

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Strategic Plan for Population Health

▪ June 2014 ▪



POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH



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▪ June 2014 ▪

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Executive Summary

In 2011, the Health Commission identified three budget priorities for the San Francisco Department of Public Health (SFDPH): an Integrated Delivery System, Public Health Accreditation (PHA), and Financial Efficiency. 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.

In coordination with nonprofit hospitals and academic partners as well as the broader San Francisco community, SFDPH built on the success of the 14-month CHA effort to create the 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 success of [Community Vital Signs](#), (San Francisco's past community health assessment effort conducted in 2010), SFDPH 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 community 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.

Through further engagement of **160 community residents and local public health system partners**, we identified the following key priorities for the Community Health Improvement Plan.

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



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.

In collaboration with community residents and stakeholders, SFPDPH 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 CHIP project leads assigned to identified strategies – including a range of government agencies, public, community collaborations, community-based organizations (CBOs), 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, SFPDPH and its partners plan to conduct a CHA/CHIP process every three years in alignment with other health improvement initiatives. 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.



Graphic artist Dan Jumanan illustrated community dialogue at several focus group sessions in which participants shared their views on health as well as San Francisco’s strengths and opportunities for growth in terms of health and wellness. Please see above for examples from the Mission and Chinatown neighborhoods.

Phase one began in November 2011 with the redesign of the division formerly known as Population Health & Prevention (PHP). We gathered input from a number of stakeholders including SFPDPH leadership, PHP Directors, and staff from across the Division. We relied on a number of mechanisms to do these 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 to the community through a series of neighborhood-based meetings. The input and recommendations were inspiring, and our staff and City residents shared a bold vision for how we can improve health and well being in San Francisco.

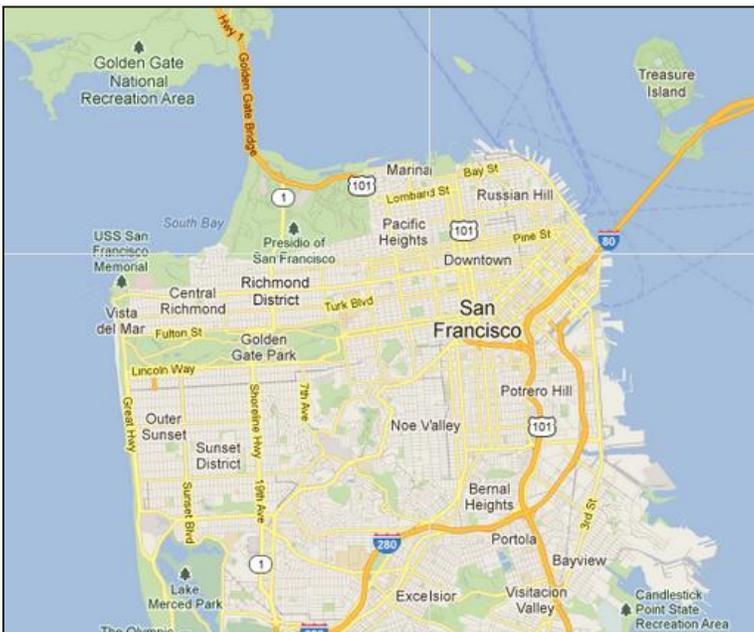
Phase two of the process focused on developing the health indicators that the health department will focus on in the strategic plan. The indicators align with the goals identified in the CHIP and were expanded to focus our efforts on Health Equity within populations that have experienced greater disparities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

- **Ensure Safe + Healthy Living Environments**
- **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**

Pages 13-57 highlight the Headline Indicators for each of the focus areas identified above. We have provided you with baseline data for each of the indicators as well as a forecast if we so not do something about each one. Included next is a story 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 have provided 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. We have identified strategies that have a collection of actions with a reasonable chance of improving the results.

San Francisco Snapshot

Overview



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

Although San Francisco was once considered home to a relatively young population, the city/county has experienced a decrease among

children and families with young children. In addition, over the next two decades, it is estimated that 55 percent of the population will be over the age of 45, and the population over age 75 will increase from seven to 11 percent. San Francisco's population will continue to change given that there are more people moving out of the city/county than are moving in.

About the San Francisco Department of Health

As SFPDPH'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. SFPDPH is an integrated health department with two major Divisions (see p. 9 for an organizational chart): the San Francisco (SF) Health Network and the Population Health Division.

The SF Health Network is comprised of the direct health services SFPDPH provides to thousands of insured and uninsured residents of San Francisco, including those most socially and medically vulnerable. The services the SF Health Network provides are not new – rather, they are newly aligned to achieve the triple aim of Health Reform: better care for individuals; better health for the population; and lower cost through improvement. Unlike other public or private systems, the SF Health Network contains the crucial components needed to build a seamless continuum of care: patient-

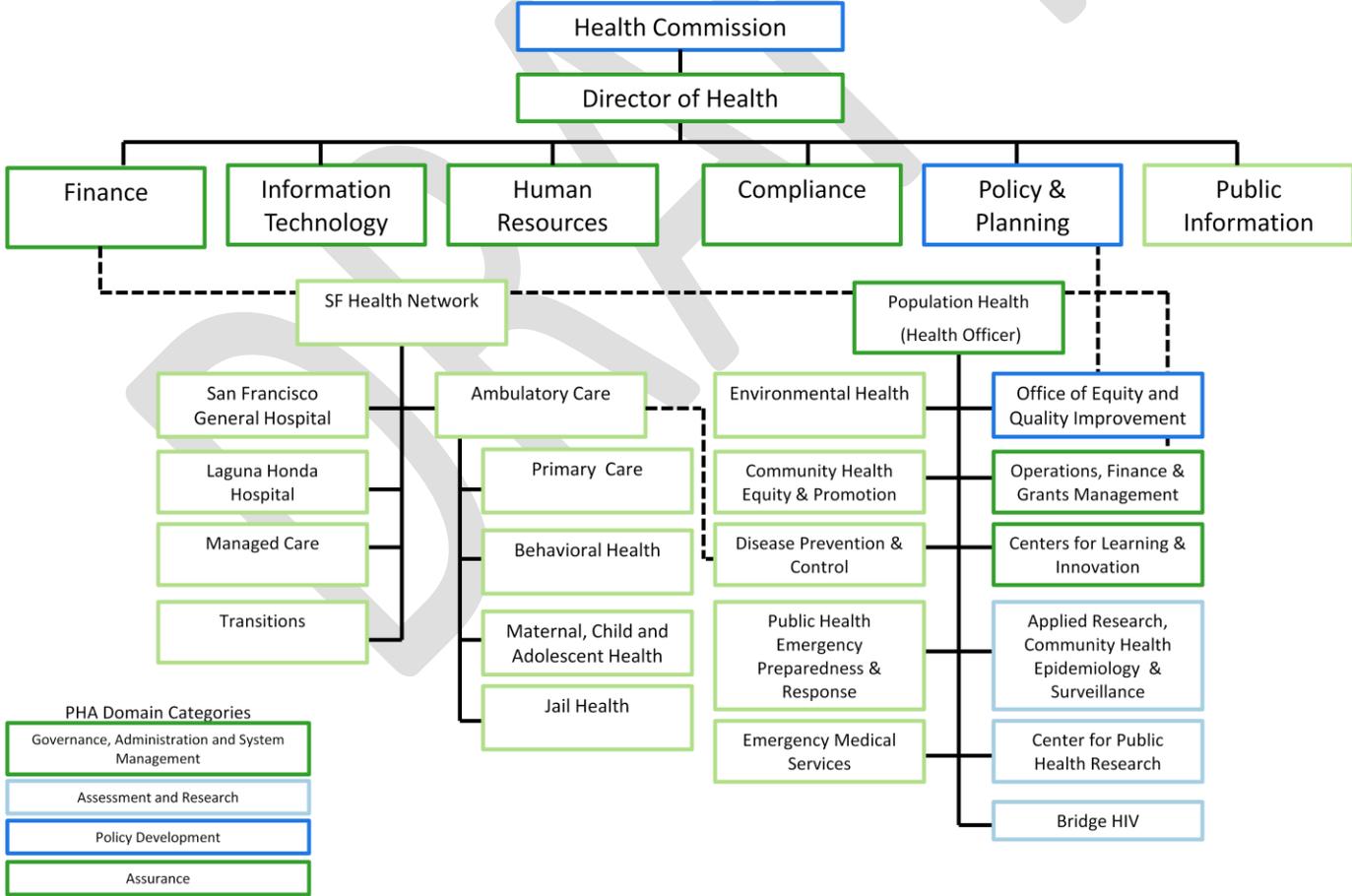


Back Row (left to right): Commissioner David Singer; Commissioner Belle-Taylor McGhee; Commissioner Judith Karshmer; DPH Director Barbara A. Garcia; Commissioner Cecilia Chung; Commissioner David J. Sanchez Jr. **Front Row:** Commissioner Edward A. Chow, President; Commissioner Sonia Melara, Vice President

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 to the health care services, SFPDH provides 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, SFPDH's Community Behavioral Health Services provides 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.

The other section of the health department is the Population Health Division (PHD). Addressing public health concerns, including consumer safety, health promotion and prevention, and the monitoring of threats to the public's health will remain a SFPDH priority. Through PHD, the health department assesses and monitors the health status of San Francisco and implements traditional and innovative public health interventions. Measures of performance and opportunities to improve can be identified through ongoing provision of data to the SF Health Network, SFPDH, and the broader community. PHA specifically focuses on measurement of health department performance against a set of nationally recognized, practice-focused, and evidence-based standards based on the ten essential public health services, as well as management, administration, and governance. (Appendix A provides a description of the offices, centers, and branches.)

Figure 1: SFPDH Organizational Chart



The Strategic Planning Process

For many years in San Francisco, public health activities consisted of autonomous sections that reported directly to the Health Officer; most of the funding and activities were categorical and disease-focused. While the jurisdiction has been successful in leading the nation in practice innovations and research, the categorical structure combined with the lack of infrastructure to coordinate and align activities severely limited its ability to adapt and respond to a rapidly changing external environment. The nationally recognized Triple Aim provides a framework for assessing and categorizing the “triple threat” public health department’s face: emerging changes in public health problems, practices, and financing. The first Phase of the strategic plan was to look at redesigning the structure of PHP. By reorganizing, we are strategically positioning ourselves to not only survive and thrive, but to embrace and respond to the public health needs of San Francisco. The second phase focused the health department’s efforts on the health issues with the greatest morbidity (the level of disease in SF) and mortality (deaths due to those conditions).

Framework for Organizational Design

The first phase in the strategic planning process was the redesign of the Division. Redesigning the division that oversees public health activities was challenging in that we could not afford to hire an organizational design consultant and there is little in the way of published data on the topic for local health departments. Given these limitations, we adapted a social ecological model (the dynamic ways that various personal and environmental factors interconnect) of population health, reviewed Public Health Accreditation domains and standards, studied business organization design books and concepts, and reviewed national standards such as the Baldrige Criteria for Performance Excellence (a national quality award given by the President of the United States). 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 (see Figure 2 page 11) and organizational chart (see Figure 1 page 9).

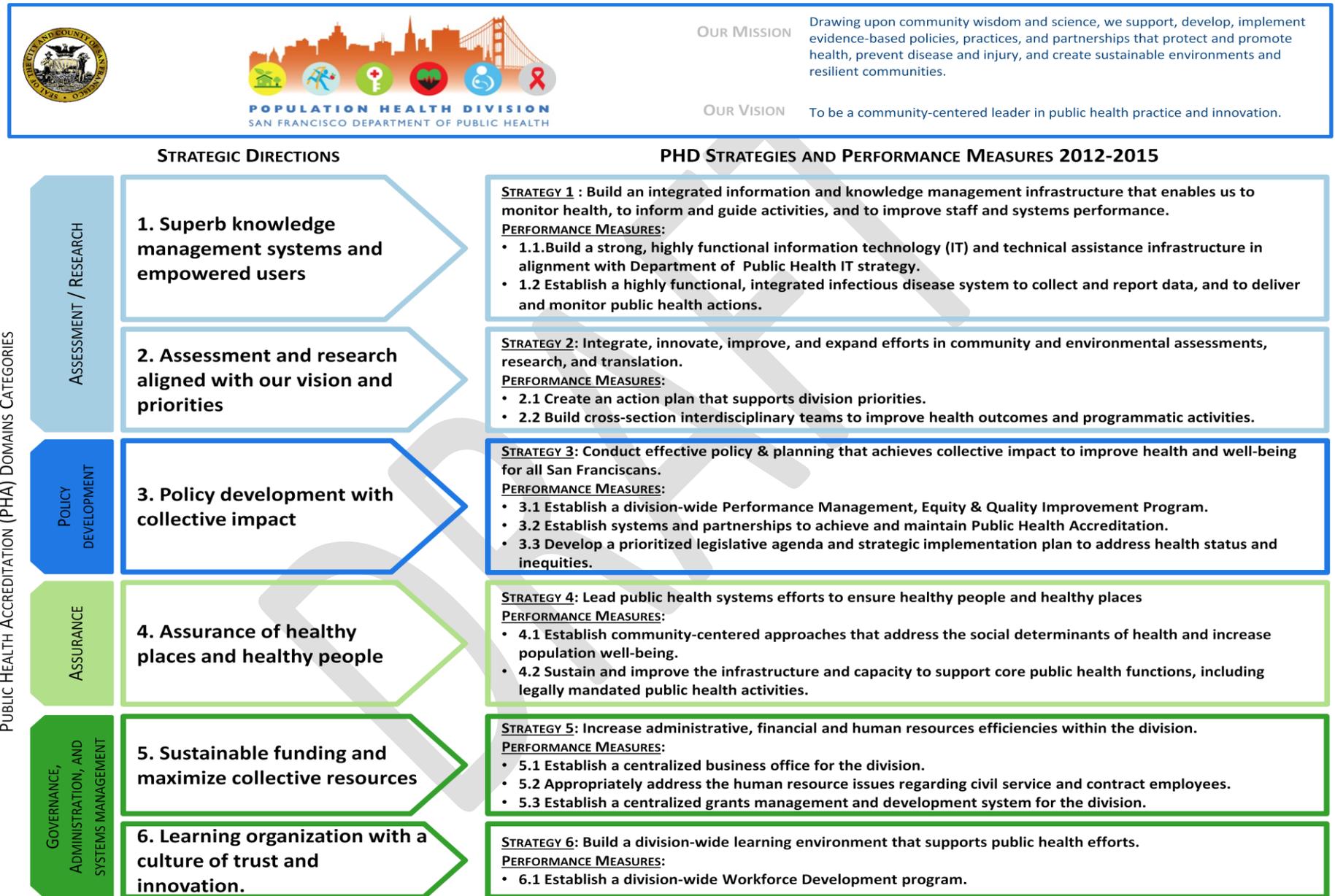
Through this process, general themes emerged that drove the organizational design of the division:

- **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 Division of 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.

Figure 2: Population Health Strategic Map



Headline Indicators

The field of public health aims to prevent disease, prolong life and promote health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals. We are concerned with threats to health based on population health analysis. The population in question can be as small as a handful of people (e.g., E.coli outbreak), or as large as all the inhabitants of several continents (for instance, in the case of a pandemic). The dimensions of health can encompass "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", as defined by the United Nations' World Health Organization. Public health incorporates the interdisciplinary approaches of epidemiology, biostatistics and health services. Emergency Preparedness and Response, Environmental health, community health, behavioral health, health economics, public policy, insurance medicine and occupational health (respectively occupational medicine) are other important subfields.

While all of these efforts are critical functions of public health, SFDPH chose to focus this strategic plan on local "winnable battles" that were selected through the community health improvement plan 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 the department will continue all core public health efforts. For a larger list of activities and services supported by the jurisdiction see Appendix A)

Phase two of the process focused on developing the health indicators that the health department 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. While population health activities support all of 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 venerable population

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

For each Focus Area we have provided you with baseline data for each of the Indicators as well as a forecast (dashed line   ) that indicates where we believe the trend will continue to go if we do nothing different. We also provide you a story 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 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. We have identified strategies that have a collection of actions with a reasoned chance of improving the results



Focus Area: Safe and Healthy Living Environments (CHIP)

San Francisco is one of the wealthiest and most socially progressive cities in the United States. Despite the numerous advantages that come with living here, not everyone in San Francisco has a safe and healthy place to live. While many neighborhoods have great access to parks, public transit, grocery stores, and other resources that benefit health and wellness, other neighborhoods, often poor communities of color, must rely on fast food and alcohol outlets for their nutritional needs, and are near freeways, industrial pollutants, and other factors that contribute to high rates of disease, death, injury, and violence. Community members raised concerns about the latter neighborhoods in focus groups, community meetings and hearings during the extensive outreach process the resulted in three reports being used to guide the City's health and wellness efforts: the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) and Health Care Services Master Plan (HCSMP). The department is also aware of concerns related to these neighborhood conditions through formal grievances by citizens, as well as inspections made and regulatory actions taken by our Environmental Health Branch.

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

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

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

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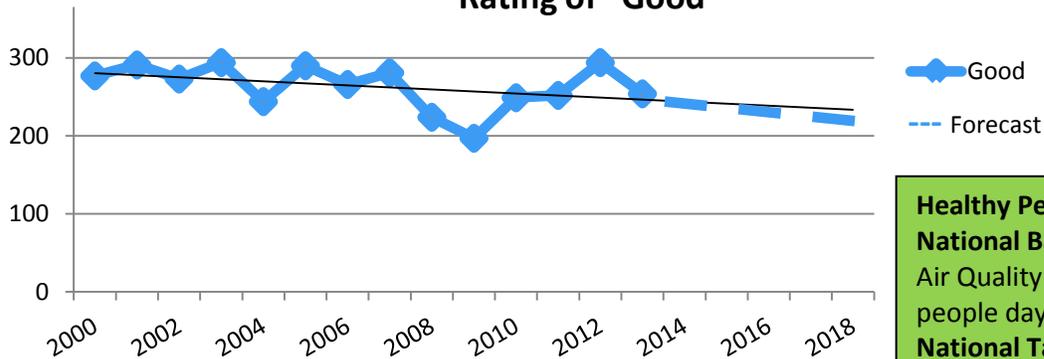
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Headline Indicator: Number of days in San Francisco with good air quality

BASELINE CURVE

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



Healthy People 2020
National Baseline: 2.2 billion
Air Quality Index-weighted
people days exceeded 100
National Target: 1.98 billion
AQI-weighted people days

Data source: U.S. EPA

THE STORY BEHIND THE BASELINE

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

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

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

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

in the city and addressing these should result in a new positive trend for air quality.

WHAT WORKS

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

PARTNERS

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

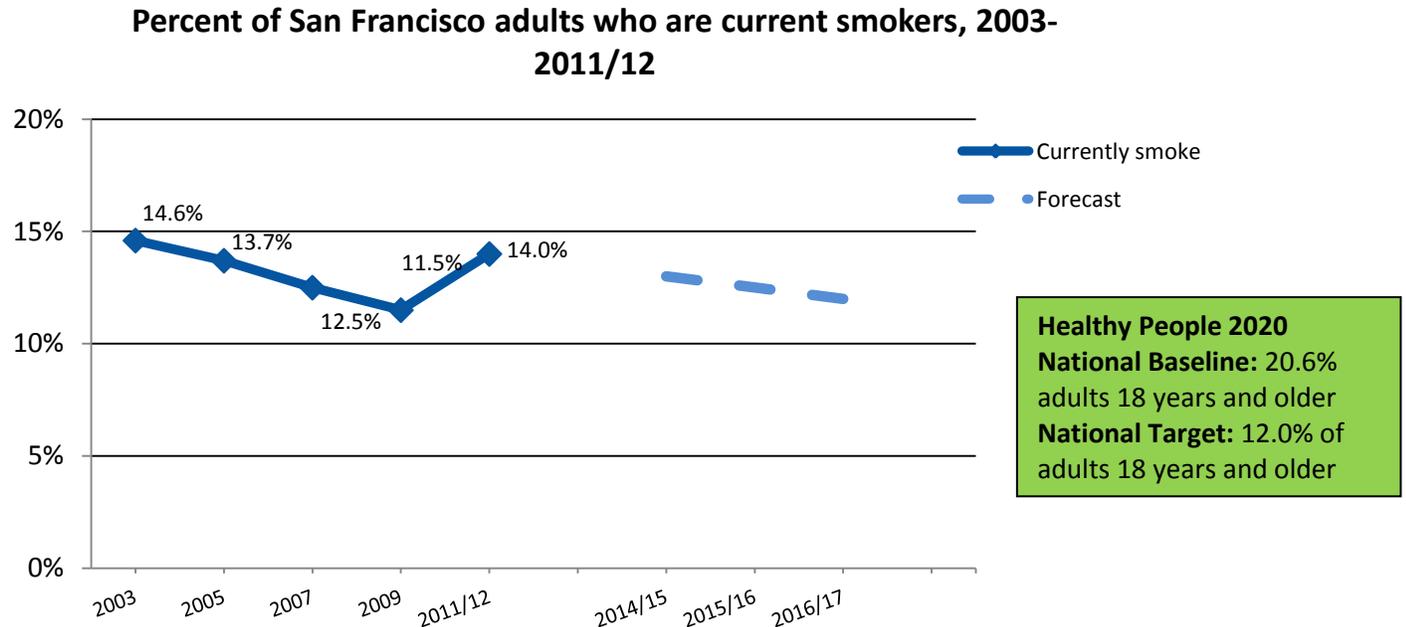
STRATEGIES

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



Headline Indicator: Percent of adults who smoke

BASELINE CURVE



Source: California Health Interview Survey

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

WHAT WORKS

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

PARTNERS

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

STRATEGIES

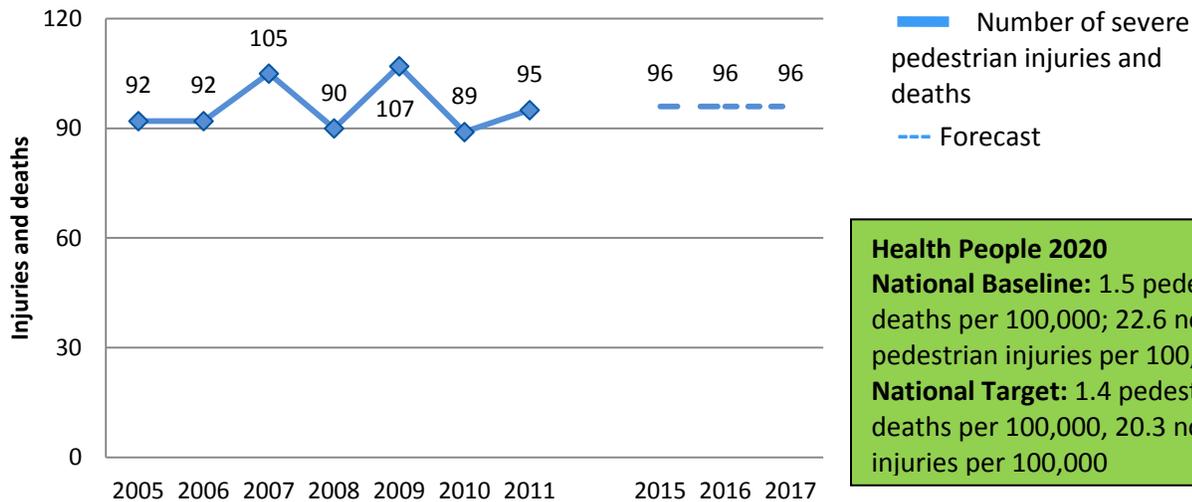
- Continue to enforce and support the policy and regulations that reduce exposure to environmental tobacco smoke, reduce youth access to tobacco products, and counter pro-tobacco influences, such as emerging products like e-cigarettes
- Support feasibility of ordinance for smoke-free housing that will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



Headline Indicator: Number of severe pedestrian injuries and deaths

BASELINE CURVE

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



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

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

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.

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

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

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

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

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

WHAT WORKS

Traffic Safety best practice focuses on the “5 Es”: Engineering, Enforcement, Education, Encouragement, and Evaluation.

- Education Campaigns, Engagement and Advocacy – supporting a larger cultural shift that focuses on pedestrian and road safety; ensuring the community holds City agencies accountable and that populations 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.

STRATEGIES

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



Focus Area: Healthy Eating and Physical Activity (CHIP)

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

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

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

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

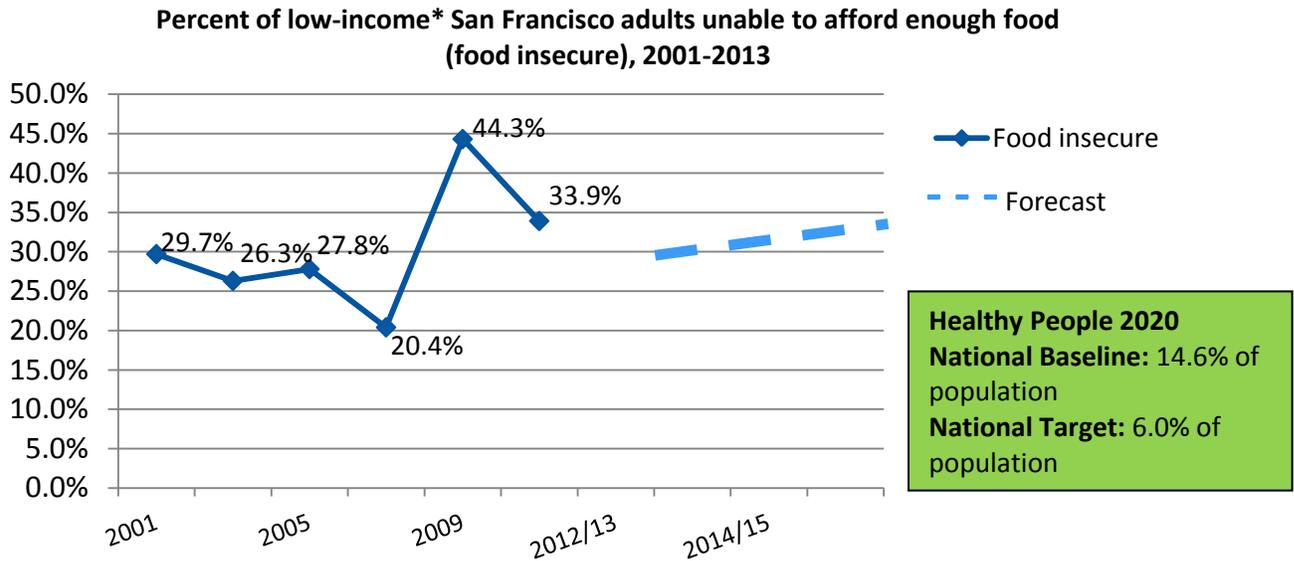
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Headline Indicator: Percent of residents who do not have food security (resource, access, consumption)

BASELINE CURVE



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

*Low-income defined as those whose income is less than 200% of the Federal Poverty Level

THE STORY BEHIND THE BASELINE

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

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

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

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

costs for housing and food, as well as increasing numbers of seniors. Other root causes of food insecurity such as lack of healthy food retail options in lower-income neighborhoods and lack of complete kitchens to prepare healthy meals must be addressed.

WHAT WORKS

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

PARTNERS

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

STRATEGIES

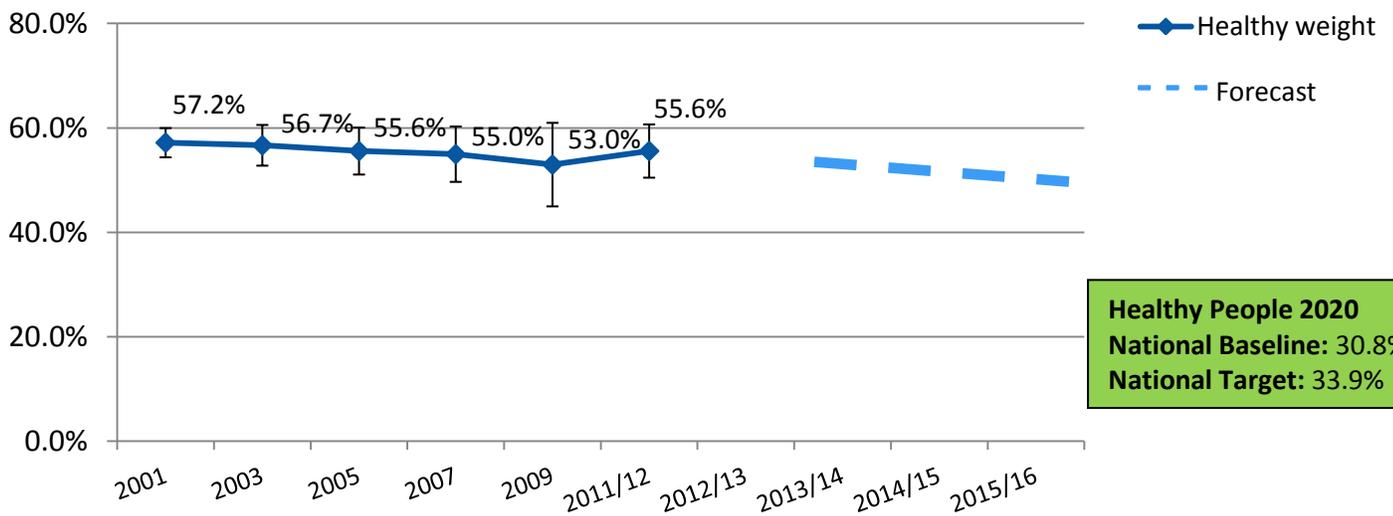
- Support the SF Food Security Task Force and implement its recommendations to increase resources for and access to healthy affordable foods
- Develop public policies, including sustainable funding strategies, that directly and indirectly promote healthy nutrition for food insecure San Franciscans
-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



Headline Indicator: Percent of residents who maintain a healthy weight

BASELINE CURVE

Percent of San Francisco Adults with a Healthy Weight (BMI between 18.5 - 24.99)



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

THE STORY BEHIND THE BASELINE

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

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).

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

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

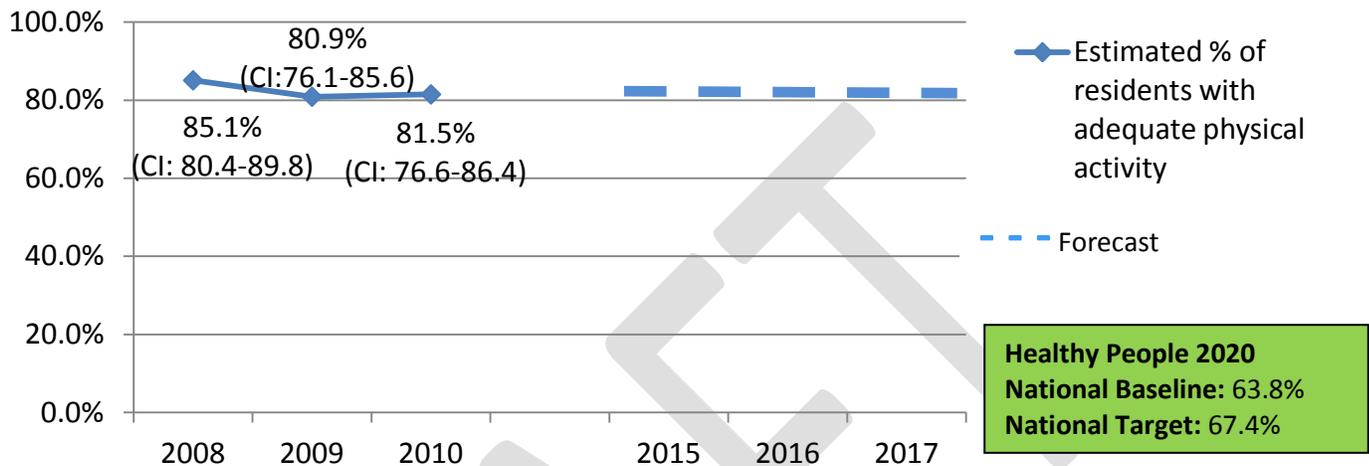
- Implement Shape Up SF Strategic Plan
- Promote programs that create safe, accessible spaces for active transportation, recreation and access to healthy food
- Develop and support implementation of public policies and programs that directly and indirectly promote healthy eating and physical activity



Headline Indicator: Percent of residents who have adequate physical activity

BASELINE CURVE

Percent of San Francisco Adults who Participated in any Physical Activities



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

THE STORY BEHIND THE CURVE

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

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

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

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

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

WHAT WORKS

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

PARTNERS

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

STRATEGIES

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



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

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

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

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

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

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

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

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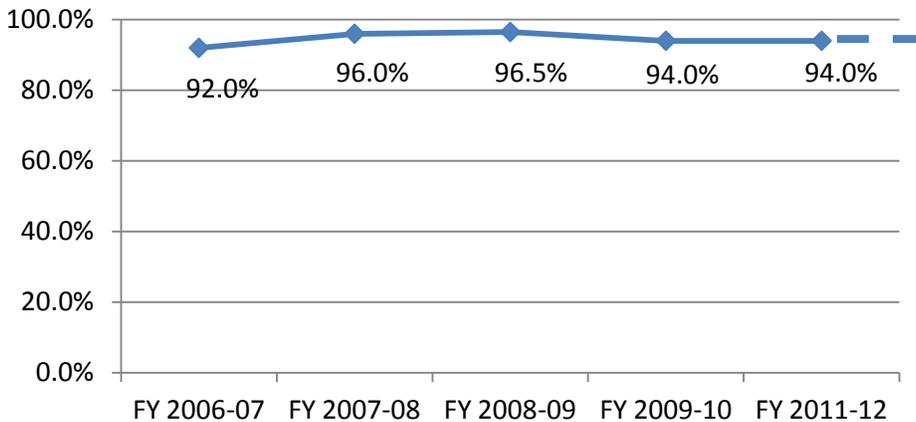
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Headline Indicator: Percent of San Francisco residents enrolled in either health insurance or Healthy San Francisco

BASELINE CURVE

Percent of San Franciscans Who Have Insurance or Are Enrolled in a Comprehensive Access Program



Healthy People 2020:
National Baseline: 83.2%
Target: 100%

Source: SFHIP Health Matters in San Francisco
<http://www.sfhhip.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=7229439>

STORY BEHIND THE BASELINE

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

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

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

infrastructure to coordinate and align activities, has severely limited our ability to adapt and respond to a rapidly changing external environment.

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

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

WHAT WORKS

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

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.

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

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.

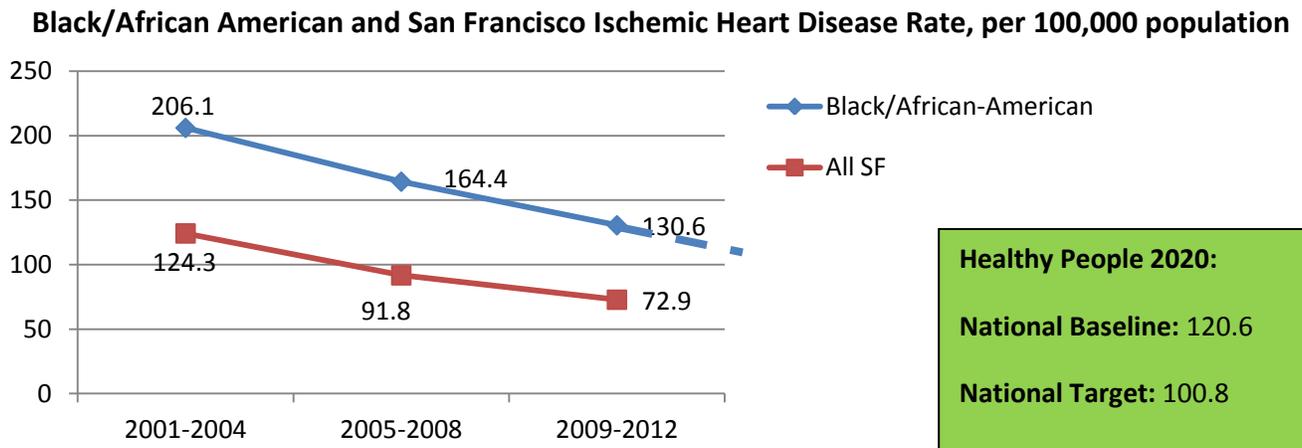
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Headline Indicator: Percent of Blacks/African Americans with heart disease

BASELINE CURVE



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.

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

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.

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 (e.g., UCSF, SF State, City College)
- Churches and Religious Organizations
- Community (to participate and identify strategies)

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.

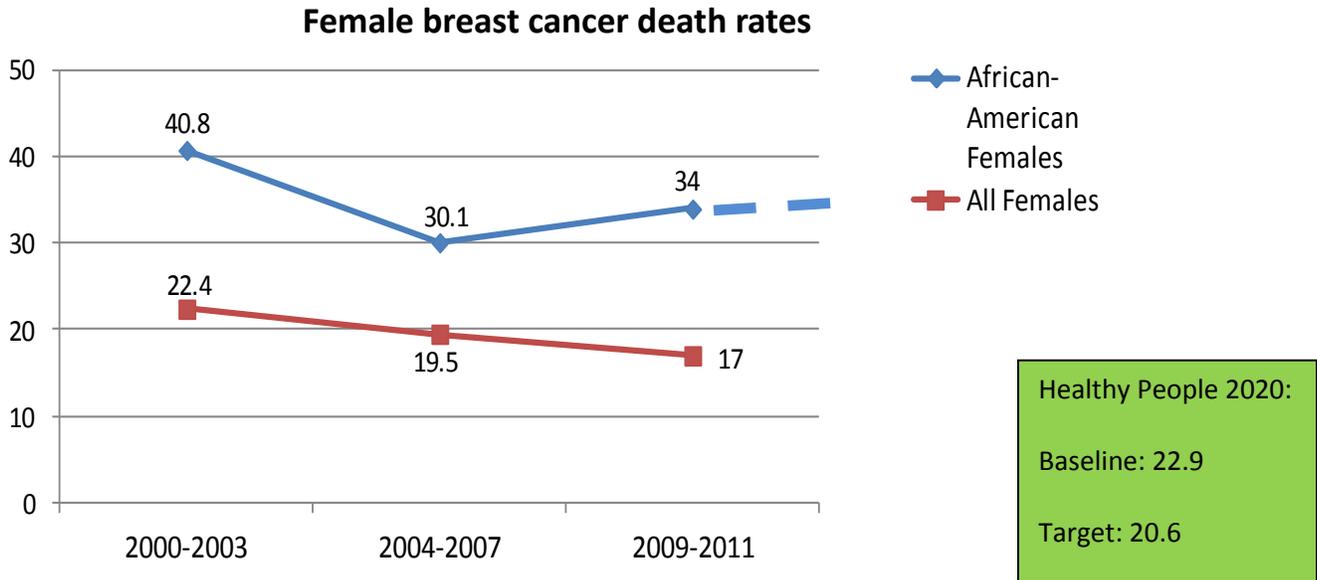
STRATEGIES

- 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



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.

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

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.

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.

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 (e.g., UCSF, SF State, City College)
- Pharmaceutical companies - clinical trials

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

STRATEGIES

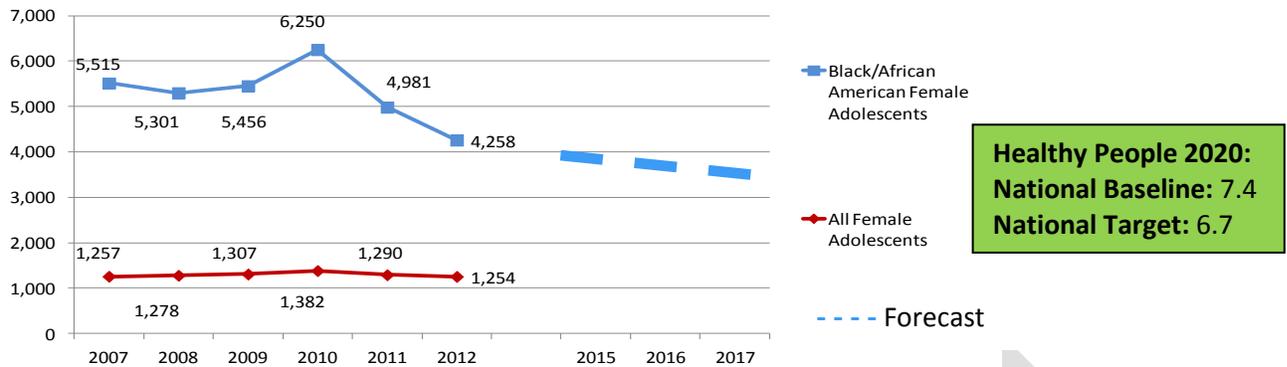
- Improve support systems for Black/African American women diagnosed with breast cancer
- Expand patient navigation programs in other settings including SFGH Women's Cancer Center
- Lessen time between screening that shows questionable results and diagnosis/treatment of Black/African American women



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



THE STORY BEHIND THE BASELINE

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

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

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

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)

WHAT WORKS

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

TOP 1-3 STRATEGIES

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

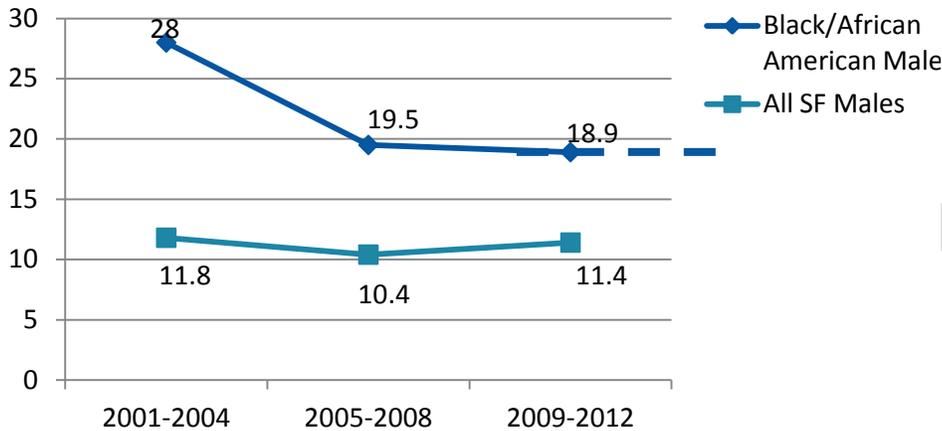
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Headline Indicator: Mortality rates among Black/African American men due to alcohol

BASELINE CURVE

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



Healthy People 2020:

National Baseline: 9.1

National Target: 8.2 (10% improvement)

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.

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.

Research findings on drinking patterns and problems among African Americans can be summarized as follows: (1) African Americans report higher abstention rates than do whites; (2) African Americans and whites report

similar levels of frequent heavy drinking; (3) rates of heavy drinking have not declined at the same rate among African American men and women as among white men; and (4) variables such as age, social class, church attendance, drinking norms, and avoidance coping may be important in understanding differences in drinking and drinking problem rates among African Americans and whites.

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

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 (e.g., UCSF, SF State, City College)
- Churches and Religious Organizations
- Community (to participate and identify strategies)

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

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 assuring 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 to address 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.

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

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

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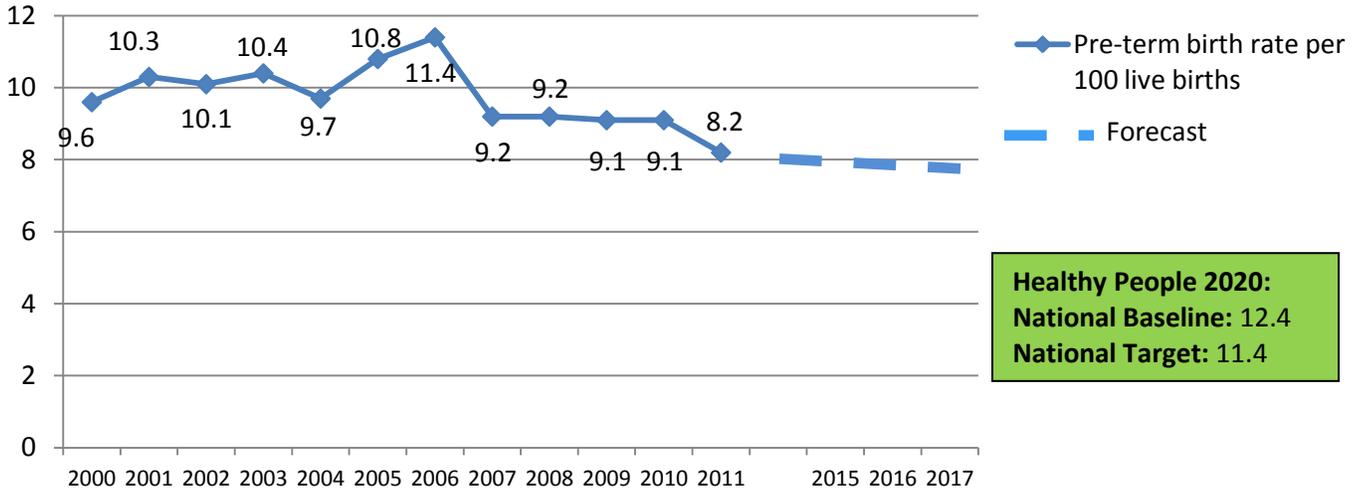
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Headline Indicator: Percent of pre-term infants

BASELINE CURVE

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



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.

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

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

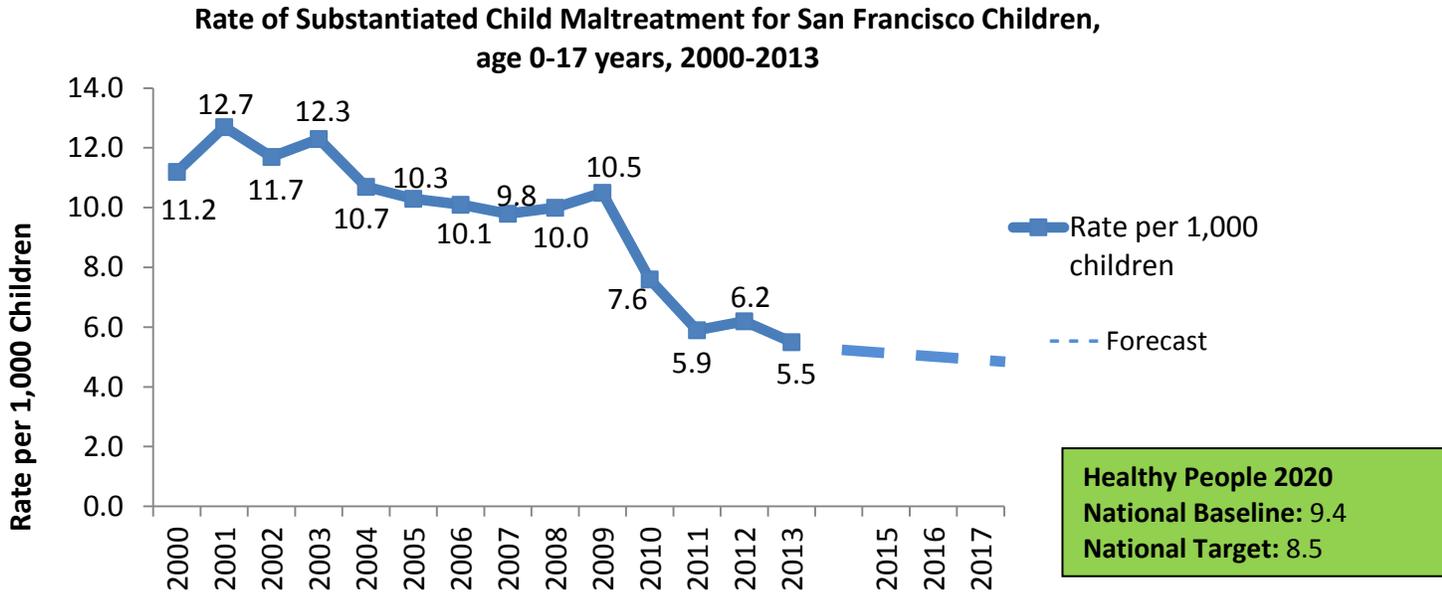
TOP 1-3 STRATEGIES

- 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 Population Health Division activities



Headline Indicator: Rate of substantiated child maltreatment

BASELINE CURVE



Source: UC Berkeley Center for Social Services Research

THE STORY BEHIND THE BASELINE

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

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

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

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

- HSA instituted a process 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

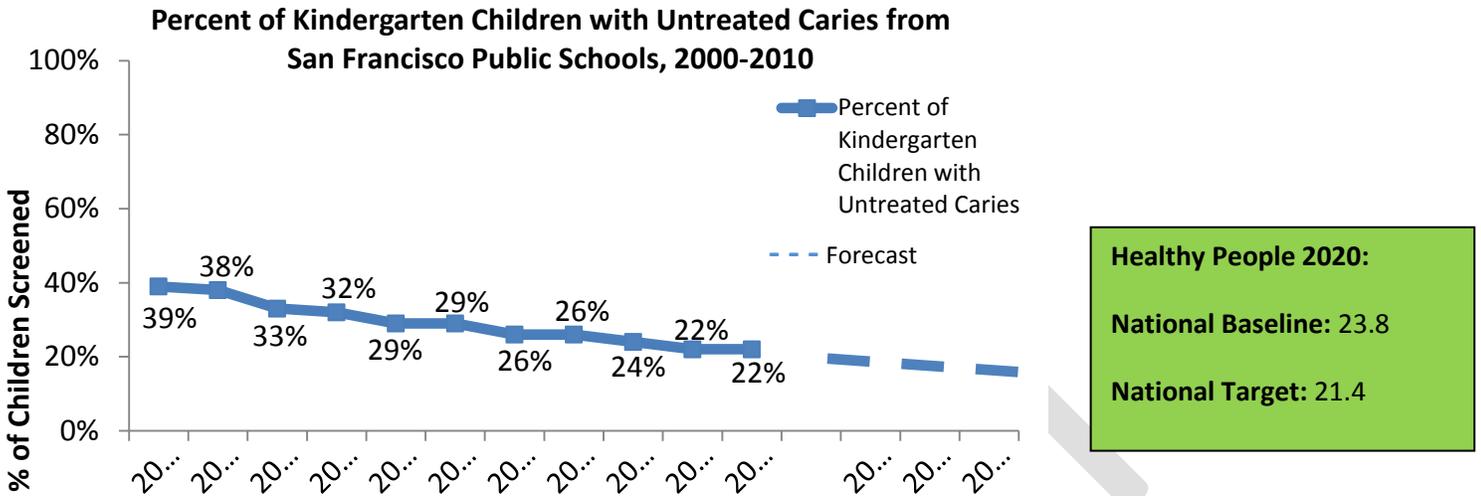
STRATEGIES

- 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



THE STORY BEHIND THE BASELINE

Oral health is essential to overall health. Children with untreated 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. In particular, rates of caries have been shown to be drastically higher in areas of San Francisco with high concentrations of immigrant populations, especially Chinatown. Because prevention is the most cost effective

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.

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

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

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
- Integrating Oral Health with overall health using current medical mechanisms
- Community wide promotion of oral health education; reach parents early, often using varying modalities¹¹
- The co-location of school based dental services
- Annual dental screenings for all kindergarten classes
- 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)

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: males who have sex with males (MSM); transgender females who have sex with males; and injection drug users. 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 15% of the nearly 19,000 people living with HIV/AIDS (PLWHA) are unaware of their status. 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, 28% of PLWHA who know their status have unsuppressed viral load, and 50% of newly diagnosed 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.

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

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

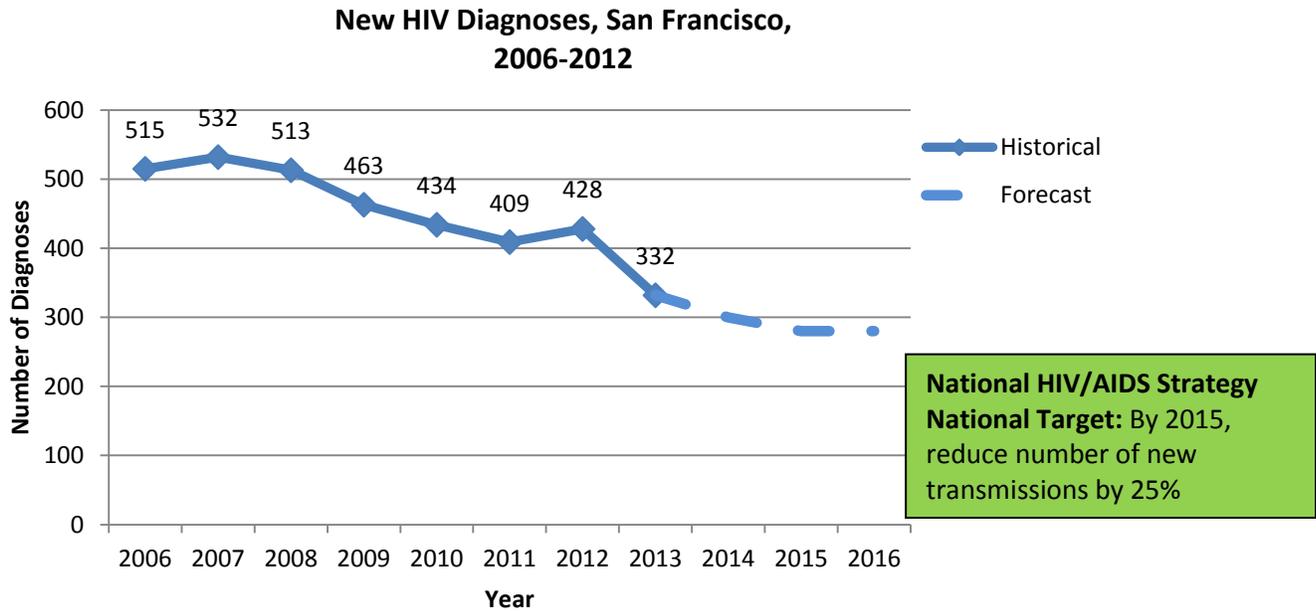
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Headline Indicator: Number of new HIV diagnoses

BASELINE CURVE



THE STORY BEHIND THE BASELINE

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

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

The San Francisco epidemic continues to be concentrated in gay and bisexual males and other males who have sex with males (MSM) who continue to make up 85% of new diagnoses. San Francisco appears to be on a strong path to improvement with this population and we believe we could achieve additional substantial reductions in new HIV infections by continuing current strategies and adding three new strategies that are coming available: 1) Use 4th generation HIV tests in community-based sites which are much more sensitive than current tests and can detect people who are acutely infected and are have very high viral loads, which increases risk of transmission to partners; 2) Scale-up HIV pre-exposure prophylaxis (PrEP) for persons at increased risk; and 3) Increase integrated health and wellness community and clinical

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.

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, Latinos, and Asian/Pacific Islanders (API) 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 (daily emtricitabine/tenofovir for HIV negatives to prevent HIV acquisition)

PARTNERS

HMOs, PPOs, care providers

- CBO's
- Lab Corp, Quest, Walgreens
- Research community
- At risk communities
- Gilead

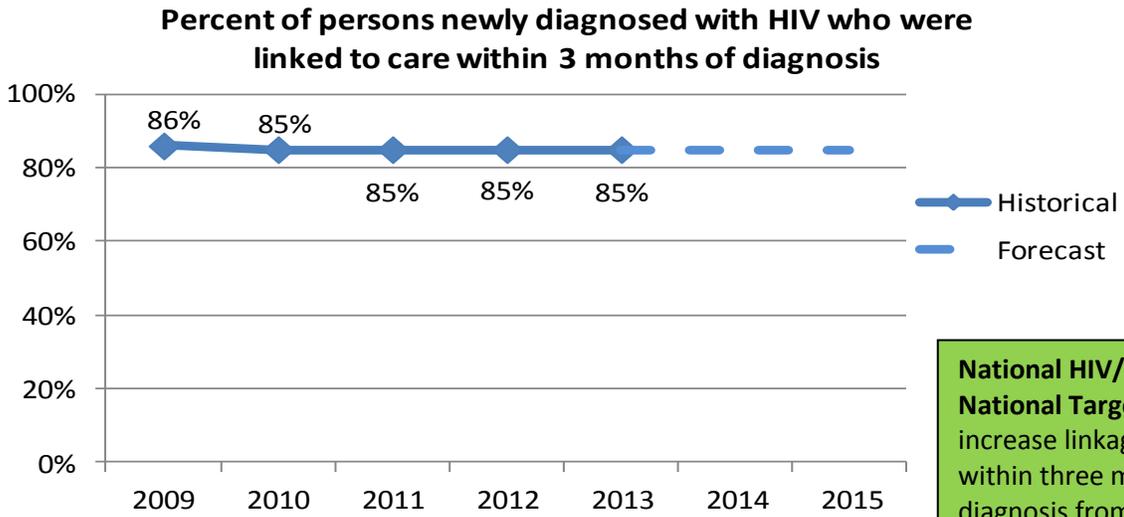
STRATEGIES

- 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 and increased identification of acute infections.
- 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 males who have sex with males (MSM) with case managers, including both HIV and non-HIV care. Pay particular attention to young MSM, Latinos, and API in whom HIV diagnoses are declining less than in diagnoses in other groups.



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

BASELINE CURVE



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

THE STORY BEHIND THE BASELINE

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

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

One SFDPH program that contributes to the city’s success in linkage is the Linkage, Integration, Navigation, and Comprehensive Services Team (LINCS), which will identify, locate, and connect 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 Support Team (PHAST) 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, Latino/API/Other race, MSM/IDU and those with no reported risk (NRR) all had substantially lower rates of linkage to care than other groups. The LINCS program takes a holistic approach to linking patients to care and supporting other needs, such as housing, substance abuse,

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

WHAT WORKS

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

PARTNERS

- Medical providers
- HIV Positive community
- CBOs
- LINCS, PHAST team
- PPOs, HMOs

STRATEGIES

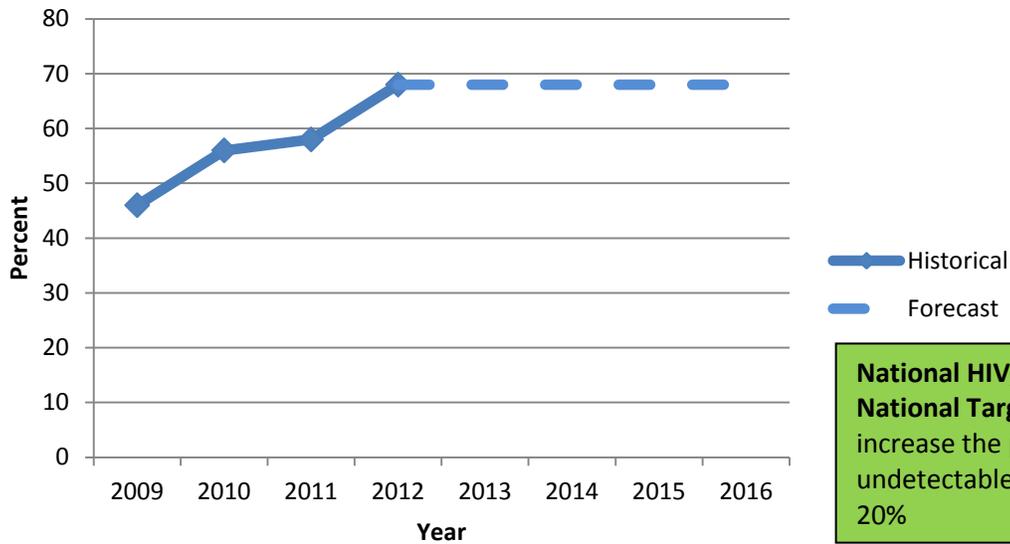
- Increase case management of newly diagnosed persons to facilitate rapid entry into care once tested positive
- Integrated/co-located HIV and non-HIV care services
- Addressing linkage to care by addressing other barriers to care such as housing, insurance, substance abuse and stigma.



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

BASELINE CURVE

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



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

THE STORY BEHIND THE BASELINE

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

Achieving a low amount of HIV virus in your body—By taking ART regularly, you can achieve viral suppression, meaning a very low level of HIV in your blood. You aren’t cured. There is still some HIV in your body. But lowering the amount of virus in your body with medicines can keep you healthy, help you live longer, and greatly reduce your chances of passing HIV on to others.

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

- Linkage to care navigators (LINCIS); PHAST team
- HIV Care Council, CBOs
- Medical providers, PPOs, HMOs, Pharmacies (e.g., Walgreens, SFGH, Moms)
- 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 LINCIS

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

PHA DOMAIN CATEGORY: ASSESSMENT/RESEARCH APPLIED RESEARCH, COMMUNITY HEALTH EPIDEMIOLOGY, & SURVEILLANCE	
STRATEGIC DIRECTION	Superb knowledge management systems and empowered users
GOAL 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.
OBJECTIVES 2012-2015	<p>OBJECTIVE 1.1: Build a strong, highly functional information technology (IT) and technical assistance infrastructure in alignment with Department of Public Health IT strategy.</p> <p>OBJECTIVE 1.2: Establish a highly functional, integrated infectious disease system to collect and report data, and to deliver and monitor public health actions.</p>
DESCRIPTION	This new Branch will coordinate 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 will maintain systems to gather, explore, analyze, and present data to inform decision-making to maximize public health. Data across conditions, populations, and health status will be 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:	<ul style="list-style-type: none"> • Develop integrated platform • Surveillance of all communicable diseases • Case investigation and case management • Monitor health outcomes • Program evaluation and implementation science • Develop and assess Continuous Quality Improvement measures

PHA DOMAIN CATEGORY: ASSESSMENT/RESEARCH

CENTER FOR PUBLIC HEALTH RESEARCH

STRATEGIC DIRECTION	Assessment and research aligned with our vision and priorities
GOAL 2	Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.
OBJECTIVES 2012-2015	<p>OBJECTIVE 2.1: Create an action plan that supports division priorities.</p> <p>OBJECTIVE 2.2: Build cross-section interdisciplinary teams to improve health outcomes and programmatic activities.</p>
DESCRIPTION	<p>This new Branch will provide 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 will provide 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 will be leveraged to improve the health of San Francisco and the world.</p>
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • 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	
STRATEGIC DIRECTION	Assessment and research aligned with our vision and priorities
GOAL 2	Integrate, innovate, improve, and expand efforts in community and environmental assessments, research, and translation.
OBJECTIVES 2012-2015	<p>OBJECTIVE 2.1: Create an action plan that supports division priorities.</p> <p>OBJECTIVE 2.2: Build cross-section interdisciplinary teams to improve health outcomes and programmatic activities.</p>
DESCRIPTION	Bridge HIV is one of our Branches that provide 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), to conduct innovative research that guides global approaches to prevent HIV and AIDS.
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • 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

STRATEGIC DIRECTION	Policy development with collective impact
GOAL 3	Conduct effective policy and planning that achieves collective impact to improve health and well-being for all San Franciscans.
OBJECTIVES 2012-2015	<p>OBJECTIVE 3.1: Establish a division-wide Performance Management, Equity & Quality Improvement Program.</p> <p>OBJECTIVE 3.2: Establish systems and partnerships to achieve and maintain Public Health Accreditation.</p> <p>OBJECTIVE 3.3: Develop a prioritized legislative agenda and strategic implementation plan to address health status and inequities.</p>
DESCRIPTION	This new Branch serves as the principal advisor and coordinator of Division-wide efforts to reduce disparities and improve health equity in San Francisco. The Branch will work in partnership with the DPH Policy and Planning Section to develop and implement a legislative agenda; as well as support the health department’s efforts to achieve and maintain Public Health Accreditation. Accreditation signifies that a health department is meeting national standards for ensuring essential public health services that are provided in the community.
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • Serves as principal advisor across the Division in matters related to health disparities, health equity, and priority population and/or community health • Establishes and manages a division-wide Quality Improvement and Performance Management Program • 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.

PHA DOMAIN CATEGORY: ASSURANCE

DISEASE PREVENTION & CONTROL

STRATEGIC DIRECTION	Assurance of healthy places and healthy people
GOAL 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
OBJECTIVE 2012-2015	<p>OBJECTIVE 4.1: Establish community-centered approaches that address the social determinants of health and increase population well-being.</p> <p>OBJECTIVE 4.2: Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.</p>
DESCRIPTION	This new Branch integrates the core public health communicable disease functions, along with specialty care & 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 will also be 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:	<ul style="list-style-type: none"> • Specialty Clinics (Immunization and Travel Clinic, STD, and TB) • Public Health Lab • 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

PHA DOMAIN CATEGORY: ASSURANCE

COMMUNITY HEALTH EQUITY & PROMOTION

STRATEGIC DIRECTION	Assurance of healthy places and healthy people
GOAL 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
OBJECTIVE 2012-2015	OBJECTIVE 4.1: Establish community-centered approaches that address the social determinants of health and increase population well-being.
DESCRIPTION	This new 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 will continue to plan, implement, and evaluate prioritized community initiatives, including promoting active living, decreasing HIV, sexually transmitted infections, viral hepatitis, and effects of trauma.
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • 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

ENVIRONMENTAL HEALTH

STRATEGIC DIRECTION	Assurance of healthy places and healthy people
GOAL 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
OBJECTIVE 2012-2015	<p>OBJECTIVE 4.1: Establish community-centered approaches that address the social determinants of health and increase population well-being.</p> <p>OBJECTIVE 4.2: Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.</p>
DESCRIPTION	This Branch will implement San Francisco's environmental policies and laws and innovate new policies and programs to ensure safe and nutritious food, quality housing, livable neighborhoods and protection from air pollutants, excessive noise and hazardous chemicals.
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • Monitoring and enforcement of local and state laws for: <ul style="list-style-type: none"> ◆ Food safety ◆ Housing habitability ◆ Neighborhood sanitation ◆ Noise ◆ Indoor air pollutants ◆ Vector control ◆ Chemical hazards ◆ Tobacco sales • Monitoring of community-level social and environmental determinants of health and well-being • Implementation of comprehensive interventions to improve: <ul style="list-style-type: none"> ◆ Community food security ◆ School food quality ◆ Asthma morbidity • Support of interagency partnerships for: <ul style="list-style-type: none"> ◆ Sustainable land use development ◆ Sustainable transportation projects ◆ Park renovations and green connections ◆ Pedestrian and bicycle safety ◆ Prevention of labor law violations ◆ Government transparency

PHA DOMAIN CATEGORY: ASSURANCE

PUBLIC HEALTH EMERGENCY PREPAREDNESS & RESPONSE

STRATEGIC DIRECTION	Assurance of healthy places and healthy people
GOAL 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
OBJECTIVE 2012-2015	OBJECTIVE 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:	<ul style="list-style-type: none"> • 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 our goals

PHA DOMAIN CATEGORY: ASSURANCE

EMERGENCY MEDICAL SERVICES

STRATEGIC DIRECTION	Assurance of healthy places and healthy people
GOAL 4	Lead public health system efforts to create an upstream approach to ensuring healthy people and healthy places.
OBJECTIVE 2012-2015	OBJECTIVE 4.2: Sustain and improve the infrastructure and capacity to support core public health functions, including legally mandated public health activities.
DESCRIPTION	This Branch is tasked with the oversight of Emergency Medical System (EMS) protocol and policy pursuant to Title 22 Division 9 of the California Code of Regulations, Division 2.5 of the California Health and Safety Code and Article 14 of the San Francisco Health Code to provide high quality, accessible emergency medical care in both normal operations and disaster settings.
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • Certification of Emergency Medical Technicians (EMT) • Accreditation of Paramedics • Inspection of ambulances • Designation of hospitals as Receiving Hospitals and Specialty Centers • Designation of 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 • Development and maintenance of a local 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

PHA DOMAIN CATEGORY: GOVERNANCE, ADMINISTRATION, AND SYSTEMS MANAGEMENT

OFFICE OF OPERATIONS, FINANCE, & GRANTS MANAGEMENT

STRATEGIC DIRECTION	Sustainable funding and maximize collective resources
GOAL 5	Increase administrative, financial and human resources efficiencies within the division.
OBJECTIVES 2012-2015	<p>OBJECTIVE 5.1: Establish a centralized business office for the division.</p> <p>OBJECTIVE 5.2: Appropriately address the human resource issues regarding civil service and contract employees.</p> <p>OBJECTIVE 5.3: Establish a centralized grants management and development system for the division.</p>
DESCRIPTION	This new 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. This will allow 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.
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • Fiscal management • Grants/Contracts development, set-up & administration • Human Resources coordination • Purchasing • Payroll coordination • Fund development coordination & management • Project management • Performance Management

PHA DOMAIN: GOVERNANCE CATEGORY, ADMINISTRATION, AND SYSTEMS MANAGEMENT

CENTER FOR LEARNING AND INNOVATION

STRATEGIC DIRECTION	Learning organization with a culture of trust and innovation.
GOAL 6	Build a division-wide learning environment that supports public health efforts.
OBJECTIVE 2012-2015	OBJECTIVE 6.1: Establish a division-wide professional development program.
DESCRIPTION	This new Branch will lead and coordinate professional development activities across the Division to assure a competent public health workforce. The Branch will create novel training opportunities for internal and external groups and develop the workforce of tomorrow by implementing a Division-wide Health Equity Fellows program.
FUNCTIONS INCLUDE:	<ul style="list-style-type: none"> • Prioritize and integrate professional development to build staff capacity • Inventory employee skills to develop tailored training approaches that will meet individual Branch and collective Division needs • Convene a Division-wide Training Working Group that will identify best practices and develop plans to address cross-cutting training needs • Maintain a robust learning management system that will closely track training requirements for PHD employees and deliver 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 • Create a Health Equity Fellows program to create meaningful internship opportunities for graduate and undergraduate candidates that will combine training and mentored projects • Offer and coordinate technical assistance to external partners in Division-wide areas of expertise • Communicate internal and external training opportunities through an interactive website, email, newsletters, and social media

Appendix B: List of Acronyms (in alphabetical order)

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
CBOs	Community-Based Organizations
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
CRRP	Community Risk Reduction Plan
HCSMP	Health Care Services Master Plan
HIV	Human Immunodeficiency Virus
HSA	Human Services Agency
IDU	Injection Drug Users
LINCS	Linkage, Integration, Navigation, and Comprehensive Services Team
MAPP	Mobilizing for Action through Planning and Partnerships
MSM	Males who have sex with males
PPACA or (ACA)	Patient Protection and Affordable Care Act
PLWHA	People Living With HIV/AIDS
PrEP	Pre-Exposure Prophylaxis
PHA	Public Health Accreditation
PHD	Population Health Division
PHP	Population Health & Prevention
PHAST	Positive Health Access Support Team
SF	San Francisco
SFPDPH	San Francisco Department of Public Health
SFGH	San Francisco General Hospital
UCSF	University of California, San Francisco

DRAFT