Office of Equity & Quality Improvement
Focus on: Community Health Improvement Plan

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San Francisco Health Commission,
Community and Public Health Committee
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Three ongoing processes and requirements for Public Health Accreditation

- Community Health Assessment (CHA)
- Community Health Improvement Plan (CHIP)
- Public Health Strategic Plan
Community Health Assessment: Identifies key health needs and issues in San Francisco through systematic, comprehensive data collection and analysis

Key Elements

1. Community Health Assessment (quantitative data)
2. Assessment of Prior Assessments (quantitative and qualitative data)
3. Community Engagement (qualitative data)
4. Health Need and Identification Process

Population Health Division
San Francisco Department of Public Health
Office of Equity & Quality Improvement
Purpose of Community Health Needs Assessment

- Health Care Service Master Plan
- Hospitals’ Community Benefits Plan
- Hospitals’ Community Health Needs Assessment
- Public Health Accreditation
- Community Health Improvement Plan
Community Prioritized Health Needs

- Access to Care
- Health Eating and Physical Activity
- Behavioral Health
What is the Community Health Improvement Plan (CHIP)?

“It’s the implementation Plan for SFHIP Partners”
• Developed criteria for the development of the SFHIP Implementation Plan

• Identified data sources (indicators) for each of the health objectives identified that can be stratified by issues of equity and can be matched to a relevant state or national standard

• Identified health goals that align with the prioritized health needs

• Identified baseline data and citywide improvement targets for each objective stratified by issues of equity

• Identified and aligned indicators with current collective impact initiatives

• Identified partners that are currently working on the health indicator

• Identified linkages and networks that should be connected to work on the health indicators
Overarching Goals

• Foster physical, emotional and mental wellbeing

• Prevent complex chronic diseases

• Coordinate services and care that are culturally and linguistically appropriate across the continuum
Health Indicators for Access to Care

• Increase the rates of African American, Asian, & Latino public school kindergarteners who have not experienced dental carries

• Decrease the rates of preventable hospitalizations among African American and residents from the Tenderloin, SOMA and Bayview due to ambulatory care sensitive conditions – chronic composite
Health Indicators for Healthy Eating and Physical Activity

- Decrease the number of pregnant women on Medi-Cal who are food insecure

- Decrease the number of seniors waiting more than 30 days for a home delivered meal

- Increase the number of African American, Latino Native Hawaiian and Pacific Islander public school 7th graders meeting 6 of 6 Healthy Fitness Zone standards
Health Indicators for Behavioral Health

- Decrease the rates of adult hospitalizations for major depression among African American, transitional aged youth, middle aged and residents in the Tenderloin & SOMA

- Decrease the rates of emergency room rates due to alcohol abuse among middle aged and residents in the Tenderloin & SOMA

- Decrease the rates of African American, Latino and under 1 year old children experiencing child maltreatment
## Vision
Healthy People, Healthy Families, Healthy Communities for San Francisco

## Mission
Mobilizing San Francisco and resources to eliminate health disparities and inequities

### Values

- **Health Equity:** Providing opportunities for all San Franciscans to enjoy highest level of health
- **Community Engagement:** Partner with residents and community based organizations to support health and well being
- **Alignment:** Ensuring maximum impact of resources to advance health priorities

### Priority Health Needs

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Access to Care</th>
<th>Healthy eating + physical activity</th>
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<tr>
<td>• Foster physical, emotional and mental wellbeing</td>
<td>• Prevent complex chronic diseases</td>
<td>• Coordinate services and care that are culturally and linguistically appropriate across the continuum</td>
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### Priority Health Needs Data Indicators

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<th>Data indicators</th>
<th>Overarching Goals</th>
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<tr>
<td>Adult hospitalizations for major depression among AA, transitional aged youth, middle aged and residents in the Tenderloin &amp; SOMA</td>
<td>• Foster physical, emotional and mental wellbeing</td>
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## Strategic Approaches

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<tr>
<th>Policy</th>
<th>Partnerships</th>
<th>Linkages &amp; Networking</th>
<th>Initiatives</th>
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Next steps

- Complete the list of linkages and networks that should be connected to work on the health indicators - August 18, 2016
- Complete targets for each objective stratified by issues of equity - September 15, 2016
- Finalize and approve the SFHIP Implementation Plan - September 15, 2016
- Approval from Health Commission (anticipated Fall 2016)
- Develop actions plans for implementation