FILE NO. 140246

Petitions and Communications received from March 3, 2014, through March 10, 2014, for reference by the President to Committee considering related matters, or to be ordered filed by the Clerk on March 18, 2014.

Personal information that is provided in communications to the Board of Supervisors is subject to disclosure under the California Public Records Act and the San Francisco Sunshine Ordinance. Personal information will not be redacted.

From Building Inspection, regarding the release of Permit and Project Tracking System project reserve. (1)

From concerned citizens, regarding transportation network companies and taxi services. 4 letters. File No. 140020. Copy: Each Supervisor. (2)

From Philip Carleton, regarding phone etiquette. Copy: Each Supervisor. (3)

From Jim Noble, regarding English as the official language. (4)

From Capital Planning Committee, regarding Port supplemental appropriation ordinance and Airport Commission Capital Plan Bonds and related supplemental appropriation request. Copy: Each Supervisor. (5)

From Mayor, designating Supervisor Katy Tang as Acting-Mayor from March 8, 2014, until March 9, 2014. Copy: Each Supervisor. (6)

From Mayor, regarding status of Civil Grand Jury recommendations. File Nos. 130601, 130602, 130606, and 130607. Copy: Each Supervisor. (7)

From SFUSD, regarding status update to Civil Grand Jury Report. File No. 130603. Copy: Each Supervisor. (8)

From Clerk of the Board, regarding the following appointment by the Mayor:
William K. Cleaveland - Fire Commission. (9)

From Sophia De Anda, regarding Swords to Plowshares. (10)

From Jordan Angle, regarding pursuit of liquor license at 493 Broadway. File No. 130444. (11)

From Controller, submitting "Five-Year Financial Plan Update for General Fund Supported Operations FY 2014-15 through FY 2017-18." Copy: Each Supervisor. (12)

From concerned citizens, regarding proposed ordinance on electronic cigarettes. 9 letters. File No. 131208. Copy: Each Supervisor. (13)

From concerned citizens, regarding proposed ordinance on bottled water. File No. 131207. 18 letters. Copy: Each Supervisor. (14)

From Controller, submitting "Department of Health: A Summary of Health Reform Readiness." File No. 131240. Copy: Each Supervisor. (15)

From concerned citizen, regarding freezing MUNI fares and young commuters. Copy: Each Supervisor. (16)

From Clerk of the Board, reporting the following individuals have submitted Form 700 Statements: (17)

Harvey Rose - Budget & Legislative Analyst - Annual
Debra Newman - Budget & Legislative Analyst - Annual
Jason Fried - LAFCo - Annual
Lauren Kahn - Legislative Aide - Leaving
Matthias Mormino - Legislative Aide - Annual

City and County of San Francisco
Department of Building Inspection

Orig: BtF Clerk
COB, BtF Chair, Leg. Dep Gayle

Edwin M. Lee, Mayor
Tom C. Hui, S.E., C.B.O., Director

February 28, 2014

Angela Calvillo
Clerk of the Board of Supervisors
1 Dr. Carlton B. Goodlett Place
City Hall, Room 244
San Francisco, CA 94102

Subject: Release of Permit and Project Tracking System Project Reserve

Dear Ms. Calvillo:

I respectfully request that the reserve in the amount of $460,000 on the Department of Building Inspection's Permit and Project Tracking System (project PBIPTE) be released and scheduled to be heard before the Budget and Finance Committee.

The Permit and Project Tracking System (PPTS) is a joint project with the Department of Building Inspection and the Planning Department. This system will improve and enhance the City's permitting and project tracking systems by sharing data between the two departments; combining project, permit, GIS, property and billing data into one system; and will allow for a more transparent process by making data accessible to the public and allowing for applications to be submitted and tracked on-line.

The reserve was placed on this project in the FY 2009-10 budget (File Number 090779, Ordinance Number 184-09), pending the outcome of contract negotiations for the final scope and cost of the integrated Permit Tracking System.

The PPTS contract was executed on September 12, 2011 between the City and Accela-21 Tech, LLC for $4,321,146, and has been amended to include additional reports and customized scripts to bring the current contract amount to $4,881,146. An additional amendment for reports is under discussion. The project is scheduled to go live in the summer of 2014.

The release of this reserve is necessary to have sufficient appropriation to pay for consultant expenses related to the design and configuration of the system.

If there are any questions in regards to this request, please contact the Department of Building Inspection's Acting Chief Financial Officer, Gayle Revels, at 558-6213 or Gayle.Revels@sfgov.org.

Sincerely,

Tom C. Hui

Tom C. Hui, S.E. C.B.O.
Director

1

City and County of San Francisco
Department of Building
Inspection

Edwin M. Lee, Mayor
Tom C. Hui, S.E., C.B.O., Director

cc: Gayle Revels, Acting Chief Financial Officer
Chris Simi, Mayor's Budget Analyst
Theresa Kao, Controller's Budget Analyst
Linda Wong, Board of Supervisor's Committee Clerk
Catherine Stefani, Office of Supervisor Mark Farrell, Legislative Aide

From: Board of Supervisors
To: Evans, Derek
Subject: File 140020: Ride-sharing Services

From: Alexander Warneke [mailto:warneke7@gmail.com]
Sent: Tuesday, March 04, 2014 4:23 PM
To: Board of Supervisors
Cc: Mar, Eric (BOS); Avalos, John; Breed, London; Campos, David; Chiu, David; Cohen, Malia; Farrell, Mark; Tang, Katy; Wiener, Scott; Yee, Norman (BOS); Kim, Jane
Subject: Ride-sharing Services

Supervisors,

As someone who regularly uses ride-sharing services to travel within the city, I can tell you that Supervisor Mar's suggestion to limit the number of vehicles is a huge mistake. These organizations are already self governing the number of vehicles available, and doing a great job of providing an adequate supply relative to the demand. Imposing arbitrary limitations on the number of vehicles would significantly detract from the efficiency and usability of the service.

One of the main reasons these companies have been successful is because of the nightmare that was trying to get a cab during peak hours. This lack of cabs has an extreme negative effect on our community, as it encourages drunk and/or buzzed driving in certain populations. Regulation would send us right back to that problem. While I understand the need for the city to protect us by imposing rules and regulations on ride sharing services, this is NOT the place to start - you're trifling with a supply/demand system that is already perfecting itself.

Thank you for considering my opinion,

Alex Warneke

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From: Board of Supervisors
To: BOS-Supervisors; Evans, Derek
Subject: File 140020: Ramifications of the Demise of the SF Taxi Industry

From: Buzz Brooks [mailto:buzzardjazz@gmail.com]
Sent: Thursday, March 06, 2014 1:17 PM
To: Board of Supervisors
Subject: Ramifications of the Demise of the SF Taxi Industry

Dear Supervisors:

Thank you for having a hearing on the taxi industry, especially Supervisor Mar for bringing it.
I would like to bring to your attention this statistic from the San Francisco Travel website:

San Francisco hosted **16.5 million visitors** in 2012, including hotel guests, those staying with friends and relatives, those staying in accommodations outside the city but whose primary destination was San Francisco, and regional visitors driving in for the day. Visitor spending reached the highest ever in 2012, with more than **$8.93 billion spent in local businesses** (up 5.5% from 2011). This means during an average day in San Francisco, 131,128 visitors are spending $24.46 million.

As you can see, and as you undoubtedly already know, this visitor industry is the life blood of San Francisco.

In any major city anywhere in the US that attracts visitors, there is always a local cab industry. Most visitors, especially tourists from other countries, rely on taxis as part of the transportation infrastructure. Few have the smartphone apps for illegal cabs such as Lyft and Sidecar.

Now, for just a minute, try to imagine Manhattan with no taxicabs.

Now, let me ask you, would you like San Francisco to be the first city in the country to have suffered the complete demise of the local cab industry? Replaced by an unregulated, unsafe, and, as Mr Mar says, a wild west enterprise with pricing all over the map?

That is what will happen if you do not take serious action on this issue of TNCs. The cab companies cannot stay in business if drivers do not show up to rent the cabs from the companies, plain and simple.

Furthermore, is it not the policy and the mandate of the city of San Francisco to DISCOURAGE the use of private autos? How many programs are in place for this very purpose? Dozens, I'm sure. Yet when 1500 or more exhaust spewing cars show up on the streets every day, the city turns a blind eye...why IS that?

So eventually, if nothing is done, cab companies will fold, because real taxi drivers will not be able to make a living due to an excessive supply of vehicles for hire.

Ultimately, our brochure that we send out to convention planners all over the world, will say, "Come to San Francisco! Where we don't have any taxicabs!"

The visitor industry is the HAND THAT FEEDS YOU. Fail to act, and you are biting that very same hand.

Respectfully submitted by Buzz Brooks, in the SF taxi industry since 1980.

From: Board of Supervisors
To: BOS-Supervisors; Evans, Derek
Subject: File 140020: Ride Share Service Car Cap

-----Original Message-----
From: Morgan Ellsworth [mailto:morgan.v.ellsworth@gmail.com]
Sent: Tuesday, March 04, 2014 12:05 PM
To: Board of Supervisors
Subject: Ride Share Service Car Cap

Dear Supervisors,

I am writing to let you know that I am vehemently opposed to the proposal by Eric Mar that would cap the number of cars ride share services such as Uber, Lyft and Sidecar use. I and many others use these services frequently and prefer them 10/10 times over any cab. I have had an extremely negative experiences with cabs in this city. The only reason these services prosper is because the cab situation in SF is the worst of any major city in America. Issues such as not accepting credit cards, refusing service to distant locations (all within the city limits), unfriendly and occasionally angry drivers as well as not showing up when called are all commonalities w/ cabs. In my estimation, the ride car services do literally everything better than the cabs. If you want to fix the "problem" of ride car services, perhaps you should concentrate on improving the quality of our cab service.

Thank you for your time,

Morgan Ellsworth

From: Board of Supervisors
To: BOS-Supervisors; Evans, Derek
Subject: File 140020: Technology & Taxi

From: Alaric Von Boerner [mailto:taxijazz@rocketmail.com]
Sent: Wednesday, March 05, 2014 3:03 PM
To: Board of Supervisors
Subject: Technology & Taxi

I've driven a taxi since 1975 ...analyzing what other people are doing, and determining how to operate safely for nearly 40 years.

In 38 years I got rear-ended 9 times... at a stop light, stop sign, or when yielding for a pedestrian. Nine times in 38 years, and then recently within a 4 month period I got rear-ended 3 times. Nine times in 38 years, and then 3 times within 4 months with unusual circumstances. There has been a dramatic change, and I have been watching it evolve.

Within the taxi industry there was the introduction, several years ago, of "computer dispatch". A signal would command the driver to look at a text message with urgency. The driver only had so many seconds to respond, and it didn't matter what was happening on the roadway. There were many incidents, but if anyone got injured they couldn't blame the technology... it was the drivers responsibility to deal with the distraction safely. Text messages while driving are very dangerous, but it wasn't against the law at the time; the company could ignore the reality of the hazard, and place all the blame on the driver. There was no documentation reflecting the dangers of a text based dispatching system, but now we know because text messages have become commonplace, and they clearly should be prohibited while driving.
The computer dispatch method has been established, but allowing it to continue should be reconsidered.

There are other ways where technology didn't provide the efficiency that it has in other industries (other than putting more money into fewer peoples pockets), because when taxi service was radio operated the driver would hear cross streets called out continuously, and by listening to this he would construct a grid in his mind so that he knew how to find every street. He could also hear where there were a lot of calls and work his way to whatever part of town had more need. But after computer dispatch was in place he was driving blind, not knowing where there might be more need for service. And after awhile he didn't know the streets.

The taxi industry became much less efficient, and to solve the problem created by technology -- more technology came along. A phone while you drive?! Well, we are supposed to know by now that using a phone while you drive isn't safe. I ended up forced to use Flywheel (I quit the computer dispatch company, and can show you pictures of wreaked cars), and I insist for safety, to only use such a system when the car is in park. Flywheel doesn't like it that I don't respond while I'm driving. When the system didn't work it took me 3 months to get a response, having to call

several times, and they told me that I had to interface my cell phone with the system for it to work anymore. Sorry, I don't use a cell phone while I'm driving.

Technology trumps all; an unsafe platform is promoted, and then unlicensed operators with inadequate insurance, and little scrutiny, flood the streets. If this is an experiment it may be time to put a stop to it. There are so many issues that point to absurdity in allowing it that the question most people would ask is; Who is getting paid off, and how much are they paid to ignore public safety and the law? If the State of California wants to say that it's OK to have a lit screen in front of your face (Sorry, it is impossible to keep one eye on a screen and one on the road; and any illumination within the field of vision can be a hazard. Consult cognitive science.), and that text messaging is allowed to provide public transportation... These things might be OK in some places, but they should be strictly prohibited in San Francisco. There are too many pedestrians wandering into the street without looking, arrogant bicyclists that challenge drivers, and confused motorists all over the place. San Francisco is no place to have your ability to drive safely encumbered in any way. Technological devices with text or any amount of light at night cannot be allowed in cars if you want safe streets. Whoever says we can't stand in the way of innovation should be held responsible for the pedestrian who is standing there.

Drivers in general have taken a dip in relating to what is going on around them. Needless to say there is too much distraction while driving, and; a popular failure to acknowledge that despite the comfort of your car -- operating a motor vehicle is extremely dangerous. Illumination within a vehicle at night compromises processing information on the road. Text messaging totally disrupts attention. Driving a car is one area where the introduction of technology carries with it many hazards. Driving a car is NOT safe despite all of the illusions about safety, and even a little compromise against paying attention to the road may be too much. Telling people to look twice is of no use if they have too many things going on within their vehicle, and things that compromise the processing of information within their visual field.

Aside from the hazards of using a phone while driving (Cognitive science has also determined that even hands-free is unsafe), the application of the phone to a taxi business has extended itself to providing taxi service without a license. Thus empowered, Uber, Lyft, and Sidecar, and whatever else, can get around all the rules... and then ignore traffic laws, and safety sense. They do anything they want, and are building a time bomb in the process.

An Uber driver will roam the street and try to hustle people into his car and rip them off when business is slow... It happens, and I've heard many complaints, but who else should anyone complain to? They can call the police and say "Well, it was a black car." Years ago a woman was picked up by an unlicensed taxi, another guy jumped in, and the two men took turns raping her while they drove her around The City for several hours. Uber would be perfect for that.

Lyft advertises as if it's a social event, with people sitting in the front seat. The safest place for a customer is in the back set, and driving in San Francisco is not the same as sitting in a coffee house... They encourage distraction even beyond the technology. Also they advertise that drivers make outrageous amounts of money... With no expensive license, insurance, and not realizing what the maintenance of their vehicle is going to amount to; they might believe they will eventually get

there. But when their car starts breaking down, and they are desperate to make this big money they were promised... Do you want to allow this to transpire?

In the midst of this insane technology the taxi industry has been destroyed.
You might want to avert this before it's too late, because:
To have clearly marked vehicles... Do you believe it might be a good idea?
The medallion system provided that people with a vested interest in a public utility would be on the streets as supervisors. So both the public and the company could identify errant drivers easily. So, a clearly market vehicle can make a big difference, and there was a lot of insistence upon it for the sake of safety in the past. In addition to requiring that public transportation vehicles be clearly marked and scrutinized, the distractions within the vehicles should be eliminated. There should be no screens or lights in the field of vision, and all information to drivers should be processed through a 3rd party... Sorry if I sound old fashioned, but using a microphone for a couple seconds is not a distraction, and way safer than talking on the phone "hands-free". Perhaps taxi companies should upgrade their radio systems, and the dispatcher can look at screens.

In any event, I've studied this for about 40 years, and I've used the technology. I know a lot about technology. It's not safe while operating a motor vehicle. For other reasons Lyft, Uber, etc. should be prohibited from operating in San Francisco.

Dean Alaric von Boerner
(415) 225 8881

From: Philip D Carleton [carletonp@usfca.edu]
Sent: Wednesday, March 05, 2014 4:16 PM
To: Lee, Mayor; Kim, Jane; Wiener, Scott; Campos, David; Chiu, David; Mar, Eric (BOS); Avalos, John; Breed, London; Tang, Katy; Cohen, Malia; Farrell, Mark; Yee, Norman (BOS)
Cc: Board of Supervisors
Subject: Telephone etiquette of your staff and volunteers

Dear Mayor Lee and Supervisors Avalos, Breed, Campos, Chiu, Cohen, Farrell, Kim, Mar, Tang, Wiener, Yee:

I write to ask that you advise and insist that the all of staff and volunteers in your office improve their telephone etiquette.

I am over 60 years of age and have a hearing loss that may be attributable to my service in the United States Army. I am not the only member of the California public that has a hearing loss.

In the past when I have called **your** offices, some of **your** staff have mumbled, spoken so quickly that I could not understand what they said, not spoken into the mouth piece, and have become arrogant and derisive to the point of being insulting when I have had to ask them to repeat their initial greeting and subsequent statements.

I request that you do advise and insist that all of your staff and volunteers do the following:

1. speak into the mouthpiece of the telephone, not holding it at their chest or elsewhere.

2. speak slowly and distinctly into the mouthpiece with a greeting that you approve, such as, "Good morning, Good afternoon, this is Mayor Lee's or Supervisor X's office. My name is XYZ. How may I help you?" We the public want to know that we have reached the office phone that we have dialed and want to know at the beginning whom we are speaking to.

3. listen carefully to the messages and questions of the caller and take careful notes, asking for spelling of names, places, etc and writing down numbers and dates etc. The office assistants should repeat their understandings of the messages to be certain that they written down the intended messages/information of the callers.

4. always speak slowly, enunciate words distinctly, spell slowly the names of people, offices and places and speak slowly and distinctly telephone and other numbers. It is a waste of the callers' time and the office assistants' time to have to repeat a message 3 or 4 times in order for the callers to understand the messages of the office assistants.

5. Sincerely thank the callers for their calls before they say "Goodbye," not just hang up.

Lazy, arrogant telephone staff and volunteers who refuse to follow these basic rules of polite telephone etiquette should be resigned to other duties or fired!

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If you want to listen to an example of a perfect S.F. public servant, pick up your telephone and call the Clerk of the Board's telephone number and speak with Hyacinth. I spoke with her today and understood her perfectly. Order all of your staff and volunteers to call her and listen to her as an example of the finest telephone etiquette.

I want to also suggest that you incorporate in all of your webpages a "Customer Satisfaction Form" such as the one in the Clerk of the Board's webpage.

I hope you have the courtesy to respond to this message. On January 9, 2014, I sent an email message with the subject heading "Suggestions of ways to reduce vehicle-caused injuries and deaths." Only one supervisor had the courtesy to respond with an email message, and then with a fixed, inane one. I spent hours working on that 1/9/14 message because I care about and am determined to help reduce the number of individual and MUNI vehicle-caused injuries and deaths in San Francisco. Also, I have spent at least 1 hour on this message today 3/5/14. If you do not have the courtesy to respond to messages and do not want the public to send you messages, just tell us that so that we do not waste our time writing and sending them.

Somewhat respectfully yours,

Philip Carleton

--
Philip D. Carleton

Office tel. no. 415 422-6282 ; carletonp@usfca.edu

Assistant professor of English as a second language

Room 260, Kalmanovitz Hall

University of San Francisco

2130 Fulton Street

San Francisco, CA 94117-1080

From: Board of Supervisors
To: BOS-Supervisors
Subject: FW: Please introduce an official English resolution!

-----Original Message-----
From: video@got.net [mailto:video@got.net]
Sent: Wednesday, March 05, 2014 12:33 AM
To: Board of Supervisors
Subject: Please introduce an official English resolution!

Jim Noble
14890 Big Basin Way
Boulder Creek, CA 95006-9319

March 5, 2014

City and County of San Francisco
1 Drive Carlton B. Goodlett Place
San Francisco, CA 94102-4603

Dear City and County of San Francisco:

Polk County, Wisconsin just adopted an official English resolution.

I strongly support this effort of English unity and I urge you to introduce a similar resolution in our county.

Rasmussen Reports found recently that an overwhelming 85% of likely voters support official English. High levels of support for official English have remained unchanged for the past decade.

It's time to limit taxpayer-funded translations and encourage English language learning in our county.

Please make official English an agenda item for this year.

Sincerely,

Jim Noble

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BOS-11, B/F Clerk Cpage

Capital Planning Committee

Naomi M. Kelly, City Administrator, Chair

MEMORANDUM

February 25, 2014

To: Supervisor David Chiu, Board President

From: Naomi Kelly, City Administrator and Capital Planning Committee Chair

Copy: Members of the Board of Supervisors
Angela Calvillo, Clerk of the Board
Capital Planning Committee

Regarding: (1) Approval of the San Francisco Port supplemental appropriation ordinance; and (2) Approval of the resolution and related supplemental appropriation ordinance authorizing the issuance of San Francisco Airport Commission Capital Plan Bonds.

In accordance with Section 3.21 of the Administrative Code, on February 24, 2014, the Capital Planning Committee (CPC) reviewed two action items to be considered by the Board of Supervisors related to the Port of San Francisco and the San Francisco International Airport. The CPC's recommendations are set forth below.

1. Board File Number: TBD	**Approval of the Port of San Francisco's Supplemental Request appropriating $1,089,250 of savings from the 2008 Clean & Safe Neighborhood Park's General Obligation (G.O.) Bond Program to fund eligible capital improvement projects**
Recommendation:	Recommend the Board of Supervisors approve the authorizing ordinance.
Comments:	The CPC recommends approval of these items by a vote of 11-0.
	Committee members or representatives in favor include: Naomi Kelly, City Administrator; Judson True, Board President's Office; Nadia Sesay, Controller's Office; Ed Reiskin, Director, SFMTA; Mohammed Nuru, Director, Public Works; Harlan Kelly, General Manager SFPUC; John Rahaim, Director, Planning Department; Kate Howard, Mayor's Budget Director; Ivar Satero, San Francisco International Airport; Dawn Kamalanathan, Recreation and Parks Department; and Daley Dunham, Port of San Francisco.
Board File Number: TBD	**Approval of a Resolution Authorizing the issuance of up to $1,969,830,773 in San Francisco Airport Commission Capital Plan Bonds and related Supplemental Appropriation Request**

3

Recommendation:	Recommend the Board of Supervisors approve the authorizing resolution and related supplemental ordinance.
Comments:	The CPC recommends approval of these items by a vote of 11-0.
	Committee members or representatives in favor include: Naomi Kelly, City Administrator; Judson True, Board President's Office; Nadia Sesay, Controller's Office; Ed Reiskin, Director, SFMTA; Mohammed Nuru, Director, Public Works; Harlan Kelly, General Manager SFPUC; John Rahaim, Director, Planning Department; Kate Howard, Mayor's Budget Director; Ivar Satero, San Francisco International Airport; Dawn Kamalanathan, Director, Recreation and Parks Department; and Daley Dunham, Port of San Francisco.

OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE
MAYOR

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BOARD OF SUPERVISORS
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March 7, 2014

Ms. Angela Calvillo
San Francisco Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102

Dear Ms. Calvillo,

Pursuant to Charter Section 3.100, I hereby designate Supervisor Katy Tang as Acting-Mayor from Saturday, March 8 at 11:11 am to Sunday, March 9 at 9:47 pm.

In the event I am delayed, I designate Supervisor Tang to continue to be the Acting-Mayor until my return to California.

Sincerely,

Edwin M. Lee
Mayor

cc: Mr. Dennis Herrera, City Attorney
All Members, Board of Supervisors

1 DR. CARLTON B. GOODLETT PLACE, ROOM 200
SAN FRANCISCO, CALIFORNIA 94102-4681
TELEPHONE: (415) 554-6141

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BOS-11, COB
cpage

OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE
MAYOR

File 130601
130602
130606
130607

March 7, 2014

Angela Calvillo, Clerk of the Board of Supervisors
Attn: Government Audit and Oversight Committee
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102

Dear Ms. Calvillo:

Attached please find a consolidated summary of the status of recommendation updates for the following 2012-13 Civil Grand Jury recommendations:

- "Are the Wheels Moving Forward? A Follow-Up to the 2009-2010 Civil Grand Jury Report *Sharing the Roadway: From Confrontation to Conversation,"* Recommendation 4.2.
- "Building a Better Future at the Department of Building Inspection," Recommendations 1.1, 1.2, and 5.1.
- "Log Cabin Ranch: Planning for the Future, a Continuity Report," Recommendations 3 and 4.2.
- "Optimizing the Use of Publicly-Owned Real Estate: Achieving Transparency, Momentum, and Accountability," Recommendation 3.

This status of recommendations report should be included in the official legislative file for consideration at the Government Audit and Oversight Committee.

Sincerely,

Kate Howard
Mayor's Budget Director

1 DR. CARLTON B. GOODLETT PLACE, ROOM 200
SAN FRANCISCO, CALIFORNIA 94102-4681
TELEPHONE: (415) 554-6141

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Status of the Recommendations
by the Civil Grand Jury
2012-13

California Penal Code Section, 933.05 (b), requires the responding party to report for each recommendation of the Civil Grand Jury one of the following actions:

1. Recommendation Implemented	2. Will Be Implemented in the Future	3. Requires Further Analysis	4. Will Not Be Implemented: Not Warranted or Not Reasonable
- Date Implemented - Summary of Implemented Action	- Anticipated Timeframe for Implementation	- Explanation - Timeframe *(Not to exceed six months from date of*	- Explanation

For each recommendation below, indicate one of the four actions you have taken or plan to take in the "Action Plan" column and provide the required explanation in the "2014 Response Text" column.

CGJ Year	Report Title	Recommendation	Response Required	Action Plan	2014 Response Text
2012-13	Are the Wheels Moving Forward?	4.2. Through collaboration with SFPD, BAC, and SFMTA the City should build an Enforcement Safety Campaign around the goals in Recommendation 10 and alert the public to the SFPD enforcement plan that will follow.	Mayor	Recommendation to be implemented in 2014	In response to the recommendations contained in the "Are the Wheels Moving Forward?" Civil Grand Jury report, the Mayor's Office asked the SFMTA, in conjunction with the Department of Public Health, to convene a working group comprised of city agencies focused on bicycle crash analysis and solutions. As mentioned in the SFMTA response, "This group aims to establish the locations where data demonstrates the highest number and/or severity of traffic collisions involving bicyclists, and make recommendations for engineering, education, enforcement and evaluation actions. This effort parallels the analysis and planning work that has already been done for pedestrian crashes through the Pedestrian Safety Task Force." This March, the SFMTA will convene a larger steering committee to review the analysis and assemble the recommendations. Additionally, the Mayor, along with SFMTA, SFPD, and the Fire Department announced a new "Be Nice, Look Twice" public awareness campaign. Launched last month, the campaign will remind all road users to not only slow down and pay more attention to their surroundings, but also help and care for one another as we all travel San Francisco's streets and sidewalks. In addition to the new public awareness campaign, the SFPD will increase enforcement on City streets. The SFPD will target 50 intersections Citywide, leveraging the latest City data to identify and target hotspots. All 10 district stations will participate in the increased enforcement.
2012-13	Are the Wheels Moving Forward?	4.2. Through collaboration with SFPD, BAC, and SFMTA the City should build an Enforcement Safety Campaign around the goals in Recommendation 10 and alert the public to the SFPD enforcement plan that will follow.	SFMTA	Recommendation will be implemented in 2014	Last November, the SFMTA in conjunction with the Department of Public Health convened a working group comprised of city agencies which is focused on bicycle crash analysis and solutions. This group aims to establish the locations where data demonstrates the highest number and/or severity of traffic collisions involving bicyclists, and make recommendations for engineering, education, enforcement and evaluation actions. This effort parallels the analysis and planning work that has already been done for pedestrian crashes through the Pedestrian Safety Task Force. In March, we plan to convene a larger steering committee to review the analysis and assemble the recommendations. In addition, the Board of Supervisors also urged the City to convene a working group comprised of the City Administrator's office, the SFMTA, San Francisco County Transportation Authority, the Department of Public Health, the Police Department, the Department of Public Works, the Transbay Joint Powers Authority, Walk San Francisco, the San Francisco Bicycle Coalition and stakeholders representing trucking companies and drivers, including the teamsters and the California Trucking Association, to create a standardized baseline for driver education and mandatory driver safety curriculum for all CCSF employed drivers and drivers that contract with the City and identify and implement programs that increase the safety of efficient goods and commuter movement by all large vehicles utilizing city streets with the goal of implementing training and safety programs by 2015. The SFMTA convened the first working group to create a driver education and safety curriculum on January 28, 2014. The SFMTA will continue to lead this group to create programs and identify responsible agencies and departments to increase the safety of efficient goods and commuter movement by all large vehicles with the goal of implementing this training program by 2015.

(1) "--" Department did not respond with one of the four required actions.

Status of the Recommendations
by the Civil Grand Jury
2012-13

CGJ Year	Report Title	Recommendation	Response Required	Action Plan	2014 Response Text
2012-13	Are the Wheels Moving Forward?	4.2. Through collaboration with SFPD, BAC, and SFMTA the City should build an Enforcement Safety Campaign around the goals in Recommendation 10 and alert the public to the SFPD enforcement plan that will follow.	SFPD	Agree - Partially implemented. Will be implemented in the future	The SFPD has initiated numerous enforcement operations to address transit safety in the City. Those operations have been data driven. Our primary enforcement effort is entitled "Focus on the Five" which directs our resources to the top five problematic intersection in each of the 10 police districts. This effort also directs our officers to focus their efforts on observing and issuing citations for the top five traffic violations that are the primary cause of traffic collisions (speeding, red light running, stop sign violations, drivers that fail to yield to pedestrians in crosswalks and failing to yield while making left or u-turns). The SFPD and SFMTA have distributed reports to the public that identifies the most problematic areas of the city as it relates to traffic collisions. The SFPD district stations regularly inform their respective communities of enforcement efforts. We routinely coordinate enforcement efforts with the media in an effort to use these enforcement operations as educational opportunities. Through these collaborative efforts with the media, we highlight the problematic behavior as it relates to transit safety, showcasing the enforcement efforts which will ultimately change behavior. The SFPD regularly attends BAC meetings and advise of our enforcement efforts. In January 2014, the SFPD representative attended a meeting of BAC to address concerns on enforcement efforts. A collaborative "Enforcement,Safety Campaign" with input from BAC is still in the works.
2012-13	Building a Better Future at the Department of Building Inspection	1.1 The DBI management should retain a consultant to update the 2007 BPR findings and recommendations and present the findings to BIC and the DBI Director. 1.2 The BIC and DBI Director should develop a detailed action plan with firm due dates for implementing BPR report recommendations that the consultant identifies as not completed. 5.1. The Board of Supervisors shall hold a hearing within six months of the release of this report by the 2012-2013 Jury to see if BIC has taken action on the issues raised.	BIC and DBI Director	Recommendation Implemented OR Will Be Implemented in the Future	DBI, with BIC agreement, sent out bid requests for a qualified consultant on February 4, 2014, with a closure date of February 18, 2014. These bid requests, with the detailed scope of work, were sent to a total of six consultants listed upon the City-approved vendor list, including: AECOM Technical Services, Inc.; Landrum & Brown Incorporated; Inspiration Quest, Inc.; EPC-CM West JV; Leighfisher Inc.; and MOORE IACOFANO GOLTSMAN. DBI received zero responses from the above firms, excepting only Inspiration Quest, Inc., which responded only to say the firm was too busy currently to bid upon this requested scope of work. DBI will provide language to achieve this scope of work to the City Attorney within the next week and is submitting it for a full Request for Proposal (RFP) that will be posted on the City's OCA web site. We hope to receive competitive bids from qualified firms within two-three weeks of the OCA web site posting of this RFP, and will move immediately to finalize a contract, and to fulfill both the GAO/Board of Supervisors' recommendations, and the Civil Grand Jury recommendations, in order to complete implementation of the Business Process Reengineering (BPR) recommendations.
2012-13	Log Cabin Ranch: Planning for the Future	3. Fund a master plan for Log Cabin Ranch to determine the programmatic and capital requirements for a viable facility.	Mayor	Recommendation implemented	The Juvenile Probation Department sought a master plan in its FY 2012-13 budget and was provided funding for a portion of that master plan - a needs assessment intended to identify the needs of San Francisco's youth as an input to a master plan to address those needs. The needs analysis was conducted and a preliminary draft plan developed. However, at this time, due to the complexity of the project and departmental turnover the needs assessment is still incomplete. A completed needs assessment will inform the development of the master plan, which is currently funded as part of the base FY 2014-15 budget. The City Services Auditor has expressed an interest in assisting the Juvenile Probation Department with completion of the needs assessment The City and County of San Francisco FY 2014-15 and FY 2015-16 budget will officially be adopted July, 2014.
2012-13	Log Cabin Ranch: Planning for the Future	4.2. Examine collaboration with regional counties to develop programs to address the needs of high-risk and at-risk youth.	Mayor	Recommendation implemented	In recent years, the JPD has reached out to former Probation Chiefs in both Alameda and San Mateo Counties regarding regional strategies designed to work with high-risk offenders.1. Discussions with other counties have been initiated to explore the possibility of joint initiatives supported by intergovernmental agreements. While these discussions are in their infancy, preliminarily they have been positive and fruitful. San Mateo County maintains and operates a ranch for adjudicated minors about a half mile from Log Cabin Ranch. The two facilities coordinate sporting events together and have extended mutual aid in past years. This aid has included allowing LCR to use shower facilities and LCR allowing Camp Glenwood to utilize its gymnasium. In those instances where youth have AWOL'd from either facility, communications between the two have helped increase awareness, vigilance and cooperation between the two sites. The ability to share a single physical location could prove mutually beneficial to both counties and lead to overall fiscal efficiency for these two Bay area counties and the youths and families they serve. Efforts to explore possible agreements will continue.

(1) "–" Department did not respond with one of the four required actions.

Status of the Recommendations
by the Civil Grand Jury
2012-13

CGJ Year	Report Title	Recommendation	Response Required	Action Plan	2014 Response Text
2012-13	Optimizing the Use of Publicly-Owned Real Estate	3. The Board of Supervisors should amend Chapter 23A of the Administrative Code to include an incentive for City Departments to identify and dispose of surplus and underutilized properties and to broaden the purposes for which surplus and underutilized properties may be used.	Mayor	Will not be implemented: not warranted	Since this recommendation is directed to the Board of Supervisors it cannot be implemented by the Mayor. Legislative clean up of Chapter 23A of the Administrative Code is awaiting input from the community engagement process now being led by City Planning, the Office of Economic and Workforce Development and the City Administrator's Real Estate Division relative to public site development. Any proposed changes beyond legislative clean up must be reviewed and approved by the Board of Supervisors. Current City policy directs surplus property to be developed as affordable housing.

(1) "--" Department did not respond with one of the four required actions.

c: BOS-11, COB cpage

San Francisco Unified School District
OFFICE OF THE GENERAL COUNSEL
555 Franklin Street, 3rd Floor, San Francisco, CA 94102
TELEPHONE (415) 241-6054; FACSIMILE (415) 241-6371

Richard Carranza
Superintendent of Schools

Donald L. Davis
General Counsel
donalddavis@sfusd.edu

Angela Miller
Sr. Deputy General Counsel
millera1@sfusd.edu

orig
File 130608

March 5, 2014

San Francisco Board of Supervisors
c/o Erica Major, Assistant Committee Clerk
1 Dr. Carlton B. Goodlet Place
Room 244
San Francisco, CA 94102-4689

Dear Ms. Major:

Attached please find the San Francisco Unified School District's 6-month status update to the 2012-2013 Civil Grand Jury Report entitled "*Optimizing the Use of Publicly-Owned Real Estate*" which was released on June 13, 2013.

Sincerely,

Angela Miller

Angela Miller, Senior Deputy General Counsel

Encl.

Doc# 13564

8

SAN FRANCISCO UNIFIED SCHOOL DISTRICT
6 MONTH STATUS UPDATE REGARDING THE CIVIL GRAND JURY REPORT ENTITLED "OPTIMIZING THE USE OF PUBLICLY OWNED REAL ESTATE"

March 5, 2014

This memorandum provides the San Francisco Unified School District/Board of Education (SFUSD/BOE) 6-month update regarding the civil grand jury report entitled "Optimizing the Use of Publicly Owned Real Estate" that was released on June 13, 2013. The SFUSD/BOE original response to this report was submitted on August 13, 2013.

Recommendation 4: The Board of Supervisors and the SF Board of Education should each adopt rules which limit the length of time property may remain on their respective surplus list without action and which address consequences for such inaction.

Original Response: The recommendation will not be implemented because it is not warranted or reasonable. The District will comply with Education Code requirements for declaring properties as surplus and for disposing of surplus properties. The educational program and administrative facility requirements for the District are fluid and the District must remain flexible with regard to the disposition and use of school sites and properties in order to respond to these changing needs, as explained in response to Finding #3 above.

6 Month Update:

In its August 13, 2013 response to Recommendation 4, the Board of Education answered that the recommendation would not be implemented because it is not warranted or reasonable. There is no further update or change to this original response.

BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 554-5227

MEMORANDUM

Date: March 10, 2014

To: Honorable Members, Board of Supervisors

From: Angela Calvillo, Clerk of the Board

Subject: APPOINTMENT BY THE MAYOR

The Mayor has submitted the following appointment:

- William (Ken) Cleaveland, Fire Commission, term ending January 15, 2017

Under the Board's Rules of Order, Section 2.18.3, a Supervisor may request a hearing on an appointment by notifying the Clerk in writing.

Upon receipt of such notice, the Clerk shall refer the appointment to the Rules Committee so that the Board may consider the appointment and act within 30 days of the appointment as provided in Charter, Section 3.100(18).

Please notify me in writing by **5:00 p.m., Thursday, March 13, 2014,** if you would like to request a hearing on the above referenced appointment.

Attachments

9

OFFICE OF THE MAYOR
SAN FRANCISCO

Orig: Rules Clerk
C: COB, Leg Dep.
Dep. City Attny
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EDWIN M. LEE
MAYOR

RECEIVED
BOARD OF SUPERVISORS
SAN FRANCISCO
2014 MAR -7 PM 2:25

Notice of Appointment

March 7, 2014

San Francisco Board of Supervisors
City Hall, Room 244
1 Carlton B. Goodlett Place
San Francisco, California 94102

Honorable Board of Supervisors:

Pursuant to Section 3.100 (18) of the Charter of the City and County of San Francisco, I hereby make the following appointment:

William K. Cleaveland to the Fire Commission, assuming the seat formerly held by Donald R. Carmignani, for a term ending January 15, 2017.

I am confident Ken, a CCSF elector, will serve the City and County well. Attached are his qualifications to serve, which will demonstrate how this appointment represents the communities of interest, neighborhoods, and diverse populations of San Francisco.

Should you have any questions related to this appointment, please contact my Director of Appointments, Nicole Wheaton, at (415) 554-7940.

Sincerely,

Edwin M. Lee
Mayor

OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE
MAYOR

March 7, 2014

Angela Calvillo
Clerk of the Board, Board of Supervisors
San Francisco City Hall
1 Carlton B. Goodlett Place
San Francisco, CA 94102

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Sincerely,

Edwin M. Lee
Mayor

Biography

William K. Cleaveland
Vice President, Public Policy
Building Owners and Managers Association of San Francisco
233 Sansome Street, 8th Floor
San Francisco, CA 94104
415-362-8567
kenc@boma.com

William K. (Ken) Cleaveland, 65, has represented the legislative, political and regulatory interests of BOMA San Francisco members since 1995. He has had a long and distinguished career as an advocate for the commercial real estate and construction industries that has spanned more than 30 years and has included work at the local, state and national levels. As the Vice President for Public Policy for the Building Owners and Managers Association of San Francisco, he currently works with the BOMA volunteer leadership to set effective strategies for accomplishing the organization's advocacy goals:

- Protecting and defending the rights of commercial property owners and managers while promoting their responsibilities to adopt and employ the best in sustainable practices in buildings.
- Increasing energy conservation and other sustainable practices in commercial office buildings through promotion of energy benchmarking, energy audits, recycling, sub-metering, re-commissioning, water conservation upgrades, and increased bicycle parking facilities.
- Promoting legislation in San Francisco that will enhance our economy, grow jobs, and keep our city the beacon of opportunity, innovation, and multi-cultural enlightenment for all residents and visitors alike.
- Continuing BOMA's commitment to political action and the support of candidates and/or issues that are sensible, practical, and who will support a stronger, more vibrant business community. BOMA is firmly committed to promoting private sector incentives and public-private partnerships to improve government services and the quality of life for all San Franciscans.

Prior to joining BOMA San Francisco, Mr. Cleaveland worked for the Northern Virginia Building Industry Association, and several local chapters of the Associated Builders and Contractors, a national commercial contractors association. He began his professional career in city government with the City of Jacksonville (Fla.) as its Personnel Recruiter.

Mr. Cleaveland has served as the President of the Northern California Society of Association Executives (1999-2001), an organization that represents professional trade association managers in the Bay Area. He has served on a number of local civic boards including the San Francisco Dept. of Public Works' Newsrack Committee, the Mayor's Graffiti Advisory Board, the San Francisco Public Utilities Commission's Citizen Advisory Committee, and currently sits as a mayoral appointment to the San Francisco Finance Corporation, a body that oversees much of the city's bonded indebtedness. He is currently on the board of the Power Association of Northern California, an organization representing the electric and gas industry, and the board of the Alice B. Toklas LGBT Democratic Club.

Mr. Cleaveland received his Bachelor of Arts degree in Sociology (minor: Psychology) from Florida State University. He served as a Peace Corps volunteer in India, and is a resident of the Portola neighborhood in San Francisco (District 9).

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OFFICE OF THE MAYOR
SAN FRANCISCO

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Sincerely,

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Mayor

9

OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE
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March 7, 2014

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San Francisco City Hall
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San Francisco, CA 94102

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###

From: Board of Supervisors
To: BOS-Supervisors
Subject: FW: Swords To PLowshares Continues To Exclude Homosexual Veterans From SFDPH Services
Attachments: Sword_Plwshrs_DeAnda[1][2].pdf

From: Sophia De Anda [mailto:deanda_sophia@yahoo.com]
Sent: Friday, March 07, 2014 9:10 AM
To: Board of Supervisors
Subject: Fw: Swords To PLowshares Continues To Exclude Homosexual Veterans From SFDPH Services

Dear Board of Supervisors,

Included in attachment is a official report from Non-Profit, Veteran Organization Swords To Plowshares (STP) which they "allege"they serve all veterans but I filed a public records act from DPH in 2010 and apparently STP has not been serving all veterans and their definition of "all" is only African American/White male veterans. Many of these male veterans are so violent they most employers won't hire them because some have are Registered Sex Offenders and placed on national data base from U.S. Department of Justice (DOJ). Other male veteran subject female/Lesbian, Gay, Bisexual, Transgender (LGBT) veterans to hostile environment while seeking services that if we "snitch"on them they bully, haze, intimidate, and threaten gang rape because this is part of the military culture they learned and they are bringing it to SFDPH CBHS funding.

Please enjoy reading this report because after 4 years they have not changed and the number of females enrolled in STP is in the single digits while males in the 1,500 and this demonstrates they are not effectively doing outreach and management restricts them from addressing rape, sexual assaults, and domestic violence in there program because "the boys"will get emotionally aroused. The management also doesn't welcome transgender male to females to receive services or change their CA I.D. and name, but "the boys"they serve are homeless and they like to beat up on women in the streets and they don't want to trigger them so we are asked to stay away and cater to Executive Director, Michael Blecker, lost heterosexual children. During womens week STP has chosen to ignore it but instead give male veterans cup and cookies so they continue be dependent on pity.

Sincerely,

Sophia De Anda

P.S. Please note Rape is huge problem in the military and some of these veterans they serve may have raped females/males in the military and they are bringing there culture to STP but unleashing it out against women walking by on streets, children walking home from school, and STP nicotine bullies smoking directly into women and babies in strollers while passing by.

10

Swords to Plowshares

VET'S HELPING VETS SINCE 1974

January 4, 2010

Eileen Shields, Public Information Officer
San Francisco Department of Public Health
101 Grove Street, Room 316
San Francisco, CA 94102

Re: 1) Request for records relating to Gay, Lesbian, Bisexual, Transgender outreach and enrollment of women veterans, Latinos, Asian, Native Americans and LGBT
2) Request for public records - LGBT Veterans Outreach
3) Request for public records – LGBT support services

Dear Ms. Shields,

Kindly accept this letter in response to the request for records addressed to me and originating from Edwin Batongbacal, LCSW, Director, Adult and Older Adult Systems-of-Care Community Behavioral Health, copy enclosed.

1) Enclosed please find: Relevant excerpts from Swords to Plowshares Client Demographic Report for the 12 months ending November 30, 2009, providing gender and race/ethnicity data for the 1655 unduplicated veterans served during that period.

   Please be advised that Swords to Plowshares does not inquire as to the sexual orientation of any of our clients. The only place that such information may be held would be in confidential mental health or attorney case notes as may be appropriate and germane on a case-by-case and individual basis.

2) Please be advised that to the best of my knowledge, Swords to Plowshares has not conducted LGBT-specific outreach. Our outreach efforts are to the entire veteran community in San Francisco and the greater Bay Area.

3) Please be advised that Swords to Plowshares does not and has not formally developed any LGBT-specific Support Services. If clients who identify as LGBTQ feel that their specific needs are not being addressed adequately by existing programming, appropriate referrals are made to outside agencies with specific programming for LGBTQ clients. These clients do not experience any reduction in services, as where appropriate the outside referrals augment services they receive directly from Swords to Plowshares. Clients do work with individual case managers, counselors, or therapists in Swords to Plowshares residential and

outpatient programs on the full range of issues affecting them, including issues of sexual orientation and gender, and staff is vigilant to ensure that no client is treated disrespectfully by other clients for any reason, with particular sensitivity to issues of race, ethnicity, sexual orientation and gender. We do our utmost to ensure that group activities are safe and welcoming for all participants.

As with clients, we do not ask staff to divulge their sexual orientation either. However, LGBT staff are well represented at all levels of this organization, from senior management to line staff, helping to ensure that Swords lives up to its policies of providing services to all veterans regardless of race, ethnicity, gender, sexual orientation, branch or type of military service or military discharge status.

Please let me know if I may be able to provide any additional information or need for clarification.

Sincerely,

Leon Winston
Chief Operating Officer

Copy: Edwin Batongbacal – DPH/CBHS
Michael Blecker – Swords to Plowshares

Swords to Plowshares Client Demographic Report for the 12 months ending November 30, 2009

GENDER	Count
Male	1553
Female	98
Transgender	4
Total:	**1655**

RACE/ETHNICITY	Count
American Indian/Alaskan Native	10
Asian	56
Black/African/American	699
Native Hawaiian/Other Pacific Islander	3
White	684
American Indian/Alaskan Native & White	4
Asian & White	4
Black/African American & White	7
Other Multi-Racial	4
Hispanic	138
Unknown/Denied Information	46
Total:	**1655**

From: Board of Supervisors
To: BOS-Supervisors
Subject: 493 Broadway

From: Jordan Angle [mailto:jordan@jordanangle.com]
Sent: Thursday, March 06, 2014 11:06 PM
Subject: 493 Broadway

To whom it may concern,

After careful examination and review with my family, business partners, legal counsel, and community at large, we have decided to pursue, albeit reluctantly, the path of a type 47 liquor license contingent upon the conditions both from the city and the state that are reasonable and customary as well as sustainable for our business. Therefore, I have asked the SFPD ALU to present us with conditions from the city, and then we need to ask for the state's conditions at the same time, so we can begin to move forward.

If the revitalization of Broadway is to be genuine, my family's property is a centerpiece, especially given that we have owned it for 150 years, which sets us apart from all others.

This is a huge compromise for us, one that makes us very nervous about our future, but also one that we are willing to commit to as long as we have conditions that allow for the success and sustainability of our business.

Sincerely,
Jordan Angle

Jordan Angle

P 415.559.3245 | F 415.887.9480

jordan@jordanangle.com | www.jordanangle.com

130404

11

From: Toy, Debbie (CON) [debbie.toy@sfgov.org]
Sent: Thursday, March 06, 2014 1:17 PM
To: Calvillo, Angela (BOS); BOS-Supervisors; BOS-Legislative Aides; Kawa, Steve (MYR); Leung, Sally (MYR); Howard, Kate (MYR); Volberding, Emily (MYR); Falvey, Christine (MYR); Tsang, Francis (MYR); Elliott, Jason (MYR); Campbell, Severin; Newman, Debra; Rose, Harvey; SF Docs (LIB); Rosenfield, Ben (CON); Zmuda, Monique (CON); Lane, Maura (CON); CON-CCSF Dept Heads; CON-Finance Officers
Cc: Allersma, Michelle (CON); Sandler, Risa; Macaulay, Devin (CON)
Subject: Controller's Office Report: The Five-Year Financial Plan Update for General Fund Supported Operations FY 2014-15 through FY 2017-18

San Francisco Administrative Code Section 3.6(b) requires that in each even-numbered year, the Mayor, Board of Supervisors Budget Analyst, and Controller submit an updated estimated summary budget for the remaining four years of the City's Five-Year Financial Plan. This report provides updated expenditure and revenue projections assuming no changes to current policies and staffing levels. This report projects shortfalls of $66.7 million in FY 2014-15, $133.4 million in FY 2015-16, $282.6 million in FY 2016-17 and $339.4 million in FY 2017-18.

While the projected shortfalls reflect the difference in projected revenues and expenditures over the next four years if current service levels and policies continue, San Francisco's Charter requires that each year's budget be balanced. Balancing the budgets will require some combination of expenditure reductions and/or additional revenues. These projections assume no ongoing solutions are implemented. To the extent budgets are balanced with ongoing solutions, future shortfalls will decrease.

Please select: http://openbook.sfgov.org/webreports/details3.aspx?id=1708 to access the full report.

12

City and County of San Francisco

Controller, Mayor, Board of Supervisors' Budget Analyst

Five Year Financial Plan Update for General Fund Supported Operations FY 2014-15 through FY 2017-18

Joint Report by the Controller's Office, Mayor's Office, and Board of Supervisors' Budget Analyst

March 6, 2014

City and County of San Francisco

Five Year Financial Plan Update for General Fund Supported Operations **March 6, 2014**

Summary

San Francisco Administrative Code Section 3.6(b) requires that in each even-numbered year, the Mayor, Board of Supervisors Budget Analyst, and Controller submit an updated estimated summary budget for the remaining four years of the City's Five-Year Financial Plan. This report provides updated expenditure and revenue projections for Fiscal Years (FY) 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, assuming no changes to current policies and staffing levels. The next full update of the City's Five-Year Financial Plan will be submitted by the Mayor on or before March 2, 2015.

Table 1 summarizes the projected changes in General Fund supported revenues and expenditures over the next four years. As shown in Table 1, this report projects shortfalls of $66.7 million in FY 2014-15, $133.4 million in FY 2015-16, $282.6 million in FY 2016-17 and $339.4 million in FY 2017-18.

Table 1. Summary of General Fund Supported Operations
Projected Budgetary Surplus/(Shortfall) ($ Millions)

	Savings/ (Cost) Change from Prior Year, $ Million			
	FY 2014-15	**FY 2015-16**	**FY 2016-17**	**FY2017-18**
Sources				
Use of One-Time Sources, Prior Year Fund Balance & Reserves	(34.3)	(16.3)	(105.4)	-
Regular Revenues, Transfers, & Other	160.9	147.1	89.7	92.2
Subtotal - Sources	**126.6**	**130.8**	**(15.7)**	**92.2**
Uses				
Salaries & Benefits	(98.9)	(52.2)	(48.8)	(71.2)
Other Expenditures, Reserves & Transfers	(94.4)	(145.3)	(84.8)	(77.8)
Subtotal - Uses	**(193.3)**	**(197.5)**	**(133.5)**	**(149.0)**
Total Net GF Impact (from Prior Year)	(66.7)	(66.7)	(149.3)	(56.8)
Total Net GF Impact (Cumulative)	**(66.7)**	**(133.4)**	**(282.6)**	**(339.4)**

While the projected shortfalls shown in the above table reflect the difference in projected revenues and expenditures over the next four years if current service levels and policies continue, San Francisco's Charter requires that each year's budget be balanced. Balancing the budgets will require some combination of expenditure reductions and/or additional revenues. These projections assume no ongoing solutions are implemented. To the extent budgets are balanced with ongoing solutions, future shortfalls will decrease.

Key Assumptions

Key assumptions affecting the FY 2014-15 through FY 2017-18 projections are:

- **No major changes to service levels and number of employees:** This projection assumes no major changes to policies, service levels, or the number of employees from previously adopted FY 2013-14 and FY 2014-15 budgeted levels. This report does assume passage of the current year $4.5 million Nonprofit Rent Stabilization supplemental appropriation and the $1.4 million Homeless Services supplemental appropriation currently pending at the Board of Supervisors.

- **Continued economic recovery:** These projections assume the economic recovery that began in FY 2009-10 will continue through the forecast period and will be reflected in tax revenue increases. The rapid rates of growth experienced in the early part of the recovery (FY 2010-11 and FY 2011-12) have slowed. Economic growth, and the revenue derived from it, is heavily dependent on changes in employment, business activity and tourism. These are expected to increase at this slower pace in the first two years of the forecast. This report does not assume any economic downturns or large changes in macroeconomic conditions; however, the City has historically not experienced more than six consecutive years of expansion, and the final two years of this report assume slower rates of revenue growth.

- **Preliminary estimate of state and federal budget changes:** The State of California is projecting a budget surplus this year and this report does not assume significant cuts from the State. However, one notable exception is the State's "claw back" of realignment payments for county indigent health care. This report assumes a $33.8 million reduction in FY 2014-15, which is ongoing through FY 2017-18. The exact amounts of the claw back will not be known until the State budget is finalized. Similarly, the federal government is expected to take back its Disproportionate Share Hospital Funding in calendar year 2016 as a result of Affordable Care Act (ACA) implementation. However, the effect of this on the Department of Public Health is not yet known so is not assumed in this report. The City will continue to assess the effects of the federal budget, as well any additional changes to the State's fiscal outlook. Given the growth in the General Reserve and improvement in the state's budget, this projection does not assume a reserve for state or federal budget cuts.

- **No change in closed or open labor agreements in FY 2014-15, and inflationary increase on open labor agreements starting in FY 2015-16:** This projection assumes no change to closed collective bargaining agreements. It also assumes no changes to open labor agreements in FY 2014-15, which reflects adopted budget levels. Beginning in FY 2015-16, open contracts are assumed to have salary increases equal to the change in the Consumer Price Index (CPI-W). This is projected by the California Department of Finance to be 2.21% for FY 2015-16 and 2.45% for FY 2016-17 and FY 2017-18. The City is currently in negotiations with 27 of its labor unions for FY 2014-15 and beyond. This report assumes negotiated wage increases of 0.0%, 1.0%, 2.0% and 2.0% in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, respectively, for police officers. The same assumptions are made for firefighters, whose agreement is pending final approval.

- **Retirement plan employer contribution rates and implementation of pension reform (Proposition C).** This report assumes total retirement costs continue to increase in FY 2014-15 due to investment losses in the San Francisco Employees' Retirement System (SFERS) and California Public Employees' Retirement System (CalPERS) during the prior

recession. SFERS employer contribution rates are based on projections prepared by the Retirement System's actuary in November 2013. They assume continuation of the SFERS Board adopted policy of decreasing estimated future investment returns from 7.75% to 7.5%; however, final rates for FY 2014-15 will be adopted by the Retirement Board in the coming months. For CalPERS members, this report includes rate increases starting in FY 2016-17 due to adjusted mortality assumptions adopted by the CalPERS Board in February 2014. Projections reflect employee contributions to retirement required under Proposition C. The maximum employer contribution rate for non-safety employees is 24.8% in the current fiscal year. This rate is projected to increase to 27.7% in FY 2014-15 and then decline to 26.0%, 24.3% and 23.6% in FY 2015-16, FY 2016-17, and FY 2017-18, respectively,

- **Health and dental insurance cost increases:** This projection assumes that the employer share of health and dental insurance costs will increase by approximately 5.0% in each year of the report. The Health Service System will be negotiating rates for calendar year 2015 throughout the spring and summer of 2014. For retiree health benefits, this report assumes that the City will continue its pay-as-you-go practice of funding the amounts currently due for retirees. The growth in this obligation has been estimated based on projected actual cost increases of approximately 9.0% per year.

- **Inflationary increase on non-personnel operating costs:** This projection assumes that the cost of materials and supplies, professional services, contracts with community-based organizations and other non-personnel operating costs will increase by the CPI-U (as projected by the California Department of Finance) rates of 2.2%, 2.4% and 2.4%, respectively for FY 2015-16, FY 2016-17 and FY 2017-18. The projection reflects the adopted FY 2014-15 budget.

- **Ten-Year Capital Plan and inflationary increases on equipment and IT funding:** This projection assumes that capital funding will increase over the next four years based on the levels assumed in the City's FY 2014-23 Ten-Year Capital Plan. For FY 2014-15, the capital projection reflects the previously adopted FY 2014-15 budget, which did not include full funding of the Capital Plan. Additionally, this report reflects the adopted FY 2014-15 equipment and fleet budget. In FY 2015-16, the projection assumes that equipment and fleet will be entirely cash funded at the level the City previously funded through cash and the lease finance program. For FY 2015-16 through FY 2017-18 the projection assumes the equipment and fleet budget will grow by CPI-U. The report assumes that Information Technology (IT) investments will increase by 10% per year from FY 2015-16 through FY 2017-18 in accordance with the City's Five-Year Information and Communication Technology (ICT) Plan, and also assumes an increase in funding starting in FY 2015-16 for major IT investments that increase by 10% in FY 2016-17 and FY 2017-18.

- **Rainy Day Reserve:** For years in which General Fund revenues decline, the Charter allows the City to withdraw up to 50% of the City's Rainy Day Economic Stabilization Reserve. The Charter also allows withdrawals of up to 25% of the Rainy Day Reserve for the San Francisco Unified School District (SFUSD) in years when inflation-adjusted per-pupil revenues decline. Withdrawals are at the discretion of the Mayor and Board of Supervisors. This report projects that the City will not meet the threshold for withdrawal from the Economic Stabilization Reserve during the projection period. The projected FY 2013-14 year-end balance is $20.5 million, including an estimated deposit of $3.0 million and allocation of $5.8 million to the SFUSD.

- **Renewal of PEEF and the Children's Amendment:** The Public Education Enrichment Fund (PEEF) and the Children's Amendment (The Children's Fund and the Children's Baseline) are two pieces of local legislation that set aside General Fund dollars for services for San Francisco children and families. The PEEF legislation sunsets at the end of FY 2014-15 and the Children's Amendment sunsets at the end of FY 2015-16. This report assumes that both pieces of legislation will be renewed and funding will continue at the same levels and rates of growth as specified under current legislation.

- **Police and Fire multi-year hiring plans:** This report assumes there will be one Fire Academy class (42 firefighters per class) and three Police Academy classes (50 police officers per class) each year over the next four years.

- **Annualization of supplemental:** This report assumes that the proposed Homeless Outreach Services supplemental appropriation of $1.4 million in FY 2013-14 is annualized to $5.6 million in FY 2014-15.

Key Factors That Could Affect These Forecasts

As with all projections, substantial uncertainties exist regarding key factors that could affect the City's financial condition. These include:

- **Economy:** Historically, periods of economic expansion are followed by economic contraction, or recession. Since the end of the Great Depression there have been 13 recessions, or approximately one every six years on average. The current economic expansion began over four and a half years ago. It would be an historic anomaly to not experience a recession within the projection period of this report. Because of the difficulty of projecting the timing of a recession, this report assumes slower rates of growth, rather than declines, in revenue in the final two years of the report; however, it is important for the City to closely monitor the economic conditions over the coming years.

- **Outcome of state and federal budget-balancing efforts**: At the time of report issuance, uncertainty remains around the local effects of state and federal budget deliberations, including formula- or sequestration-related changes to key grants and the claw back of realignment for county indigent care.

- **Collective bargaining agreement negotiations:** Other than approved wage increases in collective bargaining agreements and inflation on open contracts in FY 2015-16, FY 2016-17 and FY 2017-18, this report does not assume any contract changes due to ongoing labor negotiations. Wage or benefit changes above or below these assumptions would increase or decrease the City's projected deficit.

- **Pending or Proposed Legislation – Potential Fee / Departmental Revenue Increases:** Fee increases may be proposed to the Board of Supervisors before the end of the year or as part of the FY 2014-15 and FY 2015-16 budget. No increases are assumed in this projection.

- **Potential New Revenue Proposals and Charter Amendments in Future Elections:** This report makes some assumptions about the impact of potential revenue proposals or Charter amendments that may be included on future election ballots, which are outlined below:

- **The Earthquake Safety and Emergency Response (ESER) 2 Bond:** The City's Ten-Year Capital Plan assumes the City pursues a $400 million General Obligation (G.O.) bond on the June 2014 ballot, which was recently approved by the Board of Supervisors. This report assumes $11.6 million in reimbursements to the General Fund from bond proceeds for related planning expenses already incurred. If this bond does not pass, this reimbursement will not be received. In addition, this report assumes the associated furniture, fixture and equipment (FF&E) and move costs for new buildings constructed and seismically strengthened with bond proceeds. If this bond does not pass, the Police, Fire and the Medical Examiner's budgets could also be affected.

- **Public Education and Enrichment Fund (PEEF) and Children's Amendment:** This plan assumes that the Children's Amendment and PEEF legislation will be renewed in the November 2014 election before their respective sunset dates at the current legislation's prescribed funding levels and rates of growth. Electoral changes to these pieces of legislation, or their failure to be renewed, will affect this report's projections.

- **Vehicle License Fee increase and Transportation and Street Improvements Bond:** The Mayor's Transportation Task Force, led by the Controller's Office and the San Francisco Planning and Urban Research Association (SPUR), released its recommendations in November of 2013. The Task Force recommended that the City pursue an increase to the Vehicle License Fee as well as a $500 million Transportation and Street Improvements G.O. bond to fund critical transportation infrastructure needs such as fleet renewal, street repaving, and pedestrian and bicycle safety projects in November 2014. This report does not assume the passage of these revenue measures.

- **Changes to the Minimum Wage:** This projection assumes no change to the current minimum wage. However, discussions continue at both the federal and local level about raising the minimum wage. Depending on the ultimate change in the minimum wage, there will be a financial impact to the City in the form of increases for some contracted services, as well as a potential increase due to increased wages for certain City employees.

- **Public Health Facilities Seismic Improvements Bond**: The Ten-Year Capital Plan proposes the City pursue a $435 million G.O. bond for the Department of Public Health in 2015. This report assumes the associated furniture, fixture and equipment (FF&E) and move costs for new buildings constructed and seismically strengthened with this bond funding. If this bond does not pass, the Department of Public Health's budget could be affected.

- **Affordable Care Act implementation:** The Department of Public Health, along with other affected City agencies, is in the first year of implementation of federal health care reform, known as the Affordable Care Act (ACA). The net fiscal effect of this significant policy change continues to be uncertain, including potential state and federal take-backs of funds for indigent care, the impact on revenue of transitioning more patients from the Medi-Cal fee-for-service payment model to a capitated rate model, and patient insurance enrollment and facility utilization levels. This report assumes modest revenue growth at San Francisco General Hospital as formerly uninsured patients obtain insurance coverage through the State's Medi-Cal expansion program.

- **Public Utilities Hetch Hetchy Power Enterprise:** Absent corrective action, the Public Utilities Commission (PUC) is facing a significant structural deficit in the Hetch Hetchy Power Enterprise due to:
    - An increase in projected annual costs resulting from the expiration of the PG&E interconnection agreement for the transmission and distribution of electricity;
    - Additional regulatory mandates created by the regional council governing power utilities;
    - Increased capital costs related to the Mountain Tunnel rehabilitation capital project; and
    - Potential revenue reductions due to drought conditions.

  This report assumes that General Fund power utility rates will increase by one-half cent per kilowatt hour (kWh) each year of the forecast. Based on the most recent financial plan provided by the PUC, potential deficit solutions include raising City department power utility rates, which could have a significant effect on the City's General Fund; however, the extent of this impact is unknown at this time.

- **Fire Department Exclusive Ambulance Operating Agreement:** The Fire Department needs to be able to meet State standards on emergency medical service systems in light of rising call volumes and market share; however, this report assumes no changes to current staffing levels or funding at this time. The Fire Department will need to further determine optimal resource and deployment levels, which could negatively affect the Fire Department's budget.

Schedule of Upcoming Reports Containing Budget Projections

- **Early May - Controller's Nine-Month Budget Status Report:** This report will provide updated revenue, expenditure, and ending fund balance projections for FY 2013-14.
- **Mid-June - Controller's Discussion of the Mayor's Fiscal Year 2014-15 and 2015-16 Proposed Budget ("Revenue Letter"):** This report will provide the Controller's opinion regarding the reasonableness of the revenue estimates in the Mayor's Proposed Budget.

Appendix: Projected Changes to General Fund Supported Revenues and Expenditures

Table A-1. Key Changes to General Fund Supported Sources and Uses

Table A-2a. Summary of General Fund Supported Operating Revenues and Transfers In

Table A-2b. Growth Factors for General Fund Supported Sources

Table A-3a. Reserve Withdrawal & Appropriation Amounts

Table A-3b. Net Budgetary Impact of Changes to Reserves

Appendix: Projected Changes to General Fund Supported Revenues and Expenditures

Table A-1. Key Changes to General Fund Supported Sources and Uses

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
SOURCES Increase / (Decrease)				
General Fund Taxes, Revenues and Transfers	188.7	119.2	79.3	81.8
Change in Use of One-Time Sources	(34.3)	(16.3)	(105.4)	-
Department of Public Health Revenues	(24.4)	24.8	7.4	7.5
Fire Department Ambulance Revenues	(4.1)	0.4	0.4	0.4
Other General Fund Supported Revenues	0.8	2.6	2.6	2.5
TOTAL CHANGES TO SOURCES	**126.6**	**130.8**	**(15.7)**	**92.2**
USES Decrease / (Increase)				
Baselines and Reserves				
Public Education Enrichment Fund Annual Contribution	(4.8)	(4.5)	(4.4)	(2.5)
Housing Trust Fund	(2.8)	(2.8)	(2.8)	(2.8)
All Other Baselines and Set-Asides	(19.3)	(14.5)	(17.4)	(9.7)
Contributions to Reserves	(8.8)	25.9	1.0	9.2
Subtotal Baselines and Reserves	**(35.8)**	**4.1**	**(23.6)**	**(5.7)**
Salaries & Benefits				
Annualization of Partial Year Positions	(13.9)	(1.0)	-	-
Projected Costs of Closed Labor Agreements	(25.1)	(5.1)	(9.4)	(9.5)
Projected Costs of Open Labor Agreements	-	(37.9)	(43.7)	(44.6)
Health & Dental Benefits - Current Employees	(8.7)	(9.5)	(12.1)	(12.7)
Health & Dental Benefits - Retired Employees	(8.2)	(9.1)	(9.9)	(10.8)
Retirement Benefits - Employer Contribution Rates	(42.0)	19.8	22.6	5.8
Other Salary & Benefits Savings / (Costs)	(0.9)	(9.4)	3.7	0.6
Subtotal Salaries & Benefits	**(98.9)**	**(52.2)**	**(48.8)**	**(71.2)**
Citywide Operating Budget Costs				
Capital, Equipment, & Technology	(25.4)	(64.2)	(39.3)	(29.8)
Inflation on Non-personnel Costs and Grants to Non-profits	-	(21.6)	(22.1)	(22.6)
Debt Service & Lease Financings	(6.2)	(7.1)	(1.2)	4.8
Workers' Compensation	0.2	(2.1)	(1.9)	(2.0)
Other Citywide Savings / (Costs)	1.2	(1.1)	0.5	(2.4)
Subtotal Citywide Operating Budget Costs	**(30.2)**	**(96.0)**	**(64.0)**	**(52.0)**
Departmental Costs				
City Administrator's Office - Convention Facilities Subsidy	0.0	(4.5)	0.0	(0.0)
Elections - Number of Scheduled Elections	3.0	(4.8)	3.5	0.7
Ethics Commission - Public Financing of Elections	(2.0)	(1.2)	1.4	0.3
Fire and Police - Opening of the Public Safety Building	9.2	(1.9)	(0.1)	(0.1)
Fire and Police - Multi-Year Hiring Plans	(7.8)	(10.7)	(11.4)	(4.9)
Human Services Agency - Aid	0.0	(4.4)	(4.7)	(4.8)
Public Health - SFGH Rebuild on-going and one-time costs	(27.0)	(20.9)	19.5	(0.8)
Public Health - Inflationary, Regulatory, & Annualization of Initiatives	4.9	(7.5)	(7.8)	(8.1)
Treasurer-Tax Collector - Gross Receipts Tax Implementation	(3.3)	2.7	1.0	1.0
Annualization of Supplementals	(5.6)	-	-	-
All Other Departmental Savings / (Costs)	0.0	(0.1)	1.5	(3.3)
Subtotal Departmental Costs	**(28.4)**	**(53.4)**	**2.9**	**(20.1)**
TOTAL CHANGES TO USES	**(193.3)**	**(197.5)**	**(133.5)**	**(149.0)**
Projected Surplus (Shortfall) vs. Prior Year	**(66.7)**	**(66.7)**	**(149.3)**	**(56.8)**
Cumulative Projected Surplus (Shortfall)	**(66.7)**	**(133.4)**	**(282.6)**	**(339.4)**

Notes to Table A-1

SOURCES – Revenues and Transfers In

General Context Underlying Revenue Estimates: These projections assume continued modest growth in tax revenues during the next four years. With the exception of property tax revenues, which did not decline during the last recession, local tax revenues bottomed out in FY 2008-09 and FY 2009-10, and returned to pre-recessionary levels by FY 2011-12, one to two years earlier than projected at the start of the recovery. The pace of revenue growth during the projection period will depend heavily on the strength of the national economy and local technology industry.

National Economy: Since the end of the Great Depression there have been 13 recessions, or approximately one every six years on average. Since the official end of the recession in June 2009, the national economy has expanded in 16 of 17 quarters, or for more than four consecutive years, suggesting there is risk of a slowdown during the final two years of this report. Because of the difficulty of projecting the timing of recessions, this report does not assume one. However, this would mean the current economic expansion lasts for ten years, or equal to the longest period of national Gross Domestic Product (GDP) expansion on record, which is unlikely to be the case.

Local economy: The technology industry is increasingly important for San Francisco's economy. Since 1997 employment in the technology sector has increased as a percentage of all San Francisco employment from less than 2% to more than 6% in 2012. According to data from the Bureau of Labor Statistics (BLS), since 2010 San Francisco has added approximately 32,000 new jobs of which more than 30% have been in the technology sector. This rapid expansion of the technology sector in San Francisco increases the City's exposure to volatility in the sector. The relative timing of a national recession and/or a downturn in the technology sector are critical for the San Francisco economy over the next four years; signs of over-valuation in our local technology sector may be the best leading indicators of an impending downturn.

In the near term, strong housing prices, consumer credit, tourism, job growth and demand for real estate in global gateway cities will support growth in tax revenues. Projected rates of revenue growth are slightly lower in the final two years of this report to reflect the risk of a downturn. General Fund taxes, revenues and transfers are projected to increase by $468.9 million over the next four years. These projections exclude certain revenue changes that have offsetting expenditure changes. This report projects continued moderate economic growth with higher growth rates in the first two years, supported by robust commercial and residential real estate markets, steady tourism and job growth. The final two years of the report include slower rates of growth to reflect the risk of a downturn. Below are details on specific revenue streams included in the General Fund Taxes, Revenues and Transfers line of Table A- 2a.

Property Tax: The FY 2014-15 General Fund share of property tax, which was originally budgeted at $1,153 million, is projected to increase to $1,232 million. These revenues are projected to grow to $1,295 million in FY 2015-16, $1,346 million in FY 2016-17, and $1,393 million in FY 2017-18. The value of the FY 2014-15 secured roll is estimated assuming growth of the Assessor's working roll through the remainder of the current year equal to the average pace of the first seven months. It also assumes a 40% drop in temporary (Prop 8) reductions granted by the Assessor due to the recovery of property market values in downtown neighborhoods between the January 1, 2013 and January 1, 2014 annual lien dates.

Base roll growth allowed under Proposition 13 is 0.45% in FY 2014-15, and is assumed at 2.00% in each of the following three years (the maximum allowed under Proposition 13). For FY 2015-16 through FY 2017-18, additional roll growth of 2.00% for change in ownership and other typical new construction assessments is also included. In addition, the assessed values of high-value commercial or high-rise residential properties (those with market values above $20 million) are assumed to be enrolled within two years of construction completion or change in ownership, increasing the tax base by $2.4 billion in FY 2015-16. Current construction is anticipated to add at least $0.5 billion to assessed values in FY 2016-17 and FY 2017-18.

Supplemental and escape property tax revenues fluctuate based upon the changes in ownership and new construction processed by the Assessor-Recorder. The General Fund share of supplemental and escape property tax assessments is estimated to be $65 million in FY 2014-15, and declining 10% per year to reflect a potential reduction in the volume of prior-year changes to be enrolled. Funds set aside for assessment appeals are estimated to decline 15% per year, assuming that the most significant adjustments to assessed property values are reflected in the Assessor's Roll and that market values continue to improve through FY 2017-18. The Property tax increment allocated to the Office of Community Investment and Infrastructure (the successor agency to the Redevelopment Agency) remains relatively constant throughout the projection period.

Private payrolls and business taxes grow steadily: Private employment, a key lagging indicator, reached a trough in calendar year 2010 and expanded at an average rate of 3% from 2011 to 2013. It is expected to grow, peaking at a rate of approximately 2.8% in 2015 before slowing down with growth rates of 1.2% and 1.6% in 2016 and 2017, respectively. As discussed above, projections are sensitive to the timing of national economic downturn and continued growth in the local technology sector. Wages are projected to grow at or slightly above projected rates of inflation (approximately 2.3%).

Sales tax revenues reflect projected employment growth: San Francisco's decline in sales tax revenue during the recession came later and recovered to prior peak levels earlier than the state as a whole as they are highly correlated with local employment and inflation. Continued expansion of the local technology sector and sustained growth of local tourism will support revenue growth in the later projection years.

Hotel tax revenue rebounds: Hotel tax receipts are projected to exceed their prior peak in the current year due to historically high room rates, now that occupancy rates have stabilized. One contributing factor was the completion of Moscone Convention Center renovations in July 2012, which boosted growth from convention-related business.

Commercial real estate values have rebounded: Real property transfer taxes were robust in FY 2011-12 and FY 2012-13 with approximately $230 million received in each year. Revenues are expected to remain at that level in FY 2014-15 before declining in the following three years. Revenue changes are largely a function of projected changes in office sales, which peaked in calendar year 2012, declined in 2013, and are expected to increase in 2014 and 2015 before tapering off in 2017 and 2018. Sales are expected to be driven by available capital being invested in commercial and multi-family residential properties by pension funds, real estate investment trusts and foreign investors.

Tables A-2a and A-2b summarize revenues and transfers-in. Highlights are noted below.

Table A-2a. Summary of General Fund Operating Revenues and Transfers In ($ Millions)

	FY 2012-13 Year-End Actuals	FY 2013-14 Original Budget	FY 2013-14 6-Month Report	FY 2014-15 Projection	FY 2015-16 Projection	FY 2016-17 Projection	FY 2017-18 Projection
Property Taxes	$ 1,114.1	$ 1,153.4	$ 1,175.0	$ 1,232.0	$ 1,295.0	$ 1,346.0	$ 1,393.0
Business Taxes	479.6	533.0	534.7	564.0	597.1	634.8	660.1
Sales Tax	122.3	125.7	128.4	134.2	140.2	145.1	150.2
Hotel Room Tax	182.4	273.9	295.9	315.0	333.1	343.4	353.9
Utility Users Tax	91.9	93.5	91.4	91.7	91.9	93.1	94.0
Parking Tax	81.6	83.3	82.5	84.5	87.1	88.8	89.7
Real Property Transfer Tax	232.7	225.2	225.2	235.0	220.0	190.0	175.0
Stadium Admission Tax	2.8	2.8	2.8	1.3	1.4	1.4	1.4
Access Line Tax (FY09 incl. $37.1m 911 fee revei	42.6	42.6	42.6	43.5	44.3	45.2	46.1
Subtotal - Local Tax Revenues	**2,350.1**	**2,533.3**	**2,578.3**	**2,701.2**	**2,810.1**	**2,887.8**	**2,963.4**
Licenses, Permits & Franchises	26.3	25.5	25.7	26.1	26.2	26.4	26.6
Fines, Forfeitures & Penalties	6.2	9.1	6.8	4.2	4.2	4.2	4.2
Interest & Investment Income	10.3	10.9	9.8	7.1	8.5	9.3	9.3
Rents & Concessions	36.4	23.1	23.1	21.1	17.5	17.5	17.5
Subtotal - Licenses, Fines, Interest, Rent	**79.2**	**68.6**	**65.5**	**58.5**	**56.4**	**57.4**	**57.6**
Social Service Subventions	192.9	201.9	203.6	204.7	204.7	204.7	204.7
Other Grants & Subventions	4.3	12.5	12.3	2.5	2.5	2.5	2.5
Subtotal - Federal Subventions	**197.1**	**214.5**	**215.9**	**207.2**	**207.2**	**207.2**	**207.2**
Social Service Subventions	151.3	148.2	169.0	152.1	152.1	152.1	152.1
Health & Welfare Realignment - Sales Tax	147.7	133.9	133.9	140.1	145.1	144.2	147.2
Health & Welfare Realignment - VLF	27.4	27.4	30.5	29.0	29.0	27.4	27.4
Health & Welfare Realignment - CalWORKs MOE	25.5	23.5	23.3	23.8	23.8	23.8	23.8
Health/Mental Health Subventions	82.1	97.8	92.1	96.2	96.2	96.2	96.2
Public Safety Sales Tax	83.2	86.8	87.4	91.8	95.5	98.3	101.3
Motor Vehicle In-Lieu (County & City)	0.8	-	0.7	-	-	-	-
Other Grants & Subventions	32.6	45.2	45.5	43.2	43.2	43.2	43.2
Subtotal - State Subventions	**550.6**	**562.9**	**582.4**	**576.1**	**584.8**	**585.3**	**591.2**
General Government Service Charges	46.2	45.4	48.9	46.2	46.2	46.2	46.2
Public Safety Service Charges	27.5	26.3	27.7	26.8	26.8	26.8	26.8
Recreation Charges - Rec/Park	16.3	14.8	14.8	15.2	14.7	14.7	14.7
MediCal, MediCare & Health Svc. Chgs.	47.3	65.8	55.5	60.4	57.8	58.3	58.7
Other Service Charges	15.3	14.5	14.5	13.9	13.9	13.9	13.9
Subtotal - Charges for Services	**152.6**	**166.8**	**161.4**	**162.5**	**159.5**	**159.9**	**160.3**
Recovery of General Government Costs	11.9	10.3	10.3	10.3	10.3	10.3	10.3
Other General Fund Revenues	17.7	19.0	13.2	23.7	12.1	11.7	11.7
TOTAL REVENUES	**3,359.3**	**3,575.3**	**3,627.0**	**3,739.5**	**3,840.4**	**3,919.6**	**4,001.8**
Transfers in to General Fund							
Airport	36.5	37.0	36.6	37.7	38.4	40.3	41.9
Other Transfers	158.6	181.0	182.7	177.1	177.1	177.1	177.1
Total Transfers-In	**195.1**	**218.0**	**219.3**	**214.8**	**215.4**	**217.3**	**219.0**
TOTAL GF Revenues and Transfers-In	**3,554.3**	**3,793.3**	**3,846.3**	**3,954.3**	**4,055.8**	**4,136.9**	**4,220.8**

Table A-2b. Revenue Growth Factors

	FY 2014-15		FY 2015-16	FY 2016-17	FY 2017-18
	% Chg from FY 2013-14 Original Budget	% Chg from FY 2013-14 6-Month	% Chg from FY 2014-15	% Chg from FY 2015-16	% Chg from FY 2016-17
Property Taxes	6.8%	4.9%	5.1%	3.9%	3.5%
Business Taxes	5.8%	5.5%	5.9%	6.3%	4.0%
Sales Tax	6.8%	4.5%	4.5%	3.5%	3.5%
Hotel Room Tax	15.0%	6.5%	5.7%	3.1%	3.1%
Utility Users Tax	-2.0%	0.3%	0.2%	1.3%	1.0%
Parking Tax	1.5%	2.5%	3.1%	2.0%	1.0%
Real Property Transfer Tax	4.4%	4.4%	-6.4%	-13.6%	-7.9%
Stadium Admission Tax	-51.8%	-51.8%	2.0%	0.0%	0.0%
Access Line Tax	2.0%	2.0%	2.0%	2.0%	2.0%
Subtotal - Tax Revenues	**6.6%**	**4.8%**	**4.0%**	**2.8%**	**2.6%**
Licenses, Permits & Franchises	2.1%	1.3%	0.6%	0.6%	0.6%
Fines, Forfeitures & Penalties	-53.5%	-38.0%	0.0%	0.0%	0.0%
Interest & Investment Income	-35.1%	-27.8%	19.7%	9.4%	0.0%
Rents & Concessions	-8.4%	-8.4%	-17.3%	0.0%	0.0%
Subtotal - Licenses, Fines, Interest, Rent	**-14.7%**	**-10.6%**	**-3.6%**	**1.7%**	**0.3%**
Social Service Subventions	1.4%	0.5%	0.0%	0.0%	0.0%
Other Grants & Subventions	-79.8%	-79.4%	0.0%	0.0%	0.0%
Subtotal - Federal Subventions	**-3.4%**	**-4.0%**	**0.0%**	**0.0%**	**0.0%**
Social Service Subventions	2.6%	-10.0%	0.0%	0.0%	0.0%
Health & Welfare Realignment - Sales Tax	4.6%	4.6%	3.6%	-0.6%	2.1%
Health & Welfare Realignment - VLF	5.8%	-5.2%	0.0%	-5.3%	0.0%
Health & Welfare Realignment - CalWORKs MOE	1.4%	2.4%	0.0%	0.0%	0.0%
Health/Mental Health Subventions	-1.6%	4.5%	0.0%	0.0%	0.0%
Public Safety Sales Tax	5.7%	5.0%	4.0%	3.0%	3.0%
Motor Vehicle In-Lieu (County & City)	0.0%	0.0%	0.0%	0.0%	0.0%
Other Grants & Subventions	-4.5%	-5.2%	0.0%	0.0%	0.0%
Subtotal - State Subventions	**2.4%**	**-1.1%**	**1.5%**	**0.1%**	**1.0%**
General Government Service Charges	1.7%	-5.6%	0.0%	0.0%	0.0%
Public Safety Service Charges	1.9%	-3.2%	0.0%	0.0%	0.0%
Recreation Charges - Rec/Park	2.9%	2.9%	-3.1%	0.0%	0.0%
MediCal, MediCare & Health Svc. Chgs.	-8.2%	8.9%	-4.3%	0.7%	0.7%
Other Service Charges	-4.0%	-4.3%	0.0%	0.0%	0.0%
Subtotal - Charges for Services	**-2.5%**	**0.7%**	**-1.9%**	**0.3%**	**0.3%**
Recovery of General Government Costs	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Other Revenues	**25.0%**	**80.0%**	**-48.9%**	**-3.2%**	**0.0%**
TOTAL REVENUES	**4.6%**	**3.1%**	**2.7%**	**2.1%**	**2.1%**
Transfers in to General Fund					
Airport	2.1%	3.1%	1.7%	5.0%	4.1%
Other Transfers	-2.2%	-3.1%	0.0%	0.0%	0.0%
Total Transfers In	**-1.5%**	**-2.1%**	**0.3%**	**0.9%**	**0.8%**
TOTAL GF Revenues and Transfers-In	**4.2%**	**2.8%**	**2.6%**	**2.0%**	**2.0%**

SOURCES – One-Time Sources Including Fund Balance & One-Time Reserves

Change in starting fund balance: This report assumes available fund balance will be split evenly across the two upcoming budget years resulting in a net loss in General Fund supported starting fund balances of $16.0 million in FY 2014-15, $0 in FY 2015-16, and $103.9 million in FY 2016-17 comprised of:

> **Loss of prior year General Fund supported fund balances:** This represents the loss of $119.9 million in prior year General Fund supported fund balances used to support the FY 2013-14 budget that is not available in FY 2014-15.
>
> **Gain of FY 2013-14 starting General Fund supported balances:** This report projects a gain of the $103.9 million from the balance at the end of FY 2013-14 as projected in the Controller's Six-Month Budget Status Report used evenly over the upcoming two budget years.

In addition to changes in starting fund balance, this report assumes changes in one-time sources will result in reduced revenue of $18.3 million in FY 2014-15, $16.3 million in FY 2015-16 and $1.5 million in FY 2017-18. Additional information on the use of one-time reserves is provided in the Uses section on Baselines and Reserves below.

SOURCES – Other Citywide and Departmental Revenues

Public Health Revenues: The Department of Public Health (DPH) projects a revenue decrease of $24.4 million in FY 2014-15, followed by increases of $24.8 million in FY 2015-16, $7.4 million in FY 2016-17 and $7.5 million in FY 2017-18. These revenues are offset by increasing expenditures listed in the Uses section below. The revenue changes include:

> **San Francisco General Hospital (SFGH) Patient Revenues:** SFGH revenue estimates are based on projections from a study commissioned in 2013 to evaluate the effects of the Affordable Care Act (ACA). Projections include an increase of $64.6 million in FY 2014-15 in capitated revenues due to new enrollees under the ACA's Medi-Cal expansion, growing to $93.7 million by FY 2017-18. However, these increases are offset by reductions in fee-for-service revenues of $80.1 million in FY 2014-15 as former Medi-Cal beneficiaries transition into managed care programs. This amount declines to $69.6 million by FY 2017-18. These projections are preliminary and are based on assumptions regarding the capitated and supplemental reimbursement for enrollees in the Medi-Cal expansion program. Projections assume the Department of Public Health will provide service to 15,000 expanded Medi-Cal beneficiaries by FY 2014-15 and retain this membership over the life of the program, and that reimbursement will be sufficient to cover anticipated costs of approximately $400 per member per month. Because of the significant uncertainty about the effects of ACA, which began implementation in January 2014, it is possible these projections will change significantly once actual data is available on enrollments and reimbursements under the new law, likely in April or May 2014.
>
> **Realignment Claw Back:** As mentioned previously, this report assumes an ongoing $33.8 million reduction in FY 2014-15 due to the State's "claw back" of realignment payments for county indigent care. The exact amount of the claw back will not be known until the State budget is finalized.

Laguna Honda Hospital (LHH) Rate Change: DPH projects $10.0 million in additional ongoing revenue at LHH due to a change in the State's payment calculations. The State now uses more current cost data, which represents higher costs, resulting in more timely settlements and higher payments to LHH.

SB 208 Revenues: The State provides supplemental payments to agencies implementing the Medi-Cal managed care expansion program for seniors and persons with disabilities. DPH is expecting to receive this ongoing payment of $15.0 million in FY 2014-15 through FY 2017-18.

Fire Department Revenues: The Fire Department is experiencing a shortfall in ambulance revenues in the current fiscal year. Assuming no policy changes, the Department will have a $4.1 million revenue gap in their FY 2014-15 budget. Revenues in FY 2015-16, FY 2016-17, and FY 2017-18 are expected to experience mild growth as a result of inflationary increases.

Other General Fund-Supported Revenues: Other General Fund supported revenues are projected to increase by $0.8 million, $2.6 million, $2.6 million and $2.5 million in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, respectively. These revenues include Human Services Agency revenues and Airport revenues as described below.

Human Services Agency Revenues: The Human Services Agency (HSA) is projected to draw incremental state and federal revenues to pay for additional salaries and fringe benefit costs. The Department estimates they will draw revenues for approximately 36% of salary and benefit costs in FY 2015-16 and FY 2016-17, and 35% of salary and benefit costs in FY 2017-18, resulting in incremental revenue increases of $2.1 million, $0.7 million and $0.9 million in FY 2015-16, FY 2016-17 and FY 2017-18, respectively.

Airport Revenues: The General Fund receives a portion of Airport concessions revenue annually. For FY 2014-15 through FY 2017-18, the Airport projects these revenues to increase by $0.8 million, $0.6 million, $1.9 million, and $1.6 million, respectively.

USES – Changes to Reserves and Baselines

Changes to Reserves: The net change in reserves is estimated to be a cost of $12.5 million in FY 2014-15, followed by savings of $20.8 million in FY 2015-16, $1.0 million in FY 2016-17, and $9.2 million in FY 2017-18. Key changes to reserves are summarized below and reflected in Table A-3a and Table A-3b.

Rainy Day Reserve: For years in which General Fund revenues decline, the Charter allows the City to withdraw up to 50% of the City's Rainy Day Economic Stabilization Reserve. The Charter also allows withdrawals of up to 25% of the Rainy Day Reserve for the San Francisco Unified School District (SFUSD) in years when inflation-adjusted per-pupil revenues decline. Withdrawals are at the discretion of the Mayor and Board of Supervisors. This report does not project a City withdrawal from the Economic Stabilization Reserve during the projection period. The projected FY 2013-14 year-end balance is $20.5 million, including an estimated deposit of $3.0 million and allocation of $5.8 million to the SFUSD. Table A-3a reflects the budgeted use of $1.5 million of the Rainy Day One-Time Reserve in FY 2013-14, and assumes no further withdrawals during the projection period. The estimated FY 2013-14 year-end balance of the One-Time Reserve is $3.0 million.

Recreation & Park Reserve: The FY 2013-14 budget used $9.7 million of Recreation & Park Budget Savings Incentive Reserve to support one time expenditures in the Recreation and Park Department, leaving an available balance of $5.1 million in the reserve to support one time expenditures in the Department's FY 2014-15 budget. This report does not assume use of this reserve to support future year budgets beyond FY 2014-15.

General Reserve: Consistent with the financial policies adopted by the Board of Supervisors in April 2010 and codified in Administrative Code Section 10.60(b), this report anticipates the General Reserve rising from $44.7 million in FY 2013-14 to 1.5% of regular General Fund revenues in FY 2014-15 (projected at $56.2 million) to 1.75% in FY 2015-16 ($67.3 million), and to 2.0% in FY 2016-17 ($78.5 million) and FY 2017-18 ($80.1 million). This report also assumes no withdrawals and that unspent monies at the end of each fiscal year will be carried forward to the subsequent year.

Budget Stabilization Reserve: Consistent with the financial policies adopted by the Board of Supervisors in April 2010 and codified in Administrative Code Section 10.60(b), this report anticipates a deposit of $22.8 million into the Budget Stabilization Reserve in FY 2014-15, $1.4 million in FY 2015-16, and $0 in FY 2016-17 and FY 2017-18. These deposits are related to projected Real Property Transfer Tax revenues above.

Salaries and Benefits Reserve: This report assumes previously adopted FY 2014-15 budget levels for the salary and benefits reserve, and projects increasing the salary and benefits reserve by CPI-W in each year of the projection period from the $13.5 million level appropriated in the FY 2014-15 budget to support costs related to labor agreements not budgeted in individual departments.

Litigation Reserve: This report projects increasing the Litigation Reserve by CPI in each year of the projection period from the $11.0 million level appropriated in the FY 2013-14 budget to $17.0 million based on current estimates of liabilities related to claims, settlements and judgments.

Table A-3a. Reserve Withdrawal and Appropriation Amounts ($ Millions)

	Orig. Budget FY 2013-14	Projected FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Reserve Withdrawals Used to Support Budget					
Rainy Day One-Time Reserve	$ 1.5	$ -	$ -	$ -	$ -
Recreation & Park Reserve	9.7	5.1	-	-	-
Total Withdrawals	**$ 11.2**	**$ 5.1**	**$ -**	**$ -**	**$ -**
Appropriations to Reserves					
General Reserve Requirement	*$ 44.7*	*$ 56.2*	*$ 67.3*	*$ 78.5*	*$ 80.1*
General Reserve Deposit	22.8	16.0	11.1	11.2	1.6
Budget Stabilization Reserve	16.0	22.8	1.4	-	-
Salaries & Benefits Reserve	13.1	13.5	13.8	14.1	14.4
Litigation Reserve	11.0	17.0	17.0	17.0	17.0
Total Appropriations	**$ 62.9**	**$ 69.2**	**$ 43.3**	**$ 42.3**	**$ 33.1**

Table A-3b. Net Budgetary Impact of Changes to Reserves ($ Millions)

	Change from Prior Year Budget FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Increase (Decrease) in Reserve Withdrawals Used to Support Budget				
Rainy Day Reserve	$ (1.5)	$ -	$ -	$ -
Recreation & Park Reserve	(4.6)	(5.1)	-	-
Subtotal Changes to Withdrawals	**$ (6.1)**	**$ (5.1)**	**$ -**	**$ -**
Decrease (Increase) in Appropriations to Reserves				
General Reserve Requirement	*$ 11.5*	*$ 11.1*	*$ 11.2*	*$ 1.6*
General Reserve Deposit	6.9	4.9	(0.1)	9.6
Budget Stabilization Reserve	(6.8)	21.4	1.4	-
Salaries & Benefits Reserve	(0.4)	(0.3)	(0.3)	(0.3)
Litigation Reserve	(6.0)	-	-	-
Subtotal Changes to Appropriations	**$ (6.3)**	**$ 25.9**	**$ 1.0**	**$ 9.2**
Net Budgetary Impact of Changes to Reserves	**$ (12.5)**	**$ 20.8**	**$ 1.0**	**$ 9.2**

Baseline and Mandate Requirements: The Charter specifies baseline-funding levels for various programs or functions that are generally linked to changes in discretionary General Fund revenues, though some are a function of Citywide expenditures or base-year program expenditure levels.

As a result of growing discretionary revenue, the City's mandated contributions to baselines and set-asides is increasing by $23.5 million, $18.9 million, $24.5 million and $14.9 million in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18. Key changes to baseline contributions are summarized below and in Table A-4a and Table A-4b.

Public Education Enrichment Fund Annual Contribution: Proposition H created the Public Education Enrichment Fund Annual Contribution as well as the Public Education Baseline. The Public Education Enrichment Fund (PEEF) contribution is projected to increase by $4.4 million, $4.2 million, $4.0 million and $2.3 million in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, respectively. These increases reflect the

percentage increase in the City's aggregate discretionary revenue over the next four years, as prescribed by Charter Section 16.123-2. The local legislation for PEEF sunsets at the end of FY 2014-15. This report assumes that the legislation will be renewed by voters, no repayment of amounts deferred by the City due to budget shortfalls, and funding will continue at the same level and rate of growth as prescribed by the current legislation.

The Public Education Baseline is projected to grow by $0.4 million, $0.3 million, $0.4 million and $0.2 million in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, respectively.

Children's Baseline: This report assumes that the required expenditure appropriation for the Children's Baseline is more than exceeded in each year, therefore, no net budgetary impact is projected.

Housing Trust Fund: This report assumes that the Housing Trust Fund will continue to grow by $2.8 million in each year, as prescribed by legislation.

Table A-4a. Projected Baseline & Select Mandated Expenditures ($ Millions)

	Orig. Budget	Projected			
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Municipal Transportation Baseline	$ 232.0	$ 245.9	$ 255.6	$ 268.3	$ 275.3
MTA Transfer In - Lieu of Parking Tax	66.6	67.6	69.7	71.0	71.8
Library Preservation Baseline	57.7	61.1	63.6	66.7	68.5
Public Education Baseline	7.3	7.7	8.1	8.5	8.7
Public Education Enrichment Fund (PEEF) Annual Contribution	73.2	77.5	81.7	85.8	88.0
Children's Baseline - Required Appropriation	125.5	133.0	138.3	145.1	149.0
Human Services Care Fund	13.7	14.4	14.4	14.4	14.4
Controller - City Services Auditor	12.9	13.8	13.8	13.9	14.0
Housing Trust Fund	20.0	22.8	25.6	28.4	31.2
Total Baselines & Select Mandates	**$ 608.8**	**$ 621.1**	**$ 645.2**	**$ 702.1**	**$ 720.8**

Table A-4b. Baseline & Select Mandated Expenditures, Change from Prior Year Budget ($ Millions)

	Projected			
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Municipal Transportation Baseline	$ (13.9)	$ (9.8)	$ (12.6)	$ (7.1)
MTA Transfer In - Lieu of Parking Tax	(1.0)	(2.1)	(1.4)	(0.7)
Library Preservation Baseline	(3.5)	(2.4)	(3.1)	(1.8)
Public Education Baseline	(0.4)	(0.3)	(0.4)	(0.2)
Public Education Enrichment Fund (PEEF) Annual Contribution	(4.4)	(4.2)	(4.0)	(2.3)
Children's Baseline - Required Appropriation*	-	-	-	-
Human Services Care Fund	0.5	-	-	-
Controller - City Services Auditor	(0.9)	(0.1)	(0.1)	(0.1)
Housing Trust Fund	(2.8)	(2.8)	(2.8)	(2.8)
Total Baselines & Select Mandates	**$ (23.5)**	**$ (18.9)**	**$ (24.5)**	**$ (14.9)**

** This report assumes the budgeted funding levels for the Children's Baseline meets mandated expanditure levels as described in the text.*

USES – Salaries and Benefits

This report projects General Fund supported salaries and fringe benefits to increase by $98.9 million in FY 2014-15, $52.2 million in FY 2015-16, $48.8 million in FY 2016-17, and $71.2 million in FY 2017-18. These increases, discussed in greater detail below, reflect the annualization of partial year positions approved in the current fiscal year, provisions in collective bargaining agreements, health and dental benefits for current and retired employees, retirement benefit costs, and other salary and benefit costs.

Annualization of Partial Year Positions: In FY 2014-15, the City is projected to incur $13.9 million in additional costs to annualize positions funded for only a partial year in the FY 2013-14 budget, and an additional $1.0 million in FY 2015-16 for positions already approved to begin mid-year in FY 2014-15.

Projected Costs of Closed Labor Agreements: The additional salary and benefit costs of closed labor agreements are projected to be $25.1 million for FY 2014-15. These costs include agreed-upon wage increases of 3.0% during FY 2013-14 and annualization of this wage increase in FY 2014-15 for most City employees. Most of the City's current labor agreements end on June 30, 2014. However, the Memorandum of Understanding (MOU) for police officers is now closed through FY 2017-18; this MOU includes negotiated wage increases of 0.0%, 1.0%, 2.0% and 2.0% over the next four years. This report assumes the same for firefighters, whose agreement is pending final approval. The City is projected to incur additional General Fund costs of $25.1 million, $5.1 million, $9.4 million and $9.5 million in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, respectively, as a result.

Projected Costs of Open Labor Agreements: This projection assumes no additional raises in FY 2014-15 for open labor contracts, which the City is currently negotiating, (although the projections do incorporate a cost increase in FY 2014-15 due to the annualization of prior agreed-upon raises). Beginning in FY 2015-16, this report assumes that bargaining units receive salary increases equivalent to the change in the Consumer Price Index (CPI-W) of 2.21%, 2.45% and 2.45% percent in FY 2015-16, FY 2016-17 and FY 2017-18, respectively. The additional salary and benefit costs for open collective bargaining agreements, using these assumptions, are projected to be $37.9 million, $43.7 million in FY 2016-17, $44.6 million in FY 2017-18. **These increases are provided for projection purposes only; actual costs will be determined in labor negotiations to be concluded by May 15, 2014.**

Health and Dental Benefits for Current Employees: In July 2013, the Board of Supervisors adopted Health Plan rates for calendar year 2014, the first half of the current fiscal year. The Health Service System anticipates negotiating rates for calendar year 2015 in late spring 2014, to be adopted in late summer of 2014. These projections assume historical average increases of approximately 5.0% in health and dental rates in each year. Given these assumptions, health and dental insurance premium costs related to current employees are projected to increase by $8.7 million in FY 2014-15, $9.5 million in FY 2015-16, $12.1 million in FY 2016-17, and $12.7 million in FY 2017-18. While the adopted rates include the effect of federal taxes and fees levied on employer-based health plans as part of the implementation of the Affordable Care Act, which was a key uncertainty at this time last year, challenges in projecting rates remain. A new flat-contribution cost-sharing model will go into effect for many employees in January of 2015; additional employee groups may elect to adopt this model, which may affect migration among plans. Utilization and cost trends shift due to demographic changes, plan design, and other factors.

Health and Dental Benefits for Retired City Employees: Charter Section A8.428 mandates health coverage for retired City employees. The cost of medical benefits for retirees is projected to increase by $8.2 million, $9.1 million, $9.9 million, and $10.8 million in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, respectively. Proposition B, passed by voters in June of 2008, began to address this unfunded liability by requiring employees hired after January 10, 2009 and the City to pay 2.0% and 1.0% of pre-tax compensation, respectively, into a Retiree Health Care Trust Fund. Proposition C, passed by voters in November of 2011, enhanced Proposition B's efforts by requiring all remaining employees and the employer to begin contributing to this fund beginning in FY 2016-17. Starting July 1, 2016, employees hired before January 10, 2009 will begin contributing 0.25% of pre-tax compensation into the retiree health care trust fund with additional 0.25% of each subsequent year, up to a maximum of 1.0%, and the City will match the contribution commensurately. To date, the City's contribution to the Retiree Health Care Trust Fund per Proposition C has been paid through existing departmental budgets; however, the growth rate of employees hired after January 10, 2009 is estimated at an 18.0% increase per year from FY 2014-15 to FY 2017-18. Therefore, this report now assumes General Fund support will grow $0.8 million, $1.0 million, $4.1 million and $3.9 million each year in FY 2014-15, FY 2015-16, FY 2016-17 and FY 2017-18, respectively.

Retirement Plan Employer Contribution Rates and Implementation of Pension Reform (Proposition C). The majority of City employees are part of the San Francisco Employees Retirement System (SFERS), and some public safety personnel are part of the California Public Employees Retirement System (CalPERS). In November 2011, Proposition C changed the way the City and employees share in funding pension benefits. The base employee contribution rate remains at 7.5% for most employees when the City contribution rate is between 11% and 12% of payroll. When the City contribution rate is above 12%, employees pay an additional amount based on the salary band in which their wages fit.

Total retirement costs continue to increase in FY 2014-15 due to investment losses in the San Francisco Employees' Retirement System (SFERS) and California Public Employees' Retirement System (CalPERS) during the 2008 recession. The SFERS employer contribution rates below are assumed in this report and are based on projections prepared by the Retirement System's actuary in November 2013. They assume continuation of the SFERS Board adopted policy of decreasing estimated future investment returns from 7.75% to 7.5%; however, final rates for FY 2014-15 will be adopted by the Retirement Board in the coming months. Table A-6 below reflects the total contribution rate, the portion of the rate that employees contribute, and the City's portion. Rates for Police and Fire safety employees vary based on date of hire. Employees hired after January 2009 contribute based on the band 3 rate.

For CalPERS members, the projections in this report assume previously adopted rates, as well as projected rate increases starting FY 2016-17 due to adjusted mortality assumptions adopted by the CalPERS Board in February 2014. Proposition C requires the City to achieve comparable savings from CalPERS members as SFERS members. The table below reflects employee contributions for CalPERS members.

The net result of these changes is an increase in total General Fund supported employer contributions into SFERS and CalPERS of $42.0 million in FY 2014-15, followed by incremental cost decreases of $19.8 million in FY 2015-16, $22.6 million in FY 2016-17, and $5.8 million in FY 2017-18.

Table A-6. Employee and Employer Retirement Contribution Rates

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
San Francisco Employees Retirement System (SFERS)					
Non-Safety					
Employee Contribution (1)					
Band 1, < $24.53/hour	7.50%	7.50%	7.50%	7.50%	7.50%
Band 2, < $49.07/hour	11.00%	11.25%	11.00%	11.00%	11.00%
Band 3, >$49.07/hour	11.50%	11.75%	11.50%	11.50%	11.50%
Employer Contribution (1)					
Band 1, < $24.53/hour	24.82%	27.70%	26.00%	24.30%	23.60%
Band 2, < $49.07/hour	21.32%	23.95%	22.50%	20.80%	20.10%
Band 3, >$49.07/hour	20.82%	23.45%	22.00%	20.30%	19.60%
Police and Fire Safety Employees (2)					
Employee Contribution	12.00%	12.25%	12.00%	12.00%	12.00%
Employer Contribution	20.32%	23.25%	21.50%	19.80%	19.10%
California Public Employees Retirement System (CalPERS)					
Total Contribution Rate (3)	21.59%	22.94%	24.60%	27.70%	31.90%
Employee Contribution	4.50%	3.30%	3.30%	3.30%	3.30%
Employer Contribution	17.09%	19.73%	22.10%	24.40%	28.60%

(1) Employees are divided into three bands based on wages. The wages shown are based on the FY 2013-14 wage floors.

(2) Employee base contribution rates vary depending on hire date. For employees hired before July 1, 2010, the rate is 7.5%. For those hired after July 1, 2010, the rate is 9.0%. For display purposes, this table assumes an average rate of 7.5%.

(3) Rates vary among employees; this table displays average rates.

Other Salaries and Fringe Benefits Costs: Other salary and benefit cost changes are expected to be modest, with the biggest changes occurring due to the changing number of work days in a given fiscal year. Most fiscal years consist of 261 workdays for regularly scheduled shifts and 365 days for 24/7 operations. FY 2013-14 and FY 2014-15 are normal years; however, FY 2015-16 is a leap year and contains 366 days for 24/7 operations and 262 workdays for regularly scheduled shifts, therefore the City incurs additional General Fund costs of $7.8 million in that year, which go away in FY 2016-17. FY 2017-18 again contains only 260 regularly scheduled workdays and the City expects to see savings in that year of $4.5 million.

Other salary and benefit changes include changes to costs for unemployment insurance, Long Term Disability, and any changes to the FICA income cap, as well as other small salary and fringe adjustments and MOU-related agreements. The combined effect of these changes is a General Fund cost increase of $0.9 million in FY 2014-15 and $9.4 million in FY 2015-16, followed by decreases of $3.7 million and $0.6 million in FY 2016-17 and FY 2017-18.

USES – Citywide Operating Budget Costs

Table A-1 displays other non-salary Citywide cost increases of $30.2 million, $96.0 million, $64.0 million, and $52.0 million for FY 2014-15, FY 2015-16, FY 2016-17, and FY 2017-18, respectively.

Capital, Equipment, & Technology: As shown in Table A-5, changes in funding for capital, equipment, and technology will result in an increase in General Fund support of $25.4 million in FY 2014-15, $64.2 million in FY 2015-16, $39.3 million in FY 2016-17, and $29.8 million in FY 2017-18.

Table A-5. Capital, Equipment and Technology Costs ($ Millions)

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Ten-Year Capital Plan Budget	(37.9)	(24.2)	(15.2)	(10.9)
Capital One-Time Bond Reimbursements	11.6	(11.6)	-	-
Capital FF&E, moving and operating costs	-	(2.2)	(19.8)	(14.2)
Equipment and Fleet	(1.8)	(7.6)	(0.4)	(0.4)
Five-Year Information & Communication Technology Plan Budget	2.7	(3.1)	(2.3)	(2.5)
Major IT Investments	-	(15.4)	(1.5)	(1.7)
Total Capital, Equipment, & Technology	**(25.4)**	**(64.2)**	**(39.3)**	**(29.8)**

This report assumes that capital budget funding will increase based on the levels assumed in the City's FY 2014-23 Ten-Year Capital Plan for FY 2014-15, 2015-16, FY 2016-17, and FY 2017-18, which represents an increase in General Fund support of $37.9 million, $24.2 million, $15.2 million and $10.9 million, respectively in each year. For FY 2014-15, the capital projection reflects the previously adopted FY 2014-15 budget, which did not include full funding of the Capital Plan. In addition, this report assumes $11.6 million in one-time bond reimbursements in FY 2014-15 from the Earthquake Safety and Emergency Response (ESER) 2 bond for past planning dollars funded through the City's pay-as-you-go General Fund capital budget. The ESER 2 bond will be before the voters in June 2014; if the bond does not pass, this $11.6 million in revenue will not be received. Additionally, the City is experiencing increasing furniture, fixture and equipment costs (FF&E) associated with new and upgraded City facilities related to the ESER 2 bond (for the Police Department, the Medical Examiner's Office, and the Fire Department) and the proposed 2015 Public Health Facilities Seismic Improvements bond for the Department of Public Health (DPH) in the amounts of $2.2 million in FY 2015-16, $19.8 million in FY 2016-17, and $14.2 million in FY 2017-18. This report assumes this bond will be approved by voters. Additionally there are operating and FF&E costs for the new Public Safety Building and San Francisco General Hospital. These costs are discussed in the departmental section of this report in greater detail.

This report assumes levels of cash purchased equipment and fleet replacement costs for the FY 2014-15 adopted budget, which represents an increase of $1.8 million over FY 2013-14. In FY

2015-16, this report assumes that equipment and fleet will increase by $7.6 million to reach previous levels of investment as well as projected need. This projection assumes increases in costs according to CPI, or $0.4 million per year, in FY 2016-17 and FY 2017-18. Captured in the equipment and fleet projection are replacement schedule assumptions for Police vehicles, City fleet vehicles, and Fire apparatus as well as assumptions based on past requests from Recreation and Park, Public Works, Public Health, and other General Fund departments. This projection assumes that no equipment and fleet purchases will be funded through the use of lease revenue bonds in any of the next four years. By using cash instead of debt financing, the City saves on financing costs, reducing the overall cost of equipment purchases over the long term.

Citywide technology costs are projected to decrease by $2.7 million in FY 2014-15, as reflected in the previously adopted FY 2014-15 budget. Technology costs are projected to increase by $3.1 million in FY 2015-16, $2.3 million in FY 2016-17, and $2.5 million in FY 2017-18 per recommendations outlined in the City's Information and Communication Technology (ICT) Plan for FY 2013-14 through FY 2017-18. This report also assumes an increase in funding for major Information Technology investments in the amount of $15.4 million starting in FY 2015-16 and increasing by 10.0% in FY 2016-17 and FY 2017-18, consistent with capital planning and ICT Plan assumptions to grow funding for IT and capital as time goes on. This increase in funding is assumed to reflect the risk the City faces with replacing the City's aging information and communication technology systems over the coming several years. The City's ICT Plan recognizes this risk and specifically identifies the replacement of the City's financial system ($72.2 million), replacement of public safety radio systems ($69.0 million), and replacement of the Assessor-Recorder's property tax database ($13.0 million) as critical and currently unfunded projects. These projects are projected to need significant amounts of funding; therefore, this assumption represents an investment strategy for funding these projects over the next several years. This level of funding for major IT investments will be reviewed by the Committee on Information Technology (COIT) during the budget process and also revisited in the City's next Five-Year ICT plan due to the Board of Supervisors in spring of 2015.

Inflation on Non-Personnel Costs and Grants to Non-Profits: Over the next four years, this report assumes that the cost of materials and supplies, professional services, contracts with Community-Based Organizations and other non-personnel operating costs will rise by Consumer Price Index (CPI-U) increases of 2.2%, 2.4%, and 2.4% for FY 2015-16, FY 2016-17 and FY 2017-18, respectively. The projection reflects the adopted FY 2014-15 budget spending levels in the first year of the report. This generates an increase in costs to the City of $21.6 million, $22.1 million, and $22.6 million in FY 2015-16, FY 2016-17 and FY 2017-18, respectively.

Debt Service & Lease Financings: Over the next four years, total debt service and lease financing costs are projected to increase by $6.2 million in FY 2014-15, $7.1 million in FY 2015-16, $1.2 million in FY 2016-17, and then decrease $4.8 million in FY 2017-18. These projections are based on current debt repayment requirements and projected debt service costs for investments anticipated in the Capital Plan. These projections do not include debt service related to the Moscone Convention Center, which is reflected in the Convention Facilities Fund subsidy projection. The increases over the next several years are primarily due to the repayment of Certificates of Participation (COPs) for the War Memorial Veterans Building seismic upgrade, equipment leases for SF General Hospital, HOPE SF, and the Jail Replacement project.

Workers' Compensation: Workers' compensation costs are projected to decrease by $0.2 million in FY 2014-15, and then increase by $2.1 million in FY 2015-16, $1.9 in FY 2016-17, and $2.0 million in FY 2017-18. These projections are based on projected actual spending in FY 2013-14, known changes to State workers compensation requirements, and an assumed 5.0% medical inflation rate.

Other Citywide Costs: This category includes assumed costs of real estate transactions for the City's General Fund departments; rate increases by the Public Utilities Commission (PUC) for electricity, natural gas and steam, sewer and water; the expiration of one-time costs from the prior year budget; and other minor changes. These items together result in General Fund savings of $1.2 million in FY 2014-15, increased costs of $1.1 million in FY 2015-16, decreased costs of $0.5 million in FY 2016-17, and increased costs of $2.4 million in FY 2017-18.

USES –Departmental Costs

Table A-1 displays other departmental cost increases of $28.4 million in FY 2014-15 and $53.4 million in FY 2015-16, savings of $2.9 million in FY 2016-17, and cost increases of $20.1 million in FY 2017-18.

City Administrator – Convention Facilities Fund Subsidy: This Plan assumes the Convention Facilities Fund will need a General Fund subsidy increase of $4.5 million ongoing starting in FY 2015-16. These cost increases are due to lower than expected operating revenue at the facilities due to the partial closure during expansion of the facility, and loss of one-time prior year fund balance.

Elections Department – Number of Elections: The number of elections, and the associated costs for holding elections, varies annually. Currently, one November gubernatorial election is projected for FY 2014-15, two elections are projected in FY 2015-16 (a municipal election and a June Presidential primary), one Presidential General Election is projected in FY 2016-17, and one gubernatorial primary election in FY 2017-18. This schedule results in a projected incremental savings of $3.0 million in FY 2014-15, a cost of $4.8 million in FY 2015-16, and savings of $3.5 million and $0.7 million in FY 2016-17 and FY 2017-18, respectively. Any special election not included in this projection would result in increased General Fund costs dependent on the complexity of the ballot and the size of the electorate.

Ethics Commission – Public Financing of Elections: The Ethics Commission administers the Election Campaign Fund. Annual General Fund deposits to the Campaign Fund are governed by ordinance. Amounts in the Fund not used in one election are carried over for use in the following election, and at no time shall the total amount in the Fund exceed $7.0 million. This projection assumes that a General Fund deposit will occur in all four years of the forecast and that eligible candidates will qualify and accept disbursements each fiscal year based on historical actuals. An additional cost of $2.0 million is assumed in FY 2014-15. The following years of the projection assume the Fund will start with a balance of $7.0 million each year but could fluctuate based on actual disbursements to supervisorial and mayoral candidates. In FY 2015-16, an additional cost of $1.2 million is projected, followed by a savings of $1.4 million in FY 2016-17, and a savings of $0.3 million in FY 2017-18.

Fire and Police – Opening of the Public Safety Building: In addition to the project costs for the Public Safety Building and Fire Station 4 funded through the Earthquake Safety and Emergency Response 1 bond, there are associated operating and furniture, fixture and

equipment (FF&E) costs for these new projects. None of these costs may be paid using bond proceeds, and therefore require additional General Fund support. Operating costs for the Public Safety Building (PSB) are $5.4 million in FY 2014-15 increasing by $1.9 million in FY 2015-16 and increasing by a further $0.1 million in both FY 2016-17 and FY 2017-18; these cost increases are offset in FY 2014-15 by a reduction in General Fund support of $14.6 million due to the expiration of one-time uses for furniture, fixtures and equipment (FF&E) related to the PSB.

Fire and Police – Multi-Year Hiring Plans: Over the next four years, the report assumes there will be one Fire Academy class and three Police Academy classes each year. The Police portion of the hiring plan assumes the City will hire 150 officers a year at an increasing cost of $12.6 million in FY 2014-15, $11.1 million in FY 2015-16, $11.2 million in FY 2016-17 and $3.3 million in FY 2017-18. The Fire portion of the hiring plan assumes the City will hire 42 new firefighters a year, resulting in overtime expenditure reductions of $4.8M in FY 2014-15 and $0.4M in FY 2015-16, and increasing costs of $0.2M in FY 2016-17 and $1.6M in FY 2017-18.

Human Services Agency – Aid: The Human Services Agency projects that aid and the Care Not Cash programs will require an increases in General Fund support of $4.4 million in FY 2015-16, $4.7 million in FY 2016-17, and $4.8 million in FY 2017-18. These changes are primarily due to the new Maintenance of Effort (MOE) of the In-Home Support Services program, which mandates that local support for the IHSS program increase by 3.5% each year. In addition, there are changes in support related to state policy changes in the Foster Care program, as well as projected changes in caseloads.

Public Health: The Department of Public Health (DPH) projects cost increases of $22.1 million in FY 2014-15 and $28.4 million in FY 2015-16, savings of $11.7 million in FY 2016-17, and increases of $8.9 in FY 2017-18. The expenditure changes are summarized below:

> **San Francisco General Hospital Rebuild:** The new San Francisco General Hospital is expected to open in December 2015. Total expenditures for furniture, fixtures and equipment (FF&E) are expected to total $170.0 million over FY 2013-14 and FY 2014-15. The General Fund supports a portion of these expenses. In FY 2014-15, General Fund support for FF&E is expected to increase by $27.0 million primarily due to the reduction of one-time sources budgeted in the prior year. In FY 2015-16, DPH projects $25.0 million in expenditures related to transition planning and $26.9 million to staff the new building for a partial year; however, the net change in General Fund support is $20.9 million due to the expiration of one-time FF&E expenditures. In FY 2016-17, the new hospital experiences overall savings of $19.5 million, as expenditures for transition planning expire. In FY 2017-18, DPH assumes additional costs of $0.8 million due to CPI on new hospital operating costs.
>
> **Inflationary, Regulatory, and Annualization of Initiatives:** Because inflation on medical goods and services is typically higher than inflation in other areas, DPH is projecting inflation slightly higher than CPI. Furthermore, there are projected expenditure savings in FY 2014-15 and FY 2015-16 due to budgeted initiatives from the prior planning cycle, including a reduction in community program contracts and reprogramming of the Behavioral Health Center. As a result, the report assumes savings of $4.9 million in FY 2014-15 and cost increases of $7.5 million in FY2015-16, $7.8 million in FY 2016-17, and $8.1 million in FY 2017-18.

Treasurer-Tax Collector – Gross Receipts Tax Implementation: In November of 2012, the citizens of San Francisco passed Proposition E, mandating the transition of the City's primary

business tax from the current payroll tax structure to a new tax based on gross receipts. The Office of the Treasurer-Tax Collector projects costs to increase as a result of Gross Receipts Tax implementation by $3.3 million in FY 2014-15. As implementation transitions to regular operations, project costs will decrease by $2.7 million in FY 2015-16, $1.0 million in FY 2016-17, and $1.0 million in FY 2017-18.

Annualization of Supplementals: This report assumes that the proposed Homeless Outreach Services Supplemental Appropriation of $1.4 million in FY 2013-14 is annualized to $5.6 million in FY 2014-15.

All Other Departmental Savings/(Costs): This section includes other smaller departmental changes including the cost of labor negotiations which fluctuates year by year depending on the negotiations schedule; the expiration of limited-term project costs; costs and savings associated with the closure of Candlestick Park, and several other small changes.

STAFF CONTACTS

Michelle Allersma, Director of Budget & Analysis, Controller's Office, Michelle.Allersma@sfgov.org

Kate Howard, Mayor's Budget Director, Kate.Howard@sfgov.org

Severin Campbell, Board of Supervisor's Budget Analyst's Office, Severin.Campbell@sfgov.org

From: Evans, Derek (BOS)
Sent: Thursday, March 06, 2014 1:36 PM
To: Miller, Alisa (BOS)
Cc: Smith, Derek (DPH); Nevin, Peggy (BOS)
Subject: FW: File 131208: E-cigarette prohibition #131208

From: Board of Supervisors
Sent: Thursday, March 6, 2014 11:45 AM
To: BOS-Supervisors; Evans, Derek (BOS)
Subject: File 131208: E-cigarette prohibition #131208

From: Nicholas Wellington [mailto:nickwell@pacbell.net]
Sent: Wednesday, March 05, 2014 5:59 PM
To: Board of Supervisors
Subject: E-cigarette prohibition #131208

As a frequent visitor to the City, for business and pleasure, I urge you to enact the proposed ordinance to prohibit use of e-cigarettes, e-hookah and vapor pens in exactly the same way that regular cigarettes are regulated.
Thank you,
Nicholas Wellington
Kensington, CA 94707

13

From: Board of Supervisors
To: BOS-Supervisors; Evans, Derek
Subject: File 131208: E-cigarette prohibition #131208

From: Nicholas Wellington [mailto:nickwell@pacbell.net]
Sent: Wednesday, March 05, 2014 5:59 PM
To: Board of Supervisors
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Thank you,
Nicholas Wellington
Kensington, CA 94707

From: Board of Supervisors
To: Evans, Derek
Subject: File 131208: cigarette butt epidemic

-----Original Message-----
From: Wil James [mailto:duca2@me.com]
Sent: Wednesday, March 05, 2014 10:38 AM
To: Board of Supervisors; Wiener, Scott; Mar, Eric (BOS); Kim, Jane; Tang, Katy; Yee, Norman (BOS); Chiu, David; Campos, David; Avalos, John; Breed, London; Cohen, Malia; Farrell, Mark
Subject: cigarette butt epidemic

Dear Supervisors:

Is our city doing anything about controlling the disposal of cigarette butts, particularly in front of bars, where they are tossed into the gutter, and then washed into the sewer system, and then into the bay?

A few bars have cigarette receptacles outside of their establishments, which are great, and some have people sweep up the butts as well. But many don't do anything. Can we as a city do something about this or have we already and it's just not being enforced, like no smoking in parks?

Thank you,

Wil James
North Beach resident

From: Board of Supervisors
To: Purcell, Derk (UCSF)
Subject: File 131208: cigarette butt epidemic

-----Original Message-----
From: Wil James [mailto:duca2@me.com]
Sent: Wednesday, March 05, 2014 10:38 AM
To: Board of Supervisors; Wiener, Scott; Mar, Eric (BOS); Kim, Jane; Tang, Katy; Yee, Norman (BOS); Chiu, David; Campos, David; Avalos, John; Breed, London; Cohen, Malia; Farrell, Mark
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Thank you,

Wil James
North Beach resident

From: Evans, Derek (BOS)
Sent: Thursday, March 06, 2014 1:30 PM
To: Miller, Alisa (BOS)
Cc: Smith, Derek (DPH); Nevin, Peggy (BOS)
Subject: FW: Ordinance #131208

FYI

From: uma <uma4rom@gmail.com>
Sent: Thursday, March 6, 2014 1:12 PM
To: Lee, Mayor (MYR); Avalos, John (BOS); Breed, London (BOS); Chiu, David (BOS); Cohen, Malia (BOS); Farrell, Mark (BOS); Kim, Jane (BOS); Tang, Katy (BOS); Wiener, Scott (BOS); Campos, David (BOS); Mar, Eric (BOS); Yee, Norman (BOS); Evans, Derek (BOS); Board of Supervisors
Subject: Ordinance #131208

Dear Board of Supervisors & Neighborhood Services & Safety Committee,

I urge you to OPPOSE banning e-cigarette use where smoking is banned. ECigarettes are normalizing NOT smoking. They produce vapor, not smoke. They are a far safer, magnitudes safer, alternative to real cigarettes. Smokers who cannot quit smoking the real cigarettes, are discovering that the eCig simulates smoking to the point they actually forget to light up a real cigarette! This is the beauty of the product, it helps people to accidentally quit smoking.

Smoking is said to kill millions of smokers globally, every year. That is a lot of tax money going down the tubes. The eCigs, on the other hand, are not known killers of taxpayers. In fact, all genuine studies have shown that eCigs are 98% safer than real smokes, not only for the user, but for the passerbys and environment as well. They are not a tobacco product, because, they do NOT contain tobacco. They contain nicotine, to help smokers transition from smoking to not smoking comfortably and happily. Nicotine in its unadulterated state, as used in eCigs, is just a notch more addicting than caffeine. The eCig users easily dilute their nicotine strengths as their bodies adjust to a life without real smokes. Real smokes, by contrast, are ridiculously addictive. Smokers smoke because they enjoy the habit & the nicotine, but they die from the tar, carcenogens, and toxins. The eCigs only have the nicotine! Unadulturated nicotine at that, which is not as addictive as cigarettes nicotine is.

Banning ex smokers from using the only method that has ever worked for them to not smoke, will toss them back into the life of being a smoker. Forcing them to go without their method of not smoking, then forcing them to stand with smokers, will be detrimental. It is setting ex smokers up to fail. This makes MSA happy, yes, especially those whose jobs will be lost if everyone quits smoking cigarettes. The ALA, ACS, TFK, etc all rely on TSET/MSA which is why they campaign so hard against eCigs.

Ex smokers are fighting for their lives.

I recommend an ordinance that declares "no clouds, but vaping just fine" wherever appropriate. Vapor dissipates within seconds. Stealth vaping means no vapor is exhaled, but instead held until dissipated. It's easy to do, and believe it or not, ex smokers have been doing this for over 6 years right next to you without your awareness. It's not a nuisance. Vaping a vapor product, to keep from smoking, should be celebrated. Anything that keeps a smoker from lighting up tar and toxins should be celebrated.

Thank you for listening,
Uma

From: Steve Heilig [heilig@sfms.org]
Sent: Thursday, March 06, 2014 8:41 AM
To: Board of Supervisors; Chiu Intern; Chiu, David (BOS); Campos, David (BOS); Breed, London (BOS); Avalos, John (BOS); Farrell, Mark (BOS); Cohen, Malia (BOS); Kim, Jane (BOS); Mar, Eric (BOS); Wiener, Scott (BOS); Tang, Katy (BOS); Yee, Norman (BOS); Miller, Alisa (BOS); Evans, Derek (BOS)
Cc: Lawrence Cheung
Subject: E-Cigarettes: Gateway to Nicotine Addiction for U.S. Teens, Says UCSF Study (re: Ordinance No. 131208)

Please consider this additional input re the proposed e-cig regulations; thank you.

Steve Heilig
San Francisco Medical Society
***

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 6, 2014
TO COINCIDE WITH PUBLICATION IN *JAMA PEDIATRICS*

E-Cigarettes: Gateway to Nicotine Addiction for U.S. Teens, Says UCSF Study

First National Analysis Strongly Associates E-Cigarettes with Smoking for Many Adolescents

E-cigarettes, promoted as a way to quit regular cigarettes, may actually be a new route to conventional smoking and nicotine addiction for teenagers, according to a new UC San Francisco study.

In the first analysis of the relationship between e-cigarette use and smoking among adolescents in the United States, UCSF researchers found that adolescents who used the devices were more likely to smoke cigarettes and less likely to quit smoking. The study of nearly 40,000 youth around the country also found that e-cigarette use among middle and high school students doubled between 2011 and 2012, from 3.1 percent to 6.5 percent.

"Despite claims that e-cigarettes are helping people quit smoking, we found that e-cigarettes were associated with more, not less, cigarette smoking among adolescents," said lead author Lauren Dutra, a postdoctoral fellow at the UCSF Center for Tobacco Control Research and Education.

"E-cigarettes are likely to be gateway devices for nicotine addiction among youth, opening up a whole new market for tobacco," she said.

The study will be published online on March 6 in *JAMA Pediatrics*.

E-cigarettes are battery-powered devices that look like cigarettes and deliver an aerosol of nicotine and other chemicals. Promoted as safer alternatives to cigarettes and smoking cessation aids, the devices are rapidly gaining popularity among adults and youth in the U.S. and around the world. Unregulated by the U.S. Food and Drug Administration, e-cigarettes have been widely promoted by their manufacturers as a way for people to quit smoking conventional cigarettes. They are sold in flavors such as chocolate and strawberry that are banned in conventional cigarettes because of their appeal to youth.

In the new UCSF study, the researchers examined survey data from middle and high school students who completed the National Youth Tobacco Survey in 2011 and 2012.

The authors found that the devices were associated with higher odds of progression from experimenting with cigarettes to becoming established cigarette smokers. Additionally, adolescents who smoked both conventional cigarettes and e-cigarettes smoked more cigarettes per day than non-e-cigarette users.

Contrary to advertiser claims that e-cigarettes can help consumers stop smoking conventional cigarettes, teenagers who used e-cigarettes and conventional cigarettes were much less likely to have abstained from cigarettes in the past 30 days, 6 months, or year. At the same time, they were more likely to be planning to quit smoking in the next year than smokers who did not use e-cigarettes.

The study's cross-sectional nature didn't allow the researchers to identify whether most youths initiated with conventional cigarettes or e-cigarettes. But the authors noted that about 20 percent of middle school students and about 7 percent of high school students who had ever used e-cigarettes had never smoked regular cigarettes – meaning that some kids are introduced to the addictive drug nicotine through e-cigarettes, the authors said.

"It looks to me like the wild west marketing of e-cigarettes is not only encouraging youth to smoke them, but also it is promoting regular cigarette smoking among youth," said senior author Stanton A. Glantz, PhD, UCSF professor of medicine and director of the Center for Tobacco Control Research and Education.

The new results are consistent with a similar study of 75,000 Korean adolescents published last year by UCSF researchers, which also found that adolescents who used e-cigarettes were less likely to have stopped smoking conventional cigarettes (visit bit.ly/1fFNWbc to learn more).

In combination, the two studies suggest that "e-cigarettes may contribute to nicotine addiction and are unlikely to discourage conventional cigarette smoking among youths," said the scientists.

The federal Centers for Disease Control and Prevention reported last year that the majority of adolescents who have ever smoked e-cigarettes also have smoked regular cigarettes. An estimated 1.78 million U.S. students have used the devices as of 2012, the CDC reported.

The research was funded by the National Cancer Institute (grants CA-113710 and CA-060121).

The Center for Tobacco Control Research and Education specializes in tobacco control research focused on policy change, smoking cessation, nicotine addiction, health disparities in smoking, novel tobacco devices and tobacco marketing. It also houses the Legacy Tobacco Documents Library, a rich resource of previously confidential tobacco industry documents.

UCSF is a leading university dedicated to promoting health worldwide through advanced biomedical research, graduate-level education in the life sciences and health professions, and excellence in patient care. It includes top-ranked graduate schools of dentistry, medicine, nursing and pharmacy, a graduate division with nationally renowned programs in basic biomedical, translational and population sciences, as well as a preeminent biomedical research enterprise and two top-ranked hospitals, UCSF Medical Center and UCSF Benioff Children's Hospital.

From: Alex Clark [nybandago.alex@gmail.com]
Sent: Thursday, March 06, 2014 7:23 AM
To: Lee, Mayor (MYR); Avalos, John (BOS); Breed, London (BOS); Chiu, David (BOS); Cohen, Malia (BOS); Farrell, Mark (BOS); Kim, Jane (BOS); Tang, Katy (BOS); Wiener, Scott (BOS); Campos, David (BOS); Mar, Eric (BOS); Yee, Norman (BOS); Evans, Derek (BOS); Board of Supervisors
Subject: Ordinance No. 131208 (Electronic Cigarette Indoor Use Prohibition)

Councilman Mar et al,

Although I am not a San Francisco Resident, I am employed by a San Francisco based company. I am concerned about the proposed ordinance to regulate indoor electronic cigarettes (and any "vapor product" for that matter). Electronic cigarettes have been a "miracle" for me and millions of others. It would be a huge mistake for San Francisco to treat them the same as Combusted Tobacco products.

A little over a year ago, I was in San Francisco for my company's annual management meeting/holiday dinner. During the meetings, our CEO strongly encouraged all staff to quit smoking. He shared links to a cessation aid/quit program and made it very clear that he was concerned for our health.

Two months later, I discovered Electronic Cigarettes when I saw someone in New Jersey using them successfully to stop smoking. I was intrigued. February, 11th, 2013 was the last time I had a Combusted Tobacco Cigarette and I'm confident that as long as electronic cigarettes are available and affordable I will remain Smoke Free.

As a result of my adopting electronic cigarettes to replace my deadly smoking habit, my staff in New Jersey quickly saw how effective the products were. Within six months three other smokers in my office had quit or significantly cut down their consumption of combusted tobacco. Almost a year later, my office remains almost 95% smoke free (those that do smoke, consume 1 - 3 tobacco cigarettes on any given day). This is in stark contrast to our main office in San Francisco which has not seen ECigs used in the workplace and continues to have the same amount of staff that smokes.

The benefits of seeing former smokers use and enjoy electronic cigarettes is clear. On the other hand, the harm that will be caused by this ordinance is not so easily explained, however, it is significant. By treating electronic cigarettes the same as combusted tobacco cigarettes the city will be sending the message to current smokers that they are equally as harmful. The net result will be to discourage recalcitrant smokers from switching to a reduced harm, smoke free alternative.

The city supervisors would be better serving their constituents by passing an ordinance supporting local businesses who choose to prohibit "vaping". Please take care with ECig regulations, as this could be a profound turning point in the effort to reduce smoking rates. Also, take note - Electronic Cigarettes (or "electronic smoking devices") were added to the NJ SmokeFree Air Act in 2010. Since then, smoking rates have remained stagnant and by some accounts even ticked up. The law is relatively unenforceable and has only served to protect the Combusted Tobacco market.

Please Reject Ordinance No. 131208

Thank You for your time and Attention,
- Alex Clark

(New Jersey)

--

Alex Clark
New York Region Fleet Manager
415.401.7659 ext. 2523
415.401.7347 fax

Please Note:
For General Bandago correspondence, please CC info@bandago.com for quickest response time.

From: Board of Supervisors
To: BOS-Supervisors
Subject: File No. 131208

From: Tarl [mailto:tcsdboys@hotmail.com]
Sent: Wednesday, March 05, 2014 8:50 PM
To: Campos, David; Mar, Eric (BOS); Yee, Norman (BOS); Evans, Derek; Board of Supervisors
Subject: Ordinance No. 131208

Hello,

My name is Tarl Wood, I live in Big Bear Lake, CA and order some of my products from vendors in the San Francisco area. I was a cigarette smoker for 17 years. I starting using e-cigs (vaping) a year and a half ago and have not had a cigarette since. I have always been respectful of non-smokers and avoided smoking around them. The same is true with vaping. I understand that not everyone shows this level of respect to the public so people feel the need exists to put restrictions on the use of e-cigs. With the number of people who have switched from traditional cigarettes to vaping it's only a matter of time before the government puts some prohibition on it. However, to label e-cigs as tobacco and requiring vendors to have tobacco licenses to sell vaping products is obsurd. There is absolutely no tobacco being used in these products and it is an effective way for people who have been struggling for years to quit smoking cigarettes to finally be able to quit. I strongly urge you all to vote NOT to recommend Ordinance 131208.

- Smoking bans are enacted to protect the public from the harm of secondhand smoke, but e-cigarettes have not been shown to cause harm to bystanders. In fact, all evidence to date shows that the low health risks associated with e-cigarettes are comparable to other smokeless nicotine products.
- The low risks of e-cigarettes is supported by research done by Dr. Siegel of Boston University, Dr. Eissenberg of Virginia Commonwealth, Dr Maciej L Goniewicz of the Roswell Park Cancer Institute, Dr. Laugesen of Health New Zealand, Dr. Igor Burstyn of Drexel University, and by the fact that the FDA testing, in spite of its press statement, failed to find harmful levels of carcinogens or toxic levels of any chemical in the vapor.
- A comprehensive review conducted by Dr. Igor Burstyn of Drexel University School of Public Health based on over 9,000 observations of e-cigarette liquid and vapor found "no apparent concern" for bystanders exposed to e-cigarette vapor, even under "worst case" assumptions about exposure.
- Electronic cigarette use is easy to distinguish from actual smoking. Although some e-cigarettes resemble real cigarettes, many do not. It is easy to tell when someone lights a cigarette from the smell of smoke. E-cigarette vapor is practically odorless, and generally any detectable odor is not unpleasant and smells nothing like smoke. Additionally, e-cigarette users can decide whether to release any vapor ("discreet vaping"). With so little evidence of use, enforcing use bans on electronic cigarettes would be nearly impossible.
- The ability to use electronic cigarettes in public spaces will actually improve public health by inspiring other smokers to switch. Surveys of thousands of users indicate that the majority of those who switch completely replace tobacco cigarettes with the electronic cigarettes, reducing their health risks by an estimated 99%.

- By switching to a smokeless product, you have greatly reduced your health risks.

Thank you for your consideration,
Tarl Wood

File 131208

From: Cassie Ray [cassie.ray@cancer.org]
Sent: Wednesday, March 05, 2014 11:29 AM
To: Lee, Mayor; Avalos, John; Breed, London; Chiu, David; Cohen, Malia; Farrell, Mark; Kim, Jane; Tang, Katy; Wiener, Scott; Campos, David; Mar, Eric (BOS); Yee, Norman (BOS); Evans, Derek; Board of Supervisors; Miller, Alisa
Subject: Support of ordinance 131208
Attachments: San Francisco e-cigarettes.docx

Dear Mayor Lee and Members of the Board of Supervisors:

Attached you will find a letter from the American Cancer Society Cancer Action Network in support of ordinance 131208, which redefine smoking to include e-cigarettes and other electronic smoking devices, and would prohibit the use of e-cigarettes wherever smoking is prohibited, require a tobacco permit to sell e-cigarettes, and prohibit sales of cigarettes wherever tobacco is not permitted to be sold. We encourage you to pass the proposed ordinance for the protection of the health of the residents of San Francisco.

Cassie Ray | Northern California Government Relations
American Cancer Society Cancer Action Network, Inc.
980 9th Street Suite 2200
Sacramento, CA 95814-2742
Phone: 707.290.0003 | Mobile: 707.290.0003 | Fax: 916.447.6931
acscan.org

March 4, 2014

Mayor Edwin M. Lee
City Hall, Room 200
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Dear Mayor Lee and Members of the Board of Supervisors:

The American Cancer Society Cancer Action Network is committed to protecting the health and well-being of the residents of San Francisco. As such we support ordinance 131208, which would amend the San Francisco Health Code, and redefine smoking to include e-cigarettes and other electronic smoking devices, making them subject to the same codes that currently cover smoking within the city. The proposed ordinance would prohibit the use of e-cigarettes wherever smoking is prohibited, require a tobacco permit to sell e-cigarettes, and prohibit sales of cigarettes wherever tobacco is not permitted to be sold.

The health effects of e-cigarettes – especially the longer-term effects – are scientifically uncertain. Currently, only a limited number of studies have examined the contents of e-cigarette vapor. Some of the studies have found the vapor to contain only propylene glycol, nicotine, and flavorings, and other studies found them to contain heavy metals, volatile organic compounds and tobacco-specific nitrosamines, among other ingredients. A 2009 study done by the FDA found cancer-causing substances in several of the e-cigarette samples tested. Additionally, Food and Drug Administration (FDA) tests found nicotine in some e-cigarettes that claimed to contain no nicotine.

There is general agreement among scientists in the field that, in the short run, at least, e-cigarettes are almost certainly less harmful than combusted cigarettes. But there are still serious questions about the safety of inhaling the substances in some e-cigarette vapor. E-cigarettes have not been subject to thorough, independent testing, so users cannot be sure of what they are actually inhaling. Some studies have shown that some e-cigarettes can cause short-term lung changes and irritations and the long-term health effects, as noted above, are unknown. Additionally, the effects of secondhand vapor from e-cigarettes require further study, especially to determine differences among the many brands and types of e-cigarettes. In

American Cancer Society Cancer Action Network
980 9th Street, Suite 2200 ▪ Sacramento, CA 95814 ▪ 707.290.0003

addition, allowing the use of electronic smoking devices in public places where smoking is otherwise prohibited can create confusion with enforcement issues as well, as there are concerns that they may create new tobacco users and reverse efforts that have made smoking socially unacceptable.

The appeal of e-cigarettes to youth is a new and rapidly growing problem, as e-cigarettes are sold in an assortment of flavors that appeal to youth, and CDC data shows that the marketing of these products is enticing to this population. The CDC reported that the use of e-cigarettes by youth, among both high school and middle school students, doubled from 2011 to 2012. San Francisco has sought to reduce youth smoking by reducing youth access, and we encourage similar protections be implemented for e-cigarettes. The code currently restricts where cigarettes may be sold and requires that retailers purchase a permit; we ask that these same restrictions be applied to e-cigarettes.

Other cities such as New York, Chicago, and most recently, Los Angeles, have chosen to protect their citizens, by taking the important step of redefining smoking to include these electronic devices. The American Cancer Society Cancer Action Network encourages San Francisco to do the same with the adoption of this ordinance.

Sincerely,

Cassie Ray,
Government Relations Director
American Cancer Society Cancer Action Network

American Cancer Society Cancer Action Network
980 9th Street, Suite 2200 ▪ Sacramento, CA 95814 ▪ 707.290.0003

From: Andrew Makuch [andrewmakuch16@msn.com]
Sent: Tuesday, March 04, 2014 6:45 PM
To: Lee, Mayor; Avalos, John; Breed, London; Chiu, David; Cohen, Malia; Farrell, Mark; Kim, Jane; Tang, Katy; Wiener, Scott; Campos, David; Mar, Eric (BOS); Yee, Norman (BOS); Evans, Derek; Board of Supervisors
Subject: Please OPPOSE the e-cigarette ban Ordinance No. 131208

Dear Representative,

As a California citizen and bay area resident, though currently living in Arizona, I support banning sales of e-cigarettes to minors, yet OPPOSE banning e-cigarette use where smoking is banned.

Switching to e-cigarettes has changed my life tremendously, with enjoying better health for the first time in 40 years!

Smoking bans are enacted to protect the public from the harm of secondhand smoke, but e-cigarettes have not been shown to cause harm to bystanders. In fact, all evidence to date shows that the low health risks associated with e-cigarettes are comparable to other smokeless nicotine products.

The low risks of e-cigarettes is supported by research done by Dr. Siegel of Boston University, Dr. Eissenberg of Virginia Commonwealth, Dr Maciej L Goniewicz of the Roswell Park Cancer Institute, Dr. Laugesen of Health New Zealand, Dr. Igor Burstyn of Drexel University, and by the fact that the FDA testing, in spite of its press statement, failed to find harmful levels of carcinogens or toxic levels of any chemical in the vapor.

A comprehensive review conducted by Dr. Igor Burstyn of Drexel University School of Public Health based on over 9,000 observations of e-cigarette liquid and vapor found "no apparent concern" for bystanders exposed to e-cigarette vapor, even under "worst case" assumptions about exposure.

Electronic cigarette use is easy to distinguish from actual smoking. Although some e-cigarettes resemble real cigarettes, many do not. It is easy to tell when someone lights a cigarette from the smell of smoke. E-cigarette vapor is practically odorless, and generally any detectable odor is not unpleasant and smells nothing like smoke. Additionally, e-cigarette users can decide whether to release any vapor ("discreet vaping"). With so little evidence of use, enforcing use bans on electronic cigarettes would be nearly impossible.

The ability to use electronic cigarettes in public spaces will actually improve public health by inspiring other smokers to switch. Surveys of thousands of users indicate that the majority of those who switch completely replace tobacco cigarettes with the electronic cigarettes, reducing their health risks by an estimated 99%.

By switching to a smokeless product, you have greatly reduced your health risks.

For more information, please visit the CASAA.org website, as well as the CASAA Research Library.

Thank you.

Sincerely,

Andrew Makuch
1301 E. Mabel St.

Tucson, AZ 85719

From: Steve Heilig [heilig@sfms.org]
Sent: Wednesday, March 05, 2014 1:23 PM
To: Board of Supervisors; Chiu Intern; Chiu, David; Campos, David; Breed, London; Avalos, John; Farrell, Mark; Cohen, Malia; Kim, Jane; Mar, Eric (BOS); Wiener, Scott; Tang, Katy; Yee, Norman (BOS); Miller, Alisa; Evans, Derek
Subject: Electronic Cigarettes: Regulations needed (Ordinance No. 131208)

TO: SF Board of Supervisors
RE: Electronic cigarettes: Proposed regs

Greetings:

Please see our San Francisco Medical Society letter from today's *San Francisco Examiner* in support of the proposed regulations on "e"cigs"

Appended below that is the California Medical Association policy on this we first drafted; it mirrors the San Francisco Health Commission policy on this topic as well..

Note also that Los Angeles approved such regulations this week.

No doubt you will also receive much input in opposition to these regulations and, as with previous healthy policies such as banning smoking in restaurants and workplaces, it might well be interesting to request that anybody testifying disclose any financial or other ties they might have to the e-cig and/or tobacco industries.

Thank you for your leadership!

Steve Heilig
STEVE HEILIG, MPH
(415)561-0850x270
San Francisco Medical Society
http://www.sfms.org

***

Lead letter in today's SF Examiner:

http://www.sfexaminer.com/sanfrancisco/letters-regulate-e-cigarettes/Content?oid=2721250

Letters: Regulate e-cigarettes

RE: "E-cigarette rules proposed," The City, Monday

Regulate e-cigarettes

Electronic cigarettes are very much in need of more regulations, in order to minimize marketing and access to them by kids and to reduce exposure to their vapors for everybody.

The San Francisco Medical Society has had a policy supporting such regulations for years, and a growing number of other medical and health organizations — and cities — are agreeing that e-cigarettes can pose health risks. Contrary to heavy lobbying by e-cig and tobacco interests, the proposed San Francisco regulations pose

no burden to those who might actually use e-cigs to help quit tobacco smoking, and we commend the San Francisco supervisors who are proposing stricter, healthier regulations.

Dr. Lawrence Cheung

President, San Francisco Medical Society

San Francisco

***

CALIFORNIA MEDICAL ASSOCIATION (2011)

TITLE: Regulation of Electronic Cigarettes

WHEREAS electronic cigarettes, also called e-cigarettes, are increasingly-sold devices for delivering nicotine in virtually smokeless form and are not regulated by the United States Food and Drug Administration (FDA) and are available for purchase widely; and

WHEREAS electronic cigarette manufacturers and retailers are making unproven health claims about their products by asserting that they are safe or safer than traditional cigarettes and that they can be used as an aid to smoking cessation; and

WHEREAS the FDA has warned the public about the potential health risks of using e cigarettes and initial FDA studies found that e-cigarettes contain known carcinogens and intends to propose a regulation that would extend the Agency's "tobacco product" authority to E-cigarettes that contain nicotine "made or derived from tobacco" and

WHEREAS e-cigarette packages do not supply warnings about possible adverse effects on health comparable to FDA-approved nicotine replacement products or conventional cigarettes[i]; and

WHEREAS there is no scientific evidence that e-cigarettes can help smokers quit smoking and the World Health Association does not consider e-cigarettes to be a legitimate therapy for smokers trying to quit tobacco and FDA studies found that certain e cigarettes misrepresent nicotine content on their labels and sometimes contain far more nicotine than FDA-approved smoking cessation products; and

WHEREAS electronic cigarettes may not be legally sold to minors in California but electronic cigarette producers market their product to children by flavoring their products with candy, fruit, and other flavors and the FDA has raised concerns that electronic cigarettes can increase nicotine addiction among young people and may lead youth to try conventional tobacco products[ii]; and

WHEREAS electronic cigarettes' resemblance to conventional cigarettes increases the likelihood that people will break the law by lighting up cigarettes because they see what appears to be someone smoking, undermining compliance with existing smoking regulations and prompting confusion regarding laws prohibiting smoking in certain locations; and

WHEREAS the Department of Transportation has banned the use of electronic cigarettes on U.S. carrier and foreign carrier flights, and the San Francisco Airport Commission bans electronic cigarettes, and electronic

cigarettes have been banned in indoor public places and workplaces by King County (Seattle), Washington, New Jersey and Suffolk County, New York while electronic cigarette sales have been banned throughout Canada, and

WHEREAS the American Cancer Society Cancer Action Network, American Heart Association, and American Lung Association support including e cigarettes in smoke-free laws.[iii]

RESOLVED, that the CMA will support policies that prohibit the use of electronic cigarettes and other nicotine delivery devices not approved by the FDA as smoking cessation aids in those places where smoking is prohibited by law, and that will require a tobacco permit for the sale or furnishing of electronic cigarettes and other nicotine delivery devices not approved by the FDA as smoking cessation aids.

From: Board of Supervisors
To: ~~BOS-Supervisors~~; Ausberry, Andrea
Subject: File 131207: Please support Supervisor Chiu's bottled-water-free ordinance

-----Original Message-----
From: Catherine Sparks [mailto:cathsparks@gmail.com]
Sent: Thursday, March 06, 2014 7:47 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Catherine Sparks
1086 St Louis St
394 university ave palo alto
Victoria, BC 94107

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From: Board of Supervisors
To: BOS-Supervisors; Ausberry, Andrea
Subject: File 131207W: Please support Supervisor Chiu's bottled-water-free ordinance

-----Original Message-----
From: Laura Lynn [mailto:lauralynn1223@gmail.com]
Sent: Wednesday, March 05, 2014 10:31 AM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Laura Lynn
78 Clipper st
San Francisco, CA 94114

From: Board of Supervisors
To: BOS-Supervisors; Ausberry, Andrea
Subject: File 131207: Please send to all supervisors - Vote NO NO NO on banning water!

From: Sama Meshel [mailto:contestsama@gmail.com]
Sent: Monday, March 03, 2014 1:28 PM
To: Board of Supervisors
Subject: Please send to all supervisors - Vote NO NO NO on banning water!

As a San Francisco resident, I urge you to NOT support Board of Supervisors President Chiu's bottled-water-free ordinance.
Those of us who do not drink soda have the right to our choice of drinks too.

Thank you,
Sama Meshel

File 131207

From: Gail Caswell [musette1986@yahoo.com]
Sent: Thursday, February 27, 2014 2:32 AM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Gail Caswell
839 Post St. #208
San Francisco, CA 94109

From: Michael Mills [Biologica@hotmail.com]
Sent: Wednesday, February 26, 2014 9:45 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Michael Mills
915 Pierce St Apt 206
San Francisco, CA 94115

From: Kirk White [kmw73@yahoo.com]
Sent: Wednesday, February 26, 2014 7:51 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Kirk White
381 turk st
sf, CA 94102

From: Clark Anderson [antler2001@hotmail.com]
Sent: Wednesday, February 26, 2014 6:45 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Clark Anderson
1598 Fulton St
San Francisco, CA 94117

From: Linda Weiner [lindawiner@aol.com]
Sent: Wednesday, February 26, 2014 3:15 PM
To: Board of Supervisors
Subject: Please support bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support the recently proposed bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Linda Weiner
72 Gates Street
San Francisco, CA 94110

From: Thomas Gourley [twgourley1100@sbcglobal.net]
Sent: Wednesday, February 26, 2014 2:38 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Thomas Gourley
1628 Hopkins St
Berkeley, CA 94121

From: David Spero [Nurse@davidsperorn.com]
Sent: Wednesday, February 26, 2014 3:10 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. Bottled water is a terrible waste of the energy, water, and plastic used to make the bottles. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

David Spero
405 Serrano Drive, Apt. 11L
405 Serrano Drive Apt 11 - L
San Francisco, CA 94132

From: Alan Martin [starlinsf@yahoo.com]
Sent: Wednesday, February 26, 2014 12:52 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Alan Martin
18th Street
San Francisco, CA 94114

From: Jazzmyne Oda [Jandjoda@aol.com]
Sent: Wednesday, February 26, 2014 12:36 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Jazzmyne Oda
2000 post
San francisco, CA 94115

From: elliot helman [muzungu_X@yahoo.com]
Sent: Wednesday, February 26, 2014 12:25 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

elliot helman
park st.
SF, CA 94110

From: Timothy Larkin [FlyBearSF@aol.com]
Sent: Wednesday, February 26, 2014 12:23 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Timothy Larkin
1515 Sutter Street #210
San Francisco, CA 94109

From: Judy Brady [jibasmil@aol.com]
Sent: Wednesday, February 26, 2014 12:20 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Judy Brady
2868 Harrison Street
San Francisco, CA 94110

From: Wayne Day [wnzwrld@gmail.com]
Sent: Wednesday, February 26, 2014 12:19 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Wayne Day
798 Post St. Apt. 500
San Francisco, CA 94109

From: Motch Dalition [Mitchdsf@gmail.com]
Sent: Wednesday, February 26, 2014 12:18 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Motch Dalition
350 Broderick Street
San Francisco, CA 94117

From: Board of Supervisors
To: BOS-Supervisors; Ausberry, Andrea
Subject: File 131207: Please support Supervisor Chiu's bottled-water-free ordinance

-----Original Message-----
From: Andrea Sreiber [mailto:suomigirl666@hotmail.com]
Sent: Thursday, February 27, 2014 11:34 PM
To: Board of Supervisors
Subject: Please support Supervisor Chiu's bottled-water-free ordinance

Dear Supervisors,

As a San Francisco resident, I urge you to support Board of Supervisors President Chiu's bottled-water-free ordinance. San Francisco should continue to lead the way in reducing the use of bottled water by eliminating the sale of bottled water on municipal property, while simultaneously increasing access to the city's pristine tap water. This ordinance will keep tens of thousands of plastic bottles out of our landfills each year and increase residents' ability to access safe, healthy drinking water. It is good for the environment and the public, and I ask you to vote yes.

Best,

Andrea Sreiber
5 Nassau Ave
Schenectady, NY 12304

File 131240

From: McGuire, Kristen
Sent: Wednesday, March 05, 2014 2:00 PM
To: Calvillo, Angela; Nevin, Peggy; BOS-Legislative Aides; BOS-Supervisors; Kawa, Steve; Howard, Kate; Falvey, Christine; Tsang, Francis; Elliott, Jason; Steeves, Asja; Campbell, Severin; Newman, Debra; Rose, Harvey; CON-EVERYONE; CON-Finance Officers; CON-CCSF Dept Heads; SF Docs (LIB); Chawla, Colleen; Pickens, Roland
Subject: Issued: Department of Health: A Summary of Health Reform Readiness

The Controller's Office is providing this summary of the 2013 consultant engagement between the Department of Public Health (DPH) and Health Management Associates (HMA). Supported by the Controller's Office, the purpose of the consultant contract and accompanying process is to prepare DPH and the City for the dramatic changes under the Affordable Care Act. The report highlights key goals, recommendations, and implementation strategies coming out of this joint effort by HMA, DPH leadership and staff. To view the full report, please visit our website at: http://openbook.sfgov.org/webreports/details3.aspx?id=1691

You can also access the report on the Controller's website (http://www.sfcontroller.org/) under the News & Events section. For more information on the report please contact Mike Wylie at (415) 554-7570 or michael.wylie@sfgov.org. You may also contact the Controller's Office City Services Auditor Division at (415) 554-7463.

This is a send-only e-mail address. Follow us on Twitter @sfcontroller

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City and County of San Francisco

Office of the Controller – City Services Auditor

DEPARTMENT OF PUBLIC HEALTH

A Summary of Health Reform Readiness

March 5, 2014

OFFICE OF THE CONTROLLER

CITY SERVICES AUDITOR

The City Services Auditor (CSA) was created in the Office of the Controller through an amendment to the Charter of the City and County of San Francisco (City) that was approved by voters in November 2003. Under Appendix F to the Charter, CSA has broad authority to:

- Report on the level and effectiveness of San Francisco's public services and benchmark the City to other public agencies and jurisdictions.
- Conduct financial and performance audits of city departments, contractors, and functions to assess efficiency and effectiveness of processes and services.
- Operate a whistleblower hotline and website and investigate reports of waste, fraud, and abuse of city resources.
- Ensure the financial integrity and improve the overall performance and efficiency of city government.

Project Team: Peg Stevenson, Director
Michael Wylie, Project Manager
Michelle Schurig, Performance Analyst
Jennifer Tsuda, Performance Analyst

City and County of San Francisco

Office of the Controller – City Services Auditor

Department of Public Health
Summary of Health Reform Readiness

March 5, 2014

[redacted]

Health Care Reform Overview

The mission of DPH is to protect and promote the health of all San Franciscans. In October 2013, DPH re-organized its healthcare delivery system into the San Francisco Health Network ("the Network") as a step toward achieving the goal of a fully integrated delivery system. The Network must cover more people, improve quality, and rein in costs, in order to remain a competitive provider in the new environment outlined below.

- **Federal Health Care Reform**: ACA requires individuals have insurance, provides additional options to obtain coverage, and changes reimbursement mechanisms.
- **State Implementation of the ACA:** The roll-out of the state's insurance exchange, Covered California, provides the new options, and expansion of Medi-Cal increases revenues. This is coupled with reductions in historical state and federal payments that support the safety net.
- **Local Implementation of the ACA:** The City passed a health care access solution four years before the ACA, called the Health Care Security Ordinance (HCSO), which requires employers to make health care expenditures on behalf of their employees and established a program for the uninsured. The intersection of the HCSO with ACA continues to be investigated by the City, DPH, and engaged stakeholders.

DPH Implementation & the HMA Engagement

Building on a two-year planning effort, DPH engaged HMA, a firm with experience in public health delivery systems, to assist in integrating its service delivery system and to:

- Prepare DPH to effectively compete for clients as the environment changes and financial reimbursement moves from fee-for-service toward capitation (fixed monthly payment)
- Transform DPH's delivery system and its corresponding support systems in order to become a "provider of choice," going beyond being "provider of last resort"

Key Network Challenges

- **Provide timely access to care** now that there are provisions ensuring clients have a right to care within a reasonable time
- **Capitation** which creates a greater incentive to reduce unnecessary use of high cost care and to invest in prevention and care management
- **Competition** since more providers are interested in the same clients as DPH and traditional clients will have more choice

Recommendations

The report groups recommendations into three topic areas:

1. **Patient Care Access and Quality Improvement:** Achieve quality patient care and efficient service delivery through improved access, capacity, coordination, and client flow
2. **Managed Care**: Develop and manage a new managed care network through focus on operational accountability, utilization, and new contracts
3. **Financial Sustainability:** Strive for financial sustainability through exploitation of financial opportunities and key cost management efforts

Additional supplemental recommendations include:

- **Investments:** Clinic, HR, and IT infrastructure investments required to implement the above recommendations
- **Partnerships:** Strategic partnerships and collaborations required in the new healthcare environment to achieve the above recommendations

See the summary of all strategies and key milestones on next page

Copies of the full report may be obtained at:
Controller's Office • City Hall, Room 316 • 1 Dr. Carlton B. Goodlett Place • San Francisco, CA 94102 • 415.554.7500
or on the Internet at http://www.sfgov.org/controller

Key Strategies for Adapting to Health Reform Changes

	Highlighted Accomplishments	Key Strategies	Short Term Milestones	Long Term Milestones
Patient Access & Improvement	• Combined direct services under the SF Health Network ("Network") • Created a plan to ensure Network client care is accessible and coordinated	• Increase primary care access and capacity (e.g., centralized call center, increased productivity) • Establish a central care management database to identify high-risk clients • Track unnecessary or inappropriate utilization of health services		• Access to high quality and timely care • Continuous quality improvement • High client and staff satisfaction scores
Managed Care	• Identified the Network's "vision" to continuously increase quality and value of services to clients, staff, and partners • Created an Office of Managed Care	• Reinforce the plans and vision statement for the new Network through internal and external education with staff and partners • Staff the new Office of Managed Care • Select appropriate metrics to manage risk and increase accountability		• Full Network implementation and culture change • Fiscal stewardship Network-wide • Clear accountabilities via reporting and metrics
Financial Sustainability	• Developed detailed labor and productivity reporting tools to improve expense tracking at SF General Hospital (SFGH) • Reduced the amount of time for state reimbursement at Laguna Honda Hospital (LHH)	• Increase managed care revenue and continue to seek new state and federal funding • Improve cost management through improved contract management and expense tracking and analysis		• Reduced fiscal uncertainty • Clear fiscal accountabilities • Financial sustainability achieved
Investments	• Hired key Network leadership • Began hiring process improvements	• Increase staffing flexibility and continue to resolve hiring barriers • Develop a strategic short and long term information technology and financing plan • Invest in clinic facilities to help the Network become a provider of choice		• Necessary assets obtained to improve client access and achieve financial sustainability
Partnerships	• Evaluated the UCSF physician group partnership in light of health reform • Identified community partners • Engaged key stakeholders on the Network's structure, vision, plans • Began strategizing with the SF Health Plan in light of reform	• Strengthen and manage partnerships to improve quality, increase revenue, and manage costs (e.g., SF Health Plan, Covered CA health plans, UCSF, labor) • Continue to engage and inform key stakeholders (e.g., SF Clinic Consortium, state leaders, local leaders, business)		• Continuous improvement of the Network's strategic position • Successfully competing to retain and attract clients in the new healthcare environment

CITY AND COUNTY OF SAN FRANCISCO
OFFICE OF THE CONTROLLER

Ben Rosenfield
Controller
Monique Zmuda
Deputy Controller

March 5, 2014

Barbara Garcia
Director of Health
Department of Public Health, City and County of San Francisco
101 Grove Street, Room 308
San Francisco, CA 94102

Dear Ms. Barbara Garcia:

The Controller's Office is pleased to provide this summary of recent planning and steps needed to prepare for federal health care reform. Our office contributed by supporting DPH's engagement of a health care consulting firm, Health Management Associates (HMA), and provided contract monitoring and other assistance during the process.

This report aims to summarize key highlights and recommendations from the consultant engagement and related work occurring in 2013. This is not a comprehensive list of all HMA activities and products but our office's attempt to provide the major results to city policymakers and the public, placed in context of the new healthcare environment and DPH's achievements already underway.

The report organizes the many recommendations and strategies into three broad topic areas, listed below. From a citywide perspective, some of the key takeaways of the work are:

1. **Patient Care Access and Quality Improvement**. For DPH and its current network of direct health services to sustain itself in the new healthcare environment, it must implement numerous critical strategies and changes to transform into a "provider of choice" for its clients, going beyond "provider of last resort." Key changes include:
   - Increasing primary clinic and ambulatory care access, capacity, and productivity
   - Improving patient care quality and resulting client satisfaction
   - Continued integration of services and improved coordination of care
   - Increasing patient flow through DPH's institutions, including reduced length of stays and unreimbursed patient days

2. **Managed Care.** The provisions of the Affordable Care Act (ACA) have altered the operating environment for healthcare especially for public systems. To sustain DPH's network of services in the era of managed care and capitated payments for our insured clients, the system must attain a high level of accountability and success regarding quality, utilization, and cost management. Key changes include:
   - Implementing a Managed Care Office to provide needed focus on performance reporting, efficiency, and new contracts with health plans in the state insurance exchange ("Covered California")
   - Implementation of network-wide metrics and accountabilities

3. **Financial Sustainability**. As a result of this engagement, the City has a revised five-year projection of the City's health system clients, costs, and revenues. The new ACA environment introduces a higher level of revenue uncertainty. Assuming DPH's current level of service without increases in enrollment or capitated revenue, the financial outlook is not sustainable, with the City's general fund contribution projected to increase to $831 million by FY18-19. Some of the strategies to achieve financial stability include:
    - Increasing the number of insured and covered clients, by maximizing the current Medi-Cal expansion, contracts with health plans, and other enrollment efforts
    - Actively pursuing targeted opportunities for additional state and federal funding
    - Better controlling spending through improved cost center tracking, as well as new reporting and shared financial incentives in the UCSF contract

We have greatly valued the opportunity to work with DPH staff on this project. The department and its partners continue to show a high level of professionalism and commitment to protecting and promoting the health of all San Franciscans. We specifically appreciate the collaboration and support from Colleen Chawla, Greg Wagner, Roland Pickens, Tangerine Brigham, Lindsey Angelats, and all Action Team members. Lastly, we acknowledge your vital leadership as director, in proactively addressing the dramatic change coming in health care and leading the agency to thrive in the challenging environment ahead.

Respectfully,

Ben Rosenfield
Controller

cc: Mayor's Office
Board of Supervisors

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LIST OF ABBREVIATIONS AND ACRONYMS

ACA	Affordable Care Act
ALOS	Average Length of Stay
BHC	Behavioral Health Center
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCMS	Coordinated Case Management System
City	City and County of San Francisco
CMS	Centers for Medicare & Medicaid
Covered CA	Covered California or the Exchange
CPG	Clinical Practice Group
CPMC	California Pacific Medical Center
DHR	San Francisco Department of Human Resources
DOFR	Division of Financial Responsibility
DPH	San Francisco Department of Public Health
eCW	eClinicalWorks
EHR	Electronic Health Record
ESR	Employer Spending Requirement
FPL	Federal Poverty Level
HCSO	Health Care Security Ordinance
HMA	Health Management Associates, Inc.
HMA Engagement	2013 DPH-HMA Health Reform Readiness Engagement
HSA	Human Services Agency
HSF	Healthy San Francisco
HUMS	High Users of Multiple Systems
HUSS	High Users of Single Systems
IDS	Integrated Delivery System
IRS	Internal Revenue Service
ISC	Integration Steering Committee
LHH	Laguna Honda Hospital
LLOC	Lower Level of Care
MEC	Minimum Essential Coverage
NEMS	North East Medical Services
OC	Nurse Orientation Clinics
OON	Out of Network
PCBH	Primary Care Behavioral Health
PCMH	Patient-Centered Medical Home
SF PATH	San Francisco Provides Access to Health Care
SFGH	San Francisco General Hospital
SFHN-UMC	San Francisco Health Network – Utilization Management Committee
SFHP	San Francisco Health Plan
SPA	State Plan Amendment
The Network or SFHN	San Francisco Health Network
Transitions	Formerly Community Placement Division
UCSF	University of California, San Francisco
UHC	Universal Healthcare Council

INTRODUCTION

Purpose

The evolving healthcare operating environment increases the number of insured individuals and changes the payors of health care services. Prior to the implementation of the Affordable Care Act (ACA), there were 84,000 uninsured San Franciscans. However, the implementation of the ACA on January 1, 2014, provided 56,000 of these individuals with access to health insurance.[1] The challenge for DPH is that the newly insured can choose to elect private and non-profit providers for their health care. At the same time, reimbursement for services is moving away from fee-for-service and toward capitation; meaning instead of receiving reimbursement for every service provided or "fee-for-service", systems are reimbursed a set amount per member per month or "capitation". These factors bring about a major change for county health care systems because they must move from being a "provider of last resort" to a "provider of choice" to compete with other providers for clients and revenue.

To adapt to the new healthcare environment, DPH like many public health systems is being challenged to become the **provider of choice,** not the provider of last resort.

The purpose of this report is to educate and provide engaged stakeholders and city policymakers with a summary of the 2013 consultant engagement between the Department of Public Health (DPH) and Health Management Associates (HMA). This report highlights the resulting recommendations and strategies for the City and County of San Francisco (City) to achieve a fully integrated delivery system and to succeed under the Affordable Care Act (ACA). The organization of this report aims to inform readers of the major environmental healthcare factors as well as key DPH operational milestones identified. Addressing the external environmental issues and timely meeting implementation milestones will significantly impact DPH's fiscal sustainability and ability to continue to provide high quality care within the community safety net.

Background

The mission of DPH is to protect and promote the health of all San Franciscans. To achieve this, DPH must adapt to the changing healthcare operating environment brought about by the ACA, which represents the most significant social policy change in a generation. The ACA requires individuals have insurance and provides additional options to obtain coverage. The State of California implemented the ACA and continues to support the ACA's goals through the implementation of the state's health insurance exchange, Covered California (Covered CA), and the expansion of the state's Medicaid program, Medi-Cal. At the local level, the City and County of San Francisco (City) passed an innovative, local solution four years before the ACA was enacted called the Health Care Security Ordinance (HCSO), which required employers to make health care expenditures on behalf of their employees and established a public health benefit program that included Healthy San Francisco (HSF), a health care access program for the uninsured.

[1] There will still be a significant number of residually uninsured San Franciscans for two reasons: (1) due to the ACA provisions, there will be individuals ineligible for coverage (e.g., undocumented, etc.) and (2) there will be individuals who are eligible but do not enroll.

DPHs' goals align with the intent of the policies enacted at the federal, state, and local levels to: cover more people, improve quality, and rein in costs. Internally, DPH has undergone a three-year transformation to adapt to this new healthcare landscape by reorganizing, revamping business processes, implementing new technologies, hiring and retraining staff, and more efficiently serving new and existing clients. HMA was hired in February 2013 to assist DPH in this effort; additional information about HMA is in Appendix I.

New Healthcare Environment

Federal Level: The Affordable Care Act

Federal health reform or the Affordable Care Act (ACA), passed in 2010, has two primary components (1) it requires individuals have health insurance (the "individual mandate") and (2) it provides additional options to obtain health insurance. Many of the major provisions went into effect on January 1, 2014.[2]

Individual Mandate. The Individual Shared Responsibility provision of the ACA (aka Individual Mandate), requires most U.S. residents to obtain health insurance that meets minimum essential coverage (MEC) guidelines for themselves and their dependents, per federal income tax guidelines or pay a penalty, beginning in 2014. There are some exceptions to the mandate, such as undocumented individuals, the incarcerated, and those experiencing hardship, among other exceptions, but most U.S. residents will be subject to the mandate. Penalties for not complying with individual mandate are $95 or one percent of income in 2014 and will increase incrementally on an annual basis, to $695 or 2.5 percent of income in 2016.

Additional Health Insurance Options. The second component of the ACA provides additional options to obtain qualified health insurance in three ways.[3]

1. *State Implemented Reforms*: The ACA expands public insurance for low income citizens through the Medicaid program, called Medi-Cal in California, and creates an online insurance marketplace where individuals can compare and buy insurance; these provisions are further described in the section below.
2. *Employer Incentives & Penalties*: The ACA does not explicitly mandate that employers offer their employees acceptable health insurance. However, it does provide tax benefits for small businesses that offer affordable insurance and imposes penalties on certain "large employers" that do not offer affordable insurance.
3. *Market Reforms*: The final way in which health reform is making health insurance more accessible, is through health insurance marketplace reforms. Examples of these new health insurer standards are below.
    - Coverage of essential benefits for small group and individual plans
    - Ensures that all plans offer a baseline of benefits
    - Enables comparisons across plans
    - Guarantees issue and renewal or prohibits insurers from refusing to renew a policy because of the amount of health care services used in the previous year
    - Eliminates pre-existing condition exclusions
    - Extends dependent coverage up to age 26
    - Eliminates cost-sharing for prevention

[2] Additional information regarding the Affordable Care Act and its provisions can be found on the IRS website.

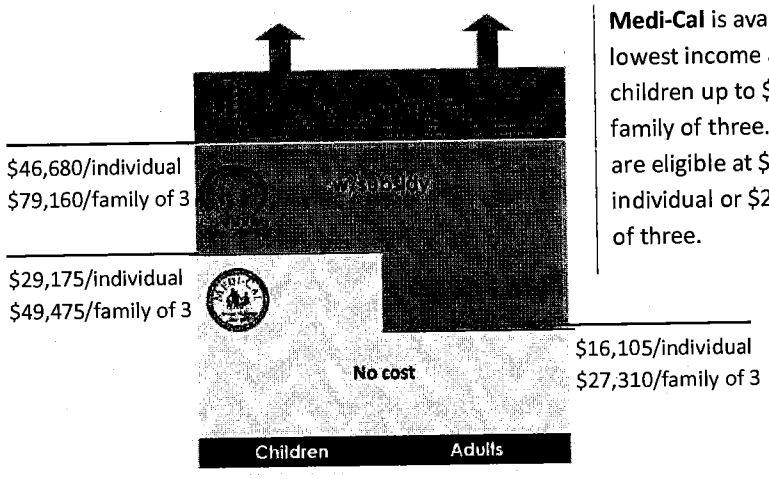
[3] "Qualified" health insurance is insurance that meets the minimum essential coverage (MEC) outlined in the ACA and on the IRS website.

State Level: Medi-Cal Expansion & Covered California

The State of California now has two expanded options for health insurance: Medi-Cal and Covered CA.[4] Figure 1 shows, by income, how Medi-Cal and Covered CA expand health insurance coverage.

Figure 1: Post-ACA Expanded Eligibility for Health Insurance

Covered CA takes over where Medi-Cal stops. Individuals with incomes up to 400% of federal poverty level, or $47k for an individual and $79k for a family of three, are eligible for sliding scale subsidies for insurance purchased through Covered CA. Individuals with incomes above 400% of poverty can purchase insurance through Covered CA without a subsidy.



Medi-Cal is available for the lowest income and for children up to $49k for a family of three. Now adults are eligible at $16k for an individual or $27k for a family of three.

Source: Department of Public Health.

Medi-Cal Expansion. Previously, single healthy low-income adults were not eligible for Medi-Cal, yet this population comprises a significant portion of the uninsured.[5] On January 1, 2014, adults aged 18-64 with incomes below 138% of the federal poverty level (FPL), which is about $16,105 for a single person, became eligible for Medi-Cal, named the "Medi-Cal Expansion" population. Existing and new Medi-Cal clients will enroll into one of the two San Francisco managed care plans – Anthem Blue Cross or the San Francisco Health Plan (SFHP). Although more individuals are eligible, enrollment is not automatic. Prior to expansion, approximately 1.3 million Californians were already eligible for Medi-Cal but did not enroll. Individuals can apply for Medi-Cal any time during the year, but joint enrollment efforts between DPH and the Human Services Agency (HSA) will be key to successful implementation of Medi-Cal expansion at the local level.

As of January 1, 2014, approximately 14,000 individuals have been transitioned from the low income health plan (LIHP) to Medi-Cal.

Covered California. The second option for health insurance is the state Health Insurance Exchange created by the ACA, called Covered California (Covered CA), an online marketplace where individuals can purchase health insurance. Individuals who have incomes that are above Medi-Cal eligibility and small businesses can purchase insurance on the exchange. More than five million Californians are eligible for Covered CA. Plans are standardized so that they are

[4] California is one of 26 states that chose to expand Medicaid in 2014 and one of only 17 states that chose to operate a state-based health insurance exchange marketplace in 2014. Kaiser Family Foundation, State Decisions on Health Insurance Marketplaces and the Medicaid Expansion.

[5] Medi-Cal was previously only for low-income individuals who are children, in families, over age 65, or disabled.

easily compared across insurers. There are four tiers from lowest to highest monthly premiums based on the actuarial value of the plan[6] – bronze, silver, gold, and platinum. There are sliding scale subsidies available to low income individuals up to 400 percent FPL. Currently, there are five plans approved for San Francisco: Anthem Blue Cross, Blue Shield, Chinese Community Health Plan, HealthNet, and Kaiser. Like many insurance offerings, enrollment can only occur in a specified period – October to March for the initial open enrollment, and October to December annually thereafter.

Local Level: Health Care Security Ordinance

At the local level, the San Francisco Health Care Security Ordinance (HCSO) was passed unanimously by the Board of Supervisors in July 2006, four years before federal health reform, and codified as Chapter 14 of the San Francisco Administrative Code. The two main components are: the Healthy San Francisco program and the Employer Spending Requirement.

Healthy San Francisco. A health access program – called "Healthy San Francisco" (HSF) – created by the DPH. HSF will still be available to those who need it, but insurance through Covered CA or Medi-Cal is better for clients as it provides access to affordable medical care when and where needed, covers routine care that prevents illness and improves health, and protects families from high costs in the event of major injury or illness.

Employer Spending Requirement. An Employer Spending Requirement (ESR), which mandates that employers subject to the HCSO "make required health care expenditures to or on behalf of their covered employees each quarter."[7] The City's Office of Labor Standards Enforcement (OLSE) enforces the ESR and annually collects employer data regarding compliance with the health care expenditure requirement.

On July 25, 2013, the Mayor asked the Director of Health to reconstitute the Universal Healthcare Council to engage stakeholders in a data-driven process to examine the intersection of the ACA and HCSO.[8] Two findings emerged: the HCSO to remain intact alongside the ACA and potential affordability concerns remain for some.

DPH Preparedness

DPH is focused on transitioning the uninsured to health insurance by (1) exiting or reducing DPH health coverage programs (SF PATH and HSF enrollees), (2) providing outreach to specific, vulnerable, but eligible populations (i.e., homeless, public housing residents, jail inmates, etc.), and (3) growing partnerships with community-based organizations and city departments. The Network must transition to become a provider of choice and achieve the following goals to remain a competitive provider of care in the new healthcare environment: (1) cover more people, (2) improve quality of care, and (3) rein in costs.

Figure 2 provides the new integrated delivery system's vision. For additional information on the development of this structure and the new DPH organizational structure, please refer to Appendix I.

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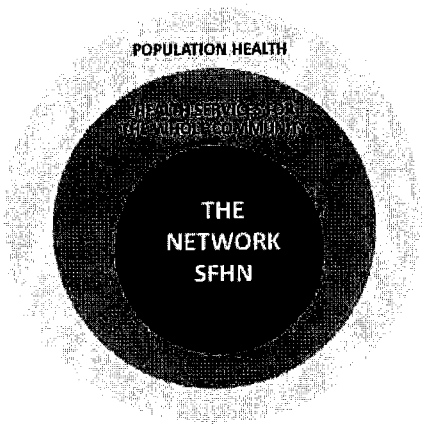
[6] Actuarial values are estimates of how much the insurance plan will pay of an average person's medical expenses. California Healthcare Foundation, "Health Reform in Translation: What is Actuarial Value?" August 2013.

[7] The HCSO is codified in Chapter 14 of the San Francisco Administrative Code, and is available via the HCSO website: www.sfgov.org/olse/hcso.

[8] More information regarding the Universal Healthcare Council (UHC) can be found at http://www.sfdph.org/dph/comupg/knowlcol/uhc/default.asp.

Figure 2: DPH's IDS Vision



The Network (SFHN) provides direct health care services to insured or covered clients whose care is managed through the Network, from primary to acute to long term care.

Health services for the whole community include services for those clients outside of the Network but still in the safety-net, for example, undocumented immigrants and homeless/transient populations. Includes community behavioral health and trauma services.

Population health aims to improve the health of the entire population through environmental health, disease control, assessment, and housing.

Source: Department of Public Health.

Report Organization

This report aims to provide engaged stakeholders and city policymakers with the major recommendations and strategies that resulted from the HMA engagement. Implementation of these recommendations and strategies will ensure that DPH is prepared to address the challenges of the new healthcare environment. The report is organized around three topic areas below. Each chapter begins with the predicted impact of ACA and includes key strategies to achieve the recommendations.

- **Chapter 1: Patient Care Access and Improvement**
  - Goal: Achieve Quality Patient Care and Efficient Service Delivery, through improved access, capacity, coordination, and flow
- **Chapter 2: Managed Care**
  - Goal: Development and Management of the Network, through focus on operational accountability and utilization
- **Chapter 3: Financial Sustainability**
  - Goal: Strive for Financial Sustainability, through exploitation of financial opportunities and key cost management efforts in the ACA environment

Further background information and additional areas of HMA analysis are included in the Appendices.

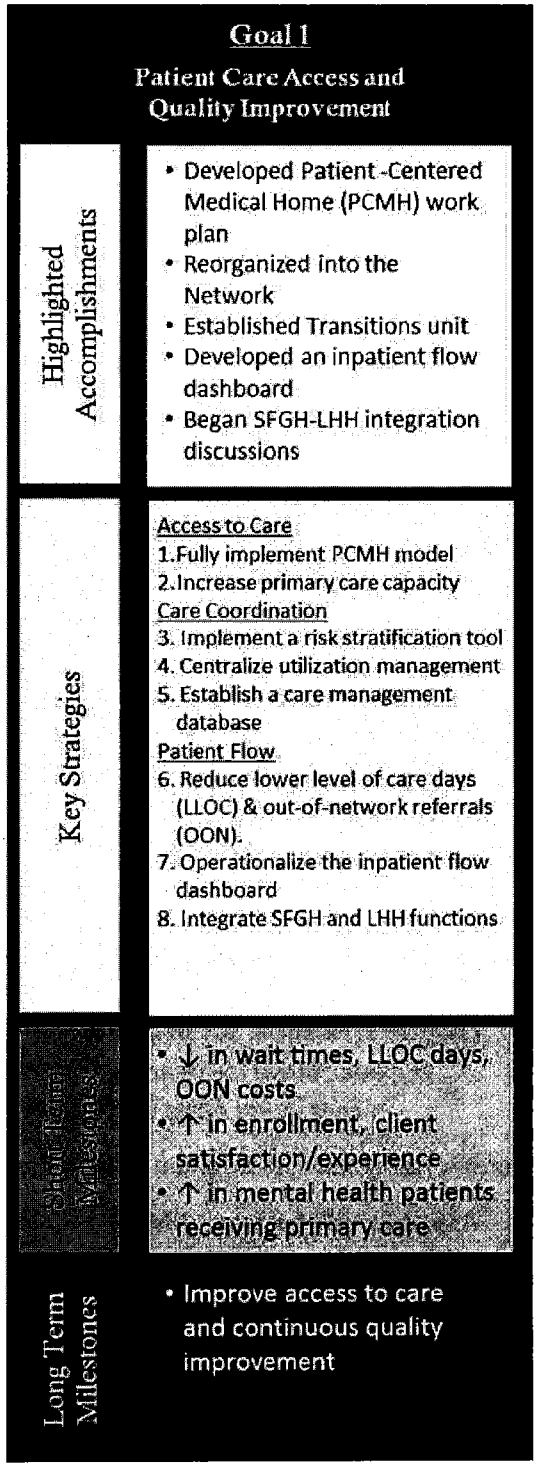
- **Appendix I: IDS History, HMA Engagement, and Action Teams**
  - Provides a brief history of the IDS development, HMA engagement, and key achievements to date
- **Appendix II: Investments**
  - Provides additional details on the investments required in clinic, HR, and IT infrastructure to implement the changes described in Chapters 1 through 3
- **Appendix III: Partnerships**
  - Provides additional information on the strategic partnerships and collaborations required in the new healthcare environment

CHAPTER 1: PATIENT CARE ACCESS AND QUALITY IMPROVEMENT

Background

The Affordable Care Act (ACA) strives to make healthcare more affordable, increase the quality of patient care, and make service delivery more efficient. For example, to increase access to preventive care, the ACA provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost. In addition, to increase quality of care, a new provision by the ACA, effective in January 2015, will tie physician payments to the quality of care provided.

As a result of recent health reform readiness efforts by the San Francisco Health Network (referred to as "the Network" in this report), and recommendations resulting from the Health Management Associates (HMA) engagement, the Network began and continues to implement several strategies to achieve higher quality patient-centered care and more efficient service delivery aimed to increase access to care, improve care coordination, and improve patient flow.



Access to Care

The new healthcare environment creates additional demand for high quality, efficient care since individuals are required to have health insurance and will now have a broader choice in their providers. Internally at DPH this means the Network must effectively compete with other providers and transform into a provider of choice rather than a provider of last resort through increasing access to care. This can be achieved by:

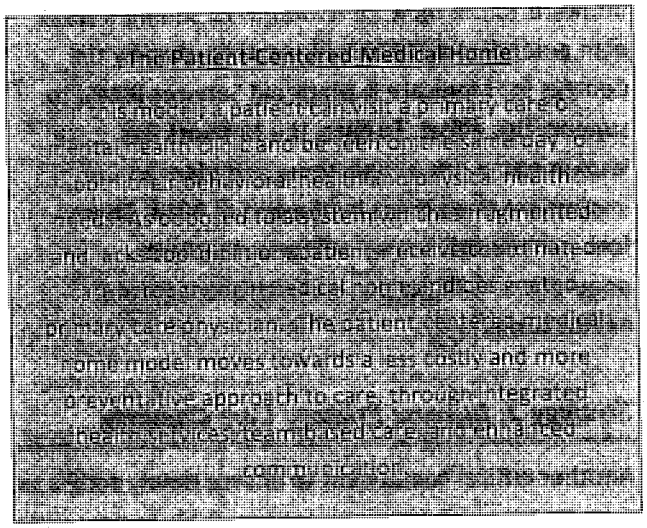
- better integrating and coordinating services,
- improving quality of care,
- increasing their capacity for providing care, and
- improving the client experience by decreasing wait times, increasing efficiency, and improving customer service.

DPH continues to expand its efforts to improve access to care, these include the addition of a nurse advice line,

improvements in scheduling appointments, the use of nurse practitioners to improve team access and continuity of care, and the integration of behavioral health and primary care. However, there is significant additional work to be done to improve access to care.

Strategy 1: Fully Implement the Patient-Centered Medical Home (PCMH) Model of Care

The Network's commitment to the implementation of the Patient-Centered Medical Home (PCMH) model of care aligns with the goal to improve access to care. This model, as described to the right, provides patient-centered, comprehensive, team-based, coordinated, and accessible care focused on quality and safety. PCMH also emphasizes an integrated approach to care. DPH continues to implement integrated care in its clinics, including staffing primary care clinics with behavioral health staff (Behaviorists and Behaviorist Assistants).



HMA conducted assessments of three hospital-based primary care health centers, four community health centers, and one behavioral health center. In addition, HMA analyzed data on clients, payers, staff, and providers. HMA also performed site assessments and interviews with central primary care leaders in administration, medicine, nursing, behavioral health, care management, and finance. HMA used this quantitative and qualitative analysis to make findings and recommendations to fully implement the PCMH Model of Care within the Network.

Key recommendations:

- Clearly define the role of Behaviorist and Behaviorist Assistants through the standardization of job descriptions, core competencies, and performance evaluation.
- Review billing practices, including the charge master and encounter forms, for behavioral health services within PCMH. Provide ongoing training to ensure the capture of all available revenue utilizing the work completed by the Revenue Generation Committee to inform this effort.
- Identify and empower on-site supervisors of Behaviorists and Behaviorist Assistants to support and ensure accountability of all PCMH team members in integrated care.
- Utilize lessons learned from behavioral health integration in primary care to inform future integration efforts.

In the medium and long term, the Network will continue to work toward achieving the PCMH model via the strategies listed throughout Chapter 1. DPH is also in the process of piloting four health homes as an additional longer term strategy towards achieving the PCMH Model of Care. A description of health homes is to the right. DPH intends to submit a state plan amendment (SPA) for federal funding by the Centers for Medicare & Medicaid Services (CMS) to support this effort. To date, the Network has implemented one health home and plans to implement three more by the end of 2014. These four pilot health homes will focus on client populations with serious and persistent mental health conditions.

Defining Health Homes under Medicaid's State Plan Option

Health homes are a new integrated model of care that allows states to provide comprehensive care coordination for Medicaid beneficiaries with two or more chronic conditions, one chronic condition and risk of another, or one serious and persistent mental health condition. States that meet the health home criteria can receive enhanced federal funding during the first two years of implementation.

Source: Centers for Medicare & Medicaid Services

Strategy 2: Increase Primary Care Capacity

Another critical component to ensure timely access to care is the availability and efficiency of scheduling primary care visit appointments available to new and returning clients. HMA identified several priority areas for increasing primary care capacity:

- Meet panel size and productivity targets
- Implement a call center
- Implement nurse orientation clinics and chronic disease visits
- Increase capacity for specialty care
- Hire qualified staff to fill all vacant primary care provider positions

Strategy 2A: Meet Panel Size and Productivity Targets

The Network developed and utilizes a robust methodology for predicting the number of future visits. However, until recently, the Network's primary care clinics did not set panel size targets. Determining primary care panel size targets is a complicated process that must take into account several variables including the number of visits per client per year, the number of provider visits per day, and the number of provider days per year. The challenge is to estimate the optimal panel size to effectively care for a client population. A panel size that is too large can result in service delays and interruptions in care, whereas a panel that is too small can be unsustainable since there are not enough clients to support the Network.

Defining Panel Size

Panel size is the number of individual patients under the care of a specific provider (e.g., physician). An appropriate panel size is necessary to effectively manage primary care workloads and optimize patient access to care.

HMA assisted the Network in conducting a provider full time equivalent (FTE) staffing analysis to develop sustainable targets. The results of the analyses indicated the primary care system must retain the current client

population of 54,000. While primary care provider FTEs are adequate, the addition of patients with complex health issues may strain capacity. And, although staffing ratios are near-adequate, some redistribution is needed. With an average panel size of 826 patients per FTE in October 2013, the Network set a target panel size goal of 1350 patients per FTE. As of December 2013, the panel size targets were implemented at the Network's primary care clinics for primary care providers and reports are being sent to the San Francisco Health Plan (SFHP) monthly to improve accountability.

HMA evaluated current visit productivity levels. Currently it is estimated that providers have a current visit productivity level of 1.5 visits per hour. This is far beneath national standards. HMA recommends that the Network increase visit productivity levels by 50 percent from the October 2013 calculated level of 1.5 visits per hour to 2.25 per hour. To achieve this, HMA recommends incorporating the no show rate into the scheduling system.

The Network aims to achieve a panel size target of 1350 patients per FTE. Currently, the Network's panel size is 826 patients per FTE.

The Network's target provider productivity rate is 2.5 patient visits per hour. This is a 50 percent increase in provider productivity from the current rate of 1.5 patient visits per hour.

Strategy 2B: Implement a Centralized Call Center

Planning for a centralized call center is underway at the Network. As identified during the HMA engagement, the Network's primary care clinics need an improved phone system by which clients can request and schedule appointments. The reasons for implementing a centralized call center are to:

- Improve telephone response for appointments and ensure timely access to care
- Help coordinate the appropriate use of healthcare providers and facilities
- Reduce emergency room and urgent care visits
- Reduce no-show rate
- Increase customer satisfaction scores; by providing excellent customer service and increasing loyalty, the Network can maintain and grow the market share of its primary care members[9]

Since December 2013 a subcontractor was hired to provide expert technical assistance in call center design and product purchase. To date the Network has completed a preliminary return on investment analysis for call center options and begun to determine the factors that will impact staffing (e.g., call duration, number of calls, etc.).

The Network is currently evaluating the feasibility of implementing an internal or externally-hosted call center across 16 outpatient clinics. Depending on the results of this evaluation and departmental priorities, the Network goal is to develop a clear call center plan by late 2014.

[9] DPH Primary Care customer satisfaction has historically been very low with the CAHPS Clinician & Group Survey scores of 35 percent, significantly below the National Research Corporation average rating of 62.6 percent. Source: Presentation by the SFDPH Centralized Call Center Workgroup, January 30, 2014.

Strategy 2C: Implement Nurse Orientation Clinics and Chronic Care Visits

Long patient wait times can negatively impact the client experience and challenge effective access to care. In December 2013, the Network began implementing nurse orientation clinics (OC) with the goal of eliminating wait lists. To date, the Network standardized the OC scheduling template and routinely scheduled OCs at all Network primary care clinics.

Nurse orientation clinics (OCs) provide an individual with a health care screening, an opportunity to discuss information about their primary care appointment, and a scheduled visit with their primary care provider. Effective implementation of OCs can reduce the work load of primary care providers.

Another strategy to increase access to care is chronic care visits for individuals with chronic illnesses. Chronic care management is a major focus of the ACA and an essential benefit. In many ways, chronic care management is dependent on a client's ability to manage their own condition and to know when to seek help from their primary care provider. Managing a chronic disease is dependent on a client motivation to adhere to medication, engage in physical activity, eat healthfully, and manage stress. As part of the HMA engagement, the Network developed a standard set of nurse competencies in self-management support and tools. Nurses received training tailored to these competencies. Chronic disease visits are essentially group visits by registered nurses and pharmacists to help patients better control their disease and provide a safe environment for clients to ask questions and express concerns. To date, the Network has implemented chronic disease visits at one SFGH clinic and three Network primary care clinics. The goal is continue ongoing development for chronic disease visits with pilots through 2014, and Network-wide implementation in 2015.

Strategy 2D: Increase Capacity for Specialty Services

To ensure adequate access to specialty services, the Network must assess staff and space requirements in light of demand for specialty care services. Major specialty services include cardiology, dermatology, endocrinology, gastroenterology, hematology, nephrology, oncology, pulmonary, and rheumatology. As a result of the HMA engagement, the Network accomplished the following.

- Identified units requiring additional space and/or staff to meet necessary standards
- Identified key ambulatory procedures to reduce wait times to target
- Confirmed operational standards and prepared business plans for staff expansion
- Developed and implemented discharge criteria in an additional two to four priority specialty clinics

For 2014, the Network is working to establish sufficient specialty capacity and aim to achieve these milestones.

- Ensure that 60 percent of specialists have a wait time of less than 45 calendar days; 20 percent have 45-60 days; and only 20 percent have more than 60 days
- Identify specialty capacity at Laguna Honda Hospital (LHH)
- Develop a system to anticipate and backfill absences
- Begin collecting patient satisfaction data for all specialty clinics
- Develop accountability mechanisms for specialty care with UCSF
- Identify targets for increased specialty care capacity and implement plan

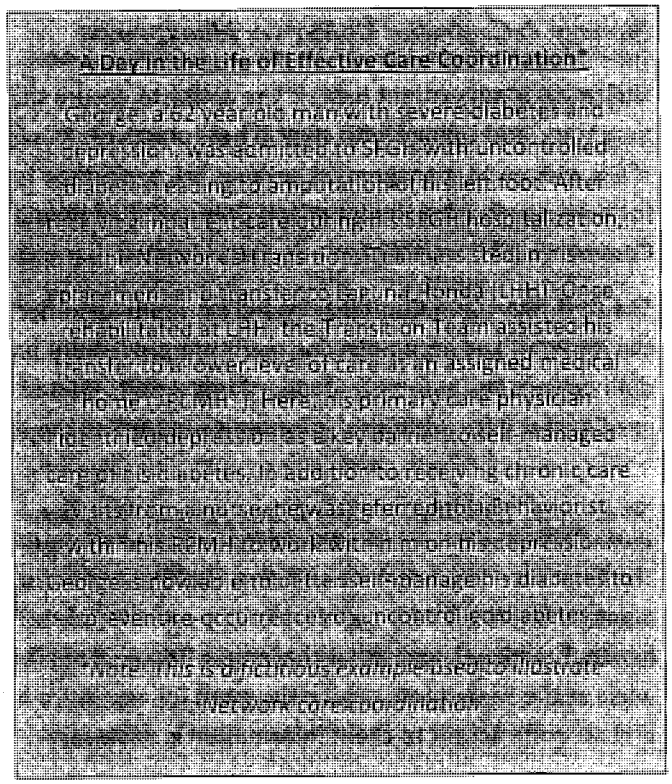
Strategy 2E: Make Necessary Clinic Facility Investments

To further increase access to care, HMA recommended expanding clinic facility space to accommodate team-based care and to ensure that providers have a minimum of two exam rooms for clinical sessions with clients.

HMA conducted an environmental assessment that indicated the need for investment and improvements in clinic facilities to attract and retain patients. Staff suggested improving health center aesthetics by increasing the size of waiting rooms, increasing privacy in reception areas, adding new furniture in waiting rooms, applying fresh paint, and other improvements.

Care Coordination

Effective care coordination ensures quality patient care and efficient service delivery. Care coordination aims to facilitate beneficial, efficient, safe and high quality client experiences, prevent avoidable health care-related costs, and improve the health, functional status, wellness, and social outcomes for Network clients. As a result of the HMA engagement, the Transitions Division, formally Community Placement, was created and is responsible for the movement and coordination of patients between health care providers and settings as their condition and care needs change. An example of care coordination is illustrated to the right.



Strategy 3: Implement a Risk Stratification Tool

Risk stratification can enhance care coordination. It is used to identify and predict which clients are at high risk or likely to be at high risk and enables the care team to prioritize the management of their care in order to prevent worse outcomes.[10] Globally assessing and understanding client risk is necessary for the Network to more efficiently identify high cost clients and better manage the entire Network population. A risk stratification tool will enable the Network to achieve the following:

- Develop a systematic process for identifying and predicting patient risk levels relating to health care needs, services, and coordination

[10] On a technical level, risk stratification is a periodic and systematic assessment utilizing detectable criteria and characteristics associated with an increased chance of experiencing unwanted outcomes. By identifying factors before the occurrence of an event, it is possible to personalize a client's care plan and develop targeted interventions to mitigate their impact. *Source: American Academy of Family Physicians, http://bit.ly/1fWxfg6.*

- Utilize algorithms involving registries, payer data, physician/provider judgment/input, and patient self-assessments and experiences to assess each client's health risk status to develop an individualized care plan
- Identify those at the highest risk or likely to be at high-risk and prioritizing the management of their care to prevent poor health outcomes
- Maximize use of limited time and resources to prioritize needs of their patient population

To conduct appropriate risk adjustment for clients, the Network researched various algorithms for risk stratification. While the Network identifies the appropriate risk stratification tool, the Transitions team is currently using the Coordinated Case Management System (CCMS), a compilation of several health and social service databases, to identify high users of multiple systems (HUMS) and high users of single systems (HUSS) to prioritize high risk clients in need of care coordination.[11]

Strategy 4: Centralize Utilization Management

Utilization Management (UM) is the ability to ensure that health care services are medically appropriate, necessary, and aligned with clinical best practices. This is a key component to effective care coordination. At SFGH, utilization management reviews are performed to ensure a client is receiving clinically appropriate care for their needs using the InterQual Criteria for Adult and Pediatrics. The Network Utilization Management Committee (SFHN-UMC) has now been created to monitor utilization throughout the Network.

The DPH-HMA Care Coordination Action Team identified the utilization management indicators to collect across the Network and accompanying quality improvement processes. In the long term, Network analysts will track data metrics and assemble standardized reports related to utilization, outcome measures, and quality. Please see Chapter 2 for additional information regarding the development of Network Performance Metrics.

Strategy 5: Establish a Care Management Database

The term care management and care coordination are often used interchangeably. At the Network, the care manager improves care coordination by providing direct care management to clients with a combination of health, functional, and social challenges. The goal of effective care management is to improve clients' health, while at the same time, reduce the need for expensive health care services. To achieve this, however, current and accurate access to client information is necessary.

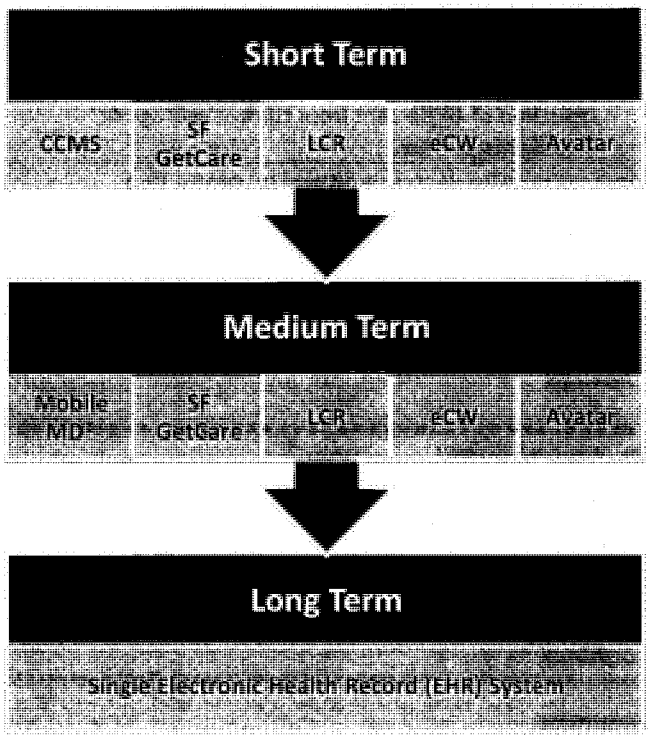
HMA conducted an assessment of the Network's information technology (IT) and information systems (IS). While there are many information systems used within the Network to view client clinical data, most systems operate in isolation from one another. This negatively impacts client care processes and limits the amount of financial and utilization data available for quality and efficiency purposes. These data are essential for a managed care environment.

During the HMA engagement, the Network identified the following systems that contain key information for care coordination. Primary care is in the process of implementing eClinical Works (eCW). ECW has some reporting capabilities, but the Network is determining the best strategy for enhancing its reporting capabilities

[11] Within the HUMS population, the top one percent of users of urgent/emergent services comprises about 25 percent of the costs. The top five percent comprises over 50 percent of the costs. Source: Department of Public Health.

further so that it can readily produce actionable data for care coordination. Additional information regarding the Network's information technology and the factors that must be taken into consideration as the Network begins to plan for a single electronic health record (EHR) is in Appendix II.

Figure 3: Steps Toward a Single Electronic Health Record System



The Network's Information Systems

- **Coordinated Case Management System (CCMS)** An integrated electronic charting, reporting, and communication tool for teams working with vulnerable adult served across multiple systems of care.
- **SF GetCare** A countywide, integrated web-based information system focused on older and disabled adults
- **Life Time Clinical Record (LCR)** An EHR utilized by various partners, including local hospitals, the San Francisco Community Clinics Consortium (SFCCC), the Department of Housing, and the county jail system.
- **eClinicalWorks (eCW)** A unified electronic medical records and practice management system for Ambulatory Services being implemented in Community and Hospital-based Primary Care and Specialty Clinics.
- **Avatar** The behavioral health electronic record system.
- **MobileMD®** An outsourced health information exchange for health systems, hospitals, physicians, labs and ancillary healthcare providers with secure messaging, analytic solutions, and an electronic medical record system to physician practices. Connects healthcare providers and patients through secure clinical and patient portals.

Source: Department of Public Health, Care Coordination Action Team Final Report.

Client Flow

An important aspect to improve the quality and efficiency of health care is to optimize client flow, or, the movement of clients through the health care system ensuring the most appropriate level of care is achieved.

Strategy 6: Reduce Lower Level of Care Days and Out-of-Network Referrals

The Network has developed key strategies to improve client flow. One of the primary goals is to reduce non-acute lower level of care (LLOC) inpatient days and out-of-network (OON) referrals. Reducing LLOC days can reduce costs and increase capacity by effectively transferring clients that no longer need acute care to an outpatient setting, and, thereby freeing up additional capacity in inpatient care. To accomplish this, processes need to be in place to be able to effectively transfer clients from inpatient to other services (e.g., their primary care medical home, LHH, community beds, etc.). Below is a table of recent achievements and future goals.

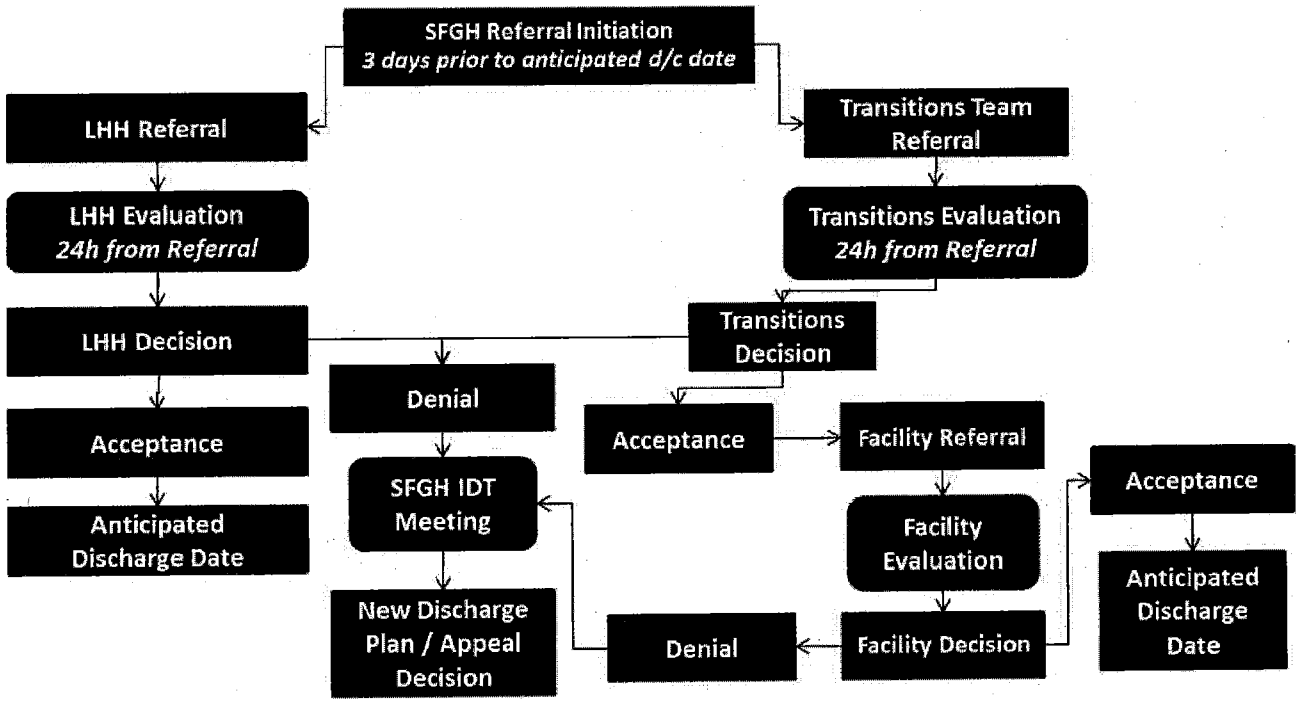
Figure 4: Lower Level of Care and Out-of-Network Key Achievements and Goals

	2012-2013 Achievements	2013-2014 Goals
SFGH	Reduced the percentage of Medical/Surgical LLOC days from 14 to 11 percent of total days Increased the percent of utilization management reviews performed within 24 hours from 30 percent to 64 percent	Reduce LLOC days by 60 percent of its FY12 level and increase acute admissions by 640 per year • 10 LLOC patients per day for Medical/Surgical; reduction of 51 percent from current average of 20.5 patients per day • 18 LLOC patients per day for Psychiatry; reduction of 49 percent from current average of 35 patients per day
LHH	Reduced the average wait time from referral to admission from 9.4 to 7.5 days via internal and external relationship development	Reduce the average length of stay (ALOS) by 12.4 percent, from 629 days to 551, and increase DPH referrals by an additional 140 per year
Transitions Division	Formally established the Transitions Division (formerly Community Placement)	Reduce ALOS in community placements by 50 percent to increase capacity for SFGH and LHH referrals

Source: Department of Public Health, Institutional/Post-Institutional Action Team Final Report.

In addition, the Institutional and Post-Institutional Care Action Team closely reviewed the current client flow process between SFGH and LHH and began work on streamlining client flow, as illustrated below.

Figure 5: Revised Client Flow from SFGH to LHH and Transitions



Source: Department of Public Health, Institutional/Post-Institutional Action Team Final Report.

Strategy 7: Develop and Operationalize an Inpatient Flow Dashboard

To achieve the above targets for improvements to client flow, the Network developed a set of metrics on inpatient flow, access, and post-institutional follow-up for inpatient clients.

Figure 6: Key Inpatient Flow Metrics

SFGH	LHH	Transitions Division
Daily LLOC days	Average length of stay (ALOS) – Bed Turnover Rate	Number of clients
Barriers to Discharge	Barriers to Discharge	ALOS
Discharge Destinations	Discharge Disposition	
30 Day Related Readmissions	Readmissions	

Source: Department of Public Health.

The Network plans to develop a dashboard to be able to easily view and review metrics data on a regular basis. The dashboard will allow Network staff and leadership to drill down to more detailed levels of information, depending on need and level of access. Dashboard reports are intended to be used by three different staffing levels within the Network: (1) Network leadership, (2) Network Management, and (3) Frontline or Point of Care Staff. The reports will be a useful tool for guiding discharge planning decisions, monitoring progress or areas for improvement, and creating a culture of accountability across the Network.

The Controller's Office is assisting the Network to complete an interim dashboard tool. The Network will also continue to create an automated dashboard in a data visualization tool and operationalize this across the Network.

Strategy 8: Pursue Opportunities for SFGH and LHH Integration

To become a fully integrated system and improve client flow across the system, the Network is exploring the integration of certain functions of SFGH and LHH. A Joint Hospital Executive Council was developed and is responsible for approving an integration performance improvement program that will enhance care delivery, client flow, and communication between the hospitals, ambulatory, and community sites. The HMA engagement identified opportunities and high priority areas to further pursue integration, listed below.

Figure 7: SFGH-LHH Areas Identified for Integration

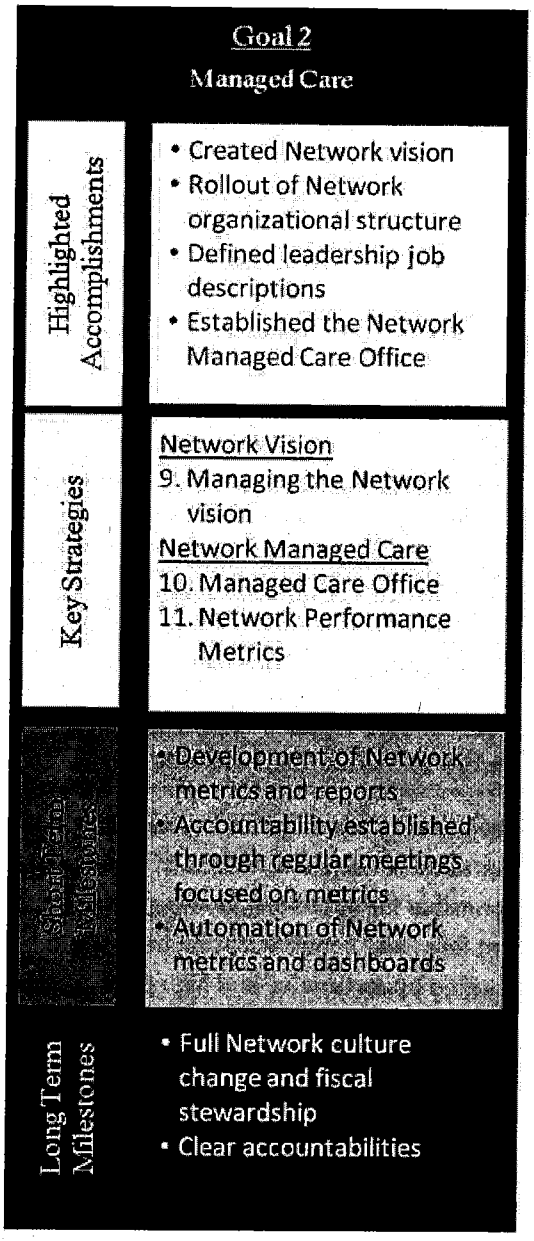
- Cafeteria
- Food Services Management
- Clinical Nutrition
- Electrocardiogram
- Electroencephalogram
- Chronic Dialysis
- Interpreter Services
- Clinical Laboratories
- Pharmacy
- Radiology
- Rehabilitation
- Respiratory Therapy
- Telecommunication
- Biomedical
- Utilization Management
- Social Services
- Performance Improvement

CHAPTER 2: MANAGED CARE

The Birth of the San Francisco Health Network (The Network)

As mentioned in the background section, the provisions of the Affordable Care Act (ACA) altered the operating environment for healthcare, particularly for public health systems. For DPH, health care reform requires a major transformation of the patient delivery system to become a fully integrated delivery system (IDS) that will facilitate improved patient care and the more effective use of resources. A major accomplishment that resulted from the HMA engagement was the development of the San Francisco Health Network (referred to as "the Network" in this report), which combines the patient delivery services under one system (see Figure 16).

The new healthcare environment requires the Network to become a provider of choice. Therefore, to remain competitive, creation of the Network includes development of a Managed Care Office aimed at managing risk and increasing the number of clients seen at Network clinics.



The Network Vision

HMA interviewed key leadership and staff throughout DPH and underwent an intensive, collaborative process to develop a detailed and clear vision for the Network and the necessary components, in particular the Managed Care Office. The Network's vision is to continuously increase the quality and value of services to clients, staff, and partners.

The Network is unique to other private and public systems as it has a robust set of key services needed to build a seamless continuum of care: patient-centered medical homes (PCMH), outpatient specialties and diagnostics, inpatient acute services, long term care (both institutional and home and community-based), and comprehensive behavioral health services. In addition, because the Healthy San Francisco program covered the City's uninsured, the Network was able to predict with fair precision the number of clients that would need coverage after health reform. These two elements, having a full complement of health care services and a defined population, served as the starting point for the development of the Network.

Strategy 9: Managing the Network Vision

As mentioned above, the Network centralizes the service delivery side of DPH. The new organizational structure in Figure 16 was informed by six DPH-HMA Action Teams, HMA consultants, and DPH key staff and physicians of all levels. The DPH vision for the Network is summarized below.

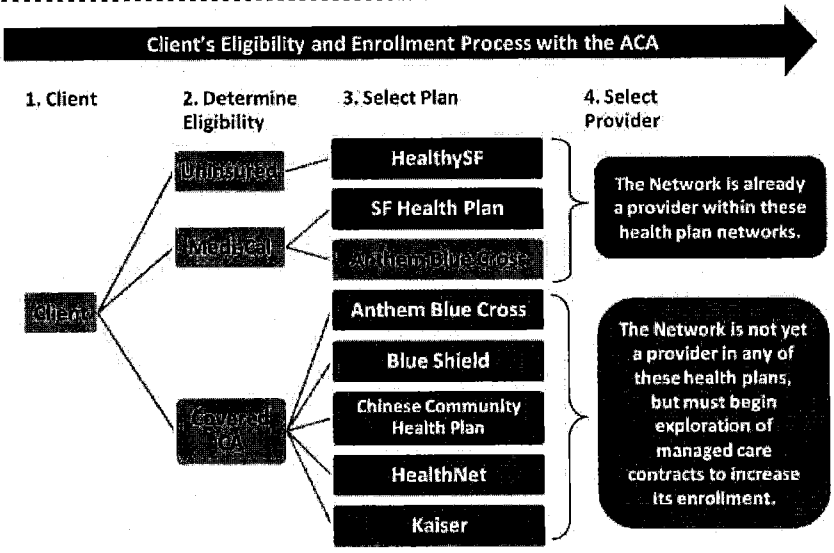
- Provide and manage the care for a defined number of new and existing clients
- Organize elements of the delivery system into one Network which will work together to assure that gaps are filled, duplication is eliminated, quality is enhanced, and the health of the population is improved
- Build an integrated operational infrastructure (including the necessary elements of a managed care structure) that supports the delivery of care in a way that maximizes efficiency, consistency, and quality
- Assure that all patients are cared for timely and at the most appropriate level of care
- Collaborate with other providers, partners, and health plans to assure the long term sustainability of the Network, which is the core of DPH and broader San Francisco safety net

Managed Care under the Network

With the implementation of the ACA, a critical part of the overall business strategy for a financially sustainable Network is managing financial risk. In contrast to the fee-for-service model, managed care and capitation will make the Network accountable for cost, utilization, quality, and health of its clients. Therefore, unnecessary or preventable health care expenditures are problematic to DPH.

Also, in managed care, acute services transitions from a revenue source in fee-for-service to a cost in capitation, if over the monthly capitated rate. With the implementation of the ACA and Covered CA, clients now have additional choices in the health plan they choose to enroll in. To sustain the Network and grow the number of Network clients, it will be necessary to pursue and secure managed care contracts with the qualified Covered CA health plans, as depicted in the figure below. Please refer to Appendix III for additional information.

Figure 8: Network Managed Care Contracting Opportunities



Note: Anthem Blue Cross is a product line under Medi-Cal and a separate product line under Covered CA.

Strategy 10: Operationalize the Managed Care Office

Broadening the managed care base, retaining enrolled members, and successfully competing with other healthcare providers and delivery systems, requires a restructuring and realignment of critical operational and business development activities, including contract management and provider relations, performance data analysis and reporting, beneficiary relationship management, business development, marketing, and outreach. A key recommendation that emerged as part of the HMA engagement was the establishment of a Network Managed Care Office. The multifaceted roles of the Managed Care Office are described below.

- **Contract management and provider relations** includes the development and compliance monitoring of standards for Medi-Cal managed care, as well as contracting with and monitoring community providers and services that serve Network clients.
- **Performance reporting and analysis** is critical to the successful managed care cost, quality, and population health outcomes. Managed care performance reporting and analysis provides management information to evaluate performance against required managed care business metrics.
- **Beneficiary relations management** includes serving as a liaison to the health plans customer service department complaints and grievances, assuring quality client care, assuring access to primary care and medically necessary service within required timeframes, assisting in enrollment and reenrollment assistance, and communicating with beneficiaries.
- **Business development, marketing, and outreach** includes the development of current and future business opportunities to position the organization to expand market share, development and distribution of internal and external marketing and collateral materials, and strategic outreach to community and business organizations.

Strategy 11: Network Performance Metrics

To ensure that the Network vision is being implemented in alignment with DPH and ACA goals (to increase enrollment, quality of care, reduce out of network expenditures, and maximize revenues, etc.), HMA recommended and Network leadership agreed to the development of performance metrics to regularly measure, evaluate, and improve performance to deliver the highest-quality healthcare and maximize efficiencies. Performance measurement will promote transparency, open communication, and accountability across the Network.

In the short term, the goal is to develop Network metrics and associated reports from existing systems to share at regular meetings with key staff to promote knowledge-sharing and accountability. The Controller's Office is assisting the Network with initial development of key performance metrics that resulted from the HMA engagement in:

- Patient Flow
- Finance
- Quality and Safety
- Patient Satisfaction
- Staff Satisfaction

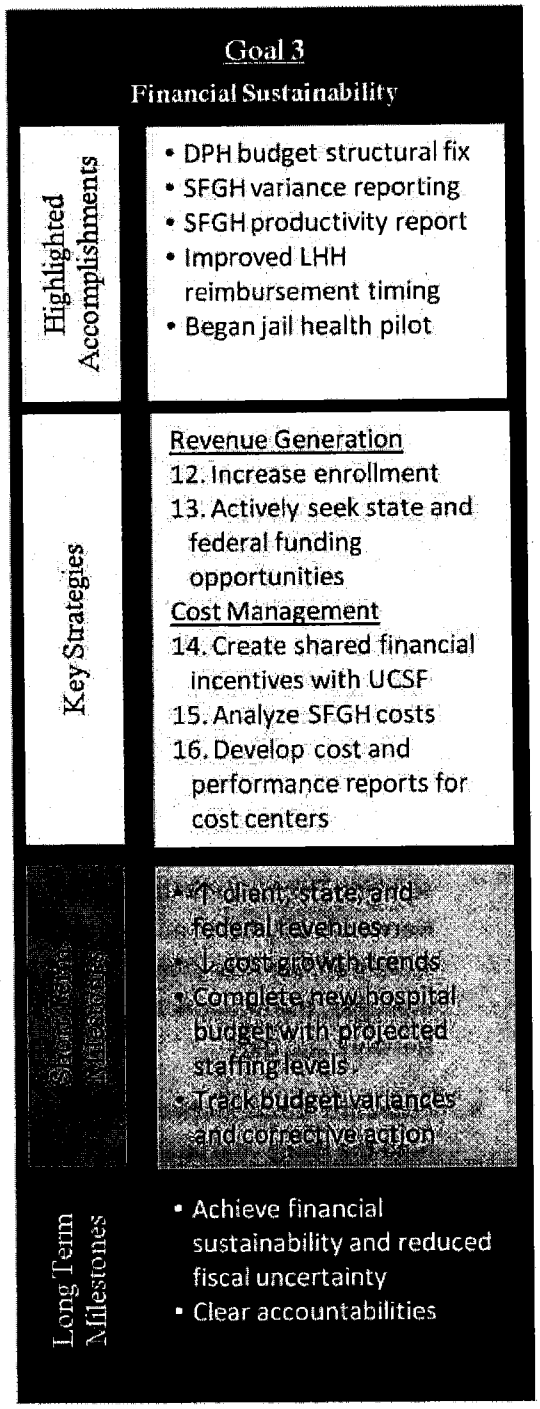
In the future, the Network aims to transform these metrics into automated dashboards viewable to key leadership and staff to monitor trends and continue to hold appropriate personnel accountable.

CHAPTER 3: FINANCIAL SUSTAINABILITY

ACA Impact on DPH Financial Sustainability

Financial management in many sectors is challenging, from healthcare to technology to financial services, but one financial goal remains the same - to manage risks and increase predictability in cost and revenue. The Affordable Care Act (ACA) made a giant leap forward for health care access, but the unpredictability of a provider's patients and the ever-changing healthcare regulatory and reimbursement landscape makes financial planning and management of risk even more challenging. This is particularly true for public health departments facing an historically complex safety net patient population and a financial system built around finding dollars to cover costs. The HMA engagement and the two year integrated delivery system planning process began the shift toward improving internal efficiencies while maintaining care excellence and quality.

In light of the new healthcare environment, which aims to increase coverage for more people, improve quality, and control costs, DPH must strive for financial sustainability through (1) delivery of coordinated quality preventative care as described in previous sections of this report, (2) exploitation of financial opportunities, and (3) cost control and management strategies. At DPH, the increased number of insured individuals as a result of the ACA provides current and potential San Francisco Health Network (the Network) clients with a choice regarding where to access care. Each Network client retained or newly enrolled helps maintain or increase revenues to sustain the Network. On the other hand, if Network clients choose to get their health care elsewhere and move out of the Network, DPH will lose revenue to support its current system of care. During the HMA engagement, DPH underwent an intensive internal process to develop a model to project future revenue streams in light of health reform and clear strategies to achieve cost containment and revenue generation. The next two sections provide the Network's key financial strategies and a rough timeline of intended outputs and outcomes as health reform and its impacts continue to unfold.



Revenue Generation Strategies

Revenue Outlook

As a result of the ACA, it is projected that DPH will realize a 16 percent decrease in the historical state and federal safety net dollars. Capitated revenues are anticipated to partially offset this loss. The impact of health reform on DPH's financial sustainability is broken down into four main categories: Primary Care Capacity, Change in Reimbursement Mechanism, Insurance Status, and State and Federal Revenues.

- *Primary Care Capacity.* As discussed in the Chapter 1 and Appendix II, increasing primary care capacity to meet demand directly impacts quality of care as well as managed care revenues. Not only is the Network currently challenged to meet demand and in need of additional capacity but also the ACA requires that clients have timely access to care. Therefore, the Network must strengthen its primary care system to increase capacity to ensure timely access to care. This will allow DPH to provide patients preventative and early interventions to keep its patients healthy, improve quality outcomes, and minimize avoidable hospital admissions.

- *Change in Reimbursement Mechanism.* To incentivize more efficient use of services and as a means to manage risk, the reimbursement mechanism in the new healthcare environment is moving away from fee-for-service and towards capitated payments. Fee-for-service is a payment for each service provided. There is predictability in payment for services, but also fewer incentives to reduce costs. Medi-Cal is moving away from the fee-for-service model to a capitated rate. Capitation provides a fixed amount of money to care for each patient, regardless of utilization or cost. There is predictability in payment for patients, but it requires better cost control mechanisms to ensure financial sustainability. As an emerging practice in the public sector identified by HMA, the Network must become more efficient and cost conscious at all levels of client delivery and educate clients about the Network's new managed system of care. Medi-Cal expansion and Covered CA have moved to a fixed per member per month (PMPM) rate to manage the care of clients regardless of how frequently or infrequently they use services. This new reimbursement environment will be challenging as a large proportion of the Network's clients are multi-diagnosed and complex. However, the Network has a broader, deeper system of care than many competing managed care systems; therefore, if care is well coordinated and managed, the Network's full continuum of care can help retain clients and ensure the viability of the Network and DPH.

- *Insurance Status.* Network clients' insurance status is essential to DPH's revenues as these revenues fund the many vital health services for the whole community as illustrated in Figure 2. Therefore, to continue to provide a viable safety net, the City must increase the number of Network clients and increase revenue.

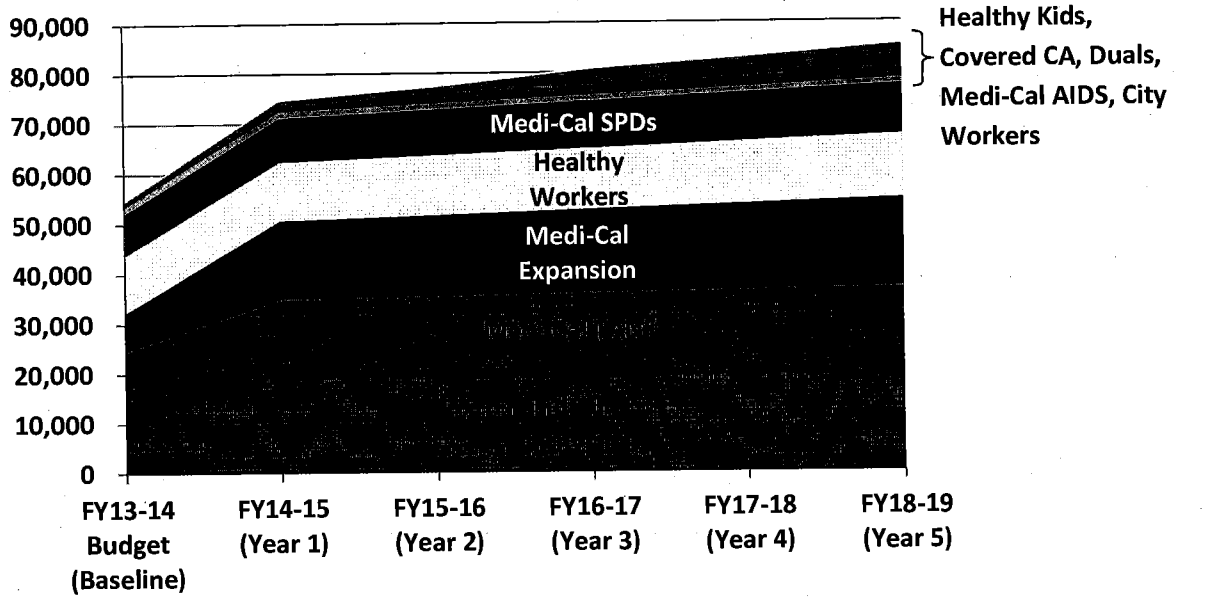
  As intended, ACA's impact will result in an increase in the number of insured and a decrease in the number of uninsured. A majority of the state's insured will gain coverage through Medi-Cal as a result of Medi-Cal expansion while the remainder will gain coverage through Covered CA. Programs that historically served the uninsured in San Francisco will shrink as more clients are covered under the ACA.

For example, SF PATH (San Francisco Provides Access to Health Care)[12] ended on December 31, 2013 and its clients transitioned into the newly expanded Medi-Cal. The remaining uninsured, who are not eligible for Medi-Cal or Covered CA, will remain in Healthy San Francisco.

Based on the HMA engagement five-year projection model, the figure below illustrates the forecasted trend of Network clients by program over the five year period from FY14 to FY19. The key drivers of the increase from FY14 to FY15 are the Medi-Cal expansion and Covered CA clients. The major assumptions within this projection are listed below:

- **Total Projected Client Increase**: Network clients are forecasted to increase from approximately 57,000 to 85,500 clients over a five year period. Key assumptions are listed below.
    - **Medi-Cal Expansion**: Network to enroll nearly 15,000 individuals eligible for the Medi-Cal expansion around January 2014. The monthly ("PMPM") capitation rate for the new Medi-Cal expansion population as of January 2014 is assumed to start at approximately $400.
    - **Covered CA:** Network to enroll 2,000 individuals eligible for Covered California (insurance exchange) in or around January 2015.
    - **Dual Eligibles**[13]**:** State's transition of dual eligibles (Duals) into managed care is anticipated around 2016 resulting in a one-time increase in the number of Duals clients within the Network.

Figure 9: Projected Trend of Network Clients by Program FY14-FY19



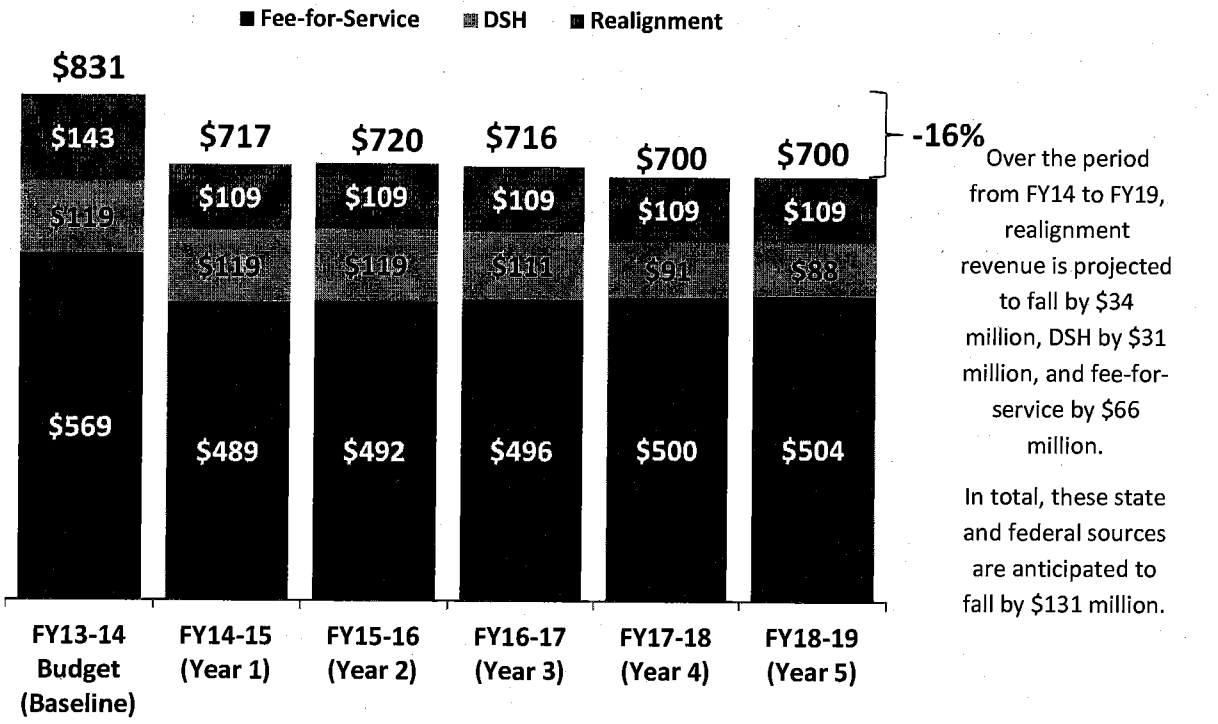
Source: Department of Public Health via the HMA Financial Projection Model. Note: Projections are based on HMA and DPH assumptions regarding estimated client membership.

[12] SF PATH: The City and County of San Francisco's Low Income Health Program (LIHP) was created by the state in July 2011 as a temporary program for certain Californians eligible for free or low cost health insurance as a part of the federal health reforms that took effect in 2014.

[13] Dual eligibles are those eligible for both Medicare and Medi-Cal.

- *State and Federal Revenue.* Under the ACA, there are major changes in how counties receive state and federal revenues. The historical state and federal "lump sum" payments to support the uninsured and safety net services will be reduced with the expectation they will be partially offset by an increase in Medicaid revenue and earned managed care revenues. The three major losses of historical revenues include federal Disproportionate Share Hospital (DSH) payment reductions ($31 million), state "realignment" funds for indigent health ($34 million), and traditional fee-for-service patient revenues ($66 million). These losses amount to a 16 percent reduction in revenues from FY14 to FY19. The figure below illustrates the net reduction of these three revenue streams over this period.

Figure 10: Projected Reductions in Three Major State and Federal Revenues FY14-FY19 (in millions)



Source: Department of Public Health via the HMA Financial Projection Model.

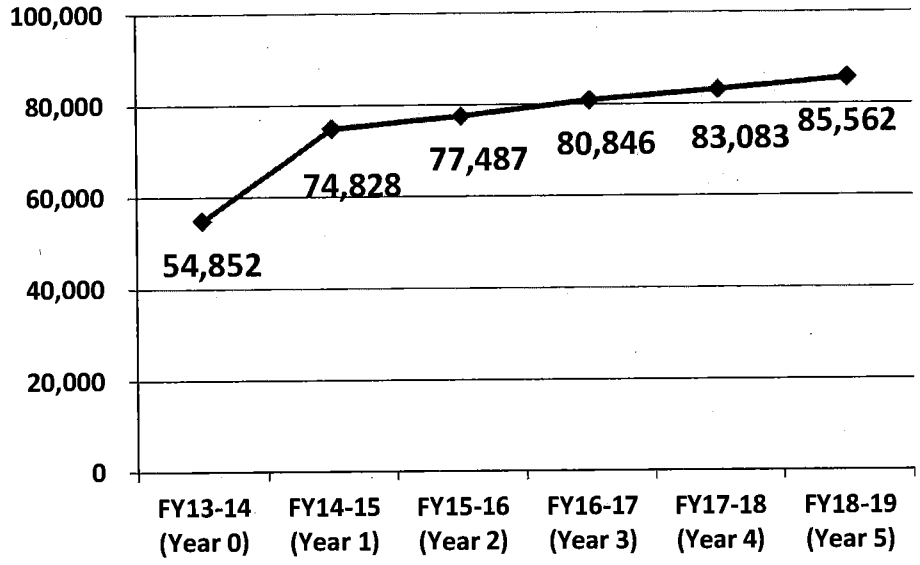
Strategy 12: Increase Network Clients by Strengthening the Ambulatory Care System

During the HMA engagement, the Network developed a detailed work plan to improve the Ambulatory Care system. It is imperative the Network increase the number of insured clients to create adequate and stable funding to the Network. Chapter 1 describes the strategies aimed at strengthening the Ambulatory Care system to achieve this increase, such as increasing panel sizes, implementing a call center, and improving the physical appearance of clinic sites to attract and retain Network clients.

The Network projects that over the next five year period there will be an average 10 percent increase in Network clients each year, reaching approximately 85,500 clients by FY19. A key assumption is that the number of Network clients will increase by 36 percent in health reform's first year, from approximately 54,900 to 74,800 clients by June 30, 2015. Attaining this year-over-year increase is imperative to DPH's financial sustainability as a

result of the anticipated state and federal revenue losses. Over time, successful increases in Network clients will reduce revenue uncertainty.

Figure 11: Projected Monthly Network Clients FY14-FY19



Over the period from FY14 to FY19, Network clients are projected to increase 36 percent in FY14 and increase by an average of three percent each of the following years.

Source: Department of Public Health via the HMA Financial Projection Model. Note: Projections are based on HMA and DPH assumptions regarding estimated client membership.

Strategy 13: Actively Seek Additional State and Federal Funding Opportunities

DPH has recently increased its work with state and federal officials on targeted opportunities to support San Francisco's innovative programs. This dialogue led to the prioritization, achievements, and next steps listed below.[14]

- *Timeliness of LHH Supplemental Payment Calculation*. The Network recently worked with state officials to assure the timeliness of supplemental payment calculations for Laguna Honda Hospital (LHH) in terms of both amounts received and the timing of that receipt. By utilizing more current cost data, which represents higher costs, the amount of settlement costs increased. In addition, the use of more current cost data will now result in the more timely settlement and therefore payment for LHH.
- *Health Homes*. The Network, with HMA expertise, monitored developments regarding ACA Section 2703, the Medicaid Health Home State Plan Option, and began to explore options to establish Health Homes within the Network. In the future, the Network will attempt to garner additional funding for Health Homes through a SPA or Medicaid 1115 Waiver project. See Chapter 1 for more information on the establishment of Health Homes.
- *FQHC Clinic Visit Reimbursements*. HMA identified current State Plan Amendments (SPAs) that allow supplemental Federally Qualified Health Center (FQHC) payments as a way to increase the rate of

[14] These opportunities were not incorporated into the HMA five-year financial forecast model as these strategies are additional revenue opportunities yet to be realized.

reimbursement from the Federal government. After additional exploration, DPH discovered the current California SPA cannot be used for this. However, DPH found the state may be supportive of an effort to allow for certified public expenditures (excluding intergovernmental transfers or IGTs) to draw down federal financial participation for unreimbursed FQHC costs.

- *Jail Health Enrollment.* The Network initiated implementing a Jail Health pilot enrollment project to ensure enrollment of the jail population into a coverage program prior to release from jail. Ensuring the jail population has coverage and access to care prior to or when being released from jail will further decrease the uninsured rate in our community and reduce pressures on the safety net. If these newly enrolled individuals choose to access care at a Network clinic or hospital, then this is also another source of client revenue for the Network. The Network is currently working with the Human Services Agency (HSA), the Sheriff's Department, and Jail Health staff to ensure health care enrollment occurs at, or just after, release.

Over the next five year period, these opportunities could increase state and federal funding to help offset projected decreases in revenues.

Cost Control & Management Strategies

Expenses Outlook

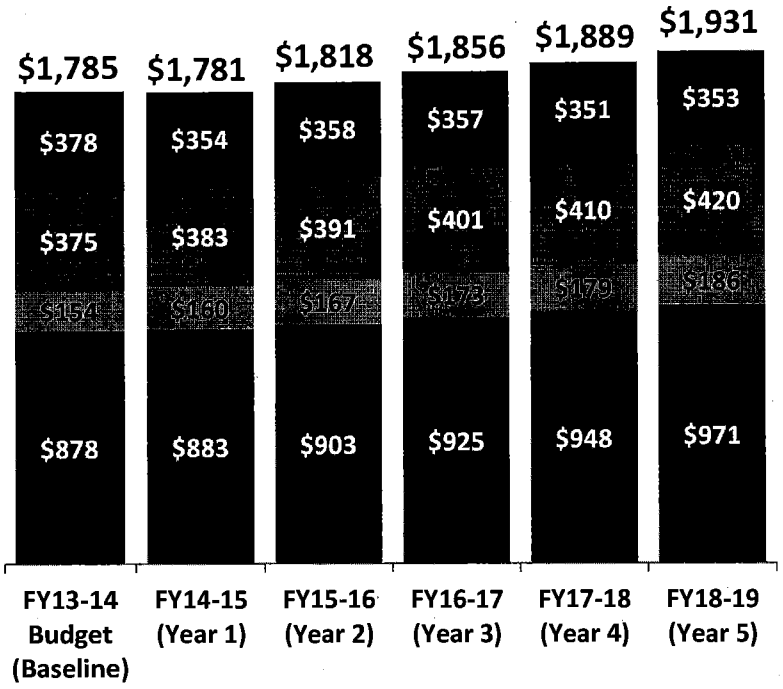
As stated at the beginning of this section, one of the major financial impacts of the ACA is an approximately 16 percent reduction in revenues (DSH, fee-for-service, realignment). These reductions can be offset with increases in managed care (capitated) revenues; however, expenditures must be managed carefully to ensure financial stability.

Capitated revenues will only partially offset the anticipated state and federal revenue losses.

Cost management and control strategies must also be used to curb expense growth.

As illustrated below, over the next five year period DPH's current operating expenses are projected to increase by eight percent, to approximately $2 billion. DPH's costs can be broken down into four main categories: salaries and benefits comprise 50 percent, UCSF comprises nine percent, and other contractual services and other costs together comprise 41 percent. Twenty-two percent of the eight percent increase in costs is attributed to the UCSF Affiliation Agreement and 63 percent of the increase is from DPH salaries and benefits. These expense projections include inflationary factors outlined in the City's Three-Year Budget Projection ("Joint Report"), but do not reflect any new initiatives or programs above the FY13-14 budget nor the operating budget for the new San Francisco General Hospital.

Figure 12: Projected Increase in Total DPH Operating Expenses FY14-FY19 (in millions)



Over the next five year period, DPH's operating costs are projected to increase by 8 percent.

Twenty-two percent of this projected increase comes from the UCSF Affiliation Agreement and 63 percent from DPH salaries and benefits.

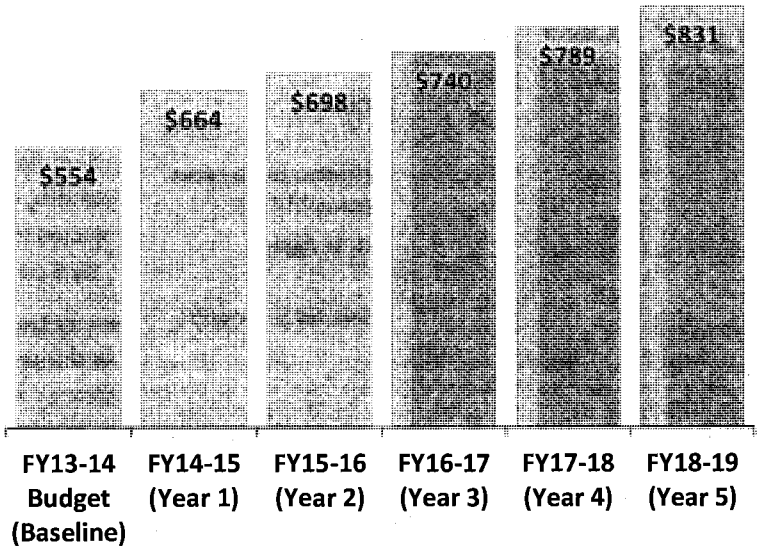
Source: Department of Public Health via HMA Financial Projection Model.

One of the fiscal challenges facing public health departments as a result of health reform is accurately projecting capitated revenue as this is based on enrollment projections, depicted in Figure 9. The level of uncertainty for projected revenue remains high. However, over time and with greater market experience DPH will continue to refine and should be able to more accurately predict enrollment numbers.

To estimate DPH's general fund subsidy for its baseline operating costs in FY15 through FY19, the department utilized the HMA financial model provided during the engagement, updating it with more recent information and to reflect DPH's current operating budget. Based on this update, the City's net general fund contribution to DPH is anticipated to increase by 50 percent from FY14 to FY19, as illustrated below. During its engagement, HMA pointed out that historical cost trends must be reversed or otherwise mitigated for DPH to attain the goal of long term financial sustainability.

This projection assumes the aforementioned 16 percent revenue loss from DSH, realignment, and fee-for-service, the forecasted eight percent cost increase, the current FY14 baseline general fund subsidy, general-funded capital and project dollars are constant, and the same level of service in other DPH programs. In addition, the methodology used to project the estimated general fund subsidy does not include increases in enrollment or capitated revenues.

Figure 13: Projected General Fund Subsidy Increases FY14-FY19 (in millions)



These cost growth rates, coupled with the impact of the ACA, will be unsustainable unless historical cost trends are reversed or otherwise mitigated.

Absent any interventions, the general fund contribution by the City is projected to reach $831 million in FY19, for a total of $4.3 billion over the period from FY14-FY19.

Source: Department of Public Health via HMA Financial Projection Model.

Given DPH's main cost drivers and HMA's fiscal recommendations, the following are three key areas to control costs: the UCSF Affiliation Agreement, SFGH operating costs, and cost reporting. This section will identify the actions already accomplished and strategies for cost control and management.

Strategy 14: Create Shared Financial Incentives with UCSF

The UCSF relationship is a long standing, mutually beneficial partnership that has served the San Francisco community for more than one hundred years, formalized in a written Affiliation Agreement since 1959. However, with health reform and a new managed care environment, public health systems around the country are working to better measure and rein in costs. The UCSF Affiliation Agreement is at $154 million in FY14 and comprises approximately ten percent of the annual DPH budget and 15 percent of the annual SFGH budget. Through the HMA engagement, the Network identified key areas around fiscal management of the UCSF agreement to improve data collection and accountability for both parties. The next section identifies these strategies to improve tracking, accountability, and fiscal management. Additional information regarding the UCSF partnership can be found in Appendix III.

Health reform and the managed care environment require tracking, measuring, and reporting for regulatory compliance and achieving a competitive edge.

As a large portion of SFGH staff and the DPH budget, the UCSF Agreement must be restructured and new measures enforced to remain competitive.

To move forward under this new managed care environment, DPH is exploring additional accountability and tracking measures throughout Network operations as described in Chapter 2. Therefore, one key strategy for the Network to control costs is data-

driven management of the UCSF Affiliation Agreement as well.

- By the end of FY14 the Network intends to support a benchmarking study to identify best practices in hospital-academic institution affiliation agreements across the country to understand key reporting and accountability measures.
- By the end of FY15 the Network intends to utilize the best practice research when evaluating the Agreement, in particular the addition of key reporting requirements, risk-reward provisions, billing expectations, and regular review of non-faculty costs and leases.

Through the implementation of these strategies, DPH, in particular the Network, will centralize all UCSF contract management and decision making to ensure transparency and, most importantly, realize improved productivity and reduced cost growth. This year-over-year management of the UCSF Affiliation Agreement and associated costs will help DPH achieve financial sustainability and increase mutual accountability.

Strategy 15: Analyze SFGH New Facility Costs

SFGH operating costs comprises approximately one-third of DPH's annual General Fund subsidy and more than 50 percent of DPH expenses. Furthermore, in the new managed care, capitated environment, services provided to a Network client will not be reimbursed on a fee-for-service basis, but costs must be within the capitated rate for the Network to remain financially sustainable. So, there are opportunities to prevent acute admissions through a strengthened ambulatory system (as discussed in Chapter 1), as well as opportunities to control costs in the acute setting at SFGH. As a result of the HMA engagement, there have been three key financial achievements at SFGH: (1) implementation of salary and fringe variance reporting by cost center, (2) development of an SFGH productivity report, and (3) a re-evaluation of the new SFGH operating budget via data gathering and assessment of proposals.

In the next year, the following three strategies will be pursued to continue to manage SFGH costs.

- SFGH will continue to evaluate one-time transition costs and ongoing new facility costs to ensure that new equipment and FTEs are justified by volumes.
- Staffing costs comprise approximately 50 percent of SFGH's operating expenses; therefore, a detailed examination of staffing levels against similar hospitals and benchmarks coupled with a study of the client population and volumes is needed by the end of FY15.
- SFGH will also operationalize a benchmark database so SFGH can compare productivity and volumes against similar academic teaching hospitals across the nation.

These strategies will be used to refine the operating budget for the new SFGH. This updated budget coupled with proactive budget variance reporting will provide SFGH with tools to better manage and control costs. SFGH's ability to manage costs is imperative to the overall financial sustainability of the Network, DPH, and the City as many of the services provided in an acute setting are now capitated. Close management of costs against volumes is a key strategy to achieve financial sustainability in the long term.

Strategy 16: Develop Cost and Performance Reports for Cost Centers

In recent years, DPH has required supplemental funding from the General Fund or new revenues to cover actual expenses. The FY14 adopted budget added funding to address the previous structural gap with SFGH staff funding. In addition, DPH leadership implemented expanded financial reporting to the Health Commission to hold DPH accountable to the Commission and City leaders if overruns occur. If overruns occur, DPH will present a corrective action plan.

To allow managers to make effective decisions on resources, DPH aims to develop cost and performance tools for all Network units and cost centers. DPH has committed to use these reports to hold the appropriate staff accountable. It is anticipated these reports will be produced for all units and cost centers over the next few years.

In sum, the Network must not only increase the number of clients served to help offset state and federal revenue losses, but also effectively manage costs to ensure the Network, DPH, and the City remain financially sustainable over the long term. Additional investment and partnership strategies can be found in Appendix II and III.

APPENDIX I: IDS HISTORY, HMA ENGAGEMENT, AND ACTION TEAMS

DPH has worked toward integrating patient delivery for nearly three years and developed the following definition for DPH's integrated delivery system (IDS): a comprehensive system of care that is clinically and financially accountable to provide coordinated health services to the individuals it serves and improve the health of the community. The IDS vision is based on the local history of healthcare delivery and the changing healthcare landscape described in the introduction.

History of IDS at DPH

The initial planning and implementation efforts were and continue to be rooted in the contention that DPH is critical to the populations and communities it serves. Between June 2011 and May 2012, an internal IDS planning and visioning effort took place that resulted in over 40 recommendations aligned with the Health Commission's priorities. This significant effort involved over 100 staff and community partners in the IDS planning groups.[15] Between July 2012 and March 2013, initial implementation efforts took place in which five work teams were created to begin implementation of the recommendations.[16]

HMA Engagement

To further the transformation of DPH into a fully integrated delivery system, DPH engaged Health Management Associates (HMA), a consulting firm with experience in public healthcare delivery systems, in February 2013 through a formal solicitation process. The Controller's Office funded and provided contract and project management support for the engagement. In line with the changing healthcare environment, HMA's two main objectives were:

1. Prepare DPH to compete for clients as the healthcare environment changes and financial reimbursement moves away from fee-for-service and towards capitation
2. Transform and integrate DPH's delivery system and corresponding support systems into a provider of choice and away from the provider of last resort

HMA's work took place in three main stages: visioning, prioritization, and implementation.

Visioning

Building upon the previous IDS work, HMA began the engagement with a series of key internal and external stakeholder interviews and intensive document review. HMA developed an environmental assessment and clear statement of the vision for DPH as depicted in Figure 14. This graphic illustrates DPH's relationship between the health of our community's population and the importance of a strong integrated delivery system. The core of public health must be strong for the greater San Francisco system to have and maintain a healthy population.

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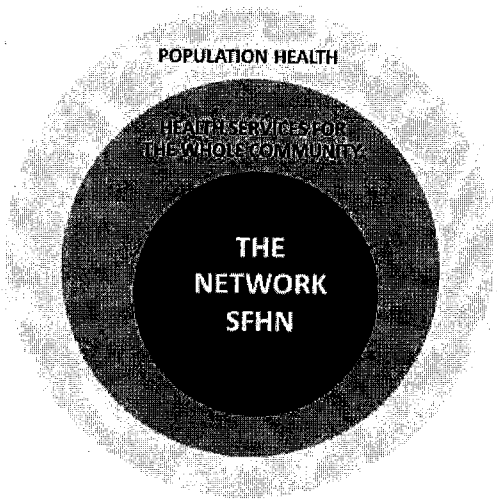
[15] Department of Public Health. Presentation of the Integrated Delivery System Planning Project, May 15, 2012. Retrieved January 15, 2014 from http://bit.ly/1pWU3kk.

[16] The teams were Care Management, Clinical Leadership, Health Promotion and Disease Prevention, Innovations in Health Care, and Quality and Utilization Management. Department of Public Health.

The two primary roles of DPH in this new healthcare environment are to (1) externally, improve the health of the population by maximizing enrollment into new health insurance options and (2) internally, DPH must prepare the health care delivery system to become the provider of choice for clients.

Figure 14: DPH's IDS Vision



SF HEALTH NETWORK

The Network (SFHN) provides direct health care services to insured or covered clients whose care is managed through the Network, from primary to acute to long term care.

Health services for the whole community include services for those clients outside of the Network but still in the safety-net, for example, undocumented immigrants and homeless/transient populations. Includes community behavioral health and trauma services.

Population health aims to improve the health of the entire population through environmental health, disease control, assessment, and housing.

Source: Department of Public Health.

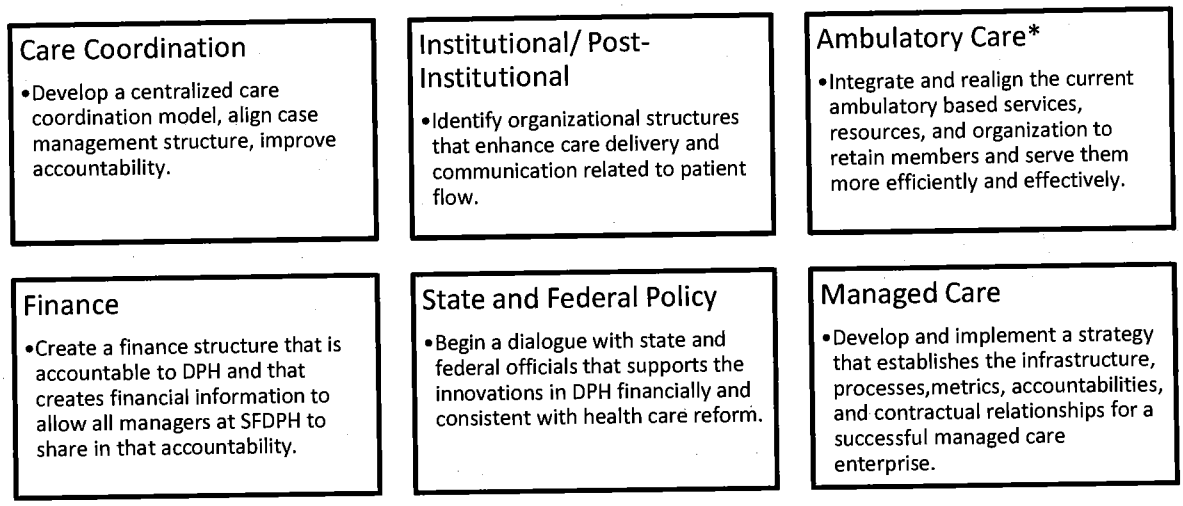
Prioritization

The intensive DPH IDS development, prioritization, and planning effort took place over the summer of 2013 via DPH-HMA Action Teams. The process aimed to (1) establish broad areas for attention, (2) develop Action Teams or work groups to prioritize actions and develop champions within DPH, and (3) move the two years of IDS planning into the implementation phase. Figure 15 depicts the six Action Teams developed and the main objective of each team. Throughout the process, the leaders of the Action Teams formed the Integration Steering Committee (ISC), which served as the key planning and monitoring group for health reform readiness activities and IDS development.

The output of this three-month, joint DPH-HMA effort from June to September 2013 included strategic and intensive intra-departmental collaboration, and a priority list of key recommendations for improved systems change in light of health reform. On October 1, 2013, the planning phase ended and implementation began with the launch of the City's public health integrated delivery system, called the San Francisco Health Network (referred to as "the Network" in this report).

Figure 15: DPH-HMA Action Team Objectives

From June to September 2013, DPH and HMA worked intensely via six Action Teams on specific objectives, all aimed to turn DPH's integrated delivery system into a reality.

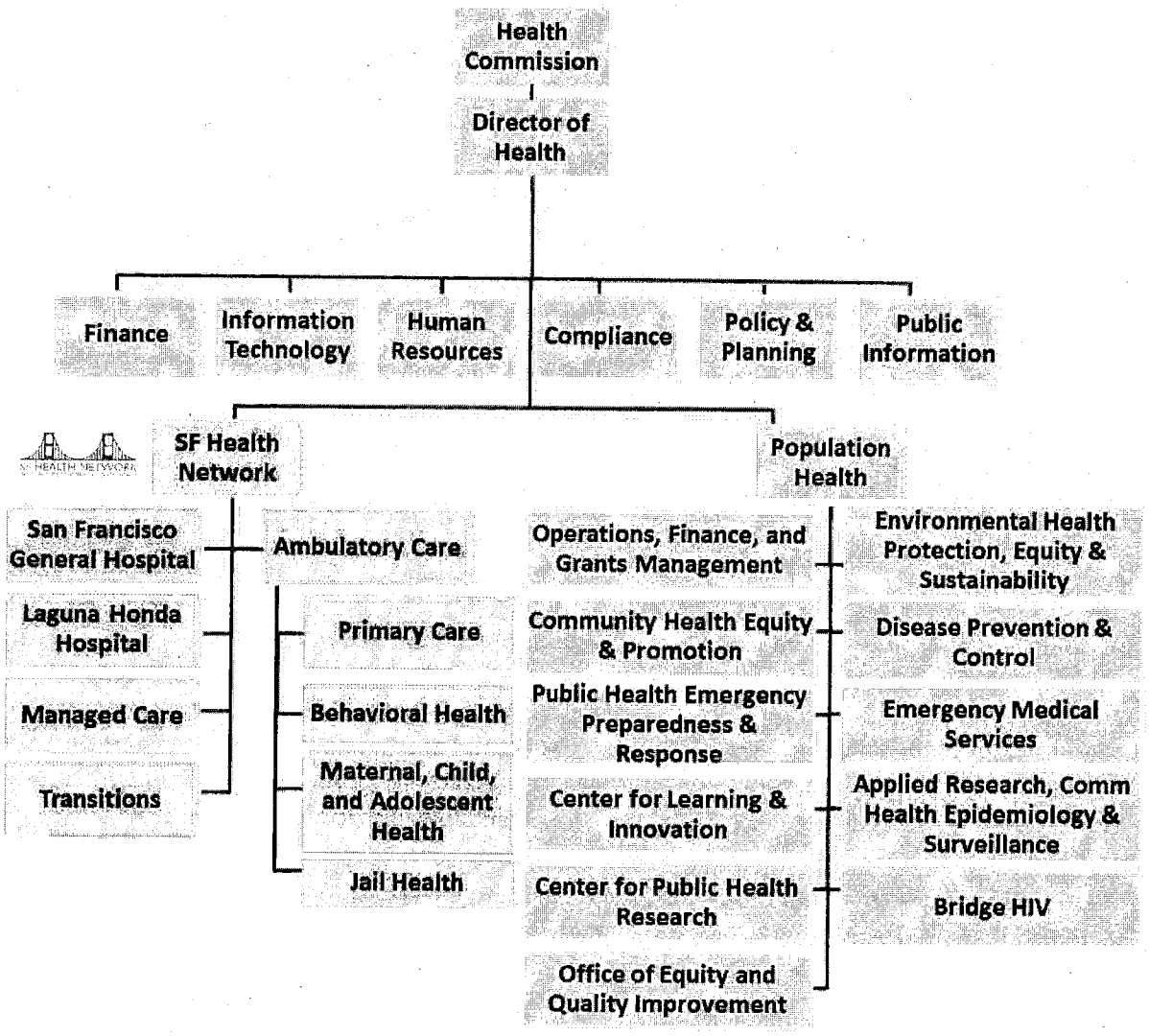


*Source: Department of Public Health. *The ambulatory care sub-groups included the following: 1. Panel Sizes, 2. Operational Issues, 3. Organizational Structure, 4. Critical Capital and HR Investments, 5. Health Homes, 6. Specialty Services*

Implementation

HMA assisted DPH to reorganize management and reporting structures to be able to fully support an integrated delivery system. This significant effort resulted in a new organizational chart for DPH. The reorganization and integration of DPH's patient delivery system into the San Francisco Health Network is depicted in Figure 16. As Figure 14 illustrates, the core of the public health system (the Network) must be strong in order for the greater San Francisco system to maintain a healthy population.

Figure 16: San Francisco Department of Public Health Organizational Structure



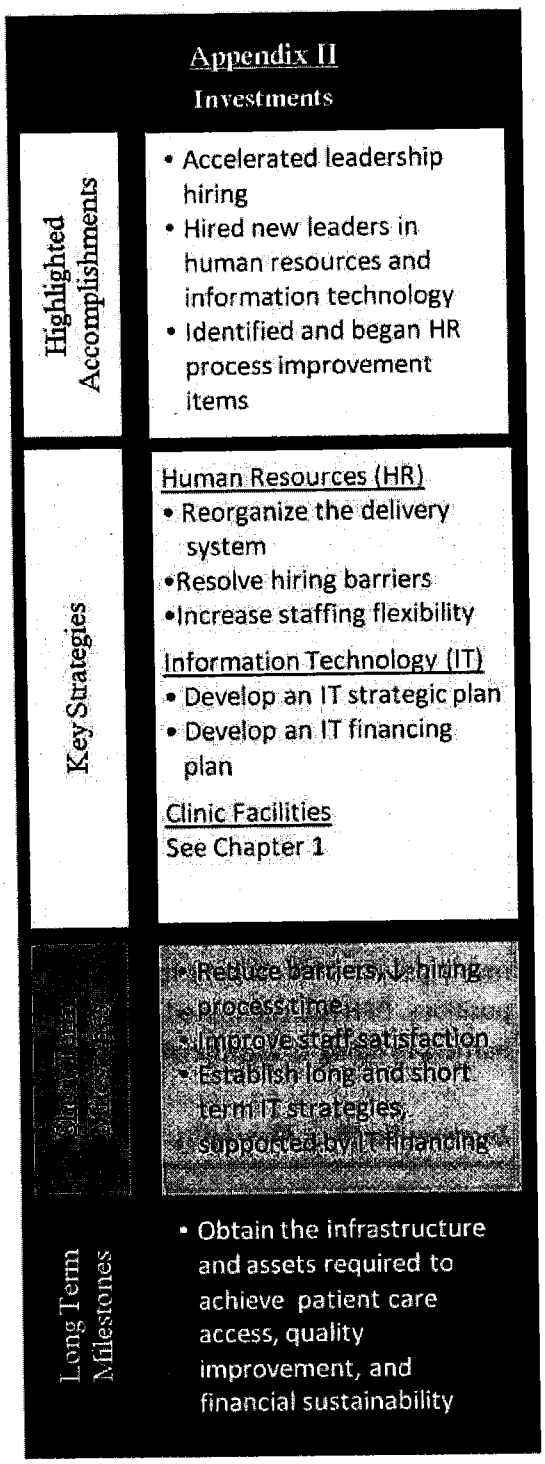
Source: Department of Public Health.

APPENDIX II: INVESTMENTS

ACA Impact on Investments

As the Background and Chapter 3 state, the provisions of the Affordable Care Act (ACA) and resulting changes to the healthcare environment are challenging the San Francisco Health Network (the Network) to improve efficiency of care while also improving quality. The three main challenges facing the Network are: (1) timely access to care (with ACA, clients have a right to care within a reasonable time), (2) adapting to capitation payments, which create greater incentives to reduce unnecessary high cost care and invest in prevention and care management, and (3) increased competition, since clients now have more choice in choosing their provider. The Network must move from a "provider of last resort" to a "provider of choice."

To meet these new challenges and succeed in the new environment, the City and the Network must quickly identify and strategically increase investments in its health system infrastructure; in particular, investments in human resources, information technology, and clinic facilities. Please refer to Chapter 1 for a discussion of clinic facility investments important to improving access to care and patient flow. The next two sections discuss key strategies coming out of the HMA engagement regarding human resource and information technology investments.



Human Resource Strategies

For organizations in direct patient care such as hospitals, clinics, and public health systems, the ACA and the managed care setting require quality, cost-effective, and cost-conscious care. There are several key steps to achieve this; for public health systems, these include: (1) reorganize and restructure into an integrated delivery system, (2) identify and resolve barriers to expedite hiring, and (3) increase staffing flexibility based on demand for services and the number of staff available based on client volume. Discussed more below, these strategies are needed to help the Network improve wait times, provide more efficient care, and more effectively compete with other providers.

Reorganize and Restructure the Delivery System

The DPH IDS planning process and the HMA engagement, including the work of the 2013 Action Teams, resulted in the development and adoption of the San Francisco Health Network on October 1, 2013. The rollout of the Network and reorganization of the delivery system as depicted in Figure 16 is a crucial first step towards becoming a "provider of choice." Informed by HMA's experience integrating other county public health systems, the Network developed job descriptions for key leadership positions in 2013. These key positions include the Network Director and Ambulatory Care Director. In addition, the reorganization established a Managed Care Office for the Network which aims to hire a Managed Care Director by the end of FY14. For more information on new leadership positions and the Managed Care Office, see Chapter 2. For more information on additional Ambulatory Care human resource strategies, see Chapter 1. In addition to the Network leadership positions, DPH also hired key leadership positions, including the Human Resources Director and Chief Information Officer.

Throughout FY14 and continuing into FY15, the Network needs to continue to develop its integrated structure and staffing strategies among Ambulatory Care, Finance, Managed Care, and Transitions (formerly Community Placement). The Network has pledged to monitor the impact of organizational and culture changes on staff through a quality improvement process, including a staff satisfaction survey. In the long term, staff satisfaction will be an indicator of the Network's effectiveness.

Identify and Resolve Barriers to Hiring

A key HMA recommendation was to develop effective strategies as soon as possible to reduce recruitment and hiring barriers. This includes streamlining the DPH and City recruiting and hiring processes to reduce the time to hire.

The hiring of DPH's Director of Human Resources in August 2013 was a major milestone. As a result of the HMA engagement, DPH identified and started to implement 14 action items to improve personnel processes in conjunction with the City's Department of Human Resources (DHR). This includes a secured agreement from DHR to accelerate hiring of key DPH and Network leaders, and ongoing weekly meetings with DPH divisions to identify and accelerate hiring of key positions. DPH has committed to continue to identify and resolve barriers to hiring to appropriately and flexibly staff the Network.

To meet the human resource challenges of ACA, the Network must strategically and successfully engage DHR and other City partners to remove hiring barriers and increase staffing flexibility.

Increase Staffing Flexibility

The third human resource strategy identified during the HMA engagement is staffing flexibility through redeployment of staff; that is, redeployment based on client demand, cross-training, and professional development. HMA's early assessment of DPH included a lack of front-line workers, over-staffing in certain areas, and inefficient staffing structures that have led to uncertainty regarding accountability. HMA emphasized the need to sufficiently and appropriately staff the front-end of the network (i.e., primary care) in order to retain its clients. HMA also identified a lack of clear messaging to contract and labor partners regarding the future need for staffing flexibility as a result of the new environment.

Recent achievements to improve staffing flexibility, efficiency, and hiring include:

- **Implementing LEAN at SFGH**: To improve efficiency in select hospital units, SFGH adopted the process and quality improvement method known as "LEAN" in 2012. Through August 2013, 35 staff have taken LEAN certification training, four units have undergone a value stream mapping process to increase efficiency, and 11 "Kaizen," or rapid improvement events, have taken place.
- **Hiring Key Leadership and Messaging:** Prior to January 1, 2014, DPH began to hire and staff key leadership and staff positions described in Chapter 1, Strategy 1, who have begun to educate and inform key partners of the impacts of ACA on staffing.
- **Measuring Staff vs. Volume.** DPH has prioritized the measurement of staffing needs. HMA developed a productivity measurement tool as a first step in helping SFGH leadership identify staffing compared to volume, with high-level comparisons to select hospital systems across the country.
- **Identifying Physician Recruitment Issues.** HMA identified the high cost of living in San Francisco compared to relative salaries offered at DPH as a key barrier to primary care physician recruitment and retention. Refer to Appendix III for information regarding physician pay-for-performance incentives.
- **Creating an HR Strategy for PCMH.** HMA recommended the creation of a human resources strategy specific to the Network's adoption of the Patient-Centered Medical Home (PCMH) model. This includes developing the competencies, job descriptions, performance evaluation, and identifying essential positions specific to PCMH teams. HMA recommended closely linking competencies in training programs and ongoing competence building for PCMH practices. See Chapter 1, Strategy 1 for more information.

In sum, the Network must continue to track staffing and patient volume while proactively and creatively recruiting, training, and redeploying its staff and physicians, with a focus on matching supply to demand (clients and volume).

Information Technology Strategies

The new healthcare environment must be accompanied by robust data and reporting systems that enable identification of key issues and trends. The backbone to creating a fully integrated delivery system within DPH is to integrate information systems containing client clinical records. Currently, the Network has over 50 systems that contain medical and psychosocial information, however many of the systems are not integrated with each other which can lead to misunderstandings and inefficiencies (refer to Figure 3).

In addition, HMA found there is a lack of useable data across the system. The Network is hampered by the multiplicity of data sources, a lack of financial data (granularity or matching operations properly), and often a distrust of the validity of the data produced. There currently is an inability to combine data sources to facilitate accountability and effective planning. At the same time, DPH staff and partners are overwhelmed with the amount of data currently required to be collected and reported (e.g., regulatory, research, grant program evaluation).

DPH has made strides integrating its approach to information technology (IT) development through home-grown innovative approaches to connectivity and the recent on-boarding of DPH's Chief Information

Among many IT needs of the Network, implementing system-wide electronic health records and financial management solutions will be critical to success under the ACA.

In the short term this requires significant planning and identification of sustained financial resources.

Officer (CIO), but is still significantly behind other delivery systems in the establishment of an effective and integrated IT system. DPH is committed to the long term implementation of a system-wide electronic health record system (EHR)[17], but in the short term, immediate solutions are needed to support connectivity, client management, and financial accountability. To accomplish this, DPH must as soon as possible (1) develop an overarching IT strategic plan and (2) identify and implement a sustainable financing strategy to support the long term plan. Otherwise, the adoption of fragmented systems without linking each new system to the overall strategy leads to inefficiencies.

Develop a Short Term and Long Term IT Strategic Plan

DPH's hiring of its CIO was a key step in reorganizing and integrating the IT organizational structure. For the short term, HMA provided strategies and helped the Network to approach interim solutions.

1. **Assessment.** Prior and during the HMA engagement, a preliminary assessment of the existing IT systems took place. Moving forward DPH must immediately conduct a formal assessment of the IT system options and identify a system-wide, interim solution in lieu of an expensive, stand-alone EHR.
2. **Interim Interfaces.** Using the formal assessment results, the second, complimentary approach is the strategic implementation of interfaces and updates to software and hardware, including the IT recommendations for ambulatory care discussed in Chapter 1. The Network is now exploring the following options prior to the identification and purchase of a large EHR or financial solution:
    - **Reporting.** Reporting tools that provide standardized reports across multiple systems. These tools, including data visualization, may cost in the thousands of dollars per license annually.
    - **Business Intelligence/Decision Support.** Tools aimed at providing a means to aggregate, analyze, and report key financial information. In some cases, these tools can cost hundreds of thousands of dollars, and relies on feeds from existing systems in lieu of a larger integrated solution. The Controller's Office provided DPH with some benchmarking information in this area.

However, in the long term the Network must assess, develop, and implement a robust and sustainable IT infrastructure, including a single EHR solution, to support the comprehensive services provided. Through Controller's Office benchmarking interviews, a single EHR may cost approximately $200-$300 million to develop and implement, and requires significant ongoing staff commitment and support. DPH is already exploring the implementation and ongoing maintenances costs for a single EHR solution with a technology consultant.

Regardless of the specific solution obtained, an integrated IT system and strategy must include:

- An application that provides dashboards and reports client information using a data warehouse
- Standardization and interoperability, enabling the quality measurement, coordinated care, and financial rigor required by the new ACA environment
- Population care management tools that allow for tracking and optimization of key prevention and disease management outcomes
- An integrated, county-wide health information system for clinical, quality, and financial measures
- Training and staff support

[17] Electronic Health Record: a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR has the ability to generate a complete record of a clinical patient encounter including evidence-based decision support, quality management, and outcomes reporting.

Identify and Implement an IT Financing Strategy

A diverse and sustainable financing strategy must be developed to support the resulting long term IT Strategic Plan. The Mayor's Office, Controller's Office, and the Committee on Information Technology (COIT) will be key stakeholders in supporting the final strategy. Purchasing and implementing a network-wide EHR is not only a significant financial commitment but there is also a resource commitment for leaders and staff to utilize the system to its full potential. HMA recommended two strategies to finance this large commitment.

1. **Partnerships**. During the HMA engagement the following stakeholders were identified as highly interested or proceeding with EHR implementation. The key to this recommendation is to engage stakeholders in the planning process to determine the type of partnership and mutual investments that could help offset the cost of EHR implementation. Examples of these benefits include the following:
   - For the *UCSF Medical Center*, a shared EHR would significantly improve communication and the sharing of information between SFGH and UCSF providers and UCSF residents, resulting in better care coordination.
   - For the *UCSF Medical School*, training residents and performing research may be easier and more cost effective with quick access to client data through a shared EHR.
   - For the *San Francisco Health Plan (SFHP)*, an EHR will result in higher levels of compliance and a higher ranking among health plans.

2. **Self-Financing**. Of the numerous financing options explored through the HMA engagement, HMA recommended self-financing as a possible sustainable option. This option could improve long term financial performance and operations and would reinforce the cost-conscious culture created by health reform.

   In the long term, self-financing can be achieved through a change in DPH's control over surplus funds. During its engagement, HMA pointed out that when annual surpluses are available to an enterprise organization, they can be used for needed investments in information technology, infrastructure, or other needs. In this arrangement, there is an incentive to find innovative, cost-effective solutions to challenges so that surpluses can be carried over and utilized for long term projects.

   Currently, SFGH is listed as an enterprise fund within the City budget. SFGH and DPH overall are still supported by and reliant on the City's general fund. Conversely, the City can sweep any remaining funds at year-end back to the general fund. Since any surplus monies if they occurred would be returned, the desire to find innovative solutions to operational and reimbursement challenges is muted since there is a lack of incentive to save or increase revenue.

> DPH and the City will need to commit to significant investments in human resources, information technology, and clinic facilities in order to meet the ACA requirements for patient care access and quality improvement, and to achieve financial sustainability.

In sum, the Network and DPH should develop a clear IT strategy and sustainable IT financing plan, which include exploring potential partnerships and engaging the major financial stakeholders of the City.

APPENDIX III: PARTNERSHIPS

ACA Impact on Partnerships

In light of the new healthcare environment which aims to cover more people, improve quality, and rein in costs, partnerships will become all the more important. DPH and the Network must build and strengthen its strategic partnerships and collaborations to increase revenue and manage costs.

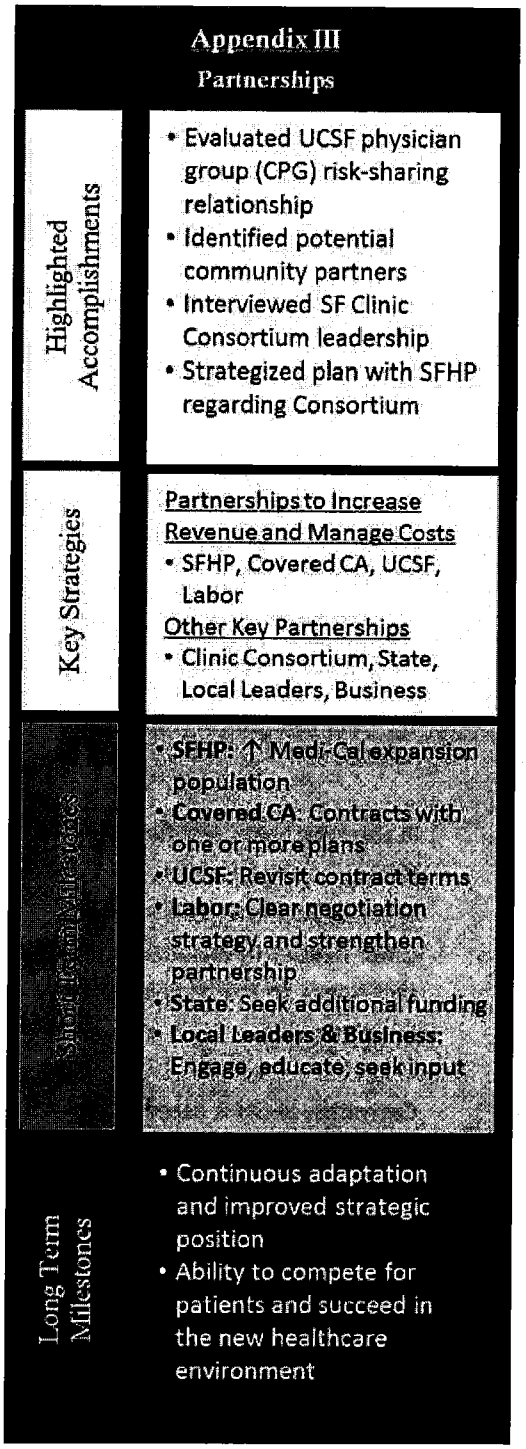
Partnerships to Increase Revenue and Manage Costs

As discussed in Chapter 2, the recent DPH reorganization and development of the San Francisco Health Network (the Network) has established a new Managed Care Office. Although the recruitment of a Managed Care Director is still pending (who would lead much of this work), the HMA engagement identified key partnerships and risk arrangements to help increase revenue and manage costs.

San Francisco Health Plan

With HMA's expertise, the Network worked closely with the San Francisco Health Plan (SFHP)[18] to create a plan to contractually to set up contracts for sharing capitation payments with consortium clinic partners. Moving forward, the Network must next work closely with SFHP to accomplish the following strategies.

1. **Medi-Cal Expansion Population Enrollment Strategy**. The Network should work with SFHP to continue to reach out to the potential Medi-Cal expansion population.
2. **Assess Division of Financial Responsibility**. The Network should re-assess the current division of financial responsibilities with SFHP. This is spelled out in a contract exhibit used by health plans and providers to identify payment obligations. By describing all service categories and designating the entity fiscally responsible, the agreement governs the risk arrangement between the organizations.



[18] San Francisco Health Plan: SFHP is a licensed community health plan that provides affordable health care coverage to over 80,000 low and moderate-income families. It is one of the two Medi-Cal plans offered in SF County and also acts as the Healthy San Francisco program's third party administrator.

3. **Explore Future Collaborations and Plans.** The Network must assess the current services received as part of the four percent administration fee to SFHP for Medi-Cal administration and determine additional mutually beneficial investments and collaborations, such as the investment in an EHR system discussed in Appendix II. SFHP would benefit from a continued close partnership due to the expansive set of services and providers offered through the Network. The Network would also benefit due to the large number of Medi-Cal enrollees and potential Covered CA enrollees (if SFHP decides to become a qualified health plan on the Exchange).

In the future, a successful partnership and enrollment strategy with SFHP will result in an increased share of the Medi-Cal expansion currently underway and its related client revenues.

Covered California Health Plans

As described in the background section and in Chapters 2 and 3, Covered CA currently offers five qualified health plans for San Francisco residents. During the HMA engagement, the Network explored contracting with one of the five plans. As of the end of 2013, the Network still is not currently a provider within any of the qualified health plans. In the medium and long term, the Network should continue to pursue this possibility and Network leadership has committed to doing so through its new Managed Care Office.

University of California, San Francisco

As described in Chapter 3, the Affiliation Agreement with UCSF is a critical partnership to providing the system's quality patient care, but it is also a growing cost that cannot be sustained over the long term, with an increase of more than seven percent alone from FY13 to budgeted FY14 costs. In addition, UCSF physicians possess a significant amount of control over operational efficiency in the Network but HMA found without a clear and structured mechanism for accountability. Thus there is an opportunity for expense control through the successful management of this Agreement.

During its engagement with DPH, HMA recommended the Network re-evaluate, and through negotiations, build a stronger and more strategic collaboration with UCSF via these strategies:

- Reduce SFGH operating costs and make the Network more cost-effective and market competitive
- Encourage UCSF and its faculty to support the goals of the Network through better accountability
- Encourage UCSF to support the DPH operationally and financially (i.e., in the implementation or sharing of an Electronic Health Record (EHR) as described in Appendix II)

An extensive delay in obtaining valid and reliable UCSF physician cost data was a major challenge in HMA's analysis.

To solve this, additional contractual reporting requirements will be added to the UCSF Affiliation Agreement over the next two years.

Through the HMA engagement, DPH has already recommended the use of utilization rates as a strategy to refine and simplify risk-sharing under the capitated contracts between UCSF's Clinical Practice Group (CPG) and SFGH. In the medium term, the Network plans to continue to work with SFHP and UCSF to develop a clear payment methodology and incentive structure for the CPG.

As a result of the HMA engagement and the lack of data necessary for tracking and analysis of UCSF expenses at the hospital and Network level, HMA recommended the following strategies to bring the UCSF Affiliation Agreement in line with more recent affiliation agreements across the country.

- **Physician Pay-for-Performance**. Physician compensation based on performance metrics is growing across the country and is now more common than not in group practices. At-risk compensation amounts to about 7 percent of physician pay, on average. Public hospitals have been generally slower to adopt "pay for performance" for physicians. Even fewer public hospitals that contract with universities utilize this practice; however, several notable public hospitals have begun such incentive programs and more are considering their implementation, including New York City Health and Hospitals, Minneapolis/Hennepin County, and Denver Health. Common components of compensation goals for physicians include productivity, quality of care, and other institutional goals related to operations and finance.
- **Metric Requirements, Risk-Reward Provisions, and Contract Management**. In the medium term, additional risk-reward provisions through the use of metrics should be explored, as well as closer contract monitoring and management.
- **Restructuring for Accountability**. In the long term, a re-assessment and potential restructuring of the Agreement to ensure a clear mechanism for accountability.
- **Benchmarking Assessment**. In the short term, additional benchmarking of affiliation agreements between hospitals and academic institutions is needed to inform the types of reporting requirements for the Agreement.

Labor

In health care markets, employee organizations and their agreements with health provider organizations significantly impact the cost of doing business. The City values its employees as the most important asset in providing quality health care to its residents. However, according to HMA many of the Network's private and non-profit competitors, as well as other public health systems across the country, have the ability to change faster than in San Francisco. To meet the goal of adapting to the new environment, therefore, DPH and the City must identify and effectively strategize for the outcomes most important to the Network's success in its labor agreements.

During the HMA engagement and during DPH's roll-out of the new Network, DPH leadership reached out to its employee organizations regarding the updated changes. DPH and the Network have committed to continue this outreach and partnership, which will be crucial to facing the health care changes together and making the Network and the greater health system viable into the future.

During the HMA engagement, some benchmarking data on staffing and volumes was gathered, as available. This will help the Network assess staffing needs (supply) versus volume (demand), as described in Appendix II. SFGH has committed by the end of FY14 to begin to supply data to a shared database sponsored by the University Healthcare Consortium and will have the ability to receive benchmark staffing and volume data from peer hospitals. An additional product is still pending from HMA regarding budgeting and staffing for the new building at SFGH. This improved information, combined with planned collection of Network performance metrics, will aid in developing a clear strategy and attaining a strengthened relationship with the Network's labor partners.

Other Key Partnerships

Clinic Consortium

The San Francisco Clinic Consortium is a group of community-based, non-profit health clinics, inclusive of a select number of the Network's community clinics. During the HMA engagement, DPH interviewed and informed Clinic Consortium leadership to discuss and share the new Network's strategy. In the medium and long term, the Network and its Ambulatory Care leadership need to continue to engage the Clinic Consortium, assessing this partnership and the associated opportunities and risks.

State of California

As discussed in Chapter 3, it is essential that the Network maintain a positive working relationship with the state, pursuing opportunities for improved reimbursement and new programs. The state will remain a critical, ongoing source of funding in the new environment, playing a central role in key revenues such as Medi-Cal rates and Realignment funding. Please refer to Chapter 3 for specific initiatives and strategies.

Local Leaders and Decision Makers

The City and County of San Francisco's departments, the Board of Supervisors, the Health Commission, and the Mayor's Office have historically provided strong financial support for the DPH mission. In the short term, DPH must educate local leaders and decision makers on the impact of health reform on DPH and the entire health care system in the city. DPH leadership in conjunction with the Health Commission has committed to look to target support to the areas that will have the most profound and positive impact on the health system's operational and fiscal future.

Business Community

As a key provider of health care coverage, the business community is a key stakeholder that DPH must continue to have an open dialogue and partnership with for ACA to succeed in San Francisco.

The Mayor's Universal Healthcare Council (UHC), a diverse group of public, business, health and education stakeholders, was re-convened in 2013 to identify and assess issues resulting from the intersection of the ACA and the City's Health Care Security Ordinance (HCSO). The 41-member UHC was co-chaired by Director Barbara Garcia and Dr. Sandra Hernandez, former CEO of The San Francisco Foundation. The data-driven process did not seek consensus from all members, but did examine San Francisco's implementation of the federal ACA and provided a summary report with collected recommendations from the group.

As health reform and its impact on the business and labor communities unfold over the next few years, DPH and the City must remain engaged in the issues and challenges that arise. Additional information regarding the UHC can be found at http://www.sfdph.org/dph/comupg/knowlcol/uhc/default.asp.

BOS-11 cpage

Subject: San Francisco MUNI

In my opinion, as a concerned citizen, I believe that we need to freeze the MUNI fare hike. San Francisco MUNI has been depleting their manual budget and burning through tax payer dollars in a feeble attempt to repair a system that is broken down beyond repair.

San Francisco is among the most expensive cities to live in nationwide. We need to band together and help one another or we will be lost. We have got to stop our dependence on bleeding out the weak, the disadvantaged, and those individuals earning under $60k annually. On January 28th, 2014, San Francisco Board of Supervisors held a board meeting in which they agreed to purchase a total of 60 trolley buses at $94,950,444. Shortly after this meeting, San Francisco MTA held a meeting proposing fare hikes. Passengers cannot afford any more increased to their cost of living.

I believe a better solution is to create a referendum allowing voters to decide on the following:

1) That all department heads and MUNI employees earning more than $100k annually should be subject to a 10% cut in pay;
2) That all department heads and MUNI employees earning more than $200k annually should be subject to a 20% cut in pay;
3) Individuals selected to pay cuts will be remunerated for the loss when MUNI is in a healthy fiscal state.

Obviously this is just one man's opinion and the proposal I've outlined might be in need of some refinement. The point I am making is that if MUNI continues to be a problem due to their inefficiency, perhaps, the city of San Francisco will have no alternative but to outsource the transit system that have a proven track record of success.

Thank you for your attention,

Sign

Thevoice.fitch3@gmail.com

No exception: A Call to Action

Kids, black, Latino, or white, our mission is their safety no matter what the child's parents' income. A child is a child. A child is not responsible for his or her parents' hourly wage, they are not responsible and they shouldn't be held accountable.

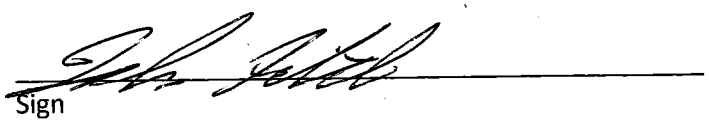
Minority kids are not a victim of bad luck. Kids don't get to push a button to order what color hair they want, what color eyes, or what type of nose they want. They have to be thankful for who you are. They don't need to be pacified. This is 2014! A cup of coffee is not the only thing integrated in San Francisco. We must stop living in the past; what's good for one is good for all. Love all, trust a few, do wrong to none.

Some individual parents step up to the plate to provide for their children and take care of his woman. Anybody can get a woman, but not everyone can take care of that woman. That's called responsibility.

These are kids. Kids are forever losing and forgetting things. No child should be put off a San Francisco MUNI bus because of failure to pay. There is too much mob action going on in various districts; if SF MUNI allows these ideas to work you will have leverage when it comes time for a fare increase.

In closing, we don't have to agree on everything but we have to agree on doing something.

We move forward only when we do so together.



Sign
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BOARD of SUPERVISORS

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Date: March 10, 2014

To: Honorable Members, Board of Supervisors

From: Angela Calvillo, Clerk of the Board

Subject: Form 700

This is to inform you that the following individuals have submitted a Form 700 Statement:

Harvey Rose – Budget & Legislative Analyst – Annual
Debra Newman - Budget & Legislative Analyst – Annual
Jason Fried – LAFCo – Annual
Lauren Kahn – Legislative Aide – Leaving
Matthias Mormino - Legislative Aide – Annual