San Francisco
Department of Public Health

Annual Report
Fiscal Year 2002-2003

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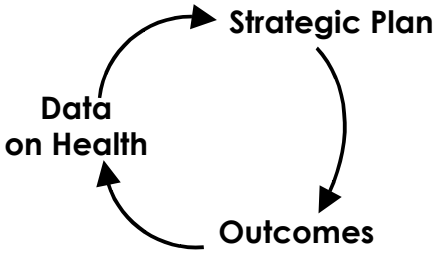
Message from the Director

I am pleased to present the Annual Report for the City and County of San Francisco Department of Public Health for fiscal year 2002-2003. This year's report is formatted differently than in previous years.

We have taken the information that was historically presented in three separate publications – the Annual Report, the Strategic Planning Update, and the State of the City Public Health Address – and consolidated it into one comprehensive report.



We have done this because we believe that the three documents represent an important circle of planning and accountability, whereby our strategic plan is guided by health status data and the health status data is the ultimate evaluation of our outcomes, and the most important input for updates of our strategic plan.

The Department's challenge during the last fiscal year was to do more with less. Fiscal crises at the local, State and federal levels, increases in the costs of providing standard of care within the Community Health Network due to new medications and procedures becoming available, inflation in the cost of providing care and treatment, and increased demand for our services, have all required us to look at more creative ways to fund and operate our programs. I am very proud of our staff's efforts to accomplish this daunting task.

Although the City General Fund contribution to the Department's budget decreased by $16 million between Fiscal Years 2001-2002 and 2002-2003, the Department's total budget increased by $62 million. This increase – which allowed the continuation of vital services – was possible because the Department successfully competed for grants resulting in a $14 million increase in grant revenues. In addition, efficiencies in billing

third-party payers resulted in increased Medi-Cal and private insurance payments. Further, our Office of Policy and Planning worked with the Mayor's Office, the California Association of Public Hospitals and Assemblyman Dario Frommer to pass legislation at the State to establish the Medicaid Hospital Outpatient Supplemental Reimbursement Program, which allows San Francisco General Hospital (SFGH) to draw down additional federal Medicaid dollars to help meet the unreimbursed cost of providing outpatient services to Medi-Cal beneficiaries. The Department expects to receive approximately $1.5 million annually from this program to help address the budget shortfalls that are expected to continue for the foreseeable future.

Besides finding ways to increase our grants and revenue budgets we also developed creative and cost-effective ways to expand and enhance programs and services for San Francisco residents. For example, the Patient Flow Pilot Project at SFGH focuses on the timely transition of acute psychiatric patients to the next appropriate level of care. This ensures that psychiatric patients receive the care they need in the least restrictive setting possible and also reduces the number of acute days at SFGH that are decertified by Medi-Cal because the patient no longer needs this high level of care. We also are using technology wherever possible to do more with less. For example, the Public Health Laboratory in collaboration with the Department's Sexually Transmitted Disease (STD) Control Unit, installed a new machine that allows the laboratory to process more tests for STD infections without increasing staff.

With a large community focus on homeless issues, the Department implemented several new initiatives aimed at serving this vulnerable population. Among the Department's most successful and innovative programs is the Direct Access to Housing (DAH) program. In Fiscal Year 2002-2003, the Department's Office of Housing and Urban Health (HUH) moved 107 formerly homeless San Franciscans into permanent, supported housing at the Camelot and Star Hotels. The addition of these two new DAH hotels brings the total number of facilities to six and the total number of units to 393.

To further address the needs of the homeless population, the Department established a new program to serve homeless public inebriates. The McMillan Drop-In Center, a collaboration of the Department's Tom Waddell Health Center and Chemical Awareness Treatment Services, provides a place for homeless public inebriates to sober up safely. Once sober, clients have access to medical, behavioral health, housing, and case management services to assist in their recovery. In addition, because public inebriates place a considerable burden on the emergency health care system, we expect that this new program will reduce inappropriate ambulance trips and emergency room visits. This program was funded by contributions from private nonprofit hospitals in San Francisco, and by assuming that the facility will decrease the expense of caring for this population in the SFGH Emergency Department.

In addition to addressing the significant issues of budget cutbacks and homelessness, the Department maintained its core public health responsibilities and was able to rapidly respond to emerging public health threats that surfaced in fiscal year 2002-03, including smallpox, SARS and syphilis. To improve our capability to respond to a large-state health emergency the Department held a practice drill in June. Over 700 volunteers and 200 DPH staff volunteers participated in the mock inoculation drill making it the largest bioterrorism exercise conducted to date in the United States.

The SARS (Severe Acute Respiratory Syndrome) epidemic surfaced in early 2003. Though there were no SARS cases in San Francisco, the Communicable Disease Control Unit acted quickly to ensure that San Francisco clinicians, hospitals, ambulatory care settings and the general public were provided with education and outreach about the disease. A SARS web page was created as part of the Department's Internet site. Fact sheets on SARS were created for the general public and were available in English, Chinese, Vietnamese, Spanish and Tagalog. Communicable Disease Control Unit staff made presentations on SARS at the University of California, San Francisco, at San Francisco General Hospital, and at the San Francisco Clinic Consortium. In addition, we created a SARS Information Hotline that continues to provide recorded information on SARS in English and Chinese 24 hours per day.

In 2002, syphilis cases in San Francisco rose to epidemic proportions with nearly a 160 percent increase in cases compared to 2001 primarily occurring among men who have sex with men. The Department's STD Program responded to this health emergency by developing a syphilis reduction plan for the City, that included educating health care providers, placing regular advertisements in the local weekly gay newspaper, implementing an on-line syphilis testing and incentive program, and implementing a partner-delivered therapy program.

I am fortunate to be a local health director in a city that so strongly supports public health and health care services and to work in a department with such a committed and knowledgeable staff. Our ability to meet the health needs of our community is dependent upon the caliber of our workforce. I am proud and appreciative of their expertise, their dedication, and their spirit.

My continued gratitude to the Mayor, the Board of Supervisors, and the San Francisco Health Commission for their leadership, their support and their commitment to health. They have made San Francisco a leader in health care and health care access. I look forward to our continued work together to improve the health status of all San Franciscans.

November 2003

Mitchell H. Katz, M.D.

Who We Serve

This chapter explores the demographics of both the county's overall population and of the clientele of the major programs and services offered by the Department.

SAN FRANCISCO'S DEMOGRAPHICS

San Francisco's demographics include a various characteristics of the county's population, such as age, sex, ethnicity, language, and household structure. Since there are notable differences in health and conditions relevant to health based on the distribution of ethnicity, sex, and age, it is important to understand the composition of the San Francisco population whose health it is the Department's mission to protect and promote.

Population: Age and ethnicity/race

With a population of 776,733, San Francisco has the eleventh largest population among California counties according to the 2000 U.S. Census. Since 1990 San Francisco's population has increased 7.3 percent in contrast to a statewide increase of 13.9 percent. As is shown in Figure 2-1, San Francisco's ethnic makeup is unique when compared to the rest of the State with a significantly larger proportion of Asian/Pacific Islanders (31.3% vs. 11.2%), and smaller proportions of Latinos (14.1% vs. 32.4%) and whites (43.6% vs. 46.6%). Among the non-white groups, Chinese make up the largest single ethnicity in San Francisco.

Figure 2-1.

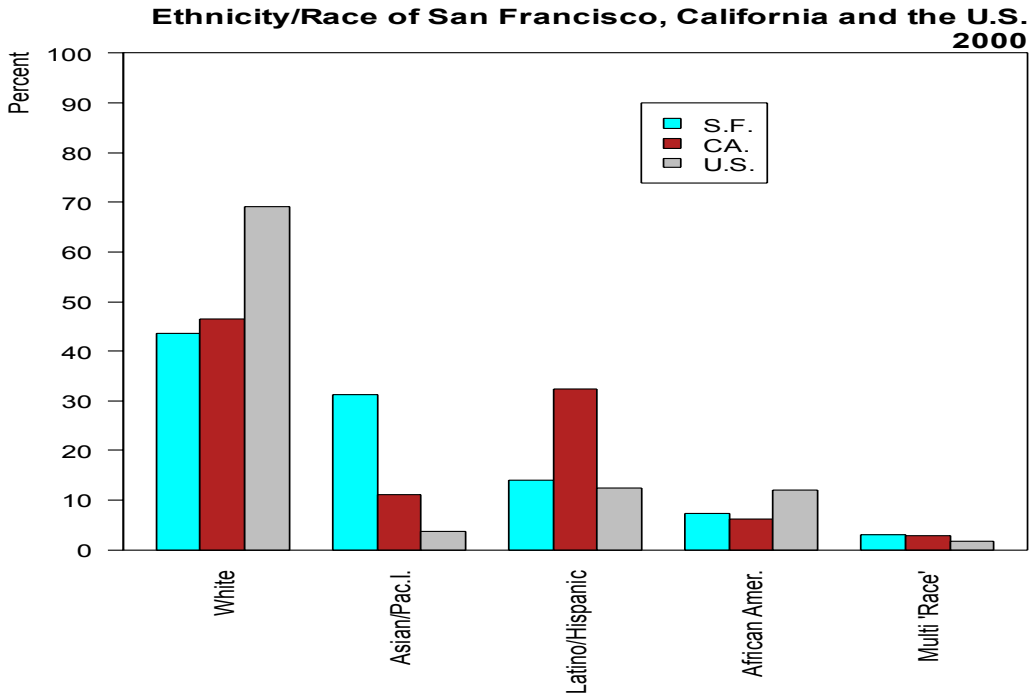
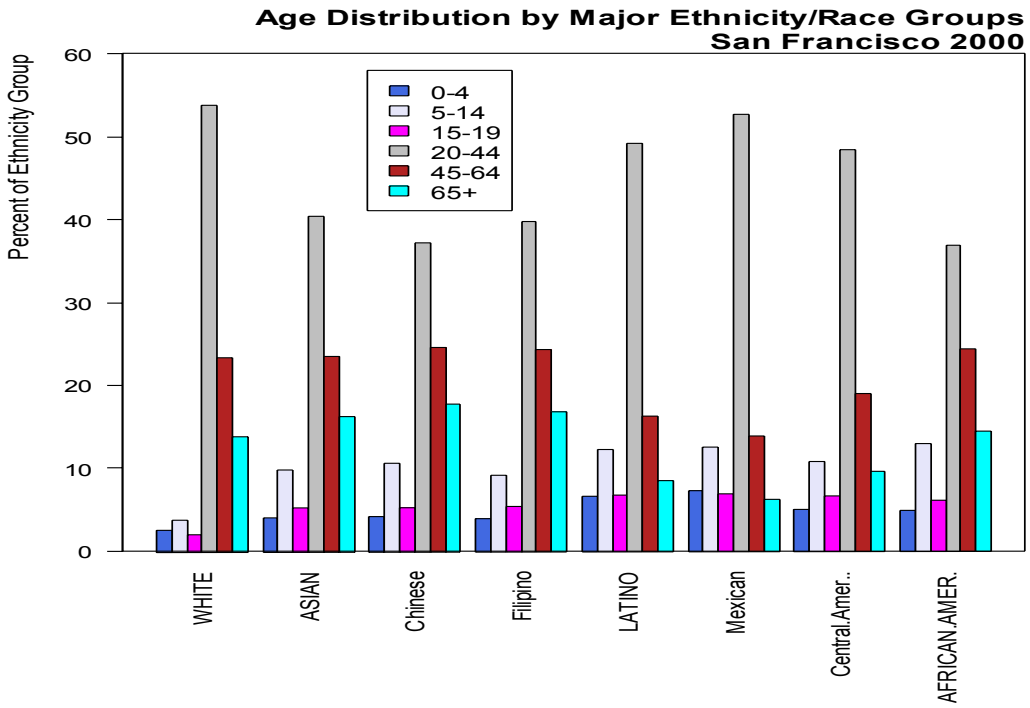


Figure 2-2 shows the age distribution by ethnicity. Whites have the lowest proportion of children and youth, and Latinos (especially from Mexico) the highest; Chinese and Filipinos have the highest proportion of people over age 65, while Latinos have the lowest.

Figure 2-2.



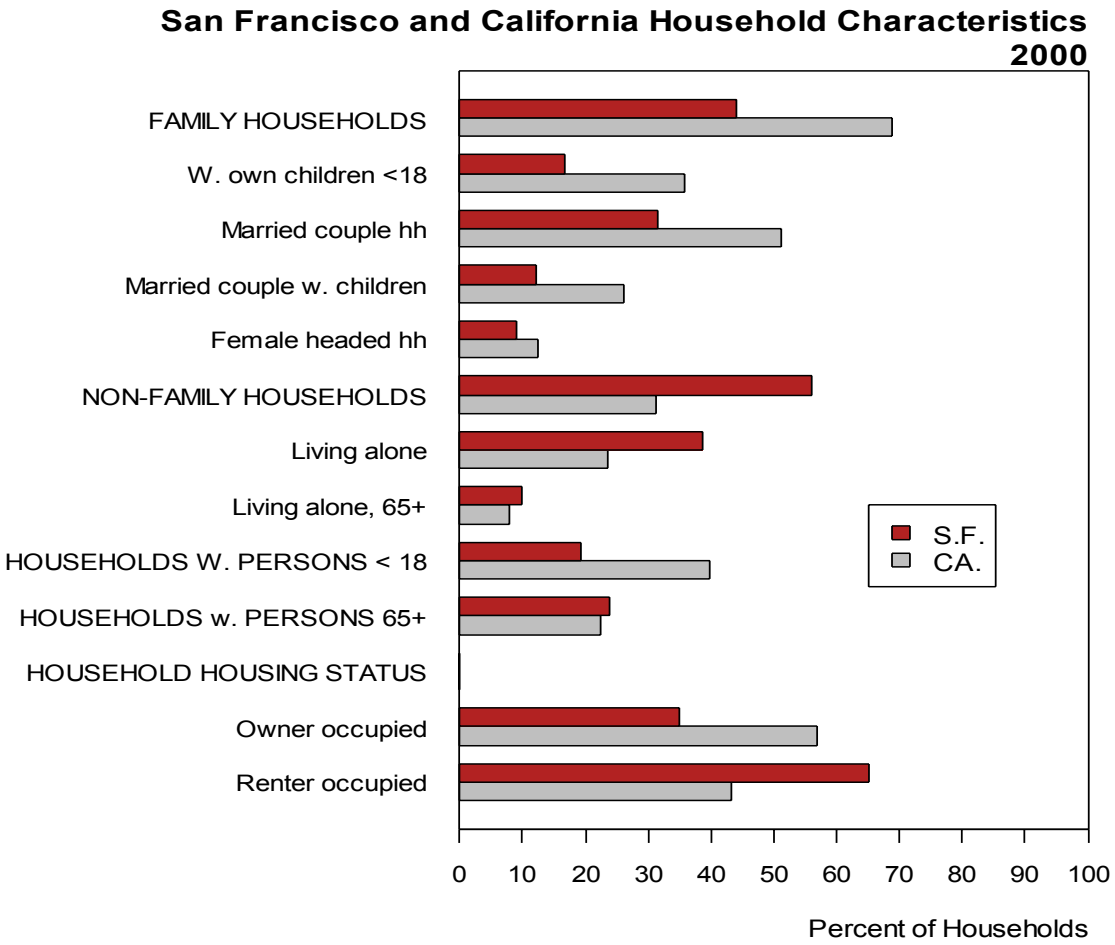
Household composition

The composition of San Francisco households reflects the City's large proportion of non-elderly adults, individuals living alone and residents in other non-family households. Figure 2-3 shows that when compared to California as a whole, San Francisco has:

- almost twice the proportion of non-family households;
- larger proportions of men and women living alone; and
- less than half of the proportion of households with children under age 18.

San Francisco has 127,000 single-person households (40% of all households), split evenly between men and women. However, a third of single person households of women are over 65, while only a sixth of those of men are over 65. Less than half of San Francisco's households are families (defined as having related persons living together). Even among married-couple families, only 40 percent have children under 18 in the household. About two-thirds of San Francisco's households are renting their housing, compared to 43 percent statewide.

Figure 2-3.



Immigration and language

The composition of San Francisco's population continues to be affected by the many immigrants coming into the City; two out of five San Francisco residents were born in foreign countries. They are split fairly evenly among those arriving here over each of the last three decades. Slightly more than half of these immigrants have become naturalized citizens. A smaller proportion of Latinos than Asians have become naturalized citizens; larger proportions of Latinos are U.S. born and non-citizens than among Asians.

Among the estimated 293,000 San Franciscans living in households where English is not the only language spoken, half of non-citizens (about 48,000 people) do not speak English well or at all, compared to about 38 percent of naturalized citizens (47,000 people) and only 1 percent of U.S.-born. San Francisco's households are characterized by considerable linguistic diversity. Almost half as many households speak any of the Asian languages (primarily Cantonese) as speak English, and about half that number speak Spanish.

A linguistically isolated household is one in which no member 14 years old or over (1) speaks only English or (2) speaks a non-English language and speaks English very well. In other words, all household members 14 years old and over have at least some difficulty with English.

Table 2-1. Linguistic Isolation of San Francisco Households and People by Ethnicity and Age.

	% Linguistically Isolated Households	% of Population of Age… in Linguistically Isolated Households		
		5-17	18-64	65+
All SF	13.3	19.2	11.9	25.1
White (NH)	3.7	5.2	2.2	10.7
Asian (NH)	36.4	34.6	28.0	48.2
Chinese	43.5	40.8	34.0	56.5
Filipino	15.0	14.0	9.2	19.7
Vietnamese	43.8	35.9	41.3	40.6
Japanese	26.6	21.4	16.6	29.8
Pacific Islander (NH)	8.7	5.0	4.6	19.0
Latino (Hispanic)	22.6	20.6	19.6	26.0
Mexican American	21.6	22.8	20.9	24.8
Central American	27.0	21.5	22.7	26.3
African American (NH)	0.8	0.3	0.7	0.2
Native American (NH)	4.4	5.3	4.3	0.0
Other Race Alone (NH)	9.4	7.0	8.0	19.1
Multiple Race (NH)	8.6	4.6	5.7	18.6

(NH) = Non-Hispanic

Table 2-1 shows the percent of households that are linguistically isolated by ethnicity, as well as the proportion of that ethnicity in each age group that live in linguistically isolated households.

Chinese and Vietnamese have the highest proportion of linguistically isolated households, and the highest proportion of people in each age group living in such households.

THE DEPARTMENT'S CLIENTS

The Department's programs and services are available for all residents and visitors. Many services, however, are relied upon by particular groups within the larger community.

Community Health Network

The Community Health Network (CHN) was developed and continues to evolve to meet the challenges of a rapidly evolving health care environment. Established as the division of the Department that encompasses all personal health care services, the CHN has the unique role of addressing the broad health needs of all San Franciscans, with a special emphasis and commitment to serving the City's most vulnerable, diverse populations. CHN's mission is to deliver humanistic, cost-effective and culturally competent care for the City and County of San Francisco. The CHN encompasses a wide array of services, maintaining the City's only Level I Trauma Center at SFGH. Major service components include primary care, specialty care, acute care, home care, long-term care, and emergency care.

The data provided in this section include the services provided at the Department's Primary Care Clinics and at San Francisco General Hospital Medical Center (SFGHMC). (Laguna Honda Hospital, though considered part of CHN, is summarized independently in the following section.) The Primary Care Clinics provide ongoing care to communities throughout San Francisco while SFGH makes a unique contribution to the City in a number of clinical, academic, and research areas: comprehensive emergency services, trauma care, AIDS care, mental health and substance abuse, forensics, medical education and medical research.

In Fiscal Year (FY) 2002-2003, the CHN provided health care services to 118,028 unduplicated clients. Throughout the system, the top diagnoses in order were:

Emergency Department	Acute Inpatient Care	Primary Care Clinics
♦ Abdominal pain	♦ Psychosis	♦ Hypertension
♦ Alcohol abuse	♦ Hypertension	♦ Diabetes
♦ Depressive disorder	♦ Normal delivery	♦ HIV disease
♦ Hypertension	♦ HIV disease	♦ Hyperlipidemia
♦ Acute Upper Respiratory Infection	♦ Pneumonia	♦ Depressive disorder

CHN Provided the following services

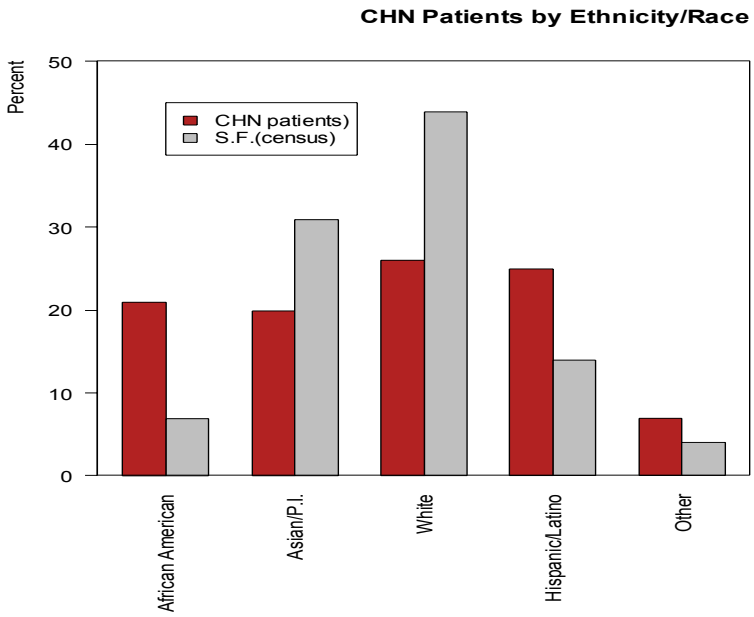
In FY 2001-2002	In FY 2002-2003
♦ 336,036 Primary Care Visits	♦ 323,552 Primary Care Visits
♦ 180,741 Specialty Visits	♦ 195,521 Specialty Visits
♦ 9,571 Dental Visits	♦ 9,377 Dental Visits
♦ 10,662 Urgent Visits	♦ 11,112 Urgent Visits
♦ 63,224 Emergency Visits	♦ 63,310 Emergency Visits
♦ 56,769 Medical Emergencies 14.7% Admitted	♦ 56,486 Medical Emergencies 15.1% Admitted
♦ 6,475 Psych Emergencies 33.5% Admitted	♦ 6,824 Psych Emergencies 35.9% Admitted
♦ 3,296 Patients Requiring Level 1 Trauma Center Services	♦ 3,300 Patients Requiring Level 1 Trauma Center Services
♦ 102,274 Acute Inpatient Days	♦ 100,695 Acute Inpatient Days
♦ 19,801 Home Health Care Visits	♦ 21,110 Home Health Care Visits
♦ 9,835 SFGH Skilled Nursing Days	♦ 10,016 SFGH Skilled Nursing Days
♦ 50,726 MHRF Skilled Nursing Days	♦ 43,232 MHRF Skilled Nursing Days

CHN patients by race and ethnicity

The CHN's patient population continues to have a high percentage of ethnic minorities. The hospital and Primary Care Clinics are a major health resource for culturally diverse populations, including new immigrants, and can accommodate patients who speak many languages other than English.

Figure 2-4.

The City's African-American and Hispanic/Latino populations rely on the CHN's services in significantly higher proportions relative to the City's population than do White and Asian/Pacific Islander patients as Figure 2-4 illustrates.

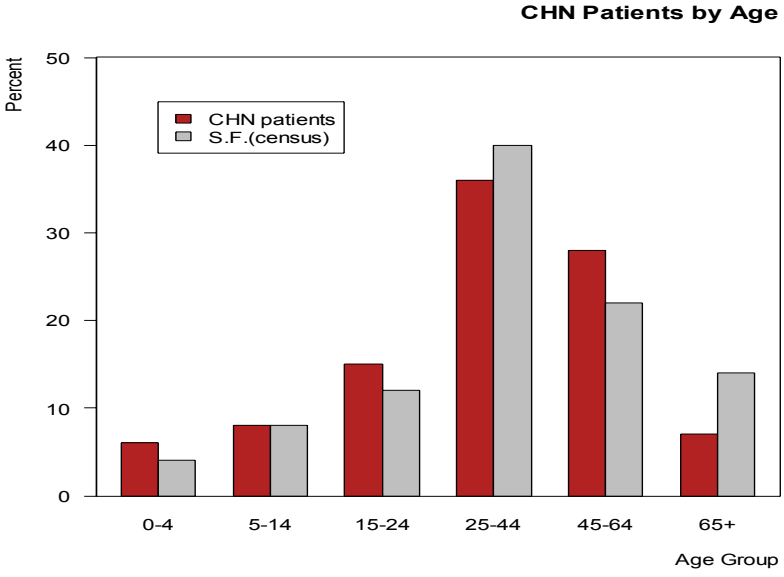


CHN patients by age

The age distribution of the CHN patients is similar to the age distribution in the City as a whole though adults ages 25 to 64 are represented in higher proportions, while fewer senior patients are served. Adults in this age group make up 64 percent of the patient population, while seniors make up only 7 percent and children and adolescents make up 29 percent.

Figure 2-5.

Figure 2-5 shows the ages seen in FY 2002-2003 at SFGH and the Primary Care Clinics.

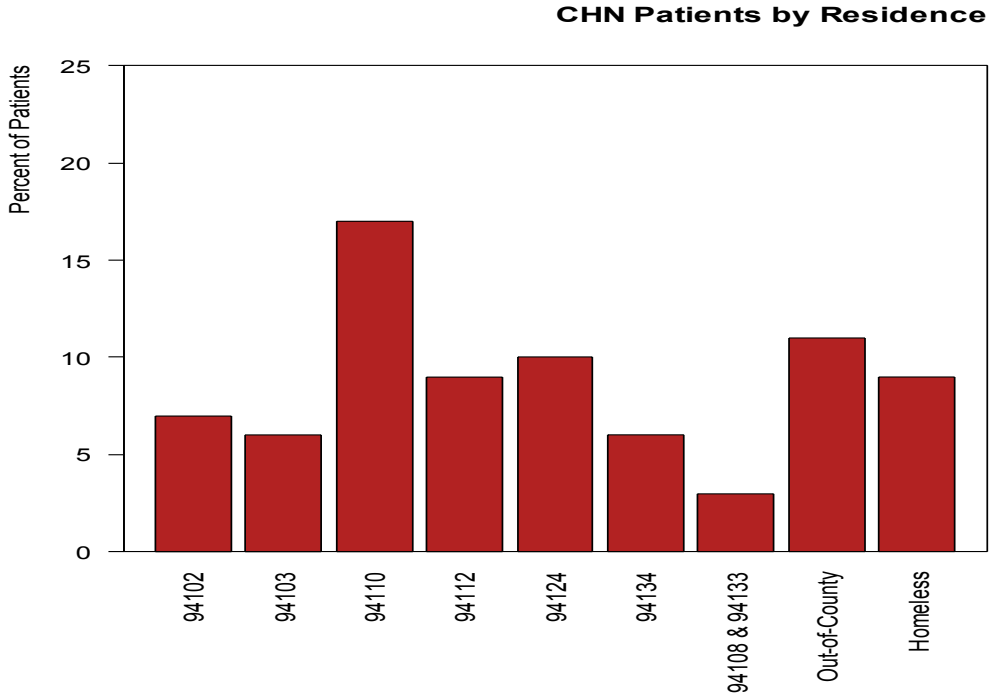


CHN patients by neighborhood of residence

The Department's Strategic Plan identifies seven target neighborhoods, with the goal of improving health care and improving health outcomes and eliminating health disparities among neighborhoods. These seven target neighborhoods represent 56 percent of the patients seen at the CHN in FY 2002-2003.

SFGH is the primary community hospital for residents living in the southeast and northeast sections of the City. Figure 2-6 shows that the greatest proportion of patients seen at the hospital and clinics in FY 2002-2003 lived in the Mission, near the SFGH campus. A significant percentage of patients (11%) were from out-of-county, a slight decrease from last year (13%). The percentage of homeless patients (9%) is unchanged from last year.

Figure 2-6.



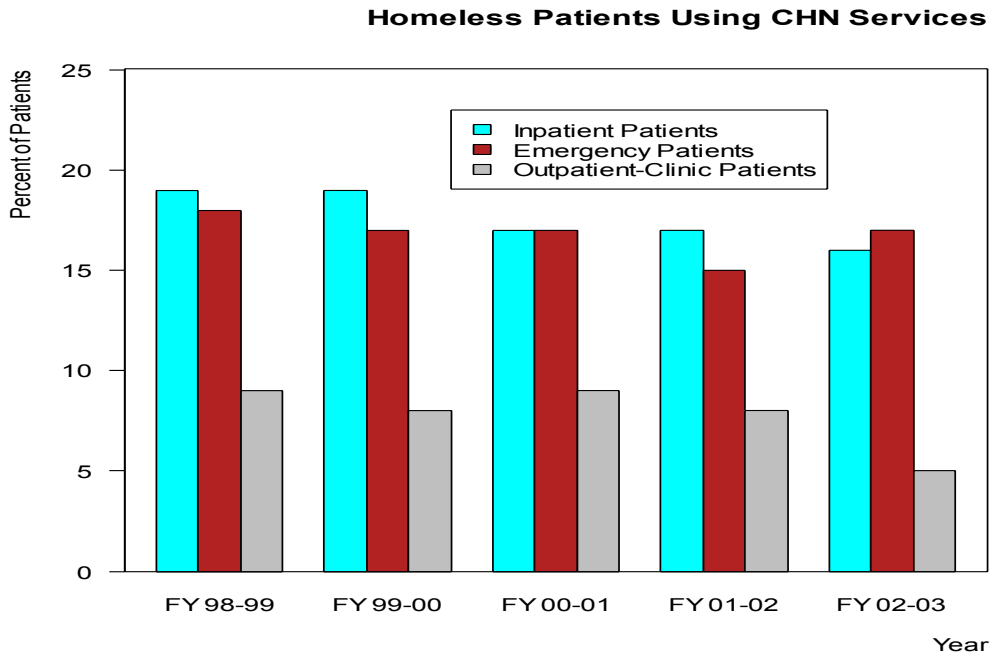
94102: North of Market, Tenderloin
94103: South of Market
94110: Inner Mission, Bernal Heights
94112: Outer Mission
94124: Bayview-Hunters Point
94134: Visitacion Valley, Sunnydale
94108 & 94133: Chinatown

CHN utilization by homeless patients

When a patient is seen at the hospital or a clinic, the Department's Registration Clerk requests a home address. If an individual does not provide a home address, or notes that he or she is living on the street, the patient is categorized as homeless. The accepted Citywide definition of homelessness is much broader than living on the street. It also includes individuals or families in shelters, staying with friends or extended family members, living in single room occupancy (SRO) hotels without tenancy rights, and more. Therefore, the data collected by the CHN represent a subset of the homeless population in San Francisco.

In FY 2002-2003, nine percent of the CHN's patients were classified in the registration system as homeless at the time of at least one visit. Overall, 24 percent of inpatient days, 24 percent of emergency care visits, and seven percent of clinic visits are by homeless patients. The percentage of homeless patients (an unduplicated count) for FY 2002-2003 was 16 percent for inpatient care, 17 percent for emergency care, and five percent for outpatient care. Figure 2.7 illustrates the percentage of homeless patients, registered without an address, seen at the CHN since Fiscal Year 1998-1999. Figure 2-7 shows a decrease in inpatients and outpatients, but an increase from last year in emergency room homeless patients. In all settings, however, fewer homeless are utilizing services than in previous years, 1998-1999 and 1999-2000.

Figure 2-7.



Laguna Honda Hospital and Rehabilitation Center

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) provides high quality long-term care and rehabilitative inpatient services. Services for City residents have been provided at Laguna Honda since 1866, when "The Almshouse" was established as a shelter for the homeless. The hospital quickly evolved when it was hastily called upon to treat smallpox patients during the 1868 epidemic. Later, in 1906, "The Relief Home" was called upon to provide care and emergency housing for victims of the earthquake and fire.

Shortly after, a hospital section for the chronically ill opened. In 1926, the first units of the main building were completed with the last units coming into service in 1940. Until the 1950's, there was no clear distinction between the respective services of Laguna Honda and SFGH; residents and interns rotated between the facilities and major surgery was performed at Laguna Honda. The rehabilitation center was state licensed in 1962. In 1963, Laguna Honda was accredited as a hospital.

LHH provided the following services:

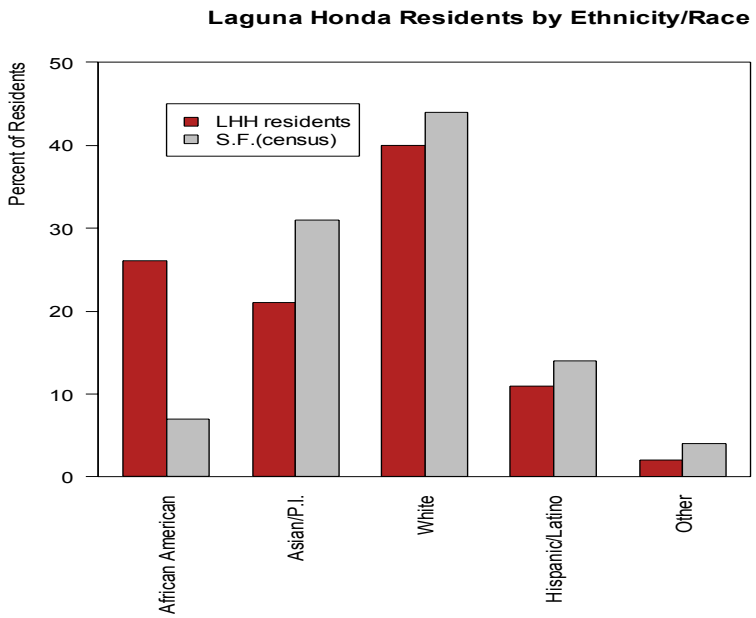
In FY 2001-2002	In FY 2002-2003
♦ 386,286 Skilled Nursing Days	♦ 378,412 Skilled Nursing Facility (SNF) days
♦ 2,668 Acute Days	♦ 1,385 Acute Days
♦ Served 1,662 residents	♦ Served 1,707 residents
♦ 1,059 = Average Daily Census	♦ 1,041.8 = Average Daily Census
♦ 10.5 days = Average Length of Stay in LHH Acute Units	♦ 9.5 days = Average Length of Stay in LHH Acute Units
♦ 393.2 days = Average Length of Stay in Laguna Honda Skilled Nursing Facility Units	♦ 408.9 days = Average Length of Stay in Laguna Honda Skilled Nursing Facility Units

Laguna Honda residents by race and ethnicity

Figure 2-8 compares the percentage of Laguna Honda patients in five racial and ethnic categories with the corresponding percentages for the City as a whole. These differences are consistent with the same comparisons for the CHN, with one exception. Utilization rates for the City's Hispanic/ Latino population are more than twice as high for all the CHN services than for Laguna Honda services (25% of all the CHN services vs. 10.5% of Laguna Honda services).

As is seen in other care settings of the Department, the African-American population is represents a larger proportion of LHH residents than of the City as a whole.

Figure 2-8.

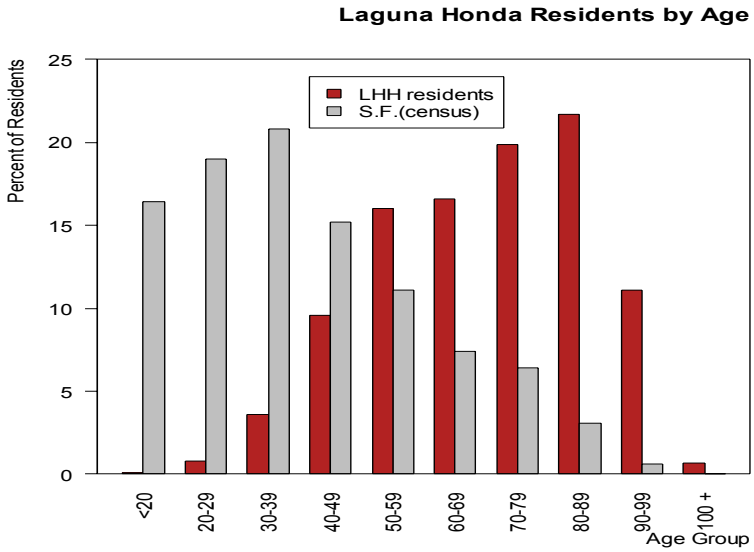


Laguna Honda residents by age

Laguna Honda residents are, on average, considerably older than other City residents. This characteristic is consistent with Laguna Honda's mission to serve the City's frail elderly and disabled, and also consistent with the Department's Strategic Plan goal to emphasize services to its target populations. Although seniors aged 65 and over-represented only 7 percent of the CHN patient population, they represented 64 percent of the population served by Laguna Honda during FY 2002-2003.

However, as can be seen in Figure 2-9, the entire age spectrum is represented at Laguna Honda. The largest difference from the previous year was in ages 21 through 54. Some 22 percent of the residents treated at Laguna Honda in FY 2002-2003 were in this category, as compared with 19 percent in this category at the end of FY 2001-2002.

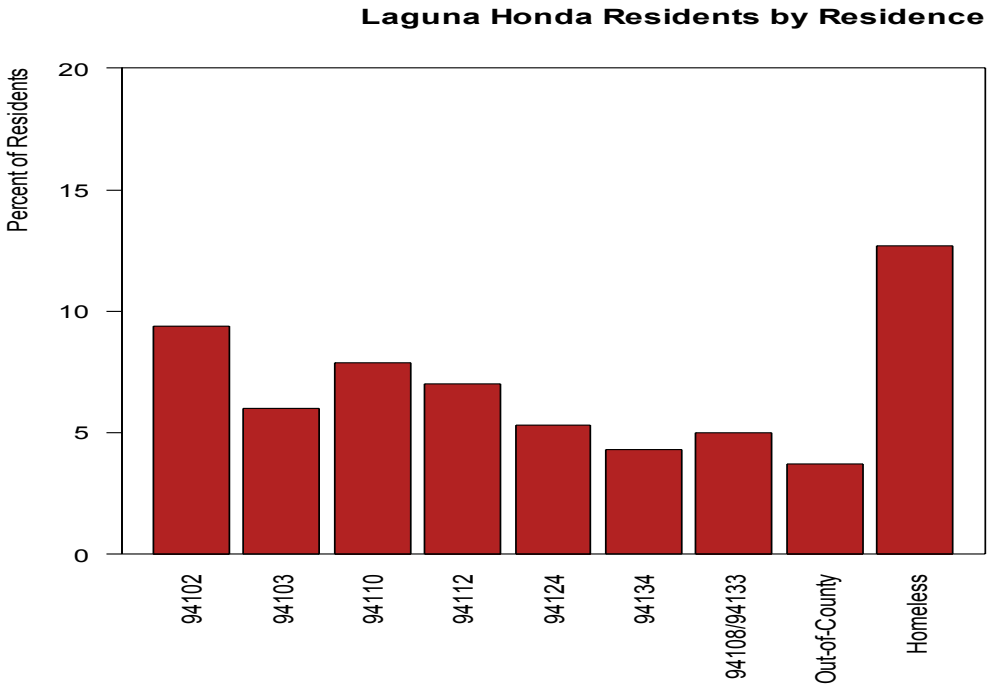
Figure 2-9.



Laguna Honda residents by neighborhood of residence

The Department's Strategic Plan has targeted seven neighborhoods where health outcomes should be improved and health disparities must be minimized. Figure 2-10 shows that about 45 percent of the individuals who received care at Laguna Honda Hospital during FY 2002-2003 came from these target neighborhoods. The homeless are another principal population targeted by the Department. About 13 percent of the individuals who received care at Laguna Honda Hospital during FY 2002-2003 were designated at admission as homeless, as compared with about 9 percent of all individuals who received care at any CHN site.

Figure 2-10.



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Laguna Honda Hospital admissions and discharges

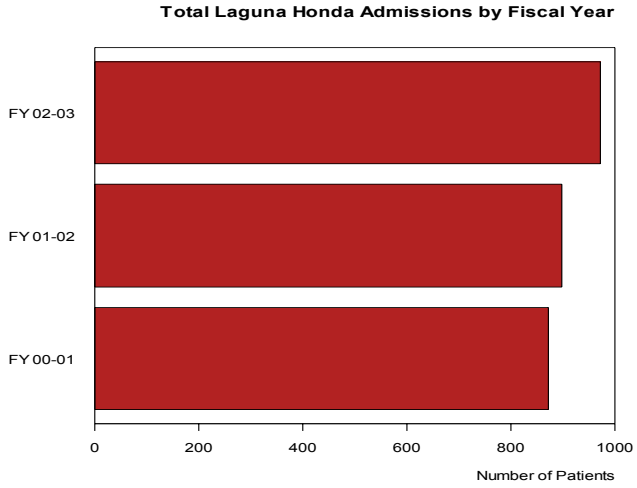


Figure 2-11.

The total number of admissions to Laguna Honda from all sources increased by 8 percent from 899 in FY 01-02 to 973 in FY 2002-2003.

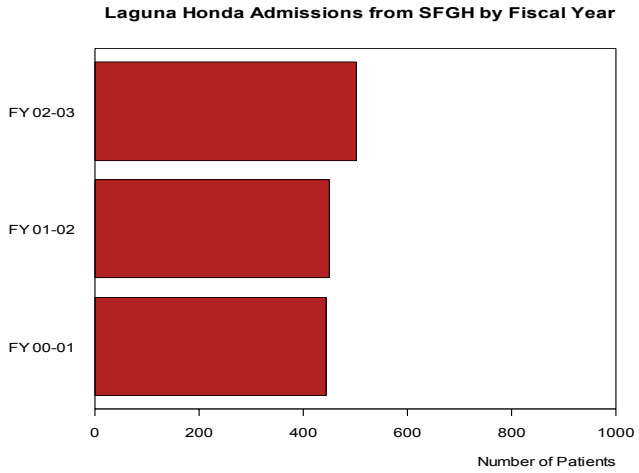


Figure 2-12.

The number of admissions from SFGH to Laguna Honda increased by 11 percent from 451 in FY 01-02 to 502 in FY 2002-2003.

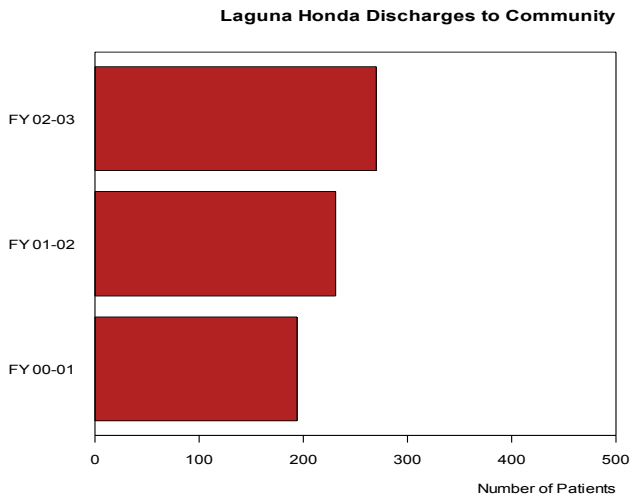


Figure 2-13.

Total Laguna Honda discharges to the community increased by 17 percent from 231 in FY 01-02 to 270 in FY 2002-2003. Discharges to the community are important because they increase access to beds for others in need of long-term care and because they reflect the success of LHH in the area of rehabilitation and reintegration into the community.

Community Mental Health Services

Outpatient mental health services are the mainstay of the Department's Community Mental Health Services (CMHS) delivery system. The Department partners with many community-based organizations and local governmental agencies in order to meet the needs of children, youth and adults in need of mental health services. Outpatient services include assessment, medication monitoring, and individual, couple and family therapy. These services are provided in many different locations, including Primary Care Clinics, in-home, at school, in supportive housing sites, and more.

The Department recognized the common overlap of patients receiving services from both CMHS and Community Substance Abuse Services (CSAS). In response, CMHS and CSAS began merging services. Though the merger will not be entirely complete until 2005, the programs were folded together under the rubric of Community Behavioral Health Services (CBHS) in June 2003. For most of FY 2002-2003, CMHS and CSAS tracked data separately and are reported independently in this Annual Report.

In FY 2002-2003, CMHS served a total of 22,887 unduplicated clients, including 18,195 adult and 4,692 children and youth. CMHS has seen a steady increase of unduplicated clients served over the past few years, even as funding has become more difficult to secure. Table 2-2 shows the increase of clients over the past three years.

Table 2-2.

Fiscal Year	Clients Served
2000-2001	20,422
2001-2002	21,535
2002-2003	22,887

In the past year, CMHS has increased the number of clients served and program capacity in a number of key areas, illustrated in Table 2-3.

Table 2-3.

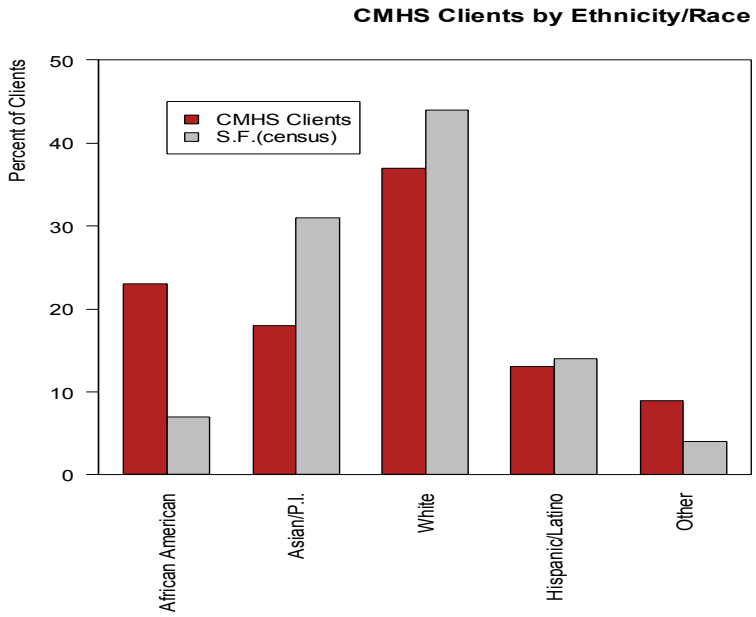
CMHS Program Type	2001-2002	2002-2003
Adult Crisis Services	5,307 served	5,447 served
Adult Transitional Residential Treatment	140 beds	160 beds
Adult Co-op and Supportive Housing	590 beds	668 beds
Adult Day Treatment	744 served	904 served
Adult Outpatient Services	14,431 served	17,120 served
Children/Youth/Family Outpatient Services	2,356 served	2,689 served
Children/Youth/Family Intensive Case Management	364 served	474 served

CMHS clients by race and ethnicity

It can be seen in Figure 2-14 that African Americans represent a larger proportion of CMHS clients than of the City population as whole. In FY 2002-2003, 5,230 clients served were African American (23%).

The 7,772 white clients comprised the largest ethnic group served. The ethnic mix of CMHS clients is virtually unchanged from last year.

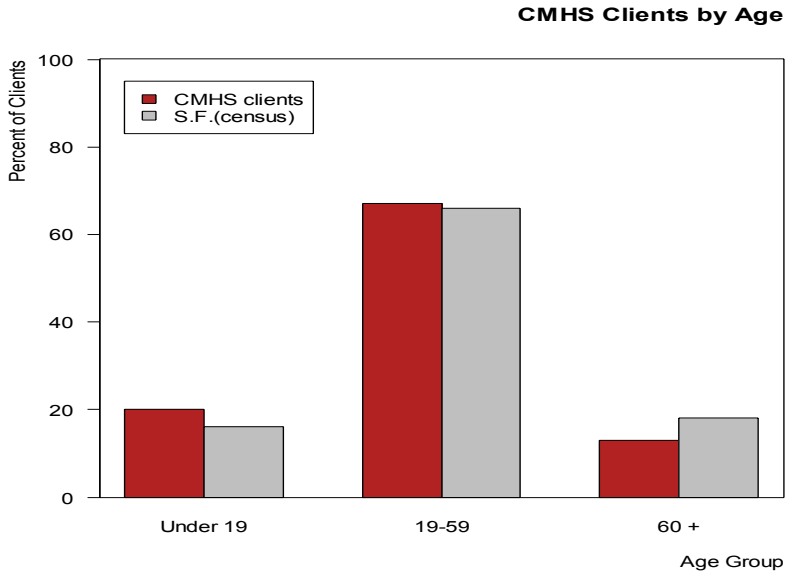
Figure 2-14.



CMHS clients by age

The age ranges of CMHS clients are relatively the same as the City's population as a whole. However, children are somewhat over-represented while seniors are somewhat under-represented. Figure 2-15 shows the percentage of children and youth, adults and seniors who received CHMS services in FY 2002-2003 as compared to the City's population.

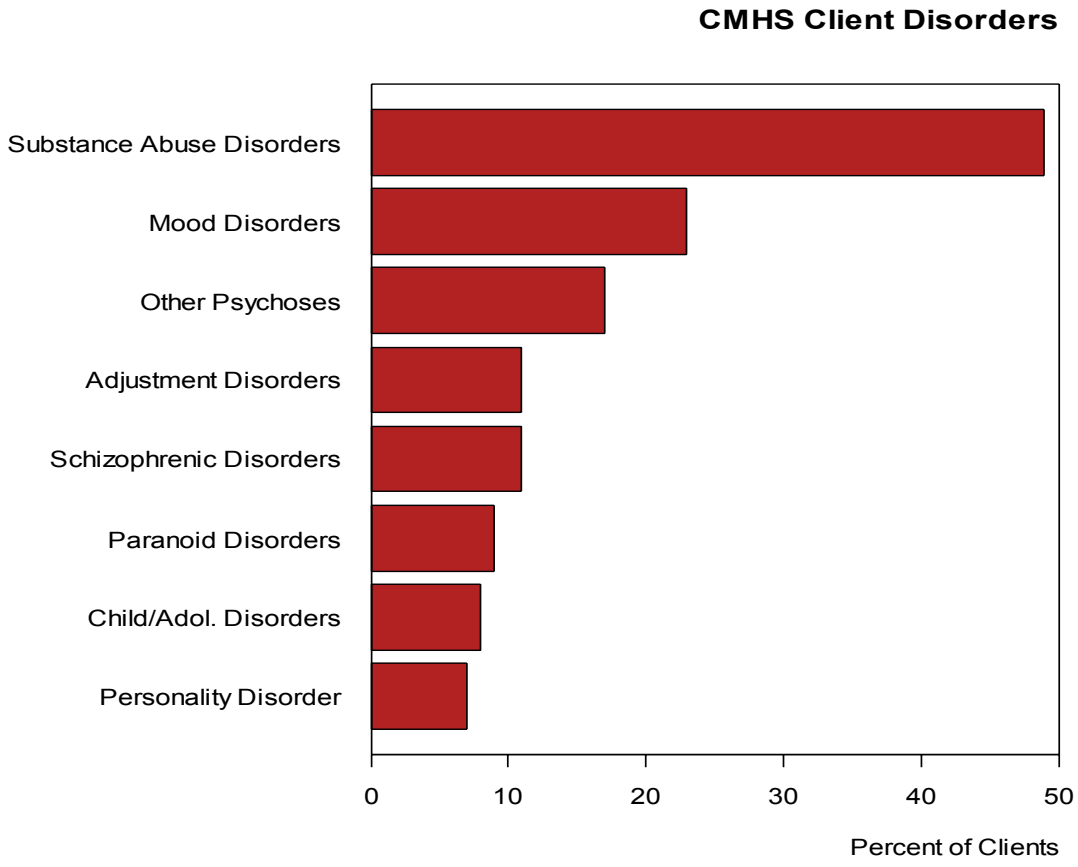
Figure 2-15.



CMHS client disorders

CMHS tracks patient disorders based on the diagnosis given at the time of their most recent episode of care. Many clients suffer from more than one diagnosis. Substance abuse is the most common co-existing diagnosis and exacerbates existing mental health disorders. Nearly 49 percent of all CMHS clients were diagnosed as substance abusers. Though not an exhaustive list, Figure 2-16 shows the most common diagnostic categories for the clients seen by CMHS in FY 2002-2003.

Figure 2-16.



Housing and Urban Health

The Department's Housing and Urban Health (HUH) section's main goal is to provide community-based housing and innovative healthcare services to homeless and disabled persons. HUH's work in the housing arena focuses on developing effective community-based housing that provides healthy and supportive environments for people who have been living on the streets, in shelters, and/or rotating through institutional settings.

The total number of beds provided through HUH programs increased from 1,453 in FY 2001-2002 to 1,730 in FY 2002-2003. This increase of 277 beds was primarily due to the opening of the Star and Camelot hotels which offer permanent housing for chronically homeless people with a particular emphasis on services for individuals with mental illness and/or HIV/AIDS. During this same time period there was also an expansion in the number of emergency hotel rooms.

Community Substance Abuse Services

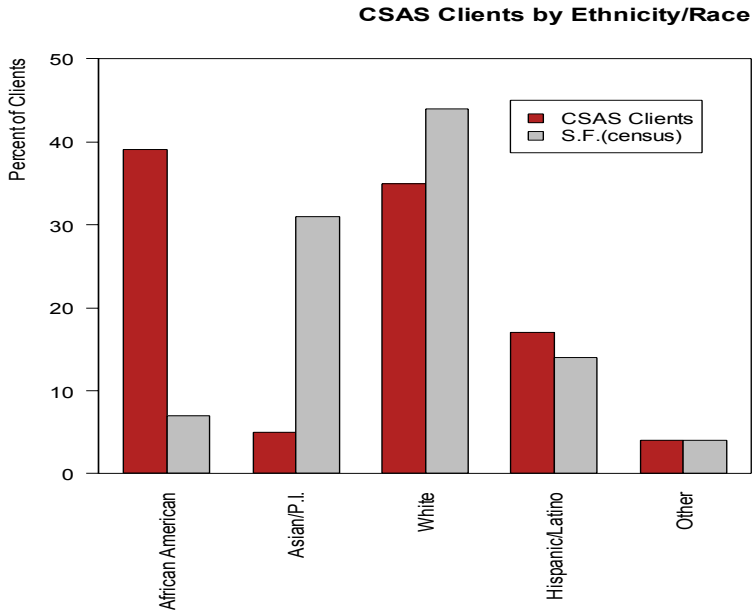
The Department's Community Substance Abuse Services (CSAS) is guided by two principles which are used in the development and management of a wide variety of community programs. The first is harm reduction, a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use to managed use to abstinence. The second is treatment on demand, which aims to reduce the harm associated with alcohol and drugs by creating enough services to meet the demand. In FY 2002-2003, CSAS served a total of 11,750 unduplicated clients in outpatient programs, with 13,109 served in all programs including residential. (*Figures 2-17 through 2-19 are based on outpatient clients only.*)

CSAS clients by race and ethnicity

Figure 2-17 shows that two of the Department's targeted minority populations (African Americans and Hispanics) have relatively high CSAS utilization rates. On the other hand, African Americans are over-represented in the CSAS programs and Asian/Pacific Islanders are under-represented. In fact, it is in the Department's substance abuse services that this is seen most dramatically.

Though 7 percent of the City's residents are African-American, 39 percent (4,859) of CSAS clients are African-American. In a reverse trend, 31 percent of the City's residents are Asian-American, while only 5 percent (600) of CSAS clients are of Asian descent.

Figure 2-17.

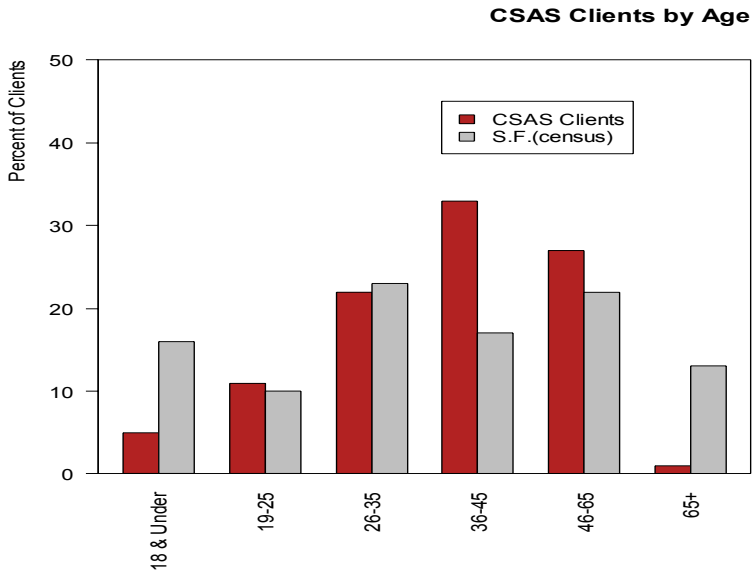


CSAS clients by age

The largest grouping of CSAS clients (4,038 clients) is between the ages of 36 and 45. This population is represented in higher proportions than in the City population at large (32% compared to 17%).

Individuals under the age of 19 and those over the age of 65 are much less likely to seek drug treatment through the Department's programs than are people of other age groups, as is demonstrated in Figure 2-18.

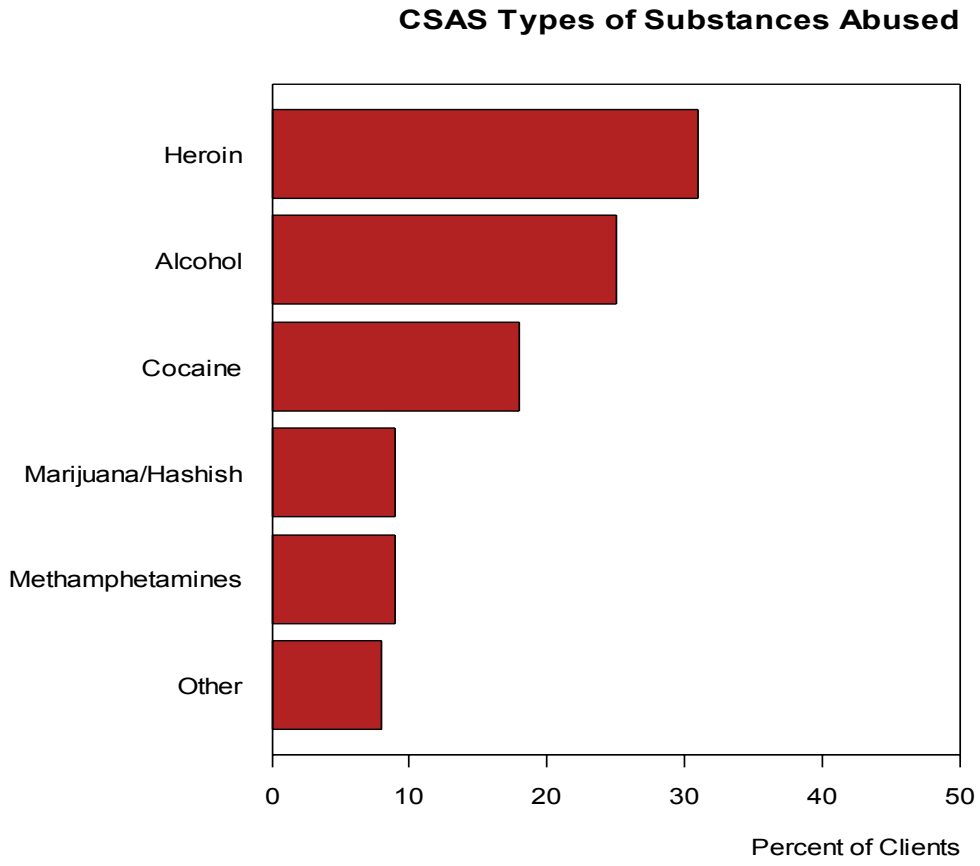
Figure 2-18.



CSAS client substance abuse problems

CSAS tracks the substances that clients identify as the main substance they abuse. Heroin is the most commonly used drug for which 31 percent of clients seek treatment. However, this is down nine percentage points from the previous year (FY 2001-2002), when 40 percent of clients sought treatment for heroin addiction. Since last year there have been increases in alcohol (25 percent this year compared to 23 percent last year) and methamphetamine use (9 percent this year compared to 8 percent last year). Figure 2-19 shows the most common drugs abused by CSAS clientele in FY 2002-2003.

Figure 2-19.



San Francisco City Clinic

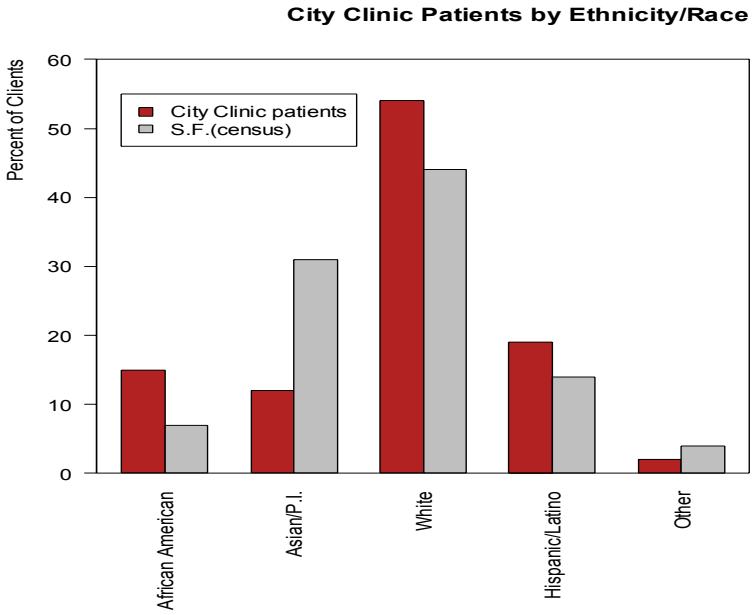
The Department's City Clinic is a drop-in clinic providing free and low-cost diagnosis and treatment of sexually transmitted diseases. City Clinic is San Francisco's only municipal STD Clinic and provides confidential, low cost, convenient drop-in services to all people over the age of 12, regardless of their ability to pay.

The following information reflects City Clinic's clientele from FY 2002-2003. In this time period there were 20,855 patient visits.

City Clinic patients by race and ethnicity

Whites make up the majority (53%) of City Clinic patients. Figure 2-20 shows that African Americans, whites and Hispanic/Latino visitors are represented at City Clinic in higher proportions than they are in the City's population. Asian/Pacific Islanders are under-represented.

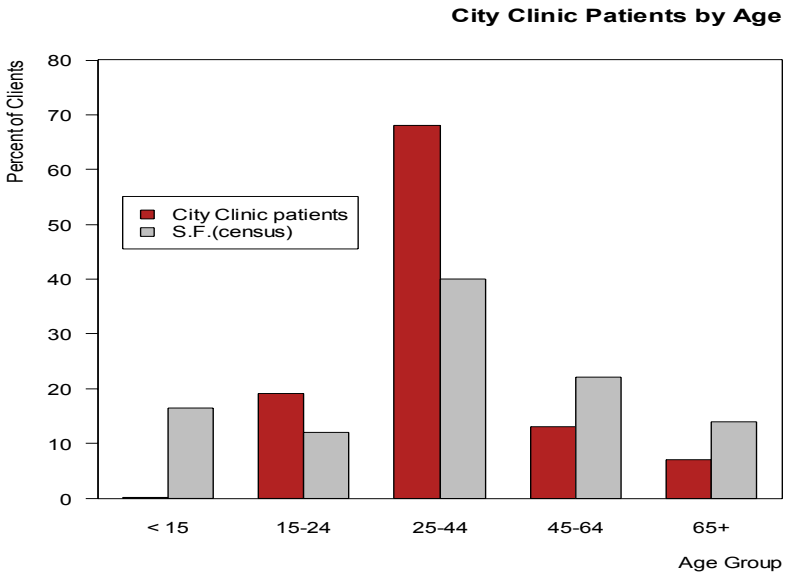
Figure 2-20.



City Clinic patients by age

Most patients seen at the City Clinic are between the ages of 25 and 44. As can be seen in Figure 2-21, 68 percent of all patients are in this age range, much higher than in the overall population, which already has a high representation in San Francisco (40%). Patients in the 15 to 24 age range make up the next highest proportion of patients at 19 percent.

Figure 2-21.



Factors Influencing Health

INTRODUCTION

For the first time the Department has included information previously found in the *Overview of Health in San Francisco* as an integral part of the *Annual Report*. The *Overview* provides the Department's broadest view of the health and well-being of our community and is intended to contribute to the best evidence on health conditions and needs in San Francisco. In addition to the overall demographic information presented in Chapter 2, the Overview of Health in San Francisco covers factors and conditions which have an important impact on the health of our population in Chapter 3, and data on the health of the population in Chapter 4.

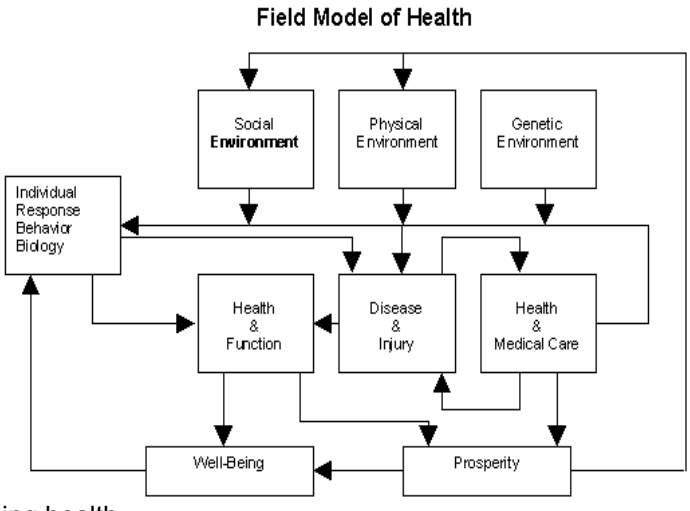
The data presented here on the health of San Franciscans is driven by two ideas:

1. Evidence-based public health: the idea that the Department's actions should be based on the best available data on the health of our population; and
2. A conceptual model of what influences the population's health: the framework that goes beyond health outcomes, by exploring the most important factors producing the patterns of health outcomes we observe. The Department wants to monitor these factors as part of its core public health role of assessing population health.

Models of factors influencing population health

The Department embraces a broad concept of health and well-being, and the factors that promote or detract from it. A schematic of the relationships among these factors and health is shown in Figure 3-1.

Figure 3-1.



Source: RG Evans & GL Stoddart. Producing health, consuming health care. Soc. Sci. Med. Vol. 31, No. 12, pp 1347 – 1363, 1990.

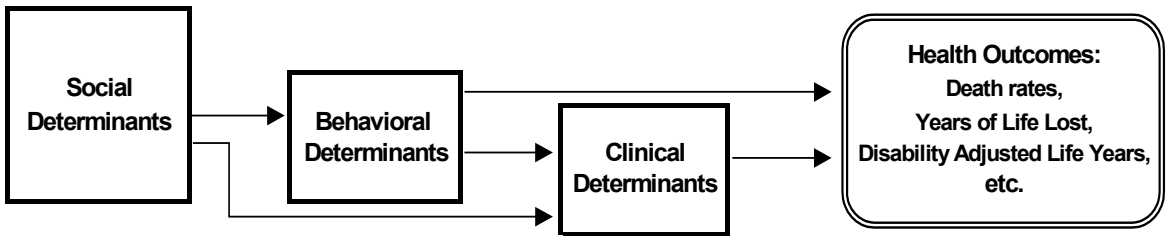
In general, the determinants that appear higher up in Figure 3-1 contribute to or influence the occurrence of factors lower down on the diagram. Some useful considerations about how a population's health is produced and represented by the diagram are:

- The contribution of medical care to a population's health is limited.
- Conditions of the social and physical environment play an important role in producing different health, disease and injury patterns in our population.
- Individual factors, such as risk decisions or response to stress, can moderate the general effects of broader environmental factors on health. The occurrence of individual factors can also be patterned by the social and physical environment.
- Disease and injury, which can be clinically determined and reported in health systems data, are not quite the same thing as health and well-being, which is based on how people experience their own conditions and function with them.
- To change a population's health profile, there is more to consider than health care, especially possible changes in their physical and social environment and in the factors influencing behavior. Indeed, since many health care interventions occur late in sometimes long sequences of events leading to diseases or injuries, in many cases earlier interventions would be more effective or more cost-effective at reducing the ultimate burden of disease.

Each box in the diagram is complex, and not likely to be reducible to a single variable in its influence on (or representation of) any population's health and well-being. To further help thinking about and organizing this complexity, we can turn to another model of the pathways toward health or health problems, the "simplified causal web linking exposures and outcomes." Figure 3-2 is a simplified causal web linking exposures and outcomes.

Figure 3-2.

Simplified Causal Pathways to Population Health Outcomes



Source: CJ Murray & AD Lopez. On the comparable quantification of health risks: lessons from the Global Burden of Disease Study. Epidemiology. Vol. 10, No. 5, pp 594-605, 1999.

Figure 3-2 expresses the idea that there are complex relationships among different levels of factors on the pathway from health to disease. The levels shown here move from more general, large-scale social conditions (like poverty, discrimination, inequality, social exclusion or isolation, neighborhood characteristics like safety, availability of healthy food, recreational resources, alcohol and drugs, community participation organizations, and so on) in the column at the left, to individual behaviors (like getting regular exercise, having a healthy diet, using drugs like tobacco, alcohol, or heroin, or practicing violence), to physiological processes (like the development of atherosclerosis, high blood pressure, or overweight).

Two important implications of this way of considering the pathways to disease are,

1. Most diseases can be "caused" by several factors, and most factors contribute to the occurrence of more than one disease outcome; and

2. Intervening to change conditions, and risk, at any level will influence pathways to the right in the model—but not to the left.

To illustrate how this model might work, consider heart disease, which is the leading cause of premature death in every zip code and among every ethnic group in San Francisco. Distal social determinants such as stress, work strain, and socioeconomic context contribute directly to heart disease, and also to greater exposure to such proximal determinants of heart disease as physical inactivity, poor diet, and smoking. Poor diet and physical inactivity lead to obesity, hypertension, diabetes, and lipid disorders, all of which are physiological determinants of heart disease. Smoking increases the risk of heart disease by adversely affecting such physiological determinants as lipid profile, risk of diabetes, and by other mechanisms. Each determinant influences multiple outcomes. For this reason, our report takes very seriously all of the possible influences on the health of San Franciscans, at all levels of influence.

By assessing our population's health in this manner, and by implementing prevention efforts that are informed by this assessment, the Department hopes to address the two main goals of Healthy People 2010: increase the quality and years of healthy life, and eliminate health disparities within populations.

Sources

- R Wilkinson & M Marmot. The Solid Facts: Social Determinants of Health. WHO Regional Office for Europe. 1998. http://www.who.dk/document/E59555.pdf

- US Department of Health and Human Services, Healthy People 2010. http://www.healthypeople.gov

- McGinnis JM, Foege WH. "Actual Causes of Death in the United States". JAMA, 270(18):2207-12, 1993.

SOCIAL DETERMINANTS

Economic conditions: Low income and income inequality

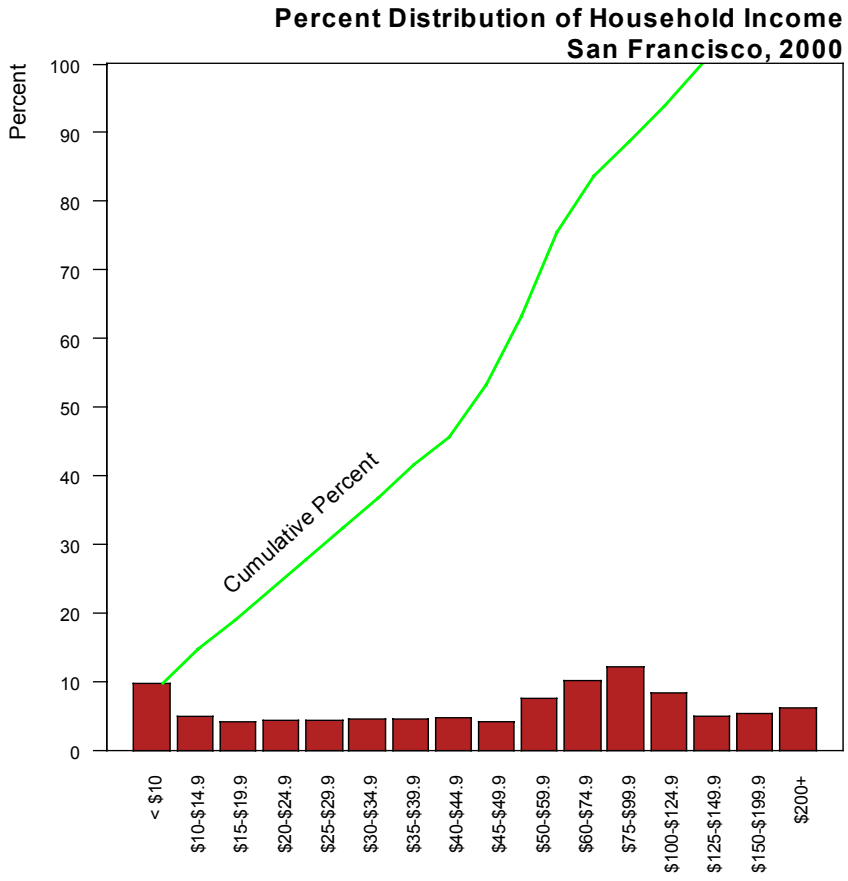
Income distribution

In 2000, 45 percent of households in San Francisco made less than $50,000 a year, and almost a third made less than $35,000. Family households had a much higher median income, ($63,545) than non-family households ($46,457), and the median income of males ($31,772) was much higher than that of females ($23,696).

Wages were a source of income for 77 percent of households, while 46 percent derived income from investments, including interest, dividends, trusts, or rent; 21 percent from Social Security; 13 percent from retirement; 6.7 percent from Supplementary Security Income; and 3.9 percent of households got public assistance income.

San Francisco families send a lot of members to work. Among married couple families, 61 percent had at least two workers.

Figure 3-3.



Source: US Census 2000

Figure 3-3 shows San Francisco's household income distribution in 2000. While a substantial number and proportion of households have higher incomes, there are also very many who make less than the basic family wage needed for families to live modestly. The households include a large number of non-families, most of them single-person households, but even so, more than 40,000 such households have incomes below the level of the California minimum wage.

Poverty and low income

The federal poverty level (FPL) is a measure that was developed four decades ago, based on the assumption that families would spend no more than 30 percent of their income on housing. It continues to be used, despite widespread belief that it is based on outdated and unrealistic assumptions that generally cause it to underestimate the number of families living below the level of basic subsistence needs.

The latest federal estimates for San Francisco (2002) show that poverty continues to be highest among children and youth, with the highest levels among young adults 18-24 and children under age 5. Disparities in poverty rates for families by ethnicity differ by family composition. Within each ethnicity, poverty rates are higher among non-couple families than among married-couple families, and among non-couple families, higher among female-headed households than among male-headed households.

Table 3-1.

Poverty by Age, San Francisco 2002

Age	Male	Female
ALL	9.8	11.2
<5	18.3	28.3
6-17	12.7	12.1
18-24	20.4	22.0
25-64	8.1	8.8
65-74	7.9	9.1
75+	8.9	14.4

Numbers estimated from 12 monthly surveys
Source: US Census, American Community Survey 2002

Housing and homelessness

San Francisco has a much higher proportion of households that are renters than the State as a whole, 65 percent compared to 43.1 percent statewide. Housing affordability is generally defined as housing costs no greater than 30 percent of a household's income. San Francisco has notoriously high housing costs. According to the 2000 census, 37.2 percent of rental household were paying more than 30 percent of their income for rent, including 17.1 percent who were paying over 50 percent of their income. While the recent recession has caused rents to decline somewhat, they are still high enough to create substantial affordability problems for lower income San Franciscans as can be seen in Table 3-2. For example, about half of all San Francisco households have incomes below the $56,200 income level that would make a one-bedroom apartment at fair market rent affordable (see Figure 3-3).

Table 3-2.

San Francisco Rental Housing Affordability, 2003

	0 BR	1 BR	2 BR	3 BR
Fair Market Rent (2004)				
California 2003	$ 748	$ 878	$ 1,101	$ 1,510
San Francisco 2003	$ 1,084	$ 1,405	$ 1,775	$ 2,435
San Francisco 2002	$ 1,185	$ 1,535	$ 1,940	$ 2,661
Income needed to afford Fair Market Rent				
California 2003	$ 29,914	$ 35,117	$44,054	$ 60,417
San Francisco 2003	$ 43,360	$ 56,200	$71,000	$ 97,400
Percent of family AMI	47%	61%	78%	106%
San Francisco 2002	$ 47,400	$ 61,400	$77,600	$ 106,440
Hourly wages needed to afford Fair Market Rent				
California 2003	$ 14.38	$ 16.88	$ 21.18	$ 29.05
San Francisco 2003	$ 20.85	$ 27.02	$ 34.13	$ 46.83
Percent of minimum wage	309%	400%	506%	694%
Min. wage hours/wk to afford	124	160	202	277
Percent of SF living wage	93	120	152	208
San Francisco 2002	$ 22.79	$ 29.52	$ 37.31	$ 51.17
Maximum affordable monthly housing cost by % of family AMI				
	30%	**50%**	**80%**	**100%**
California 2003	$ 459	$ 765	$ 1,223	$ 1,529
San Francisco 2003	$ 686	$ 1,144	$ 1,830	$ 2,288
San Francisco 2002	$ 646	$ 1,076	$ 1,722	$ 2,152

BR = bedrooms; AMI = area median income (HUD)
Ca. minimum wage = $6.75/hour; S.F. living wage = $9.00/hour
"Affordable" rents: standard of housing costs of no more than 30% of income
Source: National Low Income Housing Coalition, "Out of Reach" 2002 & 2003.

While homelessness continues to be an important and visible problem in San Francisco, it represents the extreme end of a spectrum of problems reflecting the intersection of lack of affordable housing, incomes below minimal subsistence needs, and in some cases behavioral, mental and physical problems (see map, Figure 4-23, which shows the proximity of serious violence to low income areas, as indicated by low-income housing). This population continues to be very difficult to monitor statistically. The table here presents data on the characteristics of a large sample of homeless and near-homeless persons, for a study done by the University of California, San Francisco.

Table 3-3.

Characteristics of a Sample of Homeless and Marginally Housed Persons, San Francisco 1996

	N	%		N	%
Whole sample	2,508	100%	**SF resident** > 1 yr.	2,087	83%
Biological sex			**Institutional history**		
Male	1,958	78%	Prison (ever)	600	24%
Race/ethnicity			Among non-MSM IDU*	282	40%
African American	1,133	45%	Psychiatric hosp. (ever)	555	22%
White	1,006	40%			
Hispanic	147	6%	**Health conditions**		
Asian/Pac. I.	117	5%	Pos. TB test (ever)	791	32%
Age 30+	2,228	89%	HIV+		11%
Education			Syphilis dx (ever)	211	8%
12th grade +	1,846	74%			
<12th grade	659	26%	**Health risk behavior**		
			IDU (ever)	1,033	41%
Housing			Sex trade (ever)	679	27%
Currently homeless	1,084	43%	Needle share (ever)	591	24%
Chronic homelessness**	1,301	52%	MSM (ever)	475	19%

* Percent of non-MSM ever-injection drug users having gone to prison.

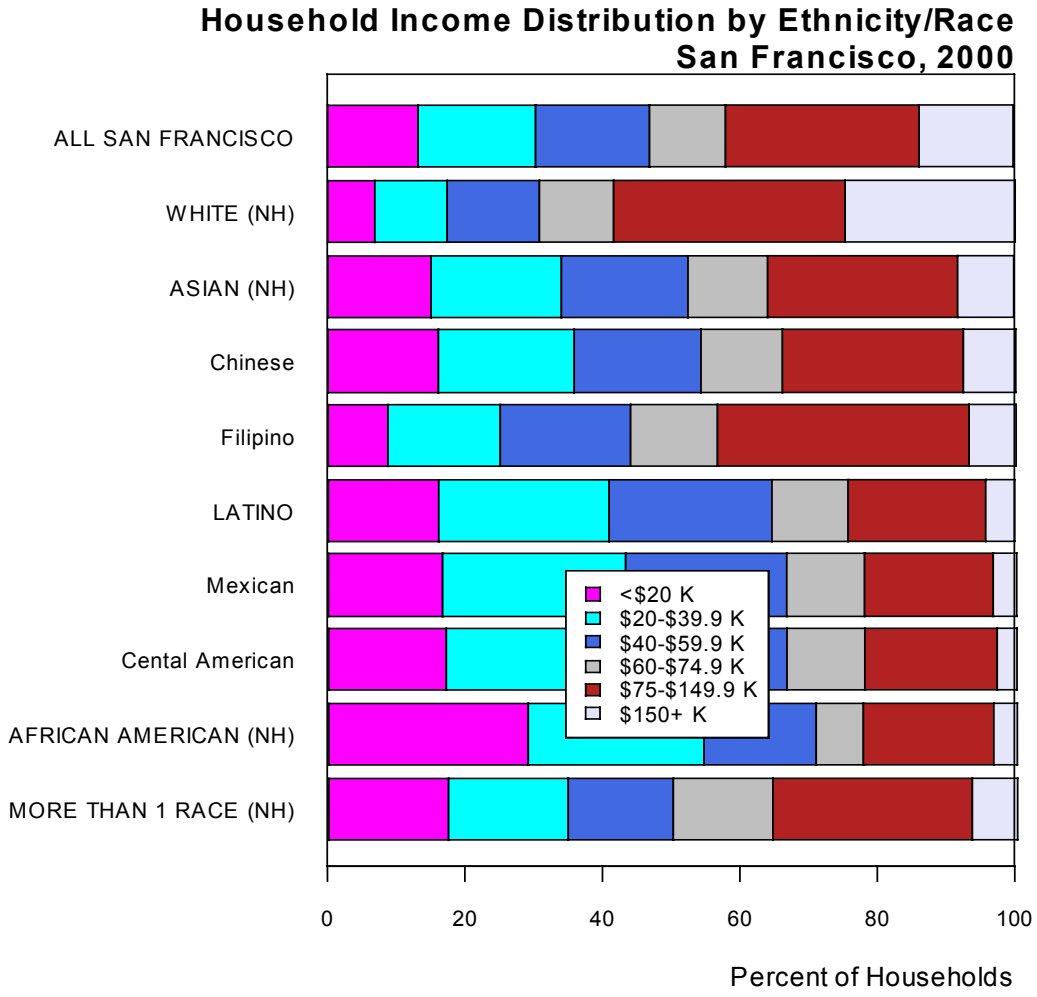
** Chronic homelessness defined as a history of >12 months being homeless.

source: MJ Robertson, RA Clark, ED Charlebois, J Tulsky, H Long, DR Bangsberg, AR Moss. "HIV Seroprevalence Among Homeless and Marginally Housed Adults in San Francisco," ms (2003).

Racial disparities

The distribution of income varies greatly by ethnicity/race, as shown in Figure 3-4. Almost three-fifths of white households have incomes above $75,000, but less than a quarter of African-American or Latino households had incomes that high. At the lower end, 55 percent of African-American households had incomes below $40,000, compared to 18 percent of white households with incomes that low. The California Budget Project had estimated that an income above $50,000 was needed for a family with 2 children to live minimally comfortably in San Francisco.

Figure 3-4.



Source: US Census 2000

Each ethnicity in San Francisco has higher per capita income than in California as a whole (whites are $30,000 higher, Hispanics are $5,900 higher), but Asian and African-American median household incomes are lower than the State's (Table 3-4).

Table 3-4.

Income and poverty measures by ethnicity/race, San Francisco and California 2000

	Per capita income		Median household income		Below poverty
	S.F.	Cal.	S.F.	Cal.	S.F.
White	$ 51,986	$ 31,700	$ 65,431	$ 53,734	7.7%
Asian	$ 22,357	$ 22,050	$ 49,596	$ 55,366	10.9%
Latino or Hispanic	$ 18,584	$ 11,674	$ 46,553	$ 36,532	15.6%
African American	$ 19,275	$ 17,447	$ 29,640	$ 34,956	25.1%
All	$ 34,556	$ 22,711	$ 55,221	$ 47,493	11.3%

Asian refers only to Asians and excludes Pacific Islanders
Source: US Census 2000

Transportation

Transportation affects health in a variety of ways, including traffic safety, air and noise pollution, social isolation or interaction, exercise, and time pressures. Table 3.5 shows data from 2002 about the means by which San Franciscans travel to work.

Table 3.5

Means of Travel to Work, San Francisco 2002

Means of Travel	Percent	Number	LCI , UCI
Total:	100.0	395,542	389,148 , 401,936
Car, truck, or van:	51.0	201,819	194,744 , 208,894
Drove alone	42.3	167,510	160,443 , 174,577
Carpooled	8.7	34,309	30,715 , 37,903
Public transportation:	30.8	121,854	116,228 , 127,481
Bus or trolley bus	22.6	89,235	83,750 , 94,720
Physically Active	10.2	40,165	n/a n/a
Walked	8.0	31,742	28,117 , 35,367
Bicycle	2.1	8,423	6,649 , 10,197
Worked at home	6.5	25,908	23,118 , 28,698

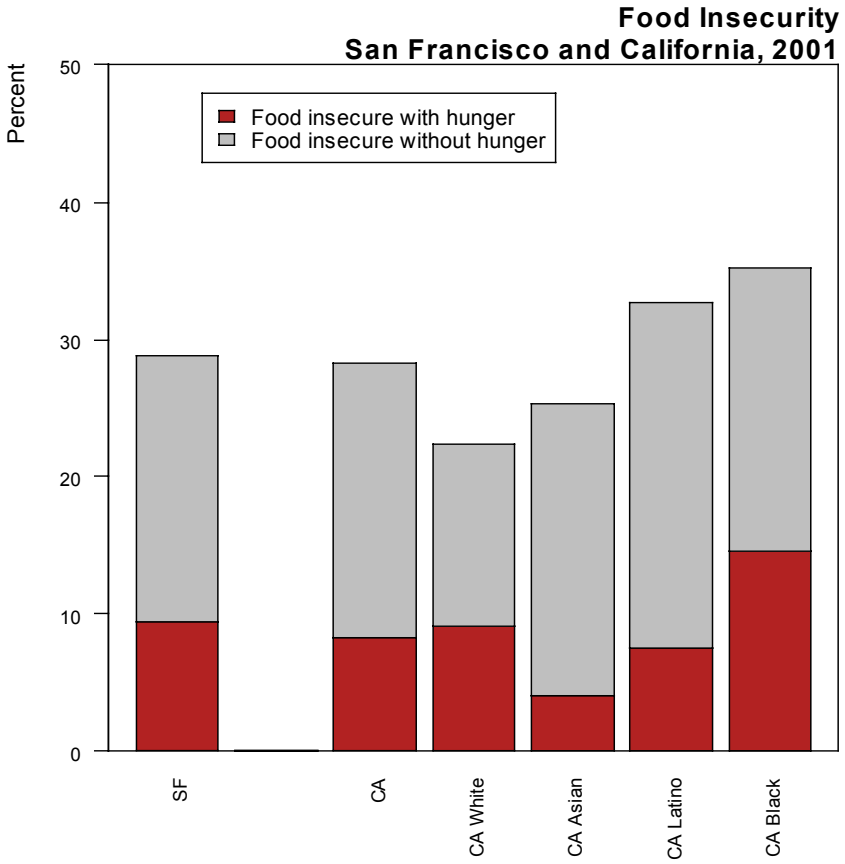
Workers 16 years and over
LCI, UCI: lower, upper 95% confidence intervals
Numbers estimated from 12 monthly surveys
Source: US Census, American Community Survey 2002

Access to food

Lacking assured access to adequate food through socially appropriate means is called "food insecurity." The California Health Interview Survey measured this in 2001 for those it surveyed that were at or below 200 percent of the federal poverty level (e.g., $36,200 for two parents with two children, which is $8,120 more than the income from two full-time minimum wage jobs). The results showed that, for San Francisco, approximately 28.8 percent said they struggled to regularly provide food. This included approximately 9.4 percent who experienced physical hunger sensations.

Small sample sizes prevented breaking these data down further for parts of San Francisco's population, so statewide levels by major ethnicity/race group are shown in Figure 3-5.

Figure 3-5.



Source: GG Harrison, DiSogra CA, Manalo-LeClair G, Aguayo J, Yen W. "Over 2.2 Million Low-Income California Adults are Food Insecure; 658,000 Suffer Hunger." UCLA Center for Health Policy Research, 11/05/02 rev.

PHYSICAL ENVIRONMENT

Air Quality

There are many aspects of the physical and social environment that impact people's health and well-being. An aspect of the physical environment for which the Department has monitoring data is air quality. The federal Clean Air Act directs the Environmental Protection Agency (EPA) to implement health based standards for certain air pollutants, including ozone, nitrogen dioxide, and particulate matter (PM_{10}, particulate matter less than 10 microns in diameter, and $PM_{2.5}$, particulate matter less than 2.5 microns in diameter.) The ozone and nitrogen dioxide standards were not exceeded over the last four years, but larger particulates (PM_{10}) exceeded the state standard (which is stricter than the federal standard) on 15 days over the past four years, compared to 6 days exceeded in the previous four years. San Francisco exceeded the newer federal standard for smaller particulates ($PM_{2.5}$) on 4 days in 2002. Particulate matter can make asthma and other respiratory problems worse.

Table 3-6. **San Francisco Air Quality Monitoring Data, 1999-2002**

Measure	Standard	SF 1999	SF 2000	SF 2001	SF 2002	Bay Area 2002
OZONE						
Maximum Hourly						
Days > state standard	.09 ppm*	0	0	0	0	16
Days > national standard	.12 ppm*	0	0	0	0	2
Highest day measured (ppm)		0.08	0.06	0.06	0.05	
3 year average					0.0	
*(Days with 1 measurement greater than the state (0.09 parts per million) or national (0.12 ppm) standard)						
Daily 8-Hour Averages						
Days > national standard	.08 ppm	0	0	0	0	7
Highest day measured (ppm)		0.06	0.04	0.05	0.05	
3 year average					4.4	
*(Days w. 1 8-hour period greater than the national 8-hour standard of 0.08 parts per million)						
NITROGEN DIOXIDE						
Days > state standard	.25 ppm* (1 hr.)	0	0	0	0	0
Annual average	.053 (nat'l)	0.021	0.020		0.019	
Highest day measured		0.10	0.07	0.07	0.08	
* (Days w. 1 measurement greater than the state hourly standard of 0.25 parts per million)						
PARTICULATES (PM_{10})						
State standard	50 $\mu g/m^3$ *					
Days > standard (measured)**		6	2	5	2	6
Days > standard (calculated)**		36	12	24	12	
Annual average (geo. mean)	30 $\mu g/m^3$	22.6	21.6	25.8	21.0	
National standard	150 $\mu g/m^3$					
Days > standard (measured)		0	0	0	0	0
Days > standard (calculated)		0	0	0	0	
Annual average	50 $\mu g/m^3$	26.4	24	28.9	24.7	
Highest day measured		78	63	65	74	
PARTICULATES ($PM_{2.5}$)						
National standard						
Days > national standard	65 $\mu g/m^3$				4	5
Highest day measured					70	
3 year average					48	
Annual average	15 $\mu g/m^3$				13.1	
3 year average					11.9	

$\mu g/m^3$ = micrograms per cubic meter; ppm = parts per million.

*(Days with a measurement greater than the standard, in micrograms per cubic meter. State and national averages differ because state calculates a geometric mean, and national uses arithmetic mean.)

** (Measured days are those with actual measurements exceeding standards. Measurements typically collected every 6 days. Calculated days are expected number had measurements been taken daily.)

Source: *Overview of Health in SF 2002*; Air Quality Board, "Bay Area Air Pollution Summary-2002".

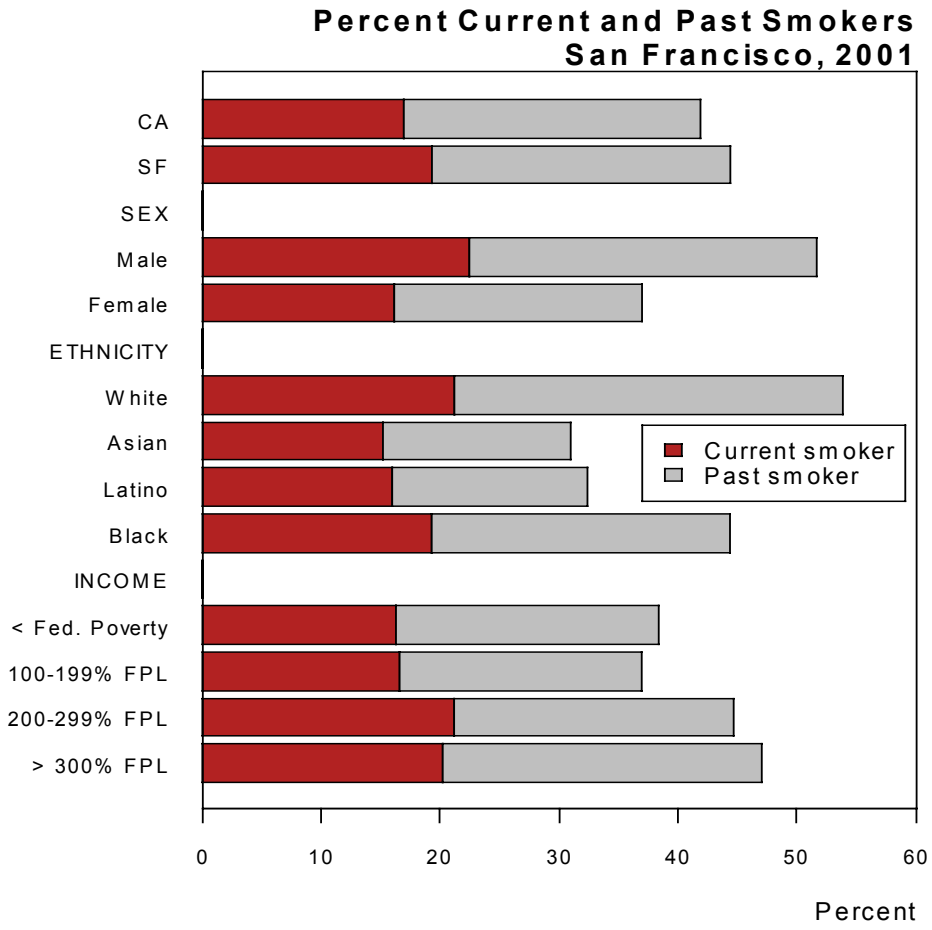
BEHAVIORAL RISK FACTORS

Smoking

According to the Surgeon General, "cigarette smoking is the leading preventable cause of disease and death in the United States." Although the rates of smoking in California are lower than the national average, smoking is still one of the major contributing factors in California's disease and death rates.

Figure 3-6 shows that tobacco use varies among ethnic groups, age groups, between the sexes, and among income and educational levels. Men smoke more than women. Whites and African Americans have the highest rates of smoking. Generally, lower income has been associated with greater smoking rates in most state and national surveys. The lack of an income gradient in these recent survey data for San Francisco needs to be confirmed, but if it reflects a true change in smoking patterns it may be a result of the differential effect of anti-smoking campaigns, including increased tobacco taxes, on lower-income people.

Figure 3-6.



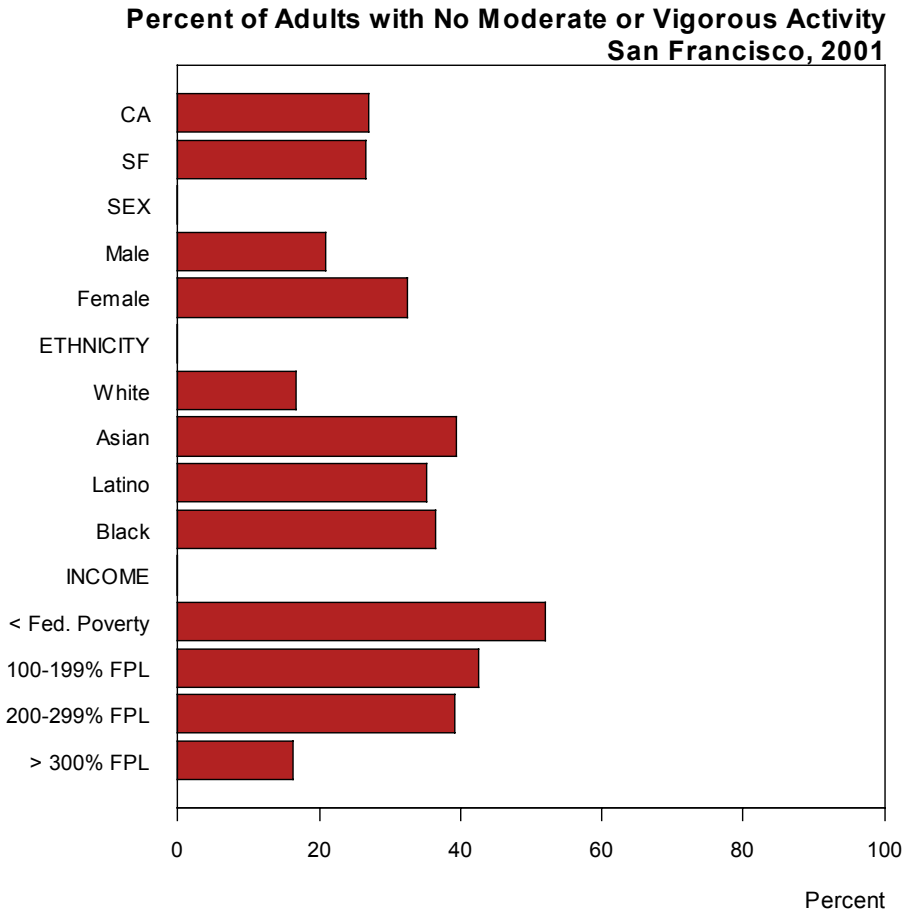
Source: California Health Inventory Survey

Physical inactivity

After tobacco exposure, physical inactivity is now considered the second leading determinant of death in the U.S. A recent Surgeon General's report on physical inactivity states that people who are inactive can improve their health and reduce their risk of developing or dying from heart disease, diabetes, high blood pressure, and colon cancer by becoming even moderately active on a regular basis.

Figure 3-7 shows that in San Francisco, the overall level of inactivity is the same as for the State, but there are substantial differences in degree of lack of physical activity by demographic category. The significant differences are that males are less inactive than females; whites are less inactive than the other ethnic groups; and the highest income group is much less inactive than any of the lower income groups.

Figure 3-7.

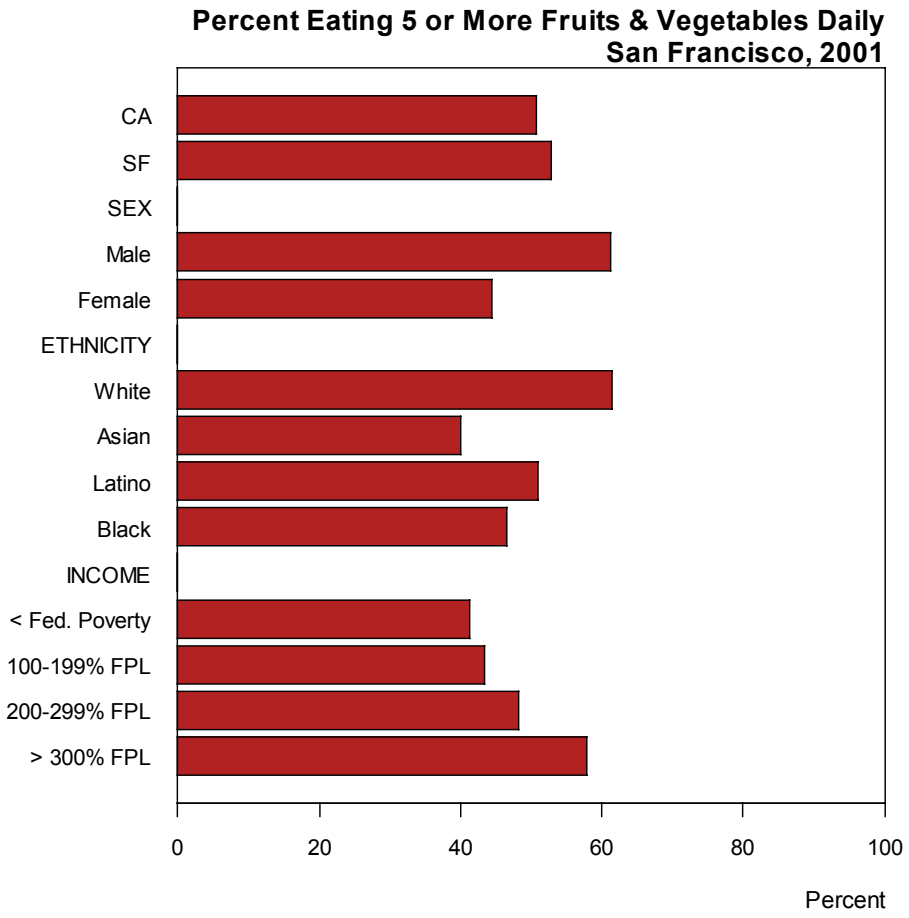


Source: California Health Inventory Survey

Diet

Lack of a healthy diet has been linked to an ever-larger share of mortality in the U.S., both because of greater knowledge about the impact of diet on many health conditions, and because of diet's contribution to the epidemic of obesity in the U.S. Healthy People 2010 provides specific objectives for the consumption of fruits (75% of the population should consume fruit at least twice a day) and vegetables (50% of the population should consume at least three daily servings of vegetables, with at least one-third being dark green or orange vegetables). Figure 3-8 shows the need for improvement across all demographic groups. The significant differences among these group are: males have a higher percent than females, whites are higher than Asians, and those with incomes above three times the federal poverty level have a higher percent than those with incomes below poverty.

Figure 3-8.



Source: California Health Inventory Survey

Alcohol and other drugs

Although death rates due to drug overdose have recently declined, alcohol and drug-related mortality and morbidity continue to pose a significant public health crisis for San Francisco. Table 3-7 shows how highly four main alcohol and drug-related causes of death and disability rank among all causes in San Francisco.

Table 3-7.

Ranking of Main Alcohol and Drug-Related Causes of Death by San Francisco Measures of Overall Mortality and Morbidity

Measure:	Years of Life Lost (YLL)			Average YLL	Disability Adjusted Life Years		
Year:	2000-2001			per death	2001		
Outcome	All SF	Male	Female	All SF	All SF	Male	Female
Poisoning	5	4		3	13	7	
Alcohol use (psychiatric diagnosis)	14			6	2	1	3
Cirrhosis of liver	11	10		7	16	14	15
Drug use (psychiatric diagnosis)					18	15	
..Out of number ranked:	(top 20)	(top 10)	(top 10)	(top 12)	(top 20)	(top 15)	(top 15)

Source: SFDPH, Community Health Epidemiology & Disease Control

The overall rankings for these measures of the burden of disease and injury in San Francisco are presented in Chapter 4. Years of Life Lost is a measure of overall premature mortality; Average Years of Life Lost is a measure of the comparative youth of people dying from each cause: and Disability Adjusted Life Years is a measure of the combined toll of premature mortality plus time lived at less than good health due to each cause.

The National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAA) studied the economic costs associated with alcohol and drug abuse. The study estimated that costs were $246 billion in 1992 (the most recent year for which data were available). A large part of treatment costs were for drug and alcohol related hospitalizations. The NIDA /NIAAA study estimated that half of the $246 billion spent in 1992 on drug and alcohol abuse related expenses were for drug-related crime. In addition to costs, drug and alcohol abuse are responsible for a great loss life among young people.

Diagnoses for use of drugs and alcohol made in nearly 12,000 admissions shown in Table 3-8) included cases where the drugs or alcohol-related problem was the main cause of hospitalization (primary diagnosis of alcohol and/or drugs, almost 1500 admissions), as well as many more cases where drugs and alcohol were a contributing factor to treatment during the hospitalizations (any alcohol or drug diagnosis).

Table 3-8.

Alcohol & Drug Indicators: A. Health Indicators

Indicator	YEAR 1996	1997	1998	1999	2000	1999-2000 1998-99
Deaths due to drugs						
By ICD-10 coding*	--			178	138	-22%
By ICD-9 coding*: Opiates	35	34	40			
Other	133	117	136			
Alcohol-related deaths						
By ICD-10 coding*				102	117	15%
By ICD-9 coding*: entirely attributable to alcohol	101	129	117			
Partly attributable to alcohol	382	389	364			
AIDS cases diagnosed						
Total AIDS cases	1056	775	579	516	459	-11%
IVDU AIDS cases	149	109	97	160	157	-2%
Hepatitis, Type B	61	57	62	61	54	-11%

* Deaths were coded with ICD-9 codes through 1998, and with ICD-10 codes from 1999 on.

Alcohol & Drug Indicators: B. Treatment

Indicator	YEAR 1996	1997	1998	1999	2000	1999-2000 1998-99
CADDS						
Primary drug admissions						
Total admissions	13,559	13,452	14,820	17,035	16,151	-5%
Number injecting	8,048	7,812	9,060	10,169	9,492	-7%
Primary alcohol admissions	3,464	3,728	3,622	4,807	4,536	-6%
Hospital discharges						
Alcohol related						
Total, primary diagnosis	708	893	828	1,048	1,027	-2%
Alcohol related, any diagnosis*	4,306	4,700	4,757	4,693	4,898	4%
Alcohol depend syndrome	2,008	2,156	2,009	1,820	1,894	4%
Non-depend use	637	771	910	923	959	4%
Alcohol liver damage	857	857	890	873	1,010	16%
Alcohol psychoses	628	709	808	926	901	-3%
Drug related						
Total, primary diagnosis	476	388	409	394	457	16%
Drug related, any diagnosis*	6,413	6,941	7,432	7,776	6,993	-10%
Heroin/opiates	2,579	2,820	3,074	3,421	2,563	-25%
Cocaine	1,375	1,512	1,727	1,820	1,882	3%
Amphetamine	549	667	594	520	620	19%
Cannabis	194	285	315	259	420	62%
Barbiturates	70	60	93	106	91	-14%
Total primary diagnosis alcohol & drug discharges	1,184	1,281	1,237	1,442	1,484	3%
Total discharges, any alcohol or drug diagnosis*	10,719	11,641	12,189	12,469	11,891	-5%

ACCESS TO HEALTH CARE

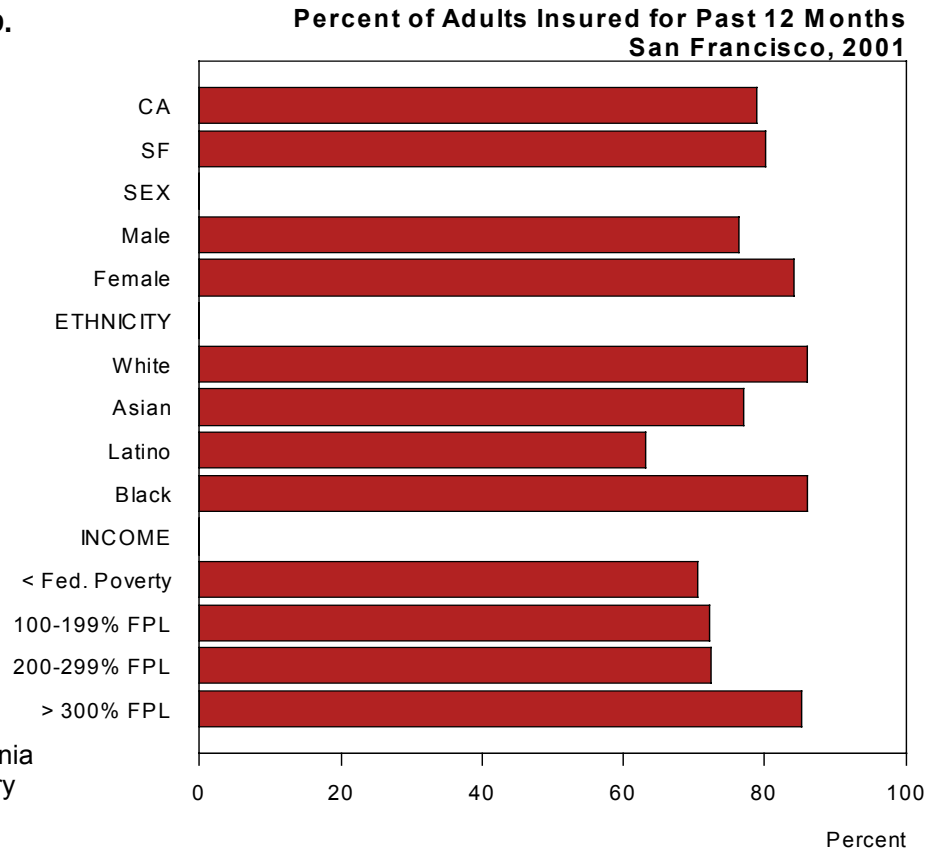
Access to health care services is a significant issue in San Francisco, as it is throughout California and the rest of the nation.

Uninsured

A common indicator of access to health care services is the availability of health insurance. Studies have shown that the uninsured were less likely to have a usual source of health care or to have seen a doctor in the past year. They were also more likely to have delayed or not gotten health care they thought they needed. National studies indicate that the recent recession has seen an increase in the number of uninsured in the U.S.

Generally in California, as in the rest of the U.S., whites have the lowest percent uninsured, African Americans and Asians have higher percents, and Hispanics have the highest percentage uninsured. The data for San Francisco from the California Health Interview Survey are in line with these findings. Figure 3-9 illustrates that about a fifth of San Francisco's adult population lacked insurance for some or all of the past year, and that having income above 300 percent of the federal poverty level is associated with a higher likelihood of having been continuously insured.

Figure 3-9.

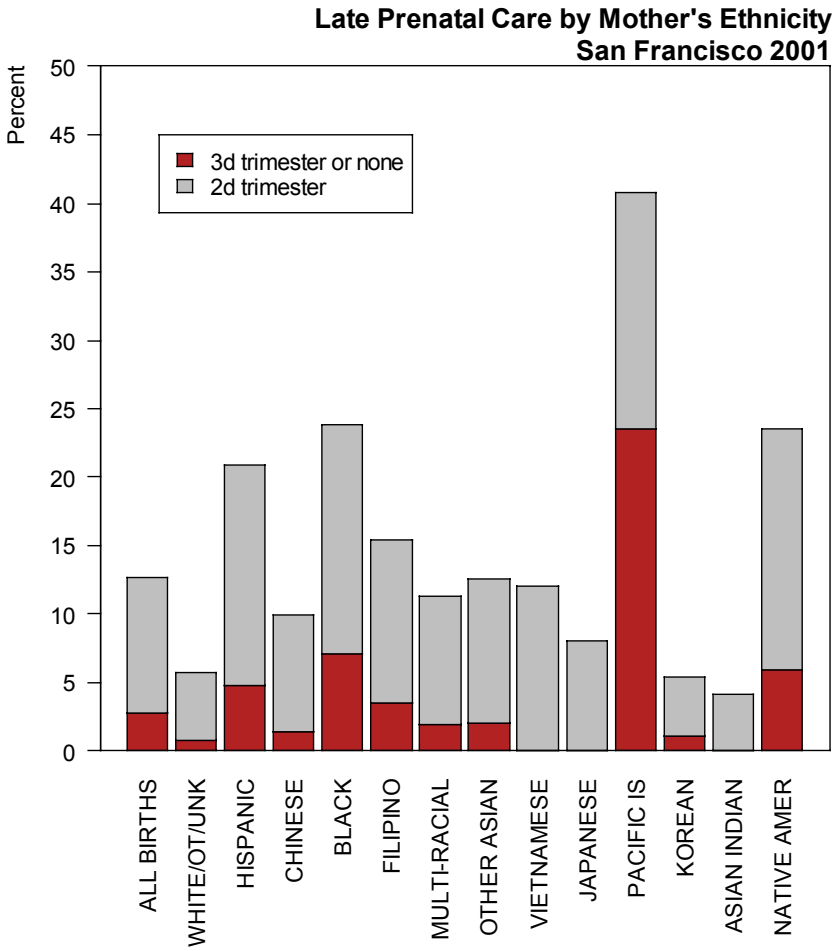


Source: California Health Inventory Survey

Prenatal care

Pregnant women should begin prenatal care in the first trimester; later entry into care is generally associated with worse perinatal and infant health outcomes. Figure 3-10 shows that Pacific Island (98 births) and African-American women (664 births) have the highest percentages of late prenatal care, followed by Hispanic and Filipina women. The percentage for Native Americans is unreliable, since it is based on only 17 births.

Figure 3-10.

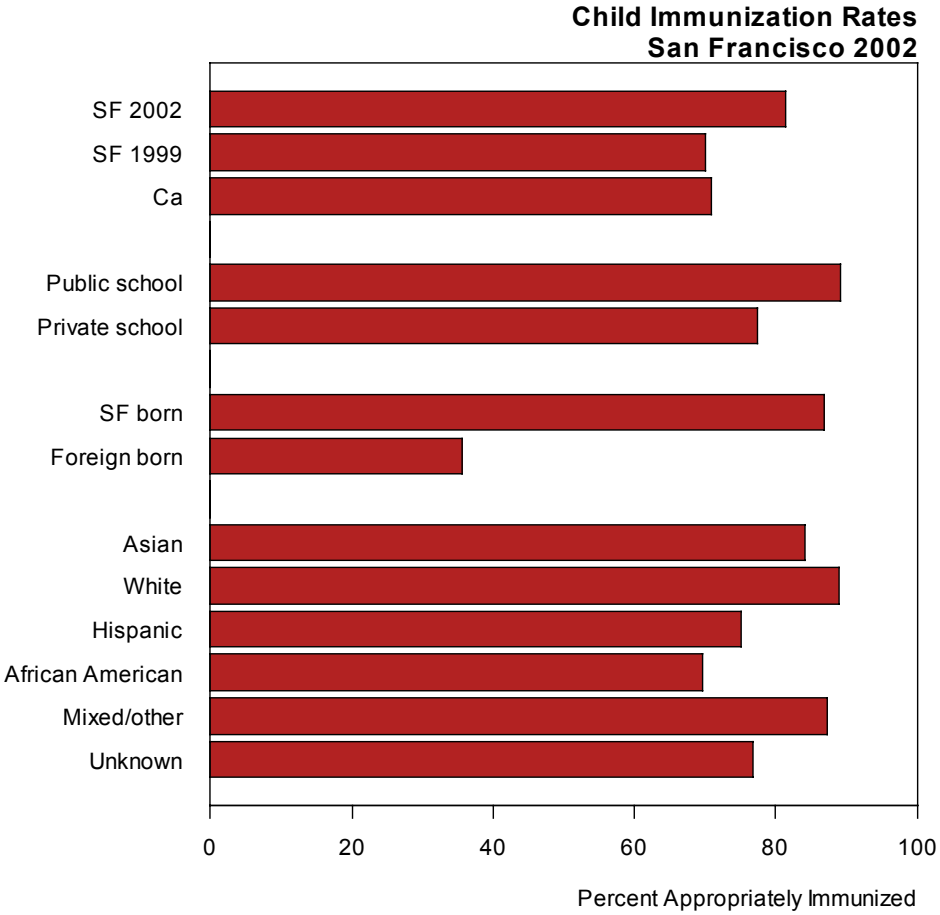


Source: SFDPH, Community Health Epidemiology & Disease Control, Public Health Information System

Immunizations

The last expanded Kindergarten retrospective study of up-to-date immunizations for which data are now available, done in 2002, provide the results shown in Figure 3-11. San Francisco overall immunization rate of 81.5 percent is well over the state rate of 71 percent and our 1999 rate of 70 percent. Since 1999, coverage increased for African-American children from 57 percent to 70 percent, and for Hispanic children from 63 percent to 75 percent.

Figure 3-11.

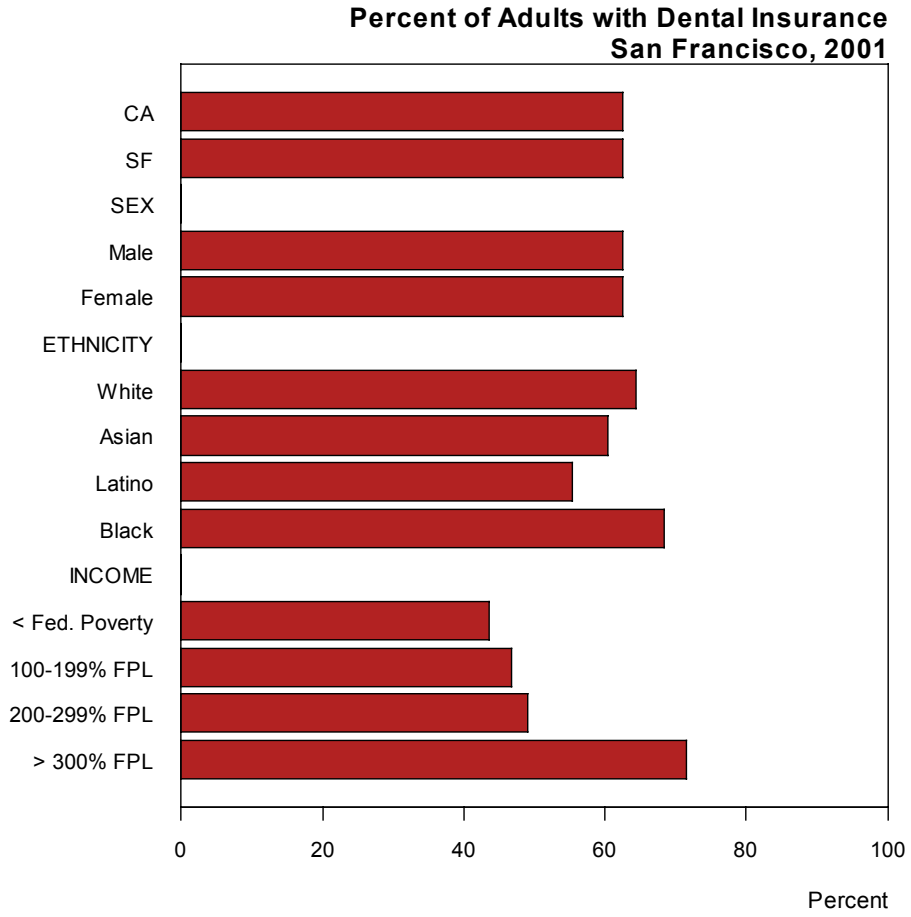


Source: SFDPH, Community Health Epidemiology & Disease Control

Dental care

Figure 3-12 illustrates that access to dental care through dental insurance for adults is most heavily influenced by income, with those with incomes below 300 percent of the FPL significantly less likely to have dental insurance than those with incomes above that level.

Figure 3-12.



Source: California Health Inventory Survey

The Health of San Franciscans

Overall Burden of Disease

This chapter examines measures which reflect aspects of the overall health of the population, based on mortality and/or the impact of ill health on the living (which can be measured using a number of dimensions, such as disability, health-related quality of life, or self-assessed health).

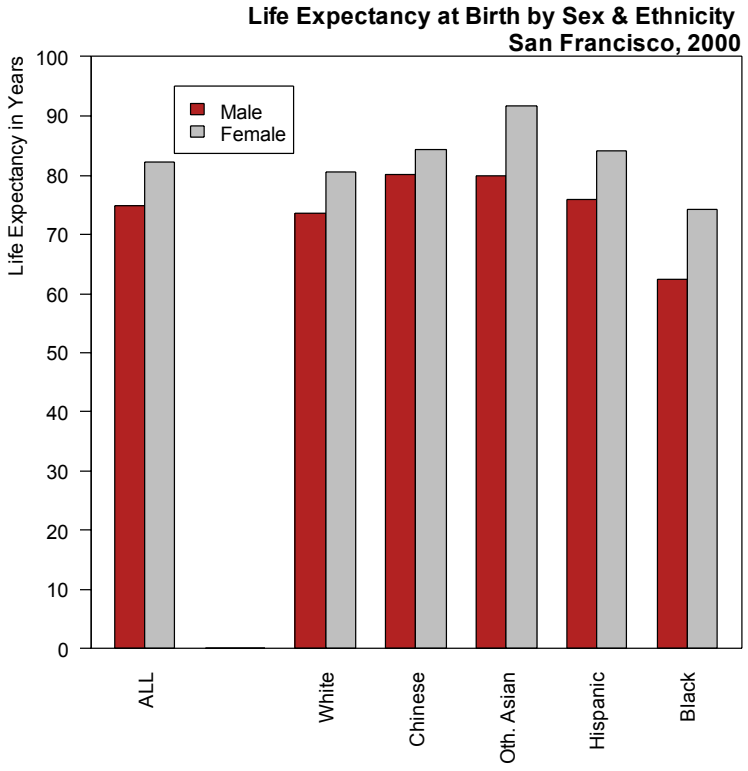
Mortality

Mortality is defined as "all deaths reported in a given population" (*National Library of Medicine*). Mortality data provide a rich source of information about a city's health. Each death certificate includes the cause of death, age, sex, race/ethnicity, and zip code. The State aggregates these data and makes them available to localities. The available data allow for an analysis of life expectancy, age-adjusted death rates, death rates by age group, comparisons with California, and years of life lost to each of the leading causes of death.

Life expectancy

Life expectancy at birth is a measure of how long a baby born now could be expected to live if he or she grew up being subject to current mortality rates. As such it is a good summary measure of mortality differences in a group over time or among groups.

Figure 4-1.



Source: SFDPH, Community Health Epidemiology & Disease Control

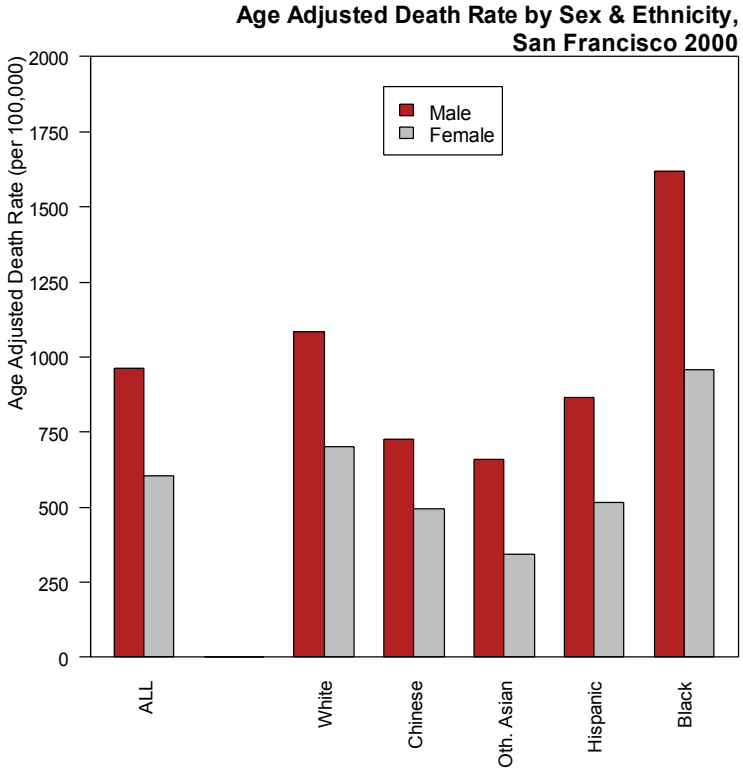
Life expectancy in San Francisco, as in California and the United States, has been increasing in recent years. But as Figure 4-1 shows, there are still marked disparities both across ethnicities and between men and women within each ethnicity. African Americans have the lowest life expectancy and highest mortality for each sex, followed by whites. Other Asian (non-Chinese) females have the greatest life expectancy. The figure clearly shows that the difference between sexes is least among Chinese. Chinese and Other Asian males have similar life expectancies, but Chinese females have much shorter life expectancies than Other Asian females.

Death rates: Overall (age adjusted)

Age-adjusted death rates are another measure of the overall force of mortality, expressed in a way that allows comparisons across groups whose populations differ in size and age. Death rates for males were more than a third higher than those for females. These overall rates also show African-American mortality to be highest for males and females, followed by that of white males and females. Asian and Hispanic mortality is the lowest.

Figure 4-2 shows a profile of relative mortality among the major sex-and-ethnicity groups that is not unique to San Francisco, but is also reflected in patterns for the State and for several surrounding counties.

Figure 4-2.



Source: SFDPH, Community Health Epidemiology & Disease Control

Death rates: by age group

Table 4-1 shows that male mortality is greater than that of females in every age group. This disparity is generally lowest during youth, when rates are lowest. It is most marked during the ages from 15 through 45, when men's greater mortality from injuries especially contributes to the differential.

Table 4-1.

Age-Specific Death Rates by Sex and Ethnicity/Race, San Francisco 2000

Age Group	0-4	5-14	15-29	30-44	45-59	60-69	70-79	80+
MALE								
SF Male	165.9	25.1	89.4	246.7	822.4	1804.0	3805.6	10950.2
White NH	152.9	14.7	69.9	259.3	925.7	2170.6	4394.2	12295.9
Chinese NH	0.0	0.0	74.6	99.9	352.6	1147.1	3249.5	10501.0
Oth. As./PI NH	294.5	72.9	26.5	74.0	450.5	1199.5	2335.4	8940.1
Latino	211.0	29.0	84.1	210.5	807.3	1577.0	3753.0	8882.1
Black NH	460.5	52.3	468.3	861.6	1913.6	3433.3	5815.4	10148.8
FEMALE								
SF Female	110.7	19.7	31.4	84.6	366.4	940.3	2261.5	8991.0
White NH	92.7	61.9	20.7	54.8	403.5	1113.2	2774.7	10452.6
Chinese NH	159.5	12.3	13.4	66.0	223.3	607.4	1864.6	8097.3
Oth. As./PI NH	57.2	0.0	40.3	74.3	195.8	644.6	1395.5	4469.6
Latina	141.9	0.0	36.1	94.5	338.7	898.0	1650.9	7524.9
Black NH	138.8	26.0	124.4	373.5	948.5	2053.5	3303.1	9357.1

NH=Non-Hispanic

Data sources: Death records, census 2000; calculated by SFDPH

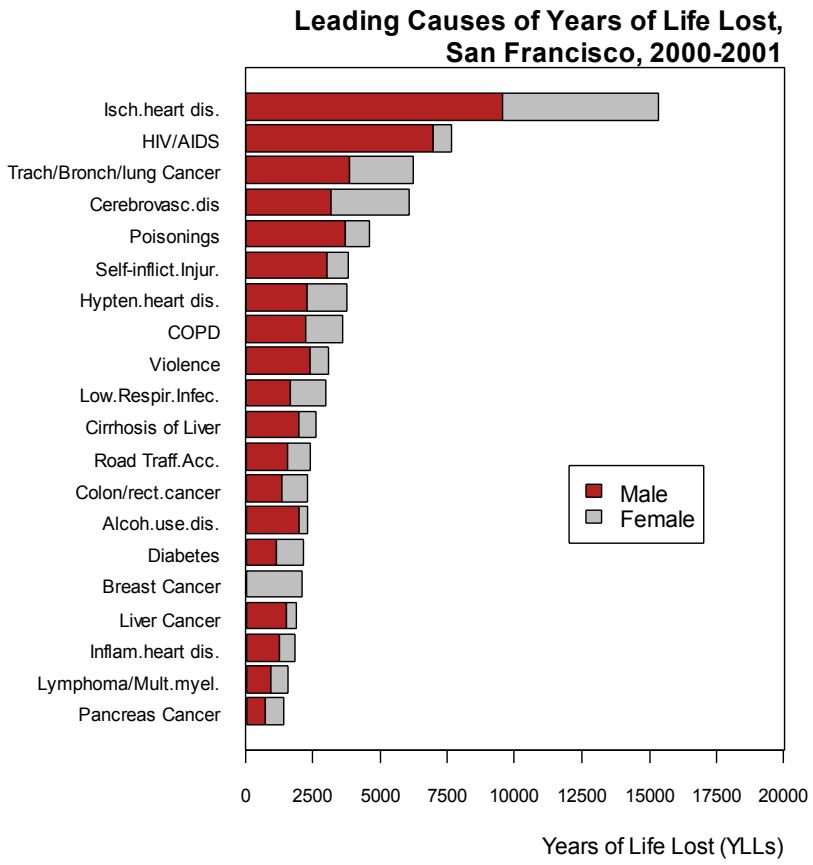
Premature death: Years of life lost (YLLs)

The Department also analyzes premature mortality based on the measure of expected "years of life lost" (YLLs). This measure subtracts the person's age at death from the life expectancy for someone that age in a standard population, so the younger the age at death, the greater the YLLs. Since many younger deaths could be prevented or postponed, this measure of premature mortality also emphasizes prevention.

Figure 4.3 shows the 15 leading specific causes of premature mortality for San Francisco for 2000. The leading cause is ischemic heart disease, followed by AIDS, stroke, lung cancer, and drug poisoning. AIDS and drug poisoning rank so high here because of a combination of the number of deaths involved, plus the fact that so many of them are to relatively younger people.

Of the list of 15 causes, men contribute more YLLs to the total than do women for all but the 15th cause, breast cancer.

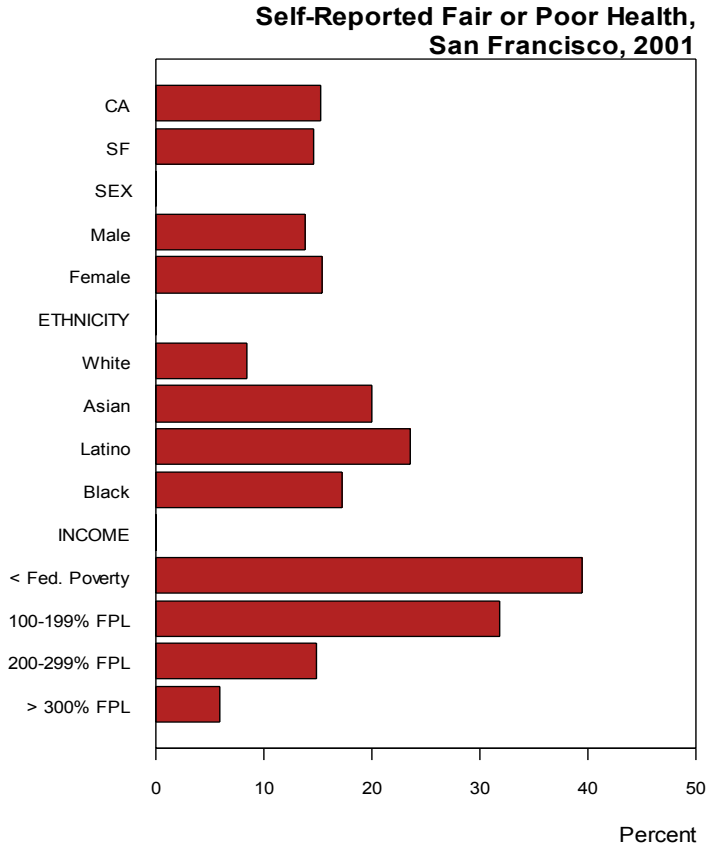
Figure 4-3.



Self-Assessed General Health

This measure provides information about people's general overall health, based on their own assessments. In Figure 4-4, San Franciscans report their health as fair or poor about as often as all Californians surveyed did in 2001. Males report less than good health slightly less than females do. Whites report less than good health much less than other ethnicities. There is also a strong relationship evident between income level and general health, with each level above poverty status reporting decreasingly low proportions of less than good health.

Figure 4-4.



Source: SFDPH, Community Health Epidemiology & Disease Control

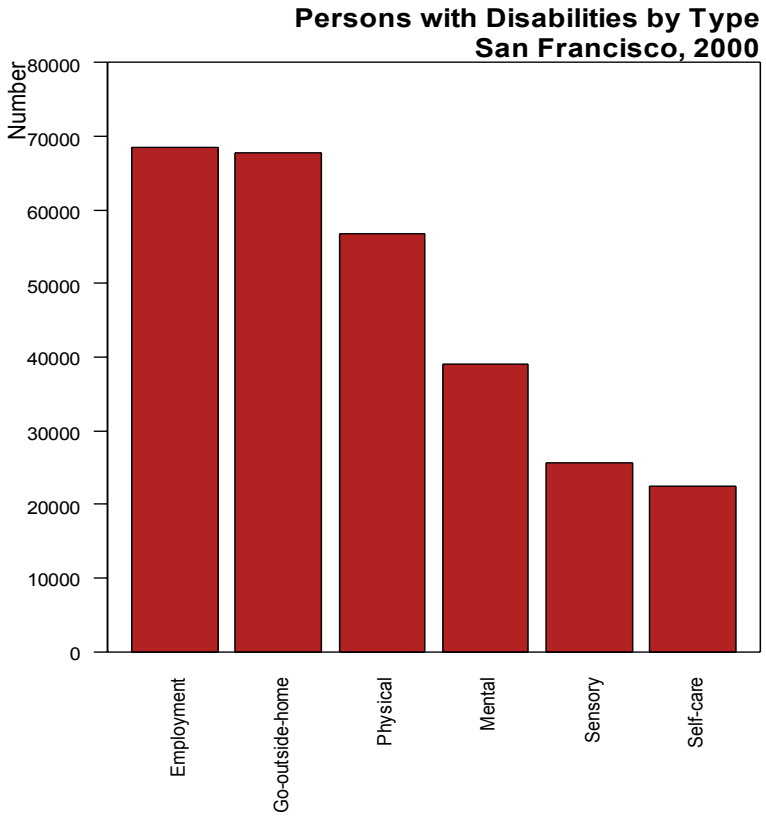
Disability

Measures of disability reflect the extent to which the population suffers from ongoing health problems, which can be defined in a variety of ways as impairing their capacity to perform physical or social activities or functions.

Figure 4-5 uses data from the 2000 Census and shows self-reported numbers of San Franciscans over age 4 with disabilities, by type of reported disability. These figures do not necessarily reflect an evaluation against a medical or program eligibility standard. The total of 280,350 people, which is well over a third of San Francisco's population, includes:

- 3,936 people ages 5-15;
- 176,974 ages 16 through 64; and
- 99,440 ages 65 or above.

Figure 4-5.



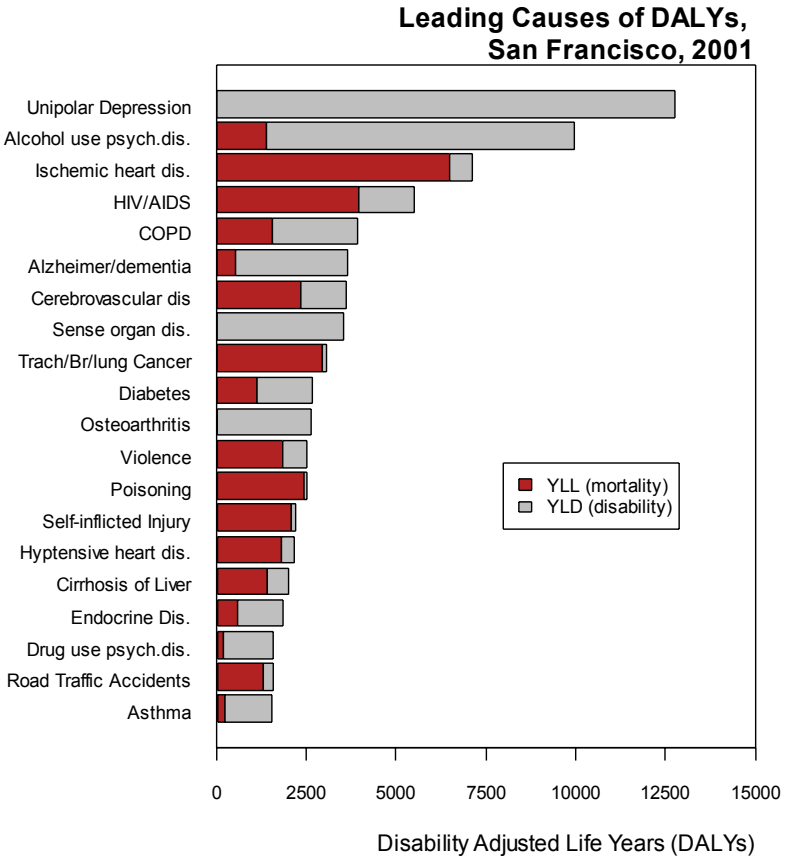
Source: US Census 2000

Disability Adjusted Life Years (DALYs)

Disability Adjusted Life Years (DALYs) are a summary measure of the overall burden of disease and injury in a population. DALYs were developed by the World Health Organization and combine years lost to premature mortality (years of life lost, YLL) and the number of years lived in less than good health with a disabling condition (YLD). The measure allows health evidence to be used to estimate the largest contributors to reduced years of healthy life due to disease, injury, disability, and death.

Figure 4-6 shows that in 2001 the four leading contributors to DALYs in San Francisco were depression, alcoholism, heart disease, and HIV/AIDS. Depression, alcoholism, dementias, sense organ disorders, and osteoarthritis are among the leading contributors to the burden of disease in San Francisco due largely or wholly to the amount of disability, rather than mortality, they cause.

Figure 4-6.

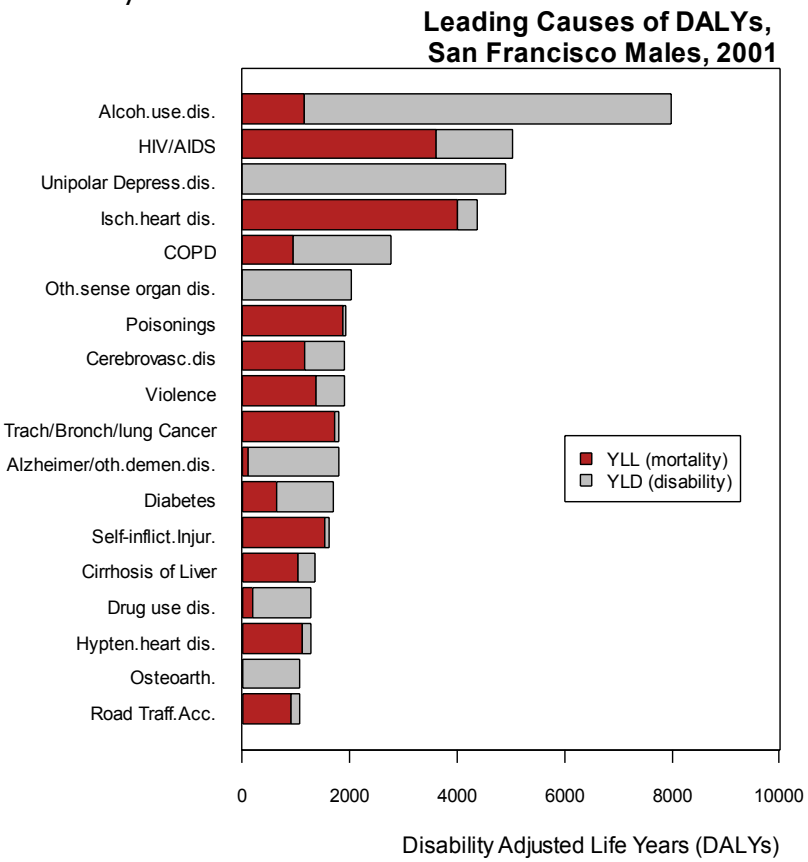


Source: SFDPH, Community Health Epidemiology & Disease Control

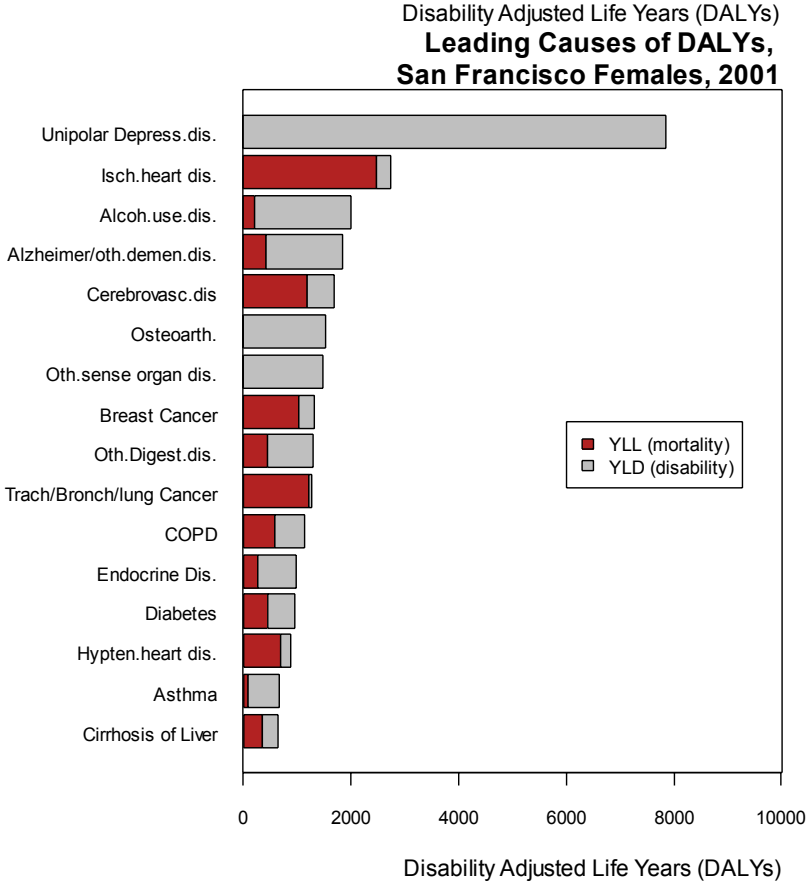
Among males, alcohol use disorder, HIV/AIDS, depression, and ischemic heart disease were the leading contributors. Among females, depression was by far the leading contributor, followed by heart disease and alcohol use disorder.

Figure 4-7.

(a) Males



(b) Females



San Francisco's "County Profile"

Table 4-2 presents data from the California Department of Health Services profile of counties for San Francisco for 1999-2001. The Rank Order column compares San Francisco with other counties in California (the lowest county rate is rank #1; the highest county rate is rank #58). San Francisco's overall age-adjusted death rate and the rates of coronary heart disease; diabetes and all cancers are lower than the State's. The rate of drug-related deaths in San Francisco is double that of California. Among all counties, San Francisco has the highest incidence of AIDS, syphilis, and tuberculosis.

Table 4-2.

SAN FRANCISCO COUNTY'S HEALTH STATUS PROFILE FOR 2003

MORTALITY

RANK ORDER		1999-2001 DEATHS (AVE./YR.)	CRUDE DEATH RATE	AGE-ADJUSTED DEATH RATE	95% CONF. LIMITS LOWER , UPPER	STATEWIDE AGE-ADJUSTED DEATH RATE	NAT'L OBJ.
12	ALL CAUSES (1999-2001 AVERAGE)	6,534.0	824.9	681.5	651.6 , 711.3	760.0	N/E
23	CORONARY HEART DISEASE	1,528.3	193.0	154.5	146.7 , 162.3	194.3	166.0
23	CEREBROVASCULAR DISEASE	574.7	72.6	57.2	52.5 , 61.9	61.2	48.0
16	DIABETES	136.7	17.3	14.4	12.0 , 16.8	20.7	N/A1
9	ALL CANCERS	1,507.3	190.3	161.3	153.1 , 169.5	176.1	159.9
6	LUNG CANCER	370.3	46.8	39.9	35.8 , 44.0	45.9	44.9
8	FEMALE BREAST CANCER	95.7	25.1	18.6	14.8 , 22.4	24.5	22.3
	AIDS						
26	UNINTENTIONAL INJURIES	281.3	35.5	32.3	28.4 , 36.1	27.2	17.5
4	MOTOR VEHICLE ACCIDENTS	54.0	6.8	6.8	4.9 , 8.7	10.3	9.2
52	HOMICIDE	55.3	7.0	7.6	5.5 , 9.7	6.2	3.0
27	SUICIDE	94.0	11.9	11.0 7	8.7 , 13.2	9.5	5.0
51	DRUG-RELATED DEATHS	153.7	19.4	17.4	14.6 , 20.2	8.4	1.0
13	FIREARM INJURIES	49.3	6.2	6.8	4.8 , 8.7	9.3	4.1

MORBIDITY

RANK ORDER		1999-2001 CASES (AVERAGE)	CRUDE CASE RATE	95% CONF. LIMITS LOWER , UPPER	STATEWIDE CRUDE CASE RATE	NAT'L OBJ.
58	AIDS INCIDENCE (AGE 13 AND OVER)	502.00	78.64	71.76 , 85.52	16.35	1.00
58	TUBERCULOSIS INCIDENCE	195.67	24.70	21.24 , 28.17	9.85	1.00
57	CHLAMYDIA INCIDENCE	2,949.33	372.37	358.93 , 385.81	271.59	N/A
58	SYPHILIS INCIDENCE	73.33	9.26	7.14 , 11.38	1.11	0.20

: Nat'l Obj: National Objective
N/E: National Objective for the Year 2010 has not been established.
N/A: Prevalence data are not available in California.
N/A1: National Objective is based on both underlying and contributing cause of death which requires use of multiple cause of death data files. A comparison was not made because these files are not yet available in California for this time period.
* Rate or percent unreliable; relative standard error greater than or equal to 23%.
Note: Crude death rates, crude case rates, and age-adjusted death rates are per 100,000 population.
Data sources: Department of Health Services: Center for Health Statistics, Birth and Death Statistical Master Files, 1999-2001, and Birth Cohort Files 1997, 1999, and 2000; Division of Communicable Disease Control, Office of Statistics and Surveillance; Office of AIDS, AIDS Case Registry
Department of Finance: 2000 Population Estimates with Age , Sex and Race/Ethnic Detail, December 1998.
Department of Finance: State Census Data Center, Census 2000, Summary Tape File 3, P87.
Source: Ca. Dept. of Health Services, from County Health Profiles 2003

NON-COMMUNICABLE DISEASE

In 2000, non-communicable diseases were responsible for 5,400 deaths, or 83.5 percent of all deaths of San Franciscans. The overall numbers of deaths and age-adjusted death rates for non-communicable diseases are shown below in Table 4-3.

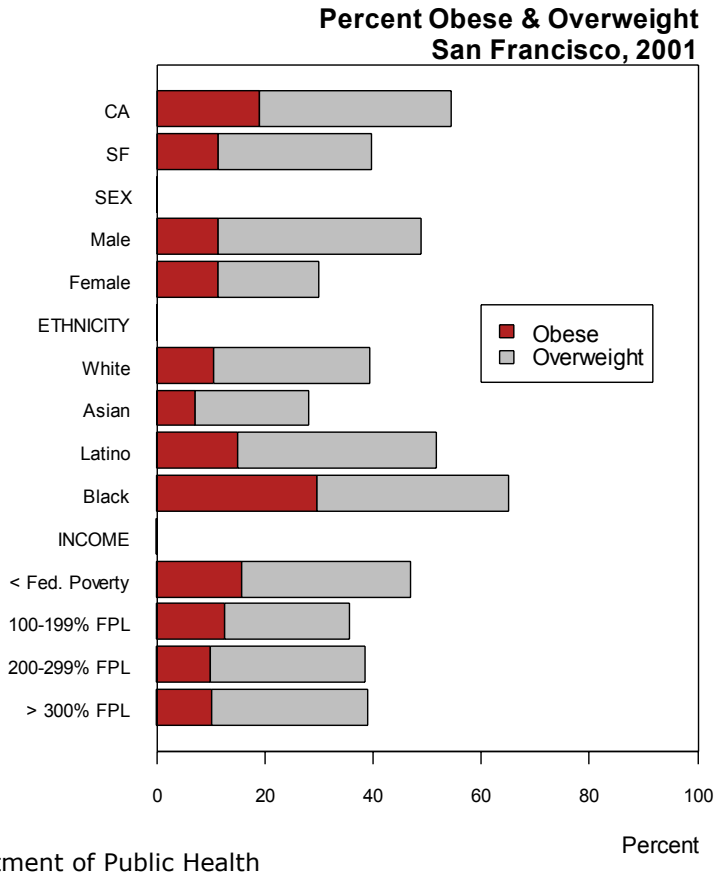
Table 4-3. Non-Communicable Disease Death Rates by Sex, San Francisco 2000

	Deaths	Adjusted Death Rate
All	5,400	640.3
Males	2,714	777.0
Females	2,686	532.2

Overweight

Being overweight increases the risk of numerous health problems, including hypertension, diabetes, heart disease, and breast cancer. Nationally, overweight has been increasing at an alarming rate, and is therefore receiving attention as an emerging national health priority. If this major health problem is to be addressed in San Francisco, there will need to be an increase in opportunities for physical activity and easy access to healthy food in all areas of the City.

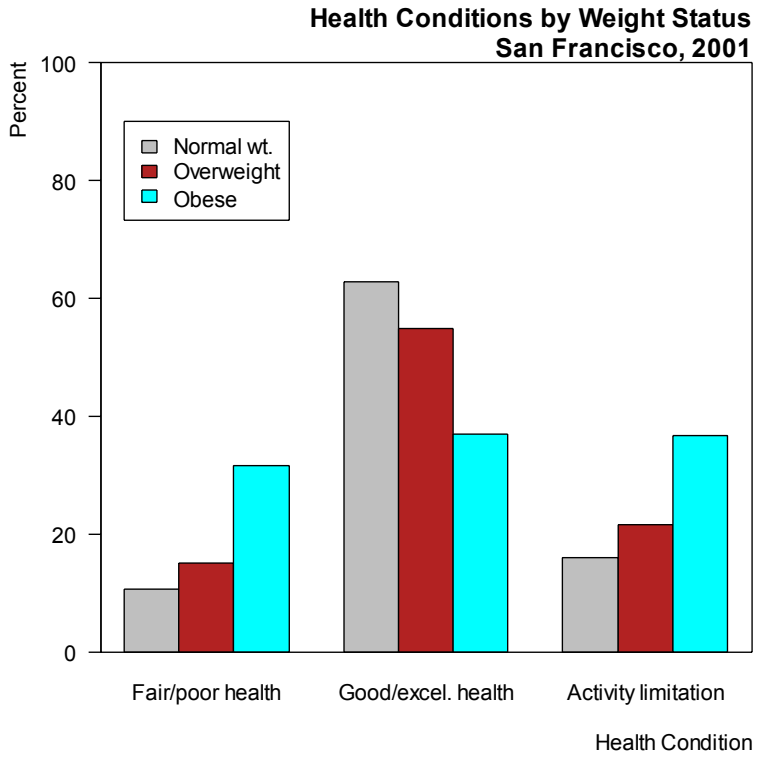
Figure 4-8.



Source: California Health Inventory Survey

Overweight is defined as having a body mass index (BMI, ratio of weight to height squared) over 25 but less than 30; a BMI over 30 is defined as obese. CHIS survey data show that, while San Franciscans are less obese and overweight than Californians as a whole, about 40 percent are still heavier than is considered healthy. A higher percentage of males than females, and of African Americans than other ethnicities, are overweight or obese.

Figure 4-9.



Source: California Health Inventory Survey

Cardiovascular disease

Cardiovascular Disease has been the leading cause of death in the U.S. every year since 1900 except 1918. In 1999 it killed almost a million people nationally. It represented 40 percent of all deaths, impacting more women than men. An estimated 62 million Americans have some form of CVD, including high blood pressure (50 million), coronary heart disease, stroke, and congestive heart failure. The numbers and age-adjusted death rates for major cardiovascular disease in 2000 are shown in Table 4-4.

Table 4-4.

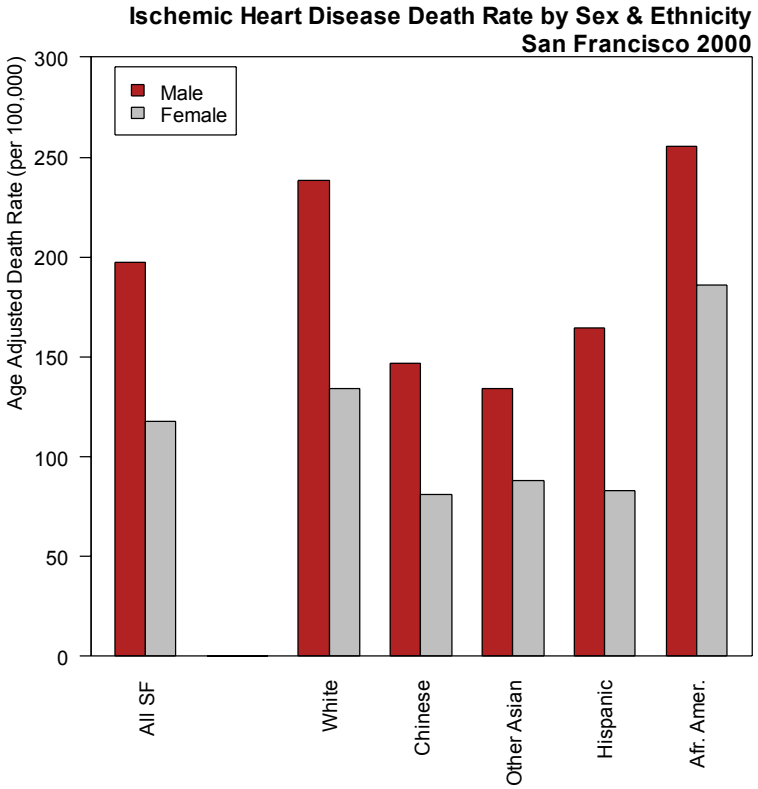
Death and death rates from major cardiovascular diseases, San Francisco 2000.

Cardiovascular Disease	All S.F.		Males		Females	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
Ischemic.heart dis.	1293	152.1	672	197.1	621	117.5
Cerebrovascular.dis	588	68.8	249	73.6	339	63.7
Hypertensive.heart dis.	256	30.3	122	34.9	134	25.8
Inflammatory.heart dis.	88	10.5	60	16.2	28	6.0

Ischemic heart disease

Ischemic heart disease (IHD, also called coronary heart disease) is the leading contributor of years of life lost for both men and women, and the leading cause of death in terms of both rates and numbers of deaths, and the third leading cause of DALYs. San Francisco's death rate for 1999-2000 combined was 159.2, significantly lower than California's rate of 201.5 (see "Coronary Heart Disease" in "County Health Status Profile", Table 4-2).

Figure 4-10.



In 2000 alone there were 1,293 deaths of San Franciscans (out of 6,468 total). IHD rates here, as elsewhere, are declining, but there continue to be large disparities by sex and ethnicity. Smoking, diet (especially fats), lack of exercise, overweight, and stress are risk factors for IHD, and dietary factors can start the disease process early in life. Interventions in any of these factors at any age can decrease risk.

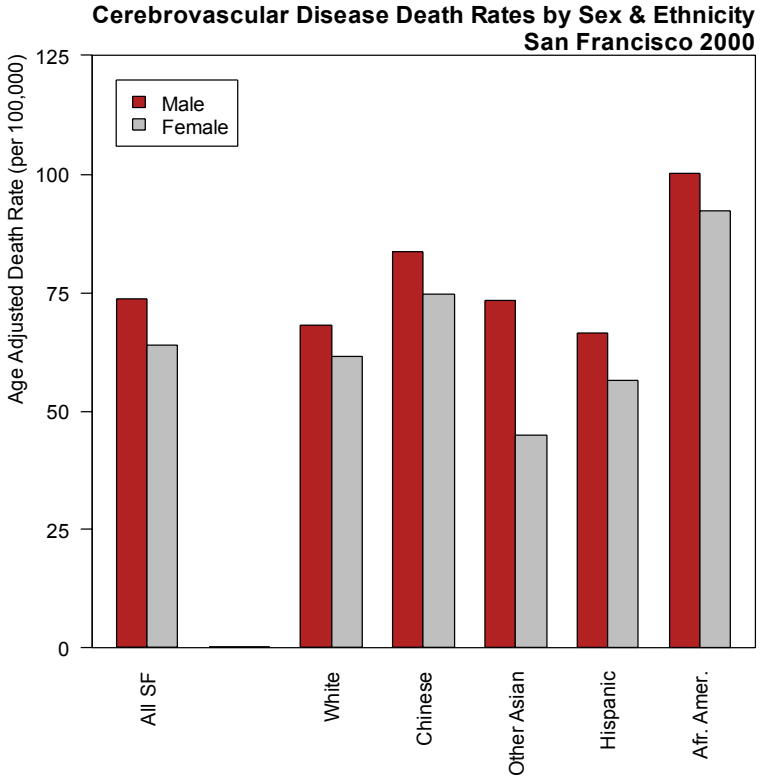
Source: SFDPH, Community Health Epidemiology & Disease Control

Stroke

Cerebrovascular disease or stroke was the third leading cause of years of life lost in San Francisco in 2000-2001, and the seventh leading cause of DALYs in 2001. Figure 4-11 shows that the stroke death rate for San Francisco in 1999-2000 was slightly, not significantly, below California's, 60.4 compared to 63.3 respectively. Stroke mortality rates are highest for African-American men and women, intermediary for white and Asian men and women, and much lower for Hispanics. Rates for males of each ethnicity are higher than those of females.

Tobacco, physical inactivity, poor diet, and drugs are among the risk factors for stroke. Fatalities from strokes that do occur could be reduced if more people recognized the warning signs and sought immediate help when they occurred.

Figure 4-11.



Source: SFDPH, Community Health Epidemiology & Disease Control

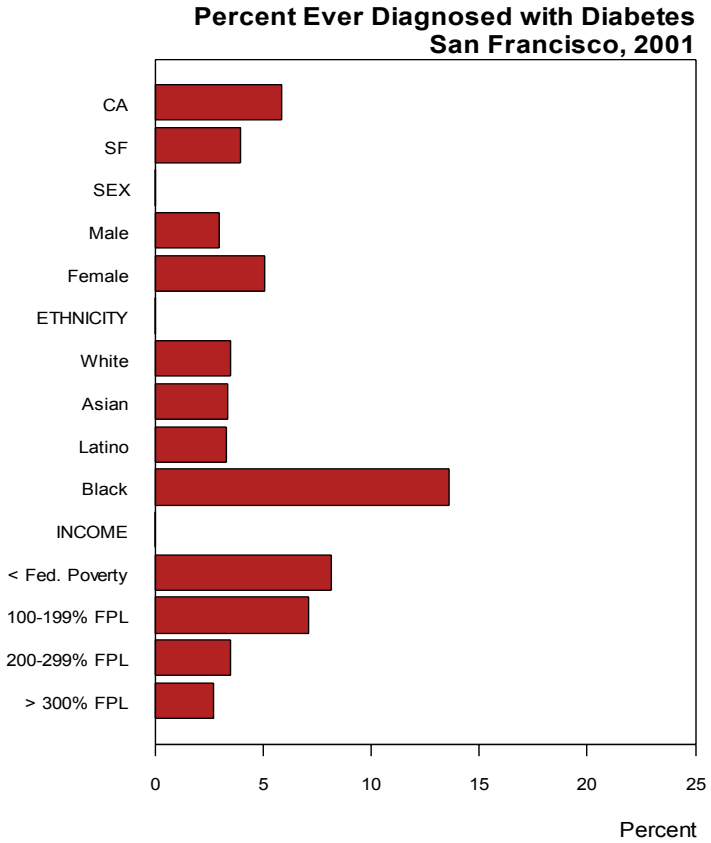
Diabetes

Diabetes prevalence has been increasing alarmingly in the U.S. over the past decade, and for people at younger ages. Youth are now being diagnosed with what was once called "adult onset diabetes."

Diabetes ranked 10th among San Francisco's leading causes of disability adjusted life years. People with diabetes are 2 to 4 times as likely to die from coronary heart disease and twice as likely to die from stroke as people without diabetes. More than 80 percent of people with diabetes die from some form of cardiovascular disease. The age-adjusted rate for the 588 deaths whose underlying cause was attributed to diabetes in 2000 was 68.8 overall, 73.6 for males, and 63.7 for females.

Figure 4-12 illustrates CHIS survey data which shows San Francisco to have a lower percent of its population diagnosed with diabetes. The prevalence for females is greater than for males; for African Americans is greater than for other ethnicities; and there is a gradient by income: the less income, the higher the prevalence of diabetes.

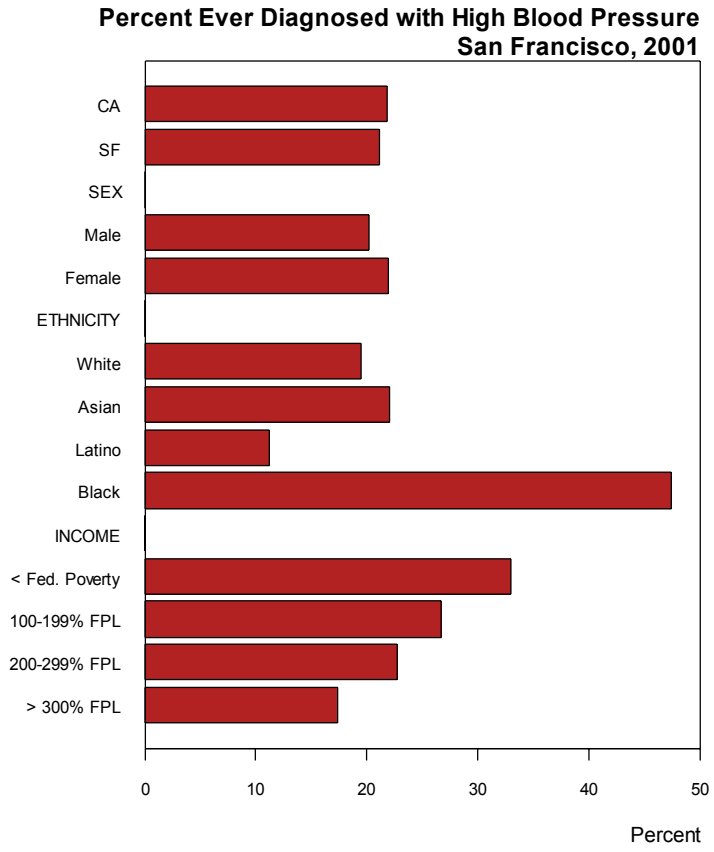
Figure 4-12.



High blood pressure

High blood pressure, or hypertension, is among the leading causes of DALYs (the 15th leading cause in 2001), and is also a major risk factor for ischemic heart disease, and stroke. Figure 4-13 shows that almost half of the African Americans surveyed in San Francisco reported having been diagnosed with high blood pressure, far higher than for any other group. People in the lowest income households also have significantly higher levels of diagnosed high blood pressure than those at higher income levels.

Figure 4-13.



Source: California Health Inventory Survey

Cancer

For this period (1996-2000), prostate cancer was the leading cause of new cancer cases (incidence) among men, and breast cancer among women, overall and for all ethnicities. Lung and colorectal cancers are the second and third leading causes of new cancer cases. However, lung cancer (about 90 percent of which is attributable to exposure to tobacco smoke) was the leading cause of death (both most deaths, and highest death rates) for both sexes and for all ethnicities.

Among females, breast cancer had almost triple the incidence of lung and colorectal cancers, but the death rate from lung cancer was more than twice that of colorectal cancer, and a third higher than breast cancer. Among males, there was twice the rate of prostate cancer as lung cancer, and more than twice the rate of colorectal cancer, but the lung cancer mortality rate was more than twice that rate for both colorectal and prostate cancer. For almost all sites and ethnicities, rates of both incidence and mortality are higher for males than for females.

There is significant variation in incidence and mortality for the leading cancer sites by ethnicity/race, as shown in the table. Cancer incidence is higher overall for African Americans and whites than for Latinos and Asians. Overall mortality rates within each gender are highest for African Americans, followed by whites.

Table 4-5.

San Francisco Leading Cancer Incidence Rates by Sex and Site, 1996-2000

	MALES	ALL MALES			ETHNICITY-SPECIFIC RATES			
Rank	Site	Cases	Rate	LCI , UCI	White	Asian/P.I.	Latino	Afric.-Am.
	ALL	10,555	539.1	528.8 , 549.6	**645.4	380.8	362.5	***768.2
1	Prostate	2,887	150.7	145.2 , 156.3	**175.8	89.0	106.1	***275.3
2	Lung	1,436	74.5	70.7 , 78.5	*76.1	*70.4	36.5	***131.3
3	Colorectal *(invasive)*	1,142	59.9	56.4 , 63.5	65.9*	55.4*	34.5	77.4*
4	Non-Hodgkin's lymphoma	696	33.0	30.6 , 35.6	***47.5	13.8	--	*30.4
5	Bladder	453	24.0	21.9 , 26.4	***36.7	11.5	10.8	18.1
6	Liver	361	17.9	16.1 , 19.9	11.8	27.1*	12.5	22.5*
7	Kaposi's sarcoma	378	16.1	14.5 , 17.8	22.5*	2.7	14.9*	22.8*
8	Stomach	285	15.1	13.4 , 17	12.3	16.1	18.9	24.2*
9	Leukemia	259	13.6	11.9 , 15.4	17.1*	10.6	8.1	16.0
10	Pancreas	207	10.8	9.4 , 12.4	11.6	9.0	16.9	16.9

	FEMALES	ALL FEMALES			ETHNICITY-SPECIFIC RATES			
Rank	Site	Cases	Rate	LCI , UCI	White	Asian/PI	Latino	Afric.-Am.
	ALL	8,943	370.5	362.7 , 378.5	***464.6	290.8	266.2	**364.8
1	Breast *(invasive)*	2,701	116.5	112.1 , 121.1	155.4*	82.7	71.8	104.7*
2	Colorectal *(invasive)*	1,148	44.0	41.4 , 46.7	48.8*	42.2*	28.4	44.3*
3	Lung	1,031	40.7	38.2 , 43.4	*51.6	31.0	23.4	***53.7
4	Breast *(in situ)*	662	29.3	27.1 , 31.7	*35.1	24.8	19.1	30.3
5	Corpus uteri	508	21.7	19.8 , 23.8	27.7*	16.9	16	18.7
6	Ovarian	348	15.2	13.6 , 17	***21.4	10.3	10.2	10.4
7	Non-Hodgkin's lymphoma	338	13.8	12.3 , 15.4	15.2	11.0	15.1	12.7
8	Pancreas	229	8.6	7.5 , 9.8	9.4	5.9	8.5	14.1*
9	Stomach	204	7.8	6.8 , 9.1	6.0	11.1*	7.8	6.9
10	Bladder	202	7.7	6.7 , 9.0	*9.9	4.8	5.1	8.2

Rates are per 100,000, age adjusted to standard US 2000 population. LCI,UCI: lower, upper 95% confidence interval.
*** Signifcantly higher than all other ethnicity groups of this sex
** Significantly higher than next lowest group of this sex
* Significantly higher than other group(s) of this sex
Source: No. Ca. Cancer Center, Cancer Incidence and Mortaltiy in the Greater San Francisco Bay Area 1988-2000. (2003). http://www.nccc.org/ResearchandTraining/pubs/research_CRpubs_annualreports.html

From 1996 through 2000, the top five causes of mortality for both men and women stayed the same as were in last year's report, covering 1995 through 1999. The incidence of Kaposi's sarcoma continues to drop among males; now it is sixth in rank. Note however that rates shown here cannot be compared with earlier reports, because of the use of a new standard for age adjustment.

Table 4-6.

San Francisco Leading Cancer Mortality Rates by Sex and Site, 1996-2000

	MALES	ALL MALES				ETHNICITY-SPECIFIC RATES			
Rank	Site	Deaths	Rate	LCI , UCI		White	Asian/PI	Latino	Afric.-Am.
	ALL	4,012	212.4	205.9 , 219.2		**233.1	172.3	157.2	***348.4
1	Lung	1,057	55.7	52.4 , 59.2		*56.9	*50.3	33.7	***98.4
2	Colorectal (invasive)	414	22.5	20.4 , 24.8		*25.3	18.5	13.8	*36.6
3	Prostate	376	21.4	19.3 , 23.8		*25.9	9.4	14.3	***58.0
4	Liver	258	12.8	11.3 , 14.6		8.2	*18.4	11.8	*19.6
5	Non-Hodgkin's lymphoma	202	10.3	8.9 , 11.9		*13.9	6.4	9.2	6.8
6	Stomach	184	9.9	8.5 , 11.5		7.1	9.9	*14.8	*20.7
7	Pancreas	189	9.9	8.6 , 11.5		*11.8	6.8	10.5	14.0
8	Leukemia	157	8.4	7.1 , 9.9		*11.0	6.7	4.0	11.0
9	Brain and nervous system	110	5.5	4.5 , 6.6		7.1	3.7	4.6	4.6
10	Bladder	79	4.4	3.5 5.5		*6.2	2.6		

	FEMALES	ALL FEMALES				ETHNICITY-SPECIFIC RATES			
Rank	Site	Deaths	Rate	LCI , UCI		White	Asian/PI	Latino	Afric.-Am.
	ALL	3,527	135.3	130.7 , 140.0		**161.8	101.5	92.0	***193.1
1	Lung	757	28.9	26.9 , 31.1		*36.2	21.3	14.2	*45.3
2	Breast	516	21.0	19.2 , 23.0		*28.2	11.1	11.7	*34.9
3	Colorectal (invasive)	418	14.9	13.5 , 16.5		16.8	13.7	7.0	19.9
4	Pancreas	208	7.6	6.6 , 8.8		8.7	5.4	5.8	*12.2
5	Ovarian	167	6.7	5.7 , 7.9		9.3*	3.6	6.1	6.5
6	Non-Hodgkin's lymphoma	154	5.7	4.8 , 6.7		6.5	4.3	6.1	6.0
7	Leukemia	130	5.1	4.2 , 6.2		*7.3	3.4	3.3	6.6
8	Stomach	122	4.5	3.8 , 5.5		3.7	5.6	4.5	4.8
9	Liver	82	3.2	2.5 , 4.1		1.6	*5.7	3.1	--
10	Brain and nervous system	63	2.6	2.0 , 3.4		*3.9	1.4	1.8	--

Rates are per 100,000, age adjusted to standard US 2000 population. LCI,UCI: lower, upper 95% confidence interval.

*** Signifcantly higher than all other ethnicity groups of this sex

** Significantly higher than next lowest group of this sex

* Significantly higher than other group(s) of this sex

Source: No. Ca. Cancer Center, Cancer Incidence and Mortaltiy in the Greater San Francisco Bay Area 1988-2000. (2003). http://www.nccc.org/ResearchandTraining/pubs/research_CRpubs_annualreports.html

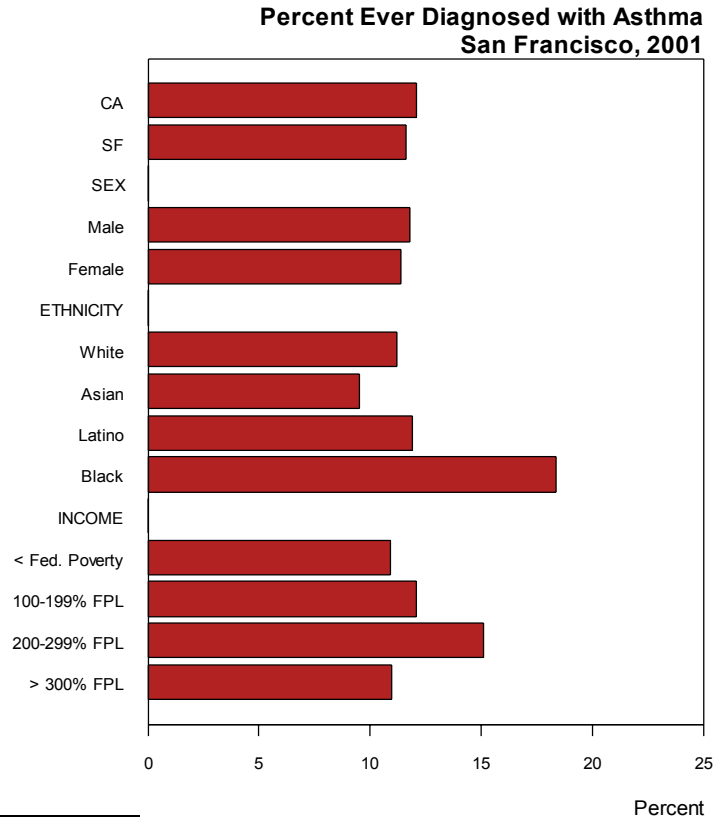
Asthma

Asthma ranked 20th among contributors to overall burden of disease in 2001 DALYs. Nationally, prevalence of asthma has been reported to have increased significantly during the past decade. Prevalence rate estimates for California, shown in Figure 4-14, were about 11.5 percent overall in 2000. It indicates highest prevalence among whites and African Americans, about twice that of the lowest group, Hispanics.

Asthma hospitalization rates for both the City and the State, however, show something different. African-American children under age 15 had the highest hospitalization rates for 1995-1997 (rate of 664 per 100,000 children), followed by Hispanic children (rate of 351); across all ages, African Americans had the highest hospitalization rate rate of 463).[1] Asthma hospitalizations are in significant part preventable with better access to and use of primary care. Long-term environmental interventions, along with medical management, can significantly reduce the burden of asthma.

The data shown in Figure 4-14, from the CHIS survey, uses a broader question about occurrence of asthma ("ever diagnosed", rather than recent active episodes of symptoms) than are used in many reports of population prevalence estimates for the disease. None of the inter-group differences for San Francisco were statistically significant.

Figure 4-14.



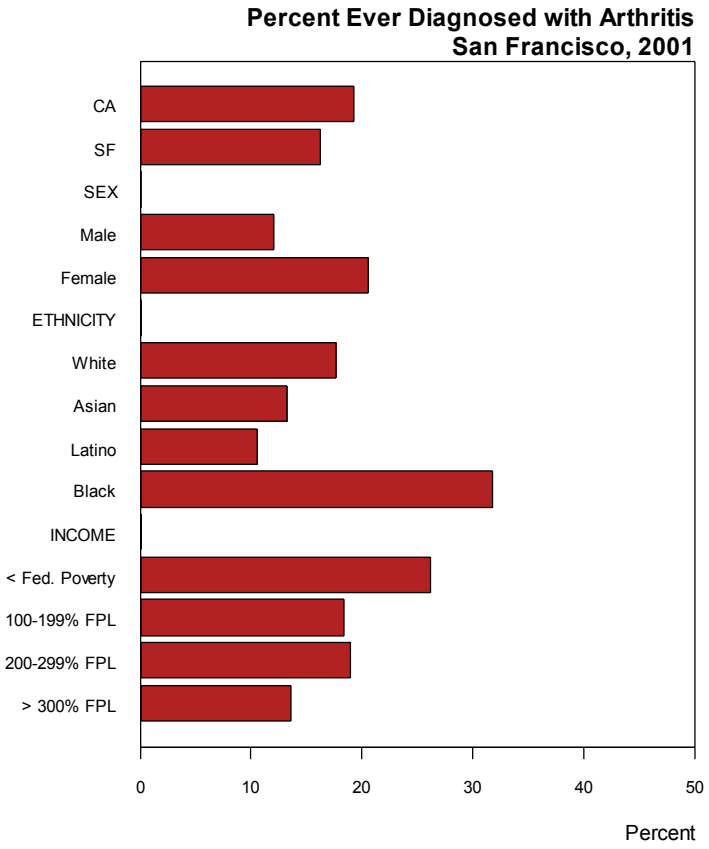
1 Ca. Dept. of Health Services, County Asthma Hospitalization Chart Book 2000; cited in Overview of Health in San Francsico, 2001.

Arthritis

Although it is not itself a cause of death, osteoarthritis is ranked as the condition making the 11th largest contribution to the overall burden of disease in San Francisco, as measured by DALYs. It was the sixth leading cause among women. Of those who had been diagnosed with arthritis, 26 percent reported having a lot of limitations due to it, and another 26 percent reported moderate limitations.

Although San Francisco's prevalence was significantly lower than California's, about one-sixth of adults surveyed, an estimated 100,000 people, reported having been diagnosed with arthritis. The percentage is significantly higher for females than males, for African Americans than for all the other ethnicity/race groups, and for those with incomes greater than 300 percent of the federal poverty level than for those below poverty level. Latino prevalence was significantly lower than that of whites or African Americans.

Figure 4-15.



COMMUNICABLE DISEASE

Communicable diseases caused just under 10 percent of San Francisco deaths in 2000. The largest contributors to mortality are HIV/AIDS and lower respiratory infections. A number of other infections, such as tuberculosis, the hepatitises, and sexually transmitted diseases (STDs) are also especially important because of the long-term threats they can pose to the health of those already infected, as well as others to whom they can be transmitted.

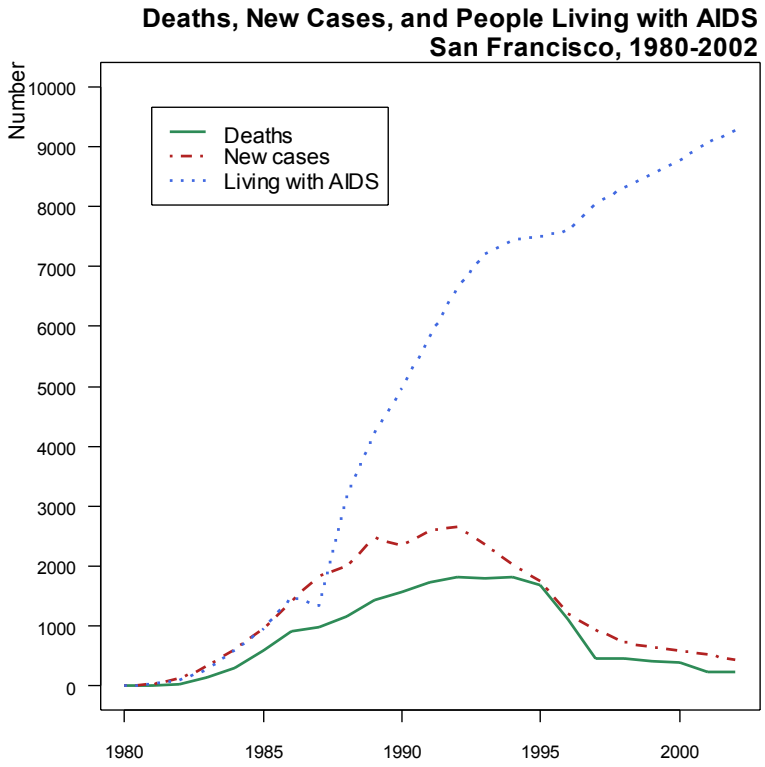
Table 4-7. Communicable Disease Death Rates by Sex, San Francisco 2000

	Deaths	Age Adjusted Death Rate
All	630	
Males	402	108.0
Females	228	46.1

HIV/AIDS

Figure 4-16 shows that AIDS deaths and newly diagnosed cases continue to decline from the early 1990s, continuing the benefit from combination therapy on survival. However, the drop in cases has leveled off in recent years. Moreover, sexual risk behavior, STDs and HIV incidence have been increasing in men having sex with men (MSM).

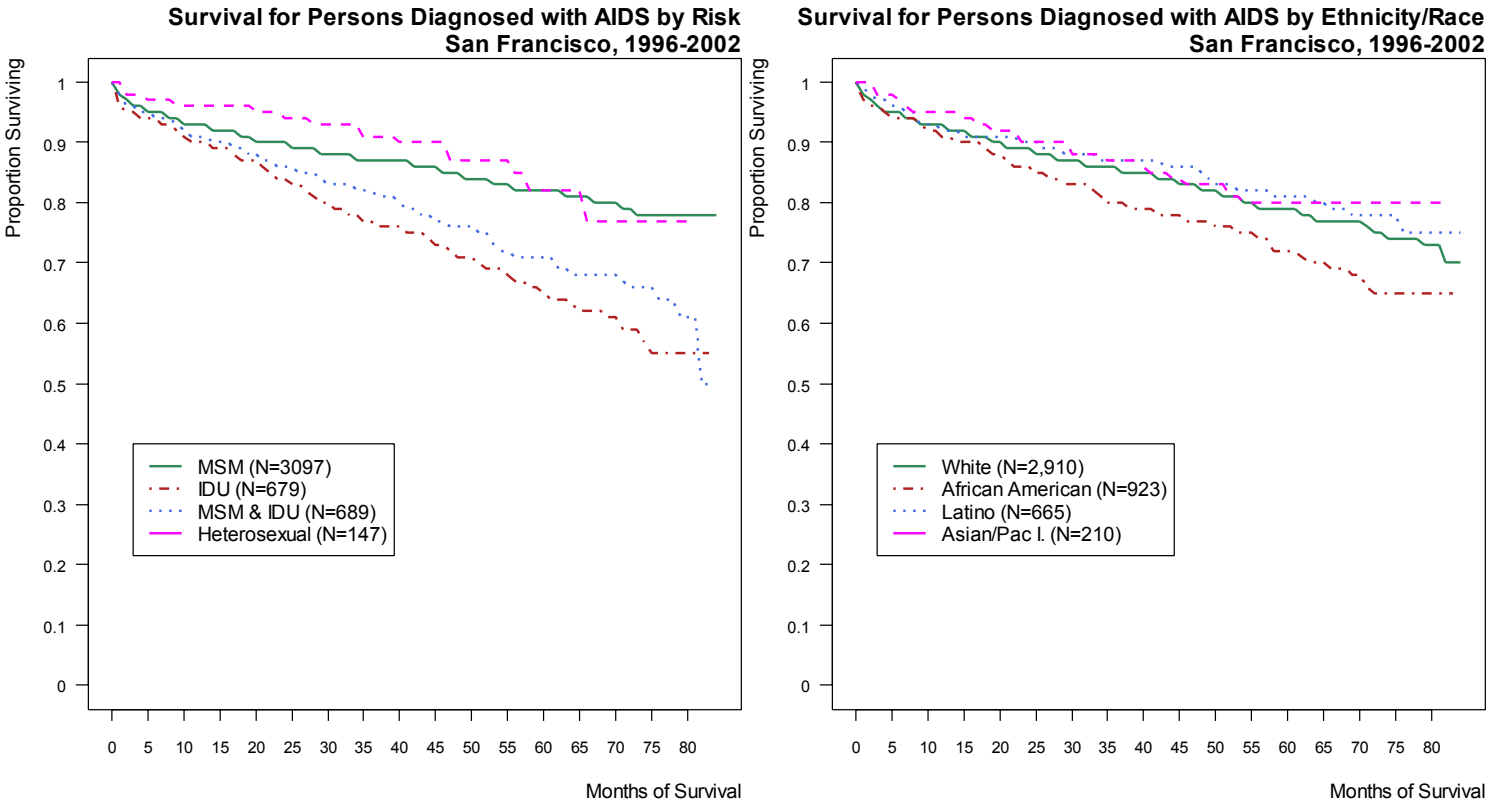
Figure 4-16.



Source: SFDPH, HIV/AIDS Epidemiology Annual Report 2002.

Figure 4-17 shows increases in survival among all groups with AIDS, but survival was still somewhat worse among African Americans than other ethnicities, and injection drug users (IDUs) than other risk groups. For those diagnosed between 1996 and 2002, survival to 60 months (5 years) after diagnosis was 65 percent for African Americans, compared to 75 percent for whites and more for the other ethnicities. Five-year survival was 71 percent for MSM IDU, 65 percent for other IDU, and 82 percent for non-IDU MSM and heterosexuals. Lower survival may partly reflect lower use of Highly Active Anti-Retroviral Therapy (HAART) therapy drugs. Worse survival among IDUs may also reflect increased mortality from other causes.

Figure 4-17. (a) Survival by Risk Group (b) Survival by Ethnicity/Race

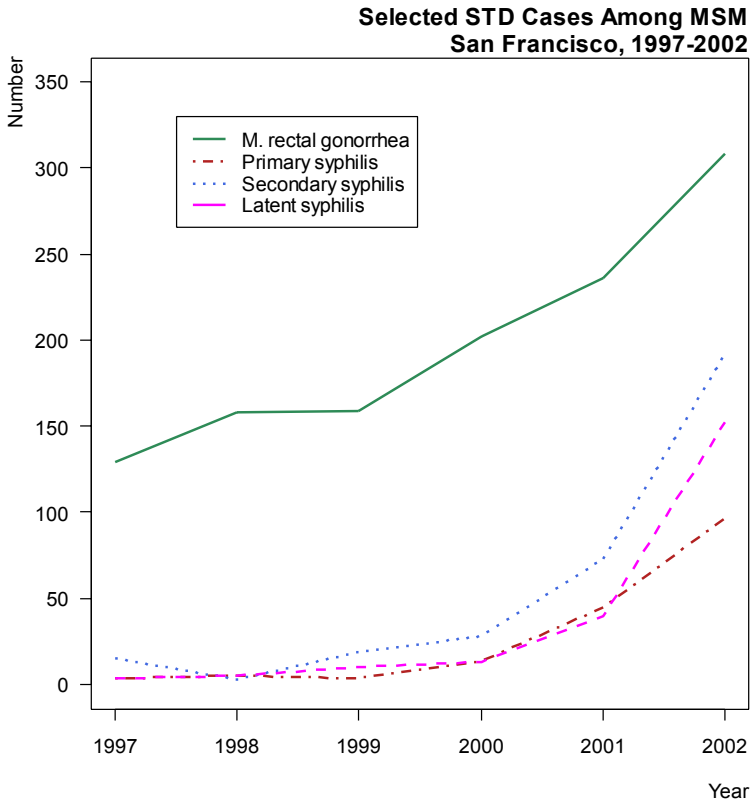


Source: SFDPH, HIV/AIDS Epidemiology Annual Report 2002.

HAART use increased survival for all groups, but was more common among MSM (76%) and heterosexuals (75%) with AIDS than among heterosexual injection drug users (63%). Its use was also less common among African Americans and Latinos (70%) than among whites (75%) or Asians (79%). These differences in treatment are reflected in survival across risk and ethnicity groups.

Data, shown in Figure 4-18, on the sharp increase in these sexually transmitted diseases (STDs) are a great concern, because these STDs are markers of high risk sexual behavior, and also increase the risk of getting and spreading HIV. The gonorrhea data are believed likely to be under-reported.

Figure 4-18.



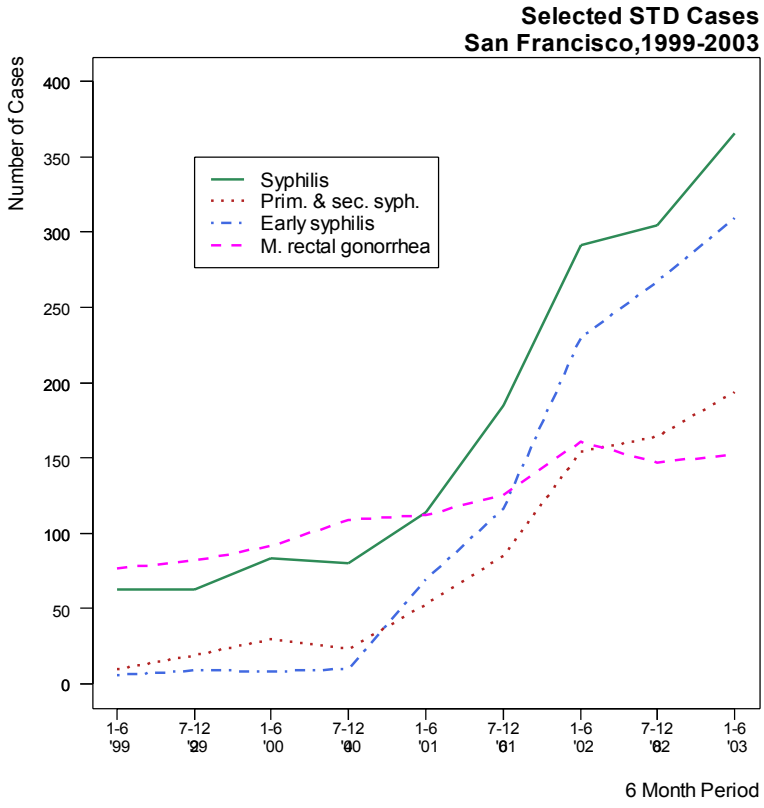
Source: SFDPH, HIV/AIDS Epidemiology Annual Report 2002.

Sexually transmitted diseases

The sharp rise in syphilis cases which began in mid-2000 has continued, as can be seen in Figure 4-19. Rectal gonorrhea, which has been increasing in San Francisco since 1995, appears to have leveled off since early 2002. These cases are thought to be concentrated among both MSM and also among young heterosexual men and women in the southeast part of city.

Chlamydia increased over the previous six years, through 2002, which was thought to be due to both increased screening (chlamydia screening of sexually active women aged 15-25 was adopted as a HEDIS "quality of care indicator") as well as increased prevalence.

Figure 4-19.

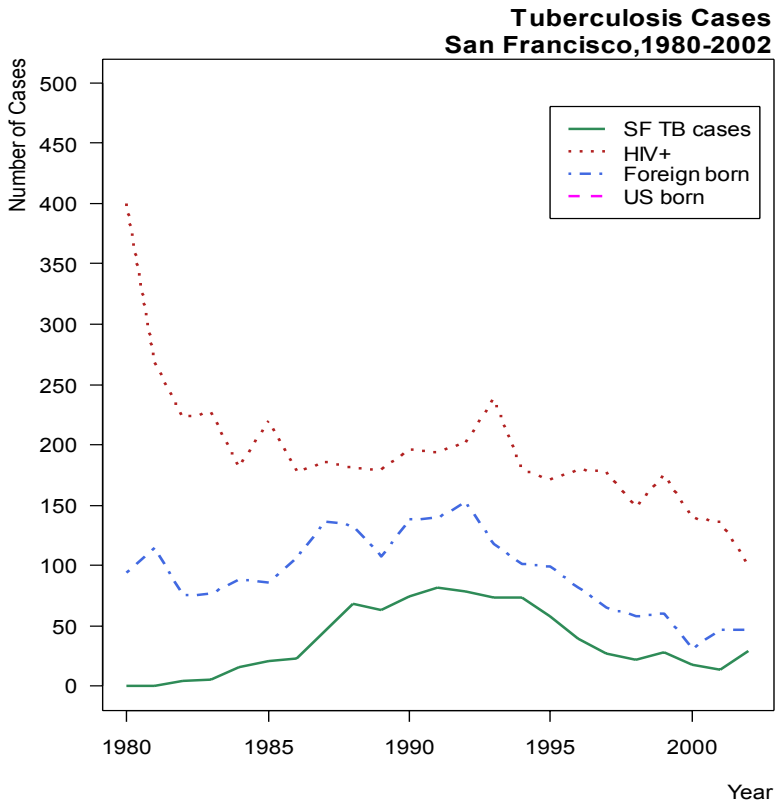


Tuberculosis

The long-term decline in number of tuberculosis (TB) cases continued in 2002; the 146 cases was the lowest number of cases in the past 20 years. San Francisco's rate (18.4 per 100,000) is still three times the national average (5.6 in 2001). Two-thirds of new cases occur among the foreign-born (90% of which have immigrated from China, the Philippines, and Southeast Asia). The decrease in 2002 cases was entirely due to a decrease, from 136 to 100, in the number of foreign-born cases.

Rates are highest among Asians (but have been declining), followed by African Americans. Of the 25 cases among African Americans, 80 percent were homeless, 60 percent were HIV-infected, and half were both.

Figure 4-20.

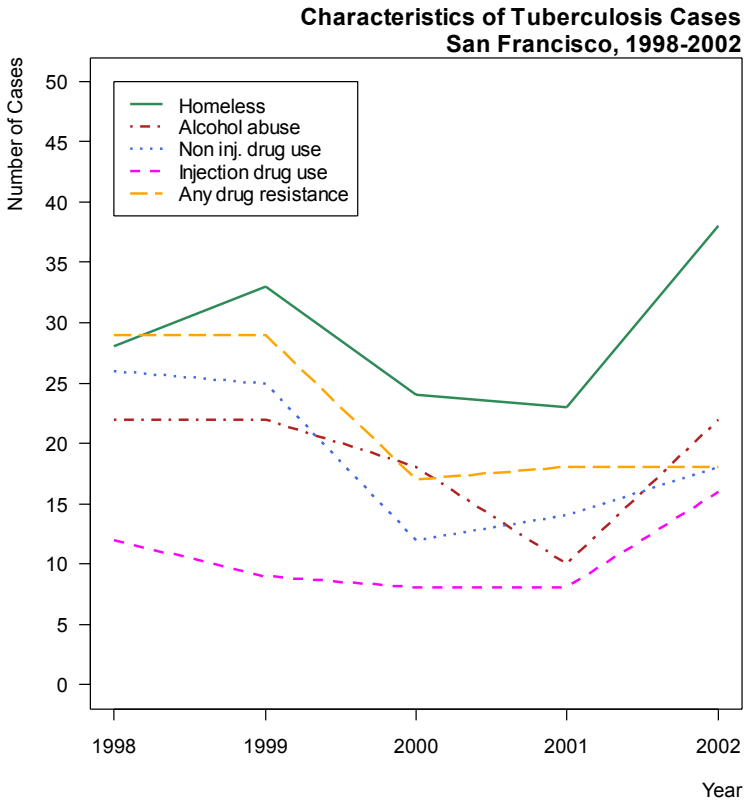


Source: SFDPH, Profile of Tuberculosis San Francisco 2002.

Figure 4-21 shows that while total cases declined in 2002, homeless cases increased by 15, to 38 (26%). The number of cases co-infected with HIV reversed its 10-year decline, and increased from 13 to 29 cases. The proportion of reported drug users also increased after declining the previous year, with 80 percent of drug and alcohol using TB cases also being homeless. The increases in drug and alcohol use and HIV infection among TB cases in 2002 is due to the increase in homeless people with TB.

Fifteen percent (n=18) of the 120 culture-positive TB cases were resistant to at least one drug. Four of these cases showed multi-drug resistance; none of these were due to acquired drug resistance.

Figure 4-21.



Source: SFDPH, Profile of Tuberculosis San Francisco 2002

INJURIES

In 2000, 6.7 percent of all residents' deaths (435 deaths) were due to injuries.

Table 4-8. Deaths from Injuries, San Francisco 2000

	Males		Females		Total
	Deaths	Death Rate	Deaths	Death Rate	Deaths
Injuries	320	76.6	115	27	435
Unintentional Injuries	202	49.1	87	20.7	289
Poisonings	91	20.4	18	4.2	109
Road Traffic Accidents	36	8.9	23	5.9	59
Falls	28	7.7	18	3.8	46
Intentional Injuries	118	27.5	28	6.4	146
Self-inflicted Injuries	76	17.8	19	4.2	95
Violence	41	9.5	9	2.1	50

Residents and non-residents

Hundreds of thousands of non-San Francisco residents spend time in the City each day, as workers or visitors to its stores, services, and tourist attractions. These people are subject to being injured or killed here, as San Francisco residents are when they travel elsewhere. Injury rates can be calculated for residents, because it is known for the City's residential population. It is impossible to know how many people are here at any time and therefore it is impossible to compute rates. Thus in this area numbers or proportions of injuries by characteristics of injury or injured are often reported.

Drug poisoning was the leading mechanism of injury death for residents and non-residents dying here, while falls was the leading mechanism for both residents and non-residents hospitalized here, based on 1998 data.

Unintentional injuries

Poisoning

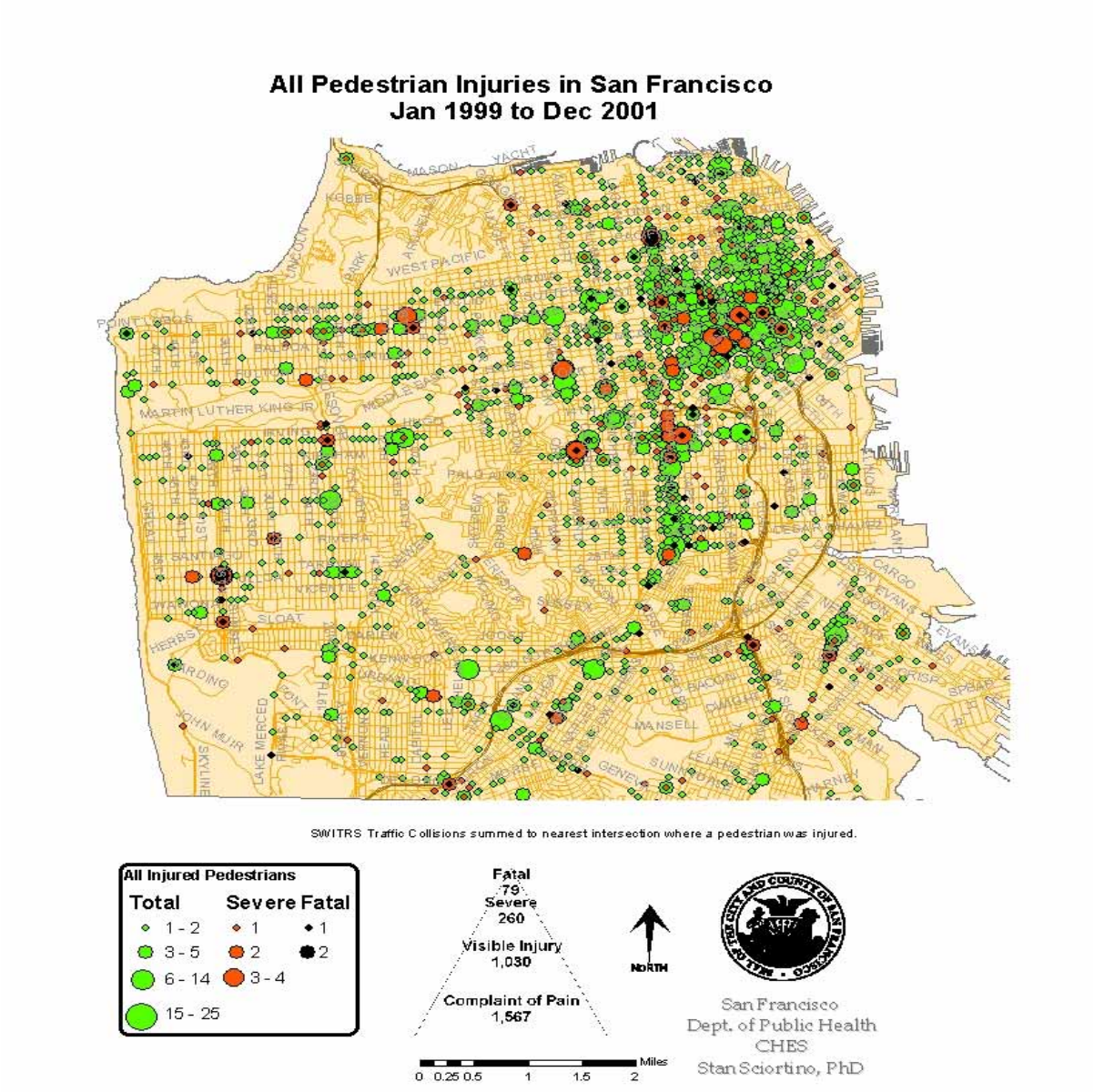
Poisoning ranked as the fourth leading cause of premature mortality (Years of Life Lost, YLLs) in San Francisco, and third among males. While this category includes accidental poisoning from toxic household substances and prescribed and over-the-counter drugs, the great majority of poisoning deaths in San Francisco are due to drug abuse. Of the 91 deaths to males in 2000, 55 were to white men and 25 to African-American men; their age-adjusted rates were 25.2 and 78.5, respectively.

Motor vehicle injuries: Pedestrian injuries

The number of people killed and injured in motor vehicle accidents has remained fairly level over the five years through 2000, as has the contribution of driving under the influence (DUI) to these injuries. DUI continues to be a much larger contributor to more severe accidents, involving fatalities, than to non-fatal injury accidents.

These figures cover all injuries involving motor vehicles. Because San Francisco is an urban county, its overall motor vehicle accident rate is low; its death rate of 6.8 for 1999-2001 ranked fourth lowest among California counties. In 2000, 33 of the 49 people killed in San Francisco in motor vehicle accidents were pedestrians. The map in Figure 4-22 shows the location of pedestrian injuries for 1999-2001.

Figure 4-22.



Intentional injuries

Intentional injuries include those that are self-inflicted (suicides and attempts) and inflicted on others (homicides and assaults). In 2001, San Francisco had somewhat higher rates for both than either the State or the nation (Table 4-9).

Table 4-9.

Intentional Injury Death Rates for San Francisco, California and the U.S., 2001

	S.F.	Ca.	U.S.
Intentional Injuries	19.5	16.0	16.7
Suicide	12.0	9.6	10.6
Homicide	7.5	6.4	6.1

Source: SFDPH, San Francisco Violent Injury Reporting System (SFVIRS)

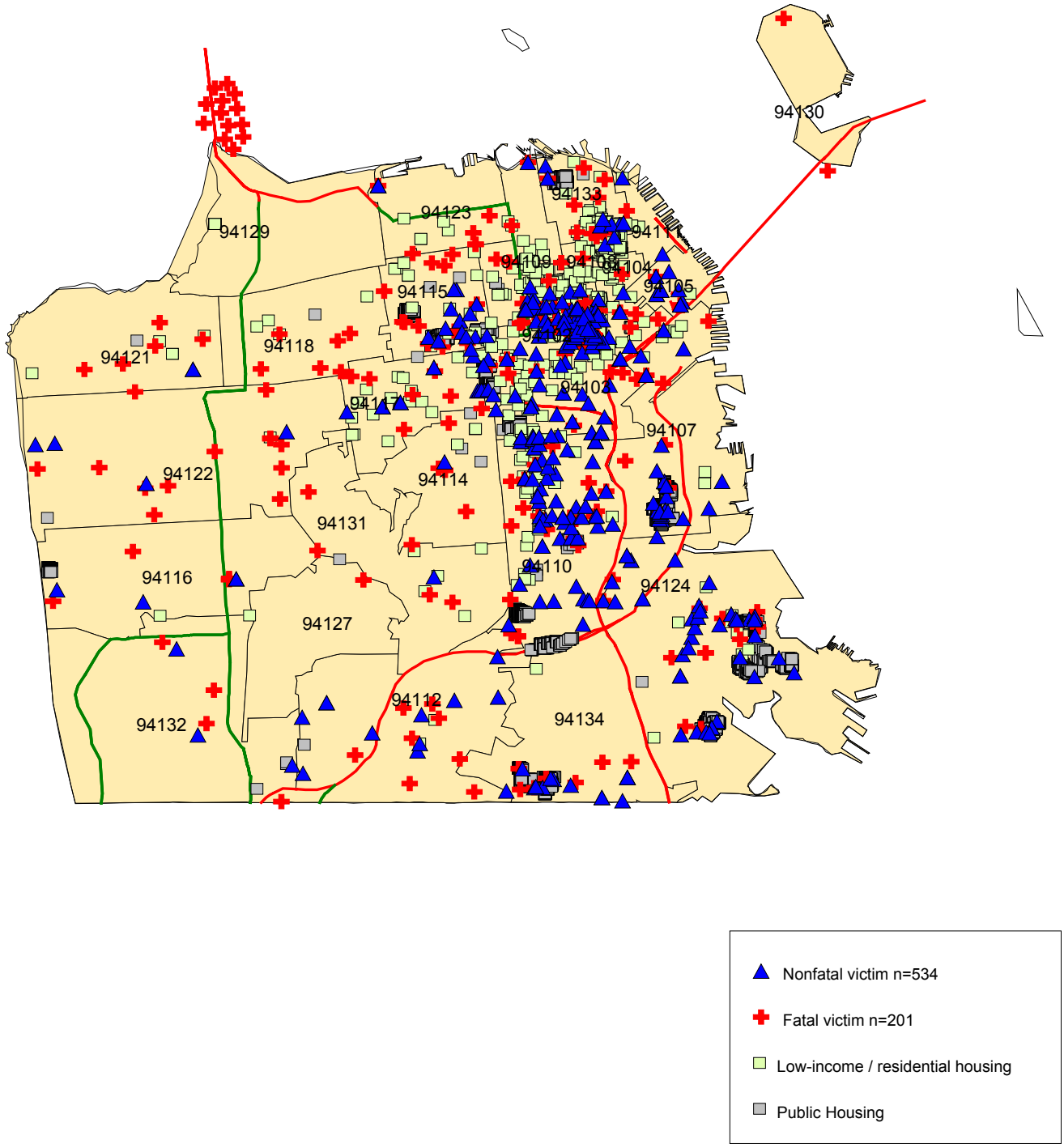
Among counties with populations over 500,000, San Francisco's suicide rate in 2001 was the highest, while its homicide rate was below only those of L.A. (11.2) and San Joaquin (8.9), and tied with Fresno's. Use of firearms for intentional deaths was lower in San Francisco than for the State or country, both for homicide (52.4% compared to 71.3% for California and 64.4% for the U.S.) and especially for suicide (15.1% S.F. compared to 46.9% and 56.5%).

Figure 4-23 shows the geographic distribution of intentional injuries in 2001. It includes self-inflicted injuries and assaults by others that resulted in injuries or death. These data are not strictly comparable to mortality data for homicide and suicide, which include San Francisco residents regardless of where the fatal event occurred; the data shown here include fatal or non-fatal injuries known to have occurred in San Francisco, regardless of where the victims lived. The injury data include all requiring inpatient admission to hospitals, plus gunshot wounds seen in hospital emergency departments even if not admitted.

Of the 201 deaths, there were 126 suicides and 66 homicides; the other 9 were legal interventions or unknown. Assaults included 502 of the 534 nonfatal injuries, and 26 were known to have been suicide attempts.

Figure 4-23 shows the heaviest concentration along the Market and Mission St. corridors and in the Tenderloin, with other concentrations including Haight near Golden Gate Park, North Beach, and along and around Third Street in Bayview Hunters Point. The areas of densest concentration on this map are within areas of highest residential density and lower income, as reflected by the location of low-income housing and housing projects in the same areas.

Figure 4-23. Intentional Injuries in SF, 2001.

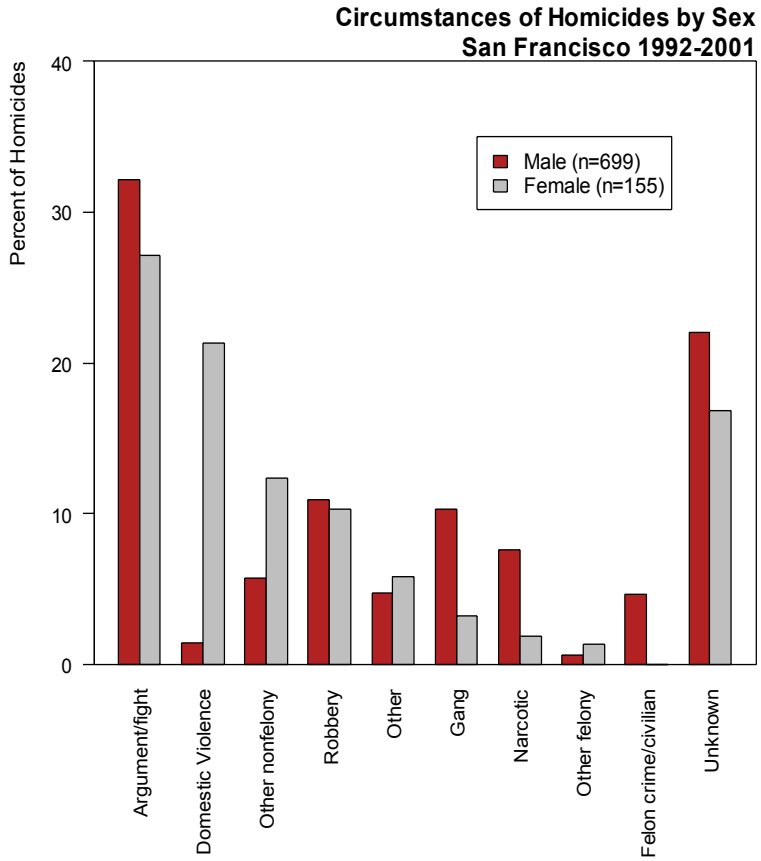


Source: SFDPH, San Francisco Violent Injury Reporting System (SFVIRS)

Violence

The number of homicides in San Francisco declined from a cyclical peak of 134 in 1993 to 64 in 1997, and has hovered between 59 and 71 from then through 2001. The circumstances of homicides over the decade ending in 2001 are shown by sex of the victims (Figure 4-24). Arguments or fights are the common circumstance for both sexes, but domestic violence is the next leading cause for females. More than four times as many males as females were victims of homicide during this period, and males were at least two-thirds of the victims for each of the circumstances shown except for domestic violence; females were victims of 77 percent of the domestic violence killings. Domestic violence is the second leading circumstance of death among women murdered in San Francisco over the past decade. Of these 43 deaths, 86 percent occurred in the victim's own or shared residence, and the other 14 percent occurred in the street, parking lots, or cars. Firearms were used in 39 percent of these cases.

Figure 4-24.



Source: SFDPH, San Francisco Violent Injury Reporting System (SFVIRS)

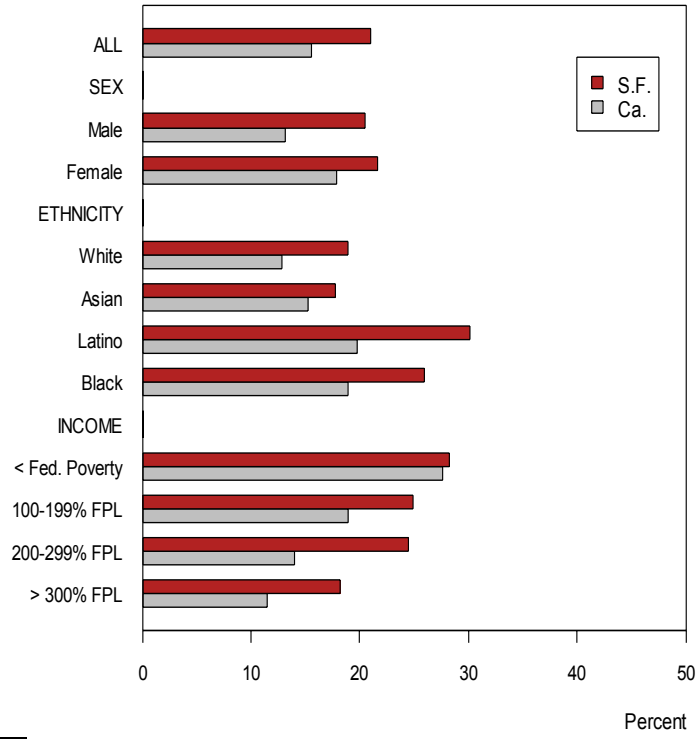
MENTAL HEALTH

Mental illness, depression, and other psychological disorders

Although psychological disorders are very prevalent and take a large toll on the health and well-being of the population, the Department lacks direct local methods for monitoring the range of mental health disorders in San Francisco. Estimates for the U.S. population over age 18 are that in a given year, about 22 percent have a diagnosable mental disorder, including 9.5 percent with a depressive disorder (5% having a major episode in any year), bipolar disorder and schizophrenia each occurring in slightly over 1 percent, and about 13 percent with an anxiety disorder.[2] The Department estimates that the number one and two contributors to the overall burden of disease in San Francisco are psychological: unipolar depression and alcohol-related psychological disorders.

Data, as shown in Figure 4-25, asking people to assess the extent to which emotional problems interfered with their usual work show that about a fifth of the population has such problems. San Francisco reports significantly higher levels than the State overall, for both sexes, for whites and Latinos, and for the two higher income groups (above 200% of the federal poverty level). These differences could reflect higher levels of emotional problems in our population, greater willingness to recognize or report such problems, or a combination of such factors.

Figure 4-25. **Didn't Do Usual Work Due to Emotional Problem, by Social and Economic Characteristics, San Francisco and California, 2001**



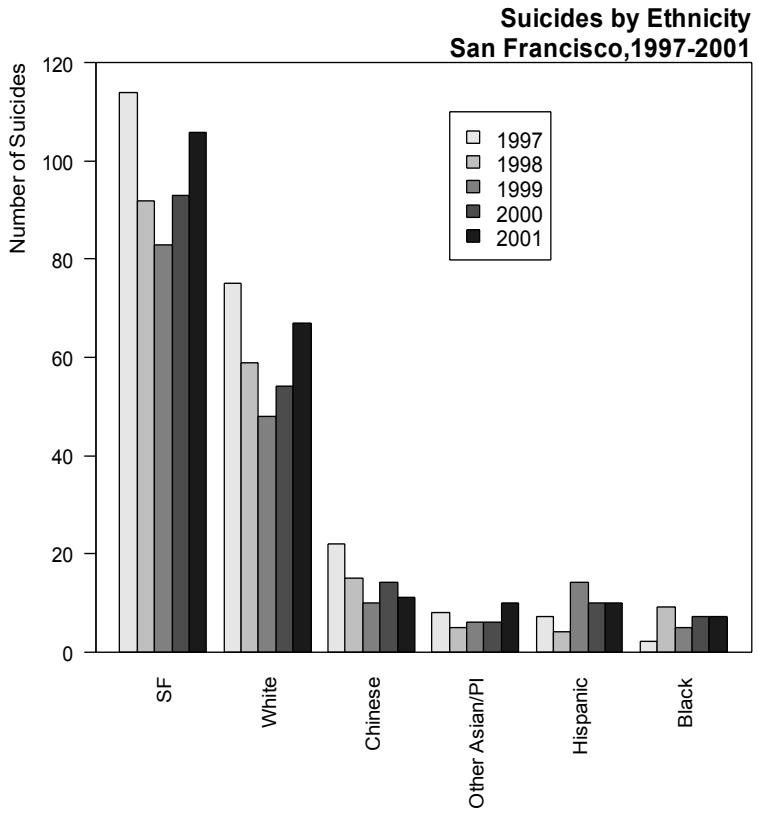
Comparing groups within San Francisco, women have significantly higher levels than men, Latinos are higher than whites and Asians, and those below poverty are higher than those above 300 percent of the poverty level.

[2] NIMH, "The Numbers Count: Mental Disorders in America," pub no. 01-4584, Jan. 2001

Suicide

San Francisco's suicide rate in 2001 was higher than the State's and the country's, and the highest among California counties larger than a half million. The rate for males is higher than that for females, but generally the numbers involved in breakdowns by sex or ethnicity/race are too small to produce rates that are stable or reliable. Figure 4-26 shows suicides by race and ethnicity.

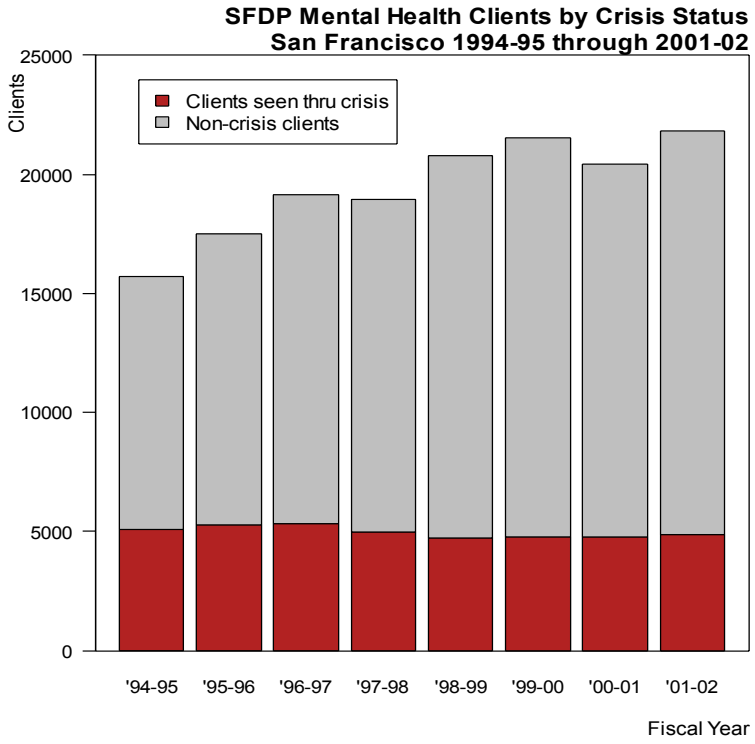
Figure 4-26.



Source: SFDPH, Community Health Epidemiology & Disease Control

Many of those with the most serious needs for treatment receive it through the Department. While the number and rate of clients served by the Department went up between 1994 and 2001 (by 35%, compared to a 5% population increase over this period), there was a decrease in the number of clients who had a crisis episode as shown in Figure 4-27. Preventing crisis episodes has been one of Community Mental Health's primary goals. These data may reflect an increased focus on more intensive outpatient and case management services, to allow clients to get the treatment they need before a crisis occurs.

Figure 4-27.



Source: SFDPH, Community Mental Health Services

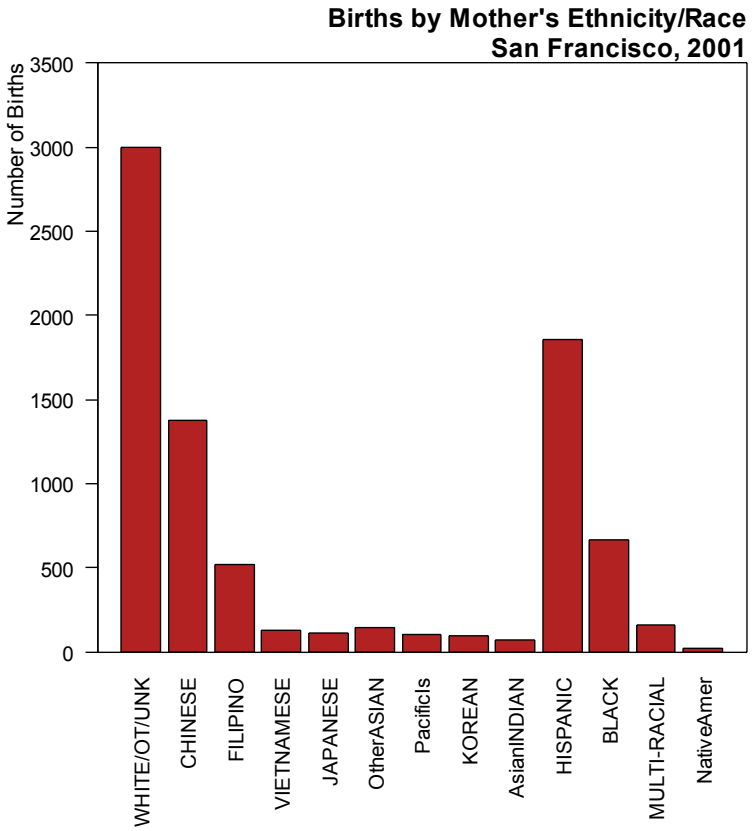
From 1990-1991 through 1999-2000, San Francisco has also had the first or second highest involuntary detention rate among California counties; the 1999-2000 rate, 135.2 (per 10,000 adults) is almost three times the statewide rate, 47.6. Taken together, the data from suicide rates, CHIS data, and involuntary detentions suggest that not only are mental health disorders very prevalent in the population, but that these may present a larger problem in San Francisco than in many or most other counties.

MATERNAL AND CHILD HEALTH

Births

There were 8,233 births to residents in 2001. The distribution by ethnicity/race of the mother is shown in Figure 4-28. Latinos constitute 14 percent of the population, but 22 percent of births; whites are 44 percent of the population, but 36 percent of births.

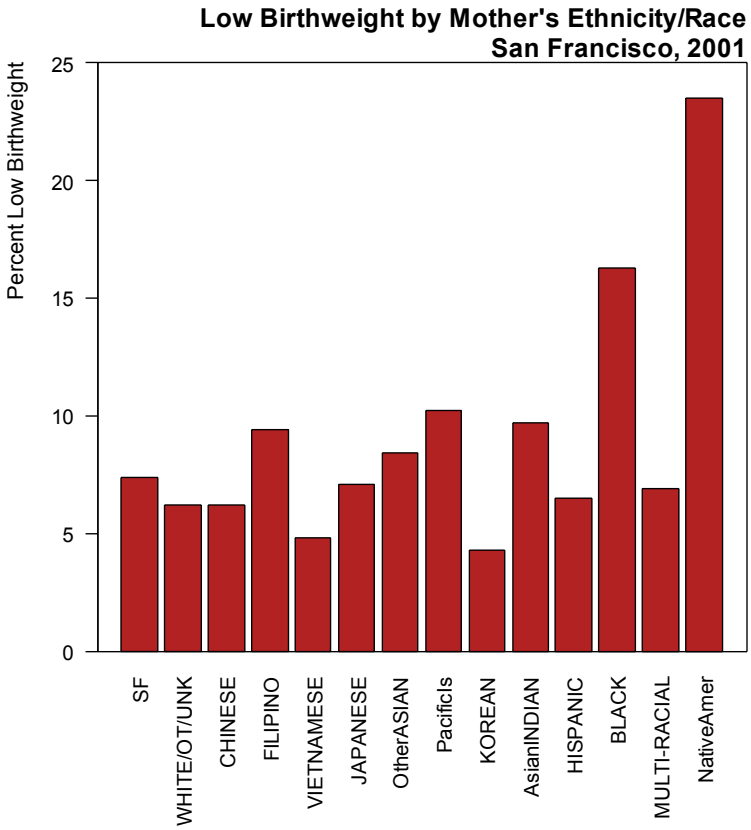
Figure 4-28.



Low birth weight

Low birth weight (birth weight less than 2500 grams) increases infants' risk of infant mortality and other health problems, and very low birth weight (birth weight less than 1500 grams) increases these risks even more. Figure 4-29 shows that in San Francisco, the highest rates of low and very low birth weight babies are born to African-American women (excluding the last column, Native Americans, which figure is based on only 17 births).

Figure 4-29.



Infant mortality

Infant mortality is widely considered to be a core indicator of a community's health status. The overall infant mortality rate for San Francisco is lower than that for California as a whole. Small numbers of deaths makes comparing rates by ethnicity inherently unreliable, even for several years of data. However, the data for San Francisco, as shown in Table 4-10, do show that African-American infant mortality continues to be elevated compared to other groups, comparably to ethnic-specific infant mortality differences for the State.

Table 4- 10. Infant Death Rates by Ethnicity, SF 1997, 1999 and 2000

SF County Rank		Ave. Deaths/Yr.	SF Cohort Death Rate	LCI , UCI	CA Cohort Death Rate	National Objective
11	ALL	36	4.3	2.9 , 5.7	5.7	4.5
20	ASIAN/OTHER	10	3.4 *	1.3 , 5.6	5.3	4.5
46	BLACK	11.7	15.1 *	6.4 , 23.7	12.6	4.5
22	HISPANIC	7.0	3.7 *	1.0 , 6.5	5.4	4.5
10	WHITE	7.3	2.7 *	0.7 , 4.6	4.9	4.5

* Rate unreliable; relative std. error >=23%
Rates are per 1,000 live births, age-adjusted to 2000 population
LCI=lower 95% confidence interval for birth rate; UCI=upper 95% confidence interval.
Data are from California linked birth-death infant cohort for 1997, 1999, & 2000 combined
source:Ca Dept. Health Services, *California County Health Profiles 2003.*

HEALTH DISPARITIES

One of the nation's two major health goals for the year 2010 is the elimination of health disparities among segments of the population. Much of the data presented here shows such differences in health outcomes and in the conditions that most influence health, by dimensions of ethnicity/race, sex/gender, and socio-economic position. The existence of differences based on these characteristics has been widely reported.

Sex/Gender Disparities

Table 4-11 shows a comparison of selected health measures by sex or gender. In most cases, males do worse than females. This is especially true of mortality measures (note that all of the non-communicable disease and injury measures are for deaths, unless otherwise noted). Females report higher levels of mental/emotional problems, but males commit suicide more often.

With respect to health-influencing conditions, males' median income is higher, and according to CHIS, they are less inactive and are more likely to eat adequate fruits and vegetables, but also smoke more. Males also suffer from much higher levels of alcohol- and drug-related mortality. The factors contributing to disparities by sex, especially the

markedly higher level of male mortality overall and for so many different leading causes of death, are complex and remain to be adequately explained.

Table 4-11.

Comparison of Health Measures by Sex/Gender, San Francisco

Measure	Male	Female	M/F Ratio	M-F Difference	Unit	Year	Data Source
HEALTH							
Burden of Disease							
Life Expectancy	74.8	82.2	0.91	-7.4	years	2000	SFDPH
Age-Adjusted Death Rate	962.3	605.3	**1.59**	357	10^5	2000	SFDPH
Age-Specific Death Rates	varies by age		**1.22-2.91**	varies	10^5	2000	SFDPH
Years of Life Lost	142,037	81,862	**1.74**	60,175	YLLs	2000-2001	SFDPH
Fair/poor health	0.139	0.159	***0.87***	-0.02	%	2001	CHIS
Disability Adj'd Life Years	69,237	46,322	**1.49**	22,915	DALYs	2001	SFDPH
Non-Communicable Disease	777.0	532.2	**1.46**	244.8	10^5	2000	SFDPH
Overweight	11.4	11.3	1.01	0.1	%	2001	CHIS
Ischemic Heart Disease mortality	197.1	117.5	**1.68**	79.6	10^5	2000	SFDPH
Stroke mortality	73.6	63.7	**1.16**	9.9	10^5	2000	SFDPH
Diabetes diagnosis	12.9	14.1	0.91	-1.2	%	2001	CHIS
High Blood Pressure	20.0	22.2	0.90	-2.2	%	2001	CHIS
Cancer mortality--Overall	212.4	135.3	**1.57**	77.1	10^5	1996-2000	NCCC
Lung	55.7	28.9	**1.93**	26.8	10^5	1996-2000	NCCC
Colorectal	22.5	14.9	**1.51**	7.6	10^5	1996-2000	NCCC
Cancer incidence--Overall	539.1	370.5	**1.46**	168.6	10^5	1996-2000	NCCC
Lung	74.5	40.7	**1.83**	33.8	10^5	1996-2000	NCCC
Colorectal	59.9	44.0	**1.36**	15.9	10^5	1996-2000	NCCC
Asthma	11.8	11.4	1.04	0.4	%	2001	CHIS
Arthritis	12.1	20.6	***0.59***	-8.5	%	2001	CHIS
Cirrhosis of liver	65	22	**2.95**	43	N	2001	SFDPH
COPD	155	126	**1.23**	29	N	2001	SFDPH
Communicable Disease	107.3	45.4	**2.36**	61.9	10^5	2000	SFDPH
AIDS Deaths	274	29	**9.45**	245	N	2002	SFDPH
AIDS cases	392	35	**11.20**	357	10^5	thru 2002	SFDPH
Tuberculosis cases	98	48	**2.04**	50	N	2001	SFDPH
Injuries	76.6	27.0	**2.84**	49.6	10^5	2001	SFDPH
Poisoning	20.4	4.2	**4.86**	16.2	10^5	2001	SFDPH
Road Traffic Accident	36	23	**1.57**	13	N	2001	SFDPH
Falls	28	18	**1.56**	10	N	2001	SFDPH
Homicide	699	155	**4.51**	544	N	1992-2001	SFDPH
Argument	225	42	**5.36**	183	N	1992-2001	
Domestic violence	10	33	**0.30**	-23	N	1992-2001	SFDPH
Mental Health							
Suicide	75	33	**2.27**	42	N	2001	SFDPH
Did less-emotional problems	14.0	18.2	***0.77***	-4.2	%	2001	CHIS
Needed help-emotional/MH	18.4	23.1	***0.80***	-4.7	%	2001	CHIS
Not usual work--emotional problem	20.5	21.6	0.95	-1.1	%	2001	CHIS
CONDITIONS							
Income							
Median	$ 31,772	$ 23,596	**1.35**	$ 8,176	$	2000	Census
Unemployment	4.7%	4.4%	1.07	0.3%	%	2000	Census
(Number)	11,614	8,995	**1.29**	2,619	N	2000	Census
Not in Labor Force	28.7%	38.6%	***0.74***	-0.099	%	2000	Census
(Number)	98,310	129,397	***0.76***	(31,087)	N	2000	Census
RISK BEHAVIOR							
Smoking	51.7	37.1	***1.39***	14.6	%	2001	CHIS
Physical inactivity	20.8	32.5	***0.64***	-11.7	%	2001	CHIS
Adequate fruits/vegetables	61.2	44.4	***1.38***	16.8	%	2001	CHIS
ACCESS							
Insured prior 12 months	76.3	84.2	***0.91***	-7.9	%	2001	CHIS

Differences of 10% or more between males and females are shown in bold. N=number of events
Female higher than male shown in italics if difference >10% 10^5= rate per 100,000

How We are Funded

THE DEPARTMENT'S BUDGET

The Department's mission and Strategic Plan necessitate a broad and multi-faceted range of services. One of the Department's four goals within its Strategic Plan is entirely devoted to funding issues: Services, programs and facilities are cost-efficient and resources are maximized. The Department's plan recognizes that there are ongoing funding constraints, and that the strategic direction should be to:

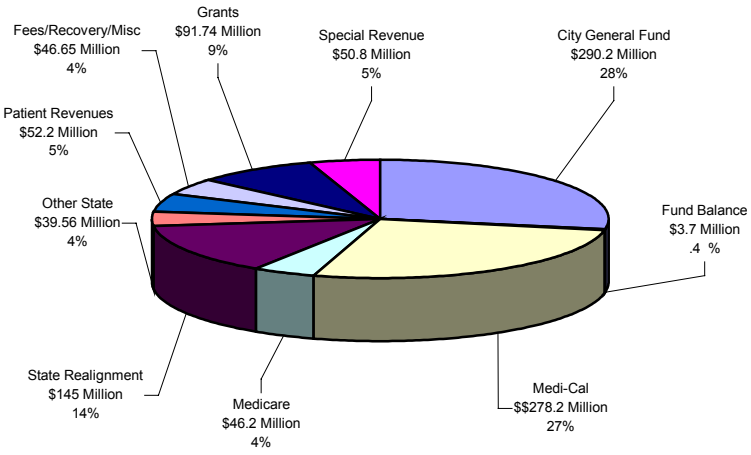
- Expand community-based alternatives – decrease the need for institutional care;
- Target populations receiving services – allocate resources to those most in need and who lack options;
- Strengthen and promote prevention; and
- Use data to reorganize, reprioritize, reduce or eliminate services based on priorities, performance measures and the strategic plan.

The Strategic Plan was a guide to the Department in FY 2002-2003 in making decisions related to current and projected budget reductions. In order to secure adequate funding to support the many services, from health care for an uninsured person at Chinatown Public Health Center to pedestrian safety campaigns, the Department relies upon a mix of federal, State and local funds. The Department, like other governmental agencies, confronted shrinking revenues in FY 2002-2003 and was expected to reduce its budget due to shortfalls on the State and local levels. Using the Strategic Plan as a guide has helped the Department fare better than expected during these difficult budget times.

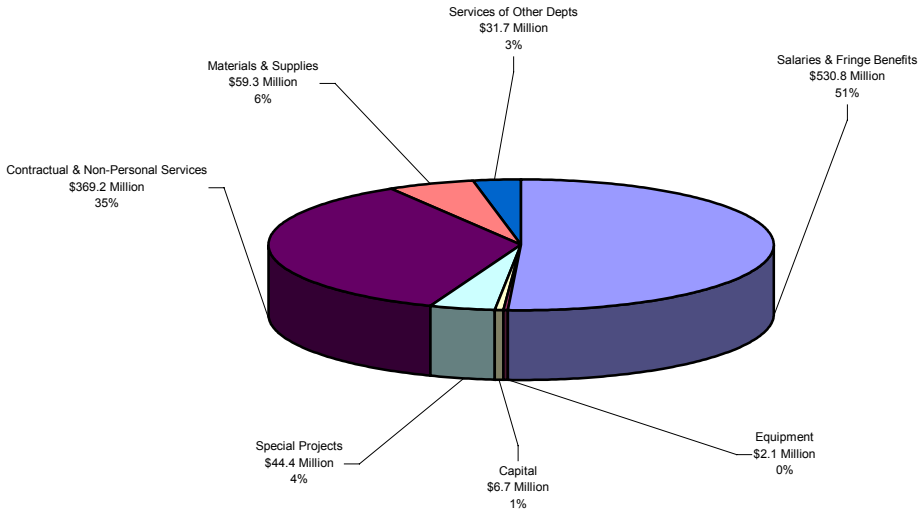
The Department is doing more with less. Though public health needs are stronger than ever, funding is becoming less reliable each year. In FY 2002-2003, the Department's budget was $1,044,158,374. This represented an increase over the previous fiscal year of approximately $62 million. Though the actual dollars are more than the previous year, the increase was 60 percent lower than last year's budget increase. In the previous fiscal year (FY 2001-2002), the Department experienced a $99 million increase to its budget. The following graphs show the Departments revenue and expenditures for FY 2002-2003:

Revenues and Expenditures

Department of Public Health
FY 2002-2003 Revenues
$1,044,158,374
(by source)



Department of Public Health
FY 2002-2003 Expenditures
$1,044,158,374
(by source)



Local Foundations and Volunteers

San Francisco Public Health Foundation

The primary purpose of the San Francisco Public Health Foundation is to raise funds to support public health programs and services that are not included in the Department's budget. In FY 2002-2003, the San Francisco Public Health Foundation received gifts totaling $98,188.

This is a partial list of some of the programs and services supported by these gifts.

- *Rattlesnake* – HIV Education/Prevention Project
- Community Health Education Section Events
- Support Activities for Homeless Program Participants
- Domestic Violence Clinic & Teen Breast Cancer Prevention - Maxine Hall
- Community Health Epidemiology & Disease Control Materials
- Advertisements, Incentives and Outreach Materials for STD Prevention
- Ocean Park Health Center
- Emergency Medical Services

San Francisco General Hospital Foundation

The San Francisco General Hospital (SFGH) Foundation is dedicated to improving the care and comfort of patients at San Francisco General Hospital. The SFGH Foundation is the only organization dedicated to pursuing significant gifts for the hospital and has an independent board of 30 directors drawn from the community. The Foundation has raised more than $10 million since it was founded in 1994. Funds are raised for a variety of projects, such as capital improvements and state of the art equipment. The sources of SFGH Foundation funding are as follows:

- 49 percent from Foundations and Trusts;
- 42 percent from Individuals;
- 6 percent from Corporations; and
- 3 percent from Government Grants.

In FY 2002-2003 grants totaling $1,121,441 were provided by the SFGH Foundation to support various hospital projects and programs. For example, the Foundation completed remodeling the Child and Adolescent Sexual Abuse Resource Center. The Foundation also recently launched the Children's fund, which will help to provide supplemental services needed by children.

Laguna Honda Hospital and Rehabilitation Center Foundation

Work is progressing rapidly on the establishment of the Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) Foundation as a 501(c)3 Public Benefit Corporation. Consulting expertise has been retained to help with the formation of the Foundation and to craft a capital campaign of $40 million for the furniture, fixtures and equipment for the hospital's replacement project. In FY 2002-2003, consultants worked on drafting a case statement, customizing a campaign strategy, developing a communications plan, developing recommendations for potential board members, and

recruiting a CEO for the new Laguna Honda Foundation. It is expected that the Laguna Honda Foundation will be incorporated before the end of 2003. Upon completion of the campaign, the Laguna Honda Foundation will continue functioning to benefit the residents of Laguna Honda through research, training and scientific endeavors which advance rehabilitation and long term healthcare delivery systems.

San Francisco General Hospital Volunteers

The Volunteers to San Francisco General Hospital Medical Center, established as a nonprofit, 501(c)(3) corporation in 1957, have long contributed both human resources and funding to the hospital, and its patients and staff. The mission of the Volunteers is to create the opportunity to give back to the community and to enhance the quality of life for patients, volunteers and staff of SFGH and its affiliates.

In FY 2002-2003 the more than 900 Volunteers donated 95,000 hours (equivalent to roughly $3 million in salary contributions) and collected $314,549 in cash donations. Donations to SFGH and its affiliates totaled $186,105. These gifts included grants of $20,581 and cash donations of $165,524. These gifts were used for many activities, with the following list being just a few examples:

- OB-GYN/Childbirth Patient Education
- Psychiatric Occupational Therapy Activities
- Skilled Nursing Facility Patient Activities
- Sickle Cell Summer Camp
- Stop Smoking Program
- Teen Prenatal Program
- Heart Failure Program
- Support After Neonatal Death
- Waiting Room Furnishings
- Emergency Patient Food and Transportation
- Children's Holiday Celebration

Laguna Honda Hospital Volunteers

Volunteers at Laguna Honda not only offer their time but also provide funding to support events and services for the residents. In FY 2002-2003, the volunteers donated $221,007.25. This funding was more than double what was given last year, and supported the following projects:

- Board Directed Special Projects
- Holiday Gifts
- Holiday Show
- Aquarium
- Internet Service for Residents
- Laguna Honda Express
- Plant Beautification
- Recreational Activities
- Refreshments & Sundries
- Volunteer Luncheons/Tea

Agencies and Organizations that Provided Grants to the Department in FY 2002-20003

Asian American Recovery Services, Inc.
California Department of Alcohol & Drugs
California Department of Corrections
California Department of Fish and Game
California Department of Health Services
California Department of Mental Health
California Emergency Preparedness Office
California Environmental Health Services
California Family Health Council, Inc.
California Healthcare for Indigents Program
California Office of AIDS
California Office of Family & Domestic Violence Prevention
California Office of Traffic Safety
California State and Local Injury Control
California Tobacco Control Section
California Water Resources Control Board
Women, Infants, and Children Program
Center for Substance Abuse Treatment
Centers for Disease Control and Prevention
Comprehensive Drug Court Implementation
Corporation for Supportive Housing
Eli Lily and Company
Franklin Benevolent Corporation
Fred Hutchinson Cancer Research
Harvard School of Public Health
Join Together Organization
Mayor's Criminal Justice Council
National Center for Tuberculosis Prevention
National Institutes of Health
Public Health Foundation Enterprises, Inc.
Regents of the University of California
Richard and Rhoda Goldman Fund
San Francisco Private Industry Council
San Francisco Unified School District
Stanford University
The California Endowment
The San Francisco Foundation
U.S. Department of Health and Human Services
U.S. Department of Justice
U.S. Environmental Protection Agency
U.S. National Institute on Drug Abuse
U.S. Office of Minority Health
U.S. Program Support Center
U.S. Substance Abuse & Mental Health Services Admin.
U.S. Health Resources and Services Administration
UCSF Center for AIDS Prevention Studies
University of California at San Francisco
Universitywide AIDS Research Program

Who We Are

THE HEALTH COMMISSION

The Health Commission acts as the governing and policy-making body for the Department to ensure that the wide range of public health services and programs are positively promoting the health of San Francisco residents. The Health Commission meets to consider issues relevant to the Department and approves resolutions in order to establish policy. These meetings are held the first and third Tuesday of each month and are open to the public. The four joint conference committees of the Health Commission also meet monthly to provide insight to the crucial components of the Department. The Health Commissioners are appointed by the Mayor and are responsible for providing a sound and efficient plan for the Department to follow.

The San Francisco Health Commission
Back row from left: John I. Umekubo, MD; Michael L. Penn Jr., PhD; David J. Sanchez, Jr., PhD; Harrison Parker, Sr., DDS
Front row from left: Roma P. Guy, MSW; Edward A. Chow, MD; Lee Ann Monfredini

Health Commission members 2003

Listed below are the Health Commissioners and the Department Committees they serve on:

Edward A. Chow, MD, President

- Chair, Joint Conference Committee for the Community Health Network
- Commissioner Chow is a practicing Internist, and is the Medical Director of the Chinese Community Health Plan.

Roma P. Guy, MSW, Vice President

- Member, Joint Conference Committee for the Community Health Network
- Chair, Joint Conference Committee for Population Health and Prevention
- Commissioner Guy is the Director of the Bay Area Homelessness Program and Lecturer in the Department of Health Education at San Francisco State University.

Lee Ann Monfredini

- Chair, Budget Committee
- Member, Joint Conference Committee for San Francisco General Hospital
- Commissioner Monfredini is a self-employed public relations and event planning consultant.

Harrison Parker, Sr., DDS

- Chair, Joint Conference Committee for San Francisco General Hospital
- Member, Joint Conference Committee for Population Health and Prevention
- Member, In-Home Supportive Services Public Authority
- Commissioner Parker has been a practicing dentist in the Bayview/Hunters Point Neighborhood for over 35 years.

Michael L. Penn Jr., PhD

- Member, Budget Committee
- Member, Joint Conference Committee for Population Health and Prevention
- Commissioner Penn is a Product Manager in BioOncology Marketing at Genentech, Inc. in South San Francisco. He is also co-founder of Brothers Building Diversity in the Sciences, a non-profit organization founded that encourages under-represented minority students to pursue biomedical science careers.

David J. Sanchez, Jr., PhD

- Chair, Joint Conference Committee for Laguna Honda Hospital
- Member, Joint Conference Committee for the Community Health Network
- Member, San Francisco General Hospital Foundation.
- Commissioner Sanchez is Assistant Vice Chancellor of Academic Affairs, faculty associate for Academic and Student Outreach, and professor in the Department of Family and Community Medicine at the University of California, San Francisco.

John I. Umekubo, MD

- Member, Joint Conference Committee for Laguna Honda Hospital
- Member, Budget Committee
- Member, San Francisco Health Authority
- Commissioner Umekubo has a private practice in Internal Medicine in Japantown. He is the Chief of Medical Staff at St. Mary's Hospital and the Medical Director of the San Francisco Community Convalescent Hospital.

Michele Olson, Executive Secretary

Resolutions passed in fiscal year 2002-2003

The following lists the resolutions and policies passed by the Health Commission in FY 2002-2003.

- Concurring With the Analysis of Department Staff and Pending Controller's Certification That the Laundry Services Can Be Performed For the Department of Public Health, Laguna Honda Hospital, By Private Contractor For a Lower Cost Than Similar Work Performed By City and County Employees, No. 8-02

- Approving Ordinance Amendments To the San Francisco Health Code To Update Lead Hazard Definitions To Be Consistent With State and Federal Definitions, No. 9-02

- Adopting Findings Pursuant To the California Environmental Quality Act and Approving the Laguna Honda Hospital Replacement Project, No. 10-02

- Approving the Proposal For the Use of Smokeless Tobacco Settlement Funds, No. 11-02

- Approving an Ordinance Increasing the Licensing Fee For Garbage Trucks and the Amount Deposited Into the Mandatory Refuse Collection Service, No. 12-02

- Institutional Police To the San Francisco Sheriff's Department and Authorizing the Director Of Health To Enter Into a Letter of Management Agreement Regarding This Transfer, No. 13-02

- Approving a three percent General Fund Reduction To the Department Of Public Health's Budget for Fiscal Year 2002-2003, No. 14-02

- Approving the Department of Public Health's Base Budget for Fiscal Year 2003-2004, and Urging the Mayor and the Board of Supervisors To Develop Strategies for Avoiding Serious Cuts To the County's Health Safety Net Services, No. 1-03

- Supporting the Work of the Task Force To End the Exploitation of Youth, No. 2-03

- Approving the Continued Provision of Surgical and Anesthesia Services By San Francisco General Hospital for Laguna Honda Hospital Residents and Patients, and a New Agreement That Memorializes This Arrangement, No. 3-03

- Approving the Application for Licensure of the Chronic Renal Dialysis Center By San Francisco General Hospital To Provide Services To Patients of the City and County of San Francisco With End-Stage Renal Disease, No. 4-03

- Accepting the San Francisco General Hospital Air Medical Access Feasibility Study, No. 5-03

- Rejecting the Department of Public Health's Contingency Budget for Fiscal Year 2003-2004, and Urging the Business community, Organized Labor and Residents, To Work With the Mayor and the Board of Supervisors To Avoid Devastating Cuts To the County's Health Safety Net Services, No. 6-03

- Approving Renewal of Two (2) Master Contract Agreements With Siemens Medical solutions Health Services Corporation (Remote Computing Option and Products and Services), No. 7-03

- Approving the Extension of the Terms of Fiscal Year 2002-2003 AIDS Office Contracts for the Department of Public Health, No. 8-03

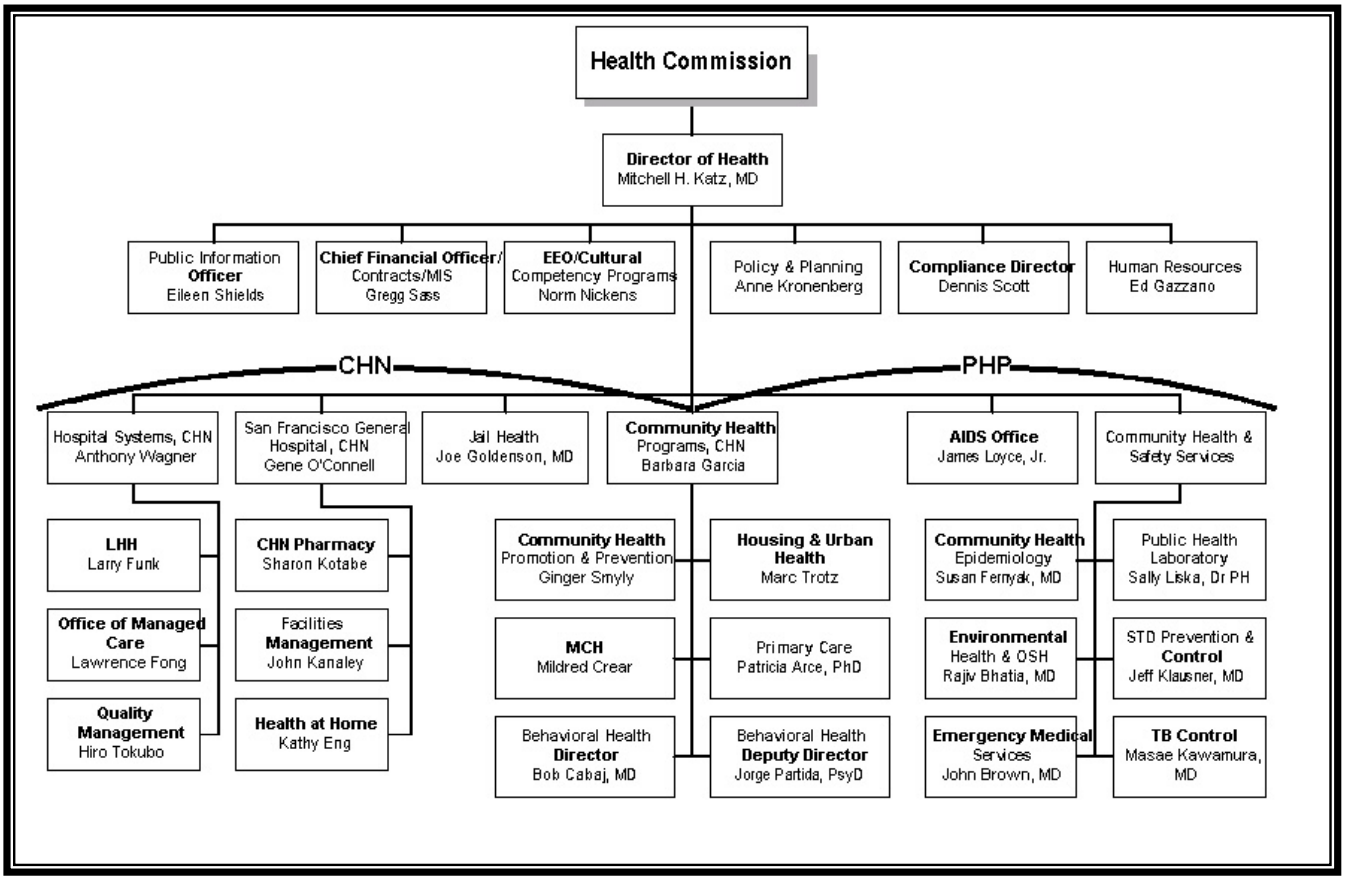
- Approving an Extension of the Terms of Fiscal Year 2003/04 Behavioral Health Contracts for the Department of Public Health, No. 9-03

- Supporting Youth Involvement In the San Francisco Health Commission and Establishing a Youth Health Advisor Appointee To the Population Health and Prevention Joint Conference Committee, No. 10-03

- Supporting the Women's Health Plan: Partnering In Wellness With Women and Girls In San Francisco 2003-2006, No. 11-03

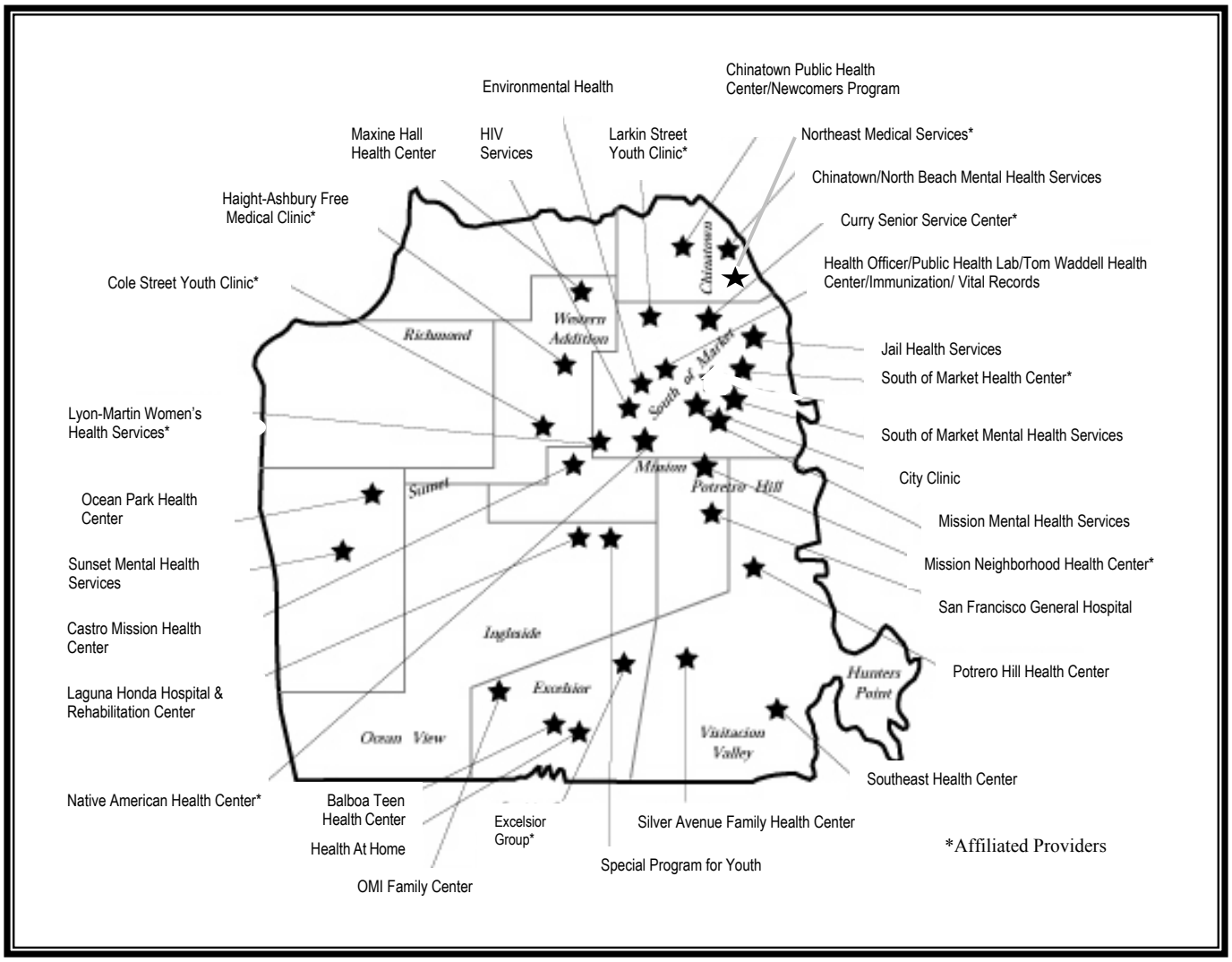
- Supporting the Strategic Plan of the San Francisco Asthma Task Force to Promote Effective Asthma Management Prevention Strategies for San Francisco, No. 12-03

THE DEPARTMENT'S ORGANIZATIONAL CHART



This Organizational Chart reflects the Department's structure in FY 2002-2003, showing the major sections of the Department. The Community Health Network (CHN) represents the personal health care services section of the Department and offers direct patient care. The Population Health and Prevention section represents the population health services, and includes Environmental Health, Emergency Medical Services and other programs that impact all San Franciscans. These programs are bridged together through Community Health Programs, which represents sections that work within both realms, like Housing and Urban Health and Maternal and Child Health.

THE DEPARTMENT'S SERVICE SITES



This map shows the Department's service sites and the community clinics affiliated with the Department. As can be seen here, the Department offers services at locations spread throughout the City.

THE DEPARTMENT'S WORKFORCE

The Department has a staff of fewer than 6,000 individuals. Above and beyond the paid staff are a wide range of collaborating agencies and volunteers that help make the Department's work possible. The mission of the Department is to protect and promote the health of all San Franciscans. In addition, staff, collaborating agencies and volunteers work toward the following goals:

- Assess and research the health of the community;
- Develop and enforce health policy;
- Prevent disease and injury;
- Educate the public and train health care providers;
- Provide quality, comprehensive, culturally-proficient health services; and
- Ensure equal access to all.

Recruitment, retention and training of staff

The Department's Strategic Plan has a strategy to "improve recruitment, retention, and training of Department staff." The objectives of this strategy include:

- Address the recruitment issues of skilled workers in competitive job fields;
- Ensure that the Department maintains and continually expands its culturally and linguistically competent workforce;
- Increase resources for staff recruitment;
- Utilize community outreach programs;
- Increase the number of students in training programs.

FY 2002-2003 was a challenging year for staff recruitment and retention due to the difficult budget situation. However, the Department has not lost sight of the importance of a complete staff. The Department endeavored to retain necessary staff to the greatest extent possible and continued to prioritize staff training and cultural and linguistic competency.

Linguistic Capability of DPH Staff (as certified by EOCC):

Language	# of Employees
Spanish	521
Chinese (*Cantonese*)	243
Tagalog	57
Chinese (*Mandarin*)	45
Vietnamese	24
Russian	19
Cambodian	8
Korean	3
Afrikaans	1
Danish	1
French	1

Linguistic capability

Providing services that are culturally and linguistically competent is essential in San Francisco, where an especially diverse clientele accesses public health services. Many staff members speak more than one language, whether or not it is required for their particular position. For positions that require bilingual personnel, however, the Department ensures appropriate linguistic capability during the hiring process. Individuals holding positions that require bilingual capacity take a language proficiency test administered by the Department's Office of Equal Opportunity and Cultural Competency. There is a total of 923 staff

members certified in a language other than English. This is an increase of 110 staff members since last year.

Employee Awards and Recognition

The Health Commission extends monthly Employee Recognition Awards to exceptional Department employees for their outstanding efforts and accomplishments. Employees are recognized as individuals or as part of a team, and are nominated by their colleagues. In FY 2002-2003, the following employees received Employee Recognition Awards:

August 2002

- Marcos Bañales, Health Worker III, SFGH – Jail Health Services, Forensics AIDS Project
- Nancy Madden, NP, Shannon Thyne, MD, and Rajeev Venkayya, MD, SFGH – Children's Environmental Health Promotion

September 2002

- Suzanne Garnier, RN, CHN – Health at Home
- Environmental Health Services, Complaint Program, Field and Support Staff, PHP – Environmental Health Services

October 2002

- Roban San Miguel, Community Substance Abuse Services
- Michael Seely, Central Administration
- Eileen Shields, Central Administration

November 2002

- Ellen Apolinario, RN, Nurse Manager, Laguna Honda Hospital Nursing Unit D5/E6
- Asian Focus/Chronic Cluster Team: Elaine Gecht, MD, Unit Attending; Camay Ko, Activity Therapist; Rita Ng, Medical Social Worker; Stella Yim, RN, Nurse Manager, Laguna Honda Hospital, Nursing and Medical Services

December 2002

- Barbara Kawaguchi, SFGH – Administration
- Mary Magee, RN, SFGH – Birthing Center
- Thelma Viray, SFGH – Skilled Nursing Facility
- Tahnee Grant, LCSW and Margaret Amaral, LCSW, SFGH – Medical Social Services and Trauma

January 2003

- Steven Tierney, EdD, Director of HIV Prevention Services
- Ana Carcamo, Secretary, Environmental Health Section
- SFGHMC Adult Medical Center Nursing Team: Maribel Amodo, RN, Margo Dextraze-Cordova, RN, and Amalia Fyles, RN, MS,

February 2003

- David (Shao) He, IS Administrator II, Emergency Medical Services
- Fredy Ramos, Environmental Services Supervisor, Environmental Services
- Syphilis Response Team: Felipe Acosta, Bart Bartolini, Gloria Calero, Joseph Engelman, Larry Hanbrook, Jacqueline Siller, Terrance Sha, and Ilene Zolt, STD Pevention and Control Services

April 2003

- Tom Hoynes, DPH Jail Health Services/ STD
- IS Desktop Support Team: Melvin Javonillo, Elouise Joseph, Anthony Kwok, Steve Lee, Bill Nay, Hung Quach, and Timothy Wong, SFGH Information System Department
- Patient Flow Team: Lynne Eggers, RN, LCSW, Liz Gray, MSN, RN and Elayne Hada, RN, CHN Community Mental Health Services

May 2003

- James Alexander, Budget Manager, DPH Central Administration – Finance Unit
- Women's Health Care Team:

Lindy Edward, RN, Amy Krehbiel, RN, and Daena Petersen, Health Worker, DPH Tom Wadell Health Center

May's Team Employee Recognition Award Winners, from Left to Right: Lindy Edwards, RN; Amy Krehbiel, RN; Daena Petersen, Health Worker

June 2003

- Isabel Barajas, Eligibility Worker,

DPH Maxine Hall Health Center

The Department's Advisory Groups

The Department provides a broad range of services for a wide variety of individuals within the San Francisco area. The Department works with over 50 specialized advisory groups that are invaluable to the decision-making processes that help maintain the excellence of our programs and services. The advisory groups are composed of clients, patients, neighbors, community-based organization representatives, and business leaders. The following is a list of active advisory groups in FY 2002-2003.

Community Health Programs

- Adult Sexual Assault Services Planning Group
- CalWORKS Behavioral Health and Domestic Violence Committee
- Transgender Youth Advisory Committee
- Women and Girls' Health Advisory Committee

Mental Health

- AB2034 consumer Advisory Board
- Children's Mental Health Systems of Care Council
- Youth Advisory Task Force
- Community Mental Health Services Consumer Council
- Mental Health Board
- Mental Health Committee for Culturally Competent Systems of Care
- Wellness and Recovery Oversight Committee

Substance Abuse

- Substance Abuse Treatment on Demand Planning Council and Subcommittees
- City-Wide Alcohol Advisory Board
- Drug Abuse Advisory Board
- Perinatal Substance Abuse Coordinating Council
- San Francisco Substance Abuse Practice/Research Collaborative
- Youth Substance Abuse Providers Group

Community Health Epidemiology

- City-Wide Influenza Coalition
- San Francisco Immunization Coalition

Emergency Medical Services

- EMS Operations Advisory Committee
- EMS Clinical Advisory Committee
- EMS Research Committee
- Trauma Medical Advisory
- Trauma System Advisory Committee
- Disaster Registry Program Task Force

Environmental Health

- Bayview/Hunters Point Health and Environmental Task Force
- Lead Hazard Reduction Citizen's Advisory Committee
- Lead Poisoning Prevention Citizen's Advisory Committee
- Potrero Power Plant Task Force
- Asthma Task Force

Maternal and Child Health

- Black Infant Health Task Force
- San Francisco Breastfeeding Promotion Coalition
- San Francisco Maternal, Child, and Adolescent Health Advisory Board

Community Health Promotion and Prevention

- Community and Home Injury Prevention Project for Seniors Community Council
- Newcomers Health Program Advisory Council
- San Francisco Pedestrian Safety Task Force
- San Francisco Tobacco Free Coalition
- San Francisco Violence Prevention Network

HIV/AIDS

- HIV Health Services Planning Council – Ryan White CARE Council
- HIV Prevention Messages/Circuit Party Study Community Advisory Board
- HIV Prevention Planning Council
- HIV Prevention and Vaccine Trials Community Advisory Board
- Prevention for HIV Positives Community Advisory Board
- Rave/Club Drug Task Force

Laguna Honda Hospital

- Laguna Honda Hospital Replacement Project Community Advisory Group

Primary Care

- Breast Cancer Town Hall Advisory Group
- Castro-Mission Health Centers Community Advisory Board
- Chinatown Public Health Center Community Advisory Board
- City-Wide Community Advisory Board
- Dimensions Collaborative Board
- End the Exploitation of Youth Task Force
- Maxine Hall Health Center Community Advisory Board
- North of Market Senior Services Governing Board of Directors
- Ocean Avenue Health Center Community Advisory Board
- Potrero Hill Health Center Community Advisory Board
- Silver Avenue Family Health Center Community Advisory Board
- Special Programs for Youth Community Advisory Board
- Southeast Health Center Community Advisory Board
- Tom Waddell Health Center Community Advisory Board

Tuberculosis Control

- San Francisco Tuberculosis Advisory Task Force

STD Control

- Sexually Transmitted Disease (STD) Prevention Community Action Coalition
- STD Program Advisory Committee
- STD Youth Community Action Coalition/Advisory Committee

The Department's Contractors

The Department relies heavily on its community partners to provide services throughout the community. Many of the programs and services provided by the Department are community-based and focus on a specific target population. Contractors are primarily trusted community-based organizations that are able to engage their community's residents. In FY 2002-2003, the Department contracted with the following community agencies:

Aguilas, Inc.
AIDS Community Research Consortium
AIDS Emergency Fund
AIDS Legal Referral Panel
Alameda County Health Services Agency
American College of Traditional Chinese Medicine
American Lung Association
Ark of Refuge, Inc.
Asian & Pacific Islander Wellness Center
Asian American Recovery Services, Inc.
Asian Women's Shelter
Baker Places, Inc.
Bar Association of San Francisco
Bay Area Young Positives
Bayview Hunters Point Adult Day Health Center
Bayview Hunters Point Foundation For Community Improvement, Inc.
Big Brothers Big Sisters of San Francisco
Black Coalition on AIDS, Inc.
Booker T. Washington Community Service Center
BVHP Health and Environmental Resource Center
Caduceus Outreach Services
California Acupuncture Resources
California Pacific Medical Center
CAL-PEP
Catholic Charities CYO
Center for Human Development
Center on Juvenile and Criminal Justice
Centerforce, Inc.
Central American Resource Center
Central City Hospitality House
Children's Council of San Francisco
Chinatown Community Development Center
Chinese Progressive Association
Community Awareness & Treatment Services, Inc.
Compass Family Center
CompassPoint NonProfit Services
Conard House
Continuum
County of Marin Dept. of Health & Human Services
CVE, Inc.
Dolores Street Community Services
Economic Opportunity Council of San Francisco
Edgewood Center for Children and Families
Eldergivers
Episcopal Community Services of San Francisco
FamiliesFirst, Inc.
Family Service Agency
Family Support Services of the Bay Area
Fort Help Methadone Program
Friendship House Association of American Indians, Inc.

Glide Foundation
Haight Ashbury Free Clinics, Inc.
Hamilton Family Center
Harm Reduction Coalition
Health Initiatives for Youth
Homeless Children's Network
Homeless Prenatal Program
Horizons Unlimited of San Francisco, Inc.
Huckleberry Youth Programs
Immune Enhancement Project
Institute for Community Health Outreach
Instituto Familiar De La Raza, Inc.
International Institute of San Francisco
Iris Center
Japanese Community Youth Council
Jelani, Inc.
Jewish Family and Children's Services
Jewish Vocational Services
La Casa de las Madres
Larkin Street Youth Services
Latino Commission on Alcohol of San Mateo
Lavender Youth Recreation & Info Center
Learning Services of Northern California
Legal Services for Children, Inc.
Lincoln Child Center
Lutheran Social Services of Northern California
Lyon-Martin Women's Health Services
Maitri
Men Overcoming Violence
Mission Council on Alcohol Abuse
for the Spanish Speaking
Mission Housing Development Corp.
Mission Neighborhood Health Center
Mobilization Against AIDS International
Morrisania West, Inc.
Mount St. Joseph-St. Elizabeth
National Council on Alcoholism and
Other Drug Addictions-Bay Area
New College of California
New Directions 21st Century
New Leaf Services
NICOS Chinese Health Coalition
North East Medical Services
North of Market Senior Services
Oakes Children's Center, Inc.
Ohlhoff House, Inc.
Positive Directions Equals Change
Positive Resource Center
Potrero Hill Neighborhood House
Progress Foundation
Project Open Hand
Quan Yin Healing Arts Center
Recreation Center for the Handicapped, Inc.
Richmond Area Multi-Services, Inc.
RISE Institute
Rose Resnick Lighthouse for the Blind/Visually Impaired
SAGE Project, Inc.
Saint Francis Memorial Hospital
Samoan Community Development Center
San Francisco AIDS Foundation
San Francisco Community Clinic Consortium
San Francisco Food Bank
San Francisco Health Plan
SF Medical Society / Community Service Fndnn
SF Mental Health Education Funds, Inc.
SF Network Ministries Housing Corp.
SF Pretrial Diversion Project, Inc.
SF Psychoanalytic Institute and Society
SF State University
SF Study Center
SF Suicide Prevention
SF Unified School District
San Mateo County Health Services Agency
San Mateo County Mental Health
Self Help for the Elderly
Seneca Center
Shanti
South of Market Health Center
Southeast Neighborhood Jobs Initiative Roundtable
Special Services for Groups /
Occupational Therapy Training Program
St. James Infirmary
St. John's Educational Thresholds Center
St. Luke's Health Care Center
St. Luke's Hospital
St. Mary's Medical Center
St. Vincent de Paul Society
Stop AIDS Project
Support for Families of Children with Disabilities
Survivors International

Swords to Plowshares
Tenderloin AIDS Resource Center
Tenderloin Housing Clinic
Tides Center / Women's Community Clinic
UCSF AIDS Health Project
UCSF Center on Deafness
UCSF Citywide Case Management-Forensic Project
UCSF Positive Health Program
UCSF Urban Health Study
UCSF Women's Specialty Program
University of the Pacific School of Dentistry
Urban Indian Health Board, Inc.
Victor Treatment Centers, Inc.
Volunteer Center of San Francisco
Walden House, Inc.
Westbay Filipino Multi-Service Center
WestCoast Children's Center
Western Dental Services, Inc.
Westside Community Mental Health Center, Inc.
YMCA of San Francisco
Youth Leadership Institute

The Strategic Plan

INTRODUCTION

In 1999, the Department began a process to articulate in a clear, concise, and definitive manner its strategy to fulfill its mission to "protect and promote the health of all San Franciscans." The Strategic Plan, adopted by the Health Commission in January 2001 is the Department's effort to position itself proactively for changes in the financing, regulation, and delivery of public health services. It provides the basis by which the Department can continually reevaluate how it will meet its two fundamental public health roles:

- As the government entity responsible for carrying out population-based health activities;
- As a provider of personal health care services.

Strategic planning is the formal and ongoing process of developing, implementing, and evaluating goals to guide the actions and decision making of an organization. It is used by organizations to help them determine how best to meet their missions. Its overarching goal is to match the organization's resources and capabilities to the external environment faced by the organization. In the Department, for example, there are numerous and often competing health issues of concern to the community. Due to resource constraints (e.g., financial, time, expertise), some of these concerns may not be able to be addressed fully. A strategic plan helps the Department prioritize the community health concerns it identifies. This proactive planning can help ensure that new funds are allocated prudently to meet community needs as well as minimize reductions in priority program areas when faced with declining financial resources.

STRATEGIC PLAN OVERVIEW

The Strategic Plan identifies four goals for the Department to meet its mission. They include:

1. San Franciscans have access to the health services they need, while the Department emphasizes services to its target population.
2. Disease and injury are prevented.
3. Services, programs, and facilities are cost-effective and resources are maximized.
4. Partnerships with communities are created and sustained to assess, develop, implement, and advocate for health funding, policies, programs, and services.

Under each goal are a series of between three and 11 specific strategies, which articulate the approach or recommendation that the Department should pursue. It is predicated on the notion that successful implementation of the policy direction articulated in the strategy will enable the Department to fulfill its mission.

HOW THE STRATEGIC PLAN IS USED

The Strategic Plan is the roadmap for the Department. Sections within the Department have used the plan to evaluate their own program priorities and direction, and in some cases (e.g., San Francisco General Hospital), have developed their own strategic plan based on the Department's document. The major divisions within the Department (Population Health and Prevention, Community Health Network, and Central Administration) each took responsibility to implement relevant portions of the plan and report regularly to the Office of Policy and Planning, the unit responsible for oversight and monitoring of the plan, progress toward implementation. Each section has been asked as part of its annual update to the Health Commission to report its accomplishments within the context of the Strategic Plan, notably how its work fits within and furthers the goals and objectives of the plan.

On the broadest level, the Department uses the plan to determine priorities when planning for program development and reductions. A number of the Department's highest visibility initiatives such as Behavioral Health integration, the McMillan Stabilization Center, Healthy Kids insurance coverage, expansion of the Housing and Urban Health Direct Access to Housing program, and the Prevention Framework, have all been rooted in and shaped by the Strategic Plan. Additionally, during the annual budget process, particularly with the difficult decisions the Department faced in the FY 2003-2004 budget, the Strategic Plan was instrumental in determining budget priorities. As a result of the Strategic Plan, for example, the Department chose to prioritize residential treatment in behavioral health over day treatment and street outreach to maximize the likelihood of client success and therefore return on investment.

Accomplishments

The specific accomplishments of the Department for FY 2002-2003 with regard to the Strategic Plan are explored in more detail in Chapter 8 of the Annual Report. More broadly, however, the Department has achieved measurable accomplishments as a result of the guidance of the Strategic Plan. They include:

Strategy	Accomplishment
1.1 and 1.2	Service expansions, including the ISIS Clinic, Bayview Asthma Program, McMillan Stabilization Center, and the Office Based Opiate Addiction Treatment (OBOAT) Program, among others that focus on target populations and neighborhoods.
1.3	Healthy Kids, the Health Care Accountability Ordinance, and other efforts to expand health care coverage to San Francisco's uninsured population.
1.4 and 3.3	Plans to rebuild San Francisco General Hospital and address the capital needs of the primary care centers.

Strategy	Accomplishment
1.6	Behavioral Health integration and adoption of the Harm Reduction Policy designed to improve integration of services for populations in need of multiple services.
1.8	Limited disruption of services to clients as a result of the difficult FY 2003-2004 budget cycle.
1.9	Adoption of guidelines for developing health services.
1.10	Community Programs, San Francisco General Hospital, and Laguna Honda Hospital have all developed quality management and customer satisfaction benchmarks, while Maternal Child Health, STD Prevention and Control, Immunization, and Tobacco Control and Prevention have all established objectives based on *Healthy People 2010* standards.
1.11 and 4.4	The annual *Overview of Health* and the Building a Healthier San Francisco needs assessment, as well as other evaluations and data sources are used to guide program planning and priority setting.
2.1 and 2.2	The Prevention Section developed the Prevention Framework.
2.3	Housing and Urban Health, the Living Wage Ordinance, and the Health Care Accountability Ordinance are all designed to address the social and economic determinants of health.
3.1 and 3.2	All sections continue to work to decrease costs, increase revenues, and overall work more efficiently.
3.6	The Department is implementing the Contracts On-Line (COOL) system in order to streamline the contracting process for both contractors and the Department.
3.7	In addition to the COOL system, the Department's IT section continues to make improvements in information management both for the public through greater access to information and services through the internet, and for Department staff through technology upgrades such as the recent contract with Siemens, which will transition San Francisco General Hospital, Laguna Honda Hospital, Primary Care, and Jail Health Services to a new standard set of applications.
4.1	The Department continues to see success in its federal and state lobbying efforts including the 2002 passage and 2003 CMS approval of AB 915 providing supplemental payments to publicly operated adult day health centers and distinct-part nursing facilities, and federal earmarks of $750,000 each of the DAH and HIV/AIDS programs.

Strategy	Accomplishment
4.2	The Department has worked to streamline and enhance the work of its community advisory boards.
4.3	The Department continually seeks ways to partner with other City departments and community-based agencies on common health issues, including housing and homelessness, children's services, disabled and older adult services, and other programs.

EVALUATING AND UPDATING THE PLAN

Adopted in 2001, the plan, conceived as a three- to five-year document, is now nearly three years old. During this period, the Department's emphasis has been on implementation of the plan and achievement of the goals and objectives outlined in the 2001 document. By its nature, strategic planning is an iterative process. Following implementation, there is a need to continually evaluate the plan. This process helps determine the effectiveness of the plan and the need to update it. The time to begin that process is now. Evaluating and updating the plan will include internal processes to gather and interpret input from Department staff as well as external process to solicit and include feedback from community members and contractors.

Framework for updating the Plan

As with the original strategic planning effort, updating the plan will require the Department to have a thorough understanding of the external and internal factors that can have an impact on the Department's ability to fulfill its mission. These factors provide the context for revising the plan.

As part of updating the Strategic Plan, external and internal assessments will be made. External assessment entails examining and analyzing the social, economic, political, and technological trends in the environment and determining how they affect the Department. An internal assessment involves an objective review of the Department and its resources, including its strengths and weaknesses.

EXTERNAL FACTORS

1. Health industry changes

Over the past several years, the Department has weathered a number of challenges in health financing and service delivery, particularly within the context of being a public-sector safety-net provider. Specifically, the Department confronts:

- Shrinking health services funding for safety net systems and steadily diminishing public health funding, particularly from the State and federal governments.
- Increased demand for services, particularly from those who are multiple-diagnosed.
- Capitation as a predominant reimbursement mechanism.
- Declines in the state, national, and particularly the local economy resulting in lower tax revenue to support public programs and higher rates of uninsurance as displaced workers lose employer-sponsored health benefits.

Despite these challenges, local community and political support for public health has been strong, translating into fewer service cuts than the Department anticipated for FY 2003-2004. Whether this support is sustainable in the long run, particularly if the economy and tax revenues remain weak, is unknown.

2. Socio-economic and demographic changes in San Francisco

The diversity of San Francisco – culturally, linguistically, economically, and educationally – requires the Department to assess and adapt its services continually to address the specific needs of communities. Socio-economic and demographic factors that the Department must consider include:

- Aging of the population.
- Small and decreasing population of children and youth.
- Shortage of low-income housing.
- Persistence of homelessness.
- Growing cultural and linguistic diversity due to immigration.
- Significant percentage of residents living in poverty.

While some of these factors are purely demographic and will directly affect the services provided by the Department (e.g., an aging population and declining population of children and youth may support a greater emphasis on services for seniors), others have a greater influence on the health of residents. For example, the shortage of low-income housing and persistence of homelessness can be linked to poorer health and behavioral health outcomes.

3. Local health status and trends

Overall, San Francisco residents are healthy. However, as the Department reported in the *2002 Overview of Health*, San Francisco has a number of emerging health issues that cannot be ignored. Some of these include:

- Increased need for long-term care services (both home- and community-based and institutional-based).
- Significant numbers of uninsured residents.
- Higher than average morbidity and mortality due to substance dependence.
- Wide racial and ethnic disparities in health status.
- High levels of preventable morbidity and mortality.
- Significant rates of communicable diseases (e.g., tuberculosis, HIV, syphilis, hepatitis).

Health data and epidemiology should underlie Departmental decisions related to program development or discontinuation, and strategic planning must take health status and trends into account.

4. Activities of other City departments and CBOs

In taking a very broad view of health, the Department implicitly believes and explicitly recognizes that the health of San Franciscans is a shared responsibility. Many City departments that provide social and supportive services to the same individuals who seek care from the Department. These departments include:

- Aging and Adult Services
- Children, Youth and Their Families
- Environment
- Human Services
- Mayor's Office on Homelessness
- Mayor's Office of Housing
- Recreation and Park
- Status of Women

It is not uncommon for programs or initiatives within other City departments or community-based agencies to affect residents' health either directly or indirectly. In those cases it is crucial that the Department work with that other agency to ensure coordination of services. The strategic planning process should increase collaborations and coordination with other City departments and community-based organizations.

5. Threat of bioterrorism and general need for emergency preparedness

In the post-September 11 world, threats of bioterrorism and other forms of terrorism that affect the health of residents cannot be ignored. While general emergency preparation has always been a responsibility for the Department, September 11, 2001 clearly demonstrated the need for communities and health departments to make preparedness a top priority. The strategic planning process needs to make emergency preparedness an explicit priority.

6. Political changes

The recall of Governor Davis and election of Governor-elect Schwarzenegger on October 7 has brought significant changes to the political landscape of California. While it is clear that health and health funding will be impacted, it is less clear how. During his campaign, Governor-elect Schwarzenegger emphasized his commitment to children, particularly young children, which may bode well for programs like Healthy Families and Maternal Child Health. However, given the likely state of the budget for 2003-2004 and even possible mid-year cuts in the current budget, he has noted that "waste in the Medi-Cal system" could be a target for cuts.[1] Given the lack of clarity in his current agenda, particularly related to health, the Department will be listening carefully to his plans for changes in health services and funding for California.

[1]Robert Salladay, "What He Has to Do," *San Francisco Chronicle*, October 9, 2003, p. A20.

Also on the political landscape is the April 2003 release of the Little Hoover Commission's *To Protect and Prevent: Rebuilding California's Public Health System*, which calls for development of a State department dedicated to traditional public health activities, separate from the health services financing activities that the current Department of Health Services also undertakes. It remains unclear as to how or if this recommendation will be implemented.

7. Legislative factors

While its implementation remains unclear, SB 2, Senator Burton and Speier's "Pay or Play" Health Coverage Legislation could dramatically change the way health coverage is provided and significantly lower the uninsurance rate in California. The measure creates the State Health Purchasing Program whereby specified employers will be required to pay a fee to the state's insurance pool for employees and, in some cases, dependents. The employer may be exempted from the fee if the employer demonstrates that its health care coverage meets or exceeds the state's program. The Program will be managed by the Managed Risk Medical Insurance Board (MRMIB) and becomes effective for large employers (200 or more employees) on January 1, 2006 and for medium employers (20 to 199 employees) on January 1, 2007. Governor-elect Schwarzenegger has opposed SB 2 and may work to rescind it, and the business community, notably the California Chamber of Commerce has vowed to repeal it through a voter initiative or court challenge on California constitutional grounds or as a violation of the federal ERISA law.

The five-year authorization of the Ryan White Care Act is due to expire in 2004. Unless congressionally reauthorized, there would be no funding under Ryan White after that date. There has been significant discussion in Congress over the past year about San Francisco's "hold harmless" clause, and additionally, reauthorization would likely take into account HIV cases rather than AIDS cases. Because California's tracking of HIV cases is new, it is unclear how funding for San Francisco under Title I would be impacted by such a change.

8. Regulatory changes

For the current and previous fiscal years, California has been "held harmless" on the Medicaid Upper Payment Limit (UPL). Starting in State fiscal year 2003-2004, California's amount over the UPL will be reduced by 15 percent, and will continue to be reduced by increments of 15 percent until it fully takes effect on October 1, 2008, at which time the full 100 percent UPL rule will apply. Once the UPL is fully implemented, California will lose at least $300 million annually, and the loss to San Francisco is estimated to be $10 million annually.

9. Improvements in technology

The Department is poised to begin implementing some major changes to the current clinical and financial systems over the next 24 months. Phase I will involve transitioning the current systems at San Francisco General Hospital (SFGH), Laguna Honda, Jail Health and Primary Care to a new software applications known as SOARIAN for Lifetime Clinical Record, Clinical Care Plans, Provider Order Entry, Patient Registration and Scheduling, and Pharmacy. In addition, Patient Accounting applications at Laguna Honda will be replaced in Phase I, and those at SFGH will be converted in Phase II.

INTERNAL FACTORS

In addition to the external factors that affect the Department's ability to fulfill its mission, there are also internal factors (strengths and weaknesses) that need to be considered.

During the 1990s, significant effort was made to restructure the Department to help it meet its mission. From that work, the Department reorganized itself into two divisions to meet its dual purpose: Population Health and Prevention to address population-based health activities and Community Health Network to focus on personal health care services. While this basic reorganization has helped the Department to meet its mission and achieve its goals, the Department still faces a number of challenges, including:

- An ongoing need to integrate services within and across the divisions (e.g., Community Behavioral Health Services and Primary Care).
- The systematic gathering and use of appropriate data to inform program planning decisions.

As a part of this strategic planning update process, additional analysis assessment of the internal factors will be undertaken.

Timeline

The Department estimates that the evaluation and updating will take approximately eight months to complete culminating in a final report for Commission approval by the end of the current fiscal year. Details related to the timeline are contained in the chart below.

	2003		2004					
Task	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Report to Health Commission	■							
Develop Planning Process		■						
Conduct External and Internal Assessment		■	■					
Conduct Community Forums			■	■	■			
Conduct DPH Staff Forums			■	■	■			
Develop Draft for Director's Review						■		
Director Reviews, Modifies, and Approves							■	
Finalize Report for Commission Approval								■

ACCOMPLISHMENTS AND PROGRAM HIGHLIGHTS

This chapter highlights many of the Department's new programs and service expansions that took place in FY 2002-2003.

GOAL 1: SAN FRANCISCANS HAVE ACCESS TO THE HEALTH SERVICES THEY NEED, WHILE THE DEPARTMENT EMPHASIZES SERVICES TO ITS TARGET POPULATIONS

Strategy: Focus population-based public health services on the entire community and personal health care services on target populations

Population-Based Services

Centralizing disaster response activities

The Emergency Medical Services Section, with the support of many Department employees, has developed a Department Operations Center (DOC), the headquarters for the Department in time of disaster. The DOC is located within walking distance of the Department's main building at 101 Grove Street and has "turn-key" capability, with a set-up time of 15 to 20 minutes.

In time of disaster, the Department's administrative personnel would report to the DOC and assume duties as outlined in the Department's Emergency Operations Plan. The administrative structure of the Department would be streamlined into four branches--Operations, Planning, Finance and Logistics--which is the State standard for disaster operations. The DOC has conference rooms for the Operations and Planning branches and office space for Logistics and Finance branches as needed. Communication links include satellite phone, two radio systems, 800 MHz two way multiple phone and fax lines, and the Mayor's Emergency Telephone System. When fully staffed, it will operate with approximately 30 personnel and will be supported by the City's emergency management system. The DOC will report to the Emergency Operations Center along with other City departments.

Preparing for the possibility of SARS

In March 2003, the Centers for Disease Control and Prevention issued an alert regarding Severe Acute Respiratory Syndrome (SARS) to health authorities across the nation, including the Department. SARS was a new flu-like infection for which there is currently no treatment or vaccine. The Department's Communicable Disease Control Unit immediately issued a Health Advisory regarding the recent outbreak of SARS to all San

Francisco clinicians, and local hospital emergency departments and infection control units. The advisory included information for the case definition, diagnosis, referral, control, treatment, and reporting of suspected SARS patients.

In addition to this advisory, the Department promptly provided education and outreach to San Francisco clinicians, hospitals, ambulatory care settings and the general public. The staff of the Community Health Epidemiology and Disease Control Section also conducted the following activities to educate the public and health care providers:

- Developed and posted a SARS webpage on the Department's Internet site, (http://www.dph.sf.ca.us/HealthInfo/SARS/SARS.htm);
- Presented on the topic at the University of California, San Francisco, San Francisco General Hospital, and to the Medical Directors of the San Francisco Community Clinic Consortium;
- Created guidelines on SARS for ambulatory care settings;
- Convened five press conferences on SARS;
- Created "Frequently Asked Questions" on SARS in English, Chinese, Vietnamese, Spanish and Tagalog for the general public;
- Created SARS Information Line in English and Cantonese (554-2905); and
- Held several presentations and informational meetings with community groups.

These efforts taken by the Department helped San Franciscans understand SARS and allowed the health care community to prepare for a possible outbreak of the disease.

Responding to the emerging syphilis epidemic

In 2002, syphilis cases rose to epidemic proportions in the City (491 early cases in 2002 compared to 189 in 2001). The majority of the cases were among white, gay men residing in the Castro Area of the City. Many of these individuals met their sexual partners on-line and reported using methamphetamine during these encounters. The Sexually Transmitted Disease (STD) Program responded to this health emergency in the following ways:

- Convened a working group of concerned individuals from the target population, called the STD Community Partners, that helped develop a syphilis reduction plan for the City, and implement activities designed to increase awareness and reduce the spread of syphilis in the City;
- Implemented a provider visitation program to educate providers;
- Placed regular ads in San Francisco's weekly gay newspaper, the Bay Area Reporter;
- Implemented an online syphilis testing and incentive program and expanded syphilis testing to other community sites, such as programs catering to speed users;
- Implemented syphilis partner delivered therapy whereby persons infected with syphilis can get medication to give to their partners;
- Maintained the Healthy Penis 2003 STD Awareness Campaign; and

- Worked closely with the City's sex clubs, adult bookstores and bars/clubs to reduce the amount of unsafe sexual activity and increase awareness about syphilis.

Personal Health Care Services

Restorative care for the frail elderly and people with chronic disease and disabilities

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) has a long tradition and philosophy of helping individuals achieve their highest level of functioning and independence. This commitment to functional independence is integral to keeping residents connected to their environment, and for facilitating discharges. To effectively address current resident needs, an interdisciplinary performance team undertook an initiative to create a new model for a restorative nursing care program. The long-term impact of this effort is expected to improve resident functioning in activities of daily living and/or to prevent loss of these activities.

This initiative has been a collaborative effort between a number of Laguna Honda units, including Nursing, Education and Training, Physical Therapy, Speech Therapy, and Occupational Therapy, beginning from the educational aspects up to the clinical delivery of care. The Activity Therapy Department has also responded by redirecting some resident activities to reflect a restorative care perspective and by increasing the Activity Therapists' participation in resident care planning conferences.

Housing the chronically homeless

The Star and Camelot Hotels opened in 2003 and are the two of the Department's newest Direct Access to Housing sites. The Star and Camelot Hotel provides 107 units of permanent housing coupled with on-site support services. The two hotels target chronically homeless people who have been living on the street and/or revolving through high-cost institutional settings. The majority of residents housed in the program are struggling with a combination of mental health, addiction, and physical health issues. The primary goal of the program is to achieve long-term residential stability, improved health status, and reduction in the overuse of high-cost services.

Long-term care for immigrants, including the undocumented, newcomers and monolingual individuals

Laguna Honda, like the entire Department, emphasizes services to target populations. According to the Strategic Plan, three important target populations are the frail elderly, people with chronic disease and disabilities and immigrants, including the undocumented, newcomers and monolingual individuals needing long-term care. In February 2003 the interdisciplinary leadership of Laguna Honda's Unit E5 worked with staff, residents and the community to establish a new program to meet the needs of both the Spanish-speaking population at Laguna Honda as well as residents with dementia.

As the need for dementia services for Spanish-speaking residents increased, the team developed a new program and transitioned from a chronic care service to a dementia service, with a focus on serving Spanish-speaking residents. As a means of providing culturally sensitive activities, a Spanish-speaking Activity Therapist joined the E5 team. In March, the unit celebrated the first phase of the transition with an open house and "*tardiada*" or afternoon tea. By mid March, approximately 45 percent of the E5 population was Spanish-speaking with approximately 85 percent of the unit population meeting the "Dementia" criteria. As part of this transition, Spanish-speaking staff have been enlisted on Unit E5 to ensure cultural appropriateness and sensitivity.

Strategy: Clarify the target neighborhoods that the Department should consider as priorities for services

Reducing chlamydia among youth in the Bayview

During the last year, the STD Program collaborated with the Providence Baptist Church to reduce chlamydia among African-American youth in the Bayview area of the City. Over 2,000 youth were provided with HIV/STD education and 557 were screened for gonorrhea and chlamydia. Twenty-one of these individuals (3.8 percent) were infected with asymptomatic disease and received treatment. Additionally, over 10,000 condoms and lube packets were distributed. Additionally, the STD Program maintained its Jail STD Screening Program. This program was very effective in identifying a high number of asymptomatic chlamydia infections and is thought to have played a role in decreasing female chlamydia morbidity in Bayview. During this period at Southeast Health Center, the community health center serving the largest numbers of at-risk youth, female chlamydia decreased by about 50 percent, from 8.2 percent to 4.4 percent.

A magnet for gay men's health services

The Department's HIV Prevention Section launched several new initiatives which will result in fewer new infections and better education and support for those who are HIV positive. San Francisco is a key pilot project site for rapid HIV testing with several sites in operation and more joining every week.

One of these sites, Magnet (a new center for gay men's health), opened in FY 2002-2003. In the first six weeks, more than 200 people received testing and STD screenings. Magnet, located in the heart of the Castro, provides sexual health services for gay men in a convenient and welcoming environment. Magnet's staff and community partners offer an array of services including HIV testing, screening and testing for STDs, as well as professional staff trained to understand the complex social and sexual factors that influence the decisions gay men make that impact their health.

Community planning in Bayview Hunters Point

FY 2002-2003 saw a number of achievements in the Department's HIV Health Services section. One example is the HIV Health Services Planning Council decision to allocate funds to support a community planning process aimed at enhancing primary care services for African Americans in the San Francisco Bayview Hunters Point district. The HIV Health Services Planning Council identified the need to improve the health status of

people of color, especially African Americans, as one of the overarching goals in their comprehensive plan. A planning effort is needed to summarize the information available, share best practices across agencies, and plan for improved services, greater access to care, and better health status for African Americans living with HIV/AIDS.

Strategy: Ensure that the Community Health Network continues its vital role in the delivery of care

Ensuring privacy and security through HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal mandate that improves health insurance accessibility for people changing employers or leaving the workforce. HIPAA also includes privacy provisions for health care providers, health plans and clearinghouses to encourage and protect the electronic transmission of health-related data. The focus of the Department's implementation efforts is on the privacy and security provisions of HIPAA.

Since the HIPAA implementation efforts began in December 2002, there have been significant privacy and security improvements throughout the Department. The Department has been on time in meeting HIPAA requirements, including the following:

- A Compliance Manual updated with Privacy Policy;
- A Notice of Privacy Practices available in targeted languages;
- Privacy and operation training completed for department staff; and
- Implementation of a Department-wide Privacy Policy and Notice of Privacy Practices.

The implementation of the HIPAA area of privacy was 99 percent complete as of July 2003. Implementation will continue with the Department performing a post-implementation review, as well as providing additional training for staff in health-related fields. The Department has also been crucial in providing consultation to other City departments on their compliance program, as well as assisting the City Attorney's Office in determining which departments are covered under the HIPAA Privacy Rule.

Supporting the City's only Level 1 trauma center

San Francisco General Hospital (SFGH) offers the only Level 1 Trauma Center available for over 1.5 million people living and working in San Francisco and northern San Mateo County. In fiscal year 2002-2003, 3,300 patients were treated for injuries requiring the services of a Level 1 Trauma Center.

In order to maintain its Level 1 status, SFGH hired a new Trauma Program Manager in FY 2002-2003 to help guide SFGH through the process of recertification by the American College of Surgeons (ACS). The program is also fully staffed, for the first time in 3 years, with a trauma educator and two trauma nurse practitioners. This team will help physician leaders prepare for the ACS survey, assisting managers and directors of departments and services responsible for the trauma continuum of care to prepare for

the ACS survey at the department level, arranging all logistics of the site survey in coordination with ACS and the SF EMS Agency, and preparing for a "continual state of ACS readiness" in preparation for the three-year ACS site survey.

A state of readiness

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluates and accredits more than 17,000 health care organizations and programs in the United States. SFGH has made a commitment to have its leadership and staff maintain a constant state of JCAHO readiness, incorporating JCAHO standards, National Patient Safety Goals and all other regulatory changes into hospital and medical staff policies and procedures. SFGH's Quality Management department recently hired a Manager of JCAHO and Regulatory Affairs to better coordinate the hospital's preparation for JCAHO's triennial survey and all other regulatory visits, e.g. DHS and Cal-OSHA.

Starting in 2004, JCAHO is launching a new survey process entitled, "Shared Visions - New Pathways." While continuing to focus on safety and quality, the new process is intended to better integrate the standards with the survey process, shifting to more interactions with the 'front line' staff (nurses, physicians, etc) and less with Administration. By July 2005, all JCAHO health care organizations will have their triennial surveys on an unannounced basis; SFGH will only know approximately when JCAHO will survey by the last survey date. Once JCAHO arrives to the health care organization for survey, they will then create their agenda by focusing on patients, populations, issues and clinical focus groups. With all the new changes in standards and process, SFGH has modified their preparation process. SFGH's next scheduled survey date would be spring of 2005. However, SFGHMC has volunteered to be on the unannounced survey schedule. Therefore, the next triennial survey can be as early as January, 2005 and as late as December, 2005.

Strategy: Ensure that contract agencies are viable partners with the Department in providing health services

Helping clients access SSI benefits

Under the leadership of DPH, a Citywide SSI Advocacy Workgroup (a coalition of providers, advocates, City departments, and the Social Security Administration) implemented SSI Advocacy pilots in three of the Department's mental health programs. The pilots have legal advocates serve as resources to the clinician as well as the patient, creating a team that works together on behalf of the patient throughout the SSI application process. Advocates work directly with mental health professionals, clarifying eligibility requirements, screening clients, assisting with paperwork, helping compile the medical evidence necessary for the application, and guiding clients through the appeal process when necessary. Given the success of the pilots, the Workgroup developed and plan to implement nine recommendations that will further the ultimate goal to "assure the Department's patients and clients who are eligible for SSI benefits attain them." This will allow the Department and its contractors to leverage limited resources, increase client engagement, and improve services.

Strategy: Improve integration of services (physical, prevention, behavioral, social and environmental) for target, vulnerable and at-risk populations who need multiple services

Nursing services at needle exchange sites

As part of the Soft Tissue Infection Initiative, the Department has achieved the goal of providing medical care at all City-supported needle exchange sites in San Francisco. Each week, 14 needle exchange sites are staffed to provide medical services onsite. The goals of this project are to:

- Engage injection drug users;
- Treat urgent medical problems including soft tissue infections;
- Teach HIV/HCV and abscess prevention techniques; and
- Refer to ongoing primary care and drug treatment.

All non-medical needle exchange services are provided by either the HIV Prevention Project of the San Francisco AIDS Foundation funded from the HIV prevention branch of the AIDS Office or the Haight-Ashbury Free Medical clinic.

Integrating medical and mental health services for at-risk youth

The Department's Integrated Satellite Health Clinics program now integrates mental health and medical services for at-risk youth and their families in community health centers and agencies. Four mental health agencies partner with four medical clinics to serve clients in Visitacion Valley/Sunnydale neighborhoods, the Castro and greater Mission neighborhoods, the Chinatown, North Beach, and Tenderloin neighborhoods, and the Ingleside and Sunset neighborhoods. Clinics offer support group meetings, family planning, play therapy, individual, group, and family counseling, child abuse and sexual abuse counseling, as well as physical health exams, health screening and referral, primary care to infants, children, and adolescents, and dental care, among other services. In the next year, substance abuse screening, treatment, and referral for youth and caregivers will be integrated into daily operations.

Expanding programs for homeless individuals

The Department's new Community Behavioral Health Services (combined mental health and substance abuse) section provides substance abuse treatment through Targeted Capacity Expansion (TCE) grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The Walden House Homeless Addict Vocational and Educational Network (HAVEN) initiated services in February 2003 and provides 13 residential treatment slots to homeless individuals while addressing issues of substance abuse, mental health, housing, education, vocational training, and medical problems. The program is extremely successful in retaining clients and over 90 percent of the clients have stayed in treatment. Clients are just starting to graduate to the second phase of treatment provided at satellite facilities. The program plans to serve 155 clients over the three-year grant period.

Another new program funded through SAMHSA is the Post Release Education Program (PREP) that provides treatment services to individuals recently released from County jail. A collaboration with the Sheriff's Office, this program allows individuals who would otherwise not receive services during the tumultuous post-release period to have access to substance abuse treatment, assistance in securing shelter, mental health and medical care, and vocational and education training. There is also a family focus component of the program that helps the families of PREP clients gain an understanding of treatment issues and the PREP program. Over 100 individuals received service through PREP during the first nine months of service.

Coordinating health care services in the home

The Department's Health at Home (HAH) program continues to expand its services to meet the needs of clients. Seventy-four percent of the agency's clients are referred from San Francisco General Hospital and a smaller percent from the community primary care clinics. The agency's nursing and therapist case managers, along with the home care interdisciplinary team, work collaboratively with primary care providers to improve the continuity of care for clients, with the goal of decreasing the chance of hospital readmission.

SFGH has increased referrals to HAH for three types of patients: those needing complex wound care, those requiring intravenous (IV) therapy, and oncology patients needing home case management. A certified wound care nurse provides care for the more complicated cases and provides oversight and consultation to staff on assessment and treatment of wounds. Providers have noted the remarkable improvements which have occurred in patients having more difficult non-healing wounds. RNs also provide IV therapy in the home and teach patients self-infusion, when appropriate. The HAH Oncology/Palliative Care Team provides patients with pain, symptom and medication management.

Strategy: Prioritize Department services within funding limitations

Establishing a new sobering unit

The McMillan Drop-In Center, a collaboration of the Department's Tom Waddell Health Center and Chemical Awareness Treatment Services, provides a place for homeless public inebriates to sober up safely. Once sober, clients have access to medical, behavioral health, housing, and case management services to assist in their recovery. In addition, because public inebriates place a considerable burden on the emergency health care system, the Department expects that this new program will reduce inappropriate ambulance trips and emergency room visits. This program was funded by contributions from private nonprofit hospitals in San Francisco, and by assuming that the facility will decrease the expense of caring for this population in the SFGH Emergency Department.

A recent recommendation from the Board of Supervisors' Ambulance Diversion Task Force was to establish a sobering unit to reduce emergency visits and improve health outcomes for chronic public inebriates. The target pilot project populations are homeless public inebriates and existing clients at the McMillan Drop In Center. The new project offers 20 stabilization beds and aims to achieve the following goals:

- To provide better care for chronic public inebriates and improve their health outcomes;
- To decrease the number of inappropriate ambulance trips that transport chronic public inebriates to the emergency department; and
- To decrease the number of inappropriate chronic public inebriates seen in the emergency room.

Addressing the exploitation of youth

In August 2002, the San Francisco Board of Supervisors passed a resolution that established the End the Exploitation of Youth Task Force. The Task Force was created in response to increasing community concerns about the seriousness of sexual exploitation of youth in San Francisco and the lack of appropriate local services. The vision of the Task Force was to raise public awareness about the sexual exploitation of children and youth, create a responsive social service system, eliminate the criminalization of exploited youth and reduce the number of victims of sexual violence.

Members of the Task Force include representatives from City agencies, social service agencies, physical and mental health services, and multidisciplinary professionals. The Coordinator of the Department's Office of Adolescent Health co-staffed the Task Force and the Coordinator of the Department's Office of Women's Health served as a Task Force member. The Task Force developed three recommendations considered necessary first steps for the development of a safer and healthier environment for sexually exploited youth:

- Open a secured residential program – The program would provide a secure housing option for long-term treatment and support.
- Establish a 24-hour hotline – The hotline would provide culturally appropriate crisis intervention, harm reduction and health promotion strategies, and links to services for sexually exploited youth.
- Expand community outreach services – Community outreach efforts would be focused on bridging service gaps that currently exist for sexually exploited youth.

A bright future for adolescent health

Adolescents in San Francisco comprise 16 percent of the total San Francisco population and are the most ethnically and racially diverse population in the City. As a group, adolescents in San Francisco are generally physically healthy; however, some struggle with mental and emotional health issues, and may have difficulty in accessing primary health care services. A major goal of the Department's new Office of Adolescent Health is to eliminate the health services gaps that exist for underserved youth in San Francisco. Underserved youth include those of specific ethnic and racial groups, in the juvenile justice system, in foster care, homeless, LGBTQ, newcomers, or those with special needs due to developmental or physical disabilities.

In January 2003, the Office of Adolescent Health completed an Adolescent Health Plan for San Francisco that will span two years and improve services for youth, particularly those currently identified as underserved. This report is the first strategic health plan adopted by the Department that focuses entirely on the needs of San Francisco's youth population (ages 10-24). The Adolescent Health Plan provides strategies to improve services across seven health issues (e.g., behavioral health, violence, nutrition and physical activity, etc.). Implementation of prevention services and programs that are sensitive to the comprehensive needs of San Francisco's diverse youth, as well as special training for health care delivery personnel, are already in progress. The Office of Adolescent Health also arranges for strategic collaborations between the Department, local agencies, and community programs in order to provide a healthier environment for San Francisco's youth to develop into healthy adults.

Partnering in wellness for women and girls

In May 2003, "The Women's Health Plan: Partnering in Wellness with Women and Girls in San Francisco 2003-2006" was issued by the Department's Office of Women's Health. This plan will guide the Department in its efforts to safeguard, promote and improve the health and well-being of the women and girls of San Francisco. The Women's Health Plan outlines multiple current challenges to women's health and well-being, and in response, formulates six core recommendations and suggests numerous possible Department strategies for their achievement.

The Women's Health Plan encourages the provision of gender-specific comprehensive health care services that are sensitive to the needs and social roles of women, and that are made accessible to vulnerable populations of women including those that are homeless, incarcerated or uninsured. The Plan envisions the elimination of health disparities based on race and ethnicity, disabilities and sexual orientation. Prevention,

through health screening and health education services, and the need for reduction of cancer rates are also highlighted in the Plan. The Plan intends to diminish the public health impact of violence on women, girls and their families by targeting intimate partner violence, sexual assault and gun-related violence. The Women's Health Plan will be implemented between 2003 and 2006 with an evaluation in 2007.

Strategy: Use data and evaluation more routinely and uniformly to guide program planning and priority setting

Tracking HIV Infection

The responsibilities of the Department's HIV/AIDS Statistics and Epidemiology Section (formerly the AIDS Surveillance and Seroepidemiology Section) expanded in July 2002 to include the reporting of persons with HIV infection who had not yet developed AIDS. HIV case reporting differs from AIDS case reporting because both laboratories and health care providers are required to report to the local health department and because persons with HIV infection are reported using a non-name code. Implementing HIV case reporting has required substantial efforts on the part of staff, laboratories, HIV counseling and testing sites, hospitals, and private medical providers. This collaborative effort has paid off and HIV reporting is now well established in San Francisco.

From July to September 2003, 4,186 persons with HIV infection were reported to the HIV/AIDS Statistics and Epidemiology Section; 3,462 of the case reports reflect persons diagnosed with HIV prior to 2002 and 724 were persons who were known to be first diagnosed with HIV in 2002-2003. Based on prior estimates, the Department anticipates that an additional 1,500 persons will be reported during the remainder of 2003 and through 2004. Although the data are incomplete, preliminary analysis suggests that compared to persons living with AIDS, persons with HIV infection without an AIDS diagnosis are younger and are more likely to have private health insurance. More information can be found online at **www.dph.sf.ca.us/PHP/AIDSSurvUnit.htm**.

Evaluating regional needs for homeless families

The San Francisco Bay Area Homeless Perinatal Planning Committee is led by the Department's Maternal and Child Health Program and brings together representatives from San Francisco, Alameda, Contra Costa, Marin, San Mateo, Santa Clara and Solano counties and the City of Berkeley to promote regional awareness of homeless issues that affect families in our communities. The Committee sponsored the 2nd Annual Networking Conference in September 2002, titled "Repairing the Safety Net for Homeless Families," and the 7th Annual Homeless Perinatal Conference in May 2003 in Oakland, titled "Survivors: Homeless Children & Their Families." In addition, the committee developed a Bay Area Help Card, which can be found on the San Francisco Department of Public Health Web Site http://www.dph.sf.ca.us/PHP/PregantHlp.htm. The card contains information and resources for the seven Bay Area counties.

GOAL 2: DISEASE AND INJURY ARE PREVENTED

Strategy: Strengthen primary prevention activities of the Department

Preventing influenza at Laguna Honda Hospital and Rehabilitation Center

Prevention of illness, disability and injury is one of the cornerstones of all public health programs and institutions. As part of the public health system that spans the entire continuum of care for San Franciscans, Laguna Honda strives to include preventive services in all its programming. One example is Laguna Honda's influenza prevention program. Laguna Honda has had a vigorous influenza vaccination program for years, reaching over 92 percent of residents. The influenza prevention program includes the following components:

- Vaccination of residents and staff;
- Surveillance;
- Antiviral prophylaxis and treatment; and
- Infection control and outbreak control.

In late 2002 the Laguna Honda Infection Control Committee reviewed its data from the 2001-2002 flu season and concluded that its most effective intervention would be to increase the staff vaccination rate using an educational campaign, enhanced access to vaccinations, and incentives. The percentage of staff receiving the flu vaccination increased from 26 percent in 2001-2002 to 37 percent in 2002-2003. The number of influenza cases decreased from 30 to 4. The program was presented as a model at the California Adult Immunization Summit in May 2003.

Reducing the risk of falls for Laguna Honda residents

Fall prevention is a public health issue advocated by the Centers for Disease Control and Prevention, which notes that falls are the most common cause of injuries and hospital admissions for trauma. Falls account for 87 percent of all fractures in people 65 years and older, and are the leading cause of injury and death among this group. Incidence of falls in long term-care residents is even higher.

Laguna Honda developed programs for fall risk management and successfully reduced the percentage of residents using one or more restraints to 4 percent, significantly below state (17%) and national (9%) nursing home averages, without a commensurate increase in fall rates or injuries associated with falls. Interdisciplinary teams at Laguna Honda now have fall risk assessment tools to evaluate and intervene for fall risk reduction without using restraints. Interventions are tailored to the individual, including environmental alterations; pharmacy consultations; therapy consultations; exercise; and restraint alternatives. Laguna Honda's incidence of new fractures is 1.3 percent, in

contrast to the comparison group average of 1.8 percent, while prevalence of falls at Laguna Honda is 7 percent, half that of the comparison group.

The pedestrian and traffic safety program

The Pedestrian and Traffic Safety Program had four main areas of focus in the last year:

- **Pedestrian Injury Surveillance**: The Department compiled data from San Francisco's Trauma Registry reports, Emergency Medical Services reports and Police Department collision reports. The data allow staff and community to identify neighborhoods and age groups that may be at higher risk for pedestrian injury.
- **Technical Assistance:** Staff in the Community Health Education Section provided technical assistance to pedestrian and traffic safety advocates by convening the Traffic Safety Advisory Council; convening the Mission and Tenderloin Pedestrian Safety Working Groups; providing training on community organizing, fundraising, advocacy and other tools for activists; and linking community groups and City agencies.
- **Mini-Grants for Community-Based Organizations:** The Department funded community-based organizations to conduct pedestrian and traffic safety projects in their neighborhoods, utilizing funds awarded by the California Office of Traffic Safety.
- **Media Campaigns:** In conjunction with the Department of Parking and Traffic, the Department, conducted an annual media campaign targeting traffic safety in San Francisco. The media campaign was funded by the fines for running red lights. In 2003, the focus of the media campaign was to promote courtesy between drivers and pedestrians.

Improving medication safety

In 2002, the CHN's Medication Use and Safety Officer noted a problem with the manufacturer's labels on two injectable medications. The problem had the potential to

lead to serious medication errors. The drugs, acetazolamide and acyclovir, were packaged in identical size and shape vials, both were available as 500mg vials, and the color used for the labels on both products were variations of blue and white. Because drugs are usually stored in alphabetical order by pharmacies, on nursing units, and in other medication storage areas, the potential that busy hospital staff might mistake the products for each other was great.

The Pharmacy contacted several national medication safety "watchdog" organizations with this concern. As a result, the manufacturer recently notified the CHN and the national organizations of its intent to change the labeling on the vials to make the drug name more easily readable and the products more readily differentiated. Through this action, medication safety was improved nationwide for patients for whom these drugs are ordered and used.

Researching ways to prevent HIV

The Department's HIV Research Section's mission is to conduct ethical, innovative research likely to have the greatest impact on preventing HIV infection and AIDS in this changing epidemic. The Research Section provides leadership in developing critical research questions and communicating its study results widely. In addition to their research, the Research Section serves as a mentor to both national and international sites. Sister research sites are in Puerto Rico and Argentina, and the Research Section helped to develop HIV vaccine research centers in Honduras, the Dominican Republic, and Jamaica.

The research is currently split into two major categories, behavioral prevention of HIV and clinical prevention of HIV. Behavioral prevention efforts consist of two studies: the Explore study, which involved 735 men who have sex with men (MSM) at the San Francisco site and over 3,000 others nationwide; and Project Mix, which is a peer based intervention to encourage safe sex among substance using MSM. Clinical prevention efforts consist of testing HIV vaccines for safety and efficacy. In the last fiscal year, the Research Section began testing two phase I HIV vaccines and is scheduled to begin three additional phase I trials before the end of the calendar year.

Strategy: Address social and economic determinants of health status

The Health Impact Assessment

Neighborhood rezoning plans must undergo environmental impact assessments (EIA) to inform governmental decision-makers and the public about the potential, significant effects of proposed decisions and activities. Laws mandating EIA recognize that social and physical environments are interrelated; however, EIA has been traditionally deficient in addressing how projects impact social determinants of health, and health agencies have traditionally had limited involvement with EIA.

In San Francisco's Mission neighborhood, a coalition of community organizations, the Mission Anti-displacement Coalition (MAC), convened to represent the needs of residents in a city rezoning process. MAC has begun using the Health Impact Assessment as a vehicle to evaluate the health and social impacts of alternative zoning proposals, increase community capacity to engage with land use planning, and develop public awareness of the relationship between land use and health.

The Department facilitates the assessment planning and implementation, coordinates and documents the process and its findings, trains community member research activities, and provides other research support. Multiple qualitative, quantitative, and popular research methods are being applied to the assessment. Findings will be integrated into a document and will be disseminated through multiple, culturally relevant and language appropriate media. The partnership will develop a plan to monitor the influence of the assessment both on the zoning decision as well as local agency approaches to community involvement.

Mental health consultation in homeless and domestic violence shelters

The Department's Child, Youth, and Family Section began providing mental health consultation and treatment services to children age birth to 5 years and their families living in 11 homeless shelters, transitional housing programs and domestic violence shelters. Services include assessment, direct treatment, therapeutic play groups, group therapy, and staff consultations and training.

Mental health services address disturbances related to the trauma of the current episode of homelessness (e.g., anxiety, fear, anger and hostility). Mental health services also address problems related to negative influences in the past, such as growing up in foster care or with alcoholic or drug addicted parents. The program is being evaluated by interviewing mothers in the shelters at intake and every six months thereafter, and asking mental health consultants and shelter staff to complete surveys every six months about progress the child and family is making on a variety of mental health indicators.

Increasing access to healthy foods

The mission of the San Francisco Food Systems Council is to bridge San Francisco residents to the sustainable production, equitable distribution, nutritious consumption and responsible recycling of food and promoting community relevant policies that support an equitable food system. The Food Systems Council's work has focused on four major activities:

- Strategic planning for the development of the San Francisco Food Systems Council;
- Planning for and promoting community food assessments in San Francisco in order to prioritize community concerns, develop projects strategically and build capacity of existing organizations to do more sustainable food systems work;
- Educating City agencies and existing community-based organizations about the work of the San Francisco Food Systems Council and how it might apply to their organization; and
- Working with San Francisco Unified School District to determine the feasibility of a Farm-to-School project.

An action guide for children and youth

The Department's Child, Youth, and Family System of Care section worked together with the San Francisco Unified School District School Health Programs Department to develop two sections on depression and suicide prevention for the district's Action Guide for students and families. The guide, which was sent to the home of every public high school student in San Francisco, addresses the warning signs of depression and suicidal intention, what parents can do, where to get help, and how students can help other students who are in need of help. The guide was also translated into Spanish and Chinese.

Strategy: Develop a multi-year prevention plan.

Coordinating prevention efforts

In FY 2002-2003, the Department's Prevention Planning Team and Prevention Workgroup developed a Strategic Prevention Plan. This Plan is to be used as guide for the development of prevention activities throughout the Department. It is designed to build on existing efforts, eliminate or mitigate disparities, and select interventions based on evidence. The Plan will provide an integrated approach for the Department's prevention efforts, whereby various sections within the Department can develop primary prevention interventions that build upon a common foundation. Implementation will begin throughout various sections and programs in 2004. The Community Programs' Expanded Management Team will provide ongoing oversight.

GOAL 3: SERVICES, PROGRAMS AND FACILITIES ARE COST-EFFECTIVE AND RESOURCES ARE MAXIMIZED

Strategy: Make overall improvements in financing operations

Maximizing revenues at Laguna Honda Hospital and Rehabilitation Center
As revenue generation becomes increasingly important in long-term care, Laguna Honda has undertaken a major initiative to maximize revenues that are determined by the completion of Minimum Data Set (MDS). This comprehensive functional assessment of some 250+ questions, originally designed in 1989 to be used as the foundation for planning and delivering care to all nursing home residents, has gained increasing importance in providing regulatory oversight and revenue generation.

The MDS is also presently being used in 27 states to determine Medicaid reimbursement with California expected to start using the MDS for Medi-Cal reimbursement in the near future. Responding to the present financial landscape with the knowledge that Medi-Cal reimbursement will soon depend upon an accurate completion of the MDS, Laguna Honda has established a program to train registered nurses to coordinate the input of the Interdisciplinary Team and complete the MDS in an accurate and timely manner. Staff will continue to monitor the impact on revenue due to enhanced knowledge and accuracy of coding.

Improving billing procedures at San Francisco General Hospital
To contend with ongoing economic downturns and reductions in City General Funds, San Francisco General Hospital (SFGH) is taking measures to identify new sources of revenue to minimize the reduction of services. In Fiscal Year 2002-2003, SFGH implemented an Operating Room major trauma charge and continued efforts to identify late charges on inpatient accounts, improve coding on billing forms and ancillary department requisitions, acquire billing numbers for all new providers, ensure proper charging of supplies and develop a supply formulary, and determine and facilitate patient eligibility for various programs. In addition, SFGH hired two revenue enhancement specialists and began efforts to better utilize existing staff to support ongoing efforts to maximize revenue.

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

Developing the Behavioral Health Court

This past year, the Department's Jail Health Services and Behavioral Health Services (mental health and substance abuse services combined) in collaboration with the Courts, the District Attorney's Office, and the Public Defender's Office implemented a voluntary Behavioral Health Court (BHC). This therapeutic court, created with no additional funds, offers defendants with serious mental illness a chance for treatment instead of incarceration. The court has a multi-disciplinary team working with the defendant to obtain Supplemental Security Housing (SSI), housing, and appropriate levels of community based treatment. Being a participant in BHC requires an immense amount of effort by the client. In the first 8 months, 90 clients have actively participated with BHC and it appears to be a successful alternative to the traditional court system for this special needs population.

Ensuring the appropriate level of care - The Patient Flow Pilot Project

The Patient Flow Pilot Project focuses on creating greater capacity at SFGH for acute psychiatric patients by facilitating timely patient transition to the next appropriate level of care. By making timely transfers, patients are assured the least restrictive level of care and SFGH is able to reduce its number of administrative days, which are reimbursed by Medi-Cal at amounts significantly lower than the cost of providing acute psychiatric care. During the pilot, staff carefully monitored several quality indicators to ensure clinical appropriateness. The data collected from March through October 2002 showed favorable results.

There was an average increase of 65 acute patients per month admitted to SFGH due to increase in capacity. At the same time, SFGH experienced an average decrease of 424 administrative days per month. The average length of stay decreased from 15 days to 10.5 days. During the same time period, the number of patients requiring transfer from Psychiatric Emergency Services to hospitals due to lack of capacity decreased from 173 to 31.

Streamlining STD testing

Recognizing the importance of surveillance for controlling and preventing the transmission of Sexually Transmitted Diseases (STD) like gonorrhea and chlamydia infections, the Department's Laboratory has teamed up with the STD Control unit to increase screening for STDs. To handle the increase in specimens tested, the laboratory installed the Viper automatic pipetting device in December 2002 to streamline specimen handling and testing. This instrument allows the laboratory to process more specimens without increasing staff. The automation also controls contamination of the environment and reduces ergonomic activity for staff.

Strategy: Address the infrastructure needs on the San Francisco General Hospital campus and at the primary care sites

Planning for air medical access

San Francisco is the only locality within the top 25 municipalities in the United States without air medical access. The inability to air transport patients into and out of San Francisco General Hospital Medical Center (SFGH) compromises its ability to respond to critically injured patients whose needs are best served at a Level 1 Trauma Center. To better serve all trauma patients within this region and maintain American College of Surgeons verification as a Level 1 Trauma Center, SFGH conducted a needs assessment and feasibility study to determine the need for air medical access and determine whether a helipad could be located at the SFGH campus. In March 2003, the Health Commission reviewed the findings of the "SFGH Air Medical Access Needs Assessment & Feasibility Study" and adopted a resolution directing SFGH to continue planning for air medical access.

The next steps for SFGH air medical access planning are conducting an environmental impact review (EIR), designing a medical helipad for an SFGH rooftop location, and obtaining the necessary permits for an SFGH medical helipad. The successful accomplishment of this goal requires the development and implementation of a Phase II air medical access action plan, convening a Phase II team to implement the plan, hiring contractors to conduct the work (EIR, design, and permit), adhering to time specific objectives, and ensuring community outreach to neighborhoods, community groups and health care professionals.

Rebuilding San Francisco General Hospital

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

At the end of FY 2002-2003, SFGH had three scenarios as part of its Institutional Master Plan. One scenario would rebuild SFGH on the Potrero Street campus and the other two scenarios include a Mission Bay site. The next steps are, with guidance from the Rebuild Steering Committee, Combined Advisory Committee, and the SFGH and Community Health Network Joint Conference Committees, to choose the best of the three alternatives and present a final proposed Institutional Master Planning concept to the Health Commission for approval in October 2003. In addition, a financial plan will be developed for funding the hospital rebuild, which will include a general obligation bond package for submission to the Capital Improvement Advisory Committee by March 2004 for a ballot initiative in November 2004.

Strategy: Design an e-government strategy and presence for the department

Developing a single information system to support the continuum of care
SFGH is undertaking major information systems projects needed to simplify clinical and diagnostic functions and comply with various State and federal laws. In April 2003, the Health Commission approved a plan to transition to SOARIAN beginning in 2004. SOARIAN is a comprehensive, Internet-based suite of applications for patient registration, accounting, patient scheduling, clinical care plan documentation, clinical orders, and the Lifetime Clinical Record. This system will standardize information technology systems across DPH institutions and adds the potential to integrate clinical and financial data. This product will allow SFGH to comply with Senate Bill 1875, which requires hospitals to implement a computerized provider order entry system by 2005 to reduce medication errors.

Meanwhile, SFGH is continuing to perform essential upgrades to existing systems, replace obsolete workstations and move towards a filmless radiology department through a Picture Archiving Communications System (PACS). The PACS system will store electronic images, thereby eliminating the lost film problem and the need to reprint films.

Strategy: Improve recruitment, retention and training of Department staff

Improving retention and recruitment
It has been projected that there will be a 40 percent rate of retirement among City employees from 2000 to 2011. As of September 2002, the total rate of vacancies at SFGH was 12 percent, and the turnover rate was 8.7 percent. Shortages in key healthcare professions including registered nurses, pharmacists, respiratory therapists, and radiology technicians are challenging recruitment efforts. Cost of living in the Bay Area and current pay scales will continue to be barriers to filling vacancies, including those of physicians. SFGH hopes to decrease turnover and vacancy rates by improving staff retention and recruitment. Efforts by the Department's Nursing Leadership Council included the establishment of "Nursing Notes" a quarterly newsletter that highlights accomplishments and other issues of relevance to nurses.

In another effort, the Private Industry Council with the joint participation of eight San Francisco hospitals, including Laguna Honda and San Francisco General Hospital, SEIU Local 250, and the City College of San Francisco, received grant funding from the State of California to address the nursing shortage. Other partners in the grant include Jewish Vocational Services, Hospital Council of Northern California and Regional Health Occupations Resource Center. The grant project aims to provide career ladder training for incumbent non-licensed hospital employees to become licensed vocational nurses or registered nurses. The grant will fund the eligible hospital staff tuition, fees, uniforms, supplies and/or books. Laguna Honda, as a prospective participating hospital, will commit to releasing employees who meet eligibility and selection criteria to attend

classes during regular working hours, with pay, not to exceed eight hours per week. SEIU Local 250 and Jewish Vocational Services will also provide educational counseling and case management to employees participating in the program.

Training Department staff to treat opiate addiction

In October 2002, the federal Food and Drug Administration approved buprenorphine for use in the treatment of heroin and other opiate addiction. Like methadone, buprenorphine is a medication that addicts can take to block withdrawal symptoms and the craving for opiates without producing a strong narcotic "high". In January 2003, the Department responded by sponsoring free buprenorphine training for Department staff. More than 160 individuals attended the training, including 100 physicians. Physicians who attended this training may apply to CSAT for permission to prescribe buprenorphine. The Department is developing guidelines for the use of buprenorphine, building on the work of the Office-based Opiate Treatment Program (OBOT) Program planning process and the integration of substance abuse and mental health services. A specialized induction clinic has been developed for OBOT patients initiating buprenorphine.

GOAL 4: PARTNERSHIPS WITH COMMUNITIES ARE CREATED AND SUSTAINED TO ASSESS, DEVELOP, IMPLEMENT AND ADVOCATE FOR HEALTH FUNDING, POLICIES, PROGRAMS AND SERVICES

Strategy: Restructure and enhance the Department's relationship with its community advisory groups

Mental health consumer initiatives

The Department's Community Mental Health Services section implemented several consumer initiative programs based on wellness and recovery in FY 2002-2003, including:

- The Peer Internship Program trained 19 mental health clients and placed them in various mental health programs. The program also provided peer counseling and support services. Four of the nineteen individuals were then hired by the agencies.
- The Asian Consumer Leadership Team conducted four peer workshops in multiple Asian languages.
- A Wellness and Recovery Task Force composed of clients, family members and providers completed its task of submitting recommendations for the development and implementation of a recovery-oriented system of care. The recommendations included suggested action steps to enhance the role of consumers at all levels in the system-of-care, and to develop and support multiple pathways to recovery (including increasing the availability of "non-clinical" resources such as housing, vocational rehabilitation services, supportive education, socialization and volunteer opportunities).

Strategy: Explore opportunities to partner with other providers and their community on common health issues

High Quality Child Care Mental Health Consultation Initiative

The High Quality Child Care Mental Health Consultation Initiative places mental health consultants in over 80 childcare centers and over 100 family day care homes. The consultants provide direct therapeutic services to children and indirect consultation and training to childcare staff. The most prominent issues that children face (as rated by teachers) include family/economic hardship, family instability, traumatic stress, and witnessing violence.

The Initiative has demonstrated positive outcomes for young children and child care staff. Children identified for treatment showed statistically significant improvements in social maturity, and they matured at a faster rate than children not identified for treatment. Children with clinically related problem behaviors made statistically significant improvements as compared to children not identified for treatment. Childcare center staff indicated strong satisfaction with the services provided by the mental health consultants. Over 90 percent of parents participating in the evaluation reported that they were very satisfied with the services their children were receiving, and that they were better able to understand and address their child's needs and difficulties.

Thinking clean and green

The Clean and Green program is designed to provide San Francisco businesses with an opportunity to develop model precautionary business practices through education and training. The training includes technical assistance for preventing workers' exposure to toxins and chemicals by utilizing environmentally friendly products that are also better for health. The training also includes determining environmental management practices, a method of finding the most efficient application of an idea or use. The program provides outreach to help prevent future problems and accidents involving chemicals in the workplace, and fosters an open level of communications between the Department and the private business sector.

In October 2002, the first specialized Clean and Green workshop series was offered to the automotive industry in San Francisco. The workshop was co-sponsored by the Department of Toxic Substances Control (DTSC). They were able to provide hydrophobic mops, pollution prevention t-shirts, and training videos to the workshop attendees. To date, 47 of these businesses have been successfully converted to thinking "clean and green." The Clean and Green program now provides free workshops, environmental tools, private consultation, and health education materials to City businesses and agencies that are interested in protecting their workers and becoming a certified "clean and green" business.

Children and youth domestic violence free

During the third year of the Children and Youth Domestic Violence Free project, the Community Health Education Section planned and conducted a citywide conference entitled, "San Francisco Children and Families Domestic Violence Free: Multidisciplinary Approaches to Addressing Family Violence." The conference was co-planned by the San Francisco Safe Start Project, and many city, state and local community-based agencies joined as sponsors, including the State Attorney General's Office.

The purpose of the conference was to discuss early intervention, legislation and prevention of intimate partner violence and the effects such violence has on children. Over 243 representatives of public and private agencies attended the conference from a broad range of disciplines. The Community Health Education Section took this opportunity to obtain valuable input and feedback on the intimate partner violence strategic prevention plan, now nearing completion.

Collaborating for the behavioral health project

The behavioral health project is a collaboration between the Housing & Urban Health section (HUH) and two community-based organizations (Baker Places, Inc. and Fort Help). The project is designed to provide one-on-one mental health and substance abuse counseling, group counseling and off-site residential and detoxification services for the residents of the Direct Access to Housing Program (DAH). This model of on-site case management, medical services and counseling with augmented services off-site is expected to assist in stabilizing the residents of the DAH facilities and reduce hospitalizations (both psychiatric and medical) and evictions. The DAH program currently provides 360 units of permanent supportive housing in five single room occupancy (SRO) residential hotels and an additional 33 units in a licensed residential care facility.

Because many of the DAH residents have chronic medical, substance abuse and mental health disorders, maintaining stability in housing demands wrap-around integrated health services. At present, all six DAH sites have intensive case management services provided by community-based organizations and some medical services (either on-site or through consultation) provided by HUH. With the development of this service, Baker Places provides on-site counseling services and off-site residential behavioral health and detoxification services. Fort Help is providing methadone maintenance services.

Improving emergency care and coordination

The Emergency Medical Services Section recently approved the San Francisco Fire Department's (SFFD) Pilot Program, called the Rapid Paramedic Response System, to add a paramedic to the City's fire engines. In most medical emergencies, both an SFFD engine and an ambulance are dispatched to the request for help. Since there are more than twice as many engines as ambulances, and they are distributed more evenly throughout the City, the engines frequently arrive at a patient's side more quickly than an ambulance. The fire engines are staffed with firefighters who are also Emergency Medical Technicians (EMTs) and they start basic emergency medical care but must wait for a paramedic to arrive to administer medications or perform airway treatments.

By putting paramedics on engines, the pilot program demonstrated an improvement in the time interval from a 9-1-1 call until a paramedic arrived at the scene of the emergency without sacrificing patient care while being transported in the ambulance. (Many paramedics had to be shifted from ambulances to engines, creating a number of ambulances staffed with one paramedic and one EMT.) The SFFD plans to utilize the results from this study to staff more engines in areas of the City with long response intervals for paramedic service with the eventual goal, endorsed by the Health Commission, of having a paramedic on every fire engine in San Francisco. This will bring the City in line with recommendations from the EMS Medical Directors Association of California for a 5-minute response interval for defibrillator-equipped personnel and a 10-minute response interval for paramedics in urban areas. This truly is one of the landmarks of a 21st-century EMS system.

Strategy: Continue and expand assessment of community health needs (i.e., risks to health and safety).

Teaching healthy eating habits to reduce obesity

Since 2001 services have been provided to the community and schools to encourage exercise and eating well-balanced meals with at least 5 fruits and vegetables. The program was a precursor to the current interest in childhood obesity. The Nutrition Services section received funding in FY 2002-2003 to provide services to the Hispanic community to reduce obesity, which leads to Type II diabetes, which is more prevalent in the Hispanic community. The staff developed partnerships with community-based groups in the Mission district and with the YMCA. The groups contacted parents through outreach and provided information on purchasing appropriate foods, meal preparation (with demonstrations), and the importance of exercise. A conference was also held for the entire city and region called "Weighty Matters" and was attended by 300 people. Materials were made available which could be used in a variety of situations to help families and communities reduce the impact of obesity.