GOAL 1
San Franciscans have access to the health services they need

OBJECTIVE
Improve health outcomes among San Francisco residents

Avon Comprehensive Breast Cancer Care Program
Since its inception in 2000 with original funding over five million dollars the Avon Comprehensive Breast Care Program (ACBCP) at San Francisco General Hospital has strived to identify the most critical breast cancer needs of poor women in the City and County of San Francisco; to develop and implement core services to address those needs; and to become a national leader of innovative research in the care of underserved women. The Avon Foundation renewed its support of ACBCP by awarding a new one million dollar gift for the period (October 2006 – September 2007) to continue and enhance services at SFGH. The new gift will fund on-going and enhanced services in the following areas:

- Community and patient education: raise awareness and understanding regarding breast cancer, particularly screening and survival, CARE Program Management
- Outreach: recruitment of women into screening and care
- Screening and follow-up: find the disease, ensure adherence
- Cancer Risk Assessment: identify and screen high risk women and families
- Treatment: provide high quality, evidence-based therapies and make them available to all
- Survivorship support: help women live after cancer
- Public Advocacy: act on behalf of underserved women with cancer to improve systems and treatments for all, Community Advisory Council
- Research: clinical and community-based research about cancer risk, treatment, and psychosocial issues, Clinical Trials Enrollment

In collaboration with Avon, the City and County of San Francisco funds:

1) Operations and management of the Mammography Van and the Avon Comprehensive Breast Center totaling 5.0 FTE and $642,039, and
2) Operations and management of the highly successful Patient Navigator Program totaling 6.0 FTE and $479,587. In addition, this program will produce new patient billing revenues totaling $580,800.

AMA Hospitals Recognition Program for Innovative Patient Centered Communication
San Francisco General Hospital was one of eight sites (from a pool of 80 nominated hospitals), selected by the American Medical Association and the Ethical Force Program in recognition of innovative work to support patient-centered communication. In

December of 2005, SFGH hosted a two-day site visit from the AMA and the Health Research and Educational Trust, where SFGH staff had the opportunity to share their innovative programs. During the site visit, SFGH received a plaque recognizing the hospital's efforts toward cultural competency and patient-centered care. SFGH was also included in a report to the Commonwealth Fund that outlined promising practices for patient-centered communication.

Improving self-management support for Diabetes Mellitus – The goals of the IDEALL Project (Improving Diabetes Efforts Across Language and Literacy) are to implement and evaluate disease management programs tailored to the language and literacy levels of patients with diabetes. The IDEALL project has two main objectives: the first is to test the feasibility and acceptability of health communication interventions in a public delivery system and the second is to compare the effects of technologically-oriented vs. interpersonally-oriented chronic disease support among patient with communication barriers.

Promoting safety and effectiveness in anticoagulation care and stroke prevention – Miscommunication between clinicians and patients is common and may lead to medication-related errors and poor clinical outcomes. This may be particularly true for such medications as warfarin (Coumadin), a medication that can prevent as many as 80% of strokes in vulnerable patients. With seed support from the American Heart Association, we have developed and implemented a computerized visual medical schedule (VMS) for weekly warfarin regimens in 3 languages to improve the performance of our hospital systems' anticoagulation care management program.

Promoting self-management for children with asthma – The Pediatric Asthma Clinic at San Francisco has provided specialty asthma evaluations and follow-up since 1999. Referrals to this clinic come from providers, public health nurses, urgent care and inpatient clinicians, and from schools. We collaborate with environmental control specialists from the San Francisco Department of Public Health (SFDPH), a public health nurse trained in asthma care, and trainees from local programs. In 2001, the *Yes We Can* Urban Asthma Partnership joined in efforts to control asthma among San Francisco's diverse childhood population. This partnership brought community health workers (CHWs) into the mix of providers, adding linguistic and cultural expertise to the already strong staff.

CenteringPregnancy – This program moves prenatal care out of the exam room and into a group space, where participants receive health assessment, health education and social support. Each group includes 8-12 women who are expected to deliver in the same month and who meet together for 10 two-hour sessions over the course of their pregnancies. Because the process of the group encourages participation, discussions are rich and more likely to be culturally appropriate and relevant than education imparted in the traditional exam room encounter.

SFGH participates in the Institute for Healthcare Improvement's 100,000 Lives Campaign

An overarching goal of SFGH is to improve patient safety. In working towards this goal, the hospital was awarded in 2005 a $75,000 grant to participate in the Institute for

Healthcare Improvement's 100,000 Lives Campaign. This national campaign has the goal of making health care safer and more effective and to ensure that hospitals achieve the best possible outcomes for all patients. The Campaign's focus is to use six proven interventions, implemented on a wide enough scale to avoid 100,000 deaths over the next 18 months and every year thereafter. Of the six interventions, SFGH is focusing on three: (1) Deploy Rapid Response Teams, (2) Deliver Reliable Evidence-Based Care for Acute Myocardial Infarction to prevent deaths from heart attack, and (3) Prevent Adverse Drug Event by implementing medication reconciliation.

OBJECTIVE

Decrease health disparities between racial and ethnic populations and between residents of different neighborhoods

Decrease Health Disparities in Bayview Hunters Point Neighborhood

Pediatric Health

Bayview is home to more children than any other neighborhood in San Francisco. Although the physical and mental health challenges they face are greater on average than those faced by kids living in other neighborhoods, the resources that provide care to BVHP's kids lie largely outside of the community. To address this need, Southeast Health Center is at the center of an effort to strengthen the pediatric services available in BVHP. In the past year, two pediatricians have joined the staff and continue to grow their practices.

Adolescent Health

The satellite of Southeast Health Center, the Healing Arts Center (HAC) Clinic, has continued to grow, seeing more adolescents each week. The clinical services at the 5901 Third Street location have been developed with input from youth in the community and continue to be molded through youth-driven initiatives. To date we have over 100 patients and have diagnosed dozens of sexually transmitted infections, facilitated pregnancy prevention, and assisted youth in getting involved on sports teams and other healthy activities.

Adult Health

The centerpiece of SEHC has been its adult services. In addition to high-quality primary health care, SEHC has hosted a variety of disease focused initiatives and health education groups. With continuity health care services alongside urgent care clinics and brief nurse visits, SEHC meets the diverse needs of our patient population. With a renewed focus on quality improvement, SEHC is using its additional resources and new management team to improve outcomes.

LHH Opens Specialty Care Unit

LHH opened a specialty care unit on Unit E3 to better meet the needs of residents with selected diagnoses. The focus of this unit is on patients with cerebral palsy, epilepsy, autism and mental retardation. The unit has been open since December 2005 and census ranges between 15 to 20 residents. One important focus of the unit is to promote and maintain the community ties of its residents and to develop an effective activity program to meet the special needs of the unit's population. Specifically, the focus of the E3 program is to provide age therapeutic interventions that increase and/or maintain each

resident's functional abilities in the areas of physical, emotional, and cognitive domains. Nurses and all other members of the Interdisciplinary Team are building a therapeutic program that promotes each resident's highest level of independence and highest sense of self worth.

One very exciting component of the program is the increased collaboration between LHH and Golden Gate Regional Center (GGRC). Many residents attend community day programs outside of LHH. For the residents on the unit, meaningful activities are key to providing a stimulating and therapeutic environment. In February, the unit was fortunate to welcome an Activity Therapist to the team. While on E3, the Activity Therapist has built a comprehensive program that is at once pleasurable for the residents as well as cognitively stimulating. The activity goals are:

- Improvement in physical functioning
- Improvement in cognitive functioning
- Improvement in communication and social skills
- Reduction in non-adaptive behavior
- Increase in age appropriate behavior in the community
- Enhancement of friendship and social support networks

Videoconference Medical Interpretation

Approximately 20% of all patients at SFGH do not speak English; there are over 20 languages that Interpreter Services staff interprets for on a routine basis. In response to demands for linguistic services, DPH recently implemented a VMI (Videoconference Medical Interpretation) system, with partial support from The California Endowment. VMI refers to the conducting of medical interpretation through a videoconference call -- the provider and patient on one end (using a simple, mobile video unit) and the interpreter on the other end (using a stationary unit in the interpreter services office). Videoconferencing equipment now has adequate visual and audio capabilities and is no longer cost prohibitive – making its application in public health venues feasible. The primary purpose is to improve the communication between patients with limited English skills and providers by increasing access to interpreter services and significantly shortening the wait time.

Comprehensive Child Crisis Services

Comprehensive Child Crisis Services (CCCS) is located in Bayview Plaza, and provides a wide variety of crisis services to children and families citywide. In response to the needs of children and families impacted by gun violence, CCCS created a Post Traumatic Stress Disorder (PTSD) Clinic. PTSD services are targeted at victims/families of community gun violence. The clinic offers short-term evidence based interventions that target PTSD symptomology.

In addition, CCCS facilitates debriefing and defusing services in communities and schools throughout the city. Debriefings are one shot opportunities for psycho-education about and processing of trauma resulting from exposure to community gun violence.

OBJECTIVE

Decrease the rate of uninsurance among San Francisco residents

The San Francisco Health Access Plan

Last year, Mayor Newsom and Supervisor Ammiano both worked on proposals to expand healthcare coverage in San Francisco. In the winter of 2006, Mayor Newsom appointed the Universal Healthcare Council to make recommendations on expanding coverage to the approximately 82,000 uninsured San Francisco residents. On June 23rd, the Universal Healthcare Council recommended development and implementation of the Health Access Program (HAP). On August 7, 2006, Mayor Newsom and Supervisor Tom Ammiano signed the historic San Francisco Health Care Security Ordinance into law. The ordinance, passed unanimously by the Board of Supervisor's, combines two separate pieces of legislation: Supervisor Ammiano's Workplace Security Ordinance and the enabling legislation to implement Mayor Newsom's SF HAP.

The SF HAP will improve the health status of thousands of previously uninsured residents and, at the same time, will significantly impact the way DPH operates. The ordinance requires that large and medium-sized businesses pay a minimum amount toward healthcare expenditures for their employees. The employer-spending requirement begins on July 1, 2007 for businesses with 50 or more employees and April 2008 for firms with 20 to 49 employees. Enrollment of individuals into the SF HAP will begin in spring 2007.

The ordinance combines the HAP model with a health-spending mandate affecting businesses with more than 20 employees. Businesses have a variety of methods for fulfilling the health-spending mandate including providing private insurance, paying for the HAP for their employees, or setting up accounts for employees to draw on for medical expenses.

The Department's goal is to use HAP as an opportunity to re-envision our health care delivery system. Besides expanding our network to increase capacity, we also wish to use this as an opportunity to provide all our clients with primary care homes, to emphasize prevention, and to increase the use of self-management and support groups. Our financial and IT systems will need to change to accept point-of-service charges at our clinics and track expenditures and utilization in different ways. Ultimately, we believe the HAP will replace the sliding scale system as our method of meeting our California Section 17000 obligation for providing indigent health care.

OBJECTIVE

Provide a comprehensive array of quality and culturally competent services

Baby Friendly Hospital Initiative
Over the past several years, SFGH has worked diligently to become a Baby Friendly Certified Hospital. This coveted accreditation from the World Health Organization and UNICEF recognizes hospitals that give optimal levels of support to breastfeeding infants and their mothers. Through instituting the baby-friendly program, SFGH has experienced a 55% increase in the number of breast-fed babies at the time of discharge. SFGH was surveyed in May 2006 and is awaiting its final acknowledgment from Baby Friendly USA. Once SFGH received certification, it will be the only hospital in San Francisco that is accredited as Baby Friendly, and only the second hospital throughout the Bay Area with such accreditation.

Let's Be Healthy Project
Let' Be Healthy, a project of Community Oriented Primary Care (COPC), trained five *"Pomoshniks"* - community health leaders - to work with the Russian community in San Francisco. Let's Be Healthy offers between 12-15 culturally and linguistically appropriate healthy living activities each month to Russian speaking newcomers, such as walking groups, yoga classes, nutrition seminars, and cooking classes. Over 180 different individuals participated in these activities in FY 05-06. In addition, the project team worked with Ocean Park Primary Care Center to establish a new Russian language group and medical visits for patients with cardiovascular risk factors. This model will be replicated at the Family Health Center in 2007.

LHH Art with Elders
Now in its ninth year, the Art with Elders program at LHH continues to thrive. The program encourages and offers LHH residents an opportunity to explore artistic abilities through weekly painting classes taught by professional artists from the community.

Art with Elders also promotes essential connections between LHH residents and the wider community through an annual exhibition of their art, which travels throughout the year. During the Grand Opening Celebration of the de Young Museum, 20 LHH residents presented their work as part of the Art with Elders exhibit. Many of the residents whose artwork was on display were in attendance and recognized for their work. The exhibit then traveled throughout the Bay Area to different venues, allowing the community to connect with the LHH residents through their artwork.

Residents in the program are not only partaking in an enjoyable activity but also demonstrate a renewed sense of enthusiasm and self-esteem.

The Mental Health Services Act (Proposition63).
Although Proposition 63 (the California Mental Health Services Act- MHSA) passed in November of 2004, an extensive community planning process to prioritize needed services continued into 2005. Over 70 community meetings and forums were held

throughout the City between April and August 2005, allowing for broad input across communities and in targeted neighborhoods. Outreach to consumers and family members resulted in a high degree of participation and input into the development of the proposed plan for services. The 40-member Behavioral Health Innovations Task Force developed the plan that was submitted to the state in November 2005. The plan included four target populations:

- children/youth/families,
- transitional age youth,
- adult and
- older adults.

The state Department of Mental Health gave final approval for the plan in early 2006. A Request for Proposals (RFP) was published to select contractors to provide MHSA services in May 2006. Consistent with the inclusive, consumer orientation of the MHSA, one third of the reviewers of the RFP proposals were community representatives. A newly formed MHSA Advisory Board that includes many members of the original Task Force began meeting on a bi-monthly basis in April 2006. Through this effort and related public forums, CHBS anticipates that the MHSA will continue to shape new directions for mental health services throughout the City and County of San Francisco.

OBJECTIVE
Ensure contractor viability

Contractors' Cost of Living Adjustment (COLA)
The Department of Public Health included $6,011,161 for Contractors' COLA in the FY 2006-2007 budget to provide its' Community Based Organization (CBOs) nonprofit contracting partners with a 3.0 percent increase. The COLA was supported by Mayor Newsom and included in the Board of Supervisors budget.

UC Affiliation Agreement
The UC Affiliation Agreement was increased by an additional $3,000,000 in the FY 2006-2007 budget. This is in addition to the 2.0 percent COLA noted above. The total amount budgeted for Contractors' COLA for the UC Affiliation Agreement is $4,747,315, or $3.0 million more than the 2.0 percent COLA amount of $1,747,315.

OBJECTIVE
Improve integration of services

Integration Steering Committee (ISC)
Last year, the Controller's Office hired Health Management Associates (HMA) to perform an audit of DPH's long-term care delivery system. The final report was issued in the summer of 2005. The Department agreed with many of the audit recommendations, and implemented a number of them in the 2005-06 fiscal year. The number one recommendation in the report was to assemble an Integration Steering Committee, comprised of senior administrative and clinical leadership representing the various

components of the Department's delivery system. The committee was formed in August 2005 and has met bi-weekly since its inception.

At an all day retreat in November, the ISC agreed the integrated delivery system needed to be focused around the needs, care and the experience of the patients that it is designed to serve. In addition, that all decisions related to the operations of and resource allocations for individual programs, facilities or divisions within DPH must be made in the context of what is good for the entire system, the full continuum of care, even if such decisions may be detrimental to any one component of that system. Finally that communicating between all levels of the system—and to those external to the system—with a consistent message about the DPH focus and processes is critical to the success of integration. ISC developed the following vision and mission statements:

Vision

San Francisco will have the best integrated public health system in the country.

Mission

To (1) place clients first (2) promote the good of the entire Department (3) maximize resources by aligning with the Department's mission and vision (4) and communicate effectively about the Department's role and function.

The ISC has formed a number of subcommittees, which will be highlighted in this report, the Placement Task Force, the Integrated Finance Committee, the Capital Integration Committee, the Information Technology Task Force, and the Medical and Nursing Advisory Committees.

Hiring Long Term Care Coordinator

One of HMA's report recommendations was to create a new position at DPH to coordinate long term care across the Department's continuum of services. This position was created in FY 05-06, and was filled in August 2006. The new Long Term Care Coordinator (LTC), Elizabeth Gray is responsible for the research, analysis and development of LTC options to strengthen the continuum of care within DPH. She will also supervise the Targeted Case Management program that is responsible for identifying persons at Laguna Honda Hospital or at risk of entering LHH who wish to receive community-based LTC services as an alternative to institutional services.

Integration of Mental Health and Substance Abuse Services

CBHS' mental health system of care includes outpatient services, intensive case management, childcare center and school-based mental health services, day treatment, socialization programs, vocational support and training, self/mutual help and advocacy services, supportive and co-op housing, residential care facilities that support people with mental illness, transitional residential treatment, homeless shelter-based mental health services, acute diversion units, long-term care facilities, crisis services and acute psychiatric inpatient services. This system assists children, youth, families, adults and older adults. CBHS's mental health system served about 23,900 unduplicated individuals in FY 2005-06.

CBHS' substance abuse services include outpatient, intensive outpatient, day treatment, methadone detox, methadone maintenance, residential detox, residential and short-stay residential care. CBHS' substance abuse services system served over 10,470 individuals in FY 2005-06.

To better serve clients seeking assistance within the CBHS system, Behavioral Health has continued the process of integrating mental health and substance abuse services. Several key activities were accomplished in the effort to make "any door the right door" into the system. A Consensus Statement outlining integration objectives and goals was developed and signed on a voluntary basis by CBHS contract agencies. Programs analyzed and revised welcoming practices and procedures to be consistent with the goals of integrated services. Many providers nominated "Change Agents" for the integration process that participated actively in training on the Comprehensive, Continuous Integrated System of Care model. Change Agents also assisted their agency to complete an assessment of integrated practices, and to develop action plans to improve services based on the findings of the assessment. To further develop organizational relationships and sharing of clients with Co-Occurring Issues or Dual Diagnosis Disorders (COI/DD), CBHS asked programs to begin to form Behavioral Health Partnerships between mental health and substance abuse programs. Some programs also initiated partnerships with Primary Care providers. These voluntary activities will pave the way for integration activities throughout the system in the next fiscal year.

Substance Abuse Outpatient System of Care Request for Proposal (RFP)
Community Behavioral Health Services (CBHS) issued a Request for Proposal (RFP) in FY05-06 to redefine and restructure the entire substance abuse outpatient system of care. The RFP achieved several objectives, including changing the service model to recognize the complex nature of clients being served in addiction settings; increasing access to opiate replacement therapy; and, making unit rates and the cost per unduplicated clients more uniform.

The revised service protocol stressed that dual diagnosis is an expectation, not an exception. The model enhanced the capacity of the substance abuse system and mental health system to work as partners in the CBHS system and to accommodate care referral from Mental Health outpatient clinics and associated Primary Care clinics. The entire system of care is now moving toward implementation of the Comprehensive Continuous Integrated System of Care. In addition to service protocol revisions, the RFP shifted service orientation, including providing support during and after transition to housing for Project Homeless Connect participants, providing services directly aimed at the Methamphetamine and HIV epidemics, and increasing access to Methadone and Buprenorphine maintenance. Prior to the RFP, the outpatient system of care consisted of 32 outpatient and intensive outpatient programs, with total a General Fund allocation in excess of $10 million. Unit of service rates varied from $29.08 to $119.00, and cost per unduplicated client ranged from $276 to $7,847. A total of 23 outpatient programs were funded under the RFP. Successful contractor rates range from $65 to $80 per unit and $2,000 to $3,000 per unduplicated client. Finally, CBHS allocated a total of $1,260,000 to Methamphetamine services.

OBJECTIVE

Improve patient flow and standardize record keeping, in order to improve continuity of care and reduce decertified days. The continuum of care should include acute care (SFGH), skilled nursing (LHH), residential care, intermediate care, and community-based care

Integration Steering Committee – Patient Task Force

The Integration Steering Committee convened a Placement Task Force that is focusing on the timely and appropriate placement of patients. The Department needs a range of Long Term Care (LTC) options for persons with complex care needs who lack appropriate placements, including housing. The Task Force includes representatives from San Francisco General, Laguna Honda, Primary Care, Housing and Urban Health, Jail Health and the Conservator's Office, and is also reaching out to representatives from Residential Care Facilities, shelters, supportive housing and out-of-county skilled nursing facilities. Monthly meetings began in December 2005. The Task Force set as its goal a 50 percent decrease in waiting times for patients at SFGH and LHH who need to be placed in a lower level of care setting.

Two major subcommittees have been created. The first is focusing on monitoring patient placement, both from SFGH and LHH, to determine what barriers exist to timely placement and to what degree policy, process, and/or capacity are factors in these delays. This group will identify the gaps in placement and will work with vendors to develop the services that the Department needs.

The second is focused on placement criteria, working to develop clinical consensus for placement into community settings. Physicians from all of the Department's divisions (SFGH, LHH and community programs) are involved in this subcommittee's efforts to define what levels of function warrant what level of care, identify situations and clients that are exceptions, and focus on placements that are available for "intake" as opposed to those locations that one must graduate into after their status within the system changes. This subcommittee will also focus on educating and getting feedback from physicians and other clinicians.

As it formulates its recommendations, the Task Force will apply the goals of a "recovery model" approach, striving to promote rehabilitation and self-reliance through community integration and support. A successful recovery model will reduce reliance upon institutional settings (i.e. hospitals, skilled nursing facilities, and jails), and allow clients to achieve increasing levels of self-responsibility, including affordable, supportive housing and vocational opportunities.

Medical Respite Program Description

The FY 06-07 budget includes $1.86 million in new funding for a Medical Respite program that will create at least 60 new beds at two sites. Medical respire is defined as a safe place for ill homeless people struggling with medical, mental health, and/or substance abuse issues to stabilize and recuperate, prior to placement in an appropriate

longer-term residential setting. The primary target population for this program would be medically complex homeless people who have been high utilizers of emergency medical systems. The Medical Respite program will provide a critical bridge between acute care, such as the care provided at SFGH, and the expanding network of supportive housing.

At the outset, the program will accept referrals from San Francisco General Hospital. Based on availability and resources, after the initial period, referrals from other San Francisco hospitals, Emergency Departments and designated clinics will be accepted.

OBJECTIVE

Ensure the quality of pre-hospital emergency medical services

EMRESOURCE - Hospital Resource Tool

EMResource and EMTrack, a new and improved hospital resource tool and electronic patient tracking system, respectively, have been purchased by the Department and are in the implementation process. EMResource replaces the "HART" System. This web-based communication system provides real-time communication and resource management for San Francisco hospitals, EMS Agency, DPH Department Operations Center, and the City Emergency Operation Center during any multi-casualty incident. Authorized users log on to a secure web site and view regional emergency department status and available hospital resources to support patient transport and transfer decision-making. During mass casualty incidents, hospital capacity is queried by triage category and inpatient bed capacity. Secure, redundant servers are reliably accessed 24/7 providing an excellent communication infrastructure for emergency management personnel, acute healthcare providers and public health officials.

EMTRACK – Patient Tracking

DPH has begun implementation of "EMTrack" a patient tracking system in preparation for disasters in accordance with National Preparedness Goals. The primary objectives of the patient tracking system is to track the origination and destination of each patient or victim, to appropriately notify receiving facilities of incoming patients, to appropriately manage the distribution of patients and to better notify loved ones of the location of patients and victims. Additional modular capabilities are also available that will provide greatly improved command level management during disasters such as integration of the Disaster Registry Program database to pre-populate the patient tracking database, volunteer and disaster service worker tracking to facilitate many complex incident safety issues not otherwise addressed and facilitating the Medical Examiners role during incidents involving mass fatalities.