Materials in preparation for the San Francisco Health Commission Meeting on Population Health
October 6, 2015
Role of Director of Health, Health Officer and California County Health Mandates

Community Health Improvement Plan & Strategic Plan for Population Health

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

Current Collective Impact Projects

Special Projects

Alignment with Health Network and Highlights from the Maternal, Child, and Adolescent Health Section

Population Health Division Budget
The Roles of the Director of Health and Health Officer

CITY AND COUNTY OF SAN FRANCISCO CHARTER

SEC. 4.110. HEALTH COMMISSION.

The Health Commission shall consist of seven members appointed by the Mayor, pursuant to Section 3.100, for four-year terms. The Commission shall have less than a majority of direct care providers. Members may be removed by the Mayor only pursuant to Section 15.105. The Commission shall control the property under its jurisdiction.

The Commission and the Department shall manage and control the City and County hospitals, emergency medical services, and in general provide for the preservation, promotion and protection of the physical and mental health of the inhabitants of the City and County, except where the Charter grants such authority to another officer or department. The Commission and the Department may also determine the nature and character of public nuisances and provide for their abatement.

SEC. 4.126. DEPARTMENTS – GENERAL PROVISIONS.

Except as otherwise provided by this Charter, the responsibilities of each department within the executive branch shall be prescribed by ordinance.

The administration and management of each department within the executive branch shall be the responsibility of the department head. Such officials may:
1. Appoint qualified individuals to fill all positions within their departments which are exempt from the Civil Service provisions of this Charter;
2. Adopt rules and regulations governing matters within the jurisdiction of their respective departments, subject, if applicable, to Section 4.102; and
3. With the approval of the City Administrator, reorganize their respective departments. No person serving on a board or commission created by state law to discharge a state function specifically within the City and County may be employed as a paid staff member to a board or commission created by this Charter.

California Health & Safety Codes

§101460
Every governing body of a city shall appoint a health officer, except when the city has made other arrangements, as specified in this code, for the county to exercise the same powers and duties within the city, as are conferred upon city health officers by law.

§101000-§101005
101000. Each board of supervisors shall appoint a health officer who is a county officer.
101005. The county health officer shall be a graduate of a medical college of good standing and repute. His or her compensation shall be determined by the board of supervisors.
Process and Timeline for the Selection of the Current Health Officer

<table>
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<tr>
<th>Event</th>
<th>Date</th>
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<tr>
<td>As authorized under SEC. 4.126. of the City Charter, Director Garcia formally asked Dr. Aragón in writing to fill the position and duties of the Health Officer for the Department of Health on an interim basis, pending appointment of the San Francisco Board of Supervisors</td>
<td>January 3, 2011</td>
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<td>Supervisor David Chiu referred for adoption without committee reference agenda at the next Board of Supervisor Meeting</td>
<td>January 4, 2011</td>
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<tr>
<td>As authorized by California Health &amp; Safety Codes §101460 and §101000 the Board of Supervisors passed a motion to accept Dr. Aragón as the health officer for the county officer.</td>
<td>January 11, 2011</td>
</tr>
</tbody>
</table>

Summary

In California, police powers of the state with respect to health are delegated to counties. By state law, each county Board of Supervisors must appoint a physician health officer. Most cities defer health authority to the county health officer. Berkeley (Alameda County), Long Beach (Los Angeles County), and Pasadena (Los Angeles County) have their own health officers and health departments. The California Department of Public Health, through the California Conference of Local Health Officers (CCLHO), coordinates and supports health officers throughout California. CCLHO recommends that health officers direct sufficient public health resources to execute legal authority to protect the public’s health. These public health resources usually come from local health departments (LHDs). LHDs operate as a stand-alone agency, as part of a health services agency, or as part of a human services agency.

San Francisco is the only city and county in California. Therefore, the county health officer (Dr. Tomás Aragón), while appointed by the Board of Supervisors, works for the city. Dr. Aragón directs the Population Health Division which are the core public health resources to exercise legal authority and to protect and promote health. The Population Health Division is part of a health services agency—the San Francisco Department of Public Health, which is directed by Director of Health Ms. Barbara A. Garcia, MPA. The health officer serves at the pleasure of the Director of Health.
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<th>Ref. #</th>
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<tr>
<td>1</td>
<td>BH</td>
<td>Adult and Children's Mental Health Services</td>
<td>1) CCR, Title 9, Div. 1, Chapter 11; 2) W&amp;I Code, Div. 5, §§5000 et seq.</td>
<td>1) Specialty mental health services shall be provided to Medi-Cal beneficiaries of each county through a mental health plan which contracts with the CA Department of Mental Health to provide services to Medi-Cal beneficiaries and to share in the financial risk of providing those services; 2) The California Mental Health Act, including the Lanterman Petris-Short Act and Bronzan-McCorquodale Act.</td>
<td>1) &amp; 2) Medi-Cal Entitlement 3) Sep Entitlement</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>BH</td>
<td>Alcohol and Drug Abuse Services</td>
<td>1) Penal Code §§1210-1210.1; Health and Safety Code §§ 11999.4 - 11999.13, 11999.20 - 11999.25; 2) CCR, Title 9, Div. 4, Chap. 3; 3) Penal Code §§ 1000 - 1000.6, 1000.8 - 1000.10</td>
<td>1) Certain non-violent adult drug offenders are placed on formal probation and are required to participate in drug treatment, in lieu of incarceration; 2) Regulates Programs for Alcohol and Drug Impaired Drivers; 3) Regulates Deferred Entry of Judgment (PC 1000) Programs.</td>
<td>Somewhat</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>3</td>
<td>BH</td>
<td>Alcohol, tobacco, and drug abuse prevention services throughout the County.</td>
<td>1) PL 102-321; 2) CCR Title 22, Div. 5; 3) H&amp;S Code, Div. 10.5, §§11750 et seq. and Div. 10.7, §11999 et seq.; 4) 45 CFR 96.124&amp;96.125; 5) SB 627, Statutes of 1992; 6) H&amp;S Code, §11802</td>
<td>1) Counties accepting mental health and substance abuse block grants agree to provide services in accordance with federal and State statute; 2) Regulates substance abuse prevention and treatment services; 3) Regulates substance abuse prevention and treatment services; 4) Federal regulations governing Substance Abuse Prevention and Treatment Block Grants; 5) Authorizes Negotiated Net Amount Contract between State and County to administer substance abuse funding; 6) Regulates primary prevention activities between County and schools.</td>
<td>Through Negotiated Net Amount Contract with State.</td>
<td>19% Federal SAPT block grant funds 8% Federal Drug Medi-Cal funds 12% State General Fund 61% SF General Fund</td>
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<tr>
<td>4</td>
<td>BH</td>
<td>Behavioral Health Services Admin.</td>
<td>1) CCR, Title 9, Div. 1 and Div. 4; 2) W&amp;I Code §§ 5751 - 5751.2; 3) W&amp;I Code, §§ 5520 - 5523</td>
<td>1) Includes administrative requirements for community mental health and county alcohol &amp; drug programs; 2) Regulates qualifications of local mental health directors, staff, and contractors; 3) State requirements for patients' rights advocates.</td>
<td>Yes</td>
<td>For substance abuse: 100% Federal Drug Medi-Cal</td>
</tr>
<tr>
<td>5</td>
<td>BH</td>
<td>Children and Youth Services</td>
<td>1) W&amp;I Code §§5600 et seq.; 2) CCR, Title 15, Div. 4; 3) CCR Title 9, Div. 1, Chap. 11, and Title 22, Divs. 5 - 6</td>
<td>1) Mental health (Bronzan-McCorquodale Act) services provided to seriously emotionally disturbed children and adolescents; 2) Juvenile health services, (includes mental health services) provided to youthful offenders detained at juvenile halls, juvenile homes, campus, or forestry camps; 3) Medi-Cal Specialty Mental Health Services provided to children under age 21 to correct or ameliorate a mental illness.</td>
<td>Yes</td>
<td>34% EPSDT FFP 31% EPSDT State share 5% EPSDT SF General Fund 5% Grants 5% Realignment 15% work orders 5% SF General Fund</td>
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<td>6</td>
<td>BH</td>
<td>Crisis Counseling</td>
<td>1) Robert T. Stafford Disaster Relief and Emergency Assistance Act (as amended by Public Law 100-707), §416 (42 U.S.C. §5183; 2) Government Code §3100 et.seq.; 3) Government Code §8607; 4) W&amp;I Code §5600.3</td>
<td>1) Federal law regarding crisis counseling services following presidential declaration of disaster; 2) California regulations declare all public employees to function as disaster services workers; 3) California regulations establish standardized emergency management system; 4) California regulations specify mental health programs’ target population to include persons who need brief treatment as a result of natural disaster or severe local emergency.</td>
<td>No</td>
<td>Federal Emergency Management Agency (FEMA) - for short-term crisis counseling services to eligible victims of Presidential declared disasters.</td>
</tr>
<tr>
<td>7</td>
<td>DPC</td>
<td>Communicable disease and epidemic investigation and control</td>
<td>H&amp;S Code §§120130, 120175-120250, 120275-120300; CCR Title 17, Div. 1, Chap. 3, §1276(c), Chap. 4, §§2501(a), 2512-2540, 2550-2640</td>
<td>Health Officer responsibilities and powers to control communicable diseases, including the use of quarantine and isolation.</td>
<td>Yes</td>
<td>Federal and SF General Fund</td>
</tr>
<tr>
<td>8</td>
<td>DPC</td>
<td>Reportable diseases and conditions</td>
<td>CCR, Title 17, Div. 1, Chap. 4, §§2500-2643.20</td>
<td>Duties of Health Officer related to reporting of reportable diseases to the State Department of Public Health.</td>
<td>Yes</td>
<td>Federal and SF General Fund</td>
</tr>
<tr>
<td>9</td>
<td>DPC</td>
<td>Perinatal Hepatitis B Program</td>
<td>Not mandated but a State contract requirement; H&amp;S Code §§125080-125105</td>
<td>Designate a Perinatal Hep B coordinator &amp; case manage low income women (&amp; their babies) testing Hep B positive at time of birth.</td>
<td>Yes</td>
<td>Federal funding through CDPH Immunization Contract</td>
</tr>
<tr>
<td>10</td>
<td>DPC</td>
<td>STD control</td>
<td>H&amp;S Code §§120500-120715; CCR, Title 17, Div. 1, Chap. 3, §1276(c); Chap. 4, §§2554, 2577, 2578, 2585, 2617, 2636</td>
<td>Local health department and Health Officer requirements related to sexually transmitted disease control.</td>
<td>Yes</td>
<td>Federal, State, SF General Fund, Medi-Cal, Family PACT</td>
</tr>
<tr>
<td>11</td>
<td>CHEP</td>
<td>Hepatitis C testing</td>
<td>H&amp;S Code §120917</td>
<td>Enables trained and state certified HIV test counselors to administer skin puncture rapid blood tests for HCV and HCV/HIV in addition to rapid HIV blood tests.</td>
<td>No</td>
<td>CDC, SF General Fund for counselor training and certification.</td>
</tr>
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<td>12</td>
<td>DPC</td>
<td>STD control</td>
<td>H&amp;S Code §§120500-120715; CCR, Title 17, Div. 1, Chap. 3, §1276(c); Chap. 4, §§2554, 2577, 2578, 2585, 2617, 2636</td>
<td>Local health department and Health Officer requirements related to sexually transmitted disease control.</td>
<td>Yes</td>
<td>Federal, State, SF General Fund, Medi-Cal, Family PACT</td>
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<td>13</td>
<td>DPC</td>
<td>STD control</td>
<td>8 USC §1521 (Immigration &amp; Naturalization Act §411)</td>
<td>Federal requirements to notify and pay local health authorities for refugees determined to have medical conditions affecting the public health and requiring treatment.</td>
<td>No</td>
<td>Federal pass-through grant for core programming</td>
</tr>
<tr>
<td>14</td>
<td>DPC</td>
<td>Immunization</td>
<td>H&amp;S Code §§120400 et seq.</td>
<td>Health Officer may establish immunization programs, including for childhood immunization, rubella, measles, and anti-rabic treatment.</td>
<td>No</td>
<td>Federal and State</td>
</tr>
<tr>
<td>15</td>
<td>DPC</td>
<td>Pediatric Immunization</td>
<td>H&amp;S Code §§120325-120380, 120400-120435</td>
<td>Requirements related to pediatric immunization prior to school admittance. Requires Health Officer to organize and maintain a program to make required immunizations available.</td>
<td>Yes</td>
<td>Federal and State funding through CDPH Immunization Contract</td>
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<tr>
<td>16</td>
<td>DPC</td>
<td>Travel immunization</td>
<td>None</td>
<td>N/A</td>
<td>No</td>
<td>Self-funded through revenue</td>
</tr>
<tr>
<td>17</td>
<td>DOPC</td>
<td>Adult influenza immunization</td>
<td>None</td>
<td>N/A</td>
<td>No</td>
<td>Vaccine provided through State</td>
</tr>
<tr>
<td>18</td>
<td>CHEP</td>
<td>Refugee health</td>
<td>8 USC §1521 (Immigration &amp; Naturalization Act §411)</td>
<td>Federal requirements to notify and pay local health authorities for refugees determined to have medical conditions affecting the public health and requiring treatment.</td>
<td>No</td>
<td>Federal pass-through grant for core programming</td>
</tr>
<tr>
<td>19</td>
<td>BH</td>
<td>Juvenile hall health and mental health services</td>
<td>CCR, Title 15, Div. 1, Chap. 1, §§1400, et seq.; W&amp;I Code §§299, 14029.5; specific juvenile court orders</td>
<td>Determines level of medical and mental health services to be provided to minors in detention.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>20</td>
<td>EMS</td>
<td>Prehospital emergency services</td>
<td>H&amp;S Code §§1797, et seq., §§1798, et seq.; CCR Title 22, Div. 9</td>
<td>Local EMS agency requirements for prehospital emergency medical services, including EMT and advanced EMT certification, accreditation of paramedics, disciplinary actions, trauma care plans, automatic external defibrillator registration, training, quality improvement, medical control and medical disaster preparedness, and ambulance regulation.</td>
<td>Yes</td>
<td>SF General Fund and Maddy EMS Fund (State)</td>
</tr>
<tr>
<td>21</td>
<td>EMS</td>
<td>Advanced life support (paramedic) program</td>
<td>H&amp;S Code §§1797, et seq.</td>
<td>Counties with an EMS system must designate a local EMS agency to plan, implement and evaluate an EMS system, have a medical director to provide medical control and to assure medical accountability, and be responsible for implementation of advanced life support systems and for monitoring of training programs.</td>
<td>Yes</td>
<td>SF General Fund and Maddy EMS Fund (State)</td>
</tr>
<tr>
<td>22</td>
<td>EMS</td>
<td>Paramedic base hospitals; trauma centers</td>
<td>H&amp;S Code §§1798, et seq.</td>
<td>Mandates the local EMS agency to designate and contract with base hospitals to provide medical direction of prehospital emergency medical care personnel; requires the local EMS agency implementing a trauma care system to establish policies and procedures and to designate and regulate the trauma centers.</td>
<td>Yes</td>
<td>SF General Fund and Maddy EMS Fund (State)</td>
</tr>
<tr>
<td>23</td>
<td>EMS</td>
<td>Disaster management</td>
<td>H&amp;S Code §§1797.150-1797.153</td>
<td>Requires the State EMS Authority to coordinate through local EMS agencies, medical and hospital disaster preparedness with other local, state and federal agencies and departments having a responsibility relating to disaster response, including authority to mobilize and coordinate emergency medical mutual aid resources.</td>
<td>No</td>
<td>SF General Fund and Maddy EMS Fund (State)</td>
</tr>
<tr>
<td>24</td>
<td>EH</td>
<td>Beach monitoring program</td>
<td>H&amp;S Code §§115875-115915</td>
<td>Local requirements for beach testing, sanitation, closure, and posting.</td>
<td>Yes</td>
<td>State Water Resource Control Board Grant</td>
</tr>
<tr>
<td>25</td>
<td>EH</td>
<td>Body art</td>
<td>H&amp;S Code §§119300-119309</td>
<td>Register practitioners and inspect local body arts establishments.</td>
<td>No</td>
<td>Regulatory License Fees</td>
</tr>
<tr>
<td>26</td>
<td>EH</td>
<td>California Smoke-free Workplace Law.</td>
<td>Labor Code §6404.5</td>
<td>Local enforcement of California’s Smoke-free Workplace law.</td>
<td>Yes</td>
<td>Dedicated Tobacco Tax Funds, Food facility license fees</td>
</tr>
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<td>27</td>
<td>EH</td>
<td>Childhood Lead Poisoning Prevention</td>
<td>H&amp;S Code §§105275-105310, 124125-124165; CCR, Title 17, Div. 1, Chap. 6, §33008</td>
<td>Local requirements related to the Childhood Lead Poisoning Prevention Program.</td>
<td>Yes</td>
<td>CDPH - Childhood Lead Poisoning Prevention Branch</td>
</tr>
<tr>
<td>28</td>
<td>EH</td>
<td>County sealer</td>
<td>B&amp;P Code §§12013-13730</td>
<td>Requirement that each county have a sealer, and duties and requirements of the sealer related to weights, measures, point-of-sale systems, and petroleum product sales.</td>
<td>Yes</td>
<td>Regulatory fees</td>
</tr>
<tr>
<td>29</td>
<td>DPH/OSH</td>
<td>Employee health</td>
<td>1) CCR, Title 17, Div. 1, Chap. 3, §1276(j); 2) CCR, Title 17, Div. 1, Chap. 3, §1306; 3) CCR, Title 8, Div. 1, Chap. 4, §5193; 4) CCR, Title 8, Div. 1, Chap. 4, §5197</td>
<td>1) Occupational health as a basic health service of a local health department; 2) Qualifications for occupational health trained staff; 3) Blood borne pathogen control plan, post-exposure evaluation and treatment; 4) Aerosol transmissible diseases.</td>
<td>Yes, but level flexible</td>
<td>General Fund</td>
</tr>
<tr>
<td>30</td>
<td>EH</td>
<td>Environmental health specialists</td>
<td>H&amp;S Code §§106000-106735</td>
<td>Requirements related to registered environmental health specialists.</td>
<td>No</td>
<td>State grant</td>
</tr>
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<td>31</td>
<td>EH</td>
<td>Food safety program</td>
<td>H&amp;S Code §§113700-113725.3</td>
<td>Requirements and local enforcement of California Retail Food Code.</td>
<td>No</td>
<td>Regulatory Fees</td>
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<tr>
<td>32</td>
<td>EH</td>
<td>Hazardous waste management program</td>
<td>H&amp;S Code §§25100-25250.30</td>
<td>Requirements regarding the proper disposal and handling of hazardous waste.</td>
<td>Yes</td>
<td>Inter-departmental Work Orders</td>
</tr>
<tr>
<td>33</td>
<td>EH</td>
<td>Housing and institutions</td>
<td>H&amp;S Code §§17000-17910, 17920-17928, 18897, 101045</td>
<td>Inspection authority for hotels, motels, detention facilities, employee housing, labor camps, and organized camps.</td>
<td>No</td>
<td>SF General Fund, Regulatory License Fees</td>
</tr>
<tr>
<td>34</td>
<td>EH</td>
<td>Medical waste regulation</td>
<td>H&amp;S Code §§117600-118360</td>
<td>Disposal requirements of medical waste including local authority and requirements.</td>
<td>Yes</td>
<td>Regulatory License Fees</td>
</tr>
<tr>
<td>35</td>
<td>EH</td>
<td>Rodent extermination</td>
<td>H&amp;S Code §§116125-116170</td>
<td>Local authority regarding extermination of rodent infestations.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>36</td>
<td>EH</td>
<td>Solid waste management</td>
<td>Penal Code §§374.3-374.5</td>
<td>Local authority regarding proper disposal of solid waste.</td>
<td>No</td>
<td>Regulatory License Fees</td>
</tr>
<tr>
<td>37</td>
<td>EH</td>
<td>Swimming pool &amp; spa program</td>
<td>Yes, CHSC</td>
<td>Local inspection of public pools and spas.</td>
<td>Yes</td>
<td>Regulatory License Fees</td>
</tr>
<tr>
<td>38</td>
<td>EH</td>
<td>Underground storage tanks</td>
<td>H&amp;S Code §§25280-25299.8</td>
<td>Inspection and permitting of underground storage tanks.</td>
<td>Yes</td>
<td>Regulatory License Fees</td>
</tr>
<tr>
<td>39</td>
<td>EH</td>
<td>Vector control</td>
<td>H&amp;S Code §§101275-101285, 116110-116112, 116175-116183</td>
<td>Local authority and requirements on prevention of and response to vector borne diseases.</td>
<td>No</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>40</td>
<td>EH</td>
<td>Well monitoring program</td>
<td>H&amp;S Code §§116325-116345</td>
<td>Local requirements for inspection, monitoring, and surveillance of water supply systems.</td>
<td>Yes</td>
<td>Regulatory License Fees</td>
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<td>42</td>
<td>CHEP</td>
<td>Health Education</td>
<td>CCR, Title 17, Div. 1, Chap. 3, §1276(b)</td>
<td>Minimum standards for health education programs.</td>
<td>No</td>
<td>SF General Fund</td>
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<tr>
<td>43</td>
<td>CHEP</td>
<td>Bicycle, Scooter, Skateboard, Skate Helmet Requirement</td>
<td>VC §21212</td>
<td>Establishes requirements for helmet use by individuals under age 18, distribution of fines for non-use, including to local health departments, and appropriate expenditures of trust fund.</td>
<td>No</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>44</td>
<td>CHEP</td>
<td>Child Passenger Restraint Requirements</td>
<td>VC §§27360, et seq.</td>
<td>Establishes requirements for child passenger restraint, distribution of fines for non-use, including to local health departments, and appropriate expenditures of trust fund.</td>
<td>No</td>
<td>SFPD special revenue from traffic citations</td>
</tr>
<tr>
<td>45</td>
<td>EH</td>
<td>EH</td>
<td>Soils Analysis</td>
<td>SF Health Code 22A</td>
<td>Analysis of excavated soil in designated areas</td>
<td>No Regulatory License Fees</td>
</tr>
<tr>
<td>46</td>
<td>EH</td>
<td>California Smoke-free Workplace Law</td>
<td>Labor Code §6404.5</td>
<td>Local enforcement of California's Smoke-free Workplace law.</td>
<td>Yes</td>
<td>San Francisco Master Settlement Agreement Funds</td>
</tr>
<tr>
<td>47</td>
<td>HIV Health Services</td>
<td>Ryan White-funded services</td>
<td>Title XXVI of the Public Health Services Act (PL 111-87)</td>
<td>Provisions of funding under the Ryan White HIV/AIDS Treatment Extension Act of 2009.</td>
<td>Yes (maintenance of effort)</td>
<td>Federal funding with local and State MOE</td>
</tr>
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<td>48</td>
<td>DPC/CHEP</td>
<td>HIV testing, reporting, and intervention</td>
<td>H&amp;S Code §§120900-121140, 121025-121035; CCR, Title 17, Div. 1, Chap. 4, §§2641.5-2643.20</td>
<td>Responsibilities and requirements related to HIV testing, reporting, and intervention, including partner notification and names-based reporting.</td>
<td>Yes</td>
<td>CDC, State Office of AIDS for reporting. CDC, SF General Fund for counselor training and certification, labs and health navigation.</td>
</tr>
<tr>
<td>49</td>
<td>CHEP</td>
<td>HCV/HIV testing</td>
<td>H&amp;S Code §120917</td>
<td>Enables trained and state certified HIV test counselors to administer skin puncture rapid blood tests for HCV and HCV/HIV in addition to rapid HIV blood tests.</td>
<td>No</td>
<td>CDC, SF General Fund for counselor training and certification.</td>
</tr>
<tr>
<td>50</td>
<td>DPC</td>
<td>Reportable diseases and conditions</td>
<td>CCR, Title 17, Div. 1, Chap. 4, §§2500-2643.20</td>
<td>Duties of Health Officer related to reporting of reportable diseases to the State Department of Public Health.</td>
<td>Yes</td>
<td>CDC, State Office of AIDS for reporting. CDC, SF General Fund for lab support and reporting to HIV epi on community testing.</td>
</tr>
<tr>
<td>51</td>
<td>Jail Health</td>
<td>Jail medical services</td>
<td>Penal Code §§44000 et seq., 6030 et seq.; CCR, Title 15, Div. 1, Chap. 1, §§1200, et seq.; Federal Case Law based on the 5th and 14th amendments to the Constitution (i.e., Estelle v. Gamble)</td>
<td>Minimum required level of health services, or need to identify alternative services (e.g., contract hospital), available to adults in correctional facilities. Case Law establishes standard of access to health care.</td>
<td>Yes</td>
<td>SF General Fund, plus federal grants (Centers of Excellence, Prevention) for HIV/AIDS services</td>
</tr>
<tr>
<td>53</td>
<td>MCAH</td>
<td>MCAH Services Generally</td>
<td>CCR, Title 17, Div. 1, Chap. 3, §1276</td>
<td>Requirement that local health provide medical, nursing, educational, and other services to promote maternal and child health.</td>
<td>No</td>
<td>Federal Title V Block Grant, Federal Title XIX, USDA (Nutrition Services), Prop H (CHHP), Prop 10 (CHHP), SF General Fund</td>
</tr>
<tr>
<td>54</td>
<td>MCAH</td>
<td>Comprehensive Perinatal Services</td>
<td>H&amp;S Code §§123225-123255, W&amp;I Code §14134.5</td>
<td>Establishes local requirements for local Comprehensive Perinatal Services programs.</td>
<td>Yes</td>
<td>Federal Title V Block Grant, Federal Title XIX, SF General Fund</td>
</tr>
<tr>
<td>55</td>
<td>MCAH</td>
<td>Childhood Health, Disability &amp; Prevention Services (CHDP)</td>
<td>H&amp;S Code §§124025-124110; CCR, Title 17, Div. 1, Chap. 4, §§6800 et seq.; CCR, Title 22, Div. 3, Chap. 3, §§51340, 51532</td>
<td>Requirements for the CHDP program, including EPSDT services provided through CHDP.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, SF General Fund</td>
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<td>56</td>
<td>MCAH</td>
<td>Family Planning</td>
<td>CCR, Title 17, Div. 1, Chap. 3, §1276(k); H&amp;S Code §§101050, 101055, 124300; W&amp;I Code §14132; Title X of the Public Health Service Act (PL 91-572)</td>
<td>Requirements related to family planning, birth control, and pregnancy services.</td>
<td>Yes, but can be available via community clinics</td>
<td>Federal Title X, State General Fund, SF General Fund</td>
</tr>
<tr>
<td>57</td>
<td>MCAH</td>
<td>Family Planning Education</td>
<td>H&amp;S Code, §§101050, 101055, 124300; CCR, Title 17, Div. 1, Chap. 3, §1276(k); Title X of the Public Health Service Act (PL 91-572)</td>
<td>Designates Title X Family Planning Coordinator and coordinates Title X activities, including clinical and educational interventions, at local level.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, SF General Fund</td>
</tr>
<tr>
<td>58</td>
<td>MCAH</td>
<td>Well Child / Sick Child clinics</td>
<td>1) CCR, Title 17, Div. 1, Chap. 4, §§6800, et seq., W&amp;I Code §§16934 et seq.; 2) CCR, Title 22, Div. 3, Chap. 3, §§51340, 51532, et seq.</td>
<td>1) Requirements under CHDP; 2) Service mandates for EPSDT.</td>
<td>Yes</td>
<td>Federal Title XIX, Federal Title V Block Grant, SF General Fund</td>
</tr>
<tr>
<td>59</td>
<td>MCAH</td>
<td>Pediatric Immunization</td>
<td>H&amp;S Code §§120325-120380, 120400-120435</td>
<td>Requirements related to pediatric immunization.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, SF General Fund</td>
</tr>
<tr>
<td>60</td>
<td>MCAH</td>
<td>Child Health and Disability Prevention Education</td>
<td>H&amp;S Code §§124025-124110, 104395</td>
<td>Designates CHDP Medical Director and delineates CHDP activities at local level.</td>
<td>Yes</td>
<td>Federal Title V, SF General Fund</td>
</tr>
<tr>
<td>61</td>
<td>MCAH</td>
<td>Sudden Infant Death Syndrome</td>
<td>H&amp;S Code, §123740</td>
<td>Establishes qualifications and duties of SIDS follow up by local health departments.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, Federal Title XXI, SF General Fund</td>
</tr>
<tr>
<td>62</td>
<td>MCAH-CCS</td>
<td>California Children’s Services</td>
<td>H&amp;S Code §§123800-123995; CCR Title 17, Div. 1, Chap. 3, §1253, Div. 1, Chap. 4, §§2890-2932; CCR Title 22, Div. 2, Chaps. 1-13, §§41510-42720</td>
<td>Regulation for administration of California Children Services program, county match, determination of eligibility, and administrative staffing standards.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, Federal Title XXI, SF General Fund</td>
</tr>
<tr>
<td>63</td>
<td>MCAH-CCS</td>
<td>California Children’s Services</td>
<td>CCR, Title 22, Div. 3, Chap. 3, §§10103</td>
<td>Case Management of Medi-Cal beneficiaries.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, Federal Title XXI, SF General Fund</td>
</tr>
<tr>
<td>64</td>
<td>MCAH-CCS</td>
<td>California Children’s Services</td>
<td>CCR, Title 2, Div. 9, Chap. 1, §§560300-60330; Government Code §§7570-7587</td>
<td>Medical Therapy Program relationship with Education Agencies.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, Federal Title XXI, SF General Fund</td>
</tr>
<tr>
<td>65</td>
<td>MCAH-CCS</td>
<td>California Children’s Services</td>
<td>Insurance Code §§12693.62-12693.69</td>
<td>California Children Services program carve-out from Healthy Families.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, Federal Title XXI, SF General Fund</td>
</tr>
<tr>
<td>66</td>
<td>MCAH-CCS</td>
<td>California Children’s Services</td>
<td>W&amp;I Code §§14093-14094.3</td>
<td>California Children Services program carve-out from Medi-Cal managed care.</td>
<td>Yes</td>
<td>Federal Title XIX, Federal Title V Block Grant, SF General Fund</td>
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<td>67</td>
<td>MCAH-Ph Nursing</td>
<td>Public Health Nursing</td>
<td>H&amp;S Code §§101100-101115; CCR, Title 17, Div. 1, Chap. 3, §§1253, 1276(d)</td>
<td>Requirements for local Public Health Nursing, including basic services (communicable and infectious disease control; maternal, child &amp; adolescent health; abuse prevention &amp; detection in the home; case management of handicapped children; assessment/prevention of accidents in the home; &amp; provision of services for populations at risk). Public health nursing staff will be under the supervision of a Director of Public Health Nursing.</td>
<td>No</td>
<td>Federal Title XIX, Federal Title V Block Grant, SF General Fund</td>
</tr>
<tr>
<td>68</td>
<td>MCAH-Ph Nursing</td>
<td>Registered Nurses</td>
<td>CCR Title 16, Div. 14, Art. 9, §§1409-1459, 1470-1474</td>
<td>Nursing regulations for Registered Nurses.</td>
<td>Yes</td>
<td>Federal Title XIX, Federal Title V Block Grant, SF General Fund</td>
</tr>
<tr>
<td>69</td>
<td>MCAH-Ph Nursing</td>
<td>Public Health Nurses</td>
<td>CCR Title 16, Div. 14, Art. 9 §§1490-1494</td>
<td>California Board of Registered Nursing certification requirements for Public Health Nurses.</td>
<td>Yes</td>
<td>Federal Title XIX, Federal Title V Block Grant, SF General Fund</td>
</tr>
<tr>
<td>70</td>
<td>MCAH-Ph Nursing</td>
<td>Pre- and Perinatal Substance Abuse</td>
<td>H&amp;S Code, Sec.123600, 123605</td>
<td>Pre- and perinatal substance abuse protocols.</td>
<td>Yes</td>
<td>Federal Title XIX, State General Fund, SF General Fund</td>
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<tr>
<td>71</td>
<td>MCAH-Ph Nursing</td>
<td>Foster Care Public Health Nursing</td>
<td>W&amp;I Code §§160101-160106, 16501.3</td>
<td>Health Care Program for Children in Foster Care.</td>
<td>Yes</td>
<td>Federal Title XIX, Federal Title XXI, State General Fund, SF General Fund</td>
</tr>
<tr>
<td>72</td>
<td>MCAH-Ph Nursing</td>
<td>Services for Children with Special Health Care Needs</td>
<td>W&amp;I Code §17710</td>
<td>Requirements for children with special health care needs, including individualized health care plan and individualized health care team.</td>
<td>Yes</td>
<td>Federal Title XIX, SF General Fund</td>
</tr>
<tr>
<td>73</td>
<td>MCAH-Ph Nursing</td>
<td>Mandated Reporters</td>
<td>W&amp;I Code §§15610-15610.65, 15630-15632, 15659</td>
<td>Mandated reporting of abuse of the elderly and dependent adults.</td>
<td>No</td>
<td>Federal Title XIX, Federal Title V Block Grant, SF General Fund</td>
</tr>
<tr>
<td>74</td>
<td>MCAH-Ph Nursing</td>
<td>Mandated Reporters</td>
<td>PC §§11164-11174.3</td>
<td>Mandated reporting of child abuse or neglect.</td>
<td>No</td>
<td>Federal Title XIX, SF General Fund</td>
</tr>
<tr>
<td>75</td>
<td>MCAH-Ph Nursing</td>
<td>Public health nurses</td>
<td>H&amp;S Code §§101100-101115</td>
<td>Cities or counties may employ public health nurse(s), who are registered nurses, and who shall attend to the health and sanitary conditions of the city or county.</td>
<td>Yes</td>
<td>Federal Title V Block Grant, Federal Title XIX, USDA (Nutrition Services), Prop H (CCHP), Prop 10 (CCHP), SF General Fund</td>
</tr>
<tr>
<td>76</td>
<td>Medically Indigent</td>
<td>Medical services for indigents</td>
<td>W&amp;I Code §§17000, et seq.</td>
<td>Requires County to relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, when such persons are not supported and relieved by their relatives or friends, their own means, by state hospitals or other state or private institutions.</td>
<td>No, but counties can't limit care to emergency services only</td>
<td>Realignment, SF General Fund</td>
</tr>
<tr>
<td>77</td>
<td>Medically Indigent</td>
<td>Emergency Medical Services (Maddy) Fund (EMSF)</td>
<td>H&amp;S Code §§1797.9B(a), et seq.</td>
<td>Authorizes establishment of the Emergency Medical Services Fund and provides specifications on the distribution of penalty assessments.</td>
<td>No</td>
<td>State (Maddy) funds</td>
</tr>
<tr>
<td>78</td>
<td>Medically Indigent</td>
<td>Trauma Care Funds (TCF)</td>
<td>H&amp;S Code §1797.199</td>
<td>Reimbursement for hospitals that provide trauma care services.</td>
<td>Yes</td>
<td>State (Maddy) funds with federal match</td>
</tr>
<tr>
<td>79</td>
<td>PHEPR</td>
<td>Public health emergency preparedness and response</td>
<td>CDC Public Health Emergency Preparedness (PHEP) Program Agreement</td>
<td>Establishes key areas for strengthening all hazards public health response. By accepting the agreement with CDPH, the Department agrees to plan and implement preparedness and response activities consistent with the agreement.</td>
<td>Yes, per agreement with CDPH</td>
<td>Federal (CDC) funds passed through CDPH with occasional one-time funding from State Homeland Security Grant Program (SHSGP) and Urban Area Security Initiative (UASI) funds</td>
</tr>
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<td>80</td>
<td>PHEPR</td>
<td>Healthcare Preparedness Program</td>
<td>HHS Hospital Preparedness Program Agreement</td>
<td>Enhance capacity of healthcare entities re all-hazards plans, interoperable communication systems, medical surge, healthcare worker protection, training, and response.</td>
<td>Yes, per agreement with CDPH</td>
<td>Federal HHS Hospital Preparedness Program passed through CDPH with occasional one-time funding from SHSGP and UASI</td>
</tr>
<tr>
<td>81</td>
<td>PHEPR</td>
<td>Natural or intentional biological, chemical, or other health threats</td>
<td>H&amp;S Code §101230</td>
<td>Use of public health funds allowed to increase capacity to respond to natural or intentional biological, chemical, or other health threats.</td>
<td>No</td>
<td>Federal (CDC) funds passed through CDPH with occasional one-time funding from SHSGP and UASI</td>
</tr>
<tr>
<td>82</td>
<td>PHD-General</td>
<td>Appointment of a Health Officer</td>
<td>H&amp;S Code §§101000-101010</td>
<td>Mandate and qualifications for a Health Officer.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>83</td>
<td>PHD-General</td>
<td>Enforcement of Health Officer orders by Sheriff and peace officers</td>
<td>H&amp;S Code §101029</td>
<td>Sheriff and peace officers may enforce orders of Health Officer to prevent the spread of any contagious, infectious, or communicable disease.</td>
<td>No</td>
<td>Not a DPH function – Sheriff &amp; SFPD responsibility</td>
</tr>
<tr>
<td>84</td>
<td>PHD-General</td>
<td>Control of communicable disease</td>
<td>H&amp;S Code §101030</td>
<td>The Health Officer shall enforce orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters; orders, including quarantine and other regulations, prescribed by CDPH; and statutes relating to public health.</td>
<td>No</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>85</td>
<td>PHD-General</td>
<td>Medical advisement</td>
<td>H&amp;S Code §101035</td>
<td>The Health Officer shall advise on medical matters any board or body vested with the management of any county pension or retirement system.</td>
<td>No</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>86</td>
<td>PHD-General</td>
<td>Emergency measures</td>
<td>H&amp;S Code §101040</td>
<td>The Health Officer may take necessary preventive measures during &quot;state of war emergency,&quot; &quot;state of emergency,&quot; or &quot;local emergency&quot; as defined in Government Code, and may certify any public health disaster condition if required for federal or state disaster relief.</td>
<td>No</td>
<td>Federal Emergency Management Agency (FEMA) - for Presidential declared disasters</td>
</tr>
<tr>
<td>87</td>
<td>PHD-General</td>
<td>Sanitary conditions of jails and detention facilities</td>
<td>H&amp;S Code §101045</td>
<td>The Health Officer shall investigate health and sanitary conditions in every county jail, every other publicly operated detention facility in the county and all private work furlough facilities and programs.</td>
<td>No</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>88</td>
<td>PHD-General</td>
<td>County family planning and birth control clinics</td>
<td>H&amp;S Code §101050</td>
<td>The Health Officer shall prepare a list of family planning and birth control clinics located in the county.</td>
<td>No</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>89</td>
<td>PHD-General</td>
<td>Control of prescription drugs and controlled substances</td>
<td>H&amp;S Code §101070</td>
<td>The Health Officer may take action against a person who, without a license, is distributing a prescription drug, controlled substance, or dangerous drug or device.</td>
<td>No</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>90</td>
<td>PHD-General</td>
<td>Local public health funding</td>
<td>H&amp;S Code §101230</td>
<td>Formula for and uses of public health funding including communicable disease control and public health surveillance activities.</td>
<td>No</td>
<td>State</td>
</tr>
<tr>
<td>91</td>
<td>PHD-General</td>
<td>Collection, tabulation, and analysis of public health statistics</td>
<td>CCR Title 17, Div. 1, Chap. 3, §1276(a).</td>
<td>Collection, tabulation and analysis of public health statistics, including mortality, natality, and morbidity, are required.</td>
<td>Type of product is at discretion of the Health Officer</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>92</td>
<td>DPC</td>
<td>Availability of public health laboratory services</td>
<td>H&amp;S Code §§101150 et seq.</td>
<td>The local health department shall have the services of a public health laboratory for the examination of specimens from suspected cases of infectious and environmental diseases.</td>
<td>No</td>
<td>50% SF General Fund; 50% revenue &amp; grants</td>
</tr>
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<td>93</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>H&amp;S Code §101150-101160; CCR, Title 17, Div. 1, Chap. 2, §§1029 et seq., 1705-1084</td>
<td>Requirement that the public health, the local health department of a city or county have available the services of a public health laboratory for the examination of specimens from suspected cases of infectious and environmental disease. Requires the laboratory and its personnel be approved by the State Department of Public Health and comply with the requirements of the federal Clinical Laboratory Improvement Amendments (CLIA).</td>
<td>Yes, but can be done by contract</td>
<td>50% SF General Fund; 50% revenue &amp; grants</td>
</tr>
<tr>
<td>94</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1, Chap. 2, §§1255 and 1302</td>
<td>Standards and requirements of the Public Health Laboratory Director.</td>
<td>Yes</td>
<td></td>
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<td>95</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>Yes, CCR, Title 17, Div. 1, Chap. 2, §1276</td>
<td>Basic public health laboratories required for counties of 50,000 or more.</td>
<td>Yes</td>
<td>50% SF General Fund; 50% revenue &amp; grants</td>
</tr>
<tr>
<td>96</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1, Chap. 4, §2505</td>
<td>Reporting requirements for laboratories confirming specific diseases or agents.</td>
<td>Yes</td>
<td>50% SF General Fund; 50% revenue &amp; grants</td>
</tr>
<tr>
<td>97</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1, Chap. 4, §2534</td>
<td>Public health laboratory test requirements for release of a case or carrier of specified communicable diseases.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>98</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1, Chap. 4, §2550</td>
<td>Clearance of food handlers for amebiasis must be performed by a public health laboratory.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>99</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1., Chap. 4, §2606</td>
<td>Requirements for testing of rabies samples by a public health laboratory.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>100</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1, Chap. 4, §2612</td>
<td>Requirements for testing of Salmonella infection samples by a public health laboratory.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>101</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1., Chap. 4, §2613</td>
<td>Requirements for testing of Shigella infection samples by a public health laboratory.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>102</td>
<td>DPC-Lab</td>
<td>Public Health Laboratory</td>
<td>CCR, Title 17, Div. 1, Chap. 4, §2628</td>
<td>Requirements for testing of typhoid fever samples by a public health laboratory.</td>
<td>Yes</td>
<td>SF General Fund</td>
</tr>
<tr>
<td>103</td>
<td>Vital Records</td>
<td>Registration of all births and deaths, including fetal deaths, and issuance of burial permits</td>
<td>H&amp;S Code §§ 102275 et seq.; CCR Title 17, Div. 1, Chapter 3, §§901 - 915 and Chapter 3, §1276(a); Elections Code §205</td>
<td>Local administration of birth and death registration and role of local health departments; sets fee amounts; regulations for records and statistics and public health services; requires notification of deaths to County election officials; can be done in conjunction with County Recorder’s office.</td>
<td>Yes</td>
<td>State Vital Records fees and SF General Fund</td>
</tr>
<tr>
<td>104</td>
<td>Vital Records</td>
<td>Sale of certified copies of the record of births, fetal deaths, and deaths</td>
<td>H&amp;S Code §103525 et seq.</td>
<td>The local registrar shall, upon request and payment of the required fee, supply a certified copy of the record of any birth, fetal death, or death registered with the official.</td>
<td>Yes</td>
<td>State Vital Records fees and SF General Fund</td>
</tr>
<tr>
<td>105</td>
<td>Vital Records</td>
<td>Data entry of birth, fetal death, and death information into the Automated Vital Statistics System (AVSS)</td>
<td>CCR Title 17, Sec 1276(a).</td>
<td>Requirement to collect, tabulate and analyze all public health statistics, including population data, natality, mortality and morbidity records. The method is at the discretion of the Health Officer</td>
<td>SF General Fund</td>
<td></td>
</tr>
<tr>
<td>Ref. #</td>
<td>Section</td>
<td>Program Area</td>
<td>Mandate Citation</td>
<td>Mandate Description</td>
<td>Is a level of service mandated?</td>
<td>Funding</td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td>--------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>-------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>106</td>
<td>Vital Records</td>
<td>Issuance of Medical Cannabis ID Cards</td>
<td>H&amp;S Code §§11362.7-11362.83</td>
<td>Counties shall provide applications upon request, receive and process completed applications, maintain records of identification card programs, utilize protocols developed by CDPH, and issue identification cards to approved applicants and designated primary caregivers. Counties may add a fee in addition to the state fee to cover county expenses.</td>
<td>Yes</td>
<td>State Medical Marijuana fee and SF General Fund</td>
</tr>
<tr>
<td>107</td>
<td>EH (local)</td>
<td>Air Quality</td>
<td>SF Health Code, Article 38</td>
<td>Review and installation of air cleaning equipment for residences in toxic pollutant zone</td>
<td>No</td>
<td>Regulatory fees</td>
</tr>
<tr>
<td>108</td>
<td>EH (local)</td>
<td>Alternate Water Sources for Non-potable uses</td>
<td>SF Health Code, Article 12C</td>
<td>Review of graywater system plans</td>
<td>no</td>
<td>Regulatory fees</td>
</tr>
<tr>
<td>109</td>
<td>EH (local)</td>
<td>Hazardous Material and Waste (HMUPA)</td>
<td>H&amp;S Code, Chapters 6.7, 6.75, 6.95, 6.11 of Div. 20, SF Health Code, Article 21</td>
<td>Registration and inspection of businesses that store hazardous materials in excess of threshold amounts</td>
<td>yes</td>
<td>Regulatory fees</td>
</tr>
<tr>
<td>110</td>
<td>EH (local)</td>
<td>Massage</td>
<td>SF Health Code, Article 29</td>
<td>Inspection and Permitting of Massage Establishments and Practitioners</td>
<td>No</td>
<td>Regulatory License Fees</td>
</tr>
<tr>
<td>111</td>
<td>EH (local)</td>
<td>Medical Marijuana Dispensaries</td>
<td>SF Health Code, Article 33</td>
<td>Inspection and Permitting of Medical Marijuana Dispensaries</td>
<td>no</td>
<td>Regulatory License Fee</td>
</tr>
<tr>
<td>112</td>
<td>EH (local)</td>
<td>Soils Analysis</td>
<td>SF Health Code 22A</td>
<td>Analysis of excavated soil in designated areas</td>
<td>No</td>
<td>Regulatory License Fees</td>
</tr>
</tbody>
</table>
San Francisco Community Health Improvement Plan

December 2012

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Executive Summary

In coordination with nonprofit hospital and academic partners as well as the broader San Francisco community, the San Francisco Department of Public Health (SFDPH) built on the success of the 14-month community health assessment (CHA) effort to create a community health improvement plan (CHIP) for San Francisco. Serving California’s only consolidated city and county and a diverse population of 805,235 residents, SFDPH and its partners endeavored to create a community-driven and transparent CHIP aligned with community values.

Building on the past success of Community Vital Signs, SFDPH relied on the Mobilizing for Action Through Planning and Partnerships (MAPP) framework to guide the current CHIP. The result was a community-driven CHIP development process that engaged more than 160 community residents and local public health system partners to identify the following key health priorities for action:

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

In collaboration with community residents and stakeholders, SFDPH and its partners developed goals and objectives for each priority as well as related measures and strategies that comprise the current CHIP. The diversity of project leads assigned to identified strategies – including a range of government agencies, public/nonprofit/community collaborations, nonprofit organizations, and other entities – demonstrates that the current CHIP is a bold effort to harness the collective impact of San Francisco’s communities and local public health system partners to improve population health. Slated to begin implementation in early 2013, SFDPH and its partners plan to conduct a CHA/CHIP process every three years in alignment with other health improvement initiatives. Please find a summary of San Francisco’s CHIP on the next page.

SFDPH encourages residents and community groups to join the CHIP process as it enters the Action Phase. For more information, please email chip@sfdph.org. By collaborating on priority health issues, community members will help realize the vision of making San Francisco the healthiest place in which to live, learn, play, and earn.

---

1 Please note that the summary CHIP presents broad-level priorities, goals, and objectives only. The detailed CHIP presents specific data at the citywide level and also highlights existing disparities by objective.
### PRIORITY 1: ENSURE SAFE + HEALTHY LIVING ENVIRONMENTS

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE</th>
</tr>
</thead>
</table>
| **a. Improve safety and crime prevention** | i. ▼ violent injury\(^2\)  
ii. ▲ feelings of safety at night  
iii. ▼ severe and fatal pedestrian injuries |
| **b. Reduce exposure to environmental hazards** | i. ▼ exposure to air pollution  
ii. ▼ exposure to traffic noise  
iii. ▼ housing violations  
iv. ▼ exposure to second-hand smoke |
| **c. Foster safe, green, “active” public spaces** | i. ▲ park/playground safety  
ii. ▲ access to open spaces and natural areas |

\(^2\) “Violent injury” refers to stab wounds, gunshot wounds, and injury from assault with blunt force.

### PRIORITY 2: INCREASE HEALTHY EATING + PHYSICAL ACTIVITY

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE</th>
</tr>
</thead>
</table>
| **a. Increase physical activity** | i. ▲ fitness in children  
ii. ▲ time spent walking and/or biking daily |
| **b. Increase healthy eating** | i. ▲ access to healthy, diverse food resources  
ii. ▲ daily consumption of fruits and vegetables  
iii. ▼ consumption of sugar-sweetened beverages |
| **c. Increase number of residents who maintain a healthy weight** | i. ▼ youth obesity  
ii. ▼ adult obesity |

### PRIORITY 3: INCREASE ACCESS TO QUALITY HEALTH CARE + SERVICES

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Improve integration + coordination of services across the continuum of care</strong></td>
<td>i. 100% of San Franciscans enrolled in either health insurance or Healthy San Francisco</td>
</tr>
</tbody>
</table>
| **b. Increase connection of individuals to the health services they need** | i. ▼ barriers to medical care  
ii. ▼ preventable hospital stays among seniors and persons with disabilities |
| **c. Ensure services are culturally + linguistically appropriate** | i. ▼ cultural and linguistic barriers to care |
| **d. Ensure San Franciscans have access to a health care home** | i. ▲ number of residents with a primary care provider |
Committed to a community-driven health improvement process, San Francisco selected Mobilizing for Action Through Planning and Partnerships (MAPP) as the framework for developing its community health improvement process. Developed by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC), MAPP is a community-wide strategic planning process for improving community health. Facilitated by public health leaders and used by local health departments across the country, MAPP helps communities apply strategic thinking to prioritize public health issues and to identify the resources needed to address them. MAPP is not an agency-focused assessment framework; rather, it is an interactive process that can improve the efficiency, effectiveness, and performance of local public health systems.

The MAPP process includes six key phases:

- Organizing for success and partnership development
- Visioning
- Conducting the four MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action: planning, implementing, and evaluating

Having completed the first three MAPP phases as part of its Community Health Assessment (CHA) process, San Francisco progressed to the stages of identifying strategic issues and formulating related goals and strategies to complete the current Community Health Improvement Plan (CHIP). SFDPH, in collaboration with the community and its partners, will begin implementing the CHIP – the final phase of the MAPP process – in early 2013.

The MAPP framework complements the city/county’s commitment to engage the community in health planning and action in a deliberate and meaningful way. MAPP also builds well on past community health improvement processes while more consistently involving traditional and non-traditional partners of the local public health system. In this way, MAPP offers a “new way of doing business” in San Francisco while achieving greater alignment between all members of the local public system and community.
Community + Partner Engagement

San Francisco’s CHA process engaged hundreds of community residents and local public health system stakeholders. Building on that success, SFDPH sought to engage a range of community stakeholders at each step of CHIP development. Specifically:

- **Hospital and academic partners** continued to partner with SFDPH on San Francisco’s CHA/CHIP Leadership Council, which has guided the development and will guide the implementation of San Francisco’s CHIP. The Leadership Council remains committed to transparency and community and partner engagement throughout the community health improvement process.

- **Nearly 30 community stakeholders** – including representatives from San Francisco’s nonprofit hospitals, academic institutions, health plans, the African American Health Disparities Project, San Francisco Human Services Agency, and SFDPH – gathered for a half-day session on August 3, 2012 to apply standard criteria to cross-cutting data themes and identify San Francisco’s top three health priorities for action.

- **Close to 70 community residents and members of the local public health system** – including representatives from K-12 education, higher education, philanthropy, nonprofit agencies, minority health equity coalitions, government (including the San Francisco Mayor’s Office and Health Commission), hospitals, and more – came together for a full-day session on August 28, 2012 to review San Francisco’s identified health priorities and draft goals and possible strategies for each priority.

- **More than 60 health content experts** engaged with SFDPH as well as its hospital and academic partners to refine priority goals, objectives, measures, and strategies that have come to form the current CHIP.

SFDPH wishes to acknowledge the expertise, enthusiasm, and countless hours committed to CHIP efforts by all persons listed above. SFDPH is committed to building on this foundation of community engagement and partnership as it implements and evaluates the impact of San Francisco’s CHIP.

San Francisco’s Vision for Health and Wellbeing

Healthy People, Healthy Families, Healthy Communities: living, learning, playing, earning in San Francisco

To develop a community-informed health and wellness vision for San Francisco, SFDPH commissioned four community focus groups between September 22, 2011 and March 22, 2012. In addition, SFDPH and its partners hosted a specific visioning session on June 13, 2012. To ensure adequate focus on vulnerable populations, the four community focus groups took place in those San Francisco neighborhoods with residents most likely to have high health disparities. While the focus of these meetings was access to health services, feedback from community members included broader concerns, including cultural and linguistic competency in service delivery, the need for community outreach and education, the importance of partnerships with community-based organizations, community safety concerns as prerequisite to health, expansion to a broader “wellness” orientation, and the socioeconomic factors that impact health in a community, such as unemployment, housing, and violence. The June 13, 2012
meeting focused on eliciting a vision of health and engaged 21 San Francisco residents, each representing a different neighborhood and none affiliated with a health or health care service agency.

In each of these sessions, participants answered the following questions, “What does health and wellbeing mean to you? Think about your family, your neighbors, your street, your community. What is your vision for health in San Francisco? What would you do to achieve that vision?”

The work of these community participants resulted in San Francisco’s vision for health and wellbeing, which SFDPH reviewed with and received endorsements for from its hospital and academic partners as well as SFDPH leadership, the San Francisco Mayor’s Office, and the San Francisco Health Commission.

At the Foundation: Values for Health and Wellness

From the visioning activities three key values emerged, which serve as the foundation for the process of community health improvement. These are cross-cutting principles that participants and community members viewed as essential to achieving San Francisco’s health vision. The three values for the Community Health Improvement Planning efforts include:

- **To facilitate ALIGNMENT of San Francisco’s priorities, resources, and actions to improve health and wellbeing.**
  - Engaging communities and health system partners to identify shared priorities and develop effective partnerships.
  - Harnessing the collective impact of individuals and organizations working together in coordination.

- **To promote COMMUNITY CONNECTIONS that support health and wellbeing.**
  - Getting to know each other and looking out for one another.
  - Increasing communication and collaboration among individuals and organizations within communities.

- **To ensure that HEALTH EQUITY is addressed throughout program planning and service delivery.**
  - Reducing disparities in health access and health outcomes for San Francisco’s diverse communities.
  - Partnering with those most affected by health disparities to create innovative and impactful health actions.

Each of the values is described in more detail below.

**Alignment**

During the CHA/CHIP process, many residents and service providers expressed the need for greater alignment of efforts in order to have the greatest impact on health; participants repeatedly commented on being in meetings with the same people for similar purposes and the need to merge related endeavors. As such, this plan defines “alignment” as shared priorities, partnerships, and collective effort to reach goals. Also, SFDPH, the University of California – San Francisco (UCSF), and San Francisco’s nonprofit hospitals have come together in a new leadership group under the banner of “Aligned for Action” to coordinate San Francisco’s health assessment and improvement activities.
Alignment brings together a number of intersecting initiatives, all of which share common aims:

- **San Francisco Health Improvement Partnerships (SFHIP):** A program of UCSF to improve the health of the community by integrating the interests, assets, and expertise of UCSF, community, and civic stakeholders to address the most compelling public health issues in San Francisco.

- **Health Care Services Master Plan (HCSMP):** Created by local ordinance, the HCSMP requires SFDPH and the San Francisco Planning Department to create a plan that identifies the current and projected needs for health care services in San Francisco and recommends how to achieve and maintain an equitable and appropriate distribution of health care services in the city.

- **Nonprofit Hospital Community Needs Assessment:** Building a Healthier San Francisco is a citywide collaborative of nonprofit hospitals, SFDPH, local foundations, health plans, and a variety of health organizations and philanthropic foundations that conducts a community health needs assessment for San Francisco every three years as required by state and now federal law.

- **Public Health Department Accreditation:** Public health department accreditation seeks to advance quality and performance within public health departments nationwide. Accreditation is conferred by the national Public Health Accreditation Board and documents the capacity of a public health department to perform the core functions of public health and the 10 Essential Public Health Services. Accreditation signifies that the health department has an appropriate mission and purpose and the ability to meet the needs of the community it serves. SFDPH is pursuing public health department accreditation for which this CHIP is a prerequisite.

Exhibit 2 below depicts how these various processes align.
“Community Connections” refers to engaging people and communities to solve problems collectively. Community members, including those unaffiliated with health or healthcare service agencies, expressed interest in being part of the process and not just the objects of interventions designed to “improve their health.”

Additionally, people stated their desire for greater social cohesion through connection to their communities by getting to know better and look out for their neighbors. They also noted the need for increased communication and collaboration among individuals and organizations within their communities as ways to foster community connection.

Connection with community exemplifies how San Francisco completed its CHA/CHIP by engaging San Franciscans in envisioning health for the city and in articulating and defining the strategies that will lead us to that vision. This value will become increasingly important during the implementation phase as we work to connect people and organizations to accomplish the goals and objectives of the CHIP.

Vulnerable populations and communities often experience health disparities; that is, they have poorer health outcomes than other segments of the population. Health disparities that are avoidable, associated with social disadvantages that create barriers to opportunity, and are considered ethnically unfair are called health inequities. Health equity requires addressing the social determinants of health (e.g., poverty, educational attainment) as a necessary first step to have a lasting and positive impact on health disparities (e.g., disparities in mortality and morbidity).

A NATIONAL MODEL IDENTIFYING THE SOCIAL + ECONOMIC FACTORS AFFECTING HEALTH

County Health Rankings is a project of the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation that helps counties across the country understand what influences how healthy residents are and how long they will live. The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work, and play. This important tool looks at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, access to healthy foods, air pollution levels, and income as well as rates of smoking, obesity and teen births. Each county is then ranked in each category and on each measure relative to other counties in the state.

---


4 www.countyhealthrankings.org
The *County Health Rankings* model, which appears in Exhibit 3, shows schematically how health factors affect health outcomes. The *Rankings* measure four types of health factors including physical environment, social and economic factors, clinical care, and health behaviors. (A fifth set of factors that influence health – genetics and biology – is not included in the *Rankings* model.)

As Exhibit 3 shows, the *Rankings* model holds that social and economic factors – also called social determinants of health – account for 40 percent of the impact on health outcomes. A clear implication of this framework is that vulnerable populations and communities often experience health disparities, at the foundation of which are often health inequities.

The *Rankings* uses the following seven indicators to measure the social and economic factors influencing health; San Francisco ranks 14 out of 56 counties in California for these factors.

### Exhibit 3. County Health Rankings Model

![County Health Rankings model ©2012 UWPHI]

### Exhibit 4. County Health Rankings 2012 Measures for San Francisco for Social + Economic Factors

<table>
<thead>
<tr>
<th>Social &amp; Economic Factors</th>
<th>San Francisco County</th>
<th>National Benchmark*</th>
<th>California</th>
<th>SF Rank Among CA Counties (of 56)^</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High school graduation</strong></td>
<td>76%</td>
<td>None Noted</td>
<td>74%</td>
<td>30</td>
</tr>
<tr>
<td><strong>Some college</strong></td>
<td>82%</td>
<td>68%</td>
<td>60%</td>
<td>1</td>
</tr>
<tr>
<td><strong>Unemployment</strong></td>
<td>9.5%</td>
<td>5.4%</td>
<td>12.4%</td>
<td>4</td>
</tr>
<tr>
<td><strong>Children in poverty</strong></td>
<td>15%</td>
<td>13%</td>
<td>22%</td>
<td>8</td>
</tr>
<tr>
<td><strong>Inadequate social support</strong></td>
<td>26%</td>
<td>14%</td>
<td>25%</td>
<td>44</td>
</tr>
<tr>
<td><strong>Children in single-parent households</strong></td>
<td>29%</td>
<td>20%</td>
<td>30%</td>
<td>24</td>
</tr>
<tr>
<td><strong>Violent crime rate per 100,000 population</strong></td>
<td>824</td>
<td>73</td>
<td>500</td>
<td>54</td>
</tr>
</tbody>
</table>

* 90th percentile (i.e., only 10 percent are better)  
^ “1” represents the best possible county rank; “56” the worst.
THE SOCIAL + ECONOMIC FACTORS AFFECTING HEALTH IN SAN FRANCISCO’S DIVERSE COMMUNITIES

One key challenge of the Rankings is the inability to drill down and assess these indicators for San Francisco’s neighborhoods and/or racial/ethnic populations; these data do not tell the whole story for San Francisco’s diverse population. To better illustrate San Francisco’s socioeconomic reality, and using the Rankings’ measures as a guide, the CHIP presents below a series of similar socioeconomic indicators for which data exist by neighborhood and subpopulation to highlight disparities within San Francisco.

Exhibit 5 below shows high school non-graduation, unemployment, poverty, and inadequate social support by race/ethnicity in San Francisco. As reported in the Rankings, these measures have critical and studied links to health:

- Educational attainment has an important impact on health as years of formal education correlates strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.
- Unemployment may lead to physical health responses ranging from self-reported physical illness to mortality, especially suicide. It has also been shown to lead to an increase in unhealthy behaviors related to alcohol and tobacco consumption, diet, exercise, and other health-related behaviors, which in turn can lead to increased risk for disease or mortality. Because employee-sponsored health insurance is the most common source of health insurance coverage, unemployment can also limit access to health care.
- Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors.
- Poor family support, minimal contact with others, and limited involvement in community life are associated with increased morbidity and early mortality. Furthermore social support networks have been identified as powerful predictors of health behaviors, suggesting that individuals without a strong social network are less likely to participate in healthy lifestyle choices.

The disproportionately high rates for Black/African American residents for every one of these socioeconomic factors underscores the significant health equity issues that exist for Black/African American San Franciscans.

---

5 Please note that, diverging from the Rankings, the current CHIP does not present data on children living in single-parent households. San Francisco’s rate of children in single-parent households may be higher than other areas given its significant lesbian, gay, bisexual, and transgender population. Please note that the US Census Bureau defines “family” as a group of two or more people living together who are related by birth, marriage, or adoption.
Exhibit 6 displays these same socioeconomic factors by San Francisco neighborhood. Only those neighborhoods consistently above the citywide average appear on the chart. Please note that it is primarily the same four to five neighborhoods that have the highest disparities among these social and economic determinants of health: Bayview, Chinatown, Downtown/Civic Center, Visitacion Valley, and Excelsior. The Financial District also shows significant disparities, but these data are less reliable due to the relatively small population living in this area.
Exhibit 7 displays violent crime in San Francisco’s neighborhoods. High levels of violent crime compromise physical safety and psychological wellbeing. Crime rates can also deter residents from pursuing healthy behaviors such as exercising outside. Additionally, some evidence indicates that increased stress levels may contribute to obesity, even after controlling for diet and physical activity levels.

Many of the same neighborhoods with low educational attainment, high unemployment, and high rates of poverty correlate with high rates of violent crime, specifically, Downtown/Civic Center, Bayview, and Chinatown. As in the chart above, only those neighborhoods with rates above the citywide average are displayed.
ADDRESSING SOCIAL + ECONOMIC INEQUITIES IN IDENTIFIED SAN FRANCISCO POPULATIONS AND NEIGHBORHOODS IS A PREREQUISITE TO ELIMINATING HEALTH DISPARITIES IN THESE COMMUNITIES

The data in the three previous exhibits identify the following key health equity issues in San Francisco:

- Black/African American San Franciscans fare worse than other residents on every social and economic factor affecting health status.
- Latino residents also fare more poorly than other San Franciscans on the social determinants of health.
- A handful of San Francisco neighborhoods rate poorly on multiple socioeconomic indicators known to lower residents’ health status:
  - Bayview
  - Chinatown
  - Downtown/Civic Center
  - Mission
  - South of Market
  - Visitacion Valley

The socioeconomic indicator data on these San Francisco neighborhoods and racial/ethnic populations strongly correlate with health disparities among San Franciscans. CHIP stakeholders repeatedly indicated the need to address these socioeconomic disparities before those communities and residents most affected by them can turn to the downstream factors that impact health. Please note, however, that while education, employment, income, social support, and other socioeconomic factors are important for health and wellbeing, the current CHIP does not address these issues directly. This is largely because these factors are broad social issues that require systematic, institutional change reaching beyond a local public health system’s primary activities. By highlighting the importance of social and economic factors on community health, we hope to provide further motivation to promote broad, cross-cutting efforts to affect change in these areas. To underscore the importance of addressing health equity as a foundational value for addressing population health, health disparities are highlighted in a separate “Equity” column in the health priority section of this CHIP. (Please see Page 19 for more information.)
Developing Health Priorities for San Francisco

In July and August 2012, SFDPH and its partners collaborated with the community to identify the following three key health priorities for San Francisco:

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

The following sections describe the community- and data-driven process that led to selection of these priorities for action.

**Data Sources + Synthesis**

**BLENDING THE PAST + PRESENT TO IMPROVE THE FUTURE**

Guided by the Mobilizing for Action Through Planning and Partnerships (MAPP) framework, SFDPH and its partners conducted four health assessments to identify community health needs and inform health priority selection: Community Themes and Strengths Assessment, Local Public Health System Assessment, Forces of Change Assessment, and Community Health Status Assessment. (All assessments may be accessed at [www.sfdph.org](http://www.sfdph.org). Please note that the purpose of and data sources for each assessment are noted in the exhibit below.) To build on its successful history of community engagement and health assessment, San Francisco elected to synthesize data collected from the four MAPP assessments with data gathered as part of [Community Vital Signs](http://www.sfdph.org) (CVS), the city/county’s last community health assessment and improvement effort conducted in 2010. Combining CVS and MAPP data yielded a more aligned community health assessment approach tailored to San Francisco.

**Exhibit 8. San Francisco CHA Data Sources**

- **Community Themes & Strengths Assessment (CTSA)**: What is important to our community? Perceptions about quality of life? What assets do we have?
  - Population Health & Prevention Integration Focus Groups
  - Health Care Services Master Plan (HCSMP) Task Force Recommendations
  - HCSMP Public Comment and Focus Groups

- **Local Public Health System (LPHSA)**: What are the activities, competencies, and capacities of our local public health system?
  - Conducted by Department of Environment with support from SFDPH

- **Forces of Change Assessment (FCA)**: What is occurring or might occur that will affect the LPHS or the community?
  - Compilation of HCSMP Issue Briefs

- **Community Health Status Assessment (CHSA)**: What does our health status look like? How healthy are our residents?
  - Header file document comprised of 150+ data indicators
To honor community members’ substantive contributions of time and energy devoted to generating MAPP data for the 2012 CHA process, San Francisco’s CHA/CHIP Leadership Council – consisting of SFDPH, nonprofit hospital, and academic partner representatives – took initial responsibility for synthesizing MAPP and CVS data.

The data synthesis process occurred as follows:

1. SFDPH staff grouped MAPP and CVS data by common themes, using “sticky wall” technology to group like data points.
2. SFDPH documented the outcomes of the sticky wall exercise in grid form, presenting easy-to-understand high-level data concepts by data source (e.g., MAPP assessment vs. CVS) and overarching theme. (Please see Appendix A.)
3. SFDPH staff vetted the resulting data synthesis grid with members of the CHA/CHIP Leadership Council, the San Francisco’s Mayor’s Office, and SFDPH leadership and amended the document as necessary.
4. On August 3, 2012, community residents and members of the broader local public health system had the opportunity to comment on the data synthesis grid following an in-depth presentation of MAPP and CVS data. Event participants approved and finalized the grid and cross-cutting data themes.

**CROSS-CUTTING THEMES**

CHA data synthesis yielded the seven cross-cutting themes listed below:

- Ensure safe and healthy living environments
- Improve behavioral health
- Increase access to quality health care and services
- Increase physical activity and healthy eating
- Reduce the spread of infectious disease
- Support early childhood development
- Support seniors and persons with disabilities

**What is a “sticky wall”**?

A sticky wall is a large adhesive surface that affords groups a visual and consensus-based means of organizing similar ideas into cross-cutting concepts and themes. Commonly used as part of Technology of Participation (ToP) facilitation methods, the sticky wall technique:

- Engages the participation of all group members,
- Helps groups – small and large – reach consensus, and
- Builds an effective team partnership.

SFDPH relied on the sticky wall technique throughout its CHA/CHIP process, using it to develop San Francisco’s health vision and values, synthesize CHA data into possible health priorities, and identify possible strategies for action along each identified priority.
HEALTH PRIORITY SELECTION

On August 3, 2012, SFDPH and its nonprofit hospital and academic partners convened nearly 30 stakeholders for a half-day session to identify community-driven, data-based health priorities for action in San Francisco. Participants included representatives from SFDPH, San Francisco’s nonprofit hospitals and other members of the Community Benefit Partnership, the University of California – San Francisco, and the San Francisco Human Services Agency. Following a brief presentation of San Francisco’s CHA efforts and resulting data and cross-cutting themes, session participants selected San Francisco’s three health priorities as follows:

1. Participants reviewed a set of five standard criteria developed and vetted by San Francisco’s CHA/CHIP Leadership Council. Inspired by the “Hanlon Method,” San Francisco priority-selection criteria include:
   - Magnitude/Size of the Public Health Issue
   - Other Factors Related to Importance of the Public Health Issue
   - Effectiveness of Interventions
   - Feasibility and Sustainability of Intervention Implementation
   - Equity

Please note that San Francisco elected to highlight equity as a priority-selection criterion to uphold the city/county’s fundamental value of reducing disparities in health access and outcomes for San Francisco’s diverse communities. (Please see Appendix B for a more detailed explanation of San Francisco’s priority-selection criteria.)
2. Each participant individually ranked the seven identified cross-cutting data themes against health priority-selection criteria with “1” indicating highest rank and “7” indicating lowest rank. (Please see Appendix C for the rating tool and a more detailed explanation of the scoring process.)

3. Facilitators totaled individual scores for each data theme and criterion to identify San Francisco’s top three health priorities for action. These priorities include:
   - Ensure Safe + Healthy Living Environment
   - Increase Healthy Eating + Physical Activity
   - Increase Access to Quality Health Care + Services

4. Session participants reviewed the identified priorities and agreed that all selected priority issues were reasonable and appropriate for San Francisco.

**PRIORITY ALIGNMENT WITH OTHER HEALTH IMPROVEMENT INITIATIVES**

As indicated in Exhibit 9 below, San Francisco’s health priorities align with and complement other health improvement efforts at the local, state, and national levels. Locally, current priorities align with goals identified by [Community Vital Signs](#), San Francisco’s community health assessment and improvement effort conducted in 2010. At the state level, San Francisco priorities reflect those of the [Let’s Get Healthy California](#) initiative. San Francisco’s health priorities also mirror those set forth by [Healthy People 2020](#) and the [National Prevention Strategy](#), both national level efforts.

**Exhibit 9. San Francisco Health Priority Alignment with Local, State, and Federal Initiatives**
The following sections detail goals, objectives, indicators, and targets for San Francisco’s health priorities as well as strategies and community assets/resources aligned with each priority. Please note that San Francisco selected the best available indicators to measure community health improvement along its chosen health priorities; however, San Francisco acknowledges that all indicators present limitations, meaning that more specific and appropriate indicators may become available in the future. In addition, please note that San Francisco presents only a select number of strategies in the current CHIP. This list in no way represents the full spectrum of efforts and partners working to improve population health in San Francisco; rather, listed strategies serve as an abbreviated representation of health improvement work happening in San Francisco among community residents, community-based organizations, as well as the private and public sectors.

San Francisco elected to set targets for each health improvement objective for both 2020 – in alignment with Healthy People 2020 – and 2016. In general, San Francisco determined the 2020 targets by adopting the Healthy People 2020 methodology of setting a 10 percent improvement over the most recent citywide baseline measurement for the respective indicator. This translates to an intermediate target of five percent improvement for 2016.

Focused on health equity, San Francisco deliberated its target setting methodology, considering whether to base targets on citywide averages versus targets that reflect the best-performing sub-populations (e.g., racial/ethnic group, neighborhood, or age group depending on the measure). San Francisco ultimately set targets based on the citywide average – intentionally not setting distinct targets by subpopulation – to show levels of acceptable improvement while also conveying the conviction that all San Francisco residents are entitled to the same high standard of health and wellness. (Please note, however, that, for each measure in the grids that follow, San Francisco highlights data for the best performing subpopulation as an indication of what is possible.) Some targets may appear especially ambitious; however, health equity – and the disparities health inequities cause – is a fundamental San Francisco value that drives decisions on resource allocation and intervention strategies.

To ensure CHIP readability, please note the icons below. Each icon corresponds to a different San Francisco health priority for action.

**Exhibit 10. San Francisco Health Priority Icons**

- **Priority 1: Ensure Safe + Healthy Living Environments**
- **Priority 2: Increase Healthy Eating + Physical Activity**
- **Priority 3: Increase Access to High Quality Health Care + Services**
Ensure Safe + Healthy Living Environments

Despite being one of the wealthiest and most socially progressive cities in the country, not everyone in San Francisco has a safe and healthy place to live. Some neighborhoods in San Francisco, for example, have great access to parks, public transit, grocery stores, and other resources that benefit health and wellness. Other neighborhoods – often poor communities of color – are closer to fast food and alcohol outlets, freeways, industrial pollutants, and other factors that contribute to high rates of disease, death, injury, and violence.

Community residents echoed the above in focus groups, community meetings throughout San Francisco’s CHA, and also as voiced through formal grievance channels such as through SFPDH’s Environmental Health Section. Bayview-Hunters Point residents, for example, voiced concerns about environmental hazards in their neighborhood and emphasized – along with other communities – the need for access to clean, green open spaces to support their health and wellbeing.

Exhibit 11. Premature Death by Homicide by Age-Adjusted Years of Life Lost (YLL)* for Males by Race/Ethnicity, 2004-2007

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>YLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>129 YLL</td>
</tr>
<tr>
<td>Black</td>
<td>1,388 YLL</td>
</tr>
<tr>
<td>Latino</td>
<td>224 YLL</td>
</tr>
<tr>
<td>White</td>
<td>6,988 YLL</td>
</tr>
</tbody>
</table>

*Years of life lost (YLL) equals the number of deaths multiplied by a standard life expectancy at the age at which death occurs.
Source: CADPH Annual Master Death File, calculated by SFPDH

Community data also indicate that certain neighborhoods and particular racial/ethnic groups are more impacted by crime and violence. San Francisco has an annual violent crime rate of 824 per 100,000, which is higher than both the state average (500 per 100,000) and the national benchmark (73 per 100,000). Looking at homicides alone, San Francisco experienced a decline in the number of homicides between 2007 and 2009; however, Black/African American residents, followed by Latinos, are more likely than other racial/ethnic groups to be killed prematurely by homicide.

The “Ensure Safe + Healthy Living Environments” priority highlights 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.

6 County Health Rankings, 2012
### PRIORITY 1: ENSURE SAFE + HEALTHY LIVING ENVIRONMENTS

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE (Source)</th>
<th>INDICATOR (Source)</th>
<th>SF BASELINE</th>
<th>EQUITY</th>
<th>2016 CITYWIDE TARGET (5% Improvement)</th>
<th>2020 CITYWIDE TARGET (10% Improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Improve safety and crime prevention</td>
<td>i. 👇 violent injury (SFGH)&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Annual SFGH violent injury incident rate per 100,000 population (SFGH Trauma Registry)</td>
<td></td>
<td>Black/African American: 453.8</td>
<td>75.1 (606/year = actual number)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Latino: 121.1</td>
<td></td>
<td>71.3</td>
<td>67.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best-performing: Asian: 18.9</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>ii. ↑ feelings of safety at night (SF City Survey/SCI)</td>
<td>Perceived safety at night among adult residents (SF City Survey)</td>
<td>Mission Bay: 15.80%</td>
<td>94107: 33.9%</td>
<td>51.1%</td>
<td>53.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Financial District: 7.10%</td>
<td>94112: 32.8%</td>
<td></td>
<td>56.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SOMA: 6.10%</td>
<td>94102: 31.4%</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bayview: 4.40%</td>
<td>94134: 22.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Excelsior: 4.00%</td>
<td>94124: 13.1%</td>
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<td></td>
<td></td>
<td></td>
<td>Best-performing: 94114: 75%</td>
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<tr>
<td></td>
<td>iii. 👇 severe and fatal pedestrian injuries (SF Pedestrian Safety Task Force)</td>
<td>Severe and fatal pedestrian injuries per 100 road miles, annually (SWITRS via SCI)</td>
<td>District 3: 22.8</td>
<td>District 3: 22.8</td>
<td>8.3</td>
<td>6.2&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>District 6: 19.6</td>
<td>District 6: 19.6</td>
<td></td>
<td>4.2&lt;sup&gt;9&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>District 5: 14.0</td>
<td>District 5: 14.0</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>District 1: 10.3</td>
<td>District 1: 10.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>District 11: 10.2</td>
<td>District 11: 10.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best-performing: District 7: 5.4</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>b. Reduce exposure to environmental hazards</td>
<td>i. 👇 exposure to air pollution (SCI)</td>
<td>Proportion of population living in area with 10 ug/m3 or higher 2.5 concentration (SFPDPH and Bay Area Air Quality Management District via SCI)</td>
<td></td>
<td>Mission Bay: 15.80%</td>
<td>1.20%</td>
<td>1.14%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Financial District: 7.10%</td>
<td></td>
<td></td>
<td>0.08%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SOMA: 6.10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bayview: 4.40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Excelsior: 4.00%</td>
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</tr>
</tbody>
</table>

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<sup>7</sup> “Violent injury” refers to stab wounds, gunshot wounds, and injury from assault with blunt force.

<sup>8</sup> Represents a 25% reduction in alignment with the San Francisco Pedestrian Safety Action Plan (PSAP).

<sup>9</sup> Represents a 50% reduction in alignment with the San Francisco PSAP.
<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE (Source)</th>
<th>INDICATOR (Source)</th>
<th>SF BASELINE</th>
<th>2016 CITYWIDE TARGET (5% Improvement)</th>
<th>2020 CITYWIDE TARGET (10% Improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.</td>
<td><img src="image" alt="exposure to traffic noise (SCI)" /></td>
<td>Percent of population living within an area with average daytime and nighttime noise levels greater than 60 decibels (SFDPH via SCI)</td>
<td><a href="#">Downtown/Civic Center: 99%</a> <a href="#">Western Addition: 98%</a> <a href="#">Financial District: 97%</a> <a href="#">Haight Ashbury: 96%</a> <a href="#">SOMA: 95%</a></td>
<td>70%</td>
<td>67%</td>
</tr>
<tr>
<td>ii.</td>
<td><img src="image" alt="housing violations (SFDPH)" /></td>
<td>Annual number of housing violations per 1,000 residents (SFDPH and Department of Building Inspection via SCI)</td>
<td><a href="#">Downtown/Civic Center: 24.5</a> <a href="#">Nob Hill: 13.2</a> <a href="#">SOMA: 11.5</a> <a href="#">Mission: 10.3</a> <a href="#">Russian Hill: 9.8</a></td>
<td>5.4</td>
<td>5.1</td>
</tr>
<tr>
<td>iii.</td>
<td><img src="image" alt="exposure to second-hand smoke (HP 2020)" /></td>
<td>Percent of adults who smoke (CHIS)</td>
<td><a href="#">Black/African American: 28.5%</a> <a href="#">Adults 18-24: 26.7%</a></td>
<td>11.5%</td>
<td>11.0%</td>
</tr>
<tr>
<td>c.</td>
<td><img src="image" alt="park/playground safety (CHIS)" /></td>
<td>Percent of San Francisco playgrounds scoring an “A” or “B” for infrastructure quality and condition, cleanliness, and upkeep (San Francisco Playground Report Card)</td>
<td>Subpopulation disparity data unavailable.</td>
<td>61.0%</td>
<td>64.1%</td>
</tr>
</tbody>
</table>

* Statistically unstable due to small subpopulation sample size; best data available.
## PRIORITY 1: ENSURE SAFE + HEALTHY LIVING ENVIRONMENTS

### GOAL

<table>
<thead>
<tr>
<th>OBJECTIVE (Source)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ii.  (^\uparrow) access to open spaces and natural areas (SCI)</td>
</tr>
</tbody>
</table>

### INDICATOR (Source)

<table>
<thead>
<tr>
<th>INDICATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of land that is open space (SF Planning Department via SCI)</td>
</tr>
</tbody>
</table>

### SF BASELINE

#### EQUITY

<table>
<thead>
<tr>
<th>CITYWIDE</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

#### 2016 CITYWIDE TARGET (5% Improvement)

<table>
<thead>
<tr>
<th>2016 CITYWIDE TARGET (5% Improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.8%</td>
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</tbody>
</table>

#### 2020 CITYWIDE TARGET (10% Improvement)

<table>
<thead>
<tr>
<th>2020 CITYWIDE TARGET (10% Improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.9%</td>
</tr>
</tbody>
</table>

### PROJECT LEAD(S)

<table>
<thead>
<tr>
<th>PROJECT LEAD(S)</th>
<th>SELECTED STRATEGIES</th>
<th>POSSIBLE INDICATOR(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOPE SF, Mayor’s Office</td>
<td>Implement recommendations of HOPE SF program, an initiative that seeks to transform eight of San Francisco’s most distressed public housing sites into vibrant, thriving communities through holistic revitalization.</td>
<td>Agendas and/or minutes from public implementation meetings</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Promote public-private partnerships to support community gardening projects, which promote individual and neighborhood health and wellbeing.</td>
<td>Creation and maintenance of community gardens</td>
</tr>
<tr>
<td>Mayor’s Office, Department of Children Youth and Their Families</td>
<td>Fully implement San Francisco’s Violence Prevention Plan.</td>
<td>• Dedicated staff to implement plan • Progress reports</td>
</tr>
<tr>
<td>SF Department of Environment</td>
<td>Implement recommendations of the Healthy Homes Project, a collaboration to develop a plan to transform the community’s vision of healthy homes and neighborhoods into achievable goals and actions with a particular focus on San Francisco’s southeastern neighborhoods.</td>
<td>• Agendas and/or minutes from public meetings • Evidence of trainings (e.g., training materials) provided to residents on Integrated Pest Management and the use of safer cleaning products</td>
</tr>
<tr>
<td>SF Department of Public Health</td>
<td>(^\uparrow) number of low-income households receiving free healthy homes assessments and, as needed and as funds are available, supporting physical improvements to the home environment.</td>
<td>Documentation that at least 100 low-income households have received free healthy homes assessment by 2016</td>
</tr>
</tbody>
</table>
### PRIORITY 1: ENSURE SAFE + HEALTHY LIVING ENVIRONMENTS

<table>
<thead>
<tr>
<th>PROJECT LEAD(S)</th>
<th>SELECTED STRATEGIES</th>
<th>POSSIBLE INDICATOR(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF Department of Public Health, Community Transformation Grant Team</td>
<td>Reduce exposure to second hand smoke in multi-unit housing.</td>
<td>Outline of findings gathered from apartment owners and tenants rights groups’ regarding smoke free housing through surveys, focus groups, and/or meetings</td>
</tr>
<tr>
<td>SF Department of Public Health, Community Transformation Grant Team</td>
<td>Facilitate creation of joint use agreements through creation of an online reservation system that will allow community groups to reserve school play yards during non-school hours (Evidence-Based).</td>
<td>Existence of single online database and reservation system expected by October 2015</td>
</tr>
<tr>
<td>SF Health Improvement Partnerships, SF Department of Public Health</td>
<td>Assess Deemed Approved Uses Ordinance (DAO) enforcement and implementation.</td>
<td>• Agendas and meeting notes</td>
</tr>
<tr>
<td>SF Human Services Agency – Department of Aging and Adult Services</td>
<td>Implement recommendations of the Age and Disability-Friendly San Francisco Work Group</td>
<td>• Surveys</td>
</tr>
<tr>
<td>SF Planning Department</td>
<td>Implement San Francisco Better Streets Plan, which creates a unified set of standards, guidelines, and implementation strategies to govern how San Francisco designs, builds, and maintains its pedestrian environment.</td>
<td>Minutes from public meetings focused on implementation</td>
</tr>
<tr>
<td>SF Planning Department</td>
<td>Completion of first phase, Green Connections grant program, which will result in a Citywide network of green streets that can be built over time, improving pedestrian and bicycle access to parks, open space, and the waterfront.</td>
<td>• Six concept plans</td>
</tr>
<tr>
<td>SF Recreation and Parks</td>
<td>Offer athletic programs to reduce violence.</td>
<td>SF Recreation and Parks online calendar of events + activities</td>
</tr>
</tbody>
</table>

### COMMUNITY ASSETS + RESOURCES (Examples)
- Strong interagency and community collaboration (e.g., SFHIP, CBP, Community Transformation Grant Team, Healthy Homes Project)
- **Sustainable Communities Index**, which facilitates health impact assessment in land use planning
- Strong existing programs that address these issues such as SF Tobacco Free Project and Bayview Safe Haven afterschool program (Effective Practice)
- Strong network of existing and well-maintained parks
Increase Healthy Eating + Physical Activity

Science links health conditions such as heart disease, diabetes, and cancer to daily practices like eating a healthy, balanced diet and getting 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 factors – such as whether people can afford to buy nutritious foods and safely engage in exercise in their neighborhoods – and environmental factors – such as whether healthy food options are locally available – impact what individuals eat as well as their activity practices.

As indicated in Exhibit 12 below, 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. 10

Physical activity can be discouraged by risk for injury. In San Francisco, for example, pedestrians face greater risk for injury and death in some neighborhoods than others. The Financial District, Chinatown, South of Market, Downtown/Civic Center, North Beach, Castro/Upper Market, Western Addition, Glen Park, and Mission neighborhoods exceed the citywide average for pedestrian injury and death. 11

The “Increase Healthy Eating + Physical Activity” priority strives to demonstrate the link between diet, inactivity, and chronic disease and 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 move more.


<table>
<thead>
<tr>
<th></th>
<th>San Francisco Percentage</th>
<th>California Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (ages 2-11), 2009</td>
<td>25.2</td>
<td>48.7</td>
</tr>
<tr>
<td>Teens (ages 12-17), 2009</td>
<td>6.8</td>
<td>19.9</td>
</tr>
<tr>
<td>Adults (ages 18+), 2005</td>
<td>46.9</td>
<td>48.7</td>
</tr>
</tbody>
</table>

Source: CHIS, 2005 and 2009

[Young people’s] diets are horrible corner store diets, they don’t have physical education in schools, and they are not paying attention to their health.

- Bernal Heights youth services provider

10 California Health Interview Survey, 2009
11 Calculated from 2004-2008 SWITRS data and 2007 population data from Applied Geographic Solutions, Inc.
## PRIORITY 2: INCREASE HEALTHY EATING + PHYSICAL ACTIVITY

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE (Source)</th>
<th>INDICATOR (Source)</th>
<th>SF BASELINE</th>
<th>2016 CITYWIDE TARGET (5% Improvement)</th>
<th>2020 CITYWIDE TARGET (10% Improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Increase physical activity</td>
<td>i. ↑ fitness in children (LGHC)</td>
<td>Percentage of physically fit children within the San Francisco Unified School District who score 6 of 6 on the California Fitness-gram test (CDE and SFUSD)</td>
<td>5th Grade (African American): 11.5% 7th Grade (African American): 12.9% 9th Grade (Native Hawaiian/Pacific Islander): 5.1%</td>
<td>5th grade: 20.3% 7th grade: 30.4% 9th grade: 34.8%</td>
<td>5th grade: 22.3% 7th grade: 33.4% 9th grade: 38.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best-performing: 5th Grade (White): 27.3% 7th Grade (Asian): 41.5% 9th Grade (Asian): 44.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ii. ↑ time spent walking and/or biking daily (SCI)</td>
<td>Minutes per day residents spend walking and/or biking for non-leisure, utilitarian trips (SFCTA via SCI)</td>
<td>Outer Mission, Bayshore, Hill Districts, and Sunset: &lt; 20 min.</td>
<td>27.6 min.</td>
<td>29.0 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best-performing: SOMA: 43.3 min.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Increase healthy eating</td>
<td>i. ↑ access to healthy, diverse food resources (SCI)</td>
<td>Food Market Access Score (SCI)</td>
<td>Treasure Island: 0 Visitacion Valley: 25 Lakeshore: 29 Bayview: 33 Ocean View: 45</td>
<td>56</td>
<td>59</td>
</tr>
</tbody>
</table>
## PRIORITY 2: INCREASE HEALTHY EATING + PHYSICAL ACTIVITY

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE (Source)</th>
<th>INDICATOR (Source)</th>
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<th>2020 CITYWIDE TARGET (10% Improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>EQUITY</td>
<td>CITYWIDE</td>
<td></td>
</tr>
<tr>
<td>ii.</td>
<td>↑ daily consumption of fruits and vegetables (CHIS)</td>
<td>Percent of children and teens (ages 2-17) who consume five or more servings of fruits and vegetables daily (CHIS)</td>
<td>Black/African American: Not Available(^\text{12}) White: 17.6%* Asian: 17.2%*</td>
<td>18.3%* 19.2%</td>
<td>20.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best-performing: Latino: 26.7%*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii.</td>
<td>↓ consumption of sugar-sweetened beverages (LGHC)</td>
<td>Percent of children and adolescents who consumed two or more glasses of soda or sugary drink yesterday (CHIS)</td>
<td>Asian: 24.2%* Latino: 33.9%*</td>
<td>17.2% 16.3%</td>
<td>15.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best-performing: White: 4.4%*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Increase number of residents who maintain a healthy weight</td>
<td>Percent of youth (San Francisco students in Grades 5, 7, and 9) who score within the “High Risk” category (obese) for body composition on the Fitnessgram physical fitness test (CDE via Kaiser Permanente)</td>
<td>American Indian/Alaska Native: 42.6% Latino: 37.7% Black/African American: 32.8%</td>
<td>24.2 23.0%</td>
<td>21.8%</td>
</tr>
<tr>
<td>i.</td>
<td>↓ youth obesity (LGHC/HP 2020)</td>
<td></td>
<td>Best-performing: Asian: 15.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii.</td>
<td>↓ adult obesity (HP 2020)</td>
<td>Percent of adults that report a BMI ≥ 30 (CHIS)</td>
<td>Latino: 56.9% Black/African American: 33.4%*</td>
<td>17.2% 16.3%</td>
<td>15.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Best-performing: Asian: 7.1%*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Statistically unstable due to small subpopulation sample size; best data available.

\(^{12}\) Please note that Black/African Americans and other racial/ethnic groups may be underrepresented among children and teens who consume 5+ servings of fruits and vegetables daily; CHIS does not provide estimates for samples smaller than 500 people.
# PRIORITY 2: INCREASE HEALTHY EATING + PHYSICAL ACTIVITY

<table>
<thead>
<tr>
<th>PROJECT LEAD(S)</th>
<th>SELECTED STRATEGIES</th>
<th>POSSIBLE INDICATOR(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Heart Association</td>
<td>Support healthy food procurement and healthy food retail incentives.</td>
<td>Documented procurement and incentive policies for healthy food</td>
</tr>
<tr>
<td>Boys and Girls Club of SF</td>
<td>Implement Power Play, 30 minutes of daily fun, non-competitive physical activity at each of San Francisco’s nine Boys and Girls Clubs.</td>
<td>Average daily attendance records</td>
</tr>
<tr>
<td>Children’s Council of SF</td>
<td>Increase physical activity by developing and enforcing a physical activity policy for child care providers involved in the US Department of Agriculture’s Child and Adult Care Food Program.</td>
<td>Written, approved physical activity policy</td>
</tr>
<tr>
<td>SF Department of Public Health</td>
<td>Maintain Safe Routes to Schools programming (Evidence-Based).</td>
<td>Continued online presence and project updates posted for Safe Routes to Schools Program</td>
</tr>
<tr>
<td>SF Human Services Agency - Department of Aging and Adult Services</td>
<td>Continue to support evidence-based preventive programs for adults with disabilities and seniors such as Chronic Disease Self-Management and Healthier Aging.</td>
<td>Department of Aging and Adult Services Annual Area Plan Update</td>
</tr>
<tr>
<td>SF Municipal Transportation Agency</td>
<td>Encourage more regular physical activity through a citywide network of Sunday Streets events (Promising Practice).</td>
<td>Online calendar of Sunday Streets events</td>
</tr>
<tr>
<td>SF Municipal Transportation Agency, SF Bike Coalition</td>
<td>Connect emerging regional bike sharing project with HOPE SF projects and other city-funded development to ensure the presence of bike sharing at the new developments.</td>
<td>Map of bike sharing stations + HOPE SF project locations</td>
</tr>
<tr>
<td>SF Municipal Transportation Agency, SF Bike Coalition</td>
<td>↑ creation of new separated bikeways in San Francisco.</td>
<td>Agendas and/or minutes from public meetings advancing installation of bike sharing system</td>
</tr>
<tr>
<td>Shape Up SF</td>
<td>Promote physical activity through Shape Up SF’s annual Walking Challenge.</td>
<td>Data from Walking challenge website + database</td>
</tr>
<tr>
<td>Shape Up SF</td>
<td>↑ education and awareness efforts regarding the health impacts of sugar-sweetened beverages.</td>
<td>• Organizations adopting wellness policies • Copies of awareness campaign materials</td>
</tr>
<tr>
<td>Shape Up SF, Kaiser Permanente, Healthy Eating Active Living (HEAL) Zone, Southeast Food Access Work Group, Tenderloin Healthy Corner Store Coalition, SF Department of Public Health, Community Transformation Grant Team</td>
<td>Conduct healthy retail assessments in the Bayview-Hunters Point and Tenderloin neighborhoods.</td>
<td>Store assessment data from Bayview and Tenderloin as well as retail assessments from other neighborhoods</td>
</tr>
<tr>
<td>Shape Up SF/Physical Education Advocates, University of California-Berkeley, SF Unified School District</td>
<td>↑ amount of physical education for elementary school students by working with SFUSD administration and principals.</td>
<td>University of California, Berkeley Physical Education Assessment</td>
</tr>
</tbody>
</table>
### PRIORITY 2: INCREASE HEALTHY EATING + PHYSICAL ACTIVITY

<table>
<thead>
<tr>
<th>PROJECT LEAD(S)</th>
<th>SELECTED STRATEGIES</th>
<th>POSSIBLE INDICATOR(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast Food Access Work Group + Other Neighborhood-Specific Groups</td>
<td>Implement Food Guardian program in underserved neighborhoods.</td>
<td>Agendas and/or minutes from public meetings advancing expansion of Food Guardian program to other neighborhoods</td>
</tr>
<tr>
<td>YMCA of San Francisco</td>
<td>Develop and implement healthy eating and nutritional standards in all YMCA youth and out-of-school time programs in San Francisco.</td>
<td>Audit of YMCA-provided meals and snacks by JNC Consulting</td>
</tr>
<tr>
<td>YMCA of San Francisco</td>
<td>Develop and implement physical activity standards measuring minutes per day on age- and program-appropriate basis.</td>
<td>Evidence of written physical activity standards</td>
</tr>
</tbody>
</table>

### COMMUNITY ASSETS + RESOURCES (Examples)

- Strong interagency and community collaboration to improve nutrition (e.g., SFHIP, Southeast Food Access Network, SF Food Security Task Force)
- Strong interagency and community collaboration to improve opportunities for physical activity (e.g., Sunday Streets, Walk First, Bayview HEAL Zone, Safe Routes to School, SFHIP)
- Current Assessment Efforts: Communities of Excellence in Nutrition, Physical Activity, and Obesity Prevention (CX³)
Increase Access to High Quality Health Care + Services

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 – ranging from low-income persons to non-native English speakers seeking culturally competent care in their primary language – 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.13 As indicated in Exhibit 13 above, however, San Francisco falls short of the Healthy People 2020 target for residents with a usual source of care.

<table>
<thead>
<tr>
<th>Usual source of care (all ages)</th>
<th>San Francisco Percentage</th>
<th>California Percentage</th>
<th>HP 2020 National Target Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>86.8</td>
<td>85.8</td>
<td>95.0</td>
</tr>
</tbody>
</table>

Source: California Health Interview Survey (CHIS), 2009; Healthy People 2020

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. According to a study conducted in 2008, 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.14

Data also suggest that San Franciscans who speak English less than very well – as well as English speakers with limited literacy skills – may struggle to access 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.

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

13 Health Matters in San Francisco; American Community Survey 1-Year Estimates, 2010
### PRIORITY 3: INCREASE ACCESS TO HIGH QUALITY HEALTH CARE + SERVICES

<table>
<thead>
<tr>
<th>GOAL</th>
<th>OBJECTIVE (Source)</th>
<th>INDICATOR (Source)</th>
<th>SF BASELINE</th>
<th>2016 CITYWIDE TARGET (5% Improvement)</th>
<th>2020 CITYWIDE TARGET (10% Improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>EQUITY</td>
<td>CITYWIDE</td>
<td>CITYWIDE</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>94%</td>
<td>99%</td>
</tr>
<tr>
<td>a.</td>
<td>Improve integration + coordination of services across the continuum of care</td>
<td>i. 100% of San Franciscans enrolled in either health insurance or Healthy San Francisco (HP 2020/Community Target)</td>
<td>Percent of currently insured (CHIS) + percent enrolled in Healthy San Francisco (HSF)</td>
<td>Subpopulation data unavailable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>94%</td>
<td>99%</td>
</tr>
<tr>
<td>b.</td>
<td>Increase connection of individuals to the health services they need</td>
<td>i. bar. to medical care (HP 2020)</td>
<td>Percent of persons who delayed or did not obtain medical care (CHIS)</td>
<td>White: 23.5%</td>
<td>Black/African American: 19.7%*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15.1%</td>
<td>14.3%</td>
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<td></td>
<td></td>
<td><strong>Best-performing:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Asian: 2.5%</td>
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<td></td>
<td></td>
<td></td>
<td>Subpopulation data unavailable</td>
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<td></td>
<td></td>
<td>49</td>
<td>47</td>
</tr>
<tr>
<td>c.</td>
<td>Ensure services are culturally + linguistically appropriate</td>
<td>i. cultural and linguistic barriers to care (Community Target)</td>
<td>Percent of adults who speak a language other than English at home who have difficulty understanding their doctor (CHIS)</td>
<td>Spanish: 29.9%*</td>
<td>English &amp; Spanish: 9.9%*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.1%</td>
<td>2.0%</td>
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<tr>
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<td></td>
<td></td>
<td><strong>Best-performing:</strong></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>English: 0.6%</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Ensure San Franciscans have access to a health care home</td>
<td>i. number of residents with a primary care provider (HP 2020/Community Target)</td>
<td>Percent of persons who have a usual place to go when sick or need health advice (CHIS)</td>
<td>Asian: 85.4%</td>
<td>Latino: 86.8%*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>86.8%</td>
<td>91.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Best-performing:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Black/African American: 97.8%*</td>
<td></td>
</tr>
</tbody>
</table>

* Statistically unstable due to small subpopulation sample size; best data available.
### PRIORITY 3: INCREASE ACCESS TO HIGH QUALITY HEALTH CARE + SERVICES

<table>
<thead>
<tr>
<th>PROJECT LEAD(S)</th>
<th>SELECTED STRATEGIES</th>
<th>POSSIBLE INDICATOR(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF Department of Public Health</td>
<td>Implement the Medical Home Model at all SFDPH clinics (Evidence-Based)</td>
<td>Health Commission meeting minutes</td>
</tr>
<tr>
<td>SF Department of Public Health, Community Transformation Grant Team</td>
<td>↑ the number of primary care health systems in San Francisco that use community health workers to help patients manage chronic conditions (Evidence-Based).</td>
<td>Post-graduation placement data from City College of San Francisco Community Health Worker Certificate Program</td>
</tr>
</tbody>
</table>
| SF Department of Public Health; participating SF hospitals, community clinics, and medical groups | Maintain Healthy San Francisco (HSF) program. | • Continued [HSF online presence](#)  
• HSF Annual Reports |
| SF hospitals | Provide charity care to qualified individuals. | Annual Charity Care Report |
| SF hospitals | Provide medical financial assistance for those who qualify. | Annual Charity Care Report |
| SF Human Services Agency - Department of Aging and Adult Services | ↑ access to long-term supports and services through better coordination of primary care and long-term supports and services. | Creation of Long-Term Care Integration Plan |
| SF Medical Society | Sustain a local health information exchange. | Continued online presence and operation of [HealthShare Bay Area](#) |
| YMCA of San Francisco | Develop and implement with health care providers and insurers community-based chronic disease prevention programs, such as the CDC-approved diabetes prevention program. | Written program brochures/materials |

### COMMUNITY ASSETS + RESOURCES (Examples)

- Health Reform as driver toward primary care home as well as integration and Coordination
- Healthy San Francisco + SFPATH
- SF system of care (SFDPH, nonprofit hospitals, community clinics, private providers)
As noted previously, the *County Health Rankings* model shows how four different factors (physical environment, health behaviors, clinical care, and social and economic factors) affect health outcomes. Health outcomes measure the health of a community and are often described as measures of morbidity (how healthy people feel) and mortality (how long people live).

San Francisco’s three CHIP priorities, combined with the CHIP’s foundational value of health equity, align with these four health factors. Exhibit 14 below illustrates this alignment and how it impacts key health outcomes currently facing San Francisco, as outlined in the Community Health Status Assessment.

**Exhibit 14. Alignment of CHIP to the *County Health Rankings* Model**

<table>
<thead>
<tr>
<th>Rankings Health Factor</th>
<th>CHIP Priority or Value</th>
<th>CHIP Goal</th>
<th>Improved Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Environment</td>
<td>Ensure Safe + Healthy Living Environments</td>
<td>Improve safety and crime prevention, Reduce exposure to environmental hazards, Foster safe, green, “active” public spaces</td>
<td>↓ injury and death due to violence, ↓ pedestrian injuries, ↓ obesity, ↓ incidence of cardiovascular disease, ↓ preventable emergency room visits</td>
</tr>
<tr>
<td>Health Behaviors</td>
<td>Increase Healthy Eating + Physical Activity</td>
<td>Increase healthy eating, Increase physical activity, Increase number of residents who maintain a healthy weight</td>
<td>↓ injury and death due to violence, ↓ pedestrian injuries, ↓ obesity, ↓ incidence of cardiovascular disease, ↓ preventable emergency room visits</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>Increase Access to High Quality Health Care + Services</td>
<td>Improve integration &amp; coordination of services across the continuum of care, Increase connection of individuals to the health services they need, Ensure services are culturally &amp; linguistically appropriate, Ensure San Franciscans have access to a health care home</td>
<td>↓ injury and death due to violence, ↓ pedestrian injuries, ↓ obesity, ↓ incidence of cardiovascular disease, ↓ preventable emergency room visits</td>
</tr>
<tr>
<td>Social &amp; Economic</td>
<td>Foundational Value of Health Equity</td>
<td>Equity measures for each objective, Highlight socio and economic determinants of health</td>
<td>↓ injury and death due to violence, ↓ pedestrian injuries, ↓ obesity, ↓ incidence of cardiovascular disease, ↓ preventable emergency room visits</td>
</tr>
</tbody>
</table>

- **↑** prenatal outcomes
- **↑** chronic disease outcomes
- **↓** health disparities
From Planning to Action: Next Steps

CHIP Implementation, Evaluation, and Sustained Action

San Francisco will begin CHIP implementation in early 2013. After implementation, San Francisco will:

- Continue to engage community stakeholders via CHIP implementation and evaluation activities.
- Evaluate and track progress along priority objectives and measures. This monitoring will take place annually and at the end of the current CHIP’s lifecycle. As required by specific objectives, longer term measures will be tracked as directed.

The current CHIP reflects coordinated health improvement efforts for the period 2013 to 2015 inclusive. In alignment with other initiatives, San Francisco will conduct a new CHA/CHIP process every three years. Such aligned initiatives include:

- SFDPH pursuit of public health department accreditation;
- Nonprofit hospital health assessment and community benefit requirements set forth by federal Health Reform, California Senate Bill 697, and the San Francisco Charity Care Ordinance;
- University of California, San Francisco Health Improvement Partnerships;
- Health Care Services Master Plan; and
- US Centers for Disease Control and Prevention Community Transformation Grant

To support sustained action, San Francisco is currently working to develop a community health improvement leadership structure that will include traditional and non-traditional partners as well as community residents. This body will oversee CHA/CHIP planning and implementation going forward and will assure alignment of San Francisco’s health improvement efforts for the benefit of all San Franciscans.

What You Can Do to Improve Community Health in San Francisco

SFDPH and its partners encourage all community residents and stakeholders to participate in improving health in San Francisco. Engagement can take many forms. For example:

- **Join** SFDPH and its partners as San Francisco enters the Action Phase of CHIP implementation. Please email chip@sfdph.org for more information.

- **Attend** regular meetings of the Community Benefit Partnership (CBP), which meets on the first Friday of each month from 10 am – 12 noon. CBP seeks to harness the collective energy and resources of San Francisco’s private nonprofit hospitals, City/County departments, community clinics, health plans, and nonprofit providers, residents, and advocacy groups to improve the health status of San Francisco residents as guided by community-identified health priorities.

- **Commit** yourself or your agency to improving health along a San Francisco-identified health priority. SFDPH and its partners acknowledge that the number of possible objectives and strategies for each health priority exceed what could reasonably be included in the current CHIP; however, all are welcome to use the CHIP to guide their own work and related efforts to improve health in San Francisco!
Appendix A: San Francisco CHA Data Synthesis Grid by Cross-Cutting Theme + Data Source

Please see the pages that follow for San Francisco’s final CHA data synthesis grid by cross-cutting theme and data source.

## Potential Priority Health Issues for San Francisco

<table>
<thead>
<tr>
<th>SOURCE ASSESSMENT</th>
<th>2012 ASSESSMENTS</th>
<th>2010 ASSESSMENT</th>
<th>Community Vital Signs</th>
</tr>
</thead>
</table>
| **Ensure Safe & Healthy Living Environments** | Community Themes and Strengths Assessment  
- Population Health & Prevention (PHP) Integration Focus Groups  
- Health Care Services Master Plan (HCSMP) Task Force Recommendations  
- HCSMP Public Comment and Focus Groups | Local Public Health System Assessment  
Conducted by Department of Environment with support from SFDPH | Forces of Change Assessment  
Compilation of HCSMP Issue Briefs | Community Health Status Assessment  
Harder+Co. document comprised of 150+ data indicators |
| | Certain communities and subpopulations face violence to greater degrees than others. In addition to threatening one’s physical health, violence also subjects communities to trauma and possible mental health issues. When asked to envision what a healthy San Francisco would look like, many residents cited safety as a key component. | There is moderate activity by the local public health system to diagnose and investigate health problems and health hazards. | San Francisco has an annual violent crime rate that is higher than the state average and national benchmark. | Rate of pedestrian injuries and deaths  
- **Current**: 101/100,000  
- **Target**: 20/100,000 |
| | Residents noted the importance of access to a quality, affordable education and economic (i.e., job) opportunities in order to secure a living wage that supports healthy choices. | There is significant activity by the local public health system to enforce laws and regulations that protect health and ensure safety. | Disparities in crime appear to exist by race/ethnicity and neighborhoods. | Violent crime rate  
- **Current**: 8.45/1,000  
- **Target**: 1.0/1,000 |
| | Many community residents cited the importance of a clean environment in promoting optimal health and wellbeing. Bayview residents, for example, cited concerns about environmental toxicity. | The HCSMP should address identified social and environmental factors that impede and prevent access to optimal care, including but not limited to violence and safety issues as well as environmental hazards. | Significant disparities exist between neighborhoods for risk of ped. injury & death. | Ratio of bike lanes and bike paths to miles of road  
- **Current**: 0.066 miles of bike lanes to 1 mile of streets  
- **Target**: 0.054 miles of bike lanes to 1 mile of streets |
| | The HCSMP should address identified social and environmental factors that impede and prevent access to optimal care, including but not limited to violence and safety issues as well as environmental hazards. | San Francisco has an annual violent crime rate that is higher than the state average and national benchmark. | Homicide is the leading cause of death among Latino males in San Francisco. | • Rate of pedestrian injuries and deaths  
- **Current**: 101/100,000  
- **Target**: 20/100,000 |
| | • San Francisco has an annual violent crime rate that is higher than the state average and national benchmark. | Disparities in crime appear to exist by race/ethnicity and neighborhoods. | Although there appears to be a recent dramatic decline in the number of homicides in San Francisco, Blacks/African Americans are more likely than those in other racial/ethnic groups to die of homicide. | Violent crime rate  
- **Current**: 8.45/1,000  
- **Target**: 1.0/1,000 |
| | • Significant disparities exist between neighborhoods for risk of ped. injury & death. | Significant disparities exist between neighborhoods for risk of ped. injury & death. | Although there appears to be a recent dramatic decline in the number of homicides in San Francisco, Blacks/African Americans are more likely than those in other racial/ethnic groups to die of homicide. | Ratio of bike lanes and bike paths to miles of road  
- **Current**: 0.066 miles of bike lanes to 1 mile of streets  
- **Target**: 0.054 miles of bike lanes to 1 mile of streets |
<table>
<thead>
<tr>
<th>SOURCE ASSESSMENT</th>
<th>TOPIC</th>
<th>ASSESSMENT</th>
<th>2010 ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Themes and Strengths Assessment</td>
<td>Improve Behavioral Health</td>
<td>Population Health &amp; Prevention (PHP) Integration Focus Groups</td>
<td>Income inequality is growing. San Francisco has the highest degree of income inequality among Bay Area counties, and certain sub-populations are more likely than others to experience poverty.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Care Services Master Plan (HCSMP) Task Force Recommendations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCSMP Public Comment and Focus Groups</td>
<td></td>
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<td></td>
<td></td>
<td>Local Public Health System Assessment</td>
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</tr>
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<td></td>
<td></td>
<td>Conducted by Department of Environment with support from SFDPH</td>
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<td>Forces of Change Assessment</td>
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<td>Compilation of HCSMP Issue Briefs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Community Health Status Assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Harder+Co. document comprised of 150+ data indicators</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Community Vital Signs</td>
</tr>
<tr>
<td>Improve Access to Quality Health Care &amp; Services</td>
<td>Increase Access to Quality Health Care &amp; Services</td>
<td>The need for culturally competent health care services, including language access, emerged throughout public comment and focus groups.</td>
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<tr>
<td></td>
<td></td>
<td>Some members of the public as well as participants in the monolingual Spanish focus group noted that they experienced limited access to health care services due to unlimited hours of operation.</td>
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<tr>
<td></td>
<td></td>
<td>Many focus group participants noted the need for greater access to affordable dental and vision services.</td>
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<td>Medi-Cal recipients expressed a desire for more options when choosing a health care</td>
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<td></td>
<td>There is moderate activity by the local public health system to evaluate the effectiveness, accessibility, and quality of personal and population-based health services.</td>
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<tr>
<td></td>
<td></td>
<td>There is moderate activity to inform, educate, and empower individuals and communities about health issues.</td>
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<td>There is moderate activity to place greater demand on San Francisco’s health care resources.</td>
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<td>Health care finance trends – including reimbursement mechanisms – impact the provision and outcomes of patient care.</td>
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<td>More than 12 languages are spoken in San Francisco, a sign of its cultural diversity.</td>
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<td>San Francisco offers a rich array health care services and resources to residents; however, resource availability does not necessarily equate with access.</td>
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<td>The Tenderloin, South of Market and Bayview-</td>
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<td>98 percent of San Franciscans have health insurance or enrolled in a comprehensive access program (Goal = 100%).</td>
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<td>Preventable emergency room visits:</td>
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<td>o Current: 3.237.8/10,000</td>
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<td>o Target: 234.6/10,000</td>
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<td></td>
<td>Hospitalization rate due to congestive heart failure</td>
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<td>o Current: 30.9/10,000</td>
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<td><strong>ASSESSMENT</strong></td>
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<td>Community Health Status Assessment Harder+Co. document comprised of 150+ data indicators</td>
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<td><strong>provider.</strong></td>
<td>• Many focus group participants cited cost as a barrier to care, particularly for the uninsured.</td>
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<td><strong>Public comment &amp; focus group comments touched on the importance of the location of health care facilities. Several members of the public – and representatives from all focus groups – noted that lengthy travel between home &amp; health care, particularly via public transit, pose a barrier to care.</strong></td>
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<td><strong>Focus groups participants &amp; community members noted long wait times for appointments can be a barrier to care &amp; can encourage inappropriate emergency room use.</strong></td>
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<td><strong>Many focus group participants, especially those with private health coverage, noted overall satisfaction with services received in San Francisco, and many noted the importance of customer service in the provision of health care.</strong></td>
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<td><strong>Public comment &amp; focus group participants commonly noted the importance of support services (e.g., navigators and “promotoras”) in helping people access needed services and health information.</strong></td>
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<td><strong>Focus group participants &amp; community members noted that lack of information or knowledge about resources prevents them from accessing the health care services they need. They cited the need for greater outreach &amp; education to bridge this information gap.</strong></td>
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<td><strong>by the local public health system to link people to needed personal and health services and assure the provision of health care when otherwise available.</strong></td>
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<td><strong>• Innovations in health information technology and health care delivery are shaping San Francisco’s health care future and offer the potential to improve access to care for all San Franciscans, including the city/county’s more vulnerable residents.</strong></td>
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<td><strong>• Approximately 24% of San Franciscans age five and older speak English less than very well, leaving them at risk for poorer health outcomes and more limited health care access.</strong></td>
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<td><strong>• Certain San Francisco subpopulations are more susceptible to limited health literacy and related outcomes – including San Francisco’s vulnerable populations (e.g., older adults, Hunters Point neighborhoods far exceed the city/countywide rate and goal for preventable emergency room visits.</strong></td>
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<td><strong>Hospitalization rate due to uncontrolled diabetes</strong></td>
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<td>o <strong>Target</strong>: 18.3/10,000</td>
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<td>o <strong>Current</strong>: 0.40/10,000</td>
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<td>o <strong>Target</strong>: 0.40/10,000</td>
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<tr>
<td><strong>Hospitalization rate due to immunization-preventable pneumonia or flu</strong></td>
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<td>o <strong>Current</strong>: 7.1/10,000</td>
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<td>o <strong>Target</strong>: 2.6/10,000</td>
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</table>
| TOPIC  | Community Themes and Strengths Assessment | • Population Health & Prevention (PHP) Integration Focus Groups  
• Health Care Services Master Plan (HCSMP) Task Force Recommendations  
• HCSMP Public Comment and Focus Groups | Local Public Health System Assessment Conducted by Department of Environment with support from SFDPH  
Forces of Change Assessment Compilation of HCSMP Issue Briefs  
Community Health Status Assessment Harder+Co. document comprised of 150+ data indicators | Community Vital Signs |

- The HCSMP should ensure that health care and support service providers have the cultural, linguistic, and physical capacity to meet the needs of San Francisco’s diverse population.
- The HCSMP should ensure that San Francisco residents – particularly those without regular car access – have available a range of appropriate transportation options (e.g., public transportation, shuttle services, bike lanes, etc.) that enable them to reach their health care destinations safely, affordably, and in a timely manner.
- The HCSMP should, to maximize service effectiveness and cost-effectiveness, ensure collaboration between San Francisco’s existing health and social services networks and the community.
- The HCSMP should facilitate sustainable health information technology systems that are interoperable, consumer-friendly, and that increase access to high-quality health care and wellness services.
- The HCSMP TF encourages SFDPH and the Planning Department to explore incentives for the development of needed health care infrastructure. Incentives should facilitate and expedite projects that meet the goals of the HCSMP TF, without creating unintended negative consequences (e.g., housing displacement).
- The HCSMP should promote the development of cost-effective health care delivery models that address patient needs.

- minority populations, immigrants, low-income persons, etc.).
- Existing service, or “connectivity,” gaps (e.g., in transportation, cultural and linguistic access, etc.) in San Francisco may prevent San Francisco’s vulnerable populations from accessing appropriate health care services needed to optimize their health and wellness.
- Promote community collaboration across the local public health system (e.g., with community-based organizations, academic institutions, etc.) to improve health outreach, education, and service delivery.
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</table>
| Community Themes and Strengths Assessment | Increase Physical Activity and Healthy Eating | • Population Health & Prevention (PHP) Integration Focus Groups | • Adults engaging in moderate physical activity
• Health Care Services Master Plan (HCSMP) Task Force Recommendations | o Current: 26.3%
• HCSMP Public Comment and Focus Groups | o Target: 30%
| | | • Forces of Change Assessment Compilation of HCSMP Issue Briefs | • Retail food environ. index
• Community Health Status Assessment Harder+Co. document comprised of 150+ data indicators |
| | | • HCSMP | o Current: 3.18 fast food/convenience stores per produce outlet
| | • Many focus groups – including all neighborhood focus groups – emphasized the importance of healthy eating and active living. Residents noted the need for affordable, accessible fresh foods and safe and affordable opportunities for physical activity. | o Target: 3.10 fast food/convenience stores per produce outlet
• Many residents noted their desire for increased green space in San Francisco to facilitate activity. | • Proportion of households within ½ mile of a farmer’s market
• The HCSMP should assess the need for future health care facility development and plan for San Francisco’s evolving health care needs to support “healthy” urban growth. | o Current: 35%
• Four of the top five leading causes of death for men in San Francisco are related to cardiovascular disease. | o Target: 88%
• Three of the top five causes of death for women in San Francisco are related to cardiovascular disease. | • 7th grade students who are physically fit
• African-Americans have far higher rates of death due to cardiovascular disease than San Franciscans overall. | o Current: 66.3%
• Among San Franciscans, Latinos are at greatest risk for obesity. | o Target: 66.1%
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| **Reduce the Spread of Infectious Disease** | Community Themes and Strengths Assessment  
- Population Health & Prevention (PHP) Integration Focus Groups  
- Health Care Services Master Plan (HCSMP) Task Force Recommendations  
- HCSMP Public Comment and Focus Groups | Local Public Health System Assessment  
Conducted by Department of Environment with support from SFDPH | Forces of Change Assessment  
Compilation of HCSMP Issue Briefs | Community Health Status Assessment  
Harder+Co. document comprised of 150+ data indicators |
| **Support Early Childhood Development** | | | Community Vital Signs |

- There is moderate activity to inform, educate, and empower individuals and communities about health issues.
- HIV/AIDS is the 7th leading cause of death among men in San Francisco, with a death rate among Black/African American men nearly three times that of the city overall.
- San Francisco has experienced an increase in active tuberculosis (TB) cases and ranks third statewide. Foreign-born Asians bear the largest TB burden; TB rates among Latinos have increased significantly.
- Number of clinicians on the SF Hep B Free Clinician’s Honor Roll (DPH)  
  - **Current**: 702 clinicians  
  - **Target**: 1,350 clinicians
- Infants fully immunized at 24 months  
  - **Current**: 79%  
  - **Target**: 90%
- HIV incidence estimate  
  - **Current**: 621 new infections  
  - **Target**: 467 new infections
- Chlamydia incidence rate  
  - **Current**: 530.4/100,000  
  - **Target**: 314.6/100,000
- Gonorrhea incidence rate  
  - **Current**: 258.6/100,000  
  - **Target**: 47.5/100,000
- Primary and secondary syphilis rate  
  - **Current**: 44.0/100,000  
  - **Target**: 2.1/100,000
- Liver and bile duct cancer incidence rate  
  - **Current**: 14.8/100,000  
  - **Target**: 5.5/100,000
- Tenderloin residents reported a lack of nearby family health services such as prenatal and pediatric care
- Black/African American babies in San Francisco have notably higher peri-natal and infant mortality rates compared to other racial/ethnic groups.
- The South of Market, Mothers who received early prenatal care  
  - **Current**: 87.3%  
  - **Target**: 90%
- Hospitalization rate due to pediatric asthma  
  - **Current**: 11.9/10,000  
  - **Target**: 3.3/10,000
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<td>Local Public Health System Assessment</td>
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<td>Support Seniors and Persons with Disabilities</td>
<td>The HCSMP should ensure that San Francisco has a sufficient capacity of long-term care options for its growing senior population and for persons with disabilities to support their ability to live independently in the community</td>
<td>Excelsior, Bayview-Hunters Point and Visitacion Valley neighborhoods, exceed city/county rates across three prenatal care and birth outcome risk factors.</td>
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<td>Over the next two decades, it is estimated that 55 percent of San Franciscans will be over the age of 45, and the population over age 75 will increase from seven percent to 11 percent by 2030. This has implications for the need of more long-term care options moving forward.</td>
<td>• Influenza immunization rate for residents age 65+ ○ Current: 76.2% ○ Target: 90%</td>
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<td>San Francisco has experienced a decrease in the number of families with young children.</td>
<td>• Hospitalization rate due to hip fractures among women ages 65+ ○ Current: 581.5/100,000 ○ Target: 433.8/100,000</td>
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<td>• Average wait time before receiving home-delivered meals ○ Current: 36 days ○ Target: 45 days (target met)</td>
<td>• Hospitalization rate due to hip fractures among men ages 65+ ○ Current: 319.2/100,000 ○ Target: 204.7/100,000</td>
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<td></td>
<td>• Disabled persons with health insurance ○ Current: 94.1% ○ Target: 100%</td>
<td>• Average wait time before receiving home-delivered meals ○ Current: 36 days ○ Target: 45 days (target met)</td>
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<td>• Percentage of San Francisco corners with curb ramps ○ Current: 89% ○ Target: 100%</td>
<td>• Disabled persons with health insurance ○ Current: 94.1% ○ Target: 100%</td>
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<td>Community Health Status Assessment</td>
<td>Number of SFDPH-subsidized supportive housing units o Current: 996 units o Target: 1650 units</td>
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<td>Mammogram history o Current: 81.2% o Target: 70%</td>
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<td>Colon Cancer Screening o Current: 77.8% o Target: 50% (target met)</td>
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### Appendix B: San Francisco Criteria for Prioritizing Key Health Issues

#### Criteria A: Magnitude/Size of the Public Health Issue
- Percent of population at risk
- Mortality rate, premature death rate, prevalence, incidence, or other measure of issue’s impact on population
- Degree of disparity between various groups (e.g., county versus other county, state, or federal comparisons; intra-county comparisons between groups)

#### Criteria B: Other Factors Related to Importance of the Public Health Issue
- Importance to the community; degree of public concern on the issue
- Level of support from community members and other stakeholders
- Alignment with national, state, and/or local health objectives
- Work on the issue is “mandated” by statute or other authority
- The local public health system has a clearly established role to address the issue
- Legal or ethical concerns related to the issue
- Linkage to an environmental concern, including safety

#### Criteria C: Effectiveness of Interventions
- Interventions have been successfully applied to the issue
- Level of evidence supporting the interventions
- Other rationale for use of interventions
- Preventability of the issue or condition
- Extent to which interventions will address root causes

#### Criteria D: Feasibility and Sustainability of Intervention Implementation
- Within the power of the local public health system to control
- Cost-effectiveness of the interventions
- Interventions are culturally appropriate and acceptable to community members
- Size of the gap between community resources currently addressing the issue and need
- Needed resources are available
- Timeliness of implementation and expected benefits
- Ease of implementation
- Ease and likelihood of sustainability/maintenance of effort
- Legal or ethical concerns that may arise as a result of the intervention

#### Criteria E: Equity
- Some groups are more affected by the issue/a health inequity exists for the issue (e.g., by race/ethnicity, gender, age, other social determinant of health)
**Criteria Definitions**

- **Health Disparity**: Difference in the distribution of disease and illness across populations.

- **Health Equity**: Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

- **Health Inequity**: Systemic, unfair, avoidable, and unjust differences in health status and mortality rates

- **Intervention**: Action intended to improve a specific public health issue

- **Social Determinant of Health**: Economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole
### Appendix C: San Francisco Health Prioritization Worksheet

**Instructions:**
1. Working by criteria across rows, rank each potential priority from 1 to 7, with 1 being the highest rank and 7 being the lowest. Each row of criteria should contain boxes with numbers 1 through 7.
2. Tally each column and put the totals in the Total Score row, so that each potential priority has a single score.
3. Rank the potential priorities from 1-7, with the column with the lowest score ranking 1 (highest) and the highest score ranking 7 (lowest).

<table>
<thead>
<tr>
<th>Criteria A: Impact on Health Status</th>
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<tbody>
<tr>
<td>Percent of population at risk</td>
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<td>Mortality rate, premature death rate, prevalence, incidence, or other measure of issue’s impact on population</td>
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<thead>
<tr>
<th>Criteria B: Importance of the Public Health Issue</th>
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<td>Importance to the community, degree of public concern on the issue</td>
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<tr>
<td>Level of support from community members and other stakeholders</td>
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<tr>
<td>Alignment with national, state, and/or local health objectives</td>
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<tr>
<td>Work on the issue is “mandated” by statute or other authority</td>
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<tr>
<td>The local public health system has a clearly established role to address issue</td>
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<tr>
<td>Legal or ethical concerns related to the issue</td>
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<tr>
<td>Linkage to an environmental concern, including safety</td>
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<tr>
<th>Criteria C: Effectiveness of Interventions</th>
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<tr>
<td>Interventions have been successfully applied to the issue</td>
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<tr>
<td>Level of evidence supporting the interventions</td>
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<tr>
<td>Other rationale for use of interventions</td>
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<td>Preventability of the issue or condition</td>
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<td>Extent to which interventions will address root causes</td>
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<tr>
<th>Criteria D: Feasibility and Sustainability of Intervention Implementation</th>
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<tr>
<td>Within the power of the local public health system to control</td>
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<td>Cost-effectiveness of the interventions</td>
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<tr>
<td>Interventions are culturally appropriate and acceptable to community members</td>
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<tr>
<td>Size of gap between community resources currently addressing the issue and need</td>
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<tr>
<td>Needed resources are available</td>
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<tr>
<td>Timeliness of implementation and expected benefits</td>
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<tr>
<td>Ease of implementation</td>
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<tr>
<td>Ease and likelihood of sustainability/maintenance of effort</td>
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<tr>
<td>Legal or ethical concerns that may arise as a result of the intervention</td>
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<th>Criteria E: Equity</th>
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<tr>
<td>Some groups are more affected by the issue/a health inequity exists for the issue (e.g., by race/ethnicity, gender, age, other social determinant of health)</td>
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<tr>
<td>Degree of disparity between various groups (e.g., county versus other county, state, or federal comparisons; intra-county comparisons between groups)</td>
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<th>Total Score</th>
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<tr>
<th>Priority Ranking</th>
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Appendix D: CHIP Acronym Glossary

- ACS: American Community Survey
- CBP: Community Benefit Partnership
- CDC: Centers for Disease Control and Prevention
- CDE: California Department of Education
- CHA: Community Health Assessment, a process that engages with community members and local public health system partners to systematically collect and analyze qualitative and quantitative health related data from a variety of sources within a specific community.
- CHIP: Community Health Improvement Plan, an action-oriented plan outlining the priority community health issues (based on CHA findings as well as community member and local public health system partner input) and how these issues will be addressed, including strategies and measures, to ultimately improve community health.
- CHIS: California Health Interview Survey. (Note: Due to small CHIS sample size, data by race/ethnic group and other subpopulations may be statistically unstable.)
- CHR: County Health Rankings
- CHSA: Community Health Status Assessment
- CTSA: Community Themes and Strengths Assessment
- CVS: Community Vital Signs
- DAO: Deemed Approved Ordinance
- FCA: Forces of Change Assessment
- HCSMP: Health Care Services Master Plan
- HEAL Zone: Healthy Eating Active Living Zone
- HOPE SF: Housing Opportunities for People Everywhere in San Francisco
- HP 2020: Healthy People 2020
- HSF: Healthy San Francisco
- LGHC: Let’s Get Healthy California
- LPHSA: Local Public Health System Assessment
- MAPP: Mobilizing for Action Through Planning and Partnerships
- NACCHO: National Association of County and City Health Officials
- PSAP: Pedestrian Safety Action Plan
- SCI: Sustainable Communities Index
• **SEFA:** [Southeast Food Access Work Group](#)

• **SF:** San Francisco

• **SFCTA:** [San Francisco County Transportation Authority](#)

• **SFDPH:** [San Francisco Department of Public Health](#)

• **SFPD:** [San Francisco Police Department](#)

• **SFGH:** [San Francisco General Hospital](#)

• **SFHIP:** [San Francisco Health Improvement Partnerships](#)

• **SF PATH:** [San Francisco Provides Access to Health Care](#)

• **SFUSD:** [San Francisco Unified School District](#)

• **UCSF:** [University of California, San Francisco](#)

• **YLL:** Years of Life Lost. YLL equals the number of deaths multiplied by a standard life expectancy at the age at which death occurs.
San Francisco Strategic Plan for Population Health

June 2014

Population Health Division
San Francisco Department of Public Health

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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

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 for Community Health**. 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

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.
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.

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 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 health 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

**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.

### PHD Strategies and Performance Measures 2012-2015

#### 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.

#### 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.

#### 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.

#### 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 health functions, including legally mandated public health activities.

#### 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.

#### Strategy 6: Build a division-wide learning environment that supports public health efforts.

**Performance Measures:**
- 6.1 Establish a division-wide Workforce Development Program.
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 look 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

<table>
<thead>
<tr>
<th>FOCUS AREA</th>
<th>HEADLINE INDICATOR</th>
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| Safe and Healthy Living Environments (CHIP) | • Percent exposed to air pollution  
• 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 diagnosis  
• Percent of newly diagnosed with HIV who receive care  
• Percent of HIV infected who are virally suppressed |
Prior to the question, the focus of the text is on the importance of safe and healthy living environments in San Francisco. The city is described as one of the wealthiest and most socially progressive in the United States, but not everyone has access to safe and healthy living conditions. While some neighborhoods enjoy good access to parks, public transit, grocery stores, and other resources that benefit health and wellness, others, often poor communities of color, rely on fast food and alcohol outlets. Freeways, industrial pollutants, and other factors contribute to high rates of disease, death, injury, and violence. Community outreach resulted in three reports: the Community Health Assessment (CHA), the Community Health Improvement Plan (CHIP), and the Health Care Services Master Plan (HCSMP). These reports guide the City’s health and wellness efforts.

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

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Description</th>
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<tbody>
<tr>
<td>Clean Air</td>
<td>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)</td>
</tr>
<tr>
<td>Tobacco Free Living</td>
<td>In alignment with the San Francisco philosophy related to smoking reduction, the department is committed to decreasing the percent of adults who smoke.</td>
</tr>
<tr>
<td>Pedestrian Safety</td>
<td>The department is a participant in the city wide initiative to decrease the number of deaths and severe injuries of pedestrians.</td>
</tr>
</tbody>
</table>

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 Franciscans live, learn, earn, and play.
Headline Indicator: Number of days in San Francisco with good air quality

**BASELINE CURVE**

**Number of Days in San Francisco with an EPA Air Quality Index Rating of "Good"**

Data source: U.S. EPA

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**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.

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).
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 SFPDH’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
THE STORY BEHIND THE BASELINE

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 accidents.
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

- 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 disproportionately 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
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.

<table>
<thead>
<tr>
<th>Priority Areas for Ensure Safe and Healthy Living Environments</th>
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<tbody>
<tr>
<td><strong>Food Security</strong></td>
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<tr>
<td><strong>Healthy Weight</strong></td>
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<tr>
<td><strong>Physical Activity</strong></td>
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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.
**Headline Indicator: Percent of residents who do not have food security (resource, access, consumption)**

**BASELINE CURVE**

### Percent of low-income* San Francisco adults unable to afford enough food (food insecure), 2001-2013

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.

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

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**Healthy People 2020**

**National Baseline:** 14.6% of population  
**National Target:** 6.0% of population

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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.
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
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.

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 or 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

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.

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.

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

BASELINE CURVE

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.

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.

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 health jurisdiction.
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, 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.

<table>
<thead>
<tr>
<th>Priority Areas</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Heart Health</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Women’s Health</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Sexual health</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

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

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.

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 Latino, 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 who 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

Female breast cancer death rates

- African-American Females
- All Females

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.

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.

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.

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

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.

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).

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).
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/gonorrhoea 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

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.

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

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.
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 San Francisco Department of Public Health’s Maternal, Child and Adolescent Health (MCAH) Branch has a mission to promote the health and well-being of women of childbearing age, families, infants, children and adolescents who are at increased risk of adverse health outcomes by virtue of financial, language or cultural barriers, or mental or physical disabilities by ensuring access to health promotion and health care services. MCAH focuses on the most vulnerable children and families and fills what would otherwise be a serious public health gap. MACH 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 in 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.

<table>
<thead>
<tr>
<th>Priority Areas for Mother, Child, and Adolescent Health</th>
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<td>Healthy Births Outcomes</td>
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<td>Child Well Treatment</td>
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<tr>
<td>Children’s Oral Health</td>
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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

Pre-term birth rates per 100 live births, San Francisco, 2008-2011

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.

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.

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.
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
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 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 in which it 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 recommends:
  - 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

**Percent of Kindergarten Children with Untreated Caries from San Francisco Public Schools, 2000-2010**

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.

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.

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.
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 experience 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 local pool 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\textsuperscript{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 patient
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. It is estimated that 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 PLWHA 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 to ensure 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.

<table>
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<tr>
<th>Priority Areas for Health for People at Risk of Living with HIV</th>
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<tr>
<td>Reducing New HIV Diagnoses</td>
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<tr>
<td>Access to Care for Newly HIV Diagnosed</td>
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<tr>
<td>Viral Suppression</td>
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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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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.

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 the 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 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
- CBO’s
- 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.

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

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.

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 ensure 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/IDU and those with no reported risk

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

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

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Data Source: HIV Surveillance Data, San Francisco Department of Public Health
(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
- CBOs
- 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**

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.

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

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**National HIV/AIDS Strategy National Target:** By 2015, increase the proportion with undetectable viral load by 20%
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 < 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, CBOs
- 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
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 improvements processes that will be used to develop Strategic Actions Plans. Each 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 the 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 a visuals of 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.
# Appendix A: Descriptions of Offices, Centers and Branches in the Population Health Division

## PHA Domain Category: Assessment/Research
### Applied Research, Community Health Epidemiology, & Surveillance

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<tbody>
<tr>
<td>Strategy 1</td>
<td>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.</td>
</tr>
<tr>
<td>Performance Measures 2012-2015</td>
<td><strong>Performance Measure 1.1:</strong> Build a strong, highly functional information technology (IT) and technical assistance infrastructure in alignment with Department of Public Health IT strategy. <strong>Performance Measure 1.2:</strong> Establish a highly functional, integrated infectious disease system to collect and report data, and to deliver and monitor public health actions.</td>
</tr>
<tr>
<td>Description</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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 |
<table>
<thead>
<tr>
<th>STRATEGIC DIRECTION</th>
<th>Assessment and research aligned with our vision and priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGY 2</td>
<td>Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.</td>
</tr>
<tr>
<td>PERFORMANCE MEASURES 2012-2015</td>
<td></td>
</tr>
<tr>
<td>PERFORMANCE MEASURE 2.1: Create an action plan that supports division priorities.</td>
<td></td>
</tr>
<tr>
<td>PERFORMANCE MEASURE 2.2: Build cross-section interdisciplinary teams to improve health outcomes and programmatic activities.</td>
<td></td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>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. 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.</td>
</tr>
</tbody>
</table>
| 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**

**Bridge HIV**

<table>
<thead>
<tr>
<th>Strategic Direction</th>
<th>Assessment and research aligned with our vision and priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy 2</td>
<td>Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.</td>
</tr>
</tbody>
</table>
| 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 |
### PHA Domain Category: Policy Development

**Office of Equity & Quality Improvement**

<table>
<thead>
<tr>
<th>Strategic Direction</th>
<th>Policy development with collective impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 3</strong></td>
<td>Conduct effective policy and planning that achieves collective impact to improve health and well-being for all San Franciscans.</td>
</tr>
<tr>
<td><strong>Performance Measures 2012-2015</strong></td>
<td><strong>Performance Measure 1.2:</strong> Establish a highly functional, integrated infectious disease system to collect and report data, and to deliver and monitor public health actions.  &lt;br&gt;<strong>Performance Measure 3.1:</strong> Establish a division-wide Performance Management, Equity &amp; Quality Improvement Program.  &lt;br&gt;<strong>Performance Measure 3.2:</strong> Establish systems and partnerships to achieve and maintain Public Health Accreditation.  &lt;br&gt;<strong>Performance Measure 3.3:</strong> Develop a prioritized legislative agenda and strategic implementation plan to address health status and inequities.</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>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 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 &amp; 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.</td>
</tr>
<tr>
<td><strong>Functions Include:</strong></td>
<td>- Serves as principal advisor across the Division in matters related to health disparities, health equity, and priority population and/or community health  &lt;br&gt;  - Supports the development of an integrated infectious disease system to collect and report data, and to deliver and monitor public health actions.  &lt;br&gt;  - Establishes and manages a division-wide Quality Improvement and Performance Management System  &lt;br&gt;  - Provides policy consultation, technical assistance, communication strategies and practice resources for effective public health efforts  &lt;br&gt;  - Serves as liaison to internal and external stakeholders to foster collaborative activities and strategic partnerships  &lt;br&gt;  - Consults Federal agencies and other public and private sector agencies and organizations to align local efforts to national strategies, initiatives and health priorities.</td>
</tr>
</tbody>
</table>
### PHA Domain Category: Assurance

#### Environmental Health

<table>
<thead>
<tr>
<th>Strategic Direction</th>
<th>Assurance of healthy places and healthy people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy 4</td>
<td>Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.</td>
</tr>
</tbody>
</table>

**Performance Measures 2012-2015**

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Measure 4.1:</strong> Establish community-centered approaches that address the social determinants of health and increase population well-being.</td>
<td></td>
</tr>
<tr>
<td><strong>Performance Measure 4.2:</strong> Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.</td>
<td></td>
</tr>
</tbody>
</table>

**Description**

This Branch implements San Francisco’s environmental laws and health in all policies activities and programs to ensure safe and nutritious food, quality housing, livable neighborhoods and protection from air pollutants, excessive noise and hazardous chemicals.

**Functions Include:**

- Monitoring and enforcement of local and state laws for:
  - Food safety
  - Housing habitability
  - Neighborhood sanitation
  - Noise
  - Indoor air quality
  - Vector control
  - Chemical hazards
  - Tobacco and smoking regulation
- Monitoring of community-level social and environmental determinants of health and well-being
- Implementation of comprehensive interventions to improve:
  - Community food security
  - School food quality
  - Asthma morbidity
  - 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
  - Urban informatics and government transparency
  - Climate and health
  - Safe and effective use of non-potable water
  - Protection to exposures from indoor and outdoor pollutants
<table>
<thead>
<tr>
<th>STRATEGIC DIRECTION</th>
<th>Assurance of healthy places and healthy people</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRATEGY 4</td>
<td>Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.</td>
</tr>
<tr>
<td>PERFORMANCE MEASURES 2012-2015</td>
<td>PERFORMANCE MEASURE 4.1: Establish community-centered approaches that address the social determinants of health and increase population well-being.</td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>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, the Branch continues to plan, implement, and evaluate prioritized community initiatives, including promoting active living, decreasing HIV, sexually transmitted infections, viral hepatitis, and effects of trauma.</td>
</tr>
</tbody>
</table>
| 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 |
### PHA Domain Category: Assurance

#### Disease Prevention & Control

<table>
<thead>
<tr>
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<tr>
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</tr>
</tbody>
</table>

**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 integrates the core public health communicable disease functions, along with specialty care and treatment, and laboratory diagnostics. The goal is to find opportunities to increase capacity, align services, and deliver effective and efficient services at the client and community level. This Branch is also responsible for interacting with SFDPH Health Delivery Systems in order to coordinate and maximize disease screening and other prevention activities in primary care and the hospitals.

**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
- Clinical preventative services (providing education and technical assistance to promote clinical prevention best practices)
- Direct Observed Therapy
- Case management
- Expert clinical and laboratory consultation
- Coordinate efforts with other PHD Branches
<table>
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<td><strong>PERFORMANCE MEASURE 4.2</strong>: Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.</td>
</tr>
<tr>
<td><strong>DESCRIPTION</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **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**

<table>
<thead>
<tr>
<th><strong>Strategic Direction</strong></th>
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<tbody>
<tr>
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<td>Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.</td>
</tr>
<tr>
<td><strong>Performance Measures 2012-2015</strong></td>
<td><strong>Performance Measure 4.2:</strong> Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **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. |
<table>
<thead>
<tr>
<th><strong>STRATEGIC DIRECTION</strong></th>
<th>Sustainable funding and maximize collective resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRATEGY 5</strong></td>
<td>Increase administrative, financial and human resources efficiencies within the division.</td>
</tr>
<tr>
<td><strong>PERFORMANCE MEASURES 2012-2015</strong></td>
<td><strong>PERFORMANCE MEASURE 5.1</strong>: Establish a centralized business office for the division. <strong>PERFORMANCE MEASURE 5.2</strong>: Appropriately address the human resource issues regarding civil service and contract employees. <strong>PERFORMANCE MEASURE 5.3</strong>: Establish a centralized grants management and development system for the division.</td>
</tr>
<tr>
<td><strong>DESCRIPTION</strong></td>
<td>This Branch integrates core administrative, operations and fiscal functions across all PHD Branches. 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 Branch 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.</td>
</tr>
</tbody>
</table>
| **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 |
<table>
<thead>
<tr>
<th><strong>PHA Domain: Governance Category, Administration, and Systems Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Center for Learning and Innovation</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Strategic Direction</strong></th>
<th>Learning organization with a culture of trust and innovation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 6</strong></td>
<td>Build a division-wide learning environment that supports public health efforts.</td>
</tr>
<tr>
<td><strong>Performance Measures 2012-2015</strong></td>
<td><strong>Performance Measure 6.1</strong>: Establish a division-wide professional development program.</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>This Branch leads and coordinates professional development activities across the Division to assure a competent public health workforce. The Branch creates novel training opportunities for internal and external groups and develops the workforce of tomorrow by implementing a Division-wide Health Equity Fellows program.</td>
</tr>
</tbody>
</table>
| **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 |

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### Appendix B: Project Management Dash Board for the Strategic Plan

<table>
<thead>
<tr>
<th>Project Cycle</th>
<th>Action Steps</th>
<th>Accomplishment</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing Mission, Vision and Values</td>
<td>Identifying Formal and Informal Organizational Mandates</td>
<td>- Tables from Staff Directors retreat and Staff focus groups of formal and informal organizational mandates, August 2012</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Determining the Type and Level of Stakeholder Engagement</td>
<td>- Diagram illustrating the Integration stakeholder engagement process, June 2012</td>
<td>✔️</td>
</tr>
</tbody>
</table>
|                               | Developing Organizational Values Statements                                   | - Document providing the vision and overview of the process, January 2012  
- FAQ of the integration process and information on staff focus groups, June 2012 | ✔️       |
|                               | Developing Mission Statement                                                  | - Mission statement finalized, January 2013                                                                                                   | ✔️       |
|                               | Developing Vision Statement                                                   | - Vision statement finalized, January 2013                                                                                                    | ✔️       |
|                               | Communicating Vision, Mission and Values                                       | - 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                                           | - Assessment of current quantitative data                                                                                                     | ✔️       |
|                               | Collecting Additional Data/Information as Needed                             | - 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                                                  | - Completed Community Health Assessment (CHA) (quantitative data), September 2012  
- Completed Mind Maps of qualitative data, August 2012                                                                                   | ✔️       |
<table>
<thead>
<tr>
<th>Project Cycle</th>
<th>Action Steps</th>
<th>Accomplishment:</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyzing Results and Selecting Strategic Priorities</td>
<td>Completing a SWOT/SWOC Analysis</td>
<td>- Analysis of quantitative and qualitative data, (see Project Cycle 2)</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Compiling of data from stakeholder input, December 2012</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Compiling of data for cross cutting PHD themes, September 2013</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Identifying and Framing Cross-cutting Themes, Emerging Issues and Key Strategic Issues</td>
<td>- Identified cross-cutting themes that align with PHD priorities, June 2013</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Prioritizing and selecting Strategic Issues</td>
<td>- Community Health Improvement Plan, December 2012</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Developed a strategic map for the Integration of the Division, March 2013</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Prioritizing Headline Indicators for the Division, September 2013</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Products Cycle 2: Community Health Status Assessment, and graphic illustrations of stakeholder priorities</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Developing the Strategic Plan</td>
<td>Identifying Results Statements and Populations</td>
<td>- Develop results and populations statements, September 2013</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Identifying Headline Indicators, what works, partners and strategies</td>
<td>- Develop Headline Indicators, September 2013</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Develop strategies to support headline indicators</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Develop stories behind the baselines, May 2014</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Identify what works, partners and strategies, May 2014</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Present update to Health Finance Committee, December 5, 2013</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Present Strategic Plan to Health Commission, June 3, 2014</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Health Commission Resolution to Approve the Strategic Plan, June 17, 2014</td>
<td>✔️</td>
</tr>
<tr>
<td>Product Cycle 4: PHD Strategic Plan</td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>
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
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) 554-8141

EDWIN M. LEE
MAYOR
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<tr>
<td>CBOs</td>
<td>Community-Based Organizations</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CHA</td>
<td>Community Health Assessment</td>
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<td>CHIP</td>
<td>Community Health Improvement Plan</td>
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<td>CRRP</td>
<td>Community Risk Reduction Plan</td>
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<tr>
<td>HCSMP</td>
<td>Health Care Services Master Plan</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSA</td>
<td>Human Services Agency</td>
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<tr>
<td>IDU</td>
<td>Injection Drug Users</td>
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<tr>
<td>LINCS</td>
<td>Linkage, Integration, Navigation, and Comprehensive Services Team</td>
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<tr>
<td>MAPP</td>
<td>Mobilizing for Action through Planning and Partnerships</td>
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<tr>
<td>MSM</td>
<td>Males who have sex with males</td>
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<tr>
<td>NACCHO</td>
<td>National Association of County and City Health Officials</td>
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<tr>
<td>PPACA or ACA</td>
<td>Patient Protection and Affordable Care Act</td>
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<tr>
<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
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<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<tr>
<td>PHA</td>
<td>Public Health Accreditation</td>
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<tr>
<td>PHD</td>
<td>Population Health Division</td>
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<td>PHP</td>
<td>Population Health &amp; Prevention</td>
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<td>PHAST</td>
<td>Positive Health Access to Services and Treatment</td>
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<tr>
<td>REACH</td>
<td>Result, Equity, and Accountability for Community Health</td>
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<tr>
<td>SES</td>
<td>Social economic status</td>
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<tr>
<td>SF</td>
<td>San Francisco</td>
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<tr>
<td>SFDPH</td>
<td>San Francisco Department of Public Health</td>
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<tr>
<td>SFHIP</td>
<td>San Francisco Health Improvement Partnership</td>
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<td>SFGH</td>
<td>San Francisco General Hospital</td>
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<tr>
<td>SFUSD</td>
<td>San Francisco Unified School District</td>
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<tr>
<td>UCSF</td>
<td>University of California, San Francisco</td>
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Table of Contents for Branch, Centers and Office in Population Health Division

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The descriptions 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.

<table>
<thead>
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<th>Public Health Accreditation Categories</th>
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<td>Assessment/Research</td>
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<tr>
<td>Governance, Administration, and Systems Management</td>
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1 Accreditation signifies that a health department is meeting national standards for ensuring essential public health services that are provided in the community.
### Public Health Accreditation Domain Category: Assessment/Research
Applied Research, Community Health Epidemiology, & Surveillance

<table>
<thead>
<tr>
<th>Strategic Direction</th>
<th>Superb knowledge management systems and empowered users</th>
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<tbody>
<tr>
<td><strong>Strategy 1</strong></td>
<td>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.</td>
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</tbody>
</table>
| **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 |

**Viral Hepatitis Surveillance**

Through funding by the Centers for Disease Control and Prevention (CDC) over the past 10 years, the SFDPH’s Viral Hepatitis Surveillance Team in ARCHES has been able to develop and maintain an active, enhanced surveillance system for viral hepatitis. The Hepatitis Team stores reported information in the Integrated Case and Outbreak Management System (ICOMS), a home-grown, relational database which integrates hepatitis data with communicable disease data. The database is person-based and allows case management, as well as the collection and analysis of longitudinal data. Faxed and mailed positive hepatitis reports are hand-entered, while electronic files received from three large medical centers are electronically imported into ICOMS. Hepatitis data stored within ICOMS is reported monthly and quarterly to the CDC and annually to the California Department of Public Health (CDPH), and has been used to produce registry match reports and annual SFDPH surveillance reports.
Labs and clinicians report positive hepatitis results to the SFDPH’s Hepatitis Team in compliance with the CA Code of Regulations. The received data represent core surveillance and include basic demographic information and test results. Detailed demographics and hepatitis risk factors are unavailable through routine reporting and present a gap in the surveillance system. However, through this CDC funding, the SFDPH’s Hepatitis Team has been able to conduct enhanced surveillance on hepatitis B (HBV) and hepatitis C (HCV) cases to acquire this information and close this gap. The Hepatitis Team’s enhanced surveillance has included collecting patient data through faxing a data collection form to the clinician; interviewing randomly sampled HBV and HCV cases; and chart reviews of randomly sampled HCV cases. These activities have improved the completeness of demographic data and have provided the SFDPH with the opportunity to identify risk factors, reasons for testing, and treatment status. Phone interviews have been crucial in offering hepatitis education, counseling, and recommending prevention practices. Furthermore, the SFDPH’s Hepatitis Team uses core hepatitis surveillance data to identify trends in testing, to study clinician practices, and to guide clinician outreach. With this more robust demographic and risk factor data, the SFDPH’s Hepatitis Team has been able to identify special populations, (e.g., A/PIs, African Americans, “baby-boomers,” people who inject drugs) for targeted outreach.

Viral Hepatitis Surveillance Funding for 11/01/2014-10/31/2015: $519,945

Viral Hepatitis Staffing:
Manager I: .7 FTE
EPI I: .6 FTE
EPI I: .7 FTE (includes significant support to Communicable Disease Control and Prevention)
Budget Analyst: .1 FTE
Health Worker II: .88 FTE (includes support to Communicable Disease Control and Prevention)
Research Assistants: 1.11 FTE (includes support to Communicable Disease Control and Prevention)

HIV Programs: Medical Monitoring Program, Molecular Surveillance, Incidence Surveillance, Core Surveillance, Data to HIV Care, and Getting to Zero.

Medical Monitoring Project (MMP)
MMP is national surveillance system conducted by state and local health departments along with the Centers for Disease Control and Prevention (CDC). San Francisco has been a MMP site since 2006. MMP samples a locally and nationally representative sample of people living with HIV. Behavioral and medical record data from sampled participants is collected to learn about the experiences and needs of people who are living with HIV including medical care, the health status and behaviors of people living with HIV. Because MMP’s estimates are designed to be representative, information gathered from MMP can be used by prevention planning groups, policy leaders, health care providers, and people living with HIV to highlight disparities in care and services and advocate for needed resources. MMP can answer the following questions:
- How many people living with HIV are receiving medical care for HIV?
- How easy is it to access medical care, prevention, and support services?
- What are the met and unmet needs of people living with HIV?
- How is treatment affecting people living with HIV?

Prior to 2015, MMP sampled only people receiving HIV care. To improve the usefulness of MMP data, in 2015 MMP was expanded to also include people living with HIV who are not receiving medical care. This information is used both locally and nationally to guide policy and funding decisions aimed at increasing engagement in care and improving quality of care for people living with HIV throughout the United States.

MMP Funding: 2016 $524,488
MMP Staffing:
Manager I .25 FTE (includes ARCHES Acting Director)
HPC III .5 FTE
HPC II .15 FTE
Data Manager .5 FTE
Epi II 1.11 FTE
Research Assistants 4.0 FTE

HIV Incidence Surveillance
In collaboration with Centers for Disease Control and Prevention (CDC) and 25 health jurisdictions, including San Francisco, the HIV Epidemiology Section in ARCHES is conducting a supplemental HIV incidence surveillance system. The goal of HIV incidence surveillance is to estimate new HIV infections occurring in San Francisco annually. Traditional (core) HIV surveillance systems collect information on newly diagnosed cases of HIV, some of whom may have been infected long before they tested for HIV. HIV incidence attempts to estimate new infections, as opposed to new diagnoses, among all people living in San Francisco.

The HIV incidence surveillance system uses existing methods from core HIV/AIDS surveillance to identify people newly diagnosed with HIV. In addition, HIV testing history information and a remnant blood specimen from their HIV test is collected. The blood specimen is tested using a method called serologic testing algorithm for recent HIV seroconverters (STARHS) to determine if the HIV infection occurred recently or is a long standing infection. Information from the testing history and the result of the STARHS test is used to make population-based estimates of all new infections, HIV incidence, in each given year. Incidence estimates provide crucial data to monitor current trends in HIV transmission, characterize recent infections and more effectively target prevention resources in San Francisco.

HIV Incidence Funding: 2016 $232,615.00
HIV Incidence Staffing:
Manager I .20 FTE
HPC I .5 FTE
IT Support .5 FTE (includes support for 25 Van Ness)
Lab Assistant .12 FTE
Epi II .2 FTE

Molecular HIV Surveillance
In collaboration with the Centers for Disease Control and Prevention (CDC), the HIV Epidemiology Section in ARCHES is conducting a supplemental surveillance project, Molecular HIV Surveillance (MHS). MHS incorporates the collection of HIV nucleotide sequences into routine HIV case reporting. Together with case report data, HIV sequences can be used to achieve three primary goals: (1) to assess prevalence and trends in acquired and transmitted HIV drug resistance; (2) to evaluate HIV genetic diversity; and (3) to describe HIV transmission patterns for the purpose of evaluating the impact of HIV prevention strategies, guiding public health action, and enhancing the understanding of the burden of HIV in the United States. The objectives of MHS are as follows:

- Collect all HIV nucleotide sequence data from laboratories that perform HIV genotypic drug resistance testing;
- Use molecular epidemiologic techniques to assess HIV drug resistance, evaluate HIV genetic diversity, and describe HIV transmission patterns; and
- Disseminate results of molecular HIV data analyses to assist HIV treatment, prevention, and program planning and evaluation.

Molecular HIV Surveillance Funding: $49,000
Molecular HIV Surveillance Staffing:
Epi II .35 FTE

Core HIV Surveillance
California Code of Regulations (CCR), Title 17, Section 2500 requires health care providers to report persons meeting the CDC AIDS surveillance case definition to the local health department and requires the local health department to report AIDS cases to the California Department of Health Services (DHS). Name-based reporting of HIV non-AIDS cases became effective in California on April 17, 2006. The California Health and Safety Code 121022 requires that the health care providers and laboratories report cases of HIV infection using patient names to the local health department, and local health departments report unduplicated HIV cases by name to the DHS. The laboratories are required to report confirmed HIV antibody tests and all viral load tests.

In San Francisco, HIV infections and AIDS diagnoses are reported through a combination of passive and active surveillance. Passive surveillance is conducted through state required reporting of HIV and AIDS cases by health care providers and reporting of HIV-positive test results from laboratories to the local health department. Active surveillance is accomplished through routine visits by SFPDHP staff to hospitals, physician offices, and outpatient clinics to ensure completeness, timeliness, and accuracy of reported data. HIV/AIDS surveillance relies on SFPDHP staff to perform active case surveillance, on-site chart reviews and case report completion. Core HIV surveillance ensures the timeliness and completeness of HIV case reporting and ensures the prompt identification and response to emerging problems in the field.

Core HIV Surveillance Funding: Annual Budget 2016: $1,010,161.00
Core HIV Surveillance Staffing:
Manager I 1.2 FTE (includes ARCHES Acting Director)
HPC III .25 FTE
IT Support .60 FTE (includes support for 25 Van Ness)
Data Manager .75 FTE
Epi II 1.15 FTE
Research Assistant 1.0 FTE
IS Administrator .25 FTE (Chuck Perez)

ARCHES Supports the LINCS team with Data to Care
Data collected from HIV Core Surveillance is used by the LINCS team in DPC to:

1. Determine if patients testing HIV-positive at SFPDHP funded testing sites are new or known cases to prioritize linkage and partner services activities to newly diagnosed patients.
2. Determine if sex partners named by a newly diagnosed patient are already known to be HIV+ to prioritize partner services for HIV-negative partners.
3. Refer patients testing positive in private medical sites to LINCS for linkage and partner services.
4. Determine if not-in-care (NIC) clinic patients are receiving care elsewhere or have moved out of SF prior to referral of cases to LINCS or further clinic action.

Funding for LINCS Support comes from Core HIV Surveillance Funding

ARCHES Supports Getting to Zero Initiative
ARCHES staff are providing in-kind support and Core and Incidence HIV Surveillance data for all of the Getting to Zero (GTZ) subcommittee’s metrics including the RAPID treatment, Retention, PrEP and Stigma subcommittees. In addition,
ARCHES staff serve on each of these subcommittees and work in-kind on GTZ initiatives such as PrEP surveillance, data to care, retention, etc.

STD Program Staff Activities and Funding

STD SURVEILLANCE
ARCHES staff support surveillance activities for the reportable sexually transmitted diseases (STDs), through oversight and quality assurance of data-entry of Case Morbidity Reports; importation and quality assurance of electronic laboratory reports; and coordination and collaboration with the California Department of Public Health staff who manage ELR and CalREDIE for the state. ARCHES staff prepare the STD Annual Summary and support the preparation of the monthly STD Report, which include statistics and epidemiologic analyses of citywide STD cases and rates.

STD REGISTRY
ARCHES staff maintain and continuously improve the STD Integrated Surveillance and Clinical Health Tracking Registry (ISCHTR), which not only houses STD morbidity and treatment reports, but also the San Francisco City Clinic (SFCC) electronic medical records; case management services and outcomes for field services including gonorrhea and chlamydia treatment verification, syphilis and HIV partner services, and HIV linkage or navigation to care; and community-based STD and HIV testing conducted by the Community Health and Equity Promotion (CHEP) Branch. ARCHES staff also enable continuous quality improvement by providing routine reports to Disease Prevention and Control (DPC) Branch and CHEP staff to aid in monitoring their activities, case assignments, and outcomes. We also meet regularly with both the SFCC staff and DPC staff who serve as Disease Intervention Specialists (DIS) to review their workflows and key metrics to monitor the quality of their work and related outcomes, and make improvements to ISCHTR as needed.

SUPPORT TO STD AND HIV GRANTS AND PROGRAMS
ARCHES staff are integral to a number of CDC-funded STD and HIV grants:
The work of STD Surveillance Network (SSuN) is solely conducted by ARCHES staff. SSuN was established as a dynamic network comprised of local enhanced STD surveillance systems that follow common protocols. The purpose of SSuN is to improve the capacity of national, state, and local STD programs to detect, monitor, and respond rapidly to trends in STDs through enhanced collection, reporting, analysis, visualization, and interpretation of disease information. San Francisco has been funded during the previous two 5-year grant cycles, and is currently in Year 3 of the 3rd SSuN cycle. Activities include routine data submission of STD morbidity and clinic encounters at SFCC and 4 San Francisco Health Network Title X clinics, and interviews with a sample of gonorrhea cases.

$150,000/year for 5 years
Epi II – 59% FTE
Epi I (Vacant) – 20% FTE
Viva Delgado – in-kind interviewer

Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies (STD-AAAPPS) provides funding to 50 states, 7 cities, and two territories to decrease the burden and long term health effects of STDs.
Part A: The initiative provides grantees flexibility to direct resources to support STD prevention activities as needed based on the local epidemiology. STD-AAPPS supports staff and work primarily in DPC and CHEP, but ARCHES supports the data collection, maintenance, analysis, and reporting AAPPS activities.

Part B: The Gonococcal Isolate Surveillance Project (GISP) is a collaborative project between CDC, regional GISP laboratories, and local or state STD programs and their affiliated STD clinic(s), and local public health laboratories to collect and analyze gonorrhea strains. GISP is critically important given the current state of increasing signs of antibiotic resistance in gonorrhea, in particular because the gonorrhea control strategy relies on effective antibiotic therapy. ARCHES maintains the clinical and laboratory data collected for GISP and alerts DPC field and clinical staff to patients with antibiotic MIC levels that might require clinical or case management follow-up.

$1,296,937 in Year 2, 5-year cooperative agreement
Epi II – 41% FTE
Epi II – in-kind epidemiologist

SFDPH HIV Prevention is funded in part by PS12-1201: Comprehensive HIV Prevention Programs for Health Departments, coordinated by CHEP. ARCHES staff are responsible for the quality assurance and data analysis of results and client information obtained through HIV testing conducted at community-based organizations and by medical providers. ARCHES also provides the analysis of HIV outcomes resultant from LINCS program services: partner services, linkage to care for newly diagnosed person, and re-engagement in care for previously diagnosed person not in care.

- PS12-1201 funds directed to STD Program = $460,263
  - Epi I (Vacant) – 41% FTE
  - Trang Nguyen, Epi II – 30% FTE
- HIV Prevention General Fund funds directed to STD Program = $364,479
  - Epi I (Vacant) – 39% FTE
  - Annie Vu – in-kind epidemiologist

SUPPORT TO OTHER SFDPH INITIATIVES
ARCHES staff support SFDPH-wide projects including:

- REACH/Healthy Hearts Project
  - $700,000/year for 3 years
    - Trang Nguyen, Epi II – 20% FTE
- BAAHI
  - Trang Nguyen, Epi II – 50% FTE STD General Fund
  - Robert Kohn, Epi II – in-kind epidemiologist
- Getting to Zero Initiative
  - Trang Nguyen, Epi II – 50% FTE STD General Fund
  - Susan Scheer Man I – in-kind
  - Alison Hughes, Epi II – in kind
  - Anne Hirozawa, in-kind
- Emergency Response
  - Trang Nguyen, Epi II – in-kind epidemiologist
  - Susan Scheer, Manager I – in-kind
  - Sharon Pipkin Epi II-- in kind
  - Maree Kay Parisi HPC III – in-kind
  - Emily Yunkun --- PHFE – data entry, administrative assistance – in-kind
Tuberculosis Prevention and Control Program

The mission of San Francisco TB Control is to control, prevent and finally eliminate tuberculosis in San Francisco by providing compassionate, equitable, and supportive care of the highest quality to all persons affected by this disease.

The ARCHES TB epidemiologist (2802) is responsible for:
- Reporting diagnosis and completion of treatment for active TB disease cases to state and federal partners.
- Reporting of TB contact investigation outcomes to state and federal partners.
- Reporting of mandatory evaluation and treatment outcomes of new immigrants identified by the Department of State in conjunction with the CDC’s Department of Global Migration and Quarantine for high risk TB infection.
- TB Outbreak detection through review of TB isolate genotype results.
- Oversight and maintenance of the TB program’s database, Oaxaca, including data integrity, data security, and data interoperability with the health records of the TB clinic.
- Liaison with the public health informatics officer for ongoing projects, including electronic laboratory reporting, public health integrated surveillance database (PHNIX), electronic health record for the San Francisco Health Network (TBD)
- Special projects – initiating project with CDC and CDPH regarding drug resistance reporting in preparation for revision of the required Report for Verified Cases of TB.

In addition to the ARCHES TB epidemiologist, the TB program has an epidemiologist who serves as a research coordinator for the TB program (80%) and administrator supporting program management which include supervising line staff and overseeing HR hiring processes (20%).

The research projects managed by the epidemiologist include:
- TB Epidemiology and Surveillance Consortium (TBESC) Task Order 1 (year 4 of 10) - clinical trial comparing predictive value of TB tests for progression to active TB disease. The focus of this project is changing to more of a community transformation project to study ways to accelerate the diagnosis and treatment of TB infection in primary care.

- Smartphone Directly Observed Therapy Implementation Project – done in conjunction with the University of California San Diego. The project focuses on using smartphones and HIPAA secure app/website to conduct virtual smartphone base observation of medication ingestion by reviewing videos of patients taking their anti-TB medications, and ensuring that this modality is noninferior to face to face encounters.

TB Program funding: $238489
- 1.0 FTE 2802 - $106449 (cooperative agreement – CDC)
- 1.1 FTE 2803 - $132040 (20% cooperative agreement, 80% TBESC)
**PUBLIC HEALTH ACCREDITATION DOMAIN CATEGORY: ASSESSMENT/RESEARCH**

**CENTER FOR PUBLIC HEALTH RESEARCH**

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<thead>
<tr>
<th><strong>STRATEGIC DIRECTION</strong></th>
<th><strong>Description</strong></th>
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<tr>
<td>Assessment and research aligned with our vision and priorities</td>
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| **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 Public Health Accreditationmacological 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** |

**CHPR projects, funding, and staff: HIV-related:**

1. National HIV Behavioral Surveillance  
   a. Surveys of MSM, IDU, high risk heterosexuals  
   b. ~$450,000 per year from CDC
c. staff: 7.25 fte

2. SHINE Transfemale Youth Cohort
   a. Longitudinal study of risk behavior and health of transwomen age 15 to 24 years
   b. ~$386,000 per year from NIH
   c. Staff: ~ 3.5 fte

3. Presidents Emergency Program For AIDS (PEPFAR) and other contracts from UCSF
   a. Multiple projects in several countries on maximizing the HIV prevention and care response
   b. ~$350,000 per year from CDC
   c. Staff: Civil Service 3.8 fte

4. SPNS Transwomen of Color Initiative housed at Tri City Health Center, SPNS Social Media grant
   a. Addressing health needs of transwomen
   b. ~$300,000 per year from NIH, diverse other sources
   c. Staff: 1 fte

5. Training grants
   a. NIH T32 for post-doc traineeship, funded from UCSF 0.1 FTE
   b. NIH R25 SHARP for undergraduates training, 0.2 fte

The Substance Use Research Unit (SURU)

**Naltrexone**

Double-blinded randomized controlled trial of naltrexone vs. placebo to determine whether naltrexone will reduce meth use among actively using, meth-dependent MSM with high-risk sexual behavior.

5.0 FTE
$524,718

**Mirtazapine**

Double-blinded randomized controlled trial of mirtazapine daily vs. placebo to determine whether mirtazapine will reduce meth use and HIV sexual risk behaviors a month meth-dependent MSM.

4.45 FTE
$446,296

**Reboot**

Feasibility and acceptability pilot with social network aim to address opioid overdose, HIV risk behaviors, and opioid use patterns among opioid dependent persons who have suffered a prior overdose and have received take-home naloxone.

2.00 FTE
$197,384

**Vivitrol**

Study to evaluate the feasibility, acceptability, and preliminary effectiveness of SFDPH naltrexone injectable pilot for people with alcohol dependence.

.75 FTE
$197,384
Nose (1yr no-cost ext)
Implementation science study of prescription of naloxone to patients receiving chronic opioid analgesics.
.75 FTE
$63,925

Opioid Overdose
Analyze opioid analgesic drug overdose deaths, gathering info from vital statistics, medical records, and local public health services to enhance monitoring of drug overdose deaths and to guide interventions to address overdose risk.
.20 FTE
$54,900

Adios
Pilot research project to develop, evaluate, and assess feasibility of an academic detailing program to educate providers on naloxone prescription within the context of an opioid safety agenda.
1.13 FTE
$86,209

Say When
Examining the efficacy of taking an FDA-approved medication on an as-needed basis in anticipation of drinking to reduce binge drinking and alcohol-related sexual risk behaviors.
2.7 FTE
$279,608

Say When Supplement
Evaluating changes in substance use among sexually-active, binge-drinking MSM at high risk for acquiring or transmitting HIV.
.22 FTE
$12,001

TasP-C
Evaluating and comparing two strategies to improve the use of novel medications to treat hepatitis C (HCV) for persons who currently inject drugs, and to study the challenges experienced by this population while using a medication to treat HCV.
1.1 FTE
$193,453
<table>
<thead>
<tr>
<th>PUBLIC HEALTH ACCREDITATION DOMAIN CATEGORY: ASSESSMENT/RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRIDGE HIV</td>
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<table>
<thead>
<tr>
<th>STRATEGIC DIRECTION</th>
<th>Assessment and research aligned with our vision and priorities</th>
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<tbody>
<tr>
<td>STRATEGY 2</td>
<td>Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.</td>
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<tr>
<th>PERFORMANCE MEASURES 2012-2015</th>
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<tbody>
<tr>
<td>PERFORMANCE MEASURE 2.1:</td>
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<td>PERFORMANCE MEASURE 2.2:</td>
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<table>
<thead>
<tr>
<th>DESCRIPTION</th>
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<tr>
<td>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 <a href="https://www.sfdph.org">San Francisco Department of Public Health</a> and affiliated with the <a href="https://www.ucsf.edu">University of California, San Francisco (UCSF)</a>, we conduct innovative research that guides global approaches to prevent HIV and AIDS.</td>
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<th>FUNCTIONS INCLUDE:</th>
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<tbody>
<tr>
<td>• Maintain highest quality HIV prevention clinical trials program</td>
</tr>
<tr>
<td>• Develop and test integrated prevention strategies including vaccines, PrEP, microbicides, treatment as prevention, HIV/STI testing, couples interventions</td>
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<tr>
<td>• Collaborate broadly across disciplines, institutions</td>
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<tr>
<td>• Engage Bay Area communities to build research literacy, and inform research</td>
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<tr>
<td>• Obtain independent funding for research activities</td>
</tr>
<tr>
<td>• Mentor diverse population of early career investigators and staff</td>
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<tr>
<td>• Disseminate research findings to scientific and general community</td>
</tr>
<tr>
<td>• Convene the PHD HIV Working Group and lead its contributions to the city-wide Getting to Zero effort</td>
</tr>
</tbody>
</table>

Bridge HIV participates in three clinical trials networks funded by the National Institute of Allergy and Infectious Diseases (NIAID) a division of the National Institutes of Health (NIH): HIV Prevention Trials Network (HPTN); HIV Vaccine Trials Network (HVTN); and the Microbicide Trials Network (MTN). Bridge HIV staff are trained across protocols and are thus funded across protocols. Staff also work on various investigator initiated projects as needed. Total Funding including PHFE as the prime applicant: $4,385,368.

**Bridge HIV Leadership:**

- **Susan Buchbinder, MD**, is the Director of Bridge HIV and is responsible for the overall scientific leadership of the research unit.

- **Albert Liu, MD**, serves as the Clinical Research Director and oversees study implementation, ensuring that staff has the resources and skills needed to successfully carry out protocols, and, along with Dr. Buchbinder, provides guidance and mentorship to the team.
• **Aliza Norwood, MD** is the Clinical Operations Director/Study Clinician. Dr. Norwood oversees operations for all clinical studies. She ensures that all internal and external functions are set up and managed to enable efficient start-up, conduct, and completion of studies. She serves as the backup clinician and conducts study visits as needed.

• **Delia Molloy, MA**, serves as the Deputy Director of Bridge HIV and oversees staffing and fiscal/grants management.

• **Hyman Scott, MD**, is a Research Scientist who was awarded an NIH training grant, the PHASST project. Dr. Buchbinder is his primary mentor.

**Clinical Team: 1 Study Coordinator, 2.5 Clinicians, 3 Research Associates, 1 Laboratory Coordinator, 1 Program Assistant**

• **Theresa Wagner, MPH**, is the Senior Clinical Research Coordinator and oversees compliance to all study protocols; manages quality control systems, completion and submission of study-related documentation; ensures that regular audits and other quality management activities specified in the QM plan are carried out.

• **Megan Henry, NP, and Elizabeth Faber, NP**, serve as clinicians on all study protocols.

• **Laura Potter and Alfonso Diaz** serve as Research Associates on all study protocols.

• **Kenneth Coleman** serves primarily as a Research Associate on non-network studies, but is crossed-trained on several protocols and assists with other studies as needed.

• **Kimberly Marsh, MPH**, is the Laboratory Coordinator and is responsible for daily lab operations, lab maintenance, and quality assurance.

• **Program Assistant**, (Vacant) provides programmatic support: reviews research forms (Informed Consents, Lab Results, paper and electronic Case Report Forms (CRFs) and Checklists) for accuracy, completion, and protocol compliance and act as a liaison to make necessary corrections with the clinical team.

**Administrative/Support Staff: 1 Receptionist, 1 Regulatory Affairs Associate, 1 Database Administrator**

• **Receptionist** (Vacant) greets and checks-in study participants and supports clinical team in basic administrative tasks.

• **Emily Schaeffer** is the Regulatory Affairs Associate who manages IRB submissions for all studies conducted at Bridge HIV.

• **Patricia von Felten** is the Database Administrator who manages the participant tracking system for all studies conducted at Bridge HIV

• **Grants Manager** (shared position with other PHD Branches—in transition) .5 FTE

• **Grants Assistant** (shared position with other PHD Branches—in transition) .25 FTE

**Community Programs Team: 1 Community Programs Manager, 1 Designer, 1 full time Recruiter, 3 part time Recruiters**

• **Community Programs Manager** (Vacant) develops and implements strategic vision for community engagement for Bridge HIV; collaborates with the clinical team to develop community education and recruitment strategies to meet education and recruitment goals

• **Janie Vinson** is the Senior Designer who is responsible for the design, development, implementation and production of creative collateral for a wide variety of recruitment, community education and organizational brand needs.

• **Rafael Gonzalez, Michael Barajas, Andy Shen, and Jose Carlos Asencios** are Clinical Studies Recruiters for all studies conducted at Bridge HIV.
<table>
<thead>
<tr>
<th>STRATEGIC DIRECTION</th>
<th>Policy development with collective impact</th>
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<tbody>
<tr>
<td>STRATEGY 3</td>
<td>Conduct effective policy and planning that achieves collective impact to improve health and well-being for all San Franciscans.</td>
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</tbody>
</table>
| 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 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 |

See special imitative section for descriptions of projects: Public Health Accreditation (PHA), Quality Improvement (QI), Public Health Network Information eXchange (PHNIX), and San Francisco Health Improvement Partnership (SFHIP)
## PUBLIC HEALTH ACCREDITATION DOMAIN CATEGORY: ASSURANCE

### ENVIRONMENTAL HEALTH

<table>
<thead>
<tr>
<th><strong>STRATEGIC DIRECTION</strong></th>
<th>Assurance of healthy places and healthy people</th>
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<tbody>
<tr>
<td><strong>STRATEGY 4</strong></td>
<td>Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.</td>
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<tr>
<td><strong>PERFORMANCE MEASURES 2012-2015</strong></td>
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<tr>
<td><strong>PERFORMANCE MEASURE 4.1:</strong> Establish community-centered approaches that address the social determinants of health and increase population well-being.</td>
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<tr>
<td><strong>PERFORMANCE MEASURE 4.2:</strong> Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.</td>
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<tr>
<td><strong>DESCRIPTION</strong></td>
<td>Our 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.</td>
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<tr>
<td><strong>FUNCTIONS INCLUDE:</strong></td>
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<tr>
<td>● Monitoring and enforcement of local and state laws for:</td>
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<tr>
<td>◆ Food safety</td>
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<tr>
<td>◆ Water quality</td>
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<td>◆ Housing habitability</td>
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<td>◆ Neighborhood sanitation</td>
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<td>◆ Noise</td>
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<td>◆ Indoor air quality</td>
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<td>◆ Vector control</td>
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<td>◆ Chemical hazards</td>
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<td>◆ Non-ionizing radiation</td>
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<tr>
<td>◆ Tobacco and smoking regulation</td>
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<tr>
<td>◆ Consumer protection and agricultural pests</td>
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<tr>
<td>● Monitoring of community-level social and environmental determinants of health and well-being</td>
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<tr>
<td>● Implementation of comprehensive interventions to improve:</td>
<td></td>
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<tr>
<td>◆ Asthma morbidity and childhood health</td>
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<tr>
<td>◆ Community resiliency</td>
<td></td>
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<tr>
<td>● Support of interagency partnerships for:</td>
<td></td>
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<tr>
<td>◆ Safe livable neighborhoods</td>
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<tr>
<td>◆ Sustainable transportation projects</td>
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<tr>
<td>◆ Parks and green space</td>
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<tr>
<td>◆ Pedestrian and bicycle safety</td>
<td></td>
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<tr>
<td>◆ Safe healthy work environments</td>
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</table>
City and County of San Francisco
DEPARTMENT OF PUBLIC HEALTH
POPULATION HEALTH DIVISION

- Urban informatics and government transparency
- Climate and health
- Safe and effective use of non-potable water
- Protection to exposures from indoor and outdoor pollutants

**Environmental Health Branch Programs**

**Food Safety Program** - This program ensures that all retail food stored, handled and served to the public is done safely by conducting risk-based food inspections and educating the food establishments on safe food handling practices. There are approximately 8000 food facilities, including restaurants, bakeries, markets, food trucks, bars and taverns. We conduct plan check for these facilities to ensure that structural and equipment installations are code compliant. We also inspect Certified Farmers Markets, Temporary Events (Street Fairs), Sporting Events and Cottage Food operations. We make sure that food facilities are aware of current food recalls.

# of staff - 40

Budget – $4.9 million plus operational costs

**Healthy Housing and Vector Control** – This program ensures a coordinated and comprehensive effort to preventing health problems caused by unhealthy environmental conditions in multi-unit residential buildings, hotels, SROs, shelters, transitional homes and that they maintain safe, sanitary and habitable conditions at all times. There are approximately 17,000 multi-unit residences and 700 hotels (tourist and SROs) in the City.

# of staff – 16

Budget – $2.0 million plus operational costs

**Hazardous Materials and Waste Program** – This program ensures that businesses store, treat and dispose of hazardous materials safely. This program also ensures that underground storage tanks are operated and removed safely. It educates business owners of pollution prevention and toxics reduction. The program regulates 2424 businesses.

# of staff – 15

Budget – $2.2 million plus operational costs

**Children’s Environmental Health Promotion Program** – This program works with other agencies to ensure the best possible environments for children with a focus on comprehensive healthy housing, prevention of lead hazards, and environmental risk factors for asthma.

# of staff – 10

Budget – $808,000 plus operational costs

**Agriculture and Weights and Measures Program** – This program is responsible for plant quarantine, pest monitoring, pest eradication and pest management programs to prevent the introduction and further spread of invasive pests that pose a threat to California food production and food systems. This program ensures that pesticide operators are licensed and apply pesticides safely. The San Francisco County Sealer of Weights and Measures is responsible for the inspection, testing, and certification of all commercial scales and meters within the City and County of San Francisco. The goal of the Weights and Measures Program is to ensure and enforce fair competition for industry, protect consumers, and guarantee accurate value comparison. There are 5300 locations that have scales, meters and point of sales devices.

# of staff – 14

Budget – $1.6 million plus operational costs
Solid Waste Program – This program ensures that there is adequate refuse service for all residential and commercial properties so that public nuisances do not occur. And the program ensures the general public is protected by inspecting and permitting solid waste transfer stations, landfills, recycling centers, garbage trucks and other transporters.
# of staff – 4.5
Budget - $548,000 plus operational costs

Air, Noise, Smoking and Radiation Program – This program implements policies to reduce exposure of residents to toxic air particulates, noise from fixed noise sources and tour buses, smoking in public areas, commercial buildings and residences, and radiation from cellular transmitter sites. This program also permits the 1000 tobacco sales businesses and enforces regulations on tobacco sales to minors.
# of staff – 3.6
Budget – $591,000 plus operational costs

Program on Health, Equity and Sustainability- This program is an inter-disciplinary team that works in partnership with residents, public agencies and private organizations to advance healthy environments and social justice. Staff is focusing on Vision Zero to reduce pedestrian injuries and the San Francisco Health Indicator Project.
# of staff -3
Budget – $500,000 plus operational costs

Massage and Body Art Program – This program is responsible for permitting massage establishments and practitioners. They inspect the 250 massage establishments routinely and for complaints. This program also coordinates the Massage Task Force that targets high risk facilities where illegal activity may be occurring. In addition, this program permits the 55 body art establishments and body art practitioners to ensure that tattoos and piercings are applied safely.
# of staff – 4.5
Budget – $654,000 plus operating costs

Water Quality Program – This Program ensures that public pools are built correctly and routinely inspected. An inspector also conducts weekly sampling of the beaches. Staff also inspects all monitoring wells that are constructed and destroyed (usually for construction). Staff also ensures that backflow devices are checked annually and that backflow testers are certified. In addition, this program reviews plans, issues permits and provides ongoing oversight for alternate water source systems (e.g. rainwater, storm water, and graywater reuse).
# of staff- 2.5
Budget – $365,000 plus operational costs

Site Mitigation and Local Oversight Program – This program ensures that construction sites are evaluated for chemical contamination and that contaminated soil is mitigated. This program is essential for development in SF.
# of staff – 3
Budget – $678,000 plus operational costs

Medical Cannabis Dispensary Program – This program ensures that patients who are prescribed medical cannabis receive their medicine safely and legally. Staff permits and inspects 28 dispensaries.
# of staff – 1
Budget – $165,000 plus operational costs

Municipal Hazardous Waste Program – This program coordinates hazardous waste disposal for most city departments. Staff ensures that hazardous waste disposal complies with complex state regulations.
# of staff – 5
Budget – $1.1 million plus operational costs

**Asbestos Program** – This program works with other agencies to protect the public from asbestos hazards by ensuring that building managers and contractors maintain asbestos materials and follow safe practices with asbestos building materials during renovations and repairs.
# of staff – 1
Budget – $145,000 plus operational costs

**Cryptosporidiosis Surveillance Project** – This program works with SFPUC, the California Emerging Infections Program, and local health departments in Alameda, San Mateo, Santa Clara, and Tuolumne to implement active surveillance for cryptosporidiosis so that outbreaks may be identified early enough to allow timely investigation and possible intervention.
# of staff – 2.5
Budget – $388,000 plus operational costs

**Hunter’s Point Shipyard Cleanup and Development** – This program ensures that contractors preparing ground and building on Hunters Point Shipyard parcels under City & County control follow proper procedures to protect the neighborhood, including representing DPH at formal community advisory meetings. Staff also represents DPH during construction at Treasure Island.
# of staff – 1
Budget – $200,000 plus operational costs

**Climate and Health and Health Impact Analysis Program** - The Climate and Health Program works to address the public health consequences of climate change at the local level and improve climate change preparedness and resilience in San Francisco. The HIA program is funded by the CDC to support healthy decision making to further develop, expand and institutionalize the department’s HIA practice and Health in all Policies through ongoing and existing collaborations with other local and regional government agencies, community stakeholders, developers, coalitions, policy makers, and other stakeholders in land use and community design.
# of staff – 0.5
Budget – $340,000 plus operational costs

**Administration** – This program supports all the other programs in the Env. Health Branch. It includes management, operations, budgeting, planning, purchasing, and IT support.
# of staff – 12
Budget - $4.4 million (most of the Branch operational costs are in this program)
| **PUBLIC HEALTH ACCREDITATION DOMAIN CATEGORY: ASSURANCE**  
| **COMMUNITY HEALTH EQUITY & PROMOTION**  |
| **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 |
| **Specific programs include:** | **HIV and HCV Prevention**  
Community-based HIV testing  
Health education and risk reduction to address drivers |
Prevention with positives – Holistic health projects to address HIV-related disparities –
Transgender health
Syringe access & disposal
Condom distribution
Minority AIDS Initiative Targeted Capacity Expansion (MAI TCE)
HIV Prevention Planning Council (HPPC)

**STD Prevention**
YUTHE (Youth United Through Health Education) program Street-based outreach
Venue-based outreach
Community-based STD and HIV testing.
Trainings and workshops
Community Engagement

**Chronic Disease Prevention**
District 10 Wellness Collaborative
Bayview Healthy Eating Active Living (HEAL) Zone
Healthy Hearts SF
Healthy Retail SF
PE (Physical Education) Advocates
Rethink Your Drink
Shape Up SF
Safe Routes to School (part of the larger Safe & Active Transportation Initiative)
Tobacco Free Project (also included in CHEP’s Safe Environments Action Plan)
Safe & Healthy Living Environments
Pedestrian Safety
The Tobacco Free Project (TFP)
Community-Clinical Linkages
Newcomers Health Program
Tattoo removal
Senior Injury Prevention (CHIPPS)
Prevention of Human Trafficking

**Community Health Equity & Promotion Programs and Services**

**Overall Approach:** The Community Health Equity and Promotion Branch works in conjunction with community members and organizations to develop evidence based, data driven, sustainable initiatives to address priority public health issues with a focus on ensuring health equity. Community engagement is central to the work of the branch. Examples of this work include participating in, staffing, and/or supporting community coalitions, planning bodies, and partnership groups such as the Tobacco Free Coalition, San Francisco Coalition of Asylee, Immigrant, and Refugee Services (SF CAIRS), Shape Up San Francisco, HIV Prevention Planning Council, Getting to Zero Initiative, San Francisco Health Improvement Partnership, Adolescent Community Partners Group, Gay Men’s Partners Group, and others. CHEP often takes a role in facilitating “collective impact,” bringing representatives together from diverse areas to focus on shared goals and a common agenda to solve health and other social problems.
CHEP plans and coordinates programs with the San Francisco Health Network (SFHN) to increase access to quality care, integrate prevention and health promotion strategies and resources for SFHN patients, and collectively work towards reducing health disparities in San Francisco through a systems approach. Examples of CHEP programs with close linkages to SFHN are: Healthy Hearts San Francisco and District 10 Wellness Collaborative (access to healthy eating and physical activity community services) Newcomers Health Program (access to care for vulnerable immigrants), Tobacco Free Project (smoking cessation services), HCV, STD, HIV (coordinating access to testing and health services).

**Pedestrian Safety/Vision Zero**
Vision Zero employs Traffic Safety best practice, which focuses on the “5 Es” of Engineering, Enforcement, Education, Encouragement, and Evaluation. CHEP leads on Education/Engagement, in particular, the Safe Routes to School collaborative. CHEP also secures funding for its own activities, administers community awards, builds community capacity, and works with other partners to develop plans for education, enforcement, engineering, and evaluation. 1.5 FTE
Total: $293,500
Grants: $200,000
GF: $156,500

**Safe Streets for Seniors**
Safe Streets for Seniors is a new program of Vision Zero being coordinated by CHEP to conduct significant education and outreach to seniors and disabled populations, including engineering, enforcement and education initiatives. This will also include community education and engagement in diverse cultures and languages. Specifically, CHEP staff hired through the program will implement the program, including administration of mini-grants to CBOs for education to seniors of diverse cultures on road safety. SFDPH will provide Vision Zero coordination, data, funding, training, and technical assistance to CBOs.
1.1 FTE
GF: $263,000

**Tobacco Free Project**
CHEP TFP staff leads the Tobacco Free Coalition to implement progressive tobacco control efforts throughout SF. CHEP provides technical assistance on policy development to community organizations and policy makers; mobilizes communities through education and social marketing; conducts media advocacy; funds community-based organizations to implement the Community Action Model (CAM); offers “Quit Smoking” (cessation) services; and participates in the SF Health Network (SFHN) systems planning for cessation services. CHEP partners with PHD’s Environmental Health Branch, which focuses on enforcement of tobacco control policies.
6.5 FTE
Total: $1,570,000
Grants: $250,000
Settlement: $1,320,000

**Newcomers Health Program**
The Newcomers Health Program provides comprehensive health and mental assessments, health education and ensures linkages to ongoing primary care for newly arrived/status granted refugees and asylees and victims of human trafficking. The program also provides supportive services to recent immigrants with other designations as resources allow. Activities include outreach to eligible groups and individuals, providing a cultural/linguistic bridge to primary care (e.g.,
through interpretation provided during medical visits), education about health and social service benefits and related linkages, and collaboration with many different agency partners at city, regional, state and federal levels.
5.5 FTE
Total: $583,500
Grant: $370,000
GF: $213,500

Human Trafficking Outreach
Leverages existing complementary work to improve the overall health of San Francisco workers. Through a CHEP and Environmental Health (EH) collaboration, this program aims to improve knowledge of SF labor rights and link vulnerable SF massage and restaurants workers to a variety of resources. EH inspectors will be trained to recognize signs of labor violations, the rights of SF employees, existing resources for vulnerable employees, and link vulnerable and exploited workers to specialized health workers. Linguistically and culturally competent Health workers will conduct outreach to provide support and linkage to health, social, and legal services. Health workers will serve as a bridge to ensure that vulnerable workers in SF are able to address the social determinants influencing their health and quality of life.
1.1 FTE
GF: $107,816

Deemed Approved Uses Ordinance (DAO)/Alcohol prevention
CHEP staff implement the DAO, an ordinance that helps ensure that alcohol sales occur in a manner that protects the health, safety, and welfare of SF residents and communities. CHEP staff educate the community and merchants about the ordinance, including providing linkages to healthy retail opportunities. We also partner on alcohol prevention collaborations, both Department- and City-wide.
2.00 FTE
Total: $473,000
Special Revenue: $433,000
GF: $40,000

Senior Home Injury Prevention (CHIPPS)
CHEP staff provide educational presentations, workshops, home assessments and coordinate small home modifications for San Francisco seniors to prevent falls.
.85 FTE
GF: $152,000

District 10 Wellness Collaborative
CHEP funds and provides capacity-building assistance to CBO partners. Community-based organization efforts provide physical activity, stress reduction, nutrition, health advocacy, healing services, and asthma navigation and management.
1.20 FTE
Total: $1,748,000
GF: $1,501,000
MHSA: $247,000

Healthy Hearts SF
CHEP directs and manages the program operations and provides capacity-building for HHSF, which increases opportunities for free physical activities for African Americans and Latinos, as well as strengthens linkages between the health care system and community prevention resources.
3.20 FTE
CDC: $799,159

Healthy Retail
This program assists corner stores in areas with little access to healthy and fresh foods. CHEP leads community engagement efforts, provides capacity-building to coalitions and merchants and linkages to technical assistance resources including evaluations.
1.2 FTE
Grants: $100,000

Shape Up SF
Shape Up SF's mission is to advocate for and promote environments, systems, and policies that make the healthy choice the easy choice to prevent health disparities. CHEP supports the city wide Shape Up SF Coalition and leads the Shape Up SF Initiative, which is SFPD's key contribution to SUSF's vision and mission and encompasses these programs
Rethink Your Drink- CHEP provides trainings on the health impacts of sugary drinks; supports organizations to develop wellness policies, conducts public education campaigns, provides policy technical assistance, and supports enforcement of existing policies
PE Advocates -CHEP convenes and organizes partners in an initiative that aims to increase the quality and quantity of PE in SFUSD schools.
SEFA -CHEP convenes the Southeast Food Access (SEFA) Working Group, a key partner in the HEAL Zone collaboration
ShapeUp SF Coalition: CHEP staff the Coalition, which is a multi-disciplinary coalition committed to reducing health disparities in chronic diseases.
1.75 FTE
Total=$332,500
GF: $257,500
Grants: $75,000

Safe Routes to School
CHEP leads the Safe Routes to School collaborative—an initiative to increase safe and active walking and biking to/from school in SF. CHEP secures funding, funds partners, conducts evaluations, and works with other partners to develop plans for enforcement, engineering, and evaluation.
2.0 FTE
Grants: $948,085

Bayview HEAL Zone
Also a part of Shape Up SF, Bayview HEAL Zone is a Kaiser Permanente-funded initiative to create environments and promote social norms to increase healthy eating and physical activity in the Bayview neighborhood. HEAL Zone funds the Food Guardians (which originated in SEFA) who conduct outreach, education, and community organizing in the Bayview to promote food security and justice, urban agriculture, and nutrition education and awareness.
4.75 FTE
Grants: $750,000
Community Based HIV/HCV Testing
CHEP funds CBOs and methadone clinics to provide site-based and mobile HIV testing. Two large testing programs (San Francisco AIDS Foundation and UCSF Alliance Health Project) provide most of the testing services to the three high prevalence populations. Several smaller testing programs provide testing within the context of holistic health services.
3.0 FTE
$3,904,877
GF and CDC grant funding.

Health Education and Risk Reduction
CHEP funds two CBOs (SFAF Stonewall Project and Instituto Familiar de la Raza) to provide HIV prevention services to HIV-negative individuals affected by substance use and other drivers (gonorrhea, multiple partners). These programs are intended to address factors that have been shown to be linked directly to new HIV infections.
.50 FTE
GF: $796,871

Holistic Health to Address HIV Health Disparities
Four projects address the groups that bear a disproportionate burden of HIV – MSM regardless of race/ethnicity, African American MSM, Latino MSM, and transgender females. The projects offer holistic HIV prevention support to these groups regardless of HIV status, and also provide HIV testing.
2.0 FTE
GF and CDC: $2,703,895

Prevention with Positives
CHEP supports prevention with HIV-positive people both through a subcontract to SFAF STOP AIDS Project and funding for selected Ryan White Centers of Excellence. Prevention with positives focuses on the health needs of the clients/patients, including linkage to and retention in care, treatment adherence, and sexual and substance use behaviors.
.50 FTE
GF: $1,006,452

Transgender Health
In addition to HIV prevention for transfemales, CHEP supports the broader DPH efforts to promote health and wellness for transgender people, including serving as liaison to the Transgender Advisory Group, participating in conversations related to data collection, supporting the TEACH study, implementing the Transgender 101 training for SFDPH staff, and many other projects.
.50 FTE
$95,000

Syringe access and disposal services
CHEP funds SF AIDS Foundation to coordinate the City’s syringe access and disposal program, which distributes safe injection supplies to persons who inject and collects and disposes of used supplies. CHEP also leads community and police relations, and implements innovative community-driven solutions to concerns (e.g., in response to concerns about improperly discarded syringes, CHEP took the lead to have disposal boxes installed in appropriate locations).

1.25 FTE
GF: $1,909,613

Condom distribution
CHEP purchases male and female condoms and provides them free of charge to any agency or business that wants them. CHEP funds a targeted condom distribution program that provides condoms at bars, gyms, and other venues where gay men, people who inject drugs, and transfemales work and play.

.50 FTE
CDC and GF: $315,000

Minority AIDS initiative Targeted Capacity Expansion (MAI-TCE)
Through a grant from SAMHSA, MAI-TCE provides HIV-informed integrated behavioral health services to people living with and at risk for HIV at multiple primary care sites and other clinical settings. Although the grant ends in September 2015, the services have proved to be extremely valuable, and CHEP is working on ways to sustain the effort.

8.50 FTE
SAMHSA grant: $1,320,087

HIV Prevention Planning Council (HPPC)
The HPPC is SF’s federally mandated HIV prevention community planning group. CHEP Co-Chairs and provides staff and technical support to the Council. The Council is working towards integration with the HIV Health Services Planning Council to improve seamless planning for HIV prevention, care, and treatment services.

2.0FTE
$180,000

Drug Users Health
The drug user health initiative is an effort to bring an increased focus to the role that substance plays in HIV transmission, HIV health outcomes, and overall health. Currently in the planning stage, it will address priorities raised by the HPPC, gaps in services, systems-level barriers, unmet hepatitis C-related needs, and other pressing concerns that influence the health of this population. CHEP envisions an integrated, comprehensive service system that bridges HIV, HCV, and overdose prevention services within both HIV prevention and behavioral health programs.

.50 FTE
GF and CDC: $45,000

YUTHE (Youth United Through Health Education)
The YUTHE Program’s goal is to reduce rates of STDs and their sequelae among African American adolescents living in Southeast SF by increasing the utilization of STD preventive services through a peer education outreach intervention model. CHEP staffs the YUTHE Program. YUTHE staff conduct street outreach for African American youth/young adults
up to 25 years of age in Bayview/Hunter’s Point, Visitation Valley, and Sunnydale neighborhoods. They provide condoms, lubricants, and referrals and encourage chlamydia/gonorrhea screening.

2.50 FTE
GF: need to get from Nora.

**Street and Venue-based community outreach**

CHEP staff provide venue-based STD and HIV testing for four primary target populations: 1) gay/bisexual men, 2) TMSM, 3) transgender females, and 4) young women 25 and under. CHEP staff conduct street outreach for gay/bisexual men, TMSM, and transfemales in high STD morbidity areas, providing condoms, lubricants, and information about where to get tested. Key neighborhoods include the Tenderloin, Castro, and South of Market (SOMA). The CHEP STD prevention program has strong relationships with coffee shops, bars, gyms, bookstores, and other businesses whose clientele include gay/bisexual men, TMSM, and transfemales, and where sex might occur on site. CHEP staff provide education to the business owners and staff on STDs and help build their capacity to be part of the STD prevention effort.

2.75 FTE
CDC: $350,005

**Trainings and workshops**

STD trainings and workshops are provided to case managers, STD counselors, and others at community-based organizations and clinics. CHEP staff also provide trainings for the sex clubs and other sex industry partners. In addition, the YUTHE program provides skills-building workshops for young African Americans at community-based organizations and juvenile detention facilities. The workshops focus on healthy relationships, self-efficacy, and self-confidence around negotiation of sex and other relationship issues, decision-making, STD/HIV 101, and prevention strategies.

2.50 FTE
CDC: TBD

**Community engagement**

CHEP staff have a number of approaches to engaging community members in STD prevention efforts. CHEP staff convene the STD Partners Group, which includes community-based organizations, business owners (e.g., sex industry), and other community experts. CHEP also convenes the Adolescent Community Partners Group, which includes providers, community-based organizations, schools, UCSF, and other stakeholders. Lastly, staff lead an e-coalition of over 500 people, which is focused primarily on syphilis prevention. The group convenes as needed to provide input on how best to address syphilis in SF. CHEP also conducts focus groups annually with gay men and African American youth to assess behavior and obtain input on strategies for prevention.

1.1 FTE
CDC: $75,000
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<td>Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.</td>
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<td>PERFORMANCE MEASURES 2012-2015</td>
<td><strong>PERFORMANCE MEASURE 4.2:</strong> Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.</td>
</tr>
<tr>
<td>DESCRIPTION</td>
<td>Disease Prevention and Control (DPC) oversees public health clinical services including treatment and biomedical prevention, public health laboratory testing and broad communicable disease investigation (DIS) services. DPC 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, DPC staff work closely with the San Francisco Health Network to optimize clinical policies and care in the DPC core areas.</td>
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<tr>
<td>FUNCTIONS INCLUDE:</td>
<td></td>
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|                     | • 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 |
STD Prevention and Control:
SF City Clinic
The municipal STD clinic conducted 18,902 visits in 2013, serving approximately 10,982 unduplicated clients. The clinic provides STD screening, diagnosis and treatment; offers family planning services including emergency contraception, contraceptive counseling and prescription (including Depo-Provera) and referral for same-day long-acting reversible contraception (LARC); cervical cancer screening and colposcopy; HIV/STD health education and risk reduction counseling; and Hepatitis A, B and HPV vaccination (to qualifying patients). Many of the individual programs listed below occur fully or are primarily based in City Clinic.
Staff (includes vacant positions):
Total = 25 FTE
Budget: $8,069,327

HIV testing program
Conducts > 6000 HIV tests annually (including screening for acute HIV infection) in patients at elevated risk for HIV infection. 6752 tests were conducted in 2013 and 109 patients were identified with HIV (21.1% of whom had Acute HIV – a stage of infection with very high viral loads and therefore high risk of transmission to partners. Treatment early for Acute HIV may also improve a patient’s individual health outcome).
Staff are included in clinic and LINCS

Biomedical HIV prevention (nPEP and PrEP) programs:

nPEP
Provides >450 courses of nPEP annually to patients who have had a high risk exposure to HIV infection with the prior 72 hours. The nPEP program includes baseline HIV testing and counseling, provision of a 2-day starter pack of PEP medications, prescription for remainder of course (including referral to SFGH for free medications for uninsured, SF residents), and follow-up phone calls to assure the patient picked up his/her prescription, check-in regarding side effects, provide ongoing supportive counseling and remind the client about the importance of repeat HIV testing after the completion of the nPEP course.

PrEP
Provides PrEP education and counseling to clients at ongoing, elevated risk for HIV-infection. Provides PrEP navigation to those who are insured to assist them with accessing PrEP in primary care, and provides PrEP initiation and maintenance to those who are uninsured (and qualify for Gilead Patient assistance) or who are insured or underinsured and unable to access or afford PrEP in primary care. In addition, program staff work with the client to enroll in comprehensive health insurance (if he is uninsured), to choose a new plan (if he is underinsured) and to identify a PCP and medical home where he can access PrEP. As of 8/1/2015 we have provided PrEP navigation to >600 clients and have initiated 220 clients on PrEP.
Staff = 3.5 FTE

Syphilis prevention program
Conduct contact investigation and provide partner services to all clients with primary and secondary syphilis, and select patients with early latent syphilis (staffing permitting). Refer HIV-negative partners of syphilis cases to high-impact HIV prevention services (nPEP and PrEP) and offer LINCS services (see below) to HIV-positive partners of syphilis cases. Provide brief, intensified case management to pregnant women with syphilis to ensure optimal fetal outcomes.
Staff = Included in LINCS
LINCS Program

LINCS partner services and RAPID linkage identifies, locates, and connects those who test positive for HIV anywhere in San Francisco to HIV care services. Patients with acute HIV (AHI) are linked and initiated on ART on the day results are disclosed whenever possible. RAPID linkage requires an assessment of the client’s insurance status, income, and cultural/geographic preferences such that the client can be linked to a clinic that best fits his/her needs. 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 have had a high risk exposure within the 72 hours prior to notification, they are linked to post-exposure prophylaxis and if they are at ongoing, elevated risk for HIV they are linked to pre-exposure prophylaxis (PrEP). All partners are offered brief health education and risk reduction counseling. If they test positive, a LINCS staff member offers assistance with linkage to care and partner services.

LINCS Navigation works with HIV+ patients who are out-of-care, with the goal of re-linkage to HIV primary care. The HIV Care Navigators work with HIV positive patients intensively for up to 90 days to help them engage in primary medical care, and connect them to long-term case management and other services through warm referrals and direct handoffs. Navigator activities are non-prescribed and typically include check-in phone calls to patients, home visits, escorts to care appointments and coordinating the transition to a traditional case manager. Navigators also help patients attend appointments for benefits enrollment or substance use treatment. LINCS Navigation is set up to be a safety net under existing services for HIV positive patients in the community, and Navigators can work with patients anywhere along the HIV treatment cascade, from diagnosis to viral suppression. By re-linking HIV-infected clients to care, the navigators are working to increase the percent of HIV infected individuals in San Francisco who are taking anti-retroviral therapy and achieving durable viral suppression.

Staff = 15 FTE

GC/CT screening and surveillance program

This program works to ensure that all San Francisco residents with GC or CT receive adequate treatment for their infection within a timely fashion. SF City Clinic is a GISP (gonococcal isolate surveillance project) site and the first 30-isolates of GC/month are tested for antibiotic resistance. Patients with GC isolates with elevated MICs to cefixime, azithromycin or ceftriaxone are contacted and interviewed. In addition, the program currently supports approximately 30 screening sites by providing them with GC/CT test kits and technical assistance around best practices in GC/CT screening. Through the CDC-funded AAPPS grant, this program is also working to optimize compliance with CDC recommendations for Chlamydia screening (which are USPSTF grade A) across the health network and to decrease Chlamydia rates among young women of color through a range of clinic-based and, in collaboration with CHEP, community based activities.

Staff = 4 FTE

Early Care Program

SF City Clinic’s Early CARE program provides an accessible site for immediate entry into care for patients newly diagnosed with HIV, and for HIV positive clients who are new to the city, transitioning from private to public systems of care, and/or out of care and motivated to re-engage. The goal of the program is to bring people into care, assist them with accessing benefits, including comprehensive health insurance, and then help them transition into a medical home. In addition, the clinic offers RAPID (same day) initiation of ART for patients with acute or recent HIV who qualify for ADAP.

Staff = 1 FTE (plus in-kind 4 clinicians, nurses and HWs included in staff numbers above)

Education and training
The STD clinic serves as a major training site for nursing and medical students, and for medical housestaff (interns, residents and fellows) across a range of disciplines (internal medicine, family medicine, OB/Gyn, pediatrics, preventative medicine, and infectious diseases). In addition, the clinic collaborates with the STD/HIV prevention training center to provide CME courses for providers conducting a sexual history and male/female genital examination, and in performing wet mounts and urine microscopy.

Staff = Included in above estimates

Research activities
The STD/HIV program and City Clinic have participated in and led a range of applied STD/HIV research studies over the past several decades, including 1) developing new diagnostics for STDs, including HIV; 2) assessing the efficacy of new treatments for STDs; 3) assessing efficacy of various behavioral interventions and contraceptive counseling techniques; 4) performing implementation research, e.g. for PrEP. Research projects are selected based on their potential to improve sexual health in San Francisco, and to address health disparities.

Staff = 3 FTE

Academic detailing
At present, provider outreach and education activities of the HIV/STD program are limited and sporadic. We provide direct outreach to providers who are not complying with GC/CT or syphilis treatment guidelines and provide technical assistance, including providing Bicillin to providers who do not stock this medication. We offer 1:1 consultation to PCPs who have questions about nPEP, PrEP, or immediate (pre-genotype) initiation of ART. We now have an additional physician in the program who will be providing more coordinated academic detailing around sexual health.

Staff = 1 NP to be hired through 15-1506

TB Prevention and Control:
The mission of the San Francisco TB prevention and Control Program is to control, prevent and finally eliminate tuberculosis in San Francisco by providing compassionate, equitable and supportive care of the highest quality to all persons affected by this disease. Overall number of staff: 31

Budget: $4,835,464

The San Francisco Tuberculosis Clinic
The San Francisco Tuberculosis Clinic is the referral and specialty clinic for the diagnosis and treatment of tuberculosis disease and complicated tuberculosis infection in the city and county of San Francisco. The clinic sees new patients and referrals six half days a week and evaluates and treats over 2500 patients annually. The clinic has facilities to effectively isolate infectious TB patients, a sputum induction booth, phlebotomy, and dispenses TB medication.

Staff: 15 FTE

Outbreak Detection and Surveillance section
Outbreak Detection and Surveillance section takes in all reports of people who have been diagnosed with TB disease or are suspected to have TB disease, and ensures that those reported are receiving appropriate treatment and are properly isolated to limit the spread of TB. The section also includes the staff who support the program’s field services and perform the contact investigations and are responsible for finding and evaluating those who have been exposed to and infectious TB patient in San Francisco in households, workplaces, schools, and other community settings.

Staff: 5 FTE

Directly Observed Therapy
This service provides face to face verification of medication ingestion in the field, at the TB clinic, or video DOT via smartphone. This service tracks a patient’s adherence to anti-TB treatment and is one of the key components of case management.
Staff: 2 FTE

**Case Management**
This program, which is supported by interdisciplinary team of nurses, physicians, social workers, health workers, and disease control investigators, ensures completion of treatment of patients who are being treated for TB disease by tracking response to treatment, number of doses observed by DOT, identifies barriers to adherence and addresses these with interventions including incentives and enablers. Persons who are suspected of having TB disease on empiric treatment and complicated TB infection are also case managed.
Staff: 5 FTE

**Clinical Preventive Services**
Clinical Preventive Services include outreach to the community with TB screening (Project Homeless Connect), support of primary care clinics for TB screening and treatment of uncomplicated TB infection, provision of access to interferon gamma release assays to DPH and consortium clinics, and promotion of diagnosis and treatment of TB infection in primary care.
Staff: 2 FTE

**Expert clinical and laboratory consultation**
Expert clinical and laboratory consultation is available to the community providers 24/7 regarding questions related to the diagnosis, treatment and infection control of TB. The TB controller and medical director are accessible through a TB hotline after hours, e-referral, and accessible to the community at the clinic during business hours.
Staff: 0.5 FTE

**Research**
Currently participating in clinical trials that involve projects related to smartphone directly observed therapy and interferon gamma release assays and their ability to predict progression to TB disease.
Staff: 1.5 FTE

**Communicable Disease Control and Prevention:**
**Adult Immunization and Travel Clinic**
Adult Immunization and Travel Clinic (AITC) at 101 Grove Street is open to the general public. AITC serves as an appointment-only travel medicine clinic providing preventive care including vaccinations, anti-malaria and other travel-related prescription medications, and comprehensive health advice for adults and families planning personal or business-related international travel. AITC also serves as drop-in immunization clinic offering all US-licensed vaccines for teens and adults, TB testing, and blood testing for immunity to vaccine-preventable diseases. Finally, AITC offers on-location flu vaccination and TB testing for SF businesses, schools, and organizations. All services are fee-based.
Staff: 10.8 FTE
Budget: $1,891,330

**The Communicable Disease Prevention Unit**
The Communicable Disease Prevention Unit houses the state-funded SFDPH Immunization Program, which includes programs to prevent a wide range of vaccine-preventable diseases. Key aspects include case management to prevent perinatal acquisition of hepatitis B, receipt and distribution of federally- and state-purchased vaccines to local clinics,
and technical assistance to providers, schools, and the public regarding immunization requirements, vaccination as a component of disease outbreak management, and proper vaccine storage and handling.

Staff: 4.2 FTE
Budget: $1,904,017

The Communicable Disease Control Unit (CDCU) is responsible for investigating and providing public health management of approximately 80 communicable diseases in accordance with Title 17, California Code of Regulations, in order to prevent the spread of these diseases in the community. CDCU investigates and manages outbreaks reported by medical providers, group living facilities, community members and other sources, and collaborates closely with the medical community to share information concerning communicable disease issues. The diseases we manage include bacterial infections, gastrointestinal illness, influenza, vaccine preventable diseases such as measles and pertussis, emerging infections, and rabies in bats. We provide education and recommendations for both individual clients and group living facilities. This year we are working specifically with skilled nursing facilities in order to better manage and prevent outbreaks of influenza, which can be deadly in this population. Emergency activations in recent years have involved measles, Shigellosis (a gastrointestinal illness), H1N1 (Swine Flu), and Ebola preparedness. We are currently monitoring returning travelers from Ebola-affected countries to ensure timely and safe response should one of these exposed persons come down with symptoms of Ebola. We are also responsible for reporting communicable diseases covered by Title 17, California Code of Regulations to the State Department of Public Health, so that they can compile this information for the entire state of California and manage interjurisdictional clusters and outbreaks of diseases. We maintain and administer the only system citywide that can send out urgent health communications to our medical community, community based organizations and others key partners in public health.

Staff: 9.0 FTE
Budget: $1,647,239

Public Health Laboratory
The Public Health Laboratory (PHL) serves the entire city of San Francisco as a testing site for communicable diseases of greatest public health importance. The laboratory also provides testing expertise to providers and clinical laboratories throughout the city. The PHL provides specialized testing for rabies, TB, HIV, chlamydia, gonorrhea and syphilis along with many other infections. The work of PHL is deeply connected to the disease intervention and control work done by the disease intervention (DIS) staff also working in the DPC branch. For instance, for any individual diagnosed with gastrointestinal infections such as Shigella or Salmonella, the communicable disease DIS work with the patient and have their specimens tested at the PHL to assure that the infection has cleared before they can return to work in certain occupations which may put the public at risk of contracting the same infection – such as restaurant, daycare or healthcare workers.

As another example, PHL is the only laboratory in San Francisco currently looking directly for HIV virus in all specimens with a negative HIV antibody result. This additional testing step allows detection of acute HIV infection – the very earliest stage of infection which cannot be detected by standard tests but during which individuals are highly likely to transmit HIV unknowingly to partners. Once the lab identifies a patient with acute HIV infection, Disease Intervention Specialist colleagues in DPC rapidly notify him or her and link them immediately to HIV medical care and treatment which improves individual health and also prevents HIV transmission to sex partners. This is just one example of how the laboratory contributes to the larger public health disease interventions city-wide, such as Getting to Zero new HIV infections. The Public Health Laboratory is also the reference laboratory and connection the California Department of Public Health Laboratory and to CDC Labs. The PHL offers rapid technical assistance and guidance in cases of emerging infectious diseases or outbreaks, and is an important part of SFDPH public health emergency preparedness. In 2014 when SFDPH Department Operations Center was activated in preparation for possible travelers with Ebola, the PHL
helped provide information and assistance to hospital clinical laboratories in San Francisco as they were developing protocols to safely handle specimens from patients under evaluation for Ebola.

Staff: 21 FTE
Budget: $2,181,032
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**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

**Public Health Emergency Preparedness (PHEP) Program**


This document outlines 15 PHEP Capabilities intended to serve as national standards for State and local planning efforts. The California Department of Public Health (CDPH) basis its yearly grant application on these Capabilities. Guiding principles around achieving these capabilities include:

- Maintain essential activities to respond to public health emergencies.
- Ensure sufficient capacity to respond to all hazards.
- Focus on activities that lay the foundation for others, creating a natural progression of activities.
- Focus first on core public health and overarching capabilities while LHDs and CDPH obtain a baseline assessment of their status across all capabilities to develop priorities for future grant years. Local health jurisdictions are required to show progress based on grant work plans, in the prioritized PHEP capabilities for each year.

PHEP Funding: $1,070,403

PHEP Staffing:
Sr. Physician Specialist – in-kind, 0.80 FTE PHEPR General
Fund Nurse Manager – in-kind, 1.00 FTE General Fund
Registered Nurse – 0.25 FTE
HPC III – 0.75 FTE & in-kind, 1.00 FTE HIV General Fund
Health Educator – in-kind, 0.70 FTE PHEPR General
Fund HPC II – 0.67 FTE
HPC I – 1.29 FTE
Budget Analyst – 0.825
FTE Senior Clerk – 1.17
FTE
PS Aide Health Services – 0.50 FTE

Cities Readiness Initiative (CRI)
The Cities Readiness Initiative (CRI) supports the Medical Countermeasure Dispensing (MCM) and the Medical Materiel Management and Distribution Capabilities. CRI enhances MCM distribution and dispensing activities for all-hazards with a focus on responding to a large-scale biologic attack centered on the aerosolized anthrax planning scenario. Through CRI, state and large metropolitan public health departments develop plans to respond to a large-scale bioterrorist event by dispensing antibiotics to the entire population of an identified metropolitan statistical area with 48 hours. All LHDs receiving CRI funds must address all functions and priority resource elements for Medical Countermeasure Dispensing and Medical Material Management and Distribution Capabilities.

CRI Funding: $257,630

CRI Staffing:
Sr. Physician Specialist – 0.10
FTE HPC II – 0.12 FTE
HPC I – 1.00 FTE
Emergency Preparedness Associate – 1.00 FTE

Hospital Preparedness Program (HPP)
This document outlines eight Capabilities as the basis for healthcare system, Healthcare Coalitions, and healthcare organization preparedness. CDPH’s yearly grant application uses these capabilities to define the HPP work plan for that year. Guiding principles around achieving these capabilities include:
-Maintain essential activities to respond to public health and medical emergencies.
- Ensure sufficient capacity to respond to all hazards.
- Focus on activities that lay the foundation for others, creating a natural progression of activities.
- Allow local flexibility while providing standardization in key areas.
- Focus first on core medical capabilities while healthcare organizations obtain baseline assessments of their status across all capabilities to develop priorities for future grant years.

A cornerstone of HPP has been the requirement that Local Entities establish functional HealthCare Coalitions that include hospitals, clinics, skilled nursing facilities, LHDs, local EMS agencies, mental health facilities, community services agencies, local emergency management agencies, tribal and community participants. These Coalitions are required to plan, train, drill and exercise throughout the grant year.

HPP Funding: $417,665

HPP Staffing:
HPC I – 2.00
FTE
PS Aide Health Services – 1.00 FTE
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<th><strong>PUBLIC HEALTH ACCREDITATION DOMAIN CATEGORY: ASSURANCE</strong></th>
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<td><strong>DESCRIPTION</strong></td>
<td>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.</td>
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</table>
| **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 |
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<tr>
<th>PROGRAM</th>
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<tbody>
<tr>
<td>EMT Certification and Paramedic Accreditation</td>
<td>• Maintain certification of 1,800 EMT’s and local accreditation of 400 Paramedics</td>
<td>Camilla Arcia and Lt. Babe Franey</td>
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<tr>
<td>EMS Provider Agency, Training Agency and Receiving Facility Certification</td>
<td>• Regular review of EMS providers in San Francisco compliance with policy and procedure including Site Visits (Division of Emergency Communications 911 dispatch center, SF Fire Department, King American Ambulance, Pro-Transport 1 Ambulance, NorCal Ambulance, Bayshore Ambulance, St. Joseph’s Ambulance) and inspect ambulances annually&lt;br&gt;• Regular review of EMS training providers in SF compliance with training requirements (SF Fire Department, City College of SF, University of San Francisco, UCSF, King American Ambulance Company, AMR Ambulance Company)&lt;br&gt;• Regular review of Receiving Hospital, Specialty Center and alternate receiving center compliance with policies and protocols (12 Receiving Hospitals, 1 Base Station, 1 Trauma Center, 1 Sobering Center, 5 STAR Centers, 7 Stroke Centers, 2 Pediatric Critical Care Centers, 4 Reimplantation Centers, 1 Burn Center, 4 Critical OB Centers)</td>
<td>Crystal Wright, Aram Bronston and John Brown</td>
</tr>
<tr>
<td>EMS System Coordination</td>
<td>• Facilitate EMS constituent advisory committees, including 911 Provider Committee, EMS Advisory Committee, Trauma Systems Advisory Committee, STAR Subcommittee and QI Committee&lt;br&gt;• Participate in health systems advisory groups including the Hospital Council Emergency Preparedness Partnership, Public Health Division Branch Directors meetings</td>
<td>Mike Dayton</td>
</tr>
<tr>
<td>EMS Fund Administration</td>
<td>• Administer the EMS Fund for reimbursement of fees collected from moving violations for hospital ED use, uncompensated care for EM physicians, and EMS Agency administration</td>
<td>Fermi Chau</td>
</tr>
<tr>
<td>EMS Provider Education</td>
<td>• Teach EMS providers</td>
<td>John Brown</td>
</tr>
</tbody>
</table>

SUMMARY OF EMS AGENCY/BRANCH PROGRAMS 2015
| Regional systems of emergency care coordination | • Teach Emergency Medicine Residents from UCSF/SFGH EM training program on EMS and Disaster Issues  
• Direct EMS/Disaster Fellowship program for post-doctoral fellows | Mike Dayton, John Brown and Mary Magocsy |
| Medical oversight of process improvement, special events and EMS programs | • Participate in Regional Trauma Care Committee  
• Participate in EMS Medical Directors of California and the EMS Administrators Association of CA group  
• Participate in EMS Authority workgroups such as the CA Patient Movement Workgroup | Mary Magocsy, Mike Dayton, John Brown |
| Disaster coordination for EMS functions | • Develop and maintain the local EMS Plan, the local Trauma plan, the EMS QI plan  
• Review and approve EMS plans for local special events  
• Review, participate in and approve local EMS research  
• Participate in CPR Consortium, maintain AED database, improve cardiac arrest survival | John Brown, Mary Magocsy |
|  | • Provide Medical Health Operations Area Coordinator function  
• Provide EMS system oversight in Emergency Operations Center activation for MCI and disasters |  |
## Public Health Accreditation Domain Category: Governance, Administration, and Systems Management
### Office of Operations, Finance, & Grants Management

<table>
<thead>
<tr>
<th>Strategic Direction</th>
<th>Sustainable funding and maximize collective resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategy 5</td>
<td>Increase administrative, financial and human resources efficiencies within the division.</td>
</tr>
</tbody>
</table>
| 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 |
# Public Health Accreditation Domain: Governance Category, Administration, and Systems Management

## Center for Learning and Innovation

<table>
<thead>
<tr>
<th><strong>Strategic Direction</strong></th>
<th>Learning organization with a culture of trust and innovation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy 6</strong></td>
<td>Build a division-wide learning environment that supports public health efforts.</td>
</tr>
<tr>
<td><strong>Performance Measures 2012-2015</strong></td>
<td><strong>Performance Measure 6.1</strong>: Establish a division-wide professional development program.</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>The mission of the Center for Learning &amp; 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 <em>internal</em> DPH audiences as well as <em>external</em> 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.</td>
</tr>
</tbody>
</table>
| **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 |

*Good Participatory Practices Online Training Program* ($50K/year): 0.10 FTE manager (CCSF)
General Fund Training and WD Staff (1.0 Health Educator, and 0.50 2232 PI)

PTBI: 0.15 FTE PI (CCSF)

CFAR Mentoring Program Director 0.15 FTE PI

Internally, we deliver interactive face-to-face training in change management, building trust, and results-based planning methods. CLI also helps other PHD Branches to organize and evaluate training for their staff and affiliated providers, and can confer continuing education credits. We share training opportunities with PHD through monthly e-newsletters. Through our Bright Spots column, we use digital storytelling to highlight the innovative work being done across the Division in communicable disease, surveillance, chronic disease prevention, emergency preparedness, and environmental health. In addition, we support a wide range of internship opportunities to build the public health workforce of tomorrow. Our flagship program, the Summer HIV/AIDS Research Program (SHARP), is an intensive NIH-funded, 12-week mentored research experience that seeks to inspire undergraduates from underrepresented backgrounds in science to consider future careers in HIV prevention research.

SHARP (Summer HIV/AIDS Research Program): 0.5 FTE intern coordinator (PHFE) and summer stipends for 4-6 scholars

Capacity Building Assistance (CBA)

CLI is one of eight national Centers for Disease Control and Prevention-funded Capacity Building Assistance (CBA) providers that support local and state health departments in their efforts to implement high-impact HIV prevention. Our CBA program leverages the expertise of over 40 faculty across PHD to encourage targeted HIV testing; to offer effective bio-behavioral interventions, such as pre-exposure prophylaxis (PrEP), to HIV negative persons at risk; and to share policy innovations. Through our CBA program, we have built our own capacity to host webinars; harness social media to educate and to market our services; create and share online courses; and facilitate learning communities using the latest videoconferencing technologies.

CBA for HDs-- $1,298,402
Total FTE funded:
Sr. Physician Specialist – 0.30 FTE
Manager I – 0.20 FTE
HPC III – 1.05 FTE
HPC II – 0.30 FTE
HPC I – 0.25 FTE
Sr. Health Educator – 0.10 FTE
Epi II – 0.20 FTE
Junior Management Assistant – 0.75 FTE
Accountant IV – 0.025 FTE
Sr. Admin Analyst – 0.05 FTE
Date to Care – 0.50 FTE
Communications Specialist – 1.00 FTE
Program Assistant – 1.00 FTE
Evaluation Specialist – 0.50 FTE
Co. Principal Investigator – 0.40 FTE
Testing Specialist – 0.10 FTE
Finance and Ops Manager – 0.05 FTE
Receptionist – 0.025 FTE
IT – 0.025 FTE
Interns – 1.00 FTE
Counseling Specialist – 0.05 FTE
Project Manager – 0.20 FTE

Other positions are funded outside CLI in DCP and CHEP.
List of Content Collective Impact Projects
Highlighted in this Binder

Vision Zero
Black/African American Health Initiative
Preterm Birth Initiative
Children’s Oral Health Initiative
Getting to Zero
Vision Zero San Francisco: A Collective Impact Case Study

Health & Safety Context
San Francisco, at just 49 square miles, is home to almost one million residents, a major employment center, and an international destination with world-class attractions. Every day over one million people travel to work, school, to shop or socialize with family and friends by foot, bike, transit, and car. San Francisco is one of the nation’s most walkable and bikeable cities with the accompanying health benefits from physical activity. However, more than 50 percent of traffic deaths in San Francisco are people walking—compared to 14 percent nationally, and cyclist deaths have increased in recent years. San Francisco ranks first (worst) among California’s counties for walking injuries and seventh for bicycling injuries based on the state Office of Traffic Safety.

Just 12% (125 miles) of city streets account for over 70% of severe and fatal injuries. The built environment, including the design of our transportation system, plays a major role in severe and fatal traffic injuries. High traffic volumes, high densities of people living and working, and wider, higher speed streets called “arterials” are established environmental risk factors. Vehicle speeds kill—with a pedestrian 5 times more likely to die at 40 mph compared to 25 mph. In neighborhoods like the Tenderloin, the South of Market, and Chinatown, all of these factors in one area contribute to geographic disparities in injury concentrations, particularly to pedestrians. 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 in a pedestrian injury. Children are also at risk for pedestrian injury due to their physical, developmental, and cognitive attributes depending on age. The annual medical costs alone of pedestrian injuries seen at SF General Hospital are $15 million, with the total pedestrian injury health-related economic costs estimated at a much higher $564 million a year.

San Francisco needs safer streets for all people—including the most vulnerable who are reliant on walking. While 30% of San Francisco’s streets are located in areas defined as Communities of Concern, half of the City’s high injury corridors are located in these communities. Communities of Concern include low-income communities, communities of color, seniors and people who rely on walking and transit as their primary means of transportation.

A Common Agenda
Vision Zero SF is a policy adopted by the City to create a culture in which city residents, workers and visitors prioritize traffic safety, and ensure that people do not die or get serious injuries when they make mistakes while using our streets. Vision Zero SF strengthens the City’s long-standing commitment to create a thriving, safe, and healthy city by implementing engineering, enforcement and education initiatives to prioritize safety. Vision Zero SF aims to eliminate traffic deaths in San Francisco by 2024. This “safe systems” approach seeks to protect people from serious injury or death when a crash occurs by creating safe roads, slowing speeds, improving vehicle design, educating people and enforcing laws to support safer road user behaviors. This has been effective in Sweden where Vision Zero originated in 1997, where traffic deaths have been cut in half since its adoption.

Utilizing a data-driven process and following international best practices, Vision Zero SF is working to ensure that city resources are spent where they will have the greatest impact in creating safer streets. City Agencies are working to complete the actions detailed in the Vision Zero Two-Year Action Strategy, released in February 2015 and organized by traffic safety best practices focused on the “5 Es” of Engineering, Enforcement, Education, Encouragement, and Evaluation. SFPDH has a lead role in Education, Encouragement, and Evaluation initiatives, and a supportive role in Engineering and Enforcement.

Mutually-reinforcing Activities
Interagency collaboration is at the core of Vision Zero SF. Agencies, departments, and elected officials across the city are working together to develop, fund and implement effective strategies to save lives. SFPDH co-chairs the Citywide Vision Zero Task Force with SFMTA, with quarterly public meetings to support accountability attended by representatives from over a dozen city agencies as well as community stakeholders, including from the Vision Zero Coalition—led by Walk San Francisco and comprised of over 40 community-based organizations from the most impacted communities.
**Shared Measurement**
The annual reporting of fatal as well as severe injuries is the primary benchmark of success in reaching Vision Zero in San Francisco. In addition, progress is being assessed annually based on additional benchmarks that are indicators of incremental progress towards the goal – such as engineering safety projects implemented, SFPD citations administered for dangerous traffic violations, speeds on local streets, and the impact of education campaigns – as well as the quarterly progress on the specific actions detailed in the VZSF Two-Year Action Strategy.

**Continuous Improvement, Communication, Backbone Support**
Vision Zero city agency staff are accountable to the Two-Year Action Strategy items and have routine check-ins via a City Steering Committee, chaired by the Mayor’s Office, that meets approximately monthly with respect to progress on action items and challenges. City staff also report out on a quarterly basis to the Citywide Vision Zero Task Force which includes community stakeholders, as well as to the SF Transportation Authority Board’s Vision Zero Committee, comprised of members of the Board of Supervisors.

**Achievements and Next Steps**
San Francisco Vision Zero key accomplishments to date include: launching a two-year Citywide Action Strategy and advancing implementation of engineering, education, enforcement, evaluation and policy initiatives; launching the VisionZeroSF.org website; the adoption of additional Vision Zero supportive resolutions by nine city agencies, councils or commissions; and a day-long site visit from the National Highway Safety Administration and the State Office of Traffic Safety spotlighting Vision Zero SF as a national best practice to advance safe walking and biking in April 2015. With respect to progress on the 5 “Es”:

- **Engineering**: The San Francisco Municipal Transportation Agency, with its partners including SF Department of Public Works and SF Planning, is prioritizing safety improvements on the high injury network, and has identified over 24 street safety engineering projects that are being expedited and are on track for completion by January 2016. As of September 2015, 17 of 24 projects have been completed.

- **Enforcement**: The San Francisco Police Department has implemented Focus on the Five, a citywide enforcement initiative that targets the five most dangerous traffic violations that contribute to traffic injuries and deaths that resulted in a 60% increase in traffic citations from 2013 to 2014 to people not following the laws while driving, walking and biking.

- **Education, Engagement**: SFDPH leads the Safe Routes to Schools Program educating schoolchildren and their families about safe and active walking and is partnering with SFMTA on multiple traffic safety media campaigns. SFDPH collaborates with community partners, including Walk San Francisco, and administers community awards for safety initiatives on streets with high numbers of severe and fatal injuries. With generous support from the Mayor’s Office and Supervisor Mar, SFDPH will be launching Safe Streets for Seniors in FY 15-16, a new program to reduce traffic fatalities and injuries to seniors and people with disabilities.

- **Evaluation and Analysis**: SFDPH partners with other city agencies, including the SF Municipal Transportation Agency and the SF Police Department, to monitor progress regarding injury reduction targets, evaluate effectiveness of efforts including education, engineering, and enforcement initiatives and conduct analyses to inform data-driven, evidence-based investments. SFDPH is leading initiatives to both expand surveillance, in partnership with the SF General Hospital and Trauma Center, and develop tools to institutionalize a data-driven approach to targeting traffic safety investments via an online, open-source analytics database called TransBASESF.org. SFDPH’s identified the Vision Zero High Injury Network for targeted safety improvements, which is now being used by SFMTA, SF Planning, SFPW, and SFCTA.

In the coming year SFDPH will continue to implement the Two-Year Action Strategy Actions as well as increase its engagement with state agencies and cities across the state to advance initiatives to save lives.
Despite incremental forward steps to improve the health of San Franciscans, many disparities still exist among Black/African American residents. The San Francisco Department of Public Health (SFDPH) leadership has recognized that in order to adequately address and make a significant impact on the health disparities among the Black/African American population in San Francisco, a focused and deliberate process must be prioritized across the Department so that appropriate staffing and resources can be assigned to key strategic activities.

The Black/African American Health Initiative (B/AAHI) has three major focus areas:

- A focus of racial/cultural humility
- A focus on workforce development
- A focus on collective impact

**Cultural Humility**

Cultural humility is a concept that was conceived by doctors Melanie Tervalon and Jann Murray-Garcia after the Rodney King incident/riot. The idea was to have medical professionals have a discussion around social justice issues through a multicultural framework. For many cultures health care is a cultural construct, arising from beliefs about the nature of disease and the human body, therefore looking at cultural issues are actually central in the delivery of health services treatment and preventative interventions.

Cultural Humility was introduced as an alternative to cultural competence, which assumes that cultures are monolithic and that one can actually reach a full understanding of a culture to which they do not belong. In general, Cultural Humility encompasses 3 objectives: Lifelong learning and Critical Self Reflection, the mitigation of power imbalances, and Institutional Accountability. Cultural Humility requests that people make a consistent commitment to understanding different cultures and focuses on self-humility rather than achieving a state of knowledge or awareness. It is the ability to maintain an openness of someone else's cultural identity. We as providers bring our own belief/value systems, biases, and privileges to our work and the idea of cultural humility emphasis the impact of these beliefs on consumers with which we work.

**Workforce Development**

The Department of Public Health’s Mission is to protect and promote the health of all San Franciscans. A highly competent workforce is key to achieving this mission. To recruit and retain a talented and diverse workforce requires our organization to implement thoughtful hiring practices, offer continuing education, technical assistance and networking opportunities for staff. Ultimately, the goal is to have a workforce that is able to be culturally proficient and able to effectively work with African American staff and patients and clients to reduce the disproportionate number who have adverse, chronic health conditions.

To support this need, DPH has developed an integrated and aligned Workforce Development Plan which includes both Divisions within DPH (San Francisco Health Network and Population Health Division) as well as Administrative Support. The Training and Workforce Development Committee (TWDC) has been instituted and is working to design a plan that meets the challenges of the public health department of the 21st Century as well as the stated expectations of our SFDPH Leadership. One of those DPH expectations is ensuring that African American staff have their priority workforce needs addressed and have the
Collective Impact

Collective impact has captured the imagination of public health practitioners worldwide because its approach to solving complex problems through community transformation “just makes sense.” At SFDPH, we are deploying collective impact using five components. Although the term collective impact was coined in 2011 we can see that collective impact is just continuous quality improvement applied to mutually reinforcing activities focused on a common goal with well-defined measures of progress and success. Collective impact is conducted with diverse partners whose efforts are aligned, coordinated, measured, and improving.

Because the problems we propose to tackle are complex (e.g., Black/African American health disparities), collective impact requires focus, passion, patience, humility, creativity, discipline, and unrelenting optimism. Probably the most important quality is humility. We must be prepared to fail often but learn. We must balance well-intentioned advocacy with humble inquiry and genuine curiosity.

Although collective impact is commonly conducted with cross-sectoral organizational partners, its principles can be applied in any setting, including a large health system like ours. The simplest example of a collective impact approach is a coordinated case manager that aligns and coordinates the care of a complex patient with a multidisciplinary team of professionals (providers, therapists, social worker, etc.). Therefore, we are already familiar with the collective impact approach. SFDPH staff will be invited to serve on Collective Impact Work Groups to participate in planning and to provide guidance and recommendations. Technical leadership will come from the Ambulatory Care and Primary Care quality improvement programs.

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</table>
What Is Cultural Humility?

BLACK / AFRICAN AMERICAN HEALTH INITIATIVE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
July 25, 2014

1 INTRODUCTION

Cultural humility is a concept that was conceived by doctors Melanie Tervalon and Jann Murray-Garcia after the Rodney King incident/riot. The idea was to have medical professionals have a discussion around social justice issues through a multicultural framework. For many cultures, healthcare is a cultural construct, arising from beliefs about the nature of disease and the human body, therefore looking at cultural issues are actually central in the delivery of health services, treatment, and preventative interventions.

Cultural Humility was introduced as an alternative to cultural competence, which assumes that cultures are monolithic and that one can actually reach a full understanding of a culture to which they do not belong. In general, Cultural Humility encompasses 3 objectives: Lifelong learning and Critical Self Reflection, the mitigation of power imbalances, and Institutional Accountability. Cultural Humility requests that people make a consistent commitment to understanding different cultures and focuses on self-humility rather than achieving a state of knowledge or awareness. It is the ability to maintain an openness of someone else’s cultural identity. We as providers bring our own belief/value systems, biases, and privileges to our work and the idea of cultural humility emphasis the impact of these beliefs on consumers with which we work.

2 BLACK / AFRICAN AMERICAN HEALTH INITIATIVE

Our major focus will be to start a dialogue across divisions about the topic of Cultural Humility and how the ideal of Cultural Humility can be achieved across the different sections within DPH.

Our initial objectives will be to explore ways that Cultural Humility can be incorporated into DPH practices to better understand the patient and workforce experience department wide in the work that different sections are doing; and, to look at ways to incorporate Cultural Humility in leadership, hiring’s, supervision, with staff from the different sections.

We will launch our work with the following questions:

- Given our common understanding of Cultural Humility how do you see the definition working at SFDPH?
- How do you see this definition working with your individual unit?
- How do you see the definition working with the leadership within your program?
- How do you see this definition being applied with co-workers?
What Is Workforce Development?

BLACK / AFRICAN AMERICAN HEALTH INITIATIVE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

July 25, 2014

1 INTRODUCTION

The Department of Public Health’s Mission is to protect and promote the health of all San Franciscans. A highly competent workforce is key to achieving this mission. To recruit and retain a talented and diverse workforce requires our organization to implement thoughtful hiring practices, offer continuing education, technical assistance and networking opportunities for staff. Ultimately, the goal is to have a workforce that is able to be culturally proficient and able to effectively work with African American staff and patients and clients to reduce the disproportionate number who have adverse, chronic health conditions.

To support this need, DPH has developed an integrated and aligned Workforce Development Plan which includes both Divisions within DPH (San Francisco Health Network and Population Health Division) as well as Administrative Support. The Training and Workforce Development Committee (TWDC) has been instituted and is working to design a plan that meets the challenges of the public health department of the 21st Century as well as the stated expectations of our SFDPH Leadership. One of those DPH expectations is ensuring that African American staff have their priority workforce needs addressed and have the information and supports to access continuous learning and development and employment mobility opportunities in DPH.

2 BLACK / AFRICAN AMERICAN HEALTH INITIATIVE

Our focus will be on identifying strategies to support the Training and Workforce Development Committee (TWDC) recommendations in the following areas:

- Developing and supporting strategies to recruit interested African American applicants, students, and volunteer

- Developing and supporting strategies for retaining, motivating, and showing value towards current African American staff

- Working with DPH Administration, Human Resources and Unions to support continuing education and learning opportunities pathways for existing African American staff

- Developing conflict, grievance, and possible resolution process for African American staff, before Union involvement
WHAT IS COLLECTIVE IMPACT?

BLACK / AFRICAN AMERICAN HEALTH INITIATIVE
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

July 23, 2014

"Collective Impact is the commitment of a group of actors from different sectors to a common agenda for solving a complex social problem.”

www.FSG.org

1 INTRODUCTION

Collective impact has captured the imagination of public health practitioners worldwide because its approach to solving complex problems through community transformation “just makes sense.” At SFDPH, we are deploying collective impact using five components (Table 1).1 Although the term collective impact was coined in 2011 [1, 2, 3], we can see that collective impact is just continuous quality improvement applied to mutually reinforcing activities focused on a common goal with well-defined measures of progress and success. Collective impact is conducted with diverse partners whose efforts are aligned, coordinated, measured, and improving.

Because the problems we propose to tackle are complex (e.g., Black/African American health disparities), collective impact requires focus, passion, patience, humility, creativity, discipline, and unrelenting optimism. Probably the most important quality is humility. We must be prepared to fail often but learn. We must balance well-intentioned advocacy with humble inquiry and genuine curiosity [4].

Although collective impact is commonly conducted with cross-sectoral organizational partners, its principles can be applied in any setting, including a large health system like ours. The simplest example of a collective impact approach is a coordinated case manager that aligns

---

1 For the 5th component FSG lists “Backbone Organization: Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.”

Table 1: Collective impact components (adapted from: www.FSG.org)

<table>
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</tr>
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<td>Common Agenda:</td>
<td>All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions</td>
</tr>
<tr>
<td>Shared Measurement:</td>
<td>Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable</td>
</tr>
<tr>
<td>Mutually Reinforcing Activities:</td>
<td>Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action</td>
</tr>
<tr>
<td>Continuous Communication:</td>
<td>Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation</td>
</tr>
<tr>
<td>Continuous Improvement:</td>
<td>Continuous quality improvement methods applied to mutually reinforcing activities</td>
</tr>
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and coordinates the care of a complex patient with a multidisciplinary team of professionals (providers, therapists, social worker, etc.). Therefore, we are already familiar with the collective impact approach.

SFDPH staff will be invited to serve on **Collective Impact Work Groups** to participate in planning and to provide guidance and recommendations. Technical leadership will come from the Ambulatory Care and Primary Care quality improvement programs.

## 2 Black / African American Health Initiative

For Black / African American Health Initiative we are focusing on four high-priority health areas (Table 2) within the San Francisco Health Network (SFHN) that represent significant population health and health care disparities, and align with the Population Health Division (PHD) Strategic Plan.

Our initial major focus will be to improve cardiovascular health using an enhanced version of the CDC Million Hearts Initiative that we are calling **Healthy Hearts San Francisco** (HHSF). HHSF will focus on primary prevention and/or management of the ABCDS: Aspirin when appropriate, Alcohol in moderation, Blood pressure control, Cholesterol control, Diabetes management, and Smoking cessation.

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## References


Preterm Birth: Problem, Causes & Strategies & Partners Draft 2014-08-11

Describe a local problem
Babies were more likely to be born preterm or with low-birth weight among women with specific risk factors—poverty/Medi-Cal insured, Latina, Black, working, smoking, and obese.

Population Indicators: How is the county doing?

Data A: Overall Trend

<table>
<thead>
<tr>
<th>Year</th>
<th>Preterm Birth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>9.6</td>
</tr>
<tr>
<td>2001</td>
<td>10.3</td>
</tr>
<tr>
<td>2002</td>
<td>10.1</td>
</tr>
<tr>
<td>2003</td>
<td>10.4</td>
</tr>
<tr>
<td>2004</td>
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The overall rate of prematurity in San Francisco is 8.2% but significant disparities persist by poverty, health insurance type, ethnicity, healthcare access, existing health conditions, and behaviors.

Data B: Disparities

- Women <35yo with Medi-Cal insurance were 40% more likely to have preterm birth than those with private insurance (7.6% vs 5.5%).
- Women >35yo with Medi-Cal insurance were 70% more likely to have preterm birth than those with private insurance (9.9% vs 5.9%).
- The relative risk of preterm births for Medi-Cal versus private insurance is approximately 1.6 - 1.7 in San Francisco, after stratifying by advanced maternal age and ethnicity.
- Latina and Black women are much more likely to have preterm births.
- Among women with Medi-Cal, those who worked up to the month of delivery were twice as likely to give preterm birth as those who stopped working in month prior to delivery.
- The prematurity rate among women who were obese before pregnancy is 8.4%, forty percent higher than those who are normal weight (5.8%).

Key causes of the problem:

“There is clear evidence that a favorable lifestyle and a greater degree of health consciousness are associated with a reduced risk of preterm birth above and beyond what can be measured effectively and controlled in observational studies. Despite the lack of success in pinpointing behaviors that affect the occurrence of preterm birth, continued efforts are needed to better understand and ultimately pinpoint the aspects of a favorable lifestyle that are associated with a reduced risk of preterm birth. The results of research on psychosocial factors and preterm birth have accumulated rapidly in recent years. What is most clear from this large body of evidence is that psychosocial factors should not be grouped together as if they were one risk factor. Rather, they must be studied as the distinct theoretical risk factors that they are. Evidence indicates that some psychosocial factors in the etiology of preterm birth include major life events, chronic and catastrophic stress, maternal anxiety, personal racism, and lack of support.”

- The Institute of Medicine report on Preterm Birth (2007)

Factors of Preterm Birth: (Adapted from IOM Report on Preterm Birth: Causes, Consequences, and Prevention, 2007.)

<table>
<thead>
<tr>
<th>Sociodemographic</th>
<th>Psychosocial</th>
<th>Behavioral</th>
<th>Medical &amp; Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal age: U-shaped. &lt;16yo, &gt;35 years old</td>
<td>Stress</td>
<td>Tobacco. RR 1.5 for smoking 10-20cig/d; 2.0 for 20+ cig/day</td>
<td>Chronic HTN. OR 4.06</td>
</tr>
<tr>
<td>Marital status: OR: 1.41 single mothers living alone</td>
<td>Life events. (divorce, death in family, illness, injury, loss of job)</td>
<td>Alcohol. Heavy users of alcohol (e.g., &gt;1 drink/day during pregnancy)</td>
<td>Asthma &amp; Lung Dz</td>
</tr>
<tr>
<td>Race &amp; Ethnicity: Particularly African-Americans</td>
<td>Chronic stress</td>
<td>Cocaine users. OR 2</td>
<td>Previous PTB OR 2.45</td>
</tr>
<tr>
<td>Socioeconomic conditions</td>
<td>Anxiety. OR 2.1</td>
<td>Work conditions. RR=1.3 for work &gt;42h/wk, standing &gt;6h/d, low levels of job satisfaction.</td>
<td>BMI&lt;20 OR 3.96</td>
</tr>
<tr>
<td>Neighborhood conditions</td>
<td>Depression. OR 1.96</td>
<td>Lack of leisure physical activity</td>
<td>Birth spacing &lt;6m RR 1.3 – 1.6</td>
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<tr>
<td></td>
<td>Racism</td>
<td></td>
<td>Infertility treatment</td>
</tr>
<tr>
<td></td>
<td>IPV. OR 1.37</td>
<td></td>
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<tr>
<td></td>
<td>Unintended pregnancy RR 1.62</td>
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</table>
Community Perspectives in SF – Causes:

Socioeconomic, cultural and environmental conditions
Low income-income disparity; Neighborhoods, School rop-out rate/ low academic achievement; Trauma; Food desert - no access to healthy foods; Single parents (stress);Low access to health services/overcrowded clinics; Unwelcoming clinical services

Living and working conditions (institutions)/health conditions
Stress; Discrimination; Trauma; Unemployment; Poverty; Poor nutrition; Inadequate housing; Unregulated work environments; Inadequate jobs; No training and job development programs Undocumented immigrants –stress; Stigma-access to mental health and other services

Social and community networks
Stress; Isolation; Depression; Gentrification-cultural isolation; Lack of culturally specific providers; Limited culturally competent prenatal care; Erosion of culture (e.g., dance, traditional community organizations); No emphasis of girl-to-womanhood programs

Individual lifestyle
Stress-health disparities chronic diseases; Low self efficacy/esteem, self-advocacy, or personal empowerment; Poor nutrition; Depression/mental health; Trauma; Lack of financial empowerment-education and money management; Low positive cultural identity; Life planning; Unintended mistimed pregnancies

Best practice strategies or intervention activities to prevent preterm births

The WHO, March of Dimes, and other health experts have summarized the evidence-based approaches to prevent preterm births and reduce deaths among premature babies in its *Born Too Early* report (2012).

The “Preconception care package” is further described to prioritize 5 specific interventions for all women and 4 specific interventions for women with special risk factors that increase the risk for preterm birth.
The “Born to Soon” report also summarizes “actions before and between pregnancies to reduce the risk of preterm birth.

Table 3.2: Priority interventions and packages during the preconception period and before pregnancy to reduce preterm birth rates

<table>
<thead>
<tr>
<th>Preconception care services for the prevention of preterm birth for all women</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prevent unintended pregnancies and promote birth spacing and planned pregnancies</td>
</tr>
<tr>
<td>• Optimize pre-pregnancy weight</td>
</tr>
<tr>
<td>• Promote healthy nutrition including supplementation/fortification of essential foods with micronutrients</td>
</tr>
<tr>
<td>• Promote vaccination of children and adolescents</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preconception care services for women with special risk factors that increase the risk for preterm birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Screen for, diagnose and manage mental health disorders and prevent intimate partner violence</td>
</tr>
<tr>
<td>• Prevent and treat STIs including HIV/AIDS</td>
</tr>
<tr>
<td>• Promote cessation of tobacco use and restrict exposure to secondhand smoke</td>
</tr>
<tr>
<td>• Screen for, diagnose and manage chronic diseases, including diabetes and hypertension</td>
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Table 3.4: Actions before and between pregnancy to reduce the risk of preterm birth

<table>
<thead>
<tr>
<th>Invest and plan</th>
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<tr>
<td>• Assess institutional need for preconception care services and opportunities in local health system to deliver.</td>
</tr>
<tr>
<td>• Use every opportunity to reach girls and women and couples with preconception messages, beginning in school and extending to health care settings and community events. Preconception health must also involve boys and men, to improve their health; and to engage them in ensuring better outcomes for women and girls.</td>
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<table>
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<tr>
<th>Implement</th>
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<tr>
<td>Seize opportunities through existing programs (including non-health programs) to:</td>
</tr>
<tr>
<td>• Educate women and couples of reproductive age to have a reproductive plan that includes age at first pregnancy, method to prevent unintended pregnancy, and number of children they wish to have</td>
</tr>
<tr>
<td>• Scale up personal development programs and skills-building to negotiate safe sexual behavior in adolescence. Adapt preconception interventions to maximize uptake by adolescents</td>
</tr>
<tr>
<td>• Implement universal coverage of childhood and booster vaccinations for infectious diseases known to cause adverse pregnancy outcomes</td>
</tr>
<tr>
<td>• Screen for and treat infectious diseases, particularly sexually transmitted infections.</td>
</tr>
<tr>
<td>• Promote healthy nutrition and exercise to prevent both underweight and obesity in girls and women</td>
</tr>
<tr>
<td>• Promote food security for communities and households. Expand nutrition programs to include adolescent girls and women. Particularly for underweight women, provide protein calorie supplementation and micronutrients. A cost-effective way to ensure adequate levels of micronutrient consumption would be to enact large-scale fortification of staple foods.</td>
</tr>
<tr>
<td>• Implement public health policy to reduce the number of men and women of reproductive age who use tobacco</td>
</tr>
<tr>
<td>• Implement strategies for community development and poverty reduction, since living environments and socioeconomic constructs have a significant impact on health</td>
</tr>
<tr>
<td>• Ensure universal access to education to empower girls and women with the basic knowledge and skills they need to make decisions for themselves, such as when to access care</td>
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<table>
<thead>
<tr>
<th>Scale up</th>
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<tr>
<td>• Promote effective contraception for women/couples to space pregnancies 18 to 24 months apart</td>
</tr>
<tr>
<td>• Screen for chronic conditions, especially diabetes, and institute counseling and management as early as possible to improve neonatal outcomes</td>
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<table>
<thead>
<tr>
<th>Inform and improve program coverage and quality</th>
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<tbody>
<tr>
<td>• Develop indicators for baseline surveillance and to monitor progress in preconception care</td>
</tr>
<tr>
<td>• Include preterm birth among tracking indicators</td>
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</table>

<table>
<thead>
<tr>
<th>Innovate and undertake implementation research</th>
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<tbody>
<tr>
<td>• Invest in research and link to action</td>
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</table>

For decades, medical practice in the United States and other developed nations have steadily researched and improved its clinical management of preterm labor (by obstetricians) and medical care of premature babies (by neonatologists). However, families 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 evidence-based interventions that address inequities in living and working conditions, stress, and access to healthcare.

Community Perspectives in SF – Strategies:

Influencing policy and legislation
Increase education spending; Affordable housing; Zoning laws (limit liquor stores); Revitalize neighborhoods (schools, library, parks, community centers) book mobile, jazz mobile; Re-entry policy; Criminal justice reform.

Changing organizational practices
Recruit and retain staff of color; Health promotion/media campaign; Coordination of services; More PHN in community; Client centered reproductive life planning counseling and education; Operational practices that are client centered; Mental health practitioner/liaison in every program; Coordinate messages

Educating providers
Collective impact; Early intervention

Community education
Advocacy for young women; Culturally relevant education; Opportunity for community engagement (volunteer, neighborhood focus activity); Culture revitalization

Strengthen individual knowledge and skills
Self-advocacy; Self-care; Eat better, exercise, meditate, rest

List stakeholder or community partner organizations who will help to address the problem

- Department of Public Health
- Human Service Agency
- Women, Infant & Children
- SF Housing Authority
- Office of Economic and Workforce Development
- Dept of Children Youth & Families
- First 5
- SF Unified School District
- Mental health providers
- Substance abuse providers
- Advocacy organizations for adolescents
- Advocacy organizations for working families
- Smoking cessation programs
- Social services for women with special risk factors
- Workplace Policies Advocates
- 5 Delivery hospitals
- Prenatal care providers. OB-GYN
- Primary care for young women & adolescents
- Family planning
- Health-focused Universities (UCSF)
- March of Dimes

Key References:
4. Iams J et al., Primary, secondary, and tertiary interventions to reduce the morbidity and mortality of preterm birth. Lancet 2008; 371: 164–75

On February 17th 2015, the San Francisco Health Commission approved a resolution in support of the SFHIP Children’s Oral Health (COH) Strategic Plan to improve children’s’ oral health in our county. The work of implementing the plan continues to be coordinated by the SF HIP COH Core team (shared leadership: UCSF School of Dentistry and SFDPH MCAH, with the partial funding from a 2 year grant from the Hellman Foundation). With this grant funding the core team has the support from a ¼ time UCSF administrative staff person and planning consultant. With guidance and assistance from a 20 member all volunteer Implementation Coordinating Committee (ICC), they have worked together to develop and implement the plan’s Year One measures. Progress during this first half year, has been achieved in the following areas:

COORDINATION
Year 1: Provide coordination and oversight for the implementation of the COH Strategic Plan
- Core Team (meets biweekly)
- 4 work teams with chairs, (meet monthly and assist in the actual implementation efforts)
- Advisory Committee: ICC (meets quarterly: March 26, June 4 & Sept. 10th scheduled)
- Permanent COH Coordinator 1.0 FTE staff position was approved by the BOS - to coordinate oral health activities across DPH sections, and across departments of SF Governmental agencies. HR process has begun.

PROMOTION
Year 1: Organize and mobilize most-impacted communities to develop and implement culturally specific oral health education campaigns relevant to their neighborhoods
- Two SF HIP COH Community Briefings: April 30 Chinatown YMCA, June 9 Mission YMCA (Over 50 Medical Providers and community members at each event with Media Coverage and political leadership: 2 Supervisors, Health Commissioner Chow & others.)
- Planned: Oct. Bayview/Hunter’s Point COH Community Briefing
- Chinatown COH Task Force has formed (NICOS taking the lead) and has met once; will coordinate with larger ICC, beginning with Sept. 10th meeting.

Dissemination (Goal to raise the importance of, and disparities in children’s oral health in SF).
- SF Dental Hygiene Society website/online newsletter
- National Children’s Oral Health Foundation
- SF Dental Society website
- The SF Medical Society (SFMS) website
- UCSF News article
- 2 SF Examiner articles
- Telemundo Television/Video interview
- SF Chronicle article
- Mission Local article
- KTSF article

Presentations to:
- SF Community Clinics Consortium (SFCCC) Board of Medical Directors, and Health Policy Director
- SF First Five Children and Families’ Commission
- SF Health Plan Medical Director and CEO
- SF Pediatric Advisory Council. Council
- Kaiser Grand Rounds
- API Health Parity Coalition
- SF Dental Society
INTEGRATION
Year 1: Institute fluoride varnish (FV) applications and oral health education in well child pediatric visits and immunizations – Spearheaded by SF HN Ambulatory Care
- 5 Monthly meetings held with SF HN Primary Care leadership (Ambulatory Care)
- Developed and implemented first SFHN family medicine clinics pilot for implementation of Fluoride Varnish (FV) during well child visits, at SFHN Family Health Center, to be spread across all primary care clinics in SFHN
- Began providing FV 8/31 at Chinatown Public Health Center (CTPHC); 9/3 at FHC
- Template developed to be shared across other SF community primary care clinics.
- Multiple FV trainings presented to community clinics
- FV survey sent to medical providers to gain their input, with summary distributed. (Co-developed by SF Health Plan and MCAH CHDP)
- SF Health Plan has partnered with the Integration Team and is developing a plan to incentivize providers to apply FV during well child visits

ACCESS
Year 1: Establish billing mechanism for “non-traditional site” billing. Work with Federally Qualified Health Centers (FQHCs) and other key stakeholders to share information and strategies on billing. Develop template with Federal, State, local and licensing regulations.
- In Progress: SFUSD MOU for Fluoride Varnish and CDE Waiver for all community based dental clinics to work with SFUSD
- Developing plans for instituting screening and Fluoride Varnish (FV) at SFUSD ECE sites.
- FV application instituted at Mission Head Start Screenings
- 2 dentists; 2 dental aides hired at SFHN Dental Services
- Challenges: We met several times with a FQHC Billing consultant, developed a work plan for him, and signed MOU to develop a SF specific guide for SF FQHCs to bill for dental services provided at non-traditional sites. Unfortunately, the company was ultimately not able to begin work. We are in process of developing RFP for this specialized consultant to renew our search.

EVALUATION
Year 1: Develop and establish an ongoing oral health population-based surveillance system to address the oral health of San Francisco children
- Performance measures have been developed for each of the 4 COH Strategies.
- Developing a protocol to monitor these measures (outline surveillance plan) and exploring how to display dental data dashboard
- Updated oral health section of CHA Report
- Improved SFUSD (DPH) dental screening software/hardware; SFHN Dental Services was supplied with an encrypted laptop to continue surveillance of SF kindergarteners.

CHALLENGES
Challenges continue to face our community based collaborative:
- Primarily volunteer time for all participants, makes sustainable participation challenging.
- Motivating continued engagement by ICC and leadership
- Aligning multiple agencies with our goals in the face of competing priorities
- Lack of dedicated staff and hard/software infrastructure for surveillance and data analysis
- Lack of support staff for SF HN Dental Services (EWs, Clerks and RDAs)
Health & safety context
The San Francisco Department of Public Health reports that there were 15,901 persons living with HIV in the City at the end of 2013: 92% are male, and 55% are 50 years of age or older. There were 359 new HIV diagnoses in 2013, fewer than half the number in 2002. In 2013, 182 people died of AIDS, and HIV-infected younger people (under 40) and those who were homeless were least likely to be fully virally suppressed.

The City has a robust HIV surveillance system, widespread HIV testing, syringe access programs, comprehensive HIV care, and was the first in the country to recommend treatment for all persons living with HIV, a policy which has since been adopted nationwide. The City has also led the way in implementing programs for pre-exposure prophylaxis (PrEP) for HIV prevention. As a result of these activities, HIV prevention and treatment have become more successful each year. Despite improvements in rates of new diagnoses and viral suppression rates, there remain significant disparities in HIV prevention and health outcomes. In particular, African Americans have the highest rates of new HIV diagnoses, and have been under-represented in PrEP prevention programs. Viral suppression and survival rates are also lower in women, African Americans, and people who inject drugs. Furthermore, some preventable deaths, including overdoses, are on the rise in people living with HIV, and STDs and drug use are increasing in men who have sex with men.

To address these disparities, we need to ensure that all San Franciscans, including youth, are knowledgeable about HIV, know how to protect themselves, and have skills to support HIV-infected friends. All San Franciscans need easy access to medical, mental health, and substance use services and stable housing. We also need efforts to mitigate and measure stigma, because even today, persons living with and affected by HIV still face stigma from family, friends, and community that hampers access to prevention and care. It will take a broad coalition of community members, schools, businesses, government agencies, and HIV providers to work together to address these challenges.

Common agenda
San Francisco is on the path to become the first municipal jurisdiction in the United States to achieve the UNAIDS vision of “Getting to Zero”: Zero new HIV infections, Zero HIV deaths and Zero HIV stigma. From the very beginning and throughout the HIV epidemic, the City has led the way in responding to the enormous challenge of HIV and setting standards for prevention, care and treatment recognized around the world. In 2014, we established the San Francisco Getting to Zero Consortium—a multi-sector independent consortium operating under the principles of collective impact. Our overall goal is to improve the health for persons at risk for or living with HIV/AIDS in San Francisco, with an emphasis on underserved populations. Our short term goal is to reduce both HIV infections and HIV deaths by 90% from their current levels by 2020. Our strategic plan calls for 3 signature initiatives to start – 1) expansion of PrEP (use of antiretroviral medications for prevention), 2) RAPID ART (expedited initiation of antiretroviral therapy and linkage to HIV care at the time of diagnosis), and 3) Retention in HIV Care (maintaining HIV-infected persons in primary care) -- that focus on eliminating new HIV infections, preventing HIV-related disease complications and reducing the health disparities for HIV infected and affected populations in San Francisco. Additionally, a newly launched Ending Stigma committee is identifying priorities and goals for this critical effort.

Shared measurement
As described above, our goal is to reduce both HIV infections and HIV deaths by 90% from their current levels by 2020. Additional milestones include having >90% of people with HIV linked to care, >90% of people with HIV retained in care, and >90% of people with HIV virally suppressed. We will measure our success by monitoring
these community level indicators through our City’s HIV surveillance system. In addition, each of our GTZ committees (PrEP, RAPID, Retention, and Stigma) has established specific metrics of success, which are reviewed and discussed at regular Consortium meetings with the community.

**Mutually-reinforcing activities**
This collective impact approach calls for investment and participation by public health, university, private foundation, health system, pharmaceutical industry, and business sector partners to achieve our goal. Specifically, the Getting to Zero Consortium is comprised of representatives from the SF Department of Public Health, UCSF, many San Francisco-based CBOs, activists, government representatives, and other interested members. Under the direction of a Steering Committee and with broad partnerships with community organizations, the Consortium will coordinate efforts around the city, leverage existing resources, and secure multi-sector funding and support to achieve the goals of Getting to Zero. We are committed to exchanging best practices with other cities pursuing similar initiatives.

**Continuous improvement and communication**
A Steering Committee provides overall direction and at least one steering committee member liaisons with each working committee (PrEP, RAPID, Retention, and Ending Stigma). Each committee is led by co-chairs who coordinate overall activities of the group and assure goals and priorities are developed and metrics are met. Communication is promoted through regular committee meetings, email and conference calls, online project management tools, and quarterly Consortium meetings with the public. In addition, new information, updates, and events from each committee are posted on the SF Getting to Zero website: [www.gettingtozerosf.org](http://www.gettingtozerosf.org). Finally, all Consortium members participate in an email listserv providing rapid dissemination of new research, upcoming events, requests for support, and cross-pollination of ideas.

**Backbone support**
Strategic planning and leadership of the San Francisco Getting to Zero Consortium is provided by a Steering Committee composed of senior leaders across public, private, and the non-profit sector. In addition, the Consortium is supported by a part-time coordinator who provides overall program support and coordination across committees and leads website development and updates.

**Achievements, challenges, and next steps:**
Since its inception 2014, the Getting to Zero Consortium has established a diverse Steering Committee providing overall leadership to the Consortium and four committees to move each of the GTZ initiatives forward. Each committee independently develops action plans, milestones, a budget, and metrics to track progress. We have held 7 Consortium meetings to date and presented a plan and budget to the San Francisco Board of Supervisors, who were in strong support of the Consortium. They committed to back-filling positions cut through federal, state, and local budget tightening and endorsed ongoing support for successful existing programs. The SFDPH is the first large sponsor of this initiative, agreeing to contribute $1.1 million to support GTZ efforts; several additional proposals have been submitted or are in development to request additional funding from Foundations, Industry, government, and other sources. The Consortium has also launched its website ([www.gettingtozerosf.org](http://www.gettingtozerosf.org)) and met with numerous local, national, and international groups and delegations about GTZ efforts. Challenges have included the need for additional resources and coordination for each of the committees to successfully achieve their goals and milestones, which are being addressed through several funding proposals. Each of the committees will be providing updates on their activities at the upcoming Town Hall meeting on World AIDS Day 2015.
List of Content Collective Impact Projects
Highlighted in this Binder

Public Health Accreditation

Public Health Network Information Exchange

Quality Improvement

San Francisco Health Improvement Partnership
PUBLIC HEALTH ACCREDITATION (PHA)

WHAT ARE WE TRYING TO ACCOMPLISH?

In response to the San Francisco Health Commission’s mandate, the Population Health Division (PHD) of the Department of Public Health is pursuing achievement of public health accreditation from the Public Health Accreditation Board (PHAB). PHAB has issued a set of national Standards to use as the baseline for judging quality in services provided by public health departments and issues accreditation to those departments that meet the specific Measures they have prioritized. This process is voluntary and will aid PHD as we continue the process of integration of our Division. It will also provide the Department of Public Health with the public acknowledgement that we are a department that meets national standards and provides excellent services to the citizens of San Francisco. The goals for this initiative align with the PHD Strategic goals of Policy development with collective impact:

1. Establish a division-wide Performance Management, Equity and Quality Improvement program
2. Establish systems and partnerships to achieve and maintain Public Health Accreditation

HOW DO WE MEASURE SUCCESS?

Success will be realized through achieving the following short and long-term objectives:

- Development of 5-year plans that include a Strategic Plan, Workforce Development Plan and Quality Improvement Plan in alignment with Emergency Operations Plan
- Development of documentation that demonstrates the quality of our work meets the PHAB Standards
- Submission of our documentation to PHAB within the 12 month period provided
- Completion of a 2-day Site Visit from PHAB
- Receipt of notification that SFDPH has achieved accreditation for a 5 year period
- Development of annual reports during the 5 years of accreditation that demonstrate our achievement of a culture of continual quality improvement and excellence

WHAT OTHER CONDITIONS MUST EXIST?

Successful completion of this project requires:

- Sufficient dedicated staff to support completion of submission of documentation to PHAB

HOW DO WE GET THERE?

1. Complete gathering of all documents for use in documentation by October 2, 2015
2. Complete preparation of documents for submission to PHAB by October 30, 2015
3. Upload all documentation and complete quality assurance checks by November 13, 2015
4. Prepare staff and leadership for Site Visit to occur 5 to 6 months after submission
5. Respond in timely fashion to any additional requests during and after the Site Visit occurs

CURRENT STATUS

At this time the Project is on track to submit our documentation to PHAB by November 15, 2015. Planning for the steps that occur after submission will depend on feedback from the PHAB staff. Once PHAB staff rules our submission sufficient, the process to set up our Site Visit will begin.

PROJECT TEAM

**PHD Project Manager**
Karen Pierce
(karen.pierce@sfdph.org)

**Public Health Accreditation Team (PHAcT)**
Laura Brainin-Rodriguez
Priscilla Chu
Karen Cohn
Tara Connor
Jennifer Grinsdale
Alice Hu

Alecia Martin
Marise Rodriguez
Kenpou Saechao
Nashanta Stanley
John White
Karen Yu
WHAT ARE WE TRYING TO ACCOMPLISH?

The Population Health Division, Public Health Network Information Exchange (PHNIX) is a HIGH PRIORITY INITIATIVE to provide the City and County of San Francisco, Department of Public Health, with a comprehensive and interoperable, secure, web-based public health information system for integrated communicable disease client/case management, monitoring of prevention and control activities, surveillance and reporting, and decision support for client- and population-based interventions and public health actions.

An integrated public health information system will strengthen San Francisco’s current population health continuum of prevention, care, and treatment by creating a unified system to identify and monitor disease trends and conduct public health action. The goals for this initiative align with the overall SFDPH goals of:

Integrated systems and services – Combining data and efforts to mobilize communities, conduct health promotion, test, diagnose, treat, and/or vaccinate those in need of these services to improve the health among populations affected by multiple diseases

Financial and operational efficiencies - Increasing service efficiency by reducing duplicate services and redundancy

Population health and health equity – Through integrated knowledge management, develop a population health model that ensures health and health equity for all people in San Francisco

HOW DO WE MEASURE SUCCESS?

Success of the PHNIX system will be realized through achieving the following short and long-term objectives.

- City-wide integration of surveillance and reporting activities for all communicable diseases
- Sharing of public health data so that it may be used in planning, implementation, and evaluation of overall health practice
- Effective and efficient utilization of data for public health action
- Improved collection of information on integrated services supported through DPH and community efforts
- Improved client health outcomes through integrated, targeted interventions
- Maximized resources by reducing redundant services and information gathering
- Interoperability between laboratory, clinical, and public health data systems within DPH
- Automated surveillance reporting to CA and CDC partners
- Meeting HITECH meaningful use requirements for public health reporting

WHAT OTHER CONDITIONS MUST EXIST?

Successful completion of this project and long-term benefits of the PHNIX system requires:

- Redesign of current PHD work processes to ensure PHNIX maximizes effective and efficient, integrated communicable disease activities and decision-making
- Collaborative decision-making, design, and implementation of PHNIX across PHD Branches and program areas

<table>
<thead>
<tr>
<th>PHNIX PROJECT TEAM</th>
<th>PHD Project Manager</th>
<th>IT Project Manager</th>
<th>Technical Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jennifer Grinsdale</td>
<td>Tina Lee (Acting)</td>
<td>Jackvin Ng</td>
<td></td>
</tr>
<tr>
<td>(<a href="mailto:Jennifer.Grinsdale@sfdph.org">Jennifer.Grinsdale@sfdph.org</a>)</td>
<td>(<a href="mailto:Tina.Lee@sfdph.org">Tina.Lee@sfdph.org</a>)</td>
<td>(<a href="mailto:Jackvin.Ng@sfdph.org">Jackvin.Ng@sfdph.org</a>)</td>
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Dedicated, assigned IT and PHD program staff for development and ongoing system maintenance

Coordination with SFDPH enterprise electronic health record development and implementation

Project delays have occurred and will continue as a result of these needs not being met consistently throughout the project.

HOW DO WE GET THERE?

CURRENT STATUS

The PHNIX project is currently 10 months behind schedule (original go-live date was 4/24/14), primarily due to unavailability of IT and program staff to work on the project and contractual issues with securing necessary software. As of 7/6/15, work on project deliverables has been on hold due to failure to secure additional funding, however, PHD and IT are working to extend existing contracts and hire additional IT staff support. Work on the project will resume once additional staff are assigned to the project.

Despite project delays, the HIV module (Release 1), is scheduled for March 2016. Additional work is needed before the system will be fully operational, however, significant development has occurred, and PHNIX currently contains the following functionality to support integrated HIV prevention, control, and surveillance activities.

- Identify new or known HIV infections based on information stored within PHNIX
- Assign new HIV cases for partner services and linkage to care services
- Track navigation and re-linkage/engagement in care efforts
- Accept community-based and medical HIV testing information and export that information for import into CDC’s EvaluationWeb database
- Accept case-based HIV surveillance data and export that information for import into the CA Office of AIDS/CDC database (eHARS)
- Produce quality assurance (QA) reports and work queues

PHNIX PROJECT TEAM

PHD Project Manager
Jennifer Grinsdale
(Jennifer.Grinsdale@sfdph.org)

IT Project Manager
Tina Lee (Acting)
(Tina.Lee@sfdph.org)

Technical Developer
Jackvin Ng
(Jackvin.Ng@sfdph.org)
WHAT ARE WE TRYING TO ACCOMPLISH?

The purpose of the Quality Improvement Plan is to develop an organizational culture of continuous quality improvement in Population Health Division. The plan serves as the roadmap for how we will achieve that goal.

Our vision is to develop a quality improvement program with two parts. This program will have 1) a quality improvement training program and 2) a quality improvement project office. The training program will describe public health quality improvement tiered competencies. We will incrementally build capacity by focusing on the basics, developing tools, and sending staff to trainings. 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. The project office would provide support for quality improvement projects with technical assistance, coordination, and project management.

HOW DO WE MEASURE SUCCESS?

The final product will be a continuous quality improvement 5-year plan that includes a roadmap to developing the quality improvement program. The plan includes the time that we will take to learn quality improvement methods and develop a training curriculum. By implementing the trainings, we will increase our quality improvement capability and build a team with quality improvement expertise. The plan also documents the work on quality improvement that has been done to date along with the current and future projects in the near term.

This plan will meet the requirements for Public Health Accreditation and will be aligned with the Performance Management System, the Workforce Development Plan, and the Strategic Plan.

WHAT OTHER CONDITIONS MUST EXIST?

- This project requires close collaboration with the authors of the Performance Management System and the Workforce Development Plan
- Development of the plan is an iterative process and the plan will improve with each iteration
- We want broad input on the plan from all levels of staff

HOW DO WE GET THERE?

- Collect input from division director, sponsors, project management team, branch directors, managers, and line staff
- Finalize the plan before November 2015

CURRENT STATUS

- We completed two major revisions of the plan that incorporated input from the executive sponsor and Division Director, the other sponsors, and the project managers team
- The branch directors within our division have given feedback on the plan
- We are close to finalizing the plan
SAN FRANCISCO HEALTH IMPROVEMENT PARTNERSHIP (SFHIP)

WHAT ARE WE TRYING TO ACCOMPLISH?

In 2012, San Francisco’s nonprofit hospitals, San Francisco Department of Public Health, and UCSF’s Clinical and Translational Science Institute came together in collaboration with residents and stakeholders to create a Community Health Improvement Plan (CHIP) for San Francisco focusing on eliminating health disparities. San Francisco Health Improvement Partnership (SFHIP) was formed in the fall of 2013 as a multi-sector collaboration to collectively work to implement the CHIP. SFHIP is guided by a Steering Committee comprised of nonprofit hospitals, SFDPH, UCSF, health equity coalitions (African American; Asian Pacific Islander, and the Chicano/Latino/Indigena), SFUSD, Mayor’s Office, and representatives from philanthropy, nonprofits, residents and businesses.

SFHIP’s goal is to facilitate alignment of San Francisco’s priorities, resources, and actions to improve health and well-being; ensure that health equity is addressed throughout program planning and service delivery; and promote community connections that support health and well-being. Through our role in staffing the Backbone of SFHIP and, we provide logistical support and strategic coherence to the initiative. Specific activities include meeting coordination, project management, communications, research, evaluation, policy analysis, and fundraising.

HOW DO WE MEASURE SUCCESS?

- SFHIP is has advanced all five core elements of Collective Impact (Common Agenda, Shared Metrics, Mutually Reinforcing Activities, Continuous Communication and Backbone).
- SFHIP has developed an action agenda to guide the initiative’s work.
- SFHIP oversees and completes tri-annual Community Health Assessment, Annual Report, review and revisions to the Community Health Improvement Plan, all required for Accreditation.

WHAT OTHER CONDITIONS MUST EXIST?

- Steering Committee must agree on priorities and activities.
- The Backbone team must have adequate resources to implement the Steering Committee’s priorities.
HOW DO WE GET THERE?

- SFHIP will hold a facilitated retreat in Fall 2015 to develop priorities and action agenda.
- SFHIP will utilize FSG’s framework for Backbone effectiveness to assess, prioritize and improve the work of SFHIP’s Backbone.
- SFHIP obtains resources to support gaps in the Backbone.
- SFHIP has embedded learning processes and structures in the ongoing activities.
San Francisco Maternal, Child and Adolescent Health

The Maternal, Child and Adolescent Health (MCAH) Section of the San Francisco Department of Public Health focuses on the most vulnerable children and families, filling what would otherwise be a serious public health gap. We assess the needs of MCAH populations, and identify and address urgent MCAH issues in collaboration with key partners. The work of MCAH is critical to protecting and promoting the health of San Francisco women and children. We aim to reduce health disparities and improve health outcomes by strengthening the public health systems and services that address the root causes of poor health.

The MCAH population has been singled out for the following reasons:

- 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 in 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.
- Physiological and developmental characteristics that influence risk for, and progression of, disease and disability require services tailored to the specific needs of children, youth, and mothers.
- Lacking political influence, children, youth, and low-income women are served instead by the advocacy of MCAH.
- By promoting strong and healthy families and communities, MCAH promotes the health, educational achievement, and social development of children and youth.

MCAH Programs and Core Functions

1. Improving Access to High Quality Health Care
   - Child Health Disability Prevention (CHDP)
   - Comprehensive Perinatal Services Program (CPSP)
   - Family Planning
   - Fetal-Infant Mortality Review
   - Health Care for Children in Foster Care Program
   - Office of Childhood Hearing
   - Preconception/Young Women’s Health

2. Promoting MCAH
   - Black Infant Health Program
   - Prevention of Sudden Infant Death Syndrome
   - Population and Place-based MCAH Programs
     - CalWorks
     - Child Care Health Project
     - HOPE SF – Hunter’s View Pilot
     - MCAH Field Public Health Nursing
     - Nurse Family Partnership
     - Child Welfare Services: Substance Abuse/HIV
     - Child Welfare Services: Zero to Five

3. Preventing Chronic Diseases in MCAH Population
   - Epidemiology
   - Nutrition Services
     - Feeling Good Project
     - Women, Infant & Children Supplemental Nutrition Program (WIC)

4. Ensuring Comprehensive Health Care for Children and Youth with Special Health Care Needs
   - California Children’s Services
   - Medical Therapy Unit

Core functions

1) Improving Access to High Quality Health Care
3) Promoting Women, Infant, Child and Adolescent Health
4) Preventing Chronic Diseases in Women, Children and Youth, Including Through Nutrition and Physical Activity
5) Ensuring Comprehensive Health Care for Children and Youth with Special Health Care Needs
Essential MCAH Services in the Department of Public Health and SF Health Network

- **Improve Access to Health Care Services.** Link vulnerable and yet-to-be-reached populations to enrollment and needed personal health services. Prioritize low income and CYSHCN. Promote utilization of clinical preventive services, e.g., family planning, lactation support, tobacco cessation.
- **Investigate Health Problems** affecting women, children and youth.
- **Inform and Educate the Public** about maternal, youth, and child health issues.
- **Engage Community Partners** such as health care providers, families, child and youth advocates, the general public, and others to identify and solve maternal and child health problems.
- **Promote and Implement Evidence-based Practices,** such as WIC provision of Participant Centered Education, Motivational Interviewing, Breastfeeding Peer Counseling, and the Baby Behavior parent education program.
- **Assess and Monitor MCAH Health Status** to identify and address health problems.
- **Maintain the Public Health Work Force** to effectively address maternal and child health needs.
- **Develop Public Health Policies and Plans** that support individual, provider and community health efforts, e.g., Access to Timely Prenatal Care Committee.
- **Enforce Public Health Laws** that protect the health and safety of women, children, and youth and that ensure public accountability for their well-being.
- **Ensure Quality Improvement.** Partner with other agencies to monitor health status, service effectiveness, accessibility, and quality to identify and solve community health problems.

**Emerging Priorities**

A “Life Course Approach” recommended by federal health authorities points out that health is “particularly affected during critical or sensitive periods” and that “the broader community environment – biologic, physical, and social – strongly affects the capacity to be healthy.” SFDPH-MCAH leverages clinical and community experience, shared resources, and collaborations to develop upstream policies and systems that improve health and living conditions.

Critical problems of childhood and family health that are inequitably exacerbated by the high living costs, density, and social segregation of cities like San Francisco include: stress, anxiety, depression and other mental illness, social isolation, family violence and abuse, malnutrition, and physical inactivity. MCAH continues to reassess health status and community resources, redesigning programs accordingly.

Examples of new efforts that promote wellness during the most critical phases of life include:

- Designing, implementing and evaluating new strategies to close the Black-White gap in health outcomes. Strategies range across family planning, social support and community dialogues on racism, i.e., *Equity in Young Black Women’s Health and Birth Outcomes Project.*
- Supporting young women during pregnancy and families during the early years of childrearing with a new, evidence-based home visiting program – *Nurse Family Partnership* – and through a revamped group centered model for young Black women – *Black Infant Health.*
- Implementing standards of excellence in parental leave, lactation accommodation, and wellness policies, i.e., “*Healthy Mothers Workplace*” Assessment & Award.
- Ensuring national standards of excellence in childcare nutrition and physical activity, i.e., “*Healthy Apple Award*” for child care centers and family child care providers.
- Realigning Public Health Nursing services to children in Child Welfare *Zero to Five Program* from telephone case management to home visiting using evidence-based *Safe Care* model.
### Simplified Map of Maternal Child & Adolescent Health Programs to Address Countywide Health Issues

San Francisco Department of Public Health. Draft 20150908

#### Integrated Goals of each MCAH Program

- **Promote health & well-being**
- **Screen for disease & risks**
- **Ensure healthcare access**

---

#### 15 Priority Health Issues

**Identified in 2015-2020 Needs Assessment & Action Plan**

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Infant</th>
<th>Childhood</th>
<th>Adolescent &amp; Preconception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate Partner Violence, Depression, Substance Abuse</td>
<td>Breastfeeding</td>
<td>Child abuse, Parental Stress of CSHCN</td>
<td>Adolescent Depression</td>
</tr>
<tr>
<td><em>Timely prenatal care</em></td>
<td><em>Preterm birth</em></td>
<td><em>Children’s Oral Health</em></td>
<td><em>Well-woman visits</em></td>
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</tbody>
</table>

---

#### Strategies

<table>
<thead>
<tr>
<th>Provide</th>
<th>Direct Services to vulnerable populations</th>
<th>Improve Health Systems for vulnerable populations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women Infant Children (WIC) &amp; Nutrition Services</strong></td>
<td><strong>Public Health Nursing Home Visiting Program</strong></td>
<td><strong>Comprhnsv Perinatal Services Prog</strong></td>
</tr>
<tr>
<td><strong>Foster Care PHN</strong></td>
<td><strong>Nurse Family Partnership</strong></td>
<td><strong>Women’s Health Advisory Council</strong></td>
</tr>
<tr>
<td><strong>Medical Therapy Unit</strong></td>
<td><strong>Baby-Friendly Hospitals</strong></td>
<td><strong>Office of Childhood Hearing</strong></td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td><strong>Pediatrics Advisory Council</strong></td>
<td><strong>California Children’s Services</strong></td>
</tr>
<tr>
<td><strong>Young Women’s Health</strong></td>
<td><strong>Healthy Mothers Workplace</strong></td>
<td><strong>Early Childhood Health Program:</strong></td>
</tr>
<tr>
<td><strong>Infant Enrichment Centers</strong></td>
<td><strong>Social Media for Health</strong></td>
<td><strong>Childcare-Preschool; Family Resource Centers</strong></td>
</tr>
<tr>
<td><strong>Healthy Apple Child Care</strong></td>
<td><strong>&lt; --- Feeling Good Project (NEOP) ---- &gt;</strong></td>
<td><strong>California Children’s Services</strong></td>
</tr>
<tr>
<td><strong>CalWORKs, Jelani House</strong></td>
<td></td>
<td><strong>Office of Childhood Hearing</strong></td>
</tr>
</tbody>
</table>
## Scope of Work 2015-16: Maternal, Child & Adolescent Health Public Health Title V Programs

### #1: Access

<table>
<thead>
<tr>
<th>Direct Services</th>
<th>Assessment</th>
<th>Policy Development</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCAH Direct Services: QI of referrals (Field Nursing, NFP, BIH)</td>
<td>+ Define risk levels + Determine rates of referrals, participation, &amp; completion.</td>
<td>Procedures for referring providers Procedures for MCAH program</td>
<td>+ Utilize HVP Database</td>
</tr>
<tr>
<td>Racism affecting health care access, quality &amp; outcomes</td>
<td>+ Assess feasibility of Office of Black Family Health + HIA of institutional racism on health care access and outcomes</td>
<td>+ Support “Equity in Young Black Women”</td>
<td></td>
</tr>
<tr>
<td>Affordable Housing</td>
<td>+PhotoVoice: Impact of housing insecurity to MCAH +Assess best-practices nationally and current local efforts to address housing insecurity through healthcare encounters.</td>
<td>+ Build capacity of MCAH services to address housing issues</td>
<td></td>
</tr>
</tbody>
</table>

### #2 Maternal

<table>
<thead>
<tr>
<th>Public Health Nursing</th>
<th>Assessment</th>
<th>Policy Development</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visiting during Pregnancy &amp; Postpartum</td>
<td>Internal: QI External: Issues: Housing, cycles of poverty</td>
<td></td>
<td>Field PHN &amp; NFP direct services</td>
</tr>
<tr>
<td>OASIS Sister Circle: Maternal Stress Intervention</td>
<td>Design &amp; develop curriculum</td>
<td>Implement in 4 pilot sites</td>
<td></td>
</tr>
<tr>
<td>CPSP:</td>
<td>Perinatal Linkage CPSP Roundtable</td>
<td>Evaluate effect of CPSP Roundtable</td>
<td></td>
</tr>
<tr>
<td>Women’s Health Advisory Council</td>
<td>+ Assess: existing collab among hospitals, feasibly for collaboration + Develop format: Data Dashboard</td>
<td>Topic #1: Pregnancy Weight Gain Topic #2: Breastfeeding. Topic #3: TBD + Develop systems for collaboration</td>
<td></td>
</tr>
<tr>
<td>Intimate Partner Violence during Pregnancy</td>
<td>Inform key stakeholders of problem. Convene mtg w/ core partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Complete 1-page topic brief</td>
<td>Convene mtg w/ core partners</td>
<td></td>
</tr>
<tr>
<td>Perinatal Substance Abuse</td>
<td>Estimate prevalence of ATOD in pregnancies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Timely Prenatal Care</td>
<td>HEDS prenatal care rates</td>
<td>Educate SFHP &amp; Anthem members: importance of early prenatal care</td>
<td>↑ timely PNC among MC by 5%</td>
</tr>
<tr>
<td>Preterm Birth</td>
<td>+ Update data brief: Preterm Births + Assess ptb% women participating in social programs.</td>
<td>Communicate CI Approach • Preconception health • Family planning</td>
<td></td>
</tr>
</tbody>
</table>
| Medical-Legal Partnership for Pregnancies & Parents | Prenatal Care  
Social determinants of reproductive & pregnancy health |
| Healthy Mothers Workplace | ↑ Improve criteria of assessment  
↑ Info to employers  
+ Award Certificates & Ceremony |
| **#3 Infant** | |
| FIMR / SIDS | Review 10y of SUIDs w/ CDRT | Report findings (written report and/or public meeting) |
| Baby Friendly Hospitals | Complete analysis of 5 of 5 hospitals Baby-Friendly Self-Assessment | + Standardized staff training  
+ Inventory of BF support svcs |
| Clinics promote breastfeeding | 5/5: Infant Feeding Policy posted  
2/5: Staff training requirements |
| Infant Enrichment Centers | # infants reach by existing programs Types of programs offered | + Develop standards for IECs  
+ Single flyer summarizing programs from SFPL, CCSF, FRCs, Rec&Park |
| **#4 Nutrition & Physical Activity across Lifespan** | |
| Childhood Nutrition & Physical Activity Collab | Assessed preferences of reps from SF organizations | Roster of committed members Meeting topics |
| ACTive Zones, PowerPlay & PowerPlay | + Dashboard of indicators for physical activity across lifespan  
+ Barriers to PA | + Collaborate with CHDP/NEOP to develop community resource referrals |
| **#5 Children’s Health** | |
| Child Welfare Agency – Public Health Nurse Home Visit | Assess significance & effectiveness of home visits for young children (0-5y) referred to Family Care. | Design policies, procedures, and metrics for referrals to home visits |
| SafeCare offered to children in Family Maintenance | + Offer SafeCare to all children 0-5y referred to FM. | Δ in FM offered/completed SafeCare. |
| Oral Health of Children | Design data dashboard | FV in 5 new primary care clinics  
Update Denti-Cal referral directory |
| Child Abuse | Assess gaps in countywide strategies to prevent child abuse | Support Child Abuse Council in strategies to prevent child abuse.  
Collaborate w/ FCS in CSEC Training |
| Healthy Early Childhood Environment | 1. Health education  
2. Screen for health conditions & ensure healthcare access  
3. Develop and ensure policies | Description of places  
Description of services  
# of places  
# of children |
| Childcare & Preschool Family Resource Centers CalWORKs Jelani House | | |
| Healthy Apple Childcare | Develop TA sys for child care | ↑ child care centers participating  
↑ healthy practices |
<p>| Parental Stress for CYSHCN | Develop tool to measure stress among parents of CYSHCN | Engage community partners |</p>
<table>
<thead>
<tr>
<th>#6 Adolescent &amp; Preconception Health</th>
</tr>
</thead>
</table>
| **Young Women’s Primary Care Utilization** | +Assess utilization of preventive health services at SFHP & SFHN  
+Assess barriers to care | +Young Women’s Health Advisory  
↑Collab: SFDPH-UCSF-SFHP-CDPH |
| **Adolescent Depression** | |
| **Family Planning** | |
| **LARC Access in SFHN & Title X clinic** | |
| **FP Access for Vulnerable populations** | Assess rates/policies/procedures for ensuring equitable access to family planning through specific programs. | Engage with: CalWORKS, Behavioral Health, Jail Juvenile Hall |
| **Pregnancy Testing & EC** | Secret shopper for safety-net clinics | QI plan with 30 clinics.  
↑ clinics providing preg test & EC within 1d by 15% |
| **Social Media for Health** | | |
### POPULATION HEALTH DIVISION
**FY 2015-2016 GENERAL FUND REVENUE AND EXPENDITURE BUDGET**

<table>
<thead>
<tr>
<th>Branch</th>
<th>Operating Revenue</th>
<th>General Fund Support</th>
<th>Total General Fund Expenditure Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Equity &amp; Promotion</td>
<td>$2,327,840</td>
<td>$13,310,106</td>
<td>$15,637,946</td>
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<tr>
<td>Disease Prevention &amp; Control</td>
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<tr>
<td>Environmental Health</td>
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<tr>
<td>PHD Administration*</td>
<td>$0</td>
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<tr>
<td>Public Health Emergency Preparedness &amp; Response</td>
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<td>$567,724</td>
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<tr>
<td>Totals</td>
<td>$25,708,794</td>
<td>$29,581,873</td>
<td>$55,290,667</td>
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*Expenditure budget includes Emergency Medical Services Branch, Office of Equity & Quality Improvement, and Office of Operations, Finance & Grants Management.
Population Health Division

General Fund Revenue and Expenditure Budget

FY 2015-2016

Operating Revenue 46%

General Fund Support 54%
## POPULATION HEALTH DIVISION
### FY 2015-2016 EXPENDITURE BUDGET

<table>
<thead>
<tr>
<th>Branch</th>
<th>General Fund Expenditure Budget</th>
<th>Grant Expenditure Budget</th>
<th>Total Expenditure Budget</th>
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</thead>
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<tr>
<td>Applied Research, Community Health Epidemiology, &amp; Surveillance</td>
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<tr>
<td>Bridge HIV*</td>
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<td>Center for Learning &amp; Innovation</td>
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*Brances with grants ($5,826,856 not included in total amount) received by partner agencies.

**Expenditure budget includes Emergency Medical Services Branch, Office of Equity & Quality Improvement, and Office of Operations, Finance & Grants Management.
## POPULATION HEALTH DIVISION
## FY 2015-2016 EXPENDITURE BUDGET BY CHARACTER LEVEL

<table>
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<tr>
<th>Branch</th>
<th>Character 011 Salaries</th>
<th>Character 013 Fringes</th>
<th>Character 020 Overhead</th>
<th>Character 021 Non Personal Services</th>
<th>Character 040 Materials &amp; Supplies</th>
<th>Character 081 Work Order</th>
<th>Total Expenditure Budget</th>
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<tbody>
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<td>$375,000</td>
<td>$75,000</td>
<td>$147,037</td>
<td></td>
<td>$2,874,520</td>
</tr>
<tr>
<td>Public Health Emergency Preparedness &amp; Response</td>
<td>$1,519,536</td>
<td>$568,199</td>
<td>$53,877</td>
<td>$370,500</td>
<td>$31,039</td>
<td></td>
<td>$2,543,162</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>$36,667,735</strong></td>
<td><strong>$14,476,828</strong></td>
<td><strong>$1,055,125</strong></td>
<td><strong>$22,552,493</strong></td>
<td><strong>$2,959,354</strong></td>
<td><strong>$7,174,878</strong></td>
<td><strong>$79,886,413</strong></td>
</tr>
</tbody>
</table>

*Branches with grants ($5,826,856 not included in total amount) received by partner agencies.

**Expenditure budget includes Emergency Medical Services Branch, Office of Equity & Quality Improvement, and Office of Operations, Finance & Grants Management.
## POPULATION HEALTH DIVISION
### FY 2015-2016 REVENUE BUDGET BY CHARACTER LEVEL (EXCLUDING GRANTS)

<table>
<thead>
<tr>
<th>Branch</th>
<th>Character 020 Overhead</th>
<th>Character 096 Expenditure Recovery</th>
<th>Character 200 Licenses &amp; Permits</th>
<th>Character 250 Fines &amp; Forfeitures</th>
<th>Character 600 Charges for Services</th>
<th>Total Revenue Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Equity &amp; Promotion</td>
<td>$825,149</td>
<td>$302,691</td>
<td>$200,000</td>
<td>$1,000,000</td>
<td></td>
<td>$2,327,840</td>
</tr>
<tr>
<td>Disease Prevention &amp; Control</td>
<td></td>
<td>$2,199,220</td>
<td>$7,818,195</td>
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<td>$3,132,199</td>
<td>$3,132,199</td>
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<tr>
<td>Environmental Health</td>
<td></td>
<td></td>
<td>$10,231,340</td>
<td>$20,248,755</td>
<td></td>
<td>$20,248,755</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>$825,149</td>
<td>$2,501,911</td>
<td>$8,018,195</td>
<td>$1,000,000</td>
<td>$13,363,539</td>
<td>$25,708,794</td>
</tr>
</tbody>
</table>
POPULATION HEALTH DIVISION
REVENUE BUDGET BY CHARACTER LEVEL
FY 2015-2016

- Character 200 Licenses & Permits: 31%
- Character 086 Expenditure Recovery: 10%
- Character 020 Overhead: 3%
- Character 250 Fines & Forfeitures: 4%
- Character 600 Charges for Services: 52%