City and County of San Francisco

Department of Public Health

Edwin M. Lee
Mayor

Barbara A. Garcia, MPA
Director of Health

Tomás J. Aragón, MD, DrPH
Health Officer

Date: December 14, 2015

To: Health Commissioners

From: Tomás J. Aragón, MD, DrPH
Health Officer, City & County of San Francisco
Director, Population Health Division (PHD)

Through: Barbara A. Garcia, MPA
Director of Health

This memorandum is to inform you that we have updated the Strategic Plan for Population Health. The revised plan includes the Continuous Quality Improvement Plan and Performance Measures for population health services. These updates supports and promotes a framework for organizational quality improvement efforts as required to achieve Public Health Accreditation.

Please note that there are no changes to the core elements of the Strategic Plan that was approved and adopted by the Health Commission on June 17, 2014 (Resolution No. 14-7). The new information has been embedded in the Strategic Plan. The Continuous Quality Improvement (CQI) Plan can be found on pages 64 through 70. The CQI plan outlines a timeline for the development of a quality improvement program for the Population Health Division (PHD) as well as specific projects that are currently occurring in PHD.

The revised Strategic Plan also includes specific program-specific performance measures. This information can be found on page 70 and Appendix F (pages 87 through 90). These program-specific performance measures will be part of the data that we will share with the Health Commission and the public on an annual bases in the spirit of transparency and accountability.

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Strategic Plan for Population Health

▪ December 2015 ▪

POPULATION HEALTH DIVISION

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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San Francisco Strategic Plan for Population Health

▪ December 2015 ▪

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Version 2: Original June 2014 and updated December 2015

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Message from the Director of Health

City and County of San Francisco
Edwin M. Lee
Mayor

San Francisco Department of Public Health

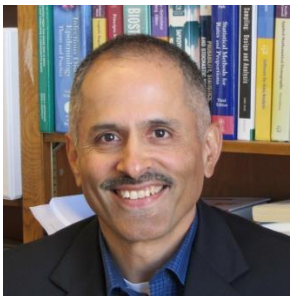
Barbara A. Garcia, MPA
Director of Health

The San Francisco Department of Public Health has been a leader in the field of public health for decades, providing important innovations in interventions and programs. Health care access and coverage is available to every San Franciscan without regard to employment or immigration status and has been since before the Patient Protection and Affordable Care Act, commonly referred to as ACA, was implemented this year. Our surveillance, assessments, and research efforts are a model for the nation. We have a long tradition of community engagement and planning that has led to policy changes to improve key health outcomes (e.g., reduced rates of smoking and new HIV infections), and we have developed new ways to measure the health of our environments and communities. There are many other examples of initiatives that have been acknowledged as emerging best practices and shared around the country and the world.

However, in spite of these successes, our city faces extraordinary health challenges: a striking epidemic of adult and youth obesity and its complications (e.g., childhood type 2 diabetes and hypertension); high rates of infant mortality, and persistent health inequities related to ethnic, social, economic, and environmental factors. Our ongoing efforts to restructure our Department to meet emerging challenges and commitment to continuous quality improvement are reflected in this Strategic Plan for our Population Health Division.

As we continue to address the needs of the new millennium, the San Francisco Department of Public Health is committed to strategic responses to the changing landscape of health care. The reorganized Divisions show the firm alignment between the delivery of health care services and the maintenance of health and wellness. This Strategic Plan exhibits how we will continue to enhance that commitment by addressing the most pressing needs of our City.

Message from the Health Officer and Director of the Population Health Division



Tomás J. Aragón, MD, DrPH,
Health Officer & Director,
Population Health Division

The Strategic Plan is the next step on our journey to public health accreditation. We have completed the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP). The CHIP is our citywide plan to protect and improve the health of all San Francisco residents, and is overseen by the San Francisco Health Improvement Partnership (SFHIP)---a citywide, cross-sectoral, multidisciplinary health coalition. In contrast, the Strategic Plan is how the San Francisco Department of Public Health (SFDPH), specifically the Population Health Division, will contribute to the CHIP, deliver the ten essential public health services, and become a community-centered, high reliability, high performance learning health organization.

For us, public health accreditation is about the passionate and disciplined pursuit of results, equity, and accountability for community health. Naturally, we call our strategic framework **REACH**---*for Results, Equity and Accountability with Cultural Humility*. To ensure high performance and continuous improvement we are focused on (1) achieving aspirational **results**, (2) integrating health **equity** into quality improvement activities, (3) ensuring **accountability** for continuous process improvements, and (4) integrating community-based voice, wisdom, and knowledge with science and practice-based evidence.

REACH is focused on achieving aspirational results! Although we are healthier than most regions in the US, we still have room for improvement. We continue to have health inequities in San Francisco, especially with our eastern neighborhoods and with Black/African Americans and Latinos. We have adopted a results-based, collective impact framework that is community-centered, data-driven, and evidence-based. Our Strategic Plan presents "result statements" and "headline indicators" for our highest priority focus areas.

REACH is focused on integrating health equity into quality improvement! We have moved health equity from the mission and values statements to quality improvement practice. This ensures that our health equity efforts transform public health practice, improve continuously, and improve health outcomes. For example, we are partnering with our clinical division---the SF Health Network---to improve the health and wellness of Black/African American patients and clients in our clinical, mental health, and substance abuse systems.

REACH is focused on ensuring accountability for continuous process improvements! Achieving results is not sufficient if we are not investing in our workforce and improving our business processes. Through our new Center for Learning and Innovation we are investing in our current and future workforce with leadership and quality improvement trainings, and internship opportunities. Through a CDC grant at the UC Berkeley School of Public Health we are developing a training for health officials to improve strategic decision making in complex environments. This lays the foundation to incorporate cost and budget efficiencies into decision making and priority setting.

Finally, with support and technical assistance from the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO), we re-organized our public health services into the new Population Health Division---an integrated, community-centered public health division.

Executive Summary

In November 2011, the San Francisco Health Commission identified three budget priorities for the San Francisco Department of Public Health (SFDPH): 1) an Integrated Delivery System, 2) Public Health Accreditation (PHA), and 3) Financial Efficiency. In July 2012, we began the journey to Accreditation. There are three prerequisites to apply for PHA; they include the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and the department Strategic Plan.

Community Health Assessment

In coordination with nonprofit hospital and academic partners, the health department engaged in a 14-month community health assessment process. Serving California's only consolidated city and county – as well as a diverse population of 805,235 residents – the department and our partners strove to foster a **community-driven** and **transparent** CHA aligned with **community values**.

Building on the success of Community Vital Signs (San Francisco's previous community health assessment effort conducted in 2010), we relied on the Mobilizing for Action Through Planning and Partnerships (MAPP) framework to guide the current CHA. The result was a community-driven process that **engaged more than 500 residents and local public health system partners** and embraced the following values:

- To facilitate **alignment** of San Francisco's priorities, resources, and actions to improve health and well-being.
- To ensure that **health equity** is addressed throughout program planning and service delivery.
- To promote **community connections** that support health and well-being.

To complete the CHA, we relied on 2010 Community Vital Signs data as well as data compiled from the four **MAPP assessments**:

- Community Themes and Strengths Assessment
- Local Public Health System Assessment
- Forces of Change Assessment
- Community Health Status Assessment

Community Health Improvement Plan

Utilizing the data from the CHA and through further engagement of **160 community residents and local public health system partners**, the following key priorities for were developed for the Community Health Improvement Plan (CHIP):

- **Ensure Safe + Healthy Living Environments**
- **Increase Healthy Eating + Physical Activity**
- **Increase Access to Quality Health Care + Services**

In collaboration with residents and community stakeholders, the department and our partners developed goals and objectives for each priority as well as related measures and strategies that comprise the current CHIP. The diversity of CHIP project leads assigned to identified strategies – including a range of government agencies, public, community collaborations, community-based organizations, and other entities – demonstrates that the current CHIP is a bold effort to harness the collective efforts of San Francisco's communities and local public health system partners to improve population health. SFDPH and its partners plan to conduct a CHA/CHIP process every three years in alignment with other health improvement initiatives.

Health Equity Gives Context to San Francisco's CHIP

Community residents and stakeholders agree that addressing the social determinants of health (e.g., poverty, educational attainment) are a necessary first step in improving population health and eliminating health disparities. San Francisco's CHIP highlights health equity as a fundamental value by:

- Presenting select socioeconomic data to identify subpopulations and neighborhoods most likely to face health disparities and inequities.
- Highlighting baseline data along relevant CHIP indicators for which identified subpopulations face health disparities.
- Setting ambitious citywide targets for health improvement, guided by the conviction that all San Franciscans are entitled to a high standard of health and wellness.

Community residents and local public health system partners gathered on August 28, 2012 to review CHIP priorities and brainstorm possible related strategies. The event afforded stakeholders the opportunity to share information and "connect" in meaningful ways.

Strategic Plan

Graphic artist Dan Jumanan illustrated community dialogue at several focus group sessions in which participants shared their views on health as well as San Francisco's strengths and opportunities for growth in terms of health and wellness.

Building on the values and priorities identified by community partners, the health department began the process of developing the strategic plan for population health. The Strategic Plan was developed in two phases.

Phase one began with the redesign of the division formerly known as Population Health and Prevention (PHP). We gathered input from a number of stakeholders including SFDPH leadership, PHP Directors, and staff from across the Division. We relied on a number of mechanisms to get input including focus groups, where we invited broad participation and covered a wide range of topics such as workforce development, community engagement, and monitoring health outcomes. In addition, we engaged community through a series of neighborhood-based meetings. The input and recommendations were inspiring, and staff and City residents shared a bold vision for how we can improve health and well-being in San Francisco. This phase ended with the development of the new Population Health Division (PHD) and the completion of our strategic map.

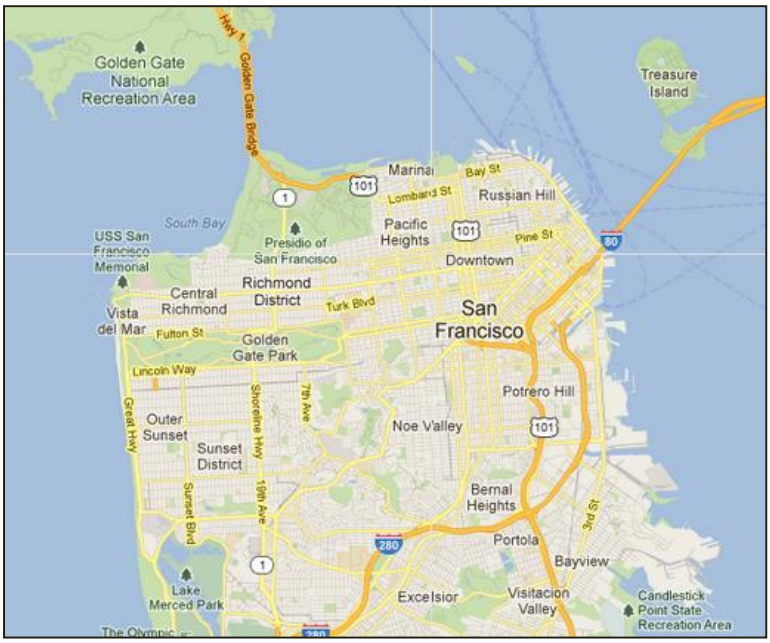
Phase two of the process was dedicated to developing the health indicators that we will focus on in the strategic plan. The indicators align with the goals identified in the CHIP and were expanded to focus our efforts on Health Equity within populations that have experienced greater disparities and inequities in health outcomes.

- **Ensure Safe + Healthy Living Environments (CHIP)**
- **Increase Healthy Eating + Physical Activity (CHIP)**
- **Increase Access to Quality Health Care + Services (CHIP)**
- **Black/African American Health**
- **Mother, Child and Adolescents Health**
- **Health for People at Risk and Living with HIV**

This plan highlights the Headline Indicators for each of the focus areas listed above. Baseline data for each of the indicators is provided first, with a forecast of what can be expected if nothing is done (expect the status quo). Included next is a story behind the data. The story provides background and context of the data in the graph as well as possible root causes behind the data. The idea of telling stories is to explain our perspective of how we got where we are today. The evidence based practices that are included as ways we can improve the results, come from national initiatives such as Healthy People 2020 and the National HIV/AIDS Strategy, and from partners the division must work with to improve health outcomes. We have identified strategies that have a collection of actions with a reasonable chance of improving the results.

San Francisco Snapshot

Overview



Located in northern California, San Francisco is a seven by seven square mile coastal, metropolitan city and county that includes Treasure Island and Yerba Buena Island just northeast of the mainland. The only consolidated city and county in the state, San Francisco is densely populated and boasts culturally diverse neighborhoods in which residents speak more than 12 different languages. According to the 2010 Decennial Census, San Francisco has a population of 805,235 residents and experienced mild population growth of nearly four percent between 2000 and 2010.

Although San Francisco was once considered home to a relatively young population, the city/county has experienced a decrease among children and families with young children. In addition, over the next two decades, it is estimated that 55 percent of the population will be over the age of 45, and the population over age 75 will increase from seven to 11 percent.

About the San Francisco Department of Health

As SFDPH's governing and policy-making body, the San Francisco Health Commission is mandated by City and County Charter to manage and control the City and County hospitals, to monitor and regulate emergency medical services and all matters pertaining to the preservation, promotion and protection of the lives, health, and mental health of San Francisco residents.

Back Row (left to right): *Commissioner David Singer; Commissioner Belle-Taylor McGhee; Commissioner Judith Karshmer; DPH Director Barbara A. Garcia; Commissioner Cecilia Chung; Commissioner David J. Sanchez Jr.* ***Front Row:*** *Commissioner Edward A. Chow, President; Commissioner Sonia Melara, Vice President*

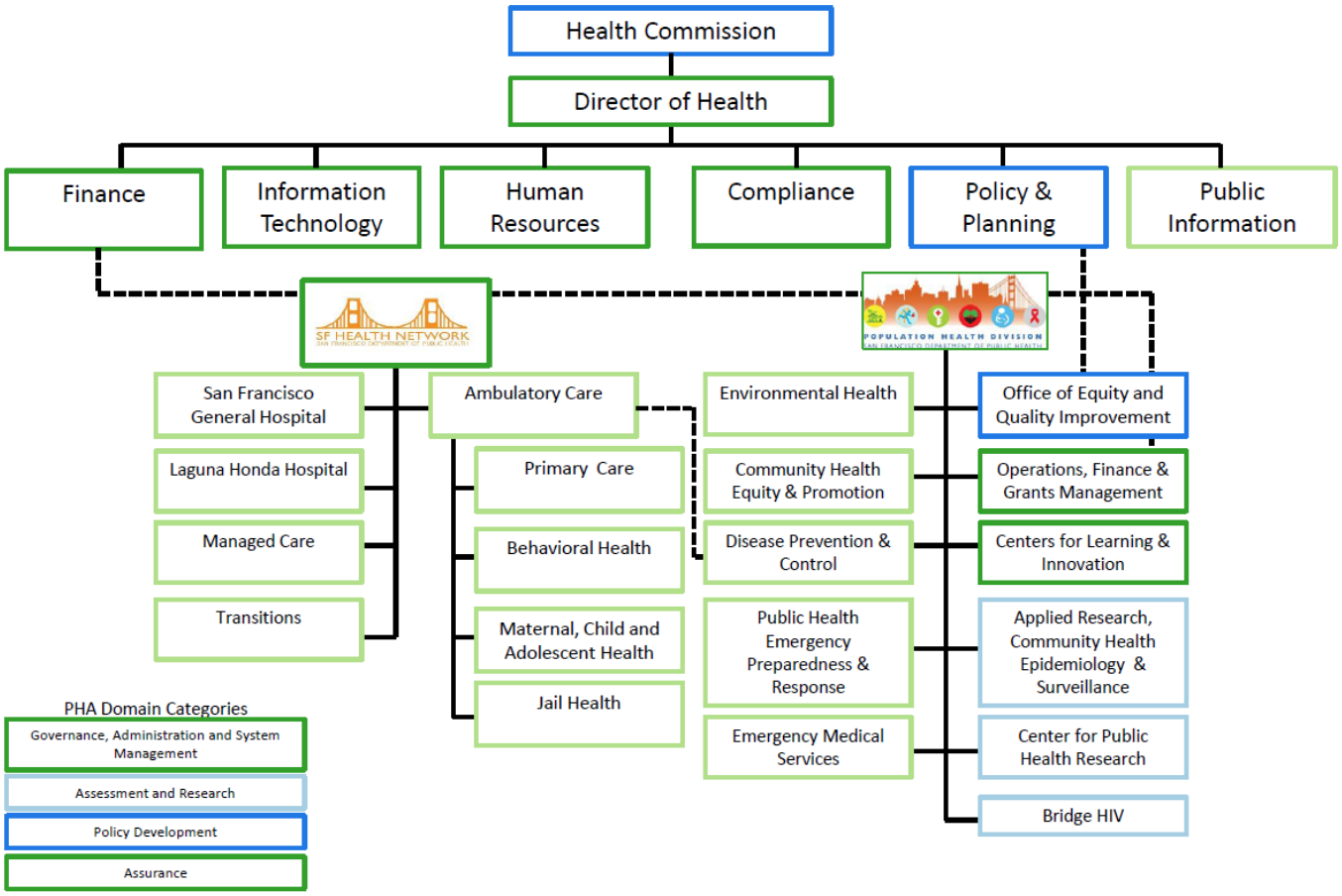
The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans. SFDPH is an integrated health department with two major Divisions (see p. 9 for an organizational chart): the Population Health Division and the San Francisco (SF) Health Network.

The Population Health Division (PHD) provides core public health services for the City and County of San Francisco: health protection, health promotion, disease and injury prevention, and disaster preparedness and response. The PHD consists of six branches (Applied Research, Community Health Epidemiology, and Surveillance; Environmental Health Branch; Community Health Equity and Promotion; Disease Prevention and Control; Emergency Medical Services; and Public Health Preparedness and Response), two offices (Office of Equity and Quality Improvement; Office of Operations, Finance, and Grants Management), and three centers (Center for Innovation and Learning; Center for Public Health Research; and Bridge HIV (HIV research). We deliver the following ten essential public health services: (1) conduct and disseminate assessments focused on population health status and public health issues

facing the community; (2) investigate health problems and environmental public health hazards to protect the community; (3) inform and educate about public health issues and functions; (4) engage with the community to identify and address health problems; (5) develop public health policies and plans; (6) enforce public health laws; (7) promote strategies to improve access to health care services; (8) maintain a competent public health workforce; (9) evaluate and continuously improve processes, programs, and interventions; and (10) contribute to and apply the evidence base of public health.

The SF Health Network is comprised of the direct health services provided to thousands of insured and uninsured residents of San Francisco, including those most socially and medically vulnerable. The services that we provide through the SF Health Network are not new – rather, they are newly aligned to achieve the triple aim of Health Care Reform: better care for individuals; better health for the population; and lower cost through improvement. Unlike other public or private systems, our network contains the crucial components needed to build a seamless continuum of care: patient-centered medical homes provided by primary care clinics located throughout the community; comprehensive behavioral health services; acute care and specialty services provided at San Francisco General Hospital; skilled nursing care provided at Laguna Honda Hospital; and other home- and community-based services. In addition, we provide critical health care services for the broader community. San Francisco General Hospital, for example, is the only trauma center serving all of San Francisco and northern San Mateo County. Additionally, the Network's Behavioral Health Services provide mental health and substance abuse services to all low-income San Franciscans who need them. Services such as these are essential components of the San Francisco safety net.

Figure 1: SFDPH Organizational Chart



The Strategic Planning Process

The Strategic Plan is the next step on our journey to public health accreditation. We have completed the Community Health Assessment and the Community Health Improvement Plan. The Assessment involved extensive community engagement with stakeholders throughout San Francisco representing diverse sectors. The Community Health Improvement Plan is our citywide plan to protect and improve the health of all San Francisco residents, and is overseen by the San Francisco Health Improvement Partnership (SFHIP) – a citywide multidisciplinary health coalition. This Strategic Plan outlines what contributions the health department, particularly the Population Health Division, will (1) contribute to the CHIP, (2) deliver the ten essential public health services, and (3) become a community-centered, high reliability, high performance learning health organization. Appendix B provides you with our Project Management Dash Board for the Strategic Plan that was used to monitor the planning process. This was adapted from the NACCHO document "*Developing a Local Health Department Strategic Plan: A How-To Guide"* and modified to meet our local framework. This Strategic Plan was adopted and approved by the San Francisco Health Commission on June 17, 2014 (see Appendix C for a copy of the resolution) and supported by Mayor Edwin M. Lee (see Appendix D).

Background

Public health practice is changing: we are moving from reacting to event-driven triggers (e.g., reportable communicable diseases and outbreaks) to proactive, community-centered assessments, policy development, policy solutions, and enforcement. While health care services are moving to patient-centered homes, public health is similarly moving to community-centered, "health in all policies" approaches. Epidemiology, a basic science of public health, is expanding to include public health informatics, knowledge management, and strategic decision support. Our skills now include health impact assessments (HIAs), multi-criteria decision making, social network analysis, and system dynamics and epidemic modeling. Public health accreditation requires comprehensive community engagement and assessments, community health improvement planning, departmental strategic planning, performance management and continuous quality improvement systems, and operational plans to address health equity and social determinants of health. These changes are also being driven by national and state guidelines and priorities including the National Prevention Strategy, National Strategy for Quality Improvement in Health Care, Healthy People 2020, and Let's Get Healthy California.

For many years, our sections that focused on public health services consisted of autonomous, mostly categorical disease-focused services that reported separately to the Health Officer. Most of our categorical funding and activities promoted siloed specialization that resulted in significant research and practice innovations. In spite of these strengths and achievements, our former structure and lack of infrastructure to coordinate and align activities severely limited our ability to adapt and respond to a rapidly changing, increasingly complex and interdependent health, social, economic, and technological environment. To meet these challenges and opportunities, and to build the health department of the future, we decided to re-organize the public health division (formerly called Population Health and Prevention) into the new Population Health Division.

Framework for Organizational Design

The first phase in the strategic planning process was to redesign the sections that provided public health services. With support and technical assistance from the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO), we embarked on an extensive re-organization of our categorical public health services into a community-, client-, and patient-centered Population Health Division. Our overarching goal was to design a learning health organization that is responsive, agile, and adaptive to current and emerging public health challenges and opportunities

The knowledge base for re-organizing local health departments is limited, and we did not have funding for organization design consultants. Therefore, we did the following: (1) adapted a socio-ecological model of population health; (2) reviewed public health accreditation domains and standards; (3) studied business organization design books and concepts; (4) reviewed the Baldrige Criteria for Performance Excellence; (5) conducted community, staff, and stakeholder engagement; (6) developed a strategic map (strategic directions and performance measures Figure 2, page 14); (7) developed an organization design framework and organization chart; (8) designed a health organization performance and improvement framework (i.e., REACH); and (9) leveraged funding and technical assistance from the CDC and NACCHO to keep us on track.

With input gathered through community, staff, and stakeholder engagement, these concepts were blended to develop an organizational design framework to help us create a Strategic Map and Organizational Chart (see Figure 1, page 11). Both of the figures are color coded to show how we align with the Public Health Accreditation Domains Categories of Assurance/Research; Policy Development; Assurance; Governance, Administration, and System Management.

Through this process, general themes and overarching goals emerged that drove the organizational design of the Division:

- Lead SFDPH efforts in health protection, health promotion, disease prevention, and disaster preparedness
- Be community-centered ("healthy people")—not pathogen-centric
- Promote healthy, sustainable environments ("healthy places")
- Operationalize division-wide focus on health equity
- Become agile, adaptive, and responsive to emerging challenges
- Strengthen service excellence to communities, clients, and providers
- Become a learning organization with a culture of trust, innovation, and continuous improvement
- Strengthen culture of discovery and world class research
- Achieve and maintain Public Health Accreditation

The former Population Health and Prevention was reorganized into the new Population Health Division (PHD). The reorganization focused on four major areas:

1. The integration of health assessment, surveillance, epidemiology, and informatics to support division, departmental, and citywide efforts;
2. The integration of communicable disease prevention and control services;
3. The integration of specialists in community engagement, planning, and mobilization to focus on health promotion and health education in communities; and
4. The creation of division-wide infrastructure to support professional development, continuous quality improvement, grant development and management, operations and fiscal efficiency, and public health accreditation.

The Strategic Map illustrates the internal strategic directions, strategies and performance measures selected to improve the infrastructure of the Division in order to build the health department of the future. It includes our mission and vision statements.

Population Health Division Mission and Vision Statement

Our Mission: Drawing upon community wisdom and science, we support, develop, and implement evidence-based policies, practices, and partnerships that protect and promote health, prevent disease and injury, and create sustainable environments and resilient communities.

Our Vision: To be a community-centered leader in public health practice and innovation.

Figure 2: Population Health Division Strategic Map

REACH for Results, Equity and Accountability with Cultural Humility

The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The Institute of Medicine defines public health as "fulfilling society's interest in assuring conditions in which people can be healthy." In a public health classic C.E. Winslow defined public health as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals." We are inspired by these definitions because they go beyond the traditional idea of reacting to illness and emergencies, and direct us to put a focus on wellness and the promotion of holistic health of mind, body and spirit at all stages of life.

The health department's mission is "To protect and promote the health of all San Franciscans." Our PHD vision is "To be a community-centered leader in public health practice and innovation," and our PHD mission: "Drawing upon community wisdom and science, we support, develop, and implement evidence-based policies, practices, and partnerships that protect and promote health, prevent disease and injury, and create sustainable environments and resilient communities."

While the mission is to deliver the ten essential public health services, we chose to focus our strategic plan on local "winnable battles" that were selected through the Community Health Improvement Plan (CHIP) and, health department identified priorities based on morbidity (the level of disease in SF) and mortality (deaths due to those conditions). It is important to recognize that we continue to provide all core public health efforts. For a larger list of activities and services supported by the jurisdiction see Appendix A.

Phase two of the strategic planning process focused on developing health indicators for the strategic plan. The indicators align with the goals identified in the CHIP and, were expanded to focus our efforts on Health Equity within populations that have experienced greater disparities and inequities in health outcomes. While population health activities support all SF residents, commuters (people who work in SF, but live outside the city), and visitors, our primary customer is San Francisco's vulnerable population. Our ultimate result is to ensure that San Franciscans have optimal health and wellness at every stage of life.

The focus areas for this strategic plan are:

- **Ensure Safe + Healthy Living Environments**
- **Increase Healthy Eating + Physical Activity**
- **Increase Access to Quality Health Care + Services**
- **Black/African American Health**
- **Mother, Child and Adolescents Health**
- **Health for People at Risk and Living with HIV**

Population: San Francisco's vulnerable population

Result Statement: San Franciscans have optimal health and wellness at every stage of life.

The Plan has baseline data for each Indicator within the Focus Areas, as well as a forecast signified by a dashed line (▬ ▬ ▬) for where we believe the trend will continue to go if nothing different is done. We provide a story to explain what is behind the data. The story provides background and context of the data presented in the graph as well as possible root causes behind the data. The idea of telling stories allows us to explain our perspective of how we got where we are today. We also provide Information on evidence-based practices that can improve the results; these practices come from national initiatives such as Healthy People 2020 and the National HIV/AIDS Strategy, as well as partners the division must work with to improve health outcomes. The identified strategies include a collection of actions with a reasonable chance of improving the results.

PHD Result and Headline Indicators

POPULATION: San Francisco's vulnerable populations
RESULT STATEMENT: San Franciscans have optimal health and wellness at every stage in life

FOCUS AREA	HEADLINE INDICATOR
Safe and Healthy Living Environments (CHIP)	• Number of days in San Francisco with good air quality • Percent of adults who smoke • Number of severe pedestrian injuries and deaths
Healthy Eating and Physical Activity (CHIP)	• Percent of residents who have food security (resource, access, consumption) • Percent of residents who maintain a healthy weight • Percent of residents who have adequate physical activity
Access to Quality Care and Services (CHIP)	• Percent of San Francisco residents enrolled in either health insurance or Healthy San Francisco
Black/African American Health	• Percent of Blacks/African Americans with heart disease • Mortality rate of Black/African American women with breast cancer • Rates of Chlamydia among young Black/African American women • Mortality rates among Black/African American men due to alcohol
Mother, Child, & Adolescent Health	• Percent of pre-term infants • Rate of substantiated child maltreatment • Proportion of children with healthy teeth (annual dental visit and no caries)
Health for people at risk or living with HIV	• Number of new HIV diagnoses • Percent of newly diagnosed with HIV who receive care • Percent of HIV infected who are virally suppressed

Focus Area: Safe and Healthy Living Environments (CHIP)

San Francisco is one of the wealthiest and most socially progressive cities in the United States. Despite the numerous advantages that come with living here, not everyone in San Francisco has a safe and healthy place to live. While many neighborhoods have great access to parks, public transit, grocery stores, and other resources that benefit health and wellness, other neighborhoods, often poor communities of color, must rely on fast food and alcohol outlets for their nutritional needs. They live near freeways, industrial pollutants, and other factors that contribute to high rates of disease, death, injury, and violence. In focus groups, community meetings and hearings, neighborhood residents raised concerns about their social and physical environment. This extensive outreach process resulted in three reports that guide the City's health and wellness efforts: the Community Health Assessment (CHA), the Community Health Improvement Plan (CHIP), and the Health Care Services Master Plan (HCSMP). We also learn about these neighborhood conditions through our Environment Health Branch that receives citizen complaints, and conducts inspections and regulatory actions.

The Safe and Healthy Living Environments focus area acknowledges the need for health- and wellness-oriented land use planning, meaningful opportunities for outdoor recreation, and a positive built environment for the health of all individuals and communities.

Priority Areas for Ensure Safe and Healthy Living Environments	
Clean Air	The department will work with policy makers to reduce the amount of air pollution and foster interagency collaboration and coordination for policy development using evidence, as outlined in the Community Risk Reduction Plan (CRRP)
Tobacco Free Living	In alignment with the San Francisco philosophy related to smoking reduction, the department is committed to decreasing the percent of adults who smoke.
Pedestrian Safety	The department is a participant in the city wide initiative to decrease the number of deaths and severe injuries of pedestrians.

This Strategic Plan identifies three headline indicators that will be used to measure progress in optimizing the Safe and Healthy Living Environments in San Francisco. The next phase of the process will be to work with the San Francisco Health Improvement Partnership to review all of the current efforts and work together to develop common performance measures and strategies that aim to have collective impact that improve the environment in which San Franciscan live, learn, earn and play.

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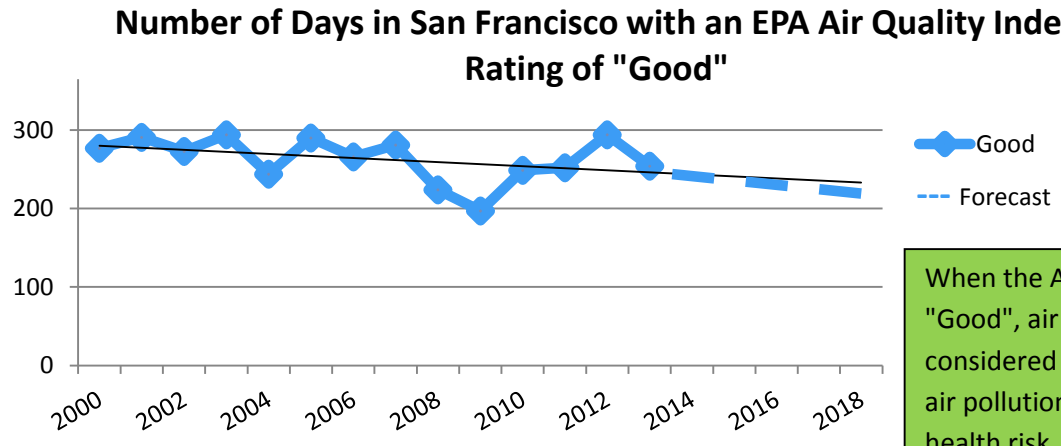
Headline Indicator: Number of days in San Francisco with good air quality

BASELINE CURVE



Data source: U.S. EPA

When the Air Quality Index is "Good", air quality is considered satisfactory, and air pollution poses little or no health risk.

THE STORY BEHIND THE BASELINE

Between 2000 and 2007, the number of days with Good Air Quality remained relatively steady between 244 and 291, and then fell in 2009 to a low of 197. The annual number of days with Good Air Quality has increased since then; however, there is no clear indication that the trend toward improvement is permanent.

Improving citywide air quality is a priority because of its strong relationship to numerous adverse health outcomes. Scientific studies consistently show an association between exposure to air pollution and significant human health problems. Most well known are the respiratory effects such as aggravated asthma, chronic bronchitis, and reduced lung function. Air pollution affects heart health and can trigger heart attacks and strokes that cause disability and death. Air pollutants may be a contributing factor to leading causes of death recorded for San Francisco's population (ischemic heart disease; lung, bronchus, and tracheal cancers; cerebrovascular disease; chronic obstructive pulmonary disease; hypertensive heart disease and lower respiratory infection). Exposure to air pollutants that are carcinogens can also have significant human health consequences. For example, exposure to diesel exhaust is an established cause of lung cancer.
Because of its geography, local meteorology, and limited industrial activity, San Francisco has relatively good air quality. However, in many parts of San Francisco, concentrations of air pollutants may exceed health-protective standards.

The Environmental Protection Agency (EPA) calculates and publishes an Air Quality Index (AQI) each day based on real-time monitoring by the Bay Area Air Quality Management District at a single location on Arkansas Street in San Francisco. This location monitors five major air pollutants regulated by the Clean Air Act: ground-level ozone, particle pollution (also known as particulate matter), carbon monoxide, sulfur dioxide, and nitrogen dioxide.

San Francisco has increasingly fewer stationary sources of air pollution-- power plants in Hunters Point and Potrero Hill were closed in 2006 and 2010, respectively, and many industrial businesses have since left the city. However, air pollution from other stationary sources such as diesel generators, gas stations and dry cleaners continue to contribute to poor air quality in the city. Air pollution from cars, trucks, ships, emissions from construction equipment, and tire and brake wear on roadways contribute substantially to air pollution-related health outcomes. These mobile sources of air pollution are the biggest root cause of poor air quality in the city and addressing these should result in a new positive trend for air quality.

WHAT WORKS

- Promote policies that reduce the number of car trips in the city by improving the environment and culture for use of public transportation
- Ensure equitable access to transportation networks and improve safety for all users
- Assess pedestrian and bicycle safety in order to support improvements to make walking and biking safer and more attractive
- Participate in policies to improve outdoor and indoor air quality

PARTNERS

- Bay Area Air Quality Management District, Metropolitan Transportation Commission and other Regional Regulating and Planning Authorities
- SF Department of the Environment, SF Department of Planning, SF Unified School District and other city and county departments and agencies
- Community Based Organizations with a focus on environmental justice, transportation, pedestrian safety, health equity and wellness

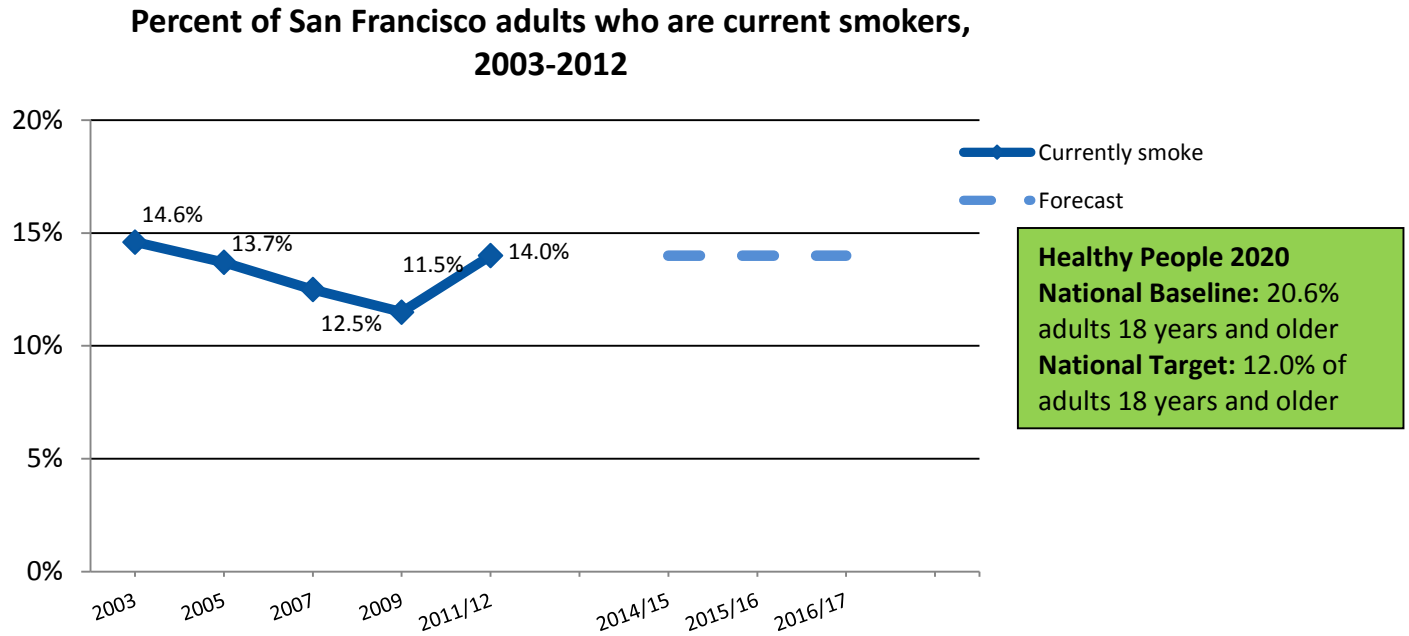
STRATEGIES

- Revise and continue implementation of Article 38 of the Health Code to protect residents in high air pollution areas of the city
- Foster interagency collaboration and coordination for policy development using evidence, as outlined in the Community Risk Reduction Plan (CRRP).

Headline Indicator: Percent of adults who smoke

BASELINE CURVE

Source: California Health Interview Survey



Data source: California Health Interview Survey

THE STORY BEHIND THE BASELINE

Since the 1990's, smoking rates in SF have declined significantly mainly due to efforts in California to remove advertising, educate the public, and increase cigarette taxes. SF was among the first localities to enact workplace, playground, and restaurant smoking bans and has been a leader in implementing strong and progressive policies to discourage smoking and protect individuals from secondhand smoke. These efforts have reduced smoking in the city from 20% in 1990 to 12-14% in the 2000's. Compared nationally, San Francisco's average annual decrease in adult smoking between 1996 and 2012 has been among the highest in the country for both men and women, at about 3%. However, since 2003, the rate of adult smoking has remained relatively unchanged around 13%, which is higher than most of our neighboring counties in the Bay Area.

Tremendous work to change San Francisco's culture around tobacco use has been facilitated through the SFDPH's Tobacco Free Project. The Project specifically works to reduce exposure to environmental tobacco smoke, reduce youth access to tobacco, and counter pro-tobacco influences. The Project worked to pass specific measures including: banning free distribution of tobacco products, banning tobacco advertising on city property, banning smoking in workplaces including restaurants, mandating that tobacco be sold behind store counters and eliminating vending machines, banning tobacco advertising on taxis, adding a cigarette butt litter mitigation fee to the sale of cigarettes, requiring a permit for tobacco sales, banning tobacco in public parks and plazas, banning smoking at transit stops, banning the sale of tobacco in retailers with a pharmacy, and passage of the Smoke Free Ordinance (Article 19F of the Health Code). In 2013, Article 19M of the Health Code was enacted requiring landlords to disclose whether their lease agreement allows smoking and which of their neighboring units allow for smoking.

WHAT WORKS

- Increasing Tobacco Use Cessation including mobile phone-based interventions
- Reducing tobacco use and exposure to second hand smoke
- Revitalizing laws and policies related to smoking

PARTNERS

- San Francisco Health Network
- City Departments including City Planning, Housing Authority, Human Services Agency
- County Agencies including San Francisco Unified School District, Human Rights Commission, Rent Board
- Tobacco Free Coalition, Tenant Advocacy Groups, Apartment Associations, and Community Based Organizations
- Community (to participate and identify strategies)

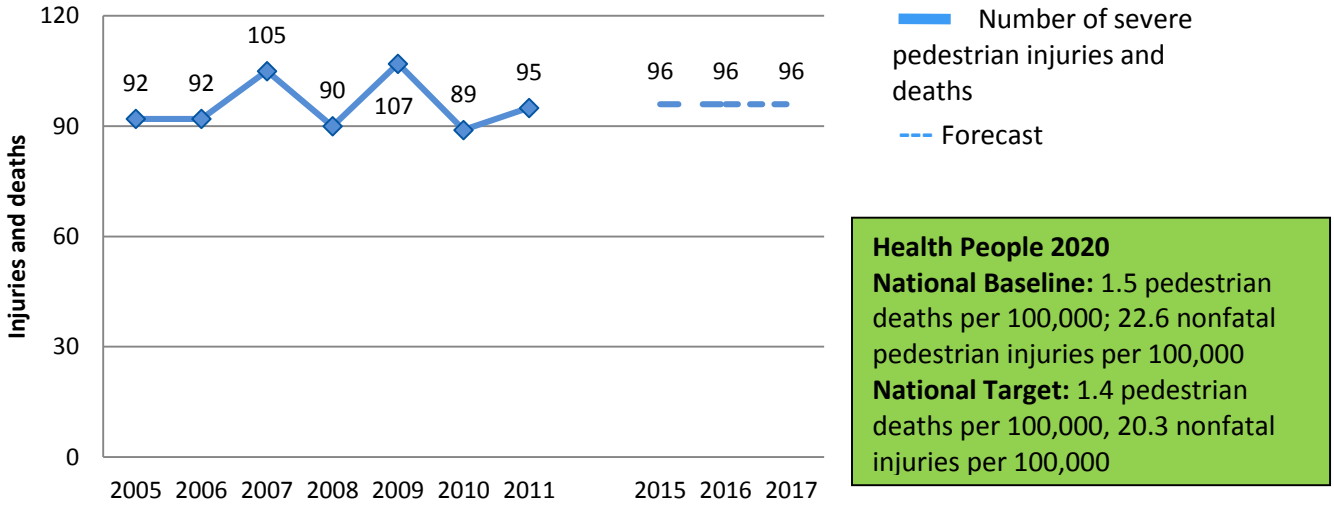
STRATEGIES

- Continue to enforce and support the policy and regulations that reduce exposure to environmental tobacco smoke, reduce youth access to tobacco products, and counter pro-tobacco influences, such as emerging products like e-cigarettes
- Support feasibility of ordinance for smoke-free housing that will not allow evictions due to smoking
- Continue to provide smoking cessation services and education and promote institutional cessation policies

Headline Indicator: Number of severe pedestrian injuries and deaths

BASELINE CURVE

Number of severe pedestrian injuries and deaths, 2005-2011 and future projected



Health People 2020
National Baseline: 1.5 pedestrian deaths per 100,000; 22.6 nonfatal pedestrian injuries per 100,000
National Target: 1.4 pedestrian deaths per 100,000, 20.3 nonfatal injuries per 100,000

Data source: Statewide Integrated Traffic Records System (SWITRS) Data, California Highway Patrol (CHP).

THE STORY BEHIND THE BASELINE

California Highway Patrol's definition of severe injuries: An injury other than a fatal injury which results in: broken bones; dislocated or distorted limbs; severe lacerations; or unconsciousness at or when taken from the collision scene. Severe injuries do not include minor lacerations.

San Francisco is a city that walks. Walking is a simple, affordable way for community members to get around, and has numerous benefits for our physical and mental health. Every trip begins and ends with walking, and approximately 20% of trips each day in San Francisco are solely walking trips. At the same time, San Francisco County has the highest per capita rate of pedestrian injuries and deaths in the state. The built environment, including the design of our transportation system, plays a major role in pedestrian injuries. High traffic volumes, high concentration of people living and working in the city, and wider, higher speed streets called "arterials" are established environmental risk factors for pedestrian injuries. Vehicle speeds kill – with a pedestrian five times more likely to die at 40 mph compared to 25 mph. In SF neighborhoods like the Tenderloin, the South of Market, and Chinatown, all of these factors contribute to geographic disparities in pedestrian injuries. These communities also have higher concentrations of low-income, disabled, non-English speaking, and immigrant populations that rely on walking and transit for transportation. In San Francisco, seniors are five times more likely than younger adults to be fatally injured as a pedestrian. Children are also at risk for pedestrian injury due to their physical, developmental, and cognitive attributes depending on age.

Over 800 people are injured while walking each year on SF streets– and approximately 100 people are severely injured or killed. Sixty percent of severe and fatal injuries occur on only six percent of our City's streets (high injury corridors). Approximately two-thirds of the time, drivers are cited to be at fault in vehicle-pedestrian collisions. Approximately 20% of pedestrian injuries are not reported in police collision reports. This is notable

since studies have shown that collisions involving African-American pedestrians are half as likely as other groups to be recorded in a police report. The annual medical costs of pedestrian injuries seen at SFGH are $15 million, with the total pedestrian injury health-related economic costs estimated at a much higher $564 million a year.

There are multiple agencies responsible for designing, upgrading and monitoring pedestrian safety. In 2010, the Mayor issued an Executive Directive instructing these agencies to reduce severe and fatal pedestrian injuries by 50% by 2021. In 2014, the San Francisco Board of Supervisors, Municipal Transportation Agency and Police Department adopted "Vision Zero" – with a goal of zero traffic deaths by 2024, expanding the focus to include pedestrian, bicycle, and motor vehicle safety. As a part of Vision Zero, "WalkFirst" is a set of pedestrian safety capital projects and programs released by the Mayor in March 2014, to improve pedestrian safety conditions on the streets with the highest injury densities.

WHAT WORKS

- Traffic Safety best practice focuses on the "5 Es": Engineering, Enforcement, Education, Encouragement, and Evaluation.
- Education Campaigns, Engagement and Advocacy – supporting a larger cultural shift that focuses on pedestrian and road safety; ensuring the community holds City agencies accountable and that populations disproportionally affected by these tragedies are represented.
- Evaluation and Analysis –monitoring progress of City initiatives, conducting analyses to inform targeted investments, and assessing the effectiveness of interventions, including engineering, enforcement and education efforts.

PARTNERS

- City Departments including: Municipal Transportation Agency, Police Department, County Transportation Authority, Planning, Public Works, District Attorney's Office and others
- San Francisco General Hospital and Trauma Center
- Walk San Francisco, San Francisco Pedestrian Safety Advisory Committee and other Community Organizations that focus on pedestrian safety

STRATEGIES

- Collaborate with community partners, including Walk San Francisco and administer community awards for safety initiatives on streets with high numbers of severe and fatal injuries
- Partner with other city agencies to monitor progress regarding injury reduction targets, evaluate effectiveness of efforts including education, engineering, and enforcement initiatives and conduct analyses to inform investments
- Co-Chair the Citywide Vision Zero Task Force with the San Francisco Municipal Transportation Agency

Focus Area: Healthy Eating and Physical Activity (CHIP)

Science links health outcomes for heart disease, diabetes, and cancer to daily practices like eating a healthy, balanced diet and regular exercise. However, the healthy choice is not always the "easy" choice – particularly for San Francisco's more vulnerable residents – as was repeatedly voiced by community members throughout the CHA/CHIP development process. Socioeconomic and environmental factors impact what individuals eat and how they achieve physical activity.

San Franciscans of all ages fall short of the California average in terms of consumption of five or more fruits and vegetables daily. In addition, disparities exist among different racial/ethnic groups in terms of obesity risk; Latino adults are at greatest risk for obesity, followed by Black/African American residents. These same disparities are mirrored in food security.

Priority Areas for Ensure Safe and Healthy Living Environments	
Food Security	The department will partner with other agencies to increase food security for San Franciscans.
Healthy Weight	The department will work to increase the percent of San Franciscans with a healthy weight.
Physical Activity	Partnering with community organizations and community groups, the department is encouraging increased physical activity for all San Franciscans.

The three Headline Indicators that will be used to measure progress in optimizing increased healthy eating and physical activity strive to demonstrate the link between diet, inactivity, and chronic disease and focus on ways to help San Francisco create environments that make healthy choices the easy choices, so all San Francisco residents have an equal chance to eat well and be more active.

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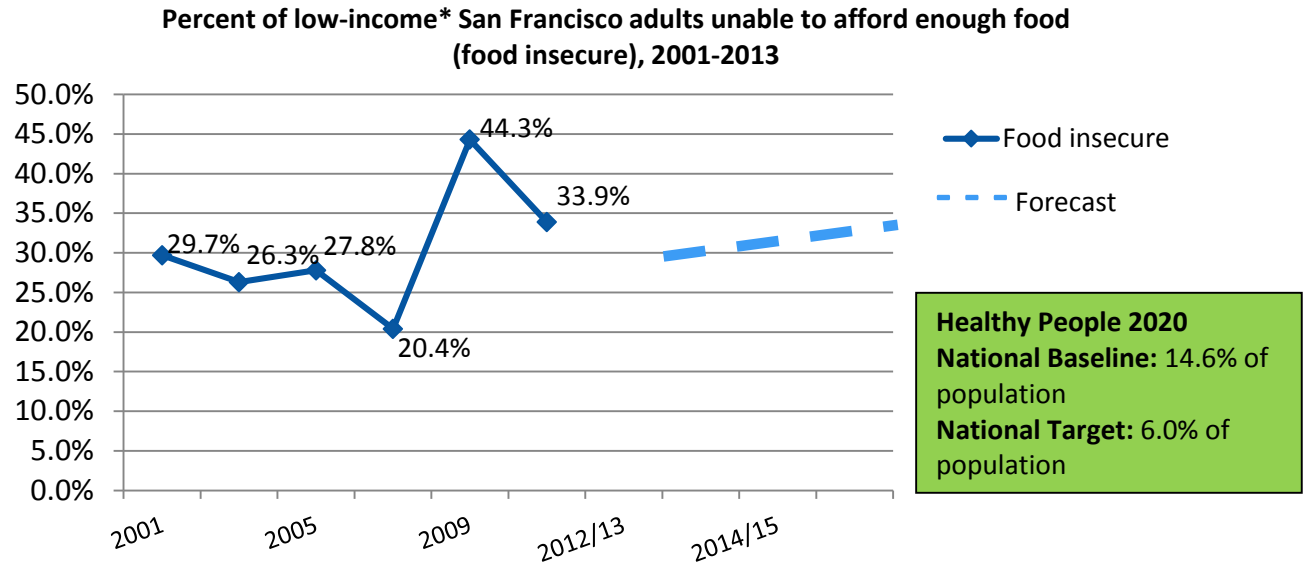
Headline Indicator: Percent of residents who do not have food security (resource, access, consumption)

BASELINE CURVE



Healthy People 2020
National Baseline: 14.6% of population
National Target: 6.0% of population

Data source: 2001-2011/12 California Health Interview Survey
*Low-income defined as those whose income is less than 200% of the Federal Poverty Level

THE STORY BEHIND THE BASELINE

Between 2001 and 2007, the percentage of low-income adults who were food insecure decreased from 29.7 to 20.4 percent. In 2009, food insecurity climbed to a high of 44.3 percent before returning to a lower level of 33.9 percent in 2011-12. Although food insecurity was lessened between 2009 and 2012, there is not a clear trend toward improvement.

Food insecurity may lead to behaviors that undermine health, such as skipping meals, binge eating, food rationing and eating more fats and carbohydrates due to lack of access to fruits and vegetables. Science links daily practices like having a poor diet to an increase in health conditions such as heart disease, diabetes, and cancer. Proper nutrition is critical for healthy development and aging, and is especially important for intellectual and emotional development of children, diabetes management, and health of people living with HIV and AIDS.

Food security refers to the state in which all persons are able to obtain a nutritious and culturally acceptable diet through local non-emergency sources. Socioeconomic and environmental factors impact whether individuals can consistently afford to eat regular, balanced meals. San Franciscans face a high cost of living, largely because of high housing costs. Lack of adequate income may result in difficulty paying for food.

The increase in food security between 2009 and 2011-12 may be directly related to the increase in enrollment in CalFresh (formerly known as food stamps and known nationally as Supplemental Nutrition Assistance Program or SNAP). Additional resources for CalFresh recipients were funded through federal stimulus funds, and the city increased food pantries in San Franciscan to respond to the decline in the economy. However, many immigrants, residents on Supplemental Security Income (SSI), and residents whose income is over 130% of poverty are not

eligible for CalFresh/SNAP. The number of food insecure San Franciscans may still increase due to increasing costs for housing and food, as well as increasing numbers of seniors. Other root causes of food insecurity such as lack of healthy food retail options in lower-income neighborhoods and lack of complete kitchens to prepare healthy meals must be addressed.

WHAT WORKS

- Enrollment/use of federal nutrition programs (school-based nutrition programs, CalFresh, WIC, out of school time meals, after school meals, child care food)
- Community based nutrition programs (i.e. congregate meals, food banks, senior meals, childcare meals, home delivered groceries and meals)
- Connecting individual's food needs to clinical and case management (Chronic Disease Self-Management Program, community health workers to support patients/navigation, assessment for food security among all patients)
- Geographic access to food (retail assessments; support healthy food procurement and health food retail incentives, healthy vending)
- Subsidizing purchase of healthy food (supporting demand)
- Urban Ag – adopting and implementing policies in planning and zoning for cottage kitchen, community gardens (community food gardens)
- Supporting food guardians/community health workers in neighborhoods

PARTNERS

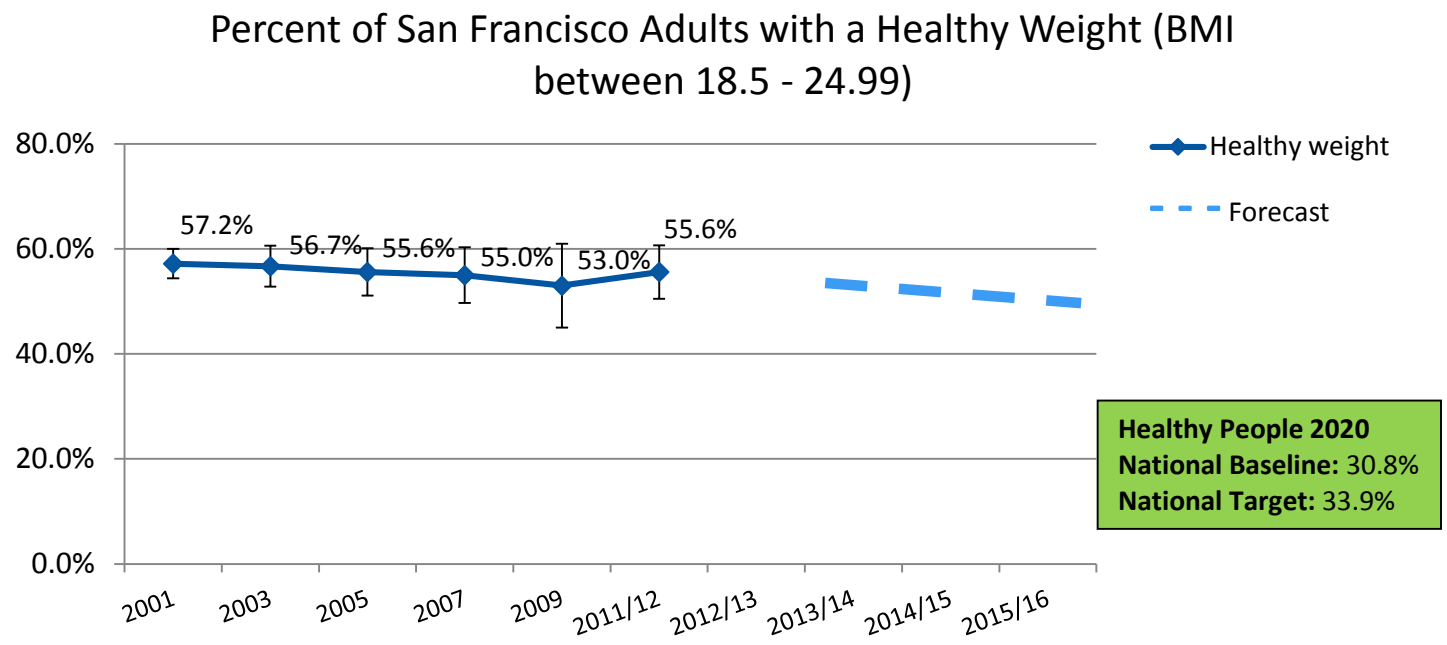
- San Francisco Health Network, Primary Care, etc.
- Community Based Organizations
- Colleges and Universities (e.g., UCSF, SF State, City College)
- Food Security Advocacy Groups
- Community (to participate and identify strategies)

STRATEGIES

- Support the SF Food Security Task Force and implement its recommendations to increase resources for and access to healthy affordable foods
- Develop public policies, including sustainable funding strategies, that directly and indirectly promote healthy nutrition for food insecure San Franciscans
- Increase access to food preparation and knowledge of basic nutrition, safety and cooking

Headline Indicator: Percent of residents who maintain a healthy weight

BASELINE CURVE



Data source: 2001-2011/12 California Health Interview Survey

THE STORY BEHIND THE BASELINE

Between 2001 and 2009, the percentage of adults in San Francisco who reported a healthy weight decreased slightly, from 57.2 to 53.0 percent; however, in 2011-12, the percentage of adults reporting a healthy weight increased to 55.6 percent. Although there has been some improvement between 2009 and 2012, there is not a clear trend.

Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women.

San Franciscans of all ages fall short of the California average in terms of consumption of five or more fruits and vegetables daily. However, food and beverages high in fat, salt and sugar are cheap and readily available, particularly in poor neighborhoods. As consumption of sugary drinks has increased so has obesity (defined as having a BMI over 30.0).

WHAT WORKS

- Technology Obesity Prevention and Control: Technology-Supported Multicomponent Coaching for Counseling Interventions to Reduce Weight and Maintain Weight Loss
- Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults
- CDC guide to strategies to increase the consumption of fruits and vegetables
- Effective primary care through relevant treatments for obesity in adults
- Behavioral counseling to promote a healthy diet

PARTNERS

- San Francisco Health Network, Primary Care, Behavioral Health Services
- City Agencies including Recreation and Parks, Children, Youth and Their Families, Shape UP SF Coalition
- San Francisco Unified School District
- Community Based Organizations, Chamber of Commerce, Boys and Girls Club, YMCA
- Community (to participate and identify strategies)

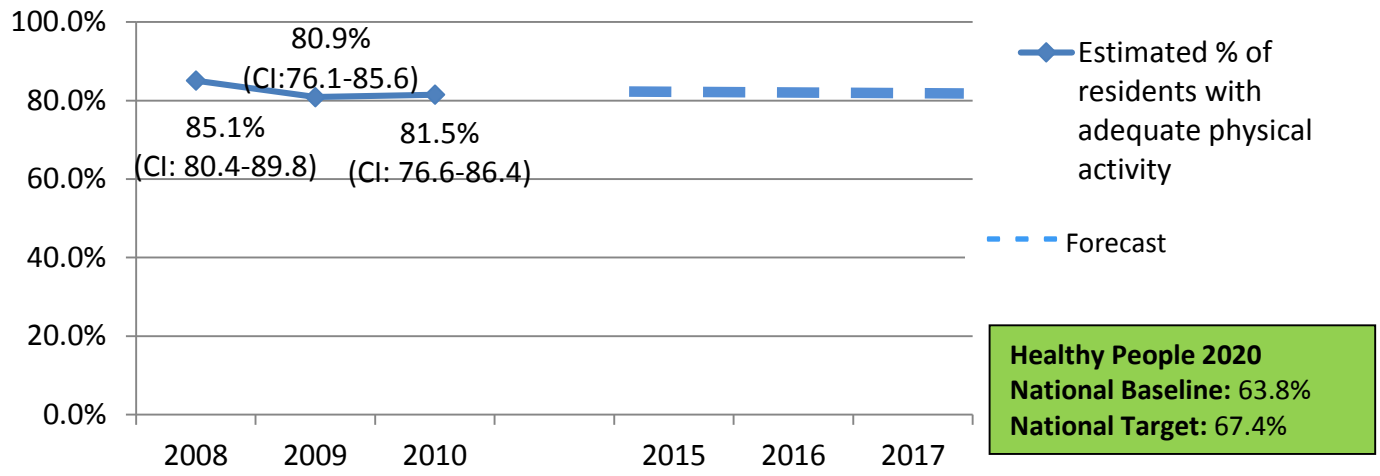
STRATEGIES

- Implement Shape Up SF Strategic Plan
- Promote programs that create safe, accessible spaces for active transportation, recreation and access to healthy food
- Develop and support implementation of public policies and programs that directly and indirectly promote healthy eating and physical activity

Headline Indicator: Percent of residents who have adequate physical activity

BASELINE CURVE

Percent of San Francisco Adults who Participated in any Physical Activities



Data source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. SMART BRFSS. Atlanta, Georgia: U.S. Department of Health and Human Services, Center for Disease Control and Prevention, 2008-2010. Accessed 9/19/2013

THE STORY BEHIND THE CURVE

The percentage of adults in San Francisco who reported participating in any physical activities declined between 2008 and 2010, the period for which data are available. The cause of this decline is not clear.

Science links health conditions such as heart disease, diabetes, and cancer to the amount of daily participation in regular physical activity. Physical activity offers multiple benefits beyond physical health including good mental health and cognitive performance. Safety, socioeconomic factors, and availability have a strong effect on physical activity opportunities for all age groups.

Regardless of the cause, the reality and perception of safety impacts willingness to engage in physical activity. Pedestrians face greater risk for injury and death in the Financial District, Chinatown, South of Market, Downtown/Civic Center, North Beach, Castro/Upper Market, Western Addition, Glen Park, and Mission neighborhoods. Additionally, residents in some neighborhoods face greater risk of violence than in others and may not engage in certain kinds of physical activity because they perceive it is not safe to do so.

Physical activity is defined as any bodily movement that requires a person to use energy. The term "physical activity" should not be mistaken with "exercise". Physical activity includes exercise as well as other activities which involve bodily movement and are done as part of playing, working, active transportation, house chores and recreational activities.

Affordability impacts access to physical activity opportunities as well; whereas active transportation (like walking or biking) may not always be an option, regular free classes, programs like Sunday Streets and, school based programs such as PE support opportunities for physical activity and can lead to life-long practices for healthy, active lives.

WHAT WORKS

- Policies that support active living in the Workplace, at schools, childcare centers, etc.
- Improving the built environment to support safe and active physical activity including safe transportation alternatives, play areas, etc.
- State mandated physical education minutes in schools
- Access to regular, free physical activity opportunities

PARTNERS

- Recreation and Parks Department, Department of Children, Youth and Their Families, Department of City Planning, Metropolitan Transportation Authority
- Physical Activity Advocacy Groups including Shape UP SF Coalition, YMCA, Boys and Girls Club, Walk SF, Bike Coalition, etc.
- Community members

STRATEGIES

- Implement Shape Up SF Strategic Plan
- Develop and support implementation, enforcement, evaluation and possible expansion of public policies that directly and indirectly promote physical activity
- Collaboration to promote programs that create safe, accessible spaces for active transportation and recreation

Focus Area: Access to Quality Care and Services (CHIP)

Access to comprehensive, high quality health care and other services is essential in preventing illness, promoting wellness, and fostering vibrant communities. While San Francisco often outperforms the state and other California counties in terms of health care resources like primary care doctors, availability does not always equal accessibility. Many of San Francisco's more vulnerable residents struggle to get the services they need to be healthy and well.

As of 2010, 94 percent of San Franciscans between the ages of 18 and 64 either had health insurance or were enrolled in Healthy San Francisco, a program that is part of San Francisco's safety net. However, San Francisco falls short of the Healthy People 2020 target for residents with a usual source of care.

Some residents may lack a usual source of care because they do not have insurance and are not enrolled in Healthy San Francisco; others, because providers do not accept their coverage. California providers are less likely to serve Medi-Cal beneficiaries compared to those with private insurance or Medicare, likely because of the state's low reimbursement rate.

Data also suggest that San Franciscans who speak English less than very well may struggle to receive the services they need. In focus groups, residents often expressed the importance of the linguistic and cultural competency of service providers in diminishing their anxiety and frustration.

Priority Areas for Access to Care	
Access to Care	The department is committed to providing quality care for all San Franciscans. The Division will continue to support efforts to enroll participants in health insurance and Healthy SF.

The "Increase Access to High Quality Health Care + Services" priority strives to bridge gaps in care, so all residents may access the services they need to support their health and wellbeing.

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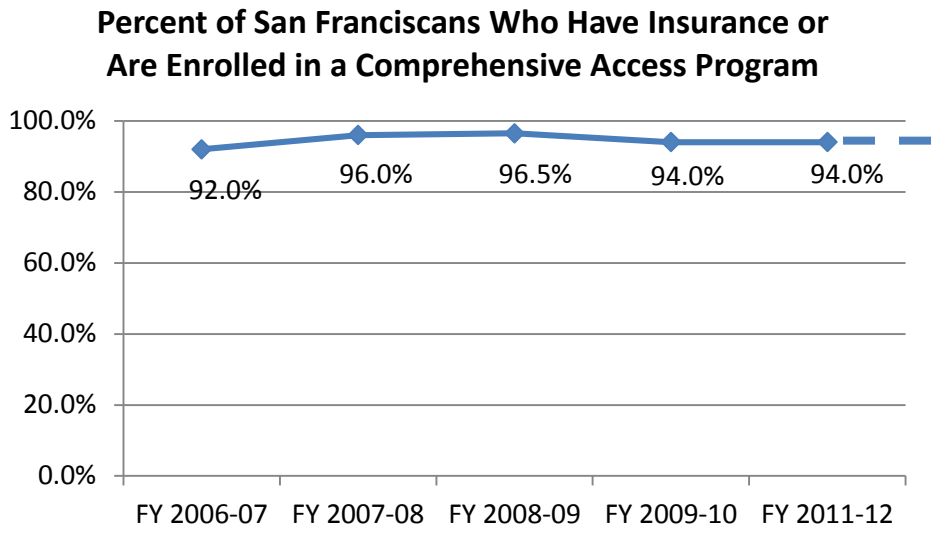
Headline Indicator: Percent of San Francisco residents enrolled in either health insurance or Healthy San Francisco

BASELINE CURVE



Healthy People 2020:

National Baseline: 83.2%

Target: 100%

Data Source: SFHIP Health Matters in San Francisco

STORY BEHIND THE BASELINE

Access to comprehensive, high quality health care and other services is essential in preventing illness, promoting wellness, and fostering vibrant communities. With the implementation of the Patient Protection and Affordable Care Act (PPACA), as well as continued support for Healthy San Francisco, San Francisco will outperform the state and other California counties in the enrollment of residents into health coverage. As of 2010, 94 percent of San Franciscans between the ages of 18 and 64 either had health insurance or were enrolled in Healthy San Francisco, a program that is part of San Francisco's safety net. However, SF falls short of the Healthy People 2020 target for residents with a usual source of care.

Healthy SF is a program designed to make health care services available and affordable to uninsured San Francisco residents. It is operated by the SFDPH. Healthy SF is available to all residents regardless of immigration status, employment status, or pre-existing medical conditions. The program currently provides health coverage to over 50,000 uninsured SF residents. Healthy SF is not health insurance; therefore the coverage is not portable outside of our health jurisdiction.

The Population Health Division (PHD) of the San Francisco Department of Public Health (SFDPH) oversees three specialty clinics, the Adult Travel and Immunization Clinic, the Municipal STD Clinic (City Clinic), and the TB Clinic, as well as supports resources to Community Based Organizations (CBOs) to conduct prevention services. While these services are supported by the health department, they have been provided outside of the health care network. With the detachment from the network, PHD implements the core public health service of providing access to health care to the community regardless of an individual's insurance status. Most of the funding and activities have been categorical (disease-focused) and the health department has been successful in leading the nation in practice innovations and research. In spite of these strengths, the categorical structure, and lack of infrastructure to coordinate and align activities, has severely limited our ability to adapt and respond to a rapidly changing external environment.

As a part of DPH, the Division has an opportunity to work with our Office of Managed Care to identify and develop new protocols and partnerships that support promotion, education and /or enrollment of San Franciscan's without medical coverage into health insurance. Since PHD administers three specialty clinics and supports multiple CBOs, these efforts can directly work with participants in helping them navigate through the process.

WHAT WORKS

- Health Outreach Partners, National Outreach Guidelines for Underserved Populations
- Out stationed eligibility workers
- Using technology and web-based approaches

PARTNERS

- DPH Office of Finance, DPH Office of Policy and Planning
- San Francisco Health Network, Office of Managed Care Department of Health Services Administration
- Community Based Organizations
- Industries/businesses who have employees who are not insured
- EMS providers

STRATEGIES

- Enrolling clinic patients
- Enrolling CBO/program participants into care
- Promoting and marketing coverage options

Focus Area: Black/African American Health

Black/African Americans have been a part of San Francisco (SF) since the Gold Rush. William Leidesdorff, a Caribbean immigrant of African and Danish heritage, was the captain of the first steamship to enter SF harbor and later served as the City's Treasurer, becoming a significant civic leader. The Black population experienced significant growth from the Gold Rush through the 1970's. World War II increased the City's Black population. Many Black/African Americans came as part of the Great Western Migration, when a portion of the 5 million or more people who moved from the South, came to California and other western states. Many African Americans settled in the Fillmore District and most started in housing especially built to accommodate folks working in the Hunters Point Naval Shipyard, and other shipyards in the area.

In the 1950s, SF went through a large scale redevelopment and many Black residents were forced to move from their homes in the Fillmore to newly constructed projects in the Western Addition or to existing public housing that had been converted after the US Department of Defense gave its excess housing to the city. Many were forced to move to other cities such as Oakland. The out-migration of Black residents continues to occur. San Francisco's Black population was 78,931 in 1990, according to the U.S. Census Bureau. By 2010, it had declined to 50,768, a 35.7 percent decrease, now comprising just 6.3 percent of The City's population of 805,235. While Black/African-Americans make up a little more than 6% of the population; data continues to show disparities in their health status. The SFDPH is committed to improving health amongst our Black residents. The department has selected four priority areas to focus on through this strategic plan.

Priority Areas Black/African American Health	
Heart Health	The department will work with the community and partners to tailor a campaign to increase awareness about heart disease prevention and empower Black residents to take control of their heart health. The department will also use quality improvement activities to standardize the delivery of care for patients with high blood pressure.
Women's Health	The department is committed to advancing Black women's health in SF. The efforts will begin by supporting efforts to decrease the time between diagnosis and treatment and increasing efforts to ensure that women who are diagnosed with breast cancer achieve optimal health outcomes.
Sexual Health	This priority areas will focus on increasing good reproductive and sexual health for young Black females, including good communication about sex, decrease rates of STDs, increase rates of condom use with culturally-specific sexual health programs and services.
Behavioral Health	Through the integration of behavioral health and primary care and through partnerships with Community Providers, the department will address the mental wellbeing among Black male patients and develop strategies to decrease the misuse of alcohol.

This Strategic Plan identifies four headline indicators that will be used to measure progress in optimizing the health of the Black residents of SF. The next phase of the process will be to work with the department's San Francisco Health Network to review all of the current efforts and work together to develop common performance measures and strategies that aim to improve the quality of life in the Black/African American communities of San Francisco.

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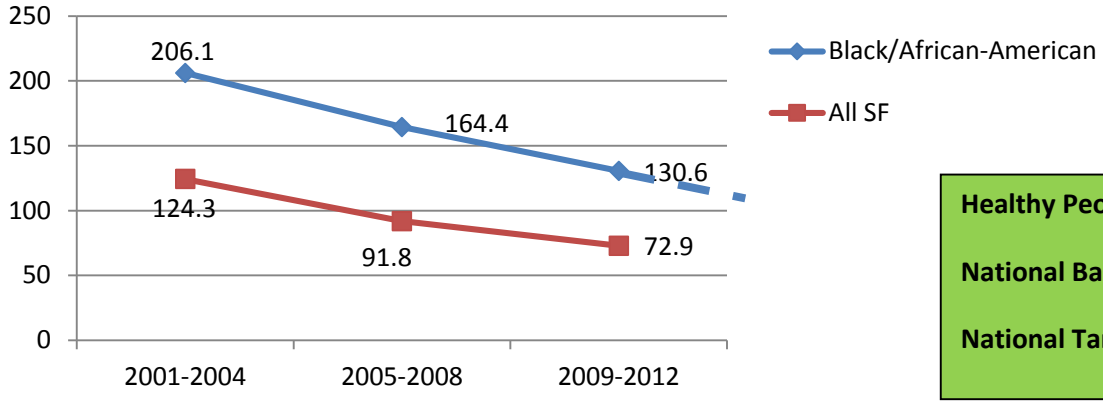
Headline Indicator: Percent of Blacks/African Americans with heart disease

BASELINE CURVE

Black/African American and San Francisco Ischemic Heart Disease Rate, per 100,000 population



Healthy People 2020:

National Baseline: 120.6

National Target: 100.8

Data source: California Department of Public Health annual county death files

STORY BEHIND THE BASELINE

As the result of better medical interventions, including support to decrease smoking and increase screening of cholesterol, hypertension (also known as high blood pressure), and universal access to care in San Francisco, there has been improvement overall. However, a great disparity remains for Black/African American San Franciscans. The trend may continue to go down, however it is unclear whether it is a result of better care or the significant out-migration of Black residents over the last 15 years, which might account for some of the changes seen in the data. However, the disparities in health remain at least double for all indicators. In a study published in 2008, heart disease is still the leading cause of premature death among Black/African American males in SF.

Ischemic Heart Disease (Coronary Artery Disease) is the leading cause of death in the United States, affecting over 5 million Americans. It is a narrowing of the coronary arteries, the vessels that supply blood to the heart muscle, generally due to the buildup of plaques in the arterial walls, a process known as atherosclerosis. Plaques are composed of cholesterol-rich fatty deposits, collagen, other proteins, and excess smooth muscle cells.

Black/African Americans have about a one-in-100 chance of developing heart failure while still in their 30s or 40s, a far higher rate than in whites. According to a longitudinal study that corroborates some differences between the races long observed in cross-sectional analyses, Black/African Americans' risk of heart failure at that age is closely tied to whether they have been diagnosed with hypertension, obesity, or renal dysfunction earlier in adulthood. One study showed that the precursors of heart failure are present when individuals are in their 20s. An elevated blood pressure and higher body-mass index were strongly associated with developing heart failure two decades later, when the individuals were in their 40s.

High blood pressure, obesity and diabetes are the most common conditions that increase the risk of heart disease and stroke. Studies have consistently reported a higher prevalence of hypertension in blacks than in whites, a main reason for the higher incidence of cardiovascular disease in blacks. Research suggests Black/African-Americans may carry a gene that makes them more salt sensitive, increasing the risk of high blood pressure. A higher sensitivity to alcohol could be added to that list.

Black/African-Americans are disproportionately affected by obesity. To assess differences in prevalence of obesity among blacks, whites, and Latinos, in 2009, CDC analyzed data from Behavioral Risk Factor Surveillance System (BRFSS) surveys conducted during 2006--2008. Overall, for the 3-year period, blacks (35.7%) had 51% greater prevalence of obesity, and Latinos (28.7%) had 21% greater prevalence, when compared with whites (23.7%). Black/African Americans are twice as likely to be diagnosed with diabetes as whites. In addition, blacks are more likely to suffer complications from diabetes, such as end-stage renal disease and lower extremity amputations. Although Black/African Americans have the same or lower rate of high cholesterol as their non-Hispanic white counterparts, they are more likely to have high blood pressure.

WHAT WORKS

- Quality improvement strategies for hypertension management: a systematic review.
- The effectiveness of urban design and land use and transport policies and practices to increase physical activity: a systematic review.
- Recommendations to increase physical activity in communities.
- Obesity Prevention and Control: Technology-Supported Multicomponent Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss.

PARTNERS

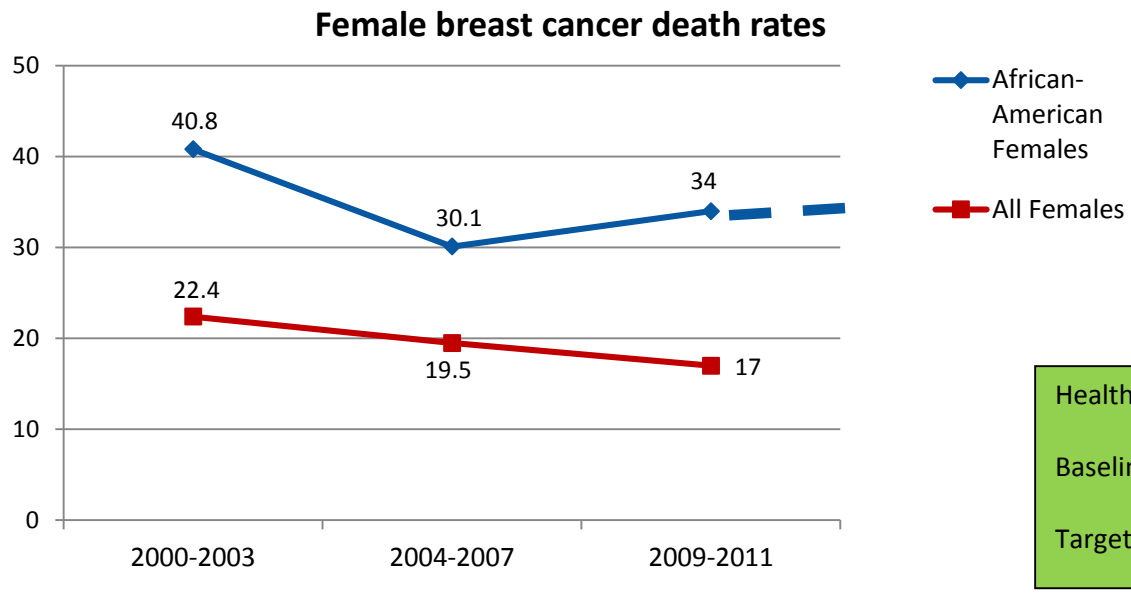
- San Francisco Health Network, Primary Care, Behavioral Health Services, Jail Health Services and Programs for Youth
- Community Based Organizations that provide services to Black/African Americans
- Colleges and Universities
- Churches and Religious Organizations
- Community (to participate and identify strategies)

STRATEGIES

- Customize and implement a culturally-appropriate Million Hearts Campaign for Black/African Americans in San Francisco
- Work with the SF Health Network to Increase screening for blood pressure, diabetes, and cholesterol
- Increase community-based physical activities and screening for hypertension, diabetes, and cholesterol

Headline Indicator: Mortality rate of Black/African American women with breast cancer

BASELINE CURVE



Healthy People 2020:

Baseline: 22.9

Target: 20.6

Data source: California Department of Public Health annual county death files

THE STORY BEHIND THE BASELINE

San Francisco was successful in reducing the black/white gap in mortality rate due to breast cancer between the years 2000-2007. The data shows that the gap widened again but, while the disparity is growing in many of the largest cities in the US, over the last 20 years, San Francisco has been able to maintain the status quo; and, if we do nothing different, that trend should continue. However, the gap remains unacceptable. As the data shows, a significant drop in the rate of death for both black and white women occurred between 2004 and 2007, lessening the disparity significantly. And, while there is a slight upward trend in the black rate, the current disparity is basically the same as in 2000.

Breast cancer is a type of cancer that forms in tissues of the breast. The most common type of breast cancer is ductal carcinoma, which begins in the lining of the milk ducts (thin tubes that carry milk from the lobules of the breast to the nipple). Another type is lobular carcinoma, which begins in the lobules (milk glands) of the breast. Invasive breast cancer is breast cancer that has spread from where it began to surrounding normal tissue. Breast cancer occurs in both men and women, although male breast cancer is rare.

San Francisco is fortunate to have a breast health program which provides patient navigation for those who are treated at our facilities. A significant factor reported by patient navigators within our system is that black women may be addressing co-morbidities which cause them to delay addressing a cancer diagnosis. And, recent studies have identified obesity as a factor in breast cancer.

Data shows that, generally, Black women are diagnosed at later stages than White women. Yet, the rate of screening for black and white women is nearly even today. There is recent research that shows that factors other than screening rates may be contributing to the continued disparity. A study of the quality of

mammogram images in Chicago, IL found that racial/ethnic identity and lower income were associated with lower quality of technician analysis which was subsequently associated with later stage at diagnosis; and, that university affiliated screening facilities provided more skilled technician image quality. The conclusion is that gains could be made in increasing image quality through better technician quality leading to earlier diagnosis. The department's breast health program completed its latest mammography technician training in Spring 2014 as a continuing quality improvement project.

San Francisco's breast cancer navigator program, by providing support to overcome these barriers, may be the primary answer to the question of how we have been able to keep the gap from growing.

WHAT WORKS

- Patient navigation and peer educators
- Systematic approaches for tracking screening results and assurance that follow-up and treatments are provided within predetermined intervals
- Centralized data system used to monitor and assure the quality of screening and timely diagnosis and treatment

PARTNERS

- San Francisco Health Network, Primary Care, SFGH Breast Clinic, Breast and Cervical Cancer Services, Behavioral Health Services
- San Francisco Women's Cancer Network
- Community Based Organizations who provide services to Black/African Americans
- Support groups/survivors, Community advocates, Churches and Religious Organizations
- Colleges and Universities
- Pharmaceutical companies - clinical trials

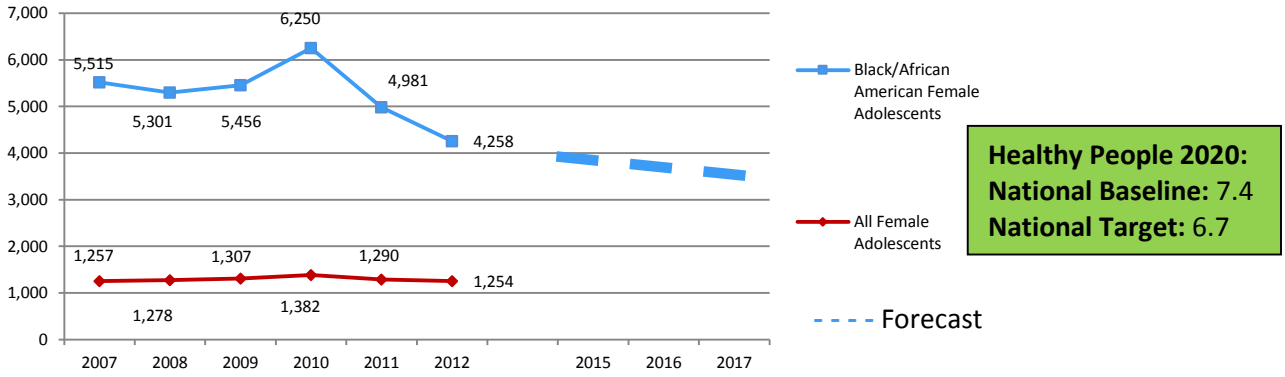
STRATEGIES

- Improve support systems for Black/African American women diagnosed with breast cancer
- Expand patient navigation programs in other settings including SFGH Women's Cancer Center
- Lessen time between screening that shows questionable results and diagnosis/treatment of Black/African American women

Headline Indicator: Rates of Chlamydia among young Black/African American women

BASELINE CURVE

San Francisco Chlamydia Rates (per 100,000) Among Adolescent Females (<26), 2007-2012



Healthy People 2020:
National Baseline: 7.4
National Target: 6.7

Data source: STD Surveillance Data, San Francisco Department of Public Health

THE STORY BEHIND THE BASELINE

While the rates of chlamydia among Black/African American young women decreased between 2010-2012, rates of these infections are still disproportionately high compared to other young women in San Francisco. We are not certain of all the factors that led to the decrease, but there are several that may be contributing including high levels of screening and treatment in youth clinics and youth detention, providing treatment to the partners of patients diagnosed with chlamydia (expedited partner therapy), and sexual health education efforts through the SFDPH - Youth United Through Health Education (YUTHE) team and others. Based on our current knowledge, we forecast that chlamydia rates in young African American women in San Francisco will continue to decline in the coming years, but rates will still exceed those of their peers.

Chlamydia is the most commonly reported STD in the United States. It can cause serious, permanent damage to a woman's reproductive system, making it difficult or impossible for her to get pregnant later on. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the womb).

Factors that might negatively affect the trend may be stigma about sexual health and STDs, economic and safety concerns that overshadow health, and the fact that the number of African American youth in San Francisco continues to decrease, with possible loss of community identity and cohesion. Furthermore, over 50% of chlamydia infections are asymptomatic, especially among females, and are diagnosed and treated solely through screening[1]. Chlamydia screening of all sexually active women 25 years and younger is a level "A" recommendation of the United States Preventive Services Task Force (USPSTF)[2] and covered without cost to patients under the Affordable Care Act, but screening levels at SFDPH clinics, including those that serve a large population of African American patients, are varied, and have room for improvement (SFDPH unpublished data).

WHAT WORKS

- Annual screening for all young women under age 26
- Condom distribution and Health Education
- Access to high quality sexual health services

PARTNERS

- San Francisco Health Network, Primary Care, and Programs for Youth
- Community Based Organizations and youth serving agencies
- San Francisco Unified School District and SF Juvenile and Adult Detention
- Community, especially youth (to participate and identify strategies)

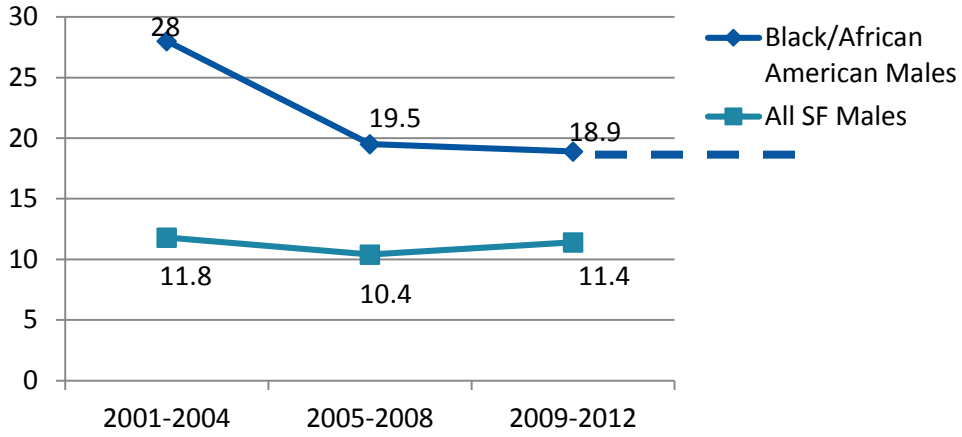
STRATEGIES

- Increase routine chlamydia/gonorrhea screening for Black/African American adolescent females
- Develop priority agenda through SFDPH African American Health Initiative Working Group
- Promote healthy sexual relationships among Black/African American young women

Headline Indicator: Mortality rates among Black/African American men due to alcohol

BASELINE CURVE

Black/African American and San Francisco Male Cirrhosis Death Rates, 2001-2012



Healthy People 2020:

National Baseline: 9.1

National Target: 8.2 (10% improvement)

Data source: California Department of Public Health annual county death files

STORY BEHIND THE BASELINE

While there was a significant decline from 2001-2005 in the rates of death due to Cirrhosis in San Francisco (SF) amongst Black/African American male, the rate has been stable since 2005. Black males also continue to be disproportionately affected by the disease as compared to all males. This signifies that we will need to review our current strategies or the trend in rate of death will continue to stay the same. In a study published in 2008, alcohol disorders were the fourth leading cause of premature death among Black/African American males in SF.

Cirrhosis is a slowly progressing disease in which healthy liver tissue is replaced with scar tissue, eventually preventing the liver from functioning properly. The scar tissue blocks the flow of blood through the liver and slows the processing of nutrients, hormones, drugs, and naturally produced toxins. It also slows the production of proteins and other substances made by the liver. Hepatitis C, fatty liver, and alcohol abuse are the most common causes of cirrhosis of the liver in the United States.

Drinking alcohol has effects that can increase the risk of many harmful health conditions in addition to Cirrhosis. According to the CDC, excessive alcohol use, including underage drinking and binge drinking, can lead to increased risk of health problems. Excessive alcohol use has immediate effects that increase the risk of many harmful health conditions. These immediate effects are most often the result of binge drinking and include unintentional injuries, violence, risky sexual behavior, and alcohol poisoning. Over time, excessive alcohol use can lead to the development of cardiovascular problems neurological impairments, psychiatric problems, and social problems.

Research findings on drinking patterns and problems among African Americans can be summarized as follows: (1) African Americans report higher abstention rates than do whites; (2) African Americans and whites report similar levels of frequent heavy drinking; (3) rates of heavy drinking have not declined at the same rate among African American men and women as among white men; and (4) variables such as age, social class, church attendance, drinking norms, and avoidance coping may be important in understanding differences in drinking and drinking problem rates among African Americans and whites.

Researchers have also found that, compared to whites, African Americans report later initiation of drinking, lower rates of use, and lower levels of use across almost all age groups. Nevertheless, African Americans also have higher levels of alcohol problems than whites. After reviewing current data regarding these trends, the researchers provide a theory to understand this apparent paradox as well as to understand variability in risk among African Americans. Certain factors appear to operate as both protective factors against heavy use and risk factors for negative consequences from use. For example, African American culture is characterized by norms against heavy alcohol use or intoxication, which protects against heavy use but also provides within-group social disapproval when use does occur. African Americans are more likely to encounter legal problems from drinking than whites, even at the same levels of consumption, perhaps thus resulting in reduced consumption but more problems from consumption. There appears to be one particular group of African Americans, low-income African American men, who are at the highest risk for alcoholism and related problems. Researchers theorize that this effect is due to the complex interaction of residential discrimination, racism, age of drinking, and lack of available standard life reinforcers (e.g., stable employment and financial stability). Further empirical research will be needed to test their theories and otherwise move this important field forward.

WHAT WORKS

- Preventing Excessive Alcohol Consumption: Electronic Screening and Brief Interventions (e-SBI)
- Increasing alcohol beverage taxes is recommended to reduce excessive alcohol consumption and related harms
- Recommendations on maintaining limits on days and hours of sale of alcoholic beverages to prevent excessive alcohol consumption and related harms
- Recommendations for reducing excessive alcohol consumption and alcohol-related harms by limiting alcohol outlet density

PARTNERS

- San Francisco Health Network, Primary Care, Behavioral Health Services, Jail Health Services and Programs for Youth
- Law enforcement and criminal justice system
- Community Based Organizations who provide services to Black/African Americans
- Colleges and Universities
- Churches and Religious Organizations
- Community (to participate and identify strategies)

STRATEGIES

- Implement and improve SF performance standards for all off-sale alcoholic beverage premises
- Work with the SF Health Network to develop evidence based practice and harm reduction approaches within for African-American males who use alcohol

Focus Area: Mother, Child and Adolescent Health

The life course approach to thinking of health care needs and services evolved from research documenting the important role early life events play in shaping an individual's health path. The relationship of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime. San Francisco is committed to supporting health and wellness throughout the lifespan of its residents. The mission of the Maternal, Child and Adolescent Health (MCAH) Branch is to promote the health and well-being of women of childbearing age, families, infants, children and adolescents. MCAH focuses on the most vulnerable children and families and fills what would otherwise be a serious public health gap. MCAH assesses the health of the population, and identifies and addresses urgent issues in collaboration with key partners. The work of MCAH is critical to protecting and promoting the health of San Francisco women and children. MCAH aims to reduce health disparities and improve health outcomes by strengthening the public health systems and services that address the root causes of poor health.

Supporting the health and wellness of mothers, children, and adolescents is important because:

- Promoting health in infancy, early childhood, and childhood is the key to lifelong health and wellness, reducing disparities, preventing and minimizing chronic conditions, and ultimately reducing health care costs.
- Prevention and early intervention with women of child bearing age, children, and youth result in proven long-term benefits in school readiness, adult productivity, life expectancy, and cost savings for more intensive services.

The special needs of children and youth with chronic conditions demand specialized policy and program development and progression of disease and disability require services tailored to the specific needs of children, youth, and mothers.

Priority Areas for Mother, Child, and Adolescent Health	
Healthy Births Outcomes	In working with community and providers across San Francisco, the department is committed to lowering the number of pre-term births.
Child Well Treatment	The department is actively working to lower the rate of substantiated child maltreatment.
Children's Oral Health	The department is engaging the community to prevent caries and to identify and treat caries as early as possible.

This Strategic Plan identifies three headline indicators that will be used to measure progress in optimizing the health of mothers, children, and adolescent residents of SF. MCAH leverages clinical and community experience, shared resources, and collaborations to develop upstream policies and systems that improve health and living conditions; and in selecting these priority areas, the life course was taken into consideration.

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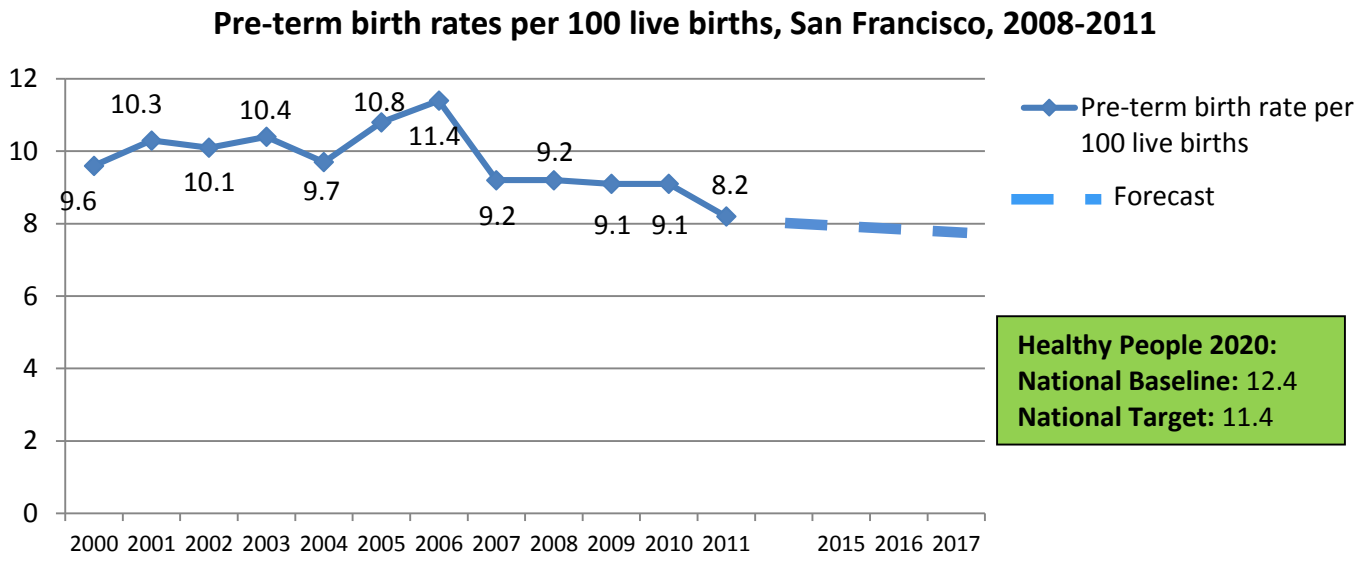
Headline Indicator: Percent of pre-term infants

BASELINE CURVE



Data source: California Department of Public Health annual county birth files

THE STORY BEHIND THE BASELINE

For the percent of pre-term and low birth weight infants citywide, rates are improving; however, ethnic and social economic status (SES) disparities are worsening. Going without prenatal care can cause many problems for women and their babies. Studies show that women who do not get prenatal care often have more complicated (and expensive) births. The health department monitors the rates and risk factors of pre-term birth through birth record data. The pre-term rate of specific at-risk groups shows the social disparities, associated risk factors, and opportunities for improvement.

Delivering a baby before 37 weeks is called a preterm birth and the baby is considered premature. Pre-term birth can cause serious health problems or even be fatal for a baby, particularly if it happens very early. In general, the more mature a baby is at birth, the better his/her chances of surviving and being healthy.

Research has shown that in most cases, pinpointing the exact cause of pre-term birth cannot be identified. Therefore, issues connected to early delivery have been looked at to help explain the cause. There are a number of risk factors that may contribute to birthing prematurely these include smoking, abuse of alcohol, or using drugs (especially cocaine) during pregnancy. Evidence indicates that some psychosocial factors in the cause of preterm birth include major life events, chronic and terrible stress, maternal anxiety, personal racism, and lack of support. Studies have also shown that a collection of healthy lifestyle behaviors are associated with more positive pregnancy outcomes. These may include a healthy diet, plenty of rest, starting prenatal care early, regular checkups, leisure time physical activity, and managing stress level.

Evidence has shown that the following primary prevention for women can improve pregnancy outcomes:

- Public educational interventions – Inform public about potentially avoidable risk factors
- Workplace policies, for example: Minimum duration of paid pregnancy leave of 14 weeks, time off for prenatal visits, release from night shifts, and protection from workplace hazards
- Smoking control and prevention

For decades, medical practice in the United States has steadily improved its clinical management of preterm labor and medical care of premature babies. However, families of lower socioeconomic status are still disproportionately affected by preterm births. In the past decade, increasing understanding about the social, psychological, and behavioral factors of preterm labor have led to logical and evidence-based interventions that address inequities in living and working conditions, stress, and access to healthcare.

WHAT WORKS

Preconception care services for the prevention of preterm birth for all women:

- Prevent pregnancy in adolescence
- Prevent unintended pregnancies and promote birth spacing and planned pregnancies
- Optimize pre-pregnancy weight
- Promote healthy nutrition including supplementation/fortification of essential foods with micronutrients
- Promote vaccination of children and adolescents

Preconception care services for women with special risk factors that increase the risk for preterm birth:

- Screen for, diagnose and manage mental health disorders and prevent intimate partner violence
- Prevent and treat sexually transmitted infections (STIs), including HIV/AIDS
- Promote cessation of tobacco use and restrict exposure to secondhand smoke
- Screen for, diagnose and manage chronic diseases, including diabetes and hypertension

PARTNERS

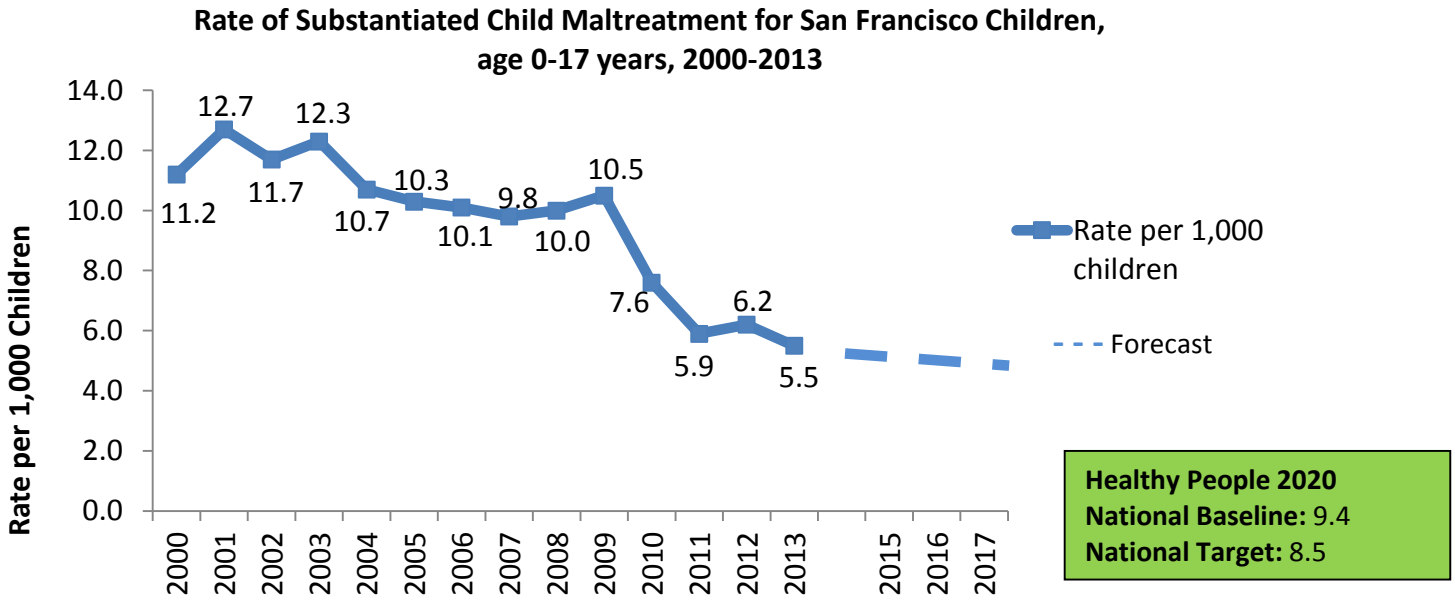
- Health Plans
- Prenatal care and obstetrics
- Primary care & Family Planning
- San Francisco Unified School District
- CBOs serving Transitional Age Youth, Adolescents
- Governmental agencies serving women and children, including Human Service Agency, Housing Authority, First 5, DCYF, Office of Economic and Workforce Development
- CBHS, Mental Health, and Substance Use Prevention Services

STRATEGIES

- Increase utilization of preconception care for young women, particularly those experiencing high-risk exposures
- Develop citywide plan to improve young women's health in San Francisco
- Integrate pre-conception health message and services into activities

Headline Indicator: Rate of substantiated child maltreatment

BASELINE CURVE



Data source: UC Berkeley Center for Social Services Research

THE STORY BEHIND THE BASELINE

The San Francisco rate of substantiated child maltreatment moved in a positive direction over the past 14 years, decreasing from 11.2 to 5.5 cases per 1,000 children aged 0-17 years. The rate declined minimally during the decade from 2000 to 2009, dropped substantially over the next two years, and stagnated between 2011 and 2013. Racial–ethnic disparities in the rate worsened over the time period under review. In 2013, Asian children had the lowest rate (1.7); White children had the second lowest (2.6); Latino children had a rate over three times that of Whites (9.6); and Black children had a rate over 16 times that of Whites (32.9). Approximately 800 San Francisco children aged 0-17 remain in out of home placements in 2014.

Child maltreatment is physical abuse, sexual abuse, emotional abuse or neglect of a child under 18 years of age by a parent or care giver. Approximately 80% of child maltreatment cases include neglect, which is the failure to meet a child's basic needs, e.g., housing, food, clothing, medical care.

Child maltreatment causes suffering to children and families and can have long-term consequences. Maltreatment causes stress that is associated with disruption in early brain development. Extreme stress can impair the development of the nervous and immune systems. Consequently, as adults, maltreated children are at increased risk for behavioral, physical and mental health problems such as: perpetrating or being a victim of violence; depression; smoking ; obesity; high-risk sexual behaviors; unintended pregnancy; and alcohol and drug misuse. These risk factors can lead to long term health issues such as heart disease, cancer, suicide and sexually transmitted infections.

The health department partners with the city's Human Services Agency (HSA) which implemented significant improvements in the 2000's that came before the reduction in rates seen after 2009. The policy and program changes are described below:

- HSA instituted a process which divided the reporting of child abuse and neglect by risk level. Children reported at high or moderate risk are addressed directly by HSA. Children reported at lower risk where HSA does not open a case, are referred to community organizations (CBO's) for family support services to help reduce the future risk of a report.

- HSA standardized the family assessment of risk and safety. When children are assessed as being at lower risk, they are more likely to be left in the care of their families because of confidence in the results of the assessment.

In addition, several years ago, City funders required that Family Resource Centers and other community programs offering parent education to transition to an evidence-based curriculum. The health department's Community Behavioral Health section administers the Parent Training Institute, which administers parent education classes, and implements an evaluation of program impact.

WHAT WORKS

- Effective programs aimed at prevention of child maltreatment include family support, such as parent education and skills training, home visiting, or similar services
- Strengthening parent-child relationships through education about child development, communication and discipline
- Provision of social support to reduce stress and offer models of stable family life
- Treating parents with mental health or substance abuse problems
- The Departments of Public Health and Human Services recommend:
  - Parenting education , support groups, and family strengthening programs
  - Home visiting to pregnant women and families with infants, e.g., Nurse Family Partnership
  - Respite care for families that have children with special health care needs
  - Family Resource Centers
  - Behavioral health services for parents with mental health and substance abuse problems

PARTNERS

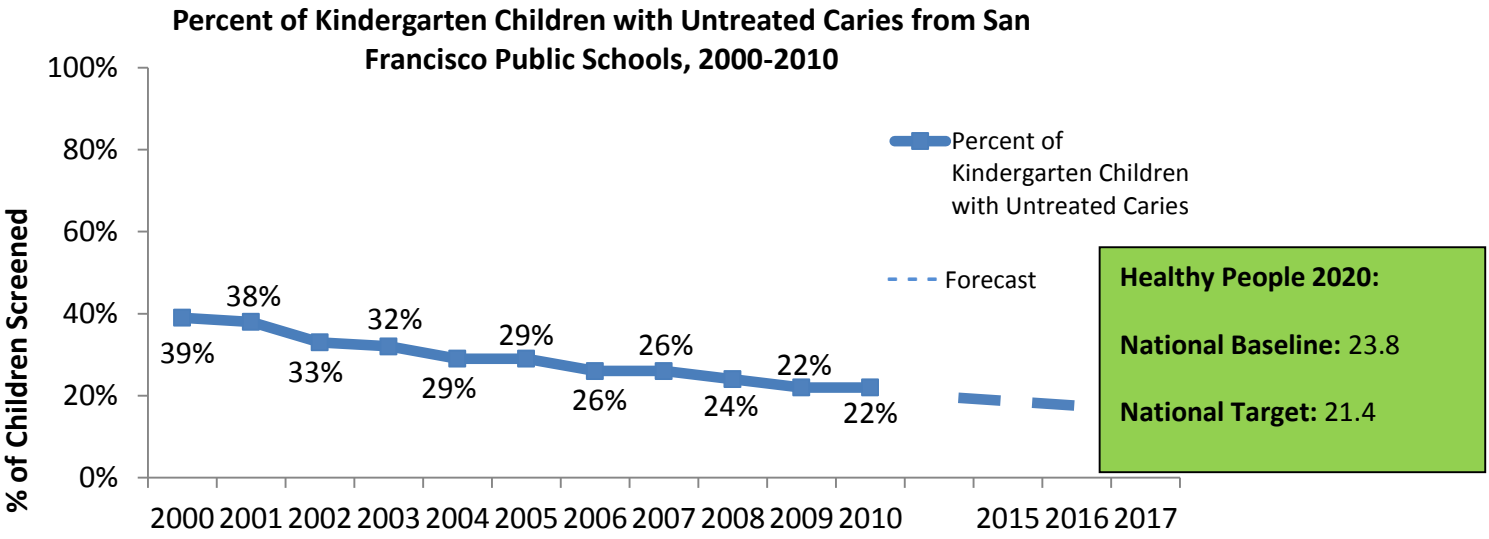
- San Francisco Human Services Agency, Mayor's Office of Housing
- Behavioral Health Services, Public Health Nursing
- Community Based Organizations
- Community members

STRATEGIES

- Promote safe, stable, and nurturing relationships and environments for children and families.
- Improve the social environment for young families to reduce stressful circumstances
- Ensure cultural and linguistic relevance of family support activities

Headline Indicator: Proportion of Kindergarteners that are caries free (no experience of caries)

BASELINE CURVE



Data source: San Francisco Unified School District Oral Health Screening Program

THE STORY BEHIND THE BASELINE

Oral health is essential to overall health. Children with untreated caries (cavities) experience pain, dysfunction, school absences, difficulty concentrating, and low self-esteem—problems that affect a child's quality of life and ability to succeed. Although almost entirely preventable, dental caries is the most common chronic disease affecting children. This is evident in San Francisco with 34% of children having experienced dental decay by the time they entered kindergarten and 22% with untreated caries in public schools. Low-income and minority populations are affected disproportionately by caries, both caries experience and untreated decay.

Dental cavities are holes (or structural damage) in the teeth. Oral health is essential to overall health. Children with untreated cavities experience pain, dysfunction, school absences, difficulty concentrating, and low self-esteem—problems that greatly affect a child's quality of life and ability to succeed. Because caries experience includes current and past tooth decay, it is an indication of pre-school and toddler oral health.

In San Francisco, 13.3% of children live in poverty. These children face significant barriers in accessing healthcare and have higher rates of dental decay. In the lowest-income schools in San Francisco (those with 100% of children eligible for free or reduced meals), over 40% of children have dental decay. And although all low-income children who qualify for Medi-Cal (California's Medicaid program) also receive dental benefits through Denti-Cal, these services are greatly underutilized. From 2011-2012, over half of Denti-Cal eligible children in San Francisco did not see a dentist.

Most San Francisco residents living in poverty also belong to racial and ethnic minorities, another factor leading to oral health disparities. Black, Latino, and Asian families experience higher levels of poverty than White residents and also experience far greater rates of dental decay. In San Francisco, only 9.5% of White residents are living below the federal poverty level (FPL), while 29.7% of Blacks, 16.6% of Latinos, and 12.9% of Asians are below the FPL. In San Francisco, 16% of White kindergarten children have experienced caries, compared to 38%, 37%, and 43% of Black, Latino, and Chinese children, respectively. In

particular, rates of caries have been shown to be drastically higher in areas of San Francisco with high concentrations of immigrant populations, especially Chinatown. Because prevention is the most cost effective strategy to reduce dental disease, most dental public health experts emphasize the impact of primary prevention. If our prevention efforts are successful, caries experiences should decrease.

Gaps to address:

- More than half of children and youth do not see a dentist annually
- Disparities in Denti-Cal utilization by income, which is reflected in ethnicity and neighborhood
- Low utilization of dental sealants
- Systematic targeted education during the perinatal period is not taking place
- Many private dentists do not accept the 0-3 year old children

Challenges:

- Denti-Cal reimbursement was reduced by 10%, causing the nunber of Medi-Cal dentists to drop
- *Safety Net* Dental Clinics are short staffed and cannot meet demand
- Medi-Cal Fluoride Varnish benefit is being provided in only a handful of clinics
- Oral health screening and referral follow-up is voluntary in SFUSD schools
- Denti-Cal utilization is low due to:
  - Lack of access to dentists and long wait times for appointments
  - Dental care is seen as a low priority
  - Parents' health status and stress levels influence their trust in and use of health care services

WHAT WORKS

- Dental care, including fluoride treatments, and dental sealants, has been proven to prevent tooth decay; treatments offered in both dental, medical and school settings
- Access to Dental Care: Promoting age 1 dental visit; increase Denti-Cal utilization
- Community wide promotion of oral health education; reach parents early, often using varying modalities[11]
- The co-location of school based dental services
- Annual oral health screenings for low-income children enrolled in subsidized child care centers
- Programs to systematically increase tooth brushing in some child care
- Intensive, multi-lingual, team case management
- Universal health insurance for low income children (Denti-Cal and Healthy Kids)

PARTNERS

- San Francisco Dental Society
- San Francisco Unified School District
- San Francisco Dental Hygiene
- San Francisco Child Health & Disability Prevention (CHDP) Program
- University Dental Schools
- Pre-school agencies
- Children's Medical Service
- Native American Health Center Dental Clinic

STRATEGIES

- Start upstream and Integrate oral health with medical health:
  - Provide outreach and education to families on the availability and importance of oral health services for young children
  - Increase the number of dentists that accept Denti-Cal patients

Focus Area: Health for People at Risk or Living with HIV

San Francisco has a strong history of leadership addressing HIV. Our efforts have brought a leveling of new infections, with some indication of a downward trend. HIV, once epidemic, is now considered endemic (persistent and established) in San Francisco. While there have been some successes, high prevalence populations continue to exist: gay and bisexual males and other males who have sex with males (MSM); transgender females who have sex with males; and injection drug users (IDU). In addition, there are populations disproportionately impacted by HIV-related morbidity and mortality, particularly Latino and African American MSM. Given these disparities and the endemic state of HIV, we must refocus our efforts by promoting scalable, innovative, integrated, effective interventions reaching high-prevalence populations. In addition, we must promote structural approaches to curb new infections and ensure people living with HIV achieve optimum health.

Approximately 207-429 people continue to become infected each year in San Francisco. In San Francisco the estimate of people unaware of their HIV status is 6.4% overall and 7.5% for MSM. Current HIV testing frequency among high-prevalence populations is insufficient to reduce the unknown infection rate. One in four people living with HIV are not engaged in primary medical care, and 32% of newly diagnosed cases remain unsuppressed within a year of diagnosis. HIV prevalence increases every year due to longer survival and a rate of new infection that more than replaces deaths due to AIDS. Thus, the endemic state of HIV is no cause for complacency.

San Francisco's HIV efforts focus on reaching the individuals at highest risk for HIV with primary prevention and testing efforts and ensuring those living with HIV are reached by a continuum of secondary and tertiary prevention efforts – that they know their status, receive partner services, are linked to care, remain engaged in care, and achieve viral suppression. This progression of the HIV continuum of care informed our headline indicators: the reduction of new HIV diagnoses, increasing access to care for newly diagnosed with HIV, and, for people living with HIV, viral suppression.

Priority Areas for Health for People at Risk of Living with HIV	
Reducing New HIV Diagnoses	The department is committed to reducing the number of people who are newly diagnosed with HIV.
Access to Care for Newly HIV Diagnosed	Earlier care leads to higher life expectancy and better quality of life for people living with HIV. The department's goal is for all newly diagnosed with HIV to be engaged in care within three months.
Viral Suppression	Viral suppression, an important measure that is also a proxy for quality access to care and treatment, is a priority goal.

This Strategic Plan identifies three headline indicators that will be used to measure progress in optimizing the Health for People at Risk or Living with HIV residents of SF. San Francisco community and departmental leadership, coupled with action at the federal level through the National HIV/AIDS Strategy and the Affordable Care Act, and the growing body of research showing treatment as prevention, make this an exciting and hopeful time for addressing HIV in San Francisco.

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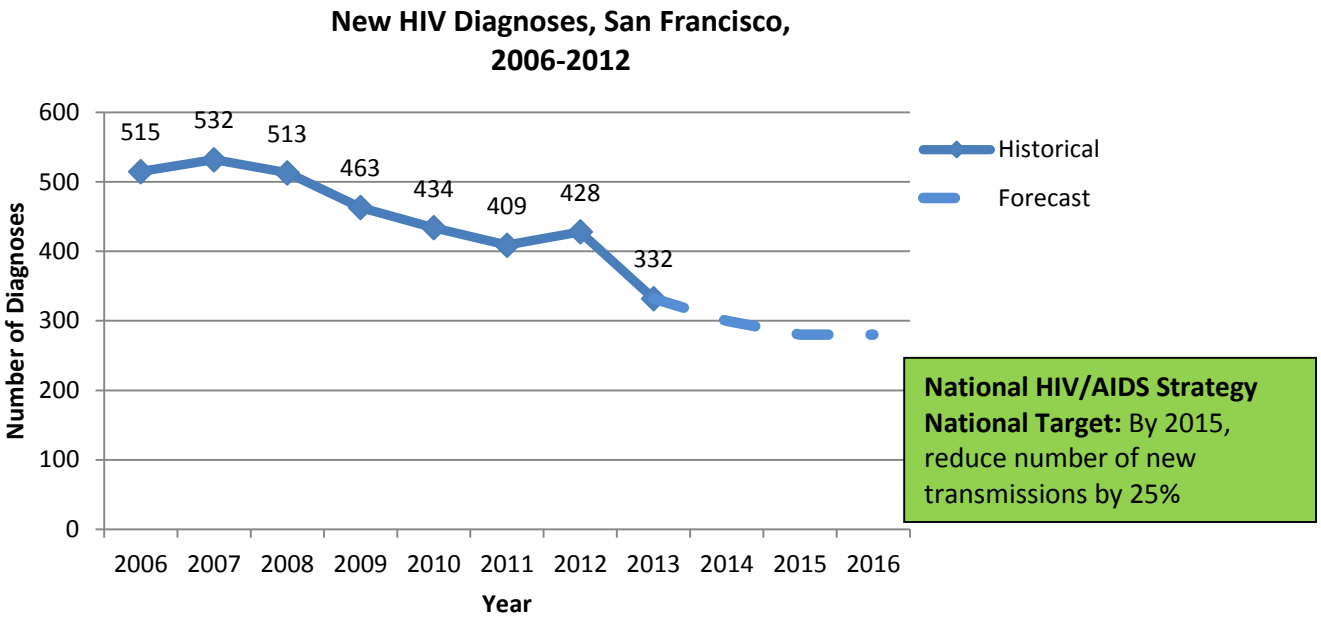
Headline Indicator: Number of new HIV diagnoses

BASELINE CURVE



Data Source: HIV Surveillance Data, San Francisco Department of Public Health

THE STORY BEHIND THE BASELINE

New HIV diagnoses have declined in San Francisco since the late 2000's; and the graph above shows data since 2006 when newly diagnosed cases began being reported by name in California. Evidence indicates that the decrease in new diagnoses is likely due to three factors related to the preventive effects of early HIV treatment: 1) increased rates of HIV testing, including detection of early HIV infection (which reduces HIV transmission); 2) earlier, rapid and effective linkage of HIV infected people into care, which ensures earlier treatment; and 3) increased uptake of highly effective HIV treatment, which makes it less likely for an HIV positive person to transmit HIV. We believe that these factors, in a context of stable rates of risk behavior for much of the period, along with continuous support for evidence based practice will continue to lead health outcomes in a positive direction.

An HIV diagnosis is conducted with tests used to detect the presence of the human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS). Such tests may detect antibodies, antigens, or RNA. Long term trends in the reduction of numbers of new diagnoses of HIV may be used as a way to monitor the trends of new infections.

The San Francisco epidemic continues to be concentrated in gay and bisexual males and other males who have sex with males (MSM) who continue to make up 85% of new diagnoses. San Francisco appears to be on a strong path to improvement with this population and we believe we could achieve additional substantial reductions in new HIV infections by continuing current strategies and adding three new strategies that are coming available: 1) Use 4th generation HIV tests in community-based sites which are much more sensitive in detecting acute infection (acute HIV infection is the period of time immediately following infection with HIV) ; 2) Scale-up HIV pre-exposure prophylaxis (PrEP) for persons at increased risk; and 3) Increase integrated health and wellness community and clinical programs that include case management to help link HIV negative people

PrEP is a new HIV prevention method in which people who do not have HIV take a daily pill to reduce their risk of becoming infected. When used consistently, PrEP has been shown to reduce the risk of HIV infection.

to Pre-Exposure Prophylaxis (PrEP) and HIV positives to care. Special efforts must be given to novel programs that reach young MSM, as well as Latino and African American MSM who remain at disproportionately high risk for HIV.

WHAT WORKS

- HIV testing for previously undiagnosed HIV positives (which gets them into care, reduces risk practices)
- Case management services that link people newly diagnosed to care, link known positives back into care, and support retention in care to decrease the time between diagnosis and initiation of medical care and treatment
- Treating HIV infected persons to improve their own health and to reduce transmission to HIV uninfected partners
- Pre-Exposure Prophylaxis for HIV negatives to prevent HIV acquisition

PARTNERS

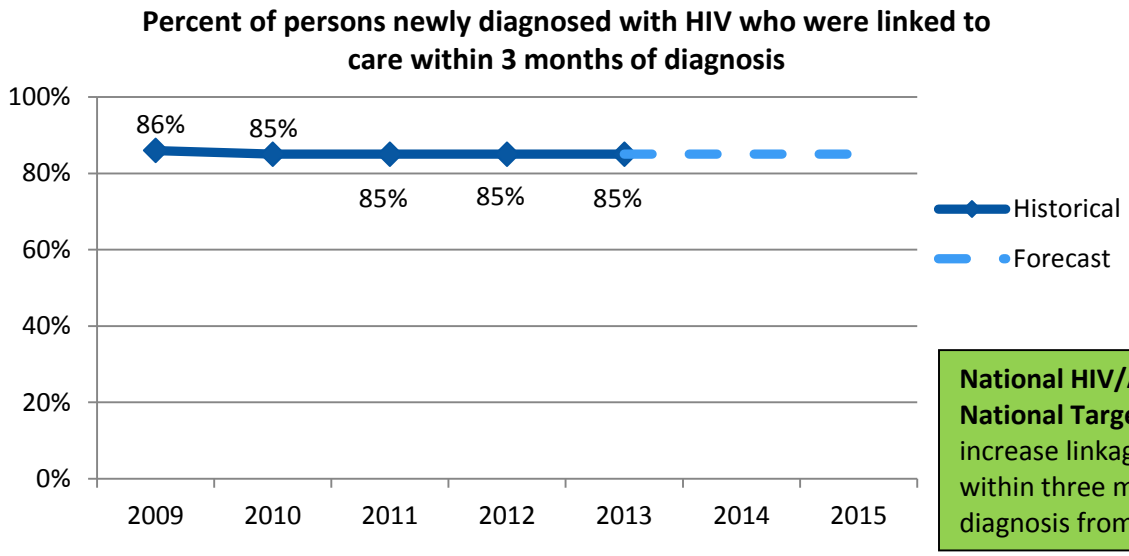
- Community-Based Organizations
- Insurance providers, care providers
- Private Labs and Pharmacies
- Research community
- At risk communities

STRATEGIES

- HIV Testing: Develop and implement strategies to increase HIV testing with 4th generation assays at appropriate intervals. Explore innovative strategies such as utilizing electronic medical record systems to flag patients due for an HIV test.
- Pre-Exposure Prophylaxis (PrEP): Scale up capacity to deliver PrEP among providers and increase interest and knowledge about PrEP among potential users. This would include potentially offering PrEP after an HIV negative test for MSM and Trans women at substantial risk.
- Health and Wellness: Increase integrated health and wellness care for MSM with case managers, including both HIV and non-HIV care. Pay particular attention to African American MSM in whom HIV diagnoses are declining less than in diagnoses in other groups.

Headline Indicator: Percent of newly diagnosed with HIV who receive care

BASELINE CURVE



National HIV/AIDS Strategy National Target: By 2015, increase linkage of care within three months of HIV diagnosis from 65% to 85%

Data Source: HIV Surveillance Data, San Francisco Department of Public Health

THE STORY BEHIND THE BASELINE

Timely linkage to medical care is a hallmark of San Francisco's comprehensive HIV prevention plan. HIV infected persons in medical care not only have improved individual health and wellness but are also more likely to be virally suppressed, thereby reducing subsequent HIV transmission to others. San Francisco has implemented a number of programs to enhance timely linkage to care for newly diagnosed persons which has resulted in the high and sustained trend.

Linkage to care is defined as a person newly diagnosed with HIV receiving HIV medical care within 90 day after receiving their diagnoses.

One SFDPH program that contributes to the city's success in linkage is the Linkage, Integration, Navigation, and Comprehensive Services Team (LINCS), which identifies, locates, and connects those who test positive for HIV to HIV care services and ensures those who have fallen out of care are re-engaged. In addition, LINCS works with these individuals to support notifying their sexual and/or needle-sharing partners they may have been exposed to HIV and offer testing to these partners. If the partners test negative, LINCS staff work with them on primary prevention efforts to support them to stay negative. If they test positive, a LINCS staff member offers assistance with linkage to care and partner services. San Francisco General Hospital (SFGH) has another program, known as Positive Health Access to Services and Treatment (PHAST) team that encourages increased HIV testing in clinics and links newly diagnosed persons into care.

Improvements, especially among some underserved and more difficult to reach populations, need to be made to achieve better rates of linkage. Younger adults, African Americans, MSM who inject drugs and those with no reported risk (NRR) all had substantially lower rates of linkage to care than other groups. The LINCS program

takes a holistic approach to linking patients to care and supporting other needs, such as housing, substance abuse, other social services and food assistance; needs that may impact their ability to successfully link to and remain in HIV care. Additionally, HIV stigma, particularly among some HIV infected populations, may be a barrier to care, making access to culturally competent care a priority. Lastly, changes in health care delivery as a result of the Affordable Care Act (ACA) will likely change the landscape of HIV care and the role of public health in linking HIV infected persons to care. If done properly, ACA should increase rapid linkage to care. However, as the program is being rolled out, we anticipate some confusion about assignment of the primary care "home" for newly diagnosed persons, which could result in a delay in linkage to care.

WHAT WORKS

- Case workers, peer health navigators; "warm hand-off" directly to a provider from testing; linkage services, to decrease the time between diagnosis and initiation of medical care (and treatment)
- Social service support
- Access to insurance and health coverage

PARTNERS

- Medical providers
- HIV Positive community
- Community-Based Organizations
- LINCS, PHAST team
- Insurance providers

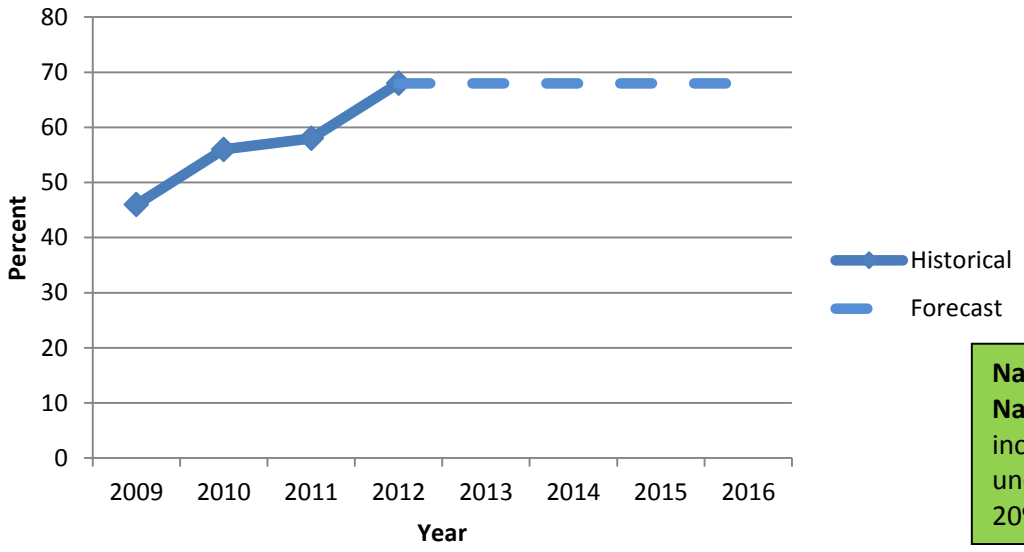
STRATEGIES

- Increase case management of newly diagnosed persons to facilitate rapid entry into care once tested positive
- Integrated/co-located HIV and non-HIV care services
- Addressing linkage to care by addressing other barriers to care such as housing, insurance, substance abuse and stigma.

Headline Indicator: Percent of people living with HIV who are virally suppressed

BASELINE CURVE

Proportion of newly diagnosed HIV positives achieving viral suppression within 12 months, San Francisco, 2009-2016



National HIV/AIDS Strategy National Target: By 2015, increase the proportion with undetectable viral load by 20%

Data Source: HIV Surveillance Data, San Francisco Department of Public Health

THE STORY BEHIND THE BASELINE

The data shows continued progress in maximizing viral suppression through anti-retroviral treatment (ART). Since 2009, the number of people with HIV who achieve viral suppression has improved over time. Data show that earlier treatment is beneficial for an HIV infected person's health and has the additional community benefit of reducing HIV transmission. In 2010, the SFDPH recommended universal HIV treatment to anyone newly diagnosed with HIV regardless of their immune status. Suppression of HIV viral load (<200 ml/copies) indicates that HIV infection is being well managed and data from HIV surveillance indicates that the percent of HIV infected persons who are virally suppressed is high in San Francisco and has increased over time. Viral suppression can be negatively influenced by lack of continuous medical care, poor adherence to HIV medications, substance abuse, lack of stable housing and weak social support. Furthermore, changes in the Ryan White program in the era of the Patient Protection and Affordable Care Act (PPACA) may require HIV infected patients to identify new HIV care providers which may result in delays or disengagement in care.

Achieving a low amount of HIV virus in your body— By taking ART regularly, one can achieve viral suppression, meaning a very low level of HIV in the blood. That is not a cure. There is still some HIV in the body. But, lowering the amount of virus in someone's body with medicines can keep them healthy, help them live longer, and greatly reduce chances of passing HIV on to others.

Therefore, we must develop strategies to address HIV positive persons who are not yet virally suppressed and to support efforts by those in care to stay in care. In many cases, these individuals may belong to socially or economically vulnerable populations, may struggle with substance use or mental health problems, and may require extensive support to not only remain in care, but to be able to benefit from consistently taking ART for

HIV. Data suggest that viral suppression rates are lower among HIV positive persons under 40 years old and the homeless. Careful monitoring of trends in viral suppression and identification of populations not achieving timely viral suppression after HIV diagnosis can assist linkage to care programs to reach people without adequate HIV care and address barriers to care and ultimately viral suppression. Support is needed not only for patients, but also for clinical providers who are counseling and supporting their patients and clients about early initiation of ARTs. Additional citywide efforts will be needed to understand and then address the needs of these populations if we are to further increase the percentage of people living with HIV in San Francisco who are virally suppressed.

WHAT WORKS

- Rapid linkage to care
- Health insurance to cover primary care and medication
- Case management for HIV positives who drop out of care or have difficulty with medication adherence
- SMS text linkage to clinic when initiating antiretroviral therapy

PARTNERS

- LINCS and PHAST teams
- HIV Care Council
- Community-Based Organizations
- Medical providers, Insurance providers, Pharmacies
- HIV positive community

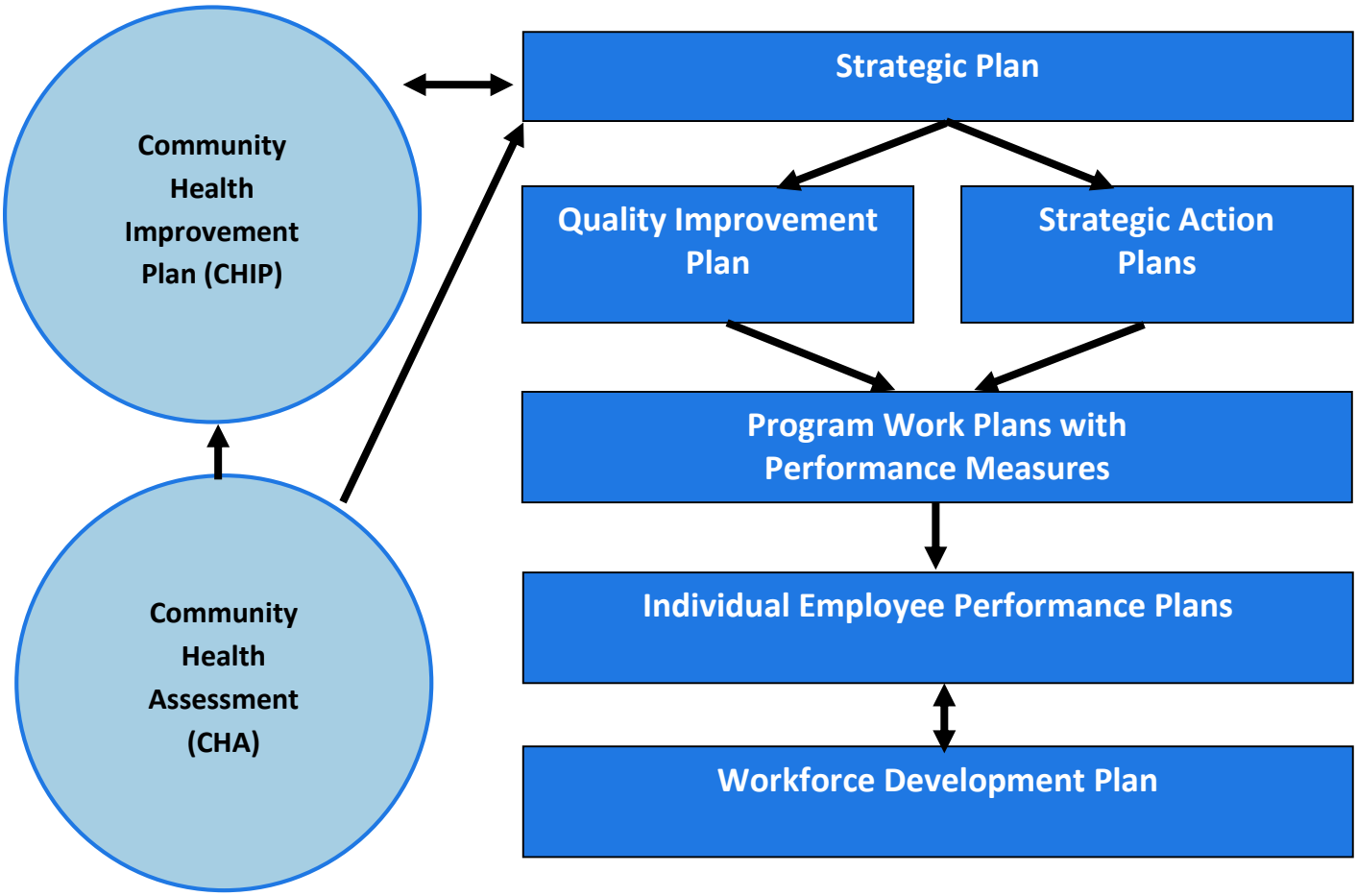
STRATEGIES

- Prioritize substance abuse treatment slots for patients not virally suppressed
- Provide comprehensive education to clinicians about the advantages of and recommendations regarding universal treatment at diagnosis
- Expand the use of HIV surveillance to identify patients who are not virally suppressed and refer these patients to LINCS

Next Steps

The Strategic Plan is just one part of our journey to developing an overall Performance Management System for the Population Health Division. The next steps are to develop the Quality Improvement Plan that provide the Branches, Offices, and Centers with the tools to supporting improvement processes that will be used to develop a Strategic Actions Plan for the Division. The Strategic Action Plan will outline the customers, performance measures, partners and strategies that will be used to contribute to the headline indicators identified in this Strategic Plan. The Program Work Plans that include performance measures will help shape each individual employee's performance plans. The Division is committed to ensuring that the staff has the ongoing technical skills and support they will need to develop a culture of quality improvement. This will be provided by a Division-wide Work Force Development Plan. Figure 3 provides you with the next steps and was adapted from the NACCHO document "*Developing a Local Health Department Strategic Plan: A How-To Guide"* and modified to meet our local framework.

Figure 3



Continuous Quality Improvement Plan

Introduction

The San Francisco Department of Public Health's Population Health Division (PHD) is committed to protecting and improving the health, safety, and well-being of all San Franciscans and those who visit our City. To sustain this commitment, we must constantly assess our performance and make changes and adjustments when necessary. While quality improvement has existed as a core operating principle in the fields of manufacturing and health care for decades, this is a new, but welcome, shift in the way we conduct our prevention oriented, population health work. To reflect our commitment to constant learning and adjustment, we have entitled this plan the Continuous Quality Improvement Plan (CQIP).

Our goal is to become a high performing organization that accomplishes its mission. We aim for a culture of continuous improvement. The purpose of this Plan is to provide a context and framework for quality improvement activities in PHD. This is the roadmap for our quality improvement program. It is based on our current reality, ongoing and planned quality improvement projects and trainings, and a proposed evaluation and monitoring process.

Our Strategic Plan is a communication and accountability tool as well as a quality improvement tool. Our Performance Management System links this Continuous Quality Improvement Plan, the Workforce Development Plan and our Emergency Preparedness and Response Plan to our overall 5-year Strategic Plan. The performance measures identified in the PHD Action Plan appended to this Strategic Plan are the quality improvement measures for the Division.

Description of Quality Improvement

Quality Improvement (QI) in public health is a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in our services. It uses established QI techniques, such as Plan-Do-Study-Act, which is an iterative, team oriented process to implement, adjust, and scale successful activities. Quality improvement in public health is the identification of inefficiencies (waste) which directly affect quality and cost; it is client focused and population focused; is both top down and bottom up; and is both process focused and organization-wide. Quality is never an accident. It is always the result of high intention, intelligent direction, and skillful execution. (It is important to note that QI in public health is not evaluation; it is not about meeting standards (quality assurance), and it is not about meeting specifications (quality control).)

Quality improvement can take place at different levels organizationally – macro, meso, and micro. At the macro level, quality improvement touches on systems improvements. For PHD, that includes results-based methods for collective impact. Meso level quality improvement includes the organizational level, which may include performance improvement within our Branch action plans. Micro level quality improvement is process improvement at the program or line staff level; quality improvement methods like Lean might be implemented at this level.

The Plan

To facilitate cross-branch learning and planning around continuous quality improvement, PHD has established the Office of Equity and Quality Improvement (OEQI). This team coordinates and manages cross-cutting CQI activities that include the Division as a whole. OEQI has the lead role for continued development and sustainability of our quality improvement program.

What are we trying to accomplish?

The vision for successfully implementing performance improvement in our Population Health Division (PHD) is to have a well-planned, sustainable and agile quality improvement program. Two areas of staff support are needed to accomplish the goals of this program: 1) a quality improvement training plan and 2) a project office that provides technical assistance when requested. Both of these vital functions will be housed in our Learning Lab maintained by OEQI.

1. The training plan will adopt standardized public health quality improvement competencies with tiers. The competencies include elements of public health quality improvement, while the tiers are based on the organizational structure (similar to how the 10 Essential Services of Public Health are organized). The learning opportunities are both in-house PHD trainings and approved outsourced trainings (i.e., San Francisco General Hospital Quality Improvement and Leadership Academy, Institute for Health Care Improvement). We will incrementally build capacity by focusing on the basics, developing tools, and sending staff to trainings. The PHD trainings will focus on the elements of REACH (Results, Equity, and Accountability with Cultural Humility), including use of the 4 Strategic Questions (4SQ) and collective impact using a results-based framework. Staff will have multiple entry points for learning. Fulfillment of the core elements of the training plan will result in a cross-cutting team of experts trained in quality improvement methods.

2. The project office will provide support for quality improvement projects with: technical assistance, coordination, and project management.

What are our measures of success?

- Strong leadership support and participation
- Completion of the Learning Lab
- Adoption of competencies
- Development of the training plan
- Formation of a cross-Branch team of quality improvement experts / champions
- Development of an approach for prioritizing quality improvement projects requesting technical assistance

What other conditions must exist?

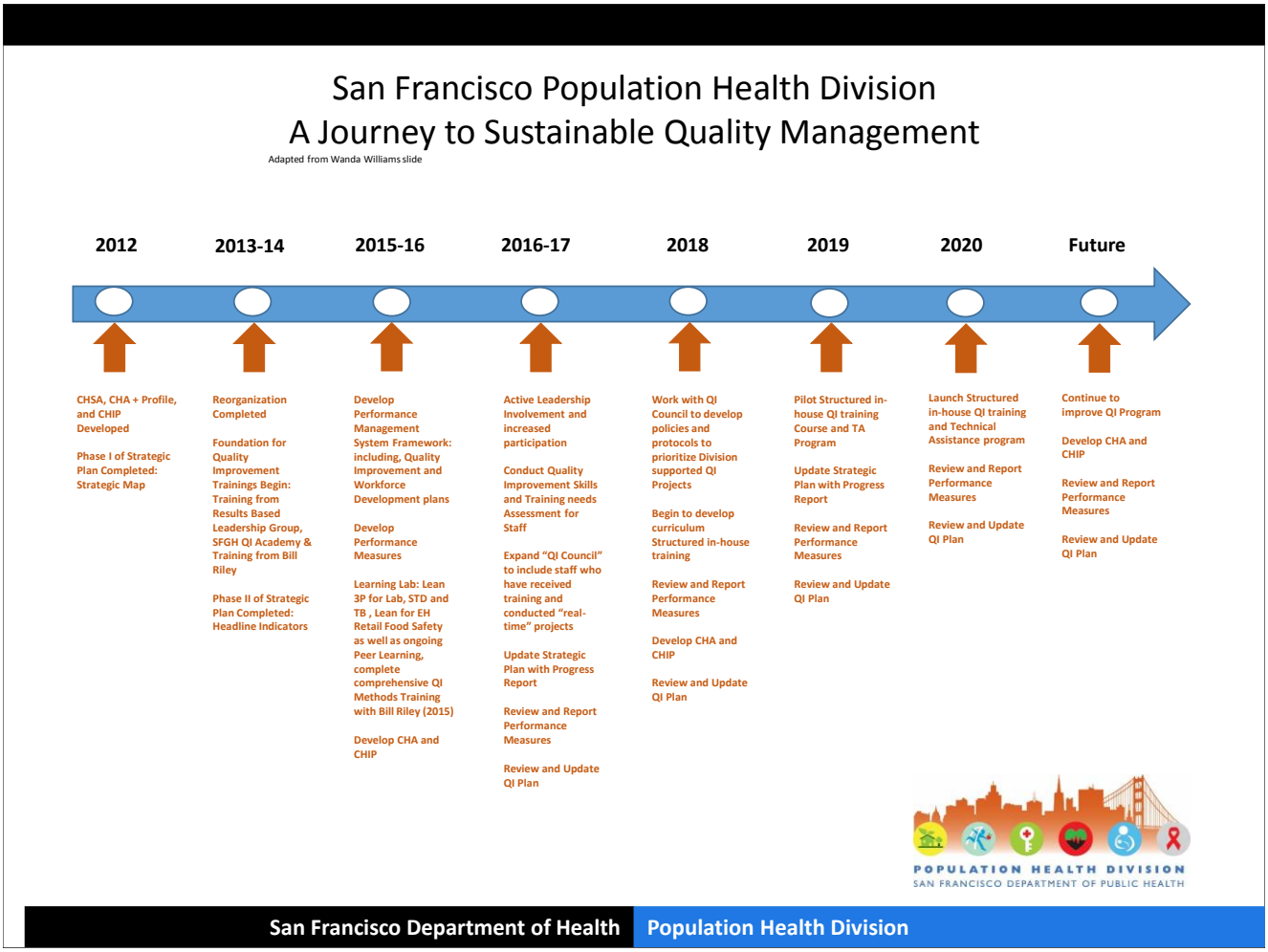
- Funding is secured for Lean projects
- The program is focused on improving processes at different levels across the Division
- A collaborative relationship on training is sustained with the Center for Learning and Innovation (CLI)
- Low staff turnover is achieved so that people trained in QI become subject matter experts for their Branches

How we develop the program?

The work will be phased; some phases may occur simultaneously. Staff at all levels throughout the Division will be actively involved in the design and planning. We will apply our customized framework: Results, Equity, and Accountability with Cultural Humility (REACH) for quality improvement in Population Health Division together with collective impact principles. Figure 4 provides you with a

timeline for the development of a Continuous Quality Improvement Program.

Figure 4



Current Efforts

Using a phased approach, leadership and strategically placed staff have received training in the results-based framework which we are using in our strategic planning. Select analytical staff have received intensive training in QI methods with Dr. William J. Riley and the majority of staff throughout the Division have completed at least one Introduction to Quality Improvement Methods session. Staff have also begun applying QI thinking through development of Branch Action Plans that are aligned with our Strategic Map (see p. 14 of the Strategic Plan), and are gaining additional understanding of quality improvement thinking through Brown Bag Lunch workshops and Lean training.

Currently, the Quality Improvement Team is comprised of the Director of PHD and the Branch Directors which shows a clear and substantial commitment on the part of Leadership. A subset of this Team, made up of the Director of PHD, the Deputy Director and Director of the Office of Equity and Quality Improvement established the mandate and process for currently implemented CQI projects with input into QI projects.

2015-2016 Continuous Quality Improvement Projects

Project	Lead	Participants	Resources	Date
Developing Performance Measures with Results-Based Methods	Priscilla Chu, Knowledge Management and Quality Improvement Coordinator	All PHD staff	Center for Learning and Innovation Deitre Epps, Results Based Accountability Consultant	September 2014 – October 2015
3P for Public Health Laboratory	Melisa Olivero	Disease Prevention and Control, SFGH Quality Improvement staff, Operations, PHD director	Mike Rona and Associates	August 31 - September 4, 2015
Brown Bag	Priscilla Chu, Knowledge Management and Quality Improvement Coordinator	All interested staff	Dara Geckeler	Winter 2015 (quarterly)
Book Club on Lean	Priscilla Chu, Knowledge Management and Quality Improvement Coordinator	All interested staff	Book: Toyota Way	Winter 2015-2016
3P for STD Clinic	Melisa Olivero	STD Clinic staff, SFGH Quality Improvement staff, Operations	Mike Rona and Associates, Lean Consultants	Winter 2015
Training on 4 Strategic Questions (4SQ) for Division	Priscilla Chu, Knowledge Management and Quality Improvement Coordinator and Alecia Martin, Trainer, Center for Learning and Innovation	All PHD staff	Center for Learning and Innovation	January – December, 2016
Conducting effective data driven meetings	Priscilla Chu, Knowledge Management and Quality Improvement Coordinator	Start with PHD leaders and managers	Deitre Epps, Results Based Accountability Consultant Center for Learning and Innovation	Spring 2016
3P for TB Clinic	Melisa Olivero	TB Clinic staff, SFGH Quality	Mike Rona and Associates, Lean Consultants	Spring 2016

Project	Lead	Participants	Resources	Date
		Improvement staff, Operations		
Lean for Environmental Health	Melisa Olivero	Environmental Health staff, Center for Learning and Innovation, Office of Equity and Quality Improvement, Operations	Mike Rona and Associates, Lean Consultants	Spring 2016

Continuous Quality Improvement Learning Lab

Our Continuous Quality Improvement Program (CQIP) Learning Lab is being developed organically and will grow in well-designed phases over the next 5 years to encompass all organizational levels. Starting in 2013, we engaged PHD Branch directors, select Managers and Project Management staff in Results Based Accountability (RBA) training. By March 2015, most PHD staff had received basic introduction to quality improvement methods.

Additionally, Directors, managers and other levels of staff have been involved in applying our REACH framework (Results, Equity, and Accountability with Cultural Humility) in development of the PHD Action Plan. The Action Plan identifies the performance measures and strategies that will be applied to achieve our annual performance improvements, including longer-term Headline Indicator improvements. The results will be measured and communicated to our stakeholders, clients and the general public through our performance management system.

During 2015 the Learning Lab is being expanded through training in the application of 3P Lean principles for projects in our Public Health Laboratory, City Clinic (STDs Clinic) and TB Clinic. Also, during this phase, our Environmental Health Division will be involved in comprehensive Lean training and application. The materials developed through these projects will be adapted for future quality improvement curricula by our staff in the Office of Equity and Quality Improvement in 2016.

During 2017, staff will evaluate the Learning Laboratory, including consultants used during the initiation phases in 2015 and 2016. The new Quality Improvement Council with responsibilities that include analysis and interpretation of collected data to set priorities and make suggestions for future Learning Lab projects will play a major role in the evaluation. By 2018, policies and procedures for selection and prioritization of quality improvement projects will be adopted. A pilot training program will be implemented in 2019. And, by 2020, a training plan that includes all levels of staff will be launched.

The Strategic Plan is just one part of our journey to developing an overall Performance Management System for the Population Health Division. The Division is committed to ensuring that the staff has the ongoing technical skills and support they will need to develop a culture of quality improvement. This will be provided by our Division-wide Work Force Development Plan.

Our Strategic Plan, including the Continuous Quality Improvement Plan, will not be sustainable if we do not include a clearly defined process or roadmap for measuring our progress and making informed decisions for future goals and results. Our Performance Management System as illustrated above, provides that roadmap for success.

The Performance Management System

The starting point for our Performance Management System was development of Headline Indicators for this Strategic Plan. As we applied our REACH framework to analysis of our CHA data, a better understanding of the need to design the infrastructure to allow for efficient access to our ongoing progress became apparent. Discussions on what measures were attainable and would aid toward meeting our Result drove conversations about our readiness to gather and report on progress. As decisions were being made on a commercial data system, discussions included our readiness to develop our own IT solution. For the present, we are using the Results Based Scorecard for gathering and reporting our progress.

With completion of our PHD performance (attached as Appendix F), which includes specific performance measures for every Branch as well as performance measures that are cross-Branch, we are ready for our first full test of the System. As indicated in the Performance Management System Diagram (Figure 5), adoption of our performance measures is where our System starts.

Development of all performance measures in the Action Plan was supported by OEQI as well as including the measures in the data system that produces our Dashboard. Each of our Branches, Centers and Offices are responsible for gathering performance data on a quarterly basis and sharing that data with our Performance Management Team (PM Team). The PM Team, made up of the QI Coordinator and two OEQI staff members trained in both RBA and QI methodology. The PM Team will interpret and compile the data, i.e., review all data for clarity and develop the "Story behind the curve" for the Quality Improvement Council's reference. The Council is the ultimate decision-maker on actions to be taken as a result of our reported progress. The Council is also charged with such decisions as the need to update or revise the Strategic Plan.

The Quality Improvement Council will develop an annual list of priority projects to be carried out in order to meet Division commitments and expectations. OEQI is charged with implementing the priority list including working closely with CLI to ensure that Workforce Development support is in alignment with the priorities. The Continuous Quality Improvement Projects annual Workplan will be updated as required by the Council's annual list.

Currently, the Quality Improvement Council is comprised of the Director of PHD and the Branch Directors. As the infrastructure continues to be built, the composition of the Council will change to include staff representing all levels within the Branch, not solely the Senior Management. The vision is that the Council will have up to 2 each of Branch Directors, Section Managers, and Direct Supervisors and, up to 6 staff in non-management roles. The Quality Improvement Council will always include the Director of Population Health Division. The staff roll for the Council will be recognized as a dedicated part of each Members job and included as a performance measure in individual performance expectations.

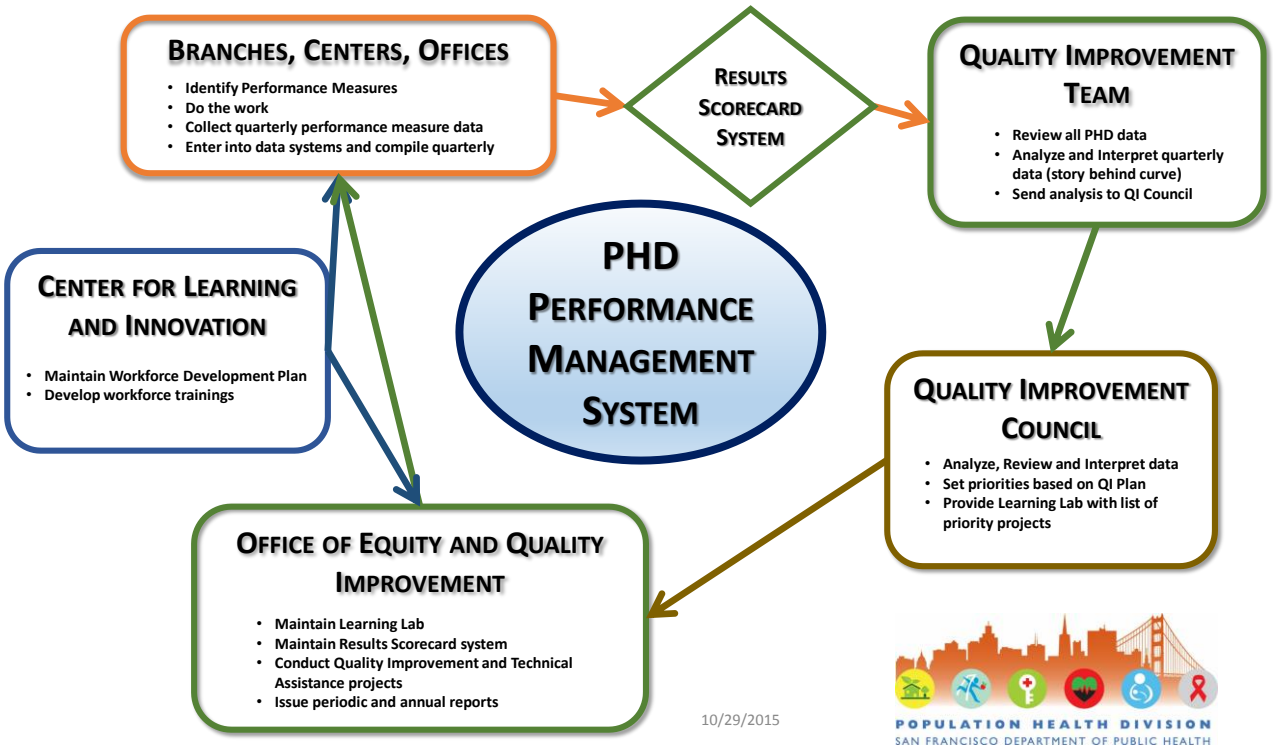
Except for the Director, all members will serve a 2-year term with no renewal. The terms are staggered. The makeup of the future Quality Improvement Council assures that subject matter experts from all levels of the Division have an active role in setting the improvement agenda.

As the Performance Management System diagram shows, performance will be reported on a quarterly basis to the Performance Management Team. The PM Team will prepare a report for the QI Council that provides the complete picture of reported progress. The QI Council will review, assess, analyze and discuss the reported progress on a regular basis, at least once annually. As a result of that analysis, decisions will be make on future actions for the Division including what strategies exhibit waste and need improvement steps to be taken, what actions, if any, must be taken to sustain the existing level of performance, what strategies are not working and should be eliminated and celebration of all progress.

This can be viewed in a Plan – Do – Study – Act cycle: Branches/Centers/Offices DO perform the strategies identified in their performance measures; the Performance Management Committee and the Quality

Improvement Council STUDY the reported progress and decide on what to do next; the backbone teams, OEQI and CLI then ACT on the priority list by providing the necessary tools, technical assistance and training to the Branches/Centers/Offices to they can apply the new strategies when they DO them.

Figure 5:



Performance Measures

The Population Health Division's Strategic Map describes broad strategies and performance measures. This plan lists specific program measures (see Appendix F) related to each strategy. The division is publishing these program-specific performance measures in the spirit of transparency and accountability. The division is accountable to the community and the performance measures are organized according the Strategic Map. Measures that are linked to a headline indicator from the main body of the Strategic Plan are denoted with a logo.

Appendix A: Descriptions of Offices, Centers and Branches in the Population Health Division

PHA DOMAIN CATEGORY: ASSESSMENT/RESEARCH APPLIED RESEARCH, COMMUNITY HEALTH EPIDEMIOLOGY, & SURVEILLANCE (ARCHES)	
STRATEGIC DIRECTION	Superb knowledge management systems and empowered users
STRATEGY 1	Build an integrated information and knowledge management infrastructure that enables us to monitor health, to inform and guide activities, and to improve staff and systems performance.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 1.1**: Build a strong, highly functional information technology (IT) and technical assistance infrastructure in alignment with Department of Public Health IT strategy. **PERFORMANCE MEASURE 1.2**: Establish a highly functional, integrated infectious disease system to collect and report data, and to deliver and monitor public health actions.
DESCRIPTION	This Branch coordinates data collection, processing, management, analysis and interpretation related to health and morbidity in San Francisco. Working with private and public clinics, community based organizations, outreach, research, and the laboratories, this Branch maintains systems to gather, explore, analyze, and present data to inform decision-making to maximize public health. Data across conditions, populations, and health status are integrated to assess and help solve community health problems; diagnose and investigate health problems and health hazards in the community; evaluate effectiveness of interventions and services, and monitor quality.
FUNCTIONS INCLUDE:	• Develop integrated platform • Surveillance of all communicable diseases • Case investigation and case management • Monitor health outcomes • Program evaluation and implementation science • Develop and assess Continuous Quality Improvement measures

PHA DOMAIN CATEGORY: ASSESSMENT/RESEARCH CENTER FOR PUBLIC HEALTH RESEARCH (CPHR)	
STRATEGIC DIRECTION	Assessment and research aligned with our vision and priorities
STRATEGY 2	Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 2.1**: Create an action plan that supports division priorities. **PERFORMANCE MEASURE 2.2**: Build cross-section interdisciplinary teams to improve health outcomes and programmatic activities.
DESCRIPTION	This Branch provides expertise in epidemiology, clinical trials, evaluations, and implementation science research. Our focus has been on substance use and HIV, but we also assess and address other infectious diseases including viral hepatitis, sexually transmitted infections, diarrhea, malaria, and other pathogens affecting our city and marginalized populations globally. Our research focus is the populations and health issues of San Franciscan's. Being embedded within the Health Department allows a seamless process of identifying research questions, carrying out the research and disseminating findings back to Health Department programs and policy makers. The Branch provides SFDPH and its partner's technical training, consultation, expertise, and oversight in population survey design, questionnaire development, data collection modalities, statistical methods, GIS mapping, the conduct of clinical trials, and implementation science. The team is proficient in methodologies to sample and enumerate diverse communities, particularly hidden and hard to reach populations; to conduct cohort studies and pharmacological and behavior intervention trials; and to employ qualitative and mixed methods for health research for disproportionately affected populations in San Francisco and worldwide. Our team brings a wealth of public health research experience from our city and internationally. These focus areas are leveraged to improve the health of San Francisco and the world.
FUNCTIONS INCLUDE:	• Design and implement population-based research health assessments and epidemiological surveys, including cross-sectional and longitudinal studies • Design and implement behavioral, biological, and pharmacological clinical trials for substance use and other risk behaviors • Develop and implement sampling methodologies to obtain robust population samples of hidden, hard-to-reach, and marginalized populations • Provide training, capacity-building, and technical support for quantitative and qualitative research throughout PHD and the city and county of San Francisco • Provide high level statistical support and analyses

PHA DOMAIN CATEGORY: ASSESSMENT/RESEARCH BRIDGEHIV	
STRATEGIC DIRECTION	Assessment and research aligned with our vision and priorities
STRATEGY 2	Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 2.1**: Create an action plan that supports division priorities. **PERFORMANCE MEASURE 2.2**: Build cross-section interdisciplinary teams to improve health outcomes and programmatic activities.
DESCRIPTION	Bridge HIV provides global leadership in HIV prevention, research, and education. This Branch works with local and international scientists and communities to discover effective HIV prevention strategies through research, community partnerships, and educational initiatives. Operating as a clinical trials unit within the San Francisco Department of Public Health and affiliated with the University of California, San Francisco (UCSF), we conduct innovative research that guides global approaches to prevent HIV and AIDS.
FUNCTIONS INCLUDE:	• Maintain highest quality HIV prevention clinical trials program • Develop and test integrated prevention strategies including vaccines, PrEP, microbicides, treatment as prevention, HIV/STI testing, couples interventions • Collaborate broadly across disciplines, institutions • Engage Bay Area communities to build research literacy, and inform research • Obtain independent funding for research activities • Mentor diverse population of early career investigators and staff • Disseminate research findings to scientific and general community • Convene the PHD HIV Working Group and lead its contributions to the city-wide Getting to Zero effort

PHA Domain Category: Policy Development Office of Equity & Quality Improvement (OEQI)	
Strategic Direction	Policy development with collective impact
Strategy 3	Conduct effective policy and planning that achieves collective impact to improve health and well-being for all San Franciscans.
Performance Measures 2012-2015	**Performance Measure 1.2**: Establish a highly functional, integrated infectious disease system to collect and report data, and to deliver and monitor public health actions. **Performance Measure 3.1:** Establish a division-wide Performance Management, Equity & Quality Improvement Program. **Performance Measure 3.2:** Establish systems and partnerships to achieve and maintain Public Health Accreditation. **Performance Measure 3.3:** Develop a prioritized legislative agenda and strategic implementation plan to address health status and inequities.
Description	This Office serves as the principal advisor and coordinator of Division-wide efforts to reduce disparities and improve health equity in San Francisco. The Office is responsible for the development of a Division-wide Performance Management System and Quality Improvement Plan to evaluate the impact of the health department's efforts to improve the quality of life of county residents. The Office works in partnership with the DPH Policy & Planning office to develop and implement a legislative agenda; as well as support the department's efforts to achieve and maintain Public Health Accreditation which signifies that a health department is meeting national standards for ensuring essential public health services are provided in the community.
Functions include:	• Serves as principal advisor across the Division in matters related to health disparities, health equity, and priority population and/or community health • Supports the development of an integrated infectious disease system to collect and report data, and to deliver and monitor public health actions. • Establishes and manages a division-wide Quality Improvement and Performance Management System • Provides policy consultation, technical assistance, communication strategies and practice resources for effective public health efforts • Serves as liaison to internal and external stakeholders to foster collaborative activities and strategic partnerships • Consults Federal agencies and other public and private sector agencies and organizations to align local efforts to national strategies, initiatives and health priorities. • Implementation of comprehensive interventions to improve community food security and School food quality

PHA DOMAIN CATEGORY: ASSURANCE ENVIRONMENTAL HEALTH (EH)	
STRATEGIC DIRECTION	Assurance of healthy places and healthy people
STRATEGY 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 4.1:** Establish community-centered approaches that address the social determinants of health and increase population well-being. **PERFORMANCE MEASURE 4.2:** Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.
DESCRIPTION	This branch ensures environmental health and safety for San Francisco residents, business owners, workers, and tourists. We accomplish this through enforcement of environmental health laws and the implementation of health in all policies for safe food and water, quality housing, livable neighborhoods, safe streets, protection from air pollution, excessive noise, radiation and chemical hazards. We ensure that customers are provided the accurate amount of goods and services when they patronize businesses.
FUNCTIONS INCLUDE:	• Monitoring and enforcement of local and state laws for: ♦ Food safety ♦ Water quality ♦ Housing habitability ♦ Neighborhood sanitation ♦ Noise ♦ Indoor air quality ♦ Vector control ♦ Chemical hazards ♦ Non-ionizing radiation ♦ Tobacco and smoking regulation ♦ Consumer protection and agricultural pests • Monitoring of community-level social and environmental determinants of health and well- being • Implementation of comprehensive interventions to improve: ♦ Asthma morbidity and childhood health ♦ Community resiliency • Support of interagency partnerships for: ♦ Safe livable neighborhoods ♦ Sustainable transportation projects ♦ Parks and green space ♦ Pedestrian and bicycle safety ♦ Safe healthy work environments

PHA DOMAIN CATEGORY: ASSURANCE COMMUNITY HEALTH EQUITY & PROMOTION (CHEP)	
STRATEGIC DIRECTION	Assurance of healthy places and healthy people
STRATEGY 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 4.1:** Establish community-centered approaches that address the social determinants of health and increase population well-being.
DESCRIPTION	This Branch integrates the core public health functions of informing, educating and empowering community. The goals are to improve and sustain community health and work towards health equity through sustainable change approaches, mobilization, and community partnerships. Through the use of comprehensive approaches across the spectrum of prevention and based on community input and engagement, the Community Health Equity and Promotion Branch plans, implements, and evaluates priority community initiatives, including the HIV/HCV and STD prevention, Chronic Disease Prevention, Safe and Healthy Living Environments, Community-Clinical Linkages, with a focus on implementation of the Black/African American Health Initiative.
FUNCTIONS INCLUDE:	• Community and stakeholder engagement • Community based testing and vaccination programs and projects • Community based prevention programs and initiatives • Community capacity building and service alignment • Effective, efficient, and culturally appropriate data-driven approaches • Community planning • Sexual health initiatives • Social marketing and social media • Sustainable community initiatives • Facilitating collective impact

PHA DOMAIN CATEGORY: ASSURANCE DISEASE PREVENTION & CONTROL (DPC)	
STRATEGIC DIRECTION	Assurance of healthy places and healthy people
STRATEGY 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 4.1:** Establish community-centered approaches that address the social determinants of health and increase population well-being. **PERFORMANCE MEASURE 4.2:** Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.
DESCRIPTION	This Branch oversees public health clinical services including treatment and biomedical prevention, public health laboratory testing and broad communicable disease investigation (DIS) services. The Branch performs many of the legally mandated activities intended to protect public health and therefore serves everyone in San Francisco. This Branch is also responsible for informing and guiding San Francisco clinicians in best practices for communicable disease prevention, control and treatment including during outbreaks and is a resource for expert clinical and laboratory consultation. Within SFDPH, staff work closely with the San Francisco Health Network to optimize clinical policies and care in the DPC core areas.
FUNCTIONS INCLUDE:	• Specialty Clinics (Immunization and Travel Clinic, STD, and TB) • Public Health Laboratory • Outbreak investigation • Partner Services (Partner Elicitation and Notification Services) • Linkage and Health Navigation Services • Provides education and technical assistance to promote best practices for communicable disease clinical preventative services, screening and treatment • Directly Observed Therapy • Case management for select conditions (TB, HIV, STD, HIV PrEP) • Expert clinical and laboratory consultation • technical assistance to schools, providers and the public about immunization • Coordinate efforts with other PHD Branches

PHA DOMAIN CATEGORY: ASSURANCE PUBLIC HEALTH EMERGENCY PREPAREDNESS & RESPONSE	
STRATEGIC DIRECTION	Assurance of healthy places and healthy people
STRATEGY 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 4.2:** Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities. .
DESCRIPTION	This Branch serves the public, Department of Public Health (DPH), and partners by coordinating health emergency preparedness, response, and recovery efforts. The Branch staff acts as stewards through strategic planning, efficient allocation of resources, and leveraging of SFDPH and citywide capabilities. PHEPR promotes a culture of preparedness to ensure that, in an emergency, disease and injury are prevented and, accessible, timely, and equitable health and clinical services are available.
FUNCTIONS INCLUDE:	• Focus on all-hazards public health preparedness and response planning for San Francisco and DPH • Ensure that all populations are equally served • Work collaboratively with partners • Ensure transparency in goals, resources, and activities • Integrate a culture of preparedness into everyday operations • Empower SFDPH staff, partners, and San Francisco community to respond effectively • Represent the Department through responsiveness, organization, and effectiveness in accomplishing goals

PHA DOMAIN CATEGORY: ASSURANCE EMERGENCY MEDICAL SERVICES (EMS)	
STRATEGIC DIRECTION	Assurance of healthy places and healthy people
STRATEGY 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
PERFORMANCE MEASURES 2012-2015	**PERFORMANCE MEASURE 4.2:** Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.
DESCRIPTION	This Branch is tasked with the oversight of Emergency Medical System (EMS) protocol and policy pursuant to Title 22 Division 9 of the California Code of Regulations, Division 2.5 of the California Health and Safety Code and Article 14 of the San Francisco Health Code to provide high quality, accessible emergency medical care in both normal operations and disaster settings.
FUNCTIONS INCLUDE:	• Certification of Emergency Medical Technicians (EMT) • Accreditation of Paramedics and inspection of ambulances • Designation of hospitals as Receiving Hospitals and Specialty Centers and other ambulance receiving facilities such as sobering centers • Review of the impact of emergency department closures ("Prop Q" hearing preparation) and addition or moving of emergency department facilities • Development of treatment protocols for all levels of pre-hospital providers (EMTs and Paramedics) • Certification of pre-hospital provider training and continuing education programs • Certification of operation (maintenance of an exclusive operating area) for pre-hospital provider agencies (SF Fire Department, Division of Communications 911 Center, private ambulance companies) • Development of policies for pre-hospital providers including operations, communications, direct medical oversight (base hospital functions), quality improvement and multi-casualty incident management (disasters) • Development and maintenance of a local trauma care plan and EMS plan • Oversight of medical care provided by ground and air ambulance services for inter-facility transfer of patients • Administration of the EMS Fund • Oversight of Automatic External Defibrillator programs • Provision of Medical Health Operational Area Coordination in disasters where out-of-county health resources are required • Physician Medical Education on pre-hospital care: Provide medical oversight for the UCSF/SFGH Emergency Medicine Residency and EMS/Disaster Fellowship program, partner with community organizations such as the San Francisco Medical Society, the San Francisco Emergency Physicians Association and the San Francisco Paramedic Association • Coordinate EMS medical research, including dispatch effectiveness, cardiac arrest treatments, stroke recognition and disaster medicine evaluation of triage • Provide medical oversight for EMS medical plans for all special events in San Francisco • Participate in regional systems of care, including Regional Trauma Care Committee, Regional Medical and Health Disaster Coordination and California EMS Medical Administrators and Medical Directors Associations.

PHA Domain Category: Governance, Administration, and Systems Management Office of Operations, Finance, & Grants Management (OFGM)	
Strategic Direction	Sustainable funding and maximize collective resources
Strategy 5	Increase administrative, financial and human resources efficiencies within the division.
Performance Measures 2012-2015	**Performance Measure 5.1**: Establish a centralized business office for the division. **Performance Measure 5.2**: Appropriately address the human resource issues regarding civil service and contract employees. **Performance Measure 5.3**: Establish a centralized grants management and development system for the division.
Description	This Office integrates core administrative, operations and fiscal functions across all PHD Branches, Offices and Centers. The goal is to increase capacity and efficiency of administrative functions by pooling and cross-training administrative staff which allows for equitable administration across Branches. This Office provides project management for key division initiatives. This Office will also establish a Performance Management System by which the Division aligns resources, systems and employees to strategic objectives and priorities. The goal of the performance management system will be to encourage, support and reward good performance.
Functions include:	• Fiscal management • Grants/Contracts development, set-up and administration • Human Resources coordination • Purchasing • Payroll coordination • Fund development coordination and management • Project management • Performance Management • Facilities • Administrative/Clerical

PHA Domain: Governance Category, Administration, and Systems Management Center for Learning and Innovation (CLI)	
Strategic Direction	Learning organization with a culture of trust and innovation.
Strategy 6	Build a division-wide learning environment that supports public health efforts.
Performance Measures 2012-2015	**Performance Measure 6.1**: Establish a division-wide professional development program.
Description	The mission of the Center for Learning & Innovation (CLI) is to foster a culture of learning, trust and innovation. CLI supports a Division-wide learning culture by offering customized training and technical assistance to our diverse and talented public health workforce. Our group focuses on building the capacity of *internal* DPH audiences as well as *external* audiences such as local community providers and other health departments across the country. CLI conducts training needs assessments and taps trusted DPH and outside experts to address a wide range of core competencies required of public health professionals. CLI staff are trained in user-centered design principles to facilitate the creation and testing of public health innovations. Our team members also play key leadership roles in organizing Division-wide workforce planning. We also partner with Human Resources and other DPH groups to spearhead Department-wide training and workforce development efforts.
Functions include:	• Prioritize and integrate professional development to build staff capacity • Inventory employee skills to develop tailored training approaches that meet individual Branch and collective Division needs • Convene a Division-wide Training Working Group that identifies best practices and develop plans to address cross-cutting training needs • Maintain a robust learning management system that closely tracks training requirements for PHD employees and delivers distance learning • Support a culture of learning, strategic planning through interdisciplinary grand rounds • Foster coaching and career mentorship through informal and formal mechanisms • Maintain strong linkages with local academic partners (e.g., City College of San Francisco) to inform their public health-focused educational efforts • Support a Health Equity Fellows program that creates meaningful internship opportunities for graduate and undergraduate candidates and that combines training and mentored projects • Offer and coordinate technical assistance to external partners in Division-wide areas of expertise • Communicate internal and external training opportunities through an interactive website, email, newsletters, and social media

Appendix B: Project Management Dash Board for the Strategic Plan

Project Management Dash Board for the Strategic Plan			
Project Cycle	**Action Steps**	**Dash Board** Completed / In Progress / Not Started	**Progress**
Developing Mission, Vision and Values	Identifying Formal and Informal Organizational Mandates	Accomplishment: • Tables from Staff Directors retreat and Staff focus groups of formal and informal organizational mandates, August 2012	✓
	Determining the Type and Level of Stakeholder Engagement	Accomplishment: • Diagram illustrating the Integration stakeholder engagement process, June 2012	✓
	Developing Organizational Values Statements	Accomplishment: • Document providing the vision and overview of the of process, January 2012 • FAQ of the integration process and information on staff focus groups, June 2012	✓
	Developing Mission Statement	Accomplishment: • Mission statement finalized, January 2013	✓
	Developing Vision Statement	Accomplishment: • Vision statement finalized, January 2013	✓
	Communicating Vision, Mission and Values	Accomplishment: • 5 Staff FAQ Introduction, January –March 2013 • Overview of PHD, March 19, 2013 • Business Case, March 19, 2013 • 17 Presentations and Town Halls, March-May 2013	✓
	Products Cycle 1: Vision and Mission Statements for the PHD; Communication Plan, including FAQs, Presentations and Town Halls		✓
Compiling Relevant Information: Environmental Scan	Determining Value of Existing Data	Accomplishment: • Assessment of current quantitative data	✓
	Collecting Additional Data/Information as Needed	Accomplishment: • Gathering of quantitative data for the Community Health Status Assessment, July 2012 • Gathering qualitative data from stakeholders (17 community focus groups, 6 staff focus group, 3 Directors retreats and ongoing monthly meetings), Summer 2012	✓
	Summarizing Data/Information	Accomplishment: • Completed Community Health Assessment (CHA) (quantitative data), September 2012 • Completed Mind Maps of qualitative data, August 2012	✓

Project Management Dash Board for the Strategic Plan			
Project Cycle	**Action Steps**	**Dash Board** Completed / In Progress / Not Started	**Progress**
	Products Cycle 2: Community Health Status Assessment, Community Health Assessment, and graphic illustrations of stakeholder priorities		
Analyzing Results and Selecting Strategic Priorities	Completing a SWOT/SWOC Analysis	Accomplishment: • Analysis of quantitative and qualitative data, (see Project Cycle 2) • Compiling of data from stakeholder input, December 2012 • Compiling of data for cross cutting PHD themes, September 2013	
	Identifying and Framing Cross-cutting Themes, Emerging Issues and Key Strategic Issues	Accomplishment: • Identified cross-cutting themes that align with PHD priorities, June 2013	
	Prioritizing and selecting Strategic Issues	Accomplishment: • Community Health Improvement Plan, December 2012 • Developed a strategic map for the Integration of the Division, March 2013 • Prioritizing Headline Indicators for the Division, September 2013	
	Products Cycle 3: Community Health Improvement Plan, and PHD Headline Indicators		
Developing the Strategic Plan	Identifying Results Statements and Populations	Accomplishment: • Develop results and populations statements, September 2013	
	Identifying Headline Indicators, what works, partners and strategies	Accomplishment: • Develop Headline Indicators, September 2013 • Develop strategies to support headline indicators • Develop stories behind the baselines, May 2014 • Identify what works, partners and strategies, May 2014	
	Approval of Strategic Plan from San Francisco Health Commission	Accomplishment: • Present updates to Health Commission Public Health Committee, October 15, 2013 • Present update to Health Finance Committee, December 5, 2013 • Present Strategic Plan to Health Commission, June 3, 2014 • Health Commission Resolution to Approve the Strategic Plan, June 17, 2014	
	Product Cycle 4: PHD Strategic Plan		

Appendix C: San Francisco Health Commission Approval and Adoption of the Strategic Plan

Health Commission
Resolution No. 14-7

RESOLUTION IN SUPPORT OF THE SFDPH POPULATION HEALTH DIVISION STRATEGIC PLAN

WHEREAS, the San Francisco Health Commission and the Mayor's Office have made achieving Public Health Accreditation a priority for the Department of Public Health; and,

WHEREAS, the San Francisco Health Commission passed a resolution naming an Integrated Delivery System, Public Health Accreditation, and Financial Efficiency the three budget priorities for the Department of Public Health; and,

WHEREAS, in collaboration with our numerous partners whose missions are to protect the health and wellness of our citizens; and,

WHEREAS, a public process that included over 600 participants has resulted in the adoption of the Community Health Assessment and the Community Health Improvement Plan, as required pre-requisites to applying for public health accreditation; and,

WHEREAS, the San Francisco Department of Public Health has been a leader in public health innovation and provision of services; and,

WHEREAS, the Department has completed a reorganization to ensure that it remains ahead of the changes necessary to provide services in the 21st Century health arena; and,

WHEREAS, the Department has a commitment to continuous quality improvement as recognized by the Public Health Accreditation Board; and,

WHEREAS, the newly reorganized Population Health Division of the San Francisco Department of Public Health, has completed its 5-year Strategic Plan; and,

WHEREAS, the Department of Public Health has a strong history of working closely with the San Francisco community and all of the populations that make up this great City; and,

WHEREAS, the 5-year Strategic Plan for the Population Health Division has been presented to the Health Commission;

BE IT RESOLVED THAT, the San Francisco Health Commission approves and adopts the Strategic Plan for Population Health Division; and,

BE IT FURTHER RESOLVED THAT, the San Francisco Department of Public Health applies forthwith for accreditation through the Public Health Accreditation Board (PHAB).

I hereby certify that at the San Francisco Health Commission at its meeting of June 17, 2014 adopted the foregoing resolution.

Mark Morewitz, Health Commission Executive Secretary

Appendix D: Mayor's Letter of Support

OFFICE OF THE MAYOR
SAN FRANCISCO

EDWIN M. LEE
MAYOR

June 18, 2014

Kaye Bender, RN, PhD, FAAN
President and Chief Executive Officer
Public Health Accreditation Board
1600 Duke Street, Suite 200
Alexandria, VA 22314

Re: San Francisco Department of Public Health's Application for Public Health Accreditation

Dear Ms Bender,

San Francisco is proud of its history of being a leader in health policy and delivery of services. Over the last 40 years, the San Francisco Department of Public Health has established ways of working with our communities to address and overcome epidemics, outbreaks and day-to-day health concerns. Our methods have been adopted and used by many other health departments across the nation.

Given this proud tradition, I have proudly supported the San Francisco Health Commission in prioritizing efforts to achieve accreditation through the Public Health Accreditation Board. Accreditation will acknowledge our presence as a leader in public health policy, prevention and care. It will bolster our commitment to a culture of quality improvement, and will also provide a roadmap for other Departments in the City to develop a culture of continuous quality improvement that is essential to our continued leadership in the delivery of services to our residents and visitors.

Progress through this important endeavor is supported and being closely tracked by my office.

Sincerely,

Edwin M. Lee
Mayor

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

Appendix E: List of Acronyms (in alphabetical order)

AIDS	Acquired Immunodeficiency Syndrome
ARCHES	Applied Research, Community Health Epidemiology, & Surveillance
ART	Anti-Retroviral Treatment
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHA	Community Health Assessment
CHEP	Community Health, Equity, & Promotion
CHIP	Community Health Improvement Plan
CLI	Center for Learning and Innovation
CPHR	Center for Public Health Research
CRRP	Community Risk Reduction Plan
DPC	Disease Prevention and Control
EH	Environmental Health
EMS	Emergency Medical Services
HCSMP	Health Care Services Master Plan
HIV	Human Immunodeficiency Virus
HSA	Human Services Agency
IDU	Injection Drug Users
LINCS	Linkage, Integration, Navigation, and Comprehensive Services Team
MAPP	Mobilizing for Action through Planning and Partnerships
MSM	Males who have sex with males
NACCHO	National Association of County and City Health Officials
OEQI	Office of Equity and Quality Improvement
OFGM	Operations, Finance, and Grants Management
PPACA or ACA	Patient Protection and Affordable Care Act
PLWHA	People Living With HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
PHA	Public Health Accreditation
PHD	Population Health Division
PHEPR	Public Health Emergency Preparedness and Response
PHP	Population Health & Prevention
PHAST	Positive Health Access to Services and Treatment
REACH	Result, Equity, and Accountability for Community Health
SES	Social economic status
SF	San Francisco
SFDPH	San Francisco Department of Public Health
SFHIP	San Francisco Health Improvement Partnership
SFGH	San Francisco General Hospital
SFUSD	San Francisco Unified School District
UCSF	University of California, San Francisco

Appendix F: Performance Measures

Population Health Division Strategic Map

PUBLIC HEALTH ACCREDITATION (PHA) DOMAIN CATEGORIES	STRATEGIC DIRECTIONS	PHD STRATEGIES AND PERFORMANCE MEASURES 2012-2015
ASSESSMENT / RESEARCH	**1. Superb knowledge management systems and empowered users**	STRATEGY 1 : Build an integrated information and knowledge management infrastructure that enables us to monitor health, to inform and guide activities, and to improve staff and systems performance. PERFORMANCE MEASURES: 1.1.Build a strong, highly functional information technology (IT) and technical assistance infrastructure in alignment with Department of Public Health IT strategy. 1.2 Establish a highly functional, integrated infectious disease system to collect and report data and to deliver and monitor public health actions.
	2. Assessment and research aligned with our vision and priorities	STRATEGY 2: Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation. PERFORMANCE MEASURES: 2.1 Create an action plan that supports division priorities. 2.2 Build cross-section interdisciplinary teams to improve health outcomes and programmatic activities.
POLICY DEVELOPMENT	**3. Policy development with collective impact**	STRATEGY 3: Conduct effective policy and planning that achieves collective impact to improve health and well-being for all San Franciscans. PERFORMANCE MEASURES: 3.1 Establish a division-wide Performance Management, Equity and Quality Improvement Program. 3.2 Establish systems and partnerships to achieve and maintain Public Health Accreditation. 3.3 Develop a prioritized legislative agenda and strategic implementation plan to address health status and inequities.
ASSURANCE	**4. Assurance of healthy places and healthy people**	STRATEGY 4: Lead public health systems efforts to ensure healthy people and healthy places PERFORMANCE MEASURES: 4.1 Establish community-centered approaches that address the social determinants of health and increase population well-being. 4.2 Sustain and improve the infrastructure and capacity to support core public
GOVERNANCE, ADMINISTRATION, AND SYSTEMS MANAGEMENT	**5. Sustainable funding and maximize collective resources**	STRATEGY 5: Increase administrative, financial and human resources efficiencies within the division PERFORMANCE MEASURES: 5.1 Establish a centralized business office for the division. 5.2 Appropriately address the human resource issues regarding civil service and contract employees. 5.3 Establish a centralized grants management and development system for the division.
	6. Learning organization with a culture of trust and innovation	STRATEGY 6: Build a division-wide learning environment that supports public health efforts. PERFORMANCE MEASURES: 6.1 Establish a division-wide Workforce Development Program.

Strategic Direction 1. Superb knowledge management systems and empowered users

Strategy 1: Build an integrated and information and knowledge management infrastructure that enables us to monitor health, to inform and guide activities, and to improve staff and systems performance.

Performance Measure 1.2 Establish a highly functional, integrated infectious disease system to collect and report data and to deliver and monitor public health actions.
1. ↑ Percent of PHD branches requesting data through ARCHES to improve programs (target: 10 branches (100%)) (ARCHES) 2. ↑ Number of PHD performance measures using ARCHES support (target: 9 Branches) (ARCHES)

Strategic Direction 2. Assessment and Research aligned with our vision and priorities

Strategy 2: Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.

Performance Measure 2.1 Create an action plan that supports division priorities.
3. ↑ Number of new grants in collaboration with other PHD or DPH branches (target: 1 per Principal Investigator per year) (CPHR)

Performance Measure 2.2 Build cross-section interdisciplinary teams to improve health outcomes and programmatic activities.
4. ↑ Number of local community presentations on research findings (target: 1 per Principal Investigator per year) (CPHR) 5. ↑ Number of PHD/San Francisco Health Network collaborative publications (target: 2 per Principal Investigator per year) (CPHR)

Strategic Direction 3. Policy development with collective impact

Strategy 3: Conduct effective policy and planning that achieves collective impact to improve health and well-being for all San Franciscans.

Performance Measure 3.1 Establish a division-wide Performance Management, Equity and Quality Improvement Program.
6. Develop Continuous Quality Improvement Plan by 12/31/15 (OEQI) 7. Develop performance measure for the Performance Management System by 12/31/15 (OEQI)

Performance Measure 3.2 Establish systems and partnerships to achieve and maintain Public Health Accreditation.
8. ↑ Percent of staff engaged in Public Health Accreditation activities (target: 70% of PHD staff) (OEQI)

Strategic Direction 4. Assurance of healthy places and healthy people

Strategy 4: Lead public health systems efforts to ensure healthy people and healthy places

Performance Measure 4.2 Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.
9. ↑ Percent of farmers market vendors in compliance with state required local/organic certifications (target: 100% of vendors) (EH) 10. ↑ Percent of targeted child care settings adopting asthma-readiness protocols (target: 90% of settings) (EH) 11. ↑ Percent of improved housing conditions for target families from community collaboration-generated environmental investigations (target: 90% of target families) (EH) 12. ↑ Percent of timely correction (within 90 days) of lead hazard notices of violation (target: 71% of noticed violations) (EH) 13. ↑ Percent of homes with improved environments due to asthma home environmental assessment (target: 95% of assessments) (EH) 14. ↑ Number of city departments that have contracts with the City Hazardous Waste Program (target: 40 contracts) (EH) 15. ↑ Percent of inspected food facilities with score of 94 and above (target: 50% inspected facilities) (EH) 16. ↓ Number of food facilities not inspected within 1 year by (target: <200 facilities) (EH) 17. ↑ Staff time dedicated to identifying unregulated hazardous materials storage facilities (target: 1600 hours total staff time) (EH) 18. ↑ Number of certified new Clean and Green businesses (target: 20 new businesses certified) (EH) 19. ↓ Number of tobacco permits issued in each supervisorial district (target: <45 per district) (EH) 20. ↑ Percent of smoke free master lease and public multiple unit residential buildings and hotels (target: 5% increase) (EH) 21. ↑ Number of underground storage tank cases closed by the Local Oversight Program (LOP) (target: 25 case closures per year) (EH) 22. ↑ Percent of released unpaid garbage service tax liens (target: 50% released liens) (EH) 23. ↑ Percent permitted systems safely using their alternate water source (target: 100% permitted systems) (EH) 24. ↑ Percent of businesses using point of sale devices in compliance with state law (target: 70% of businesses inspected) (EH) 25. ↑ Percent of weights and measures devices in compliance with state law (target: 80% of inspected devices) (EH)