020 Census.
*Employment Development Department, May 2022
+ American Community Survey, 2015-2019

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Significant Health Needs

The 2022 CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

These foundational issues play a significant role in creating and intensifying the health needs identified in the community health needs assessment:

Significant Health Need	Description	Intend to Address?
Access to Welcoming Healthcare	Access to Welcoming Healthcare refers to the right to accessible and affordable, culturally grounded, relevant, and competent acute and preventative healthcare. Welcoming care is delivered in local neighborhoods, by healthcare professionals who are from the communities they are serving, are grounded in anti-racism and interpersonal bias, have knowledge of the community's historic relationship with (and harm done by) the healthcare system, and are equitably compensated for their work.	●
Behavioral Health & Substance Use	Behavioral Health and Substance Use refers to access, stigma, availability, and affordability of behavioral and mental health professionals and services. Substance use refers to substance access, use, and availability of support for substance misuse. Behavioral Health also refers to the freedom from external and environmental trauma. Community violence decreases the real and perceived safety of a neighborhood disrupting social networks by inhibiting	●

Significant Health Need	Description	Intend to Address?
	social interactions, causing chronic stress among residents who are worried about their safety, and acting as a disincentive to engage in social interactions.	
Economic Opportunity	Economic opportunity refers to the financial and socioeconomic conditions which allow for an individual and community to effectively afford the tangible and intangible materials and resources necessary to thrive. Additionally, economic opportunity includes (but is not limited to) exposure to environmental/climate-related factors and/or hazards, freedom from violence and trauma, and the ability to obtain nutrient-dense, culturally relevant food items, and affordable housing.	●

Significant Needs the Hospital Does Not Intend to Address

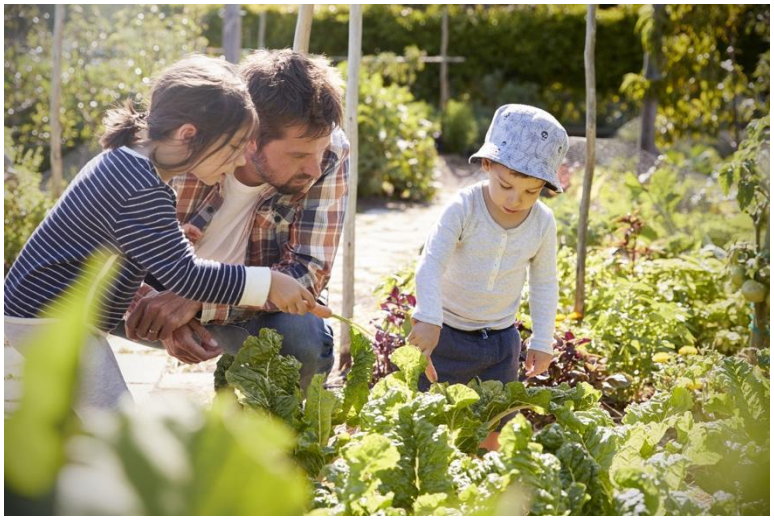
The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2025 Report and 2026 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY25 and planned activities for FY26, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan



The hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included Care Coordination, Emergency Department, Nursing, Graduate Medical Education, Surgery, Business Development, Mission, and Palliative Care. Department leaders were asked about their staff and patient needs, connection to community resources, and department goals. Staff shared that valuable insights such as need to break down silos in the organization, support patients with services pre- and post-hospitalization, access city services and increase safety for staff in the Emergency Department.

Community input or contributions to this implementation strategy included San Francisco Health Improvement Partnership, San Francisco CalAIM Providing Access and Transforming Health (PATH) Collaborative, and monthly meeting on the care for patients under 5150 holds. In these convenings attendees provided valuable input on the needs of the community for case management, better transitions of care, and other community supports like housing, and substance use treatment.

From this input the Hospital decided to focus its efforts on supporting three priority populations:

- Medi-Cal and Medi-Care patients
- Dual Diagnosis patients
- Seniors

The programs and initiatives described here were selected on the basis of existing programs with evidence of success and impact, research into effective interventions, access to appropriate resources and addressing immediate goals of the hospital.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Economic Opportunity

Strategy or Program Name	Summary Description	Active FY25	Planned FY26
Health Professions Education	HH provides training opportunities for prospective nurses, physical and occupational therapists, chaplains, and sterile processing technicians	☒	☒
Health Professions Education: Clinical Pastoral Education Program (CPE)	One-year program that provides CPE students with a collaborative, interfaith and clinical learning environment to develop their skills in pastoral reflection, pastoral formation, pastoral competence and pastoral specialization.	☒	☒
Health Professions Education: Nurse Preceptor	In partnership with local colleges and universities, HH's Nursing Preceptor Program is designed to provide student nurses with the tools, skills, and experience of the Registered Nurse (RN). This includes one-on-one time with an RN where the students develops assessment, clinical reasoning, leadership, and delegation skills.	☒	☒
Health Professions Education: Dietetic Intern	In partnership with the San Francisco State University, HH's Food and Nutrition Department serves as a preceptor for Dietetic intern students. This internship provides the knowledge and practice requirements necessary to be eligible to take the Registered Dietitian (R.D.) examination.	☐	☒
Cal-AIM	Cal-AIM is a re-imagining of the Medi-Cal system to create investments into upstream determinants of health. Hyde and St. Mary's are looking to ensure staff know how to refer patients to program perks like case management, medically tailored meals and housing navigation.	☒	☒
Medication Assisted Treatment and Substance Use	As a result of a 2018 pilot, HH's leadership, physicians and support staff saw that the need for increased substance use disorder (SUD) and medication assisted treatment (MAT)	☒	☒

Navigator (formerly Alcohol & Other Drugs Counselor)	services far exceeds the current capacity to provide treatment options to patients. Since then, HH has hosted a Substance Use Navigator, in partnership with the California Bridge Program to expand substance use treatment and referral, including increased capacity for Medical Director and Addiction Specialist to oversee the program, provide specialized communication training to destigmatize SUD and provide support to prescribing physicians and care-teams for complex patient cases.		

Impact: The hospital's initiatives to economic opportunity are anticipated to result in: improved pathways to employment and opportunities for healthy choices and wraparound services among currently or formerly homeless individuals.

Collaboration:

PATH CalAIM Collaborative*:* San Francisco Department of Homelessness and Supportive Housing, A Anthem Blue Cross, San Francisco Health Plan, Chapman Consulting, San Francisco Department of Public Health, Project Open Hand, San Francisco Dept. of Disability & Aging Services, Independent Living Systems, Stepping Stone Health, North East Medical Service, Curry Senior Center, Kaiser Permanente

San Francisco Police Department, San Francisco Department of Public Health, GLIDE, San Francisco Health Plan.

Health Need: Access to Welcoming Healthcare

Strategy or Program Name	Summary Description	Active FY25	Planned FY26
Tenderloin Health Services	In FY 24 the hospital has entered into a street-based medicine pilot for homeless individuals with the San Francisco Community Health Clinic, provided a van and financial support to expand Code Tenderloin's nights and weekend navigation program and worked with Curry Senior Center on a Medical Respite project.	☒	☒
Serious Illness Project for Chinese Seniors	With Self-Help for the Elderly and All-American Medical Group, Hyde and St. Mary's are collaborating to create a holistic wrap around model to support the health of Chinese seniors with support from a Stupski grant. Along with post discharge support, the program includes palliative care/Advanced Care Plans, and AI directed primary care outreach using AAMG's insurer database.	☒	☒
Trans Support Group	Hyde started to host a weekly Trans Support Group in partnership with Mental Health SF.	☒	☒
San Francisco Health Improvement Partnership	Hyde Hospital participated in the San Francsico Health Improvement Partnership to conduct the Community Health Needs Assessment (CHNA) with partner hospitals, Joint Health Equity groups and the San Francisco Department of Public health. After the needs assessment, SFHIP is scoping out future venues for collaboration by exploring each	☒	☒

	partners implementation strategy to address the needs identified in the CHNA.		

Impact: The hospital's initiatives to address access to coordinated, culturally and linguistically appropriate care and services are anticipated to result in: improved access to appropriate health care services, providers, social services and support, particularly for the uninsured and underinsured, vulnerable and/or marginalized populations. Accessible health care can prevent disease and disability, detect and treat illnesses, maintain quality of life, and extend life expectancy. From a population health perspective, regular access to quality health care and primary care services also reduces the number of unnecessary emergency room visits and hospitalizations and can save public and private dollars. While the availability and access to health care and social services in San Francisco may be better than many other places, significant disparities exist by race, age, and income.

Collaboration: The hospital partners with San Francisco Community Health Clinic, San Francisco Department of Public Health, Healthy San Francisco, Curry Senior Center, GLIDE, Code Tenderloin, Self-Help for the Elderly, All-American Medical Group, community-based clinics and organizations.

Health Need: Behavioral Health & Substance Use

Strategy or Program Name	Summary Description	Active FY25	Planned FY26
Tenderloin Health Services	In FY 24 the hospital has entered into a street-based medicine pilot for homeless individuals with the San Francisco Community Health Clinic, provided a van and financial support to expand Code Tenderloin's nights and weekend navigation program and worked with Curry Senior Center on a Medical Respite project.	☒	☐
Delancey Street Foundation	HH partners with the Delancey Street Foundation to provide Delancey's residential substance abuse rehabilitation and vocational training participants with health services at the Hyde Hospital Health Center.	☒	☒
Rally Family Visitation Services	Launched by the San Francisco Unified Family Court in 1991, Rally was adopted by Hyde Hospital in 1997. Rally is the only program of its kind in the San Francisco Bay Area providing services to families dealing with diverse situations, including allegations and/or history of domestic violence, child abuse (sexual, physical, emotional, etc.), substance abuse, mental health issues, parenting concerns, and cases referred for lack of contact between the non-custodial parents and their child/children in Marin, San Francisco, and San Mateo counties. These visitation services are designed for children who may be at risk of emotional or physical harm following their parents' separation or divorce and is staffed by highly trained and licensed mental health professionals and volunteers who supervise visits and exchanges between children and parents.	☒	☒
Medication Assisted Treatment and Substance Use Navigator (formerly	As a result of a 2018 pilot, HH's leadership, physicians and support staff saw that the need for increased substance use disorder (SUD) and medication assisted treatment (MAT) services far exceeds the current capacity to provide treatment	☒	☒

Alcohol & Other Drugs Counselor)	options to patients. Since then, HH has hosted a Substance Use Navigator, in partnership with the California Bridge Program to expand substance use treatment and referral, including increased capacity for Medical Director and Addiction Specialist to oversee the program, provide specialized communication training to destigmatize SUD and provide support to prescribing physicians and care-teams for complex patient cases.		
Convening on Care for 5150 Patients	With the support of Hyde Emergency Department leadership, the hospital began convening meetings with SFPD: CIT, SFDPH: Comprehensive Crisis Services around coordinating care for patients under 5150 holds. The meetings have grown to encompass SFFD: SCRT and SFDPH: AOT, and have been helpful in creating clearer connections between the various partners worked	☒	☒

Impact: The hospital's initiatives to address safety and violence from trauma are anticipated to result in safer and secure environments to reduce rates of injury, death and emotional trauma among clients served by Rally Family Visitation Services and Tenderloin residents.

Collaboration:
Rally Family Visitation Services: San Francisco Unified Family Court, service providers working in domestic violence, mental health, and substance use.
Convening on Care for 5150 Patients: San Francisco Police Department: Crisis Intervention Unit, San Francisco Fire Department: Paramedics Division and EMS Division, San Francisco Department of Public Health: Comprehensive Crisis Services

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY25, the hospital awarded the grants below in conjunction with St. Mary's Center totaling $275,888 for both hospitals. St. Francis Memorial Hospital's share:

Grant Recipient	Project Name	Amount
Code Tenderloin	Nights and Weekends Street Navigation Project	$50,000 ($100,000 total*)
Self Help for the Elderly	Asian Health Collaborative	$50,000 ($100,000 total*)
18 Reasons	Nourishing Pregnancy	$9,398 ($18,796 total*)
SF City Vitals	Vehicle for Patient Navigation	$9,398 ($18,796 total*)
Healing Well	Recovery Support Services	$9,398 ($18,796 total*)
Good Shepherd Gracenter	Transitional Housing and Addiction Recovery Program for Homeless Women	$9,750 ($19,500 total*)

*Hyde and St. Mary's jointly funded projects

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Tenderloin Health Services	
Significant Health Needs Addressed	• Access to Coordinated, Culturally and Linguistically Appropriate Care and Services
Program Description	Tenderloin Health Services is a program where Hyde Hospital seeks to align, coordinate and support health services within the Tenderloin. Hyde continued work with San Francisco Community Health Center's street-based outreach team, Code Tenderloin's Nights and Weekend Street Navigation Program, and Curry Senior Center's Medical Respite Project.
Population Served	Homeless, dual-diagnosis, and medi-cal patients in the Tenderloin
Program Goal / Anticipated Impact	Set up regular check-ins between SFCHC team and HH team to assess our progress, make improvements in real time, discuss and triage patients as needed. Develop a coordinated tracking system that is shared between HH and SFCHC. Street-based team will document and track all street-based efforts and chart all patient notes, referrals, and lab results through our electronic health record system. This will enable us to monitor patient health progress and outcomes, as well as track overall project progress. CodeTenderloin's Night and Weekend Navigation team will increase referrals from the Emergency Department to substance use treatment, housing, and workforce programs. The program provides navigation for Tenderloin patients and patients of the Hyde Emergency Department during the night time and weekends, when services are not traditionally offered by institutional organizations. CodeTenderloin has been able to successfully refer patients to SOMA Rise, Dore, Medical Respite, crisis stabilization beds and shelter during the off-hours. Hyde has not been able to refer patients to these services at night and during the weekend.
FY 2025 Report	
Activities Summary	In FY25 Hyde Hospital continued to deepen collaborations with Code Tenderloin, San Francisco Community Health Center and Curry Senior Center.

	Additionally, the hospital sourced and created new collaborations with SF City Vital and From this work, Hyde Hospital was invited to present at the Department of Health Care Service's Hospital Best Practices presentation on December 5, 2024 to share the hospital's strategy of leveraging CalAIM partners to support medi-cal patients. Starting in FY23 the Saint Francis Foundation and Hyde Hospital engaged with the San Francisco Community Health Clinic to begin the Street-Based Medicine Outreach program to provide primary care and labs work to homeless individuals in the Tenderloin. The program increased the days that the outreach team is out in the field and also provided a connection to the Hyde Hospital by enabling staff to refer patients that reside in the TL for follow up by the outreach team.
Performance / Impact	Healthier communities by ensuring homeless patients receive primary care services closer to home. Created regular status meetings between SFCHC and Code Tenderloin to assess our progress, make improvements in real time, discuss and triage patients as needed.
Hospital's Contribution / Program Expense	Staff time to create linkages for street based outreach and centering work in the emergency department setting.
FY 2026 Plan	
Program Goal / Anticipated Impact	Develop a coordinated tracking system that is shared between HH and SFCHC and Code Tenderloin. Deepen coordination between CalAIM Enhanced Case Management providers for patients at Hyde Hospital by bringing the outreach teams on-site to connect with patients and make the ECM referral to the Medi-Cal Managed Care Plans. We anticipate this will streamline referrals and allow hospital staff to have a personal contact with Street-based team will document and track all street-based efforts and chart all patient notes, referrals, and lab results through our electronic health record system. This will enable us to monitor patient health progress and outcomes, as well as track overall project progress. With all these interventions the hospital plans to reduce Medi-Cal and Medi-Care all-cause readmissions for patients to the statewide average of 13%. In CY24 Hyde Hospital's readmission rate is 15.4% for Medi-Care patients (422/2,740) and 17.9% for Medi-Cal patients (178/997).

Planned Activities	Continue to iterate and connect patients to outpatient services in the community in conjunction with SFCHC and their street-based teams. Set up monthly connection points with providers and community organizations to evaluate referrals and see where we can better connect patients. Bring ECM providers on-site to hasten ECM on-boarding and increase trust.

Medication Assisted Treatment and Substance Use Navigator (formerly Alcohol & Other Drugs Counselor)

Significant Health Needs Addressed	● Access to Coordinated, Culturally and Linguistically Appropriate Care and Services ● Social, Emotional and Behavioral Health
Program Description	Many HH patients live 200% below the poverty line, struggle with homelessness, substance use disorder (SUD), chronic mental health conditions, and other health outcomes associated with poverty. In 2018, HH initiated a pilot program for Medication for Opioid Use Disorder (MOUD) and Medication Assisted Treatment (MAT) in the Emergency Department and determined that the need for increased SUD and Medication Assisted Treatment (MAT) services exceeded the hospital's capacity to provide treatment options. Since 2019, HH has worked to expand this work, including increased capacity for Medical Director and Substance Use Navigator (SUN) to oversee the program, provide specialized communication training to destigmatize SUD and provide support to prescribing physicians and care-teams for complex patient cases. The SUN in particular gives patients in the Emergency Department setting time to decompress, ask questions and evaluate whether they'd like to receive MAT services.
Population Served	The primary beneficiaries of the program are the patients and community members getting referrals and connections to services.
Program Goal / Anticipated Impact	Increase HH's ability to identify and provide onsite medication assisted treatment (buprenorphine, methadone, suboxone) and community-based support to patients with alcohol/substance use disorders. ● Improved coordination between AOD Counselors, Patient Navigator, Social Workers, and X-Waivered Physicians to expand access to MAT and improved care coordination. ● Increased number of Emergency Department patients started or continued on MOUD ● Increase number of In-patient Medicine patients started or continued on MOUD

FY 2025 Report	
Activities Summary	In FY25 the SUN left their role at Hyde Hospital for a growth position. The substance use navigator at Hyde met with referred patients of the hospital to connect them to treatment and harm reduction services. They also supported the Stimulant Use Prevention in Communities of Color initiative. Finalized a Housing and Homelessness Incentive Program (HHIP) grant from the San Francisco Health Plan to fund the SUNs.
Performance / Impact	While services were interrupted, Emergency Department staff continued to connect patients to SUD treatment through community paramedics and DPH street teams.
Hospital's Contribution / Program Expense	Grant scoping work and management of CHW staff and reporting and partial salary for staff.
FY 2026 Plan	
Program Goal / Anticipated Impact	Increase HH's ability to identify and provide onsite medication assisted treatment (buprenorphine, methadone, suboxone) and community-based support to patients with alcohol/substance use disorders.
Planned Activities	In FY26 staff plans to connect the SUN to the new substance-use treatment services in San Francisco and send final reports for the HHIP grant. Care Coordination leadership successfully hired a replacement Substance Use Navigator amidst two hiring freezes. Community Health staff connected new substance use treatment services to the Emergency Department staff to ensure patients had

Rally Family Visitation Services

Significant Health Needs Addressed	• Safety from Violence and Trauma • Social, Emotional and Behavioral Health
Program Description	Through the Rally Family Visitation Services program, HH provides a safe and secure structured environment in which children can visit with their court-ordered non-custodial parent when there is a high level of high conflict, including domestic violence, between divorced/separated parents. The program serves predominantly low-income families.
Population Served	Children and their court-ordered non-custodial parent Custodial domestic violence survivors

Program Goal / Anticipated Impact	Provide supervised visitation to families in need of supervised visitation in three Bay Area Counties.
FY 2025 Report	
Activities Summary	In FY25 the newly hired executive director Katharine Berg increased the program visits, successfully increased contracted dollars for the program amid turbulent funding areas and managed a capital project to move the San Mateo office to a new location. This entailed learning new UCSF processes, educating new leadership about Rally's importance, and making reasonable requests to meet our contract obligations. Under Katharine's leadership Rally has increased the hours visitation services, stabilized staffing, and taken steps to reduce the waitlist of families waiting to enter the service.
Performance / Impact	Rally is the only program of its kind in the Bay Area. Without these services, parents who cannot afford private providers would not be able to see their children. ● Provided a secure and safe environment for visits ● Ensured children have access to both parents in a healthy environment ● Ensured safety for victims of domestic violence while at Rally ● Secured new locations for services due to hospital visitor limitations. In FY25 Rally restarted in-person services in Marin County, increased the visits for staff from 1,332 to 1,762. This represents a 32% increase in services for families.
Hospital's Contribution / Program Expense	Hospital contributed $1,703,805 on staff salaries, benefits, use of space and supplies.
FY 2026 Plan	
Program Goal / Anticipated Impact	Provide supervised visitation to families in need of supervised visitation in San Francisco, Marin and San Mateo. Evaluate and streamline data reporting and on-boarding processes to serve more patients.
Planned Activities	In FY26 Rally will enact a staffing model to lessen dependency on per-diem employees to expand availability of services during the peak requested hours of the Friday – Sunday. Rally will also explore using AI and electronic signatures to streamline on-boarding and data reporting.

San Francisco Health Improvement Partnership	
Significant Health Needs Addressed	• Access to Coordinated, Culturally and Linguistically Appropriate Care and Services • Food Security, Healthy Eating and Active Living • Housing Security and an End to Homelessness • Safety from Violence and Trauma • Social, Emotional and Behavioral Health
Program Description	San Francisco Health Improvement Partnership is a collaborative body who mission is to improve community health and wellness in San Francisco through collective impact. Hyde partners with hospitals, community-based non-profits organized into three Joint Health Equity Coalitions and the Department of Public Health to commission one Community Health Needs Assessment every three years. The Needs Assessment also provides a vehicle to spur collaboration between the parties.
Population Served	The primary beneficiaries of this program are the residents of San Francisco.
Program Goal / Anticipated Impact	Seek to address community inequities by fostering multi-sector alignment, building common agenda, investing in and supporting mutually reinforcing activities, building measurement and evaluation capacity, and providing backbone support.
FY 2025 Report	
Activities Summary	In FY25 SFHIP completed the 2025 Community Health Needs Assessment; collectively prioritizing the health needs of San Francisco. SFHIP then shared the results of the needs assessment with the community. We also deepened our relationship with SFDPH on the needs assessments. There was more intentional data sharing between the two organizations, and a commitment to partner for the 2028 Community Health Needs Assessment/Community Health Assessment. This means there will be one document for the 2028 cycle. Additionally, SFDPH invited SFHIP members to join their Community Health Improvement Process. A representative from Hyde Hospital, as well as the API, and African American Joint Health Equity Groups are participating in the process.
Performance / Impact	• Fostered alignment across social determinants of health among community-based organizations and city agencies, including neighborhood safety and park activation and community capacity to strengthen overdose prevention services. • Participated in policy development/advocacy efforts, elevating community voice at local levels.

	• Created commitments to align future work during the 2028 Community Health Needs Assessment cycle.
Hospital's Contribution / Program Expense	Staff time dedicated to the SFHIP program is included as part of the total Community Benefit Operations net benefit reported in the Economic Value of Community Benefit section of the report. Dollars paid to consultants to pay for the 2025 Community Health Needs Assessment.
FY 2026 Plan	
Program Goal / Anticipated Impact	In FY26 Hyde Hospital will deepen collaborations with our partners at the San Francisco Health Improvement Partnership.
Planned Activities	In FY26 Hyde Hospital will work to learn about each partners Community Health Implementation Strategies, evaluate areas for collaboration and work with the San Francisco Department of Public Health's Community Health Improvement Process.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

Advocacy
HH staff advocate for local and state health policy. HH staff engages with elected and appointed officials at the local, state and federal level as well as a diversity of healthcare thought leaders from the public and private sector in support of HH strategic objectives.

Charity Care
HH continues to work hand in hand with the Department of Public Health on the issues of health reform and Charity Care. The Charity Care Workgroup, which includes representatives from the San Francisco Department of Public Health and all of the city's hospitals, meets periodically throughout the year to discuss the annual citywide Charity Care Report and examine issues related to charity care.

Healthy San Francisco
The goal of Healthy San Francisco is to make healthcare services accessible and affordable to uninsured San Francisco residents. The program is not designed as insurance but as an innovative reinvention of the City's healthcare safety net, enabling and encouraging residents to access primary and preventive care. The San Francisco Health Plan, in partnership with the San Francisco Department of Public Health, administers Healthy San Francisco.

High Users of Multiple Systems (HUMS)
HH staff participates in this workgroup of providers caring for the patients with high rates of utilization of Emergency Medical Services (ambulances), hospital emergency departments, sobering services and a variety of case management services. The aim of the program is to reduce recidivism through case conferencing and intensive service delivery on a case by case basis.

San Francisco Health Improvement Partnership (SFHIP)
HH staff are active in the HHIP leadership and steering committees. HHIP is motivated by a common vision, values, and community-identified health priorities and as such HHIP will drive community health improvement efforts in San Francisco. The HH community health plan and strategy is designed to align with HHIP priorities.

San Francisco Hep B Free
HH continues to be an active partner in the Hepatitis B Coalition, participating in coalition activities including sponsoring the annual gala.

Economic Value of Community Benefit

227 Hyde Hospital

Complete Summary - Classified (Occurrences) - Including Non Community Benefit (Medicare and Bad Debt)
For period from 07/01/2024 through 06/30/2025

	Persons	Total Expense	Offsetting Revenue	Net Benefit
Benefits for Poor or Vulnerable				
Financial Assistance	2,599	$8,153,197	$1,528,576	$6,624,621
Medicaid	11,847	$94,838,147	$29,553,434	$65,284,713
Other Means Tested Programs	16	$82,425	$0	$82,425
Community Services				
A Community Health Improvement Services	10,514	$2,284,555	$528,640	$1,755,915
E Cash and In-Kind Contributions	6	$137,944	$0	$137,944
F Community Building Activities	1	$11,660	$0	$11,660
G Community Benefit Operations	1	$110,766	$0	$110,766
Totals for Community Services	**10,514**	**$2,544,925**	**$528,640**	**$2,016,285**
Totals for Poor or Vulnerable	**24,976**	**$105,795,561**	**$31,610,650**	**$74,008,044**
Benefits for Broader Community				
Community Services				
A Community Health Improvement Services	1	$5,254	$0	$5,254
B Health Professions Education	213	$965,206	$0	$965,206
E Cash and In-Kind Contributions	3	$12,500	$1,250	$11,250
Totals for Community Services	**213**	**$982,960**	**$1,250**	**$981,710**
Totals for Broader Community	**213**	**$982,960**	**$1,250**	**$981,710**
Total Community Benefit	**25,189**	**$106,601,654**	**$31,611,900**	**$74,989,754**
Medicare	13,566	$84,775,499	$42,436,886	$42,338,613
Totals with Medicare	**38,755**	**$191,377,153**	**$74,048,786**	**$117,328,367**

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of

Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Hospital Board and Community Board Roster

Community Hospital Board			
First Name	Last Name	Title	
Joshua	Adler, MD*	Chief Medical Officer	UCSF Health
Benjamin	Durie	Senior Principal Counsel	UCSF Health
Suresh	Gunasekaran	Chief Executive Officer	UCSF Health
Fernando	Morano	Chief Financial Officer	UCSF Health Network

*Board Chair

Community Advisory Board of the Community Hospitals			
Name First	Last Name	Title	Organization
Diana	Aycinena, RN	Associate Director of Street-Based Services	San Francisco Community Health Center
Ruben	Chavez	Deputy Director	Curry Senior Services
Anni	Chung	Executive Director	Self Help for the Elderly
Ray	Difasio	Member	Stanyan and Hyde Patient Experience Council
Rommel	Gotico	Assistant Nurse Manager - Bothin Burn Center	Hyde Hospital, UCSF Health
Donna	Hilliard	Executive Director	Code Tenderloin
Clem	Jones, MD	Orthopedic Surgeon	San Francisco Spine Doctors
Johanna	Liu	Executive Director	San Francisco Community Clinic Consortium
Joyce	Maxion	Care Coordination Assistant	Stanyan Hospital, UCSF Health
Richard	Podolin, MD	Physician	Cardiovacular Medical Group
Edwin	Poon	Chief Equity Officer	San Francisco Health Plan