The San Francisco Health Improvement Partnership (SFHIP) is a cross sector collaboration designed to improve the health and wellness of all San Franciscans. Inspired by the Collective Impact model, SFHIP is using the model’s principles, lessons, and structure to achieve transformational change locally. Collective Impact is defined as the commitment of a group of actors from different sectors to a common agenda for solving specific social problems. Using a structured form of collaboration, Collective Impact initiatives are distinguished from other types of collaboration by creating or expanding upon these five conditions of success:

**Common Agenda:** SFHIP has developed a shared vision, mission and core values for change, including a common understanding of the problem and a framework for how they will take actions.

**Shared Measurement:** The collaborative has identified indicators to measure and monitor data to ensure efforts remain aligned and participants hold each other accountable.

**Mutually Reinforcing Activities:** While each SFHIP member may provide different activities, they will be coordinated through a mutually reinforcing plan of action.

**Continuous Communication:** SFHIP is committed to consistent and open communication across all of the players to build trust, assure mutual objectives, and appreciate common motivation.

**Backbone Organization:** Partners have come together to create and manage the collective work to serve as the backbone for the entire collaborative in order to coordinate the work of participating organizations and agencies.

The SFHIP collaboration includes representatives from coalitions including the African-American Community Health Equity Council; Chicano/Latino/Indígena Health Equity Coalition; the Asian Pacific Islander Health Parity Coalition; and the SF Interfaith Council. Partners also include the San Francisco’s Hospital Council and their local Community Benefits Programs; the Clinical and Translational Science Institute (CTSI) at the University of California, San Francisco; the San Francisco Department of Public Health; the Mayor’s Office; the San Francisco Unified School District; San Francisco Community Clinic Consortium; philanthropy; community representatives; and the business sector.
# Table of Contents

- A Message from SFHIP Co-Chairs ........................................ 4
- A Message from Barbara Garcia, Director of Health for the City and County of San Francisco ................... 5
- Mission, Vision, Values ....................................................... 6
- San Francisco Snapshots ................................................... 7
- Criteria, Goals and Strategic Approaches ............................ 9
- Priority Health Need: Access to Care .................................. 10
- Priority Health Need: Healthy Eating and Physical Activity ................................................................. 12
- Priority Health Need: Behavioral Health ................................ 15
- Next Steps ........................................................................ 18
- Acknowledgements ............................................................ 19
- References ......................................................................... 20
It is our pleasure to share with you the 2016-2017 San Francisco Health Improvement Partnership (SFHIP) Strategic Priorities. On behalf of the members, we hope you find this information useful, and are inspired to join our efforts to mobilize San Franciscans and our collective resources to eliminate health disparities and inequities.

We would like to thank the many community residents, community-based organizations, and health care partners that contributed to this document. A special thank you goes out to the backbone support of SFHIP, staffed by the Department of Public Health, the Hospital Council, and the University of California at San Francisco, for their work and project management.

The Community Health Improvement Plan (CHIP), now known as the SFHIP Strategic Priorities, is part of an ongoing community health improvement process. The document highlights the key values of the collaborative.

We began with the Community Health Needs Assessment (CHNA). The CHNA takes a broad view of health conditions and status in San Francisco and provides citywide data to identify health needs. The San Francisco CHNA, as well as the data appendices, can be found at www.sfhip.org.

Through this process seven health needs surfaced: 1) healthy eating, 2) physical activity, 3) psychosocial health, 4) substance abuse, 5) access to culturally and linguistically appropriate health care services, 6) safety and violence prevention, and 7) housing stability and homelessness.

In order to focus our action, SFHIP consolidated and prioritized them into three Priority Health Needs: 1) Access to Care, 2) Healthy Eating & Physical Activity, and 3) Behavioral Health. While the health needs are broad, available indicator data allows us to look at specific issues where disparities are apparent.

A core value for SFHIP is a focus on Health Equity. We recognize that all San Franciscans do not have equal opportunities for good health, and are committed to eliminating health disparities and inequities by working together across sectors to achieve health equity for all.

We hope this document clearly names the health needs we are committed to working on so that you can join our efforts to improve the health of San Francisco.

Estela Garcia DMH & Abbie Yant RN, MA, SFHIP Co-Chairs
I am pleased to present the 2016-2017 San Francisco Health Improvement Partnership (SFHIP) Strategic Priorities. This document is part of our commitment to protect and promote the health of all San Franciscans. It is also essential for achieving and maintaining Public Health Accreditation. Accreditation signifies that the health department is meeting national standards for ensuring essential public health services and improving and protecting the health of the public.

The Strategic Priorities is part of a broader citywide plan that support the health and wellness of San Francisco residents. Our health jurisdiction has a long tradition of engaging the community in our planning; from identifying policy changes to improving health outcomes (e.g., reduced rates of smoking and new HIV infections). Together, we have developed new ways to measure the health of our residents, our communities, and our environment.

The process brought stakeholders together to prioritize health needs and indicators that focus on issues of health equity that can be addressed through collective impact efforts. Like many previous endeavors, it is dependent on the community voices we heard. I am especially thankful for the contributions of community groups that partnered with us and look forward to future collaborations.

All of our accomplishments can be directly credited to the voices of the community members who contributed to this process and the exceptionally dedicated staff and leadership at SFDPH and our SFHIP partners. I am grateful for their enduring commitment to this public health mission that we share and thank them for their ongoing efforts to protect and promote the health of all San Franciscans.

Best regards,

Barbara A. Garcia, MPA
Director of Health
San Francisco Department of Public Health
City and County of San Francisco
SFHIP took the planning process as an opportunity to review and revise its vision and mission statements. The vision statement “Healthy people, healthy families, healthy communities for San Francisco” signifies what the collaborative sees as the inspirational state for all San Francisco residents. The new mission statement “Mobilizing San Francisco and resources to eliminate health disparities and inequities” affirms SFHIP’s commitment to focusing on health equity and recognizes that it is critical to engage and partner with residents and community-based organizations to support health and well-being. The core values developed by SFHIP uphold the vision and mission statements, and provide the principles by which the collaborative guides its planning process and work.

**VISION**

Healthy people, healthy families, healthy communities for San Francisco

**MISSION**

Mobilizing San Francisco and resources to eliminate health disparities and inequities

**CORE 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:** Ensure maximum impact of resources to advance health priorities

---

*From the community:*

“I am missing a family provider. In the Philippines, one doctor knows your family’s health overall. We are only known in emergencies.”

“Language is sometimes related to value and quality of care”

“A lot more of a population need mental health that aren’t visually crazy – I have anxiety and temper issues. That’s all mental – causes problems in my daily life, little stuff that causes big stress”
San Francisco Health Improvement Partnership

San Francisco Health Improvement Partnership

San Francisco Snapshot

Population Growth
San Francisco is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. At roughly 47 square miles, it is the smallest county in the state, but is the most densely populated large city in California (with a population density of 18,187 residents per square mile) and the second most densely populated major city in the US, after New York City.1

Between 2010 and 2014 the population in San Francisco grew by 5% to 845,602, outpacing population growth in California (3.9%).2,3 By 2030, San Francisco’s population is expected to total nearly 970,000.4

An Aging Population
The proportion of San Francisco’s population that is 65 years and older is expected to increase from 13.7% in 2010 to 19.9% in 2030.4 The proportion of the population 75 years and older is expected to increase from 6.9% to 9.8%. At the same time, it is estimated that the proportion of working age residents (25 to 64 years old) will decrease from 63% in 2010 to 57.7% in 2030. This shift could have implications for the provision of social services.

Ethnic Shifts
In the past 50 years, the most notable ethnic shifts have been a steep increase in the Asian and Pacific Islander population, and a decrease in the Black/African American population.5-6 By 2030, growth is expected in the number of multi-ethnic and Latino residents, while the number of Black/African American residents will likely continue to drop unless addressed.4 The white population is expected to continue to increase in numbers, but will decrease as a percentage of the total population.

Currently, about one third of San Francisco’s population is foreign born, with 23% of residents reporting that they speak a language other than English at home and speak English less than “very well.”1 The majority of the foreign born population comes from Asia (64%), while 20% were born in Latin America, making Chinese (Mandarin, Cantonese, and other) (18%) and Spanish (12%) the most common non-English languages spoken in the City.

Families and Children
Although San Francisco has a relatively small proportion of households with children (19%) compared to the state overall (36%), the number of school-aged children is projected to rise.7

As of 2013, San Francisco was home to 58,000 families with children, 29% of which were headed by single parents. There were approximately 114,000 children under the age of 18. Although the overall number of children under 18 decreased 7% in the last 20 years, the number of school-aged children is projected to rise by 28% by 2020.7

The neighborhoods with the greatest proportion of households with children are: Seacliff, Bayview Hunters Point, Visitacion Valley, Outer Mission, Excelsior, Treasure Island, and Portola.
Criteria for selecting an indicator and developing measurable targets

Before identifying and prioritizing indicators and developing measurable targets, SFHIP developed criteria for indicators based on our core values. These criteria were then applied to health data available for San Francisco residents. The criteria for indicators selection included:

- Clearly align with the priority health need identified
- Have evidence that indicates that data indicator is an attributing factor associated with the priority health need
- Must focus on health equity
- Must be able to be stratified by population groups to assess equity
- Must be available at a minimum on an annual basis
- The data source identified must have a level of stability
- Must communicate and resonate well with the population being addressed
- Aligns to a local, state, or national benchmark (e.g., Healthy People 2020).

Through the process of reviewing multiple sources of data, SFHIP recognized that often data did not meet the criteria discussed. Data were often unavailable at the city level, was not available for specific ethnic groups, or was not available on a regular basis. In order to assess progress towards reducing or eliminating health inequity, SFHIP will document data needs through the creation of a data development agenda.

The indicators that SFHIP has selected can be mapped across the life course of San Francisco residents. The life course perspective is a multidisciplinary approach to understanding the mental, physical and social health of individuals, which incorporates both life span and life stage concepts that determine the health path of an individual or community.

Overarching Goals

Many of the health conditions identified have overlapping pathways which exacerbate the negative health effects of any or all of the conditions. SFHIP developed overarching goals to address and connect all of the health conditions identified through the planning process:

- Foster physical, emotional and mental well-being
- Prevent complex chronic diseases
- Coordinate services and care that are culturally and linguistically appropriate across the continuum

Four strategy approaches for taking action

SFHIP understands that if an action agenda is to be effective, it must consider both the feasibility and potential impact of action steps that steering committee members, backbone staff and partners can take. The most attractive options are ones with both high impact and high feasibility. Options with low impact and low feasibility should be avoided. Tradeoffs need to be considered for options that have a mix of high/low impact and feasibility. Actions that will have modest impact but are very feasible may be attractive as a way to demonstrate ability to move actions forward. Actions that have more challenging feasibility but have great potential impact may be worth trying if a group is willing to take some risk to pursue large potential gains. SFHIP adopted a four strategy framework for how it may approach taking action to improve the health indicators selected:

- **Policy:** Support or advance legal or organizational policies that can address the health needs
- **Partnerships:** Form strategic partnerships with existing collective impact coalitions to advance health priorities
- **Linkages and Networking:** Catalyze networking opportunities and connect organizations to better coordinate efforts to address the identified priorities
- **Initiatives:** Sponsor a new collective impact project in which SFHIP members and partners collectively agree to move the needle on an identified health priority

Throughout this report we highlight quotes from community members about each of the health needs, as well as the key actions SFHIP will take using these four strategic approaches.

The **Community Health Needs Assessment (CHNA)** is a part of our ongoing community health improvement process, and provides data to allow the identification of priority issues affecting health. To identify the most significant health needs in San Francisco, the SFHIP Steering Committee and the SFHIP CHNA Subcommittee identified health needs through a multistep process. First, participants reviewed data and information from the Community Health Status Assessment, the Assessment of Prior Assessments, and the Community Engagement meetings, as well as the health priorities from the 2012 Community Health Improvement Plan. Then, using the Technology of Participation approach to consensus development, participants engaged in small group focused discussions about the data. Finally, participants developed consensus on the health needs. Throughout the process needs were screened using pre-established criteria.
The Institute of Medicine defines access to health care as “the timely use of personal health services to achieve the best possible health outcomes.” Access can be influenced by many factors, such as the availability of providers, location, affordability, hours, and cultural and linguistic appropriateness of health care services. Accessible health care can prevent disease and disability, detect and treat illness, maintain quality of life, and extend life expectancy.

From a population health perspective, regular access to quality health care and primary care services also reduces the number of unnecessary emergency room visits and hospitalizations, which can save public and private dollars that can be reinvested in community services. While access to health care in San Francisco is better than in many other places, significant disparities exist by race, age and income.

Thirteen percent of San Franciscans do not have a usual place to go for medical care, and 41% of adults have not had a routine check-up in the past year.

High rates of preventable hospitalization can be considered indicators of inadequate access to primary care and community-based resources to maintain wellness. While preventable hospitalizations for most health conditions have decreased over time, preventable hospitalizations for diabetes and hypertension have increased. Preventable hospitalizations are significantly higher among Black/African Americans compared to all other ethnicities in San Francisco. Similarly, preventable Emergency Room visits are much higher among adults 18 to 24 year olds. The rate of preventable hospitalizations is higher for adults age 45-64 than the rate for the 64-75 age group, and are higher in the southeastern section of San Francisco, coinciding with areas of low socioeconomic status and lower levels of insurance coverage.

Language barriers and lack of cultural competency of services are serious barriers to receiving quality care. Those with limited English proficiency are more likely to report problems understanding a medical situation, problems with understanding labels, and bad reactions to medications.

Oral health is an important part of the overall health and wellness of children. In 2012, 35% of San Francisco Unified School District (SFUSD) students experienced dental caries (tooth decay) in their primary and permanent teeth by the time they entered kindergarten, resulting in reduced attendance and contributing to poor academic performance. Poor oral health can cause pain, dysfunction, school or work absences, difficulty concentrating, and poor appearance – problems that greatly affect quality of life and ability to interact with others. Children who experience dental decay have an increased risk for a lifetime of dental problems. Poor oral health can cause systemic inflammation, which over time may limit growth and development, as well as increase risk of adverse health outcomes, including hypertension, cardiovascular disease, and cancer.

Tooth decay is the most common chronic disease of childhood in the United States. Despite steady decreases in the incidence of caries in San Francisco over the past 5 years, tooth decay remains a prevalent local health problem. Consistent with nationwide patterns and trends, disparities in oral health persist in San Francisco. In San Francisco, low-income, Asian, Black/African American, and Latino children continue to be two times more likely to experience dental decay than higher-income and White children.

From the community:

“Interpreting for mental health is hard. It makes things more complicated when you have three people in a session.”

“The Arab community is a very diverse community with differing needs…It is important to have infrastructure that understands religion and culture.”

“It’s important to have health professionals who mirror me.”

“Health insurance is complex and breaks up the family. Work changes cause changes in providers and the family is covered and need to go to separate doctors and they need to make it less stressful.”
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local, State or National Benchmark and Target</th>
<th>San Francisco Baseline (e.g., rate, %) By Disparities</th>
<th>SFHIP TARGETS 2018</th>
<th>SFHIP TARGETS 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent of Public School kindergarteners who have not experienced dental caries</strong> Source: SFDPH-SFUSD-SFDS Kindergarten Oral Health Screening Program, 2016</td>
<td>Healthy People 2020 Benchmark: 33.3%</td>
<td>Asian/PI: 46.5% African American: 40.3% Latino: 36.9%</td>
<td>SF: 39.4%</td>
<td>Asian/PI: 38%</td>
</tr>
<tr>
<td></td>
<td>Healthy People 2020 Target: 30%</td>
<td></td>
<td></td>
<td>African American: 36% Latino: 33%</td>
</tr>
<tr>
<td><strong>Rate of preventable hospitalization due to ambulatory care sensitive conditions</strong> Rates per 100,000 (aged 18 and over) Source: OSHPD (Chronic Composite-PQI 92), 2011-13*</td>
<td>California Benchmark: 672.48</td>
<td>African American: 2545 Native Americans**</td>
<td>5% reduction in African American and Native American rates:</td>
<td>10% reduction:</td>
</tr>
<tr>
<td></td>
<td>SF: 580.59</td>
<td></td>
<td>African American: 2418</td>
<td>African American: 2291</td>
</tr>
</tbody>
</table>

*Prevention Quality Indicators (PQI) composite of chronic conditions per 100,000 population, ages 18 years and older includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.

**Although Native Americans comprise .2% of the San Francisco population, there are a significant number of preventable hospitalizations amongst Native Americans.

**Explaining the Terms**

**Caries experience** refers to any current or past experience of having a decayed, pulled or filled tooth due to tooth decay or cavities.

**Preventable hospitalization** is a hospital admission that might have been averted by appropriate, timely care in community-based settings. For this indicator, SFHIP is focusing on chronic health conditions. The term chronic is often used when the course of the disease lasts for more than three months. Common chronic diseases include conditions such as asthma, heart disease, and diabetes.

**Disparity** means that one group is experiencing a health condition at a significantly higher or lower rate than the overall population.

**Rates** are key to understanding the health, morbidity (illness), and mortality (death) of populations. Rate helps define the frequency at which a circumstance occurs per unit of time, population, or other standard of time. Plain numbers of events, such as the number of hospital admissions have very little meaning in themselves, lacking a context in which they can be understood. Calculating rates supplies such a context, by transforming the data in terms of the population at risk and the time period relevant.
A lack of physical activity and poor nutrition contributes to at least 5 of the top 10 causes of death in San Francisco--heart failure, stroke, hypertension, colon cancer, Alzheimer’s, and other dementias--as well as to the 11th top cause of death, diabetes.

Eating healthy requires that people have enough money to purchase food on a regular basis. Yet many of our residents do not have enough money to sustain healthy eating practices. In 2014-15 in San Francisco, 37% of adults living below 200% of the federal poverty level were food insecure, meaning they are not able to afford enough food at some time during the year. In San Francisco, 29% of the population live with incomes below 200% of the federal poverty level. In addition to income, other factors influence healthy eating including: food availability, transportation, time, availability of facilities to store and cook foods, and food preferences. Factors vary across the city and result in neighborhood differences in consumption. Locations to purchase healthy foods are not evenly distributed across the city. While some neighborhoods, including Chinatown, have a dense array of food options, others, especially Oceanview, Merced, Ingleside, Bayview Hunters Point, Visitation Valley, and Treasure Island have less access to healthy food outlets.

In San Francisco, residents can call 211 to access information about resources they need. The 211 line tracks the primary and secondary reason residents call. In 2014, the primary reason for 50% of the calls to 211 was that residents needed food. 35% of the secondary reasons for calling was also related to food access.

Populations that are at high risk for food insecurity include low income pregnant women and seniors. In San Francisco, 24% of pregnant women on Medi-Cal report that they do not have enough money to purchase food. The concern is especially prevalent among Latina and African American women. Food insecurity has significant negative health outcomes, and during pregnancy may increase risk of pregnancy complications, including gestational diabetes, and in some cases, preterm birth.

The population in San Francisco is aging, which has implications for the provision of health and social services. Additionally, seniors in San Francisco are more likely to be low-income than the overall population. Nutrition programs are essential to achieving the goal of supporting seniors with living independently and remaining healthy in the community for as long as possible. Data from San Francisco shows that a growing number of vulnerable and isolated seniors are experiencing long wait times to access home delivered meals. In 2013, the city adopted a goal that the wait time for seniors to begin receiving home delivered meals after enrolling in the meal program for low income elders would be no more than 30 days. However, as of December 2015, the average wait time for a senior to receive a home delivered meal was 41 days.

In addition to proper nutrition, physical activity promotes health. Studies have shown that just 2.5 hours of moderate intensity physical activity, defined by the Centers for Disease Control and Prevention (CDC) as any activity that expends 3.5 to 7 calories per minute each week, is associated with a gain of approximately three years of life. Residents who live in a low-income, high crime neighborhood have fewer community parks, fewer safe open spaces, and fewer safe bike paths or sidewalks, which can prevent children from being physically active. Aerobic fitness is one of the most important components of overall fitness. Students in San Francisco Unified School District are tested on a variety of physical fitness areas during the fifth, seventh and ninth grades. Data from SFUSD shows racial and ethnic inequities in the proportion of children who meet Healthy Fitness Zone standards, which represent the levels of fitness that offer some degree of protection against diseases that can result from sedentary living. For example, during the seventh grade, overall, 67.6% of SFUSD students are aerobically fit, while 81.8% of Asian and 75.4% of White students are aerobically fit. However, only 42.2% of Black/African American, 51.2% of Hispanic, 43.8% of Native Hawaiian or Pacific Islander, and 35.7% of American Indian or Alaska Native 7th grade students are aerobically fit.

In San Francisco, residents can call 211 to access information about resources they need. The 211 line tracks the primary and secondary reason residents call. In 2014, the primary reason for 50% of the calls to 211 was that residents needed food. 35% of the secondary reasons for calling was also related to food access.
Healthy Eating & Physical Activity

The home delivered meal program targets frail, homebound or isolated seniors at high risk for malnutrition. This program is managed by the San Francisco Department of Aging and Adult Services and funded through federal, state and local public funds, as well as private funds raised by CBOs who are contracted as vendors for the program. This program supports well-being and can help seniors maintain independence and continue living in the community. In addition to nutrition, the meal delivery program also serves as a daily wellness check and opportunity for face-to-face contact and social engagement. Home delivered meals also support seniors as they transition from hospitals and more acute settings back to their homes. To receive meals, seniors are asked questions to determine the level of their need, and they are placed on a wait list to receive meals. As the senior population in San Francisco grows, the need for this program will continue to increase.

### Table 2. Priority Indicators for Healthy Eating and Physical Activity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local, State or National Benchmark and Target</th>
<th>San Francisco Baseline (e.g., rate, %)</th>
<th>SFHIP TARGETS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors (60+) waiting more than 30 days to get home delivered meals / average wait time</td>
<td>San Francisco Target: 30 days</td>
<td>SF: 41 days</td>
<td>SFHIP TARGETS 2018 2020: 90% of seniors will be served within 30 days (with emphasis on burdened populations) + Reduce wait time to 14 days</td>
</tr>
</tbody>
</table>

Source: SF Department of Aging and Adult Services Q2, 2015-16

| Percent of pregnant women who are food insecure                        | California Benchmark (2012): 18.6%            | SF: 8.1%                              | SFHIP TARGETS 2018 2020: 0% of pregnant women on Medi-Cal + 12% of pregnant women on Medi-Cal |

Source: Maternal Infant Health Assessment, 2010-11

*Note: the sample size for African American women reporting on food insecurity was too small to be included. However, due to other data – including high poverty (57.4% of African American pregnant women were below 100% poverty) and high use of Medi-Cal (67% of maternal post-partum care), African American women are also a focus for this indicator.

### Explaining the Terms

**Food insecure** means a person is unable to consistently access or afford adequate food.

**Medi-Cal** refers to California Medical Assistance Program, a program that provides health care coverage for individuals with low incomes (below 138% of poverty).

**Aerobic Capacity** is a term used to describe cardiovascular fitness. It is measured using three fitness tests. The tests evaluate the maximum rate that the body can take in, transport, and use oxygen during exercise. The fitness tests are part of the annual FitnessGram®, which is a set of standard tests administered to all 5th, 7th, and 9th graders in San Francisco Unified School District. Students’ scores on these tests are classified into three categories to help identify fitness and health risks. The three categories are: 1. Healthy Fitness Zone (meaning that the student is at a level of fitness for good health), 2. Needs Improvement (student might have a health risk in the future), 3. Health Risk (student has clear potential for future health risks). The goal is to increase the percentage of 7th and 9th graders who are at the Health Fitness Zone.
## Table 3. Priority Indicators for Healthy Eating and Physical Activity

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local, State or National Benchmark and Target</th>
<th>San Francisco Baseline (by Grade Level)</th>
<th>By Disparities</th>
<th>SFHIP Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>5th</strong></td>
<td>7th</td>
<td>9th</td>
</tr>
<tr>
<td>Percent of 7th and 9th grade school students who meet the Healthy Fitness Zone for Aerobic Capacity</td>
<td>California Benchmark: 7th grade: 65.4% 9th grade: 63.8%</td>
<td>69.4%</td>
<td>67.6%</td>
<td>65.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66.7%</td>
<td>61.6%</td>
<td>51.2%</td>
</tr>
</tbody>
</table>

**Data not available at time of publication.**
Behavioral Health is a term used to address mental health and wellness, and the spectrum of substance use disorders.

Risk factors for mental health disorders include both individual level (e.g., genetics, stress, trauma) and environmental (e.g., social, cultural, economic) factors. Mental illness is higher among certain groups, such as the homeless, the incarcerated, and those leaving the child welfare system. Being subjected to racial, ethnic, and cultural discrimination is also a significant risk factor for mental disorder.

Addressing high rates of psychological distress requires a culturally sensitive approach. Ethnic groups show differences that are complex and may represent stigma, lack of availability of culturally competent services, or other barriers preventing access to needed preventative and treatment services. Asian and Pacific Islander residents report needing help less often and are less often hospitalized for depression, but have the second highest rate of suicide. Rates of hospitalizations for major depression in San Francisco between 2012 and 2014 were highest among Black/African Americans and Whites. Between 2006 and 2014, hospitalizations due to major depression increased significantly among young adults 18 to 24 years old. Residents of the zip codes 94102 and 94103, which include the Tenderloin and South of Market neighborhoods, also experience some of the highest disparities in hospitalizations for major depression.

Serious psychological distress is reported by 9% of adults and some groups experience even greater frequency.

"From the community:

“A lot more of a population that need mental health that aren't visually crazy – I have anxiety and temper issues, that's all mental, causes problems in my daily life, little stuff that causes big stress.”

“Issue connected to mental health is not easy to talk about or how to get help that is culturally and linguistically appropriate you don’t know how to get access.”

“STRESS: you have work, care for children, tending to your husband, you have lots of things you have to take care of.”

“Lack of time, always work or school or both, money, drug addicts, alcoholics on the street, especially with grandson, it is not a good environment for them especially right now very dangerous there are shootings at night time.”
In San Francisco, 55% of chronically homeless individuals acknowledge having a psychological or emotional condition. Poor mental health is related to greater participation in risky health behaviors (e.g., smoking, low physical activity, insufficient sleep, excessive drinking) which can also lead to chronic disease.

Substance abuse has serious consequences in San Francisco. The number of hospitalizations due to acute and chronic alcohol abuse is greater than for diabetes, hypertension, or COPD. 18% of homeless persons report drug and alcohol abuse as the primary cause of their homelessness. Among homeless persons living in San Francisco, 62% are experiencing a chronic drug or alcohol abuse condition. Black/African American, Latino and White residents visit the emergency room due to alcohol abuse at higher rates than Asians. Neighborhoods with the highest density of off-sale alcohol outlets coincide with those with higher rates of hospitalizations and emergency room visits due to alcohol.

A life-course approach is increasingly used to better understand population health and wellbeing. In a recent study of homeless adults, poor mental health was associated with trauma in childhood. Child maltreatment comprises both child abuse, including physical, sexual and emotional abuse, and child neglect, which includes not providing adequate food, shelter, medical care or supervision. Children whose parents are experiencing substance abuse and/or mental illness, major stresses, such as poverty, domestic violence, or living in poor or unsafe neighborhoods, are more likely to experience maltreatment.

In 2015, there were 6.2 substantiated maltreatment incidences per 1,000 children in San Francisco. African American children had the highest rates of child maltreatment of all race/ethnic groups, followed by Native American and Latino children. Children under age 1 also experienced higher rates of maltreatment at 13.6 cases per 1,000 children. Statewide, child abuse and neglect cases occur among children of color, especially African American/Black and American Indian/Alaska Native children at a higher rate than White and Asian children.
## Table 4. Priority Indicators for Behavioral Health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Local, State or National Benchmark and Target</th>
<th>San Francisco Benchmark (e.g., rate, %) By Disparities</th>
<th>SFHIP TARGETS</th>
<th>2018</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rate of adult hospitalization for major depression</strong> Rate per 10,000 (age adjusted hospitalization rates due to major depression in adults aged 18 and over)</td>
<td>California Benchmark: 9.5</td>
<td>Race/ethnicity: African American: 14.23 Place: 94102: 16.61 94103: 14.61</td>
<td>SFHIP TARGETS</td>
<td>Reduce by 5% rates for groups* &gt;100% of SF baseline rates</td>
<td>Reduce by 10% rates for groups* &gt;100% of SF baseline rates</td>
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<td><strong>Rate of ER visits due to alcohol abuse</strong> Rate per 10,000 patients (emergency room visit rate due to acute or chronic alcohol abuse in adults 18 and over)</td>
<td>California Benchmark: 8.84</td>
<td>Race/ethnicity: African American: 24.04 Place: 94102: 70.63 94103: 60.26 94019: 25.66 94110: 26.11 94124: 20.2 Age 45-64: 37.48</td>
<td>SFHIP TARGETS</td>
<td>Reduce by 5% of SF Rate in target areas</td>
<td>Reduce by 10% of SF Rate in target areas</td>
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<td><strong>Rate of children experiencing child maltreatment</strong> Substantiated incidences per 1,000 children</td>
<td>Let’s Get Healthy California 2022 Target: 3</td>
<td>African American: 36.1 Native American: 11.0 Latino: 10.2 Children under 1 year old: 13.6</td>
<td>SFHIP TARGETS</td>
<td>Reduce by 10% rates for groups** &gt;100% of SF baseline rates</td>
<td>Reduce by 20% rates for groups** &gt;100% of SF baseline rates</td>
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*African American or 94102/94103**

**Race/ethnicity/age

### Explaining the Terms

The National Institute of Mental Health defines **depression** as a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks. Hospitalization due to major depression may be able to be prevented given appropriate care in the community-based setting.

**Substance use disorders** (formerly called alcohol abuse) occurs when the repeated use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Emergency room visits due alcohol use disorders might have been prevented given appropriate care and services in a community-based setting.

**Child maltreatment** is a term used to describe child abuse and neglect. It is the act or failure to act by a parent, caregiver, or other person defined by state law that results in physical abuse, neglect, medical neglect, sexual abuse, emotional abuse, or presents an imminent risk of harm to the child. Neglect means failing to provide: food, clothing, adequate supervision, protection from known dangers, safe/hygenic shelter, education, medical care, and nurturing/affection. When looking at this indicator, it is critical to stress that children are never to be blamed and that there are multiple, economic, social and community factors that may increase the risk of child maltreatment. This also includes the relationship and characteristics of a parent or a person who may be a caregiver to the child.
Next Steps

The Strategic Priorities are just one part of our journey to developing an overall action plan for the SFHIP collaborative.

SFHIP understands that if an action agenda is to be successful, it must consider both the likelihood that steering committee members, backbone staff and partners can take potential actions and that the actions will have a possible impact on the health indicators identified.

Below are highlights on how we will use the four strategy approach to developing an action plan for working on the health indicators selected:

POLICY: SFHIP will work with community partners and stakeholders to identify, support, and advance polices that can improve the health needs identified in the 2016-2017 Strategic Priorities report. For example alcohol has had a huge negative impact on particular populations in San Francisco. In order to address this issue, SFHIP took a policy position to support a new state law that would stop powdered alcohol from being sold in California. This policy strategy is ongoing as opportunities to improve polices happen on a continuous basis.

PARTNERSHIPS: Throughout the development of the 2016-2017 Strategic Priorities, we identified existing collective impact coalitions in San Francisco. A core principal of collective impact is not to start “new initiatives” if one already exist. The goal is to align and help coordinate these activities. Beginning in the winter of 2016, SFHIP will meet with each of the initiatives to discuss barriers, gaps or additional resources the coalitions may need to improve the health indicators. During these working sessions, SFHIP will identify action steps that aim at supporting the current collective impact coalitions.

LINKAGES AND NETWORKING: Linkages and networking is different from identifying existing partnerships and coalitions. The goal is to identify networking opportunities and help bridge community residents and organizations to better coordinate efforts to address the identified priorities. The strategy also aligns with our core values of community engagement. The strategy is also ongoing because SFHIP believes that engagement is not an isolated activity, and community partnership must continually be nurtured and developed.

INITIATIVES: SFHIP identified health “initiatives,” indicators that do not have specific “initiatives” but reflect a health need that may be addressed by many organizations and city and county agencies. For these health needs, SFHIP will meet with partners to address how we can apply a collective impact model.

The next steps are to develop annual work plans with key objectives, actions steps, and a timeline to achieve our goals.

From the community:
What actions can we take as residents, community groups, and SFHIP to improve health in the community?

“Culturally and linguistically appropriate services”
“Build accessible housing”
“Attract community involvement”
“Improved accessibility for Native Americans”
“Simplify and make healthcare affordable”
“Quality coordination of services”
“More resources in the schools”
“Increase personal connection (with non-healthcare providers)”
“Access to quality healthcare”
“Enhance dignity and quality of life”
“Access to food that is healthier”
San Francisco Health Improvement Partnership Steering Committee
(listed alphabetically by last name)

Tomás J. Aragón
San Francisco Department of Public Health

Estela Garcia (Co-Chair)
Chicano/ Latino/ Indigena Health Equity Coalition

Shalini Iyer
Metta Fund

Amor Santiago
Asian and Pacific Islander Health Parity Coalition

Aneeka Chaudhry
San Francisco Mayor’s Office

Kevin Grumbach
Clinical and Translational Science Institute’s Community Engagement and Health Policy Program, UCSF

Deena Lahn
San Francisco Community Clinic Consortium

Kim Shine
Human Service Network

Saeeda Hafiz
San Francisco Unified School District

Perry Lang
African American Community Health Equity Council

Cecilia Thomas
Sutter Health California Pacific Medical Center

Stuart Fong
Chinese Hospital

Barry Lawlor
St. Mary’s Medical Center

Abbie Yant (Co-Chair)
Saint Francis Memorial Hospital

SFHIP Alternates and Former Members

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Colleen Chawla, SFDPH

Kim Coates, San Francisco Unified School District

Catherine Collen, Metta Fund

Lani Kent, SF Mayor’s Office

Jennifer Lacson, St. Francis Memorial Hospital

Perry Lang, African-American Health Equity Council

Debbie Lerman, Human Service Network

Saeeda Hafiz, SFUSD

Scott Hauge, CAL Insurance and Associates, Inc.

Monique LeSarre, African American Community Health Equity Coalition

Esperenza Macias, Chicano/ Latino/ Indigena Health Equity Coalition

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Community Engagement Partners

Advancing Justice of the Asian Law Caucus

Asociación Mayab

Asian Pacific Islander Health Parity Coalition

Black/African American Mother’s Group in Western Addition

CARECEN

Filipino American Development Foundation

Instituto Familiar de la Raza

Larkin Street Youth

LGBT Center

Native American Health Center

On Lok 30th Street Senior Center

Swords to Plowshares

Transitions Clinic
2016-2017 Strategic Priorities

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San Francisco Health Improvement Partnership
Strategic Priorities 2016-2017

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