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

OBJECTIVE
Improve health outcomes among San Francisco residents

Breastfeeding Rates at California Hospitals
Davis Human Lactation Center and the California WIC Association (CWA) rank nearly every hospital in the state in terms of the rate of new mothers who breastfeed while in the hospital. The analysis reveals stark differences in rates, with a concentration of low-performing hospitals in Southern California counties, and demonstrates that the breastfeeding gap is greatest in hospitals serving ethnic low-income mothers and babies. But the report goes on to show that, when hospitals improve their newborn feeding policies and practices, they dramatically increase their breastfeeding rates.

SFGH is proof that policies matter when it comes to breastfeeding support. Even though nearly all of the 1,266 mothers giving birth at SFGH in 2007 were on Medi-Cal, the breastfeeding rate was 88.9 percent. SFGH institutionalized policies that make breastfeeding a priority by becoming certified as a Baby-Friendly Hospital. Neonatologist Dr. Colin Partridge says, “Along with all the benefits of breastfeeding, the initiative led to a remarkable improvement in our support of family-centered, comprehensive care for mothers and children.” The research shows when model policies and practices are implemented, breastfeeding rates increase.

Maternal Child and Adolescent Health (MCAH)
FY 2007-08 has been a highly productive year for the MCAH Public Health Nursing (PHN) Field Unit. 10,460 targeted case management face-to-face visits with women, infants and children were completed. This is a 45 percent increase over the previous year. Most common type of PHN intervention requiring urgent referral to medical providers are as follows:

- decreased fetal movement;
- newborn jaundice that could possibly cause irreversible brain damage;
- infant apneic (shortness of breath) episodes;
- newborn weight loss greater than 10 percent of birth weight;
- opening or rupture of a cesarean section incision; and
- elevated or low blood pressure.

Quarterly data shows that MCAH PHNs make approximately 80 of these high risk urgent care referrals to our medical providers to reduce risks or improve health outcomes.

Foster Care PHN Facilitated care for children in placement included the completion of:

- Clearance Exams 315
- Wellness Exams 1545
- Sick Care Visits 648
- HIV Screen Follow-up 109
- Children Linked to Medical home 59
- Specialty Care follow up exams 223

San Francisco: A Healthy City

On May 29, 2008, the American College of Sports Medicine (ACSM) released its first "American Fitness Index," ranking San Francisco and the Bay Area as the top metropolitan area for health, community fitness and health care. This designation coincided with the American Cancer Society's "Active for Life" campaign undertaken throughout the City, which encouraged employees to make healthy lifestyle choices by increasing their level of physical activity and eating healthy food. DPH sponsored 11 "Active for Life" teams with nearly 150 employees participating.

OBJECTIVE

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

Increasing Access to Health Services for Immigrant Population

By taking the lead on various collaborations and partnerships, the Newcomers Health Program, is working to increase access to health services for vulnerable immigrant populations, and create partnerships. In partnership with Family Health Center's Refugee Medical Clinic, Newcomers has implemented an assessment of issues and needs confronting victims of human trafficking. The connections made with various entities ranging from SFPD to local domestic violence agencies, and issues identified will help Newcomers and Refugee Clinic collaborate in providing culturally-appropriate services to help ensure access to care for this vulnerable and medically underserved population. Newcomers is also the lead agency of the recently-formed San Francisco Coalition for

Asylee, Immigrant and Refugee Services (SF CAIRS). This past year SF CAIRS embarked on a strategic planning process to develop a three-to-five year strategic plan for influencing and creating positive change for the local refugee, asylee and immigrant communities. This process and plan will help solidify the relationships among the agencies that created SF CAIRS.

The Community Benefit Partnership
An outgrowth of the Building a Healthier San Francisco (BHSF) needs assessment process and the Charity Care Project (CCP), the Community Benefit Partnership seeks to harness the collective energy and resources of San Francisco's private non-profit hospitals, community clinics, health plans, and non-profit providers and advocacy groups to improve the health status of San Francisco residents. The Partnership came together in spring 2008 to work on four goals identified as part of the 2007 BHSF needs assessment process, which could be affected through the collective efforts of the members of BHSF and the CCP. The four goals include:

- Improve Access to Care
- Prevent Chronic Disease and Increase Wellness
- Reduce the Incidence of Communicable Disease
- Engage in Violence Prevention

HIV Health Services Website
HIV Health Services launched a comprehensive website that features information about health services for people with HIV in San Francisco, links to service providers, contractual information and resources for navigating the San Francisco system of care and living with HIV. The HHS website address is: http://www.sfhivcare.org.

The Family Mosaic Project
The Family Mosaic Project (FMP) offers wrap-around services to children between the ages of three and eighteen who have serious emotional disabilities and who are at risk of out-of-home placement. Multidisciplinary teams consist of Case Managers, Psychiatrists, Individual and Family therapists, Mentors, Peer Parents and a part-time nurse. In FY 2007-08 more than one hundred children and families were linked to medical services. One example of success was when 12 young women ages 12 to 18 were linked and accompanied to a clinic where they obtained sensitive services, which included receiving counseling, having a health exam and obtaining birth control. Three pregnant teens were linked and accompanied to prenatal services at SFGH. They were also enrolled at Hilltop School and two have since delivered healthy babies. The third (12 years old) will deliver in September. Three children saw optometrists and were fitted with glasses or contact lenses, which dramatically improved their school performance.

OBJECTIVE

Decrease the rate of uninsurance among San Francisco residents

Healthy San Francisco

FY 2007 -08 saw the initiation of Healthy San Francisco enrollment of all uninsured individuals seeking care in Primary Care Centers. Approximately 60 percent of all HSF enrollees are patients of DPH community-based and SFGH clinics. The other 40 percent have been seen through the Community Clinic Consortium. In addition, One-e-App was enhanced to shorten wait times and improve appropriateness for specialty appointments. See Chapter 7 for more details.

AARP the Magazine's Healthiest Hometowns

AARP named the San Francisco Bay Area as the 9th healthiest area in the United States for those 50+ age to live, citing Healthy San Francisco as one of the signature programs.

SAN FRANCISCO BAY AREA, CALIFORNIA

By Sarah Mahoney and Brad Edmondson

Spanning more than 100 miles, from the vineyards of Napa Valley to the Silicon Valley, the San Francisco Bay Area is famous for its natural beauty and free spirits. But it's also a great place to be healthy after 50. Its residents are among the least likely in the country to be overweight. Plus, they are among the least likely to smoke.

One visit to the Bay Area and you can quickly see why the region fosters health and vitality. Densely populated, with lots of neighborhoods where residents can easily get around via foot, bicycle, or public transportation, the region also has a long history of people banding together to improve services. Then there are the region's world-famous medical centers, including those of Stanford and the University of California, San Francisco. And last year the city of San Francisco launched Healthy San Francisco, an initiative that offers free or subsidized health care to uninsured residents. San Francisco's pedestrians are treated to urban forestry, greenways, and plenty of public toilets, and the city is fierce in its environmental commitment. It was first to ban plastic bags, and it is now restricting plastic water bottles.

Community Behavioral Health Systems (CBHS) Mental Health Programs Assist Clients on SSI Applications

For the second year in a row, 25 CBHS outpatient mental health programs exceeded their FY 2007 -08 objectives assisting more than 25 percent of their potentially eligible SSI clients submit applications for Supplementary Security Income (SSI) assistance. CBHS mental health programs worked collaboratively with Positive Resource Center (PRC), Disability Evaluation Assistance Program (DEAP), and Homeless Advocacy Project (HAP), to help their disabled clients apply for SSI. CBHS is setting even higher targets for FY 2008 -09 hoping to assist 50 percent of eligible clients apply for SSI and improve their quality of life. SSI advocacy and application assistance is highly effective. In FY 2007 -08, 86 percent of CBHS clients (311 out of 362) whose benefit claims were fully adjudicated through PRC representation had favorable decisions on their SSI applications.

MCAH Child Health Disability Prevention (CHDP) Program

CHDP promotes early intervention by ensuring children in need are linked to specialty care to prevent disability and mitigate the impact of illness for the children's optimal

health and development. CHDP assures clients have access to health insurance coverage and are given a regular medical and dental home for their periodic check ups. In FY 2007 -08 the CHDP Program assisted 6,774 individuals and families complete Medi-Cal applications and connected them to other programs such as Healthy San Francisco, Healthy Families and Healthy Kids. CHDP providers completed 35,722 physical exams, requiring 1,850 medical and dental specialty visits. CHDP and dental staff use community fairs such as Carnaval, SOMA Block Party and the Bayahan Resource Center to outreach and promote medical and dental health.

OBJECTIVE

Provide a comprehensive array of quality and culturally competent services

SFGH Improved Access to Service
SFGH partnered with the Consortium Clinics to improve access to e-Referral, and expanded e-Referral to over 20 specialty clinics including Cardiology, Chest, Endocrinology, Gastroenterology, Hematology, High Risk Asthma, Liver, Rheumatology, and the Renal Clinics with plans to expand to the Diabetes Clinic in FY 2008 -09.

The General Medicine Clinic at SFGH is the DPH clinic with the most Healthy San Francisco enrollees, reaching its goal of 500 enrollees. SFGH also accomplished its goal of expanding the Family Health and General Medicine Clinic hours to accommodate Healthy San Francisco enrollees (an additional 10½ hours/week and 12 hours/week, respectively).

San Francisco General Hospital was redesignated as a Level I Trauma Center by the American College of Surgeons Committee on Trauma Certification in August 2007. SFGH also completed several other surveys successfully, including the Joint Commission Clinical Laboratory & Pathology Accreditation Survey in November 2007, the Alcohol, Drug, Treatments Program Licensing Survey and Mental Health Rehabilitation Center Licensing Survey in April 2008 and the American College of Surgeons Committee on Cancer Survey in May 2008. SFGH received Joint Commission Certification for Stroke Care in June 2008.

The San Francisco Children's System of Care (SF-CSOC) partnered with Lavender Youth Recreation and Information Center
Providing behavioral health services to youth from the lesbian, gay, and bisexual community can be challenging to providers. The SF-CSOC partnered with Lavender Youth Recreation and Information Center (LYRIC) on a youth-guided project designed to:

- identify the behavioral health needs of services to Lesbian, Gay, Bisexual, Intersex, Questioning and 2-Spirited (LGBTQI2-S) youth;
- train community providers on care for LGBTQI2-S youth; and.
- create recommendations for system-level policies, standards and guidelines on LGBTQI2-S youth and families.

This project, named SPIRAL, is based on an internship model created by LYRIC. LGBTQI2-S youth in the SPIRAL project will use their "lived experiences" to create and perform a theater piece to address issues around access to culturally sensitive and competent behavioral health services in San Francisco. Themes stressed within the project include the importance of partnerships between DPH and community-based organizations, LGBTQI2-S health and wellness, youth development principles, youth-adult partnerships and anti-oppression strategies.

Revitalized CBHS Services for Transition-Age Youth (TAY)
CBHS behavioral health services for TAY were bolstered July 1, 2007 through funding from the Mental Health Services Act (MHSA). TAY clients are provided with team and individual therapy, intensive case management, medication support, group therapy, outreach and psycho-educational support. The team works creatively and flexibly with youth who have the most acute need for behavioral health services, including those who have been in the mental health system; with youth who have had difficulty connecting to mental health services; and with young adults who experience their first psychotic break and are afraid of having a mental disability.

Two TAY Full-Service Partnership (FSP) programs are now up and running, one via a contract with Family Services Agency and the other a civil-service-run program at 755 South Van Ness. These newly-established TAY FSP programs are intensive case management programs equipped with wrap-around services and with housing units for the youth through a contract with Larkin Street Youth Services. Additional MHSA-funded services provided through the contract with Larkin Street include added housing units for non-FSP TAY clients, case management services to support CBHS TAY clients maintain housing, and Peer Center services for clients. CBHS TAY-services receive referrals from outpatient clinics, hospitals, residential treatment programs, schools, juvenile/adult probation, walk-ins (self referrals) or parents.

OBJECTIVE
Ensure contractor viability

Childcare Health Project Trains Child Care Providers in Disaster Preparedness
In FY 2007 -08 CCHP provided disaster preparedness trainings targeting the family child care providers of SF and provides disaster supply buckets to each attendee.

CCHP and MCAH Child Care Health Project purchased Disaster Preparedness supplies for Child Care Centers. CCHP team identified priority items especially designed for addressing needs of children at child care sites in the City. The Disaster Preparedness kits were distributed as a gift to 57 child care sites reaching 200 providers. Sites include four transitional shelter settings that serve children up to five years of age.

Data on Disaster Preparedness Training to the Child Care Community

Month of Training	Training Site	Number of Providers Trained
July 2007	Family Child Care Association	88
August 2007	Children's Council	42
January 2008	Headstart	11
April 2008	Family Child Care Association	54
May 2008	Foster Parents	15
June 2008	Asian Family Child Care Association	43
April-June 2008	57 Child Care Sites	200
Total Trained		**453**

OBJECTIVE

Improve integration of services

Integration Steering Committee (ISC)

The ISC was formed in August 2005 as an outgrowth of a recommendation contained in the Health Management Associates audit continues to be active, meeting twice monthly. The ISC is comprised of senior administrative and clinical leadership representing the various components of the Department's delivery system. The vision of the committee is, **"San Francisco will have the best integrated public health system in the country."**

The ISC has a number of active subcommittees including, the Placement Task Force, the Integrated Finance Committee, the Capital Integration Committee, and the Information Technology Task Force. Accomplishments of these various committees are contained throughout this report.

Much of the FY 2007 -08 focus was on implementation of Healthy San Francisco which kicked off in July, 2007 (see chapter 7 for more details.) As part of this process, the ISC spent considerable time re-envisioning DPH's service delivery system and brought the following model with Primary Care at its core to the Commission for adoption early in 2008.

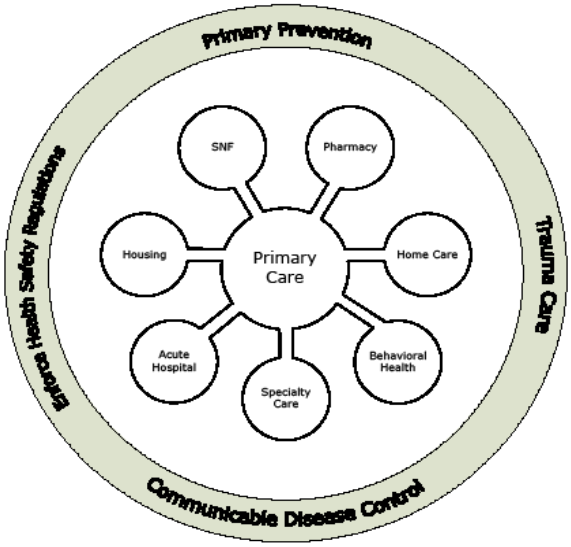
San Francisco Department of Public Health
Mission: To Promote & Protect the Health of all San Franciscans

Vision:

1. To provide effective primary prevention, communicable disease control, trauma care, and enforcement of health safety regulations to all San Franciscans and visitors.
2. To connect every uninsured San Franciscan to a primary care home.
3. To create a comprehensive, coordinated array of services available to patients throughout the network.

Key Objectives:

1. Develop a modern IT infrastructure to ensure quality care, integration, and coordination throughout the network.
2. Create a single contract for each nonprofit agency contracting with us.
3. Evaluate our services with outcomes not outputs.



Integrated Service Experience

The Mental Health Services Act (MHSA) addresses the problem of fragmented, uncoordinated, and "silo" service provision that characterize the behavioral health service system at the state and local levels. San Francisco's MHSA-funded programs strive to provide an integrated service experience to clients whose previous experiences with social service systems have not been helpful or sufficient to address their needs. The Full Service Partnerships (FSP) utilizes various strategies of outreach, engagement, service provision, and linkages based on needs of the clients they serve. Some of these strategies include use of peer outreach workers, home visits, immediate tangible benefits (e.g., food or housing), persistence in outreach and engagement and culturally-specific interventions.

Visitation Workgroup
In the spring of 2007, the San Francisco Human Services Agency's (SFHSA) Family and Children Services Division convened a "Visitation Workgroup" as one component of its strategies to provide better services for the children and the families they serve. Recognizing that both entry and exit cohorts for Reunification within 12 months fell below national standards, and the median time to reunification, and re-entry following reunification were both above national standards, SFHSA stepped up its efforts improve service delivery to San Francisco children and their families to assure they are protected from abuse and neglect. Now, in FY 2008 -09, a new Visitation Program has been launched. CYF-SOC contracted with two of its EPSDT agencies to provide intensive family therapy to approximately 70 high need families. These services will meet Visitation Best Practices by providing: 1) Frequent, purposeful visitation contributing to successful placement and reunification and reducing the time to reunification; 2) Successful visitation including arranging visits along a continuum of increasingly stressful situations in order to assist the parents in developing increased confidence and competence in parenting; and 3) Visitation between the child and family increasing in frequency and duration as the goal of reunification approaches. The Foster Care Mental Health Program (FCMHP) will assure priority entry to families in need of therapeutic visitation, as well as those in need of evidence-based parenting interventions and step-down therapeutic mental health 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

DORE Urgent Care Center Opens
Over the course of FY 2007 -08, DPH Community Behavioral Health Services worked with Progress Foundation to establish the Dore Urgent Care Center (DUCC), which opened its doors in early July. The program is designed to assist SFGH Psychiatric Emergency (PES) and other hospital emergency services by accepting clients in psychiatric crisis who do not require hospitalization but who are overcrowding into PES for evaluation and assessment. The DUCC will provide a social rehabilitation model approach to crisis intervention as a helpful diversion from PES for individuals who do not require involuntary treatment, seclusion or restraint. Its goal is to improve patient care outcomes by providing services designed to meet the distinct needs of this population.

The DUCC is a medically-staffed psychiatric crisis stabilization clinic that is open 16 hours per day (7am – 11pm) seven days per week. An alternative to PES, the clinic has capacity for 12 people at any one time. Referrals are limited to San Francisco Police Department, other law enforcement, the DPH Mobile Crisis Team, PES, Westside Crisis, and other designated DPH programs. DUCC will also have a 14-bed short-term crisis residential treatment program capability, Dore House, located on the same site, for clients who need continued support beyond the limited operating hours of the DUCC. The

residential component opened in September 2008. It is modeled on the acute diversion units, but designed with a much shorter stay of only three to five days. The DUCC is located at 52 Dore Alley between Folsom and Howard and 9th and 10th Streets.

Long-Term Care Services

This has been a very active and productive year for Long-Term Care Services (LTC). Long Term Care Services is comprised of:

- Policy and Planning for DPH long-term care,
- Targeted Case Management (TCM) Program at LHH,
- DPH Placement for both medical and mental health services,
- Contract monitoring for long-term care facilities,
- Adult Residential Facilities (ARF),
- Residential Care Facilities for the Elderly (RCFE),
- Hotels, and
- Authorization into and out of placement for approximately 3000 beds/and or treatment slots.

In FY 2007 -08, LHH's LTC TCM was actively working with LHH administration in efforts to close Clarendon Hall and facilitate the efficient construction timeline for the rebuild project. LTC TCM brought on a new Director who was instrumental in setting positive policy for TCM and developing relationships with both internal and external partners. LTC Services also hired a new Deputy Director of LTC who is responsible for the placement functions.

During this past budget year, LTC Services:

- Authorized and admitted 125 patients to LTC facilities not including the Behavioral Health Center.
- Authorized and discharged 179 clients from LTC facilities into to lower levels of care (LLC).
- One hundred nineteen SFGH Medical Emergency Room patients were diverted from Medical Emergency Room (MER) or diverted to LLC from inpatient units. Fifty-one percent went to RCFE, 25 percent went home, 12 percent to ARF, seven percent to respite, and five percent went to a hotel.
- Total authorizations and admissions into ARF and RCFE were 96.
- LTC Services TCM discharged directly from LLH a total of 47 residents while assisting in the discharges of the remaining residents.

Data is not currently available for other levels of care placement but hopefully will be available in next few months with the implementation of the DPH Client Placement database. LTC Services is spearheading the development and implementation of the DPH Client Placement database as well as the SFGH non-acute tracking database.

LTC Services was involved in the conversion of locked and unlocked long-term care beds to community-based lower level of care. Five new RCF and RCFE have been contracted within the last year. Additional hotel rooms have been added including hotel rooms for non-ambulatory persons.

Positive Care Program at LHH
The Positive Care Program opened a second care unit and expanded to 56 beds. The program expansion has been helpful in many ways. The Positive Care Program provides access to highly skilled levels of care for persons failing in the community. It relieves SFGH and other community hospitals of acute clients needing skilled nursing care, and the expansion of another unit allows for more space to work with residents having special needs, including some levels of AIDS related dementia.

Along with the regular schedule of daily activities, the residents are offered art therapy, meditation, community meetings, POZ group (education and support), women's group, SATS group (substance abuse treatment services), pastoral care, as well as ongoing family and one-on-one support. Bereavement services are offered for anticipatory as well as grief and multiple losses. The Positive Care staff is highly skilled in HIV/AIDS care and treatment in all stages of the disease. They offer their expertise to other care providers both inside LHH and when residents are transferred to other facilities.

The Positive Care interdisciplinary team works closely together and collaborates with community providers, as part of the continuum of care, to ensure proper discharge of the residents to the appropriate settings.

OBJECTIVE
Ensure the quality of pre-hospital emergency medical services

Emergency Medical Services (EMS) System Plan Submitted to State EMS Authority
The EMS Agency's Annual EMS plan was approved by the State EMS Authority. The plan outlines the current status of the San Francisco EMS system, including:

- the nationally accredited paramedic training program at City College of San Francisco;
- the receiving hospital system including specialty centers for trauma, pediatric critical care, stroke, burn, obstetrics and microsurgery; and
- pre-hospital disaster preparedness measures.

Current ongoing projects include the revision of the multi-casualty incident policy, improvement of the system for triage and treatment of heart attack patients, and the integration of a second multi-casualty patient treatment vehicle into the disaster response system.

Continuous Quality Improvement Systems Improved
Quality Improvement System achievements include:

- the increase in ambulance inspection pass rates to 95 percent on first review;
- the institution of a comprehensive monitoring program for high-risk, infrequently performed skills such as airway management in critical patients; and
- the introduction of an electronic pre-hospital patient care record, which makes data analysis, review and research easier and more accurate.

DPH continues to monitor and report EMS system response intervals and work with the Department of Emergency Management and the San Francisco Fire Department to improve them, most recently by improving dispatch time intervals some 12 to 15 percent by instituting a streamlined rapid dispatch protocol for the calls with highest patient acuity.

Pre-hospital Treatment Improvements

The care of patients with heart conditions was recently improved with the ability of the ambulance personnel to perform 12 lead electrocardiograms at the patient's side in the field, and utilize the results to speed patient care at the hospital where the patient is transported. Care for patients with lung disease and heart conditions causing respiratory difficulty was improved with the institution of continuous positive airway pressure devices on ambulances. This therapy, previously available only at a hospital, is useful in decreasing the need for endotracheal intubation and intensive care treatment of these patients. DPH continues to work toward a seamless pre-hospital and hospital treatment system for heart attack and congestive heart failure victims.